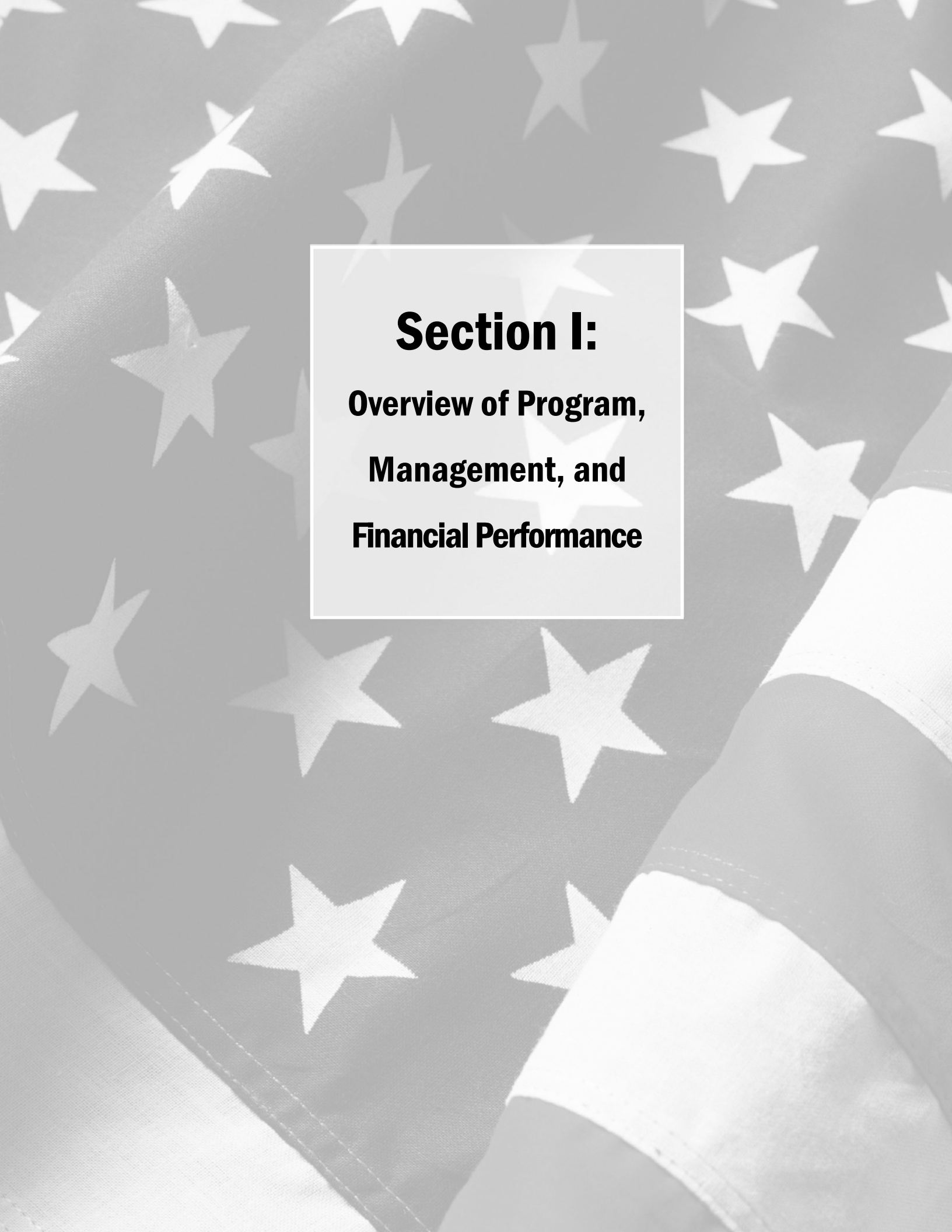


Section I:

Overview of Program, Management, and Financial Performance

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

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

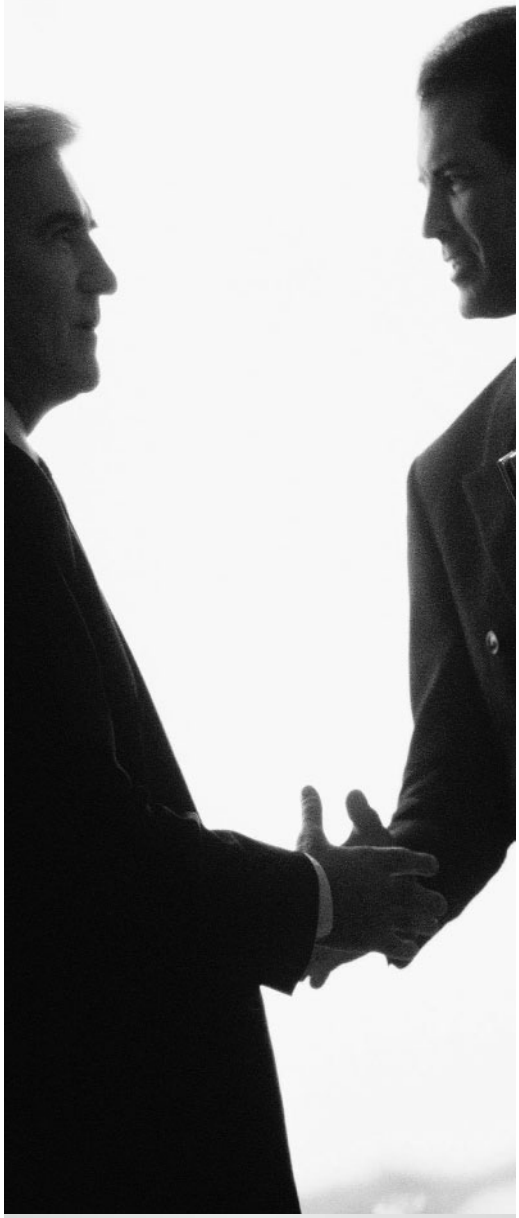
With a new Administration and the events of September 11th, HHS adjusted its priorities. Secretary Thompson has identified specific high priority goals needing urgent attention, including preparedness for bio-terrorism incidents and enhanced food safety. These priorities are consistent with the HHS strategic plan, which contains six broad goal categories for carrying out the HHS mission:

- *Reduce the major threats to the health and productivity of all Americans;*
- *Improve the economic and social well being of individuals, families, and communities in the United States;*
- *Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs;*
- *Improve the quality of health care and human services;*
- *Improve the nation's public health systems; and*
- *Strengthen the nation's health science research enterprise and enhance its productivity.*

Scope of Services

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

- *Conduct and sponsor medical and social science research to improve Americans' health and well being;*
- *Guard against the outbreak of infectious diseases through immunization services and the elimination of envi-*



HHS' Mission

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

ronmental health hazards near people's homes and work places;

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

HHS' Organization: Structured to Accomplish our Mission

HHS is made up of components that administer its many complex and important programs. All of these components and the Program Support Center, which provides centralized administrative support, are under the leadership of the Office of the Secretary of HHS.

Below is a list of each HHS component:

CENTERS FOR MEDICARE & MEDICAID SERVICES (FORMERLY KNOWN AS HEALTH CARE FINANCING ADMINISTRATION)

ADMINISTRATION FOR CHILDREN AND FAMILIES

THE NATIONAL INSTITUTES OF HEALTH

CENTERS FOR DISEASE CONTROL AND PREVENTION

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

FOOD AND DRUG ADMINISTRATION

HEALTH RESOURCES AND SERVICES ADMINISTRATION

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

INDIAN HEALTH SERVICE

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

ADMINISTRATION ON AGING

A more detailed discussion of the Office of the Secretary and each of the components is located in Appendix A.

HHS Partners: Working Together

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

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

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

- *HHS is the largest grant-making agency in the federal government - providing more than $184 billion of the total estimated $325 billion in federal funds awarded to states and other entities in FY 2001;*

✹ *HHS funds more than 50,000 research investigators affiliated with about 2,000 university, hospital, and other research facilities;*

✹ *HHS helps fund and foster a nationwide network of more than 3,000 sites that provided needed primary and preventive care to 10.5 million medically underserved patients last year;*

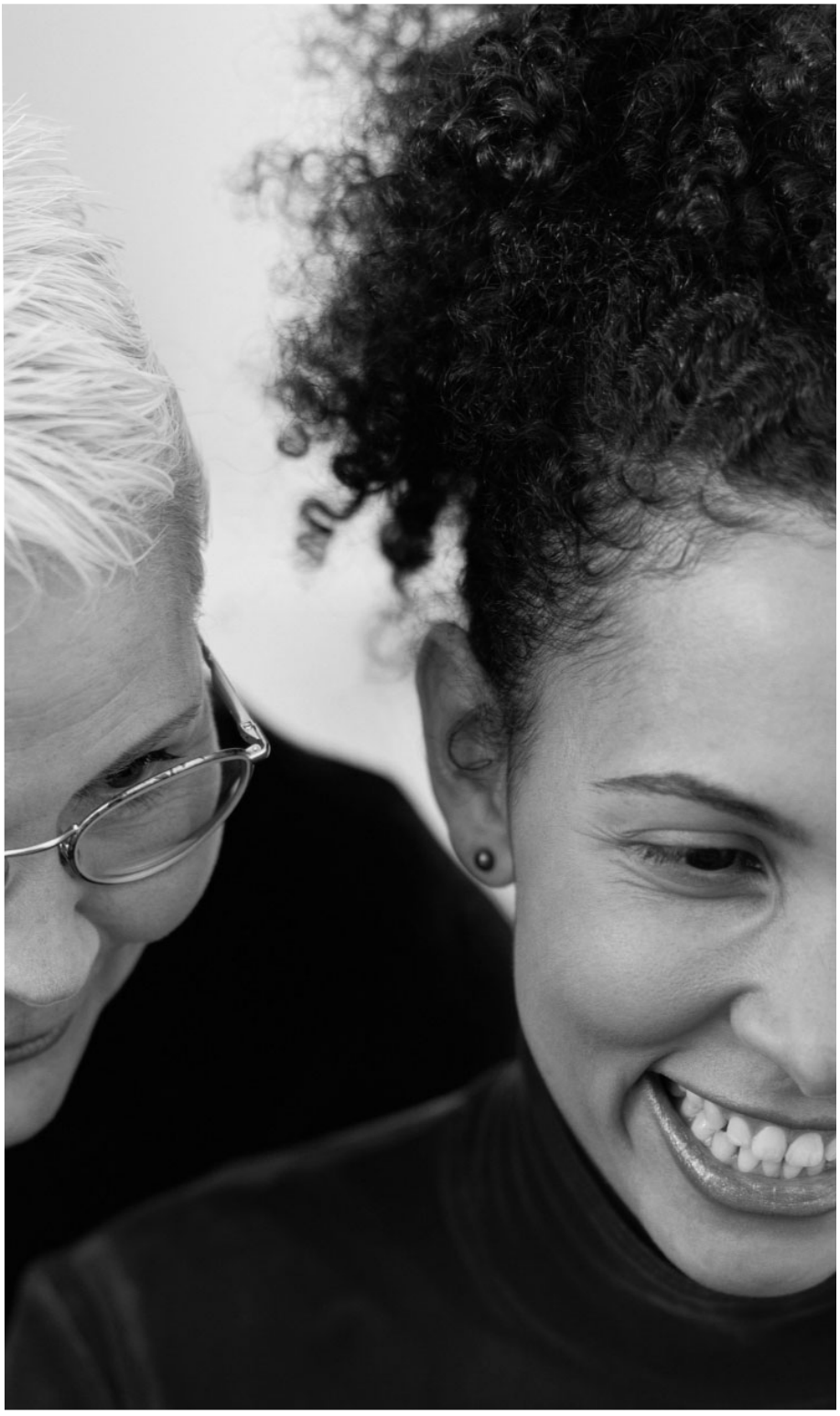
✹ *Another nationwide network that HHS supports is the Aging Network. The Aging Network includes 56 state units on aging, 655 area agencies on aging, 233 tribal and native organizations representing 300 American Indian and Alaska Native tribal organizations, and two organizations serving Native Hawaiians, plus 27,000 service providers and adult care centers, and innumerable caregivers and volunteers;*

✹ *Nation-wide networks of state agencies provide substance abuse and mental health services;*

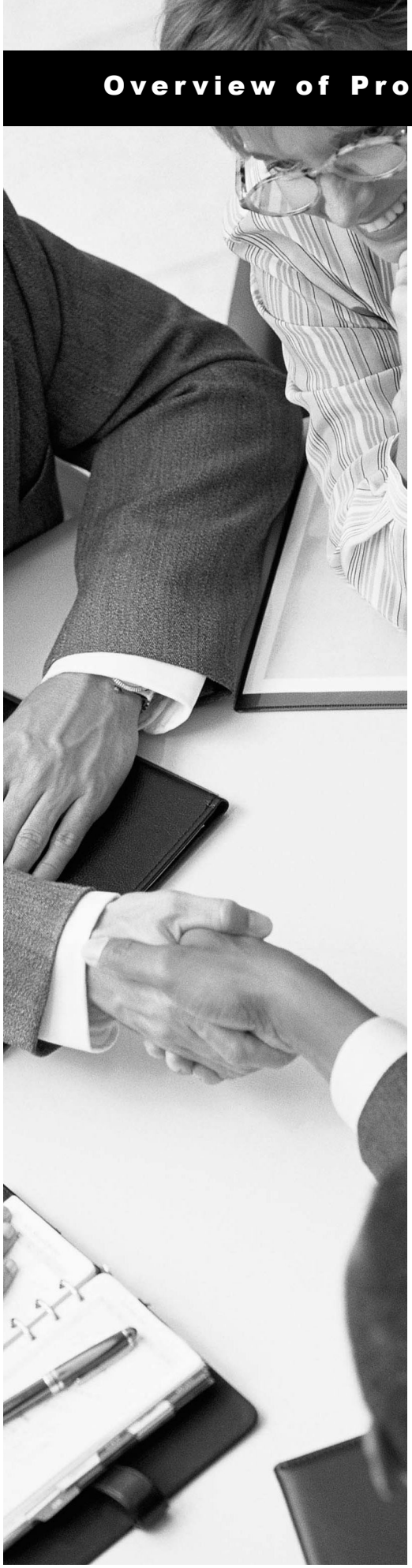
✹ *Nearly 40,000 providers of health care are certified to provide Medicare services and 22,400 employees of 49 Medicare contractors have primary responsibility for processing Medicare claims; and*

✹ *Approximately 18,500 centers and 48,500 classrooms help to provide comprehensive development services with HHS support under the Head Start program for about 905,000 low-income pre-school children, ages birth to five, including approximately 55,000 children under the age of three served through Early Head Start.*

These are just a few examples of the scope of the services that HHS and its partners provide.



Overview of Program Performance



HHS, with the cooperation and effort of other government and non-government organizations, manages over 300 programs that aim to improve the health and well being of Americans.

The key programs, which are discussed in this report, are well known to the American public. They include Medicare, Medicaid, State Children's Health Insurance Program, Temporary Assistance for Needy Families (welfare reform), Child Care, Child Welfare, Child Support Enforcement, and Head Start, as well as Substance Abuse Prevention and Treatment block grants, Infectious Diseases, and Biomedical and Medical Research. Performance on several key Secretarial priorities is also discussed. Many of these programs are interrelated and have multiple purposes; therefore, they may contribute to several goals and objectives.

More information on the relationship of HHS programs with net costs, budget functions, and goals is contained in Appendix B. For more detail regarding criteria and sources for selection, and the relationship to resources for the key HHS program performance information discussed in this report, see Appendix C.

HHS has begun to use more than 750 annual performance goals and many more measures and targets under those goals as a means of directing annual program activities and determining the progress toward those goals. These performance goals and measures assess the processes, outputs, outcomes, and results of the programs. Assessment of HHS' performance can be made by whether targets were met.

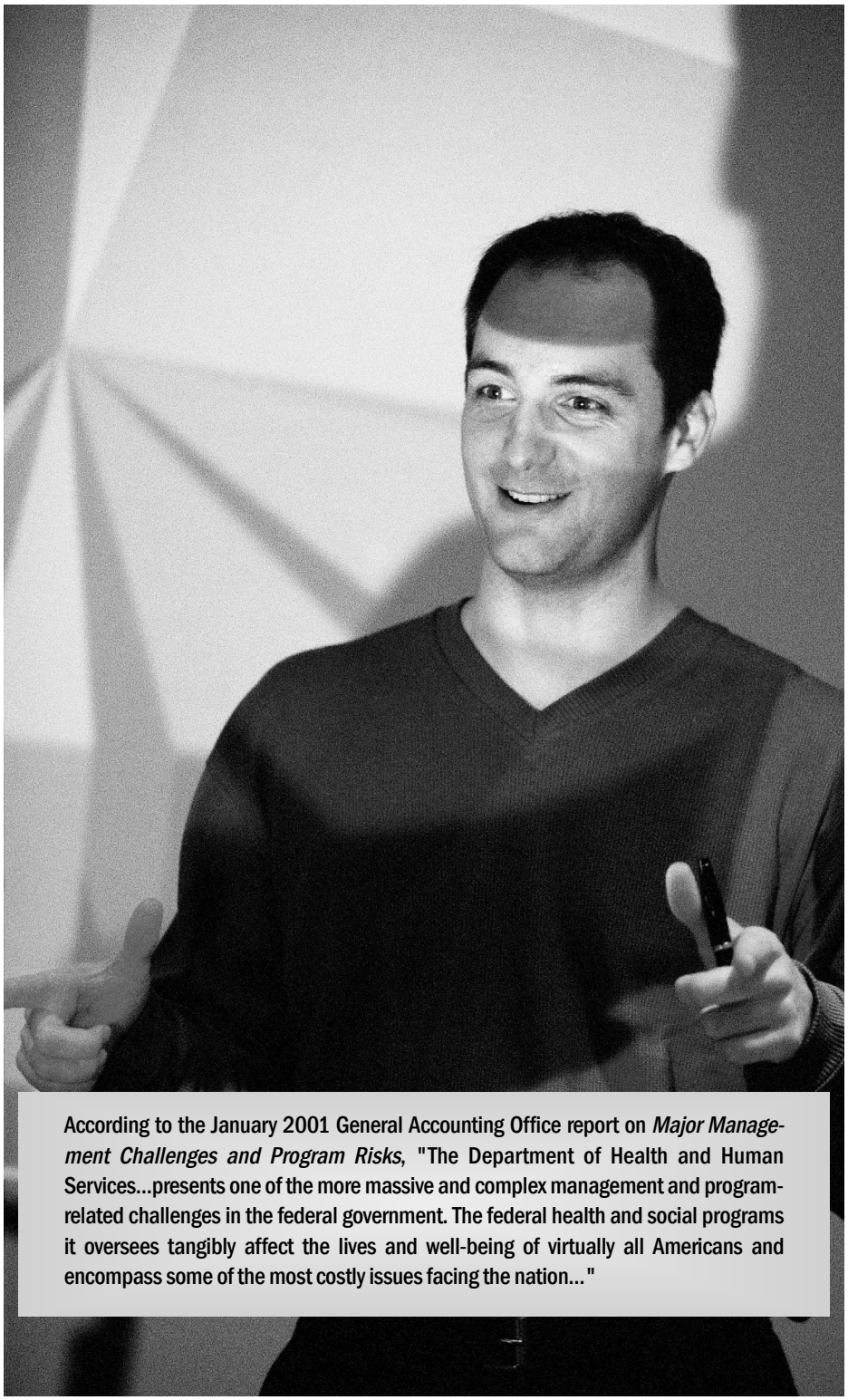
In the discussion of the various programs that follows, it will be clear that for many HHS programs, the targets, outcomes and results can only be achieved with the cooperation and effort of other federal agencies and HHS' many partners. The results discussed here reflect the contributions and efforts of all of these partners.

Third-party government — the delivery of HHS programs via third-party administrative and financing arrangements presents significant challenges for accountability and assessment of performance. Most HHS programs are implemented through grants, cooperative agreements, and contracts with state, local, and tribal governments and non-profit and for-profit organizations. Additional challenges in measuring program

performance may include the nature of the program; the speed with which program benefits can be measured; and delays inherent in relying on program partners to collect and report their data.

