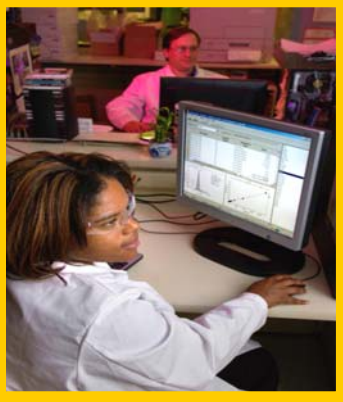
Section I:

Management Discussion and Analysis




Section I Contents

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INTRODUCTION

The Department of Health and Human Services (HHS) is the principal Federal agency responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Encompassing hundreds of programs, HHS is the Nation's largest health insurer and the U.S. Government's largest grant-making agency.

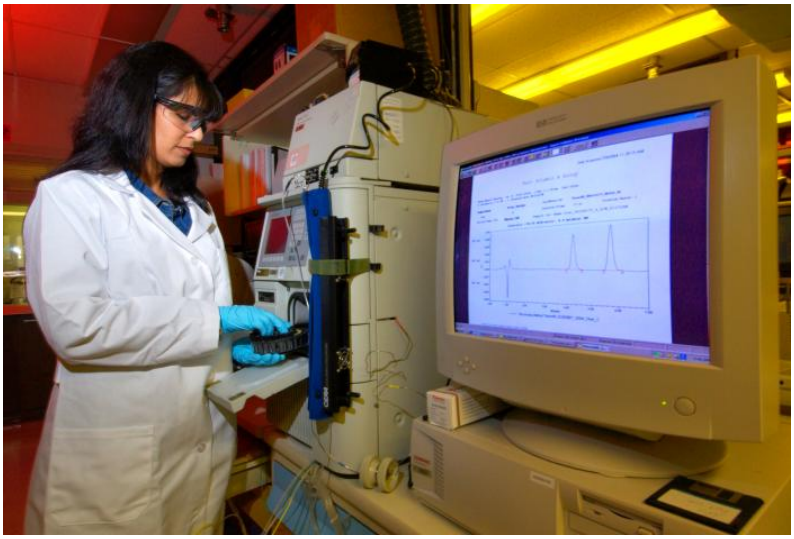
The HHS FY 2005 Performance and Accountability Report (PAR) is produced pursuant to the Reports Consolidation Act of 2000 and discusses the Department's accomplishments, issues, and initiatives during fiscal year (FY) 2005 (October 1, 2004, through September 30, 2005). The financial section of this report (Section III) also includes comparative results for FY 2004.

The PAR contains a high level overview of:

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

This is HHS' fourth PAR, and tenth annual report prepared pursuant to the Chief Financial Officers Act, as amended. In this report to the Department's "stockholders," the American public, HHS explains how its funds are used to benefit the American people. HHS also provides this information to a wide array of decision makers, including the Office of Management and Budget (OMB) and the Congress.

This report is designed to provide a complete, accurate, and useful understanding of HHS. HHS' component Operating Divisions (OPDIVs) also issue OPDIV-specific reports, which provide more detailed program and financial information. These and other reports can be found at the individual OPDIV's respective websites (see HHS Agency Descriptions and Highlights later in this document).



MISSION, STRATEGIC GOALS, AND SCOPE OF SERVICES

HHS' Mission

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

Healthy and productive individuals, families, and communities are the very foundation of the Nation's security and prosperity. Under HHS' programs, initiatives, and leadership, virtually all Americans and many others throughout the world are positively impacted by the Department's direct health services, advances in science, and dissemination of information to help improve healthy decision making. In a society that is diverse in culture, language, and ethnicity, HHS also manages an array of programs that aim to improve health status and access to health services and increase opportunities for disadvantaged individuals to work and lead productive lives.

In his 500 Day Plan, Secretary Mike Leavitt has outlined his high priority goals needing urgent attention, including transforming the health care system; modernizing Medicare and Medicaid; advancing medical research; securing the Homeland; protecting life, family, and human dignity; and improving the human condition around the world. HHS also focuses on measuring and reducing improper payments, encouraging senior citizens to take advantage of the new prescription drug benefit under Medicare, and reducing burdensome HHS regulations. To carry out its mission, HHS articulated these and other priorities in its FY 2004 - FY 2009 Strategic Plan through eight strategic goals and hundreds of performance measures. The Department's performance report (Section II) and the performance overview later in this section tie the representative performance measures to the strategic goals. HHS also has aligned its efforts with the President's Management Agenda (PMA) initiatives, which articulate the Administration's strategy for "improving the management and performance of government."

HHS Strategic Goals

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

Scope of Services

HHS accomplishes its eight strategic goals by managing and delivering hundreds of programs across several disciplines. The following examples illustrate the breadth of activities that occur at HHS and indicate the strategic goals that they support.

- Conduct and sponsor medical and social science research to improve Americans' health and well-being (Goal 4);
- Guard against the outbreak of infectious diseases through immunization services and the elimination of environmental health hazards near people's homes and workplaces (Goals 1 and 2);
- Ensure the safety of food and drugs (Goal 2);
- Provide health services for elderly and disabled Americans, as well as low-income adults and children (Goal 3);
- Promote services that increase the proportion of older Americans who stay active and healthy (Goal 6);
- Provide financial assistance and employment support services for low-income families (Goal 6);
- Reduce medical errors (Goal 5);
- Increase consumer and patient use of health care quality information (Goal 5);
- Reduce the regulatory burden on providers and consumers of HHS services (Goal 8);
- Increase the percentage of children and youth living in a permanent, safe environment (Goal 7);
- Prevent child abuse and domestic violence (Goal 7);
- Provide and improve substance abuse prevention and treatment services (Goal 1);
- Provide and improve mental health services (Goal 6); and
- Enhance the use of electronic commerce in service delivery and record keeping (Goal 8).

500-Day Plan

HHS Secretary Mike Leavitt established a 500-Day Plan to provide the Department a management tool for guiding its energies toward fulfilling the President's vision of a healthier and more hopeful America. As a personal expression of the Secretary's priorities in the daily leadership and management of the Department and its more than 67,000 dedicated employees, the Plan offers a core set of public policy principles that form the philosophical standard to uphold fiscal responsibility and good stewardship of the fiscal responsibilities for which HHS is charged.

Specifically, the Plan offers the Department a prism through which those who work with the Secretary can look to determine how the Secretary will approach goals associated with transforming the U.S. health care system; modernizing Medicare and Medicaid; advancing medical research; helping to secure the Homeland; protecting life, family and human dignity; as well as improving the human condition around the world.

The strategies in the Plan focus on actions during a rolling 500-day period that will achieve significant progress for the American people over a 5,000-day horizon. The Plan is updated every 200 days. For more information, visit www.hhs.gov/500DayPlan.

HHS Partners - Working Together

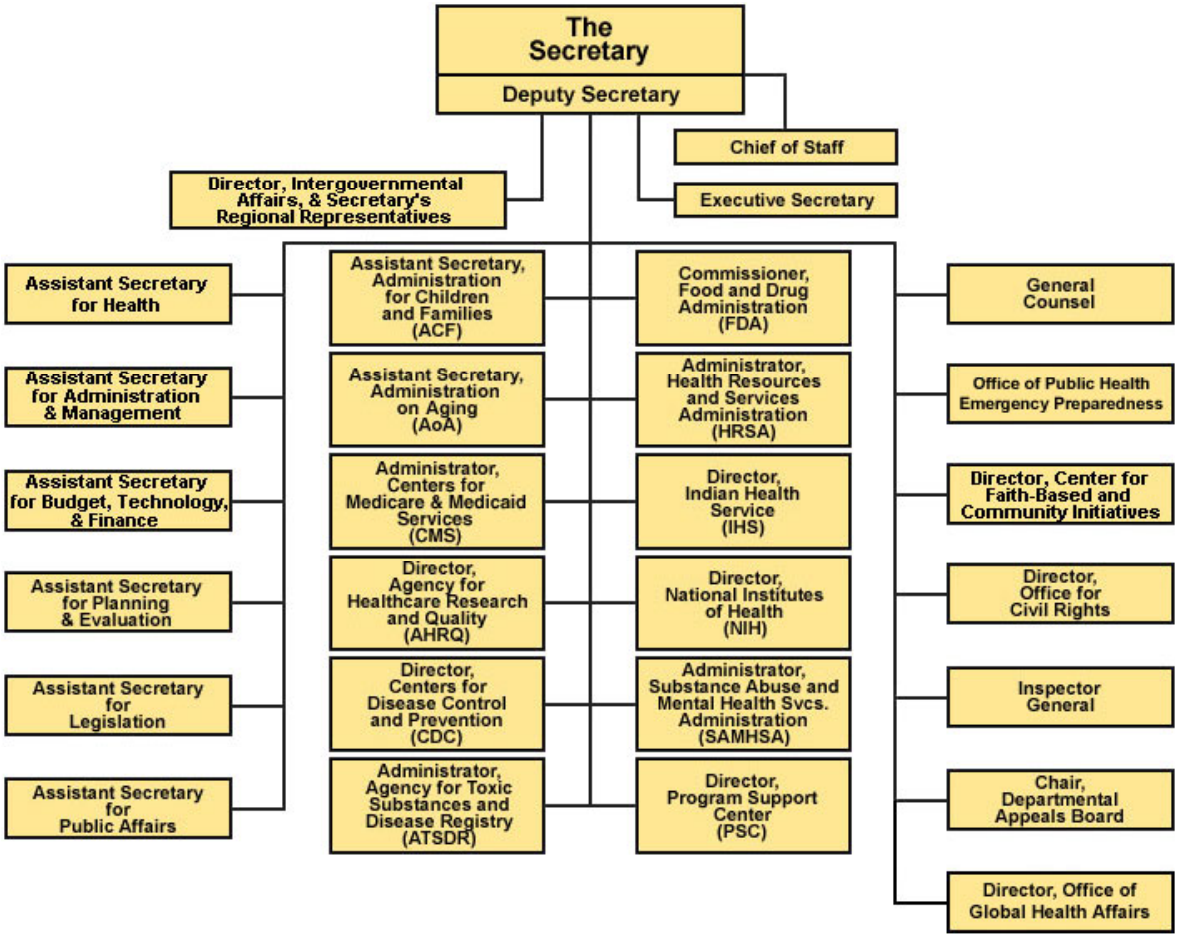
Often the needs of individuals and families transcend individual HHS program boundaries. HHS' ability to meet client needs and accomplish its goals is tied directly to the commitment, cooperation, and success generated by HHS employees and the Department's partners, other Federal agencies, state and local governments, Tribal organizations, community-based organizations, faith-based organizations, and others.

HHS' commitment to preparing America for and responding to national crises is exemplified in its response to helping those affected by Hurricanes Katrina and Rita. These hurricanes, two of the most devastating in the history of the Nation, hit the Gulf Coast in the late summer of 2005 and displaced more than 1 million people, killed more than 1,000, and caused immediate damages costing more than $200 billion. HHS led the largest ever mobilization of the U.S. Public Health Service Commissioned Corps to provide medical and mental health benefits and services to those impacted by the storms and to augment care in affected hospitals and shelters to hundreds of thousands of evacuees. For Katrina alone, more than 1,400 officers from more than 40 states came together to work with state, local, and private agencies in Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, and Texas.

HHS provides direct services for the underserved populations of America, including American Indians/Alaska Natives. For many programs, HHS' partners provide direct services and have great discretion in program implementation. HHS supports its partners' goals and efforts by providing funding, technical assistance, outreach, education, training, research, and demonstration projects to test new programs, processes, or policies.

HHS ORGANIZATION – STRUCTURED TO ACCOMPLISH THE DEPARTMENT'S MISSION

Eleven Operating Divisions (OPDIVs) led by the Office of the Secretary provide a wide range of services and benefits. The Office of the Secretary consists of several staff divisions, including the Assistant Secretary for Budget, Technology, and Finance, which is responsible for producing this report. HHS also actively coordinates, in 10 regions throughout the U.S., the crosscutting and complementary efforts that are needed to accomplish the mission. The following pages provide a brief overview of HHS' organization and the purpose and accomplishments of each OPDIV, including a twelfth HHS organization, the Program Support Center (PSC). The PSC provides administrative, financial, and human resource services to the Department. The following summary of each OPDIV's responsibilities and highlights of its activities includes references to the corresponding strategic goal(s) addressed by these activities. Unless otherwise noted, the highlights that follow reflect the most current information available to HHS at the time of completion of this report.



Administration for Children and Families (ACF)
www.acf.hhs.gov

ACF programs promote the economic and social well-being of families, children, individuals, and communities. Major ACF programs include Temporary Assistance for Needy Families (TANF), Child Support Enforcement, and Head Start for preschool children. ACF also provides funds to help low-income families pay for child care, prevent child abuse and domestic violence, provide incentives for adoption of children, and create self-sufficiency for refugees.

ACF Highlights:

- Large numbers of people continue to move from welfare to work. The number of TANF recipients has continued to decline through March 2005. Many adult welfare recipients are earning money by working at paying jobs. In FY 2003, 28 percent of adult recipients were working (including employment, work experience, and community service), compared with less than 7 percent in 1992 and 11 percent in 1996. The recent decline in work rates underscores the importance of welfare reform reauthorization, which would reinstate a meaningful work participation rate so that more families achieve self-sufficiency. (Goal 6)
- The Child Support Enforcement program established approximately 11.5 million child support orders from 16 million cases in FY 2003. This program collected $21.2 billion for child support in FY 2003 representing a 33 percent increase since 1999, and collected a record $1.6 billion in delinquent child support in tax year 2003, on behalf of 1.6 million families, using tax refund and administrative offset tools. The percentage of child support cases with support orders rose to a high of 72 percent, exceeding the FY 2003 performance target of 67 percent. (Goal 7)
- From FY 1997 through 2003, 318,000 children were adopted from the child welfare system. In FY 2003, preliminary data indicate there were 50,000 adoptions. This number is expected to increase as additional adoptions for that year are reported. This represents a significant growth in the number of adoptions over the years, up from 47,000 adoptions in FY 1999 and 31,000 adoptions in 1997. While the number of adoptions has held fairly constant in the most recent years, the adoption rate (adoptions as a percentage of those in foster care) increased from 8.4 percent in FY 1999 to 9.2 percent in FY 2003. (Goal 7)
- The Head Start program has made advancements in improving the development and learning readiness of Head Start children. Overall, children in Head Start programs are gaining in word knowledge, emergent literacy, language skills, mathematics, and social skills. In improving the development and learning readiness, as appropriate, of infants, toddlers, and preschoolers in 2002: the program reached the target average of 32 percent or a 10.0-scale point increase in word knowledge; met the target of 43 percent or a 3.0–scale point increase in mathematical skills; and surpassed the goal of a gain of 10 percent or 1.4-scale points in social skills with a gain of 13 percent or 1.9-scale points. In 2004, the percentage of teachers with an associate, bachelor, or advanced degree, or a degree in a field related to early childhood education exceeded the target of 56

percent with an actual percentage of 64.8 percent. Finally, the Head Start Bureau is in the third year of implementing a national child outcomes and assessment reporting system (NRS) to strengthen program effectiveness. Over 400,000 four-year olds were assessed in the fall of 2004 and over 400,000 four- and five-year olds were assessed in the Spring of 2005. Fall 2005 assessments are currently underway. (Goal 7)

Administration on Aging (AoA)
www.aoa.gov

AoA is the Federal focal point for programs and services for the elderly, and aims to assist elderly individuals maintain independence and dignity in their homes and communities. Through policy and program development, planning, and service delivery, AoA seeks to address the needs and concerns of the elderly, their families, and their caregivers. AoA leverages its funds through a nationwide service infrastructure to deliver comprehensive in-home and community-based services, including nutrition services, to the elderly. AoA funds also make preventive health services, elder rights, and long-term care ombudsmen programs available to elderly Americans. Established in 1965, AoA partners with state and area agencies on aging, Tribal organizations, and service providers within the aging network to accomplish its mission.

AoA Highlights:

- AoA collaborated with the Centers for Medicare & Medicaid Services (CMS) to help the elderly learn about and enroll in prescription drug coverage authorized by the Medicare Improvement and Modernization Act. AoA utilized the infrastructure of the National Aging Services Network to provide specialized information, technical assistance, outreach, and education to beneficiaries, with a particular emphasis on reaching out to limited-English speaking and hard-to-reach populations. (Goal 1)
- The agency continued implementation of initiatives to create greater balance in long-term care, improve access, and emphasize prevention. Aging and Disability Resource Centers, funded in partnership with CMS, are providing consumers in 43 states with objective information about their care options and are helping states to streamline access and control costs. Evidenced-Based Disease Prevention projects are assisting aging service provider organizations in 12 communities to translate research findings into high-quality preventive interventions targeted to seniors (Goals 1 and 6).

- AoA helped seniors remain in their homes and communities by providing a variety of supportive, nutrition, and caregiver services in FY 2004, including approximately 38 million rides to doctors offices, grocery stores, and other critical daily activities; 248 million congregate and home-delivered meals; 9.5 million information contacts on caregiver program and service, and 20 million hours of in-home services such as personal care, homemaker, and chore services. (Goal 6)

Agency for Healthcare Research and Quality (AHRQ)
www.ahrq.gov

AHRQ leverages its research and information-sharing programs to improve the quality, effectiveness, and accessibility of health care; and to reduce health care costs. AHRQ conducts and supports the research needed to guide decision-making and improvements in both clinical care and health care organization and financing. Furthermore, the Agency also promotes the incorporation of research-based information from AHRQ and others into effective health care choices and treatment by developing tools for public and private decision-makers and by broadly disseminating the results of the research.

