SECTION II:
Overview of Accountability within HHS

Essential Foundation for Accomplishing HHS Programs

Health and Human Services (HHS), as one of the four largest federal agencies (measured by net outlays), has an enormous responsibility for financial accountability. This *Accountability Report* demonstrates our commitment to, and our leadership in, accountability throughout the Department. In today's environment, accountability is built on a foundation of an appropriately-skilled and motivated workforce, supported by sophisticated, integrated computer information systems. Yet, we face challenges in both arenas, as we discuss below. In fact, the General Accounting Office (GAO) has cited human capital management and information security as top management challenges government-wide (*High Risk Series: An Update*, GAO-01-263). Also in this section, the reader will find a brief description of our activities in other financial management and related areas.

Human Capital Assets

The HHS Workforce

HHS, like many other federal agencies, is facing what some have called a "human capital crisis." At HHS, 26.6% of our current workforce is either eligible or will become eligible for retirement within the next five years. The average age of an HHS employee is 46 with 15.4 years of service.

In the federal government there is a keen need for historical knowledge and in-depth familiarity with the nuances of the laws and regulations of complicated federal programs. These skills are often attained only after decades of federal experience. Clearly, HHS needs to build a pipeline of junior-level workers in order to have experienced workers in the decades to come. HHS wants to ensure that it has effective capacity and institutional memory to meet its goals of serving the public and stewarding tax dollars. Yet studies show that federal careers do not rank as high in desirability as they once did in surveys among recent college graduates. Thus, HHS has several initiatives to improve the quality of worklife within the Department, to help improve the image of federal employment, and to maintain high morale for the existing HHS employees.

HHS recognizes the importance of its human capital assets in helping to meet customer and stakeholder needs and in effectively stewarding

tax dollars. Our people help to create results that tangibly support the Department's current and future goals and our public service mission.

The HHS emphasis on human capital recognizes the transformation occurring in the federal government toward greater emphasis on performance and accountability and the indispensable role that our people play in achieving strategic goals and serving the public. HHS employees provide direct services, coordinate with partners, award grants and contracts, ensure that services reach intended recipients, and develop new policies and better approaches to meet customer needs.

HHS FY 2000 Comparable Full-Time Equivalent (FTE)

HHS Component	FY 1999 Actual	FY 2000 Actual
Food and Drug Administration (FDA)[g]	8,924	8,931
Health Resources and Services Administration (HRSA)[l]	2,014	2,054
Statutorily Exempt	*89*	*74*
Indian Health Service (IHS)[m/n]	14,584	14,676
Statutorily Exempt	*1*	*1*
Centers for Disease Control and Prevention (CDC)[d/h/i/n]	7,470	7,848
Statutorily Exempt	*4*	*37*
National Institutes of Health (NIH)[b/e]	15,305	16,022
Statutorily Exempt	*22*	*17*
Substance Abuse and Mental Health Services Administration (SAMHSA)	632	611
Statutorily Exempt	*71*	*70*
Agency for Healthcare Research and Quality (AHRQ)	253	266
Health Care Financing Administration (HCFA)	4,219	4,446
Administration for Children and Families (ACF)	1,509	1,470
Administration on Aging (AoA)[f]	120	119
Office of Inspector General (OIG)	1,273	1,374
Office for Civil Rights (OCR)[a]	210	215
Departmental Management (DM)[c/k]	1,337	1,421
Program Support Center (PSC)[j]	1,071	1,069
Total FTE	**58,921**	**60,522**
Total Statutorily Exempt	***187***	***199***

Note: Statutorily exempt FTE shown in italics are non-adds and are included in total FTE level.

The HHS fiscal year (FY) 2000 Full-time Equivalent (FTE) chart highlights the employment distribution within HHS. The FTE measure gives a better picture of total staffing than a count of the number of people at HHS, since not all individuals hold full-time jobs.

HHS has already taken, and will continue to take, concrete steps designed to minimize disruptions from any larger than normal retirements levels and plan for a workforce that meets customers' needs. As part of this effort, we are engaged in workforce planning, which consists of comparing employees' current skill and experience base and comparing it to future departmental needs, followed by the development of plans to meet future workforce needs.

In 1999, the Office of the Assistant Secretary for Management and Budget (ASMB) published *Building Successful Organizations: Workforce Planning in HHS*, a workforce planning guide for the Department. An ASMB team is working with the Department's divisions to better understand current versus future needs, to support human capital budget requests, and to meet other objectives designed to leverage our key human capital assets.

