Performance and Accountability Report

Fiscal Year 2003

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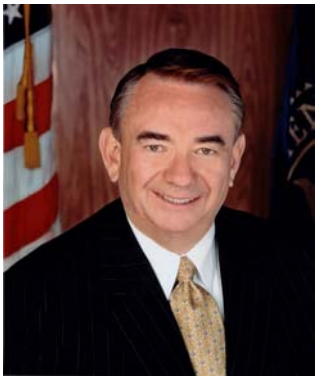
MESSAGE FROM THE SECRETARY



In 2003, the U.S. Department of Health and Human Services (HHS) marked its 50th anniversary as a cabinet-level agency. The change and growth we have experienced in those 50 years is enormous. In terms of budget and programs, we have become the largest department in the Federal Government, with almost a quarter of total federal outlays. We administer more grant dollars than all other federal agencies combined. Our Medicare program processes more than 1 billion claims per year. Our Food and Drug Administration alone regulates products that represent 25 cents of every dollar in U.S. consumer spending. In so many ways, HHS is the federal agency that most affects Americans in their everyday lives.

In the 21st century, the pace of change seems sure to grow even faster and with it, the Department's responsibilities. We are at the vanguard of a revolution in biomedical research and development. We have special new responsibilities in protecting Americans from terrorism. Globalization demands new approaches in many health and social programs. And at the same time, we are at the dawn of an unprecedented growth in the number and proportion of our older population as the baby boomers age. All of these trends, and more, are creating new and urgent demands.

This annual report is a snapshot of the Department in motion. It shows how HHS is responding to our special missions in public health as well as service to those in need. It also reflects our longer-range efforts to meet the great scientific, fiscal, and management challenges that lie ahead.

In fiscal year 2003, HHS was responsible for $505 billion in net outlays. In the area of financial management, we achieved our fifth consecutive unqualified or "clean" audit opinion on the Department's consolidated financial statements. We continued vigorous efforts to ensure that America is prepared for any terrorist attack, especially the possibility of bioterrorism. These efforts also helped strengthen our public health system for coping with natural disease outbreaks, as we saw in the strong response to Severe Acute Respiratory Syndrome (SARS) in 2003. Moreover, we increased support for disease prevention, especially to help Americans understand the steps they can take to improve their own health. We took new steps in improving the quality of health care and patient safety, and we pursued new avenues for modernizing and strengthening Medicare. We also continued the build-up of our nation's community health centers, providing care especially to those without adequate health insurance.

It is my assertion that the financial information contained in this report is complete and reliable, based upon data contained in the Department's and Medicare contractors' financial information systems, and is reported in conformance with U.S. generally accepted accounting principles. Further, the financial statements have been deemed to "fairly represent" the financial condition and results of operations of the Department by our Office of Inspector General. It is also my assertion that the program performance information contained in this report is complete and reliable, based on information from the HHS component organizations.

This report includes information that satisfies the reporting requirements for the Federal Managers'

Financial Integrity Act (FMFIA) of 1982. HHS's management controls are in compliance with FMFIA and provide reasonable assurance that the Department's resources are protected from fraud, abuse, and mismanagement. Our financial management information systems and reporting processes, as well as our Medicare contractor systems, are not in conformance with FMFIA. Our systems implementation projects discussed in this report - including a new Medicare financial system - provide for long-term achievement of compliance with FMFIA. In Appendix D of this report, we present the complete FMFIA report.

Given our broad and diverse missions, we have a special responsibility to be accountable for the funds we manage and for achieving results. We have established long-term strategic goals to help steer our efforts on behalf of Americans. The report is structured in accordance with our strategic goals allowing our customers and stakeholders to track our performance more clearly.

I welcome your interest in this report. As HHS embarks on its next 50 years, we must be prepared for rapid change and difficult demands. With all of the 65,000 employees of this Department, I pledge our continued dedication, hard work, high standards and measurable results.

Tommy G. Thompson

Section I - Management Discussion and Analysis

Management Discussion and Analysis

Introduction

The Department of Health and Human Services (HHS) is the U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Spanning more than 300 programs, HHS is the Nation's largest health insurer and the U.S. Government's largest grant-making agency.

This is HHS's eighth annual accountability report, and the second to include the Department's official performance report. In this report to our "stockholders," the American public, we account for the return on the taxpayers' investment. We also provide this information for a wide array of decision-makers, including the Office of Management and Budget (OMB) and the Congress.

The *HHS FY 2003 Performance and Accountability Report* (PAR) is produced under the Reports Consolidation Act of 2000. This report covers fiscal year (FY) 2003 (October 1, 2002, through September 30, 2003). Performance information in this report covers multiple fiscal years through June 30, 2003, unless otherwise noted. The PAR contains a high level overview of:

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

The report contains a discussion of key program, management, financial, and performance information (Sections I and II). The report also includes HHS's FY 2003 financial statements that discuss the Department's financial condition (Section III), and the auditors' opinion (Section IV), which is an independent, objective assessment that provides reasonable assurance about whether the financial statements are free from material misstatements. Finally, this comprehensive report contains other streamlined statutorily required reports that demonstrate management accountability, financial, and program performance (Section V).

This single report provides a more complete, accurate, and useful understanding of the Department. Many of our components also issue similar reports, which provide detailed program and financial information.

Mission and Strategic Goals

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

HHS's Mission:

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

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

Secretary Thompson has identified a number of high priority goals needing urgent attention, including preparedness for terrorism incidents, emphasis on healthy choices and disease prevention activities for Americans, and continued progress in helping all Americans become self-sufficient. He has also aimed at increased cooperation between HHS and its partners and stakeholders, encouraged states to be more innovative, and pushed for reform of unnecessarily burdensome HHS regulations. To carry out its mission, HHS articulates these priorities in its draft FY 2004 - FY 2009 strategic plan through eight strategic goals. In the Department's performance report (Section II) and the performance overview later in this section, performance measures are aligned with these revised goals in anticipation of their implementation. HHS has also aligned its efforts with the initiatives of the President's Management Agenda (PMA), which articulates the Administration's strategy for "improving the management and performance of government."

HHS's Strategic Goals:

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

Scope of Services

HHS works toward accomplishing these goals through managing and delivering more than 300 programs across several disciplines. The list below illustrates the breadth of activities that occur at HHS and indicates the Strategic Goals that they support.

- Conduct and sponsor medical and social science research to improve Americans' health and well-being (Goal 4);
- Guard against the outbreak of infectious diseases through immunization services and the elimination of environmental health hazards near people's homes and work places (Goals 1 and 2);
- Assure the safety of food and drugs (Goal 2);
- Provide health services for elderly and disabled Americans, as well as low-income adults and children (Goal 3);
- Promote the availability of home- and community-based services (Goal 6);
- Provide financial assistance and employment support services for low-income families (Goal 6);
- Facilitate child support enforcement (Goal 7);
- Improve maternal and infant health (Goal 3);
- Improve preschool development and learning readiness (Goal 7);
- Prevent child abuse and domestic violence (Goal 7);

- Provide and improve substance abuse prevention and treatment services (Goal 1);
- Provide and improve mental health services (Goal 6); and
- Provide services for older Americans (Goal 6).

One HHS

HHS's over-arching central direction is to function as a single entity, as "One HHS ," rather than as a collection of disparate and unrelated agencies. To this end, HHS is reforming Department management processes, improving its programs, and continues to increasingly collaborate and coordinate significant activities among HHS agencies. The importance of a one-team approach has been underlined by the extensive new demands on HHS and its agencies to rapidly enhance preparedness against terrorism. The HHS Strategic Plan contains a management improvement and excellence goal, which includes strategies to consolidate personnel offices; modernize and improve human, financial, and technological management at HHS; and reform regulations to reduce excessive paperwork and burden on doctors and hospitals so that they may have more time to deliver quality care. To provide accountability, feedback, and a record of progress, HHS has instituted performance contracts (tied to the strategic goals and objectives) for its senior leadership. These contracts establish explicit standards to measure HHS officials' progress and achievements, which will cascade throughout the Department.

HHS Partners - Working Together

HHS's ability to meet client needs and accomplish its goals is directly tied to the commitment, cooperation, and success generated by HHS employees and those of other federal agencies, state and local governments, tribal organizations, community-based organizations, faith-based organizations, and others.

HHS provides direct services for the underserved populations of America, including American Indians and Alaska Natives. However, for many programs, HHS's partners provide direct services and have great discretion in how the programs are implemented. In those cases, HHS contributes to goal accomplishment by providing funding, technical assistance, information dissemination, education, training, research, and demonstration projects.

Often the needs of individuals and families transcend individual HHS program boundaries. HHS works internally and with its many, diverse partners to coordinate service planning and delivery to optimize resource use, for example:

- HHS is the largest grant-making agency in the Federal Government, providing more than $200 billion of the more than $350 billion in federal funds awarded to states and other entities in FY 2002;
- HHS funds more than 50,000 research investigators affiliated with about 2,000 university, hospital, and other research facilities;
- HHS helps fund and foster a nationwide network of more than 3,400 community health center sites that provided primary and preventive care to 11.32 million medically underserved patients last year;
- HHS partners with the Aging Network, which includes 56 state units on aging, 655 area agencies on aging, 243 tribal and native organizations representing 300 American Indian and Alaska Native tribal organizations, and two organizations serving Native Hawaiians, plus more than 29,000 service providers and innumerable caregivers and volunteers;
- HHS supports networks of state and private agencies to provide and improve substance abuse and mental health services;

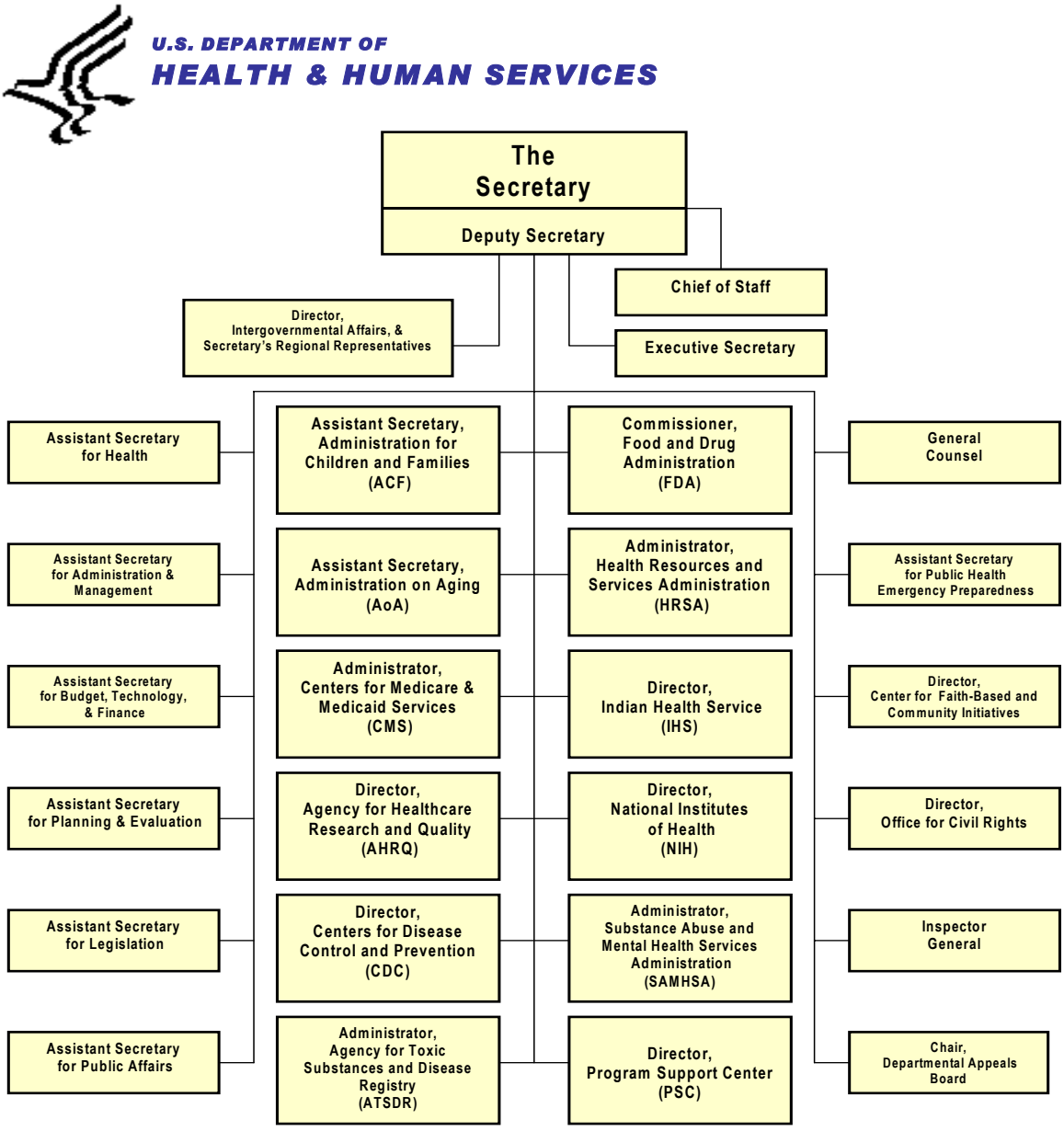
- HHS coordinates public health efforts to respond to multiple widespread disease outbreaks, including the West Nile virus epidemic, the global outbreak of Severe Acute Respiratory Syndrome (SARS), and the first U.S. human cases of monkeypox;
- Medicare contractors process over 1 billion fee-for-service claims, answer over 45 million inquiries, process over 4 million appeals, enroll and educate providers, and assist beneficiaries;
- Approximately 18,865 centers and 49,800 classrooms help to provide comprehensive development services with HHS support under the Head Start program for more than 912,000 low-income pre-school children, ages birth to five, including approximately 62,000 children under the age of three served through Early Head Start; and
- More than 45,000 health care providers are enrolled in the Vaccines for Children Program, furnishing free vaccines to more than one-third of our Nation's children.

Steps to a Healthier US

The value and benefits of partnership are particularly evident in the Steps to a HealthierUS initiative. Steps to a HealthierUS is the new prevention initiative for the Nation which was launched in April of 2003. This initiative provides a blueprint for a healthy, strong Nation where diseases are prevented when possible, controlled as necessary, and treated as appropriate. Specifically, Steps to a HealthierUS targets diabetes, obesity, and asthma, and the associated lifestyle choices of nutrition, physical activity, and tobacco use. Many of the HHS's agencies including AoA, CDC, NIH, FDA, AHRQ, HRSA, IHS, and CMS are participating and collaborating in this program. Moreover, the centerpiece of this initiative is a cooperative agreement grant program that relies on public-private partnerships at the community level to support programs and activities that enable people to adopt healthy lifestyles that prevent or delay chronic diseases. More information on this initiative is available at www.healthierUS.gov .

HHS Organization - Structured to Accomplish our Mission

HHS is made up of eleven agencies and led by the Office of the Secretary (OS). The OS consists of several staff divisions, including the Assistant Secretary for Budget, Technology, and Finance (ASBTF). The ASBTF is responsible for producing this report. HHS also actively coordinates, in ten regions throughout the U.S., the crosscutting and complementary efforts that are needed to accomplish our mission. HHS Headquarters is located at 200 Independence Avenue, SW, Washington, DC, 20201. The following pages provide a brief overview of HHS's organization and the purpose and accomplishments of each HHS agency, as well as a twelfth HHS organization, the Program Support Center (PSC), which provides administrative services to the Department.