The Government Performance and Results Act (GPRA) information presented in this FY 2001 report was the most current data available as of December 1, 2001. The lag in reporting data occurs primarily in programs where HHS must rely on third parties for performance data. In addition, some data collections are not conducted annually. Therefore, assessment of HHS performance can best be determined by a comparison of annual trends from year to year, as more performance information becomes available.

Where FY 2001 data are not available, the report has included activities that indicate HHS' continuing efforts to achieve program performance goals and targets.



According to the January 2001 General Accounting Office report on *Major Management Challenges and Program Risks*, "The Department of Health and Human Services...presents one of the more massive and complex management and program-related challenges in the federal government. The federal health and social programs it oversees tangibly affect the lives and well-being of virtually all Americans and encompass some of the most costly issues facing the nation..."

Response to the September 11th Attacks on America

On September 11, 2001 our nation experienced multiple attacks on our physical infrastructure and our way of life. The Department of Health and Human Services (HHS) has been at the forefront of our nation's response to these tragedies.

In a photograph taken by Deputy Secretary Claude Allen, Secretary Tommy Thompson lends a helping hand in New York City at the Twin Towers disaster.

Our Response to the September Attacks

HHS has overall responsibility for public health in national emergencies. We provided medical personnel and funds for the World Trade Center (WTC) and Pentagon disasters as well as the plane crash site in rural Pennsylvania. Altogether, more than 1,500 HHS personnel were deployed in response to these disasters.

Response was Immediate

✹ *At 9:10 a.m. on September 11, 23 minutes after the WTC was hit, HHS activated the Emergency Operations Center at the Office of Emergency Preparedness in Rockville, MD.*

✹ *At 9:30 a.m. that morning, Secretary Thompson directed that the National Disaster Medical System (NDMS) be placed on a heightened state of readiness. The NDMS provides medical personnel rapidly to support local areas when they need assistance to meet a substantial emergency situation.*

✹ *Secretary Thompson also declared a Public Health Emergency that day, mobilizing the NDMS.*

HHS Agencies Pull Together

While the emergency operations at the three disaster sites were obviously at the forefront of HHS efforts, there was other important recovery work being carried out across HHS by a variety of our HHS components.

✹ *CDC dispatched a 50-ton "Push Package" from the National Pharmaceutical Stockpile to NYC, the first-ever deployment of one of these emergency supply packages.*

✹ *The National Institute for Occupational Safety and Health (NIOSH) conducted sampling for total and respirable dust, silica, asbestos, and volatile organic compounds.*

✹ *CMS issued monetary advances to ten New York area hospitals that experienced problems with cash flow and meeting payrolls.*

DMATs were instrumental in the personnel staging process, as it was imperative that the right people got to the appropriate spot with the right equipment in order for the relief effort to be most effective.

✹ *Immediately following the attacks, ACF, SAMHSA and AOA released $2.5 million in special grants for disaster-related temporary shelter, mental health services, and other services.*

✹ *In addition to the "Push Packages," CDC also provided 84,000 bags of intravenous fluid, 600 portable and stationary ventilators, and other supplies.*

✹ *AOA and CMS jointly established an 800 telephone number for seniors and persons with disabilities who are homebound or have questions or needs related to their health care.*

✹ *SAMHSA reorganized its web page to help parents, teachers, seniors, and others affected by the tragedy to find local mental health and counseling resources.*

✹ *FDA's Northeast Regional Laboratory in Jamaica, Queens, NYC offered lab space to the Customs Service, which used it to analyze a variety of substances, including illicit drugs.*

✹ *CDC deployed 14 workers to assist the NYC Health Department in providing patient care and follow-up needs.*

✹ *IHS provided physicians and nurses to assist with relief efforts in New York City.*

✹ *CDC deployed 35 members of the Epidemic Intelligence Service to hospitals throughout NYC to assist health officials and physicians to monitor diseases. No anomalies were indicated.*

✹ *Special agents with HHS' Office of the Inspector General (OIG), assisted the FBI in conducting investigative leads; agents also served as the HHS liaison to a joint terrorism task force in New York City.*

Meeting the Needs On-Site

While HHS employees were on site in Pennsylvania and at the Pentagon, at least 75 percent of total responders were in New York City.

Of those employees on site at the three locations, the overwhelming majority were involved in either the Disaster Medical Assistance Teams (DMAT) or Disaster Mortuary Operational Response Teams (DMORT) operations.

DMATs operated a number of medical clinics within five blocks of the WTC site. They were also instrumental in the personnel staging process, as it was imperative that the right people got to the appropriate spot with the right equipment in order for the relief effort to be most effective.

DMORTs were instrumental in helping to process and identify victims' remains. DMORT personnel provided 24 hour support to the NYC Medical Examiner in the following capacities: data entry, morgue clean up, photo/scanning, liaison officers, and in supervisory capacities.

Other HHS personnel served important functions during that period:

✹ *Helping to relieve nursing staff at the Presbyterian Hospital burn center;*

✹ *Providing mental health assistance to rescue workers;*

✹ *Veterinary medicine personnel tended to the search dogs assisting with the rescue operation; and*

✹ *Helping to staff the USNS Comfort, which provided meals, respite, and mental health services for responders.*

Response to Bioterrorism

A new threat to the health of the United States population has emerged. For the first time in history, anthrax was used in mail attacks. The surreptitious attacks were discovered early, with leadership from HHS' Centers for Disease Control and Prevention(CDC), which alerted state and local health agencies on September 11 to be watchful.

Unlike explosives or chemical releases, an attack involving biological agents can go undetected for days. Only when individuals present themselves to physicians or clinics with symptoms does any evidence of the attack appear, and even then the initial symptoms might not be recognized and accurately diagnosed. Furthermore, those presenting themselves with symptoms could be at great distances from the original site of exposure by the time symptoms occurred.

Because the anthrax mail attack was detected in October 2001 (i.e, FY 2002), the HHS agencies' actions to protect Americans affected by those attacks, will be reported on more fully in the FY 2002 Accountability Report which covers that period. It is important to note though that HHS had already begun significant expansion of its emergency response capability in recent years. Since 1999, this has included special focus on response to any instances of bioterrorism. Funding and preparedness for bioterrorism had increased in FY 2001, even before the attacks.

This preparation did help HHS' CDC to discover the surreptitious attacks early and to alert state and local health agencies quickly in operating in this uncharted medical terrain. Prior to the fall of 2001, there was little experience, especially in the United States, with the deliberate release of biological agents to cause major disease outbreaks.

HHS has taken countermeasures to fight bioterrorism in five areas:

- *Improving the nation's public health surveillance network, to quickly detect and identify the biological agent that has been released;*
- *Strengthening the capacities for medical response, especially at the local level;*
- *Expanding the stockpile of pharmaceuticals for use if needed;*
- *Expanding research on the disease agents that might be released, rapid methods for identifying biological*

Recent events have shown how rapid response is critical in minimizing the impact of a bioterrorism agent. Tools and capacities for responding are continuing to be enhanced to meet this need.

agents, and improved treatments and vaccines; and

- *Preventing bioterrorism by regulation of the shipment of hazardous biological agents or toxins.*

The responsibility for responding to medical emergencies falls first and heaviest on local communities. Yet many of the special needs in responding to a bioterrorist attack (from the capacity to identify the problem to the availability of appropriate drugs) generally exceed the capacities of local systems. National response resources need to be prepared for use in cooperation with local and state officials and health personnel. Training for such unusual situations also needs to be developed and carried out with federal assistance. New working partnerships between public health, medical, public safety and intelligence agencies are needed.

In FY 2001, nine states and two communities received bioterrorism emergency preparedness grants from CDC for technical and program assistance for assessment, plan development, exercise support, and coordinating services. Fortunately, New York City and Washington, DC were the two communities that received the funding. Their responses in mitigating the adverse health outcomes of the attacks were shaped in some measure by the planning, preparedness, and mock events that were facilitated through the grants. The country's bioterrorism preparedness and response was also bolstered in FY 2001 by $45 million in cooperative agreements to 50 states, Guam, and four major metropolitan health departments (Chicago, Los Angeles, New York City, and Washington, DC). These grants enhanced epidemiological and surveillance capacity, as well as laboratory capacity for providing or gaining access to rapid testing for biologic and chemical agents.

As of this year, seven biologic and 120 chemical toxic substances likely to be used by terrorists can now be measured rapidly. Once these substances are detected, the news must also be communicated rapidly. The Health Alert Network which lays the foundation for a nationwide health alert system of communication of rapid and accurate information in a terrorism event, was expanded in FY 2001 to all 50 states, one territory, and four major metropolitan areas.

All of these CDC activities met or exceeded the performance targets for FY 2001. State and major health department participation targets were a total of 11 states/major health departments for the preparedness grants, 55 for epidemiological and surveillance, and 53 for laboratory capacity. These participation rates have been constant over the past two years with the exception that the laboratory capacity in states and major city laboratories increased by 10 from the FY 2000 capacity. The Health Alert Network also met its target of 55 participants for FY 2001, an increase from 40 the prior fiscal year.

In FY 2001 FDA also received funds that permitted continuing efforts to develop the necessary expertise and infrastructure to address regulatory activities related to the expeditious development and licensing of new vaccines. This will help to treat or prevent outbreaks from exposure to pathogens identified as bioterrorist agents. NIH also conducted multiple evaluations on the status and direction of biomedical research in the areas of bioterrorism prevention and treatment, and evaluated what the nation and NIH should do to support its research.

The dangers of bioterrorism will continue to be a major challenge to public health and healthcare systems. Recent events have shown how rapid response is critical in minimizing the impact of a bioterrorism agent. Tools and capacities for responding are continuing to be enhanced to meet this need.

Ensured Food Safety

An estimated 76 million people fall sick from foodborne illnesses each year. Recent attacks against the nation have heightened awareness that food, especially imported food, could be used as a vehicle for terrorism.

HHS Ensured Food Safety

HHS through the FDA, regulates 80 percent of all food consumed in the United States to promote food safety and reduce or eliminate foodborne illnesses. The task of ensuring a safe food supply has become more difficult because the nature of food and foodborne illness has changed significantly. Foods are technologically more complex; the number of foodborne pathogens has increased fivefold in the past 50 years; consumers are eating more of the foods at higher risk; and our vulnerable populations have increased. In addition to its on-going efforts to safeguard the nation's food supply, recently HHS focused its efforts on preventing mad cow disease and on international cooperation.

Preventing Mad Cow Disease

Bovine spongioform encephalopathy (BSE), also known as Mad Cow Disease, is a brain-wasting disease that affects cattle. The United Kingdom's 180,000 cases of BSE make up the vast majority of cases so far, but to date the United States has not seen any cases of the disease. This is in large part due to the efforts of FDA. Many FDA regulated products contain bovine products in addition to food itself. FDA and its state counterparts continued inspections of renderers, feed mills, ruminant feeders, protein blenders, feed haulers, and distributors in FY 2001 to ensure that BSE did not become a part of the food supply or medical products. In FY 2001, FDA accomplished 37 percent rather than the targeted 50 percent biennial inspection coverage of registered animal drug and feed establishments because resources were shifted to work on the priority BSE inspections. This shift enabled the completion of FDA's goal to inspect 100 percent of renderers,

protein blenders and feed mills and the development of a new goal to inspect 100 percent of renderers, protein blenders and feed mills which handle prohibited material annually, and to conduct sampling of ruminant feeders. Prior to this event, FDA had exceeded its FY 2000 target for inspecting 27 percent of registered animal drug and feed establishments. The FY 2000 result was 39 percent inspected.

To further strengthen the nation's food supply, Secretary Thompson released a four-point action plan in August 2001. The plan will increase protections for Americans against BSE through the coordinated efforts of FDA and Department of Agriculture (inspections), CDC (surveillance), and NIH (research).

U.S/Mexico Cooperative Agreement

The FDA, U.S. Department of Agriculture, and Mexico's Secretar a de Agricultura, Ganader a, Desarrollo Rual, Pesca y Alimentacion (SAGARPA) and Secretar a de Salud signed a cooperative agreement in September 2001 to enhance existing food safety measures through expanding programs, sharing information, and coordinating specific activities. The agreement will operate to share information on the sources of fresh produce and to investigate the causes of any contamination of these products. The USDA's Food Safety and Inspection Service and Foreign Agriculture Service and SAGARPA will take steps to ensure the safety of meat, poultry, and egg products in both countries. These efforts are expected to ensure that borders remain open and that safe products continue to flow freely between the countries. The agencies will also collaborate on other specific projects to achieve common understanding on issues of mutual concern.

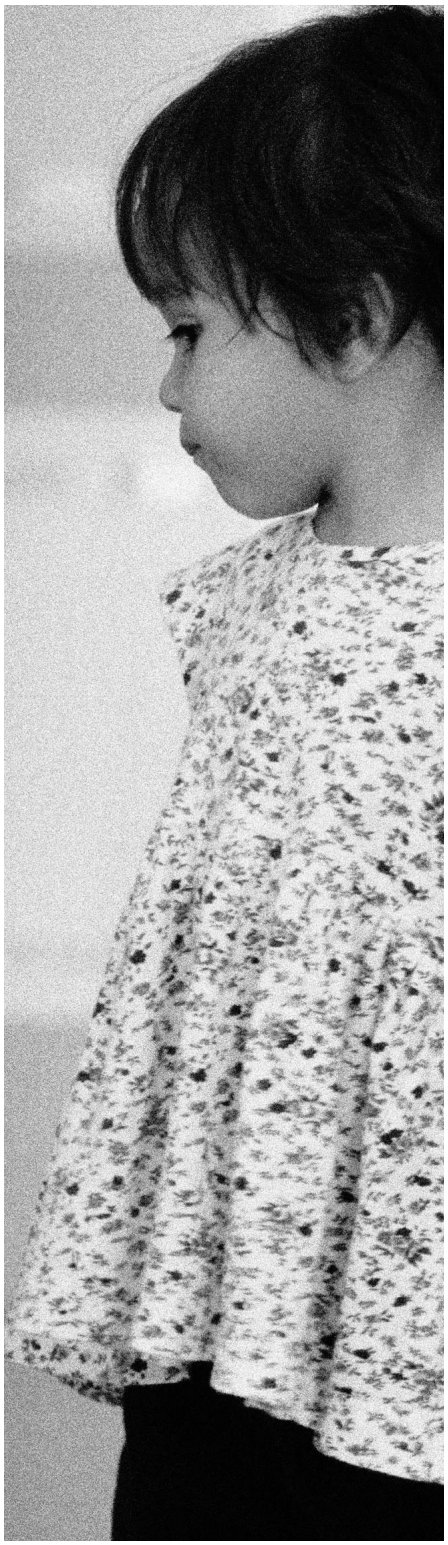
Regulatory Initiatives

In FY 2001 FDA also worked to improve food safety through issuing regulations and guidance including:

- *A compliance policy guide and a field inspection guide on allergens to help in assessing conditions that can cause foods to contact allergens.*

- *A final rule on food labeling, safe handling, and refrigeration of shell eggs for retail establishments such as grocery stores, nursing homes, and restaurants.*

- *A proposed rule concerning food developed through biotechnology.*



Responded to Other Health Threats to Our Nation and Communities

In addition to dealing with terrorist attacks, HHS and its components have continued to address on-going health threats to Americans that affect our daily lives. HHS continues to take a lead role in advancing the overall health of the nation through initiatives to prevent disease, ensure proper nutrition, as well as prevent and treat substance abuse and mental health problems.

As Americans continue with their daily lives, there is good news that life expectancy for Americans reached a record high of 76.9 years in 2000, according to the most recent preliminary figures from CDC. Mortality declined for several of the leading causes of death, namely for heart disease and cancer.

The leading causes of death and disability—heart disease and stroke, cancer, diabetes, and arthritis—are chronic diseases and are among the most prevalent, costly, and preventable of all health problems. More than 90 million Americans live each day with chronic diseases and seven out of ten Americans die of these diseases. The problems are caused in large part, by behaviors established during youth—tobacco use, high-fat diets, inadequate physical activity, drug and alcohol use, and risky sexual behaviors.

Although chronic diseases account for the majority of all United States deaths, infectious diseases remain a leading cause of death worldwide. Earlier predictions of the elimination of infectious disease did not take into account changes in demographics and human behaviors and the extraordinary ability of microbes to adapt, evolve, and develop resistance to drugs. Because of the advances and accessibility of modern transportation, epidemics can jump from city to city and from continent to continent within just hours. HIV/AIDS and the West Nile Virus are just two of the infectious diseases that currently threaten the American population. There is also a continuing need for immunization of children from various infectious diseases and adults from influenza, pneumonia, and Hepatitis B.

Over the past several decades the nation's capability to determine and address potential environmental health threats has eroded. Such threats also continue to pose risks to our health and pose significant challenges to public health and environmental policy makers.

HHS, its components, and many partners continued to direct resources and effort in FY 2001 to address these concerns.

"Americans on average are living longer than ever before, and much of this is due to the progress we've made in fighting diseases that account for a majority of deaths in the country. But we can do more by eating right, exercising regularly, and taking other simple steps to promote good health and prevent serious illness and disease."

-Tommy G. Thompson.

HHS and its components are working with their partners to provide Americans the protection and information necessary to prevent and treat these chronic and infectious diseases, as well as environmental diseases such as asthma.

Heart Disease Prevention

Cardiovascular disease (CVD)—primarily heart disease and stroke—is the nation's number-one killer of men and women across all racial and ethnic groups. More than 40% of deaths in the United States—900,000 each year—are directly attributable to heart disease and stroke, and CVD is the leading cause of death in all states, with associated annual costs exceeding $286 billion.

In FY 2001, state-based cardiovascular health programs were expanded to include 27 states and the District of Columbia. The number of states with five of the seven core prevention capacities that support healthy behavior and appropriate health care also increased. The seven core prevention capacities include partnership development, scientific capacity, policy and environmental strategies, state cardiovascular health plan, training and technical assistance, population-based strategies, and strategies for priority populations.

The performance target for FY 2001 was to have 15 states that have five of the seven core prevention capacities. Although data are not available for FY 2001 until the summer of 2002, the GPRA targets have been exceeded for the prior two years. The FY 1999 and FY 2000 targets of 8 and 11 respectively, were in actual performance, accomplished by 11 and 15 states, respectively. This is a continuing positive trend, which started from a low of 7 states in FY 1998.

In FY 2001 CDC also developed a first-ever, comprehensive resource to assist states' programs in focusing their prevention strategies for men. CDC released a report on "Men and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality." The atlas shows disparities of heart disease death rates among U.S. men aged 35 years and older.

Diabetes Prevention

Nearly 16 million Americans suffer from diabetes, and the number of new cases is increasing steadily by approximately 800,000 per year. Diabetes is the primary cause of new cases of blindness, non-traumatic amputations, and kidney failure in adults. According to the American Diabetes Association, in 1997, the medical expenditures incurred by people with diabetes were $10,071 per capita, compared with $2,669 per capita for people without diabetes.

AN OUNCE OF PREVENTION IS WORTH....

As many as 50,000 U.S. adults die annually of vaccine preventable diseases of influenza, pneumococcal infections, and Hepatitis B, the cost to society exceeds $10 billion each year.

For every $1 spent, childhood vaccines for

Diptheria, Tetanus, and Pertussis save $27.00,

Measles, Mumps, and Rubella save $13.50, and

Chickenpox (Varicella) saves $5.40.

Every 1 to 3 percent reduction in fat intake would reduce the overall incidence of coronary heart disease by 32,000 to 92,700 cases, saving $4.1 billion to $12.7 billion in medical costs and productivity losses over 10 years (US$1993).

A regular exercise regimen would cost only $3,433 per life-year gained (US$1985).

Early detection through screening and timely intervention can reduce the incidence of severe vision loss in diabetic mellitus sufferers by 50 percent to 90 percent. The cost of providing currently suggested screening and treatment of diabetic retinopathy is $1757 per person-year of sight saved.

In addition to the high costs of morbidity and mortality, HIV has high economic costs. The estimated lifetime cost in the U.S. of treating just one person infected with HIV is $155,000. Multiplied by 40,000 persons infected each year, this means additional annualized costs of more than $6 billion every year.

Drug prevention investments and decreases in the prevalence of drug abuse have a direct correlation. Cost benefit ratios range from 8:1 to 15:1 on reduced costs in crime, school and work absenteeism, as well as reduced need for and costs of substance abuse treatment.

