Section V - Appendices

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Appendix A - HHS FY 2002 Top Management Challenges Identified by the Office of Inspector General (OIG)

The following list of Top Management Challenges was identified by the HHS Office of Inspector General (OIG) for the fiscal year ending September 30, 2002. For each issue, the OIG has prepared a description of the challenge, and an assessment of management's progress in addressing the challenge. Those sections are followed by HHS management's brief comments.

Management Issue #1: Bioterrorism Preparedness

Management Challenge
Events of and since September 11, 2001 have underscored the need for the necessary infrastructure and tools to respond to potential future terrorist events, including bioterrorism, and other public health emergencies. The OIG's concerns center on HHS' vulnerabilities to outside threats and the readiness and capacity of responders at all levels of government to protect the public health since the Department is responsible for so much of the Nation's federal heath care resources and programs.

The OIG initiated a number of security-related reviews in FY 2002 and plans to continue security and health system preparedness studies in FY 2003. The OIG assessed security controls at the CDC and NIH campuses and is completing reviews of several FDA laboratory facilities. In addition, reviews at 11 college and university laboratories have been conducted, all of which included an assessment of the institutions' compliance with the USA Patriot Act of 2001, which requires prohibition on access to select agents by "restricted persons." Reviews at agency facilities and laboratories to date reveal substantial problems in each of the areas covered by DOJ's "Vulnerability Assessments of Federal Facilities."

The OIG is now evaluating the effectiveness of CDC's bioterrorism preparedness efforts, assessing state and local health departments' ability to detect and respond to bioterrorist events, as well as the agency's readiness for deployment of the National Pharmaceutical Stockpile. Reviews are also determining the integrity of CDC's vaccine procurement program and CDC's implementation of the regulation governing facilities that transfer and receive select agents.

Assessment of Progress in Addressing the Challenge
As a result of these completed and ongoing reviews, HHS agencies are identifying resources to implement corrective action plans addressing OIG's findings and recommendations. Federal, state, and local health departments are working cooperatively to ensure that bioterrorist attacks are detected early and responded to appropriately. As part of this effort, CDC has taken steps to increase the supply of pharmaceuticals needed in the event of chemical, biological, or radiological attacks.

Management's Comments in Brief

Before the terrorist attacks on September 11, 2001, and the subsequent anthrax attacks via the postal systems, HHS had given CDC key responsibilities to help protect our Nation from, and respond to, acts of bioterrorism. During FY 2002, CDC led the public health response to the first bioterrorism attack in U.S. history and greatly enhanced preparedness in the event of future attacks. CDC's major contributions to this effort include the following:

- Expanded the existing bioterrorism cooperative agreements to fund all states, four localities, and eight territories. All jurisdictions now receive funding for each of the key elements of bioterrorism preparedness and response, which are: preparedness planning and readiness assessment; surveillance and epidemiology laboratory capacity; communications and information technology; health risk communication and information dissemination; and education and training. The program has been centralized in CDC's Office of the Director giving projects a single, coordinated point of contact for bioterrorism preparedness.

- Awarded more than $900 million in cooperative agreements within one month of the President's signature on supplemental appropriations, giving states flexibility to spend immediately on urgent needs while developing detailed workplans.

- Increased to 150 the number of chemicals in the Rapid Toxic Screen, which in the event of a chemical emergency or chemical terrorism, would provide vital information on chemical agents. CDC also funded five state environmental health laboratories to provide additional surge capacity in the event of a major chemical terrorism incident.

- Increased to 12 the number of National Pharmaceutical Stockpile 50-ton "push packages" that contain medical and pharmaceutical materials stored in special weather-resistant cargo containers. These portable stockpiles can be rapidly deployed to a disaster site, as was demonstrated on September 11, 2001, when a push package arrived in New York City within seven hours of approved deployment. CDC has also created a number of vaccine repositories at strategic sites around the country and developed mechanisms for rapid vaccine mobilization.

- Filled more than 50 separate orders for antibiotics to carry out anthrax post-exposure prophylaxis in 11 states and the District of Columbia via the National Pharmaceutical Stockpile.

- Issued new guidelines for protecting emergency responders and for safeguarding building ventilation systems from attack, addressing self-contained breathing apparatus respirators for occupational use by emergency responders against chemical, biological, radiological, and nuclear agents.

Management Issue #2: Grant Management

Management Challenge
Departmental discretionary grants, estimated to total over $35 billion in FY 2002, must be used appropriately so as to achieve their intended purposes. Most of the departmental agencies rely on the grant mechanism as a pivotal tool in meeting their mission objectives, such as providing critical health services to underserved individuals, researching the causes and treatments of disease, elevating the social and economic status of vulnerable populations, and supporting the nationwide infrastructure for the health surveillance and prevention network. As such, it is incumbent upon HHS to award grant funds to the most worthy and competent organizations and to adequately monitor program results and use of federal funds. However, the programs are numerous and diverse. Vigilance is required to assure that specific awards are free of abuse and the monitoring systems to manage them are capable of identifying improper behavior.

To address this challenge, OIG has initiated a two-part grant management review plan. The OIG is studying several HHS OPDIV grantmaking and oversight processes to identify vulnerabilities and to assess criteria and procedures for determining grantee risk and developing and monitoring corrective action plans for high-risk grantees. At the same time, reviews are conducted to assess individual grantees' program activities and stewardship of funds. This two-part strategy is designed so that findings and recommendations derived at the agency level can be used in examinations at the grantee level and vice versa.

Assessment of Progress in Addressing the Challenge
Through the governmentwide Federal Grant Streamlining Program, the HHS grant management environment is undergoing changes. The program implements the Federal Financial Assistance Management Improvement Act of 1999, which requires agencies to improve the effectiveness and performance of their grant programs, simplify the grant application and reporting process, improve the delivery of services to the public, and increase communication among entities responsible for delivering services. As the lead agency in this multi-year initiative, HHS has worked to streamline projects since the law's enactment. Because the initiative requires grant officials to examine the way they do business, they are in a good position to focus not only on streamlining the grant process but also on ensuring that results are achieved and federal funds are used appropriately.

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

- OPDIVs are continuing their efforts to establish **performance goals** in various grant programs by requiring applicants, as part of their grant application proposals, to identify performance targets to be achieved by the end of each budget period. OPDIVs review grantee progress reports to assess achievement of performance targets and, if deemed

necessary, more intensive monitoring and/or technical assistance may be provided to assist grantees in accomplishing identified outcome(s).

- **Targeted reviews** of specific grant operations within the Department are currently underway or being planned under the aegis of the Assistant Secretary for Administration and Management. These reviews, building on previously developed grants management systems review protocols, examine a variety of pre-award and post-award activities performed by an HHS awarding agency. For example, a review of the Administration for Developmental Disabilities (ADD), a program within the Administration for Children and Families (ACF), was conducted in FY 2002 to ascertain whether ADD grant practices are in compliance with established departmental regulations and policies; evaluate pre-award processes, including a determination as to whether the award process effectively maximizes competition; and examine post-award monitoring activities, including performance and financial report submissions and site-visits. A similar review is underway encompassing ACF's Administration for Native Americans.

- HHS' Grants Management **Balanced Scorecard** is a self-administered review protocol enabling OPDIVs to assess perceptions of performance by soliciting feedback from a variety of internal and external users/customers. The results provide indicators as to how well an OPDIV is performing a variety of pre-award and post-award grant award activities enabling OPDIVs to develop and implement action plans to address areas targeted for improvement. To date, all OPDIVs have administered both phases of the Balanced Scorecard (Phase 1 consisting of internal OPDIV surveys; Phase 2 external surveys of grant recipients). OPDIVs are at varying stages in reviewing Scorecard data results, developing action plans to implement process improvements and re-administering the Scorecards. OPDIVs such as HRSA, AHRQ and AoA, for example, have developed and implemented initial process improvements and will measure their success in future administrations of the Scorecard.

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

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

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

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

- As one of several initiatives designed to ensure that the Department meets the President's Management Agenda for improving the management and performance of the Federal government, the Office of Grants Management, within the Office of the Assistant Secretary for Administration and Management, was authorized by the Secretary to conduct a **departmental review of grants management activities** involving the pre-award process. Special interest was given to the development of funding announcements in order to develop best practices, afford greater efficiencies and increased accountability, and ensure that

announcements are consistent with regulations and departmental policies. The departmental review has identified various recommendations for improvements in announcement preparation and presentation which have subsequently been promulgated through a directed action transmittal to the awarding components. All OPDIVs are making strides at integrating best practices into the development of their announcements resulting in greater consistency across the Department.

Management Issue #3: Payment for Prescription Drugs

Management Challenge

Because prescription drugs are such a significant part of 21st century medical care to help ensure proper treatment and maximum wellness, it is important that Medicare and Medicaid beneficiaries' access to pharmaceuticals is not hindered by overpricing. Overall, in calendar year 2001, Medicare Part B spent over $6.5 billion for prescription drugs. Similarly, in 2001, the federal share of dollars spent for Medicaid prescription drugs was nearly $14.3 billion.

The OIG has consistently found that Medicare pays too much for prescription drugs - more than most other payers. For example, Medicare payments for 24 leading drugs in 2000 were $887 million higher than actual wholesale prices available to physicians and suppliers and $1.9 billion higher than prices available through the Federal Supply Schedule. This has occurred because the reimbursement methodology is fundamentally flawed.

By law, Medicare's payment is equal to 95 percent of a drug's average wholesale price (AWP). However, the AWPs are not really wholesale prices; for the most part, they are reported by manufacturers to companies that publish drug pricing data. As OIG reports have indicated, the published AWPs that Medicare uses to establish drug prices bear little or no resemblance to actual wholesale prices available to physicians, suppliers, and large government purchasers. Further, because physicians and suppliers keep the difference between the actual price they pay for a drug and 95 percent of its AWP, they have a financial incentive to buy from a drug company with artificially inflated AWPs. Some may argue that the high drug payments are offset by insufficient Medicare payments to administer the drugs.

Several OIG reports indicate that Medicaid is also paying too much for prescription drugs because state reimbursement methodologies are based on inflated AWPs. States should change their reimbursement methodologies to reflect the drug pricing categories, i.e., single-source innovator drugs, multiple-source innovator drugs not covered by the Federal Upper Limits, multiple-source noninnovator drugs not covered by the Federal Upper Limits, and drugs on the Federal Upper Limit schedules. Also, a connection is needed between how Medicaid pays for drugs and how rebates are calculated. Currently, any increases in pricing would not represent a corresponding increase in rebates; in fact, Medicaid could be paying more for drugs while getting less in rebates.

In recent large settlements, two pharmaceutical manufacturers allegedly set and reported some AWPs at levels far higher than the actual acquisition cost paid by the majority of their customers and caused those customers to receive excess Medicare and/or Medicaid reimbursement. To

resolve their liability for this and other conduct, TAP Pharmaceuticals and the Bayer Corporation agreed to pay $875 million and $14 million, respectively, to federal health care programs.

Assessment of Progress in Addressing the Challenge
Despite attempts by CMS to work with the Congress to develop and implement more realistic Medicare and Medicaid reimbursement methods for prescription drugs, OIG reports continue to show that these flawed payment methodologies remain essentially unchanged. As of this writing, legislative progress is being made but a consensus bill has yet to be passed. However, the Benefits Improvement and Protection Act (BIPA) of 2000 gave the Secretary authority to make some administrative adjustments to the payment methodology in Medicare.

Management's Comments in Brief

The CMS continues to collect and analyze data on drug pricing and the costs of physicians administering drugs. For example, it is studying non-Medicare drug pricing of selected drugs covered under Part B to determine the feasibility of other approaches to more accurately determine AWP. In addition, the CMS has begun to utilize a single contractor to determine payment rates to eliminate the current variation in contractor prices.

Management Issue #4: Protection of Critical Systems and Infrastructure

Management Challenge
To accomplish its major missions of providing health care to the elderly, the disabled, and the poor; facilitating research; preventing and controlling disease; and serving families and children, the Department must rely on a distributed and open computing environment for information processing, knowledge sharing, and collaboration. Management, therefore, must ensure the creation of an integrated process to establish security policies for information technology and monitor compliance; this process is essential for an effective IT security program.

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

Assessment of Progress in Addressing the Challenge
HHS has made much progress in securing the most critical of essential assets. Core requirements for security controls were established and distributed, and systems architecture documents are being developed. However, recent OIG assessments (CFO and GISRA) found numerous information systems general control weaknesses in entity-wide security, access controls, service continuity, and segregation of duties. A collective assessment of deficiencies in Medicare systems resulted in the reporting of a material weakness in the FY 2001 HHS financial statement audit.

While OIG has not found any evidence that these weaknesses have been exploited, they leave the department vulnerable to: 1) unauthorized access to and disclosure of sensitive information; 2) malicious changes that could interrupt data processing or destroy data files; 3) improper payments; or 4) disruption of critical operations.

Management's Comments in Brief

Under Secretary Thompson's leadership, HHS is addressing Information Technology (IT) Security as one of its top management priorities. IT security is a prominent part of the HHS Enterprise Information Technology Strategic Plan, which established an enterprise approach to project planning and implementation for critical infrastructure services in HHS. Based on plan priorities, contracts were awarded in FY 2002: to install multi-tier virus protection across HHS; to implement vulnerability scans of critical HHS systems; and to provide perimeter protection for all Internet access points. For FY 2003, contracts are in place to establish round-the-clock monitoring of security alerts; to provide certification and accreditation for all Critical Infrastructure Protection assets; reduce GISRA corrective action items and continue the Project Matrix process through the implementation of a Phase 2 Analyses of Critical Assets. Security, like other infrastructure issues, has received enhanced emphasis since the events of September 11, 2001. HHS is encouraged that the OIG has found no evidence that any security weaknesses have been exploited. To further strengthen our security posture, HHS has continued the emphasis placed on functional areas such as the CMS Medicare, CDC Bioterrorism, NIH Computing Center, FDA Product Tracking, and other OPDIV operations through implementation of a comprehensive systems security program. The program features initiatives in four fundamental areas: security policy; training and awareness; engineering; and oversight. Such a coordinated investment facilitates both remedial corrections and improved preventative measures across all of the Department's activities. The HHS CIO and CIO Council will continue to provide departmental oversight of the Security Program to insure that all HHS security and privacy requirements are efficiently and effectively met.

HHS also addressed the issue of physical security during FY 2002. For example, FDA:

- Increased physical security and provided increased guard services at FDA facilities;
- Improved security systems at FDA laboratories and offices;
- Installed physical barriers at the entrances to FDA's buildings and parking lots;
- Purchased secure storage for select agents, including lockable storage cabinets, refrigerators and freezers to prevent unauthorized use or theft; and
- Developed a continuity of operations plan.

Along the same lines, CDC:

- Increased security guard force and armed guards;

- Restricted entry points to laboratories and buildings;
- Instituted random car searches and routine inspections of all delivery vehicles;
- Conducted building evacuation drills and established accountability procedures;
- Upgraded emergency notification systems; and
- Increased the use of lighting, closed circuit TV cameras, and check points.

Additionally, NIH convened three groups with interlocked membership to manage security planning, policy, and operations. Under the active leadership of the NIH Acting Director, a NIH Security Task Force was assembled. This Security Task Force ratifies overall agency security policy and planning and is the liaison with other federal and state entities on security policy and response. Members of NIH organizations involved in actually delivering security provide staff support to the Task Force.

NIH security procedures and access control to NIH facilities vary in response to the perceived level of risk and in accordance with direction from the Executive Office, Congress, and local law enforcement.

Other NIH security measures include the following:

- Cars are challenged at all perimeter access points onto the NIH campus. Visitor cars and service vehicles are inspected for contraband. Vehicles with valid NIH parking permits driven by staff with valid NIH IDs are waved through perimeter checkpoints. However, these vehicles may be subject to random inspections by NIH security.
- NIH police and uniformed contract inspectors are engaged in securing the perimeter.
- Entrance to NIH buildings is either via proximity cards or a security guard checkpoint. In buildings with security guards, visitors must show a valid photo ID and sign in/out. At facilities with many outside visitors, security personnel screen or search bags and use metal detectors. NIH also conducts surveillance at loading docks.

Management Issue #5: Nursing Facilities

Management Challenge

Given the vulnerability of nursing home facility residents, it is imperative that appropriate and quality care be a top priority for all involved care providers. At the same time, payments need to be made accurately both to ensure financial stability for nursing homes and to protect the financial integrity of the Medicare program.

Financial controls and quality of care provided in nursing homes continue to be a focus of the OIG. In looking at nursing home resident assessments, OIG found differences between the minimum data set and the rest of the medical record, some of which may affect care planning.

The OIG now has a number of additional studies underway. These include evaluations of the role of the nursing home medical director, quality assurance committees, nurse aid training, trends in survey and certification deficiencies, consistency and reliability of the certification process, identifying repeat offenders in the certification process, social work services, and complaints to long-term-care ombudsmen. The results of these studies will be published over the coming year.

With respect to payments, OIG found that some services were paid for twice - once to the facility under the prospective payment system and again to the supplier**.** The OIG also examined the medical necessity of Part B therapy provided in nursing homes, both underutilization and overutilization, and found that 24 percent of the total allowed amount of this therapy in 1999 was paid in error. In addition, over one-third of Medicare Part B payments for psychiatric services in nursing homes were inappropriate.

Assessment of Progress in Addressing the Challenge

The CMS has made progress in Part A nursing home reforms, which are important to controlling fraud and abuse. The CMS issued a fraud alert addressing the prevalent types of errors found in OIG's initial review of services that were paid under the prospective payment system and again to the suppliers. Additionally, OIG recommended recovery of the improper payments and that CMS establish payment edits in its Common Working File (CWF) and the Medicare contractors' claims processing systems to ensure that outside providers and suppliers comply with the consolidated billing provision.

The CMS agreed with the recommendations and indicated that meaningful progress had been made toward implementing edits to identify potentially inappropriate payments and recover overpayments made in connection with services that were paid for under the prospective payment system and again to the supplier. In addition, CMS issued a task order to one of its payment safeguard contractors to identify overpayments in three States. The OIG is continuing work in this area to determine if overpayments persist.

CMS rolled out a nationwide nursing home quality initiative in Fall 2002 which made public facility-specific information regarding the quality of care in nursing homes to benefit those who are looking for a facility that can best provide needed care for a family member. This is an expansion of an earlier six-state pilot undertaken by CMS.

Management's Comments in Brief

The CMS concurs with OIG's assessment. The CMS has made significant gains in assuring that services being paid under the skilled nursing facility prospective payment system (SNF PPS) by fiscal intermediaries are not also billed to and paid by carriers. In April 2002, CMS implemented CWF edits that will detect and deny cases in which carriers are being billed for services that the CWF shows to be in a Medicare covered Part A stay during the period in which the supplier billed the carrier for the service. In July 2002, CMS also implemented edits that will detect and mark payments that were made by carriers for persons in the course of a Medicare covered SNF stay where the SNF claim did not post to the CWF record before the carrier claim was paid, thus resulting in an incorrect payment. In January 2003, CMS plans to implement CWF edits that will detect similar incorrect cases in the fiscal intermediary claims processing system.

In addition, CMS has developed a Web site application that can be used by a physician, practitioner or supplier to determine if a service at the Common Procedure Coding System level should be billed to the SNF (because it is bundled under SNF PPS) or to the carrier (because it is separately payable).

