Appendices

Appendix A - HHS Organization and Operations

There are 13 HHS components that administer the Department's programs. The Agency for Toxic Substances and Disease Registry is reported with the Centers for Disease Control and Prevention. Therefore, this report refers to 12 components. Leadership is provided by the Office of the Secretary (OS), which is also considered one of the 13 components. Five staff divisions also report to the Secretary and they are headed by Assistant Secretaries, one of which the Assistant Secretary for Budget, Technology, and Finance (formerly Assistant Secretary for Management and Budget), is responsible for this report. HHS is also active in ten regions throughout the United States, to coordinate the crosscutting and complementary efforts that are needed to accomplish our mission. HHS Headquarters is located at 200 Independence Avenue, SW, Washington, DC, 20201. The Offices of Inspector General (OIG), General Counsel, and Intergovernmental Affairs (IGA), Office for Civil Rights, and Departmental Appeals Board (DAB) also support this mission across the Department. The net budget outlay for FY 2001 and FY 2000 for providing this leadership was $568 million and $768 million, respectively. The net cost of the OS activities for FY 2001 and FY 2000 was $842 million and $772 million, respectively. The net outlay and net cost dollars shown in this section are rounded.

HHS FY 2001 NET BUDGET OUTLAY:	$426.4 billion
HHS FY 2000 NET BUDGET OUTLAY:	$382.6 billion
HHS FY 2001 CONSOLIDATED NET COST:	$432.9 billion
HHS FY 2000 CONSOLIDATED NET COST:	$385.5 billion

This section provides more information on the responsibilities and funds managed by each of the HHS components. Net budget outlay dollars are those shown in Appendix J. The HHS components are presented in alphabetical order.

Administration for Children and Families (ACF)

ACF is responsible for approximately 60 programs that promote the economic and social well being of families, children, individuals and communities. With its partners, ACF administers the state-federal welfare reform program, Temporary Assistance to Needy Families (TANF). ACF administers the national Child Support Enforcement program and also administers the Head Start program for preschool children.

ACF was established in 1991, bringing together several pre-existing programs. ACF provides funds to assist low-income families in paying for childcare and supports state programs to provide for foster care and adoption assistance. It also funds programs to prevent child abuse and domestic violence. ACF is organized into eight program offices and five staff offices that operate in Washington, DC and ten regional offices. Five regions also act as hub sites for activities that affect several regions.

FY 2001 NET BUDGET OUTLAY:	$42.2 billion
FY 2000 NET BUDGET OUTLAY:	$36.5 billion
FY 2001 CONSOLIDATED NET COST:	$43.7 billion
FY 2000 CONSOLIDATED NET COST:	$37.4 billion

Administration on Aging (AoA)

AoA is the federal focal point devoted exclusively to representing the needs and concerns of older people and their families and the policy and program development, planning, and service delivery to those persons in need. Through a nationwide service delivery infrastructure, AoA funds are leveraged to deliver comprehensive in-home and community services, including meals for older individuals. AoA funds also make legal services, counseling and ombudsmen programs available to elderly Americans.

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

FY 2001 NET BUDGET OUTLAY:	$952.0 million
FY 2000 NET BUDGET OUTLAY:	$884.5 million
FY 2001 CONSOLIDATED NET COST:	$959.0 million
FY 2000 CONSOLIDATED NET COST:	$902.0 million

Agency for Healthcare Research and Quality (AHRQ)

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

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

FY 2001 NET BUDGET OUTLAY:	$33.0 million
FY 2000 NET BUDGET OUTLAY:	$50.8 million
FY 2001 CONSOLIDATED NET COST:	$221.0 million
FY 2000 CONSOLIDATED NET COST:	$161.0 million

Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR)

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

CDC was established in 1946, as the Communicable Disease Center. CDC's personnel are stationed in its national headquarters in Atlanta, GA, 18 locations throughout the United States and territories, in more than 37 foreign countries and in 47 state health departments, and numerous local health agencies.

FY 2001 NET BUDGET OUTLAY:	$3.3 billion (including ATSDR)
FY 2000 NET BUDGET OUTLAY:	$2.5 billion
FY 2001 CONSOLIDATED NET COST:	$4.1 billion (including ATSDR)
FY 2000 CONSOLIDATED NET COST:	$2.8 billion (including ATSDR)

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

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

FY 2001 NET BUDGET OUTLAY:	$75.0 million (reported through HHS)
FY 2000 NET BUDGET OUTLAY:	$74.5 million (reported through EPA)
FY 2001 CONSOLIDATED NET COST:	$75.2 million
FY 2000 CONSOLIDATED NET COST:	$87.7 million

Centers for Medicare & Medicaid Services (CMS), formerly Healthcare Financing Administration (HCFA)

CMS is the largest purchaser of healthcare in the world. CMS administers the Medicare, Medicaid, and the State Children's Health Insurance (SCHIP) programs. The Medicare, Medicaid, and State Children's Health Insurance programs provide healthcare for one in four Americans. The outlays for Medicare and Medicaid, including state funding, represent 33 cents of every dollar spent on healthcare in the United States. Medicare provides health insurance for elderly and disabled Americans. Medicaid, a joint federal-state program, provides health coverage for low-income persons (50 percent of enrollees are children). Medicaid also pays for nursing home coverage for low-income elderly, covering almost half of total national spending for nursing home care. SCHIP, a federal-state program, provides health insurance coverage for children who otherwise would be without coverage.

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

FY 2001 NET BUDGET OUTLAY:	$350.4 billion
FY 2000 NET BUDGET OUTLAY:	$316.1 billion
FY 2001 CONSOLIDATED NET COST:	$352.3 billion
FY 2000 CONSOLIDATED NET COST:	$317.0 billion

Food and Drug Administration (FDA)

The FDA, established in 1927, is a science-based regulatory agency whose mission is to promote and protect the public health and well-being by ensuring that safe and effective products reach the market in a timely way, and to monitor products for continued safety after they are in use. FDA is responsible for overseeing a regulated industry that produces over one trillion dollars worth of products. The average cost of this effort to the taxpayers is about $4.00 per person per year. The products include the vast majority of the nation's food supply; over-the-counter and prescription medications; blood products; vaccines; tissues for transplantation; medical equipment and implantable devices; devices that emit radiation; animal drugs and feed; and cosmetics. FDA operations are headquartered in Rockville, Maryland and are organized into six centers, two offices, and five regions throughout the United States.

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

FY 2001 NET BUDGET OUTLAY:	$1.1 billion
FY 2000 NET BUDGET OUTLAY:	$1.0 billion
FY 2001 CONSOLIDATED NET COST:	$1.1 billion
FY 2000 CONSOLIDATED NET COST:	$1.0 billion

Health Resources and Services Administration (HRSA)

HRSA is an important component of the nation's health safety net; HRSA improves the nation's health by assuring equitable access to comprehensive, quality healthcare. HRSA and its state, local, and other partners, work to eliminate barriers to care and eliminate health disparities for Americans who are underserved, vulnerable, and have special needs. It also works to assure that quality healthcare professionals and services are available.

HRSA was established in 1982, bringing together several pre-existing programs. Its headquarters are located in Rockville, MD. HRSA works to decrease infant mortality and improve maternal and child health. It provides services to people with AIDS through the Ryan White CARE Act programs and oversees the organ transplantation and bone mar-

row donor systems. HRSA also works to build the healthcare workforce and maintains the National Health Service Corps. HRSA uses a structure of four bureaus, three centers, and several support offices to accomplish its mission.

FY 2001 NET BUDGET OUTLAY:	$5.1 billion
FY 2000 NET BUDGET OUTLAY:	$4.3 billion
FY 2001 CONSOLIDATED NET COST:	$5.3 billion
FY 2000 CONSOLIDATED NET COST:	$4.4 billion

Indian Health Service (IHS)

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

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

FY 2001 NET BUDGET OUTLAY:	$2.6 billion
FY 2000 NET BUDGET OUTLAY:	$2.4 billion
FY 2001 CONSOLIDATED NET COST:	$2.7 billion
FY 2000 CONSOLIDATED NET COST:	$2.4 billion

National Institutes of Health (NIH)

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

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

FY 2001 NET BUDGET OUTLAY:	$17.2 billion
FY 2000 NET BUDGET OUTLAY:	$15.4 billion
FY 2001 CONSOLIDATED NET COST:	$17.0 billion
FY 2000 CONSOLIDATED NET COST:	$15.6 billion

Program Support Center (PSC)

PSC is a self-supporting component of the Department that provides administration services for HHS and other federal agencies. The PSC is organized to provide competitive services on a fee-for-service basis in three key areas: financial management, human resources, and administrative operations. PSC provides these services to at least 14 other executive branch departments, 20 independent federal agencies, and the General Accounting Office. Activities and services of PSC are supported through the HHS Service and Supply revolving fund. PSC's services are fee-based and self-sustaining.

PSC is located in Rockville, MD. PSC was established in 1995 as a business enterprise from various administrative support units of HHS.

FY 2001 NET BUDGET OUTLAY:	$260.0 million - Reimbursable
FY 2000 NET BUDGET OUTLAY:	$137.1 million - Reimbursable.
FY 2001 CONSOLIDATED NET COST:	$2.2 billion
FY 2000 CONSOLIDATED NET COST:	$523.0 million

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA works to strengthen the capacity of the Nation's healthcare system to provide substance abuse prevention, addictions treatment, and mental health services for Americans experiencing or at risk for mental illness, substance abuse disorder, or co-occurring mental and addictive illnesses. SAMHSA provides funding through block grants to states for direct substance abuse and mental health services, including treatment for Americans with serious substance abuse problems, prevention intervention services, and services for adults and children with serious mental illnesses or emotional disturbances. Other programs provide the additional 1,200 grants for substance abuse and mental health services.

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

FY 2001 NET BUDGET OUTLAY:	$2.7 billion
FY 2000 NET BUDGET OUTLAY:	$2.5 billion
FY 2001 CONSOLIDATED NET COST:	$2.6 billion
FY 2000 CONSOLIDATED NET COST:	$2.5 billion

Appendix B - Comprehensive List of HHS Programs Net Costs

The following four pages present the programs accomplished by the Department during FY 2001 and FY 2000 within the framework of strategic goals based on dollars invested, and organized in a descending order of the FY 2001 net costs of those programs. This listing includes programs aggregated from the more than 300 total HHS programs. The net cost information is extracted from draft and final HHS components' Consolidated Statement of Net Cost for FY 2001 and FY 2000. *This table supplements the programs identified in the Consolidated Statement of Net Cost.*

HHS Program Index (in thousands)

HHS Program	FY 2001 HHS Net Cost ($)	FY 2000 HHS Net Cost ($)	Position Number in Descending Order in Net Cost Column		Budget Function	HHS Component Responsible for Program	Supports HHS Strategic Goals
			FY 2001	FY 2000			
Medicare	219,357,000	197,041,000	1	1	Medicare	Centers for Medicare & Medicaid Services	Goals 1, 2, 3, 4
Medicaid	130,450,000	118,705,000	2	2	Health	Centers for Medicare & Medicaid Services	Goals 1, 2, 3 , 4
Temporary Assistance to Needy Families	17,886,274	16,366,930	3	3	Education, Training & Social Services/ Income Security	Administration for Children and Families	Goal 2
Research Program	16,007,346	14,690,329	4	4	Health	National Institutes of Health	Goal 6
Child Welfare	7,014,178	5,735,557	5	5	Education, Training & Social Services/ Income Security	Administration for Children and Families	Goal 2
Head Start	6,014,077	4,677,539	6	6	Education, Training & Social Services/ Income Security	Administration for Children and Families	Goal 2
Child Care	4,118,955	3,260,168	7	7	Education, Training & Social Services/ Income Security	Administration for Children and Families	Goal 2
Child Support Enforcement	3,270,104	2,630,516	8	8	Education, Training & Social Services/ Income Security	Administration for Children and Families	Goal 2
State Children's Health Insurance Program	2,487,000	1,273,000	9	14	Health	Centers for Medicare & Medicaid Services	Goals 1, 2 , 3
Low-Income Home Energy Assistance	2,167,894	1,508,110	10	12	Education, Training & Social Services/ Income Security	Administration for Children and Families	Goal 2
Public Health Service Commissioned Corps	1,969,599	368,869	11	29	Health	Program Support Center	All Goals
Social Services Block Grant	1,859,959	1,849,521	12	9	Education, Training & Social Services	Administration for Children and Families	Goal 2
Substance Abuse Prevention and Treatment Block Grant	1,593,509	1,614,606	13	10	Health	Substance Abuse and Mental Health Services Administration	Goal 1
HIV/AIDS Programs	1,466,191	1,604,835	14	11	Health	Health Resources and Services Administration	Goal 3
Clinical Services	1,385,862	1,276,002	15	13	Health	Indian Health Service	Goal 3
Infectious Diseases	1,280,868	1,090,729	16	16	Health	Centers for Disease Control and Prevention	Goals 1, 5
Primary Health Care	1,266,717	1,261,921	17	15	Health	Health Resources and Services Administration	Goal 3
Immunization	1,254,758	385,172	18	26	Health	Centers for Disease Control and Prevention	Goal 3
Health Professionals	1,175,980	378,313	19	28	Health	Health Resources and Services Administration	Goals 3, 4
Training/Career Development Program	1,118,276	870,728	20	17	Health	National Institutes of Health	Goal 6
Matemal and Child Health	893,307	780,576	21	18	Health	Health Resources and Services Administration	Goal 3
Community Based Services (1)	890,161	N/A	22	N/A	Education, Training & Social Services	Administration on Aging	Goals 1, 4
Community Services	661,803	555,631	23	19	Education, Training & Social Services/ Income Security	Administration for Children and Families	Goals 2, 3
Chronic Disease Prevention	622,781	401,453	24	23	Health	Centers for Disease Control and Prevention	Goals 1, 6
Environmental and Occupational Health	481,651	396,627	25	24	Health/ Natural Resources & Environment	Centers for Disease Control and Prevention/ Agency for Toxic Substances & Disease Registry	Goal 5
Contract Health Care	412,658	380,407	26	27	Health	Indian Health Service	Goals 1, 2, 3, 4, 6
Knowledge Development and Application	403,016	443,187	27	22	Health	Substance Abuse and Mental Health Services Administration	Goal 1

HHS Program Index (in thouusands) — Continued

HHS Program	FY 2001 HHS Net Cost ($)	FY 2000 HHS Net Cost ($)	Position Number in Descending Order in Net Cost Column		Budget Function	HHS Component Responsible for Program	Supports HHS Strategic Goals
			FY 2001	FY 2000			
Foods and Cosmetics	390,085	364,914	28	30	Health	Food and Drug Administration	Goals 4, 5
Refugee Resettlement	385,723	447,892	29	20	Education, Training & Social Services/ Income Security	Administration for Children and Families	Goal 2
Community Mental Health Services Block Grant	377,742	291,649	30	32	Health	Substance Abuse and Mental Health Services Administration	Goal 3
Public Health and Social Services	335,852	443,596	31	21	Health	Office of Secretary	Goal 5
Tribal Contract Support	255,456	235,443	32	36	Health	Indian Health Service	Goal 3
Human Drugs	255,316	251,243	33	34	Health	Food and Drug Administration	Goal 5
General Departmental Management	242,825	285,721	34	33	Health	Office of Secretary	All Goals
Family Planning	241,626	232,091	35	37	Health	Health Resources and Services Administration	Goals 1, 3
Medical Devices and Radiological Health	223,320	203,773	36	38	Health	Food and Drug Administration	Goals 5, 6
Hospitals - Facilities Support	183,923	180,727	37	41	Health	Indian Health Service	Goals 1, 3, 4, 5
Facilities Program	178,609	187,006	38	40	Health	National Institutes of Health	Goal 6
Office of Inspector General	162,143	38,528	39	57	General Support	Office of Secretary	All Goals
Biologics	160,889	132,860	40	43	Health	Food and Drug Administration	Goal 4
Youth	140,953	201,235	41	39	Education, Training & Social Services/ Income Security	Administration for Children and Families	Goals 2, 4
Office of Special Program	123,795	42,009	42	55	Health	Health Resources and Services Administration	All Goals
Epidemic Services	114,656	100,063	43	45	Health	Centers for Disease Control and Prevention	Goal 1
Program of Regional National Significance /Targeted Capacity Expansion**	113,909	N/A	44	N/A	Health	Substance Abuse and Mental Health Services Administration	Goal 1
Injury Prevention and Control	105,681	76,258	45	47	Health/ Admin of Justice	Centers for Disease Control and Prevention	Goals 1, 2
Developmental Disabilities	105,251	139,533	46	42	Education, Training & Social Services/ Income Security	Administration for Children and Families	Goal 2
Preventive Health	97,106	92,583	47	46	Health	Indian Health Service	Goals 1, 2
Rural Health	90,903	64,421	48	51	Health	Health Resources and Services Administration	Goals 3, 4
Preventative Health and Health Services Block Grant	87,397	246,224	49	35	Health/Admin of Justice	Centers for Disease Control and Prevention	Goals 1, 5
Animal Drugs and Feeds	83,106	63,591	50	52	Health	Food and Drug Administration	Goals 5, 6
The Clinical Laboratory Improvement Amendments Program	83,000	(18,000)	51	98	Health	Centers for Medicare & Medicaid Services	Goals 3, 4
Sanitation Facilities	72,171	71,483	52	48	Health	Indian Health Service	Goals 1, 4, 5
OAS Block Grant Set-Aside/Data Collection**	62,577	N/A	53	N/A	Health	Substance Abuse and Mental Health Services Administration	Goals 1, 5
Health Statistics	62,460	37,497	54	58	Health	Centers for Disease Control and Prevention	Goal 5
Children's Mental Health Services Program	57,462	69,293	55	49	Health	Substance Abuse and Mental Health Services Administration	All Goals
Third Party Collections - Medicaid	53,107	41,629	56	56	Health	Indian Health Service	Goals 2, 4

HHS Program Index (in thousands) — Continued

HHS Program	FY 2001 HHS Net Cost ($)	FY 2000 HHS Net Cost ($)	Position Number in Descending Order in Net Cost Column		Budget Function	HHS Component Responsible for Program	Supports HHS Strategic Goals
			FY 2001	FY 2000			
Toxicological Research	43,033	43,347	57	54	Health	Food and Drug Administration	Goals 5, 6
Health Care Access Program	40,141	13,538	58	73	Health	Health Resources and Services Administration	Goal 3
Training, Research, & Demonstrations (2)	38,752	N/A	59	N/A	Education, Training & Social Services	Administration on Aging	Goals 2, 4
Health Care Facilities Construction	36,996	28,733	60	59	Health	Indian Health Service	Goal 3
Medical Expenditure Panel Surveys	35,555	25,230	61	63	Health	Agency for Healthcare Research and Quality	Goal 5
Diabetes Initiative	34,922	22,929	62	65	Health	Indian Health Service	Goals 1, 4
Domestic Violence	30,233	7,861	63	78	Education, Training & Social Services/ Income Security	Administration for Children and Families	Goal 1
Native American	29,956	47,575	64	53	Education, Training & Social Services	Administration for Children and Families	Goal 2
Urban Health Projects	28,680	27,081	65	61	Health	Indian Health Service	Goals 1, 2, 6
Protection & Advocacy for Individuals with Mental Illness	27,371	22,142	66	66	Health	Substance Abuse and Mental Health Services Administration	Goals 1, 2, 3, 4, 5
Projects for Assistance in Transition from Homelessness	26,452	26,503	67	62	Health	Substance Abuse and Mental Health Services Administration	All Goals
Third Party Collections - Medicare	26,368	13,819	68	71	Health	Indian Health Service	Goals 2, 4
Indian Health Professions	25,452	27,702	69	60	Health	Indian Health Service	Goals 1, 2, 3, 4, 6
Third Party Collections - Private Insurance	25,387	3,923	70	87	Health	Indian Health Service	Goals 2, 3, 4
Office for Civil Rights	20,009	23,611	71	64	Health	Office of Secretary	Goals 2, 3, 4
Services for Native Americans (3)	18,593	N/A	72	N/A	Education, Training & Social Services	Administration on Aging	Goals 1, 2, 3
Office of Policy Research	16,419	12,751	73	74	General Support	Office of Secretary	All Goals
Catastrophic Health Emergency Fund	16,122	13,715	74	72	Health	Indian Health Service	Goals 1, 2
Prevention Research	15,535	4,957	75	83	Health	Centers for Disease Control and Prevention	Goal 6
Ombudsman Services (4)	13,010	N/A	76	N/A	Education, Training & Social Services	Administration on Aging	Goal 4
Contributions Indian Health Facilities	12,725	21,629	77	67	Health	Indian Health Service	Goals 1, 3, 4, 5
Administrative Operations Service	11,586	6,451	78	79	General Support	Program Support Center	All Goals
Research on Health Cost, Quality and Outcomes	11,018	68,930	79	50	Health	Agency for Healthcare Research and Quality	Goal 4
Tribal Self Governance	8,768	9,688	80	76	Health	Indian Health Service	Goals 1, 2
High Risk Youth	8,678	4,390	81	85	Health	Substance Abuse and Mental Health Services Administration	All Goals
Telehealth	5,820	4,916	82	84	Health	Health Resources and Services Administration	Goals 3, 4, 5
Federal Occupational Health	5,294	(28)	83	95	Health	Health Resources and Services Administration	Goals 3, 4, 5
Consolidated Working Fund	4,152	9,280	84	77	Health	Indian Health Service	Goal 2
Operations and Maintenance of Quarters	4,053	3,833	85	88	Health	Indian Health Service	Goals 1, 4
State Data Infrastructure**	2,726	N/A	86	N/A	Health	Substance Abuse and Mental Health Services Administration	Goals 1,5

HHS Program Index (in thousands) — Continued

HHS Program	FY 2001 HHS Net Cost ($)	FY 2000 HHS Net Cost ($)	Position Number in Descending Order in Net Cost Column		Budget Function	HHS Component Responsible for Program	Supports HHS Strategic Goals
			FY 2001	FY 2000			
Tribal Management	2,567	1,723	87	91	Health	Indian Health Service	Goals 1, 2
Program Support	2,509	2,388	88	90	Health	Agency for Healthcare Research and Quality	All Goals
Other	2,064	6,409	89	80	Health	Various Components	All Goals
Ticket to Work**	2,000	N/A	90	N/A	Health	Centers for Medicare & Medicaid Services	Goals 2,3
Human Resources Service	1,291	(3,956)	91	96	General Support	Program Support Center	All Goals
Individual Development Accounts	908	3,559	92	89	Education, Training & Social Services	Administration for Children and Families	Goal 2
Tobacco	297	5,434	93	82	Health	Food and Drug Administration	Goal 1
Expired Programs-WHCOA	1	24	94	94	Education, Training & Social Services	Administration for Children and Families	Goals 2, 4
Expired Programs	-	6,124	95	81	Health	Substance Abuse and Mental Health Services Administration	All Goals
Community Schools	(67)	174	96	93	Administration of Justice	Administration for Children and Families	Goals 2, 4
HHS Service and Supply Fund	(168)	1,138	97	92	Health	Office of Secretary	All Goals
Financial Management Service	(2,223)	(6,123)	98	97	General Support	Program Support Center	All Goals
Federal Occupational Health	(6,716)	N/A	99	N/A	General Support	Program Support Center	All Goals
Supportive Services and Centers (1)	N/A	323,436	N/A	31	Education, Training & Social Services	Administration on Aging	Goal 4
Congregate Meals (1)	N/A	390,499	N/A	25	Education, Training & Social Services	Administration on Aging	Goal 1
Home Delivered Meals (1)	N/A	122,626	N/A	44	Education, Training & Social Services	Administration on Aging	Goal 1
Preventive Health Services (1)	N/A	17,593	N/A	69	Education, Training & Social Services	Administration on Aging	Goal 2
State & Local Innovation and Projects of National Significance (2)	N/A	14,151	N/A	70	Education, Training & Social Services	Administration on Aging	Goals 2, 4
Alzheimer's Disease (2)	N/A	4,201	N/A	86	Health	Administration on Aging	All Goals
Grants to Indian Tribes (3)	N/A	19,350	N/A	68	Education, Training & Social Services	Administration on Aging	Goals 1, 2, 3
Vulnerable Older Americans (4)	N/A	11,696	N/A	75	Education, Training & Social Services	Administration on Aging	Goal 4
Total Net Costs *	**$432,983,236**	**$385,484,940**					

N/A: Not Applicable

* Differs from the Consolidated Statement of Net Cost due to rounding

** New program in FY 2001

(1): For FY 2001, the net costs for these four programs - the Supportive Services and Centers program, the Congregate Meals program, the Home Delivered Meals program, and the Preventive Health Services program are combined and reported under the Community Based Services program

(2): For FY 2001, the net costs for these two programs - the State & Local Innovation and Projects of National significance program and the Alzheimer's Disease program are combined and reported under the Training, Research, & Demonstrations program.

