DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year
2016

General Departmental Management
Office of Medicare Hearings and Appeals
Office for Civil Rights
National Coordinator for Health Information Technology
Health Insurance Reform Implementation Fund
Nonrecurring Expenses Fund
Service and Supply Fund
Retirement Pay & Medical Benefits for Commissioned Officers

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENTAL MANAGEMENT

	FY 2016	
	FTE	**Budget Authority**
General Departmental Management	1135	492,516,000
Proposed Law (Pending A-19 Approval)[2]	-	*2,000,000*
Pregnancy Assistance Fund	2	25,000,000
PHS Evaluation Set-Aside – Public Health Service Act	144	66,078,000
HCFAC[1]	76	10,000,000
GDM Program Level	***1,357***	***593,594,000***
Office of Medicare Hearings and Appeals	1,475	140,000,000
Proposed Law (Pending A-19 Approval)[2]	-	*130,000,000*
Office of Civil Rights	299	42,705,000
Office of the National Coordinator for Health IT	200	91,800,000
Service and Supply Fund	1,311	0
TOTAL, Departmental Management	**4,642**	**868,099,000**

[1] The reimbursable program (HCFAC) in the General Department Management (GDM) account reflects estimates of the allocation account for 2016. Actual allocation will be determined annually.

[2] The RAC Recoveries reflect $2,000,000 in GDM and $130,000,000 in OMHA, pending approval of A-19 Legislative Proposal.

INTRODUCTION

The FY 2016 Congressional Justification is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 (GPRA) and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2016 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Citizens' Report. These documents are available at http://www.hhs.gov/budget.

The FY 2016 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2016 Annual Performance Report and FY 2016 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The Summary of Performance and Financial Information summarizes key past and planned performance and financial information.

Message from the Assistant Secretary for Financial Resources

I am pleased to present the Congressional Justification for Departmental Management activities within the Office of the Secretary. This Budget request represents the Administration's priorities for guiding the Department of Health and Human Services (HHS) to enhance the health and well-being of all Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

The Budget request supports the Secretary in her role as chief policy officer and general manager of HHS. The request totals $868 million. The request will ensure the Secretary's ability to successfully manage the Department while increasing accountability in oversight functions and improving the transparency of information and decision-making. The request increases funding for the Office of Medicare Hearings and Appeals, to ensure its continued ability to process cases within legally mandated timeframes while providing Medicare beneficiaries with unfettered access to coverage. The Office of the National Coordinator for Health IT budget request will allow ONC to continue responding to the evolving health IT landscape and ensure that health IT continues to meet the needs of a diverse set of users. The request also increases funding for the Office of Civil Rights to support OCR's centralized case management operations.

The Secretary looks forward to working with the Congress toward the enactment and implementation of an FY 2016 Budget that advances the Nation's health and supports families.

/Ellen G. Murray/

Ellen G. Murray
Assistant Secretary for Financial Resources

Departmental Management Overview

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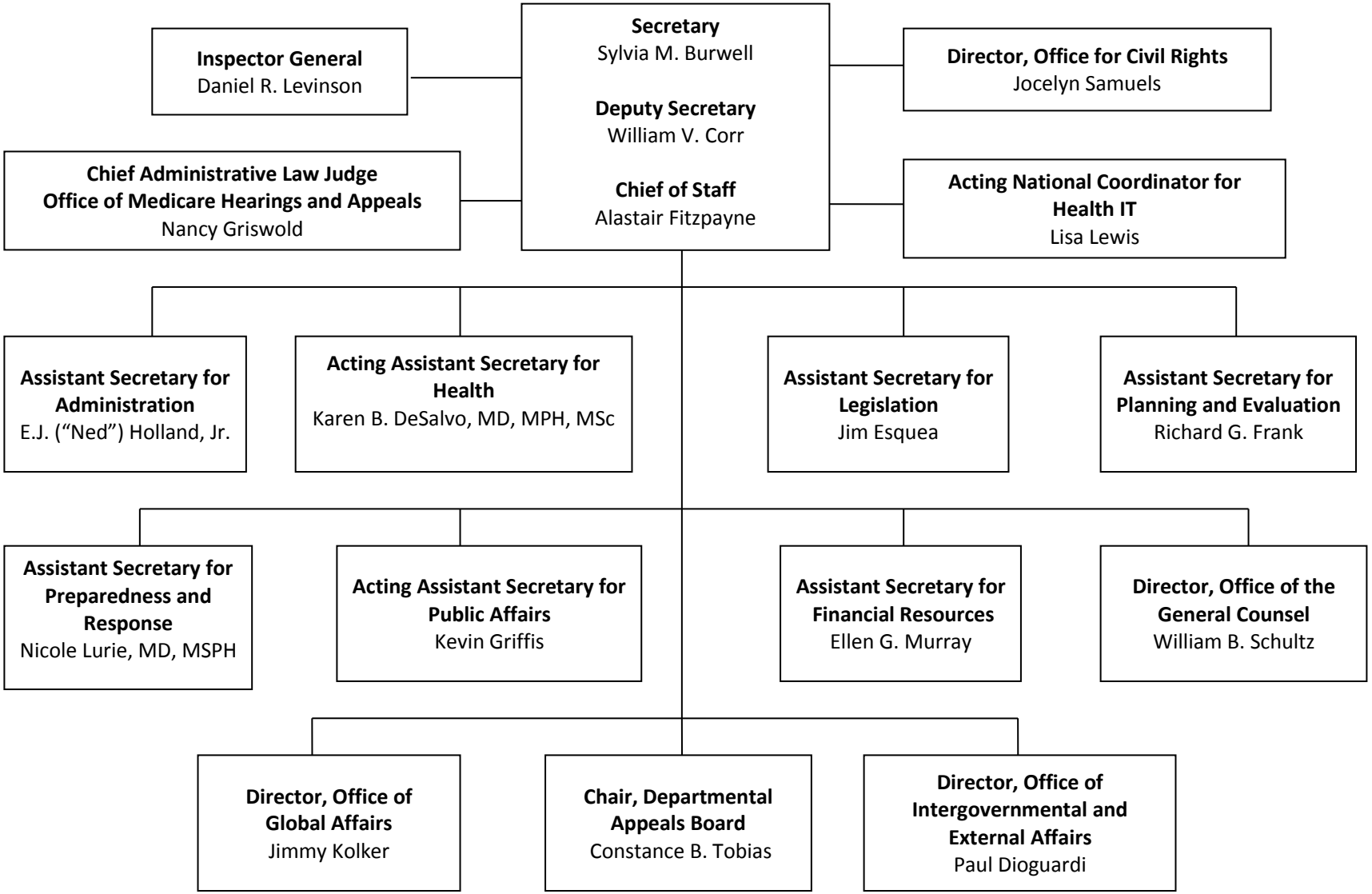
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY



ORGANIZATIONAL CHART: TEXT VERSION

Department of Health and Human Services

- Secretary Sylvia M. Burwell
  - Deputy Secretary William V. Corr
  - Chief of Staff Alastair Fitzpayne

The following offices report directly to the Secretary:

- Inspector General
  - Daniel R. Levinson
- Chief Administrative Law Judge of the Office of Medicare Hearings and Appeals
  - Nancy Griswold
- Director of the Office for Civil Rights
  - Jocelyn Samuels
- Acting National Coordinator for Health Information Technology
  - Lisa Lewis
- Assistant Secretary for Administration
  - E.J. “Ned” Holland
- Acting Assistant Secretary for Health
  - Karen B. DeSalvo, MD, MPH, MSc
- Assistant Secretary for Legislation
  - Jim Esquea
- Assistant Secretary for Planning and Evaluation
  - Richard G. Frank
- Assistant Secretary for Preparedness and Response
  - Nicole Lurie, MD, MSPH
- Acting Assistant Secretary for Public Affairs
  - Kevin Griffis
- Assistant Secretary for Financial Resources
  - Ellen G. Murray
- Director of the Office of the General Counsel
  - William B. Schultz
- Director of the Office of the Global Affairs
  - Jimmy Kolker
- Chief of the Departmental Appeals Board
  - Constance B. Tobias
- Director of the Office of Intergovernmental and External Affairs
  - Paul Dioguardi

DEPARTMENTAL MANAGEMENT OVERVIEW

Departmental Management (DM) is a consolidated display that includes the Office of the Secretary (OS) activities funded under the following accounts:

- General Departmental Management (appropriation);
- Office of Medicare Hearings and Appeals (appropriation);
- Office of Civil Rights (appropriation);
- Office of the National Coordinator for Health Information Technology (appropriation); and
- Service and Supply Fund (revolving fund).

The mission of OS is to provide support and assistance to the Secretary in administering and overseeing the organization, programs, and activities of the Department of Health and Human Services.

The overall FY 2016 Budget request for DM totals $868,099,000 in program level funding, including 4,642 full-time equivalent (FTE) positions, an increase of $135,066,000 above the FY 2015 Enacted level.

The **General Departmental Management (GDM)** appropriation supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department in administering and overseeing the organization, programs, and activities of HHS. These activities are carried out through eleven Staff Divisions (STAFFDIVs), including the Immediate Office of the Secretary, the Departmental Appeals Board, and the Offices of: public affairs; legislation; planning and evaluation; financial resources; administration; intergovernmental and external affairs; general counsel; global affairs; and assistant secretary for health. For FY 2016, the GDM Budget includes a total of $492,516,000 in budget authority and 1,135 FTE.

The **Office of Medicare Hearings and Appeals (OMHA)** was created in response to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). As mandated by MMA, OMHA opened its doors on July 1, 2005, to hear Medicare appeals at the Administrative Law Judge level, for cases under titles XVIII and XI of the Social Security Act. OMHA is funded from the Medicare Hospital Insurance and Supplemental Medical Insurance Trust Funds. OMHA is also proposing a series of legislative proposals to permit HHS to make regulatory and policy changes as well as provide additional sources of funding for OMHA in the amount of $130,000,000. For FY 2016 President's Budget, OMHA is requesting a total of $275,000,000 and 1475 FTE.

The **Office of Civil Rights (OCR)** is the primary defender of the public's right to privacy and security of protected health information and the public's right to non-discriminatory access to Federally-funded health and human services. For FY 2016 President's Budget, OCR is requesting a total of $42,705,000 in budget authority and 199 FTE.

The **Office of the National Coordinator for Health Information Technology (ONC)** was authorized by the Health Information Technology for Economic and Clinical Health Act, signed by President Obama on February 17, 2009. ONC became operational on August 19, 2005, in response to Executive Order 13335, signed on April 27, 2004. For FY 2016 President's Budget, ONC requests $91,800,000 and 200 FTE, to coordinate national efforts related to the implementation and use of electronic health information exchange.

The **Service and Supply Fund** (SSF), the HHS revolving fund, is composed of two parts: the Program Support Center (PSC) and the Non-PSC activities. For FY 2016 President's Budget, the SSF is projecting total revenue of $1,201,716,000 and usage of 1,311 FTE.

DEPARTMENTAL MANAGEMENT
BUDGET BY APPROPRIATION

(Dollars in thousands)

Details	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
General Departmental Management	$456,712	$448,034	$492,516
Proposed Law (Pending A-19 Approval)[2]	*$0*	*$0*	*$2,000*
Pregnancy Assistance Fund	$23,200	$23,175	$25,000
PHS Evaluation Funds	$69,211	$64,828	$66,078
HCFAC Funds[1]	$13,000	$10,000	$10,000
Subtotal, GDM Program Level	***$562,123***	***$546,037***	***$593,594***
Office of Medicare Hearings and Appeals	$82,831	$87,831	$140,000
Proposed Law (Pending A-19 Approval)[2]	*$0*	*$0*	*$130,000*
Office of Civil Rights	$38,798	$38,798	$42,705
Office of the National Coordinator for Health Information Technology	$60,367	$60,367	$91,800
Total, Departmental Management	**$744,149**	**$733,033**	**$868,099**

[1] The reimbursable program (HCFAC) in the General Department Management (GDM) account reflects estimates of the allocation account for 2016. Actual allocation will be determined annually.
[2] The RAC Recoveries reflect $2,000,000 in GDM and $130,000,000 in OMHA, pending approval of A-19 Legislative Proposal.

General Departmental Management

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APPROPRIATIONS LANGUAGE

GENERAL DEPARTMENTAL MANAGEMENT

For necessary expenses, not otherwise provided, for general departmental management,including hire of **[**six**]** passenger motor vehicles, and for carrying outtitles III, XVII, XXI, and section 229 of the PHS Act, the United States-MexicoBorder Health Commission Act, and research studies under section 1110 of theSocial Security Act, **[**$448,034,000**]** *$472,196,000*, together with **[**$64,828,000**]***$66,078,000* from the amounts available under section 241 of the PHS Act to carryout national health or human services research and evaluation activities: *Provided*, That **[**of this amount, $52,224,000**]** *of the funds made available under this heading,$53,900,000* shall be for minority AIDS prevention and treatment activities:*Provided further,* That of the funds made available under this heading,**[**$101,000,000**]** *$104,790,000* shall be for making competitive contracts and grantsto public and private entities to fund medically accurate and age appropriateprograms that reduce teen pregnancy and for the Federal costs associated withadministering and evaluating such contracts and grants, of which not more than10 percent of the available funds shall be for training and technical assistance,evaluation, outreach, and additional program support activities, and of the remainingamount 75 percent shall be for replicating programs that have been proven effective through rigorous evaluation to reduce teenage pregnancy, behavioral riskfactors underlying teenage pregnancy, or other associated risk factors, and 25percent shall be available for research and demonstration grants to develop, replicate,refine, and test additional models and innovative strategies for preventingteenage pregnancy: *Provided further*, That of the amounts provided under thisheading from amounts available under section 241 of the PHS Act, $6,800,000shall be available to carry out evaluations (including longitudinal evaluations) ofteenage pregnancy prevention approaches: *Provided further,* That of the fundsmade available under this heading, $1,750,000 is for strengthening the Department'sacquisition workforce capacity and capabilities **[**: *Provided further*, Thatwith respect to the previous proviso, such funds shall be available for**]** *, including*training, recruiting, retaining, and hiring members of the acquisition workforceas defined by 41 U.S.C. 1703, for information technology in support of acquisitionworkforce effectiveness and for management solutions to improve acquisitionAccount Number: 009-90-9912 General Departmental Management (APPROPRIATIONS)(Department of Health and Human Services - Departmental Management) Page: 1Agency: Department of Health and Human Services Printed: 5:48 PM Thursday, January 15Bureau: Departmental Management For General Counsel Reviewmanagement: **[***Provided further,* That of the funds made available under thisheading, $5,000,000 shall be for making competitive grants to provide abstinenceeducation (as defined by section 510(b)(2)(A)-(H) of the Social Security Act) to adolescents,and for Federal costs of administering the grant: *Provided further,* That grants made under the authority of section 510(b)(2)(A)-(H) of the Social Security Act shall be made only to public and private entities that agree that, with respect to an adolescent to whom the entities provide abstinence education under such grant, the entities will not provide to that adolescent any other education regarding sexual conduct, except that, in the case of an entity expressly required by law to provide health information or services the adolescent shall not be precluded from seeking health information or services from the entity in a different setting than the setting in which abstinence education was provided: *Provided further*, That funds provided in this Act for embryo adoption activities may be used to provide to individuals adopting embryos, through grants and other mechanisms, medical and administrative services deemed necessary for such adoptions: *Provided further*, That such services shall be provided consistent with 42 CFR 59.5(a)(4)**]** *Provided further, That funds made available under this heading may also be used for activities to encourage innovative approaches to increase efficiency and effectiveness in the Department's programs. In addition, to supplement the Department's activities*

related to implementation of the Digital Accountability and Transparency Act (DATA Act; Public Law 113–101;31 U.S.C. 6101 note), $10,320,000, of which $500,000 shall be available to supportthe Department's implementation of a uniform procurement instrument identifier,as described in 48 C.F.R. subpart 4.16. In addition, for a Digital Service team for HHS, $10,000,000. (Department of Health and Human Services Appropriations Act, 2015.)

LANGUAGE ANALYSIS

Language Provision	Explanation
Provided, further, That funds made available under this heading may also be used for activities to encourage innovative approaches to increase efficiency and effectiveness in the Department's programs. In addition, to supplement the Department's activities related to implementation of the Digital Accountability and Transparency Act (DATA Act; Public Law 113–101;31 U.S.C. 6101 note), $10,320,000, of which $500,000 shall be available to support the Department's implementation of a uniform procurement instrument identifier, as described in 48 C.F.R. subpart 4.16. In addition, for a Digital Service team for HHS, $10,000,000.	This language supports the Data Act and Digital Services Legislation.

AUTHORIZING LEGISLATION

(Dollars in Thousands)

Details	2015 Authorized	2015 Enacted	2016 Authorized	2016 Request
General Departmental Management: except account below:	Indefinite	$169,070	Indefinite	$202,361
Reorganization Plan No. 1 of 1953	-	-	-	-
Office of the Assistant Secretary for Health: Public Health Service Act,	-	-	-	-
Title III, Section 301	Indefinite	175,586	Indefinite	$187,485
Title, II Section 229 (OWH)	1	$32,140	1	$31,500
Title XVII Section 1701 (ODPHP)	2	6,726	2	$7,000
Title XVII, Section 1707 (OMH)	3	$56,670	3	$56,670
Title XVII, Section 1708 (OAH)	4	$1,442	4	$1,500
Title XXI, Section 2101 (NVPO)	5	$6,400	5	$6,000
Subtotal	-	*278,810*	-	*$290,155*
Total Appropriation	**-**	**$458,034**	**-**	**$492,516**

AMOUNTS AVAILABLE FOR OBLIGATION

Detail	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Annual appropriation	$458,056,000	$448,034,000	$492,516,000
Rescission	-	-	-
Sequestration	-	-	-
Transfers	-$1,344,000	-	-
Subtotal, adjusted general funds	***$456,712,000***	***$448,034,000***	***$492,516,000***
Trust fund annual appropriation	-	-	-
Subtotal, adjusted budget authority	***$456,712,000***	**$448,034,000**	***$492,516,000***
Unobligated balance lapsing	-	-	-
Total Obligations	**$456,712,000**	**$448,034,000**	**$492,516,000**

Summary of Changes

(Dollars in Thousands)

Budget Year and Type of Authority	Dollars	FTE
FY 2015 Enacted Level	448,034	1,000
Total Adjusted Budget Authority	448,034	1,000
FY 2016 Current Request	492,516	1,128
Total Estimated Budget Authority	492,516	1,128
Net Changes	**44,482**	**128**

Increases	FY 2015 Enacted Level	FY 2016 Request Change from Base
Immediate Office of the Secretary	10,566	434
Chief Technology Officer – Idea Lab	0	3,000
Secretary's Initiative/Innovations	2,629	0
Assistant Secretary for Administration	17,258	742
Assistant Secretary for Public Affairs	8,408	292
Digital Service Teams	0	10,000
Assistant Secretary for Legislation	3,643	157
ASFR, Financial Systems Integration and Acquisition Reform	29,594	2,356
DATA Act	0	10,320
Office of Intergovernmental and External Affairs	9,202	2,780
Office of the General Counsel	37,697	1,503
Departmental Appeals Board	10,043	2,457
Office of Global Affairs	6,026	494
Rent, Operations and Maintenance	15,789	711
Shared Operating Services - Enterprise IT, SSF Payments	13,369	2,891
Office of the Assistant Secretary for Health	28,909	7,986
Teen Pregnancy Prevention	*101,000*	*3,790*
Minority HIV/AIDS	52,224	1,676
Minority Health	56,670	0
Total	**403,027**	**51,589**

Decreases	FY 2015 Enacted Level	FY 2016 Request Change from Base
Office of Assistant Secretary for Health	6,867	-467
Office of Women's Health	32,140	-640
Embryo Adoption Awareness Campaign	1,000	-1,000
Abstinence Education	5,000	-5,000
Total	**45,007**	**-7,107**

Total Changes	FY 2015 Enacted Level	FY 2015 FTE	FY 2016 Request Change from Base	FY 2016 FTE Change from Base
Total Increase Changes	403,027		51,589	128
Total Decrease Changes	45,007		-7,107	0
Total	**448,034**	**1,000**	**44,482**	**128**

BUDGET AUTHORITY BY ACTIVITY - DIRECT

(Dollars in Thousands)

Activity	FY 2014 FTE	FY 2014 Final	FY 2015 FTE	FY 2015 Enacted	FY 2016 FTE	FY 2016 President's Budget
Immediate Office of the Secretary	72	10,995	72	10,566	76	14,000
Secretarial Initiatives and Innovations	-	2,735	-	2,629	-	2,629
Assistant Secretary for Administration	116	17,958	114	17,258	114	18,000
Assistant Secretary for Financial Resources	149	28,974	149	27,844	149	30,200
Acquisition Reform	1	1,750	1	1,750	1	1,750
DATA Act	-	-	-	-	12	10,320
Assistant Secretary for Legislation	26	3,791	27	3,643	27	3,800
Assistant Secretary for Public Affairs	56	8,749	54	8,408	56	8,700
Digital Services Team	-	-	-	-	30	10,000
Office of General Counsel	184	39,226	167	37,697	173	39,200
Departmental Appeals Board	75	10,450	70	10,043	82	12,500
Office of Global Affairs	24	6,270	22	6,026	23	6,520
Office of Intergovernmental and External Affairs	70	9,576	68	9,202	70	10,600
Center for Faith-Based and Neighborhood Partnerships	-	-	-	-	7	1,382
Office of the Assistant Secretary for Health	267	228,426	255	225,586	314	236,255
Embryo Adoption Awareness Campaign	-	997	-	1,000	-	-
HIV-AIDS in Minority Communities	1	52,082	1	52,224	1	53,900
Shared Operating Expenses	-	13,317	-	13,369	-	16,260
Rent, Operations, Maintenance and Related Services	-	16,429	-	15,789	-	16,500
Abstinence Education	-	4,986	-	5,000	-	-
Total, Budget Authority	**1,041**	**456,712**	**1,000**	**448,034**	**1,135**	**492,516**

BUDGET AUTHORITY BY OBJECT CLASS – DIRECT

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
11.1	Full-time permanent	91,229	87,950	100,321
11.3	Other than full-time permanent	11,509	11,828	12,524
11.5	Other personnel compensation	2,916	2,898	2,946
11.7	Military personnel	3,754	2,685	3,881
Subtotal	***Personnel Compensation***	***109,408***	***105,361***	***119,673***
12.1	Civilian personnel benefits	28,077	27,431	30,724
12.2	Military benefits	1,504	1,277	1,536
13.0	Benefits for former personnel	-	-	-
Total	***Pay Costs***	***138,989***	***134,069***	***151,933***
21.0	Travel and transportation of persons	4,830	4,737	5,027
22.0	Transportation of things	185	185	190
23.1	Rental payments to GSA	16,342	16,556	16,904
23.3	Communications, utilities, and misc. charges	1,939	1,826	1,967
24.0	Printing and reproduction	851	851	871
25.1	Advisory and assistance services	23,009	26,848	27,354
25.2	Other services from non-Federal sources	38,468	37,004	37,988
25.3	Other goods and services from Federal sources	64,797	65,716	84,991
25.4	Operation and maintenance of facilities	6,246	5,606	6,037
25.5	Research and development contracts	-	-	-
25.6	Medical care	-	-	-
25.7	Operation and maintenance of equipment	4,990	4,590	5,631
25.8	Subsistence and support of persons	106	106	108
26.0	Supplies and materials	1,449	1,449	1,485
31.0	Equipment	447	447	456
32.0	Land and Structures	-	-	-
41.0	Grants, subsidies, and contributions	154,060	148,040	151,571
42.0	Insurance claims and indemnities	3	3	3
44.0	Refunds	-	-	-
Total	***Non-Pay Costs***	***317,723***	***313,965***	***340,584***
Total	***Budget Authority by Object Class***	**456,712**	**448,034**	**492,516**

BUDGET AUTHORITY BY OBJECT CLASS – REIMBURSABLE

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
11.1	Full-time permanent	47,720	47,720	53,632
11.3	Other than full-time permanent	3,305	3,305	2,905
11.5	Other personnel compensation	934	934	944
11.7	Military personnel	1,491	1,491	924
Subtotal	***Personnel Compensation***	***53,450***	***53,450***	***58,406***
12.1	Civilian personnel benefits	10,184	10,184	10,887
12.2	Military benefits	444	444	526
13.0	Benefits for former personnel	-	-	-
Total	***Pay Costs***	***64,078***	***64,078***	***69,818***
21.0	Travel and transportation of persons	1,230	1,230	1,159
22.0	Transportation of things	107	107	108
23.1	Rental payments to GSA	6,108	6,108	6,526
23.3	Communications, utilities, and misc. charges	207	207	146
24.0	Printing and reproduction	35	35	34
25.1	Advisory and assistance services	40,491	40,491	39,135
25.2	Other services from non-Federal sources	19,132	19,132	18,717
25.3	Other goods and services from Federal sources	90,972	93,071	84,837
25.4	Operation and maintenance of facilities	2,551	2,551	2,603
25.5	Research and development contracts	-	-	-
25.6	Medical care	-	-	-
25.7	Operation and maintenance of equipment	3,173	3,173	3,194
25.8	Subsistence and support of persons	-	-	-
26.0	Supplies and materials	399	399	383
31.0	Equipment	256	256	261
32.0	Land and Structures	54	54	55
41.0	Grants, subsidies, and contributions	3,107	3,107	3,172
42.0	Insurance claims and indemnities	-	-	-
44.0	Refunds	-	-	-
Total	***Non-Pay Costs***	***167,822***	***169,921***	***160,330***
Total	***Budget Authority by Object Class***	**231,900**	**233,999**	**230,148**

SALARY AND EXPENSES

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
11.1	Full-time permanent	91,229	88,055	100,322
11.3	Other than full-time permanent	11,509	11,828	12,524
11.5	Other personnel compensation	2,916	2,898	2,946
11.7	Military personnel	3,754	2,685	3,881
Subtotal	***Personnel Compensation***	***109,408***	***105,466***	***119,674***
12.1	Civilian personnel benefits	28,077	27,457	30,724
12.2	Military benefits	1,504	1,277	1,536
13.0	Benefits for former personnel	-	-	-
Total	***Pay Costs***	***138,989***	***134,200***	***151,934***
21.0	Travel and transportation of persons	4,830	4,737	5,027
22.0	Transportation of things	185	185	190
23.3	Communications, utilities, and misc. charges	1,939	1,826	1,967
24.0	Printing and reproduction	851	851	871
25.1	Advisory and assistance services	23,009	26,848	27,354
25.2	Other services from non-Federal sources	38,468	37,004	37,988
25.3	Other goods and services from Federal sources	64,797	65,585	84,990
25.4	Operation and maintenance of facilities	6,246	5,606	6,037
25.5	Research and development contracts	-	-	-
25.6	Medical care	-	-	-
25.7	Operation and maintenance of equipment	4,990	4,590	5,631
25.8	Subsistence and support of persons	106	106	108
Subtotal	***Other Contractual Services***	***145,422***	***147,339***	***170,163***
26.0	Supplies and materials	1,449	1,449	1,485
Subtotal	***Non-Pay Costs***	***146,871***	***148,788***	***171,648***
Total	***Salary and Expenses***	***285,860***	***282,988***	***323,582***
23.1	Rental payments to GSA	16,342	16,556	16,904
Total	***Salaries, Expenses, and Rent***	**302,202**	**299,544**	**340,486**
Total	***Direct FTE***	**1,041**	**1,000**	**1,128**

APPROPRIATION HISTORY TABLE

(Dollars in Thousands)

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
2006	**-**	**-**	**-**	**-**
Appropriation	353,325,000	338,695,000	353,614,000	352,703,000
Rescission	-	-	-	-3,585,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
2007	**-**	**-**	**-**	**-**
Appropriation	362,568,000	-	-	350,945,000
Rescission	-	-	-	-500,000
Supplemental	13,512,000	-	-	-
Trust Funds	5,851,000	-	-	5,793,000
2008	**-**	**-**	**-**	**-**
Appropriation	386,705,000	342,224,000	386,053,000	355,518,000
Rescission	-	-	-	-6,312,000
Transfers	-	-	-	-983,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,792,000
2009	**-**	**-**	**-**	**-**
Appropriation	374,013,000	361,825,000	361,764,000	391,496,000
Transfers	-	-1,000,000	-1,000,000	-2,571,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
2010	**-**	**-**	**-**	**-**
Appropriation	403,698,000	397,601,000	477,928,000	493,377,000
Transfers	-	-1,000,000	-1,000,000	-1,074,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
2011	**-**	**-**	**-**	**-**
Appropriation	490,439,000	651,786,000	-	651,786,000
Rescission	-	-1,315,000	-	-1,316,000
Transfers	-	-176,551,000	-	-176,551,000
Trust Funds	-	5,851,000	-	5,851,000
2012				**-**
Appropriation	363,644,000	343,280,000	476,221,000	475,221,000
Rescission	-	-	-	-898,000
Transfers	-	-	-	-70,000
2013	**-**	**-**	**-**	**-**
Appropriation	306,320,000	-	466,428,000	474,323,000
Rescission	-	-	-	-949,000
Sequestration	-	-	-	-23,861,000
Transfers	-	-	-	-2,112,000
2014	**-**	**-**	**-**	**-**
Appropriation	301,435,000	-	477,208,000	458,056,000
Rescission	-	-	-	-
Sequestration	-	-	-	-
Transfers	-	-	-	-1,344,000
2015				
Appropriation	278,800,000	-	442,698,000	448,034,000
Rescission	-	-	-	-
Sequestration	-	-	-	
Transfers	**-**	**-**	**-**	**-**

General Departmental Management
All Purpose Table

(Dollars in Thousands)

GDM	FY 2014 Actual	FY 2015 Enacted Level	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	**$456,712**	**$448,034**	**$492,516**	**+$44,482**

Related Funding	FY 2014 Actual	FY 2015 Enacted Level	FY 2016 President's Budget	FY 2016 +/- FY 2015 PB
Pregnancy Assistance Fund P.L. (111-148)	*$23,200*	*$23,175*	*$25,000*	*+$1,825*
PHS Evaluation Set-Aside – Public Health Service Act	*$69,211*	*$64,828*	*$66,078*	*+$1,250*
HCFAC[1]	*$13,000*	*$10,000*	*$10,000*	*$0*
Base Level Program	**$562,123**	**$546,037**	**$593,594**	**$47,557**
Proposed Legislation Recovery Audit Recoveries[2]	*0*	*0*	*$2,000*	*+$2,000*
FTE	**1,250**	**1,283**	**1,357**	**+74**

[1] The reimbursable program (HCFAC) in the General Department Management (GDM) account reflects estimates of the allocation account for 2016. Actual allocation will be determined annually.
[2] The RAC Recoveries reflect $2,000,000 in GDM, pending approval of A-19 Legislative Proposal.

GENERAL DEPARTMENTAL MANAGEMENT
Overview of Performance

The General Departmental Management (GDM) supports the Secretary in her role as chief policy officer and general manager of HHS in administering and overseeing the organizations, programs and activities of the Department.

The Office of the Assistant Secretary for Health (OASH) is the largest single STAFFDIV within GDM, managing thirteen cross-cutting program offices, coordinating public health policy and programs across HHS operating and staff divisions (OPDIVs/STAFFDIVs), and ensuring the health and well-being of Americans.

The FY 2016 Congressional Justification reflects decisions to streamline performance reporting and improve HHS performance-based management. In accordance with this process GDM STAFFDIVs have focused on revising measures that depict the main impact or benefit of the program and support the rationale articulated in the budget request. This approach is reflected in the Department's Online Performance Appendix (OPA). The OPA focus on key HHS activities, and includes performance measures that link to the HHS Strategic Plan for three GDM offices. They are: Immediate Office of the Secretary (IOS), Offices the Assistant Secretary for Administration (ASA), and OASH.

This justification includes individual program narratives that describe accomplishments, for most of the GDM components. The justification also includes performance tables that provide performance data for specific GDM components: ASA, IOS, OASH, and the Departmental Appeals Board (DAB).

FY 2015 BUDGET BY HHS STRATEGIC GOAL

(Dollars in Millions)

HHS Strategic Goals and Objectives	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
1.Strengthen Health Care	***79.466***	***79.213***	***81.670***
1.A Make coverage more secure for those who have insurance and extend affordable coverage to the uninsured			
1.B Improve health care quality and patient safety	10.450	10.043	12.500
1.C Emphasize primary & preventative care, link with community prevention services			
1.D Reduce the growth of health care costs while promoting high-value, effective care	12.500	12.500	12.500
1.E Ensure access to quality culturally competent care, including long-term care services and support, for vulnerable populations	56.516	56.670	56.670
1.F Improve health care and population through meaningful use of health information technology			
2. Advance Scientific Knowledge and Innovation	***6.756***	***6.493***	***6.800***
2.A Accelerate the process of scientific discovery to improve health	6.756	6.493	6.800
2.B Foster and apply innovative solutions to health, public health, and human services challenges	13.119	11.085	11.085
2.C Advance the regulatory sciences to enhance food, safety, improve medical product development, and support tobacco regulations			
2.D Increase our understanding of what works in public health & human service practice			1.000
2.E Improve laboratory, surveillance, and epidemiology capacity			
3. Advance the Health, Safety and Well-Being of the American People	***192.877***	***251.682***	***258.205***
3. A Promote the safety, well-being and healthy development of children and youth	130.412	130.442	131.290
3. B Promote economic and social well-being for individuals, families and communities.	.997	1.000	0.000
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults			
3.D Promote prevention and wellness across the lifespan	54.809	52.188	58.995
3.E Reduce the occurrence of infectious diseases	60.200	60.026	61.400
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies	15.249	6.026	6.520
4. Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs	***269.905***	***199.389***	***234.834***
4.A Strengthen program integrity and responsible stewardship	8.558	8.558	8.558
4.B Enhance access to and use of data to improve HHS programs and to support improvements in the health and well-being of the American People	55.415	52.177	75.813
4.C Invest in the HHS workforce to help meet America's health and human services need	20.057	17.258	18.000
4.D Improve HHS environmental, energy, and economic performance to promote sustainability	185.875	121.396	132.463
Total GDM Program Level	**562.123**	**546.037**	**593.594**

OVERVIEW OF BUDGET REQUEST

The FY 2016 President's Budget for General Departmental Management (GDM) includes $492,516,000 in appropriated funds and full-time equivalent (FTE) positions. This request is $44,482,000 above the FY 2015 Enacted Level.

The GDM appropriation supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department. In FY 2014 HHS took steps to continue implementation of Health Reform and other ongoing public health initiatives through eliminating or reallocating resources and support new and focused strategic partnerships to provide national health leadership. This justification includes narrative sections describing the activities of each STAFFDIV funded under the GDM account, including the Rent and Common Expenses accounts. This justification also includes selected performance information.

The Budget restores an $8,000,000 reduction from the FY 2015 Omnibus bill that supports positions, facilities and programs within the OS Staff Divisions. This restoration of funds is described in each narrative section and outlines the activities that will be restored. The FY 2016 President's Budget proposes the following programmatic changes.

Funding for Embryo Adoption Awareness Campaign (-$1,000,000) and Abstinence Education (-$5,000,000), was appropriated in 2015, but not requested by HHS. HHS is not requesting continuation of funds for these programs in FY 2016.

Immediate Office of the Secretary (+$3,000,000) - This increase supports the growth of the HHS IDEA Lab. The resources will allow HHS to pilot new programmatic activities to support innovative ideas that increase efficiency and effectiveness by providing time, resources, and methodological training to internal teams to help staff take ideas through prototyping and pilot phases.

Digital Accountability and Transparency Act (DATA) (+$10,320,000) - To implement the DATA Act of 2014 as well as expand the Federal Funding Accountability and Transparency Act of 2006 to improve transparency of Federal spending and Government-wide financial data standards. The focus will make improvements to Grants.gov as well as data standardization efforts that will include both financial and non-financial data.

Office of Intergovernmental and External Affairs (+$2,780,000) – The increase of $2,780,000 supports personnel costs, continued coordination of a wide range of outreach activities, and will facilitate cross-cutting initiatives in the field such as ongoing support of the Affordable Care Act along with Tribal activities. This increase also includes the addition of the Center for Faith Based and Neighborhood Partnerships which is being reallocated from the Administration on Children and Families. Additional funding is being reallocated from the Secretary's Flexibility Account to expand IEA's support to state, territorial and tribal representatives.

Digital Services Team (+$10,000,000) – The implementation of $10,000,000 is to establish and staff an agency Digital Services team. The success rate of government digital services is improved when agencies have digital service experts on staff with modern design, software engineering, and product management skills. To ensure the agency can effectively build and deliver important digital services, the FY 2016 Budget includes funding for staffing costs to build a Digital Service team that will focus on

transforming the agency's digital services with the greatest impact to citizens and businesses so they are easier to use and more cost-effective to build and maintain. The request will enable HHS to focus on the implementation of milestones to build capacity and support the development of a Digital Services team and drive the efficiency and effectiveness of the agency's highest-impact digital services.

Departmental Appeals Board (+$2,000,000) - The request supports DAB's efforts to keep pace with the dramatic increase in caseload associated with the Medicare Appeals.

Office of the Assistant Secretary for Health (+$12,346,000) – The Budget request continues the ASH's responsibility as the senior advisor to the Secretary and Administration on public health and science by addressing several highly visible public health needs, such as: viral hepatitis; fostering greater coordination among the various HHS entities to continue implementation of the Environmental Health action plan; and continued coordination of the HHS Tobacco Control Implementation Steering Committee. The request will also continue support for the Office of the Surgeon General and the Regional Health Administrators.

IMMEDIATE OFFICE OF THE SECRETARY

Budget Summary
(Dollars in Thousands)

Immediate Office of the Secretary	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	10,995	10,566	14,000	+3,434
FTE	72	72	76	+4

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The Immediate Office of the Secretary (IOS) provides leadership, direction, policy, and management guidance to HHS and supports the Secretary and Deputy Secretary in their roles as representatives of both the Administration and HHS. IOS serves as the nucleus for all HHS activities and shepherds the Department's mission of enhancing the health and well-being of Americans. IOS also provides assistance, direction, and coordination to the White House and other Cabinet agencies regarding HHS issues.

The IOS mission involves coordinating all HHS documents, developing regulations requiring Secretarial action, mediating issues among Departmental components, communicating Secretarial decisions, and ensuring the implementation of those decisions. IOS works with other Departments to coordinate analysis of and input on healthcare policy decisions impacting activities within their purview.

IOS leads efforts to reform health care across HHS by improving the quality of the health care system and lowering its costs, computerizing all medical records, and protecting the privacy of patients. In addition, IOS increases the quality of care to all Americans by instituting temporary provisions to make health care coverage more affordable.

The IOS' Chief Technology Officer (CTO) provides guidance and input to the Operating and Staff Divisions on new approaches to problem solving on key agency initiatives and advises agencies on key technology policies, open government practices and applications of data to improve health care. In addition, the CTO oversees the HHS Idea Lab which consists of a small group of entrepreneurs who have expertise in technology, policy, and program management methods that assist the Department's workforce through open innovation techniques.

The IOS Executive Secretariat works with pertinent components to develop comprehensive briefing documents, facilitates discussions among staff and operating divisions, and ensures final products reflect HHS policy decisions.

IOS sets the HHS regulatory agenda and reviews all new regulations and regulatory changes to be issued by the Secretary and performs on-going reviews of regulations which have already been published, with particular emphasis on reducing regulatory burden.

Funding History

Fiscal Year	Amount
FY 2011	$11,108,000
FY 2012	$11,289,000
FY 2013	$10,995,000
FY 2014	$10,995,000
FY 2015	$10,566,000

Budget Request

The FY 2016 budget request for $14,000,000 is $3,434,000 above the FY 2015 Enacted Level. Current funding levels will be utilized to restore FY 2015 reductions to personnel costs and other services which support achieving the Department's Health Care, Human Services, Scientific Research, Health Data, Idea Lab, and Workforce Development Strategic Goals. The funding will assist with development of tracking and coordination of Departmental correspondence and inquiries at a strategic level in regards to implementation and review of new and proposed laws. IOS will utilize $434,000 of the budget increase to address new and existing contractual initiatives for the Secretary's new Policy Tracking System. OS will utilize the additional $3,000,000 increase to fund personnel and activities for its mission critical IDEA Lab, including programmatic and contractual initiatives related to the HHS Ignite, Ventures, Innovates, and Entrepreneurs programs.

Immediate Office of the Secretary - Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
1.1 Increase number of identified opportunities for public engagement and collaboration among agencies (Output)	FY 2014: 747 Target: 500 (Target Exceeded)	510	N/A	*
1.2 Increase number of high-value data sets and tools that are published by HHS (Output)	FY 2014: 1657 Target: 1200 (Target Exceeded)	1440	N/A	*
1.3 Increase the number of participation and collaboration tools and activities conducted by the participation and collaboration community of practice (Output)	FY 2014: 13 Target: 13 (Target Met)	14	N/A	*

***Submission of proposed new measures for FY 2016 identified on "Summary of Proposed Changes to Performance Measure," table.**

Performance Analysis

1.1 Increase number of identified opportunities for public engagement and collaboration among agencies

In 2014, HHS exceeded its targets. The Department projected 500 engagement opportunities and identified 747 opportunities in that year. A key mechanism for engaging with the public is through the HHS Federal Advisory Committees. As HHS continues to advance its use of webcasting technologies across the Department, all of the HHS Federal Advisory Committees are utilizing webcasting technologies or other means to engage the public in open meetings. On the challenge competition front, HHS issued fewer challenges than expected, in part due to the setback faced by the closure of General Services Administrations' challenge.gov platform for non-technical challenges. However, it is notable that some of the challenges issued over the course of FY 2014 have been very innovative. For example, the Breast Cancer Startup Challenge issued by that National Institutes of Health National Cancer Center has led to the creation of 11 new start-up companies and was recognized as a Secretary's pick in the HHS Innovates competitions. It is notable that the newly hired Director of Open Government Challenges and Competitions has been ramping up outreach and assistance to challenge managers across HHS. One important mechanism of outreach has been a regular email communication to all the HHS challenge managers and an on-line learning series. During FY 2014, the digital strategy has continued to call attention to the development of Application Programming Interface (API's) as an important mechanism for allowing the public to access HHS data. During this time, HHS added more than a hundred new API's.

Also notable is that in FY 2014 HHS formally established the HHS Innovation Design Entrepreneurship and Action (IDEA) Lab. As a result, during FY 2015, IOS expects to further increase opportunities for public collaboration and engagement, double the number of challenges, and increase the number of APIs.

1.2 Increase number of high-value data sets and tools that are published by HHS

In 2014, HHS continued executing its Health Data Initiative Strategy & Execution plan which directs the liberation of more data as well as multiple activities that communicate the data's availability and value for innovations across health care and social service delivery. HHS published 102 datasets and has federated datasets from states (454) and cities (66) into the catalog as part of the execution plan which recognizes that valuable data also resides at the local level and is a valuable resource for innovators. Federation of datasets continues as HHS began federating health data from USDA (10) and continues to work with federal agencies like the Veterans Administration and CFPB to harness additional health specific datasets for a comprehensive catalog of data resources. It is also important to acknowledge that a portion of this year's data liberation effort has been in the development of the Enterprise Data Inventory for compliance with the Open Data Policy M13-13, and the coordination of the Public Access Memo within our research agencies, both of which are expected to yield additional HHS datasets in the future. The IDEA Lab continues to educate our data communities on the content of HHS data through increased use of the HealthData.gov blog, expanded social media presence, while benefiting from health data focused events like the well-known Health Datapalooza. IOS continues to explore additional innovative uses of our datasets by contributors to health care and social services across the health ecosystem.

1.3 Increase the number of participation and collaboration tools and activities conducted by the participation and collaboration community of practice

In 2014, the HHS Innovations Staff and its agency collaborators (e.g. innovation staff from HHS operating and staff divisions who partner with OS on projects) successfully implemented 13 projects. Each of the

projects is labor-intensive, and thus only a few projected are selected in a given year. In 2014, the following projects were successfully executed:

1) The second round of HHS Ignite, an innovation program that provides seed funding and mentoring to HHS employees for the purpose of incubating and testing new ideas. HHS employees submitted 76 applications, and among these 12 were chosen for funding.

2) Roll out of Yammer, a web-based collaboration tool, to employees across HHS for purposes of professional collaboration. Currently, more than one fifth of all HHS employees are active on Yammer and it has been effectively used to disseminate new information and create collaborative workgroups.

3) The seventh round of the HHS Innovates competition, a program that recognizes and shares promising new approaches developed by HHS employees. The public voting was extremely successful, garnering thousands of page hits from public viewers.

4) The third round of HHS Entrepreneurs, a program that pairs internal and external expertise to solve high priority problems. It is expected to bring to HHS a total of four external entrepreneurs on four projects, across four different Operating and Staff Divisions.

5) Held 10 HHS Innovation Council meetings in which speakers from inside and outside of government engaged HHS leadership and staff on innovation topics such social networking and behavior insight theory.

6) IOS led the development and successful execution of the fifth annual HHS Datapalooza, an event that attracted over 2000 participants and showcased 250 exciting new health applications and products.

7) A second partnership with the West Health Institute the Innovator in Residence Program, which serves as a bridge to the entrepreneurial community to further the development of new health care-related applications and services. The IIR hired in 2014 is developing solutions focused on patient engagement.

8) Held a public meeting in collaboration with HRSA to receive public input on new methodologies and potential applications HHS text libraries.

9) HHS Fairtrade launched a Beta site at the end of May to a small group of testers within HHS for two-month pilot to provide feedback on usability, functionality and the concept.

10) IDEA Lab has solicited submissions from the various agencies for v 3.0 of the Open Government Plan with a goal of having a draft for clearance by July 1st. The plan focuses on 3 major areas – Transparency, Participation & Collaboration.

11) A new initiative within HHS IDEA Lab focused on addressing a critical problem in government, which is that 94% of all IT projects in excess of $10 million fail for one reason or another. The objective of the project is to significantly increase the success rate by doing the following: a)Testing innovative procurement methodologies for IT service acquisition (and sharing the results in Use Cases for everyone to benefit); b)Developing newer, easier, and effective procurement models and processes; c)Engaging all key stakeholders) with effective Education/Outreach.

12) Convened an HHS-wide working group for public access to scientific research and draft plans submitted by each agency were sent to Office of Science and Technology Policy (OSTP) in July.

13) Made good progress towards all 5 strategic goals for the Health Data Initiative with notable progress in the area of Data Federation and increasing the number of machine readable data sets.

Immediate Office of the Secretary

Summary of Proposed Changes to Performance Measures – 2B & 4B

Unique Identifier	Change Type	Original Measure Wording	Proposed Change	Reason for Change	HHS Performance Plan (APP/R) Measure?
1.1	Retire	Increase number of identified opportunities for public engagement and collaboration among agencies (Output)	Retire	Refinement of public engagement goal using challenge data as a measure	Yes
1.4	New	Increase the number of opportunities for the public to co-create solutions through open innovation		Refinement of public engagement goal using challenge data as a measure	Yes
1.2	Move and Revise	Increase number of high-value data sets and tools that are published by HHS (Output)	Migrate to 4B; revise wording to "Increase the number of strategically relevant data sets published across the department as part of the Health Data Initiative"	This measure is more applicable to Objective 4B, which involves access and use of data sets, therefore recommendation is to move it to that objective.	Yes
1.3	Retire	Increase the number of participation and collaboration tools and activities conducted by the participation and collaboration community of practice (Output)	Retire	Refinement of goal to look at IDEA Lab programming and its impact across the Department	Yes
1.5	New	Increase the number of innovation solutions developed across the Department		Refinement of goal to look at IDEA Lab programming and its impact across the Department	Yes
1.6	New	Expand access to the results of scientific research funded by HHS		New measure in Objective 4B to capture HHS's efforts to make research more readily available	Yes

SECRETARIAL INITIATIVES AND INNOVATIONS

Budget Summary
(Dollars in Thousands)

Secretarial Initiatives and Innovations	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	2,735	2,629	2,629	0
FTE	0	0	0	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The Secretarial Initiatives and Innovation request will aid the Secretary in most effectively responding to emerging Administration priorities while supporting the missions of HHS Operating Divisions (OPDIVs) and Staff Divisions (STAFFDIVs). The funding allows the Secretary the necessary flexibility to identify, refine, and implement programmatic and organizational goals in response to evolving business needs and legislative requirements. Additionally, the request will allow the Secretary to promote and foster innovative, high-impact, collaborative, and sustainable initiatives that target HHS priorities and address intradepartmental gaps. The request will help meet the needs of the Secretary, while remaining within a reasonable and modest funding level.

This funding allows the Secretary to proactively respond to the needs of the Office of the Secretary (OS) as it continues to implement programs intended to improve and ensure the health and welfare of Americans. These funds will be directed to the Secretary's highest priorities and are implemented and monitored judiciously. The impact of these resources will be monitored based on the Secretary's stated goals and objectives for their use.

Funding History

Fiscal Year	Amount
FY 2011	$1,600,000
FY 2012	$2,738,000
FY 2013	$2,735,000
FY 2014	$2,735,000
FY 2015	$2,629,000

Budget Request

The FY 2016 Budget for Secretarial Initiatives and Innovation is $2,629,000, the same as the FY 2015 Enacted Level. The funding will continue to allow the Secretary to support HHS component offices as they respond to new and ongoing legislative requirements and seek to implement innovative programs to address new and existing critical health issues.

ASSISTANT SECRETARY FOR ADMINISTRATION

Budget Summary
(Dollars in Thousands)

Assistant Secretary for Administration	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	17,958	17,258	18,000	+742
FTE	114	114	114	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The Office of the Assistant Secretary for Administration (ASA) advises the Secretary on all aspects of administration; provides leadership, policy, oversight, supervision, and coordination of long and short-range planning for HHS; and supports the agency's strategic goals and objectives. ASA also provides critical Departmental policy and oversight in the following major areas: the Immediate Office, Office of Human Resources, Equal Employment Opportunity Compliance and Operations Division, Office of the Chief Information Officer and the Office of Business Management and Transformation. ASA also leads the Real Estate & Logistics Portfolio (REL) and The Office of Security and Strategic Information, and the Program Support Center which are funded through other sources and not included in this request.

Office of Human Resources (OHR)

OHR provides leadership in the planning and development of personnel policies and human resource programs that support and enhance the Department's mission. OHR also provides technical assistance to improve planning and recruitment of human resources. OHR serves as the Departmental liaison to central management agencies on related matters. OHR provides leadership in creating and sustaining a diverse HHS workforce free of discrimination. OHR proactively enhances the employment of women, minorities, veterans, and people with disabilities through policy development, oversight, complaint prevention, investigations, processing, outreach, commemorative events, and standardized education and training programs.

In support of the President's hiring reform initiative, OHR convened a hiring process assessment team to identify and modify major pain points in the current hiring process. The results of this initiative have included policy modifications that clarify the role of hiring managers including their designation of subject matter experts (SMEs); a more active role in position classification process improvements.

Equal Employment Opportunity Compliance and Operations Division (EEOCO)

EEOCO provides service to HHS employees and applicants ensuring access to EEO services. The Compliance Team provides leadership, oversight, technical guidance and engages in policy development for the complaint processing units in the EEO Offices. EEOCO serves as HHS' liaison with lead agencies such as EEOC, Merit Systems Protection Board (MSPB), and Office of Personnel Management (OPM) in matters involving EEO complaint processing.

Office of the Chief Information Officer (OCIO)

In its leadership role, OCIO coordinates the implementation of IT policy from the Office of Management and Budget (OMB) and guidance from Government Accountability Office (GAO) throughout HHS and ensures IT investments remain aligned with HHS' strategic goals and objectives. OCIO coordinates the HHS response to federal IT priorities including: Data Center consolidation; cloud computing; information management, sharing, and dissemination; and shared services.

OCIO establishes and provides assistance on the use of technology-supported business process reengineering, investment analysis and performance measurement while managing strategic development and application of information systems and infrastructure in compliance with the Clinger-Cohen Act. OCIO disseminates HHS IT policies supporting enterprise architecture, capital planning and project management, and security.

OCIO is also responsible for compliance, service level agreement management, delivery of services, service and access optimization, technology refreshment, interoperability, and migration of new services. The office work provides a coordinated view to ensure optimal value from IT investments by addressing policy and architecture standards, maximizing smart knowledge sharing, sharing best practices, and implementing and executing an expedited investment management process.

Office of Business Management and Transformation (OBMT)
OBMT provides results-oriented strategic and analytical support for key HHS management and improvement initiatives necessary to achieve desired objectives. OBMT also provides Department-wide multi-sector workforce management activities, business process reengineering services, reorganization approval processes, and delegation of authority for the Secretary's signature, and promotes innovation or implement effective management practices within the Department.

Funding History

Fiscal Year	Amount
FY 2011	$19,482,000
FY 2012	$19,463,000
FY 2013	$17,958,000
FY 2014	$17,958,000
FY 2015	$17,258,000

Budget Request

The Assistant Secretary for Administration FY 2016 request is $18,000,000, an increase of $742,000 above the FY 2015 Enacted level. This funding level includes a restoration of $700,000 from the FY 2015 Omnibus decrease. The increase will cover the maintenance, operations and helpdesk support for the Information Collection Request, Review and Approval System (ICRAS) contract in FY 2016. In addition; this request will allow ASA to continue its established mission of policy and oversight. ASA will offset the inflationary increases by reducing contracts, limiting travel, and lowering the number of employees that utilize Blackberrys in FY 2016.

ASSISTANT SECRETARY FOR ADMINISTRATION – Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2015 PB Target	FY 2016 Request Target	FY 2016 Request +/- FY 2015
1.1 Increase the percent employees on telework or AWS (Output)	FY 2013: 38.0% Target: 16.0% (Target Exceeded)	18.0%	44.0%	+26%
1.2: Reduce HHS fleet emissions	FY 2013: 11,129 MTCO2e Target: 12454 MTCO2e (Target Exceeded)	12,454 MTCO2e	11,961 MTCO2e	-493
1.3: Ensure Power Management is enabled in 100% of HHS computers, laptops and monitors	FY 2013: Data Pending Target: 90.0% (Target not met)	100%	100%	0
2.1 Reduce the average number of days to hire	FY 2013: 68 Target: 60 (Target not met)	60	60	0

Performance Analysis

1.1: Increase the percent employees on telework or on Alternative Work Schedule

This goal supports the implementation of the HHS Strategic Sustainability Performance Plan (SSPP) prepared under Executive Order (EO) 13514. This EO requires HHS to reduce greenhouse gas (GHG) emissions by technological, programmatic and behavioral changes. This measure tracks progress towards the 20% target of employees who use an alternative work schedule (AWS) and/or regularly scheduled telework to avoid commuting at least 4 days per pay period.

Increasing the percentage of teleworking/AWS employees reduces vehicle miles traveled, which in turn reduces GHG emissions and other pollutants in our air, soil and water, which can be harmful to human health. Commuting typically causes employee stress and decreases the amount of time employees can devote to other health activities such as physical activity, planning and preparing healthy meals, and developing social capital by spending time with family or in the community. Widespread telework/AWS coupled with office sharing and swing space can reduce overall facilities costs in rents, waste removal, waste-water treatment and energy use.

Currently, information on telework is being collected manually through HHS-wide data calls. An automated system for data collection is in the process of being deployed. Results for the first year exceeded the target by 1%. Subsequent years' targets have increased and in 2013 already significantly exceeded the 2015 goal of 18% of employees reducing commute time through telework or Alternative Work Schedule. As a result, the 2015 goal has been adjusted upwards accordingly.

1.2: Reduce HHS fleet emissions

HHS is committed to replacing gasoline-powered vehicles with alternative fuel vehicles (AFV) in accordance with GSA acquisition guidelines. As a result, the fleet's petroleum consumption will decrease, as will the amount of carbon dioxide the fleet releases into the atmosphere.

This goal was established in FY 2010, in alignment with HHS Sustainability Plan and the Executive Order to reduce greenhouse gases. HHS is aiming to reduce fleet emissions by 2% annually. This measure uses Million Metric Tons of Carbon Dioxide equivalents, or MTCO2e, a standard measure of greenhouse gas emissions. In 2013, primarily through reducing its gasoline fuel use, HHS reduced its

CO2e emissions substantially, bringing the number under the 2013 target. HHS's CO2e emissions are expected to improve going forward.

1.3: Ensure Power Management is enabled in 100% of HHS computers, laptops and monitors
HHS IT contracts have been revised to include power-saving configuration requirements. HHS is measuring the percentage of eligible computers, laptops and monitors with power management, including power-saving protocols in the standard configuration for employee workstations. Consistent application of power management will decrease the electricity use of HHS facilities. This initiative supports the HHS strategic initiative to be a good steward of energy resources.

The target for this measure is for 100% of HHS eligible computers, laptops and monitors to have power management. HHS set aggressive goals to move from the 2010 level of 32% of devices with power management enabled to 100% of devices with power management by 2013 and to maintain that level continuing through 2015. In 2011, 85% of eligible devices were reported in compliance across the department, while in 2012 this increased to 94%. In 2013, an improved Department-wide surveying showed that 97% of HHS laptops and computers had power management enabled (108,805 of 112,311 devices), while 89% of monitors were enabled across the Department (621,290 of 697,592 devices), for a total of 90% of devices covered by power management.

2.1: Reduce the average number of days to hire
Prompt turn-around times for recruitment requests are not only necessary for hiring highly qualified candidates in today's competitive market, but are also required under Office of Personnel Management (OPM) directives. OHR has set aggressive HHS-wide goals that exceed the OPM federal hiring targets. To optimize performance, OHR has implemented a number of process and systems improvements to support hiring managers in their recruitment efforts.

