Section V - Appendices

Appendix A - HHS FY 2003 Top Management Challenges Identified by the Office of Inspector General

Management Issue #1: Bioterrorism Preparedness

Management Challenge

The tragedy of September 11, 2001, and events since then underscore the importance of having the infrastructure and resources to respond to threatened and actual acts of terrorism and bioterrorism, as well as other public health emergencies. Because the Department of Health and Human Services (HHS) manages most of the Nation's federal health resources through research, surveillance, coordination, and delivery programs, the Office of Inspector General (OIG) has focused on vulnerabilities in those programs. We assess how well programs recognize and respond to outside health threats, the security of HHS laboratory facilities, and the readiness and capacity of responders at all levels of government to protect the public health.

In evaluating the effectiveness of the Centers for Disease Control and Prevention (CDC) bioterrorism preparedness efforts, OIG assessed the ability of 12 state and 36 local health departments to detect and respond to bioterrorist events. We also conducted a review of the deployment capability of the National Pharmaceutical Stockpile (now known as the Strategic National Stockpile, a program designed to supplement and restock state and local public health agency pharmaceutical supplies in the event of a biological or chemical incident) in 11 states and 21 localities. We found that states and localities were underprepared, and that planning documents tended to overstate preparedness. At CDC's request, we are currently conducting follow-up reviews on progress made by states and localities in improving their readiness.

We also assessed security controls at a number of laboratory facilities operated by CDC, the National Institutes of Health, and the Food and Drug Administration, and several colleges and universities. Reviews to date reveal substantial problems regarding perimeter, entry, and interior security, and security planning measures at these labs. In addition, we found that CDC's implementation of the regulation governing facilities that transfer and receive select agents needs improvement.

Assessment of Progress to Address the Challenge

HHS agencies have sought additional resources and are working on corrective action plans responsive to our concerns. Federal, state, and local health departments are working cooperatively to ensure that bioterrorist attacks are detected early and responded to appropriately. CDC has taken steps to expand the availability of pharmaceuticals needed in the event of chemical, biological, or radiological attacks. States and localities are currently strengthening their bioterrorism preparedness programs, and recent increases in HHS funding address some of our concerns. However, we continue to believe that the general readiness of state and local governments to detect and respond to bioterrorist attacks is below acceptable levels. Until we confirm that our recommendations regarding lab security have been implemented, we also remain concerned about significant vulnerabilities. As a result, we have begun follow-ups at departmental laboratory facilities, as well as reviews at ten additional colleges and universities. We also initiated reviews to examine states' progress in developing and implementing Laboratory Response Networks (LRN); state health departments' legal authorities to respond to bioterrorism; and accountability for funds under the Hospital Bioterrorism Program and the CDC Bioterrorism Cooperative Grant.

Management's Comments in Brief

To address the challenges associated with terrorist threats, CDC, in FY 2003, intensified its strategic direction, programmatic activities, and resources to address the preparedness and response capacity of the public health system. CDC's major contributions to this effort include the following:

- Developed a National Public Health Strategy for Terrorism Preparedness and Emergency Response. The strategy identified several strategic imperatives that must be addressed to prepare public health: (1) timely, effective, and integrated detection and investigation; (2) sustained prevention and consequence management programs; (3) coordinated public health emergency preparedness and response; (4) qualified, equipped, and integrated laboratories; (5) a competent and sustainable workforce; (6) protected workers and workplaces; (7) innovative, relevant, and applied research and evaluation; and (8) timely, accurate, and coordinated communications. Within this framework, CDC channels its terrorism preparedness and response efforts to address three key themes and components of biodefense:

    - Biointelligence;
    - Containment and response; and
    - Recovery.

- Awarded more than $1 billion to the 62 grantees (all 50 states, the four largest urban areas, Puerto Rico, the Virgin Islands, and six Pacific Territories); provided oversight, technical assistance, and site visits to all 62 grantees; evaluated grantee progress toward achievement of the critical capabilities and benchmarks outlined in the program guidance; supported the review of grantees' emergency public health powers to assist them in strengthening their legal preparedness for terrorism and other public health threats and emergencies; and supported five states in building capacity to rapidly measure the metabolites of chemical agents in blood and urine of persons who are/were potentially exposed to chemical terrorism.

  The following is a list of some of the terrorism preparedness and response enhancements made by the 62 grantees to date:

    - Eighty two percent have established systems to rapidly detect terrorist events through mandatory disease reporting;
    - Ninety five percent operate 24/7 systems to activate response plans;
    - Ninety eight percent have the capability to test for b. anthracis (anthrax);
    - Ninety eight percent operate systems to disseminate health risk information to the public and key partners; and
    - Ninety one percent can initiate a field investigation within six hours of an urgent disease report from all parts of their jurisdiction on a 24/7 basis.

- Developed the following new performance measures for the State and Local Preparedness Program to provide a more complete representation of overall national preparedness:

    - Properly equipped public health emergency response teams will be on-site within four hours of notification by local public health officials to assess the public health impact and determine the appropriate public health intervention in response to Category A agents;

    - One hundred percent of state public health agencies will improve their capacity to respond to exposure to chemicals or category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified;

    - One hundred percent of state and local public health agencies will be in compliance with CDC recommendations for using standards-based electronic disease surveillance systems for appropriate routine public health information collection, analysis, and reporting to appropriate public health authorities;

    - One hundred percent of LRN laboratories will pass proficiency testing for bacillus anthracis, yersina pestis, Francisella tularensis, Clostridium botulinum toxin, Variola major, vaccina, and varicella;

    - One hundred percent of states will have level-1 chemical laboratory capacity, and have agreements with and access to (specimens arriving within eight hours) a level-three chemical laboratory equipped to detect exposure to nerve agents, mycotoxins, and select industrial toxins;

    - One hundred percent of state public health agencies are certified by CDC as prepared to receive material from the Strategic National Stockpile and distribute material in accordance with public health response plans; and

    - One hundred percent of state and local public health agencies will be in compliance with CDC recommendations for using standards-based, public health information network systems for appropriate routine public health information collection, analysis, and reporting to public health authorities.

- CDC has committed substantial resources to support the Select Agent Program (SAP). FY 2002's budget of approximately $5 million was more than tripled in FY 2003. Two letter contracts were awarded in February 2003. One contractor, Constella Health Sciences, is providing services for registering and inspecting laboratory facilities. More than 100 inspections have already been done under the new regulation. Inspections will be prioritized according to potential risk and other appropriate factors. The other contractor, Science Applications International Corporation, is developing and implementing a new database management system that will provide a web-based interface. Nineteen of the 21 FTE positions committed to the SAP have been filled. The SAP has received approximately 487 registration applications under the new regulation (42 CFR Part 73) from laboratory facilities to date. Program officials are contacting more than 200 laboratory facilities that had previously declared possession of a select microbiological agent or toxin to determine their current status.

- Improved the LRN through laboratorian training, testing research, and technical assistance for the

transfer of agents to a confirmatory laboratory. The following accomplishments demonstrate:

  - Enhanced LRN to include smallpox roll out capability across U.S. clinical labs;
  - Seventy five percent, structures established to provide rapid and effective laboratory services to support terrorism preparedness and response;
  - Eighty four percent, timeline prepared to improve relations between clinical labs and LRN member labs;
  - Ninety eight percent, can test for Bacillus anthracis;
  - Eighty six percent, can test for Yersinia pestis;
  - Eighty six percent, can test for Francisella tularensis; and
  - Thirty three percent, systems in place to screen for radiological, explosive, and chemical risk of specimens prior to biological analysis.

- Increased the number of rapid diagnostic tests to 39. Specifically, 39 Polymerase Chain Reaction (nucleic acid detection) and Time-Resolved Fluorescence (antigen detection) assays were developed to cover additional biodetection needs with ten bioterrorism agents on five different instrument platforms. Final results will be reported in December 2003.

- Developed a memorandum of understanding with the Federal Bureau of Investigation and U.S. Department of Agriculture that will expand the LRN to include the addition of public health laboratories, animal laboratories, and laboratories overseas.

- Managed the Strategic National Stockpile (SNS), a national repository of life-saving pharmaceuticals and medical material. Maintained 12 12-hour Push packages of pharmaceuticals, antidotes, and medical supplies designed to provide rapid delivery of a broad spectrum of assets for an ill-defined threat within the early hours of an event; and maintained a follow-on vendor managed inventory (VMI) available to ship within 24 to 36 hours if the incident requires additional pharmaceuticals. VMI can also be tailored to respond to a defined threat. CDC initiated a SNS project named "Chempack" that is the forward placement of SNS nerve agent antidotes. Chempack material will be under state and selected municipalities' custody for quick access for state and local responders. The project will begin in December 2003 with full deployment over the next two years.

- In January 2003, CDC opened its state-of-the-art Director's Emergency Operations Center (DEOC). The DEOC serves as the agency's central public health incident management center for coordinating and supporting staff, information, and other assets associated with CDC/ATSDR's preparedness for, and response to, public health emergencies. The DEOC also serves as a central point for monitoring and tracking CDC/ATSDR's worldwide public health commitments.

- As of August 8, 2003, 38,267 health care and public health responders were vaccinated. Of these, 2,667 are first responders (fire fighters, police, and emergency medical services personnel).

The Smallpox Emergency Personnel Protection Act (SEPPA) was passed on April 30, 2003. Note that the actual implementation of SEPPA is pending the approval of the compensation injury table that will outline eligibility criteria for benefits. Therefore, we are unable to judge if passing this legislation has affected vaccination rates. Unfortunately, since April 30 the numbers of volunteers for smallpox vaccination have continued to decrease each week. Prior to April 30 the number of volunteers ranged between 1,097 and 5,336, with an average of 3,097 volunteers each week. Since May 2 a total of 2,354 volunteers have been vaccinated, with an average of 168 volunteers per week.

Besides a smallpox compensation program, factors that have been attributed to the low acceptance of the vaccine include the following:

- Low perceived threat of a smallpox event;
- Concerns about hospital liability related to potential nosocomial transmission of vaccinia from vaccinated health care workers;
- Continuing concerns about personal risk of adverse reactions to vaccination, highlighted by the recent discovery of cardiac adverse events (myo-pericarditis); and
- Other public health emergencies such as Severe Acute Respiratory Syndrome (SARS).

Because interpretations of the phased approach to implementing the smallpox vaccination program vary widely, CDC has outlined a new strategy for smallpox grantees which does not emphasize "phases" or "stages." CDC will not recommend offering the vaccine to all traditional first responders and all health care providers. Rather, the focus will be on enhancing response teams so that they can quickly perform all the necessary activities to contain any potential smallpox outbreaks. CDC will allow states to decide the types of staff they need to respond, such as those the Advisory Committee on Immunization Practices (ACIP) identified for public health teams in its April 4, 2003, recommendations, that included persons designated as medical team leaders, public health advisors, medical epidemiologists, disease investigators, diagnostic laboratory scientists, nurses, personnel who could administer smallpox vaccines, security or law enforcement personnel, and other medical personnel to assist in evaluating suspected smallpox cases. Using this approach, we would concentrate less on the number of people being vaccinated and more on groups of individuals trained in their roles and responsibilities as part of smallpox response teams. This approach emphasizes a focus on all the elements needed to assure acceptable levels of readiness for a smallpox event. This new direction takes advantage of public health response strategies needed to control and contain an outbreak of smallpox and includes the following preparedness elements that must be addressed:

- Preparing key responders before an event occurs;
- Rapid detection, identification, investigation, and response to suspect or confirmed cases of smallpox; and
- Protection of the public, including the provision of mass vaccination clinics.

- According to the World Health Organization (WHO), 8,437 people worldwide became sick with SARS during the course of this outbreak; and of these, 813 died. Through July 2003, 192 SARS cases had been reported in the U.S., including 159 suspect and 33 probable cases. Of the 33 probable cases, only eight had laboratory evidence of SARS-CoV (SARS-associated Coronavirus) infection. No SARS-related deaths occurred in the U.S., and SARS cases reported in the U.S. occurred primarily among people who traveled to SARS-affected areas. Only one person may have contacted SARS after exposure in the U.S. (this person is the spouse of a SARS case who was exposed overseas). There was no evidence that SARS spread more widely within the U.S.

To minimize the risk for SARS among U.S. residents, the public health system took careful and thorough precautions to prevent the spread of SARS. People who were suspected of having SARS were isolated from others and received care, while people arriving from affected parts of the world (who might have been exposed to SARS) received information about SARS and instructions on what they should do if they became ill. SARS patients and their contacts were monitored to help prevent spread of the disease. CDC worked closely with WHO and other partners in a global effort to address the SARS outbreak. For its part, CDC took the following actions:

- Activated its Emergency Operations Center to provide round-the-clock coordination and response;
- Committed more than 800 medical experts and support staff to work on the SARS response;
- Deployed medical officers, epidemiologists, and other specialists to assist with on-site investigations around the world;
- Provided assistance to state and local health departments in investigating possible cases of SARS in the U.S.;
- Conducted extensive laboratory testing of clinical specimens from SARS patients to identify the cause of the disease; and
- Initiated a system for distributing health alert notices to travelers who may have been exposed to cases of SARS.

In addition, CDC is continuing to work with federal, state, and local health departments and other professional organizations to plan for a rapid recognition and response should SARS reemerge.

Management Issue #2: Payment for Prescription Drugs

Management Challenge

Because prescription drugs are such a significant part of medical care, it is important that Medicare and Medicaid beneficiaries' access to pharmaceuticals not be hindered by overpricing. Yet our work has revealed just such overpricing of drugs.

Medicare does not pay for most outpatient prescription drugs. However, under specific circumstances, Medicare Part B will cover drugs that are furnished incident to a physician's service that are not usually self-administered and certain prescription drugs that are used with durable medical equipment, infusion

devices, dialysis, chemotherapy, pain management, and organ transplantation. Yet, in calendar year 2002, Medicare and its beneficiaries paid more than $8.2 billion for such prescription drugs, nearly six times the $1.4 billion allowed in 1994. In the Medicaid program, drug costs represent one of the fastest growing categories of expenditures. The federal share of dollars spent for Medicaid prescription drugs was $15.8 billion compared with $8.2 billion in FY 1994.

We have consistently found that Medicare and Medicaid pay too much for prescription drugs -- more than most other payers. For example, Medicare payments for 24 leading drugs in FY 2000 were $887 million higher than actual wholesale prices available to physicians and suppliers and $1.9 billion higher than prices available through the Federal Supply Schedule. This excessive payment continues to grow as the amount paid by Medicare increases. In an August 2001 report, we estimated that the Medicaid program could have saved as much as $1 billion if brand name prescription drug reimbursement (not including the dispensing fee) had been in line with the pharmacies' estimated acquisition costs for the drugs.

Excessive Medicare and Medicaid payments have occurred because the reimbursement methodologies are fundamentally flawed. By law, Medicare's payment is equal to 95 percent of a drug's average wholesale price. However, the prices used to set Medicare and Medicaid payments are not really wholesale prices. These published prices used to establish drug reimbursement often bear little or no resemblance to actual wholesale prices available to physicians, suppliers, and large government purchasers. Further, because physicians and suppliers keep the difference between the actual price they pay for a drug and 95 percent of the published wholesale price, they have a financial incentive to buy from a drug company with the highest published prices, and manufacturers may have a financial incentive to artificially inflate their published data in an attempt to gain market share.

Numerous OIG reports indicate that Medicaid is also paying too much for prescription drugs because state reimbursement methodologies are also based on inflated published wholesale prices. Most states currently reimburse pharmacies for drugs using an average discount of 10.3 percent of the average wholesale price. Our reviews have shown that the actual acquisition costs can range from 17.2 percent to 72.1 percent discounts off the published prices depending upon the classification of the drug.

As further evidence of the vulnerabilities in the drug area, the Federal Government recently settled with three pharmaceutical manufacturers who allegedly set and reported certain wholesale prices at levels far higher than the actual acquisition cost. The government alleged that these prices were higher than those paid by the majority of their customers and resulted in excess Medicare and/or Medicaid reimbursement. To resolve their liability for this and other conduct, these three companies agreed to pay $875 million, $355 million, and $14 million; a total of $1.25 billion. Additional examples involve three companies that paid almost $400 million to resolve their liabilities in cases involving their failure to pay appropriate rebates under the Medicaid drug rebate program.

Assessment of Progress in Addressing the Challenge

OIG reports continue to show that these flawed payment methodologies remain essentially unchanged. However, the Benefits Improvement and Protection Act of 2000 authorized the Secretary to make some administrative adjustments to the Medicare payment methodology. The Centers for Medicare & Medicaid Services (CMS) would prefer that Congress reform the drug payment system legislatively. However, in the interim, CMS has issued a notice of proposed rulemaking, soliciting comments on four options to reform Medicare prescription drug payment methodology.

Management's Comments in Brief
As of November 2003, the different Medicare bills proposed in the House and Senate are in conference, but to date no legislation has been enacted. In the absence of legislation, CMS published a notice of proposed rulemaking (NPRM) on August 20, 2003 (68 FR 50428).

Management Issue #3: Nursing Facilities

Management Challenge
Given the vulnerability of nursing facility residents, appropriate and quality care is a top priority for the OIG. We continue to be concerned about the quality of living conditions and care in these facilities.

