

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



**Accountability Report:
Fiscal Year 1999**

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
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and Human Services**



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Fiscal Year 1999**

February 29, 2000

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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.

A handwritten signature in black ink, appearing to read "D. Shalala". The signature is fluid and cursive, with a large initial "D" and "S".

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.

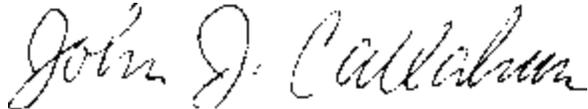
In this report, we have expanded our reporting on financial management performance, using the performance measures and targets from our companion document, the FY 1999 Chief Financial Officers Financial Management Status Report and Five-Year Plan, as a basis. Our performance targets all support our two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



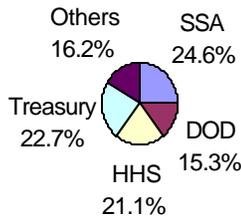
John J. Callahan

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.)

**Federal FY 1999 Outlays
by Agency**



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:

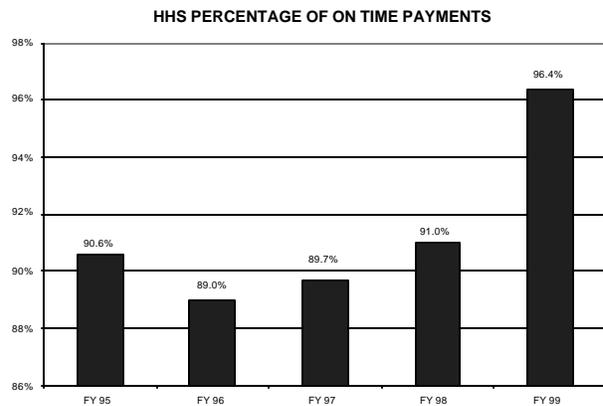
- Accounting systems not adequate to prepare reliable and timely financial statements;
- Lack of an Integrated Financial System at the Medicare Contractor and change process for recognizing Medicare Secondary Payer (MSP) receivables; and
- EDP Systems Control weaknesses at HCFA’s Central Office, Medicare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

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)



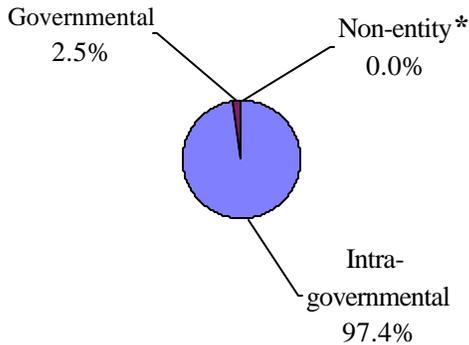
Debt Collection:

Collected \$14.2 billion in FY 1999.
 (Compared to over \$13 billion in FY 1998.)

Electronic Funds Transfer Rates:

Payment Type	FY 1997	FY 1998	FY 1999
Grants	100%	100%	100%
Salary	98%	97%	99%
Vendor	42%	77%	85%

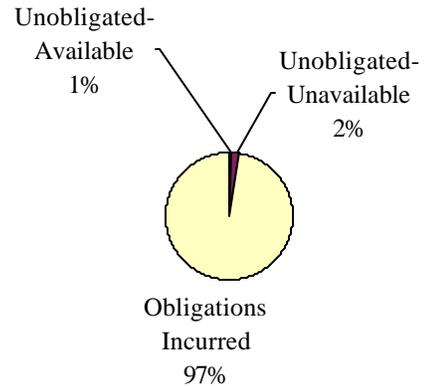
HHS FY 1999 Assets



Most HHS assets are Medicare's claims on the U.S. Treasury, and are categorized as Intragovernmental.

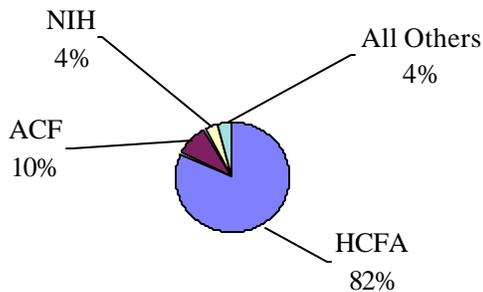
* Note: Non-entity assets were far less than .1% of total assets.

Status of Budgetary Resources at End of FY 1999

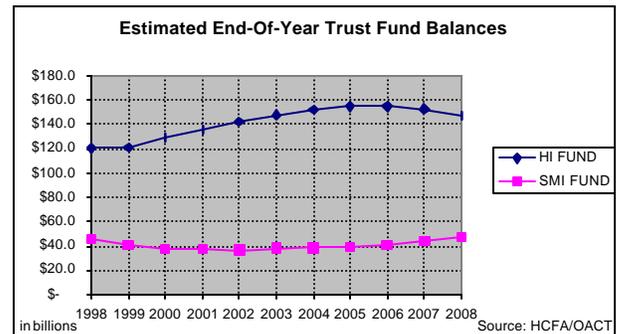


Most of the budgetary resources available to HHS during FY 1999 were categorized as incurred obligations at year end.

FY 1999 Net Cost of Operations by OPDIV



HCFA, ACF, and NIH account for the largest percentages of HHS' FY 1999 Total Net Cost of Operations.



Child Support Enforcement Collections:

FY 1997	FY 1998	FY 1999
\$13.38 billion	\$14.3 billion	\$15.5 billion

Note: Data changes as more information becomes available. This is the data reported as of January 2000.

Medicare Fee-for-Service Estimated Error Rates:

Estimate Type	FY 1996	FY 1997	FY 1998	FY 1999 Draft
Mid-point dollar	\$23.2 billion	\$20.3 billion	\$12.6 billion	\$13.5 billion
Mid-point Percentage	14%	11%	7.1%	7.97%

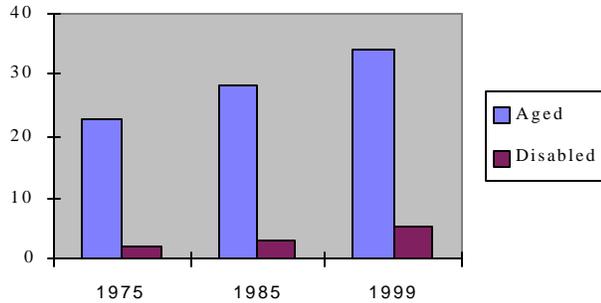
Program Highlights At-a-Glance

Highlights of the Most Recent Reported Performance:

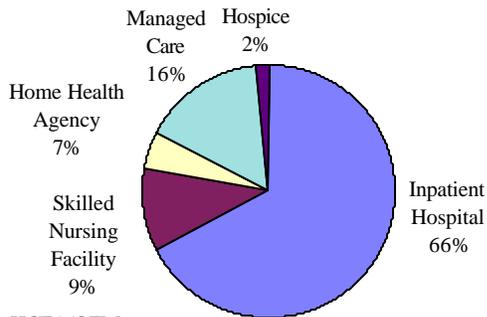
Medicare

- 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.

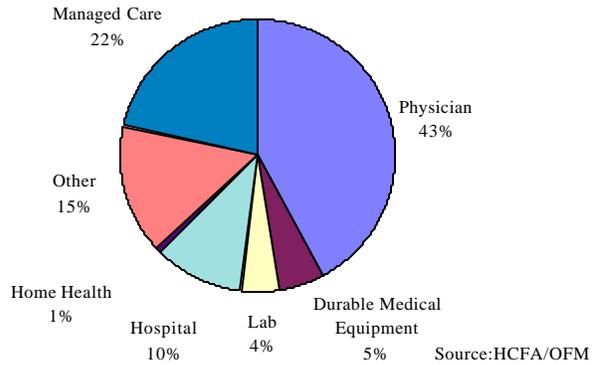
**Medicare Enrollment
(in millions)**



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



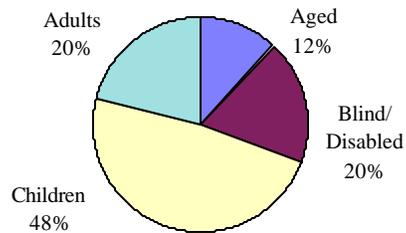
**1999 Supplemental Medical Insurance (SMI)
Medicare Part B Benefit Payments**



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



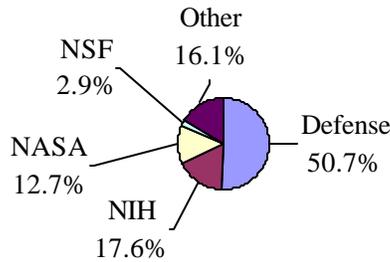
Temporary Assistance To Needy Families

- 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.

Number of AIDS Cases Reported During 12 Month Period	
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.

Use of Any Illicit Drug In a Year		
	1998	1999
8th Graders	21.0%	20.5%
10th Graders	35.0%	35.9%
12th 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.

Percentage of Teenagers (In Grades 9-12) Who Smoke	
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.

SECTION I:

OVERVIEW OF DEPARTMENTAL OPERATIONS

Overview of Departmental Operations

INTRODUCTION

This is the fourth Accountability Report for the U.S. Department of Health and Human Services (HHS), and the third as an official member of 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 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 this comprehensive 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 Accountability Reports; these will give the reader more detailed program and finance information.

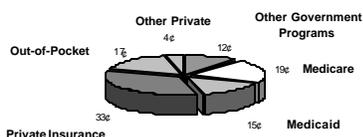
*Our mission is to enhance
the health and well-being
of Americans
by providing for effective
health and human services
and by fostering strong,
sustained advances in the
sciences
underlying medicine,
public health, and social
services.*

WHO WE ARE AND WHAT WE DO



Children are the focus of many HHS programs.

The Nation's Health Care Dollar 1998



Source: HCFA/OACT

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 for each OPDIV are derived from the U.S. Treasury Year-End Report and September monthly Treasury statement.

The Consolidated Net Cost figures that appear for each OPDIV 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.

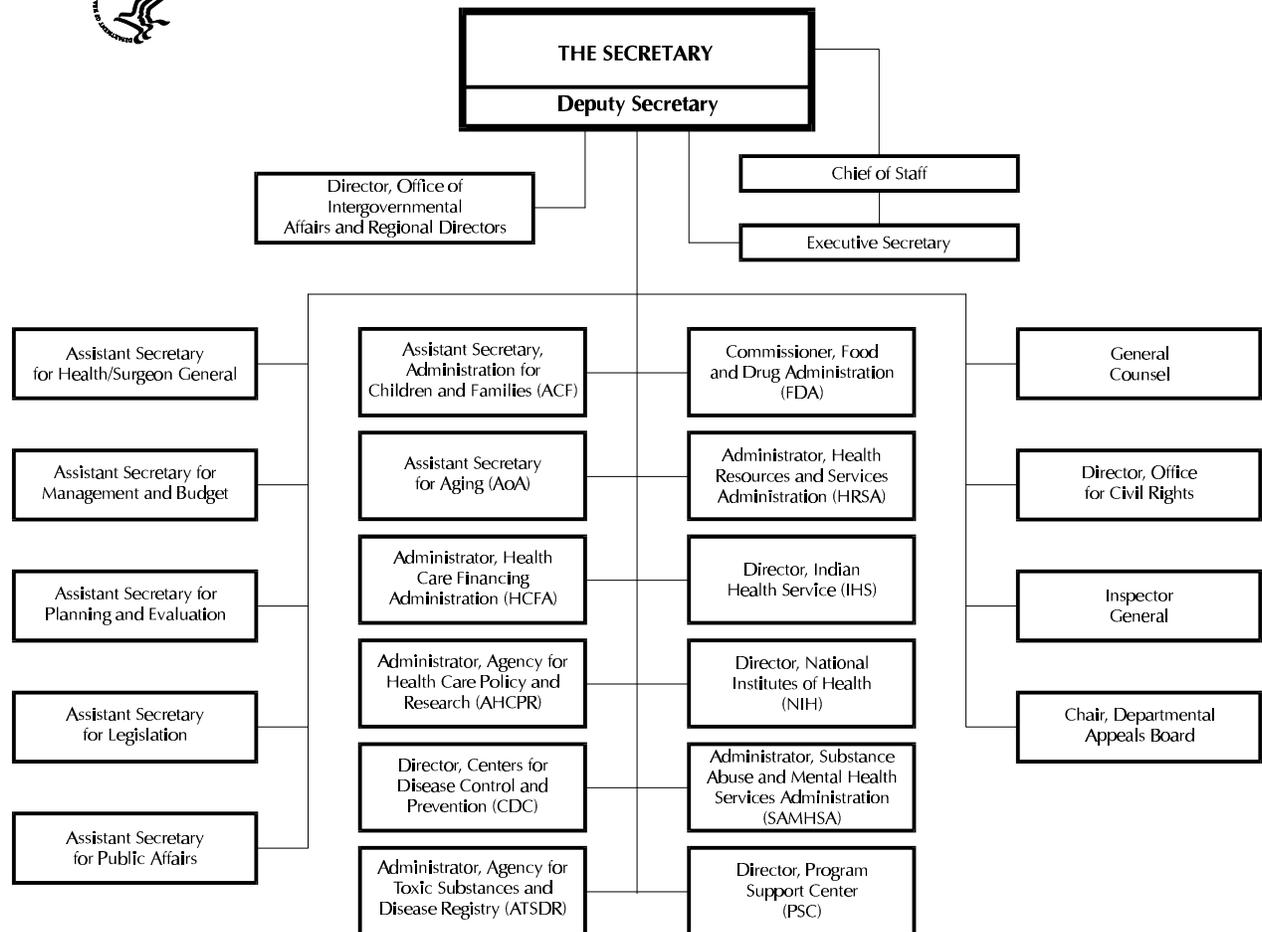
A chart of the current organizational structure of HHS follows. There was no significant organizational change in HHS in FY 1999. In December 1999 the name of Agency for Health Care Policy and Research was legislatively changed to Agency for Healthcare Research and Quality so this change will be reflected 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



HHS OPERATING DIVISIONS

The HHS OPDIVs are presented in the descending order of their budget outlays (rounded) for FY 1999.

Health Care Financing Administration (HCFA)

HCFA is the largest purchaser of health care in the world. HCFA administers the Medicare and Medicaid programs, which provide health care coverage to about one in every four Americans. In FY 1998 a major new health insurance program for children was implemented cooperatively by HCFA and the states to provide health insurance, preventive health care, and other important health services to children in need.

Outlays for Medicare and Medicaid, including state funding, represent 33.7 cents of every dollar spent on health care in the United States. Medicare provides health insurance for 39.5 million elderly and disabled Americans. Medicaid, a joint federal-state program, provides health coverage for 41.9 million low-income persons (48% of enrollees are children). In FY 1999 the Federal matching rates for various State and local benefits costs averaged 57% and administration costs averaged 56%. Medicaid also pays for nursing home coverage for low-income elderly, covering almost half of total national spending for nursing home care. HCFA operates from Baltimore, MD, Washington, DC, and ten regional offices. HCFA was established in 1977, incorporating the pre-existing Medicare and Medicaid programs.

ADMINISTRATOR: NANCY-ANN MIN DePARLE

FY 1999 NET BUDGET OUTLAY: \$299 billion

FY 1999 CONSOLIDATED NET COST: \$294 billion

Administration for Children and Families (ACF)

ACF is responsible for almost 50 programs that promote the economic and social well being of families, children, individuals, and communities. With its partners, ACF administers the new state-federal welfare reform program, Temporary Assistance to Needy Families (TANF) providing assistance to an average of 6.88 million persons monthly as of June, 1999. ACF administers the national child support enforcement system collecting some \$14.4 billion in 1998 in payments from non-custodial parents referred for collection follow-up. It also administers the Head Start program serving around 835,000 pre-school children.

ACF provides funds to assist low-income families in paying for childcare and supports state programs to provide for foster care and adoption

assistance. It also funds programs to prevent child abuse and domestic violence. ACF is organized into 8 program offices and five staff offices that operate in Washington, DC and ten regional offices. Five regions also act as hub sites for activities that affect several regions. ACF was established in 1991, bringing together several pre-existing programs.

ASST. SECRETARY FOR CHILDREN AND FAMILIES:

OLIVIA A. GOLDEN, Ph.D.

FY 1999 NET BUDGET OUTLAY: \$33.6 billion

FY 1999 CONSOLIDATED NET COST: \$35.6 billion

National Institutes of Health (NIH)

NIH is the world's premier medical research organization supporting some 35,000 research projects nationwide in diseases such as cancer, Alzheimer's, diabetes, arthritis, heart ailments, and AIDS. The NIH consists of 25 Institutes and Centers (ICs) that improve the health of all Americans by advancing medical knowledge and sustaining the nation's medical research capacity in disease diagnosis, treatment, and prevention. More than \$8 out of every \$10 appropriated to NIH flows out to the scientific community at large. NIH's research activities extend from basic research that explores the fundamental workings of biological systems, to studies that examine disease and treatments in clinical settings, to prevention, and to population-based analyses of health status and needs.

To accomplish its mission and these research activities NIH provides scientific leadership and establishes research priorities, funds the best research in the scientific community at large, conducts leading-edge research in NIH laboratories, effectively disseminates scientific results and information, facilitates the development of health-related products, ensures a continuing supply of well-trained laboratory and clinical investigators, sustains the nation's research facilities, and collaborates with other federal agencies. NIH is located in and near Bethesda, MD. NIH was established in 1887, as the Hygienic Laboratory, Staten Island, NY.

DIRECTOR: HAROLD E. VARMUS, M.D. (until January 1, 2000)

FY 1999 NET BUDGET OUTLAY: \$13.8 billion

FY 1999 CONSOLIDATED NET COST: \$14.4 billion

Health Resources and Services Administration (HRSA)

HRSA is the nation's health safety net provider; HRSA improves the nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA and their state, local, and other partners, work to eliminate barriers to care and eliminate health

disparities for the estimated 44 million Americans who are underserved, vulnerable, and special need populations. They also assure that quality health care professionals and services are available.

HRSA works to decrease infant mortality and improve maternal and child health. It provides services to people with AIDS through the Ryan White CARE Act programs and oversees the organ transplantation and bone marrow donor systems. HRSA also works to build the health care workforce and maintains the National Health Service Corps. HRSA uses a structure of four bureaus, centers, and special policy and support offices to accomplish its mission. Its headquarters are in Rockville, Md. HRSA was established in 1982, bringing together several pre-existing programs.

ADMINISTRATOR: CLAUDE EARL FOX, M.D., M.P.H.
FY 1999 NET BUDGET OUTLAY: \$3.86 billion
FY 1999 CONSOLIDATED NET COST: \$4.1 billion

Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR)
CDC is the "Nation's Prevention Agency"; it is the lead federal agency responsible for promoting health and quality of life by preventing and controlling disease, injury, and disability. CDC helps to save lives and health costs by working with partners throughout the nation and the world to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthy environments, and provide public health leadership and training.

CDC is well known for its response to disease outbreaks and health crises worldwide. CDC's personnel are stationed in its national headquarters in Atlanta, in 18 locations throughout the United States and territories, and in more than 37 foreign countries and in 47 state health departments, and numerous local health agencies. CDC also provides immunization services and national health statistics. CDC was established in 1946, as the Communicable Disease Center.

DIRECTOR: JEFFREY P. KOPLAN, M.D, M.P.H.
FY 1999 NET BUDGET OUTLAY: \$2.4 billion
FY 1999 CONSOLIDATED NET COST: \$2.6 billion (including ATSDR)

ATSDR helps to prevent exposure and adverse human health effects and diminished quality of life associated with exposure to hazardous substances. ATSDR is a unique component of HHS

because it is funded and therefore accountable for those funds through the EPA Superfund account. However, ATSDR reports to the Director of CDC because of its complementary functions. Because of this the CDC financial statements include ATSDR. ATSDR conducts public health assessments, health studies, surveillance activities, and health education training in communities around waste sites on the U.S. Environmental Protection Agency's National Priorities List. ATSDR also has developed toxicological profiles of hazardous chemicals found at these sites. ATSDR's headquarters are in Atlanta, GA. ATSDR was established in 1980.

ASST. ADMINISTRATOR: HENRY FALK, M.D.

FY 1999 NET BUDGET OUTLAY: \$72.9 million (reported through EPA)

FY 1999 CONSOLIDATED NET COST: \$ 75.5 million

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA works to improve the quality and availability of substance abuse prevention, addiction treatment, and mental health services. There are conservatively estimated to be over 51 million adults and 8 million children that experience some form of mental disorder. An estimated 13.6 million Americans are current users of illicit drugs in 1998. SAMHSA provides funding through block grants to states for direct substance abuse and mental health services, including treatment for over 340,000 Americans with serious substance abuse problems. It helps improve substance abuse treatment through its Knowledge Development and Applications grant program.

SAMHSA also monitors the prevalence and incidence of substance abuse and mental illness. SAMHSA carries out its work through 3 centers and 6 offices that coordinate effort on certain special issues. SAMHSA headquarters are in Rockville, Md. SAMSHA was established in 1992. (A predecessor agency, the Alcohol, Drug Abuse and Mental Health Administration, was established in 1974.)

ADMINISTRATOR: NELBA R. CHAVEZ, PH.D

FY 1999 NET BUDGET OUTLAY: \$2.2 billion

FY 1999 CONSOLIDATED NET COST: \$2.3 billion

Indian Health Service (IHS)

The IHS is the principal Federal health care provider and health advocate for Indian people, who experience the lowest life expectancies in the country for both men and women. In partnership with American Indians and Alaska Natives from more than 557 federally recognized Tribes, IHS's mission is to raise the

physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. IHS and the Indian Tribes serve 1.5 million American Indians and Alaska Natives through direct delivery of local health services.

The IHS funds 49 hospitals, 209 health centers, 6 school health centers, and 279 health stations, which are administered by Indian Tribes or IHS itself. There are also 34 health programs operated by urban Indian Health Organizations that provide various services to American Indians and Alaska Natives living in urban areas of the country. When unavailable from IHS or the Indian Tribes, medical services are also purchased from other providers to ensure that needed care is received. IHS headquarters are in Rockville, MD, and its twelve area offices are further divided into service units for reservations or a population concentration. IHS was established in 1924 (mission transferred from the Department of Interior in 1955.)

DIRECTOR: MICHAEL H. TRUJILLO, M.D., M.P.H., M.S.

FY 1999 NET BUDGET OUTLAY: \$2.2 billion

FY 1999 CONSOLIDATED NET COST: \$2.2 billion

Food and Drug Administration (FDA)

FDA is one of our nation's oldest consumer protection agencies.

It assures the safety of foods and cosmetics, and the safety and efficacy of human and animal drugs, biological products (vaccines and blood products), and medical devices - products that represent 25 cents out of every dollar in U.S. consumer spending. To carry out this mandate, FDA monitors the manufacture, import, transport, storage, and sale of \$1 trillion worth of products each year. The average cost of this effort to the taxpayer is about \$3 per person.

FDA's primary strategy is to ensure that safety is built into a product before a product goes on the market and that products are honestly and informatively labeled. Sound scientific analysis, regulatory standards, and communication help to ensure that industry does this. The standards are also enforced in postmarket surveillance. FDA operations are headquartered in Rockville, MD and are organized into six centers and five regions throughout the United States to accomplish its purpose. FDA was established in 1906.

COMMISSIONER: JANE E. HENNEY, M.D.

FY 1999 NET BUDGET OUTLAY: \$950 million

FY 1999 CONSOLIDATED NET COST: \$1.0 billion

Administration on Aging (AoA)

AoA is the federal focal point devoted exclusively to representing the needs and concerns of older people and their families and the policy and program development, planning, and service delivery to those persons in need. Through a nationwide service delivery infrastructure, AoA funds are leveraged to deliver comprehensive in-home and community services, including approximately 240 million meals for older individuals each year. AoA funds also make legal services, counseling and ombudsmen programs available to elderly Americans. AoA accomplishes this mission in collaboration with its partners – state and area agencies on aging, Tribal organizations, and the providers of services that comprise the aging network. AoA headquarters are in Washington, DC. AoA was established in 1965.

ASSISTANT SECRETARY FOR AGING:

JEANETTE C. TAKAMURA, Ph.D.

FY 1999 NET BUDGET OUTLAY: \$879 million

FY 1999 CONSOLIDATED NET COST: \$923 million

Program Support Center (PSC)

PSC is a self-supporting operating division of the Department that provides administration services for HHS and other federal agencies. The PSC is organized to provide competitive services on a service-for-fee basis in three key areas: financial management, human resources, and administrative operations. PSC provides these services to at least 13 other executive branch departments, 18 independent federal agencies, and the General Accounting Office. Activities and services of PSC are supported through the HHS Service and Supply revolving fund. Though PSC's services are fee-based and self-sustaining, the Statement of Net Cost shows the largest cost is for Retirement Pay and Medical Benefits for Commissioned Officers. PSC is located in Rockville, MD. PSC was established in 1995 as a business enterprise from various administrative support units of HHS.

DIRECTOR: LYNNDA M. REGAN

FY 1999 NET BUDGET OUTLAY: \$280 million - Reimbursable.

FY 1999 CONSOLIDATED NET COST: \$717 million

Agency for Health Care Policy and Research (AHCPR)

AHCPR acts as the catalyst for improving the quality, effectiveness, accessibility, and cost of health care as a result of its research and sharing of information. AHCPR conducts and supports the research needed to guide decisionmaking and improvements in both clinical care and the organization and financing of health care. AHCPR also promotes the incorporation of its and other research-based information into effective choices and treatment

in health care by developing tools for public and private decisionmakers and by broadly disseminating the results of the research.

Recent legislation in December 1999 changed the name of Agency for Health Care Policy and Research to the Agency for Healthcare Research and Quality (AHRQ). AHCPR/AHRQ operates six centers as well as its special policy and information offices. AHCPR is located in Rockville, MD. AHCPR/AHRQ was established in 1989.

DIRECTOR: JOHN M. EISENBERG, M.D.

FY 1999 NET BUDGET OUTLAY: \$79 million

FY 1999 CONSOLIDATED NET COST: \$174 million



We are the People's Department.

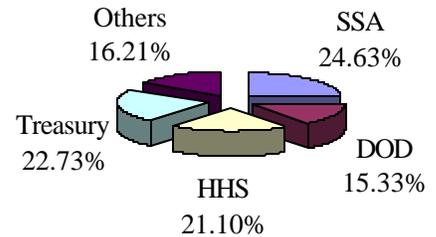
HIGHLIGHTS OF OUR BUDGETARY OUTLAYS

In FY 1999, HHS had net outlays of \$359.7 billion, representing 21.1% of all Federal net outlays. This represents an increase from \$350.6 billion (21.2% of Federal net outlays) in FY 1998. Only the SSA (which became independent from HHS in 1995) and the Department of the Treasury exceeded HHS spending in FY 1999.

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

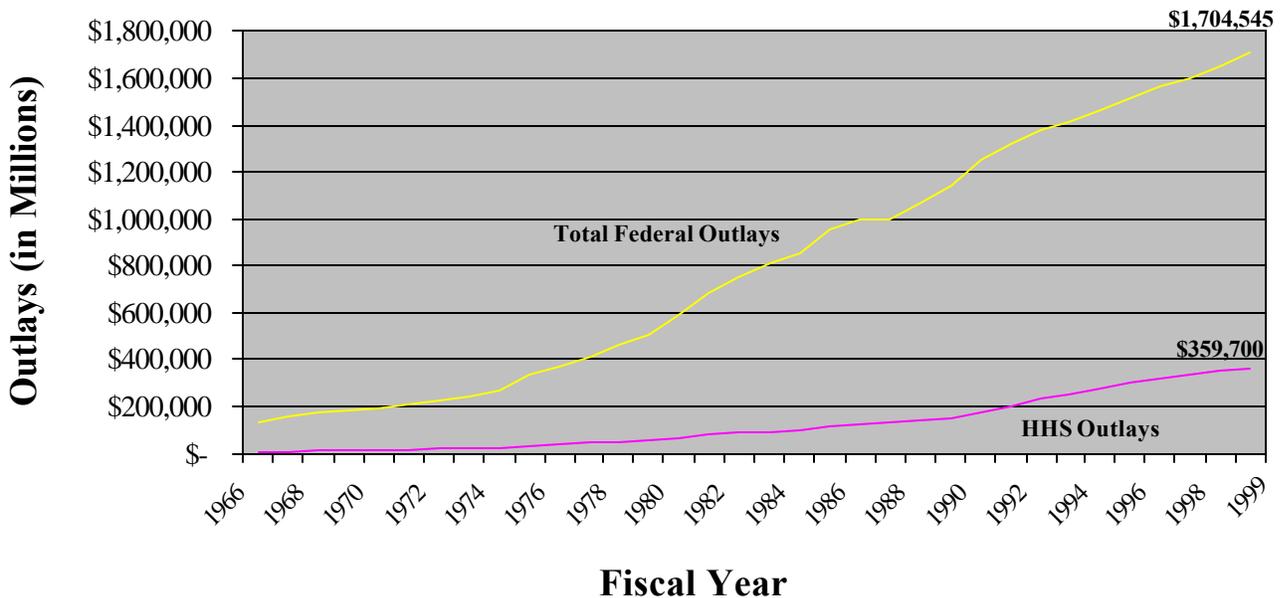
When the Medicare and Medicaid entitlement programs were enacted in 1966, HHS net outlays accounted for only 4% of Federal net outlays. As the ranks of the enrollees and beneficiaries of these entitlement programs has swelled along with the increasing costs of health care treatment, the impact on the Federal budget has been quite significant. The net outlays for Medicare alone now account for 11% of the Federal budget.

Federal FY 1999 Outlays by Agency



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

HHS and Total Federal Net Outlays FYs 1966-1999



Source: Historical Tables, Budget of the United States Government Fiscal Year 2000, Executive Office of the President

HHS FY 1999 Net Outlays by Budget Function and OPDIV
 (In Thousands)

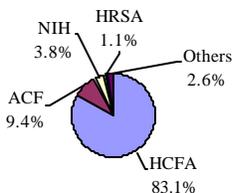
OPDIV	Education, Training, Employment, and Social Services	Health	Medicare	Income Security	Administration of Justice	TOTAL	HHS FY 1999 Net Outlays by OPDIV %
Health Care Financing Administration		\$ 108,572,992	\$ 190,440,645			\$ 299,013,637	83.13%
Administration for Children & Families	\$ 12,657,584			\$20,896,446	\$ 69,618	33,623,648	9.35%
National Institutes of Health		13,802,146				13,802,146	3.84%
Health Resources and Services Administration		3,859,672				3,859,672	1.07%
Centers for Disease Control & Prevention		2,380,432			47,758	2,428,190	0.68%
Substance Abuse and Mental Health Svs. Adm.		2,213,905				2,213,905	0.62%
Indian Health Service		2,193,221				2,193,221	0.61%
Food and Drug Administration		950,140				950,140	0.26%
Administration on Aging	879,268					879,268	0.24%
Office of the Secretary		376,730				376,730	0.10%
Program Support Center *		280,125				280,125	0.08%
Agency for Healthcare Research and Quality		79,375				79,375	0.02%
HHS SUBTOTAL	\$ 13,536,852	\$ 134,708,738	\$ 190,440,645	\$ 20,896,446	\$ 117,376	\$ 359,700,057	100.00%

* Though PSC's services are fee-based and self-sustaining, net outlays shown include \$201,689 thousand for Retirement Pay and Medical Benefits for Commissioned Officers with the remainder attributable to the HHS Service and Supply Fund and miscellaneous trust funds.

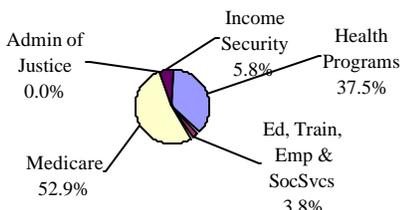
Source: Treasury Year End Report. Proprietary receipts from the public and intrabudgetary transactions have been allocated to each HHS OPDIV based on detailed amounts in the September monthly Treasury statement.

Note: The FY 1999 financial statements' supplemental schedules present data under six budget functions, rather than just the 5 shown here. This is because ATSDR's expenditures under the Natural Resources budget function are included in HHS financial statements, but excluded from HHS outlay figures; they are included in EPA's outlay figures.

HHS FY 1999 Net Outlays by OPDIV



HHS FY 1999 Net Outlays by Budget Function



HHS dollars are allocated to the OPDIVs across budget functions. The accompanying matrix chart of "HHS FY 1999 Net Outlays by Budget Function and OPDIV" details this distribution and facilitates the identification of concentrations of outlays. The largest single budget function is Medicare (which has a category all its own), with \$190.4 billion in spending. The second largest functional category, at \$134.7 billion, is Health where most of the funds are spent by HCFA (for Medicaid) and by NIH (for research). ACF has the bulk of responsibility for budget function dollars categorized as Education, Training, Employment and Social Services, and also for Income Security through the Temporary Assistance for Needy Families and Child Support Enforcement programs.

Measured by program spending, HCFA is by far the largest of the HHS OPDIVs, followed by ACF, then NIH, HRSA, CDC, SAMHSA, and other OPDIVs. The relative portion of total HHS net outlays by OPDIV is illustrated in the accompanying pie chart.

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

Readers will note in Section IV that the Statement of Net Cost, which was a new principal financial statement for FY 1998, allocates costs by OPDIV and by budget function. Costs reported will be concentrated in a similar fashion as the budget figures, noted above, for net outlays reported in this section of the Accountability Report.

OUR KEY ASSET: OUR EMPLOYEES

HHS, like any organization, cannot accomplish its mission without its employees. They provide the necessary direct services, coordinate with partners, award grants and contracts, and develop policy. The following chart shows the employment level distribution within HHS. The Full Time Equivalent (FTE) measure gives a better picture of total staffing than a count of the number of people at HHS, since some work full-time and some work part-time.

WORK FORCE PLANNING

In its simplest terms workforce planning is getting “the right number of people with the right skills, experiences, and competencies in the right jobs at the right time.” This definition covers a comprehensive process that provides managers with a framework for making staffing decisions based on an organization’s mission, strategic plan, budgetary resources, and a set of desired workforce competencies.

Many models for workforce planning have been developed, but all rely on comparing the present workforce to that needed in the future; determining the gaps and surpluses between the present and future in terms of knowledges, skills, abilities, and competencies; then developing strategic plans for workforce transition.

In 1999 the Office of the Assistant Secretary for Management and Budget (ASMB) published *Building Successful Organizations: Workforce Planning in HHS*, a workforce planning guide for the Department. An ASMB team is now working with OPDIV budget and human resources staff to help them refine workforce planning data to support fiscal year 2002 budget requests and then to institutionalize the workforce planning process.

HHS FY 1999 FTE

OPDIV	FY 1999 Actual	FY 1999 Percentage
FDA	8,910	15.1
HRSA	2,014	3.4
IHS	14,586	24.8
CDC	7,491	12.7
NIH	15,329	26.0
SAMHSA	632	1.0
AHCPR	253	.4
HCFA	4,219	7.2
ACF	1,509	2.6
AoA	120	.2
OIG	1,273	2.2
OCR	210	.4
DM	1,313	2.2
PSC	1,071	1.8
<i>Total Employment</i>	<i>58,930</i>	<i>100%</i>

* Total includes 187 statutorily exempt FTE. Those employees designated statutorily exempt are exempt due to Congressional statutes. An example statute is Public Law 100-140, the “Federal Physicians Comparability Allowance Amendments” of 1987. Other statutes may be authorized to achieve government’s recruitment and retention efforts in areas requiring highly specialized occupations.

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 this 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.

HOW WELL WE PERFORMED ON KEY PROGRAMS

PERFORMANCE INFORMATION FOR KEY HHS PROGRAMS

In this section we discuss the performance information for key programs and initiatives of HHS including some program performance goals and measures.

Financial management performance information and measures are discussed in the section titled Overview of Financial Management. Other useful performance information is contained in the Reports and Other Information section of this report. The performance information that follows is consistent with the Government Performance and Results Act of 1993 (GPRA) requirements and it supports and is aligned with the HHS strategic goals and selected strategic objectives under each goal. This information is also consistent with those GPRA programs discussed in the OPDIV-level financial statements as we begin to associate a program's performance with its costs. Performance information from other reliable sources was used as well. The source of the information is either cited or included in the listing of references in Appendix C.

Data on the results of our performance in various programs may be available on a limited basis and lag in time for several reasons. The data may be gathered infrequently due to cyclical reporting or may not be required because of legislative intent; the reliance on third parties to provide the data, including grantee reports; the cost of gathering the information; and the nature of the data, such as research results. The availability of performance data is also discussed under the Challenges section of this report and the validation/verification of the data is discussed more fully in the individual OPDIV performance plans and reports. Therefore, some of the performance information in this FY 1999 report is for prior years because that is the most current information that is available or because that information became known during FY 1999. Trends of our performance can eventually be determined by a comparison of annual trends in Accountability Reports from year to year.

For more comprehensive GPRA results, see the HHS FY 1999 GPRA Performance Report Summary and individual OPDIV GPRA Reports that will appear under <http://www.hhs.gov/progorg/asmb/budget/plans.html>

A key purpose of GPRA is to improve the confidence of the American people in the capability of the federal government by systematically holding Federal agencies accountable for achieving program results.



= In areas where we have met or exceeded the FY 1999 target we have noted that with a bullseye.

GOAL 1: REDUCE THE MAJOR THREATS TO THE HEALTH AND PRODUCTIVITY OF ALL AMERICANS.

Good health lies at the heart of the nation's well being. A healthy work force is more productive; a healthy student body is ready to learn; and healthy people are able to build a better society. HHS investments in reducing or eliminating behavioral threats to life and good health can pay off heavily in improved health and productivity of the American people.

For every \$1 spent on tobacco, drug, alcohol and sexuality education, \$14 are saved in avoided health care costs.

❖ **We took steps to reduce tobacco use especially among youth.**

Every day, 3000 teenagers start smoking, and 1 out of 3 will die of smoking-related diseases.

Between 1991 and 1997 tobacco use among youth increased from 27.5 percent to 36.4 percent. In response to this disturbing trend HHS established an initiative to reduce tobacco use among minors.

CDC's Heart Disease and Health Promotion program seeks to prevent tobacco use. SAMHSA collects youth smoking rates as part of its National Household Survey on Drug Abuse (NHDSA) and administers the Synar Amendment to support programs for compliance to reduce the sale of tobacco to minors and measures changes in youth smoking. FDA efforts emphasize its regulatory role and aim to increase the number of compliance checks performed at retail shops to enforce the requirement that minors do not purchase tobacco products.

The Department will measure the impact of its activities for FY 1999 through CDC's and the Office of Public Health Services' goal to stop the increase in youth smoking. The FY 1999 target for this goal is based on the FY 1997 levels of the biennial Youth Risk Behavior Survey. In the future the Department will use the SAMHSA National Household Survey on Drug Abuse to measure the impact of its activities.

In FY 1999 CDC began funding all 50 states and the District of Columbia to develop and maintain tobacco control programs — an increase of 18 states above last year. Baseline performance data is being developed. CDC also developed and released a set of "best practices" to help states assess their options for tobacco control programs and local funding priorities.

Also, under the Synar regulation states are to reduce the availability rate of tobacco sales to minors to 20 percent or less by the end of FY

**Percentage of Teenagers
 (In Grades 9-12) Who Smoke**

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

Source: CDC Youth Risk Behavior Survey

2002. SAMHSA assists in this effort through technical assistance and sampling studies in the states funded through the Substance Abuse Block Grant — a portion of which must be applied to prevention efforts.

The yearly targets were established with the initial implementation of the Synar regulation, based on the perceived amount of effort required in the state to reduce the sales to minors. For example, States with initial rates above 60 percent were given 2 years to reduce their rates to 40 percent and an additional 3 years to achieve 20 percent. The achievements above expectations resulted in the aggressive goal of 36 states for FY 2001.

In October 1999 SAMHSA announced that average retailer sales rates of tobacco products to minors dropped significantly from 40 percent in 1997 to 24 percent in 1998. This substantial decline reflects the growth of effective state tobacco enforcement programs established as a result of legislation and regulations.

FDA also contributes to this effort by entering into contracts with states to perform compliance checks in order to reduce the number of retailers who sell tobacco products to minors. The increase in compliance checks reflects the increase in participating states from 10 in 1997 to all 50 in FY 1999.



❖ **We helped to improve the diet and the level of physical activity of Americans.**

Lack of a good diet, or *nutrition*, along with physical activity contributes to at least four of the 10 leading causes of death and disability. The costs associated with diet-and activity-related health conditions, including direct health care and lost productivity are estimated at \$71 billion a year, according to a U.S. Department of Agriculture paper. Older Americans are particularly vulnerable to poor nutrition.

To combat this problem in FY 1999 \$504 million was provided to states, area agencies, and tribes which are part of the Administration on Aging's nationwide Aging Network for meals served in *congregate (group or community) settings*, and *home-delivered meals and other community-based services*. The Aging Network comprises 57 State Units on Aging, 655 Area Agencies on Aging, 225 Indian Tribal organizations, and 2 organizations serving Native Hawaiians.

Goal: (SAMSHA) Assure services availability for Synar Amendment implementation activities.

1. FY 1999 Target: 8 states have a violation rate of tobacco sales to minors at or below 20%

FY 1999 Actual: Exceeded the target; 21 states have a rate at or below 20%.

FY 1997 Baseline: 4 states, FY 1998 12 states



2. FY 1999 Target: SAMHSA provides technical assistance to help all states implement the regulations.

FY 1999 Actual: Met the target.

FY 1997 Baseline: 12 states



For every \$1 of federal congregate funds, \$1.70 additional funding is leveraged; for every \$1 of federal home-delivered funds, \$3.35 additional funding is leveraged. The average cost of a meal, including the value of donated labor and supplies, was \$5.17 for a group meal and \$5.31 for a home-delivered meal.

Compliance Checks Conducted

FY 1999	106,186
FY 1998	40,234
FY1997	6,464

Goal: Provide Home-Delivered Meals
FY 1999 Target: Maintain level of service provision at 119 million home-delivered meals.
FY 1999 Actual: Actual performance data will be available in September 2001.
Trend: FY 1996: 119 million meals, FY 1997: 123 million meals

Goal: Provide Congregate Meals
FY 1999 Target: Maintain level of service provision at 123.4 million congregate meals.
FY 1999 Actual: Actual performance data will be available in September 2001.
Trend: FY 1995: 123.4 million meals, FY 1996: 118.6 million meals, and FY 1997: 113 million meals.

Rates for reported primary and secondary syphilis	
1998	2.6 per 100,000
1990	20.3 per 100,000
CDC 1998 Sexually Transmitted Disease Surveillance Report	

The Network leverages funds received from AoA to provide meals and other community-based services. These meals provided 40 percent to 50 percent of a client's daily intake from one meal per day according to the 1996 program evaluation.

The congregate meal trend is decreasing while the trend toward home-delivered meals is increasing. This is consistent with the pattern of states transferring funding from the congregate meals to the home-delivered meals programs. The FY 1999 targets were set based on the 1995 data available at that time. AoA has adjusted its GPRA targets for future years as a result and will use the FY 1997 actuals as the baseline for both measures in the future.



❖ **We actively promoted the reduction of unsafe sexual behaviors.**

About 12 million new cases of *sexually transmitted diseases* (STDs), 3 million of them among teenagers, occur annually. The annual direct and indirect costs of selected major STDs are approximately \$10 billion (\$17 billion if sexually transmitted HIV infections are included).

Unsafe sexual behavior can result in sexually transmitted diseases and contributes to some of the most rapidly spreading diseases in the country. The U. S. leads industrialized countries in rates of sexually transmitted diseases (STDs). In addition, unsafe sexual behavior among teens can result in unintended pregnancies and potentially life-damaging consequences of adolescent sexual experimentation. HHS has addressed the spread of STDs by prevention activities, surveillance, and research.

Syphilis disproportionately affects a small percentage of the population, particularly African-Americans living in poverty. Syphilis elimination efforts that focus on populations in areas where syphilis persists will help close one of the most glaring racial gaps in health status. CDC will measure the effectiveness of its effort to eliminate syphilis in project areas using an indicator of racial disparity. Beginning in FY 1999 CDC has set targets to reduce racial disparity in syphilis by 15 percent each year over the FY 1998 baseline of 34.2 percent.



To help prevent and control the spread of the deadly AIDS virus, in FY 1999 CDC continued to fund local prevention activities, helped HIV prevention programs to improve their services by applying effective behavioral interventions, and supported researchers to help identify successful approaches that community HIV programs can use. HIV surveillance guidelines were also developed in FY 1998. CDC efforts help state and local education agencies implement HIV prevention programs in schools nationwide to reduce risky behaviors among the 50 million young people who attend school.

In October CDC reported that AIDS fell from the top 15 causes of death in the United States declining an estimated 21 percent from 1997 to 1998, a rate of 4.6 deaths per 100, 000 — the lowest rate since 1987. HIV mortality has declined more than 70 percent since 1995.

CDC is also providing assistance to state and local health agencies and community-based organizations to implement effective surveillance of the incidence of HIV and AIDS. HIV reporting data are increasingly necessary to monitor the effect of the epidemic.

CDC published Guidelines for National Human Immunodeficiency Virus Case Surveillance, including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome in the MMWR Recommendations and Reports (December 10, 1999/Vol 48/No. RR-13).



In October 1999 HHS announced that the *teen birth rate* fell for the seventh straight year and reached its lowest level since 1987. We also released a new guide to help local communities and non-profit organizations establish successful teen pregnancy prevention programs.

In addition to the prevention efforts of CDC, grants such as the Maternal and Child Health Block Grant plus the Abstinence Education program, and the Adolescent Family Life demonstration activities in FY 1999 promoted and tested promising interventions to reduce teenage pregnancies.

HHS awarded \$100 million in new bonuses to four states and the District of Columbia for achieving the nation's largest decreases in out-of-wedlock births between 1994 and 1997.



Goal: (CDC) Improve the ability of the Nation's HIV/AIDS surveillance system to identify incidence and prevalence of HIV infection. (CDC)

FY 1999 Target: Update current HIV surveillance guidelines for security and confidentiality to include minimum performance standards for state, local and HIV/AIDS surveillance systems.

FY 1999 Actual: 100% of the states adopted the confidentiality standards.



Number of AIDS Cases Reported During 12 Month Period

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

❖ **We worked to curb alcohol use and reduce the use of illicit drugs.**

An estimated 13.6 million Americans were current users of illicit drugs in 1998, meaning that they used an illicit drug at least once during the 30 days prior to the interview for the 1998 National Household Survey on Drug Abuse. SAMHSA issued the results of the survey in 1999. Although this number is slightly less than the 13.9 million estimate for 1997 the difference is not statistically significant. By comparison, the number of current illicit drug users was at its highest in 1979 when the estimate was 25.0 million.

The 1999 Monitoring the Future study of overall drug use among 8th, 10th, and 12th graders also found that use generally remained unchanged since the 1998 survey. The NIH National Institute on Drug Abuse funds the study.

The use of illicit drugs remains at unacceptable levels. HHS and its partners actively deal with these problems through prevention, intervention, and treatment. In addition to the states, one of HHS's partners is the Office of National Drug Control Policy (ONDCP) which coordinates overall federal efforts through strategic goals and objectives. The first ONDCP strategic goal is to educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

To work with states in substance abuse prevention and treatment for youths and others, SAMHSA awarded \$1.56 billion in block grants in FY 1999. SAMHSA strives to improve how states spend their substance abuse prevention dollars by encouraging them to promote six prevention strategies: information dissemination, education, alternative activities, problem identification and referral, community mobilization, and environmental activities.

Drug abuse prevention programs are effective in changing individual characteristics that predict later substance abuse. SAMHSA's ongoing prevention intervention studies on predictor variables support the ONDCP strategic goal and will generate new empirical knowledge about effective approaches for changing the developmental path of children at risk for substance abuse. Although the outcomes of the interventions are not available yet, preliminary findings show significant improvement in the children in the intervention group. The goals of the interventions are to decrease the use of alcohol and tobacco by 10 percent and of marijuana by 5 percent by the end of the program.

