Performance and Accountability Report

Fiscal Year 2002

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Section I - Management Discussion and Analysis

MESSAGE FROM THE SECRETARY

For the U.S. Department of Health and Human Services (HHS), just as for the entire Nation, 2002 was a year of transformation. It was a year that began with unprecedented challenges – and ended with a strong record of response, consolidation and building for the future. It was a year when new dangers threatened us, but also a year when we rose to confront those threats and prepared ourselves for a changed world. At the same time, it was a year when we took new steps against our oldest adversaries – disease, poverty, and constricted opportunity.

In 2002, we built new foundations: to protect against terrorism; to advance biomedical science into uncharted realms; to make HHS a more effective instrument on behalf of Americans; and in every HHS activity, to help unleash the power of the individual - from those needing help toward self-sufficiency, to those needing to embrace the power of disease prevention in their own lives.

In these and many other ways, 2002 was indeed a year of new beginnings for our Department. It was likewise a year of progress for the on-going activities in the more than 300 programs administered by HHS agencies. This report presents a Department-wide picture of our performance in FY 2002. It reflects the efforts of some 65,000 dedicated HHS employees in all parts of the United States and around the world. These employees – working with states, counties and cities, and with our thousands of other partners – have delivered service and value to the American people.

For fiscal year 2002, HHS was accountable for more than $466 billion in net outlays. In the area of financial management, we achieved our fourth consecutive unqualified, or “clean” audit opinion on the Department’s consolidated financial statements. However, we face significant ongoing challenges to improve the timeliness and reliability of our financial information for decision-making purposes, resolve issues identified by our auditors, and reduce the level of manual intervention needed to prepare financial reports and statements. In response to these challenges, we are developing a Unified Financial Management System (UFMS), a multi-year financial management effort. The new system will not only provide more timely financial information to our managers for decision-making, but will also enable us to meet more frequent and accelerated reporting deadlines now required for Departmental financial statements.

This report also presents the financial health of Medicare’s Hospital Insurance and Supplementary Medical Insurance Trust Funds separately, based on Financial Accounting Standards Advisory Board (FASAB) standards in effect at the time of the audit. Going forward, the Administration is developing a more comprehensive measure of Medicare’s financial position that will analyze Medicare as a whole.

As required by the Reports Consolidation Act of 2000, it is my assertion that the financial information contained in this report is complete and reliable, based upon data contained in the Department's and contractors' financial information systems, and is reported in conformance with U.S. generally accepted accounting principles. Further, it has been deemed to "fairly represent" the financial condition and results of operations of the Department by our Office of Inspector General. Regarding program performance information, the FY 2002 Annual Performance Report for each HHS component describes the methodology HHS components use to verify and validate program performance data and any related data issues, including the completeness and reliability of the data. Where required, the components have included discussions of any actions planned to improve the completeness and reliability of data.

This report includes information that satisfies the reporting requirements for the Federal Managers' Financial Integrity Act (FMFIA) of 1982. HHS' management controls are in compliance with FMFIA and provide reasonable assurance that the Department's resources are protected from fraud, abuse, and mismanagement, except for the specific management control material weakness cited in this report that is being addressed in accordance with its corrective action plan. Our financial management information systems and reporting processes, as well as our Medicare contractor systems, are not in conformance with FMFIA. Our systems implementation projects discussed in this report - including a new Medicare financial system - provide for long term achievement of compliance with FMFIA. In Appendix C of this report, we present the complete FMFIA report.

HHS is one of the largest departments in the Federal government. We are responsible for almost a quarter of all federal spending, and our programs touch the lives of every American in many ways. We have a special responsibility to be accountable for the funds we manage and for achieving results. We have established long-term strategic goals to help steer our efforts on behalf of Americans. The report is structured in accordance with our strategic goals which will allow our readers to more clearly track our performance.

I welcome your interest in HHS and its programs. On behalf of every HHS employee, I pledge our continued vigilance and dedication to the compassionate goals of this Department.

Tommy G. Thompson

Mission and Organization

Introduction

This is the seventh annual accountability report for the U.S. Department of Health and Human Services (HHS), and the first to include the Department's official performance report. In this report to our "stockholders," the American public, we account for the return on the taxpayers' investment. We also provide this information for the wide array of decision-makers, including the Office of Management and Budget (OMB) and the Congress, who are interested in our performance.

The *HHS FY 2002 Performance and Accountability Report* is produced under the Reports Consolidation Act (RCA) of 2000. Prior to this act, it was developed under the auspices of the Government Management Reform Act (GMRA) of 1994.

This report covers the period of October 1, 2001 through September 30, 2002, Fiscal Year (FY) 2002, and contains a high level overview of

- The Department's purposes and programs;
- The nature of resources entrusted to HHS; and
- HHS' management of and accountability for those resources.

The report contains a discussion of key program, management, financial, and performance information (Sections I and II). The report also includes the Department's FY 2002 financial statements that discuss our financial condition (Section III) and includes the auditors' opinion, which is an independent, objective assessment that provides reasonable assurance about whether the financial statements are free from material misstatements (Section IV). Also this comprehensive report contains other streamlined reports required under various statutes that demonstrate accountability for our management, financial, and program performance (Section V).

By synthesizing all of this information into a single report, we provide a more complete, accurate, and useful understanding of the Department. Most of our components are also issuing similar reports, which provide detailed program and financial information.

Mission and Strategic Goals

Healthy and productive individuals, families, and communities are the very foundation of the Nation's security and prosperity. Through its leadership, HHS impacts virtually all Americans and people around the world, whether through direct services, the benefits of advances in science, or information that helps them to live better and to make healthy choices.

In a society that is diverse in culture, language, and ethnicity, HHS also manages an array of programs that aim to close the gaps and eliminate disparities in health status and access to health services that increase opportunities for disadvantaged individuals to work and lead productive lives.

HHS' Mission:

"To enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services."

Secretary Thompson has identified a number of high priority goals needing urgent attention, including preparedness for terrorism incidents, emphasis on healthy choices and disease prevention activities for Americans, and continued progress in helping all Americans become self-sufficient. He has also aimed at increased cooperation between HHS and its partners and stakeholders; encouraged states to be more innovative; and pushed for reform of unnecessarily burdensome HHS regulations. To carry out its mission, HHS articulates these priorities in its draft FY 2003-2008 strategic plan through eight strategic goals. In Section II and the GPRA summary presentation later in this section, we have aligned our performance measures with these revised goals in anticipation of their implementation.

HHS' Strategic Goals:

- Reduce the Major Threats to the Health and Well-being of Americans;
- Enhance the Ability of the Nation's Health Care System to Effectively Respond to Bioterrorism and Other Public Health Challenges;
- Increase the Percentage of the Nation's Children and Adults Who Have Access to Health Care Services, and Expand Consumer Choices;
- Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise;
- Improve the Quality of Health Care Services;
- Improve the Economic and Social Well-being of Individuals, Families, and Communities, Especially Those Most In Need;
- Improve Stability and Healthy Development of our Nation's Children and Youth; and
- Achieve Excellence in Management Practices.

Scope of Services

Through managing more than 300 programs, HHS works toward accomplishing these goals that cut across individual HHS components and programs. For example, HHS works directly and with its partners to:

- Conduct and sponsor medical and social science research to improve Americans' health and well-being;
- Guard against the outbreak of infectious diseases through immunization services and the elimination of environmental health hazards near people's homes and work places;
- Assure the safety of food and drugs;

- Provide health insurance for elderly and disabled Americans, low-income people, and children;
- Promote the availability of home and community based services;
- Provide financial assistance and employment support services for low-income families;
- Facilitate child support enforcement;
- Improve maternal and infant health;
- Improve preschool development and learning readiness;
- Prevent child abuse and domestic violence;
- Prevent and treat substance abuse;
- Provide mental health services; and
- Provide services for older Americans.

One HHS

The over-arching central direction of the Department is to function as a single entity, as "One HHS". To ensure that HHS is "One Department" rather than a collection of disparate and unrelated agencies, we have taken a number of actions, and are planning more. We are reforming the management of the Department and improving the programs that our Department runs. Over the next few years we will be increasingly collaborating and coordinating significant activities among HHS agencies, such as work on HIV/AIDS, Medicare, Medicaid, delivery of health care services to children and families, privacy and confidentiality policies, and research on the effectiveness of HHS programs.

For the first time ever, the HHS Strategic Plan contains a Management Improvement Goal, including strategies to reduce the number of personnel offices; modernize and improve human, financial, and technological management at HHS; and reform regulations to reduce excessive paperwork and burden to doctors and hospitals. To provide accountability, as well as feedback and tracking of how we are doing, we are instituting performance contracts (tied to the strategic goals and objectives) for the Department's senior leadership which will cascade throughout the Department. This performance contract will institute explicit standards against which HHS officials' work will be measured.

HHS Partners: Working Together

The achievement of HHS' mission and goals, the success of HHS' programs, and the ability of HHS to meet the needs of clients are directly tied to the commitment, cooperation, and success generated by our employees and those of other federal agencies, state and local governments, tribal organizations, community-based organizations, faith-based organizations and others.

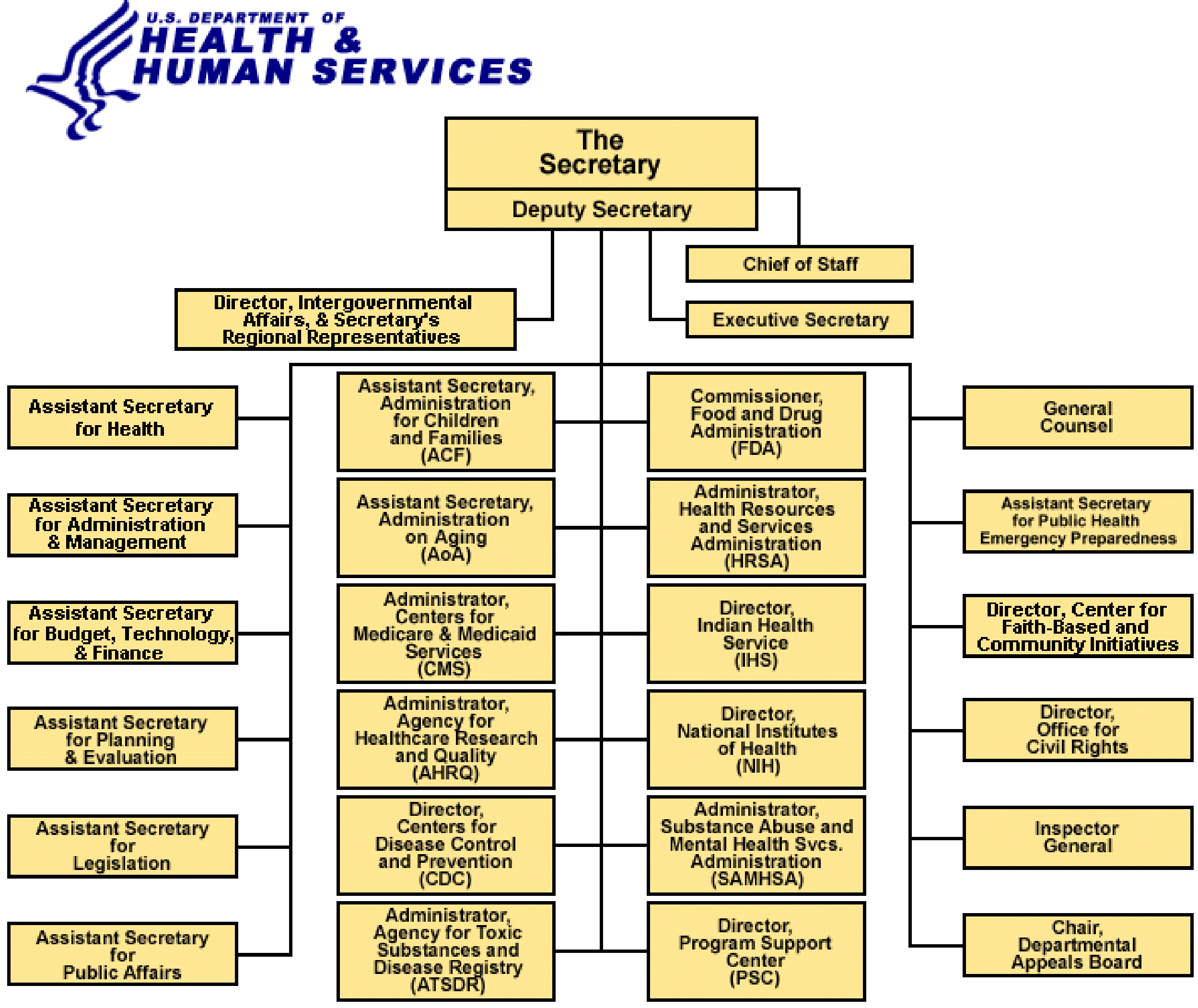
HHS provides direct services for the underserved populations of America, including American Indians and Alaska Natives. However, for many programs, HHS' partners provide direct services and have much discretion in how the programs are implemented. In those cases, HHS contributes to accomplishing the program goals through funding, technical assistance, information dissemination, education, training, research, and demonstration projects.