In recent work, we found increases in the total number of deficiencies and in the proportion of nursing homes being cited for substandard care deficiencies. Specifically, the deficiencies cited by surveyors in 2001, compared with those cited in 1998, showed that the overall number went up both in the aggregate and in the number per nursing home surveyed. We found that 78 percent of the nursing homes received at least one deficiency in the three categories related to quality of care, an eight percent increase from 1998. The greatest overall increase in deficiency citations was for resident assessments and care plans, important tools in developing the framework for the appropriate care of residents. In 2001, 50.1 percent of nursing homes had at least one deficiency related to resident assessments, up from 11.6 percent in 1998.

We also found that inconsistencies in citing deficiencies resulted from variations of survey focus, unclear guidelines, lack of a common review process for draft survey reports, and high surveyor staff turnover.

In our review of psychosocial services in nursing homes, we found that not all of the facilities had developed the necessary care plans to address psychosocial needs and that 46 percent of beneficiaries with such plans did not receive the care outlined in them. A further indication of quality of life and care problems is evident in the increasing number of nursing home complaints registered in the National Ombudsman Reporting System.

Assessment of Progress in Addressing the Challenge
CMS has taken a number of steps to strengthen the survey and certification process, including clarifying its guidance to states on citing deficiencies. CMS indicated that it had initiated a contract to develop guidance for determining the severity of deficiency findings and for citing single or multiple deficiencies. The agency also agreed to improve nurse aide training and competency evaluation program requirements, and to strengthen the oversight process associated with the psychosocial service portion of the resident assessment. Nevertheless, because of the pervasive and continuing nature of the problems we found, there is still cause for serious concerns.

Management's Comments in Brief
There has been an increase in the number of deficiencies resulting from nursing home surveys. However, it would not be accurate to assume the number of deficiencies is an automatic reflection of decreased quality of care to residents. The CMS has undertaken a number of initiatives that explain, at least in part, the pattern of deficiency citations discussed under "Management Challenge." The CMS initiatives have had an impact on the regulation of nursing homes and resulted in the identification of problems that may have previously been present but not identified. These initiatives include the following:

- An increased focus on acceptable care related to pressure ulcers, dehydration, and unintended weight loss. The increased focus on these areas of care included issuance of additional protocols in 1999 to guide surveyor information gathering and decision-making associated with determining compliance with federal requirements;

- Emphasis has been placed on citing not only compliance issues related to quality of care tags but also failures associated with related assessment and care planning requirements. The result of this effort has been an increased citation of noncompliance with assessment and care planning requirements. Prior to this effort there was greater inconsistency in the pattern of citations (citing specific care practices and not making an association with the related process requirements);

- The CMS presented a national satellite broadcast for surveyors and providers on "Mental Illness in Nursing Facilities." Objectives of the broadcast were to educate surveyors about implementation of the Preadmission Screening and Resident Review (PASRR) requirements, and enhance surveyor ability to determine facility compliance using an assessment process to identify residents with mental illness or significant change in mental health and to develop appropriate care plans. We anticipate this training may result in the identification of additional problems in facilities and believe this is an indication that surveyors are better prepared to identify when problems of compliance may be present. As previously stated, this should not be automatically construed to mean there has been a decrease in the quality of care;

- The CMS developed and implemented the use of state performance standards to evaluate survey agency (SA) performance. Use of the performance standards by regional office staff is one method of evaluating each SA. The performance standards include evaluation of the survey findings and whether actions leading to certification by the SA are fully documented and consistent with applicable law, regulations, and general instructions. We believe this process of SA evaluation will identify if problems are present regarding the adequacy of documentation by surveyors;

- The CMS is developing additional survey process guidance. This guidance includes developing additional instructions with the assistance of national experts to upgrade clinical information and provide specific information regarding determining severity levels of critical tags. This effort is capable of leading to additional findings of noncompliance and changes in the level of severity associated with determinations of deficient practice. This is shared as an indication of how a change in the number of deficiencies or their severity may occur even though there has not necessarily been a decline in the quality of care;

- The CMS has developed a complaint tracking system and is currently in the final stages of a national pilot prior to implementation. The Aspen Complaint and Incident Reporting System (ACTS) will assist in managing complaints and their investigations by SAs. This is mentioned since we believe more complete reporting and tracking of complaints may occur although it would be an error to conclude that care has diminished simply because we have mechanisms for better reporting the number and nature of complaints; and

- The General Accounting Office is currently conducting a study of the manner in which SAs budget their expenses and CMS distributes funds to carry out the certification program. It is possible this study may

impact on the adequacy of funding and to the extent that surveyor salaries are related to turnover, which may prove informative to CMS.

Management Issue #4: Integrity of Medicaid Payments

Management Challenge

Accuracy in the federal share of Medicaid costs is important to help ensure fairness across all state Medicaid programs as well as assure these federal health care dollars reach and achieve their maximum intended health care purposes. We found that some states inappropriately inflated the federal share of Medicaid by billions of dollars by requiring public providers to return Medicaid payments to the state governments through intergovernmental transfers. Once the payments were returned, the states used the funds for other purposes, some of which were unrelated to Medicaid. Although this abusive practice could potentially occur with any type of Medicaid payment to public facilities, we identified serious problems with this practice in Medicaid enhanced payments available under upper payment limits and Medicaid disproportionate share hospital payments. These federal/state enhanced payments are made to nursing homes, or hospitals; and these facilities then return the monies to the states through intergovernmental transfers.

Assessment of Progress in Addressing the Challenge

To curb abuses and ensure that state Medicaid payment systems promote economy and efficiency, CMS issued final rules, effective March 13, 2001, November 5, 2001, and May 14, 2002, which modified upper payment limit regulations in accordance with the Benefits Improvement and Protection Act of 2000. The regulatory action created three aggregate upper payment limits – one each for private, state, and non-state government-operated facilities. The new regulations will be gradually phased in and become fully effective on October 1, 2008. CMS projects that these revisions combined will save $90 billion in federal Medicaid funds over the next ten years.

However, when fully implemented, these changes will only limit, not eliminate, the amount of state financial manipulation of the Medicaid program because the regulations do not require that the targeted facilities retain the enhanced funds to provide medical services to Medicaid beneficiaries. We also believe the transition periods included in the regulations are longer than needed for states to adjust their financial operations.

CMS has developed procedures for conducting Financial Management Reviews to ensure state accountability with respect to disproportionate share payments to hospitals. We are continuing audit work in this area and will recommend program improvements once the work is completed.

Management's Comments in Brief

The CMS and the OIG will continue to work closely on analyzing the effects of the upper payment limit issue and regulations, and the correct expenditure of disproportionate share hospital funds. During FY 2003, CMS requested the assistance of the OIG in the review of upper payment limit and disproportionate share hospital methodologies in ten states. These OIG reviews will greatly aid CMS in the identification of abusive upper payment limit and disproportionate share hospital practices.

Regarding the length of the upper payment limit transition periods, CMS has little control. The two- and

five- year transition periods were adopted pursuant to notice and comment rulemaking. The Benefits Improvement and Protection Act (BIPA) of 2000 further extended the transition periods by mandating the eight-year transition period.

In August 2003, CMS commenced in-depth questioning of states' funding and payment recycling practices. It is CMS's goal to end all state practices that result in federal Medicaid dollars not being used for their maximum intended health care purposes.

Management Issue #5: Oversight of Medicare Contractors

Management Challenge

Because of the crucial role that Medicare claims processing contractors play in helping to deliver efficient and effective health care to approximately 41 million Medicare beneficiaries, it is important they be held accountable for their responsibilities in the health care financing and delivery system. For several years, we have been concerned about Medicare contractors' financial management problems, such as accounts receivable documentation inadequacies and the lack of integrated dual-entry accounting systems; information systems control weaknesses; integrity issues; and weaknesses in the way they assign and maintain provider numbers. These deficiencies could contribute to the loss of program funds through improper payments, manipulation, fraud, and abuse.

Of particular concern is that the integrity of the contractors themselves continues to be an issue, and the potential for fraud exists. Since 1993, 18 settlements and agreements (criminal and civil) have resulted in over $458 million in HHS recoveries for alleged improper contractor operations. One contractor agreed to pay $76 million to settle allegations of misconduct while acting as a Medicare Part B carrier between 1966 and 1998. Among other things, the contractor had failed to process claims properly, then submitted false information to CMS regarding the accuracy and timeliness with which it handled those claims. In addition, a former Medicare fiscal intermediary agreed to pay $9.3 million to resolve its potential liability under the False Claims Act and Civil Monetary Penalties Law for allegedly falsifying its performance data on Medicare cost reports.

Assessment of Progress in Addressing the Challenge

Some progress is being made with respect to financial management problems cited above, but more needs to be done. The OIG expressed an unqualified opinion on the CMS FY 1999 through FY 2002 financial statements because CMS continued to contract for validation and documentation of accounts receivable. However, once again, OIG's FY 2002 financial statement audit disclosed that the lack of a fully integrated financial management system continued to impair CMS's and the Medicare contractors' abilities to adequately support and analyze accounts receivable and other reported financial balances. To address these problems, CMS has initiated steps to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS). This is expected to be fully operational in FY 2007.

FY 2002 reviews of information systems (IS) controls also disclosed numerous and continuing general control weaknesses at Medicare contractors, as well as application control weaknesses in contractors' shared systems. The most significant IS weakness, the distribution of source code to Medicare contractors, was corrected during FY 2002. However, as a result of the remaining vulnerabilities, controls would not effectively prevent unauthorized access, malicious changes, improper Medicare payments, or

critical operation disruptions. Corrective action is needed to address the fundamental causes of control weaknesses. We continue to assess the status of these weaknesses in our annual audit of the CMS financial statements.

With regard to the integrity of the contractors themselves, the OIG and CMS continue to work to resolve cases as they arise with resulting settlements as previously discussed.

Management's Comments in Brief

The CMS concurs with the OIG's assessment. The fact that CMS's financial statements received an unqualified opinion for the fourth consecutive year reflects the steady progress that CMS has made in achieving its financial management goals. A key element of our strategic vision is to implement a state-of-the-art financial management system that fully integrates CMS's accounting system with those of our Medicare contractors. Recent HIGLAS accomplishments include the mapping of HIGLAS requirements to the Oracle Federal Financial software and the completion of nine technical requirement pilots and six conference room pilots needed to complete the business and technical design for the pilot contractors. Pilot test training development and end-user training development are also underway. Validation and user testing at the two contractor pilot sites (Major Milestone 1 of the project) is on track to begin in October 2003 as scheduled. Prior to HIGLAS implementation, CMS continues to conduct Statement on Auditing Standards (SAS) 70 internal control reviews to validate Medicare contractors' accounts receivable.

The Medicare Information Systems and Controls material weakness is an accumulation of findings at the fee-for-service contractor operations as well as at the CMS Central Office. The weakness is not attributable to any one location or any one vulnerability, nor has there been any evidence that the weakness has been exploited. This weakness will in all likelihood remain an issue until CMS is well along on its information technology (IT) modernization effort.

- The President's budget for FY 2004 includes $65 million to revitalize CMS's IT systems. A secure system environment is a key component of the IT Modernization Plan;

- A good example of how this will impact security is data center consolidation. Data center consolidation will reduce the number of locations within the Medicare security perimeter; and

- Rather than focus resources on managing corrective actions of individual findings or implementation of safeguards, CMS IT modernization emphasizes funding the architectural foundation needed to protect our systems and infrastructure.

The CMS is implementing Electronic Data Processing (EDP) security safeguards at the Medicare contractors. A total of 683 safeguards have been funded. Contractors have reported completing about two thirds of the safeguards. The CMS is validating the implementation of the safeguards. Implementation of all the safeguards will improve security, although as mentioned the long-term fix for the Medicare contractors lies in the CMS IT Modernization initiative.

Management Issue #6: Medicare Payment Errors

Management Challenge

To help ensure the financial integrity of the Medicare program, continued access to Medicare benefits, as well as the long-term viability of the Medicare trust fund, documented and accurate bills for properly rendered health care services must be submitted for correct payment. Based on a statistical sample, OIG estimated that improper Medicare benefit payments made during FY 2002 totaled $13.3 billion, or about 6.3 percent of the $212.7 billion in processed fee-for-service payments reported by CMS. These improper payments could range from reimbursement for services provided, but inadequately documented, to inadvertent mistakes, to outright fraud and abuse. When these claims were submitted for payment to Medicare contractors, they contained no visible errors; however, the overwhelming majority were detected through medical record reviews. While OIG's seven-year analysis indicates continuing progress in reducing improper payments, unsupported and medically unnecessary services remain pervasive problems.

We have also conducted targeted audits and inspections to identify improper payments and problem areas in specific parts of the program. These reviews have analyzed duplicate payments for the same service, payments made on behalf of deceased beneficiaries, payments made for incarcerated beneficiaries, and other types of improper payments. For example, we found over $45 million in improper payments for equipment and supplies billed by durable medical equipment suppliers for beneficiaries residing in skilled nursing facilities. And Medicare made over $64 million in potential overpayments for ambulance and radiology services billed for beneficiaries during their inpatient stays in prospective payment system hospitals.

An issue was identified where a provider manipulated the Medicare payment rules in the hospital outlier payments. Reviews of a major chain of providers have shown that the chain's actions to aggressively increase charges for services triggered higher than normal Medicare outlier payment increases of several hundred million dollars. CMS issued a regulation to address this problem. However, this manipulation by the chain highlights the vulnerability present in Medicare payments that are extra or that are made to enhance the basic payments.

We will continue these targeted reviews to ensure that Medicare payments are made in accordance with program rules. For example, we are currently reviewing the accuracy of payments for power wheelchairs, ambulance services, chiropractic services, allergy treatments, physician evaluation and management services, and services and supplies billed "incident to" physician services.

Assessment of Progress in Addressing the Challenge

The FY 2002 error rate is less than half of the 13.8 percent reported for FY 1996. Since we developed the first error rate, CMS has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans. In addition, due to CMS's work with the provider community to clarify reimbursement rules and to impress upon health care providers the importance of fully documented services, the overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly.

In FY 2003, CMS will fully implement its Comprehensive Error Rate Testing (CERT) program and Hospital Payment Monitoring Program (HPMP) to produce a Medicare fee-for-service error rate. This methodology will establish, for the first time, baselines to measure each contractor's progress toward correctly

processing and paying claims. The result will reflect the contractor's performance and will identify specific provider billing anomalies in the region. Contractors will then develop targeted corrective action plans to reduce payment errors through provider education, claim reviews, and other activities; and CMS will evaluate their rate of improvement. We will also continue targeted reviews of specific Medicare benefits where vulnerabilities have been identified, to determine appropriateness of payments.

Management's Comments in Brief

The CMS concurs with the OIG's assessment. In FY 1996, the OIG began estimating the national Medicare fee-for-service paid claims error rate. By FY 2000, the error rate was cut in half due in part to CMS's corrective actions that enhanced internal pre- and post- payment controls; targeted vulnerable program areas; and educated providers regarding documentation guidelines and common billing errors.

Since the OIG's error rate measure was valid only at the national level, CMS developed a new, more precise measure for 2003 and beyond. The CMS's CERT program and Hospital Payment Monitoring Program HPMP will produce the following error rates in November 2003:

Monitoring Program	Type of Error Rate(s) Produced	Provider Compliance Error Rate	Paid Claims Error Rate	Processed Claims Error Rate
Comprehensive Error Rate Testing (CERT)	For all carriers (as a group)	✓	✓	✓
	For all Durable Medical Equipment Carriers (DMERCs) (as a group)	✓	✓	✓
	For all Fiscal Intermediaries (FIs) (as a group)	Available in 2005	✓	Available in 2005
	For each individual carrier	✓	✓	✓
	For each individual DMERC	✓	✓	✓
	For each individual FI	Available in 2005	Available in 2004	Available in 2005
	By type of service	✓	✓	✓
	By type of provider	✓	✓	✓
Hospital Payment Monitoring Program (HPMP)	For all Quality Improvement Organizations (QIOs) (as a group)	Not Produced	✓	Not Produced
	For each individual QIO	Not Produced	✓	Not Produced
	By type of service	Not Produced	Not Produced	Not Produced
CERT + HPMP	A Medicare-wide rate	Not Produced	✓	Not Produced

Management Issue #7: Grant Management

Management Challenge

Departmental discretionary grants, estimated to total over $35 billion in FY 2003, must be used appropriately to achieve their intended purposes. Most of the departmental agencies rely on the grant

mechanism as a pivotal tool in meeting their mission objectives, such as providing critical health services to underserved individuals, researching the causes and treatments of disease, elevating the social and economic status of vulnerable populations, and supporting the nationwide infrastructure for the health surveillance and prevention network. As such, it is incumbent upon HHS to award grant funds to the most worthy and competent organizations and to adequately monitor program results and use of federal funds. However, the programs are numerous and diverse. Vigilance is required to ensure that specific awards are free of abuse and the monitoring systems to manage them are capable of identifying improper behavior.