To promote the adoption of best practices in reducing alcohol and drug abuse the SAMHSA National Clearinghouse for Alcohol and

Use of Any Illicit Drug In a Year		
	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

"For the past two years we have been cautiously optimistic as a series of encouraging reports seemed to indicate a leveling off and even a possible decline in drug use among teens after years of dramatic increases. While it looks like we have turned the corner...we must not rest."

**Donna Shalala, Secretary of HHS
 August, 1999**

Goal (SAMHSA): Assure availability of services.
FY 1999 Target: 80% of states spend prevention funds in each of the six strategy areas.
FY 1999 Actual: Exceeded the target; 90% of states spent prevention funds in each of the six categories.



Drug Information (NCADI) distributes public information on prevention, intervention, and treatment. NCADI has experienced tremendous growth in the number of requests that it receives for information. In 1999 SAMHSA dramatically exceeded its target of a five-percent increase from its 1997 baseline. NCADI had a 129 percent increase, an average of 40,285 requests for information per month.



Prevention, intervention and treatment reduce drug abuse.

NCADI's toll free telephone number is 1-800-729-6686.

Goal (SAMHSA): Bridge the gap between knowledge and practice.
FY 1999 Target: 5% increase in number of NCADI information requests per month over FY 1997 baseline.
FY 1999 Actual: 129% increase over baseline.
Trend: FY 1997 Baseline: 17,600 requests per month; FY 1998: 25,289; FY 1999: 40,285.



Effectiveness of Treatment: In its 1996 National Treatment Improvement Evaluation Study (NTIES), SAMHSA found a clear linkage between the provision of substance abuse treatment services and improved life outcomes for both children and adults. The following are examples of NTIES findings on treatment effectiveness:

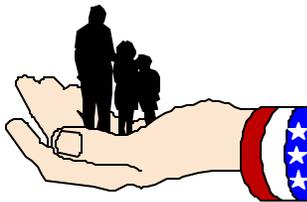
- 78 % reduction in the percentage of individuals engaging in both the sale of illicit drugs and violent crimes;
- 19 % increase in the rate of employment;
- 42 % decrease in the percentage of individuals who were homeless;
- 53 % decrease in alcohol and other drug-related medical visits;
- 28 % decrease in inpatient mental health visits; and
- 34-56 % decrease in "high risk" sexual behaviors associated with the transmission of HIV.

Cornell University researchers in a study of 6,000 students in NY State found that the odds of drinking, smoking, and using marijuana were 40% lower among students who participated in a school-based substance abuse program in grades 7-9 than among their counterparts who did not.



GOAL 2: IMPROVE THE ECONOMIC AND SOCIAL WELL-BEING OF INDIVIDUALS, FAMILIES, AND COMMUNITIES IN THE UNITED STATES.

Each person, regardless of age, sex, physical ability, or racial/ethnic background, should have the opportunity to lead an economically and socially productive life. With its partners, HHS supports strategies that create opportunities for individuals, families, and communities to be economically and socially productive.



❖ **We worked to increase the economic independence of families on welfare.**

Under the *Temporary Assistance to Needy Families* (TANF) program, whose net cost was \$15.475 billion in FY 1999, states have extensive flexibility in designing programs that promote work, responsibility, and self-sufficiency. Almost every state requires personal responsibility contracts and 32 states expect clients to work within six months. In August 1999, data was released that showed all 50 states and the District of Columbia met the overall work participation rates for all families in 1998 — the first full year of the new welfare reform law. Welfare caseloads are at their lowest level since 1967 and the welfare rolls have fallen by nearly half since 1994. Nationwide the rolls have fallen by 49 percent and from 14.2 million to 6.9 million.

TANF WORK PARTICIPATION RATES FOR FY 1998	
All Family Rates	Two-Parent Family Rates
35.4%	42.3%

Source: ACF Data & Statistics

Twenty-seven states received high performance bonuses totaling \$200 million for excellent performance in moving welfare recipients into jobs. The performance bonus program was authorized by law. The states placed 1.3 million welfare recipients into new jobs in 1998. Eighty percent of working recipients remained employed for an average of three months. In addition, their earnings rose from \$2,100 in the first quarter of employment to \$2,650 in the third. A recent General Accounting Office report found that between 63 percent and 87 percent of adults have worked since leaving the welfare rolls. These results are similar to state studies funded by HHS.

States also reported a new record percentage of parents on welfare that are working. Data released in 1999 shows that 35 percent of all adult welfare recipients were working, looking for employment or enrolled in work preparation activities in 1998. The percentage of employed recipients reached an all-time high at 23 percent compared to less than 7 percent in 1992 and 13 percent in 1997. Similarly, the proportion of recipients who were working, including employment, work experience, and community service reached 27 percent which is nearly a fourfold increase over the 7 percent recorded in 1992.

ACF's goal under the National Performance Review's (NPR) "High Impact Agency" initiative was to increase self-sufficiency for low-income families by moving one million welfare recipients into new employment by 2000. In FY 1999 ACF reported that the goal was achieved earlier than anticipated with 46 states reporting 1.3 million job entries for FY 1998.



CHANGE IN WELFARE CASELOADS SINCE ENACTMENT OF NEW WELFARE LAW			
Total TANF Families and Recipients (in thousands)			
	Aug-96	June-99	Percent Change
Families	4,415	2,536	- 43%
1,879,000 fewer families			
Recipient s	12,241	6,889	- 44%
5,352,000 fewer recipients			

Source: ACF Data & Statistics

TANF helps to increase the self-efficiency for low-income families.



As part of the same NPR initiative and consistent with ACF's *child welfare* activities and the Administration's adoption goal for 2001, ACF adopted a goal of increasing the number of children who are adopted from the public foster care system to 51,000 by FY 2001. Adoptions have increased from 28,000 in FY 1996 to 36,000 in FY 1998. In 1999 ACF awarded \$20 million in the first adoption bonuses to 35 states that had increased the number of children adopted from foster care.

Child Care and Development fund grantees have many efforts underway to address affordability and access to child care for low-income families. ACF work continues in partnership with states to increase and identify the number of children served by the grants. On

Goal: (ACF) Increase parental responsibility.
FY 1999 Target: Collect \$16.3 billion in child support collections.
FY 1999 Actual: \$15.5 billion (preliminary)
Trend: FY 1996: \$11.9 billion collected, FY 1997: \$13.38 billion collected, FY 1998: \$14.3 billion collected.

October 19, 1999 the Secretary of HHS released a report indicating that nationally, in an average month of 1998, 1.5 million low and moderate-income children eligible for this grant assistance from states received help through the program.

❖ **We helped to increase the financial and emotional resources available to children from their noncustodial parents.**

The *Child Support Enforcement Program* (CSE) obtains support for children by locating parents, establishing paternity, and establishing and enforcing support orders. The national employment database, known as the National Directory of New Hires, more than doubled its success in its first year by matching selected state cases and found over 2.8 million delinquent parents.

Paternities establishment rose to 1.5 million in 1998, a more than three-fold increase from 516,000 in 1992. The Passport Denial program collected more than \$2.25 million in lump sum child support payments and is currently denying 30-40 passports to delinquent parents per day.



❖ **We supported the improvement of the healthy development and learning readiness of preschool children.**

Head Start is the nation's premier early childhood development program for low-income children and families. Head Start has grown from 714,000 in 1993 to 835,000 children in FY 1999 who were enrolled in programs to enhance children's growth and development; strengthen families, and provide children's educational services.

Head Start has begun to assess how program efforts influence the development of emergent literacy, numeracy, and cognitive skills; gross and fine motor skills; and social skills of participating children through its Family and Child Experiences Survey (FACES). Baseline data collected from 1997-1999 indicate that children experienced improvement in all of these dimensions. For example, the data shows that Head Start helps children improve their vocabulary skills during both their Head Start year and kindergarten years at a faster rate than the average rate of improvement for children of all income levels. ACF is establishing performance goals to assess learning development using the measurement scales employed for the FACES.

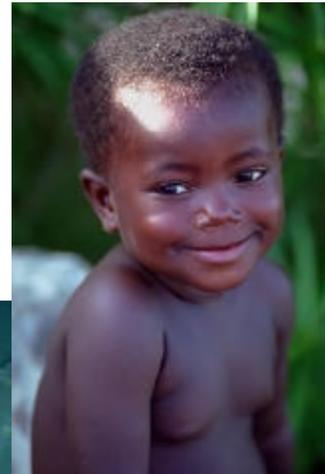


Head Start helps to give children a good foundation for learning.

Head Start also emphasizes the importance of the early identification of health problems. Every child is involved in a comprehensive health program, which includes immunizations, medical, dental, and mental health, and nutritional services. ACF wants to assure that Head Start children are able to receive medical treatment when they are identified as needing medical services.

In FY 1999, ACF was just short of its goal of 88 percent, with 87 percent of Head Start children receiving care after being identified as needing services. It is important to bear in mind that Head Start has a predictable turnover rate, that is, children leave the program during its course for various reasons and so while a referral may have been made programs may not have follow up information for those children. Nevertheless, Head Start has chosen to increase targets of performance in future years.

The American Customer Satisfaction Index is a national economic indicator of customer satisfaction with the quality of goods and services available to household consumers in the United States. In December 1999 the partners that produce the ACSI released the result of customer evaluations of various federal agency services and products. The parents of Head Start students rated the program 87 out of 100 points; the highest rating received for the federal programs evaluated.



Children are our Nation's future.

GOAL 3: IMPROVE ACCESS TO HEALTH SERVICES AND ENSURE THE INTEGRITY OF THE NATION'S HEALTH ENTITLEMENT AND SAFETY NET PROGRAMS.

Without insurance, access to health services is severely compromised. With its partners HHS broadens access to services and maximizes the number of low-income or special-needs populations served. HHS also prevents waste, fraud, and abuse of its entitlement and safety net programs, particularly Medicare and Medicaid because of their size and their impact on the total health care system.

Goal (HCFA): Decrease the number of uninsured children by working with states to implement SCHIP and increase enrollment of eligible children in Medicaid.
FY 1999 Target: Establish target and baselines.
FY 1999 Actual: Met.
Trend: FY 1997: 22.7 million in Medicaid; none in SCHIP



Healthy children mean a healthy future and lower health cost.

❖ **We are helping to bring about an increase in the percentage of the Nation's children who have health insurance coverage.**

Nearly 11 million children in the United States—one in seven—are uninsured because their families cannot afford private insurance and therefore are at significantly increased risk for preventable health problems.

In 1999 HHS continued to work diligently with its partners to develop and implement plans to extend health care coverage to millions of uninsured children. On September 8, 1999, HHS announced that the *State Children's Health Insurance Program* (SCHIP), which was passed in the Balanced Budget Act of 1997 and amendments, had been approved in all 56 states and territories in the country. Under the program, Congress and the Administration agreed to set aside \$24 billion over five years to help expand health insurance to children whose families earn too much to qualify for traditional Medicaid, yet not enough to afford private health insurance. States are improving their processes to achieve these enrollment levels.

HCFA met its target of developing a FY 2000 objective for decreasing the number of uninsured children by enrolling eligible children in Medicaid and SCHIP. The target is to enroll 1 million more children each year than the prior year.

In FY 1999, SCHIP enabled the states to serve many more women and children because community Health Centers are responding aggressively to the opportunities offered through SCHIP. HRSA and its Health Center grantees recognize that ongoing and intensified outreach and educational efforts will be necessary to assure that all the children who are eligible under SCHIP are enrolled.



❖ **We increased the availability of primary health care services.**

There is mounting evidence that access to a usual and regular source of care can reduce and even eliminate health status disparities among subsets of the population. The high quality primary health care received in HRSA's Health Centers has been shown to reduce hospitalizations and emergency room use, reduce annual Medicaid costs, and helps prevent more expensive chronic disease and disability for these populations.

Community Health Centers and the National Health Service Corps (NHSC) combined provides primary health care services to approximately 11.5 million low income, underserved patients. This represents one-fourth of approximately 44 million persons (according to 1998 data) in more than 4,000 communities across the nation who lack access to a primary care provider. For health centers, the patients include 3.52 million uninsured persons, of whom more than 1.2 million are children. This is a 59 percent increase since 1990. To help meet patient needs, 60 percent of the NHSC 2,526 physicians, nurses, dentists, and other primary care providers work in underserved communities throughout the country, in addition to the 40 percent who work in health centers. In FY 1999 they served 4 million of the total patients served.

In FY 1999, 52 new and expanded community health center were funded. The awards increased access to primary and preventive health care for approximately 200,000 underserved people.



To assure a health professions workforce that meets the health care needs of the American people, HRSA's **Health Professions Programs** operate more than 40 grant and student assistance activities focused on improving the diversity and distribution of the nation's health care practitioners. Thirty-three percent of family practice residents and 40 percent of nurse trainees, nurse practitioners, and midwives from HRSA-funded programs practice in medically underserved communities. In FY 1999 HRSA created a federal-state NHSC loan repayment partnership with 35 states to obtain the services of health professionals by repaying their educational loans using matching funds.



Goal: (HRSA) Increase utilization of health care for underserved populations.
FY 1999 Target: Increase to 8.9 million the number of uninsured and underserved persons served by health centers, with emphasis on areas with high proportions of uninsured children to help implement the SCHIP program
Trend: FY 1997: 8.3 million, FY 1998: 8.7 million.

Goal: (HRSA) Assure access to preventive and primary care for minority individuals.
FY 1999 Target: 65% of population served are minority individuals
Trend: FY 1997: 65% of population served at Health Centers, FY 1998: 64% of population served at health centers.

Goal: (HRSA) Assure access to preventive and primary care for uninsured individuals.
FY 1999 Target: 42%
Trend: FY 1997: 39% of population served at health centers, FY 1998: 41% of population served.

Data for all three goals will be available in May 2000. Percents for the last two goals will include NHSC patients.

On June 4, 1999, the Health Resources and Services Administration announced that two students enrolled in Howard University's Nursing Careers for the Homeless Program are the first to complete their bachelor of science in nursing degree programs. This program was launched in 1993 and since then 96 students were enrolled and are either enrolled in college-level nursing programs or employed in entry-level nursing positions.

Source: HRSA News Brief issued June 4, 1999.

Goal (SAMHSA): Assure services availability/meet targeted needs.

FY 1999 Target: Increase referrals from non-mental health agencies for mental health services by 10%.

FY 1999 Actual: Increased referrals to 80.1%.

Trend: FY 1997: 75%, FY 1998: 79.7%.

Although the target was not achieved, the results are moving in the direction of the target.

FY 1999 Target: Increase percent of client children attending school 75% of the time by 10%.

FY 1999 Actual: Exceeded the target. 88.9% attending at 12 months.

Trend: FY 1997 Baseline: 70%, FY 1998: 78.8% (12% increase)



Every year, more than 51 million adult Americans experience diagnosable mental disorders. Of them, more than 6.5 million are disabled by severe mental illness, including as many as 4 million children and adolescents.

Community mental health services block grants improve community-based systems of care in order to increase the level of functioning and quality of life for adults with serious mental illnesses and for children with serious disturbances. SAMHSA awarded \$288.8 million in community mental health grants in FY 1999. An estimated 151,000 clients were served in systems receiving funds in FY 1999. Performance indicators are still being discussed with the states. A significant problem is the development and use of comparable definitions for the proposed measure. However, for children and their families who receive services at grantee sites under a comprehensive community mental health program, results are demonstrated by measures such as interagency collaboration and client outcomes.



In response to the severe and ongoing crisis regarding **HIV/AIDS**, HRSA's goal is to provide access to state-of-the-art HIV clinical care for those who have HIV/AIDS and approximately 250,000 HIV-positive people who know their status but are not under care. HRSA awarded \$710 million in formula grants to 50 states, the District of Columbia and U.S. territories to improve access to HIV/AIDS primary care, support services, and medications for people living with HIV/AIDS and their families. This amount includes \$461 million earmarked for state **AIDS Drug Assistance Programs**, ensuring that more than 100,000 low-income individuals living with HIV/AIDS receive life-saving and life-sustaining drug therapies.

Goals for the six Ryan White Care Act programs focus on increasing access to health care services and anti-retroviral therapy and reducing perinatal transmission. The programs have also established goals to serve women and minorities in proportions that exceed their representation in overall AIDS prevalence by a minimum of five percent. Despite the reduction seen in overall AIDS morbidity, the proportion of AIDS cases among women and minorities continues to increase. The benefits provided by new combination drugs have not uniformly reduced the incidence of AIDS. The performance noted below reflects significantly increased efforts across all of the programs to target communities of color.

- *Access to primary medical, dental, mental health, substance abuse, rehabilitative, and home health care:* HIV Emergency Relief Grants: Providing the core response in metropolitan areas hardest hit by the AIDS epidemic. Title I grantees reported 2.79 million visits in FY 1998, moving towards the FY 1999 target of 2.88 million visits. Also in FY 1998 the program exceeded its FY 1999 targets to serve 30 percent women and 64 percent minorities, serving 30.7 and 67.7 percent respectively.
- *HIV Care Grants to States:* In FY 1998 Title II programs reported 1.45 million visits, a 26.2 percent increase over FY 1997 and exceeding the FY 1999 target by approximately 230,000 visits. The program also exceeded its FY 1999 targets for serving minorities and women in FY 1998: 29.4 percent program beneficiaries in FY 1998 were women and 64.1 percent minorities, compared to the FY 1999 targets of 27 percent women and 59 percent minorities served.
- *Access to Primary Care:* In FY 1998 the Title III Early Intervention program exceeded its FY 1999 target of 90,433 clients receiving primary care services. A total of 105,398 persons received primary care services in FY 1998, a 9.3 percent increase compared to FY 1997. In addition, the program provided services to 72,242 minorities in FY 1998, an increase of 14 percent (8,819 minority clients) over FY 1997. The program has exceeded its 1999 target to serve 60,000 minorities for the past two years.
- *Access to Anti-retroviral Therapy:* In FY 1999, an average of 64,500 persons received anti-retroviral therapies each month through the AIDS Drug Assistance Program (ADAP). While an average of 9,500 additional clients were served per month in FY 1999 compared to FY 1998, because of data collection system revisions, the program did not meet its FY 1999 target to serve an average of 78,088 persons per month. The FY 1999 target was set prior to the full implementation of the data collection system for this measure in FY 1999.

Proportion of Women and Minorities served by Emergency Relief Grantees and State Grantees Compared to the Proportion of the U.S. Population with AIDS

Year	Proportion of AIDS patients who are women	Proportion of AIDS patients served by HRSA-funded programs who are women	Proportion of AIDS patients who are minorities	Proportion of AIDS patients served by HRSA-funded programs who are minorities
1996	15.3%	30.3%	53.8%	64.2%
1998	15.8%	30.0%	55.4%	68.0%

HRSA. Note: Source data contain duplicated client/beneficiary counts.



Of special concern also are health care services for mothers and children of low-income or isolated populations, who otherwise would have limited access to care. In 1999 the safety net for women and children was significantly expanded.

The **Maternal and Child Health Services (MCH)** provided \$576.2 million in funds to 59 States and jurisdictions in FY 1999 under a matching formula that takes into consideration the percent of the nation's low-income children residing in each. Since MCH is a block grant, the states have discretion in how they spent funds to meet the goals of the program. HRSA will use the aggregated state core measures that states report on, to assess the overall performance in FY 2001. In FY 1999 the program established baselines for the measures and set targets for FY 2001. Selected MCH goals include:



Prenatal health care is important to both mother and child.

- Decrease the infant mortality rate from the FY 1997 rate of 7.1/1000 to 6.9/1000 in FY 2001, and decrease the ratio of the black infant mortality rate to the white infant mortality rate from 2.4 to 1 in FY 1996 to 2.1 to 1 in FY 2001.
- Increase the percent of infants born to women receiving care beginning in the first trimester from 82.5 percent in FY 1997 to 90 percent in FY 2001.
- Increase the percent of children with special health care needs in the State with a medical/health home (as defined and recommended by the American Academy of Pediatrics) from 69 percent in FY 1997 to 80 percent in FY 2001.
- In the Healthy Start Initiative, decrease the percentage of low birth weight babies born to Healthy Start clients from 12.09 percent in FY 1998 to 11.75 percent in FY 2001.

Healthy Start was launched in 1991 to reduce infant mortality in areas with extremely high infant mortality and low birth weight babies. In FYs 1998 and 1999 HRSA focused on replicating the Healthy Start successes. Fifty-five new communities are replicating infant mortality reduction strategies from other communities.

INFANT MORTALITY RATES IN THE UNITED STATES (DEATHS PER 1,000 LIVE BIRTHS FOR INFANTS UNDER 1 YEAR OLD)					
	1960	1970	1980	1990	1997 *
Infant (All Races)	26.0	20.0	12.6	9.2	7.2**
White	22.9	17.6	10.9	7.6	6.0
Black	44.3	33.3	22.2	18.0	14.2
Hispanic	-	-	-	7.8	6.0

Source: Tables HC 1.1.A & 1.1.B- 1999 Trends in the Well-Being of America's Children & Youth (HHS)

** Preliminary Data*

*** In 1997, the infant mortality rate for American Indians/Alaskan Natives was 8.7 and for Asian/Pacific Islanders was 5.0.*

The ***National Immunization Program*** focuses on several major programmatic areas to achieve its goals, including childhood immunization, adult immunization, and global polio eradication. State and local health agencies play a primary role by using federal grant funds for a wide variety of immunization activities including surveillance. As a result, information shows that immunization coverage levels for adults in the United States have increased for influenza and pneumococcal disease. Progress is still needed among African-Americans and Hispanics.

CDC and HCFA share complementary goals to increase the number of annual influenza and lifetime pneumococcal vaccinations among selected populations aged 65 and over. For example, CDC and HCFA shared the FY 1999 goals to increase the annual influenza vaccination rate to near 60 percent. Although final data for this measure is not yet available, CDC data indicates that the rate of vaccination for influenza among persons aged 65 and older increased from 33 percent in FY 1989 to 63 percent in FY 1997.

CDC's REACH grants provide funding for adult immunization activities aimed at eliminating the health disparities. HCFA also stepped up its efforts to increase the number of minorities receiving flu and pneumonia vaccinations this year by mailing nearly 8 million postcards in four languages to remind Medicare beneficiaries to get immunized.

Also, on September 23, 1999, CDC announced that the nation's overall immunization rate for preschool children increased to a record 80 percent in 1998 attaining the highest rate ever recorded. Because childhood vaccination levels in the United States are at an all-time high, disease and death from diphtheria, pertussis, tetanus, measles, mumps, rubella and H.influenza B are at or near record lows. There was only one reported case of diphtheria, 100 reported cases of measles, and no reported cases of wild poliovirus for 1998.

Data show that cases of vaccine-preventable childhood diseases have been reduced by 97 percent from peak levels before the vaccines were available. To ensure that preschool age children continue to be vaccinated against preventable diseases, CDC and HCFA have developed complementary goals to increase the percentage of 2-year old children to receive all recommended childhood vaccinations. CDC's efforts focus on maintaining a 90 percent coverage rate among children 19-35 months for each recommended vaccine. While FY 1999 data will not be available until 2000, data from FY 1997 indicate that CDC met that goal for all but two vaccines. HCFA will continue to develop its goal to increase the percentage of Medicaid enrolled two-year-old children who are fully immunized. The first group of 16 states began developing their methods of measurement and its

Vaccination rate among persons 65 or older		
	FY 1995	FY 1997
Influenza	58%	65%
P. Pneumonia	34%	43%

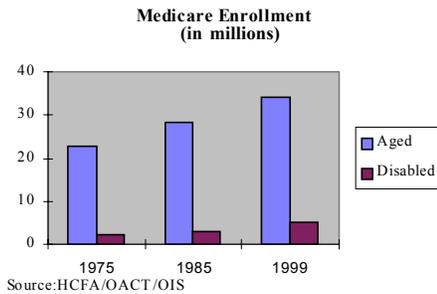
CDC National Health Interview Survey: FY 1997 data is preliminary.

Goal: Increase pneumococcal pneumonia and influenza vaccination among persons of 65 years or more.
1999 Targets: Vaccination Rates for Influenza 60%. Pneumococcal pneumonia 54%.
1999 Actuals: Data is not available yet.

For every \$1 spent on diphtheria/tetanus/acellular pertussis vaccination, \$27 is saved.



Immunization should begin at an early age.



Goal: (HCFA) Improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance.
FY 1999 Target: Work with states to establish an enrollment target for beneficiaries for FY 2000.
FY 1999 Actual: Met.




Medicare and Medicaid provide health services to many Americans.

baselines in FY 1999. They will complete setting their baselines by the end of FY 2000.

All of the national 1996 immunization coverage goals of vaccinating 90 percent of the nation’s children by aged two with the most critical doses of routinely recommended vaccines have been achieved and maintained except for Hepatitis B. Coverage for Hepatitis B in 1998 is only three percentage points short of the goal.



❖ **We protected and improved beneficiary health and satisfaction with Medicare and Medicaid.**

Medicare and Medicaid together provide health insurance coverage for approximately 75 million elderly, disabled, and economically disadvantaged Americans.

Medicare covers both hospital insurance and insurance for physician and outpatient care, laboratory tests, home health care, durable medical equipment, designated therapy services, and other services not covered by hospital insurance. A new program under Medicare, Medicare+Choice, was created in 1997 to increase health care options for beneficiaries through a greater variety of managed care and fee-for-service plans. Over the last thirty years, Medicare has significantly contributed to life expectancy, to the quality of life, and to protection from poverty for the aged and disabled. In FY 1999, Medicare costs were \$184.5 billion.

HCFA and states established a FY 2000 target of a 4 percent increase in enrollments. An additional 211,000 beneficiaries would be enrolled in a dual eligible program (i.e., for both Medicare and Medicaid).

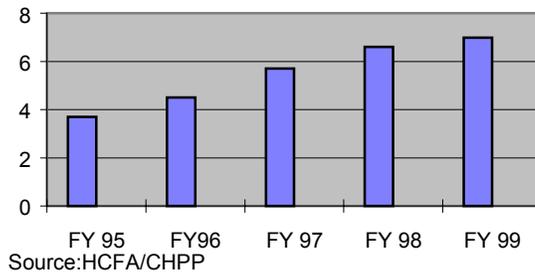
HCFA was among the 30 federal agencies that participated in the independent American Customer Satisfaction Index ratings of customer satisfaction. Recent Medicare beneficiaries were queried for their satisfaction with their HCFA contacts and they gave a rating of 71 percent satisfaction, which exceeds the aggregated federal government rating of 68.6 percent.

In FY 1999 HCFA also continued to develop an appropriate performance measurement methodology for fee-for-service arrangements and a goal for managed care plans.

In addition, HCFA set a goal and target for sustaining high quality health care options for beneficiaries. Achievement of this goal is dependent upon the marketplace and on receiving applications for managed care operations in rural areas and areas where there are no managed care organizations.

However, in FY 1999 the number of new applications or service areas did not materialize, and 45 managed care organizations terminated their contracts and 54 reduced their service area.

Managed Care Enrollment
(in millions)



The prevalence of physical restraints is an accepted indicator of quality of care and is considered a proxy for measuring quality of life for nursing home residents. The use of physical restraints can cause incontinence, pressure sores, loss of mobility and other problems. Many providers and consumers still mistakenly believe that restraints are necessary to prevent residents from injuring themselves.



Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security, End Stage Renal Disease or Railroad Retirement benefits.

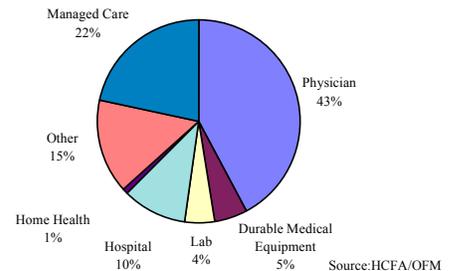
Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over, End Stage Renal Disease beneficiaries and disabled people entitled to Part A.

Goal (HCFA): Sustain health plan choices where Medicare beneficiaries have at least one managed care option/choice.
FY 1999 Target: 80% of Medicare beneficiaries have at least one managed care option/choice.
FY 1999 Actual: 76% have at least one managed care option/choice.

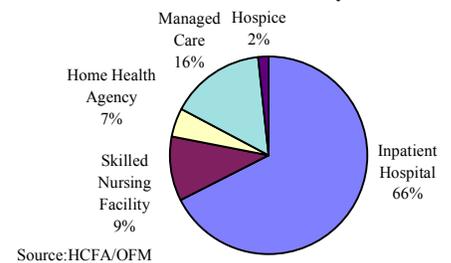
Goal: (HCFA) Decrease the prevalence of restraints in long-term care facilities.
FY 1999 Target: Decrease use of restraints to 14%.
FY 1999 Actual: Exceeded the target; 11.7%



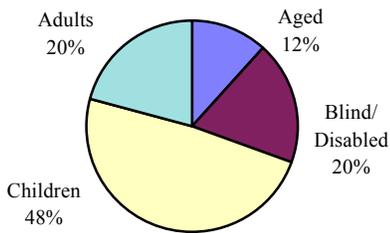
1999 SMI Medicare Benefit Payments



1999 HI Medicare Benefit Payments



1999 Medicaid Enrollees



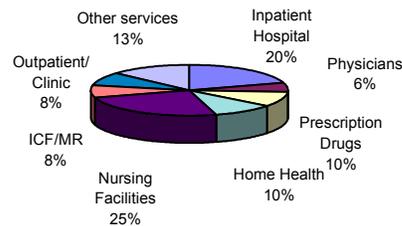
Source: HCFA/OACT

Medicaid is the primary source of health care for medically vulnerable Americans such as poor families, the disabled, and persons with developmental disabilities requiring long term care. Medicaid is administered in partnership with the States. HCFA issues the matching payment grants to states and territories for medical assistance and administrative costs. Medicaid provides health coverage for 41.9 million low-income persons. Medicaid has improved birth outcomes, childhood immunization rates, and access to preventive services, resulting in overall improvements in the health of America's children. Medicaid costs in FY 1999 were \$109.0 billion.

Goal: Provide to states linked Medicare and Medicaid data files for dually eligible beneficiaries.
FY 1999 Target: To provide data to 27 states.
FY 1999 Actual: Met the target; data is available to 27 states.



Medicaid Vendor Payments



Source: HCFA/OIS

There were approximately 6 million individuals dually eligible for Medicare and Medicaid. HCFA hopes to foster a service delivery system that is better integrated and more flexible in meeting the needs of dually eligible beneficiaries.



Twenty percent of Medicaid's vendor payments are made to inpatient hospitals.



❖ **We enhanced the fiscal integrity of HCFA programs and ensured the best value health care for beneficiaries.**

HCFA made great strides in 1999 to further define and implement its overall strategy for reducing payment errors in the Medicare and Medicaid programs. HCFA developed a comprehensive program integrity plan based on the key payment safeguard principles for fraud prevention, detection, enforcement, and coordination.

In 1999 HCFA also required more than 250 Medicare managed care risk-based plan (paid on a per-capita rate computed by actuaries) and cost-based plan (paid based on a cost report and audit) **contractors to report on measures of performance** on managed care programs. These measures included effectiveness of care, use of services, access to care, and other relevant areas that will provide a better understanding of the performance of the Medicare managed care plans.



Under the ***Health Care Fraud and Abuse Control Program***, HCFA, the HHS Inspector General, the Federal Bureau of Investigation, and the Department of Justice, as well as other agencies, including the Administration on Aging, are working together to detect and prevent fraud and abuse.

HHS and the Department of Justice have reported more than \$1.6 billion in fines and restitution returned to the Medicare Trust Fund during fiscal years 1997, 1998 and 1999. During these years HHS also excluded more than 8,600 individuals and entities from doing business with Medicare, Medicaid, and other Federal and State health care programs for engaging in fraud or other professional misconduct.

HHS/OIG works with HCFA to develop and implement recommendations to correct systemic vulnerabilities detected during evaluations and audits. These corrective actions often result in health care “funds not expended” (that is, funds put to better use as a result of implemented recommendations for program improvement). During FY 1999 the funds not expended on improper or unnecessary care amounted to approximately \$11.8 billion, an increase of \$1 billion above FY 1998. Much of this amount reflects savings achieved as a result of legislative amendments brought about by the Balanced Budget Act of 1996 (BBA).



HHS increased convictions in health care cases from 127 convictions in FY 1996 to 303 convictions in FY 1999.



Fraud Hot Line
Call Toll Free: 1-800-HHS-TIPS
(1-800-447-8477)
e-mail: HTips@os.dhhs.gov

During FY 1998 and FY 1999, AoA's efforts resulted in training 16,000 retired professionals and other volunteers in the Medicare and Medicaid programs. These volunteers, in turn, educated over 325,000 beneficiaries to identify and protect themselves against fraudulent, wasteful, and abusive health care practices. Where there were questionable charges for medical services, volunteers referred the cases (5,000 in FY 1999) back to health care providers, appropriate Medicare carriers, and ultimately to the HHS Inspector General.



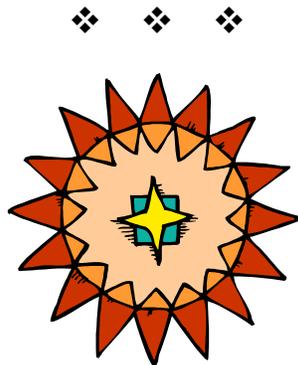
In FY 1998, HHS announced that for the first time Medicare would hire special consultants who specialize in audits, medical reviews, and internal controls for health programs as an additional effort for the Administration's fight against waste, fraud and abuse. HCFA awarded contracts in FY 1999 to thirteen Program Safeguard Contractors who will work with the **Medicare Integrity Program** to end criminal activities by fraudulent health care providers, ensure that Medicare pays only for medically necessary services, and identify honest errors that lead to improper payments.

While we have long known there are billing abuses in the Medicare program, the FY 1996 financial statement audit process gave us our first statistically valid estimated error rate in our Medicare fee-for-service program. Generally, the HHS Inspector General has found that the vast majority of claims are paid correctly based on information submitted on the claim. However, when supporting medical documentation was requested from providers and the services were reviewed the IG found errors in the claims. These errors range from inadvertent mistakes and missing documentation to outright fraud and abuse. The portion attributable to fraud cannot be quantified.

The estimated error rate is quantified in terms of ranges of both dollars and as a percent of program payments. Midpoint estimates are derived from the range figures.

Medicare Fee-for-Service Estimated Error Rates				
	FY 1996	FY 1997	FY 1998	FY 1999 Draft
Midpoint Dollar Estimate	\$23.2 billion	\$20.3 billion	\$12.6 billion	\$13.5 billion
Midpoint Percentage Estimate	14%	11%	7.1%	7.97%

As this Accountability Report goes to print, the final results on the FY 1999 error rate are not available. However, draft results indicate that the rate of improvement in the estimated error rate plateaued in FY 1999, as is indicated in the accompanying chart.



❖ **We strove to improve the health status of American Indians and Alaska Natives.**

In direct partnership with the Tribes, and in recognition of their expanding role in developing and managing the health needs of *American Indians and Alaska Natives*, (AI/AN), IHS is working to provide access to basic health services. This includes the assurance of adequate facilities and equipment for the provision of health services and adequate support services to the Tribal health delivery system.

The IHS, with the Tribes, developed and implemented a policy to ensure tribal consultation and participation in important IHS processes. The policy was in effect at the start of FY 1999. The stakeholders have elected to revisit specific consultation processes and IHS will conduct a baseline satisfaction survey after the policy is updated. IHS also continued to work with Indian Tribes exercising their



IHS provides access to health care for American Indians and Alaskan Natives.

Goal: (IHS) Reduce prevalence of diabetes among AI/AN population.
FY 1999 Target: Establish Area age-specific prevalence rates for the AI/AN population.
FY 1999 Actual: Rates are available for IHS Area and sex for 4 age groups from 0 –19 to 65 and over.

self-determination rights through Tribal contracts, Tribal compacts, or continuation of services from the IHS health delivery system.

In FY 1999 under the *Hospitals and Clinics Program*, IHS and the Tribes provided essential services for inpatient care, routine and emergency ambulatory care; and support services. The program includes initiatives targeting special health conditions that affect AI/ANs.

In FY 1999 more than \$30 million was obligated for 286 grants awarded to IHS facilities, Indian Tribes/Tribal organizations and urban Indian organizations to address the prevention and treatment of diabetes. Diabetes continues to grow in epidemic proportions in Native American communities. In some AI communities, up to half of the adults have diabetes. *Diabetes* is 4-8 times more common among American Indians compared to the general U.S. population. Through these grants, diabetes prevention and treatment programs will reach more than 100,000 American Indians/Alaska Natives suffering from diabetes as well as another 30,000 to 50,000 who are at risk.



Once a facility has been completed, IHS has experienced an average increase of approximately 60% more patient visits than in the old facility. To maintain the level of service in the IHS health care delivery system over \$182 million was expended for health care facilities. A priority system determines which and when facilities are constructed.



Many Indian homes lack either a safe water supply or adequate sewage disposal system, or both. There is a demonstrated link between adequate *sanitation facilities* and reduced infant mortality, gastroenteritis, and other environmentally related diseases. IHS has undertaken a major effort to provide those facilities. These improvements will also help to reduce the related demands on the IHS health delivery system.



Under the Older Americans Act, the Administration on Aging provided funding to 225 Indian Tribal organizations representing more than 300 tribes and 2 organizations representing Native Hawaiians. Over 750,000 units of in-home services were provided to Native American older adults in FY 1999 for personal care, homemaker services health aide services, case management, and family support. A total of 600,000 rides to congregate (community) meal sites, doctor appointments, and grocery shopping were also provided. Without the transportation provided, Native Americans residing in isolated areas would not be able to conduct many activities essential to meet their everyday needs.

Goal: (IHS) Improve access to health care by construction of approved new health care facilities.
FY 1999 Target: Conduct construction of facilities scheduled for FY 1999
FY 1999 Actual: Met the target. The completion phase of construction was reached for the Hopi (Polacca), Arizona Health Center. Construction was started on Ft. Defiance, Arizona Hospital and the Parker, Arizona Health Center.



Goal: (IHS) Provide sanitation facilities.
FY 1999 Target: Provide sanitation facilities to 14,130 homes.
FY 1999 Actual: 16,571 homes received sanitation facilities.
Trend: FY 1998: 14,373 homes.



GOAL 4: IMPROVE THE QUALITY OF HEALTH CARE AND HUMAN SERVICES.

The quality of health and human services needs to improve continually to address constantly changing problems. HHS accomplishes this goal by a wide range of quality improvement activities designed to provide better ways of addressing the changing problems that confront the health care and human service delivery system, such as changes in family structures, demographics, and financing of health services.

❖ **We promoted the appropriate use of effective health services.**

Significant improvements in health, as well as reductions in costs associated with unnecessary remedial care, could be achieved by improving the extent to which physicians and other practitioners deliver the most appropriate treatments. Without a significant investment in research initiatives, there will not be enough *new knowledge produced to improve the health care system.*

To determine the funding priorities for research resources AHCPR, in FY 1999, succeeded in developing a research agenda for the future through consultations with its customers. The research agenda addresses the three AHCPR strategic research goals to improve:

- the structure and process of health care,
- the quality of that care, and
- access to care.

Consistent with these goals AHCPR awarded new research grants in the following critical areas to assess the outcomes and cost effectiveness of:

- access and outcomes of HIV care in America,
- medical outcomes in the pricing of hospital procedures,
- measuring the quality of care for diabetes, managed care and quality for children with chronic conditions, and
- improving heart failure care in minority communities.



In FY 1999 AHCPR continued to evaluate the outcomes of the investments that the agency funds. Over 3,100 articles appeared in the print media that cited the Agency and its programs; the combined circulation of the periodicals was over 253 million. Findings from at least 10 AHCPR research activities were published in major peer reviewed professional publications. Thirteen of AHCPR research activities were implemented in the health care system.

Goal (AHCPR): Initiate FY 1999 research initiatives.

1999 Target: Fund a minimum of 21 projects in:

- Consumer use of information
- Value-based purchasing
- Measure national care quality
- Vulnerable populations
- Translate research into practice

1999 Actual: 54 projects



Some Results of Recent AHCPR Research

Beta Blockers: Only 21% of heart attack patients receive beta blockers, which are more effective than calcium-channel blockers that are used 3 times as often.

Medical Errors: Adverse drug events are preventable if appropriate systems such as computerized monitoring programs are in place in hospitals.

Schizophrenia: Produced the evidence needed for the development of treatment recommendations for patients that have been used by the National Alliance for the Mentally Ill in a consumer booklet for families and patients.



We are concerned about improving the quality of health care.

Also the “Outcomes of Outcomes Research at AHCPR” report was issued in FY 1999. This evaluation study assessed the impact of AHCPR sponsored products in advancing methods to measure and improve health care. See <http://www.ahrq.gov/clinic/outcosum.htm>.

To see more findings of AHCPR research go to: Research Findings under www.ahrq.gov



In FY 1999 AHCPR also launched the National Guideline Clearinghouse <http://www.guideline.gov>, an internet-based source of information on clinical care that will help health professionals to improve the quality of care they provide to their patients. There were more than 640,000 web site visits in its first 10 months toward the end of 1999. NGC had an average of 16,000-18,000 visits per month. In addition, AHCPR’s publications clearinghouse continued to disseminate information and received 1999 customer satisfaction ratings of 97.2 percent for providing requested assistance.



❖ **We increased consumers’ understanding of their health care options.**

In 1998 HHS launched a nationwide effort to help patients rate their health plans and to help consumers choose among plans. The effort is built on a new survey tool, the *Consumer Assessment of Health Plans* (CAHPS), that provides a consumers-eye view of the care and service they receive from health plans. The survey asks how easily beneficiaries can access specialists and urgent care and seeks information on the general level of consumer satisfaction.

In FY 1999 AHCPR used its evaluation results of the CAHPS to improve the usefulness of this consumer-oriented tool. According to preliminary findings, quality affects consumer choice of health care plans. Consumers do have a favorable reaction to CAHPS reports and they do use CAHPS data when choosing a plan.



Consumers can also gain an understanding of their health care options and obtain help in making reliable personal health choices by searching several locations on the HHS web sites. In FY 1999 HHS has continued and expanded its *presence on the Internet*.

HEALTHFINDER, at <http://www.healthfinder.gov>, the gateway that links to more than 1,250 Web sites, was expanded to include: Hot Topics (top 20 topics and some perennial favorites), Smart Choices (wellness and prevention) and Just For You (age-specific links).

MEDLINE, at <http://www.nlm.nih.gov>, contains the world's most extensive collection of published medical information. It is useful for those seeking information about health conditions, research, and treatment. In FY 1999 NIH's National Library of Medicine revamped Medline for use by the public.

MEDICARE, at <http://www.medicare.gov>, offers a variety of useful information and details new choices available to beneficiaries under the Balanced Budget Act.



To help consumers make informed decisions about the medications they use and give their families, FDA issued a new regulation in FY 1999 to provide new, easy-to-understand **labeling on non-prescription drugs**. By clearly showing a drug's ingredients, dose, and warnings, the new labeling will make it easier for consumers to understand information about a drug's benefits and risks as well as its proper use.



❖ **We improved consumer protection.**

In June 1999 HCFA announced new patient protections in standards to protect the health and welfare of hospitalized patients in compliance with the Administration's **Consumer Bill of Rights**. The patient's rights regulations strengthen existing protections for patient health and safety and will assure that high quality care is provided to all patients in hospitals participating in Medicare and Medicaid. The six basic patient rights specified in the regulations include the right to confidentiality of patient records and communications, and the freedom from the inappropriate use of restraints and seclusion.



HRSA's National Practitioner Data Bank (NPDB) tracks adverse professional actions against physicians and dentists as well as medical malpractice settlements and judgments against all licensed health care professionals and can be queried by licensing, privileging, and credentialing authorities prior to granting licensure or extending clinical privileges. In FY 1999 NPDB received 399,943 queries and matched responses containing malpractice payment, adverse action, or

FDA asked principal food shoppers and food preparers in American households about the usefulness and clarity of food labeling and the usefulness of consumer alerts. In the ASCI ratings, FDA scored a rating of 66% satisfaction. As a result, FDA is going to increase public awareness of its actions to ensure food safety.

Goal (HRSA): Assure effectiveness of health care.
FY 1999 Target: Provide responses to 3,200,000 inquiries.
FY 1999 Actual: Exceeded the target; provided responses to 3,235,631 inquiries.



About 1.6 million elderly and disabled Americans receive care in approximately 16,800 nursing homes across the United States.

Goal (AoA): Protect vulnerable older Americans.
FY 1999 Target: Maintain 71.48% national resolution/partial resolution rate of complaints by Ombudsmen.
FY 1999 Actual: Data will be available in September 2001.
Trend: FY 1995 Baseline: 71.48%

exclusion report information, and 2,835,318 responses that confirmed that the named practitioner had no malpractice payments, adverse actions, or exclusions. Based on previous user surveys conducted by the OIG, an estimated 10,800 licensure, credentialing, or membership decisions were affected by these match responses during FY 1999.



HCFA also strengthened federal oversight of state enforcement of health and safety requirements at *nursing homes*. In March 1999, a final regulation was issued that allows HCFA and states to impose civil monetary penalties for each serious violation. States also must investigate any complaint that alleges harm to a resident.



To ensure the *Protection of Vulnerable Older Americans*, long-term Care Ombudsman programs in every state and 586 local areas helped to resolve nursing and board-and-care home resident's problems; provide information to residents, potential residents, and their loved ones; and advocate on behalf of these health care consumers. In FY 1998 ombudsmen nationwide handled approximately 250,000 complaints made by over 121,000 individuals and provided information to another 210,000 people. To support ombudsmen in their demanding work, the AoA has funded the National Long-Term Care Ombudsman Resource Center. The Center is operated by the National Citizen's Coalition for Nursing Home Reform in conjunction with the National Association of State Units on Aging. The Center provides on-call technical assistance and intensive annual training to ombudsmen to enhance the effectiveness of their interventions in complex situations.

In FY 1998, 82 percent of the cases closed by Ombudsman programs involved nursing homes. The five most frequent nursing home complaints concerned:

- Requests for assistance needed,
- Shortage of staff,
- Personal hygiene neglected,
- Menu, food service, and
- Accidents, improper handling.

During FY 1999 training was provided for state ombudsmen to help them better assist residents and their families. A primary area of focus was information and methods for handling the involuntary discharge of residents from nursing homes.



In FY 1999, AoA increased funding for the *Eldercare Locator*, a toll-free national telephone directory assistance service designed to link callers to Older Americans Act information and assistance programs around the country. As a result of the additional funding, the Locator served an average of 7,196 people per month in FY 1999, almost a 10 percent increase over the 6,578 served in FY 1998. As a result of the Locator, assessment, referral, and appointment services were provided to over 600 more Americans per month and 7,400 more per year.



To help ensure the protection of consumer rights to access to HHS programs, the HHS Office for Civil Rights (OCR) established goals for *compliance with non-discrimination legislation*, to assess whether there had been an increase in compliance in priority areas as a result of OCR actions. Each completed corrective action or no violation finding reported by OCR represents a provider in compliance with the law, either because the provider made changes in policies and practices or because OCR determined that there was no violation.

The levels selected for the FY 1999 Targets reflect OCR's commitment to focus its effort in high priority areas.



**Call Eldercare Locator at
 1-800-677-1116.**

Goal (OCR): HHS grantees and providers found to be in compliance with Title VI in limited English proficient reviews/ investigations.

FY 1999 Target: 125 corrective actions and no violations.

FY 1999 Actual: Exceeded the target; 146 corrective actions and no violation findings.

FY 1998 Baseline: 98 corrective actions and no violations.



Goal (OCR): State and Local TANF agencies and service providers found to be in compliance with Title VI, Section 504 and American with Disabilities Act.

FY 1999 Target: 16 corrective actions and no violation findings.

FY 1999 Actual: 23 corrective actions and no violation findings.

FY 1998 Baseline: 8 corrective actions and no violations findings.

GOAL 5: IMPROVE PUBLIC HEALTH SYSTEMS.

