

**United States
Department of Health
and Human Services**



**Accountability Report:
Fiscal Year 1999**

**EXECUTIVE
SUMMARY**

DEPARTMENT OF HEALTH AND HUMAN SERVICES WEB SITES

Office of the Secretary (OS)	www.hhs.gov
Administration for Children and Families (ACF)	www.acf.dhhs.gov
Administration on Aging (AoA)	www.aoa.dhhs.gov
Agency for Health Care Policy and Research (AHCPR)	www.ahrq.gov
Agency for Toxic Substances And Disease Registry (ATSDR)	atsdr1.atsdr.cdc.gov:8080
Centers for Disease Control and Prevention (CDC)	www.cdc.gov
Food and Drug Administration (FDA)	www.fda.gov
Health Care Financing Administration (HCFA)	www.hcfa.gov
Health Resources and Services Administration (HRSA)	www.hrsa.gov
Indian Health Service (IHS)	www.ihs.gov
National Institutes of Health (NIH)	www.nih.gov
Program Support Center (PSC)	www.psc.gov
Substance Abuse and Mental Health Services Administration (SAMHSA)	www.samhsa.gov

All of the information contained herein is extracted from the HHS FY 1999 Accountability Report. Please see the full report for the financial statements, audit opinion, and more detailed information.

United States Department of Health and Human Services



Accountability Report: Fiscal Year 1999

February 29, 2000

**EXECUTIVE
SUMMARY**

A Century of Progress and A Look to the Future

	IN 1900	BY 1999
World Population	1.6 Billion	Over 6 Billion
U.S. Population	76 Million	270 Million +
U.S Life Expectancy	47.3 Years	76.5 Years

TOP ACHIEVEMENTS IN HEALTH AND WELL BEING IN THE 20TH CENTURY

Today, people living in the United States on average live more than 29 years longer than people of 1900. Most of those years are attributable to advances in public health. They reflect what has been and what can be accomplished by the public health and welfare community with the American public, scientists, technology and national as well as international cooperation. With this widespread cooperation, the well-being of all Americans improved.

- Antibiotics significantly reduced the incidence of pneumonia, tuberculosis, and other **INFECTIOUS DISEASES** that were among the leading causes of death in 1900. In 1997 they were heart disease, cancers and strokes.
 - Decreased age-adjusted death rates for **HEART DISEASES AND STROKES** from 307.4 and 88.5 per 100,000 respectively, in 1950 to 134.6 and 26.5 per 100,000 in 1996. Healthy behavioral choices, early diagnosis, and improvements in treatment have helped.
 - Increased use of sanitation, vaccines, antibiotics and technologic advances to identify and/or reduce **UNPREDICTABLE DISEASES** as they emerge, re-emerge and evolve.
 - Reduced cases of **SMALLPOX, DIPHTHERIA, MEASLES and WILD-TYPE POLIO** by 100% since the early 1900's as a result of vaccines. Vaccines also decreased **MUMPS, RUBELLA, and H INFLUENZA TYPE B** cases by over 99%.
 - Decreased nutritional deficiency diseases of **RICKETS, GOITER, SCURVY,**
- BERI-BERI AND PELLAGRA** of the early 1900's so in the last half of the century the focus shifted to the use of proper nutrition for chronic disease prevention.
- Increased use of sanitation standards, proper pesticide and herbicide controls, improved surveillance and diagnostic tools helped to reduce incidences of illnesses caused by **FOODBORNE PATHOGENS.**
 - Decreased **MOTOR VEHICLE DEATHS** by 90% from 18 deaths per 100 million miles traveled in 1925 to 1.7 per 100 million miles traveled, although 6 times as many people and 10 times as many miles are traveled by motor vehicles in 1997. Safer driving behavior as well as safer roads and vehicles have contributed to the decline.
 - Decreased **WORKPLACE DEATHS** due to unintentional injury from 37 per 100,000 workers in 1933 to 4 per 100,000 workers in 1997 although 3 times as many people are now in the workforce. These risks have been reduced through work environments that are safer and a comprehensive focus on occupational disease and injury.