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

Finally, CMS has made significant strides in its oversight of the SNF PPS through a program safeguard contract that examines the minimum data set 2.0 resident assessment data, including some on-sight reviews at nursing homes.

Management Issue #6: Medicaid Payment Systems

Management Challenge
Accuracy in the federal share of Medicaid costs is important to help ensure fairness across all state Medicaid programs as well as assure these federal health care dollars reach and achieve their maximum intended health care purposes. The OIG found that some states inappropriately inflated the federal share of Medicaid by billions of dollars by requiring public providers to return Medicaid payments to the state governments through intergovernmental transfers. Once the payments were returned, the states used the funds for other purposes, some of which were unrelated to Medicaid. Although this abusive practice could potentially occur with any type of Medicaid payment to public facilities, OIG identified this practice in two types of payments: 1) Medicaid enhanced payments available under upper payment limits (UPL); and 2) Medicaid disproportionate share hospital (DSH) payments.

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

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

The CMS intends to develop regulations that will outline accountability standards that states must address when making DSH expenditures. The OIG is continuing audit work on Medicaid DSH payments and will recommend program improvements once the work is completed.

Management's Comments in Brief
The CMS and the OIG have worked closely on analyzing the effects of the upper payment limit issue and regulations, and plan to continue this effort. We note that CMS has limited control over the length of the transition periods. The two- and five-year transition periods were adopted pursuant to notice and comment rulemaking. The BIPA further extended the transition periods by mandating the eight-year transition period.

Management Issue #7: Accuracy of Medicare Fee-for-Service Payments

Management Challenge
To help ensure the financial integrity of the Medicare program, continued access to Medicare benefits, as well as the long-term viability of the Medicare trust fund, it continues to be essential that documented and accurate bills are submitted for correct payment for properly rendered health care services. Based on a statistical sample, OIG estimated that improper Medicare benefit payments made during FY 2001 totaled $12.1 billion, or about 6.3 percent of the $191.8 billion in processed fee-for-service payments reported by CMS. These improper payments, as in past years, could range from reimbursement for services provided but inadequately documented to inadvertent mistakes to outright fraud and abuse. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. The overwhelming majority (97 percent) of the improper payments were detected though medical record reviews. While the OIG's six-year analysis indicates continuing progress in reducing improper payments, unsupported and medically unnecessary services remain pervasive problems.

In addition to determining the overall Medicare error rate, we have conducted targeted audits and inspections to identify improper payments and problem areas in specific parts of the program. These reviews have included analyzing duplicate payments for the same service, payments made on behalf of deceased beneficiaries, and payments made for incarcerated beneficiaries. We have also determined payment error rates for specific supplies and services. For example, in a study of Medicare payments for orthotics, we found that 30 percent of orthotic claims in 1998 were inappropriately coded and therefore should not have been paid. We also found that in 1997, orders for 25 percent of sampled claims for blood glucose test strips failed to establish beneficiaries' eligibility for the supplies. Additionally, in a review of 1998 home health services, we found an improper payment rate of 19 percent. Another review found that 24 percent of the total allowed amount of Part B therapy in 1999 was paid in error. Finally, we found that 27 percent of Part B mental health services provided in nursing homes in 1999 were unnecessary and lacked any psychiatric documentation. We will continue these targeted reviews to ensure that Medicare payments are made in accordance with program rules.

Assessment of Progress in Addressing the Challenge
The FY 2001 error rate is less than half of the 13.8 percent reported for FY 1996. We believe that since we developed the first error rate, CMS has demonstrated continued vigilance in

monitoring the error rate and developing appropriate corrective action plans. In addition, due to CMS' work with the provider community to clarify reimbursement rules and to impress upon health care providers the importance of fully documented services, the overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly.

In FY 2003, CMS will fully implement its Comprehensive Error Rate Testing (CERT) program to produce a Medicare fee-for-service error rate. CMS intends to run the CERT program in parallel with OIG's CFO audit for at least one year. After that time, OIG will continue to oversee this effort. The OIG will also continue targeted reviews of specific benefits where vulnerabilities have been identified to determine inappropriate payments in these areas.

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

Since the OIG's error rate measure is valid only at the national level, CMS has been developing a new, more precise measure for use in the future. In May 2000, CMS awarded a Program Safeguard Contractor contract to implement the CERT program. The CERT program will produce national, contractor specific, and benefit category specific fee-for-service paid claims error rates. The CERT program began to be phased in starting in FY 2001. All contractors will be included in the CERT process by the end of FY 2002. The CMS is scheduled to replace the OIG fee-for-service error rate with CERT in FY 2003.

Management Issue #8: Medicare Contractors

Management Challenge
Because of the crucial role Medicare contractors play in helping facilitate efficient and effective health care delivery to 39.5 million Medicare beneficiaries, it is important that they be held accountable for their role in the health care financing and delivery system. For several years, OIG has been concerned about Medicare contractors' financial management problems, such as accounts receivable documentation inadequacies and the lack of integrated dual-entry accounting systems; information systems control weaknesses; integrity issues; and weaknesses in the way they assign and maintain provider numbers so as to better safeguard the program and its funds. These failures could contribute to loss of program funds; improper payments; and manipulation, fraud, and abuse.

Contractor integrity continues to be an issue, and the potential for fraud exists. Since 1993, there have been 15 separate settlements or agreements (criminal and civil) involving Medicare contractors, resulting in over $400 million in HHS recoveries for alleged improper operations. In the last year alone, the OIG has identified contractor integrity problems which include a contractor who agreed to pay $76 million to settle allegations of misconduct while acting as a Medicare Part B carrier between 1966 and 1998. Among other things, the contractor had failed

to process claims properly, then submitted false information to CMS regarding the accuracy and timeliness with which it handled those claims. In addition, a former Medicare fiscal intermediary agreed to pay $9.3 million to resolve its potential liability under the False Claims Act and Civil Monetary Penalties Law for allegedly falsifying data regarding its performance on Medicare cost reports.

Assessment of Progress in Addressing the Challenge
The OIG expressed an unqualified opinion on the CMS FY 1999 through FY 2001 financial statements largely because CMS continued to contract for validation and documentation of accounts receivable. However, once again OIG's FY 2001 financial statement audit disclosed that the lack of a fully integrated financial management system continued to impair the reporting of accurate financial information. To address these problems, CMS has initiated steps to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS), expected to be fully operational at the end of FY 2007.

The FY 2001 reviews of information systems controls also disclosed numerous and continuing weaknesses at Medicare contractors, as well as application control weaknesses in contractors' shared systems. These vulnerabilities do not effectively prevent unauthorized access, malicious changes, improper Medicare payments, or critical operation disruptions. Corrective action is needed to address the fundamental causes of control weaknesses.

Management's Comments in Brief
The CMS concurs with the OIG's assessment and has been constantly striving to improve Medicare contractor financial management weaknesses. The CMS has made significant improvements in this area over the last few years as evident by the unqualified opinions on the CMS fiscal years 1999, 2000, 2001, and 2002 financial statements. The CMS long term solution for addressing many of these issues is the HIGLAS.

CMS procured a systems integrator to implement HIGLAS and have initiated implementation of an approved Joint Financial Management Improvement Program commercial off-the-shelf product at two Medicare contractor pilot sites. CMS also continues to validate the Medicare contractors' financial reporting by contracting with certified public accounting firms to conduct Statement of Auditing Standards (SAS) 70 internal control reviews and accounts receivable consulting reviews. The SAS 70 reviews concentrate on the functional areas of Electronic Data Processing (EDP) claims processing, financial management, and debt collection. The accounts receivable reviews ascertain the accuracy and completeness of the accounts receivable activity. Until HIGLAS is fully implemented, CMS will continue to rely on these ongoing activities aimed at compensating for the lack of a modernized system. The CMS has also continued to revise and clarify financial reporting and debt collection policies and procedures based on various audit and review findings.

Our comprehensive systems security program includes the operations of our Medicare fee-for-service contractors. A key feature of the program for the Medicare contractors was the development and dissemination of codified core security requirements (CSR). During FY 2002, CMS received each Medicare contractor's second annual assessment of their compliance against

the CSR. Along with an independent contractor, CMS is completing its final evaluation of each Medicare contractor submission. The CMS requested, received, and distributed $9.7 million in additional FY 2002 funding for proposed safeguards and corrective actions. These safeguards and actions will be implemented throughout FY 2003. The CMS will continue to fund needed safeguards in future years, to the extent of available resources.

Other Issues Identified in FY 2001 Not Cited by OIG in FY 2002

Medicare Managed Care
The CMS is gratified to see that Medicare managed care no longer appears on the OIG's list of top HHS management challenges. The streamlined marketing review process instituted in FY 2002 was successful and therefore was again used for the FY 2003 renewal season. The CMS has also completely revised the 2003 model Evidence of Coverage based on consumer testing and beneficiary advocacy and managed care industry input.

Oversight of Prospective Payment System (PPS) Implementation
The CMS is gratified to see that oversight of PPS implementation no longer appears on the OIG's list of top HHS management challenges. The CMS' ongoing research to improve and refine the home health, skilled nursing facilities, and inpatient rehabilitation facilities prospective payment systems will ensure continued appropriate payments and beneficiary access to care.

Medicare Mental Health Services
The CMS is gratified to see that Medicare mental health services no longer appears on the OIG's list of top HHS management challenges. The CMS concluded the partial hospitalization and psychiatric outpatient services intensive education pilot program. During the course of the pilot, the claims processing contractor had face-to-face interactions with 42 providers and conducted two teleconferences with providers unable to attend the face-to-face training. A clinician conducted training that was comprised of a detailed walk-through of all relevant Medicare billing and coverage guidelines. In addition, participants were provided with a manual containing all the information for their reference.

Post-training evaluations revealed that the intensive education pilot program was extremely successful. The CMS reviewed partial hospitalization and psychiatric outpatient claims after the training and found a significant drop in denial rate. For example, one state’s denial rate was reduced from 90 percent to 17 percent. In another state, the denial rate dropped from 80 percent to 23 percent. Overall, providers were very satisfied with the training, and felt that their questions were answered.

The pilot program validates the importance of CMS’ recent efforts to interact with the provider community through education. The training provided a great opportunity for working partnerships to develop between CMS and providers allowing for increased communication and increased appropriate payments of Medicare benefits.

Child Support Enforcement

The Office of Child Support Enforcement (OCSE), an office within ACF, is gratified to see that child support enforcement was removed from this year's list. OCSE continues to operate Project Save Our Children (PSOC) screening units throughout the country. PSOC is now fully operational nationwide. The volume of cases processed by the screening units is expected to increase significantly this year. Outreach efforts to states and the local law enforcement community will continue to reinforce existing relationships and forge new ones in the newly expanded areas. Our ongoing training partnership with staff from the DOJ, the U.S. Attorney's Office, state agencies, and the HHS OIG, while shifting this year from a centralized approach at the DOJ National Advocacy Center to a more local level collaboration, will continue to be supported by all parties.

Appendix B - Net Cost of HHS Top 50 Programs
(in thousands)

The following table presents the programs accomplished by HHS during FY 2002 and FY 2001 based on dollars invested, and organized in descending order of the FY 2002 net costs of those programs. This listing includes programs aggregated from the more than 300 total HHS programs. The net cost information is extracted from draft and final HHS components' Consolidated Statements of Net Cost for FY 2002 and FY 2001. This table supplements the programs identified in the Consolidated Statement of Net Cost.

HHS Program	FY 2002 HHS Net Cost ($)	FY 2001 HHS Net Cost ($)	in Descending Order in Net Cost Column		Budget Function	HHS Component Responsible for Program
Medicare	231,132,000	219,357,000	1	1	Medicare	Centers for Medicare & Medicaid Services
Medicaid	150,101,000	130,450,000	2	2	Health	Centers for Medicare & Medicaid Services
Temporary Assistance to Needy Families	19,069,036	17,886,274	3	3	Education, Training & Social Services/ Income Security	Administration for Children and Families
Research Program	19,057,871	16,007,346	4	4	Health	National Institutes of Health
Child Welfare	6,739,651	7,014,178	5	5	Education, Training & Social Services/ Income Security	Administration for Children and Families
Head Start	6,502,536	6,014,077	6	6	Education, Training & Social Services/ Income Security	Administration for Children and Families
Child Care	4,512,180	4,118,955	7	7	Education, Training & Social Services/ Income Security	Administration for Children and Families
Child Support Enforcement	4,056,166	3,270,104	8	8	Education, Training & Social Services/ Income Security	Administration for Children and Families
SCHIP	3,662,000	2,487,000	9	9	Health	Centers for Medicare & Medicaid Services
HIV/AIDS Programs	1,791,106	1,466,191	10	14	Health	Health Resources and Services Administration
Social Services Block Grant	1,764,638	1,859,959	11	12	Education, Training & Social Services/ Income Security	Administration for Children and Families
Low-Income Home Energy Assistance	1,760,110	2,167,894	12	10	Education, Training & Social Services/ Income Security	Administration for Children and Families
Substance Abuse Prevention & Treatment Block Grant	1,673,053	1,593,509	13	13	Health	Substance Abuse and Mental Health Services Administration
Primary Care	1,533,487	1,266,717	14	17	Health	Health Resources and Services Administration
Clinical Services	1,501,349	1,385,862	15	15	Health	Indian Health Service
Immunization	1,344,526	1,254,758	16	18	Health	Centers for Disease Control and Prevention
Training/Career Development Program	1,247,219	1,118,276	17	20	Health	National Institutes of Health
Infectious Diseases	1,101,764	1,280,868	18	16	Health	Centers for Disease Control and Prevention
Community Based Services	1,020,528	890,161	19	22	Education, Training & Social Services	Administration on Aging
Maternal and Child Health	966,931	893,307	20	21	Health	Health Resources and Services Administration
PHS Commissioned Corps (Note 1)	812,941	1,969,599	21	11	Health	Program Support Center
Health Professions	804,005	1,175,980	22	19	Health	Health Resources and Services Administration
Public Health and Social Services Emergency Fund	715,235	335,852	23	31	Health	Office of Secretary
Community Services	665,923	661,803	24	23	Education, Training & Social Services/ Income Security	Administration for Children and Families
Chronic Disease Prevention	626,139	622,781	25	24	Health	Centers for Disease Control and Prevention
Refugee Resettlement	488,364	385,723	26	29	Education, Training & Social Services/ Income Security	Administration for Children and Families
Contract Health Care	452,384	412,658	27	26	Health	Indian Health Service
Foods and Cosmetics	431,053	390,085	28	28	Health	Food and Drug Administration
Community Mental Health Services Block Grant	420,474	377,742	29	30	Health	Substance Abuse and Mental Health Services Administration
HIV/AIDS, STD &TB Prevention Note 2	364,630	N/A	30	N/A	Health	Centers for Disease Control and Prevention
General Departmental Management	336,100	242,825	31	34	Health	Office of Secretary
Knowledge Development & Application	314,698	403,016	32	27	Health	Substance Abuse and Mental Health Services Administration
Human Drugs	280,402	255,316	33	33	Health	Food and Drug Administration
Tribal Activities: Contract Support	271,497	255,456	34	32	Health	Indian Health Service
Family Planning	269,752	241,626	35	35	Health	Health Resources and Services Administration

Appendix B - Net Cost of HHS Top 50 Programs
(in thousands)

HHS Program	FY 2002 HHS Net Cost ($)	FY 2001 HHS Net Cost ($)	in Descending Order in Net Cost Column		Budget Function	HHS Component Responsible for Program
Facilities Program	269,527	178,609	36	38	Health	National Institutes of Health
Program of Regional National Significances/Targeted Capacity Expansion	257,911	113,909	37	44	Health	Substance Abuse and Mental Health Services Administration
Medical Devices & Radiological Health	240,885	223,320	38	36	Health	Food and Drug Administration
Research on Health Cost, Quality and Outcomes	227,432	11,018	39	79	Health	Agency for Healthcare Research and Quality
Environmental and Occupational Health	215,158	481,651	40	25	Health/ Natural Resources & Environment	Centers for Disease Control and Prevention
Office of Special Programs	210,324	123,795	41	42	Health	Health Resources and Services Administration
Hospitals-Facilities Support	203,819	183,923	42	37	Health	Indian Health Service
Occupational Safety and Health (Note 2)	202,439	N/A	43	N/A	Health	Centers for Disease Control and Prevention
Office of the Inspector General	197,591	162,143	44	39	Health	Office of Secretary
Biologics	187,416	160,889	45	40	Health	Food and Drug Administration
Preventive Health & Health Services Block Grant	160,221	87,397	46	49	Health	Centers for Disease Control and Prevention
Developmental Disabilities	142,191	105,251	47	46	Education, Training & Social Services/ Income Security	Administration for Children and Families
Epidemic Services	129,577	114,656	48	43	Health	Centers for Disease Control and Prevention
Environmental Health (Note 2)	122,497	N/A	49	N/A	Health	Centers for Disease Control and Prevention
Animal Drugs and Feeds	112,736	83,106	50	50	Health	Food and Drug Administration
All Other HHS Programs (53 programs)	1,783,841	1,440,671	51-103	51-103	Various	Various Components
Total Net Costs (Note 3)	**$ 472,454,313**	**$ 432,983,236**				

N/A: Not Applicable
Note 1: The FY 2002 reduction is the result of a change in the method used to calculate the actuarial liability for the Commissioned Corps Pension.
Note 2: Shown as a new program in FY 2002 due to program realignment.
Information.

Appendix C - HHS FY 2002 Federal Managers' Financial Integrity Act (FMFIA) Report on Systems and Controls

Background

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

The Department's FMFIA program supports a key objective in our HHS FY 2002 CFO Financial Management Plan to respond to our diverse customers' needs by ensuring that the financial information for their programs is accurate and that the financial systems and processes that support them maintain the highest level of integrity. HHS components are to have written strategies for assessing management controls on an ongoing basis and these strategies should be consistent with the Financial Management Plan goals and targets.

In addition to our goal of obtaining a clean audit opinion on our annual audited financial statements, we have a related goal of resolving all internal control material weaknesses and reportable conditions cited by the auditors, including instances of non-compliance with the Federal Financial Management Improvement Act (FFMIA) as well as those identified through FMFIA reviews. For tracking and reporting on audit material weaknesses, HHS has developed a department-wide CFO audit Corrective Action Plan, referred to as the "CAP". The CAP includes all of the findings resulting from the financial statement audits, including qualifications (if any), material weaknesses, and reportable conditions. The CAP was submitted to OMB on a quarterly basis beginning in FY 2002. The milestones for the material weaknesses included in this FMFIA report (see below) are consistent with the CAP milestones.

Report Summary

The FMFIA annual assurance required by the act is contained in the Message from the Secretary at the beginning of this Performance and Accountability Report. The details of this year's FMFIA Annual Report, in addition to this narrative summary, are in the statistical summary in this Appendix. It reflects the cumulative total of material weaknesses identified and corrected.

Section 2 Material Weakness: Weakness in the Enforcement Program for Imported Foods

At publication time, there is one material weakness pending correction under Section 2 of the Act; specifically, *Weakness in the Enforcement Program for Imported Foods in the Food and*

Drug Administration (FDA 89-02). A second material weakness from last year's report at NIH, *Deficiencies in the Public Health Service Technology Transfer Activities* (NIH 93-02) has been corrected due to the implementation of a new Technology Transfer System. In FY 2002, NIH completed the milestones intended to implement a new system and resolve the material weakness cited in prior years for Deficiencies in Technology Transfer Activities. We believe sufficient corrective actions have been taken and the desired results achieved. Both of these findings originally resulted from prior year OIG program audits and/or internal management reviews.