Quality of Work Life

HHS' recognition of the importance of its key assets — its employees- is strikingly evident in the Quality of Work Life (QWL) Initiative. QWL, launched in 1996 to improve employee satisfaction, enhance workplace learning and improve the management of change and transition, recently completed its fourth year.

For the third consecutive year the HHS-wide annual employee survey results showed an improvement in employee satisfaction. While not statistically significant, the improvement was widespread with 9 out of 12 components increasing their scores in the years 1999 to 2000. While each of the components tailored its quality of work life efforts to meet the special concerns of its own employees, there have been HHS-wide accomplishments as well.

The first Conference on Diversity was held in March 2000 to develop recommendations for making diversity a source of performance excellence. Components have addressed the recommendations in their annual QWL plans. In addition, this year all civil servants within HHS received a comprehensive, personalized benefits statement that provides valuable information about retirement, Thrift Savings Plan, insurance and other benefits.

In response to the President's Executive Order (EO) 13111, "Using Technology to Improve Training Opportunities for Federal Government Employees," and to meet the vision of "any place, any time learning," HHS has developed a Distributed Learning Network (DL\net) Learning Portal. This Internet site will bring learning and information directly to the employee's desktop, giving every employee access to consistent, high-quality learning and information. In the future it will also enable HHS to offer learning opportunities to partners such as state and local officials and grantees.

While QWL began as an initiative, it is increasingly becoming institutionalized as "business as usual," with attention to employees' quality of work life being seen as integral to the performance of the HHS mission.

Information Systems

Program Information Systems

While the current HHS Information Technology (IT) systems are functioning, they are highly decentralized, heterogeneous, and there-

fore vulnerable to exploitation. HHS has adopted an innovative enterprise infrastructure management approach that centralizes, standardizes, and secures continuity and conformity. The Office of the Secretary and the component agencies work together to enhance interoperability within the Department (such as core financial systems), reduces duplication of equipment and services, and provide for secure systems during emergencies (such as supporting a response to Bioterrorism). IT management practices are streamlined through department-wide IT policies, standard operating procedures and measurable service level agreements. Some of the key activities include automated asset management; Public Key Infrastructure for identification; rapid software distribution and recovery; virus detection and defense; and response to network intrusion.

Enterprise infrastructure management is required to conform with the Information Technology Management Reform Act (ITMRA), also known as the Clinger-Cohen Act; the Government Information Security Reform Act (GISRA), also known as the Thompson-Lieberman Act; Office of Management and Budget (OMB) Circular A-127; OMB Circular A-130; National Institute of Standards and Technology (NIST) security guidelines; Critical Infrastructure Protection; and Counter Terrorism. Enterprise infrastructure management defines the Department's IT architecture and streamlines IT infrastructure costs, systems, policies, and procedures. Of the $75 million investment that will be required over the next three years it will save and avoid costs of $343 million over the next five years in IT security, asset management, problem management, network management, scheduled and emergency software distribution, public key infrastructure, enterprise resource planning, configuration management, change management, and capital planning. With the initial FY 2000 funding HHS has successfully piloted many of these components. Full production implementation is now required. The Enterprise Infrastructure Management Program also provides enterprise software and service contract discounts across the Department. This has already saved over $21 million in software costs for the next three years. HHS has expanded this process to address the consolidation of financial, human resources, grants, and acquisitions management systems.

Consolidating these activities reduces cost and avoids waste. For example, in FY 2000 each agency proposed establishing and conducting their own process to determine what assets required critical infrastructure protection. The estimate was several millions of dollars. The ASMB/OIRM achieved savings by directing the agencies to use one standard process for the entire Department.

Accounting Information Systems

There are five accounting systems within HHS. They are located in the following components: HCFA, FDA, CDC, NIH, and PSC (which services all other components). PSC also houses a payroll system for the Department and a grants management system that services HHS and other federal agencies.

The cross-servicing systems at PSC have received reviews following the guidelines of Statement on Auditing Standards No. 70 (SAS 70), ensuring customers of the integrity of the systems operations. In FY 1999, HHS installed the Automated Financial System (AFS), to better synchronize the consolidation of the HHS component financial statements into the department-wide statements via new Web-based technology. In FY 2000, the system had further modifications to include preparation of the financial statement footnotes and supplemental schedules. These efforts are an interim step in addressing the audit finding on financial reporting which will require a long-term solution.