- Increased environmental interventions, improvements in nutrition, advances in clinical medicine, improvements in access to health care and other improvements decreased the **INFANT MORTALITY** rate by more than 90% from 100 per 1,000 live births before age 1 in 1915, to 7.2 per 1,000 live births in 1997.
- Decreased **MATERNAL DEATHS** due to the same improvements by almost 99% from 1900 down to 0.1 reported death per 1,000 live births (derived from 7.7 maternal deaths per 100,000 live births in 1997).
- Decreased **DENTAL CAVITIES** among children by 40% - 70% in the last half of the century due to water fluoridation.
- Decreased annual per capita **CIGARETTE CONSUMPTION** from 4345 cigarettes in 1963 to 2261 in 1998 through smoking prevention and cessation initiatives.
- Saved thousands of lives through successful development and use of surgical procedures for transplanting hearts, kidneys, livers, and other human organs.
- Provided **TEMPORARY ASSISTANCE TO NEEDY FAMILIES** as a means of helping families survive economically. Currently work participation is required in exchange for financial help. The number of recipients of temporary assistance to needy families as a percent of the total U.S. population was 1.7% in 1960, rose to a peak of 5.5% in 1994, and decreased to 2.5% as of June 1999. Continued progress on welfare reform and a strong economy has reduced welfare caseloads to their lowest percentage of the U.S. population since 1967 and the nationwide welfare rolls have fallen by 49 percent from 14.2 million in 1994 to 6.9 million in 1999.
- **HEALTH INSURANCE COVERAGE** is provided for approximately 75 million elderly, disabled and economically disadvantaged Americans under Medicare and Medicaid. Health coverage is also being expanded under the State Children's Health Insurance Program to uninsured children whose families earn too much for existing public health insurance but too little to afford private coverage.
- Used national resources to achieve strategic goals for **INCREASING THE SPAN OF HEALTHY LIFE, REDUCING HEALTH DISPARITIES AND ACHIEVING ACCESS TO PREVENTIVE SERVICES** for everyone. Many of the objectives have been met or are moving toward the target.
- Made progress in providing all Americans **ACCESS TO HEALTH CARE** through increasing school-based health centers, rural health care programs, health services offered in pre-school educational programs plus new initiatives for special populations such as adolescents, minorities, the elderly, etc.
- A national program initiated in 1965 to provide **COMPREHENSIVE DEVELOPMENTAL SERVICES FOR AMERICA'S LOW-INCOME, PRE-SCHOOL CHILDREN** ages three to five and social services for their families has been implemented in 1,520 community-based programs. Enrollment has grown to 835,000 in FY 1999.
- **AMERICANS WITH DISABILITIES** have obtained accommodations through legislation and increased awareness so they can lead more productive lives.
- **OLDER AMERICANS** obtained needed nutrition and community support services to help them remain independent as long as they can. They also have a strong network and ombudsmen program to protect their rights.

A LOOK TO THE FUTURE

“As we enter the new millennium, we hope to build on our successes. We will continue to move people from welfare to work, expand and improve health care and...work diligently to unlock the mysteries of cancer, AIDS, and other diseases that threaten mankind.”

Donna E. Shalala, Secretary of Health and Human Services

Projected Significant Changes in American Demographics:

	IN 2000	BY 2100
Total Resident U.S. Population	275 million	571 million
Mean Age:	36.5	42.4
Number over 65 years of age	34.8 million (12.66%)	131 million (22.9%)
Makeup of Population (rounded):		
African-American	13%	15%
American Indian	1%	1%
Asian and Pacific Islander	4%	13%
Hispanic	12%	33%,
White (Non-Hispanic)	72%	40%

We will need to continue to serve and improve the health and well being of all Americans, especially older and vulnerable Americans. The major advances in human genome science and tissue engineering, research in cancer, AIDS, among others, will revolutionize the ability to survive. To ensure that these advances benefit everyone, we will have to address the increasing pressures on the health insurance safety net. In addition, we will need to continue to protect the well being of our children, families, and those who need economic and living assistance to survive and lead productive lives.

Sources: Morbidity and Mortality Weekly Reports, and 1999 National Vital Statistics report: Centers for Disease Control and Prevention
Other program information provided by OPDIVs
Monthly Estimates of Population, Historical National Estimates, and Projections of Population: U.S. Census Bureau

Message From The Secretary

I am pleased to present the U.S. Department of Health and Human Services (HHS) Fiscal Year (FY) 1999 Accountability Report, detailing our achievements during the final year of the 20th century. This report includes an unqualified, or “clean,” financial statement audit opinion from the Office of Inspector General. This “clean” opinion reflects very significant improvements over recent years in our financial accountability and internal controls. Our commitment is to hold government accountable to the same high financial standards that are required of publicly held firms in the private sector. We are living up to that commitment, and we will continue vigorously to address areas that need further attention.



Secretary Shalala

This past year saw a wide range of accomplishments:

Providing a safe and healthy childhood for our children has always been a high priority of HHS, and in 1999 we awarded the first adoption bonuses to 35 states that had increased the number of children adopted from foster care. The teen birth rate fell again, continuing a seven-year trend; the immunization rate for preschool children increased to a record 80 percent; and retail tobacco sales to minors and illicit drug use among teenagers declined.

In 1999 we also took a number of steps to increase Americans’ access to health care. We worked with states to increase the availability of Medicaid, particularly to young adults leaving the foster care system; made it possible for disabled Americans to keep federally-funded health insurance when they return to work; obtained initial funding for a new program to improve health care access for the uninsured; and made it easier for children to get health insurance through their non-custodial parents after a separation or divorce. We also completed the approval of all 56 States and Territorial plans under the State Children’s Health Insurance Program (SCHIP) which will provide health insurance for children in low-income families. And we recovered almost \$500 million as a result of efforts against health care fraud and abuse, with most of those funds being returned directly to the Medicare Trust Fund.