(3): For FY 2001, the net costs for the Grants to Indian Tribes program is reported under the Services for Native Americans program.

(4): For FY 2001, the net costs for the Vulnerable Older Americans program is reported under the Ombudsman Services program.

Criteria and Sources for the Key HHS Program Performance Information Discussed in this Report

Most of the programs discussed in Section I of the report were selected from the programs whose HHS net costs are in the $1 billion range or more for FY 2001. In addition, programs which represent HHS components that would otherwise not have been represented, plus several key Secretarial initiatives are also included.

Criteria

The total sum of the net costs of the key programs discussed in the MD & A is equivalent to approximately 97 percent of the total FY 2001 HHS net costs. These costs were for services and products in addition to those discussed in this report. HHS partners incur additional costs above these costs.

The program performance information that appears in Section I of this report is consistent with the Government Performance and Results Act of 1993 (GPRA) requirements and it supports and is aligned with the HHS strategic goals. The performance measures that were included are selected samples of many measures that exist in the GPRA report and are usually one of many measures used to assess the program that they support.

Sources

The source of information for the GPRA data is the HHS components' performance plans and performance reports available as of September 2001 and actual data in support of those plans/reports that was available as of December 1, 2001 and that appeared in the HHS components' draft FY 2001 financial reports or overviews. Performance information from other reliable sources was used as well, especially where FY 2001 GPRA data is not available yet. The source information is either cited or included in the listing of references in Appendix N.

HHS long ago resolved that performance data must be credible to be useful to decision-making. Overall, HHS has a large number of administrative and survey data systems to draw upon that provide

high quality information. All parts of the Department have focused on the fundamentals of data verification and validation. However, program units have diverse functions and data needs; consequently, they vary widely in how they collect, verify and validate timely performance data. HHS program units have also addressed other factors that affect data collection and quality. These include reliance on achieving agreement by program partners, the timeliness of data, the resource-intensive nature of data collection, the diversity of data sources, and the suitability of data systems.

Since this is only the third year of GPRA performance reporting, indicators of program success are still evolving and issues of availability and reliability of performance data are still being addressed by many programs. It takes considerable time for partners to work together, develop shared priorities and goals, address weaknesses in data collection, and determine an optimum set of measures.

For a more detailed discussion of data validation and verification and for more comprehensive GPRA program results, see the HHS GPRA Performance Plan and Report Summary and individual HHS component GPRA plans and reports that will appear online under http://www.hhs.gov/budget/docgpra.htm. The HHS strategic plan can be found at http://aspe.hhs.gov/hhsplan/. Additional discussion of the financial condition of programs is contained in individual HHS component financial reports that appear under their component's web site or through http://www.hhs.gov/of/reports/account/.

A key purpose of GPRA is to improve the confidence of the American people in the capability of the federal government by systematically holding Federal agencies accountable for achieving program results.

HHS press releases undergo an independent clearance process with all the relevant OPDIVs and STAFFDIVs, so they reflect department-wide confirmation of factual information and policy at the time they are issued. They are archived at that point.

Resources

The resources for the key programs discussed in this report are included in the programs identified in Appendix B of this report.

Top Management Challenges Identified by the HHS OIG

The Reports Consolidation Act of 2000 requires that the Department's Office of Inspector General annually update its list of most serious management challenges, and management's progress in dealing with those challenges. Those challenges are identified and assessed here, along with a brief commentary from HHS management.

Management Issue 1: Bioterrorism

Management Challenge

Events of and since September 11 have underscored the need for the necessary infrastructure and tools to respond to potential future terrorist events, including bioterrorism, and other public health emergencies. The OIG is concerned about departmental vulnerabilities to outside threats and the readiness and capacity of responders at all levels of government to protect the public health. As such, a number of reviews have been initiated. The OIG is assessing security controls at CDC, NIH, and FDA and plans to conduct such assessments at college and university laboratories, including a look at how these institutions are handling the USA Patriot Act of 2001 prohibition on access to select agents by "restricted persons."

The CDC's Center for Bioterrorism Preparedness makes grants and provides technical assistance to state and local health departments to improve the Nation's response capacity to bioterrorist events; the OIG is assessing state and local health departments' ability to detect and respond to bioterrorism events, as well as their capacity and readiness for deployment of medical supplies. The OIG also plans to evaluate the integrity of CDC's vaccine procurement program and adherence to CDC's regulation governing facilities that transfer and receive select agents. In addition, the OIG is working with FDA to improve the security of the Nation's food supply.

Assessment of Progress in Addressing the Challenge

The Department is fully cooperating with the OIG's efforts to expedite these reviews. The reviews underway at agency labs to date reveal substan-

tial problems in each of the areas covered by the DOJ's "Vulnerability Assessments of Federal Facilities." The Department, however, is taking important actions to address the identified weaknesses. In addition, the Department is working on a proposal to increase the supply of pharmaceuticals and to assist State and local governments in meeting a bioterrorist attack.

Management's Comments in Brief

CDC has been working to address critical areas related to the rapid deployment of critical information and resources, to improve the public health infrastructure for detection and response, and to prepare for rapid deployment of "push packages" containing pharmaceutical and medical supplies. These behind-the-scenes efforts to prepare our country for the specter of bioterrorism suddenly moved to center stage after the terrorist attacks on September 11, 2001. CDC rapidly deployed the first of these push packages to aid rescue and recovery efforts in NYC and sent staff to both NYC and Washington, DC. CDC also activated its Health Alert Network, which provides rapid information to all health departments, and sent teams of specialized personnel to assist state and local efforts at the sites of the attacks.

A top priority of Secretary Thompson, HHS is working to prevent bioterrorism by hardening the security of its laboratories at NIH, CDC, and FDA with a view toward precluding accidental release or unauthorized removal of dangerous pathogens; by intensifying its oversight of the transfer of highly infectious microbes and dangerous toxins between laboratories; and by providing technical assistance to universities, public health laboratories, and other institutions regarding laboratory safety and security. In addition, HHS is fostering State and local accountability and preparedness for bioterrorism and other public health emergencies by providing awards to strengthen public health infrastructure related to detection and control of outbreaks of infectious disease, to upgrade the capabilities of hospitals to deal with mass casualties, and to enhance municipal-level planning for addressing the medical consequences of terrorism. Further, HHS is upgrading the terrorism response assets of the Federal Government by continuing development of the National Pharmaceutical Stockpile, procuring smallpox vaccine to protect the U.S. population in the event of an outbreak, developing a second generation anthrax vaccine, and expanding research into microbial genomics to develop new or improved diagnostics, drugs, and vaccines for the pathogens most likely to be used by bioterrorists.

Management Issue 2: Medicare Contractors

Management Challenge

For several years, OIG has been concerned about Medicare contractors' financial management problems such as accounts receivable documentation inadequacies, electronic data processing control weaknesses, integrity issues, and weaknesses in the way contractors assign and maintain provider numbers so as to better safeguard the program and its funds. These failures contribute to loss of program funds, improper payments and manipulation, fraud and abuse.

Assessment of Progress in Addressing the Challenge

The OIG expressed an unqualified opinion on the CMS FY 1999 and 2000 financial statements, largely because CMS continued to contract for validation and documentation of accounts receivable. However, once again OIG's FY 2000 financial statement audit disclosed that the lack of a fully integrated financial management system continued to impair the reporting of accurate financial information. To address these problems, CMS has initiated steps to implement an integrated general ledger system, expected to be fully operational at the end of FY 2006.

During FY 2000 EDP reviews, numerous and continuing weaknesses were noted at Medicare contractors, as well as application control weaknesses at contractors' shared systems in the area of electronic data processing. These vulnerabilities do 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.

Contractor integrity continues to be an issue, and the potential for fraud exists.

Management's Comments in Brief

The CMS concurs with the OIG's assessment and has been constantly striving to improve Medicare contractor financial management weaknesses. CMS has made significant improvements in this area over the last few years as evident by the unqualified opinions on the CMS fiscal years 1999,

2000, and 2001 financial statements. CMS' long term solution for addressing many of these issues is the Healthcare Integrated General Ledger System (HIGLAS). CMS is in the process of finalizing the first phase of this system and has selected two pilot sites for testing.

We also continue to validate the Medicare contractors' financial reporting by contracting with Certified Public Accounting (CPA) firms to conduct Statement of Auditing Standards (SAS) 70 internal control reviews and accounts receivable consulting reviews. The SAS 70 reviews concentrate on the functional areas of Electronic Data Processing (EDP) claims processing, financial management, and debt collection. The accounts receivable reviews ascertain the accuracy and completeness of the accounts receivable activity. Until HIGLAS is fully implemented, CMS will continue to rely on these on-going activities aimed at compensating for the lack of a modernized system. CMS has also continued to revise and clarify financial reporting and debt collection policies and procedures based on various audit and review findings.

In response to the OIG EDP findings identified during FY 2001, CMS developed a set of core security requirements for the Medicare contractors, directed each contractor to perform an assessment of their current security posture against the requirements, and found resources to fund these assessments. CMS asked the contractors to identify security safeguards for any requirements not being met. CMS is currently evaluating the proposed safeguards and we will fund the safeguards to the extent of available resources. In addition, CMS has developed a process to request and evaluate the reasonableness of corrective action plans as a result of EDP reviews and have developed an on-site review protocol to validate the actual implementation of the corrective action plans.

Converting Medicare claims payment systems completely to "binary releases" (not releasing source code) is a difficult technical and managerial problem. CMS concurs that this is a valid security issue, and is addressing the issue with its available resources. Beginning in 2001, the Common Working File (CWF) maintainer no longer issues source code. CMS has also initiated strict (compensating) controls on the local use of the FISS source code at Medicare contractors. Local code changes to the maintainer source code must be approved by CMS and CMS is collecting a current inventory of source code modifications. Starting in FY 2002, CMS will audit each FISS data center annually for adherence to these controls. CMS is committed to addressing this issue; however, the availability of funds and of system maintainer subject matter experts limits how quickly conversion can be achieved.

In order to adequately safeguard the assigning and maintaining of provider numbers, CMS has implemented the Medicare Exclusions Database (the electronic version of the OIG exclusion list). CMS is also proceeding with the implementation of the National Provider System, which will produce a National Provider Identifier (NPI) to standardize and simplify the provider enumeration process. The Provider Enrollment, Chain, and Ownership System is also being implemented and will serve as a more effective and efficient database for the identification and maintenance of provider enumerations.

Management Issue 3: Protection of Critical Infrastructure

Management Challenge

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

Assessment of Progress in Addressing the Challenge

HHS has made much progress in securing the most critical of essential assets. Core requirements for security controls were established and distributed, and systems architecture documents are being developed. However, recent OIG assessments (PDD-63, CFO, and GISRA) found numerous information systems general 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 2000 HHS financial statement audit. While OIG has 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.

Management's Comments in Brief

Under Secretary Thompson's leadership, HHS is addressing Information Technology Security as one of its top management priorities. IT security is a prominent part of the HHS Enterprise Information Technology Strategic Plan, which establishes an enterprise approach to project planning and implementation for critical infrastructure support services in HHS. Based on plan priorities, contracts were awarded in September to implement a security awareness program for all HHS employees and to prepare enterprise-wide plans for perimeter protection at internet access points, incident response capability, and risk mitigation strategies based on an enterprise risk assessment. Priority projects recommended in these plans will be funded in FY 2002. Projects installing multi-tier virus protection and vulnerability scans for critical systems as well as specialized training for all security staff will also be implemented in FY 2002.

Management Issue 4: Pricing Prescription Drugs

Management Challenge

The OIG's work has consistently shown the Department pays for prescription drugs at rates which are excessive. These rate differentials amount to millions of dollars of excessive payments each year. The method used to determine the amount to be paid for the outpatient drugs covered under Medicare is fundamentally flawed. The payments are based on the drug's Average Wholesale Price (AWP), a list price reported by the drug manufacturers. The OIG's reviews indicate that the AWP is neither average nor wholesale and bears little or no resemblance to the actual wholesale prices available to physicians and suppliers who participate in the Medicare program.

Several OIG reports indicate that Medicaid may also be paying too much for some prescription drugs because reimbursement methodologies are based on the flawed AWP and manufacturer rebates are based on the average manufacturers price (AMP).

OIG's work over the last several years identified problems with different aspects of the Section 340B program of the Public Health Service (PHS) Act, which established ceiling prices for outpatient drugs to eligible entities, including entities receiving funding under the PHS Act such as federally funded community health centers and state and local government programs.

Assessment of Progress in Addressing the Challenge

CMS has been working to develop and implement more realistic Medicare and Medicaid reimbursement methods for prescription drugs. As of this writing, significant progress is being made but a consensus approach has not yet been achieved.

With regard to the 340B program, HRSA is attempting to implement the OIG's recommendations to make participation in the 340B program a condition of grant awards. An earlier proposal was withdrawn. Instead, HRSA will implement another administrative option to increase participation in the 340B program, thereby encouraging purchasing practices that meet federal requirements regarding reasonable and cost effective purchasing.

Management's Comments in Brief

CMS agrees with OIG's assessment. CMS continues to collect and analyze data on drug pricing. For example, it is studying non-Medicare drug pricing of selected drugs covered under Part B to determine the feasibility of other approaches to more accurately determine AWP. CMS also will shortly evaluate the feasibility of using a single contractor to determine payment rates to eliminate the current variation in contractor prices.

Management Issue 5: Skilled Nursing Facilities

Management Challenge

The OIG's continues to monitor quality of care and implementation of certain Balanced Budget Act (BBA) of 1997 provisions pertaining to skilled nursing facilities to ensure they are working as intended by the Congress.

The OIG initial examination of Part A consolidated billing indicates that a significant number of payments were inappropriately made to suppliers, resulting in the Medicare program paying twice for the same service.

The OIG is monitoring the effects of the BBA and Balanced Budget Refinement

Act of (BBRA) 1999 on therapy provided to Medicare beneficiaries in SNFs. The BBRA suspended the Medicare reimbursement caps on Part B physical, occupational and speech therapy that were imposed by the BBA. OIG's work examined the medical necessity of Part B therapy provided in nursing homes, both underutilization and overutilization.

The OIG continues to be concerned about the quality of care in nursing homes and has looked systematically at the Omnibus Budget Reconciliation Act of 1987 reforms. The OIG issued reports on nursing home resident assessment and found differences between the minimum data set (MDS) and the rest of the medical record, some of which may affect care planning. The OIG examined the integration of the prospective payment system with resident assessment. Under PPS, 44 Resource Utilization Groups (RUGs-II) flow from MDS and drive Medicare reimbursement to nursing homes. OIG's work found that both upcoding and downcoding of RUGs exist, indicating perhaps difficulties in implementing the MDS, as well as possible efforts to increase Medicare reimbursement.

Other OIG studies are currently underway to more fully assess what progress has been made in improving quality of care, include evaluations of the role of the nursing home medical director, family experience with nursing home care, quality assurance committees in nursing homes, nurse aid training, as well as survey and certification consistency and reliability. The results of these studies will be published over the coming year, at which time a fuller assessment by the OIG will then be available.

Assessment of Progress in Addressing the Challenge

Part A reforms of the BBA are fully implemented, and they are important to controlling fraud and abuse in nursing homes; however, some services were paid for twice—once to the facility under the prospective payment system and again to the supplier. CMS issued a fraud alert addressing the prevalent types of errors found in our initial review. Additionally, the OIG recommended recovery of the improper payments and that CMS establish payment edits with its common working file and the Medicare contractors' claims processing systems to ensure outside providers and suppliers comply with the consolidated billing provision.

The CMS agreed with our recommendations and indicated meaningful progress has been made towards implementing edits for identifying potentially inappropriate payments and recovery of overpayments. The CMS has also completed a mandatory training conference for Medicare contractors to discuss consolidated billing and instructed the contractors to schedule consolidated billing training to their providers and suppliers. In addition, CMS has issued a task order to one of its payment safeguard contractors to identify overpayments in three States. We are continuing our work in this area by reviewing another year to determine if overpayments are continuing.

Management's Comments in Brief

CMS concurs with OIG's assessment. CMS agrees that more needs to be done to ensure that services being paid under the Skilled Nursing Facility Prospective Payment System (SNF PPS) by fiscal intermediaries are not also billed to and paid by carriers. In April 2002, CMS will implement common working file (CWF) edits that will detect and deny cases in which carriers are being billed for services that the CWF shows to be in a Medicare covered Part A stay during the period in which the supplier billed the carrier for the service. In July 2002, CMS is planning to implement edits that will detect and mark payments that were made by carriers for persons in the course of a Medicare covered SNF stay where the SNF claim did not post to the CWF record before the carrier claim was paid, thus resulting in an incorrect payment. Moreover, CMS is examining how to effectively and efficiently run a utility against past claims data to detect overpayments that were made before these claims processing procedures are in place.

In addition, CMS is developing a website application that can be used by a physician, practitioner or supplier to determine if a service should be billed to the SNF (because it is bundled under SNF PPS) or to the carrier (because it is separately payable).

We believe that enforcement of longstanding policy through the CWF edits, combined with ongoing provider education efforts, will greatly reduce the problems created by failure of suppliers to seek payment from SNFs for services for which the SNF is being paid as part of SNF PPS.

Management Issue 6: Medicare Payment Error Rate

Management Challenge

Based on a statistical sample, OIG estimated that improper Medicare benefit payments

made during FY 2000 totaled $11.9 billion, or about 6.8 percent of the $173.6 billion in processed fee-for-service payments reported by CMS. These improper payments could range from inadvertent mistakes to outright fraud and abuse. While contractors' claim processing controls were generally adequate for ensuring beneficiary and provider Medicare eligibility, pricing claims based on information submitted, and ensuring that services billed were allowable under Medicare rules and regulations, they were not effective in detecting the kinds of errors the OIG audit found. While the OIG's 5-year analysis indicates continuing progress in reducing improper payments, unsupported and medically unnecessary services remain pervasive problems. These two error categories accounted for over 70 percent of the total improper payments over the five years.

Assessment of Progress in Addressing the Challenge

The FY 2000 error rate is almost half that initially estimated by OIG in FY 1996, primarily as a result of CMS' continued vigilance in monitoring Medicare payments, the development of appropriate corrective actions, and work with the provider community to clarify reimbursement rules. The CMS needs to sustain its efforts to maintain progress in reducing improper payments.

Management's Comments in Brief

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' corrective actions which 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 is valid only at the national level, CMS has been developing a new, more precise measure for use in the future. In May 2000, CMS awarded a Program Safeguard Contractor contract to implement the Comprehensive Error Rate Testing (CERT) program. The CERT program will produce national, contractor, provider type, and benefit category specific fee-for-service paid claims error rates. The CERT program began to be phased in starting in FY 2001. All contractors will be included in the CERT process by the end of FY 2002. CMS' goal is to eventually replace the OIG fee-for-service error rate with CERT.

Management Issue 7: Medicare Managed Care

Management Challenge

The OIG audits and evaluations have been watching the managed care approach to medical care, and the work has raised some concerns that center on Medicare payments rates, which the OIG believes may be excessive, as well as quality of care issues and marketing materials to beneficiaries to help them make informed consumer choices.

Assessment of Progress in Addressing the Challenge

As requested by CMS, the OIG audited 186 of the proposals submitted by 55 managed care organizations (MCOs) detailing their estimate of funds required to cover medical and administrative costs for providing services to Medicare beneficiaries. These submissions were based upon a new proposal process initiated by CMS in January 2000. The OIG review found that a high percentage of the proposals had not been prepared according to CMS instruction and that a higher percentage contained errors that affected the amounts for medical and administrative costs or additional revenues.

A review of marketing materials for beneficiary information found some materials were difficult to understand and that CMS did not completely meet its goals to expedite the marketing material review process, reduce the need for resubmissions or ensure uniform reviews across the country. CMS has begun to implement many of the OIG recommendations, including requiring a standard format for plan benefit summaries.

Management's Comments in Brief

CMS concurs in part with the OIG's assessment. We appreciate the assistance that the OIG provided in the first round of Adjusted Community Rate (ACR) audits. These audits are required on one-third of managed care organizations each year. The OIG assisted CMS during the first year of the ACR audits. Prior to 2000, ACRs were subject to desk reviews only and no in-depth review or audit had previously been conducted. As a result, CMS believed it was critical to sample the audit work that was done in 2000 in order to address any needed changes in the audit program.