U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES
The Secretary
Deputy Secretary
Chief of Staff
Executive Secretary
Director, Intergovernmental Affairs, & Secretary's Regional Representatives
Assistant Secretary for Health
Assistant Secretary for Administration & Management
Assistant Secretary for Budget, Technology, & Finance
Assistant Secretary for Planning & Evaluation
Assistant Secretary for Legislation
Assistant Secretary for Public Affairs
Assistant Secretary, Administration for Children and Families (ACF)
Assistant Secretary, Administration on Aging (AoA)
Administrator, Centers for Medicare & Medicaid Services (CMS)
Director, Agency for Healthcare Research and Quality (AHRQ)
Director, Centers for Disease Control and Prevention (CDC)
Administrator, Agency for Toxic Substances and Disease Registry (ATSDR)
Commissioner, Food and Drug Administration (FDA)
Administrator, Health Resources and Services Administration (HRSA)
Director, Indian Health Service (IHS)
Director, National Institutes of Health (NIH)
Administrator, Substance Abuse and Mental Health Services Administration (SAMHSA)
Director, Program Support Center (PSC)
General Counsel
Assistant Secretary for Public Health Emergency Preparedness
Director, Center for Faith-Based and Community Initiatives
Director, Office for Civil Rights
Inspector General
Chair, Departmental Appeals Board

HHS Agency	HHS Agency Description and Highlights
Administration for Children and Families (ACF) www.acf.hhs.gov	ACF administers approximately 60 programs that promote the economic and social well-being of families, children, individuals, and communities. Major ACF programs include Temporary Assistance for Needy Families (TANF), Child Support Enforcement, and Head Start for preschool children. ACF provides funds to help low-income families pay for childcare, to prevent child abuse and domestic violence, and to support state programs providing for foster care and adoption assistance. Established in 1991 as a result of a merger of the Family Support Administration and the Office of Human Development Services, ACF has eight program offices and five staff offices that operate in Washington, DC, and ten regional offices. A predecessor agency, the Social and Rehabilitation Service, was created within the Welfare Administration in 1963.
	ACF Highlights: • Record numbers of people are moving from welfare to work. Since the August 1996 passage of Personal Responsibility and Work Opportunity Reconciliation Act, recipient caseloads are down by 58%. Job retention rates are promising and all states met the TANF all-families work participation requirements in FY 2002. • The Head Start program established a National Reporting System to track the progress and accomplishments of all four and five-year old Head Start children on specific child outcomes. In FY 2003, Head Start served more than 912,000 low-income pre-school children including 62,000 children under the age of three and 121,000 children with disabilities. Head Start children completing the program are achieving an average 32 percent gain in word knowledge compared to an average gain of 19 percent among all children during the pre-K year. • The Children's Bureau has implemented Child and Family Services reviews which track outcomes for children and families in the areas of safety-permanency and child and family well-being. 268,000 children were adopted from the child welfare system in FY 1997-2002. Significant proportions of these adoptions were children who had been in the system for a long time. • The Office of Child Support has increased the paternity establishment percentage among children born out of wedlock and increased the percentage of Social Security Act IV-D cases having support orders. In FY 2002, over 70% of parents who sought help from the child support enforcement program have child support orders in place (up from 66% in FY 2001). Nearly 70% of the cases with orders received collections.
Administration on Aging (AoA) www.aoa.gov	AoA is the federal focal point for aging programs and services. Through policy and program development, planning, and service delivery, AoA seeks to address the needs and concerns of older people, their families and their caregivers. AoA leverages its funds through a nationwide service infrastructure to deliver comprehensive in-home and community-based services, including nutrition services, to the elderly. AoA funds also make preventive health services, elder rights and long-term care ombudsmen programs available to elderly Americans. Established in 1965, AoA partners with state and area agencies on aging, tribal organizations, and service providers within the aging network to accomplish its mission.
	AOA Highlights: • In partnership with CMS, co-led the creation of Aging and Disability Resource Centers to provide consumers with objective information about long-term care options and to help states create citizen-centered care systems by increasing community-based care choices and controlling costs. • Continued the implementation of the National Family Caregiver Support Program, which (based on preliminary data) provided: (1) program and service information to over 3.8 million caregivers; (2) access assistance services to approximately 436,000 caregivers; (3) counseling and training services to almost 180,000 caregivers;(4) respite to over 70,000 caregivers; and (5) supplemental services to over 50,000 caregivers in FY 2002. • Helped seniors to remain in their homes and in their communities by providing a variety of supportive and nutrition services in FY 2001, including over 40 million rides to doctors offices, grocery stores, and other critical daily activities; almost 260 million congregate and home-delivered meals; and approximately 23 million hours of in-home services such as personal care, homemaker, and chore services.

HHS Agency	HHS Agency Description and Highlights
Agency for Healthcare Research and Quality (AHRQ) **www.ahrq.gov**	AHRQ leverages its research and information-sharing programs to improve the quality, effectiveness, and accessibility of health care; and to reduce health care costs. AHRQ conducts and supports the research needed to guide decision-making and improvements in both clinical care and health care organization and financing. Furthermore, the agency also promotes the incorporation of its and other research-based information into effective health care choices and treatment by developing tools for public and private decision-makers and by broadly disseminating the results of the research. Established in December 1989 as a Public Health Service agency in HHS, the Agency for Health Care Policy and Research (AHCPR) was reauthorized as AHRQ on December 6, 1999. Located in Rockville, MD, AHRQ operates five centers as well as its special policy and information offices.
	AHRQ Highlights: • AHRQ's U.S. Preventive Services Task Force issued a number of recommendations in FY 2003, including breastfeeding counseling, hormone replacement therapy, prostate cancer screening, routine dietary counseling, cervical cancer screening, gestational and type 2 diabetes screening, and routine screening for dementia. • On behalf of the HHS Patient Safety Task Force, AHRQ and its partners began development of a new Patient Safety Database. • AHRQ launched its web-based National Quality Measures Clearinghouse (NQMC) at http://www.qualitymeasures.ahrq.gov. The NQMC will contain the most current evidence-based quality measures and measure sets available to evaluate and improve the quality of health care. • AHRQ developed the newly published Mortality and Morbidity (M&M) website (http://webmm.ahrq.gov), a monthly peer-reviewed, web-based medical journal that showcases patient safety lessons drawn from actual cases of near misses (medical errors that result in no harm) in order to educate health care providers about medical errors in a blame-free environment. • Agencies, grantees, and preparedness constituencies are using AHRQ bioterrorism research findings as a basis for planning activities, including capacity, regional models of response and readiness, health care personnel training and disaster drills, information technology (IT) and communication technology for surveillance and response, medication and vaccination distribution, and facilities and equipment preparedness needs.
Agency for Toxic Substances and Disease Registry (ATSDR) **www.atsdr.cdc.gov**	ATSDR helps to prevent exposure to hazardous substances and adverse human health effects and diminished quality of life associated with exposure to them. Funded through the Hazardous Substances Superfund established by the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, ATSDR is a separate entity within HHS, which is administered by the Centers for Disease Control and Prevention (CDC). As such, the CDC financial statements include results of ATSDR operations. Established in 1980 and headquartered with CDC in Atlanta, GA, ATSDR conducts public health assessments, health studies, surveillance activities, and health education training in communities around waste sites on the Environmental Protection Agency's National Priorities List. ATSDR also has developed toxicological profiles of hazardous chemicals found at these sites.
	ATSDR Highlights: • Conducted toxicologic research that yielded critical information about the health effects of hazardous substances. For example, ATSDR's toxicological profiles summarize information about many of the most hazardous substances found at Superfund sites, and its interaction profiles summarize information about mixing hazardous substances. In 2003, ATSDR released a CD-ROM containing 161 toxicological profiles and 9 interaction profiles, which cover more than 250 substances. • Established Pediatric Environmental Health Specialty Units (PEHSUs) in all ten federal regions. In FY 2002, PEHSU pediatricians, who are cross-trained in environmental medicine, evaluated more than 1,500 children and provided an additional 1,500 phone consultations to other pediatricians in their regions.

HHS Agency	HHS Agency Description and Highlights
Centers for Disease Control and Prevention (CDC) www.cdc.gov	As the Nation's "Prevention Agency," CDC is the lead federal agency responsible for promoting health and quality of life by preventing and controlling disease, injury, and disability. CDC helps save lives and to reduce health costs by working with partners throughout the Nation and the world to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthy environments, and provide public health leadership and training. CDC also provides immunization services and national health statistics. CDC is well-known for its response to disease outbreaks and health crises worldwide. Established in 1946 as the Communicable Disease Center, CDC operates out of its national headquarters in Atlanta, GA, 15 other field offices and 8 quarantine stations throughout the United States and territories, more than 47 foreign countries and 47 state health departments, and numerous local health agencies.
	CDC Highlights: • Coordinated public health efforts to respond to multiple widespread disease outbreaks, including the West Nile Virus epidemic, the global outbreak of SARS, and the first human cases of monkeypox in the U.S. CDC response involved surveillance and epidemiology, laboratory and special transmission investigations, infection control and containment strategies, and communication with U.S. public health officials. • Helped prepare the Nation for future terror attacks by analyzing eight metropolitan areas to assess surveillance capacities for early detection of terrorist events and to identify tools and resources. CDC also developed an *Inventory of Terrorism-related Surveillance Systems and Projects* to store and analyze information collected from 101 terrorism-related surveillance systems and projects from throughout CDC. • Expanded access to crucial health information for public health practitioners, the public, and CDC partners by using its web-site, which had a peak of 17 million visitors during April 2003, to provide public health practice guidelines and intervention information; by continuing to develop the Health Alert Network; by publishing and distributing print and electronic publications, and by using the Epidemic Information Exchange (Epi-X) to post information about the outbreak, spread, and prevention of SARS. • Acted to reduce the leading causes of death and disability by: (1) addressing diabetes, asthma, and obesity through participation in *Steps to a HealthierUS* initiative; (2) strengthening state and local programs that target heart disease and stroke, cancer, and diabetes and their principal risk factors; (3) striving to reduce injury and disability through collecting and studying injury surveillance data, and conducting and testing programs and interventions; and (4) reducing childhood lead poisoning, one of the most preventable environmental health diseases affecting children in the U.S. (from 890,000 affected U.S. children in 1988 to 434,000 between 1999 and 2000), through screening, treatment and intervention referrals, and education.
Centers for Medicare and Medicaid Services (CMS) www.cms.gov	CMS administers the Medicare and Medicaid programs, and the State Children's Health Insurance Program (SCHIP), which combined, provide health care for one in four Americans. These programs' combined outlays, including state funding, represent more than 33 cents of every dollar spent on health care in the United States, making CMS one of the largest purchasers of health care in the world. Medicare provides health care coverage for elderly and disabled Americans. Medicaid, a joint federal-state program, provides health coverage for low-income persons (46 percent of enrollees are children), and also pays for nursing home coverage for low-income elderly. SCHIP, a federal-state program, provides health insurance coverage for children who otherwise would be without coverage. CMS (formerly known as the Health Care Financing Administration or HCFA) was established in 1977, incorporating the pre-existing Medicare and Medicaid programs. CMS operates from Baltimore, MD; Washington, DC; and ten regional offices.

HHS Agency	HHS Agency Description and Highlights
CMS (continued)	CMS Highlights: • The President continued his commitment to modernize and reform Medicare in ways that will provide drug coverage, more health care options, and better choices for our seniors and people with disabilities. This summer both the House and Senate passed bills that moved us forward in that effort. CMS continues to work closely with lawmakers to bring the best possible bill to the President's desk. • CMS has taken many steps toward improving the quality and satisfaction with care that beneficiaries receive. The CMS Quality Initiative empowers consumers by giving them facility-specific information with which to make better choices and encourages providers to improve their services. CMS began with nursing homes and has expanded available information to include home health agencies and is piloting a program for hospitals. • The Administration continues to take aggressive steps to increase and improve health plan options for Medicare beneficiaries. CMS expanded the successful preferred provider demonstration options and expanded the PACE (Program for All-inclusive Care for the Elderly) plans. • CMS continues to raise the service level, increase responsiveness, and reduce the paperwork burden of its programs through such activities as open door forums and other educational and informational activities. The 14 monthly and bi-monthly open door forums address issues specific to Medicare and Medicaid, focusing on areas such as hospitals, nursing homes and long-term care, physicians, home health, and durable medical equipment. • CMS continues to enhance the National Medicare & You Education Program to ensure Medicare beneficiaries and their caregivers know how to access reliable and accurate information to help them make the best health plan choices. In FY 2003, call volume to 1-800-MEDICARE increased 30 percent and page views of the www.medicare.gov website increased 25 percent as a result of CMS's outreach efforts. • In the Medicaid program, CMS took a number of steps to allow states greater flexibility to design health insurance programs to meet the health care needs of their low-income and children populations. CMS continues to be more responsive to states' requests for waivers and amendments as well. Since January 2001, CMS has approved almost 3,200 State Plan Amendments and waivers that have expanded eligibility to more than 2.2 million people and enhanced benefits for nearly 7.1 million people.
Food and Drug Administration (FDA) **www.fda.gov**	FDA is a science-based regulatory agency whose mission is to promote and protect public health and well-being by ensuring that safe and effective products reach the market in a timely manner, and to monitor products for continued safety once in use. FDA is divided into six program areas: foods, drugs, biological products, veterinary medicine, medical devices, and toxicological research. Each program area, except for toxicological research, is responsible for ensuring the safety and, where applicable, the effectiveness of products through their entire life cycle - from initial research through manufacturing, distribution, and consumption. These programs, supported by a national field force of scientific investigators, also monitor the safety of more than seven million import shipments that arrive at our borders each year. FDA-regulated products account for about 25 cents of every consumer dollar spent. The toxicological research program conducts peer-reviewed research that provides the basis for FDA to make sound, science-based regulatory decisions. Established in 1927 (Congress passed the Food and Drugs Act in 1906), FDA is headquartered in Rockville, MD, and is organized into six program centers, two offices, and five regions nation-wide.

HHS Agency	HHS Agency Description and Highlights
FDA (continued)	FDA Highlights: • Published the four food safety proposed regulations required by the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, which gave the Agency expanded authority to protect the nation's food supply. • Approved Strattera, the first new drug in three decades for treatment of symptoms of attention deficit hyperactivity disorder (ADHD), and FluMist, a flu shot alternative, to prevent influenza illness due to influenza vaccination A and B viruses in healthy persons, ages 5 - 49. • Implemented the Medical Device User Fee and Modernization Act of 2002 which provides resources to perform medical device review. • Participated in Operation Liberty Shield with increased monitoring of imported foods along with increased food facility inspections and products sampling. • Investigated the counterfeiting of several contaminated products including two major drugs.
Health Resources and Services Administration (HRSA) **www.hrsa.gov**	HRSA, an important component of the Nation's health safety net, improves the Nation's health by helping to assure equitable access to comprehensive, quality health care. HRSA and its state, local, and other partners work to eliminate barriers to care and health disparities for Americans who are underserved, vulnerable, and have special needs. It also works to assure the quality and availability of health care professionals and services. Established in 1982 and located in Rockville, MD, HRSA operates through four bureaus and several offices to support comprehensive primary care services, decrease infant mortality, improve maternal and child health, provide services to people with Acquired Immune Deficiency Syndrome (AIDS) through the Ryan White Comprehensive AIDS Resources Emergency (Ryan White CARE) Act programs, and oversee the Nation's organ transplantation and bone marrow donor systems. HRSA also works to build the health care workforce and maintains the National Health Service Corps.
	HRSA Highlights • As part of a Presidential initiative to assure access to needed care, the Health Centers program added 171 new service sites in FY 2002 and substantially expanded an additional 131 sites, thereby increasing the capacity to serve an estimated 11.32 million persons, up from 10.3 million in 2001. • Through the Ryan White Care Act's State AIDS Drug Assistance Program (ADAP), nearly 74,000 individuals received essential HIV/AIDS medications for at least one month during the year in FY 2001, exceeding the previous year's number by nearly 3,500 persons. • In FY 2002, more than 75% of National Health Service Corps clinicians remained in service to underserved areas for at least one year following completion of their service contracts. • In FY 2003, HRSA released 16 grants that fund scholarships, stipends, and pre-entry preparation and retention activities for disadvantaged students, including students from racial and ethnic minority groups that are underrepresented among registered nurses. The grants help ensure that a competent health profession is prepared and available in areas where care is needed most.

HHS Agency	HHS Agency Description and Highlights
Indian Health Service (IHS) www.ihs.gov	IHS is the principal federal health care provider and health advocate for American Indian people, who experience the lowest life expectancies in the country for both men and women. In partnership with American Indians and Alaska Natives from more than 557 federally recognized tribes, IHS's mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. IHS and the Indian tribes are responsible for serving 1.5 million American Indians and Alaska Natives through direct delivery of local health services. IHS was established in 1924 (mission transferred from the Department of Interior in 1955) and funds hospitals, health centers, school health centers, and health stations, which are administered by Indian tribes or IHS itself. There are also 34 health programs operated by urban Indian Health Organizations that provide various services to American Indians and Alaskan Natives living in urban areas of the country. When unavailable from IHS or the Indian tribes, IHS also purchases medical services from other providers to ensure delivery of needed care. IHS is headquartered in Rockville, MD, and its 12 area offices are further divided into service units for reservations or population concentration.
	IHS Highlights: • Developed and implemented the Behavioral Health Management Information System (BHMIS) to more effectively document services and analyze trend data at over 100 tribal sites. • Monitored diabetic control in over 75% of treated diabetics on a routine basis (HP 2010 goal is 50% monitoring). • Increased Pneumococcal vaccination rates to 65% of adults over 65 years old. • Developed and implemented asthma case management software to increase compliance with clinical practice guidelines and track clinical outcomes of asthma patients.
National Institutes of Health (NIH) www.nih.gov	NIH is the world's premier medical research organization supporting research projects nation-wide in diseases such as cancer, Alzheimer's, diabetes, arthritis, heart ailments, and AIDS. NIH Institutes and Centers improve the health of all Americans by advancing medical knowledge and sustaining the Nation's medical research capacity in disease diagnosis, treatment, and prevention. More than 8 out of every 10 dollars appropriated to NIH flows out to the scientific community at large. NIH's research activities extend from basic research that explores the fundamental workings of biological systems, to studies that examine disease and treatments in clinical settings, to prevention, and to population-based analyses of health status and needs. Established in 1887 as the Hygienic Laboratory in Staten Island, NY, NIH provides scientific leadership and establishes research priorities, funds the best research in the scientific community at large, and conducts leading-edge research in NIH laboratories. NIH also disseminates scientific results and information, facilitates the development of health-related products, ensures a continuing supply of well-trained laboratory and clinical investigators, sustains the Nation's research facilities, and collaborates with other federal agencies. NIH is located in Bethesda, MD.
	NIH Highlights: • In April 2003, The International Human Genome Sequencing Consortium, led in the U.S. by the NIH National Human Genome Research Institute (NHGRI) and the Department of Energy (DOE), announced the successful completion of the Human Genome Project more than two years ahead of schedule. The sequencing of the human genome - which contains 3 billion DNA letters - now is essentially complete. • NIH-funded scientists have reported that, by blocking a particular enzyme, lithium slows the accumulation of the protein thought to form Alzheimer's plaques. This scientific advance will aid investigators in attaining their goal of identifying clinical interventions to delay the progression, delay the onset, or prevent Alzheimer's disease. • NIH-supported researchers have fully mapped the DNA sequence of the deadly anthrax microbe, *Bacillus anthracis*. Researchers also found a number of genes that play a crucial role for the bacterium's ability to enter its host's cells. This type of genetic information is invaluable in providing new drug targets to fight against a dangerous pathogen.