Our accountability is also illustrated in our ability to detect and correct material weaknesses in our operations. This report includes information, which satisfies the reporting requirements for the Federal Managers’ Financial Integrity Act (FMFIA) of 1982. The management control material weaknesses (as defined by FMFIA) we have identified at the end of FY 1999 are presented in Section VI of this report. I hereby provide reasonable assurance that taken as a whole:

1. HHS is in compliance with the management control and financial systems requirements of the FMFIA; and
2. The resources entrusted to the Department are protected from fraud, abuse and mismanagement, though we have noted and are addressing the material weaknesses identified in this report. We will continue to focus on reducing the payment error rate in Medicare.

As we enter the next millennium, we hope to build on our past successes. We will continue to move people from welfare to work, expand and improve health care and, with the budget increase we secured for NIH in FY 2000, we will work diligently to unlock the mysteries of cancer, AIDS and other diseases that threaten our health.



Donna E. Shalala

Message From The Chief Financial Officer

As Chief Financial Officer (CFO) of the U.S. Department of Health and Human Services (HHS), I am pleased to present our final Accountability Report of the twentieth century. This notable milestone offers an opportunity to reflect on impacts the Department has made, and continues to make, on our nation's finances and on the health and family issues over which we have jurisdiction. Our achievements are many, not the least of which includes obtaining our first "clean" opinion on the Departmentwide financial statement audit for FY 1999.



CFO John J. Callahan

HHS accounts for over \$359.7 billion in net Federal outlays, or 21.1% of the Federal budget. Additionally, nearly 60% of all Federal grant funds flowed through HHS systems on their way to recipients. Those statistics alone highlight the need for HHS to be fully accountable to the taxpayers for the use of their dollars.

The independent financial statement audit process is one of the most reliable methods of determining the strength of internal controls and the reliability of financial information. As such, the Department has been subject to financial statement audits since FY 1996. Since that time we have worked hard to obtain our "clean" opinion. However, due to our systems limitations, we have had to devote significant amounts of resources at year end to the audit process to perform manual reconciliations and other work that is best automated and performed on a monthly or more frequent basis. We still need to upgrade and better integrate our financial systems and internal control mechanisms. Until we do so, the financial statement audit will continue to be a major challenge each year.

In this report, we have expanded our reporting on financial management performance, using the performance measures and targets from our companion document, the FY 1999 Chief Financial Officers Financial Management Status Report and Five-Year Plan, as a basis. Our performance targets all support our two broad financial management strategic goals:

- Decision makers have timely, accurate, and useful program and financial information, and
- All resources are used appropriately, efficiently, and effectively.

We are pleased that in many areas, our performance met or exceeded our targets. For example, we exceeded several of our electronic commerce targets, exceeded our target for timely resolution of cross-cutting financial assistance audits associated with our grantees, and far surpassed our targets for in-house financial management training. These accomplishments are in addition to our efforts to resolve our prior year audit qualifications so that we could achieve our clean opinion for FY 1999.

Preparedness for the Year 2000 was the major management effort during FY 1999, and through that process we learned a great deal that we can apply to other efforts. One of the most important systems initiatives we have begun to tackle is the growing threat of cyber-terrorism. Additionally, we must continue to integrate and strengthen our program and financial systems.

I am proud of the achievements we have made over the last five years that I have served as CFO. Our foundation is stronger now, yet we will face challenges in workforce planning, continued needs for system enhancements and reductions in the Medicare payment error rates, and opportunities for strategic partnering with program managers.



John J. Callahan

Financial Management Highlights At-a-Glance

FY 1999 Budget:

HHS FY 1999 Net Outlay Budget as Compared to Total Federal: 21.1% (Compared to 21.2% in FY 1998.)
HHS FY 1999 Net Outlays: \$359.6 billion
(Compared to \$350.6 billion in FY 1998.)

FMFIA:

FY 1999 Year End Pending Weaknesses: 6
(Compared with 6 for FY 1998)
Material Weaknesses Corrected in FY 1999: 0
(Compared with 1 in FY 1998)

Prompt Payment:

FY 1999 Rate: 96.4%
(Compared to 91% in FY 1998)

Departmentwide Financial Statement Audit:

FY 1999 Audit Opinion: Unqualified ("Clean")
(FY 1998 Opinion was Qualified)
FY 1999 Qualifications: 0
(Compared to 2 in FY 1998)

Auditor's Report on Internal Controls:

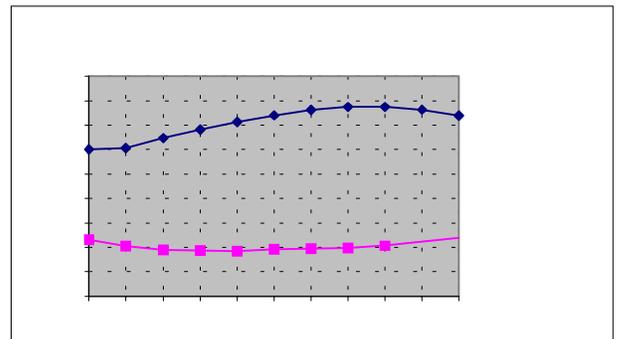
FY 1999 Material Weaknesses: 3
(Compared to 3 in FY 1998)
FY 1999 Reportable Conditions: 4
(Compared to 5 in FY 1998)

Report on Compliance with Laws and Regulations:

FFMIA Instances of Non-Compliances:

- Accounting systems not adequate to prepare reliable and timely financial statements;
- Lack of an Integrated Financial System at the Medicare Contractor and change process for recognizing Medicare Secondary Payer (MSP) receivables; and
- EDP Systems Control weaknesses at HCFA's Central Office, Medicare contractors, and the Payroll System.