Following completion of the FY 2000 audits, CMS contracted with an independent firm to conduct an analysis of the audit findings and to verify the auditors' estimate of overcharges. The review disclosed a number of methodological issues that CMS felt needed to be addressed. Using the alternative methodology, CMS found that 63 plans had possible overcharge errors totaling about $89 million.

CMS believes that efforts must be directed to develop a methodology that is reasonable and appropriate. Additional auditing requirements have also been imposed by the Benefits and Improvement and Protection Act (BIPA) of 2000. Under BIPA, the CMS Office of the Actuary is responsible for the review of the actuarial assumptions and data used by M+C organizations. CMS is currently working to incorporate these reviews into the audit process. It would continue to be CMS' intent to carefully consider the results of these audits, and accountability requirements under BIPA, prior to implementation of any further actions.

CMS believes it has made significant strides in expediting the marketing material review process. For example, CMS instituted a streamlined review process for the FY 2002 renewal season, and the managed care industry has informed CMS that it has improved review time frames. CMS has also implemented section 613 of the BIPA, which provides for an expedited 10-day review for any organization that follows the CMS model material without modification. The Agency is taking further steps to improve the quality of marketing materials by working closely with the managed care industry and beneficiary advocacy groups to revitalize and improve the model Evidence of Coverage so that it is easier to understand.

Management Issue 8: Child Support Enforcement

Management Challenge

The goal of Office of Child Support Enforcement (OCSE) is to support families in their efforts to attain and retain self-sufficiency. OCSE and the OIG established multi-agency, multi-jurisdictional task forces to identify, investigate and prosecute the most serious non-support cases. To help improve the efficiency and effectiveness of program operations, the OIG completed a number of studies on OCSE issues where program vulnerabilities existed.

Assessment of Progress in Addressing the Challenge

In response to OIG recommendations about ways to improve the effectiveness of the child support program, OCSE has offered technical assistance to states focused on implementing the recommendations. Additional efforts have been made to ensure the Department complies with Executive Order 12953 and acts as a model employer in the area of child support. OCSE is also using OIG recommendations to design demonstration programs on the issue of order establishment and compliance.

Management's Comments in Brief

In FY 2002, the Office of Child Support Enforcement (OCSE) in the Administration for Children and Families is supporting the efforts of the Inspector General described in the Assessment of Progress section. OCSE continues to operate and expand the number of OCSE Project Save Our Children (PSOC) screening units throughout the country to a total of 11. Recently, the sixth Task Force was opened in the Atlanta region. Four additional Task Forces are scheduled to open in FY 2003. This expansion will fully extend the PSOC operations nationwide and provide service to the remainder of the States. The volume of cases processed by the screening units is expected to triple this year to over 3000. Outreach efforts to states and the local law enforcement community will reinforce currently existing relationships and forge new ones in the newly expanded areas. Our on-going training partnership with staff from the Department of Justice (DOJ), the U.S. Attorney's Office, State agencies and the OIG, while shifting this year from a centralized approach at the DOJ National Advocacy Center, to a more local level collaboration will continue to be supported by all parties.

Management Issue 9: Oversight of PPS Implementation

Management Challenge

The OIG continues to monitor CMS' implementation of prospective payment systems for hospital outpatient services, inpatient rehabilitation facilities, home health agencies and nursing homes. The OIG is also concerned about CMS' ability to oversee the implementation of all these complex payment systems over such a short time period.

Assessment of Progress in Addressing the Challenge

CMS implemented a PPS system on July 1, 1999 for nursing facilities, a PPS system for hospital outpatient services on August 1, 2000, and a PPS system for home health providers on October 1, 2000. A PPS system for inpatient services in rehabilitation hospitals is scheduled to go into effect on January 1, 2002, and a PPS system for long-term care hospitals is scheduled to be implemented in October 2002.

Given the complexity of these several payment systems, the OIG is conducting in depth reviews of CMS' controls established to monitor and evaluate these systems to determine appropriateness of payment rates in comparison with incurred costs. CMS is taking steps to curb excessive transitional pass-through payments associated with the outpatient program payment system.

As described in the management issue "Skilled Nursing Facilities," CMS has taken actions to improve compliance with the consolidated billing provisions of the skilled nursing facility prospective payment system. The OIG will examine the extent to which these actions have curbed unallowable payments by auditing CY 2000 claims.

Management's Comments in Brief

CMS concurs with the OIG's assessment. CMS has an ongoing analytical plan that evaluates utilization trends under home health PPS, payment trends under PPS and provider and beneficiary characteristics. As part of our monitoring of home health PPS implementation, CMS staff holds monthly calls with the home health industry.

Management Issue 10: Abuses in Medicaid Payment Systems

Management Challenges

The OIG found that some States inappropriately inflate the Federal share of Medicaid by billions of dollars by requiring their 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 would, potentially, occur with any type of Medicaid payment to public facilities, we identified this practice in two types of payments: (1) Medicaid enhanced payments available under upper payment limits (UPL) and, (2) Medicaid disproportionate share hospital (DSH) payments.

Assessment of Progress in Addressing the Challenge

In an effort to curb abuses and ensure that State Medicaid payment systems promote economy and efficiency, CMS issued a final rule, effective March 13, 2001, 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. These new regulations also set the upper payment level for non-state government owned hospitals at 150 percent of what would be paid under Medicare payment principals.

We commend CMS for changing the upper payment limit regulations. The CMS projected that these revisions would save $55 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 regulation does not require that the enhanced funds be retained by the targeted facilities to provide medical services to Medicaid beneficiaries. Many factors played a part in the development of the transition periods. We do believe, however, that the transition periods included in the regulation are longer than needed for States to adjust their financial operations. In addition, on November 23, 2001, CMS published a Notice of Proposed Rulemaking that would lower the upper payment limit for non-State government hospitals from 150 percent to 100 percent. The CMS estimates the proposed rule would save $9 billion over five years.

We are expanding our audit work of Medicaid DSH payments and will make recommendations for program improvements once our audit work is completed.

Management's Comments in Brief

The CMS and the OIG have worked closely on analyzing the effects of the upper payment limit issue and regulations and

plan to continue this effort. It should be noted that the $9 billion in savings is in addition to the $55 billion expected under the prior UPL rule change. We also note that CMS has limited control over the length of the transition periods. The two and five year transition periods were adopted pursuant to notice and comment rulemaking. The Benefits Improvement and Protection Act of 2000 further extended the transition periods by mandating the 8-year transition period.

Management Issue 11: Medicare Payments for Mental Health Services

Management Challenge

Medicare payments for various mental health services remain a concern of the OIG. OIG work found that Medicare was paying for services to beneficiaries receiving partial hospitalization services with no history of mental illness as well as those whose condition would preclude them from benefiting from mental health programs. In the hospital outpatient setting, OIG work found that a significant portion of psychiatric services reviewed were unallowable or unsupported. OIG's work performed in 1996 showed that Part B mental health services provided in nursing homes were found to be unnecessary 32 percent of the time. The OIG repeated the work in 2001 and found 27 percent of the services reviewed were unnecessary and lacked any psychiatric documentation. Part B services in other settings indicated services were provided that were not medically necessary, were billed incorrectly, were rendered by unqualified providers or was undocumented or poorly documented.

Assessment of Progress in Addressing the Challenge

The OIG's work described above indicates a pattern of inappropriate claims for mental health services for a variety of provider types. The CMS took several steps in response to our recommendations regarding partial hospitalization services provided by Community Mental Health Centers (CMHC). These included a 10-point plan to develop a comprehensive strategy to improve CMS management of the benefit. The plan included, among other steps, intensified FI medical reviews of centers' partial hospitalization claims in the five States identified in the OIG's review and site visits of centers seeking initial enrollment in the Medicare program, undergoing a change of ownership, or for which CMS determines there is a need.

As far as current quality oversight mechanisms, the OIG found them to be limited with onsite surveys by contractors with specialized training falling by 65 percent between 1993 and 1998. In addition, these surveyors are not used in PPS-exempt psychiatric units, which account for the largest portion of inpatient psychiatric admissions for Medicare. These units do not have to meet the two special conditions of participation related to psychiatric hospitals.

Management's Comments in Brief

The CMS adjusted some of their instructions to fiscal intermediaries on how to conduct medical review. For example, CMS issued new Program Integrity instructions on review of Partial Hospitalization claims. The CMS also felt the need to increase awareness of incorrect payments. From this need an intensive education pilot project was created. This project will assist CMS in evaluating how intensive education works to achieve the desired results. The CMS will also continue to monitor billing practices for Partial Hospitalization claims.

Appendix E - Federal Financial Management Improvement Act Compliance (FFMIA)

Auditors of financial statements of Executive Agencies are required to report on whether or not the agencies' financial management systems are in substantial compliance with the requirements of the Federal Financial Management Improvement Act (FFMIA) of 1996. Such audits are to be conducted in accordance with OMB's revised FFMIA Implementation Guidance, dated January 4, 2001.

Under FFMIA, agencies 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 2001 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.

Non-Compliance Number 1: Financial Systems and Processes

✹ *The financial management systems and processes used by HHS and the operating divisions 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 operating divisions, 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. CMS needed extensive consultant support to establish reliable accounts receivable balances.*

Non-Compliance Number 2: EDP Access Controls

✹ *Access and application controls over the Medicare contractors' financial management systems' 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 2001 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 for the areas of non-compliance.*

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 reconciliations and analyses, and implementing a web-based automated financial system (AFS) 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 the end of FY 2007. HHS will comply with FFMIA by replacing various existing and antiquated financial systems with a Unified Financial Management System (UFMS). A major sub-component of this effort is the Healthcare Integrated General Ledger Accounting System (HIGLAS). With implementation of the HIGLAS system in FY 2007 the financial material weakness under FFMIA will be eliminated. Following are examples of the Department's FY 2001 achievements/efforts:

Unified Financial Management System (UFMS)

✹ *Launched the Unified Financial Management System Initiative to replace five legacy accounting systems currently in use across the HHS operating divisions;*

✹ *Established the strategic direction and overall goal for the UFMS effort;*

✹ *Developed a concept of operations to support the business case for the system;*

✹ *Established the management structure for overseeing and guiding the effort;*

✹ *Worked with OMB officials to gain approval to fund the effort; and*

✹ *Began financial transaction and account analyses to help support the configuration and structure of the system.*

Healthcare Integrated General Ledger Accounting System (HIGLAS)

✹ *CMS provided additional instructions for improving internal controls and reliability of financial data to its Medicare contractors through additional Formal guidance and training conferences;*

✹ *CMS established a program office to work with contractors in developing the CMS financial management system redesign - Healthcare Integrated General Ledger Accounting System (HIGLAS);*

✹ *CMS established a project management team and internal audit function to help improve the financial performance of CMS components;*

✹ *CMS issued CFO FY 2001 project plans that identified milestones for achieving pertinent financial management goals and initiatives;*

✹ *CMS completed automated applications for preparing three of the five required principal financial statements. The two remaining statements are planned for automation during FY 2002;*

✹ *CMS issued additional instructions to the CMS Central/Regional Offices regarding processing and following up on corrective action plans resulting from CFO audits and, Statement on Auditing Standards (SAS) 70 reviews, as well as other financial management audits and reviews preformed by public accounting firms, the Office of Inspector General (OIG), and the General Accounting Office (GAO);*

✹ *CMS had SAS 70 reviews performed that documented and assessed internal control at 15 Medicare contractor sites. These reviews included assessing progress in implementing corrective actions from prior audits;*

✹ *CMS performed reviews to assess the effectiveness of internal control processes and validity of accounts receivable at twelve contractor locations. The reviews noted progress in resolving prior findings at larger contractors. Such contractors account for approximately 82 percent of total Medicare contractors' accounts receivable balances; and*

✹ *CMS referred an additional $2.1 billion of delinquent debt to the Department of Treasury for collection as a result of expansion efforts of the debt referral process.*

EDP Systems Access Controls

The OIG acknowledged in its findings that during FY 2001 the Department made considerable progress in identifying weaknesses in its automated processing systems. Specifically, CMS identified several weaknesses in the performance of vulnerability assessments, SAS 70 internal control reviews, the compilation of Medicare contractor controls self-assessments, OIG assessment and related procedures. This effort provides a base line 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.

In the long term HHS will continue to improve data integrity and reliability of its financial statements and financial reporting processes. Performing routine periodic reconciliations and financial analysis will help do this. Past performance on the part of HHS resulted in improved financial discipline and the achievement of a clean audit opinion on HHS financial statements for FYs 1999, 2000, and 2001. 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 Five-Year Plan.

FY 2001 Report on Systems and Controls

Background

HHS' 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 2001 CFO 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 components are to have written strategies for assessing management controls on an ongoing basis and these strategies should be consistent with the HHS FY 2001 CFO Five-Year Plan goals and targets and CFO audit Corrective Action Plans (CAPs). 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, as well as those identified through FMFIA reviews. HHS has developed corrective action plans to address all of the findings resulting from the financial statement audits, including qualifications, material weaknesses, and reportable conditions, and corrective actions are underway.

Report Summary

The FMFIA annual assurance required by the Act is contained in the Message from the Secretary at the beginning of this Accountability Report. The details of this year's FMFIA Annual Report, in addition to this narrative summary, are in the accompanying statistical summary which reflects the cumulative total of Section 2 material weaknesses and Section 4 material non-conformances identified and corrected to date, including two pending Section 2 material weaknesses and one Section 4 material non-conformance.

As identified in the FY 2001 CFO financial statement audit, the Department continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. In this year's report, we are reporting this finding as a Section 4 material non-conformance. (Note: In the FY 2000 FMFIA Report, this finding was reported as a Section 2 material weakness which comprised two prior year material weaknesses identified by the auditors in the FY 1999 and FY 2000 CFO Audits:

1) Financial Systems and Reporting (HHS 99-01); and 2) Medicare Accounts Receivable (HCFA 97-02). For this year's report, the

Medicare accounts receivable portion of the finding, a repeat condition, is a sub-set of the Financial Systems and Processes Section 4 material non-conformance, but is reported in a separate exhibit called Financial Systems and Regional and Central Office Oversight (See CMS-01-01). *The Financial Systems and Processes* non-conformance (HHS-00-01) from FY 2000 also includes the finding of a weakness involving the analysis and preparation of financial statements reported by CDC.

A second internal control material weakness reported by the auditors at CMS — *Medicare Information Systems Controls* — is also a sub-set of the Financial Systems and Processes material non-conformance and is a repeat condition, although the auditors noted in the FY 2000 audit that this weakness was no longer considered material at CMS headquarters.

The FMFIA-style corrective action plans (CAPs) for the pending Section 4 material non-conformance above as well as for two material weaknesses from previous OIG program audits and/or internal management reviews, which were included in last year's report, are included in this FMFIA report.

Financial Systems and Processes Department-wide, Section 4 Material Non-Conformance

The Department continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. In the FY 2000 financial statement audits at CMS, as well as the audits of several HHS components, the auditors identified problems related to account analyses and reconciliation.

In the short term, HHS components have made substantial progress in addressing account analysis and reconciliation problems. For example:

• During FY 2001 most accounts for PSC and its customers were reconciled by year-end and the Program Support Center continued its plan to perform reconciliations for all major accounts as specified by DHHS departmental accounting;

• The Program Support Center, Division of Financial Operations (PSC/DFO) implemented a more efficient process for preparing financial statements; and

• The system review of the Payment Management System (PMS) by the audit firm of Ernst & Young completed in FY 2001 determined that the grant advance reconciliation and reporting problems identified in FY 2000 were corrected. All related processes were tested and found to be operating sufficient to provide reasonable assurance that the control objectives specified were achieved. This resolved the findings found in the FY 2000 audit of PSC customer agencies including HRSA, ACF, IHS, SAMSHA, and AoA.

In the long term, the most significant step we are taking to address this problem is the Unified Financial Management System. Specifically, consistent with the President's Management Agenda, under the improving financial performance initiative, HHS has announced a "one department" approach to information technology that emphasizes the management of resources on an enterprise basis with a common infrastructure. To this end, HHS will adopt a unified financial management system to replace five legacy systems. Specifically, HHS will have a unified financial management system comprised of two major sub-com- ponents, one for the CMS and the Medicare Contractors called the Healthcare Integrated General Ledger and Accounting System (HIGLAS), and the other for the rest of HHS. Both components will feed into a Departmental reporting system. The benefits of having a unified system, compared to multiple systems include lower costs, a more secure systems environment, and the capability to provide more timely and accurate information for management purposes. In addition, it is easier to maintain uniform business rules, data standards and accounting policies and procedures across HHS, and to communicate directly with the new centralized Departmental financial reporting system.

Financial Systems and Regional and Central Office Oversight at the Centers for Medicare & Medicaid Services (Medicare Accounts Receivable)

(Note: This finding is a sub-set of the one Section 4 material non-conformance, Financial Systems and Processes.)

CMS relies on a decentralized organization, complex systems, and ad hoc reports to accumulate data for financial reporting due to the lack of an integrated financial accounting system at the contractor level. As a result, integrated financial systems and a strong oversight function are needed to ensure that periodic analyses and reconciliations are completed to detect errors and irregularities in a timely manner. CMS needs to continue to

improve the level of oversight, supervision, and guidance provided to the contractors. CMS needs to develop control mechanisms to identify and investigate significant fluctuations in accounts receivable contractor balances and activity between reporting periods, and to ensure fluctuations are properly supported by detailed transactions. Additionally, CMS' regional offices need to perform a follow-up on findings noted in reviews conducted by central and regional offices or consultants to ensure corrective actions were completed by the contractors.

CMS continues to provide instructions and guidance to the Medicare contractors and to CMS' central and regional offices (CO/ROs). CMS also continues to contract with Independent Public Accountants (IPAs) to test financial management internal controls and to analyze accounts receivable at Medicare contractors. In addition, contractor performance evaluation (CPE) reviews of financial management issues were performed by CMS national teams at Medicare contractors.

The lack of an integrated financial management system continues to impair CMS' and the Medicare contractors' abilities to adequately support accounts receivable and other financial balances reported. However, CMS is following a comprehensive plan to bring its systems into compliance. Specifically, CMS has initiated steps to implement an integrated general ledger system (known as the Healthcare Integrated General Ledger Accounting System or HIGLAS) for the contractors, Regional Offices, and Central Office. HIGLAS is expected to be fully operational in FY 2007. As CMS progresses toward its long-term goal of developing an integrated general ledger system, the HIGLAS system, CMS continues to provide training to the contractors to promote a uniform method of reporting and accounting for accounts receivable and related financial data. Once the HIGLAS system is fully operational, CMS anticipates full resolution of the accounts receivable material weakness.

Medicare Information Systems Controls

(Note: This finding is also a sub-set of the material non-conformance in Financial Systems and Processes.)

CMS relies on extensive EDP operations at both their central office 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 2000, numerous and continuing weaknesses at the Medicare contractors, as well as certain application control weaknesses at the contractors' shared systems, were prevalent. 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. In FY 2000, the OIG aggregated the findings at the Medicare contractors and CMS central office into one material weakness (which was identified as HCFA 98-01a). No finding at a single location was considered material. The pending material weakness related to the Medicare contractors is included in this year's report as CMS-01-02, formerly HCFA 98-01a, will remain open until corrective action is complete.

CFO Financial Statement Audits and the FMFIA

The 2001 FMFIA Report continues to bring the findings from the CFO audits and the FMFIA closer together. HHS components are to report to the Department all deficiencies (findings) from the audit consistent with OMB Circular A-123, which requires that a deficiency should be reported if it is or should be of interest to the next level of management. This includes all material weaknesses and instances of systems non-compliance with FFMIA identified in the FY 2000 CFO audits, including any which the HHS component may be aware of from the FY 2001 CFO audit at the time they prepared their FMFIA Report.

HHS components are asked to recommend which, if any, of their CFO audit material weaknesses and FFMIA non-compliance should be included as an FMFIA material weakness in the Department's Report, i.e., are significant enough to be reported outside the agency to the President and the Congress. Under departmental policy, a corrective action plan is required for all CFO audit material weaknesses that are tracked under the CFO audit process. However, for those material weaknesses and FFMIA non-compliance the HHS component recommends for inclusion in the Department's FMFIA Report, HHS components are required to include a corrective action plan in the FMFIA format and submit it with their report. Those material weaknesses which

resulted from the FY 2000 and FY 2001 CFO audits are included in the Department's FY 2001 FMFIA report.

However, with the exception of those discussed above, all of the audit material weaknesses reported by the HHS components are not included in the Department's FMFIA report because HHS believes that the remaining material weaknesses do not reach a level of significance that require reporting to the President and the Congress as defined under Revised OMB Circular A-123. HHS requires corrective action plans to address all of the findings resulting from the CFO financial statement audits, including qualifications, material weaknesses and reportable conditions. Therefore, including all material weaknesses from the CFO audits of the HHS components in the Department's FMFIA report would result in a duplication of the financial statement audit process.

2001 FMFIA Section 4 Material Non-Conformance: Schedule of Corrective Actions (HHS 00-01)

Title and Description of Material Non-Conformance: Financial Systems and Processes

The Department continues to have *serious* internal control weaknesses in its financial systems and processes for producing financial statements. (Note: In the FY 2000 FMFIA Report, this material non-conformance comprised two prior year material weaknesses identified by the auditors in the FY 1999 and FY 2000 CFO Audits.) 1) Financial Systems and Reporting (HHS 99-01); and 2) Medicare Accounts Receivable (HCFA 97-02). For this year's FMFIA report, the Medicare accounts receivable portion of the finding, a repeat condition, continues to be a sub-set of the Financial Systems and Processes, but is reported in a separate exhibit called Financial Systems and Regional and Central Office Oversight (See CMS-01-01).

