U.S. Department of Health and Human Services
President's Management Agenda Report
Fiscal Year 2004

TO HHS EMPLOYEES:

The Department of Health and Human Services has accomplished a great deal over the past year thanks to your efforts and focus on results. It is important that we take time to look back on all we have accomplished together and celebrate even as we look forward to future achievements.

OVERVIEW

The Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The Department manages more than 300 programs, covering a wide spectrum of activities. Some highlights include:

- *Health and social science research*
- *Preventing disease, including immunization services*
- *Assuring food and drug safety*
- *Medicare and Medicaid*
- *Financial assistance and services for low-income families*
- *Improving maternal and infant health*
- *Head Start (pre-school education and services)*
- *Preventing child abuse and domestic violence*
- *Services for people with disabilities*
- *Substance abuse treatment and prevention*
- *Services for older Americans, including home-delivered meals*
- *Comprehensive health services for Native Americans and Alaska Natives*
- *Medical preparedness for emergencies, including potential terrorism.*

HHS represents almost a quarter of all federal outlays, and it administers more grant dollars than all other federal agencies combined. HHS' Medicare program is the nation's largest health insurer, handling more than 900 million claims per year. Medicare and Medicaid together provide health care insurance for one in four Americans.

HHS works closely with state and local governments, and many HHS-funded services are provided at the local level by state or county agencies, or through private sector grantees. The Department's programs are administered by 11 operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies. In addition to the services they deliver, the HHS programs provide for equitable treatment of beneficiaries nationwide, and they enable the collection of national health and other data.

In FY 2004 HHS realized many accomplishments, including:

- ✓ "Steps to a Healthier US" Ad Campaign (the "body parts" ads) – Announced with the news that overweight/physical inactivity is about to overtake smoking as the leading cause of preventable death. Food and Drug Administration (FDA) has established a task force to focus its anti-obesity efforts, and National Institutes of Health (NIH) has developed a research program. (64% of Americans are overweight, and the cost is $117 billion per year.)

- ✓ Medicare Obesity Coverage Policy – In July 2004 HHS took another important step in the fight against obesity. HHS' Centers for Medicare and Medicaid Services (CMS) revised its Medicare coverage policy to allow members of the public to request that Medicare review the scientific evidence to determine whether specific anti-obesity interventions could be covered by Medicare. The new policy opens the door to allowing Medicare to cover treatments for diseases related to obesity, improving the health outcomes for seniors and disabled Americans. As a first step, CMS will convene its Medicare Coverage Advisory Committee in the fall to evaluate the medical evidence on obesity-related surgical procedures that may reduce the risk of heart disease and other illnesses.

- ✓ <u>Health IT</u> – President Bush has called for the widespread adoption of interoperable Electronic Health Records in ten years. Interoperability through standards will enable us to share electronic patient records, which will improve the quality of health care. Standards are adopted for health IT use by all Federal agencies through the efforts of the multi-agency Consolidated Health Informatics (CHI), a joint venture of HHS, Department of Veterans Affairs (VA) and Department of Defense (DOD). Adoption of these standards will increase our ability to share medical data within the health community.

- ✓ <u>Pharmaceutical Bar-coding</u> - FDA's final regulation on bar-coding for pharmaceuticals was published in February. The measure aims to protect patients from preventable medication errors by helping ensure that health professionals give patients the right drugs at the appropriate dosages. FDA estimates that the rule will help prevent nearly 500,000 adverse events and transfusion errors while saving $93 billion in health costs over 20 years.

- ✓ <u>New Anthrax Vaccine</u> – Requested proposals for development, testing and manufacture of a new anthrax vaccine. We will acquire up to 75 million doses of the recombinant protective antigen (rPA) anthrax vaccine for the Strategic National Stockpile (SNS). The new rPA anthrax vaccine will be stronger and more effective than the vaccine being used today. It will require fewer doses per individual to provide immunity against the effects of anthrax inhalation. The vaccine would be used to protect the public against a terrorist attack in which anthrax spores are released.

- ✓ <u>Safety in Dietary Supplements</u> – FDA developed a new legal approach using existing authority to protect Americans from unsafe dietary supplements. The effort to remove ephedra is succeeding. FDA is also considering action against andro.

- ✓ <u>Countering Drug Counterfeiting</u> – The nation's drug supply is being infiltrated by a marked increase in the incidence of counterfeit drugs. In addition, illicit diversion and theft of prescription drugs in domestic and international markets has increased dramatically in recent years causing an increased vulnerability to the introduction of counterfeit drugs and further compromising legitimate distribution channels. The public health implications stemming from this problem has never been greater. FDA has launched an initiative to detect and prevent the sale of counterfeit drugs.

- ✓ <u>First-ever Multistate Purchasing Pools</u> – Approved plans by five states to pool their collective purchasing power to gain deeper discounts on prescription medicines for their state Medicaid programs (Michigan, Vermont, New Hampshire, Alaska, Nevada). This give states unprecedented leverage in negotiating with drug manufacturers for lower prices. The ability to purchase drugs at lower cost will help states continue to provide critical medications to the millions of low-income citizens who depend on the Medicaid program. CMS will also provide guidance to states on forming new purchasing pools and joining existing purchasing pools.

- ✓ <u>New Initiative on Care for Chronic Illnesses</u> – New Medicare initiative, under Medicare Modernization Act (MMA), will improve quality of care for people with multiple chronic illnesses by helping them manage their conditions and encouraging better coordinated care. The initiative will reach about 150,000 to 300,000 beneficiaries who have multiple chronic conditions, including congestive heart failure, complex diabetes and chronic obstructive pulmonary disease.