The infrastructure of public health systems needs to be preserved and improved to conduct the interventions that save lives and ameliorate suffering. HHS contributes to an effective public health system by supporting improvements in training staff, encouraging the sharing of reportable disease information electronically, and ensuring that food and drug safety systems exist and work.

Goal: (AHCPR) Release and disseminate MEPS data and information products in timely manner for use by researchers, policy makers, purchasers, and planners.

1. FY 1999 Target: Core MEPS public use files available through Web site and CD-ROM within 9-12 months after data collection completed.

FY 1999 Actual/Baseline year: Significant progress towards releasing public use files within a year after data collected.

2. FY 1999 Target: Customer Satisfaction from use of MEPS tapes and products rated at 85%.

FY 1999 Actual/Baseline year: Web data: 92% customer satisfaction. Publications 93-96%. CD data: 86%



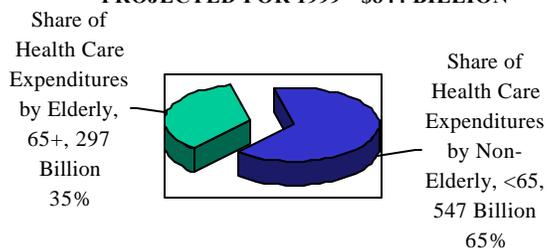
❖ **We improved the public health system’s capacity to monitor the health status and identify threats to the health of the Nation’s population.**

The *Medical Expenditure Panel Surveys* (MEPS), had \$29.3 million budgeted for FY 1999. MEPS is a household-based survey that collects detailed information regarding health care services from a nationally representative sample of Americans. It tracks the health care services use and payment from a nationally representative sample of the civilian non-institutionalized population. It tracks the health care services used by American families and individuals, the expense (including out-of-pocket expense) associated with those services, and the cost, scope and breadth of private health insurance coverage held by and available to the U. S. population. This sole and unique level of detailed information permits estimates of the impact of changes in financing, coverage and reimbursement policy, as well as estimates of who benefits and who bears the cost of a change in policy.

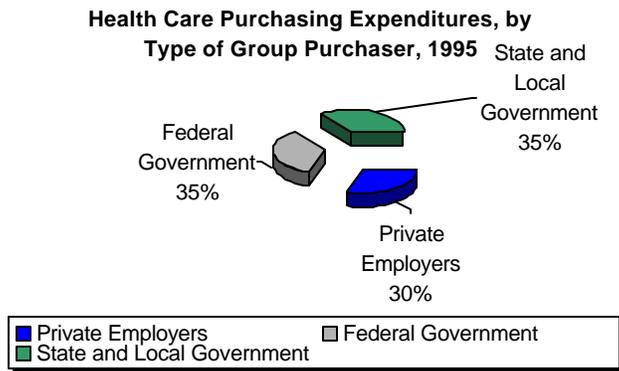
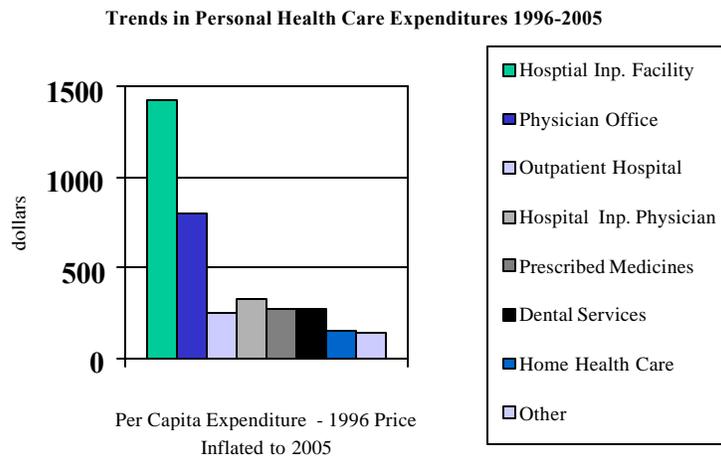
In FY 1999 the timeliness of MEPS data products and customer satisfaction with those products was the focus of MEPS performance. There were four specific products due for release in FY 1999; of those products, one was delivered in March 1999 and the rest were delivered at intervals through December 1999.

The web site for MEPS is: <http://www.meps.ahrq.gov>

SHARE OF HEALTH CARE EXPENDITURES CIVILIAN, NON-INSTITUTIONALIZED POPULATION: PROJECTED FOR 1999 - \$844 BILLION



■ Share of Health Care Expenditures by Elderly, 65+, 297 Billion
 ■ Share of Health Care Expenditures by Non-Elderly, <65, 547 Billion



Threats to the nation’s health can arise from malicious intent and from environmental toxins as well as from diseases and injuries that are discussed throughout this report. The public health system has to be prepared to monitor and respond to bioterrorism and environmental risks as well as other health risks.

To protect against *bioterrorism threats*, HHS efforts are directed especially in four areas:

- improving the nation’s public health surveillance network,
- strengthening the capacities for medical response,
- creating and maintaining a stockpile of pharmaceuticals for use if needed, and
- expanding research into the disease agents that might be released.

The initiative focuses on strengthening the public health capacity at the federal, state, and local level to respond to a terrorist event.

Goal (CDC): Increase the number of toxic substances that can be measured by CDC's environmental health laboratory to 40 new substances by the year 2002.

FY 1999 Target: Develop methods to measure human exposure to 8 new toxic substances.

FY 1999 Actual: Met the target; methods were developed for 8 new substances.

FY 1997 baseline: Methods exist for measuring 200 toxic substances in humans.



Special care must be taken to prevent exposure and adverse human effects from hazardous substances.

In FY 1999 CDC awarded \$41 million to 48 states and 3 cities for upgrading and improving their preparedness and response capabilities, laboratory services, epidemiology and surveillance systems, and electronic communication. Developing this infrastructure increases the ability to detect and respond to biological and chemical agents and bioterrorist acts in the United States. CDC achieved its FY 1999 target of creating a national pharmaceutical "stockpile" available for deployment to respond to terrorist use of potential biological or chemical agents, including the ability to protect 1-4 million civilians from anthrax attacks.



CDC has unique capabilities in the area of biomonitoring. While the Environmental Protection Agency measures environmental hazards in air, soil, and water, CDC measures human exposure to *environmental hazards*.

Environmental health monitoring was implemented in FY 1999 at the Bunker Hill Mine and Metallurgical site. It is the first site to meet all of ATSDR's criteria for a medical monitoring program. It was projected that at least two sites would be targeted for medical monitoring in the FY 1999 reporting period, but Bunker Hill was the only site that was determined to be appropriate and feasible for medical monitoring of the population affected.



In FY 1999 the HHS, Office of the Public Health Service and other OPDIVs worked actively with stakeholders to monitor the progress on *Healthy People 2000* and to develop an agenda for Healthy People 2000-2010 for disease prevention and health promotion efforts.

Healthy People is a national health promotion and disease prevention initiative that brings together national, State, and local government agencies; nonprofit, voluntary, and professional organizations; businesses; communities; and individuals to improve the health of all Americans, eliminate disparities in health, and improve years and quality of healthy life. Current "national objectives" have been referred to throughout this document. They support and exert an influence on the GPRA strategic objectives and performance plan, but are longer-term and are focused on national rather than agency achievements. The goals focus on increasing the span of healthy life, reducing health disparities, and achieving access to preventive services for everyone.

In FY 1999 the HHS, Office of the Public Health Service and other OPDIVs worked actively with stakeholders to monitor the progress

on Health People 2000 and to develop an agenda for Healthy People 2000-2010 for disease prevention and health promotion efforts.

Progress reviews were conducted in FY 1999 on the national objectives for maternal and infant health, diabetes and other chronic disabling conditions, family planning, heart disease and stroke, clinical preventive services, and physical activity and fitness. The most recent data available on the progress achieved in those areas being monitored by the Healthy People 2000 Program are found at <http://www.cdc.gov/nchs/hp2000hp.htm>



❖ **We worked to ensure food and drug safety by increasing the effectiveness of science-based regulation.**

HHS worked to ensure the safety, reliability, and efficacy of drugs and medical products. Americans have the world’s safest food supply although food-borne illnesses represent an emerging threat.

Under the *Prescription Drug User Fee Act* (PDUFA) manufacturers paid for improved processing procedures and time for new drug and biologics (the study of blood and blood products) applications. The objective of PDUFA is to expedite the application review process so beneficial drugs will be available for use quickly without compromising safety or sacrificing the quality that Americans expect. The FDA had committed to certain performance goals in response to these additional resources, and has met or exceeded these goals since FY 1995. This success occurred even with unexpected, continued growth in the number of marketing applications filed for review.

As a result, in 1997 Congress reauthorized PDUFA under the Food and Drug Modernization Act for another five years (known as PDUFA II). In 1998 90 new medicines were approved.

For all open cohorts during FY 1999 (individual application requests grouped by the fiscal year they were submitted), FDA’s Center for Drug Evaluation and Research took 185 actions on new drug applications, 77 of which were approvals. The median approval time was 11.9 months, a 1 percent decrease in median approval time compared with FY 1998. Final on-time performance information for the FY 1999 submission cohort is not yet available but FDA expects to exceed its targets.

Goals (FDA): Review and act on 90% of standard new drug applications within specified times.
FY 1999 Target: 90% within specified times
FY 1999 Actual: Final Data will be available in January 2001.



FDA regulates prescription drugs.

Fiscal Year 1998 Cohort as of 9/30/99

Submission Type	Number of Submissions Filed with CDER	Goal (months)	Number of Reviews "On Time"	Percent of Reviews "On Time"
Priority New Drug Application	30	90% in 6 months	30	100%
Standard New Drug Application	83	90% in 12 months	83	100%



FDA is responsible for blood bank inspections.

Goal: Complete biennial inspections of registered **blood banks, source plasma operations and biologics manufacturers.**
FY 1999 Target: Conduct 43% of biennial inspections
FY 1999 Actual: 64% conducted.
Trend: FY 1997 and FY 1998 biennial period: 46% conducted



Goal (CDC): Develop and strengthen epidemiologic and laboratory methods for detecting, controlling, and preventing infectious diseases.
1999 Target: Detect and investigate 23 large or unusual outbreaks of diarrheal and/or foodborne illness.
1999 Actual: Exceeded the target; 25 outbreaks were investigated.
Trend: FY 1998: 15 outbreaks were investigated; 40% of causative organism/toxin detected.




FDA is also required to conduct inspections to determine compliance with good manufacturing practices for certain products. In FY 1999 FDA exceeded its target, making a significant improvement above the last biennial period.



FDA has also exceeded its targets for ensuring that the quality and accuracy of **mammography facilities** that met inspection standards FDA conducted 9,488 facility inspections and issued 5,499 MSQA 3-year facility certificates.



The President's *Food Safety Initiative* is intended to build a national early warning system for hazards in the food supply by enhancing capacity for surveillance and outbreak investigations at the state and federal levels and by linking state health departments and federal agencies with sophisticated computer and communication systems.

The *PulseNet System* was put to work in the first year of the Food Safety Initiative to identify common sources of illnesses and speed outbreak trace back and containment. State laboratories, CDC, FDA, and USDA PulseNet systems determine bacterial subtypes with a high degree of accuracy and transmit the information digitally to a central computer at CDC. The CDC computer can match a newly submitted pathogen fingerprint to those in a databank, and can confirm whether or not disparate outbreaks are connected by a common source.

CDC helped investigate 25 outbreaks of foodborne illness in FY 1999 and was able to identify the causative organism or toxin in 48 percent of these outbreaks and the causative food in 50 percent.

According to CDC, although there has been a decline in the overall incidence of salmonella since 1996, there are about 300,000 cases of salmonella enteritis occurring each year because of undercooked eggs. In July 1999 FDA, HHS and the U.S. Department of Agriculture's Food Safety and Inspection service announced new measures to prevent illness from contaminated eggs. FDA is proposing safe handling on labels of shell eggs to warn consumers about the risks.



CDC's lab workers detect infectious diseases.

FDA has also improved food safety in FY 1999 through the *Hazard Analysis and Critical Control Point System* (HACCP) a preventive approach to a food safety that applies science-based controls all along the production chain from raw materials to finished product. Manufacturers and food preparers identify potential safety problems in the production points and take steps to prevent them. FDA sets the targets for food industries. The domestic seafood industry far exceeded its target in FY 1999. In FY 1999 proposed rules were published for the fruit and vegetable juice industry.

Goal: 50% of the domestic seafood industry will be operating preventive controls for safety as evidenced by functioning HACCP systems.
FY 1999 Target: 50% of domestic seafood industry complies.

Performance information for the goal is due in March 2000. Preliminary data indicates that the goal was met (56%).



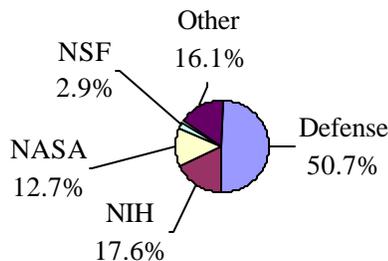
GOAL 6: STRENGTHEN THE NATION'S HEALTH SCIENCES RESEARCH ENTERPRISE and ENHANCE ITS PRODUCTIVITY.

Improvements in health are grounded in knowledge acquired through research. HHS sets the pace for the world in medical, epidemiological (incidence, distribution, and control of disease), behavioral, and health services research. We sponsor and conduct public and private research through strong, sustained public support for health sciences.

Today we are at the brink of discoveries that have the potential to revolutionize the prevention, diagnosis, and treatment of disease as well as the delivery of quality health care in America and around the world. As a Department, HHS has recognized the potential for health research advances and continues to pursue a focused and balanced approach to funding research and the infrastructure necessary to take advantage of research opportunities.

This year NIH established a formal working group of the Advisory Committee of the Director that conducted an independent assessment of NIH performance under this goal.

Federal FY 1999 Research Outlays



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

NIH accounted for 17.6% of the entire Federal research budget in FY 1999.



HHS recognizes the importance and benefit of basic research.

❖ We improved the understanding of normal and abnormal biological processes and behaviors.

This year again brought news of significant gains in biomedical research. Research findings about normal and abnormal biological functions constitute an essential knowledge base to support advances in prevention and treatment science and to determine what efforts are possible and effective across the population.

Human cancer cells were created in the laboratory by altering the expression of a defined set of genes and affecting at least four cellular pathways. The ability to introduce specific genetic alterations to transform normal cells paves the way for more precisely defining the biochemical pathways in the cell that must be disrupted in the development of cancer. This information will open new avenues for exploring the roles of various cellular pathways that become disrupted and for determining the sequence of events that must occur as cancer develops.

Studies in rodents resulted in the first evidence that adult neural stem cells can be used to *repair damage from a broad array of brain accidents/diseases where cell dysfunction is "global"* or spread throughout the brain. Other researchers demonstrated that bone marrow stem cells could give rise to liver cells and that neural stem cells become blood-forming cells. This new knowledge changes the way we think about the brain and treatment for brain disease and

injury and has obvious implications for the development of new treatment modalities for a number of devastating illnesses and injuries.

A family of *proteins (toll-like receptors) that are involved in the body's immune response* to bacteria was discovered. When these proteins detect and signal the presence of the bacteria, they trigger a severe immune reaction that can lead to septic shock. This new knowledge could facilitate development of new vaccine strategies and new approaches to the treatment of septic shock. Drugs that could interfere with the activation of toll-like receptors by bacteria during an acute infection could save thousands of lives.

The working group determined that this target was exceeded after a review of nearly 300 descriptions of research outcomes published in FY 1999.



The *human genome project* seeks to understand the genetic instructions that make us unique. Critical genomic resources continued to be developed by achieving a FY 1999 U.S. annual production rate of human genomic sequence of 173 million base-pairs, a world-wide rate of 265 million base-pairs, a total of 442 million completed world-wide and completing the sequence of the 97 million base-pairs of the *C. elegans* genome.

The *C. elegans* is a roundworm and its genetic sequencing marked a historic accomplishment since it provides biologists with a powerful tool to experiment with and learn how whole genomes function. The ability to compare the sequence of genes across multiple species and develop model systems in simpler organisms will significantly enhance the ability of researchers to identify the functional roles of the encoded proteins and thereby contribute to a better understanding of the molecular basis for human health and disease.

All of the publicly funded U.S. centers sequencing the human gene are meeting and in many cases, exceeding the standards of quality assurance for their data. The working group determined that these targets were exceeded based upon public databases.



❖ We improved the prevention, diagnosis, and treatment of disease and disability.

Heart disease is the nation's number one killer among men and women of all racial and ethnic groups. More than 40 percent of all deaths in

Goal (NIH): Add to the body of knowledge about normal and abnormal biological functions and behavior.

FY 1999 Target: Progress in advancing scientific understanding in key fields bearing on our knowledge of biological functions and behavior in their normal and abnormal state.

FY 1999 Actual: Exceeded the target.



Goal (NIH): Develop critical genomic resources, including the DNA sequences of the human genome, and the genomes of important model organisms and disease-causing microorganisms.

FY 1999 Targets:

- 1) U.S. annual production rate of human genomic sequence: 90 million base-pairs.
- 2) Worldwide rate: 220 million base-pairs.
- 3) Total completed worldwide at the end of FY 1999: 400 million base-pairs.
- 4) Complete the sequence of the *C. elegans* genome.

FY 1999 Actual: Exceeded the targets for 1) - 3) and met the target for 4).



Goal (CDC): Reduce morbidity and mortality attributable to behavioral risk factors by building nationwide programs in chronic disease prevention and health promotion and intervening in selected diseases and risk factors.
1999 Target: 85 % of states participating in the Behavioral Risk Factor Surveillance System communicate the findings of their annual behavioral risk factor data collected.
1999 Actual: Data is not available yet.

the United States, 900,000 each year, are directly attributable to heart disease and stroke. Associated annual costs exceed \$286 billion.

In FY 1999 CDC expanded the first state-based program for developing policies and conducting research to prevent cardiovascular disease—the leading cause of death of men and women across all racial and ethnic groups—from 8 to 11 states and strengthened the capacity of the initial 8 programs to address racial and ethnic disparities in cardiovascular disease.

In September, the National Heart, Lung, and Blood Institute and the National Institute of Diabetes and Digestive and Kidney Diseases of NIH issued an alert on the increasing importance of *diabetes mellitus* as a major risk factor for cardiovascular disease.



In addition, NIH's research program resulted in the following accomplishments in FY 1999:

- Development of a promising new technique for detecting lung cancer at an earlier and potentially more curable stage.
- Development of an improved approach for preventing mother-to-child transmission of HIV.
- Development of a new test for diagnosing a particularly devastating aggressive cancer that can involve the brain, spinal cord, and the eye.
- Identification of an effective non-surgical treatment for fistulas, a serious complication associated with the chronic inflammatory bowel disease known as Crohn's disease.
- Progress towards the Administration's goal of developing an AIDS vaccine by 2007 by increasing the number and dollar value of awards made for vaccine discovery.
- Development and implementation of the Clinical Trials database, a consolidated source of information related to federally and privately funded clinical trials for drugs used for serious or life threatening diseases and conditions.

Progress toward the various performance goals of new methods, technologies or approaches for diagnosing, preventing, or treating disease and the NIH working group also assessed disability. All FY 1999 targets were met, successfully met, or substantially exceeded. Suggestions were also provided for improving one of the goal areas.



❖ **We actively supported the research capacity of the country.**

Through its *Research Training and Career Development Program*, NIH supports a critical aspect of scientific research:

- The development of a talent base capable of producing advances in science.

To evaluate its success in attracting, developing, and retaining a diverse group of scientists, NIH has established several performance goals to assess the agency's success in attracting qualified applicants. For example, in FY 1999 NIH met its goal to maintain an application flow consistent with success rates close to historical levels of 40 percent for fellowships and 60 percent for research training grants and entry-level career awards.

NIH increased the pool of clinical researchers who can conduct patient-oriented research by issuing 85 mentored Patient-Oriented Research Career Development awards, 83 mid-career Investigator awards in Patient-Oriented research, and 35 curriculum development awards.

NIH also encouraged interest in scientific research careers by making information on training and career development opportunities widely available to students and post-doctorates (e.g., Independent Scientist Award, Minority and Disability Research supplements, Mentored Clinical Scientist Development Award).

AHCPR also supported 69 pre- and 86 post-doctoral National Research Service Award trainees to ensure that investigators will exist to perform the research necessary to improve quality and cost effective health care.



NIH supports *construction of facilities* on the NIH campus, as well as grants to fund facility improvements at institutions outside of NIH.

- Completed 56.4 percent of Louis Stokes Laboratory Building although the FY 1999 target was 65 percent completion. The NIH assessment revealed that this shortfall could be attributed to the need to make space adjustments to support current and projected research requirements. Construction is expected to be complete in December 2000, rather than the end of FY 2000.
- Completed design and over 66 percent of the construction for the Dale and Betty Bumpers Vaccine Research Center.
- Made major progress in the design and site work for the Mark O. Hatfield Clinical Research Center.



Research capacity must keep pace with research priorities and technological advances.

Challenges We Are Addressing

Our Nation faces enormous challenges to the health and well-being of our citizens. The challenges we face are both programmatic and administrative. The programmatic issues may get more public attention, but the administrative infrastructure issues are vital to the efficient delivery of health and social services. We face myriad challenges, and we list a few below.

Programmatic Challenges

- Responding to the threat of bio-terrorism.
- Responding to the threat of cyber-terrorism.
- Advancing our medical knowledge about treating and preventing infectious diseases such as HIV/AIDS.
- Promoting healthy lifestyles and non-smoking to prevent chronic health problems such as cancer and heart disease.
- Providing health care to the uninsured and underinsured.
- Ensuring the privacy of medical records.
- Ensuring safe, quality childcare for parents who work.
- Ensuring Medicare trust fund solvency.
- Working to reduce the incidence of deaths and injuries from drug interactions and medical errors.

Administrative Challenges

- Planning for workforce changes in the short term, when a significant portion of the workforce is eligible for retirement.
- Enhancing our information systems capabilities and electronic commerce interfaces.
- Obtaining “clean” financial statement audit opinions in future years.
- Continuing our advances in electronic commerce.
- Overcoming data issues for measuring performance such as the complexity of data systems, the timeliness of data, lack of resources for data, vast range of sources of data and the inherent variability of the programs.

Using the Internet to Transact Business

The Internet has changed the way the world lives and we are working to do more business and provide more customer service via this technology. We use the Web to provide a great deal of programmatic information to the public and to facilitate our administrative work. There are many Web sites identified throughout this document. Here are some examples.

Programmatic Uses of the Internet

- FDA's MedWatch collects and provides information about dangerous drug interactions.
- FDA's Healthfinder is a clearinghouse of consumer information on health.
- NIH's online medical research library provides information in all areas of medical research.
- CDC's Home Page has Travel Alerts providing information about foreign disease outbreaks.
- NIH's web site provides both the general public and NIH staff with significant amounts of information pertaining to the policies, practices and funding opportunities of NIH granting and training processes.
- SAMHSA's Knowledge Exchange Network (KEN) provides Americans with free information about mental health and mental illness as well as referrals to community mental health organizations and self-help groups.
- HCFA's State Children's Health Insurance Program provides information on how to apply for a state-run SCHIP program.

Administrative Uses of the Internet

- The HHS Office of Finance established a web site for HHS travelers to provide information about travel policy as well as links to other important travel-related web sites.
- The HHS Office of Grants and Acquisition Management posts contracting opportunities on the web.
- HHS job postings are available on the web.
- The HHS Office of Finance established a web site to collect program information for the Catalog of Federal Domestic Assistance.
- HHS now uses an internet application to collect data for the preparation of the Department's consolidated financial statements.
- HHS fact sheets are available on the World Wide Web at: <http://www.dhhs.gov>.
- HCFA's www.medicare.gov website was designed with the beneficiary in mind and offers easy to read information about the Medicare programs, health plan options, costs, benefits, performance and satisfaction, nursing homes, publications including Spanish and Chinese versions, and wellness information.
- HCFA's www.medicare.gov website has an important contact database that has over 3,000 phone numbers for Medicare-related agencies and partners across the United States. A Beneficiary Outreach Calendar allows beneficiaries, and those who act on behalf, to search for information about local events, health affairs, or educational meetings.

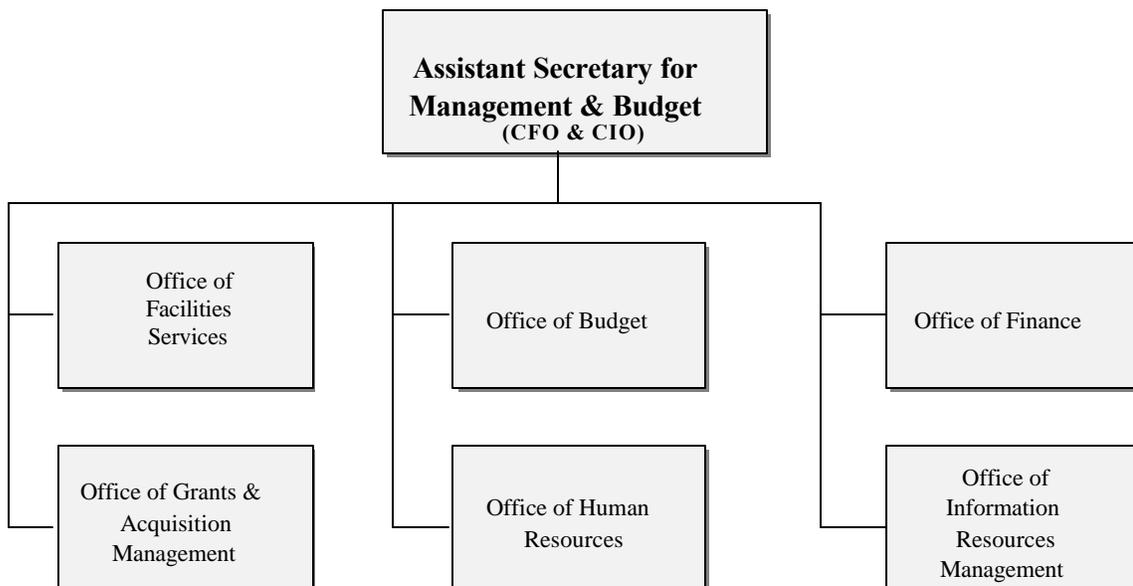
SECTION II:

**OVERVIEW OF FINANCIAL MANAGEMENT:
ISSUES AND ACCOUNTABILITY**

Overview of Financial Management: Issues and Accountability

FINANCIAL MANAGEMENT RESPONSIBILITY AND ORGANIZATION

HHS had net outlays of \$359.7 billion in FY 1999 (21.1% of the Federal budget). Therefore, we have an enormous responsibility for financial accountability. HHS is a key player in the Governmentwide financial statement audit, which was prepared for the first time for FY 1997. In 1993, the Administration first promoted the idea of a Governmentwide financial statement audit in the Vice President's National Performance Review report on "Improving Financial Management" (Recommendation FM 10.1). The Administration also strongly supported the Government Management Reform Act (GMRA) of 1994, which amended the CFO Act of 1990, and expanded financial statement audit coverage to include Departmentwide and Governmentwide audited financial statements. This Accountability Report demonstrates our involvement in, and our dedication to, the Administration's commitment to strong financial management. All HHS managers with responsibility for Federal resources are, to some degree, financial managers. However, official responsibility for financial management matters is delegated from the Secretary to the Senate-confirmed CFO who also holds the titles of Assistant Secretary for Management and Budget (ASMB) and Chief Information Officer (CIO). The Offices of the ASMB are illustrated in the accompanying organization chart. Other ASMB responsibilities include the functions of budget, human resources, grants, acquisitions, and facilities services.



The Office of Finance, which prepares this Accountability Report, is headed by the Deputy Assistant Secretary for Finance who is also the Deputy Chief Financial Officer (DCFO). This office is responsible for implementation of an ever-increasing volume of Federal financial legislation and initiatives within an environment of evolving technologies, limited staffing, and cost containment. The list of legislation related to financial management includes:

- Prompt Pay Act of 1982 (as amended)
- Federal Managers Financial Integrity Act (FMFIA) of 1982
- Chief Financial Officers (CFOs) Act of 1990
- Cash Management Improvement Act (CMIA) of 1990
- Government Performance and Results Act (GPRA) of 1993
- Government Management Reform Act (GMRA) of 1994
- Federal Financial Management Improvement Act (FFMIA) of 1996
- Debt Collection Improvement Act (DCIA) of 1996
- Information Technology Management Reform Act (ITMRA) of 1996
- Travel and Transportation Reform Act of 1998
- Federal Activities Inventory Reform Act (FAIRA) of 1998

The Office of Finance has responsibility (in partnership with our OPDIVs) for many new and ongoing initiatives such as: developing and implementing accounting and financial policies, systems and reports; resolving financial statement audit findings; implementing financial and program performance measurement; prompt payment; budget execution; improving reliability of financial information; policy development and coordination for debt collection; implementing all financial management legislation; and integrating all of the financial management initiatives. These initiatives are coordinated with the various OPDIVs of HHS through the policy-level HHS CFO Council and the operating-level Financial Policies Group (FPG).

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.

This 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 this 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

Modification in Target Year Identification

Our original approach for establishing goals and targets related to the financial statement audit tried to reflect the fact that audit results are not available until the subsequent year. Thus, a goal related to the FY 1999 financial statements would come under the heading "FY 2000 Target (Covering FY 1999 Opinion). However, we have realized that this approach was cumbersome and, at times, confusing because for any given fiscal year some targets related to the stated year and others related to a prior year.

In the FY 1999 HHS Accountability Report, we have converted all targets to the fiscal years for which they related. In other words, targets related to the FY 1999 audit opinion are found under FY 1999 Target, even though the results are not known until almost mid-FY 2000. Future Five-Year Plans will incorporate this conversion.

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 FFMIA instances of non-compliance.	1997	3	3	3	3	The HHS FFMIA 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.

Measure	Baseline	Performance Trend			FY 1999 Target	Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual		
Number of financial and financial-mixed mission critical and non-mission critical systems/applications that are Y2K compliant.	1998	n/a	n/a	100%	100%	
Percentage of OPDIVs providing grants data to Tracking Accountability in Government Grants System (TAGGS).	1998	n/a	83% (10 of 12)	100%	92% (11 of 12)	
Number of HHS employees with access to TAGGS data.	1998	n/a	10	All HHS Employees and public	50	TAGGS is now on the Internet. 
Payment Management System state of development and implementation.		Under Development	Under Development	Under Development	To Be Operational	This is a PSC system which makes grant payments. It has been designated by the US CFO Council as one of two grant payment systems to be used by all civilian agencies. Scheduled to be operational April 1, 2000. Implementation had been delayed due to Y2K remediation efforts.
Financial Assistance Reporting System (FARS) state of implementation.		Under Development	Under Development	Under Development	To Be Operational	This is a PSC system which reports Federal assistance awards by Congressional district. Implementation is now planned for April 1, 2000.

Measure	Baseline	Performance Trend				Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual	FY 1999 Target	
Number of mission critical financial systems/applications that are Y2K compliant.	1998	n/a	3 of 20	23 of 24	23 of 24	As of December 1999 (FY 2000), 24 of 24 was achieved. 
Total number of Departmental Accounting Manual (DAM) chapters on Internet.	1998	n/a	13 of 52	21 of 53	18 of 52	Two old chapters were revised and one new chapter on reimbursable accounting was added. 
Percent of DAM pages on the Internet.	1998	n/a	18.2%	48%	40%	Many old chapters are not in electronic form. They must be re-typed and/or revised before posting. 
Percent of Grants Administrative policies available on the HHS Intranet and Internet.	1998	n/a	70%	100%	80%	

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.

Measure	Baseline	Performance Trend			FY 1999 Target	Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual		
Percent of eligible non-waived delinquent debt referred to Treasury for cross-servicing.	1998	n/a	0%	22.8%	100%	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.
Percent of eligible waived delinquent debt referred to PSC for cross-servicing.	1999	n/a	n/a	3.7%	100%	See above.
Percent of eligible delinquent debt referred to Treasury for offset.	1998 (2nd quarter)	n/a	20.20%	10.5%	100%	See above.
Dollars of child support payments collected.	1998		\$14.367B	\$15.5 Based on info available as of 2/11/2000	\$16.3	Figures for child support enforcement collections are often revised upward as more states report collection activities over time.
Number of OPDIVs with established IT architecture and investment analysis/capital planning process.	1998	n/a	2 (ACF & NIH)	6	7	6 OPDIVs have met the target. Another OPDIV has an investment analysis/capital planning process and is working with ASMB on the HHS IT architecture.

Measure	Baseline	Performance Trend			FY 1999 Target	Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual		
Number of prior year Department level FMFIA material weaknesses resolved.	1997	4	1	0	3	
Number of new Department level FMFIA material weaknesses identified in current year.	1997	3	2	1	TBD	New weakness identified: financial systems and reporting.
Number of Department level FMFIA material weaknesses pending at year end.	1997	9	6	6	3	Two material weaknesses for Medicare EDP Controls were combined into one weakness with two parts.
Amount of outlay variance compared with outlay estimate.	1997	1.7%	-1.60%	-2.90%	+/- 1%	If HCFA (Medicare and Medicaid) were excluded in the FY 1999 Actual figure, the variance would have been -1% (on target).
Percent of apportionments approved within 3 weeks.	1997	46%	45.90%	76.60%	50%	
Percent of apportionments approved within 4 weeks.	1997	70%	56.8%	91.0%	75%	

Measure	Baseline	Performance Trend			FY 1999 Target	Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual		
President's Budget reflects final figures from Standard Form 133 on Budget Execution and FACTS II.	FY 1999	n/a	n/a	11 of 12 OPDIVs for FY 2000 sub-mission	12 of 12	OPDIVs Provide both the information for the Standard Form 133s and the Program and Financing Schedule of the budget submission so the information should reconcile and there should be no discrepancies. The target is for all of the OPDIVs and HHS as a whole to have consistent data in both documents. The SF 133 information will begin to be reported on in the FACTS II electronic reporting system starting in the Fall of 1999. This will eventually eliminate the need for reconciling FMS 2108, SF 133, and Program & Financing Schedule in the President's budget.
Number of Department level EDP material weaknesses cited by auditors.	1997	1	1	1	0	For details, see auditor's opinion in Section V.
Number of Department level EDP reportable conditions cited by auditors.	1997	0	0	1	0	For details, see auditor's opinion in Section V.
Reduction of average time for resolution of cross-cutting audits compared with prior year.	1998	n/a	151	113	3%	A 25% reduction was achieved. 

Measure	Baseline	Performance Trend			FY 1999 Target	Comments
		FY 1997 Actual	FY 1998 Actual	FY 1999 Actual		
Number of training hours offered times the number of attendees at the HHS in-house financial training sessions.	1998	n/a	480	2540	600	In FY 1999 we stepped up our training efforts to ensure we had done everything possible to prepare staff to obtain a clean opinion. Additionally, we offered several sessions on Budget Execution. Some training was performed by contractors, sponsored by ASMB. Some training earned CPE, whether awarded by HHS or contractor. 
HHS receives and retains official certifications as a finance CPE sponsor.	1998	n/a	No	Yes	Yes	HHS was awarded with CPE sponsorship certification in June 1999. 
Number of OPDIVs with succession planning strategies for financial management staff.	1998	n/a	2 (NIH, HRSA)	3 (NIH, HRSA, PSC)	3 (NIH, HRSA, PSC)	The 3 OPDIVs cited report having succession planning strategies. 

Quality of Work Life

The Secretary's Quality of Work Life Initiative, launched in 1997 to improve employee satisfaction, enhance workplace learning and improve the management of change and transition, completed its second full year. The HHS Union-Management Partnership Council continues to serve as the steering committee for this effort.

For the second year in a row the HHS-wide annual employee survey results showed an improvement in employee satisfaction. The improvement was both statistically significant and widespread, with ten out of twelve OPDIVs increasing their scores. Most remarkably one OPDIV, which engaged in a full-scale improvement effort, jumped from next to the last in the standings to first, setting a new high for the Department at the same time. While each of the OPDIVs tailored its quality of work life efforts to meet the special concerns of its employees, there have been HHS-wide accomplishments as well.

Based on recommendations made at an HHS conference on Family-Friendly Work Options, restrictions on managers' use of flexible work options was rescinded. Also as a result of recommendations from the conference, three pilot projects to replicate work done in the private sector to help employees better balance work and family life, while simultaneously improving mission accomplishment, are underway. Responding to the need to better manage change, a cadre of employees from across HHS have been trained as "change agents" to assist with or lead management of change and transition in their respective organizations.

This year also saw the initiation of several major new projects to continue the improvements already underway. In response to the President's Executive Order 13111, "Using Technology to Improve Training Opportunities for Federal Government Employees," a study to develop a design for a distributed learning network to further enhance employee development opportunities is just being completed, and recommendations are expected shortly. Utilizing the concept of "any place, any time learning," this project would bring learning and information directly to the employee's desktop, giving every employee access to consistent, high-quality learning and information. A major initiative using Appreciative Inquiry to develop a vision for a truly diverse and inclusive work environment has been launched, and a Departmentwide conference on diversity and inclusion is scheduled for early March 2000. What began as an initiative is increasingly becoming "business as usual," with attention to the quality of work life being seen as simply a good management practice.

Automated Financial Statements

In the past, HHS, Office of Finance manually prepared the department's financial statements. The manual process of consolidating the HHS OPDIVs Financial Statements was labor intensive, time consuming and prone to errors. In last year's audit this process was considered a material weakness.

To begin the first step of implementing a process that will consolidate the department's statements, the Office of Finance implemented an online web-based system to collect and automate the financial statement reporting process. The on-line web-based Automated Financial Statements System (AFS) will provide immediate access to OPDIV Financial Statements, track all changes, automatically update the Departmental Statements and Notes and produce printable and electronic formats of the Financial Statements.

Future plans include evaluating the feasibility of directly linking the OPDIV statement files with AFS, improving the reporting and publication process and developing a long-term solution for the Department.

Travel

During FY 1999, HHS and its new travel card contractor, successfully converted over 40,000 employee cardholders to the VISA travel card. The major travel card program change planned for FY 2000 is the rollout of the travel card contractor's Customer Automation and Reporting Environment (C.A.R.E.) system to provide automated support for travel card administrative and reporting functions.

During FY 1999, HHS formed a Task Force to make policy recommendations and facilitate the HHS implementation of travel regulations stemming from the Travel and Transportation Reform Act (TTPR) of 1998. Mandatory travel card use is one of the major provisions of the law. The Task Force, composed of union, operating and staff division representatives, will continue its efforts and play a key role in successful HHS implementation of these new regulations during FY 2000.

Also during FY 1999, HHS formed a Task Force to convert the Department's Travel Policy Manual into electronic form, while updating

chapters as necessary. We also developed a table of contents for a HHS Travel Policy web site and identified “hot links” to GSA travel regulations and other internet sites of interest for HHS travelers. The web site became operational during calendar 1999.

Debt Collection

HHS has successfully implemented the two main provisions of the Debt Collection Improvement Act (DCIA) of 1996. While delinquent debt has been referred to Treasury for cross-servicing and offset, much work remains to be done with HCFA Medicare contractor debt which has proved particularly difficult to validate for DCIA referral purposes. HCFA is working to implement a corrective action plan to refer these debts.

HHS wrote off \$2.9 billion in fiscal year 1999. Much of this debt was written off using OMB Circular A-129 guidance, which removed it from HHS financial statements, though efforts to collect it using DCIA’s collection tools will continue. The majority of this debt is Medicare Secondary Payer debt, which will be referred to the Program Support Center (PSC), for additional collection action. The PSC will also refer this debt to the Treasury Offset Program (TOP).

HHS centralized the DCIA delinquent debt referral process in one place by establishing the PSC as HHS’ delinquent debt collection center. Additionally, HHS obtained a cross-servicing waiver for a number of different types of program debts (e.g. Medicare Secondary Payer, unfiled Medicare cost reports and various health professional loans). The PSC will cross-service these debts itself and refer them to TOP.

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

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

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

THE PROGRAM SUPPORT CENTER'S (PSC'S) FINANCIAL MANAGEMENT SERVICE



The Financial Management Service (FMS) supports the financial operations of HHS and other departments through the provision of payment management services, cost allocation negotiation, general accounting support, debt management and collection and development of systems and reports for workforce management. The FMS also provides specialized ADP systems development in the area of workforce management.

Significant FMS/PSC FY 1999 accomplishments include:

- Completed 1,972 negotiation assignments that produced \$440 million in cost savings and negotiated cash refunds of approximately \$45 million.
- Timely payments to vendors have been consistently above the 95% OMB requirement. The FY 1999 rate was 98.3%, up from 97.4% in FY 1998.
- The percentage of vendor payments made by electronic funds transfer (EFT) rose from 49% in FY 1998 to 75.9% in FY 1999.
- Referred more than \$160 million in delinquent debt owed by customers to the Treasury Administrative Offset Program.
- Processed 268,977 payment transactions totaling more than \$179 billion in grant funds. Also added 1,491 grant recipient accounts for a total of more than 22,400 customers.
- Received an unqualified opinion on the SAS 70-audit report on the Payment Management System for the fourth consecutive year.
- Distributed approximately \$1.3 billion in federal tax offsets from individuals with delinquent child support payments to participating states in FY 1999.
- Received a decision from Federal District Court confirming our Division of Cost Allocation findings that the State of California should refund \$240 million in applicable credits and interest to the federal government. The state has appealed the decision to the appellate level.

Trust Fund Solvency

Medicare Part A Trust Fund Solvency

The part of Medicare that pays for hospital insurance (the Part A Hospital Insurance (HI) Trust Fund) is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Income not currently needed to pay benefits and related expenses is held in a trust fund and invested in U.S. Treasury securities.

The financial projections shown for the HI program in the 1999 Trustees Report (which reports on calendar 1998) represent a considerable improvement over those shown in the 1998 report. The improvement arises from higher payroll tax revenues in 1998 than had been estimated and lower benefit expenditures, together with adjustments to projected income and expenditure growth for the future based on this experience. In 1998, HI income exceeded expenditures by \$4.8 billion – the first time in four years that the trust fund has experienced a positive cash flow on an annual basis. Collectively, these impacts are estimated to postpone the depletion of the HI trust fund from 2008 until 2015.

Medicare Part B Trust Fund Solvency

The part of Medicare that pays for supplementary medical insurance (the Part B Supplementary Medical Insurance (SMI) Trust Fund), primarily physician and outpatient care, is financed primarily by appropriated funds (73%) and monthly premiums paid by beneficiaries (24%). Interest income makes up for the remainder. Income not currently needed to pay benefits and related expenses is also held in a trust fund (separate from the hospital insurance trust fund) and invested in U.S. Treasury securities. This trust fund is expected to remain adequately financed into the indefinite future because beneficiary premiums and government contributions are set (by law) to meet expected costs each year. Program costs have generally grown faster than the GDP and this trend is expected to continue under present law.

For more detailed information on the Medicare Trust Funds, please refer to the Trustees' reports at the HCFA web site: <http://www.hcfa.gov>

Understanding Medicare Trust Fund Investments



The Medicare trust fund assets are invested in U.S. Treasury Securities, which earn interest while Treasury uses those resources for other purposes (decreasing the Treasury's need to borrow from the public in order to finance the Federal debt). Unlike the assets of private pension plans, trust funds do not consist of real economic assets that can be drawn down in the future to fund benefits. Instead, they are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing benefits or other expenditures. (When financed by borrowing, the effect is to defer today's costs to even later generations who will ultimately repay the funds being borrowed for today's Medicare beneficiaries.) The existence of large trust fund balances, therefore, does not make it easier for the Government to pay benefits.

SECTION III:

OVERVIEW OF FINANCIAL PERFORMANCE: ANALYSIS AND INTERPRETATION

Overview of Financial Performance: Analysis and Interpretation

FINANCIAL STATEMENT REPORTING

HHS has prepared Departmentwide audited financial statements since FY 1996. Financial statements are also prepared for all OPDIVs (CDC's include ATSDR); the nine largest are audited. The audited OPDIVs account for virtually all HHS assets and expenditures. HCFA, FDA, CDC, and NIH do their own accounting and prepare their own financial statements. The Program Support Center (PSC) does the accounting and prepares the statements for the Office of the Secretary, Administration for Children and Families, Administration on Aging, Health Resources and Services Administration, Indian Health Service, Substance Abuse and Mental Health Services Administration and PSC. In addition to the Departmentwide audited statements, OMB only requires "stand-alone" audited financial statements for HCFA. However, HHS management believes that each OPDIV should take responsibility for its own financial management, and there is no better measure for financial accountability than a financial audit opinion from a professional independent third party. Therefore, we submit the financial statements of all but our smallest OPDIVs for voluntary audits. In order to complete our Departmentwide FY 1999 audit in a timely manner, audit resources were shifted. The result was that some OPDIV audits will not be completed until after the completion of the Departmentwide audit.

In this Accountability Report, HHS is presenting its Departmentwide FY 1999 audited financial statements. Readers are encouraged to refer to Section IV of this report for the actual financial statements, notes and supplemental schedules, and to the HHS FY 1998 Accountability Report for FY 1998 audited financial statements.



Definitions of Financial Statement Asset Categories

Entity Assets are those assets which the reporting entity holds and has the authority to use in its operations.

Non-entity assets are those assets which the reporting entity holds but does not have the authority to use in its operations.

Intragovernmental assets are those assets that arise from transactions among Federal agencies.

FINANCIAL STATEMENT AUDIT FINDINGS AND MANAGEMENT COMMENTS

Audit Opinions



Unqualified Opinion

(Also known as a
“Clean Opinion”) –

Issued when 1) accounting principles used are appropriate, 2) disclosures are adequate, 3) data is presented in a reasonable manner, 4) underlying events and transactions are fairly reflected in the financial statements, and 5) the financial statements have not been materially affected by changes in accounting principles.

Qualified Opinion – Issued when there is 1) a lack of sufficient evidential matter, or 2) a departure from Generally Accepted Accounting Principles (GAAP).

Disclaimer of Opinion – Issued when the auditor has not collected sufficient evidential matter to form an opinion on the financial statements. The effects are so material that it would be inappropriate to issue a qualified opinion.



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

HHS received an unqualified, or “clean” audit opinion on the Departmentwide FY 1999 financial statements. This is a first for the Department, and a notable accomplishment over our FY 1996 disclaimer of opinion. For details, please see the auditor’s opinion in Section V.

Individual OPDIV audit findings were not all finalized as this report went to print. When available, those reports will be posted to the respective OPDIV home pages. Those addresses are found on the inside front cover of this report.

Reviews in accordance with Statement on Auditing Standards (SAS) 70 were conducted during FY 1999 for several shared financial systems, and the auditors findings from those reviews were incorporated into the Departmentwide auditor’s report.

In keeping with the U.S. CFO Council’s “streamlining” philosophy of issuing one “accountability” document and one “planning” document per year, the Department’s published Financial Management Five-Year Plan provides detailed information on our plans and goals for maintaining our “clean” opinion and resolving our audit findings.

Limitations of the Financial Statements

In accordance with OMB Bulletin 97-01, "Form and Content of Agency Financial Statements," we are disclosing the following limitations of the HHS FY 1999 financial statements, which are contained in this Accountability Report.

- The financial statements have been prepared to report the financial position and results of operations of HHS, pursuant to the requirements of the Chief Financial Officers (CFO) Act of 1990, as amended by the Government Management Reform Act (GMRA) of 1994.
- While statements have been prepared from HHS' books and records in accordance with the formats prescribed by OMB, the statements are different from the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.
- The statements should be read with the realization that they are for a component of a sovereign entity, that liabilities not covered by budgetary resources cannot be liquidated without the enactment of an appropriation, and the payment of all liabilities other than for contracts can be abrogated by the sovereign entity.

Issue Category	HHS Audit Findings History: FY 1996 – FY 1999							
	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	Qualifications	Material Weakness
Medicare Accounts Payable	X	X*		X				
SMI Revenue	X							
Medicare/ Medicaid 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
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	3
Resolved From Prior Year	Not Applicable	Not Applicable	4	1**	4	3	2	0
New	7	5	2	1	1	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.

