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United States General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-282988

July 20, 1999

The Honorable Dick Armey
Majority Leader
House of Representatives

The Honorable Dan Burton
Chairman, Committee on Government Reform
House of Representatives

The Honorable Fred Thompson
Chairman, Committee on Governmental Affairs
United States Senate

Subject: Observations on the Department of Health and Human Services' Fiscal Year 2000 Performance Plan

As you requested, we have reviewed and evaluated the fiscal year 2000 performance plans for the 24 Chief Financial Officers (CFO) Act agencies that were submitted to the Congress in accordance with the Government Performance and Results Act of 1993 (Results Act). Enclosure I to this letter provides our observations on the fiscal year 2000 performance plan for the Department of Health and Human Services (HHS). Enclosure II lists management challenges we and HHS' Inspector General identified that face the agency and the applicable goals and measures in the fiscal year 2000 annual performance plan. Enclosure III is HHS' comments.

Our objectives were to (1) assess the usefulness of the agency's plan for decisionmaking and (2) identify the degree of improvement the agency's fiscal year 2000 performance plan represents over the fiscal year 1999 plan. Our observations were generally based on the requirements of the Results Act, guidance to agencies from the Office of Management and Budget (OMB) for developing the plan (OMB Circular A-11, Part 2), our previous reports and knowledge of HHS' operations and programs, and our observations on HHS' fiscal year 1999

B-282988

performance plan. Our summary report on the CFO Act agencies' fiscal year 2000 plans contains a complete discussion of our objectives, scope, and methodology.¹

As agreed, unless you announce the contents of this letter earlier, we plan no further distribution until 30 days from the date of the letter. The major contributors to this report are listed in enclosure IV. Please call me on (312) 220-7600 if you or your staff have any questions.



Leslie Aronovitz
Associate Director, Health Financing
and Public Health Issues

Enclosures - 4

¹Managing for Results: Opportunities for Continued Improvements in Agencies' Performance Plans (GAO/GGD/AIMD-99-215, July 20, 1999).

Observations on the Department of Health and Human Services' Performance Plan for Fiscal Year 2000

HHS' fiscal year 2000 annual performance plan consists of a 250-page department wide summary and 13 individual agency plans. Although the plan more clearly ties performance goals to the Department's strategic plan than the 1999 plan did, HHS' 2000 performance plan provides a limited picture of intended performance across the Department, a limited discussion of strategies and resources the Department will use to achieve its goals, and limited confidence that HHS' performance information will be credible. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) characterizes the data that will be used to measure progress in offering outreach services to homeless and mentally ill persons as "very good" because "the sources of the data are the local agencies that provide the services." SAMHSA appears to be assuming that these data are valid without making any effort to verify the quality of these data, which are critical to measuring the agency's performance. The following figure highlights the plan's major strength and key weaknesses as HHS seeks to make additional improvements to its plan.

Figure I.1: Major Strength and Key Weaknesses of Fiscal Year 2000 Annual Performance Plan

Major Strengths

- Agency performance goals that are tied to Department strategic plan and program activities.

Key Weaknesses

- Agency performance goals not consistently measurable.
- Some key management challenges, such as Year 2000 compliance for certain key systems and financial system weaknesses, are not adequately addressed.
- Agency procedures to verify and validate performance data or identify actions to compensate for low quality data are not adequately described.
- The strategies and resources the agency will use to achieve its performance goals are not always adequately discussed.
- Sufficient information about strategies to mitigate external factors and to marshal the human capital needed to achieve results are not provided.

HHS' fiscal year 2000 performance plan indicates some degree of progress in addressing the weaknesses that we identified in our assessment of its fiscal year 1999 performance plan. In reviewing HHS' fiscal year 1999 plan, we observed that the plan could (1) more consistently set measurable performance goals; (2) provide information about how HHS agencies will coordinate with one another and other performance partners, such as states, to achieve related goals; (3) identify the resources HHS needs to accomplish its goals; (4) discuss how HHS intends to address problems with performance data; and (5) more consistently link performance goals with HHS' mission, strategic goals, and program activities. Improvements in the fiscal year 2000 plan include (1) a description of how Department strategic goals relate to key programs and initiatives, and identification of some agency performance goals that

implement Department strategic goals; (2) better descriptions of strategies and resources needed to accomplish performance goals; and (3) better identification of data to be used to measure performance and better discussions of data weaknesses. For example, HHS' fiscal year 2000 performance plan includes an expanded departmentwide summary that links Departmental strategic goals to programs and initiatives and selected performance goals and measures from the agencies' performance plans. Further, the plan identifies the agencies responsible for implementing departmentwide goals.