**Payment
Type**



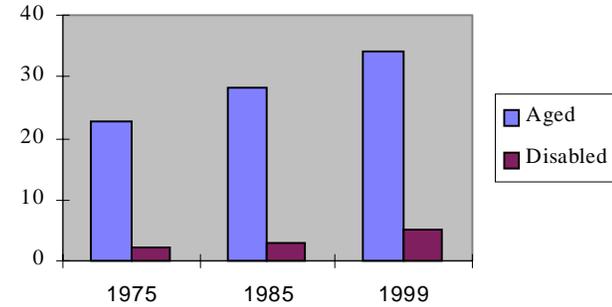
Program Highlights At-a-Glance

Highlights of the Most Recent Reported Performance:

Medicare

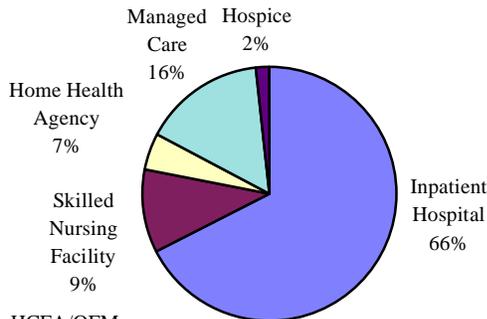
- Improved access to care for elderly and disabled beneficiaries who do not have public or private supplemental insurance by working with states to set targets to increase beneficiary enrollment in Medicare.
- Continued to develop an appropriate performance measurement and reporting methodology to assess beneficiary satisfaction with fee-for-service arrangements.
- Sustained health care choices so 76% of Medicare beneficiaries have at least one managed care option; the target was 80% but marketplace conditions affected achievement.

**Medicare Enrollment
(in millions)**



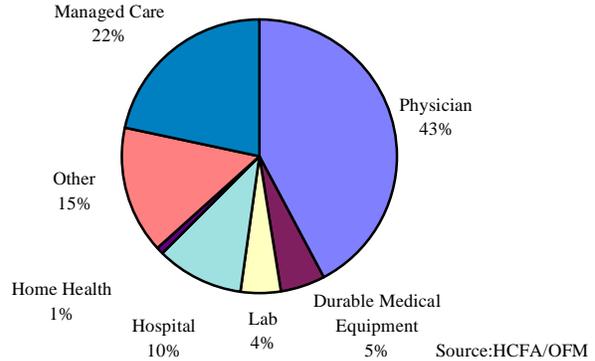
Source:HCFA/OACT/OIS

**1999 Hospital Insurance (HI)
Medicare Part A Benefit Payments**



Source:HCFA/OFM

**1999 Supplemental Medical Insurance (SMI)
Medicare Part B Benefit Payments**

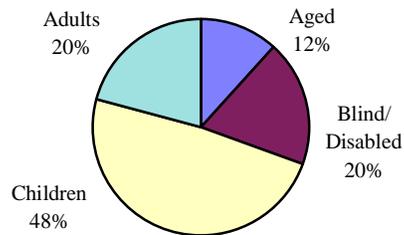


Source:HCFA/OFM

Medicaid

- Provided linked Medicare and Medicaid data files for dually eligible beneficiaries to states so the service delivery system will be better integrated and more flexible in meeting the needs of dually eligible beneficiaries.

1999 Medicaid Enrollees



Source:HCFA/OACT

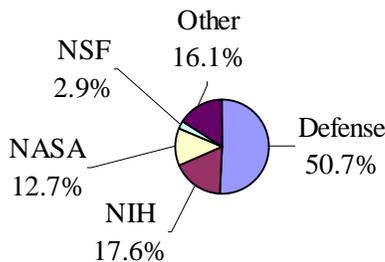
Temporary Assistance To Needy Families

- Forty-six states reported that low-income families increased their self-sufficiency when 1.3 million welfare recipients moved into new employment.

Biomedical Research

- Significant advances resulted in improved understanding of our genetic make-up, new insights into the relationships among growth and development, aging, and cancer at the cellular and molecular levels of proteins involved in the body's immune response to bacteria, and evidence that adult neural stem cells can be used to repair brain damage.

Federal FY 1999 Research Outlays



Source: President's Budget for Fiscal Year 2001, Historical Table 9.8

Head Start

- 835,000 children of low-income families received comprehensive services for their growth and development.
- 87% of Head Start children received needed medical treatment, just short of the 88% target.

Infectious Diseases

- Due to research and prevention, AIDS dropped out of the leading causes of death.
- The nation's overall immunization rate for preschool children vaccination levels increased to a record 80% based on the most recent data.