Pace of Corrective Action:
Year Identified: FY 2000
Original Targeted Correction Date: N/A
Correction Date in Last Report: FY 2007
Current Correction Date: FY 2007

Lead Managerial Contact: Gerald W. Thomas, Director, Office of Program Management and Systems Policy

Source of Discovery: FY 2000 and FY 2001 financial statement audits by OIG

Appropriation/Account: All Appropriations

(For Corrected Items Only)

Validation Process Used:

Results Indicators:

2001 FMFIA Section 4 Material Non-Conformance: Schedule of Corrective Actions (HHS 00-01)

Department-wide:

While significant progress has been made to improve the financial statement preparation process, because many systems were not fully integrated, and in some cases were in the process of being upgraded or replaced, the preparation of financial statements continued to require numerous manual accounting adjustments involving billions of dollars. In addition, significant analysis by Department staff as well as outside consultants was necessary to determine proper balances months after the close of the fiscal year. The FY 2000 CFO audits of several HHS components identified the following problems in the preparation of adequate, reliable, and timely financial statements:

Grant expenditures, grant advances, and the grant accrued expense calculation contained billions of dollars in errors until final balances corrections were made. The errors were the result of the Payment Management System (PMS) expenditure disbursement subsystem, which is used to produce and process Federal Cash Transactions Reports. It was not fully tested when the Program Support Center (PSC) implemented the new PMS in July 2000. The errors delayed conclusion of the audits and the Department's compilation of the financial statements. The financial statements of NIH, ACF, SAMHSA and CDC were most affected.

At NIH Institutes, an integrated accounting system was not in place to consolidate the accounting results of transactions by the Institutes requiring extensive, time-consuming manual adjustments before reliable financial statements could be prepared. At most HHS components, suitable internal control systems were not in place to adequately explain significant fluctuations in grant transactions.

At CDC, CDC's central accounting system lacks the integration with the reimbursable agreements subsidiary system, does not facilitate the preparation of the financial statements, and has not fully adopted the Treasury Standard General Ledger.

Briefly define (purpose, scope, methodology, resources) the corrective action plan (CAP) that corrects/improves this material non-conformance.

Department-wide:

For the long-term, consistent with the President's Management Agenda, under the improving financial performance initiative, HHS has announced a "one department" approach to information technology that emphasizes the management of resources on an enterprise basis with a common infrastructure. To this end, HHS will adopt a unified financial management system to replace five legacy systems. Specifically, HHS will have a unified financial management system comprised of two sub-components one for the CMS and Medicare contractors called the Healthcare Integrated General Ledger and Accounting System (HIGLAS), and the other for the rest of HHS. Both components will feed into a Department reporting system. The benefits of having a unified system, compared to multiple systems, include lower costs, a more secure systems environment, and the capability to provide more timely and accurate information for management purposes. In addition, it is easier to maintain uniform business rules, data standards and accounting policies and procedures across HHS, and to communicate directly with the new centralized Departmental financial reporting system.

2001 FMFIA Section 4 Material Non-Conformance: Schedule of Corrective Actions (HHS 00-01)

Overall Status of Material Non-conformance:

For the short term, during FY 2001, the following efforts were made to resolve these material non-conformances.

Department-wide:

Reconciliations were performed for all major accounts as specified by the Department's accounting policy.

The Program Support Center, Division of Financial Operations (PSC/DFO) implemented a more efficient preparation process for preparing financial statements.

The new Payment Management System (PMS) was brought online to provide centralized electronic funding and cash management services for federal civilian grants. Management has taken action to address issues identified in the audit related to the recording and reporting of grant transactions. However, the systems review examination started in the Spring and ending in December 2001 provided management the assurance that the problems noted have been corrected.

Centers for Disease Control and Prevention (CDC):

The fiscal year 2000 financial statement audit identified one material weakness: Analysis and Development of Financial Statements. CDC's central accounting system lacked integration with the reimbursable agreements subsidiary system, did not facilitate the preparation of the financial statements, and did not fully adopt the Treasury Standard General Ledger. The financial reporting system needs several adjusting journal entries and a significant amount of manually intensive processes prior to reporting accurate financial statements. The amount of human effort required during the financial statement process resulted in untimely reporting of financial information that supports management decision-making. Additionally, certain reconciliation processes relating to reimbursable agreements were not adequately performed to ensure differences between subsidiary systems and the general ledger were properly identified, researched and resolved and that account balances were complete and accurate.

2001 FMFIA Section 4 Material Non-Conformance: Schedule of Corrective Actions (HHS 00-01)

Major Milestones Department-wide (Long Term):	**Scheduled Due Dates**
Unified Financial Management System implemented department-wide.	FY 2007
NIH to implement its components of UFMS in phases. First phase is the general ledger Module.	FY 2003
CMS to develop and implement its components of UFMS (an integrated standard general ledger) for all Medicare contractors. (See exhibit CMS-01-01.)	FY 2007

Major Milestones — Centers for Disease Control and Prevention (CDC):

CDC has developed the following corrective action plan to resolve this material non-conformance:

Action Plan	**Target Completion Date**
1. CDC is planning to enhance the current financial database.	3/31/02
2. CDC obtained consulting assistance from a major accounting firm to develop a program providing for the periodic review of CDC's consolidated financial statements. CDC is considering their recommendations.	9/30/01
3. CDC is planning to automate the preparation of month-end financial statements. Additional automation of some manual processes may be necessary.	3/31/02
4. CDC significantly improved the automation of year-end closing entries. CDC also automated data collection for SF 133 preparation, and a detailed year-end closing plan was developed.	9/30/01
5. CDC issued a task order to a public accounting firm to develop polices and procedures to record and maintain reimbursable agreements. The report is under review.	9/30/01
6. With assistance from a public accounting firm, CDC is currently developing a reimbursable database to automate billings and collections which will automatically post appropriate accounting transactions and generate required subsidiary reports.	9/30/01
7. CDC increased training for financial statement preparation staff and reimbursable agreement staff.	9/30/01

2001 FMFIA Section 4 Material Non-Conformance: Schedule of Corrective Actions (CMS 01-01)
(Note: This finding is a sub-set of the one Section 4 material non-conformance (HHS-00-01.)

Title and Description of Material Non-Conformance: Financial Systems and Regional and Central Office Oversight

CMS relies on a decentralized organization, complex systems, and ad hoc reports to accumulate data for financial reporting due to the lack of an integrated financial accounting system at the contractor level. As a result, integrated financial systems and a strong oversight function are needed to ensure that periodic analyses and reconciliations are completed to detect errors and irregularities in a timely manner. CMS needs to continue to improve the level of oversight, supervision, and guidance provided to the contractors. CMS needs to develop control mechanisms to identify and investigate significant fluctuations in contractor accounts receivable balances and activity between reporting periods, and to ensure fluctuations are properly supported by detailed transactions. Additionally, CMS's regional offices did not perform a follow-up on findings noted in reviews conducted by central and regional offices or consultants to ensure corrective actions were completed by the contractors.

Pace of Corrective Action: Continuous
Year Identified: FY 1997
Original Targeted Correction Date: FY 1999
Correction Date in Last Year's Report: FY 2001
Current Correction Date: FY 2007
Reasons for Changes in Dates: Long-term activities related to the development of integrated general ledger system.

Lead Managerial Contact: Marvin Washington, Deputy Director, Division of Accounting, Accounting and Risk Management Group, Office of Financial Management

Source of Discovery: FY 1997 financial statement audit by OIG and other sources.

(For Corrected Items Only)

Validation Process Used:

Results Indicators:

2001 FMFIA Section 4 Material Non-Conformance: Schedule of Corrective Actions (CMS 01-01)
(Note: This finding is a sub-set of the one Section 4 material non-conformance (HHS-00-01.)

Briefly define (purpose, scope, methodology, resources) the corrective action plan (CAP) that corrects/improves this material non-conformance.

CMS continues to provide instructions/guidance to the Medicare contractors and our central and regional offices (CO/ROs). CMS continues to contract with Independent Public Accountants (IPAs) to test financial management internal controls and to analyze accounts receivable at Medicare contractors. In addition, contractor performance evaluation (CPE) reviews of financial management issues were performed by CMS national teams at Medicare contractors. As CMS progresses toward its long-term goal of developing an integrated general ledger system, we continue to provide training to the contractors to promote a uniform method of reporting and accounting for accounts receivable and related financial data.

Overall Status of Material Non-Conformance at the Close of FY 2001 (global progress toward correcting/improving this weakness over this fiscal year).

All short-term corrective actions for FY 2001 have been completed. In May 2001, we issued revised 750/751 contractor financial reporting instructions to be effective October 1, 2001. Also in May 2001, we issued written standard policies and procedures for CO and ROs to follow in processing corrective action plans (CAPs) resulting from Chief Financial Officer (CFO) audits, Statement on Auditing Standards (SAS-70) reviews, as well as other financial management audits and reviews performed by consulting/certified public accounting firms, the Office of Inspector General, and the General Accounting Office. All Medicare contractors that had audit findings in FY 2000 submitted CAPs and received comments from CMS regarding the adequacy of their submitted plan. In addition, we received quarterly updates to the CAPs that described financial activities and efforts underway to correct prior year findings. During FY 2001, the consultants, CO and RO staff followed up on contractor CAPs during the accounts receivable CPE reviews to ensure that findings were corrected.

We acquired consultant services to ensure that the accounts receivable balances for FY 2001 are valid and properly valued and to review implementation of CAPs. Specifically, the consultants assisted in:

- Reconstructing and validating the FY 2001 beginning balance,
- Validating the first six months of FY 2001 accounts receivable activity,
- Identifying variances between subsidiary records and reports submitted to CMS,
- Documenting appropriate adjustments to accounts receivable for variances,
- Reviewing processes and procedures relative to receivables, and
- Reviewing CAPs.

For the past two years, CMS hired consultants to assist us in developing analytical tools necessary to perform more expansive trend analysis of critical financial and related data, specifically accounts receivable. These tools provide the steps necessary to identify unusual variances and potential areas of risk. Additionally, the tools allow us to readily perform more extensive data analyses, follow up with Medicare contractors, and determine the need for additional actions to ensure that problems are adequately resolved. These enhancements, along with additional staff members hired during FY 2000, allowed us to conduct trend analysis starting with quarter ending June 30, 2000. CMS is now performing a more structured and robust financial analysis and review each quarter. During FY 2001, we also issued instructions to our regional offices to perform trending analysis on their own accounts receivable data, starting with the quarter ending June 30, 2001.

2001 FMFIA Section 4 Material Non-Conformance: Schedule of Corrective Actions (CMS 01-01)
(Note: This finding is a sub-set of the one Section 4 material non-conformance (HHS-00-01.)

CMS is also implementing the Healthcare Integrated General Ledger Accounting System (HIGLAS) that is an integrated general ledger accounting system, which incorporates Medicare contractors' financial data (including claims activity) into CMS' internal accounting system, the Financial Accounting and Control System (FACS).

CAP Milestones for FY 2002:	**Scheduled Due Date**
1. Issue instructions/guidance to Medicare contractors on required trend analysis procedures. **Milestone Status:** In progress	December 2001
2. Develop a process to report the status of changes that contractors are required implementing to the Medicare Change Control Board quarterly. **Milestone Status:** In progress	December 2001
3. Test CMS 1522 CPE protocol at two contractor sites. **Milestone Status:** In progress	January 2002
4. Provide 750/751 training to all Medicare contractors and CMS Regional offices. **Milestone Status:** In progress	April 2002
5. Acquire Consultant services to ensure that the accounts receivable balances for FY 2002 are valid and properly valued and to review the implementation of prior year CAPs. **Milestone Status:** In progress	June 2002
6. Implement HIGLAS project. **Milestone Status:** In progress	September 2002-2006
7. Perform trend analysis of quarterly CMS 750/751 reports received from Medicare contractors in order to timely identify unusual items and inconsistencies. a. Quarter ending December 31, 2001 b. Quarter ending March 31, 2002 c. Quarter ending June 30, 2002 d. Quarter ending September 30, 2002 **Milestone Status:** In progress	 a. February 15, 2002 b. May 15, 2002 c. August 15, 2002 d. November 15, 2002

2001 FMFIA Section 4 Material Non-Conformance: Schedule of Corrective Actions (CMS 01-02)
(Note: This finding is a sub-set of the one Section 4 material non-conformance (HHS-00-01.)

Title and Description of Material Non-Conformance: Medicare Elecgronic Data Processing (EDP) Controls

OIG found weaknesses at the CMS Central Office and the Medicare contractors. 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. Further, weaknesses in the Medicare contractors' entity-wide security structure do not ensure that EDP controls are adequate and operating effectively. Overall, one continuing weakness remains in the EDP systems environment. CMS should continue its focus on implementing appropriate corrective action plans in resolving all findings to improve the controls over integrity, confidentiality, and availability of Medicare data.

Pace of Corrective Action: Continuous
Year Identified: FY 1998
Original Targeted Correction Date: FY 1999
Correction Date in Last Year's Report: FY 2000
Current Correction Date: FY 2002
Reasons for Changes in Dates: Aggregation of findings in FY 2001 and long-term project goals and objectives.

Lead Managerial Contact: Richard Lyman, Director, Security and Standards Group, Office of Information Services

Source of Discovery: FY 1997 financial statement audit by OIG and other sources.

Appropriation/Account:

(For Corrected Items Only)

Validation Process Used:

Results Indicators:

2001 FMFIA Section 4 Material Non-Conformance: Schedule of Corrective Actions (CMS 01-02)
(Note: This finding is a sub-set of the one Section 4 material non-conformance (HHS-00-01.)

Briefly define (purpose, scope, methodology, resources) the corrective action plan (CAP) that corrects/improves this material non-conformance.

CMS recognizes the significance of controls and security issues regarding Medicare EDP issues as they relate to the integrity, confidentiality and availability of sensitive Medicare data. CMS has established an enterprise-wide systems security program. That portion applying to internal systems has been phasing in since late FY 1998. The first major accomplishment was the development of CMS' Systems Security Plan (SSP) Methodology, which established procedures for developing a 3-tiered hierarchical SSP structure. The first tier is the enterprise-wide systems security master plan. Tiers 2 & 3 apply to the development of general support system (GSS) and SSPs, which are applicable enterprise-wide. The Master SSP and a number of GSS SSPs are currently under development.

CMS has revised its information systems security requirements for Medicare contractors. The revision includes CMS Core Information Security Requirements. The core requirements are based on a synthesis of OMB Circular A-130, PDD 63, General Accounting Office Federal Information System Controls Audit Manual, Internal Revenue Service Publication 1075, Health Insurance Portability and Accounting Act and new CMS requirements for systems architecture and security handbook:

• Contractors were given a Contractor Assessment Security tool (CAST) to document their compliance with the core security requirements;

• CMS has begun conducting an Independent Verification and Validation review for Medicare contractor security program documentation;

• Contractors are required to have independent reviews conducted of their implementation of the CMS core security requirements; and

• Gaps identified in the evaluation of each contractor's compliance with the core security requirements will be funded to the extent of available resources.

Overall Status of MW at the close of FY 2001 (global progress toward correcting/improving this weakness over this fiscal year).

CMS continues to make progress toward resolving this issue in FY 2002 by revising its information systems security requirements for Medicare contractors. The Core Information Security Requirements adhere to guidelines set forth in OMB Circular A-130 and implement effective control procedures. Contractors are now required to document their compliance with CMS' Core Information Security Requirements. In June 2001, we developed entity-wide control procedures for significant production applications and systems software programs. The milestones below apply to our Medicare contractors. Compliance with due dates is dependant on resources.

2001 FMFIA Section 4 Material Non-Conformance: Schedule of Corrective Actions (CMS 01-02)
(Note: This finding is a sub-set of the one Section 4 material non-conformance (HHS-00-01)

CAP Milestones for FY 2002:	Scheduled Due Date
CMS will adhere to OMB Circular A-130 guidelines for entity-wide security plans to ensure appropriate consideration is given to safeguarding Medicare data. **Milestone Status:** In progress	September 2002
CMS will 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. **Milestone Status:** In progress	September 2002
CMS will develop consistent and effective procedures over the implementation, maintenance, access, and documentation of operating systems software products used to process Medicare data. **Milestone Status:** In progress	September 2002
CMS will develop a segregation of duties to ensure accountability and responsibility for access to Medicare applications and data are appropriately assigned. **Milestone Status:** In progress	September 2002
CMS will update and appropriately document service continuity procedures to recover Medicare processing in case of a system outage. **Milestone Status:** In progress	September 2002

2001 FMFIA Section 2 Material Weaknesses: Schedule of Corrective Actions (FDA-89-02)

Title and Description of Material Weaknesses: Weakness in the Enforcement Program for Imported Foods in the Food and Drug Administration (FDA) - (FDA-89-02). The Office of Inspector General reported that FDA did not inspect a large enough sample of imported foods to ensure the safety of the public health.

Pace of Corrective Action:
Year Identified: FY 1989
Original Targeted Correction Date: FY 1990
Correction Date in Last Year's Report: FY 2000
Current Correction Date: FY 2001
Reasons for Changes in Dates:

Name of Responsible Program Manager: Dennis Baker, Associate Commissioner for Regulatory Affairs

Source of Discovery: OIG (Report A-15-90-00001) and internal FDA management reviews.

Appropriation/Account: 7520600

Validation Process Used: A corrective action review will be completed following correction of the material weakness.

Results Indicators: FDA determined that a 20 percent minimum inspection rate to assure the safety of the imported foods was unrealistic and that goals could be achieved more cost effective with science based targeting of inspection resources. As a result, a revised strategy for how the Agency will deal with imported foods has been prepared. FDA's new approach will focus on products and problems, which present a high risk to the American public, or firms and countries of origin that have a history of noncompliance. FDA also anticipates making improvements and an increased presence due to the substantial added FY 2002 resources provided by bioterrorism funding.

2001 FMFIA Section 2 Material Weaknesses: Schedule of Corrective Actions (FDA-89-02)

Title and Description of Material Weakness: Weakness in the Enforcement Program for Imported Foods in the FDA.

Major Milestones	Milestone Dates		
	Original Plan	Revised Plan	Actual Date
Completed actions/events:			
FDA uses a structural and selective sampling method, based on both the entry level and product intelligence to provide an effective level of examination coverage. This assessment is supported by historical data covering the period of 1972-1992.			FYs 1992/93
FDA developed a Revised Imports Strategy, which embodies intelligence based sampling of imports to provide an effective level of coverage, and includes performance indicators. With this new approach, FDA focuses its import activities on products and problems presenting a high health risk to the American public, or firms and countries of origin having a history of non-compliance. Electronic screening, improved strategic alliances and improved pre-market and post-market surveillance are key components of the revised strategy.			FYs 19994/2001
FDA has expanded the use of an electronic entry processing system (EEPS) for imports using the Custom's Automated Commercial System. EEPS enables FDA to screen import entries and electronically make "May Proceed" decisions on products of low risk and high compliance rates. At this time, EEPS has been implemented at all major ports where electronic entry of imports is available.			FY 1995
FDA plans to maintain its pre-market surveillance through a vigorous foreign inspection program designed to identify problems at their source. FDA completed 65 foreign inspections during FY 1995.			FY 1995
The number of foreign inspections completed during FY 1997 was 40, FY 1998 was 40, and FY 1999 was 87.			FYs 1997,98,99

2001 FMFIA Section 2 Material Weaknesses: Schedule of Corrective Actions (FDA-89-02)			
Major Milestones	**Milestone Dates**		
	Original Plan	**Revised Plan**	**Actual Date**
FDA will complete the full rollout of OASIS version 2 to all district offices.			FY 1998
The default "May proceed" rate for all food commodities has been set at 70 percent or greater. However, the "May proceed" rate measured at any particular time may be lower as FDA intensifies a problem with a firm, country or product. These adjustments are considered essential to FDA surveillance activities.			FY 1998
Planned/continuing agency actions: All facets of the Revised Imports Strategy will continue to be implemented and evaluated.			FYs 2000/01
FDA continues to develop and evaluate agreements with foreign governments whose requirements and regulatory infrastructure are equivalent to FDA's. As these agreements are developed and finalized, surveillance resources can be targeted toward countries whose internal requirements supply less assurance of compliance with U.S. requirements.			FYs 2000/01
During FY 2001, FDA performed 27,032 food import physical examinations out of 4,577,861 representing a 0.6 percent coverage exam rate. FDA believes that identifying firms and countries with inspection systems comparable to those in the U.S. and in accordance with the Food Safety Initiative, combined with targeted physical examinations, is a viable and realistic strategy to addressing the surge of imported FDA-regulated products.			FY 2001
The number of foreign inspections planned for FY 2002 is 1,201.			FY 2002
In FY 2002, FDA received a counter-terrorism supplemental that includes $97.1 million to allow increased inspections of imported food products. The additional resources will allow the FDA to hire 665 more inspectors, lab specialists and other compliance experts, in addition to allowing the FDA to invest in new technology and scientific equipment to detect select agents and monitor imports. The new technology and scientific equipment to detect select agents and monitor imports. The primary focus of this request focuses on those activities that protect the U.S. border against the potential vulnerabilities to the Nation's Food Supply. Also, FDA and the Centers for Disease Control (CDC) are enhancing their surveillance activities with respect to diseases caused by foodborne pathogens, and are working with our federal, state and local partners to coordinate these activities.			FY 2002
The request will also allow the expansion of FDA's information systems that monitor imports and those that provide tools to compare pathogenic findings in the food supply. One of these systems is the eLEXNET system that provides multiple government agencies engaged in food safety regulatory activities with the new ability to rapidly detect, compare, and communicate unusual findings in laboratory analyses.			FY 2002
FDA will enhance the field's Operational and Administrative System for Import Support (OASIS) computer software, including a real-time screening interface with multi-agency import databases to help target import inspection resources.			FY 2002

2001 FMFIA Section 2 Material Weaknesses: Schedule of Corrective Actions
National Institutes of Health (PHS-93-02)

Title and Description of Material Weaknesses: Deficiences in the Public Health Service (PHS) technology transfer activities.

Deficiencies were noted in the PHS technology transfer activities. The technology transfer deficiencies include, 1) the management information systems are inadequate, and 2) the processes to ensure that royalties and other payments received are inadequate.

Pace of Corrective Action:
Year Identified: FY 1993
Original Targeted Correction Date: FY 1994
Correction Date in Last Year's Report: FY 2001
Current Correction Date: FY 2002
Reasons for Changes in Dates: Contractor failed to provide system in accordance with contract terms and budget. Program is contracting through NASA to modify their technology transfer system to meet NIH's requirements. Contracts awarded in December 2000 are planned for completion in December 2001.

Name of Responsible Program Manager:
Dr. Maria Freire

Source of Discovery:
NIH Alternative Management Control Review

Appropriation/Account: 7530846

Validation Process Used: NIH management will be required to demonstrate to the Department that corrective actions have been completed. This will be followed by a corrective action review within one year to demonstrate that corrective actions taken remain effective.

Results Indicators: Existence of policies, procedures, and information system.

2001 FMFIA Section 2 Material Weaknesses: Schedule of Corrective Actions (PHS-93-02)

Title and Description of Material Weakness: Deficiencies in the Public Health Service Technology Transfer Activities.