Over the past three years, transaction reports have shown steady progress and an overall decrease in the hiring cycle time as measured from receipt of a complete job requisition package to job offer. However, in FY2013, days-to-hire rose to 68. One potential cause for this rise is adaptation to the decentralization of HR offices; HHS transitioned from having 3 HR centers to an HR center at each OPDIV, which resulted in staff changes and the need to train new staff. HHS is working to reach its 60-day goal by transitioning some HR hiring functions to the National Finance Center over the next 18 months, which is anticipated to have a positive impact on days to hire.

ASSISTANT SECRETARY FOR FINANCIAL RESOURCES

Budget Summary
(Dollars in Thousands)

Staff Division Name	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	28,974	27,844	30,200	+2,356
FTE	149	149	149	+0

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

Office of Budget (OB) – OB manages the performance budget and prepares the Secretary to present the budget to the Office of Management and Budget (OMB), the public, the media, and Congressional committees; serves as the HHS appropriations liaison; and manages HHS' apportionment activities, which provide funding to the HHS Operating Divisions and Staff Divisions. OB coordinates, oversees, and convenes resource managers and financial accountability officials within OS to update, share and implement HHS/OS wide policies, procedures, operations, rules, regulations, recommendations, and priorities. In addition, OB supports OS and Service and Supply Fund by providing budget process, formulation and execution support including: budget analysis and presentation, account reconciliations, reporting, status of funds tracking and certification of funds availability. OB manages the implementation of the Government Performance and Results Act (GPRA) and all phases of their performance budget improvement activities.

Office of Finance (OF) – OF provides financial management leadership to the Secretary through the CFO and the Departmental CFO Community. OF manages and directs the development and implementation of financial policies, standards and internal control practices in accordance with the CFO Act, OMB Circulars, and the Federal Accounting Standards Advisory Board (FASAB) and prepares HHS' annual consolidated financial statements. The OF oversees the Department's financial management systems portfolio, and also has business ownership responsibility for the Unified Financial Management System (UFMS).

OF prepares the Agency Financial Report. HHS earned an unqualified or "clean" opinion on the HHS audited Consolidated Balance Sheet, and Statements of Net Cost and Changes in Net Position, and Combined Statement of Budgetary Resources. The Department received the Association of Government Accountants' *Certificate of Excellence in Accountability Reporting* for the FY 2013 AFR.

OF manages HHS-wide policies and standards for financial and mixed financial system portfolios. HHS' financial systems portfolio operates on the same commercial-off-the-shelf (COTS) platform that consists of three major components: (1) UFMS, which is the integrated financial management system that operates across most HHS OPDIVs; (2) the Healthcare Integrated General Ledger Accounting System (HIGLAS) at the Centers for Medicare & Medicaid Services (CMS); and (3) NIH's Business System (NBS).

OF leads HHS' Program Integrity Initiative which seeks to ensure that every program operates in an effective and efficient manner, spending HHS dollars in the manner for which they were intended. .

OF supports the Program Integrity Coordinating Council (PICC), who provide strategic direction and oversight for the Initiative.

In FY 2014 , OF continued the implementation the Financial Systems Improvement Program (FSIP) to enhance, upgrade, standardize, simplify, maintain security, strengthen internal controls, improve reporting, minimize risk, and manage risk assessment data in the financial systems environment. System environment improvement will increase efficiencies, simplify operations, and reduce customizations maintaining compliance with the Federal Financial Management Improvement Act (FFMIA). The standard accounting practices will improve data integrity, accuracy of financial reporting, and reduce the needs for manual reconciliations. Furthermore, transition to commercial shared service provider for managed cloud/hosting services will reduce operating costs, increase efficiencies, and promote standardization.

In addition, the office continues its role with the Financial Business Intelligence Program (FBIP) to develop comprehensive business intelligence capabilities transforming data from disparate business domains such as finance and grants into "real" data which will increase transparency; improve compliance with FFMIA; improve strategic and tactical decision-making, and enhance reporting capability to external stakeholders.

Office of Grants and Acquisition Policy and Accountability (OGAPA) – OGAPA provides HHS-wide leadership, management, and strategy in the areas of grants, acquisition, and small business policy development, performance measurement, oversight, and workforce training, development and certification. OGAPA also fosters collaboration, innovation, and accountability in the administration and management of the grants, acquisition, and small business functions throughout HHS. OGAPA also fulfills HHS's role as managing partner of Grants.gov and supports the Federal Funding Accountability and Transparency Act (FFATA) and Open Government Directive by maintaining and operating HHS's Tracking Accountability in Government Grants System and Departmental Contract Information System.

In FY 2014, OGAPA supported government-wide grants policy initiatives through the Counsel on Financial Assistance Reform to include: the development and implementation of the new uniform guidance at 2 CFR 200, developed HHS's implementing regulation at 45 CFR 75, and updated internal policy guidance within the Grants Policy Statement and Grants Policy Administration Manual.

OGAPA also led an initiative to update the HHS Acquisition Regulation, which is due to be published in FY 2015; participated in acquisition rule-making; made improvements to the HHS acquisition workforce training and certification programs; and began acquisition lifecycle framework reform to improve program management and acquisition outcomes across-HHS. In addition, OGAPA established and monitored appropriate grant and acquisition related internal controls and performance measures; provided technical assistance and oversight to foster stewardship, transparency, and accountability in HHS's grants and acquisition programs.

Finally, OGAPA ensured that small businesses were given a fair opportunity to compete for HHS contracts; managed and tracked small business goal achievements; provided technical assistance and Small Business Program training to HHS's contracting and program officials; conducted outreach and provides guidance to small businesses on doing business with HHS; and developed and implemented a new online tool to produce and publish HHS's procurement forecast.

Funding History

Fiscal Year	Amount
FY 2011	$28,103,000
FY 2012	$29,771,000
FY 2013	$28,820,000
FY 2014	$28,974,000
FY 2015	$27,844,000

Budget Request

ASFR's FY 2016 request is $30,200,000, an increase of $2,356,000 above the FY 2015 Enacted level. The increase will allow ASFR to reestablish FY2015 funding reduction impacts applied to travel, training, and federal sourced contracts. Inflation will be absorbed by reducing operating expenses. The requested resources will be used by ASFR to maintain its responsibilities associated with financial management; program integrity; budget and performance analysis and support; grants and acquisition policies; grant transparency; acquisition workforce development; and improving the use of program, performance, and financial data to inform business decisions.

In FY2016, the Office of Finance will continue to modernize HHS-wide financial systems by enabling new functionality, standardizing and simplifying financial systems environment, strengthening internal controls and improving financial reporting. When completed, this multi-year modernization initiative will standardize financial management across HHS, modernize financial reporting to provide timely, reliable and accurate information about HHS' finances and enhance, standardize and simplify financial systems environment.

DATA ACT

Budget Summary

(Dollars in Thousands)

Staff Division Name	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	0	0	10,320	+10,320
FTE	0	0	12	+12

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The Digital Accountability and Transparency Act of 2014 (DATA Act) expands the Federal Funding Accountability and Transparency Act (FFATA) in an effort to improve the transparency of Federal spending.

The DATA Act Project Management Office (PMO) objective is to focus on establishing a stable organizational infrastructure and lead the Health and Human Services implementation of the DATA Act. The PMO and Departmental Integrated Project Teams (IPT) will conduct analytic support efforts related to the formulation of new data standards that result from the DATA Act and assess the potential impact of those standards on HHS' financial lifecycle. This analysis and associated recommendations will benefit the Department as a whole, and facilitate a long term strategy toward the adoption and incorporation of agreed upon standards into HHS' policies, processes and systems. The PMO is also tasked with leading the implementation of the Section 5 DATA Act grants pilot on behalf of OMB as well as engaging with the government-wide Interagency Advisory Council for the DATA Act.

Funding History

Fiscal Year	Amount
FY 2011	$0
FY 2012	$0
FY 2013	$0
FY 2014	$0
FY 2015	$0

Budget Request

The DATA Act FY 2016 request is $10,320,000. HHS will use $500,000 of the funding to implement a uniform procurement instrument identifier. The additional funding will be used to implement a stable organizational infrastructure; conduct analytic support; implement new data standards; assess potential impacts; facilitate long term policies, processes, and systems; and establish a grants pilot.

Section 5 Grants Pilot - funding will be used to support both federal FTE as well as contract resources as HHS carries out the DATA Act Section 5 Grants pilot. The DATA Act Section 5 Grant pilot activities will focus on three areas of work:

- Leveraging technology to support the use of data standards across the federal community and facilitate recipient's access to and understanding of common federal data standards;

- Incorporating agreed upon data standards into grants-related processes/systems to assess the impact of new standards on federal business practices as well as opportunities to streamline and/or reduce recipient reporting burden;

- Developing a sustainable governance and outreach model that ensures appropriate engagement of the federal and recipient community in the development & use of common financial data standards.

- HHS will serve as the government-wide lead on grants data standardization and partner with OMB and DATA Act stakeholders as appropriate to facilitate the analysis and adoption of data standards to facilitate greater financial transparency & accountability.

- HHS will continue its strategic planning and implementation of the DATA Act in partnership with its' components.

- Funding will be used to support related to procurement spending and management as well as acquisition workforce changes

ACQUISITION REFORM

Budget Summary
(Dollars in Thousands)

Acquisition Reform	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	1,750	1,750	1,750	0
FTE	1	1	1	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

In March 2009, the President mandated that all federal agencies improve acquisition practices and performance by maximizing competition and value, minimizing risk, and reviewing the ability of the acquisition workforce to develop, manage, and oversee acquisitions appropriately. Guidance from the Office of Management and Budget (including the memorandum *Improving Government Acquisition*, issued July 29, 2009; and *the Guidance for Specialized information Technology Acquisition Cadres*, issued July 13, 2011) directed agencies to strengthen the acquisition workforce and increase the civilian agency workforce, to more effectively manage acquisition performance.

The federal acquisition workforce includes contract specialist, procurement analyst, program and project managers, and contracting officer representatives (CORs). This funding will be used to mitigate the risks associated with gaps in the capacity and capability of the acquisition workforce government-wide, enhance suspension and debarment program, increase contracting activities oversight, increase contract funding compliance, and improve the effectiveness of that workforce, in order to maximize value in Federal contracting. The Office the Assistant Secretary for Financial Resources (ASFR) will continue to lead this initiative.

Successful acquisition outcomes are the direct result of having the appropriate personnel with the requisite skills managing various aspects of the acquisition process. Increased workload for the acquisition workforce has left less time for effective acquisition planning and contract administration, which can then lead to diminished acquisition outcomes. This lack of capacity and capability in the acquisition workforce also results in tradeoffs during the acquisition lifecycle, which can reduce the chance of successful outcomes while increasing costs and impacting schedule.

Funding History

Fiscal Year	Amount
FY 2011	$700,000
FY 2012	$700,000
FY 2013	$681,000
FY 2014	$1,750,000
FY 2015	$1,750,000

Budget Request

Acquisition Reform's FY 2016 request is $1,750,000, the same as the FY2015 Enacted Level. Inflation will be absorbed by reducing operating expenses. The requested resources will be used to implement HHS's Acquisition Lifecycle Strategic Initiatives. The FY 2016 funds will be used to develop the capabilities and capacity of HHS's Acquisition workforce through rotational and mentor programs, training and certification initiatives to close competency gaps, and refinements to HHS's acquisition regulation, policies, directives, guidance, instructions, and systems. Additionally, funds will be used to enhance the level of oversight of HHS' acquisition lifecycle building the framework required to drive improvements for program/project management, requisite business practices, compliant contracting activities, and performance management.

ASSISTANT SECRETARY FOR LEGISLATION

Budget Summary
(Dollars in Thousands)

Assistant Secretary for Legislation	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	3,791	3,643	3,800	+157
FTE	26	27	27	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The Office of the Assistant Secretary for Legislation (ASL) serves as the principal advocate before Congress for the Administration's health and human services initiatives; serves as chief HHS legislative liaison and principal advisor to the Secretary and HHS on Congressional activities; and maintains communications with executive officials of the White House, OMB, other Executive Branch Departments, Members of the Congress and their staff, and the Government Accountability Office (GAO).

ASL informs the Congress of HHS's views, priorities, actions, grants and contracts and provides information and briefings that support the Administration's priorities and the substantive informational needs of the Congress. The mission of the office also includes reviewing all HHS documents, issues and regulations requiring Secretarial action.

ASL is organized into six divisions:

- Immediate Office of the Assistant Secretary for Legislation;
- Office of the Deputy Assistant Secretary for Discretionary Health Programs;
- Office of the Deputy Assistant Secretary for Mandatory Health Programs;
- Office of the Deputy Assistant Secretary for Human Services;
- Office of the Deputy Assistant Secretary for Congressional Liaison; and
- Office of Oversight and Investigations.

Immediate Office of the Assistant Secretary for Legislation - Serves as principal advisor to the Secretary with respect to all aspects of HHS's legislative agenda and Congressional liaison activities. Examples of ASL activities are:

- Working closely with the White House to advance Presidential initiatives relating to health and human services;
- Managing the Senate confirmation process for the Secretary and the 19 other Presidential appointees requiring Senate confirmation;
- Transmitting the Administration's proposed legislation to the Congress; and
- Working with Members of Congress and staff on legislation for consideration by appropriate Committees and by the full House and Senate.

Office of the Deputy Assistant Secretary for Discretionary Health Programs - Assists in the legislative agenda and liaison for discretionary health programs. This portfolio includes:

- Health-science-oriented operating divisions, including HRSA, SAMHSA, FDA, NIH and CDC
- Health IT
- Medical literacy, quality, patient safety, privacy and
- Bio-defense and public health preparedness

Office of the Deputy Assistant Secretary for Legislation for Mandatory Health Programs - Assists in the legislative agenda and liaison for health services and health care financing operating divisions, including the Centers for Medicare and Medicaid Services (CMS) and the Indian Health Service (IHS). This portfolio includes Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), as well as private sector insurance.

Office of the Deputy Assistant Secretary for Legislation for Human Services - Assists in the legislative agenda and liaison for human services and income security policy, including the Administration for Children and Families (ACF) and the Administration for Community Living (ACL).

These three offices develop and work to enact HHS's legislative and administrative agenda; coordinating meetings and communications of the Secretary and other HHS officials with Members of Congress; and preparing witnesses and testimony for Congressional hearings. ASL successfully advocates the Administration's health and human services legislative agenda before the Congress. ASL works to secure the necessary legislative support for HHS's initiatives and provides guidance on the development and analysis of HHS legislation and policy.

The Office of the Deputy Assistant Secretary for Congressional Liaison (CLO) -Maintains HHS's program grant notification system to Members of Congress (public access at: *GrantsNet* and *TAGGS*), and is responsible for notifying and coordinating with Congress regarding the Secretary's travel and events schedule. In addition, CLO provides staff support for the Assistant Secretary for Legislation coordinating responsibilities to the HHS regional offices, and coordinates the Continuity of Operations Plan (COOP). Activities include:

- Responding to Congressional inquiries and notifying Congressional offices of grant awards (via EconSys) made by HHS;
- Providing technical assistance regarding grants to Members of Congress and their staff; and
- Facilitating informational briefings relating to HHS programs and priorities.

The Office of Oversight and Investigations - Responsible for all matters related to Congressional oversight and investigations, including those performed by the General Accounting Office (GAO), and assists in the legislative agenda and liaison for special projects. This includes coordinating HHS responses to Congressional oversight and investigations; and acting as HHS liaison with the GAO and coordinating responses to GAO inquiries.

Funding History

Fiscal Year	Amount
FY 2011	$3,423,000
FY 2012	$3,893,000
FY 2013	$3,885,000
FY 2014	$3,791,000
FY 2015	$3,643,000

Budget Request

The FY 2016 request for ASL is $3,800,000; an increase of $157,000 above the FY 2015 Enacted Level. The increase will allow ASL to reestablish FY 2015 reduction impacts and return to full-operation levels. The requested resources will be used to provide critical support to the legislative Healthcare and Human Services agenda that, among others, includes reauthorization of the Temporary Assistance to Needy Families (TANF) Program, the Older Americans Act, and the Head Start Program. In FY 2016, ASL will continue to support facilitating the President's commitment to strengthen the systems that protect our food and medical products supply, ongoing activities related to public health emergency preparedness, the reauthorization of the Substance Abuse and Mental Health Services Administration, and others.

In addition, the requested funding will support facilitating increased communication between the HHS and Congress. This requires continued work on several mission critical areas with Members of Congress, Congressional Committees and staff including: managing the Senate confirmation process for HHS nominees; preparing witnesses and testimonies for Congressional hearings; coordinating HHS response to Congressional oversight and investigations as well as coordinating responses to GAO inquiries; improving Congressional awareness of issues relating to the programs and priorities of the Administration and advising Congress on the status of key HHS priority areas.

ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

Budget Summary
(Dollars in Thousands)

Assistant Secretary for Public Affairs	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	8,749	8,408	8,700	292
FTE	56	54	56	0

Authorizing Legislation: ……Title III of the PHS Act
FY 2016 Authorization……Indefinite
Allocation Method……Direct Federal

Program Description and Accomplishments

The Office of the Assistant Secretary for Public Affairs (ASPA) serves as the HHS' principal Public Affairs office, leading HHS efforts to promote transparency, accountability and access to critical public health and human services information to the American people. ASPA is also responsible for communicating the HHS' mission, Secretarial initiatives and other activities to the general public through various channels of communication. ASPA plays an important role by:

- Overseeing efforts to expand HHS' transparency and public accountability efforts through new and innovative communications tools and technology.
- Providing timely, accurate, consistent and comprehensive public health information to the public and ensuring the information is easy to find and understand.
- Advising and preparing the Secretary for public communications including communicating HHS strategic plans.
- Coordinating public health and medical communications across all levels of government and with international and domestic partners.
- Developing and managing strategic risk communications plans in response to national public health emergencies.
- Serving as the central HHS press office handling media requests developing press releases and managing news issues that cut across HHS.
- Overseeing the HHS flagship website HHS.gov.
- Developing Departmental protocols and strategies to utilize social media and the web.
- Supporting television, web, and radio appearances for the Secretary and senior HHS officials; managing the HHS studio and providing photographic services; producing and distributing internet, radio, and television outreach materials.
- Writing speeches, statements, articles, and related material for the Secretary, Deputy Secretary and Chief of Staff and other senior HHS officials.
- Overseeing HHS FOIA and Privacy Act program policy, implementation, and operations.
- Increasing focus on public education efforts surrounding benefits of the Affordable Care Act.

Funding History

Fiscal Year	Amount
FY 2011	$5,477,000
FY 2012	$8,983,000
FY 2013	$8,965,000
FY 2014	$8,749,000
FY 2015	$8,408,000

Budget Request

ASPA's FY 2016 Budget request is $8,700,000, is $292,000 above the FY 2015 Enacted Level. The FY 2016 funds will be used to provide the necessary staffing and support to accomplish ASPA's mission of ensuring that all Americans have the most transparent access to critical public health and human services information. The funding level will allow ASPA to restore $292,000 from the FY 2015 Omnibus decrease and will allow fully-staffed levels in the Freedom of Information Act (FOIA) and Privacy Act Division, continued momentum to the FOIA backlog reduction initiatives, and the updating of program policy and regulations.

ASPA will continue efforts geared toward increased public awareness of HHS tools, resources, and health education initiatives. ASPA also expects to continue public education activities around the Health Insurance Marketplaces under the Affordable Care Act that went into effect in 2014, thus increasing FOIA and privacy inquiries. These initiatives require increased staffing levels to support these activities; however, ASPA will continue to explore opportunities to cut contract costs through collaboration with other HHS agencies whenever practicable.

DIGITAL SERVICES TEAM

Budget Summary
(Dollars in Thousands)

Digital Services Team	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	0	0	10,000	10,000
FTE	0	0	30	30

Authorizing Legislation: .....Such sums as may be appropriated
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

Purpose: HHS is taking significant steps to ensure that digital communications and data services demonstrate impact on the health and well-being of the American public. Along with the Digital Government Strategy and the Digital Services Playbook, these existing efforts - including interviews with HHS leadership and key stakeholders - can be leveraged in the establishment of the Digital Services Team.

In FY 2016, HHS will establish a sustainable digital services program that results in improved program services, greater accountability, and better and more easily understood information that is achieved through new approaches to problem-solving, strategic use of external technical experts and more efficient use of shared technologies and services.

The principal pillars supporting this vision are:

- **Technology, Content and Process Integration**: Sustained success for this effort will require tighter collaboration across existing digital-focused operations, principal offices being the Office of the Chief Information Officer (OCIO), the Office of the Chief technology Officer (OCTO) and the Office of the Assistant Secretary for Public Affairs (OASPA).
- **Policy Integration**: Policy integration will define how technology should be implemented in a modern organization. This will build upon open data policies, 508 compliance for technology systems and digital content, Federal Information Technology Acquisition Reform Act (FITARA), Digital Accountability and Transparency Act (DATA), and open innovation initiatives of the Administration.
- **Shared Infrastructure and Services**: Providing, or facilitating HHS-wide access to, cloud-based services and applications can lower cost, increase efficiency and provide the platform for superior integration of HHS content and data. Specific shared infrastructure goals would be based on the needs of identified projects but could include the development of an HHS-wide data warehouse and/or providing space for IT and communication development 'sandboxes' that permit secure agile development.
- **Shared Standards**: Shared services and common infrastructure require common standards to maximize the value-added benefits of a common underlying technologies and platforms. Data standards, for text, tabular and visual data, will improve machine readability, increase efficiency and allow for greater transparency and openness of HHS information. Moreover, common taxonomies will help link content and data resources across organizational boundaries within HHS to create added value in information services and products as well as content structuring and syndication.

- **Accountability**: Data-informed decisions will be the standard for all aspects of the Digital Services Team's work. This ranges from establishing data-informed processes to identify and vet target projects, to the development of a standard set of performance metrics that can be used to evaluate the work of the Digital Services Team and their projects.

Oversight: Sustainable Digital Services Team (DST) support will require coordinated oversight by the HHS OCIO, OCTO and OASPA. This group will establish the process for choosing projects, identify skill sets needed for the core DST members, recruit suitable candidates and develop performance metrics to evaluate the success of approved projects.

Core Members: The establishment of a core group of individuals that can both oversee daily operations of the DST and participate in individual projects will help ensure the use of shared resources and standards. With an entirely distributed model, where projects are largely independent of systemic coordination, the risk for ignoring shared standards or implementing one-off solutions that don't contribute to the larger digital goals of the Department is too high. The initial group will need core expertise in program management, program evaluation, procurement, data science, information architecture, and structured content.

Project-specific: In addition to the core DST members, additional support will be required on a project-by-project basis. These individuals will be identified and recruited as dictated by the requirements of the projects chosen. The number of individuals needed per project will vary and will be influenced by the ability of host offices to contribute expertise to the project. All projects should include DST and host office participation as capacity building and modernization of our business and management operations is an inherent goal to this effort.

Funding History

Fiscal Year	Amount
FY 2011	$0
FY 2012	$0
FY 2013	$0
FY 2014	$0
FY 2015	$0

Budget Request

Funding will be used for salaries and benefits to support 30 FTE, travel, communications, and other program support as well as contracts, acquisition services, training, and the infrastructure needed to establish this project. The results of this effort will reinforce cultural and management changes at HHS designed to establish digital operations as an integrated tool for driving program value and achieving program goals. The program will raise the skill level of HHS programs and bring new project management approaches instilling entrepreneurial approaches that encourage intelligent risk tolerance, promoting pursuit of new approaches and problem-solving. The American public will experience improved program services, greater accountability, and better and more easily understood information from HHS agencies. Finally, through this program, HHS will be well positioned to engage in private sector partnerships that can catalyze innovation, use open data to develop incentives and create new business opportunities.

OFFICE OF THE GENERAL COUNSEL

Budget Summary
(Dollars in Thousands)

Office of the General Counsel	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	39,226	37,697	39,200	+1,503
FTE	173	173	173	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The Office of the General Counsel (OGC), with a team of over 400 attorneys and a comprehensive support staff, is one of the largest, most diverse, and talented law offices in the United States. It provides client agencies throughout HHS with representation and legal advice on a wide range of highly visible national issues. OGC's goal is to support the strategic goals and initiatives of the Office of the Secretary and HHS by providing high quality legal services, including sound and timely legal advice and counsel.

Accomplishments:

- OGC's Public Health Division (PHD) spearheaded the efforts to resolve over $1.5 billion in contract support costs claims stemming from the multi-year Indian Self-Determination and Education Assistance Act (ISDEAA) contract litigation against the Indian Health Service. This effort has resulted in settling $965 million in claims for $505 million, a savings of $459 million from Nov 2013-July 25, 2014.
- In FY 2014, OGC's Centers for Medicare and Medicaid Division (CMSD) provided advice on numerous legal issues that arose in launching, for the first time, a number of important Affordable Care Act (ACA) provisions. The provisions that took effect in 2014 were far-reaching in scope and extremely complex, including the new "single risk pool" and community rating requirements, a new "guaranteed availability requirement," and implementation of the new individual and small employer health care exchanges. OGC helped the CMS to align statutory and regulatory requirements with the reality of systems limitations.
- During FY 2014, OGC's General Law Division (GLD) was instrumental in advising CMS regarding the ACA, including advising HHS Contracting Officials regarding the administration of relevant contracts, as well as providing advice on the disclosure and handling of information needed for successful outreach and enrollment, as well as essential fiscal law advice that was needed to facilitate funding for key programs and initiatives.
- In FY 2014, OGC's Children, Families, and Aging Division (CFAD) provided daily legal support to various HHS components and other federal partners as part of the interagency Unified Coordination Group in response to the influx of Unaccompanied Children (UAC) across the southwest border of the United States. CFAD support has included regular staffing at the Federal Emergency Management Agency National Response Coordination Center, as well as litigation support to the Justice Department in related litigation. The influx reflects a substantial increase in the number of Unaccompanied Children in HHS custody from under 15,000 in FY 2012 to over 70,000 in FY 2014.

Funding History

Fiscal Year	Amount
FY 2011	$39,911,000
FY 2012	$40,274,000
FY 2013	$39,226,000
FY 2014	$39,226,000
FY 2015	$37,697,000

Budget Request

The Office of the General Counsel (OGC) requests $39,200,000, a $1,503,000 increase from the FY 2015 Enacted Level. The funding level will restore $1,503,000 from the FY 2015 Omnibus and will enable OGC to restore its total staffing level and fully fund its Information Technology (IT) contract. The FY 2016 Budget will fund the salaries, benefits, and operating costs incurred by OGC as a result of providing HHS with legal representation on key social, economic, and healthcare issues. Specifically, authorized funding will enable the OGC Divisions/Regions to provide the following legal services to HHS Operational Divisions.

In FY 2016, the ACA will continue to be a high priority. Accordingly, OGC will provide legal advice pertaining to fiscal law, grants, and procurements related to ACA programs and initiatives. OGC attorneys will be highly involved in rulemaking and will continue to assist and support the CMS in its mission of making health insurance available, transforming the health care delivery system and the Medicaid program, and reducing fraud, waste and abuse in the federal health care systems.

Additionally, OGC will continue to provide support to all HHS clients in primary practice areas that include: procurement law support for all agency acquisitions of goods and services; fiscal law support for questions related to proper use of federal funds, the starting point for all government programs and activities; information law and other general administrative law support that is part of all federal programs. In the labor and employment law area specifically, OGC will continue litigating a large number of cases.

OGC will continue to work with the Health Resources and Services Administration (HRSA) to implement ACA initiatives, including expanded access and integration of behavioral and mental health care by health centers; transformation of the Ryan White HIV/AIDS Program; updating of preventive services guidelines for women, infants, and children; and the evidence-based maternal, infant, and early childhood home visiting program.

OGC will continue to provide legal advice to clients seeking to revise and update regulations, such as those for HRSA's health professional shortage designation, Substance Abuse and Mental Health Services Administration's (SAMHSA) confidentiality of substance abuse patient records, and the 340B Drug Program. OGC will also advise and assist the National Institutes of Health (NIH) on many important and complex matters, including the agency's large research grants portfolio, intellectual property, technology transfer, third-party reimbursement at NIH's Clinical Center, genomic data sharing, biodefense research, and diversity initiatives.

Furthermore, OGC will advise on multiagency preparedness efforts related to pandemic influenza, MERS-CoV and other chemical, biological, radiological, and nuclear threats. OGC will also coordinate and ensure consistency in the negotiation of over 300 Indian Self-Determination and Education

Assistance Act (ISDEAA) contracts and compacts, which transfer $2 billion annually to Tribes, and will handle approximately 1,500 contract dispute claims under ISDEAA.

OGC will remain involved in the implementation of the 2007 Hague Convention on the International Recovery of Child Support and Other Forms of Family Maintenance. OGC will continue to assist in the finalization of major rulemaking efforts by the Office of Child Support Enforcement (OCSE) and the Office of Child Care. In addition, OGC will continue to provide defense of litigation challenging Designation Renewal System rules and re-competition decisions for the Head Start program.

Additionally, OGC will continue to serve as a principal legal advisor to the Assistant Secretary for Preparedness and Response (ASPR) (including the Biomedical Advanced Research and Development Authority (BARDA)) regarding a host of matters.

DEPARTMENTAL APPEALS BOARD

Budget Summary
(Dollars in Thousands)

Departmental Appeals Board	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	10,450	10,043	12,500	+2,457
FTE	75	70	82	+12

Authorizing Legislation:.....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The Departmental Appeals Board (DAB) provides impartial, independent hearings and appellate reviews, and issues Federal agency decisions under more than 60 statutory provisions governing HHS programs. DAB's mission is to provide fast, low-cost, high-quality adjudication and other conflict resolution services in administrative disputes involving HHS, and to maintain efficient and responsive business practices. Cases are initiated by outside parties who disagree with a determination made by a HHS agency or its contractor. Outside parties include States, universities, Head Start grantees, nursing homes, clinical laboratories, doctors, medical equipment suppliers, and Medicare beneficiaries. Disputes heard by the DAB may involve over $1 billion in Federal funds in a single year. DAB decisions on certain cost allocation issues in grant programs have government-wide impact because HHS is the agency whose decisions in this area legally bind other Federal agencies. DAB is organized into four Divisions:

Board Members – Appellate Division

The Secretary appoints the DAB Board Members; the Board Chair is also the STAFFDIV Head of DAB. All Board Members are judges with considerable experience who, acting in panels of three, issue decisions with the support of Appellate Division staff. In other cases, Board Members provide appellate review of decisions by DAB ALJs or Department of Interior ALJs (in certain Indian Health Service cases). Board review ensures consistency of administrative decisions, as well as adequacy of the record and legal analysis before court review. For example, Board decisions in grant cases promote uniform application of OMB cost principles. Board decisions are posted on the DAB Website and provide precedential guidance on ambiguous or complex requirements.

In FY 2014, the Board/Appellate Division received 120 cases and closed 120 (67 by decision). Ninety-two percent of Board decisions issued in FY 2014 had a net case age of six months or less.

Administrative Law Judges – Civil Remedies Division (CRD)

CRD staff support DAB ALJs who conduct adversarial hearings in proceedings that are critical to HHS healthcare program integrity efforts, as well as quality of care concerns. Hearings in these cases may last a week or more. Cases may raise complex medical or clinical issues. Some cases require presentation of evidence to prove allegations of complicated fraudulent schemes. Cases may also raise legal issues of first impression. For example, appeals of enforcement cases brought under the Patient Protection and Affordable Care Act (ACA) are likely to raise new issues.

DAB ALJs hear cases appealed from CMS or OIG determinations to exclude providers, suppliers, or other healthcare practitioners from participating in Medicare, Medicaid, and other Federal healthcare programs or to impose civil money penalties (CMPs) for fraud and abuse in such programs. CRD's jurisdiction also includes appeals from Medicare providers or suppliers, including cases under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Expedited hearings are provided when requested in certain types of proceedings, such as provider terminations and certain nursing home penalty cases. These cases typically involve important quality of care issues. DAB ALJs also hear cases which may require challenging testimony from independent medical/scientific experts (for example, in appeals of Medicare Local Coverage Determinations or issues of research misconduct).

Through reimbursable inter-agency agreements, ALJs conduct hearings on CMPs imposed by the Inspector General of the Social Security Administration (SSA) and on certain debt collection cases brought by the SSA. DAB ALJs also conduct hearings in certain regulatory actions brought by the Food and Drug Administration (FDA), including CMP determinations, clinical investigator disqualifications, and other adverse actions.

In FY 2014, CRD received 2,014 new cases and closed 1,937 (96%), 463 by decision. Of these new cases, about half (1,105) were appealed under the FDA reimbursable agreements, which will expire in late FY 2015.

Medicare Appeals Council – Medicare Operations Division (MOD)

The MOD provides staff support to the Administrative Appeals Judges (AAJs) and Appeals Officers (AOs) on the Medicare Appeals Council (Council). The Council provides the final administrative review for claims for entitlement to Medicare and individual claims for Medicare coverage and payment filed by beneficiaries or health care providers/suppliers. Council decisions are based on a *de novo* review of decisions issued by ALJs in the Office of Medicare Hearings and Appeals (OMHA). CMS (or one of its contractors) and SSA may also refer ALJ decisions to the Council for own motion review. In the majority of cases, the Council has a statutorily imposed 90-day deadline by which it must issue a final decision.

An appellant may file a request with the Council to escalate an appeal from the ALJ level because the ALJ has not completed his or her action on the request for hearing within the adjudication deadline. MOD has been receiving a greater number of these escalations as the caseload has been increasing at the OMHA level. The Council also reviews cases remanded back to the Secretary from Federal court; related to this workload, the MOD is responsible for preparing and certifying administrative records to Federal court.

Cases may involve complex issues of law, such as appeals arising from overpayment determinations, non-sample audits, or statistical sampling extrapolations involving thousands of claims and extremely high monetary amounts. Some cases, particularly those filed by enrollees in a Medicare Advantage plan, require an expedited review due to the pre-service nature of the benefits at issue (e.g., pre-service authorization for services or procedures or authorization for prescription drugs).

In FY 2015, through a reimbursable agreement with CMS, MOD will begin adjudicating appeals filed under a CMS demonstration project with the state of New York. The demonstration project, called "Fully Integrated Duals Advantage" Plan (FIDA), offers an estimated 170,000 Medicare-Medicaid enrollees in New York an opportunity for more coordinated care. FIDA will provide a streamlined appeals process which gives beneficiaries the opportunity to address denials of items and services through a unified system that includes all Medicare and Medicaid protections. These new FIDA cases are not included in the MOD workload Chart C below. DAB will incorporate them into its future workload projections after gaining an experience base from which to project annual FIDA case closures.

In FY 2014, MOD received 4,500 new cases and closed 2,515 (56%).

Alternative Dispute Resolution Division - Alternative Dispute Resolution (ADR) Division

The ADR provides services in DAB cases and supports the Chair in her role as DHHS' Dispute Resolution Specialist. The ADR provides mediation in DAB cases, provides or arranges for mediation services in other HHS cases (including workplace disputes and claims of employment discrimination filed under the HHS Equal Employment Opportunity program), and provides policy guidance, training, and information on ADR techniques (including negotiated rulemaking – a collaborative process for developing regulations with interested stakeholders).

Under the Administrative Dispute Resolution Act, each Federal agency must appoint a dispute resolution specialist and must engage in certain activities to resolve disputes by informal methods, such as mediation, that are alternatives to adjudication or litigation. The DAB Chair is the Dispute Resolution Specialist for HHS and oversees ADR activities under the HHS policy issued under the Act. Using ADR techniques decreases costs and improves program management by reducing conflict and preserving relationships that serve program goals (*e.g.*, between program offices and grantees, or among program staff). Using ADR also furthers compliance with the Administration's directive of January 24, 2009, entitled "Memorandum to the Heads of Executive Departments and Agencies on Transparency and Open Government." The President called on the Executive Branch to provide increased opportunities for the public to participate in policymaking and to use innovative tools, methods and systems to cooperate with other Federal Departments and agencies, across all levels of government, and with non-profits, businesses and the private sector.

In FY 2014, ADR received 89 requests for ADR services and closed 80 (89%).

Workload Statistics:

Board Members – Appellate Division

Chart A shows total historical and projected caseload data for this Division. FY 2014 data is based on database records and FY 2015 and FY 2016 data are projected based on certain assumptions, including:

- Receipt of new cases arising under various newly implemented ACA provisions in FY 2015 and FY 2016;
- Retirement of a long-time Board Member in January 2015 and time needed for appointment and training of a replacement; and
- Reassignment of two of the four Appellate Division staff attorneys to the Medicare Operations Division during the second quarter of FY 2015

APPELLATE DIVISION CASES – Chart A

Cases	FY 2014	FY 2015	FY 2016
Open/start of FY	51	51	86
Received	120	125	135
Decisions	67	55	55
Total Closed	120	90	95
Open/end of FY	51	86	126

Administrative Law Judges – Civil Remedies Division

Chart B shows total historical and projected caseload data for CRD. FY 2014 data is based on database records and FY 2015 and FY 2016 data are projected based on certain assumptions, including:

- A continued upward trend in cases having statutory or regulatory deadlines, such as provider/supplier enrollment cases, due to heightened enforcement and oversight efforts by DHHS OIG, CMS, and OCR;
- Expiration of the intra-agency agreements to hear FDA cases by the end of Q3 FY 2015;
- Not backfilling positions that became vacant in FY 2014;
- Restoring FY 2015 FTE decrease in FY 2016; and
- Receipt of new cases arising under various newly implemented ACA provisions in FY 2015 and FY 2016.

CIVIL REMEDIES DIVISION CASES – Chart B

Cases	FY 2014		FY 2015		FY 2016
	Non-FDA	FDA	Non-FDA	FDA	Non-FDA
Open/start of FY	306	184	333	234	403
Received	909	1105	900	1750	950
Decisions	199	264	185	264	200
Total Closed	882	1055	830	1984	880
Open/end of FY	333	234	403	0	473

The data in the preceding chart separates the FDA cases, which will expire by the end of the third quarter of FY 2015, and non-FDA cases, which is CRD's core work.

Medicare Appeals Council – Medicare Operations Division

Chart C contains historical and projected caseload data for MOD. FY 2014 data is based on database records and FY 2015 and FY 2016 are projected based on information from OMHA and CMS. DAB reports data about cases requiring individual determinations, while noting the associated individual claims (a single case may represent hundreds of Medicare claims and more than one Medicare contractor denial).

Assumptions on which the data are based include:

- Increased case receipts in FY 2015 and FY 2016 as OMHA's case receipt and disposition rate increases;
- Increased overpayment (including Recovery Audit (RA)) and statistical sampling cases;
- Restoring FY 2015 FTE decrease in FY 2016, and adding new staff;
- Increased CMS demonstration projects across the country; and
- Increased requests for certified administrative records in cases appealed to Federal court.

MEDICARE OPERATIONS DIVISION CASES – Chart C

Cases	FY 2014	FY 2015	FY 2016
Open/start of FY	5,147	7,132	16,812
Received	4,500	12,000	14,000
Cases Closed (claims closed)	2,515 (12,575 claims)	2,320 (11,600 claims)	3,280 (15,600 claims)
Open/end of FY	7,132	16,812	27,532

Alternative Dispute Resolution Division

In FY 2014, the ADR provided services in 80 cases and provided 15 conflict resolution seminars. In FY 2014, the Division also continued its initiative with the Indian Health Service to mediate all EEO complaints requiring travel via video teleconference (VTC). IHS personnel are located in tribal areas

throughout the country, often in remote locations. Using VTC has provided an effective way to conduct face-to-face mediation conferences, saving staff time and travel costs. In addition, the Division undertook an initiative with the Phoenix Area Indian Health Service to train managers in conflict management skills and to train new mediators for the Phoenix Area mediator cadre. For FY 2015 and FY 2016, ADR projects case receipts at approximately the same level. Also, ADR projects losing one staff member in FY 2015 and filling the position in FY 2016.

Funding History

Fiscal Year	Amount
FY 2011	$10,583,000
FY 2012	$10,730,000
FY 2013	$10,450,000
FY 2014	$10,450,000
FY 2015	$10,043,000

Budget Request

DAB's FY 2016 request is $12,500,000, which is $2,457,000 above the FY 2015 Enacted Level of $10,043,000. The request restores the FY 2015 reduction of $407,000 and provides additional funding to replace staff lost in FY 2015 and to hire seven new staff for the Medicare Operations Division.

With additional staff, MOD will increase closures by almost 1,000 cases, but the growing backlog will continue to challenge overall productivity. MOD's backlog is now projected to grow to over 27,000 cases by the end of FY 2016, and average case age in Part B cases is likely to increase to over 1,000 days. In addition to the increased volume of receipts, MOD anticipates a greater percentage of technically complex statistical sampling cases and multi-claim overpayment cases (such as Recovery Audit Program audits). Furthermore, MOD cases often generate voluminous administrative records, and when cases are appealed to Federal court MOD staff must prepare and certify the accuracy of the record for the court. These factors combined make it difficult to meet the statutorily and regulatory mandated decision deadlines.

HHS is actively pursuing a number of administrative and legislative initiatives at the CMS, OMHA, and DAB levels of appeal to address the backlog and improve the overall Medicare appeals process. The additional funds will enable MOD to address growing receipts pending the outcome of these initiatives.

Outputs and Outcomes Table

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2015 Enacted	FY 2016 Request	FY 2016 Request +/- FY 2015
1.1 Percentage of Board Decisions with net case age of six months or less	2014: 92% Target: 86% (Target Exceeded)	75%	60%	-15%
2.1 Percentage of Board decisions meeting applicable statutory and regulatory deadlines for issuance of decisions.	FY 2014: 100% Target: 100% (Target Met)	100%	100%	Maintain
3.1 Percentage of decisions issued within 60 days of the close of the record in HHS OIG enforcement, fraud and exclusion cases.	FY 2014: 100% Target: 100% (Target Met)	90%	95%	+5%
3.2 Percentage of decisions issued within 60 days of the close of the record in SSA OIG CMP cases and other SSA OIG enforcement cases.	FY 2014: 100% Target: 100% (Target Met)	90%	95%	+5%
3.3 Percentage of decisions issued within 180 days from the date appeal was filed in provider/supplier enrollment cases.	FY 2014: 100% Target: 100% (Target Met)	90%	95%	+5%
4.1 Cases closed in a fiscal year as a percentage of total cases open in the fiscal year.	FY 2014: 77% Target: 65% (Target Exceeded)	67%	65%	-2%
5.1 Number of conflict resolution seminars conducted for HHS employees.	FY 2014: 15 Sessions Target: 15 Sessions (Target Met)	10	12	+2
5.2 Number of DAB cases (those logged into ADR Division database) requesting facilitative ADR interventions prior to more directive adjudicative processes.	FY 2014: 89 Target: 80 (Target Exceeded)	80	80	Maintain
6.1 Average time to complete action on Part B Requests for Review measured from receipt of the claim file.	FY 2014: 321 days Target: 231 days (Target Not Met)	750 days	1200 days	+450 days
7.1 Number of dispositions	FY 2014: 2,515 Target: 3,280 (Target not met)	2,320	3,280	+960 cases

Performance Analysis

DAB has made measurable progress in the strategic management of human capital by reengineering its operations and improving its case management techniques. DAB shifts resources across its Divisions as needed to meet changing caseloads and targets mediation services to reduce pending workloads.

Appellate Division

In FY 2014, 92% of Appellate decisions had a net case age of six months or less, exceeding the Measure 1.1 target of 86%. One Board Member is retiring at the end of January 2015. Even if the position is filled quickly, it will take time for the new Board Member to become as productive. In addition, as a result of the surge in Medicare appeals received by the MOD, another Board Member will be devoting increasing amounts of time to MOD appeals, and two staff attorneys will be reassigned to MOD during the second quarter of FY 2015. Therefore, Appellate is reducing target 1.1 from 86% to 75% for FY 2015 and 60% for FY 2016. In FY 2014, Appellate met the deadline for issuing decisions in 100% of appeals having a deadline, achieving the target for 2.1. Appellate projects that it will meet the targets again in FY 2015 and FY 2016.

Civil Remedies Division

Measures 3.1, 3.2, and 3.3 relate to the percentage of cases in which CRD ALJs meet the statutory or regulatory deadline for rendering final decisions in particular types of cases (60 days for OIG and SSA enforcement, fraud, or exclusion cases; 180 days for CMS provider/supplier enrollment cases). CRD expects an upward trend in the cases targeted by 3.1, 3.2, and 3.3. For FY 2015, the targets for 3.1 and 3.2 are adjusted downward due to this increase and to fewer staff. For FY 2016, the targets are adjusted slightly upward to reflect the restoration of staffing levels in FY 2015. CRD expects to meet all three adjusted targets in FY 2015 and FY 2016.

Measure 4.1 tracks cases closed as a percentage of all cases open during the fiscal year. CRD exceeded its FY 2014 target by closing 77% of open cases, due in large part to the high closure rate of FDA cases (82%). FDA cases (open as well as received) will be transferred to FDA in FY 2015 due to the expiration of the FDA agreement. Therefore, the FY 2015 and FY 2016 targets are based only on CRD's non-FDA work. CRD adjusted the FY 2016 target slightly downward from 67% to 65% due to the combined effect of: 1) the increased backlog (403 cases open at start of FY16) and 2) the projected increase in new cases (950 new receipts in FY16). CRD expects to meet the target in both those years.

Medicare Operations Division

MOD did not meet its FY 2014 targets for Measures 6.1 and 7.1. Those targets assumed fewer case receipts and more staff (which did not materialize due to flat funding). Average case age in Part B cases (Measure 6.1) increased to 321 days in FY 2014 and, is projected to increase to 750 days in FY 2015 and 1,200 in FY 2016. Case closures (Measure 7.1) decreased to 2,515 in FY 2014, and with a staff reduction in FY 2015 will decrease further to 2,320. The sheer volume of receipts in FY 2015 and FY 2016 will outpace capacity and, despite staff increases in FY 2016, will lead to unprecedented backlogs and difficulty in meeting statutorily and regulatory mandated decision deadlines.

Alternative Dispute Resolution (ADR) Division

In FY 2014, the ADR met Measures 5.1 and 5.2 by leveraging its limited resources through: (1) mediating via video-teleconferencing instead of in-person, thereby reducing staff-time otherwise needed for travel; (2) continuing its training partnership with DOT; and (3) using the Federal Sharing Neutrals Program to mediate HHS cases when needed. In FY 2015, ADR will lose one FTE which is about 1/3 of ADR's current staff, so trainings completed and cases closed will decrease proportionally. Since case receipts are projected to be about the same, a backlog of about 25 cases will develop in FY 2015. By restoring one FTE in FY 2016, the backlog should decrease to roughly 15 cases. Also, trainings will

increase, but to 12 rather than 15 per year, due to a slight change in demand from trainings to casework. The Division is on track to meet its adjusted FY 2015 and FY 2016 targets.

OFFICE OF GLOBAL AFFAIRS

Budget Summary
(Dollars in Thousands)

Staff Division Name	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	6,270	6,026	6,520	+494
FTE	24	22	23	+1

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The Office of Global Affairs (OGA) promotes the health of the world's population by advancing HHS's global strategies and partnerships and working with HHS Divisions and other U.S. Government (USG) agencies in the coordination of global health policy and international engagement. OGA develops policy recommendations and provides staff support to the Secretary, Deputy Secretary and other senior HHS leadership in the areas of global health and social issues. OGA coordinates these matters across HHS, and represents the HHS in the governing structure of major crosscutting global health initiatives.

HHS has a range of relationships with most Cabinet Departments as well as nearly all of the world's Ministries of Health. Multilateral partners include the World Health Organization (WHO), the Pan American Health Organization (PAHO), the Global Fund to Fight AIDS, Tuberculosis and Malaria, the UN Joint Program on HIV/AIDS (UNAIDS), the Organization for Economic Cooperation and Development (OECD), and the GAVI Alliance.

OGA's Policy and Program Coordination Division (PPCD) includes global health experts on a range of policy issues, including non-communicable diseases, infectious diseases, immunizations, intellectual property and trade, global health security, as well as staff to support and coordinate global health policy positions and harmonize global management issues across HHS. While the International Relations Division (IRD) staff lead regional efforts on these issues, the PPCD staff address from a cross-cutting perspective, ensuring a consistent and comprehensive approach.

OGA's Border Health Commission works to increase the number of border residents who are covered by insurance, receive public health education or health screenings and address specific disease threats. Community-Based Healthy Border Initiatives are valued on both sides of the U.S.-Mexico border.

Significant accomplishments include the following:

- In 2014, OGA's health attaché in China orchestrated a breakthrough in the country that consumes by far more tobacco than any other, working with China's government and industry partners the China-U.S. Smoke-free Worksite partnership which was launched in 2012. Nearly 70 U.S. and Chinese employers agreed to limit or ban smoking in their workplaces, a huge change from previous norms and practices. The U.S. and China continue to promote, expand, and advance the interests of this effort within the private and public sectors.
- The multilateral staff and the OGA attaché play a pivotal role in promoting U.S. positions through engagement with WHO secretariat staff and other member states, and support the Secretary's role as head of the U.S. delegation to the annual World Health Assembly. In 2014,

the Assembly adopted 19 resolutions on health topics, ranging from antimicrobial resistance to a newborn health action plan. During the Assembly, the OGA co-chaired negotiations resulting in a consensus resolution on violence against women and children.

- Due to active diplomacy, led by OGA, the U.S. achieved its goals and gained endorsement of its positions on various topics including support for consideration of further research goals on the smallpox virus; endorsement of the Director-General's use of the International Health Regulation framework to promote the vaccination of travelers from polio-affected areas, and a resolution on hepatitis.
- OGA organized the Global Health Security Agenda launch event in February 2014. Attendees included the Directors-General of the World Health Organization (WHO), World Organization for Animal Health (OIE), and Food and Agriculture Organization (FAO), and senior representatives from 28 partner countries from across health, foreign affairs, defense, and agricultural sectors. International partners announced commitment and leadership across all objectives of the Global Health Security Agenda.

Funding History

Fiscal Year	Amount
FY 2011	$6,329,000
FY 2012	$6,438,000
FY 2013	$6,270,000
FY 2014	$6,270,000
FY 2015	$6,026,000

Budget Request

OGA's FY 2016 Budget request of $6,520,000 is $494,000 above the FY 2015 Enacted Level. This funding level includes a restoration of $244,000 from the FY 2015 Omnibus decrease which will allow OGA to continue to perform the critical work of coordinating HHS' engagements with international stakeholders. The additional $250,000 will support the implementation of the National Strategy for Combating Antibiotic-Resistant Bacteria (CARB). OGA will address the international aspects of the Strategy to prevent, detect, and control illness and death related to infections caused by antibiotic-resistant bacteria by coordinating with USG and international partners to implement measures to mitigate the emergence and spread of antibiotic resistance and ensure the continued availability of therapeutics for the treatment of bacterial infections.

OGA's health diplomacy and policy coordination role will include, but not be limited to:

- Strengthening international communication of critical events that may signify new resistance trends with global public and animal health implications
- Co-chairing the Trans-Atlantic Task Force on Antimicrobial Resistance (TATFAR), seeking to harmonize and improve reporting across international surveillance programs
- Developing bilateral, multilateral, and public-private collaborations to gather and disseminate information on drivers of antibiotic resistance, identify effective interventions, and to advance drug development
- Supporting efforts to coordinate regulatory approaches with bilateral partners and international organizations

Office of Global Affairs - Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2015 PB Target	FY 2016 Request Target	FY 2016 Request +/- FY 2015
1.1 USMBHC development and implementation of strategies that are directly related to HHS and/or Secretary's priorities	FY 2014: Target: 25 (Project delayed to FY 2015)	25	75	+50
1.2 The implementation of USMBHC priorities (which are linked to the Department's priorities)	FY 2014: 44,344 Target: 58,765 (Target not met)	46,600	49,000	+5%
1.3 The effectiveness of OGA's communication and outreach activities	FY 2014: 246,525 Target 97,000 (Target Exceeded)	271,200	298,300	+10%

Performance Analysis

The Office of Global Affairs will continue its work to promote the health outcome objectives of the Healthy Border 2020 Strategy; as well as increase the number of border residents who receive public health education and/or health screenings each year through the Community-Based Healthy Border Initiatives that are celebrated on both sides of the U.S.-Mexico border. OGA's numbered performance measures are fairly new, but have had much success in increasing the number of unique visitors to OGA supported websites.

Program Data Chart

Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Contracts	$1,262,000	$1,367,000	$1,315,328
Grants/Cooperative Agreements	$1,430,000	$1,326,000	$1,300,000
Inter-Agency Agreements (IAAs)	$202,000	$201,000	$205,221
Operating Costs	$3,376,000	$3,376,000	$3,699,451
Total	$6,270,000	$6,270,000	$6,520,000

Grants

Grants (whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	4	4	4
Average Award	$325,000	$325,000	$325,000
Range of Awards	$280,000 - $445,000	$290,000 - $455,000	$290,000 - $455,000

OFFICE OF INTERGOVERNMENTAL AND EXTERNAL AFFAIRS

Budget Summary
(Dollars in Thousands)

Staff Division Name	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	9,576	9,202	10,600	+1,398
FTE	70	68	70	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The Office of Intergovernmental and External Affairs (IEA) serves the Secretary as the primary link between the HHS and state, local, territorial and tribal governments and non-governmental organizations and its mission is to facilitate communication related to HHS initiatives with these stakeholders. IEA not only communicates HHS positions to the stakeholders but brings information back to the Secretary for use in the HHS policymaking process.

The IEA is composed of a headquarters team that works on policy matters within HHS Operating and Staff Divisions. In addition to the Headquarters team, IEA has ten regional offices which include the Secretary's Regional Directors, Executive Officer, Outreach Specialist and Intergovernmental Affairs Specialists responsible for public affairs, business outreach and media activities. The Regional Directors (RD) coordinate the HHS Regional Offices in planning, development and implementation of HHS policy. The Office of Tribal Affairs, in IEA, coordinates and manages tribal and native policy issues, assists tribes in navigating through HHS programs and services, and coordinates the Secretary's policy development for Tribes and national Native organizations. In FY 2014 the Centers for Faith Based Neighborhood Partnerhip (CFBNP) was realigned within IEA and now receives executive leadership and management direction from IEA. This request will redirect funding from Administration for Children and Families' Federal Administration Budget to GDM's Budget.

IEA has led an HHS communications and outreach effort that has achieved considerable results. IEA undertook the challenge of leading, draft and coordinating with the Centers for Medicare & Medicaid Services (CMS) in an HHS-wide strategy to communicate, educate and actively engage with all stakeholders around the implementation of the Affordable Care Act (ACA). IEA has conducted over 9,000 ACA outreach activities reaching approximately 800,000 consumers. IEA efforts significantly increased the awareness and understanding of states, local, tribal and territorial governments; organizations, groups, private institutions, academia, private sector and labor unions of the various provisions contained within the ACA. IEA has established various electronic mechanisms to capture the concerns and communicate with governmental and non-governmental stakeholders. These electronic avenues have proven to be hugely successful in improving the communication, timeliness and ultimately the relationships with stakeholders across the country.

Funding History

Fiscal Year	Amount
FY 2011	$9,688,000
FY 2012	$9,831,000
FY 2013	$9,576,000
FY 2014	$9,576,000
FY 2015	$9,202,000

Budget Request

IEA's FY 2016 request for $10,600,000 is $1,398,000 above the FY 2015 Enacted Level. The funding level will allow IEA to restore $374,000 from the FY 2015 Omnibus decrease. The additional $1,024,000 will support personnel costs, continue coordination of a wide range of outreach activities, and facilitate cross-cutting initiatives. The increase in funding will allow IEA to return to fully-staffed levels.

IEA will continue mission critical activities via personnel who are knowledgeable about the complexity and sensitivity of various HHS programs including health insurance marketplace, consumer/population distinctions, governmental organizations and external organizations, to ensure successful communication and coordination of healthcare and human services policy issues and other priority initiatives of the Department, Secretary and the Administration. IEA will continue to utilize video technology, electronic communication capabilities and in-person meetings to enhance relationships with stakeholders across the country.

CENTER FOR FAITH-BASED AND NEIGHBORHOOD PARTNERSHIPS

Budget Summary
(Dollars in Thousands)

Center for Faith-Based and Neighborhood Partnerships	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	1,299	1,299	1,382	+83
FTE	7	7	7	0

FY 2016 Authorization……Such sums as may be appropriated
Allocation Method……Direct Federal

Program Description and Accomplishments

Purpose: Center for Faith-Based and Neighborhood Partnerships (CFBNP) is the Department's liaison to the grassroots. The Partnership Center works to engage secular and faith-based non-profits, community organizations, neighborhoods and wider communities as it reaches people who need servicing the most by ensuring that local institutions that hold community trust have up-to-date information regarding health and human service activities and resources in their area.

CFBNP works to build partnerships between government and community and faith-based organization, which help HHS serve individuals, families, and communities in need. The Partnership Center was realigned within the Office of Intergovernmental and External Affairs (IEA) in FY 2014 and now receives executive leadership and management direction from IEA. This request will redirect funding from Administration for Children and Families' Federal Administration Budget to GDM's Budget. CFBNP's role of external engagement is assumed and works in collaboration with IEA to:

- Make community groups an integral part of the economic recovery and poverty a burden fewer have to bear when recovery is complete.
- Be one voice among while addressing the needs of women, children, teen pregnancy and the reduction of the need for abortion.
- Strive to support fathers who stand by their families, by working to get young men off the streets and into well-paying jobs, and encouraging responsible fatherhood, and
- Work with the National Security Council to foster interfaith dialogue with leaders and scholars around the world.