Sources: "An Ounce of Prevention...What are the Returns?," 2nd Edition, October 1999, CDC, CDC FY 2003 GPRA plan, and the Office of National Drug Control Policy.

"Americans on average are living longer than ever before, and much of this is due to the progress we've made in fighting diseases that account for a majority of deaths in the country. But we can do more by eating right exercising regularly and taking other simple steps to promote good health and prevent serious illness and disease."

— Tommy G. Thompson

In FY 2001, a landmark study on diabetes was concluded. On August 8, 2001, Secretary Thompson and NIH's National Institute of Diabetes and Digestive and Kidney Diseases announced results of the Diabetes Prevention Program, a major clinical trial comparing diet and exercise to treatment with the diabetes drug metformin in more than 3,200 people with impaired glucose tolerance, a condition that often precedes diabetes. The study showed that people at high risk for type 2 diabetes could sharply lower their chances of getting the disease with diet and exercise. The study proves that diet and exercise-as little as 30 minutes a day-can surpass drug treatment efforts.

Also, on May 4, 2001, the National Diabetes Education Program,(NDEP), a joint federal program run by NIH and CDC, joined forces with CMS to help older adults understand that routine self-monitoring of blood sugar levels can help delay or prevent the complications of diabetes.

There are some populations that are more likely to have diabetes than the rest of the U.S. general population. A recent Harvard/CDC study found that the lowest life expectancies in the country for both men and women exist in American Indian communities. Further, the more current National Center for Health Statistics mortality data (1996-1998) found that the diabetes health disparity is worsening for American Indian/Alaska Native (AI/AN) people. The diabetes death rate for AI/AN people is now 291 percent higher than the general population; an increase over the 249 percent cited in last year's *Accountability Report*.

To deal with this trend, HHS' Indian Health Service (IHS) and Indian tribes continued to deliver IHS-funded diabetes prevention and treatment services in FY 2001. The IHS Diabetes program conducts an annual medical record review of a random sample of charts to assess compliance with the standards of care for diabetes. For FY 2000, the most recent data available, key indicators directed at reducing complications of diabetes including blindness, remained the same or improved. Glycemic control continued to increase over the past three years, from 22 percent in FY 1998, to 24 percent in FY 1999, and 26 percent in FY 2000. The FY 2000 target for improvement over the FY 1999 target of 25 percent was met. The blood pressure control targets were not met in FY 1999 or FY 2000 and the actual performance has fluctuated from 27 percent in FY 1997, to 38 percent in FY 1998, while the 35 percent actual rate in FY 2000 is essentially the same as the 36 percent rate in FY 1999. The FY 2001 actual performance data will not be available until problems with aggregated data reporting in the automated patient records data system are corrected.

In FY 2001, funding and technical assistance were also provided by CDC to the national network of diabetes control programs. CDC documented that 100 percent of the programs have adopted, promoted, and implemented guidelines for improving the quality of care for persons with diabetes. Also, studies were conducted on translating research findings into clinical and public health practice, which were then published in peer-reviewed journals.

Increasing Immunization for Infectious Diseases

By all accounts, efforts to protect children in the U.S. from vaccine-preventable disease have been a success. CDC data shows that because of high levels of childhood vaccinations, diseases and deaths associated with chickenpox (varicella), diptheria, pertussis, tetanus, measles, mumps, rubella, and Hib (cause of bacterial meningitis) are at, or near, all time lows in the United States. Cases of most vaccine-preventable diseases of childhood are down by more than 97 percent from peak levels before vaccines were available. The FY 2001 incidence data is not available until the fall of 2002, however the FY 2000 data show that polio, rubella, measles, and tetanus cases decreased from FY 1999. The 90 percent vaccination rate for children aged 19 to 35 months was achieved for four of the six recommended vaccines, and there was significant improvement for the chickenpox vaccinations.

Progress also continued toward meeting the Healthy People 2010 goal for immunization coverage rates for influenza and pneumococcal disease among adults aged 65 years and older. These coverage rates have continually increased to 67 percent for influenza and 54 percent for pneumococcal vaccination in FY 1999. The target rate of 70 percent for influenza may not be met for FY 2000 because CDC has a preliminary estimate of 68 percent for influenza coverage in FY 2000. This was accomplished despite challenges in production and supply of the influenza vaccine for that year. The FY 2001 performance target was to have 72 percent of adults aged 65 years and older vacci-

In 2000, an estimated 500,000 people received HIV medical care and related supportive services through HRSA's Ryan White Comprehensive AIDS Resources Emergency Act programs.

nated for influenza and 63 percent for pneumococcal disease. Data is expected by the summer of 2003.

In FY 2001, in response to delay and a possible vaccine shortage, CDC developed recommendations for use of influenza vaccine during the 2001–2002 influenza season. CDC, with the Advisory Committee on Immunization Practices and other partners, also prepared a media campaign, developed a Web site to facilitate purchase and possible redistribution of influenza vaccine, and provided technical assistance to state and local health departments dealing with vaccine delays.

Expanding HIV/AIDS Treatment

Of the infectious diseases, HIV remains a deadly infection for which there is no vaccine or cure and for which there are limited treatments. Recent advances in highly effective antiretroviral medications allow people to live longer with HIV. As people live longer with infection, the potential for spreading infection increases.

An estimated 800,000-900,000 persons are living with HIV infection in the United States. Although incidence has decreased substantially from the high of 150,000 cases per year in the late 1980s, CDC estimates that some 40,000 Americans become infected with HIV every year.

HHS' Health Resources and Services Administration (HRSA) is the focal point for the federal response to the needs of those who are living with the HIV disease. HRSA partners with states, heavily impacted metropolitan areas, and community-based providers to provide health care and support services to those with HIV/AIDS.

In FY 2000, an estimated 500,000 people received HIV medical care and related supportive services through HRSA's Ryan White Comprehensive AIDS Resources Emergency Act programs. Outpatient and ambulatory care services for women and racial/ethnic minorities (per CDC reports, groups for which the incidence of AIDS cases continue to increase, despite the reduction seen overall), increased from FY 1998 to FY 1999. The targets for serving a proportion of women and racial/ethnic minorities in Title I-funded programs that exceed their representation in national AIDS prevalence data, by a minimum of five percent for FY 2000 and FY 2001, are 64 percent and 69 percent, respectively. Actual performance data will be available for these years in January 2002 and January 2003. However, the FY 1999 target of 64 percent was exceeded when a 68.9 percent rate was achieved.

Concerns about the confidentiality of HIV surveillance data could hamper state-based initiatives to include HIV surveillance as part of their HIV prevention plans. Therefore, CDC issued technical guidance for HIV/AIDS surveillance that precludes the release of HIV/AIDS surveillance data for non-public health purposes. In FY 2001, 100 percent of the states had adopted and maintained recommended security and confidentiality standards.

HHS and CDC's HIV/AIDS activities are not limited to the United States. In June 2001, CDC expanded the Global Aids program to include and address the HIV/AIDS epidemic in the Caribbean and Latin America.

Although the incidence has not risen to the same level as the other diseases discussed, the spreading threat of West Nile virus and other arboviral diseases prompted CDC to provide more than $16 million in funding to 47 states, 5 cities, and the District of Columbia to bolster their epidemiologic and laboratory capacity for surveillance of and response to the West Nile Virus.

Preventing and Controlling Asthma

Environmental factors may be linked to existing health conditions that have worsened over the past few years. For example, an estimated 14.9 million Americans have asthma (including 4.8 million children). The number of people with asthma increased by 102 percent between 1980 and 1994. The financial burden of asthma was $6.2 billion in FY 1990 and approximately $11 billion in 1998.

In FY 1998, CDC established asthma contacts in all 50 states to act as focal points for initiation of asthma programs. The first step in developing a national program to address this epidemic is to enable all states and major cities that can document an asthma problem to implement core asthma programs that track incidence, ensure that interventions are science-based, and develop partnerships within the state.

CDC and the states exceeded the FY 2001 performance targets for improving state and local public health capacity to prevent and control asthma. Although the target was 18 states to have implemented core asthma programs, 22 states implemented core asthma programs. This trend has steadily increased from zero states in 1997, to four in FY 1999, and 12 in FY 2000.

Providing Food Nutrition

Poor nutrition and lack of physical activity contributes to at least four of the ten leading causes of death and disability. The costs associated with diet-and activity-related health conditions, including direct health care and lost productivity were estimated at $71 billion a year, according to a U.S. Department of Agriculture paper issued several years ago. Older Americans are particularly vulnerable to poor nutrition.

To combat this problem, in FY 2001 funds were provided to states, area agencies, and tribes which are part of the Administration on Aging's nationwide Aging Network for meals served in congregate (group or community) settings, and home-delivered meals and other community-based services. The Aging Network is comprised of 56 State Units on Aging, 655 Area Agencies on Aging, 233 Indian Tribal organizations, and two organizations serving Native Hawaiians.

The Network leverages funds received from AoA to provide meals and other community-based services. These meals provided 40 percent to 50 percent of a client's daily intake from one meal per day according to the 1996 program evaluation entitled "Serving Elders at Risk".

Based on an analysis of the most recent available information for FY 1999, the trend toward an increase in home-delivered meals continued up from 119 million meals served annually in FY 1995 to 134.9 million in FY 1999. AoA exceeded its FY 1999 target of 119 million for home-delivered meals. Congregate meals served decreased from 114.1 million in FY 1998 to 112.8 million in FY 1999. The target for FY 1999 had been 123.4 million so this target was not met. The FY 2001 targets are 176 million and 115.2 million for home-delivered and congregate meals, respectively. Actual data will be available in February 2003.

Preventing and Treating Mental Illness

An estimated 51 million Americans, including eight million children suffer from mental illness. The attacks of September 11th emphasize the traumatic effect tragic events have on mental health, for people both directly or indirectly involved. In FY 2001, HHS' Substance Abuse and Mental Health Administration (SAMHSA), funded $28 million in grants to provide immediate support to victims; SAMHSA also provided mental health support throughout the nation.

SAMHSA works in partnership with state and local governments, other federal agencies, non-profit treatment providers, consumers, clients, and a wide range of grantees to provide needed mental health services through the Community Mental Health Services Block Grant program. The program assists adults with serious mental illness and children with serious mental disturbances. The purpose of the program is to move the care for adults and children from costly and restrictive inpatient hospital care to the community where they can receive the necessary treatment and support to live more fulfilling and productive lives.

In 1999, 16 states began a pilot project to develop uniform data and unduplicated counts of people served in state hospitals, as part of the 32 performance indicators which will be used to assess performance under the block grants. The FY 2000 and FY 2001 targets for the 16 state project were to have 16 states participating and doing piloting of the 32 performance indicators. These targets were met. The pilot program was due to be completed by the end of FY 2001 and the pilot program results will be published in FY 2002. Concerns remain regarding the ability of states other than the 16 pilot states to adopt the indicators without assistance from SAMHSA.

The Comprehensive Community Mental Health Services for Children and their Families Program also provided 67 grants in 43 states to develop comprehensive community-based systems of care. Improvement in children's outcomes such as school attendance (which has a positive relationship with school performance) and absence of contacts with law enforcement can be used to demonstrate the extent to which a system of care makes a difference in a child's life.

In FY 2001, the target for the first indicator of percent of children attending school 75 percent or more of the time was not exceeded; the target was to increase the percent of children by 18 percent over the FY 1997 baseline of 70 percent of children. Although the target was not met, actual data did show though that 80 percent (a 14.2 percent increase) of the children included in the study, did attend school 75 percent or more of the time after 12 months of care. It may be that the children for whom outcomes were reported during FY 2001 entered systems of care with greater mental health needs than children for whom outcomes had been reported in previous years, e.g., in FY 1999 when 88.9 percent of children studied achieved this goal.

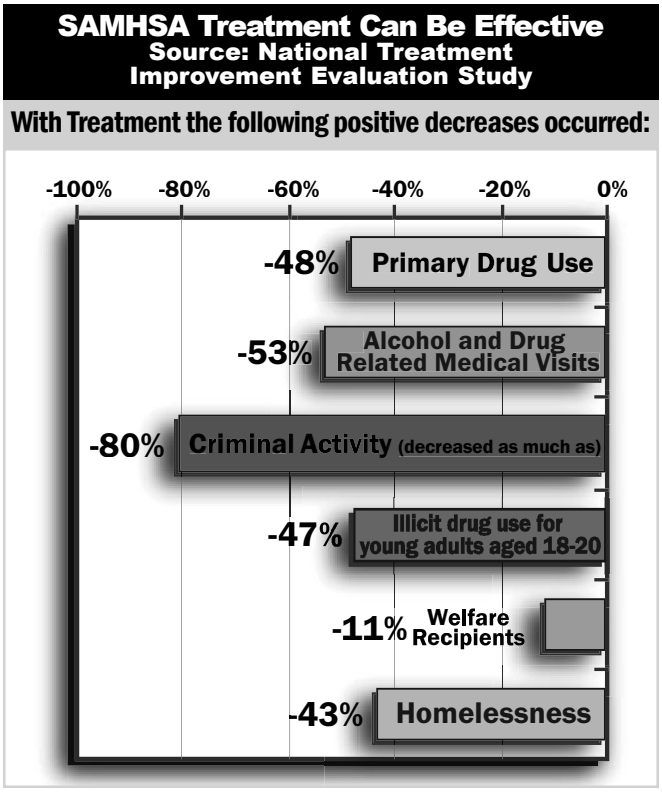
The second indicator, the percent of children with law enforcement contacts at entry who had no law enforcement contacts after 12 months of care, remained at the same level in FY 2001, compared with FY 2000 (44 percent). The FY 2001 target was 43 percent. This indicator appears to have stabilized.

In FY 2001, the HHS Surgeon General issued an updated report on mental health that focused on the disparities in mental health incidence and treatment.

Continued to Fight Substance Abuse and Address Gaps in Its Treatment

Based on SAMHSA's FY 2000 National Household Survey on Drug Abuse, overall rates of current use of illicit drugs were relatively unchanged, although drug use did decline among early teenagers. Leading indicators for drug use—including rates of use among the youngest age group and the number of new users—suggest possible future declines. Among youths aged 12 and 13, a key target audience of the National Youth Anti-Drug Media Campaign, the rate of past month illicit drug use declined from 3.9 percent in FY 1999 to 3.0 percent in FY 2000. The estimated number of new marijuana users has declined from a recent peak of 2.6 million in FY 1996 to 2 million in FY 1999. Illicit drug use includes marijuana, cocaine, heroin, hallucinogens and inhalants.

Where illicit drug use occurs, research such as the National Treatment Improvement Evaluation Study, has consistently shown that drug abuse treatment can be effective in reducing drug use and the consequences of addiction. Yet many people are not being treated. The Office of National Drug Control Policy estimates that as many as 5 million Americans are in need of drug abuse treatment services. However, fewer than half of those who need treatment actually receive services. SAMHSA provides its partners funding and assistance to address this need through the Substance Abuse Prevention and Treatment Block grant. For substance abuse treatment, one measure of performance is the number of clients served. Actual performance data for FY 2001 with the target of 1,635,422 clients served, will not be available until 2003. In the meantime, the most recent actual performance data available for FY 1998 show that 1,564,156 clients were served.



Creating Opportunities for People and Communities

A primary mission for HHS, the Administration for Children and Families (ACF), and our partners involves creating opportunities for individuals, families, and communities to become more economically and socially productive. Our overarching goal is to help people become more self-sufficient within their communities.

This means that our programs are helping people to gain the skills and competence necessary to make their own way in the world. This can have a galvanizing effect on a community as the potential reality of self-sufficiency can transform the outlook of others who have not yet become self-sufficient.

Our services are directed towards improving job skills, access to social services, family and community stability and independent living for low-income families, children, the elderly, persons with disabilities, and distressed communities. HHS' role in helping people to become self-sufficient is to provide leadership, funding and technical assistance to its partners, conduct research, promote best practices, and work to eliminate barriers to access of services.

Continuous Improvement, Measurable Results

A commitment to continuous improvement has focused our attention on measurable results. Substantial progress has been made in the past several years in helping welfare recipients move to work, increasing child support payments, and providing child care and early learning services to low and moderate income families.

In FY 1996, a comprehensive, bipartisan welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) dramatically changed the nation's welfare system into one that requires work in exchange for time-limited assistance. States, tribes, and territories receive block grants from ACF under the Temporary Assistance to Needy Families (TANF) program, established by PRWORA, to cover benefits, administrative expenses, and services.

Welfare Caseloads Have Fallen to Historic New Lows

Since then, welfare caseloads have fallen to historic new lows. They are at their lowest level since 1965. Since states began implementing the TANF program in FY 1997, the number of recipients has dropped by 56 percent as

Record numbers of people are moving from welfare to work. Retention rates are promising. States also reported an average earnings increase.

of June 2001. From its peak of 14.4 million recipients in March 1994, the number has dropped by 62.6 percent to 5.4 million in June 2001. In addition, during FY 1999, 1.2 million people got jobs after being unemployed during that year.

The states, tribes, and territories have great flexibility to design and implement programs to move clients from welfare to work, including eligibility requirements, benefit levels, and services provided, as long as they are consistent with the purposes of the program.

Congress established work participation performance standards and created the High Performance Bonus (HPB) incentive system to facilitate the goal of moving recipients from welfare to work and self-sufficiency. Although HPB is voluntary, most states are participating. Forty-eight states and the District of Columbia competed for the FY 2000 HPB and $200 million in awards were issued to 28 states in December 2000.

From Welfare to Work

Record numbers of people are moving from welfare to work. Retention rates are promising. States also reported an average earnings increase. The target for FY 1999 was that all states meet the two-parent work participation rates. For that year, 74 percent of the states met the target of 90 percent work participation. The FY 2001 target is also 100 percent of families. That data will be available in December 2003, and the FY 2000 data is expected in December 2002. In FY 1998, the corresponding percentage was 66 percent of states.

Often, working parents lack the necessary supports that will enable them to succeed in the workforce, such as access to affordable, quality childcare, transportation, and training opportunities. Welfare reform has been less effective in addressing the needs of clients with multiple barriers to work such as inadequate fluency in English, mental health problems, addiction to alcohol or drugs, developmental and learning disabilities and domestic violence. Increasingly, state agencies are reporting that the proportion of clients with these barriers is growing.

There are four steps that must be completed before we can claim success in reforming the welfare system. First, reaching all families. HHS must reach the families that are still on the welfare caseloads. Second, moving families into work and promoting success at work. For parents to succeed at work and provide for their children, we must ensure that they have sufficient family income and basic work supports. Third, transforming the welfare office. States are reorganizing their operations to focus on assisting recipients in finding and retaining employment, rather than on distributing benefit checks. Fourth, maintaining investment. To accomplish the first three steps, states need to sustain the involvement of all parties in the process of helping people move from welfare to work.

Congress will consider reauthorization for TANF next year. HHS officials held listening sessions around the nation with states, tribes, employers, and advocates to lay the groundwork for the reauthorization legislation. Given the success documented above, it will be important for this program to continue into the future so that more American families can move from dependency to financial independence, and to reap the benefits for their families that such a transformation can provide.

HHS has coordinated efforts to increase parental responsibility through promoting and encouraging father involvement through the Fathers' Initiative that has representatives from all HHS agencies. Meeting regularly to foster coordination and collaboration across HHS, this group has established working relationships with many non-governmental groups working to promote more father involvement in the lives of children. The faith-based community has been contacted to help spread the word on parental responsibility and child support services. HHS will continue efforts to broaden parental responsibility, especially the involvement of fathers in the lives of their children, through several means. First, by focusing attention on the fathers' positive role in improving their childrens' well being. Second, by ensuring that the HHS research agendas pay adequate attention to the role of fathers in families and the effects of fathering on children's well being. Third, by using positive messages and language about fathers and fatherhood in publications and announcements; and finally, by ensuring that HHS' own workforce policies encourage and enable fathers to balance work and family life responsibilities.