- ✓ <u>Ending Chronic Homelessness</u> – In March of 2003, Secretary Thompson became chair of the Interagency Council on Homelessness and released Strategies for Action, the first comprehensive HHS plan to focus HHS resources on reducing and ultimately ending chronic homelessness. Accomplishments include: First Step, a compilation of information front–line caseworkers need to assist homeless people including programs in HHS, Department of Housing and Urban Development (HUD), VA, Social Security Administration (SSA), Department of Agriculture and Department of Labor; and, State Policy Academies which bring State policymakers together to improve service coordination for homeless. Forty-five States will have attended at least one policy academy by April of 2004. HHS has committed $33 million towards collaboration with HUD and VA on new approaches to chronic homelessness.

These and many other accomplishments were realized in part due to improved effectiveness of management practices being implemented across the Department with the help of the President's Management Agenda.

THE PRESIDENT'S MANAGEMENT AGENDA

The President's Management Agenda (PMA) is a bold strategy for improving the management and performance of the federal government. The PMA contains five government-wide goals to improve federal management and deliver results that matter to the American people:

- Strategic Management of Human Capital
- Competitive Sourcing
- Improved Financial Performance
- Expanded Electronic Government
- Budget and Performance Integration

The PMA was designed to "address the most apparent deficiencies where the opportunity to improve performance is the greatest." It focuses on remedies to problems generally agreed to be serious, and commits to implementing them fully.

In addition to the five government-wide management initiatives, the PMA also focuses on nine-agency specific reforms, of which HHS has three of the Program Initiatives:

- Faith-Based and Community Initiative
- Better Research and Development (R&D) Investment Criteria
- Broadened Health Insurance Coverage Through State Initiatives

In keeping with the PMA, HHS has achieved management performance results in FY 2004 that are important to HHS' mission and to the American taxpayer. HHS has done well in institutionalizing our focus on results and citizen-centric government, and we have achieved a "green" in all areas of the PMA for progress. We have also moved to "green" for status in the areas of Competitive Sourcing and R&D Investment Criteria, and "yellow" for Human Capital, Budget and Performance Integration, Broadening Health Coverage, and Faith-based and Community Initiatives.

As we continue our focus on management results, we look forward to the benefits of a fully integrated department providing 21st century service to our employees and customers, in a more cost effective and timely manner.

STRATEGIC MANAGEMENT OF HUMAN CAPITAL

To accomplish our many critical mission objectives, HHS has implemented strategies to ensure our ability to recruit and retain appropriately skilled employees. We have conducted comprehensive workforce analyses to provide a solid foundation for workforce planning. We have launched strategic recruiting initiatives to build a diverse and competent workforce. We have revamped the Human Resources organization to achieve new levels of efficiency, providing improved services to job applicants. We have implemented comprehensive workforce development programs that will nurture the knowledge and leadership required to meet new challenges, and have implemented accountability systems and executive performance contracts to ensure that goals and objectives are met. These many activities give evidence of HHS' commitment to strategic management of human capital, so that we are always able to put the right person in the right job at the right time.

Emerging Leaders Program

One of our greatest successes has been the Emerging Leaders Program, a 2-year internship for recent college graduates that leads to permanent employment. In its first two years, the Emerging Leaders Program has allowed us to recruit over 120 highly qualified individuals into public service, with a very high retention rate. In the third year of the program, the number of emerging leaders selected has expanded to over eighty individuals who will begin their rotations in July.

Senior Executive Service (SES) Candidate Development Program

Recognizing that a significant proportion of SES employees are available for retirement in the next 5 years, we established an SES candidate development program to encourage the smooth transition of leadership in

the department. From a pool of 350 applicants, we chose 25 participants for the SES candidate development program. Individuals were chosen both from inside and outside government, and have developmental assignments within HHS, as well as training in core executive leadership skills.

HHS University

HHS University was established in January of 2003 to provide consistent and equitable learning opportunities for all Department of Health and Human Services employees. HHS U provides numerous opportunities for employees to sharpen their skills and prepare themselves to meet the organization's strategic objectives.

Improved Human Resources Services

In FY 2004, HHS completed the consolidation of 40 personnel offices scattered throughout the Operating Divisions (OPDIVs) into four departmental Human Resource (HR) service sites. In doing so, we eliminated redundancy and duplication of effort, reduced HR staffing levels, and improved service delivery by installing automated tools to replace labor and paper intensive processes, including hiring, job classification, and maintenance of employee records.

EXPANDED ELECTRONIC GOVERNMENT (E-GOV)

HHS participates in the 20 of the 24 PMA e-gov initiatives that apply to our mission, as well as the in the cross-cutting e-Authentication initiative. HHS serves as the leader for two initiatives (grants.gov and Federal Health Architecture) and actively participates on executive level boards or councils, as required.   In addition, HHS is a strong contributor to the Lines of Business Task Forces for Financial Management, Grants Management, and Federal Health Architecture.

Information Technology (IT) Security

Prior to 2001, the IT security effort at HHS was decentralized. Individual programs were managed at the Operating Division (OPDIV) level, with little oversight from the Department, resulting in very different IT security programs across HHS. HHS as a whole was not meeting federal mandates and reporting requirements due to a lack of an integrated, enterprise-wide IT security program.