HHS' Performance Plan Provides a Limited Picture of Intended Performance Across the Agency

HHS' annual performance plan for fiscal year 2000 provides a limited picture of intended performance across the Department. To provide a clearer picture of intended performance, the plan should contain sets of performance goals as well as measures that address important dimensions of program performance. HHS' individual agency performance plans do not consistently do this. For example, although ensuring product safety is one of the Food and Drug Administration's (FDA) strategic initiatives, the human drug section of the plan contains no goals to improve the inspection of foreign pharmaceutical facilities—an area GAO has identified as needing many improvements.¹

Some performance goals do not include specific baseline and trend data to allow an evaluation of goal accomplishment. For example, the Administration for Children and Families (ACF) has a performance goal to increase employment among adult recipients of Temporary Assistance for Needy Families (TANF). Three areas of performance ACF plans to measure with respect to this goal are an increase in the number of adult TANF recipients who become newly employed, an increase in the number who retain employment, and an increase in their average quarterly earnings. However, these goals are considered in the “developmental” stage and the baselines, against which ACF could measure such results, have not been established.

Performance plans should also include performance goals or strategies addressing mission critical management problems. The Health Care Financing Administration (HCFA) plan contains such goals, including ones that relate to areas of concern previously highlighted by GAO and HHS' Office of the Inspector General. For example, HCFA has goals related to Year 2000 computer challenges, implementation of the Balanced Budget Act of 1997 provisions, improvements in HCFA's fiscal year 1998 financial statement audit opinion, and security of information systems. However, other plans do not include comparable goals. For example,

¹See *Food and Drug Administration: Improvements Needed in the Foreign Drug Inspection Program* (GAO/HEHS-98-21, Mar. 17, 1998).

the Program Support Center (PSC) operates and maintains the Payment Management System (PMS)—one of only two such systems in the federal government—which serves 11 different federal agencies and disburses approximately \$165 billion in grants annually, including half of all federal grants and all Medicaid grants to states. Yet the PMS section of the PSC performance plan contains no reference to that system's Year 2000 renovation effort.²

While HHS' performance plan recognizes the importance of financial management goals, goals to improve financial weaknesses were not established in some areas where financial weaknesses had been identified. For example, the fiscal year 1998 financial statement audit of HHS noted that both the departmentwide and draft financial statements for some HHS operating divisions have material weaknesses related to their financial reporting process.³ Yet the plans of HCFA, ACF, and the National Institutes of Health (NIH) did not address these financial reporting weaknesses. Further, HHS' plan does not specify which material weaknesses the Department wants to eliminate by fiscal year 2000, and it does not indicate a specific date for achieving the goal of substantial compliance with the requirements of the Federal Financial Management Improvement Act (FFMIA).

Some discussions of goals in the agencies' plans identify programs in other agencies or departments that contribute to the same or similar goals and indicate that coordination will occur. For example, FDA has a goal to develop and make available an improved method for the detection of several foodborne pathogens. FDA's discussion of this goal refers to an interagency research plan that more effectively coordinates the food safety research activities in FDA and the U.S. Department of Agriculture.

By linking complementary performance goals of different agencies, the plan's departmentwide summary suggests how differing program strategies can be mutually reinforcing. For example, one of HHS' strategic objectives is to reduce tobacco use, especially among youth. To contribute to this objective, the Centers for Disease Control and Prevention (CDC) has a performance goal to reduce the percentage of teenagers who smoke by conducting education campaigns, providing funding and technical assistance to state programs, and working with nongovernmental entities. FDA has a complementary goal to reduce easy access to tobacco products and eliminate the strong appeal of these products to

²GAO recently testified before the House Government Reform Subcommittee on Government Management, Information and Technology that PMS is not yet Year 2000 compliant and that is unclear when it will be. See Year 2000 Computing Crisis: Readiness Status of the Department of Health and Human Services (GAO/AIMD-99-92, Feb. 26, 1999). PMS was scheduled for replacement with a new system that would be Year 2000 compliant, but since its inception, the planned PMS replacement has encountered problems and is still not operational.