Section 4 Material Non-Conformance: Financial Systems and Processes Deparmentwide

Under Section 4 of the Act, there is one pending financial systems material non-conformance. The FMFIA-style corrective action plans (CAPs) for the Section 2 and Section 4 material non-conformance are included in this Appendix.

The Department continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. The FY 2001 department-wide financial statement audit and the FMFIA Report reflected a material non-conformance department-wide under Section 4 of the FMFIA called *Financial Systems and Processes* (HHS-00-01). This finding combined the department-wide audit finding, Financial Systems and Processes, with the audit findings at the Centers for Medicare and Medicaid Services (CMS) specifically: *Financial Systems and Regional Central Office (CO) Oversight, and Medicare EDP Controls (CMS 01-02).* For FY 2002, the CFO auditors reported the same material weaknesses at the department and at CMS which are again combined under the one Section 4 material non-conformance, *Financial Systems and Processes*. This material non-conformance also encompasses the auditors findings that NIH was in non-compliance with the FFMIA. The Central Accounting System (CAS) uses most, but not all, of the U.S. Standard General Ledger accounts and processing rules at the transaction level. Some mixed systems do not provide financial transactions to the CAS using consistent processing rules. In addition, some of these systems are not fully and seamlessly integrated but are otherwise linked with the CAS. For instance, the property management information system does not comply with financial systems requirements. In addition, the audits of several HHS components which also identified continuing problems related to account analyses and reconciliation.

While the problems have not been totally resolved, HHS components have made substantial progress in addressing account analysis and reconciliation problems. For example:

- *Preparation and analysis of financial statements*: The Program Support Center (PSC) has improved the reconciliation and financial reporting processes during FY 2002. PSC contracted out to assist in the monthly reconciliations between general ledger and subsidiary ledger balances. The PSC continued to develop enhancements and streamline the manual preparation of financial statements to implement a more efficient process for preparing financial statements.

- *Reconciling fund balances with Treasury*: In response to the auditor's finding that IHS continues to have difficulty reconciling fund balances in Agency records with the fund balances at Treasury, IHS has developed and adopted a standard mechanized system for reconciling cash balances and validating general ledger accounts.

- *Strengthening year-end closing process*: NIH has implemented a new, more disciplined and controlled process to prepare the trial balances from which financial statements are prepared.

Unified Financial Management System: The Long-Term Solution

The Unified Financial Management System (UFMS) initiative—a critical component of the Department's efforts to modernize its financial management systems and information technology infrastructure—was initiated during FY 2001 at the direction of Secretary Thompson. The initiative is a key element of HHS' effort to improve its financial operations and supports the "improve financial performance" initiative of the President's Management Agenda. The Program's overall strategic goal is to unify HHS' financial management by designing and implementing a modern, department-wide financial management system.

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

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

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

The Program entered its implementation phase in October 2002. Following are the key Program accomplishments during FY 2002.

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

- Developed key planning documents, including Risk Assessment and Mitigation Plan, Change Management (Business Transformation) Plan, Performance Management Plan, and Core Target Business Model.
- Developed the UFMS business case (which was finalized by the UFMS PMO and approved by the HHS Information Technology Internal Review Board on November 5, 2002).

Additionally, shortly after the end of FY 2002, the HHS Investment Technology Investment Review Board (ITIRB) formally approved the UFMS business case.

Implementation of UFMS in accordance with the approved implementation plan will allow HHS to comply with the requirements of the Federal Financial Management Improvement Act by the end of fiscal year 2005. OMB, as a result of its review of key UFMS planning documents and discussions with HHS officials, recognized in its first quarter progress report that the Department's current financial management "status could improve when [the] new accounting system [UFMS] is substantially implemented at the end of [FY] 2005."

CMS: Financial Systems, Analyses and Oversight (CMS-01-01) (Formerly titled: Financial Systems and Regional Central Office Oversight)
Note: This finding is a sub-set of the material non-conformance Financial Systems and Processes Department-wide (HHS-00-01)

The financial statements auditors reported that, overall, the Medicare contractors have made significant improvements in maintaining supporting records for Medicare activities and year-end balances. However, the lack of an integrated financial management system continues to impair CMS and its Medicare contractors' abilities to adequately support and analyze accounts receivable and other reported financial balances. Additionally, the auditors reported that, CMS' regional office (RO) and central office (CO) staff did not perform certain oversight procedures to ensure that all financial data, including data provided by Medicare contractors, was reliable, accurate and complete.

The CMS required Medicare contractors that had audit findings during the FY 2001 audit to submit CAPs to resolve those findings. The CMS evaluated the CAPs submitted and provided comments to the Medicare contractors on the adequacy of their CAPs. The CMS also requires quarterly updates to the CAPs that describe the status or progress of their CAP implementation to correct prior year findings.

At CMS CO, procedures were implemented related to preparing trend analyses to validate the accuracy of financial data. Additionally, CMS created workgroups comprised of CO and RO consortia staff responsible for addressing four key areas identified by auditors: follow up on CAPs, reconciliations of funds expended to paid claims, trend analysis, and internal controls. The objectives of each workgroup are to clearly define CO and RO roles and responsibilities, as well as developing the national strategic plans to strengthen CMS' Medicare contractor financial management oversight in these areas. The detailed CAP to correct this material weakness is included in this report and is consistent with the quarterly CAP provided to OMB.

CMS: Medicare EDP Controls (CMS 01-02)
Note: This finding is also a sub-set of the material non-conformance Financial Systems and Processes Department-wide (HHS-00-01)

The financial statements auditors reported that CMS relies on extensive EDP operations to administer the Medicare program and process accounts for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. Numerous weaknesses at the Medicare contractors, as well as certain application control weaknesses with the Medicare contractors' shared systems were prevalent. Such weaknesses do not effectively prevent 1) unauthorized access to and disclosure of sensitive information, 2) malicious changes that could interrupt data processing or destroy files, 3) improper Medicare payments, or 4) disruption of critical operations.

Additionally, the auditors reported that weaknesses in CMS' entity-wide security plans; Medicare data file and physical data center access controls; and service continuity do not ensure that EDP security controls are adequate and operating effectively. The CMS continues to make progress toward resolving these issues by revising its information systems security requirements for both CMS central office and the Medicare contractors. CMS received $9.7 million in August 2002 for distribution to the Medicare contractors. While the funding enabled CMS to make a start on correction of this material weakness in FY 2002, it was not sufficient to complete the project which is currently estimated for completion in FY 2003. The detailed CAP to correct this material weakness is included in this Appendix and is consistent with the quarterly CAP provided to OMB.

The lack of an integrated financial management system at CMS continues to impair CMS' and the Medicare contractors' abilities to adequately support accounts receivable and other financial balances reported. The CMS is implementing a comprehensive plan to bring its systems into compliance. Specifically, CMS has initiated steps to implement an integrated general ledger system known as HIGLAS for the Medicare contractors, regional and central offices. HIGLAS will replace the 53 different systems currently used by Medicare contractors. HIGLAS will integrate the new system with Medicare's three existing standard claims processing systems. In addition, the current mainframe-based financial system will be replaced by HIGLAS, a web-based system. HIGLAS is expected to be compliant with FFMIA by the end of FY 2005 (the largest Medicare Contractors will be using the new HIGLAS system); and fully operational by 2007.

Financial Statement Audits and the FMFIA

The 2002 FMFIA Report continues to more closely align the findings from the financial statement audits and the FMFIA. HHS components are to report to the Department all deficiencies (findings) from the audit consistent with OMB Circular A-123, which requires that a deficiency should be reported if it is or should be of interest to the next level of management. This includes all material weaknesses and instances of systems non-compliance with FFMIA identified in the FY 2001 financial statement audits, including any which the HHS component

may be aware of from the FY 2002 financial statement audit at the time they prepared their FMFIA Report.

HHS components are asked by the ASBTF/Office of Finance to recommend which, if any, of their financial statement audit material weaknesses and FFMIA non-compliance should be included as an FMFIA material weakness in the Department's Report, i.e., are significant enough to be reported outside the agency to the President and Congress. For those material weaknesses and FFMIA non-compliances an HHS component recommends for inclusion in the Department's FMFIA Report, the component is required to include a corrective action plan in the FMFIA format and submit it with their report.

However, with the exception of those material findings discussed above, all of the audit material weaknesses reported by the HHS components are not included in the Department's FMFIA report because HHS believes that the remaining material weaknesses do not reach a level of significance that require reporting to the President and Congress as defined under Revised OMB Circular A-123. Further,since HHS requires corrective action plans to address all of the findings resulting from the financial statement audits, including qualifications, material weaknesses and reportable conditions. HHS submits a department-wide CAP update quarterly to OMB and the most recent OMB scorecard recognizes that HHS has made "good progress" in the CAP.

2002 FMFIA SECTION 4 MATERIAL NON-CONFORMANCE: SCHEDULE OF CORRECTIVE ACTIONS (HHS 00-01)

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

The Department continues to have serious internal control weaknesses in its financial systems and processes for producing financial statements. (Note: The FY 2001 department-wide financial statement audit and the FMFIA Report reflected a material non-conformance department-wide under Section 4 of the FMFIA called *Financial Systems and Processes* (HHS-00-01). This finding combined the department-wide audit finding, Financial Systems and Processes, with the audit findings at the Centers for Medicare & Medicaid Services (CMS), specifically, *Financial Systems and Regional Central Office Oversight, and Medicare EDP Controls (CMS 01-02)*. For FY 2002, the CFO auditors reported the same material weaknesses at the Department and at CMS which are again combined under the one Section 4 material non-conformance, *Financial Systems and Processes*). Financial Systems and Processes also encompasses the audit findings that NIH was in non-compliance with FFMIA. The Central Accounting System (CAS) uses most, but not all, of the U.S. Standard General Ledger accounts and processing rules at the transaction level. Some mixed systems do not provide financial transactions to the CAS using consistent processing rules. In addition, some of these systems are not fully and seamlessly integrated but are otherwise linked with the CAS. For instance, the property management information system does not comply with financial systems requirements. In addition to the CMS findings and NIH findings, the audits of several HHS components (PSC and IHS) also identified continuing problems related to account analyses and reconciliation.

Pace of Corrective Action
Year Identified: FY 2000
Original Targeted Correction Date: N/A
Correction Date in Last Report: FY 2007
Current Correction Date:
FY 2005 – FFMIA Compliance for UFMS and HIGLAS (the largest Medicare Contractors will be using the new HIGLAS system)1/;
FY 2007 – full HIGLAS implementation
Reason for Changes in Dates: 1/ Implementation of UFMS in accordance with approved implementation plan will allow HHS to comply with the FFMIA by the end of FY 2005. OMB, as a result of its review of key UFMS planning documents and discussions with HHS officials, recognized in its first quarter progress report that the Department's current financial management "status" could improve when the new accounting system (UFMS) is substantially implemented at the end of FY 2005.

Lead Managerial Contact: Margie Yanchuk, Director, Division of Financial Systems and Damon Sutton, Acting Director, Division of Accounting and Fiscal Policy, Office of Program Management and Systems Policy
Source of Discovery: FY 2000, FY 2001 and FY 2002 financial statement audits by OIG
Appropriation/Account #:

For Corrected Items Only
Validation Process Used:

Results Indicators:

2002 FMFIA SECTION 4 MATERIAL NON-CONFORMANCE: SCHEDULE OF CORRECTIVE ACTIONS (HHS 00-01)

Department-wide:

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

Briefly Define (purpose, scope, methodology, resources) the Corrective Action Plan (CAP) That Corrects/Improves This Material Non-Conformance:

The Unified Financial Management System (UFMS) initiative—a critical component of the Department's efforts to modernize its financial management systems and information technology infrastructure—was initiated during fiscal year 2001 at the direction of Secretary Thompson. The initiative is a critical element of HHS' effort to improve its financial operations and supports the "Improve Financial Performance" initiative of the President's Management Agenda. The program's overall strategic goal is to unify HHS' financial management by designing and implementing a modern, department-wide financial management system.

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- Developed a department-wide budget and accounting classification structure (BACS).
- Compiled department-wide financial requirements applicable to UFMS.
- Developed key planning documents, including Risk Assessment and Mitigation Plan, Change Management (Business Transformation) Plan, Performance Management Plan, and Core Target Business Model.
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2002 FMFIA SECTION 4 MATERIAL NON-CONFORMANCE: SCHEDULE OF CORRECTIVE ACTIONS (HHS 00-01)

Overall Status of Material Non-Conformance:

Department-wide:

During FY 2002, the following efforts were made to resolve the material non-conformance:

The financial audits of several HHS components, identified continuing problems related to account analyses and reconciliation. HHS components have made substantial progress in addressing account analysis and reconciliation problems. For example:

1. Preparation and analysis of financial statements -- The Program Support Center (PSC) has improved the reconciliation and financial reporting processes during FY 2002. PSC contracted out to assist in the monthly reconciliations between general ledger and subsidiary ledger balances.

2. Reconciling fund balances with Treasury – In response to the auditor's finding that IHS continues to have difficulty reconciling fund balances in agency records with the fund balances at Treasury, IHS has developed and adopted a standard mechanized system for reconciling cash balances and validating general ledger accounts.

3. The Program Support Center continued to develop enhancements and streamline the manual preparation of financial statements to implement a more efficient process for preparing financial statements.

2002 FMFIA SECTION 4 MATERIAL NON-CONFORMANCE: SCHEDULE OF CORRECTIVE ACTIONS (HHS 00-01)

Major Milestones Department-wide (Long Term):	**Scheduled Due Dates**
NIH Business and Research Support System (NBRS) Complete deployment (implementation)	FY 2005
UMFS and HIGLAS: FFMIA Compliance Target date for resolving outstanding financial systems and processes material weaknesses and complying with the FFMIA	End of FY 2005
UMFS – Department-wide (Full Implementation)	FY 2007
HIGLAS - Full implementation	

2002 FMFIA SECTION 4 MATERIAL NON-CONFORMANCE: SCHEDULE OF CORRECTIVE ACTIONS (CMS 01-01)

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

Title and Description of Material Non-Conformance: Financial Systems, Analysis, and Oversight

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

Pace of Corrective Action: Continuous
Year identified: FY 1997
Original Targeted Correction Date: FY 1999
Correction Date in Last Year's Report: FY 2007
Current Correction Date:
FY 2005 – FFMIA Compliance for UFMS and HIGLAS (the largest Medicare Contractors will be using the new HIGLAS system)1/;
FY 2007 – full HIGLAS implementation
Reason for Changes in Dates: 1/ Implementation of UFMS in accordance with approved implementation plan will allow HHS to comply with the FFMIA by the end of FY 2005. OMB, as a result of its review of key UFMS planning documents and discussions with HHS officials, recognized in its first quarter progress report that the Department;'s current financial management "status" could improve when the new accounting system (UFMS) is substantially implemented at the end of FY 2005.

Lead Managerial Contact: Maria C. Montilla, Director, Division of Financial Oversight, Accounting Management Group, Office of Financial Management

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

For Corrected Items Only
Validation Process Used:

Results Indicators:

2002 FMFIA SECTION 4 MATERIAL NON-CONFORMANCE: SCHEDULE OF CORRECTIVE ACTIONS (CMS 01-01)
Note: This finding is a sub-set of the one Section 4 material non-conformance department-wide (HHS-00-01)

Briefly define the corrective action plan that corrects this material non-conformance:

While CMS have made significant improvements in financial reporting, our long-term solution to this material weakness is the Healthcare Integrated General Ledger Accounting System (HIGLAS). Until this system is implemented, CMS will continue projects and activities aimed at compensating for the lack of the modernized system. Until HIGLAS can be fully implemented, CMS will continue to implement short-term corrective actions, as outlined in our Chief Financial Officer (CFO) Comprehensive Plan for Financial Management, to address this material weakness. The plan contains 8 goals and 24 initiatives to achieve our strategic vision. The four key financial management objectives of our plan are to: 1) improve financial reporting, guidance, and oversight by providing timely, reliable, and accurate financial information that will enable CMS managers and other decision makers to make timely and accurate program and administrative decisions, 2) design and implement effective financial management systems that comply with the Federal Financial Management Improvement Act (FFMIA), 3) improve debt collection and internal accounting operations, and 4) validate key financial data to ensure its accuracy and reliability.

Briefly give an overall status of this material non-conformance at the close of FY 2002.

The annual CFO audits have identified financial management and electronic data processing (EDP) weaknesses that limit our ability to effectively manage the Medicare and Medicaid programs. Correcting these deficiencies is essential to demonstrate our commitment to improve financial management and internal controls. Therefore, audit resolution is a top priority at CMS. Medicare contractors, regional offices (ROs), and central office (CO) components are required to prepare a corrective action plan (CAP), which describes specific activities to correct all prior year findings. Quarterly updates to the CAPs are also required. The CAPs and their quarterly updates are reviewed by CMS for adequacy.

During FY 2002, CMS created workgroups comprised of CO and RO consortia staff responsible for addressing four key areas identified by the auditors: 1) follow up on CAPs; 2) 1522 reconciliation of funds expended to paid claims; 3) trend analysis; and 4) internal controls. The objective of each workgroup is to clearly define CO/RO roles and responsibilities, and to develop the national strategic plans that will strengthen CMS' Medicare contractor financial management oversight in these areas:

- The CMS created a CAP Workgroup that is responsible for developing policies and procedures for overseeing Medicare contractors' reporting and implementation of CAPs. The workgroup issued final manual instructions that required the submission of a "Universal CAP Report" by Medicare contractors that receive various financial management audits by either the Office of Inspector General (OIG), the General Accounting Office (GAO), external certified public accounting firms, as well as CMS RO and CO staff. The Universal CAP Report standardizes the format of the Medicare contractors' CAPs submissions, and facilitates CMS' monitoring responsibilities of these reports. Training on these new instructions was provided during our annual CFO training conferences. Furthermore, we hired consultants to develop a CAP tracking system that will enable us to monitor the progress at which the Medicare contractors are implementing their CAPs.

- We utilized consultants, CO, and RO staff to follow up on contractors' CAPs during the Statement on Auditing Standards No. 70 (SAS 70) internal control reviews and accounts receivable consulting reviews that were performed in FY 2002. Also, RO systems security staff visited Medicare contractors to ensure that EDP problems were corrected.

- The CMS created the CMS 1522 Cash Reconciliation Workgroup that is tasked to develop policies and procedures that require Medicare contractors to reconcile, on a monthly basis, total funds expended by CMS to the corresponding Medicare claims that have been submitted and paid. Through a partnership with OIG, CMS provided Medicare contractors a better understanding of these reconciliations by providing training in this area during our annual CFO training conferences. Additionally, the 1522 Reconciliation Workgroup finalized a review protocol to ensure the Medicare contractors perform this reconciliation. During FY 2002, the workgroup provided training to CMS RO and CO staff on the final protocol, and selected and performed reviews at six Medicare contractor locations. We plan to issue final guidance to the Medicare contractors in FY 2003 to require them to perform a reconciliation of the total funds requested, reported on the CMS 1522 Monthly Contractor Report, to detail paid claims data.