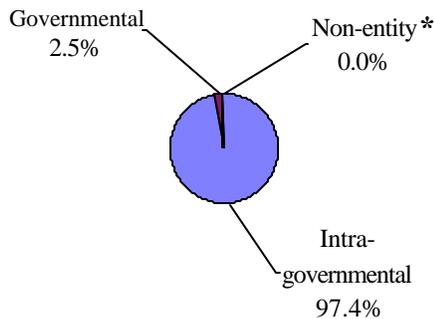
ANALYSIS OF FINANCIAL POSITION (BALANCE SHEET)

ASSETS

HHS had over \$271.6 billion in total assets (including non-entity assets) at the end of FY 1999, compared to \$235.3 billion at the end of FY 1998. This 15.4% increase is due largely to increased balances in the Medicare Trust Funds and in Fund Balances with Treasury.

The balance sheet separately identifies intragovernmental assets from all other assets. The bulk of HHS' assets are intragovernmental, meaning that they are HHS claims against other Federal agencies. These are for accounts such as the Medicare Trust Funds' Investments in U.S. Treasury Securities and the Fund Balance at Treasury.

HHS FY 1999 Assets



Most HHS assets are Medicare's claims on the U.S. Treasury, and are categorized as Intragovernmental.

* Note: Non-entity assets were far less than .1% of total assets.

Assets Analysis by Account Type

Investments (at \$184.8 billion) remains the largest HHS Asset. It is made up almost 68% of total assets at FYE 1999, compared to 69% (\$161.9 billion) in 1998. These investments represent the cumulative excess of collections and appropriations over expenditures of the Medicare HI and SMI trust funds, which are invested with the U.S. Treasury Special Issue Securities. Treasury, in turn, uses these funds to finance other operations of the Federal Government thus reducing the need for Federal borrowing from the public. These securities had been accumulating since the inception of the Medicare program in 1966. According to the 1999 Trustees Report, 1995 was the first year that expenditures exceeded income and Medicare started to call upon its Trust Fund resources. These resources will continue to be called upon in years where annual expenditures exceed revenues.

Unlike the assets of private pension plans, Medicare trust funds do not consist of real economic assets that can be drawn down in the future to fund benefits. Instead, they are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing benefits or other expenditures. When financed by borrowing, the effect is to defer today's costs to even later generations who will ultimately repay the funds being borrowed for today's Medicare beneficiaries. The existence of large trust fund balances, therefore, does not make it easier for the Government to pay benefits. Reflecting both the law and existing Federal accounting standards, no liability is recorded for benefits which may be paid in the future on behalf of today's workers who are currently paying taxes into the trust funds and who expect to be future beneficiaries upon their retirement.

The next largest category of assets is ***Fund Balance with Treasury*** at approximately 27%, which represents other undisbursed balances (largely appropriated funds, but also amounts related to revolving and other funds) held at the Treasury Department (which acts as a sort of bank for HHS).

Accounts Receivable from the Public (Net), at \$4.3 billion and ***Loans Receivable (Net)*** at \$401 million represent a total of only 1.8% of HHS assets, but are the focus of a great deal of attention with respect to our debt collection initiatives, which are covered elsewhere in this report. Medicare's Contractor Accounts Receivable (which makes up the substantial portion of HHS Accounts Receivable) had been the subject of a qualification in prior auditor's reports and presented a significant barrier to both HCFA and HHS "clean opinions" until a major effort was undertaken during FY 1999 to analyze and verify the subsidiary account records. The effort resulted in the write-off of \$2.9 billion in Medicare contractor receivables. For further details, see financial statement footnote number four in Section IV.

Property, Plant and Equipment (PP&E), at almost \$1.8 billion (net of accumulated depreciation) amounts to less than one percent of total assets, and is largely concentrated at NIH (numerous high technology research centers with high technology equipment), IHS (many facilities), FDA, and CDC. Since FY 1997, the capitalization threshold was increased from \$5 thousand to \$25 thousand, reducing the burden of accounting for smaller equipment purchases.

Assets Analysis by Budget Function

When assets are analyzed by budget function (see supplemental schedules in Section IV), Medicare (with its own budget function category) holds the vast majority (70%) of HHS assets (composed largely of the Trust Fund account balances). The health budget function (which covers the Medicaid program, NIH, HRSA, CDC, SAMHSA, IHS, FDA and AHCPR), the second largest (18%), is composed mostly of Fund Balances with Treasury, with lesser amounts attributed to Investments and PP&E.

LIABILITIES

Relative to HHS assets, there are few liabilities. This is because neither Federal law nor Federal accounting standards recognize any long term liabilities associated with covering future Medicare costs for today's workers contributing to the system today who become beneficiaries

upon their retirement. In other words, the amount of trust fund assets accumulated over more than three decades do not have an offsetting liability for future retirees.

Most of the HHS liabilities represent an estimate of accrued ***Entitlement Benefits Payable*** associated with the Medicare and Medicaid programs.

The noteworthy item in the HHS liabilities is the amount of ***Liabilities Not Covered by Budgetary Resources***, which are largely unfunded pension expenses of the Commissioned Corp recognized at PSC, but also include accrued annual leave and disability compensation for employees at all OPDIVs. The inherent differences between the way funds are appropriated in the Federal budget process, and how they are accounted for under generally accepted accounting principles (GAAP) cause these unfunded liabilities. Budgets are formulated on more of a cash basis, while GAAP is on an accrual basis. In other words, financial (accrual) accounting recognizes that the cost of today's HHS employees consists of today's salaries and benefits actually received, as well as the accrual of benefits to be paid out at a later date (for a "full cost" amount). Budgetary accounting delays recognizing the earned but unpaid benefits for years, until the payments are actually made to the employees/retirees. The Federal budget process does not recognize the future employee benefits costs of today's employees, but instead budgets for those future expenses in the future years when they are actually paid. The result is that while employee expenses (present and future) are recognized in accrual-based financial statements, they are under-represented in the cash-based Federal budget. This is one excellent example of the benefits of accrual accounting financial statements; there are no surprises regarding liabilities for employee benefits.

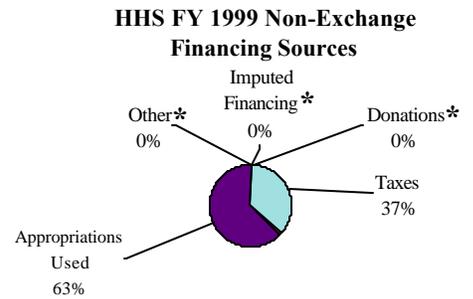
NET POSITION: BALANCE SHEET AND STATEMENT OF CHANGES

Net Position is the difference between total assets and total liabilities shown on the balance sheet. Starting in FY 1998, net position was broken down into two categories: unexpended appropriations and cumulative results of operations.

Unexpended Appropriations is the amount of authority granted by Congress that has not been expended or used. It is mostly attributed to ACF, NIH, and HCFA.

Cumulative Results of Operations are the net results of operations since inception, plus the cumulative amount of prior period adjustments. HCFA accounts for most of the balance in the account.

The Statement of Changes in Net Position begins with the net cost of operations (taken from the Statement of Net Costs) and nets these costs with all sources of financing HHS received in FY 1999 (through appropriations or otherwise) to attain net results of operations. That amount is added to the increase in the amount of unexpended appropriations to determine the change in net position from FY 1998 to FY 1999. The amount of the change is then added to the Net Position beginning balance to arrive at the ending balance of \$224 billion. This statement provides more detailed information on non-exchange financing sources than can be found in other statements.



The HHS FY 1999 Statement of Changes in Net Position reveals that general appropriations and taxes are the largest source of non-exchange financing.

*** Note: Imputed Financing, Donations, and Other Financing Sources were far less than .1% of the total.**

ANALYSIS OF NET COSTS

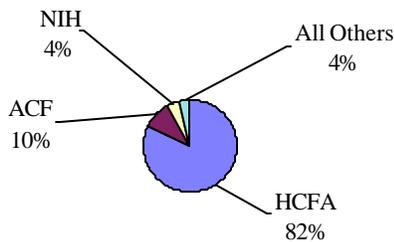
The Statement of Net Costs (which has been required for FYs 1998 and beyond) can loosely be equated with the former “Statement of Operations” which focused on how the Department’s money was spent, using such categories such as grants, salaries, contracts, etc. At the Departmental level presented in this Accountability Report, the net cost of operating each OPDIV is presented in aggregate and by budget function. There is little information for analysis. Details would need to be obtained from the individual OPDIV financial statements.

The FY 1999 GPRA annual performance plans identified major programs. Those programs are shown on the OPDIVs’ respective FY 1999 statements. Due to this number of OPDIV programs, presentation and analysis of cost by program will, of necessity, be at the OPDIV level. The OPDIV financial statements will be available on their respective Internet Web sites. For reporting at the Departmental level, these programs have been rolled up by budget functions. HHS’s largest budget function is Medicare.

In addition, the Statement of Net Costs will allow for linking program performance under GPRA reporting to the costs of programs reflected on the OPDIVs’ respective statements. The concept of linking resources to results will finally be achieved by the display of total program costs.

The format of the HHS-level Statement of Net Costs is now quite similar to the schedule of HHS FY 1999 net outlays by budget function and OPDIV (see Budgetary Highlights in Section I). The difference between the two is that the Statement of Net Costs represents expenses computed using accrual accounting techniques which recognize costs when incurred, regardless of the year the money was appropriated during the budget process. The net outlays chart in Section I identifies only the outlay (issuance of checks, disbursement of cash, or electronic transfer of funds) of those funds ‘tagged’ during the budget process as FY 1999 funds.

**FY 1999 Net Cost of Operations
by OPDIV**



*HCFA, ACF, and NIH account
for the largest percentages of HHS'
FY 1999 Total Net Cost of Operations.*

ANALYSIS OF THE STATEMENT OF BUDGETARY RESOURCES

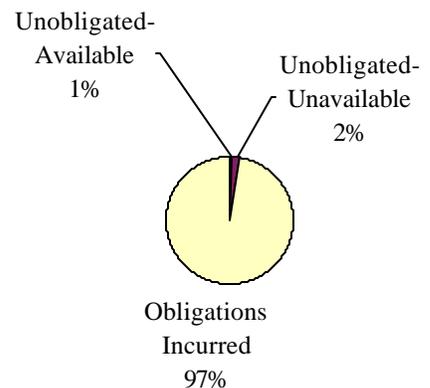
The Statement of Budgetary Resources illustrates to financial statement readers how the budgetary resources were made available and the status at the end of the period. It presents the relationship between budget authority to budget outlays and reconciles obligations to total outlays. This is a fundamental change in financial statement reporting in that the budget process became a part of the financial statement audit process when this statement was first required for FY 1998.

The purpose of the statement is to explain the sources of appropriated dollars and to provide the status (obligated or not) of those appropriated dollars. The total resources and the total status of budgetary resources equal the same amount. Thus, we have a type of budgetary “balance sheet.” The statements show us that of the total \$483.6 billion in FY 1999 HHS budgetary resources, they are largely derived from budget authority (\$484.7 billion) and unobligated balances at the beginning of the year (\$176.5 billion).

Total resources provided were reduced by a sizeable adjustment (\$182.5 billion). During FY 1999, OMB revised Circular A-34, clarifying the reporting for “Adjustments” and “Unobligated balances – available” on the Statement of Budgetary Resources. The change required that “Adjustments” include the portion of receipts collected in the current fiscal year for trust funds that is precluded from obligation due to Public Law 101-508. In FY 1998, these receipts were reported as “Unobligated balances – available” (for obligation). In FY 1999, these receipts are reported as (negative) amounts on the “Adjustments” under HCFA’s HI and SMI trust funds, and, additionally, HI and SMI must have no “Unobligated balances – available.” The status section of the report reveals that most (\$470.7 billion) of the resources budgeted for FY 1999 has either already been spent or has already been marked for specific things. Although there is an unobligated available year-end balance of \$5.6 billion.

The Statement of Budgetary Resources also provides information on total outlays for the year, which is calculated by netting the beginning and ending unpaid obligations and adding the obligations incurred during the year (which is, incidentally, the same obligations incurred number reported earlier in the statement), less adjustments. Total FY 1999 outlays in the Statement of Budgetary Resources amounted to almost \$451.8 billion. This amount excludes intrabudgetary transactions and proprietary receipts from the public such as those for Medicare’s SMI (Part B) insurance premiums. When those amounts are included (as is practice for several budget execution reports) the figure becomes a total net outlays amount of \$359.7 billion, a figure which is also used in this report (particularly in the section on budgetary highlights).

**Status of Budgetary Resources
at End of FY 1999**



Most of the budgetary resources available to HHS during FY 1999 were categorized as incurred obligations at year end.

SECTION IV:

**FINANCIAL STATEMENTS, NOTES,
SUPPLEMENTAL AND OTHER
ACCOMPANYING INFORMATION**

Principal Financial Statements and Notes:

Consolidated Balance Sheet

Consolidated Statement of Net Cost

Consolidated Statement of Changes in Net Position

Combined Statement of Financing

Combined Statement of Budgetary Resources

Notes to the Financial Statements

U.S. Department of Health and Human Services
CONSOLIDATED BALANCE SHEET
September 30, 1999
(in millions)

	Consolidated Totals
<i>Assets</i>	
Entity Assets:	
Intragovernmental	
Fund Balance with Treasury (Note 2)	\$ 73,160
Investments, Net (Note 3)	184,764
Accounts Receivable, Net (Note 4)	6,623
Other (Note 10)	<u>84</u>
Total Intragovernmental	264,631
Accounts Receivable, Net (Note 4)	4,338
Loans Receivable, Net (Note 5)	401
Advances with the Public (Note 6)	205
Cash and Other Monetary Assets (Note 7)	56
Inventory and Related Property, Net (Note 8)	75
General Property, Plant & Equipment, Net (Note 9)	<u>1,822</u>
Total Entity	<u>271,528</u>
Non-Entity Assets:	
Intragovernmental	
Fund Balance with Treasury (Note 2)	44
Accounts Receivable, Net (Note 4)	<u>2</u>
Total Intragovernmental	46
Accounts Receivable, Net (Note 4)	<u>60</u>
Total Non-Entity	<u>106</u>
Total Assets	<u><u>\$ 271,634</u></u>

U.S. Department of Health and Human Services
CONSOLIDATED BALANCE SHEET
September 30, 1999
(in millions)

	Consolidated Totals
<i>Liabilities</i>	
Liabilities Covered by Budgetary Resources	
Intragovernmental	
Accounts Payable	\$ 25
Employment Tax Revenue Adjustment (Note 11)	2,867
Environmental and Disposal Costs (Note 14)	1
Other (Note 17)	<u>476</u>
Total Intragovernmental	3,369
Accounts Payable	522
Entitlement Benefits Payable (Note 12)	35,302
Accrued Grants (Note 13)	1,518
Loan Guarantees (Note 15)	333
Other (Note 17)	<u>969</u>
Total Liabilities Covered by Budgetary Resources	<u>42,013</u>
Liabilities Not Covered by Budgetary Resources	
Intragovernmental	
Environmental and Disposal Costs (Note 14)	2
Other (Note 17)	<u>19</u>
Total Intragovernmental	21
Environmental and Disposal Costs (Note 14)	12
Federal Employee & Veterans Benefits (Note 16)	4,940
Other (Note 17)	<u>421</u>
Total Liabilities Not Covered by Budgetary Resources	<u>5,394</u>
<i>Total Liabilities</i>	<u>47,407</u>
<i>Net Position</i>	
Unexpended Appropriations (Note 18)	60,962
Cumulative Results of Operations (Note 18)	<u>163,265</u>
<i>Total Net Position</i>	<u>224,227</u>
<i>Total Liabilities & Net Position</i>	<u>\$ 271,634</u>

The accompanying notes are an integral part of these statements. In addition, more detailed information can be found in the following supplemental schedules:
 "Consolidating Balance Sheet by Budget Function" and "Consolidating Balance Sheet by OPDIV"

U.S. Department of Health and Human Services
CONSOLIDATED STATEMENT OF NET COST
For the year ended September 30, 1999
(in millions)

	Combined Totals	Intra-HHS Costs (-)	Eliminations Revenues (+)	Consolidated Totals
Operating Division				
ACF	\$ 35,644	\$ (47)	\$ 17	\$ 35,614
AoA	924	(1)		923
AHCPR	100	(6)	80	174
CDC	2,531	(42)	80	2,569
FDA	1,008	(49)	16	975
HCFA	363,898	(69,892)	-	294,006
HRSA	4,114	(72)	27	4,069
IHS	2,192	(50)	37	2,179
NIH	14,602	(1,182)	1,014	14,434
OS	408	(39)	121	490
PSC	570	(24)	171	717
SAMHSA	<u>2,290</u>	<u>(17)</u>	<u>12</u>	<u>2,285</u>
 Net Cost of Operations	 <u>\$ 428,281</u>	 <u>\$ (71,421)</u>	 <u>\$ 1,575</u>	 <u>\$ 358,435</u>

The accompanying notes are an integral part of these statements. In addition, detailed information on individual operating divisions (OPDIVs) can be found in the following supplemental schedules: "Consolidating Statement of Net Cost by Budget Function" and "Public and Intragovernmental Net Costs."

U.S. Department of Health and Human Services
CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the year ended September 30, 1999
(in millions)

	Consolidated Totals
Net Cost of Operations	\$ 358,435
Financing Sources (other than exchange revenues):	-
Appropriations Used	243,641
Taxes (and other non-exchange revenue)	143,868
Donations (non-exchange revenue)	211
Imputed Financing	281
Transfers-in	1,819
Transfers-out	(1,818)
Other Financing Sources	<u>715</u>
Net Results of Operations	30,282
Prior Period Adjustments (Note 21)	<u>(1,491)</u>
Net Change in Cumulative Results of Operations	28,791
Increase (Decrease) in Unexpended Appropriations	<u>7,249</u>
Change in Net Position	36,040
Net Position-Beginning of Period	<u>188,187</u>
Net Position-End of Period	<u>\$ 224,227</u>

The accompanying notes are an integral part of these statements.

**U.S. Department of Health and Human Services
 COMBINED STATEMENT OF FINANCING
 For the year ended September 30, 1999
 (in millions)**

Resources Used to Finance Activities:

BUDGETARY:

Budgetary resources obligated for orders and delivery of goods and services to be received or benefits received or benefits to be provided to others	\$470,749
Less: Offsetting collections, recoveries of prior-year authority, and changes in unfilled customer orders	<u>(9,660)</u>
Net Budgetary resources used to finance activities	<u>461,089</u>

NON-BUDGETARY:

Property received from others without reimbursement	2,090
Property given to others without reimbursement	(1,818)
Cost incurred by others for the entity without reimbursements	305
Other non-budgetary resources	<u>7</u>
Net non-budgetary resources used to finance activities	<u>584</u>

TOTAL RESOURCES USED TO FINANCE ACTIVITIES **\$461,673**

Relationship of Total Resources to the Net Cost of Operations:

Deduct Resources Used to Fund Items Not Part of the Net Cost of Operations:

Increase or (decrease) in budgetary resources obligated to order goods and services not yet received or benefits not yet provided	\$ 9,026
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Budgetary offsetting collections that do not increase exchange revenue or decrease expenses:

Decrease or (increase) in revenue collected in advance	(30)
Credit program collections that increase liabilities for loan guarantees or allowances of subsidy	(73)

Adjustments other than collections made to compute net budgetary resources that do not affect cost of operations:

Recoveries of prior-year authority	(951)
Decrease or (increase) in unfilled customer orders	98
Other	3

Resources that fund expenses recognized in prior period 39,598

Resources that finance the acquisition of assets or liquidations of liabilities 276

Other resources used to fund items not part of the net cost of operations (552)

Total resources used to fund items not part of the net cost of operations \$ 47,395

RESOURCES USED TO FINANCE NET COST OF OPERATIONS **\$414,278**

Components of Net Cost of Operations That Do Not Require or Generate Resources During the Reporting Period:

Expenses or Exchange Revenue Related to the Disposition of Assets or Liabilities,

or Allocations of Tier Costs over Time:

Expenses related to use of assets	\$ (602)
Losses or (gains) from revaluation of assets and liabilities	77
Decrease or (increase) in exchange revenue receivable from the public	102
Other	<u>(21,534)</u>
Subtotal	(21,957)

Expenses That Will Be Financed with Budgetary Resources Recognized in Future Periods:

Annual leave from increase in annual leave liability	8
Other	<u>35,959</u>
Subtotal	35,967

Other net cost components that do not require or generate resources during the reporting period (7)

Total Components of Net Cost of Operations That Do Not Require or Generate Resources During The Reporting Period \$ 14,003

Net Cost of Operations **\$428,281**

The accompanying notes are an integral part of these statements. For FY 1999, this statement is presented on a combined basis and agrees with the combined totals shown in the Consolidating Statement of Net Cost by Budget Function.

U.S. Department of Health and Human Services
COMBINED STATEMENT OF BUDGETARY RESOURCES
For the year ended September 30, 1999
(in millions)

	Combined Total
Budgetary Resources:	
Budget Authority	484,689
Unobligated Balances - Beginning of Period	176,537
Spending Authority From Offsetting Collections	4,938
Adjustments	<u>(182,521)</u>
Total Budgetary Resources	<u><u>483,643</u></u>
 Status of Budgetary Resources:	
Obligation Incurred	470,749
Unobligated Balances - Available	5,591
Unobligated Balances - Not Available	<u>7,303</u>
Total Status of Budgetary Resources	<u><u>483,643</u></u>
 Outlays:	
Obligations Incurred	470,749
Less: Spending Authority from Offsetting Collections and Adjustments	<u>(9,797)</u>
Subtotal	460,952
Obligated Balance, Net - Beginning	47,515
Obligated Balance Transferred, Net	(110)
Less: Obligated Balance, Net - End of Period	<u>(56,594)</u>
Total Outlays	<u><u>451,763</u></u>

The accompanying notes are an integral part of these statements.

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTES TO THE FINANCIAL STATEMENTS
AS OF SEPTEMBER 30, 1999**

NOTE 1. SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

The Department of Health and Human Services consists of thirteen Operating Divisions (OPDIVs) which have diverse missions and programs. There are twelve financial reporting entities:

1. Administration for Children and Families (ACF)
2. Centers for Disease Control (CDC)/Agency for Toxic Substances and Disease Registry (ATSDR)
3. Food and Drug Administration (FDA)
4. Health Care Financing Administration (HCFA)
5. Health Resources and Services Administration (HRSA)
6. Indian Health Service (IHS)
7. National Institutes of Health (NIH)
8. Program Support Center (PSC)
9. Substance Abuse and Mental Health Services Administration (SAMHSA)
10. Administration on Aging (AoA)
11. Agency for Health Care Policy and Research (AHCPR)
12. Office of the Secretary (OS)

The Agency for Toxic Substances and Disease Registry is combined with the Centers for Disease Control for financial reporting purposes. In FY 1999, the first nine OPDIVs listed above received full scope audits, while the last three were reviewed as part of the Departmental consolidated audit. Each OPDIV is considered a responsibility segment for purposes of preparing the HHS-wide Statement of Net Cost.

Basis of Presentation

The financial statements have been prepared to report the financial position and results of operations of HHS as required by the Chief Financial Officers Act of 1990, and amended by the Government Management Reform Act of 1994. They have been prepared from Departmental records in accordance with the form and content guidance of OMB Bulletin 97-01, and generally accepted accounting principles. These statements are therefore different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control HHS's use of budgetary resources.

The financial statements consolidate the balances of about one hundred and forty discrete appropriations and fund accounts, and a number of accounts used for suspense, collection of receipts and general governmental functions. Material intra-HHS balances have been eliminated in the consolidation of the account balances from the financial statements of HHS's twelve OPDIVs; each issued under separate cover. Intra-entity eliminations are presented on the Consolidating Balance Sheet, Statement of Net Cost, and Statement of Changes in Net Position. The effects of intra-entity transactions are not eliminated in the presentation of the other principal statements. These other statements are labeled as combined/combining statements rather than consolidated/consolidating statements. Supplemental information is accumulated from the OPDIV reports, regulatory reports and other sources within HHS. Information is generally presented

herein on a summary level, hence greater detail on OPDIV programs and activities is found in the annual reports prepared by the OPDIVs.

Basis of Accounting

For most HHS programs, transactions are recorded on an accrual accounting basis and a budgetary basis. Under the accrual method, revenues are recognized when earned and expenses are recognized when a liability is incurred, without regard to the receipt or payment of cash. Budgetary accounting facilitates compliance with legal constraints and controls over the use of federal funds.

The cash basis is used by HCFA for Medicare benefit payments and Medicaid Program draws by States to cover current quarter expenses, and a number of other OPDIV programs. For these programs, an accrual method adjustment is made by recording year-end estimates of unpaid liabilities.

Entity and Non-Entity Assets

Entity assets are those assets which the reporting entity holds and has the authority to use in its operations. Non-entity assets are assets the entity holds but does not have the authority to use. An example of non-entity assets is income tax receivables, which the IRS collects for the U.S. Government but does not have authority to spend.

Fund Balance with Treasury

The Department maintains all cash accounts with the U.S. Treasury. The account, "Fund Balance with Treasury," represents appropriated, revolving, trust, and other funds available to pay current liabilities. The U.S. Treasury processes cash receipts and disbursements for HHS.

Investments

Trust fund balances in excess of current needs are invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States.

Accounts Receivable

Accounts receivable consists of amounts owed to the Department by other Federal agencies and the public. Amounts due from the public are presented net of an allowance for loss on uncollectable accounts. The allowance for loss is based on past collection experience and/or an analysis of the outstanding balances. Accounts receivable also includes interest due to the Department other than interest on direct loans and loan guarantees. HHS non-entity receivable balances represent amounts that cannot be used by HHS once collected. Such receipts are transferred to the General Fund of the Department of the Treasury.

Loans Receivable

Loans are accounted for as receivables after funds are disbursed. In accordance with credit reform legislation, for loans obligated prior to October 1, 1991, loan principal, interest, and other cost are reduced by an allowance for loss based on historical data and current market factors. For loans obligated on or after October 1, 1991, the amount of gross loans receivable is reduced by an allowance equal to the present value of the subsidy costs associated with these loans. Loans receivable also includes interest due to the Department for direct loans and defaulted loan guarantees.

Advances and Prepayments

Advances are cash outlays made by the Department to its grantees, employees, or others to cover a part or all of the recipients' anticipated expenses or as advance payments for the costs of goods and services the Department receives. Prepayments are payments made to cover certain periodic expenses before they are incurred. Progress payments on work in process are not included in advances and prepayments. Advances to the public, primarily grant advances, are reported in Note 6, "Advances to the Public." Advances to other Federal agencies are reported in Note 10, "Other Assets."

Inventory and Related Property

Inventory and Related Property includes: Inventories Held for Sale; Operating Materials and Supplies, and Stockpile Materials. Inventories Held for Sale (Inventories) consists of small equipment and supplies held by the various OPDIV Service and Supply Funds for sale to HHS components and other Federal entities. Operating Materials and Supplies (OMS) consist of pharmaceuticals, biological products, vaccines, and other medical supplies, which are used, in providing medical services and conducting medical research in the various OPDIVs. Both Inventories and OMS are recorded as assets when purchased, and expensed when they are consumed or sold. Generally, these inventories are recorded at (1) historical cost (or a method which reasonably approximates historical cost), or (2) the lower of cost (using weighted-average cost method) or market. Stockpile materials represent supplies of biological materials and vaccines held for use in case of a national emergency.

General Property, Plant and Equipment

The basis for recording purchased General Property, Plant and Equipment (PP&E) is full cost, including all costs incurred to bring the PP&E to a form and location suitable for its intended use. The cost of PP&E acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. The cost of PP&E acquired through donation is the estimated fair value when acquired. The cost of PP&E transferred from other Federal entities is the net book value of the transferring entity. All PP&E with an initial acquisition cost of \$25,000 or more and an estimated useful life of two (2) years or greater are capitalized. PP&E are depreciated on a straight-line basis over the estimated useful life of the item. Land and land rights, including permanent improvements, are not depreciated. Normal maintenance and repair costs are expensed as incurred.

Liabilities

Liabilities are recognized for amounts of probable future outflows or other sacrifices of resources as a result of past transactions or events. Since HHS is a component of the U.S. Government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. Payments of all liabilities other than contracts can be abrogated by the sovereign entity. In accordance with Public Law and existing Federal accounting standards, no liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare Hospital Insurance (HI) Trust Fund.

Liabilities Covered by Budgetary Resources are those liabilities funded by available budgetary resources including: (1) new budget authority, (2) spending authority from offsetting collections, (3) recoveries of unexpired budget authority, (4) unobligated balances of budgetary resources at the beginning of the year, and (5) permanent indefinite appropriation or borrowing authority.

Liabilities Not Covered by Budgetary Resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. HHS recognizes such liabilities for

employee annual leave earned but not taken, and amounts billed by the Department of Labor for Federal Employee's Compensation Act (disability) payments. For HHS revolving funds, all liabilities are funded as they occur.

Accounts Payable

Accounts Payable consists of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

Entitlement Benefits Payable

Entitlement Benefits Payable represents benefits due and payable to the public from entitlement programs enacted by law. In HHS, the largest entitlement programs, which comprise the bulk of HHS entitlement spending, are Medicare and Medicaid (HCFA).

Accrued Grants

HHS grant programs are classified into two categories, block grants and non-block grants.

Block Grants: For most block grant programs, the OPDIVs record expenses as the grantees draw funds. Therefore the year-end accrual for block grants is equal to the amount of funds drawn that have not already been recorded as expenditures.

Non-Block Grants: For non-block programs, grantees draw funds (recorded as advances in OPDIV systems) commensurate with their immediate cash needs. When grantees pay bills they report this to HHS' Division of Payment Management (DPM), quarterly and DPM reports these grantee expenditures to the OPDIVs. The OPDIVs then record an expense and reduce the grantee advance balance accordingly.

In 1998, all OPDIVs except HCFA adopted a new process to estimate and accrue unreported grantee expenditures. Grantees report their expenses on a quarterly basis using the grantee expenditure report, SF 272. The new process divides unreported grantee expenditures into two components: 1) fourth quarter grantee expenditures incurred and expected to be reported on the September 30 SF 272, and 2) fourth quarter grantee expenditures incurred but not expected to be reported (IBNR) on the September 30 SF 272.

The estimate of the first component was based upon historical grantee data. Grantee advances have proven to be a reliable predictor of quarterly grantee expenditures. Based on this relationship a regression analysis, using historical grantee advance and expenditure data, was used to estimate fourth quarter grantee expenditures. The estimated Fourth quarter grantee expenditures were calculated by PMS, transmitted to the OPDIVs and are reported in the accompanying financial statements.

To estimate the second component, IBNR, HHS gathered information on spending patterns from four different groups of grantees to determine if they had unreported expenses at year-end and if so, in what amounts. As a result, HHS determined that grantees typically had year-end IBNR equal to approximately 2 weeks of annual expenditures. OMB has agreed that this accrual methodology appears reasonable. This two-week accrual of grantee IBNR expenses is reported in the accompanying financial statements.

Federal Employee and Veterans' Benefits

Federal Employee and Veterans' Benefits consist of the actuarial portions of future benefits earned by Federal employees and Veterans, but not yet due and payable. These costs include pensions, other retirement benefits, and other post-employment benefits. These benefits programs are normally administered by OPM and not by the Department of Health and Human Services, or any of the individual operating divisions of the Department. Therefore, HHS does not recognize any liability on the Balance Sheet for pensions, other retirement benefits, and other post-employment benefits. HHS does, however, recognize the imputed cost and imputed financing related to these benefits in the Statement of Net Cost and the Statement of Changes in Net Position, respectively.

The lone exception to this policy is the Public Health Service (PHS) Commissioned Corps Retirement System. The HHS-administered PHS Commissioned Corps Retirement System is discussed in Note 16, "Federal Employee and Veterans' Benefits."

Pensions: Pensions provide benefits upon retirement and may also provide benefits for death, disability, or other termination of employment before retirement. Pension plans may also include benefits to survivors and dependents, and they may contain early retirement or other special features. Most HHS employees participate in the Civil Service Retirement System (CSRS) or the Federal Employee Retirement System (FERS). Under CSRS, HHS makes matching contributions equal to 8.51 percent of basic pay. For FERS employees, HHS contributes the employer's matching share for Social Security and contributes an amount equal to 1 percent of employee pay to a savings plan and matches up to an additional 4 percent of pay. Most employees hired after December 31, 1983 are covered by FERS. The Office of Personnel Management reports on CSRS and FERS assets, accumulated plan benefits, unfunded liabilities, if any, applicable to Federal employees.

Other Retirement Benefits (ORB): Retirement benefits other than pensions are all forms of benefits to retirees or their beneficiaries provided outside the pension plan. Examples include health and life insurance. Retirement health care benefits are the primary ORB expense.

Other Post-employment Benefits (OPEB): Post-employment benefits other than pensions include all types of benefits provided to former or inactive (but not retired) employees, their beneficiaries, and covered dependents. Inactive employees are those who are not currently rendering services to their employers and who have not been terminated, but who are not eligible for an immediate annuity, including those temporarily laid off or disabled. OPEB includes salary continuation, severance benefits, counseling and training, continuation of health care or other benefits, and unemployment and workers' compensation benefits paid by the employer entity.

Leave

Annual leave is accrued as it is earned, and the accrual is reduced as leave is taken. Each year, the balance in the accrued annual leave account is adjusted to reflect current pay rates. To the extent that current or prior year funding is not available to cover annual leave earned but not taken, funding will be obtained from future financing sources. Sick leave and other types of non-vested leave are expensed as taken. Any liability for sick leave that is accrued but not taken by a CSRS-covered employee is transferred to the Office of Personnel Management upon the retirement of that individual. No credit is given for sick leave balances upon the retirement of FERS-covered employees.

Obligations Related to Canceled Appropriations

Payments may be required of up to 1 percent of current year appropriations for valid obligations incurred against prior year appropriations that have been canceled. The total potential payments related to canceled appropriations is estimated to be \$648 million as of September 30, 1999.

Revenues and Other Financing Sources

Funding for the Department/OPDIV is classified as revenue or other financing sources. Revenue is an inflow of resources that the Government demands, earns, or receives by donation. Revenue comes from two sources: exchange transactions and nonexchange transactions. Exchange revenues arise when a Government entity provides goods and services to the public or to another Government entity for a price. Another term for “exchange revenue” is “earned revenue.” Nonexchange revenues arise primarily from exercise of the Government’s power to demand payments from the public (e.g., taxes, duties, fines, and penalties) but also include donations. Other Financing Sources include appropriations used, transfers of assets from other Government entities, and imputed financing.

Other Financing Sources: Congressional appropriations are the primary funding source for most of the Department’s programs. For financial statement purposes, appropriations used are recognized as a financing source as expenses are incurred.

Imputed financing is an “other financing source” which reflects cost incurred by one Federal entity which is paid for by another Federal entity. These are also known as inter-entity costs. For financial statements covering fiscal years 1998 and 1999, OMB is limiting the inter-entity costs to be recognized by Federal agencies to the following: (1) employee’s pension benefits, (2) the health, life insurance, and other benefits for retired employees, (3) other post-employment benefits for retired, terminated, and inactive employees, which include severance payments, training and counseling, continued health care, and unemployment and worker’s compensation under the Federal Employees’ Compensation Act, and (4) losses in litigation proceedings (FASAB Interpretation No. 2, Accounting for Treasury Judgement Fund transactions).¹

Financing for the Public Health Service (PHS) Commissioned Corps Retirement System is provided through annual appropriations. The estimate for PHS Commissioned Corps employees is an intra-HHS elimination because the PSC recognizes the liability for their retirement plan.

Nonexchange Revenue: Nonexchange revenues include income taxes, excise taxes, duties, fines, penalties, and other inflows of resources arising from the Government’s power to demand payments, as well as voluntary donations. Nonexchange revenue is recognized when a reporting entity establishes a specifically identifiable, legally enforceable claim to cash or other assets. It is recognized to the extent that the collection is probable and the amount is measurable.

Medicare’s Hospital Insurance program, also known as HI or Medicare Part A, is financed through the HI Trust fund, whose revenues come primarily through Medicare’s portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). The Medicare payroll tax rate was 2.9 percent of annual wages-employees and employers were each required to contribute 1.45 percent of employees’ wages, with no limitation, to the HI Trust Fund. Self-employed individuals paid the full 2.9 percent themselves.

¹ Memorandum from G. Edward DeSeve, Controller, OMB, dated April 6, 1998, entitled “*Technical Guidance for the Implementation of Managerial Cost Accounting Standards for the Federal Government.*”

Medicare's Supplemental Medical Insurance program, also known as SMI or Medicare Part B, is financed primarily by general fund appropriations (Payments to the Health Care Trust Funds) provided by Congress and by monthly premiums paid by beneficiaries. Premium payments from Medicare beneficiaries are matched approximately 3 to 1 by congressional appropriations. Interest revenue on investments is recognized as it is earned.

Exchange Revenue: Revolving funds recognize exchange revenue at the time goods or services are provided to the public or to another Government entity. Reimbursable service agreements between HHS activities and with other Federal agencies generally recognize these revenues when the related expenses are incurred. Various user fees are collected to offset the cost of providing services.

Contingencies

A contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible gain or loss to the Department/OPDIV. The uncertainty will ultimately be resolved when one or more future events occur or fail to occur. With the exception of pending, threatened or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is more likely than not, and the related future outflow or sacrifice of resources is measurable. For pending, threatened or potential litigation, a liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is likely to occur, and the related future outflow or sacrifice of resources is measurable.

Use of Estimates in Preparing Financial Statements

The preparation of financial statements in accordance with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates.

Intra-Governmental Relationships and Transactions

In the course of its operations, HHS has relationships and financial transactions with numerous Federal agencies. The more prominent of these are with the Social Security Administration (SSA) and the Department of the Treasury. The SSA determines eligibility for Medicare programs, and also allocates a portion of Social Security benefit payments to the Medicare Part B Trust Fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing over outlays, and issues interest-bearing securities in exchange for the use of those monies. At the Government-wide level, the assets related to the trust funds on HHS' financial statements and the corresponding liabilities on the Treasury's financial statements should be eliminated.

Comparative Data

OMB Bulletin 97-01, "Form and Content of Agency Financial Statements" provides that comparative financial statements are permitted but not required until reporting periods beginning after September 30, 1999 (FY 2000). Management has determined that, due to the implementation of new FASAB accounting standards and new financial statement formats and disclosures for FY 1999, it is not feasible nor prudent to attempt to restate FY 1998 amounts in the current statements. Therefore, comparative data will not be presented in the financial statements for FY 1999.

Accounting Changes

The following accounting changes were made in the 1999 financial statements:

On the Combined Statement of Budgetary Resources, adjustments are reported due to OMB's FY 1999 revision to Circular A-34, clarifying the reporting for "Adjustments" and "Unobligated balances – available" on the Statement of Budgetary Resources. The change required that "Adjustments" include the portion of receipts collected in the current fiscal year for trust funds that is precluded from obligation due to Public Law 101-508. In FY 1998, these receipts were reported as "Unobligated balances – available" (for obligation). In FY 1999, these receipts are reported as (negative) amounts on the "Adjustments" under HCFA's HI and SMI trust funds, and, additionally, HI and SMI must have no "Unobligated balances – available."

On the Consolidating Statement of Changes in Net Position, transfers made from HCFA's Payments to the Health Care Trust Funds to HI and SMI are reported as financing sources twice: (1) as "Appropriations Used" under HI and SMI and (2) as "Taxes and Other Non-Exchange Revenue (SMI)" and "Other Financing Sources" (HI). To avoid double reporting these financing sources, HCFA previously eliminated the "Appropriations Used" amounts. HCFA believes the proper elimination should be against the "Taxes and Other Non-Exchange Revenue" and "Other Financing Sources" line items, which will match the elimination of intragovernmental revenues with intragovernmental expenses within HCFA.

Unless otherwise stated, amounts are presented in millions of dollars.

NOTE 2. FUND BALANCE WITH TREASURY

HHS' undisbursed account balances are listed below by fund type. Other Funds include balances in deposit, suspense, clearing and related non-spending accounts.

	Entity	Non-Entity
	Assets	Assets
Trust Funds	4,082	18
Revolving Funds	731	1
Appropriated Funds	68,259	(2)
Other	88	27
Total Fund Balance with Treasury	73,160	44

NOTE 3. INVESTMENTS, NET

HHS invests trust fund cash that is in excess of current needs in U.S. Treasury Securities. The U.S. Treasury Department is HHS' agent and advisor for investing.

	Cost	Unamortized (Premium) Discount	Investments, Net
Non-Marketable: Par Value	180,307	-	180,307
Non-Marketable: Market-Based	1,434	20	1,454
Subtotal	181,741	20	181,761
Accrued Interest	3,003		3,003
Total Investments, Net	184,744	20	184,764

HCFA invests in U.S. Treasury Special Issues exclusive to HI and SMI Trust Funds that are purchased and redeemed at face value. Certificates are short-term and pay 6 1/4 percent. Bond interest rates range from 5 7/8 to 10 3/8 percent. Bonds mature at various dates from June 1999 to June 2014. The accrued interest receivable on investments totaled approximately \$3 billion as of September 30, 1999.

During FY 1999, a series of trust fund transactions related to investments in U.S. Treasury securities were posted incorrectly and not detected until FY 2000. These errors resulted in HI interest income being overstated by \$154 million and SMI trust fund income being understated by \$237 million. HCFA and HHS management are pursuing options to make each trust fund "whole" in FY 2000. HCFA has taken steps to prevent such errors in the future.

HRSA's Vaccine Injury Compensation Trust Fund invests in market-based (MK) special securities. Securities currently held are MK Bills and Notes maturing in fiscal years 1999, 2004, and 2008.

The NIH invests a portion of their trust fund cash in short-term U. S. Treasury Securities. The majority of HHS' investments in securities are held to maturity and no provision is made for unrealized gains and losses.

NOTE 4. ACCOUNTS RECEIVABLE, NET

HCFA recorded a \$6 billion anticipated Congressional appropriation to cover liabilities incurred as of September 30 by the Medicaid program and the Payments to the Health Care Trust Funds appropriation. HCFA recorded a \$5,735 million anticipated appropriation in FY 1999 for incurred but not reported claims that exceeded the available unexpended Medicaid appropriation. The Medicare SMI program is financed primarily by the general fund appropriation, Payments to the Health Care Trust Funds, and by monthly premiums paid by beneficiaries. The appropriated amount is an estimate calculated annually by HCFA's actuary and can be insufficient in any particular fiscal year. In FY 1999, the estimate was insufficient and the matching ceased prior to the close of the fiscal year. Subsequently, HCFA's actuary valued the unmatched amount as \$295 million and HCFA reported the \$295 million as revenues earned in FY 1999, although the actual transfer of funds will occur in FY 2000.

HCFA's Medicare receivables are primarily due to overpayments to providers, beneficiaries, physicians and suppliers. The Medicaid balance is the net realizable value of disallowances in dispute with the States.

HHS non-entity receivable balances represent amounts that cannot be used by HHS once collected. Such receipts are transferred to the General Fund of the Department of the Treasury.

The allowance for loss on accounts receivable is based upon analytical procedures on both individual and group basis. Individual analysis is based upon the debtor's ability to pay, the debtor's payment record and willingness to pay and the probable recovery of amounts from secondary sources, including liens garnishments, etc. To estimate allowance for loss by groups, HHS stratifies receivables into groups exhibiting similar characteristics. Estimated losses are then projected based upon statistical sampling or through historical loss experience. The allowance is periodically reviewed and adjustments are made as required.

Entity	Gross	Interest	Allowance	Combined Net	Intra-HHS Eliminations	Consolidated Net
Intragovernmental	7,075	-	(31)	7,044	(421)	6,623
From the Public						
Medicare	7,315	-	(3,092)	4,223	-	-
Medicaid	30	-	(7)	23	-	-
Other Public	104	-	(12)	92	-	-
Total, Public	7,449	-	(3,111)	4,338	-	4,338
Non-Entity						
Intragovernmental	6	4	(8)	2	-	2
From Public	245	-	(185)	60	-	60

During FY 1999, HCFA management directed an analysis of accounts receivable balances at Medicare contractors. The analysis revealed two major findings: 1) Many receivables were aged to such an extent that collectibility was extremely unlikely and recognition of those receivables materially overstated gross receivables. Also, 2) some receivables balances could not be verified with documentation or the debtor organization no longer exists. For the first group, which amounted to \$2.7 billion, HCFA has written off those gross receivables and the related allowance balances to zero. However, collection activities will continue, though recovery is extremely unlikely. For the second group, which amounted to \$.2 billion, the receivables balances were adjusted to zero, and no collection activities can be pursued.

NOTE 5. LOANS RECEIVABLE, NET

Loans receivable are included for the Health Education Assistance Loans (HEAL) guaranteed loan program which is administered by HRSA. The gross receivables amount for this program represents defaulted loans, which have been paid to lenders under the guarantee, and includes principal and interest.

	Principal	Interest	Gross	Allowance	Net
Pre-1992 loans	496	13	509	(136)	373
Post-1991 loans	38	1	39	(11)	28
Total Loans Receivable, Net	534	14	548	(147)	401

NOTE 6. ADVANCES WITH THE PUBLIC

Advances with the Public includes advances to grantees in excess of their grant-related expenses, payments to HHS employees for travel and emergency salary advances, and advances to Non-Federal agencies for goods and services to be provided to HHS.

Grant Advances	67
Travel Advances and Emergency	
Employee Payments	84
Other	<u>54</u>
Total Advances With the Public	<u>205</u>

“Advances with the Public” does not include advances to Federal agencies for goods and services to be provided—these advances are reported as “Advances to Other Federal Entities” in Note 10, “Other Assets.”

NOTE 7. CASH AND OTHER MONETARY ASSETS

Restricted cash is the total amount of time account balances at the Medicare contractors’ commercial banks. The Checks Paid Letter-of-Credit method is used for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against a Medicare benefits account maintained at commercial banks. In order to compensate commercial banks for handling the Medicare Benefits accounts, Medicare funds are deposited into non-interest-bearing time accounts. The earnings allowances on the time accounts are used to reimburse the commercial banks.

NOTE 8. INVENTORY AND RELATED PROPERTY, NET

HHS inventories are valued at historical cost. Inventory items are classified into appropriate categories, when received, based upon U.S. Standard General Ledger definitions derived from Statement of Federal Financial Accounting Standard (SFFAS) No. 3, Accounting for Inventory and Related Property.

HHS inventories are comprised of inventory held for sale, operating materials and supplies used in general operations and stockpile materials. CDC is mandated by law to maintain a vaccine stockpile to meet unanticipated needs for the vaccines, and for national emergencies. Vaccine stockpiles are maintained by the vaccine manufacturers and consist of several types of vaccines. CDC may only sell these vaccines to state, local, or territorial health departments.

Operating Materials and Supplies reserved for future use	25
Excess, obsolete, and unserviceable operating material and supplies	<u>(4)</u>
Total, operating materials and supplies	21
Inventory held for current sale	36
Stockpile material held for emergency or contingency	<u>18</u>
Total Inventory and Related Property, Net	<u>75</u>

NOTE 9. GENERAL PROPERTY PLANT AND EQUIPMENT, NET

Balances for the major categories of HHS Property, Plant and Equipment are listed below:

	Depreciation Method	Est. Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land and Land Rights	N/A	N/A	47	-	47
Construction In Progress	N/A	N/A	321	-	321
Buildings, Facilities and Other Structures	Straight Line	3-10 yrs	2,065	(953)	1,112
Assets Under Capital Lease	Straight Line	Life of Lease	23	(2)	21
Leasehold Improvements	Straight Line	7-15 years or life of lease	1	-	1
Equipment	Straight Line	3-10 years	647	(327)	320
Total General Property Plant and Equipment, Net			3,104	(1,282)	1,822

See the supplemental disclosure *Deferred Maintenance* in the Required Supplementary Information section for information on deferred maintenance for General PP&E.