Often the needs of individuals and families go beyond individual HHS programs. Frequently, programs are only focused on one particular need of a recipient because of the specific authority and funding for the program. However, to meet all the needs of a person, an integrated and comprehensive approach must be crafted with other HHS programs, other federal agencies, and HHS' partners. HHS therefore works internally and with its many, diverse partners to plan and deliver services in a coordinated way that maximizes resources and provides an integrated approach to clients' needs.

For example:

- HHS is the largest grant-making agency in the Federal government – providing more than $200 billion, including funds for the Medicaid and Temporary Assistance for Needy Families (TANF) programs, of the total estimated $360 billion in federal funds awarded to states and other entities in FY 2002;
- HHS funds more than 50,000 research investigators affiliated with about 2,000 university, hospital, and other research facilities;
- HHS helps fund and foster a nationwide network of more than 3,500 sites that provide needed primary and preventive care to 12.5 million medically underserved patients last year;
- HHS partners with the Aging Network, which includes 56 state units on aging, 655 area agencies on aging, 241 tribal and native organizations representing more than 300 American Indian and Alaska Native tribal organizations, and two organizations serving Native Hawaiians, plus more than 29,000 service providers and innumerable caregivers and volunteers;
- Networks of state and private agencies provide substance abuse and mental health services;
- Medicare contractors process over 1 billion fee-for-service claims, answer 40 million inquiries, process nearly 8 million appeals, enroll and educate providers, and assist beneficiaries;
- Approximately 18,700 centers and 49,800 classrooms help to provide comprehensive development services with HHS support under the Head Start program for more than 915,000 low-income pre-school children, ages birth to five, including approximately 62,000 children under the age of three served through Early Head Start; and
- More than 45,000 health care providers are enrolled in the Vaccines for Children Program, furnishing free vaccines to more than one-third of our Nation's children.

HHS' Organization: Structured to Accomplish our Mission



HHS is made up of Operating Divisions (OPDIVs), and led by the Office of the Secretary (OS). The Program Support Center (PSC), which is part of OS, provides administrative support to the Department and other federal agencies. The PSC is a self-supporting component of HHS. It provides competitive services on a fee-for-service basis, through HHS' Service and Supply revolving fund, in three key areas: financial management, human resources, and administrative operations. PSC provides these services to HHS and approximately 30 other federal agencies.

PSC is located in Rockville, MD. PSC was established in 1995 as a business enterprise from various administrative support units of HHS. In 2001, the PSC became part of the OS. Because of its nature as a service provider, it continues to be audited as a financial reporting entity.

HHS' Operating Divisions are:

- Administration for Children and Families (ACF);
- Administration on Aging (AoA);
- Agency for Healthcare Research and Quality (AHRQ);
- Agency for Toxic Substances and Disease Registry (ATSDR);
- Centers for Disease Control and Prevention (CDC);
- Centers for Medicare & Medicaid Services (CMS);
- Food and Drug Administration (FDA);
- Health Resources and Services Administration (HRSA);
- Indian Health Service (IHS);
- National Institutes of Health (NIH); and
- Substance Abuse and Mental Health Services Administration (SAMHSA)

Eight staff divisions, seven of which are headed by an Assistant Secretary, report to the HHS Secretary. The Assistant Secretary for Budget, Technology, and Finance (ASBTF), is responsible for producing this report. HHS also actively coordinates, in ten regions throughout the United States, the crosscutting and complementary efforts that are needed to accomplish our mission. HHS Headquarters is located at 200 Independence Avenue, SW, Washington, DC, 20201. The Offices of Inspector General (OIG), Intergovernmental Affairs, Office for Civil Rights, Center for Faith-Based and Community Initiatives, and Departmental Appeals Board also support this mission across the Department.

Administration for Children and Families (ACF)
ACF was established in 1991, bringing together several pre-existing programs. ACF is responsible for approximately 60 programs that promote the economic and social well-being of families, children, individuals, and communities. Major programs that ACF administers include Temporary Assistance to Needy Families (TANF), Child Support Enforcement, and Head Start for preschool children.

ACF provides funds to assist low-income families in paying for childcare, preventing child abuse and domestic violence, and supports state programs to provide for foster care and adoption assistance. ACF is organized into eight program offices and five staff offices that operate in Washington, DC and ten regional offices.

Administration on Aging (AoA)
AoA is the federal focal point for aging programs and services. Through policy and program development, planning, and service delivery, AoA seeks to address the needs and concerns of

older people and their families and those persons in need. AoA funds are leveraged through a nationwide service infrastructure to deliver comprehensive in-home and community services, including meals for older individuals. AoA funds also make legal services, counseling and ombudsmen programs available to elderly Americans.

AoA was established in 1965. AoA accomplishes its mission in collaboration with its partners – state and area agencies on aging, Tribal organizations, and the providers of services that comprise the aging network. AoA headquarters are located in Washington, DC.

Agency for Healthcare Research and Quality (AHRQ)
AHRQ acts as the catalyst for improving the quality, effectiveness, accessibility, and cost of health care as a result of its research and sharing of information. AHRQ conducts and supports the research needed to guide decision-making and improvements in both clinical care and the organization and financing of health care. AHRQ also promotes the incorporation of its and other research-based information into effective choices and treatment in health care by developing tools for public and private decision-makers and by broadly disseminating the results of the research.

AHRQ was established in 1989 and is currently located in Rockville, MD. AHRQ operates six centers as well as its special policy and information offices.

Agency for Toxic Substances and Disease Registry (ATSDR)
ATSDR helps to prevent exposure and adverse human health effects and diminished quality of life associated with exposure to hazardous substances. ATSDR is a unique component of HHS because, prior to FY 2001, it had been funded through the Environmental Protection Agency (EPA) Superfund as an allocation of funds and, therefore, EPA was accountable for the funds. However, beginning in FY 2001, ATSDR is funded through the EPA Superfund through a transfer of the funds and, as a result, HHS is accountable for the funds. ATSDR reports to the Director of CDC because of its complementary functions. Because of this relationship, the CDC financial statements include those from ATSDR.

ATSDR was established in 1980. ATSDR conducts public health assessments, health studies, surveillance activities, and health education training in communities around waste sites on the EPA's National Priorities List. ATSDR also has developed toxicological profiles of hazardous chemicals found at these sites. CDC and ATSDR's headquarters are located in Atlanta, GA.

Centers for Disease Control and Prevention (CDC)
CDC is the "Nation's Prevention Agency"; it is the lead federal agency responsible for promoting health and quality of life by preventing and controlling disease, injury, and disability. CDC helps to save lives and health costs by working with partners throughout the nation and the world to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthy environments, and provide public health leadership and training. CDC also provides immunization services and national health statistics. CDC is well known for its response to disease outbreaks and health crises worldwide.

CDC was established in 1946, as the Communicable Disease Center. CDC's personnel are

stationed in its national headquarters in Atlanta, GA, 18 locations throughout the United States and territories, more than 37 foreign countries and 47 state health departments, and numerous local health agencies.

Centers for Medicare & Medicaid Services (CMS), formerly Health Care Financing Administration

CMS is the largest purchaser of health care in the world. CMS administers the Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). The Medicare, Medicaid, and SCHIP programs provide health care for one in four Americans. The outlays for Medicare, Medicaid, and SCHIP including state funding, represent more than 33 cents of every dollar spent on health care in the United States. Medicare provides health insurance for elderly and disabled Americans. Medicaid, a joint federal-state program, provides health coverage for low-income persons (almost 48 percent of enrollees are children). Medicaid also pays for nursing home coverage for low-income elderly, covering almost half of total national spending for nursing home care. SCHIP, a federal-state program, provides health insurance coverage for children who otherwise would be without coverage.

CMS was established in 1977, incorporating the pre-existing Medicare and Medicaid programs. CMS operates from Baltimore, MD, Washington, DC, and ten regional offices.

Food and Drug Administration (FDA)

The FDA, established in 1927, is a science-based regulatory agency whose mission is to promote and protect the public health and well-being by ensuring that safe and effective products reach the market in a timely way, and to monitor products for continued safety after they are in use. FDA is responsible for overseeing a regulated industry that produces over one trillion dollars worth of products. The average cost of this effort to the taxpayers is about $5.00 per person per year. The products include the vast majority of the nation's food supply; over-the-counter and prescription medications; blood products; vaccines; tissues for transplantation; medical equipment and implantable devices; devices that emit radiation; animal drugs and feed; and cosmetics. FDA operations are headquartered in Rockville, Maryland and are organized into six centers, two offices, and five regions throughout the United States.

To accomplish its mission, FDA is divided into six program areas: foods, drugs, biological products, veterinary medicine, medical devices, and toxicological research. Each program area, except for toxicological research, is responsible for ensuring the safety and, where applicable, the effectiveness of products through their entire life cycle - from initial research through manufacturing, distribution, and consumption. These programs, supported by a national field force of scientific investigators, also monitor the safety of more than seven million import shipments that arrive at our borders each year. The toxicological research program conducts peer-reviewed research that provides the basis for FDA to make sound, science-based regulatory decisions.

Health Resources and Services Administration (HRSA)

HRSA is an important component of the nation's health safety net; HRSA improves the nation's health by assuring equitable access to comprehensive, quality health care. HRSA and its state, local, and other partners work to eliminate barriers to care and eliminate health disparities for

Americans who are underserved, vulnerable, and have special needs. It also works to assure that quality health care professionals and services are available.

HRSA was established in 1982, bringing together several pre-existing programs. Its headquarters are located in Rockville, MD. HRSA works to decrease infant mortality and improve maternal and child health. It provides services to people with Acquired Immune Deficiency Syndrome (AIDS) through the Ryan White Comprehensive AIDS Resources Emergency (Ryan White CARE) Act programs and oversees the organ transplantation and bone marrow donor systems. HRSA also works to build the health care workforce and maintains the National Health Service Corps. HRSA uses a structure of four bureaus and several offices to accomplish its mission.