Through June 1999	47,083
Through June 1998	54,140
Through June 1997	64,597
Cumulative Total as of June 1999	711,344

CDC HIV/AIDS Surveillance Report, Table 2, Vol.11, No.1 1999

Substance Abuse Prevention

- Illicit drug use was slightly less than that reported for 1997.

	1998	1999
8 th Graders	21.0%	20.5%
10 th Graders	35.0%	35.9%
12 th Graders	41.4%	42.1%

University of Michigan 1999
 Monitoring the Future Survey

Tobacco

- Substantial declines occurred in the average retailer sales rates of tobacco products to minors, according to reported data.

FY 1997	36.4%
FY 1995	34.8%
FY 1993	30.5%
FY 1991	27.5%

Source: CDC Youth Risk Behavior Survey

Health Disparities

- Health care for 8.7 million uninsured and underserved people was provided at Health Centers, according to the most recent data.
- Research on heart failure care for minorities was conducted and led to more effective treatment.
- New health care facilities were constructed to provide American Indians needed health care.

INTRODUCTION

This is the Executive Summary of the fourth Accountability Report for the U.S. Department of Health and Human Services (HHS), prepared under the U.S. Chief Financial Officer Council pilot program being conducted under the auspices of the Government Management Reform Act (GMRA) of 1994.

This report covers the period of October 1, 1998 through September 30, 1999, Fiscal Year (FY) 1999, and contains a high level overview of

- what we do,
- what we did with the federal funds entrusted to us, and
- how well we managed them.

It is our report to our “stockholders,” the American public, and as such we are accounting for the return on the taxpayer’s investment.

To substantiate what we say the full report also contains the Department’s FY 1999 audited financial statements that discuss our financial condition as well as the auditors’ opinion that is an independent, objective assessment of how accurately we have represented our financial condition. Also the full report contains many other streamlined reports required under various statutes that make us accountable for our financial, management, and program performance. It contains new information that better explains how we managed federal funds and the actual costs of our programs.

By synthesizing all of this information into this single report, we hope to provide a more complete, accurate and useful understanding of the Department. Some of our components also are issuing their own

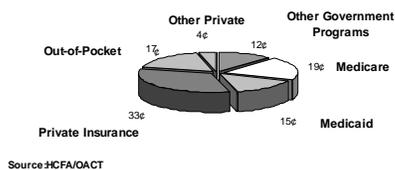
*Our mission is to enhance
the health and well-being
of Americans
by providing for effective
health and human services
and by fostering strong,
sustained advances in the
sciences
underlying medicine,
public health, and social
services.*

WHO WE ARE AND WHAT WE DO



Children are the focus of many HHS programs.

The Nation's Health Care Dollar 1998



The Department of Health and Human Services (HHS) is the United States government's principal agency whose mission is to enhance the health and well being of Americans. HHS accomplishes its mission by providing leadership in the administration of programs to improve the health and well being of Americans and to maintain the United States as a world leader in biomedical and public health sciences.

The Department manages more than 300 programs covering a wide spectrum of activities that impact all Americans, whether through direct services, the benefits of advances in science, or information that helps them to live better and to make healthy choices. These programs include:

- Conducting and sponsoring medical and social science research,
- Preventing outbreak of infectious disease including immunization services and eliminating environmental health hazards,
- Assuring food and drug safety,
- Providing health insurance for elderly and disabled Americans, health insurance for low-income people, and health insurance for children,
- Providing financial assistance and employment support/services for low-income families,
- Facilitating child support enforcement,
- Improving maternal and infant health,
- Ensuring pre-school education and services,
- Preventing child abuse and domestic violence,
- Preventing and treating substance abuse and treatment and
- Providing services for older Americans, including home-delivered meals.

In addition to the services they deliver, the HHS programs provide for equitable treatment of beneficiaries nationwide, and they facilitate the collection of national health and other data for research and publication.

Many of the goals, objectives, and activities of programs administered by HHS are shared within HHS and they also complement those of other federal agencies, and many state and local governments, as well as private organizations. Often the people being served are the same or similar. Because of this shared purpose, HHS works closely with its partners to accomplish its programs.

- HHS is the largest grant-making agency in the federal government, providing over 59,000 grants to states, among others, in the amount of more than \$158 billion per year (per the latest FY 1998 information). This is nearly 60% of all Federal grants awarded annually.
- More than \$8 out of every \$10 appropriated to a leading medical research organization of HHS funds more than 50,000 investigators that are affiliated with some 2,000 university, hospital and other research facilities.
- A nationwide network of 700 community and migrant health centers plus programs for the homeless and residents of public housing, served 8.7 million uninsured, underserved Americans as of 1998.
- Another nationwide network includes the states, 655 Area Agencies on Aging, 225 Indian Tribal organizations, and 2 organizations serving Native Hawaiians. It is responsible for assessing the needs of older persons, coordinating existing resources with the more than 27,000 service providers and developing new resources to meet local priorities for services to the elderly.
- Nearly 40,000 providers of health care are certified to provide Medicare services and 21,500 employees of 56 Medicare contractors have primary responsibility for processing Medicare claims.
- Some 1,327,000 community volunteers now help to provide comprehensive development services for low-income, preschool children ages three to five.