NOTE 10. OTHER ASSETS

Other Assets at September 30, 1999 is comprised of the following:

Other Assets	
Advances to Other Federal Entities	152
Other	<u>78</u>
Total Combined Other Assets	230
Less: Intra-HHS eliminations	<u>(146)</u>
Total Consolidated Other Assets	<u>84</u>

NOTE 11. EMPLOYMENT TAX REVENUE ADJUSTMENT

For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employees' wages, and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the HI Trust Fund. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

NOTE 12. ENTITLEMENT BENEFITS PAYABLE

Entitlement Benefits Payable represents benefits due and payable to the public from entitlement programs enacted by law. In HHS, the largest entitlement programs, which comprise the bulk of HHS entitlement spending, are Medicare and Medicaid (HCFA).

Medicare	23,676
Medicaid	—11,626
Total Entitlement Benefits Payable	35,302

NOTE 13. ACCRUED GRANTS

For non-block grants, OPDIVs record the initial draw down of funds from grant awards as an Advance with the Public. When grantees submit their quarterly expense reports (SF 272), OPDIVs reduce the advance and increase expense for the amounts reported by the grantee. At fiscal year end, OPDIVs book an accrual for IBNR grant expenses. If grant advances outstanding at year-end exceed the accrual for IBNR, then the OPDIV reports an asset for net grant advances. Otherwise, the OPDIV reports a liability called Accrued Grants for the excess of IBNR over outstanding grant advances. However, operating on a cash basis of accounting, the accrual is calculated to equal the grant liability.

At the department level, the asset and liability balances for the individual OPDIVs are separately combined and reported as separate line-items on the HHS-wide Balance Sheet. Netting OPDIV grant advance balances with OPDIV accrued grant liability balances would result in a net liability for HHS of almost 1.5 billion dollars, as follows:

Grant Advances, Net	67
Accrued Grants	—1,518
Total Net of Grant Liabilities and Advances	(1,451)

NOTE 14. ENVIRONMENTAL and DISPOSAL COSTS

Environmental and Disposal Costs Cleanup costs are the costs of removing, containing, and or disposing of (1) hazardous waste from property, or (2) material and or property that consists of hazardous waste at a permanent or temporary closure or shutdown of associated PP&E. In accordance with SFFAS # 5 Accounting for Liabilities of the Federal Government and SFFAS #6 Property Plant and Equipment, HHS has recognized a liability for cleanup of \$15 million. The following table presents HHS OPDIV cleanup costs; the total estimated cleanup cost is the liability recognized:

OPDIV	Method for Assigning Cost	Liability recognized for cleanup costs
NIH	Estimated cost of similar remediation	9
FDA	Estimated cost of similar remediation	6
Total Environmental Disposal Cost		15

NOTE 15. LIABILITY FOR DEFAULTED LOAN GUARANTEES

HHS' loan guarantees are with HRSA's Health Education Assistance Loan (HEAL) program. The liability for loan guarantees is equal to the amount of defaulted guaranteed loans.

	Defaulted Loan Guarantees
Pre-1992 guarantees	38
Post-1991 guarantees	295
Total Defaulted Loan Guarantees	333

NOTE 16. FEDERAL EMPLOYEE AND VETERANS' BENEFITS

PHS Commissioned Corps Pension: HHS administers the PHS Commissioned Corps Retirement System for approximately 5,764 active duty officers and 4,077 retiree annuitants or survivors. Authorized by Public Law 78-410, it is a defined benefit plan and is non-contributory. The plan does not have accumulated assets, funding is provided entirely on a "pay as you go" basis by Congressional appropriations. Administrative costs are not borne by the plan. The actuarial present value of accumulated plan benefits is \$4,802 million, of which 478 million is non-vested. The assumed interest rate is 6.50 percent. Economic assumptions are the same as those used by the Military Retirement System. Withdrawal and retirement rates are based on the historical trends of officers in the PHS retirement system. The actuarial liability was established based upon the Public Health Service's Report for Commissioned Corps Retirement System for Plan Year Ending September 30, 1999.

Future Workers' Compensation Benefits: The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical and miscellaneous costs for approval compensation cases. The liability is determined using a method that utilizes historical benefit payment patterns related to a specific incurred period to predict the ultimate payment related to that period. Consistent with past practice, these projected annual benefit payments have been discounted to present value using the Office of Management and Budget's economic assumptions for 10-year Treasury notes and bonds. Interest rate assumptions utilized for discounting in 1999 was 5.69 percent in year 1 and thereafter.

To provide more specifically for the effects of inflation on the liability for future workers' compensation benefits wage inflation factors (cost of living adjustments or COLAs) and medical inflation factors (consumer price index medical or CPIMs) are applied to the calculation of projected future benefits. These factors are also used to adjust the methodology's historical payments to current year dollars. The methodology also includes a discounting formula to recognize the timing of compensation payments per year instead of one lump sum per year. The projected number of years of benefit payments is 37 years.

Both the PHS Commissioned Corps Pension and Future Workers' Compensation Benefits are liabilities not covered by budgetary resources.

PHS Commissioned Corps Pension	4,802
Future Workers' Compensation Benefits	138
Total Federal Employee and Veterans' Benefits	4,940

NOTE 17. OTHER LIABILITIES

The Vaccine Injury Compensation Program (VICP), administered by HRSA, provides compensation for vaccine-related injury or death. The liability of \$404 million represents the estimated future payment value of injury claims outstanding for VICP as of September 30, 1999. Other liability categories are described in Note 1, Significant Accounting Policies.

	Liabilities Covered		Liabilities Not Covered	
	by Budgetary Resources		by Budgetary Resources	
	Intra-governmental	With the Public	Intra-governmental	With the Public
Vaccine Injury Compensation Program		404		
Advances from Other Federal Agencies	81			
Accrued Payroll and Benefits	21	290		
Accrued Worker Compensation		1		
Accrued Leave Liability		7		345
Deferred Revenue	125	211		30
Custodial Liabilities	(12)	1		1
Liability for Deposits Funds		11	(2)	33
Capital Lease Liabilities		6	21	
Other Liabilities	261	38		12
Total Other Liabilities	476	969	19	421

NOTE 18. NET POSITION

Net position is the difference between assets and liabilities. The section contains two line items: Unexpended Appropriations, including unobligated appropriations and undelivered orders, and Cumulative Results of Operations. Unobligated appropriations are either available for obligation or not available (permanently or temporarily) pursuant to a specific provision in law. Undelivered orders represents appropriations obligated (i.e., legally reserved) for the amount of goods or services ordered but not yet received. Cumulative results of operations represents the net difference between (1) expenses and losses and (2) financing sources, including appropriated capital used, and revenues and gains since the inception of the activity.

Unexpended Appropriations:	
Unobligated	
Available	\$ 2,863
Unavailable	9,290
Undelivered Orders	<u>48,809</u>
Total Unexpended Appropriations	60,962
Cumulative Results of Operations	<u>163,265</u>
Total Net Position	<u>\$ 224,227</u>

NOTE 19. LEASES

Capital Leases: HHS and its components have entered into various capital leases with Indian Tribes and the General Services Administration (GSA) for office and warehouse space. Lease terms vary from one to twenty years. Capitalized assets acquired under capital lease agreements and their related liability are reported at the present value of minimum lease payments.

Operating Leases: HHS and its components also have commitments under various operating leases with private entities and GSA for office, laboratory space, and land. Leases with private entities have initial or remaining noncancelable lease terms from one to twenty years. GSA leases in general are cancelable within 120 days notice.

Future minimum lease payments due for capital and operating leases are as follows:
(Note: Lease payments are reported in THOUSANDS.)

Period	Capital	Operating	Total
Year 1	2,538	75,336	77,874
Year 2	2,538	77,113	79,651
Year 3	2,538	75,675	78,213
Year 4	2,538	75,198	77,736
Year 5	2,538	65,670	68,208
After 5 years	<u>43,263</u>	<u>340,499</u>	<u>383,762</u>
Total Lease Payments	55,953	709,491	765,444

NOTE 20. GROSS COST AND EARNED REVENUE BY BUDGET FUNCTIONAL CLASSIFICATION

Costs incurred by budget function are presented below with the respective earned revenue to derive Net Cost by Budget Function.

	Education, Training and Social Services	Health	Medicare	Income Security	Admin of Justice	Natural Resources and Env.	Combined
Intragovernmental Costs		1,420	70,782			15	72,217
With the Public	<u>13,172</u>	<u>137,951</u>	<u>205,129</u>	<u>23,304</u>	<u>179</u>	<u>60</u>	<u>379,795</u>
Gross Cost	13,172	139,371	275,911	23,304	179	75	452,012
Less: Earned Revenue	<u>(17)</u>	<u>(2,142)</u>	<u>(21,564)</u>		<u>(8)</u>		<u>(23,731)</u>
Total Net Cost	<u>13,155</u>	<u>137,229</u>	<u>254,347</u>	<u>23,304</u>	<u>171</u>	<u>75</u>	<u>428,281</u>

NOTE 21. PRIOR PERIOD ADJUSTMENTS

Prior period adjustments are included in the calculation of the net change in cumulative results of operations to correct errors and accounting changes with retroactive effect. The majority of the prior period adjustments noted in the table below result from some of the HHS FY 1998 OPDIV audits not being complete as of the date the FY 1998 HHS-wide Accountability report was published. This “timing difference” caused some of the OPDIV net position ending balances to differ from the ending balances reported in the HHS-wide statements. These prior period adjustments reconcile these differences.

Correction of Errors	(1,349)
Change in Accounting Principles	<u>(142)</u>
Total Prior Period Adjustments	<u>(1,491)</u>

NOTE 22. CUSTODIAL ACTIVITY

ACF receives monies from the Internal Revenue Service for outlay to the states for child support. These monies represent delinquent child support payments withheld from internal revenue tax refunds. During FY 1999, receipts amounts to \$1,325 million and outlays amounted to \$1,328 million. At September 30, 1999, ACF held \$3 million in its Fund Balance with Treasury accounts relating to these funds.

NOTE 23. MEDICARE BENEFIT PAYMENTS

Medicare Claims Estimated Improper Payments

Federal government audits require the review of programs for compliance with Federal laws and regulations. Accordingly, the OIG reviewed a statistically valid sample of Medicare claims to determine that claims were paid properly by Medicare contractors, and that services were actually performed and were medically necessary. Medicare, like other insurers, makes payments based on a standard claims form. The internal claims process involves reviewing claims as billed and paying the correct amount for the services rendered. The claims submitted for payment to Medicare contractors contained no visible errors. However, when the medical review asked for documentation from providers to support their claims, there was a 7.97 percent error rate with a dollar value in the range of \$9.1-17.9 billion (\$13.5 billion midpoint). This is a slight increase from 1998 error rate of 7.1 percent with a dollar value in the range of \$7.8 – 17.4 billion (\$12.6 billion midpoint). While this year’s estimate is bigger than last year’s, the OIG could not conclude that the current error rate is substantially different. The majority of the errors fell into four broad categories: lack of medical necessity, incorrect coding, insufficient or no documentation and noncovered/unallowable services.

Cost Report Settlement Process

The cost report settlement process represents the value of final outlays to providers based on fiscal intermediary audits, reviews and final settlements of Medicare cost reports. All institutional providers are required to file Medicare cost reports. For providers paid under the Prospective Payment System (PPS), the cost report includes costs that are not covered under PPS, such as disproportionate share, hospital payments, indirect medical education payments, and other indirect costs. For providers paid on a cost basis, the cost report represents the total costs incurred by the provider for medical services to patients and reflects the final distribution of these costs to the Medicare program.

In 1999, 34,791 cost reports totaling \$110.1 billion were reviewed. Approximately \$82 billion represented inpatient claims to PPS providers. The cost report settlements, therefore, focused on the remaining non-PPS balance of about \$28 billion.

1999 Cost Report Summary
(\$ in millions)

	Desk Reviews and Others		Audits	Total
Providers	28,045		6,746	34,791
Costs Claimed	\$ 41,271	\$ 68,858		\$ 110,129
Disallowed	\$ 1,084	\$ 1,632		\$ 2,716

The \$2.7 billion disallowed represents 10 percent of this \$28 billion non-PPS balance. Based on the current disallowance rates, if the full-scope audits were expanded to include the entire universe, the total amount disallowed would range from \$2.7 billion to \$3.3 billion. Therefore, by limiting the amount of full-scope audits that were conducted, HCFA may have overpaid providers by as much as \$600 million.

HCFA routinely processes and settles cost reports for institutional providers. As part of this process some providers have filed suits challenging aspects of the cost report settlement process. We cannot reasonably estimate the probability of the providers successfully winning their suits nor the potential liability for the Department. However, in the opinion of management the resolution of these matters will not have a material impact on the results of operations and financial condition of HHS.

NOTE 24. MEDICARE PREMIUMS COLLECTED AND FEDERAL MATCHING CONTRIBUTION

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The monthly SMI premium per beneficiary is \$43.80 from October 1998 through December 1998 and is \$45.50, beginning January 1999. Premiums collected from beneficiaries totaled \$20.2 billion in FY 1999 and were matched by a \$62.2 billion contribution from the Federal government.

Required Supplementary Stewardship Information:

Stewardship Property, Plant and Equipment
Stewardship Investments -
Investment in Human Capital
Investment in Research and Development

**U. S. Department of Health and Human Services
Stewardship Property, Plant, and Equipment
For Year Ended September 30, 1999**

HHS only has one division that has Stewardship assets. That division is the Indian Health Service (IHS). IHS has three types of assets for stewardship reporting: heritage, former Federal properties, and Indian Trust Lands.

Heritage assets are PP&E that are historically, architecturally, or culturally significant. This category includes buildings on the National Historic Register, cemetery sites, etc.

Former Federal Properties are sites, built with Federal funds, whose ownership has been transferred to State/local governments or Indian tribes through the Indian Self-Determination and Education Assistance Act, P.L. 93-638 105(f)(2), as amended.

Public Law (P.L.) 103-413, the Indian Health Care Reform Act of 1994, modified P.L. 93-638, the Indian Self-Determination Act, to allow the Indian Health Service to ‘...donate to an Indian tribe or tribal organization title to any personal or real property...’ section 105 (f) (2). Under this authority, the final regulations governing these transfers were developed and published on June 24, 1996, as 25 CFR Part 900.

Indian Trust lands are those lands that do not meet the definition of Stewardship land (i.e., land other than those acquired for or used in connection with general (capitalized) PP&E), but have always been held by IHS as separate and distinct, because of the Government’s long-term trust responsibility. All Trust lands, when no longer needed by IHS in connection with its general use PP&E, must be returned to the Department of the Interior’s Bureau of Indian Affairs, for continuing trust responsibility and oversight.

IHS asset accountability reports differentiate Indian Trust land parcels, by site and installation numbers and trust lands, from general PP&E situated thereon. The Indian Trust land balances have been removed from IHS FY 1999 Balance Sheet, and reported as Stewardship Assets - Indian Trust Lands.

IHS Stewardship Classes

<u>Asset Descriptions</u>	<u>Number of Sites</u>	<u>Total Square Footage</u>	<u>Federal Acreage</u>	<u>Total Acreage</u>
Heritage Assets	3	3,429	5.32	5.32
Former Federal Properties	2	142,850		
Indian Trust Lands	83		469	469

Distribution of Stewardship Assets by Type and Area

	Heritage Assets			Former Federal Buildings		Indian Trust Land	
	Number of Sites	Square Footage	Total Acreage	Number of Bldgs.	Square Footage	Number of Sites	Total Acreage
Aberdeen						9	74.7
Alaska	2	1,134	5.32				
Albuquerque						4	3.6
Bemidji						2	9.4
Billings						7	47.8
Navajo						34	256.1
Oklahoma City				2	142,850	2	9.9
Phoenix	1	2,295				15	53.3
Portland						5	1.8
Tucson						5	12
Total-IHS	<u>3</u>	<u>3,429</u>	<u>5.32</u>	<u>2</u>	<u>142,850</u>	<u>83</u>	<u>468.6</u>

See Required Supplementary Information for the reporting of the evaluation of deferred maintenance.

**U.S. Department of Health and Human Services
 Stewardship Investments
 Investment in Human Capital
 For the Year Ended September 30, 1999**

“Investments in Human Capital” are expenses incurred by Federal education and training programs for the public, which are intended to maintain or increase national productive capacity. Two operating divisions of the department conduct education and training programs under this category: ACF and NIH.

Administration for Children and Families (ACF)

ACF is unable to provide baseline data for two of its programs for FY 1999. Under both the Temporary Assistance for Needy Families (TANF) program and the Office of Refugee Resettlement (ORR), States have flexibility in how they spend their money. Under TANF, States are authorized in part to spend money on training and education that prepares people for work, as well as transitional services for training on-the-job. ORR grants are used by States to provide employment-related and social services to refugees. Under both TANF and ORR programs, each State decides how much it will spend on these and other activities. Since there is nothing in statute or regulation requiring States to report discretely how much they spend on training and education, ACF is unable to provide detailed information on these two programs at this time.

In contrast, the Administration on Developmental Disabilities (ADD) program within ACF is able to estimate their investment in human capital from existing data collection activities. Under ADD, 22 grants were awarded for Projects of National Significance (PNS). PNS grants are awarded to non-profit institutions to enhance the independence, productivity, integration, and inclusion of people with developmental disabilities into the community. Monies also support the development of national and state policy to serve this community.

National Institutes of Health (NIH)

The NIH Research Training and Career Development Program addresses the need for trained personnel to conduct medical research. The primary goal of the support that NIH provides for graduate training and career development is to produce new, highly trained investigators who are likely to perform research that will benefit the Nation’s health. Our ability to maintain the momentum of recent scientific progress and our international leadership in medical research depends upon the continued development of new, highly trained investigators.

	(in millions)	
<u>OPDIV/Program</u>	<u>1998</u>	<u>1999</u>
ACF		
TANF	N/A	N/A
ORR	N/A	N/A
ADD	\$ 1	\$6
NIH		
Research, Training & Career		
Development	660	821
<u>Total</u>	<u>\$661</u>	<u>\$827</u>

**U.S. Department of Health and Human Services
 Stewardship Investments
 Investment in Research and Development
 For the Year Ended September 30, 1999
 (in thousands)**

OPDIV	Basic	Applied	Developmental	Total 1999	Total 1998
ACF		\$ 18,790		\$ 18,790	\$ 12,730
AoA					30
AHCPR		97,100		97,100	139,510
CDC		433,307		433,307	400
FDA		16,595	\$ 2,097	18,692	53,360
HRSA		18,300		18,300	43,990
NIH	\$ 7,876,030	3,877,430	1,709,839	13,463,299	11,037,920
OS					14,400
SAMHSA					<u>1,540</u>
Total	<u>\$ 7,876,030</u>	<u>\$ 4,461,522</u>	<u>\$ 1,711,936</u>	<u>\$ 14,049,488</u>	<u>\$ 11,303,880</u>

Required Supplementary Information:

**Combining Statement of Budgetary Resources
Condensed Balance Sheet – Franchise and Intragovernmental
Support Revolving Funds
Condensed Statement of Net Cost – Franchise and
Intragovernmental Support Revolving Funds
Deferred Maintenance
Intragovernmental Transactions - Assets
Intragovernmental Transactions - Liabilities**

**U.S. Department of Health and Human Services
 Combining Statement of Budgetary Resources
 For the year ended September 30, 1999
 (in millions)**

	HCFA			Other Budgetary Accounts ¹	Combined Total
	Medicare HI	Medicaid	Medicare SMI		
Budgetary Resources:					
Budget authority	\$ 152,333	\$ 102,394	\$ 85,278	\$ 144,684	\$ 484,689
Unobligated balances – beginning of period	116,762	6,012	40,875	12,888	176,537
Spending authority from offsetting collections		60		4,878	4,938
Adjustments	<u>(138,222)</u>	<u>3,792</u>	<u>(45,615)</u>	<u>(2,476)</u>	<u>(182,521)</u>
Total Budgetary Resources	<u>\$ 130,873</u>	<u>\$ 112,258</u>	<u>\$ 80,538</u>	<u>\$ 159,974</u>	<u>\$ 483,643</u>
Status of Budgetary Resources:					
Obligations incurred	\$ 130,873	\$ 111,141	\$ 80,538	\$ 148,197	\$ 470,749
Unobligated balances - available		1,117		4,474	5,591
Unobligated balances - not available	<u>-</u>	<u>-</u>	<u>-</u>	<u>7,303</u>	<u>7,303</u>
Total Status of Budgetary Resources	<u>\$ 130,873</u>	<u>\$ 112,258</u>	<u>\$ 80,538</u>	<u>\$ 159,974</u>	<u>\$ 483,643</u>
Outlays:					
Obligations incurred	\$ 130,873	\$ 111,141	\$ 80,538	\$ 148,197	\$ 470,749
Less: spending authority from offsetting collections and adjustments		(3,852)		(5,945)	(9,797)
Obligated balance, net – beginning of period	352	5,504	14	41,645	47,515
Obligated balance transferred, net				(110)	(110)
Less: obligated balance, net – end of period	<u>(465)</u>	<u>(4,751)</u>	<u>(34)</u>	<u>(51,344)</u>	<u>(56,594)</u>
Total Outlays	<u>\$ 130,760</u>	<u>\$ 108,042</u>	<u>\$ 80,518</u>	<u>\$ 132,443</u>	<u>\$ 451,763</u>

¹ "Other Budgetary Accounts" includes the major budgetary accounts of the eleven HHS OPDIVs other than HCFA, as well as the remaining budgetary accounts not reported by HCFA under Medicare and Medicaid. Information on the major budgetary accounts for individual OPDIVs can be found in each OPDIV's own annual report. OPDIVs reports can be accessed via the Department of Health and Human Services website at: www.hhs.gov.

U.S. Department of Health and Human Services
Condensed Balance Sheet
Franchise and Intragovernmental Support Revolving Funds
For the year ended September 30, 1999
(in millions)

	HHS Service and Supply Fund	NIH Service and Supply Fund	HRSA FOH	FDA Certification Fund	Combined Total
Assets					
Fund Balance with Treasury	\$ (50)	\$ 4	\$ 6	\$ 4	\$ (36)
Accounts Receivable, Net	139	11	31		181
Property, Plant and Equipment, Net	7	11		1	19
Other Assets	<u>21</u>	<u>18</u>	<u>-</u>	<u>-</u>	<u>39</u>
Total Assets	<u>\$ 117</u>	<u>\$ 44</u>	<u>\$ 37</u>	<u>\$ 5</u>	<u>\$ 203</u>
Liabilities					
Accounts Payable	\$ 24	\$ 26	\$ 13	\$ -	\$ 63
Other Liabilities	<u>13</u>	<u>9</u>	<u>3</u>	<u>1</u>	<u>26</u>
Total Liabilities	37	35	16	1	89
Net Position					
Cumulative Results of Operations	<u>80</u>	<u>9</u>	<u>21</u>	<u>4</u>	<u>114</u>
Total Liabilities and Net Position	<u>\$ 117</u>	<u>\$ 44</u>	<u>\$ 37</u>	<u>\$ 5</u>	<u>\$ 203</u>

U.S. Department of Health and Human Services
Condensed Statement of Net Cost
Franchise and Intragovernmental Support Revolving Funds
For the year ended September 30, 1999
(in millions)

Program/Business Line	Gross Costs	Less: Earned Revenue	Net Costs
HHS Service & Supply Fund			
Administrative Operations Services	\$ 203	\$ (205)	\$ (2)
Financial Management Services	47	(49)	(2)
Human Resources Services	<u>48</u>	<u>(41)</u>	<u>7</u>
Total	<u>\$ 298</u>	<u>\$ (295)</u>	<u>\$ 3</u>
NIH Service & Supply Fund			
Administrative Services	\$ 146	\$ (143)	\$ 3
Information Technology	73	(73)	-
Instrumentation Services	10	(11)	(1)
Animal Services	<u>23</u>	<u>(22)</u>	<u>1</u>
Total	<u>\$ 252</u>	<u>\$ (249)</u>	<u>\$ 3</u>
HRSA FOH			
Clinical Occupational Health	\$ 41	\$ (42)	\$ (1)
Environmental Health	11	(12)	(1)
Employee Assistance	<u>33</u>	<u>(34)</u>	<u>(1)</u>
Total	<u>\$ 85</u>	<u>\$ (88)</u>	<u>\$ (3)</u>
FDA Certification Fund			
Foods	<u>\$ 7</u>	<u>\$ (4)</u>	<u>\$ 3</u>
Grand Total - HHS Revolving Funds	<u>\$ 642</u>	<u>\$ (636)</u>	<u>\$ 6</u>

**U.S. Department of Health and Human Services
Deferred Maintenance
For the Year Ending September 30, 1999**

Category of Asset	Condition	Cost to Return to Acceptable Condition (in millions)
General PP & E		
Land	1	
Building	3-5	642.2
Other Structures	4	2.8
Equipment	2	18.0
Total		663.0

Asset condition is assessed on a scale of 1-5 as follows:

Excellent = 1 Good = 2 Fair = 3 Poor = 4 Very Poor = 5

A "Fair" or "3" rating is considered acceptable operating condition. Although PP&E categories may be rated as acceptable, individual assets within a category may require maintenance work to return them to acceptable operating condition. Therefore, assets categories with an overall rating of "Fair" or above may still report necessary costs to return to acceptable condition.

U.S. Department of Health and Human Services
Intragovernmental Transactions - Assets
For Year Ended September 30, 1999
(in millions)

<u>Agency</u>	<u>TFM Dept Code</u>	<u>Fund Bal. w/ Treasury</u>	<u>Investments</u>	<u>Accounts Receivable</u>	<u>Other</u>
Dept of Agriculture	12		\$ -	\$ 2	\$ -
Dept of Commerce	13		-	-	1
Dept of Defense	17, 21, 57, 97		-	40	-
Dept of Education	91		-	6	-
Dept of Energy	89		-	7	-
Dept of HUD	86		-	-	-
Dept of HHS	75		-	548	147
Dept of the Interior	14		-	1	-
Dept of Justice	15		-	16	-
Dept of Labor	16		-	2	-
Dept of State	19		-	7	-
Dept of Transportation	69		-	-	-
Dept of the Treasury	20	\$ 73,204	184,764	6,050	-
Dept of Veterans Affairs	36		-	55	6
Agency for International Dev	72		-	46	-
Environ Protection Agency	68		-	67	-
Fed Emergency Mgmt Agency	58		-	14	-
Small Business Admin	73		-	-	-
General Services Admin	47		-	19	20
National Aeronautics & Space Admin	80		-	1	-
National Science Foundation	49		-	-	-
Nuclear Regulatory Commission	31		-	-	-
Office of Personnel Mgmt	24		-	-	-
Social Security Admin	28		-	10	-
All other Federal agencies			-	155	56
Total		<u>\$ 73,204</u>	<u>\$ 184,764</u>	<u>\$ 7,046</u>	<u>\$ 230</u>

U.S. Department of Health and Human Services
Intragovernmental Transactions - Liabilities
For Year Ended September 30, 1999
(in millions)

Agency	TFM Dept Code	Accounts Payable	Environmental & Disposal Costs	Debt	Other
Dept of Agriculture	12	\$ -	\$ -	\$ -	\$ -
Dept of Commerce	13	-	-	-	-
Dept of Defense	17, 21, 57, 97	9	-	-	-
Dept of Education	91	-	3	-	-
Dept of Energy	89	-	-	-	5
Dept of HUD	86	-	-	-	-
Dept of HHS	75	481	-	-	110
Dept of the Interior	14	4	-	-	-
Dept of Justice	15	-	-	-	20
Dept of Labor	16	5	-	-	2
Dept of State	19	-	-	-	-
Dept of Transportation	69	-	-	-	-
Dept of the Treasury	20	2,867	-	-	230
Dept of Veterans Affairs	36	-	-	-	-
Agency for International Dev	72	-	-	-	-
Environ Protection Agency	68	-	-	-	4
Fed Emergency Mgmt Agency	58	-	-	-	13
Small Business Admin	73	-	-	-	-
General Services Admin	47	35	-	-	24
National Aeronautics & Space Admin	80	12	-	-	-
National Science Foundation	49	-	-	-	-
Nuclear Regulatory Commission	31	-	-	-	-
Office of Personnel Mgmt	24	-	-	-	10
Social Security Admin	28	-	-	-	1
All other Federal agencies		46	-	-	76
Total		<u>\$ 3,459</u>	<u>\$ 3</u>	<u>\$ -</u>	<u>\$ 495</u>

Other Accompanying Information:

Consolidating Balance Sheet by Budget Function

Consolidating Balance Sheet by Operating Division

Consolidating Statement of Net Cost by Budget Function

**Consolidating Statement of Changes in Net Position by
Budget Function**

Public and Intragovernmental Net Costs

**U.S. Department of Health and Human Services
 Consolidating Balance Sheet by Budget Function
 September 30, 1999
 (in millions)**

	Education, Training and Social Services	Health	Medicare	Income Security	Admin. of Justice	Natural Resources & Environ	Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Assets									
Entity Assets:									
Intragovernmental									
Fund Balance with Treasury	\$ 9,213	\$ 38,278	\$ 3,839	\$ 21,635	\$ 185	\$ 10	\$ 73,160	\$ -	\$ 73,160
Investments, Net	-	1,466	183,298	-	-	-	184,764	-	184,764
Accounts Receivable, Net	3	6,390	590	-	-	61	7,044	(421)	6,623
Other	-	230	-	-	-	-	230	(146)	84
Total Intragovernmental	9,216	46,364	187,727	21,635	185	71	265,198	(567)	264,631
Accounts Receivable, Net	-	115	4,223	-	-	-	4,338	-	4,338
Loans Receivable, Net	-	401	-	-	-	-	401	-	401
Advances with the Public	-	133	70	-	-	2	205	-	205
Cash and Other Monetary Assets	-	-	56	-	-	-	56	-	56
Inventory and Related Property, Net	-	75	-	-	-	-	75	-	75
General Property, Plant & Equipment, Net	-	1,802	19	-	-	1	1,822	-	1,822
Other	-	-	-	-	-	-	-	-	-
Total Entity	9,216	48,890	192,095	21,635	185	74	272,095	(567)	271,528
Non-Entity Assets:									
Intragovernmental									
Fund Balance with Treasury	-	41	-	3	-	-	44	-	44
Accounts Receivable, Net	-	2	-	-	-	-	2	-	2
Total Intragovernmental	-	43	-	3	-	-	46	-	46
Accounts Receivable, Net	-	60	-	-	-	-	60	-	60
Total Non-Entity	-	103	-	3	-	-	106	-	106
Total Assets	\$ 9,216	\$ 48,993	\$ 192,095	\$ 21,638	\$ 185	\$ 74	\$ 272,201	\$ (567)	\$ 271,634
Liabilities									
Liabilities Covered by Budgetary Resources									
Intragovernmental									
Accounts Payable	\$ (2)	\$ 228	\$ 355	\$ (5)	\$ 16	\$ -	\$ 592	\$ (567)	\$ 25
Employment Tax Revenue Adjustment	-	-	2,867	-	-	-	2,867	-	2,867
Environmental and Disposal Costs	-	1	-	-	-	-	1	-	1
Other	1	309	166	-	-	-	476	-	476
Total Intragovernmental	(1)	538	3,388	(5)	16	-	3,936	(567)	3,369
Accounts Payable	13	498	-	4	3	4	522	-	522
Entitlement Benefits Payable	-	11,626	23,676	-	-	-	35,302	-	35,302
Accrued Grants	(204)	770	-	922	30	-	1,518	-	1,518
Loan Guarantees	-	333	-	-	-	-	333	-	333
Other	6	767	195	-	-	1	969	-	969
Total Liabilities Covered by Budgetary Resources	(186)	14,532	27,259	921	49	5	42,580	(567)	42,013
Liabilities Not Covered by Budgetary Resources									
Intragovernmental									
Environmental and Disposal Costs	-	2	-	-	-	-	2	-	2
Other	-	19	-	-	-	-	19	-	19
Total Intragovernmental	-	21	-	-	-	-	21	-	21
Environmental and Disposal Costs	-	12	-	-	-	-	12	-	12
Federal Employee and Veterans Benefits	3	4,936	-	-	-	1	4,940	-	4,940
Other	12	373	31	3	-	2	421	-	421
Total Liabilities Not Covered by Budgetary Resources	15	5,342	31	3	-	3	5,394	-	5,394
Total Liabilities	\$ (171)	\$ 19,874	\$ 27,290	\$ 924	\$ 49	\$ 8	\$ 47,974	\$ (567)	\$ 47,407
Net Position									
Unexpended Appropriations	\$ 9,379	\$ 30,595	\$ 34	\$ 20,669	\$ 217	\$ 68	\$ 60,962	\$ -	\$ 60,962
Cumulative Results of Operations	8	(1,476)	164,771	45	(81)	(2)	163,265	-	163,265
Total Net Position	\$ 9,387	\$ 29,119	\$ 164,805	\$ 20,714	\$ 136	\$ 66	\$ 224,227	\$ -	\$ 224,227
Total Liabilities & Net Position	\$ 9,216	\$ 48,993	\$ 192,095	\$ 21,638	\$ 185	\$ 74	\$ 272,201	\$ (567)	\$ 271,634

In addition to this schedule, more detailed information on individual operating divisions (OPDIVs) can be found in the OPDIVs' audited financial statement. OPDIV financial statements can be accessed on the Internet at: www.hhs.gov

**U.S. Department of Health and Human Services
 Consolidating Balance Sheet by Operating Division
 September 30, 1999
 (in millions)**

	ACF	AoA	AHCPR	CDC	FDA	HCFA	HRSA	IHS	NIH	OS	PSC	SAMHSA	Combined Totals	Intra-HHS Eliminations	Consolidated Totals
Assets															
Entity Assets:															
Intragovernmental															
Fund Balance with Treasury	\$ 30,728	\$ 264	\$ 162	\$ 2,307	\$ 432	\$ 17,768	\$ 3,674	\$ 1,121	\$ 14,225	\$ 603	\$ -	\$ 1,876	\$ 73,160	\$ -	\$ 73,160
Investments, Net	-	-	-	-	-	183,298	1,454	-	12	-	-	-	184,764	-	184,764
Accounts Receivable, Net	-	3	4	90	13	6,325	32	154	140	150	130	3	7,044	(421)	6,623
Other	-	-	-	8	18	60	6	-	138	-	-	-	230	(146)	84
Total Intragovernmental	30,728	267	166	2,405	463	207,451	5,166	1,275	14,515	753	130	1,879	265,198	(567)	264,631
Accounts Receivable, Net	-	-	6	7	9	4,249	-	35	18	2	9	3	4,338	-	4,338
Loans Receivable, Net	-	-	-	-	-	-	401	-	-	-	-	-	401	-	401
Advances with the Public	-	-	2	47	-	129	-	23	4	-	-	-	205	-	205
Cash and Other Monetary Assets	-	-	-	-	-	56	-	-	-	-	-	-	56	-	56
Inventory and Related Property, Net	-	-	-	27	-	-	-	13	14	-	21	-	75	-	75
General Property, Plant & Equipment, Net	-	-	-	157	178	20	-	643	814	1	7	2	1,822	-	1,822
Total Entity	30,728	267	174	2,643	650	211,905	5,567	1,989	15,365	756	167	1,884	272,095	(567)	271,528
Non-Entity Assets:															
Intragovernmental															
Fund Balance with Treasury	3	-	(2)	-	-	-	15	18	1	9	-	-	44	-	44
Accounts Receivable, Net	-	-	-	-	-	-	-	-	2	-	-	-	2	-	2
Total Intragovernmental	3	-	(2)	-	-	-	15	18	3	9	-	-	46	-	46
Accounts Receivable, Net	-	-	-	-	-	60	-	-	-	-	-	-	60	-	60
Total Non-Entity	3	-	(2)	-	-	60	15	18	3	9	-	-	106	-	106
Total Assets	\$ 30,731	\$ 267	\$ 172	\$ 2,643	\$ 650	\$ 211,965	\$ 5,582	\$ 2,007	\$ 15,368	\$ 765	\$ 167	\$ 1,884	\$ 272,201	\$ (567)	\$ 271,634
Liabilities															
Liabilities Covered by Budgetary Resources															
Intragovernmental															
Accounts Payable	\$ 8	\$ 1	\$ 2	\$ 8	\$ 17	\$ 355	\$ 16	\$ 2	\$ 138	\$ 17	\$ 23	\$ 5	\$ 592	\$ (567)	\$ 25
Employment Tax Revenue Adjustment	-	-	-	-	-	2,867	-	-	-	-	-	-	2,867	-	2,867
Environmental and Disposal Costs	-	-	-	-	1	-	-	-	-	-	-	-	1	-	1
Other	1	-	74	47	1	237	3	61	(10)	28	34	34	476	-	476
Total Intragovernmental	9	1	76	55	19	3,459	19	63	138	7	51	39	3,936	(567)	3,369
Accounts Payable	17	-	6	88	26	-	36	64	257	14	-	14	522	-	522
Entitlement Benefits Payable	-	-	-	-	-	35,302	-	-	-	-	-	-	35,302	-	35,302
Accrued Grants	703	31	-	15	-	-	174	-	511	11	-	73	1,518	-	1,518
Loan Guarantees	-	-	-	-	-	-	333	-	-	-	-	-	333	-	333
Other	5	-	1	34	39	209	428	46	138	45	22	2	969	-	969
Total Liabilities Covered by Budgetary Resources	734	32	83	192	84	38,970	990	173	1,044	77	73	128	42,580	(567)	42,013
Liabilities Not Covered by Budgetary Resources															
Intragovernmental															
Environmental and Disposal Costs	-	-	-	-	2	-	-	-	-	-	-	-	2	-	2
Other	-	-	(2)	21	-	-	-	-	-	-	-	-	19	-	19
Total Intragovernmental	-	-	(2)	21	2	-	-	-	-	-	-	-	21	-	21
Environmental and Disposal Costs	-	-	-	-	3	-	-	-	9	-	-	-	12	-	12
Federal Employee and Veterans Benefits	3	-	-	11	18	-	23	48	-	14	4,805	18	4,940	-	4,940
Other	14	1	2	37	50	33	17	88	145	32	(3)	5	421	-	421
Total Liabilities Not Covered by Budgetary Resources	17	1	-	69	73	33	40	136	154	46	4,802	23	5,394	-	5,394
Total Liabilities	\$ 751	\$ 33	\$ 83	\$ 261	\$ 157	\$ 39,003	\$ 1,030	\$ 309	\$ 1,198	\$ 123	\$ 4,875	\$ 151	\$ 47,974	\$ (567)	\$ 47,407
Net Position															
Unexpended Appropriations	\$ 30,007	\$ 235	\$ 77	\$ 2,264	\$ 300	\$ 8,082	\$ 3,113	\$ 1,157	\$ 13,348	\$ 622	\$ 15	\$ 1,742	\$ 60,962	\$ -	\$ 60,962
Cumulative Results of Operations	(27)	(1)	12	118	193	164,880	1,439	541	822	20	(4,723)	(9)	163,265	-	163,265
Total Net Position	\$ 29,980	\$ 234	\$ 89	\$ 2,382	\$ 493	\$ 172,962	\$ 4,552	\$ 1,698	\$ 14,170	\$ 642	\$ (4,708)	\$ 1,733	\$ 224,227	\$ -	\$ 224,227
Total Liabilities & Net Position	\$ 30,731	\$ 267	\$ 172	\$ 2,643	\$ 650	\$ 211,965	\$ 5,582	\$ 2,007	\$ 15,368	\$ 765	\$ 167	\$ 1,884	\$ 272,201	\$ (567)	\$ 271,634

In addition to this schedule, more detailed information on individual operating divisions (OPDIVs) can be found in the OPDIVs' audited financial statement. OPDIV financial statements can be accessed on the Internet at: www.hhs.gov

U.S. Department of Health and Human Services
Consolidating Statement of Net Cost By Budget Function
For the Year Ended September 30, 1999
(in millions)

Operating Division:	Education,					Natural	Combined	Intra-HHS Eliminations		Consolidated
	Training, & Social Services	Health	Medicare	Income Security	Admin of Justice	Resources & Environment		Cost (-)	Revenue	
ACF	\$ 12,231	-	-	\$ 23,304	\$ 109	-	\$ 35,644	\$ (47)	\$ 17	\$ 35,614
AoA	924	-	-	-	-	-	924	(1)	-	923
AHCPR	-	100	-	-	-	-	100	(6)	80	174
CDC	-	2,394	-	-	62	75	2,531	(42)	80	2,569
FDA	-	1,008	-	-	-	-	1,008	(49)	16	975
HCFA	-	109,551	254,347	-	-	-	363,898	(69,892)	-	294,006
HRSA	-	4,114	-	-	-	-	4,114	(72)	27	4,069
IHS	-	2,192	-	-	-	-	2,192	(50)	37	2,179
NIH	-	14,602	-	-	-	-	14,602	(1,182)	1,014	14,434
OS	-	408	-	-	-	-	408	(39)	121	490
PSC	-	570	-	-	-	-	570	(24)	171	717
SAMHSA	-	2,290	-	-	-	-	2,290	(17)	12	2,285
Net Cost of Operations	\$ 13,155	\$ 137,229	\$ 254,347	\$ 23,304	\$ 171	\$ 75	\$ 428,281	\$ (71,421)	\$ 1,575	\$ 358,435

The accompanying notes are an integral part of these statements. In addition, detailed information on individual GPRA programs and other activities for the individual operating divisions (OPDIVs) can be found in the OPDIVs' audited financial statement. OPDIV financial statements can be accessed on the Internet at: www.hhs.gov

U.S. Department of Health and Human Services
Consolidating Statement of Changes in Net Position by Budget Function
For the year ended September 30, 1999
(in millions)

	Education, Training and Social Services	Health	Medicare	Income Security	Admin. of Justice	Natural Resources & Environment	Combined Totals	Eliminations (Non-exchange Revenues)
Net Cost of Operations	\$ 13,155	\$ 137,229	\$ 254,347	\$ 23,304	\$ 171	\$ 75	\$ 428,281	\$ (69,846)
Financing Sources (other than exchange revenues):								
Appropriations Used	13,124	137,152	69,846	23,348	100	71	243,641	
Taxes (and other non-exchange revenue)	-	-	206,348	-	-	-	206,348	(62,480)
Donations (non-exchange revenue)	-	211	-	-	-	-	211	
Imputed Financing	10	269	-	-	-	2	281	
Transfers-in	-	139	1,680	-	-	-	1,819	
Transfers-out	-	(9)	(1,809)	-	-	-	(1,818)	
Other Financing Sources	-	49	8,032	-	-	-	8,081	(7,366)
Net Results of Operations	(21)	582	29,750	44	(71)	(2)	30,282	-
Prior Period Adjustments	1	(1,492)	-	-	-	-	(1,491)	-
Net Change in Cumulative Results of Operations	(20)	(910)	29,750	44	(71)	(2)	28,791	-
Increase (Decrease) in Unexpended Appropriations	513	4,778	(758)	2,671	41	4	7,249	-
Change in Net Position	493	3,868	28,992	2,715	(30)	2	36,040	-
Net Position-Beginning of Period	8,894	25,251	135,813	17,999	166	64	188,187	-
Net Position-End of Period	\$ 9,387	\$ 29,119	\$ 164,805	\$ 20,714	\$ 136	\$ 66	\$ 224,227	\$ -

**U.S. Department of Health and Human Service
Public and Intragovernmental Net Costs
For the year ended September 30, 1999
(in millions)**

Operating Division	Intra - Governmental	With the Public	Gross Costs	Less: Earned Revenue	Combined Net Cost of Operations
ACF	\$	\$ 35,669	\$ 35,669	\$ (25)	\$ 35,644
AoA		925	925	(1)	924
AHCPR		164	164	(64)	100
CDC	320	2,362	2,682	(151)	2,531
FDA	275	893	1,168	(160)	1,008
HCFA	70,825	314,776	385,601	(21,703)	363,898
HRSA		4,457	4,457	(343)	4,114
IHS		2,783	2,783	(591)	2,192
NIH	258	14,586	14,844	(242)	14,602
OS	540		540	(132)	408
PSC		865	865	(295)	570
SAMHSA	<u>-</u>	<u>2,314</u>	<u>2,314</u>	<u>(24)</u>	<u>2,290</u>
Total Public and Intragovernmental Costs	<u>\$ 72,218</u>	<u>\$ 379,794</u>	<u>\$ 452,012</u>	<u>\$ (23,731)</u>	<u>\$ 428,281</u>

SECTION V:

**INDEPENDENT AUDITORS' REPORT
ON DEPARTMENT'S FINANCIAL STATEMENTS
AND MANAGEMENT RESPONSE TO THE AUDIT**



FEB 29 2000

To: The Secretary
Through: DS _____
COS _____
ES _____

From: Inspector General

Subject: Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 1999 (CIN: A-17-99-00002)

PURPOSE

Our purpose is to provide you with our audit report on the Department's Consolidated/Combined Financial Statements for Fiscal Year (FY) 1999. This audit is required by the Government Management Reform Act of 1994.

The attached report reiterates several problems reported at the Health Care Financing Administration (HCFA) and highlights systemic problems noted during eight other operating divisions' financial statement audits.

Following is a summary of the major issues discussed in the Departmentwide audit report.

INFORMATION TEXT

In our opinion, the Department of Health and Human Services (HHS) FY 1999 financial statements present fairly, in all material respects, the HHS financial position at September 30, 1999; the consolidated net costs and changes in net position; and the combined budgetary resources and financing for the year then ended in accordance with generally accepted accounting principles.

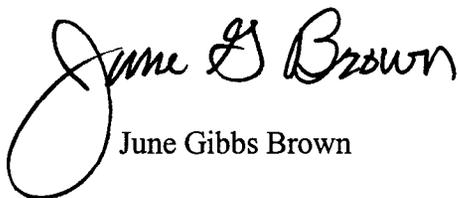
As discussed in our report on internal controls, financial systems and reporting continue to be a problem. Although improved from FY 1998, draft financial statements and notes for all divisions, as well as the Departmentwide statements, were again provided late in the audit process. In some instances, adjustments to operating division financial statements were still being made in February 2000, 5 months after the fiscal year ended. We again report HHS' need for a fully functioning, integrated financial system. We also once again point out the need to conduct periodic reconciliations and account analyses throughout the year.

Our report on internal controls notes two other internal control weaknesses that we consider to be material under standards established by the American Institute of Certified Public Accountants and Office of Management and Budget Bulletin 98-08, as amended.

1. Significant improvements are still needed in Medicare contractors' development, collection, and reporting of receivable activity.
2. The HCFA central office and HCFA contractors continue to have material internal control weaknesses in electronic data processing controls relating to security access and application development and change controls.

Material weaknesses are those problems that are systemic across a number of operating divisions, as well as significant dollar issues affecting only one division. These weaknesses are synopsized in this report and are fully described in the individual financial statement audit reports which we released separately.

We are grateful for the cooperation the Department has extended to us in performing this audit. If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.



June Gibbs Brown

Attachment

cc:

John J. Callahan
Assistant Secretary
for Management and Budget

George H. Strader
Deputy Assistant Secretary, Finance

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REPORT ON THE FINANCIAL STATEMENT
AUDIT OF THE DEPARTMENT OF
HEALTH AND HUMAN SERVICES
FOR FISCAL YEAR 1999**



**JUNE GIBBS BROWN
Inspector General**

**FEBRUARY 2000
A-17-99-00002**

Office of Inspector General

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions and HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

INDEPENDENT AUDITOR'S REPORT

INSPECTOR GENERAL'S REPORT ON THE DEPARTMENT OF HEALTH AND HUMAN SERVICES CONSOLIDATED/COMBINED FINANCIAL STATEMENTS FOR FISCAL YEAR 1999

To: The Secretary of Health
and Human Services

We have audited the accompanying consolidated balance sheet of the Department of Health and Human Services (HHS) as of September 30, 1999; the related consolidated statements of net cost and changes in net position; and the combined statements of budgetary resources and financing (principal financial statements) for the fiscal year (FY) then ended. These financial statements are the responsibility of HHS management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards; *Government Auditing Standards* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 98-08, *Audit Requirements for Federal Financial Statements*, as amended. These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the principal financial statements referred to above present fairly, in all material respects, the financial position of HHS at September 30, 1999; the consolidated net costs and changes in net position; and the combined budgetary resources and financing for the year then ended in accordance with generally accepted accounting principles.