AHRQ Highlights:

- The Pharmaceutical Outcomes portfolio, as part of its work to implement Section 1013 of the Medicare Modernization Act, has begun work to establish a new effectiveness program. The three legs of the effectiveness program – evidence synthesis, evidence generation, and evidence translation – are transparent resources that can serve the need for better information well. (Goals 1 and 5)
- Working within the structure of the Patient Safety portfolio, researchers and partners have successfully used existing research structures and networks to implement research, supported the development of new networks of patient safety researchers, trained patient safety experts, and funded the world's largest portfolio of patient safety research. (Goals 1 and 5).

Agency for Toxic Substances and Disease Registry (ATSDR)
www.atsdr.cdc.gov

ATSDR is the principal Federal public health agency charged with evaluating the human health effects of exposure to hazardous substances. The Agency's mission is to serve the public by using the best science, taking responsive public health actions, and providing trusted health information to prevent harmful exposures and disease-related exposures to toxic substances.

ATSDR was created by the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, more commonly known as the Superfund law. The Superfund program is responsible for finding and cleaning up the most dangerous hazardous waste sites in the country. Currently, the U.S. Environmental Protection Agency (EPA) lists 1,241 "final" National Priorities List sites for cleanup. ATSDR leads Federal public health efforts at these and other sites with actual or potential toxic exposures. In accomplishing this purpose, ATSDR's priorities include (1) mitigating the risks of health effects at sites with documented exposures, (2) preventing exposures and resulting health effects, and (3) determining what health effects, if any, are associated with exposures.

ATSDR Highlights:

ATSDR measures the effectiveness of its interventions by documenting the reduced occurrence or risk of health effects at sites with documented exposures. To capture this information, ATSDR selects the most appropriate measure(s) for each site that poses an urgent or public health hazard. These measures include (1) comparative morbidity/mortality rates, (2) biomarker tests, (3) levels

of environmental exposures, and/or (4) behavior change of community members and/or health professionals. Using one or more of these measures, ATSDR then tracks the sites where human health risks or disease have been mitigated.

- Setting a baseline in FY 2004, ATSDR determined that its efforts had mitigated health risks or disease at 33 percent of its urgent and public health hazard sites. The Agency has established a long-term target of 80 percent by 2010. (Goal 1)

ATSDR responds to toxic substance releases when they occur or as they are discovered, and provides recommendations for protecting public health to EPA, state regulatory agencies, or private agencies. As a non-regulatory agency, ATSDR is able to prevent or mitigate exposures most effectively when these other agencies adopt and implement its recommendations.

- ATSDR has reported three consecutive years of performance data showing an increase in the percentage of adopted recommendations. It has established a long-term target of 85 percent by 2010. (Goal 1)

Centers for Disease Control and Prevention (CDC)
www.cdc.gov

CDC works in the U.S. and abroad to ensure people have the opportunity and the ability to achieve the best quality of life at every stage throughout their lifespans. CDC is focused on transforming public health to ensure that its strategies, programs, research, and science continue to secure the Homeland; improve the human condition around the world; and protect the lives of Americans. CDC focuses its efforts through three overarching goals:

- All people, especially those at greater risk due to health disparities, will achieve their optimal lifespan with the best possible quality of health at every stage of life.
- People in all communities will be protected from infectious, occupational, environmental, and terrorist threats.
- The places where people live, work, learn, and play should protect and promote human health and eliminate health disparities.

Established in 1946 as the Communicable Disease Center, CDC operates from its national headquarters in Atlanta, GA. CDC's workforce includes approximately 9,400 employees, including those in state and local health departments, and quarantine offices across the U.S. and in 45 countries around the world.

CDC Highlights:

- CDC is redefining itself to best address current and imminent threats to the health of the world's people. Within the framework of the new CDC, a set of strategic goals has been developed to maximize health impact and reduce health disparities. These goals are organized by three thematic areas – people (by life stage), preparedness (related to terrorism, infectious diseases, environmental, and occupational emergencies), and places (to create and maintain healthy environments). CDC will ensure these goals are the focus of its programmatic activities and that the greatest impact on health is achieved through measurement, accountability, and strategic direction. (Goals 1 and 2)

- In FY 2005, CDC funded approximately $5 billion for its extramural programs, including grants/cooperative agreements and research contracts. Extramural programs are those programs for which the actual work is done outside of CDC by such organizations as state and local public health departments, universities, nonprofits, community-based organizations, etc. The programs are widespread across CDC and address areas related to infectious diseases, global health, chronic diseases, injuries, environmental health, terrorism prevention and control, occupational safety and health, and birth defects. (Goals 1 and 2)
- CDC provided onsite technical assistance and/or training to China, Vietnam, Thailand, and Malaysia for the avian influenza outbreak and technical assistance to South Korea and Taiwan through training at CDC. To enhance detection of influenza, including avian influenza, CDC provided support for influenza surveillance in Asia, Europe, and Latin America to monitor for variant viruses that could circulate in the U.S. in the future. (Goal 1)
- Working with communities, Racial and Ethnic Approaches to Community Health (REACH 2010) continues to demonstrate that health disparities can be reduced and that significant progress can be made in improving health in communities of racial and ethnic minority groups. Communities throughout the Nation are realizing improvements in the health care system and in personal behaviors as a result of targeted efforts relevant to racial and ethnic minority groups. REACH 2010 continues to be an excellent example of how communities can leverage resources to improve disparities in health in a variety of settings and through a variety of interventions and activities. (Goals 1 and 6)
- Research provides much needed evidence to support specific programs, practices, and policies that affect health decisions made by the American public and those responsible for health policies and programs. Through its health protection research initiative, CDC is building a cadre of health protection researchers, research training programs, and centers of excellence that encourage multidisciplinary approaches to public health practice. In the first year of dedicated support, FY 2004 funding allowed CDC to award 57 extramural research grants in support of health promotion and prevention activities in the workplace, training for public health researchers, and two new centers of excellence in economics. Efforts in FY 2005 began to address the need for a multidisciplinary approach to health marketing and health communication, public health informatics, and innovative statistical methods to estimate the burden of disease. (Goal 4)

Centers for Medicare & Medicaid Services (CMS)
www.cms.gov

The CMS, one of the largest purchasers of health care, administers the Medicare program and works in partnership with the states to administer the Medicaid program and the State Children's Health Insurance Program (SCHIP). Medicare provides health care coverage for elderly and disabled Americans. Medicaid, a joint Federal-State program, provides health coverage for low-income persons, and also pays for nursing home coverage for low-income elderly. The SCHIP provides health insurance coverage for children who otherwise would be without coverage. In addition to these programs, CMS has other responsibilities that lead to and support various important CMS contributions to the delivery of health care for its beneficiaries.

CMS Highlights:

- The CMS is working hard to implement the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. A more modern Medicare brings more affordable health care, prescription drug coverage to all people with Medicare, expanded health plan options, improved health care access for rural Americans, and preventive care services. The Medicare prescription drug benefit will officially begin January 1, 2006. Based on the strong response that CMS has received for this program, CMS expects to deliver the drug benefit on schedule, everywhere in the country. The CMS still has the Medicare Prescription Drug Discount Card and Transitional Assistance program in place until the prescription drug benefit starts. This program allows eligible Medicare beneficiaries to obtain prescription drugs at a discounted price as well as a credit up to $600 for the purchase of prescription drugs. In addition, Medicare beneficiaries will have more health plan choices and greater savings with the expansion of the Medicare Advantage program. The CMS recently approved 143 new Medicare Advantage plans in 49 states. (Goal 3)
- The CMS continues to strengthen its program integrity and financial management activities in the Medicaid program. The CMS examined detailed information on how states are financing their share of Medicaid program costs. The CMS also has continued to expand the Medi-Medi program to better coordinate Medicare and Medicaid program integrity. The Medi-Medi program has led to cost avoidances, savings, recoveries, investigations, and law enforcement referrals. In addition, CMS has hired 97 individuals to monitor state activities, enforce compliance with CMS financial management procedures, and improve Medicaid financial management oversight. (Goal 8)
- The CMS successfully implemented the Health Care Integrated General Ledger Accounting System (HIGLAS) at four Medicare contractor sites during FY 2005. HIGLAS is a component of the Unified Financial Management System (UFMS) and part of CMS' total financial management system to enhance its financial structure, improve internal controls, and ensure reliable data. The new system will help CMS meet the Federal requirements of a dual entry accounting system and improve CMS' ability to track payments. (Goal 8)

Food and Drug Administration (FDA)
www.fda.gov

FDA is a science-based regulatory Agency whose mission is to promote and protect public health and well-being by ensuring that safe and effective products reach the market in a timely manner, and to monitor products for continued safety once in use. FDA is divided into six program areas: (1) foods, (2) drugs, (3) biological products, (4) veterinary medicine, (5) medical devices, and (6) toxicological research. Each program area, except for toxicological research, is responsible for ensuring the safety and, where applicable, the effectiveness of products through their entire life cycle, from initial research through manufacturing, distribution, and consumption. These programs, supported by a national field force of scientific investigators, also monitor the safety of import shipments that arrive at America's borders each year. The Toxicological Research program conducts peer-reviewed research that provides the basis for FDA to make sound, science-based regulatory decisions.

FDA Highlights:

- FDA joined three other Federal agencies (Department of Agriculture, Department of Homeland Security, and the Federal Bureau of Investigation) to form the Agroterrorism Strategic Partnership Initiative. This initiative will send teams of specialists from the four agencies to assess food security issues from farm-to-table and consider ways to better protect America's food supply. These visits will help the Federal partners better consider how states and industry can protect the food supply, gain more information about the food industry's protection needs and assist government and industry in refining its efforts including research and development goals. (Goal 2)
- FDA has made a series of improvements to strengthen the safety program for marketed drugs. FDA commissioned a study by the Institute of Medicine to examine the effectiveness of the drug safety system and its post-market phase, and to make necessary improvements. A drug safety oversight board also was established to oversee the management of important drug safety issues within the Center for Drug Evaluation and Research. The board is composed of members from the FDA Centers, other HHS OPDIVs, and other Federal departments (e.g., Department of Veterans Affairs). Other actions include creating a Drug Watch web page to share emerging data and risk information and foster increased use of consumer-friendly material written for health care professionals and patients; appointing a new director for the Office of Drug Safety, which is responsible for overseeing the post-marketing safety program for all drugs; and creating and publishing risk management guidance to assist pharmaceutical firms manage risks involving drugs and biological products. (Goal 1)
- FDA cleared for marketing the first Deoxyribose Nucleic Acid (DNA) microarray laboratory test that will allow physicians to consider unique genetic information from patients in selecting medications and doses of medications for a wide variety of common conditions such as cardiac disease, psychiatric disease, and cancer. A microarray is similar to a computer microchip, but instead of tiny circuits, the chip contains millions of tiny DNA molecules. "Physicians can use the genetic information from this test to prevent harmful drug interactions and to assure drugs are used optimally, which in some cases will enable patients to avoid less effective or potentially harmful treatment choices," said, former FDA Commissioner, Dr. Lester M. Crawford. The test is performed using DNA that is extracted from a patient's blood. A person's DNA sequence is determined based on the sequence of the probe molecule to which the DNA is most similar. (Goal 5).

Health Resources and Services Administration (HRSA)
www.hrsa.gov

HRSA, an important component of the Nation's health care safety net, improves the Nation's health by helping to ensure equitable access to comprehensive, quality health care. HRSA and its state, local, and other partners work to eliminate barriers to care and health disparities for Americans who are underserved, vulnerable, and have special needs.

HRSA programs and services support comprehensive primary care services, decrease infant mortality, improve maternal and child health, provide services to people with Acquired Immunodeficiency Syndrome (AIDS) through the Ryan White Comprehensive AIDS Resources Emergency (Ryan White CARE) Act programs, oversee the Nation's organ transplantation and bone marrow donor systems, and

help hospitals and health care workers prepare in the event of bioterrorism or other mass public health emergency. HRSA also helps build a well-qualified health care workforce and maintains the National Health Service Corps.

HRSA Highlights:

- Through the Ryan White CARE Act's State AIDS Drug Assistance program, more than 86,000 individuals received essential Human Immunodeficiency Virus (HIV)/AIDS medications during at least 1 month of the year in FY 2003, exceeding the previous year's number by more than 5,100 persons. (Goal 3)
- In FY 2003, more than 78 percent of National Health Service Corps clinicians remained in service to underserved areas for at least 1 year following completion of their service contracts. (Goal 3)

Indian Health Service (IHS)
www.ihs.gov

IHS is the principal Federal health care provider and health advocate for American Indian/Alaska Native (AI/AN) people. In partnership with AIs/ANs from more than 562 Federally-recognized Tribes, IHS' mission is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. IHS and the Indian Tribes are responsible for serving 1.8 million AI/ANs through direct delivery of local health services. Currently, AI/AN people experience lower life expectancy than the U.S. general population.

IHS funds hospitals, health centers, school health centers, and health stations, which are administered by Indian Tribes directly or by IHS. There are also 34 Urban Indian health programs that provide various services to AI/ANs living in urban areas of the country. When health care services are unavailable from IHS or the Indian Tribes, IHS purchases medical services from other providers to ensure delivery of needed care.

IHS Highlights:

- Developed and implemented IHS National Core Formulary. This formulary, which was implemented in all Federally-operated facilities by October 1, 2005, will help ensure that standard-of-care medications based on the most current medical practice and evidence are available to all patients using Indian, Tribal, and Urban pharmacies. (Goal 3)
- Developed an influenza vaccine reporting and redistribution process to assure that all IHS and Tribal sites had sufficient Influenza vaccine to meet needs of high-risk patients during 2004-05 influenza season. (Goal 5)
- Deployed the IHS Electronic Health Record, a robust integrated health information system in a graphical user format, at over 25 health care facilities. (Goal 5)
- Enhanced the Clinical Reporting System software

(formerly called GPRA+). One of the new tools included in the FY 2005 version of this software is the ability for individual Indian, Tribal, and Urban facilities to generate lists of patients based on specific health measures. (Goal 5)

- Enhanced the widely-deployed Behavioral Health System (currently in use at over 250 IHS direct, Tribal, and Urban sites), including a graphical user interface version and a suicide reporting form developed to support the Agency's behavioral health initiative. (Goal 5).

National Institutes of Health (NIH)
www.nih.gov

NIH is the world's premier medical research organization, supporting studies nationwide in diseases such as cancer, Alzheimer's, diabetes, arthritis, heart disease, and AIDS. Through the research they support, the NIH Institutes and Centers contribute to improving the health of all Americans by advancing knowledge of biology and behavior and sustaining the Nation's medical research capacity in disease diagnosis, treatment, and prevention. More than $8 out of every $10 appropriated to NIH is awarded to researchers at universities, medical schools, hospitals, and other research facilities in all 50 states, U.S. territories, and points abroad. NIH's research activities extend from basic research that explores the fundamental workings of biological systems, to studies that examine disease and treatments in clinical settings, to prevention, and to population-based analyses of health status and needs.

The NIH traces its roots to 1887, when a one-room laboratory was created within the Marine Hospital Service, predecessor agency to the U.S. Public Health Service (PHS). NIH provides scientific leadership and establishes research priorities, funds the best research in the scientific community at large and conducts leading-edge research in its laboratories; develops and maintains scientific human and physical resources; communicates and disseminates scientific results and information; and collaborates with other Federal agencies. The main campus of NIH is located in Bethesda, MD.

NIH Highlights:

- NIH scientists completed the Chemical Effects on Biology Systems (CEBS) System Biology object model (SysBio-OM) or data linkage map to capture data on the regulation of genes, proteins, and metabolites in individuals exposed to toxins. (Goal 4)
- NIH scientists also completed the CEBS System Toxicology object model (SysTox-OM) or data linkage map to enable the capture of toxic effects data, along with information such as time, dose, and severity of disease/disorder. (Goal 4)

- Microarray, toxicology and pathology datasets generated by the National Center for Toxicogenomics, the National Toxicology Program, by pharmaceutical companies, and by other outside groups have been deposited in CEBS. (Goal 4)
- CEBS (version 1.5) has been made available to the public. This program provides simple query download capability of global molecular expression and toxicology/pathology data on a select number of studies of environmental chemicals and drugs. (Goal 4)

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov

SAMHSA is the lead Federal agency for substance abuse and mental health services, enabling service capacity expansion and the implementation of evidence-based practices. SAMHSA provides services indirectly through grants and contracts to nonprofit organizations, universities, government agencies, and Indian Tribes for children, adolescents, and adults. SAMHSA administers two block grants that provide funding to states and territories for direct substance abuse and mental health services, as well as discretionary grants for other recipients.

SAMHSA is organized into the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment, as well as two program offices, the Office of the Administrator and the Office of Applied Studies.

SAMHSA Highlights:

- SAMHSA initiated the new Mental Health state Incentive Grants for Transformation in FY 2005. This program will support an array of infrastructure and service delivery improvement activities to help grantees build a solid foundation for delivering and sustaining effective mental health and related services. These grants are unique in that they will support new and expanded planning and development to promote transformation to systems explicitly designed to foster recovery and meet the multiple needs of consumers (Goal 3). For more information, see the following website: http://www.samhsa.gov/grants/2005/nofa/sm05009_mht_sig.aspx
- In collaboration with the states, SAMHSA began implementation of and reporting on the National Outcome Measures (NOMs). These measures encompass 10 domains which embody meaningful, real life outcomes for people who are striving to attain and sustain recovery, build resilience, and work, learn, live, and participate fully in their communities. (Goal 8). For more information, see the following website: http://www.nationaloutcomemeasures.samhsa.gov/
- SAMHSA has initiated expansion of its National Registry of Evidence-Based Programs and Practices (NREPP) to include interventions to prevent and/or treat mental and substance use disorders. NREPP's precursor, the National Registry of Effective Prevention Programs, identified interventions with demonstrated success in preventing or reducing substance use and other related high-risk behaviors that had been tested in communities, schools, social service organizations, and workplaces across America. The current NREPP expansion will further refine the scientific review process and review criteria, improve the practical implementation information available to users, and support innovative interventions seeking NREPP status. SAMHSA solicited public comment on its plans througha Federal Register notice published in August 2005 (Goal 1) (http://modelprograms.samhsa.gov).