Since that time HHS has improved and will continue to improve the overall HHS IT security posture to protect confidentiality, integrity, and availability of IT resources; ensure minimum security standards enterprise-wide that are consistent with Federal guidelines and best practices; support integration of IT security into HHS lines of business; and promote an environment in which all employees' actions reflect the importance of IT security.

HHS has deployed the "Secure One HHS" program, resulting in raised compliance with security mandates, better security, and better systems at HHS. Privacy Impact Assessments (PIA) on systems that may collect personally identifiable information are being conducted to ensure the protections of individual privacy.

Finally, HHS system security analyses have dramatically improved:

- Increased from 8% to 96% of systems having been assessed for risk assessments as of June 30, 2004; 2004 goal: complete risk assessments on 100% of reportable systems.

- Increased from 3% to 93% of systems having been Certified and Accredited (C&A'd) as of June 30, 2004; 2004 goal: 90% C&A's systems.

- HHS security training of employees has increased from 56% (2001) to 81% (2003) to our 2004 goal of 100% of HHS employees having received annual security awareness training.

Enterprise Architecture

Enterprise Architecture (EA) identifies and defines an organization's business processes and practices, the data required to support those processes, the applications to process that data, and the technology that

supports those applications. A unified EA allows for a better use of resources to support the business activities of HHS, both administrative and health related.

Prior to 2001, there was no formalized process to address an HHS-wide enterprise information technology architecture. In 2003, formal HHS-wide Enterprise Architecture efforts began, with the establishment of EA Program Management Office. Planned EA efforts will firmly define the HHS-wide roadmap to achieve our Department's mission through optimal performance of our core business processes within a more supportive IT environment.

HHS EA program aligns with and supports Office of Management and Budget's (OMB) Federal Enterprise Architecture and its strategy to implement e-government solutions in order to better serve the business, citizen, and government communities. HHS has developed and published an Enterprise Architecture blueprint with performance linkages to strategic and capital planning and budget processes.

HHS.gov

In late 2001 the HHS Web Portal Project began with the goal of recasting the Department's philosophy and approach to reaching out to the public via the Web in a more citizen-centric and usable way to offer the public instant access to timely, often urgently needed, information on HHS' vital health and human services programs. Usability testing of the new site demonstrated that over 90% of test users could find the information sought versus just over 40% in old design.

Since October 2002, when the new site was launched, integration among HHS web sites and managers has improved; enterprise-wide search capabilities reach across the entire HHS web presence (includes NIH, Centers for Disease Control and Prevention (CDC), FDA); and the development and maintenance of the frequently asked questions (FAQs) database now allows customers to answer their own questions, resulting in fewer unique questions directed to the Department.

Site statistics show an average increase for the corresponding nine months of October through June of approximately 80,000 visits per month. In addition, the frequently asked questions database received an average increase in visitors of only 22,000. Despite the increase in visitors to FAQs, approximately 18,000 fewer questions and answers were viewed each month, and over 120 fewer unique questions per month submitted to the Department. The statistics demonstrate that the HHS.gov Web site serves more visitors per month, more effectively, as visitors find the information sought through information available on the Web site and in the FAQ database.

Perhaps the most significant business impact has been in the area of Health Insurance Portability and Accountability Act (HIPAA) privacy rule information dissemination. From April 2003 through April 2004, OCR had over 1,000,000 visits to its Privacy web pages and also had over 1.9 million Privacy Rule answers viewed on the frequently asked questions site maintained by HHS. These materials have consistently been the most in demand of all HHS.gov subject matter resources. Office for Civil Rights (OCR) and its sister divisions in the Department, particularly CMS, but also the NIH, CDC, and the Substance Abuse and Mental Health Services Administration (SAMHSA) among others, have worked and continue to work in concert to produce materials and guides responsive to the needs of the wide range of healthcare industry segments that are affected by the Privacy Rule. For example, OCR has created a page on its website that allows smaller providers, and other small businesses, to quickly access resources and guidance of particular interest to them. In addition, in anticipation of the April 14, 2004 small health plan compliance date, OCR published new FAQs targeted to small health plans, particularly group health plans.

HHS continues to improve upon the site, include continued web site analyses, and integrate usability principles and evidence-based design. HHS also established in FY 2004 a Web Management Team that will manage the Department's Web presence and serve as a Department-wide resource for delivering effective and usable Web communications to the American public. In addition, HHS served on a federal interagency work group tasked to establish standards for Frequently Asked Questions e-mail responses under the PMA e-gov initiative, USA Services. HHS also complied with a requirement of the e-gov initiative, GovBenefits, by ensuring a link from hhs.gov to the GovBenefits.gov site is present where applicable.

Grants.gov

Prior to 2001, there was no unified, integrated mechanism for the public to find and apply for grant opportunities within the federal government. Today, "Grants.gov" is up and running and is one of 24 e-government initiatives that are fulfilling the President's Management Agenda. The goal of Grants.gov is to make the grant location, application, and submission process faster, easier, and more efficient. Grant-making agencies are required to post summaries of all discretionary grant funding opportunities. HHS serves as the Managing Partner for this cross-government initiative, and HHS was an early adopter to Grants.gov and began posting all of its competitive grant opportunities during February 2003.