To address this challenge, we have initiated reviews that will focus on the effectiveness and efficiency of management controls over federal grants. We are systematically studying several HHS agencies' grant-making and oversight processes. At the same time, we are assessing individual grantees' program performance-based outcomes and stewardship of funds. This strategy is designed so that findings and recommendations derived at the agency level can be used in examinations at the grantee level and vice versa.

Thus far, we have found inadequate performance on the part of some grantees in achieving grant objectives, limited required reporting to federal offices on progress in meeting program objectives, and the misuse of grant funds. In addition, we noted poor oversight on the part of federal program offices and inadequate follow-up on significant identified problems. We will continue to address grant oversight and performance throughout the Department's grant-making programs in FY 2004.

Assessment of Progress in Addressing the Challenge

Through the government-wide Federal Grant Streamlining Program (FGSP), the HHS grant management environment is undergoing significant changes. The program is intended to implement the Federal Financial Assistance Management Improvement Act of 1999, which requires agencies to improve the effectiveness and performance of their grant programs, simplify the grant application and reporting process, improve the delivery of services to the public, and increase communication among entities responsible for delivering services. The initiative requires grant officials to examine the way they do business, focusing not only on streamlining the grant process but also on ensuring that results are achieved and federal funds are used appropriately for maximum benefit of program recipients.

Management Comments in Brief

A wide variety of departmental activities are currently underway which are complementing the various OIG studies and providing a renewed focus on how departmental staff assess grantee progress in achieving grant outcomes and monitoring grantee compliance with federal and agency specific grant requirements. Specific initiatives include the following:

- HHS agencies are continuing their efforts to establish performance goals in various grant programs by requiring applicants, as part of their grant application proposals, to identify performance targets to be achieved by the end of each budget period. HHS agencies review grantee progress reports to assess achievement of performance targets and, if deemed necessary, more intensive monitoring and/or technical assistance may be provided to assist grantees in accomplishing identified outcome(s);

- Targeted reviews of specific grant operations within the Department are currently underway or being planned under the aegis of the Assistant Secretary for Administration and Management. These reviews, building on previously developed grants management systems review protocols, examine a variety of pre- and post- award activities performed by an HHS awarding agency. For example, a

review of a grant program in the Division of Adolescent and School Health (DASH), a program within the Centers for Disease Control and Prevention, was conducted in FY 2003 to ascertain whether DASH grant practices are in compliance with established departmental regulations and policies; i.e. evaluations of pre-award processes, including a determination as to whether the award process effectively maximizes competition; and examinations of post-award monitoring activities, including performance and financial report submissions and site-visits;

- HHS's Grants Management Balanced Scorecard is a self-administered review protocol enabling HHS agencies to assess perceptions of performance by soliciting feedback from a variety of internal and external users/customers. The results indicate how well an HHS agency is performing a variety of pre- and post- award grant activities enabling HHS agencies to develop and implement action plans to address areas targeted for improvement. To date, all HHS agencies have administered both phases of the Balanced Scorecard (Phase One focused on internal HHS agency surveys, and Phase Two focused on external surveys of grant recipients). HHS agencies are at varying stages in reviewing Scorecard data results, developing action plans to implement process improvements, and re-administering the Scorecards. For example, HHS agencies such as HRSA, AHRQ, and AoA have developed and implemented initial process improvements and will measure their success in future Scorecard surveys;

- Special award conditions of a programmatic and/or administrative nature may be appropriate if an organization has a history of poor programmatic performance, is financially unstable, has inadequate management systems, or has not complied with the terms of previous HHS awards. If special conditions are included in an award, the awarding office is required to designate the grantee as "high risk/special award conditions". In order to notify all HHS awarding offices of entities considered "high risk/special award conditions" by one or more awarding offices and/or those for which the OIG has issued an alert, HHS maintains a Department Alert List. If an award contains special conditions, the HHS agencies must ensure that the grantee is aware of those conditions and understands the action that is necessary to satisfy them. Furthermore, HHS agencies must develop a corrective action plan with the affected grantee, monitor improvement, and assess, at the conclusion of the corrective action period (generally no more than two years), whether the special award conditions can be removed. SAMHSA has been especially diligent in placing appropriate organizations on the Alert List in a timely manner, monitoring progress with corrective action plans, and removing them from the Alert List once the corrective actions have been satisfactorily addressed;

- Through the government-wide FGSP, the HHS grant management environment is undergoing changes. The FGSP is an effort required by Public Law 106-107, the Federal Financial Assistance Management Improvement Act of 1999, which requires all federal agencies to improve the effectiveness and performance of their grant programs, simplify the grant application and reporting process, improve the delivery of services to the public, and increase communication among entities responsible for delivering services. As the lead agency in this multi-year initiative, HHS continues to provide both strategic oversight for the Act's implementation as well as a leadership role in the various streamlining and simplification workgroups created under the FGSP. Achievements to date include, but are not limited to, the establishment of the Grants.gov Office within HHS which collaborates with multiple federal agencies to help meet the requirements for electronic access to funding opportunities and electronic submission of applications; participation in the development and issuance of several *Federal Register* notices soliciting public comment on key initiatives encompassed under the act; e.g.,

proposals for simplifying and clarifying the various government-wide cost principles applicable to grant programs; and increased development and use by HHS agencies of electronic technologies to ensure the ability to electronically receive and process applications as well as required reports under grant awards; and

- The National Institutes of Health (NIH), which continues to actively represent the Department's research programs in the interagency forums, was one of the original participants in developing the concept and planning for the e-Grants portal, which built on the NIH Commons concept. NIH also was an active partner in the development of the Transaction Set 194, which is serving as the starting point for the core data set for applications to be submitted through the e-Grants portal. In addition, NIH is developing a web-based system that will provide easier grantee access and a friendlier user-interface for submission of Financial Status Report data to replace its current electronic system. The HHS agencies are also making greater use of fillable forms and electronic processing of grant applications. While most of this activity is directed at discretionary grants, SAMHSA is using an automated block grant application system, which it plans to convert to an interactive system.

Because these initiatives require grant officials to examine the way they do business, they are in a good position to focus not only on streamlining the grant process but also on ensuring that results are achieved and federal funds are used appropriately.

As one of several initiatives designed to ensure that the Department meets the President's Management Agenda for improving the management and performance of the Federal Government, the Office of Grants Management and Policy, within the Office of the Assistant Secretary for Administration and Management, was authorized by the Secretary to conduct a departmental review of grants management activities involving the pre-award process. Special interest was given to the development of funding announcements in order to develop best practices, afford greater efficiencies and increased accountability, and ensure that announcements are consistent with regulations and departmental policies. The departmental review has identified various recommendations for improvements in announcement preparation and presentation which have subsequently been promulgated through a directed action transmittal to the awarding components. All HHS agencies are making strides at integrating best practices into the development of their announcements resulting in greater consistency across the Department.

Management Issue #8: Protection of Critical Systems,

Management Challenge

To accomplish its major missions – providing health care to the elderly, the disabled, and the poor; facilitating research; preventing and controlling disease; and serving families and children – the Department must rely on a computing environment that is decentralized, accessible to all users, and distributed over multiple platforms, agencies, and operating systems. Management, therefore, must ensure the creation of an integrated process to establish security policies for IT and to monitor compliance. This process is essential for an effective IT security program, both for existing systems and those being developed. Due to its major responsibilities for public health and safety, the Department has been identified as a Tier I agency, which signifies a dramatic negative national impact should certain HHS systems be compromised. Additional HHS systems are critical for maintaining the financial integrity of billions of dollars expended on services to the American public.

Through Presidential Decision Directive 63 and the Federal Information Security Management Act, the Federal Government has been mandated to assess the controls in place to protect assets critical to the Nation's well-being and report on their vulnerability. 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 the government. However, reviews at contractors, grantees, HHS agencies, and states continue to disclose significant impediments to the creation of an effective security program. And the Department now faces the additional challenge of ensuring the privacy of medical records in electronic systems and transmissions, as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, effective April 14, 2003.

Assessment of Progress in Addressing the Challenge

HHS has made progress in securing the most critical of essential assets, both physical and cyber-based, such as Department laboratories, computer systems, and data communication networks. Core requirements for security controls were established and distributed, and systems architecture documents are being developed. However, recent OIG assessments found numerous control weaknesses in entity-wide security, access controls, service continuity, and segregation of duties. A collective assessment of deficiencies in Medicare systems resulted in the reporting of a material weakness in the FY 2002 HHS financial statement audit. Although we have not found any evidence that these weaknesses have been exploited, they leave the Department vulnerable to: (1) unauthorized access to and disclosure of sensitive information; (2) malicious changes that could interrupt data processing or destroy data files; (3) improper payments; or (4) disruption of critical operations.

While continuing to assess Medicare systems controls, OIG reviews will place new emphasis on compliance with HIPAA privacy rules and on security plans for the development of new systems, such as the Unified Financial Management System and the Health Insurance General Ledger Accounting System.

Management's Comments in Brief

In accordance with external guidance and initiatives, HHS has increased its focus on security. As HHS relies more heavily on using IT to support its business and services to citizens, clearly defined IT security strategies and standard practices are required. This includes providing safeguards to protect the security and confidentiality of patient health information as well as providing a secure environment for leading researchers to share and store their research information.

The Department's critical IT infrastructure is composed of thousands of interconnected computers, servers, routers, switches, and fiber optic cable, that allow its critical information systems to work. A healthy, well-functioning IT infrastructure is essential to enable HHS to serve its citizens and meet their needs. Unfortunately, recent national events have highlighted the existence of IT vulnerabilities and the fact that malicious entities are seeking to exploit those vulnerabilities.

A number of internal initiatives and HHS enterprise goals support investment in an enterprise wide approach to security. These include:

- **Secretary Priorities:** The Secretary of HHS has publicly stated that IT security is one of his top priorities. His *One HHS* vision also has ramifications within IT security, from the need to establish an overarching IT security program to enhancing communication and collaboration across HHS, to consolidating IT infrastructures and common administrative systems;

- **Emerging role of HHS as a key organization in the area of Homeland Security:** Certain homeland security initiatives, such as first responder programs for biological, chemical, and terrorism attacks, and other domestic emergencies rely heavily on HHS resources and capabilities for information. Should key security functions be compromised during a crisis, the effects of the disaster would be intensified because of the disruption in information flow to the end users;

- **HHS Enterprise Strategic Goals:** IT security is directly integrated into three of five HHS's Enterprise Strategic Goals: Goal 1 – Provide a secure and trusted IT environment, Goal 2 – Enhance the ability of the Nation's healthcare system to effectively respond to bioterrorism and other public health challenges, and Goal 3 – Achieve excellence in IT management practices;

- **HHS Enterprise IT Strategic Plan:** The HHS Enterprise IT Strategic Plan for FY 2003 - FY 2008 defines IT mission, vision, goals, initiatives, and measures for the Department including the development of an HHS IT Security Program; and

- **Growing Impact of Security:** Related events, such as denial of service attacks, virus incidents, system intrusions, and other events adversely effect HHS mission of "improving the health, safety, and well being of the American people."

The external legislation and guidance, and internal business demands, defined above, clearly highlight the importance and priority of IT security in fulfilling the HHS mission, both at a strategic level through IT strategies as well as at the operational level through enterprise IT initiatives.

HHS has made progress in securing the most critical of essential assets, both physical and cyber-based, such as Department laboratories, computer systems, and data communication networks. Core requirements for security controls were established and distributed, and systems architecture documents are being developed.

To further meet the aggressive demands of an overarching HHS security program, Secure One HHS, a strong governance structure with clearly defined roles, responsibilities, and security expertise is required. At the Headquarters (HQ) level, the Department Chief Information Officer (CIO) leads all Department IT efforts and the HHS Chief Security Officer (CSO) leads all security efforts. The CSO reports to the CIO and is legislatively charged with coordinating all department-wide IT security activities. At the HHS agency level, each HHS agency has its own CIO, CSO or equivalent, and IT organization.

Secure One HHS will function as an overarching IT security program, managed at the HQ level by the HHS CSO, with control and implementation responsibilities distributed across the 12 HHS agencies. By managing the program at the HQ level, HHS will achieve a consistent IT security baseline across the HHS agencies by relying upon systematic and universal security requirements; however, local implementation control within the HHS agencies will enable the HHS agencies to implement security controls within the confines of their unique operating environments.

Appendix B - Net Cost of Key HHS Programs
For the Fiscal Years Ended September 30, 2003 and 2002
(in millions)

The following table presents the Net Costs of key HHS programs (based on their FY 2003 net cost) for FY 2003 and FY 2002. This listing includes programs aggregated from all HHS GPRA programs. The net cost information is extracted from HHS agencies' Consolidated Statements of Net Cost for FY 2003 and FY 2002, and supplements the programs identified in the Department's Consolidated Statement of Net Cost. The shaded programs below relate to the programs discussed in the Performance Overview section of the "Management Discussion & Analysis" and in the "Program Performance by HHS Strategic Goal" section of this report.

HHS Program	HHS Net Cost ($)		Rank by ($)		Budget Function	HHS Component Responsible for Program
	FY 2003	FY 2002	FY 2003	FY 2002		
Medicare	250,074	231,132	1	1	Medicare	Centers for Medicare and Medicaid Services
Medicaid	161,721	150,101	2	2	Health	Centers for Medicare and Medicaid Services
Research Program	21,359	19,058	3	4	Health	National Institutes of Health
Temporary Assistance to Needy Families	19,348	19,069	4	3	Education, Training & Social Services/Income Security	Administration for Children and Families
Child Welfare	6,952	6,740	5	5	Education, Training & Social Services/Income Security	Administration for Children and Families
Head Start	6,780	6,503	6	6	Education, Training & Social Services	Administration for Children and Families
Child Care	5,089	4,512	7	7	Education, Training & Social Services/Income Security	Administration for Children and Families
SCHIP	4,360	3,662	8	9	Health	Centers for Medicare and Medicaid Services
Child Support Enforcement	4,060	4,056	9	8	Education, Training & Social Services/Income Security	Administration for Children and Families
Low-Income Home Energy Assistance	2,030	1,760	10	12	Education, Training & Social Services/Income Security	Administration for Children and Families
HIV/AIDS Programs	1,981	1,791	11	10	Health	Health Resources and Services Administration
Primary Care (Note 1)	1,862	1,533	12	14	Health	Health Resources and Services Administration
Social Services Block Grant	1,741	1,765	13	11	Education, Training & Social Services	Administration for Children and Families
Immunization	1,734	1,345	14	16	Health	Centers for Disease Control & Prevention
Substance Abuse Prevention & Treatment Block Grant	1,733	1,673	15	13	Health	Substance Abuse and Mental Health Services Administration
Clinical Services	1,591	1,490	16	15	Health	Indian Health Service
Public Health and Social Services (Note 2)	1,483	715	17	23	Health	Office of the Secretary
Training/Career Development Program	1,405	1,247	18	17	Health	National Institutes of Health
Community Based Services	1,225	1,021	19	19	Education, Training & Social Services	Administration on Aging
HIV/AIDS, STD &TB Prevention	1,093	365	20	30	Health	Centers for Disease Control & Prevention
Health Professions	1,066	804	21	22	Health	Health Resources and Services Administration
Maternal and Child Health (Note 3)	971	967	22	20	Health	Health Resources and Services Administration
Chronic Disease Prevention	771	626	23	25	Health	Centers for Disease Control & Prevention
Community Services	727	666	24	24	Education, Training & Social Services	Administration for Children and Families
Foods and Cosmetics	491	431	25	28	Health	Food and Drug Administration
Contract Health Care	467	452	26	27	Health	Indian Health Service
Infectious Diseases	458	1,102	27	18	Health	Centers for Disease Control & Prevention
Refugee Resettlement	449	488	28	26	Education, Training & Social Services/Income Security	Administration for Children and Families
General Departmental Management	435	336	29	31	Health	Office of the Secretary
Office of Special Programs	419	210	30	42	Health	Health Resources and Services Administration
Community Mental Health Services Block Grant	413	420	31	29	Health	Substance Abuse and Mental Health Services Administration
Knowledge Development & Application	367	315	32	32	Health	Substance Abuse and Mental Health Services Administration
PHS Commissioned Corps	357	944	33	21	Health	Program Support Center
Program of Regional National Significances/Targeted Capacity Expansion (new)	313	258	34	37	Health	Substance Abuse and Mental Health Services Administration

HHS Program	HHS Net Cost ($)		Rank by ($)		Budget Function	HHS Component Responsible for Program
	FY 2003	FY 2002	FY 2003	FY 2002		
Human Drugs	297	280	35	33	Health	Food and Drug Administration
Facilities Program	287	270	36	36	Health	National Institutes of Health
Tribal Activities: Contract Support	283	270	37	35	Health	Indian Health Service
Family Planning	261	270	38	34	Health	Health Resources and Services Administration
Medical Devices & Radiological Health	247	241	39	38	Health	Food and Drug Administration
Occupational Safety and Health	246	202	40	43	Health	Centers for Disease Control & Prevention
Environmental Health	234	122	41	49	Health	Centers for Disease Control & Prevention
Biologics	202	187	42	45	Health	Food and Drug Administration
Hospitals-Facilities Support	198	231	43	39	Health	Indian Health Service
Research on Health Cost, Quality and Outcomes	194	227	44	40	Health	Agency for Healthcare Research and Quality
Epidemic Services	174	130	45	48	Health	Centers for Disease Control & Prevention
Developmental Disabilities	150	142	46	47	Education, Training & Social Services	Administration for Children and Families
Injury Prevention and Control	130	108	47	51	Health	Centers for Disease Control & Prevention
Rural Health	127	100	48	55	Health	Health Resources and Services Administration
Preventive Health & Health Services Block Grant	126	160	49	46	Health	Centers for Disease Control & Prevention
Domestic Violence	125	106	50	52	Education, Training & Social Services	Administration for Children and Families
All Other HHS Programs	1,698	1,851			Various Components	Various Components
Total Net Costs (Note 4)	**$510,304**	**$472,454**				

Note 1: Includes HRSA's Health Center program discussed in Sections I and II of this report.