CFBNP is now positioned to take advantage of IEA's established relationships and communication networks, including HHS' regional offices.

Funding History

Fiscal Year	Amount
FY 2011	$1,373,000
FY 2012	$1,370,000
FY 2013	$1,299,000
FY 2014	$1,299,000
FY 2015	$1,299,000

Budget Request

CFBNP's FY 2016 Budget request is $1,382,000, $83,000 above the FY 2015 Enacted Level. Funds requested will be used to support the realignment of CFBNP within IEA and to provide the necessary staffing to accomplish CFBNP's mission to effectively administer federal programs that promote the economic and social well-being of families, children, individuals, and communities. ACF's FY 2016 Budget will not include funding for CFBNP.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Budget Summary
(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	281,506	278,810	290,155	+11,345
FTE	268	256	315	+59

Agency Overview

The Office of the Assistant Secretary for Health (OASH), headed by the Assistant Secretary for Health (ASH), is a Staff Division of the Office of the Secretary in the U.S. Department of Health and Human Services (HHS). The ASH serves as the senior advisor for public health and science to the Secretary and coordinates public health policy and programs across the Staff and Operating Divisions of HHS. OASH is charged with leadership in development of policy recommendations on population-based public health and science and coordination of public health issues and initiatives that cut across the Staff and Operating Divisions of HHS. OASH provides leadership on population-based public health and clinical preventive services, ensuring the health and well-being of all Americans.

The mission of OASH is "mobilizing leadership in science and prevention for a healthier Nation". In support of this mission, OASH has identified three priorities to enhance the health and well-being of the Nation:

- Creating better systems of prevention;
- Eliminating health disparities and achieving health equity; and
- Making Healthy People come alive for all Americans.

As an organization, OASH represents a wide, cross-cutting spectrum of public health leadership including:

- 13 core public health offices – including the Office of the Surgeon General, U.S. Public Health Service Commissioned Corps, and 10 Regional Health Administrators
- 14 Presidential and Secretarial advisory committees
- 12 Department-wide Action Plans and Strategic Initiatives

OASH contributes to two of the Department's Priority Goals, serving as the goal lead on Tobacco control and as a partner on reducing Healthcare Associated Infections.

Overview of Performance

To evaluate performance and achievement toward the mission of OASH, the five specific objectives that support the three priorities identified are:

- Shape public health policy at the local, state, national, and international, levels;
- Communicate strategically;
- Promote effective partnerships;
- Build a stronger science base; and,
- Lead and coordinate key initiatives of HHS and Federal health initiatives.

Achievement of these objectives is dependent on various health programs and providers, all levels of government, and the efforts of the private sector as well as individual contributions. In some instances,

OASH's contributions act as a catalyst for action; in other instances OASH provides the leadership and coordination to support the collective efforts of agency partners as they work to shape effective public health policy.

The OASH goals and objectives will be achieved through implementation of the strategies outlined for each goal.

Goal 1: Creating Better Systems of Prevention

Objective A: Shaping Policy at the Local, State, National, and International Level

Strategy 1.A.1: Lead the oversight of *Healthy People 2020* for the Nation.

Strategy 1.A.2: Lead the monitoring of the *National Vaccine Plan* to ensure coordination of the various components of the Nation's vaccine system in order to achieve optimal prevention of human infectious diseases through immunization.

Strategy 1.A.3: Lead the HHS reproductive health programs that reduce unintended pregnancies, adolescent pregnancies, and the transmission of sexually transmitted diseases by developing and implementing policies and programs related to family planning and other preventive healthcare services, including education and social support services.

Objective B: Communicate Strategically

Strategy 1.B.1: Ensure that *healthfinder.gov* becomes the pre-eminent federal gateway for up-to-date, reliable, evidence-based prevention information so that individuals are empowered to adopt healthy behaviors.

Strategy 1.B.2: Maximize the number of Americans who know their HIV health status through targeted HIV awareness and testing campaigns.

Strategy 1.B.3: Emphasize effectively with federal, state, and local stakeholders the extensive systems changes needed in school nutrition and physical activity programs, community infrastructure, and nutrition programs for the poor to reduce childhood obesity.

Strategy 1.B.4: Advance programs and activities that improve health literacy through provision of evidence-based and culturally competent health care.

Objective C: Promote Effective Partnerships

Strategy 1.C.1: Use the *Healthy People Consortium* to make Americans healthier by encouraging use of *Healthy People 2020* objectives at national, state, and local levels.

Strategy 1.C.2: Partner with national public health organizations and medical associations to identify emerging public health and science issues, disseminate information on key initiatives and priorities, and leverage existing programs in order to maximize the positive impact on the nation's health.

Strategy 1.C.3: Through a variety of collaborations, drive community-led discussions about HIV-related stigma and risk behaviors to strengthen HIV/AIDS prevention efforts.

Objective D: Build a Stronger Science Base

Strategy 1.D.1: Lead the promotion and evaluation of evidence-based *Physical Activity Guidelines* for the Nation to help Americans achieve appropriate levels of physical activity that lead to good health.

Strategy 1.D.2: Lead, with the United States Department of Agriculture, the promotion and evaluation of evidence-based *Dietary Guidelines for Americans*, which provides information and advice for choosing a nutritious diet that will meet nutrient requirements, maintain a healthy weight, keep foods safe to avoid food-borne illness, and reduce the risk of chronic disease.

Strategy 1.D.3: Promote future *Surgeon General's Calls to Action* such as those on the prevention of deep venous thrombosis and pulmonary embolism, on the prevention and reduction of underage drinking, on improvement of the health and wellness of persons with disabilities, on the promotion of oral health, and on the prevention and reduction of overweight and obesity.

Objective E: Lead and Coordinate key Initiatives of HHS and Federal health initiatives

Strategy 1.E.1: Lead the department in its effort to improve vaccine safety and public confidence in vaccines in order to maintain high national immunization rates.

Strategy 1.E.2: Continue to implement a HHS plan to reduce healthcare associated infections (HAI) that includes prioritizing recommended clinical practices, strengthening data systems, and developing and launching a national HAI prevention campaign.

Strategy 1.E.3: Lead the Federal initiative to prevent childhood overweight and obesity, by partnering with communities and schools throughout the Nation that are helping kids stay active, encouraging healthy eating habits, and promoting healthy choices.

Strategy 1.E.4: Lead the *President's Council on Fitness, Sports, and Nutrition (PCFSN)* in efforts to significantly increase physical activity in this country.

Strategy 1.E.5: Continue OASH's historic leadership to prevent and treat tobacco abuse and dependence.

Goal 2: Eliminating Health Disparities and Achieving Health Equity

Objective A: Shape public health policy at the local, state, national, and international levels

Strategy 2.A.1: Provide leadership across the Nation to guide, organize, and coordinate the systemic planning, implementation, and evaluation of policies and programs designed to achieve targeted results relative to minority health and health disparities reduction.

Strategy 2.A.2: Provide leadership to promote health equity for women and girls through the development of innovative programs, through the education of health professionals, and through the motivation of consumer behavior change by disseminating relevant health information.

Strategy 2.A.3: Expand Commissioned Corps initiatives to recruit and retain officers in assignments that meet the public health needs of underserved populations.

Objective B: Communicate strategically

Minority Health Resource Center become the nation's pre-eminent gateways for women's health and minority health information.

Strategy 2.B.2: Significantly increase the number of health care professionals using the nationally accredited on-line *Cultural Competency Training* modules to increase their knowledge and skills to better treat the increasingly diverse U.S. population.

Strategy 2.B.3: Advocate for widespread access for health care providers to foreign language resources to improve communications with patients and families with limited English proficiency (LEP).

Objective C: Promote effective partnerships

Strategy 2.C.1: Ensure that the *National Partnership for Action to End Health Disparities* connects and mobilizes organizations throughout the Nation to build a renewed sense of teamwork across communities, share success stories for replication, and create methods and tactics to support more effective and efficient actions.

Strategy 2.C.2: Provide technical assistance to minority communities so that they are at the forefront in the fight against HIV/AIDS.

Objective D: Build a stronger science base

Strategy: 2.D.1: Develop and test interventions designed to address racial and ethnic disparities through community-level activities that promote health, reduce risks, and increase access to and utilization of appropriate preventive healthcare and treatment services.

Strategy 2.D.2: Foster the development of evidence-based health and disease prevention practices for women through innovative national and community-based programs focused on conditions affecting women's health.

Objective E: Lead and coordinate key initiatives of HHS and Federal Health Initiatives

Strategy 2.E.1: Ensure that the distinctive cultural, language, and health literacy characteristics of minority and special needs populations are integrated into all-hazards emergency preparedness plans.

Strategy 2.E.2: Provide leadership and oversight for the *Minority AIDS Initiative* to ensure that departmental efforts strengthen the organizational capacity of community-based providers and expand HIV-related services for racial and ethnic minority communities disproportionately affected by HIV/AIDS.

Strategy 2.E.3: Lead and manage the *HHS American Indian Alaska Native Health (AI/AN) Research Advisory Council* to ensure input from tribal leaders on health research priorities, to provide a forum through which HHS can better coordinate its AI/AN research, and to establish a conduit for improved dissemination of research to tribes.

Strategy 2.E.4: Lead and manage the *HHS Work Group on Asian, Native Hawaiian and Other Pacific Islander issues* to provide a forum for HHS to develop strategies for improving the health of these communities.

Goal 3: Making Healthy People Come Alive for All Americans

Objective A: Shape public health policy at the local, state, national, and international levels

Strategy 3.A.2: Provide advice and consultation to the Executive Branch on ethical issues in health, science, and medicine.

Strategy 3.A.3: Lead the development of national blood, tissue, and organ donation policy to maintain and enhance safety through prevention of disease transmission and other adverse events during transfusion and transplantation.

Strategy 3.A.4: Strengthen the public health mission of the Public Health Service through research, applied public health, and provision of health care services including behavioral and mental health.

Objective B: Communicate strategically

Strategy 3.B.1: Foster effective communication to the public that promotes and increases blood and organ donation.

Strategy 3.B.2: For people with multiple chronic conditions, advocate for changes in the research, clinical, health professional education, financing, and health delivery enterprises so that their health can be better managed and acute exacerbations of conditions can be prevented.

Objective C: Promote effective partnerships

Strategy 3.C.1: As appropriate, expand memorandums of understanding (MOUs) and memorandums of agreement (MOAs) between the Commissioned Corps and local, state, and federal health agencies to allow placement of officers in other government organizations (outside HHS).

Strategy 3.C.2: Support Commissioned Corps initiatives to recruit, develop, and retain a competent health care workforce.

Objective D: Build a stronger science base

Strategy 3.D.1: Educate the broad research community on federal regulations that protect human subjects in research.

Strategy 3.D.2: Educate the broad research community on research integrity to minimize cases of research misconduct and to decrease the number of misconduct cases that go unreported.

Strategy 3.D.3: Ensure that *Public Health Reports* remains a pre-eminent peer-reviewed journal on public health practice and public health research for healthcare professionals.

Objective E: Lead and coordinate key initiatives of HHS and Federal health initiatives

Strategy 3.E.1: Consider engaging the Commissioned Corps in health diplomacy missions to provide critically needed medical and public health services beyond our borders.

Strategy 3.E.2: Support the Regional Health Administrators as key coordinators of prevention and preparedness activities at the local, state, and regional level.

Strategy 3.E.3: Lead HHS initiatives to enhance transfusion and transplantation safety and to improve blood availability through collaboration and coordination with relevant stakeholders internal and external to HHS.

OASH SUMMARY TABLE - DIRECT

(Dollars in Thousands)

Office	FY 2014 FTE	FY 2014 Final	FY 2015 FTE	FY 2015 Enacted	FY 2016 FTE	FY 2016 President's Budget
Immediate Office of the Assistant Secretary for Health	55	12,152	50	11,678	87	17,995
Office of HIV AIDS and Infectious Disease Policy	6	1,459	6	1,402	9	1,500
Office of Disease Prevention and Health Promotion	23	6,999	23	6,726	24	7,000
President's Council on Fitness, Sports and Nutrition	6	1,215	6	1,168	8	2,100
Office for Human Research Protections	33	6,756	31	6,493	33	6,800
National Vaccine Program Office	17	6,659	17	6,400	17	6,000
Office of Adolescent Health	4	1,500	4	1,442	6	1,500
Public Health Reports	2	486	2	467	2	400
Teen Pregnancy Prevention	16	100,726	16	101,000	13	104,790
Office of Minority Health	63	56,516	57	56,670	65	56,670
Office on Women's Health	43	33,958	43	32,140	43	31,500
Office of Research Integrity (Non-Add)	24	8,558	24	8,558	28	8,558
HIV-AIDS in Minority Communities	-	52,082	-	52,224	1	53,900
Embryo Adoption Awareness Campaign	-	997	-	1,000	-	-
Subtotal, GDM	***268***	***281,506***	***255***	***278,810***	***315***	***290,155***
-	-	-	-	-	-	-
PHS Evaluation Set-Aside	-	-	-	-	-	-
OASH	-	4,664	-	4,285	-	4,285
Teen Pregnancy Prevention Initiative	-	8,455	-	6,800	-	6,800
Subtotal, PHS Evaluations	***-***	***13,119***	***-***	***11,085***	***-***	***11,085***
-	-	-	-	-	-	-
Total, OASH	***268***	***294,625***	***255***	***289,895***	***315***	***301,240***
GRAND TOTAL OASH PROGRAM LEVEL	**268**	**294,625**	**255**	**289,895**	**315**	**301,240**

IMMEDIATE OFFICE

Budget Summary
(Dollars in Thousands)

Immediate Office	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	12,151	11,687	17,995	+6,308
FTE	55	55	87	+32

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The Assistant Secretary for Health (ASH) and the Immediate Office of the Assistant Secretary for Health (OASH), serve in an advisory role to the Secretary on issues of public health and science. The Immediate Office of the ASH drives the OASH mission, "mobilize leadership in science and prevention for a healthier Nation", by providing leadership and coordination across the Department in public health and science; and advice and counsel to the Secretary and Administration on various priority initiatives such climate change, tobacco cessation and Lesbian, Gay, Bisexual, and Transgender health.

Senior public health officials within the Immediate Office work to ensure a public health and prevention perspective is addressed in Secretarial and Presidential priorities. This is accomplished by the IOASH through effective networks, coalitions, and partnerships that identify public health concerns and undertake innovative projects. Three key priorities established by the ASH provide a framework for addressing public health needs:

- Creating Better Systems of Prevention
- Eliminating Health Disparities & Achieving Health Equity
- Making Healthy People Come Alive for all Americans.

Creating Better Systems of Prevention

OASH leads and coordinates many inter- and intra-departmental initiatives on behalf of the Secretary. Efforts to create better systems of prevention require the ASH to coordinate activities of Federal partners to enable HHS to leverage the scientific, evaluative, or programmatic findings of one agency for replication and dissemination through other agencies and government-wide.

In FY 2014 the Office of the Surgeon General released the *Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014*, through this and other calls to action the Surgeon General of the Public Health Service continues to focus the Nation's attention on important public health issues. OASH continues to lead department efforts regarding implementation of *Ending the Tobacco Epidemic, A Tobacco Control Strategic Action Plan.* The ASH serves as the chair of the Tobacco Control Implementation Steering Committee and the lead for the HHS Agency Priority Goal to reduce combustible tobacco use. OASH partners to lead the Tobacco-Free College Campus Initiative (TFCCI), which is a public-private partnership involving key leaders from universities, colleges, and the public health community, to promote the adoption of tobacco-free policies at institutions of higher learning. Since the inception of TFCCI in 2012 the program has grown to over 1,000 participating campuses.

Healthcare Associated Infections and Adverse Drug Events
Through the Office of Disease Prevention and Health Promotion (ODPHP), OASH continued its leadership on healthcare associated infections and adverse drug events through the National Action Plan to Prevent Health Care-Associated Infections (HAIs): Road Map to Elimination and the National Action Plan for Adverse Drug Event Prevention (ADE), respectively. In FY 2014, progress continued in reducing Healthcare HAIs, including improved surveillance systems, inclusion in quality improvement efforts such as the Quality Improvement Organization (QIO) program, and investments in innovative intervention efforts. Two HAI measures are included in the Deputy Secretary's annual performance goal, and the HAI Action Plan is one of the key strategies tracked in the Secretary's Strategic Planning System. ODPHP released the ADE Action Plan in FY2014 and has initiated efforts to implement components of the action plan, including the development of an online training toolkit to educate health professionals on the principles outlined in the Action Plan.

OASH also partners and leads other Department prevention-related initiatives and strategic actions to, such as:

- Viral hepatitis – *Combating the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care, and Treatment of Viral Hepatitis*
- Multiple chronic conditions – *Multiple Chronic Conditions: A Strategic Framework*
- Public health quality –Established a public health quality curriculum for public health education and facilitated adoption of the 9 Aims of public health quality by the National Quality Forum.

Eliminating Health Disparities and Achieving Health Equity
The IOASH provides leadership in the area of health equity by raising awareness; and improving the health care and health system experience for populations disproportionally affected by health disparities including those identified by race, ethnicity, and gender. Efforts in this area include improving cultural and linguistic competency and access to preventive services through enrollment in the ACA. Additionally, OASH relies on research and evaluation outcomes to further policy in adolescent health and reducing teen pregnancy; addressing care and prevention across the life span and using health information technology to reduce health disparities.

OASH continues to implement the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*, which promotes integrated approaches, evidence-based programs and best practices to reduce health disparities. The Action Plan enables HHS to continuously assess the impact of all policies and programs on racial and ethnic health disparities, working ultimately to create a nation free of disparities in health and healthcare.

Making Healthy People Come Alive for All Americans
Healthy People 2020, established health goals for the nation, tracks progress toward meeting targets, and aligns national efforts to guide action for public health. In addition to continuing support for *Healthy People 2020,* OASH continues the Leading Health Indicators (LHI) initiative which identifies critical health priorities for the Nation. The LHI initiative also serves as an effective policy framework for policymakers and public health professionals at the local, state, and national level for tracking progress toward meeting key national health goals. LHIs assist in focusing efforts to reduce some of the leading causes of preventable deaths and major illnesses.

The OASH Regional Office presence through Regional Health Administrators (RHAs) is an important link to overall support for the OASH priorities. The RHAs perform essential functions to promote Departmental and OASH priorities, including:

- regional implementation of Department and OASH initiatives;
- regional support and amplification of OPDIV/STAFFDIV programs; and
- regional coordination and integration of the agency's numerous prevention and public health programs.

The RHAs ensure that the priorities of Department, OASH, and *Healthy People* are better incorporated at the local, state, and national level.

Funding History

Fiscal Year	Amount
FY 2011	$12,495,000
FY 2012	$13,474,000
FY 2013	$12,151,000
FY 2014	$12,151,000
FY 2015	$11,687,000

Budget Request

The FY 2016 President's Budget request of $17,995,000 is $6,308,000 above the FY 2015 Enacted Level, which includes a restoration of $430,000 from the FY 2015 Omnibus decrease. The additional funding primarily accounts for a FTE increase that reflects shift in use of contract staff to support mission critical program operations. The FY 2016 request supports the ASH's program and policy responsibilities as the senior advisor to the Secretary on public health and science. These responsibilities include operations and overhead support for the 12 program and 10 regional offices. In addition, the FY 2016 funding will support activities such as the Office of the Surgeon General (OSG); the HHS role in Administration initiatives on Climate Change and Department and Administration policy related to Environmental Health; HHS Tobacco Control Implementation Steering Committee and ongoing support for the HHS domestic and international response to the 2014 Ebola epidemic.

The FY 2016 requested level will continue the management of OSG. The Surgeon General provides Americans with scientific information on how to improve their health and reduce the risk of illness and injury. In FY 2014 the Office of the Surgeon General released the *Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General, 2014*, through this and other calls to action the Surgeon General of the Public Health Service continues to focus the Nation's attention on important public health issues.

Funding at this level fully supports the operating and program costs associated with the functions of the RHAs. RHAs play an important role in connecting and coordinating Regional initiatives, which support the Department's wide ranging investments in public health and prevention. Support of HHS programs and priorities by RHAs in the 10 HHS regions is critical to leveraging OPDIV investments and efforts with local and state health partners.

OASH will continue to lead implementation of the HHS *Ending the Tobacco Epidemic, A Tobacco Control Strategic Action Plan*. The funding will continue OASH's leadership of the Tobacco-Free College Campus Initiative (TFCCI), which is a public-private partnership involving key leaders from universities, colleges, and the public health community, to promote the adoption of tobacco-free policies at institutions of

higher learning. Since the inception of TFCCI in 2012 the program has grown to over 1,000 participating institutions.

In FY 2016 funds will support cross-federal and national efforts to prevent health care associated infections (HAIs) and adverse drug events (ADEs). These two important pillars of national patient safety are actively supported through the National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination (HAI Action Plan) and the recently released National Action Plan for Adverse Drug Event Prevention (ADE Action Plan), respectively. Continuing in FY 2016, ODPHP will oversee national efforts to advance this work including convening stakeholders to identify new prevention strategies, enhance surveillance systems, and coordinate with public and private partners to recognize and promote examples of leadership.

In FY 2016 OASH will continue coordinating and overseeing the federal response to the national Viral Hepatitis Action Plan (VHAP). Making use of information obtained through public with cross-governmental representatives to produce an updated Viral Hepatitis Action Plan, released April 2014, which outlines federal actions that will be undertaken during FY 2014-2016. OASH will continue to work with a broad cross-section of governmental and non-governmental partners to disseminate U.S. Preventive Services Task Force Recommendations supporting hepatitis C and hepatitis B screening and to leverage opportunities to expand access to needed viral hepatitis diagnostic, treatment and immunization services.

Immediate Office - Outputs and Outcomes Table
Long Term Objective: Creating Better Systems of Prevention

Program/Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.a: Shape policy at the local, State, national and international levels (Outcome) Measure 1: The number of communities, state and local agencies, Federal entities, NGOs or international organizations that adopt (or incorporate into programs) policies and recommendations generated or promoted by OASH through reports, committees, etc.	FY 2014: 40,094 Target: 40,292 (Target Not Met but Improved)	312	372	+60
1.b: Communicate strategically (Outcome) Measure 1: The number of visitors to Websites and inquiries to clearinghouses; Measure 2: Number of regional/national	FY 2014: 46,744,091 Target: 33,939,393 (Target Exceeded)	24,770,771	27,600,000	+2,829,229

workshops/conferences, community based events, consultations with professional and institutional associations; Measure 3: new, targeted educational materials/campaigns; Measure 4: media coverage of OASH-supported prevention efforts (including public affairs events).				
1.c: Promote effective partnerships (Outcome) Measure 1: Number of formal IAAs, MOUs, contracts, cooperative agreements, and community implementation grants with governmental and non-governmental organizations that lead to prevention-oriented changes in their agendas/efforts.	FY 2014: 895 Target: 363 (Target Exceeded)	355	355	Maintain
1.d: Strengthen the science base (Outcome) Measure 1: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally; Measure 2: number of research, demonstration, or evaluation studies completed and findings disseminated; Measure 3: the number of promising practices identified by research, demonstrations, evaluation, or other studies.	FY 2014: 159 Target: 61 (Target Exceeded)	68	90	+22
1.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome) Measure 1: Number of prevention-oriented	FY 2014: 257 Target: 163 (Target Exceeded)	120	120	Maintain

initiatives/entities within HHS, across Federal agencies, and with private agencies, and with private organizations that are convened, chaired, or staffed by OASH; Measure 2: Number of outcomes from efforts in measure 1 that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc.				

Long Term Objective: Eliminating Health Disparities and Achieving Health Equity

Program/Measure	Most Recent Result	FY 2015 PB Target	FY 2016 Request Target	FY 2016 Request +/- FY 2015
2.a: Shape policy at the local, State, national and international levels (Outcome) Measure 1: The number of communities, NGOs, state and local agencies, or Federal entities, that adopt (or incorporate into initiatives) policies and recommendations targeting health disparities that are generated or promoted by OASH through reports, committees, etc.	FY 2014: 313 Target: 228 (Target Exceeded)	174	182	+8
2.b: Communicate strategically[1] (Outcome) Measure 1: The number of visitors to Websites and inquiries to clearinghouses; Measure 2: number of regional/national workshops/conferences or community based events; Measure 3: new, targeted educational materials/campaigns; Measure 4: media coverage of OASH-	FY 2014: 6,587,474 Target: 1,487,614 (Target Exceeded)	1,494,114	2,402,307	+908,193

supported disparities efforts (including public affairs events); and estimated number of broadcast media outlets airing Closing the Health Gap messages.				
2.c: Promote Effective Partnerships (Outcome) Measure 1: Number of formal IAAs, MOUs, contracts, cooperative agreements and community implementation grants with governmental and non-governmental organizations that lead to changes in their agendas/efforts to address health disparities.	FY 2014: 212 Target: 408 (Target Not Met)	272	187	-85
2.d: Strengthen the science base (Outcome) Measure 1: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally; Measure 2: number of research, demonstration, or evaluation studies completed and findings disseminated; Measure 3: number of promising practices identified in research, demonstration, evaluation, or other studies.	FY 2014: 99 Target: 49 (Target Exceeded)	39	53	+14
2.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome) Measure 1: Number of prevention-oriented initiatives/entities within HHS, across Federal agencies, and with private agencies, and with private organizations that are	FY 2014: 229 Target: 57 (Target Exceeded)	61	50	-11

convened, chaired, or staffed by OASH; Measure 2: Number of outcomes from efforts in measure 1 that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc.				

Long Term Objective: Making *Healthy People* Come Alive for All Americans

Program/Measure	Most Recent Result	FY 2015 PB Target	FY 2016 Request Target	FY 2016 Request +/- FY 2015
3.a: Shape policy at the local, State, national and international levels (Outcome) Measure 1: The number of communities, NGOs, state and local agencies, Federal entities, or research organization that adopt (or incorporate into programs) policies, laws, regulations and recommendations promoted or overseen by OASH.	FY 2014: 4,264 Target: 10,179 (Target Not Met but Improved)	11,153	163[1]	-11,015
3.b: Communicate strategically (Outcome) Measure 1: The number of visitors to Websites and inquiries to clearinghouses; Measure 2: number of regional/national workshops/conferences, community based events and consultations with professional and institutional associations; Measure 3: new, targeted educational materials/campaigns.	FY 2014: 6,424,934 Target: 3,334,220 (Target Exceeded)	3,550,397	5,660,603	+2,110,206

[1] The FY16 target reflects operational changes within the Office of the Surgeon General and related activities previously reported.

3.c: Promote Effective Partnerships (Outcome) Measure 1: Number of formal IAAs, MOUs, contracts, cooperative agreements and community implementation grants with governmental and non-governmental organizations that lead to changes in their agendas/efforts related to the public health or research infrastructure.	FY 2014: 85 Target: 307 (Target Not Met)	91	96	+5
3.d: Strengthen the science base (Outcome) Measure 1: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally; Measure 2: number of research, demonstration, or evaluation studies completed and findings disseminated; Measure 3: number of public health data enhancements (e.g. filling developmental objectives or select population cells; development of state and community data) attributable to OASH leadership.	FY 2014: 113 Target: 49 (Target Exceeded)	67	48	-19
3.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome) Measure 1: Number of relevant initiatives/entities within HHS, across Federal agencies, and with private organizations that are convened, chaired, or staffed by OASH; Measure 2:	FY 2014: 36,829 Target: 6,122 (Target Exceeded)	6,436	32[2]	-6.404

[2] FY16 target reflects changes to the US PHS Commissioned Corps ending the Reserve Officer Corps.

specific outcomes of the efforts in measure 1 that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc. [OSG] M\4: # Officers trained				

FY2014-FY2015: Agency Priority Goal

Program/Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.5 Reduce the annual adult combustible tobacco consumption in the United States (cigarette equivalents per capita)	FY 2012: 1,259 (Baseline)	1,174	NA*	NA

***** Agency Priority goal closes in FY 2015.

Performance Analysis

The OASH performance measures represent an aggregate of the functions and programs carried out through the OASH program offices as well as the OASH led strategic plans. Each measure supports the efforts in accomplishing the objectives and strategies as outlined in the OASH Overview of Performance. Over the past fiscal year OASH has made significant progress in executing the identified strategies.

Moving forward, OASH will continue progress in targeted key measures related to the implementation of the HHS strategic plan and OASH priorities, such as the Healthy People 2020 and reducing health disparities, while maintaining and strategically reducing others to maximize budget resources. Significant investments will continue to shape policy at the state, local, and national level through OASH policies, regulations, and recommendations. Simultaneously, OASH will streamline efforts in the production of peer-reviewed texts, demonstration or evaluation findings, and public health data enhancements to optimize budget resources while continuing to strengthen the science base.

In those cases where performance targets have not been met, OASH has actively engaged to improve performance. In future fiscal years, OASH will re-evaluate targets to set ambitious and achievable performance results.

OFFICE OF HIV/AIDS AND INFECTIOUS DISEASE POLICY

Budget Summary
(Dollars in Thousands)

Office of HIV/AIDS and Infectious Disease Policy	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	1,459	1,402	1,500	+98
FTE	6	6	9	+3

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

Responsibility for coordinating, integrating, and directing the HHS policies, programs, and activities related to HIV/AIDS, viral hepatitis and blood and tissue safety and availability is delegated by the Secretary to the Assistant Secretary for Health (ASH). The Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) works with the ASH to support the HHS mission and goals related to these subject areas by undertaking department-wide planning, internal assessments, and policy evaluations which identify opportunities to maximize collaboration, eliminate redundancy, and enhance resource alignment to address strategic priorities.

OHAIDP develops and shares policy information and analyses with HHS OPDIVs and STAFFDIVs and ensures that senior Department officials are fully briefed on ongoing and emerging issues pertaining to HIV/AIDS, viral hepatitis, and blood and tissue safety and availability. OHAIDP is in close communication with non-federal stakeholders, community leaders, service providers and other experts and maintains a high level of transparency by disseminating information about federal domestic programs, resources, and policies pertaining to HIV/AIDS and viral hepatitis on AIDS.gov. OHAIDP manages two federal advisory committees:

- Advisory Committee on Blood and Tissue Safety and Availability (ACBTSA) – provides advice and recommendations directly to the Secretary on issues pertaining to blood and tissue safety and availability as well as infectious disease concerns related to organ transplantation
- Presidential Advisory Council on HIV/AIDS (PACHA) – provides advice and recommendations directly to the Secretary on programs and policies that reduce HIV incidence; improve health outcomes for people living with HIV; address HIV-related health disparities; and advance research on HIV/AIDS

<u>Blood and Tissue Safety</u>

OHAIDP provides internal coordination of policies, programs and resources related to blood, organs and tissues, through the Blood Organ and Tissue Senior Executive Council (BOTSEC), a cross-department council comprised of representatives from several agencies within HHS. OHAIDP actively participates in the Department's preparedness and response activities addressing the safety and availability of blood and tissues during national emergencies. OHAIDP is also responsible for coordinating cross-governmental efforts to collect vital policy information such as distribution and utilization of allograft tissue from deceased donors and incidence and prevalence of HIV, HBV, and HCV infection among deceased potential tissue and organ donors.

HIV/AIDS

Following the release of the National HIV/AIDS Strategy (NHAS) and the Federal Implementation Plan, in July 2010, OHAIDP was delegated the responsibility for coordinating the response to NHAS across HHS and other federal departments. The Implementation Plan identifies specific tasks and activities HHS must perform through calendar year 2015. In FY 2014, OHAIDP worked collaboratively with HHS OPDIVs as they deployed changes to adopt the common HIV program indicators and reduce reporting burden in a manner that preserves accountability for program outcomes. At the end of FY 2013, OHAIDP completed a detailed inventory of all HIV Indicators in use across HHS and continues to use this information to standardize HHS HIV data indicators and their specifications, reduce duplicative HIV data collection, and enhance data harmonization and sharing within and between Operating Divisions. In FY 2014, continued efforts to prepare several of these core indicators for inclusion in Meaningful Use Stage 3, which will facilitate their incorporation into electronic medical records and support enhanced data collection which will, in turn, help us to direct efforts to improve outcomes along the HIV care continuum.

Efforts to improve coordination of HIV/AIDS Programs across HHS include hosting regular meetings of senior HIV/AIDS leadership to discuss HIV/AIDS-related activities and policies; supporting topical webinars and hosting or actively collaborating in technical consultations on strategic issues related to NHAS implementation. For example, in FY 2014, OHAIDP hosted a webinar to highlight promising practices and suggest new areas of research on the topic of improving HIV-related health outcomes for black gay, bisexual and other men having sex with men (MSM). In FY 2014, OHAIDP also participated in a technical consultation with Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA) and the National Alliance of State and Territorial AIDS Directors to explore options for integrating planning for federally funded HIV prevention and care programs so as to improve program outcomes, decrease redundancy and improve resource targeting. In FY 2014, OHAIDP also contributed information that was included in the White House's Fact Sheet: "Progress in Four Years of the National HIV/AIDS Strategy."

OHAIDP has worked across HHS and with other federal partners to improve HIV program planning and coordination. When the White House released the report "Improving Outcomes: Accelerating Progress along the HIV Continuum of Care", OHAIDP was charged with coordinating the implementation of the five key recommendations, which span actions across HHS as well as other federal offices. OHAIDP has actively monitored implementation efforts, most recently by hosting a major progress review where federal leaders shared information about headway in implementing the specific actions outlined in the plan. OHAIDP has also taken a leadership role in the implementation of the fifth recommendation "Provide information, resources, and technical assistance to strengthen the delivery of services along the care continuum, particularly at the state and local levels." These implementation efforts include coordinating a government-wide inventory of current training and technical assistance resources related to the HIV continuum of care so as to better promote resources and identify gaps in required materials and trainings. OHAIDP has also collaborated with ONAP to conduct town halls around the country to highlight progress toward achieving the goals of the NHAS, share lessons learned, and to build state, local and tribal government support.

OHAIDP remains actively involved in in coordinating implementation of the Care and Prevention of HIV in the United States (CAPUS) which is supported by the Office of the Secretary's Minority AIDS Fund and supporting the federal response to the National Viral Hepatitis Action Plan.

Funding History

Fiscal Year	Amount
FY 2011	$1,429,000
FY 2012	$1,498,000
FY 2013	$1,459,000
FY 2014	$1,459,000
FY 2015	$1,402,000

Budget Request

The FY 2016 President's Budget request Level of $1,500,000 is an increase of $98,000 above the FY 2015 Enacted Level. The FY 2016 request will restore as well as fund staff to support baseline activities in support of the President's Advisory Council on HIV/AIDS (PACHA). The FTE increase reflects shift in use of contract staff to support mission critical program operations.

PACHA plans to monitor the benchmarks of the National HIV/AIDS Strategy (NHAS). PACHA will continue to make significant progress in meeting the goals of the NHAS, specifically addressing ways to reduce HIV-related health disparities and improve outcomes along each step of the HIV Care Continuum. In FY 2016, PACHA also plans to continue to provide advice and consultation to ensure improved health outcomes for people living with HIV.

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

Budget Summary
(Dollars in Thousands)

Office of Disease Prevention and Health Promotion	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	6,999	6,726	7,000	+274
FTE	23	23	24	+1

Authorizing Legislation: ……..Title XVII, Section 1701 of the PHS Act
FY 2016 Authorization……..……Expired
Allocation Method……Direct Federal, Contract, and Cooperative Agreement

Program Description and Accomplishments

The Office of Disease Prevention and Health Promotion (ODPHP) provides leadership for a healthier America by initiating, coordinating, and supporting disease prevention, health promotion, and healthcare quality activities, programs, policies, and information through collaboration with HHS and other Federal agencies.

Healthy People

ODPHP meets its Congressional mandate to establish health goals for the Nation by leading the development and implementation of *Healthy People*. *Healthy People* provides science-based, 10-year national objectives for improving the health of all Americans, underpins many HHS priorities and strategic initiatives, and provide a framework for prevention and wellness programs for a diverse array of Federal and non-Federal stakeholders.

For example, the priorities identified by the National Prevention Strategy, the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, and other Administration health initiatives align with specific *Healthy People 2020* objectives. Many state and local health departments draw on Healthy People to develop their own health plans. The fourth iteration of the Healthy People 2020 objectives was released in December 2010.

In FY 2014, ODPHP maintained and expanded the online version of *Healthy People 2020* (available at www.HealthyPeople.gov), which is aimed at making *Healthy People* 2020 information widely available and easily accessible. ODPHP collaborated with the National Center for Health Statistics and other partners in updating a user-centered, web-based resource that expands the reach and usefulness of the national objectives. This new web tool gives users a platform from which to learn, collaborate, plan, and implement objectives and has been continually updated and improved since its launch in FY 2011.
In FY 2014, healthypeople.gov received the Merit Health Web Award, recognizing the site as a leader among all health websites and continued to receive high consumer satisfaction scores of about 84%, which is well above the Federal government average of 73% (ForeSee Results American Customer Satisfaction Index (ACSI).

In FY 2014, ODPHP continued a series of monthly public webinar-based progress reviews of the Healthy People 2020 objectives and Leading Health Indicators (a subset of objectives representing high-priority health issues) , which allowed the Assistant Secretary for Health, in collaboration with the National Center for Health Statistics, the federal agencies that manage specific objectives, and community-based organizations, to demonstrate progress toward achieving the 10-year targets and identify areas needing

additional work. In FY 2014, webinars continued to be well-attended. On average, more than 1,000 sites registered to attend each webinar. In partnership with the American Public Health Association, ODPHP offered Continual Medical Education, Continuing Nursing Education, and Certified Health Education Specialist credits to webinar participants.

Dietary Guidelines for Americans

ODPHP plays a leadership role on behalf of HHS in co-coordinating the development, review, and promotion of the recommendations of the *Dietary Guidelines for Americans* (DGA) as required by Congress (P.L. 101-445). Published jointly every five years by HHS and the U.S. Department of Agriculture (USDA), the DGA is the basis of Federal nutrition policy and programs. ODPHP managed and supported the 2015 Dietary Guidelines Advisory Committee (DGAC), which was established to provide the Departments with independent, science-based advice and recommendations for development of the *DGA 2015*. The DGAC held four public meetings in FY 2014 and two in FY 2015and finished its report for the Secretaries in January 2015. The DGA 2015 will be released by the end of 2015.

Based on the preponderance of current scientific evidence, the DGA provides information and advice for choosing a nutritious diet that will reduce the risk of chronic disease, meet nutrient requirements, maintain a healthy weight, and keep foods safe to avoid food-borne illness. It also serves as the basis of the nutrition and food safety objectives in *Healthy People 2020* and supports the Secretary's initiative to Help Americans Achieve and Maintain Healthy Weight.

Physical Activity Guidelines for Americans

ODPHP, in collaboration with the President's Council on Fitness, Sports, and Nutrition; National Institutes of Health (NIH); and Centers for Disease Control and Prevention (CDC), led the Department's development and release in 2008 of the first comprehensive Federal *Physical Activity Guidelines* (PAG), a set of evidence-based recommendations for physical activity for individuals six years and older to improve health and reduce disease. The PAG served as the primary basis for physical activity recommendations of the 2010 DGA and the physical activity objectives in *Healthy People 2020* as well as support for the Secretary's initiative to Help Americans Achieve and Maintain Healthy Weight.

In FY 2014, following the 2013 release of the *Physical Activity Guidelines for Americans Midcourse Report*: *Strategies to Increase Physical Activity Among Youth*, ODPHP began planning for the next iteration of the PAG. ODPHP convened national subject matter experts in physical activity to explore various issues for consideration in the next set of guidelines.

healthfinder.gov

ODPHP fulfills its congressional mandate to provide reliable prevention and wellness information to the public primarily with healthfinder.gov. Since 1997, healthfinder.gov has received numerous awards as a key resource for finding the best government and non-profit online health information. In FY 2014, healthfinder.gov received two Merit Web Health Awards: one for the *myfamily* app (in the Mobile App: Tool/Resource category) and the other for healthfinder's Everyday Healthy Living quiz (in the Interactive Content/Rich Media category). In FY 2014, healthfinder.gov extended the reach of actionable prevention information by disseminating content via Twitter, email newsletters, widgets, e-cards, and a mobile application. The healthfinder.gov Twitter following grew by approximately 17,000 new followers in FY 2014 to approximately 237,000 followers. A Facebook page was launched in FY 2012 and had over 12,000 "likes" in FY 2014. The healthfinder.gov-powered mobile app launched in FY 2013 had more than 7,000 downloads and 1,800 active users in FY 2014.

Health Topics A-Z/myhealthfinder

As of FY 2014, healthfinder.gov provided over 100 featured topics and tools that use everyday language and examples to explain how taking small steps to improve health can lead to big benefits. The website also includes the myhealthfinder tool, developed in a joint effort with Agency on Health Research Quality, to provide personalized recommendations for clinical preventive services. This interactive tool provides personalized decision support for all of the preventive services covered under the Affordable Care Act. The website has both a content syndication and two Application-Programming Interfaces (API) that provide a way for healthfinder.gov content to be placed onto other websites; in FY 2014 healthfinder.gov content was viewed on other sites approximately 277,000 times, using both tools.

ODPHP continues to play a leadership role in improving health literacy. In FY 2014, the HHS Health Literacy Workgroup developed an Action Plan under the co-leadership of ODPHP and CDC and will continue work on the plan by setting measures and targets in FY 2015. Additionally, ODPHP represents OASH at the Institute of Medicine Roundtable on Health Literacy. In FY 2014, ODPHP assumed a leadership role on the Roundtable by helping develop a Roundtable Workshop on technology, prevention and health literacy planned for FY 2015.

Funding History

Fiscal Year	Amount
FY 2011	$7,200,000
FY 2012	$7,186,000
FY 2013	$6,999,000
FY 2014	$6,999,000
FY 2015	$6,726,000

Budget Request

The FY 2016 President's Budget request of $7,000,000 is $274,000 greater than the FY 2015 Enacted Level. The FY 2016 request allows ODPHP to support disease prevention and health promotion, activities through continued support for: Healthy People, Dietary Guidelines for Americans, Physical Activity Guidelines for Americans, health literacy, and healthfinder.gov. The FTE increase reflects shift in use of contract staff to support program operations to supporting inherently governmental program operations with FTEs.

Healthy People

In FY 2016, ODPHP will conduct a midcourse review of Healthy People 2020 to provide a comprehensive assessment of progress in achieving the national objectives mid-way through the decade and to identify successes and opportunities for improvement. Healthypeople.gov will provide additional interactive tools and resources to facilitate communities' use of evidence-based practices to help move the nation toward achievement of the Healthy People 2020 goals and objectives. These activities will be supported through an ongoing collaboration with the National Center for Health Statistics, other HHS agencies, and other federal Departments that manage Healthy People, including the Departments of Agriculture and Education.

Additionally, in FY 2016 HHS will initiate development of the next decade's objectives, Healthy People 2030, using as a starting point the findings of a Healthy People User's Assessment aimed at garnering feedback from a diverse set of health professionals and policymakers at various levels and across sectors both within and outside of government.

Dietary Guidelines for Americans

Strategic communications activities for the DGA will take place during FY 2016, including the official launch and dissemination of the DGA 2015 policy and accompanying consumer information, internet-based outreach and promotion, and partnership engagement. In FY 2016, work will continue on systematic literature reviews of nutritional needs, eating patterns, and developmental stages of the birth to 24 month age group so that the DGA 2020 will include this age group as well as pregnant women as now required by P.L. 113-79.

Physical Activity Guidelines for Americans

HHS is considering initiating in FY 2016 the development of the 2nd edition of the PAG in response to substantial public and private interest in reviewing the science and providing updated recommendations on the amounts and types of physical activity that can improve health. ODPHP plans to partner with President's Council on Fitness, Sports, and Nutrition; CDC; and NIH in this effort. A new edition of the PAG 2018 would build on the 2008 recommendations with updated scientific evidence. Pending availability of funds, in FY 2016, a PAG Advisory Committee would be appointed, hold two or three of its six public meetings and begin a comprehensive literature review with the goal of developing an Advisory Committee Report by the end of 2017, which would be the scientific basis for the PAG 2018 policy document.

Healthfinder.gov

In FY 2016, ODPHP will collect data for Healthy People 2020 health communication objectives to increase health websites that adhere to specific quality standards, meeting the Healthy People requirement to collect data two-three- times throughout the decade. Data on these objectives show trends of quality, health-related websites and motivate action to improve American's access to reliable and easy- to- use health informationHealthfinder.gov will continue to stay up to date with personalized recommendations for clinical preventive services covered under the Affordable Care Act (ACA) and to provide tools for users to improve their health and their decision making skills related to prevention. Healthfinder.gov will also create new interactive content to remain an informational but engaging website for users to find trusted heath information. Additionally, ODPHP will continue its outreach and partnership building around use of healthfinder.gov's content syndication and API tools, making its content available for free to use on their sites.

ODPHP - Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
I.b Visits to ODPHP-supported websites (Output)	FY 2013: 12.59 Million Target: 17.85 Million (Target Not Met)	6.7 Million[1]	6.93 Million	+0.23 Million
I.c Consumer Satisfaction with healthfinder.gov, measured every three years (Output)	FY 2013: 75% Target: 80% (Target Not Met)	N/A[2]	80%	N/A
II.a Percentage of States that use the national disease prevention and health promotion objectives in their health planning process (Outcome)	FY 2013: 90% Target: 35% (Target Exceeded)	84%	90%	+7%

1 In alignment with the Federal digital strategy, ODPHP's website visits reporting methodology has been changed from using "log files" to "page tagging" resulting in fewer but more meaningful numbers.
2 Baseline data for this measure was collected in FY13; ODPHP will establish performance targets in the FY 2016 budget.

Performance Analysis

ODPHP has a Congressional mandate to provide health information to professionals and the public. ODPHP continues to consolidate and move a substantial amount of program activities online, enhancing the value to the public and professionals. Healthy People, once a paper-based initiative, is now essentially an online resource with multiple interactive tools for tracking and implementing National health objectives (HealthyPeople.gov). The Physical Activity Guidelines for Americans has established an online community for stakeholders. Outreach for the Dietary Guidelines for Americans, for which HHS will have the lead in FY 2015, will be primarily web-based as well. Healthfinder.gov, once a general health information portal, has been redesigned to provide prevention and wellness information supporting the ACA's coverage of preventive services. As the data reflect, ODPHP is increasing its reach and engagement with Americans and exceeding performance targets. As a result the public and professionals have more evidence- based tools, resources, and support for their prevention and wellness activities.

ODPHP expects to continue to grow its online presence over the next two years. Continued funding will allow ODPHP to help Americans be more productive in their prevention and wellness activities by offering social media, interactive learning technologies, data visualization tools, and forums that have proven to increase public and professional engagement. It also allows ODPHP to continue developing user-centered information and websites based on health literacy and plain language principles, extending the reach and impact to those who are not savvy users of health information or the internet. It will also allow ODPHP to continue to offer online professional training, with free continuing education credit, to help participants explore the challenges, successes, and processes involved in creating and sustaining healthier people and communities. All content is evidence based and reviewed by subject matter experts across HHS.

ODPHP expects State use of the national disease prevention and health promotion objectives to continue to increase each year following the launch of Healthy People 2020 in December of 2010 and mirror the uptake of experience seen with the previous decade's objectives—Healthy People 2010. By the end of the last decade, 100% of states used Healthy People 2010 to inform their health planning processes.

Continued funding will allow ODPHP to improve the resources provided to users of Healthy People 2020, provided primarily online via healthypeople.gov and through other social media and electronic means. The online presence of Healthy People will provide access to the latest data for the more than 1,200 national health objectives, making demographic data collected via surveys and surveillance systems from across the Department and other agencies understandable and relevant to a larger number of users. It will also provide a relational database integrating objectives with evidence-based practices and demographic data, which will make implementation significantly more targeted and actionable

Program Data Chart

Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Contracts			
ODPHP Web and Communication Support	1,468,954	2,284,000	1,500,000
Subtotal, Contracts	1,468,954	2,358,000	1,500,000
Grants/Cooperative Agreements			
Disease Prevention and Health Promotion Scholarship Program	200,000	0	0
Subtotal Grants/Coop	200,000	0	0
Inter-Agency Agreements (IAAs)			
Disease Prevention and Health Promotion Scholarship Program[2]	280,000	200,000	280,000
Performance measures collection, outreach management, website infrastructure	60,000	111,000	90,000
Subtotal Inter-Agency Agreements (IAAs)	340,000	311,000	370,0000
Operating Costs	4,990,046	4,131,000	5,130,000
Total	6,999,000	6,726,000	7,000,000

Grants

Grants (whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	1	0	0
Average Award	$200,000	0	0
Range of Awards	--	--	--

PRESIDENT'S COUNCIL ON FITNESS, SPORTS AND NUTRITION

Budget Summary
(Dollars in Thousands)

President's Council on Fitness, Sports, and Nutrition	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	1,215	1,168	2,100	+932
FTE	6	6	8	+2

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The President's Council on Fitness, Sports and Nutrition (PCFSN) was originally established as the President's Council on Youth Fitness by Executive Order 13545. Since inception, the scope of the Council's mission expanded to include nutrition and the name of the organization was changed through an additional Executive Order in June 2010. PCFSN is a federal advisory committee of up to 25 volunteer citizens who serve at the discretion of the President. Its mission is to engage, educate, and empower Americans of all ages, socio-economic backgrounds and abilities to adopt a healthy lifestyle that includes regular physical activity and good nutrition. PCFSN advises the President, through the Secretary, and develops programs and partnerships with the public as well as private and non-profit sectors to promote healthy lifestyles through regular physical activity and good nutrition.

PCFSN coordinates programmatic activities in consultation with offices across the Department of Health and Human Services as well as through the Departments of Agriculture, Defense, State, Education, Interior, and others to highlight the importance of quality physical education and physical activity in schools. The Council's activities and programs are aligned with and support the Department's mission to help provide the building blocks that Americans need to live healthy, successful lives.

President's Challenge Physical Activity, Nutrition, and Fitness Awards Program

The Council promotes the recommendations of HHS' *Healthy People 2020* through continued promotion of and enhancements to its long-standing President's Challenge Physical Activity, Nutrition, and Fitness Awards program (www.presidentschallenge.org/); also known as the President's Challenge. Established in 1966, the President's Challenge provides low-cost, easy-to-use tools for educators, organizational leaders, families, and individuals' use to track fitness, physical activity, and healthy eating. The President's Challenge is administered by Indiana University (IU) School of Public Health—Bloomington\Department of Kinesiology via a co-sponsorship agreement with SHAPE America. It reaches a wide range of individuals through a listserv of approximately 131,000 subscribers. Additionally, the President's Challenge reached an estimated 90,000 health and physical educators through the distribution of its Annual Educator Booklet and other resources. In FY 14, over 300 organizations signed on to promote the mission of PCFSN through programs such as the Presidential Active Lifestyle Award (PALA+) through their networks.

Presidential Youth Fitness Program

Launched in FY 12, the Presidential Youth Fitness Program (PYFP) (www.presidentialyouthfitnessprogram.org) is now the only comprehensive national youth fitness program. PYFP includes resources for physical educators to facilitate proper assessment,

implementation, and recognition for school-aged youth and reporting mechanisms to track and share progress over time. The Council's goal for the program is to reach 90 percent of US public and private schools by 20.

PYFP provides a model for fitness education that includes a health-related fitness assessment, educational tools and recognition items to support a quality physical education curriculum. By using the assessment and related tools, the program seeks to enhance youth fitness and physical activity and, ultimately, improve students' overall health by giving them the knowledge, skills and abilities to do so.

In FY 2014, during the program's second year of implementation, PCFSN:

- Attracted 59,824 unique visitors to the PYFP website.
- Hosted a webinar to train stakeholders on resources available to assess students with disabilities and secured supplemental Brockport Physical Fitness Test resources for schools.
- Received the 2013 Domestic Excellence in Partnering award from the Centers for Disease Control and Prevention (CDC).
- Confirmed second year program renewals for 463 schools, a 91 percent renewal rate.

An estimated 13,500 schools are participating in PYFP with the potential of reaching an estimated 6,750,000 students. Among participating schools, Georgia became the first state to fully implement the program in FY14.

Let's Move! Active Schools

In FY14, PCFSN continued support for the *Let's Move!* Active Schools (LMAS), with public and private sector partners. This sub-initiative focuses on creating active school environments to ensure students achieve at least 60 minutes of physical activity per day. The goal of LMAS is to reach over 50,000 schools across the nation by 2018, adding at least 10,000 schools per academic school year.

In FY14, LMAS:

- Honored 698 schools with the LMAS National Recognition Award.
- Delivered 24 customized professional development training sessions reaching a total of 1,055 Champions.
- Teamed with the NBA, through the NBA FIT initiative, to increase LMAS activations and inventory submissions. Throughout the three-month long promotion, 260 schools opted in and 30 schools enrolled in the program as a result.

Moreover, over 9,000 schools enrolled in LMAS, 16 school districts enrolled 100 percent of its schools in LMAS, and more than 10 other districts are on their way to full district enrollment by the end of FY14.

I Can Do It, You Can Do It!

It is estimated that 56 million Americans have a disability that requires special services. The Council is addressing health disparities through evaluation and implementation of the *I Can Do It, You Can Do It!* (ICDI) program. ICDI facilitates and encourages opportunities for all Americans, regardless of ability, to lead a healthy lifestyle that includes regular physical activity and good nutrition. ICDI previously focused only on youth participation. In FY14 ICDI sites began to onboard, train, and serve people with disabilities in local communities nationwide. The Council's goal is to expand and implement the program in at least 100 sites by 2018. To date in FY14, there are 36 sites on board and PCFSN has engaged over 300 stakeholders in the program.

During FY 2014, PCFSN established a partnership with disability.gov, the U.S. federal government website for information on disability programs and services nationwide. As a result, ICDI is now listed as a resource and a special edition blog was posted to the site. The Council's ICDI program has benefitted from cross-department collaboration with the CDC (e.g., featured in its Physical Activity and Disabilities section) and other operating divisions such as Administration for Children and Families, Administration for Community Living (ACL), National Institutes of Health, and the Indian Health Service, to garner staff expertise and input with respect to the ICDI program manual content.

Joining Forces Fitness Initiative

PCFSN's continued partnership with the American Council on Exercise (ACE) and the International Health, Racquet & Sports-club Association (IHRSA) has provided free fitness benefits for the families of deployed active duty National Guard and Reserve members. In FY 2014, PCFSN evaluated the need for diversifying fitness offerings and expanding the eligibility requirements to include more service members and their families.

In FY 2014, an estimated 430 new personal trainers committed to providing 4,300 new personal training hours through ACE's certification process. In addition, approximately 110 new gyms have been added which equates to 1,110 new gym memberships offered since the start of the fiscal year.

Funding History

Fiscal Year	Amount
FY 2011	$1,225,000
FY 2012	$1,248,000
FY 2013	$1,215,000
FY 2014	$1,215,000
FY 2015	$1,168,000

Budget Request

The FY 2016 President's Budget request of $2,100,000 is $932,000 above FY 2015 Enacted Level. The FY 2016 request enables PCFSN to continue promotion of its programs and initiatives such as the President's Challenge Physical Activity, Nutrition, and Fitness Awards; the Presidential Youth Fitness Program; *Let's Move!* Active Schools; Joining Forces Fitness Initiative; Nutrition Promotions; and, *I Can Do It, You Can Do It!* to help inspire Americans of all ages and abilities to be active, eat well, and get healthy. Each of the Council's programs and initiatives are aligned with and support the Department's mission to help provide the building blocks that Americans need to live healthy, successful lives.

PCFSN will continue to work with the Office of Disease Prevention and Health Promotion to implement and expand adoption of the *Physical Activity Guidelines for Americans* (PAG) and the PAG Midcourse Report. This effort will include a national outreach strategy to create, increase, and improve multi-component opportunities for youth (ages 3 – 17) to be physically active each day where they live, learn, and play.

At the FY16 requested level, PCFSN will bring on two additional staff to support the Council's priorities and programs. The additional staff will be critical to the success of the Council's overall operations as well as the advancement and promotion of its mission.

These activities are vital to the Council's legacy as a federal advisory committee and will enable the Department to chronicle the accomplishments to address the public health and human services needs of the American people to enhance physical activity, sports participation, and good nutrition.

PCFSN - Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
8.1 Percentage of the Department of Education's Physical Education Program (PEP) grantees adopting the Physical Activity Guidelines (PAG)	FY 2013: 31% of students served by the PEP grant engage in 60 minutes of daily physical activity (Baseline)	90% percent of students served by the PEP grant engage in 60 minutes of daily physical activity	90% of students served by the PEP grant engage in 60 minutes of daily physical activity	0
8.2 Number of website visits to the PAG or PAG Midcourse Report including downloads of collateral material (e.g. PAG info-graphic)	FY 2013: 1,380,000 (Baseline)	1,800,000	800,000	-1,000,000
8.3 Number of social media impressions promoting the PAG or PAG Midcourse Report (e.g., Facebook, Twitter)	FY 2013: 275 million media impressions (Baseline)	300 million media impressions	100 million media impressions	-200 million

Performance Analysis

The PCFSN performance measures track the national engagement strategy to promote and ensure the widespread adoption of HHS' 2008 *Physical Activity Guidelines for Americans* (PAG) and the PAG Midcourse Report released in December 2012. To meet the PAG recommendations for youth and adults, PCFSN increased its target for the number of the Carol M. White Physical Education Program (PEP) grant recipients that will provide opportunities for all students to participate in at least 60 minutes of moderate-to-vigorous physical activity per day from 85 percent in FY 2014 to 90 percent in FY15. PCFSN will maintain this target level into FY16. The target decreases to measures 8.2 and 8.3 represents the normalization of website visits and social media impressions after the initial release of the PAG Mid-Course Report.