Program Support Center (PSC)
www.psc.gov

PSC is the shared services provider of administrative support services to all components of HHS and other Agencies in the Federal Government. The purpose of the PSC is to provide efficient and cost-effective services and products that will allow its customers to focus on their core missions and program objectives. PSC offers over 50 products and services to government entities across the Nation. Services are provided on a fee-for-service basis in five major business areas: human resources, financial management, administrative operations, health care resources, and strategic sourcing.

Established in 1995, the PSC is supported through the HHS Service and Supply Fund, a revolving fund, and is organizationally aligned under the Assistant Secretary for Administration and Management, Office of the Secretary.

PSC Highlights:

- PSC successfully led the payroll conversion from the HHS Payroll System to the Defense Finance and Accounting System (DFAS). It was the single largest civilian agency payroll conversion ever completed by DFAS. (Goal 8)
- PSC is leading the Department–wide implementation of eTravel that is designed to consolidate the Department's 24 Travel Management Center's in to one center. PSC has successfully migrated all of its customers to GovTrip, the Department's end–to-end eTravel solution. (Goal 8)
- The PSC was re-designated by the Department of the Treasury as a Debt Collection Center for the next 5 years. It is the only designated Debt Collection Center government-wide. E-government solutions recently have been implemented to improve electronic processes with PSC customers and allow for electronic collection of funds from debtors. (Goal 8)

AN OVERVIEW OF HHS PROGRAM PERFORMANCE

A Focus on Outcomes

HHS manages hundreds of programs that improve the health and well-being of the American public. The HHS Strategic Plan encompasses eight strategic goals which cover all HHS activities. To gauge program effectiveness, HHS uses performance measures as a basis for comparing actual program results with established program performance goals, as required by the Government Performance and Results Act (GPRA). Given the complexity and vast number of programs and measures, HHS, with OMB's concurrence, focuses on key priorities in this report to illustrate HHS' significant efforts and achievements during FY 2005. The programs and corresponding measures in this report are presented according to the strategic goal each supports. The Department's FY 2005 Annual Performance Report, summarized in the following pages and presented in detail in Section II, provides readers with a sense of the far-reaching and positive effects of HHS programs

Performance Data Collection and Reporting

HHS programs collect data through several entities including state and local governments, nonprofit and faith-based organizations, and universities and research institutions. Several HHS programs rely on third parties for data collection and reporting, which can result in performance data availability lags. In addition, not all HHS performance data are collected or available annually. For example, the Head Start program's goal "to achieve at least 80 percent of children completing the Head Start program rated by parent as being in excellent or very good health" experiences a data lag. The data for this goal are collected through the Family and Child Experiences Survey (FACES) study, an ongoing longitudinal study of program quality and impact. Because FACES has triennial cohorts, data for a comparable sample of 4-year-olds in Head Start is only available every 3 years. Data for the 2003 FACES cohort from the 2003-2004 program year will be reported in 2004, 2005, and 2006.

An internal HHS data verification process ensures accuracy of performance data reported in this report. In the HHS Office of Budget, staff review and update performance data submitted by HHS OPDIVs. The following documents, the FY 2006 Performance Budget and the FY 2005 and FY 2006 HHS Annual Plan, are used to reference and review the data submitted by the OPDIVs to ensure consistency and accuracy in reporting. Analysts in the Office of Budget complete a checklist to make sure that reporting is consistent throughout these documents and the supporting documentation such as OPDIV websites display accurate and current data. The internal data verification process in the Office of Budget ensures consistency and accuracy in the reporting of performance information. This model of data verification cascades down to each of the OPDIVs as they ensure data is valid and accurate; thus, the information reported in this section is accurate and the performance report is accurate and transparent. Each program also has its own data validation procedures that are described in detail Section II and in the performance budget volumes.

Risks and Uncertainties Affecting Performance

External factors and influences beyond HHS' control affect achievement of the Department's strategic goals and objectives. These factors introduce risks and uncertainties into the Department's planning environment and pose challenges that may be difficult to overcome. For example, after September 11, 2001, our public health infrastructure refocused to address the threat of bioterrorism and funding was redirected for that purpose. State and local governments are major partners of the Department, both in determining health and social service funding levels and program implementation. Even during the best of economic times, the competition between health and social services, and other priorities, for limited public funds affects the achievement of long-term HHS goals. Similarly, social trends, reflecting individuals' daily decisions, have significant influence on the overall health and welfare of the Nation.

Additional Performance Information

The following overview in the Management Discussion and Analysis section provides summary performance highlights from each of the programs discussed in the performance report. This summary includes a table with the most recent results available for each performance measure followed by a supplemental narrative that provides a discussion of performance results (including those targets that were not met) and historical trend data when available. The tables displaying the measures highlighted for each strategic goal present the OPDIV and program name, the performance measure, the most recent fiscal year for which results are available, the most recent result available, and an indicator of whether or not the goal was met. Under goal met, a check mark √ signifies that the target was met for the most recent year, a blank square indicates that it was not met, and "N/A" indicates that it is not applicable because this is a new measure. Section II of this report, HHS' Annual Performance Report, contains additional details about the programs and accomplishments discussed in the following pages.

HHS OPDIVs annually prepare performance budgets provide a comprehensive look at the Department's programs and performance goals and show how the goals support of HHS' Strategic Plan. Individual OPDIV performance budgets are submitted to Congress in February. This information is available at the following locations on the HHS website:

- HHS performance goals, objectives, and measures, (the HHS Strategic Plan): http://aspe.hhs.gov/hhsplan/
- OPDIV performance budgets: http://www.hhs.gov/budget/opdivs.html

Strategic Goal 1
Reduce the Major Threats to the Health and Well-being of Americans

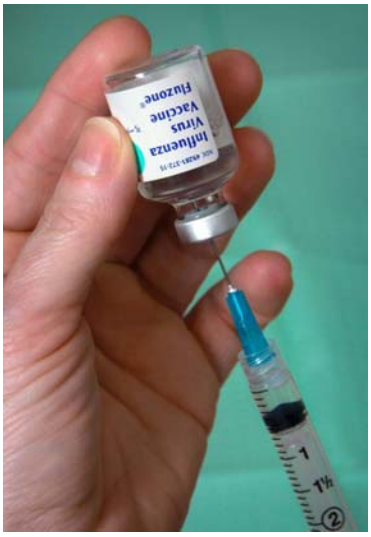
Each year, HHS renews its commitment to reduce health threats and promote healthy behaviors, and this commitment remains a critical priority. This goal supports the Department's vision to improve the health and well-being of people in this country and throughout the world. HHS recognizes that this vision can be accomplished only through coordination across the Department, and through partnerships with states, communities, and health professionals.

OPDIV and Program	Measure	FY	Target	Result	Goal Met
CDC National Immunization Program	1a. Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: 4 doses DTaP vaccine[1], 3 doses Hib vaccine, 1 dose MMR vaccine[2], 3 doses hepatitis B vaccine, 3 doses polio vaccine, 1 dose varicella vaccine, and 4 doses pneumococcal conjugate vaccine (PCV7)[3]	2004	90% coverage	DTaP 86%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 88%.	
CDC HIV/AIDS Prevention in the U.S.	1b1. Reduce the number of HIV infection cases diagnosed each year among people under 25 years of age.	2004	Overall: 1900 reported cases in 25 areas	New measures in FY 2004. Baseline: 2002: 2926 cases in 25 areas 2003: 2331 cases in 25 areas.	N/A
CDC HIV/AIDS Prevention in the U.S.	1b2. Decrease the number of perinatally acquired AIDS cases from the 1998 base of 235 cases.	2003	<139 cases	58 cases	√
SAMHSA Substance Abuse Prevention and Treatment Block Grant	1c. Number of clients served	2003	1,884,654 clients	1,840,275 clients	

National Immunization Program (CDC): Vaccines are one of the most successful and cost-effective public health tools for preventing disease and death. In the United States and globally, CDC is engaged in a variety of efforts to ensure all recommended immunizations are provided safely and effectively to children, adolescents, and adults. Through the National Immunization Program, CDC has worked to achieve or sustain immunization coverage of at least 90 percent of children 19- to 35 months of age. In FY 2004, CDC achieved the 90 percent target for most vaccines, except for varicella and Diphtheria-Tetanus-Pertussis (DTaP).

[1] Due to a shortage of vaccine and temporary change in recommendations, reported 3 doses from 2002 – 2003.
[2] Includes any measles-containing vaccine.
[3] Performance targets for newly recommended vaccines, such as pneumococcal conjugate vaccine and influenza vaccine, are reported in GPRA 5 years after Advisory Committee on Immunization Practices recommendation. Measures for pneumococcal conjugate vaccine (PCV7) will begin in 2006 and influenza in 2009.

In 2004, the coverage rate for four doses of DTaP did not achieve the 90 percent goal. While the administration of the first three doses of DTaP coincides with regular well-baby visits, the fourth dose does not. As such, there are fewer incentives to come in for the fourth dose. Moreover, in 2002 and 2003, CDC modified reporting on the measure for DTaP from four doses to three doses because vaccine shortages limited the availability of the fourth dose to children. This change was made because the Advisory Committee on Immunization Practices recommends that if this vaccine is in short supply, or not available, the fourth dose of DTaP may be dropped. The first three doses are considered the most critical to prevent disease. The change was temporary and reporting for the fourth dose has now been implemented.



Varicella is the most recently introduced vaccine that has a measurable target in 2005. Varicella immunization rates are rising from coverage at only 43 percent in 1998 to 88 percent in 2004. CDC is close to meeting the 90 percent varicella vaccines coverage goal. Children who have been exposed to chickenpox do not receive the varicella vaccine, so this is an ambitious target for a recently-introduced vaccine.

HIV/AIDS Prevention (CDC): CDC will continue efforts to prevent and control the spread of HIV infections in the United States by engaging in surveillance, research, intervention, capacity building, and evaluation activities. Through the CDC's domestic HIV prevention activities, CDC will work to reduce the major threats to the health and well-being of Americans from HIV/AIDS. This goal has two measures: (1) Reduce the number of HIV infection cases diagnosed each year among people less than 25 years of age, and (2) Decrease the number of perinatally-acquired AIDS cases from the 1998 base of 235 cases. With respect to the first measure, 2,926 cases were reported in 25 areas in FY 2002 and 2,331 cases were reported in 25 reporting areas in FY 2003. The results for the 2004 target of reducing the number of HIV infection cases diagnosed each year among people less than 25 years of age to 1900 cases in 25 areas are expected in November 2005. In prior years, performance information for this measure had to be updated as data was finalized.

Decreasing perinatal HIV transmission is one of four strategies included in CDC's advancing HIV Prevention Initiative. Data for 2003 show low levels of perinatally-acquired AIDS cases, from 90 in 2002 to 58 in 2003. The results for the 2004 target of less than a 100 cases of perinatally-acquired AIDS will be available in November 2005. It is expected that the results will indicate a continued trend of decreasing the number of perinatally-acquired AIDS cases diagnosed. A policy change was made to change date for reporting results from August 2005 to November 2005 to allow for complete collection and analysis of data.

SAMHSA's Substance Abuse Prevention and Treatment Block Grant Program works to improve the well-being of Americans by bringing effective alcohol and drug treatment and prevention services to every community through a block grant to states. In FY 2001 1,739,796 clients were served, in FY 2002 1,882,584 clients were served, and in FY 2003 1,840,275 clients were served. Data from SAMHSA's Treatment Episode Data set, representing admissions to treatment, not the total number of individual clients served, are used as a proxy for this measure. FY 2003 is the most recent year for which data are currently available, because of the time required for states to report data on the number of admissions in any given year. The target was met for 2001 and 2002 but missed for 2003 (FY 2003 target was 1,884,654). SAMHSA is examining the reasons for the missed target.

Strategic Goal 2
Enhance the Ability of the Nation's Health Care System to Effectively Respond to Bioterrorism and Other Public Health Challenges

HHS has a number of initiatives and programs directed at protecting Americans from bioterrorist attacks and other public health challenges. The events of September 11, 2001, and subsequent anthrax attacks have reinforced the lead role HHS plays in protecting Americans from attacks on the Nation's health and food supply. HHS role in enhancing the Nation's level of preparedness and overall response capabilities is absolutely vital to helping maintain America's vigilance and security.

OPDIV and Program	Measure	FY	Target	Result	Goal Met
FDA Field Foods Activities	2a. Perform prior notice import security reviews on food and animal feed line entries considered to be at risk for bioterrorism and/or present the potential of a significant health risk.	2005	38,000	86,187	√
HRSA National Bioterrorism Hospital Preparedness Program	2b. Percent of awardees that have developed plans to address surge capacity.	2005	100%	100%	√
CDC Terrorism Preparedness and Emergency Response Program (Strategic National Stockpile)	2c1. 100 percent of State public health agencies improve their capacity to respond to exposure to chemicals or category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified.	2005	25%	New measure in FY 2005. Baseline data is not available. Results to be reported: 12/2005.	N/A
CDC Terrorism Preparedness and Emergency Response Program (Strategic National Stockpile)	2c2. 100 percent of State public health agencies are prepared to use materiel contained in the Strategic National Stockpile as demonstrated by evaluation of standard functions as determined by CDC.	2004	60% certified	72% certified	√

Field Foods Activities (FDA): The FDA continues to improve the Nation's health care system to respond to bioterrorism and other public health challenges by ensuring the safety of foods, drugs, biological products, and medical devices, and by providing timely medical products to deal with emerging public health and terror threats. In FY 2005, the FDA supported the goal of ensuring food safety by surpassing its target of prior notice security reviews for foods and animal feeds line entries considered to be at risk for bioterrorism and that presented the potential of a significant health risk. In FY 2005, FDA with the help of Department of Homeland Security has completed 86,187 such reviews, exceeding its target of 38,000. There were over 53,000 more reviews in 2005 than 2004. However, it should be noted that FDA is not able to know in advance how many of the prior notices submitted will need to have a security review due to continuing changes in the criteria (intelligence and others) that must be met for determining when a security review is required. This information is tracked and verified through a variety of sources including the Operational and Administrative System Import Support. In addition, there is no trend

information available as this measure is the result of the Bioterrorism Act which became effective in December of 2003.

HRSA's Bioterrorism Hospital Preparedness program is designed to enable State and regional planning among local hospitals, emergency medical services systems, health centers, poison control centers, and other health care facilities to improve their preparedness to work together to combat terrorist attacks and deal with infectious disease epidemics and other public health emergencies. HRSA met its FY 2005 target of 100 percent of Hospital Preparedness program awardees having surge capacity plans. This represents an increase from 89 percent in FY 2004.

Terrorism Preparedness (CDC): The CDC's terrorism efforts are a critical element in the drive to protect the American public from a terrorist attack. Many of CDC's programs are interconnected and strive to provide the best possible coverage and results under the unifying goal of protecting the population. One such program is the Strategic National Stockpile, which is designed to supplement local efforts by reaching and providing advanced treatment to areas affected by a terrorist attack or mass trauma event. One target is for 70 percent of state public health agencies to be prepared to use Stockpile materials in 2005. The data for this measure is expected to be available in December of 2005. In 2004, the target of 60 percent was exceeded. Another target for measuring emergency preparedness in 2005 is for 25 percent of state public health agencies improve their capacity to respond to chemicals or category A agents. This data will be available in December 2005. This is a new measure; there is no 2004 data for this measure.

Strategic Goal 3
Increase the Percentage of the Nation's Children and Adults Who Have Access to Health Care Services, and Expand Consumer Choices

HHS is working to expand health care to all and remains committed to its many efforts aimed at increasing the percentage of the Nation's children and adults who have access to care and expanding consumer choices. The Department also will continue to promote increased access to health care for uninsured and underserved people and for those whose health care needs are not adequately met by the private health care system. In support of this goal, HHS will continue to promote a wide variety of activities intended to increase access to health care; encourage the development of low-cost health insurance options; reduce health disparities; and strengthen and improve health care services for targeted populations with special health care needs.