Note 2: This is a CDC-administered program funded by OS appropriations, and includes CDC's Terrorism Preparedness and Emergency Response program discussed in Sections I and II of this report.

Note 3: Includes HRSA's National Bioterrorism Hospital Preparedness program discussed in Sections I and II of this report.

Note 4: Total Net Costs agrees with HHS agency Combined Totals in the Consolidating Statement of Net Cost by Budget Function, located in Other Accompanying Information.

The shaded programs above relate to the programs discussed in the Performance Overview section of the MD&A and in the HHS Performance section of this report.

Highlighted Programs (#)	16	16
Highlighted Programs ($)	$479,813	$443,168
Highlighted Programs (%)	94.02%	93.80%

Appendix C - Program Assessment Rating Tool (PART) - Summary of HHS Program Assessments

Program	HHS Agency	Overall Rating	PART Score			
			Purpose	Planning	Management	Results / Accountability
317 Immunization Program	Department	Adequate	100	57	60	42
Center for Biologics Evaluation and Research	FDA	Results Not Demonstrated	100	86	77	33
Center for Devices and Radiologic Health	FDA	Results Not Demonstrated	100	75	69	27
Center for Drug Evaluation and Research	FDA	Results Not Demonstrated	100	86	77	33
Center for Food Safety and Applied Nutrition	FDA	Results Not Demonstrated	100	86	69	27
Center for Veterinary Medicine	FDA	Results Not Demonstrated	100	86	69	27
Childrens Mental Health Services	SAMHSA	Moderately Effective	80	86	82	58
Chronic Disease - Breast and Cervical Cancer	CDC	Results Not Demonstrated	100	71	64	25
Chronic Disease - Diabetes	CDC	Results Not Demonstrated	100	71	60	33
Data Collection and Dissemination	AHRQ	Moderately Effective	83	89	80	67
Domestic HIV/AIDS Prevention	CDC	Results Not Demonstrated	100	57	33	8
Foster Care	ACF	Results Not Demonstrated	80	43	63	8
Head Start	ACF	Results Not Demonstrated	80	50	55	27
Health Alert Network	CDC	Adequate	100	86	78	40
Health Care Fraud and Abuse Control (HCFAC)	OIG	Results Not Demonstrated	100	17	83	25
Health Centers	HRSA	Effective	100	86	82	80
Health Professions	HRSA	Ineffective	60	71	73	13
IHS Federally-Administered Activities	IHS	Moderately Effective	100	78	60	74
IHS Sanitation Facilities Construction Program	IHS	Moderately Effective	100	83	89	67
Maternal and Child Health Block Grant (MCHBG)	HRSA	Moderately Effective	100	71	78	73
Medicare Integrity Program (HCFAC)	CMS	Effective	100	71	88	80
National Health Service Corps	HRSA	Moderately Effective	100	100	82	47
Nursing Eduction Loan Repayment and Scholarship Program	HRSA	Adequate	90	71	82	17
Projects for Assistance in Transition from Homelessness	SAMHSA	Moderately Effective	80	100	78	67
Refugee and Entrant Assistance	ACF	Adequate	100	57	89	50
Ryan White	HRSA	Adequate	80	86	55	59
State and Community-Based Services Programs on Aging	AoA	Results Not Demonstrated	100	29	67	25
State Childrens Health Insurance Program	CMS	Moderately Effective	80	86	43	75
Substance Abuse Treatment Programs of Regional and National Significance	SAMHSA	Adequate	80	86	64	33
Translating Research into Practice	AHRQ	Adequate	100	88	56	33

Source - Fiscal Year 2004 Budget of the U.S. Government; Performance and Management Assessments, pages 111-140.

Note - Score is on a scale of 0-100 with 0 being least effective and 100 being most effective.

Appendix D - FY 2003 Federal Managers' Financial Integrity Act (FMFIA) Report on Systems and Controls

Introduction

This year, we have abbreviated the FMFIA report based on reader comments and comparisons with other agency reports. We believe this streamlined report will be more useful and appealing to readers.

Overall Results

The FMFIA requires agencies to provide an annual statement of assurance on the effectiveness of their management, administrative and accounting controls, and financial management systems. The Department's annual assurance statement is contained in the Message from the Secretary (see page i) of this Performance and Accountability Report (PAR).

During FY 2003, HHS had no increase in Section 2 material weaknesses. One material weakness from prior years -- "Deficiency in the Enforcement Program for Imported Foods" *(FDA 89-02)* -- is no longer considered by HHS to be material at the department-wide level due to the substantial efforts made at the agency level by FDA to address this matter. One Section 4 material non-conformance related to financial systems and processes department-wide remained unresolved. The chart on page V.D.12 contains a summary of the FY 2003 findings including target correction dates.

In FY 2003, HHS managers were asked to review the GAO's 2003 High Risk list for HHS to determine if a material weakness exists. Except for GAO's findings -- Financial Systems and Processes and Medicare Information System Controls -- which were identified by the auditors in prior year CFO audits and included in our FMFIA reports, there were no new material weaknesses reported by the HHS agencies as FMFIA material weaknesses in their FMFIA reports.

HHS Management Control Program

HHS's management control program under the FMFIA and Revised OMB Circular A-123, *Management Accountability and Control*, reflects the Department's continuing commitment to safeguard the resources entrusted to it by reducing fraud, waste, and abuse, and preventing financial losses in HHS programs. HHS continually evaluates its program operations and systems through CFO annual financial statement audits, as well as other OIG and GAO audits, management reviews, systems reviews, etc., to ensure the integrity and efficiency of its operations. HHS program managers continue to improve management controls by identifying and correcting management control deficiencies.

The Department's FMFIA program supports a key objective in our HHS *FY 2003 CFO Financial Management Five-Year Plan* to respond to our diverse customers' needs by ensuring that the financial information for their programs is accurate and that the financial systems and processes that support them maintain the highest level of integrity. HHS operating divisions are to have written strategies for assessing management controls on an ongoing basis and these strategies should be consistent with the Five-Year Financial Management Plan goals and targets.

In addition to our goal of obtaining a clean audit opinion on our annual financial statements, we have a related goal of resolving all internal control material weaknesses and reportable conditions cited by the auditors, including instances of non-compliance with the Federal Financial Management Improvement Act

(FFMIA) as well as those identified through FMFIA reviews. For tracking and reporting on audit material weaknesses, HHS has developed a department-wide CFO Corrective Action Plan, referred to as the "CAP". The CAP includes all of the findings resulting from the financial statement audits, including qualifications, material weaknesses, and reportable conditions. In FY 2003, we continued to submit the CAP quarterly to OMB. HHS achieved "green" in quarterly scorecard reports in part as a result of HHS making "good progress" in the CAP. The milestones for the material weaknesses included in this FMFIA report (see below) are consistent with the quarterly CAP milestones reported to OMB.

Material Weaknesses and Accounting System Non-Conformances

FY 2002 FMFIA Section 2, Material Weaknesses

In its FY 2002 Performance and Accountability report, HHS provided a qualified assurance for a material weakness at the Food and Drug Administration: *"Deficiency in the Enforcement Program for Imported Foods" (FDA 89-02)* under Section 2 of the FMFIA. As stated above, the Department has determined that FDA has made substantial efforts to date to address this material weakness. As a result, HHS has determined that this material weakness does not represent a material weakness at the HHS corporate level, although FDA continues to report this material weakness in its FMFIA report.

Following are some of the improvements FDA has made in its Enforcement for Imported Foods program:

- Hired 600 new inspectors and lab personnel to monitor food imports;
- Signed an agreement with the U.S. Army to design and develop mobile laboratories to be deployed to borders to analyze samples;
- Acquired analytical equipment for field labs to handle large numbers of samples in case of terrorist contamination;
- Acquired hand-held rapid test kits for 18 select agents;
- Inspected, examined, and analyzed 106,080 imported foods; and
- Conducted 167 inspections of foreign food establishments, priority "high risk", consistent with goal of 160 such inspections.

In the FY 2002 report, FDA estimated that it would complete corrective action to remove this material weakness by FY 2006. However, FDA has revised its estimate for completing corrective action from FY 2006 to FY 2005. FDA reported that they are developing a risk-based inspection strategy, and that recently hired staff under the counterterrorism funding needs to be fully trained and utilized in performing some import-related functions.

FMFIA Section 4, Systems Non-Conformances

The FY 2002 FMFIA Report reflected a material non-conformance, *Financial Systems and Processes (HHS-00-01*), under Section 4 of the FMFIA. This finding comprised three component findings: the department-wide audit finding and the two separate audit findings at the Centers for Medicare and Medicaid Services (CMS) -- *Financial Systems Analysis and Oversight (CMS-01-01)* and *Medicare EDP Controls (CMS 01-02).* See below for detailed corrective action plans to address this Section 4 material non-conformance.

Unified Financial Management System – The Long Term Solution

The HHS financial auditors have cited the Department's lack of an integrated accounting system as a material weakness and a specific impediment in preparing timely financial reports and statements. Secretary Thompson has directed a "One HHS" approach to managing the Department. One of the major

tenets of the Secretary's approach is the development and implementation of the Unified Financial Management System (UFMS) for the Department. In accordance with Secretary Thompson's June 2001 direction, the UFMS is to be composed of two primary components—one component for the Centers for Medicare & Medicaid Services (CMS) called the Health Care Integrated General Ledger System (HIGLAS), and another component for the rest of the Department. The two components will be integrated to provide for department-wide financial reporting. The unified system is to generate interim and annual financial statements, as well as other required external and internal financial reports. HHS will continue implementation of UFMS/HIGLAS per the approved implementation plan to achieve compliance with the FFMIA/FMFIA Section 4 by FY 2005 and to remove related material weakness in financial statements. The substantial implementation of the UFMS department-wide to achieve FFMIA compliance by FY 2005 includes implementation of the NIH Business and Research Support System (NBRSS), which will replace NIH's current accounting system.

In the short term, HHS operating divisions have continued to make substantial progress in addressing account analysis and reconciliation problems including implementing a more efficient process for preparing financial statements. NIH, for example, has implemented numerous additional analyses and reconciliations and a new, more disciplined process to prepare trial balances for preparation of NIH's financial statements.

CMS has also made substantial progress on mitigating the Electronic Data Processing (EDP) control weaknesses and has revised its target for completing corrective action to FY 2004. Implementation of all the safeguards will improve security, although the long-term fix for the Medicare contractors lies in the CMS IT Modernization initiative**.**

Federal Financial Management Improvement Act (FFMIA)

The Federal Financial Management Improvement Act (FFMIA) mandates among other things, that agencies "…implement and maintain financial and management systems that comply substantially with federal financial management systems requirements, applicable federal accounting standards, and the United States Government Standard General Ledger at the transaction level." FFMIA also requires that remediation plans be developed for any entity that is unable to report substantial compliance with these requirements.

For a full assessment of the Department's compliance efforts under FFMIA, please refer to Appendix E of this report.

Section 4 Material Non-Conformance – Corrective Action Plan

Following are the summary corrective action plans for the Section 4, Material non-conformance.

Material Non-Conformance: (HHS-00-01) Department-wide Financial Systems and Processes

Description

The Department continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. The FY 2002 CFO audit and the FMFIA Report reflected a material non-conformance department-wide under the FFMIA, which was reported under Section 4 of the FMFIA called Financial Systems and Processes (HHS-00-01). This finding combined the department-wide audit finding with the audit findings at the Centers for Medicare and Medicaid Services (CMS). CMS's FY 2002 financial statements audit revealed the same two material weaknesses as in the FY 2001 audit, specifically: Financial Systems and Analysis (CMS-01-01) and Medicare EDP Controls (CMS 01-02).

Pace of Corrective Action:	**Responsible Program Manager:**
	Tom Doherty, Director, UFMS Program Management Office
Year Identified: FY 2000	
Original Targeted Correction Date: N/A	
Correction Date in Last Report: FY 2005	
Current Correction Date: FY 2005	**Source of Discovery:** FY 2000, FY 2001, and FY 2002 financial statement audits by OIG.
FY 2005 – FFMIA/FMFIA Compliance for UFMS and HIGLAS (the largest Medicare Contractors will be using the new HIGLAS system) 1/; FY 2007 – Full UFMS/HIGLAS implementation	
1/ Implementation of UFMS in accordance with approved implementation plan will allow HHS to comply with the FFMIA/FMFIA by the end of FY 2005. OMB, as a result of its review of key UFMS planning documents and discussions with HHS officials, recognized in its quarterly progress reports that the Department's current financial management "status" could improve when the UFMS is substantially implemented at the end of FY 2005.	
In the short term, account analysis and reconciliations are helping to mitigate systems weaknesses.	

Completed Actions and Events:	
Department-wide **FY 2002:** • Selected the commercial off-the-shelf software to serve as the core system application/infrastructure and 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 HHS agencies' Chief Financial Officers and Chief Information Officers, actively participate. • Developed key planning documents, including Risk Assessment and Mitigation Plan, Change Management (Business Transformation) Plan, Performance Management Plan, and Core Target Business Model. • Developed the UFMS business case (which was finalized by the UFMS PMO and approved by the HHS Information Technology Internal Review Board on November 5, 2002).	See FY 2002 FMFIA Report in HHS FY 2002 Performance and Accountability Report.

Planned/Continuing Agency Actions:	
FY 2003:	**Planned/Actual Dates:**
Following are key deliverables provided to OMB under the President's Management Agenda (PMA):	
• Submitted an outline of the UFMS Security Plan for addressing National Institute of Standards and Technology requirements.	January 29, 2003
• Supplemented the project management plan provided on January 29, 2003 to OMB to include concrete costed deliverables and specific due dates for each stage of UFMS implementation.	February, 2003
• Submitted draft security certification/accreditation strategy to include definition of minimum system boundaries.	April, 2003
• Submitted detailed work breakdown structure mapped to earned value measurement and to performance measures (Tracking Matrix).	April, 2003 and every two months thereafter
• Reported progress on UFMS Development/Acquisition Phase *(see 2.4.2 of UFMS Security Plan).*	April 30, 2003
• Submitted a detailed UFMS security plan.	September 15, 2003
Note: Detailed updates on Corrective Actions are provided quarterly to OMB. These Corrective Action Plans (CAPs), address both short-term and long-term measures to address this weakness.	
Long-Term UFMS Milestones:	
NIH Business and Research Support System (NBRSS) - complete deployment	FY 2005
UFMS and HIGLAS: FFMIA/FMFIA Compliance	End of FY 2005
UFMS and HIGLAS: Full Implementation	FY 2007

Material Non-Conformance: (CMS 01-01) CMS Financial Systems, Analysis and Oversight

This finding is a sub-set of the one Section 4 material non-conformance department-wide (HHS-00-01).

The financial statements auditors reported that the Centers for Medicare & Medicaid Services (CMS) relies on a decentralized organization, complex and antiquated systems and ad hoc reports to accumulate data for financial reporting due to the lack of an integrated accounting system at the Medicare contractor level. An integrated financial system and strong oversight are needed to ensure that periodic analyses and reconciliation are completed to detect errors in a timely manner.

Pace of Corrective Action: Continuous **Year identified:** FY 1997 **Original Targeted Correction Date:** FY 1999 **Correction Date in Last Year's Report:** FY 2005 **Current Correction Date:** FY 2005 – FFMIA/FMFIA Compliance for UFMS and HIGLAS (the largest Medicare Contractors will be using the new HIGLAS system) 1/; FY 2007 – Full UFMS/HIGLAS implementation 1/ Implementation of UFMS in accordance with approved implementation plan will allow HHS to comply with the FFMIA/FMFIA by the end of FY 2005. OMB, as a result of its review of key UFMS planning documents and discussions with HHS officials, recognized in its quarterly progress reports that the Department's current financial management "status" could improve when the new accounting system (UFMS) is substantially implemented at the end of FY 2005.	**Lead Management Contact:** Maria C. Montilla, Acting Director, Accounting Management Group, and Director of Financial Oversight, Office of Financial Management **Source of Discovery:** FY 1997 financial statement audit by OIG and other sources.