Our audit was conducted for the purpose of forming an opinion on the principal financial statements referred to in the first paragraph. The information presented in the overview of HHS and the supplemental information of HHS is not a required part of the principal financial statements but is supplementary information required by OMB Bulletin 97-01, *Form and Content of Agency Financial Statements*. Such information, including trust fund projections, has not been subjected to the auditing procedures applied in the audit of the principal financial statements; accordingly, we express no opinion on it.

REPORT ON INTERNAL CONTROLS

We conducted our audit in accordance with generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 98-08, *Audit Requirements for Federal Financial Statements*, as amended.

In planning and performing our audit, we considered the HHS internal controls over financial reporting by obtaining an understanding of internal controls, determining whether these controls had been placed in operation, assessing control risk, and performing tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin 98-08, as amended. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982, such as those controls relevant to ensuring efficient operations. The objective of our audit was not to provide assurance on internal control. Consequently, we do not provide an opinion on internal control.

The HHS management is responsible for establishing and maintaining internal controls. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs of internal control policies and procedures. The objectives of internal controls are to provide management with reasonable, but not absolute, assurance that (1) assets are safeguarded against loss from unauthorized use or disposition, (2) transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in accordance with generally accepted accounting principles, and (3) data that support reported performance measures are properly recorded and accounted for to permit preparation of reliable and complete performance information.

Our consideration of internal controls over financial reporting would not necessarily disclose all matters in these controls that might be reportable conditions. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of internal controls that, in our judgment, could adversely affect the HHS ability to record, process, summarize, and report financial data consistent with the assertions by management in the financial statements. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts material to the financial statements may occur and not be detected within a timely period by employees in the normal course of performing their duties. Because of inherent limitations in internal controls, misstatements, losses, or noncompliance may nevertheless occur and not be detected. Also, projections of any evaluation of internal controls

may become inadequate because of changes in conditions, or the degree of compliance with policies or procedures may deteriorate. However, we noted certain matters discussed below involving internal controls and their operation that we consider to be reportable conditions and material weaknesses.

In addition, we considered the HHS internal controls over Required Supplementary Stewardship Information by obtaining an understanding of the internal controls, determining whether the controls had been placed in operation, assessing control risk, and performing tests of controls as required by OMB Bulletin 98-08, as amended. Our procedures were not intended to provide assurance on these controls; accordingly, we do not provide an opinion on them.

Finally, with respect to internal controls related to performance measures reported in the *FY 1999 HHS Accountability Report*, we obtained an understanding of the design of significant internal controls related to the existence and completeness assertions, as required by OMB Bulletin 98-08, as amended. Our procedures were not designed to provide assurance on performance measure controls, and we do not provide an opinion on them.

Using the criteria and standards established by the American Institute of Certified Public Accountants and OMB Bulletin 98-08, as amended, we identified three internal control weaknesses that we consider to be material and four reportable conditions, as follows:

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MATERIAL WEAKNESSES

1. Financial Systems and Reporting (Repeat Condition)

Since passage of the Chief Financial Officers Act, as amended by the Government Management Reform Act of 1994, agencies have prepared financial statements for audit by the Inspectors General. The act emphasized production of reliable financial statements; consequently, HHS worked diligently to prepare statements capable of receiving an unqualified audit opinion. With this year's audit, HHS has achieved the important milestone of an unqualified, or "clean," opinion.

A clean audit opinion, however, assures financial statement users only that the information is reliable and fairly presented. It provides no assurance about the effectiveness and efficiency of financial systems used to prepare the statements and to produce other information for management use. Two key directives address Federal agency requirements concerning these systems. The OMB Circular A-123, *Management Accountability and Control*, specifies the management control standards agencies must follow. Among the standards is the requirement that transactions be promptly recorded, properly classified, and correctly accounted for to prepare timely accounts and reliable financial and other reports. The OMB Circular A-127, *Financial Management Systems*, specifies the system requirements agencies must follow to meet management control standards. The term "system" includes manual processes, such as reconciliations and analyses, and automated processes.

In our opinion, the Department still has serious problems with controls over financial systems and reporting. The process used to prepare financial statements required numerous manual account adjustments before reliable, accurate statements were produced. This process caused delays in preparing the statements, increased the risk of material misstatements, and limited the resources available for financial analyses. Because the operating divisions did not conduct such analyses and account reconciliations throughout the year, management had little assurance of detecting accounting aberrations and obtaining reliable financial information.

The extent and magnitude of account adjustments required at yearend demonstrate that the systems in place during FY 1999 were not operating efficiently or effectively. The need for these manual adjustments increased resource requirements.

However, even with additional resources, many operating divisions were not able to produce auditable information until 5 months after the fiscal year ended. For example:

The financial statement preparation process required many yearend manual adjustments, which caused delays and increased the risk of material errors.

- ❑ **Health Care Financing Administration (HCFA).** The Department's largest operating division with \$299 billion in net outlays, HCFA issued the first FY 1999 financial statements in mid-December 1999 and then made billions of dollars in adjustments to payables and receivables before producing final, auditable financial statements in late January 2000. Oversight by the HCFA central and regional offices was not adequate to provide reasonable assurance of promptly detecting material errors in Medicare contractor financial data.

- ❑ **Administration for Children and Families (ACF).** The ACF, the second largest operating division with net budget outlays of about \$34 billion, made billions of dollars in adjustments to current and prior-year accounts before preparing a complete set of reliable financial statements in January 2000. Although some adjustments related to those used to prepare the FY 1998 financial statements, they had not been posted to the general ledger as of September 30, 1999. The volume of these adjustments and the time it took to prepare the statements indicate that the level of analysis was insufficient to meet current OMB reporting requirements. Had the adjustments not been made, the condition of the financial statements, particularly the statement of budgetary resources, the statement of financing, and the statement of changes in net position, would have precluded expression of an audit opinion. Details follow:
 - The ACF's budgetary accounts needed numerous adjustments totaling over \$100 billion because thousands of transactions had been incorrectly recorded and accounts had not been analyzed for several years to correct such errors. Accumulated errors in the account balances therefore required one-time "catch up" adjustments. In addition, certain amounts shown on the first draft of the statement of budgetary resources changed by over \$500 million from the amounts on the final statement.

 - The ACF did not reconcile its net position accounts with operating and budgetary activity in its general ledger during the year. As a result, ACF was again unable to provide complete details or an analysis of the composition of the net position balance at September 30, 1999. Problems in reconciling net position accounts arose because a significant number of adjustments were recorded only during the financial statement preparation process. Those made while preparing the financial statements had an absolute value of over \$8 billion, were made outside the general ledger, and included entries related to prior-year activity. We also noted that \$87 million of net position activity during the year was initially reflected as a prior-period adjustment but in fact related to unexpended appropriation activity.

- ❑ **National Institutes of Health (NIH).** The NIH, with net outlays of \$14 billion, made hundreds of adjustments totaling over \$7 billion to current and prior-year accounts before preparing a reliable set of financial statements. While these entries were normal yearend account closing adjustments, many were identified or recorded as late as January or early February 2000. For example, from December 1999 to January 2000, NIH reclassified asset account credit balances of \$629 million as liabilities. In addition, auditors identified unrecorded grant expenses of \$84 million. Numerous other entries totaling \$350 million — some error corrections and others forced adjustments — were made as late as February 2000.

- ❑ **Substance Abuse and Mental Health Services Administration (SAMHSA).** The SAMHSA, with net budget outlays of about \$2 billion, made over 50 adjustments aggregating over \$8 billion before completing its financial statements in February 2000. Many of the adjustments related to errors in prior-year budgetary account balances that had accumulated in the accounting system over time and remained unadjusted (i.e., one-time “catch-up” adjustments).

In our view, the operating divisions’ financial process is designed to prepare auditable yearend balances, not to portray accurate financial information for routine management decision-making or for identification of discrepancies or unusual trends. The operating divisions conducted

Reconciliations and account analyses were not conducted throughout the year to detect accounting aberrations.

reconciliations and account analyses sporadically, not periodically throughout the year. Because an updated departmental policy emphasizing the need for periodic reconciliations and analyses was not issued until July 29, 1999, this was a systemic problem for most of the year. Compounding these problems were the widespread practices of adjusting financial statement amounts but not the underlying general ledger, using accounts not prescribed by the U.S. Standard General Ledger, and not posting accounts in accordance with prescribed U.S. Standard General Ledger rules.

Reconciliations and account analyses are key internal controls because they bring accounting aberrations to management’s attention for resolution. When they are not performed in the normal business cycle, material errors and irregularities will not be promptly detected. The resulting financial statements will be at risk of being inaccurate, unreliable, and unauditabile.

Following are examples of problems that occurred because of the lack of reconciliations and analyses:

- The HCFA did not independently verify the Medicare Supplementary Medical Insurance (SMI) and Hospital Insurance (HI) trust fund balances, did not reconcile these accounts at a sufficiently detailed level, and used ineffective methodologies to calculate SMI and HI transfers. As a result, the SMI fund was underfunded by \$18 billion and HI was overfunded by \$14 billion. The SMI fund lost interest earnings of \$237 million and the HI fund realized excess interest earnings of \$154 million as a consequence. Although aggregate fund balances with Treasury and investment balances for each trust fund were properly stated in HCFA's FY 1999 financial statements, cash transfers related to the principal to make the individual trust funds whole did not occur until October 1999. Issues relating to interest will require additional action to restore the trust funds to the amount that would have been reflected had such errors not occurred. A corrective action plan to preclude similar problems in the future has been implemented.
- The HCFA did not periodically validate the National Claims History File to ensure the existence and completeness of the data. Due to a breakdown in internal quality controls, the file was missing 100 million Medicare claims amounting to over \$13 billion — or more than 25 percent of the processed claims — from June until December 1999. This file, which has since been corrected, is critical to accurately estimate Medicare benefits payable, to prepare the Medicare trustees report, to determine the SMI monthly premiums, to establish managed care rates, to update the diagnostic-related groups for inpatient hospitals, and to develop annual budget projections.
- At ACF, the grant accrual on the initial draft of the financial statements was in error. After researching the fluctuation from the 1998 accrual levels, an audit adjustment of approximately \$660 million was necessary.

While corrective action is underway or completed on the above problems, these matters should have been detected during the normal business cycle through routine reconciliation and analysis of accounts.

For FY 1999, the Department implemented an automated, Internet-based financial statement reporting system to produce the HHS financial statements from a compilation of operating division financial statements. Although this is a first step toward implementing a fully integrated and unified accounting system, it is clear from the problems identified that the Department must take steps in the interim to improve accounting procedures and financial reporting processes. In particular, the Department should closely monitor operating division compliance with the recently revised reconciliation policy and emphasize the need to analyze account information in the normal business cycle. Without significant improvement, existing financial systems will

continue to require inordinate resources at yearend to prepare financial statements, will not adequately serve management needs for reliable interim data, and will jeopardize the Department's ability to maintain unqualified opinions on future financial statements.

Recommendations. We recommend that the Assistant Secretary for Management and Budget (ASMB) and operating division Chief Financial Officers (CFO):

- continue the work already begun on producing reliable financial statements on time;
- ensure that accounting staff reconcile and analyze accounts throughout the year, as prescribed by revised departmental policy issued July 29, 1999;
- ensure that interim accounting information is sorted and accumulated in a manner useful to operating division management and for financial reporting purposes — an even more critical need since passage of the Government Performance and Results Act;
- continually assess financial systems for compliance with Federal financial system requirements, Federal accounting standards, and the U.S. Standard General Ledger at the transaction level, and focus these efforts on the generation of financial statements from the general ledger rather than adjunct accounting systems; and
- develop and implement yearend closing procedures that facilitate timely production of financial statements.

2. Medicare Accounts Receivable (Repeat Condition)

Medicare accounts receivable primarily represent overpayments owed by providers to HCFA and funds due from other entities when Medicare is the secondary payer. The HCFA contractors are responsible for reporting and collecting the majority of these receivables — over 81 percent of the outstanding balance at yearend — and the HCFA central office and regional offices manage the remainder.

We noted major improvement in validating accounts receivable, but inadequate internal controls persist.

In FY 1998, we qualified the Departmentwide opinion mainly because Medicare contractors could not support beginning accounts receivable balances, reported incorrect activity and collections, and could not reconcile reported ending balances with subsidiary records. We

reported Medicare accounts receivable as a material internal control weakness because Medicare contractors (1) used rudimentary, single-entry accounting systems that lacked general ledger capabilities for Medicare program activity and (2) reported receivable activity to HCFA based on ad hoc spreadsheets.

The HCFA initiated a major effort in FY 1999 to validate and document accounts receivable. The HCFA and OIG staff, together with two independent public accounting firms, validated receivables at 15 Medicare contractors which accounted for over 80 percent of the contractor receivable balance, the 10 HCFA regional offices, and the HCFA central office. This effort identified over \$2 billion in overstated and understated receivables. These receivables included about \$1 billion in biweekly advance payments (referred to as periodic interim payments, or PIP) to providers for which claims had already been submitted. Specifically, the validation team found the following problems:

- Contractors did not always follow HCFA policies, and HCFA regional offices maintained inadequate oversight of contractor adherence. About \$191 million was found in clerical errors because of inadequate internal controls and oversight. In addition, support could not be found to validate \$1.3 billion in receivables, including about \$700 million attributable to cases where Medicare was the secondary payer.
- Some contractors reported PIP receivables net of payables due to providers; others reported them on a gross basis. Some contractors did not record estimates for PIP at the end of the period, and others misclassified the amounts recorded. One contractor alone incorrectly included \$500 million as a PIP receivable, an error that was identified by HCFA central office controls.
- When receivables were transferred, controls were not in place to notify contractors that regional offices accepted or rejected the transfers. As a result, about \$85 million in transferred receivables was erroneously included in the accounting records of both the Medicare contractors and the HCFA regional offices or, in some cases, neither.

Contractors refer receivables to the regional offices when they have exhausted collection efforts, which generally consist of sending three overpayment demand letters to providers. The first request is sent immediately after discovery or determination of the overpayment. The second and third demand letters are mailed at 30-day intervals after the first letter for Medicare Part A and at 45-day intervals for Part B. If the regional office determines that HCFA should take further collection action, the contractor transfers the receivable to that office which, in turn, sends

at least one additional 30-day demand letter to the provider. If the refund is not received within 60 days, the case should be considered for termination or other collection action. For example, the case may be transferred to the central office for referral to the HCFA Office of General Counsel.

The validation team found almost \$900 million in outstanding receivables at the regional offices and the central office as of October 1, 1998. This debt was in various stages of collection. For example, \$149 million was in litigation or appeal, and \$166 million had been forwarded to the Department's debt collection office or the Department of Treasury for cross-servicing. We are most concerned, however, that some \$243 million involved bankruptcy cases and \$294 million was still pending further debt collection action. Some of this debt was already 6 months old when it was transferred from the contractors and therefore may not have been in compliance with the Debt Collection Improvement Act of 1996. The act requires that any non-tax debt owed to the Federal Government that is 180 days delinquent be referred to the Department of the Treasury for collection. The team also noted that about half of the debt due from institutional providers involved a type of provider with a high incidence of bankruptcy. Timely debt collection becomes even more critical when millions of dollars in overpayments are due from high-credit-risk providers.

As a result of the validation effort, the receivables balance was fairly presented as of the year's end. However, HCFA and the Medicare contractors still do not have adequate internal controls to ensure that future receivables will be properly reflected in their financial reports. Therefore, similar validation procedures will be needed on future receivable activity and balances. Our current review also showed that the lack of an integrated financial management system continued to impair HCFA's and the contractors' ability to adequately support reported accounts receivable activity and balances. The contractors still used ad hoc, single-entry accounting systems, did not accrue liabilities in accordance with generally accepted accounting principles, and did not use proper cutoff procedures.

Moreover, we again found that the HCFA central office did not routinely analyze or monitor receivable balances other than on a very aggregate basis. Because HCFA did not perform a detailed review or analysis of contractor data submissions, it had limited assurance that account balances were accurate and supported by appropriate documentation, and it could not readily identify emerging trends in accounts receivable activity that might require additional management attention. Additionally, HCFA could not readily isolate or identify accounts receivable activity that might have a material impact on the financial statements. For example, HCFA did not perform a detailed analysis throughout FY 1999 to gauge the effect of providers' transitioning to the interim payment and prospective payment systems. Coupled with full implementation of provisions of the 1997 Balanced Budget Act, one contractor's activity ultimately resulted in increased accounts receivable collectively exceeding \$1 billion. Some of

these receivables are associated with providers that are now insolvent, have withdrawn from the Medicare program, or have negotiated extended repayment plans.

In addition, we found that:

- one Medicare contractor offset a receivable with a payable, thereby understating the receivable balance by \$130 million, and
- another contractor overstated receivable balances by \$58 million because it did not account for all claim and payment activity.

Recommendation. We recommend that ASMB continue monitoring HCFA's development of an integrated Medicare financial management system which includes a double-entry general ledger. Detailed recommendations are outlined in the HCFA audit report.

3. Medicare Electronic Data Processing (Repeat Condition)

The HCFA relies on extensive electronic data processing (EDP) operations at both its central office and the Medicare contractors to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. Although HCFA fully recognized the importance of these controls, its FY 1999 resources were devoted in large part to addressing Year 2000 readiness issues. As a consequence, not all prior-year EDP findings were resolved.

Year 2000 compliance efforts delayed corrective action on prior EDP internal control deficiencies.

The HCFA central office systems maintain administrative data, such as Medicare enrollment, eligibility, and paid claims data, and process all payments for managed care. In FY 1999, managed care payments totaled about \$37 billion.

The Medicare contractors, each with its own data processing system, use one of several "shared" systems to process and pay fee-for-service claims. These shared systems generally interface with the Common Working File (CWF) to obtain authorization to pay claims and to coordinate Medicare Part A and Part B benefits. The CWF uses seven distributed databases provided by contractors known as CWF host sites. The shared systems and the CWF are maintained by contractors referred to as system maintainers. This network accounted for and processed \$169.5 billion in Medicare expenditures during FY 1999.

Our review of EDP internal controls covered general and application controls. EDP general controls involve the entity-wide security program, access controls, application development and program change controls, segregation of duties, operating system software, and service continuity. General controls affect the integrity of all applications operating within a single data processing facility and are critical to ensuring the reliability, confidentiality, and availability of HCFA data. Application controls involve input, processing, and output controls related to specific EDP applications.

We found numerous EDP general control weaknesses at the HCFA central office and the Medicare contractors, as well as application control weaknesses at the contractors' shared systems. Such weaknesses do not effectively prevent (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy data files, (3) improper Medicare payments, or (4) disruption of critical operations. Further, weaknesses in HCFA's entity-wide security structure do not ensure that EDP controls are adequate and operating effectively. As noted below, two of these weaknesses were considered material.

- ❑ **HCFA central office.** The HCFA central office has begun to implement several actions to improve controls, such as planning for additional security software to restrict access to sensitive Medicare databases. However, because these actions had not been completed as of the year's end, some previously reported weaknesses in general and application controls remained unchanged. Most problematic was the deficiency in mainframe database access controls, which was also reported as a material control weakness in both FYs 1997 and 1998. Additional problems were noted this year in entity-wide security and operating system controls.
- ❑ **Medicare contractors.** Our reviews at a sample of 14 Medicare contractors included reviews of general controls at 4 contractors, general and application controls at 3 contractors, and change controls at 3 contractors, as well as reviews of prior-year findings at 4 contractors. While our follow-up work found that many of the prior-year findings had been resolved, problems continued in the Fiscal Intermediary Standard System (FISS).

The material weakness in the FISS remained unchanged from that reported in FYs 1997 and 1998; that is, Medicare data centers had full access to the FISS source code and could make local changes to FISS programs. Although HCFA required contractors to restrict local changes to emergency situations, the local changes were still not subjected to the same controls that exist in the standard FISS change process.

For the Multi-Carrier System, on the other hand, the previous finding that each individual carrier could deactivate HCFA-mandated edits was resolved.

Recommendation. We recommend that ASMB continue overseeing HCFA's implementation of corrective actions to address EDP control weaknesses at Medicare contractor sites and the HCFA central office. Detailed recommendations are contained in the HCFA audit report.

REPORTABLE CONDITIONS

1. HCFA Regional Office Oversight of Medicare (New Condition)

During FY 1999 and early FY 2000, HCFA began a series of initiatives to improve oversight of the Medicare claim processing contractors. Among these initiatives is the use of independent contractors to review (1) contractors' cost report quality review programs and enhanced protocols and (2) more than 20 of the major contractors' systems and processes. While these are excellent first measures, inappropriate claim payments continued at a high level, and OIG investigations showed ongoing problems with Medicare contractor activities.

Regional office oversight was not sufficient to ensure that financial data provided by contractors were reliable, accurate, and complete. For example, regional offices did not:

- provide sufficient coverage of contractor performance evaluations or conduct sufficient on-site reviews of the completeness and accuracy of contractors' provider cost report information and Medicare secondary payer operations;
- adequately monitor contractor reports, specifically the Statements of Financial Position (HCFA 750), Status of Accounts Receivable (HCFA 751), and Monthly Contractor Financial Report (HCFA 1522);
- adequately verify the completeness and accuracy of the accounts receivable tracking reports, the Provider Overpayment Report (POR) and the Physician Supplier Overpayment Report (PSOR); or
- timely implement HCFA central office directives.

Recommendation. We recommend that ASMB oversee HCFA's efforts to improve regional office oversight of the Medicare program. Specific recommendations to HCFA are covered in a separate report.

2. Medicaid Estimated Improper Payments (Repeat Condition)

The Medicaid program, enacted in 1965 under Title XIX of the Social Security Act, is a grant-in-aid medical assistance program largely for the poor, the disabled, and persons with developmental disabilities requiring long-term care. Funded by Federal and State dollars, the program is administered by HCFA in partnership with the States via approved State plans. Under these plans, States reimburse providers for medical assistance to eligible individuals, who numbered more than 33 million in 1999. In FY 1999, Federal and State Medicaid outlays totaled about \$180.8 billion; Federal expenses were \$109 billion.

We found that HCFA still lacked a methodology to estimate the extent of improper Medicaid payments on a national level. For the last 4 years, the OIG reviewed a statistically valid sample of Medicare claims and estimated the extent of payments that did not comply with laws and regulations. The majority of errors fell into four broad categories: insufficient or no documentation, lack of medical necessity, incorrect coding, and noncovered services. This information helped HCFA to monitor and reduce improper Medicare payments. Because HCFA has not established a similar methodology for the Medicaid program, it cannot reach conclusions on the extent of Medicaid payment errors. We recognize that Medicaid is a State-administered program, so estimates of improper payments will require the cooperation of States.

We noted some recent progress in this area. In FY 1999, HCFA established a departmental workgroup to review the Medicaid error rate issue. Also, HCFA requested \$5 million in the FY 2001 budget for grants to a sample of States to begin developing this information.

Recommendation. We recommend that ASMB and HCFA work with the States to develop procedures and implement a methodology for determining the extent of improper Medicaid payments.

3. Departmental Electronic Data Processing (Repeat Condition)

The following summarizes some of the systemic EDP control weaknesses identified in audits of operating division financial statements and service organization operations. Other weaknesses are reported in the individual reports on these entities.

- ❑ **Division of Financial Operations (DFO) Financial Management Systems.** The Program Support Center's DFO provides financial management and accounting services to certain operating divisions. To provide the services, the DFO uses several automated systems. While the DFO continues to strengthen controls over these systems, further improvements are needed.

- The DFO had access control weaknesses associated with its security software, which was intended to protect the financial management systems' production data and programs. Some users had excessive access privileges inconsistent with their job responsibilities.
 - The source code for production programs was maintained in a single library that was accessible to all application programmers.
 - The DFO did not adequately separate the duties of its contract programmers. The programmers could process transactions and create or change authorized functions within the financial management systems. They did in fact process approximately 100 transactions during FY 1999.
- **NIH.** The NIH policies and procedures related to requests for systems access need to be strengthened. Application programmers had full access to the development, testing, and production environment. The NIH management has begun developing draft policies and procedures to enhance the logical access and program change controls. Without such procedures, management cannot ensure that internal controls over access to applications are consistently applied or that controls over production program and data integrity are not compromised.
- **Food and Drug Administration (FDA).** In FY 1998, FDA had several findings under each of the six major categories of general controls. Although FDA resolved many of these findings, some were still outstanding this year. When viewed in the aggregate, these exceptions constituted a reportable condition. Areas that still need improvement include the security program, access controls, software change controls, system software, separation of duties, and service continuity. Similar to the DFO, FDA had an excessive number of users with privileges to affect system operations and critical files.

Recommendation. We recommend that ASMB oversee the efforts of the operating divisions and service organizations to improve system access controls, application development and program change controls, and service continuity plans. Specific recommendations are covered in the separate reports.

4. Property, Plant, and Equipment (Repeat Condition)

In FY 1998, we reported that improvements in accounting for and controlling property, plant, and equipment were needed at NIH and FDA. Improvements are still needed, as noted below.

- NIH.** We found that NIH posted depreciation expenses in whole-year increments only. As a result, accumulated depreciation was understated by \$8.4 million for 68 buildings and was overstated by \$5.6 million for 19 buildings. One additional building was depreciated beyond its original cost by \$612,500.
- FDA.** Although FDA improved its Property Management Information System, we still noted problems in tracking property transfers and maintaining supporting documentation.

Recommendation. We recommend that ASMB oversee the implementation of the corrective actions being taken by NIH and FDA. Specific recommendations are provided in separate audit reports.

OTHER MATTERS

FMFIA Reporting

As part of our audit, we also obtained an understanding of management's process for evaluating and reporting on internal control and accounting systems, as required by the Federal Managers' Financial Integrity Act (FMFIA), and compared the material weaknesses reported in the HHS FY 1999 FMFIA report relating to the financial statements under audit with the material weaknesses noted in our report on internal controls. Under OMB guidelines for FMFIA reporting, HHS reports as a material weakness any deficiency that the Secretary determines is significant enough to be disclosed outside the agency. This designation requires HHS management to judge the relative risk and significance of deficiencies. In making this judgment, HHS management pays particular attention to the views of the HHS Inspector General. The HHS management agrees with the HHS Inspector General in reporting to the President and the Congress the three material weaknesses described in this report.

Medicare National Error Rate

While our previous reports included the Medicare national error rate in the "Report on Compliance With Laws and Regulations" section, OMB, the General Accounting Office, and other Federal agencies have differing views on how to properly report national error rates. Development of such error rates is an emerging area, and OMB is developing consistent

reporting requirements. Until we receive clarification, we are reporting the Medicare error rate as "Other Matters."

At HCFA's request, we developed a national error rate of the extent of improper Medicare fee-for-service payments for FY 1999. As discussed in detail in our separate report (CIN: A-17-99-01999), and based on our statistically valid sample, we estimate that improper Medicare benefit payments made during FY 1999 totaled \$13.5 billion, or about 7.97 percent of the \$169.5 billion in processed fee-for-service payments reported by HCFA. This year's error rate is about \$1 billion more than the FY 1998 estimate of \$12.6 billion, \$6.8 billion less than the FY 1997 estimate of \$20.3 billion, and \$9.7 billion less than the FY 1996 estimate of \$23.2 billion. While this year's estimate is higher than last year's, we cannot conclude that the current error rate is statistically different. The increase may be due to sampling variability; that is, selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

These improper payments, as in past years, could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. The overwhelming majority (92 percent) of these improper payments were detected through medical record reviews coordinated by the OIG. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. Although HCFA has made substantial progress since FY 1996 in reducing improper payments in the Medicare program, continued efforts are needed.

STATUS OF PRIOR-YEAR INTERNAL CONTROL WEAKNESSES

During FY 1999, HHS and its operating divisions substantially completed corrective actions on two prior-year reportable conditions, as discussed below:

Departmental Accounts Payable

This year HHS substantially resolved the previously reported departmental deficiencies in controls over accounts payable. However, accounts payable problems remain a reportable condition at NIH and are so reported in the auditor's report on the NIH financial statements. Problems with HCFA's payables are addressed in "Financial Systems and Reporting" (material weakness No. 1) of this report because they no longer merit separate reporting.

Estimating Losses From Pending Litigation

In FY 1998, we reported that management at several operating divisions did not assess the likelihood of losses from pending claims and lawsuits. Federal accounting standards require

agency management to determine whether it is probable that a legal claim will end in a loss and, if it is estimable, to recognize an expense and a liability for the full amount of the expected loss.

In November 1998, HHS issued final guidance to the operating divisions directing that management obtain from counsel an assessment of the likelihood that lawsuits will result in losses. If a loss is probable and the amount is estimable, management is to record that amount in its accounting records. We consider this condition to be substantially resolved.

REPORT ON COMPLIANCE WITH LAWS AND REGULATIONS

We conducted our audit in accordance with generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 98-08, *Audit Requirements for Federal Financial Statements*, as amended. These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements referred to above are free of material misstatement.

The HHS management is responsible for complying with applicable laws and regulations. As part of obtaining reasonable assurance about whether the HHS financial statements are free of material misstatement, we performed tests of management compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and with certain other laws and regulations specified in OMB Bulletin 98-08, as amended, including the requirements referred to in the Federal Financial Management Improvement Act (FFMIA) of 1996.

The results of our tests of compliance with laws and regulations, exclusive of FFMIA, disclosed no instances of noncompliance required to be reported under *Government Auditing Standards* and OMB Bulletin 98-08, as amended.

Under FFMIA, we are required to report whether HHS financial management systems substantially comply with Federal financial management systems requirements, Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. Therefore, we performed tests of compliance using the FFMIA implementation guidance included in

Appendix D of OMB Bulletin 98-08, as amended. The results of our tests disclosed instances in which HHS financial management systems did not substantially comply with certain requirements. The following instances of noncompliance were identified:

- The accounting systems used by HHS and the operating divisions were not adequate to prepare reliable, timely financial statements. Instead, a manually intensive and error-prone process was used. These weaknesses prevented the Department from preparing reliable financial statements from the general ledger in a timely manner.
- The HCFA did not have an integrated accounting system to capture expenditures at the Medicare contractor level. This means that for most dollars appropriated to the Department, management depended on ad hoc, nonstandard accounting systems used by the Medicare contractors.

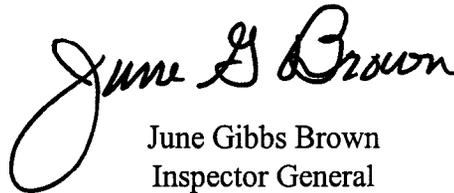
- ❑ The HCFA central office and Medicare contractor access and application control weaknesses were significant departures from requirements in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

The HHS CFO prepared a 5-year plan to address FFMIA and other financial management issues. Although certain milestone dates have passed, we recognize that the plan will require periodic updating to reflect changed priorities and available resources.

Although we performed tests of the Department's compliance with certain provisions of these laws and regulations, our objective was not to provide an opinion on overall compliance with such provisions. Accordingly, we do not express such an opinion.

Comments from HHS, which are included as appendix II, have been incorporated in this report where appropriate. We appreciate the cooperation and assistance of HHS staff during this audit.

Additionally, we would like to acknowledge the significant contributions made by the staff of the General Accounting Office.



June Gibbs Brown
Inspector General
Department of Health and Human Services

February 25, 2000
CIN: A-17-99-00002

**FISCAL YEAR 1999 CFO REPORTS ON
HHS OPERATING DIVISIONS AND SERVICE ORGANIZATIONS**

Nine separate financial statement audits of HHS operating divisions were conducted in FY 1999:

- ▣ Administration for Children and Families (*CIN: A-17-99-00003*)
- ▣ Centers for Disease Control and Prevention (*CIN: A-17-99-00013*)
- ▣ Food and Drug Administration (*CIN: A-17-99-00011*)
- ▣ Health Care Financing Administration (*CIN: A-17-00-00500*)
- ▣ Health Resources and Services Administration (*CIN: A-17-99-00005*)
- ▣ Indian Health Service (*CIN: A-17-99-00006*)
- ▣ National Institutes of Health (*CIN: A-17-99-00012*)
- ▣ Program Support Center (*CIN: A-17-99-00007*)
- ▣ Substance Abuse and Mental Health Services Administration (*CIN: A-17-99-00004*)

Four Statement on Auditing Standards 70 examinations were conducted:

- ▣ Center for Information Technology, NIH (*CIN: A-17-99-00015*)
- ▣ Central Payroll and Personnel System, PSC (*CIN: A-17-99-00009*)
- ▣ Division of Financial Operations, PSC (*CIN: A-17-99-00008*)
- ▣ Payment Management System, PSC (*CIN: A-17-99-00014*)



FEB 25 2000

June Gibbs Brown
Inspector General
U.S. Department of Health and Human Services
Washington, DC 20201

Dear Inspector General Brown:

This letter responds to the Office of Inspector General opinion of the FY 1999 audited financial statements of the U.S. Department of Health and Human Services. We concur with your findings and recommendations.

We are tremendously pleased that your report reflects an unqualified, or "clean", audit opinion for the Department for the first time ever. Through our joint efforts, we were able to achieve our goal of both a clean and, for the second year, timely Departmental financial statement audit.

We also acknowledge that significant internal control weaknesses remain. We can now focus our attention on improving our financial systems to resolve these material weaknesses and we are already directing our efforts in that direction.

I would like to thank your office for its continuing professionalism during the course of the audit as they worked in conjunction with my office to address complex financial accounting issues.

Sincerely,

A handwritten signature in black ink, appearing to read "John J. Callahan".

John J. Callahan

Assistant Secretary for Management and Budget/
Chief Financial Officer

SECTION VI:
REPORTS AND OTHER INFORMATION

**Department of Health and Human Services
 FY 1999 and 1998 Prompt Payment Report Summary**

Fiscal Year Ending September 30, 1999 and 1998

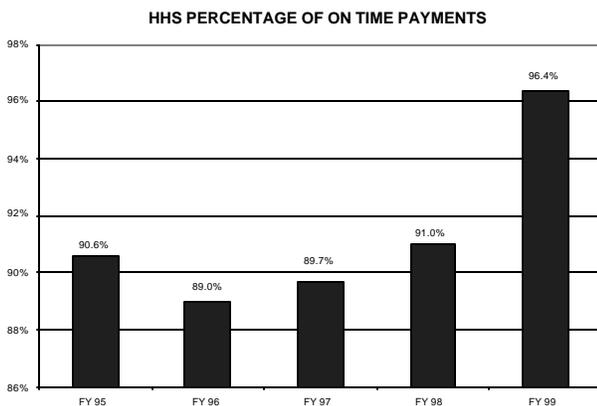
	<u>1999</u>	<u>1998</u>
I. Invoices paid subject to the Prompt Payment Act and OMB Circular A-125:		
A. Dollar value of invoices	\$ 5,442,692,282	\$ 4,407,139,852
B. Number	1,269,584	1,114,740
II. Invoices paid late:		
A. Dollar value	\$ 440,713,958	\$ 560,334,680
B. Number (sum of II.C.2, and II.F.1.b.)	44,490	100,781
C. Late payment interest penalties paid:		
1. Dollar amount	\$ 692,902	\$ 990,788
2. Number	21,108	48,561
3. Relative frequency (II.C.2./I.B.)	1.66%	4.36%
D. Additional penalties paid for failure to pay interest penalties:		
1. Dollar amount	\$ -	\$ -
2. Number	-	-
3. Relative frequency (II.D.2./I.B.)	0.00%	0.00%
F. Interest and other late payment penalties which were due but not paid:		
1. Total: (99.9% were less than \$1)		
a. Interest dollars	\$ 17,630	\$ 43,821
b. Number	23,382	52,220
III. Invoices paid 8 days or more before due date, except where cash discounts taken:		
A. Subject to a determination under section 4.1 of circular A-125:		
1. Dollar amount	\$ 74,894,986	\$ 59,869,051
2. Number	67,633	58,298
3. Relative frequency (III.A.2./I.B.)	5.33%	5.23%

PROMPT PAYMENT

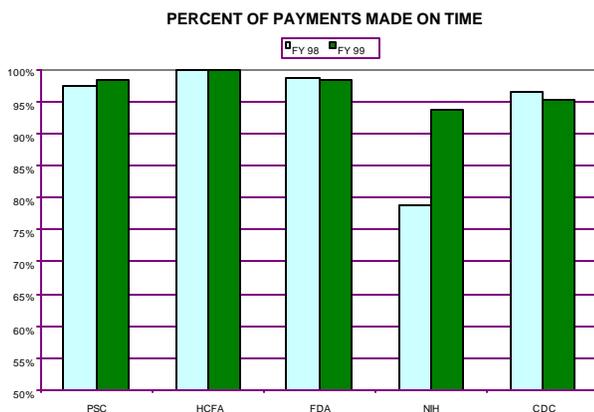
Prompt payment of vendor invoices is an important part of cash management since it reduces the amount of late payment interest penalties. During FY 1999 HHS:

- Paid 1.3 million vendor invoices valued at \$5.4 billion
- Paid 96.4% of these items on time, compared to 91% of time for FY 1998
- Paid interest penalties of \$692,902 on 1.66% of vendor payments
- Paid an average penalty of \$32.83 and an average of \$127 in late payment penalties for every \$1 million in vendor payments.

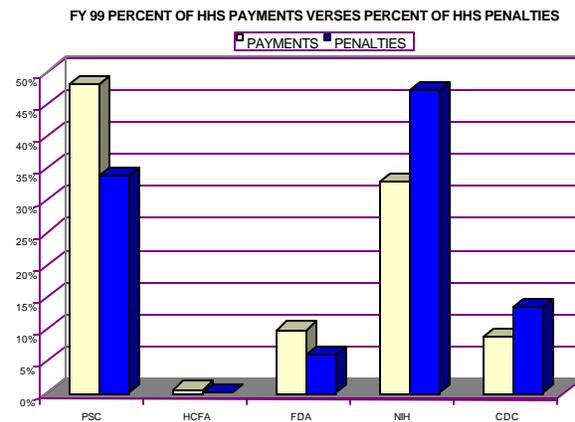
The FY 1999 rate of on time payments was the highest ever achieved by the Department and is a significant improvement over the last few years, as shown in the chart below.



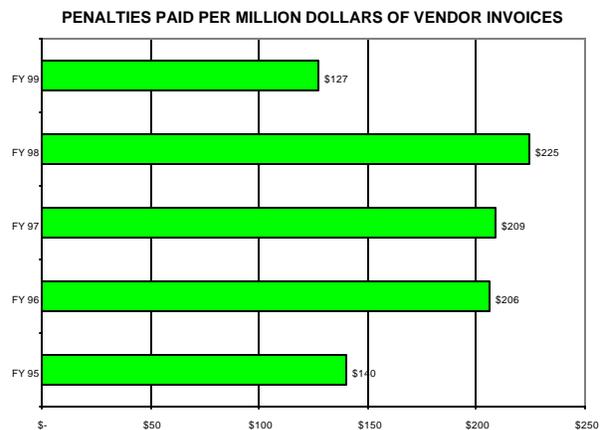
The improved prompt pay performance resulted in the Department exceeding its goal of making 95% of all vendor payments on time. During FY 1999 four of the five Department's payment components were able to exceed the 95% on time goal while the other component reached 93.5% for the year. The next chart shows performance by payment component for FY 1998 and FY 1999.



NIH is the second largest vendor payment office, paying 32.9% of all HHS vendor invoices in FY 1999, and therefore its performance has a major impact on the Department. As the previous chart shows, NIH made a dramatic improvement in on time payments in FY 1999. The next chart reflects the impact of each payment component's performance on the Department totals by showing the percent of HHS vendor payments versus the percent of HHS late payments interest penalties for each component during FY 1999.



The dollar value of invoices paid in FY 1999 increased by over 23%, compared to FY 1998, and the number of invoices increased by 14%. The dollar amount of interest penalties paid decreased by 30% compared to FY 1998, while the number of penalties dropped by 56%. The goal is to reduce the amount of penalties paid as much as possible. Prompt pay performance is monitored and to keep penalties paid in perspective, the amount of penalties paid per each million dollars of invoices paid is tracked and is shown in the next chart.



CIVIL MONETARY PENALTIES

Civil Monetary Penalties (CMP) are non-criminal penalties for violation of Federal law. The Federal Civil Penalties Inflation Adjustment Act of 1990 provides for periodic evaluation to ensure that CMPs maintain their deterrent value and that the imposed penalties are properly accounted for and collected. HCFA is the only OPDIV that has CMPs. Our FY 1999 CMP report is summarized below.

FY 1999 Civil Monetary Penalties Report		
Outstanding Receivables	Number	Amount (in Dollars)
Beginning FY 1999 Balances	222	210,077,869
Assessments (+)	524	43,515,590
Collections (-)	(174)	(27,752,153)
Adjustments	(39)	(14,573,773)
Amounts Written Off	0	0
Ending Balance	533	211,267,533
a. Current Receivables	449	79,299,648
b. Non-Current Receivables	84	131,967,885
Allowance		42,732,753
Net Receivables	533	168,534,780
Total Delinquent	408	201,981,245
Total Non-Delinquent	125	9,286,288

HHS FISCAL YEAR 1999 FEDERAL FINANCIAL MANAGEMENT IMPROVEMENT ACT (FFMIA) COMPLIANCE REPORT

Fiscal year 1999 is the third year for which auditors, who are auditing the financial statements of Executive Agencies, are required to report on whether or not the agencies are in substantial compliance with the requirements of the Federal Financial Management Improvement Act (FFMIA) of 1996. Under FFMIA, the auditors are required to report whether HHS financial management systems substantially comply with the federal financial management systems requirements, the federal accounting standards, and the United States Government Standard General Ledger at the transaction level. To meet this requirement the auditors using the implementation guidance for FFMIA included in OMB Bulletin 98-08 and performed the required test of compliance and reported their findings in the annual financial statement audit report.

The fiscal year 1998 financial statement audit revealed three instances where HHS financial management systems did not substantially comply with FFMIA requirements. The three instances identified were:

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

The same three instances of non-compliance were cited in fiscal year 1999; however, substantial progress was made in each of the areas. Also all financial and financial-mixed systems/applications were Y2K compliant. The HHS FFMIA Remediation Plan is provided in the CFO's Financial Management Status Report and Five Year Plan, published annually. The following is a summary of some of the corrective actions taken and the current status for each of the areas of non-compliance.

1. HHS Accounting Systems were not adequate to prepare reliable and timely financial statements.

The initial focus was on improving the quality of data in the accounting systems. In fiscal year 1999 revised departmental reconciliation guidance was issued and periodic reconciliations in key areas were implemented; but were not conducted throughout the entire year. In addition, an automated system was developed and implemented to improve the process for preparing departmental financial statements.

2. Lack of Integrated Accounting System to capture expenditures at the Medicare Contractor level.

HCFA has eliminated the MSP receivable section of the fiscal year 1998 non-compliance by revising the criteria for the establishment and reporting of MSP receivables and have adjusted the MSP receivable balances to the true economic value.

Efforts to implement an Integrated Accounting System were delayed because of Y2K initiatives. HCFA has now developed a long-range multi-year plan for an integrated general ledger system.

3. EDP Systems Controls weaknesses at HCFA Central Office, and Medicare contractors.

Full resolution of these issues was delayed because of Y2K initiatives. The OIG acknowledged in its findings that HCFA had made substantial improvement in the areas of systems access control, application software development, and change control. HCFA has developed a Corrective Action Plan to resolve this finding in FY 2000.

The Payroll EDP processing systems control issues cited in fiscal year 1998 were resolved.

HHS FY 1999 FEDERAL MANAGERS FINANCIAL INTEGRITY ACT REPORT ON SYSTEMS AND CONTROLS

A. Background

HHS' management control program under the Federal Managers Financial Integrity Act (FMFIA), reflects the Department's continuing commitment to safeguard the resources entrusted to us by reducing fraud, waste and abuse and preventing financial losses in HHS programs. HHS continually evaluates its program operations and systems utilizing management reviews, systems reviews, CFO financial statement audits and other OIG and GAO audits, etc. to ensure the integrity and efficiency of its operations. Consistent with revised OMB Circular A-123, *Management Accountability and Control* and the *CFO 5 Year Plan*, HHS program managers continue to improve management controls by identifying and correcting management control deficiencies.

The Department's FMFIA program supports a key objective in our CFO 5 Year Plan to respond to our diverse customers' needs by ensuring that the financial information for their programs is accurate and that the financial systems and processes that support them maintain the highest level of integrity.

In addition to our primary goal of obtaining a clean audit opinion on our financial statements, we have a related goal of resolving all internal control material weaknesses and reportable conditions cited by the auditors, as well as those identified through FMFIA management control reviews and systems reviews. OPDIVs need to have written strategies for assessing management controls on an ongoing basis and these strategies for assessing management controls should be consistent with the 1999 CFO 5 Year Plan goals and targets and CFO audit Corrective Action Plans (CAPs).

HHS has developed corrective action plans to address all of the findings resulting from the financial statement audits, including qualifications/ material weaknesses and reportable conditions, and corrective actions are underway. In addition, in response to the May 26, 1998 Presidential Memorandum: "Actions to Improve Financial Management", since July 1998 HHS has reported quarterly to OMB on the status of corrective action for the qualifications in our FY 1998 financial statement audit. We plan to update our corrective action plan in April to reflect the findings from the FY 1999 financial statement audits which are described elsewhere in this Accountability Report.

B. Summary of the Report

The FMFIA Annual assurance required by the Act is contained in the Message from the Secretary at the beginning of this Accountability Report. The details of this year's FMFIA Annual Report, in addition to this narrative summary, are in the statistical summary on page VI - 4.5, which reflects the cumulative total of material weaknesses identified and corrected including a total of six pending material weaknesses. A listing of the six material weaknesses, which includes one new material weakness identified in FY 1999, is shown on page VI - 4.6. The FMFIA-style corrective action plans (CAPs) for the six pending material weaknesses begins on page VI - 4.7.

Three of the six material weaknesses were reported by the auditors in the FY 1999 HHS-wide CFO financial statement audit: 1) Financial Systems and Reporting; 2) Medicare Accounts Receivable; and

3) Medicare EDP Controls. The remaining three material weaknesses are the result of OIG program audits and/or internal management reviews and were included in prior year FMFIA reports.

In last year's report we determined that financial reporting did not reach a level of significance that required reporting to the President and Congress under FMFIA. However, in the FY 1999 HCFA financial statement audits, as well as the audits of several OPDIVs, problems related to account analyses and reconciliation were identified which were deemed material in HCFA under FMFIA. The exhibit, *Financial Systems and Reporting (HHS-99-01)*, contains HCFA's corrective action plan with milestones as well as milestones for addressing the Department-wide financial systems and reporting problems.

Exhibit HHS 99-01 reflects that HCFA did not independently verify the Medicare Hospital Insurance/Supplemental Medical Insurance (HI/SMI) Trust Fund balances, did not reconcile these accounts at a sufficiently detailed level and used ineffective methodologies to calculate HI and SMI transfers. These errors caused the HI Trust Fund to be overfunded by \$14 billion and the SMI Trust Fund to be underfunded by \$18 billion. As a result of these errors, the HI Trust Fund earned excess interest in the amount of about \$154 million and the SMI Trust Fund lost interest earnings in the amount of about \$237 million for FY 1999. HCFA also did not periodically validate the National Claims history file to ensure the existence and completeness of the data. The File was missing 100 million Medicare claims amounting to over \$13 billion – or more than 25 percent of the processed claims – from June until December 1999. HCFA has already developed and begun implementation of a CAP to resolve the trust fund error and prevent a recurrence as reflected in the CAP's milestones which indicate completion in FY 2000. HCFA has also resolved the problem with the National Claims History File.