OPDIV and Program	Measure	FY	Target	Result	Goal Met
HRSA Health Centers Program	3a1. Increase the infrastructure of the Health Center program to support an increase in utilization via new or expanded sites.	2005	153	158	√
HRSA Health Centers Program	3a2. Increase the number of uninsured and underserved persons served by Health Centers.	2004	13.2 million	13.13 million	
HRSA Health Centers Program	3a3. Continue to assure access to preventive and primary care for racial/ethnic minorities.	2004	8.58 million (65%)	8.3 million (64%)	

OPDIV and Program	Measure	FY	Target	Result	Goal Met
IHS National Diabetes Program	3b. By 2010 increase the percentage of patients with ideal glycemic control to 40%.	2004	33%	34%	√
CMS Medicaid and the State Children's Health Insurance Program (SCHIP)	3c1. Decrease the number of uninsured children by working with states to enroll children in SCHIP and Medicaid	2004	Maintain enrollment at FY 2003 levels.	Goal met. +2,900,000 above FY 2003 enrollment levels.	√
CMS Medicaid and the SCHIP	3c2a. Improve health care quality across Medicaid and SCHIP Improve Health Care Quality Across Medicaid	2005	Refine the strategy and work plan for the provision of technical assistance to states in performance measurement calculation and reporting; collect 2002 performance measurement data from a minimum of 10 states; and continue to provide technical assistance to improve state capability for performance measurement calculation and reporting, and to encourage voluntary reporting by additional states.	Goal met. A data collection tool for states to voluntarily report measurement data on the core set of performance measures as a pilot test was developed and cleared at OMB in May 2004. Results from these 10 states support continued improvement in Medicaid health care quality. Analysis suggests that these data can be used to calculate a current set of performance measures in states with predominately fee-for-service programs.	√
CMS Medicaid and SCHIP	3c2b. Improve health care quality across Medicaid and SCHIP Improve Health Care Quality Across SCHIP	*2005*	Continue to collect core performance measurement data from states through the state annual reports; use the new automated State Annual Report Template System to analyze and evaluate performance data; and provide technical assistance to states on establishing baselines, measurement methodologies, and targets for SCHIP core measures.	Goal met. The State Annual Report Template System continues to provide CMS and states with the tools to evaluate performance of those states voluntarily submitting data. The collection of this data helps states to gain insight into their current status from which they can set goals for the future.	√

OPDIV and Program	Measure	FY	Target	Result	Goal Met
CMS Medicare	3d1. Implement the new Medicare-Endorsed prescription drug card	2005	Continue providing information to people with Medicare about the program through written materials, the www.medicare.gov website, and 1-800-MEDICARE.	Goal met. The following activities were completed: 1. The development and publication of the requirements for the Medicare-Endorsed Prescription Drug Discount Card program. 2. Solicitation and approval of applications from drug card sponsors. 3. Provision of information to people with Medicare about the drug card program (completed and ongoing).	√
CMS Medicare	3d2. Improve satisfaction of Medicare beneficiaries with the health care services They receive. <u>Managed Care</u>: • Access to care. Collect and share data toward FY 2005 target. • Access to specialist. Collect and share data toward FY 2005 target. <u>Fee For Service:</u> • Access to care. Collect and share data toward FY 2005 target. • Access to specialist. Collect and share data toward FY 2005 target.	2004	Monitor annual data toward 5-year target	Goal met Surveys were fielded annually to representative samples of beneficiaries enrolled in each Medicare Managed Care plan, the original Medicare fee-for-service plan, and providing comparable sets of specific performance measures collected in the Medicare Consumer Assessment of Health Plans Survey to our partners and stakeholders. Data from the target year (FY 2005) for the access to care/specialist measures will be available July 2006.	√

OPDIV and Program	Measure	FY	Target	Result	Goal Met
CMS Quality Improvement Organizations	3e. Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal	2003	Flu: 72.5% Pneumococcal: 67%	Flu: 70.4% Pneumococcal: 66.4% Influenza vaccine shortages and distribution delays in FY 2003 impacted the delivery of immunizations. Traditionally, pneumococcal immunizations are given by health care providers along with the influenza immunization. It is possible that disruptions of influenza vaccine supply may have impacted the pneumococcal vaccination rates also.	

HRSA's Health Centers program provides regular access to high quality, family-oriented, and comprehensive primary and preventive health care, regardless of patients' ability to pay. In 2004, the Health Centers program served 13.13 million persons, up from 12.39 million in 2003. While the program did not meet the target of 13.2 million persons served, the actual number served is extremely close to meeting the projected target based on the program's projections on resources needed per patient. This represents a growth of more than 700,000 persons over FY 2003 and an increase of nearly 3 million persons since the beginning of the President's initiative in FY 2002. In FY 2005, HRSA aimed to provide health services to 14 million persons. FY 2005 data are expected in August 2006.

The IHS National Diabetes program is an integral part of the IHS Hospitals and Health Clinics program. The ongoing emphasis on diabetes care within IHS programs recognizes the role of diabetes as a major cofactor in morbidity and mortality among American Indian/Alaska Native people. Maintaining ideal blood glucose levels is vital for diabetic patients in delaying or preventing many of the complications associated with diabetes, including cardiovascular, kidney, and eye disease. To achieve improvements in glycemic control, IHS combines glucose-lowering medications with a continued emphasis on proper diet and exercise. From FY 2002 to FY 2005, IHS achieved a 4 percent increase in diabetic patients demonstrating ideal blood sugar control (from 30 to 34 percent).

CMS is committed to its goal of assessing health care quality for children enrolled in **Medicaid** and **SCHIP**. Through the use of a core set of national performance measures developed in partnership with states, CMS

continues to meet yearly targets related to this goal. For several years, CMS has collected voluntary performance measurement data from states and continues to provide technical assistance to improve State capability for performance measurement calculation and reporting. These data provide CMS and States with the tools to evaluate performance of those states voluntarily submitting data. The collection of this data helps states to gain insight into their current status, from which they can set goals for the future. These data are reported by states on a voluntary basis. In FY 2003, CMS partially met its target to identify a timeline for implementing recommendations for Medicaid; identify a strategy for improving health care delivery and quality, and specify measures for gauging improving and initiate action steps for implementing recommendations for Medicaid and SCHIP. In FY 2004, CMS continued to work with state representatives and updated the timeline for implementing recommendations and identified a strategy for improving health care delivery and quality and for implementing recommendations. In FY 2005, CMS met its target to refine the strategy and work plan for the provision of technical assistance to states in performance measurement calculation and reporting.

For SCHIP, CMS met its FY 2003 target to identify a timeline for implementing recommendations; its FY 2004 target to refine the data submission, methodological processes, and reporting; and its FY 2005 goal to continue to collect core performance measurement data from states through the state annual reports.

CMS has published final program regulations and will establish a major initiative to educate health care providers and consumers about the **Medicare Prescription Drug, Improvement, and Modernization Act (MMA)**. The MMA, signed into law by the President in early FY 2004, provides enhanced coverage for the lowest income beneficiaries and an immediate prescription drug discount card for all beneficiaries who choose to obtain such a card until the full drug benefit is available nationwide. CMS plans to continue to provide information to all beneficiaries about the drug card program through written materials, the www.medicare.gov website, and 1-800-MEDICARE. CMS monitors the information needs of people with Medicare about the program. For example, the questions that come into the 1-800-MEDICARE call center are reviewed to ensure that the customer service representatives have the information needed to answer specific questions. When additional information needs are identified, CMS will modify print materials and the website as needed.

Strategic Goal 4
Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise

HHS recognizes the important role research plays in improving the Nation's health. As a result, many of the strategies that HHS has identified as important components in achieving its other strategic goals also incorporate a research base. This goal, therefore, focuses on creating the underlying knowledge and strategies that improve and maintain the research infrastructure that produces advances in health science.

HHS is committed to advancing the understanding of the environmental factors that contribute to human disease. In order to accomplish this objective, HHS will continue to support basic, clinical, and applied biomedical and behavioral research with stringent peer review for scientific quality of research proposals. HHS will also develop and implement processes for setting research priorities that ensure that research is responsive to public health needs, scientific opportunities, and advances in technology. HHS places a high priority on improving the coordination, communication, and application of health research results.

OPDIV and Program	Measure	FY	Target	Result	Goal Met
NIH International HapMap Project	4a. By 2005, create the next generation map of the human genome, a so-called haplotype map (HapMap), by identifying the patterns of genetic variation across all human chromosomes.	2005	Develop a first-pass draft HapMap containing 600,000 single nucleotide polymorphisms (SNPs).	Completed first-pass draft HapMap with 1.007 million single nucleotide polymorphisms. Begun in FY 2003, the target for this measure has been met or exceeded each year.	√
NIH Knowledge Base on Chemical Effects in Biological Systems (CEBS)	4b. By 2012, develop a knowledge base on chemical effects in biological systems using a systems toxicology or toxicogenomics approach.	2005	Create and provide public access to a global molecular expression and toxicology/pathology database of environmental chemicals and drugs (CEBS), featuring simple query download capability.	CEBS (version 1.5) has been made available to the public. This program provides simple query download capability of global molecular expression and toxicology/pathology data on a select number of studies of environmental chemicals and drugs. Begun in 2003, CEBS has attained its annual targets each year including 2005.	√

NIH completed a first-pass draft HapMap containing 1.007 million single nucleotide polymorphisms or SNPs. Phase II, to be released in October 2005 , will contain about 3.6 million SNPs. The NIH significantly exceeded its target of releasing a HapMap containing 600,000 SNPs, and met or exceeded its annual targets. This information can be verified using the SNP Database.

NIH is in the process of establishing a knowledge base on the effects of chemicals and drugs in biological systems in order to better understand the role of gene-environment interactions in disease. In FY 2005, NIH met its annual target of creating and providing public access to a global molecular expression and toxicology/pathology by making its **database of environmental chemicals and drugs (CEBS)**, featuring simple query download capability, available to the public. In future years, NIH has set a target of enhancing the CEBS database to add and integrate data on transcriptomics, proteomics, and toxicology for the same chemical compound. In the long term, this data is expected to lead to the discovery of characteristic gene- and protein-expression signatures that will help classify exposure to these chemicals by their biological activity, and provide a means for predicting effects on human health from such exposure. This measure has met it annual targets since its inception in 2003. Data for this system can be validated at CEBS website at http://cebs.niehs.nih.gov.

Strategic Goal 5
Improve the Quality of Health care Services

Improving the quality of life in the United States includes improving the quality of the health care services that people receive. This strategic goal is to improve health care services by reducing medical errors, improving consumer and patient information, and accelerating the development and use of electronic health information.

To achieve this goal, HHS will continue the implementation of a variety of strategies designed to improve the delivery of health care services. These strategies include the development and dissemination of evidence-based practices, information systems, new technologies for the home and clinical setting, and improved reporting systems for medical errors and adverse events. Health quality improvement also means translating new knowledge of effective health services into strategies, educational tools, and information to help clinicians and health care policy makers improve health care quality. HHS will work to expand provider networks to disseminate health care quality information, enabling consumers to make informed choices. HHS will provide leadership to promote the development of a national health information infrastructure that takes advantage of the most current technology available.

OPDIV and Program	Measure	FY	Target	Result	Goal Met
FDA Medical Product Surveillance Network (MedSun)	5a. Expand the implementation of the MedSun System to a network of 350 facilities.	2005	350 facilities	354 facilities	√
AHRQ Prevention Portfolio	5b1. Increase the quality and quantity of preventive services that are delivered in the clinical setting especially focusing on priority populations.	2005	Establish baseline quality and quantity of preventative services delivered.	Baselines: • % of women (18+) who report having had a Pap smear within the past 3 years: 81.3% • % of men and women (50+) report they ever had a flexible sigmoidoscopy/ colonoscopy: 38.9% • % of men and women (50+) who report they had a fecal occult blood test within the past 2 years: 33% • % of people (18+) who have had blood pressure measured within preceding 2 years and can state whether their blood pressure is normal or high: 90.1% • % of adults (18+) receiving cholesterol measurement within 5 years: 67.0% • % of smokers receiving advice to quit smoking: 60.9%	√
AHRQ Prevention Portfolio	5b2. Increase the number of partnerships that will adopt and promote evidence-based clinical prevention.	2005	Establish baseline of partnerships within the Prevention Portfolio promoting clinical prevention.	Federal partners: 8 Non-federal partners: • Primary care organizations: 10 • Health care delivery organizations: 2 • Consumer organizations:1 • Employer organizations: 3 • Other organizations: 3	√

FDA MedSun: continues to improve the quality of health care services by reducing medical errors involving FDA-regulated products. FDA also strives to improve patient and consumer safety by increasing the use of health care quality information, strengthening consumer and patient protections, and monitoring the safety of FDA-related products already on the market. In FY 2005 the Medical Products Surveillance Network for medical devices (MedSun), supported this goal by exceeding its target of bringing 350 facilities into the MedSun network by four facilities. MedSun has met or exceeded its targets each year since 2002. This information can be validated by the FDA and the contractor responsible for managing the MedSun system.

Current chronic diseases such as cancer, diabetes, heart disease, and stroke are among the most common and costly of all health problems, yet they are among the most preventable[4]. A critical step in reducing the burden caused by chronic disease is improving the quality of clinical services that prevent those diseases. Thus the **Agency for Healthcare Research and Quality** plays a key role in improving quality of care through activities accomplished within the **Prevention Portfolio**.

In FY 2005, **AHRQ** met its targets for both measures: 1) Establishing baselines for the quality and quantity of preventive services delivered; and 2) Forming partnerships with both Federal and non-Federal organizations. The portfolio now has baselines for clinical services delivered for Pap smear (81.3 percent), flexible sigmoidoscopy/colonoscopy (38.9percent), fecal occult blood test (33 percent), blood pressure measurement (90.1 percent), cholesterol measurement (67.0 percent), and smokers receiving advice to quit smoking (60.9 percent). These measurements were verified using the National Healthcare Quality Report, National Health Interview Survey and the Medical Expenditure Panel Survey. The Prevention Portfolio now has baseline measure of partners – 8 federal partners and 19 non-federal partners. A count of active partnerships is provided by outside contractors through stakeholder meeting, expert panel meetings and groups with clinicians. Since the both targets were established in FY 2005, no trend data is available.

Strategic Goal 6
Improve the Economic and Social Well-being of Individuals, Families, and Communities, Especially Those Most in Need

HHS promotes and supports interventions that help disadvantaged and distressed individuals, families, and communities improve their economic and social well-being. To achieve this strategic goal, HHS supports targeted efforts to increase the independence and stability of low-income families, people with disabilities, older Americans, American Indians/Alaska Natives, victims of domestic violence, refugees, and distressed communities.

OPDIV and Program	Measure	FY	Target	Result	Goal Met
ACF Temporary Assistance for Needy Families (TANF)	6a. Increase (from FY 2000) the percentage of adult TANF recipients/former recipients employed in one quarter of the year that were still employed in the next two consecutive quarters.	2003	68%	59%	
AoA Aging Services Program	6b1. (*Targeting*) Increase the number of severely disabled clients who receive selected home and community-based services.	2004	New in 2004 2003 baseline: 280,454. 2005 target: 302,000 (Baseline + 8%)	293,500	N/A

[4] http://www.healthierus.gov/steps/summit/prevport/power/ ; accessed November 1, 2005

OPDIV and Program	Measure	FY	Target	Result	Goal Met
AoA Aging Services Program	6b2. *(Client Outcomes)* Increase the percentage of caregivers reporting that services have ***definitely*** helped them provide care longer for older individuals.	2004	New in FY 2004 2003 baseline: 48%. 2005 target: 62%.	52%	N/A

The purpose of **Temporary Assistance for Needy Families (TANF)** is to increase the self-sufficiency and stability of low-income families by promoting employment and job readiness as well as activities that support healthy marriages. Welfare reform has been largely successful in increasing the financial independence of recipients since the Personal Responsibility and Work Opportunity Reconciliation Act passed in 1996. In March 2005, there were 63 percent fewer individuals receiving TANF benefits than in August 1996.

TANF has several work-related measures, including job entry, job retention, and earnings gain. The program has made progress in each of these areas, but did not meet some of the FY 2003 targets because of the unanticipated effects of the caseload reduction credit in reducing the recipient work participation rates. For example, the job retention rate measures the percentage of current or former TANF recipients who are employed in one quarter of the year and remain employed in the next two quarters. In FY 2003, the job retention rate was 59 percent, missing the original 68 percent target. Since then, the program has revised its performance targets to reflect the effects of the caseload reduction credit. Also, as welfare recipients continue to move from welfare to work, the President's TANF reauthorization proposal emphasizes the continued importance of strengthening work participation and achievement of TANF recipients.

AoA's Aging Services program provides a comprehensive set of services to elderly individuals and family caregivers that help keep America's rapidly growing older population healthy, secure and independent in the community. These services are especially important as part of a community-based long-term care system designed to give the elderly choice and control and delay institutionalization. Program performance measures included in this report reflect the importance AoA places on rebalancing the Nation's long-term care system toward more home and community-based care. For the first performance measure 6b1: *Increase the number of severely disabled clients receiving selected (home-delivered meals) home and community-based services*, AoA collected baseline data in FY 2003. At baseline, there were 280,454 severely disabled home-delivered meal clients. In FY 2004, there were 293,500 severely disabled home-delivered meal clients, over a 4 percent increase. The FY 2005 performance target is 302,000. AoA anticipates achieving this target. For the second performance measure 6b2: *Increase the percentage of caregivers reporting that services have definitely helped them provide care longer for older individuals,* AoA collected baseline date in FY 2003. At baseline, 48 percent of caregivers reported that services definitely helped them provide care longer. In FY 2004, 52 percent reported that services definitely helped. The FY 2005 performance target is an ambitious 62 percent. Two years of data shows improved program performance for both measures.

Strategic Goal 7
Improve the Stability and Healthy Development of Our Nation's Children and Youth

In order to promote the development and stability of our nation's children and youth, HHS will continue moving forward with several important efforts. HHS will continue to support the social and cognitive development of preschool children; provide supports for family formation and healthy marriages; support programs that increase the involvement and financial support of non-custodial parents; and increase the percentage of children and youth living in a safe and stable environment.

OPDIV and Program	Measure	FY	Target	Result	Goal Met
ACF Child Support Enforcement	7a. Increase the Title IV-D collection rate for current support.	2003	58%	58%	√
ACF Child Welfare	7b. Increase the number of adoptions.	2003	58,500	50,000[5]	
ACF Head Start	7c. Achieve goal of at least 80 percent of children completing the Head Start program rated by parent as being in excellent or very good health.[6]	2002	80%	79%	

ACF Child Support Enforcement: The mission of Child Support Enforcement (CSE) is to ensure that children receive the financial and medical support they need by locating parents, establishing paternity, and enforcing support obligations. Child support is an important source of income to improve the quality of life for children and for families striving for self-sufficiency. In FY 2003, the CSE program met its target of collecting 58 percent of current support due (collections on current support/current support owed). Current support collections totaled $15.7 billion in FY 2003, an increase of approximately 4 percent over the previous fiscal year. In fact, the CSE program has met or exceeded its target for current support collections in every year since 2001, collecting 58 percent in 2002 and 57 percent in 2001. Data for FY 2005, which increases the target current support collection rate to 61 percent, is not yet available.

CSE is largely dependent on state administrative systems for collecting performance data. In terms of data quality and reliability, states maintain information on the necessary data elements for CSE program measures. The Office of CSE reviews the states' and auditors' ability to produce valid data. Data reliability audits are conducted annually. Self-evaluation by states and the Office of CSE audits provide an ongoing review of the validity of the data and the ability of automated systems to produce accurate data.