Increased Childcare Accredited Facilities

Research has begun to document the most important early influences on children's development and factors that contribute to the quality of early childcare. For example, the National Institute for Child Health and Human Development (NICHD) study of early child care, When Child-Care Classrooms Meet Recommended Guidelines for Quality (1998), shows that children attending centers meeting professional standards for quality score higher on school-readiness and language tests and have fewer behavioral problems than their peers in centers not meeting such standards. The study found that children fared better when child-staff ratios were lower and teachers had more training and education. Similarly, a four-year follow-up of children studied in the 1995 Cost, Quality, and Child Outcomes Study, as well as the Carolina Abecedarian Program Study, shows positive long-range effects of quality early childhood services.

ACF works with state administrators, professional groups, service providers, and others to identify elements of quality and appropriate measures; inform states, professional organizations, and parents about the constituents of child care quality; influence the training and credentialing of child care workers and accreditation of child care facilities; improve linkages with health care services and with Head Start; and take steps to improve the quality of child care nationally.

As an accomplishment for FY 2001, approximately 20 states now report offering higher subsidy reimbursement rates to providers demonstrating high quality care. Most states indicated they are working toward a system of professional development for childcare providers and workers. Nearly a dozen states have implemented the North Carolina TEACH model combining professional development and training with salary enhancements.

The performance target for FY 2001, with data to be available early in FY 2002, is to increase by 1 percent the number of regulated child care centers and homes nationwide accredited by a nationally recognized early childhood development professional organization from the FY 2000 baseline. The FY 2000 baseline was 9,535.

It continues to be difficult to provide an accurate count of the total number of childcare facilities. The language for the accreditation of facilities measure has been revised to measure the number of accredited facilities in relationship to the number of regulated child care centers and homes, as reported by the independent national bodies.

Empowering Parents Through Vigorous Child Support Enforcement

The Child Support Enforcement program collected $18.9 billion in FY 2001, serving an estimated 17.4 million child support cases. Since the creation of the Child Support Enforcement program, child support

When government can spend money which both helps our citizens to grow in healthy ways and at the same time receive a healthy financial return on our investment in our people, that is a cost-effective way of using our resources.

collections within the program have grown annually. States have increased collections by using a wide variety of approaches such as income withholding, offset of income tax refunds, support guidelines and reporting to credit bureaus. In addition, states are beginning to reap the benefits of the tools provided by PRWORA:

✹ *In FY 2000, 62 percent of all cases had orders, 42 percent of all cases had collections, and total collections increased by 49 percent since FY 1996.*

✹ *The government collected a record $1.6 billion in overdue child support from Federal income tax refunds for tax year 2000. More than 2.1 million families benefited from these collections.*

✹ *A program to match a list of delinquent parents with financial institution records found 1.5 million accounts belonging to more than 879,000 delinquent non-custodial parents nationwide with a value in excess of $3.1 billion.*

✹ *The number of paternities established or acknowledged was almost 1.6 million in FY 2000. Of these, over 689,000 were established through in-hospital acknowledgement programs. An additional 867,000 paternities were established through the Child Support Enforcement program.*

✹ *The Passport Denial program resulted in collections of over $6 million in lump sum child support payments in FY 2000.*

✹ *Using the expanded Federal Parent Locator Services, OCSE was able to provide states information on over three million non-custodial parents and putative fathers, doubling the number of interstate cases from the year before.*

✹ *As a result of matching the Federal Case Registry with the National Directory of New Hires, employer and address information for 3 million non-custodial parents has been identified.*

As of January 2001, 52 states and territories are reporting data to the Federal Case Registry (FCR), which locates absent parents across state lines. The FCR contains 17.5 million child support cases. When absent parents are found, HHS promotes state use of the Internal Revenue Service (IRS) tax refund and administrative offsets for child support. For FY 2001, a record $18.9 billion was collected in comparison to $17.9 billion in FY 2000 and $15.8 in FY 1999.

The Cost-Effectiveness of Self-Sufficiency

When government can spend money which both helps our citizens to grow in healthy ways and at the same time receive a healthy financial return on our investment in our people, that is a cost-effective way of using our resources. The Child Support Enforcement program has such a measure, which is derived by measuring the total dollars collected against the administrative dollars expended by HHS and its partners. The objective is to increase the dollars collected per administrative dollar spent. In FY 2000, total administrative expenditures were $4.5 billion. Compared with the $17.9 billion collected, the cost-effective-

HHS funds a number of programs that focus on preventing maltreatment of children in troubled families, protecting children from abuse, and finding permanent placements for those who cannot safely return to their homes.

ness ratio for this program is $3.95. That is, $3.95 is collected for every administrative dollar expended.

The continuing challenge for ACF is to locate absent parents and increase their parental responsibilities by involving them in raising their children. In this way, families can achieve the self-sufficiency that they would otherwise have achieved, but for the wayward parental support. Self-sufficient families will leave a legacy in their children, who will see that productive, vibrant lives can be more than a dream.

Child Welfare

HHS funds a number of programs that focus on preventing maltreatment of children in troubled families, protecting children from abuse, and finding permanent placements for those who cannot safely return to their homes. Programs such as Foster Care, Adoption Assistance, and Independent Living provide stable environments for those children who cannot remain safely in their homes, assuring the child's safety and well-being while their parents attempt to resolve the problems that led to the out-of-home placement. When the family cannot be reunified, foster care provides a stable environment until the child can be placed permanently with an adoptive family. Adoption Assistance funds are available for a one-time payment for the costs of adopting a child as well as for monthly subsidies to adoptive families for care of the child.

The Adoption Incentives program was enacted into law by the bipartisan Adoption and Safe Families Act of 1997. The passage of this incentive program along with state, local and private initiatives focusing attention on the needs of children in foster care awaiting permanent adoptive families, are resulting in unprecedented increases in the number of children adopted from foster care.

The Adoption Opportunities program funds grants and contracts to public and private organizations to facilitate the elimination of barriers to adoption and to provide permanent, loving home environments for children who would benefit from adoption, particularly children with special needs. There are approximately 118,000 children in the public foster care system that cannot return safely to their own homes and parents. About 46,000 of these children are legally free and immediately available for adoption. Such children are typically school-aged, in sibling groups, have experienced neglect or abuse, or have a physical, mental, or emotional disability. While the children are of all ages and races, children of color and older children (over the age of 10) are over-represented.

The Child Welfare Services program funds grants to states and Indian tribes to provide services to children and their families without regard to income. Family Preservation and Support Services, renamed Promoting Safe and Stable Families, focuses on strengthening families, preventing abuse, and protecting children. These grants help states and tribes operate preventive family preservation services and community-based family support services for families at risk or in crisis, family reunification and adoption support services. Our goal for FY 2000 was to have 46,000 children adopted from the public foster care system and 51,000 for FY 2001. The actual figure for 2000 was 50,000 children, compared to 46,000 in FY 1999 and 36,000 in FY 1998. Data for FY 2001 will be available in September 2002.

Ultimately, decisions about placing children are made by judges in juvenile and family court systems throughout the nation. Improved judicial handling of child welfare cases will be essential to achieving permanency goals for children. Children in the child welfare system have many medical and mental health problems, while many of their parents are incapacitated by chronic substance abuse, mental health problems, homelessness, limited education, and similar problems. The availability of services from other sectors to meet these needs is uneven. The expansion or contraction of services in various parts of the country will affect our overall performance. Major changes in assistance programs for low-income families as part of welfare reform will also have an unknown impact on the child welfare system over the next several years.

Head Start

Head Start is a national program that provides comprehensive developmental education, mental health, nutrition and social services for

Head Start programs teach an appreciation of the cultures of all enrolled children and provide culturally relevant classroom and other activities.

America's low-income, preschool children ages three to five and their families. The basic philosophy guiding the Head Start program is that children benefit from quality early childhood experiences and that effective intervention can be accomplished through high quality comprehensive services for children, along with family and community involvement. Head Start provides diverse services to meet the goals of three major content areas: early childhood development and health services; family and community partnerships; and program design and management. Grants are awarded to local public or private non-profit agencies; the 1998 Head Start Reauthorization made profit-making agencies eligible as well. The community must contribute twenty percent of the total cost of a Head Start program. Head Start programs operate in all 50 States, the District of Columbia, Puerto Rico, and the U.S. territories.

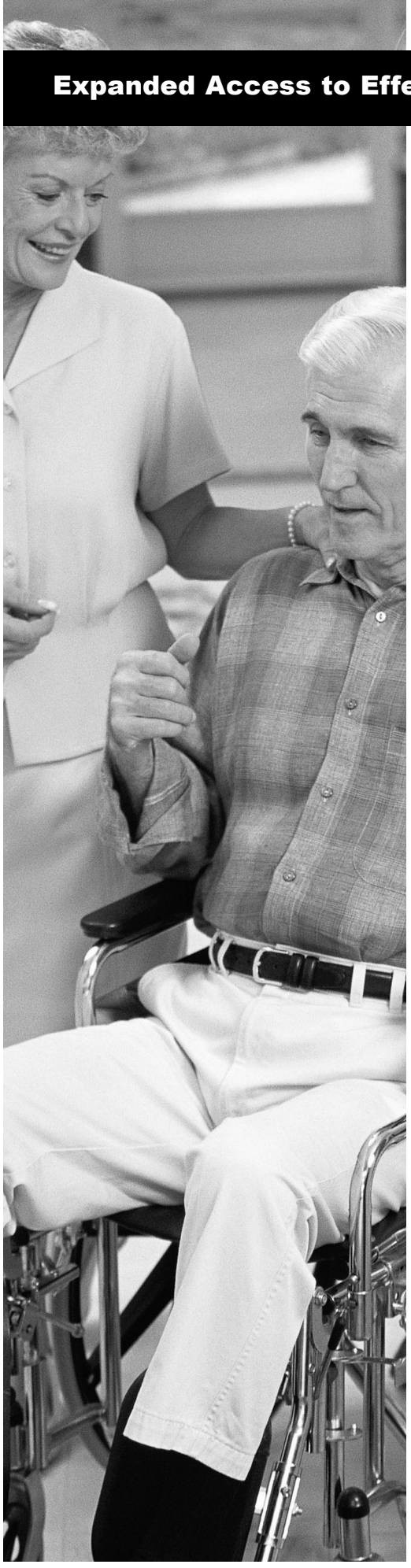
The National Institute of Child Health and Human Development (NICHD) recently established an Early Childhood Education and School Readiness Initiative to investigate a range of issues impacting early childhood learning. The goals of this effort are to support research planning grants to establish effective, multidisciplinary scientific collaborations as well as a comprehensive analysis of assessment needs and the development of appropriate tools.

Approximately 1,525 community-based organizations from Miami, Florida to Nome, Alaska, and from Puerto Rico to Micronesia, develop unique and innovative programs to meet specific needs, following the guidelines of Program Performance Standards, last updated in January 1998. In FY 2001, nearly 905,000 children were enrolled in Head Start programs. Head Start programs operated 18,500 centers with 48,500 classrooms. Of the children served, 34.5 percent are African-American; 30.4 percent are White; 28.7 percent are Hispanic; 3.3 percent are American Indian; and 2.0 percent are Asian. Sixty-four percent of all Head Start programs enrolled children from more than one dominant language and 20 percent enrolled children from four or more dominant language groups. Head Start programs teach an appreciation of the cultures of all enrolled children and provide culturally relevant classroom and other activities.

Our measure for this area involves the number of classroom teachers with a degree in early childhood education (ECE), a child development associate credential, a state-awarded preschool certificate, a degree in a field related to ECE plus a state-awarded certificate or who are in Child Development Associate (CDA) training and have been given a 180-day waiver, consistent with the provisions of Section 648A(a)(1) of the Head Start Act. The target for FY 2000 and beyond was 100 percent while the FY 2000 actual was 94 percent. The baseline for FY 1999 was 93 percent. Data for 2001 will be available in 2002.

The shortfall in meeting this target is due to a combination of staff turnover and/or limited access to training and credentialing opportunities in certain areas of the country. In partnership with institutions of higher education, Head Start is working to ensure that a majority of teachers obtain associate's or bachelor's degrees in early childhood education over the next few years. More than $80 million in annual funding has been earmarked to pay for teacher training and to continue to increase staff compensation. Grantees were required to develop plans for using their allocation from the $80 million to increase the numbers of teachers with degrees. Head Start additionally provided $3 million in funding to 24 higher education training partnership projects, largely to provide training towards degrees at Historic Black Colleges and Universities (HCBU), Hispanic-serving Institutions of Higher Education (HIHE), and Indian-controlled land grant colleges and universities. HHS also initiated a new 5-year project at $1 million per year with Wheelock College for higher education faculty development. A teacher's education level is correlated with classroom quality—classrooms have higher-quality language activities, offer more creative activities to children and have higher overall quality as rated by the Early Childhood Environment Rating Scale (ECERS).

Expanded Access to Effective Health Care Services



HHS is the largest purchaser of health care in the world, administering Medicare, Medicaid, and the State Children's Health Insurance Program. Outlays for these programs, including state funding, represent 33 cents of every dollar spent on health care in the United States.

Millions of Beneficiaries

Individualized Service

While HHS covers millions of beneficiaries and outlays more than $350 billion per year on our health insurance programs, we are striving to ensure that all beneficiaries have unfettered access to our programs and that they are provided with quality health care services. One of our main objectives is to improve the health and satisfaction of beneficiaries in our programs. This includes educating beneficiaries, improving Medicare services, and using research and oversight to protect beneficiaries from substandard care. We are also striving to promote fiscal integrity in our programs to the greatest extent possible. Additionally, we seek to increase the availability of health care services for America's underserved populations, including American Indians and Alaskan Natives.

Improved Services through Re-organization

An initiative was undertaken by Secretary Thompson this year to reform and strengthen the services and information available to our beneficiaries and the health care providers who serve them. As part of that effort, Secretary Thompson unveiled the new name for the HHS component that runs the Medicare and Medicaid programs - the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration. The new name reflects the increased emphasis at HHS on responsiveness to beneficiaries and providers, and on improving the quality of care that beneficiaries receive in all parts of Medicare and Medicaid.

To achieve these goals, the Centers for Medicare & Medicaid Services launched a national media campaign to give seniors and other Medicare beneficiaries more information and restructured CMS around three centers that reflect the agency's major lines of business.

An initiative was undertaken by Secretary Thompson this year to reform and strengthen the services and information available to our beneficiaries and the health care providers who serve them.

CMS will use major television, print, and other media to reach out and share information and educational resources to all Americans who rely on Medicare, their families, and their caregivers. CMS also plans many other future changes that will make CMS more responsive to the needs of the beneficiary population.

HHS leadership has also worked with the White House to develop principles for strengthening and improving Medicare. HHS also developed a Prescription Drug Card as part of our comprehensive Medicare Prescription Drug plan.

Medicare, Medicaid, and Medicare+Choice

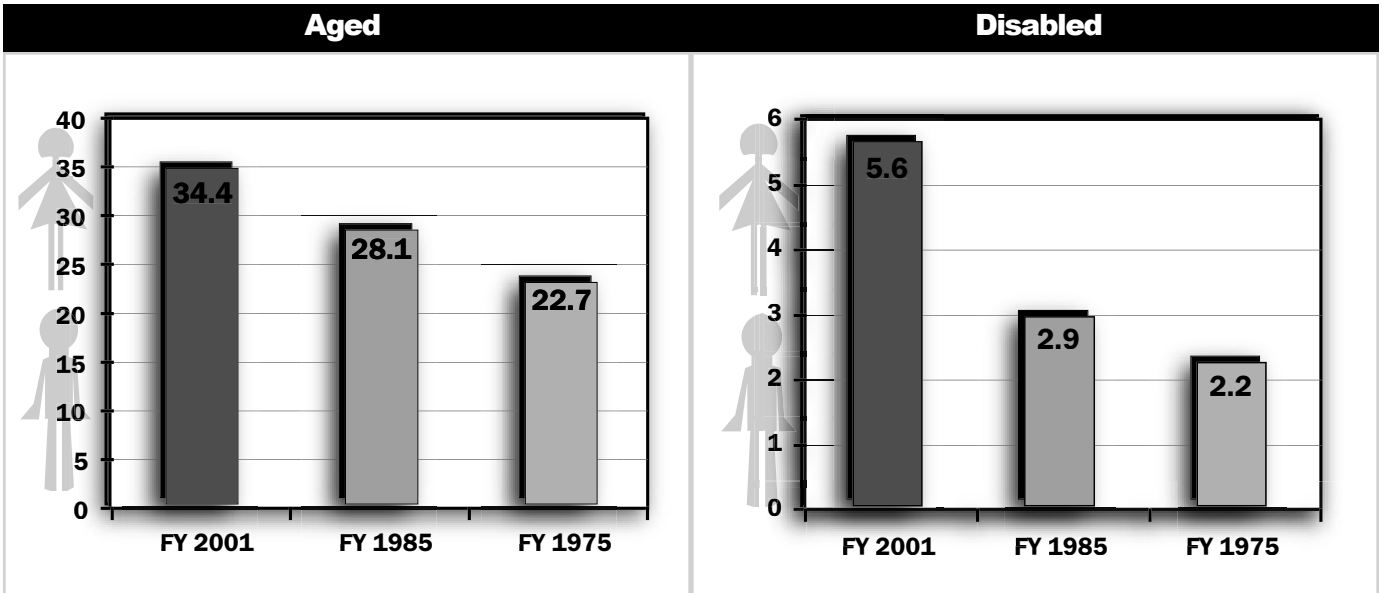
HHS, working through CMS and the Medicare contractors, is the nation's largest health insurer, providing coverage to 40 million Medicare beneficiaries as well as 34 million Medicaid enrollees in conjunction with the states. Medicare alone processes 930 million claims each year, for some 700,000 physicians, 6,000 hospitals, and thousands of other providers and suppliers.

Comprehensive Coverage

Medicare covers both hospital insurance and insurance for physician and outpatient care, laboratory tests, skilled nursing facility care, home health care, durable medical equipment, designated therapy services, and other services not covered by hospital insurance. Medicare+Choice was created in 1997 to increase health care options for beneficiaries through a greater variety of managed care and fee-for-service plans. With these programs, over the last 30 years, Medicare has significantly contributed to increased life expectancy, a better quality of life, and protection from poverty for the aged and disabled.

Medicaid is the primary source of health care for medically vulnerable Americans such as poor families, the disabled, and persons with developmental disabilities requiring long term care. Medicaid is administered in partnership with the states. States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines. States have a great deal of programmatic flexibility to tailor their Medicaid programs to individual state circumstances and priorities. HHS issues the matching payment grants to states and territories for medical assistance and administrative costs. Medicaid has improved birth outcomes, childhood immu-

FY 2001 Medicare Enrollment
(in millions)
Source: CMS/OACT



One of HHS' central concerns is that Medicare beneficiaries are able to get the care they need when they want it, and that they are not impeded by such factors as cost, health status, location or the availability of health care support networks.

nization rates, and access to preventive services, resulting in overall improvements in the health of America's children.

One of HHS' central concerns is that Medicare beneficiaries are able to get the care they need when they want it, and that they are not impeded by such factors as cost, health status, location or the availability of health care support networks. Certain subgroups, such as minorities, persons with disabilities or individuals without health care insurance, are particularly vulnerable to substandard or nonexistent medical attention.

We Have Increased Dual-Eligibility Enrollment

HHS has expanded access to the dual-eligibility programs of Medicare and at least some aspects of Medicaid, to ensure that low-income Medicare beneficiaries get assistance with cost-sharing expenses. In essence, low-income Medicare beneficiaries have some of their cost sharing (coinsurance and deductibles) paid for by their state. This increases potential access for those beneficiaries, as they will not defer medical treatment for financial reasons. HHS has worked with federal agencies and states to raise awareness of the dual eligibility program, leveraged improvements through grants to states, sponsored regional training sessions and developed resource guides to help expand the program and, thereby, enroll more beneficiaries.