All twenty-six federal grant-making agencies have followed suit and are posting all of their active grant opportunities on Grants.gov. As of July 21, 2004 there are almost 1,500 active grant opportunity postings and over 3,800 total postings on Grants.gov. HHS has over 390 active funding opportunities posted, and over 1,300 total postings on Grants.gov. On average, Grants.gov's "Find" mechanism receives over 1.2 million hits per week. The heavy use of the Grants.gov Find mechanism allows HHS to reach a broader and more diverse applicant pool by increasing exposure and awareness across the grantee community of available funding opportunities. Also, HHS was one of the first agencies to post a grant application package on the website and will be able to collect grant applications electronically through Grants.gov.

As of July 21, 2004 there are over 160 grant programs available for electronic application, and over 850 applications have been received electronically through the Grants.gov system. HHS has posted 115 application packages on Grants.gov, and has received 525 electronic applications. NIH, Administration for Children and Families (ACF), and Health Resources and Services Administration (HRSA) have been working with Grants.gov to develop system-to-system interfaces to electronically accept applications automatically into their existing backend grants management systems. Grants.gov accomplishes the mandates of the President's Management Agenda to provide to the public a unified citizen-centric web site that provides accurate, reliable information in a centralized location and simplifies the burden of the application process for the grant community by delivering a unified location to apply for grants across the federal government.

Health Information Technology

Before 2001, there were no medical data standards universally recognized by the U.S. government; however, many were commonly used. In 2002, under HHS' leadership, the multi-agency Consolidated Health Informatics (CHI) endeavor began. The goal of CHI is for the Federal government to adopt health data standards and require that those who interact with the government do so using those standards and result in moving the entire health community toward interoperability by using those standards.

HHS and the other federal departments that deliver health care services -- the Departments of Defense and Veterans Affairs -- are working with other federal agencies to identify appropriate, existing 24 "domains" or "data standards," and to endorse them for use across the federal health care sector.

Adoption of these standards will increase our ability to share medical data within the health community and they will be used as agencies develop and implement new information technology systems. Interoperability through standards will enable us to share electronic patient records, which will improve the quality of health care.

Some highlights of CHI to date:

- In 2003, the U.S. Government adopted five standards for use.

- In 2004, standards were adopted in 15 more domains. Also a medical vocabulary (Systemized Nomenclature of Medicine Clinical Terms or SNOMED CT) has been licensed for use throughout the United States at no cost to the users. This is a key part of the emerging National Health Information Infrastructure (NHII).

- In 2004, CHI became a part of the new Federal Health Architecture (FHA) E-Gov initiative. CHI will continue to examine additional health data domains to be considered for adoption as a federal standard.

- In 2004, based on the President's Executive Order, Secretary Tommy Thompson recently identified a new HHS position, the National Health Information Technology Coordinator and named Dr. David Brailer to fill that role. Dr. Brailer is charged with guiding ongoing health information standards development work, coordinating partnerships between government agencies and private sector stakeholders to speed adoption of health information technology, and achieving the President's vision for most Americans to have a personal electronic medical record within 10 years. Dr. Brailer will work closely with the HHS-managed federal-wide FHA program.

Citizen Centric Service

In 2004, the Centers for Disease Control and Prevention (CDC) launched its newly redesigned website. CDC has one of the most frequently visited websites in the government. CDC is the authoritative trusted source of public health information for healthcare providers, public health officials, the media, and the general public, attracting an average of over nine million different visitors per month. The Severe Acute Respiratory Syndrome (SARS) outbreak resulted in over 17 million different visitors in April 2003, alone.

The Bioterrorism Preparedness and Response Act of 2002 required the Food and Drug Administration (FDA) to implement several changes to strengthen its' food safety regulations including the registration of Food facilities. Because FDA has other registration activities including Drug Registration and Listing, FDA chose to merge these activities into one modular system referred to as FDA Unified Registration and Listing System (FURLS). This system uses the Internet as a vehicle for collecting vital registration information. FURLS was successfully implemented on schedule to enable the food industry to register on line as required by Congress. Approximately 190,000 facilities are registered, with slightly more than half foreign facilities and the remainder domestic.

The Administration on Aging (AoA) continues to use the AoA.Gov web site to disseminate information to the Aging Network. The AoA E-Newsletter is a successful informational publication distributed electronically to the Aging Network and AoA partners. States and tribes working with AoA report electronically on activities supported by AoA funds through the AoA.Gov web site by uploading quarterly reports and inputting various statistics on the site. AoA has updated and enhanced its public Internet web site for improved accessibility and enhanced data segregation allowing better search capabilities for our constituents.

IT Consolidation

In 2001, employees of HHS were provided IT support via organizationally "stove-piped" help desks and support teams, which resulted in disparate IT practices and policies as well as incompatible implementations of hardware, software, and security systems and services. This situation represented significant annual cost as well as cross-OPDIV incompatibility.

In 2004, the Information Technology Service Center ("ITSC") was created to eliminate unnecessary duplication of functions and infrastructure by consolidating and replacing the IT help desks at the "Small OPDIVs" (ACF, Agency for Healthcare Research and Quality (AHRQ), AOA, HRSA regional offices, SAMHSA, Office of the Secretary (OS), Program support Center (PSC) and the Office of the Inspector General (OIG)). This consolidated IT infrastructure ensures that all HHS Small OPDIVS are able to meet their unique business objectives while achieving compatibility, interoperability, standardization and open communication. The ITSC:

- Provides help desk support for over 8,000 HHS staff and on-site contractors
- Handles 400 help desk contacts per day with a single help desk
- Has taken responsibility for over 500 servers across the small OPDIVs
- Reduced the number of federal staff providing IT infrastructure services for these small OPDIVs from 144 to 55, for a savings of $8.7 million.
- Reduced the number of contractors from 183 to 125, for a savings of $6.8 million.