ACF Child welfare programs, like Foster Care, Promoting Safe and Stable Families, and Adoption Incentives, provide an array of services to children in at-risk families or children who need to be removed from the home. ACF is dedicated to protecting children, reunifying families when possible, and finding safe and stable permanent homes for children who cannot return to their families. In FY 2003 ACF finalized adoptions for 50,000 children from the child welfare system, but missed the goal of 58,500 adoptions. The goal of 58,500 adoptions in FY2003 was not met for a variety of complex reasons, including the decline in the number of children in foster care; the increase in age of the children entering care and waiting to be adopted; the increase in the percentage of children with a case plan goal of reunification; and the decline in the percentage of children with a case plan goal of adoption. To meet

[5] Revised from 49,000 as reported in the FY 2006 Congressional Justification.
[6] In FY 2002, 881,869 children were up-to-date on a schedule of age-appropriate preventive and primary health care; 186,572 children received medical treatment as a result of a diagnosed health condition.

their adoption goals, the Children's Bureau is implementing a major effort to recruit adoptive families called "AdoptusKids." In addition, the Children's Bureau will continue to use the Child and Families Services Reviews (CFSR) to work with states to improve their child welfare systems. In FY 2002, there were 53,000 adoptions; 50,000 in FY 2001; and 51,000 in FY 2000. State child welfare agencies report data on foster care and adoption through the Adoption and Foster Care Analysis and Reporting System; system data is subject to edit checks for reliability.

ACF's Head Start program promotes school readiness by enhancing the social and cognitive development of low-income children through the provision of educational, health, nutritional, social, and other services. During FY 2002, the most recent period for which data are available, 79 percent of children completing the Head Start program were rated by their parent as being in excellent or very good health. This is within 1 percentage point of meeting the target for this measure. A likely contributor to this shortfall is the persistent difficulty low-income families face in gaining timely access to needed health care, with particular problems in receiving oral health care. To address this need, the Head Start Bureau has implemented, in partnership with HRSA's Maternal and Child Health Bureau, an Oral Health Initiative which since 2004 has supported a national network of technical assistance designed to improve Head Start children's access to oral health care. With this resource focused on improved oral health care access, and its continued attention to the overall health of Head Start children, Head Start expects to reach the 80 percent target. The FY 2002 result represents an improvement from 77 percent in FY 2000.

Strategic Goal 8
Achieve Excellence in Management Practices

HHS is committed to improving the efficiency and effectiveness of the Department's programs by creating an organization that has a citizen-based focus, is results-oriented, and is market-driven, where practicable. The President's Management Agenda identifies key elements needed for HHS to achieve its commitment to establishing more effective Department management. In particular, HHS is dedicated to improving management of its financial resources; using competition to obtain the best price for services acquired; improving the management of its human capital and tying human capital goals to program performance goals; using technology wisely and in a cost effective manner; and achieving an integrated performance budget.

OPDIV and Program	Measure	FY	Target	Result	Goal Met
CMS Medicare Integrity Program	8a. Reduce the percentage of improper payments made under the Medicare Fee-For-Service program	*2005*	7.90%	5.20%	√

OPDIV and Program	Measure	FY	Target	Result	Goal Met
Office of Inspector General	8b. Returns per budget dollar invested in the Office of Inspector General	2005	$176	$168	

CMS will continue its focus on maintaining program integrity in the Medicare program to ensure that it pays the right amount to legitimate providers for covered, reasonable, and necessary services to eligible beneficiaries. CMS sets ambitious annual program integrity targets, including reducing the percentage of improper payments made under the Medicare fee-for-service program, as well as reducing the contractor error rate and improving the provider compliance error rate. The Comprehensive Error Rate Testing (CERT) program, initiated in FY 2003, has produced a national error rate for each year since its inception. The Office of Inspector General produced error rate information for years before those included in the FY 2003 report. In 2004, CMS began reporting gross error rates in addition to the net error rates previously reported. This change was necessary in order to comply with new Improper Payments Information Act requirements. As a transition, the FY 2004 reports will contain both net and gross numbers. A gross improper payment amount is calculated by adding underpayments to overpayments. A net improper payment amount is calculated by subtracting underpayments from overpayments. Future reports will contain only gross numbers.

The FY 2005 paid claims error rate of 5.2 percent exceeded CMS' Medicare Fee for Service Error Rate GPRA goal of 7.9 percent. Because of this dramatic improvement, CMS has chosen to revise its GPRA goals for 2006 and beyond. The FY 2004 Medicare error rate was 10.1[7] percent, FY 2003 was 5.8[8] percent and FY 2002 was 6.3 percent. The FY 2004 error rate is the baseline for future error rate estimates reflecting the CERT program. CMS did not meet its FY 2004 target error rate of 4.8 percent. The original target error rates were developed based upon the assumption that the CERT program would discover similar findings in its reports as the Office of Inspector General. However, the numbers reported did not align with the target assumptions; therefore CMS has revised its baseline target data to reflect CERT data. CMS and the CERT contractors audit the data through ongoing quality control measures that include comparison of the number of claims in the CERT universe (i.e., all claims Medicare contractors receive) to an independent CMS report of the number of claims Medicare contractors received and verification that paid amounts for sampled claims match independent CMS records of claims payments.

The Office of Inspector General (OIG) will continue to combat fraud, waste, and abuse, and recommend ways of increasing the economy, efficiency, and effectiveness of HHS programs and management practices. To accomplish this, the OIG will conduct and supervise audits, inspections, and investigations; and provide guidance to the health care industry.

Return on investment (ROI) has long been the primary measure of the effectiveness and efficiency of the OIG. It is the ratio of savings that would not have been possible in the absence of effective OIG work to the OIG operating budget. The savings that are claimed by the OIG consist of expected recoveries from investigations, audit disallowances, and savings from legislative and administrative changes that were stimulated by recommendations in OIG reports. The source data used for these results are the following: expected recoveries from investigations are entered into the OIG investigations data system "IRIS." Documents that officially report the conclusion of criminal and civil proceedings, including the amount of fines, penalties, and restitution must be received by the OIG before the expected recoveries are allowed into the IRIS system. Audit disallowances are entered into the OIG WEB AIMS system by the Audit Resolution staff of the HHS Office of the Assistant Secretary for Budget Technology and Finance, and are

[7] Per Improper Payments Information Act (IPIA) requirements, HHS began reporting on gross (under- and over-payments) results (as shown in the table above) in FY 2004. The FY 2004 net result was 9.3%.
[8] HHS reported an unadjusted paid claims error rate of 9.8%, and an adjusted paid claims error rate of 5.8% (as shown in the table above) in FY 2003.

reconciled to the OIG audit disallowance issuances. Savings from legislative and administrative changes are those scored and published by the Congressional Budget Office as part of the legislative process. All of the above are subject to periodic audit by the Government Accountability Office (GAO).

In 2002, the target for ROI was $79:1, but the final result was $121:1. The ROI target has risen each year, and in FY 2005 was $176:1. The FY 2002 result was $121:1. There was a decrease in FY 2003 to $117:1, but that result exceeded the $114:1 target. FY 2004 exceeded the previous year's results by 28% and the target for that year by 10 percent. The ROI target has risen each year, and in FY 2005 was $176:1. The FY 2005 result was $168:1 - an increase of 12% over FY 2004, but 5 percent below the target. Since the results of OIG work are not realized during the same year in which resources related to the results are expended - often requiring five or more years to be realized - it is inevitable that an increase in resources in any given year will impact ROI negatively. The results of OIG work often require five or more years to be realized because they are not realized during the same year in which resources related to the results are expended. Therefore, it is inevitable that an increase in resources in any given year will impact ROI negatively. In most years, the impact is not sufficient to result in an ROI that misses its target, but that did occur in FY 2005 when nearly $11 million was added to the OIG budget for the purpose of carrying out mandates contained in the MMA. If the MMA supplement were excluded from the ROI calculation, OIG FY 2005 ROI would have been $177:1, which exceeded the $176:1 target. With or without the MMA supplement, the result continued the OIG record of returns that far exceed its cost of operation.

PRESIDENT'S MANAGEMENT AGENDA

The President's Management Agenda (PMA) articulates the Administration's strategy for improving the management and performance of government. It established goals for five government-wide initiatives (Strategic Management of Human Capital, Competitive Sourcing, Improved Financial Performance, Expanded Electronic Government, and Budget and Performance Integration) and several program-specific initiatives. As a result, agencies develop and implement action plans to achieve those goals. The Office of Management and Budget (OMB) uses PMA scorecards to hold agencies publicly accountable for their status in achieving the goals of each initiative and for their progress in implementing their action plans. Agencies also use these scorecards as blueprints for improvement efforts. The scorecards, which are released quarterly, employ a simple grading system of green for success, yellow for mixed results, and red for unsatisfactory.

What the PMA Scores Indicate		
Score	**Status**	**Progress**
G	Agency meets all of the Standards for Success.	Implementation is proceeding according to plans agreed upon with agencies.
Y	Agency has achieved intermediate levels of performance in all criteria.	Some slippage or other issues requiring adjustment by the agency in order to achieve initiative objectives on a timely basis.
R	Agency has any one of a number of serious flaws.	Initiative in serious jeopardy. Unlikely to realize objectives absent significant management intervention.

The following table shows HHS status and progress on both the five government-wide initiatives that apply to all Federal agencies and the five program initiatives that impact HHS programs and operations: Broadening Health Insurance Coverage, Faith-Based and Community Initiative, Real Property Asset Management, Research and Development (R&D) Investment Criteria, and Eliminating Improper Payments. As of September 30, 2005, HHS earned three green status scores and nine of ten green progress scores.

HHS PMA Initiatives					
Government-wide Initiatives	**Status***	**Progress in Implementation***	**Program Initiatives**	**Status***	**Progress in Implementation***
Government-wide Initiatives			**Program Initiatives**		
Strategic Management of Human Capital	G	G	Eliminating Improper Payments	R	Y
Competitive Sourcing	G	G	Broadening Health Insurance Coverage	Y	G
Expanded Electronic Government	Y	G	Faith-Based and Community Initiative	Y	G
Budget and Performance Integration	Y	G	Real Property Asset Management	R	G
Improved Financial Performance	R	G	R&D Investment Criteria	G	G

* As of September 30, 2005.

The following tables discuss HHS' efforts during FY 2005 to further the PMA and action plans to promote progress in FY 2006.

STATUS G

STRATEGIC MANAGEMENT OF HUMAN CAPITAL

PROGRESS G

Overview

The Strategic Management of Human Capital initiative intends to build, sustain, and effectively deploy a skilled, knowledgeable, diverse, and high-performing workforce to meet current and emerging needs, and align strategies with organizational mission, vision, core values, goals, and objectives.

People are the single most significant resource available to HHS leadership. To support the PMA, the Department is building a fully integrated human capital management approach that bridges the gap between where HHS is today and where HHS needs to be in the future. HHS has become a better-managed organization that is leveraging its human capital, systematically measuring its performance, remaining focused on its mission, and anticipating and responding to future requirements.

FY 2005 Accomplishments

- Completed implementation of the electronic official personnel file within each Human Resources Center.
- Submitted to the Office of Personnel Management (OPM) a revised non-Senior Executive Service (SES) multi-tiered performance management system, mirroring the new SES system.
- Developed a mid-career level competency-based leadership program, which prepares top employees for advancement through leadership development opportunities.
- Created a competency framework for the entire Department that identifies necessary competencies for HHS supervisors, managers, and executives.
- Provided further data on HHS mission-critical occupations. HHS provided information on employees currently assessed for technical and leadership mission-critical occupation competencies.
- Reduced under-representation, particularly in mission-critical occupations and leadership ranks; established processes to sustain diversity.
- Solidified position to meet its planned aggressive hiring timeline goals and hiring process improvements.
- Provided current on-board strength of HHS' 13 mission-critical occupations and set goals to close predicted gaps.
- Submitted survey analysis of HHS' Emerging Leaders Program.
- Worked with OPM to assess gaps in the OPM accountability system.
- Reviewed human capital survey results and planned follow-up activities.

FY 2006 Action Plan

- 100 percent of OPDIVs/Staff Divisions set and meet targets through leadership succession plans to close competency gaps.
- 100 percent of annual performance plans track to performance budget plans including program performance goals and targets.
- 100 percent completion of competency project to close potential competency gaps in mission-critical occupations.
- Achieve 100 percent deployment of scheduled Human Resource Information Technology initiatives.

STATUS G

COMPETITIVE SOURCING

PROGRESS G

Overview

The Competitive Sourcing initiative aims to achieve efficient and effective competition between public and private sources by simplifying and improving the procedures for evaluating public and private sources, better publicizing the activities subject to competition, and ensuring senior-level agency attention to the promotion of competition.

For competitive sourcing, HHS is at the forefront of civilian agencies. For example, HHS was one of the first Federal agencies to develop and implement a long-range competitive sourcing plan (known as a Green Plan), consistent with the revised OMB Circular A-76, *Performance of Commercial Activities*. The Department also supports a fair and reasoned approach to competitive sourcing and encourages input from competitive sourcing programs across HHS OPDIVs.

FY 2005 Accomplishments

- To date HHS has announced or completed numerous competitions. The studies already completed, when fully implemented over the next several fiscal years, are expected to yield significant savings for the greater benefit of HHS programs and the American taxpayer.
- HHS has implemented a Federal Activities Inventory Reform (FAIR) Act database that maintains Departmental FAIR Act inventory data. The database system is tailored to HHS specifications and allows for greater ease in obtaining necessary information. The system processes data to assist in the assembly of informative reports and serves to promote consistency in the application of functional codes across the Department through side-by-side comparisons of organizational unit inventories. FAIR Act inventory results are utilized as a basis for determining future studies.

FY 2006 Action Plan

- Consistent with the Green Plan, HHS has developed and will implement an FY 2006 competition plan. Based on the competitive sourcing knowledge that the Department has acquired over the past several years, the FY 2006 plan is designed to maximize efficiencies and savings. For example, the FY 2006 plan encourages the formation of most efficient organizations for streamlined studies, which under the revised OMB Circular A-76 are required only for standard studies.
- HHS will demonstrate positive anticipated net savings and performance improvements from completed competitions. On a random sample basis, HHS will independently validate that the anticipated savings are being realized as planned.
- HHS will structure competitions to encourage increased private sector participation and regularly review work performed to determine whether performance standards are met and take corrective action when services provided are deficient.

STATUS Y

EXPANDED ELECTRONIC GOVERNMENT

PROGRESS G

Overview

The Expanded Electronic Government initiative aims to leverage the use of information technology (IT) to significantly improve the government's ability to serve citizens, reduce the costs of delivering those services, and ensure electronic transactions are private and secure.

HHS continues to make significant progress in expanding the use of electronic government (e-Gov) to conduct Departmental business and to serve citizens more effectively and efficiently, while helping to improve the delivery of its services to government, businesses, and the American people. HHS' strategic planning and performance management efforts have aligned all major IT projects with HHS IT strategic planning goals and objectives and those, in turn, are aligned with the Departmental goals and objectives.

FY 2005 Accomplishments

- Submitted an Enterprise Architecture completion and use plan.
- Migrated HHS employees to the Defense Finance and Accounting Service payroll system.
- Executed all e-Gov/Line of Business Memoranda of Understanding and transferred funds pursuant to OMB instructions.
- Completed the update to the annual HHS Information Resources Management and Performance Plan, which is mapped to the HHS Enterprise IT Strategic Plan.
- Deployed a portfolio management tool for HHS to manage IT investment decision making under HHS' Capital Planning and Investment Control (CPIC) program.
- Implemented a network and security-monitoring tool to ensure consistent and continuous security of the HHS technical environment.
- Achieved 92.1 percent of HHS major investments having cost and schedule variances not greater than –10 percent.
- Certified and accredited 99 percent of HHS IT systems under the Secure One HHS IT Security Program.
- Introduced a new enterprise-wide web search capability for the HHS.gov website.
- Provided electronic official personnel file access to 84.3 percent of HHS employees.

FY 2006 Action Plan

- Ensure 100 percent of HHS IT systems are certified and accredited and 100 percent of HHS employees have received annual security training.
- Align the OPDIVs' Plan of Action and Milestones process with the Secure One HHS IT Security Program.
- Approve and effect funds transfers as required for all e-Gov initiatives, per OMB instructions.
- Install and migrate to an enterprise Earned Value Management System tool.
- Require corrective action plans for investments that have greater than –10 percent variance for cost or schedule.
- Issue final CPIC policy and procedures and establish a CPIC training program.
- Submit acceptable business cases for all FY 2008 proposed major IT investments.
- Implement e-Authentication service for Grants.gov.
- Continue improvements to HHS.gov, to include continued website analyses, and integrating usability principles and evidence-based design.

STATUS Y

BUDGET AND PERFORMANCE INTEGRATION

PROGRESS G

Overview

The Budget and Performance Integration initiative requires Federal agencies to use performance information to inform funding and management decisions and to improve program performance. The results will be a more effective and efficient Federal Government.

HHS has participated actively in the OMB Program Assessment Rating Tool (PART) process, completing a total of 62 PART assessments. Under the PART process, OMB evaluates a program's purpose and design, planning, management, and results and accountability to determine its overall effectiveness. HHS uses PART information to improve program performance and efficiency and to inform program management and budget decisions. Section II of this report, Program Performance Report, contains additional information on the PART.

FY 2005 Accomplishments

In FY 2005, HHS continued to successfully integrate performance information into budget and management decision processes at the Department, OPDIV, and program level. HHS' success in budget and performance integration is highlighted below.