Brief Description of Corrective Action Plan

While CMS has made significant improvements in financial reporting, our long-term solution to this material weakness is the Healthcare Integrated General Ledger Accounting System (HIGLAS). Until this system is implemented, CMS will continue projects and activities aimed at compensating for the lack of the modernized system. Until HIGLAS can be fully implemented, CMS will continue to implement short-term corrective actions, as outlined in our Chief Financial Officer (CFO) Comprehensive Plan for Financial Management, to address this material weakness. The four key financial management objectives of our plan are to: (1) improve financial reporting, guidance, and oversight by providing timely, reliable, and accurate financial information that will enable CMS managers and other decision makers to make timely and accurate program and administrative decisions; (2) design and implement effective financial management systems that comply with the Federal Financial Management Improvement Act (FFMIA); (3) improve debt collection and internal accounting operations; and (4) validate key financial data to ensure its accuracy and reliability.

Completed Actions and Events:	
FY 2002: The CMS has accomplished the following initiatives to effectively implement HIGLAS: • Established a CMS HIGLAS Program Office staffed with 20 FTEs. • Initiated implementation of an approved Joint Financial Management Improvement Program commercial off-the-shelf product at two pilot sites. • Established the HIGLAS project baseline and began the design and building of HIGLAS functional specifications/requirements for two Medicare contractor pilot locations. • Finalized the following project management plans: Business Solution Test Plan; Communications Plan; Configuration Management Plan; Quality Assurance Plan; and Risk Management Plan. • Conducted five Conference Room Pilots to refine business requirements/solutions. All activities completed. • Conducted five Technical Requirement Pilots in nine sessions. All activities completed. • Established the Application Service provider and technical infrastructure. • Initiated running 11 non-production instances of the ORACLE software in a test environment. • Established the HIGLAS Change Control Board with support from the Technical Configuration Committee, Requirements Management Committee, and the Performance Work Group to assure decisions are made accurately and timely. • Established HIGLAS Portal, e-Room, for project communication. • Created a HIGLAS website to provide program status for project stakeholders.	See FY 2002 FMFIA Report in HHS FY 2002 Performance and Accountability Report.

CAP Milestones for FY 2002 - FY 2003	Planned/Actual Dates:
• Provided annual financial management training including trend analysis to contractors.	Completed
Acquired CPA services to validate accounts receivable balances.	Completed
Revised financial management internet manual.	Completed
Completed CPA accounts receivable reviews.	Completed
Established CAPs from accounts receivable reviews.	Completed
Contractors implemented CAPs from reviews.	On-going
• CMS 1522 Cash Reconciliation Workgroup provided policy and procedures to ensure contractors reconcile funds expended.	Completed
Developed review procedures for monitoring the CMS 1522.	Completed
Provided procedures and trained regional offices to perform reviews.	Completed
Performed onsite reviews at 11 contractors.	Completed
Monitor the monthly CMS 1522 reconciliation submitted by contractors.	Monthly
Issued draft & final instructions to contractors that require a reconciliation of the CMS 1522 detailed claims data.	Completed
Implement final instructions that require a reconciliation of the CMS 1522 claims data.	January, 2004
• Formed Trend Analysis Workgroup to develop and implement trend analysis procedures.	Completed
Issued contractor trend analysis procedures.	Completed
Perform trend analysis on receivable balances reported.	Quarterly
Issued final RO procedures to perform trend analysis and to review contractors trending analysis.	Completed
• Implemented procedures for quarterly and yearly financial statements.	Completed
• UFMS and HIGLAS compliance with FFMIA/Section 4 FMFIA.	End of FY 2005
• Complete UFMS/HIGLAS implementation.	FY 2007

Material Non-Conformance: (CMS 01-02) Medicare EDP Controls

This finding is a sub-set of the one Section 4 material non-conformance department-wide (HHS-00-01).

The financial statement auditors reported that electronic data processing (EDP) controls at the Center for Medicare & Medicaid Services (CMS) central office (CO) and the Medicare contractors could result in: 1) unauthorized access to and disclosure of sensitive information; 2) malicious changes that could interrupt data processing or destroy files; 3) improper Medicare payments; or 4) disruption of critical operations. The auditors reported that weaknesses continue to exist in the areas of entity-wide security plans, Medicare data file, physical data center access controls, and service continuity. No individual weakness was determined to be material, but in the aggregate, the weaknesses were considered material.

Pace of Corrective Action: Continuous **Year identified:** FY 1998 **Original Targeted Correction Date:** FY 1999 **Correction Date in Last Year's Report:** FY 2003 **Current Correction Date:** FY 2004	**Responsible Program Manager:** Richard Lyman, Director, Security and Standards Group, Office of Information Services **Source of Discovery:** FY 1997 financial statements audit by OIG.

The CMS recognizes the significance of security measures regarding Medicare EDP issues as they relate to the integrity, confidentiality, and availability of sensitive Medicare data. The CMS received funding in August 2002 to mitigate the most vulnerable weaknesses at the Medicare contractors and data centers. Distribution based on risk analysis was to fund system security plans for the contractor claims processing systems, access controls, systems software, segregation of duties, and service continuity. Funding decisions were risk-based and business driven. Funding has been requested for FY 2004 as part of the CMS Modernization Initiative to resource major weaknesses. The CMS Initiative will be effective in addressing these security issues. The strategy is to make investments to create a secure systems environment where security platforms have been implemented and integrated, e.g., robust firewalls, intrusion detection, authentication etc., and not to expend all available resources on addressing audit findings.

CAP Milestones for FY 2003 - FY 2004	Planned/Actual Dates:
Medicare Contractors	
• Required Medicare contractors to adhere to OMB A-130 guidelines for entity-wide security plans to ensure appropriate safeguarding of Medicare data.	Completed
• Require Medicare contractors to use CMS systems security methodology to develop plans in the future as funding permits.	September, 2004
• Develop consistent and effective physical and logical access procedures, including administration and monitoring of access by contractor personnel in the course of their job responsibilities.	September, 2004
• Develop consistent and effective procedures over the implementation, maintenance, access, and documentation of operating systems software products used to process Medicare data.	September, 2004
• Develop a segregation of duties to ensure that accountability and responsibility for access to Medicare applications and data are appropriately assigned.	September, 2004
• Update and appropriately document service continuity procedures to recover Medicare processing in case of a system outage.	September, 2004
CMS Central Office	
• Complete the CMS master plan and the supporting general support systems plans that application plans will refer to.	September, 2004
• Recertified all personnel with physical access to the data center.	Completed

HHS FMFIA Reporting Summary

FMFIA Section 2 Material Weakness and Section 4 Material Nonconformances Outstanding							
	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
Section 2 Material Weaknesses Outstanding							
From Prior Year	2	3	4	5	5	2	1
New	1	1	1	0	0	0	0
Corrected/Reclassified	0	0	0	0	3*	1	1**
Outstanding as of 9/30/2003.							**0**
Section 4 Material Nonconformances Outstanding							
From Prior Year	0	0	0	0	0	1	1
New	0	0	0	0	1*	0	0
Corrected/Reclassified	0	0	0	0	0	0	0
Outstanding as of 9/30/2003							**1**

***** Financial Systems and Processes (HHS-00-01). This single Section 4 material non-conformance reflects HHS's action during FY 2001 to combine the following three prior year Section 2 material weaknesses into a single finding, and reclassify the combined finding as a Section 4 material non-conformance (details and status in chart below):

- Financial Systems and Processes (HHS-00-01) (1a below);
- Financial Systems Analysis and Oversight (CMS 01-01) (1b below); and
- Medicare EDP Controls (CMS 01-02) (1c below).

****** "Deficiency in the Enforcement Program for Imported Foods" (FDA 89-02). Due to substantial FDA efforts, HHS no longer considers FDA 89-02 to be material at the department-wide level. FDA continues to report this material weakness in its FMFIA report with a targeted correction date of FY 2005.

Status of Outstanding FMFIA Material Weaknesses or Nonconformances			
#	**Title & Identification Code**	**First FY Reported**	**Target Correction Date**
Section 2			
	None		
Section 4			
1a	Financial Systems & Processes ID: HHS-00-01	FY 2001	UFMS FMFIA and FFMIA compliance (FY 2005). UFMS full implementation (FY 2007).
1b	CMS Financial Systems Analysis and Oversight (Medicare Accounts Receivable) ID: CMS 01-01 (formerly HCFA 97-02)	FY 2001	HIGLAS FMFIA and FFMIA compliance. (FY 2005) HIGLAS full implementation (FY 2007)
1c	Medicare EDP Controls, including Application Controls for Medicare Contractors. ID: CMS 01-02 (formerly HCFA 98-01a)	FY 2001	FY 2004 (previously reported as FY 2003 in FY 2002 report).

Appendix E – HHS FY 2003
Federal Financial Management Improvement Act (FFMIA)
Report on Compliance

Auditors of Executive Agencies' financial statements are required to report if the agencies' financial management systems are in substantial compliance with the requirements of the Federal Financial Management Improvement Act of 1996. Such audits are to be conducted in accordance with OMB's revised FFMIA Implementation Guidance, dated January 4, 2001.

Under FFMIA, agencies also are required to report whether their financial management systems substantially comply with the federal financial management systems requirements, applicable federal accounting standards, and the United States Government Standard General Ledger at the transaction level.

The Department's FY 2003 financial statement audit revealed two instances (discussed below) in which HHS financial management systems did not substantially comply with federal financial management systems requirements. HHS concurs with the auditors' findings.

Instances of Non-Compliance

Non-Compliance Number 1: Financial Management Systems and Processes

- The financial management systems and processes used by HHS and its agencies made it difficult to prepare reliable, timely financial statements. The processes required extensive, time-consuming manual spreadsheets and adjustments in order to report accurate financial information;

- At most HHS agencies, suitable systems were not in place to adequately support sufficient reconciliation and analyses of significant fluctuations in account balances; and

- The CMS did not have an integrated accounting system to capture expenditures at the Medicare contractor level, and certain aspects of the financial reporting system did not conform to the requirements specified by the Joint Financial Management Improvement Program. The CMS needed extensive consultant support to establish reliable accounts receivable balances.

Non-Compliance Number 2: General and Application Controls.

- General and application controls over the Medicare contractors' financial management systems, as well as systems of certain other operating divisions were significant departures from requirements specified in OMB Circular A-127, "Financial Management Systems," and OMB A-130, "Management of Federal Information Resources."

The FY 2003 audit recognized the significant steps taken by the Department to resolve material weaknesses found in previous years. Following is a summary of some of the corrective actions taken and the current status for each of the areas of non-compliance.

Corrective Actions

Financial Management Systems and Processes

The Department's long-term strategic plan to resolve this material weakness is to replace the existing accounting systems and certain other financial systems within the Department. The short-term focus has been on improving the quality of the data in the accounting systems by increasing periodic reconciliation and analyses, and implementing a web-based Automated Financial System for collecting and consolidating financial statements department-wide. Over the last several years HHS has continued to make progress in strengthening its financial management and has a plan to bring its financial management systems into compliance with the FFMIA by replacing antiquated financial systems with the Unified Financial Management System.

A major sub-component of the unified system is the CMS Healthcare Integrated General Ledger Accounting System (HIGLAS), which will replace the Medicare contractors' different systems, both manual and automated, currently used by Medicare contractors. HIGLAS will integrate with Medicare's three existing standard claims processing systems. In addition, the current mainframe-based financial system will be replaced by this web-based system. With national implementation of HIGLAS, the financial material weakness under FFMIA will be eliminated. Following are examples of the Department's FY 2003 achievements:

- At the CMS central office (CO), procedures were implemented that resulted in adjustments to accounts receivable balances reported by the contractors. However, these procedures did not ensure that accounts receivable activity included on the contractor financial reports was properly supported by detailed transactions. CMS uses formal procedures for financial reporting analysis; and

- CMS continues to provide instructions and guidance to the Medicare contractors and its CO and regional offices (RO). They continue to contract with Independent Public Accountants to test financial management internal controls and to analyze accounts receivable at Medicare contractors. CMS created workgroups comprised of CO and RO consortia staff to serve as subject matter experts responsible for addressing four key areas: follow up on the Corrective Action Plans; reconciliation of funds expended to paid claims; trend analysis; and internal controls. As CMS progresses toward its long-term goal of developing an integrated general ledger system, they continue to provide training to the contractors to promote a uniform method of reporting and accounting for accounts receivable and related financial data. CMS also completed automated applications for preparing all five required principal financial statements.

Unified Financial Management System (UFMS)

- Established the UFMS Program Management Office, including hiring 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 (COTS) software to serve as the core system

application/infrastructure.

- Developed a department-wide budget and accounting classification structure.
- Compiled department-wide financial requirements applicable to UFMS.
- Developed key planning documents, including Risk Assessment and Mitigation Plan, Change Management (Business Transformation) Plan, Performance Management Plan, and Core Target Business Model.
- Developed the UFMS business case (which was finalized by the UFMS PMO and approved by the HHS Information Technology Internal Review Board on November 5, 2002).
- NIH commenced implementation of the general ledger component of the NIH New Business System in October 2002.
- NIH is participating in the UFMS planning and global activities. NIH will assess the impact of changes to its core financial management implementation and will work with the UFMS program team to incorporate the changes, as global elements are determined. NIH will participate in and follow the direction of the UFMS Change Control Board.
- Began implementation at CDC. CDC has participated in Global Fit/Gap analysis sessions for CDC specific requirements. CDC has completed the initial process design and is participating in configuration workshops.
- Completed the CDC Global Conference Room Pilot 1.
- Began implementation at FDA. Finalized the FDA requirements, completed FDA process flows and accessed the impact on the FDA workforce.

Healthcare Integrated General Ledger Accounting System (HIGLAS)

- Established CMS HIGLAS Program Office with a staff of 20 FTEs.
- Initiated implementation of an approved CMS Joint Financial Management Improvement Program COTS product at the two pilot Medicare contractors.
- Established the HIGLAS project baseline and began the design and build of HIGLAS functional solution for two Medicare contractor pilots.
- Finalized the following project management plans:
    - Business Solution Test Plan;
    - Communications Plan;
    - Configuration Management Plan;

- Detailed Pilot Implementation Plan;
- Master Project Plan;
- Project Management Plan;
- Project Work Plan;
- Quality Assurance Plan;
- Requirements Management Plan;
- Risk Management Plan;
- Stress Test Plan;
- Systems Software Process Improvement Plan; and
- First of multiple iterations of the Architectural View.

- Conducted four Conference Room Pilots to refine business requirements and solutions.
- Established the Application Service Provider and technical infrastructure, and are running 11 non-production instances of the Oracle software in a test environment.
- Established the HIGLAS Change Control Board with support from the Technical Configuration Committee, Requirements Management Committee, and the Performance Work Group to assure decisions are made accurately and timely.
- Established an Earned Value Management System that produces reports to assist project monitoring and control.
- Established HIGLAS Systems Engineering Portal for project communication.
- Created a HIGLAS website at www.cms.hhs.gov/ to provide program status for project stakeholders.

General and Application Controls

For CMS, the OIG acknowledged in its findings that during FY 2003 the Department made considerable progress in identifying weaknesses in its automated processing systems. Specifically, CMS identified several weaknesses in the performance of vulnerability assessments, Statement on Auditing Standards (SAS) 70 internal control reviews, the compilation of Medicare contractor controls self-assessments, OIG assessment, and related procedures. This effort provides a baseline for further improvements. CMS embraces the need to assess the risks inherent in its operations and programs, assess financial and operational priorities, and seek additional resources as necessary to correct known deficiencies.

CMS relies extensively on EDP operations at CO and the Medicare contractors to administer the Medicare

program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. In FY 2003, weaknesses at the Medicare contractors, as well as certain application control weaknesses at the contractors' shared systems, continued. Such weaknesses do not effectively prevent: 1) unauthorized access to and disclosure of sensitive information; 2) malicious changes that could interrupt data processing or destroy files; 3) improper Medicare payments; or 4) disruption of critical operations. The OIG aggregated the findings at the Medicare contractors and CMS CO into one material weakness. No findings at a single location were considered material.

CMS continues to make progress toward resolving this issue by revising our information systems security requirements for Medicare contractors. The CMS Core Information Security Requirements adhere to guidelines in the Office of Management and Budget (OMB) Circular A-130 and implement effective control procedures. In FY 2003, CMS completed a prototype of a system security plan methodology for Medicare contractors and developed and implemented new background investigation procedures. We also developed policy and procedures for software quality assurance, as well as developed, tested, and implemented a systems software change audit review process.

The other HHS agencies will continue to make progress toward resolving their general and application control issues. Additionally, UFMS will be designed and implemented within a secure application environment.

In the long term, HHS will continue to improve data integrity and reliability of its financial statements and financial reporting processes. Performing routine periodic reconciliation and financial analysis will help do this. Past performance on the part of HHS resulted in improved financial discipline and the achievement of an unqualified audit opinion on HHS financial statements for FYs 1999 – 2003. In addition, HHS will continue to strengthen Medicare EDP controls and improve systems security.

The corrective actions to remedy these issues will be developed by HHS components and included in the HHS CFO's Five-Year Plan.

Appendix F - Management Report on Final Action

October 1, 2002 - September 30, 2003

Background

The Inspector General (IG) Act Amendments of 1988 require departments and agencies to report to Congress on the actions they have taken and the amount of funds recovered or saved in response to the IG's audit recommendations. This annual management report gives the status of IG reports in the Department and summarizes the results of actions taken to implement IG audit recommendations during the reporting period.