HHS' five large OPDIVs (CDC, CMS, FDA, Indian Health Service (HIS) and NIH) have also taken steps over the prior three years to consolidate IT services, including:

- CDC: Reduced e-mail servers by 40%; reduced remote access servers from 6 to 2; and reduced public call center services from 36 to 1

- CMS: Consolidated into a single integrated help desk for desktop services, voice communications, mainframe, network services, and hardware/software service.
- FDA: Consolidated to one call center; provided secure remote access.
- IHS: Consolidated IHS national Help Desk from four systems to a single system; pursuing administrative system consolidation to reduce the number of ARMS servers from 13 to 1.

NIH: Consolidated 20,000 e-mail accounts into the central NIH server; consolidated 29 NIH Help Desks into one.

FINANCIAL MANAGEMENT

In FY 2004, HHS made important performance improvements in its financial management activities. Specifically, HHS:

- Streamlined and accelerated the annual financial reporting process making financial information more useful in decision-making by shortening the time for providing financial information from 6 months to 45 days after the fiscal year-end.

- Combined in our Performance and Accountability Report for the first time our annual audited financial statements with program performance information to better assess the Department's performance relative to its strategic goals and objectives.

- Performed more frequent financial analyses thereby strengthening the accuracy of our financial data.

- Initiated an OPDIV-wide analysis to identify the extent to which financial and performance information is currently being used to support routine or 'day-to-day' management decisions. This analysis is intended to ultimately help identify core mission business functions within OPDIVs and across the Department and to improve the utility and use of routine financial and performance information to support program and Department management decision-making.

- Added a quarterly financial reporting cycle to provide more timely information and to facilitate the annual reporting cycle.

- Began a phased-in implementation plan for a standardized financial management system (Unified Financial Management System) in all operating components beginning with NIH effective FY 2004,to culminate with IHS and the final phase of CMS contractors in FY 2007.

- Began to leverage economies of scale by replacing 5 obsolete systems thus reducing administrative costs.

- Initiated a study to consolidate resources performing similar activities, typically spread across the Department, facilitating enhanced service delivery for core financial processes. Utilizing a shared services delivery environment will standardize and streamline traditional financial transaction processes; such as Accounts Payable, Accounts Receivable, General Ledger, and Procurement thereby lowering costs, improving efficiency, and reducing processing cycle times. Implementing a shared services solution will achieve operating efficiencies by leveraging technological investments and standardizing processes across business units.

- Reduced by more than half the Medicare error rate of 13.8% in FY 1996 to 5.8% in FY 2003 (HHS is currently working on measuring payment errors for six other major programs – Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), Foster Care, Head Start, and Child Care.)

- Developed and implemented internal PMA scorecard to communicate to OPDIV employees their responsibilities and achievements under the PMA.

- Awarded a contract for Recovery Auditing services.

- Developed and began implementing a project plan to comply with the Improper Payments Information Act (IPIA).

BUDGET AND PERFORMANCE INTEGRATION

In FY 2004, HHS successfully integrated performance information into budget decisions and activities through several critical action steps. These are highlighted below:

Senior Level Manager Meetings

Senior management staff actively uses performance information to inform budget decisions. The following examples are highlighted below:

- Reducing payment errors by contractors who process payments to Medicare providers is an important priority for the Medicare program. At CMS, senior officials routinely consider financial and performance data on Medicare payments when making decisions in the Comprehensive Error Rate Testing (CERT) program. In January 2004, CMS produced for the first time contractor-specific error rates for Fiscal Intermediaries. In June, senior CMS officials were briefed on the error rate findings and were presented with a draft CMS Error Rate Reduction Plan. Decisions were made regarding changes needed to the plan. In addition, senior CMS officials briefed the Department and Office of Management and Budget officials on the CMS Error Rate Reduction Plan. A number of decisions were made concerning the high provider non-response rate for 2003 and corrective actions to reduce the amount of improper payments in 2004.

- In the third quarter of FY 2004, the Assistant Secretary for Aging and AoA executives met on multiple occasions specifically to develop budget initiatives based on program performance and financial data. With OMB endorsement of AoA's efficiency, consumer assessment, and targeting data in the FY 2005 Program Assessment Rating Tool (PART) process, AoA executives determined that the most significant improvements to AoA's base programs would be possible with continued emphasis on program innovation activities. The performance data and PART results were also prominent in the decision of the Assistant Secretary and senior AoA executives to evaluate three major program subcomponents in FY 2004 and 2005.

- SAMHSA senior managers use performance and financial information to inform decisions about management of SAMHSA programs. For example, the Center for Substance Abuse Treatment's implementation of a sophisticated data collection system for Program of Regional and National Significance allows the Center Director and Agency management as well as Center program and management staff access to timely program performance information.

- On a quarterly basis, the Chief of Staff of HHS meets with OPDIV heads to assess financial, budget and performance issues affecting HHS programs. In addition, OPDIV Executive Officers meet monthly in a Management Forum with the Assistant Secretary for Administration and Management (ASAM) and the Assistant Secretary for Budget, Technology and Finance (ASBTF) to examine reports that integrate financial and performance information and use them to make decisions about the management of the Department's programs.