- Submitted first integrated performance budgets to Congress.
- Completed and submitted performance sections for the FY 2004 Performance and Accountability Report, linking program performance to Departmental strategic goals.
- Introduced an electronic newsletter to provide information on budget and performance integration activities on a regular basis to the OPDIVs.
- Reviewed performance appraisals for heads of OPDIVs and Staff Divisions for inclusion of management and program objectives.
- Conducted an HHS-wide conference on budget and performance integration.
- Implemented a process for tracking PART recommendations.
- Demonstrated that four programs can calculate marginal cost, using HHS' marginal cost methodology.
- Identified cost savings associated with PART program efficiency measures.

FY 2006 Action Plan

For FY 2006, HHS has identified the following priorities to focus efforts to achieve a green status rating for the Budget and Performance Integration initiative. The Department has adopted an aggressive strategy that will take time but will continue to produce results.

- Decrease the percentage of PART programs rated "Results Not Demonstrated."
- Increase the number of PART programs with an efficiency measure.

STATUS R

IMPROVED FINANCIAL PERFORMANCE

PROGRESS G

Overview

The Improved Financial Performance initiative requires Federal agencies to ensure financial systems produce accurate and timely information to support operating, budget, and policy decisions by improving timeliness, enhancing usefulness, and ensuring reliability by obtaining and sustaining clean audit opinions.

The goals and initiatives in HHS' Financial Management Five-Year Plan correlate with the key success elements articulated in the PMA. HHS' overarching financial management goals seek to (1) provide decision makers with timely, accurate, and useful financial and program information; and (2) ensure that HHS resources are used appropriately, efficiently, and effectively. In correlation with the PMA, the plan's focal points include, but are not limited to the results and timeliness of the annual financial statement audit, and the continued development and implementation of a Unified Financial Management System (UFMS).

FY 2005 Accomplishments

- Successfully completed the UFMS implementation at CDC and FDA; "Go-live" was successful.
- UFMS implementation at the PSC is underway, on schedule, and on budget.
- Began a rollout to Medicare contractors of the Healthcare Integrated General Ledger Accounting System (HIGLAS).
- Earned a sixth consecutive clean audit opinion on the FY 2004 financial statement audit.
- Performed more frequent data analyses, thereby enhancing the accuracy of financial data, and continued to produce timely interim and annual financial statements and other required reports, enabling managers to make timely decisions.
- Corrected two FMFIA Section 2 material weaknesses (FISMA and Departmental Financial Reporting) and had a third downgraded to a reportable condition (Medicare EDP Controls).
- Conducted a Department-wide analysis to identify the extent to which HHS is currently integrating financial and performance information to support routine or day-to-day program, management, and operations decisions.
- Submitted HHS' A-123 Implementation Plan to improve internal controls to OMB and created a governance structure and charters for a Department-level Risk Management and Financial Oversight Board, and a HHS/OPDIV Senior Assessment Team.

FY 2006 Action Plan

- Submit FY 2005 PAR by November 15, 2005, and earn a seventh consecutive clean audit opinion.
- Complete implementation of the NIH Business and Research Support System and merge it with UFMS.
- Project PSC "Go-live" for UFMS implementation.
- Implement HIGLAS at two additional CMS Medicare contractors.
- Develop a Green Plan to improve access to and use of financial performance information to support project management and operations decisions.
- HHS' goal is to complete the risk assessments by the end of the second quarter and complete testing in the third quarter to support the Appendix A assurances as of June 30 and September 30, 2006.

STATUS R

ELIMINATING IMPROPER PAYMENTS

PROGRESS Y

Overview

Eliminating improper payments is central to the Administration's efforts to improve financial performance government-wide, enhance the integrity of Federal programs, and ensure that limited resources are used for their intended purpose. In previous years, this area was included under the PMA initiative "Improved Financial Performance." In FY 2005, this stand-alone scorecard initiative was created to increase attention to this critical area and to ensure that Federal agencies are held accountable for achieving results in its improper payment reduction efforts.

HHS has always been committed to ensuring taxpayer resources are spent wisely. In FY 1996, HHS began measuring payment errors in one of its largest programs (Medicare fee-for-service). Since the enactment of the Improper Payments Information Act of 2002 (IPIA), HHS has determined methodologies for estimating payment errors in two other programs (Foster Care and Head Start), finalized a plan for estimating payment errors in a component of its second largest program (Medicaid), conducted risk assessments of its largest programs, implemented a recovery auditing program, and taken appropriate corrective action measures to reduce the extent of payment errors identified in HHS programs.

Additional information on HHS' improper payments activities can be found in Appendix C of this report.

FY 2005 Accomplishments

- ***Medicare*** – Reduced the FY 2004 paid claims error rate of 10.1 percent, or $21.7 billion, in gross improper payments to 5.2 percent, or $12.1 billion, in FY 2005.
- ***Head Start*** – Reduced the FY 2004 improper payment rate of 3.9 percent to 1.6 percent.
- ***Foster Care*** – Implemented a methodology to estimate payment errors and determined an improper payment rate of 10.3 percent. Also, began to identify and implement corrective actions.
- ***Medicaid*** – States participating in the Payment Accuracy Measurement (PAM) pilot determined Medicaid payment accuracy rates. Also, HHS formulated a plan for estimating improper payment errors/rate in the Medicaid fee-for- service component.
- ***SCHIP*** – States participating in the PAM pilot determined SCHIP payment accuracy rates. Also, HHS formulated a plan for estimating improper payment errors/rate in the SCHIP fee-for-service component.
- ***TANF*** – Engaged in various activities toward identifying a methodology for estimating payment errors.
- ***Child Care*** – Expanded State participation in the Child Care improper payments pilot project from 11 states to 18, and engaged in various activities toward identifying a methodology for estimating improper payments.
- ***Recovery Auditing*** – Engaged in recovery auditing activities in which a very insignificant amount of improper payments was identified.
- ***Risk Assessments*** – Completed FY 2005 program risk assessments.

FY 2006 Action Plan

- Identify and implement appropriate corrective action to further reduce the FY 2005 reported payment errors rates for Medicare, Foster Care and Head Start.
- Determine and begin to implement methodologies for estimating payment errors for TANF and Child Care.
- Finalize plan for estimating administrative improper payments for Foster Care.
- Implement plans for estimating payment errors in the Medicaid and SCHIP fee-for-service components to report in the FY 2007 PAR. Also, complete plans for measuring payment errors in the managed care component and for eligibility.
- Complete HHS program risk assessments.
- Continue HHS recovery auditing activities.

STATUS Y

BROADENING HEALTH INSURANCE COVERAGE

PROGRESS G

Overview

The Broadening Health Insurance Coverage initiative aims to increase the number of individuals with access to affordable health insurance by increasing state flexibility to provide health insurance to low-income individuals while ensuring prudent management of Federal Medicaid and State Children's Health Insurance Program (SCHIP) funds.

The Medicaid Program provides healthcare to millions of low-income Americans who otherwise would lack health insurance coverage. In 2002, CMS first announced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, which puts emphasis on broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with incomes below 200 percent of the Federal poverty level.

FY 2005 Accomplishments

- The CMS estimates that HIFA demonstrations, if fully implemented, could result in as many as 825,250 new enrollees. The original estimates have not been achieved to date as states have either only partially implemented their programs or have not yet implemented their program such as in the case of California.
- The CMS analyzed the draft Urban Institute case studies related to uninsurance rates and to identify model practices and lessons learned to disseminate internally to project officers and the Departmental review team.
- The CMS approved Virginia's HIFA demonstration and Idaho's request to amend its existing HIFA demonstration.

FY 2006 Action Plan

- Continue to work with states to expand coverage and provide state flexibility through available waivers under the Medicaid Plan.
- Create an action plan to develop a research method to evaluate the relationship between the HIFA demonstrations and the number of uninsured in states that implement HIFA demonstrations.

STATUS Y

FAITH-BASED AND COMMUNITY INITIATIVE

PROGRESS G

Overview

The mission of the Faith-Based and Community initiative at HHS is to create an environment within the Department that welcomes the participation of faith-based and community organizations as valued and essential partners in helping Americans in need. Through the collaborative efforts of the Center for Faith-Based and Community Initiatives (CFBCI) and several OPDIVs, HHS has accomplished the following in outreach/technical assistance, pilot projects, data collection, and regulatory reform.

FY 2005 Accomplishments

- HHS contributed to a report released by the White House Office of Faith-Based and Community Initiatives on grant awards made to faith-based organizations in FY 2004.
  - The report noted that HHS awarded $681 million through 908 grants to faith-based organizations in FY 2004.
  - This was a 43 percent increase in the amount of funding awarded to faith-based organizations from 2002 and an 88 percent increase in the number of grants awarded over the same period.
- CFBCI released the 2005 Grant Opportunities Notebook that provides information about multiple grant opportunities at the Department.
- HHS has participated in regional conferences on the Faith-Based and Community initiative and has developed web resources and information to help organizations increase their capacity and improve grant applications.
- HHS has finalized the design study for the Mentoring Children of Prisoners Program and submitted it for Departmental clearance.
- The Office of General Counsel has taken steps to train HHS staff on the implementation of the Equal Treatment and Charitable Choice regulations published in previous fiscal years.
- HHS is working with other Federal agencies to develop guidance for state and local administrators of Federal funds on the implementation of Charitable Choice and Equal Treatment regulations. This effort will level the playing field for grassroots organizations at all levels of government.

FY 2006 Action Plan

- Participate and contribute to White House Regional Conferences on the Faith-based and Community initiatives.
- Distribute regulatory guidance to state and local governments.
- HHS will provide a report detailing the participation of faith-based and community organizations in select grant programs in the Department. This report will include information about the amount granted to organizations and an analysis of the applicants to select grant programs.
- Coordinate with the Office of General Counsel and OPDIVs to provide regulatory training throughout HHS.
- Conduct evaluative research on HHS pilot programs, including Compassion Capital Fund, Mentoring Children of Prisoners, and Access to Recovery Program.

STATUS R

REAL PROPERTY ASSET MANAGEMENT

PROGRESS G

Overview

The Real Property Asset Management initiative aims to improve asset management and rightsize inventory. The Department is currently developing and implementing a number of tools to achieve these goals, including an HHS Real Property Asset Management Plan (RAMP), Automated Real Property Inventory System and government-wide performance measures, consistent with Federal Real Property Council (FRPC) guidance, and HHS-specific performance measures used in the daily management of the HHS Real Property Asset Management Program.

These tools are also expected to aid HHS in real property management by fostering mission success through occupant productivity and efficiency, and maintaining appropriate stewardship of real property. Key components of the Department's approach to fulfill these goals include acquiring a comprehensive understanding of current HHS asset management procedures, leveraging Departmental work groups, identifying Federal/private sector best practices, and obtaining contractor assistance.

FY 2005 Accomplishments

- Completed OPDIV training (land holding and non-land holding HHS components) on the HHS Automated Real Property Inventory System and completed down-loading of 23 FRPC and 33 HHS-specific data elements for CDC, FDA, and NIH owned and leased properties.
- Completed testing and began capturing FRPC-mandated facility utilization, cost, mission dependency, and facility condition metrics, and HHS-specific construction performance measures for inclusion in the Department's December 2005 submission to the government-wide Federal Real Property Profile database.
- Submitted a draft HHS Real Property Asset Management Plan for OMB approval.

FY 2006 Action Plan

- Identify FY 2006 actions required to meet the goals and objectives outlined in an OMB-approved Real Property Asset Management Plan, with a three-year timeline. The projects identified in the timeline should result in required change to inventory, i.e. disposing of unneeded assets, improving the condition of mission critical and mission dependent assets, reducing costs or operating assets at an acceptable cost level, etc.
- Implement the HHS Automated Real Property Inventory System consistent with FRPC standards, provide required data to government-wide database, and use information in daily real property management decision making.
- Implement FRPC-required and HHS-specific performance measures and use data analyzed in daily real property management decision making.

STATUS G

RESEARCH AND DEVELOPMENT INVESTMENT CRITERIA

PROGRESS G

Overview

The Research and Development (R&D) investment Criteria initiative requires Federal agencies to develop objective investment criteria for Federal research and development projects that will better focus the government's research programs on performance.

HHS continues its commitment to ensuring that its investments in R&D are effective and yield new knowledge for the development of diagnostics, treatments, and preventive measures to improve health and quality of life for all Americans. Central to the development and implementation of objectives under the Department's strategic goal 4, "Enhance the capacity and productivity of the Nation's health science research enterprise," are the OMB R&D investment criteria: relevance, quality, and performance. These criteria are considered carefully as research goals and associated targets are developed, as management changes are considered, and as HHS and its OPDIVs make budget decisions.

FY 2005 Accomplishments

- Used R&D criteria to develop replacement Government Performance and Results Act goals.
- Included a section that discusses NIH use of the R&D investment criteria in the FY 2006 Congressional Justification.
- Received at least "Moderately Effective" rating on programs reviewed by PART.

FY 2006 Action Plan

- All NIH grants will be competitively peer-reviewed based on quality (e.g., rigorousness of the research proposal, likelihood for success, commitment to support work of the highest scientific caliber); relevance (e.g., response to public health need, burden of disease); and performance (e.g., annual performance goal monitoring and progress reports on deliverables).
- Include a section that discusses NIH use of the R&D investment criteria in the FY 2007 Congressional Justification.
- Continue to receive at least "Moderately Effective" rating on 75 percent of programs subject to PART.

ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

For the seventh consecutive year HHS received a clean audit opinion on its financial statements. The financial statements have been prepared in accordance with Federal accounting standards and audited by the independent accounting firm of Ernst & Young, LLP. Preparation and audit of these statements is required by the Chief Financial Officers Act of 1990 and is part of the Department's goal to improve financial management and to produce accurate and reliable information that is useful in assessing performance and allocating resources.

The following table summarizes HHS' financial condition at the end of FY 2005 (dollars in millions).

FINANCIAL CONDITION	FY 2004	FY 2005	INCREASE (DECREASE)	% CHANGE
Total Assets	$ 403,751	$ 428,487	$ 24,736	6.1%
Total Liabilities	$ 66,818	$ 70,959	$ 4,141	6.2%
Net Position	$ 336,933	$ 357,528	$ 20,595	6.1%
Net Cost of Operations	$ 547,220	$ 581,320	$ 34,100	6.2%

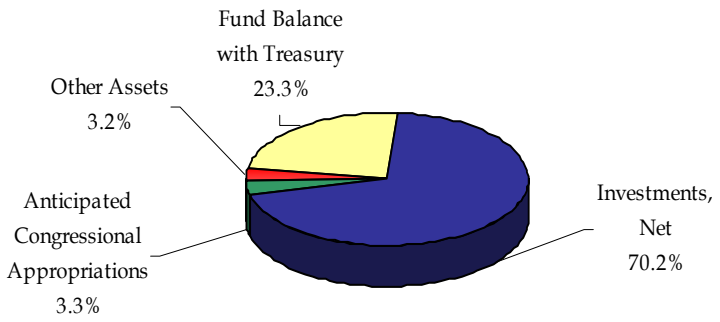
Assets

ASSETS *(Dollars in Millions)*	FY 2004	FY 2005	% Change
Fund Balance with Treasury	$ 97,667	$ 99,638	2.0%
Investments, Net	$ 287,886	$ 300,664	4.4%
Anticipated Congressional Appropriations	$ 9,248	$ 14,272	54.3%
Other Assets	$ 8,950	$ 13,913	55.5%
Total Assets	$ 403,751	$ 428,487	6.1%

HHS assets were $428 billion at the end of FY 2005. This represents an increase of $25 billion, or 6.1 percent over the prior year's assets totaling $404 billion. This variance is largely attributable to increases in Investments, Anticipated Congressional Appropriations, and Other Assets. The Investments increase was related primarily to growth in the Medicare trust fund for Hospital Insurance (HI). The majority of the Anticipated Congressional Appropriations increase was related to the rise in Medicaid funding to cover the unfunded portion of the Incurred But Not Reported. The increase in Other Assets was due primarily to prepaid expense payments to health maintenance organizations.

Investments and Fund Balance with Treasury together comprise 93.4 percent of total assets, while Anticipated Congressional Appropriations account for 3.3 percent. Other assets of 3.2 percent consist of Accounts Receivable; Loans Receivable; Cash and Other Monetary Assets; Inventory and Related Property; General Property, Plant, and Equipment; and Other Assets.

FY 2005 Assets by Type



Medicare Trust Funds

At the end of FY 2005, approximately $298 billion or 99.3 percent of HHS investments were in U.S. Treasury securities to support the Medicare trust funds, which include HI and the Supplementary Medical Insurance (SMI) trust funds. Established in 1965 as Title XVIII of the Social Security Act,

Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people age 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease requiring dialysis or kidney transplant, and people age 65 or older who elect Medicare coverage. Medicare is a combination of three programs: HI, SMI, and Medicare Advantage. Since 1966, Medicare enrollment has increased from 19 million to approximately 42 million beneficiaries.

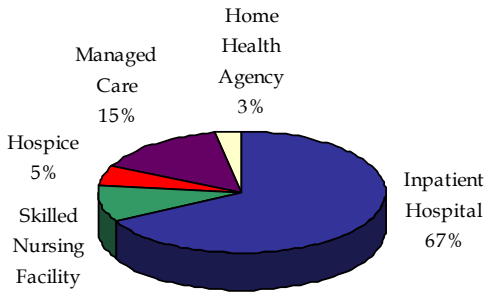
Hospital Insurance

HI or Medicare Part A, usually is provided automatically to people age 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI Program pays for hospital, skilled nursing facility, home health, and hospice care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities. As reported in the Required Supplementary Stewardship Information section of this report, HI trust fund assets steadily increase through 2011. At that point, expenditures start to exceed income including interest, thus drawing down assets until 2020 when they would be depleted. The shortfall between income and expenditures arises as a result of health costs increases that are expected to continue to grow faster than workers' earnings. Actual economic or other conditions, however, could delay or accelerate this condition. Based on estimates from the Mid-Session Review of the FY 2005 President's Budget, inpatient hospital spending accounted for 67 percent of HI benefit outlays. Managed Care spending comprised 15 percent of total HI outlays. During FY 2005, HI benefit outlays grew by 9.4 percent. The HI benefit outlays per enrollee are projected to increase by 7.8 percent to $4,300.