³HHS, Office of the Inspector General, Report on the Department of Health and Human Services Consolidated/Combined Financial Statement for Fiscal Year 1998, A-17-98-00015 (Feb. 1999), pp. V-8 through V-12, as taken from United States Department of Health and Human Services Accountability Report: Fiscal Year 1998 (Feb. 26, 1999).

children by conducting 400,000 compliance checks and selecting certain sites to target for intensified enforcement efforts to determine the effectiveness of different levels of effort.

HHS' fiscal year 2000 performance plan shows moderate improvement over last year's plan in portraying intended performance across the agency. In our review of the fiscal year 1999 plan, we observed that it would have been more useful if it had more consistently linked performance goals with HHS' mission, strategic goals, and program activities. The fiscal year 2000 performance plan includes an expanded departmentwide summary that links departmental strategic goals to agency programs and initiatives and selected performance goals and measures from the agencies' performance plans. Further, the plan identifies the agencies responsible for implementing departmentwide goals.

Although the linkages have been improved, in some cases, agencies that are identified in the departmentwide summary as being responsible for contributing to the accomplishment of a strategic goal have not included related performance goals in their agency plans. For example, according to the HHS performance plan, the Health Resources and Services Administration (HRSA) supports the strategic goal, "improve the diet and the level of physical activity of Americans." Specifically, HRSA's health centers are to expand the counseling of patients regarding tobacco, alcohol, drug use, oral health, fitness, and nutrition. However, the HRSA performance plan does not mention such an expansion in counseling services. Further, in a table linking HHS' strategic goals to its own performance goals, HRSA did not identify this particular HHS goal as one that HRSA supports.

Our review of the fiscal year 1999 plan also noted that HHS could substantially improve its plan by consistently acknowledging the crosscutting nature of many programs and discussing coordination among its own agencies and with other agencies that work toward related program goals. In the fiscal year 2000 plan, HHS' agencies more consistently state their intention to coordinate their efforts with other programs both within and outside the agency. However, the descriptions of how the agencies will accomplish this continue to be insufficiently detailed.

For example, CDC's plan notes that the HIV/AIDS program will continue to work closely with HRSA and the National Academy of Sciences to implement the Ryan White legislation and to evaluate state efforts to reduce perinatal transmission of HIV, and it will collaborate with SAMHSA and the National Institute for Drug Abuse on issues related to transmission of HIV among the population of injecting drug users. The plan does not, however, indicate what specific collaborative efforts will take place among these agencies. Further, while the plan states that CDC has established a work group related to its HIV/AIDS program, it does not identify the agencies participating in the work group.

Similarly, although HCFA recognizes the groups with which it should work to achieve many performance goals, specific details about planned coordination strategies are sometimes

limited. For example, HCFA developed a performance goal to decrease the prevalence of pressure ulcers in patients residing in long-term care facilities, partially in response to concerns we raised in earlier reviews of nursing home care.⁴ In addressing this performance goal, HCFA's plan notes only that it intends to work with national provider associations, national experts on pressure ulcer reduction, peer review organizations, states, and consumer advocates. The plan does not indicate how and for what specific purposes HCFA will work with these groups.

HHS' Performance Plan Provides a Limited Discussion of the Strategies and Resources the Agency Will Use to Achieve Its Goals

HHS' performance plan does not provide sufficiently specific discussions of strategies and resources the Department will use to achieve performance goals. Although some individual agency performance plans show how program activities and budgetary resources are linked to the achievement of performance goals, not all agencies do so. For example, the Indian Health Service (IHS) plan connects budgetary resources with the achievement of performance goals, provides a matrix linking program activities and budgetary accounts to IHS' four strategic goals, and links these strategic goals to a series of performance indicators.