Regarding Medicare Accounts Receivable (Exhibit HCFA 97-01), HCFA has made substantial efforts to resolve this material weakness which was identified as a qualification by the auditors in the HCFA FY 1997 and FY 1998 financial statement audits. The short-term milestones to address the FY 1998 audit qualification have been implemented and the qualification has been reported as resolved in the FY 1999 financial statement audit. However, the long-term solution to the Medicare accounts receivable issue is the development of an integrated accounting system for Medicare contractors which is planned for FY 2004.

This report also reflects the combining of two 1998 material weaknesses for Medicare EDP into one. This is consistent with the FY 1999 HHS-wide and HCFA CFO financial statement audits, which identify Medicare EDP as one material weakness with two parts. The two parts of the Medicare EDP material weakness are reflected in this report as follows: (a) *Improve Medicare Contractors Systems Application Controls, Exhibit HCFA 98-01a* (formerly HCFA 98-01); and (b) *System Access Controls at HCFA Central Office, Exhibit HCFA 98-01b* (formerly HCFA 98-02). The CAPs for these material weaknesses reflect that corrective action is now scheduled for completion in FY 2000.

C. CFO Financial Statement Audits and the FMFIA

In the FY 1998 CFO financial statement audits, certain OPDIVs were cited by the auditors for a reportable condition based on the fact that their 1998 FMFIA Reports did not report an FMFIA material weakness for each of the CFO audit material weakness. We have been working closely with OIG staff on an approach to bring the 1999 FMFIA Report and the CFO audits closer together as follows:

- All material weaknesses and instances of systems non-compliance with the Federal Financial Management Improvement Act (FFMIA) identified in the FY 1998 CFO audits, including any which the OPDIV may be aware of from the 1999 CFO audit at the time they prepared their FMFIA Report, were required to be reported to the Department. This is also consistent with Revised OMB Circular A-123 that requires that "...a deficiency should be reported if it is or should be of interest to the next level of management."
- OPDIVs were asked to recommend which, if any, of their CFO audit material weaknesses and FFMIA non-compliances should be included as an FMFIA material weakness in the Department's Report, i.e., are significant enough to be reported outside the agency to the President and Congress.
- Under existing departmental policy a corrective action plan is required for all CFO audit material weaknesses which are tracked under the CFO audit process. However, for those material weaknesses and FFMIA non-compliances the OPDIV recommends for inclusion in the Department's FMFIA Report, OPDIVs were required to include a corrective action plan in the FMFIA format and submit it with their report. Those material weaknesses which resulted from the CFO audits and are included in the Department's 1999 FMFIA report were described under "Section B" above.

However, all of the audit material weaknesses, with the exception of those discussed in Section B, are not included in the Department's FMFIA report because HHS believes that the remaining material weaknesses do not reach a level of significance that require reporting to the President and Congress as defined under Revised OMB Circular A-123. Further, as stated previously, HHS requires corrective action plans to address all of the findings resulting from the CFO financial statement audits, including qualifications/ material weaknesses and reportable conditions. Reporting all CFO audit material weakness in the Department's FMFIA report would duplicate the CFO process.

D. Federal Financial Management Improvement Act (FFMIA) and Section 4 FMFIA

The auditor's opinion on the Department-wide FY 1999 CFO financial statement audit identified three instances of non-compliance with the FFMIA, which are reported elsewhere in the HHS Accountability Report. The FFMIA non-compliances are as follows:

1. The accounting systems used by HHS and the operating divisions were not adequate to prepare reliable and timely financial statements (also known as financial systems and reporting).
2. HCFA did not have an integrated accounting system to capture expenditures at the Medicare contractor level.
3. The HCFA central office and Medicare contractor access and application control weaknesses were significant departures from requirements of OMB Circulars A-127, Financial Management Systems, and A-130, Management of Federal Information Resources.

(1) Financial Systems and Reporting

As stated above, HHS is declaring a Departmentwide material weakness in financial systems and reporting in this year's Report. The auditors reported instances of non-compliance including: adjusting financial statement amounts but not the underlying general ledger; using accounts not prescribed by the U.S. Standard General Ledger (SGL); and not posting accounts in accordance with prescribed SGL rules. However, HHS systems remain in overall compliance with Section 4 of the FMFIA.

(2) Financial Management Controls at the Medicare Contractors

Regarding financial management controls for Medicare contractors, HCFA has made substantial progress; however its efforts to complete corrective action, including efforts to implement an integrated accounting system for HCFA and the Medicare contractors, have been delayed due to the need to first address Y2K issues. HCFA has now developed a long_range multi_year plan for an integrated general ledger system. In the meantime, HCFA continues to utilize information collected from the contractors for the standard general ledger as part of the entry into HCFA's accounting system, which is validated through reviews performed by central office staff. Therefore, the Department believes that the lack of an integrated accounting system at this time does not constitute an FMFIA Section 4 non-compliance.

(3) EDP Controls

As reported above, HCFA has carried over two material weaknesses from the FY 1998 report addressing the need for EDP controls including systems access and application controls at the HCFA central office and the Medicare contractors. Full resolution of these issues was delayed because of Y2K initiatives. The OIG acknowledged in its findings that HCFA had made substantial improvement in the areas of systems access control, application software development and change control. HCFA has developed a Corrective Action Plan to resolve this finding in FY 2000.

The Payroll EDP processing systems control issues cited in FY 1998 were resolved.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Statistical Summary of FMFIA Material Weaknesses and Non-Conformances
Management Control

	Number of Material Weaknesses		
	Number reported for the first time in:	For that year, number that have been corrected:	For that year, number still pending:
Prior Years	344	336	3 1/
1997 Report	3	2	1
1998 Report	2	0*	1*
1999 Report	1	0	1
Total	349	338	6 ¹
Of the total number corrected, how many were corrected in 1999? <u>0</u>			

Financial Management Systems

	Number of Material Non-Conformances		
	Number reported for the first time in:	For that year, number that have been corrected:	For that year, number still pending:
Prior Years	11	8	0 2/
1997 Report	0	0	0
1998 Report	0	0	0
1999 Report	0	0	0
Total	11	8	0 ¹
Of the total number corrected, how many were corrected in 1999? <u>0</u>			

¹ The number of corrected and pending material weaknesses from prior years does not add to the total pending because: a) excludes 1 pending material weakness formerly reported by HHS for the Social Security Administration (SSA) is being reported by SSA in their accountability report; b) excludes 3 HCFA deficiencies formerly reported as material weaknesses, since these deficiencies are no longer material and, therefore, do not require reporting outside the agency; and c) includes an adjustment of -1 to reflect combining HCFA Medicare Secondary Payer (HCFA 89-01) with HCFA Accounts Receivable (HCFA 97-02).

² The number of corrected and pending material non-conformances does not add to the total reported because this number excludes 3 pending material non-conformances formerly reported by HHS for the Social Security Administration. SSA now reports on the status of those material non-conformances in their accountability report.

* 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. This is consistent with the FY 1999 HCFA CFO financial statement audit.

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

NOTE: The number of material weaknesses reported on in this section is consistent with the number shown on page VI - 4.5.

* 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.

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (HHS 99-01)**

<p><u>Title and Description of Material Weakness:</u> Financial Systems and Reporting: Departmentwide routine periodic reconciliations and account analyses were not done throughout the year which resulted in various problems including:</p> <p>a) Departmentwide: Numerous material adjustments were needed to financial statements at year-end before reliable financial statements could be produced and provided to the auditors. These included instances of: adjusting financial statement amounts, but not the underlying general ledger; using accounts not prescribed by the U.S. Standard General Ledger (SGL); and not posting accounts in accordance with prescribed SGL rules.</p> <p>b) HCFA: Lack of account analysis and validation led to inaccurate balances in the Hospital Insurance/Supplemental Medical Insurance (HI/SMI) Trust Funds and missing Medicare benefit claims data. HCFA did not independently verify the Medicare Hospital Insurance/Supplemental Medical Insurance Trust Fund balances, did not reconcile these accounts at a sufficiently detailed level and used ineffective methodologies to calculate HI and SMI transfers. HCFA also did not periodically validate the National Claims history file to ensure the existence and completeness of the data. However, the National Claims History File problem has been resolved and internal controls have been strengthened to ensure the accuracy of trust fund balances.</p>	
<p><u>Pace of Corrective Action</u> Year Identified: 1999 Original Targeted Correction Date: N/A Correction Date in Last Report: NA Current Correction Date: FY 2000</p>	<p>Lead Managerial Contact: Department: Sue Mundstuk, Director, Division of Accounting and Fiscal Policy</p> <p>HCFA: Jeff Chaney, Director, Division of Accounting, Financial Service Group, Office of Financial Management</p> <p>Source of Discovery: FY 1999 financial statement audit by OIG and other sources.</p> <p>Appropriation/Account #:</p>
<p><u>For Corrected Items Only</u> Validation Process Used:</p> <p>Results Indicators:</p>	

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
(HHS 99-01)****Description of Material Weakness (Continued)****a) Financial Systems and Reporting, Department-wide:**

To address the problem that routine analyses and reconciliations were not being done throughout the year, the Department revised its procedures in guidance issued July 29, 1999 to strengthen requirements for periodic analyses and reconciliations. Various reconciliation/account analysis problems were identified in several OPDIVs which were most material in HCFA as noted below.

b) Financial Reporting, HCFA**Trust Fund Reconciliation:**

During fiscal year (FY) 1999, a series of bookkeeping errors caused the Medicare Hospital Insurance (HI) Trust Fund to be overfunded by \$14 billion and the Supplemental Medical Insurance (SMI) Trust Fund to be underfunded by \$18 billion. As a result of these errors, the HI Trust Fund earned excess interest in the amount of about \$154 million and the SMI Trust Funds lost interest earnings in the amount of about \$237 million for FY 1999. The net total loss of interest to the Medicare Trust Funds is approximately \$83 million. The Office of the Actuary is reviewing and finalizing these amounts.

During the last 9 months of FY 1999, the monthly adjustments that were made between the estimated amount deposited into the transfer accounts during the month and the actual Medicare benefit outlays were made in error. For example, if funds remained in the transfer accounts at month end, and funds were to be returned to the Medicare Trust Funds, the actual adjustment that was made had the effect of transferring additional funds to the transfer accounts. In addition, the adjustments were not reconciled to month-end transfer account balances shown on the Undisbursed Appropriation Account Ledger (FMS-6653) report, which the Department of the Treasury's Financial Management Service supplies to agencies monthly. Finally, it appears that, because of insufficient training, staff did not understand that the large month-end transfer account balances on the FMS-6653 (positive or negative amounts) were indicative of problems in the adjustment process. It is evident that the checks and balances designed to prevent these kinds of errors from occurring were not effective, and supervision was not adequate. A CAP has been developed to address this situation and to prevent these problems from occurring again.

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (HHS 99-01)**

Briefly define (purpose, scope, methodology, resources) the corrective action plan (CAP) that corrects/improves this material weakness

Department: Working with the Office of Inspector general, evaluation teams will be formed consisting of Department and OIG staff. The teams will focus on critical reconciliation issues in the OPDIVs to resolve audit findings and avoid future audit findings. Specific tasks include: 1) determine if OPDIVs have proper internal control procedures in place; 2) if so, determine that proper financial reporting procedures are being followed; and 3) test the procedures to see if they are effective. OIG will also test the Medicare National Claims History file.

HCFA: As part of HCFA’s CAP to correct the trust fund error, HCFA has taken steps to correct the error by making the necessary transactions to decrease the balance of the HI Trust Fund and to increase the balance of the SMI Trust Fund. HCFA is in the process of seeking approval/authority to reduce the HI Trust Fund interest revenue and to increase the SMI Trust fund interest revenue. HCFA has performed a detailed analysis of the Medicare Trust Funds account activity and processes affecting this account to determine the reason for these internal control weaknesses and to eliminate them in the future. Consequently, we have implemented procedures that will ensure that employees involved in the process have the appropriate level of expertise and that each person involved in the process fully understands his/her assigned duties.

HCFA has instituted protocols to provide qualified and continuous supervision to ensure that employees adequately perform their assigned duties, and has established a formal system of monthly reconciliations and analyses of key financial data that includes readily available supporting documentation and senior management approval.

5) CAP Milestones for FY 2000

Scheduled Due Dates

Financial Reporting HHS-wide

Form evaluation teams of Department and OIG staff	June, 2000
Build an efficient process for producing financial statements in the PSC and NIH financial systems	June, 2000 (start date)

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (HHS 99-01)**

CAP Milestones for FY 2000

Scheduled Due Dates

HCFA – Trust Fund Reconciliation

A. Analyze the condition of the Trust Funds Account as of October 1999 and determine the corrective action necessary to eliminate the cause and internal control weaknesses of the inappropriate account balances and to correct the error.

October 1999

Milestone status: Completed

B. Determine the impact on the interest earnings on the Trust Funds account

October 21, 1999

Milestone status: Completed

C. OMB, Treasury and HHS are in negotiations to determine the appropriate actions to correct the interest earnings in the HI and SMI Trust Fund accounts.

ASAP

Milestone status: In process

D. Strengthen internal controls to prevent future errors by making the adjustment to the Trust Fund Accounts on the 6th day of the month, which is the next day after the required source documents are received in the Division of Accounting.

November, 1999

Milestone Status: Completed.

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (HHS 99-01)**

CAP Milestones for FY 2000

Scheduled Due Dates

HCFA (Continued)

E. Implement monthly use of the Benefit Adjustment spreadsheet for use in performing analyses, calculations and verification of the monthly Trust Fund Account adjustment.

November 18, 1999

Milestone status: Completed.

F. Develop written, detailed procedures on the use of the Benefit Adjustment spreadsheet and the preparation of the Statements of Non expenditure Transfers (SF-1151's and current Month's Statement of transactions (SF-224's).

March 15, 2000

Milestone Status: In process. Procedures have been drafted

G. Staff responsible for preparing the SF-1151 and the SF-224 received detailed training for the preparation of these forms and the use of the Benefit Adjustment spreadsheet.

November 18, 1999

Milestone Status: Completed

H. All supporting documentation will be reviewed and approved at least monthly by an Accountant, the Accounting Systems Management Branch Chief, Division of Accounting Director, and the Deputy Director of the Financial Services Group. The package will contain the transmittal letter to Treasury, the required SF-1151, the Benefit Adjustment spreadsheet and the source documents to support the adjustment. The signature on the letter and any SF-1151 returning funds to the Trust Funds will be that of the Director, Division of Accounting.

November 18, 1999

Milestone Status: Completed.

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
(HHS 99-01)****ADDITIONAL BACKGROUND INFORMATION ON TRUST FUNDS**

The Medicare Trust Funds are invested in interest-bearing securities managed by the Department of the Treasury. Medicare benefit payments are paid out of non-interest bearing accounts commonly referred to as transfer accounts. There are two separate transfer accounts, one for HI and one for SMI. Each week, based on estimated Medicare benefit outlays, the Department of the Treasury transfers (deposits) funds from the Medicare Trust Funds into the Medicare transfer accounts. Then, as Medicare benefits are paid throughout the month by our contractors, the outlays are charged to the transfer accounts.

The deposits into the transfer accounts are based on estimates. At the end of the month, the actual Medicare benefit outlays are determined by HCFA's Division of Accounting (DA), and an adjustment is made between the estimated amounts that have been deposited into the transfer accounts and the actual Medicare benefit outlays that have occurred. If the estimate was too high during the month, and excess funds were deposited into the transfer accounts, funds are returned from the transfer accounts to the Medicare Trust Funds. However, if the estimate was too low, and insufficient funds were deposited into the transfer accounts, then additional funds are transferred from the Medicare Trust Funds into the transfer accounts.

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (ACF-90-05)**

<p>Title and Description of Material Weakness: Increase Office of Child Support Enforcement (OCSE) Internal Control Efforts to Promote Improvements in State Financial Controls Over Child Support Collections and Expenditures - ACF-90-05.</p> <p>Increased federal stewardship is needed to promote adequate internal controls and cash management practices states establish to guarantee that child support collections are safeguarded and distributed properly, that unidentified collections are reconciled, and that interest on collections is offset against program expenditures.</p>	
<p><u>Pace of Corrective Action</u> Year Identified: 1990 Original Targeted Correction Date: FY 1999 Correction Date In Last Year's Report: FY 2000 Current Correction Date: FY 2005 Reason for Change in Dates:</p>	<p>Name of Responsible Program Manager: David Ross Source of Discovery: Management assessment report dated August 1990; and recent management reviews by OCSE Audit Division Lead Managerial Contact: Keith Bassett Appropriation/Account #: 75XI501</p>
<p>Validation Process Used: Upon request, managers will be held accountable for providing appropriate documentation to the Agency or Department to validate the correction of the material weakness.</p> <p>Results Indicators:</p> <ol style="list-style-type: none"> 1. Staffs in both the ACF Regional Offices and the States should be trained in the area of internal controls and cash collection responsibilities. 2. Potentially inappropriate financial reporting of Child Support Collections and interest earned on these collections should be identified in a more timely manner. 	

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (HCFA-97-02)**

Title and Description of Material Weakness: Improved financial reporting to properly account for Medicare Accounts Receivable and other financial information.

The HHS Office of Inspector General (OIG) has not been able to provide assurance as to the reasonableness and accuracy of the AR in the Health Care Financing Administration's (HCFA) financial statement reported by the Medicare contractors due to the lack of documentation to support AR activity. A revised corrective action plan (CAP) was implemented during FY 1999 to address this issue. In FY 1999, HCFA worked diligently to improve the financial reporting of its accounts receivable and other financial information at contractor sites. As a result, we have achieved many of our goals including: the issuance to all contractors of revised Financial Reporting Policies, the development and issuance of clear policies on write-offs and adjustments, and the development of a revised policy for identifying and reporting Medicare Secondary Payor receivables. However, many Medicare contractors remain limited in their financial reporting because they still lack general ledger systems that incorporate double entry book keeping. As a result, some Medicare contractors are still unable to adequately and consistently support their financial reporting activities in accordance with HCFA policies. For this reason HCFA believes this issue will still be considered a material weakness in FY 1999.

Pace of Corrective Action

Year Identified: FY 1997

Original Targeted Correction Date: FY 1999

Correction Date in Last Report: N/A

Current Correction Date: 1999

Name of Responsible Program Manager: G. Jeff Chaney, Director,
 Division of Accounting, FSG/OFM

Source of Discovery:

Appropriation/Account #:

For Corrected Items Only

Validation Process Used:

Results Indicators:

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (HCFA-97-02)**

Briefly define (purpose, scope, methodology, resources) the corrective action plan (CAP) that corrects/improves this MW:

HCFA continues to provide instructions/guidance to the Medicare contractors on reconciling their quarterly financial reports to existing HCFA data to ensure accurate reporting. As HCFA progresses toward its long-term goal of developing an integrated financial management system, we continue to provide training and guidance to Medicare contractors regarding good financial reporting through educational activities, internal audits and self-assessments. HCFA will continue to use consultants to evaluate the validity and completeness of the Medicare accounts receivable.

Overall Status of Material Weakness at the Close of FY 1999 (global progress toward correcting/improving this weakness over this fiscal year).

All short term corrective actions for FY 1999 have been completed. In addition to our revised policies, HCFA entered into an agreement with the OIG to hire independent public accountants to provide consulting services to assist the agency in validating the accuracy and completeness of its accounts receivable. The consultants performed work at contractor locations that accounts for approximately 81 percent of the outstanding AR balance reflected in the agency's financial statement. Additionally, OIG performed similar work to validate AR at HCFA CO and RO.

The implementation of the revised policies and other initiatives undertaken in this FY have resulted in significant adjustments and write-offs made to HCFA's AR balance. HCFA identified about \$4.3 billion of AR that were corrected in our financial statements this year. This \$4.3 billion is made up of three segments: (1) \$2.7 billion referred to as currently not reportable, (2) \$1.3 billion in adjustments and (3) \$.3 billion written off primarily due to the expiration of the statute of limitations. The \$1.3 billion (principal and interest) reflected in HCFA's financial reporting, resulted from the validation effort performed by the OIG and the consultants, and revised policies and supplemental guidance provided by HCFA to the Medicare contractors.

CAP Milestones for FY 2000

Scheduled Due Dates

Identify CAP Milestones for FY 2000

Scheduled Due Dates

A. HCFA will continue to provide general and specific guidance to Medicare contractors regarding financial reporting activities, specifically in reconciling their financial data to HCFA records.	Ongoing
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Milestone status: Ongoing

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (HCFA-97-02)**

CAP Milestones for FY 2000

Scheduled Due Dates

B. HCFA will continue monitoring contractors' AR data and supporting documentation particularly regarding write-offs and the identification and adjustment of MSP receivables. Ongoing

Milestone status: Ongoing

C. HCFA will continue using consultant firms to support and review AR balances. March 31, 2000

Milestone status: In the planning phase.

D. HCFA will test financial management internal controls at about 25 Medicare contractors using Certified Public Accounting Firms. FY 2000

Milestone status: In Progress.

E. Long-Range Plan Milestone

Develop, an integrated general ledger system for all Medicare contractors. FY 2004

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (HCFA-98-01a)**

Title and Description of Material Weakness: Medicare EDP Controls. Note: This material weakness is in two parts as reported by the auditors in the HCFA FY 1999 financial statement audit: a) Improve Systems Application Controls for Medicare Contractors (HCFA 98-01a); and b) System Access Controls in HCFA Central Office (HCFA 98-01b). Following is a description and corrective action plan (CAP) for (a) Improving Systems Application Controls for Medicare Contractors. (Note: The CAP for the second part can be found at exhibit HCFA 98-01b immediately following this exhibit.)

There are three parts to this material weakness: 1) One fiscal intermediary had developed and implemented an override library that gave locally changed programs higher execution priority over the standard Fiscal Intermediary Shared System (FISS) Programs provided by the FISS maintainer; 2) At one fiscal intermediary, the programmers made local changes to the FISS programs outside of the Program Assistance request (PAR) process. Program changes performed locally are not subjected to the same documentation, authorization, testing, quality assurance, and other requirements present in the standard PAR process; and 3) The Medicare Carrier System (MCS) is the carrier shared system and the MCS application contains numerous edits and audits. Although the carriers do not have MCS source code, the application, by design, allows them to deactivate almost all of the edits in the application, including mandatory HCFA edits.

Pace of Corrective Action

Year Identified: 1998

Original Targeted Correction Date: FY 1999

Correction Date in Last Report: NA

Current Correction Date: FY 2000

Lead Managerial Contact: Edward King, Director, Business Systems Operations Group, Office of Information Services

Source of Discovery: FY 1997 financial statement audit by OIG

Appropriation/Account #: Bureau of Program Operations, HCFA

For Corrected Items Only

Validation Process Used:

Results Indicators:

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
(HCFA-98-01a)****Briefly define (purpose, scope, methodology, resources) the corrective action plan (CAP) that corrects/improves this material weakness**

The identified weaknesses related to the FISS and the MCS are currently being addressed. The specific local site that made the changes to the FISS code took actions to formally document the changes. The finding identified for the NCS system related to the exact duplicate edits was fixed in April 1998. As a long term solution, the process will be enhanced to limit overrides and to provide reasonable assurance that only authorized access to source code and programs is permitted. The will require the development and implementation of policies and procedures for safeguarding programs/systems that support claims processing and financial functions. Suggested control objectives have been provided to Medicare contractors for consideration as part of their internal control certification process for FY 2000.

Summarize status of Material Weakness corrective action plan at the close of FY 1999 (identify progress in correcting/improving this weakness, explain any missed milestones, etc.):

HCFA has made notable progress regarding EDP. All short term corrective actions for 1999 have been implemented. Other corrective actions have begun, but the end results are not yet evident.

Contractors have access to source codes to allow them to take immediate action in emergency situations to resolve abnormal program ends that would otherwise potentially cause serious payment to processing delays and to accommodate individual intermediary requirements such as writing special printing hardware interfaces to handle print utilities. After all Y2K activities are completed, HCFA will begin development of EDP strategies that do not require HCFA to release source codes but continue to allow contractors to take immediate action to resolve processing problems.

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (HCFA-98-01a)**

CAP Milestones for FY 2000

Scheduled Due Dates

A. FISS - Local contractor(s) review and document local changes to the PAR.

Ongoing

Milestone status: Ongoing.

B. Develop procedures which allow contractors to resolve processing problems without requiring use of the source code.

FY 2000

Milestone status: Will begin after completion of Y2K activities.

C. Implement system changes to establish internal controls:
 a) hard code HCFA mandated payment edits into standard systems or local contractor systems. b) implement access control to production program libraries.

FY 2000

Milestone status: Will begin after completion of Y2K activities.

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (HCFA-98-01b)**

<p>Title and Description of Material Weakness: Medicare EDP Controls. This is the second part of the material weakness called Medicare EDP Controls as reported by the auditors in the HCFA FY 1999 financial statement audit: System Access Controls in HCFA Central Office (HCFA 98-01b). Following is a description and corrective action plan (CAP) for Systems Access Controls in the HCFA Central Office.</p> <p>Direct command-line access to the M204 database has been granted to approximately 150 applications developers and Data Base Administrators (DBAs). With the knowledge of file names and database update passwords, these developers can intentionally or inadvertently modify or update the data structures within specific regions of the M204 database. The M204 database product is used to store data for many of HCFA's sensitive applications, including, but not limited to, the Automated Payment Plan System, Enrollment Database and Group Health Plan Applications.</p>	
<p><u>Pace of Corrective Action</u> Year Identified: 1998 Original Targeted Correction Date: 1999 Correction Date in Last Report: FY 2000 Current Correction Date: FY 2000</p>	<p>Lead Managerial Contact: Dennis Read – Director, Technology Infrastructure Group, Office of Information Services</p> <p>Source of Discovery: FY 1997/FY 1998 financial statement audits by OIG</p> <p>Appropriation/Account #:</p>
<p><u>For Corrected Items Only</u> Validation Process Used:</p> <p>Results Indicators:</p>	

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (HCFA-98-01b)**

Briefly define (purpose, scope, methodology, resources) the corrective action plan (CAP) that corrects/improves this material weakness

HCFA will use the utility product SIRSAFE to enhance M204 security controls. HCFA workgroup developed and provided training on SIRSAFE to the Group Health Plans system developers and owners in November 1999. Because of Y2K priorities and deadlines, HCFA was unable to meet its December 1999 implementation target date. The implementation process for SIRSAFE is now scheduled to begin in January 2000. Training for the other M204 developers and owners will be held the week of January 10, 2000. A detailed project plan has been developed for this effort. Also activities have been planned for intensifying training, awareness and Medicare contractor oversight in the year 2000.

Summarize status of Material Weakness corrective action at the close of FY 1999 (progress in correcting/improving this weakness, explanation of any missed milestones, etc.):

Much of our energy during 1999 was spent ensuring that our systems meet the Y2K requirement. We have made progress in addressing some of the EDP concerns addressed in the 1998 audit. Many of the corrective actions have been implemented but the end results are not yet evident.

CAP Milestones for FY 2000

Scheduled Date

A. Provide training to GHP system Developers and owners on implementing SIRSAFE security utility.

November, 1999

Milestone status: Complete

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (HCFA-98-01b)**

CAP Milestones for FY 2000

Scheduled Date

B. Provide training on SIRSAFE security utility to other M204 developers and owners.

February 2000

Milestone status: Complete.

C. Improve the process to control M204 access via a commercial product that should be in place by January 2000.

September 2000

Milestone status: In process.

D. Continue to enhance access controls through improvements in training, risk assessments, system administration, and internal audits.

Ongoing

Milestone status: HCFA has contracted the services of experienced personnel to provide assistance in the areas of Security Training & Awareness; Security WEB Site Development; Network Security Testing; Security Plan Development; Systems Accreditation; Security Engineering; Security Architecture; Technology Assessment; Physical Security; Disaster Recovery; and Emergency Response.

These efforts are an integral part of the HCFA Enterprise Systems Security initiative.

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (FDA-89-02)**

<p>Title and Description of Material Weakness: Weakness in the Enforcement Program for Imported Foods in the Food and Drug Administration (FDA) - (FDA-89-02). The Office of Inspector General reported that FDA did not inspect a large enough sample of imported foods to ensure the safety of the public health.</p>	
<p><u>Pace of Corrective Action</u> Year Identified: 1989 Original Targeted Correction Date: 1990 Correction Date in Last Year's Report: FY 1999 Current Correction Date: FY 1999 Reason for Change in Dates:</p>	<p>Name of Responsible Program Manager: Dennis Baker Source of Discovery: OIG (Report A-15-90-00001) and internal FDA management reviews. Appropriation/Account # 7520600</p>
<p>Validation Process Used: A corrective action review will be completed following correction of the material weakness.</p> <p>Results Indicators:</p> <p>FDA determined that a 20 percent minimum inspection rate to assure the safety of the imported foods was unrealistic. As a result, a revised strategy for how the Agency will deal with imported foods has been prepared. FDA's new approach will focus on products and problems which present a high risk to the American public, or firms and countries of origin which have a history of noncompliance.</p>	

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (FDA-89-02)**

Title and Description of Material Weakness: Weakness in the Enforcement Program for Imported Foods in the Food and Drug Administration (FDA)

Major Milestones	Milestone Dates		
	Original Plan	Revised Plan	Actual Date
<p><u>(a) Completed actions/events:</u> FDA uses a structural and selective sampling method, based on both the entry level and product intelligence to provide an effective level of examination coverage. This assessment is supported by historical data covering the period of 1972-1992.</p> <p>FDA developed a Revised Imports Strategy which embodies intelligence based sampling of imports to provide an effective level of coverage, and includes performance indicators. With this new approach, FDA focuses its import activities on products and problems presenting a high health risk to the American public, or firms and countries of origin which has a history of non-compliance. Electronic screening, improved strategic alliances and improved premarket and postmarket surveillance are key components of the revised strategy.</p> <p>FDA has expanded the use of an electronic entry processing system (EEPS) for imports using the Custom's Automated Commercial System. EEPS enables FDA to screen import entries and electronically make "May Proceed" decisions on products of low risk and high compliance rates. At this time, EEPS has been implemented at all major ports where electronic entry of imports is available.</p> <p>FDA plans to maintain its pre-market surveillance through a vigorous foreign inspection program designed to identify problems at their source. FDA completed 866 foreign inspections during FY 1995. This represents an increase of 16.7% from FY 1994 accomplishments. This total includes inspection of 65 food firms.</p> <p>DIOP received approval from CDER to expand ACS screening criteria for drug products. This should increase the "May Proceed" level from the current rate of 60%. FDA completed 829 foreign inspections during FY 1996. The number of foreign inspections planned in FY 96 was 1418. This represents a decrease of 4.3% from FY 1995 accomplishments.</p> <p>The number of foreign inspections planned for FY 1997 was 997. This total includes inspection of 40 food firms. FDA completed 811 foreign inspections during FY 1997. This represents a decrease of 2.2% from FY 1996 accomplishments.</p>			<p align="center">1992/93</p> <p align="center">FY 1994</p> <p align="center">FY 1995</p> <p align="center">FY 1996</p> <p align="center">FY 1997</p>

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (FDA-89-02)**

	Original Plan	Revised Plan	Actual Date
<p>FDA completed 938 foreign inspections during FY 1998. The number of foreign inspections planned was 976. This represents a 15.6% increase over FY 1997 accomplishments.</p>	FY 1998		1998
<p>Complete the full roll-out of OASIS version 2 to all district offices.</p>	FY 1998		1998
<p>The default “May proceed” rate for all food commodities has been set at 70% or greater. However, the “May proceed” rate measured at any particular time may be lower as FDA intensifies a problem with a firm, country or product. These adjustments are considered essential to FDA surveillance activities.</p>	FY 1998		
<p><u>(b) Actions Completed During FY 1999:</u> The number of foreign inspections planned for FY 1999 is 987. This included inspection of 40 food firms. FDA completed 810 foreign inspections during FY 1999. This total includes the inspection of 87 foreign food firms.</p>	FY 1999		1999
<p><u>c) Planned/continuing agency actions:</u> All facets of the Revised Imports Strategy will continue to be implemented and evaluated.</p> <p>The number of foreign inspections planned for FY 2000 is 942. This included inspection of 175 food firms.</p> <p>FDA continues to develop and evaluate agreements with foreign governments whose requirements and regulatory infrastructure are equivalent to FDA’s. As these agreements are developed and finalized, surveillance resources can be targeted toward countries whose internal requirements supply less assurance of compliance with U.S. requirements.</p> <p>The rate of increase in imported entries has been too rapid to maintain the 4% examination rate. In FY 1997, the agency processed 2,765,548 line items of food and performed 47,478 physical examinations. This represents an examination rate of 2%. Further, based on projections from entry data for the first 9 months of FY 1998, there will be approximately 3,348,000 line items of food offered for entry, a 21% increase in entry lines over FY 1997 data.</p> <p>Since maintaining the 4% examination rate is not realistic, FDA believes that identifying forms and countries with inspection systems comparable to those in the United States and in accordance with the Food Safety Initiative is a viable alternative to increasing the point of entry examination of FDA regulated products.</p>	FY 2000		

**1999 FMFIA MATERIAL WEAKNESSES: SCHEDULE OF CORRECTIVE ACTIONS
 (PHS-93-02)**

<p>Title and Description of Material Weakness: Deficiencies in the Public Health Service Technology Transfer Activities</p> <p>Deficiencies were noted in the PHS technology transfer activities. The technology transfer deficiencies include: (1) the management information systems are inadequate; (2) the processes to ensure that royalties and other payments are received are inadequate.</p>	
<p><u>Pace of Corrective Action</u> Year Identified: 1993 Original Targeted Correction Date: 1994 Correction Date in Last Year's Report: FY 1999 Current Correction Date: FY 2001 Reason for Change in Dates: Contractor failed to provide system in accordance with contract terms and budget. Program is seeking new contract to complete the work or develop a new system to replace the current system.</p>	<p>Name of Responsible Program Manager: Dr. Maria Freire Source of Discovery: NIH Alternative Management Control Review Appropriation/Account #: 7530846</p>
<p>Validation Process Used: NIH management will be required to demonstrate to the Department that corrective actions have been completed. This will be followed by a Corrective Action Review within one year to demonstrate that corrective actions taken remain effective.</p> <p>Results Indicators: Existence of policies, procedures, and information system.</p>	

**1999 FMFIA MATERIAL WEAKNESS: SCHEDULE OF CORRECTIVE ACTIONS
 (PHS-93-02)**

Title of Material Weakness: Deficiencies in the Public Health Service Technology Transfer Activities

Major Milestones	Milestone Dates		
	Original Plan	Revised Plan	Actual Date
1. OTT will improve its information systems so its staff can more easily determine what costs have been incurred, billed and collected.	Oct. 98	June, 2001	
2. OTT will revise the current model license agreements used by NIH to include standard language on auditing; develop criteria for use in determining whether or not an audit should be requested by NIH; and obtain ICD approval to enter into contracts to conduct audits as required.	Oct. 98		Aug. 98
3. OTT will improve its information systems, so it can accurately document the status of each patent application.	Oct. 98	June, 2001	
4. OTT will develop an integrated management information system that will effectively track and report on CRADAs, inventions, patent prosecution status and costs, licensing, and receipt of royalty payments for domestic and foreign filed cases.	Oct. 98	June 2001	
5. OTT will update the Technology Transfer Policy Manual, Chapter 206, and establish clear internal procedures on the processing and content of infringement log items.	March 98		March 98
6. Information from the infringement log will be migrated to the new data system where it will be maintained in the future.	Oct. 98	June 2001	
7. OTT will review how the new process for announcing the availability of technologies is working after it has been in effect for one year. Part I: Conduct an analysis Part II: Complete an Evaluation	June 98 Nov. 98		Oct. 98 Oct. 98
8. OTT will make further adjustments, as necessary, to reduce the amount of time between the filing of a patent application and publication of the abstract in the Federal Register.	Nov. 98		Aug.98 and ongoing
9. OTT will provide assistance and guidance, as necessary, in preparing technology training, and will provide oversight to ensure the training provided by the ICDs is conducted properly.	Oct.98 and ongoing		
Note: Items 1, 3, 4, and 6 are tied to the completion of the new OTT data system.			

Management Report On Final Action



October 1, 1998 - September 30, 1999

MANAGEMENT REPORT ON FINAL ACTION

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MANAGEMENT REPORT ON FINAL ACTION

October 1, 1998 - September 30, 1999

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

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

- o Initiated action to recover \$259 million through collection, offset, or other means (see Table I);
- o Completed action to recover \$93 million through collection, offset, or other means (see Table I);
- o Initiated action to put to better use \$862 million (see Table II);
- o Completed action that over time will put to better use \$997 million (see Table II).

At the end of this period there are 239 reports over a year old with uncollected balances or unimplemented monetary findings. The reasons these reports are still pending are found in the notes to the tables.

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

- o The Operating Divisions (OPDIVs) have lead responsibility for implementing and follow-up on IG audit recommendations.
- o The Assistant Secretary for Management and Budget (ASMB) establishes policy and monitors OPDIV compliance with audit follow-up requirements.

MANAGEMENT REPORT ON FINAL ACTION (continued)

- o **If necessary, the ASMB or the Deputy Secretary resolves conflicts between the OPDIVs and the IG.**

Departmental Conflict Resolution

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

The conflict resolution process escalates the disagreement through a series of steps designed to resolve the conflict within six months of the final audit report. If the OPDIV and the IG cannot resolve their disagreement within 135 days, the IG, OPDIV or the ASMB may request that the Audit Resolution Council (ARC) be convened. The Deputy Secretary, who would chair the ARC, makes the final decision for the Department. There were no disagreements requiring the convening of the Council.

STATUS OF AUDITS IN THE DEPARTMENT

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

Report on Final Action Tables

The following tables summarize the Department's actions in collecting disallowed costs and implementing recommendations to put funds to better use. The tables are set up according to the requirements of section 106(b) of the IG Act Amendments of 1988 (PL 100-504).

TABLE I

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
Management Action on Costs Disallowed in
Inspector General Reports
As of September 30, 1999
(\$ in thousands)**

	Number	Disallowed Costs \$
A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1.	289	369,247
B. Reports on which management decisions were made during the reporting period. See Note 2.	263	258,729
Subtotal (A & B)	552	627,976
C. Reports for which final action was taken during the reporting period:		
(i) The dollar value of disallowed costs that were recovered through collection, offset, property in lieu of cash, or otherwise.	230	93,001
(ii) The dollar value of disallowed costs that were written off by management.	15	3,403
Subtotal (i & ii)	245	96,404
D. Reports for which no final action has been taken by the end of the reporting period. See Note 3.	307	531,572

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

Note 2: This represents the amount of management concurrences with Inspector General's recommendations. This amount includes \$7,230,000 in management decisions that had not been recorded for the 1999 Office of Inspector General's Semi-Annual Reports, Table I, Line C.

Note 3: Includes the following lists of 239 Audits over one year old with outstanding balances to be collected. It includes audits under administrative or judicial appeal, under current collection schedule and legislatively uncollectible.

**Audit Reports Over One Year Old
 With Outstanding Balances To Be Collected
 As of September 30, 1999**

	Auditee	Date Issued	Amount \$	Explanations
01-90-05013	NARRAGANSETT	10/90	28,515	ACF--At Dept. of Treasury for offset.
01-91-06601	Connecticut/OCS	03/94	224,099	ACF--At Dept. of Treasury for offset.
01-94-25303	Waterbury/OCS	09/94	4,370	ACF--Payment Plan.
01-94-25904	Massachusetts/CC	02/95	9,225	ACF--under appeal.
01-95-32620	Connecticut/FC	05/97	4,070	ACF--Pursuing collection action.
01-95-37194	Indian Township	03/96	44,244	ACF--under appeal.
01-96-38182	Connecticut/FC	09/96	50,292	ACF--under appeal
01-96-39813	Pleasant Point/L	11/96	18,265	ACF--Treasury Offset Program.
01-96-43461	Connecticut/IV-E	01/97	1,902	ACF--under appeal.
01-97-44081	Vermont	10/97	28,252	ACF--pursuing collection action.
01-98-49834	Meri-Weather	05/98	60,864	ACF--Treasury offset program.
02-90-08393	Law Enforcem Comm.	06/90	22,597	ACF--Treasury offset program.
02-91-14405	Bedford Stuyvesa	03/92	369,770	ACF--partial appeal.
02-91-14535	Bedford Stuyvesa	03/92	373,231	ACF--referred to DOJ.
02-91-14845	Harlem Commonwealth	05/91	238,233	ACF--payment plan.
02-94-20022	New York IV-E	02/97	6,223,000	ACF--pursuing collection action.
02-95-02001	New York IV-E	02/97	945,022	ACF--pursuing collection action.
02-95-02005	Middlesex County	12/96	173,656	ACF--under appeal.
02-95-33649	Puerto Rico	12/96	1,433	ACF--under appeal.
02-97-47637	Puerto Rico IV-B	09/97	9,703	ACF--pursuing collection action.
03-91-14545	PA/WIN/Demo	06/91	800,885	ACF-under appeal.
03-92-17167	NI Coal Hispanic	06/92	1,555	ACF--At Dept. of Treasury for offset.
03-93-21104	PA/CSBG	03/94	150,000	ACF--under appeal.
03-94-27065	PA/CSBG	09/95	150,000	ACF--under appeal.
03-95-33212	PA/CSBG	09/95	137,207	ACF--under appeal.
03-95-00451	DC/Foster Care	08/97	420,606	ACF--pursuing collection action.

	Auditee	Date Issued	Amount \$	Explanations
03-96-39886	Halifax CCA/HS	05/96	53,280	ACF--Payment plan.
03-97-00587	Little Neighbor	01/98	300,465	ACF--Treasury offset program.
03-97-43787	Virginia/CCDBG	06/97	952,635	ACF--pursuing collection action.
03-97-47731	Delaware	09/97	11,880	ACF--pursuing collection action.
03-97-48111	Virginia/CCDBG	09/97	1,201,873	ACF--pursuing collection action.
03-97-48850	Little Neighborhood	11/97	91,193	ACF--At Dept. of Treasury for offset.
04-89-06323	Tallahossee CAA	04/90	35,934	ACF--payment plan.
04-91-06594	Mountain Valley	09/92	196,213	ACF--referred to DOJ.
04-92-17186	Mountain Valley	09/92	203,420	ACF--referred to DOJ.
04-93-23833	Mountain Valley	07/93	212,759	ACF--referred to DOJ.
04-93-00051	Haitian Task	03/94	200,207	ACF--referred to DOJ.
04-93-00059	Florida/ORR	12/97	24,088	ACF--Treasury offset program.
04-93-20785	Florida/Refugee	12/93	64,929	ACF pursuing collection action.
04-94-26346	PUTNAM-CLAY	09/94	86,292	ACF--At Dept. of Treasury for offset.
04-94-28234	NW GEORGIA	02/94	578,045	ACF--Treasury Offset Program.
04-94-29814	Reach Services	09/94	804	ACF payment plan.
04-94-30737	Mountain Valley	07/94	39,095	ACF referred to DOJ.
04-94-31826	W. CENTRAL GEORGIA	07/94	141,243	ACF-Treasury Offset Program.
04-95-32922	PUTNAM-CLAY-FLAG	01/95	284,172	ACF-- pursuing collection.
04-95-36519	DEKALB COUNTY	08/95	81,245	ACF pursuing collection.
04-96-38688	State of KY.	10/96	271,612	ACF pursuing collection.
04-96-42408	Oldham County	10/96	5,793	ACF-under appeal.
04-96-44126	Anderson-Oconee	02/97	143,366	ACF Treasury Offset Program.
04-97-44101	Tennessee IV-Ep	01/98	370,446	ACF--pursuing collection action.
04-97-45327	Mobil Community	07/97	127,705	ACF- Treasury Offset Program.
04-97-47475	Wash County Opp	11/97	273,151	ACF--payment plan established.

	Auditee	Date Issued	Amount \$	Explanations
04-97-49121	Florida	05/98	282,553	ACF-Treasury offset program.
05-95-00022	Illinois/IV-E	07/96	2,742,181	ACF pursuing collection action.
05-97-48402	Montgomery Cty.,CAA	11/97	79,374	ACF-District Court.
06-90-00052	Mexican Amer/Dis	04/92	1,590,600	ACF referred to DOJ.
06-94-32825	Texas Migrant/HS	04/95	70,556	ACF pursuing collection action.
06-95-36853	Albuq-Bernalilo	11/95	208,445	ACF under appeal.
06-96-40858	CADD0/HS	06/95	43,339	ACF--Payment plan .
06-96-42096	Education SV CT	09/96	728,757	ACF-under appeal.
06-97-44674	Tri-County	04/97	34,703	ACF- Treasury Offset Program.
06-97-45868	South Plains HS	07/97	1,972	ACF-under appeal
06-97-46216	E. Texas Family	09/97	12,497	ACF-Treasury Offset Program.
06-97-47730	Tri-County HE	12/97	2,451	ACF-Treasury Offset Program.
06-97-47939	Albuq/Bernalillo	08.97	210,330	ACF- Treasury Offset Program.
07-91-00413	Union Sarah Econ	01/93	633,625	ACF-Payment plan established.
08-91-15416	RAPID CITY AMER	02/92	30,257	ACF--Treasury Offset Program.
08-91-15417	RAPID CITY AMER	02/92	21,224	ACF--At Dept. of Treasury for offset.
08-92-00598	ANISHINAUBAG	08/93	43,267	ACF--At Dept. of Treasury for offset.
08-92-17549	RAPID CITY AMER	06/92	30,248	ACF--At Dept. of Treasury for offset.
08-96-01024	Child Opportunity Pro	06/97	1,483,771	ACF--pursuing collection action.
09-65148	YAVAPAI APACHE	08/86	14,814	ACF--At Dept. of Treasury for offset.
09-87-05251	YAVAPIA APACHE	04/88	32,662	ACF--At Dept. of Treasury for offset.
09-92-06592	Intertribal Cnl	09/93	181,900	ACF--payment plan.
09-92-06550	Butte County Cac	08/94	66,300	ACF--payment plan.
09-93-00083	California/Child Sup	09/97	1,429,837	ACF--pursuing collection action.
09-93-00106	California/Refugee	05/97	29,269	ACF--pursuing collection action.
09-93-21254	Arizona HS	09/93	184,274	ACF--At Dept. of Treasury for offset.
09-93-23668	CTR of EDUCATION	11/93	12,070	ACF pursuing collection.
09-93-23892	Fresno County HS	08/93	25,523	ACF--under appeal.
09-93-26204	Tohono Odham HS	02/94	90,077	ACF--under appeal.
09-94-27281	Arizona Affiliate	09/94	2,563	ACF--under appeal.

	Auditee	Date Issued	Amount \$	Explanations
09-94-28246	Butte County CAC	08/94	8,825	ACF--payment plan.
09-94-30207	Fresno County HS	11/94	22,062	ACF--under appeal.
09-95-31383	COCOPAH/HS	05/96	76,861	ACF--under appeal.
09-95-35961	Fresno County HS	08/95	29,215	ACF--under appeal.
09-96-00066	California	06/98	6,611,640	ACF--pursuing collection action.
09-96-00071	California/IV-E	04/98	15,693,626	ACF--pursuing collection action.
09-96-40113	Protec. & Advo.	04/98	80,574	ACF-under appeal.
09-96-40114	Protec. & Advo.	04/98	36,988	ACF-under appeal.
09-96-40115	Protec. & Advo.	04/98	56,344	ACF-under appeal.
09-96-42061	Tohono Odham HS	11/96	369	ACF-under appeal.
09-97-48953	Chemehuevi Ind.	06/98	5,246	ACF-under appeal.
01-89-00518	Blue Shield of MA	10/90	216,053	HCFA has instructed the carrier to calculate and recover the overpayments.
01-90-00500E	B/C of Massachusetts	09/90	7,048,076	HCFA and the hospital have signed a repayment agreement.
01-91-00508	AETNA LIFE-PARTS A&B ADM.	01/92	223,655	HCFA--Additional documentation from the contractor requests for review by OIG.
01-92-00517	BC of MA	04/93	160,122	HCFA is pursuing collection of the overpayment.
01-92-00523	MA BC/BS-Part B Lab Tests	01/94	2,250,000	HCFA is waiting a decision by the Assistant US Attorney in Boston pending criminal charges.
01-93-00512	BC/BS of MA - LAB TESTS	07/94	426,817	HCFA is pursuing collection of the overpayment.
01-94-00510	BC/BS of MS - ADM COSTS	04/95	130,299	HCFA is pursuing collection of the overpayment.
01-95-00005	DHS, NH DHS	07/96	30,565	HCFA is pursuing collection of the overpayment.
01-95-00503	G/A & CAPITOL MCLEAN HO - ADM COSTS	08/95	186,190	HCFA is pursuing collection of the overpayment.
01-96-00001	MASSACHUSETTS STATE DIVISION of MEDICAL ASSISTANCE	07/96	1,711,898	HCFA is pursuing collection of the overpayment.