Beginning in FY15, the Council will revisit all performance measures to determine how best to accurately capture its direct outreach to schools, colleges/universities, and community organizations for assessment of students' fitness levels, school-based physical activities, as well as increased access and opportunities for children and adults with disabilities.

OFFICE FOR HUMAN RESEARCH PROTECTIONS

Budget Summary
(Dollars in Thousands)

Office of Human Research Protections	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	6,756	6,493	6,800	+307
FTE	33	33	33	0

Authorizing Legislation: .....Title III, Section 301 of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal, Contracts, and Other

Program Description and Accomplishments

The Office for Human Research Protections (OHRP) is the lead federal office for ensuring the integrity of the clinical research enterprise related to the protection of human research subject volunteers. OHRP has oversight over more than 10,000 institutions in the US and world-wide, which conduct clinical and other research. This oversight includes research funded or conducted by the National Institutes of Health (NIH), and is based on statutory authority (42 U.S.C. 289.)

OHRP's mission is to assure that the well-being of volunteers is strongly protected and ensure that any harm, real or perceived, does not negatively impact the pool of volunteers for scientific studies and clinical research trials, delay the outcome of study results or prevent them altogether. OHRP's mission plays a crucial role in supporting the Secretary's Strategic Initiative to Accelerate the Process of Scientific Discovery to Improve Patient Care, and the strategy under that objective to support comprehensive and efficient regulatory review of new medical treatments.

Regulatory Reform

In FY 2014, OHRP collaborated with other HHS OPDIVs, the Office of Science and Technology Policy (OSTP), and other federal agencies to develop a notice of proposed rulemaking (NPRM), which is part of the process of revising regulations and is designed to strengthen protections and adjust the regulatory system to changes in the evolving research enterprise. The changes in the regulations will help reform the current system so as to avoid inappropriate delays in the advancement of medical knowledge. This NPRM is built on work completed in 2011, which enabled HHS, in coordination with OSTP, to publish an advance notice of proposed rulemaking (ANPRM) *titled Human Subjects Research Protections: Enhancing Protections for Research Subjects and Reducing Burden, Delay, and Ambiguity for Investigators*.

Office Structure and Objectives

OHRP consists of the Office of the Director, the Division of Compliance Oversight, the Division of Policy and Assurances, and the Division of Education and Development. The Division of Compliance Oversight evaluates written substantive indications of non-compliance with HHS regulations (45 CFR 46), conducts inquiries and investigations into alleged non-compliance, carries out not-for-cause surveillance evaluations of institutions, and responds to incident reports from Assured institutions. The Division of Policy and Assurances develops guidance explaining and interpreting the regulations, and administers a system for the filing of Federal-wide Assurances of research institutions and the registration of Institutional Review Board organizations. The Division of Education and Development develops educational materials and conducts educational activities including sponsored Research Community

Forums, Quality Assessment Workshops and other audience-specific educational workshops, meeting presentations, educational videos, webinars, and educational assistance to constituents through phone calls and emails, to promote, inform and educate research communities and the public on the protection of human subjects in research and the HHS regulations and policies that support this goal. OHRP also supports the Secretary's Advisory Committee on Human Research Protections (SACHRP).

OHRP activities contribute directly to Goal 2 of the HHS Strategic Plan, *Advance Scientific Knowledge and Innovation.* Scientific and biomedical research will only continue so long as the rights and welfare of human subjects in scientific and biomedical research are protected, so that people continue to trust the research community and agree to participate in research in sufficient numbers.

OHRP supports the OASH/HHS strategic goals by contributing to the following measures:

- Increase the number of local, state, and national health policies, programs, and services that strengthen the public health infrastructure, and the number of policies in research institutions that improve the research enterprise.
- Increase the reach and impact of OASH communications related to strengthening the public health and research infrastructures.
- Increase the number of substantive commitments to strengthening the public health and research infrastructure on the part of governmental and non-governmental organizations.
- Increase knowledge about the public health and research infrastructure, including research needs, and improve data collection needed to support public health decisions.

Funding History

Fiscal Year	Amount
FY 2011	$6,949,000
FY 2012	$6,937,000
FY 2013	$6,756,000
FY 2014	$6,756,000
FY 2015	$6,493,000

Budget Request

The FY 2016 President's Budget Request of $6,800,000 is an increase of $307,000 above the FY 2015 Enacted Level. The FY 2016 request will restore to OHRP $263,000 as well as allow the office to reestablish full program operations and to continue educational activities at the establish level, including conducting public outreach and education programs to promote and enhance public awareness of the activities of human subject protections.

The proposed request will support the following activities in FY 2016:

- Providing three Research Community Forums, four Quality Assessment Workshops, one Annual OHRP conference, four audience-specific educational workshops, numerous meeting presentations as well as development and improvement of OHRP online educational and informational resources that comprise online training programs, webinars and videocasts
- Supporting the processing of more than 3,300 Institutional Review Board Registrations, approving over 4,000 Federal wide Assurances of Compliance, and issuing two Federal Register Notices in compliance with the requirements of the Paperwork Reduction Act of 1995
- Issuing two Guidance documents

- Opening three Division of Compliance Oversight not-for-cause evaluations of institutions' human subject protections program, and processing more than 600 incident reports from institutions, which include reports of any unanticipated problems involving risks to subjects or others, any serious or continuing noncompliance with the regulations or the requirements or determinations of the institutional review board (IRB), and any suspension or termination of IRB approval
- Supporting three Secretary Advisory Committee on Human Research Protections (SACHRP) meetings and three to four meetings of SACHRP's subcommittees

NATIONAL VACCINE PROGRAM OFFICE

Budget Summary
(Dollars in Thousands)

National Vaccine Program Office	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	6,659	6,400	6,000	-400
FTE	17	17	17	0

Authorizing Legislation: .....Title XXI of the Public Health Service Act
FY 2016 Authorization.....Expired
Allocation Method.....Direct Federal; Contracts

Program Description and Accomplishments

In 1987, Congress created the National Vaccine Program Office (NVPO) to provide leadership and coordination on vaccine-related activities among federal agencies and non-federal stakeholders (state and local government, non-governmental health groups, healthcare providers, health insurers, vaccine manufacturers and the public). NVPO also advances the Secretary's priority on disease prevention by promoting public health through the optimization of the immunization system in the United States. This critical work improves the lives of many by reducing premature deaths, preventing illnesses and hospitalizations, and curtailing lost work and school days in the United States and around the world.

NVPO leads the coordination of immunization activities to ensure they are carried out in an efficient and consistent manner. These federal activities align directly to the National Vaccine Plan, which dictates the framework—goals, objectives, and strategies—for pursuing the prevention of infectious diseases through immunizations. This includes federal government efforts towards vaccine research and development, coverage, supply, financing, safety, education and communications, and international vaccine and immunization initiatives. Likewise, NVPO works with non-federal partners to develop and implement strategies for achieving the highest possible level of prevention of vaccine-preventable diseases and adverse reactions to vaccines.

FY 2014 highlights of NVPO activities include:

Coordination and Implementation of the National Vaccine Plan

The National Vaccine Plan identifies priority activities to improve the safety and effectiveness of disease prevention through immunization. In September 2012, NVPO released the National Vaccine Plan Implementation Plan, which identified the key indicators that will be used to measure progress on the National Vaccine Plan going forward. NVPO managed the development of the National Vaccine Plan Annual Report in FY 2014 with input from interagency partners.

National Vaccine Advisory Committee (NVAC)

NVPO serves as Executive Secretariat for NVAC which advises and makes vaccine-related recommendations to the Assistant Secretary for Health. Their work has included the development of a set of Standards for Adult Immunization Practices that have been widely adopted by the immunization and provider communities, publishing a comprehensive report on HHS roles in global immunization, and providing an analysis and recommendations for overcoming patient and provider barriers to maternal immunizations. Currently, the NVAC is developing recommendations for overcoming barriers to

developing new vaccines for use in pregnant women, improving HPV vaccine coverage among adolescents, and addressing vaccine hesitancy/confidence in parents of young children.

Adult Immunization
Reducing vaccine-preventable diseases in adults is a national health priority. Adult vaccination coverage rates remain low for most routinely recommended vaccines and fall well below Healthy People 2020 targets. NVPO leads the development of a National Adult Immunization Plan which is national in scope and that will identify priority areas for program efforts and establish targets for performance indicators. NVPO will also generate an implementation plan outlining discrete activities with measurable milestones to monitor progress on improving adult immunization. NVPO leads the coordination of the Assistant Secretary for Health's Adult Immunization Task Force designed to support adult immunization activities and collaboration among our federal partners.

Vaccines Financing, Coverage, and the Affordable Care Act
NVPO leads a cross-agency vaccine policy team to track and monitor Affordable Care Act implementation of vaccine-specific provisions. This includes the development of Affordable Care Act training models for healthcare providers in collaboration with CMS. NVPO has financing research underway to ensure sustainable funding for vaccines over the longer term. NVPO also coordinates with interagency and external partners on vaccine financing and its implications for access and vaccine coverage rates.

Coordination and Enhancement of Immunization Safety
NVPO continues to lead the Secretary's cross-government Federal Immunization Safety Task Force. The Task Force includes HHS OPDIVs with assets in immunization safety along with Department of Veterans Affairs and Department of Defense. It is charged with ensuring that all federal assets relevant to immunization safety are coordinated and synergies identified, coordinating vaccine safety strategic planning, including the development of a vaccine safety scientific.

Pertussis Coordination
The resurgence of pertussis, or whooping cough, has required a broad examination of the root cause(s) of the problem. NVPO co-sponsored a one-day workshop in collaboration with the Infectious Diseases Society of America, the Pediatric Infectious Disease Society, and the National Foundation for Infectious Diseases to examine this problem. The discussions and recommendations from this meeting were published in a special supplement of the Journal of Infectious Diseases in March 2014.

Vaccine Communication
NVPO works with HHS OPDIVs and STAFFDIVs to ensure that communication strategies and tactics are coordinated and leveraged to the fullest extent possible. Key activities include operating vaccines.gov and working to re-establish a Spanish-language version of the site, supporting public education activities, establishing and maintaining strong working relationships with communications staff from across the Department, and providing strategic counsel to senior leaders. NVPO and the office of the Assistant Secretary for Public Affairs led an interagency group to refine internal communications related to emerging vaccine-related issues (e.g., vaccine shortage, vaccine safety signal, etc.), which has provided valuable lessons for improved communication and coordination going forward.

Vaccine Research and Development Priorities
The National Vaccine Plan calls for the development of a catalogue of priority vaccine targets of domestic and global health importance. In support of this, NVPO backs a multiphase project conducted

by the Institute of Medicine known as the SMART Vaccines tool, designed to provide decision support in vaccine development in United States and global populations. The goals of this collaboration include:

- provision of capabilities to transform the existing SMART Vaccines' tool into a web-based platform (html open-source model) that can be supported and sustained for public access,
- iterative adaptation and refinement of the tool—or suite of tools—so that it is responsive to the dynamic and emerging information/inputs (e.g., disease burden, antigen-specific technology, and economic data),
- expansion and updating of the data warehouse (model supporting data) and standardized formats for data sharing,
- dissemination and use of the tool (and/or derivative tools) supported by direct engagement and training of the public sector, academic, and private sector stakeholders and decision-makers associated with vaccine development, purchasing, and deployment/implementation programs, .

Health Information Technology and Immunizations
Immunization Information Systems, continue to surface as a critical means to improve uptake and tracking of adult immunization. NVPO requested that HHS partners and others focus on the functionality and use of immunization information systems to improve vaccine and vaccination tracking. NVPO's goal is to develop a pilot project in FY15 for better transmission of information across state and institutional lines within Washington, D.C., Maryland, and Virginia Departments of Health.

Funding History

Fiscal Year	Amount
FY 2011	$6,839,000
FY 2012	$6,837,000
FY 2013	$6,659,000
FY 2014	$6,659,000
FY 2015	$6,400,000

Budget Request

The FY 2016 President's Budget Request of $6,000,000 is $400,000 less than the FY 2015 Enacted Level. The reduction will be accomplished primarily through absorption of previously funded activities within the base budget. The FY 2016 Budget Request will continue to maximize the impact of vaccines on the health of the United States population, advance the priorities of the NVAC, examine evidence-based practices relating to prevention with a particular focus on high-priority areas translate interventions from academic settings to real world settings, and meet the objectives of the HHS Strategic Plan to reduce the occurrence of infectious diseases, which include vaccine-preventable diseases.

NVPO will lead the following initiatives/projects in FY 2016:

- **Individual Access to Immunization Information Systems/Registry*:*** NVPO and the Office of the National Coordinator will partner to undertake projects focusing on interstate data exchange of immunization data in order for providers to have access to the full immunization record of the patient allowing for improved care.
- **Vaccines Finder**: This initiative will support technical enhancements and upgrades to the Health Map Vaccine Finder to ensure the website remains consumer friendly. This initiative will also assist with recruiting new providers, coordinate the participating provider data, and ensure providers regularly update information in the tool.

- **Vaccines.gov**: The goal of this project is to create, maintain, and enhance a comprehensive HHS website devoted to vaccines and immunization, and to host and maintain a Flu Vaccination Mapping program. This collaboration between NVPO, Center for Disease Control, and the Assistant Secretary for Public Affairs will provide consumers and stakeholders with one place to obtain information about the development, testing, licensing, supply, and safety of vaccines, and the risks and benefits of immunizations.

- **Researching Vaccine Confidence:** The NVAC working group seeks to better understand the influences on vaccination decision-making and to produce evidence-based, tested messaging in order to increase public awareness of the benefits and risks of vaccines, and increase the public's confidence of vaccine safety.

OFFICE OF ADOLESCENT HEALTH

Budget Summary
(Dollars in Thousands)

Office of Adolescent Health	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	1,500	1,442	1,500	+58
FTE	4	4	6	+2

Authorizing Legislation: ……..Section 1708 of the Public Health Service Act
FY 2016 Authorization……Expired
Allocation Method……..Direct Federal, Competitive Grants, Contracts

Program Description and Accomplishments

The Office of Adolescent Health (OAH) is responsible for coordinating the activities of the Department with respect to adolescent health, including program design and support, evaluation, trend monitoring and analysis, research projects, training of healthcare professionals, and national planning. OAH is charged with carrying out demonstration projects to improve adolescent health as well as implementing and disseminating information on adolescent health. OAH coordinates with other HHS agencies to reduce the health risk exposure and risk behaviors among adolescents, placing particular emphasis on the most vulnerable populations (i.e., those in low socio-economic areas and areas where adolescents are likely to be exposed to emotional and behavioral stress). In 2012, the office developed OAH's first Strategic Plan for FY 2012-2015 laying out strategic priorities which will advance best practices and improve the health and healthy development of America's adolescents, as well as specifying objectives and action steps. OAH leads the HHS Adolescent Health work group, which brings together representatives from across the Department to strategically plan across adolescent health and related programs.

OAH also administers the Teen Pregnancy Prevention (TPP) discretionary grant program and the Pregnancy Assistance Fund through separate appropriations. The TPP supports evidence-based and innovative approaches to teen pregnancy prevention. PAF supports competitive grants to States and Tribes to support pregnant and parenting teens and women.

OAH is engaging national partners from health care, public health, education, community and after-school programs, faith-based groups, and social services, to develop a shared agenda for putting adolescent health firmly on the nation's agenda to prevent risky behavior, promote health, and prevent disease. OAH is developing a national action-oriented agenda, Adolescent Health: Think, Act, Grow (TAG), which will provide a framework for youth-serving professionals and organizations to support young people during their second decade of life when bodies, minds, and emotions are changing rapidly and many opportunities for prevention and healthy development are missed. OAH will provide national partners, professionals, and families with ongoing access to tools and resources from across government on line and through ongoing communications and dissemination.

Funding History

Fiscal Year	Amount
FY 2011	$1,098,000
FY 2012	$1,098,000
FY 2013	$1,070,000
FY 2014	$1,442,000
FY 2015	$1,442,000

Budget Request

OAH's FY 2016 Budget Request of $1,500,000 is $58,000 above the FY 2015 Enacted Level. The FY 2016 request will restore funds reduced in FY 2015 to support the Adolescent Health Indicators Report. The funding level will allow OAH to continue its efforts to reduce the health risk exposure and risk behaviors among adolescents and coordinate program efforts with key government and non-government stakeholders. This includes support for an OAH initiative, Adolescent Health: Think, Act, Grow (TAG) and expanding program activities to include a broader awareness building campaign to engage additional organizations, families, and adolescents in supporting adolescents' health and healthy development. The FY 2016 request provides for two additional staff to support the development and implementation of the 2016-2021 OAH strategic plan as well as the TAG initiative.

PUBLIC HEALTH REPORTS

Budget Summary
(Dollars in Thousands)

Public Health Reports	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	486	467	400	-67
FTE	2	2	2	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal Contract; Cooperative Agreement

Program Description and Accomplishments

Public Health Reports (PHR) is the official journal of the U.S. Public Health Service and the Office of the Surgeon General, and has been published since 1878. Its mission is to serve as an informative and accessible resource linking science to practice for public health practitioners, researchers, scholars, and policy makers by publishing important research and presenting key discussions on the major issues confronting the public health community.

Public Health Reports is published six times per year online and in print (see http://www.publichealthreports.org/). In addition, each year, three or more supplements or special issues are published and two to three science-based webcasts are produced. PHR supplements bring focus to topics of interest to the public health community. Supplements published to date in 2014 have included: *HHS National Vaccine Program and Global Immunization: NVAC Report and Recommendations; Nursing in 3D: Workforce Diversity, Health Disparities, and Social Determinants of Health*; and *Program Collaboration and Service Integration in the Control of HIV Infection, Viral Hepatitis, STDs, and Tuberculosis in the United States*.

PHR supports the Secretary's Strategic Initiatives by accelerating the process of scientific discovery to transform health care, specifically to advance scientific knowledge and innovation, and advance the health, safety, and well-being of the American people.

Funding History

Fiscal Year	Amount
FY 2011	$448,000
FY 2012	$499,000
FY 2013	$486,000
FY 2014	$486,000
FY 2015	$467,000

Budget Request

The FY 2016 President's Budget request of $400,000 is $67,000 less than the FY 2015 Enacted Level. The FY 2016 request will consolidate technical and copy editing activities as well as targeted marketing and outreach. PHR will continue to work through existing program partners for journal production including,

journal design and layout, management of online manuscript submission, technical editing, and publishing consultation.
In FY 2016, *Public Health Reports* plans to publish six regular issues, plus supplements and/or special issues; and plans to produce two to three science-based webcasts.

TEEN PREGNANCY PREVENTION

Budget Summary
(Dollars in Thousands)

Teen Pregnancy Prevention	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	100,726	101,000	104,790	+3,790
FTE	0	0	16	+16

Authorizing Legislation: .....Section 4002 of the Affordable Care Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct federal, Contract, Grants

Program Description and Accomplishments

The Teen Pregnancy Prevention (TPP) program is a discretionary grant program to support evidence-based and innovative approaches to teen pregnancy prevention. It is administered by the Office of Adolescent Health (OAH) within the Office of the Assistant Secretary for Health. OAH leads coordination of program activities among the Department of Health and Human Services (HHS) offices and operating divisions. The TPP program is a key component of the Secretary's strategic initiative for Reducing Rates of Teen Pregnancy, Sexually Transmitted Infections, and Associated Sexual Risk Behaviors to Put Children and Youth on the Path for Successful Futures.

Competitive grants and contracts supported through TPP are awarded to public and private entities to fund medically accurate and age appropriate programs that reduce teen pregnancy and support the Federal costs associated with administration and evaluation of program activities. Additionally, the grants support both the replication of evidence-based program models identified by HHS through an independent systematic review to have proven through rigorous evaluation to prevent teen pregnancy and/or associated sexual risk behaviors, and demonstration programs to identify new effective approaches.

Grants for replication of evidence-based program models provide capacity building assistance to organizations to replicate evidence-based program models as well as support to organizations to replicate evidence-based program models to scale in communities with demonstrated need. Additionally, a contract supports the rigorous evaluation of evidence-based program models and is designed to fill significant gaps in the existing knowledge base.

Grants for demonstration programs within TPP support early innovation as well as grants to develop, refine, and rigorously evaluate additional models and innovative strategies for preventing teen pregnancy. OAH partners with the Assistant Secretary for Planning and Evaluation (ASPE) to support an ongoing review of the teen pregnancy prevention evidence-base. OAH also collaborates with ASPE, the Administration for Children and Families (ACF), and the Centers for Disease Control and Prevention (CDC) to coordinate programmatic and evaluation training and technical assistance activities for grantees. In FY 2015, OAH will select a new cohort of TPP grantees through a competitive application and objective review process. The FY 2016 request will support the second year of the new cohort of grantees.

OAH manages a performance measurement system for all TPP grantees. Each year, TPP grantees reach over 140,000 youth in 39 States and the District of Columbia and partner with over 1,800 organizations.

Of the individuals served by TPP grantees, 52% of the youth are female and 48% are male; the majority are age 16 and under; 36% are Hispanic/Latino, 31% are Black, non-Hispanic, and 24% are White, non-Hispanic. OAH grantees implement evidence-based programs with high fidelity (95% of all activities implemented as intended) and high quality (94% of all sessions rated as either very good or excellent by an observer), and show high rates of youth engagement and retention with 80% of youth served receiving at least 75% of the program. High fidelity, quality, and attendance are essential to ensuring that youth served experience the outcomes expected from receiving an evidence-based program. Furthermore, in 2013, a white paper developed independently by the Bridgespan Group, a nonprofit organization, identified the OAH TPP program as a model for implementing evidence-based programs with fidelity and quality.

OAH provides ongoing training and technical assistance to its TPP grantees to ensure high quality programming and evaluation. OAH also maintains the TPP Resource Center, an online collection of resources for professionals working to prevent teen pregnancy. The TPP Resource Center includes resources on choosing an evidence-based program; improving recruitment, retention, and engagement; implementation; engaging diverse populations; strategic communications; building collaborations; sustainability; and performance measurement and evaluation. Along with skill-building information, the TPP Resource Center also features success stories describing some of the accomplishments of the TPP grantees.

Funding History

Fiscal Year	Amount
FY 2011	$0
FY 2012	$0
FY 2013	$101,000,000
FY 2014	$100,726,000
FY 2015	$104,790,000

Budget Request

The FY 2016 Budget request of $104,790,000 is $3,790,000 above the FY 2015 Enacted Level funded through the Department's General Departmental Management (GDM) account. This funding level includes a restoration of $726,000 which will allow the program to fund the second year of TPP grantees competitively selected in FY 2015; provides program support for the grantees, including reviewing materials for medical accuracy and providing programmatic and evaluation training and technical assistance; and covering program operating costs. The increase in funding will allow OAH to fund additional grantees to replicate evidence-based teen pregnancy prevention programs and develop and test new and innovative approaches to prevent teen pregnancy.

It is anticipated that not more than 10 percent will be used for operational costs associated with running the program and providing support services to the grantees. Of the remaining funds, OAH intends to award 75 percent of the funds to support grants to replicate evidence-based program models identified by HHS through an independent systematic review of the existing research, and 25 percent to test new and innovative approaches to teen pregnancy prevention.

Contracts:

- **Rigorous Evaluation of Evidence-Based TPP Programs:** The purpose of the Rigorous Evaluation of Evidence-Based TPP Programs contract is to evaluate up to six new rigorous evaluations of

the replication of evidence-based TPP programs. Evaluations will be designed to fill significant gaps in the current knowledge base, and may include evaluating evidence-based TPP programs that are commonly implemented in the field but have only a single evaluation supporting them, identifying core components or key ingredients of evidence-based TPP programs, and testing important implementation science topics to learn more about how to best implement evidence-based TPP programs.

- **TPP Medical Accuracy**: The purpose of the Medical Accuracy contract is to provide assistance to OAH by providing rigorous reviews of curricula and materials used in TPP grant programs to ensure they are medically accurate. The program statute requires that all materials used in the TPP program be medically accurate. As a condition of their grant, OAH TPP grantees are required to submit all curricula materials proposed for use in their TPP funded grant to the OAH for review prior to implementation to ensure medical accuracy.
- **TPP Training and Technical Assistance**: The purpose of the TPP Training and Technical Assistance contract is to provide training and technical assistance to TPP grantees to ensure implementation and sustainability of high quality teen pregnancy prevention programs. The contract includes providing grantees with technical assistance products and individualized technical assistance, conducting trainings for grantees, convening grantee project director meetings, securing the services of expert and technical consultants, and coordinating training for grantees on evidence-based programs.
- **TPP OAH Strategic Communications**: The purpose of the OAH Strategic Communications contract is to support effective communications on adolescent health, the OAH website, social media, and special events, such as for Teen Pregnancy Prevention Month. The contract maintains and updates the TPP Resource Center and provides information on evidence-based TPP programs and evaluation.

TPP - Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
9.1 Number of youth served by the TPP Program	FY 2014: 140,032 Target: 121,196 (Target Exceeded)	121,196	40,000	-81,196
9.2 Number of TPP Program formal or informal partners	FY 2014: 1,803 Target: 1,762 (Target Exceeded)	1,762	1,800	+38
9.3 Number of Intervention Facilitators provided new or follow-up training	FY 2014: 3,274 Target: 3,709 (Target Not Met)	3,709	3,700	-9
9.4 Percent of youth receiving at least 75% of available TPP programming[3]	FY 2014: 80% Target: 80% (Target Met)	80%	80%	+0%
9.5 Mean percentage of the evidence-based model being implemented as intended	FY 2014: 95% Target: 80% (Target Met)	95%	95%	+0%

[3] Measure changed to percentage from whole number.

Performance Analysis

In FY 2014, the Teen Pregnancy Prevention Program served over 140,000 youth with evidence-based programs and promising strategies to reduce teen pregnancy. In total, one hundred and two grantees partnered with over 1,700 organizations and trained over 3,700 people to deliver the TPP programs. Ninety-five percent of the programs are being delivered with fidelity to the original model by the grantees. The TPP program expects these results to remain steady as the current cohort of TPP grantees complete implementation on August 31, 2015.

A new cohort of competitive grant awards will be made by the end of FY 2015. The new cohort of grantees will engage in a planning, piloting, and readiness period of up to 12 months during the first year of their grant. As a result, OAH anticipates a decrease in the number of youth served and number of youth receiving at least 75 percent of available TPP programing for the FY 2016 targets as this data will reflect the new cohort of grantees' planning and piloting period. FY 2016 funds will support the second year of funding for the new grantees and their first year of full implementation. It is expected that the new cohort of grantees will increase their reach to at least the current performance levels by their second year of funding.

Program Data Chart

Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Contracts			
Training, technical assistance , and other program support	1,600,000	1,783,403	2,270,000
Rigorous Evaluation of Evidence-Based TPP Programs contract*	-	5,000,000	5,000,000
Subtotal, Contracts	1,600,000	6,783,403	7,270,000
Grants/Cooperative Agreements			
Tier I – Replication Projects	71,926,000	65,135,963	68,500,000
Tier II – Research and Demonstration Projects	24,000,000	23,890,000	24,500,000
Subtotal, Grants/ Cooperative Agreements	95,926,000	89,025,963	93,000,000
Operating Costs	3,200,000	5,190,634	4,520,000
Total	100,726,000	101,000,000	104,790,000

Grants

Grants (whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	101	92	98
Average Award	$949,762	$967,674	$948,980
Range of Awards	$400,000-$4,000,000	$400,000-$2,000,000	$400,000-$2,000,000

OFFICE OF MINORITY HEALTH

Budget Summary
(Dollars in Thousands)

Office of Minority Health	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	56,516	56,670	56,670	0
FTE	63	57	65	+8

Authorizing Legislation: .....Title XVII, Section 1707 of the PHS Act
FY 2016 Authorization.....P.L. 111-148; Expires 2016
Allocation Method.....Direct federal, Competitive Grant and Cooperative Agreement, Contract

Program Description and Accomplishments

The Office of Minority Health (OMH) was created in 1986 as one of the most significant outcomes of the 1985 *Secretary's Task Force Report on Black and Minority Health*. OMH was subsequently established in statute by the Disadvantaged Minority Health Improvement Act of 1990 (PL 101-527), re-authorized under the Health Professions Education Partnerships Act of 1998 (PL 105-392), and most recently re-authorized under the Affordable Care Act of 2010 (PL 111-148).

OMH Mission and Vision

- OMH's mission is to improve the health of racial and ethnic minority populations through the development of policies and programs that help eliminate disparities.
- OMH's vision is to change health outcomes for racial and ethnic minority communities through leadership that strengthens coordination and impact of HHS programs and actions of communities of stakeholders across the United States.

OMH serves as the lead agency for coordinating efforts across the government to address and to eliminate health disparities. OMH convenes and provides guidance to HHS operating and staff divisions and other Federal departments to identify health disparity and health equity policy and programmatic actions. This targeted leadership improves performance through better coordination on cross-cutting initiatives, minimizes programmatic duplication, and leverages funds to reduce health disparities.

OMH Strategic Priorities

OMH focuses on translating core minority health and health disparity programs into strategic activities and policies at the federal, state, tribal, territorial, and local levels. OMH's three strategic priorities are:

- Supporting the development and implementation of the provisions of the Affordable Care Act that address health disparities and equity *(a statutorily mandated program)*
- Leading the implementation of the HHS Action Plan to Reduce Racial and Ethnic Health Disparities *(a cross-departmental collaboration)*
- Coordinating the National Partnership for Action to End Health Disparities *(a cross-governmental, cross-sector collaboration)*

OMH plays a critical role in supporting and implementing the provisions of the Affordable Care Act that address health disparities and equity. Racial and ethnic minorities have the highest rates of being uninsured, are less likely to receive preventive care, have higher rates of many chronic conditions, have fewer treatment options, and are less likely to receive quality health care. Educational outreach serves to raise the awareness of minority and underserved populations about the Affordable Care Act and to

support increased enrollment of underserved populations in health plans. OMH collaborates with strategic partners and stakeholders to increase the understanding of health plans, benefits, and eligibility as well as increase access to Health Insurance Marketplace enrollment services for racial and ethnic minorities and underserved populations.

OMH also leads and coordinates the implementation of the National Partnership for Action to End Health Disparities (NPA), whose mission is to increase the effectiveness of programs that target the elimination of health disparities through the coordination of partners, leaders, and stakeholders committed to action. The NPA promotes cross-cutting, multi-sector, and systems-oriented approaches to eliminate health disparities by coordinating the efforts of the four NPA implementation arms: the Federal Interagency Health Equity Team (FIHET), the 10 Regional Health Equity Councils (RHECs), the State and Territorial Offices of Minority Health, and National Partners. These implementation partners provide the leadership, community connection, and cross-sector representation necessary to address health disparities. OMH provides guidance and technical assistance for the activities of the implementation partners to maximize their effectiveness and ensure alignment with the goals outlined in the *National Stakeholder Strategy*.

FY 2014 Accomplishments

OMH promotes integrated approaches, evidence-based programs, and best practices to reduce health disparities. The FY 2014 accomplishments are organized by the HHS FY2014-2018 Strategic Goals (although many support multiple goals), illustrating OMH's commitment to enhancing and assessing the impact of all policies and programs on racial and ethnic health disparities.

Strategic Goal 1: Strengthen Health Care

Key accomplishments in FY 2014 include:

- Through OMH leadership the **HHS Disparities Action Plan** supported:
  - Development of the Health IT Disparities Plan,
  - Development of the oral health e-learning curriculum on cultural competency to assist oral health providers caring for diverse populations, and
  - Collaboration and coordination with CMS to develop and disseminate culturally-competent materials to support Affordable Care Act outreach and enrollment efforts.
- OMH's **Center for Linguistic and Cultural Competency in Health Care (CLCCHC)** supported:
  - The launch of a new e-learning program for oral health professionals and the development of an e-learning program for Promotores de Salud (in progress).
  - Think Cultural Health (TCH) registered 29,299 new participants in the four e-learning programs (for physicians, nurses, disaster response personnel, and oral health professionals). The programs awarded approximately 880,000 continuing education credits in FY 2014. This brings the cumulative total of registrants for these e-learning programs since their inception to the end of FY 2014 to 173,440.
- OMH furthered the adoption, implementation, and evaluation of the **National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)** by supporting:
  - Studies related to the identification and provision of the National CLAS Standards in health care such as the Joint Commission's recently released 2015 Standards for the Hospital Accreditation Program. Several of the Standards' requirements overlap with the intent and objectives of the National CLAS Standards.

Strategic Goal 2: Advance Scientific Knowledge and Innovation

Key accomplishments in FY 2014 include:

- A continuing partnership between OMH and the National Center for Health Statistics (NCHS) in support of the Native Hawaiian and Pacific Islander (NHPI) National Health Interview Survey (NHIS) aims to address the persistent lack of data for this small and hard to reach population. This project supports the HHS Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and Disability Status required by Section 4302 of the Affordable Care Act. Data from the NHPI NHIS are expected to be available summer 2015.
- OMH produced the data brief "Characteristics of Uninsured Males by Race and Ethnicity (Ages 18-64 years)" in June 2014. This data brief was one of the first briefs produced by the Department that details socio demographic information specifically about uninsured men of color.
- The **HHS American Indian and Alaska Native (AI/AN) Health Research Advisory Council (HRAC)** supported:
    - Submission of recommendations to HHS on issues of concern from the tribal communities including: Tribal Epidemiology Centers being recognized as public health authorities; and research topics such as suicide prevention, chronic disease risk factor reduction, and methamphetamine prevalence/prevention.
    - Development of an Annual Health Research Report that includes summaries of various HHS research projects focusing on AI/ANs used as a resource to share research findings, topics, and available federal programs with tribes.

Strategic Goal 3: Advance the Health, Safety, and Well-Being of the American People

Key accomplishments in FY 2014 include:

- The **Office of Minority Health Resource Center (OMHRC)** supported:
    - National Minority Health Month (theme – Prevention is Power: Taking Action for Health Equity) in April 2014, achieving more than 389 media hits, and media outlets with OMH-related coverage received approximately 45.3 million unique visitors. The Minority Health Month "*Let's Talk Prevention Twitter Relay*" reached an estimated audience of 2 million.
    - Capacity building training to public health offices, community based organizations and associations, including conducting three webinars and supporting individually based training for more than 1,100 health care professionals in 21 community organizations, and across 9 HHS Regions.
- The **American Indian and Alaska Native (AI/AN) Health Disparities Program** supported:
    - Distribution of over 5,390 culturally and linguistically appropriate written educational materials through outreach in the community, at health fairs and exhibit booths.
- The **Curbing HIV/AIDS Transmission Among High Risk Minority Youth and Adolescents (CHAT) Project** supported:
    - Grantees providing HIV prevention education, counseling/testing, and social services (via peer-to-peer outreach models and social media) to nearly 22,500 high risk minority youth.
- The **HIV/AIDS Health Improvement for the Re-entry Population Demonstration Program (HIRE) Project** supported:
    - Grantees providing HIV/AIDS-related services to 19,000 individuals; HIV counseling, testing, and linkages services to 5,000 individuals; and HIV/AIDS prevention education to 7,000 individuals. Findings show 98% of recently released individuals who, at the time of the first HIRE Program encounter were newly diagnosed with HIV, were entered into continuum of care HIV treatment, within 30 days of the new diagnosis. In addition, 97% of recently released individuals that had already been diagnosed with HIV prior to their first HIRE Program contact received HIV treatment services within 30 days.

- The **Youth Empowerment Program (YEP*)*** supported:
  - Services for approximately 17,000 at-risk minority youth and their families. Findings show that the rate of promotion to the next grade was 17 percent higher among YEP participants than local comparison groups and school suspension rates are 2.5 times higher in comparison groups than among YEP participants.
- The **FIHET Equity in All Policies Workgroup** supported:
  - A panel session at the National Health Impact Assessment conference in Washington, DC, on ongoing efforts to integrate or consider equity in policies and programs in public, private, health, and non-health sectors. The workgroup also organized a series of monthly health equity webinars featuring state and local promising practices, including California, Maryland, Massachusetts, Minnesota, and Ohio. A total of 901 individuals participated in the first six webinars. On average, 90 percent of participants agreed their knowledge of strategies for integrating equity in policies and programs increased, and 88% percent of participants agreed they would be able to apply the information learned to their work.
- The **RHECs** have supported:
  - ACA outreach activities in four regions, reaching approximately 3,250 consumers eligible for coverage under the ACA in seven states, with almost 50% expressing intent to enroll in coverage. Technical assistance from OMH was used to support their data collection activities through the development of a tool used by RHEC to assess the impact of outreach efforts.
  - Specific examples of events include:
    - A Community Forum and Expo on the ACA with more than 250 attendees, translated in four additional languages (Chinese, Korean, Hindi, and Tagalog).
    - An educational session for 622 attendees from all five racial and ethnic minority groups across Michigan on general policies and procedures for implementation of ACA.
    - 27 ACA presentations to a diverse range of organizations including business associations, HIV planning groups, parole boards/programs for the re-entry population, churches, and local departments of health.
- OMH leadership for the **Youth National Partnership for Action (yNPA)** supported:
  - A Memorandum of Understanding with the Stanford University Youth Medical Science Program to provide technical assistance to partners such as academic institutions, national organizations, and statewide or community coalitions who want to adapt the Public Health Advocacy curriculum for youth enrolled in their program.
  - Two pilot presentations for Marshall University and West Virginia State University, reaching 187 high school students from an Upward Bound and a Healthcare Pipeline program.

Strategic Goal 4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

OMH supports this goal by maintaining, strengthening, and evaluating OMH's internal performance improvement and management system and evaluating implementation of the HHS Disparities Action Plan and the National CLAS Standards. OMH also plays a critical role in educating students about health disparities and social determinants of health and preparing them become future leaders and practitioners. Key accomplishments in FY 2014 include:

- OMH's **Performance Improvement and Management System (PIMS)** supported:
  - Development of initial project profiles and an evaluation plan assessment report for all new 2014 state partnership grantees to guide their subsequent evaluation planning and data collection, including identification of evaluation planning best practices.
  - Completion of three rounds of evaluation monitoring/check-ins with all continuing and completing grantees.

  - Development of emerging evidence briefs and drafting of final evidence reports for all grant programs that continue beyond or end in FY 2014.
- OMH's monitoring of the implementation of the **HHS Disparities Action Plan** supported:
  - Evaluation of health disparity impact statements for policies and programs.
  - Evaluation and assessment of the development of a multifaceted health disparities data collection strategy across HHS, as outlined in the HHS Disparities Action Plan.
  - Initial development of a framework for the long-term evaluation of National CLAS Standards. OMH started a new evaluation project in CY 2014 to systematically describe and examine the awareness, knowledge, adoption, and implementation of the National CLAS Standards.
- OMH's monitoring of the implementation of the **NPA** supported:
  - Development of the second comprehensive NPA evaluation report in 2014 and use of the information to identify accomplishments and make adjustments in NPA implementation to maximize impact.

Funding History

Fiscal Year	Amount
FY 2011	$55,888,000
FY 2012	$55,782,000
FY 2013	$39,533,000
FY 2014	$56,516,000
FY 2015	$56,670,000

Budget Request

The FY 2016 President's Budget request of $56,670,000 is equal to the FY 2015 Enacted Level. In FY 2016, OMH will continue to provide leadership in coordinating policies, programs, and resources to support implementation and monitoring of both the HHS Disparities Action Plan and the NPA. The FTE increase reflects increasing responsibility and programmatic and policy initiatives. OMH will increase FTE by reallocating resources from operational expenses. OMH will continue coordination of HHS health disparity programs and activities; assessing policy and programmatic activities for health disparity implications; building awareness of issues impacting the health of racial and ethnic minorities; developing guidance and policy documents; collaborating and partnering with agencies within HHS, across the federal government, and with other public and private entities; funding demonstration programs; and supporting projects of national significance.

Additionally, OMH will continue to serve in a critical leadership role within HHS in outreach and education of racial and ethnic minorities on the Affordable Care Act and the Health Insurance Marketplace through its many national, regional, state and territorial, tribal, and community-based partnerships and networks across the nation. To align with the FY 2016 funding level, OMH will target the most at-risk populations for outreach and awareness activities to reduce health disparities and improve minority health.

In FY 2016, OMH will continue to support program activities through leadership of workgroups and committees, grants, contracts, and strategic use of interagency agreements to achieve coordination of federal efforts related to health disparities. Specific grants and contracts include:

Grants:

- The **American Indian and Alaska Native (AI/AN) Partnership Program** provides support to tribal epidemiology centers and their respective tribal leaders to manage more effectively and facilitate evidence-based health care decision making. In FY 2016, an estimated 1,800 individuals are projected to receive services, training, and technical assistance.
- The **Youth Empowerment Program (YEP*)*** seeks to address unhealthy behaviors in at-risk minority youth and provide them with opportunities to learn skills and gain experiences that contribute to more positive lifestyles. This program will serve approximately 257,000 at-risk minority youth and their families in FY 2016.
- The **Youth Empowerment Program II (YEP II)** addresses unhealthy behaviors in minority males (10-18 years-old) at-risk of violence and provides them opportunities to learn skills and gain experiences that contribute to more positive lifestyles. In FY 2016, it is expected this program will impact almost 7,000 high risk minority youth and their families.
- The **Minority Youth Violence Prevention (MYVP)** program is a partnership between the Office of Minority Health and the Department of Justice, Office of Community Oriented Policing Services, to support an initiative to integrate public health and violence prevention approaches. In FY 2016, this program is expected to impact almost 10,000 young minority males and their communities through violence prevention and crime reduction services.
- **Communities Preventing Childhood Trauma (CPCT)** is a multidisciplinary initiative to improve the education and health status of minority males and males from disenfranchised populations. CPCT grantees will serve high-risk minority and other disenfranchised males and their families living in communities with significant rates of violence, homicides, suicides, substance abuse, depressive episodes, and incarceration/legal detention. In FY 2016, this program is expected to impact approximately 2,500 males from minority and disenfranchised populations through community-based, community-focused intervention programs.
- The **National Workforce Diversity Pipeline (NWDP) Program** supports projects that develop innovative strategies to identify promising students in their first year in high school and provide them with a foundation to pursue a successful career in a health profession. It is anticipated the NWDP will expand the diversity of health professional pipelines. In FY 2016, it is expected this program will impact almost 5,000 minority youth.
- The **Partnerships to Increase Coverage in Communities II (PICC II)** program educates minority populations about the Health Insurance Marketplace and assists them with enrollment, completion of the application to determine their eligibility and purchase of health insurance offered through the Marketplace.
- The **State Partnership Grant Program to Improve Minority Health** supports State-level partnerships through direct surveillance programs to address health disparities. It is estimated that the SPG will engage more than 220,000 organizations and consumers in FY 2016.
- The **HIV/AIDS Initiative for Minority Men (AIMM)** establishes HIV Integrated Centers for Care and Supportive Services that employ evidence-based disease management, preventive health and supportive service programs. In FY 2016, AIMM grantees are expected to serve approximately 12,000 minority MSMs living with or at-risk for HIV/AIDS.

Contracts and IAAs:

- The **Office of Minority Health Resource Center (OMHRC)** will continue to provide English and Spanish web sites for OMH, publications distribution, exhibits, Affordable Care Act outreach and education, and campaign support for the NPA and the Healthy Baby Begins with You/Preconception Peer Educators infant mortality campaign, and other OMH and HHS initiatives.

- The **Implementation of the National Partnership for Action to Eliminate Health Disparities (NPA)** includes three contracts:
  - **Core Implementation** of the NPA includes monitoring and updating the implementation strategy for the NPA; supporting and sustaining implementation at the state, territorial, regional, national, and federal levels; coordinating and streamlining the implementation-related activities of OMH and the various contractors; documenting and sharing implementation successes, challenges, and lessons learned.
  - **Logistical** support is provided throughout the year in the form of telephone and webinar conference coordination for the Regional Health Equity Councils (RHECs), as well as logistical technical support for the Federal Interagency Health Equity Team (FIHET.
  - **Core Evaluation** support includes collecting, analyzing, and summarizing baseline data and initial follow-up data to explore indicators of immediate and intermediate outcomes.
- The **Center for Linguistic and Cultural Competency in Health Care (CLCCHC)** will: increase the support and promotion of cultural competency e-learning curriculum modules for physicians, nurses, promotores de salud (community health workers), and other health professionals with updates, additional on-line resources, and marketing plans for each curriculum.

OMH – Projected Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2015 PB Target	FY 2016 Request Target	FY 2016 Request +/- FY 2015
4.2.1 Increased percentage of continuing education credits earned or awarded to enrollees who complete at least one or more of OMH's accredited 'Think Cultural Health' e-learning programs (Output)	FY 2014: 43% Target: 15% (Target Exceeded)	20%	25%	+5%
4.3.1 Increased average number of persons participating in OMH grant programs per $1 million in OMH grant support (Efficiency)	FY 2014: 33,667 Target: 16,593 (Target Exceeded)	12,928	13,316	+388
4.3.2 Increased average number of OMH grant program participants per $1 million in OMH grant support through partnerships established by grantees to implement funded interventions. (Efficiency)	FY 2014: 26,040 Target: 28,804 (Target Not Met)	4,533	4,669	+136
4.4.1 Unique visitors to OMH-supported websites (Output)	FY 2014: 1,712,413 Target: 590,000 (Target Exceeded)	595,000	600,000	+5,000
4.5.1 Increased percentage of State and Territorial Offices of Minority Health/Health Equity that have incorporated national disease prevention and health promotion	FY 2014: 44% Target: 27% (Target Exceeded)	37.5%	41%	+3.5%

(e.g., Healthy People 2020) and health equity (e.g., National Partnership for Action to End Health Disparities) goals in their health disparities/ health equity planning processes. (Output)				
4.6.1: Increase the percentage of promising approaches, models, and evidence-based practices produced by OMH-funded grantees and cooperative agreement partners (Output)	FY 2013: 40% Target: 32% (Target Exceeded)	35%	36%	+1%

Performance Analysis

4.2.1: Think Cultural Health (TCH) is an online continuing education program dedicated to advancing health equity at every point of contact. The focus is on increasing provider self-awareness and, over time, changed beliefs and attitudes that will translate into better health care. With the addition of new e-learning modules for more health care and public health professionals and service providers and sustained focus on the promotion and adoption of the CLAS Standards, OMH expects to see a 25% increase in the number of CME and CE credits earned or awarded to enrollees who complete at least one or more of OMH's accredited 'Think Cultural Health' e-learning programs in their respective fields.

4.3.1 AND 4.3.2: OMH provides grant funds to State Offices of Minority Health, community and faith-based organizations, Tribes and tribal organizations, national organizations; and institutions of higher education. These grants play a critical role in supporting the HHS Disparities Action Plan and the NPA. In FY 2016, OMH will continue a number of grant programs and initiate several new ones that address health disparities and expects to see a 3% increase in the average number of people participating in OMH grant programs per $1 million. The 2013 State Partnership Grant Program will end in FY 2015 and the expected future performance State Partnership Grant programs is in line with the FY 2016 funding level.

4.4.1: The OMH supported websites are administered by the OMH Resource Center. The main website, www.minorityhealth.hhs.gov, houses a digital database of the knowledge center collection, minority health and health disparities data and literature, resources for community- and faith-based organizations and information about OMH. The website supports community organizations and health disparities researchers in assembling accurate and comprehensive information and articles for use in program development and grant writing. The websites serve as an information dissemination tool for the HHS Disparities Action Plan and the NPA (www.minorityhealth.hhs.gov/npa) and facilitate educational outreach to Black/African American, Hispanic/Latino, American Indian, Alaskan Native, Asian American, Native Hawaiian, and Pacific Islander communities. The NPA toolkit, aimed at helping community organizations, has been viewed 1.7 million times since it was unveiled. OMHRC keeps NPA partners connected through its web page, electronic newsletter, blog, and related media. OMH expects to see at least 600,000 unique visitors to its main website in FY 2016. The target was set conservatively in anticipation of a newly redesigned website and significant reductions in users often associated with such website redesigns. With the launch of the newly designed website in August 2014, OMH expects to revisit and consider adjusting future year targets upward, based on actual performance and keeping within budget parameters.

4.5.1: OMH builds strategic partnerships and provides leadership and coordination for State and Territorial Offices of Minority Health/Health Equity. OMH expects to see a 3.5% increase in the percentage of these entities that have incorporated national disease prevention and health promotion (e.g., *Healthy People 2020*) and health equity (e.g., *National Partnership for Action to End Health Disparities*) goals in their health disparities/health equity planning processes. The expected performance of this measure is in line with the FY 2016 funding level.

4.6.1: OMH is charged with advising the Secretary and the department on the effectiveness of community-based programs and policies impacting health disparities. OMH funds demonstration grants to develop, test, and implement interventions to reduce health disparities. Results from these demonstration programs play a critical role in supporting the HHS Disparities Action Plan and the NPA`. Additionally, OMH is charged with ensuring on-the-ground implementation of many of the ACA provisions and HHS Disparities Action Plan strategies. OMH expects to see a 1% increase in the percentage of promising approaches, models, and evidence-based practices produced by OMH-funded grantees and cooperative agreement partners per year. The expected performance of this measure is in line with the FY 2016 funding level.

Program Data Chart

Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Contracts			
OMH Resource Center	3,816,000	3,500,000	3,500,000
Logistical Support Contract	2,041,939	1,800,000	1,800,000
National Partnership for Action to end Health Disparities	2,148,455	1,750,000	1,500,000
Center for Linguistic and Cultural Competency in Health Care	1,775,000	1,700,000	1,700,000
HHS Action Plan to Reduce Racial and Ethnic Health Disparities	575,000[4]	750,000	600,000
Evaluation	582,061	900,000	900,000
State Minority Health Task Force	534,802[5]	0	0
Disparities Health Prevention	0	1,016,000	0
Subtotal, Contracts	**11,474,257**	**11,416,000**	**10,000,000**
Grants/Cooperative Agreements			
State Partnership Programs	3,230,861	3,000,000	3,000,000
American Indian/Alaska Native Partnership	1,200,000	1,200,000	1,200,000
Curbing HIV/AIDS Transmission Among High Risk Minority Youth and Adolescents	1,300,000	0	0
Youth Empowerment Program	2,064,734	2,070,000	2,070,000
Conference Support	0[6]	0	0
Minority Youth Tobacco Elimination Project	0[7]	0	0
Specified Project – Lupus	2,000,000	2,000,000	2,000,000
National Umbrella Cooperative Agreements	4,475,000[8]	0	0
Minority Youth Violence Prevention	6,729,708	6,729,708	6,729,708
Partnership to Increase Coverage for Communities of Color	3,203,913	6,703,913	3,500,000

4 Funding decrease reflects funding mechanism change to IAA.
5 Funding reallocated to fund HIV/AIDS grant activities.
6 Activity cancelled in FY14.
7 Activity cancelled in FY14.
8 Decreased funding due to cancellation of one grantee award in FY14.

Communities Preventing Childhood Trauma (CPCT)	0	0	3,000,000
Reentering Citizens Community Linkages Program (RCCL)	0	0	2,000,000
Multiple Chronic Condition Management (MCC)	0	0	3,000,000
Partnership Active Communities to Achieve Health Equity	0	0	0
HIV/AIDS Initiative for Minority Men (AIMM)	2,624,814	3,749,814	2,249,814
OASH National Prevention Partnership Awards	1,693,287	0	0
National Workforce Diversity Pipeline Program (NWDP)	0	2,500,000	2,500,000
Subtotal, Grants/Coop	**28,522,317**	**27,953,435**	**31,249,522**
Inter-Agency Agreements (IAAs)	**1,786,962**	**2,255,000**	**500,000**
Operating Costs	**14,732,503**	**15,045,565**	**14,920,478**
Total	**56,516,000**	**56,670,000**	**56,670,000**

Grants

Grants (whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	105	101	116
Average Award	$267,108	$276,767	$269,392
Range of Awards	$65,000-$2,000,000	$150,000-$2,000,000	$200,000 -$2,000,000

OFFICE ON WOMEN'S HEALTH

Budget Summary
(Dollars in Thousands)

Office on Women's Health	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	33,958	32,140	31,500	-640
FTE	43	43	43	0

Authorizing Legislation: .....Title II, Section 229 of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct federal, Competitive grants, Contracts

Program Description and Accomplishments
The Office on Women's Health (OWH) was established in 1991 and authorized by the Patient Protection and Affordable Care Act (ACA) of 2010. The mission of OWH is to provide national leadership to improve the health of women and girls through policy, education, and model programs. OWH seeks to produce model programs and policies that providers, communities, agencies, and other stakeholders across the country replicate and expand. To achieve these goals, the office works with many partners, including federal agencies; nonprofit organizations; consumer groups; associations of health care professionals; tribal organizations; and state, county, and local governments.

Impact National Health Policy as it Relates to Women and Girls
OWH coordinates health policy, leads and administers committees, and participates in government-wide policy efforts.

HHS Coordinating Committee on Women's Health (CCWH), chaired by OWH, advises the Assistant Secretary for Health on current and planned activities across HHS that safeguard and improves the health of women and girls. Accomplishments in FY 2014 include:

- Launched a web portal to centralize access to federal information and resources on interpersonal violence,
- Submitted two articles for publication and developed an interactive website and timeline in celebration of the 30th anniversary of the coordinating committee, and
- Sponsored a challenge.gov competition to create tools to educate women about the Affordable Care Act

HHS Violence Against Women (VAW) Steering Committee (VAW-SC) works collaboratively on issues involving violence against women and girls. OWH and the Family Violence Prevention and Services Program within the Administration for Children and Families (ACF), chair the committee, which works strategically to improve awareness, increase collaboration, and advance evidence-based programs and policies. Accomplishment in 2014 include:

- Collaborated on projects and educational activities to highlight Dating Violence Month, Elder Abuse Day, Sexual Assault Month and Domestic Violence Month, and
- Co-hosted an event with the White House celebrating the release of the Report of Recommendations for Interagency Actions Working Group on HIV/AIDS, Violence Against Women, and Gender-Related Health Disparities in February 2014

Chronic Fatigue Syndrome Advisory Committee (CFSAC), which OWH leads, is composed of non-federal researchers, clinicians, a patient representative, and federal *ex-officio* representatives. This committee makes recommendations to the Secretary on a broad range of topics including research, clinical care, and quality of life for patients with Chronic Fatigue Syndrome. Accomplishment in 2014 include:

- Formed two new work groups: (1) to evaluate current and potential opportunities to influence medical professionals regarding diagnosis and treatment, and (2) to provide a set of recommendations aimed at increasing awareness among researchers; both workgroups have provided recommendations to the Secretary
- Based a recommendation from the CFSAC, the Institute of Medicine (IOM) is conducting a study to identify the evidence for various diagnostic clinical criteria using stakeholder input

OWH represents HHS on the White House Council of Women and Girls, which ensures that federal agencies account for the needs of women and girls in the policies they draft, the programs they create, and the legislation they support. Accomplishments in F Y 2014 include:

- Helped to organize the White House Summit on Working Families
- Launched a working group on women veterans

OWH represents HHS on the White House Working Group on the Intersection of HIV/AIDS, Violence against Women and Girls, and Gender-Related Health Disparities, which is comprised of leaders from across the federal government. The working group published its first report in September 2013, which included a detailed implementation plan. Accomplishments in FY 2014 include:

- Published a Progress Report in February 2014

<u>Model Programs on Women's and Girls' Health</u>

OWH supports activities and programs aimed at gathering evidence on effective strategies to help women and girls of all ages live healthier lives. For example, OWH continues Project Connect, a multi-state initiative, which educates public health professionals about the effects of violence and victimization on women's health. OWH programs continue to provide training on the relationship between violence against women and HIV/AIDS while engaging men and faith-based communities as partners in violence prevention.

OWH launched Phase II of the Coalition for a Healthier Community (CHC) program in September 2011, which since inception has comprised of local, regional, and national organizations, academic institutions, and public health departments developing and implementing a strategic plan to address health conditions that adversely affected the health of women and girls in their community with goals and objectives linked to *Healthy People 2020*. Accomplishments in FY 2014 include:

- Facilitated policy changes at the local and state level
- Used participatory evaluation approaches to assess the effectiveness of gender-based systems approaches to improving women and girl's health, and
- Submitted a literature review, which identifies best or promising practices in using gender-based approaches to improve health among women and girls, for a special issue of the peer-reviewed journal Evaluation and Planning.

OWH since FY 2012, has actively worked to develop and test pilot interventions that promote healthy weight and weight reduction in lesbian and bisexual women through group support programs and community approaches. In FY 2013, OWH launched the Healthy Weight Coordinating Center and in FY 2014 completed interventions in Washington, DC, New York City, and San Francisco.

Education and Collaboration on Women's and Girls' Health

OWH administers the National Women's Health Information Center, which utilizes websites, social media, print materials, and a helpline to provide information in English and Spanish to women across the nation. Some of OWH's recent accomplishments include:

- A 30% increase in visits to OWH's main website (Womenshealth.gov) over the previous fiscal year (27,064,217 visits in FY 2014 compared with 20,894,531 in FY 2013).
- Outreach efforts to promote Girlshealth.gov resulted in 1,295,894 visits in FY 2014.
- 1.2 million subscribers to its social media channels; which reflected a more than 25% increase in subscribers since FY 2012.