The Department collaborates and coordinates on common issues and problems with other federal agencies, for example:

- Coordination on the Medicare and Medicaid programs with Social Security Administration (SSA),

- Coordination with the Departments of Agriculture and Education for health insurance enrollment outreach and the Department of Justice on health insurance integrity issues,
- Coordination on drug control with the Office of National Drug Control Policy and Departments of Education, Justice, Treasury, Housing and Urban Development, and Transportation,
- Collaboration between HHS and Labor to implement Welfare to Work, and
- Cooperation on the Head Start program with Education.

	1997	1998
Poverty Rate for the United States	13.3%	12.7%
Number of Poor People	35.6 million	34.5 million
Number of Poor Children under age 18	14.1 million	13.5 million

Source: U.S. Census Bureau

HEALTH STATISTICS					
	1990	1995	1996	1997	1998
National Health Expenditures (\$billions)	699	994	1,043	1,092	NA
Persons without Health Insurance (percent)	3.91	15.4	15.6	16.1	16.3
Days of Hospital Care per 1,000 persons	792	630	606	NA	NA

Source: U.S. Census Bureau 11/99
 NA = Not Available

HOW WE ARE STRUCTURED TO ACCOMPLISH OUR MISSION

Two key concepts are critical to understanding of the HHS financial story. Expenses are one of the ingredients of the financial statements that are in Section IV. **Expenses (or Costs)** are computed using accrual accounting techniques which recognize costs when incurred and revenues when earned and include the effect of accounts receivable and accounts payable on determining annual income. **Outlays** refer to the issuance of checks, disbursements of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred. **Budget outlays** are important because they are used to identify budget surpluses or deficits. Both concepts are important in understanding the financial condition of HHS.

The Net Budget Outlays that appear are derived from the U.S. Treasury Year-End Report and September monthly Treasury statement.

The Consolidated Net Cost figures that appear are derived from the HHS Consolidated Statement of Net Cost.

Because of the complexity and importance of the many issues involved in our mission, and consistent with the intention of congressional legislation, 13 HHS Operating Divisions (OPDIVs) administer the Department's programs. The Agency for Toxic Substance and Disease Registry is reported with the Center for Disease Control. Therefore this report refers to 12 OPDIVs. Leadership is provided by the Office of the Secretary (OS), which is also considered one of the 13 OPDIVs and five staff divisions headed by Assistant Secretaries, including the Assistant Secretary for Management and Budget (ASMB) who is responsible for this report. HHS is also active in ten regions throughout the United States, to coordinate the crosscutting and complementary efforts that are needed to accomplish our mission. Offices of the Inspector General (OIG), General Counsel, Civil Rights, Departmental Appeals Board (DAB), and Intergovernmental Affairs (IGA) also support this mission across the Department. The FY 1999 net budget outlay for providing this leadership was \$377 million. The FY 1999 net cost of the OS activities was \$490 million.

A chart of the current organizational structure of HHS follows. There was no significant organizational change in HHS in FY 1999. In December 1999 the name of Agency for Health Care Policy and Research was legislatively changed to Agency for Healthcare Research and Quality so this change will be reflected in next year's report. HHS Headquarters is located at 200 Independence Avenue, S.W., Washington, D.C., 20201.