- The CMS continued to enhance analytical tools to perform more expansive trend analysis procedures of critical financial data, specifically accounts receivable and semiannual financial statements. CMS created the Trend Analysis Workgroup that was tasked with developing policies and procedures for performing trend analysis of key financial data, such as accounts receivable, reported by CMS and the Medicare contractors. These tools provide us the steps necessary to identify unusual variances, potential errors, system weaknesses, or inappropriate patterns of financial data accumulation. Additionally, the tools allow us to perform more extensive data analyses, follow up with Medicare contractors, and determine the need for additional actions to ensure that problems are adequately resolved.

  To ensure that accounts receivable balances reported are reasonable, the workgroup issued final manual instructions requiring Medicare contractors to submit, on a quarterly basis, documentation supporting the trend analysis performed.

Training on these new instructions including CMS Form 750, Statement of Financial Position and CMS Form 751, Status of Accounts Receivable was also provided to Medicare contractors and CMS staff during the annual CFO training conferences. Additionally, the workgroup developed and trained CMS CO and RO staff on a review protocol that is used to review the adequacy of Medicare contractors' quarterly trending analysis submissions.

- To emphasize the importance of internal controls in FY 2002, CMS created the Certification Package on Internal Controls (CPIC) Workgroup that is responsible for developing, creating and communicating a heightened awareness to a culture of internal controls within the Medicare contractor community. The workgroup developed a protocol that is used to evaluate or assess the Medicare contractors' processes for complying with requirements of the Federal Managers' Financial Integrity Act of 1982.

  The workgroup finalized manual instructions that provide guidelines to strengthen internal controls. In the past, we have been criticized for not providing a level of confidence that the Medicare contractors' internal control environment had adequate systems of internal controls that were in place and operating efficiently. We believe the procedures and methods set forth in this manual have been devised to alleviate the problems and weaknesses for which the program has been cited.

- CMS continued to contract with certified public accounting firms to conduct SAS 70 internal control reviews, and performed these reviews at 17 Medicare contractor locations. The reviews indicated that all 17 Medicare contractors reviewed had one or more exceptions. To ensure that the exceptions are properly addressed in a timely manner, we have requested that the contractors develop and submit CAPs. Additionally, we require all Medicare contractors to submit an annual CPIC on their Medicare operations. In the CPIC, contractors are required to report their material weaknesses and reportable conditions. We require CAPs for all material weaknesses reported in the CPICs. For FY 2003, we will continue to perform these SAS 70 reviews and monitor contractors' progress for implementing CAPs resulting from these two initiatives.

The CMS has accomplished the following initiatives to effectively implement HIGLAS.

- Established a CMS HIGLAS Program Office staffed with 20 FTEs.
- Initiated implementation of an approved Joint Financial Management Improvement Program Commercial Off-the-shelf product at two pilot sites.
- Established the HIGLAS project baseline and began the design and building of HIGLAS functional specifications/requirements for two Medicare contractor pilot locations.
- Finalized the following project management plans: the Business Solution Test Plan, the Communications Plan, and the Configuration Management Plan.
- Conducted four Conference Room Pilots to refine business requirements/solutions.
- Established the Application Service Provider and technical infrastructure.
- Initiated running 11 non-production instances of the Oracle software in a test environment.
- Established the HIGLAS Change Control Board with support from the Technical Configuration Committee, Requirements Management Committee, and the Performance Work Group to assure decisions are made accurately and timely.
- Established HIGLAS Systems Engineering Portal for project communication.
- Created a HIGLAS Web site to provide program status for project stakeholders.

2002 FMFIA SECTION 4 MATERIAL NON-CONFORMANCE: SCHEDULE OF CORRECTIVE ACTIONS (CMS 01-01)

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

CAP Milestones for FY 2002-2003	Completion Date
Provided financial management training, including trending analysis to contractors.	June 2002
● Acquired advisory services to validate receivable balances.	July 2002
● Revised financial management Internet manual.	August 2002
● Completed advisory reviews.	September 2002
● Established CAPs from advisory reviews.	October 2002
● Contractors implemented CAPs from advisory reviews.	July 2003
CMS 1522 Cash Reconciliation Workgroup provided policy and procedures to ensure contractors reconcile funds expended.	March 2002
● Developed review procedures for monitoring the CMS 1522.	June 2002
● Provided procedures and trained regional offices to perform reviews.	June2002
● Performed onsite reviews at six contractors.	September 2002
● Monitor the monthly CMS 1522 reconciliation submitted by contractors.	Monthly

• Issue draft instructions to contractors that require a reconciliation of the CMS 1522 detailed claims data.	January 2003
• Issue final instructions that require a reconciliation of the CMS 1522 to detailed claims data.	February 2003
• Implement final instructions that require a reconciliation of the CMS 1522 to detailed claims data.	July 2003
Formed Trend Analysis Workgroup to develop and implement trend analysis procedures.	March 2002
• Issued contractor trending analysis procedures.	July 2002
• Perform trending analysis on receivable balances reported.	November 2002
• Quarter ending December 2002.	February 2003
• Quarter ending March 2003.	May 2003
• Quarter ending June 2003.	July 2003
• Issue final RO procedures to perform trending analysis and to review contractors trending analysis.	January 2002
Implement procedures for quarterly financial statements. August 2002	
• Statements due:	February 2003 May 2003 August 2003
• Implement procedures for yearly financial statements.	November 2002
Implement HIGLAS project.	2007

2002 FMFIA SECTION 4 MATERIAL NON-CONFORMANCE: SCHEDULE OF CORRECTIVE ACTIONS (CMS 01-02)
Note: This finding is a sub-set of the one Section 4 material non-conformance department-wide (HHS-00-01)

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

Although the review disclosed no exploitation of the vulnerabilities, the auditors reported that electronic data processing (EDP) controls at the Center for Medicare & Medicaid Services (CMS) central office (CO) and the Medicare contractors do not prevent: 1) unauthorized access to and disclosure of sensitive information; 2) malicious changes that could interrupt data processing or destroy files; 3) improper Medicare payments; or 4) disruption of critical operations. Further, the auditors reported that weaknesses continue to exist in the areas of entity-wide security plans, Medicare data file, physical data center access controls, and service continuity. No individual weakness was determined to be material, but in the aggregate, the weaknesses were considered material.

Pace of Corrective Action: Continuous
Year identified: FY 1998
Original Targeted Correction Date: FY 1999
Correction Date in Last Year's Report: FY 2002
Current Correction Date: FY 2003
Reason for Changes in Dates: The CMS received $9.7 million in August 2002 for distribution to the Medicare contractors. While the funding enabled CMS to make a start on correction of this material weakness in FY 2002, it was not sufficient to complete the project which is currently estimated for completion in FY 2003.

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

Source of Discovery: FY 1997 financial statement audit by OIG and other sources.
Appropriation/Account #: 75XI501

For Corrected Items Only
Validation Process Used:

Results Indicators:

2002 FMFIA SECTION 4 MATERIAL NON-CONFORMANCE: SCHEDULE OF CORRECTIVE ACTIONS (CMS 01-02)
Note: This finding is a sub-set of the one Section 4 material non-conformance department-wide (HHS-00-01)

Briefly define the corrective action plan that corrects this material weakness.

The CMS recognizes the significance of controls and security issues regarding Medicare EDP issues as they relate to the integrity, confidentiality, and availability of sensitive Medicare data. The CMS received $9.7 million in August 2002 for distribution to the Medicare contractors. The funding distribution was $5.3 million to fund system security plans for the contractor claims processing systems and $4.4 million to fund access controls, systems software, segregation of duties, and service continuity. While the funding enabled CMS to make a start on correction of this material weakness in FY 2002, it was not sufficient to complete the project which is currently estimated for completion in FY 2003.

Briefly give an overall status of material weakness at the close of FY 2002.

The CMS continues to make progress in identifying and addressing weaknesses in its automated processing systems by performing vulnerability assessments, Statement of Auditing Standards No. 70 (SAS 70) internal control reviews, and requiring Medicare contractors to perform internal control self assessments. The CMS has moved toward resolving this issue by revising its information systems security requirements. The CMS Core Information Security Requirements adhere to guidelines in the Office of Management and Budget (OMB) Circular A-130 and implement effective control procedures. In FY 2002, CMS completed a prototype of a system security plan methodology for Medicare contractors. Controls were implemented to monitor and evaluate requests for source code changes to the Fiscal Intermediary Standard System (FISS). At central office, CMS developed and implemented new background investigation procedures to strengthen access controls over sensitive Medicare data. The CMS also developed a comprehensive policy for software quality assurance, as well as developed, tested, and implemented a systems software change audit review process. Compliance with the CAP milestones for FY 2003 is dependent on resources.

2002 FMFIA SECTION 4 MATERIAL NON-CONFORMANCE: SCHEDULE OF CORRECTIVE ACTIONS (CMS 01-02) Note: This finding is a sub-set of the one Section 4 material non-conformance department-wide (HHS-00-01)	
Corrective Action Plan Milestones for FY 2003	**Completion Date**
Medicare Contractors	
● Adhere to OMB A-130 guidelines for entity-wide security plans to ensure appropriate safeguarding of Medicare data.	September 2003
● Develop consistent and effective physical and logical access procedures, including administration and monitoring of access by contractor personnel in the course of their job responsibilities.	September 2003
● Develop consistent and effective procedures over the implementation, maintenance, access, and documentation of operating systems software products used to process Medicare data.	September 2003
● Develop a segregation of duties to ensure accountability and responsibility for access to Medicare applications and data are appropriately assigned.	September 2003
● Update and appropriately document service continuity procedures to recover Medicare processing in case of a system outage.	September 2003
CMS Central Office	
● Complete the CMS master plan and the supporting general support systems (GSS) plans that application plans will refer to.	June 2003

• Recertify all personnel with physical access to the CMS Data Center.	November 2002
• Implement a three-phased approach to establishing a comprehensive Business Continuity Plan.	October 2003

2002 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS (FDA-89-02)

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

Pace of Corrective Action **Year Identified:** FY 1989 **Original Targeted Correction Date:** FY 1990 **Correction Date in Last Year's Report:** FY 2001 **Current Correction Date:** FY 2006 **Reason for Change in Dates:** FDA is not ready to declare this material weakness resolved until recently authorized staff for food inspections are fully trained and a risk-based approach to the inspections process is fully implemented.	**Name of Responsible Program Manager:** John Taylor, Associate Commissioner for Regulatory Affairs **Source of Discovery:** OIG (Report A-15-90-00001) and internal FDA management reviews. **Appropriation/Account #:** 7520600

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

Results Indicators:

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

2002 FMFIA SECTION 2 MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS (FDA-89-02)

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

Major Milestones	Milestone Dates		
	Original Plan	**Revised Plan**	**Actual Date**
Completed actions/events:			
FDA uses a structural and selective sampling method, based on both the entry level and product intelligence to provide an effective level of examination coverage. This assessment is supported by historical data covering the period of 1972-1992.			**FY 1992-93**
FDA developed a Revised Imports Strategy, which embodies intelligence based sampling of imports to provide an effective level of coverage, and includes performance indicators. With this new approach, FDA focuses its import activities on products and problems presenting a high health risk to the American public, or firms and countries of origin having a history of non-compliance. Electronic screening, improved strategic alliances and improved premarket and postmarket surveillance are key components of the revised strategy.			**FY 1994-95**
FDA has expanded the use of an electronic entry processing system (EEPS) for imports using the Custom's Automated Commercial System. EEPS enables FDA to screen import entries and electronically make "May Proceed" decisions on products of low risk and high compliance rates. At this time, EEPS has been implemented at all major ports where electronic entry of imports is available.			**FY 1995-96**
FDA plans to maintain its pre-market surveillance through a vigorous foreign inspection program designed to identify problems at their source. FDA completed 65 foreign inspections during FY 1995, 40 in FY 1997, 40 in FY 1998, and 87 in FY 1999.			**FY 1996-99**
FDA will complete the full roll-out of OASIS version 2 to all district offices.			**FY 1998**

	Original Plan	Revised Plan	Actual Date
The default "May proceed" rate for all food commodities has been set at 70 percent or greater. However, the "May proceed" rate measured at any particular time may be lower as FDA intensifies a problem with a firm, country or product. These adjustments are considered essential to FDA surveillance activities.			**FY 1999**
Planned/continuing agency actions: Prior to the events of September 11, 2001, FDA and U.S. Customs began discussions to update our Memorandum of Understanding (MOU) that will more correctly reflect our relationship. During those discussions, FDA began exploring redefining the agency's import program from one primarily focused upon border activities (e.g., field examinations, and product sampling and analyses) to one that evaluates the entire life cycle of an imported product, beginning with raw materials entering a foreign processing, packing or manufacturing facility all the way to the U.S. consumer. After September 11, 2001 the FDA embarked on a full scale reevaluation and strategic planning process at the request of the agency's Executive Council. FDA established the Import Strategic Planning Steering Committee, with membership from each of the product centers, ORA, and various offices reporting to the Commissioner, including the Office of Planning, Policy and Legislation, the Office of International Programs, the Office of the Chief Counsel and the Chief Information Officer. Of paramount importance in this reevaluation is the definition of "import coverage." For decades, this has been characterized in terms of agency "output" rather than "outcome." The result has been that programs with tenuous relationships to public health and safety have driven the agency's import operations and the agency has continued to evaluate the import functions in terms of the number of shipments examined and the number of samples analyzed. A simple review of the exponential growth of international trade in FDA regulated commodities argues against continuing this tact.	**FY 2001-02**		**Under Development**

	Original Plan	Revised Plan	Actual Date
Recently, FDA hired over 800 Consumer Safety Officers, many of whom were appropriated with Bioterrorism Supplemental monies. Much of FDA's bioterrorism activities must have a strong relation to import operations and imported products as this represents a considerable threat to the US food and drug supply. By evaluating FDA regulated imports in the context of their entire life cycle, the FDA should be able to identify risks and threats associated with imported products in whatever context they may be found. This requires substantial re-engineering on several levels within FDA's programs and operations as well as increased leveraging with other federal and state regulating partners, foreign governments and industry. Many activities performed by the agency have not been captured in a manner that reflects their true impact on international trade and imported articles. For instance, and only by way of example, when FDA conducts a foreign inspection and finds no significant processing deviations and confirms registrations, product listings, and approvals, as appropriate, the data is often not used to inform the import screening process. Instead, the next shipments from that manufacturer are screened using the same criteria as a manufacturer that has not been inspected. This is also true when a domestic inspection includes in an evaluation of an imported article that appears to have some deficiency associated with it. The result is that these traditionally non-import regulation activities are producing data that in fact relate to the quality, safety or efficacy of imported articles. However, because the data isn't effectively captured, the benefits of that historical data aren't applied on future entry inspections and screenings.	**FY 2001-02**	**Under Development**	

	Original Plan	Revised Plan	Actual Date
Industry also has the ability to provide processing, packing and manufacturing information (as well as security related data) to the agency in advance of the arrival of imported shipments which, under an auditing system, may permit the agency to focus resources on relatively unknown industry participants, allowing for a more efficient targeting of limited agency resources. The benefit to industry participants would be streamlined entry processes, efficiency and stability in trade with the U.S., and less cost in storage of imported goods. This is similar to the US Customs program, the Customs-Trade Partnership Against Terrorism (CTPAT). Additionally, FDA seeks to place the responsibility of quality and safety in imported goods on the proper parties under the law, i.e., the importers and foreign manufacturers, distributors, shippers, packers and processors. This may permit FDA to use its border operations as a "final checkpoint" for imported articles, rather than the only checkpoint. Office of Regulatory Affairs believes these principles are more in line with Congress' intent to ensure appropriate management of federal programs and are examples of the kinds of activities that should be included in "import coverage", even if they do not equate to increased physical examinations of product sampling. The Office of Regulatory Affairs expects that the Import Strategic Planning Steering Committee review will result in a substantial action plan for: ● Re-engineering of the import regulatory concept and programs; ● More effective targeting of FDA examinations, sampling, entry review, and foreign inspections; and ● More useful Mutual Recognition Agreements and Problem Solving Agreements with foreign governments. Resource flow is also critical as the re-engineering process will require significant upgrades and interaction to the agency's Information Technology infrastructure and applications.	**FY 2001-02**	**Under Development**	

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HHS FY 2002 Pending and New Material Weaknesses and Non-Conformances Under FMFIA Reporting				
No.	Title and Identification Code	First Year Reported	Target Date for Correction in 2001 FMFIA Report	Current Target Date for Completion
Management Control Material Weaknesses (Section 2)				
1.	Weak Enforcement in the Import Food Inspection Program (FDA 89-02)	FY 1989	FY 2002	FY 2006
Financial Management Systems Material Non-Conformances (Section 4)				
1.	Financial Systems and Processes (HHS 00-01)	FY 1999	FY 2007	FY 2005 UFMS FFMIA Compliance FY 2007 UFMS HHS-wide implementation
1a.	CMS Financial Systems and Regional and Central Office Oversight (Medicare Accounts Receivable)(CMS 01-01, formerly HCFA 97-02)	FY 1997	FY 2007	FY 2005 HIGLAS FFMIA Compliance FY 2007- HIGLAS full implementation
1b.	Medicare EDP Controls including Application Controls for Medicare Contractors (CMS 01-02, formerly HCFA 98-01a)	FY1998	FY 2002	FY 2003

Note: In FY 2002, NIH completed the milestones intended to implement a new system and resolv the material weakness cited in prior years for Deficiencies in Technology Transfer Activities. We believe sufficient corrective actions have been taken and the desired results achieved

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Number of Management Controls (Section 2) Material Weaknesses			
	Number reported First Time	Number Corrected	Number Still Pending
1989 Report	2 (FDA 89-02) (HCFA 89-01)	1 (HCFA 89-01)	1 (FDA 89-02)
1990 Report	1 (ACF 90-05)	1 (ACF 90-05)	0
1993 Report	1 (PHS 93-02)	1 (PHS 93-02)	0
1997 Report	3 (CMS 01-01, formerly HCFA 97-02) (ACF 97-01) (HCFA 97-01)	2 (ACF 97-01) (HCFA 97-01)	1 (CMS 01-01)
1998 Report	2 (CMS 01-02, formerly HCFA 98-01a) (HCFA 98-02 renamed HCFA 98-01b in 1999)	1 (HCFA 98-02 renamed HCFA 98-01b in 1999)	1 (CMS 01-02)
1999 Report	1 (HHS 00-01, formerly HHS 99-01)	0	1 (HHS 00-01)
2000 Report	0	0	0
2001 Report	0	0	0
2002 Report	0	0	0
Subtotal	10	6	4
Less number recategorized to Section 4 in 2001 Report	3 (CMS 01-01) (CMS 01-02) (HHS 00-01)	0	3 (CMS 01-01) (CMS 01-02) (HHS 00-01)
Total	7	6	1 (FDA 89-02)
Of the total number corrected how many were corrected in 2002? 1			

Note: In FY 2002, NIH completed the milestones intended to implement a new system and resolve the material weakness cited in prior years for Deficiencies in Technology Transfer Activities. We believe sufficient corrective actions have been taken and the desired results achieved.