In addition to media outreach, OWH coordinates the National Women and Girls HIV/AIDS Awareness Day and the National Women's Health Week observances each year to raise awareness about the increasing impact of HIV/AIDS on the lives of women and girls and the many effective steps women can take to improve their health. Accomplishments include:

- Over 11,000 visits to a newly designed section of the Womenshealth.gov website which focused on HIV/AIDS awareness. This reflects an additional 1,800 visits to the website as compared to the 9,173 during FY 2013.
- In FY 2014, thousands of events were held across the country to promote women's health and provide access to important health information and screenings.

In FY 2014, OWH partnered with CMS to supplement their Health Insurance Marketplace Public Education and Outreach Campaign, with a focus on mothers of uninsured young adults. These joint efforts raised awareness about new affordable health coverage options available for them in the Health Insurance Marketplace. Ads aired between January and March 2014 nationally on several channels including Lifetime and ABC Family. OWH also partnered with CMS, WebMD and Medscape to provide information to women and health care providers (particularly providers who specialize in treating women) on relevant components of the Affordable Care Act.

Funding History

Fiscal Year	Amount
FY 2011	$33,679,000
FY 2012	$33,682,000
FY 2013	$33,002,000
FY 2014	$33,958,000
FY 2015	$32,140,000

Budget Request

The FY 2016 President's Budget request of $31,500,000 is $640,000 less than the FY 2015 Enacted Level. At the FY 2016 request level, OWH will reduce operational costs as they continue to play a leadership role in coordinating policies, programs, and information to support the implementation of the OWH Strategic Plan in four main areas: Women's Health Across the Lifespan, Breastfeeding, Health Disparities, and Violence and Trauma.

Detailed OWH activities for FY 2016 will include:

Evaluation

- Evaluation of the Women's Health Leadership Institute: OWH will evaluate this program and assess whether the program met its goal to train experienced community health workers to take a public health systems approach when addressing chronic diseases and other health disparities.
- OWH Helpline/Call Center Evaluation: This evaluation will examine the metrics for the OWH Helpline/Call Center and will aid in determining whether OWH will continue to support this resource.
- Evaluation of the Impact of the Bakken Oil Boom on the Mental and Behavioral Health of Women in Western North Dakota and Eastern Montana: OWH plans to fund a mixed methods study to examine the impact of the Bakken oil development on the physical, mental, and emotional wellbeing of the women in these areas.

Trauma/Violence Against Women

- Violence and Trauma: Campus Sexual Assault: OWH will continue to support this grant program, which supports projects focused on policies to address sexual assault on college campuses. These awards are enhancing and implementing sexual assault prevention policies through provision of national outreach and technical assistance, development of institutional partnerships, and creation of campus coalitions.
- Trauma Informed Care for Health Care Providers – Online Clinical Cases: OWH will develop a set of interactive online clinical cases for health care providers to train them on the prevalence and impact of trauma and how to provide trauma-informed care.
- HIV Prevention Services for Survivors of Domestic Violence: A pilot training project will address the risks of contracting HIV/AIDS among women who experience intimate partner violence.
- Violence and Trauma: At-Risk Girls and Women Project: OWH will develop a training curriculum for providers about violence, trauma, and the intersection of violence and HIV.
- Women in Re-entry and Transition: Women in the criminal justice system face numerous barriers as they transition back to their community. OWH will use lessons learned from these projects to support demonstrations programs that develop a comprehensive approach to assist women in successfully reentering their communities.

Women's Health Across the Lifespan

- Caregiver Health Project: The vast majority of caregivers are women and funding will support a more comprehensive assessment of the various health effects of caregiving, in addition to identifying current evidence-based practices that can be more widely utilized.
- Adolescent Health Project: OWH has demonstrated previous success in reaching adolescent girls on a variety of health topics, including health promotion, nutrition, and physical activity. The project will work in these areas to disseminate evidence-based information to this population.
- Women of Child-Bearing Age Health Project: OWH is partnering with Health Resources and Services Administration (HRSA) on the Maternal Health Initiative to expand professional education on the leading causes of maternal morbidity and mortality**.** OWH plans to utilize a variety of methods to disseminate clinical and public health information focused on reducing maternal mortality and morbidity associated with pregnancy, labor and delivery, and the postpartum period.

Health Disparities

- Girls and Women at High Risk of HIV/AIDS: Since monogamy is recommended as a risk reduction factor, many of these women believe they are not at risk for HIV. OWH will determine the extent of this practice and belief and develop model programs to clarify this message.
- Support for Indian Health Service Women's Health HIV/AIDS Projects: OWH will partner with the Indian Health Service to evaluate the best practices and evidence-based interventions for this high-risk population.
- Older Women and HIV/AIDS: Recent CDC data indicates that 25% of all new cases of HIV/AIDS are occurring in Americans over the age of 50. Given that this age group is likely to suffer from one or more chronic health conditions, OWH will assemble evidence-based strategies and information that can provide guidance to health care providers who are caring for older persons at risk for or already diagnosed with HIV/AIDS.
- Women's Health Disparities: As women and girls with HIV/AIDS live longer, it is important to determine if the health and social service systems are prepared to meet their needs. OWH will conduct an environmental scan to determine the needs of older people living with HIV/AIDS and the barriers they face. Programs to address the barriers will then be implemented.

Breastfeeding

- Breastfeeding Initiative: OWH will strategically partner with agencies that serve underserved groups, especially individuals and non-traditional community partners, for expansion of evidence-based programs that increase breastfeeding practices
- Support for HRSA Federally-funded Health Centers: The HRSA-supported federally qualified health centers will be the focus for expansion of breastfeeding programs to pregnant women and nursing mothers. OWH expects to support a variety of interventions, such as internet-based information sharing, community-based counselors, and information shared with the health care

Affordable Care Act (ACA)

- ACA/Health Care innovations: Patient and Health Care Provider Education Campaign: While continuing to support CMS's effort to enroll the uninsured in the Marketplaces, OWH will also expand its efforts to ensure that individuals who received coverage renew their coverage and improve their insurance literacy through CMS's Coverage to Care initiative.
- ACA/Health Care Innovations: Support CMS' efforts to enroll the uninsured in Marketplaces, in addition to expanding efforts to ensure newly insured individuals renew their coverage, improve their insurance literacy, and deepen their understanding of how to use their coverage.

OWH - Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
5.2.1 Number of users of OWH's social media channels. (Output)	FY 2014: 1,283,059 Target: 810,175 (Target Exceeded)	1,150,000	1,500,000	+350,000
5.3.1 Number of users of OWH communication resources (Output)	FY 2014: 30,656,806 user sessions Target: 21,500,000 (Target Exceeded)	18,000,000 user sessions	20,000,000	+2,000,000
5.4.1 Number of girls ages 9-17 and women ages 18-85+ that	FY 2014: 1,822,395 Target: 770,461 (Target Exceeded)	1,000,000	1,000,000	+0

participate in OWH-funded programs (e.g., information sessions, web sites, and outreach) per million dollars spent annually. (Efficiency)				

Performance Analysis

OWH's outreach efforts will ensure the availability of a central source of reliable women's health information to the public. Without funding for these efforts, women and girls across the country will have to find alternate means of receiving this helpful health information. Data from the Pew Research Center shows that 86% of women who are online use the internet to find health information: (http://pewinternet.org/Reports/2011/HealthTopics/Part-2/Women.aspx). The evidence base for OWH includes the number of user sessions to the OWH websites, the number of users of OWH's social media channels, and the number of women and girls served by OWH programs and initiatives.

OWH's continued social media efforts will ensure that valuable information regarding the health of women and girls is available to the public in the most accessible and widely used formats (e.g., desktop, mobile, or tablet). Data from the Pew Research Center shows that 75% of online women use social media in a typical day (http://pewinternet.org/Commentary/2012/March/Pew-Internet-Social-Networking-full-detail.aspx). As of FY 2014, over 1.2 million users subscribed to OWH social media channels, and OWH is ranked as the #2 (@womenshealth) and #3 (@girlshealth) most popular Twitter channels at HHS.

Program Data Chart

Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Contracts			
Program Evaluation	820,926	1,620,000	1,500,000
Health Communications	4,065,696	4,193,408	4,065,000
Logistical Meeting Support	0	500,000	300,000
Women's Health Across the Lifespan	850,000	200,000	1,800,000
Incarcerated Women in Transition & Trauma	520,529	900,000	1,500,000
Health Disparities	0	250,000	0
Breastfeeding	150,000	450,000	300,000
Quick Health Data	500,000	0	0
HIV/AIDS	1,344,122	650,000	1,400,000
Violence Against Women	770,095	1,200,000	850,000
Subtotal, Contracts	**9,021,368**	**9,563,408**	**11,715,000**
Grants/Cooperative Agreements			

Affordable Care Act Enrollment	**1,910,442**	**0**	**0**
National Women's Health Prevention Awards[9]	2,123,874	3,248,874	3,248,874
Coalitions for Health Community	2,999,996	3,000,000	0
HIV/AIDS	650,000	0	0
Health Disparities	0	1,000,000	1,000,000
Violence Against Women	1,715,000	3,700,000	3,700,000
Subtotal, Grants/Cooperative Agreements	**9,399,312**	**10,948,874**	**7,948,874**
Inter-Agency Agreements (IAAs)			
Co-sponsorships (includes IAAs & others)	**5,398,095**	**1,973,200**	**1,984,000**
Operating Costs	**10,139,225**	**9,254,518**	**9,852,126**
Total	**33,958,000**	**32,140,000**	**31,500,000**

Grants

Grants (whole dollars)	**FY 2014 Final**	**FY 2015 Enacted**	**FY 2016 President's Budget**
Number of Awards	19	16	20
Average Award	$498,144	$450,000	$250,000
Range of Awards	$30,000-$1,715,000	$300,000-$2,200,000	$200,000-$400,000

OFFICE OF RESEARCH INTEGRITY

Budget Summary
(Dollars in Thousands)

Office of Research Integrity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	8,558	8,558	8,558	0
FTE	21	26	26	0

Authorizing Legislation: ……Section 493 of the PHS Act
FY 2016 Authorization……Indefinite
Allocation Method……Direct federal, Contracts, Grants

Program Description and Accomplishments

The mission of the Office of Research Integrity (ORI) is to promote integrity in biomedical and behavioral research, reduce research misconduct, and maintain the public confidence in research supported by funds of the U.S. Public Health Service (PHS). This mission supports HHS goals #2: Advance Scientific Knowledge and Innovation, and; #4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs. ORI also directly supports the OASH initiative of providing national level leadership on the quality of public health systems. Recipients of PHS funds are required by federal regulation to foster an environment that promotes the responsible conduct of research, implement policies and procedures to respond to allegations of research misconduct, protect the health and safety of the public, and conserve public funds (42 CFR Part 93). ORI functions through two divisions. The Division of Investigative Oversight (DIO) handles allegations of research misconduct and monitors institutional research misconduct processes, and the Division of Education and Integrity (DEI) manages programs to ensure that PHS-funded institutions have policies and procedures in place for handling allegations of research misconduct and provides educational resources to help institutions in preventing the occurrence of research misconduct. One example of ORI's engagement in cross-departmental collaboration is through training and oversight activities involving the Office for Human Research Protections (OHRP) and the HHS Office of the Inspector General. As for cross-governmental collaboration, ORI initiated quarterly meetings for representatives from other agencies responsible for handling research misconduct allegations, including the National Science Foundation, the Veteran's Administration, the Department of the Interior, the Environmental Protection Agency, and the Department of Defense.

ORI accomplishments in 2014 have furthered the goal of promoting research integrity as follows:

- Closed 35 cases following independent oversight review of institutional investigations, which included seven HHS findings of research misconduct;
- Closed approximately 50 cases following independent oversight review of institutional assessments or inquiries of allegations of research misconduct;
- Provided 97 instances of technical and procedural assistance to institutions involved in research misconduct proceedings through the Rapid Response for Technical Assistance (RRTA) program, including guidance in forensic image analysis and compliance with federal regulations;
- Completed three intensive trainings for non-government and government Research Integrity Officers (RIOs) responsible for handling allegations of misconduct;
- Provided input for the publication of "Research Misconduct Involving Noncompliance in Human Subjects Research Supported by the Public Health Service: Reconciling Separate Regulatory Systems," which was a tangible outcome of an ORI/OHRP/FDA sponsored meeting in 2013;

- Maintained the assurance database that tracks annual reports from the more than 5,500 institutions worldwide that receive federal funds for research and ensured that they implement policies for handing allegations of research misconduct;
- Created educational resources to promote research integrity, including "The Clinic," an interactive video addressing misconduct in clinical research settings;
- Provided competitive grant awards and continuation awards to eight U.S. institutions to fund exploratory study of efforts to prevent research misconduct and promote research integrity;
- Advised scientific journal editors on the use of forensic tools for analysis of images.

Funding History

Fiscal Year	Amount
FY 2011	$9,027,000
FY 2012	$9,027,000
FY 2013	$8,558,000
FY 2014	$8,558,000
FY 2015	$8,558,000

Budget Request

The FY 2016 President's Budget Request of $8,558,000 is the same as the FY 2015 Enacted Level. At this level, ORI will support staff needed to conduct investigative and educational activities, as well as contracts and grants needed to support the dissemination of information and training activities to increase awareness and technical skill in the conduct of research oversight by PHS-funded research institutions. ORI's specific plans for spending the requested FY 2016 funds are articulated as follows:

Salaries

Salaries and benefits for ORI staff, including health scientist administrators (HSAs), program analysts, program assistants, and supervisory HSAs are included in the planning level budget request.

Contracts

Each of the following contracts supports the HHS strategic goals: #2 "Advance Scientific Knowledge and Innovation" and #4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs.

Subject Matter Expert Contract

ORI uses a number of subject matter experts (SMEs) from the research community. These SMEs are cost effective for ORI as they provide services that may exceed the expertise of ORI staff, provide objective analysis of ORI programs, and reduce the need for ORI to hire FTEs to perform tasks that may not require full-time effort. ORI expects to continue the services of SMEs with experience in research integrity. These SMEs will perform the following tasks: 1) provide scientific expertise on cases of research misconduct involving clinical research; 2) provide database support for tracking research misconduct cases; 3) provide expertise on cases involving whistleblower protections or requiring compliance reviews; 4) design and implement study protocols related to the responsible conduct of research; and, 5) provide advanced forensics training for DIO investigators. This initiative will significantly enhance ORI's performance goal of responding to new allegations of research misconduct within a reasonable time period. ORI SMEs continue to develop and refine the software system, which organizes, documents, and tracks allegations of research misconduct. This system will be used to

generate reports on ORI's response time to handling allegations and other statistical analyses for ORI cases.

Database and Website Development Contract

ORI supports database and website development including updating and enhancing the website and developing a robust intranet portal and tracking system. The digital/web-based communication is a critical tool for ORI to accomplish program goals and support program activities. The ORI website receives over 2,000,000 page views per year from users seeking information about ORI, misconduct cases, research education, and policies and procedures. In addition, ORI uses a secure on-line email program on a monthly basis to communicate with the biomedical research and research integrity communities. The ORI website requires intensive maintenance to ensure compliance with Federal Web Policies and HHS Web Communications & New Media Policies and Standards. Finally, the ORI Intranet Portal contains a Case Tracking System used by the ORI investigative division to monitor and document the progress of research misconduct allegations and cases.

Research Integrity Training and Education

ORI plans to support five conferences and workshops related to four thematic areas: 1) Research Integrity in Asia and the Pacific Rim; 2) the Research Integrity Officer Training Program; 3) Research Misconduct and Responsible Conduct of Research; and, 4) World Conference on Research Integrity.

Research Integrity in Asia and the Pacific Rim Conference

Nearly 100 institutions throughout Asia and the Pacific Rim receive PHS research funds and are thus required to comply with U.S. regulatory requirements. ORI plans to support a meeting of 40-50 officials who handle research misconduct allegations from those research institutions in the region that have active assurances with ORI. The meeting will result in heightened awareness of compliance with federal regulation 42 CFR Part 93, training requirements particular to PHS recipient institutions in the region, and best practices for handling misconduct allegations in countries with little or no infrastructure for research integrity. The cost for the meeting is approximately $150,000.

Research Integrity Officer Training Program

ORI will support two three-day Boot Camps designed to provide formalized training for RIOs and their legal counsel. Currently, there are more than 100 RIOs on ORI's waiting list for invitations to this program, which helps institutions comply with 42 CFR Part 93. When the process is mismanaged at the institutional level, both nationally and abroad, ORI is unable to fulfil its regulatory mandate by making research misconduct findings against guilty respondents. Attesting to the national importance of this training program, the Boot Camps have led to the creation of an independent professional association, the Association for Research Integrity Officers (ARIO), to provide a forum for RIOs across the country to convene. The cost for each boot camp is $30,000-$35,000.

ORI in 2017: Research Misconduct and Responsible Conduct of Research Conference

ORI plans to support a national gathering of institutional experts in research misconduct and research integrity to promote heightened awareness of compliance with federal regulations and effective methods for preventing research misconduct. This conference will build upon the foundations laid by the "ORI at 20" national conference held in Baltimore, MD in 2013. ORI plans to invite up to 100 participants and to support initiatives designed to produce publishable quality material. The cost of the conference is approximately $150,000.

World Conference on Research Integrity (WCRI)
Since its inception, ORI has been involved in the World Conference on Research Integrity. ORI plans to support a planning meeting for the 2017 World Conference. This planning meeting will support 10-12 participants in their development of a meeting agenda for the 5th WCRI in a location to be determined. The cost of the planning meeting is approximately $65,000.

Each of these meetings aligns with the mission and objectives of both the Department and the Office of the Assistant Secretary. Each event supports the Department's Strategic Goals #2: Advance Scientific Knowledge and Innovation and #4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs. The proposed meetings also directly support the Office of the Assistant Secretary (OASH) initiative of providing national-level leadership on the quality of public health systems.

Educational Resource Development Contract
ORI plans to support educational resource development activities designed to educate the research community to comply with 42 CFR Part 93 and NIH guidelines. Materials include training videos, on-line learning and information modules, and guidance for institutional officials and responsible conduct of research coordinators. These materials will be freely available.

Extramural Research Grants
ORI plans to support up to thirteen competitive grant awards for exploration of critical questions related to the promotion of research integrity and the responsible conduct of research.

Grants

Grants (whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	8	18	13
Average Award	$187,500	$83,333	$99,253
Range of Awards	$150,000 - $300,000	$25,000 - $150,000	$25,000 - $150,000

EMBRYO ADOPTION AWARENESS CAMPAIGN

Budget Summary
(Dollars in Thousands)

Embryo Adoption Awareness Campaign	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	997	1,000	0	-1,000
FTE	0	0	0	0

Authorizing Legislation: .....Public Health Service Act, Section 1704
FY 2016 Authorization.....Indefinite
Allocation Method.....Competitive grants, Contract Inter-Agency Agreement

Program Description and Accomplishments

The purpose of the embryo donation/adoption awareness campaign is to educate the American public about the existence of frozen embryos created through in-vitro fertilization (IVF) that could be available for adoption by infertile individuals or couples

Funding History

Fiscal Year	Amount
FY 2011	$2,004,000
FY 2012	$1,996,000
FY 2013	$1,000,000
FY 2014	$997,000
FY 2015	$1,000,000

Budget Request

HHS is not requesting funds for this program for FY 2016.

HIV/AIDS IN MINORITY COMMUNITIES

Budget Summary
(Dollars in Thousands)

Minority AIDS Initiative	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	52,0820	52,224	53,900	+1,676
FTE	1	1	1	0

Authorizing Legislation:..... Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

The Minority AIDS Initiative (MAI) was established in 1999 in response to growing concern about the impact of HIV/AIDS on racial and ethnic minorities in the United States. The principal goals of the MAI are to improve HIV-related health outcomes for racial and ethnic minority communities disproportionately affected by HIV/AIDS and reduce HIV related health disparities. The resources provided through MAI supplement, rather than replace, other Federal HIV/AIDS funding and programs.

MAI allocates resources to Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of the Secretary MAI Fund (SMAIF). The Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) administers the Secretary's Fund (SMAIF) on behalf of the Office of the Assistant Secretary for Health (OASH). SMAIF funds are used to support cross-agency demonstration initiatives and are competitively awarded to HHS agencies and offices to fund innovative HIV prevention, care and treatment, outreach and education, technical assistance activities serving racial/ethnic minorities. The awards are approved and made by the Assistant Secretary for Health.

Following the release of the National HIV/AIDS Strategy (NHAS) in 2010, OHAIDP restructured the SMAIF to better align with the goals, objectives, and priorities of the NHAS including working with HHS agencies and offices to enhance the targeting and the effectiveness of SMAIF funds. These efforts seek input from various community leaders and providers about unmet HIV/AIDS prevention and care needs and emerging priorities. This is accomplished through program and process directives, including the development and use of a formal internal Funding Opportunity Announcement (FOA). The internal FOA designates four priority project areas: HIV prevention and linkage to care services for racial and ethnic minority populations; improving health outcomes for racial/ethnic minority populations living with HIV/AIDS; mobilization to reduce HIV-related health disparities among racial/ethnic minorities; and capacity development in support of NHAS goals. Approximately $25 million was awarded in FY 2014 through the FOA.

Guidance provided by OHAIDP now requires the use, where relevant services are provided, of the approved HHS core indicators and standardized training metrics for all SMAIF projects. OHAIDP has elevated the importance of cross-department collaboration by including collaboration as one of the four project proposal review criteria and through the development of innovative, cross-agency demonstration projects. For example, Care and Prevention of HIV in the U.S. (CAPUS), supported through the SMAIF is a three-year cross agency demonstration project (FYs12-14) to reduce HIV/AIDS-related morbidity and mortality by building capacity of non-governmental organizations and health

departments to increase HIV diagnoses and optimize linkage to, retention in, and re-engagement with care and prevention services by addressing social, economic, clinical and structural factors influencing HIV health outcomes. Approximately $14.5 million has been allocated annually to fund this demonstration project. After an initial planning phase, all eight participating state jurisdictions (six of which are in the south) began program implementation. Targeted technical assistance has been given to several of the jurisdictions to bolster their plan's use of surveillance data to improve the client health outcomes as well as their plan's strategies for addressing structural determinants of health
To promote optimal outcomes, SMAIF requires that funding proposals incorporate the latest behavioral and biomedical strategies for more impactful results, including "treatment as prevention" which emphasizes expanded HIV testing and active linkage to and retention in care. As research has helped us to better understand the "HIV Cascade" from HIV diagnosis to viral suppression and where serious challenges persist, several projects funded under the SMAIF in FY 2014 are designed to address gaps in the HIV Continuum of Care among racial and ethnic minority populations and are responsive to the President's July 15, 2013 Executive Order requesting prioritization of strategies addressing the continuum of HIV care. As an example of ongoing innovation, SMAIF funded a new three-year demonstration project (FY14—FY16), Partnerships 4 Care (P4C). The P4C includes CDC, HRSA-Bureau of Primary HealthCare and HRSA-HIV/AIDS Bureau in a collaborative effort to expand the capacity of Community Health Centers (CHCs), Health Departments (HDs), and their respective grantees to develop and implement effective, replicable and sustainable service delivery models that improve the identification of undiagnosed HIV infection, establish new access points for HIV care and treatment, and improve HIV outcomes along the continuum of care for underserved people living with HIV (PLWH), especially disproportionately impacted racial and ethnic minority populations. Four states, New York, Maryland, Florida, and Massachusetts will participate in this demonstration initiative, as well as up to 22 health centers within these states.

The following are additional examples of activities that have been supported with the SMAIF in FY 2014 and are also in alignment with the National HIV/AIDS Strategy and the HIV Care Continuum Initiative:

- *Capacity Development*: SAMHSA will establish an ATTC Center of Excellence to provide national subject matter expertise on working with YMSM and HRSA will provide technical assistance and training on health literacy targeting adult and young black MSM
- *Preventing HIV*: developing or expanding prevention efforts for racial and ethnic minority sub-populations, including ex-offenders; at-risk female adolescents/youth; sexual partners of incarcerated or recently released heterosexuals; African American and Hispanic Men Who Have Sex with Men; adolescent African American and Latino males in need of sexual health services; and Native and Tribal women experiencing co-morbid intimate partner violence, alcohol and other substance use/abuse and STDs
- *Improving Health Outcomes*: developing retention and re-engagement interventions for HIV-positive racial/ethnic minority patients; expanding tele-health opportunities in rural and tribal locations; and establish a resource and technical assistance center to compile and develop a comprehensive resource inventory of successful evidence-based strategies to engage and retain newly diagnosed HIV-positive BMSM in clinical care
- *Mobilization to Reduce Health Disparities*: use of emerging technologies and social marketing campaigns, including AIDS.gov, new and social media to broaden reach to racial and ethnic minority populations, including American Indian/Alaska Native youth, Black Men who have Sex with other Men and others.

Funding History

Fiscal Year	Amount
FY 2011	53,783,000
FY 2012	53,681,000
FY 2013	50,354,000
FY 2014	52,082,000
FY 2015	52,224,000

Budget Request

The FY 2016 President's Budget request of $53,900,000 is $1,676,000 above the FY 2015 Enacted Level. Projects funded in FY 2016 will include the cross-agency demonstration project, P4C, focused on improving collaboration among CDC-funded state health departments and HRSA funded community health centers to expand the provision of HIV prevention, testing, care and treatment services within racial/ethnic minority communities most impacted by HIV. In addition, funding will support a new four-year demonstration effort designed to address racial and ethnic HIV-related health disparities and improve health outcomes by developing comprehensive models of prevention and care services for MSM of color who are living with or at high risk for HIV infection and increasing the HIV prevention workforce's knowledge about relevant issues for MSM of color; and competitively-funded projects developed by the participating OPDIVs and STAFFDIVs.

The FY 2016 request will also support the continuation of several ongoing projects, including the following:

- Initiatives that seek to address HIV prevention or care among young men who have sex with men, a population that bears heavy burden of HIV and in which we have seen troubling increases in rates of new infections in recent years.
- Prevention of Substance Abuse and HIV/AIDS and the Promotion of Behavioral Health in High-Risk Populations Using Emerging Technologies, including young MSM.
- HIV Continuum of Care efforts, including linkage to care, re-engagement in care, retention in care and ART adherence and viral suppression with a particular focus on improving weak links and addressing gaps in the Continuum.
- Continued use of webinar technology to explore critical questions, issues and strategies and to reach a broad national spectrum of stakeholders
- Targeted HIV testing and prevention efforts involving disproportionately impacted racial and ethnic minorities, as well as communications, outreach, and resource avenues such as AIDS.gov, the Regional Resource Network Program and the National Resource Center for HIV/AIDS Prevention.

In addition, OHAIDP will continue to work in FY 2016 with partnering agencies, offices and key stakeholders to develop a plan to better identify and disseminate strategic information and promising practices through Webinars, blogs and other new communication means—especially for items related to the HIV Continuum of Care Initiative, The HHS Action Plan to Reduce Health Disparities among Racial/Ethnic Minorities, and community consultations such as the FY13 Black MSM Technical Consultation. The identification and dissemination of promising practices will accelerate progress in reaching targets and goals.

MAI - Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
7.1.12a: Increase the number of racial and ethnic minority clients who are tested through the Secretary's MAI fund programs. (Outcome)	FY 2011: 272,351 Target: 178,537 (Target Exceeded)	338,198	372,018	+33,820
7.1.12b: Increase the diagnosis of HIV-positive racial and ethnic minority clients through HIV testing programs supported by the Secretary's MAI Fund programs. (Outcome)	FY 2011: 201 Target: 201 (Target Met)	263.	289	+26
7.1.12c: Increase the proportion of HIV-positive racial and ethnic minority clients who learn their test results through the Secretary's MAI Fund programs. (Outcome)	FY 2011: 93% Target: 93% (Target Met)	98%	98%	0
7.1.15: Increase the proportion of newly diagnosed and re-diagnosed HIV-positive racial and ethnic minority clients linked to HIV care, as defined by attendance of at least one appointment, within three months of diagnosis, through the Secretary's MAI Fund programs. (Outcome)	FY 2011: 63% Target: 63% (Target Met)	79%	80%	+1%
7.1.17: Increase the proportion of clinical and program staff who are provided HIV-related training through the Secretary's MAI Fund programs in one or more of the following areas: (1) HIV testing and risk counseling; (2) patient navigation and medical case management; (3) adherence assessment	FY 2011: 5,319 Target: 5,319 (Target Met)	6,772	7,111	+339

and counseling; (4) alternative models for delivering HIV care (task shifting, telemedicine, etc.); or (5) cultural competency (racial/ethnic, gender, and sexual orientation). (Outcome)				
7.1.18: Increase the proportion of SMAIF community-based and faith-based organizations that adopt new or enhanced organizational policies, programs, or protocols in one or more of the following capacity building areas: (1) targeting HIV testing in community settings; (2) increasing the rate of receipt of HIV test results; (3) improving active linkage to, or re-engagement in, care for infected clients; and (4) facilitating effective patient navigation that improves retention in continuous care. (Outcome)	FY 2011: 121 Target: 121 (Target Met)	165	173	+8

Performance Analysis

HIV testing is at the center of *Measures 7.1.12.a, 7.1.12b & 7.1.12c.* The measures identify the number of racial and ethnic minorities tested for HIV; the numbers diagnosed HIV-positive; and the numbers who receive their HIV-positive diagnosis and are therefore aware of their HIV status. Increasing awareness of HIV status is a critical objective of the National HIV/AIDS Strategy where it is estimated that 16% of those who are infected do not know their status. More critically, knowledge of status anchors our prevention and care/treatment efforts and represents the first bar, HIV diagnosis, of the HIV Care Continuum. Secretary's Minority AIDS Initiative Fund (SMAIF)-funded projects continue to excel at increasing HIV testing and have met or exceeded established targets.

In addition, an essential component of HIV testing is the linkage to care activity for those who are diagnosed HIV-positive. This activity is captured under *Measure 7.1.15*. Recent studies have shown the challenges the U.S. is having along a "continuum of care" from HIV diagnosis to viral suppression of clients – estimates show 66% are linked to care; 37% are retained in care; 33% are prescribed antiretroviral medication; and only 25% are virally suppressed. SMAIF testing projects have met the target for linkage to care and reflect the importance of HIV-positive client engagement in a care system.

Measures 7.7.17 and 7.1.18, involving training and capacity building, respectively, highlighting the continued importance of funding projects that facilitate or improve, prevention, care, and treatment activities. In both areas, improved targeting and the identification of specific areas of focus are essential to improving the desired performance in health outcomes we seek. SMAIF projects have met the established targets. With increased attention to and expectations for an active linkage to care component with any and all HIV testing, it is likely that the proportion of newly diagnosed and re-diagnosed HIV-positive racial and ethnic minority clients linked to HIV care will continue to improve.

The proposed budget will enable SMAIF projects to continue to pursue the kinds of targeted HIV testing that is necessary to further identify those individuals who unaware of their HIV-positive status and link them to care. An individual's receipt of a positive diagnosis and active linkage to care anchors many of the SMAIF-funded projects and will go a long way to meeting the established targets. Similarly, being more prescriptive about the domains, focus, and targeting of SMAIF-funded training and capacity building will complement the HIV testing and linkage to care activities and makes the overall investment in SMAIF-funded activities more coherent and strategic.

RENT, OPERATIONS, MAINTENANCE AND RELATED SERVICES

Budget Summary
(Dollars in Thousands)

Rent, Operations, Maintenance and Related Services	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	16,429	15,789	16,500	+711
FTE	0	0	0	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2016 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The Rent/Operation and Maintenance (O&M) and Related Services account funds headquarters facilities occupied by the OS STAFFIVS funded by the GDM account. Descriptions of each area follow:

- *Rental payments (Rent)* to the General Services Administration (GSA) include funds to cover the rental costs of office space, non-office space, and parking facilities in GSA-controlled buildings.

- *O&M* includes funds to cover the operation, maintenance and repair of buildings for which management authority has been delegated to HHS by GSA; this includes the HHS headquarters, the Hubert H. Humphrey Building (HHH).

- *Related Services* include funds to cover non-Rent activities in GSA-controlled buildings (e.g., space management, events management, guard services, other security, and building repairs and renovations).

Funding History

Fiscal Year	Amount
FY 2011	$16,616,000
FY 2012	$18,665,000
FY 2013	$16,272,328
FY 2014	$16,429,000
FY 2015	$15,789,000

Budget Request

The Rent, Operations and Maintenance and Related Services request $16,500,000 for FY 2016, is $711,000 above the FY 2015 Enacted Level. The funding level will allow the restoration of $711,000 from the FY 2015 Omnibus decrease. This will allow HHS to restore contracts that support custodial services, personal security (guards), and return building services to 24/7 support. To absorb inflationary increases, GDM Rent will consolidate duplicative space management services and improve coordination of Safety and Environmental support services with the PSC. Improved efficiencies will also allow GDM Rent to reduce the amount of supplies and materials needed for the SW Complex.

SHARED OPERATING EXPENSES

Budget Summary
(Dollars in Thousands)

Shared Operating Expenses	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	13,982	13,369	16,260	+2,891
FTE	0	0	0	0

Common Expenses/ Service and Supply Fund (SSF) Payment

Common Expenses include funds to cover administrative items and activities which cut across and impact all STAFFDIVs under the GDM appropriation. The major costs in this area include:

- Worker's Compensation
- Federal Employment Information and Services
- Records storage at the National Archives and Records Administration
- Radio Spectrum Management Services
- Federal Executive Board in Region VI
- Telecommunications (e.g., FTS and commercial telephone expenses)
- CFO and A-123 audits
- Federal Laboratory Consortium
- Postage and Printing
- Unemployment Compensation

Payments to the SSF are included in the overall Common Expenses category, but are broken out separately here for display purposes. These payments cover the usage of goods and services provided through the SSF:

- Personnel and Payroll Services
- Finance and Accounting activities
- Electronic communication services (e.g., voice-mail and data networking)
- Unified Financial Management System (UFMS) Operations and Maintenance

FY 2015 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

The GDM will use $370,564 of its FY 2015 request to support HHS-wide enterprise information technology and government-wide E-Government initiatives. Staff Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

FY 2015 E-Gov Initiatives and Line of Business*	Original Amount	Revised Amount
Budget Formulation and Execution LoB	$6,685	$6,685
E-Rulemaking (moved from FFS)	$41,570	$20,785
Financial Management LoB	$17,736	$17,736
Geospatial LoB	$619	$619
GovBenefits.gov	$4,296	$0
Grants.gov	$152,492	$25,224
Human Resources Management LoB	$2,551	$2,551
IAE – Loans and Grants	$106,869	$34,842
Integrated Acquisition Environment	$34,207	$25,715
FY 2015 E-GOV Initiatives Total	**$367,025**	**$370,564**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Enterprise IT and government-wide e-Gov initiatives provide benefits such as standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital. End-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. They also improve sharing across the federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Funding History

Fiscal Year	Amount
FY 2011	$15,999,000
FY 2012	$16,062,000
FY 2013	$13,457,000
FY 2014	$13,982,000
FY 2015	$13,369,000

Budget Request

The FY 2016 request for other Shared Operating Expenses is $16,260,000, $2,891,000 above the FY 2015 Enacted Level. The Budget reflects an increase in GDM's contribution to the Service and Supply Fund associated with additional costs of new GDM activities proposed in FY 2016. The increase also includes an inflation factor for Service and Supply Fund charges as well as shared expenses.

PHS EVALUATION FUNDED APPROPRIATIONS

Budget Summary
(Dollars in Thousands)

Program Level	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
ASPE	41,493	41,243	41,493	+250
Federal Market Place Policy Research	0	0	1,000	+1,000
Health Care Reform	12,500	12,500	12,500	0
OASH	4,664	4,285	4,285	0
Teen Pregnancy Prevention Initiative	8,455	6,800	6,800	0
ASFR	2,099	0	0	0
Total	69,211	64,828	66,078	+1,250
FTE	139	144	144	0

ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (ASPE)

Budget Summary
(Dollars in Thousands)

ASPE	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
ASPE	41,493	41,243	41,493	+250
Health Reform	12,500	12,500	12,500	0
Federal Market Place Policy Research	0	0	1,000	+1,000
FTE	144	144	144	0

Authorizing Legislation: ……..43 U.S.C. 241 Public Health Service Act
FY 2016 Authorization……..Indefinite
Allocation Method……..Direct Federal/Intramural, Contracts; Competitive Grants, Cooperative Agreement; Other (Salaries and Expenses, etc.)

Program Description and Accomplishments
The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is a team of analysts and researchers including economists, statisticians, lawyers, ethicists, sociologists, and physicians who coordinate and conduct policy research and analysis to support leadership decision-making on policy alternatives. In addition to providing quick turnaround quantitative and qualitative policy analysis, ASPE also conducts longer range modeling, visioning and demonstration work to inform questions requiring more deliberate planning and thought, such as delivery system reform.

ASPE consults widely within the Department so that it focuses on work that is central to Departmental priorities, and is often called upon to support new HHS missions and to lead activities involving multiple HHS operating and staff divisions. Examples include ASPE's role in leading the Department's strategic planning and legislative review processes; coordinating the Department-wide plan to address the opioids epidemic in 2013; and convening an HHS analytic team to support the Marketplace open

enrollment campaign by identifying eligible populations, and producing weekly enrollment reports for HHS and Administration leadership to allocate outreach resources. In support of HHS leadership, ASPE answers questions raised by the media, the Congress, and the public about HHS programs, their effects, and design.

ASPE also leads special HHS initiatives on behalf of the Secretary, such as serving as the HHS central point for the White House's work on behavioral insights. Through routine contact with policy officials and experts inside and outside government, ASPE tracks emerging trends affecting HHS programs, policies, and regulations so that it can develop solutions for anticipated new policy challenges facing HHS.

The following outlines ASPE's programs and goals in FY 2016.

Strengthen Health Care

ASPE's evaluation studies will identify key strategies to reduce the growth of health care costs while promoting high-value, effective care. Priority projects include providing analysis and developing data to measure and evaluate the implementation and impact of specific provisions of the Affordable Care Act (ACA), improving health care and nursing home quality, developing innovative payment and delivery systems, identifying the best ways to serve individuals who are dually eligible for Medicare and Medicaid, modernizing Medicaid, and improving prevention efforts as well as public health infrastructure and financing.

ASPE will identify information needed to monitor the results of the expansion of health coverage, including both Medicaid and private market coverage, and improve methods for using survey and administrative data to measure Medicaid participation among eligible populations and the access of Medicaid participants to participating providers. ASPE will monitor health insurance premium rates in states, both inside and outside the Marketplaces, and will continue to work actively with CMS to evaluate rate review data and monitor trends.

Health care reform has opened up possibilities to those who need them most, such as frail older adults, people with behavioral health problems, low income children, and people with disabilities. To ensure that vulnerable populations benefit from reforms and new opportunities offered by the ACA, ASPE will continue research and evaluation related to the direct care workforce, the recruitment and retention of a qualified, stable and geographically well-distributed health workforce, and improving the effectiveness and efficiency of the health system through adoption of health information technology. ASPE will continue to develop and integrate HHS data capabilities for public health surveillance and health system change.

With the implementation of the ACA and the resulting expansion of health insurance coverage, demand for services of primary care professionals will increase substantially. ASPE evaluation studies will focus on the adequacy of the nation's health professions workforce in shortage areas and in those smaller communities likely to experience health professional shortages, monitor national workforce issues, and conduct evaluations on priority topics.

Affordable Care Act Activities

ASPE has undertaken and will continue a variety of policy, research, analysis, evaluation and data development activities in support of ACA implementation in FY 2016 and beyond, including:

- Data analysis and economic modeling to other parts of the federal government and improving data to track changes as the ACA is implemented and to support the development of policy alternatives relating to ACA provisions regarding coverage, affordability, and market reforms.
- Identifying effective prevention strategies and associated benefits, including in the area of community-based and clinical preventive service integration.
- Supporting outreach and enrollment activities for Medicaid and Marketplace health insurance coverage expansion to ensure that these activities are used most effectively to reach vulnerable populations.
- Developing a primer on modeling and evaluation methods to support CMS Innovation Center activities.
- Evaluating the overall impact of Medicaid expansions on vulnerable populations and of specific new Medicaid options that enable states to serve individuals with multiple chronic conditions and needs for functional assistance.
- In partnership with the operating divisions, ASPE will monitor the ACA impact on programs such as Ryan White, Community Health Centers, the Maternal and Child Health block grant, and others.

Advance Scientific Knowledge and Innovation
Priority projects under this goal include research and analysis to support regulatory risk assessment and management, the translation of biomedical research into every day health and health care practice, the development and adoption of innovation in health care, and food, drug, and medical product safety and availability.

ASPE leads an HHS-wide Analytics Team to provide recommendations for strengthening regulatory analysis and provides technical assistance on regulatory impact analysis development to HHS agencies and offices. ASPE works in close partnership with HHS operating divisions such as FDA on areas such as food safety and tobacco regulation, and with the White House, the Office of Management and Budget, and the Federal Trade Commission to continue efforts to introduce more experimental evidence into decision making around the design of regulations. For example, ASPE is working on developing a coherent framework and concrete procedures to provide a basis for benefit-cost analysis of actions affecting the consumption of addictive and habitual goods to be used for required regulatory impact analyses.

ASPE has also played a significant role in HHS Health IT initiatives and incubated the concept of an HHS Health IT initiative. ASPE also drafted the President's Executive Order creating the Office of the National Health IT Coordinator. Because of ASPE's role as a place to incubate new ideas and further develop the evidence base to inform policy decision making, ASPE now focuses on the question of how to capitalize on the growth of electronic health records and improved claims data, with attention to pilot studies and evaluations.

Advance the Health, Safety and Well-being of the American People
Priority projects will include examining residential care alternatives for the aged, improving the safety and well-being of children involved with the child welfare system, early learning, caregiver support, evidence-based clinical and community-based preventive services, mental health and substance abuse programs, and disparities in health.

ASPE assembles evidence that is critical to the design of departmental programs. For example, ASPE manages a systematic review of teen pregnancy prevention programs to identify evidence-based

interventions, as well as the Teen Pregnancy Prevention Replication Study, which tests multiple replications of three widely-used evidence-based program models currently funded through the Teen Pregnancy Prevention program, administered by the Office of Adolescent Health. Four new program models were added in the most recent round of reviews, bringing the total to 35 program models in the TPP Evidence Review. The 35 program models represent a range of different program approaches, including abstinence, comprehensive sex education, HIV/STI prevention, and youth development approaches.

ASPE also will conduct research and evaluation of important initiatives such as HIV/AIDS prevention and treatment, tobacco prevention and control, obesity prevention, and reducing health disparities. For example, ASPE provided leadership in developing the Healthy Weight Initiative and provided advice and analysis for key issues in nutrition labeling, guidance on fish consumption for at-risk individuals, and implementation of new food safety legislation.

ASPE will also develop quality measures that multiple payers can use in their payment systems and across HHS programs and will develop a quality measure public reporting inventory and strategy. ASPE leads interagency workgroups to support the alignment and public reporting of quality measures across HHS programs. One workgroup focuses on public reporting across HHS agencies while a second workgroup focuses on quality measure endorsement and input on the National Quality Strategy.

ASPE has partnered with SAMHSA, CMS, and NIMH over the past few years to develop additional quality measures for behavioral health care. The measures address important issues regarding follow-up after inpatient and emergency room treatment, screening and care for co-morbid conditions, screening for risk of suicide or other violent behavior, and fidelity to evidence-based treatments. We worked together to develop and promote these measures for use in various programs throughout the Department including the meaningful use measures used by the Office of the National Coordinator for Health Information Technology and the reporting requirements used by CMS for the inpatient psychiatric facility prospective payment system in Medicare. In addition, we worked together to sponsor a study by the Institute of Medicine on developing quality standards for psychosocial interventions.

Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

Priority projects in FY 2016 under this goal include developing metrics for performance measurement and conducting research in support of efforts to develop strategies for reducing improper payments, understanding disability, and Medicare quality improvement. ASPE will coordinate HHS data collection and analysis activities; ensure effective long-range planning for surveys and other investments in major data collection; and will proactively identify opportunities for transparency, data sharing, and dissemination through electronic posting of datasets on healthdata.gov and other means.

ASPE maintains several databases which allow for short-term monitoring and evaluation of existing and newly-implemented policies. For example, ASPE is currently evaluating why safety net hospitals that provide care for people with limited or no access to health care have higher readmission rates, and whether the recently implemented penalty for readmissions within a month disproportionally affects these providers. We also extensively use unique data sets, such as IMS Health data, in order to better monitor, evaluate, and track the effects of policies on vulnerable populations. Truven health data is being used to examine reasons for the slowdown in national health spending, as well as Medicare health spending; including the impact of the recession and ACA delivery system reform provisions.

Funding History

Fiscal Year	Amount
FY 2012	$53,993,000
FY 2013	$53,993,000
FY 2014	$53,993,000
FY 2015	$53,743,000
FY 2016 PB	$54,993,000

Grants

Grants (whole dollars)	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	3	3	3
Average Award	$800,000	$800,000	$800,000
Range of Awards	$800,000 - $1,300,000	$800,000 - $1,300,000	$800,000 - $1,300,000

Budget Request

The FY 2016 request for ASPE is $54,993,000, which is $1,250,000 above the FY 2015 Enacted Level of $53,743,000. The increase restores the FY 2015 reduction of $250,000 and also provides an additional $1,000,000 for policy research and analysis specifically for the Federal Marketplace. The request also includes $12,500,000 for ASPE to continue Affordable Care Act related research proposed in 2016. ASPE's budget request supports the continuation of research and evaluation studies, data analysis, and assessments of the costs, benefits and impacts to support leadership decision-making on policy alternatives by HHS or the Congress.

ASPE's analytic work on the Federal marketplace will include estimating state level Marketplace eligible uninsured populations; simulating health insurance enrollment under the ACA based upon eligibility for programs and subsidies, health insurance coverage and options in the family, health status, socio-demographic characteristics, and any applicable penalties for remaining uninsured; and assessing the impact of ACA requirements on employers, insurance markets, providers, and consumers. ASPE will also investigate factors that result in individuals markets not operating efficiently (e.g. specific geographic markets), markets dynamics related to insurance industry practices (reference pricing) and the interaction of public programs on market dynamics. ASPE will also examine measures that will enhance the effectiveness of consumer decision-making in the health insurance marketplace. ASPE's FY 2016 research plan extends and builds on its research program related to Health Insurance Markets with projects that support policy making aimed at improving access to affordable, high quality insurance coverage; informed consumer choice, and an understanding of the impact of the coverage expansion on PHS programs.

ASPE will maintain its grants program which awards $800,000 to $1,300,000 per year to academically based research centers to support research and evaluation of important and emerging social policy issues associated with income dynamics, poverty, transitions from welfare to work, child well-being, and special populations. The poverty center program conducts a broad range of research to describe and analyze national, regional, and state environments (e.g., economics, demographics) and policies affecting the poor, particularly families with children who are poor or at-risk of being poor. It also

focuses on expanding our understanding of the causes, consequences, and effects of poverty in local geographic areas, especially in states or regional areas of high concentrations of poverty, and on improving our understanding of how family structure and function affect the health and well-being of children, adults, families, and communities. All of the centers develop and mentor social science researchers whose work focuses on these issues.

Evaluation Funding Flexibility Pilot.

High-quality evaluations and statistical surveys are essential to building evidence about what works. They are also inherently complicated, dynamic activities; they often span many years, and there is uncertainty about the timing and amount of work required to complete specific activities--such as the time and work needed to recruit study participants. In some cases the study design may need to be altered part-way through the project in order to better respond to the facts on the ground. The available procurement vehicles lack the flexibility needed to match the dynamic nature of these projects. Additionally, some studies provide high quality information in which many federal agencies are interested, and it is frequently desirable to cosponsor these activities in order to efficiently extend the utility of the data collected. Changes in timing and content can make co-sponsorship difficult, since funds are often time-limited.

In order to streamline these procurement processes, improve efficiency, and make better use of existing evaluation resources, the Budget proposes to provide HHS with expanded flexibilities to spend funds over a longer period of time. This request is a part of a larger proposed pilot program which includes HHS's Assistant Secretary for Planning and Evaluation and the Office for Planning, Research and Evaluation in the Administration for Children and Families; The Department of Labor's Chief Evaluation Office and Bureau of Labor Statistics; The Department of Justice's National Institute of Justice and Bureau of Justice Statistics; the Census Bureau; and the Department of Housing and Urban Development's Office of Policy Development & Research. These flexibilities will allow agencies to better target evaluation and statistical funds to reflect changing circumstances on the ground.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Budget Summary
(Dollars in Thousands)

Public Health Service Evaluation - OASH	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	4,664	4,285	4,285	0
FTE	0	0	0	0

Authorizing Legislation: ……..Section 241 PHS Act
FY 2016 Authorization……...Indefinte
Allocation Method……..Direct federal, Contracts

Program Description and Accomplishments

The Office of Assistant Secretary for Health (OASH) performs an essential role in the Public Health Evaluation Set-Aside program the Department of Health and Human Services (HHS). Within OASH, the Immediate Office of the Assistant Secretary for Health (ASH) coordinates the Evaluation Set-Aside program for the ASH. Each fiscal year, OASH program offices submit proposals in an effort to improve and evaluate programs and services of the U.S. Public Health Service, and identify ways to improve their effectiveness. Studies supported by these Set-Aside funds serve decision makers in federal, state, and local government, and the private sector of the public health research, education, and practice communities by providing valuable information about how well programs and services are working. Projects that were approved for FY 2014 evaluation funds are listed below by HHS Strategic Goal:

Strategic Goal 1

- Evaluating for Correlations between the Public Health Quality 9 Aims and Improvements in Mobile Health Clinic Clinical Outcomes – Develop a prototype tool to assess quality by formulating a score for each of the nine public health quality aims. Evaluate the public health quality tool's usefulness by applying it to specific health improvement interventions in five mobile clinics. Examine for correlations between each program's score and improvements in a clinical endpoint.

- Public Health Quality Improvement Map (iMap) – Examine the feasibility of using the North Carolina iMap to demonstrate the value of public health programs and services on reducing the economic burden of specific conditions and risk factors on the health care system. Assess the ability of the iMap to accelerate stakeholder engagement to build quality improvement projects. Show the influence of public health on reducing health care costs.

- Evaluation of Adult Immunization Composite Quality Measures – Evaluate the implementation of composite quality measures for adult immunization coverage using national and/or local level data from federal data sources. Assess the technical feasibility of collecting data on adult immunization coverage composite measures. Evaluate whether the data results are informative and useful for quality improvement initiatives.

Strategic Goal 3

- Evaluating Best Practices for Using Mobile Technology – Assess best practices for using mobile technology/new media to extend the reach of public health messaging. Evaluate best ways to use mobile technology/new media to work across multiple public health issues and areas. Collect

lessons learned from work being done on the Affordable Care Act to extend the reach of other public health initiatives.

- Health Disparities Information Transfer – Assess the needs of people living with HIV/AIDS and viral hepatitis, their caregivers, individuals at high risk for undiagnosed HIV/AIDS and viral hepatitis, and service providers. Evaluate which technology/new media/communication tools are most effective in reaching those target audiences.

- Health of Older Americans - Assess the capacity of OASH program office portfolios to address health policy and program coordination to meet the health needs of older Americans, including identifying health disparities and population specific needs for healthy aging.

- Dietary Guidelines for Americans 2015, Phase Two – Evaluate and coordinate development of the 2015 Dietary Guidelines for Americans, a multi-year project spanning 2012-2015.

- Tobacco Cessation - Evaluate the effectiveness of OASH planning and management for tobacco cessation program activities, with specific focus on the Tobacco Free Campus initiative.

- Healthy People 2020: Achieving a Health Equitable Nation – Assess progress in achieving national goals and objectives. Evaluate stakeholder use of elements of Healthy People 2020, including goals, objectives, targets and online resources and identify areas needing improvement. Identify population health disparities and gaps in data collection.

- Longitudinal Program Evaluation of the "National Action Plan to Prevent Healthcare Associated Infections: Roadmap to Elimination" Program – Continue and expand the longitudinal program evaluation of the 2013 Healthcare Associated Infections Action Plan. Assess all healthcare-associated infection prevention related activities across the Department of Health and Human Services.

- Evaluation of Pregnancy Assistance Fund Grantees – Evaluate educational and social outcomes of 2-3 grantees. Assess education, health, pregnancy, and parenting skills with young women and men in institutions of higher education and/or high schools and community service centers of those participating in the program.

- Health People User Assessment – Conduct a survey to determine who is using Healthy People2020, how they are using it, what elements of Healthy People are most useful, and what improvements can be made.

- Evaluation of "I Can Do It, You Can Do It!" Program – Assess whether revisions to the program design, infrastructure and program materials increased the effectiveness of the health promotion program. Determine the extent to which "I Can Do It, You Can Do It!" should be expanded to multiple sites across the nation.

- Federal Black MSM Inventory and Assessment: HIV/AIDS and Viral Hepatitis – Identify, compile, review and conduct a comprehensive assessment of all current and recent federal HIV/AIDS and viral hepatitis programs, initiatives, policies, research and activities serving, targeting, or significantly impacting black gay, black bisexual or other black MSM.

- Evaluating the Impact of the ACA on Title X Centers – Analyze practice changes in Title X funded centers in response to the health system transformation resulting from the ACA. Assess practices and factors that affect sustainability in the different types of Title X centers.

- Evaluating Strategies to Engage Partners to Support the National Prevention Strategy – Identify and describe partnership strategies currently used across OASH to engage external partners in public health initiatives. Develop an "influence map" of key National Prevention Strategy stakeholder groups to inform development of a partnership framework.

- Process Evaluation of the Presidential Youth Fitness Program (PYFP) – Assess in-depth student, teacher, and school-level barriers and facilitators of the PYFP, as well as strategies to overcome barriers.

- Evaluating and Expanding the Use of HP 2020 in Design of the Affordable Care Act Community Benefit Plans – Assess ways in which HP 2020 can be integrated into Community Benefit Plans and help ensure coordination across efforts between hospitals and local health departments.

Strategic Goal 4

- Evaluating Healthcare Workforce Education and Training on Multiple Chronic Conditions– Assess training and educational materials for key healthcare workers on improving the care of persons with multiple chronic conditions. Develop a training and education framework that includes materials that can be used within specific healthcare categories and materials that can be used across workforce categories.

- Regional Office program support – Evaluate the existing Regional Office organizational structure to determine if current structure, staffing, and policies effectively support OASH program offices and OASH and HHS mission.

Funding History

Fiscal Year	Amount
FY 2011	$4,510,000
FY 2012	$4,510,000
FY 2013	$4,510,000
FY 2014	$4,664,000
FY 2015	$4,285,000

Budget Request

The FY 2016 President's Budget request of $4,285,000 is equal to the FY 2015 Enacted Level. In FY 2016, OASH program offices will submit proposals to improve and evaluate public health programs and identify ways to improve their effectiveness. The funding will support evaluations of community based activities supporting the health of individuals affected by health disparities. The evaluations will continue to serve decision makers in, federal, state, and local government, as well as support OASH priorities and the HHS strategic plan.

TEEN PREGNANCY PREVENTION

Budget Summary
(Dollars in Thousands)

Teen Pregnancy Prevention – PHS Evaluation	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	8,455	6,800	6,800	0
FTE	0	0	0	0

Authorizing Legislation: .....Section 241 of the PHS Act
FY 2016 Authorization.....Indefinte Allocation
Allocation Method.....Direct Federal; Contracts

Program Description and Accomplishments

The Office of Adolescent Health (OAH) supports several evaluation activities to continue to build the evidence base to prevent teenage pregnancy. OAH has supported projects that make significant contribution to the field of teen pregnancy prevention including three Federal evaluations, an economic analysis, and the HHS Pregnancy Prevention Evidence Review. Each will make a significant contribution to the evidence base of what works in teen pregnancy prevention and for expectant and parenting youth and their families.

The first Federal study, "The Pregnancy Prevention Approaches (PPA) evaluation, is an experimental evaluation study focused on assessing the implementation and impacts of seven innovative strategies and untested approaches for preventing teenage pregnancy. This work is managed by OAH and is in collaboration with the Administration for Children, Youth and Families (ACYF) "Personal Responsibility Education Program Innovative Strategies (PREIS)" program. A series of implementation and impact reports will be developed through the PPA evaluation. To date, nine of 22 implementation reports are complete and are posted on the OAH website. The second project, "The TPP Replication Evaluation", is managed in coordination with the office of the Assistant Secretary for Planning and Evaluation (ASPE). This program is an experimental evaluation study examining the implementation and impacts of three OAH TPP replications of three different evidence-based program models, for a total of nine sites. The study examines whether program models that were commonly chosen by replication grantees and widely used in the field are effective with different populations and settings. Site profiles including baseline data analyses were posted on the OAH website in 2015. The third study, "The Evaluation of Programs for Expectant and Parenting Youth", began in FY 2013 with a feasibility study that identified three potential programs for rigorous evaluation. The PAF evaluation began in FY 2014 and continues through FY 2019. It contributes to the evidence base in this field by determining the effectiveness of the selected programs on education and health outcomes.

OAH continues to support the HHS Pregnancy Prevention Evidence Review, a systematic review of the literature making up the HHS List of Evidence-Based TPP Programs. To date, four reviews have identified over 35 evidence-based TPP programs. In collaboration with ASPE and the Administration for Children and Families, Family and Youth Services Bureau, OAH supports an interagency agreement with ASPE to regularly update the evidence review and develop program implementation reports for use by community-based providers.