SECRETARY: Donna E. Shalala

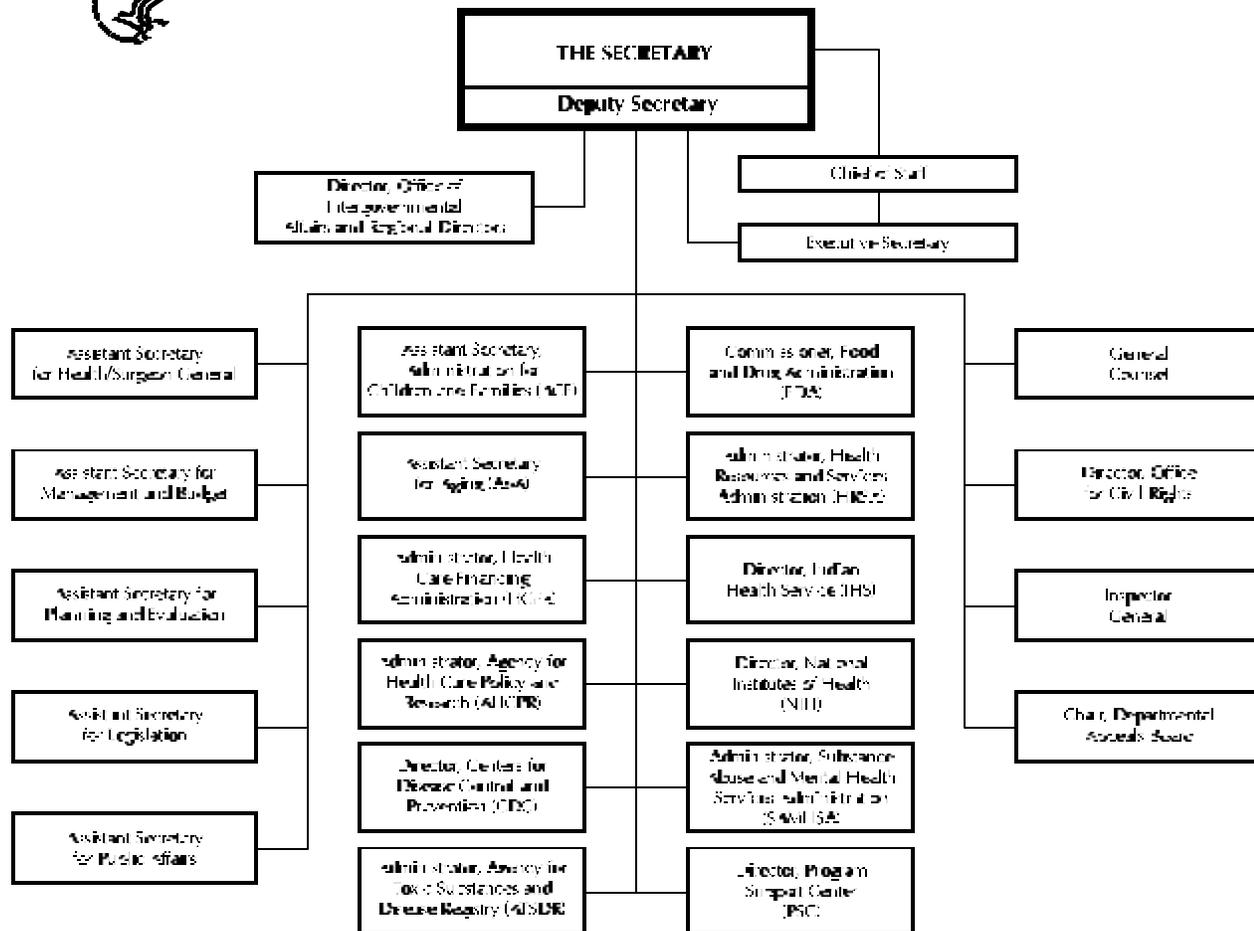
HHS FY 1999 NET BUDGET OUTLAYS:

\$359.7 Billion

HHS FY 1999 CONSOLIDATED NET COSTS:

\$358.4 Billion

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



WHAT WE ARE WORKING TOWARD

Healthy and productive individuals, families, and communities are the very foundation of the nation's security and prosperity. Through our leadership in medical sciences and public health, and as guardian of critical components of the nation's health and safety net programs, HHS has a responsibility and the opportunity to work to improve the health and well-being of our nation. The HHS strategic plan reflects this commitment in the following six strategic goals. Strategies and objectives have also been developed for each of these goals to ensure that steady, broad-based improvements result from our efforts. We are also measuring our progress toward these goals; these results are reflected in the HHS GPRA annual performance report summary and key performance results are also discussed in the Accountability Report.

HHS Strategic Goals

- GOAL 1. Reduce the major threats to the health and productivity of all Americans.***
- GOAL 2. Improve the economic and social well-being of individuals, families, and communities in the United States.***
- GOAL 3. Improve access to health services and ensure the integrity of the nation's health entitlement and safety net programs.***
- GOAL 4. Improve the quality of health care and human services.***
- GOAL 5. Improve public health systems.***
- GOAL 6. Strengthen the nation's health sciences research enterprise and enhance its productivity.***

FINANCIAL MANAGEMENT PERFORMANCE : HIGHLIGHTS OF FY 1999 ACCOMPLISHMENTS AND FINANCIAL MANAGEMENT STATUS

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

All of the CFO Five Year Plan's strategies, activities, and performance measures support one or the other of these two goals. The FY 1999 CFO Five Year Plan is organized by these two broad strategic goals, which are supported by almost 100 financial performance measures and targets.

The Accountability Report provides actual FY 1999 performance results compared to the FY 1999 performance targets. A three-year historical trend of actual results is presented, where information is available.

When performance meets or exceeds a target, it is noted with a



Where targets have not yet been met, a discussion is included in the full report.

Financial Management Strategic Goals

Goal I: Decision Makers Have Timely, Accurate, and Useful Program and Financial Information

Goal II: All Resources are Used Appropriately, Efficiently, and Effectively

Financial Management

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

Measure	Baseline	Performance Trend			FY 1999 Target	Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual		
Audited financial statements for HHS and HCFA are submitted to OMB by 3/1.	1996: No	No	Yes	Yes	Yes	Requirement of GMRA. 
Departmentwide opinion is clean.	1996: No	No	No	Yes	Yes	This is a first for the Department. 
Number of Department level qualifications.	1996 - 7	5	2	0	0	
Number of Department level internal control material weaknesses.	1996 - 5	5	3	3	3	
Number of Department level internal control reportable conditions.	1996 - 5	3	5	4	5	Details concerning reportable conditions are included in the Audit Opinion. 
Number of Department level FFMA instances of non-compliance.	1997	3	3	3	3	The HHS FFMA Remediation Plan is found in the HHS FY 1999 CFO's Five Year Plan. 
Percent of estimated improper Medicare fee-for-service payments.	1996 - 14%	11%	7.1%	7.97%	7%	The FY 1999 Actual figure is a draft estimate, as this report goes to print.