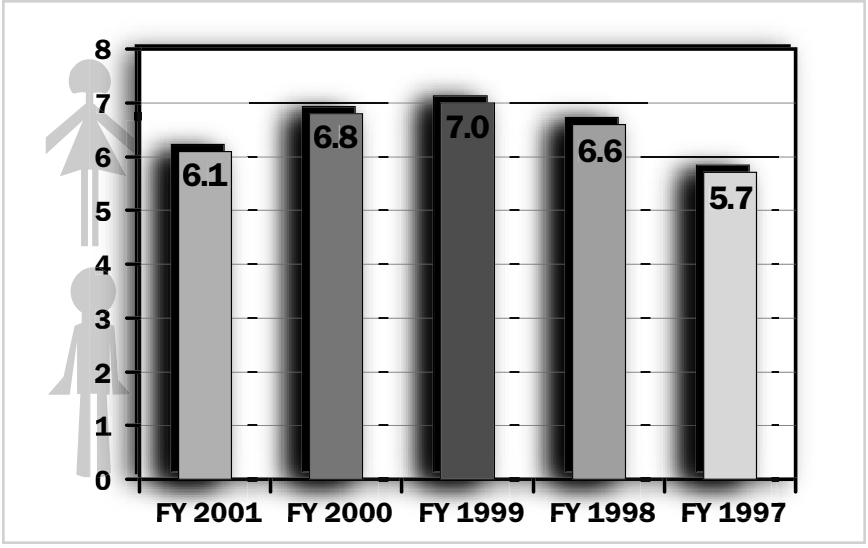
The performance goal for this section focuses on reducing financial barriers to care by increasing the enrollment of individuals who are dually qualified for Medicare and at least some aspects of the Medicaid program. Our emphasis in the initial years of this goal was on increasing enrollment for Medicare beneficiaries eligible for the Qualified Medicare Beneficiary or the Specified Low-Income Medicare Beneficiary programs. We surpassed our FY 2000 target and increased enrollment in dual eligible programs by 4.4 percent, with 5,499,349 dual-eligibles enrolled. Due to the overwhelming success of so many states in FY 2000, we modified our approach to measuring this area for FY 2001. Instead of setting a goal to achieve a national rate increase of 4 percent, we are focusing on states that received CMS grants for outreach activities and states that did not meet the FY 2000 national target.

Interim FY 2001 data indicate states are making progress in adding enrollees. Additionally, CMS implemented a strategy for increasing enrollment of dual eligible populations that was established as part of the FY 1999 performance plan that called for an increase in partnerships with a variety of public and private agencies.

Access to Medicare services continues to be a challenge that HHS leadership has focused on intently. While we have made strides in many areas, as noted above, there have been other developments that have made the broader access goal more difficult to achieve. In particular, the Medicare+Choice program, to this point, has not grown the way some have projected.

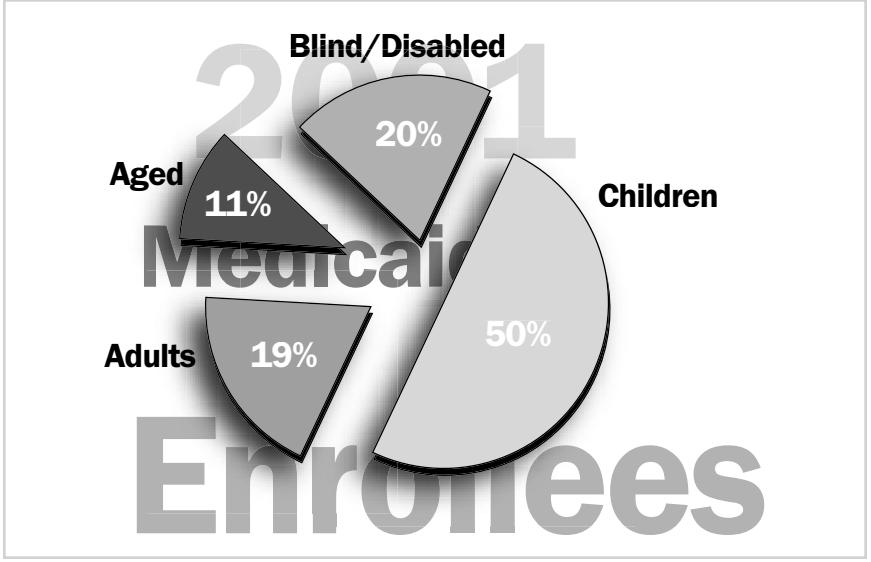
Medicare+Choice was established by the Balanced Budget Act of 1997 (BBA) to increase health care options for beneficiaries through a greater variety of managed care and fee-for-service plans. Unfortunately, the last three years have seen health plans restrict their service areas

Managed Care Enrollment – Beneficiaries
(in millions)



Important cost-sharing protections also were established so families would not be burdened with out-of-pocket expenses they could not afford.

2001 Medicaid Enrollees
Source: CMS/OACT



or pull out of Medicare altogether. The total number of Medicare managed care contracts has declined from 455 in FY 1998 to 251 in FY 2001. While many beneficiaries have other health plans available to them in their service areas, there has been, at minimum, disruption for those beneficiaries. For the current plan year, 536,000 beneficiaries were affected by plan withdrawal. Of that total, 446,000 or 83 percent, had another managed care plan in their service area. For the remaining 90,000 they would always have fee-for-service, the original Medicare plan, available.

HHS has continued to assist states in promoting the opportunity for eligible children to enroll in Medicaid. Among our efforts, we asked states to review their outreach efforts and eligibility processes to ensure that as many eligible families and children as possible are given the opportunity to enroll in the program. We also asked states to reinstate anyone who may have been improperly terminated from the program.

SCHIP

One of our most important new initiatives has been the implementation of the State Children's Health Insurance Program (SCHIP). SCHIP was created in 1997 in the BBA to address the fact that nearly 11 million American children - one in seven - were uninsured and therefore at significantly increased risk for preventable health problems. Many of these children were in working families that earned too little to afford private insurance on their own, but too much to be eligible for Medicaid.

Congress and the Administration agreed to set aside $24 billion over five years, beginning in FY 1998, to create SCHIP - the largest health care investment in children since the creation of Medicaid in 1965. These funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. To make sure that funds are used to cover as many children as possible, funds must be used to cover previously uninsured children, and not to replace existing public or private coverage.

Important cost-sharing protections also were established so families would not be burdened with out-of-pocket expenses they could not afford. HHS is working closely with states and the Congress to fulfill the challenges inherent in designing and implementing an ambitious new program such as SCHIP. Additionally, HHS has granted numerous waivers and state plan amendments to states that will increase access and expand benefits to both Medicaid and SCHIP. The coverage areas include enhanced cervical and breast cancer coverage and community long term care alternatives to institutions.

The implementation of SCHIP has been driving enormous change in the availability of health care coverage for children and in the way government-sponsored health care is viewed and delivered. The energy invested by states, communities, and the federal government in the SCHIP initiative has resulted in significant expansions in coverage as well as new systems for enrolling children into publicly funded coverage programs.

Our goal is to increase the number of children (up to age 19 for SCHIP; age

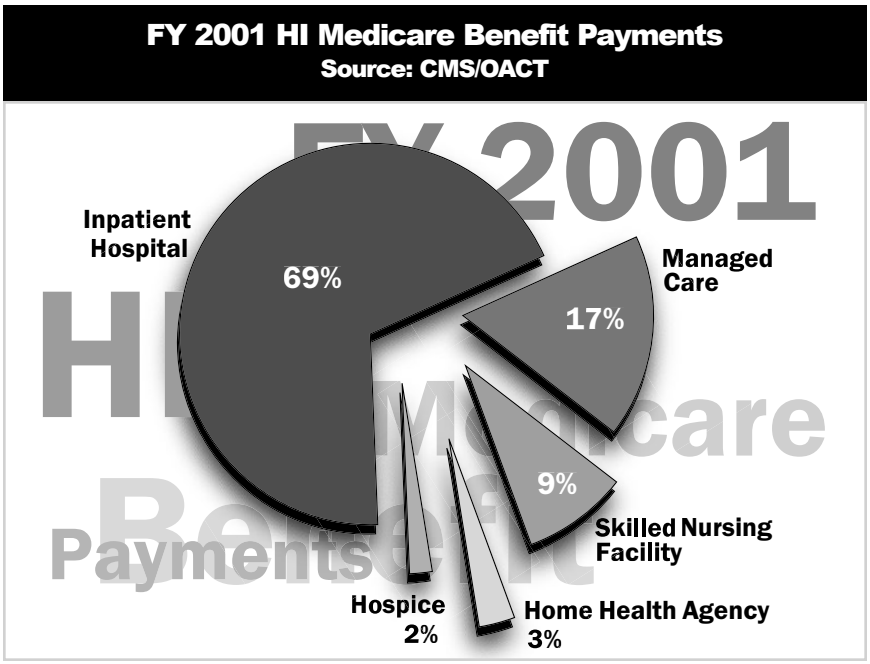
HHS recognizes the importance of ensuring the integrity of its health care programs in order to improve services, provide the best value to beneficiaries, and to eliminate fraud and abuse.

21 for Medicaid) who are enrolled in regular Medicaid or SCHIP by one million over the previous year's level. As of FY 2000, there were approximately 23,659,000 children enrolled in SCHIP and Medicaid, which exceeded our FY 2000 target. Due to the overwhelming support for the program, we anticipate continued success for our goal to increase enrollment by one million in FY 2001.

We Improved the Fiscal Integrity of Medicare and Enhanced the Value of Services Purchased for Beneficiaries

HHS recognizes the importance of ensuring the integrity of its health care programs in order to improve services, provide the best value to beneficiaries, and to eliminate fraud and abuse. HHS works to achieve these important objectives in a number of ways which include managing programs to improve quality and competition in health care programs, developing and disseminating checklists for use in the review of states' managed care contracts, and developing new payment systems that can improve services and reduce improper payments.

One of the major issues on which HHS has focused its attention is the accuracy of payments in Medicare. In recent years, HHS has made substantial progress in reducing the error rate and improper payments in the Medicare program, a critical aspect of providing strong services and maintaining stewardship over tax dollars.



HHS' goal is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Medicare's fee-for-service program is one area in which HHS has taken increasingly strong actions in recent years. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars.

The complexity of Medicare payment systems and policies, and the numbers of contractors, providers, and insurers involved in the Medicare fee-for-service program create vulnerabilities. HHS has implemented a Corrective Action Plan designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate.

Our objective is to reduce the percentage of improper payments made under the Medicare fee-for-service program. We have made substantial progress over the years, from 14 percent in FY 1996, to 6.3 percent in FY2001. This compares to our FY 2001 target of six percent. In general, the substantial reduction in the error rate since FY 1996 demonstrates that the Medicare contractor claims processing system is working well.

HHS is also committed to assisting interested states in developing methodologies and conducting pilot studies to measure and ultimately reduce Medicaid payment error rates. HHS established with the American Public Human Services Association a National Medicaid Payment Accuracy Workgroup to help define, guide, and coordinate this federal-state collaborative project.

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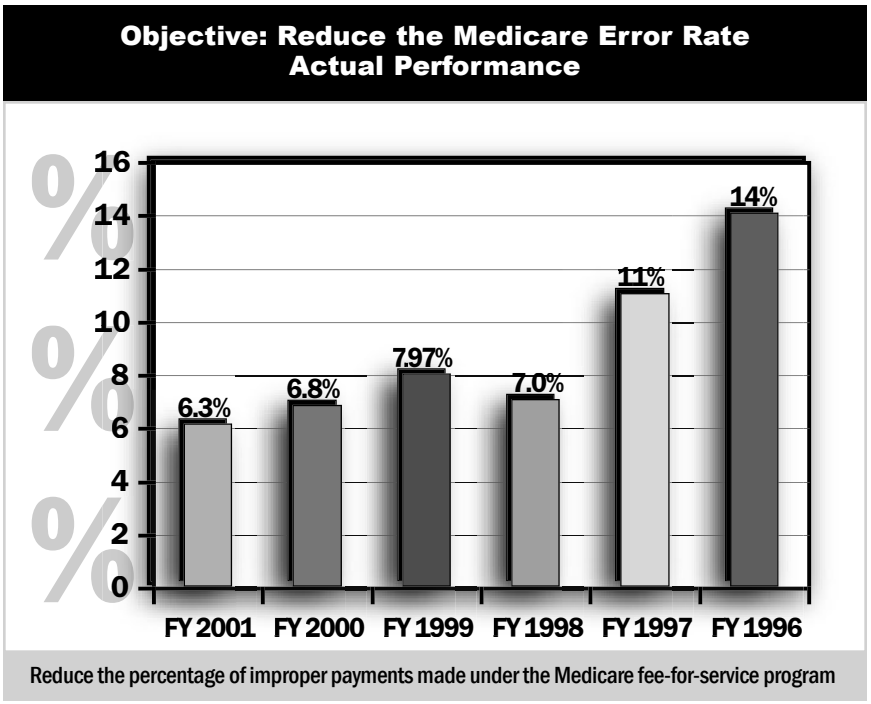


Information was collected on the significant Medicaid payment accuracy studies conducted to date (by Illinois, Texas, and Kansas), and discussions were initiated with several states that might be interested in participating in the pilot studies. Moreover, HHS is educating beneficiaries to identify and report instances of fraud, and implementing the Comprehensive Error Rate Testing program to produce contractor, benefit specific, and national error rates.

Increase the Potential for Living

Another way to ensure that we use all of our precious resources to their utmost is to focus on maximizing organ donation. HHS launched a new national initiative to encourage and enable Americans to "Donate the Gift of Life."

The need for organs for donation is growing almost twice as fast as the supply. In 1990, about 15,000 organs were transplanted while the number of persons on the list needing an organ totaled almost 22,000. According to the United Network for Organ Sharing, 22,827 organs were transplanted last year (a 5.3 percent increase over 1999), while the list of those needing a transplant has grown to more than 76,000 (a 10.2 percent increase in 2000).

Initial steps in the campaign included the launch of a national "Workplace Partnership for Life," in which employers, unions and other employee organizations will join in a nationwide network to promote donation. Secretary Thompson also released a model organ and tissue donor card, incorporating proven elements from today's donor cards. But at the same time, he said that donor cards alone are not enough to enable Americans to be sure their wishes for donation will be known and carried out. Therefore, he ordered an immediate review of the potential of organ and tissue registries where donors' wishes could be recorded electronically and made available to families and hospitals whenever needed.

HRSA will devise a new goal to measure how effective this new campaign is as we move into the future. The challenge will arise as we attempt to honor donors' wishes as well as make the donor information usable to medical organizations in real time, so that more organs can be used to save lives.

Providing Basic Health Care Needs

For more that 30 years, Health Centers, as part of America's health care safety net for the

Americans spend more on health care than any other country in the world today. In FY 1999, National Health Expenditures reached $1.2 trillion.

nation's indigent populations, have provided community-based, cost-effective, and comprehensive primary and preventive health care to many homeless, underserved, low-income and minority populations. These centers are family oriented and provide usual and regular access to high quality health care, regardless of individuals' ability to pay, which significantly improves the status of their patients.

In FY 2001, Health Centers treated 10.5 million patients at more than 3,000 sites. However, as the Health Center program increases in size, it continues to face considerable pressure because Centers frequently are the only safety net providers who serve low income, uninsured patients. This is a significant financial burden for the centers, as many of these patients cannot afford to pay much, if anything, for their health care. In FY 2000, 40 percent of Health Center patients were uninsured.

Our goal for this section is to assure access to preventive and primary care for minority individuals in the Health Centers (racial minorities). For FY 1999, 5.79 million minority individuals were seen in the Health Centers. In FY 2000, 6.49 million were seen, surpassing the goal of 6.24 million for that year. The goal for FY 2001 is 6.83 million minority individuals, with data expected later in FY 2002.

Cost Effectiveness of Health Care

Americans spend more on health care than any other country in the world today. In FY 1999, National Health Expenditures reached $1.2 trillion. In addition, as a country we spent 13 percent of GDP on health care. Given those figures, it is imperative that we utilize the most cost-effective sites when we receive health care. According to a Health Center Medicaid Beneficiary study, reductions in Medicaid costs for a comparable group seeking health care elsewhere range from 30-34 percent. In addition, Health Center Medicaid patients are 22 percent less likely to be inappropriately hospitalized than Medicaid beneficiaries who obtain care elsewhere.

The challenge in this area is to continue to provide services to a largely uninsured, minority, and low-income population when our Health Center sites are extremely vulnerable to the market-driven downward pressure on revenues.

HHS had taken broad steps in FY 2001 to mobilize efforts to increase health care quality—particularly with respect to the elderly—and to augment support systems for patient and consumer safety. Research on quality of care also resulted in findings that when implemented, can help the outcomes and costs of patient care.

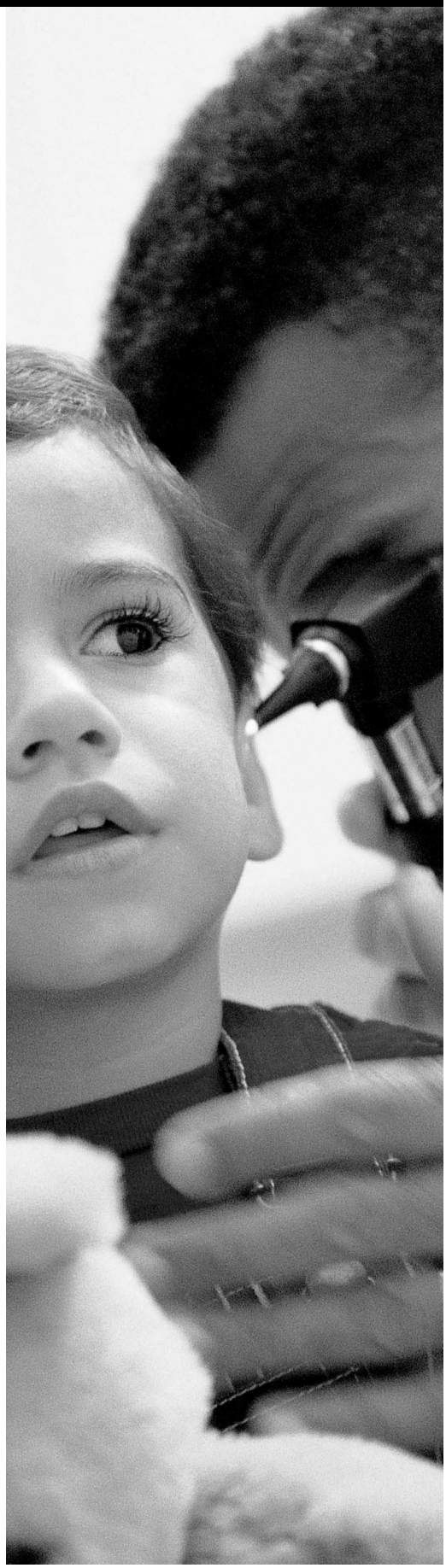
Patient Safety, Rights, and Privacy

HHS continued its effort to improve patient safety, rights, and privacy this year.

In November 1999, The Institute of Medicine reported that as many as 44,000 to 98,000 people die in hospitals each year as a result of medical errors. It is estimated that about 7,000 people die each year from medication errors alone.

On April 23, 2001, HHS formally established a new Patient Safety Task Force, led by the Agency for Healthcare Research and Quality (AHRQ), Center for Disease Control and Prevention (CDC), Food and Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS). The purpose of the task force is to identify and collect data that will be useful for healthcare providers, states, and other health agencies. The task force met to discuss the collection and use of patient safety data. Representatives of medical professional organizations, state health departments, state licensure boards, accrediting bodies, patient advocacy groups and others participated. The task force will study how to implement a user-friendly, internet-based format for reporting on patient safety to enable faster cross-matching and electronic analysis of data and more rapid responses to patient safety problems.

Overall, in FY 2001, AHRQ invested $50 million in 90 new research grants, contracts, and other projects to reduce medical errors and improve patient safety. The results of this effort will identify improvement strategies for reporting medical errors data, using information technology to prevent errors, understanding the impact of working conditions on patient safety, developing innovations, and disseminating research results. The performance target in FY 2001 was to fund a minimum of 40 projects in reducing medical errors and enhancing patient safety, therefore, AHRQ exceeded its target.



On April 12, 2001, Secretary Thompson announced that HHS would immediately begin the process of implementing the patient privacy rule that gives patients greater access to their own medical records.

Also in FY 2001, new regulations were published to give Medicaid beneficiaries in managed care plans the same types of protection that participants in managed care plans would receive under patient rights' legislation that was proposed in Congress. This would include emergency room care whenever and wherever the need arises, access to a second opinion, and grievance systems, among other rights.