In an effort to ensure excellence in scientific research, over 40 OAH TPP and ACYF/PREIS evaluation grantees have received intensive evaluation training and technical assistance, through a contractor, to ensure that all grantee evaluations are high quality, rigorous, and able to meet the HHS Teen Pregnancy Prevention evidence review standards. Grantees primarily conducting randomized controlled trials and their Federal project officers receive ongoing technical assistance on conducting, analyzing, and reporting on their evaluations. Additional evaluation resources created under this contract are utilized by TPP grantees and the larger evaluation field. Rigorous impact evaluation reports from all evaluation grantees are expected to OAH in 2015. The reports will be submitted to the HHS Pregnancy Prevention Evidence Review and grantees are encouraged to publish their reports in peer-reviewed academic journals. Committed to disseminating the work of both the federal evaluations and the grantee evaluations, OAH published a special issue in the *Journal of Adolescent Health* in March 2014 featuring the implementation work of the TPP Program and has secured a themed issue in the *American Journal of Public Health* to feature the impact findings in late 2016.

OAH continues to maintain a web-based data repository to collect standardized performance measure data for OAH's Teen Pregnancy Prevention (TPP) grantees and Pregnancy Assistance Fund (PAF) grantees. The data system allows grantees to utilize their data for continuous quality improvement work, for reporting back to partners and stakeholders, and for their sustainability efforts. Additionally, the data repository allows for future analyses of TPP Program data.

Funding History

Fiscal Year	Amount
FY 2011	$4,455,000
FY 2012	$8,455,000
FY 2013	$8,455,000
FY 2014	$8,455,000
FY 2015	$6,800,000

Budget Request

The FY 2016 President's Budget request of $6,800,000 is equal to the FY 2015 Enacted Level. OAH will support contracts and up to two grants to carry out evaluations (including longitudinal evaluations) of teen pregnancy prevention approaches.

Contracts:

- The Evaluation of Programs for Expectant and Parenting Youth study is being conducted to assess the implementation and impacts of previously untested approaches for preventing subsequent pregnancies.
- Intensive evaluation training and technical assistance for the TPP evaluation grantees to ensure that all grantee evaluations are high quality, rigorous, and able to meet the HHS evidence review standards.

Grants:

- The funds will support research projects, through grants, to conduct additional, advanced and secondary data analyses related to teen pregnancy prevention.

IAAs:

- HHS Evidence Review: Through ASPE, OAH will continue the systematic review of the teen pregnancy prevention evidence base. The new contract was awarded in FY 2014 to build the understanding of the program models that have been rigorously evaluated and shown to reduce teen pregnancy, sexually transmitted infections, or associated sexual risk behaviors. The funding provides, under contract, the collection and analysis of program evaluation materials, preparation of findings for dissemination on an HHS website, consultation with experts, and the development of papers to help advance the TPP evidence-base; funds do not support federal staff.

Evaluation Fellow: OAH will continue to fund an evaluation fellow to gain experience in conducting research and evaluation in the field of teen pregnancy prevention, creating and presenting conference presentations and academic journal articles, and working on individual projects related to TPP evaluation work.

Prevention and Public Health Fund

PREGNANCY ASSISTANCE FUND

Budget Summary
(Dollars in Thousands)

Pregnancy Assistance Fund	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Budget Authority	23,200	23,175	25,000	0
FTE	2	2	2	0

Authorizing Legislation: ……..Patient Protection and Affordable Care Act, Section 10214
FY 2016 Authorization……FY 2019
Allocation Method……Direct Federal; Competitive Contracts; Grants

Program Description and Accomplishments

The Office of Adolescent Health (OAH) is responsible for administering the Pregnancy Assistance Fund (PAF), a competitive grant program for States and Indian Tribes to develop and implement projects to assist expectant and parenting teens, women, fathers and their families. The program is authorized by Sections 10211-10214 of the Affordable Care Act (Public Law 111-148); specifically, the Act appropriates $25,000,000 for each of fiscal years 2010 through 2019 and authorizes the Secretary of the Department of Health and Human Services (HHS), in collaboration and coordination with the Secretary of Education (as appropriate) to establish and administer the PAF program. The program aims to strengthen access to and completion of education (secondary and postsecondary); improve child and maternal health outcomes; improve pregnancy planning and spacing and reduce the likelihood of repeat teen pregnancies; increase parenting skills for mothers, fathers, and families; strengthen co-parenting relationships and marriage where appropriate, increase positive paternal involvement; improving services for pregnant women who are victims of domestic violence, sexual violence or assault, and stalking; and raise awareness of available resources.

The PAF also supports the Secretary's Strategic Initiative to Promote Early Childhood Health and Development and to Put Children and Youth on the Path for Successful Futures. Additionally, these funds support the OASH's priority goals of creating better systems of prevention, eliminating health disparities, and achieving health equity.

The current cohort of 17 grantees will complete their third project period and start the fourth project period in 2016. The grants to 14 states and 3 tribes were awarded in 2013 to support expectant and parenting teens, women, fathers and their families. OAH is implementing an evaluation of two grantee projects from this cohort; however all grantees are expected to collect and report on a standard set of performance measures developed by OAH to assess program implementation and whether the program is achieving intended outcomes. By the end of 2015, grantees will have collected and reported on two years of performance data, including information on the number and characteristics of clients served, the number and type of partnerships, as well as on selected measures examining health, educational, and social indicators, including referrals for services. Grantees will also report on the type and range of public awareness and education activities conducted as part of their PAF program.

The program supports the Secretary's Strategic Initiative to Promote Early Childhood Health and Development and to Put Children and Youth on the Path for Successful Futures. Additionally, these

funds support the OASH's priority goals of creating better systems of prevention, eliminating health disparities, and achieving health equity.

Funding History

Fiscal Year	Amount
FY 2011	$25,000,000
FY 2012	$25,000,000
FY 2013	$23,725,000
FY 2014	$23,175,000
FY 2015	$25,000,000

Budget Request

The FY 2016 President's Budget request of $25,000,000 is 1,825,000 above the FY 2015 Enacted Level. The request supports the completion of the third year of program activities for PAF grantees. In addition, this request will allow for continued support of two to three new competitive PAF grant programs planned for FY 2015. The request will also provide program support to the PAF grantees. Program support activities include maintaining the PAF Resource and Training Center, which provides technical assistance and training; facilitating the exchange of information on best practices and program related resources; capacity building for program implementation; supporting program goals of recruiting and retaining young fathers, and developing strategies for sustaining programmatic efforts. Additional activities include support for tracking of grantee progress and outcomes includes collection, assessment and responding to grantee reports; site visits; six-month and annual progress reports; and review of grantee work plans and budgets. The system will also provide analytic capabilities to track grantee progress, track OAH grantee recommendations on program implementation, and provide ongoing feedback to grantees by project officers. The increase of funds will restore program operating costs.

FY 2016 Discretionary State Grants

Pregnancy Assistance Fund (PAF)

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	Difference +/- FY 2016 FY 2015
Children's Trust Fund of South Carolina	$1,500,000	$1,500,000	$1,500,000	0
Choctaw Nation of Oklahoma	$977,432	$977,432	$977,432	0
Commonwealth of Massachusetts	$1,500,000	$1,500,000	$1,500,000	0
Confederated Salish and Kootenal Tribes	$504,343	$504,343	$504,343	0
Connecticut State Department of Education	$1,500,000	$1,500,000	$1,500,000	0
Health Research, Inc./New York State Department of Health	$1,333,436	$1,333,436	$1,333,436	0
Michigan Department of Community Health	$1,500,000	$1,500,000	$1,500,000	0
Minnesota Department of Health State Treasurer	$1,500,000	$1,500,000	$1,500,000	0
Montana Department of Public Health and Human Services	$1,000,000	$1,000,000	$1,000,000	0
New Mexico Public Education Department	$1,499,990	$1,499,990	$1,499,990	0
North Carolina Department of Health and Human Services	$1,500,000	$1,500,000	$1,500,000	0
Oregon Department of Justice	$1,000,382	$1,000,382	$1,000,382	0
Riverside-San Bernardino County Indian Health	$704,355	$704,355	$704,355	0
State of California Maternal, Child, and Adolescent Health	$1,500,000	$1,500,000	$1,500,000	0
State of New Jersey Department of Children and Families	$1,500,000	$1,500,000	$1,500,000	0
Washington State Department of Health	$1,500,000	$1,500,000	$1,500,000	0
Wisconsin Department of Public Instruction	$1,499,999	$1,499,999	$1,499,999	0
New Grant Awards – TBD	$0	$0	$1,800,000	+$1,800,000
Subtotal States/Territories	**$22,019,937**	**$21,994,937**	**$23,819,937**	**+$1,825,000**
Program Support	**$1,180,063**	**$1,180,063**	**$1,180,063**	**0**
Total Resources	**$23,200,000**	**$23,175,000**	**$25,000,000**	+$1,825,000

SUPORRTING EXHIBITS

DETAIL OF POSITIONS

Detail	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Executive level I	1	1	1
Executive level II	1	1	1
Executive level III	-	-	-
Executive level IV	2	2	2
Executive level V	1	1	1
Subtotal	***5***	***5***	***5***
Total - Exec. Level Salaries	**$862,818**	**$871,446**	**$880,161**
SES	110	109	109
Total - ES Salary	**$17,926,275**	**$17,940,942**	**$18,120,351**
GS-15	197	199	214
GS-14	206	207	223
GS-13	209	177	192
GS-12	279	321	345
GS-11	166	167	179
GS-10	11	11	21
GS-9	119	120	128
GS-8	57	52	56
GS-7	37	37	41
GS-6	5	5	6
GS-5	8	8	9
GS-4	8	8	8
GS-3	9	9	10
GS-2	1	1	1
GS-1	-	-	-
Subtotal	***1,312***	***1,322***	***1,433***
Commissioned Corps	54	52	45
Total Positions	**1,481**	**1,488**	**1,592**
Average ES salary	$155,881	$157,377	$158,950
Average GS grade	13.7	13.6	13.6
Average GS Salary	$105,099	$105,466	$105,439

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT

Detail	FY 2014 Civilian	FY 2014 Military	FY 2014 Total	FY 2015 Civilian	FY 2015 Military	FY 2015 Total	FY 2016 Civilian	FY 2016 Military	FY 2016 Total
Direct	*974*	*31*	*1005*	*1018*	*43*	*1061*	*1100*	*36*	*1136*
Reimbursable	*469*	*19*	*488*	*511*	*9*	*520*	*511*	*9*	*520*
Total FTE[10]	***1443***	***50***	***1493***	***1529***	***52***	***1581***	***1611***	***45***	***1656***

[10] Totals include the reimbursable program (HCFAC) and program (PAF).

FTEs Funded by the Affordable Care Act

(Dollars in Thousands)

Program	Section	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FTEs
Pregnancy Assistance Fund Discretionary P.L. (111-148)	**Section 10214**	**$25,000**	**$25,000**	**$25,000**	**$23,175**	**$25,000**	**$25,000**	**2**

STATEMENT OF PERSONNEL RESOURCES

General Departmental Management

Total Full-Time Equivalents

Resouorce	FY 2014 Estimate	FY 2015 Estimate	FY 2016 Estimate
Direct Ceiling FTE	1041	1000	1135
Reimbursable Ceiling FTE	440	488	457
Total Ceiling FTE	**1481**	**1488**	**1592**
Total Civilian FTE	1427	1436	1547
Total Military FTE	54	52	45

FTE PAY ANALYSIS

Detail	FY 2014	FY 2015	FY 2016
Total FTE	1,041	1,000	1,135
Number change from previous year	-30	-41	135
Funding for object classes 11	$109,408	$105,361	$119,673
Average cost per FTE	$105	$105	$105
Percent change in average cost from previous year	+2.9%	+.2%	+.1%
Average grade/step of GS employee	13.7	13.6	13.6

RENT AND COMMON EXPENSES

(Dollars in Thousands)

Detail	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Rent	-	-	-	-
GDM[11]	8,524	8,524	8,703	+179
ASFR	150	150	153	+3
DAB	-	245	250	+5
OGA	500	500	511	+11
OGC	2,827	2,827	2,886	+59
OASH	4,341	4,310	4,401	+91
Subtotal	***16,342***	***16,556***	***16,904***	***+348***
Operations and Maintenance	-	-	-	-
GDM[1]	7,905	7,265	7,797	+532
ASA	268	225	268	+43
ASFR	290	290	296	+6
DAB	40	40	41	+1
OGA	231	231	236	+5
OGC	1,571	1,571	1,535	-36
OASH	1,690	1,690	1,725	+35
Subtotal	***11,995***	***11,312***	***11,899***	***+587***
Service and Supply Fund	-	-	-	-
GDM Shared Services	9,473	9,035	11,870	+2,835
ASA	1,498	1,758	1,758	-
ASFR	1,604	1,684	1,684	-
ASL	253	266	266	-
ASPA	400	420	420	-
DAB	459	482	482	-
IEA	573	602	602	-
IO	823	864	864	-
OGA	237	249	249	-
OGC	979	1,028	1,028	-
OASH	7,070	7,423	7,423	-
Subtotal	***23,369***	***23,811***	***26,646***	***+2,835***

[1] GDM Rent covers expenses for Staff Divisions except as noted in the tables.

SIGNIFICANT ITEMS IN CONFERENCE AND SENATE APPROPRIATIONS COMMITTEE REPORTS

L-HHS Appropriations Committee Omnibus (Public Law 113-235)

Item
Overhead Costs *- The Department is directed to include in its annual budget justification for fiscal year 2016, the amount of administrative and overhead costs spent by the Department for every major budget line.*

Action Taken or To Be Taken
Please refer to page 168 for a detail table for Overhead Costs.

Item
Sports-Related Injuries *- The agreement encourages the Department to investigate the development of new and better standards for testing sports equipment that is supported through independent research, governance, and industrial independence. These standards should actually replicate on-field impacts and produce testing data for "worst-practical-impact" conditions. Such standards will lead to research and development of new safety equipment to ensure that athletes have state-of-the-art gear that significantly reduces injuries.*

Action Taken or To Be Taken
Please see the National Institutes of Health's President's Budget for a narrative on this item.

Item
Lupus *- The agreement reflects strong support for this program, which is intended to engage healthcare providers, educators, and schools of health professions in working together to improve lupus diagnosis and treatment through education.*

Action Taken or To Be Taken
HHS and the Office of Minority Health (OMH) remain committed to engaging healthcare providers, educators and schools of health professions in working together to improve lupus diagnosis and treatment through education.

Currently, OMH supports the National Health Education Program on Lupus for Healthcare Providers (NHEPLHP) with the goal of improving diagnosis for those with lupus and reducing health disparities. The program engages healthcare providers, educators, schools of health professions, communities, and individuals and families in working together to improve lupus diagnosis and treatment through education. The NHEPLHP targets practicing physicians and nurses, as well as medical, nursing, and other allied health students in training.

The FY2015 Lupus program will address the following priorities:

- Expand healthcare provider training to include physician assistants, nurse practitioners, pharmacists and allied health professionals (as well as physicians and nurses) to engage them to improve lupus diagnosis and treatment through education, appropriate linkages to care, treatment, and healthcare enrollment.

- Expand the lupus program through a comprehensive community level education effort that will serve persons living with lupus and their family members. The program will include: community outreach to improve awareness and understanding of lupus and management of primary and secondary conditions; access to care and coverage to increase the number of persons linked to healthcare services and enrolled in healthcare coverage plans; and communication strategies such as electronic media and patient/provider software application development to improve disease management and outcomes and patient/provider communication.

- Support for patient and family care networks to address isolation, living with different stages of lupus, coordination of care, and provide opportunities to develop coping strategies, feel empowered, and expand community support.

Item

Transparency in Health Plans *- The agreement directs the Secretary to provide additional clarification to qualified health plans, based upon relevant and related GAO findings, to ensure greater consistency and full transparency of coverage options included in health insurance plans prior to plan purchase in the marketplace enrollment process. The agreement requests a timeline for such clarifying guidance to be submitted to the House and Senate Committees on Appropriations within 30 days after enactment of this act.*

Action Taken or To Be Taken

Please refer to the Centers for Medicare and Medicaid Services' President's Budget for a narrative on this item.

Item

Seafood Sustainability *- The agreement prohibits the Department from using or recommending third party, nongovernmental certification for seafood sustainability.*

Action Taken or To Be Taken

Please see the Food and Drug Administration's President's Budget for a narrative on this item.

Item

Healthcare Provider Complaints *- Legislation appropriating funding for the Department of Health and Human Services has carried a general provision relating to health care providers since fiscal year 2005 (Division H, Section 507(d) of Public Law 113-76). Complaints regarding reported violations of these provisions have been filed with the Office for Civil Rights at the Department of Health and Human Services. The Secretary is directed to respond to these complaints expeditiously in accordance with final rule 45 CFR Part 88 published in Federal Register Vol. 76 No. 36.*

Action Taken or To Be Taken

The Office for Civil Rights at the Department of Health and Human Services (HHS) takes seriously its responsibilities under the HHS Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 45 CFR Part 88, and is responding to complaints we have received under this regulation expeditiously and in accordance with the regulation.

Item

Lobbying *- The agreement requests an update on how the OIG is working with the HHS agencies to improve monitoring of grantee activities to ensure that no taxpayer resources are used for lobbying.*

Action Taken or To Be Taken

Please see the Office of Inspector General's President's Budget for a narrative on this item.

Item

Office for Human Research Protections (OHRP) *- Recent reviews by the OIG raise questions about the independence of the OHRP during the process to make determinations. The agreement requests the OIG conduct a formal review of OHRP procedures and make appropriate recommendations to ensure and strengthen human subjects protections in future research and ensure the independence of OHRP.*

Action Taken or To Be Taken

Please see the Office of Inspector General's President's Budget for a narrative on this item.

Item

Project Bio-Shield *- The agreement is committed to ensuring the nation is adequately prepared against chemical, biological, radiological, and nuclear attacks. The agreement recognizes a public-private partnership to develop medical countermeasures (MCMs) is required to successfully prepare and defend the nation against these threats as has been demonstrated in the decade since the initiation of the Project Bio-Shield Special Reserve Fund (SRF). Where there is little or no commercial market, the agreement supports the goal of an explicit commitment by the Government to biodefense medical countermeasures, such as was provided during fiscal years 2004-2013 by the initial SRF. Although the agreement cannot provide the authorized 5-year amount of $2,800,000,000, it continues to support the procurement of MCSs. Further, the agreement requests the agency provide an update in the fiscal year 2016 congressional budget on how it can support training and simulated events to prepare for the coordinated management and utilization of medical countermeasures.*

Action Taken or To Be Taken

Please see the Public Health and Social Services Emergency Fund's President's Budget for a narrative on this item.

Agriculture Appropriations Subcommittee (Public Law 113-235) Agriculture Report

Item

Oversight of FDA – *Over the past five years FDA's responsibilities have grown significantly and resources available to the agency have increased more than 60 percent. There is a concern that oversight of FDA has not kept pace with the growth in the agency's regulatory authority or funding. Therefore, the agreement includes $1,500,000 for the HHS Office of Inspector General specifically for oversight activities supported within the Inspector General's regular appropriation. The Inspector General is instructed to submit a plan to the Committees on the additional oversight activities planned with this funding and base funding for FDA oversight.*

Action Taken or To Be Taken

Please see the Office of Inspector General's President's Budget for a narrative on this item.

GRANTS.GOV

The following is presented pursuant to Sections 737(b) and (d) of the Consolidated Appropriations Act of 2008 (P.L. 110-161).

The Assistant Secretary for Financial Resources (ASFR) manages the Grants.gov program. Grants.gov is the Federal government's "one-stop-shop" for grants information, providing information on over 1,000 grant programs and $500 billion awarded by the 26 grant-making agencies and other Federal grant-making organizations. The initiative enables Federal agencies to publish grant funding opportunities and application packages online, while allowing the grant community of over one million organizations (State, local, and tribal governments, education and research organizations, non-profit organizations, public housing agencies, and individuals) to search for opportunities and download, complete, and electronically submit applications.

Through the use of Grants.gov, agencies are able to provide the public with increased access to government grants programs and are able to reduce operating costs associated with online posting and application of grants. Additionally, agencies are able to improve their operational effectiveness through the use of Grants.gov, by increasing data accuracy and reducing processing cycle times.

The initiative provides benefits to the following agencies:

- Department of Agriculture
- Department of Commerce
- Department of Defense
- Department of Education
- Department of Energy
- Department of Health and Human Services
- Department of Homeland Security
- Department of Housing and Urban Development
- Department of the Interior
- Department of Justice
- Department of Labor
- Department of State
- U.S. Agency for International Development
- Department of Transportation
- Department of the Treasury
- Department of Veterans Affairs
- Environmental Protection Agency
- National Aeronautical and Space Administration
- National Archives and Records Administration
- National Science Foundation
- Small Business Administration
- Social Security Administration
- Corporation for National Community Service
- Institute of Museum and Library Services
- National Endowment for the Arts

- National Endowment for the Humanities

From its inception, Grants.gov has transformed the Federal grants environment by streamlining and standardizing public-facing grant processes, thus facilitating an easier application submission process for our applicants. The Grants.gov Program Management Office (PMO) works with agencies on system adoption, utilization, and customer satisfaction.

RISK MANAGEMENT OVERVIEW: Risks are categorized and prioritized to facilitate and focus risk management activities. Risk categories are aligned with OMB risk management guidance, ensuring comprehensive consideration of possible risks and simplifying program reporting. Risk prioritization is based on the probability of occurrence and potential impact, and focuses project resources where they are most needed.

All risks are tracked in the Grants.gov Risk Management Database, from identification through resolution. This online database is accessible to all Grants.gov team members and is updated regularly, in keeping with a continuous risk management process. Although physically separate, the Risk Management Database is considered an integral part of the Grants.gov Risk Management Plan.

Risks are categorized to facilitate analysis and reporting. The Grants.gov risk categories are aligned with Office of Management and Budget (OMB) guidance on risk assessment and mitigation. The risk category describes potentially affected areas of the program, and helps put individual risks into context when assessing their severity. The categories are also used to drive risk identification: the lack of identified risks in a given category may indicate overlooked risks. The following risks have been identified to OMB:

Risk 1: The global financial crisis (2008-present) has dramatically reduced federal revenues and increased the federal deficit. Widespread calls to reduce federal spending could result in decreased funding for Grants.gov. The Grants.gov PMO operations, funded entirely by agency contributions, include: salaries and expenses for full-time staff, and support contracts for system integration, hardware platforms, upgrades, software licenses, Independent Verification and Validation, outreach and liaison, contact center, performance metrics monitoring, and office support. If the PMO does not receive sufficient funding, or if the agency contributions are not provided in a timely manner, the PMO would have to limit or stop providing the services it offers to its stakeholders.

Risk mitigation response: Grants.gov risk mitigation is a multifaceted approach that includes internal actions as well as external entities. Internally, the PMO times the majority of its contract actions toward the 3rd and 4th quarter of the fiscal year, to accommodate the speed of incoming contributions. Additionally, if sufficient funding is not available, the PMO can reduce the scope of its contracts, reprioritize contract awards, and/or postpone awarding of contracts. All contract actions and award decisions are made in the context of ensuring full, reliable functionality of the Grants.gov system. The PMO closely monitors contract expenditures and PMO activities such as training and travel expenditures to ensure the available budget will cover the actual expense. No later than the 2nd quarter of the fiscal year, the PMO develops and sends documentation to each funding agency to initiate funding transfers and then reports (weekly) the status of agency contributions to the Council on Financial Assistance Reform (COFAR), Financial Assistance Committee for e-Gov (FACE), and OMB.

Risk 2: A fundamental concept of electronic commerce is the standardization of a common set of terms to be used by trading partners during business communications. Grants.gov requires common data

processes in order to function. The inability to define common data and processes could impede program goals.

Risk mitigation response: The Grants.gov system was developed in accordance with the electronic standards for core grants data, Transaction Set 194, which were developed by the Inter-Agency Electronic Grants Committee (IAEGC). The Grants.gov PMO worked with the PL 106/107 workgroup and IAEGC to build consensus, and continues to work to minimize the required changes to agency and applicant processes. Agencies are being encouraged to simplify their forms and if possible develop a common set of forms and data definitions. To meet that goal, Grants.gov is consolidating already existing forms and working with Agencies for adoption to avoid duplicate forms used across the agencies.

FUNDING: The total development cost of the Grants.gov initiative by fiscal year -- including costs to date, estimated costs to complete development to full operational capability, and estimated annual operations and maintenance costs -- are included in the table below. Also included are the sources and distribution of funding by agency, showing contributions to date and estimated future contributions through FY 2015.

GRANTS.GOV

FY 2014 to FY 2016 Agency Contributions

Agency	Total FY 2014	Total FY 2015	Total FY 2016
HHS	4,710,238	4,964,848	5,161,848
DOT	404,959	394,724	358,714
ED	547,513	543,914	446,120
HUD	407,186	241,593	149,921
DHS	300,929	361,185	330,995
NSF	467,754	450,354	435,517
USDA	509,443	439,294	454,039
DOC	326,901	289,592	332,452
DOD	752,274	666,561	584,477
DOE	439,604	379,656	378,312
DOI	1,335,972	1,603,166	1,754,577
DOL	211,895	209,386	217,684
EPA	373,002	281,852	271,467
USAID	429,166	398,331	389,857
USDOJ	510,553	435,397	545,783
NASA	173,346	161,725	167,049
CNCS	64,809	57,453	61,574
DOS	289,976	413,404	467,400
NEH	213,889	196,177	180,501
SBA	69,120	49,186	59,023
IMLS	76,594	77,833	76,082
NEA	182,161	174,423	193,697
VA	47,753	57,304	68,765
NARA	40,623	36,160	38,622
SSA	36,370	26,578	26,327
USDOT	59,672	71,606	85,927
Grand Total	**12,981,702**	**12,981,702**	**13,236,730**

PHYSICIAN'S COMPARABILITY ALLOWANCE(PCA)

Office of the Assistant Secretary for Planning and Evaluation

Physician Categories	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
1) Number of Physicians Receiving PCAs	2	2	2
2) Number of Physicians with One-Year PCA Agreements	1	1	1
3) Number of Physicians with Multi-Year PCA Agreements	1	1	1
4) Average Annual PCA Physician Pay (without PCA payment)	$146,426	$146,426	$146,426
5) Average Annual PCA Payment	$20,000	$20,000	$20,000
6) Number of Physicians' Receiving PCA's by Category (non-add) **Category I Clinical Position**	0	0	0
Number of Physicians' Receiving PCA's by Category (non-add) Category II Research Position	2	2	2
Number of Physicians' Receiving PCA's by Category (non-add) Category III Occupational Health	0	0	0
Number of Physicians' Receiving PCA's by Category (non-add) Category IV-A Disability Evaluation	0	0	0
Number of Physicians' Receiving PCA's by Category (non-add) Category IV-B Health and Medical Admin.	0	0	0

*FY 2014 data will be approved during the FY 2016 Budget cycle.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) offers physicians filling the Category II Research positions the maximum of $30,000 per employee. These physicians provide expert medical advice and analysis on ASPE topics relating to medical care, informatics, and the management of chronic conditions and access of HHS data. The qualifications of these two medical experts provide an exceptional level of skill, expertise and experience necessary to support the ASPE office's initiatives.

ASPE has traditionally had difficulty in recruitment of research and informatics physicians. The last recruitment in our office resulted in only three candidates and most were not a good fit. ASPE has had to pursue other avenues for physicians such as short term Intergovernmental Personnel Act (IPA) employees through universities which often result in higher costs. Without the PCA, ASPE would be unable to recruit qualified physicians or retain those on board. The PCA is an excellent means of staffing for highly qualified research physicians for our office.

Recruiting physicians at the GS salary schedule would prove to be challenging without the ability to offer the PCA incentive, which assists in obtaining the qualifications and expertise useful to ASPE's efforts.

Centrally Managed Projects

The GDM Staff Divisions are responsible for administering certain centrally-managed projects on behalf of all Operating divisions in the Department. Authority for carrying out these efforts is authorized by either specific statute or general transfer authority (such as the Economy Act, 31 USC 1535). The costs for centrally-managed projects are allocated among the Operating Divisions in proportion to the estimated benefit to be derived.

Project	Description	FY 2015 Funding
The Digital Accountability and Transparency Act	The funds will focus on developing a strategy and laying the groundwork to begin incorporating agreed upon standards into the Department of Health and Human Services 'Policies, processes and systems to ensure full compliance with the Digital Accountability and Transparency Act.	$5,000,000
Department-wide CFO Audit of Financial Statements	These funds cover the costs of auditing the HHS financial statements annually (as required by the CFO Act of 1990), and stand-alone audit of the CMS producing Department-wide financial statements, and coordinating the HHS audit process, including costs for FISMA.	$13,768,664
Bilateral and Multilateral International Health Activities	These funds support activities by the Office of Global Affairs in leading the U.S. government's participation in policy debates at multi-lateral organizations on health, science, and social welfare policies and advancing HHS's global strategies and partnerships, and working with USG agencies in the coordination of global health policy and setting priorities for international engagements.	$6,563,001
Regional Health Administrators	The RHA's provide senior-level leadership in health, bringing together the Department's investments in public health and prevention by providing a health infrastructure across the ten HHS regions. Particularly in the areas of prevention, preparedness, coordination and collaboration, the RHA's represent the Secretary, Assistant Secretary for Health and Surgeon General in the Regions, and are key players in managing ongoing public health challenges.	$2,772,090
National Science Advisory Board for Bio-Security (NSABBS)	Funds will be used by the NSABBS for providing guidance on ways to enhance the culture of responsibility among researchers, developing strategies for enhancing interdisciplinary bio-security, recommending outreach strategies, engaging journal editors on policies for review, continuing international engagement, and develop Federal policy for oversight of life sciences research at the local level based on recommendations of the NSABBS.	$2,672,000
Departmental Ethics Program	These funds will be used to support attorneys and	$3,400,000

	other legal staff under the direction of HHS's Designated Agency Ethics Official, who provide ethics-related program services, financial disclosure reviews, training programs and audits, as required by the Ethics in Government Act and the Office of Government Ethics.	
Secretary's Advisory Committee on Blood Safety and Availability	The Committee advises the Secretary on a broad range of public health, ethical and legal issues related to blood transfusion and transplantation safety. Such issues require coordination across many of the Operating Divisions. Funds support Committee meetings, workshops, staff, and subject matter experts.	$1,500,000
President's Commission for the Study of Bioethical Issues	The Commission, created by Executive Order 13521 on November 24, 2009, replaced the President's Council on Bioethics. Its purpose is to advise the President on bioethical issues that may emerge as a consequence of advances in biomedicine and related areas of science and technology. Funding for the Council comes entirely from HHS.	$3,000,000
Media Monitoring and Analysis	These funds permit the Office of the Assistant Secretary for Public Affairs to provide coordinated, succinct daily monitoring services of all agency-relevant media coverage for the entire department, thus preventing duplication and overlap by individual Operating Divisions.	$784,008
NIH Negotiation of Indirect Cost Rates	At the request of Operating Divisions, NIH has expanded its capacity to negotiate indirect cost rates with commercial (for-profit) organizations that receive HHS contract and/or grant awards, to ensure that such indirect costs are reasonable, allowable, and allocable.	$1,047,000
Intradepartmental Council on Native American Affairs	These funds will be used for continued support of HHS-wide tribal consultation; support new initiatives such as tribal emergency preparedness, suicide prevention and the HHS American and Alaska Native Health Research Advisory Council and to continue to serve as the HHS focal point for Native American Health and Human Services.	$383,182
Chronic Fatigue Syndrome Advisory Committee (CFSAC)	CFSAC provides expertise in biomedical research in the area of CFS, health care delivery services, insurers and voluntary organizations concerned with the problems of individuals with CFS. They meet on research, patient care, education, and quality of life for persons with CFS.	$100,000
HHS Broadcast Studio	These funds will be used to give staff and operating divisions the ability to utilize the studio as a lead component in their communication strategies both to internal and external audiences.	$2,284,080

Office of Medicare Hearings and Appeals

Memo from the Chief Administrative Law Judge

I am pleased to present the Office of Medicare Hearings and Appeals (OMHA's) Fiscal Year 2016 Congressional Justification. This budget request reflects OMHA's strong commitment to providing an independent forum for the fair and efficient adjudication of Medicare appeals for beneficiaries and other parties.

Since beginning operations in July 2005, OMHA has been committed to continuous improvement in the Medicare appeals process through responsible stewardship. Given current resources and average receipt levels OMHA is receiving more than one year's worth of work every eight weeks. With these rising receipt levels far exceeding the adjudication capacity of its 72 Administrative Law Judges (ALJ) currently on-board, OMHA is unable to issue Medicare decisions in 90 days as envisioned by statute.

The FY 2016 budget reflects OMHA's efforts not only to build upon the operational success achieved during its first ten years, but to introduce the first steps in a multi-year strategy to balance resources with workloads and eliminate the backlog. The first of these is an Adjudication Expansion Initiative to respond to the agency's foremost challenge, its increased level of appeals receipts and the resulting backlog of appeals. OMHA has also proposed the following legislative and business process changes which will help it to adjudicate more appeals at a lower cost: Settlement Conference Facilitation, Medicare Magistrate Program, and Attorney Adjudicator Initiative. Additionally other Departmental budget requests contain critical legislative proposals that if implemented will help to reduce the backlog.

Although OMHA recognizes that the improvements to the appeals process envisioned by the proposed legislative changes must be a part of the solution, these changes alone will not enable OMHA to adjudicate the significant number of appeals that it has on hand or that it projects will be received in the coming years. In order to begin to reduce the catastrophic backlog of Medicare appeals pending at OMHA, a significant funding increase is required. The FY 2016 budget request is a starting point and must serve as a baseline for future requests.

Above all, this FY 2016 budget reflects OMHA's efforts to focus on the agency's mission, by increasing efficiency and capacity by further enhancing service to the public.

/Nancy J. Griswold/
Nancy J. Griswold
Chief Administrative Law Judge

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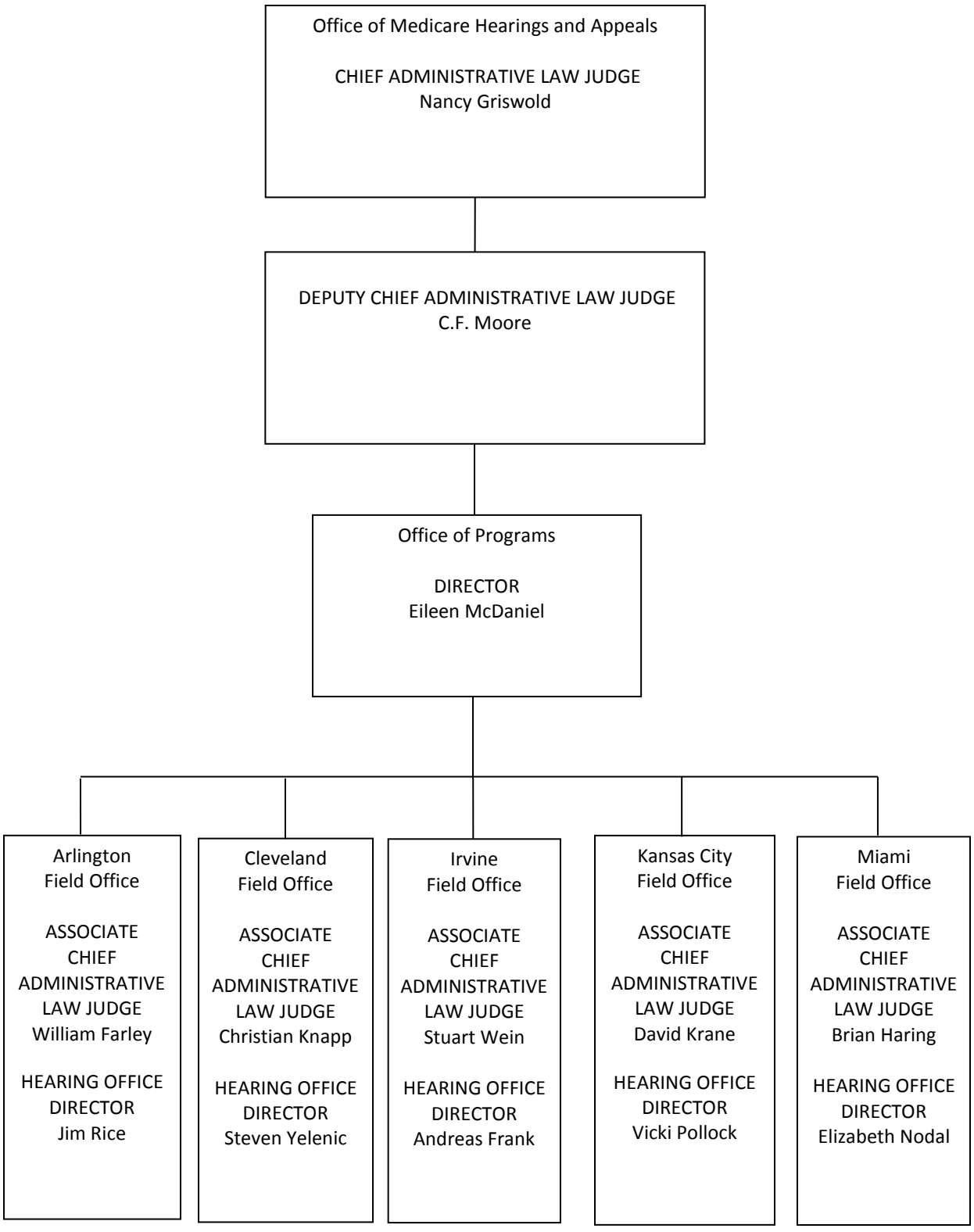
Organizational Chart



Organizational Chart: Text Version

Office of Medicare Hearings and Appeals

- Chief Administrative Law Judge, Nancy Griswold
- Deputy Chief Administrative Law Judge, C.F. Moore

The following offices report directly to the Chief Administrative Law Judge:

- Director, Office of Programs
  - Eileen McDaniel
- Arlington Field Office
  - Associate Chief Administrative Law Judge, William Farley
  - Hearing Office Director, Jim Rice
- Cleveland Field Office
  - Associate Chief Administrative Law Judge, Christian Knapp
  - Hearing Office Director, Steven Yelenic
- Irvine Field Office
  - Associate Chief Administrative Law Judge, Stuart Wein
  - Hearing Office Director, Andreas Frank
- Kansas City Field Office
  - Associate Chief Administrative Law Judge, David Krane
  - Hearing Office Director, Vicki Pollock
- Miami Field Office
  - Associate Chief Administrative Law Judge, Brian Haring
  - Hearing Office Director, Elizabeth Nodal

Introduction and Mission

The Office of Medicare Hearings and Appeals (OMHA), an agency of the U.S. Department of Health and Human Services (HHS), administers hearings and appeals nationwide for the Medicare program. OMHA ensures that Medicare beneficiaries, providers and suppliers have access to an independent forum and opportunity for hearing conducted pursuant to the Administrative Hearing Act on disputed Medicare claims. By providing a timely and impartial review of Medicare appeals, OMHA encourages providers and suppliers to continue to provide services and supplies to Medicare beneficiaries. Such access to timely adjudication of disputes is essential to the integrity of the Medicare system. On behalf of the Secretary of HHS, the Administrative Law Judges (ALJs) within OMHA conduct impartial hearings and issue decisions on claims determination appeals involving Medicare Parts A, B, C and D, as well as Medicare entitlement and eligibility appeals.

Mission

OMHA is a responsive forum for fair, credible, and timely decision-making through an accomplished, innovative, and resilient workforce. Each employee makes a difference by contributing to shaping American health care.

Vision

World class adjudication for the public good.

Statutory Decisional Timeframes

The Benefits Improvement and Protection Act of 2000 envisions that OMHA will issue decisions on disputed claims within 90 days after a request for hearing is filed.

Overview of Budget Request

The FY 2016 budget request for OMHA of $270,000,000 represents a $182,619,000 million increase over the FY 2015 enacted level of $87,381,000. The request includes $140,000,000 in budget authority and $130,000,000 in program level funding from proposed legislation.

HHS is proposing a series of legislative proposals to permit HHS to make regulatory and policy changes. The most significant would authorize access to $125,000,000 in recovery audit collections to reimburse OMHA for administrative costs related to adjudicating Recovery Audit (RA) appeals. For the past two years these appeals have represented over 50% of OMHA's total receipts. Also proposed is a provision for a refundable filing fee. If this filing fee provision is authorized it is estimated that it will add $5,000,000 in program level funding. However, the $5,000,000 in additional authority is purely an estimate and does not include the administrative costs of processing the fees.

The request positions OMHA to hear more Medicare appeals than ever before by expanding the agency's capacity from the projected 77 ALJ teams on-board at the end of FY 2015 to 196 ALJ teams nationwide, and establishing 6 new field offices. After gaining 6 to 12 months of experience, these ALJ teams will collectively adjudicate approximately 119,000 additional appeals annually, more than doubling the adjudication capacity of the agency. The expansion of adjudicatory capacity will enable OMHA to hear almost 200,000 complex appeals annually and will begin to slow the growth of its increasing backlog, which currently exceeds 800,000 appeals. The additional funding also supports several HHS and OMHA initiatives to address less complex appeals by other means, including Settlement Conference Facilitation, Medicare Magistrates, and Attorney Adjudicators. These alternative adjudication methods will increase OMHA's appeals resolution capacity at a lower cost per appeal. It is estimated with adequate support staff that the production for the both the Medicare Magistrates and Attorney Adjudicators would be similar to that of an ALJ (up to 1,000 appeals annually) and could increase OMHA's adjudicatory capacity by 103,000 appeals in FY 2016 alone.

However, OMHA has passed the critical juncture at which it is able to adequately support its workload. If the additional resources requested are not received it is estimated that the unheard claims workload will approach 3,000,000 (if the average number of claims per appeal remains at 2 to 1, this would translate to 1,400,000 appeals) by the end of FY 2016.

Overall, OMHA's budget request makes investments to support HHS Strategic Goals to Strengthen Healthcare and Ensure Efficiency, Transparency, Accountability and Effectiveness of HHS Programs. This will be accomplished by maximizing its organizational adjudicatory capacity to meet the needs of Medicare beneficiaries, who are among our nation's most vulnerable populations, providers and suppliers of services to Medicare beneficiaries, and the tax-paying public.

Overview of Performance

OMHA has remained committed to continuous improvement in the Medicare appeals process by implementing initiatives to enhance the quality and timeliness of its services. However, as workloads have grown dramatically, it has become impossible for the agency to achieve its goals. Between FY 2011 and FY 2013, OMHA experienced a 545% growth in appeals (from 60,000 appeals in FY 2011 to 384,000 appeals in FY 2013). In just the first six months of FY 2014, OMHA received 289,000 appeals – 75% of total appeals received in FY 2013. This dramatic increase in both RA and non-RA appeals has had a predictably detrimental impact on the agency's performance. For the past three years, OMHA has failed to issue decisions in 90 days. In FY 2014, OMHA adjudicated only 9.7% of its BIPA claims in 90 days, far short of the 21% performance target. The average processing time on closed workload in FY 2014 is well over a year. Because the average age of pending appeals at OMHA has climbed to 647 days, it is apparent that there will be a dramatic increase in processing times until the backlog of pending appeals has been resolved.

Given current resource levels, OMHA staff has streamlined the business process to the maximum extent possible without sacrificing program integrity. Adjudication teams have increased productivity to maximum sustainable levels of approximately 1,000 appeals per team annually. The only viable way for OMHA to fully address the receipt level and improve performance is to systematically add adjudicators over the next few years, while concurrently implementing other short and long-term departmental and OMHA policy initiatives. Lesser measures would exacerbate current challenges by adding to the pending workload, resulting in progressively longer wait times for appellants.

In FY 2014, OMHA began prioritizing the handling of beneficiary appeals, which represent appeals filed by the most vulnerable Medicare appellants and often involve pre-service denials. For beneficiary appeals filed in FY 2014 OMHA's average processing time was 120 days as opposed to 235 days for appeals filed in FY 2013. To date OMHA has already decided 91% of cases received in FY 2014.

Despite the sharp workload increase, OMHA continues its unwavering support of the HHS Strategic Goal 4 to Ensure Efficiency, Transparency, Accountability and Effectiveness. OMHA continues to evaluate its customer service through an independent evaluation that captures the scope of the Level III appeals experience by randomly surveying selected appellants and appellant representatives. Measure 1.5 aims to ensure appellants and related parties are satisfied with their Medicare appeals experience regardless of the outcome of their appeal. The measure is evaluated on a scale of 1-to-5, 1 representing the lowest score (very dissatisfied) and 5 representing the best score (very satisfied). In FY 2014, OMHA achieved appellant satisfaction scores that averaged 3.9 nationwide, exceeding the FY 2014 target of 3.6 by 0.3. However, appellant satisfaction scores have trended downward each year since FY 2011. If processing times are allowed to increase due to the influx of appeal receipts, it is certain that appellant's frustration with increasing processing times will grow and that their level of satisfaction with the process will decrease.

In support of HHS Strategic Goal 1 to Strengthen Healthcare, OMHA's leadership is proposing multiple strategies to address workload, including the expansion of field offices, implementation of internal and departmental initiatives, and legislative proposals that will support increased funding for staffing, reduce processing delays, and achieve cost savings. However, agency performance (ability to process BIPA cases within 90 days) will remain quite low until the backlog is fully resolved and OMHA is once again able to process appeals as they are received. Given these assumptions, in FY 2016 OMHA's goal is to decide the vast majority of its beneficiary appeals (which are 2% of BIPA cases) within 90 days.

Workload Mitigation Initiatives Highlights

The FY 2016 budget request will support three initiatives to reduce the backlog of pending appeals and streamline the appeals process. The Adjudication Expansion initiative will expand OMHA's capacity by 6 field offices and 119 ALJ teams nationwide. OMHA will also introduce a legislative proposal for a Medicare Magistrate program in which attorneys will adjudicate a designated portion of appeals without a hearing as a less costly alternative, an Attorney Adjudicator Initiative as an interim measure for disposition of appeals on-the–record in anticipation of the Medicare Magistrate program, and expansion of its Settlement Conference facilitation which will provide an alternative dispute resolution forum for resolution of claims that are currently pending at OMHA.

All Purpose Table

(Dollars in Thousands)

OMHA	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Discretionary Budget Authority	82,381	87,381	140,000	+52,619
Proposed Legislation	-	-	-	-
Recovery Audit Recoveries	-	-	125,000	+125,000
Refundable Filing Fee	-	-	5,000	+5,000
Total OMHA	82,381	87,381	270,000	+182,619
FTE	468	564	1,475	+911

Authorizing Legislation……Titles XVIII and XI of the Social Security Act
FY 2016 Authorization…….. Indefinite
Allocation Method……..Direct Federal

Appropriations Language

For expenses necessary for the Office of Medicare Hearings and Appeals, **[$87,381,000]** *$140,000,000,* to be transferred in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

Amounts Available for Obligation

Detail	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Trust Fund Discretionary Appropriation	82,381,000	87,381,000	140,000,000
Subtotal, adjusted trust fund annual appropriation	***82,381,000***	***87,381,000***	***140,000,000***
Unobligated balance lapsing	140,566	-	-
Total Obligations	**82,240,434**	**87,381,000**	**140,000,000**

Summary of Changes

(Dollars in Thousands)

Budget Year and Type of Authority	Dollars	FTE
FY 2015 Enacted	87,381	564
FY 2016 Adjusted Budget Authority	270,000	1,475
Net Change	**182,619**	**911**

Increases	FY 2015 FTE	FY 2015 Enacted	FY 2016 +/- FY 2015 FTE	FY 2016 +/- FY 2015 BA
Full-time permanent	564	48,716	911	78,141
Other personnel compensation	-	353	-	224
Civilian personnel benefits	-	15,103	-	25,137
Travel and transportation of persons	-	200	-	142
Transportation of things	-	182	-	10,675
Rental payments to GSA	-	6,885	-	13,999
Communications, utilities, and misc. charges	-	3,097	-	3,153
Printing and reproduction	-	154	-	44
Other services from non-Federal sources	-	904	-	25
Others goods and services from Federal sources	-	5,298	-	23,331
Operation and maintenance of facilities	-	3,946	-	5,276
Operation and maintenance of equipment	-	1,431	-	3,465
Supplies and materials	-	732	-	1,368
Equipment	-	380	-	17,639

Total Changes	FY 2015 FTE	FY 2015 Enacted	FY 2016 +/- FY 2015 FTE	FY 2016 +/- FY 2015 BA
Total Increases	564	87,381	911	182,619
Total Decreases	-	-	-	-
Total Net Change	**564**	**87,381**	**911**	**182,619**

Budget Authority by Activity – Direct

(Dollars in Thousands)

Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Office of Medicare Hearings and Appeals (OMHA)	82,381	87,381	140,000
OMHA FTE	468	564	903
Total, Budget Authority	**82,381**	**87,381**	**140,000**
Total, FTE	**468**	**564**	**903**

Authorizing Legislation

(Dollars in Thousands)

OMHA	FY 2015 Amount Authorized	FY 2015 Appropriations Act	FY 2016 Amount Authorized	FY 2016 President's Budget
Office of Medicare Hearings and Appeals, Social Security Act, Titles XVIII and XI	Indefinite	$87,381	Indefinite	$140,000
Total Appropriation	**-**	**$87,381**	**-**	**$140,000**

Appropriation History Table

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
2006	-	-	-	-
Trust Fund Appropriation	80,000,000	60,000,000	75,000,000	60,000,000
Rescissions (P.L. 109-149)	-	-	-	(600,000)
Transfers (P.L. 109-148)	-	-	-	41,000
Subtotal	80,000,000	60,000,000	75,000,000	59,359,000
2007	-	-	-	-
Trust Fund Appropriation	74,250,000	70,000,000	70,000,000	59,727,000
Subtotal	74,250,000	70,000,000	70,000,000	59,727,000
2008	-	-	-	-
Trust Fund Appropriation	70,000,000	67,500,000	70,000,000	65,000,000
Rescissions (P.L. 110-161)	-	-	-	(1,136,000)
Subtotal	70,000,000	67,500,000	70,000,000	63,864,000
2009	-	-	-	-
Trust Fund Appropriation	65,344,000	-	63,864,000	64,604,000
Subtotal	65,344,000	-	63,864,000	64,604,000
2010	-	-	-	-
Trust Fund Appropriation	71,147,000	71,147,000	71,147,000	71,147,000
Subtotal	71,147,000	71,147,000	71,147,000	71,147,000
2011	-	-	-	-
Trust Fund Appropriation	77,798,000	-	77,798,000	71,147,000
Rescissions (P.L. 112-10)	-	-	-	(142,000)
Subtotal	77,798,000	-	77,798,000	71,005,000
2012	-	-	-	-
Trust Fund Appropriation	81,019,000	71,147,000	71,147,000	72,147,000
Rescissions (P.L. 112-74)	-	-	-	(136,000)
Subtotal	81,019,000	71,147,000	71,147,000	72,011,000
2013	-	-	-	-
Trust Fund Appropriation	84,234,000		79,908,000	72,010,642
Rescissions (P.L. 113-6)	-	-	-	(144,021)
Sequestration (P.L. 112-25)	-	-	-	(3,622,567)
Transfers	-	-	-	1,200,000
Subtotal	84,234,000	-	79,908,000	69,444,054
2014	-	-	-	-
Trust Fund Appropriation	82,381,000	-	82,381,000	82,381,000
Subtotal	82,381,000	-	82,381,000	82,381,000
2015	-	-	-	-
Trust Fund Appropriation	100,000,000	-	-	87,381,000
Subtotal	100,000,000	-	-	87,381,000
2016	-	-	-	-
Trust Fund Appropriation	140,000,000	-	-	-
Subtotal	**140,000,000**	**-**	**-**	**-**

Narrative by Activity

Program Description and Accomplishments

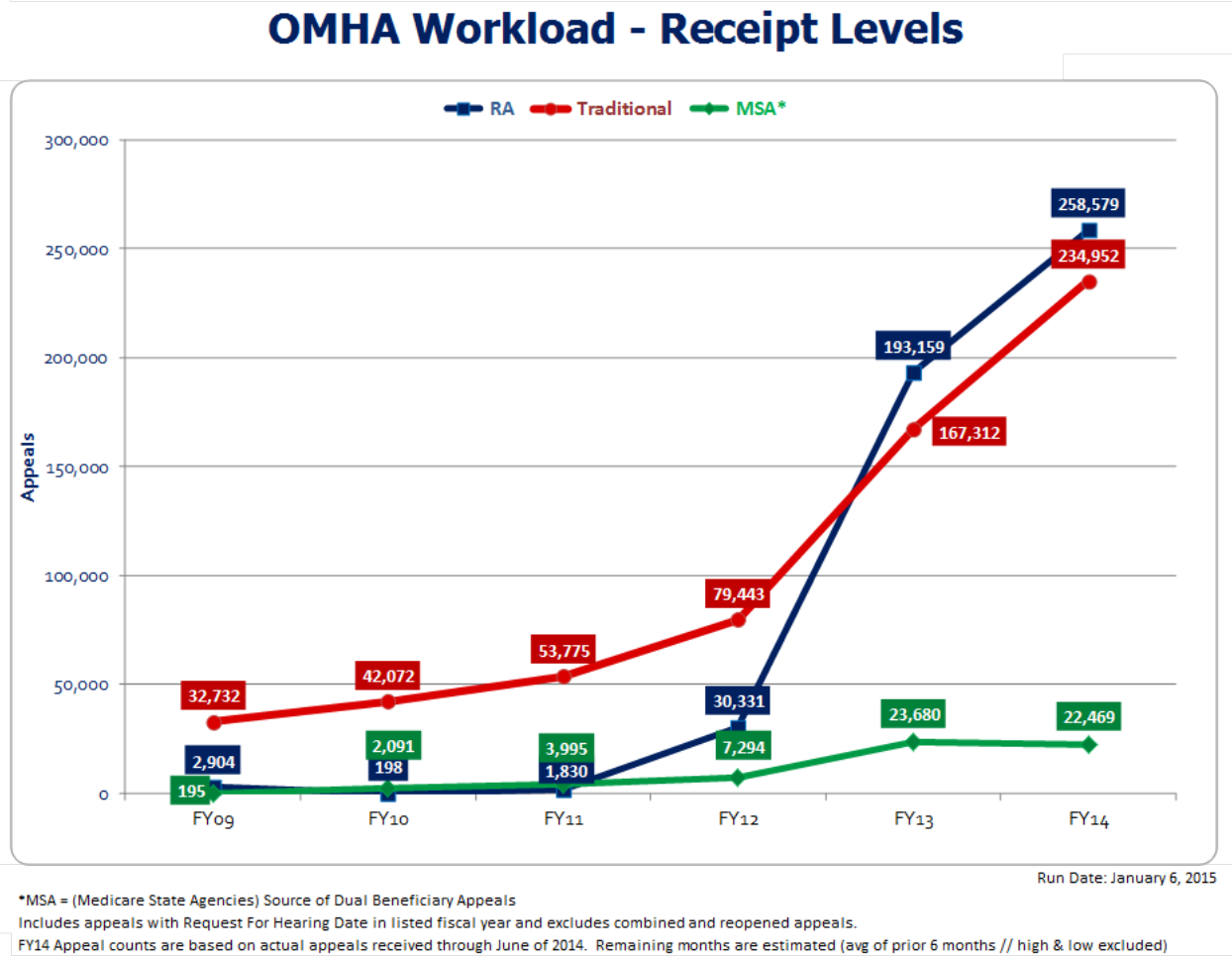
OMHA opened its doors in July 2005 pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which sought to respond to the delays in processing of Medicare appeals that existed at the Social Security Administration (SSA) by establishing a forum dedicated solely to the adjudication of Medicare appeals. According to the Government Accountability Office (GAO), SSA ALJs took on average 368 days to resolve appeals in 2003. While SSA had no statutory timeframe for case adjudication, the Benefits Improvement and Protection Act (BIPA) envisioned that most Medicare appeals would be decided by OMHA within 90 days of filing. Furthermore, the MMA provided for the addition of ALJs and staff as needed to insure for the "timely action on appeals before administrative law judges," (MMA § 931(c), 117 Stat. 2398-99). However, since 2010, OMHA has lacked sufficient funding to handle the volume of appeals being received and has developed a backlog of appeals awaiting disposition.

OMHA serves a broad sector of the public, including Medicare service providers and suppliers and Medicare beneficiaries who are often elderly and disabled and among the nation's most vulnerable populations. Ensuring that providers and suppliers have a forum for independent and timely resolution of their disputes over Medicare payments also contributes to the security of the Medicare system by encouraging them to continue to provide services and supplies to Medicare beneficiaries. OMHA administers its program in five field offices, including Miami, Florida; Cleveland, Ohio; Irvine, California; Arlington, Virginia; and the recently established office in Kansas City, Missouri.

At the time of OMHA's establishment, it was envisioned that OMHA would receive a traditional Medicare Part A and Part B workload. However, OMHA has seen an increased caseload due to the expansion of its original jurisdiction to include areas not originally envisioned to be within its authority. Specifically, in 2006, OMHA began hearing appeals arising from the new Medicare Part D Prescription Drug Plan. In 2007, OMHA was also given additional responsibility for conducting hearings and issuing decisions in Medicare Part B Income-Related Monthly Adjustment Amount (IRMAA) appeals.

Most significantly, however, OMHA began receiving new cases as a result of the Centers for Medicare & Medicaid Services (CMS) Recovery Audit (RA) pilot program in 2007. This program included RA reviews of Medicare Part A and Part B claims on a post-payment basis, and reviews for Medicare Secondary Payer recoupments. As a result of the RA pilot OMHA received more than 20,000 RA claims through FY 2009. In January 2010, the RA program became permanent and was expanded to all 50 States. As a result of this expansion, OMHA received nearly 195,000 RA claims in FY 2013 alone. Although the RA expansion legislation provided funding for the administrative costs of the program at CMS, OMHA is unable to use RA recoveries to fund RA appeals.