Major Milestones	Milestone Dates		
	Original Plan	Revised Plan	Actual Date
1. Office of Technology Transfer (OTT) will improve its information systems so its staff can more easily determine what costs have been incurred, billed and collected.	October 1998	February 2002	
2. OTT will revise the current model license agreements used by NIH to include standard language on auditing; develop criteria for use in determining whether or not an audit should be requested by NIH; and obtain Institute Center Division (ICD) approval to enter into contracts to conduct audits as required.	October 1998		August 1998
3. OTT will improve its information systems, so it can accurately document the status of each patent application.	October 1998	February 2002	
4. OTT will develop an integrated management information system that will effectively track and report on Collaborative Research and Developer Agreements (CRADAs), inventions, patent prosecution status and costs, licensing, and receipt of royalty payments for domestic and foreign filed cases.	October 1998	February 2002	
5. OTT will update the Technology Transfer Policy Manual, Chapter 206, and establish clear internal procedures on the processing and content of infringement log items.	March 1998		March 1998
6. Information from the infringement log will be migrated to the new data system where it will be maintained in the future.	October 1998	April 2002	
7. OTT will review how the new process for announcing the availability of technologies is working after it has been in effect for one year.	June 1998 November 1998		October 1998
Part 1: Conduct an analysis Part II: Complete an Evaluation	November 1998		October 1998
8. OTT will make further adjustments, as necessary, to reduce the amount of time between the filing of a patent application and publication of the abstract in the Federal Register.			
9. OTT will provide assistance and guidance, as necessary, in preparing technology training, and will provide oversight to ensure the training provided by the ICDs is conducted properly.	October 1998 and ongoing		August 1998 and ongoing
Note: Items 1, 3, 4, and 6 are tied to the completion of the new OTT data system.			

HHS FY 2001 Pending and New Material Weaknesses and Non-Conformances Under FMFIA Reporting				
No.	Title and Identification Code	First Year Reported	Targeted Date for Correction in 2000 FMFIA Report	Current Target Date for Completion
Management Control Material Weaknesses				
1.	Weak Enforcement in the Import Food Inspection Program (FDA-89-02)	1989	FY 2001	FY 2002
2.	Deficiencies in Technology Transfer Activities at NIH (PHS-93-02)	1993	FY 2001	FY 2002
Financial Management Systems Material Non-Conformances				
3.	Financial Systems and Processes (HHS-00-01)	1999	FY 2007	FY 2007
3a.	CMS Financial systems and Regional and Central Office Oversight (Medicare Accounts Receiveable) (CMS 01-01, formerly HCFA 97-02)	1997	FY 2007	FY 2007
3b.	Medicare EDP Controls including Application Controls for Medicare Contractors (CMS 01-02, formerly HCFA 98-01a)	1998	FY 2001	FY 2002

Notes:

The number of material weaknesses and non-conformances reported on in this section is consistent with the number shown in the statistical table above. This year, HHS has re-categorized issues related to financial management information systems from the Management Control category (Section 2) as material weaknesses to the Financial Management Systems category (Section 4) as material non-conformances. We believe this improves the presentation of the report, and helps to delineate program management control issues from financial systems issues which are being addressed as a concerted effort under the auspices of the Unified Financial Management System and its sub-components.

1 and 2: These two material weaknesses are the result of previous OIG program audits and/or internal management reviews and were included in prior year FMFIA reports.

3. The Financial Systems and Processes (HHS-00-01) material non-conformance is a repeat condition and has been reclassified from a material weakness and updated to reflect the findings from the FY 2000 and FY 2001 CFO audits. The target date for correction of FY 2007 is based on the planned implementation date for the Unified Financial Management System.

3a. Medicare accounts receivable, also a repeat condition, was included under Financial Systems and Processes (HHS-00-01) in the FY 2000 report. It continues to be a sub-set of the Financial Systems and Processes material nonconformance, but is reported in a separate exhibit called Financial Systems and Regional and Central Office Oversight (See CMS-01-01). The target date for correction is based on the planned implementation date for the HIGLAS integrated general ledger system.

3b. Medicare Electronic Data Processing Controls (CMS-01-02, formerly HCFA 98-01a) is also a repeat condition, although the auditors noted in the FY 2000 audit that this weakness is no longer considered material at CMS headquarters.

Statistical Summary of FMFIA Material Weanesses and Non-Conformances

Number of Management Controls (Section 2) Material Weaknesses			
	Number Reported First Time	Number Corrected	Number Still Pending
1989 Report	2 (FDA 89-02) (HCFA 89-01)	1 (HCFA 89-01)	1 (FDA 89-02)
1990 Report	1 (ACF-90-05)	1 (ACF 90-05)	
1993 Report	1 (PHS-93-02)	0	1 (PHS-93-02)
1997 Report	3 (CMS 01-01, formerly HCFA 97-02) (ACF 97-01) (HCFA 97-01)	2 (ACF 97-01) (HCFA-97-01)	1 (CMS 01-01)
1998 Report	2 (CMS 01-02, formerly HCFA-98-01a) HCFA 98-02 renamed HCFA 98-01b in 1999)	1 (HCFA 98-02 renamed) HCFA 98-01b in 1999)	1 (CMS 01-02)
1999 Report	1 (HHS-00-01, formerly HHS 99-01)	0	1 (HHS 00-01)
2000 Report	0	0	0
2001 Report	0	0	0
Subtotal	10	5	5
Less number recategorized to Section 4 in 2001 Report	3 (CMS 01-01) (CMS 01-02) (HHS 00-01)	0	3 (CMS 01-01) (CMS 01-02) (HHS 00-01)
Total	7	5	2 (FDA 89-02) (PHS-93-02)
Of the total number corrected, how many were corrected in 2001? 0			

Number of Financial Management Systems (Section 4) Material Non-Conformance			
	Number Reported First Time	Number Corrected	Number Still Pending
1997 Report	1 (CMS 01-01)	0	1 (CMS 01-01)
1998 Report	1 (CMS-01-02)	0	1 (CMS-01-02)
1999 Report	1 (HHS 00-01)	0	1 (HHS 00-01)
2000 Report	0	0	0
2001 Report	0	0	0
Subtotal	3	0	3
Less number combined with 1999 finding:	2 (CMS 01-01) (CMS-01-02)		2 (CMS 01-01) (CMS-01-02)
Total	1	0	1 (HHS 00-01)
Of the total number corrected, how many were corrected in 2001? 0			

The Inspector General (IG) Act Amendments of 1988 require departments and agencies to report twice a year 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 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.

Background

Departmental Findings

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

- *Initiated action to recover $416 million through collection, offset, or other means (see Table I);*
- *Completed action to recover $305 million through collection, offset, or other means (see Table I);*
- *Initiated action to put to better use $549 million (see Table II); and*
- *Completed action that over time will put to better use $549 million (see Table II).*

At the end of this period there are 297 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 three key elements to the HHS audit resolution and follow-up process:

- *The HHS components have lead responsibility for implementing and follow-up on most IG and independent auditor recommendations;*
- *The Assistant Secretary for Budget, Technology, and Finance (ASBTF) establishes policy and monitors OPDIV compliance with audit follow-up requirements; and*
- *If necessary, the ASBTF or the Deputy Secretary resolves conflicts between the HHS components and the Office of the Inspector General.*

Departmental Conflict Resolution

In the event that OPDIV 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, OPDIVs follow up on IG recommendations effectively and within regulatory time limits. The OPDIVs usually reach a management decision within the six-month period that is prescribed by PL 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, etc. Costs associated with recommendations that funds be put to better use through cost avoidance, budget savings, etc. The tables are set up according to the requirements of section 106(b) of the IG Act Amendments of 1988 (PL 100-504).

Table I

Management Action on Costs Disallowed in Inspector General Reports

As of September 30, 2001 (in thousands)

	Number	Disallowed Cost
A. Reports for which final action had not been taken by the commencement of the reporting period.[1]	403	$ 535,456
B. Reports on which management decisions were made during the reporting period.[2]	233	415,729
Subtotal (A & B)	**636**	**$ 951,185**
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.	178	304,586
(ii) The dollar value of disallowed costs that were written off by management.	11	11,249
Subtotal (i & ii)	**189**	**$ 315,835**
D. Reports for which no final action has been taken by the end of the reporting period.[3]	447	$ 635,350

[1] Includes adjustments of amended disallowances and disallowances excluded from the previous reporting period.

[2] This represents the amount of management concurrence with the Inspector General's recommendations. This amount includes $232,262 in management decisions recorded in Part B, above, that has not been recorded for the 2001 Office of Inspector General's Semi-Annual Reports, Table I, Line C.

[3] Includes the list of Audits (starting on page G.4) over one year old with outstanding balances to be collected. It 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, 2001

	Number	Disallowed Cost
A. Reports for which final action has not been taken by the commencement of the reporting period.	4	$ 9,048,608
B. Reports on which management decisions were made during the reporting period.	9	549,048,631
Subtotal (A & B)	**13**	**$ 558,097,239**
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	9	549,048,631
– Based on legislative action	0	0
(ii) The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed	0	0
Subtotal (i & ii)	**9**	**$ 549,048,631**
D. Reports for which no final action has been taken by the end of the reporting period.[4]	4	$ 9,048,608

[4] Includes the following list of four reports 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, 2001

Audit Number	Auditee	Date Issued	Amount	Explanations
04-95-02110	SC BC (Hospice of Lake & Sumter, Inc.) – ORT	04/97	$2,500,000	CMS is reassessing whether seeking the identified OIG hospice overpayment is the appropriate action to take.
05-95-00060	Wisconsin Department of Health and Social Services	09/97	$2,400,000	The State of Wisconsin plans to establish a workgroup to meet and review HMO financial data related to Medicaid HMOs.
06-92-00043	BC/BS of Texas, Inc. – GME Costs	03/94	$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.
06-95-00095	Palmetto Gov. Ben. Admin. (Family Hospice/Dallas)–ORT	04/97	$69,648	CMS is reassessing whether seeking the identified OIG hospice overpayment is the appropriate action to take.

Summary:

HHS component: Centers for Medicare & Medicaid Services

Total Number of Reports: 4

Total Amount for Better Use: $9,048,608

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected

As of September 30, 2001

OPDIV	Audit Report Number	Auditee	Date Issued	Amount (in dollars)	Comments
ACF	04-89-06323	Tallapossa Caa/HS	Aug-1990	$ 5,934	Payment plan
ACF	03-91-14545	PA/Win-Demo	Jun-1991	252,362	Appeal process
ACF	02-91-14405	Bedford Stuyvesanto/O	Mar-1992	67,170	Referred to DOJ
ACF	06-90-00052	Mexican Amer/Discret	Apr-1992	112,234	Referred to DOJ/ Payment plan
ACF	08-9217549	Rapid City Amer/Seds	Jun-1992	30,248	Transferred to Treasury Offset Program
ACF	04-91-06594	Mountain Valley/HS	Sep-1992	196,213	Referred to DOJ
ACF	04-92-17186	Mountain Valley/HS	Sep-1992	203,420	Referred to DOJ
ACF	04-93-23833	Mountain Valley/HS	Jul-1993	212,759	Referred to DOJ
ACF	08-92-00598	Anishinaubag	Aug-1993	26,361	Transferred to Treasury Offset Program
ACF	09-92-06592	Intertribal Cnl/Hs	Sep-1993	131,812	Payment plan
ACF	09-93-21254	Arizona/HS	Sep-1993	85,511	Transferred to Treasury Offset Program
ACF	09-93-23668	Center of ED/HS	Nov-1993	12,070	Pursuing collection
ACF	04-93-20785	Florida Refugee	Dec-1993	46,820	Pursuing collection
ACF	09-93-26204	Tohono O Odham/HS	Feb-1994	90,077	Appeal process
ACF	04-94-28234	NW Georgia Service/HS	Feb-1994	578,045	Transferred to Treasury Offset Program
ACF	01-91-06601	Connecticut/OCS	Mar-1994	224,099	Transferred to Treasury Offset Program
ACF	03-93-21104	PA/CSBG	Mar-1994	150,000	Appeal process
ACF	04-93-00051	Haitian Task	Mar-1994	200,207	Referred to DOJ
ACF	09-94-28246	Butte County CAC	Apr-1994	8,826	Payment plan
ACF	04-94-30737	Mountain Valley/HS	Jul-1994	39,095	Referred to DOJ
ACF	04-94-31826	W. Central GA, CAC/HS	Jul-1994	141,505	Transferred to Treasury Offset Program
ACF	09-92-06550	Butte County CAC	Aug-1994	66,300	Payment plan
ACF	09-94-27281	Arizona Affiliated H/S	Sep-1994	2,563	Appeal process
ACF	04-94-26346	Putnam-Clay-Flagler/H	Sep-1994	86,292	Transferred to Treasury Offset Program
ACF	09-94-30207	Fresno County/HS	Nov-1994	22,062	Appeal process
ACF	04-95-32922	Putnam-Clay-Flagler/H	Jan-1995	178,320	Transferred to Treasury Offset Program
ACF	01-94-25904	Massachusetts/CCDBG	Feb-1995	9,225	Appeal process
ACF	09-95-35961	Fresno County/HS	Aug-1995	29,215	Appeal process
ACF	03-94-27065	PA/CSBG	Sep-1995	150,000	Appeal process
ACF	03-95-33212	PA/CSBG	Sep-1995	137,207	Appeal process
ACF	06-95-36853	Albuq-Bernalilo/HS	Nov-1995	208,445	Appeal process
ACF	01-95-37194	Indian Township/Liea	Mar-1996	44,244	Appeal process
ACF	03-96-39886	Halifax CCA/HS	May-1996	53,281	Payment plan
ACF	09-95-31383	Cocopah/HS	May-1996	76,861	Appeal process
ACF	05-95-00022	ILL/IV-E	Jul-1996	$ 89,239	Pursuing collection
ACF	06-96-40858	Caddo H/S	Aug-1996	43,339	Payment plan
ACF	01-96-38182	Connecticut/FC	Sep-1996	50,292	Appeal process
ACF	04-96-38688	State of KY	Oct-1996	8,049	Pursuing collection

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected

As of September 30, 2001

OPDIV	Audit Report Number	Auditee	Date Issued	Amount (in dollars)	Comments
ACF	01-96-39813	Pleasant Point/Liea	Nov-1996	18,266	Transferred to Treasury Offset Program
ACF	02-95-33649	Puerto Rico	Dec-1996	1,433	Appeal process
ACF	02-95-02005	Middlesex County/HS	Dec-1996	173,656	Appeal process
ACF	01-96-43461	Connecticut/IV-E	Jan-1997	1,902	Appeal process
ACF	04-96-44126	Anderson-Oconee/HS	Feb-1997	143,366	Transferred to Treasury Offset Program
ACF	06-97-44674	Tri-County	Apr-1997	34,703	Transferred to Treasury Offset Program
ACF	01-95-32620	Connecticut/FC	May-1997	4,070	Pursuing collection
ACF	09-93-00106	CA/Rufugee	May-1997	29,269	Pursuing collection
ACF	08-96-01024	Child Opportunity Program	Jun-1997	1,104,700	Transferred to Treasury Offset Program
ACF	03-97-43787	Virginia/CCDBG	Jun-1997	937,769	Pursuing collection
ACF	04-97-45327	Mobile Community Action	Jul-1997	127,705	Transferred to Treasury Offset Program
ACF	03-95-00451	DC/FC	Aug-1997	420,606	Pursuing collection
ACF	06-97-47939	Albuq/Bernalillo	Aug-1997	210,330	Transferred to Treasury Offset Program
ACF	09-93-00083	CA/Child Support	Sep-1997	1,429,837	Pursuing collection
ACF	02-97-47637	Puerto Rico IV-B	Sep-1997	9,703	Pursuing collection
ACF	03-97-47731	Delaware	Sep-1997	11,880	Pursuing collection
ACF	06-97-46216	E Texas Family Srv	Sep-1997	12,497	Transferred to Treasury Offset Program
ACF	01-97-44081	Vermont	Oct-1997	28,252	Pursuing collection
ACF	04-97-47475	Wash Cty Support Inc.	Nov-1997	273,151	Payment plan
ACF	05-97-48402	Montgomery Co CAA	Nov-1997	79,374	District Court
ACF	03-97-48850	Little Neighborhood	Nov-1997	91,193	Transferred to Treasury Offset Program
ACF	06-97-47730	Tri-County Head Start	Dec-1997	2,451	Transferred to Treasury Offset Program
ACF	03-97-00587	Little Neighborhood	Jan-1998	300,465	Transferred to Treasury Offset Program
ACF	09-96-00071	CA/IV-E	Apr-1998	15,693,626	Pursuing collection
ACF	09-96-40113	Protective & Adv Mariana	Apr-1998	80,574	Appeal process
ACF	09-96-40114	Protective & Adv Mariana	Apr-1998	36,988	Appeal process
ACF	09-96-40115	Protective & Adv Mariana	Apr-1998	56,344	Appeal process
ACF	04-97-49121	Florida	May-1998	282,553	Transferred to Treasury Offset Program
ACF	09-96-00066	California	Jun-1998	4,504,493	Pursuing collection
ACF	06-97-48284	E Texas Family Srv	Nov-1998	$ 9,130	Transferred to Treasury Offset Program
ACF	04-98-49931	Sumter County Opport	Nov-1998	94,829	Appeal process
ACF	08-98-01036	Ogden Area CA/HS	Nov-1998	496,407	Appeal process
ACF	02-97-47931	Puerto Rico	Jan-1999	307,996	Pursuing collection
ACF	06-97-48531	Texas DHS	Jan-1999	11,209	Pursuing collection
ACF	06-99-54784	Texas DP&R/FC	Jan-1999	8,057	Pursuing collection
ACF	06-97-47756	Louisiana DSS/FC	Feb-1999	7,470	Pursuing collection

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected

As of September 30, 2001

OPDIV	Audit Report Number	Auditee	Date Issued	Amount (in dollars)	Comments
ACF	09-99-55450	Farm Supp Srv Bay Area	Mar-1999	13,892	Appeal process
ACF	03-99-53419	Delaware DHSS	Mar-1999	45,404	Pursuing collection
ACF	09-96-39178	AZ Aff Tribes	Mar-1999	258,824	Transferred to Treasury Offset Program
ACF	09-96-43765	AZ Aff Tribes	Mar-1999	66,526	Transferred to Treasury Offset Program
ACF	05-98-51567	Ohio DHHS	Mar-1999	14,334	Pursuing collection
ACF	04-99-55653	Tennessee	Mar-1999	38,487	Pursuing collection
ACF	10-97-47406	Idaho/IV-D OCSE	Apr-1999	88,817	Pursuing collection
ACF	04-96-00105	Delta Foundation	Apr-1999	1,225,291	Payment plan
ACF	08-97-43975	Oglala Sioux Tribe	May-1999	6,494	Transferred to Treasury Offset Program
ACF	03-99-59858	Virginia/FC	Jun-1999	4,830	Pursuing collection
ACF	03-98-52659	DC/CSBG	Jul-1999	173,116	Pursuing collection
ACF	10-98-50308	Coastal Community AC	Jul-1999	5,274	Transferred to Treasury Offset Program
ACF	09-95-00091	Walter McDonald Asso.	Jul-1999	23,553	Payment plan
ACF	10-97-49306	Alaska	Jul-1999	5,716	Pursuing collection
ACF	09-98-00075	California/IV-E	Aug-1999	38,953,679	Pursuing collection
ACF	04-96-00107	Harambee Child Level	Aug-1999	124,811	Transferred to Treasury Offset Program
ACF	07-98-01035	Nebraska IV-A,E	Oct-1999	635,552	Pursuing collection
ACF	08-97-46601	Ute Indian Tribe	Oct-1999	62,865	Appeal process
ACF	08-99-57703	Connejos-Costil	Oct-1999	21,145	Transferred to Treasury Offset Program
ACF	01-99-57863	Connecticut	Oct-1999	670,700	Pursuing collection
ACF	06-97-47657	Five Sandoval	Nov-1999	46,660	Transferred to Treasury Offset Program
ACF	04-99-55388	North Carolina	Nov-1999	5,640	Pursuing collection
ACF	04-99-57894	Georgia	Nov-1999	4,143	Pursuing collection
ACF	01-97-48573	Waterbury CT	Nov-1999	54,184	Payment plan
ACF	07-98-50741	Citizens Housing	Dec-1999	2,678	Transferred to Treasury Offset Program
ACF	02-99-58335	Puerto Rico	Dec-1999	75,753	Appeal process
ACF	02-99-57987	New Jersey IV-E	Jan-2000	547	Pursuing collection
ACF	08-99-59826	Crow Creek Si.	Jan-2000	$ 26,660	Transferred to Treasury Offset Program
ACF	10-99-58040	Washington	Jan-2000	70,011	Pursuing collection
ACF	08-99-59693	Utah	Feb-2000	62,333	Pursuing collection
ACF	08-99-60047	Alamosa HS.	Feb-2000	8,605	Transferred to Treasury Offset Program
ACF	05-98-00010	Wisconsin	Feb-2000	3,318,857	Pursuing collection
ACF	10-00-58628	Kuigpagmiut, In.	Apr-2000	18,119	Appeal process
ACF	10-98-00008	Siletz River Co.	Apr-2000	27,316	Appeal process
ACF	09-97-44614	East Bay Perina.	May-2000	241,892	Pursuing collection
ACF	07-99-57228	Douglas Community	Jun-2000	35,043	Pursuing collection
ACF	09-95-00056	CA/IV-E	Jun-2000	2,597,545	Appeal process