Under Medicare, the appeal process is a critical safeguard already available to all Medicare beneficiaries to ensure their rights. This appeal process allows beneficiaries to challenge denials of payment or service. On April 27, 2001, CMS released a policy letter that requires Medicare+Choice organizations to report to CMS on their internal aggregate level appeal data. CMS will analyze this information to understand more about the number and type of appeals filed by beneficiaries and the disposition of the appeals. This letter satisfies part of the FY 2001 target. The other part of the target, collection of appeal data, has been delayed due to concerns regarding burdening Medicare+Choice organizations with increased reporting requirements. This same concern delayed implementation in FY 2000. Therefore, that part of the target was not met. Further evaluative efforts will be undertaken to determine data needs necessary to comply with the Benefits Improvement and Protection Act, and the extent to which new, additional data elements should be collected in order to improve the administration of this essential beneficiary protection.

In addition to safety and other protections, citizens have the right to keep their medical records confidential. On April 12, 2001, Secretary Thompson announced that HHS would immediately begin the process of implementing the patient privacy rule that gives patients greater access to their own medical records and more control over how their personal information is used. The Secretary indicated he will issue modifications and guidance as necessary to correct unintended effects of the rule on access to or the quality of health care. Then on July 6th, HHS issued the first in a series of guidance material on new federal privacy protections for medical records and other personal health information.

Heart Attack Survival Rates

Adverse health conditions clearly affect a large number of Medicare beneficiaries, and heart disease is the most common condition for which Medicare beneficiaries are hospitalized.

Improving treatment for heart attacks has been a focus of CMS' Health Care Quality Improvement Program since its inception in 1992. CMS works through a network of health care providers to reduce deaths from heart attacks by improving hospital performance, using such techniques as aspirin administered to prevent blood clots, beta blockers to decrease the heart's workload and oxygen need, and counseling to assist patients in eliminating smoking. This nation-wide effort focused on implementing known successful interventions for properly treating heart attacks and preventing second heart attacks.

Program performance for improved heart attack survival rates is measured by the one-year mortality rate for Medicare beneficiaries following hospital admission for heart attack. The target periods cover two years. In FY 1995-1996, the baseline was a 31.2 percent mortality rate. This rate increased for the FY 1997-1998 and FY 1998-1999 target periods (31.7 and 32.3 percent, respectively). This may be attributable to several factors including that our efforts in this area have been phased in gradually; there may have been a change in diseases that exist or occur concurrently; and the age distribution of the Medicare population has increased, which could require risk adjustment. Analyses are underway to try to determine the effect of these factors and to modify the goal accordingly. The FY 2000-2001 target was 27.4 percent; actual performance data will be available in FY 2003.

A national intervention program, similar to the pilot project, was initiated in FY 2000. It is expected that this will result in a decline in one-year mortality after heart attacks by about one percentage point once interventions are widely adopted.

Medicaid Outcomes at Health Centers versus Other Sources of Health Care

Health Centers for the underserved and uninsured provide a high quality of primary health care that reduces

Improving treatment for heart attacks has been a focus of CMS' Health Care Quality Improvement Program since its inception in 1992.

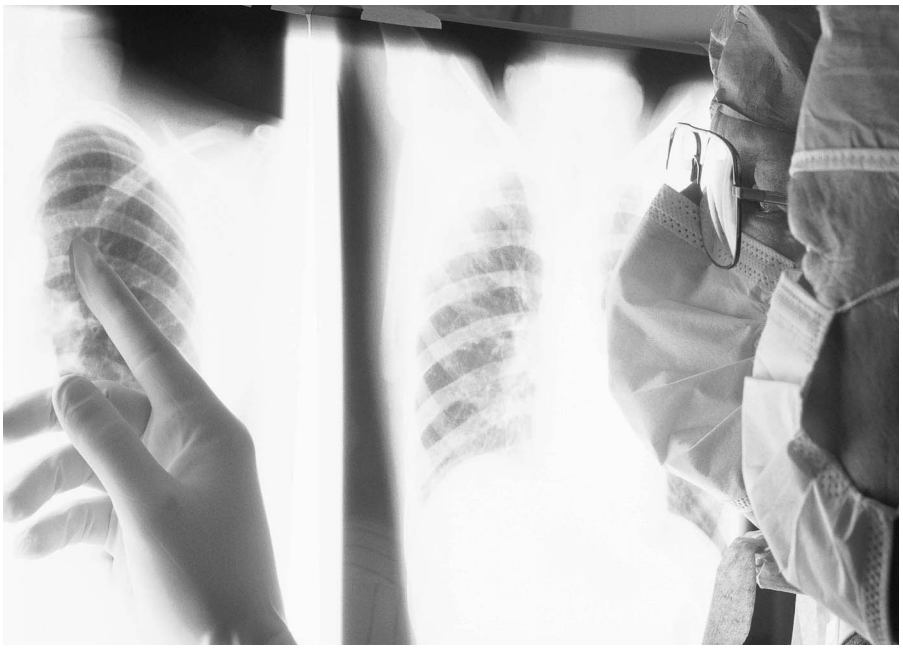
hospitalizations and emergency room use, reduces annual Medicaid costs, and helps prevent more expensive chronic disease and disability. Having a regular source of primary health care has been shown to have as much of an effect on health status disparities as income inequality. This bodes well for eventual reduction and elimination of their health status disparities. This is evidenced by the facts that: 1) Health Center Medicaid patients are 22 percent less likely to be inappropriately hospitalized than Medicaid beneficiaries who obtain care elsewhere, and 2) while patients at Health Centers have rates of hypertension and diabetes that far exceed national prevalence rates for comparable racial/ethnic and socioeconomic groups, Health Center patients who are diabetics are twice as likely to have their glycohemoglobin tests performed at regular intervals than national norms, and hypertensives are more than three times as likely to report that their blood pressure is under control.

The performance targets for FY 2001 are that 90 percent of Health Center diabetics have up to date glycohemoglobin testing and 96 percent of Health Center hypertensives report that their blood pressure is under control. Actual performance data will be available in late 2002 and 2003, respectively. According to the latest actual data, a 60 percent glycohemoglobin test rate was achieved in FY 1999, which met the target for that year. Also the reported hypertension control rate was 90 percent in FY 1995. The FY 2001 target for decreasing the proportion of Health Center users who are hospitalized for potentially avoidable conditions is 13 per 1000. According to the most recent data, that rate was 14.7 per 1000 in FY 1997.

Tracking individual Health Center performance on all these measures will enable the program to continuously improve its overall level of performance. Successful strategies employed in Health Centers with rates that far exceed the average can be shared with Centers that could use improvement in their rates.

Long-Term Care and Nursing Homes

Individuals in long term care facilities, or nursing homes, are a particularly vulnerable population, and consequently, it is an area of considerable importance. Achieving low prevalence of physical restraint use is an accepted indicator of quality of care, and considered a proxy for measuring the quality of life for nursing home residents. The use of restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. CMS seeks to protect beneficiaries by surveying facilities participating in the Medicare program. This is accomplished by the State Survey and Certification Program, which has been successful. The most recent FY 2000 data shows that the target to decrease use of restraints in nursing homes to 10 percent was met. The target for FY 2001 is also no more than 10 percent and final data is expected in March 2002. Other improvements were made to the survey and certification program in FY 2001 to ensure that states conduct surveys on a timely basis. The CMS used a new price-based methodology for state budgets that reflected whether states met the average national survey time for long term care facilities.



Health Centers for the underserved and uninsured provide a high quality of primary health care that reduces hospitalizations and emergency room use, and reduces annual Medicaid costs.

Assisted living facilities are often viewed as providing an alternative to nursing home care. This past year, the first national study of assisted living facilities for elderly individuals was released. "A National Study of Assisted Living for the Frail Elderly" was published in August 2001. It has been underway since 1994 and profiles the residents, staff, walk-through observations, and the facilities. Among the major findings was that most residents surveyed feel that they are treated with respect, affection and dignity by facility staff, however, they were concerned over the number of staff available and staff turnover. This report will be useful for the elderly and their caregivers in assessing long term care options.

Also, in February 2001 the HHS National Family Caregiver Support Program was launched to help family members provide care for the elderly at home. As the largest new support program under the Older Americans Act since 1972, states received $113 million in grants to run programs that provide critical support, including home and community-based services, to help families maintain their caregiver roles.

New Freedom Initiative

On February 1, 2001 President Bush announced the New Freedom Initiative to help remove barriers that can prevent the 54 million Americans living with disabilities from participating fully in community life. As part of this effort, Secretary Thompson is heading the Interagency Council on Community Living, a special task force supported by HHS, the Departments of Education, Justice, Labor, Housing and Urban Development, and the Social Security Administration. The Council is charged with evaluating the programs, statutes, and regulations of their respective agencies to determine whether they should be revised or modified to improve the availability of community-based services for qualified individuals with disabilities. In February, HHS began awarding grants under a new $50 million grant program for improving the home and community-based services available to children and adults with disabilities.

Research into the fields of health and medical science plays an important role in improving the nation's knowledge about disease and our efforts to combat it. The "health research" goal recognizes the prominence of health research in HHS and its importance in fostering a more healthy society.

The objectives under this goal focus on creating knowledge that ultimately is useful in addressing health challenges and in maintaining and improving the research infrastructure that produces scientific advances. HHS strives to advance the scientific understanding of normal and abnormal biological behaviors and functions, and to improve our understanding of how to prevent, diagnose, and treat disease and disability.

HHS carries out this mission in several ways. It conducts research in its own laboratories. It supports research of non-federal scientists in universities, medical centers, hospitals, and research institutions throughout the country and abroad. It helps train research investigators. In addition, it fosters communication of medical information. HHS invests the public's resources and support for medical science in three basic and interrelated ways. First and foremost, we conduct and support medical research. Second, we contribute to the development and training of the pool of scientific talent. Third, we participate in the support, construction, and maintenance of the laboratory facilities necessary for conducting cutting-edge research.

Human Genome

One of the most important research projects undertaken in recent years is the sequencing of the human genome. To fully understand and catalogue the genetic make-up of a human being could lead to further unprecedented breakthroughs with potential life-changing and life-enhancing benefits.

The goal was to develop critical genomic resources, including the DNA sequences of the human genome and the genomes of important model organisms and disease-causing microorganisms. More specifically, our FY 2001 goal was to complete the "full shotgun", or draft sequence of human genome sequence (95 percent complete with 99.9 percent accuracy), to finish one-

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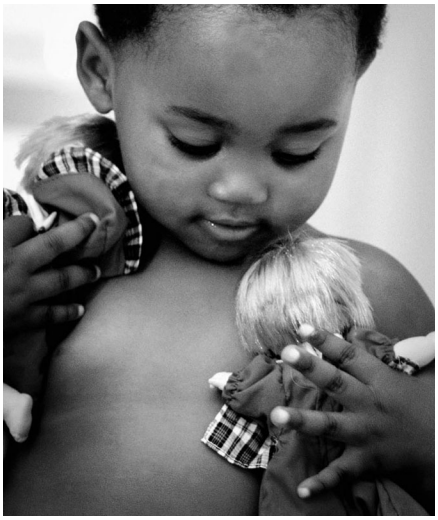
third of the complete human genome at 99.99 percent accuracy, and identify 2,500,000 human single nucleotide polymorphisms (SNP).

The results are as follows: The "full shotgun" has been completed and 54 percent of the genome was in the completely finished form at 99.99 percent accuracy, and the public database that serves as a central repository for SNPs had received submissions for 3,845,647 SNPs for the human genome.

Scientific Achievements

Biomedical researchers have made astounding breakthroughs in unlocking mysteries of biology and disease. The following section provides just a few examples of some of NIH's most important achievements in FY 2001:

✹ *Researchers found that infants who die of Sudden Infant Death Syndrome (SIDS) have abnormalities in several parts of the brain stem. This finding builds upon the results of earlier work in which abnormalities in parts of the brain were found in children who dies of SIDS. The findings suggest that SIDS may originate early in fetal life;*



✹ *Animal studies suggest that early life stress may have important consequences on the adult, with implications for long-lasting changes in resilience to disease. These studies provide a basis for observed relationships between early life events and health in adulthood;*

✹ *The use of DNA microarray chips to examine the patterns of gene expression for hundreds or even thousands of genes in a single experiment is a major discovery tool for biomedical researchers. Using this large-scale approach enables researchers to focus on key genes and tease out the regulatory factors in the pathways that lead to cell death and failure of tissues to repair; and*

✹ *New research shows that those who use methamphetamine risk long term damage to their brain cells similar to that caused by strokes or Alzheimer's disease.*

Stem Cell Research

In August of 2001, President George W. Bush outlined a very promising new research path:

"Eight years ago, scientists believed fetal tissue research offered great hope for cures and treatments -yet, the progress to date has not lived up to its initial expectations. Embryonic stem cell research offers both great promise and great peril. So I have decided we must proceed with great care.

As a result of private research, more than 60 genetically diverse stem cell lines already exist. They were created from embryos that have already been destroyed, and they have the ability to regenerate themselves indefinitely, creating ongoing opportunities for research. I have concluded that we should allow Federal funds to be used for research on these existing stem cell lines, where the life and death decision has already been made.

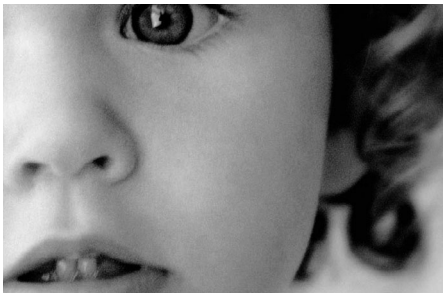
Leading scientists tell me research on these 60 lines has great promise that could lead to breakthrough therapies and cures. This allows us to explore the promise and potential of stem cell research without crossing a fundamental moral line, by providing taxpayer funding that would sanction or encourage further destruction of human embryos that have at least the potential for life."

In supporting the development of this policy in FY 2001, NIH performed critical work analyzing the existing knowledge about stem cell research, including both embryonic and adult stem cell potential. It also performed extensive work in preparing the stem cell Registry. The Registry, which was established later in 2001, lists the cells that are eligible for federally funded research (http://escr.nih.gov). A strategy for implementing President Bush's decision for funding this research was also subsequently put into place.

Publicizing our Research

As we move from basic research to applied research, it is important to let citizens know that there are tangible results from our research that can enhance their lives and, in some cases, even save lives. Another goal for this year is to publicize the opportunities for individuals to participate in a clinical trial. A clinical trial is a potentially promising experimental treatment or drug that is available to persons who have a specific condition that could benefit from the application.

The FY 2001 targets for establishing a clinical trials database included 1) promoting the database as a resource for patients, physicians, researchers, community health groups and others; 2) completing an implementation study to determine the optimal design and function of a toll-free telephone service to facilitate access to information in the Clinical Trials Database; and 3) expanding the number of industry-sponsored clinical trials in the database by 250 and the number sponsored by other federal agencies by 100.



NIH effort achieved the following results in FY 2001. NIH promoted the clinicaltrials.gov database as a resource for patients, physicians, researchers, community health groups and others. The site receives about 2 million hits per month and hosts approximately 5,300 visitors daily. NIH also completed an implementation study in March 2001 to determine the optimal design and function of a toll-free telephone service to facilitate access to the clinicaltrials.gov database. In addition, the number of industry sponsored clinical trials was increased to over 100. The number sponsored by federal agencies doubled in FY 2000.

Human Drugs Program

Another extremely important research area, with potentially broad and far-reaching effects is The Human Drugs Program. This program is responsible for ensuring that all drug products used for the prevention, diagnosis, and treatment of human disease are safe and effective, and that information on proper use is available to all users. To achieve this mandate, premarket review, postmarket surveillance, education, research, and other strategies are employed and periodically assessed. The program's specific responsibilities include:

- *Regulating the testing of investigational new drugs (INDs);*
- *Evaluating new drug applications (NDAs) and abbreviated new drug applications (ANDAs) for generic drugs;*
- *Monitoring the quality of products manufactured in, or imported into, the United States;*
- *Collecting and evaluating information on adverse effects experienced with marketed products;*
- *Regulating the advertising and promotion of prescription drugs;*
- *Establishing and monitoring standards for use, labeling, and composition of both prescription and over-the-counter drugs;*
- *Disseminating timely and accurate product information to the medical community and the public;*
- *Working with other federal agencies to assure that adequate supplies of medicine and vaccines are available to the American public in the event of a bioterrorist attack;*
- *Identifying drugs that have potential for abuse and making recommendations to the U.S. Department of Justice's Drug Enforcement Administration for drug classification and control; and*
- *Encouraging the development of new drugs.*

Premarket Review for New Drugs

The first strategic goal of the Human Drugs Program was to reduce human suffering and enhance public health by facilitating access to important, lifesaving drugs, and assuring availability of safe and effective drugs. We achieved this goal through continued efforts to meet mandated review times for NDAs and ANDAs. This was accomplished through continued communication and collaboration with industry, academia, professional societies, and healthcare organizations.

The timely performance of high-quality drug reviews in recent years

reflects the importance of managerial reforms and additional resources provided under the Prescription Drug User Fee Act (PDUFA). PDUFA, first enacted in 1992, was renewed for an additional five years in the 1997 FDA Modernization Act. Under PDUFA, the drug industry pays user fees for NDAs, efficacy supplements, and some other activities. User fees helped HHS hire additional scientists to perform reviews. PDUFA is now up for re-authorization in FY 2003.

PDUFA has resulted in increasing numbers of applications being filed, higher quality applications, and quicker approvals for products with the requisite data. HHS' goals become more challenging each year. Nonetheless, application filings and quality remain high by historic standards and approval times continue to drop. Additionally, American patients are receiving the benefits of important new drugs before they are available to citizens of other countries.

A key target for FY 2001 was to review and act on 90 percent of standard original NDA submissions within 12 months of receipt and 90 percent of priority original NDA submissions within six months. Data for 2001 will be available in early 2003.

FDA met its FY 2000 performance goal as 97 percent of the priority applications were reviewed on time and 96 percent of the standard applications were reviewed on time. The goal in each case was 90 percent.

Overview of Management Performance

Strong performance in management areas provides a strong foundation for program performance. A Department as large as HHS must have strong management systems and controls in place in order to safeguard its assets and fulfill its mission efficiently and effectively.

The President initiated five government-wide reforms in FY 2001 to improve the management of the federal government. A brief discussion on these and additional management areas follows. Additionally, readers may refer to Appendix K for information on management performance measures and actual results for FY 2001.

Human Capital and the HHS Workforce

HHS, like most federal agencies, is facing an upsurge in retirements in the next five years that will transform our workforce. Presently, 13.5 percent (7,595) of our employees are eligible to retire. By the end of 2005, 33.6 percent of our current employees will have reached retirement eligibility. We project that by that time 19 percent (10,373) of HHS' FY 2001 employees will actually have retired. The changes in our workforce that are being driven by retirements and turnover demand that we actively manage our human capital.

The "bulge" of upcoming retirements will cut into our institutional knowledge and in-depth familiarity with the nuances of the laws and regulations of complicated federal programs. These skills are often attained only after decades of federal experience. HHS is building a pipeline of junior-level workers in order to offset impending losses. We want to ensure that we have effective capacity and institutional memory to meet our goals of serving the public and stewarding tax dollars.

Part of our human capital initiative includes building the workforce of the future, recruiting new workers and actively working to retain people with essential skills. We are also providing training and development to equip our employees with the skill sets they will need to meet future challenges. Our retention efforts are aimed at improving the quality of work life in HHS, improving the image of the federal government and HHS as an employer, and maintaining high morale among HHS employees.

The HHS emphasis on human capital recognizes the transformation occurring in the federal government toward greater emphasis on

performance and accountability and the indispensable role that our people play in achieving strategic goals and serving the public.