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Number of Financial Management Systems (Section 4) Material Non-Conformances			
	Number Reported First Time	Number Corrected	Number Still Pending
1997 Report	1 (CMS 01-01)	0	1 (CMS 01-01)
1998 Report	1 (CMS 01-02)	0	1 (CMS 01-02)
1999 Report	1 (HHS 00-01)	0	1 (HHS 00-01)
2000 Report	0	0	0
2001 Report	0	0	0
2002 Report	0	0	0
Subtotal	3	0	3
Less number combined with 1999 finding	2 (CMS 01-01) (CMS 01-02)	0	2 (CMS 01-01) (CMS 01-02)
Total	1	0	1 (HHS 00-01)
Of the total number corrected how many were corrected in 2002? 0			

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Appendix D - HHS FY 2002
Federal Financial Management Improvement Act (FFMIA) Report on Compliance

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

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

The Department's FY 2002 financial statement audit revealed two instances (discussed below) in which HHS financial management systems did not substantially comply with federal financial management systems requirements. HHS concurs with the auditors' findings.

Instances of Non-Compliance

Non-Compliance Number 1: Financial Management Systems and Processes

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

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

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

Non-Compliance Number 2: Medicare Information Systems Controls

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

The FY 2002 audit recognized the significant steps taken by the Department to resolve material weaknesses found in previous years. Following is a summary of some of the corrective actions taken and the current status for each of the areas of non-compliance.

Corrective Actions

Financial Management Systems and Processes

The Department's long-term strategic plan to resolve this material weakness is to replace the existing accounting systems and certain other financial systems within the Department. The short-term focus has been on improving the quality of the data in the accounting systems by increasing periodic reconciliations and analyses, and implementing a web-based Automated Financial System (AFS) for collecting and consolidating financial statements department-wide. Over the last several years HHS has continued to make progress in strengthening its financial management and has a plan to bring its financial management systems into compliance with the FFMIA by replacing antiquated financial systems with the Unified Financial Management System (UFMS). A major sub-component of the unified system is the Healthcare Integrated General Ledger Accounting System (HIGLAS), which will replace the 53 different systems currently used by Medicare contractors. HIGLAS will integrate with Medicare's three existing standard claims processing systems. In addition, the current mainframe-based financial system will be replaced by this web-based system. With national implementation of HIGLAS, the financial material weakness under FFMIA will be eliminated. Following are examples of the Department's FY 2002 achievements:

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

- CMS continues to provide instructions and guidance to the Medicare contractors and our CO and regional offices (RO). We continue to contract with Independent Public Accountants (IPA) to test financial management internal controls and to analyze accounts receivable at Medicare contractors. CMS created workgroups comprised of CO and RO consortia staff to serve as subject matter experts responsible for addressing four key areas: follow up on the Corrective Action Plans; reconciliations of funds expended to paid claims; trend analysis; and internal controls. As CMS progresses toward its long-term goal of developing an integrated general ledger system, we continue to provide training to the contractors to promote a uniform

method of reporting and accounting for accounts receivable and related financial data. CMS also completed automated applications for preparing all five required principal financial statements.

Unified Financial Management System (UFMS)

- Established the UFMS PMO, including hiring the UFMS Program Director, to lead the effort.

- Hired a nationally recognized company to serve as the program's systems integrator.

- Established the UFMS governance structure in which top departmental executives, including the operating components' Chief Financial Officers are Chief Information Officers, actively participate.

- Selected the commercial off-the shelf software to serve as the core system application/infrastructure.

- Developed a departmentwide budget and accounting classification structure (BACS).

- Compiled departmentwide financial requirements applicable to UFMS.

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

- Developed the UFMS business case (which was finalized by the UFMS PMO and approved by the HHS Information Technology Internal Review Board on November 5, 2002).

- NIH commenced implementation of the general ledger component of the NIH New Business System in October 2002.

- NIH is participating in the UFMS planning and global activities. NIH will assess the impact of changes to its core financial management implementation and will work with the UFMS program team to incorporate the changes as global elements are determined. NIH will participate in and follow the direction of the UFMS Change Control Board.

Healthcare Integrated General Ledger Accounting System (HIGLAS)

- Established CMS HIGLAS Program Office; staffed 20 FTEs

- Initiated implementation of an approved CMS Joint Financial Management Improvement Program (JFMIP) Commercial Off-the-shelf (COTS) product at the two pilot Medicare contractors.

- Established the HIGLAS project baseline and began the design and build of HIGLAS functional solution for two Medicare contractor pilots.

- Finalized the following project management plans:

  - Business Solution Test Plan
  - Communications Plan
  - Configuration Management Plan
  - Detailed Pilot Implementation Plans
  - Master Project Plan
  - Project Management Plan
  - Project Work Plan
  - Quality Assurance Plan
  - Requirements Management Plan
  - Risk Management Plan
  - Stress Test Plan
  - Systems Software Process Improvement Plan
  - First of multiple iterations of the Architectural View

- Conducted four Conference Room Pilots to refine business requirements and solutions.

- Established the Application Service Provider and technical infrastructure, and are running 11 non-production instances of the Oracle software in a test environment.

- Established the HIGLAS Change Control Board with support from the Technical Configuration Committee, Requirements Management Committee, and the Performance Work Group to assure decisions are made accurately and timely.

- Established an Earned Value Management System that produces reports to assist project monitoring and control.

- Established HIGLAS Systems Engineering Portal for project communication.

- Created a HIGLAS Web site at www.cms.hhs.gov/ to provide program status for project stakeholders.

Medicare Information Systems Controls

The OIG acknowledged in its findings that during FY 2002 the Department made considerable progress in identifying weaknesses in its automated processing systems. Specifically, CMS identified several weaknesses in the performance of vulnerability assessments, SAS 70 internal control reviews, the compilation of Medicare contractor controls self-assessments, OIG assessment and related procedures. This effort provides a base line for further improvements. CMS embraces the need to assess the risks inherent in its operations and programs, assess financial and operational priorities, and seek additional resources as necessary to correct known deficiencies.

CMS relies extensively on EDP operations at CO and the Medicare contractors to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. In FY 2001, weaknesses at the Medicare contractors, as well as certain application control weaknesses at the contractors' shared systems, continued. Such weaknesses do not effectively prevent: 1) unauthorized access to and disclosure of sensitive information; 2) malicious changes that could interrupt data processing or destroy files; 3) improper Medicare payments; or 4) disruption of critical operations. The OIG aggregated the findings at the Medicare contractors and CMS CO into one material weakness. No findings at a single location were considered material.

CMS continues to make progress toward resolving this issue by revising our information systems security requirements for Medicare contractors. The CMS Core Information Security Requirements adhere to guidelines in the Office of Management and Budget (OMB) Circular A-130 and implement effective control procedures. In FY 2002, CMS completed a prototype of a system security plan methodology for Medicare contractors and developed and implemented new background investigation procedures. We also developed policy and procedures for software quality assurance, as well as developed, tested, and implemented a systems software change audit review process.

In the long term, HHS will continue to improve data integrity and reliability of its financial statements and financial reporting processes. Performing routine periodic reconciliations and financial analysis will help do this. Past performance on the part of HHS resulted in improved financial discipline and the achievement of an unqualified audit opinion on HHS financial statements for FYs 1999, 2000, 2001, and 2002. In addition, HHS will continue to strengthen Medicare EDP controls and improve systems security.

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

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Appendix E - Management Report on Final Action

October 1, 2001 - September 30, 2002

BACKGROUND

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

DEPARTMENTAL FINDINGS

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

- Initiated action to recover $424 million through collection, offset, or other means (see Table I);
- Completed action to recover $205 million through collection, offset, or other means (see Table I);
- Initiated action to put to better use $56 billion (see Table II); and
- Completed action that over time will put to better use $284 thousand (see Table II).

At the end of this period there are 337 reports over a year old with uncollected balances or unimplemented monetary findings. The reasons these reports are still pending are found in the notes to the tables.

THE HHS PROCESS

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

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

Appendix E - Management Report on Final Action (continued)

- If necessary, the ASBTF or the Deputy Secretary resolves conflicts between the OPDIVs and the IG.

Departmental Conflict Resolution

In the event that OPDIV and IG staff cannot resolve differences on specific report recommendations, a conflict resolution mechanism is available.

There were no disagreements requiring the convening of the Conflict Resolution Council.

STATUS OF AUDITS IN THE DEPARTMENT

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

Report on Final Action Tables

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

TABLE I

Management Action on Costs Disallowed
In Inspector General Reports
As of September 30, 2002
(in thousands)

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	420	$ 644,462
B. Reports on which management decisions were made during the reporting period. See Note 2.	252	$ 424,185
Subtotal (A + B)	672	$ 1,068,647
C. Reports for which final action was taken during the reporting period:		
(i) The dollar value of disallowed costs that were recovered through collection, offset, property in lieu of cash, or otherwise.	194	$ 205,132
(ii) The dollar value of disallowed costs that were written off by management.	42	$ 18,846
Subtotal (i + ii)	236	$ 223,978
D. Reports for which no final action has been taken by the end of the reporting period. See Note 3.	436	$ 844,669

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

2. This represents the amount of management concurrence with the Inspector General's recommendations.

3. Includes the list of audits over one year old with outstanding balances to be collected. It includes audits under administrative or judicial appeal, under current collection schedule and legislatively uncollectible.

TABLE II

Management Action on OIG Reports With Recommendations That Funds be Put to Better Use As of September 30, 2002 (in thousands)

	Number	Disallowed Costs
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	6	$ 82,848
B. Reports on which management decisions were made during the reporting period.	3	$ 55,967,284
Subtotal (A + B)	9	$ 56,050,132
C. Reports for which final action was taken during the reporting period:		
(i) The dollar value of recommendations that were actually completed based on management action or legislative action.	1	$ 284
(ii) The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed.	-	$ -
Subtotal (i + ii)	1	$ 284
D. Reports for which no final action has been taken by the end of the reporting period. See Note 2.	8	$ 56,049,848

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

Reports Containing Recommendations
To Put Funds to Better Use
Pending More Than One Year
As of September 30, 2002

AUDIT NUMBER	AUDITEE	DATE ISSUED	AMOUNT	EXPLANATIONS
OEI-12-92-00460	Inappropriate Payments for Total Parenteral Nutrition (TPN) (ES#921222-1330)	Jun-93	$69,000,000	CMS is currently determining the actual amount of the savings.
A-06-92-00043	BC/BS of Texas, Inc. -- GME Costs	Mar-94	$4,078,960	Corrective action cannot be implemented pending the resolution of an objection lodged by the providers' legal counsel with the OIG and OGC.
A-04-95-02110	SC BC (Hospice of Lake & Sumter, Inc.) - ORT	Nov-96	$2,500,000	MS is reassessing whether seeking the identified OIG hospice overpayment is the appropriate action to take.
A-06-95-00095	Palmetto Gov. Ben. Admin. (Fam. Hospice/Dallas)-ORT	Jan-97	$69,648	CMS is reassessing whether seeking the identified OIG hospice overpayment is the appropriate action to take.
A-05-95-00060	WI Department of Health and Social Services	Feb-97	$2,400,000	The State of Wisconsin plans to establish a workgroup to meet and review HMO financial data related to Medicaid HMOs to determine the actual amount of the savings.
OEI-03-99-00200	Medicare Payouts for Services After Death	Mar-97	$4,800,000	CMS is in the process of determining the amount of savings.
			$82,848,608	

Summary:
HHS component: Centers for Medicare & Medicaid Services
Total Number of Reports: 6
Total Amount for Better Use: $82,848,608

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HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2002

OPDIV	AUDIT REPORT #	AUDITEE	ISSUE DATE	AMOUNT	NOTE
ACF	01-00-64985	CT/TA	Jan-01	$4,326,021	5
ACF	01-00-64985	CT/TA	Jan-01	$159,530	5
ACF	01-94-25904	MA CCDBG	Feb-95	$9,225	5
ACF	01-95-32620	CT/FC	May-97	$4,070	5
ACF	01-95-37194	Indian Township/Liea	Mar-96	$44,244	5
ACF	01-96-38182	CT/FC	Sep-96	$50,292	5
ACF	01-96-39813	Pleasant Point/Liea	Nov-96	$492	6
ACF	01-96-43461	CT IV-E	Jan-97	$1,902	5
ACF	01-97-44081	Vermont	Oct-97	$28,252	5
ACF	01-97-48573	Waterbury CT	Nov-99	$20,681	4
ACF	01-98-02505	MA Dept of Social Services	Aug-00	$4,871,596	5
ACF	02-00-62577	Seneca Nation of Indians	Sep-01	$2,545	6
ACF	02-01-67912	New York	Jul-00	$93,223	5
ACF	02-91-14405	Bedford Stuyvesanto/O	May-92	$50,881	2
ACF	02-95-33649	Puerto Rico	Dec-96	$1,433	5
ACF	02-97-47637	Puerto Rico IV-B	Sep-97	$9,703	5
ACF	02-97-47931	Puerto Rico	Jan-99	$290,769	5
ACF	02-98-02004	State of NY, Rensselaer	Sep-01	$12,686	5
ACF	02-99-57987	NJ IV-E	Jan-00	$547	5
ACF	02-99-58335	Puerto Rico	Dec-99	$75,753	5
ACF	03-01-66390	DC Department of Human Services	Jun-01	$81,761	5
ACF	03-01-66391	DC Department of Human Services	Jun-01	$406,796	5
ACF	03-91-14545	PA Win-Demo	Jun-91	$252,362	5
ACF	03-93-21104	PA CSBG	Mar-94	$150,000	5
ACF	03-94-27065	PA C40/CSBG	Sep-95	$150,000	5
ACF	03-95-00451	DC/FC	Aug-97	$420,606	5
ACF	03-95-33212	PA CSBG	Sep-95	$137,207	5
ACF	03-96-39886	Halifax CCA/HS	May-96	$53,281	4
ACF	03-97-00587	Little Neighborhood	Jan-98	$300,465	6
ACF	03-97-43787	VA/CCDBG	Jun-97	$937,769	5
ACF	03-97-47731	Delaware	Sep-97	$11,880	5
ACF	03-97-48850	Little Neighborhood	Nov-97	$91,193	6
ACF	03-98-51186	Council of Southern MT	Feb-99	$45,968	4
ACF	03-98-52659	DC CSBG	Jul-99	$173,116	5
ACF	03-99-03305	Research Assessment State of MD	Jul-00	$4,453,336	6
ACF	03-99-53419	DE DHSS	Mar-99	$45,404	5
ACF	03-99-59858	VA/FC	Jun-99	$4,830	5
ACF	04-00-60897	State of FL	Nov-00	$31,251	5
ACF	04-00-64117	State of AL Child Care & Develp. Fund Mand.	Aug-01	$591,697	5

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2002

OPDIV	AUDIT REPORT #	AUDITEE	ISSUE DATE	AMOUNT	NOTE
ACF	04-00-64497	Coastal Community Action Inc.	May-01	$24,644	5
ACF	04-00-64861	State of NC	Mar-01	$357,591	6
ACF	04-00-66032	State of FL	Jan-01	$41,989	5
ACF	04-01-67440	Catawba	Aug-01	$8,000	6
ACF	04-91-06594	Mountain Valley/HS	Sep-92	$196,213	2
ACF	04-92-17186	Mountain Valley/HS	Sep-92	$203,420	2
ACF	04-93-23833	Mountain Valley/HS	Jul-93	$212,759	2
ACF	04-94-30737	Mountain Valley/HS	Jul-94	$39,095	2
ACF	04-96-00105	Delta Foundation	Apr-99	$1,225,291	4
ACF	04-96-00107	Harambee Child Level	Aug-99	$124,811	6
ACF	04-96-38688	State of KY	Oct-96	$8,049	5
ACF	04-96-44126	Anderson-Oconee/HS	Feb-97	$143,366	6
ACF	04-97-45327	Mobile Community Action	Jul-97	$127,705	6
ACF	04-97-47475	Wash Cty Opport Inc.	Nov-96	$223,151	4
ACF	04-97-49121	Florida	May-98	$282,553	6
ACF	04-98-00126	MS Review of Foster Care Payments	Oct-00	$14,780,012	5
ACF	04-99-55388	North Carolina	Nov-99	$5,640	5
ACF	04-99-55653	Tennessee	Mar-99	$38,487	5
ACF	04-99-57894	Georgia	Nov-99	$4,143	5
ACF	04-99-60712	Coastal Community Action Inc.	May-01	$24,644	5
ACF	05-00-64479	State of Ohio	Nov-00	$1,415,289	5
ACF	05-01-67360	MI Family Independence Agency	Jul-01	$41,279	5
ACF	05-01-67360	MI Family Independence Agency	Jul-01	$240,917	5
ACF	05-95-00022	ILL/IV-E	Jul-96	$89,239	5
ACF	05-97-48402	Montgomery Co CAA	Nov-97	$79,374	7
ACF	05-98-00010	Wisconsin	Feb-00	$3,318,857	5
ACF	05-98-51567	OH DHHS	Mar-99	$14,334	5
ACF	05-99-00063	IL DCFS EA Specified Relative Issue	Nov-00	$13,902,797	5
ACF	06-00-62531	NA Five Sandoval Indian Pueblos Inc.	Oct-00	$18,646	4
ACF	06-00-62566	Five Sandoval Indian Pueblos Inc.	Nov-00	$8,831	4
ACF	06-01-66840	NA Five Sandoval Indian Pueblos Inc	Aug-01	$22,066	4
ACF	06-90-00052	Mexican Amer/Discret	Apr-92	$93,439	3
ACF	06-95-36853	Albuq-Bernalilo/HS	Nov-95	$208,445	5
ACF	06-96-40858	Caddo H/S	Aug-96	$43,339	4
ACF	06-97-44674	Tri-County	Apr-97	$34,703	6
ACF	06-97-46216	E Texas Family Srv	Sep-97	$12,497	6
ACF	06-97-47657	Five Sandoval	Nov-99	$46,660	6
ACF	06-97-47730	Tri-County Head Start	Dec-97	$2,451	6
ACF	06-97-47756	LA DSS/FC	Feb-99	$7,470	5