Departmental Findings

For the fiscal year covered by this report, the Department accomplished the following:

- Initiated action to recover $315 million through collection, offset, or other means (see Table I);
- Completed action to recover $405 million through collection, offset, or other means (see Table I);
- Initiated action to put to better use $56 billion (see Table II); and
- Completed action that over time will put to better use $342 thousand (see Table II).

At the end of this period there are 310 reports over a year old with uncollected balances or unimplemented monetary findings. The reasons these reports are still pending are found in the notes to the tables.

The HHS Process

There are four key elements to the HHS audit resolution and follow-up process:

- The HHS agencies have a lead responsibility for implementation and follow-up on most IG and independent auditor recommendations;
- The Assistant Secretary for Budget, Technology, and Finance (ASBTF) establishes policy and monitors HHS agencies' compliance with audit follow-up requirements;
- The audit resolution process includes the ability to appeal disallowances administratively under such programs as Head Start, Foster Care and Medicaid pursuant to the Board's regulations in 45 C.F.R. Part 16; and
- If necessary, the ASBTF or the Deputy Secretary resolves conflicts between the HHS agencies and the IG.

Departmental Conflict Resolution

In the event that the HHS agencies and IG staff cannot resolve differences on specific report recommendations, a conflict resolution mechanism is available. There were no disagreements requiring the convening of the Conflict Resolution Council.

Status of Audits in the Department

In general, the HHS agencies follow up on IG recommendations effectively and within regulatory time limits. The HHS agencies usually reach a management decision within the six-month period that is prescribed by P.L. 100-504 and OMB Circular A-50. For the most part, they also complete their final actions on IG reports, including collecting disallowed costs and carrying out corrective action plans within a reasonable amount of time. However, we continue to monitor this area to improve procedures and assure compliance with corrective action plans.

Report on Final Action Tables

The following tables summarize the Department's actions in collecting disallowed costs and implementing recommendations to put funds to better use. Disallowed costs are those costs that are challenged because of a violation of law, regulation, grant term or condition, etc. Funds to be put to better use relate to those costs associated with cost avoidances, budget savings, etc. The tables are set up according to the requirements of section 106(b) of the IG Act Amendments of 1988 (P.L. 100-504).

TABLE I

Management Action on Costs Disallowed
In Inspector General Reports
As of September 30, 2003
(in thousands)

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	409	$ 968,542
B. Reports on which management decisions were made during the reporting period. See Note 2.	262	314,609
Subtotal (A + B)	671	$1,283,151
C. Reports for which final action was taken during the reporting period:		
(I) The dollar value of disallowed costs that were recovered through collection, offset, property in lieu of cash, or otherwise.	282	404,724
(ii) The dollar value of disallowed costs that were written off by management.	17	2,538
Subtotal (I + ii)	299	$407,262
D. Reports for which no final action has been taken by the end of the reporting period. See Note 3.	372	$75,889

1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period.
2. Represents the amount of management concurrence with the Inspector General's recommendations. For this fiscal year, the management reporting date was earlier than the Inspector General's reconciliation with the HHS agencies.
3. Includes the list of audits over one year old with outstanding balances to be collected. Includes audits under administrative or judicial appeal, under current collection schedule and legislatively uncollectible.

TABLE II

Management Action on OIG Reports With Recommendations That Funds be Put to Better Use As of September 30, 2003 (in thousands)

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	11	$56,249,316
B. Reports on which management decisions were made during the reporting period.	5	171,854
Subtotal (A + B)	16	$56,421,170
C. Reports for which final action was taken during the reporting period:		
(i) The dollar value of recommendations that were actually completed based on management action or legislative action.	3	342
(ii) The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed.	0	-
Subtotal (i + ii)	3	$342
D. Reports for which no final action has been taken by the end of the reporting period. See Note 2.	13	$56,420,828

1. Includes adjustments of amended disallowances and disallowances excluded from the previous reporting period.
2. Includes the nine reports shown on the following page with recommendations to put funds to better use that were pending for more than one year. These reports involve major policy questions as well as legislative remedies that are difficult and time consuming to resolve.

Reports Containing Recommendations
To Put Funds to Better Use
Pending More Than One Year
As of September 30, 2003

Audit Number	Auditee	Date Issued	Amount	Explanations
OEI-12-92-00460	Inappropriate Payments for Total Parenteral Nutrition (ES#921222-1330)	Jun-93	$69,000,000	CMS currently is determining the amount of the savings.
A-06-92-00043	BC/BS of Texas, Inc. -- GME Costs	Mar-94	4,078,960	Corrective action cannot be implemented pending the resolution of an objection lodged by the providers' legal counsel with the OIG and OGC.
A-04-95-02110	SC BC (Hospice of Lake & Sumter, Inc.) – ORT	Nov-96	2,500,000	CMS is reassessing whether seeking the identified OIG hospice overpayment is the appropriate action to take.
A-06-95-00095	Palmetto Gov. Ben. Admin. (Fam. Hospice/Dallas)-ORT	Jan-97	69,648	CMS is reassessing whether seeking the identified OIG hospice overpayment is the appropriate action to take.
A-05-95-00060	WI Department of Health and Social Services	Feb-97	2,400,000	The State of Wisconsin plans to establish a workgroup to meet and review HMO financial data related to Medicaid HMOs to determine the actual amount of the savings.
OEI-03-99-00200	Medicare Payouts for Services After Death	Mar-97	4,800,000	CMS is in the process of determining the amount of savings.
A-06-01-00053	Medicaid Pharmacy	May-02	470,000,000	Actual acquisition costs of generic prescription drug products.
A-05-92-00006	Medicare Prospective Payment System	Mar-95	233,000,000	Follow-up audit on hospital admissions not requiring an overnight stay.
A-03-00-00216	Medicaid Enhanced Payments	Nov-01	55,497,000,000	Review to local public providers and the use of intergovernmental transfers.
Total 9 Reports - CMS	**CMS**		**$56,282,848,608**	

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2003

HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
ACF	01-95-32620	CT/FC	May-97	$4,070	25
ACF	02-00-64555	Utica-HS	Oct-01	166,880	6
ACF	02-91-14405	Bedford Stuyvesanto/O	Mar-02	34,593	3
ACF	02-97-47637	Puerto Rico IV-B	Sep-97	9,703	25
ACF	02-97-47931	Puerto Rico	Jan-99	290,769	25
ACF	02-98-52012	Puerto Rico	Apr-02	10,827	6
ACF	02-99-57987	NJ IV-E	Jan-00	547	25
ACF	02-99-58335	Puerto Rico	Mar-99	5,400	25
ACF	03-01-00510	Council Southern MT	Nov-01	11,635	6
ACF	03-02-72227	State of VA	Jan-01	1,100,000	1
ACF	03-91-14545	PA Win-Demo	Jun-91	252,362	25
ACF	03-97-00587	Little Neighborhood	Jan-98	300,465	6
ACF	03-97-43787	VA/CCDBG	Jun-97	937,769	25
ACF	03-97-47731	Delaware	Sep-97	11,880	25
ACF	03-97-48850	Little Neighborhood	Nov-97	91,193	6
ACF	03-98-51186	Council of Southern MT	Feb-99	35,961	4
ACF	03-99-03305	Research Assessment State of MD	Jul-00	4,453,336	6
ACF	04-00-60897	State of FL	Nov-00	33,397	25
ACF	04-00-60897	State of FL	Nov-00	31,251	25
ACF	04-00-64117	State of AL Child Care & Dev. Fund Mand.	Aug-01	28,161	25
ACF	04-00-64861	State of NC	Mar-01	357,591	6
ACF	04-00-66032	State of FL	Jan-01	41,989	25
ACF	04-01-67440	Catawba	Aug-01	8,000	6
ACF	04-01-68839	State of FL	Apr-02	155,973	25
ACF	04-01-68839	State of FL	Apr-02	10,523	25
ACF	04-91-06594	Mountain Valley/HS	Sep-92	196,213	2
ACF	04-92-17186	Mountain Valley/HS	Sep-92	203,420	2
ACF	04-93-23833	Mountain Valley/HS	Jul-93	212,759	2
ACF	04-94-30737	Mountain Valley/HS	Jul-94	39,095	2
ACF	04-96-00105	Delta Foundation	Apr-99	1,225,291	4
ACF	04-96-00107	Harambee Child Level	Aug-99	124,811	6
ACF	04-96-38688	State of KY	Oct-96	8,049	25
ACF	04-97-47475	Wash Cty Opport Inc.	Nov-97	173,151	4
ACF	04-97-49121	Florida	May-98	282,553	6
ACF	04-99-55388	North Carolina	Nov-99	5,640	25
ACF	04-99-55653	Tennessee	Mar-99	38,487	25
ACF	04-99-56945	Quitman Cty Dev Org Inc	Jun-02	6,375	6
ACF	04-99-57894	Georgia	Nov-99	$4,143	25

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HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
ACF	04-99-59501	Chapel Hill Carrboro	Jan-02	$11,256	6
ACF	05-01-67360	MI Family Independence Agency	Jul-01	24,765	25
ACF	05-01-67360	MI Family Independence Agency	Jul-01	150,000	25
ACF	05-01-67645	State of OH	Jul-02	202,473	25
ACF	05-01-68896	State of IN	Jan-02	8,154	25
ACF	05-95-00022	ILL/IV-E	Jul-96	89,239	25
ACF	05-97-48402	Montgomery Co CAA	Nov-97	79,374	2
ACF	05-98-00010	Wisconsin	Feb-00	3,318,857	25
ACF	06-00-00012	Brown Magnolia	Sep-02	196,363	1
ACF	06-00-62531	NA Five Sandoval Indian Pueblos Inc.	Oct-00	15,095	4
ACF	06-00-62566	Five Sandoval Indian Pueblos Inc.	Nov-00	7,149	4
ACF	06-01-00073	State of LA	Sep-02	1,094,708	25
ACF	06-02-72136	State of LA	Feb-02	12,110	25
ACF	06-90-00052	Mexican Amer/Discret	Apr-92	74,646	3
ACF	06-97-47657	Five Sandoval	Nov-99	46,660	6
ACF	06-97-47730	Tri-County Head Start	Dec-97	2,451	6
ACF	06-97-48284	E Texas Family Srv	Nov-98	9,130	6
ACF	06-97-48531	TX DHS	Jan-99	11,209	25
ACF	07-98-50741	Citizens Housing	Dec-99	2,678	6
ACF	07-99-57228	Douglas Community	Jun-00	35,043	25
ACF	08-02-69413	Cankdeska Cikana Colleg	Aug-02	132,212	6
ACF	08-97-43975	Oglala Sioux Tribe	May-99	6,494	6
ACF	08-97-46601	Ute Indian Tribe	Oct-99	780	6
ACF	08-99-57703	Connejos-Costil	Oct-99	21,145	6
ACF	08-99-59825	Crow Creek Si.	Jan-00	26,660	6
ACF	08-99-59907	Crow Creek Si.	Aug-00	344,504	6
ACF	08-99-60047	Alamosa HS.	Feb-00	8,605	6
ACF	09-00-63951	Tohono O Odham Nation	May-01	121,541	4
ACF	09-01-67471	Catholic Charities	Jul-02	152	6
ACF	09-92-06592	Intertribal Cnl/Hs	Sep-93	30,015	4
ACF	09-93-00106	CA Dept. of Social Svcs.	May-97	29,269	25
ACF	09-93-23668	Center of ED/HS	Nov-93	12,070	25
ACF	09-95-00091	Walter McDonald Asso.	Jul-99	23,553	4
ACF	09-96-39178	AZ Aff Tribes	Mar-99	258,824	6
ACF	09-96-40113	Protective & Adv Mariana	Apr-98	80,574	6
ACF	09-96-40114	Protective & Adv Mariana	Apr-98	36,988	6
ACF	09-96-40115	Protective & Adv Mariana	Apr-98	56,344	6
ACF	09-96-43765	AZ Aff Tribes	Mar-99	$66,526	6

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HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
ACF	09-99-56272	Rinco San Luiseno Band	Apr-01	$2,460	6
ACF	09-99-56272	NA Rincon San Luiseno Band of Mission Ind.	Apr-01	49,860	6
ACF	09-99-57168	NA Santa Y Sabel Band of Mission Indians	Jun-01	108,615	4
ACF	10-00-58628	Kuigpagmiut, In.	Apr-00	18,119	6
ACF	10-01-66783	Native Village of Mekoryuk	Apr-01	15,883	4
ACF	10-01-69183	State of WA	Feb-02	25,985	25
ACF	10-01-69183	State of WA	Feb-02	276,680	25
ACF	10-98-00008	Siletz River Co.	Apr-00	27,316	6
		Total for ACF		**$18,076,796**	
CDC	01-02-71527	State of MA	Apr-02	29,260	5
CDC	01-96-37165	Haitian American Public Health Initiative	Mar-97	20,209	5
CDC	03-02-72715	DC Dept. of Health	Jul-03	7,851	5
CDC	03-98-50835	Nat'l Organ. of Black County Officials	Jan-99	19,385	5
CDC	03-98-50836	Nat'l Organ. of Black County Officials	Jan-99	27,140	5
CDC	03-98-50837	Nat'l Organ. of Black County Officials	Mar-99	1,078	5
CDC	03-98-51634	City of Philadelphia, PA.	Jun-98	93,690	5
CDC	03-99-56842	Nat'l Assoc. for Equal Opport. in Higher Ed.	Feb-01	33,585	5
CDC	04-00-61897	American Cancer Society	Mar-01	28,654	5
CDC	04-00-65030	State of SC	Jul-00	688,633	5
CDC	04-02-72213	State of FL	Jun-02	28,612	5
CDC	04-98-51239	State of AL Child Care & Dev. Fund Mand.	Sep-98	227,200	5
CDC	05-96-40217	WI Assoc. of Black Social Workers, Inc.	Mar-97	1,649	5
CDC	06-02-70732	US-Mexico border Health Association	Jan-02	23,483	5
CDC	09-96-41444	Immigrant Center	Mar-97	2,495	5
CDC	10-98-53018	Self Enhancement, Inc.	May-00	3,452	5
CDC	10-98-53162	People of Color Against Aids Network	Sep-00	8,289	5
		Total for CDC		**$1,244,665**	
CMS	01-00-65091	State of VT	Jul-00	15,853	5
CMS	01-01-00502	Ambulance & Radiology Serv	Oct-02	51,000,000	5
CMS	01-01-00529	BC/BS of GA	Jul-02	31,139	5
CMS	01-01-00542	Associated Hospital Serv	Dec-02	518,981	5
CMS	01-89-00518	Blue Shield of MA	Oct-90	216,053	11
CMS	01-90-00500E	Blue Cross of MA	Sep-90	7,048,076	4
CMS	01-91-00508	Aetna Life-Parts A&B Adm.	Jan-92	223,655	12
CMS	01-92-00517	Blue Cross of M.	Apr-93	160,122	5
CMS	01-92-00523	BC/BS of MA -Part B Lab Tests	Jan-94	2,250,000	26
CMS	01-93-00512	BC/BS of MA-Lab Test	Jul-94	426,817	26
CMS	01-94-00510	BC/BS of MS - ADM costs	Apr-95	$130,299	5

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HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	01-95-00503	G/A & Capitol Mclean Ho- Adm Costs	Aug-95	$186,190	5
CMS	01-96-00513	Separately Billable ESRDL Lab Tests	Dec-96	6,300,000	5
CMS	01-96-00519	Nat'l Medical Care ESRD	Sep-97	4,319,361	7
CMS	01-96-00527	Clinical Lab Tests- Hosp. Outpatient Labs	Dec-00	43,632,767	5
CMS	01-98-00512	CT BC/BS Noncompliance	Jun-98	3,264	5
CMS	01-99-00501	Waterbury Hospital	Oct-99	103,588	5
CMS	01-99-00518	Danbury Hospital	May-00	62,104	5
CMS	01-99-00521	Hematology Indices	Sep-00	14,000,000	5
CMS	01-99-00522	Medicare Clinical Lab Tests	Oct-00	31,200,000	5
CMS	01-99-00523	United HealthCare Ins.	Aug-00	19,282	5
CMS	01-99-57863	State of CT	May-99	67,594	5
CMS	02-00-01023	N. Shore Long Island Jewish Hlth System	Jul-02	319,130	5
CMS	02-00-01032	St. Barnabas Hosp	Jul-02	205,100	5
CMS	02-00-01048	Triple S Inc.	Dec-01	298,693	5
CMS	02-86-62015	Empire BC/BS	Mar-88	1,277,575	9
CMS	02-86-62016	Empire BC/BS	Aug-88	3,027,672	8
CMS	02-91-01022	Prudential Ins.-ADM	Mar-92	6,837,167	14
CMS	02-92-01004	NJ DHS - Credit Balances for Eight Hosp	Sep-93	89,839	5
CMS	02-96-01010	NYS DSS	Jul-00	612,121	28
CMS	02-96-01034	Staff Blders. Home Health Inc. Buffalo-ORT	Jan-98	2,046,576	5
CMS	02-97-01026	Eddy VNA of the Capital Region	Nov-99	11,336,867	5
CMS	02-97-01041	Personal Care Svc., Westchester Cty. NY	Apr-99	687,418	5
CMS	02-99-01026	South Jersey Rehab Associates, Inc.	Nov-00	297,808	5
CMS	03-00-00211	Commonwealth of PA	Dec-01	89,492,522	5
CMS	03-01-00005	Veritus, Inc.	Oct-01	131,071	5
CMS	03-92-00150	Elmira Jeffries MNH	Jan-94	164,188	22
CMS	03-92-00201	Commonwealth of VA	Jan-93	205,177	14
CMS	03-92-00602	PA DPW - Upper limit	Sep-94	230,520	5
CMS	03-93-00013	Omega Med. Lab.	Nov-93	1,102	5
CMS	03-93-00025	PBS - Lab Fee Schedules	Sep-95	953,377	5
CMS	03-95-38380	Commonwealth of VA	Mar-96	68,333	5
CMS	03-99-00012	John Hopkins Bayview Medical Ctr	Jun-02	957,458	5
CMS	04-00-06005	Univ of Al at Birmingham Hospital	Apr-02	5,428,248	5
CMS	04-00-61448	State of GA (OGM)	Feb-00	1,032,355	24
CMS	04-00-61620	State of NC	Nov-01	57,097	5
CMS	04-00-61627	State of TN	Mar-00	359,907	24
CMS	04-00-64861	State of NC	Sep-00	24,496	5
CMS	04-01-68698	State of MS	Mar-02	$3,560,760	5