Financial Management

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

Measure	Baseline	Performance Trend			FY 1999 Target	Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual		
Percent of vendor payments made on time.	1997	89.7%	91%	96.4%	95%	In FY 1999, HHS achieved its highest-ever prompt payment rate. 
Percent of grant payments made via EFT.	1997	100%	100%	100%	100%	Measure excludes foreign grants, fellowships, and limited other categories accounting for less than one percent of total grant dollars. 
Percent of salary payments made by EFT.	1997	98%	97%	99%	100%	
Percent of vendor payments made via EFT.	1997	42%	77%	85%	69%	Excludes credit card purchases. 
Percent of travel payments made via EFT.	1997	43%	90%	93%	69%	
Percent of eligible purchase transactions made on government purchase card.	1997	77%	70%	85%	80%	
Percent increase in debt collections over prior year.	1998	n/a	\$13.3B	7% (\$14.2 B)	10% (\$14.6B)	HCFA's performance has a major impact on Departmental performance. As part of the FY 1999 financial statement audit process, HCFA's efforts related to accounts receivable focused on validating the Medicare contractor receivables balances. HCFA's FY 2000 efforts will increase focus on debt referral/collections.

Issue Category	FY 1996			FY 1997			FY 1998			FY 1999		
	Qualification Causing Disclaimer of Opinion	Material Weakness	Qualification Causing Qualified Opinion	Material Weakness	Qualification Causing Qualified Opinion	Material Weakness	Qualification Causing Qualified Opinion	Material Weakness	Qualifications	Material Weakness	Qualifications	Material Weakness
Medicare Accounts Payable	X	X*		X								
SMI Revenue	X											
Medicare/Medicare Accounts Receivable	X	X*	X		X (includes Medicare contractor receivables only, excludes Medicaid)	X (includes Medicare contractor receivables only, excludes Medicaid)				X (includes Medicare contractor receivables only, excludes Medicaid)		
Cost Reports	X		X									
Net Position	X	X	X	**								
Pension Liability	X											
Initial Audit	X											
EDP Controls		X		X		X				X		X
Grants Oversight and Accounting		X (includes oversight)	X (excludes oversight)	X (excludes oversight)								
Medicare Claims Error Rate		X		X								
Intra-Entity Departmentwide Transactions			X									
Financial Reporting				X**						X		X
New Statements					X							
TOTAL	7	5	5	5	2	3	0	0	0	3	0	3
Resolved From Prior Year	Not Applicable	Not Applicable	4	1**	4	3	2	0	0	0	0	0
New	7	5	2	1	1	0	0	0	0	0	0	0

* Consolidated into one material weakness citing both accounts payable and receivable in FY 1996.

** Net position issue from 1996 was consolidated into financial reporting issue in FY 1997.

**Department of Health and Human Services
 1999 Pending and New Material Weaknesses Under FMFIA Reporting**

No.	Title and Identification Code	Year First Reported	Target Date for Correction in 1998 FMFIA Report	Current Target Date for Correction
	DEPARTMENTWIDE			
1.	Financial Systems and Reporting (HHS 99-01)	1999	N/A	FY 2000
	ADMINISTRATION FOR CHILDREN AND FAMILIES			
2.	Need to Increase Efforts to Promote Improvements in State Controls over Child Support Collections (ACF-90-05)	1990	FY 2000	FY 2005
	HEALTH CARE FINANCING ADMINISTRATION			
3.	Improved Financial Reporting to Properly Account for Medicare Accounts Receivable and Other Financial Information (HCFA 97-02)	1997	FY 2000	FY 2004
4a*	Medicare EDP Controls: a) Improve Application Controls for Medicare Contractors (HCFA 98-01a); and	1998	FY 1999	FY 2000
4b*	b) Improve System Access Controls in HCFA Central Office (HCFA 98-01b)	1998	FY 2000	FY 2000
	FOOD AND DRUG ADMINISTRATION			
5.	Weak Enforcement in the Import Food Inspection Program (FDA 89-02)	1989	FY 1999	FY 2000
	NATIONAL INSTITUTES OF HEALTH			
6.	NIH-Deficiencies in Technology Transfer Activities (PHS-93-02)	1993	FY 1999	FY 2001

* Two 1998 material weaknesses for Medicare EDP Controls: (HCFA 98-01) and HCFA 98-02 have been combined into one material weakness with two parts and have been renumbered as HCFA 98-01a and HCFA 98-01b and are listed as 4a and 4b. This is consistent with the FY 1999 Department and HCFA CFO financial statement audits.

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**The HHS Accountability Report: FY 1999
is available on the Internet at:
<http://www.os.hhs.gov/progorg/fin>**