The significant expansion of appeals from the unfunded RA workload has exacerbated OMHA's workload challenges. In addition to the RA workload, OMHA's non-RA workload has also increased significantly as CMS contractors, (for example Medicare Administrative Contractors and Zone Program Integrity Contractors) have increased pre- and post-payment reviews. These reviews result in part from Medicare program integrity initiatives undertaken without sufficient funding to ensure the appeals process can address the increased workload. The end result is highlighted in the following graph, which charts the exponential growth in RA and non-RA (Traditional and MSA) appeals over the past 5 years.



Recognizing the importance of timely resolution of Medicare disputes, OMHA has undertaken a number of initiatives focused on improving the quality and timeliness of its services. These include:

- A redefined five year strategic plan that codifies OMHA's objectives and establishes the foundation for organizational performance
- A national data standardization initiative to promote data quality
- An Adjudicative Business Practice (ABP) Initiative to develop OMHA-wide common business practices for the adjudicative process
- A National Substantive Legal Training Program for new Administrative Law Judges and attorneys
- A Centralized Operations initiative to establish a uniform case docketing process agency-wide
- The development of OMHA's Electronic Case Processing Environment (ECAPE), currently underway
- A Statistical Sampling Pilot to resolve large groups of appeals
- A Settlement conference facilitation pilot as a less costly alternative to ALJ hearings
- Prioritization of beneficiary appeals to optimize timely adjudication of beneficiary appeals

Funding History

Fiscal Year	Amount
FY 2011	$71,005,000
FY 2012	$72,011,000
FY 2013	$69,444,054
FY 2014	$82,381,000
FY 2015	$87,381,000

FY 2016 Budget Request

The FY 2016 budget request of $270,000,000 represents a $182,619,000 increase above the FY 2015 enacted level. The request includes $140,000,000 in budget authority and $130,000,000 in program level funding from proposed legislation.

HHS is proposing a series of legislative proposals to permit HHS to make regulatory and policy changes. The most significant would authorize access to $125,000,000 in recovery audit collections to reimburse OMHA for administrative costs related to adjudicating Recovery Audit (RA) appeals. For the past two years these appeals have represented over 50% of OMHA's total receipts. Also proposed is a provision for a refundable filing fee. If this filing fee provision is authorized it is estimated that it will add $5,000,000 in program level funding. However, the $5,000,000 in additional authority is purely an estimate and does not include the administrative costs of processing the fees.

OMHA has passed the critical juncture at which it is able to adequately support its workload and is currently receiving more than one year's worth of work every eight weeks. It is estimated that the unheard claims workload will approach 3,000,000 (if the average number of claims per appeal remains at 2 to 1, this would translate to 1,400,000 appeals) by the end of FY 2016 if additional resources are not forthcoming. Currently over 96% of the budget is dedicated to fixed costs such as labor and required operational costs such as rent. As a result the agency is unable to expand its staff to accommodate the increased required to docket and adjudicate appeals. The requested funding will allow OMHA to implement administrative initiatives designed to reduce the backlog, improve processing times, and reduce overall costs. While these initiatives will begin to address the challenges facing the administrative appeals process, the backlog in processing requests for ALJ hearings is substantial, and the need for additional ALJs and supporting staff remains critical.

OMHA Workload

OMHA measures its current and prior year workloads in appeals because each appeal requires a hearing and a decision by an ALJ. An appeal best represents a complete work unit within the adjudication process. A single appeal is comprised of one or more claims. OMHA projects future workloads in claims because they have consistently proven to be reasonably predictive. In contrast, appeals have been difficult to predict because the average number of claims per appeal has varied significantly over time. This additional variable has adversely affected appeals-based projections by as much as 200%.

Appeals:
OMHA received 384,000 appeals in FY 2013, nearly triple the 131,000 appeals received in FY 2012. Though the FY 2014 receipt count is not yet fully determined due to staffing shortages in OMHA's docketing function, OMHA projects 516,000 appeals, nearly four times the 2012 receipt levels.

Claims:
The total number of claims associated with these appeals continues to increase as well. In FY 2013, OMHA received 655,000 claims, compared to 293,000 claims in FY 2012. By mid-year FY 2014, OMHA had received 471,000 claims, (total counts unavailable due to staffing shortages in docketing), a number that puts OMHA on target to reach an estimated fiscal year total of 1,000,000 claims.

OMHA Claims Received*

FY 2011	FY 2012	FY 2013
207,000	293,000	655,000

* Excludes remands

OMHA Claims Projected

FY 2014	FY 2015**	FY 2016**
1,000,000	1,200,000	1,400,000

** Pending efficiencies from initiatives

Rising receipt levels are also exacerbated by increases in complexity and intensity of medical services for aging beneficiaries, which require adjudicators to invest significantly more time and attention to the resolution of individual appeals. In the first six months of FY 2014, OMHA received 202,000 complex Part A hospital insurance appeals – 79% of the number received in all of FY 2013. RA appeals currently account for the vast majority of these. RA claim determinations that are appealed to ALJs often present complex factual patterns and are becoming increasingly adversarial, many times with multiple parties appearing at hearings.

In FY 2016, OMHA will use requested resources to fund the following initiatives intended to reduce the backlog and improve the overall Medicare appeals process:

I. Adjudication Expansion Initiative (AEI)

As of the beginning of FY 2015, OMHA has approximately 10 years of work on hand for its existing 72 teams. The FY 2016 request, will allow OMHA to increase its staffing levels by 911 FTE to support 6 new field offices, the expansion of the Arlington and Kansas City field offices to the full complement of 18 ALJ teams per office, and the expansion of Headquarters. Due to the significant learning curve required for an ALJ to be fully productive, OMHA anticipates that maximum productivity of the additional teams hired in FY 2016 will not be fully realized in FY 2017. These offices will support 119 new ALJ teams nationwide, well above the projected 77 teams on staff by the end of FY 2015. These ALJ teams will collectively increase output by 119,000 additional dispositions a year. This strategy will allow OMHA to expedite backlog reduction efforts and improve adjudication timeframes, while increasing staff towards a level that can address projected future receipts.

Specific Components:
119 new ALJ teams (511 FTE) which includes:

- Establishing 6 new field offices Nationwide
  - $40.8 M – (salary and benefits 748 additional positions = 374 FTE in FY 2016)
  - $14.9 M – operating costs
  - $10.6 M – rent
  - $23.4 M – start-up (e.g., infrastructure, IT redesign/hardware, furniture)

- Arlington Field Office, Kansas City Field Office and Headquarters Expansion
  - $15.7 M – salary and benefits - 80 new FTE in Arlington Field Office, 22 new FTE in Kansas City Field Office and 35 new FTE in HQ
  - $3.9 M – operating costs
  - $1.4 M – rent
  - $4.5 M – start-up/construction

II. Medicare Magistrate Program

A considerable portion of claims and coverage determinations appealed to OMHA involve an amount in controversy (AIC), or amount in dispute, that is below the cost to adjudicate the claim. Therefore, OMHA is proposing legislation to increase the AIC to obtain a hearing before an ALJ from $150 to the judicial review threshold ($1,460 in FY 2015). Concurrently, OMHA is seeking authority for a Medicare Magistrate program in which attorneys would serve as independent adjudicators with binding decisional authority in cases with an AIC below the judicial review threshold. Medicare Magistrates would review less complex claims, such as those involving whether a contractor dismissal was appropriate; dismissals of requests for hearing on jurisdictional grounds (untimeliness, no appealable decision, below AIC threshold); and appellant withdrawals of requests for hearing.

Magistrates would decide appeals based on a review of the record (in the place of a hearing), resulting in a significant reduction in time and cost for adjudications. ALJs would continue to review cases in which hearings are necessary. It is estimated that the expected production for a Medicare Magistrate would be similar to that of an ALJ (up to 1,000 appeals annually), while the FY 2016 estimated cost to adjudicate an appeal by a Magistrate would be $355 compared to $637 by an ALJ. Therefore, this initiative is an ideal model to better align and maximize the agency's most costly resource (ALJs) with workload demand. This initiative could increase OMHA's adjudicatory capacity by 41,000 appeals in FY 2016 alone.

Specific Components:

- $19.7 M – salary and benefits, 205 FTE
- $7.6 M – rent and operating costs

III. Attorney Adjudicator Initiative

To further reduce processing delays, achieve savings, and maximize resources, the budget request funds the attorney adjudicator program for disposition of appeals on-the-record as an interim measure in anticipation of the Medicare Magistrate program. Under this program, appellants with pending cases or filing new appeals for claims and coverage determinations will have the option to waive their right to a hearing, and instead will have the merits of the case decided on the existing record by a senior attorney advisor (with concurrence by an ALJ). It is estimated that the expected production for the attorney adjudicator would be similar to that of an ALJ (up to 1,000 appeals annually). This initiative could increase OMHA's adjudicatory capacity by 62,000 appeals in FY 2016 alone.

Specific Components:

- $13.7 M – salary and benefits, 125 FTE
- $6.2 M – rent and operating costs

IV. Settlement Conference Facilitation

OMHA's alternative dispute resolution pilot program began on June 30, 2014 for unassigned Medicare Part B cases. The pilot is supported by a few trained facilitators pulled from OMHA's existing pool of attorney advisors who primarily support ALJ's decision writing. These consent-based settlement conferences facilitate agreement between the appellant and Centers for Medicare and Medicaid Services (CMS) without a hearing by an ALJ, and are therefore less costly. In addition, a successful settlement will remove the claims from the administrative appeals process, reducing OMHA's backlog and the number of claims appealed to the Departmental Appeals Board (DAB), while allowing OMHA's ALJs to focus on claims that can be resolved only after a hearing. Based on conversations with providers and suppliers OMHA is currently revising its pilot in anticipation of the requested FY 2016 resources to expand this initiative throughout the agency.

Specific Components:

- $6.9 M – salary and benefits, 50 FTE
- $2.2 M – rent and operating costs

V. Legislative proposals:

Provide Office of Medicare Hearings and Appeals to Use RAC Collections: This proposal would expand the Secretary's authority to retain a portion of Recovery Audit (RA) recoveries for the purpose of administering the recovery audit program. This proposal will allow RA program recoveries to fully fund RA related appeals at the Office of Medicare Hearings. [$1.3 billion in cost over 10 years]

Establish a Refundable Filing Fee: This proposal would institute a refundable filing fee for providers, suppliers, and State Medicaid agencies, including those acting as a representative of a beneficiary, to pay a per-claim filing fee at each level of appeal. This filing fee would allow HHS to invest in the appeals system to improve responsiveness and efficiency. Fees will be returned to appellants who receive a fully favorable appeal determination. [No budget impact]

Outputs and Outcomes Table

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
Increase the number of BIPA cases closed within 90 days	FY 2014: 9.7% Target: 21% (Target Not Met)	15%	TBD*	TBD*
Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council	FY 2014: 1.2% Target: 1% (Target Not Met)	1%	1%	Maintain
Improve average survey results from appellants reporting good customer service on a scale of 1-5 at the Medicare Appeals level	FY 2014: 3.9 Target: 3.6 (Target Exceeded)	3.4	3.4	Maintain

*A Performance target will be determined when the backlog is reduced to a more manageable level.

Budget Authority by Object Class – Direct

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Personnel Compensation		-	-	-	-
11.1	Full-time permanent	40,177	48,716	126,857	78,141
11.5	Other personnel compensation	231	353	577	224
Subtotal	***Personnel Compensation***	***40,408***	***49,069***	***127,434***	***78,365***
12.1	Civilian personnel benefits	12,462	15,103	40,240	25,137
Total	**Pay Costs**	**52,870**	**64,172**	**167,674**	**103,502**
21.0	Travel and transportation of persons	157	200	342	142
22.0	Transportation of things	178	182	10,857	10,675
23.1	Rental payments to GSA	6,787	6,885	20,884	13,999
23.3	Communications, utilities, and misc. charges	3,215	3,097	6,250	3,153
24.0	Printing and reproduction	145	154	198	44
Other Contractual Services		-	-	-	-
25.2	Other services from non-Federal sources	4,831	904	929	25
25.3	Other goods and services from Federal sources	5,371	5,298	28,629	23,331
25.4	Operation and maintenance of facilities	6,218	3,946	9,222	5,276
25.7	Operation and maintenance of equipment	888	1,431	4,896	3,465
Subtotal	***Other Contractual Services***	***17,308***	***11,579***	***43,676***	***32,097***
26.0	Supplies and materials	681	732	2,100	1,368
31.0	Equipment	899	380	18,019	17,639
Total	**Non-Pay Costs**	**29,370**	**23,209**	**102,326**	**79,117**
Total	**Budget Authority by Object Class**	**82,240**	**87,381**	**270,000**	**182,619**

Salary & Expenses Table

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Personnel Compensation		-	-	-	-
11.1	Full-time permanent	40,177	48,716	126,857	73,141
11.5	Other personnel compensation	231	353	577	224
Subtotal	***Personnel Compensation***	***40,408***	***49,069***	***127,434***	***78,365***
12.1	Civilian personnel benefits	12,462	15,103	40,240	25,137
Subtotal	***Pay Costs***	***52,870***	***64,172***	***167,674***	***103,502***
21.0	Travel and transportation of persons	157	200	342	142
22.0	Transportation of things	178	182	10,857	10,675
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24.0	Printing and reproduction	145	154	198	44
Other Contractual Services		-	-	-	-
25.2	Other services from non-Federal sources	4,831	904	929	25
25.3	Other goods and services from Federal sources	5,371	5,298	28,629	23,331
25.4	Operation and maintenance of facilities	6,218	3,946	9,222	5,276
25.7	Operation and maintenance of equipment	888	1,431	4,896	3,465
Subtotal	***Other Contractual Services***	***21,003***	***11,579***	***43,676***	***32,097***
26.0	Supplies and materials	681	732	2,100	1,368
Subtotal	***Non-Pay Costs***	***21,684***	***15,944***	**63,423**	***47,479***
Total	**Salaries and Expenses**	**74,554**	**80,116**	**231,097**	**150,981**
23.1	Rental payments to GSA	6,787	6,885	20,884	13,999
Total	**Salaries, Expenses and Rent**	**81,341**	**87,001**	**251,981**	**164,980**
Total	**Direct FTE**	**468**	**564**	**1,475**	**911**

Rent and Common Expenses

(Dollars in Thousands)

Detail	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Rent	6,787	6,885	20,884	13,999
Subtotal	***6,787***	***6,885***	***20,884***	***13,999***
Operations and Maintenance	7,105	5,377	14,118	8,741
Subtotal	***7,105***	***5,377***	***14,118***	***8,741***
Service and Supply Fund	5,397	5,829	15,244	9,415
Subtotal	***5,397***	***5,829***	***15,244***	***9,415***
TOTAL	**19,289**	**18,091**	**50,246**	**32,155**

Detail of Full-Time Equivalent (FTE) Employment

Detail	FY 2014 Actual Civilian	FY 2014 Actual Military	FY 2014 Actual Total	FY 2015 Estimate Civilian	FY 2015 Estimate Military	FY 2015 Estimate Total	FY 2016 Estimate Civilian	FY 2016 Estimate Military	FY 2016 Estimate Total
Direct	468	0	468	564	0	564	1,475	0	1,475
Reimbursable	0	0	0	0	0	0	0	0	0
Total FTE	**468**	**0**	**468**	**564**	**0**	**564**	**1,475**	**0**	**1,475**

Fiscal Year	Average GS
FY 2012	11/3
FY 2013	11/4
FY 2014	11/4
FY 2015	11/5
FY 2016	11/1

Detail of Positions

Detail	FY 2014 Actual	FY 2015 Enacted	FY 2016 Budget
ALJ-1	*1*	*1*	*1*
ALJ-2	*6*	*6*	*12*
ALJ-3	*65*	*76*	*116*
Subtotal	***72***	***83***	***129***
Total - AL Salary	**11,247,819**	**12,325,641**	**20,234,295**
Exec. Level	2	1	1
Subtotal	***2***	***1***	***1***
Total - SES Salaries	**316,478**	**183,300**	**184,184**
GS-15	13	14	22
GS-14	24	28	66
GS-13	23	25	283
GS-12	151	163	299
GS-11	52	52	73
GS-10	0	0	0
GS-9	20	25	362
GS-8	104	110	230
GS-7	17	18	64
GS-6	18	37	208
GS-5	2	2	14
GS-4	13	15	29
GS-3	2	3	10
GS-2	0	0	0
GS-1	0	0	0
Subtotal	***439***	***492***	***1,660***
Total – GS Salary	**28,059,456**	**36,207,979**	**106,438,826**
Total Positions	**513**	**576**	**1,790**
Total FTE	**468**	**564**	**1,475**
Average AL salary	156,219	148,502	156,855
Average ES Salary	158,239	182,813	184,184
Average GS Grade	63,917	73,593	64,120
Average GS Salary	11/4	11/5	11/1

FY 2016 Budget by HHS Strategic Goal

(Dollars in Millions)

HHS Strategic Goals	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
1.Transform Health Care	**-**	**-**	**-**
1.A Make coverage more secure	-	-	-
1.B Improve health care quality and patient safety	55.00	58.00	181.00
1.C Emphasize primary & preventative care, link to prevention	-	-	-
1.D Reduce growth of health care costs promoting high-value	-	-	-
1.E Ensure access to quality culturally competent care	-	-	-
1.F Promote the adoption of health information technology	-	-	-
2. Advance Scientific Knowledge and Innovation	**-**	**-**	**-**
2.A Accelerate scientific discovery to improve patient care	-	-	-
2.B Foster innovation at HHS to create shared solutions	-	-	-
2.C Invest in sciences to improve food & medical product safety	-	-	-
2.D Increase understanding of what works in health & services	-	-	-
3. Advance the Health, Safety and Well-Being of the American People	**-**	**-**	**-**
3.A Ensure the children & youth safety, well-being & health	-	-	-
3.B Promote economic & social well-being	-	-	-
3.C Improve services for people with disabilities and elderly	-	-	-
3.D Promote prevention and wellness	-	-	-
3.E Reduce the occurrence of infectious diseases	-	-	-
3.F Protect Americans' health and safety during emergencies	-	-	-
4. Increase Efficiency, Transparency and Accountability of HHS Programs	**-**	**-**	**-**
4.A Ensure program integrity and responsible stewardship	27.00	29.00	89.00
4.B Fight fraud and work to eliminate improper payments	-	-	-
4.C Use HHS data to improve American health & well-being	-	-	-
4.D Improve HHS environmental performance for sustainability	-	-	-
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce	**-**	**-**	**-**
5.A Invest in HHS workforce to help meet America's health and human service needs today & tomorrow	-	-	-
5.B Ensure health care workforce meets increased demands.	-	-	-
5.C Enhance the ability of the public health workforce to improve health at home.	-	-	-
5.D Strengthen the Nation's human service workforce	-	-	-
5.E Improve national, State & local surveillance capacity	-	-	-
Total OMHA Program Level	**82.00**	**87.00**	**270.00**

Office for Civil Rights

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Director
Office for Civil Rights
Washington, DC 20201

February 2, 2015

Dear Reader,

I am pleased to present the Office for Civil Rights (OCR) Fiscal Year 2016 Congressional Justification. This budget supports the President's and Secretary's priority initiatives and reflects the goals and objectives of the Department.

OCR's request provides resources to help protect the public's right to equal access and opportunity to participate in and receive services from health and human services programs funded by Department of Health and Human Services (DHHS) without facing unlawful discrimination, and to protect the privacy and security of individually identifiable health information from unauthorized disclosure. Both of these activities are integral to improving health outcomes, among other benefits, and thus to enabling the Department to achieve its mission.

The budget request also supports a critical initiative, the establishment of a HIPAA Privacy, Security, and Breach Notification Rule Audit Program. The audit program will add tremendous value to OCR's compliance and enforcement mission by enabling OCR to proactively and systematically measure industry compliance with Health Insurance Portability and Accountability Act (HIPAA) requirements. This new program, mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act, will give OCR another vital enforcement tool to gauge and promote industry compliance independent of our normal complaint resolution processes. The two primary objectives of this program are to further promote voluntary compliance and to utilize audit data to better target our existing technical assistance efforts.

In the current constrained fiscal environment, OCR continues to examine ways we can do more with our resources. Over the past several years, OCR has been energetic and forward-thinking in implementing many comprehensive organizational, programmatic, and automated system improvements that directly increase OCR's efficiency. These improvements include creation of a Centralized Case Management Operations (CCMO) entity to streamline complaint intake and triage; rollout of an online complaint portal to increase accessibility and customer service; overhaul of the investigator Performance Management Appraisal Program (PMAPs) to better align mission and workforce goals; strengthening of financial practices and resource allocation procedures to make every dollar count; and enhancements to our case management system to improve internal control and documentation. We are committed to maintaining and expanding these efforts to ensure that OCR continues to provide the best possible support to the American people.

/Jocelyn Samuels/
Jocelyn Samuels
Director, Office for Civil Rights

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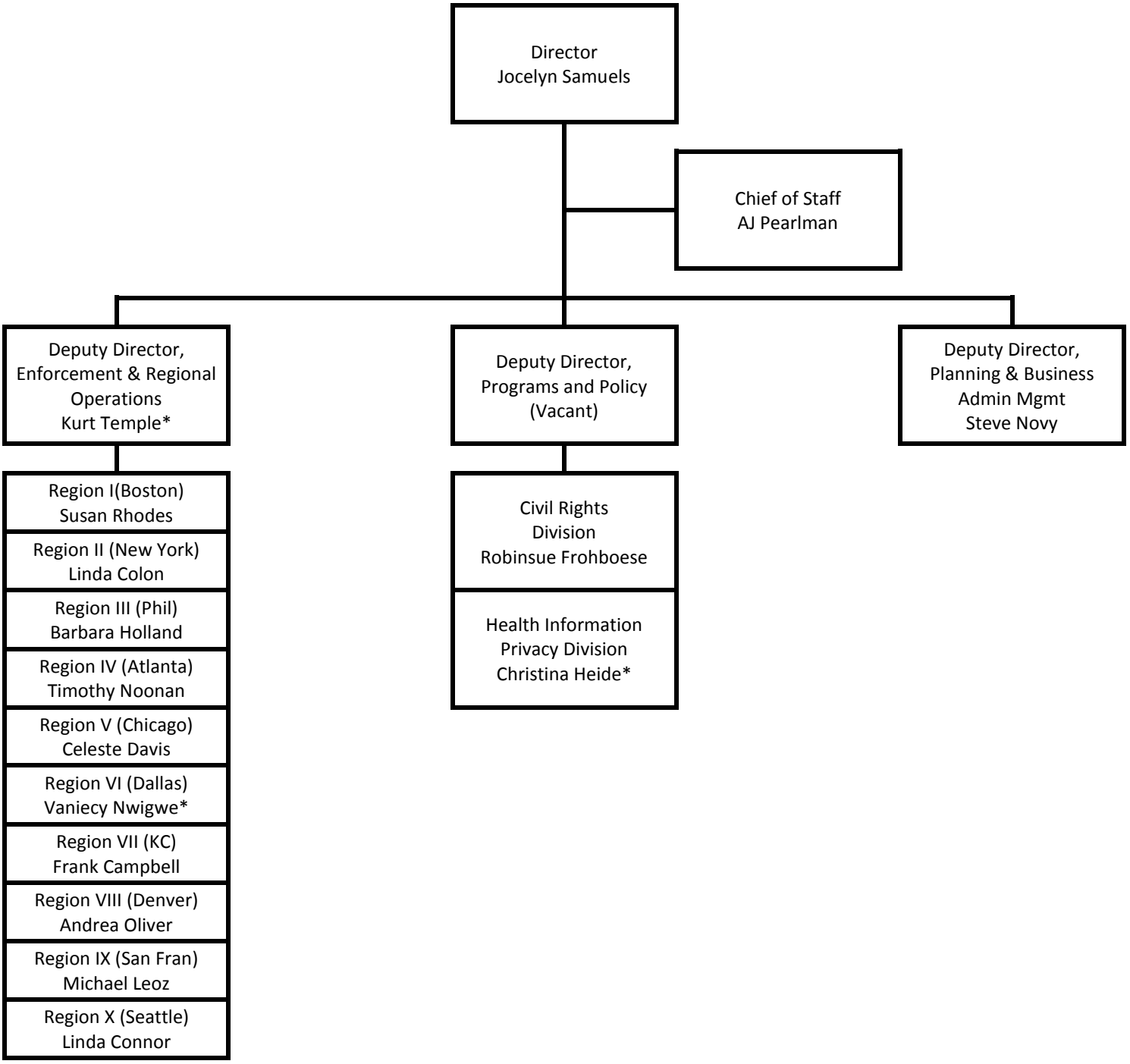
Office for Civil Rights

Organization Chart

(January 2015)



* = Acting

Organizational Chart: Text Version

Office for Civil Rights

- Director Jocelyn Samuels
- Chief of Staff AJ Pearlman

The following offices report directly to the Director:

- Acting Deputy Director, Enforcement and Regional Operations
  - Kurt Temple (Acting)
- Deputy Director, Programs and Policy
  - Vacant
- Deputy Director, Planning and Business Administration Management
  - Steve Novy

The following regional managers report to the Deputy Director, Enforcement and Regional Operations:

- Susan Rhodes, Boston Regional Office
- Linda Colon, New York Regional Office
- Barbara Holland, Philadelphia Regional Office
- Timothy Noonan, Atlanta Regional Office
- Celeste Davis, Chicago Regional Office
- Vaniecy Nwigwe (Acting), Dallas Regional Office
- Frank Campbell, Kansas City Regional Office
- Andrea Oliver, Denver Regional Office
- Michael Leoz, San Francisco Regional Office
- Linda Connor, Seattle Regional Office

The following offices report to the Deputy Director of Programs and Policy:

- Civil Rights Division
  - Robinsue Frohboese
- Health Information Privacy Division
  - Christine Heide (Acting)

Introduction and Mission

The Office for Civil Rights (OCR), a staff division of the U.S. Department of Health and Human Services (HHS), ensures that individuals receiving services from HHS-funded programs are not subject to unlawful discrimination, and that the privacy and security of their health information is protected. By removing discriminatory barriers to HHS-funded services, OCR carries out the HHS mission of improving the health and well-being of all Americans and providing essential human services, especially for those who are least able to help themselves. In FY 2014, OCR resolved nearly 20,000 citizen complaints alleging discrimination or a health information privacy or security violation.

OCR Vision

Through investigations, voluntary dispute resolution, enforcement, technical assistance, policy development and information services, OCR will protect the civil rights of all individuals who are subject to discrimination in health and human services programs and protect the health information privacy and security rights of consumers.

Mission

- Ensure that the estimated 4.5 million recipients of HHS Federal financial assistance comply with our Nation's civil rights laws by enforcing civil rights protections that prevent discrimination on the basis of race, color, national origin (including limited English proficiency), disability, age, and sex.
- Enforce rights under the Affordable Care Act (ACA) which promote access to health care by prohibiting discrimination in health care programs or activities.
- Ensure the practices of an estimated 4 million health care providers, health plans, healthcare clearinghouses, and their business associates adhere to Federal privacy, security, and breach notification regulations through the investigation of citizen complaints, self-reports of breaches, or compliance reviews and audits.
- Implement and enforce privacy, security, and breach notification regulations issued by the Secretary under the Health Insurance Portability and Accountability Act (HIPAA) as further amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act contained in the American Recovery and Reinvestment Act (ARRA) of 2009; the privacy protections under the Genetic Information Nondiscrimination Act of 2008; and the confidentiality provisions of the Patient Safety and Quality Improvement Act of 2005.

Overview of Budget Request

OCR's FY 2016 budget request of $42,705,000 represents a $3.907 million increase over the FY 2015 Enacted Level.

The FY 2016 budget request supports OCR's essential programmatic focus as the primary defender of the public's right to nondiscriminatory access to and receipt of Federally funded health and human services, and privacy and security protections for individually identifiable health information.

Program increases:

Audit Program (+3.907M): The increase funds an initiative for a HIPAA Privacy, Security, and Breach Notification Rule Audit Program as mandated by Section 13411 of the HITECH Act. The audit program would add value to OCR's compliance and enforcement mission by proactively and systematically measuring industry compliance with HIPAA privacy and security requirements. In order to continue to respond to workload demands due to OCR's evolving jurisdictional responsibilities related to health information privacy and security, and civil rights, OCR will also invest in its Centralized Case Management Operations (CCMO).

Overview of Performance

Both of OCR's overarching goals encompass multiple supporting objectives that align to the Department's Strategic Plan:

OCR Goal	OCR Supporting Objectives	HHS Goal/Objectives*
1. Raise awareness, increase understanding, and ensure compliance with all federal laws requiring non-discriminatory access to HHS funded programs and protect the privacy and security of personal health information	A. Increase access to and receipt of non-discriminatory quality health and human services while protecting the integrity of HHS federal financial assistance	#1 E , #3 A,C,E
	B. Protect the privacy and security of personally identifiable health information for healthcare consumers (HIPAA rule activities and enforcement)	#1 E,F
	C. Provide information, public education activities, and training to representatives of health and human service providers, other interest groups, and consumers (Civil rights and health information privacy mission activities)	#1 E , #3 B
	D. Increase the number of covered entities that take corrective action, including making substantive policy changes or developing new policies as a result of review and/or intervention	#1 E
2. Enhance operational efficiency	A. Maximize efficiency of operations by streamlining processes and the optimal allocation of resources	#4 A
	B. Improve financial management and the integration of budget and performance data (Increase resource management process oversight, strengthen internal controls, maintain viable performance objectives)	#4 A
	C. Advance human capital management (Provide training, develop and mentor subordinates, promote effectiveness)	#4 C

[* As reflected in the "FY 2016 Budget by HHS Strategic Objective" table included herein.]

Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 Target +/- FY 2015 Target
1.1.1 The number of covered entities taking corrective actions as a result of OCR intervention per year (Outcome)	FY 2014: 2,897 Target: 5,900 (Target Not Met)	5,900	5,900	Maintain
1.1.2 The number of Covered Entities making substantive policy changes as a result of OCR intervention/year(Outcome)	FY 2014: 1,784 Target: 3,600 (Target Not Met)	1,000	750	-250
1.1.3A Percent of closure for civil rights cases/ cases received each year (Outcome)*	FY 2014: 92% Target: 86% (Target Exceeded)	90%	90%	Maintain
1.1.3B Percent of closure for health information privacy cases/cases received each year(Outcome)	FY 2014: 94% Target: 62% (Target Exceeded)	66%	75%	+9%
1.1.3C Percent of closure for Medicare application review/reviews received each year(Output)*	FY 2014: 77% Target: 90% (Target Not Met)	90%	90%	Maintain
1.1.4 Percent of Civil Rights cases and Medicare application reviews resolved per received per year. (Outcome)	FY 2014: 87% Target: 92% (Target Not Met)	92%	92%	Maintain
1.1.6 Number of individuals whom OCR provides information and training annually (Output)**	FY 2014: 3,107,229 Target: 213,500 (Target Met)	3,263,000	3,426,000	+163,000
1.1.7 Percent of civil rights complaints requiring formal investigation resolved within 365 days(Output)	FY 2014: 36% Target: 52% (Target Not Met)	41%	41%	Maintain
1.1.8 Percentage of civil rights complaints not requiring formal investigation resolved within 180 days (Output)	FY 2014: 90% Target: 100% (Target Not Met)	80%	80%	Maintain
1.1.9 Percentage of health information privacy complaints requiring formal investigation resolved within 365 days (Output)	FY 2014: 66% Target: 65% (Target Exceeded)	68%	68%	Maintain
1.1.10 Percentage of health information privacy complaints not requiring formal investigation resolved within 180 days (Output)	FY 2014: 92% Target: 100% (Target Not Met)	72%	75%	+3%

* 1.1.3 *Percentage of closure for civil rights cases, health information privacy cases, and Medicare reviews/ cases and reviews received"* is now captured as 1.1.3 A, B, and C. 1.1.5 *"Percentage of privacy cases resolved per cases received"* was eliminated as the data is captured in 1.1.3 B.

**FY15 and FY16 targets for 1.1.6 were adjusted upward to account for the change in methodology for calculating this measure. Beginning in FY 2014, this measure accounted for the number of times the OCR website is viewed.

FY 2016 Budget by HHS Strategic Objective

(Dollars in Millions)

HHS Strategic Goals and Objectives	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
1.Strengthen Health Care	**20.1**	**20.1**	**21.0**
1.A Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured	-	-	-
1.B Improve health care quality and patient safety	-	-	-
1.C Emphasize primary & preventative care, linked with community prevention services	-	-	-
1.D Reduce the growth of health care costs while promoting high-value, effective care	-	-	-
1.E Ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations	10.6	10.6	11.2
1.F Improve health care and population health through meaningful use of health information technology	9.5	9.5	9.8
2. Advance Scientific Knowledge and Innovation	**-**	**-**	**-**
2.A Accelerate the process of scientific discovery to improve health	-	-	-
2.B Foster and apply innovation solutions to health, public health, and human services challenges	-	-	-
2.C Advance the regulatory sciences to enhance food safety, improve medical product development, and support tobacco regulation	-	-	-
2.D Increase our understanding of what works in public health and human services practice	-	-	-
2.F Improve laboratory, surveillance, and epidemiology capacity	-	-	-
3. Advance the Health, Safety and Well-Being of the American People	**18.4**	**18.4**	**21.4**
3.A Promote the safety, well-being, resilience, and healthy development of children and youth	1.7	1.7	2.0
3.B Promote economic and social well-being for individuals, families, and communities	16.4	16.4	17.7
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults	-	-	1.3
3.D Promote prevention and wellness across the life span	-	-	-
3.E Reduce the occurrence of infectious diseases	0.3	0.3	0.4
3.F Protect American' health and safety during emergencies, and foster resilience to withstand and respond to emergencies	-	-	-
4. Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs	**0.3**	**0.3**	**0.3**
4.A Strengthen program integrity and responsible stewardship by reducing improper payments, fighting fraud, and integrating financial, performance, and risk management	0.2	0.2	0.2
4.B Enhance access to and use of data to improve HHS programs and to support improvements in the health and well-being of the American People	-	-	-
4.C Invest in the HHS workforce to help meet America's health and human services needs	0.1	0.1	0.1
4.D Improve HHS environmental, energy, and economic performance to promote sustainability	-	-	-
Total	**38.8**	**38.8**	**42.7**

Discretionary All Purpose Table

(Dollars in Thousands)

Program	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 (+/-) FY 2015
Enforcement and Regional Operations	26,698	27,258	29,400	+2,142
Programs and Policy	7,683	6,765	8,584	+1,819
Planning and Business Administration Management	4,417	4,775	4,721	-54
Total, Office for Civil Rights	**38,798**	**38,798**	**42,705**	**+3,907**
FTE	**202**	**195**	**199**	**+4**

Appropriations Language

For expenses necessary for the Office for Civil Rights, **[38,798,000]** *$42,705,000*.

Amounts Available for Obligation

(Dollars in Thousands)

Detail	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Annual appropriation	38,798	38,798	42,705
Rescission	-	-	-
Transfers	-	-	-
Subtotal, adjusted budget authority	***38,798***	***38,798***	***42,705***
Unobligated balance lapsing	**-20**	**-**	**-**
Total Obligations	**38,778**	**38,798**	**42,705**

Summary of Changes

(Dollars in Thousands)

Budget Year and Type of Authority	Dollars	FTE
FY 2015 Enacted	38,798	195
FY 2016 Estimated Budget Authority	42,705	199
Net Changes	**+3,907**	**+4**

Program Increases	FY 2016 PB FTE	FY 2016 PB BA	FY 2016 +/- FY 2015 FTE	FY 2016 +/- FY 2015 BA
Full-time permanent	192	18,193	+4	+931
Other than full-time permanent	5	1,440	-	+14
Other personnel compensation	-	331	-	+10
Military personnel	2	158	-	+2
Civilian benefits	-	5,929	-	+343
Military benefits	-	83	-	+1
Benefits to former personnel	-	31	-	+1
Travel and transportation of persons	-	349	-	+45
Transportation of things	-	10	-	+2
Rental payments to GSA	-	3,312	-	+147
Communication, utilities, and miscellaneous charges	-	204	-	+2
Printing and reproduction	-	60	-	+3
Other services	-	113	-	+3
Purchase of goods and services from Government accounts	-	11,538	-	+2,400
Operation and maintenance of facilities	-	347	-	+3
Operation and maintenance of equipment	-	387	-	+4
Supplies and materials	-	191	-	+2
Total Increases	**199**	**42,675**	**+4**	**3,897**

Program Decreases	FY 2016 PB FTE	FY 2016 PB BA	FY 2016 +/- FY 2015 FTE	FY 2016 +/- FY 2015 BA
Equipment	-	30	-	-5
Total Decreases	**0**	**30**	**-**	**-5**

Total Changes	FY 2016 PB FTE	FY 2016 PB BA	FY 2016 +/- FY 2015 FTE	FY 2016 +/- FY 2015 BA
Total Increases	-	-	+4	+3,912
Total Decreases	-	-	-	-5
Total Net Change	**199**	**42,705**	**+4**	**3,907**

Budget Authority by Activity - Direct

(Dollars in Thousands)

Activity	FY 2014 FTE	FY 2014 Actual	FY 2015 FTE	FY 2015 Enacted	FY 2016 FTE	FY 2016 President's Budget
Enforcement and Regional Operations	139	26,698	137	27,258	137	29,400
Programs and Policy	40	7,683	34	6,765	40	8,584
Planning and Business Administration Management	23	4,417	24	4,775	22	4,721
Total, Budget Authority	***202***	***38,798***	***195***	***38,798***	***199***	***42,705***

Authorizing Legislation

(Dollars in Thousands)

Authorizing Legislation	FY 2015 Amount Authorized	FY 2015 Appropriations Act	FY 2016 Amount Authorized	FY 2016 President's Budget
Office for Civil Rights	Indefinite	$38,798	Indefinite	$42,705
Grand Total Appropriation	**-**	**$38,798**	**-**	**$42,705**

OCR Legal Authorities

- Social Security Act of 1934, Section 508 (Public Law 74-271) (42 USC 708)
- Public Health Service Act of 1944, Titles VI, Title XVI, Section 533, Section 542, Section 794, Section 855, Section 1908, Section 1947, as amended (42 USC 291 et seq, 42 USC 300 et seq, 42 USC 290dd-1, 42 USC 295m and 296g, 42 USC 300w-7, 43 USC 290cc-33, 43 USC 300x-57)
- Civil Rights Act of 1964, Title VI , as amended (Public Law 88-352) (42 USC 2000d et seq)
- Treatment and Rehabilitation Act of 1970 (Public Law 91-616)
- Comprehensive Health Manpower Training Act of 1971 (Public Law 92-157)
- Nurse Training Act of 1971 (Public Law 92-158)
- Drug Abuse Offense and Treatment Act of 1972 (Public Law 92-255)
- Education Amendments of 1972, Title IX, as amended (Public Law 92-318) (20 USC 1681)
- Rehabilitation Act of 1973, Section 504, Section 508, as amended (Public Law 93-112) (29 USC 794)
- Comprehensive Alcohol Abuse & Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 (Public Law 93-282)
- The Church Amendments (42 USC 300a-7)
- National Research Service Award Act of 1974 (Public Law 93-348)
- Health Care Professions Educational Assist Act of 1974 (Public Law 94-484)
- Age discrimination Act of 1975, Sections 301-8, as amended (Public Law 94-135) (42 USC 6101 et seq)
- Public Telecommunications Financing Act of 1978, Section 395 (Public Law 95-567)
- Omnibus Reconciliation Act of 1981 (Public Law 97-35)
- Americans with Disabilities Act of 1990, Title II (Public Law 101-336) (42 USC 12131)
- Improving America's Schools Act of 1994, Subpart E (Public Law 103-382)
- Small Business Job Protection Act of 1996, Sections 1807/1808c (Public Law 104-188) (42 USC 1996b)
- Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191)
- Patient Safety and Quality Improvement Act of 2005 (Public Law 109-41)
- Genetic Information Nondiscrimination Act of 2008 (Public Law 110-233)
- Health Information Technology for Economic and Clinical Health (HITECH) Act, American Recovery and Reinvestment Act of 2009 (Public Law 111-5)
- Patient Protection and Affordable Care Act of 2010, Section 1557 (Public Law 111-148)

Appropriations History

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
2007	-	-	-	-
Appropriation	-	-	-	-
Base	32,969,000	32,969,000	32,969,000	32,969,000
Subtotal	32,969,000	32,969,000	32,969,000	32,969,000
Trust Funds	-	-	-	-
Base	3,314,000	3,314,000	3,314,000	3,314,000
Rescission (PL 110-5)	-	-	-	(33,000)
Subtotal	3,314,000	3,314,000	3,314,000	3,281,000
2008	-	-	-	-
Appropriation	-	-	-	-
Base	33,748,000	33,748,000	33,748,000	31,628,000
Rescission (PL 110-161)				(553,000)
Subtotal	33,748,000	33,748,000	33,748,000	31,075,000
Trust Funds	-	-	-	-
Base	3,314,000	3,314,000	3,314,000	3,314,000
Rescission (PL 110-161)	-	-	-	(57,000)
Subtotal	3,314,000	3,314,000	3,314,000	3,257,000
2009	-	-	-	-
Appropriation	-	-	-	-
Base	36,785,000	36,785,000	36,785,000	36,785,000
Subtotal	36,785,000	36,785,000	36,785,000	36,785,000
Trust Funds	-	-	-	-
Base	3,314,000	3,314,000	3,314,000	3,314,000
Subtotal	3,314,000	3,314,000	3,314,000	3,314,000
2010	-	-	-	-
Appropriation	-	-	-	-
Base	37,785,000	37,785,000	37,785,000	37,785,000
Rescission (PL 111-117)				(6,000)
Subtotal	37,785,000	37,785,000	37,785,000	37,779,000
Trust Funds	-	-	-	-
Base	3,314,000	3,314,000	3,314,000	3,314,000
Subtotal	3,314,000	3,314,000	3,314,000	3,314,000
2011	-	-	-	-
Appropriation	-	-	-	-
Base	44,382,000	44,382,000	44,382,000	37,785,000
Rescission (PL 112-10)	-	-	-	(78,000)
Subtotal	44,382,000	44,382,000	44,382,000	37,709,000
Trust Funds	-	-	-	-
Base	3,314,000	3,314,000	3,314,000	3,314,000
Rescission (PL 112-10)	-	-	-	(7,000)
Subtotal	3,314,000	3,314,000	3,314,000	3,307,000

Appropriations History (continued)

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
2012	-	-	-	-
Appropriation	-	-	-	-
Base	44,382,000	41,016,000	41,016,000	41,016,000
Rescission (PL 112-74)	-	-	-	(78,000)
Subtotal	44,382,000	41,016,000	41,016,000	40,938,000
2013	-	-	-	-
Appropriation	-	-	-	-
Base	38,966,000	-	38,966,000	40,938,000
Sequestration	-	-	-	(2,059,000)
Rescission (PL 113-6)	-	-	-	(82,000)
Transfers (PL 112-74)	-	-	-	(182,000)
Subtotal	38,966,000		38,966,000	38,615,000
2014	-	-	-	-
Appropriation	-	-	-	-
Base	42,205,000	-	42,205,000	38,798,000
Subtotal	42,205,000	-	42,205,000	38,798,000
2015	-	-	-	-
Appropriation	-	-	-	-
Base	41,205,000	-	38,798,000	38,798,000
Subtotal	41,205,000	-	38,798,000	38,798,000
2016	-	-	-	-
Appropriation	-	-	-	-
Base	42,705,000	-	-	-
Subtotal	42,705,000	-	-	-

Summary of the Request

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) is the primary defender of the public's right to privacy and security of protected health information and non-discriminatory access to Federally-funded health and human services. Through prevention and elimination of unlawful discrimination and by protecting the privacy and security of individually identifiable health information, OCR helps HHS carry out its overall mission of improving the health and well-being of all people affected by the Department's many programs. To most effectively accomplish this enormously important undertaking, OCR activities partner with government and private sector entities at the local, state, and national levels.

For FY 2016, OCR requests $42,705,000, an increase of $3,907,000 from the FY15 Enacted Level to fund its nation-wide health care anti-discrimination and health information privacy and security mission performed and supported by OCR's three activities.

- $29,400,000 for Enforcement and Regional Operations – an increase of $2,142,000
- $8,584,000 for Programs and Policy – an increase of $1,819,000
- $4,721,000 for Planning and Business Administration Management – a decrease of $54,000

Enforcement and Regional Operations

(Dollars in Thousands)

Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015 PB
Enforcement and Regional Operations	26,698	27,258	29,400	+2,142
FTE	139	137	137	0

Program Description and Accomplishments

Enforcement and Regional Operations (ERO) is charged with prevention and elimination of unlawful discrimination and protection of privacy and security of individually identifiable health information through enforcement activities under the laws within OCR's jurisdiction. ERO consists of a small headquarters element and personnel located at HHS' ten regional offices, including a satellite office in Los Angeles where additional investigators are based. The Deputy Director for Enforcement and Regional Operations reports through the Chief of Staff to the Director of OCR, and is responsible for all aspects of regional operations and performance.

The personnel based in OCR's regional offices are at the forefront of OCR's enforcement efforts and are responsible for responding to complainants, inquiries and requests from covered entities, and other healthcare consumers, and conducting investigations of alleged violations of civil rights and health information privacy and security laws. Each region is led by a regional manager who is responsible for operations within the geographical area of responsibility. OCR currently has regional offices in Boston, New York, Philadelphia, Atlanta, Chicago, Dallas, Kansas City, Denver, San Francisco, and Seattle. Additionally, there is a satellite office of the San Francisco region located in Los Angeles.

Since implementation of the Privacy Rule in 2003, the number of privacy and security complaints filed with OCR per year has steadily grown. In FY 2014, OCR actual complaint receipts were 21,247 compared to 15,043 in FY 2013. The sharp rise in receipts in late FY 2013 and FY 2014 is largely attributable to a complaint web portal implemented in July 2013 which allows the public to submit complaints electronically. OCR anticipates the volume of complaint receipts will increase to 24,434 in FY 2015 and 28,099 in FY 2016.

ERO also oversees national civil rights corporate agreements in OCR's nationwide civil rights pre-grant review program for health care provider covered entities applying to participate in the Medicare program. Through this initiative, OCR enters into civil rights corporate agreements with major health care corporations to develop model civil rights policies and procedures at all facilities under corporate ownership and control, extending their reach to facilities beyond the scope of Medicare Part A program requirements. In this way, OCR is achieving voluntary compliance with health care organizations on a large scale, thus maximizing its impact and civil rights compliance efforts within the Medicare provider community.

In order to keep pace with an increasing caseload due to OCR's evolving jurisdictional responsibilities related to health information privacy and security, and civil rights, OCR instituted a number of proactive efficiencies described below.

Centralized Case Management Operations (CCMO)

Customer Response Center (CRC)

In FY 2012, OCR implemented the CRC, which centralized the task of responding to telephone inquiries from complainants, covered entities, and the general public at OCR headquarters. This dramatic shift in OCR's core processes led to significant efficiencies by allowing regional staff to focus on investigation, outreach, and other enforcement activities. CRC staff responds to inquiries from all sources (phone, mail, fax, and web), educating callers on their responsibilities under HIPAA and numerous civil rights laws, as well as on OCR's intake and investigative processes. The CRC provides interpreter services in seven different languages to assist with the intake of complaints from foreign language speaking individuals.

Central Intake Unit (CIU)

The CIU is responsible for evaluating, triaging, and distributing cases for all ten regions. Like the CRC function, this was a task previously performed in the regions that OCR centralized at headquarters in order to facilitate the regions' main investigative responsibilities. The CIU staff resolves the vast majority of incoming complaints, enabling regional enforcement staff to address the more complex, high impact complaint investigations and compliance reviews.

Online Complaint Portal

In July 2013, OCR introduced its on-line web portal that provides a customer-friendly and expedient method for filing civil rights and health information privacy and security complaints as an alternative to the other mediums for submitting complaints (mail, fax, phone). Online complaint forms are in seven languages and the intention is to expand that number over time. Since the web portal's inception, the average number of complaints received per week has increased by 65% nationally. Despite the efficiencies gained from the centralized case management functions, the complaint increase is likely to continue and will significantly impact OCR's ability to keep pace with incoming receipts.

Accomplishments

The following items detail the most recent enforcement actions related to HIPAA privacy and security violations resulting in monetary settlements and corrective action plans.

- In December 2014, Anchorage Mental Health Services (ACMHS) agreed to settle potential violations of HIPAA by paying $150,000 and adopting a corrective action plan to address deficiencies and report on its compliance for a two-year period. OCR opened an investigation after receiving a breach notification from ACMHS affecting 2,743 individuals due to malware compromising the security of its information technology resources. OCR's investigation revealed that ACMHS had not followed sample Security Rule policies and procedures adopted in 2005 and failed to identify and address basic risks, such as running outdated, unsupported software.

- In June 2014, Parkview Health System, Inc agreed to settle potential violations of HIPAA by paying $800,000 and adopting a corrective action plan to address deficiencies in its HIPAA compliance program. OCR opened an investigation after receiving a complaint from a retiring physician alleging that Parkview had violated the HIPAA Privacy Rule. In September 2008, Parkview took custody of medical records pertaining to approximately 5,000 to 8,000 patients while assisting the retiring physician to transition her patients to new providers, and while considering the possibility of purchasing some of the physician's practice. On June 4, 2009, Parkview employees, with notice that the physician was not at home, left 71 cardboard boxes of these medical records unattended and accessible to unauthorized persons on the driveway of the physician's home, within 20 feet of the public road and a short distance

away from a heavily trafficked public shopping venue. In addition to the $800,000 resolution amount, the settlement includes a corrective action plan requiring Parkview to revise its policies and procedures, train staff, and provide an implementation report to OCR.

- In May 2014, New York and Presbyterian Hospital (NYP) paid $3,300,000 to settle potential HIPAA violations and will adopt a corrective action plan. Columbia University (CU) likewise agreed to a settlement of $1,500,000, and will institute a corrective action plan to address deficiencies in its HIPAA compliance program. OCR initiated its investigation of NYP and CU, which operate a shared network, following their submission of a joint breach report in 2010 regarding the disclosure of the ePHI of 6,800 individuals, including patient status, vital signs, medications, and laboratory results. The investigation revealed that the breach was caused when a physician attempted to deactivate a personally-owned computer server on the network containing patient ePHI. Because of a lack of technical safeguards, deactivation of the server resulted in ePHI being accessible on internet search engines. The entities learned of the breach after receiving a complaint by an individual who found the ePHI of the individual's deceased partner, a former patient of NYP, on the internet. OCR's investigation also found that neither entity made efforts prior to the breach to assure that the server was secure and that it contained appropriate software protections. Neither entity had an adequate risk management plan that addressed the potential threats and hazards to the security of ePHI. Lastly, NYP failed to implement appropriate policies and procedures for authorizing access to its databases and failed to comply with its own policies on information access management.

- In April 2014, Concentra Health Services (Concentra) agreed to a $1,725,220 monetary settlement and to adopt a corrective action plan. OCR opened a compliance review upon receiving a breach report that an unencrypted laptop was stolen from one of its facilities. While OCR's investigation revealed that Concentra had previously identified a lack of encryption on its laptops, desktop computers, medical equipment, tablets and other devices containing ePHI, Concentra's efforts to safeguard patient information were incomplete and inconsistent, leaving patient information vulnerable throughout the organization.

- In April 2014, QCA Health Plan, Inc (QCA) of Arkansas agreed to a $250,000 monetary settlement and to provide HHS with an updated risk management plan that includes specific security measures to reduce the vulnerabilities of its ePHI. QCA is also required to retrain its workforce and document its ongoing compliance efforts. OCR received a breach notice in February 2012 from QCA reporting that an unencrypted laptop computer containing the ePHI of 148 individuals was stolen from a workforce member's car. While QCA encrypted their devices following discovery of the breach, QCA failed to comply with multiple requirements of the HIPAA Privacy and Security Rules, beginning from the compliance date of the Security Rule in April 2005 and ending in June 2012.

- In March 2014, Skagit County, Washington, agreed to a $215,000 monetary settlement and to work closely with HHS to correct deficiencies in its HIPAA compliance program. OCR opened an investigation upon receiving a breach report that receipts with ePHI of seven individuals were accessed by unknown parties after the ePHI had been inadvertently moved to a publicly accessible server maintained by the County. OCR's investigation revealed a broader exposure of protected health information involved in the incident, which included the ePHI of 1,581 individuals concerning the testing and treatment of infectious diseases.

Funding History

Fiscal Year	Amount
FY 2011	$26,961,000
FY 2012	$26,908,000
FY 2013	$27,030,000
FY 2014	$26,698,000
FY 2015	$27,258,000

Budget Request

The FY 2016 request for Enforcement and Regional Operations (ERO) is $29,400,000, an increase of $2,142,000 from the FY 2015 Enacted Level. The increase supports contract staff for both the audit program initiative and continuation of OCR's centralized case management operations, including the customer response center and central intake unit.

Programs and Policy

(Dollars in Thousands)

Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015 PB
Programs and Policy	7,683	6,765	8,584	+1,819
FTE	40	34	40	+6

Program Description and Accomplishments

Programs and Policy consists of two components, Civil Rights and Health Information Privacy (HIP), with the majority of personnel working at HHS headquarters in Washington, D.C. The Deputy Director for Programs and Policy is responsible for all aspects of the operations and performance of this component and reports through the Chief of Staff to the OCR Director.

Civil Rights Division

The Civil Rights Division (CRD) performs a wide variety of critical functions to support the Department's mission to promote the health and well-being of the American public. As the component responsible for leading OCR's civil rights activities, CRD provides strategic planning for national initiatives and oversees OCR's nationwide program for civil rights enforcement, outreach, and policy development. In particular, CRD provides direction and subject matter expertise to regional staff and assists in their activities to ensure legal and policy coordination in OCR's formulation of investigative plans for complaints and compliance reviews, corrective action closure letters, voluntary compliance agreements, violation letters of finding, settlement agreements and enforcement actions. In addition, CRD supports the OCR Director's role as the Secretary's advisor on civil rights and is responsible for civil rights reviews of the Department's rulemaking and policy guidance, including drafting regulations and guidance to implement the civil rights provisions of the Affordable Care Act (ACA) and other statutes within OCR's jurisdiction and representing OCR on all HHS and other federal agency workgroups that address a wide variety of civil rights issues. Of note, CRD is responsible for leading the HHS language access steering committee, which has developed and is implementing both a HHS-wide plan and individual component plans to ensure federally conducted activities are accessible to persons with limited English proficiency.

With the advent of the ACA, OCR is charged with enforcing Section 1557, a nondiscrimination provision which ensures that all individuals have equal access to the benefits and services made available under the Act, without regard to race, color, national origin (including limited proficiency in English), disability, age, or sex. Significantly, this is the first time that sex discrimination in health care is prohibited by a national civil rights law. To help inform our regulatory development, OCR published a Request for Information (RFI) in the Federal Register in the summer of 2013. The RFI sought comment from consumers, health care providers, health insurers, and other stakeholders on a wide range of topics to inform OCR's rulemaking. OCR intends to issue an NPRM in 2015. This legislation significantly expands OCR's enforcement jurisdiction. We have already seen an increase in complaints, many of which raise issues of first impression and important policy questions, and anticipate a continued significant increase in complaints. CRD continues to play a pivotal role in ensuring civil rights protections in regulations and guidance promulgated under the Affordable Care Act, as well as other major regulations, including Home and Community Based Services and Application of the Fair Labor Standards Act to Domestic Service.

Accomplishments

- In December 2014, OCR partnered with the DOJ's Civil Rights Division to issue a Dear Colleague letter to states encouraging them to consider obligations under the integration mandate of Title II of the Americans with Disabilities Act and the 1999 Supreme Court decision in *Olmstead v. L.C* if they make budgetary and program changes to their home health services programs in response to regulatory changes made to the Fair Labor Standards Act.

- In August 2014, OCR and CMS entered into an agreement to ensure that all individuals with disabilities can access information provided by CMS and its contractors in all CMS programs. The agreement resolves two complaints filed with OCR by a national disability rights advocacy organization. The agreement requires that CMS implement a process for responding to all requests for auxiliary aids and services relating to communications between staff and beneficiaries of CMS programs, provide widespread notice of this process, and develop a longer term comprehensive approach to ensuring effective communication with CMS beneficiaries with disabilities within prescribed timelines.

- In August 2014, Mee Memorial Hospital entered into an agreement with OCR to expand accessibility for LEP persons in its main hospital and five clinics serving approximately 50,000 people throughout 2,500 square miles in rural California.

- In May 2014, OCR entered into a post fund-termination agreement to restore federal funding eligibility to a California surgeon who discriminated against an HIV+ patient by refusing to operate on him. Federal funding was conditioned upon compliance with the terms of the agreement, which required the surgeon and his staff to complete comprehensive training and to develop, implement, and notify the public of the surgeon's new nondiscrimination policy. In August 2014, OCR entered into a voluntary resolution agreement with an assisted living facility in North Carolina to remedy the facility's denial of admission to persons who are HIV+. In March 2014, as part of the White House's HIV Continuum of Care Initiative, OCR initiated civil rights and health information privacy compliance reviews of urban hospitals in the 12 cities most affected by HIV/AIDS. These cases and initiatives send an important message to health care providers about their responsibility to comply with civil rights laws and the consequences for violating them and also support the National HIV/AIDS Strategy efforts to increase access to care, improve health outcomes, reduce new HIV infections and eliminate HIV-related stigma and discrimination.