Indian Health Service (IHS)

The IHS is the principal federal health care provider and health advocate for American Indian people, who experience the lowest life expectancies in the country for both men and women. In partnership with American Indians and Alaska Natives from more than 557 federally recognized tribes, IHS's mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaskan Natives to the highest level. IHS and the Indian tribes serve 1.5 million American Indians and Alaskan Natives through direct delivery of local health services.

IHS was established in 1924 (mission transferred from the Department of Interior in 1955). The IHS funds hospitals, health centers, school health centers, and health stations, which are administered by Indian tribes or IHS itself. There are also 34 health programs operated by urban Indian Health Organizations that provide various services to American Indians and Alaskan Natives living in urban areas of the country. When unavailable from IHS or the Indian tribes, medical services are also purchased from other providers to ensure that needed care is received. IHS headquarters are in Rockville, MD, and its 12 area offices are further divided into service units for reservations or a population concentration.

National Institutes of Health (NIH)

NIH is the world's premier medical research organization supporting research projects nation-wide in diseases such as cancer, Alzheimer's, diabetes, arthritis, heart ailments, and AIDS. The NIH consists of Institutes and Centers that improve the health of all Americans by advancing medical knowledge and sustaining the nation's medical research capacity in disease diagnosis, treatment, and prevention. More than $8 out of every $10 appropriated to NIH flows out to the scientific community at large. NIH's research activities extend from basic research that explores the fundamental workings of biological systems, to studies that examine disease and treatments in clinical settings, to prevention, and to population-based analyses of health status and needs.

NIH was established in 1887, as the Hygienic Laboratory, in Staten Island, NY. To accomplish its mission, NIH provides scientific leadership and establishes research priorities, funds the best research in the scientific community at large, and conducts leading-edge research in NIH laboratories. NIH also disseminates scientific results and information, facilitates the development of health-related products, ensures a continuing supply of well-trained laboratory and clinical investigators, sustains the nation's research facilities, and collaborates with other federal agencies. NIH is located in Bethesda, MD.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA works to strengthen the capacity of the Nation's healthcare system to provide substance abuse prevention, addictions treatment, and mental health services for Americans experiencing or at risk for mental illness, substance abuse disorder, or co-occurring mental and addictive illnesses. SAMHSA provides funding through block grants to states for direct substance abuse and mental health services, including treatment for Americans with serious substance abuse problems, prevention intervention services, and services for adults and children with serious mental illnesses or emotional disturbances.

SAMHSA was established in 1992. (A predecessor agency, the Alcohol, Drug Abuse and Mental Health Administration, was established in 1974.) SAMHSA is organized into three centers (Center for Substance Abuse Prevention, Center for Substance Abuse Treatment, and Center for Mental Health Services) and three offices (Office of the Administrator, Office of Program Services, and Office of Applied Studies). SAMHSA is located in Rockville, MD.

Overview of Program Performance

HHS manages more than 300 programs that aim to improve the health and well-being of Americans, and uses more than 750 annual performance measures to direct program activities and assess progress and achievement. These performance measures, as required by the Government Performance and Results Act (GPRA) of 1993, assess program processes, outputs, outcomes, and results. Due to the volume and complexity of HHS programs and measures, this report discusses the key programs that are well known to the American public, including: Medicare, Medicaid, SCHIP, TANF (welfare reform), Child Care, Child Welfare, Child Support Enforcement, and Head Start, as well as Substance Abuse Prevention and Treatment block grants, Infectious Diseases, and Biomedical and Medical Research. This report also discusses performance relative to several key Secretarial priorities. Many of the programs discussed are interrelated and have multiple purposes; therefore, they may contribute to several goals and objectives. The FY 2002 Department-level performance report is presented in Section II of this report and summarized in the table on the following pages.

The following table highlights some of HHS' performance measures and FY 2002 results as of September 30, 2002, that are provided in greater detail in Section II of this report. However, performance data availability lags do occur, particularly in HHS programs that must rely on third parties for that data. In addition, some data collections are not conducted annually. Therefore, assessment of HHS performance can best be determined by a comparison of annual trends from year to year, as more performance information becomes available. Where FY 2002 data was not available, this report includes activities that exemplify HHS' continuing efforts to achieve program performance goals and targets. HHS used the same data collection systems to report on both Department- and OPDIV-level performance. However, data presented here may differ from that in OPDIV-level reports due to data lag times. OPDIVs may have more recent information than was available when this report was prepared.

This report presents selected performance information for HHS' key programs. OPDIVs also prepare individual performance plans and reports, which are submitted annually to the President and Congress, that collectively address all of the Department's program performance measures in greater detail. For more information on HHS' performance measures, readers are encouraged

to view the OPDIV-level Performance Plans and Reports available though the HHS web-site at: http://www.hhs.gov. Readers should refer to these OPDIV plans and reports, and Section II of this report for additional context and detail regarding the following summarized measures.

FY 2002 Performance Measures from Section II
Reported in OPDIV Audited Financial Reports

Performance Measure	*2002 Target*	*2002 Actual Result or Date Data Available*
Strategic Goal 1: Reduce the Major Threats to the Health and Well-Being of Americans.		
Increase the percentage of diabetes control programs that adopt, promote, and implement guidelines for improving the quality of care for persons with diabetes.	100% of state diabetes control programs.	12/2002 Met target of 100% in FY 2001.
Initiate, expand, or strengthen HIV/AIDS voluntary counseling and testing globally (Measure # countries/regions).	25	09/2003 Target (19) not met in FY 2001 (18).
Increase the percentage of TB patients who complete a course of curative TB treatment within 12 months of initiation (some patients require more than 12 months).	88%	Mid-2005 Target (85%) not met in FY 1999 (79.9%).
Strategic Goal 2: Enhance the Ability of the Nation's Public Health System to Effectively Respond to Bioterrorism and Other Public Health Challenges.		
Maintain a national pharmaceutical stockpile for deployment in response to terrorist use of biological or chemical agents against U.S. civilian population.	Maintain a pharmaceutical stockpile as required by FY 2002 HHS Bioterrorism Strategic Plan.	Exceeded.
Inspect at least 95% of high-risk domestic food establishments once every year.	95%	Not available. Did not meet FY 2001 target to inspect 90% of establishments. Inspected approximately 80% of 6,800 establishments.

Performance Measure	*2002 Target*	*2002 Actual Result or Date Data Available*
Perform 48,000 physical exams and conduct sample analyses on products with suspect histories.	Hire 300 new investigators and analysts who will increase the number of physical exams by 97% to 24,000 exams and conduct sample analyses on products with suspect histories.	Not available. No target in FY 2001
Strategic Goal 3: Increase the Percentage of the Nation's Children and Adults Who Have Access to Health Care, and Expand Consumer Choices.		
Improve satisfaction of Medicare beneficiaries with the health care services they receive (Managed Care).	Collect (& share) data.	Data collected; goal met.
Improve satisfaction of Medicare beneficiaries with the health care services they receive (fee-for-service).	Collect (& share) data.	Data collected; goal met.
Increase annual influenza (flu) and lifetime pneumococcal vaccination - FLU.	72%	12/2003
Increase annual influenza (flu) and lifetime pneumococcal vaccination ― PNEUMOCOCCAL.	66%	12/2003
Increase biennial mammography rates (National Claims History File–New Data Source).	52%	08/2003 Exceeded (51.6%) FY 2001 target (51%).
Improve beneficiary understanding of basic features of the Medicare program (developmental).	Baselines /future targets to be developed.	Data being analyzed. Baselines/target data will be available by the end of CY 2002.

Performance Measure	*2002 Target*	*2002 Actual Result or Date Data Available*
Increase the percentage of Medicaid 2-year old children who are fully immunized: Group I States..	Staggered development of state-specific baselines and targets.	FY 2002, 5 of 16 states reporting. FY 2001: 15 of 16 states reporting.
Group II States..	States establish baselines and targets.	All states in group established baselines and targets.
Group III States..	Recruit States.	Recruitment successful.
Assist states in conducting Medicaid payment accuracy studies for the purpose of measuring and ultimately reducing Medicaid payment error rates.	9 states conduct pilot payment accuracy study.	Met target.
Increase the number of children enrolled in regular Medicaid or SCHIP.	+1,000,000 over FY 2001.	12/2002
Increase the proportion of IHS, Tribal, or Urban (I/T/U) clients with diagnosed diabetes that have improved their glycemic control.	Improve from FY 2001.	06/2003 Improvement has occurred each year since FY 1999.
Assure that the unintentional injury-related mortality rate for American Indian/Alaskan Natives (AI/AN) people is no higher than FY 2001 rate.	Revised: target to be FY 2001 actual rate.	Not available.
Maintain 100% accreditation of all IHS hospitals and outpatient clinics.	100%	100%
Serve a proportion of racial/ethnic minorities in Title I-funded programs that exceeds their representation in national AIDS prevalence data, as reported by CDC, by a minimum of 5 percentage points.	70%	01/2004 FY 2001 data available 01/2003.
Increase the number of AIDS Drug Assistance Program (ADAP) clients receiving Human Immunodeficiency (HIV)/AIDS medications through state ADAPs during at least one month of the year.	84,800	02/2004 Exceeded (73,784) target (72,000) in FY 2001.
Increase the percent of clinicians retained in service to the underserved.	76%	04/2003 Exceeded (80%) target (75%) in FY 2001.

Performance Measure	*2002 Target*	*2002 Actual Result or Date Data Available*
Increase the percent of children with special health care needs (CSHCN) in the states' programs with a source of insurance for primary and specialty care.	91%	01/2004 FY 2001 number available 01/2003.
Assist rural facilities in converting to Critical Access Hospital status.	240	657
Continue to assure access to preventative and primary care for racial/ethnic minority individuals.	65%	08/2003 Did not meet (64%) target (65%) in FY 2001.
Award nursing loan repayment contracts.	560	12/2002
Strategic Goal 4: Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise.		
Review and act on standard original New Drug Application (NDA) submissions within twelve months of receipt.	90%	Not available. FY 2001 results available. 01/2003**.**
Review and act upon fileable generic drug applications within 6 months after submission date.	65%	Not available. Exceeded target (50%) in FY 2001 (84% of 298).
Review and act on 90% of Pre-Market approval applications (PMA) of an estimated 80 PMA first actions within 180 days.	90%	Not available. Exceeded target (90%) in FY 2001 (97% of 70).
Strategic Goal 5: Improve the Quality of Health Care Services.		
Decrease the prevalence of restraints in nursing homes.	10.0%	9.9% (FY 2002 interim data)
Decrease the prevalence of pressure ulcers in nursing homes.	9.5%	10.3% (FY 2002 interim data)
Streamline Adverse Drug Event Reporting System (AERS).	Accepting electronic submission from companies and be current with MedDRA coding versions.	Not available. Next generation of IT system completed and initial reports submitted in FY 2001.

Performance Measure	*2002 Target*	*2002 Actual Result or Date Data Available*
Expand the automated extraction of GPRA clinical performance measures and improve data quality.	Assess five sites for five performance measures.	Assessments completed.
Strategic Goal 6: Improve the Economic and Social Well Being of Individuals, Families, and Communities, Especially Those Most in Need.		
All states meet the TANF two-parent families work participation rate (Rate = 90%).	100%	09/2003 Target (100%) not met in FY 2001 (88%).
Increase the percentage of adult TANF recipients who become newly employed.	43%	09/2003
Maintain at the FY 1998 baseline the number of recipients of child protective services funded wholly or in part by SSBG funds.	1,302,895	12/2003 Exceeded target in FY 2001 (1,411,427).
A significant percentage of Older Americans Act (OAA) Title III service recipients live in rural areas.	25%	02/2004
Maintain a high ratio of Leveraged funds to AoA funds.	$ 1.50 to $1.00	02/2004
Strategic Goal 7: Improve the Stability and Healthy Development of our Nation's Children and Youth.		
Increase the number of children served by Child Care and Development Fund (CCDF) subsidies.	2.2 million	09/2003
Increase by 1 % the number of regulated child care centers and homes accredited by a nationally recognized early childhood development professional organization.	9,725	09/2003 9,237. Did not meet FY 2001 target (9,725).
Increase the collection rate for current support.	55%	09/2003 Exceeded target in FY 2001.
Increase the Paternity Establishment Percentage among children born out of wedlock.	97%	09/2003 Exceeded target in FY 2001.
Maintain the percentage of children who exit the foster care system through reunification within one year of placement.	67%	06/2003 Exceeded target in FY 2001.
Increase the number of adoptions of children in the foster care system.	56,000	09/2003; Did not meet FY 01 target.

Performance Measure	*2002 Target*	*2002 Actual Result or Date Data Available*
Strategic Goal 8: Achieve Excellence in Management Practices.		
Total expected Medicare and Medicaid recoveries and savings per dollar Invested (in millions).	$79 **:** 1	01/2003
Reduce the Medicare fee-for-service payment error rate.	5%	FY 2003
Number of Clients served (with funding from Substance Abuse Prevention and Treatment Block Grant Program).	1,751,537	09/2004

Many external factors and influences, beyond the control of HHS, may impede achievement of our strategic goals and objectives. These factors pose challenges for HHS officials by introducing risks and uncertainties that affect how well we achieve our strategic goals and objectives. In some cases, it may be possible to ameliorate the impacts of these conditions but not in all cases. For example, building the the health system's capacity to respond to public health threats in a more timely and effective manner, especially bioterrorism threats, can be hampered by new threats emerging that outpace capacity or communication links between the public health and hospital/health care sectors. In addition, national and local economic conditions can influence whether we are successful in helping families on welfare become economically independent. Also, the public's personal health habits (e.g., diet, exercise, smoking) can impact the incidence of chronic disease.

HHS is prepared to respond as challenges arise due to these external factors and influences. For example, HHS is improving it's capacity to identify new strains of pathogenic microorganisms; conducting meetings to address communications issues; and building enhanced communication though joint training exercises at state and local levels between the public health and hospital sectors. States have also been provided greater flexibility to accomplish welfare objectives under TANF including ensuring that families moving to work remain connected to other safety net programs for which they are eligible. HHS also offers a wide range of training programs focused on the correlation between personal health habits and the incidence of chronic disease.

Overview of Management Performance

It is critical that HHS focus on improving not only program performance and results, but also the Department's program management practices. Sound management practices form the foundation for providing better service to HHS customers and stakeholders. A Department as large as HHS must have strong management systems and controls in place in order to safeguard its assets and fulfill its mission effectively and efficiently.

President's Management Agenda

During FY 2001, the Administration issued the "President's Management Agenda" (PMA), which articulated the Administration's strategy "for improving the management and performance of government." The PMA consists of five government-wide initiatives (Strategic Management of Human Capital, Competitive Sourcing and Procurement, Improved Financial Performance, Electronic Government and Information System Management, and Budget and Performance Integration) and several program-specific initiatives. The Administration rates HHS and the other major federal agencies on their performance and progress relative to specific performance criteria. The ratings follow a "traffic light" approach (red or "R" for unsatisfactory, yellow or "Y" for mixed results, and green or "G" for success) to denote progressive success or progress in each of the elements.

PMA ELEMENT	Status as of Sept. 30, 2002	Progress in Implementation
Human Capital	R	G
Competitive Sourcing	R	Y
Finanical Mangement	R	Y
E-Government	R	Y
Budget & Perf. Integration	R	G

As shown in the PMA summary ratings table, while the Administration continues to rate HHS' current status, like many other departments and agencies, as red, the Department has made significant progress over the past year. This section discusses HHS' efforts during FY 2002 to further the PMA.

PMA Element #1: Strategic Management of Human Capital

HHS, like many other agencies, is undergoing a transformation of its workforce brought about by increasing retirements coupled with aggressive efforts to recruit, hire, and retain the skilled workers we will need in the future. Retirement eligibility continues to rise at HHS. At the end of FY 2002, 14.8 percent (9,917) of HHS' employees were eligible to retire. By the end of FY 2006, an estimated 27.1 percent of our current employees will reach retirement eligibility.

PMA ELEMENT	Status as of Sept. 30, 2002	Progress in Implementation
Human Capital	R	G

Retirements accounted for 31 percent (1,109) of the 3,603 permanent employees who left the Department in FY 2002. This represents one of several factors re-shaping our workforce. Resignations accounted for more losses (1,628 or 45 percent) than retirements and transfers to other agencies accounted for 13 percent (471). These different departure routes have different impacts on the Department's workforce.

Retirements rob the Department of institutional knowledge and in-depth familiarity with the nuances of the laws and regulations of complicated federal programs. Resignations and transfers eat away at our pool of future leaders as talented and career-mobile employees move on to new positions. Addressing these challenges requires that we put in place the means to strategically manage our human capital to ensure HHS has the talent and leadership it will need.

Our human capital initiative is based on building the workforce of the future, recruiting new workers and actively working to retain people with essential skills. Building the workforce also means providing training and development to equip our employees with the skills they will need to meet future challenges. Our retention efforts focus on improving the quality of work life in HHS, improving the image of the Federal government and HHS as an employer, and maintaining high morale among HHS employees.

The HHS emphasis on human capital recognizes the transformation occurring in the Federal government toward greater emphasis on performance and accountability and the indispensable role that our people play in achieving strategic goals and serving the public. It also supports the PMA, looking to de-layer organizations to speed decision-making, consolidate administrative functions, and re-deploy staff to mission-related activities. It is aimed at making the Department more citizen-centered and responsive to the needs of our customers.

HHS took a number of significant actions in FY 2002 to address these human capital challenges. Significant accomplishments included:

- Developing the Department's first Recruitment and Retention Plan as the strategic framework for department-wide efforts to attract, hire, and keep our future workforce;
- Implementing an exit interview program to provide insight to the reasons employees leave HHS;
- Carrying out a retention study to identify factors that influence employees to stay in their jobs or with HHS, and to determine the relative importance of different factors;
- Recruiting and hiring the first class for the Emerging Leaders Program, an innovative career intern program that has attracted government-wide attention for its approach and the quality of the emerging leaders;
- Consolidating HR offices in NIH and FDA to achieve savings and to position HHS for department-wide HR consolidation to four offices in FY 2003; and
- Developing the structure for the HHS Corporate University, a department-wide source of common-needs training that will provide access to skills development training as well as university-based academic education.

PMA Element #2: Competitive Sourcing and Procurement

PMA ELEMENT	Status as of Sept. 30, 2002	Progress in Implementation
Competitive Sourcing	R	Y

In FY 2002, nearly 700 HHS procurement personnel awarded and administered $6 billion worth of contracts. In addition, HHS obligated an additional $1.5 billion for specialized

contracts with Medicare intermediaries and carriers. Further, HHS used purchase cards to buy $350 million of commodities; and contractually authorized $650 million under the Indian Self-Determination Act. These contracts and purchases helped to meet the Secretary's goals of ensuring cost-effective health care and human services; ensuring the integrity of the Medicare program; enhancing health promotion and disease prevention; improving access to health care for all Americans; and providing adequate support for biomedical research.

Competitive Sourcing
HHS met the PMA FY 2002 goal of subjecting five percent of the Department's commercial Full-Time Equivalents (FTEs) to competition, and put together a plan for FY 2003 that will meet the cumulative goal of 15 percent by September 30, 2003. In addition, the PSC made training available to bring all OPDIVs up to speed on the requirements and procedures of OMB Circular A-76, *Performance of Commercial Activities*. The PSC also awarded multiple task-order contracts that make expert consultant services available to any OPDIV. Many OPDIVs have already taken advantage by placing their task orders. HHS also drafted and obtained OMB approval of a detailed procedure for streamlined cost comparisons (65 FTEs and below) that complies with Circular A-76 and provides the OPDIVs with a significant tool for expediting their smaller studies

First HHS-Wide Reverse Auction
HHS conducted its first department-wide Reverse Auction, to support the purchase of a two-year supply of copier paper worth over $6 million. The Reverse Auction was based on the efficient consolidation of paper requirements across HHS, and resulted in the award of two contracts by NIH. The innovative "Reverse Auction" technique is an electronically-secure, web-based bidding mechanism where pre-qualified bidders are given the opportunity to lower prices in real-time for government products. During the auction, bidders can see each other's quotes; however, the names of the competitors are not revealed. This dynamic, real-time price competition generated cost savings of more than $1.3 million.

Other Major Acquisition Accomplishments
Acquisition Management provided critical support to the Secretary during HHS' high-profile negotiations with Bayer AG to lower the price of Cipro, an antibiotic used to treat Anthrax. Negotiations were quite successful, resulting in a nearly 50 percent price reduction. Moreover, the HHS acquisition community continued to play a key role in meeting other bio-defense mission needs, through the issuance of various basic and applied research contracts in the area of antivirals, antibiotics, and vaccine development and testing (e.g., against smallpox and anthrax).

Using web-based and JAVA-oriented technologies, HHS continued to make improvements to the reliability, timeliness and utility of procurement data under the Departmental Contracts Information System (DCIS). For example, these efforts strengthen the servicing of both internal agency clients and the Departments of Transportation and Treasury. HHS initiated research and development (R&D) efforts to explore using web language to link agencies' procurement writing systems, thus permitting potential direct data entry to the DCIS.

The Department's Acquisition and Project Officer Training Program provided comprehensive,

formal training for both contracting professionals and project officers. Contracting personnel used over 750 training slots and project officers used over 2,000 training slots.

HHS consolidated its decentralized commercial indirect cost rate (ICR) negotiation function at NIH. The ICR function is one of NIH's core competencies. This centralized approach will: 1) result in higher productivity and improvements to the quality and timeliness of the Department's commercial ICR negotiations; 2) lead to in-house efficiencies and economies-of-scale; 3) ensure the uniform application of ICR policy; and 4) reinforce the Secretary's goal of unifying HHS.

The Office of the Secretary merged its two procurement offices into one fee-for-service contract operations office at the PSC. This initiative will drive efficiency and create economies-of-scale; promote uniformity in business policies and practices; foster acquisition competition and cost-savings; improve the quality and timeliness of service delivery; and simplify management oversight of the mission-critical acquisition function.

PMA Element #3: Improved Financial Performance

PMA ELEMENT	Status as of Sept. 30, 2002	Progress in Implementation
Finanical Mangement	R	Y

HHS regards improving its financial performance and processes as an ongoing goal. HHS continues to streamline and re-engineer its internal financial processes at the Department and operating division levels to achieve greater operating efficiencies and improve the accuracy and timeliness of HHS financial information. In FY 2002, the Department partnered with subject matter experts from private industry to identify ways to expedite the financial statement reporting process in anticipation of the mandated November 15, 2004 deadline. HHS intends to implement many of these improvements in FY 2003.

Financial Audit Results and Internal Control Improvements

HHS has made significant financial reporting and internal control process improvements since FY 1996, the first year department-wide financial statements were audited (HHS received an audit opinion disclaimer in FY 1996). For the fourth consecutive year, HHS has received an unqualified, or "clean" audit opinion on its financial statements. Since FY 1999, the Department's financial statements have been both "clean and timely" and prepared earlier than the prior year. Timeliness will become a greater focus for the Department as it strives to comply with OMB-mandated accelerated reporting requirements and deadlines. HHS has reduced the number of department-level internal control material weaknesses cited by our auditors from five in FY 1996 to two in FY 2002.

As shown in the following table, HHS' two remaining and ongoing material weaknesses are Medicare Electronic Data Processing (EDP) Controls and Financial Reporting Systems and Processes. Efforts continue to resolve the Medicare EDP Controls weakness, while implementation of the Unified Financial Management System (UFMS), as discussed below, is intended to ultimately resolve the reporting weakness.

HHS Audit Findings History: FYs 1996 - 2002														
	1996		1997		1998		1999		2000		2001		2002	
Issue	Qual.	MW	Qual.	MW	Qual.	MW	Qual.	MW	Qual.	MW	Qual.	MW	Qual.	MW
Medicare Accounts Payable	X	X*		X										
SMI Revenue	X													
Medicare/ Medicaid Accounts Receivable	X	X*	X		X	X		X		**				
Cost Reports	X		X											
Net Position	X	X	X	**										
Liability	X													
Initial Audit	X													
Medicare EDP Controls		X		X		X		X		X		X		X
Grants Oversight/ Accounting		X	X	X										
Medicare Claims Error Rate		X		X										
Intra-entity Department-wide Transactions			X											
Financial Reporting Systems and Processes				X		X		X		X		X		X
New Statements					X									
Total	7	5	5	5	2	3	0	3	0	2	0	2	0	2
Resolved from Prior Year	N/A	N/A	4	1	4	3	2	0	0	1	0	0	0	0
New	7	5	2	1	1	0	0	0	0	0	0	0	0	0
Opinion	**Disclaimer**		**Qualified**		**Qualified & Timely**		**Clean & Timely**		**Clean & Timely**		**Clean & Timely**		**Clean & Timely**	

Qual = Qualification; MW = Material Weakness

* Consolidated into one material weakness citing both payable and recievable in FY 1996.

**Merged with financial reporting and processes material weaknesses.

New Departmental Financial Management System

During FY 2001, HHS initiated the Unified Financial Management System (UFMS) initiative - a critical component of the Department's efforts to modernize its financial management systems and IT infrastructure - at the direction of Secretary Thompson. The UFMS is a critical element of

HHS' efforts to improve financial operations and performance.

The program's overall strategic goal is to unify HHS' financial management by designing and implementing a modern, Department-wide financial management system, as articulated in the Department's UFMS program vision statement:

> "The Department shall have an integrated department-wide financial system that consistently produces relevant, reliable, and timely financial information to support decision-making and cost-effective business operations at all levels throughout the

UFMS will replace the five core accounting systems currently in use across HHS. The unified system will be comprised of two primary sub-components—a system for CMS and its Medicare contractors (the Healthcare Integrated General Ledger and Accounting System or HIGLAS) and another system for the rest of HHS. UFMS will also institute a consolidated departmental financial reporting capability. The initiative is projected to continue through FY 2007, but the system is expected to be substantially implemented by the end of FY 2005.

The system, once fully implemented, will significantly enhance the Department's internal controls, management's stewardship and accountability over financial transactions, operations and assets. The system will resolve a number of material weaknesses identified by the Department's Office of the Inspector General in HHS' financial operations.

The UFMS Program Management Office (PMO) carries out the day-to-day management of the program. During FY 2002, the PMO primarily conducted pre-implementation planning activities. During the fiscal year, the UFMS Program completed its major planning activities and related documents, culminating with the Departmental approval of the UFMS Implementation Plan on September 27, 2002. The Department formally approved the UFMS business case on November 5, 2002.

The UFMS program entered its implementation phase in October 2002. Following are the key Program accomplishments during fiscal year 2002.

- Established the UFMS PMO, hired the UFMS Program Director, to lead the effort;
- Hired a nationally recognized company to serve as the Program's systems integrator;
- Established the UFMS governance structure in which top departmental executives, including the operating components' Chief Financial Officers and Chief Information Officers, actively participate;
- Selected the commercial off-the-shelf software to serve as the core system application/infrastructure;
- Developed a department-wide budget and accounting classification structure (BACS);

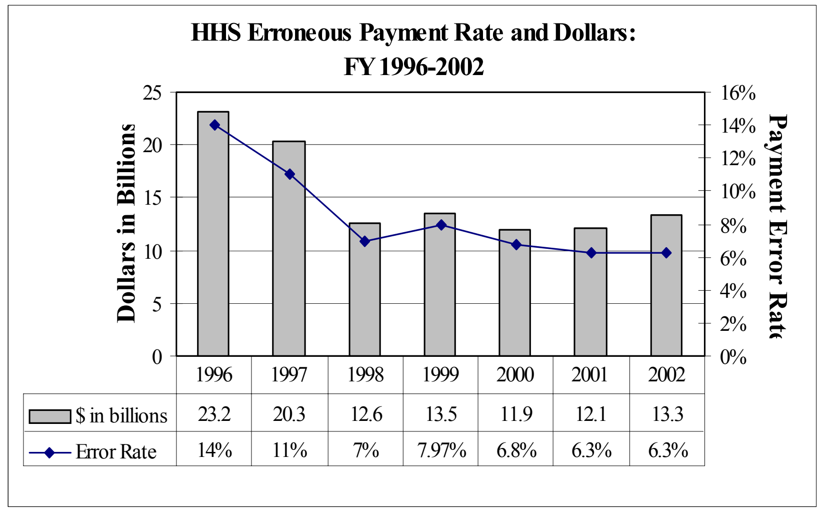
- Compiled department-wide financial requirements applicable to UFMS; and

- Developed key planning documents, including Risk Assessment and Mitigation Plan, Change Management (Business Transformation) Plan, Performance Management Plan, and Core Target Business Model, and UFMS business case.

Development and implementation of the UFMS is further discussed under *PMA Element #4, Electronic Government and Information Systems Management*.

Improper Payments and Debt Collection

The Department's plan includes ensuring that payments made by HHS and our contractors are accurate and that debts incurred are collected in a timely manner. HHS has been a pioneer in the area of monitoring and mitigating improper payments, as Medicare has had an error rate calculated annually since 1996. The subsequent reduction in this error rate from 14 percent in 1996 to well below 10 percent in every year since 1998 has helped to save billions of dollars for the taxpayers. The improper payment rate, which estimates the portion of Medicare fee-for-service payments that do not comply with all Medicare laws and regulations, was 6.3 percent in both FY 2001 and FY 2002. The Department has continued to innovate in this area. CMS has established a Medicaid Payment Accuracy Measurement (PAM) pilot project with twelve states participating and has drafted a summary and assessment for the first year of the PAM pilot. In addition, CMS will be initiating a similar pilot project for the SCHIP program in the near future. ACF has been working on plans to establish erroneous payment rates for the Head Start, Child Care, Foster Care, and TANF programs. ACF expects to have rates for these programs in the next few years.



	1996	1997	1998	1999	2000	2001	2002
$ in billions	23.2	20.3	12.6	13.5	11.9	12.1	13.3
Error Rate	14%	11%	7%	7.97%	6.8%	6.3%	6.3%

Debt management is another major financial management priority for the Department. HHS' debt collection effort focuses on the provisions of the Debt Collection Improvement Act (DCIA) of 1996. Although delinquent debt has been referred to the Department of the Treasury (Treasury) for cross-servicing and offset, HHS has centralized the DCIA delinquent debt referral process in one place by establishing the PSC as the Department's delinquent debt collection center. Additionally, Treasury has granted a cross-servicing exemption for several types of program debts (e.g. Medicare Secondary Payer, unfiled Medicare cost reports and various health professional loans). The PSC cross-services these debts and also refers them to the Treasury Offset Program (TOP). According to the FY 2002 year-end Treasury Report on Receivables

(TROR), HHS and Treasury cooperation in the overall debt collection effort have resulted in:

- HHS referral rates increased for FY 2002 as follows;
  - TOP referrals increased to 90 percent,
  - Cross-serviced debt increased to 91 percent, and
  - All referral rates will increase in FY 2003 when the Centers for Medicare & Medicaid Services (CMS) is scheduled to refer 100 percent of all debts.

- HHS collections exceeded $14.4 billion;

- Re-application for PSC to serve as HHS' delinquent debt collection center in FY 2002 and beyond was approved by the Department of the Treasury. This continued the cross-servicing exemption for Medicare Secondary Payer, Unfiled Medicare cost reports and various Health Profession Loans; and

- Disbursement of $1.5 billion in FY 2002 to the states to forward to child support recipients through TOP from the offset of federal tax and non-tax payments otherwise due to those behind in child support payments in FY 2002 to reduce child support obligations.

PMA Element #4: Electronic Government and Information Systems Management

PMA ELEMENT	Status as of Sept. 30, 2002	Progress in Implementation
E-Government	R	Y

HHS' Electronic Government (e-Gov) vision leverages Information Technology (IT) to support the Department's program and management priorities to improve performance and provide seamless and integrated services to constituents. By aggregating and consolidating IT initiatives, e-Gov creates a virtual pool of government information and services that is accessible by all constituents. This results in a more cost-efficient IT structure at HHS and a more unified, responsive level of service to the public. E-Government allows all levels of HHS to collaborate as equal partners to provide citizen-centric services that reduce burdens on businesses, increase customer satisfaction, improve knowledge management, and advance the unified Department strategy under the "One HHS" initiative.

In FY 2001, the HHS Chief Information Officer (CIO) aggregated agency IT infrastructure funds and made them available for central management of enterprise projects. HHS used this funding to support initiatives described in the HHS FY 2001 Enterprise IT Strategic Plan (IT Plan). Cross-cutting and mission-critical initiatives were prioritized, funded and centrally managed through oversight by the combined efforts of the HHS CIO Council and the Information Technology Investment Review Board (ITIRB) governance processes. That governance process requires approved projects to regularly report project status, progress and expenditures to the board(s) for continued funds approval and/or for further guidance and correction, if necessary. HHS continued this central funding management process for enterprise projects during FY 2002 for the projects defined in the FY 2002 Enterprise IT Strategic Plan signed by the Secretary in June 2002.

HHS implements e-Gov initiatives from both government-wide and Department-focused perspectives, including IT security. HHS is the lead Agency for 2 of the 24 PMA e-Gov initiatives, and continues to advance critical department-focused projects.

The following exemplifies HHS' involvement and leadership in governmentwide e-Gov initiatives:

- *e-Grants (HHS Managing Partner)*: HHS is leading Administration efforts to streamline the federal grants management process. Public Law 106-107 and the PMA support the e-Grants initiative to streamline, simplify, and provide electronic options for federal agency grants management processes, and to improve service delivery to the public. Under HHS leadership, the e-Grants initiative has established a program management office; collaborated with grant-recipient communities and federal grant-making agencies; implemented governance and financing strategies; and fulfilled all FY2002 milestones on schedule.

- *Consolidated Health Informatics (HHS Managing Partner):* The Consolidated Health Informatics (CHI) initiative seeks to adopt clinical health information standards (vocabulary with health data models and messaging standards) for federal enterprise-wide use in all new health data systems. Standards enable health data interoperability and exchange among agencies. In FY 2002, for the first time, HHS facilitated the development of government-wide partnerships and business case/financing plans to bring about clinical information standards. HHS has also advanced the development of laboratory, messaging, and other data standards.