SAS 70
A review of the internal control structure of an organization that processes transactions or accounts for assets or liabilities of another entity.

HHS is currently developing plans for streamlining its accounting operations even further, while upgrading the functionality of the systems. Most audit findings have been related to information systems weaknesses. We have been able to overcome those weaknesses through intensive manual efforts aimed at short-term resolution of potential audit qualifications. However, many of those findings have been downgraded to material weaknesses and reportable conditions that must be resolved in a systemic, automated way which will require long term solutions. The resolution of those issues can only be done with new and improved systems in order for HHS to achieve complete compliance with the Federal Financial Management Improvement Act (FFMIA). See Section VI for more discussion on FFMIA compliance. The Office of Finance has the lead in coordinating department-wide efforts to develop and improve our financial systems.

Management Activities to Improve Accountability

Department-Wide Accounting Policy Infrastructure

One of the goals of the Department is to have our accounting policy manual completely updated to reflect all of the new federal accounting standards. Unfortunately, the financial statement preparation and audit process has absorbed so many resources for the last several years, that we have not been able to complete our update of the manual. However, all existing policies are available electronically to our financial management staff via the HHS Intranet. We will continue to report on our performance measure for the percentage of the manual that is current, along with our other financial management performance measures, until after we have achieved 100%.

Department-Wide Travel Management and Policy Infrastructure

During FY 2000, HHS implemented several new Federal Travel Regulations stemming from the Travel and Transportation Reform Act of 1998. Effective for travel beginning after February 29, 2000, HHS travel policy requires employees to use the Government contractor-issued travel card for all official travel expenses, unless they have an exemption. Also, HHS components must pay a late fee for proper travel vouchers, if they are not paid within 30 calendar days of submission to the first-level reviewing official.

During FY 2000, HHS' Chief Financial Officer (CFO) established performance targets in the *CFO Five-Year Financial Management Plan* for the timely payment of outstanding balances on both individually-billed and centrally-billed government contractor-issued travel cards. Monthly HHS Travel Card Program reports were prepared by the Office of Finance and sent to the CFOs of the HHS components documenting the most recent levels of payment delinquency. During FY 2000, the Office of Finance worked with the Department's travel card contractor, U.S. Bancorp, and HHS components to rollout the contractor's Customer Automation and Reporting Environment (C.A.R.E.) system, which provides automated support for travel card administrative and reporting functions.

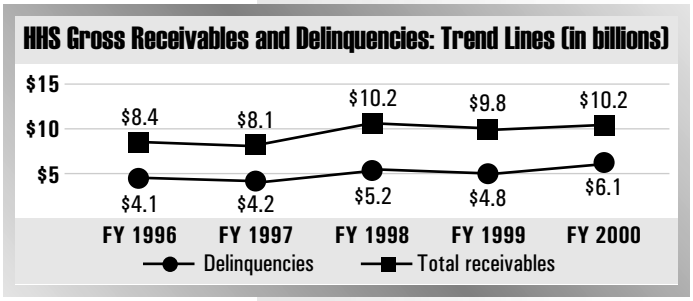
During FY 2000, HHS formed a Task Force to update the HHS Travel Manual for recent changes to Federal Travel Regulations and

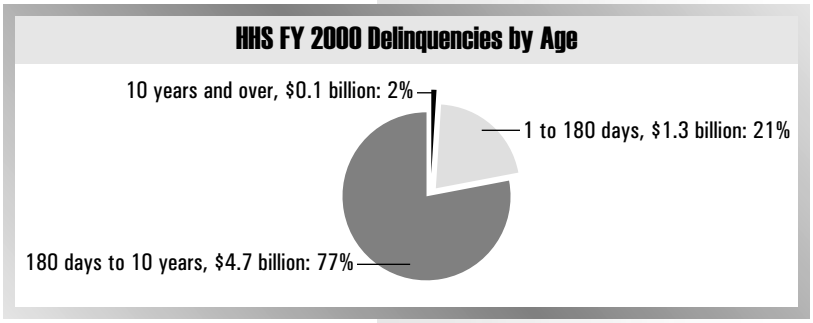
supplemental HHS policies. In February 2000, a new chapter, Travel and Transportation Reform Act of 1998, was issued. This chapter addressed mandatory travel card use, late payment fees for travel vouchers, income tax reimbursement for long-term temporary duty travel assignments, and prepayment audits of transportation bills. A total of seven chapters were under revision in FY 2000 and planned for release during FY 2001.

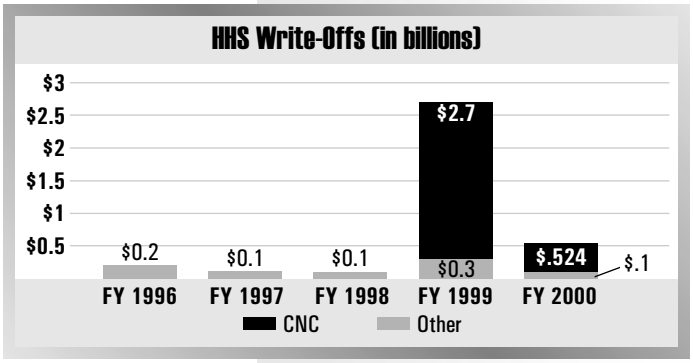
Debt Management*

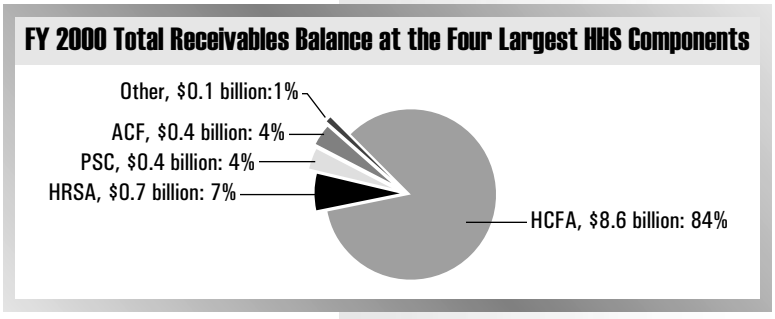
A major financial management priority for the Department has been debt collection, giving particular emphasis on the provisions of the Debt Collection Improvement Act (DCIA) of 1996. While delinquent debt has been referred to the Department of the Treasury for cross-servicing and offset, much work remains to be done with HCFA Medicare contractor debt which has proved particularly difficult to validate for DCIA referral purposes. HCFA is working to implement a corrective action plan to refer these debts.

HHS wrote off nearly $3.0 billion in FY 1999 but only $.6 billion in FY 2000. Much of this debt was written off using OMB Circular A-129 guidance, which removed the debt from HHS financial statements, though efforts to collect it using DCIA's collection tools continue to be used. This category of debt is called "currently not collectible," or CNC. The FY 2000 ending balance of CNC debt amounted to $2.561 billion. The majority of this debt is Medicare Secondary Payer debt which will continue to be referred to PSC for additional collection action. PSC also refers this debt to the Treasury Offset Program







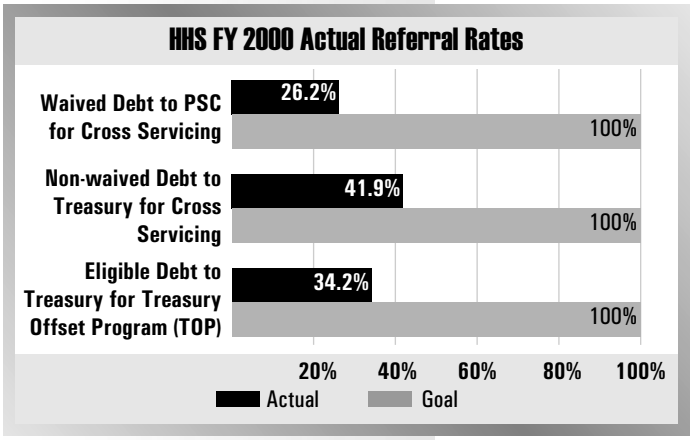


* All HHS and government-wide receivables information in this section is derived from the Treasury Reports on Receivables (TROR) on record as of 11/15/00 for the period ending 9/30/00, unless otherwise noted, and may not be identical to those in the financial statements for various reasons.

(TOP). Non-CNC debt is "written off and closed out" due to various reasons related to unenforceability.

The HHS components with the most outstanding receivables are (in descending order of dollars): HCFA, HRSA, PSC, and ACF.

The relative size of HCFA receivables (largely associated with the Medicare program) to the Department's balance sheet makes receivables a significant issue at the department-wide level. The nature of the design of the Medicare program has had the largest impact on HHS' debt management activities, practices, and delinquency rates.



Although there have been significant improvements, accounts receivable at HCFA has received a great deal of management attention for three reasons: 1) audit findings have cited HCFA contractor receivables as lacking supporting documentation, 2) receivables analysis has revealed significant delinquencies and the need for write-offs of invalid and uncollectible HCFA receivables, and 3) required referrals of HCFA receivables to PSC for debt collection activities have not met targeted goals.

Clearly, we need additional improvement in the management of HCFA receivables. Fortunately, there is synergy associated with each of the activities which serve to remedy existing problems. Regarding the audit finding, in the short term, until new systems are in place HCFA must continue to perform account verification and validation work to substantiate account balances for the financial statement audit. In the long term, Medicare contractor systems must be made to comply with the information needs of the Department. Regarding the delinquencies, HCFA needs to continue its efforts to institute more intensive collection activities on a more timely basis. Once a Medicare delinquency reaches 180 days past due, chances of collection are extremely remote. Regarding the referral of receivables to PSC, HCFA needs to dedicate sufficient resources to the painstaking, manual process of reviewing receivables files and preparing them for transferral to PSC in a format that is acceptable. Lastly, flexible multi-year funding mechanisms and/or legislation to facilitate collection expense reimbursement may be needed to provide the necessary resources for debt collection activities.

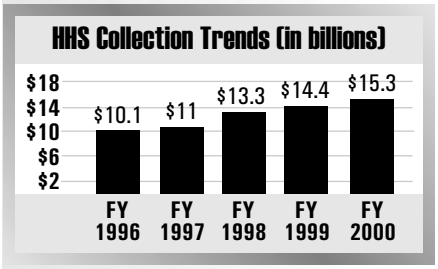
HHS centralized the DCIA delinquent debt referral process in one place by establishing PSC as HHS' delinquent debt collection center. Additionally, HHS obtained a cross-servicing waiver for a number of

different types of program debts (e.g. Medicare Secondary Payer, unfiled Medicare cost reports and various health professional loans). PSC cross-services these debts itself and also refers them to TOP. Under the Debt Collection Improvement Act of 1996, agencies are required to refer delinquent debt over 180 days old to the Treasury Offset Program (to offset other federal payments to the debtor such as income tax refunds), and to Treasury for cross-servicing.

HHS and Treasury work together to assist states in referring delinquent child support debts to the Treasury Offset Program, a voluntary program, in addition to referring these debts to the Internal Revenue Service's Tax Refund Offset Program.

Applicants in various HHS loan programs, primarily health professions program, are screened for outstanding delinquent debt as part of the loan application process. This activity also involves working with private sector lenders in some programs.

HHS has made extensive use of private collection agencies. As one of PSC's aggressive collection tools, delinquent debts may be referred to the private sector for additional collection action.



Grants Streamlining

The Federal Financial Assistance Management Improvement Act of 1999 (Public Law 106-107) (Act) requires OMB and 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 Act also provides that OMB may designate a lead agency to assist with these activities. In that regard, OMB has decided that the CFO Council's Grants Management Committee (GMC), chaired by the largest grant-making agency in the Federal government, HHS, should serve as the lead agency. Although the requirements of the law have been addressed in an organized fashion under the GMC, to date they have only been accomplished through the efforts of Federal agency part-time volunteers. As it is clear that the implementation of true simplification, streamlining, and increased access to electronic options in Federal grants can only be accomplished with full time resources, we are proposing that a temporary full time initiative be established entitled, "The Federal Grant Streamlining Program" (FGSP). The FGSP will identify unnecessary redundancies and duplication in the more than 600 Federal grant programs and implement electronic options for all grant recipients who would prefer to exercise a "common face" elec-

tronic option to apply for, receive, monitor, and close out their Federal grant awards without using the traditional paper mechanisms. The FGSP will also take the lead in coordinating recommendations for improvement throughout the Federal grant-making arena, the grantee communities, and, as necessary, with the Congress.

Efforts to Reduce Program Management Risks in Medicare

The General Accounting Office (GAO) has identified the Medicare program on its High Risk list since 1990, citing "inordinate program management risks." The Medicare program is complex and its size is vast, at 11% of the entire federal budget, and approximately 18% of our nation's health care dollars (1999 estimate per HCFA Office of the Actuary).

Areas of concern cited by GAO include 1) problems ensuring appropriate claim payments, 2) integrity issues in Medicare + Choice, and 3) inadequate information systems.

In order to help ensure appropriate claim payments, HCFA:

- Has begun using national review teams to conduct contractor evaluations.
- Established an executive-level position at its central office with responsibility for contractor oversight.
- Hired several public accounting firms to review overall internal control design and the effectiveness of financial controls at 54 Medicare contractors and required contractors to develop corrective action plans.

In order to improve integrity issues in Medicare + Choice, HCFA adopted GAO's recommendation to tighten the definition of an institution and other recommendations for HCFA to address the formatting and content standards in the marketing of provider plan materials to improve their accuracy and completeness about covered benefits.

In addressing inadequate information systems, HCFA is working to consolidating the Medicare payment systems into three standard systems: one for fiscal intermediaries, one for carriers, and one for durable medical equipment carriers. Financial systems improvements and replacements are being conducted in accordance with ITMRA of 1996. HCFA also has a security initiative that has been outlined and encompasses all aspects of HCFA information systems security: policy, administration, training, engineering, and oversight.

HCFA management reform is an Administration priority. HCFA will undertake a major effort to modernize and streamline its operations to more effectively manage current programs and implement new legislation. In particular, HCFA's role in a modernized Medicare program needs to be carefully considered. The Administration intends to consider fundamental changes in HCFA's mission and structure as part of this effort.

For more information, see also the HCFA FY 2000 Financial Report and GAO's High Risk Series: An Update (GAO-01-263).

Financial Management Accountability: FY 2000 Accomplishments

Financial Management Strategic Goals

Goal I: **Decision-makers have timely, accurate, and useful program and financial information.**

Goal II: **All resources are used appropriately, efficiently, and effectively.**

In FY 1999 financial managers from across HHS developed a more performance-oriented plan for improving the Department's financial management. This new plan resulted in a reformatted *CFO Financial Management Status Report and Five-Year Plan*, showing performance targets for each of the next five years, as well as baseline information for each performance measure (where available). HHS developed two broad strategic goals for financial management that will help build the Department's financial management infrastructure and carry out its mission.

All of the CFO Five-Year Plan's strategies, activities, and performance measures support one or the other of these two goals. The *FY 2000 CFO Five-Year Plan* is organized by these two broad strategic goals, which are supported by almost 100 financial performance measures and targets.

This *Accountability Report* provides actual FY 2000 performance results compared to the FY 2000 performance targets for key measures. A four-year historical trend of actual results is presented, where information is available.

When performance meets or exceeds a target, it is noted with a bulls-eye, shown to the right. Where targets have not yet been met, a discussion is included in this report.

A bull's-eye denotes performance that met or exceeded the FY 2000 target.

HHS Financial Management Actual Performance Results

Financial Management Strategic Goal I: Decision-makers have timely, accurate, and useful program and financial information.

Measure	Baseline	Performance Trend				FY 2000 Target	Performance/Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual	FY 2000 Actual		
Audited financial statements for HHS and HCFA are submitted to OMB by 3/1 as required by GMRA	1996: No	No	Yes	Yes	Yes 	Yes	
Clean opinion= Yes; Other = No	1996: No	No	No	Yes	Yes 	Yes	See auditor's opinion in Section V.

table continues . . .

HHS Financial Management Actual Performance Results, continued

Financial Management Strategic Goal I: Decision-makers have timely, accurate, and useful program and financial information, continued.

Measure	Baseline	Performance Trend				FY 2000 Target	Performance/Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual	FY 2000 Actual		
Number of department-level material weaknesses	1996: 5	5 Monitoring Medicare fee-for-service rate; Medicare payables; financial reporting; grant accounting; and EDP	3 Medicare accounts receivable; Medicare EDP, and financial reporting	3 Medicare accounts receivable; Medicare EDP; and financial reporting	2 Financial systems and processes; Medicare EDP 	3 Medicare accounts receivable, Medicare electronic data processing, and financial reporting	See auditor's opinion in Section V.
Number of department-level reportable conditions	1997	3 Property, plant, and equipment; grant monitoring using single audit reports; and estimating losses from pending litigation	5 Departmental accounts payable; Medicaid estimated improper payments; EDP; property, plant, and equipment; and estimating losses from pending litigation	4 HCFA regional office oversight; Medicaid improper payments; ED; and property, plant, and equipment	2 Medicaid error rate; EDP 	3 *(revised)* Medicare regional office oversight, Medicaid error rate, EDP	See auditor's opinion in Section V.
Submit *Accountability Report* to OMB by March 1	1997	No	Yes	Yes	Yes 	Yes	
Receive the Association of Government Accountant's Certificate of Excellence on Accountability Reporting	1999	Not applicable	Not applicable	No	TBD	Yes	Awards will be announced in the Fall of 2001.
Percentage of HHS components providing grants data to Tracking Accountability in Government Grants System (TAGGS)	1998	Not applicable	83% 10 of 12	100% 12 of 12	100% 12 of 12 	100% 12 of 12	
Payment Management System (PMS) stage of development and implementation		Under development	Under development	Under development	Operational July 2000 	In production beginning of 4th quarter	
Financial Assistance Reporting System (FARS) stage of implementation		Under development	Under development	Under development	Under development 	New system under development	
Percent of Department Accounting Manual (DAM) chapters on the Internet	1998	Not applicable	18.2%	48%	100% 	46% 24 of 52	While all chapters are posted, some need updating. See next measure.