HHS Agency	HHS Agency Description and Highlights
Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov	SAMHSA is the lead federal agency for substance abuse and mental health services, enabling service capacity expansion and the implementation of evidence based practices. SAMHSA provides services indirectly through grants and contracts to non-profit organizations, universities, government agencies and Indian tribes for children, adolescents and adults. SAMHSA administers two block grants that provide funding to States and territories for direct substance abuse and mental health services, as well as discretionary grants for other recipients. SAMHSA was established in 1992 from a predecessor agency, the Alcohol, Drug Abuse and Mental Health Administration that was established in 1974. Located in Rockville, MD, SAMHSA is organized into three centers, the Center for Mental Health Services, the Center for Substance Abuse Prevention and the Center for Substance Abuse Treatment. The Agency organization also includes two program offices, the Office of the Administrator and the Office of Applied Studies.
	SAMHSA Highlights: • Implemented a new matrix of priorities and principles to focus on key programmatic issues to support SAMHSA's vision and mission. • Drafted and began using a new strategic plan that contributes directly to HHS objectives of reducing substance abuse and tobacco use, and expanding access to health care services for targeted populations with special health care needs. Health care services include behavioral health care, which is related to the programs in SAMHSA's Center for Mental Health Services. • Drafted performance measures with State partners to increase joint accountability and improve performance management, by changing SAMHSA's block grants into Performance Partnerships.
Program Support Center (PSC) (administrative office)	Established through legislation in 1995 as a Working Capital Revolving Fund under the Department's Service and Supply Fund, the PSC is an Administrative Support Center. The PSC is organizationally aligned under the Assistant Secretary for Administration and Management, Office of the Secretary, and is charged with providing a full range of program support services to all components of HHS and other Federal Agencies through fee-for-service. PSC's major business lines include administrative operations, financial management, health resources and human resources.

Transfer of HHS Operations to the Department of Homeland Security

The Homeland Security Act of 2002 established the Department of Homeland Security (DHS), whose primary missions are to (1) prevent terrorist attacks within the United States, (2) reduce America's vulnerability to terrorism, and (3) minimize the damage from potential attacks and natural disasters. The Act provided for transfer of programs and functions as well as personnel, assets, and liabilities to and from many Federal agencies, including HHS.

As a result of the Act, HHS's Office of Emergency Response, National Disaster Medical System, Metropolitan Medical Response System, and the Strategic National Stockpile were transferred to DHS. One program, the Unaccompanied Alien Children Program, was transferred to HHS from the Immigration and Naturalization Service. Additional information on these programs can be found in DHS's FY 2003 Performance and Accountability Report.

President's Management Agenda

The "President's Management Agenda" (PMA), articulates the Administration's strategy "for improving the management and performance of government." The PMA consists of five government-wide initiatives (Strategic Management of Human Capital, Competitive Sourcing and Procurement, Improved Financial Management, Electronic Government and Information System Management, and Budget and Performance Integration) and several program-specific initiatives. HHS is a significant contributor to two of the program initiatives: Broadening Health Insurance Coverage; and the Faith-Based and Community Initiative. The

following sections discuss HHS's efforts in each of the elements during FY 2003 to further the PMA and action plans to further promote progress in FY 2004.

Human Capital

HHS, like many other agencies, is undergoing a transformation of its workforce brought about by increasing retirements coupled with aggressive efforts to recruit, hire, and retain the skilled workers HHS will need in the future. Retirement eligibility continues to rise at HHS. Retirements rob the Department of institutional knowledge and in-depth familiarity with the nuances of the laws and regulations of complicated federal programs. Resignations and transfers eat away at HHS's pool of future leaders as talented and career-mobile employees move on to new positions. Addressing these challenges requires that we put in place the means to strategically manage our human capital to ensure HHS has the talent and leadership it will need.

HHS's human capital initiative is based on building the workforce of the future, recruiting new workers and actively working to retain people with essential skills. Building the workforce also means providing training and development to equip employees with the skills they will need to meet future challenges. HHS's retention efforts focus on improving the quality of work life in HHS, improving the image of the Federal Government and HHS as an employer, and maintaining high morale among HHS employees.

HHS's 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. It also supports the PMA, looking to de-layer organizations to speed decision-making, consolidate administrative functions, and re-deploy staff to mission-related activities. It is aimed at making the Department more citizen-centered and responsive to customer needs.

FY 2003 Accomplishments

- Implemented performance contracts throughout HHS linking individual performance to the Department's mission and goals.
- Delayered to four or fewer organizational layers throughout HHS.
- Continued progress on HHS's recruitment and retention strategy with the completion of a pilot study of retention factors and the expansion of a web-based exit survey department-wide.
- Hired the second class into HHS's highly successful Emerging Leaders program, which is an extremely competitive two-year program to bring high potential entry level employees into HHS and provide them with training, rotational opportunities, and mentoring. Emerging Leaders are selected in five critical career paths: Scientific; Public Health; Social Sciences; Information Technology (IT); and Administrative.
- Selected 30 candidates into HHS's new Senior Executive Service (SES) Candidate Development Program. Participants receive mentoring, and developmental experiences to prepare them for certification for the SES.

FY 2004 Action Plan

- Continue to implement recruitment and retention strategy to ensure that HHS maintains a high-quality workforce with the required skill set for mission-critical occupations.
- Recruit for and hire a third class of Emerging Leaders.
- Create HHS University for common needs training opportunities department-wide.

Competitive Sourcing

Under the scorecard criteria used in FY 2003, HHS completed public-private or direct conversion competition on more than 15 percent of the full-time equivalent (FTE) employees listed on the approved Federal Activities Inventory Reform (FAIR) Act inventories.

FY 2003 Accomplishments

- Completed seven standard competitions in an average of 12 months or less, and 38 streamlined competitions under the new OMB Circular A-76.
- The Department has completed all 38 streamlined competitions announced under the new guidelines in less than 81 days. The 38 streamlined competitions were completed in an average of 70 days or less.
- By the end of FY 2003, HHS will have completed seven standard cost comparisons in an average of 12 months or less. The largest, involving 750 FTE, lasted nine months from start to finish and concluded three months ahead of the Circular deadline. An eighth standard cost comparison for 714 FTE employees is scheduled to conclude on October 22 or ten months from start to finish. This second study is occurring in four different locations across the country.
- While all the standard competition data has not yet been thoroughly analyzed, FDA's experience with the competitive sourcing initiative has replicated the research finding that OMB Circular A-76 (A-76) competitive sourcing studies typically result in a reduction of about 20 percent in costs even if the federal organization retains the function in-house. To date, FDA has completed five standard cost comparisons in an average of 12 months or less. The total expected savings over a five-year performance period is $13.6 million with no involuntary separations. HHS calculated a productivity improvement of almost 14 percent by measuring FTE reductions against the size of the workforce at the start of the study.

FY 2004 Action Plan

- Competitive sourcing activities in FY 2004 will largely be devoted to fully integrating and standardizing the use of the newly revised A-76, meeting new scorecard criteria, and building customized competitive sourcing plans on a department-wide basis.
- One aspect of the new scorecard criteria, the creation of a green competitive sourcing plan, complements HHS's long range human capital planning. This will have the desired effect of building most efficient organizations for those functions retained in-house and carefully helping HHS manage vacancies and hiring plans.
- FY 2004 will be a pivotal year as HHS agencies shift more towards ensuring that their internal commercial activity functions are as efficient as those found in the commercial sector. A greater emphasis on long range planning will help perpetuate a culture of economy to be embraced as HHS focuses on building efficient commercial activities.

Improved Financial Management

HHS is pursuing initiatives on a number of fronts to produce accurate and timely information to support operating, budget, and policy decisions. These include both process- and systems-oriented efforts. HHS is currently in the midst of implementing a $700 million Unified Financial Management System (UFMS), as part of Secretary Thompson's "One HHS" initiative. In June 2001, Secretary Thompson stated that "...the purpose of this endeavor is to achieve greater economies of scale, eliminate duplication, and provide better service delivery." Improved systems effectiveness and efficiency, enhanced management empowerment, improved compliance with legal and regulatory requirements, and strengthened internal controls are among the anticipated benefits of this new system, scheduled for full implementation in FY 2007. Please refer to

the "Systems, Controls, and Legal Compliance" discussion on page I.45 for additional information about UFMS.

HHS has earned unqualified opinions on its financial statement audits for the past five years, since the FY 1999 reporting cycle (see the following audit findings history chart). During FY 2003, HHS implemented an accelerated reporting and auditing pilot to test the Department's capacity to meet the accelerated reporting deadlines mandated for FY 2004. This accelerated effort included the introduction of a new 'Top-Down' audit approach, which consolidated several individual HHS agency audits into a single review process.

HHS Audit Findings History: FYs 1999 - 2003

Issue	1999		2000		2001		2002		2003	
	Qual.	M.W.	Qual.	M.W.	Qual.	M.W.	Qual.	M.W.	Qual.	M.W.
Medicare/Medicaid Accounts Receivable		X		*						
Medicare EDP Controls		X		X		X		X		X
Financial Reporting Systems and Processes		X		X		X		X		X
Total	**0**	**3**	**0**	**2**	**0**	**2**	**0**	**2**	**0**	**2**
Resolved from Prior Year	2	0	0	1	0	0	0	0	0	0
New	0	0	0	0	0	0	0	0	0	0
Opinion	**Clean & Timely**		**Clean & Timely**		**Clean & Timely**		**Clean & Timely**		**Clean & Timely**	

Qual = Qualification; MW = Material Weakness

* Merged with financial reporting and processes material weaknesses.

During FY 2003, HHS continued to work on determining payment error rates for seven of its programs - Medicare, Medicaid, SCHIP, TANF, Child Care, Foster Care and Head Start. These programs together account for close to 90 percent of HHS outlays. HHS is at different stages in the process of determining improper payment rates for these programs but has made the most progress in the Medicaid, Medicare, SCHIP and Head Start programs. For the Medicaid program, CMS initiated a Medicaid Payment Accuracy Measurement (PAM) pilot and will be going in to the third year of the PAM pilot in FY 2004. During FY 2004, the PAM pilot will be expanded to include SCHIP. CMS also determined payment error rates for two Medicare claims processing systems conducted under the Comprehensive Error Rate Testing (CERT) program (see error rate discussion in the Performance Overview of this Section and in Section II of this report)

ACF determined an estimated Head Start payment error rate based on the results of reviews conducted during on-site monitoring activities for FY 2003. During FY 2004, ACF will be continuing to refine the methodology that was used in the Head Start reviews. HHS continues to make progress with other programs as well. ACF completed plans for a pilot project in the Child Care program and will be implementing their plans in FY 2004. Also, ACF completed plans for determining a payment error rate for the Foster Care program and will be starting work on this initiative early in FY 2004. Under the recently enacted Improper Payment Information Act of 2002, HHS began to evaluate other HHS programs to determine their level of susceptibility to significant improper payments in FY 2003. This work will continue in FY 2004.

Section 831 of the Defense Authorization Act for FY 2002 requires that agencies institute a recovery audit program to identify and recover amounts erroneously paid to contractors. The office of the ASBTF will be working with HHS agencies in the coming months to implement audit programs which comply with the

recovery auditing mandate.

FY 2003 Accomplishments

- Implemented an accelerated reporting pilot for FY 2003 to facilitate implementation of FY 2004 accelerated reporting deadlines.
- Submitted a plan to OMB to determine Medicaid eligibility errors and revised Medicaid pilot methodology to include the SCHIP program and to include instances of underpayment as an improper payment.
- Provided error rates for two Medicare claims processing systems conducted under the CERT program.
- Proposed legislative language for data collection to develop TANF state error rates, drafted work plans to develop erroneous payments review system for TANF and Foster Care, and implemented a plan to measure error rates for the Head Start program.
- Conducted the first pilot test of key components of the UFMS system.

FY 2004 Action Plan

- Submit FY 2004 PAR by November 15, 2004.
- Conduct a second pilot test of key components of the UFMS system.
- Continue the work on establishing improper payments for those HHS programs listed in OMB Circular A-11. This includes: (1) refining the methodology used for determining an error rate for Head Start; (2) continuing payment accuracy measurement (PAM) studies for Medicaid and SCHIP; (3) initiating a payment accuracy pilot in Child Care; and (4) beginning work on establishing a payment error rate for Foster Care.
- Complete a risk assessment of all HHS programs to identify those programs susceptible to significant improper payments as required under the Improper Payment Information Act of 2002 and begin to work on estimating amounts of erroneous payments in these programs.
- Implement recovery auditing and recovery activity as required under Section 831 of the Defense Authorization Act for Fiscal Year 2002.

E-Government

HHS's strategy for ensuring that IT enables our mission is an important component of the Department's overall modernization effort. We recognize the importance of leveraging new technologies to create a modern IT delivery system that is architecture-based. HHS has revised the "HHS Information Technology Strategic Plan" that includes a Departmental e-Gov strategy, appropriate details on decision criteria, metrics of success, costs and timetables for projects addressed in the plan, including HHS's priority-level ranking of projects and the rationale.

In the HHS Information Technology Strategic Plan, we have prioritized specific foundational technical efforts that will allow us to integrate previously disparate data sources and systems, to establish communication not just within HHS agencies, but across the Department to successfully implement e-gov initiatives, and to use internet technologies to facilitate timely and accurate exchange of content. These integrated efforts ensure better communication across our business lines, directly support mission performance goals, and create exchange avenues with other departments, corporate entities and US citizens. Concurrent to these high level projects, each HHS agency continues to maintain and develop new technologies to complement business re-engineering efforts, to increase productivity, and to improve information delivery to the public. These projects dovetail with enterprise-wide initiatives, and are compliant with the blueprints being developed as our enterprise architecture.

FY 2003 Accomplishments

- HHS has implemented centralized oversight and control of IT security at the Department level.
- Consolidated Health Informatics (CHI) partners have agreed on a target portfolio of 24 clinical health data interoperability standards; five have been issued and several others are soon to be approved.
- The Grants.gov (formerly known as E-Grants) program successfully completed implementation of a unified storefront on the Internet for citizens to access grant opportunities and also completed an electronic application prototype.
- HHS has led a new effort to establish a Federal Health Architecture (FHA) that envisions an information-driven partnership among educational, private and public agencies, and citizens through an on-line public health network.
- HHS has established an Enterprise Architecture Program to integrate IT modernization with strategic planning, capital planning, and budget processes.

FY 2004 Action Plan

- Under the IT Security program, HHS plans to have at least 90 percent of its IT systems certified and accredited.
- CHI partners will continue to review and select standards. CHI partners will issue guidance for agencies to modify their health IT architectures to include the selected standards.
- Full participation in Grants.gov of the 26 grant-making agencies is expected in FY 2004.
- HHS will facilitate collaborative development of an FHA to assure the effective exchange of health information across federal departments.
- HHS will develop and publish Enterprise Architecture blueprints with performance linkages to strategic planning and budget processes.

Budget and Performance Integration

In FY 2003, HHS has demonstrated considerable success in implementing the outcomes and deliverables identified in OMB's Management Plan Agreement, which define the milestones for successful achievement of budget and performance integration. HHS efforts in this area have focused on further integrating these elements into the Department's budget decision-making process, as well as taking active measures to improve program effectiveness; coordinate goals, objectives, and programs through a revised strategic plan; and promote accountability among program managers.

HHS has also begun using results of OMB's Program Assessment Rating Tool (PART) as a means of using program performance to inform budget decisions. PART is an instrument for assessing government programs in an objective and transparent manner. Under the PART process, agencies evaluate a program's purpose and design, planning, management, and results and accountability to determine its overall effectiveness. The PART is an accountability tool that attempts to determine the strengths and weaknesses of federal programs with a particular focus on the results individual programs produce. Its overall purpose is to lay the groundwork for evidence-based funding decisions aimed at achieving positive results. The Program Performance Overview and Appendix C of this report contain additional information on PART.

FY 2003 Accomplishments

- Developed a "One HHS" Action Plan that captures performance and budget information in a single

document.

- Successfully used the FY 2005 budget process to ensure that performance information informs budget decisions.
- Implemented a methodology for identifying the full budgetary cost of programs.
- Developed and implemented a comprehensive strategy for improving program effectiveness.
- Successfully updated the HHS Strategic Plan.
- Implemented performance-based contracts for HHS employees to promote accountability.
- Successfully participated in OMB's Program Assessment Rating Tool (PART) process for the FY 2005 budget cycle (see Appendix C).