Our human capital initiative is aimed at making the Department more citizen-centered and responsive to the needs of our customers. HHS took a number of significant actions in FY 2001 to address these human capital challenges. Significant accomplishments included:

✹ *Preparing the first Department-wide workforce analysis which identifies cross-cutting skills sets; the anticipated impact of retirements in the next five years; and a series of discrete steps to address the potential loss of needed skills from the workforce;*

✹ *Establishing the HHS Career Intern Program as one way to increase entry-level hiring to replace retiring older workers. The first Career Intern Class will be hired in FY 2002;*

✹ *Developing workforce restructuring plans in each OPDIV to re-direct human capital toward mission-related activities, consolidate administrative operations, reduce management layers and achieve economies of scale;*

✹ *Establishing performance contracts for all senior leadership for the FY 2002 performance cycle; and*

✹ *Launching the HHS Learning Portal on the Internet (part of the HHS Distributed Learning Network) to make learning, information, and collaborative tools available to employees wherever and whenever needed. Currently, 12,000 HHS employees have access to more than 1,300 on-line courses and several hundred employees are participating in six pilot Communities of Practice through the Learning Portal.*

Competitive Sourcing and Procurement Management

In FY 2001, nearly 700 HHS contracting personnel awarded and administered over 230,000 procurement actions (excluding purchase card transactions), worth more than $5.0 billion. Also, HHS obligated an additional $1.63 billion from the Medicare Trust Funds for contracts with Medicare intermediaries and carriers. These procurement actions and contracts helped to meet the Secretary's goals of ensuring cost-effective health care and human services; ensuring the integrity of the Medicare Program; enhancing health promotion and disease prevention; improving access to health care for all Americans; providing adequate support for biomedical research; and implementing the Unified Financial Management System (UFMS).

Major procurement accomplishments in FY 2001 included the following:

✹ *The Department awarded over 1,400 performance-based contracts and modifications for a total of $588.6 million (excluding performance-based contracts with Medicare intermediaries and carriers); conducted a well-received Government-wide Performance-Based Contracting (PBC) seminar for the National Contract Management Association; held a successful HHS-wide conference on performance-based management; developed a PBC Lab module under its web-enabled and customer-oriented PBC Desk Reference; and strengthened its practical, hands-on PBC workshops. PBC remains one of the Administration's management priorities;*

✹ *On behalf of the Department, NIH conducted two secure, web-based, innovative "reverse auctions" for the purchase of biomedical supplies. The dynamic, real-time price competition inherent in "reverse auctions" resulted in cost savings of nearly $400,000;*

✹ *The Department overhauled and streamlined its Acquisition Regulation to focus on guiding principles and provide more decision-making discretion to OPDIV contracting officers. This*

The Department successfully negotiated a contractual mechanism to provide impartial, web-based survey services to support OPDIV implementation of our Acquisition Balanced Scorecard.

resulted in an estimated 33 percent reduction in the size of the regulation. Moreover, HHS's Acquisition Regulation was made available in electronic form to improve accessibility;

✹ *HHS used purchase cards to conduct over 680,000 micro-purchases, an increase of more than 20 percent over the prior year;*

✹ *In implementing Electronic Commerce over the past year, all 42 HHS procurement offices were successfully transitioned to the use of the FedBizOpps portal. Over 2,000 procurement opportunities (synopses and solicitations) were electronically posted;*

✹ *On behalf of the Department, CDC used its FACNET-equivalent Electronic Commerce methodology to place 86,310 routine electronic delivery orders with vaccine manufacturers and other vendors holding long-term IDIQ contracts;*

✹ *The Department submitted its third annual Commercial Activities Inventory under the FAIR Act, and achieved greater consistency among the OPDIVs in their treatment of similar functions (e.g., personnel, accounting, and budget);*

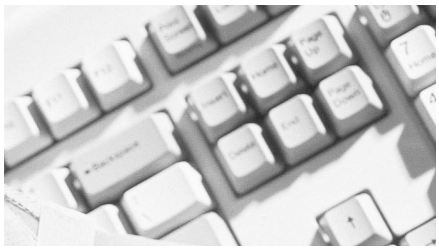
✹ *The Department successfully negotiated a contractual mechanism to provide impartial, web-based survey services to support OPDIV implementation of our Acquisition Balanced Scorecard. In addition, we obtained OMB's timely approval to conduct contractor surveys under the Scorecard;*

✹ *Using web-based and JAVA-oriented technologies, HHS continued to enhance the query and reporting capabilities of its Departmental Contracts Information System [DCIS]. This has resulted in improvements to the reliability, timeliness and utility of HHS' procurement data, as well as better support for executive decision-making. Also, the Department purchased web and database servers to enhance connectivity to the DCIS. Further, in addition to servicing its OPDIV clients and the Departments of Transportation and Treasury, HHS conducted discussions on the feasibility of providing DCIS support to Justice, NASA and Interior;*

✹ *The Department's Acquisition and Project Officer Training Program provided comprehensive, formal training for both contracting professionals and project officers. Contracting personnel used 945 training slots and project officers used 2,833 training slots. Also, HHS developed a successful executive seminar on Earned Value Project Management;*

✹ *On behalf of the Department, NIH continued to refine HHS' user-friendly Contractor Performance System—which gauges the past performance of government contractors. Also, NIH continued to add organizations to its customer base, which now includes nearly 20 Departments and major agencies; and*

✹ *HHS contracting staff took the lead in developing acquisition strategies for the two major Information Technology capital investments that serve as building blocks for the Unified Financial Management System (UFMS)—CMS' Healthcare Integrated General Ledger Accounting System (HIGLAS) and NIH's Business and Research Support System (NBRSS). Those two acquisitions were successfully accomplished, notwithstanding very complex requirements and multiple procurement protests at GAO.*



Financial Management Performance

Improving financial management is a presidential management agenda item, and has long been a goal of HHS. Regarding specific elements of the President's Management Agenda for Improving Financial Management, for the first time HHS is producing comparative financial statements in this report for the balance sheet and statement of net costs, presenting both FY 2001 and FY 2000. Regarding the issue of payment error rates, HHS has been a pioneer in the field of identifying, quantifying, and reducing payment errors in the Medicare fee-for-service program. This experience is being applied to the Medicaid program with pilot efforts. Additionally, HHS is developing plans for producing quarterly financial statements, and accelerating year-end financial reporting. The Department has made significant improvements in other financial management areas over the last several years, particularly since Department-wide financial statement audits were instituted for FY 1996.

Financial Audit Results and Internal Control Improvements

HHS has made significant improvements in internal controls and financial reporting mechanisms since FY 1996, the first year Department-wide financial statements were audited and auditors disclaimed an opinion. HHS earned its first unqualified, or "clean" audit opinion on its FY 1999 financial statements, reducing the number of audit qualifications from seven in FY 1996 to zero in FY 1999. In the two subsequent fiscal years, the Department's financial statements have been both "clean and timely" and prepared earlier than the prior year. HHS has reduced the number of department level internal control material weaknesses cited by our financial statement auditors from five in FY 1996 to two in FY 2001.

HHS Audit Findings History: FY1996- FY2001

	2001		2000		1999		1998		1997		1996	
Issue Category	Qualification	Material Weakness	Qualification	Material Weakness	Qualification	Material Weakness	Qualification	Material Weakness	Qualification	Material Weakness	Qualification	Material Weakness
Medicare Accounts Payable										X	X	X*
SMI Revenue											X	
Medicare/ Medicaid Accounts Receivable				Merged into Financial Systems and Processes material weakness		X Includes Medicare contractor receivables only, excludes Medicaid	X Includes Medicare contractor receivables only, excludes Medicaid	X Includes Medicare contractor receivables only, excludes Medicaid	X		X	X*
Cost Reports									X		X	
Net Position									X	**	X	X
Pension Liability											X	
Initial Audit											X	
Medicare EDP Controls		X		X		X		X		X		X
Grants Oversight and Accounting									X Excludes Oversight	X Excludes Oversight		X Includes Oversight
Medicare Claims Error Rate										X		X
Intra-entity Department-wide Transactions									X			
Financial Reporting Systems and Processes		X		X		X		X		X**		
New Statements							X					
Total	**0**	**2**	**0**	**2**	**0**	**3**	**2**	**3**	**5**	**5**	**7**	**5**
Resolved from Prior Year	0	0	0	1†	2	0	4	3	4	1**	N/A	N/A
New	0	0	0	0	0	0	1	0	2	1	7	5
Opinion	**Unqualified**		**Unqualified**		**Unqualified**		**Qualified**		**Qualified**		**Disclaimer**	

* Consolidated into one material weakness citing both accounts payable and receivable in FY 1996.
** Net Position issue from 1996 was consolidated into financial reporting issue in FY 1997.
† Medicare accounts receivable was merged with financial systems material weakness in FY 2000.

HHS used purchase cards to conduct over 680,000 micro-purchases, an increase of more than 20 percent over the prior year.

HHS has also improved its financial statement reporting systems since it was first identified as a material weakness by the auditors in FY 1998. In the short term, we have implemented the internet-based Automated Financial System (AFS) to facilitate HHS agency reporting for departmental consolidation purposes. However, though this system requires less manual intervention than its predecessor, it is only a short term solution for financial reporting because AFS is still manually-intensive. A long-term solution for financial management and financial reporting is being developed.

New Departmental Financial Management System

Consistent with the President's Management Agenda under the improving financial performance initiative, HHS has announced a "One Department" approach to information technology which emphasizes management of resources on an enterprise basis with a common infrastructure. In FY 2001, HHS initiated a six-year project to implement a Unified Financial Management System (UFMS) to replace five legacy systems and integrate two major sub-systems. Specifically, HHS will have one financial management system comprised of two major sub-components. One sub-component will be for CMS and the Medicare Contractors called the Healthcare Integrated General Ledger and Accounting System (HIGLAS), and another sub-component for the rest of HHS will both be integrated into a Department reporting system. This unified system will be designed to automate all internal and external financial reporting needs.

Cost accounting is a key element in determining the effectiveness of programs and the impact on those programs if funding is increased or decreased. We are currently determining the management cost accounting requirements for the UFMS that will support decision-making and accountability with the capability of linking HHS financial costs with program performance and budget information. This linkage is another of the President's Management Agenda items.

The goal of UFMS is to provide the full HHS portion of costs for services and products that influence program outcomes, and be a standard, efficient system that can accrue costs spent throughout HHS on Departmental programs or initiatives. The system will provide HHS managers with timely and complete HHS cost information with which to help monitor and improve their program results, plus integrate budget and performance.

In moving forward with the UFMS initiative, we have established a Program Management Office (PMO) and team to oversee the design and implementation of the unified system. Under the tutelage of the PMO, we are developing the business case for the system. Through the business case process we will clearly define the vision, goals and objectives for UFMS. We will develop an implementation plan, identify our risks as well as risk mitigation plans, determine our cost benefit and our return on investment and develop our performance measurements.

Debt Collection

A major financial management priority for the Department is its debt management programs. HHS' debt collection efforts focus on the provisions of the Debt Collection Improvement Act (DCIA) of 1996. Delinquent debts owed to all HHS components continue to be referred to the Department of the Treasury for collection. Treasury has designated the Program Support Center (PSC) as a debt collection center for several types of program debts (e.g. Medicare Secondary Payer, unfiled Medicare cost reports and various health professional loans). HHS centralized DCIA debt management operations in the PSC. The PSC applies a number of debt collection tools before referring these debts to Treasury's Treasury Offset Program (TOP) for collection. HHS also assists states in the collection of delinquent child support when delinquent debts are referred to TOP for collection. HHS and Treasury cooperation in the overall debt collection effort has resulted in:

- *Decreasing HHS FY 2001 total receivables by $1.2 billion from the FY 2000 balance;*
- *Increasing the overall HHS referral rate for collection for FY 2001 by 23.8 percent. The overall referral rate for HHS is expected to increase dramatically in FY 2002 when the Centers for Medicare & Medicaid Services (CMS) is scheduled to refer 100 percent of its debts;*
- *Achieving HHS total collections in excess of $14.4 billion or 52 percent of total receivables ($27.9 billion) in FY 2001. This compares favorably to the government-wide collection rate of 26 percent for the same period; and*
- *Disbursing $1.64 billion to the states through TOP from the offset of federal tax and non-tax payments in FY 2001 to reduce child support obligations.*

The HHS e-Gov Vision is to use information technology in concert with the Department's program and management priorities to create "One-HHS."

HHS Agency Financial Management Accomplishments and Initiatives

Additional financial management accomplishments occurred at the HHS agency level where five HHS components have accounting operations. Some of their financial management accomplishments include the following:

- The Office of the Secretary (OS) launched the Department's Unified Financial Management System initiative during FY 2001, a critical element in implementing the Secretary's "One HHS" vision. The system will replace five legacy systems currently used across the Operating Divisions. Once fully implemented, UFMS will integrate the Department's financial management systems structure and provide HHS leaders and managers a corporate view of critical financial management information, including costs incurred on HHS programs. During the fiscal year, the OS:
  - 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 support the "to be" configuration and structure of the system.

- CMS has established a HIGLAS Program Office to manage all aspects of the HIGLAS project, a key sub-component of the UFMS;

- CMS' expansion efforts of the debt referral process resulted in an additional $2.1 billion of delinquent debt being referred to the HHS Program Support Center and Treasury for further collection activity;

- CMS revised and clarified financial reporting and debt collection policies and procedures based on findings from previous CFO audits, oversight reviews, and systems (SAS 70) reviews. CMS also published an Accounting Procedures Manual, which will ensure that similar transactions are treated consistently and that accounting principles in use are proper;

- NIH initiated a review to address and resolve the material weakness cited in the audit of the NIH's FY 2000 financial statements. The review included NIH, HHS, and contract audit staffs. It focused on the methodology and discipline applied to the NIH's fiscal year closing process. As a result of these efforts, NIH implemented numerous additional analyses and reconciliations; NIH implemented a new, more disciplined and controlled process to prepare the trial balances from which NIH prepares the agency's financial statements, and identified additional needs for improvement for which NIH has already begun work. For example, NIH validated and changed, as appropriate, certain internal processes, and provided more training to accounting staff;

- NIH implemented a new web-based tool that allows analysis of all general ledger accounts on line. This tool quickly allows the user to review individual general ledger accounts by transaction codes. This has allowed NIH to correct and compensate for some of the deficiencies noted by its auditors. The information is more reliable and available in a timely manner for review and reporting purposes;

- NIH has completed the automation of the new loan repayment program;

- NIH completed the automation of the new royalty inventor payment system;

- FDA developed a new training manual on procedures for implementing reimbursable inter-agency agreements where FDA receives income from other agencies. Training sessions were conducted for all FDA components;

- FDA is implementing "Travel Manager," an off-the-shelf software system throughout FDA, to automate the travel process;

- CDC modified its budget structure for the first time in 30 years to align it more closely with its organizational structure;

- CDC had developed, with assistance from specialized consultants and accountants, a new method for allocating indirect costs. This method, which will be implemented during FY 2002, will directly link users of centrally mandated services — the normal, recurring expenses such as GSA rental payments, utilities, postage, maintenance, security services, and departmental assessments — with the costs of performing those services;

- CDC has begun working to enhance and improve its fiscal management activities in areas such as core accounting competencies, professional staff recruitment, financial systems, training, and customer service. A key CDC priority is strengthening its accounting staff by recruiting and hiring qualified experienced accountants, certified government financial managers, and certified public accountants;

- PSC's Division of Cost Allocation (DCA) completed over 1,895 grant and contract negotiation assignments that produced $559 million in cost avoidance and negotiated cash refunds of approximately $87 million;

- PSC referred more than $300 million in delinquent debt owed by customers to the Treasury Offset Program for additional collection activity;

- PSC implemented a major upgrade to Gov.net® in July 2000. Initial estimates of annualized savings indicate $320,000 direct savings to customers in ADP costs from the NIH/CIT. Gov.net® enables customers to acquire reports within 1-2 working days after the end of a reporting period, versus 5-7 days required under the manual distribution method. Reports are retained in Gov.net® indefinitely, allowing customers to immediately review reports crossing multiple reporting periods. All weekly, monthly, and yearly ledger and document-level reports, as well as payroll reports are distributed via Gov.net®

  July 2001 – Major upgrade to Gov.net® provided customers the capability of downloading "flat files" (record-type files in comma delimited format) of select reports directly to their local hard drive where they can view them in Excel, Access, or other spreadsheet applications;

- PSC's Division of Financial Operations (DFO) acquired a commercial off-the-shelf (COTS) package called MACCS (Managing/Accounting Credit Card System), to support credit card activity for the PSC and its customers;

  MACCS provides far better transaction level information, easier reconciliation, better reporting options, and direct transfer of transaction information into other accounting and management systems. The MACCS system has resulted in significant cost savings by enabling electronic receipt of invoices, greatly improving the efficiency of the purchase card transaction review process, and providing faster payment. In addition, the system permits electronic posting of obligation and payment transactions to the central accounting system (CORE); and

- PSC processed 281,000 payment transactions totaling more than $218 billion in grant funds. PSC also added 3,077 grant recipient accounts for a total of more than 26,900 customers.

Network modernization is a critical engine for change in HHS. A first step in this project was the development of an IT inventory that identifies opportunities for modernization and consolidation.

Electronic Government and Information Systems Management

The HHS e-Gov Vision is to use information technology in concert with the Department's program and management priorities to create "One-HHS." Having "One-HHS" closes the performance gap and will provide seamless and integrated services to our constituents. The "One-HHS" program fulfills the ultimate vision of e-Gov to create a virtual pool of government information and services available from throughout HHS and accessible by all constituents. Aggregation and consolidation of HHS IT initiatives will result in a more cost efficient IT structure at HHS along with more unified, responsive access by the public to HHS services. All levels of HHS will collaborate as equal partners to provide citizen-centric services with the result of reducing burdens on businesses, increasing customer satisfaction, improving knowledge management, and pursuing a unified strategy in the Department.

The following are examples of cross-cutting e-Gov investments:

✹**E-grants.** HHS is leading the Administration's effort to streamline the grants process. This initiative is mandated by Public Law 106-107 to streamline, simplify, and provide electronic options for the grants management processes employed by the federal agencies and to improve the delivery of services to the public.

✹**E-training.** HHS has a Distributed Learning Network (DL\net) making skills training and performance support available electronically to HHS employees. This project provides the infrastructure and support for continuous, just-in-time, cost-effective learning to enhance mission achievement.

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

In HHS, information technology is the key to providing better government services at reduced costs and is the foundation for efforts to re-engineer HHS. The Secretary's goal is to administer HHS' information technologies as a single corporate enterprise. The two top priorities in this corporate enterprise are IT security and network modernization.

With regard to IT security in September 2001, a contract was awarded to: prepare a concept of operations for Department-wide computer security incident response system that leverages existing capability; train all HHS employees in security awareness; and assess enterprise security risk. Ten security projects have been approved for immediate development and funding. Key actions included: installation of multi-tier virus protection across HHS; vulnerability scans of critical HHS systems; establishment of round-the-clock monitoring of security alerts; and perimeter protection for all Internet access points.

Network modernization is a critical engine for change in HHS. A first step in this project was the development of an IT inventory that identifies opportunities for modernization and consolidation. An asset tracking system has been installed which details all network connected devices Department-wide, and the inventory is complete. This inventory provides critical information necessary for the network modernization and consolidations of asset projects. Successful implementation of this enterprise project is building confidence for future efforts.

E-mail services for the Office of the Secretary (OS) will be consolidated at NIH; the OS Network will be consolidated at NIH. Consolidation of additional infrastructure systems in HHS is underway. Circuitry consolidation is a high priority now that the asset inventory is complete.

Cross-Cutting Functionality

A significant return on investment can be made by achieving economies of scale through consolidation of duplicative systems while providing improved service delivery. Currently the three efforts where enterprise-level system consolidation is underway at HHS are the Unified Financial Management System (UFMS), Enterprise Human Resources and Payroll System (EHRP), and the HHS Web Portal.

✹**Unified Financial Management System**

HHS will adopt a unified financial management system to replace five legacy systems. Specifically, HHS will

have one financial management system comprised of two major sub-components—one for 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 Department reporting system. The Department has established a Program Management Office to manage this project.

✹Enterprise Human Resources System

The Enterprise Human Resource Planning (EHRP) and Time and Attendance System will be an integrated, Web-based HR/Payroll system that provides managers and employees with intuitive, user-friendly, real-time desktop access to strategic HR information and processes. The EHRP initiative furthers the Department's goals and principles, notably, in the areas of enterprise, architecture consolidation, and creation of a "One-HHS."

✹HHS Web Portal to the Internet

HHS is creating an HHS Web Portal supporting a direct path for the American People. The web citizen-centric focus is defined as having a programmatic link to health initiatives for improving and expanding access to quality health care, and human services initiatives for increasing support for America's children and families.