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HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	04-02-03012	Connecticut Gen Life Insur Co	Sep-02	$7,826	5
CMS	04-02-72659	State of GA	Sep-02	142,363	5
CMS	04-91-02004	HCFA RO IV (FL BS-MSP)	Sep-93	2,694,287	5
CMS	04-93-20876	State of NC (OGCFM Lead)	Jul-93	22,244	5
CMS	04-94-01096	Humana Medical Plans, Inc.	Apr-95	624,048	5
CMS	04-95-01104	American Health Care-ORT	Jan-97	1,200,000	5
CMS	04-95-02110	SC BC (Hospice of Lake and Sumter, Inc.) ORT	Apr-97	4,000,000	5
CMS	04-95-02111	B/C of SC (Hospice of FL Suncoast, Inc.)	Mar-97	14,800,000	5
CMS	04-95-33005	State of MS (OGM)	Aug-95	63,140	12
CMS	04-95-33088	State of NC (OGM)	Sep-96	11,098	12
CMS	04-95-38310	State of MS (OGM)	Mar-96	9,069,408	22
CMS	04-96-01125	Aetna- Rosemont Health Care Ctr	Jan-02	55,306	5
CMS	04-96-01129	CA BC - ORT SNF of Washington Manor	Jan-02	284,378	5
CMS	04-96-01131	Aetna (Health Svcs. Of Green Briar)-ORT	Nov-97	202,780	5
CMS	04-96-01134	Aetna Colonnade Med. Ctr - ORT	Jan-02	385,338	5
CMS	04-96-01135	Aetna Washington Manor ORT	Jan-02	220,483	5
CMS	04-96-01136	Aetna Savanna Cay Manor -ORT	Jan-02	354,537	5
CMS	04-96-01138	BC/BS of FL-Lawnwood Reg. Med. Ctr.	Apr-97	111,986	22
CMS	04-96-01148	Aetna Life Insur. Co.	Nov-97	148,955	5
CMS	04-96-02122	Blue Cross of GA	Oct-98	791,327	6
CMS	04-96-38655	State of NC	Jan-97	5,053	12
CMS	04-97-01164	1996 ACR Proposal for FL MCP	Jan-00	9,660,000	5
CMS	04-97-01168	FL Agency for Health Care Administration	Dec-99	8,885,855	14
CMS	04-97-02130	Mutual of Omaha	Apr-99	1,709,245	5
CMS	04-97-02138	Mutual of Omaha	Apr-99	2,382,527	5
CMS	04-98-01184	Homebound Medical Care, Inc.	Jun-00	1,860,760	5
CMS	04-99-01193	Six State Review of O/P Rehab. Facilities	Jun-00	74,067,804	5
CMS	04-99-01195	Medicare Home Health Services in FL	Mar-01	57,022	5
CMS	04-99-55388	State of NC (OGM)	Jun-99	367,984	5
CMS	04-99-55479	Commonwealth of KY (OGM)	Mar-99	316,997	5
CMS	04-99-55653	State of TN (OGM)	Nov-99	309,448	5
CMS	04-99-59921	State of KY (OGM)	Oct-99	184,633	5
CMS	05-90-00013	BC/BS of MI - Admin	Dec-90	2,413,388	10
CMS	05-97-00028	OH Dept. of Human Services	Oct-98	12,674,026	5
CMS	05-97-00029	Office of Medicaid Policy and Planning - IN	Mar-99	2,000,000	5
CMS	06-00-00026	LA State Univ Medical Ctr	Feb-02	18,442,552	5
CMS	06-01-00039	TX Hlth & Human Serv Commission	Jun-02	333,298	5
CMS	06-01-68876	State of LA -OGM	Jun-02	$73,186	5

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HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	06-02-72610	State of OK - OGM	Dec-02	$1,110,228	5
CMS	06-92-00043	BC/BS of TX - GME Costs	Mar-94	4,252,743	23
CMS	06-95-00095	Palmetto Gov. (Fam Hospice/Dallas)	Apr-97	871,306	22
CMS	06-96-00027	Palmetto Gov. (VNA of TX Hospice)	Apr-97	1,156,341	22
CMS	06-97-00034	Risk Base Health Maint.	Jun-99	55,895	5
CMS	06-99-00058	State of LA (OGM)	Jun-00	5,290,000	5
CMS	06-99-56489	State of LA (OGM)	Aug-99	368,258	5
CMS	07-00-65149	NE Health & Human Serv Nursing Facility	Sep-00	1,450,104	5
CMS	07-91-00471	BC/BS of MI - Pension Seg.	Dec-92	5,021,873	10
CMS	07-91-00473	BC/BS of FL, Inc.-Pension Seg.	Aug-93	4,755,565	13
CMS	07-92-00525	BC/BS of MI -Pension Costs	Dec-92	2,135,884	10
CMS	07-92-00578	BC/BS of TX - Unfunded Pension Costs	Oct-92	6,244,637	13
CMS	07-92-00585	BS of CA - Pension Costs	Feb-94	2,973,504	5
CMS	07-92-00604	WVA BC/BS Term Pension	Jan-93	617,644	17
CMS	07-92-00608	BC/BS of Missouri	Jun-93	960,615	15
CMS	07-93-00633	Aetna Life Insurance - Pension Costs	Oct-93	3,011,376	5
CMS	07-93-00634	Travelers - Pension Seg.	Oct-93	1,026,460	18
CMS	07-93-00665	Travelers Ins.- Pension Costs	Oct-93	1,218,963	5
CMS	07-93-00679	Aetna Life Insurance - Pension Costs	May-94	4,455,857	5
CMS	07-93-00680	BC/BS of NC - Unfunded Pension Costs	Oct-94	293,629	21
CMS	07-93-00699	BC/BS of MA - Pension Seg.	Apr-94	658,471	19
CMS	07-93-00700	BC/BS of MA - Pension Costs	May-94	1,290,740	19
CMS	07-93-00701	BS/BS of MA - Pension Costs	Jul-94	839,740	19
CMS	07-93-00709	BC/BS of CT - Pension Seg.	Apr-94	119,472	19
CMS	07-93-00710	BC/BS of CT - Pension Costs	Mar-93	237,392	19
CMS	07-93-00713	PA BS - Pension Costs	Jun-95	5,490,995	5
CMS	07-94-00744	IASD Health Svcs. Corp. - Pension Seg.	Sep-94	3,079,484	20
CMS	07-94-00745	IASD Hlth Svcs. Corp. - Unfunded Pen.	May-94	574,804	20
CMS	07-94-00746	IASD Health Svcs. Corp. - Pension Seg.	May-94	842,979	20
CMS	07-94-00747	IASD Hlth Svcs. Corp. - Unfunded Pen.	May-94	10,331	20
CMS	07-94-00762	Health Care Svcs. Corp - Unfunded Pension Costs	Jul-94	1,233,337	10
CMS	07-94-00763	Health Care Svcs. Corp.- Pension Seg.	Aug-94	1,055,458	10
CMS	07-94-00768	BC/BS of SC - Pension Costs	Sep-94	840,493	13
CMS	07-94-00769	BC/BS of SC - Pension Costs	Sep-94	329,001	19
CMS	07-94-00770	BC/BS of SC- Unfunded Pension Costs	Sep-94	793,508	13
CMS	07-94-00777	BC/BS of GA - Pension Costs	Oct-94	90,736	13
CMS	07-94-00778	BC/BS of GA - Unfunded Pension Costs	Oct-94	363,921	13
CMS	07-94-00779	BC/BS of GA - Pension Seg.	Oct-94	$113,256	13

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HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	07-94-00805	BC/BS of TN -Pension Seg.	Jan-95	$1,400,063	13
CMS	07-94-00816	BC/BS of TN. -Unfunded Pension Costs	Jan-95	352,026	13
CMS	07-94-00817	BC/BS of AL - Pension Unfunded Costs	Jul-95	912,730	13
CMS	07-94-00818	BC/BS of AL - Pension Seg.	Jul-95	951,281	13
CMS	07-94-01107	BC/BS of FL - Pension SEG.	Apr-96	813,122	13
CMS	07-95-01126	BC/BS of FL - Pension Unfunded Costs	Apr-96	4,049,889	13
CMS	07-95-01149	BC/BS of TX - Pension Costs	Apr-96	874,111	13
CMS	07-95-01150	BC/BS of Oregon - Pension Seg.	Aug-97	191,312	5
CMS	07-95-01151	BC/BS of OR - Pension Unfunded Costs	Aug-97	260,335	5
CMS	07-95-01159	BC/BS of NE - Pension Seg.	Jan-96	96,955	27
CMS	07-95-01166	BC/BS of NE - Pension Unfunded Costs	Jan-96	73,509	27
CMS	07-96-01178	BC/BS of MI - Pension Costs	Nov-96	631,248	10
CMS	07-96-01185	Rocky Mt. Hlth Care Corp. - Pension Seg.	May-97	2,743,438	13
CMS	07-96-01189	BC of WA & AK- Pension Seg.	Dec-97	96,740	5
CMS	07-96-01194	Community Mutual Ins. Co. Pension Seg.	Jul-97	1,866,026	5
CMS	07-96-01195	New Mexico BC - Pension Seg.	Feb-97	801,899	13
CMS	07-96-01198	Rocky Mtn. Hlth. Care Corp Unfunded Pen.	Feb-97	543,421	13
CMS	07-97-01205	BC of WA & AK - Pension Seg.	Dec-97	15,688	5
CMS	07-97-01206	BC of WA & AK - Pension Unfunded Costs	Dec-97	106,843	5
CMS	07-97-01207	Community Mutual Ins. Co. Unfunded Pen	Sep-00	571,413	5
CMS	07-97-01208	Community Mutual Ins Co Pension Costs	Sep-00	991,972	5
CMS	07-97-01209	BC/BS of MS - Pension Seg.	Jan-98	224,711	13
CMS	07-97-01210	BC/BS of MS - Unfunded Pension Costs	Jan-98	482,549	13
CMS	07-97-01211	BC/BS of MS - Pension Costs	Jan-98	134,312	13
CMS	07-97-01213	Travelers Pension Seg.	Jan-98	5,624,747	5
CMS	07-97-01222	AdminaStar Federal of KY - Pension Seg.	Oct-98	1,236,890	13
CMS	07-97-01234	Rock Mountain Health Care Corp. Pension Term	May-98	4,079,171	13
CMS	07-97-02500	Anthem BC/BS of CT	Mar-98	122,548	5
CMS	07-98-01224	AdminaStar Federal - Pension Unfunded Costs	Oct-98	4,286,294	5
CMS	07-98-01225	AdminaStar Federal - Pension Costs	Oct-98	736,134	5
CMS	07-98-02501	Anthem BC/BS of CT - Pension Unfunded Costs	Mar-98	292,152	5
CMS	07-98-02506	Aetna Life and Casualty	Aug-98	1,407,689	5
CMS	07-98-02522	BS of CA - Pension Plan Terminated Contractor	Apr-99	7,623,524	5
CMS	07-98-02526	BC/BS of AR	Sep-98	153,269	13
CMS	07-99-01278	Rebound Inc.	Apr-02	1,042,522	5
CMS	07-99-01288	Wellmark, Inc.	Nov-01	1,169	5
CMS	07-99-02540	General American Life Insurance Company	Jul-00	6,205,564	27
CMS	08-00-64575	State of CO	May-00	$11,205,906	13

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HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
CMS	08-94-00739	BC/BS of ND - Pension Seg.	Jan-95	$730,875	13
CMS	08-94-00740	BC/BS of NC - Unfunded Pension Costs	Jan-95	671,198	13
CMS	09-89-00162	Nationwide Employer Project - MSP	Mar-95	2,218,824	16
CMS	09-95-00072	CA DHS	Nov-96	4,013,490	5
CMS	09-96-00061	BS of CA	Jun-98	1,006,192	18
CMS	09-96-00064	San Diego Hospice Corp. - ORT	Nov-98	993,779	5
CMS	09-96-00088	Care Providers- BC of CA	Jul-99	901,278	5
CMS	09-96-00089	Care Plus Home Hlth Services - BC of CA	Jul-99	389,497	5
CMS	09-96-00094	BC of Ca - Dynasty Home Hlth Inc	Jan-02	217,720	5
CMS	14-96-00202	Excluded Unlicensed Health Care Providers	Sep-97	2,931	5
CMS	17-95-00096	HCFA Financial Statement Audit for FY 1996	May-98	300,000	5
CMS	17-97-00097	HCFA Financial Statement Audit for FY 1997	Sep-98	141,796	5
		Total for CMS		**$602,576,756**	
HRSA	04-98-50281	Aaron E. Henry CHC	Sep-98	3,017	6
HRSA	08-02-70421	Aberdeen Area Tribal Chairmen's Hlth Board	Feb-03	1,509	6
		Total for HRSA		**$4,526**	
IHS	08-00-56759	SD Urban Indian Health	Nov-99	32,783	5
IHS	08-00-59899	SD Urban Indian Health	Nov-99	6,818	5
IHS	08-00-60654	Spirit Lake	Jan-00	22,031	5
IHS	08-00-61777	Turtle Mountain Band of Chippewa Indians	Nov-99	129,070	5
IHS	08-99-55284	SD Urban Indian Health	Jun-99	902,046	5
IHS	08-99-55285	SD Urban Indian Health	Jun-99	902,377	5
IHS	08-99-56446	Sisseton-Wahpeton Sioux Tribe	May-99	5,843	5
IHS	09-00-60032	Lovelock Paiute Tribe	Dec-99	74,187	5
IHS	09-01-65664	Lovelock Paiute Tribe	Dec-00	50,473	5
IHS	09-01-67778	Lovelock Paiute Tribe	Jun-01	19,129	5
IHS	09-01-68215	Pyramid Lake Paiute Tribe	Sep-01	14,919	5
		Total for IHS		**$2,159,676**	
OMH	A-03-00-64076	Nat'l Medical Association	Mar-98	27,106	29
OMH	A-03-98-50338	Nat'l Medical Association	Mar-98	12,968	29
OMH	A-15-01-20002	Congress Heights	May-01	11,300	5
		Total for OMH		**$51,374**	
OS	01-01-00004	State of ME	Sep-01	21,477	4
OS	02-01-69286	Ponce Medical School	Feb-02	70,114	6
OS	02-99-02004	Puerto Rico	Sep-01	24,113,432	6
OS	03-00-63670	State of PA	Nov-00	11,388,686	1
OS	06-00-61716	TX Dept. of Health	Sep-00	$138,870	6

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected As of September 30, 2003 - Continued

HHS Agency	Audit Report #	Auditee	Issue Date	Amount	Note
OS	08-99-59826	Crow Creek Sioux	Feb-00	$14,448	6
OS	09-97-48247	Karidat	Dec-97	50,612	1
OS	09-97-48966	Karidat	Jan-98	2,234	1
OS	09-98-52613	Marianas	Dec-98	639,432	6
OS	09-98-54245	Nevada Law Center	Dec-98	126	4
OS	09-99-57597	Bear River Band	Mar-00	1,648	6
		Total for OS		**$36,441,079**	
PSC/DPM	02-99-58263	Puerto Rico, Office of the Governor	Jul-99	27,980	5
PSC/DCA	03-90-00453	State of WV	Mar-91	12,850,856	7
PSC/DCA	06-01-68685	State of NM	Mar-03	650,000	6
PSC/DCA	06-99-59584	State of LA	Sep-00	19,261,661	1
PSC/DCA	09-92-00116	State of CA	Feb-95	95,751,452	4
		Total for PSC		**$128,541,949**	
SAMHSA	02-99-02502	Southeast Queens Community Partnership, Inc.	May-00	500,263	5
SAMHSA	04-04183	Columbus Co. Services Mgmt.	Jul-94	35,167	4
		Total for SAMHSA		**$535,430**	
		Total for HHS		**$789,632,251**	

Notes:

1. Appeal process.
2. Referred to DOJ.
3. Referred to DOJ/payment plan.
4. Payment plan.
5. Pursuing collection.
6. Transferred to Treasury Offset Program.
7. In District Court.
8. Contractor has signed the closing agreement. An amended OCD is being prepared.
9. Contractor appealed and court ruled in contractor's favor. HHS agency has appealed.
10. Pending resolution of contractor's termination audit, any related termination agreement and pending lawsuit.
11. HHS agency has instructed the carrier to calculate and recover partial overpayments. Recoupment is still on hold pending resolution of the company's appeal to an administrative law judge.
12. Additional documentation has been provided by the State or contractor. OIG and/or HHS agency reviewing.
13. HHS agency is working with all Medicare providers to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
14. HHS agency is in process of negotiating or determining outstanding overpayment amount and/or payment options.
15. HHS agency will verify that corrective action has been completed by the fiscal intermediary.