What the HI Program Pays For

Hospital
Skilled Nursing Facility
Home Health
Hospice Care

HI Medicare Benefit Payments



Source: CMS/OACT

Supplementary Medical Insurance

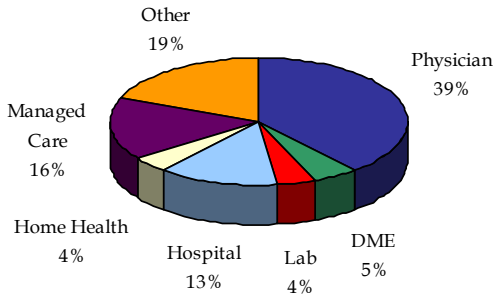
SMI, or Medicare Part B and Medicare Part D, is available to nearly all people age 65 and over, the disabled, and people with end-stage renal disease who are entitled to Part A benefits. The SMI Program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, Medicare prescription drug discount card enrollment fees and prescription drug expenses for Transitional Assistance beneficiaries, and other services not covered by HI. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. About 94 percent of HI enrollees elect to enroll in SMI.

What the SMI Program Pays For

Physician
Laboratory Tests
Durable Medical Equipment
Outpatient Hospital
Home Health
Designated Therapy
Medicare Prescription Drug Discount Enrollment Fees and Prescription Drug Expenses for Transitional Assistance Beneficiaries
Other Services Not Covered by HI

Whereas HI is funded primarily by payroll taxes, SMI obtains its funding through monthly beneficiary premiums and income from the general fund of the U.S. Treasury – both of which are established annually to cover the following year's expenditures. Thus, the SMI trust fund is in financial balance every year, regardless of future economic and other conditions, due to its financing mechanism. Funds

SMI Medicare Benefit Payments



Source: CMS/OACT

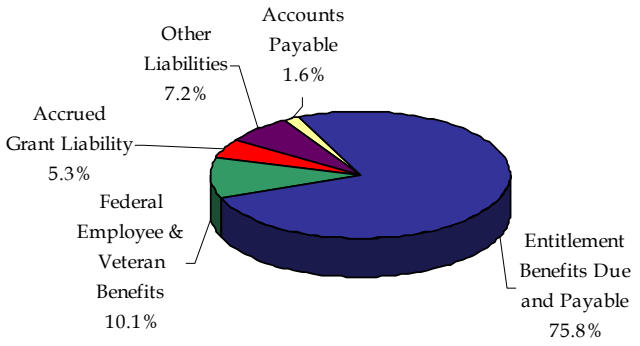
not currently needed to pay benefits and related expenses are held in the SMI trust fund, and invested in U.S. Treasury securities. Under the Trustees' intermediate set of assumptions, the HI trust fund will incur an actuarial deficit of nearly $8.6 trillion over the 75-year projection period, as compared to about $8.2 trillion in the 2004 financial report. In order to bring the HI trust fund into actuarial balance over the next 75 years, very substantial increases in revenues and/or reductions in benefits would be required. Based on estimates, during FY 2005, SMI benefit outlays grew by 12 percent. Physician services, the largest component of SMI, accounted for 39 percent of SMI benefit outlays. The SMI benefit outlays per enrollee are projected to increase 10.2 percent to $3,730. It is important to note that no liability has been recognized on HHS' balance sheet for future payments to be made to current and future program participants beyond the existing Incurred But Not Reported Medicare claim amounts as of September 30, 2005. This is because Medicare is accounted for as a social insurance program rather than a pension program. The Required Supplementary Stewardship Information within Section III of this report contains additional details of HHS' social insurance funds and other stewardship property and investments.

Liabilities

During FY 2005, HHS liabilities increased $4 billion or 6.2 percent to a total of $71 billion. This increase can be attributed primarily to a $5 billion or 9.2 percent increase to $54 billion in Entitlement Benefits Due and Payable, which represent benefits due and payable to the public from the CMS insurance programs discussed above, offset by a decrease of $314 million or 22.3 percent to Accounts Payable. The increase in Entitlement Benefits was due to increases in HI and SMI Incurred But Not Reported, HI and SMI payables to health maintenance organizations, and Medicaid Incurred But Not Reported. Accounts Payable decreased primarily due to a reduction of HI and SMI administrative cost payables.

LIABILITIES *(Dollars in Millions)*	FY 2004	FY 2005	% Change
Accounts Payable	$ 1,411	$ 1,097	-22.3%
Entitlement Benefits Due and Payable	$ 49,229	$ 53,754	9.2%
Federal Employee and Veteran Benefits	$ 7,178	$ 7,183	0.1%
Accrued Grant Liability	$ 3,755	$ 3,783	0.7%
Other	$ 5,245	$ 5,142	-2.0%
Total Liabilities	$ 66,818	$ 70,959	6.2%

FY 2005 Liabilities by Type



Entitlement Benefits and Federal Employee and Veteran Benefits account for 75.8 percent and 10.1 percent of total liabilities, respectively. Accrued Grant Liability accounts for 5.3 percent, while Accounts Payable comprises 1.6 percent. Other liabilities of 7.2 percent consist of Accrued Payroll and Benefits, Loan Guarantees, and Other Liabilities.

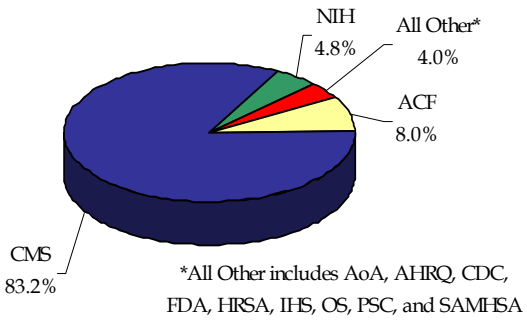
Ending Net Position

At the end of FY 2005, HHS' Net Position was $358 billion, an increase of $21 billion or 6.1 percent from the previous year. HHS net position consists of the cumulative net results of operations since inception, and unexpended appropriations, or those appropriations provided to HHS that remain unused at the end of the fiscal year.

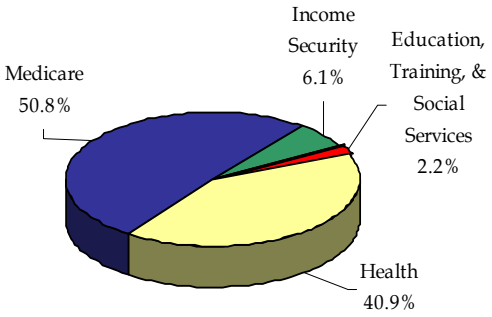
Results of Operations

HHS incurred a Total Net Cost for the year of $581 billion, which represents a $34 billion or 6.2 percent increase over FY 2004. This increase resulted primarily from program growth experienced by the Medicare HI and SMI, Medicaid, and State Children's Health Insurance Programs. The Consolidated Statement of Net Cost in Section III of this report presents HHS Net Operating Costs by HHS Agency (which comprise Departmental responsibility segments), while functional detail is provided in the footnotes to the financial statements, also in Section III. The CMS, ACF, and NIH account for a combined 96.0 percent of HHS' total Net Cost of Operations, incurring net costs of $483 billion, $47 billion, and $28 billion, respectively. HHS incurs net costs across its primary functions as defined in the budget, and HHS' Medicare (50.8 percent); Health (40.9 percent); Income Security (6.1 percent); and Education, Training, and Social Services (2.2 percent) account for all of HHS' net costs incurred during FY 2005.

FY 2005 Net Cost by HHS Agency (Responsibility Segment)



FY 2005 HHS Combined Net Cost by Budget Functional Classification



Cost vs. Outlays

The following concepts are critical for understanding the HHS financial history:

- Costs are typically reported in accounting reports and are synonymous with expenses. These are the amounts recognized when services are rendered or goods are received. They are not necessarily linked to the outflow of cash in the form of check issuance, disbursements of cash, or electronic funds transfer.
- Costs incurred or expenses are netted against exchange or earned revenues to identify the net cost of programs.
- Outlays are payments to liquidate an obligation (other than the repayment of debt principal).
- Outlays generally are equal to cash disbursements, but also are recorded for cash-equivalent transactions.

Budgetary Resources

During FY 2005, most of the funding to support net costs came from $773 billion in appropriations from Congress, as shown in HHS' Combined Statement of Budgetary Resources. This represents 94.9 percent of the gross budgetary resources available to HHS. This gross amount was offset by a pre-designated portion of funds that were either temporarily or permanently unavailable pursuant to specific legislation

to derive a net funds available amount of $794 billion, an increase of 10.1 percent over FY 2004 levels. During FY 2005, HHS incurred obligations of $776 billion, a 10.5 percent increase over FY 2004, and made 7.0 percent more net outlays totaling $581 billion.

Limitations of the Principal Financial Statements

The principal financial statements in Section III of this report 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), the Chief Financial Officers Act of 1990, as amended by the Reports Consolidation Act of 2000 (P.L. 106-531). While the statements have been prepared from the books and records of HHS 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, and that the liabilities reported in the financial statements cannot be liquidated without legislation providing resources to do so.

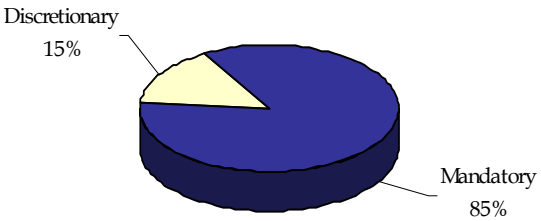
Grants Management

As the largest grant-awarding agency in the Federal Government and the Nation's largest health insurer, HHS plays a key role in Federal grants management. HHS manages an assortment of grant programs in basic and applied science, public health, income support, child development, and health and social services. Through these programs, HHS awarded an average of 74,000 grants totaling more than $230 billion annually between FYs 2001 and 2004.[1] These programs are the Department's primary means to achieving its strategic goals.

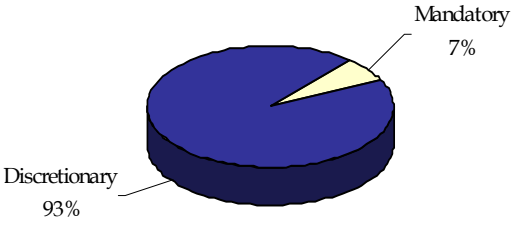
HHS awards two types of grants: mandatory and discretionary. Mandatory grants are those that a Federal agency is required by statute to award if the recipient, usually a state, submits an acceptable application and meets the eligibility and compliance requirements of the grant program's statutory and regulatory provisions. Discretionary grants permit the Federal Government, according to specific legislation, to exercise judgment in selecting the project or proposal to be supported and selecting the recipient organization through a competitive process.

For FYs 2001 through 2004, most HHS-awarded grants were discretionary (93 percent of total grant volume awarded), yet most dollars associated with HHS grants were mandatory (85 percent of total dollars awarded). The NIH awards the majority (70 percent) of HHS' total grants, but only 8 percent of total grant dollars, indicating a low dollar per grant ratio. Still, NIH grants annually account for the majority of total HHS discretionary dollars awarded. While ACF awards the greatest proportion of mandatory grants, CMS awards the majority of mandatory and total (67 percent) grant dollars, but only a small percentage of total grant volume, indicating a high dollar per grant ratio.

Average Proportion of Mandatory vs. Discretionary Grant Dollars for Fiscal Years 2001 - 2004

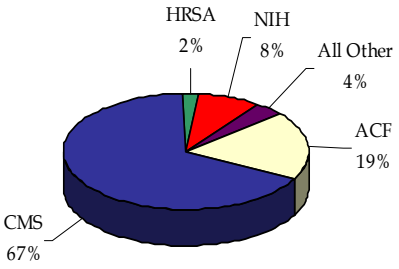


Average Proportion of Mandatory vs. Discretionary Grant Volume for Fiscal Years 2001 - 2004

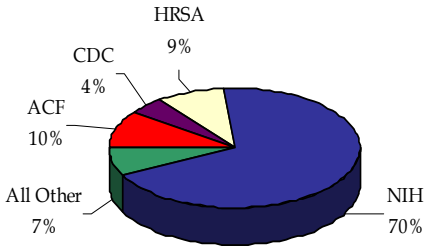


[1] Grant volume and dollar analysis covers FYs 2001-2004. FY 2005 data was omitted from this analysis as its preliminary nature at the time of completion of this report would have significantly skewed the analysis.

Average OPDIV Proportions of Total Grant Dollars
Fiscal Years 2001 - 2004



Average OPDIV Proportions of Total Grant Volume
Fiscal Years 2001 - 2004



HHS grant program stewardship and oversight responsibilities involve a variety of ongoing administrative functions, including:

- Helping OMB revise key OMB circulars pertinent to grants administration;
- Providing training and developing related guidance documents on these revised OMB circulars;
- Conducting oversight through the "Balanced Scorecard Initiative;"
- Strengthening HHS indirect cost negotiation capabilities;
- Updating internal Departmental grants administrative procedures;
- Utilizing a Department-wide grants management information system to report on grant award data across all HHS grant programs;
- Reviewing Departmental program announcements; and
- Reviewing grant single audits by HHS Office of Inspector General.
- Resolving and following up on grants audit findings.

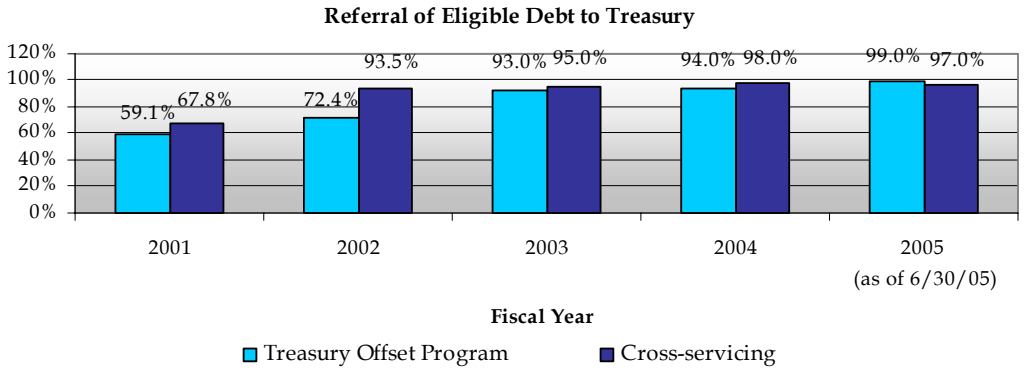
OMB designated HHS as the lead agency to manage the Federal Grant Streamlining program, a government-wide effort required by the Federal Financial Assistance Management Improvement Act (Public Law 106-107) of 1999. The program's goal is to streamline, simplify, and provide electronic options for the grants management processes employed by Federal agencies and improve the delivery of services to the public. Program initiatives encompass the entire grant life cycle and include: standardizing, simplifying, and streamlining the formats used to provide program synopses; announcing funding opportunities; and publishing the forms required to apply for and report on grant funds. HHS is also the lead agency for government-wide Grants.gov, a PMA e-Gov initiative. HHS' Grants.gov program office, in partnership with the 26 major grant-making agencies, is modifying and developing grants management practices and information systems that will allow current and prospective recipients of Federal grants to find, apply for, and manage grant funds online through a common website. HHS also manages the Tracking Accountability in Government Grants System, which contains Department-wide grants award information. Current policies, regulations, and other pertinent grants-related information are available at http://taggs.hhs.gov.

Debt Collection Improvement Act

HHS manages its delinquent debt pursuant to the Debt Collection Improvement Act of 1996. Although HHS refers delinquent debt to the Department of the Treasury (Treasury) for cross-servicing and offset, HHS has centralized the delinquent debt referral process by establishing the Program Support Center (PSC) as the Department's delinquent debt collection center. In addition, Treasury has granted a cross-servicing exemption for several types of program debts (e.g., Medicare Secondary Payer and various health professional loans). The PSC cross-services these debts and also refers them to the Treasury Offset Program.

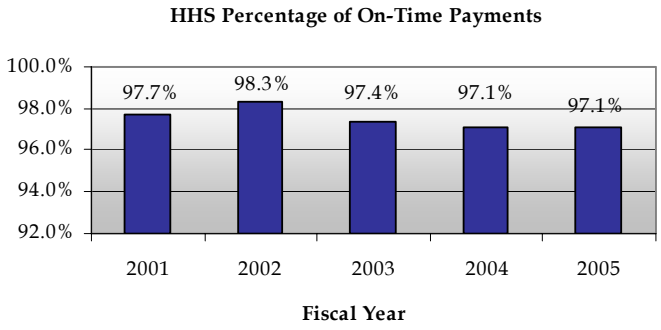
According to the FY 2005 third quarter Treasury Report on Receivables, HHS and Treasury cooperative debt collection efforts have resulted in:

- HHS referral rates at the end of the third quarter FY 2005 are as follows:
  - 99.1 percent of debt eligible for referral was referred to the Treasury Offset Program; and
  - 97.2 percent of debt eligible for referral was cross-serviced
- HHS collections were nearly $11.5 billion at the end of the third quarter FY 2005.



Prompt Payment Act

The Prompt Pay Act requires Federal agencies to make timely vendor payments and to pay interest penalties when payments are late. HHS reached a Department-wide record in FY 2002 by making over 98 percent of payments on time. Since then, HHS' prompt pay rate has decreased slightly. HHS' prompt pay rate for FY 2005 was 97.1 percent.