Budget and Performance Conference

In November 2003, the Office of Budget sponsored a Budget and Performance Integration (BPI) conference to have open dialogue and share information with the Department regarding BPI. Conference attendance included at least one budget and one performance person from each OPDIV. Conference workshops included the Program Assessment Rating Tool (PART), Full Cost, One HHS Action Plan, FY 2006 Performance Budgets, President's Management Agenda Scorecard and Performance Planning. After the conference, budget and performance managers were prepared to implement BPI into everyday activities and decisions. This included the development of a design team to create the new structure of the FY 2006 performance budget.

FY 2006 Performance Budget

In February 2005, the Department will submit to Congress an FY 2006 integrated performance budget that was created by a design team following the November 2003 conference. The FY 2006 integrated performance budget ensures that budget and program managers work together to inform management and

budget decisions. The FY 2006 performance budget includes a number of changes from the traditional budget structure. First, it contains a standardized *performance budget overview* that ties together the OPDIV mission, HHS strategic goals, OPDIV performance measurement, and the budget request. Second, a new *activity narrative section* includes updated program descriptions and new performance analysis section. Finally, the outline includes a *supporting information section* that combines performance exhibits required by Government Performance and Results Act (GPRA) and budget exhibits required by HHS, OMB, and Congress.

Methodology for Calculating Marginal Cost

In June 2004 HHS selected the FDA Animal Drugs and Feeds and CDC Sexually Transmitted Disease programs to develop methodologies for calculating the marginal cost of outputs and outcomes based on the approach taken by National Aeronautics and Space Administration (NASA). Being able to implement marginal cost methodology allows HHS to estimate the cost of changing performance goals and program design. The marginal cost methodology incorporates the program's current FY request level, full cost, and full-cost allocation to selected performance measures; the budget year targets, long-term targets, and strategic objectives for each measure; estimated time period to achieve the long-term targets; and desired outcome of achieving the long-term objectives, including its relationship to broader agency goals and the HHS strategic plan.

PART Assessment

ASBTF Principal Deputy Assistant Secretary sent a memo to OPDIV Heads and the Assistant Secretary for Health initiating the FY 2006 PART process and emphasizing the importance of the PART process in budget decision-making as well as the HHS scorecard for BPI. The Office of Budget provided technical guidance and assistance throughout the FY 2006 PART. HHS had 22 programs assessed in the FY 2006 PART. HHS actively participated in the FY 2006 PART process with OMB and welcomed the opportunity to identify program's performance rating. To date, roughly 40% of HHS programs have been assessed in the PART process. HHS regularly uses PART information to inform decisions about program budgets and management as discussed below.

PART Recommendation Follow-up Plan

In June 2004, the Deputy Assistant Secretary for the Office of Budget sent a memo to OPDIVs outlining the Department's process for the PART recommendations. The objective is to include PART recommendation updates in each of the three budget submissions: the HHS submission in June, the OMB submission in September, and the Congressional submission in February. This process ensures that HHS has a systematic and discipline process for implementing PART recommendations. On July 30, 2004 OPDIVs submitted the new PART recommendation plan, which includes milestones and deadlines for all completed PART recommendations. This will provide the baseline from which to assess performance. The Office of Budget is also collaborating with OIG and ASPE to coordinate evaluations on programs that received a "Results Not Demonstrated" or "Ineffective" PART rating.

The following examples highlight programs using PART recommendations:

- In preparation for the FY 2005 PART review, FDA made considerable efforts to implement OMB's PART recommendations from FY 2004. OMB recommended that FDA develop specific long-term outcome goals that were more directly associated with improvement of public health and safety; and efficiency goals that demonstrated more streamlined government operations. FDA identified a limited number of ambitious long-term outcome goals along with various management improvements that resulted in a significant improvement to its PART score in FY 2005, and an overall rating that improved from Results Not Demonstrated to Moderately Effective. FDA senior management also developed a map of all critical activities and annual performance measures in order to achieve the agency long-term outcome goals. During the second and third quarter of this year, FDA collected all the relevant data and re-analyzed performance and measurable progress compared to the baseline measures calculated for the set of long-term outcome goals identified in FY 2005.

- HRSA allocated a larger proportion of funds to the National Health Service Corps' loan category in response to PART recommendation regarding flexibility in allocation of funds between scholarships and loans.

- HRSA's Administrator is bolstering staff to bring a wider range of skills to bear on improving the Bioterrorism Hospital Preparedness ability to enhance performance and demonstrate effectiveness in response to a PART recommendation.

- At ACF, the PART assessment for the Office of Refugee Resettlement (ORR) informed the request for additional funding in FY 2004 for an independent and quality evaluation of the ORR social services program.

- Community Services Block Grant proposed legislation that would require in Community Action Agencies to use a common set of national measures to report outcomes based on the FY 2005 PART recommendation.

- Head Start also proposed legislation to better integrate Head Start, childcare, and state operated pre-school programs, and created a new system to assess every Head Start center on its success in preparing children for schools. Both of these initiatives were recommended in the PART assessment for FY 2004.

- Low-Income Home Energy Assistance Program requested funds in FY 2005 to conduct a nationally representative evaluation in order to address performance measures identified in the PART review.

Performance Measures

In FY 2004, HHS implemented performance measures for 100 percent of 120 HHS performance program areas. These are identified in the new structure of the FY 2006 performance budgets that will be released in February 2005. HHS also reduced the total output measures by 25 percent and increased the total number of outcome measures. The reduction of output measures enables HHS programs to focus on the results that programs achieve.

COMPETITIVE SOURCING

In FY 2004 HHS was one of the leaders of the competitive sourcing initiative. To date HHS has completed eight standard public-private competitions in an average of 12 months or less, meeting the new time standard. Two competitions covering more than 1,400 full-time equivalent employees were completed in less than 10 months. These stand out successes have clearly demonstrated both the viability and credibility of OMB's new requirement to conduct and conclude standard cost comparisons in twelve months or less.

The Department has conducted competitive sourcing studies to almost 25 percent of its commercial activities. When fully implemented over the next several fiscal years, these competitions are expected to yield annual savings of $40M+ for the greater benefit of HHS programs and the American taxpayer.

The FY 2004 Federal Activities Inventory Reform (FAIR) Act inventory was submitted to OMB on June 30, 2004. In addition to building a HHS FAIR Act dictionary of function code definitions and requiring the OPDIVs to develop an accurate and complete FAIR Act inventory, HHS has begun the process of implementing a FAIR Act database that will maintain its FAIR Act inventory data. This database system is currently being tailored to HHS specifications and will allow greater ease in obtaining necessary information, provide an ability to run numerous reports to assist with dissemination of data, and promote consistency across the OPDIVs through side-by-side comparisons of their FAIR Act Inventories.

FAITH-BASED AND COMMUNITY INITIATIVE

The mission of the Faith-Based and Community Initiative (CFBCI) at HHS is to create an environment within HHS that welcomes the participation of faith-based and community organizations as valued and essential partners in assisting Americans in need. Our mission is part of HHS focus on improving human services for our country's most needy populations. Through work completed in FY 2004, HHS has achieved a green progress rating for every quarter this fiscal year by making the following accomplishments in data collection, pilot projects, regulatory reform, and outreach/technical assistance.

Data Collection

HHS awarded $567 million through 680 grants to faith-based and community organization in 2003. This was a 19% increase in the dollars awarded that went to faith-based and community groups from 2002 and a 41% increase in number of grants awarded. $38 Million of those dollars went to 129 novice grantees that have not previously received a federal grant from HHS. This was a 7% increase from 2002 of dollars awarded to faith-based grantees and a 50% increase in number of grants awarded to these novice grantees.

HHS has begun to collect and meet the deadlines for the new data additions to the management agreement and provide that data to the White House and OMB.

HHS CFBCI continues to publish success stories about the impact made on people's lives by HHS faith-based grantees. These stories are called "Snapshots of Compassion" and can be found on the HHS CFBCI website

Pilot Projects

HHS continued its commitment to pilot projects with increase of funding to the Mentoring Children of Prisoners Grant as well as the Compassion Capital Fund. Both of these programs have also held training for all grantees this past year. HHS also announced the RFA for the Access to Recovery Program.

Regulatory Reform

HHS CFBCI published the HHS Department-wide Religious Non-Discrimination regulations for public comment and the final regulations as well. These regulations revise existing Department regulations to remove barriers to the participation of faith-based organizations in Department programs.

SAMHSA and ACF published the final Charitable Choice regulations in the Federal Register. Implementation of these regulations continues and is being monitored by HHS CFBCI.

Outreach/Technical Assistance

The Director of CFBCI held multiple outreach meetings throughout the country with potential grant applicants to provide them with an overview of the grant opportunities. This training utilized the "Deciphering Grant Opportunities" handbook developed by HHS CFBCI.

SAMHSA and HRSA both held national conferences on the faith-based and community initiative as it dealt with organizations in health, substance abuse, and mental health.

HHS CFBCI continues to improve the HHS CFBCI website by better organizing and naming topics. We use the yellow navigation bar to better attract and inform the public of new and urgent information. New sections include the Snapshots of Compassion, the Grants Opportunities Notebook, Publications and New Information sections.

ACF completed and printed the Child Care brochure for churches and religious organizations. A distribution schedule was used to provide the childcare brochure to the faith-community.

RESEARCH AND DEVELOPMENT CRITERIA

HHS continues its commitment to ensuring that its investments in R&D are effective and yield new knowledge that is applied to the development of new diagnostics, treatments, and preventive measures to improve health and health-related quality of life. Central to the development and implementation of objectives under the Department's Strategic Plan Goal 4, "Enhance the capacity and productivity of the Nation's health science research enterprise" are the OMB R&D Investment Criteria.

These criteria—*relevance*, *quality*, and *performance*—are carefully considered as research goals and associated targets are developed, as management changes are considered, and as budget decisions are made by HHS and its OPDIVs.

The first criterion—relevance—is addressed in several ways as it relates to research. One way is in setting research priorities—by considering public health needs, as judged by the incidence, severity, and cost of specific disorders as a key factor in determining areas of research support. Relevance is also ensured through seeking the views of the public into the OPDIV's research agendas. This occurs through meetings of advisory councils or boards that include representatives of the public as members, by publishing research plans for public comment, and by meeting with representatives of patient groups and presenting NIH research plans and seeking feedback. In addition, relevance is also considered when planning for activities that will occur after the research is completed. These activities, e.g., developing and disseminating educational materials or implementing public education campaigns based on results from NIH-funded research, help to ensure that the results of research reach the hands of those who can put the information to practical use. Through all of these efforts, in FY 2004, across the Nation, policymakers, consumers, patients, and providers of care are making better-informed health care decisions and are receiving higher quality care thanks to HHS-supported research.

Quality—the second criterion—is embodied by a commitment on the part of HHS OPDIVs to support work of the highest scientific caliber. The OPDIVs ensure quality through the peer review process for grants, and the principles guiding this review for scientific merit are contained in the Public Health Service Scientific Peer Review regulations. Peer review takes place in multiple steps. The initial step of the peer review process takes place in Scientific Review Groups or study sections, and the second level of peer review is carried out by the National Advisory Councils. A major effort has been underway at one of the OPDIVs to reorganize many of these review groups to keep pace with the ever-changing landscape of science, thus helping to ensure the quality of peer review. In FY 2004, the final phase of implementing that reorganization was begun and new study sections created within the reorganization framework began to meet.

The third criterion—performance—is key to each and every R&D goal set by the Department. Once priorities are set, peer review occurs, and funding decisions are made, performance is monitored on a regular basis. For example, grantees must submit annual progress reports, and this information is reviewed to assess their performance and follow-up actions taken when necessary. In addition, there are other oversight mechanisms for reviewing progress, e.g., site visits. Aside from project-specific reviews, there are state-of-the-science reviews, workshops, and other scientific meetings where knowledge in a particular area of research is reviewed, and progress and performance are assessed. The performance criterion is also executed through HHS efforts to accelerate research productivity. For example, the time from identifying a disease, e.g., influenza, to characterizing its cause, formerly took decades. But the time to identify Human Immunodeficiency Virus (HIV) was only 3 years, and with SARS, NIH-funded scientists characterized the disease within four weeks. Similarly, with the development of treatments, it took 60 years from the discovery of the infectious agent in tuberculosis to the first promising drug treatment; but for HIV, the initial treatments were introduced in 3 years; and with SARS, barely one year after characterizing the agent, we already have two candidate treatments in therapeutic trials. Because we cannot predict discoveries or anticipate the opportunities fresh discoveries will produce, HHS supports research along a broad — in fact, expanding — frontier. The overall performance of the research enterprise also requires that HHS support the human capital and material assets of science.

BROADENING HEALTH INSURANCE COVERAGE THROUGH STATE INITIATIVES

The Medicaid program provides a lifeline to millions of low-income Americans who otherwise would lack health insurance coverage. However, many Americans still lack either private or public insurance coverage. Through a variety of initiatives, and in partnership with the Nation's Governors, the Administration has made significant strides in addressing access to coverage for uninsured Americans.

The Health Insurance Flexibility & Accountability Initiative—Eligibility For New Health Care Coverage Affects Hundreds of Thousands

Since 2002, when CMS first announced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, a new approach to demonstrations in Medicaid and the State Children's Health Insurance Program (SCHIP), the Administration has encouraged new comprehensive state approaches to increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources. HIFA puts a particular emphasis on broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with income below 200 percent of the Federal poverty level (FPL). By supporting private coverage options in the states, the Administration has sought to promote new health care coverage without encouraging a "one-size-fits-all"

approach. In addition to HIFA, CMS has approved broad-based section 1115 demonstrations in states such as Utah that expanded coverage to previously uninsured individuals. *CMS estimates that HIFA demonstrations, if fully implemented, could potentially enroll as many as approximately 822,000 new people and non-HIFA demonstrations could enroll as many as 681,000.*

New Condition-Specific Health Care Coverage: Breast and Cervical Cancer

Many uninsured women need treatment for breast and cervical cancer, and CMS has been working to ensure that as many states as possible take advantage of the opportunity for enhanced Federal funding under the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA). BCCPTA gave states enhanced federal matching funds to provide Medicaid eligibility to a new group of women previously not Medicaid eligible. The new option allows states to provide full Medicaid benefits to uninsured women under age 65 who are identified through the CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP), are in need of treatment for breast or cervical cancer, including pre-cancerous conditions, and are not otherwise eligible for Medicaid. This program, effective October 1, 2000, also allows states to extend presumptive eligibility to applicants in order to ensure that needed treatment begins as early as possible and that life-saving interventions may be made in a timely fashion. Through the efforts of the Administration and the states, *49 states and the District of Columbia are now participating in the BCCPTA partnership with the CDC.* Furthermore, nearly half of those participating states also have adopted a presumptive eligibility option. *As of mid-2004, states reported having enrolled an additional 18,315 women in Medicaid since January 20, 2001.*

Health Care Coverage for Individuals with Disabilities—Improved Access and Improved Services

Access to health care coverage is also a crucial factor in allowing Americans with disabilities realize their fullest employment potential. To ensure that the contributions of disabled individuals in the workforce are not overlooked and that the business community takes full advantage of disabled individuals' skills and talents, CMS has designed and implemented two groundbreaking employment initiatives mandated by the Ticket to Work and Work Incentives Act of 1999 (TWWIA): the Demonstration to Maintain Independence and the Medicaid Infrastructure (MIG) Grants. These initiatives enable states to build supports for people with disabilities who would like to be employed. Specifically, *CMS has awarded grants to 45 states* to: develop an optional working disabled eligibility group (also known as "Medicaid buy-in"), increase the availability of statewide personal assistance services, form linkages with other state and local agencies that provide employment related supports, and create a seamless infrastructure that will maximize the employment potential of all people with disabilities. *Since passage of the TWWIA legislation, the number of states with a Medicaid buy-in program has increased from 1 to 27 and enrollment has increased from 2,000 to over 60,000*.