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected As of September 30, 2003 - Continued

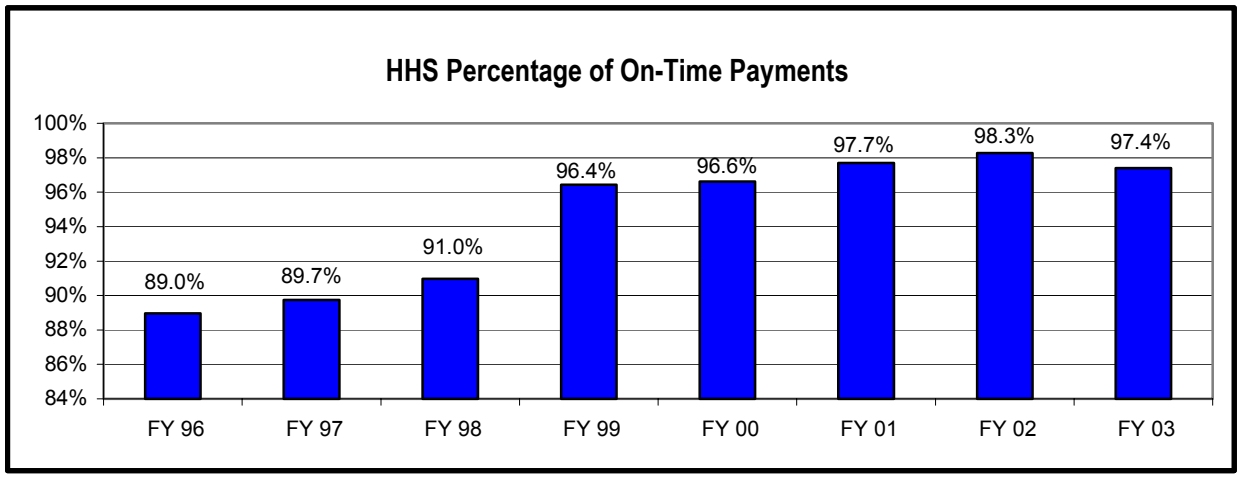
Notes Continued:

16. Demand letters were sent to employers listed in the audit. D.C. Circuit Court's decision in HIAA vs. Shalala case will result in few recoveries of funds from EGHP's timely filing limits. HHS agency is attempting to "fix" the HIAA decision via new legislation.
17. Contractor was declared insolvent and placed in receivership. DOJ has filed a claim on HHS agency's behalf.
18. HHS agency is negotiating a settlement with the State or the contractor.
19. HHS agency is of developing a formula to settle all waivers regarding pension segmentation and/or unfunded pension costs.
20. HHS agency is awaiting verification from the pension actuarial staff that an adjustment was made.
21. An onsite audit is in process. A global settlement will close pension and administrative costs.
22. The State or contractor is in the process of determining or collecting overpayment.
23. Collection activity has been suspended pending resolution of an objection lodged by two providers' legal counsel with the OIG and OCG.
24. HHS agency is verifying collection of overpayment.
25. Awaiting confirmation that account receivable may be closed out.
26. Waiting for a decision and/or action by the Asst. U.S. Attorney.
27. HHS agency is negotiating with the contractor on the related administrative costs audit.
28. HHS agency to examine related claims.
29. Working with new Executive Director to resolve all issues.

Appendix G – Prompt Pay and Civil Monetary Penalties

Prompt Pay

HHS increased its rate of on-time payments from FY 1996 through FY 2002 when it reached a department-wide record by making over 98 percent of payments on time. The rate of on-time payments for FY 2003 dipped slightly but still exceeded 97 percent.



Civil Monetary Penalties

Civil Monetary Penalties (CMP) are non-criminal penalties for violation of federal law. The Federal Civil Penalties Inflation Adjustment Act of 1990 provides for periodic evaluation to ensure that CMP maintain their deterrent value and that the imposed penalties are properly accounted for and collected. During FY 2003, only CMS and FDA imposed CMP.

For the Fiscal Year Ended September 30, 2003 CMS & FDA Combined		
Outstanding Receivables	**Number**	**Amount (in dollars)**
Beginning Balances	474	809,487,536
Assessments (+)	1,384	454,113,520
Collections (-)	(1,530)	(704,111,336)
Adjustments	(101)	(59,525,376)
Amounts Written Off	(15)	(935,044)
Ending Balance	**212**	**$499,029,300**
Current Receivables	192	488,444,038
Non-Current Receivables	20	10,585,262
Allowance	0	(418,074,718)
Net Receivables	212	80,954,582
Total Delinquent	**46**	**$1,327,157**
Total Non-Delinquent	**166**	**$497,702,143**

Appendix H - Financial Management Performance Measures

Measure	Baseline	Performance Trend					Target FY 2003
		FY 1999	FY 2000	FY 2001	FY 2002	FY 2003 Actual	
Audited financial statements for HHS and CMS are submitted to OMB by submission due date.	FY 1996: No	Yes	Yes	Yes	Yes	Yes	Yes
Number of department-level material weaknesses.	FY 1996: 5	3 Medicare accounts receivable; Medicare EDP; and financial reporting.	2 Financial systems and processes & Medicare EDP controls.	2 Financial systems and processes and Medicare EDP controls.	2 Financial systems and processes and Medicare EDP controls.	2 Financial systems and processes and Medicare information system controls.	2 Financial systems and processes and Medicare EDP controls.
Number of department-level reportable conditions.	FY 1997: 3	4 CMS regional office oversight; Medicaid improper payments; EDP; and property, plant, and equipment.	2 Medicaid improper payments and EDP.	3 Medicaid improper payments; departmental information systems controls; and management systems planning and development.	1 Departmental Information Systems Controls	1 Departmental Information Systems Controls	1 Departmental Information Systems Controls
Percentage of Medicare contractors that will be subject to a SAS 70.	FY 2000: 26 of 50	N/A	50%	32%	50%	48%	33%
Number of department-level instances of FFMIA non-compliance.	FY 1997: 4	3	2	2	2	2	2
Percent of vendor payments made on time.	FY 1998: 91%	96.4%	96.6%	97.7%	98.3%	97.4%	96%
Increase percent of debt collection over prior year.	FY 1998: $13.3 billion	$14.27 billion 7% increase	$15.3 billion 7.2% increase	$14.4 billion 5.8% decrease	$14.4 billion	Not Available	10% increase
Percent of eligible non-waived delinquent debt referred for cross-servicing to the Treasury.	FY 1998: 0%	23%	41.9%	67.8%	93.5%	Not Available	100%
Number of department-level FMFIA material weaknesses/non-conformances pending at year end. Sections 2 & 4.	FY 1997: Sec 2 - 7 Sec 4 - 0	Sec 2 - 6 Sec 4 - 0	Sec 2 - 4 Sec 4 - 0	Sec 2 - 2 Sec 4 - 1	Sec 2 - 1 Sec 4 - 1	Sec 2 - 0 Sec 4 - 1	Sec 2 - 0 Sec 4 - 1

Appendix I – Acronyms

A	ACF	Administration for Children and Families
	ACIP	Advisory Committee on Immunization Practices
	ACTS	Aspen Complaint and Incident Reporting System
	ADAP	AIDS Drug Assistance Program
	ADD	Administration for Developmental Disabilities
	ADHD	Attention Deficit Hyperactivity Disorder
	AFCARS	Adoption Foster Care Analysis and Reporting System
	AFS	Automated Financial System
	AHCPR	Agency for Health Care Policy and Research
	AHRQ	Agency for Healthcare Research and Quality
	AI/AN	American Indian/Alaskan Native
	AICPA	American Institute of Certified Public Accountants
	AIDS	Acquired Immuno-Deficiency Syndrome
	AoA	Administration on Aging
	ASBTF	Assistant Secretary for Budget, Technology, and Finance
	ASFA	Adoption and Safe Families Act of 1997
	ASPE	Assistant Secretary for Planning and Evaluation
	ATSDR	Agency for Toxic Substances and Disease Registry
	AZT	Zidovudine
B	BACS	Budget and Accounting Classification Structure
	BBA	Balanced Budget Act of 1997
	BHMIS	Behavioral Health Management Information System
	BIPA	Benefits Improvement and Protection Act
	BPHC	Bureau of Primary Health Care
C	CAHPS	Consumer Assessment Health Plans Surveys
	CAP	Corrective Action Plan
	CARE	Comprehensive AIDS Resources Emergency
	CAS	Central Accounting System
	CBRN	Chemical, Biological, Radiological, Nuclear
	CBSP	Community-Based Services Program
	CDC	Centers for Disease Control and Prevention
	CDER	Center for Drug Evaluation and Research
	CDRH	Center for Device and Radiological Health
	CERCLA	Comprehensive Environmental Response, Compensation, and Liability Act of 1980
	CERT	Comprehensive Error Rate Testing
	CFBCI	Center for Faith-Based and Community Initiatives
	CFO	Chief Financial Officer

	CFOC	Chief Financial Officer's Council
	CFR	Code of Federal Regulations
	CHI	Consolidated Health Informatics
	CIO	Chief Information Officer
	CJ	Congressional Justification
	CLO	Congressional Liaison Office
	CMP	Civil Monetary Penalties
	CMS	Centers for Medicare & Medicaid Services (formerly HCFA)
	CO	Central Office
	CORE	PSC Core Financial Management System
	COTS	Commercial Off-The-Shelf
	CRADA	Cooperative Research and Development Agreement
	CSE	Child Support Enforcement
	CSO	Chief Security Officer
	CY	Calendar Year
D	DASH	Division of Adolescent and School Health
	DASIS	Drug and Alcohol Services Information System
	DC	District of Columbia
	DCIA	Debt Collection Improvement Act of 1996
	DEOC	Director's Emergency Operations Center
	DHS	Department of Homeland Security
	DMERC	Durable Medical Equipment Center
	DNA	Deoxyribose Nucleic Acid
	DOE	Department of Energy
	DOJ	Department of Justice
	DPM	Division of Payment Management
	DTaP	Diphtheria Tetanus Acellular Pertussis
E	e-GOV	Electronic Government
	EDP	Electronic Data Processing
	EMS	Emergency Medical Services
	EPA	Environmental Protection Agency
	Epi-X	Epidemic Information Exchange
F	FACS	Financial Accounting Control Systems
	FAIR	Federal Activities Inventory Reform
	FASAB	Federal Accounting Standards Advisory Board
	FDA	Food and Drug Administration
	FDAMA	FDA Modernization Act
	FECA	Federal Employees Compensation Act
	FFMIA	Federal Financial Management Improvement Act of 1996
	FFS	Fee-for-Service

	FGSP	Federal Grant Streamlining Program
	FHA	Federal Health Architecture
	FI	Fiscal Intermediary
	FICA	Federal Insurance Contribution Act
	FMFIA	Federal Managers' Financial Integrity Act of 1982
	FSA	Family Support Administration
	FTE	Full Time Equivalent
	FY	Fiscal Year
G	GA	Georgia
	GAAP	Generally Accepted Accounting Principles
	GAO	General Accounting Office
	GATES	Grants Administration, Tracking, and Evaluation System
	GISRA	Government Information Security Reform Act
	GLAS	General Ledger Accounting System
	GMRA	Government Management Results Act
	GPRA	Government Performance and Results Act of 1993
	GSA	General Services Administration
H	HCFA	Health Care Financing Administration
	HCFAC	Health Care Fraud and Abuse Control Program
	HDS	Human Development Services
	HEAL	Health Education Assistance Loans
	HEW	Department of Health, Education and Welfare
	HHS	Department of Health and Human Services
	HI	Hospital Insurance
	Hib	Haemophilus Influenzae type B
	HIFA	Health Insurance Flexibility and Accountability
	HIGLAS	Healthcare Integrated General Ledger Accounting System
	HIPAA	Health Insurance Portability and Accountability Act
	HIV	Human Immuno-deficiency Virus
	HPMP	Hospital Payment Monitoring Program
	HQ	Headquarters
	HRSA	Health Resources and Services Administration
I	IBNR	Incurred But Not Reported
	IG	Inspector General
	IHS	Indian Health Service
	IMPAC	Information for Management, Planning, Analysis, and Coordination
	IPA	Independent Public Accountants
	IPIA	Improper Payment Information Act
	IS	Information Systems
	IT	Information Technology

J	JCAHO	Joint Commission on the Accreditation of Health Care Organizations
	JFMIP	Joint Financial Management Improvement Program
K	K23	Mentored Patient-Oriented Research Career Development Award
	K24	Midcareer Investigator Awards in Patient-Oriented Research
	K30	Clinical Research Curriculum Development Awards
L	LLP	Limited Liability Partnership
	LRN	Laboratory Response Network
M	M&M	Mortality and Morbidity
	MCHBG	Maternal and Child Health Block Grant
	MD	Maryland
	MeDSuN	Medical Product Surveillance and Radiological Health Network
	MIP	Medical Integrity Program
	MK	Market-Based
	MMR	Measles, Mumps, and Rubella
N	N/A	Not Applicable
	NBRSS	NIH Business and Research Support System
	NHGRI	NIH National Human Genome Research Institute
	NIH	National Institutes of Health
	NIS	National Immunization Survey
	NMEP	National Medicare & You Education Program
	NPRM	Notice of Proposed Rulemaking
	NQMC	National Quality Measures Clearinghouse
	NRSA	National Research Service Award
O	OAA	Older Americans Act
	OCSE	Office of Child Support Enforcement
	ODP	Office of Domestic Preparedness
	OGC	Office of General Counsel
	OGMP	Office of Grants Management and Policy
	OIG	Office of Inspector General
	OMB	Office of Management and Budget
	OPD	Orphan Products Development
	OPDIV	Operating Division
	OPM	Office of Personnel Management
	OS	Office of the Secretary

	OTPER	Office of Terrorism Preparedness and Emergency Response
P	PAM	Payment Accuracy Measurement
	PAR	Performance and Accountability Report
	PART	Program Assessment Rating Tool
	PASRR	Preadmission Screening and Resident Review
	PCV	Pneumococcal Conjugate Vaccine
	PEHSU	Pediatric Environmental Health Specialty Unit
	PHS	Public Health Service
	PMA	President's Management Agenda
	PMO	Program Management Office
	PMS	Payment Management System
	PNS	Projects of National Significance
	PP&E	Property, Plant and Equipment
	PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
	PSC	Program Support Center
	PSTF	Patient Safety Task Force
Q	QIO	Quality Improvement Organization
R	RCA	Reports Consolidation Act of 2000
	RO	Regional Offices
	ROI	Return on Investment
	RPMS	Resource Patient Management System
	RSSI	Required Supplementary Stewardship Information
S	SA	Survey Agency
	SAMHSA	Substance Abuse and Mental Health Services Administration
	SAP	Select Agent Program
	SARS	Severe Acute Respiratory Syndrome
	SARS-CoV	SARS – associated Coronavirus
	SAS	Statement of Accounting Standards
	SBR	Statement of Budgetary Resources
	SCHIP	State Children's Health Insurance Program
	SECA	Self-Employment Contribution Act
	SEDS	Statistical Enrollment Data System
	SEPPA	Smallpox Emergency Personnel Protection Act
	SES	Senior Executive Service
	SMI	Supplementary Medical Insurance
	SNS	Strategic National Stockpile
	SPR	State Program Report
	SSA	Social Security Administration

T	TAGGS	Tracking Accountability in Government Grants System
	TANF	Temporary Assistance for Needy Families
	TEDS	Treatment Episode Data Set
	TOP	Treasury Offset Program
	TOPS	Total On-Line Processing System
	TPN	Total Parenteral Nutrition
	Treasury	Department of Treasury
	TROR	Treasury Report on Receivables
U	UDS	Uniform Data System
	UFMS	Unified Financial Management System
	US	United States
V	VICP	Vaccine Injury Compensation Fund
	VMI	Vendor-Managed Inventory
W	WHO	World Health Organization

Appendix J - Key HHS Financial Management Officials

HHS CFO Council

Kerry Weems
(Acting) Assistant Secretary for Budget, Technology, and Finance

George Strader
HHS Deputy Chief Financial Officer

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Shirl Ruffin	Director, Office of Financial Policy
Karen Cavanaugh	Acting Director, Division of Financial Management Policy
Damon Sutton	Acting Director, Division of Accounting and Fiscal Policy
Margie Yanchuk	Director, Division of Financial Systems Policy
Sue Mundstuk	Director, Financial Initiatives
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