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2002

OPDIV	AUDIT REPORT #	AUDITEE	ISSUE DATE	AMOUNT	NOTE
ACF	06-97-47939	Albuq/Bernalillo	Aug-97	$210,330	6
ACF	06-97-48284	E Texas Family Srv	Nov-98	$9,130	6
ACF	06-97-48531	TX DHS	Jan-99	$11,209	5
ACF	06-99-00008	OK Foster Care Program Maintenance	Sep-00	$758,017	5
ACF	06-99-54784	TX DP&R/FC	Jan-99	$8,057	5
ACF	06-99-58786	AR Dept. of Human Services	Jul-01	$137,218	5
ACF	07-98-50741	Citizens Housing	Dec-99	$2,678	6
ACF	07-99-57228	Douglas Community	Jun-00	$35,043	5
ACF	08-00-64992	State of UT	Dec-00	$247,412	5
ACF	08-00-65093	Cankdeska Cikana Community College	Aug-01	$114,753	6
ACF	08-00-65151	Rocky Boy School District No. 87J&L	Apr-01	$1,487	6
ACF	08-96-01024	Child Opport Program	Jun-97	$1,104,700	6
ACF	08-97-43975	Oglala Sioux Tribe	May-99	$6,494	6
ACF	08-97-46601	Ute Indian Tribe	Oct-99	$16,764	5
ACF	08-99-57703	Connejos-Costil	Oct-99	$21,145	6
ACF	08-99-59693	Utah	Feb-00	$62,333	5
ACF	08-99-59825	Crow Creek Si.	Jan-00	$26,660	6
ACF	08-99-59907	Crow Creek Si.	Aug-00	$344,504	5
ACF	08-99-60047	Alamosa HS.	Feb-00	$8,605	6
ACF	09-00-63951	Tohono O Odham Nation	May-01	$204,246	6
ACF	09-92-06592	Intertribal Cnl/Hs	Sep-93	$88,530	4
ACF	09-93-00106	CA Dept. of Social Svcs.	May-97	$29,269	5
ACF	09-93-23668	Center of ED/HS	Nov-93	$12,070	5
ACF	09-95-00091	Walter McDonald Asso.	Jul-99	$23,553	4
ACF	09-95-31383	Cocopah/HS	May-96	$76,861	5
ACF	09-95-35961	Fresno County/HS	Aug-95	$29,215	5
ACF	09-96-00066	California	Jun-98	$4,504,493	5
ACF	09-96-00071	CA IV-E	Apr-98	$15,693,626	5
ACF	09-96-39178	AZ Aff Tribes	Mar-99	$258,824	6
ACF	09-96-40113	Protective & Adv Mariana	Apr-98	$80,574	5
ACF	09-96-40114	Protective & Adv Mariana	Apr-98	$36,988	5
ACF	09-96-40115	Protective & Adv Mariana	Apr-98	$56,344	5
ACF	09-96-43765	AZ Aff Tribes	Mar-99	$66,526	6
ACF	09-98-00075	CA IV-E	Aug-99	$38,953,679	5
ACF	09-99-56270	NA Rincon San Luiseno Band of Mission Indians	Apr-01	$56,664	6
ACF	09-99-56272	NA Rincon San Luiseno Band of Mission Indians	Apr-01	$49,860	6
ACF	09-99-57168	NA Santa Y Sabel Band of Mission Indians	Jun-01	$138,868	5
ACF	10-00-58628	Kuigpagmiut, In.	Apr-00	$18,119	6
ACF	10-00-61326	Maniilaq Manpower Inc.	Oct-00	$7,401	6

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2002

OPDIV	AUDIT REPORT #	AUDITEE	ISSUE DATE	AMOUNT	NOTE
ACF	10-00-61327	Maniilaq Manpower Inc.	Oct-00	$4,820	6
ACF	10-00-61328	Maniilaq Manpower Inc.	Oct-00	$1,775	6
ACF	10-01-66783	Native Village of Mekoryuk	Apr-01	$15,949	6
ACF	10-97-47406	ID IV-D OCSE	Apr-99	$88,817	5
ACF	10-97-49306	Alaska	Jul-99	$5,716	5
ACF	10-98-00008	Siletz River Co.	Apr-00	$27,316	5
		OPDIV Total for ACF		**$119,721,605**	
CDC	01-96-37165	Haitian American Public Health Initiative	Mar-97	$20,209	5
CDC	03-98-50835	Nat'l Organ. of Black County Officials	Jan-99	$19,385	5
CDC	03-98-50836	Nat'l Organ. of Black County Officials	Jan-99	$27,140	5
CDC	03-98-50837	Nat'l Organ. of Black County Officials	Mar-99	$1,078	5
CDC	03-98-51634	City of Philadelphia, PA.	Jun-98	$93,690	5
CDC	03-99-56842	Nat'l Assoc. for Equal Opport. in Higher Ed.	Feb-01	$33,585	5
CDC	04-00-61897	American Cancer Society	Mar-01	$28,654	5
CDC	04-98-51239	State of AL Child Care & Develp. Fund Mand.	Sep-98	$227,200	5
CDC	05-96-40217	WI Assoc. of Black Social Workers, Inc.	Mar-97	$1,649	5
CDC	09-96-41444	Immigrant Center	Mar-97	$2,495	5
CDC	10-98-53018	Self Enhancement, Inc.	May-00	$3,452	5
CDC	10-98-53162	People of Color Against Aids Network	Sep-00	$8,289	5
		OPDIV Total for CDC		**$466,826**	
CMS	01-00-00003	State of CT DSS	Apr-01	$202,908	5
CMS	01-00-00535	BC/BS of 'NC	Jan-00	$754,066	28
CMS	01-00-00551	BC/BS of NC	Feb-01	$10,040	29
CMS	01-00-65018	State of VT	Jul-00	$15,853	5
CMS	01-89-00518	Blue Shield of MA	Oct-90	$216,053	11
CMS	01-90-00500E	Blue Cross of MA	Sep-90	$7,048,076	4
CMS	01-91-00508	Aetna Life-Parts A&B Adm.	Jan-92	$223,655	12
CMS	01-92-00517	Blue Cross of M.	Apr-93	$160,122	5
CMS	01-92-00523	BC/BS of MA -Part B Lab Tests	Jan-94	$2,250,000	26
CMS	01-93-00512	BC/BS of MA-Lab Test	Jul-94	$426,817	26
CMS	01-94-00510	BC/BS of MS - ADM costs	Apr-95	$130,299	5
CMS	01-95-00503	G/A & Capitol Mclean Ho- Adm Costs	Aug-95	$186,190	5
CMS	01-96-00513	Separately Billable ESRDL Lab Tests	Dec-96	$6,300,000	5
CMS	01-96-00519	Nat'l Medical Care ESRD	Sep-97	$4,319,361	7
CMS	01-96-00527	Clinical Lab Tests by Hospital Outpatient Labs	Dec-00	$43,632,767	5
CMS	01-98-00512	CT BC/BS Noncompliance	Jun-98	$3,264	5
CMS	01-99-00501	Waterbury Hospital	Oct-99	$103,588	5
CMS	01-99-00518	Danbury Hospital	May-00	$62,104	5

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2002

OPDIV	AUDIT REPORT #	AUDITEE	ISSUE DATE	AMOUNT	NOTE
CMS	01-99-00521	Hematology Indices	Sep-00	$14,000,000	5
CMS	01-99-00522	Medicare Clinical Lab Tests	Oct-00	$31,200,000	5
CMS	01-99-00523	United HealthCare Ins.	Aug-00	$19,282	5
CMS	01-99-57863	State of CT	May-99	$67,594	5
CMS	02-86-62015	Empire BC/BS	Mar-88	$1,277,575	9
CMS	02-86-62016	Empire BC/BS	Aug-88	$3,027,672	8
CMS	02-91-01022	Prudential Ins.-ADM	Mar-92	$6,837,167	14
CMS	02-92-01004	NJ DHS - Credit Balances for Eight Hosp	Sep-93	$89,839	5
CMS	02-96-01010	NYS DSS	Sep-96	$612,121	30
CMS	02-96-01010	NYS DSS	Jul-00	$612,121	30
CMS	02-96-01034	Staff Blders. Home Health Inc. Buffalo-ORT	Jan-98	$2,046,576	5
CMS	02-97-01026	Eddy VNA of the Capital Region	Nov-99	$11,336,867	5
CMS	02-97-01041	Personal Care Svc.. Westchester Ctv. NY	Apr-99	$687.418	5
CMS	02-99-01026	South Jersey Rehab Associates, Inc.	Nov-00	$297,808	5
CMS	03-92-00150	Elmira Jeffries MNH	Jan-94	$164,188	22
CMS	03-92-00201	Commonwealth of VA	Jan-93	$205,177	14
CMS	03-92-00602	PA DPW - Upper limit	Sep-94	$230,520	5
CMS	03-93-00013	Omega Med. Lab.	Nov-93	$1,102	5
CMS	03-93-00025	PBS - Lab Fee Schedules	Sep-95	$953,377	5
CMS	03-95-38380	Commonwealth of VA	Mar-96	$68,333	5
CMS	04-00-61448	State of GA (OGM)	Feb-00	$1,032,355	24
CMS	04-00-61627	State of TN	Mar-00	$359,907	24
CMS	04-00-64861	State of NC	Sep-00	$24,496	5
CMS	04-00-64861	State of NC	Sep-00	$24,496	24
CMS	04-00-65030	State of SC	Jul-00	$3,528,390	5
CMS	04-01-03006	First Coast Service Options, Inc.	Apr-01	$33,036	5
CMS	04-91-02004	HCFA RO IV (FL BS-MSP)	Sep-93	$2,979,398	5
CMS	04-93-20876	State of NC (OGCFM Lead)	Jul-93	$22,244	5
CMS	04-94-01096	Humana Medical Plans, Inc.	Apr-95	$624,048	5
CMS	04-95-01104	American Health Care-ORT	Jan-97	$1,200,000	5
CMS	04-95-02110	SC BC (Hospice of Lake and Sumter, Inc.) ORT	Apr-97	$4,000,000	5
CMS	04-95-02111	B/C of SC (Hospice of Florida Suncoast, Inc.) ORT	Mar-97	$14,800,000	5
CMS	04-95-33005	State of MS (OGM)	Aug-95	$63,140	12
CMS	04-95-33088	State of NC (OGM)	Sep-96	$11,098	12
CMS	04-95-38310	State of MS (OGM)	Mar-96	$9,069,408	22
CMS	04-96-01131	Aetna (Integrated Health Svcs. Of Green Briar)-ORT	Nov-97	$202,780	5
CMS	04-96-01138	BC/BS of FL-Lawnwood Reg. Med. Ctr. ORT	Apr-97	$111,986	22

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2002

OPDIV	AUDIT REPORT #	AUDITEE	ISSUE DATE	AMOUNT	NOTE
CMS	04-96-01148	Aetna Life Insur. Co.	Nov-97	$148,955	5
CMS	04-96-02122	Blue Cross of GA	Oct-98	$791,327	6
CMS	04-96-38655	State of NC	Jan-97	$5,053	12
CMS	04-97-01164	1996 ACR Proposal for FL MCP	Jan-00	$9,660,000	5
CMS	04-97-01168	FL Agency for Health Care Administration	Dec-99	$8,885,855	14
CMS	04-97-02130	Mutual of Omaha	Apr-99	$1,709,245	5
CMS	04-97-02138	Mutual of Omaha (Silver Springs Health Ctr.)-ORT	Apr-99	$2,382,527	5
CMS	04-98-01184	Homebound Medical Care, Inc.	Jun-00	$1,860,760	5
CMS	04-99-01193	Six State Review of O/P Rehab. Facilities	Jun-00	$74,067,804	5
CMS	04-99-01195	Medicare Home Health Services in FL	Mar-01	$57,022	5
CMS	04-99-55388	State of NC (OGM)	Jun-99	$367,984	5
CMS	04-99-55479	Commonwealth of KY (OGM)	Mar-99	$316,997	5
CMS	04-99-55653	State of TN (OGM)	Nov-99	$309,448	5
CMS	04-99-59921	State of KY (OGM)	Oct-99	$184,633	5
CMS	05-90-00013	BC/BS of MI - Admin	Dec-90	$2,413,388	10
CMS	05-97-00028	OH Dept. of Human Services	Oct-98	$12,674,026	5
CMS	05-97-00029	Office of Medicaid Policy and Planning - IN	Mar-99	$2,000,000	5
CMS	06-00-61716	State of TX	Jun-00	$14,698	25
CMS	06-00-65680	State of TX	Aug-00	$14,698	25
CMS	06-92-00043	BC/BS of TX - GME Costs	Mar-94	$4,252,743	23
CMS	06-95-00095	Palmetto Gov. Ben. Admin. (Fam Hospice/Dallas)	Apr-97	$871,306	22
CMS	06-96-00027	Palmetto Gov. Ben. Admin. (VNA of TX Hospice)	Apr-97	$1,156,341	22
CMS	06-97-00034	Risk Base Health Maint.	Jun-99	$55,895	5
CMS	06-97-00055	TX Depart. of Health	Jul-98	$1,218,480	5
CMS	06-97-00055	TX Dept. of Health	Dec-98	$1,218,480	5
CMS	06-99-00058	State of LA (OGM)	Jun-00	$5,290,000	5
CMS	06-99-56489	State of LA (OGM)	Aug-99	$368,258	5
CMS	07-00-65149	NE Health & Human Services Nursing Facility	Sep-00	$1,450,104	5
CMS	07-01-65970	State of MO	Oct-00	$12,867	5
CMS	07-83-00709	BC/BS of CT - Pension Seg.	Apr-94	$119,472	19
CMS	07-91-00471	BC/BS of MI - Pension Seg.	Dec-92	$5,021,873	10
CMS	07-91-00473	BC/BS of FL, Inc.-Pension Seg.	Aug-93	$4,755,565	13
CMS	07-92-00525	BC/BS of MI -Pension Costs	Dec-92	$2,135,884	10
CMS	07-92-00578	BC/BS of TX - Unfunded Pension Costs	Oct-92	$6,244,637	13
CMS	07-92-00585	BS of CA - Pension Costs	Feb-94	$2,973,504	5
CMS	07-92-00604	WVA BC/BS Term Pension	Jan-93	$617,644	17
CMS	07-92-00608	BC/BS of Missouri	Jun-93	$960,615	15
CMS	07-93-00633	Aetna Life Insurance - Pension Costs	Oct-93	$3,011,376	5

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2002

OPDIV	AUDIT REPORT #	AUDITEE	ISSUE DATE	AMOUNT	NOTE
CMS	07-93-00634	Travelers - Pension Seg.	Oct-93	$1,026,460	18
CMS	07-93-00665	Travers Ins.- Pension Costs	Oct-93	$1,218,963	5
CMS	07-93-00679	Aetna Life Insurance - Pension Costs	May-94	$4,455,857	5
CMS	07-93-00680	BC/BS of NC - Unfunded Pension Costs	Oct-94	$293,629	21
CMS	07-93-00699	BC/BS of MA - Pension Seg.	Apr-94	$658,471	19
CMS	07-93-00700	BC/BS of MA - Pension Costs	May-94	$1,290,740	19
CMS	07-93-00701	BS/BS of MA - Pension Costs	Jul-94	$839,740	19
CMS	07-93-00710	BC/BS of CT - Pension Costs	Mar-93	$237,392	19
CMS	07-93-00713	PA BS - Pension Costs	Jun-95	$5,490,995	5
CMS	07-94-00744	IASD Health Svcs. Corp. - Pension Seg.	Sep-94	$3,079,484	20
CMS	07-94-00745	IASD Health Svcs. Corp. - Unfunded Pension Costs	May-94	$574,804	20
CMS	07-94-00746	IASD Health Svcs. Corp. - Pension Seg.	May-94	$842,979	20
CMS	07-94-00747	IASD Health Svcs. Corp. - Unfunded Pension Costs	May-94	$10,331	20
CMS	07-94-00762	Health Care Svcs. Corp - Unfunded Pension Costs	Jul-94	$1,233,337	10
CMS	07-94-00763	Health Care Svcs. Corp.- Pension Seg.	Aug-94	$1,055,458	10
CMS	07-94-00768	BC/BS of SC - Pension Costs	Sep-94	$840,493	13
CMS	07-94-00769	BC/BS of SC - Pension Costs	Sep-94	$329,001	19
CMS	07-94-00770	BC/BS of SC- Unfunded Pension Costs	Sep-94	$793,508	13
CMS	07-94-00777	BC/BS of GA - Pension Costs	Oct-94	$90,736	13
CMS	07-94-00778	BC/BS of GA - Unfunded Pension Costs	Oct-94	$363,921	13
CMS	07-94-00779	BC/BS of GA - Pension Seg.	Oct-94	$113,256	13
CMS	07-94-00805	BC/BS of TN -Pension Seg.	Jan-95	$1,400,063	13
CMS	07-94-00816	BC/BS of TN. -Unfunded Pension Costs	Jan-95	$352,026	13
CMS	07-94-00817	BC/BS of AL - Pension Unfunded Costs	Jul-95	$912,730	13
CMS	07-94-00818	BC/BS of AL - Pension Seg.	Jul-95	$951,281	13
CMS	07-94-01107	BC/BS of FL - Pension SEG.	Apr-96	$813,122	13
CMS	07-95-01126	BC/BS of FL - Pension Unfunded Costs	Apr-96	$4,049,889	13
CMS	07-95-01149	BC/BS of TX - Pension Costs	Apr-96	$874,111	13
CMS	07-95-01150	BC/BS of Oregon - Pension Seg.	Aug-97	$191,312	5
CMS	07-95-01151	BC/BS of OR - Pension Unfunded Costs	Aug-97	$260,335	5
CMS	07-95-01159	BC/BS of NE - Pension Seg.	Jan-96	$96,955	27
CMS	07-95-01166	BC/BS of NE - Pension Unfunded Costs	Jan-96	$73,509	27
CMS	07-96-01178	BC/BS of MI - Pension Costs	Nov-96	$631,248	10
CMS	07-96-01185	Rocky Mountain Health Care Corp. - Pension Seg.	May-97	$2,743,438	13
CMS	07-96-01189	BC of WA & AK- Pension Seg.	Dec-97	$96,740	5
CMS	07-96-01194	Community Mutual Ins. Co. Pension Seg	Jul-97	$1,866,026	5
CMS	07-96-01195	New Mexico BC - Pension Seg	Feb-97	$801,899	13

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2002

OPDIV	AUDIT REPORT #	AUDITEE	ISSUE DATE	AMOUNT	NOTE
CMS	07-96-01198	Rocky Mtn. Hlth. Care Corp Pension Unfunded Costs	Feb-97	$543,421	13
CMS	07-96-38172	State of IA (OGM)	Sep-96	$478	5
CMS	07-96-44051	State of IA (OGM)	Feb-97	$45,958	5
CMS	07-97-01205	BC of WA & AK - Pension Seg.	Dec-97	$15,688	5
CMS	07-97-01206	BC of WA & AK - Pension Unfunded Costs	Dec-97	$106,843	5
CMS	07-97-01209	BC/BS of MS - Pension Seg.	Jan-98	$224,711	13
CMS	07-97-01210	BC/BS of MS - Unfunded Pension Costs	Jan-98	$482,549	13
CMS	07-97-01211	BC/BS of MS - Pension Costs	Jan-98	$134,312	13
CMS	07-97-01213	Travelers Pension Seg.	Jan-98	$6,624,747	5
CMS	07-97-01222	AdminaStar Federal of KY - Pension Seg	Oct-98	$1,236,890	13
CMS	07-97-01234	Rock Mountain Health Care Corp. Pension Term	May-98	$4,079,171	13
CMS	07-97-02500	Anthem BC/BS of CT	Mar-98	$122,548	5
CMS	07-98-01224	AdminaStar Federal - Pension Unfunded Costs	Oct-98	$4,286,294	5
CMS	07-98-01225	AdminaStar Federal - Pension Costs	Oct-98	$736,134	5
CMS	07-98-02501	Anthem BC/BS of CT - Pension Unfunded Costs	Mar-98	$292,152	5
CMS	07-98-02506	Aetna Life and Casualty	Aug-98	$1,407,689	5
CMS	07-98-02522	BS of CA - Pension Plan Terminated Contractor	Apr-99	$7,623,524	5
CMS	07-98-02526	BC/BS of AR	Sep-98	$153,269	13
CMS	07-99-02540	General American Life Insurance Company	Jul-00	$6,205,564	27
CMS	07-99-59860	State of MO (OGM)	Jun-99	$94,473	5
CMS	07-99-59860	State of MO (OGM)	Dec-99	$94,473	5
CMS	08-00-64575	State of CO	May-00	$11,205,906	13
CMS	08-94-00739	BC/BS of ND - Pension Seg.	Jan-95	$730,875	13
CMS	08-94-00740	BC/BS of NC - Unfunded Pension Costs	Jan-95	$671,198	13
CMS	09-89-00162	Nationwide Employer Project - MSP	Mar-95	$2,218,824	16
CMS	09-95-00072	CA DHS	Nov-96	$4,013,490	5
CMS	09-96-00061	BS of CA	Jun-98	$1,006,192	18
CMS	09-96-00064	San Diego Hospice Corp. - ORT	Nov-98	$993,779	5
CMS	09-96-00088	Care Providers- BC of CA	Jul-99	$901,278	5
CMS	09-96-00089	Care Plus Home Hlth Services - BC of CA	Jul-99	$389,497	5
CMS	14-96-00202	Excluded Unlicensed Health Care Providers	Sep-97	$2,931	5
CMS	17-97-00097	HCFA Financial Statement Audit for FY 1997	Sep-98	$141,796	5
		OPDIV Total for CMS		**$435,207,039**	
HRSA	02-90-06275	Newark Comm. Health Centers	Nov-90	$14,038	2
HRSA	02-92-16577	Newark Comm. Health Centers	Nov-92	$31,708	6
HRSA	04-98-50281	Aaron E. Henry CHC	Sep-98	$3,017	6
HRSA	06-93-27049	Greater Houston HIV Alliance	Sep-94	$20,752	6
		OPDIV Total for HRSA		**$69,515**	