- *GovBenefits:* The GovBenefits initiative aggregates information from federal agencies through an integrated web portal to help individuals identify government benefits and assistance programs. Through the submission of information via questionnaire, individuals can access information related to their specific need. To date, HHS has linked twenty programs to the GovBenefits project, and continues to include more programs every month.

- *Online Rulemaking Management (OLRM):* While businesses and individuals currently have Internet access to federal regulations, to view such regulations requires either prior knowledge of affiliated agencies or an ability to navigate to a desired citation through the *Federal Register*. The ongoing OLRM initiative transforms the current regulatory documentation process. Through OLRM, HHS customers can access all publicly available regulatory material and can comment on proposed or pending rules. OLRM provides a unified, cost-effective regulatory management system to ensure efficiency, to capture economies of scale, and to achieve consistency for public customers and the government. HHS and FDA have been actively engaged in the ongoing development of OLRM.

- *e-Authentication:* e-Authentication is a multi-agency initiative, managed by the General Services Administration (GSA) Federal Technology Service, whose mission is to enhance public trust in the security of information exchanged over the Internet. To date, NIH personnel have participated in the initial scoping and design for, and together with HHS'

Office of Information Resources Management (OIRM), maintain day-to-day involvement in this initiative.

- *Other Initiatives:* HHS is directly involved in other electronic Government and information management initiatives, including: Wireless/SAFECOM, Disaster Management, Geospatial, e-Travel, and USA Services.

The following are examples of Department-focused electronic government and information systems management projects:

- *Electronic Insurance Validation and Verification:* The Indian Health Service (IHS) has collaborated with CMS to exchange beneficiary demographic information to allow proper IHS billing of patient visits and proper CMS assignment of beneficiary race codes. This data exchange has reduced data entry errors, decreased returned claims, and decreased batch rejections by the CMS fiscal intermediary. IHS is pursuing similar data exchanges with state Medicaid offices.

- *KnowNet:* HHS' award-winning knowledge management and performance support system supports federal, state and local government employees, contractors, and grantees in the core business areas of acquisition, grants, logistics, finance, small business, audit resolution/cost policy, and e-Business.

- *National Electronic Disease Surveillance Systems (NEDSS)*: HHS is developing NEDSS and its supporting electronic communications systems to create integrated public health information and surveillance systems. CDC has identified this challenge as a key priority in its strategic plan. The purpose of this effort is to integrate (and largely replace) the current myriad, separate systems used for public health surveillance, at the federal and state levels, into a comprehensive network. This allows for effective collection, analysis, and use of data. The system uses the Internet to collect and disseminate critical public health information to those with a need to know, using sophisticated security practices.. CDC has employed Public Key Infrastructure (PKI) in this effort with over 3,000 digital certificates having been issued to state and local health department partners. PKI represents a key component of CDC's "Secure Data Network" (SDN) for public health surveillance over the Internet.

- *Grants Administration, Tracking and Evaluation System (GATES):* ACF grants officers and specialists use GATES to manage approximately 5,500 grant recipients (totalling approximately $40 billion) from receipt through award. GATES provides a single source for data exchange allowing for information consistency, accuracy and reliability across ACF's grant programs. GATES also allows ACF senior policy executives, program managers and staff to make decisions, direct programs, and evaluate strategic objectives. As the e-Grants Initiative is fully implemented, GATES will be integrated with a more standardized HHS approach to electronic grants processing.
- *Integrated Time and Attendance System (ITAS):* PSC implemented ITAS, a system which provides virtual linkage of leave requests, approvals, and pay records to move the management of time and attendance to the desktop of employees and managers.

- *Electronic Remittance Advice/Treasury Pilot Project*: IHS has successfully collaborated with the Department of Treasury to implement an electronic lockbox for payment processing. A lockbox service is a collection point (or address) where customer payments are collected, consolidated, and processed (and then they can be deposited directly into the customer's account). The lockbox can accept payments, receipts, and/or remittance advices. This has automated the payment process and reduced medical claim processing time while increasing accounting efficiency through the elimination of manual data entry. Staff time saved at facilities is, in-turn, used to follow-up on delinquent receivables.

- *SAMHSA's National Mental Health Information Center (NMHIC): [Formerly - The National Mental Health Services Knowledge Exchange Network]* SAMHSA aggressively uses IT to facilitate the transfer of knowledge concerning mental health prevention to states, communities, and individuals and to improve program effectiveness and accountability at all levels. NMHIC is the national focal point for mental health information and referral services. The NMHIC Call Center, 1-800-789-2447, is staffed with English and Spanish speaking specialists trained to respond to mental health and treatment issues and inquiries. Specialists can also refer callers to appropriate state and local mental health resources. In addition, NHMIC operates a web-site, www.mentalhealth.samhsa.gov, which offers access to a national mental health services facility locator, state and local contact information, viewable and downloadable topical mental health publications (available in English and Spanish), resource materials, and links to other Internet resources.

- *Electronic Freedom of Information*: Recent improvements at FDA exemplify HHS efforts to implement the Electronic Freedom of Information Act. FDA works with industry to harmonize IT standards and to implement electronic data exchange capabilities. A new focus on electronic regulatory submission and review has yielded partnerships between FDA and industry to improve the delivery of safe products to market by reducing cycle time on approvals and by lowering electronic submission costs. In addition, FDA provides frequently requested and other public documents in electronic formats to facilitate access.

- *Medicare Current Beneficiary Survey (MCBS)*: Since 1996, HHS has used the MCBS, administered through the CMS website, to collect information on Internet use by Medicare beneficiaries. The CMS Office of Research, Development, and Information has established a web page on the CMS website to provide an overview of the MCBS, to disseminate data and findings from the survey, and to provide copies of the survey instruments and data.

- *Unified Financial Management System (UFMS)*:HHS is implementing UFMS, a department-wide integrated financial management system that will serve as the "cornerstone" of the Department's electronic business infrastructure. UFMS will replace the existing five core accounting systems. UFMS will be web-based and utilize modern electronic technologies. Once fully implemented, UFMS will routinely generate reliable, timely and relevant information to facilitate fact-based decision-making at all levels of the Department. The system will be comprised of two primary sub-components: a system for CMS and its Medicare contractors (HIGLAS) and another system for the rest of the Department. Both

components are being designed and implemented based on consistent technical and functional standards, and will feed into a departmental financial reporting system.

During FY 2002, the Department established the governance and program management structure to guide and manage the initiative. The UFMS PMO, in conjunction with its systems integrator, developed and received departmental approval of the primary planning documents that are being used to manage the program and measure performance against established milestones and parameters. Additional details regarding the UFMS program and associated accomplishments during FY 2002 are presented under *PMA Element #3, Improved Financial Performance*.

- *HHS Web Portal to the Internet*: In October 2002, HHS launched an improved citizen-centric, HHS web-site. The new site provides easy access for citizens and other HHS constituents to expanded information on the Department's health care initiatives, services, and resources. In the coming year, lessons learned from this effort will be applied to the development of a Department intranet, which will allow HHS personnel to better collaborate and share knowledge across traditional division lines.

- *Network Modernization*: Network Modernization is a critical component of HHS's broader IT consolidation efforts. The following modernization efforts were completed during FY 2002:

  - A department-wide IT hardware asset inventory, which details all network connected devices. This effort has generated several opportunities for modernization and consolidation;

  - A consortium of small OPDIVs has been established to consolidate IT infrastructure and management for these divisions under a single management structure. The network that currently serves the Office of the Secretary (OS) provides a model for the consolidated small OPDIV network; and

  - E-mail services for OS have been consolidated at NIH as a first step toward department-wide e-mail consolidation. Further network modernization and infrastructure consolidation are currently in process.

PMA Element #5: Budget and Performance Integration

PMA ELEMENT	Status as of Sept. 30, 2002	Progress in Implementation
Budget & Perf. Integration	R	G

HHS continues to make strides integrating budget and performance. In the majority of components' Annual Performance Plans, performance measures are organized around the Department's 300 programs so that readers can see the connection between what we intend to accomplish and the resources we will commit. HHS prepared the FY 2004 budget informed by the HHS components' individual Annual Performance Reports, and the Secretary's Budget Council directed several changes to those documents and the budgets.

Department Level Annual Performance Plan

This year for the first time, HHS has prepared a department-level Annual Performance Plan. The plan explains the future of important HHS programs, details the resources that are being budgeted for each program, and organizes those programs and their budgets using HHS' Strategic Goals. The FY 2002 Performance and Accountability Report, which this year includes the Department's Performance Report, shows how HHS has contributed to the health and well-being of Americans.

Focus on Results

HHS is a large, complex organization with several agencies and over 300 programs. Most of these activities are accomplished with, or through, state, municipal, or tribal partners. As a result, at one time, HHS had over 1,000 performance measures. But this many measures was challenging to track and difficult to manage by. Working with ACF, CDC, FDA, and the other agencies, the Department reduced that overall number of measures by almost 30% while increasing the number of measures that demonstrate healthy outcomes and tangible results for all Americans.

Program Assessment Rating Tool (PART)

OMB introduced PART as a means of measuring program effectiveness across the federal government. As soon as PART was announced, HHS became a participant in the process. Even before the effort was completely underway, the Department finished its own internal PART assessment of several programs to guide FY 2004 budget decisions. Eventually HHS actively worked with OMB to examine 31 programs in detail–from Foster Care for Children to Services for the Aging – more programs than any other federal department examined.

Financial Statement Analysis

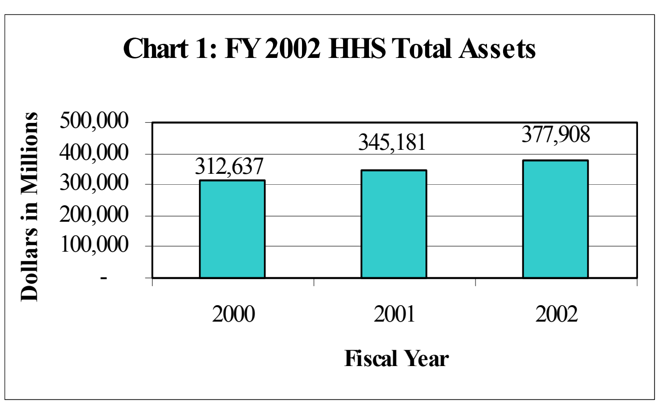
This section summarizes the significant changes in HHS' financial condition during the past year. The following table provides an overview of HHS' financial condition at the end of FY 2002 (dollars in millions).

HHS Financial Condition	FY 2002	FY 2001	Increase (Decrease)	% Change
Total Assets	$ 377,908	$ 345,181	$ 32,727	9.5%
Total Liabilities	$ 60,263	$ 54,599	$ 5,664	10.4%
Net Position	$ 317,645	$ 290,582	$ 27,063	9.3%
Net Cost of Operations	$ 472,074	$ 432,908	$ 39,166	9.0%

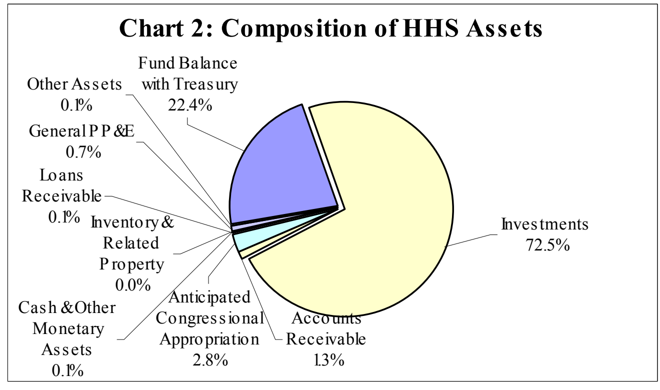
Balance Sheet

Assets

HHS Assets increased by $33 billion or 9.5 percent to a total of $378 billion during FY 2002 as shown in Chart 1. Increases of $29 billion or 11.8 percent in Investments and of $4 billion or 4.7 percent in HHS' Fund Balance with Treasury accounted for most of the change in Total Assets. As shown in Chart 2, HHS' Investments of $274 billion and its Fund Balance with Treasury of $85 billion together comprise 95 percent of HHS' Total Assets. The Fund Balance with Treasury is HHS' "checkbook balance", or the aggregate amount of funds deposited in the Treasury available to HHS to make authorized expenditures and pay liabilities.