NIH's plan, however, does not provide clear and easily understandable linkages between budget accounts and program activities. NIH elected to aggregate its program activities in its performance plan. It maintains that because of the crosscutting nature of the missions of its 25 institutes and centers, there is a similarity across the institutes and centers in performance goals and the relevant activities to accomplish these goals. However, such aggregation makes it difficult to link specific program outcomes with budgetary resources, especially because most NIH institutes and centers receive individual appropriations. Other than the aggregated crosswalk of its three core programs—research, research training and career development, and facilities—there is little discussion in the NIH plan of the resources required to accomplish the performance goals for each program.

HHS' agencies do not always adequately discuss how strategies and programs link to performance goals. For example, in the area of child welfare programs, ACF has a goal to provide children permanency and stability in their living situations and related performance measures, such as increasing the percentage of children who are adopted within 2 years of

⁴See California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998) and California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes With Serious Care Violations (GAO/T-HEHS-98-219, July 28, 1998).

foster care placement. However, ACF does not identify the strategies it will rely on to achieve this goal.

The agencies also do not adequately explain how they plan to build, maintain, and marshal the human capital needed to achieve results. For example, as we recently testified, over the next 5 years, almost a quarter of HCFA's staff—who make up a large part of the agency's management and technical expertise—will be eligible to retire.⁵ Although HCFA officials told GAO that they are taking the initial steps toward developing a long-term human resources plan, strategies for meeting workforce needs are not described in HCFA's performance plan.

The individual agency performance plans do not always identify strategies to leverage or mitigate the effects of external factors on the accomplishment of performance goals. For example, FDA's plan discusses the performance goals for its tobacco program in great detail. However, this discussion makes no mention of the multibillion-dollar settlement between the states and tobacco companies or state efforts to accomplish the agency's goal of reducing the incidence of youth smoking. States have already used some of the settlement proceeds to initiate tobacco use prevention and control programs—in many cases, with the assistance of CDC. Yet FDA's plan does not mention these state activities or how they affect FDA's goals.

HHS' fiscal year 2000 performance plan recognizes the weaknesses that we identified in our assessment of its fiscal year 1999 performance plan as it relates to providing a specific discussion of strategies and resources the Department will use to achieve performance goals and makes specific commitments to address those weaknesses. However, real progress is not yet evident. Among improvements in the fiscal year 2000 plan are that agencies more frequently identify strategies they will use to achieve their goals; in some cases, they provide more thorough descriptions of how the strategies will help them meet their performance goals. For example, HCFA's performance plan generally provides information on strategies to accomplish each of its 30 performance goals, the rationale for selecting a particular performance measure, and pertinent background information. In several instances, HCFA provides highly detailed information on how its planned strategy will help achieve performance goals. One such instance is HCFA's work to improve heart attack survival rates by encouraging hospitals to improve performance on six specific clinical interventions, including administering aspirin early in the hospital stay to prevent blood clot formation and prescribing certain medications when the patient is discharged from the hospital.

⁵See *HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition to the 21st Century* (GAO/T-HEHS-99-58, Feb. 11, 1999).

HHS' Performance Plan Provides Limited Confidence That Agency Performance Information Will Be Credible

HHS' fiscal year 2000 performance plan provides limited confidence that the Department's performance information will be credible. Many of the agency plans provide, at best, sketchy descriptions of agencies' efforts to verify and validate performance data. For example, some verification processes described in SAMHSA's performance plan do not provide confidence in the credibility of its performance information. In characterizing the data that will be used to measure progress in offering outreach services to homeless and mentally ill persons, SAMHSA's plan states "since the sources of the data are the local agencies that provide the services, the quality of the data is very good." SAMHSA appears to be assuming that these data are valid without indicating that it plans to verify the quality of the data.

Some HHS agencies also do not adequately identify actions to compensate for unavailable or poor quality data. For example, ACF's plan notes that in the area of child support enforcement, not all states have certified statewide-automated systems and some states still maintain their data manually. Additionally, the agency's Office of Child Support Enforcement has reported that where automated systems are not in place, problems of duplication and missing information could result.⁶ Yet the plan does not discuss the actions ACF will take to compensate for possibly unreliable data or the implications of these data limitations.