FY 2004 Action Plan

- Develop a FY 2006 budget that completely integrates performance and budget information at the HHS agency and Department levels.
- Implement PART recommendations.
- Continue to refine and improve the implementation of full cost per revised OMB guidance.
- Strengthen and improve the measures used to track program performance.
- Ensure that budget decisions are informed by performance information.

Broadening Health Insurance Coverage

With approximately 44 million individuals in America lacking health insurance, HHS is pursuing a wide range of initiatives to expand health care coverage. HHS has been working aggressively to improve the Medicaid and SCHIP waiver process. We have given States more flexibility to expand coverage to the uninsured through the development of the Health Insurance Flexibility and Accountability Initiative and through the new Pharmacy Plus demonstration. In addition, we have developed Independence Plus demonstrations, which expedite the ability of states to offer families greater opportunities to take charge of their own health and direct their own care. Streamlined templates were developed for these three types of waivers, which facilitate provision of information and can streamline federal review and approval.

FY 2003 Accomplishments

- Increased Medicaid eligibility from October 1, 2002 to September 30, 2003 by over 63,000 people through new HHS-approved state plan amendments and waivers.
- Approved 915 state plan amendments and waivers. Approvals included 183 Home and Community-Based Services, four Independence Plus, two HIFA, five Family Planning waivers, and one Independence Plus 1115 waiver.
- Received Congressional authorization to redistribute unused SCHIP funding to states for use in future years.

FY 2004 Action Plan

- Continue to work with states to expand coverage through use of the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative, Pharmacy Plus, Family Planning, and Independence Plus waivers.
- Pursue the Administration's proposal to modernize the Medicaid and SCHIP program by introducing

more state flexibility and fiscal stability into the program; provide states with the option of continuing in the current Medicaid program or choosing partnership allotments; and provide states with flexibility to design health insurance options for their uninsured populations.

- Develop guidance to implement the law to redistribute funding to states for SCHIP.

Faith-Based and Community Initiative

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

The mission of the Center for Faith-Based and Community Initiatives (CFBCI) is to create an environment within HHS that welcomes the participation of faith-based and community organizations as valued and essential partners in assisting Americans in need. Our mission is part of HHS's focus on improving human services for our country's most needy populations.

FY 2003 Accomplishments

- The CFBCI has worked with ACF and SAMHSA to publish the Charitable Choice regulations that provide faith-based organizations with statutory guidelines they must follow to enter a funding relationship with the federal government.
- CFBCI in conjunction with ACF, CDC, HRSA and SAMHSA completed a survey of HHS grant applicants to determine number of faith-based and community organizations that applied for specific grant programs.
- All ACF discretionary 33 grant panels applicable to faith-based and community-based organizations have been trained.
- Through approximately 21 intermediary contractors, SAMHSA held approximately 51 Grassroots Training Meetings for more than 4000 individuals from faith based and community based organizations on grant writing skills.
- Through the Compassion Capital Fund at ACF, 60 new grants worth about $8.1 million collectively were awarded to multiple faith-based organizations.
    - Under the Targeted Capacity-Building, HHS announced 50 one-time, $50,000 grants (or “mini-grants”) to help faith-based and community organizations in 35 states, the District of Columbia and the Virgin Islands.
    - Under the Compassion Capital Fund Demonstration Project, HHS announced 10 new intermediary organizations. These awards, which are in larger amounts than the Targeted Capacity-Building awards, will be used to provide training and technical assistance, as well as sub-awards, to grassroots faith-based and community organizations providing social services.
- In the first year of this Mentoring Children of Prisoners program, $9 million was given to 52 organizations to train adult volunteers to serve as mentors to children whose parents are incarcerated.

FY 2004 Action Plan

- HHS CFBCI will be working to facilitate the implementation of the Charitable Choice regulations by providing training and information to federal and state officials, as well as individuals from faith-based and community organizations
- CFBCI will continue collecting data through the *Survey to Ensure Equal Opportunity* used in 2003 to determine if application from faith-based and community organizations have increased for targeted programs and improve accessibility and knowledge of those grant programs.
- SAMHSA will again be holding approximately 60 technical assistance training events throughout the country that will focus on coalition and partnership building as well as grant writing skills.
- Pending budget approval from Congress, CFBCI will work with multiple operating divisions of HHS to implement certain pilot projects that will provide more opportunities and continue exploring ways to involve faith-based and community organizations.

Program Performance Overview

A Focus on Outcomes

This section presents an overview of HHS program performance. HHS manages more than 300 programs in over 100 program performance areas whose goal is to improve the health and well-being of Americans and uses more than 650 performance measures to direct program activities and assess progress and achievement. These measures provided a basis for comparing actual program results with established program performance goals, as required by the Government Performance and Results Act of 1993 (GPRA). Given the complexity and number of HHS programs, this summary report focuses on 18 performance program areas and measures that broadly represent the most important and significant tasks HHS endeavored to accomplish in FY 2003. The program areas represented include: Bioterrorism, Medicare, Medicaid, SCHIP, TANF, Child Welfare, Substance Abuse Prevention and Treatment, Infectious Diseases, and Biomedical and Medical Research.

The 18 measures also represent program activity contributing to each of the Department's eight strategic goals. The performance information in this report documents HHS's progress in achieving its overall strategic goals and objectives, as outlined in the HHS Strategic Plan.

Performance Data Collection and Reporting

The FY 2003 Report on Program Performance by HHS Strategic Goal is presented in Section II and summarized in the following pages. For each measure, the following tables present a target and either actual data or the expected date when actual data will become available,[1] focusing on performance over the past three fiscal years (FY 2001-FY 2003). Section II provides additional trend data for each measure and a more detailed discussion of performance results. The comparative net costs of these and other HHS programs are presented in Appendix B.

Lags in performance data availability do occur, particularly in HHS programs that rely on third parties for such data. In addition, not all data collections are conducted annually. Therefore, assessment of HHS performance can best be determined by a comparison of annual trends from year to year, as additional

[1]To accommodate accelerated reporting and unless otherwise noted, performance data as of June 30 were used to record and assess performance for the purposes of this report.

performance information becomes available. HHS used the same data collection systems to report on both Department- and HHS agency-level performance.

The following table presents HHS's 18 key performance measures, the responsible HHS agency or organization, the relevant program, and whether the programs have been evaluated under OMB's Program Assessment Rating Tool (PART). PART review and rating supports the Administration's efforts to improve program effectiveness and to inform budget decisions. The PART is a diagnostic tool that examines different performance aspects to identify a program's strengths and weaknesses. The PART fiscal year noted in the table refers to the budget year and cycle to which the analysis applies. For example, a PART year of FY 2005 indicates that the analysis would have been conducted during FY 2003 as part of the FY 2005 budget submission. PART results for FY 2003 (the FY 2005 budget cycle) are presented in Appendix C. If no date appears in the PART column, then the program has not yet been evaluated under PART.

Risks and Uncertainties Affecting Performance

Many external factors and influences, beyond the control of HHS, may impede achievement of our strategic goals and objectives. These factors introduce risks and uncertainties into the Department's planning environment. Although in some cases these factors can be successfully addressed; in other cases, they pose challenges that are difficult to overcome.

For example, an economic downturn that reduces state and local government revenues may limit their ability to address the health and social service objectives of this plan. Even during the best of economic times, health and social services must compete with other worthy interests for limited public funds. In addition, a weak economy can impact individuals by making finding jobs more difficult and can affect families on welfare seeking to become economically independent.

In another example, the public health infrastructure has received new infusions of funds following September 11, 2001, to address bioterrorist and other threats. While this offers opportunities for building needed surveillance systems and communication links, unexpected threats such as SARS continue to emerge and require immediate action diverting attention from activities with a longer time horizon.

Individuals' choices about personal health habits (exercise, diet, smoking) have a cumulative effect on the incidence of chronic disease. While the Department has many current activities addressing lifestyle health choices, its new prevention initiative, Steps to a HealthierUS, seeks to assist states, large and small communities and tribes to build on their existing efforts to address diabetes, asthma and obesity and the associated risk factors of tobacco use, poor nutrition and inactivity, in organized sustained ways that can ultimately serve as models for wider use (see p. I.4).

One way HHS has addressed changing and unpredictable conditions is by providing flexibility in program requirements. For example, HHS has offered states greater choice in Medicaid and SCHIP program design through HIFA demonstrations. This flexibility allows a state to adapt its Medicaid program, within the framework of existing law, to the individual state. HHS has sought and received major new funding to address public health infrastructure needs and is working with state and local public health officials, hospitals, and other providers to build the necessary surveillance systems and communication linkages.

Section II of this report provides a detailed discussion of each of the following measures, including individual HHS agency efforts taken to ensure the relevance and reliability of the data reported. HHS agencies annually prepare individual performance plans and reports that collectively address all of the Department's program performance measures in greater detail. For more information on HHS performance measures, refer to the HHS Agency-level Performance Plans and Reports available though the HHS web-site at http://www.hhs.gov/budget/doc.gpra. These agency plans and reports and Section II of this report provide additional context and detail regarding the measures summarized in the following pages.

Summary of FY 2003 HHS Key Performance Measures

Strategic Goal	#	Measure	OPDIV	Program	PART
Strategic Goal 1: Reduce the Major Threats to the Health and Well-being of Americans	1a	Achieve or maintain immunization coverage of at least 90% in children ages 19- to 35-months in at least seven vaccines.	CDC	National Immunization Program	FY 2004
	1b	Decrease the number of perinatally transmitted AIDS cases from the 1998 baseline of 235 cases.	CDC	Domesitc HIV/AIDS Prevention Program	FY 2004
	1c	Number of substance abuse prevention and treatment clients served.	SAMSHA	Substance Abuse Prevention and Treatment Block Grant Program	FY 2005
Strategic Goal 2: Enhance the Ability of the Nation's Health Care System to Effectively Respond to Bioterrorism and Other Public Health Challenges	2a	Enhance preparedness by assuring state, territorial, and local jurisdiction projects have written plans to respond to biological, chemical, radiological, and mass trauma hazards related to terrorism, addressing all seven focus areas of the CDC cooperative agreement.	CDC	Terrorism Preparedness and Emergency Response Program	FY 2005
	2b	Increase the percent of awardees that have developed plans to address surge capacity.	HRSA	National Bioterrorism Hospital Preparedness Program	FY 2005
Strategic Goal 3: Increase the Percentage of the Nation's Children and Adults who have Access to Health Care Services, and Expand Consumer Choices	3a1-2	Improve satisfaction of Medicare beneficiaries with the health care services they receive (Managed Care, Fee for Service).	CMS	Medicare Program	FY 2005
	3b	Increase the number of children enrolled in regular Medicaid or SCHIP.	CMS	Medicaid and SCHIP	FY 2004 (SCHIP)
	3c	Continue to assure access to preventative and primary care for racial/ethnic/minority individuals.	HRSA	Health Centers Program	FY 2004
	3d	Increase the proportion of Indian/Tribal/Urban Native American patients with diagnosed diabetes that have demonstrated improved glycemic control (blood sugar levels).	IHS	National Diabetes Program and Clinical Services	
Strategic Goal 4: Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise	4a	Increase the pool of clinician researchers trained to conduct patient-oriented research.	NIH	Research Training and Career Development Program	
Strategic Goal 5: Improve the Quality of Health Care Services	5a	Expand a facility network that constitutes a representative profile of medical device users to collect information that will be used to reduce errors associated with medical devices.	FDA	Medical Device and Radiological Health Program	FY 2004
Strategic Goal 6: Improve the Economic and Social Well-being of Individuals, Families, and Communities, Especially Those Most in Need	6a	All states meet the TANF all-family work participation rate standard.	ACF	Temporary Assistance for Needy Families	
	6b	A significant percentage of Older Americans Act (OAA) Title III service recipients live in rural areas.	AoA	Community-Based Services Program	FY 2004
Strategic Goal 7: Improve the Stability and Healthy Development of Our Nation's Children and Youth	7a	Increase the collection rate for current child support.	ACF	Child Support Enforcement Program	FY 2005
	7b	Increase the number of adoptions toward achieving the goal of finalizing 327,000 adoptions between FY 2003-FY 2008.	ACF	Child Welfare Programs	FY 2004
Strategic Goal 8: Achieve Excellence in Management Practices	8a	Reduce the percentage of improper payments made under the Medicare Fee-for-Service program.	CMS	Medicare Integrity Program	FY 2004
	8b	Target and actual returns per budget dollar invested in the OIG.	OS/OIG	Office of Inspector General	FY 2004

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

Research indicates that premature mortality and morbidity in the United States can be significantly prevented if individuals avoid certain high-risk behaviors, adopt healthy lifestyles, and reduce exposure to major environmental health risks. HHS's pursuit of this goal focuses on changing behaviors and reducing risks associated with the leading causes of premature mortality and morbidity in the United States. HHS's pursuit of this goal also includes such critical efforts as increasing immunization rates among children and adults, reducing substance abuse, and reducing the incidence of sexually transmitted diseases.

National Immunization Program (CDC)

Immunizations are among the 20th century's greatest public health achievements. Vaccines are responsible for the control of many infectious diseases, including diphtheria, measles, mumps, and pertussis, that were once common in this country; and are now available to protect children and adults against life-threatening or debilitating diseases. Cases of all vaccine-preventable diseases have been reduced by more than 97 percent from peak levels before vaccines were available, thus saving lives, as well as treatment and hospitalization costs.

CDC works with domestic and international partners to provide epidemiologic and laboratory assistance for disease tracking, vaccine for outbreak control, and other supplementary immunization activities. CDC also plays a critical role in developing immunization policy by providing technical and scientific support to policy-making advisory groups, such as the Advisory Committee on Immunization Practices (ACIP).

1a. Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for 3 doses DTaP vaccine, 3 doses Hib vaccine, 1 dose measles, mumps, and rubella (MMR) vaccine*, 3 doses hepatitis B vaccine, 3 doses polio vaccine, 1 dose varicella vaccine, and 4 doses pneumococcal conjugate vaccine.**

Fiscal Year	Target	Actual					
		DTaP	Hib	MMR	Hepatitis B	Polio	Varicella
2003	90%	Aug-04	Aug-04	Aug-04	Aug-04	Aug-04	Aug-04
2002	90%	95%	93%	91%	90%	90%	81%
2001	90%	94%	93%	91%	89%	89%	76%

Source: National Immunization Survey

* Includes any measles-containing vaccine.

** Newly recommended vaccine. Accountability for performance targets will begin in 2006.

In 1996, the ACIP introduced the varicella vaccine to the Recommended Childhood Immunization Schedule. In 2002, varicella vaccine coverage levels reached almost 81 percent, compared to 26 percent in 1997, with no racial or ethnic coverage gaps. Conjugate vaccines for Haemophilus Influenzae, type B (Hib) prevention are also highly effective. Hib is no longer the leading cause of meningitis among children younger than five years of age in the U.S. Studies of pneumococcal conjugate vaccine (PCV), prelicensure, show this vaccine to be more than 97 percent effective against invasive pneumococcal infections such as bacterial pneumonia, bloodstream infections, *otitis media* (ear infections), and sinusitis among children. Overall, CDC expects PCV to prevent more than one million episodes of childhood illness and approximately 120 deaths among children annually. ACIP added PCV to the 2001 Recommended Childhood Immunization Schedule. As this is a newly recommended vaccine, accountability for performance targets will begin in FY 2006.

Domestic HIV/AIDS Program (CDC)

During the early 1990s, before perinatal preventive treatments were available, an estimated 1,000 – 2,000 infants were born with HIV infection each year in the U.S. Today, the U.S. has seen dramatic reductions in mother-to-child, or perinatal, HIV transmission cases. These declines reflect the widespread implementation of Public Health Service (PHS) recommendations made in 1994 and 1995 to routinely counsel and voluntarily test pregnant women for HIV, and to offer zidovudine (AZT) to infected women during pregnancy and delivery, and to their infants after birth.

CDC monitors perinatal AIDS cases in the U.S., develops recommendations for perinatal prevention, and supports perinatal HIV prevention programs with state and local health departments. CDC funds 16 jurisdictions to conduct HIV perinatal prevention efforts.

1b. Decrease the number of perinatally transmitted AIDS cases from the 1998 baseline of 235 cases.

Fiscal Year	Target	Actual
2003	<139	08/2004
2002	141	12/2003
2001	151	101

Source: CDC HIV/AIDS Case Surveillance

CDC has consistently exceeded its target for this measure since 1999. Case surveillance data reported through June 2001 show sharply declining trends in perinatal AIDS cases. This decline was strongly associated with widespread AZT use in pregnant women who were aware of their HIV status. Recently, improved treatment has also likely delayed the onset of AIDS for HIV-infected children. Declines are likely to continue, but may be slowed by treatment failures and missed opportunities to prevent transmission.

Substance Abuse Prevention and Treatment Block Grant Program (SAMHSA)

SAMHSA's Substance Abuse Prevention and Treatment Block Grant, the cornerstone of states' substance abuse programs, is an integral part of the President's Drug Treatment Initiative. The block grant's goal is to improve the health of the Nation by bringing effective alcohol and drug treatment and prevention services to every community through a block grant to the states.