At the end of FY 2002, approximately $243 billion or 89 percent of HHS Investments were in U.S. Treasury Securities to support the Medicare trust funds, which include the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) trust funds. As reported in the Social Insurance discussion of the Required Supplementary Stewardship Information (RSSI) section of this report, HI trust fund assets steadily increase through 2021. At this point, expenditures start to exceed income including interest, thus drawing down the assets until 2030 when they would be depleted. The shortfall between income and expenditures is due in part to the attainment of Medicare eligibility, starting in 2011, of those born during the 1946-1964 baby boom, and also due to health costs that are expected to increase faster than workers' earnings. Actual economic conditions, however, could delay (in the case of economic recovery) or accelerate this condition.



The SMI trust fund does not face the same crises as the HI trust fund has in recent years. This is due to the fundamental difference in the way the HI and SMI trust funds are financed. Whereas HI is funded primarily through payroll taxes, SMI obtains its funding through monthly premiums and income from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures. Thus, the SMI trust fund is in financial balance every year, regardless of future economic and other conditions, due to its financing mechanism.

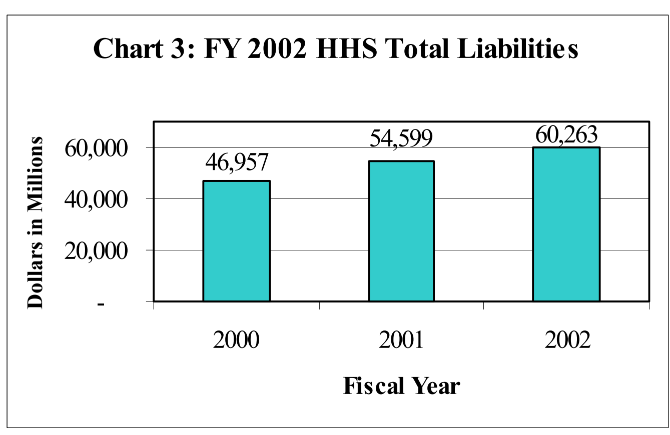
Under the Trustees' intermediate set of assumptions, the HI trust fund will incur an actuarial deficit of more than $4.9 trillion over its 75-year projection period, as compared to more than $4.5 trillion as projected in the FY 2001 report. In order to bring the HI trust fund into actuarial

balance over the next 75 years, either outlays would have to be reduced by 38 percent or income increased by 60 percent (or some combination of the two). Since the SMI trust fund is in financial balance every year, there has been substantially less attention directed toward its financial status than to the HI trust fund—even though SMI expenditures have increased faster than HI expenditures in most years and are expected to continue to do so for a number of years in the future.

It is important to note that no liability has been recognized on HHS' balance sheet for future payments to be made to current and future program participants beyond the existing "incurred but not reported" Medicare claim amounts as of September 30, 2002. This is because Medicare is accounted for as a social insurance program rather than as a pension program. A more detailed discussion of HHS' social insurance funds and other stewardship property and investments can be found in the RSSI discussion of Section III in this report.

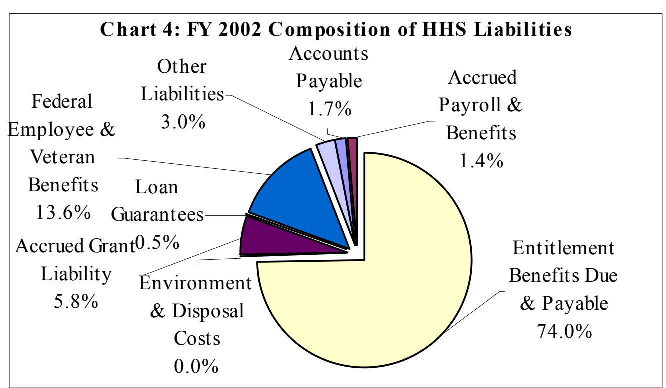
Liabilities

HHS' Liabilities increased by $6 billion or 10.4 percent to a total of $60 billion during FY 2002, as shown in Chart 3. This increase can be attributed primarily to a $4.1 billion or 10.2 percent increase to $45 billion in Entitlement Benefits Due and Payable. These amounts represent benefits due and payable to the public from the CMS insurance programs discussed above. These entitlement liabilities, along with Federal Employee & Veteran Benefits, which increased by $673 million or 9.0 percent to $8 billion during FY 2002, accounted for 88 percent of Total HHS Liabilities, as shown in Chart 4. Accounts Payable posted the largest percentage increase of 55.3 percent or $372 million, but this only represents less than 2 percent of Total Liabilities.



Statement of Changes in Net Position

HHS' Net Position, which increased by $27 billion or 9.3 percent to $318 billion at the end of FY 2002, consists of the cumulative net results of operations since inception, and unexpended appropriations, or those appropriations provided to HHS that remain unused at the end of the fiscal year.



Costs vs. Outlays
Two key concepts are critical for understanding the HHS financial story:

- Costs are typically reported in accounting reports, and are synonymous with expenses. These are the amounts recognized when services are rendered or goods are received. They are not necessarily linked to the outflow of cash in the form of check assonance, disbursements of cash, or electronic funds transfer. Costs incurred or expenses are netted against exchange or earned revenues to identify the net cost of programs.

- Outlays are typically reported in budget reports, and are represented by the net of disbursements and receipts. Outlays are used to identify budget surpluses or deficits.

Statement of Net Cost

HHS incurred total net cost for FY 2002 of $472 billion, which represents a 9.0 percent, or $39 billion increase over FY 2001. The Consolidated Statement of Net Cost presents HHS' net operating costs by Operating Division (OPDIV), while functional detail is provided in the footnotes. As can be seen in Chart 5, the Centers for Medicare & Medicaid Services (CMS), the Administration for Children and Families (ACF), and the National Institutes of Health (NIH) account for a combined 96 percent of HHS' total net cost of operations, incurring net costs of $385 billion, $46 billion, and $20 billion, respectively.

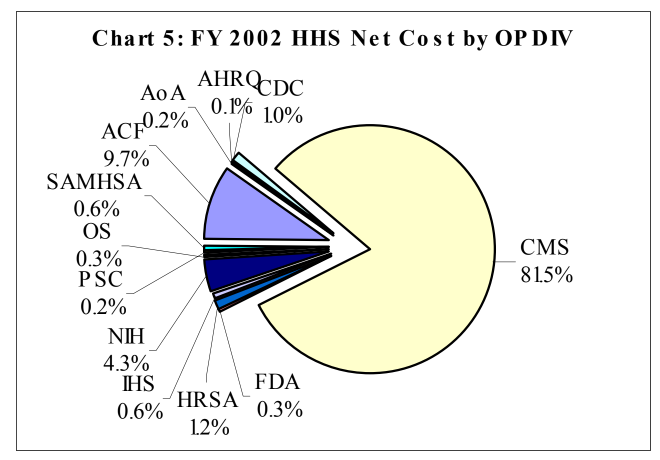
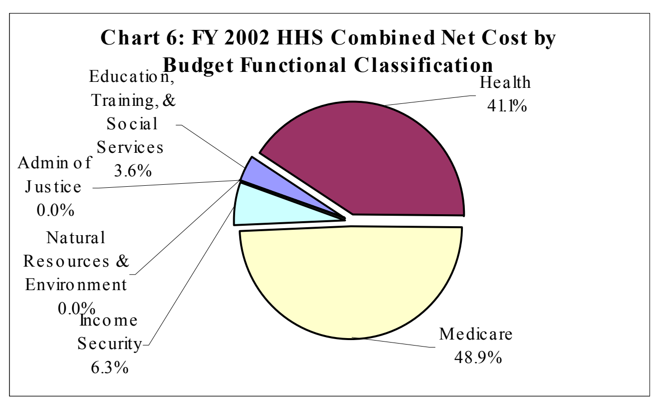


Chart 6 shows how HHS incurs net costs across its primary functions as defined in the budget. HHS' Medicare (48.9 percent); Health (41.1 percent); Income Security (6.3 percent); and Education, Training, and Social functions (3.6 percent) account for nearly all of HHS' net costs incurred during FY 2002. The percentages in Chart 6 reflect a proportional analysis of HHS' combined net costs (not accounting for intra-departmental costs and revenues). Intra-departmental net costs accounted for less than 0.1 percent of total combined net costs.



Statements of Budgetary Resources and Financing
During FY 2002, most of the funding to support net costs came from $625 billion in appropriations from Congress, as shown in HHS' Combined Statement of Budgetary Resources. This represents 97 percent of the gross budgetary resources available to HHS. This gross amount was offset by a pre-designated portion of funds that were either temporarily or permanently unavailable pursuant to specific legislation to derive a net funds available amount of $611 billion, an increase of 9.9 percent over FY 2001 levels. During FY 2002, HHS incurred obligations of $603 billion, a 9.9 percent increase over FY 2001, and made 5.6 percent more Net Outlays totaling $558 billion. Further comparison of Net Position and Budgetary Resource activity between FY 2001 and FY 2002 is limited due to required format changes to the financial statements implemented for FY 2002.

Financial Management Systems: CORE and PMS

CORE
The PSC CORE Accounting system records and reports the financial activity for eight of the twelve HHS operating components. The CORE system is the nucleus of PSC's accounting operations and accepts and processes data supplied by feeder systems from the OPDIVs as well as from the Payroll, Travel, and Payment Management Systems (PMS). The CORE accounting system is in compliance with all laws and regulations, including the Federal Managers Financial Integrity Act and the Federal Financial Management Improvement Act. The reliability of the information in the PSC CORE Accounting system has been a major factor in achieving an unqualified "clean" opinion for all of the financial statement audits for the OPDIVs serviced by PSC.

PMS

The PMS is a centralized grants payment and cash management system serving 11 Federal agencies with 44 grant awarding component offices and bureaus. During FY 2002 over $240 billion in federal grant funds was disbursed through PMS. PMS is operated by the HHS Division of Payment Management (DPM), Financial Management Service, Program Support Center. PMS has been identified by the Chief Financial Officer's Council (CFOC) as one of two civilian grant payment systems to serve all federal civilian grant awarding agencies. Of the two CFOC designated systems, PMS is the only full service system available to the grant awarding agencies. PMS is an automated system capable of receiving electronic or manual payment requests, editing them for accuracy and content, batching them for forwarding to the Federal Reserve Bank or U.S. Treasury for payment, and recording the transaction to the appropriate general ledger account(s). The legal or regulatory requirements met by this system include the Cash Management Improvement Act of 1990, OMB Circulars A-102 and A-110, Debt Collection Improvement Act of 1996, and 45 CFR Parts 74, 92, and 96 regulating HHS discretionary and Block grants.