table continues . . .

HHS Financial Management Actual Performance Results, continued

Financial Management Strategic Goal I: Decision-makers have timely, accurate, and useful program and financial information, continued.

Measure	Baseline	Performance Trend				FY 2000 Target	Performance/Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual	FY 2000 Actual		
Percent of DAM chapters on the Internet that are current (not needing updates)	2000	Not applicable	Not applicable	Not applicable	44%	46%	In FY 2000 25 chapters were current; 32 need updates.
Percent of grant administration policies that are current	1998	Not applicable	75%	85%	93% 	93% *(revised)*	85% of GAM chapters were replaced; 100% of all GPDs were reevaluated.
Percent of HHS Travel Manual chapters (domestic) updated and posted on the HHS Internet	1999	Not applicable	Not applicable	0 %	4% 	3%	1 of 21 chapters was issued and updated in FY 2000. As of December 2000, 7 chapters (33%) were updated and issued.

Financial Management Strategic Goal II: All resources are used appropriately, efficiently, and effectively.

Measure	Baseline	Performance Trend				FY 2000 Target	Performance/Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual	FY 2000 Actual		
Percent of vendor payments made on time.	1997	89.7%	91%	96.4%	96.6% 	95%	See Section VI of this report for details.
Grant payments via EFT	1997	100%	100%	100%	100% 	100%	Achieved target.
Salary payments via EFT	1997	98%	97%	99%	99%	100%	Substantially achieved target.
Vendor payments via EFT	1997	42%	77%	85%	86% 	85%	Exceeded target.
Travel payments via EFT	1997	43%	90%	93%	95% 	75% *(revised)*	Exceeded target.
Percent of individually billed travel accounts that are past due 60 or more days	2000	Not applicable	Not applicable	Not applicable	11.1% 	17.6%	While 11.1% of individually billed dollar balances were delinquent 60 days or more at FY end, this represented only 3.1% of card holders. Targets are likely to be adjusted downward in the future, but began high to reflect delinquency rates associated with the program early on.
Percent of centrally billed travel accounts that are past due 60 or more days	2000	Not applicable	Not applicable	Not applicable	27.5%	12.6%	While FY end dollar balances of centrally billed accounts past due 60 days or more stood at 27.5%, the next month (October 2000) it dropped to approximately 4%.
Percentage of eligible purchase transactions made on credit cards	1997	77%	70%	85%	84%	85%	Substantially met target.
Increase percent of collections over prior year	1998	Not applicable	$13.3 billion	7% increase $14.27 billion	7.2% increase $15.3 billion	10% increase $15.7 billion	

table continues . . .

HHS Financial Management Actual Performance Results, continued

Financial Management Strategic Goal II: All resources are used appropriately, efficiently, and effectively, continued.