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2002

OPDIV	AUDIT REPORT #	AUDITEE	ISSUE DATE	AMOUNT	NOTE
IHS	08-00-56759	SD Urban Indian Health	Nov-99	$32,783	5
IHS	08-00-59899	SD Urban Indian Health	Nov-99	$6,818	5
IHS	08-00-60654	Spirit Lake	Jan-00	$22,031	5
IHS	08-00-61777	Turtle Mountain Band of Chippewa Indians	Nov-99	$129,070	5
IHS	08-99-55284	SD Urban Indian Health	Jun-99	$902,046	5
IHS	08-99-55285	SD Urban Indian Health	Jun-99	$902,377	5
IHS	08-99-56446	Sisseton-Wahpeton Sioux Tribe	May-99	$5,843	5
IHS	09-00-60032	Lovelock Paiute Tribe	Dec-99	$74,187	5
IHS	09-01-65664	Lovelock Paiute Tribe	Dec-00	$50,473	5
IHS	09-01-67778	Lovelock Paiute Tribe	Jun-01	$19,129	5
IHS	09-01-68215	Pyramid Lake Paiute Tribe	Sep-01	$14,919	5
		OPDIV Total for IHS		**$2,159,676**	
OMH OASH	A-03-00-64076	Nat'l Medical Association	Mar-98	$27,106	31
OMH OASH	A-03-98-50338	Nat'l Medical Association	Mar-98	$12,968	31
OMH OASH	A-15-01-20002	Congress Heights	May-01	$11,300	5
		OPDIV Total for OMH/OASH		**$51,374**	
OS	01-01-68193	Ponce Medical School	Feb-01	$117,767	6
OS	06-98-53934	Osage of OK	Feb-99	$577	6
OS	08-86-43199	Am Indian	Jan-97	$12,696	6
OS	08-99-59826	Crow Creek Sioux Tribe	Feb-00	$14,448	6
OS/OPA	09-93-26171	Tohono O'Odham Natior	Mar-94	$57.090	5
OS	09-96-39220	Public School	Apr-96	$4,396	6
OS	09-98-51231	Tonto Apache	Oct-98	$526	6
OS	09-98-52613	Marianas	Dec-98	$639,432	6
OS	09-99-57597	Bear River Band	Mar-00	$1,648	6
OS	10-00-57229	State of OR	Sep-99	$6,479	6
OS	10-93-22826	Nooksack Indian	Nov-93	$3,323	6
OS	XX-00-61716	TX Dept. of Health	Sep-00	$138,870	6
OS	XX-01-00004	State of ME	Sep-01	$29,227	4
OS	XX-01-68193	Ponce Medical School	Feb-01	$117,767	6
OS	XX-54245	Nevada Law Center	Dec-98	$6,113	4
OS	XX-99-02004	Puerto Rico	Sep-01	$24,113,432	6
		OPDIV Total for OS		**$25,263,791**	
PSC	03-90-00453	State of WV	Mar-91	$12,850,856	7
		OPDIV Total for PSC		**$12,850,856**	
SAMHSA	01-00-61136	United Maine Families, Inc.	Nov-00	$9,535	5

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2002

OPDIV	AUDIT REPORT #	AUDITEE	ISSUE DATE	AMOUNT	NOTE
SAMHSA	02-99-02502	Southeast Queens Community Partnership, Inc.	May-00	$500,263	5
SAMHSA	03-92-03316	Human Services Res. Inc.	Mar-93	$200,550	1
SAMHSA	04-04183	Columbus Co. Services Mgmt.	Jul-94	$35,167	6
		OPDIV Total for SAMHSA		**$745,515**	
		Total for HHS		**$596,536,197**	

Notes:

1. Appeal process
2. Referred to DOJ
3. Referred to DOJ/payment plan
4. Payment plan
5. Pursuing collection
6. Transferred to Treasury Offset Program.
7. In District Court
8. Contractor has signed the closing agreement. An amended OCD is being prepared.
9. Contractor appealed and court ruled in contractor's favor. OPDIV has appealed.
10. Pending resolution of contractor's termination audit, any related termination agreement and pending lawsuit.
11. OPDIV has instructed the carrier to calculate and recover partial overpayments. Recoupment is still on hold pending resolution of the company's appeal to an administrative law judge.
12. Additional documentation has been provided by the State or contractor. OIG and/or OPDIV reviewing.
13. OPDIV is working with al Medicare providers to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
14. OPDIV is in process of negotiating or determining outstanding overpayment amount and/or payment options.
15. OPDIV will be verifying that corrective action has been completed by the fiscal intermediary.
16. Demand letters were sent to employers listed in the audit. D.C. Circuit Court's decision in the HIAA vs. Shalala case will result in few recoveries of funds from EGHPs timely filing limits. OPDIV is attempting to "fix" the HIAA decision via new legislation.
17. Contractor was declared insolvent and placed in receivership. The DOJ has filed a claim on OPDIV's behalf.
18. OPDIV is negotiating a settlement with the State or the contractor.
19. OPDIV is in the process of developing a formula to settle all waivers regarding pension segmentation and/or unfunded pension costs.
20. OPDIV is awaiting verification from the pension actuarial staff that an adjustment was made.
21. An onsite audit is in the process. A global settlement will close pension and administrative costs.
22. The State or contractor is in the process of determining or collecting overpayment.
23. Collection activity has been suspended pending resolution of an objection lodged by two providers' legal counsel with the OIG and OCG.
24. OPDIV is verifying collection of overpayment.
25. Awaiting confirmation that account receivable may be closed out.

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2002

OPDIV	AUDIT REPORT #	AUDITEE	ISSUE DATE	AMOUNT	NOTE

26. Waiting for a decision and/or action by the Asst. U.S. Attorney.
27. OPDIV is negotiating with the contractor on the related administrative costs audit.
28. OPDIV will validate contractor's correction procedures during next scheduled site visit.
29. OPDIV is awaiting completion of corrective action by the contractor.
30. OPDIV to examine related claims.
31. Working with new Executive Director to resolve all issues.

HHS Audit Reports Over One Year Old With Outstanding Balances To Be Collected
As of September 30, 2002

OPDIV	AUDIT REPORT #	AUDITEE	ISSUE DATE	AMOUNT	NOTE

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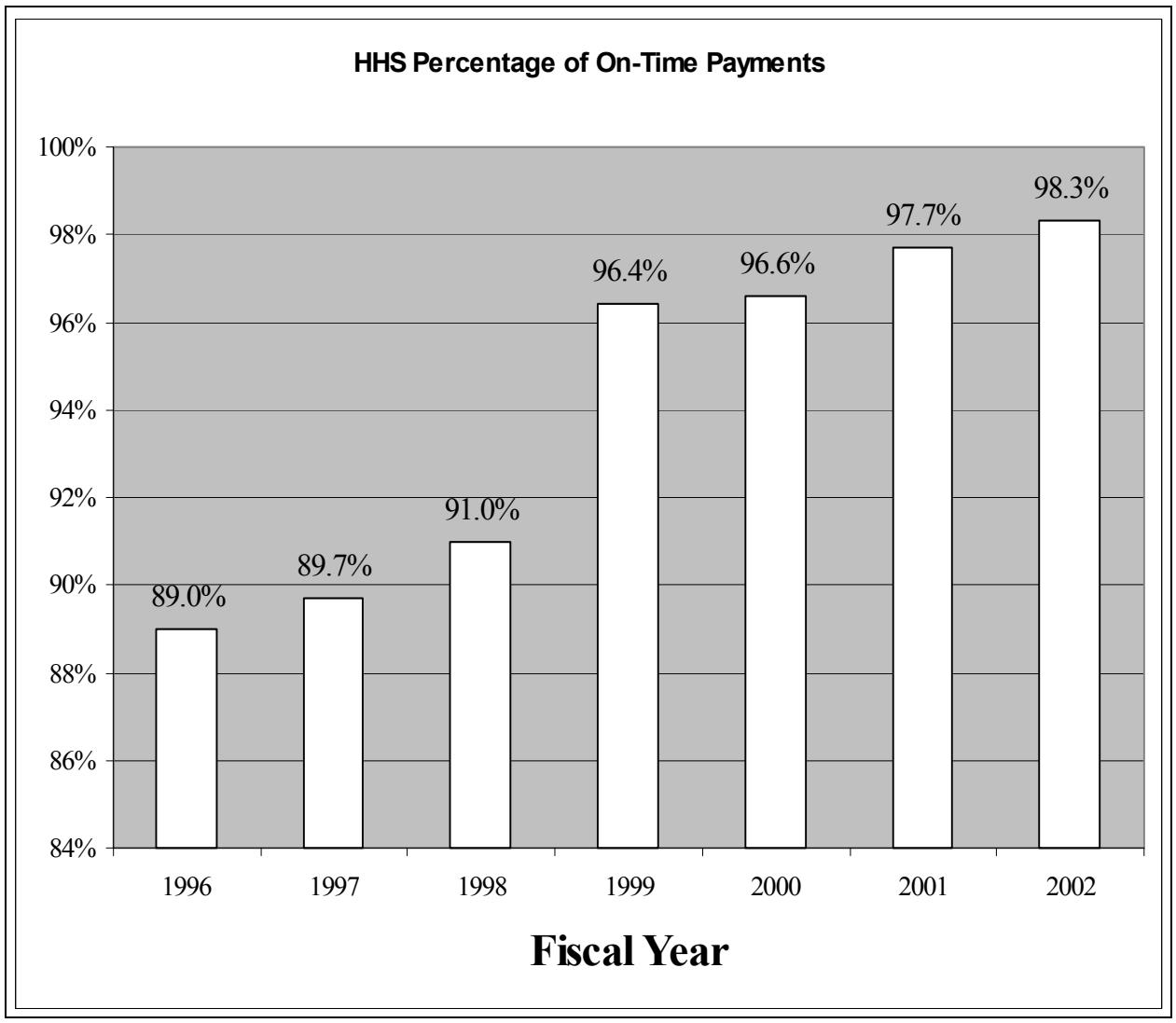
Appendix F - Prompt Pay

Since FY 1996, HHS has shown increasing rates of on-time payments. In FY 2002, HHS achieved a department-wide record by making over 98 percent of its payments on time.



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Appendix G - Civil Monetary Penalties

Civil Monetary Penalties (CMP) are non-criminal penalties for violation of federal law. The Federal Civil Penalties Inflation Adjustment Act of 1990 provides for periodic evaluation to ensure that CMP maintain their deterrent value and that the imposed penalties are properly accounted for and collected. During FY 2002, only CMS and FDA imposed CMP.

For the Fiscal Year Ended September 30, 2002
CMS & FDA Combined

Outstanding Receivables	Number	Amount (in dollars)
Beginning Balances	504	$534,282,499
Assessments (+)	1,050	1,266,023,243
Collections (-)	(1,030)	(911,758,355)
Adjustments	(49)	(54,999,754)
Amounts Written Off	(1)	(24,060,097)
Ending Balance	**474**	**$809,487,536**
Current Receivables	372	791,569,313
Non-Current Receivables	102	17,918,224
Allowance		(339,853,880)
Net Receivables	474	469,633,656
Total Delinquent	**255**	**$120,710,536**
Total Non-Delinquent	**219**	**$688,777,000**

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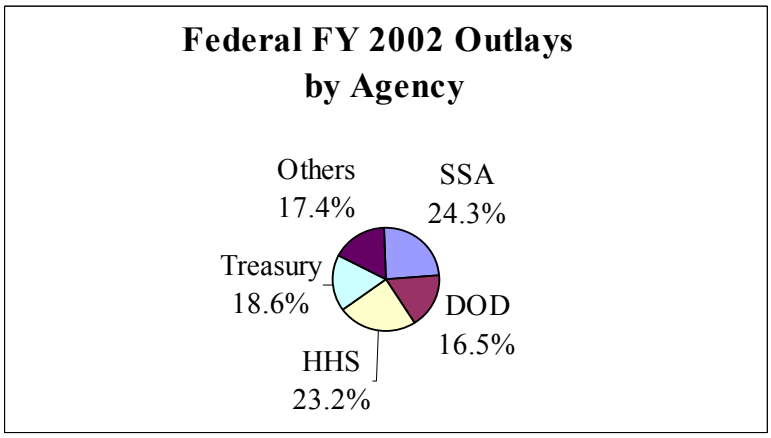
Appendix H - Highlights of HHS Budgetary Outlays

In FY 2002, HHS had net outlays of $466.1 billion, representing 23.2 percent of total net federal outlays. This represents an increase from $426.4 billion (22.9 percent of net federal outlays) in FY 2001. Only the Social Security Administration (which became independent from HHS in 1995) exceeded HHS spending in FY 2002.



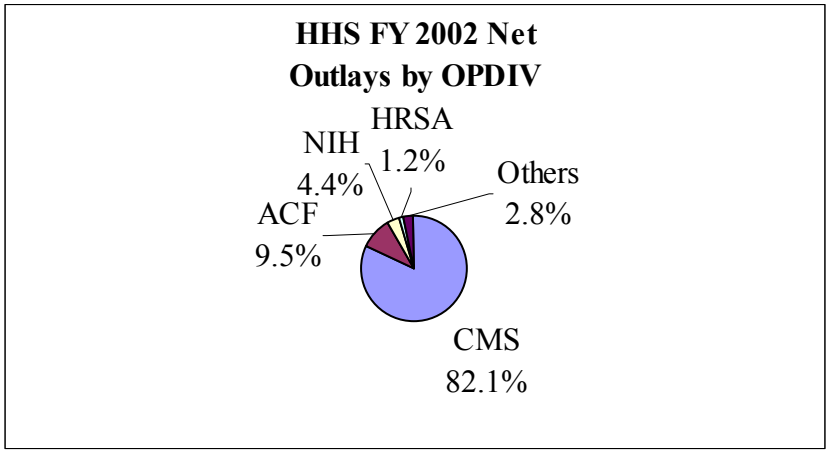
The portion of the federal budget allocated to HHS has grown significantly over the last three decades. The nature of the HHS entitlement programs is the reason for the growth in spending. HHS cannot limit the number of enrollees in its entitlement programs; every individual who meets the programs' criteria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

When the Medicare and Medicaid entitlement programs were enacted in 1966, HHS net outlays accounted for only four percent of federal net outlays. As the ranks of the enrollees and beneficiaries of these entitlement programs have swelled along with the increasing costs of health care treatment, the impact on the federal budget has been quite significant. The net outlays for Medicare alone now account for 11.5 percent of the total net federal budget outlays.

HHS dollars are allocated to the HHS OPDIVs across budget functions. The accompanying matrix chart of "HHS FY 2002 Net Outlays by Budget Function and by OPDIV" details this distribution and facilitates the identification of concentrations of outlays. The largest single budget function is Medicare (which has a category all its own), with $230.9 billion in spending. The second largest functional category, at $189.7 billion, is Health where most of the funds were spent by CMS (for Medicaid) and by NIH (for research). ACF has the bulk of responsibility for budget function dollars categorized as Education, Training, Employment and Social Services, and also for Income Security through the Temporary Assistance for Needy Families, Child Support Enforcement, and Foster Care and Adoption Assistance (which was categorized as Education, Training, Employment and Social Services in previous reports) programs.

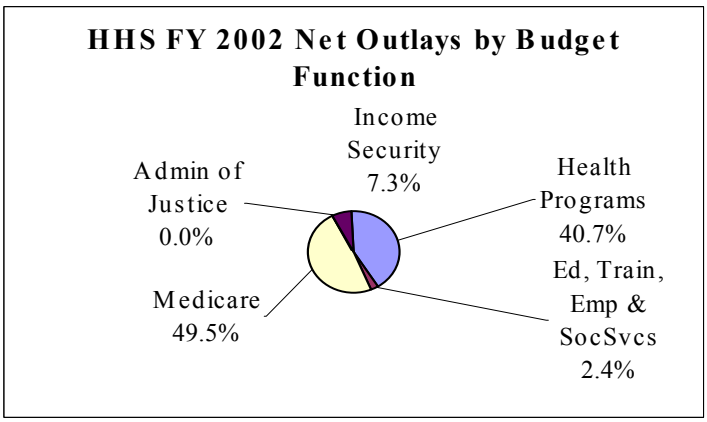
Measured by program spending, CMS is by far the largest of the HHS OPDIVs, followed by ACF, then NIH, HRSA, CDC, SAMHSA, and other HHS agencies. The relative portion of total

HHS net outlays by component is illustrated in the accompanying pie chart.



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

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



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

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

HHS FY 2002 Net Outlays by OPDIV
(in millions)

HHS Agency	FY2002	FY2002	FY2001	FY2000	FY1999	FY1998	FY1997	FY1996	FY1995
Food and Drug Administration	$ 1,125	0.2%	$ 1,073	$ 1,022	$ 950	$ 837	$ 873	$ 865	$ 858
Health Resources and Services Administration	5,755	1.2%	5,123	4,312	3,860	3,473	3,526	3,960	2,612
Indian Health Service	2,812	0.6%	2,553	2,375	2,193	2,145	2,139	1,997	1,975
Centers for Disease Control and Prevention 3/	3,628	0.8%	3,300	2,530	2,428	2,409	2,248	2,166	1,785
National Institutes of Health	20,435	4.4%	17,239	15,405	13,802	12,486	11,171	10,209	10,875
Substance Abuse and Mental Health Svs Adm.	2,885	0.6%	2,737	2,499	2,214	2,235	1,622	2,084	2,444
Agency for Healthcare Research and Quality 4/	-66	0.0%	33	51	79	77	110	81	133
Centers for Medicare & Medicaid Services 5/	382,442	82.1%	350,382	316,139	299,014	294,016	285,523	266,164	248,920
Administration for Children and Families	44,417	9.5%	42,224	36,505	33,624	31,584	31,023	31,023	31,993
Office of the Secretary	1,305	0.3%	568	768	377	233	206	195	275
Administration on Aging	1,105	0.2%	952	884	879	828	828	818	951
Program Support Center	262	0.1%	260	137	280	247	224	240	
HHS SUBTOTAL	$466,105	100.0%	$ 426,444	$ 382,627	$ 359,700	$350,570	$339,493	$319,802	$ 302,821
"Old" HHS agencies that no longer exist as separate agencies in HHS:									
OASH 1/									254
SSA 2/									
HHS TOTAL	$466,105		$ 426,444	$ 382,627	$ 359,700	$350,570	$339,493	$319,802	$ 303,075

1/ OASH accounts were merged into OS and PSC in FY 1996.
2/ SSA separated from HHS at end of FY 1994.
3/ Includes outlays for the Agency for Toxic Substances and Disease Registry (ATSDR) beginning in FY 2001 when direct appropriations were provided to HHS.
4/ Agency name changed from the Agency for Health Care Policy and Research pursuant to Public Law 106-129 enacted on 12/6/99.
5/ Agency name changed from the Health Care Financing Administration (HCFA) in June 2001.