The FY 2000 target for increasing the number of clients served was met. Data collected by the DASIS-TEDS information system showed that SAMHSA served almost five percent more clients than expected during FY 2000. FY 2001 proxy data will be available in September 2003; FY 2003 data will be available in September 2005. The proxy data being reported represents treatment admissions data. The estimated number of clients served shows progress in increasing service delivery in support of the President's Drug Treatment Initiative.

1c. Number of substance abuse prevention and treatment clients served.

Fiscal Year	Target	Actual
2003	1,884,654	09/2005
2002	1,751,537	09/2004
2001	1,635,422	09/2003

Source: Drug and Alcohol Services Information System Treatment Episode Data Set (DASIS-TEDS) issued as a proxy for this measure

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

Events of the September 11, 2001 terrorist attacks and the subsequent use of anthrax as a biological weapon have focused attention on the prospect of the deliberate release of biological agents to cause major disease outbreaks. Of particular concern is the possibility of terrorist incidents aimed at civilians. To respond to any future bioterrorist attack, the Nation will need a strong public health network (e.g., hospitals, health networks, physicians, nurses, mental health workers, and public health officials) to piece together early reports of a suspected attack, quickly determine what happened, and mount an effective response to care for casualties and prevent further exposure. This goal addresses the need to improve our network of infectious disease surveillance, including improving communications, upgrading laboratory facilities, developing advanced diagnostic techniques, and expanding emergency health care training.

Terrorism Preparedness and Emergency Response Program (CDC)

Since 1946, CDC has been responding to public health threats and emergencies. In the aftermath of the events of September 11, 2001, we have learned that the U.S. public health system is a critical element in the new war against terrorism. However, preparing the Nation to address the dangers of terrorism is a major challenge to public health and healthcare systems. CDC is leading national efforts to rapidly improve the capacity of public health to prepare for and respond to events of terrorism, including chemical, biological, radiological, nuclear (CBRN), and mass trauma.

CDC works with partners at the federal, state, and local levels to assess our Nation's capacity and ensure a timely and sufficient response to terrorist attacks and emergency events. For example, CDC collaborates with the Office of Domestic Preparedness of the DHS to assess public health capacity for preparedness and emergency response and to develop, deploy, and coordinate these efforts. Health departments are now defining their roles in order to respond effectively to a CBRN attack.

2a. Enhance preparedness by assuring state, territorial, and local jurisdiction projects have written plans to respond to biological, chemical, radiological, and mass trauma hazards related to terrorism addressing all seven focus areas of the CDC cooperative agreement.

Fiscal Year	Target	Actual
2003	50% of the 62 state, territorial, and local jurisidctions will have written plans.	12/2003
2002	N/A	N/A
2001	N/A	N/A

Source: Semi-annual progress reports

CDC received emergency supplemental funding in February 2002 to begin the process of improving state and local capacity to respond to CBRN attacks. Intramural and extramural activities to build preparedness and readiness assessment, surveillance and epidemiology capacity, laboratory capacity, communications and IT, health information dissemination, and education and training are in place.

National Bioterrorism Hospital Preparedness Program (HRSA)

The purpose of this program is to prepare hospitals and supporting health care systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies. This is one part of the larger HHS program for state and local terrorism preparedness. Working in concert

with CDC's Public Health Preparedness and Response for Bioterrorism Program and DHS's Office of Emergency Response Metropolitan Medical Response System Program, HRSA's program provides funding to states and other entities to upgrade the capacity of hospitals, outpatient facilities, emergency medical services systems, and poison control centers to respond to regional terrorist and other public health emergencies. This new program received initial funding in FY 2002.

2b. Increase the percent of awardees that have developed plans to address surge capacity.		
Fiscal Year	Target	Actual
2003	N/A	59% (baseline estimate)

Source: 2005 GPRA Plan, from states' progress reports

Surge capacity is the ability to accommodate a large and rapid increase in the number of persons requiring services. It includes elements of hospital bed capacity, isolation capacity, health care personnel, pharmaceutical caches, personal protection and decontamination, mental health capacity, trauma and burn care capacity, and communications and IT. Based on states' progress reports, HRSA estimates that a baseline of 59 percent of states have developed plans to address regional surge capacity. The goal is for at least 90 percent of the Nation's hospital regions to have developed plans to respond to a surge capacity of 500 patients per million people by FY 2004.

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

In addition to changing behavior and reducing environmental health risks, improving health in the U.S. involves assuring that everyone has access to health care. There are substantial access challenges, particularly for some groups. Overall, approximately 44 million persons in the U.S. lack health insurance. In addition, approximately 20 percent of America's population live in areas designated as having a shortage of health professionals to deliver primary medical care. Access to treatment for many persons with HIV/AIDS would be limited without support for the cost of drug therapies and associated services. A substantial majority of adults with diagnosable mental disorders do not receive treatment. Many families can not afford the cost of care for children with special health care needs. HHS addresses these challenges through a variety of entitlement and safety net programs, such as Medicare, Medicaid, SCHIP, and Community Health Centers, that provide access to health care for uninsured and low income individuals.

Medicare Program (CMS)

CMS's primary mission is to assure health care security for its beneficiaries. CMS also strives to encourage choice in the Medicare beneficiary community for medical coverage while maintaining high quality care. CMS administers Medicare, the Nation's largest health insurance program, which covers approximately 41 million Americans. Medicare provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. For nearly four decades, this program has helped pay medical bills for millions of Americans, providing them with reliable, comprehensive health benefits.

CMS developed a series of data collection activities under the Consumer Assessment of Health Plans Surveys (CAHPS) in order to standardize the measurement of and monitor beneficiaries' experience and satisfaction with the care they receive through Medicare. CMS fields these surveys annually to representative samples of beneficiaries enrolled in each Medicare-managed care plan as well as those enrolled in the original Medicare fee-for-service (FFS) plan, and provides comparable sets of specific performance measures collected in CAHPS to Quality Improvement Organizations (QIOs), health plans, and beneficiaries through various means, including the National *Medicare & You* Education Program (NMEP).

3a1: Improve satisfaction of Medicare beneficiaries with the health care services they receive (Managed Care)		
Fiscal Year	**Target**	**Actual**
2003	Collect and share data toward Calendar Year (CY) 2004 targets of 93% for access to care and 86% for access to specialist	Data continues to be collected and disseminated
2002	Collect and share data toward CY 2004 targets of 93% for access to care and 86% for access to specialist	Data collected
2001	Develop new baselines/targets to include disenrollee data	Baselines/targets developed: Baselines: Access to care: 90.5%; Access to specialist; 83.7%

Source: Medicare Consumer Assessment Health Plans Surveys (CAHPS)

CMS's multi-year efforts to improve beneficiary satisfaction with the health care they received apply to both FFS and managed care. CMS is meeting its FY 2003 target to direct efforts to improve beneficiary satisfaction in both FFS and managed care by continuing to collect and share CAHPS information from beneficiaries with health plans, QIOs, and beneficiaries.

3a2: Improve satisfaction of Medicare beneficiaries with the health care services they receive (Fee-for-Service).		
Fiscal Year	**Target**	**Actual**
2003	Collect and share data	Data continues to be collected and disseminated
2002	Collect and share data toward CY 2004 targets of 95% for access to care and 85% for access to specialist	Data collected; Goal met
2001	Develop baselines	Baselines: Access to care; 92.8%; Access to specialist; 82.8%

Source: Medicare (CAHPS)

Medicaid and SCHIP (CMS)

CMS provides oversight for Medicaid, the state-administered, means-tested medical assistance program for low-income Americans. Medicaid is jointly financed by the federal and state governments. Over the years, Congress has incrementally expanded Medicaid well beyond the traditional population of the low-income women and children and the elderly, blind, and disabled. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care.

SCHIP was created in 1997 to address the fact that nearly 11 million American children (one in seven) were uninsured and therefore at increased risk for preventable health problems. This program represents the largest single expansion of health insurance coverage for children in more than 30 years and aims to improve the quality of life for millions of vulnerable children under 19 years of age. The funds allocated for SCHIP cover insurance costs, reasonable administrative costs, and outreach services to get children enrolled.

Title XXI of the Social Security Act gave states the option to expand their Medicaid program, establish a separate child health program, or use a combination of both. CMS's goal is to increase the number of children enrolled in Medicaid or SCHIP.

3b. Increase the number of children enrolled in regular Medicaid or SCHIP.		
Fiscal Year	**Target**	**Actual**
2003	+ 5% over 2002	01/2004
2002	+ 1,000,000 over 2001	Additional 2,750,000
2001	+ 1,000,000 over 2000	Additional 3,441,000

Source: Statistical Enrollment Data System and HCFA-2082

In FY 2002, CMS exceeded the target of enrolling an additional one million children in Medicaid and SCHIP by enrolling an additional 2.75 million children in these programs (FY 1999 baseline of 22 million enrollees - see Section II). CMS has exceeded its initial targets to increase enrollment by one million over the previous year, but states are now facing fiscal challenges that may affect program outreach and enrollment, making future projections uncertain. As such, CMS set the FY 2003 target to increase enrollment by five percent over the previous year.

Health Centers Program (HRSA)

The Health Centers Program, a major component of America's health care safety net for the Nation's indigent populations, is leading a Presidential Initiative to increase health care access for Americans most in need. Millions of Americans are uninsured and lack access to a regular health care source. The Health Centers Program, operating at the community level through federal, state and community partnerships, provides regular access to high quality, family-oriented, and comprehensive primary and preventive health care regardless of patients' ability to pay. Program grants support a variety of community-based public and private nonprofit organizations for the operation of the Health Centers Program.

The number of racial/ethnic minority individuals served by the Health Centers program increased from 6.62 million in FY 2001 to an estimated 7.24 million in FY 2002, continuing a steady growth consistent with the overall growth in program clients. The proportion of racial/ethnic minority individuals has remained at 64 percent of total clients, just one percentage point below the target. The Presidential Growth Initiative for the Health Centers Program includes service capacity expansions for existing centers and the development of new service sites. Some of these new sites are or will be in underserved geographic areas (e.g., rural and frontier areas) that do not have large numbers of racial/ethnic minorities. New site locations and the substantial and rapid increases in total number of clients served impact the program's ability to maintain and increase the proportion of minority clients.

3c. Continue to assure access to preventative and primary care for racial/ethnic/minority individuals.*		
Fiscal Year	**Target**	**Actual**
2003	65%	8/2004
2002	65%	64%
2001	65%	64%

Source: HRSA Bureau of Primary Health Care (BPHC) Uniform Data System

*Data as of October 2003.

National Diabetes Program and Clinical Services (IHS)

The mission of the IHS Diabetes Program is to develop, document and sustain a public health effort to prevent and control diabetes in American Indian/Alaska Native (AI/AN) people. The program: (1) works with communities to prevent and treat diabetes, and (2) also oversees the Special Program for Diabetes in Indians. IHS encourages local efforts to improve results through lifestyle intervention and appropriate medication use through orientation, training, and monitoring provided by Area Diabetes Consultants.

IHS met the 2002 ideal glycemic control indicator for patients with diagnosed diabetes, improving upon FY 2001 performance. The use of appropriated diabetes funding may continue to improve the performance of this indicator through the use of grants and cooperative agreements for special projects aimed at targeted diabetes-related treatment and prevention areas. Area diabetes consultants encourage lifestyle intervention and appropriate medication use through orientation, training, and monitoring at the local level. Efforts to achieve this measure also include the negotiation of wholesale or 'at cost' purchases of newer, more effective (but considerably more expensive) medications for AI/AN diabetic patients. In addition, IHS has developed and deployed a clinical software application that allows sites to track and provide timely feedback on this, and other diabetic indicators.

3d. Increase the proportion of Indian/Tribal/Urban Native American patients with diagnosed diabetes that have demonstrated improved glycemic control (blood sugar levels).

Fiscal Year	Target	Actual
2003	Maintain	11/2003
2002	Improve	30%
2001	Improve	29%*

Source: Annual IHS National Diabetes Audit.
*Previously reported as 30%.

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

This goal recognizes the prominence of health research in HHS and its importance in furthering the overall mission of improving the Nation's health. While research pervades many other HHS goals, this goal focuses on creating knowledge that ultimately is useful in addressing health challenges, and addressing the need to maintain and improve the research infrastructure that produces scientific advances.

Research Training and Career Development Program (NIH)

NIH research training and career development activities nurture a talent base of well-qualified, highly trained, and diverse investigators. To achieve this objective, NIH supports pre- and post-doctoral training through the National Research Service Award (NRSA) and various career development mechanisms. Career development support helps both young and well-established trained investigators to acquire new specialized skills. Within the overarching training and career development objective, the expansion and support of the clinical research workforce is critical both to translate basic research into treatments and to guide and stimulate basic research on key barriers to effective treatment.

4a: Increase the pool of clinician researchers trained to conduct patient-oriented research.*

Fiscal Year	Target	Actual
2003	Issue at least 120 K23 awards	02/2004
	Issue at least 50 K24 awards	02/2004
2002	Issue at least 120 K23 awards	194
	Maintain a steady state level of K24 awards	48
2001	Issue at least 80 K23 awards	185
	Issue at least 80 K24 awards	58

Source: IMPAC database.
* Data as of October 2003

In 1999, under the NIH Director's Initiative on Clinical Research, NIH established three new patient-oriented research career development mechanisms:

- *Mentored Patient-Oriented Research Career Development Awards* (K23s) provide support to clinically trained professionals for 3 to 5

years of supervised, patient-oriented study and research in order for them to develop into productive clinical investigators;

- *Midcareer Investigator Awards in Patient-Oriented Research* (K24s) provide support that allows mid-career clinical investigators time to devote to both career-enhancing patient-oriented research and to mentor younger patient-oriented researchers; and
- *Clinical Research Curriculum Development Awards* (K30s) enhance clinical research curriculum development.

The primary outcome of these activities will not be evident for several years, because, as of FY 2003, the supported career development periods for K23 and K24 awardees are just now concluding, and the grantees have yet to take the steps for which they have been preparing. Thus, NIH can only assess the progress toward the goal of increasing the pool of clinician researchers only through process and output measures (e.g., the number of awards issued). From this perspective, the career award components of the Director's Initiative have had variable success.

- The K23 mechanism has outperformed the targets in every year. In FY 2002, NIH issued more than twice the number of initially recommended awards.
- The K24 mechanism supported the targeted number of grantees in FY 1999 but has fallen progressively short in subsequent years. The trend in applications for K24 awards suggests that the award mechanism may already have come close to saturating the pool of mid-career patient-oriented research mentors. Nonetheless, NIH expects the K24 mechanism to continue to facilitate increases in the number of productive scientists working in this important area.
- The K30 awards enabled institutions to develop and provide consolidated core curricula for apprentice clinical investigators regardless of their specific fields. NIH made a total of 59 new awards in FY 1999 and FY 2000.

In the FY 2004 Performance and Accountability Report, NIH will highlight progress towards creation of the next-generation map of the human genome, the halotype map, or "HapMap", which will describe the patterns of human genetic variation and help researchers learn more about how genes affect health and disease.

Strategic Goal 5
Improve the Quality of Health Care Services

Improving quality of life and health in the U.S. also involves improving the quality of human services and health care. While many Americans receive quality health care, there is evidence of a need to improve care quality. Studies show that many patients die from medical errors, some services are used unnecessarily, and screening tests are sometimes misread. Finally, when considering and selecting health care options, many Americans do not use comparative information on the quality of health care plans, doctors, or hospitals to make their choices. This goal's focus is to implement strategies to improve service quality.

Medical Devices and Radiological Health Program (FDA)

FDA's Medical Devices and Radiological Health Program is responsible for ensuring the safety and effectiveness of medical devices and eliminating unnecessary human exposure to manmade

radiation from medical, occupational, and consumer products.

A key element in any comprehensive program to regulate medical devices is a postmarket reporting system through which FDA receives reports of serious adverse events. Such reporting forms the basis for FDA corrective actions by the agency, which include warnings to users and product recalls. This is especially true as FDA moves toward less direct involvement in the premarket review of lower-risk devices.

The Medical Product Surveillance Network (MedSun), when fully implemented, will reduce device-related medical errors; serve as an advanced warning system; and create a two-way communication channel between FDA and the user-facility community. FDA projects a MedSun network of 180 facilities in FY 2003.

The Center for Device and Radiological Health (CDRH) and its MedSun contractors will coordinate with FDA's Center for Drug Evaluation and Research (CDER) to explore integrating the reporting of drug events. MedSun is currently designed to obtain reports from risk managers and biomedical engineers about problems with the use of devices in the clinical community. MedSun is also designed to train hospital personnel to accurately identify and report injuries and deaths associated with medical devices.

5a: Expand a facility network that constitutes a representative profile of medical device users to collect information that will be used to reduce errors associated with medical devices.

Fiscal Year	Target	Actual
2003	Build a MedSun hospital network of 180 facilitites	02/2004
2002	Implement MedSun by recruiting a total of 80 facilities for the network	FDA recruited, trained and had functioning more than 80 facilities for the network
2001	Recruit a total of 75 hospitals to report adverse medical device events	FDA began feasibility testing with more than 25 hospitals and worked on software changes needed for website health data security

Source: FY 2004 Congressional Justification (CJ) FDA Performance Plan

The FDA Modernization Act (FDAMA) of 1997 seeks to improve the regulation of food, drugs, devices, and biological products in an environment of increasing technological trade and public health complexities. MedSun is FDA's response to the FDAMA provision directing replacement of universal user facility reporting with a user facilities network that constitutes a representative profile of user reports. By the end of 2003, FDA projects that it will have recruited 180 facilities. The enhancement of the adverse events data system is the first line of defense against medical errors supporting the Department's initiative to improve the quality of health care services.

In FY 2002, FDA recruited, trained, and had functioning more than 80 facilities for the network, and met its performance measure. In FY 2001, FDA did not meet its performance measure of recruiting 75 hospitals because most of the effort was focused on resolving internal policy issues and addressing IT security requirements. Specifically, FDA extended software development to accommodate internet-based reporting systems (interactive web-based forms and databases), and took steps to ensure that reporters had internet access to secure servers. Despite not making the goal, FDA still recruited 25 hospitals. FDA's plans for FY 2003 focus on building MedSun to a network of 180 facilities, and with increased funding in FY 2004, expanding to 240 facilities. FDA will recruit new facilities to expand to the network capacity and to replace those that choose to leave.

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

While substantial progress occurred in the past several years to reduce poverty, evidence supports a continued focus on helping those in need. This goal's focus is to promote and support interventions that help the disadvantaged improve their economic and social well-being. HHS targets its efforts toward low-income families, children, the elderly, persons with disabilities, and distressed communities.

Temporary Assistance for Needy Families (TANF) (ACF)

ACF's Office of Family Assistance administers the TANF program directed at promoting work, responsibility, and self sufficiency and improving the economic well-being of individuals and families through state- and tribal-administered programs. TANF's purposes are to provide assistance to needy families so that children can be cared for in their own homes; to reduce dependency by promoting job readiness, work, and marriage; to prevent out-of-wedlock pregnancies; and to encourage formation and maintenance of two-parent families.

Congress established the TANF work participation performance targets for FY 1997 through FY 2002. Beginning in FY 1997, the actual all-family (one- and two-parent families that receive state and TANF assistance) and two-parent family participation rates increased significantly each year until FY 2000, when there was an 11 percent decline in the national average participation rates. Some of the all-family rate decline is attributed to the increase in the all-family minimum hours of weekly participation, from 25 to 30 hours. From FY 1998 through FY 2002, all states met the all-families target rates (this does not include territories). In the same time frame, the proportion of states meeting the more rigorous two-parent work participation rate has steadily increased (from 66 percent to 85 percent).

6a: All states meet the TANF all-families work participation rate standard. *

Fiscal Year	Target	Actual
2003	100%	09/2004
2002	100%	100%
2001	100%	100%

Source: TANF Administrative Data

* Data as of September 2003

FY 2002 findings indicate that all states (this does not include territories) are meeting the all-family rate of 50%, while a few states continue to have difficulty meeting the two-parent rate of 90%. States have the option to move their two-parent cases into a separate state program thus avoiding the two-parent work participation requirements. The statutory 90 percent two-parent participation target remains a rigorous standard. Pending reauthorization legislation would establish a single all-family rate starting at 50 percent, but it would also require recipients to participate in more hours directly related to work. At least 50 percent of all cases receiving TANF that are headed by adults would be required to participate full-time in a simulated work-week of activities (40 hours per week) and at least 24 of the 40 hours would have to be in a traditional work activity.

Community-Based Services Program (AoA)

Title III of the Older Americans Act (OAA) established a community-based services program to make community-based services available to older persons who are at risk of losing their independence. The program provides "access" services (e.g., information, outreach, and transportation); "community" services (e.g., congregate meals, pension counseling, adult day care and health and fitness programs); "in-home" services (e.g., home-delivered meals, home maintenance assistance, and personal care); and "caregiver" support (e.g., respite services and caregiver assistance).

6b. A significant percentage of Older Americans Act (OAA) Title III service recipients live in rural areas.

Fiscal Year	Target	Actual
2003	34%	02/2005
2002	25%	02/2004
2001	25%	30.4%

Source: State Program Report (SPR)

The OAA specifically requires targeting community-based services to vulnerable populations (i.e., low income, low income minority, rural, disabled, and frail). AoA tracks targeting performance for all of these groups of people. The representative targeting measure included in this report is for older people living in rural areas. AoA demonstrates effective targeting and performance for this measure (per OAA requirements) where the percentage of AoA service recipients that live in rural areas is higher than the percentage of all elderly persons that live in rural areas. In fact, 2000 Census data indicate that 23 percent of the U.S. elderly population lives in rural areas, while AoA program data for both FY 2000 and FY 2001 show that over 30 percent of AoA services recipients live in rural areas. Committed to continued improvement of program performance, AoA also tracks performance in states performing below the national average targeting index. Six of these states improved their performance by at least 10 percent between FY 2000 and FY 2001.

AoA exceeded its performance target for FY 2001, and expects to meet it in FY 2002. However, the FY 2003 performance target is much more aggressive, and AoA is challenging the entire aging network to improve performance as demonstrated by this "stretch" target.

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

While some trends in the well-being of the Nation's children and youth are positive, additional efforts are needed. The numbers of substantiated victims of child maltreatment remain high, too many children live in single-parent households, and more must be done to ensure that non-custodial parents meet their financial obligations. Finally, while the percentage of children age three to five years old that are enrolled in center-based early learning programs is decreasing (60 percent in 1999 compared to 56 percent in 2001), children below the poverty line lag behind. Through this goal, HHS focuses on nurturing the positive development of children and youth.

Child Support Enforcement Program (ACF)

ACF's Office of Child Support Enforcement (OCSE) is responsible for helping ensure that support is available to children by locating parents, as well as establishing and enforcing paternity and support obligations. ACF implements the child support provisions of Title IV-D of the Social Security Act, as amended (IV-D) by providing technical assistance, tracking parents, and helping collect court-

ordered support payments. ACF has achieved this through a variety of means, including implementing federal policy, providing technical assistance, training, and information dissemination, developing a more performance-based incentive funding structure, and providing federal oversight and assistance with state-based quality assurance. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provided new and effective tools for enforcing child support, which are having a significant impact on ACF's ability to collect support.

The Federal Government provides direction, guidance, technical assistance, oversight, and some critical services to states' Child Support Enforcement programs mandated under IV-D. This measure, a proxy for the regular and timely payment of support, compares total dollars collected with total dollars owed to yield a collection rate for current support in IV-D (child support) cases. In FY 2001, ACF achieved a collection rate of 57 percent, exceeding the target**.** This measure represents collections from non-custodial parents in IV-D cases. ACF is committed to improving performance by focusing on improved enforcement techniques which emphasize automated enforcement, collections and payment mechanisms ensuring more reliable data. PRWORA enhances these efforts.

7a. Increase the collection rate for current support. *

Fiscal Year	Target	Actual
2003	58%	09/2004
2002	55%	58%
2001	54%	57%

Source: State automated systems provide data on OCSE Form 157

* Data as of September 2003

Child Welfare Programs (ACF)

ACF's Child Welfare programs strive to prevent maltreatment of children in troubled families, protect children from abuse, and find permanent placements for those who cannot safely return to their homes. When the family cannot be reunified, foster care provides a stable environment until the child can be placed permanently with an adoptive family or in a guardianship arrangement.

When reunification with parents or relatives is not possible, the preferred permanency outcome for most children is adoption. The Adoption and Safe Families Act and other federal legislation enacted during the last 25 years has promoted the adoption of children from the public child welfare system for whom reunification was not possible. The total annual number of adoptions of children with public child welfare system involvement has increased dramatically since FY 1995 (26,000). The Adoption Incentive Program continues to reward states for increasing their number of adoptions and provides an additional incentive for the adoption of older children, a growing segment of the population of children waiting to be adopted.

7b. Increase the number of adoptions toward achieving the goal of finalizing 327,000 adoptions between FY 2003-FY 2008.*

Fiscal Year	Target	Actual
2003	58,500	09/2004
2002	56,000	51,000
2001	51,000	51,000

Source: Adoption and Foster Care Analysis and Reporting System (AFCARS)

* Data as of September 2003

States can submit AFCARS adoption data on finalized adoptions at any time and still meet the requirements of the regulation. Frequently, data on adoptions may be under-reported because entries do not occur until the states receive final paperwork from the court. Because the Adoption Incentive Program requires that only adoptions reported by the first reporting period in the following fiscal year can be counted for incentive awards, almost all adoptions are now reported within that timeframe. The numbers reported for the Adoption Incentive Program are incomplete for the reasons mentioned and are continually updated as additional adoptions are reported.

Strategic Goal 8
Achieve Excellence in Management Practices

In order to accomplish all of HHS's other goals and objectives, the Department must improve management practices. A central objective in achieving management excellence is to function as "One HHS". To ensure that HHS is "One Department" rather than a collection of disparate agencies, HHS is reforming Departmental management practices, in part by consolidating activities and by improving collaboration among agencies in administering HHS programs. This goal focuses on reducing inefficiencies, fraud, and abuse, while maximizing the integrity and efficiencies in Department management practices. This goal and related activities also address ongoing efforts to reduce Medicare payment errors.

Medicare Integrity Program (CMS)[2]

Measure 8a: Reduce the percentage of improper payments made under the Medicare fee for service program. One of CMS's key goals is to pay claims properly the first time. This means paying the right amount to legitimate providers for covered services provided to eligible beneficiaries. Paying claims right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars.

Prior to FY 2003, the OIG estimated the amount of the improper payments for Medicare claims included in the *CMS Financial Report*. Beginning in FY 2003, this activity was assumed by CMS with the intention of expanding the number of claims sampled in order to obtain more detailed information to better identify and correct payment problems.

The 2003 *CMS Financial Report* includes estimates from the results of two programs used by CMS: the Comprehensive Error Rate Testing (CERT) program with a sample of 70,567 claims; and the Hospital Payment Monitoring Program (HPMP) with a sample of 57,775 discharges. The CERT program implements a new sampling and review methodology (for non-PPS inpatient hospital claims) that provides estimates of the national error rate with tighter precision. In addition, it employs independent reviewers to make determinations for 70,567 claims providing estimates of error rates by contractor, by service type, and by provider type.

These programs provide CMS with a much more rigorous set of data to manage our contractors, identify and prevent errors, and educate providers who bill our programs. As a result of the 2003 programs, CMS believes that the paid claims error rate remains at about the same rate as last year. Our analysis determined an adjusted paid claims error rate of 5.8 percent, or $11.6 billion, compared to an unadjusted 9.8 percent rate ($19.6 billion). The unadjusted rate reflected an unusually high non-response rate because every non-response was treated as an error (54.7% of errors were due to non-responses). CMS believes the high non-response rate was due to the impact of HIPAA privacy rules, record requests made by an unfamiliar entity, and like the OIG in the first year they calculated the error rate, general difficulties in getting providers to follow-up on record requests. CMS adjusted the error rate using a conservative non-response estimate based on the OIG's average non-response rate of 12 percent for the past seven years.

For the first time CMS can use the Medicare error rate to show where it is overpaying or underpaying

[2] Information received November 2003

claims, and for what categories of service. Now that CMS has detailed error rates, it can aggressively target its efforts to fix problems they indicate.

CMS has taken a number of steps to minimize the non-response problem in the future. For example, CMS has revised the letters requesting medical records by clarifying the role of the error calculation contractor, explaining that it is not a HIPAA compliance violation to submit records to the error calculation contractor, and allowing providers to fax records. As a result, adjustments for non-response should not be necessary for FY 2004.

CMS is working with the contractors that pay Medicare claims and the QIOs on aggressive efforts to lower the paid claims error rate, including: (1) developing a tool that generates state-specific hospital billing reports to help QIOs analyze administrative claims data, (2) increasing and refining one-on-one educational contacts with providers found to be billing in error, and (3) developing projects with the QIOs addressing state-specific admissions necessity and coding concerns, as well as conducting surveillance and monitoring of inpatient payment error trends by error type.

In addition, CMS has directed the Medicare contractors to develop local efforts to lower the error rate by developing plans that address the cause of the errors, the steps they are taking to fix the problems, and other recommendations that will ultimately lower the error rate. The CERT program is an important new tool in monitoring contractor performance. It will provide CMS with the fundamental structure to hold the fee-for-service contractors accountable for the services they provide as CMS moves to performance-based contracting from simply paying contractors to process Medicare claims.

Office of Inspector General (OIG)

The OIG's primary function is to detect and prevent fraud and abuse and to recommend policies designed to promote economy, efficiency, and effectiveness in the administration of HHS and its programs. It accomplishes its purpose by conducting and supervising audits, inspections, and investigations of HHS programs, and providing guidance to the healthcare industry. Over 80 percent of OIG resources are devoted to the Health Care Fraud and Abuse Control Program (HCFAC), a mandatory program which came into being with the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a joint program of HHS and the Department of Justice, whose purpose is to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse, including the conducting of investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the U.S. The OIG has long used return on investment (ROI) as the primary measure of effectiveness and efficiency.

The OIG has increased its expected recoveries and savings from funds not expended relative to its operating cost each year, except FY 1999, when the previous year's results were equaled. Over the entire FY 1997–FY 2002 period, ROI improved by 70 percent. The targets set during the first four years of this period were conservative because of the uncertainty of the impact of changes to the Balanced Budget Act of 1997 then being considered by Congress. In each case, the targets were below the most recent actual returns of any year shown on the tables. The method of setting the target ROI was changed in the FY 2004 performance plan, and for the first time, the target exceeds previous actual results. The higher targets were derived by projecting a 10 percent improvement

8b. Target and actual returns per budget dollar invested in the OIG (ROI).

Fiscal Year	Target	Actual
2003	$100	01/2004
2002	$77	$121
2001	$75	$110

Source: OIG OMB Budget Submission

over the average of the most recent three years of actual expected recoveries and audit disallowances, along with adding $1 billion to the known savings from funds not expended as a result of legislative or administrative actions stimulated by OIG reports.

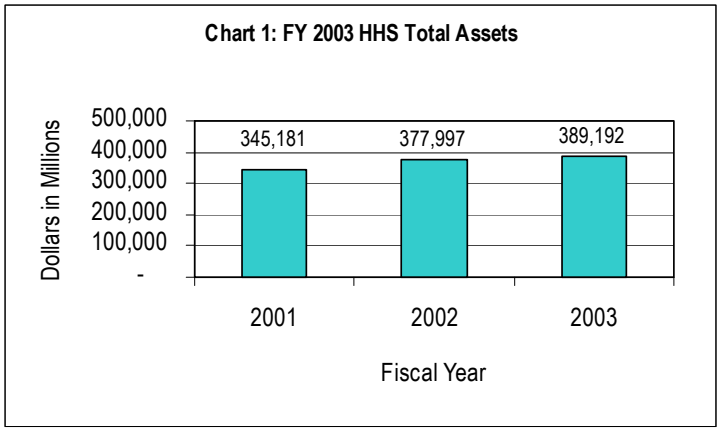
Analysis of Financial Condition and Results of Operations

This section summarizes the significant changes in HHS's financial condition during the past year. The following table provides an overview of HHS's financial condition at the end of FY 2003 (dollars in millions)

HHS Financial Condition	FY2003	FY 2002 (restated)	Increase (Decrease)	% Change
Total Assets	$ 389,192	$ 377,997	$ 11,195	3.0%
Total Liabilities	$ 63,059	$ 60,455	$ 2,604	4.3%
Net Position	$ 326,133	$ 317,542	$ 8,591	2.7%
Net Cost of Operations	$ 510,162	$ 472,142	$ 38,020	8.1%

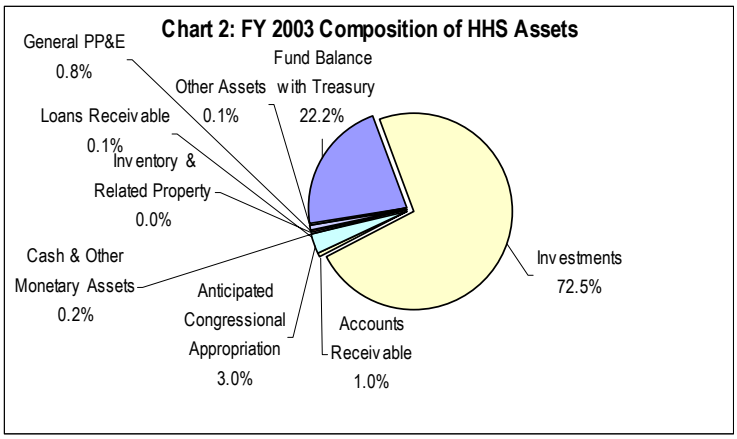
Assets - What We Own

HHS Assets increased $11 billion or 3.0 percent to a total of $389 billion during FY 2003 as shown in Chart 1. Increases of $8 billion or 3.1 percent in Investments and of $2 billion or 1.8 percent in HHS's Fund Balance with Treasury accounted for most of the change in Total Assets. As shown in Chart 2, HHS's Investments of $282 billion and its Fund Balance with Treasury of $86 billion together comprise 95 percent of HHS's Total Assets. The Fund Balance with Treasury is HHS's "checkbook balance", or the aggregate amount of funds deposited in the Treasury available to make authorized expenditures and pay liabilities.



At the end of FY 2003, approximately $280 billion or 99 percent of HHS Investments were in U.S. Treasury Securities to support the Medicare trust funds, which include Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) trust funds. Established in 1965 as title XVIII of the Social Security Act, Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people aged 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and people age 65 or older who elect Medicare coverage. Medicare is a combination of three programs: Hospital Insurance (HI), Supplementary Medical Insurance (SMI), and Medicare+Choice. Since 1966, Medicare enrollment has increased from 19 million to approximately 41 million beneficiaries.

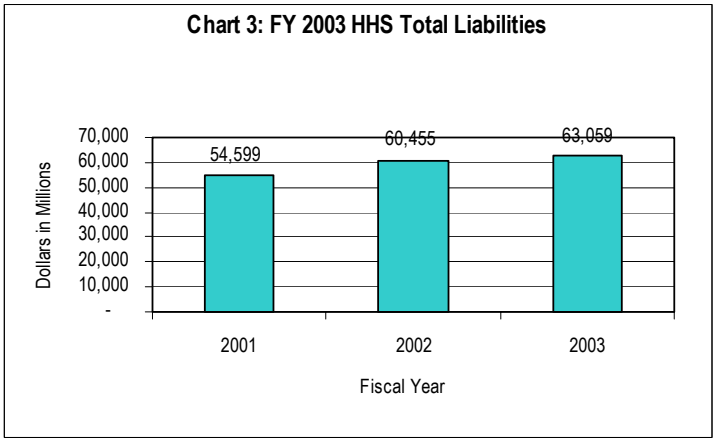
Hospital Insurance (HI)



HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for hospital, skilled nursing facility, home health, and hospice care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities. As reported in the Required Supplementary Stewardship Information (RSSI) section of this report, HI trust fund assets steadily increase through 2017. At this point, expenditures start to exceed income including interest, thus drawing down assets until 2026 when they would be depleted. The shortfall between income and expenditures is due in part to the attainment of Medicare eligibility, starting in 2011, of those born during the 1946-1964 baby boom, and also due to health costs that are expected to increase faster than workers' earnings. Actual economic conditions, however, could delay (in the case of economic recovery) or accelerate this condition. Based on estimates from the Mid-Session Review of the FY 2004 President's budget, inpatient hospital spending accounted for 72 percent of HI benefits outlays. Managed care spending comprised 12 percent of total HI outlays. During FY 2003, HI benefit outlays grew by 6.5 percent. The HI benefit outlays per enrollee are projected to increase by 5.3 percent to $3,785.

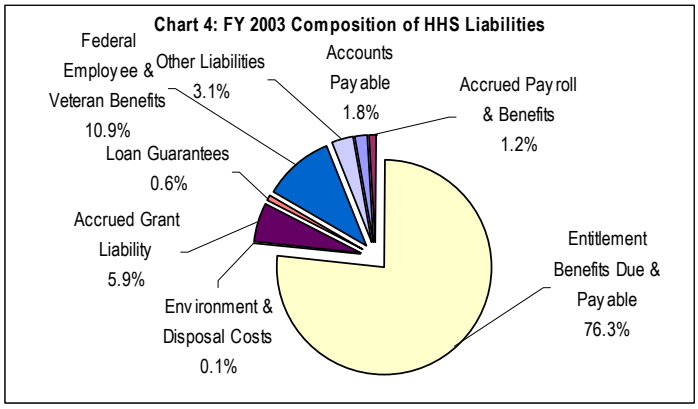
Supplementary Medical Insurance (SMI)

SMI or Medicare Part B, is available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, and other services not covered by HI. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. About 95 percent of HI enrollees elect to enroll in SMI.



Whereas HI is funded primarily by payroll taxes, SMI obtains its funding through monthly beneficiary premiums and income from the general fund of the U.S. Treasury – both of which are established annually to cover the following year's expenditures. Thus, the SMI trust fund is in financial balance every year, regardless of future economic and other conditions, due to its financing mechanism. Funds not currently needed to pay benefits and related expenses are held in the SMI trust fund, and invested in U.S. Treasury securities.

Under the Trustees' intermediate set of assumptions, the HI trust fund will incur an actuarial deficit of more than $5.9 trillion over the 75-year projection period, as compared to more than $4.9 trillion in the 2002 financial report. In order to bring the HI trust fund into actuarial balance over the next 75 years, very substantial increases in revenues and/or reductions in benefits would be required. Since the SMI trust fund is in financial balance every year, there has been substantially less attention directed toward its financial status than to the HI trust fund – even though the SMI expenditures have increased faster than the HI expenditures in most years and are expected to continue to do so for a number of years in the future. Also based on estimates, during FY 2003, SMI benefit outlays grew by 8.8 percent. Physician services, the largest component of SMI, accounted for 40 percent of SMI benefit outlays. The SMI benefit outlays per enrollee are projected to increase 7.4 percent to $3,059.

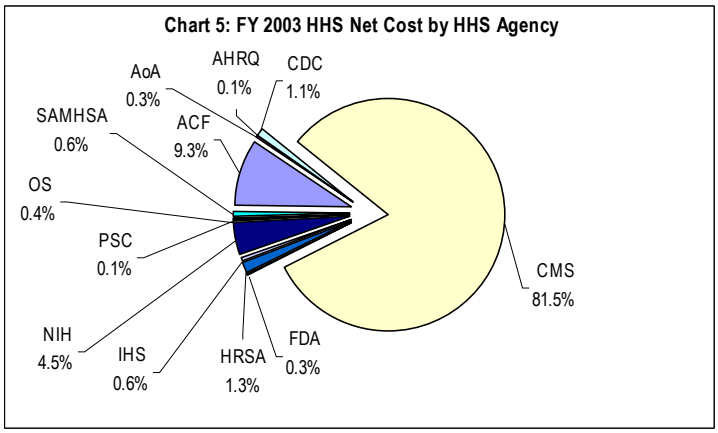


It is important to note that no liability has been recognized on HHS's balance sheet for future payments to be made to current and future program participants beyond the existing "incurred but not reported" Medicare claim amounts as of September 30, 2003. This is because Medicare is accounted for as a social insurance program rather than a pension program.

A more detailed discussion of HHS's social insurance funds and other stewardship property and investments can be found in the Section III RSSI discussion of this report. A more detailed discussion of the Medicare Trust Fund can be found in RSSI and in the CMS Financial Report.

Liabilities - What We Owe

HHS's Liabilities increased 3 billion or 4.4 percent to a total of $63 billion during FY 2003, as shown in Chart 3. This increase can be attributed primarily to a $4 billion or 8.0 percent increase to $48 billion in Entitlement Benefits Due and Payable, which account for more than three-fourths of total liabilities. Entitlement Benefits represent benefits due and payable to the public from the CMS insurance programs discussed above. This increase was offset by a $1.3 billion or 16% decrease in Federal Employee & Veteran Benefits. This decrease is attributable to a revised reporting practice at the Department of Defense (DoD) for FY 2003, whereby DOD reports the Commissioned Corps post-employment health benefits component of the actuarial liability in DoD's financial statements. HHS had previously reported these amounts in its statements.



Statement of Changes in Net Position - Where We Stand

HHS's Net Position, which increased $9 billion or 2.7 percent to $326 billion at the end of FY 2003,

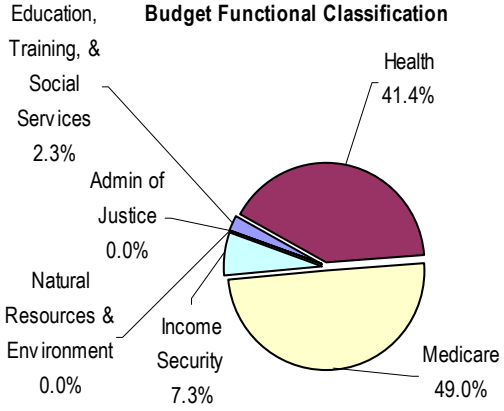
consists of the cumulative net results of operations since inception, and unexpended appropriations, or those appropriations provided to HHS that remain unused at the end of the fiscal year.

Net Cost - How We Spend

HHS incurred a total net cost for the year of $510 billion, which represents a $38 billion or 8.1 percent increase over FY 2002. The Consolidated Statement of Net Cost in Section III of this report presents HHS net operating costs by HHS agency, while functional detail is provided in the footnotes to the financial statements, also in Section III. As can be seen in Chart 5, CMS, ACF, and NIH account for a combined 95 percent of HHS's total net cost of operations, incurring net costs of $416 billion, $48 billion, and $23 billion, respectively.

Chart 6 shows how HHS incurs net costs across its primary functions as defined in the budget. HHS's Medicare (49.0 percent); Health (41.4 percent); Income Security (7.3 percent); and Education, Training, and Social Services (2.3 percent) account for nearly all of HHS's net costs incurred during FY 2003. The percentages in Chart 6 reflect a proportional analysis of HHS's combined net costs (not accounting for intradepartmental costs and revenues). Intradepartmental net costs accounted for less than 0.1 percent of total combined net costs.

Chart 6: FY 2003 HHS Combined Net Cost by Budget Functional Classification



Costs vs. Outlays

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

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

Budgetary Resources and Financing - Where the Money Comes From

During FY 2003, most of the funding to support net costs came from $646 billion in appropriations from Congress, as shown in HHS's Combined Statement of Budgetary Resources. This represents 96 percent of the gross budgetary resources available to HHS. This gross amount was offset by a pre-designated portion of funds that were either temporarily or permanently unavailable pursuant to specific legislation to derive a net funds available amount of $654 billion, an increase of 7.1 percent over FY 2002 levels. During FY 2003, HHS incurred obligations of $646 billion, a 7.3 percent

increase over FY 2002, and made 12.0 percent more Net Outlays totaling $625 billion. Further comparison of Net Position and Budgetary Resource activity between FY 2002 and FY 2003 is limited due to required format changes to the financial statements implemented for FY 2003.

Limitations of the Principal Financial Statements

The principal financial statements in Section III of this report have been prepared to report the financial position and results of operations of HHS, pursuant to the requirements of 31 U.S.C. 3515(b), the Chief Financial Officers Act of 1990, as amended by the Reports Consolidation Act of 2000 (P.L. 106-531) . While the statements have been prepared from the books and records of HHS in accordance with generally accepted accounting principles (GAAP) for federal entities and the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records. The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity, and that the liabilities reported in the financial statements cannot be liquidated without legislation providing resources to do so.

Grants Management

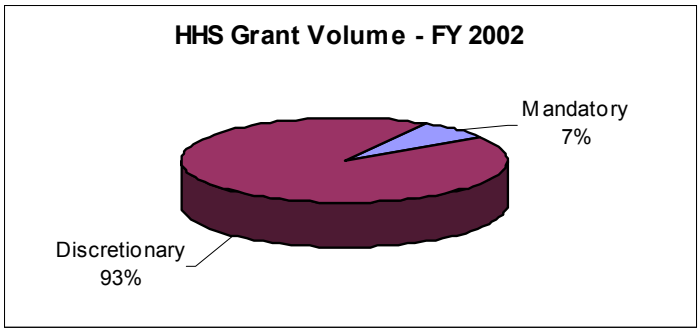
As the largest grant-awarding agency in the Federal Government, HHS plays a key role in federal grants management. Through over 100 assistance programs, HHS awards more than $300 billion in total federal grant funding.

Grant awards are financial assistance that provide support to accomplish a public purpose. Awards include grants and other agreements in the form of money, or property in lieu of money, to eligible recipients. HHS awards most grant dollars in the form of mandatory grants. A mandatory grant is a grant that a federal agency is required by statute to award if the recipients meet the eligibility and compliance requirements of the relevant statute and regulations. The remaining HHS grants are discretionary grants. Discretionary grants permit the federal government, according to specific legislation, to exercise judgment in selecting the project or proposal to be supported and selecting the recipient organization through a competitive process. HHS grant program stewardship and oversight responsibilities involve a variety of ongoing administrative functions, including:

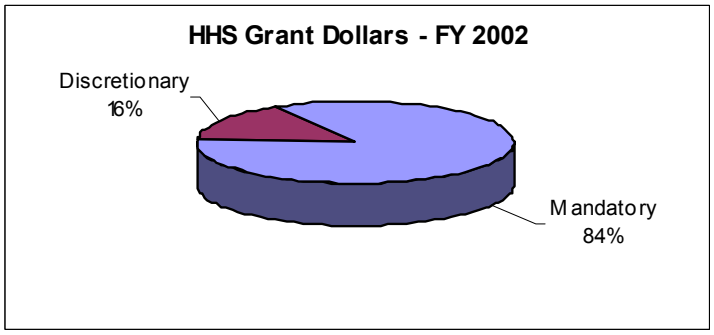
FY 2002 Grant Awards

OPDIV	Total Grants		Mandatory Grants		Discretionary Grants	
	#	$ (in millions)	#	$ (in millions)	#	$ (in millions)
ACF	7,471	$ 43,173	2,524	$ 35,994	4,947	$ 7,179
AHRQ	614	$ 160	-	$ -	614	$ 160
AOA	1,082	$ 1,176	802	$ 1,118	280	$ 58
CDC	3,616	$ 4,464	156	$ 128	3,460	$ 4,336
CMS	621	$ 145,591	327	$ 145,472	294	$ 119
FDA	129	$ 29	-	$ -	129	$ 29
HRSA	7,415	$ 5,311	112	$ 638	7,303	$ 4,673
IHS	590	$ 917	546	$ 907	44	$ 10
NIH	50,139	$ 17,695	-	$ -	50,139	$ 17,695
OS	451	$ 328	-	$ -	451	$ 328
SAMHSA	2,050	$ 2,809	232	$ 2,120	1,818	$ 689
TOTAL	**74,178**	**$ 221,653**	**4,699**	**$ 186,377**	**69,479**	**$ 35,276**
FY 2001	69,085	200,890	5,098	170,376	63,987	30,514
FY 2000	64,433	$ 184,654	4,699	$ 160,008	59,734	$ 24,646

- Assisting OMB in its revisions of key OMB Circulars pertinent to grants administration;
- Providing training and developing related guidance documents on these revised OMB Circulars;
- Conducting oversight through the "Balanced Scorecard Initiative";
- Strengthening HHS indirect cost negotiation capabilities;
- Updating internal departmental grants administrative procedures;
- Utilizing a department-wide grants management information system to report on grant award data across all HHS grant programs;
- Reviewing departmental program announcements; and
- Reviewing single audit of grants by HHS OIG.



OMB designated HHS to be the lead agency to manage the Federal Grant Streamlining Program (FGSP). The FGSP is a federal government-wide effort required by Public Law 106-107, the Federal Financial Assistance Management Improvement Act of 1999, to streamline, simplify, and provide electronic options for the grants management processes employed by federal agencies and to improve the delivery of services to the public. FGSP initiatives encompass the entire grant life-cycle and include standardizing, simplifying and streamlining the formats used to provide program synopses and announce funding opportunities and the forms required to apply for and report on grant funds. HHS is also the lead agency for the government wide Grants.gov initiative, on the President's Management Agenda e-government initiatives. The HHS Grants.gov program office, in partnership with the twenty-six major grant-making agencies are modifying and developing grants management practices and information systems that will allow current and prospective recipients of Federal grants to find, apply for, and manage grant funds on-line through a common web-site.
HHS continues to operate the Tracking Accountability in Government Grants System (TAGGS), which contains department-wide grants award information. Access to TAGGS information is available to HHS staff via the Department's intranet. Our GrantsNet web-site, www.hhs.gov/grantsnet , continues to provide public access to up-to-date policies, regulations, and other pertinent grants-related information.



Highlights of FY 2002 grant awards (most recent data available) include the following:

- HHS awarded over $220 billion in grants in FY 2002; comprised of more than $35 billion in discretionary awards and more than $186 billion in mandatory awards.
- While CMS, which administers the Medicaid Program, awarded less than one percent of the total number of grants, those grants accounted for nearly two-thirds ($146 billion) of the total grant funds awarded.
- NIH awarded more than 50,000 grants, or nearly 68 percent of the total number of grants awarded, but only eight percent of the total grant funds awarded.

- ACF, with more than 7,500 grants totaling $43 billion, awarded the second highest percentage of both total grant volume (10%) and funds (20%).
- The other eight HHS agencies each awarded between less than one and three percent of the total grant funds awarded in FY 2002.

Debt Management

HHS manages its delinquent debt pursuant to the Debt Collection Improvement Act (DCIA) of 1996. Although HHS refers delinquent debt to the Department of the Treasury (Treasury) for cross-servicing and offset, HHS has centralized the DCIA delinquent debt referral process by establishing the PSC as the Department's delinquent debt collection center. In addition, Treasury has granted a cross-servicing exemption for several types of program debts (e.g. Medicare Secondary Payer, unfiled Medicare cost reports and various health professional loans). The PSC cross-services these debts and also refers them to the Treasury Offset Program (TOP). According to the FY 2003 third quarter Treasury Report on Receivables (TROR), HHS and Treasury cooperative debt collection efforts have resulted in:

- HHS referral rates at the end of the third quarter FY 2003 as follows:
  - TOP referrals increased to 93 percent, and
  - Cross-serviced debt increased to 95 percent.
  - Note: HHS expects referral rates to increase at the end FY 2003 when the CMS s scheduled to refer 100 percent of all debts.
- HHS collections exceeded $11.9 billion at the end of the third quarter.

Systems, Controls, and Legal Compliance

This section describes select systems that are critical to HHS Departmentwide management, and discusses HHS's capacity to comply with the Federal laws and regulations that pertain to those systems and controls over the Department's resources. The systems discussion includes an overview of HHS's current key systems and details on the Department's future multi-million dollar implementation of an integrated financial management system, currently under development.

A cornerstone to improving HHS management practices is the Department's ability to maintain management systems, processes and controls that ensure financial accountability, provide useful management information and meet requirements of Federal laws, regulations and guidance. HHS seeks to comply with a variety of federal financial management systems requirements, including those articulated by the Chief Financial Officers Act of 1990, Federal Managers' Financial Integrity Act (FMFIA, 1982), Federal Financial Management Improvement Act (FFMIA, 1996), Joint Financial Management Improvement Program (JFMIP) principles, OMB Circular A-127, Government Management Results Act (GMRA) and the Clinger-Cohen Act of 1996. HHS' overall goals for its financial management systems focus on ensuring effective internal controls; timely, reliable financial and performance data for reporting; and system integration. Its immediate priorities are to address two weaknesses (as identified in its corrective action reports) in financial management system processes and electronic data processing (EDP) access controls.

HHS Financial Management Systems

The following table summarizes the existing key HHS systems that allow HHS agencies to perform the majority of financial management business functions across the Department. HHS current

financial systems environment consists of five core accounting systems including numerous feeder systems processing grants, travel, acquisitions, logistics, and other administrative systems.

System Name	Description
CORE	The PSC CORE Accounting system records and reports the financial activity for eight of the twelve HHS operating components. CORE the nucleus of PSC's accounting operations and accepts and processes data supplied by feeder systems from the HHS agencies as well as from the Payroll, Travel, and Payment Management Systems (PMS). The reliability of the information in CORE has been a major factor in achieving an unqualified "clean" opinion for all of the financial statement audits for the HHS agencies serviced by PSC.
Payment Management System (PMS)	PSC's PMS is a centralized grants payment and cash management system serving 11 Federal agencies with 44 grant awarding component offices and bureaus. PMS is operated by the HHS Division of Payment Management (DPM), Financial Management Service, Program Support Center. PMS has been identified by the Chief Financial Officer's Council (CFOC) as one of two civilian grant payment systems to serve all federal civilian grant-awarding agencies. Of the two CFOC designated systems, PMS is the only full service system available to the grant awarding agencies. PMS is an automated system capable of receiving electronic or manual payment requests, editing them for accuracy and content, batching them for forwarding to the Federal Reserve Bank or U.S. Treasury for payment, and recording the transaction to the appropriate general ledger account(s). The legal or regulatory requirements met by this system include the Cash Management Improvement Act of 1990, OMB Circulars A-102 and A-110, Debt Collection Improvement Act of 1996, and 45 CFR Parts 74, 92, and 96 regulating HHS discretionary and Block grants.
Accounting For Pay System (AFPS)	PSC's AFPS provides a systematic interface of payroll accounting information necessary to account for disbursements, expenditures, obligations and accruals for personnel costs. This interface results in the production of accounting transactions and expenditure of reports to accomplish accounting requirements and payroll reconciliation's. AFPS offers such features as Labor Distribution, Common Accounting Number (CAN) Adjustments, Automated SF-224 Report preparation, Pay and Benefit history file and additional features.
Automated Financial Statement (AFS)	AFS is a web-based system used to compile the department-wide financial statements.
Total Accounting On-Line Processing System (TOPS)	TOPS is the core financial system that supports most of the accounting functions at CDC.
General Ledger Accounting System (GLAS)	GLAS is the core financial application that supports most of the accounting functions at FDA
Central Accounting System (CAS)	Central Accounting System is the core financial system that supports most of the accounting functions at NIH.
Financial Accounting Control System (FACS)	Financial Accounting Control Systems is the core accounting system used to compile accounting functions at CMS.

HHS Financial Management System Weaknesses

Financial Management Systems Processes

HHS's primary strategy to remedy this material weakness is the implementation of the Unified Financial Management System (UFMS). Consistent with the vision of "One HHS," the Department is seeking to meet these goals by unifying and modernizing HHS financial management systems. UFMS is a business transformation effort designed to integrate Department-wide financial management systems and operations by aligning the Department's businesses with modern technological capabilities. Existing HHS financial management system configuration supports standard data elements and interface records. With UFMS, HHS will also standardize business processes for all core JFMIP functions including general ledger, accounts payable, accounts .receivable, cost management, budget execution and financial reporting

General and Application Controls

EDP weaknesses were identified for Medicare contractors in five primary types of controls, as follows: entity-wide security programs, access controls (physical and logical), systems software,

application software development and change controls, service continuity. CMS continues to make progress in identifying and addressing weaknesses in its automated processing systems. Following the establishment of a baseline in FY2002, CMS continues to assess the risks inherent in each area of vulnerability, assign priorities, and seek resources as necessary to correct known deficiencies. In addition, a critical goal of the HIGLAS investment is to integrate CMS accounting systems in order to produce audited financial statements.

The Department remains dedicated to ongoing performance improvement of its financial management environment. HHS, using the Secretary's "One HHS" vision as a guiding principle, is striving to establish a target environment which uses efficient business processes, is supported by modern financial systems, and is consistent with federal financial management requirements and best practices. The UFMS investment represents a substantial commitment towards establishing the target financial management environment across HHS. HHS will continue to monitor the progress and results of its financial management operations in the areas of financial accountability, usefulness of information and compliance.

UFMS Implementation

The UFMS investment will replace five legacy accounting systems (PSC's Core Accounting System, CDC's TOPS, FDA's GLAS, NIH's CAS, and CMS's FACS with a web-based Commercial Off-The-Shelf (COTS) product. Once fully implemented, UFMS will reduce the number of financial management systems from five to one modern accounting system, with two components. One, the Healthcare Integrated General Ledger Accounting System (HIGLAS), will support the Centers for Medicare and Medicaid Services (CMS) and the Medicare Contractors. The other will serve the rest of HHS. Upon completion, UFMS will be the largest civilian financial management system of the federal government.

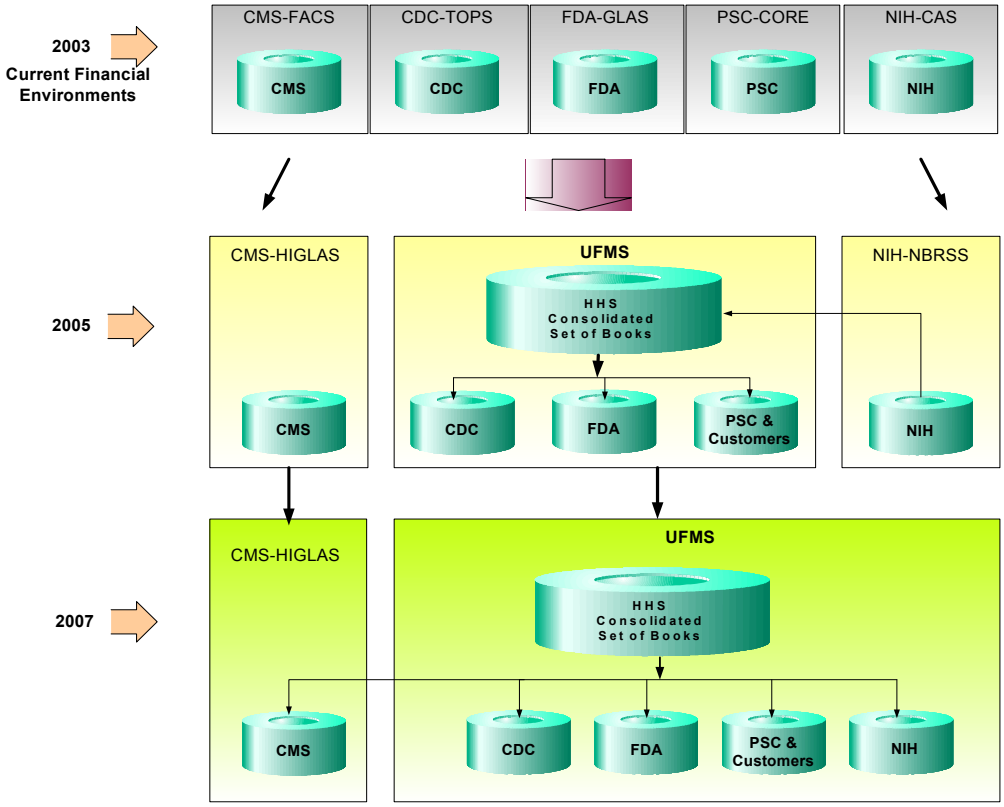
UFMS will routinely produce information that is timely, useful, and reliable and will support the integration of financial and performance information. Older, mainframe systems such as PSC's Core, FDA's GLAS and CDC's TOPS cannot produce the information that program managers and decision makers need in a timely manner, nor can they provide the real-time processes needed to support effective e-government initiatives. By eliminating redundant and outdated financial systems (core and supporting) and by standardizing business rules, data requirements and accounting policies (particularly around the accounting classification structure), UFMS will reduce the extent of manual processes now involved in producing reports. This increases the timeliness and accuracy of financial management information Department-wide, including HHS level consolidated financial statements. Within HHS, UFMS establishes the foundation for full integration of financial and administrative systems and more robust cost management ability. UFMS will also strengthen the extent of internal financial management controls by providing automated funds control that will allow managers to accurately assess available program funds on an everyday basis.

Finally, the Secretary's "One HHS" vision will also result in streamlining critical administrative systems at HHS that impact financial management functions, including grants and acquisition. In conjunction with these internal HHS streamlining efforts, the Department will continue to ensure coordination with e-government initiatives efforts such as e-Travel, e-Grants, e-Payroll and e-Procurement.

HHS has ambitious implementation goals for UFMS. As currently structured, HHS is proceeding on three parallel tracks. The first of these tracks includes implementation activities for CDC, FDA, PSC, and it's customers. NIH is proceeding on another track with its modernization initiative, the NIH

Business and Research Support System (NBRSS). NBS will be integrated with UFMS in FY 05. The final track is CMS' HIGLAS implementation. UFMS is scheduled to be integrated with CMS' HIGLAS by the end of FY 07. One major accomplishment necessary to enable the integration of these three tracks is to have a unified global design, including the budget and accounting classification structure that was recently completed. For the rest of the Department, HHS anticipates deployment at the CDC and FDA in FY05. Implementation at HHS agencies supported by PSC will be phased in from FY05 to FY07 concluding with deployment at the IHS and it's area offices. The following illustration shows HHS's UFMS implementation strategy.

UFMS Implementation Strategy



Key targets and performance:
As of the end of FY 2003, the UFMS project, all three tracks, is on budget and on schedule. Key accomplishments for FY 2003 include:

- Nov 2002 - Received Departmental approval for the UFMS business case.
- Feb 2003 - Issued initial baseline requirements.
- Apr 2003 - Completed global fit/gap analysis.
- May 2003 - Completed initial global process designs.
- Jul 2003 - Completed initial process designs for CDC-specific business processes.
- Jul 2003 - FDA kick-off meeting.
- Jul 2003 - NIH accepted General Ledger.

- Aug 2003 - NIH accepted NBS travel system.
- Oct 2003 - NIH began using General Ledger and NBS travel system.
- FY 2003 - Met all OMB-mandated deliverables, including quarterly briefings.

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

Statement of Auditing Standards (SAS) 70 Systems Reviews

Independent audits of HHS internal controls is completed annually under oversight of the HHS OIG. The audit for FY 2003 was completed under the guidelines of the American Institute for Certified Public Accountants (AICPA) Statement of Auditing Standards (SAS) Number 70 for Service Organizations. The annual audit is a "Type 2" report providing an opinion on the internal controls placed in operation and includes tests of operating effectiveness. The following summarizes HHS systems findings during the FY 2003 audits.

PSC: Core Accounting System and Feeder Systems

An independent audit was conducted of the HHS internal controls for the Program Support Center (PSC) general IT and application controls over the CORE Accounting system and Feeder Systems (i.e. Accounting for Pay System (AFPS), Travel Management System (TMS), Managing and Accounting Credit Card System (MACCS), Accounts Receivable System (ARS), and the Debt Management Collection System (DMCS). In the Auditors opinion, the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period of October 1, 2002 to June 30, 2003 except for as noted below:

- Access Controls over MACCS were not operating with sufficient effectiveness to achieve the control objective of "Controls provide reasonable assurance that computer resources are protected against unauthorized modifications, disclosure, lost, or impairment".
- Additionally, the effectiveness of the MACCS procedures for configuration management, patch management procedures and a periodic review of security configurations have not been placed in operation or did not operate effectively. This resulted in the non-achievement of the control objective "Controls provide reasonable assurance that changes to the existing systems software and implementation of new system software are authorized, tested, approved, properly implemented, and documented"

PSC: Human Resources Service Personnel and Payroll Systems

An independent audit was conducted of HHS internal controls for the PSC which examined the Program Support Center (PSC) general IT and application controls over the Human Resources Service (HRS) Personnel and Payroll Systems (i.e. Civilian Payroll System (CPS), Enterprise Human Resources and Payroll System (EHRP), and the Commissioned Officer Personnel and Payroll System (COPPS). In the Auditors opinion, the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period of October 1, 2002 to June 30, 2003 except for as noted below:

- EHRP controls to prevent incompatible personnel actions processing duties form being performed by one individual were not operating with sufficient effectiveness to achieve the control objective "Controls provide reasonable assurance that incompatible duties and critical stages of processes have been assigned to different organizational units or individuals", as it relates to EHRP.

PSC: Division of Payment Management

An independent audit was conducted of HHS internal controls for the Division of Payment Management (DPM). In the Auditors opinion, the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period of October 1, 2002 to June 30, 2003.

NIH: Center for Information Technology

An independent audit was conducted of HHS internal controls for the National Institutes of Health' Center for Information Technology (CIT). In the Auditors opinion, the controls that were tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period of October 1, 2002 to June 30, 2003.

Financial Controls and Legal Compliance

The Federal Managers' Financial Integrity Act of 1982 (FMFIA) requires that agencies establish controls that reasonably ensure the integrity of federal programs and the use of funds. The Federal Financial Managers Integrity Act of 1996 (FFMIA) requires agencies to implement and maintain systems that comply with specific governmentwide system parameters and policies. As noted in the assurance statements in the Secretary's message at the opening of this document, the following FMFIA and FFMIA issues remain outstanding at the end of FY 2003.

Federal Manager's Financial Integrity Act (FMFIA)

At the end of FY 2003, HHS reduced the number of programmatic management control material weaknesses, under Section 2 of the FMFIA, from one to zero at the HHS corporate level. The material weakness reported in the Department's report on FY 2002 pertained to the enforcement program for Imported Foods at FDA. HHS has determined that FDA has made substantial efforts to date to address this material weakness, and as a result, is no longer material at the HHS corporate level. FDA continues to report this material weakness in its FMFIA report**.** HHS's FMFIA report may be found in Appendix D.

Federal Financial Management Improvement Act (FFMIA)

FFMIA mandates that agencies"...implement and maintain financial management systems that comply substantially with Federal financial management systems requirements, applicable Federal accounting standards and the United States Government Standard General Ledger at the transaction level". FFMIA also requires that remediation plans be developed for any entity that is unable to report substantial compliance with these requirements.

As of September 30, 2003, HHS continues to have two non-conformances with the requirements of FFMIA: 1) Financial Management Systems and Processes; and 2) General and Application Controls over Medicare financial management systems and other HHS agency systems. Implementation of the UFMS will eliminate these material weaknesses.

Further details are provided in the full FFMIA Report in Appendix E. Corrective actions planned and completed are tracked in the Department's Corrective Action Plan (CAP) report that is provided to OMB on a quarterly basis.

Looking Ahead to 2004 - HHS Management Challenges and High Risk Areas

The breadth of services that HHS delivers and the myriad support functions required to support them yield a number of management challenges, which help set the course for HHS improvement efforts each year. The OIG identifies these challenges and tracks HHS's progress in resolving them. Pursuant to the Reports Consolidation Act of 2000, Appendix A addresses the challenges identified by the OIG, and management's responses to those challenges in detail.
As shown in the accompanying chart, many of the initiatives discussed in this report, both under the auspices of the PMA and HHS's own strategic goals, address these challenges. Through the Department's many initiatives, HHS continually strives to improve not only the quality of services it delivers to its "customers" and beneficiaries, but also to enhance management effectiveness and efficiency.

Crosswalk of HHS Challenges and Goals		
HHS Top Management Challenges	**President's Management Agenda**	**HHS Strategic Goals**
Bioterrorism Preparedness		# 2
Payment for Prescription Drugs		# 3
Nursing Facilities		# 3 and # 5
Integrity of Medicaid Payments	Improved Financial Performance	# 8
Oversight of Medicare Contractors	Improved Financial Performance	# 8
Medicare Payment Errors	Improved Financial Performance	# 8
Grant Management	Improved Financial Performance and Expanded Electronic Government	# 8
Protection of Critical Systems, Infrastructure, and Patient Data	Expanded Electronic Government	# 8