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ACF	09-00-62429	White Mt. Apache	Jul-2000	86,432	Appeal process
ACF	02-01-67912	New York	Jul-2000	93,223	Pursuing collection
ACF	07-00-64873	Nebraska	Jul-2000	42,824	Pursuing collection
ACF	08-00-57179	Turtle Mt. Band	Jul-2000	283	Appeal process
ACF	10-96-00007	Idaho Migrant	Aug-2000	23,885	Pursuing collection
ACF	08-00-63140	Ogden Area CA	Aug-2000	176,207	Appeal process
ACF	10-99-00050	WA State Migrant Council	Aug-2000	989,341	Appeal process
ACF	01-98-02505	MA Dept of Social Services	Aug-2000	4,871,596	Pursuing collection
ACF	08-99-59907	Crow Creek Si.	Aug-2000	344,504	Pursuing collection
				$ 86,799,547	**Subtotal, ACF**
AHRQ		None		0	
				$ -	**Subtotal, AHRQ**
AoA		None		0	
				$ -	**Subtotal, AoA**
CDC	05-96-40217	Wisconsin Assoc. of Black Social Workers, Inc.	Mar-1997	1,649	Pursuing collection
CDC	09-96-41444	Immigrant Center	Mar-1997	2,495	Pursuing collection
CDC	01-96-37165	Haitian American Public Health Initiative	Mar-1997	20,209	Pursuing collection
CDC	03-96-41385	National Assoc. for Equal Support. In Higher Ed.	Apr-1997	51,654	Pursuing collection
CDC	03-98-51634	City of Philadelphia, PA.	Jun-1998	93,690	Pursuing collection
CDC	04-98-51239	State of Alabama	Sep-1998	227,200	Pursuing collection
CDC	03-98-50835	Nat'l Organization of Black County Officials	Jan-1999	19,385	Pursuing collection
CDC	03-98-50836	Nat'l Organization of Black County Officials	Jan-1999	27,140	Pursuing collection
CDC	03-98-50837	Nat'l Organization of Black County Officials	Mar-1999	1,078	Pursuing collection
CDC	10-98-53018	Self Enhancement, Inc.	May-2000	3,452	Pursuing collection
CDC	10-98-53162	People of Color Against Aids Network	Sep-2000	$ 8,289	Pursuing collection
				$ 456,241	**Subtotal, CDC**
CMS	01-89-00518	Blue Shield of MA	Oct-1990	216,053	CMS has instructed the carrier to calculate and recover overpayments.
CMS	01-90-00500E	B/C of Massachusetts	Sep-1990	7,048,076	Repayment agreement
CMS	01-91-00508	Aetna Life-Parts A&B Adm.	Jan-1992	223,655	Additional documentation from the contractor requests for review by OIG.
CMS	01-92-00517	BC of MA	Apr-1993	160,122	Pursuing collection
CMS	01-92-00523	MA BC/BS-Part B Lab Tests	Jan-1994	2,250,000	Waiting a decision by the Asst. US Attorney in Boston pending criminal charges.
CMS	01-93-00512	BC/BS of MA-Lab Test	Jul-1994	426,817	Pursuing collection
CMS	01-94-00510	BCBS of MS -ADM costs	Apr-1995	130,299	Pursuing collection
CMS	01-95-00005	DHS, NH DHS	Jul-1996	30,565	Pursuing collection

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CMS	01-95-00503	G/A & Capitol Mclean Ho- Adm Costs	Aug-1995	186,190	Pursuing collection
CMS	01-96-00001	Massachusetts State Div. of Medical Assist.	Jul-1996	1,711,898	Pursuing collection
CMS	01-96-00513	Separately Billable ESRDL Lab Tests	Dec-1996	6,300,000	CMS sent tapes and instruction to FIS and ROS. OIG has not yet completed the carrier tapes.
CMS	01-96-00519	Nat'l Medical Care ESRD	Sep-1997	4,319,361	Pursuing collection
CMS	01-96-00527	Clinical Lab Tests by Hospital Outpatient Labs	Dec-1998	43,632,767	Pursuing collection
CMS	01-99-00521	Hematology Indices	Sep-2000	14,000,000	Pursuing collection
CMS	01-99-00523	United Health Care Ins. Cp.	Aug-2000	19,282	Pursuing collection
CMS	02-86-62015	Empire BC/BS	Mar-1988	1,277,575	Contractor appealed and court has ruled in favor of contractor. CMS has filed an appeal in July 1993.
CMS	02-86-62016	Empire BC/BS	Aug-1988	3,027,672	Contractor has signed the closing agreement. An amended OCD is being prepared.
CMS	02-91-01003	Empire BC/BS	Jul-1991	829,551	Contractor is in the process of recouping the overpayment.
CMS	02-91-01022	Prudential Ins.-ADM	Mar-1992	6,837,167	CMS is negotiating with the contractor on the outstanding overpayment.
CMS	02-91-01043	SSS-Part B/ESRD Patient	Apr-1993	844,292	Pursuing collection
CMS	02-92-01004	NJ DHS - Credit Balances for Eight Hosp	Sep-1993	89,839	Pursuing collection
CMS	02-92-01021	BCBSNJ Credit Balances	Jun-1995	$ 14,900,000	Pursuing collection
CMS	02-92-01023	Beth Israel Med Ctr - G&A	Mar-1993	7,741	Contractor is in the process of removing the unallowable costs from the 1990 Cost Reports.
CMS	02-93-01005	Empire BC/BS - Part B ADM	Mar-1995	576,683	Pursuing collection
CMS	02-93-01023	Island Pro	Oct-1994	155,540	Pursuing collection
CMS	02-96-01010	NYS DSS	Jul-2000	612,121	Under review
CMS	02-96-01034	Staff Blders. Home Health Inc. Buffalo-ORT	Jan-1998	2,046,576	Pursuing collection
CMS	02-97-01041	Audit Clearance Matter	Apr-1999	687,418	Under review
CMS	03-92-00150	Elmira Jeffries MNH	Jan-1994	164,188	The state is in the process of collecting the overpayment.
CMS	03-92-00201	Commonwealth of VA	Jan-1993	205,177	The state is in the process of making a final determination on the overpayment.
CMS	03-92-00602	PA. DPW - Upper limit	Sep-1994	230,520	Pursuing collection
CMS	03-93-00013	Omega Med. Lab.	Nov-1993	1,102	Pursuing collection
CMS	03-93-00025	PBS - Lab Fee Schedules	Sep-1995	953,377	Pursuing collection
CMS	03-95-38380	Commonwealth of VA	Mar-1996	68,333	Pursuing collection
CMS	03-99-57965	District of Columbia	Sep-1999	79,355	Under review
CMS	04-00-64861	State of North Carolina	Sep-2000	24,496	Pursuing collection
CMS	04-91-02004	HCFA RO IV (FL BS-MSP)	Sep-1993	3,370,805	Pursuing collection

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CMS	04-92-01022	NC Dpt. of Human Resources	Nov-1992	645,340	CMS initiated a verification process to determine the final disposition of the hospital credit balances. This verification stage is ongoing, however the audit may be closed in the near future.
CMS	04-93-20876	State of NC (OGCFM Lead)	Jul-1993	22,244	Awaiting documentation from state to verify funds were returned.
CMS	04-94-01096	Humana Medical Plans, Inc.	Apr-1995	624,048	Pursuing collection
CMS	04-95-01104	American Health Care-ORT	Jan-1997	1,200,000	Pursuing collection
CMS	04-95-02110	SC BC (Hospice of Lake and Sumter, Inc.) ORT	Apr-1997	4,000,000	Reassessing situation
CMS	04-95-02111	SC BC (Hospice of Florida Suncoast, Inc.) ORT	Mar-1997	14,800,000	Reassessing situation
CMS	04-95-33005	State of MS (OGM)	Aug-1995	63,140	Reviewing state's documentation to ensure that the payment adjustments have been made.
CMS	04-95-33088	State of NC (OGM)	Sep-1995	$ 11,098 -	State is in the process of determining how much of the overpayment hasalready been returned to CMS.
CMS	04-95-38310	State of MS (OGM)	Mar-1996	9,069,408	State is in the process of determining how much of the overpayment has already been returned to CMS.
CMS	04-96-01131	Aetna (Integrated Health Svcs. Of Green Briar)-ORT	Nov-1997	202,780	Pursuing collection
CMS	04-96-01138	BC/BS of FL-Lawnwood Reg. Med. Ctr. ORT	Apr-1997	111,986	Contractor is pursuing collection of the remaining overpayment.
CMS	04-96-01148	Aetna Life Insur. Co.	Nov-1997	148,955	Pursuing collection
CMS	04-96-02122	BC of GA (Medical Therapy Serv. Inc.	Oct-1998	791,327	Under review
CMS	04-96-38655	State of NC	Jan-1997	5,053	Reviewing state's supporting documentation to ensure that the payment adjustments have been made.
CMS	04-97-01164	1996 ACR Proposal for FL MCP	Jan-2000	9,660,000	Pursuing collection
CMS	04-97-02130	Mutual of Omaha	Apr-1999	1,709,245	Under review
CMS	04-97-02138	Mutual of Omaha (Silver Springs Health Ctr.)-ORT	Apr-1999	2,382,527	Under review
CMS	04-98-01184	Homebound Medical Care, Inc.	Jun-2000	1,860,760	Pursuing collection
CMS	04-99-01193	Six State Review of O/P Rehab. Facilities	Jun-2000	74,067,804	Pursuing collection
CMS	04-99-55388	State of NC (OGM)	Jun-1999	367,984	Pursuing collection
CMS	04-99-55479	Commonwealth of KY (OGM)	Mar-1999	782,019	Pursuing collection
CMS	04-99-55653	State of TN (OGM)	Nov-1999	309,448	Under review
CMS	04-99-59921	State of KY (OGM)	Oct-1999	184,633	Pursuing collection

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CMS	05-90-00013	BC/BS of MI - Admin	Dec-1990	2,413,388	This audit must remain open pending resolution of the contractor's termination audit, any related termination agreement and pending lawsuits.
CMS	05-97-00028	OH Dept. of Human Services	Oct-1998	12,674,026	Under review
CMS	05-97-00029	Office of Medicaid Policy and Planning (Indiana)	Mar-1999	2,000,000	Under review
CMS	06-00-61716	State of Texas	Jun-2000	14,698	Pursuing collection
CMS	06-92-00043	BC/BS of Tx., Inc. - GME Costs	Mar-1994	4,252,743	Collection activity suspended pending reso lution of an objection lodged by two Medicare providers' legal counsel with the OIG, OGC on January 26, 1994.
CMS	06-95-00095	Palmetto Gov. Ben. Admin. (Fam Hospice/Dallas)-ORT	Apr-1997	$ 871,306	Reassessing situation
CMS	06-96-00027	Palmetto Gov. Ben. Admin. (VNA of TX Hospice) - ORT	Apr-1997	1,156,341	Reassessing situation
CMS	06-97-00034	Risk base Health Maint.	Jun-1999	55,895	Pursuing collection
CMS	06-97-00055	Texas Dept. of Health	Dec-1998	1,100,000	Pursuing collection
CMS	06-99-00058	State of LA (OGM)	Jun-2000	5,290,000	Pursuing collection
CMS	06-99-56489	State of LA (OGM)	Aug-1999	368,258	Pursuing collection
CMS	07-91-00471	BC/BS of MI - Pension Seg.	Dec-1992	5,021,873	This audit must remain open pending resolution of the contractor's termination audit, any related termination agreement and pending lawsuits.
CMS	07-91-00473	BC/BS of Florida, Inc. - Pension Seg.	Aug-1993	4,755,565	CMS is working with all Medicare contractors 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.
CMS	07-92-00525	BC/BS of MI, Inc.- Pension	Dec-1992	2,135,884	This audit must remain open pending resolution of the contractor's termination audit, any related termination agreement and pending lawsuits.
CMS	07-92-00604	WVA BC/BS - Term Pension	Jan-1993	617,644	Contractor was declared insolvent and placed in receivership. The DOJ has filed a claim on behalf of CMS for the amount due CMS. The courts will determine how much, if any, Medicare will recover.
CMS	07-92-00608	BC/BS of Missouri	Jun-1993	960,615	CMS will be verifying that corrective action has been completed by the fiscal intermediary.

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CMS	07-93-00680	BC/BS of NC - Unfunded Pension Costs	Oct-1994	293,629	CMS is working with all Medicare contractors 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.
CMS	07-93-00712	PA BS - Pension	May-1995	521,675	Pursuing collection
CMS	07-93-00713	PA BS - Pension	Jun-1995	$ 5,490,995	Pursuing collection
CMS	07-94-00744	IASD Health Services Corp. - Pension Seg.	Sep-1994	3,079,484	CMS is working with all Medicare contractors 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.
CMS	07-94-00745	IASD Health Services Corp. - Unfunded Pension	May-1994	574,804	CMS is working with all Medicare contractors 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.
CMS	07-94-00746	IASD Health Services Corp. - Pension Seg.	May-1994	842,979	CMS is working with all Medicare contractors 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.
CMS	07-94-00747	IASD Health Services Corp. - Unfunded Pension	May-1994	10,331	CMS is working with all Medicare contractors 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.

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CMS	07-94-00768	BC/BS of SC - Pension	Sep-1994	$ 840,493 - -	CMS is working with all Medicare contractors 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.
CMS	07-94-00769	BC/BS of SC - Pension Costs	Sep-1994	329,001	CMS is working with all Medicare contractors 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.
CMS	07-94-00770	BC/BS of SC - Unfunded Pension	Sep-1994	793,508	CMS is working with all Medicare contractors 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 audit.
CMS	07-94-00777	BC/BS of GA - Pension Costs	Oct-1994	90,736	CMS is working with all Medicare contractors 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.

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CMS	07-94-00778	BC/BS of GA - Unfunded Pension	Oct-1994	$ 363,921	CMS is working with all Medicare contractors 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.
CMS	07-94-00779	BC/BS of GA - Pension Seg.	Oct-1994	113,256 -	CMS is working with all Medicare contractors 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.
CMS	07-94-00805	BC/BS of TN - Pension Seg.	Jan-1995	1,400,063	CMS is working with all Medicare contractors 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.
CMS	07-94-00816	BC/BS of TN - Unfunded Pension	Jan-1995	352,026	CMS is working with all Medicare contractors 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.

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CMS	07-94-00817	BC/BS of AL - Unfunded Pension	Jul-1995	$ 912,730	CMS is working with all Medicare contractors 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.
CMS	07-94-00818	BC/BS of AL - Pension Seg	Jul-1995	951,281	CMS is working with all Medicare contractors 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.
CMS	07-94-01107	BC/BS of FL - Pension Seg.	Apr-1996	813,122	CMS is working with all Medicare contractors 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.
CMS	07-95-01126	BC/BS of FL - Unfunded Pension	Apr-1996	4,049,889	CMS is working with all Medicare contractors 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.

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CMS	07-95-01149	BC/BS of Texas - Pension	Apr-1996	$ 874,111	CMS is working with all Medicare contractors 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 audits.
CMS	07-95-01150	BC/BS of Oregon - Pension Seg.	Aug-1997	191,312	Pursuing collection
CMS	07-95-01151	BC/BS of Oregon - Unfunded Pension	Aug-1997	260,335	Pursuing collection
CMS	07-96-01189	BC of Washington/Alaska - Pension Seg.	Dec-1997	96,740	Pursuing collection
CMS	07-96-38172	State of IA (OGM)	Sep-1996	29,381	State has processed the credits, however, they are still determining when the credits were returned to CMS via the CMS-64.
CMS	07-96-44051	State of IA (OGM)	Feb-1997	45,958	CMS is working with the state to resolve this audit.
CMS	07-97-01205	BC of Washington/Alaska - Pension Seg.	Dec-1997	15,688	Review of pension costs claimed for Medicare reimbursement.
CMS	07-97-01206	BC of Washington/Alaska - Unfunded pension	Dec-1997	106,848	CMS is working to resolve this issue.
CMS	07-97-01209	BC/BS of MS - Pension Seg.	Jan-1998	224,711	Pension segmentation review.
CMS	07-97-01210	BC/BS of MS - Unfunded Pension	Jan-1998	482,549	CMS is working to resolve unfunded pension costs.
CMS	07-97-01211	BC/BS of MS - Pension Costs	Jan-1998	134,312	Review of pension costs claimed for Medicare reimbursement
CMS	07-99-54890	State of IA (OGM)	May-1999	24,656	Pursuing collection
CMS	07-99-59860	State of MO (OGM)	Dec-1999	94,473	Pursuing collection
CMS	08-94-00739	BC/BS of ND - Pension Seg.	Jan-1995	730,875	CMS is working with all Medicare contractors 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.

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CMS	08-94-00740	BC/BS of NC - Unfunded Pension	Jan-1995	$ 671,198	CMS is working with all Medicare contractors 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.
CMS	09-89-00162	Nationwide Employer Project - MSP	Mar-1995	2,218,824	Demand letters were sent to employers listed in the audit. D.C. Circuit Court's decision in the HIAA vs. Shalala case will result in few recoveries of funds from EGHPs, because of EGHPs timely filing limits. CMS is attempting to fix the HIAA decision via new legislation.
CMS	09-95-00072	CA DHS	Nov-1996	4,013,490	Pursuing collection
CMS	09-96-00061	BS of CA	Jun-1998	1,006,192	Reviewing administrative costs.
CMS	09-96-00064	San Diego Hospice Corp. - ORT	Nov-1998	993,779	Under review
CMS	09-96-00088	Care Providers- BC of CA	Jul-1999	901,278	Under review
CMS	09-96-00089	Care Plus Home Health Services - BC of CA	Jul-1999	389,497	Under review
CMS	14-96-00202	Excluded Un-licensed Health Care Providers	Sep-1997	2,931	Pursuing collection
CMS	17-97-00097	CMS Financial Statement Audit for FY 1997	Sep-1998	141,796	Reviewing financial statements for FY 1997
				$319,827,505	**Subtotal, CMS**
FDA				0	
				-	**Subtotal, FDA**
HRSA	01-90-06082	Rural Health Centers Maine	Nov-1990	23,163	Debt referred to Justice Dept. 01/99
HRSA	02-90-06275	Newark Comm. Health Centers	Nov-1990	14,038	Debt referred to Justice Dept.12/98
HRSA	02-91-15053	Northwest Buffalo CHCC	Dec-1991	9,281	Debt referred to Justice Dept.12/98
HRSA	02-92-16577	Newark Comm. Health Centers	Nov-1992	31,708	Demand letter sent
HRSA	03-99-56491	City of Baltimore	Oct-1999	111	Debt referred to Justice Dept.
HRSA	04-93-24751	Vicksburg-Warren CHC	Dec-1993	590	Debt referred to Justice Dept. 1/99
HRSA	04-98-50281	Aaron E. Henry CHC	Sep-1998	3,017	Demand letter sent 6/99

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HRSA	06-93-27049	Greater Houston HIV Alliance	Sep-1994	$ 20,752	Dept referred to Justice Dept. 12/98
HRSA	07-90-06845	Model Cities Health Corp.	Oct-1990	41,406	Under appeal, 10/97
				144,066	**Subtotal, HRSA**
IHS	05-99-60620	Red Cliff Band of Lake Superior Chippewa Indians	Jul-1999	1,459	Pursuing collection
IHS	07-99-54163	Ponca Tribe of Nebraska	May-1999	141,475	Pursuing collection
IHS	08-99-55284	South Dakota Urban Indian Health	Jun-1999	902,046	Pursuing collection
IHS	08-99-55285	South Dakota Urban Indian Health	Jun-1999	902,377	Pursuing collection
IHS	08-99-56446	Sisseton-Wahpeton Sioux Tribe	May-1999	5,843	Pursuing collection
IHS	08-00-56759	South Dakota Urban Indian Health	Nov-1999	10,933	Pursuing collection
IHS	08-00-59899	South Dakota Urban Indian Health	Nov-1999	5,496	Pursuing collection
IHS	08-00-61777	Turtle Mountain Band of Chippewa Indians	Nov-1999	104,590	Pursuing collection
IHS	09-00-58580	Tohono O'Odham Nation	Nov-1999	6,456	Pursuing collection
IHS	05-00-60452	St. Croix Chippewa of Wisconsin	Dec-1999	26,363	Pursuing collection
IHS	05-00-60454	St. Croix Chippewa of Wisconsin	Dec-1999	224,452	Pursuing collection
HIS	09-00-60032	Lovelock Paiute Tribe	Dec-1999	74,187	Pursuing collection
IHS	09-00-60444	Yomba Shoshone Tribe	Dec-1999	64,030	Pursuing collection
IHS	10-00-59080	Norton Sound Health Corporation	Dec-1999	15,000	Pursuing collection
IHS	08-00-60654	Spirit Lake	Jan-2000	22,031	Pursuing collection
IHS	09-00-60443	Yomba Shoshone Tribe	Jan-2000	41,373	Pursuing collection
IHS	10-00-62761	Burns Paiute Tribe	Feb-2000	53,516	Pursuing collection
IHS	09-00-62572	Fresno Indian Health Assoc., Inc.	Feb-2000	10,720	Pursuing collection
IHS	08-00-61852	Native American Services Agency	Feb-2000	2,575	Pursuing collection
IHS	09-00-61853	Fresno Indian Health Assoc., Inc.	Mar-2000	11,963	Pursuing collection
IHS	07-00-63881	Santee Sioux Tribe of Nebraska	Apr-2000	10,187	Pursuing collection
IHS	10-00-63684	Hoh Indian Tribe	Apr-2000	13,602	Pursuing collection
				$ 2,650,674	**Subtotal, IHS**
NIH		None		0	
				$ 0	**Subtotal, NIH**
OS	06-98-53934	Osage of OK	Feb-1999	577	Transferred to the Treasury Offset Program

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected

As of September 30, 2001

OPDIV	Audit Report Number	Auditee	Date Issued	Amount (in dollars)	Comments
OS	08-86-43199	American Indian Healthcare, Inc.	Jan-1997	$ 12,696	Transferred to the Treasury Offset Program
OS	08-87-05251	Devil Lake	Sep-1993	50,333	Transferred to the Treasury Offset Program
OS	08-99-59826	Crow Creek Sioux Tribe	Feb-2000	14,448	Transferred to the Treasury Offset Program
OS	09-93-24906	CA Institute	Apr-1994	56,758	Transferred to the Treasury Offset Program
OS	09-96-39220	Public School	Apr-1996	4,396	Transferred to the Treasury Offset Program
OS	09-98-51231	Tonto Apache	Oct-1998	2,257	Transferred to the Treasury Offset Program
OS	09-98-52613	Marianas	Dec-1998	639,432	Transferred to the Treasury Offset Program
OS	09-99-57597	Bear River Band	Mar-2000	1,648	Transferred to the Treasury Offset Program
OS	10-93-22826	Nooksack Indian	Nov-1993	3,323	Transferred to the Treasury Offset Program
OS	10-00-57229	State of Oregon	Sep-1999	6,479	Transferred to the Treasury Offset Program
OS/OPA	09-93-26171	Tohono O'Odham Nation	Mar-1994	57,090	Pursuing collection
				$ 849,437	**Subtotal, OS**
PSC	03-90-00453	State of W.V.	Mar-1991	12,850,856	At District Court, collection suspended on 3/97.
				$ 12,850,856	**Subtotal, PSC**
SAMHSA	04-04183	Columbus Co. Services Mgmt.	Jul-1994	35,167	Pursuing collection
SAMHSA	01-51136	United Maine Families	Jan-2000	9,535	Pursuing collection
SAMHSA	09-40113	Marianas Assoc. for Retarded Citizens	May-1996	1,023	Pursuing collection
SAMHSA	09-48966	Karidat	Sep-1997	8,696	Pursuing collection
				$ 54,421	**Subtotal, SAMHSA**
				$423,632,747	**TOTAL, HHS**