An independent audit of DPM's internal controls is completed annually under oversight of the HHS OIG. The audit for FY 2002 was completed under the guidelines of the American Institute of Certified Public Accountants (AICPA) Statement on Auditing Standards Number 70 for

Service Organizations. The annual audit report is a "Type 2" report providing an opinion on the internal controls placed in operation and includes tests of operating effectiveness. Including the audit for fiscal year 2002, DPM has received six "unqualified" or clean audit opinions. DPM completes annual reviews and is compliant with the applicable provisions of the Federal Managers' Financial Integrity Act (FMFIA), the Joint Financial Management Improvement Program (JFMIP) Grant Financial Systems Requirements, the Government Information Security Reform Act (GISRA), and the Federal Financial Management Improvement Act (FFMIA).

Federal Managers' Financial Integrity Act (FMFIA)

At the end of FY 2002, HHS reduced the number of programmatic management control material weaknesses, as defined by FMFIA, from two to one. The only remaining material weakness was a weakness in the enforcement program for Imported Foods at FDA. HHS has one financial management system material non-conformance covering the Department's financial systems and processes. Further details are provided in the full FMFIA report in Appendix C of this report.

Federal Financial Management Improvement Act (FFMIA)

HHS continues to have two non-compliances with the requirements of FFMIA. They are: 1) Financial Systems and Processes; and 2) Medicare Information System Access Controls. Further details are provided in the full FFMIA Report in Appendix D. Corrective actions planned and completed are tracked in the Department's Corrective Action Plan (CAP) report that is provided to OMB on a quarterly basis.

Other Management Issues

Grants Management

As the largest grant-awarding agency in the Federal Government, HHS plays a key role in federal grants management. Through over 300 assistance programs, HHS awards more than $200 billion of the total federal grants awarded (estimated to be $360 billion).

Grant awards are financial assistance that provide support or stimulation to accomplish a public purpose. Awards include grants and other agreements in the form of money, or property in lieu of money, to eligible recipients. Most of the HHS grant dollars awarded are in the form of mandatory grants.

Stewardship and oversight responsibilities for HHS grant programs involve a variety of ongoing administrative functions, including:

- Assisting OMB in its revisions of key OMB Circulars pertinent to grants administration;
- Providing training and developing related guidance documents on these revised OMB Circulars;

- Conducting oversight through a "balanced scorecard" approach;
- Strengthening HHS indirect cost negotiation capabilities;
- Updating internal departmental grants administrative procedures;
- Utilizing a department-wide grants management information system to report on grant award data across all HHS grant programs; and
- Reviewing departmental program announcements.

OMB designated HHS to be the lead agency to manage the Federal Grant Streamlining Program (FGSP). The FGSP is a federal government-wide effort required by Public Law 106-107, the Federal Financial Assistance Management Improvement Act of 1999, to streamline, simplify, and provide electronic options for the grants management processes employed by federal agencies and to improve the delivery of services to the public. The FGSP initiatives encompass the entire grant life-cycle and include the standardization, simplification and streamlining the formats used to provide program synopses and announce funding opportunities and the forms required to apply for and report on grant funds. FGSP activities are closely coordinated with the activities of the e-Grants program office, which is also led by HHS. The E-Grants program office is charged with implementing the government-wide e-Grants initiatives outlined in the PMA and works to develop the electronic solutions necessary to implement many FGSP initiatives. Through this FGSP and e-Grants partnership, the twenty-six major grant-making agencies are modifying and developing grants management practices and information systems that will allow current and prospective recipients of Federal grants to find, apply for, and manage grant funds on-line through a common web-site.

HHS continues to operate the Tracking Accountability in Government Grants System (TAGGS), which contains department-wide grants award information. Access to TAGGS information is available to HHS staff via the Department's Intranet. Our GrantsNet web-site, www.hhs.gov/grantsnet , continues to provide public access to up-to-date policies, regulations, and other pertinent grants-related information.

Highlights of FY 2001 grant awards (most recent data available) include the following:

- HHS awarded almost $200.9 billion in grants; this included both discretionary awards totaling $30.5 billion and mandatory awards totaling over $170.4 billion;

- CMS, which administers the Medicaid Program, awarded 65 percent ($131.1 billion) of the total grant funds, representing less than one percent of the total number of grants.

- ACF awarded the next highest percentage (21 percent, $41.5 billion) of the total grant funds, representing 11 percent of the total number of grants;

- The other ten OPDIVs each awarded between one and eight percent of the remaining grant funds. NIH awarded 68 percent (47,120) of the total number of grants, which is 51 percent of the discretionary grant funds, but only eight percent of the total grant funds; and

- The six states receiving the most HHS mandatory grant funds (in billions) in FY 2001 are New York ($20.6), California ($19.3), Texas ($8.8), Pennsylvania ($7.8), Ohio ($6.4), and Florida ($6.3).

FY 2001 Grant Awards											
OPDIV	**Total Grants**			**Mandatory Grants**			**Discretionary Grants**				
	number	**$ (in millions)**		**number**	**$ (in millions)**		**number**	**$ (in millions)**			
ACF	7,834	$	41,471	3,065	$	34,786	4,769	$	6,685		
AHRQ	681	$	148	-	$	-	681	$	148		
AOA	1,003	$	1,083	727	$	1,029	276	$	54		
CDC	3,134	$	3,112	60	$	59	3,074	$	3,053		
CMS	605	$	131,061	344	$	130,931	261	$	130		
FDA	196	$	27	-	$	-	196	$	27		
HRSA	5,906	$	4,618	113	$	626	5,793	$	3,992		
IHS	593	$	905	557	$	897	36	$	8		
NIH	47,120	$	15,663	-	$	-	47,120	$	15,663		
OS	401	$	313	-	$	-	401	$	313		
SAMHSA	1,612	$	2,489	232	$	2,048	1,380	$	441		
TOTAL	**69,085**	**$**	**200,890**	**5,098**	**$**	**170,376**	**63,987**	**$**	**30,514**		

Physical Infrastructure and IT Security

Through Presidential Decision Directive (PDD) 63 and the Government Information Security Reform Act (GISRA), the Federal government was directed to assess and report on the vulnerability of controls in place to protect assets critical to the Nation's well-being. The events of September 11, 2001 greatly heightened the importance of protecting physical and cyber-based systems essential to the minimum operations of the economy and government. Due to its major responsibilities for public health and safety, the Department has been identified as a Tier-I agency, signifying a dramatic negative national impact should HHS systems be compromised.

Immediately following the attacks on the World Trade Center and the Pentagon, the Office of the Secretary (OS) organized a departmental Physical Security Work Group. The group's primary task was to develop a department-wide policy on minimum security standards based on the recommendations provided in the Department of Justice's (DOJ) *Vulnerability Assessment of Federal Facilities* guidelines. The group continues to address security issues such as contractor clearance procedures and access control in laboratories, hospitals and research facilities to ensure the safety and security of personnel and property. In addition to these efforts, all new or renewal leases are now reviewed by the Office of the Assistant Secretary for Administration and Management to ensure that HHS security needs are reflected accurately in leases.

The Physical Security Work Group has been instrumental in upgrading security measures throughout HHS and is working with the Department's Physical Security Office to continuously improve current policies and processes. Increased security guard presence at all building entrances and enhanced visual inspection of all vehicles entering the garage are among numerous actions taken to improve security at HHS facilities.

With regard to IT security, during FY 2001, HHS awarded a contract to: prepare a concept of operations for a department-wide computer security incident response system that leverages existing capability; train all HHS employees in security awareness; and assess enterprise security risk. During FY 2002, HHS approved and funded ten security projects for immediate development. Key actions for these projects included: installation of multi-tier virus protection across HHS; vulnerability of penetration scans of critical HHS systems; and perimeter protection for all Internet access points. For FY 2003, contracts are in place to establish round-the-clock monitoring of security alerts; provide certification and accreditation for all Critical Infrastructure Protection assets; reduce GISRA corrective action items; and continue the Project Matrix process through the implementation of a Phase 2, Analyses of Critical Assets.

Faith-Based Initiatives

On January 29, 2001, President Bush issued an Executive Order directing the HHS Secretary to establish a Center for Faith-Based and Community Initiatives (Cabinet Center). As specified in the Executive Order, responsibilities for this Center include:

- Identifying existing barriers to the participation of faith-based and community organizations in the delivery of social services by the Department;
- Coordinating a comprehensive departmental effort to incorporate faith-based and other community organizations in department programs and initiatives to the greatest extent possible;
- Proposing initiatives to remove barriers for participation by these organizations;
- Proposing the development of programs to increase the participation of faith-based and other community organizations in federal, state, and local initiatives;
- Developing and coordinating departmental outreach efforts to disseminate information more effectively to faith-based and other community organizations on initiatives and opportunities; and
- Reviewing the extent to which relevant programs comply with "charitable choice" provisions and promoting and ensuring compliance with "charitable choice".

HHS will provide annual reports to the President that will: report the year's progress related to continuing efforts to analyze the Department's programs to determine barriers to full participation of faith-based and other community organizations; summarize the technical assistance and other information that will be made available to faith-based and other organizations; and include annual performance indicators and measurable objectives for department-wide action.

The Compassion Capital Fund (CCF) is a $30 million fund appropriated to HHS in January 2002 that represents the first appropriated federal funds specifically targeted to assist the grassroots

organizations that are the focus of the faith-based initiative. The CCF supports four activities:

Technical Assistance to Intermediary Organizations

Nearly $25 million was awarded to 21 "intermediary organizations," which, in turn, will help smaller, faith-based and grass-roots organizations operate and manage their programs effectively, access funding from varied sources, develop and train staff, expand the types and reach of social services programs in their communities, and replicate promising programs.

In addition to providing technical assistance, these intermediary groups will issue sub-awards directly to targeted, qualified faith- and community-based organizations to expand or replicate promising or best practices in targeted areas. Priority for sub-awards is expected to be given to organizations that focus on homelessness, hunger, at-risk children, transition from welfare to work, and those in need of intensive rehabilitation such as addicts or prisoners.

To encourage organizations to work in partnership with the Federal government, intermediary organizations were expected to provide at least 50 percent of the amount of federal funds requested (i.e., one-third of the proposed total budget).

CCF funds may not be used to support religious practices such as religious instruction, worship, or prayer.

Intermediary organizations were selected to receive funding based on a competitive review process.

Compassion Capital National Resource Center

In addition, HHS awarded a $2.2 million contract to Dare Mighty Things in Vienna, Va., to establish a national resource center and clearinghouse for information related to technical assistance and training resources for faith- and community-based organizations. This resource center will ensure that the grantees funded under the Compassion Capital Fund are adequately equipped with the information and training they need to assist grassroots organizations.

The National Resource Center will also develop tools that will be useful and accessible to all interested faith-based and community groups, regardless of whether they are working with a funded intermediary. For example, the National Resource Center will develop and maintain a Web site that addresses a wide array of topics useful to faith-based and community organizations, such as "best practices" to meet the needs of individuals and families, and evaluation and assessment of program outcomes and effectiveness. It will also develop manuals on specific topics that will assist faith-based and community organizations.

Research Regarding Best Practices and Services of Intermediary Organizations

Approximately $1.6 million will be used to support research on the services and best practices of intermediary organizations and the faith-based and community organizations they serve.

Field-Initiated Research Grants

HHS also awarded four grants totaling more than $850,000 to support research regarding how faith- and community-based organizations provide social services and the role they play in communities and in the lives of the people they serve.