HHS' fiscal year 2000 performance plan shows little improvement over its 1999 plan with regard to providing confidence that the Department's performance information will be credible. The plan acknowledges the weaknesses that we identified in our assessment of the fiscal year 1999 plan and makes some attempt to address those weaknesses. However, real progress is not yet evident. While parts of the fiscal year 2000 plan contain more thorough discussions of data verification and validation, others do not, and the discussions frequently do not address serious problems with the underlying data.

For example, HCFA has a performance goal to "increase health plan choices available to Medicare beneficiaries." According to HCFA, in fiscal year 1997, 70 percent of Medicare beneficiaries had at least one managed care option and they have set this as the baseline against which its performance results will be measured. HCFA describes several data files and discusses how they will be used to provide the performance information required. However, as in last year's plan, the validation and verification section mentions only that the data are validated and verified internally on at least a quarterly basis. There are no specific

⁶See HHS, Administration for Children and Families, Office of Child Support Enforcement, Child Support Enforcement: Twentieth Annual Report to Congress (Sept. 1995), pp. 166-67.

mentions of verification and validation procedures, general data quality control procedures, or recognition of possible data shortcomings.

From an overall perspective, it does not appear that HHS has the information sources and the capacity needed to generate valid data to support its performance plan and to produce credible performance reports. The plan's departmentwide summary generally notes problems with performance information including challenges in data validation, difficulties in moving from output/process measures to outcome measures, and the need to involve partners and stakeholders in developing performance objectives and measures. However, overcoming these limitations could take the HHS agencies many years.

Other Observations on HHS' Implementation of Performance-Based Management

Because Year 2000 compliance has been the primary computer concern this year for HHS, there is little progress from fiscal year 1999 to fiscal year 2000 in the quality of HHS' financial and information systems, which generally do not contain reliable information. During GAO's fiscal year 1998 audit of the consolidated financial statements of the United States, we reported that widespread computer control weaknesses within HHS place significant amounts of federal assets at risk for fraud and misuse, financial information at risk of unauthorized modification or destruction, and sensitive information at risk of inappropriate disclosure.⁷ Weaknesses such as these place confidential HHS information—especially information contained in sensitive medical and other personal records maintained by HCFA—at risk of disclosure. Also, we reported under FFMIA that HHS' financial management systems were not in compliance with federal financial management systems requirements.⁸ HHS' Office of the Inspector General also reported significant departures from systems requirements, such as access and application control weaknesses at HCFA's central office and its Medicare contractor systems.⁹

⁷Financial Audit: 1998 Consolidated Financial Statements of the United States Government (GAO/AIMD-99-130, Mar. 31, 1999).

⁸See Financial Management: Federal Financial Management Improvement Act Results for Fiscal Year 1997 (GAO/AIMD-98-268, Sept. 30, 1998).

⁹HHS, Office of the Inspector General, Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1998, A-17-98-00098 (Feb. 1999), pp. 109–12, as taken from United States Department of Health and Human Services' Health Care Financing Administration Report Fiscal Year 1998 (Feb. 1999).

Agency Comments

HHS disagreed with our assessment of its fiscal year 2000 performance plan. Specifically, the Department expressed disagreement in five areas.

First, HHS said that our conclusion that agency performance goals are not consistently measurable is incorrect, noting that the plan contains about 1,400 concrete performance measures. It is HHS' position that while performance measures associated with some goals are in a developmental stage, all the goals are measurable and will be the subject of specific performance measures. While the HHS plan contains many measurable goals that provide the Congress and the public with information about intended performance, many goals for important HHS programs are not measurable. Furthermore, some significant programs, such as FDA's program for inspecting foreign pharmaceutical facilities, do not have performance goals.

Second, HHS disagreed with our assessment that its plan does not adequately address key management challenges, such as Year 2000 compliance and financial systems weaknesses. HHS believes that it has included appropriate goals in the plan and that it has provided more detailed information on these issues in other documents, such as the Department's quarterly Y2K reports and plans, the HHS Financial Management Status Report and Five-Year Plan, and the HHS Accountability Report. As we indicated in our assessment, however, we believe the plan has significant omissions with regard to how some key programs will address these problems. Furthermore, the other documents HHS refers to do not always provide the relevant information. For example, HHS' fiscal year 1998 Financial Management CFO Five-Year Plan states that the area of financial reporting is not a high priority.