	Auditee	Date Issued	Amount \$	Explanations
01-96-00513	Separately billable ESRDL Lab Test	12/96	6,300,000	HCFA sent tapes and instructions to Fis and Ros. OIG has not yet completed the carrier tapes.
01-96-00519	National Medical Care, Inc.	09/97	4,319,361	HCFA is pursuing collections.
02-86-62015	Empire BC/BS	03/88	1,277,575	Contractor appealed and court has ruled in favor of contractor. HCFA has filed an appeal in July 1993.
02-86-62016	EMPIRE BC/BS	08/88	3,027,672	Contractor has signed the closing agreement. An amended OCD is being prepared.
02-91-01003	EMPIRE BC/BS - OVERPAYMENTS	07/91	829,551	The contractor is in the process of recouping the overpayment.
02-91-01022	Prudential Ins.- ADM	03/92	6,837,167	HCFA is negotiating with the contractor on the outstanding overpayment.
02-91-01043	SSS - PART B/ESRD PATIENT	04/93	844,292	HCFA is in the process of collecting the overpayment.
02-92-01004	NJ DHS - CREDIT BALANCES FOR EIGHT HOSPITALS	09/93	89,839	Recovering of the overpayment is in progress.
02-92-01021	BCBSNJ - CREDIT BALANCES	06/95	14,900,000	HCFA is in the process of collecting the overpayment.
02-92-01023	BETH ISRAEL MED CTR - G&A	03/93	7,741	The contractor is in the process of removing the unallowable costs from the 1990 Cost Reports.
02-93-01005	EMPIRE BC/BS - PART B ADM	03/95	576,683	HCFA is pursuing collection of the overpayment.
02-93-01023	ISLAND PRO	10/94	155,540	Recovery of the overpayment is in progress.
02-96-01034	Staff Builders Home Health Incorporated	01/98	2,046,576	Recovery of the overpayment is in progress.
03-92-00150	ELMIRA JEFFRIES MNH	01/94	164,188	The State is in the process of collecting the overpayment.
03-92-00201	COMMONWEALTH of VA - CRED	01/93	205,177	The State is in the process of making a final determination on the overpayment.
03-92-00602	PA DPW - UPPER LIMIT	09/94	230,520	HCFA is pursuing collection of the overpayment.
03-93-00013	OMEGA MEDICAL LAB	11/93	1,102	HCFA is pursuing collection of overpayment.

	Auditee	Date Issued	Amount \$	Explanations
03-93-00025	PBS - LAB FEE SCHEDULES	09/95	953,377	HCFA is in the process of collecting the overpayment.
03-95-38380	COMMONWEALTH of VA (OGM)	03/96	68,333	HCFA is currently pursuing collection of overpayment.
04-91-02004	HCFA RO IV (FL BS - MSP)	09/93	4,147,919	Contractor is pursuing collection of the remaining overpayment.
04-92-01022	NC DEPT. of HUMAN RESOURCES	11/92	645,340	HCFA initiated a verification process to determine the final disposition of the hospital credit balances. This verification stage is ongoing, and HCFA anticipates that the audit may be closed in the near future.
04-93-20876	STATE of NC (OGCFM LEAD)	07/93	27,617	HCFA is awaiting documentation from the State to verify that funds were returned.
04-94-01096	HUMANA MEDICAL PLANS, INC. - ESRD	04/95	624,048	HCFA is pursuing collection of the overpayment with the contractor.
04-95-02110	SC BC (Hospice of Lake & Sumter, Inc.) - ORT	04/97	4,000,000	HCFA is reassessing this situation.
04-95-02111	SC BC (Hospice of Florida Suncoast, Inc.) - ORT	03/97	14,800,000	HCFA is reassessing this situation.
04-94-33005	STATE of MS (OGM)	08/95	63,140	HCFA will review the State's supporting documentation to ensure that the payment adjustments have been made.
04-95-33088	STATE of NC (OGM)	09/95	11,098	The State is in the process of determining how much of the overpayment has already been returned to HCFA.
04-95-38310	STATE of MS (OGM)	03/96	9,069,408	The State is in the process of determining how much of the overpayment has already been returned to HCFA.
04-96-01131	IHS -Fl. (Green Briar) - ORT	11/97	202,780	HCFA is pursuing collection.
04-96-01132	BC/BS of FL (Miami Jewish Home and Hospital) - ORT	04/97	91,991	Contractor is pursuing collection of the remaining overpayment.
04-96-01138	BC/BS of FL (Lawnwood Reg. Med. Ctr.) - ORT	04/97	111,986	Contractor is pursuing collection of the remaining overpayment.

	Auditee	Date Issued	Amount \$	Explanations
04-96-01148	IHSI- SNE Burbank IL. - ORT	11/97	148,955	HCFA is pursuing collections.
-4-96-38655	State of NC (OGM)	01/97	5,053	HCFA is reviewing the State's supporting documentation to ensure that the payment adjustments have been made.
05-90-00013	BC/BS of MI - ADMIN	12/90	2,413,388	This audit must remain open pending resolution of the contractor's termination audit, any related termination agreement and pending lawsuits.
06-92-00043	BC/BS of Tx, Inc. - GME Costs	03/94	4,252,743	Collection activity suspended pending resolution of an objection lodged by two Medicare providers' legal counsel with the OIG, OGC on January 26, 1994.
06-95-00095	Palmetto Gov. Ben. Admin. (Fam Hospice/Dallas) - ORT	04/97	871,306	HCFA is reassessing whether seeking the identified OIG hospice overpayment is the appropriate action to take.
06-96-00027	Palmetto Gov. Ben. Admin. (VNA of TX Hospice) - ORT	04/97	1,156,341	HCFA is reassessing whether seeking the identified OIG hospice overpayment is the appropriate action to take.
06-97-47756	State of LA (OGM)	09/97	357,089	The amount identified in the audit is a statistical projection. The State is in the process of determining the actual provider overpayments.
07-91-00471	BC/BS OF MI - SEG.	12/92	5,021,873	This audit must remain open pending resolution of the contractor's termination audit, any related termination agreement and pending lawsuits.
07-91-00473	BC/BS of FLORIDA, INC PENSION SEGMENTATION	08/93	4,755,565	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension account.

	Auditee	Date Issued	Amount \$	Explanations
07-92-00525	BC/BS of MI, INC. - PENSION	12/92	2,135,884	This audit must remain open pending resolution of the contractor's termination audit, any related termination agreement and pending lawsuits.
07-92-00604	WVA BC/BS - Term Pension	01/93	617,644	Contractor was declared insolvent and placed in receivership. The DOJ has filed a claim on behalf of HCFA for the amount due HCFA. The courts will determine how much, if any, Medicare will recover.
07-92-00608	BC/BS of MISSOURI - DENIED OUTPATIENT CLAIMS	06/93	960,615	HCFA will be verifying that corrective action has been completed by the fiscal intermediary.
07-93-00680	BC/BS of NC - UNFUNDED PENSION COSTS	10/94	293,629	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-93-00712	PA BS - PENSION	05/95	521,675	HCFA is in the process of collecting the overpayment.
07-93-00713	PA BS - PENSION	06/95	5,490,995	HCFA is in the process of collecting the overpayment.
07-94-00744	IASD HEALTH SERVICES CORP. - PENSION SEGMENTATION	09/94	3,079,484	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreement will subsume and close out the currently outstanding pension audits.
07-94-00745	IASD HEALTH SERVICES CORP. - UNFUNDED PENSION	05/94	574,804	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.

	Auditee	Date Issued	Amount \$	Explanations
07-94-00746	IASD HEALTH SERVICES CORP. - PENSION SEGMENTATION	05/94	842,979	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-94-00747	IASD HEALTH SERVICES CORP. - UNFUNDED PENSION	05/94	10,331	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-94-00768	BC/BS of SC - PENSION SEGMENTATION	09/94	840,493	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-94-00769	BC/BS of SC - PENSION COSTS	09/94	329,001	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-94-00770	BC/BS of SC - UNFUNDED PENSION	09/94	793,508	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-94-00777	BC/BS of GA - PENSION COSTS	10/94	90,736	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.

	Auditee	Date Issued	Amount \$	Explanations
07-94-00778	BC/BS of GA - UNFUNDED PENSION	10/94	363,921	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-94-00779	BC/BS of GA - PENSION SEGMENTATION	10/94	113,256	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-94-00805	BC/BS of TN - PENSION SEGMENTATION	01/95	1,400,063	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-94-00816	BC/BS of TN - UNFUNDED PENSION	01/95	352,026	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-94-00817	BC/BS of AL - UNFUNDED PENSION	07/95	912,730	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.

	Auditee	Date Issued	Amount \$	Explanations
07-94-00818	BC/BS of AL - PENSION SEGMENTATION	07/95	951,281	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-94-01107	BC/BS of FL - PENSION SEGMENTATION	04/96	813,122	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-95-01126	BC/BS of FL - UNFUNDED PENSION	04/96	4,049,889	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-95-01149	BC/BS of TEXAS - PENSION	04/96	874,111	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
07-95-01150	BC BS of Oregon - Pen Segm	08/97	191,312	HCFA is pursuing collection of the overpayment.
07-95-01151	Oregon BC/BS - Unfunded PenE	08/97	260,335	HCFA is pursuing collection of the overpayment.
07-96-01189	BC of WA and AK -Pension segmentation	12/97	96,740	HCFA is pursuing collection.
07-96-38172	State of IA (OGM)	09/96	29,381	The State has processed the credits, however, they are still determining when the credits were returned to HCFA via the HCFA-64.
07-96-44051	State of IA (OGM)	02/97	45,958	HCFA is working with the State to resolve this audit.
07-97-01205	BC of Washington and Alaska	12/97	15,688	Review of pension costs claimed for Medicare reimbursement.

	Auditee	Date Issued	Amount \$	Explanations
07-97-01206	BC of Washington and Alaska-unfunded pension costs	12/97	106,843	HCFA is working to resolve this issue.
07-97-01209	BC/BS of MS	01/98	224,711	HCFA review of pension segmentation.
07-97-01210	BC/BS of MS	01/98	482,549	HCFA is working to resolve unfunded pension costs.
07-97-01211	BC/BS of MS	01/98	134,312	HCFA is working to resolve pension costs claimed for medicare reimbursement.
08-94-00739	BC/BS of ND - PENSION SEGMENTATION	01/95	730,875	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
08-94-00740	BC/BS of ND -UNFUNDED PENSION	01/95	671,198	HCFA is working with all Medicare contractors to obtain signed advance agreements which set forth the terms and conditions of the amended Cost Accounting Standards (CAS 412). Implementation of the advance agreements will subsume and close out the currently outstanding pension audits.
09-89-00162	NATIONWIDE EMPLOYER PROJECT - MSP PAYER	03/95	2,218,824	Demand letters were sent to employers listed in the audit. D.C. Circuit Court's decision in the HIAA vs. Shalala case will result in few recoveries of funds from EGHPs, because of EGHP's timely filing limits. HCFA is attempting to fix the HIAA decision via new legislation.
09-95-00072	CA DHS	11/96	4,013,490	HCFA is pursuing collection of the overpayment.
09-96-00061	BS of California	06/98	1,006,192	HCFA is reviewing administrative costs.
14-96-00202	Unlicensed Health Care Providers	09/97	2,931	HCFA is pursuing Medicare payments.
17-95-00096	HCFA Financial Statement	05/98	300,000	HCFA is reviewing financial statements for fiscal year 1996.

	Auditee	Date Issued	Amount \$	Explanations
17-97-00097	HCFA Financial Statement	09/98	141,796	HCFA is reviewing financial statements for fiscal year 1997.
01-06082	Rural Health Centers - Maine	12/90	23,163	HRSA demand letter sent on 2/26/97.
01-36087	State of Maine	03/96	2,643	HRSA--Demand letter sent 08/25/99.
02-06275	Newark Community Health Centers	11/90	14,038	HRSA--demand letter sent on 12/19/97.
02-15053	Northwest Buffalo Comm.	12/91	9,281	HRSA--Referred to DFO Claims 6/26/97.
02-16577	Newark Community Health Centers, Inc.	11/92	31,708	HRSA--Demand letter sent on 12/19/97.
03-03313	Greater Philadelphia Health Action, Inc.	06/93	13,940	HRSA--Repayment agreement reached.
03-18235	Western PA Hospital of Nursing	10/92	5,559	HRSA--Partial payment on 05/99.
03-21785	D.C. Department of Human Services	03/94	7,726	HRSA--Demand letter sent 12/19/97.
03-51956	St. Charles Health Council	09/98	2,300	HRSA--Demand letter sent 06/15/99
06-27049	Greater Houston HIV Alliance	09/94	20,752	HRSA--Demand letter sent on 12/19/97.
04-24751	Vicksburg-Warren Community Health Center	12/93	590	HRSA--Debt referred to Justice Dept. 01/05/99.
04-50281	Aaron E. Henry CHC	09/98	3,017	HRSA--Demand letter sent 06/15/99.
04-51913	Borinquen Health Care Center, Inc.	09/98	815	HRSA--Demand letter sent on 06/15/99.
07-06845	Model Cities Health Corp.	10/90	41,406	HRSA--Under appeal, verified 10/14/97.
09-22308	Community Hlth. Foundation of Los Angles, CA., Inc.	09/93	36,968	HRSA--demand letter sent on 04/04/97.
06-91-00089	Creek Nation of OK.	04/92	445,890	IHS--We received a notification this matter has been resolved. The amended OCD will be forwarded shortly.
06-92-00017	Muscogee Creek Nation of OK.	05/92	468,217	IHS--This audit is currently under litigation; no further action will be taken until a court decision is rendered.
03-95-03313	Quality Resource Systems, Inc.	03/95	28,387	IHS--Management has decided to uphold these findings; the vendor has relocated and has not been notified.

	Auditee	Date Issued	Amount \$	Explanations
10-97-48639	Nooksack Indian Tribe	08/97	9,440	IHS--Currently under litigation.
03-90-00453	West Virginia	03/91	12,850,856	PSC/DCA--At District Court - Collection suspended on 03/12/97.
09-92-00115	California	02/95	140,880,675	PSC/DCA--At the Department of Justice - Collection suspended 12/30/96.
01-94-27891 01-95-36087	State of Maine	05/98	6,090,577	PSC/DCA -- Collection suspended.
08-87-05251	Devil Lake	03/87	50,333	OS--Transferred to the Treasury Offset Program (TOP) for offset.
09-96-39220	Public School	04/96	4,396	OS--Transferred to the TOP for offset.
10-93-22826	Nooksack	11/93	3,323	OS--Transferred to the TOP for offset.
08-86-43199	Am Indian	01/97	12,696	OS--Transferred to the TOP for offset.
09-93-24906	California	04/95	56,758	OS--Transferred to the TOP for offset.
04-04183	Columbus County Services	07/94	35,167	SAMHSA--Pursuing collection.
03-00353	DC Dept. of Human Services	04/95	257,195	SAMHSA--Pursuing collection.
09-40113	Marianas Assoc. for Retarded Citizens	05/96	1,023	SAMHSA--Pursuing collection.
09-39877	Amity, Inc.	07/98	489,110	SAMHSA--Pursuing collection.
09-48966	Karidat	09/97	8,696	SAMHSA--Pursuing collection.
03-03316	North Star Youth Services	03/93	518,575	SAMHSA--under appeal.
09-96-41444	Immigrant Center	03/97	2,495	CDC--Pursuing collection.
01-96-37165	Haitian American Public Health Initiative	03/97	20,209	CDC--Pursuing collection.
01-97-47924	Susan G. Komen Breast Cancer Foundation	05/98	47,893	CDC--Pursuing collection.
03-98-51634	City of Philadelphia, Pa.	06/98	93,690	CDC--Pursuing collection.
04-98-51239	State of Alabama	09/98	227,200	CDC--Pursuing collection.
03-96-41385	National Assoc. for Equal Opportunity in Higher Education	04/97	51,654	CDC--Pursuing collection.
05-96-40217	Wisconsin Association of Black Social Workers, Inc.	03/97	1,649	CDC--Pursuing collection.

**SUMMARY OF OPDIV
 Audit Reports Over One Year Old**

OPDIV	Number of Reports	Amount to Be Collected \$
Administration for Children and Families	93	49,384,030
Administration on Aging	0	0
Centers for Disease Control and Prevention	7	444,790
Food and Drug Administration	0	0
Health Care Financing Administration	105	145,081,321
Health Resources and Services Administration	15	213,905
Indian Health Services	4	951,934
National Institute of Health	0	0
Office of the Secretary	5	127,506
Program Support Center	4	159,822,108
Substance Abuse and Mental Health	6	1,309,766
TOTAL	239	162,211,314

TABLE II

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
Management Action on OIG Reports With
Recommendations That Funds Be Put to Better Use
As of September 30, 1999**

	Number	Disallowed Cost \$
A. Reports for which final action has not been taken by the commencement of the reporting period.	8	160,338,300
B. Reports on which management decisions were made during the reporting period.	45	862,432,973
Subtotal (A & B)	53	1,022,771,273
C. Reports for which final action was taken during the reporting period:		
(I) The dollar value of recommendations that were actually completed:		
-- based on management action:	48	996,722,665
-- based on legislative action:		
(ii) The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed.	0	0
Subtotal (I & ii)	48	996,722,665
D. Reports for which no final action has been taken by the end of the reporting period. See Note 1.	5	26,048,608

Note 1: Includes the following list of 5 reports with recommendations to put funds to better that were pending for more than one year. These reports involve major policy questions as well as legislative remedies that are difficult and time consuming to resolve.

**Reports Containing Recommendations
 To Put Funds To Better Use
 Pending More Than One Year
 As of September 30, 1999**

Audit No	Auditee	Date Issued	Amount \$	Explanations
04-95-02110	SC BC (Hospice of Lake & Sumter, Inc.) - ORT	04/97	2,500,000	HCFA is reassessing whether seeking the identified OIG hospice overpayment is the appropriate action to take.
05-95-00060	Wisconsin Department of Health and Social Services	09/97	2,400,000	The State of Wisconsin plans to establish a workgroup to meet and review HMO financial data related to Medicaid HMOs.
06-92-00043	BC/BS of Texas, Inc.- GME Costs	03/94	4,078,960	Corrective action cannot be implemented pending the resolution of an objection lodged by the providers legal counsel with the OIG, OGC.
02-91-00860	Mental Health services in Nursing Homes - ORT	09/96	17,000,000	HCFA is developing changes to respond to comments.
06-95-00095	Palmetto Gov. Ben. Admin. (Fam. Hospice/Dallas) - ORT	04/97	69,648	HCFA is reassessing whether seeking the identified OIG hospice overpayment is the appropriate action to take.

SUMMARY:

OPDIV: Health Care Financing Administration

Total Number of Reports: 5

Total Amount for Better Use: \$26,048,608

**OFFICE OF INSPECTOR GENERAL SEMI-ANNUAL REPORT SUMMARY
 FY 1999**

The following tables summarize actions taken on OIG recommendations to recover funds or to put them to better use.

TABLE I - REPORTS WITH QUESTIONED COSTS. This table summarizes the Department's response to the OIG's recommendations for the recovery or redirection of questioned and unsupported costs. Questioned costs are those costs that are challenged because of a violation of law, regulation, grant, etc. These may be costs claimed by a grantee, findings on Medicare reimbursements (such as errors in billings), ineligible beneficiaries, or where Medicare regulations are not followed. Administrative cost audits are also included where the OIG may find that a State inappropriately claimed administrative costs for a HHS program. Unsupported costs are those costs questioned because they are not supported by adequate documentation. This information is provided in accordance with the Supplemental Appropriations and Rescissions Act of 1980 (Public Law 96-304) and the Inspector General Act Amendments of 1988. These costs are separate from the amount ordered or returned as a result of OIG investigations.

	Number	Dollar Value	
		Questioned	Unsupported
A. For which no management decision had been made by the commencement of the reporting period ¹	443	\$356,603,000	\$44,003,000
B. Which were issued during the reporting period	201	\$212,070,000	\$6,168,000
Subtotal (A + B)	644	\$568,673,000	\$50,171,000
Less:			
C. For which a management decision was made during the reporting period	278	\$265,673,000	\$28,140,000
(i) dollar value of disallowed costs		\$251,499,000	\$19,618,000
(ii) dollar value of costs not disallowed		\$14,174,000	\$8,522,000
D. For which no management decision had been made by the end of the reporting period	366	\$303,000,000	\$22,031,000
E. Reports for which no management decision was made within six months of issuance	540	\$475,370,000	\$6,900,000

¹ The opening balance was adjusted to reflect a net upward revaluation of recommendations in the amount of \$8.9 million.

Source: FY 1999 OIG Semi-Annual Reports

TABLE II- RECOMMENDATIONS THAT FUNDS BE PUT TO BETTER USE. This table summarizes reports that include recommendations that funds be put to better use through cost avoidances, budget savings, etc. They can be achieved through legislative changes; specific program improvements to prevent unnecessary obligations for expenditures of agency funds; or improvements in agency systems or operations.

	Number	Dollar Value
A. For which no management decision had been made by the commencement of the reporting period ¹	49	\$1,451,106,000
B. Which were issued during the reporting period	22	\$297,763,000
Subtotal (A + B)	71	\$1,748,869,000
Less:		
C. For which a management decision was made during the reporting period		
(i) dollar value of recommendations that were agreed to by management		
(a) based on proposed management action	40	\$312,748,000
(b) based on proposed legislative action		
Subtotals (a + b)	40	\$312,748,000
(ii) dollar value of recommendations that were not agreed to by management	3	\$175,000
Subtotals (i + ii)	43	\$312,923,000
E. Reports for which no management decision was made by the end of the reporting period	28	\$1,435,946,000

¹ The opening balance was adjusted to reflect an upward revaluation of recommendations in the amount of \$206.5 million.

Source: FY 1999 OIG Semi-Annual Reports

GRANTS MANAGEMENT

As the largest granting component in the Federal Government, the Department of Health and Human Services (HHS) plays a key role in the Federal grants management arena. Through its 300 plus assistance programs, HHS awards nearly \$158 billion of the total Federal grants awarded (estimated to be over \$250 billion).

Grant awards are considered to be financial assistance that provides support or stimulation to accomplish a public purpose. Awards include grants and other agreements in the form of money, or property in lieu of money, to an eligible recipient. Most of the HHS grant dollars awarded are in the form of mandatory grants.

- **Mandatory grants** are those that a Federal agency is required by statute to award if the recipient, usually a State, submits an acceptable State Plan or application, and meets the eligibility and compliance requirements of the statutory and regulatory provisions of the grant program. In the past, mandatory grants were sometimes referred to as “formula grants.” Mandatory grants include block grants, closed-ended grants, and open-ended entitlement grants.
- The HHS **discretionary grant** awards comprise only 12.5 percent of the total HHS FY 1998 grant funds, but they account for 92 percent of the total number of HHS grant awards made in FY 1998. Discretionary grants are those that permit the Federal government, according to specific authorizing legislation, to exercise judgment, or “discretion,” in selecting the applicant/recipient organization, through a competitive grant process. The types of activities commonly supported by discretionary grants include demonstration, research, training, service, and construction projects or programs. Discretionary grants are sometimes referred to as “project grants.”

Stewardship and oversight responsibilities for HHS grant programs involve a variety of administrative functions being performed on an ongoing basis. These administrative functions include: assisting OMB in its revisions of key OMB Circulars pertinent to grants administration; providing training and developing related guidance documents on these revised OMB Circulars; conducting oversight through a “balanced scorecard” approach; strengthening HHS indirect cost negotiation capabilities; updating internal Departmental grants administrative procedures; and utilizing a department-wide grants management information system to organize and consolidate grants award data across all HHS grant programs.

During FY 1999, HHS continued to provide assistance to OMB on the government-wide cost principles for non-profits and universities and various cost management projects. In addition, HHS worked on a controversial revision to OMB Circular A-110, “Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and Other Non-profit Organizations,” concerning grantee data subject to the requirements of the Freedom of Information Act (FOIA).

HHS continued with its implementation of the Grants Policy Directive (GPD) system, which is replacing the Departmental Grants Administration Manual with current and concise policy guidance. Training sessions were conducted for headquarters and regional operations to update HHS grants management staff on the OMB Circular changes, and to provide clarification on existing regulatory guidance and internal grants administrative policies.

HHS also continues to operate the Tracking Accountability in Government Grants System (TAGGS) containing department-wide grants award information. TAGGS training was offered to grants management and program staff across HHS.

Access to TAGGS information was made available to HHS staff via the Intranet.

GrantsNet, an Internet application, continues to provide on-line access to the most up-to-date policies, regulations, and other pertinent grants-related information.

FY 1998 HHS GRANTS AWARDS

	TOTAL		MANDATORY		DISCRETIONARY	
	NUMBER	DOLLARS	NUMBER	DOLLARS	NUMBER	DOLLARS
TOTAL	59,689	\$157,903,292,908	4,736	\$138,156,439,610	54,953	\$19,746,853,298
ACF	6,588	\$35,469,380,896	2,729	\$30,792,440,700	3,859	\$4,676,940,196
AHCPR	373	\$64,305,612	0	\$0	373	\$64,305,612
AOA	695	\$849,592,216	605	\$838,799,647	90	\$10,792,569
CDC	2,204	\$1,925,728,831	61	\$179,574,631	2,143	\$1,818,580,573
FDA	144	\$21,642,729	0	\$0	144	\$21,642,729
HCFA	689	\$103,180,260,789	592	\$103,158,484,357	97	\$21,776,432
HRSA	6,400	\$3,395,880,020	408	\$1,212,674,078	5,992	\$2,183,205,942
IHS	1,108	\$503,115,801	57	\$442,377,835	1,051	\$60,737,966
NIH	39,981	\$10,295,685,376	0	\$0	39,981	\$10,295,685,376
OS	288	\$245,773,932	50	\$5,030,057	238	\$240,743,875
SAMHSA	1,219	\$1,951,926,706	234	\$1,599,484,678	985	\$352,442,028

The data in this report reflect awards made during FY 1998 since FY 1999 data is in the process of full reconciliation. The data will not necessarily agree with the FY 1998 or FY 1999 budget and accounting records (e.g., Medicaid's accounting adjustments) for several reasons. First, in some instances the data for awarded grants reflect, in addition to current year funds, the reobligations of prior years' funds. Second, costs of furnishing

personnel in lieu of cash are included in the grants data, but are recorded as personnel service costs in accounting records. Third, grants jointly funded are included in accounting records, but are not included herein unless awards are made by HHS programs. The number of grants is a count of projects or programs receiving grant funds, and is therefore less than a count of grant actions, since there may be multiple actions for a project in any fiscal year.

HIGHLIGHTS

- In FY 1998 HHS awarded nearly \$158 billion in grants; this included both discretionary awards totaling over \$19 billion, and mandatory awards totaling \$138 billion.
 - HCFA, which administers the Medicaid Program, awarded 65 percent (\$103.2 billion) of the total HHS grant funds, representing only 1 percent of the total number of grants. ACF awarded the next highest percentage (22.5 percent, \$35.4 billion) of the total HHS grant funds, representing 11 percent of the total number of grants.
 - The other ten OPDIVs awarded between 0.01 and 6.5 percent of the remaining 12 percent of HHS FY 1998 grant funds.
- NIH awarded 67 percent (39,981) of the total number of HHS grants in FY 1998, which is 52 percent of the discretionary grant funds, but only 6.5 percent of the total HHS grant funds in FY 1998. The remaining OPDIVs awarded between 0.24 and 10.7 percent of the total number of grants.
 - The six states receiving the most HHS mandatory grant funds (in billions) in FY 1998 are New York (\$17.8), California (\$16.9), Texas (\$8.5), Pennsylvania (\$6.5), Ohio (\$5.6), and Florida (\$5.3).

PROCUREMENT MANAGEMENT

In FY 1999, approximately 550 HHS procurement personnel awarded and administered about 280,000 procurement actions (excluding purchase card transactions), worth more than \$3.7 billion. Also, HHS obligated an additional \$1.6 billion from the Medicare Trust Fund for contracts with Medicare intermediaries and carriers. These procurement actions and contracts helped to meet the Secretary's goals of ensuring cost-effective health care and human services; ensuring the integrity of the Medicare Program; enhancing health promotion and disease prevention; improving access to health care for all Americans; and providing adequate support for biomedical research.

Major procurement accomplishments in FY1999 included the following:

- The Department awarded 170 performance-based contracts and modifications for a total of \$1.99 billion. This represents about a 70% and 25% increase in the volume and dollar value of performance-based contracting - - respectively - - from the previous fiscal year. Performance-based contracting is one of the Administration's highest priorities.
 - HHS used purchase cards to conduct over 500,000 micro-purchases.
 - The Department submitted its first annual Commercial Activities Inventory under the FAIR Act, and set in place a procedure for responding to challenges and appeals.
 - HHS used three Electronic Commerce methodologies - - Internet-posted solicitations, FACNET and ECWeb to issue 1,525 electronic solicitations for simplified acquisitions and major procurements.
- The Department began to conduct Web-based customer, contractor, employee and manager surveys under its Acquisition Balanced Scorecard. This initiative will result in an estimated annual cost savings of \$7,000 per contracting office, as well as a reduction of between 20 and 30 days of personnel effort per contracting office. OPDIV burdens and costs have been reduced substantially because printing and mailing survey instruments and reminder notices - - as well as data entry and verification - - are no longer necessary.
 - Using web-based and JAVA-oriented technologies, HHS continued to enhance the query and reporting capabilities of its Departmental Contracts Information System (DCIS). This has resulted in improvements to the reliability, timeliness and utility of HHS's procurement data, as well as better support for executive decision-making. Also, in addition to servicing its OPDIV clients, HHS began to provide DCIS support to a new customer - - the Treasury Department - - under a reimbursable agreement.
 - The Department's Acquisition and Project Officer Training Program provided comprehensive, formal training for both contracting professionals and project officers. Contracting personnel used 1,780 training slots and project officers used 2,909 training slots. HHS experienced success with its interactive CD-ROM Project Officer instructional module; initiated the development of a training module and knowledge repository on Performance-Based Contracting; and developed a course in the high profile area of Earned Value Project Management. The Department also redesigned its overall curricula to reflect a new competency-

HHS OPDIV Net Outlays: 1990-1999

HHS Agency	%		(In Millions)								
	FY 1999	FY 1999	FY 1998	FY 1997	FY 1996	FY 1995	FY 1994	FY 1993	FY 1992	FY 1991	FY 1990
Food and Drug Administration	950	0.3%	837	873	865	858	801	733	752	648	553
Health Resources and Services Administration	3,860	1.1%	3,473	3,526	3,960	2,612	2,695	2,467	2,333	1,763	1,594
Indian Health Service	2,193	0.6%	2,145	2,139	1,997	1,975	1,771	1,699	1,522	1,275	1,091
Centers for Disease Control & Prevention	2,428	0.7%	2,409	2,248	2,166	1,785	1,570	1,410	1,198	1,127	1,035
National Institutes of Health	13,802	3.8%	12,486	11,171	10,209	10,875	10,148	9,532	8,374	7,666	7,492
Substance Abuse and Mental Health Svs Adm.	2,214	0.6%	2,235	1,622	2,084	2,444	2,371	2,667			
Agency for Healthcare Research and Quality 5/	79	0.0%	77	110	81	133	111	84	113	12	
Health Care Financing Administration	299,014	83.1%	294,016	285,523	266,164	248,920	225,967	205,687	186,743	157,140	139,275
Administration for Children & Families	33,624	9.3%	31,584	31,023	31,023	31,993	31,354	27,545	26,703		
Office of the Secretary	377	0.1%	233	206	195	275	221	223	165	159	162
Administration on Aging	879	0.2%	828	828	818	951	859	820	544		
Program Support Center	280	0.1%	247	224	240						
HHS SUBTOTAL	359,700	100.0%	350,570	339,493	319,802	302,821	277,868	252,867	228,447	169,790	151,202
"Old" HHS agencies that no longer exist as separate agencies in HHS:											
OASH 1/					254	233	227	248	219	214	
SSA 2/						346,617	328,028	307,819	285,826	263,143	
ADAMHA 3/								2,865	2,601	2,002	
FSA 4/									17,407	15,236	
OHDS 4/									8,093	6,877	
HHS TOTAL	359,700		350,570	339,493	319,802	303,075	624,718	581,122	539,379	483,936	438,674

1/ OASH accounts were merged into OS and PSC in FY 1996.

2/ SSA separated from HHS at end of FY 1994.

3/ Three components of ADAMHA were transferred to NIH and rest of ADAMHA became SAMHSA.

4/ AoA separated from OHDS when OHDS and FSA combined to become ACF.

5/ Agency name changed from the Agency for Health Care Policy and Research pursuant to Public Law 106-129 enacted on 12/6/99.

based, matrix-oriented training approach (for FY2000 and beyond).

- The Department conducted oversight of CDC's National Pharmaceutical Stockpile Program; monitored the selection decision to use the Department of Veterans Affairs as a partner; and supported the negotiation of the interdepartmental Memorandum of Agreement that underlies the program.
- HHS facilitated the transition of long-distance telecommunication services from GSA's FTS 2000 to the FTS 2001 program; selected MCI World-Com as the Department's new long-distance service provider; and awarded a contract to SAIC to provide Transition and Management Support (TMS) services for the Department.

- On behalf of the Department, NIH continued to refine HHS's user-friendly "Contractor Performance System"- - which gauges the past performance of government contractors. For example, NIH added a link to GSA's "List of Parties Excluded from Federal Procurement and Non-procurement Programs". Further, the system now has the capability to search and update Project Officer information. Also, NIH continued to add Federal agencies to its customer base.

We will continue to focus on sharing successful practices that are identified through our acquisition performance measurement and improvement system.

APPENDICES

Appendix A

ACRONYMS

A/R	Accounts Receivable	DBA	Database Administrators
ACF	Administration for Children and Families	DCIA	Debt Collection Improvement Act
ADD	Administration on Developmental Disabilities	DCFO	Deputy Chief Financial Officer
AHCPR	Agency for Health Care Policy and Research	DMERC	Durable Medical Equipment Regional Carriers
AI/AN	American Indians and Alaska Natives	DPM	Division of Payment Management
AIDS	Acquired Immuno-deficiency Syndrome	EBT	Electronic Benefits Transfer
AoA	Administration on Aging	EC	Electronic Commerce
AHRQ	Agency for Healthcare Research and Quality	EDP	Electronic Data Processing
ARC	Audit Resolution Council	EEPS	Electronic Entry Processing System
ASMB	Assistant Secretary for Management and Budget	EFT	Electronic Funds Transfers
ATSDR	Agency for Toxic Substances and Disease Registry	EPA	Environmental Protection Agency
BBA	Balanced Budget Act	FACES	Family and Child Experiences Survey
CAHPS	Consumer Assessment of Health Plans	FAIRA	Federal Activities Inventory Reform Act
CAP	Corrective Action Plan	FASA	Federal Acquisition Streamlining Act
CB	Change Control Board	FASAB	Federal Accounting Standards Advisory Board
CDC	Centers for Disease Control & Prevention	FECA	Federal Employees Compensation Act
CFO	Chief Financial Officer	FERS	Federal Employees Retirement System
CIO	Chief Information Officer	FDA	Food and Drug Administration
CIT	Center for Information Technology	FICA	Federal Insurance Contributions Act
CMIA	Cash Management Improvement Act	FFMIA	Federal Financial Management Improvement Act
CMP	Civil Monetary Penalties	FI	Fiscal Intermediary
COLA	Cost of Living Adjustment	FIB	Financial Management and Investment Board
CPA	Certified Public Accountant	FISS	Fiscal Intermediary Shared System
CPIM	Consumer Price Index Medical	FMFIA	Federal Managers Financial Integrity Act
CRADA	Cooperative Research and Development Agreement	FMS	Financial Mgt. Service
CSE	Child Support Enforcement	FORC-G	Food Outbreaks Response Coordinating Group
CSRS	Civil Service Retirement System		
DAB	Departmental Appeals Board		

FPG	Financial Policies Group	MSP	Medicare Secondary Payer
FTE	Full Time Equivalent	NDA	New Drug Application
FY	Fiscal Year	NCCAN	National Center for Complementary and Alternative Medicine
GAAP	Generally Accepted Accounting Principles		
GMRA	Government Mgt. Reform Act	NHSC	National Health Service Corp
GPD	Grants Policy Directive	NIH	National Institutes of Health
GPRA	Govt. Performance and Results Act	OCR	Office for Civil Rights
		OCSE	Office of Child Support Enforcement
HACCP	Hazard Analysis and Critical Control Point	OGC	Office of General Counsel
HCFA	Health Care Financing Administration	OIG	Office of Inspector General
HEAL	Health Education Assistance Loans	OMB	Office of Management and Budget
HHS	Department of Health and Human Services	OMS	Operating Materials and Supplies
HI	Hospital Insurance	OPEB	Other Post Employment Benefits
HIPAA	Health Insurance Portability and Accountability Act	OPDIV	Operating Division
HIV	Human Immuno-deficiency Virus	OPM	Office of Personnel Management
HRSA	Health Resources and Services Administration	ORB	Other Retirement Benefits
		ORR	Office of Refugee Resettlement
I/T/U	IHS, Tribal and Urban	OS	Office of the Secretary
IBNR	Incurred But Not Reported	OTT	Office of Technology Transfer
IC	Institute and Centers	PAR	Program Assistance Request
ICD	Institutes, Centers and Divisions	PDUFA	Prescription Drug User Fee Act
IGA	Office of Intergovernmental Affairs	PMS	Payment Management System
IGAA	Inspector General Act Amendments	PNS	Projects of National Significance
IHS	Indian Health Service	PP&E	Property, Plant and Equipment
ITMRA	Information Technology Mgmt Reform Act	PPS	Prospective Payment System
JFMIP	Joint Financial Management Improvement Program	PSC	Program Support Center
MCH	Maternal and Child Health	SAMHSA	Substance Abuse and Mental Health Services Administration
MCS	Medical Carrier System	SAS	Statement of Accounting Standards
MEPS	Medical Expenditures Panel Survey	SECA	Self Employment Contributions Act
MK	Market Based (Securities)	SES	Socioeconomic Status
MOU	Memorandum of Understanding	SCHIP	State Children's Health Insurance Program
MPARTS	Mistaken Payment and Recovery Tracking System	SFFAS	Statements of Federal Financial Accounting Standards
		SM	Stockpile Materials
		SMI	Supplementary Medical Insurance

SSA	Social Security Administration	TTRA	Travel and Transportation
STD	Sexually Transmitted Disease		Reform Act
TAGGS	Tracking Accountability in	VICP	Vaccine Injury Compensation
	Government Grants System		Program
TANF	Temporary Assistance for	Y2K	Year 2000
	Needy Families		
TROR	Treasury Report on		
	Receivables		

Appendix B

LEGISLATION

FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT OF 1982

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

CHIEF FINANCIAL OFFICERS ACT OF 1990

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

GOVERNMENT PERFORMANCE AND RESULTS ACT OF 1993

The Government Performance and Results Act (GPRA) which is to be fully implemented beginning in FY 1999, has placed new management expectations and requirements on federal agencies by creating a framework for more effective planning, budgeting, program evaluation and fiscal accountability for Federal programs. The intent of the Act is to improve public confidence in Federal agency performance by holding agencies

accountable for achieving program results and to improve Congressional decision making by clarifying and stating program performance goals, measures and costs up front. Federal agencies are required to implement GPRA through their processes for strategic plans, annual performance plans, and annual performance reports. FY 1999 is the first year that annual performance plans are required. Actual accomplishments for FY 1999 are required to be reported in FY 2000.

GOVERNMENT MANAGEMENT REFORM ACT OF 1994

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

FEDERAL ACQUISITION STREAMLINING ACT OF 1994

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

DEBT COLLECTION IMPROVEMENT ACT OF 1996

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

Key provisions of the Act are:

- Enhanced administrative offset authority, the Treasury Offset Program
- Enhanced salary offset authority
- Taxpayer Identification Numbers required
- General extension of the Debt Collection Act of 1982 authorities
- Barring delinquent debtors from obtaining Federal credit
- Reporting to credit bureaus
- Government-wide cross servicing
- Establishment of debt collection centers
- Gainsharing
- Tax refund offset program
- Contracting with private attorneys
- Administrative wage garnishment
- Debt sales by agencies.

FEDERAL FINANCIAL MANAGEMENT IMPROVEMENT ACT OF 1996

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

INFORMATION TECHNOLOGY MANAGEMENT REFORM ACT OF 1996

Information Technology Management Reform Act (ITMRA) ensures that the Federal Government investment in information technology is made and used wisely. The law was designed to increase competition, eliminate burdensome regulations, and

help the Government benefit from efficient private sector techniques.

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

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

TRAVEL AND TRANSPORTATION REFORM ACT OF 1998

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

**FEDERAL ACTIVITIES INVENTORY
REFORM ACT OF 1998 (FAIRA)**

On October 19, 1998, the Federal Activities Inventory Reform Act of 1998 (FAIRA) was signed into law. This landmark legislation requires federal agencies to list activities eligible for privatization and to make this list available to the public. FAIRA permits prospective contractors and

other interested parties to challenge the omission of particular activities from the list. Nevertheless, although agencies are directed to review the list, FAIRA does not actually require agencies to privatize listed activities. However, the legislation directs agencies to review the activities on the list soon after the list has been made available to the public.

Appendix C

References

- 1999 Annual Report of the Board of Trustees of the Federal Hospital Insurance (HI) Trust Fund
- 1999 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance (SMI) Trust Fund
- 1998 Data Compendium: Health Care Financing Administration
- 1999 Trends in the Well-Being of America's Children and Youth
- Administration for Children and Families FY 1999 Audited Financial Statements
- Administration on Aging FY 1999 Financial Statements
- Agency for Health Care Policy and Research FY 1999 Financial Statements
- American Customer Service Index Report, December 1999. (University of Michigan, American Society for Quality, and Arthur Anderson)
- Budgets of the United States Government - FYs 1999 to 2001
- Centers for Disease Control and Prevention Audited FY 1999 Financial Statements
- Centers for Disease Control and Prevention, National Center for Health Statistics, Health United States 1999, various data and statistics from Vital Statistics, Morbidity and Mortality Weekly Reports, and surveys
- Food and Drug Administration FY 1999 Audited Financial Statements
- Health Care Financing Administration FY 1999 Audited Financial Statements
- Health Resources and Services Administration FY 1998 Audited Financial Statements
- Healthy People 2000 Progress Reviews and Update 1998 - 1999
- HHS CFO Financial Management FY 1999 Status Report and Five Year Plan
- HHS Office of Inspector General Semiannual Reports October 1, 1998 - September 30, 1999
- Indian Health Service FY 1999 Audited Financial Statements
- National Academy of Sciences, Institute of Medicine quote on the cost of Sexually Transmitted Disease
- National Institutes of Health FY 1999 Audited Financial Statements
- Office of Management and Budget's and U.S. CFO Council's Federal Financial Management Status Report and Five Year Plan, June 1999

Program Support Center FY 1999 Audited Financial Statements

Substance Abuse and Mental Health Services Administration FY 1999 Audited Financial Statements

U.S. Census Bureau Population and Poverty history and projections

University of Michigan, FY 1999, Monitoring the Future Survey

Various Press Releases and information on HHS Web Sites

Note: Some OPDIV audited financial statements were in draft at the time the Accountability Report went to press.

Appendix D

PROGRAM INDEX

To help the reader who is interested in specific key program performance and the net cost of those programs in FY 1999, we prepared the following table. The goals refer to the strategic goals under Section I of this report. The net cost information is extracted from draft and final OPDIV FY 1999 Consolidated Statement of Net Cost. Dollars are in thousands.

OPDIV	KEY PROGRAMS OF OPDIVS	LOCATION IN REPORT SECTIONS I or II	FY 1999 NET COST OF THE PROGRAM	ADDITIONAL INFORMATION
ACF	TANF	Goal 2	\$13,718,285	
	CHILD WELFARE	Goal 2	\$ 5,663,649	
	HEAD START	Goal 2	\$ 5,091,406	
	CHILD CARE	Goal 2	\$ 3,395,139	
	CHILD SUPPORT ENFORCEMENT	Goal 2	\$ 3,122,518	
AoA	CONGREGATE MEALS	Goal 1	\$370,820	
	SUPPORTIVE SERVICES and CENTERS	Goal 4	\$315,652	Eldercare Locator
AHCPR (AHRQ)	HOME-DELIVERED MEALS	Goal 1	\$145,272	
	VULNERABLE OLDER AMERICANS	Goal 4	\$6,729	Ombudsman
	RESEARCH OUTCOMES	Goal 4	\$63,195	
CDC	MEDICAL EXPENDITURE SURVEY	Goal 5	\$29,260	
	INFECTIOUS DISEASES	Goal 1 Goal 5	\$ 962,078	STDs, HIV
	IMMUNIZATION	Goal 3	\$ 437,067	
CDC/ATSDR	ENVIRONMENTAL AND OCCUPATIONAL HEALTH	Goal 5	\$ 354,636 \$ 75,479	Environmental medical monitoring
	CHRONIC DISEASE PREVENTION	Goal 1 Goal 6	\$ 327,880	Heart Disease Tobacco
FDA	FOODS and COSMETICS	Goal 4 Goal 5	\$320,680	Non-prescription drug labels, Foodborne Illnesses
	HUMAN DRUGS	Goal 5	\$223,740	PDUFA
	BIOLOGICS	Goal 4	\$146,666	Blood Inspections
	TOBACCO	Goal 1	\$21,262	

OPDIV	KEY PROGRAMS OF OPDIVS	LOCATION IN REPORT SECTIONS I or II	FY 1999 NET COST OF THE PROGRAM	ADDITIONAL INFORMATION
HCFA	BENEFIT PAYMENTS	Goal 3 Goal 4	\$315,331	Medicare, Medicaid, HCFAC, Medicare Integrity, Immunization
HRSA	HIV/AIDS	Goal 3	\$1,204,876	
	PRIMARY HEALTH CARE	Goal 3	\$1,020,435	
	MATERNAL AND CHILD HEALTH	Goal 3	\$983,948	Including Healthy Start
	HEALTH PROFESSIONS	Goal 3 Goal 4	\$434,440	Including National Practitioners Database
IHS	CLINICAL SERVICES	Goal 3	\$1,024,339	Diabetes
	TRIBAL ACTIVITIES	Goal 3	\$102,576	
	HEALTH CARE FACILITIES CONSTRUCTION	Goal 3	\$73,546	
NIH	RESEARCH	Goal 6	\$13,463,299	
	TRAINING/CAREER DEVELOPMENT	Goal 6	\$820,831	
	FACILITIES	Goal 6	\$201,139	
PSC	HUMAN RESOURCES	Section II	\$7,510	
	FINANCIAL MANAGEMENT	Section II	(\$2,380)	
	ADMINISTRATIVE OPERATIONS	Section II	(\$2,203)	
OS	OPHS	Goal 5	\$98,892	
	OCR	Goal 4	\$19,314	
	ASMB	Section II	\$147,540	
SAMHSA	SUBSTANCE ABUSE PREVENTION AND TREATMENT	Goal 1	\$1,287,966	
	KNOWLEDGE DEVELOPMENT AND APPLICATION	Goal 1	\$516,822	
	COMMUNITY MENTAL HEALTH SERVICES	Goal 3	\$278,241	

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