Measure	Baseline	Performance Trend				FY 2000 Target	Performance/Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual	FY 2000 Actual		
Percent of eligible non-waived delinquent debt referred for cross-servicing to the Treasury	1998	Not applicable	0%	22.8%	41.9%	100%	Though we did not achieve our target of 100%, we made significant improvements over FY 1999.
Percent of eligible waived delinquent debt referred to PSC for cross-servicing	1999	Not applicable	Not applicable	3.7%	26.2%	100%	Though we did not achieve our target of 100%, we made significant improvements over FY 1999.
Percent of eligible delinquent debt referred to the Treasury for offset	1998	Not applicable	20.2%	10.5%	34.2%	100%	Though we did not achieve our target of 100%, we made significant improvements over FY 1999.
Results of the departmental biannual surveys of the component customers on the effectiveness of grant, procurement, and logistics policies	1998	Not applicable	3.4 of 5	Not applicable	TBD	3.9 rating	Survey of FY 2000 performance will be conducted in FY 2001
Composite Acquisition Balanced Scorecard results.	2000	Not applicable	Not applicable	Not applicable	Completed refinement of baseline	Complete refinement of baseline.	
Number of HHS components with established IT architecture and investment analysis/capital planning processes	1998	Not applicable	2	6	11	8	11 of 13 have architecture. 12 of 13 have Information Technology Investment Review Boards (ITIRBs).
Percent of IT investments approved by the ITIRB meet review criteria	1999	Not applicable	Two meetings of the ITIRB were held	100%	100%	100%	10% of investments reviewed by the ITIRB met review criteria in FY 2000.
Location accuracy of capitalized personal property records	1998	Not applicable	90%	97%	97%	94% *(revised)*	Exceeded target.
Reduce energy consumption at HHS standard office facilities	1985	Not available	Not available	Not available	17.5% below baseline	16.5% below baseline	In prior years, standard and energy intensive statistics were combined. FY 2000 reduction is compared to 1985 baseline per EO 13123.
Reduce energy consumption at HHS energy intensive facilities	1990	Not available	Not available	Not available	12.3%	18.7% below baseline	In prior years the standard and energy intensive statistics were combined. FY 2000 reduction is compared to 1990 baseline per EO 13123.
Number of department-level FMFIA material weaknesses pending at year end	1997	6 2 ACF, 1 FDA, 3 HCFA, 1 NIH	4 2 HRSA, 1 FDA, 1 HCFA	6 1 department-wide, 1 ACF, 2 HCFA, 1 FDA, 1 NIH	4 1 department-wide, 1 HCFA, 1 FDA, 1 NIH	6 *(revised)*	See Section VI of this report for details.

table continues . . .

HHS Financial Management Actual Performance Results, continued

Financial Management Strategic Goal II: All resources are used appropriately, efficiently, and effectively, continued.

Measure	Baseline	Performance Trend				FY 2000 Target	Performance/Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual	FY 2000 Actual		
Amount of outlay variance compared with outlay estimate	1997	1.7%	–1.60%	–2.90%	–1.8%	±1.0%	Although performance improved, Medicare outlay variances again prevented HHS from meeting this goal. (Excluding Medicare, the variance was -0.9%.)
Percentage of apportionments approved within three weeks	1997	46%	45.90%	76.60%	65.4%	75% *(revised)*	
Percentage of apportionments approved within four weeks	1997	70%	56.8%	91%	77%	90% *(revised)*	
Number of departmental-level EDP material weaknesses	1997	1	1	1 Medicare contractors and HCFA central office systems access and control.	1 Medicare	1	See auditor's opinion in Section V of this report.
Number of departmental-level EDP reportable conditions	1997	0	0	1	1	1	See auditor's opinion in Section V of this report.
Reduction of average time for resolution of audits compared with prior year	1998	Not applicable	151 days	25% reduction 113 days	4.5% increase 120 days	3%	FY 2000 increase is due to the loss of two key staff members.
Number of financial management training hours offered times the number of attendees at ASMB sponsored training sessions	1998	Not applicable	480 hours	2540 hours	1606 hours	700 hours	The ASMB/Finance Office awarded more than 1400 continuing professional eduction (CPE) hours
HHS receives and retains official certification as a finance CPE sponsor	1998	Not applicable	No	Yes	Yes	Yes	
Results of HHS component customer surveys conducted biannually by the Office of Grants and Acquisition Management (OGAM) on the effectiveness of grant, procurement, and logistics training	1998	Not applicable	3.4 of 5	Not applicable	TBD	3.9 of a 0–5 scale	Survey of FY 2000 training will be conduced in FY 2001.
Average numbers of days from HHS component finance position vacancy to employee start date	1998	Not applicable	113	N/A	95.2 days average	86	
Number of HHS components with succession planning strategies for financial management staff	1998	Not applicable	2 NIH, HRSA	3 NIH, HRSA, PSC	3 NIH, HRSA, PSC	4 PSC, NIH, HRSA, and FDA	FDA's succession plan was delayed due to a major accounting reorganization.