Summary of HHS Component Audit Reports Over One Year Old

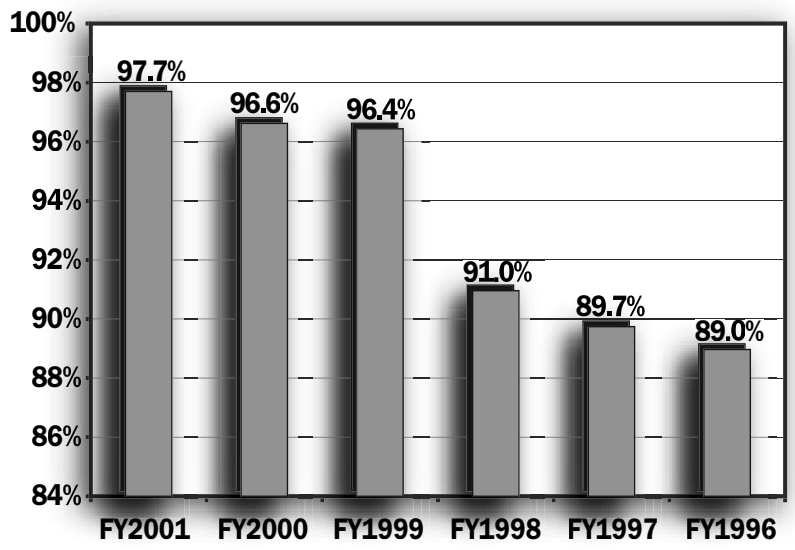
As of September 30, 2001

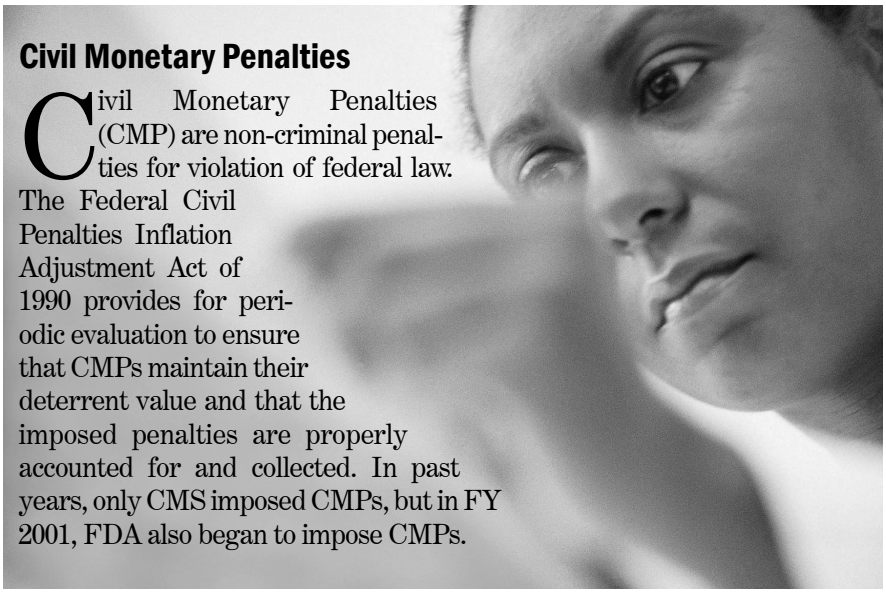
OPDIV	Number of Reports	Amount to be Collected (in dollars)
ACF	120	$86,799,547
DPM	0	0
AOA	0	0
CDC	11	456,241
FDA	0	0
CMS	118	319,827,505
HRSA	9	144,066
IHS	22	2,650,674
NIH	0	0
OS	12	849,437
PSC	1	12,850,856
SAMHSA	4	54,421
Total	**297**	**$423,632,747**

Appendix H - Prompt Pay

Since FY 1996, HHS has shown increasing rates of on-time payments. In FY 2001, HHS achieved a department-wide record by making over 97 percent of its payments on time.

HHS Percentage of On-time Payments





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 CMPs maintain their deterrent value and that the imposed penalties are properly accounted for and collected. In past years, only CMS imposed CMPs, but in FY 2001, FDA also began to impose CMPs.

U.S. Department of Health and Human Services

Fiscal Year Ended September 30, 2001

Outstanding Receivables	Number	Amount (in dollars)
Beginning FY 2001 Balances	388	$260,489,435
Assessments (+)	1,105	1,037,815,758
Collections (-)	(958)	(720,766,343)
Adjustments	(30)	(43,224,629)
Amounts Written Off	(1)	(31,722)
Ending Balance	**504**	**$534,282,499**
a. Current Receivables	493	361,899,557
b. Non-Current Receivables	4	50,005,392
Allowance	0	(190,231,505)
Net Receivables	504	344,050,994
Total Delinquent	**406**	**$186,568,070**
Total Non-Delinquent	**94**	**$347,714,429**

Appendix J - Highlights of HHS Budgetary Outlays

In FY 2001, HHS had net outlays of $426.4 billion, representing 22.9 percent of all net outlays. This represents an increase from $382.6 billion (21.4 percent of net federal outlays) in FY 2000. Only the Social Security Administration (which became independent from HHS in 1995) exceeded HHS spending in FY 2001.

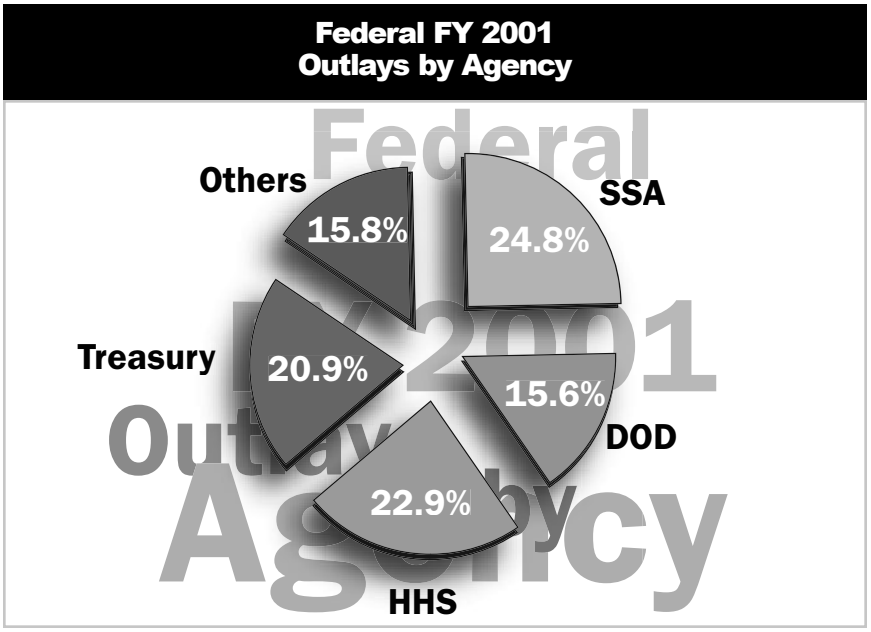
Growth and the Balance Sheet

The portion of the federal budget allocated to HHS has grown significantly over the last three decades. The nature of the HHS entitlement programs is the reason for the growth in spending. We cannot limit the number of enrollees in our programs; every individual who meets the programs' criteria must be enrolled. Nine out of every ten HHS dollars are now spent on entitlements.

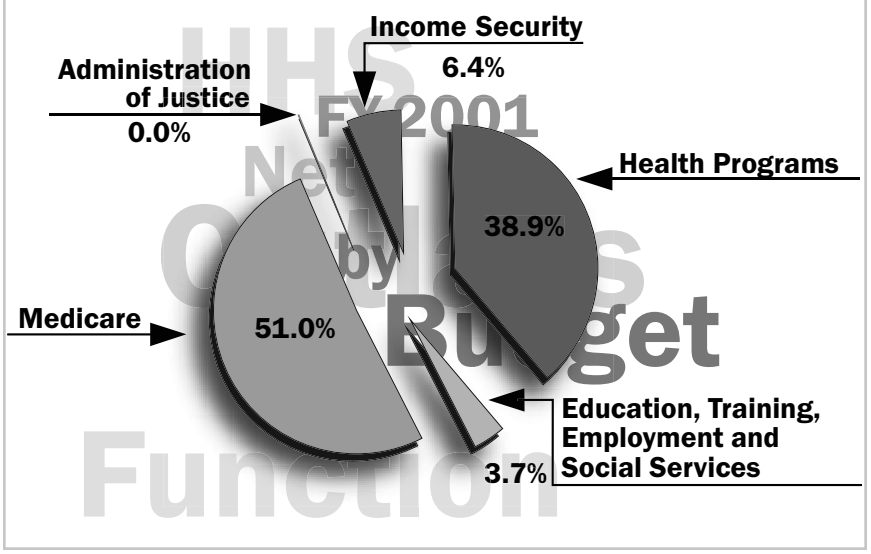
When the Medicare and Medicaid entitlement programs were enacted in 1966, HHS net outlays accounted for only 4 percent of federal net outlays. As the ranks of the enrollees and beneficiaries of these entitlement programs has swelled along with the increasing costs of healthcare treatment, the impact on the federal budget has been quite significant. The net outlays for Medicare alone now account for 11.7 percent of the federal budget.

Agencies and Allocations

HHS dollars are allocated to the HHS agencies across budget functions. The

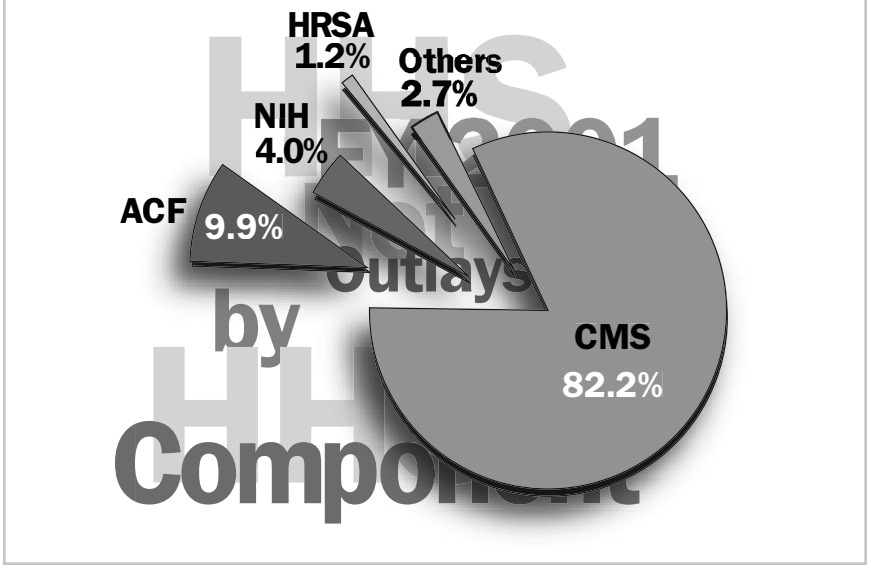


HHS FY 2001 Net Outlays by Budget Function



We cannot limit the number of enrollees in our programs; every individual who meets the programs' criteria must be enrolled. Nine out of every ten HHS dollars are now spent on entitlements.

HHS FY 2001 Net Outlays by Component



accompanying matrix chart of "HHS FY 2001 Net Outlays by Budget Function and HHS Agency" details this distribution and facilitates the identification of concentrations of outlays. The largest single budget function is Medicare (which has a category all its own), with $217.4 billion in spending. The second largest functional category, at $165.8 billion, is Health where most of the funds are spent by CMS (for Medicaid) and by NIH (for research). ACF has the bulk of responsibility for budget function dollars categorized as Education, Training, Employment and Social Services, and also for Income Security through the Temporary Assistance for Needy Families and Child Support Enforcement programs.

Program Spending

Measured by program spending, CMS is by far the largest of the HHS agencies, followed by ACF, then NIH, HRSA, CDC, SAMHSA, and other HHS agencies. The relative portion of total HHS net outlays by component is illustrated in the accompanying pie chart.

Outlays by budget function are largely concentrated in the Medicare and Health (which includes Medicaid) budget functions.

Readers' Note

Readers will note that the Statement of Net Cost allocates costs by HHS agency and by budget function. Costs reported will be concentrated in a similar fashion as the budget figures, noted above, for net outlays reported in this section of the Accountability Report.

Source: Final Monthly Treasury Statement of Receipts and Outlays of the United States Government. (Treasury includes interest on debt.)

U.S. Department of Health and Human Services

Fiscal Year Ended September 30, 2001

(in millions)

HHS Agency	FY2001	FY2001	FY2000	FY1999	FY1998	FY1997	FY1996	FY1995	FY1994	FY1993	FY 1992
Food and Drug Administration	$1,073	0.3%	$1,022	$950	$837	$873	$865	$858	$801	$733	$752
Health Resources and Services Administration	5,123	1.2%	4,312	3,860	3,473	3,526	3,960	2,612	2,695	2,467	2,333
Indian Health Service	2,553	0.6%	2,375	2,193	2,145	2,139	1,997	1,975	1,771	1,699	1,522
Centers for Disease Control and Prevention [4]	3,300	0.8%	2,530	2,428	2,409	2,248	2,166	1,785	1,570	1,410	1,198
National Institutes of Health	17,239	4.0%	15,405	13,802	12,486	11,171	10,209	10,875	10,148	9,532	8,374
Substance Abuse and Mental Health Services Administration	2,737	0.6%	2,499	2,214	2,235	1,622	2,084	2,444	2,371	2,667	N/A
Agency for Healthcare Research and Quality [5]	33	0.0%	51	79	77	110	81	133	111	84	113
Centers for Medicare and Medicaid Services [6]	350,382	82.2%	316,139	299,014	294,016	285,523	266,164	248,920	225,967	205,687	186,743
Administration for Children and Families	42,224	9.9%	36,505	33,624	31,584	31,023	31,023	31,993	31,354	27,545	26,703
Office of the Secretary	568	0.1%	768	377	233	206	195	275	221	223	165
Administration on Aging	952	0.2%	884	879	828	828	818	951	859	820	544
Program Support Center	260	0.1%	137	280	247	224	240	N/A	N/A	N/A	N/A
HHS Subtotal	**$426,444**	**100.0%**	**$382,627**	**$359,700**	**$350,570**	**$339,493**	**$319,802**	**$302,821**	**$277,868**	**$252,867**	**$228,447**
"Old" HHS agencies that no longer exist as separate agencies in HHS:											
OASH [1]								254	233	227	248
SSA [2]									346,617	328,028	307,819
ADAMHA [3]											2,865
HHS Total	**$426,444**		**$382,627**	**$359,700**	**$350,570**	**$339,493**	**$319,802**	**$303,075**	**$624,718**	**$581,122**	**$539,379**

[1] OASH accounts were merged into OS and PSC in FY 1996.

[2] SSA separated from HHS at end of FY 1994.

[3] Three components of ADAMHA were transferred to NIH and rest of ADAMHA became SAMHSA.

[4] Includes outlays for the Agency for Toxic Substances and Disease Registry (ATSDR) beginning in FY 2001 when direct appropriations were provided to HHS.

[5] Agency name changed from the Agency for Health Care Policy and Research pursuant to Public Law 106-129 enacted on 12/6/99.

[6] Agency name changed from the Health Care Financing Administration (HCFA) in June 2001.

N/A Not Applicable

Notes: Prior to FY 2001, ATSDR's expenditures were included in HHS financial statements but excluded from HHS outlay figures because they were included under the Natural Resources budget function in EPA's outlay figures. Direct appropriations were provided to HHS for ATSDR beginning in FY 2001 and these outlays are now included with CDC's Health budget function.

U.S. Department of Health and Human Services

Fiscal Year Ended September 30, 2001

(in thousands)

HHS Agency	Education, Training, Employment, and Social Services	Health	Medicare	Income Security	Administration of Justice	TOTAL
Centers for Medicare & Medicaid Services	$ -	$132,951, 604	$217,430,146	$ -	$ -	$350,381,750
Administration for Children and Families	14,754,583			27,381,962	87,651	42,224,196
National Institutes of Health		17,239,391				17,239,391
Health Resources and Services Administration		5,122,662				5,122,662
Centers for Disease Control and Prevention		3,272,483			27,350	3,299,833
Substance Abuse and Mental Health Svs. Adm.		2,736,945				2,736,945
Indian Health Service		2,552,516				2,552,516
Food and Drug Administration		1,073,294				1,073,294
Administration on Aging	951,781					951,781
Office of the Secretary		567,743				567,743
Program Support Center *		260,097				260,097
Agency for Healthcare Research and Quality		33,460				33,460
HHS Subtotal	**$15,706,364**	**$165,810,195**	**$217,430,146**	**$27,381,962**	**$115,001**	**$426,443,668**

* Though PSC's services are fee-based and self-sustaining, net outlays shown include $240,502 for Retirement Pay and Medical Benefits for Commissioned Officers with the remainder attributable to the HHS Service and Supply Fund and miscellaneous trust funds.

Note: The FY 2001 financial statements' supplemental schedules present data under six budget functions, rather than just the five shown here. This is because ATSDR's expenditures are shown under the Natural Resources and Environmental budget function in HHS financial statements.

Source: *Combined Statement of Receipts, Outlays, and Balances of the United States Government, Fiscal Year 2001*. $102 billion in receipts (proprietary receipts from the public and intrabudgetary transactions) have been distributed to appropriate HHS components based on detailed amounts in the September Monthly Treasury Statement. While the total HHS outlay reported by Treasury includes these receipts, the Statement of Budgetary Resources does not. Therefore, these receipts may be netted against total outlays reported in the Statement of Budgetary Resources to bridge the net outlay figure reported by Treasury.

Financial Management Strategic Goal I

Decision-makers have timely, accurate, and useful program and financial information.

Measure	Baseline	PERFORMANCE TREND					FY 2001 Target	Performance/Comments
		FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual		
Audited financial statements for HHS and CMS are submitted to OMB by submission due date.	1996: No	No	Yes	Yes	Yes	Yes	Yes	Did not meet 2/1/02 pilot due date. Expect to sumbit statements to OMB and Congress by 2/27/02.
Clean Opinion = Yes; Other = No	1996: No	No	No	Yes	Yes	Yes	Yes	See auditor's opinion in Section III.
Number of department-level material weaknesses.	1996: 5	5 Monitoring Medicare fee-for-service rate; Medicare payables; financial reporting; grant accounting; and EDP.	3 Medicare accounts receivable; Medicare electronic data processing (EDP); and financial reporting.	3 Medicare accounts receivable Medicare EDP; and financial reporting.	2 Financial systems and processes and Medicare EDP.	2 Financial systems and processes and Medicare EDP.	2 Financial systems and processes and Medicare EDP controls.	See auditor's opinion in Section III.
Number of department-level reportable conditions.	1997	3 Property, plant, and equipment; grant monitoring using single audit reports; and estimating losses from pending litigation.	5 Accounts payable; Medicaid estimated improper payments; EDP; property, plant, and equipment;and estimating losses from litigation.	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.	2 Medicaid improper payments and EDP.	See auditor's opinion in Section III.
Submit *Accountability Report* to OMB by submission due date.	1997	No	Yes	Yes	Yes	Yes	Yes	Did not meet 2/1/02 pilot due date. Expect to submit report to OMB and Congress by 2/27/02.
Percent of grant administration policies that are current.	1998	N/A	75%	85%	93%	96%	100%	Goal substantially achieved. The remaining GPDs to be updated are limited to previously issued directives that are scheduled tobe reevaluated based on a 4-year review cycle.
Percent of vendor payments made on time.	1997	89.7%	91.0%	96.4%	96.6%	97.7	96% (Revised)	See Appendix H of this report
Vendor payments via Electronic Fund Transfer (EFT).	1997	42%	77%	85%	86%	88%	90%	

Financial Management Strategic Goal II

All resources are used appropriately, efficiently, and effectively.

Measure	Baseline	PERFORMANCE TREND					FY 2001 Target	Performance/Comments
		FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual		
Travel payments via EFT.	1997	43%	90%	93%	95%	96%	100%	
Percent of individually billed travel accounts that are past due 61 or more days.	2000	N/A	N/A	N/A	11.1%	3.5%	5% (Revised)	While 3.5% of individually billed dollar balances were delinquent 61 days or more at FY end, this represented only 1.1% of card holders. Targets are likely to be adjusted downward in the future, but began high to reflect delinquent rates associated with the program early on.
Percent of centrally billed travel accounts that are past due 61 or more days.	2000	N/A	N/A	N/A	27.5%	15.5%	1% (Revised)	While fiscal year end dollar balances of centrally billed accounts past due 61 days or more stood at 15.5%, the next month (10/01) it dropped to approximately 6.0%
Percent of eligible purchase transactions made on credit cards.	1997	77%	70%	85%	84%	84%	87%	
Increase percent of debt collection over prior year.	1998	N/A	$13.3 billion	$14.27 Billion 7% Increase	$15.3 Billion 7.2% Increase	$14.4 Billion 5.8% decrease	10% Increase	While fiscal year and dollar collections decreased, the total receivables dollar balance decreasd by $1.2 Billion
Percent of eligible non-waived delinquent debit referred for cross-servicing to the Treasury.	1998	N/A	0%	22.8%	41.9%	67.8%	100%	Though we did not achieve our target of 100%, we made significant improvements over FY 2000.
Percent of eligible waived delinquent debt referred to PSC for cross-servicing.	1999	N/A	N/A	3.7%	26.2%	46.7%	100%	Though we did not achieve our target of 100%, we made significant improvements over FY 2000.
Percent of eligible delinquent debt referred to the Treasury for offset.	1998	N/A	20.2%	10.5%	34.2%	59.1%	100%	Though we did not achieve our target of 100%, we made significant improvements over FY 2000.
Percent of information technology (IT) investments approved by the ITIRB met review criteria.	1999	ITIRB	Two meetings with ITIRB were held.	100%	100%	100%	100%	100% of investments reviewed by the ITIRB met review criteria in FY 2001.

Financial Management Strategic Goal II – Continued

Measure	Baseline	PERFORMANCE TREND					FY 2001 Target	Performance/Comments
		FY 1997	FY 1998	FY 1999	FY 2000	FY 2001 Actual		
HHS-wide critical IT services , (WAN Internet, Data Center(s), email and telephone) are available to enableHHS mission and program operations.	2001	N/A	N/A	N/A	N/A	96%	96%	New measure for FY 2001. HHS cannot perform its critical missions without the constant availability of IT support services. Target was met for FY 2001.
Develop e-business systems targets and track the department-wide implementation of electronic commerce.	2000	N/A	N/A	N/A	Establish plan.	100%	Begin to track targets.	New measure for FY 2001. The measure indicates the degree of implementation of HHS electronic business.
Develop and issue policy for securing both Internet and external communications.	2001	N/A	N/A	N/A	N/A	PKI policy Issued	Issue PKI policy on certification authority concept of operation.	New measure for FY 2001. The Public Key Infrastructure (PKI) technology is critical to closing security vulnerability.
Location accuracy of capitalized personal property records.	1998	N/A	90%	97%	97%	97%	96%	Exceeded target.
Reduce energy consumption at HHS standard office facilities.	1985	N/A	N/A	N/A	17.5%	14.8%	20.0%	In prior years, standard and energy intensive statistics were combined to 1985 baseline per Executive Order (EO) 13123.
Reduce energy at HHS energy intensive facilities.	1990	N/A	N/A	N/A	12.3%	12.8%	13.3%	In prior years, the standard and energy intensive statistics were combined. FY 2001 reduction is compared to 1990 baseline per EO 13123.
Percent of apportionments approved within three weeks.	1997	46.0%	45.9%	76.6%	65.4%	71.4%	75.0%	
Percent of apportionments approved within four weeks.	1997	70.0%	56.8%	91.0%	77.0%	84.5%	90.0%	
Number of financial management training hours offered times the number of attendees at ASBTF sponsored training sessions.	1998	N/A	480 Hours	2540 Hours	1606 Hours	560 hours	2000 Hours	The ASBTF/Finance Office awarded 560 CPE hours during FY 2001. The reduction in hours from FY 2001 are a result of, 1) fewer budget execution courses being offered, and 2) the Spring Training was reduced from two full days to one day.
Number of HHS components with succession planing strategies for financial management staff.	1998	N/A	2 HRSA, NIH	3 HRSA, NIH, and PSC	3 HRSA, NIH, and PSC	2 HRSA, PSC	5 CMS, FDA, HRSA, NIH and PSC	

Many of the popular government programs are found under the umbrella of the Social Security Act. While the original act provided only retirement benefits, there have been numerous amendments over the years, both minor and major, to that act.

Legislation

NOTE: The following list has been divided into two sections: Selected Program Legislation and Financial Management Legislation. The program legislation cited is representative and covers the highest dollar programs in the Department including Medicare, Medicaid, and Temporary Assistance for Needy Families.

Selected Program Legislation

The Social Security Act of 1935

Many of the most popular government programs are found under the umbrella of the Social Security Act. While the original act provided only retirement benefits, there have been numerous amendments over the years, both minor and major, to that act. The Social Security Administration (SSA) oversees the retirement, disability, and survivor programs, while the titles of the act dealing with health and human services are administered by HHS. The largest of these programs are as follows:

- *Medicare, established in 1965, is the federal health insurance program for people age 65 or older and people under age 65 who are disabled or suffer from end-stage renal disease (ESRD);*

- *Medicaid, also established in 1965, is a jointly funded, federal-state program that provides medical assistance to certain groups of low-income people and others with special health care needs;*

- *The State Children's Health Insurance Program (SCHIP) is a partnership between the federal and state governments that will help provide children with the health coverage they need to grow up healthy. The Balanced Budget Act of 1997 created SCHIP under Title XXI of the Social Security Act;*

- *The Temporary Assistance for Needy Families (TANF) block grant, a single capped entitlement program, provides funds to states to design creative programs to help families move from welfare to self-sufficiency. Under TANF, recipients must engage in work activities to receive time-limited assistance. It was enacted in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Public Law 104-193); and*

- *The Child Support Enforcement (CSE) program is a joint federal, state and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders.*

The Head Start Act of 1981

The Head Start Act was passed as part of the Omnibus Budget Reconciliation Act (OBRA) of 1981. Head Start ensures that low-income children start school ready to learn.

The Prescription Drug User Fee Act of 1992

The Prescription Drug User Fee Act (PDUFA) authorizes the collection of user fees for reviewing drug applications and was reauthorized as part of the FDA Modernization Act of 1997. The Food and Drug Administration (FDA) is authorized to collect approximately $150 million in user fees each year.

Financial Management Legislation

Federal Managers' Financial Integrity Act of 1982

The Federal Managers' Financial Integrity Act (FMFIA) of 1982, Public Law 97-255, was signed into law September 8, 1982 to amend the Accounting and Auditing Act of 1950. It requires ongoing evaluations and reports on the adequacy of the systems of internal accounting and administrative controls of each executive agency.

Chief Financial Officers Act of 1990

The Chief Financial Officers (CFO) Act of 1990 focused attention on financial management improvements in the federal government by requiring the identification of a responsible official to oversee financial management. The law created a framework for financial organizations to focus on the integration of accounting, budget and other financial activities under one umbrella, the preparation of audited financial statements, and the integration of financial management systems. It also requires federal agencies to prepare a CFO strategic five-year plan. The act required 14 Cabinet–level Departments and ten major agencies to establish the position of a CFO who reports to the agency head.

Government Performance and Results Act of 1993

The Government Performance and Results Act (GPRA) which was fully implemented beginning in FY 1999, has placed new management expectations and requirements on federal agencies by creating a framework for more effective planning, budgeting, program evaluation and fiscal accountability for federal programs. The intent of the Act is to improve public confidence in federal agency performance by holding agencies accountable for achieving program results and to improve Congressional decision making by clarifying and stating program performance goals, measures, and costs up front. Federal agencies are required to implement GPRA through their processes for strategic plans, annual performance plans, and annual performance reports. FY 1999 was the first year that annual performance plans were required. Actual accomplishments for FY 2000 were reported in FY 2001. FY 2001 accomplishments will be reported in the GPRA FY 2003 performance plan/FY 2001 performance report.

Government Management Reform Act of 1994

The Government Management Reform Act (GMRA) amends the CFO Act and expands the requirement for audited financial statements to cover all programs. It also provides OMB with the authority to streamline statutory reporting by federal agencies, requires the use of electronic funds transfer for payments to federal employees and beneficiaries, and creates the Franchise Fund Pilot program for studying the concept of government enterprise.

Federal Acquisition Streamlining Act of 1994

The Federal Acquisition Streamlining Act (FASA) of 1994 was enacted to revise and streamline the acquisition laws of the federal government. FASA also expanded the definition of records, placed additional record retention requirements, and gave agencies statutory authority to access computer records of contractors doing business with the government.

Debt Collection Improvement Act of 1996

The Debt Collection Improvement Act (DCIA) of 1996, Public Law 104-134, was signed into law April 26, 1996. The law's provisions have enhanced and improved debt collection government-wide.

Key provisions of the act include the:

- *Enhancement of administrative offset authority, the Treasury Offset Program;*
- *Enhancement of salary offset authority;*
- *Requirement for taxpayer identification numbers;*
- *General extension of the Debt Collection Act of 1982 authorities;*
- *Barring of delinquent debtors from obtaining federal credit;*
- *Reporting to credit bureaus;*

- *Government-wide cross servicing;*
- *Establishment of debt collection centers;*
- *Provision for gainsharing;*
- *Establishment of the tax refund offset program;*
- *Provision for contracting with private attorneys;*
- *Administrative wage garnishment; and*
- *Debt sales by agencies.*

Federal Financial Management Improvement Act of 1996

The Federal Financial Management Improvement Act (FFMIA) of 1996, Public Law 104-208, requires that each agency shall implement and maintain financial 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.

Information Technology Management Reform Act of 1996

Information Technology Management Reform Act (ITMRA) ensures that the federal government's investment in information technology is made and used wisely. The law was designed to increase competition, eliminate burdensome regulations, and help the government benefit from efficient private sector techniques.

ITMRA requires agencies to develop a formal process for maximizing the benefits of information technology acquisition, including planning, assessment, and risk management.

The ITMRA created the statutory position of Chief Information Officer in major federal government agencies. It requires the Office of Budget, Technology, and Finance, the agencies, and the Chief Information Officers to improve information technology practices. It also requires mission and program driven strategic planning for information technology. The ITMRA requires senior management user guidance to ensure information technology activities align with agency plans and operations. It requires regular assessments of information technology skills inventory, skills requirements, and skills development programs. In short, the ITMRA requires the development of an effective and efficient, mission-oriented, user-oriented, results-oriented information technology practice in each and every federal agency.

The Balanced Budget Act of 1997 (BBA 97)

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93)

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90)

A major component of these laws (cited among others) was the emphasis on extending the solvency of the Medicare Hospital Insurance (HI) Trust Fund. These laws reduced Medicare payments to hospitals, skilled nursing facilities and home health agencies, which reduced expenditures from the HI Trust Fund. As a result of these efforts, in combination with other beneficial effects, the HI Trust Fund insolvency date has been pushed back from the year 2003 to 2029. These figures were taken from the Medicare HI Trustees Reports for 1990 and 2001, respectively.

Travel and Transportation Reform Act of 1998

The Travel and Transportation Reform Act of 1998 (TTRA), requires federal employees to use federal travel charge cards for all payment of official government travel, to amend Title 31, United States Code, to establish requirements for prepayment audits of federal agency transportation expenses, to authorize reimbursement of federal agency employees for taxes incurred on travel or transportation reimbursements, and to authorize test programs for the payment of federal employee travel expenses and relocation expenses.

Federal Activities Inventory Reform Act of 1998

On October 19, 1998, the Federal Activities Inventory Reform Act (FAIRA) of 1998 was signed into law. This landmark legislation requires federal agencies to list activities eligible for privatization and to make this list available to the public. FAIRA permits prospective contractors and other interested parties to challenge the omission of particular activities from the list. Nevertheless, although agencies are directed to review the list, FAIRA does not actually require agencies to privatize listed activities. However, the legislation directs agencies to review the activities on the list soon after the list has been made available to the public.

Federal Financial Assistance Management Improvement Act of 1999

The Federal Financial Assistance Management Improvement Act of 1999 (Public Law 106-107) requires OMB and the federal agencies to work together with the various grantee communities to streamline, simplify, and provide electronic options for the grants management processes employed by federal agencies. The purposes of this Act, signed into law on November 20, 1999, are to improve the delivery of services to the public and the effectiveness and performance of federal grant programs. Federal agencies are working with OMB to: 1) develop uniform administrative rules; 2) develop common application and reporting processes; 3) replace paper with electronic processing in administration of grant programs; and 4) identify statutory impediments to grants simplification.

Reports Consolidation Act of 2000

This legislation was enacted to authorize and encourage the consolidation of financial and performance management reports that are more meaningful and useful to the Congress, the President, and the public. The Reports Consolidation Act (RCA) provides for permanent authorization for consolidated reports, permits several alternative approaches to reporting, requires an Inspector General assertion on the agency's progress in addressing the most serious management and performance challenges, and requires the agency head to make an assertion on the completeness and reliability of the performance and financial data in the agency's report(s).

Appendix M - Acronyms

A

A/R	Accounts Receivable
ACF	Administration for Children and Families
ADD	Administration on Developmental Disabilities
ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration (now SAMHSA)
AFS	Automated Financial System
AHCPR	Agency for Health Care Policy and Research
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indians and Alaska Natives
AIDS	Acquired Immuno-Deficiency Syndrome
ANA	Administration for Native Americans
ANDA	Abbreviated New Drug Application
AoA	Administration on Aging
AQRP	Audit Quality Review Program
ARC	Audit Resolution Council
ASAM	Assistant Secretary for Administration and Management
ASBTF	Assistant Secretary for Budget, Technology, and Finance
ASH	Assistant Secretary for Health
ASP	Average Sales Price
ASMB	Assistant Secretary for Management and Budget
ASPE	Assistant Secretary for Planning and Evaluation
ATSDR	Agency for Toxic Substances and Disease Registry
AWP	Average Wholesale Price

B

BBA	Balanced Budget Act
BSE	Bovine Spongioform Encephalopathy

C

CAHPS	Consumer Assessment of Health Plans
CAP	Corrective Action Plan
CARE	Customer Automation and Reporting Environment
CB	Change Control Board
CDA	Child Development Associate
CDC	Centers for Disease Control & Prevention
CDER	Center for Drug Evaluation and Research
CFO	Chief Financial Officer
CIO	Chief Information Officer
CIT	Center for Information Technology
CLIA	Clinical Lab Improvement Act
CMHC	Community Mental Health Centers
CMIA	Cash Management Improvement Act
CMP	Civil Monetary Penalties
CMS	Centers for Medicare & Medicaid Services
CO	Central Office

Appendix M - Acronyms

COLA	Cost of Living Adjustment
CORE	Central Accounting System
COTS	Commercial off the Shelf
CPA	Certified Public Accountant
CPE	Contractor Performance Evaluation
CPI	Consumer Price Index
CPIM	Consumer Price Index Medical
CRADA	Cooperative Research and Development Agreement
CSAT	Center for Substance Abuse Treatment
CSE	Child Support Enforcement
CSRS	Civil Service Retirement System
CVD	Cardiovascular Disease
CWF	Common Working File

D

DAB	Departmental Appeals Board
DBA	Database Administrators
DCA	Division of Cost Allocation
DCFO	Deputy Chief Financial Officer
DCIA	Debt Collection Improvement Act
DCIS	Departmental Contracts Information System
DFO	Division of Financial Operations
DL\NET	Distributed Learning Network
DMAT	Disaster Medical Assistance Team
DME	Durable Medical Equipment
DMERC	Durable Medical Equipment Regional Carriers
DMORT	Disaster Mortuary Operational Response Team
DNA	Deoxyribonucleic Acid
DOI	Department of the Interior
DOJ	Department of Justice
DPM	Division of Payment Management
DSH	Disproportionate Share Hospital Payments

E

EBT	Electronic Benefits Transfer
EC	Electronic Commerce
ECE	Early Childhood Education
ECERS	Early Childhood Environment Rating Scale
EDP	Electronic Data Processing
EEPS	Electronic Entry Processing System
EFT	Electronic Funds Transfers
E-GOV	Electronic Government
EHRP	Enterprise Human Resources and Payroll System
EPA	Environmental Protection Agency
ESRD	End Stage Renal Disease

F

FACES	Family and Child Experiences Survey
FACTSII	Federal Agencies' Centralized Trial Balance System
FAIR	Federal Activities Inventory Reform
FAIRA	Federal Activities Inventory Reform Act
FASA	Federal Acquisition Streamlining Act
FASAB	Federal Accounting Standards Advisory Board
FCR	Federal Case Registry
FDA	Food and Drug Administration
FECA	Federal Employees Compensation Act
FERS	Federal Employees Retirement System
FFMIA	Federal Financial Management Improvement Act
FGSP	Federal Grant Streamlining Program
FI	Fiscal Intermediary
FIB	Financial Management and Investment Board
FICA	Federal Insurance Contributions Act
FISS	Fiscal Intermediary Shared System
FMFIA	Federal Managers Financial Integrity Act
FMS	Financial Management Service
FOH	Federal Occupational Health
FORC-G	Food Outbreaks Response Coordinating Group
FPG	Financial Policies Group
FTE	Full Time Equivalent
FY	Fiscal Year

G

GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GATES	Grants Administration, Tracking, and Evaluation System
GDP	Gross Domestic Product
GISRA	Government Information Security Reform Act
GMRA	Government Management Reform Act
GPD	Grants Policy Directive
GPRA	Government Performance and Results Act
GSA	General Services Administration
GSS	General Support System

H

HACCP	Hazard Analysis and Critical Control Point
HCBU	Historic Black Colleges and Universities
HCFA	Health Care Financing Administration
HEAL	Health Education Assistance Loans
HHA	Home Health Agency
HHS	Department of Health and Human Services
HI	Hospital Insurance

HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immuno-deficiency Virus
HMO	Health Maintenance Organization
HPB	High Performance Bonus
HRSA	Health Resources and Services Administration

I

I/T/U	IHS, Tribal and Urban
IBNR	Incurred But Not Reported
IC	Institute and Centers
ICD	Institutes, Centers and Divisions
IG	Inspector General
IGA	Office of Intergovernmental Affairs
IGAA	Inspector General Act Amendments
IHS	Indian Health Service
IHE	Institutions of Higher Education
IND	Investigational New Drugs
IOM	Institute of Medicine
IPA	Independent Public Accountant
IRS	Internal Revenue Service
IT	Information Technology
ITAS	Integrated Time and Attendance System
ITIRB	Information Technology Investment Review Board
ITMRA	Information Technology Management Reform Act

J

JFMIP	Joint Financial Management Improvement Program

K

KEN	Knowledge Exchange Network

L

M

MACCS	Managing/Accounting Credit Card System
MCBS	Medicare Center for Beneficiary Services
MCH	Maternal and Child Health
MCO	Managed Care Organization
MCS	Medical Carrier System
MDS	Minimum Data Set
MEPS	Medical Expenditure Panel Surveys
MK	Market Based (Securities)
MOU	Memorandum of Understanding
MPARTS	Mistaken Payment and Recovery Tracking System

MSP	Medicare Secondary Payer
MW	Material Weakness

N

N/A	Not Applicable/Not Available
NAS	National Academy of Sciences
NASA	National Aeronautics and Space Administration
NBRSS	NIH Business and Research Support System
NCI	National Cancer Institute
NCCAN	National Center for Complementary and Alternative Medicine
NCHS	National Center for Health Statistics
NDA	New Drug Application
NDEP	National Diabetes Education Program
NDMS	National Disaster Medical System
NEDSS	National Electronic Disease Surveillance Systems
NHSC	National Health Service Corp
NIA	National Institute on Aging
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NIMH	National Institute for Mental Health
NIOSH	National Institute for Occupational Safety and Health
NLM	National Library of Medicine
NPR	National Partnership for Reforming Government
NYC	New York City

O

OACT	Office of the Actuary (CMS)
OASH	Office of the Assistant Secretary for Health
OASDI	Old-Age, Survivors, and Disability Insurance
OBRA	Omnibus Budget Reconciliation Act
OCR	Office for Civil Rights
OCSE	Office of Child Support Enforcement
OGC	Office of General Counsel
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMS	Operating Materials and Supplies
ONDCP	Office of National Drug Control Policy
OPD	Outpatient Department
OPDIV	Operating Division
OPEB	Other Post Employment Benefits
OPHS	Office of Public Health and Science
OPM	Office of Personnel Management
ORB	Other Retirement Benefits
ORR	Office of Refugee Resettlement
ORT	Operation Restore Trust
OS	Office of the Secretary

OS/OPA	Office of the Secretary/Office of Public Affairs
OTT	Office of Technology Transfer

P

PAR	Program Assistance Request
PBC	Performance-Based Contracting
PCIE	President's Council on Integrity and Efficiency
PDD	Presidential Decision Directive
PDUFA	Prescription Drug User Fee Act
PHS	Public Health Service
PIP	Periodic Interim Payment
PL	Public Law
PMC	President's Management Council
PMO	Program Management Office
PMS	Payment Management System
PNS	Projects of National Significance
PP&E	Property, Plant and Equipment
PPS	Prospective Payment System
PRO	Peer Review Organization
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
PSC	Program Support Center

Q

QMB	Qualified Medicare Beneficiary
QWL	Quality of Work Life Initiative

R

RC	Reportable Condition
RCA	Reports Consolidation Act of 2000
RO	Regional Office
RSI	Requires Supplementary Information
RSSI	Required Supplementary Stewardship Information

S

SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Statement of Accounting Standards
SCHIP	State Children's Health Insurance Program
SDN	Secure Data Network
SECA	Self Employment Contributions Act
SES	Socioeconomic Status
SF	Standard Form
SFFAS	Statements of Federal Financial Accounting Standards
SIDS	Sudden Infant Death Syndrome
SLMB	Special Low-Income Medicare Beneficiary
SM	Stockpile Materials

SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facility
SNP	Single Nuccleotide Polymorphisms
SPA	State Plan Amendments
SSA	Social Security Administration
SSF	Service and Supply Revolving Fund
SSP	System Security Plan (CMS)
STAFFDIV	Staff Division
STD	Sexually Transmitted Disease

T

TAGGS	Tracking Accountability in Government Grants System
TANF	Temporary Assistance for Needy Families
TDY	Temporary Duty
TOP	Treasury Offset Program
TROR	Treasury Report on Receivables
TTRA	Travel and Transportation Reform Act

U

UFMS	Unified Financial Management System
UPL	Upper Payment Limits
USDA	United States Department of Agriculture

V

VA	Veterans Administration
VICP	Vaccine Injury Compensation Program

W

WTC	World Trade Center

X

Y

Y2K	Year 2000

Z

Appendix N - References

The following sources have been used to prepare this report. They are in addition to those specifically cited in the report.

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Various Press Releases and information on HHS Websites.

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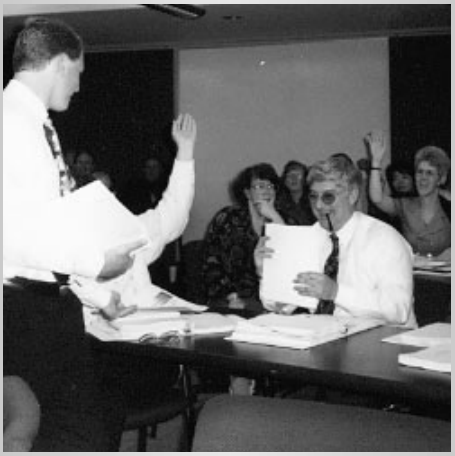

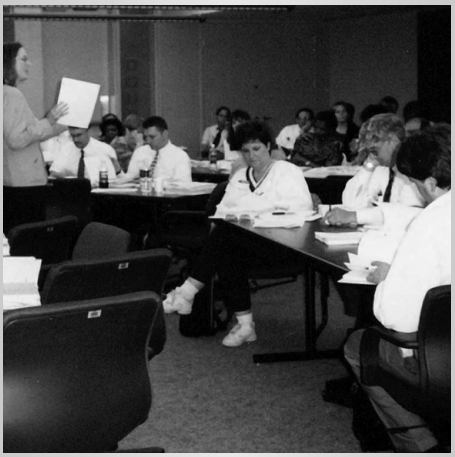

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