Note: The Outlays (net) table is prepared from the Monthly Treasury Statement and includes proprietary receipts from the public and intrabudgetary transactions. The outlays reflected in the HHS Combined Statement of Budgetary Resources (SBR) does not incorporate all of these deductions for offsetting receipts.

Source: Monthly Treasury Statement of Receipts and Outlays of the United States Government as of 12/10/02.

HHS FY 2002 Net Outlays by Budget Function and by OPDIV
(in thousands)

HHS Agency	Education, Training, Employment, and Social Services	Health	Medicare	Income Security	Administration of Justice	TOTAL
Centers for Medicare & Medicaid Services	$ -	$ 151,588,581	$ 230,853,604	$ -	$ -	$ 382,442,185
Administration for Children and Families	10,175,706			34,228,239	12,655	44,416,600
National Institutes of Health		20,435,281				20,435,281
Health Resources and Services Administration		5,754,818				5,754,818
Centers for Disease Control and Prevention		3,619,912			8,170	3,628,082
Substance Abuse and Mental Health Svs. Adm.		2,884,710				2,884,710
Indian Health Service		2,811,732				2,811,732
Food and Drug Administration		1,125,009				1,125,009
Administration on Aging	1,104,941					1,104,941
Office of the Secretary		1,305,551				1,305,551
Program Support Center *		261,633				261,633
Agency for Healthcare Research and Quality		-66,070				-66,070
HHS SUBTOTAL	$ 11,280,647	$ 189,721,157	$ 230,853,604	$34,228,239	$ 20,825	$ 466,104,472

* Though PSC's services are fee-based and self-sustaining, net outlays shown include $253,357 thousand for Retirement Pay and Medical Benefits for Commissioned Officers with the remainder attributable to the HHS Service and Supply Fund and miscellaneous trust funds.

Note: The FY 2002 financial statements' supplemental schedules present data under six budget functions, rather than just the 5 shown here. This is because ATSDR's expenditures are shown under the Natural Resources & Environmental budget function in HHS financial statements.

Source: Combined Statement of Receipts, Outlays, and Balances of the United States Government, Fiscal Year 2002. $118 billion in offsetting receipts (proprietary receipts from the public and interfund transactions) has been distributed to the appropriate HHS components based on detailed amounts in the September Monthly Treasury Statement. While the total HHS outlays reported by Treasury includes all of these receipts, the Combined Statement of Budgetary Resources includes $26 billion of proprietary receipts. It does not include interfund transactions of $92 billion. Therefore, the $92 billion of receipts may be netted against net outlays reported in the Combined Statement of Budgetary Resources to bridge the net outlay figure reported by Treasury.

Appendix I - Financial Management Strategic Goals

Goal 1 - Decision-makers have timely, accurate, and useful program information.

Measure	Baseline	Performance Trend					FY 2002 Target	Performance/Comments
		FY 1998	FY 1999	FY 2000	FY 2001	FY 2002 Actual		
Audited financial statements for HHS and CMS are submitted to OMB by submission due date.	1996: No	Yes	Yes	Yes	Yes	Yes	Yes	Due date is January 31, 2003.
Number of department-level material weaknesses.	1996: 5	3 Medicare accounts receivable; Medicare electronic data processing (EDP); and financial reporting.	3 Medicare accounts receivable; Medicare EDP; and financial reporting.	2 Financial systems and processes & Medicare EDP.	2 Financial systems and processes and Medicare EDP.	2	2	See Auditor's Opinion in Section IV.
Number of department-level reportable conditions.	1997	5 Accounts payable; Medicaid estimated improper payments; EDP; property, plant, and equipment; and estimating losses from litigation.	4 CMS regional office oversight; Medicaid improper payments; EDP; and property, plant, and equipment.	2 Medicaid improper payments and EDP.	3 Medicaid improper payments; departmental information systems controls; and management systems planning and development.	1	2	See Auditor's Opinion in Section IV.
Percentage of Medicare contractors that will be subject to a SAS 70.	2000	N/A	N/A	50%	32%	50%	20%	
Number of department-level instances of FFMIA non-compliance.	1997	3	3	2	2	2	2	See Appendix D.

Goal 2 - All resources are used appropriately, efficiently, and effectively.

Measure	Baseline	Performance Trend					FY 2002 Target	Performance/Comments
		FY 1998	FY 1999	FY 2000	FY 2001	FY 2002 Actual		
Percent of vendor payments made on time.	1997	91.0%	96.4%	96.6%	97.7%	98.3%	96% (Revised)	See Appendix F.
Percent of individually billed travel accounts that are past due 61 or more days.	2000	N/A	N/A	11.1%	3.5%	2.0%	4%	Exceeded target by 2%.
Percent of centrally billed travel accounts that are past due 61 or more days.	2000	N/A	N/A	27.5%	15.5%	0.3%	0.5%	Continued diligence has resulted in a reduction of 15.2 percnetage points in FY 2002.
Increase percent of debt collection over prior year.	1998	$13.3 billion	$14.27 billion 7% increase	$15.3 billion 7.2% increase	$14.4 billion 5.8% decrease	$14.4 billion	10% increase	While collections remained constant, total receivables decreased from $10.8 to 9.7 billion.
Percent of eligible non-waived delinquent debt referred for cross-servicing to the Treasury.	1998	0%	23%	41.9%	67.8%	93.5%	100%	HHS remains committed to achieving its target of 100% referral for eligible debts to Treasury for cross-servicing.
Percent of eligible waived delinquent debt referred to PSC for cross-servicing.	1999	N/A	3.7%	26.2%	46.7%	61.1%	100%	Improved referral for waived deliquent debts to Treasury for cross-servicing by 14.4 percentage points in FY 2002.
Percent of eligible delinquent debt referred to the Treasury for offset.	1998	20.2%	10.5%	34.2%	59.1%	72.4%	100%	Achieved a 13.3 percentage point improvement in referrals of eligible delinquent debts to Treasury for offset for FY 2002.
Number of department-level FMFIA material weaknesses/non-conformances pending at year end. Sections 2 & 4.	1997	Sec 2 - 6 Sec 4 - 0	Sec 2 - 6 Sec 4 - 0	Sec 2 - 4 Sec 4 - 0	Sec 2 - 2 Sec 4 - 1	Sec 2 - 1 Sec 4 - 1	Sec 2 - 0 Sec 4 - 1	Resolved NIH technology transfer Section 2 materia weakness.

Appendix J - Legislation

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

Selected Program Legislation

The Social Security Act of 1935

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

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

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

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

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

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

The Head Start Act of 1981

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

The Prescription Drug User Fee Act of 1992

The Prescription Drug User Fee Act (PDUFA) authorizes the collection of user fees for reviewing drug applications and was reauthorized as part of the FDA Modernization Act of 1997.

Financial Management Legislation

Federal Managers' Financial Integrity Act of 1982

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

Chief Financial Officers Act of 1990

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

Government Performance and Results Act of 1993

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

Government Management Reform Act of 1994

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

Federal Acquisition Streamlining Act of 1994

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

Debt Collection Improvement Act of 1996

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

Key provisions of the act include:

- Enhancement of administrative offset authority, the Treasury Offset Program;
- Enhancement of salary offset authority;
- Requirement for taxpayer identification numbers;
- General extension of the Debt Collection Act of 1982 authorities;
- Barring of delinquent debtors from obtaining federal credit;
- Reporting to credit bureaus;
- Government-wide cross servicing;
- Establishment of debt collection centers;
- Provision for gainsharing;
- Establishment of the tax refund offset program;
- Provision for contracting with private attorneys;
- Administrative wage garnishment; and
- Debt sales by agencies.

Federal Financial Management Improvement Act of 1996

The Federal Financial Management Improvement Act (FFMIA) of 1996, Public Law 104-208, requires each agency implement and maintain financial management systems that comply substantially with federal financial management systems requirements, applicable federal accounting standards, and the United States Government Standard General Ledger at the transaction level.

Information Technology Management Reform Act of 1996

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

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

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

The Balanced Budget Act of 1997 (BBA 97)
The Omnibus Budget Reconciliation Act of 1993 (OBRA 93)
The Omnibus Budget Reconciliation Act of 1990 (OBRA 90)

A major component of these laws (cited among others) was the emphasis on extending the solvency of the Medicare Hospital Insurance (HI) Trust Fund. These laws reduced Medicare payments to hospitals, skilled nursing facilities and home health agencies, which reduced expenditures from the HI Trust Fund. As a result of these efforts, in combination with other beneficial effects, the HI Trust Fund insolvency date has been pushed back from the year 2003 to 2030. These figures were taken from the Medicare HI Trustees Reports for 1990 and 2002, respectively.

Travel and Transportation Reform Act of 1998

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

Federal Activities Inventory Reform Act of 1998

On October 19, 1998, the Federal Activities Inventory Reform Act (FAIR Act) of 1998 was signed into law. This landmark legislation requires federal agencies to list activities

eligible for privatization and to make this list available to the public. The FAIR Act permits prospective contractors and other interested parties to challenge the omission of particular activities from the list. Nevertheless, although agencies are directed to review the list, FAIR Act does not actually require agencies to privatize listed activities. However, the legislation directs agencies to review the activities on the list soon after the list has been made available to the public.

Federal Financial Assistance Management Improvement Act of 1999

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

Reports Consolidation Act of 2000

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

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Appendix K- Acronyms

A	ACF	Administration for Children and Families
	ACIP	Advisory Committee on Immunization Practices
	ADAP	AIDS Drug Assistance Program
	ADD	Administration on Developmental Disabilities
	AED	Automated External Defibrillator
	AERS	Adverse Event Reporting System
	AFS	Automated Financial System
	AHRQ	Agency for Healthcare Research and Quality
	AI/AN	American Indian / Alaskan Native
	AIDS	Acquired Immuno-Deficiency Syndrome
	AoA	Administration on Aging
	ASBTF	Assistant Secretary for Budget, Technology, and Finance
	ASFA	Adoption and Safe Families Act of 1997
	ATSDR	Agency for Toxic Substances and Disease Registry
	AWP	Average Wholesale Price
B	BACS	Budget and Accounting Classification Structure
	BBA	Balanced Budget Act
	BIPA	Benefits Improvement and Protection Act
	BSE	Bovine Spongioform Encephalopathy
C	CAHPS	Consumer Assessment Health Plans Surveys
	CAP	Corrective Action Plan
	CARE	Customer Automation and Reporting Environment
	CBO	Community-Based Organizations
	CBSP	Community-Based Services Program
	CCDF	Child Care Development Fund
	CCF	Compassion Capital Fund
	CDC	Centers for Disease Control and Prevention
	CERT	Comprehensive Error Rate Testing
	CFBCI	Center for Faith-Based and Community Initiatives
	CFO	Chief Financial Officer
	CFOC	Chief Financial Officer's Council
	CHI	Consolidated Health Informatics
	CIO	Chief Information Officer
	CMP	Civil Monetary Penalties
	CMS	Centers for Medicare & Medicaid Services (formerly HCFA)
	CO	Central Office

	COLA	Cost of Living Adjustment
	COMIS	Center-Wide Management Information System
	COOP	Continuity of Operations Plan
	COTS	Commercial Off-the-Shelf
	CPI	Consumer Price Index
	CPIC	Certification Package on Internal Controls
	CPIM	Consumer Price Index Medical
	CPS	Current Population Survey
	CRADA	Cooperative Research and Development Agreement
	CSE	Child Support Enforcement
	CSHCN	Children with Special Healthcare Needs
	CSPIA	Child Support Performance and Incentive Act of 1998
	CSR	Core Security Requirements
	CTPAT	Customs-Trade Partnership Against Terrorism
	CWF	Common Working File
D	DCIA	Debt Collection Improvement Act
	DCIS	Departmental Contracts Information System
	DOJ	Department of Justice
	DPM	Division of Payment Management
	DSH	Disproportionate Share Hospital
E	e-GOV	Electronic Government
	EDP	Electronic Data Processing
	EEPS	Electronic Entry Processing System
	EPA	Environmental Protection Agency
	ESRD	End Stage Renal Disease
F	FACTS II	Federal Agencies' Centralized Trial Balance System
	FAIR	Federal Activities Inventory Reform
	FASA	Federal Acquisition Streamlining Act
	FBO	Faith-Based Organizations
	FASAB	Federal Accounting Standards Advisory Board
	FBO/CBO	Faith-Based and Community-Based Organizations
	FDA	Food and Drug Administration
	FECA	Federal Employees Compensation Act
	FFMIA	Federal Financial Management Improvement Act
	FFS	Fee-for-Service
	FGSP	Federal Grant Streamlining Program
	FI	Fiscal Intermediary
	FICA	Federal Insurance Contributions Act
	FISS	Fiscal Intermediary Shared System
	FMFIA	Federal Managers' Financial Integrity Act

	FSR	Financial Status Report
	FTE	Full Time Equivalent
	FY	Fiscal Year
G	GAAP	Generally Accepted Accounting Principles
	GAO	General Accounting Office
	GATES	Grants Administration, Tracking, and Evaluation System
	GDP	Gross Domestic Product
	GISRA	Government Information Security Reform Act
	GMRA	Government Management Reform Act
	GPRA	Government Performance and Results Act
	GSA	General Services Administration
	GSS	General Support System
H	HCFAC	Health Care Fraud and Abuse Control Program
	HEAL	Health Education Assistance Loans
	HEDIS	Health Plan Employer Data Information Set
	HHS	Department of Health and Human Services
	HI	Hospital Insurance
	HIFA	Health Insurance Flexibility and Accountability
	HIGLAS	Healthcare Integrated General Ledger Accounting System
	HIPAA	Health Insurance Portability and Accountability Act
	HIV	Human Immuno-deficiency Virus
	HR	Human Resources
	HRSA	Health Resources and Services Administration
	HSEP	HIGLAS Systems Engineering Portal
	HUD	Department of Housing and Urban Development
I	I/T/U	IHS, Tribal and Urban
	IBNR	Incurred But Not Reported
	ICD-9	International Classification of Disease Version 9
	ICD-10	International Classification of Disease Version 10
	ICR	Indirect Cost Rate
	ID	Identification
	IG	Inspector General
	IHS	Indian Health Service
	IPA	Independent Public Accountant
	IRS	Internal Revenue Service
	IT	Information Technology
	ITAS	Integrated Time and Attendance System
	ITIRB	Information Technology Investment Review Board
	ITMRA	Information Technology Management Reform Act
	IV-D	Title IV-D of the Social Security Act

J	JCAHO	Joint Commission on the Accreditation of Health Care Organizations
	JFMIP	Joint Financial Management Improvement Program
K		
L	LIHEAP	Low Income Energy Assistance Program
M	MCBS	Medicare Current Beneficiary Survey
	MCH	Maternal and Child Health
	MDS	Minimum Data Set
	MeDSuN	Medical Device Surveillance Network
	MOU	Memorandum of Understanding
N	NAEYC	National Association for the Education of Young Children
	NAPIS	National Aging Program Information System
	NBCCEDP	National Breast and Cervical Cancer Early Detection Program
	NBRSS	NIH Business and Research Support System
	NCAI	National Coalition for Adult Immunizations
	NCHS	National Center for Health Statistics
	NCQA	National Committee for Quality Assurance
	NDA	New Drug Application
	NDE/MIS	New Drug Evaluation / Management Information System
	NDMS	National Disaster Medical System
	NEDSS	National Electronic Disease Surveillance Systems
	NELRP	Nursing Education Loan Repayment Program
	NHIS	National Health Interview Survey
	NHSC	National Health Service Corps
	NIH	National Institutes of Health
	NMEP	National Medicare & You Education Program
	NMHIC	National Mental Health Information Center
	NPS	National Pharmaceutical Stockpile
	NQF	National Quality Forum
	NTC	Noble USPHS Training Center
O	OAA	Older Americans Act
	OASDI	Old-Age, Survivors, and Disability Insurance
	OASH	Office of the Assistant Secretary for Health
	OASPHEP	Office of the Assistant Secretary for Public Health Emergency Preparedness
	OBRA	Omnibus Budget Reconciliation Act
	OCSE	Office of Child Support Enforcement
	ODPHP	Office of Disease Prevention and Health Promotion

	OER	Office of Emergency Response
	OIG	Office of Inspector General
	OIRM	Office of Information Resources Management
	OLRM	Online Rulemaking Management
	OMB	Office of Management and Budget
	OPD	Orphan Products Development
	OPDIV	Operating Division
	OPHS	Office of Public Health and Science
	OPM	Office of Personnel Management
	ORHP	Office of Rural Health Policy
	ORR	Office of Refugee Resettlement
	OS	Office of the Secretary
	OTC	Over-the-Counter
P	PAM	Payment Accuracy Measurement
	PART	Program Assessment Rating Tool
	PDD	Presidential Decision Directive
	PDS	Project Data System
	PDUFA	Prescription Drug User Fee Act
	PHS	Public Health Service
	PKI	Public Key Infrastructure
	PMA	President's Management Agenda
	PMO	Program Management Office
	PMS	Payment Management System
	PNS	Projects of National Significance
	PP&E	Property, Plant and Equipment
	PPS	Prospective Payment System
	PRANS	Programs of Regional and National Significance
	PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
	PSC	Program Support Center
	PSOC	Project to Save Our Children
Q	QIO	Quality Improvement Organization
R	R&D	Research & Development
	RC	Reportable Condition
	RCA	Reports Consolidation Act of 2000
	RO	Regional Office
	ROI	Return on Investment
	RPMS	Resource Patient Management System
	RSSI	Required Supplementary Stewardship Information

S	SAMHSA	Substance Abuse and Mental Health Services Administration
	SAPTBG	Substance Abuse Prevention and Treatment State Block Grant
	SAS	Statement of Accounting Standards
	SBR	Statement of Budgetary Resources
	SCC	Secretary's Command Center
	SCHIP	State Children's Health Insurance Program
	SDN	Secure Data Network
	SDS	Sanitation Deficiency System
	SECA	Self Employment Contributions Act
	SEDS	Statistical Enrollment Data System
	SFC	Sanitation Facilities Construction
	SMI	Supplementary Medical Insurance
	SNF	Skilled Nursing Facility
	SSA	Social Security Administration
	SSBG	Social Services Block Grant
T	TAGGS	Tracking Accountability in Government Grants System
	TANF	Temporary Assistance for Needy Families
	TB	Tuberculosis
	TEDS	Treatment Episode Data Set
	TOP	Treasury Offset Program
	TTRA	Travel and Transportation Reform Act
U	UDS	Uniform Data System
	UFMS	Unified Financial Management System
	UPL	Upper Payment Limits
	USAID	United States Agency for International Development
V	VICP	Vaccine Injury Compensation Program
	VMI	Vendor-Managed Inventory
W	WTC	World Trade Center
X		
Y	YPLL	Years of Potential Life Lost
Z		

Appendix L - Key HHS Financial Management Officials

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