Third, HHS disagreed with our assessment of the credibility of its performance data and said that we expect excessive documentation of data verification and validation. We reported that the plan provides limited confidence that HHS' performance information will be credible because many of the individual agency plans provide, at best, sketchy descriptions of agency efforts to verify and validate performance data. In addition, they often contain insufficient information about how agencies will compensate for data they know are unavailable or of poor quality. Regarding the extent of data verification and validation, our expectation was that the plan consistently adhere to the Results Act requirement to provide some description of efforts to verify and validate performance data.

HHS also disagreed with our assessment that the performance plan does not sufficiently discuss strategies and resources the Department will use to achieve its performance goals, and the Department expressed concern that we expected the plan to duplicate information in HHS' budget justification. Our analysis showed that some HHS agencies have not provided sufficient information to link their program goals with their capital, human, information, and other resources and, in some cases, with the strategies they plan to use to achieve the goals.

We do not expect HHS to duplicate information. However, information on the strategies planned to achieve some performance goals does not exist in either the performance plan or other sections of the budget justification; in other instances, HHS does not clearly link discussions of performance goals in the plans with discussions of strategies that appear elsewhere in the budget justification.

Finally, HHS disagreed with our assessment that the plan does not provide sufficient information about strategies to mitigate external factors and to marshal the human capital needed to achieve results. In particular, HHS contends that it does not marshal directly the human capital that can achieve results for most HHS programs because programs are implemented and administered by performance partners. As HHS explained in its plan, it is a very complex responsibility to carry out major programs like HHS' through performance partners. We believe that this is precisely why it is so important for HHS to have a clear plan for marshaling the considerable human capital within the Department—over 59,000 employees in fiscal year 1999—to work with its partners to ensure achievement of HHS' goals.

We have made technical corrections in response to HHS' comments, where appropriate.

We believe that HHS' fiscal year 2000 performance plan has a number of improvements compared to its first annual plan. In its comments, HHS stated that it will continue to work with OMB and its performance partners to ensure that future performance plans continue to provide data that support budget and program decisions for HHS.

Management Challenges

The following table shows major management challenges confronting HHS and goals and measures in the HHS fiscal year 2000 performance plan relating to those challenges.

Table II.1 Management Challenges

Management challenges identified by GAO	Applicable goals and measures in HHS' fiscal year 2000 annual performance plan
<p>Scope and complexity of HHS programs create coordination, oversight, and performance measurement challenges. To manage their wide-ranging programs effectively and efficiently, HHS agencies must coordinate with each other, other federal agencies, and state and local government and private program partners. Balancing program flexibility with oversight responsibilities and the challenge of measuring program outcomes make it difficult for HHS to ensure accountability for results.</p>	<p>No HHS departmentwide performance goals, but summary includes discussion of crosscutting strategic objectives. Selected examples of performance goals from individual agency plans: HRSA—Increase to 50 the number of state offices of rural health, which have implemented performance outcome measurement indicators and reported a summary of their outcomes. HCFA—Develop a performance standard concerning the Health Insurance Portability and Accountability Act's effectiveness in resolving complaints against insurers, states, or plans.</p>
<p>HHS needs reliable data and data systems to manage programs and assess results. Data needed to manage and evaluate HHS' programs are often unavailable, inaccurate, or inconsistent, and obtaining comparable data from programs carried out by state and local partners is difficult. Year 2000 challenges will compound these problems and could put benefits and services at risk.</p>	<p>HHS departmentwide performance goals: 100% of HHS information systems will function properly into the Year 2000. Business continuity and contingency plans will be available for 100% of critical business processes and mission critical systems. Selected examples of performance goals from individual agency plans: HCFA—Ensure Year 2000 compliance (readiness) of HCFA computer systems. FDA—Develop Sentinel Surveillance System for device injury reporting based on representative user facilities. FDA—Establish an electronic data system to facilitate the submission, processing, and analysis of error and accident reports for unlicensed blood facilities. CDC—Encourage state health departments to develop efficient and comprehensive public health information and surveillance systems by promoting the use of the Internet for surveillance and electronic data interchange and by focusing on development of standards for data elements.</p>
<p>Program integrity is a continuing challenge. HHS programs are attractive targets for fraud, waste, abuse, and mismanagement: Medicare is particularly vulnerable and remains a high-risk area. HHS' fiscal year 1998 financial statements had serious deficiencies.</p>	<p>HHS departmentwide performance goals: HHS and its operating divisions will receive unqualified opinions in their FY 2000 financial statement audits. The number of material weaknesses identified in financial statement audits will be reduced from 22 in FY 1997 to not more than 3 in FY 2000. All HHS operating divisions will be in substantial compliance with the requirements of FFMIA. HHS' FY 2000 debt collections will be 10% higher than those for FY 1999.</p>

Enclosure II
Management Challenges

Management challenges identified by GAO	Applicable goals and measures in HHS' fiscal year 2000 annual performance plan
	<p>Selected performance goals from HCFA's plan: Reduce the percentage of improper Medicare fee-for-service payments to 7 percent by 2000 and 5 percent by 2002. Improve the efficiency of medical claims reviews to permit a 10-percent increase in the number of claims reviewed. Increase the ratio of recoveries to audit dollars spent. Increase Medicare secondary payer liability and no-fault recoveries. Reduce improper payments for home health services. Ensure Year 2000 compliance of HCFA computer systems.</p>
Other areas identified by HHS' Office of the Inspector General	Applicable goals and measures in HCFA's fiscal year 2000 performance plan
Highly questionable payments for mental health services	Reduce the percentage of improper payments made under the Medicare fee-for-service program.
Growth of Medicare managed care	<p>Ensure timely enrollment of beneficiaries into managed care plans. Improve Medicare managed care plans' administration of the appeals process.</p>
Questionable home health payments	Reduce the percentage of Medicare home health services provided for which improper payments are made.
Nursing facilities payment reforms and implementation of other Balanced Budget Act provisions	Develop new Medicare payments systems in fee-for-service and Medicare+Choice.

Comments From the Department of Health & Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

APR 27 1999

Ms. Leslie Aronovitz, Director
Health Financing and Public Health Issues
Health, Education and Human Services Division
General Accounting Office
Washington, DC 20548

Dear Ms. Aronovitz:

The Department of Health and Human Services (HHS) appreciates the opportunity to comment on the draft GAO assessment of the HHS Annual Performance Plan for FY 2000. We do not agree with much in the summary assessment provided, but we recognize that a performance plan that covers 300 very different programs defies generalized assessments of the sort GAO has attempted. HHS will continue to work with the Office of Management and Budget and the agency's performance partners to ensure that future HHS performance plans continue to provide data that supports budget and program decisions for HHS. The following summarizes our principal comments on the GAO assessment.

1. **The conclusion that agency performance goals are not consistently measurable is incorrect.** Performance goals throughout the HHS performance plan are accompanied by performance measures. Indeed, our Department's GPRA submission contains about 1,400 separate, concrete performance measures. While the performance measures associated with some goals are in a developmental stage, and other performance measures are not "quantitative," all GPRA goals for HHS are measurable and will be the subject of specific performance measures.

Many of HHS's performance measures are developmental because of the limits of GPRA authority. Specifically, GPRA does not require Federal program partners, such as the States, to comply with the mandatory reporting requirements of GPRA. For them, GPRA performance reporting is a purely voluntary activity. Nevertheless, even without mandated reporting, agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the States are far along in negotiations for high-quality program performance data for SAMHSA's block grant programs.

HHS will not use quantitative measures where they are not appropriate. For programs, such as NIH research and other related science programs, scientific experts agree that we must make use of descriptive or qualitative measures of performance. Nevertheless, whether our measures are in a developmental stage or are descriptive and qualitative, all HHS performance goals are measurable in a manner envisioned by GPRA.

2. **The conclusion that the HHS plan does not adequately address key management**

Page 2 -- Ms. Leslie Aronovitz

challenges, such as millennium compliance and financial systems weaknesses is incorrect. HHS management issues and challenges are the subject of performance goals and measures, and are addressed at an appropriate level of detail in the HHS performance plan. For example, not only is the Payment Management System covered by the HHS-wide commitment for millennium compliance, it is also covered in a goal in the Program Support Center Plan, immediately following the programmatic goal for that system. In addition, the most significant financial system weaknesses of HHS are covered by performance goals and measures clearly defined in the plan. We believe that GAO is incorrect to expect excessive detail on management action plans in the GPRA context, when these are clearly presented elsewhere in public documents such as the Department's quarterly Y2K reports and plans, the HHS Financial Management Status Report and Five-Year Plan, and the HHS Accountability Report.

3. **The conclusion that HHS will not have credible data and the expectation for excessive documentation of data verification and validation are incorrect.** There is simply no basis for the GAO generalization that HHS performance data will not be credible. Throughout the plan, HHS has documented its reliance on established data bases and systems that: 1) are subject to ongoing controls for reliability, and 2) have supported program decision making for years. Neither the law nor OMB regulation require the level of data validation and verification that the GAO report fosters. The data validation effort suggested by GAO would be extremely costly for the Federal Government and burdensome to the States, communities, and other Federal grantees who administer HHS programs, and who are the source of most of the HHS performance data.
4. **The conclusion that HHS does not adequately discuss the strategies and resources the agency will use to achieve its performance goals is incorrect.** HHS has raised the stature of the annual GPRA performance goals and measures by making them a part of the Congressional budget justification of the Department, which is the preeminent source of annual information on HHS program strategies and resources for the 300 programs covered by the HHS budget and performance plan. In achieving linkage of strategies, resources and goals, as illustrated by the HHS Annual Performance Plan Summary and the budget justifications, HHS also avoids the very significant burden that would result from duplicate reporting to the Congress about the strategies and resources needed for these same 300 programs. This HHS action alone, not only assures the consistency of treatment of resource and strategy discussions in the budget and performance plan, it fosters the use of the performance goals in budget decisions for HHS programs. The full incorporation of the GPRA performance plan into the HHS budget documents and processes, is one of the strongest characteristics of GPRA implementation by HHS.
5. **The conclusions that HHS does not provide sufficient information about strategies to mitigate external factors and to marshal the human capital needed to achieve results are incorrect.** These conclusions reflect most clearly the GAO review's misunderstanding of HHS programs. Because of the breadth and variety of HHS

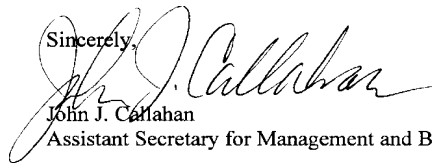
Enclosure III
Comments From the Department of Health & Human Services

Page 3 -- Ms. Leslie Aronovitz

programs, strategies and responses to external factors vary by program. It is not appropriate to generalize these strategies as GAO expects. Such strategies have been addressed throughout the plan as appropriate. As one would expect, the strategies that the Health Resources and Services Administration addressed for handling external factors associated with racial health disparities, the dominance of managed care, the number of uninsured, the aging population, the changing health care workforce, and technical advances must be different than those that FDA presented for handling greater regulatory volume, increase in adverse events, emerging international regulatory challenges and persistent threats to public health. With regard to the latter part of this final GAO observation, it is a basic fact that HHS simply does not marshal directly the human capital that can achieve HHS results for most HHS programs. Our programs are implemented and administered by performance partners who are not subjected to the level of oversight that this conclusion suggests is appropriate.

I have learned that GAO does not intend to publish its detailed findings for HHS, but will summarize its observations in a report about performance plans across government. If GAO plans to include any of the generalizations addressed above, or any other generalizations about the limited usefulness of the HHS plan, I must insist that these comments about the GAO assessment be clearly presented as well.

Sincerely,



John J. Callahan
Assistant Secretary for Management and Budget

cc: Dierde A. Lee, Acting Deputy Director for Management
Office of Management and Budget

Dan Mendelson, Program Associate Director
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