SYSTEMS, CONTROLS, AND LEGAL COMPLIANCE

This section describes select systems that are critical to HHS Department-wide management, and discusses HHS' capacity to comply with the Federal laws and regulations that pertain to those systems and controls over the Department's resources. The systems discussion includes an overview of HHS' current key systems and details on the Department's future implementation of the Unified Financial Management System (UFMS). A cornerstone to improving HHS management practices is the Department's ability to maintain management systems, processes, and controls that ensure financial accountability; provide useful management information; and meet requirements of Federal laws, regulations, and guidance. HHS seeks to comply with a variety of Federal financial management systems requirements, including those articulated by the Federal Managers' Financial Integrity Act (FMFIA), the Chief Financial Officers Act, the Government Management Reform Act, the Clinger-Cohen Act of 1996, the Federal Financial Management Improvement Act (FFMIA), as well as OMB Circular A-127, *Financial Management Systems*.

HHS' overall goals for its financial management systems focus on ensuring effective internal controls, timely and reliable financial and performance data for reporting, and system integration. The Department's immediate priorities are to address the two weaknesses (as identified in its corrective action reports) in financial management system processes, and Medicare contractors' electronic data processing (EDP) access controls.

HHS Financial Management Systems

This table summarizes the existing key HHS systems that allow HHS Agencies to perform the majority of financial management business functions across the Department. HHS current financial systems environment consists of four core accounting systems including numerous feeder systems processing grants, travel, acquisitions, logistics, and other administrative systems.

2005 HHS FINANCIAL SYSTEMS ENVIRONMENT	
System Name	**Description**
PSC CORE	The PSC CORE accounting system records and reports the financial activity for 8 of the 12 HHS operating components. The information captured in CORE and entered in AFS for consolidated reports has been a major factor in achieving an unqualified "clean" opinion for all of the financial statement audits for the HHS Agencies serviced by PSC.
Payment Management System (PMS)	PSC's PMS is a centralized grants payment and cash management system serving 12 Federal agencies with 53 grant-awarding component offices and bureaus. PMS is operated by the HHS Division of Payment Management, Financial Management Service. The Chief Financial Officers Council has identified PMS as one of two civilian grant payment systems to serve all Federal civilian grant-awarding agencies.
Accounting For Pay System (AFPS)	PSC's AFPS provides a systematic interface of payroll accounting information necessary to account for disbursements, expenditures, obligations, and accruals for personnel costs. This interface results in the production of accounting transactions and expenditure of reports to accomplish accounting requirements and payroll reconciliation's. AFPS offers such features as labor distribution, common accounting number (CAN) adjustments, automated SF-224 report preparation, and pay and benefit history file.
Automated Financial Statement (AFS)	AFS is a web-based system used to compile the Department-wide financial statements.
NIH Business System (NBS)	NBS is the new core financial system, live on General Ledger and Travel, that supports most of the accounting functions at NIH.
Financial Accounting Control System (FACS)	FACS is the core accounting system used to compile accounting functions at CMS.
Enterprise Human Resources and Payroll System (EHRP)	EHRP is the personnel system that supports HHS' personnel functions.
Defense Financial and Accounting System (DFAS)	On April 2005, PSC successfully led the Departmental payroll conversion from the HHS Legacy Payroll System to the DFAS.
UFMS	UFMS is the modernized system that replaces the Total Accounting On-Line Processing system and the General Ledger Accounting legacy system. UFMS went live with CDC and FDA in April 2005 for Core Financials and Projects for CDC and iProcurement for FDA. With the completion of these two Operating Divisions the global development effort has covered over 75% of the original core requirements, and the contract is 70% complete in execution. The key milestones moving forward are PSC go-live in 2006 and IHS go-live in September 2007. The NIH migration is being planned based on a recent study to ensure success and minimal impact to the rollout schedule and the CMS interface for consolidated reporting is still planned for October 2006.

HHS Financial Management System Weaknesses

Financial Management Systems Processes

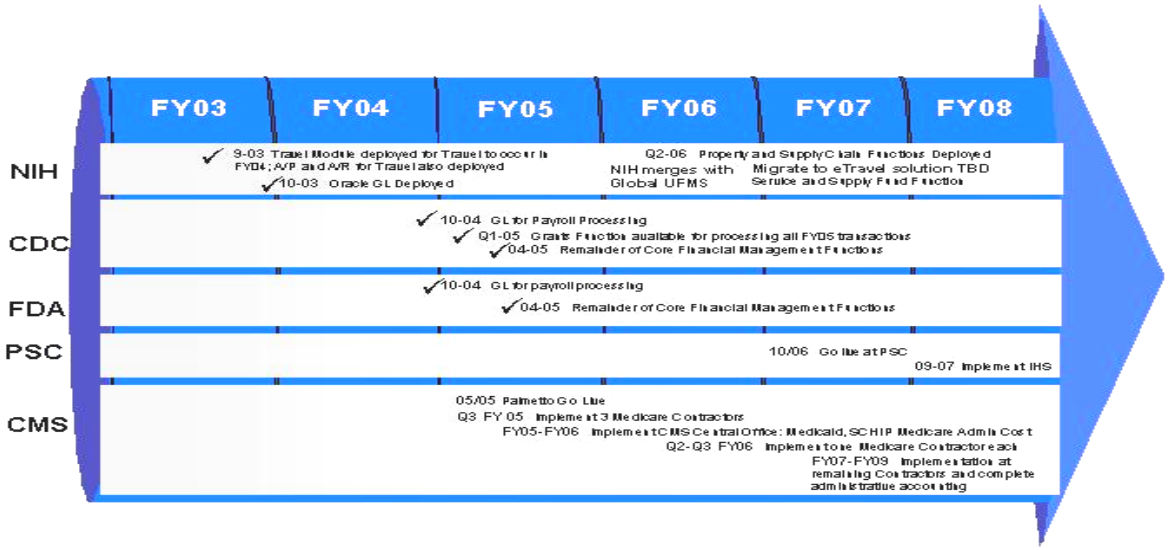
HHS continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. HHS' primary strategy to remedy this material weakness is the implementation of UFMS. UFMS is a business transformation effort designed to integrate Department-wide financial management systems and operations by aligning HHS' businesses with modern technological capabilities. The existing HHS financial management system configuration supports standard data elements and interface records. With UFMS, HHS will also standardize business processes for all core functions including general ledger, accounts payable, accounts receivable, cost management, budget execution, and financial reporting. In the CDC and FDA implementations many processes were standardized, including shared interfaces, SGL, naming conventions, Accounts Payable and Accounts Receivable. The purpose of these initiatives is to implement an integrated procurement system across all OPDIVs in HHS in collaboration with the UFMS and the asset management system.

General and Application Controls

Electronic Data Processing (EDP) weaknesses were identified for Medicare contractors in five primary types of controls: entity-wide security programs, access controls (physical and logical), systems software, application software development and change controls, and service continuity. The CMS continues to make progress in identifying and addressing weaknesses in its automated processing systems. The first phase of Healthcare Integrated General Ledger Accounting System (HIGLAS) is to develop the financial accounting and businesses related to Medicare contractor's claims payments. The next phase is to integrate all remaining Medicare Trust Funds, Medicaid, and administrative financial functionality. UFMS will contain a summary set of books, while HIGLAS would continue to process all of CMS core business program related activities and administrative processes. The first phase of HIGLAS is underway; the first implementation was Palmetto Part A, the next three implementations were Empire Part A, Empire Part B, and First Coast Part A and all four are now operating.

UFMS Implementation

The UFMS investment will replace five legacy accounting systems (PSC's CORE Accounting System, CDC's TOPS, FDA's GLAS, NIH's CAS, and CMS' FACS) with a web-based, commercial, off-the-shelf product. Once fully implemented, UFMS will reduce the legacy systems to one modern accounting system, with two components: HIGLAS will support CMS and the Medicare contractors and the other will serve the rest of HHS.



UFMS will produce information that is timely, useful, and reliable and will support the integration of financial and performance information. UFMS will produce the information that program managers and decision makers will need in a timely manner and will provide the real-time processes needed to support effective e-Gov initiatives. Finally, the Secretary's plans also will result in streamlining critical administrative systems that impact financial management functions, including grants and acquisition. In conjunction with these internal streamlining efforts, the Department will continue to ensure coordination with e-Gov initiatives efforts such as e-Travel, e-Payroll, e-Procurement, and Grants.gov.

HHS has ambitious implementation goals for UFMS. As currently structured, HHS is proceeding on three parallel tracks:

- Implementation activities for CDC, FDA, PSC, and their customers.
- NIH is proceeding with its modernization initiative which will eventually migrate with UFMS.
- UFMS is scheduled to be interfaced with CMS' HIGLAS by the end of FY 2007.

Details about the UFMS initiative can be obtained through the UFMS website at www.hhs.gov/ufms.

Payroll Conversion

PSC successfully led the Departmental payroll conversion from the HHS legacy Payroll System to the Defense Finance and Accounting System (DFAS). The payroll conversion took place on April 17, 2005 and is the single largest civilian agency payroll conversion ever completed by DFAS. The PSC was instrumental in the development of the new payroll interfaces and conversion files. PSC simultaneously kept the old payroll system and interfaces operational to ensure that more than 67,000 HHS employees continued to receive their pay.

Statement of Auditing Standards (SAS) 70 Systems Reviews

Independent examinations of HHS internal controls are completed annually under oversight of the HHS Office of Inspector General (OIG). The service auditors' examinations for FY 2005 were completed under the guidelines of the American Institute for Certified Public Accountants (AICPA) Statement of Auditing Standards (SAS) Number 70, *Service Organizations*. The annual examination is a "Type 2" report providing an opinion on the internal controls placed in operation and includes tests of operating effectiveness. The following summarizes HHS systems findings during the FY 2005 examinations.

PSC: Division of Financial Operations - CORE Accounting System and Feeder Systems

An independent examination was conducted of the HHS controls for the Division of Financial Operations (DFO) general information technology and application controls over the CORE accounting system and feeder systems (i.e., Accounting for Pay System, Travel Management System, Managing and Accounting Credit Card System (MACCS), Accounts Receivable System, and the Debt Management Collection System). The DFO's network infrastructure is operated by the Information Technology Service Center (ITSC). In the examiner's opinion, the description of controls presents fairly, in all material respects, the relevant aspects of the DFO controls that have been placed in operation as of June 30, 2005.

In the examiner's opinion, except for the following control objectives not being achieved: "Applications software development and change controls provide reasonable assurance that all programs and program modifications are properly authorized, tested, and approved and that access to and distribution of programs are carefully controlled; controls provide reasonable assurance that computer resources (data files, application programs, system software and computer-related facilities and equipment) are protected against unauthorized modification, disclosure, loss, or impairment; and controls provide reasonable assurance that changes to the existing systems software and implementation of new system software are authorized, tested, approved, properly implemented, and documented" ; the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute assurance that the control objectives were achieved during the period of July 1, 2004, to June 30, 2005.

PSC: Human Resources Service Personnel and Payroll Systems

An independent examination of HHS internal controls for the PSC examined the PSC general IT and application controls over the Human Resources Service personnel and payroll systems (i.e., Civilian Payroll System, EHRP, and the Commissioned Officer Personnel and Payroll System). In the examiner's opinion, the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period of July 1, 2004, to June 30, 2005 except for as noted below:

- The HR Processor role allows a user to process a transaction from start to finish in the system without supervisory review.
- Change control procedures developed by the Commissioned Corps Support Branch of HRS did not include procedures for segregating duties, retaining test documentation, and tracking changes; and monitoring controls were not sufficiently established.

PSC: Division of Payment Management

An independent examination was conducted of HHS internal controls for the Division of Payment Management. In the examiner's opinion, the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period of July 1, 2004, to June 30, 2005. The controls identified were suitably designed to provide reasonable assurance that the specified control objectives were achieved and all Division of Payment Management controls were complied with satisfactorily.

NIH: Center for Information Technology

An independent examination was conducted of HHS internal controls for the NIH Center for Information Technology. In the examiner's opinion, except for procedures for "System Software Implementation and Maintenance for the Windows Environment," the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period of July 1, 2004, to June 30, 2005.

Legal Compliance

FMFIA requires that agencies establish controls that reasonably ensure the integrity of Federal programs and the use of funds. FFMIA requires agencies to implement and maintain systems that comply with specific government-wide system parameters and policies. The Federal Information Security Management Act (FISMA) lays out a framework for annual information technology security reviews, reporting, and remediation planning to improve Federal agency internal controls over information resources and ensure compliance with laws and regulations regarding computer security. As noted in the assurance statements in the Secretary's message at the beginning of this report, the following FMFIA, FFMIA, and FISMA issues remain outstanding at the end of FY 2005.

Federal Manager's Financial Integrity Act

HHS reports one new Section 2 material weaknesses in 2005, Managed Care Benefit expense Cycle. Two Section 2 material weaknesses from the FY 2004 report - Federal Information Security Management Act (FISMA) Significant Deficiency, Departmental Financial Reporting - have been corrected as planned. For the Departmental Payroll System, the auditors found that substantial progress has been made and it is no longer material.

In addition, the Department reported one repeat material nonconformance, Department-wide Financial Systems and Processes. For one of the two subcomponents of this material nonconformance -- Financial Systems Analysis and Oversight -- CMS made progress which resulted in the findings in both the Medicare and Health Programs being reduced to a reportable condition or incorporated into the Managed Care Benefit Expense Cycle material weakness. Both CDC and FDA continued to record thousands of nonstandard accounting entries both prior and subsequent to the UFMS conversion. FDA

recorded 14 thousand non-standard accounting entries totaling an absolute value of approximately $9.4 billion to create the September 30, 2005 financial statements. FDA noted this was primarily due to the productivity dip and lack of familiarity with the system. To prepare the September 30, 2005 financial statements, CDC indicated that it was required to record the following:

- Accounting entries totaling an absolute value of $11.3 billion either to its statements or to another HHS operating division;
- Adjustments totaling an absolute value of $24.4 billion with the Automated Desktop Integrator Program. Generally these adjustments related to conversion, data clean up, corrections, account reclassifications, and other adjustments to conform to UFMS processing.
- A $19.1 billion absolute value adjustment to the database to generate financial statements as a result of conversion adjustments made in the UFMS which could not be extracted into the database.

For the second subcomponent -- Medicare electronic data processing controls, much of that finding has been corrected and is also now classified by the auditors as a reportable condition.

Federal Financial Management Improvement Act

FFMIA mandates that agencies "…implement and maintain financial management systems that comply substantially with Federal financial management systems requirements, applicable Federal accounting standards and the United States Government Standard General Ledger at the transaction level." FFMIA also requires that remediation plans be developed for any entity that is unable to report substantial compliance with these requirements. The Department's FY 2005 financial statement audit revealed one instance of noncompliance – Financial Systems and Processes, in which HHS financial management systems did not substantially comply with federal financial management systems requirements. The one noncompliance includes four sub-components; 1a) CMS' financial systems analysis and oversight, 1b) the Department's Payroll System, 1c) the CORE accounting system, and 1d) NIH's Center for Information Technology (CIT). HHS concurs with the auditor's findings. In last year's report (FY 2004 PAR), the auditors reported 3 FFMIA noncompliances: 1) Financial Systems and Processes, 2) CMS Financial Systems and Analysis, and 3) Departmental Payroll System. These three noncompliances have now been consolidated into one noncompliance with 2 sub-components. In addition, the auditors identified 2 new noncompliances -- the core accounting system and the NIH Center for Information Technology (CIT), which they are reporting as additional sub-components of the one noncompliance, Financial Systems and Processes.

Federal Information Security Management Act

HHS' FY 2005 FISMA evaluation determined that the significant deficiency involving contingency planning and disaster recovery for some of HHS systems has been corrected to the extent that it is no longer considered to be a significant deficiency, although some corrective actions are ongoing.

Improper Payments Information Act of 2002 (IPIA)

The IPIA requires that HHS annually review all programs and activities that it administers and identify all such programs and activities that may be susceptible to significant improper payments. For high risk programs, the IPIA requires that HHS report improper payment estimates and various other related data. Although HHS did not identify high risk programs in its FY 2005 risk assessment work, seven HHS programs were previously identified by OMB as being high risk. These programs are Medicare, Medicaid, SCHIP, TANF, Foster Care, Head Start and Child Care. HHS is reporting improper payment estimates in the Medicare fee-for-service, Head Start and Foster Care programs. For the Medicaid, SCHIP, TANF and Child Care Programs, HHS is working on developing or implementing plans to determine estimated amounts of improper payments. More detailed Information on HHS improper payment activities can be found in Appendix C.

LOOKING AHEAD TO 2006 – HHS MANAGEMENT CHALLENGES AND HIGH-RISK AREAS

The breadth of services that HHS delivers and the myriad support functions required to support them create a number of management challenges, which help set the course for HHS improvement efforts each year. The OIG identifies these challenges and tracks HHS' progress in resolving them. Pursuant to the Reports Consolidation Act of 2000, Appendix A addresses the challenges identified by the OIG, and management's detailed responses to those challenges. As shown in the accompanying chart, many of the initiatives discussed in this report, both under the auspices of the PMA and HHS' own strategic goals, address these challenges. It should be noted that because many of the PMA initiatives address, in great part, government-wide issues, there will not necessarily be a complete correlation between HHS' management challenges and each of the PMA initiatives. There is, however, a more direct relationship between the challenges identified and HHS' strategic goals. It is this relationship that articulates, in part, HHS' efforts to resolve these challenges. As such, through the Department's many initiatives, HHS continually strives to improve not only the quality of services it delivers to its "customers" and beneficiaries, but also to enhance management effectiveness and efficiency.

Crosswalk of HHS Challenges and Goals

HHS Top Management Challenges	President's Management Agenda	HHS Strategic Goal Number
Implementation of the Medicare Modernization Act		3
Accountability of Medicaid Funds	Improper Payments	8
Integrity of Medicare Payments	Improper Payments	8
Payment for Medicaid Prescription Drugs		8
Quality of Care in Long Term Care Services		3, 5
Grants Management	Improved Financial Performance; Expanded Electronic Government	8
Ensuring the Protection of Critical Systems and Infrastructure	Expanded Electronic Government	8
Public Health Readiness		2