Centralization of IT Funding

The HHS CIO is aggregating some agency IT infrastructure resources and will make them available for central management of enterprise projects. This methodology will ensure economies of scale for the crosscutting IT projects in HHS.

Using Information Technology to Better Serve our Customers

Many efforts are underway, at the HHS agency-level, to provide government services over the Internet and through alternative approaches. Some agency web sites primarily provide information; some go further, offering a variety of opportunities for the public to participate in interactive discussions, download forms, and/or apply for government services. The Department of Health and Human Services (HHS) has long been using electronic means to provide a variety of services to our customers. Some examples of these recent HHS e-Gov successes are presented below:

✹Health Alert Network (HAN)

HAN is a nationwide, integrated information and communications system serving as a platform for distribution of health alerts, dissemination of prevention guidelines and other information, distance learning, national disease surveillance, and electronic laboratory reporting, and for CDC's bioterrorism and other initiatives to strengthen state and local preparedness. The network proved to be a significant resource and communication tool for HHS in the wake of recent terrorist activity.

✹IntraMall

In the e-procurement area, the NIH IntraMall is at the leading edge of government e-commerce. The IntraMall is a fully functional web-based system available to meet all NIH and other HHS agency program needs, and become the Government's largest online purchasing system with over 1.7 million commodity products available.

✹Grants Administration, Tracking and Evaluation System

Grants Administration, Tracking and Evaluation System. The Administration for Children and Families' (ACF) main business is the administration of about 5,500 grants with a value of $35 billion. The awards under the grant programs are both discretionary and mandatory. The Grants Administration, Tracking and Evaluation System (GATES) is used by grants officers and specialists throughout ACF to manage their grant programs and process grant applications from receipt through award. It is one of the electronic grants systems being used within the Department. Financial information about grants is exchanged with the CORE accounting system daily as the status of grant applications change. GATES provides a single source of data improving consistency, accuracy and reliability of information relied upon by senior policy executives, program managers and staff to make decisions, direct programs and determine the appropriateness of strategic ACF objectives. Replacement of obsolete technology ensures continuing maintenance support from vendors and reduces operating costs. Upgrading the technology infrastructure also improves the timeliness of information provided to ACF users at all levels and helps ensure that GATES and other systems are available and accessible when needed. The realization of GATES directly contributes to the efficiency and effectiveness of ACF staff in delivering its services to clients and in reporting performance and results to Congress, the President and the public. Similar systems are operational in other HHS agencies.

✹Integrated Time and Attendance System

PSC has implemented an Integrated Time and Attendance System (ITAS), which provides virtual linkage of, leave requests, approvals and pay records to move the management of time and attendance to the desktop of employees and managers.

✹Electronic Insurance Validation And Verification

The Indian Health Service (IHS) has worked in collaboration with the U.S. Treasury to implement an electronic data exchange for the use of an electronic lockbox for payment processing to automate and reduce medical claim processing time while increasing accounting efficiency. The IHS now uses electronic insurance validation and verification for patient insurance.

The HHS CIO has aggregated agency IT infrastructure resources and will make them available for central management of enterprise projects. This methodology will ensure economies of scale for the crosscutting IT projects in HHS.

✹Knowledge Exchange Network

The Substance Abuse and Mental Health Services Administration (SAMSHA) participates in the Knowledge Exchange Network (KEN) which employs a web site to make available extensive information (in both English and Spanish) about mental health service programs to include a mental health service locator, consumer/survivor information, and pertinent publications. SAMSHA is aggressively using information technology to facilitate the transfer of prevention knowledge to States, communities, and individuals; and to improve program effectiveness and accountability at all levels. A major effort to this end is the web-based Decision Support System, which assists people in the development of effective prevention programs at the community, regional, and state levels.

✹Electronic Freedom of Information

HHS agencies are implementing the Electronic Freedom of Information Act. As an example, FDA has long worked with industry to harmonize information technology standards and implement electronic data exchange capabilities. A new focus on electronic regulatory submission and review resulted in partnerships between FDA and industry to improve the delivery of safe and regulated products to market by reducing cycle time and lower electronic submission costs. FDA has implemented the Electronic Freedom of Information Act; frequently requested and other public documents are available in an electronic format.

✹Medicare Current Beneficiary Survey

Since 1996, Medicare Current Beneficiary Survey (MCBS) through the CMS web site has been used to collect information about the availability to and use of the Internet by Medicare Beneficiaries. The CMS Office of Strategic Planning has established a web page on the CMS web site to communicate information concerning the MCBS. The page provides an overview of the MCBS, disseminates data and findings from the survey, and provides copies of the survey instruments and data files documentation along with frequency counts for the survey questions. CMS is pursuing improvements to its public web sites on a continual basis. These efforts include the addition of new interactive databases as well as the development of web-based decision tools for helping beneficiaries compare their health plan choices. CMS has recently developed a central database for all State Plan Amendments (SPA) and waivers submitted by States.

✹National Electronic Disease Surveillance Systems (NEDSS)

NEDSS and the electronic communications systems which support it are being developed to address this identified priority in CDC's strategic plan: the creation of integrated public health information and surveillance systems. The purpose is to tie together the current myriad, separate systems used for public health surveillance (at the federal and state levels) into a comprehensive solution that facilitates the efficient collection, analysis, and use of data and the sharing of computer software solutions across disease-specific program areas. Further, the system uses the Internet for the dissemination of important information on the practice of public health. CDC has also been a leader in PKI with over 3,000 digital certificates having been issued by CDC with our state and local health department business partners. This is part of what CDC has termed the secure data network (SDN) for public health surveillance over the Internet.

✹HHS Agency Web Sites

The NIH and CDC have been and continue to be an active leader and innovator in Electronic-Government (e-Gov). For example, the NIH and CDC web sites are consistently ranked among the top five most frequently referenced federal web sites, and NIH was recently rated the #1 health web site.

Integration of Budget and Performance

HHS continues to strengthen the integration of budget and performance. HHS was one of the first Departments to add tables to its GPRA Annual Performance Reports that explicitly associate resource dollars and performance measures, and we continued to refine that relationship in FY 2001. For example, the $1.1 billion allocated to funding Health Centers and the National Health Service Corps contributed to (among other activities) serving almost 11 million uninsured and underserved people in Health Centers. It also contributed to more women receiving PAP tests, mammograms, and clinical breast exams at those Health Centers.

Although we work in a challenging environment where health outcomes may not be apparent for several years, and the Federal dollar may be just one input to complex programs, HHS is committed to demonstrating to the taxpayer the value they receive for the tax dollars they pay.

Leading up to FY 2001, we made adjustments to the Annual Plans to communicate more clearly. In FY 2001, for the first time, the Secretary's Budget Council used performance data to inform their budget deliberations. We also began compiling program results across HHS and by agency. HHS' GPRA effort is committed to collecting and portraying performance information so that managers can develop more effective programs and decision makers can put scarce resources where they will do the most good.

As designated by OMB, HHS is the lead agency managing the Federal Grant Streamlining Program (FGSP).

Mandatory Grants

Mandatory grants are those that a federal agency is required by statute to award if the recipients, usually states, submit acceptable state plans or applications, and meet the eligibility and compliance requirements of the statutory and regulatory provisions of the grant program. In the past, mandatory grants were sometimes referred to as "formula grants." Mandatory grants include block grants, closed-ended grants, and open-ended entitlement grants. In FY 2000, mandatory grants comprised 87 percent of the total HHS grant funds, but only 7 percent of the total number of grant awards. (FY 2001 figures are not available as this report goes to print.)

Discretionary Grants

Discretionary grants permit the federal government, according to specific authorizing legislation, to exercise judgment, or "discretion," in selecting the applicant/recipient organizations, through a competitive grant process. The types of activities commonly supported by discretionary grants include demonstration, research, training, service, and construction projects or programs. Discretionary grants are sometimes referred to as "project grants." In FY 2000, discretionary grant awards comprise only 13 percent of the total HHS grant funds, but they account for 92 percent of the total number of HHS grant awards. (FY 2001 figures are not available as this report goes to print.)

Grants Management

As the largest granting component in the Federal Government, HHS plays a key role in federal grants management. Through over 300 assistance programs, HHS awards more than $184 billion of the total Federal grants awarded (estimated to be $325 billion).

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

Stewardship and oversight responsibilities for HHS grant programs involve a variety of administrative functions performed on an ongoing basis. These administrative functions include: assisting OMB in its revisions of key OMB Circulars pertinent to grants administration; providing training and developing related guidance documents on these revised OMB Circulars; conducting oversight through a "balanced scorecard" approach; strengthening HHS indirect cost negotiation capabilities; updating internal Departmental grants administrative procedures; and utilizing a department-wide grants management information system to organize and consolidate grant award data across all HHS grant programs.

As designated by OMB, HHS is the lead agency managing the Federal Grant Streamlining Program (FGSP). The FGSP is a Federal government-wide effort required by Public Law 106-107, the Federal Financial Assistance Management Improvement Act of 1999, to streamline, simplify, and provide electronic options for the grants management processes employed by the Federal agencies and to improve the delivery of services to the public. Additionally, HHS is undertaking several other grants consolidation initiatives within the Department, including: moratoriums on the creation of new grants offices and new electronic grants systems; accelerated annual grant planning; streamlining the competitive application review process; consolidation of functions (e.g., indirect cost rate negotiation; information technology commodities, services and other office supplies); and workforce restructuring.

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

Highlights of FY 2000 grant awards include the following:

- *HHS awarded almost $184.7 billion in grants; this included both discretionary awards totaling $24.7 billion and mandatory awards totaling over $160.0 billion.*

- *CMS, which administers the Medicaid Program, awarded 66 percent ($122.2 billion) of the total grant funds, representing less than 1 percent of the total number of grants. ACF awarded the next highest percentage (20 percent, $37.8 billion) of the total grant funds, representing 11 percent of the total number of grants.*

HHS continues to operate the Tracking Accountability in Government Grants System (TAGGS) containing department-wide grants award information.

✹ *The other ten agencies awarded between 1 and 7 percent of the remaining 14 percent of grant funds.*

✹ *NIH awarded 69 percent (44,334) of the total number of grants, which is 60 percent of the discretionary grant funds, but only 7 percent of the total grant funds. The remaining agencies awarded between 1 and 11 percent of the total number of grants.*

✹ *The six states receiving the most HHS mandatory grant funds (in billions) in FY 2000 are New York ($20.6), California ($19.3), Texas ($8.8), Pennsylvania ($7.8), Ohio ($6.4), and Florida ($6.3).*

FY 2000 Grant Awards

	Total Grants		Mandatory Grants		Discretionary Grants	
Agency	Number	Dollars (in millions)	Number	Dollars (in millions)	Number	Dollars (in millions)
ACF	7,281	$37,803	2,878	$33,545	4,403	$4,258
AHRQ	557	104	0	0	557	104
AOA	793	917	553	877	240	41
CDC	2,888	2,584	61	105	2,827	2,479
CMS	439	122,220	325	122,190	114	30
FDA	179	26	0	0	179	26
HRSA	5,482	3,908	112	626	5,370	3,281
IHS	581	756	539	751	42	5
NIH	44,334	13,696	0	0	44,334	13,696
OS	414	267	0	0	414	267
SAMHSA	1,485	2,372	231	1,913	1,254	459
TOTAL	**64,433**	**$184,654**	**4,699**	**$160,008**	**59,734**	**$24,646**

The grants data provided in this report reflect awards made during FY 2000, since FY 2001 data is in the process of full reconciliation. The data will not necessarily agree exactly with the FY 2000 budget and accounting records (e.g., Medicaid's accounting adjustments) for several reasons. First, in some instances the data for awarded grants reflect, in addition to current year funds, the reobligations of prior years' funds. Second, costs of furnishing personnel in lieu of cash are included in the grants data, but are recorded as personnel service costs in accounting records. Third, grants jointly funded are included in accounting records, but are not included herein unless awards are made by HHS programs. The number of grants is a count of projects or programs receiving grant funds, and is therefore less than a count of grant actions, since there may be multiple actions for a project in any fiscal year.

Faith-Based and Community Initiatives

Faith-based and community organizations have a long history of providing essential services to people in need in the United States. In recognition of the unique ability that these organizations have to meet the special needs of their communities, the Bush Administration has made improving funding opportunities for faith-based and community organizations a priority. Through the President's faith-based and community initiative, the administration is working to remove unnecessary barriers that may prevent these organizations from receiving federal funding, creating a "level playing field" between faith-based and community organizations and other groups that use federal funds in delivering services.

On January 29, 2001, President Bush issued an Executive Order directing the Secretary of HHS, as well as the heads of the Departments of Justice, Education, Labor, and Housing and Urban Development, to establish within each Department a Center for Faith-Based and Community Initiatives (Cabinet Centers).

As specified in the President's Executive Order, responsibilities of this center include:

Identifying existing barriers to the participation of faith-based and community organizations in the delivery of social services by the department;

Coordinating a comprehensive departmental effort to incorporate faith-based and other community organizations in department programs and initiatives to the greatest extent possible; and

HHS is leading the Administration's effort to streamline the grants process.

Proposing the development of programs to increase the participation of faith-based and other community organizations in federal, state and local initiatives.

Secretary Thompson appointed the heads of the HHS' components to form the initial workgroup for this initiative. Liaisons at the highest level were subsequently appointed within each division to work with the HHS Centers to perform an internal program review. Programs selected for review included those funding streams governed by Charitable Choice (1996 legislation providing that community-serving faith-based organizations may seek federal support for the provision of certain social services); areas where we expected there to be faith-based and community involvement; and in program areas where we thought there would be more involvement than is currently indicated. Eighty of the Department's grant programs were selected for review representing both discretionary and block grant programs. The Center staff reviewed approximately one third of them; 11 programs were reviewed in depth. Many of the rest will be reviewed over the course of the next year.

Physical Infrastructure and IT Security

Through Presidential Decision Directive (PDD) 63 and the Government Information Security Reform Act (GISRA), the Federal Government was 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.

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

The Physical Security Work Group has been instrumental in upgrading security measures throughout HHS and is working with the Department Physical Security Office to continuously improve current policies and processes. Increasing the number of security guards at all building entrances and visual inspection of all vehicles entering the garage including undercarriage inspection are two examples of the numerous increases in security operations.

At NIH, three groups with interlocked membership are operating to manage security planning, policy, and operations along with a Security Task Force, they are working to protect employees and NIH property. The NIH police force has secured the perimeters of the campus.

The OIG was asked to review security at HHS laboratory facilities. These recommendations support the Administrtion's security funding request and the plan for how those funds will be used. HHS agencies received $4.75 million in emergency funds to heighten short-term guard service in September 2001, and an additional $84 million in FY 2002 Emergency Response Funding in the Defense Appropriation bill; this includes $46 million for CDC, $25 million for NIH, and $13 million for FDA. Each agency has reviewed the OIG recommendations and established a prioirty list for security improvements. One example of implemented findings is CDC's establishment of a temporary transhipment center to keep non-federal vehicles away from the laboratory core of its Atlanta campus. CDC will be using FY 2002 Emergency Response Funds to construct a permanent transhipment center.

The Department's Chief Information Officers (CIO) Council (whose members are the HHS Agency CIOs) have developed an Information Technology Security Strategic Plan that will enable a resilient, effective, and adaptive IT security posture for the Department. The plan addresses all aspects of the Department's IT security infrastructure including telecommunications network modernization, security policy modernization, evolving capabilities of security technology, IT risk management, IT security training, and IT system survivability concepts.

Overview of Financial Statement Analysis

Starting with this year's report, the Consolidated Balance Sheet and Consolidated Statement of Net Cost are presented on a comparative basis. We believe this new format is more informative and will help the reader better understand HHS operations.

Consolidated Balance Sheet

The HHS Consolidated Balance Sheet is comprised of assets, liabilities, and net position. At the end of FY 2001, departmental assets totaled $345 billion. This is an increase of 10 percent from the $313 billion reported in FY 2000. Intragovernmental assets account for a majority of the Department's assets, including $245 billion in Investments, of which 99 percent or $243 billion of the investments being in the Medicare Trust Funds' Investments in U.S. Treasury Securities, and $81 billion in the Fund Balance with Treasury. For a more in-depth analysis of the trust funds, please refer to the required supplemental stewardship information provided with the HHS financial statements, which is prepared in accordance with FASAB guidance.

The supplemental information discloses that the Hospital Insurance (HI) Trust Fund Part A is projected to operate with an annual surplus until 2021. However, viewing the Part A Trust Fund in isolation is flawed. The Supplementary Medical Insurance (SMI) Trust Fund Part B funding situation must also be considered. A comprehensive look at *both* Trust Funds shows that, according to the President's FY 2003 Budget, the Medicare program as a whole will incur a $553 billion deficit over the next ten years. Part B will require $1.1 *trillion* in general fund transfers over this period to meet its obligations, which more than offsets the Part A surplus projection. Further, a significant percentage of the Part A surplus is the result of shifting a portion of the home health benefit costs from Part A to Part B, as required by the Balanced Budget Act of 1997. When the future of the Medicare program is discussed, Medicare must be considered in its totality rather than evaluating the trust funds individually. What is needed is the modernization and reform of the Medicare program as a whole.

Liabilities in FY 2001 totaled $55 billion, a 17 percent increase from the $47 bil-

lion reported for FY 2000. Entitlement Benefits, Federal Employee and Veterans Benefits, and Accrued Grant Liability account for approximately 93 percent of the total Department's liabilities for FY 2001. HHS ended FY 2001 with a Net Position (assets minus liabilities) of $291 billion, which is an increase of 9 percent from the prior fiscal year of $266 billion. This change in Net Position is driven by increases in Fund Balance with Treasury, Investments, and Anticipated Congressional Appropriation of $3 billion, $26 billion, and $4 billion, respectively.

Consolidated Statement of Net Cost

The Consolidated Statement of Net Cost provides a breakout of HHS net operating costs by agency component. These expenses consist of direct, indirect, and supporting service costs from both federal and non-federal entities that are used to accomplish the Department's mission and strategic goals. For FY 2001, HHS total net cost of operations after intra-HHS elimination is $433 billion, a 12 percent increase compared to the $385 billion reported for FY 2000. The Centers for Medicare & Medicaid Services, Administration for Children and Families, and National Institutes of Health account for $352 billion, $44 billion, and $17 billion, respectively, which comprises about 95 percent of the Department's total net cost of operation.

Consolidated Statement of Changes in Net Position

HHS finished FY 2001 with a consolidated net position total of $291 billion. This is a 9 percent increase from the prior fiscal year total of $266 billion. However, Net Results of Operations decreased by 30 percent from FY 2000, partly due to a 12 percent increase in the Net Cost of Operations.

Combined Statement of Budgetary Resources

The Combined Statement of Budgetary Resources explains the sources of HHS appropriated dollars and provides a status of how those funds are spent. Total outlays for the year ended September 30, 2001 are $528 billion. This represents an increase of 10 percent from the prior fiscal year outlays of $481 billion. The change in total net outlays is primarily driven by increases in obligations of budgets of $49 billion. HHS FY 2001 budget authority was $563 billion, an 8 percent increase compared to FY 2000. The Department obligated $548 billion, which is almost 97 percent of its total budget authority for FY 2001. As of September 30, 2001, the Unobligated Balances Available totaled $2 billion.

Consolidated Statement of Financing

The Consolidated Statement of Financing demonstrates the relationship between net obligations derived from HHS' budgetary accounts and net cost of operations derived from the Department's proprietary accounts by identifying and explaining key differences between the two numbers. For FY 2001, HHS total net cost of operations is $433 billion. Total resources used to finance HHS activities are $510 billion, a 23 percent increase compared to $415 billion in FY 2000. Total resources used to fund items not part of the net cost of operations for FY 2001 are $124 billion.

LIMITATIONS TO THE FINANCIAL STATEMENTS

In accordance with OMB Bulletin 01-09, "Form and Content of Agency Financial Statements," we are disclosing the following limitations of the HHS FY 2001 financial statements, which are contained in this Accountability Report.

The financial statements have been prepared to report the financial position and results of operations of HHS, pursuant to the requirements of 31 U.S.C. 3515(b).

While the statements have been prepared from HHS' books and records in accordance with generally accepted accounting principles (GAAP) for federal entities and the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.

The Statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity.