United States Department of
Health and Human Services

Chief Financial Officer's Financial Management Status Report and Five-year Plan

2001

Fiscal Year

Table of Contents

Introduction

As part of our effort to continually improve our planning and reporting processes, readers of the 2001 Five - Year Plan will notice that it differs somewhat in form and content from recent CFO plans. With the new President's Management Agenda, the major financial management initiatives are now discussed in the departmental and each component's budget submissions as well as GPRA plans. Generally, this year's CFO Five-Year plan is focused on the internal management support for the management goals included in GPRA plans and the commitments made in budget submissions that support the President's agenda. We determined that the audience for the Five-Year Plan is largely internal to HHS, though it should also be of interest to others -such as the Office of Management and Budget (OMB) and the General Accounting Office (GAO)- who are involved in our budget and audit process. Therefore, the strategies, goals, and targets in this plan are primarily the internal HHS activities most likely to help HHS accomplish the key management reform initiatives mentioned in the budget and GPRA submissions.

We have also addressed the new A-11 requirements for grants management. Specific HHS components have included an Exhibit 57, Erroneous Payments discussion in their budget submission. In this plan, we have included only a high-level discussion on the Medicare error rate measure.

As in past years, actual performance for key goals and measures will be discussed in the HHS Accountability Report and in individual HHS component financial reports. The resources required to accomplish this plan are contained in Exhibits 52 and 53 of the budget submission.

Improving Financial Performance

Programs cannot succeed without sound financial management. HHS strategies for improving financial performance cross multiple functions and focus on supporting HHS programs.

- **Maintaining a "Clean Opinion"**

Federal agencies' financial statements are audited to demonstrate to the public that they fairly and accurately represent their financial condition. A "clean" and timely audit opinion on these statements is essential if decision-makers within the agency and at OMB and Congress are to use that information to make their decisions.

As one of the four federal agencies that are significant to the government-wide consolidated financial statement each year, HHS will continue our considerable efforts to retain a clean opinion while meeting the additional challenge of the accelerated time frames established by the Reports Consolidation Act of 2000 and OMB requirements.

HHS has a number of financial reporting deficiencies due to a lack of a fully integrated financial management system. The Unified Financial Management System is the long-range solution to this challenge. The UFMS will help ensure our ability to improve and maintain consistent, accurate and reliable financial information across the Department. In the meantime, significant effort and resources will be required to prepare financial statements and related information and maintain existing systems until the UFMS is in place. Timeliness of financial information will be improved by accelerating annual financial reporting and by developing quarterly financial statements. Usefulness of financial data will be enhanced by comparative financial reporting and more HHS program cost information. In addition, increased efforts will be made to expand and enhance the financial analysis already begun at HHS, including several HHS agencies such as CMS and FDA. Trend analysis and risk assessments of financial data will help HHS to more readily detect problems and variances so HHS can identify potential areas of risk and take appropriate corrective action.

To accomplish the goal of a clean and timely opinion, HHS and our agencies undergoing audits will work with and rely on the Office of Inspector General and certified public accountant firms to conduct the audits.

- **Reducing Erroneous Payments**

HHS takes the matter of erroneous payments particularly seriously. The amount of payments HHS manages is so large that even a small percentage results in a large dollar volume. These responsibilities are a priority for the entire Department.

CMS has reduced the erroneous payment rate for the Medicare fee-for-service program from 14 percent in 1996 to a level of 6.8 percent in FY 2000. We understand fully that the FY 2000 rate represents $11.9 billion in erroneous payments. We are committed to reaching the goal of an error rate no higher than 5 percent by 2002.

Using the work that was developed to calculate an error rate for the Medicare program, HHS is working with states to develop error rates for the Medicaid program. Once HHS has established the practice of assisting states to develop error rates for state Medicaid programs, we will expand this practice to the Department's other state-based grant programs.

- **Creating a Unified Financial Management System**

Consistent with the President's Management Agenda initiative for improving financial performance, HHS is continuing to move toward the goal of one HHS. HHS information technology will be managed on an enterprise basis with a common infrastructure, rather than by many separate agencies. One of the efforts underway is the UFMS. Specifically, HHS will have one financial management system for the Centers for Medicare and Medicaid Services and the Medicare contractors called HIGLAS, and another management system for the rest of the Department, with both systems feeding into a unified departmental reporting system.

Cost information is a key element when decision-makers assess the effectiveness of programs and the impact of increased or reduced funding. We are currently determining the management cost accounting requirements for the UFMS that will support decision-making and accountability through the capability to link HHS financial costs with program performance and budget information.

The UFMS will provide the full HHS portion of costs for services and products that influence program outcomes, because it will be a standard, efficient system that can accrue costs spent throughout HHS on a particular program or initiative. Managers will then have timely and complete HHS cost information with which to help monitor and improve their program results, plus integrate budget and performance. Citizens, OMB, and Congress, as well as HHS managers will be able to

determine and know on a more frequent, reliable basis; HHS spending levels in relation to what was budgeted; the full HHS cost of each of our 311 programs in relation to how those programs are performing; what and where HHS' important assets are; what liabilities or other potential financial problems arose in operating the programs; and, overall, whether HHS' financial condition is improving or deteriorating. For instance, Medicare Trust fund investments, net costs, and transfers of funds will be available quarterly, and as compared with prior years, so trends in the status of the Trust fund can be analyzed.

This multi-year effort has already begun and will continue through FY 2007.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/Comments:
Audited financial statements for CMS are submitted to OMB by 2/1.	Yes	Yes	Yes	Yes	Yes	Yes	Baseline: No for the FY 1996 audited financial statements. More recently, the FY 2000 HHS and CMS (formerly HCFA) statements were submitted timely on 2/28 and 3/1, respectively. The due date for FY 2001 and beyond was revised to prepare for and reflect new OMB guidance. The measure was also revised to delete HHS since the HHS-level goal for a clean opinion is included in the HHS ASMB GPRA goals. Other HHS components will submit their audited financial statements to OMB based on the agreed upon audit due dates.
Number of HHS components' audited financial statements submitted by established milestone date.	10 of 10	10 of 10	10 of 10	10 of 10	10 of 10	10 of 10	Baseline: FY 1997 - zero were timely. More recently, in FY 2000, 5 of 9 HHS components' statements were timely based on mutual agreements of the parties. (SAMHSA, CDC, PSC and IHS audits were delayed for various reasons). AoA is the tenth HHS component that a will have a full audit beginning with its FY 2001 statements The key date is the completion of an audited financial statement.
Number of clean opinions earned by the HHS components.	10 of 10	10 of 10	10 of 10	10 of 10	10 of 10	10 of 10	Baseline: The audits of the HHS components' FY 1997 statements resulted in no clean opinions. More recently, the FY 2000 opinions for 8 of 9 audited HHS components' statements were clean. IHS, the ninth component, has not yet received its opinion. AoA is the tenth HHS component that will have a full audit beginning with its FY 2001 statements. The HHS-level goal for a clean opinion is included in the HHS ASMB GPRA goals. Also see Appendix A.
Number of HHS components that identify expense types within GPRA programs	3 FDA, CMS, and NIH	9 FDA,CMS, NIH, and PSC-serviced HHS components	10	10	10	10	Baseline: FY 1999 – 2 HHS components (CMS and FDA). More recently, in FY 2000, 4 components had this information available. This measure provides an additional level of information for a manager's decision-making. Targets were adjusted to reflect HHS components' submissions. FY 2001 targets were corrected to reflect a delay from FY 2001 to FY 2002 for PSC-serviced customers.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/Comments:
Number of department-level material weaknesses	2 Financial systems and processes & Medicare electronic data processing (EDP) controls	1 Reduce Medicare EDP	1	1	1	1	Baseline: FY 1997 - 5 material weaknesses were cited in the HHS audit opinion. More recently, in FY 2000, the audit opinion cited only 2 instead of the targeted 3 material weaknesses; the two were: financial systems and Medicare contractor EDP. The unified financial system Material weaknesses are also considered resolved when improvements result in their reduction down to reportable conditions. CMS is working to resolve two of the material weaknesses. The third material weakness is crosscutting among the HHS components so PSC and departmental action are needed to help resolve it.
Number of HHS component-level internal control material weaknesses	4 (Revised) ACF-1, CMS-2, NIH-1	3 (Revised) ACF-1, CMS-1, NIH-1	2 (Revised) ACF-1, CMS-1	2 (Revised) ACF-1, CMS-1	1 (Revised) ACF –1	1 (Revised) ACF –1	Baseline: FY 1997 - 21 HHS components' material weaknesses -some of which were crosscutting and have since been consolidated or resolved. More recently, in FY 2000, there were 9 material weaknesses identified (exclusive of IHS) in the HHS components' audit opinions; 3 of which were for financial systems, 5 for grant financial management, and 1 for Medicare EDP controls. See also Appendix B.
Number of department-level reportable conditions	2 Medicaid improper payments & departmental EDP	2	2	2	2	2	Baseline: FY 1997 - 3 reportable conditions. More recently, in FY 2000, there were only 2 instead of the 3 projected reportable conditions. The property finding was resolved in FY 2000, so the FY 2001 target was revised from 3 to 2. Reportable conditions are identified in the HHS audit opinion.
Number of HHS component-level internal control reportable conditions	17 (Revised) ACF-3, AoA-3, CDC-4 FDA-1, CMS-2, NIH-2, SAMHSA-2	15 (Revised) ACF-3, AoA-2, CDC-4, CMS-2, FDA-1,NIH-2, SAMHSA -1	7 (Revised) ACF-2, CDC-2, CMS-2, SAMHSA -1	5 ACF-1, CDC-1, CMS-2, SAMHSA -1	3 ACF-1 CMS-2	3 ACF-1 CMS-2	Baseline: FY 1997-59 reportable conditions. More recently, in FY 2000, 39 reportable conditions were identified (exclusive of IHS). The ultimate goal is to reduce the number of reportable conditions; however as improvements are made to qualifications and material weaknesses, the number may increase initially. A complete explanation of the reportable conditions is contained in each HHS component's audit opinion and corrective action plan. See also Appendix B.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/Comments:
Percentage of Medicare contractors that will be subjected to a SAS 70	20%	20%	20%	20%	20%	20%	Baseline: FY 2000 - 26 of 50 contractors had SAS-70 reviews; 19 of the contractor's SAS 70 reviews covered Part A; 16 covered Part B. Statement of Accounting Standard No 70 (SAS 70) is intended for all entities that outsource tasks for conducting accounting transactions and related services. It requires accountability and internal control assessments. Based on the results of the SAS 70s (Type I) performed in FY 2000, CMS will continue SAS 70s of Medicare contractors using a more detailed approach (Type II). CMS plans to review all Medicare contractors remaining in the program at least once in the five-year period.
Number of department-level instances of non-compliance	1	1	1	1	1	1	Baseline: FY 1997 – 4 instances of non-compliance. More recently, in FY 2000, HHS had 1 non-compliance with the Federal Financial Management Improvement Act. See Appendix C for the HHS FFMIA remediation plan. A detailed discussion of the findings is contained in the HHS audit report.
Number of HHS component-level instances of non-compliance	8 (Revised) ACF, CDC, CMS, FDA, HRSA, NIH, SAMHSA, and AoA	3	2	2	2	2	Baseline: FY 1998 - 8 instances of non-compliance. More recently, in FY 2000, there were also 8 instances (exclusive of IHS). The instances related to compliance with the Federal Financial Improvement Act.
Percent of improper Medicare Fee-for-Service payments	6%	5%	5%	5%	5%	5%	Baseline: FY 1996 - Non-Compliance with the Social Security Act; the estimated error rate was 14%. More recently, in FY 1999 the non-compliance finding was removed and further, in FY 2000, the estimate was 6.8%. Providers need to maintain medical records that contain sufficient documentation and to use proper procedure codes when billing Medicare for services. Improper claims for payment could range from inadvertent mistakes to outright fraud and abuse; the portion attributable to fraud cannot be quantified. Improper payment error rates are identified in the Inspector General's annual audits of the fee-for-service payments.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/Comments:
Submit HHS Accountability Report to OMB by February 1	Yes	Yes	Yes	Yes	Yes	Yes	Baseline: FY 1997 - Not timely. More recently, for the FY 2000 period, the report was one day early. The measure was revised to prepare for and to reflect new OMB guidance.
Number of HHS components that submit their Accountability or Financial Reports by due date	10 of 10	10 of 10	10 of 10	10 of 10	10 of 10	10 of 10	Baseline: FY 1998 - 8 of 8 were timely. More recently, for FY 2000 reports, 5 of 9 were timely. OPDIV overviews must be submitted to the auditors and to HHS so the HHS and government-wide audited financial statements/overviews will be on time.
Number of HHS components with useful internal reports that include cost information for individual programs	3 (Revised) CMS, HRSA, and NIH,	3 (Revised) CMS, HRSA, and NIH	3	3	3	4 ACF,CMS, HRSA, and NIH	Baseline: FY2000 – 3 HHS components. Monthly financial reports assist decision-makers throughout the year. Reports should tell program managers and other managers the actual costs of programs in a timely manner. The content of the reports will vary, depending on the needs of the user. While HHS systems are capable of producing cost information, this information has to be tailored to the needs of individual programs and linked to their GPRA performance. HHS will work with the components to establish strategies for accommodating these individual needs.
President's Budget reflects final figures from FACTS II	Yes	Yes	Yes	Yes	Yes	Yes	Baseline: FY 1999 - 5 HHS components (ACF, CDC, FDA, CMS, NIH). The target of Yes indicates that all HHS components and HHS as a whole will have budget execution and year-end closing statement information that is consistent with the President's budget.
Percent of vendor payments made on time	96% (Revised)	96% (Revised)	97% (Revised)	97% (Revised)	97% (Revised)	97%	Baseline: FY 1998: 91%. More recently, in FY 2000, 97% was achieved. Because of the volume of their activities, NIH, IHS, and PSC are the HHS components that have a critical impact on meeting these targets. For FY 2000 NIH paid 37.8%, IHS Area Offices paid 28.7%, and PSC paid 15.2% of the total HHS vendor invoices.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/Comments:
Timely payment of approved travel vouchers within 30 calendar days of submission to first-level reviewing official	95%	95%	96%	96%	96%	96%	Baseline: FY 2001 – Effective FY 2000, federal agencies are required to pay proper travel vouchers within 30 calendar days or pay a late payment fee to the employee. Since FY 2001 is the first full year of implementation, it will be used as the baseline year.
Percent of individually billed travel accounts that are past due 61 or more days	5% (Revised)	4% (Revised)	3% (Revised)	3% (Revised)	2% (Revised)	2%	Baseline: FY 2000 – 10% were past due. Employees are responsible for paying their travel card bills timely. HHS components can influence this statistic by paying proper travel vouchers timely and by educating their employees about travel card responsibilities. This measure and targets were revised to be consistent with the CFO Council's approach by using 61 instead of the former 60 days to calculate the percent of vouchers past due.
Percent of centrally billed travel accounts that are past due 61 or more days	1% (Revised)	.5% (Revised)	0% (Revised)	0% (Revised)	0% (Revised)	0%	Baseline: FY 2000 – 19% were past due. The goal is to pay bills timely and reach 0% as soon as possible. This measure and targets were revised to be consistent with the CFO Council's approach by using 61 instead of the former 60 days to calculate the percent of vouchers past due.
Percentage of eligible purchase transactions made on credit cards	87%	89%	91%	91%	91%	91%	Baseline: FY 1997: 77% of 500,000 transactions. More recently, in FY 2000, 84% of the eligible transactions were made by purchase card. Basis for measure/targets: The percent of eligible transactions is determined by the ratio of purchase transactions made under $2,500 using credit cards to the total purchases under $25,000. The targets reflect projected rates of growth in credit card use. Eligible transactions do not include the NIH DELPRO transactions.
Increase percent of collections over prior year	10% increase	10% increase	10% increase	10% increase	10% increase	10% increase	Baseline: FY 1998: $13.3 billion. More recently, in FY 2000, $15.3 billion in debts was collected. Basis for measure/target: The target is to have an increase of 10% in total dollars collected over the prior year (The FY 2001 target of $16.8 billion is 10% more than $15.3 billion collected in FY 2000). CMS's performance is critical to achieving this target.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/Comments:
Percent of eligible non-waived delinquent debt referred for cross-servicing to Treasury	100%	100%	100%	100%	100%	100%	Baseline: FY 1998: 0% referred as we were anticipating designation as a government-wide Debt Collection Center. More recently, in FY 2000, 41.9% of eligible debt was referred to Treasury for cross-servicing. Targets of 100% are in accordance with law (DCIA of 1996). CMS is a key HHS component in achieving these targets. CMS's FY 2001 target is based on a percentage of the total $2 billion overall debt referral target for FY 2001.
Percent of eligible waived delinquent debt referred to PSC for cross-servicing	100%	100%	100%	100%	100%	100%	Baseline. FY 1999: 3.7%. PSC received approval in January 1999 to act as a debt collection center for certain debts. More recently, in FY 2000, 26.2% of eligible delinquent debt was referred to PSC. The target is in accordance with law (DCIA of 1996). Baseline and targets are actual dollars referred as a percentage of eligible dollars. CMS is a key HHS component in achieving these targets. CMS's FY 2001 target is based on a percentage of the total $2 billion overall debt referral target for FY 2001.
Percent of eligible delinquent debt referred to the Department of the Treasury for offset	100%	100%	100%	100%	100%	100%	Baseline: FY 1998: 20.2% (2nd quarter baseline established in FY 1998 Plan). More recently, in FY 2000, 34.2% was referred to Treasury. Targets of 100% are in accordance with law (DCIA of 1996). Baseline and targets are actual dollars referred as a percentage of eligible dollars. CMS is a key HHS component in meeting these targets. CMS established a $2 billion target for FY 2001.
Increase the dollars for child support collections over prior year	$18.527 billion (revised)	$20.041 billion (revised)	$21.686 billion (revised)	$23.371 billion (revised)	$24.794 billion	$26.2 billion	Baseline: FY 1998: $14.367 billion as of May 1999. More recently, in FY 2000, $17.9 billion was collected. Targets for total dollars collected represent a 6-8.9% increase above the prior year. There was a slight decrease in the targets for all years as a result of a 5.8% decrease in TANF collections that were most likely due to the decreasing TANF caseload. Also, states collect the funds and they are implementing new data reliability audits that will help to refine the accuracy of reporting.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/Comments:
Number of Department level FMFIA material weaknesses pending at year end	4 (Revised)	TBD	TBD	TBD	TBD	TBD	Baseline: FY 1997: 7. More recently in FY 2000, 4 material weaknesses were pending; FY 2001 and 2002 targets were revised as a result. HHS components identify management material weaknesses and prepare a corrective action plan to resolve them. These targets reflect the plans. HHS determines which weaknesses are material, i.e., they are significant enough to warrant reporting to the President and Congress.
Percentage of apportionments approved within 3 weeks	75%	75%	75%	75%	75%	75%	Baseline: FY 1997: 46%. More recently in FY 2000, HHS achieved a rate of 65.4%. Once apportionments are received by OS from the HHS components, they are reviewed by OS Budget and Finance staff for submission to OMB. Apportionment documents are analyzed and approved by OMB. This means that HHS, HHS components, and OMB must work together and submit/approve information timely to meet the target.
Percentage of apportionments approved within 4 weeks	90%	93%	95%	95%	95%	95%	Baseline: FY 1997: 70%. More recently in FY 2000, HHS achieved a rate of 77%. Targets for FYs 2001 and 2002 have not been changed though.

Useful, Reliable and Secure Program and Financial Systems

This Administration will improve services to citizens through electronic government (E-Gov). The government will align the ways in which services are being provided with new technologies. At HHS, processes and systems are being overhauled, turning them from agency-centric to customer-facing systems. The increased responsiveness and cost effectiveness of these systems cannot be ignored, but the change management challenge is daunting. Many critical issues must be resolved such as privacy and security questions.

In HHS, a solid IT enterprise infrastructure forms the basis of the E-Gov efforts. HHS is working internally to build a solid technological foundation to support the needs of HHS customers for a more reliable network and systems availability, improved configuration management and software distribution, and flexibility in supporting changing business needs while providing security and privacy. As new systems are proposed, they are reviewed by the Information Technology Investment Review Board (ITIRB) for compliance with this strategy. Goals and targets for improving the E-business component of E-Gov are included or implicit throughout this plan and the HHS GPRA plan.

For financial information to be useful, it must be available and easily accessible to the many people inside and outside HHS. It must also be linked with program activities and information. In this exchange of information, the integrity and security of the data must be maintained in order to be reliable. If computer hackers penetrate financial information systems and corrupt them, there is the real risk that people would not receive needed health services, sensitive personal information would be vulnerable, and the solvency of such major programs as Medicare, Medicaid, and TANF could be jeopardized. Several major HHS information technology strategies and initiatives are designed to address these risks by ensuring that program and financial data are available and secure. These strategies and initiatives are the critical bedrock for all HHS transactions and information:

- Information Security and Critical Infrastructure Protection (CIP)

Information security and critical infrastructure protection is the driving force in the HHS IT strategy. The HHS program meets all level 5 requirements in the Federal CIO Council/NIST Security Self-Assessment Framework. The information security goals and performance measures in this Framework are established to focus HHS efforts and investments on attaining increased security and continuity of services.

- Enterprise Certification Authority using Public Key Infrastructure (PKI) technology

Significant vulnerabilities are inherent in the worldwide transformation to electronic commerce and interaction. To secure both internal and external electronic communications, HHS plans to implement an Enterprise Certification Authority using Public Key Infrastructure (PKI) technology. PKI is an enabling technology, which is critical to closing these security vulnerabilities.

- Enterprise Infrastructure Management

The Enterprise Infrastructure Management (EIM) is an operational information technology (IT) management framework that will protect the HHS national IT operating infrastructure by restructuring management practices, procedures, and functional boundaries, and will provide automated tools to reduce user and systems administrator workload. EIM will provide or allow the following:

- Department level monitoring with component level management independence.
- Real time security/privacy detection and alerts.
- Information systems to meet the business customers' needs for more consistently reliable network and systems availability, improved configuration management and software distribution, and flexibility in supporting changing business needs, while providing state of the art security and privacy.

  The first step in implementing EIM is to conduct six pilots of the core EIM software products at the agency level to test capabilities and functionality. Findings from these pilots will determine how best to accomplish an EIM capability department-wide.

All of the initiatives discussed above support HHS' two financial strategic goals; but primarily they support the accuracy, timeliness, and usefulness of program and financial information.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/Comments:
HHS-wide critical IT services (WAN, Internet, Data Center(s), e-mail, and telephone) are available to enable HHS mission and program operations	96%	99.5%	99.8%	TBD	TBD	TBD	Baseline: FY 2001 actual. This is a new measure. HHS cannot perform its critical missions without the constant availability of IT support services.
100% of IT investments approved by the ITIRB meet review criteria	100%	100%	100%	100%	100%	100%	Baseline: FY 1999: 3 meetings were held. The Board met once in FY 2000 and reviewed a single system: the NIH New Business System. More recently, in FY 2001, the Board met three times and reviewed the EIM and HIGLAS systems. All investments either met the requirements or were brought into compliance through Board action.
Develop e-business systems targets and track the department-wide implementation of electronic commerce	Begin to track targets Register 100% of the OPDIVs with FedBizOpps.	All operational procurement offices are using FedBizOpps	Track	Track	Track	100%	Baseline: FY 2000 – Established plan. The measure indicates the degree of implementation of HHS electronic business. FedBizOpps is the electronic government-wide point of entry for procurement opportunities. E-business measures contained elsewhere in this plan include prompt payment of vendors, the Federal Commons project, and increasing purchases by credit card. Electronic funds transfer measures are included in the HHS ASMB GPRA plan.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/Comments:
Develop and issue policy for securing both internal and external communications	Issue PKI policy on certification and certification authority concept of operations	Conduct first pilot	Partial implementa-tion	Full implementa-tion			Baseline: FY 2001. This is a new measure. The Public Key Infrastructure (PKI) technology is critical to closing security vulnerability. The policy will be issued by HHS
Initiate pilots of the core Enterprise Infrastructure Management software products at the HHS component level	6 HHS Component pilots - CDC, CMS, IHS, NIH, OIG, and PSC	3 HHS Component pilots – CDC, FDA, and NIH					Baseline: FY 2001 – 6 pilots. This is a new measure. The EIM is an operational information technology framework. The pilots will test capabilities and functionality of meeting customers needs. Future year targets will be determined by the results of the pilots and resource availability.

Consistent, Streamlined, and Improved Grants Management

HHS manages over 300 grant programs which comprise over half of all federal grants; nearly $185 billion was awarded in FY 2000 to state, local, and tribal governments and non-profit organizations to provide needed services. A chart showing the top grant programs for HHS is included in Appendix D. Consistency, streamlining, and other improvements in the grant award and administration process are essential for effective and efficient transfer and accountability for resources destined for grant beneficiaries. The HHS financial strategic goal to use resources appropriately, effectively and efficiently is supported by efforts to have consistent, streamlined and improved grants management. Such efforts will not only improve the use of resources at the Federal level, but will have even more of an impact on State, local and tribal governments and non-profit organizations.

- Consistency in Grant Award and Administration

The Department provides uniform, broad-based policy guidance to the OPDIVs and STAFFDIVs through the HHS Grants Policy Directives System which outlines requirements for the award and administration of HHS' diverse grant programs. In developing and issuing the Directives, the Department solicits input from OPDIV/STAFFDIVs through the Executive Committee on Grants Administration Policy (ECGAP). ECGAP, the Department's primary information exchange forum on grants management, meets at least quarterly to discuss department-wide and government-wide policy issues. In addition to serving as liaisons between the Office of Grants Management and HHS awarding components, its members provide valuable support through participation on ad-hoc and standing committees which address a variety of grants management related issues.

In addition to targeted assessments, HHS is utilizing a Balanced Scorecard methodology to assess the performance of the grants management function, including monitoring the effective implementation of HHS grants policy. The Balanced Scorecard examines grants administration within the HHS components from multiple perspectives, specifically four: Financial, Customer, Internal Business, and Learning and Growth. Balanced Scorecard data is collected from HHS grants and program offices and recipient organizations.

- Streamlining HHS grant programs

HHS is the lead agency for implementing the Federal Financial Assistance Management Improvement Act (Public Law 106-107) through a Federal Grant Streamlining Program (FGSP). HHS is responsible for overseeing the government-wide grant reform which will: (1) Improve the effectiveness and performance of federal financial assistance programs, (2) simplify federal financial assistance application and reporting requirements, (3) improve the delivery of services to the public, and (4) facilitate greater cooperation among those responsible for delivering the services. A balanced scorecard methodology will also be used to track and manage agency implementation of PL 106-107.

There are four FGSP interagency work groups: pre-award, post-award, audit oversight, and electronic processing, which collectively address all aspects of Federal grant administration. The focus on the pre-award and post-award efforts is on consolidation and coordination among Federal agencies to use the same or similar forms and data elements to apply for, administer, and report on grant activity. The audit team is addressing the quality, timeliness, and usefulness of audit information for grant managers. The current focus of the electronic processing work group is to establish the Federal Commons.

The Federal Commons will serve as the "common face" for e-commerce over the entire grant life cycle, offering both general information exchange and secure electronic transaction processing. It will be the portal allowing each recipient to access the Federal government through a single, web-based point of entry. The Federal Commons will translate various technology options available to the recipient community into a single data standard for transmission to the Federal agencies and will provide electronic access to grant and business process information. This information includes databases containing organizational and professional profiles, and required certifications and assurances.

The Federal Commons is intended to provide:

- a web-based gateway and a searchable synopsis of grant programs and funding opportunities through the Federal government's "FirstGov" portal, the CFDA web site, and the FedBizOpps web site (access and communication among these sites will be simple and transparent to the user);

- convenient infrastructure services for potential recipients, such as the registration, logon, account administration, and profile administration necessary for various pre and post award activities;

- electronic business process services such as application submission, application status query, award notification, post-award reporting, and common front-end to payment systems; and

- Integration of the various grant-making agencies processes, as agreed to in the context of work accomplished by the FGSP interagency work groups, into the Federal Commons.

- Improving HHS Grants Management

Seven activities, listed below, have been endorsed in concept by the Secretary as ways in which we can move to more cost-effective grants administration. HHS departmental and component staffs are engaged in preliminary discussions that will culminate in completion of an implementation plan**.**

- Provide leadership for Federal government-wide grant streamlining efforts.

- Outsource grant-related clerical and administrative activities.
- Streamline and automate the application review process.
- Consolidate and accelerate annual grant planning by linking it to the President's budget.
- Moratorium on new and consolidation of existing, grant offices.
- Consolidation of commercial indirect cost rate function.
- Moratorium on new electronic grants management systems, and develop HHS grants management user requirements.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/Comments:
Percent of grant administration policies that are current	100%	100%	100%	100%	100%	100%	Baseline: FY 1998: 75%. More recently, in FY 2000, 93% of the guidance was current. This is determined by the average of the percent of Grants Administration Manual chapters replaced by succinct, updated guidance in Grants Policy Directives (GPDs) and the percent of GPDs requiring reevaluation for reissuance on a standard review cycle.
Department participates in the inter-agency Federal Commons Project	Participate in development and completion of inter-agency project plan.	Complete testing and implement initial project modules for announcement synopsis and invention reporting	Complete grant application and financial reporting modules	Operational	Operational	Operational	Baseline: FY 2001- the interagency plan was completed and issued in May 2001.

- Non-Federal Audit Quality

HHS works closely with its partners including states, local governments, and tribes, to provide services to those who need them. Since all are accountable to taxpayers for use of the federal funds, audits of the use of those funds are conducted at the partner level as well as the HHS level. In addition to the other grants management improvements discussed above, HHS has committed to timely audit resolution in the HHS ASMB GPRA plan. Also, HHS provides assurance of the quality of audits performed by non-federal auditors via a multi-tiered approach as follows:

- Quality Control Reviews performed by the Office of Inspector General's (OIG) National External Audit Review Center (NEAR), discussed below,
- Maintenance of an up-to-date HHS Audit Compliance Supplement providing complete coverage of major programs and guidance to the auditor,
- Referral of non-federal auditors to the NEAR center and/or state societies for disciplinary review as a result of findings during the normal audit resolution process, and
- Technical assistance provided at various association meetings, state societies, internet-posted questions and answers, and individual discussion.

The OIG's NEAR center performs desk reviews on all single audit reports received from the Census Bureau. The findings and recommendations are summarized and identified by federal department officials responsible for the resolution. A written response to the HHS resolution official is requested within 30 days from the date the letter was sent out by NEAR.
In addition, quality control reviews (QCR's) of states, local governments, and non-profit organizations audits under OMB Circular A-133, are performed during the year. See summary of number of QCR's completed and scheduled below:

OIG/NEAR	FY 2001 Planned	FY 2002 Planned	FY 2003 Planned	FY 2004	FY 2005	FY 2006	Performance/Comments:
QCR-OIG Lead Agency	15	15	15	TBD	TBD	TBD	In FY 1999 and FY 2000, 14 reviews were completed.
QCR-OIG Supporting Agency	1	1	1	TBD	TBD	TBD	In FY 1999, 3 reviews were completed, and 1 was completed in FY 2000.
QCR-Contractor Personnel	5	15	20	TBD	TBD	TBD	In FY 1999, 7 reviews were completed, and 0 were completed in FY 2000.

Encouraging Excellence in Human Resources

HHS, like many other federal agencies, is facing a "human capital crisis." At HHS, 26.6% of the current workforce is either eligible or will become eligible for retirement within the next five years. The number of resignations typically exceeds the number of retirements. HHS will use rigorous workforce planning to maintain a high-quality workforce during this period of increased retirements and unpredictable resignation rates. At the same time, HHS will be finding ways to restructure our Department in line with the President's objective of de-layering the government and putting more employees in front-line, citizen-serving positions. In the Department's GPRA plan, HHS has also established a goal and targets for competitive sourcing.

Employees involved in financial management are impacted by these trends, as well as by the marketplace demand for such series as accountants; this makes it more difficult to replace and recruit for those who have the necessary skills and education, especially since government accounting has complexities which commercial accounting does not.

HHS' recognition of its key assets – its employees – and the challenge to recruit and retain well-qualified employees, is strikingly evident in the HHS initiatives to improve employee satisfaction, enhance workplace learning, and improve the management of change. We will also encourage professional certification and participation in the CFO Council's Fellows Program.

HHS' human resources strategies support both of the financial management strategic goals by ensuring the availability, readiness, and accountability of knowledgeable people—including financial management personnel-- who will contribute to the accomplishment of our programs.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/Comments:
Number of training hours offered times the number of attendees at ASMB-sponsored training sessions	2000	2000	2000	2000	2400	2500	Baseline: FY 1998: 480 estimated (8x60 attendees). More recently, in FY 2000, 1606 hours of training were conducted. The significant increase was a result of stepped up efforts to obtain a clean audit opinion. Also, courses in budget execution were conducted.
Percent of financial employees who have established individual development plans	65% average per 5 HHS components	90.2% average per 10 HHS components (Revised)	94.1% average per 10 HHS components (Revised)	95% average per 10 HHS components (Revised)	95.4% average per 10 HHS components (Revised)	95.8% average per 10 HHS components (Revised)	Baseline: FY 2001. This measure covers employees in the 501, 510, 525, and 540 series that have training plans. ACF, AHRQ, FDA, NIH, and PSC originally established targets in FY 2001; SAMHSA and CMS subsequently set targets for 2001, and CDC has committed to participate in FY 2002.
Number of HHS components with succession planning strategies for financial management staff	5 PSC, NIH, HRSA, FDA, and CMS	8 (Revised) ACF, AoA, CDC, CMS, FDA, HRSA, NIH, and PSC	8 (Revised)	8 (Revised)	8 (Revised)	8 (Revised)	Baseline: FY 1999: 2 NIH and HRSA. More recently, in FY 2000, 3 components had plans. Basis for measure/targets: Number of HHS components that have a documented strategy and evidence of implementation of that strategy. The need for succession planning varies by HHS components since the projected turnover rates and potential departures due to retirement varies by HHS component.

Other Asset Management Initiatives

Consistent with the requirements of the Energy Policy Act of 1992, HHS developed an energy conservation management program that includes the implementation of energy efficiency projects and increasing energy awareness throughout the HHS agencies. HHS components were further required to reduce energy consumption based on the mandates of E.O. 13123, *Greening the Government Through Efficient Energy Management,* issued on June 8, 1999. Our results have been promising. In the HHS energy intensive facilities (as defined by E.O. 13123, 89 percent of total HHS space is categorized as "energy intensive"), which includes laboratories, hospitals, animal centers and health clinics. We have been able to decrease energy use by 12.3 percent when comparing FY 2000 consumption to the base year of FY 1990 (E.O. goal is 20% by 2005). The BTU consumption per square foot in these facilities was reduced from 374,200 BTU in 1990 to 328,053 Btu in FY 2000. In addition, energy consumption in office space has been reduced by 17.5 percent when compared to a 1985 baseline (the E.O. goal is to reduce use by 30% by 2005). This equates to a reduction from 95,506 Btu per square foot in 1985 to 78,818 BTU in 2000. The reduction of energy use since our program began has resulted in approximately $11 million in savings.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/ Comments:
Reduction of energy consumption at HHS energy intensive facilities.	13.3%	15.3%	17.3%	19.3%	20%	21%	Baseline: 1990-373.4 million BTUs for lab/industrial space. More recently, in FY 2000, a 12.3% reduction was achieved. The target percent represents the decrease in energy consumption per year that we expect to obtain in our effort to reach the FY 2005 mandated industrial and laboratory usage target of 20%.
Reduction of energy consumption at HHS standard office facilities	20%	22%	25%	27%	30%	32%	Baseline: FY 1985 - 85 million British Thermal Units (BTUs) for office space. More recently, in FY 2000, a 17.5% reduction was achieved. The target percent represents the remaining decrease in energy consumption per year that we expect to obtain in our effort to reach the FY 2005 mandated target of 30% for office space.

Adequate stewardship over the Department's investment in capitalized equipment is essential to carrying out the Department's scientific, regulatory, and administrative missions and to producing accurate financial records. The lack of adequate property stewardship can result in unnecessary expenditures of funds. Funds must be used to replace lost items or to purchase duplicate items for equipment already in the inventory. Productivity is lost when mission essential equipment is not available. Good stewardship over equipment assets also will increase the accuracy of the Department's presentation of personal property assets in the annual financial statements required by the Chief Financial Officer's Act and provide a better understanding of the resources required to carry out the Department's missions. The strategy is to continue the inventories, encouraging good property stewardship.

	FY 2001 Target	FY 2002 Target	FY 2003 Target	FY 2004 Target	FY 2005 Target	FY 2006 Target	Performance/ Comments:
(1) Location accuracy of capitalized personal property records	96%	96%	96%	96%	96%	96%	Baseline: FY 1998: 90%. More recently, in FY 2001, a 97% accuracy rate was achieved. The targets for future years reflect the realistic level of accuracy that is recognized in HHS policy.

Both of these asset management initiatives contribute to the financial management strategic goal for the effective, efficient use of resources.

HHS and HHS Components Audit History

APPENDIX A

Entity	FY 1995		FY 1996		FY 1997		FY 1998		FY 1999		FY 2000	
	Scope of Review/ Audit	**Opinion/ Report Rendered**	**Scope of Review/ Audit**	**Opinion/ Report Rendered**	**Scope of Review/ Audit**	**Opinion/ Report Rendered**	**Scope of Review/ Audit**	**Opinion/ Report Rendered**	**Scope of Review/ Audit**	**Opinion/ Report Rendered**	**Scope of Review/ Audit**	**Opinion/ Report Rendered**
HHS	Unaudited	**No**	Full scope	**Disclaim**	Full Scope	**Qualified**	Full Scope	**Qualified**	Full Scope	**Clean**	Full Scope	**Clean**
CMS (formerly HCFA)	Limited Scope (Balance sheet only)	Disclaim	Full scope	Disclaim	Full Scope	Qualified	Full Scope	Qualified	Full Scope	Clean	Full Scope	Clean
ACF	Pre-audit survey	Manage-ment Report	Full scope	Qualified	Full Scope	Qualified	Full Scope	Split	Full Scope	Clean	Full Scope	Clean
NIH	N/A	N/A	Internal Control Assessmen t	Manage-ment Report	Full Scope	Qualified	Full Scope	Split	Full Scope	Clean	Full Scope	Clean
HRSA	N/A	N/A	Full scope	Qualified	Full Scope	Qualified	Full Scope	Split	Full Scope	Clean	Full Scope	Clean
CDC/ ATSDR	N/A	N/A	Internal Control Assessmen t	Manage-ment Report	Full Scope	Qualified	Full Scope	Clean	Full Scope	Clean	Full Scope	Clean
SAMHSA	N/A	N/A	Full Scope	Qualified	Full Scope	Qualified	Full Scope	Split	Full Scope	Clean	Full Scope	Clean
IHS	Limited Scope (Balance Sheet only)	Disclaim	Full Scope	Qualified	Full Scope	Qualified	Full Scope	Split	Full Scope	Qualified	TBD	TBD
FDA	Pre-audit survey	No	Full Scope	Qualified	Full Scope	Qualified	Full Scope	Clean	Full Scope	Clean	Full Scope	Clean
PSC	N/A	N/A	SAS 70s	N/A	SAS 70s	N/A	Balance Sheet only	N/A	Full Scope	Clean	Full Scope	Clean
AoA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Balance Sheet Only	N/A
AHRQ	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
OS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

N/A = Not Applicable TBD = To Be Determined Split = Statements of Custodial Activity, Budgetary Resources and/or Financing Disclaimed

APPENDIX B

SUMMARY OF FY 2000 AUDIT FINDINGS BY HHS COMPONENT

	HHS	ACF	CDC	FDA	CMS	HRSA	IHS[1]	NIH	PSC	SAMHSA	AoA[3]	[2]
Financial systems and processes	MW	RC	MW		MW	RC		MW	RC	RC	RC	9
Medicare EDP	MW				MW							2
Medicare regional office oversight												
Medicaid error rate	RC				RC							2
EDP	RC	RC		RC		RC			RC	RC	RC	7
Property								RC (2)				3
Medicare Entitlement Benefits Due & Payable					RC							1
Fund balance with Treasury		RC				RC		RC	RC	RC	RC	6
Grant financial management		MW				MW		MW		MW	MW	5
Reimbursable agreements			RC			RC		RC		RC		4
Controls over grants			RC (2)									2
Overhead rate								RC				1
Biological products inventory												
Service & Supply and Mgmt Fund transactions												
Treasury 2108/SF 133 reporting reqmts								RC				1
Accounts payable and unliquidated obligations								RC				1
Open document file								RC				1
Required authorizations								RC				1
Receipt and acceptance procedures								RC				1
Duplicate and Over Payments								RC				1
Accurate and timely posting of transactions								RC				1
OPAC processing												
Payroll								RC				1
Health profession student loan program												
Accounting for litigation claims												
Elimination entries												
Inventory and cost of goods sold												
Accounts receivable												
Possible anti-deficiency												
FFMIA	CLR	CLR	CLR	CLR	CLR	CLR		CLR		CLR	CLR	9
TOTAL	2 MW 2 RC 1 CLR	1 MW 3 RC 1 CLR	1 MW 3 RC 1 CLR	2 RC 1 CLR	2 MW 2 RC 1 CLR	1 MW 4 RC 1 CLR	TBD	2 MW 13 RC 1 CLR	3 RC	1 MW 4 RC 1 CLR	1 MW 3 RC 1 CLR	

MW = Material Weakness CLR = Compliance with Laws and Regulations RC = Reportable Condition TBD = To Be Determined

[1] Audit not complete
[2] Total number of findings per category
[3] Balance Sheet Audit only

Changes since 1999 Audit results.

HHS - Material weaknesses reduced from three to two, as the Medicare accounts receivable material weakness was removed and incorporated into the Financial Systems and Processes material weakness. Reportable conditions reduced from four to two, as the Medicare regional oversight and property reportable conditions were removed.

ACF - Financial systems improved to reportable condition and grant financial management regressed to material weakness.

CDC - New material weakness reported for Financial systems and processes, which had been a reportable condition in 1999. Reportable conditions reduced from eight to three, as the EDP (2), overhead rate, and biological products inventory reportable conditions were removed and the financial reporting reportable condition was changed to a material weakness.

FDA - Reportable conditions reduced from three to one. Property and Equipment reportable condition and Financial Reporting reportable condition were removed. The remaining reportable condition is EDP (information systems controls), which consists of four parts.

CMS - Medicare A/R material weakness and Medicare regional office oversight reportable condition removed.

HRSA - Financial systems improved to reportable condition, grant financial management regressed to material weakness, and health profession student loan program and accounting for litigation claims reportable conditions removed.

IHS - Audit not complete when this document was generated.

NIH - Material weaknesses increased from one to two. New material weakness reported for Grant Financial Management, which had been a reportable condition in 1999. Reportable conditions reduced from eighteen to thirteen, as the EDP (2), OPAC processing, and Service & Supply and Management Fund transactions reportable conditions were removed and the Controls over grants reportable condition was changed to a material weakness. The Prompt Payment reportable condition was revised to Duplicate and Over Payments. Compliance findings decreased from two to one, as the possible anti-deficiency finding was removed.

PSC - Financial systems improved to reportable condition, FFMIA CLR removed, and property, elimination entries, inventory and cost of goods sold, accounts receivable, and 1 fund balance with Treasury reportable conditions removed.

SAMHSA - Financial systems improved to reportable condition and grant financial management regressed to material weakness.

AoA - Component was not included in 1999 report. FY 2000 results are for balance sheet audit only.

Department of Health and Human Services
FFMIA Remediation Plan and Corrective Action Plan based on Department-wide Financial Statement Audit
Status Report as of June 30, 2001

This consolidated plan supports the target dates for resolution of the HHS material weaknesses identified in the section on Improving Financial Performance. We have consolidated the Remediation Plan and the Corrective Action Plan since most of the FY 2000 Audit findings related to Financial Systems and Reporting. In addition, we have restructured the plans to show resolved findings, repeat findings, and new findings so it will be easier to track the progress in resolving prior year findings.

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
1.Financial Systems and Processes (Material Weakness/Repeat Condition-)	The Department of Health and Human Services (HHS) currently operates five accounting systems that do not leverage up-to-date technology. As part of the HHS modernization effort, on June 14, 2001, the Secretary directed that the number of financial management systems be reduced from five to two modern accounting systems. This project, known as the Unified Financial Management system (UFMS), consists of (1) CMS [HCFA Integrated General Ledger Accounting System] HIGLAS project, (2) HHS Corporate System for all HHS agencies except CMS, and (3) a system for the HHS Financial Consolidated Reporting. The UFMS will provide the full HHS portion of costs for services and products that influence program outcomes because it will be a standard, efficient system that can accrue costs spent throughout HHS on a particular program or initiative. <u>Departmental Approach</u> 1. Establish Program Management Office 2. HHS-wide Requirements 3. Proof of Concept (NIH)	 ASMB ASMB	 08/01 08/01-01/02		**Financial Systems and Processes called Financial Systems and Reporting in our FY 1999 Report, has been retitled to incorporate continued problems with Medicare accounts receivable and the Center for Medicare & Medicaid Services (CMS) formerly the Health Care Financing Administration oversight of Medicare contractors.** **In accordance with A-11 the resources can be found in the Budget Exhibit 52**

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
	• Budget formulation, funds distribution and standard general ledger		10-12/02		
	• Travel, property, accounts receivable and funds certification	ASMB	07-09/03		
	• Phased deployment of multiple service and supply funds activities	ASMB	08/03-09/04		
	• Acquisition, supply, accounts payable and budget planning		07/04-09/04		
	5. Continue Deployment (remaining agencies) Specific deployment TBD)		2nd qtr, FY02-FY07		
	<u>CMS Approach</u>				
	1. HIGLAS Contract Award	CMS	09/01		
	2. Medicare Pilots		10/01-03/03		
	3. Deployment to all Medicare Contractors		2007		
	4. Administrative Accounting Replacement		04/03-09/05		
	<u>HHS Financial Consolidated Reporting Strategy</u>				
	1. Start Requirements		09/01		
	2. Start Implementation		09/03		
	<u>FY 1999 Findings Resolved in FY 2000</u>				
	a) Reconciliation will be performed and documented on a monthly or quarterly basis, depending on the nature of the account.	PSC	6/30/00	6/30/00	
	b) PSC will upgrade software to produce Financial				

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
	Statements	PSC	12/12/00	09/30/00	
	c) PSC is improving the JV posting process, making more time available for analysis of balances.	PSC	09/30/00	09/30/00	
	d) Journal Vouchers prepared for financial statements will be posted to CORE, where appropriate.	PSC	09/30/00	07/31/00	
	e) Correction of budgetary accounts will facilitate available/unavailable appropriation analysis needed for unexpended balances.	PSC	09/30/00	06/30/00	
	f) Current year budgetary accounts are reviewed monthly. Prior year accounts will be tested for accuracy prior to FY-end.	PSC	08/31/00	06/30/00	
	g) Journal Vouchers will be prepared and posted to CORE to correct any exiting errors in budgetary accounts prior to FY-end.	PSC	09/30/00	07/31/00	
	h) The FY 99 closing entries were expanded to include both general ledger and fund symbols not effectively closed in prior years.	PSC	03/31/00	03/31/00	
	i) Analyze and enhance the FY99 year-end closing process for full implementation in FY00.	NIH	07/00	07/00	
	j) Provide additional training for financial personnel to ensure that they understand the importance of posting entries correctly, performing account analyses and reconciliations, maintaining supporting documentation, and updating their knowledge of financial reporting requirements.	NIH	06/00	06/00	
	k) Update a plan to address immediate accounting needs to improve the accuracy of financial information.	NIH	09/00	09/00	
	Note: Resolving the Financial Reporting weaknesses is a top priority of management. The initial focus was on improving the quality of data in the accounting system. In addition, software has been developed to improve the				

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
	reconciliation and reviews processes for preparing the HHS wide financial statements.				
1.A. Certain Medicare contractors claims processing systems do not have general ledger capabilities and there are limited system interfaces currently available and in use to process and prepare data for the Centers for Medicare and Medicaid services	**Repeat Findings in 1999 and 2000** CMS is developing the HCFA Integrated General Ledger Accounting System (HIGLAS) that will mesh a proposed integrated general ledger accounting system (IGLAS) that incorporates Medicare contractors' financial data (including claims activity) into CMS's internal accounting system, the Financial Accounting and Control system (FACS). To resolve double entry & to resolve ad hoc supporting schedules. a) Acquire Systems integrator and JFMIP Commercial off the shelf (COTS) software. (Planning and Assessment Phase) b) Development/implement an approved JFMIP COTS product. 1) Phase 1 – Develop/Implement COTS product in Pilot Medicare Contractors, including Parallel Operation Phase. 2) Implement at remaining Medicare contractors 3) Phase 2 – Replacement of FACS • **OMB has approved a waiver of the three year remediation time frame due to the multi-year schedule required to implement the integrated system.**	 CMS CMS	 09/01 09/02-09/06* 09/01-03/03 04/03-09/06 04/03-09/05		

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
1.B. At CMS extensive Consultant support was needed to establish reliable accounts receivable balances and to oversee Medicare contractors					
1.B.1 Medicare Contractor Accounts Receivable					
1.B.1.a Control Weaknesses continue to be identified in the contractors' processing of both the Non-Medicare Secondary Payments (Non-MSP) and Medicare Secondary Payments (MSP) accounts receivable. Misstatements are due to systematic issues with the system used to track MSP accounts receivable (A/R) and a lack of supporting documentation.	Clarified policy on the identification and recognition of an A/R, including unified cost reports, periodic interim payments, under tolerance, claims A/R, voluntary refunds, consent settlements, and incomplete A/R. • 1a. Clarify instructions for the recognition and reporting of an A/R including a methodology for calculating allowance for uncorrectable accounts. • 1b. Clarify instruction for the financial reporting of Non-Medicare Secondary Payer (MSP) Currently Not Collectible (CNC) debt. • 1c .PM on MSP write-off of old uncollectable debt. • 1d. Issue revised CMS 750/751 contractor financial reporting manual instructions.	CMS	11/00 11/00 12/00 01/01	05/01 05/01 02/01 05/01	

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
Issues were also identified with the calculation of the allowance of uncollectable accounts.	• 1e. Issue new instructions for contractors' reporting of MSP CNC debt.		02/01	05/01	
	Provide additional training to Medicare contractors to promote a uniform method for financial reporting and accounting for A/R and related amounts.		06/01	06/01	
	• Hold annual CFO Financial Report Conferences for Medicare contractors.				
	Acquire Advisory services to ensure that the A/R balances for Fiscal Year (FY 2001 are valid and properly valued), as well as review the progress/implementation of prior year corrective action plans (CAPs). Specifically, the consultants will assist in:		06/01	06/01	
	• Reconciling the FY 2001 beginning balance. Identifying variances between subsidiary records and reports submitted to CMS.				
	• Documenting appropriate adjustments to accounts receivable for variances.				
	• Reviewing processes and procedures related to receivables.				
	• Train contractors' in trending analysis of financial data and calculating allowances for uncollectable accounts.				

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
	Review CAPs		08/01		
	• Filed work Completed		08/01		
	• Prepare briefing document for Consultants		09/01		
	• Submit proposed write-off/adjustments to CMS Central Office (CO) and Medicare Contractors' adjustment of A/R balance.				
1.B.2 Not all Medicare contractors are preparing the reconciliation on a monthly basis nor reconciling their CMS 1522 to actual paid claims tapes.	Develop a 1522 reconciliation CPE protocol to be used as a pilot.	CMS	05/01	05/01	
	Test 1522 CPE reconciliation protocol at two contractor sites. • 1st Site • 2nd Site	CMS	04/01 08/01	04/01	
	Train Regional Offices in conduction of 1522 reviews using the CPE protocol.	CMS	12/01		
	Monitor monthly 1522 reconciliations submitted by the contractors.	CMS	Monthly		
1.C. CMS oversight of Medicare Contractors.					
1.C.1. The Regional Offices (RO)s limit their					

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
quarterly monitoring of contractor submitted financial reports to the performance of trend analysis and a cursory review to ensure there are no unusual items instead of ensuring that the data reported is complete, accurate, valid and fairly represented. The follow-up on variances detected by the trend analysis is not consistent between contractors.	Review and test trend analysis procedures obtained from the CPA firm.	CMS	08/01		
	Provide additional instruction, guidance and training to communicate expectations and the procedures to be performed by regional offices to ensure that CMS 750/751 and CMS 1522 reports are submitted timely and are properly reconciled to accounting records.	CMS	06/01	06/01	
1.C.2. The ROs did not perform follow-up on findings noted in reviews conducted by CO or consultants to ensure corrective actions were completed by the contractors.	Develop and issue instructions to all CMS ROs on their role in the CAP Process related to Medicare contractor financial management findings.. The process requires the ROs to review initial CAPs and quarterly updates and provide comments to CMS CO regarding the adequacy of the CAP.	CMS	05/01	05/01	
	Develop policies and procedures for following up on Medicare Contractors (CAPs).	CMS	04/01	04/01	

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
1.C.3 ROs did not perform any Medicare contractors system security reviews.	OFM communicate expectations that ROs perform on-site reviews to ensure that contractors comply with system security reviews.	CMS	06/01	06/01	
1.C.4. ROs did not consistently follow-up with contractors that had not implemented Change Management Plans properly and timely	CMS Central Office and Consortia Contractors Management Staff (CCMS) have been working together to develop a process whereby the CCMS will report the status of changes contractors were required to implement to the Medicare Change Control Board (MCCB) quarterly. The MCCB, a board composed of executives representing all impacted agency components, will monitor the status of contractor implementations through the reports and provide guidance to the CCMS for follow-up activity.	CMS	12/01		
1.C.5. CMS did not have formalized procedures documenting the financial statement and financial reporting analysis functions. Quarterly fluctuation analysis procedures did not ensure that activity related accounts receivable included on the 751 or amounts included in these fluctuations were properly supported by detailed transactions.	Develop formalized trend analysis procedures to provide a mechanism for CO and ROs to monitor contractors' activities and enforce compliance with CMS financial procedures.	CMS	07/01		
	Continue task order that hired consultants to develop financial reporting trending analysis of Medicare contractors financial data reported to CMS.	CMS	07/01		
	Provide additional training for financial personnel at CMS CO and ROs and Medicare contractors to ensure that personnel understand the importance of posting entries correctly, performing account analyses and reconciliation, maintaining supporting documentation, and updating their knowledge of financial reporting requirements.	CMS	06/01	06/01	

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
1.D. Other Accounting Issues **1.D.1. NIH - an integrated accounting system was not in place to consolidate the accounting results of transactions by the Institutes. Extensive, time-consuming manual adjustments were needed before reliable financial statements could be prepared.**					
1.D.1.a. NIH should continue to improve its internal controls by implementing changes for effectively detecting errors and irregularities in a timely manner. NIH should strengthen controls to improve the reliability and documentation of its financial information.	The Office of Financial Management (OFM) will review and revise policies and procedures applicable to periodic reconciliation of all major financial account balances. The OFM will analyze and enhance the FY00 year-end closing process for full implementation in FY01.	NIH NIH	05/31/01 05/31/01	05/31/01 and On-going 05/31/01 and On-going	

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
1.D.1.b. The NIH should continue to develop the NIH New Business System (NBS) to facilitate the consolidation and development of financial statements in compliance with the Federal Financial Management Improvement Act of 1996	The NIH has assigned personnel that will be dedicated fulltime to the development and implementation of the NBS.	NIH	05/31/01	05/31/01 and On-going	
1.D.1.c. The NIH should perform or oversee monthly reconciliation for all major financial balances and develop supporting documentation that reflects management's understanding of the composition of accounts. Recommended that NIH develop formalized procedures to perform periodic detailed reviews of transactions within the subsidiaries.	The OFM will perform reconciliations of all major GL accounts and will perform periodic detailed reviews of significant transactions within subsidiaries. Adjustments/corrections, based on appropriate documentation, will be made in a timely manner.	NIH	Monthly	Monthly	

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
1.D.1.d. The NIH office of Financial Management should develop high level exception driven analysis techniques to obtain reports each month, array the reported information in a method that facilitates comparisons month to month, year to year against actual and budgeted amounts and against NIH management expectations to identify and follow-up on emerging trends and anomalies in reported balance.	The OFM will develop high level exception driven analysis techniques to obtain reports each month, and analyze the data contained in the reports.	NIH	Monthly	Monthly	
1.D.1.e. NIH ICs should review subsidiary ledgers and the status of funds for the current and prior years with obligated or available funding for reasonableness, and obtain query access to financial systems to identify and investigate unusual items.	NIH will re-emphasize the importance of documentation and review with and by IC staff.	NIH	09/30/01	06/30/01 and On-going	

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
1.D.1.f. Update current accounting policy and procedures manual to include, (1) processing procedures for recurring transactions; (2) formal procedures for account analyses; and (3) required year-end closing procedures to ensure the accuracy of recorded transactions and consistency in the way transactions are processed by the approximately 24 entities and NIH as a whole.	OFM will update a plan to address immediate accounting needs to improve the accuracy of financial information that will include (1) processing procedures for recurring transactions; (2) formal procedures for account analyses; and (3) required year-end closing procedures to ensure the accuracy of recorded transaction.	NIH	(1)09/30/01 (2)5/31/01 (3) 06/30/01	(1)Summer 2001 (Property Capitalized): 9/00 FACTS I & II (2) 05/31/01 and On-going (3) 06/30/01	
1.D.1.g. Update procedures to ensure: (1) greater accountability of ICs responsible for audit documentation and to (2) that required accounting reports, subsidiary ledgers, and adequate documentation are available on a timely basis to support the Treasury requirements	(1) We will emphasize the importance of documentation and review with Institutes/Centers (IC) staff. (2) OFM will ensure that required accounting documentation is available on a timely basis.	NIH NIH	(1) 09/30/01 (2) 09/30/01	(1) 06/30/01 and On-going (2) 06/30/01 and On going	

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
and financial statements reporting requirements.					
1.D.1.h. Provide additional training for financial and IC personnel to ensure that they understand the importance of posting entries correctly, performing account analyses and reconciliations, maintaining supporting documentation, and updating their knowledge of financial reporting requirements.	The NIH will provide additional job-related training for financial personnel to ensure that they understand the importance of posting entries correctly, performing account analyses and reconciliations, maintaining supporting documentation, and updating their knowledge of financial reporting requirements.	NIH	09/30/01	06/30/01 and On-going	
1.D.1.i. Update a plan to address immediate accounting needs to improve the accuracy of financial information. This would entail identifying the necessary sources of information, the necessary disclosures,	The NIH will address immediate accounting needs to improve the accuracy of financial information. This will entail identifying the necessary resources, sources of information, the necessary disclosures, and the analysis that should be performed by NIH to ensure the reliability of balances, completeness of disclosures and the adequacy of presentation of financial information.	NIH	09/30/01	06/30/01 and On-going	

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
and analysis that should be performed by the Office of Financial Management to ensure the reliability of balances, completeness of disclosures and the adequacy of presentation of financial information. In addition, NIH should review current accounting reports to determine if information is sorted and accumulated in a useful manner for financial reporting.					
1.D.1.j. Strengthen the approval process of journal entries, especially those entries not programmed in NIH's general ledger or dictated by the Department of Health and Human Services' accounting manual.	The NIH will review and update its procedures to ensure that all electronic and manual journal entries are appropriately reviewed and properly documented especially manual journal vouchers. NIH will conduct periodic meetings with accounting staff to stress the importance of documenting manual entries.	NIH	09/30/01	06/30/01 and On-going	
1.D.1.k. Refine procedures to identify intra-agency transactions	NIH will re-analyze procedures to identify intra-agency transactions and seek to properly eliminate these transactions from balances, thus allowing for preparation	NIH	09/30/01	06/30/01 and On-going	

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
and properly eliminate these transactions from balances, thus allowing for the preparation of consolidated financial statements.	of consolidated financial statements.				
1.E.. Grant Advance Reporting, Reconciliation and Analysis	**New Finding in FY 2000**				
1.E.1 The Payment Management System, an application for processing grant payments, did not record and report grant transactions properly	(a) DFO will analyze grant expenditures and accruals for quarters ending March 31, June 30 and September 30 to provide assurance that grant advances are reasonable for current and prior periods.	ACF & PSC	09/15/01 & 12/15/01		
1.E.1.a. At most operating divisions, suitable systems were not in place to adequately explain significant fluctuation in grant transactions	(b) DFO resumed the Grant Advance monthly reconciliation in FY 2001 for months ending December 2000 and thereafter, aided by new reports comparing Core and PMS data.	PSC	12/31/00	01/31/01	
	(c) DFO will prepare a comparative Statement of Net Cost semi-annually and compare it to prior period amounts to determine reasonableness. The first target date is for June 30, 2001 analysis	PSC	09/15/01 & 12/15/01		
	(d) DFO developed a system update to require all	PSC	08/31/01		

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
	transactions to be classified as governmental or non-governmental. Also, all prior classifications are being corrected.				
2. Medicare Electronic Data Processing (EDP) Controls (Material Weakness/Repeat Condition)	**FY 1999 Findings Resolved in FY 2000** The CMS (HCFA) Security Initiative encompasses all aspects of CMS (HCFA) information systems security: policy, administration, training, engineering, and oversight. The initiative establishes the structure for an evolving program that establish:	CMS			**To improve its systems security program, CMS has established an enterprise-wide system security program. That portion applying to internal systems has been passing in since late FY 1998. The first major accomplishment was the development of CMS's Systems Security Plan (SSP) Methodology, which established procedures for developing a 3-tiered hierarchical SSP structure. The first tier is the enterprise-wide systems security master plan. Tiers 2 & 3 apply to the development of general support system (GSS) SSPs and major application (MA) SSPs, respectively. Under the hierarchical structure,**
	(a) Technical framework		FFY1999	FY 1999	
	(b) Establish an administrative framework		12/00	12/00	
	(c) Implementation of security initiative:		ongoing		
	- Security Plan Methodology		FY 2000	09/00	
	- CMS (HCFA) Security Handbook		03/01	03/01	
	- Security awareness training		FY2000	09/00	
	(a) Evaluate network and systems access controls and implement procedures restricting unauthorized access.		12/00	12/00	
	(b) Initiatives to correct M204 deficiencies related to SIRSAFE access control tool include:				
	i) Developed and tested SIRSAFE Capability		09/00	09/00	
	ii) Transition applications		12/00	09/00	

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
2.A. Central Office EDP **2.A.1. Continue to develop an entity wide security program for all-significant production applications and related users.**	**Repeat Findings in 1999 and 2000** The Endeavor software limits the changes in production application programs to authorized and approved changes. (a) Implementation of Endeavor for the 25 mission critical systems. (b) Naming convention standards approved. (c) Implementation of Endeavor for non-mission critical systems. (d) Project plan to segregate test and production environment drafted.		(a) 12/99 (b) 06/01 (c) 06/01 (d) 12/00	(a) 12/99 (b) (c) (d) 09/00	**GSS and MA SSPs inherit common elements of the systems security master SSP applicable enterprise-wide and do not need to include them. The Master SSP and a number of GSS SSPs are currently under development.**
2.A.2. Continue to develop adequate, monitored, and enforceable general computer access controls to restrict sensitive data and other resources from unauthorized usage, modification, or destruction.	A formal procedure for the revocation of terminated CMS contractors was developed. A recertification request to all CMS employees was completed		12/00	12//00	
2.A.3. Continue to develop entity-wide consistent change control procedures for all significant production applications and systems software programs,	(1) Separation of Validation and Production (2) Naming convention standards approved (3) Endeavor (non-mission critical systems)		10/01 06/01 09/01	06/01	

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
which protect against unauthorized changes.					
2.A.4. Continue to improve segregation of duties to include appropriate assignment of responsibilities.	CMS has incorporated its segregation of duties policy as a separate chapter in the new CMS Information Systems Security Policy, Standards and Guidelines Handbook.		01/01	01/01	
2.A.4.a. Inadequate controls over system software integrity and changes properly restricting access to authorized personnel and protecting against unauthorized changes.	Access Control of the Core Security Requirements which addresses logical and physical access control issues to assure protection of CMS Data against unauthorized loss, modification, disclosure, or damage.		09/02		
2.B. Medicare Contractor EDP Controls	CMS (HCFA) is revising its information systems security requirements for Medicare contractors. The revision will include CMS Core Information Security Requirements. The core requirements will be based on a synthesis of OMB A-130, PDD 63, GAO FISCAM, IRS Publication 1075, HIPAA and new CMS requirements for systems architecture and security handbook. (a) Contractors will be given a tool (Contractor Assessment Security Tool (CAST) to document their compliance with the CMS core requirements. (b) CMS will conduct an Independent		09/00 (a) July 31, 2001 (CAST Submissions) (b) !2/15/01 (a) 01/31/	09/00	**The OIG acknowledged in its findings that CMS had made improvement in the areas of systems access control, application software development and change control. A number of weaknesses were identified by the auditors of the Medicare**

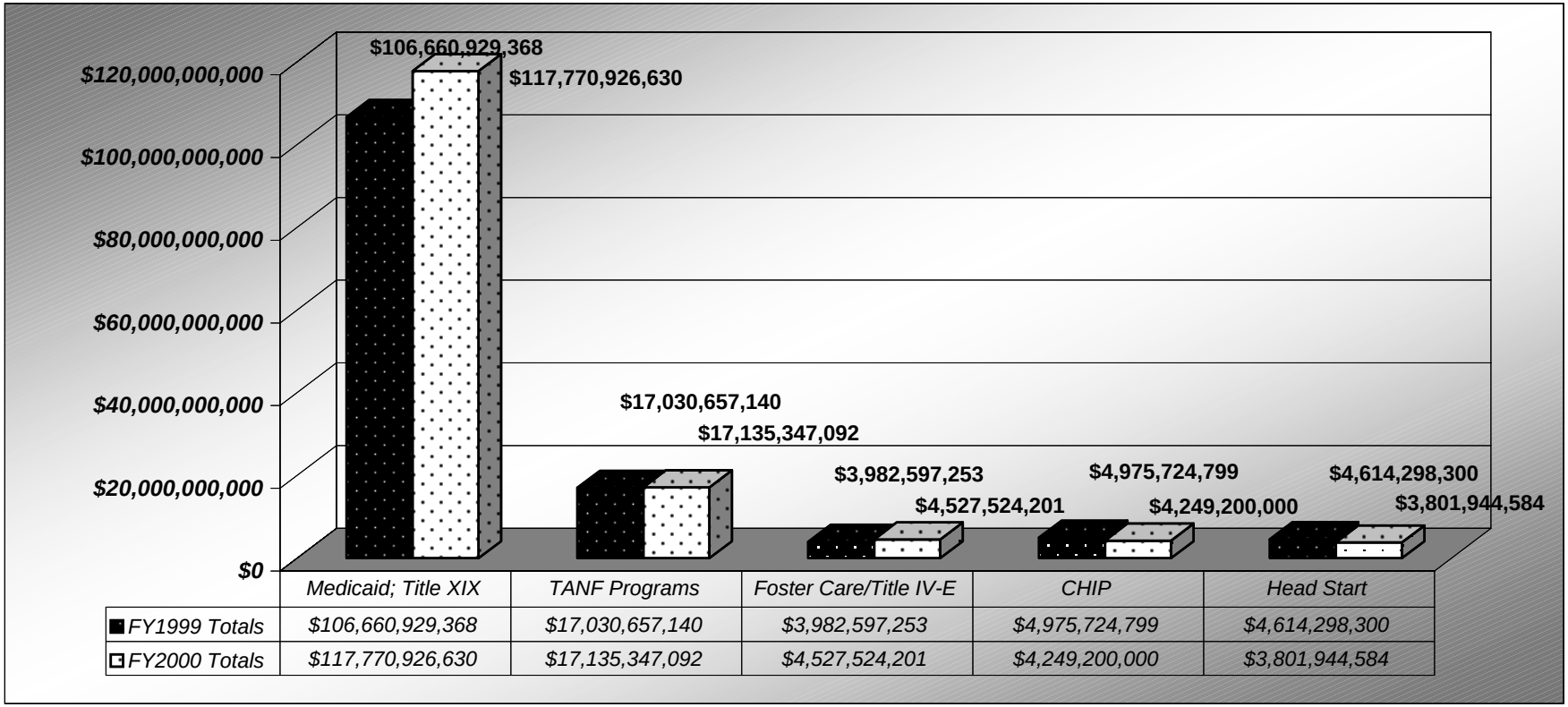
FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
	Verification and Validation review of Medicare contractor security program documentation. Contractors will be required to have independent reviews conducted of their implementation of the CMS core requirements.		02		**Contractors. The auditors also found certain application control weaknesses in the contractors' shared system. CMS will continue its focus on implementing appropriate corrective action plans to resolve all findings to improve the controls over integrity, confidentiality, and availability of Medicare data.**
2.B.1. CMS needs to adhere to OMB A-130 guidelines for entity-wide security plans to ensure appropriate consideration is given to safeguarding Medicare data.	See 2.B above		09/02		
2.B.2. CMS (HCFA) lacks consistent and effective physical and logical access procedures, including administration and monitoring of access by contractor personnel in the course of their job responsibilities	Access Control of the Core Security Requirements which addresses logical and physical access control issues to assure protection of CMS Data against unauthorized loss, modification, disclosure, or damage.		09/02		
2.B.3. CMS (HCFA) lacks consistent and effective procedures over	System Software of the Core security requirements		09/02		

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation
the implementation, maintenance, access, and documentation of operating systems software products used to process Medicare data.	addresses maintenance, access, and modification concerns regarding system software Access Control of the core security requirements addresses logical and physical access control issues to assure protection of CMS data against unauthorized loss, modification, disclosure, or damage.				

FFMIA Non-Compliance and Internal Control Weakness Findings and Recommendations	Corrective Action - Milestones	Responsible Office	Milestone Target Dates	Actual Completion Dates	Current Status/ Explanation

HHS Top Grant Programs

Appendix D



Program Name	FY1999 Totals	FY2000 Totals
Medicaid; Title XIX	$106,660,929,368	$117,770,926,630
TANF Programs	$17,030,657,140	$17,135,347,092
Foster Care/Title IV-E	$3,982,597,253	$4,527,524,201
CHIP	$4,975,724,799	$4,249,200,000
Head Start	$4,614,298,300	$3,801,944,584