- In March 2014, OCR entered into an agreement with Mississippi to ensure its state and local agencies provide limited English proficient persons with meaningful access to human service programs, including foster care and adoption services, child protective services, abuse prevention services, child visitation, and family reunification planning.

- In early 2014, OCR established a partnership with the Association of American Medical Colleges to expand OCR's medical school curriculum training on Title VI of the Civil Rights Act of 1964. During the summer of 2014, this partnership included teaching more than 1,000 pre-medical and med-students across the country.

- In August 2013, OCR secured an order terminating Medicaid payments to a California surgeon who refused to perform back surgery on an HIV-positive patient. The order was issued by the HHS Departmental Appeals Board, and concluded that the surgeon violated Section 504 of the Rehabilitation Act of 1973, which prohibits disability discrimination by health care providers who receive federal funds. This is the first instance in nearly 30 years in which OCR has undertaken efforts to withdraw federal

financial assistance for a recipient's noncompliance with civil rights laws. OCR was ultimately able to enter into an agreement with the surgeon to ensure future compliance.

Health Information Privacy Division

The Health Information Privacy (HIP) Division leads OCR's national privacy, security, and breach notification programs and performs a wide variety of mission-critical functions to support healthcare organizations, OCR's ten regional offices, and the American public. HIP is responsible for policy development, including rulemaking activities to modify the HIPAA Privacy, Security, Breach Notification, and Enforcement Rules pursuant to new statutory authorities or for other purposes as necessary; issuing guidance and developing compliance and training tools; providing public education; and raising awareness of individuals' privacy rights and protections for their health information. Through its efforts to promote robust privacy and security protections, HIP plays a leading role in other health reform movements, including advancing the adoption and meaningful use of electronic health records, and assuring privacy and security concerns are appropriately addressed by the delivery mechanisms under the ACA and American Recovery and Reinvestment Act (ARRA), in research and patient safety initiatives, and in emergency preparedness and response activities. The HIP Division also administers the confidentiality provisions of the Patient Safety and Quality Improvement Act of 2005, which provide confidentiality protections for patient safety work product.

Since September 2009, HIP staff has overseen a nationwide breach reporting system required by Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act enabling covered entities and business associates to electronically file reports with the Secretary of all breaches of the privacy of unsecured protected health information. HIPAA covered entities are also required to provide prompt notification to the individuals affected by the breach. Breaches affecting 500 or more individuals lead to compliance reviews. HIP refers the breach reports to the regional offices for validation and investigation, and is responsible for maintaining a public listing of such breaches on the HHS web site. Breach reports that affect fewer than 500 individuals are currently treated as discretionary cases and investigated as resources permit. OCR has received more than 106,000 total complaints from the 2003 compliance date of the HIPAA Privacy Rule to the end of December 2014. For breach notifications, OCR has received 1,478 reports of breaches affecting 500 or more individuals and over 130,000 reports of smaller breaches. HIP staff provides significant input into the development of compliance and enforcement strategies, as well as expert advice to regional staff in their formulation of investigative plans, letters of investigative closure, resolution agreements and corrective action plans, and notices of the imposition of civil monetary penalties following complaint investigations.

As a result of the HITECH Act, covered entities, as well as their business associates, are subject to significantly increased civil money penalties for HIPAA violations that range from $100 to $50,000 or more per violation, with a calendar year limit of $1.5 million for identical violations. OCR has leveraged these higher penalty amounts to strengthen and expand its compliance and enforcement program. In 2009, HIP expanded its enforcement scope to include the HIPAA Security Rule and has overseen its integration with OCR's ongoing privacy enforcement programs. HIP provides subject matter expertise to OCR's regional offices on the Privacy, Security, and Breach Notification Rules, thereby raising the quality of the corrective actions achieved through investigations. HIP also coordinates with the DOJ on criminal referrals under HIPAA.

Accomplishments

- In November 2014, HIP issued guidance on the HIPAA Privacy Rule in Emergency Situations (the "Ebola Bulletin"). The guidance reviews the ways in which patient information may be shared under the

Privacy Rule during an emergency situation and serves as a reminder that the protections of the Privacy Rule are not set aside during an emergency.

- In September 2014, HIP issued guidance addressing the effect of the 2013 Supreme Court decision regarding the Defense of Marriage Act (DOMA) on certain HIPAA Privacy Rule provisions, which makes clear that spouses include both same-sex and opposite-sex individuals who are legally married, whether or not they live or receive services in a jurisdiction that recognizes their marriage.

- In February 2014, HIP collaborated with CMS and the CDC to publish a Final Rule that broadens individuals' rights to access their protected health information directly from laboratories subject to HIPAA, and removes federal barriers under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) to individuals' direct access to their lab test reports.

- In February 2014, HIP issued guidance addressing when it is appropriate under the Privacy Rule for a health care provider to share the protected health information of a patient who is being treated for a mental health condition. Specifically, the guidance clarifies the circumstances under which HIPAA permits health care providers to communicate with a patient's family members, friends, or others involved in the patient's care; consider the patient's capacity to agree or object to the sharing of their information; communicate with family members, law enforcement, or others when the patient presents a serious and imminent threat of harm to self or others; and communicate to law enforcement about the release of a patient brought in for an emergency psychiatric hold.

- In January 2014, as part of President Obama's continuing efforts to reduce gun violence, HIP published a Notice of Proposed Rulemaking (NPRM) to remove unnecessary legal barriers under the HIPAA Privacy Rule that may prevent states from reporting certain information to the National Instant Criminal Background Check System (NICS). The NICS helps to ensure that guns are not sold to those prohibited by law from having them, including individuals involuntarily committed to a mental institution or otherwise who have been adjudicated to have a severe mental condition that would disqualify them from having a firearm (this provision in Federal law is known as the "mental health prohibitor"). The proposed rule would give States and certain covered entities added flexibility to ensure that accurate but limited information about individuals subject to the Federal mental health prohibitor is reported to the NICS. HIP currently is developing a final rule that, consistent with the NPRM, is carefully tailored to balance individuals' privacy interests with public safety needs.

- HIP piloted audits to ensure compliance by covered entities and business associates with the HIPAA Privacy and Security Rules and with their obligations under the HITECH Act. Comprehensive audit protocols were developed, tested, and used to conduct a total of 115 pilot audits of covered entities of varying types and sizes. An audit evaluation identified areas of program strength and recommendations for program design in FY 2016.

- HIP launched a number of efforts to increase education and awareness among covered entities and business associates about compliance with the HIPAA Privacy and Security Rules. OCR has developed six on-line educational modules that 122,868 health care providers have viewed via Medscape.org. Further, HIP has partnered with ONC and CMS to develop privacy and security protections for electronic health records that will promote their adoption and meaningful use such as the OCR Security Risk Assessment Tool, designed to assist small providers in conducting risk analysis in using certified electronic health records.

- OCR has continued to aggressively enforce the HIPAA Privacy, Security, and Breach Notification

Rules. Since July of 2008, HIP has assisted the regional offices to impose one civil money penalty and negotiate 23 settlement agreements that included detailed corrective active plans. These actions have resulted in monetary receipts that OCR has utilized towards furthering health information privacy, security, and breach enforcement efforts.

Funding History

Fiscal Year	Amount
FY 2011	$9,235,000
FY 2012	$9,217,000
FY 2013	$7,759,000
FY 2014	$7,683,000
FY 2015	$6,765,000

Budget Request

The FY 2016 request for Programs and Policy (P&P) is $8,584,000 which is an increase of $1,819,000 from the FY 2015 Enacted Level.

The increase funds OCR's initiative for a permanent HIPAA Privacy, Security, and Breach Notification Rule Audit Program. The HITECH Act provided authority for OCR to design, test, and evaluate an audit function to measure compliance with privacy, security, and breach notification requirements by covered entities and their business associates. The experience and evaluation of the methods piloted in FY 2011 and FY 2012 provided the Department with an enhanced understanding of current privacy and security risks to health information. The evaluation noted strengths of the program design and suggestions for moving forward. OCR has incorporated these ideas into its current planning for a second phase of audits. A viable audit program adds tremendous value to the compliance and enforcement mission of OCR by leveraging a proactive and systemic look at industry compliance successes and struggles, rather than the incident response efforts triggered by a complaint process. A robust audit program can generate analytical tools and methods for entity self-evaluation and prevention, fostering a culture of compliance throughout the health care sector, and serve as a foundation for appropriate enforcement action. Through widespread entity interest in and response to audit program expectations, a successful audit program can have a multiplier effect on compliance penetration beyond the number of entities selected for the audit itself.

OCR is only capable of auditing a subset of the overall population of covered entities and business associates, so OCR will target an appropriate mix of size and complexity of entities to audit. OCR will use entity-specific databases (e.g., the National Provider Identifier) to select an initial pool of several hundred covered entities. A Pre-Audit Screening Questionnaire to be completed by these entities will provide OCR with characteristics about each entity that will enable OCR to select those entities that best fit OCR criteria.

OCR will add FTE and contractors to oversee and conduct the program. OCR plans to conduct audits of covered entities and, for the first time, business associates, using OCR regional investigators and contract support (including a security expert, privacy and breach expert, and auditors). These audits will be focused on particular requirements of HIPAA breach notification, privacy, and security rules.

Planning and Business Administration Management

(Dollars in Thousands)

Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015 PB
Planning and Business Admin Mgmt	4,417	4,775	4,721	-54
FTE	23	24	22	-2

Program Description and Accomplishments

The Division of Planning and Business Administration Management (PBAM) is focused on supporting OCR's mission through a variety of service and support functions outlined below and providing direct support to the operations of OCR's other two activities (E&RO and P&P). All FTEs are located at HHS headquarters in Washington, DC. The Deputy Director for PBAM is responsible for all aspects of the operations and performance of the sections and reports through the Chief of Staff to the Director of OCR.

Budget

The Budget Section is accountable for working with leadership to formulate funding and personnel requirements. Specific focus areas are: budget formulation, budget execution, management internal controls, headquarters and regional operations support, data calls response, and resource matters that affect ongoing OCR efforts to provide quality support.

Executive Secretariat (ES)

The ES section is responsible for agency clearance requests, Congressional and other high-level correspondence, Freedom of Information Act (FOIA) actions, and other general administrative duties.

Human Resources (HR)

The HR section provides guidance to leaders, conducts the recruitment of staff personnel, and coordinates personnel support actions for headquarters and the regions. The section's key responsibilities include coordination with the Office of Human Resources (OHR), application and adherence to human resources policy, and interfacing with the labor union.

Information Technology (IT)

With personnel spread across the nation, the IT section has the challenging task of ensuring all locations receive superb and timely automation support to facilitate seamless operations. This is accomplished via the performance of a variety of tasks, including conducting inventories, planning upgrades, maintaining and replacing equipment, attaining contracts to support systems, administering the Performance Information Management System (PIMS), and fulfilling network security requirements.

Additional personnel include the Director of OCR, the Chief of Staff, and their immediate staff as well as the Deputy Director of PBAM.

Funding History

Fiscal Year	Amount
FY 2011	$4,821,000
FY 2012	$4,813,000
FY 2013	$4,843,000
FY 2014	$4,417,000
FY 2015	$4,775,000

Budget Request

The FY 2016 request for Planning and Business Administration Management (PBAM) is $4,721,000. This reflects a decrease of $54,000 from the FY 2015 Enacted Level.

Budget Authority by Object Class

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
11.1	Full-time permanent	18,813	17,262	18,193
11.3	Other than full-time permanent	1,541	1,426	1,440
11.5	Other personnel compensation	318	321	331
11.7	Military personnel	154	156	157
Subtotal	***Personnel Compensation***	***20,826***	***19,165***	***20,121***
12.1	Civilian personnel benefits	6,190	5,586	5,929
12.2	Military benefits	81	82	83
13.0	Benefits for former personnel	287	30	31
Total	***Pay Costs***	***27,384***	***24,863***	***26,164***
21.0	Travel and transportation of persons	301	304	349
22.0	Transportation of things	13	8	10
23.1	Rental payments to GSA	3,299	3,165	3,312
23.3	Communications, utilities, and misc. charges	211	202	204
24.0	Printing and reproduction	150	57	60
25.1	Advisory and assistance services	-	-	-
25.2	Other services from non-Federal sources	108	110	113
25.3	Other goods and services from Federal sources	5,244	9,138	11,538
25.4	Operation and maintenance of facilities	395	344	347
25.5	Research and development contracts	-	-	-
25.6	Medical care	1,055	-	-
25.7	Operation and maintenance of equipment	430	383	387
25.8	Subsistence and support of persons	-	-	-
26.0	Supplies and materials	158	189	191
31.0	Equipment	50	35	30
32.0	Land and Structures	-	-	-
41.0	Grants, subsidies, and contributions	-	-	-
42.0	Insurance claims and indemnities	-	-	-
44.0	Refunds	-	-	-
Total	***Non-Pay Costs***	***11,414***	***13,935***	***16,541***
Total	**Budget Authority by Object Class**	**38,798**	**38,798**	**42,705**

Salaries and Expenses

(Dollars in Thousands)

Object Class Code	Description	FY 2015 Base	FY 2016 Budget	FY 2016 +/- FY 2015
11.1	Full-time permanent	18,813	17,262	18,193
11.3	Other than full-time permanent	1,541	1,426	1,440
11.5	Other personnel compensation	318	321	331
11.7	Military personnel	154	156	157
Subtotal	***Personnel Compensation***	***20,826***	***19,165***	***20,121***
12.1	Civilian personnel benefits	6,190	5,586	5,929
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13.0	Benefits for former personnel	287	30	31
Total	***Pay Costs***	***27,384***	***24,863***	***26,164***
21.0	Travel and transportation of persons	301	304	349
22.0	Transportation of things	13	8	10
23.3	Communications, utilities, and misc. charges	211	202	204
24.0	Printing and reproduction	150	57	60
25.1	Advisory and assistance services	-	-	-
25.2	Other services from non-Federal sources	108	110	113
25.3	Other goods and services from Federal sources	5,244	9,138	11,538
25.4	Operation and maintenance of facilities	395	344	347
25.5	Research and development contracts	-	-	-
25.6	Medical care	1,055	-	-
25.7	Operation and maintenance of equipment	430	383	387
25.8	Subsistence and support of persons	-	-	-
Subtotal	***Other Contractual Services***	***7,232***	***9,975***	***12,385***
26.0	Supplies and materials	158	189	191
Subtotal	***Non-Pay Costs***	***8,066***	***10,735***	***13,199***
Total	***Salary and Expenses***	***35,450***	***35,568***	***39,363***
23.1	Rental payments to GSA	3,299	3,165	3,312
Total	**Salaries, Expenses, and Rent**	**38,749**	**38,733**	**42,675**
Total	**Direct FTE**	**202**	**195**	**199**

Detail of Full-Time Equivalent Employment

Detail	FY 2014 Actual Civilian	FY 2014 Actual Military	FY 2014 Actual Total	FY 2015 Estimate Civilian	FY 2015 Estimate Military	FY 2015 Estimate Total	FY 2016 Estimate Civilian	FY 2016 Estimate Military	FY 2016 Estimate Total
Direct	200	2	202	193	2	195	197	2	199
Reimbursable	*1*	-	*1*	*1*	-	*1*	*1*	-	*1*
Total FTE	**201**	**2**	**203**	**194**	**2**	**196**	**198**	**2**	**200**

Detail of Positions

Detail	FY 2014 Final	FY 2015 Enacted	FY 2016 Budget
Executive level I	-	-	-
Executive level II	*4*	*2*	*2*
Executive level III	1	2	2
Executive level IV	2	1	1
Executive level V	2	-	-
Subtotal	***9***	***5***	***5***
Total - Exec. Level Salaries	**$1,085,642**	**$834,510**	**$842,855**
-	-	-	-
GS-15	22	21	22
GS-14	31	30	32
GS-13	35	34	34
GS-12	83	76	76
GS-11	6	6	7
GS-10	-	-	-
GS-9	16	16	16
GS-8	-	-	-
GS-7	1	1	1
GS-6	-	-	-
GS-5	9	7	7
GS-4	-	-	-
GS-3	-	-	-
GS-2	-	-	-
GS-1	-	-	-
Subtotal	***203***	***191***	***195***
Total - GS Salary	**$19,268,358**	**$17,853,490**	**$18,790,145**
-	-	-	-
Average ES level	III	III	III
Average ES salary	$171,507	$166,902	$168,571
Average GS grade	12.9	12.8	12.9
Average GS Salary	**$95,388**	**$93,474**	**$96,360**

Rent and Common Expenses

(Dollars in Thousands)

Detail	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Rent	3,299	3,165	3,312	+147
Subtotal	***3,299***	***3,165***	***3,312***	***+147***
Operations and Maintenance	825	727	734	+7
Subtotal	***825***	***727***	***734***	***+7***
Service and Supply Fund	4,199	3,908	3,947	+39
Subtotal	***4,199***	***3,908***	***3,947***	***+39***
TOTAL	***8,323***	***7,800***	***7,993***	***+193***

National Coordinator for Health Information Technology

LETTER FROM THE NATIONAL COORDINATOR

I am pleased to present the fiscal year (FY) 2016 Budget Justification for the Office of the National Coordinator for Health Information Technology (ONC). Access to electronic health information is an essential component for achieving better care, at a lower cost and better health for all. With the goal of a transformed delivery system, it is necessary to bring better value to consumers, whether that means payment reform or innovative models of care. As the National Coordinator for Health IT, I am proud of the role that ONC's dedicated and talented team and programs have played in supporting more than sixty five percent of eligible health care clinicians and more than ninety percent of hospitals in the nation to adopt electronic health record technology certified by ONC's certification program, and meaningfully collect, share and use health IT for health care and health improvement.

The Department of Health and Human Services (HHS) has a critical responsibility to see that comprehensive health information is available when and where it matters most and to see that system and policy interoperability is seamless and sustainable. Achieving interoperability will mean that health IT can put data in the hands of the nation to improve health care quality and safety, lower health care costs and improve population and public health, and advance science. Individuals will also be empowered through the use of health IT toward personal and community health improvement.

In FY 2016, ONC will focus on developing a nation-wide, interoperable health IT infrastructure that assures data can be securely and appropriately collected, shared with, and used by the right people at the right time to achieve access to more affordable quality care and better health. ONC will move toward health IT optimization to further care transformation and increase interoperability through policies, standards, and programs that will continue to help providers and consumers leverage health IT. ONC's FY 2016 budget request includes funding for building federal and national consensus around and implementing the Federal Health IT Strategic Plan; inspiring confidence and trust in health IT; empowering consumers to meaningfully use their health information and actively participate in their health care through improved access to health information; and developing and harmonizing standards that enable multiple methods of clinical quality improvement and health information exchange. This work is crucial for advancing the promise and power of health IT and fulfilling HHS' mission to protect the health of all Americans and provide essential human services.

/Karen B. DeSalvo/
Karen B. DeSalvo, M.D., M.P.H., M.Sc.
National Coordinator for Health IT

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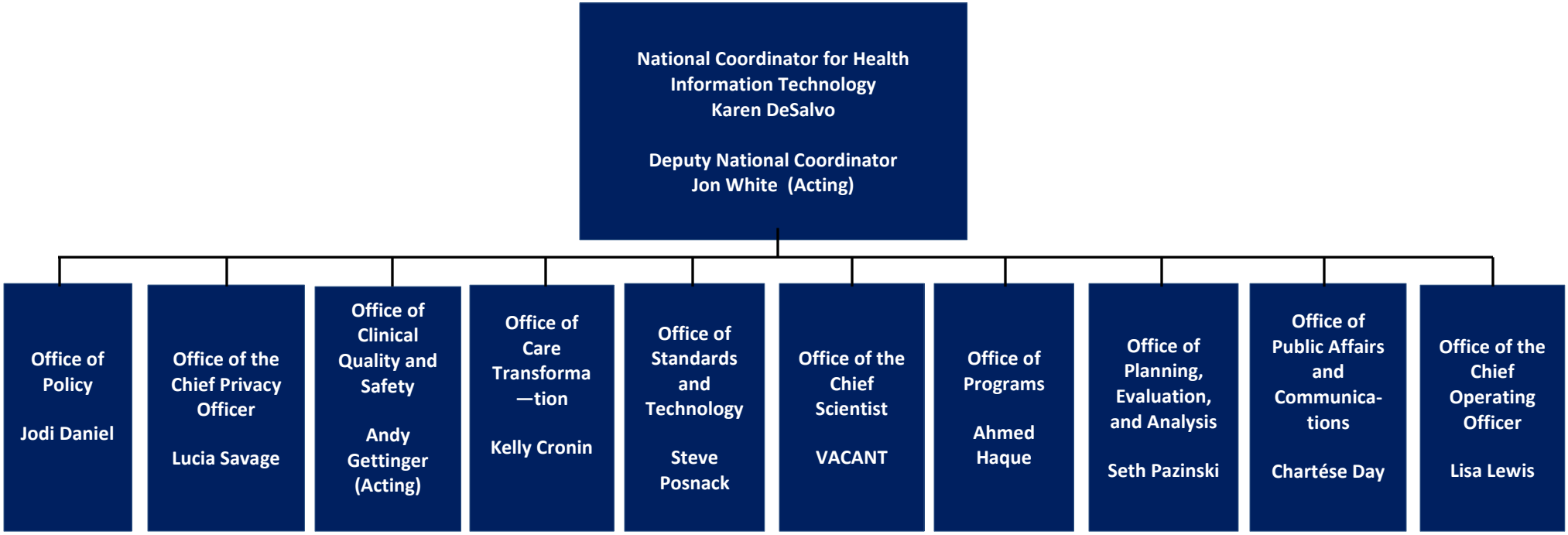
ORGANIZATIONAL CHART



ORGANIZATIONAL CHART: TEXT VERSION

National Coordinator for Health Information Technology
- Karen DeSalvo, MD, MPH, MSc

Principal Deputy National Coordinator
- Jon White, MD (Acting)

The following offices report directly to the National Coordinator:
- Office of Policy
  - Jodi Daniel, JD, MPH
- Office of the Chief Privacy Officer
  - Lucia Savage, Esq
- Office of Clinical Quality and Safety
  - Andy Gettinger, MD (Acting)
- Office of Care Transformation
  - Kelly Cronin
- Office of Standards and Technology
  - Steven Posnack, MS, MHS
- Office of the Chief Scientist
  - Vacant
- Office of Programs
  - Ahmed Haque
- Office of Planning, Evaluation and Analysis
  - Seth Pazinski
- Office of Public Affairs and Communications
  - Chartése Day, MBA
- Office of the Chief Operating Officer
  - Lisa Lewis

EXECUTIVE SUMMARY

Introduction and Mission

Agency Overview

The Office of the National Coordinator for Health Information Technology (ONC), a staff division of the U.S. Department of Health and Human Services (HHS), is the lead agency charged with formulating the federal government's health information technology (health IT) strategy and coordinating federal health IT policies, standards, programs, and investments. ONC supports HHS Strategic Plan goals 1: Strengthen Health Care and 2: Advance Scientific Knowledge and Innovation.

ONC was established in 2004 by Executive Order and was codified in legislation in 2009, with the enactment of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act (Recovery Act). HITECH also provided short term funding to HHS in support of a number of health IT related initiatives, including the Medicare and Medicaid Electronic Health Record Incentive Programs (aka Meaningful Use Program) under which certain eligible providers and hospitals may receive payments for adopting and meaningfully using electronic health record (EHR) technology. HITECH provided broad, permanent authorities for ONC to promote the widespread adoption of standardized and certified EHR technology, facilitate the secure use and exchange of interoperable health information, and promote the delivery of safe, efficient, cost effective high quality care. ONC supports the Department's goal to strengthen health care by pursuing the modernization of the care delivery infrastructure of the nation through the adoption, meaningful use, implementation and optimization of health IT. These efforts make health information available electronically for better decision-making by consumers, clinicians, health care administrators, and policy-makers at all levels of health care.

Vision

Health information is accessible when and where it is needed to improve and protect people's health and well-being

Mission

Improve health, health care, and reduce costs through the use of information and technology

Introduction

Health care delivery in the United States is transforming from volume-based fiscal incentives towards an emphasis on enhanced value to the consumer. In this new context, electronic health information is the essential ingredient to success. While many health care providers have adopted health IT, putting electronic health information in the hands of the nation in a manner that is usable by all remains the primary goal. As the federal agency charged with achieving this goal, ONC is evolving its focus to health beyond healthcare, health IT beyond EHRs, and levers beyond the Meaningful Use Program to harness the power of health IT for better care at a lower cost and better health.

ONC is working towards achieving an interoperable, learning health system through high level coordination between government and the private sector, ensuring the appropriate collection, sharing and use of data, and developing policy efforts and, when necessary, regulations. As the national convener for health IT advancement and innovation, ONC enables and informs health delivery transformation, payment reform, the adoption of certified electronic health records, and the public's

health by building upon a roadmap that allows for a robust health IT infrastructure. Better health can then be achieved by improving the flow of information so that care providers can shift from an emphasis on transactions to one of patient care and value. ONC is also continuing to leverage its existing authorities and responsibilities, which include technical standards coordination and harmonization work, a regulatory certification program, and coordination of privacy and security work through a Chief Privacy Officer — as well as ONC's core function of coordinating federal health IT policy through multiple venues, including the Federal Health IT Strategic plan, through leadership of the Federal Health Architecture (FHA), and through the work of our federal advisory committees.

ONC's existing levers, including the Meaningful Use Program and associated Certification authorities, are continuing to be used to advance these goals in partnership with our federal, state, and private sector partners. Putting electronic health information in the hands of the nation will facilitate care coordination, consumer engagement, informed and shared decisions, more transparent and seamless quality measurement, a robust and powerful research community, and an essential infrastructure for the measurement and improvement of quality and safety. This infrastructure will support the evidence base for medicine and health care evolving more rapidly as researchers and clinicians collaborate to refine our understanding of the most effective care. ONC's unique technical expertise, existing authorities, and strong relationships with the private sector make ONC remarkably well suited to champion systems and policy change through the widespread application of health IT to achieve the enhanced level of care and health all Americans deserve.

The following activities describe how ONC is creating a safe, secure, and interoperable health IT infrastructure.

<u>Policy Development and Coordination</u>

ONC develops and coordinates federal policies through collaboration with a broad range of health IT stakeholders to achieve a robust and interoperable health IT infrastructure and to address emerging health IT issues. Specific activities include:

- *Health IT Policy*: Engages stakeholders to collaboratively identify emerging issues and forge consensus-based solutions. Investigates alternative solutions in real world settings, incorporating best practices into the Meaningful Use and Certification Programs. Ensures a coordinated and consistent approach to the federal regulation and the governance of health IT.
- *Privacy and Security*: Provides subject matter expertise and technical assistance to organizations as they navigate the legal, regulatory, and technical issues surrounding the privacy and security of health information. Through direct engagement with stakeholders and coordination of federal regulations, the Chief Privacy Officer ensures that privacy and security standards are addressed in a consistent manner that reinforces the protection of private health information.
- *Health IT Safety and Usability:* Coordinates Departmental health IT safety activities to identify and mitigate the safety risks associated with the use of health IT. The program coordinates activities around health IT design, integrates clinical workflows, educates and trains health IT consumers, and develops processes designed to identify and correct unsafe conditions or uses of health IT.
- *Clinical Quality Improvement (CQI):* Ensures a comprehensive approach to integrating clinical knowledge into health IT. Provides subject matter expertise on policies, standards, and tools that give providers and consumers the information and tools needed to identify high risk conditions, assist in decision making, and measure care quality.

Standards, Interoperability, and Certification

ONC leads a variety of efforts designed to accelerate nationwide progress towards an interoperable health IT infrastructure. By supporting standards development and convening federal agencies and other partners to implement nationwide solutions to Health Information Exchange (HIE), ONC is working to create interoperable health IT infrastructures that support national priorities. Specific activities include:

- *Standards Development and Harmonization:* Provides the technical infrastructure to support the Certification Program. Through the Standards and Interoperability (S&I) Framework and the Standards Implementation and Testing Environment (SITE) Platform, ONC coordinates and convenes stakeholders to develop and harmonize standards, and provides testing and data infrastructure to ensure the efficiency of proposed standards for inclusion in the Certification Program.
- *Health Information Exchange:* Provides the leadership and resources needed to accelerate the nationwide adoption and utilization of HIE. This includes engaging HIE participants and assisting them to implement HIE services, and providing a focus on the right set of standards, protocols, legal agreements, specifications, and services needed to manage the exchange of health information.
- *Certification and Accreditation:* Provides vendors and developers with clear criteria for developing their products by issuing certification criteria for the Certification Program. Collaborates with National Institute of Standards and Technology (NIST), deploys testing procedures, data, and tools in regard to the standards and certification criteria adopted by regulation for Accredited Testing Labs (ATLs). Separately, ONC accredits authorized certification bodies to independently validate the ATLs results and certify the product.
- *Federal Health Architecture:* ONC acts as the managing partner of the FHA. Through the FHA, over 20 federal agencies have joined together to implement government-wide solutions to health IT that addresses agency business priorities while protecting citizen privacy.

Adoption and Meaningful Use of Health IT

ONC supports efforts aimed at the widespread adoption of the latest health IT and disseminates methods by which providers and consumers can meaningfully use health IT to improve decision making. Through coordinated national strategies and direct engagement with the health IT community, ONC maintains a national network of organizations that are focused on supporting individual providers and consumers in adopting and meaningfully using health IT. Specific activities include:

- *Provider Adoption Support:* Proves a forum –the National Learning Consortium (NLC) – through which health IT implementers and providers can collaborate to identify common implementation issues, develop and share best practices to mitigate challenges, and showcase innovative uses of health IT.
- *Consumer eHealth:* Engages directly with consumers to empower them to meaningfully use their health information and actively participate in their health care through improved access to health information provided by CEHRT. Works to ensure consumers are engaged in support of a robust eHealth market.
- *Planning, Evaluation, and Monitoring:* Leads the development of the Federal Health IT Strategic Plan, and uses internal and external data sources to conduct economic analysis and develop models that describe the value of investing in health IT implementation. Provides health IT monitoring, which measures the costs, benefits, and economic impacts of HITECH and Meaningful Use Programs, and provides measurements of program activities. These studies and reports inform and influence health policy and program decisions.
- *Engagement and Outreach:* Coordinates external communication and dissemination activities through HealthIT.gov and the NLC. Provides internal communication resources through the ONC's intranet.

Agency Wide Support

ONC's agency-wide support team provides dynamic and flexible support to ONC's offices and programs through administrative and central services with responsibility for overall agency efficiency and effectiveness. Activities include: acquisitions and grants; budget operations; people and culture; program integrity; operational services; monitoring and analysis; systems and planning; and demand management.

All Purpose Table

(Dollars in Millions)

Program	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 Request (+/-) FY 2015 Enacted
Budget Authority	15.556	60.367	0.000	-60.367
PHS Evaluation Funds	44.811	0.000	91.800	+91.800
Total, ONC	60.367	60.367	91.800	+31.433

Overview of Budget Request

The Fiscal Year (FY) 2016 Budget Request for ONC is $91.8 million in Public Health Service (PHS) Evaluation Funds. The FY 2016 budget request reflects ONC's commitment to developing a nation-wide, interoperable learning health system that assures that data can be securely collected, used, and shared by the right people at the right time to achieve better care and better health at a lower cost.

In FY 2016, ONC will convene stakeholders and build consensus around standards and policies. ONC will support standards development and develop a robust certification program that enables health information exchange. ONC will also continue to engage a diverse set of stakeholders and federal partners through multiple convening strategies including the federal advisory committees and the Federal Health Architecture. ONC will work with these stakeholder groups to develop, gain consensus around, and implement the FY 2015-2020 Health IT Strategic Plan, and coordinate and collaborate on other ways to optimize policies, standards, and best practices to continue care transformation through health IT. ONC will also continue to inspire confidence and trust in health IT through ensuring the privacy and security of patient data and ensuring that consumers are able to exercise control over their health information.

The focus of ONC's FY 2016 budget request is advancing the interoperability of health information technology so that electronic health information can be collected, shared, and used by consumers, providers and others to advance care and health. Interoperability is "the ability of a system to exchange information with, and use information from, other systems without special effort on the part of the customer." This means all individuals, their families, and their health care providers have appropriate access to health information that facilitates informed decision-making, supports coordinated health management, allows individuals and caregivers to be active partners and participants in their health and care, and improves the overall health of the nation's population. Too often, individuals and their care providers cannot get the health information they need in an electronic format when and how they need it to make their care convenient and well-coordinated. This gap in access to health information negatively impacts all of health care delivery - nearly one-fifth of the US economy. To address this gap, ONC will undertake critical work to operationalize governance of the nationwide health information network, further specify technology standards, lead the development of testing procedures and tools for health IT certification, support on the ground implementation of health IT, and track and monitor progress.

The core elements of this 2016 budget request enable ONC to advance progress toward a safe and secure nation-wide system of interoperable health IT that focuses on safety and usability while enabling

new payment delivery models and care delivery transformation. The critical building blocks for a nationwide interoperable health information infrastructure are:

1. Core technical standards and functions
2. Certification to support adoption and optimization of health IT products and services
3. Privacy and security protections for health information
4. Supportive business, clinical, cultural, and regulatory environments
5. Rules of engagement and governance

The following activities demonstrate how ONC is working to create a safe, secure, and interoperable health IT infrastructure that is improving health and health care for all Americans:

Policy Development and Coordination ($27.0 million, +$14.6 million from FY 2015 enacted)
These funds support the development and coordination of federal policies and strategies that promote a safe and secure interoperable learning health system. In 2016, ONC will promote interoperability by building consensus around and implementing the Federal Health IT Strategic Plan. ONC will foster innovation with a new cross-Departmental initiative targeting prescription drug overdoses, and inspire confidence and trust in health IT through ensuring the privacy and security of patient data, and ensuring that consumers are able to exercise control over their health information. ONC will also launch the Health IT Safety Center, a public-private partnership focused on integrating health IT into a culture of safety in healthcare.

Standards, Interoperability, and Certification ($33.7, +$18.4 million from FY 2015 enacted)
These funds support a variety of efforts designed to accelerate nationwide progress toward an interoperable learning health IT infrastructure. In 2016, ONC will focus on supporting interoperability by establishing consensus around standards development activities and policies related to health information exchange and precision medicine. ONC will also continue to support the Certification Program and convene federal agencies, including the Department of Veteran's Affairs and the Department of Defense, through the Federal Health Architecture.

Adoption and Meaningful Use of Health IT ($13.0 million, +$1.9 million from FY 2015 enacted)
ONC supports efforts aimed at the widespread adoption of certified health IT products and disseminates methods by which providers and consumers can use health IT to improve decision making. In 2016, ONC will promote interoperability by disseminating guides and best practices through the NLC and working with consumers and caregivers so that they can meaningfully use their health information and actively participate in their health care. ONC will also gather data and evaluate progress toward achieving interoperability.

Agency Wide Support ($18.1 million, -$3.4 million from FY 2015 enacted)
ONC's agency-wide support team provides dynamic and flexible support to ONC's offices and programs through administrative and central services with responsibility for overall agency efficiency and effectiveness. Activities include: acquisitions and grants; budget operations; human capital; program oversight; operational services; and systems and planning.

Overview of Performance

ONC continues to monitor a variety of health system measures to contextualize and inform its strategic planning and to evaluate federal health IT programs.

The Meaningful Use Program gained significant momentum in 2014, and as of June 2014 more than 400,000 eligible health care professionals (75 percent) and 4,600 hospitals (92 percent) were participating in the programs and had met the criteria for incentive payments during Stage I of the Meaningful Use Program. The progress has exceeded the HHS priority goal for FY 2014 that 375,000 providers would receive a payment from either the Medicare or Medicaid programs. The Department is continuing the same goal into FY 2016 with a target of 450,000 and will also monitor provider progress through future stages of meaningful use.

The gains in EHR adoption have been supported and accelerated by ONC's implementation of HITECH programs, including the Health IT Regional Extension Center (REC) program, which is scheduled to end in 2016. A 2013 Government Accountability Office (GAO) study demonstrated how the RECs have been succeeding as change agents in health care. The GAO report found that Medicare providers working with RECs were more than 1.9 times more likely to receive an EHR incentive payment then those who were not. The impact of the REC program is evident. Analysis conducted in 2013 of dual eligible participating in the Incentives Programs and other HHS programs showed that the RECs are working with more than 90 percent of the nation's Federally Qualified Health Centers. The data further showed that RECs are working with more than 50 percent of practices that are participating in the Center for Medicare & Medicaid Innovation (CMMI) Comprehensive Primary Care (CPC) initiative and 58 percent of all the 2011 National Committee for Quality Assurance Patient Centered Medical Home (NCQA PCMH)-certified providers.

Alongside the sustained increases in EHR adoption and the growing participation rates in HITECH programs such as the RECs and EHR Incentive Programs, health care providers are beginning to implement advanced functionalities that enable them and their patients to experience the benefits that a foundation of EHRs can provide. To this end, in FYs 2015-2016, ONC will continue monitoring the adoption of EHRs and participation the Meaningful Use Program; measurement activities will be increasingly focused to monitor provider's specific health information exchange capabilities and activity. In particular, ONC will be monitoring the extent to which providers are using EHR functionalities that enable the exchange of patient health information directly with patients and with providers outside their organization. Additionally, ONC will be monitoring changes in consumer attitudes regarding the safeguards that providers are taking to protect the privacy and security of patient personal health information.

Description of ONC's Performance Management Process

The performance management process at ONC is an embedded part of all policy, standards, and program management activities. The process includes a range of activities that provide ONC executives, managers, and staff the opportunity to develop clear and common goals, monitor progress towards goal attainment, and when necessary, revise established plans appropriately.

The ONC performance management process is enabled by a common government-wide framework of performance processes and standards, including targeted activities that focus ONC performance management with respect to: (1) priority-setting, (2) measurement and analysis, (3) regular

performance reviews, and (4) priority, strategic, and/or operational updates based on findings from performance reviews.

Priority Setting

ONC's authorizing legislation, appropriations, and implemented budgets form the basis for the multi-year and annual priority setting processes. ONC regularly receives and integrates into its priorities requests from Congress that pertain to updates on ONC activities or to renewed or reformed focus on health IT promotion and implementation.

Strategic Planning

Establishing multi-year strategic plans is critical to formulating and advancing a long-term vision for the coordination of an IT-enabled health care system. According to the HITECH Act, the Federal Health IT Strategic Plan addresses the following priority areas:

- Use of electronic exchange, health information, and the enterprise integration of such information;
- Utilization of an EHR for each person in the United States;
- Incorporation of privacy and security protections for the electronic exchange of an individual's identifiable health information;
- Use of security methods to ensure appropriate authorization and electronic authentication of health information and specifying technologies or methodologies for rendering health information unusable, unreadable, or indecipherable;
- Specification of a framework for coordination and flow of recommendations and policies among the Secretary, the National Coordinator, the advisory committees, and other health information exchanges and relevant entities;
- Use of methods to foster the public understanding of health IT;
- Employment of strategies to enhance the use of health IT to improve health care quality, reduce medical errors, reduce health disparities, improve public health, increase prevention and coordination with community resources, and improve the continuity of care among health care settings; and,
- Implementation of specific plans for ensuring that populations with unique needs, such as children, are appropriately addressed in the technology design, as appropriate, which may include technology that automates enrollment and retention for eligible individuals.[1]

Access the FY 2011-2015 Health IT Strategic Plan, and the Draft FY 2015-2020 Health IT Strategic Plan.

Following the best practices established in the Government Performance and Results Act Modernization Act of 2011, ONC is currently working on revising the Health IT Strategic Plan in order to develop a new plan that will cover 2015-2020. The process for updating the plan includes extensive planning within ONC, consultation with Federal partners, and outreach to providers and the health care community.

Annual Plans

In addition to multi-year strategic plans, ONC undertakes a number of management planning exercises that develop, revise, and enact annual plans. The ONC Organizational and National Coordinator's Annual Plans are established according to the Department's Senior Executive Service performance planning schedule, which is aligned to the fiscal year calendar. In practice, the method for establishing these plans involves disciplined and detail-oriented series of conversations where the National Coordinator,

[1] P.L. 111-5, Sec. 3001(c)(3)(A)

ONC's executives, and subject matter experts define ambitious milestones and goals for accomplishing the upcoming fiscal year's program, policy, and operational objectives.

Each year's Annual Plan includes priority goals, discreet milestones, and key measures related to organization and program-level financial and performance management priorities. The plan also establishes an important cultural tone and emphasis on core values expressing the National Coordinator's workplace and performance management philosophies.

After the National Coordinator's plan is finalized, the core performance elements are integrated into the annual performance plans for ONC's senior executives. Each ONC senior executive has a performance plan that includes critical elements of performance that are related to the achievement of the organization's program and policy goals, as well as the on-going exhibition of core management and leadership competencies. Once the National Coordinator and Senior Executive Service performance plans are in place, the process of aligning employee performance plans begins. Staff performance plans align with the expectations of ONC senior executives as well as the overarching goals of the organization and they also include specific goal statements expressing the exact contributing actions that the staff will champion during the performance period.

Measurement and Analysis

Research and Analysis of Priority Health IT Adoption Indicators

Through a variety of research projects on the development and diffusion of a national health IT market, ONC's researchers, program evaluators, and program and policy analysts support a cross-cutting research, analysis, and adoption modeling agenda. This agenda focuses on identifying barriers to health IT adoption, patterns of successful implementation, and gaps where additional research is needed to further motivate health systems changes. Together, these activities enable ONC to assess nationwide, regional, and state-level patterns of EHR adoption and HIE activity to the advantage of HHS programs and pertaining to priority groups of health care providers.

Analysis and Reporting of Program Information

ONC's performance-based policy and program management philosophies are supported by numerous information management systems that enable the consistent collection and analysis of ONC data. Program and operations data are regularly captured, analyzed, and presented across staff and manager groups through tools such as : ONC Intranet; Health IT Research Center (to be known going forward as the National Learning Consortium), and Health IT Dashboards.

ONC also has several Open Government projects that provide public access to the results of these activities:

- Health IT Dashboards
- Health IT Implementation Resources Repository
- Health IT Research Council, National Learning Consortium

Summative Feedback on HITECH Program Effectiveness through Program Evaluations

HITECH requires ONC to conduct program evaluations of the: (1) overall implementation of HITECH, (2) Health IT Extension Program, (3) Health IT Workforce Program, (4) State HIE Program, and (5) Beacon Community Program. These evaluations also generate useful analyses that can impact the implementation of the programs. For example, several of the HITECH evaluations are developing grantee typologies that help ONC project officers and grantees understand and address common problems.

Deliverables from ONC's HITECH and health IT studies and evaluations are available at http://dashboard.healthit.gov/evaluations/

Regular Performance Review

The regular review of performance is engrained at all levels of ONC through a number of mechanisms, including: the Annual Organizational Assessment and Performance Report; Mid-Year Senior Executive and Employee Performance Reviews; Quarterly Reviews; and Monthly Meetings.

Priority, Strategic and/or Operational Updates Based on Findings from the Review

The processes for planning, reviewing progress, and re-establishing priorities in a place where change is the expectation is necessarily robust and on-going. Through a predictable set of senior leadership team meetings, cross-cutting priority group meetings, and planning exercises, each ONC office has an important contribution to leading the planning and monitoring exercises that are needed to ensure that objectives are met.

BUDGET EXHIBITS

Appropriations Language

For expenses necessary for the Office of the National Coordinator for Health Information Technology, including grants, contracts, and cooperative agreements for the development and advancement of interoperable health information technology, [$60,367,000] *$91,800,000 shall be available from amounts available under section 241 of the PHS Act.* (Consolidated and Further Continuing Appropriations Act, 2015)

Language Analysis

Language Provision	Explanation
$91,800,000 shall be available from amounts available under section 241 of the PHS Act.	Provides ONC's budget from PHS Evaluation funding.

Amounts Available for Obligation

Detail	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
General Fund Discretionary Appropriation:			
Annual appropriation	60,367,000	60,367,000	91,800,000
Subtotal, Appropriation	60,367,000	60,367,000	91,800,000
Transfer	-39,000		
Transfer	-3,000		
Total, Discretionary Appropriation	*60,325,000*	*60,367,000*	*91,800,000*
Total Obligations	60,048,327	60,367,000	*91,800,000*

Summary of Changes

(Dollars in Thousands)

2015	
Total estimated program level	60,367
2016	
Total estimated program level	91,800
Net Change program level	+31,433

	FY 2015 Enacted		FY 2016 PB		FY 2016 +/- FY 2015	
	FTE	Program Level	FTE	Program Level	FTE	Program Level
Increases:						
A. Program:						
1. Policy Development & Coordination	49	12,474	56	27,000	+7	+14,526
2. Standards, Interoperability, and Certification	32	15,230	39	33,667	+7	+18,437
3. Adoption & Meaningful Use	49	11,139	50	13,000	+1	+1,861
Subtotal, Program Increases	**130**	**38,843**	**145**	**73,666**	**+15**	**+34,823**
Decreases						
A. Program:						
1. Agency Wide Support	55	21,524	55	18,133	+0	-3,391
Subtotal, Program Decreases	**55**	**21,524**	**55**	**18,133**	**+0**	**-3,391**
Net Change	**185**	**60,367**	**200**	**91,800**	**+15**	**+31,433**

Budget Authority by Activity

(Dollars in Thousands)

Activity	FY 2014 Actual	FY 2014 Actual	FY 2015 Enacted	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 President's Budget
Policy Development and Coordination						
Budget Authority	0	0,000	0	12,474	0	0,000
PHS Evaluation Funds	46	13,308	49	0,000	56	27,000
Total, Policy Development and Coordination	46	13,308	49	12,474	56	27,000
Standards, Interoperability, and Certification						
Budget Authority	0	7,836	0	15,230	0	0,000
PHS Evaluation Funds	27	7,901	32	0,000	39	33,667
Total, Standards, Interoperability, and Certification	27	15,737	32	15,230	39	33,667
Adoption and Meaningful Use						
Budget Authority	0	0,000	0	11,139	0	0,000
PHS Evaluation Funds	43	10,711	49	0,000	50	13,000
Total, Adoption and Meaningful Use	43	10,711	49	11,139	50	13,000
Agency-wide Support						
Budget Authority	0	7,720	0	21,524	0	0,000
PHS Evaluation Funds	55	12,891	55	0,000	55	18,133
Total, Agency-wide Support	55	20,611	55	21,524	55	18,133
Total, Budget Authority	**0**	**15,556**	**0**	**60,367**	**0**	**0,000**
Total, PHS Evaluation Funding	**171**	**44,811**	**185**	0,000	**200**	**91,800**
Total, Program Level	**171**	**60,367**	**185**	**60,367**	**200**	**91,800**

Authorizing Legislation

(Dollars in Thousands)

	2015	2015	2016	2016
Health Information Technology Activity:	Authorized	Enacted	Authorized	President's Budget
Health Information Technology PHS Act 42 U.S.C. 201	Indefinite	**60,367**	Indefinite	0,000
PHS Evaluation Funds (non-add)	Indefinite	0,000	Indefinite	91,800
Total Request Level		**60,367**		**91,800**

Appropriations History

(Dollars in Thousands)

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
2006				
Base	$75,000	$58,100	$32,800	$42,800
PHS Evaluation Funds	$2,750	$16,900	$12,350	$18,900
Rescissions (P.L. 109-148)				($428)
Transfer to CMS				($29)
Subtotal	$77,750	$75,000	$45,150	$61,243
2007				
Base	$89,872	$86,118	$51,313	$42,402
PHS Evaluation Funds	$28,000	$11,930	$11,930	$18,900
Subtotal	$117,872	$98,048	$63,243	$61,302
2008				
Base	$89,872	$13,302	$43,000	$42,402
PHS Evaluation Funds	$28,000	$48,000	$28,000	$18,900
Rescissions (P.L. 110-160)				($741)
Subtotal	$117,872	$61,302	$71,000	$60,561
2009				
Base	$18,151	$43,000	$60,561	$43,552
PHS Evaluation Funds	$48,000	$18,900	$0	$17,679
ARRA (P.L. 111-5)				$2,000,000
Subtotal	$66,151	$61,900	$60,561	$2,061,231
2010				
Base	$42,331	$0	$42,331	$42,331
PHS Evaluation Funds	$19,011	$61,342	$19,011	$19,011
Subtotal	$61,342	$61,342	$61,342	$61,342
2011				
Base	$78,334	$69,842	$59,323	$42,331
PHS Evaluation Funds	$0	$0	$19,011	$19,011
Rescissions (Secretary's)				($85)
Subtotal	$78,334	$69,842	$78,334	$61,257

Details	Budget Estimates to Congress	House	Senate	Appropriations
2012				
Base	$57,013	$0	$42,246	$16,446
PHS Evaluation Funds	$21,400	$28,051	$19,011	$44,811
Rescissions (P.L. 112-74)				($31)
Subtotal	$78,413	$28,051	$61,257	$61,226
2013				
Base	$26,246	$16,415	$16,415	$16,415
PHS Evaluation Funds	$40,011	$44,811	$49,842	$44,811
Rescissions (P.L. 113-6)				($33)
Sequestration				($826)
Subtotal	$66,257	$61,226	$66,257	$60,367
2014				
Base	$20,576		$20,290	$15,556
PHS Evaluation Funds	$56,307		$51,307	$44,811
User Fee	$1,000		$1,000	$0
Subtotal	$77,883		$72,597	$60,367
2015				
Base	$0			$60,367
PHS Evaluation Funds	$74,688			0
Subtotal	$74,688			$60,367
2016				
Base	$0			
PHS Evaluation Funds	$91,800			
Subtotal	$91,800			

NARRATIVE BY ACTIVITY

Policy Development and Coordination

Budget Summary
(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 (+/-) FY 2015
Budget Authority	0.000	12.474	0.000	-12.474
PHS Evaluation Funds	13.308	0.000	27.000	+27.000
Total, Program Level	13.308	12.474	27.000	+14.526
FTE	46	49	56	+7

Authorizing Legislation:
Enabling Legislation Citation……..PHS Act 42 U.S.C. 201
Enabling Legislation Status……..Permanent
Authorization of Appropriations Citation……No Separate Authorization of Appropriations
Allocation Method……..Direct Federal, Contract, Cooperative Agreement, Grant

Program Description and Accomplishments
ONC coordinates federal policies and activities necessary to develop a robust and interoperable learning health system that assures that data can be securely captured, shared with, and used by the right people at the right time to achieve better care and better health at a lower cost. In collaboration with federal partners and by engaging with a broad range of health IT stakeholders, ONC sets the direction of federal health IT policy and provides a policy framework to address emerging health IT issues regarding the use and exchange of electronic health information. This policy framework inspires trust and confidence in health IT by integrating privacy, security, and clinical best practices into every phase of health IT policy development and implementation. ONC's health IT policies enable care transformation through improved care coordination, increased patient engagement, and enhanced population health management. ONC identifies emerging issues, weaknesses, and gaps in existing policies; formulates solutions; and provides guidance to federal agencies and stakeholders so that individuals, care providers, and public health workers can get the health information they need in an electronic format when and how they need it. ONC ensures that federal health IT policies promote interoperability, patient safety, health IT usability, and clinical quality improvement by integrating a clinical perspective.

<u>Health IT Policy</u>
ONC engages a diverse group of private, non-profit, and public sector stakeholders to identify health IT policy issues and forge consensus-based solutions using our unique convening authority. By investigating alternative and creative solutions, ONC designs programs to remove barriers that limit market progress in achieving interoperability and the optimization of health IT. These solutions must keep pace with the evolving health IT market by continuing to create new opportunities for investment and improve purchasers' confidence in their health IT choices.

ONC maintains two Federal Advisory Committee Act (FACA) bodies, also known as advisory committees: the Health IT Policy Committee (Policy Committee) and the Health IT Standards Committee (Standards Committee). ONC works in collaboration with its stakeholders to promulgate regulations defining the technical standards and specifications for the Certification Program. ONC also collaborates closely with

our colleagues at the Centers for Medicare and Medicaid Services (CMS) on the Meaningful Use program and regulations associated with that program.

ONC solicits recommendations from the Policy Committee in order to inform policy decisions and guide the development of pilots, studies, and other programs that are used to inform future stages of policy development. ONC works with the Standards Committee to ensure that the standards, implementation specifications, and certification criteria (established by the Secretary in regulation), support federal health IT policies and are responsive to the needs of the health IT community and marketplace, all while promoting interoperability. ONC also utilizes more traditional mechanisms to obtain information for policy objectives and strategies, including town hall meetings, Requests for Comment, and various social media resources. Accomplishments include:

- Emerging Issues: As issues emerge related to health IT, ONC considers how they affect policies, programs, and objectives. ONC performs analysis and brings together experts so that ONC can position itself as an industry thought leader and expert. Examples of ONC's work include:
    - Telehealth: In response to Senate Report 1113-71, ONC convened all interested Federal parties, utilizing both the Federal Telehealth (Fed Tel) and the Federal HIT Advisory Council, to better identify common issues and coordinate telehealth-related strategies for interoperability.
    - mHealth: ONC continues to monitor trends on remote monitoring looking at opportunities to promote interoperability and better care coordination across the care continuum.
- Interoperability Road Map: Based on five building blocks, the ONC Interoperability Roadmap will outline a path forward for improving interoperability in support of nationwide exchange and use of health information across the public and private sector.
- Supporting Innovation in Health IT through the Health IT Certification Program: In September 2014, ONC published the second release of the 2014 Edition of standards and certification criteria. The second release added flexibility as well as clarity and improvement to the 2014 Edition and to the ONC Health IT Certification Program. It also provided more interoperable ways to securely exchange health information through the use of standards, and provided alternative approaches for the voluntary certification of health IT and more choices for health IT developers, providers and consumers. ONC is working on the forthcoming 2015 Edition of standards and certification criteria that would both facilitate greater interoperability and health information exchange across care settings, as well as support technology requirements for the next stage of the EHR Incentive Programs.

<u>Governance of Health Information Exchange</u>

The need for governance arises anytime a group of people come together to accomplish an end. ONC defines HIE governance as the establishment and oversight of a common set of behaviors, policies, and standards that enable trusted electronic health information exchange. Governance of HIE ensures that health information is kept private and secure while allowing for efficient HIE between care settings and across organizational, vendor, and geographic boundaries. ONC is working with states, health information organizations, health information service providers, and other governance entities to ensure trust among participants, as well as the interoperability across networks so that health information can follow a patient regardless of where and when they access care. Through coordination and convening of key stakeholders, ONC is supporting nationwide efforts to enhance HIE practices. Accomplishments include:

- Through a cooperative agreement, worked with one existing governance entity to collaboratively develop and adopt policies and practices that support robust, secure, and interoperable exchange.

- Received advice from the Health IT Policy Committee on how ONC should implement its authority to establish a governance mechanism for the Nationwide Health Information Network.

Privacy and Security

ONC places a high priority on ensuring that patients and providers trust that health information is kept private and secure as the adoption of health IT and health information exchange accelerates. To further this goal, the Chief Privacy Officer advises the National Coordinator on health information privacy, security, and data stewardship policies. ONC coordinates with states and regions, federal agencies, and other countries on health information privacy and security policy issues. Recognizing that the privacy and security of health information is a responsibility shared by all stakeholders, ONC also develops and distributes toolkits, multimedia technical assistance and education materials on privacy and security of health IT and health information exchange. ONC is committed to developing these materials in formats that are in plain language, concise, well-organized, and varied to meet different users' learning styles.

Development of Health IT Privacy and Security Policy, Standards, and Adoption Strategies

ONC works to ensure that privacy and security policies keep pace with the changing health IT and health information exchange landscape. Through analysis and public and private sector stakeholder engagement including the Privacy and Security Work Group of the Policy Committee and the Transport and Security Standards of the Standards Committee, ONC identifies the evolving ways that health information is electronically collected, stored, and exchanged; determines whether there are gaps and weaknesses in existing privacy and security legal protections, industry policies, practices or technical capabilities; identifies or develops potential legal, policy, or technical solutions; obtains feedback on potential solutions through a variety of means; and takes steps to make the solutions a reality, such as tying privacy and security initiatives to grants and other funding opportunities, and leveraging the rule making authority of other HHS offices and federal agencies to promote improved privacy and security protections. Accomplishments include:

- Conducted a landscape analysis to identify external stakeholders and assess their state of readiness to meet the new Clinical Laboratory and Improvement Amendments (CLIA) requirements (Final Rule Published February 2014) related to direct patient access to lab results. ONC also led an intra-agency work group to develop a lab interoperability action plan.
- Served as the HHS liaison on the White House Initiative on Big Data and Privacy and provided subject matter expertise, helping ensure that the health care sector perspective was represented and launched public discussions and held public listening sessions on big health data and privacy in support of the White House's Open Government initiative to ensure privacy protection for big data analyses in health IT.
- Published an executive summary in February 2014 of the Policy Committee Privacy and Security Tiger Team's work (now the HITPC Privacy and Security Work Group) and an infographic outlining the role the Policy Committee plays when it comes to inspiring confidence and trust in health IT to improve patient care.

Safeguarding Health Information

ONC coordinates with public and private sector stakeholders to help ensure that electronic health information is secure and protected. ONC uses multiple strategies to address security, including through provider education, assistance, and outreach; provision of guidance on threat and vulnerability analysis and mitigation planning and implementation; and identification of breach prevention technology. Accomplishments include:

- Developed and released technical assistance material including:

  - In coordination with the HHS Office for Civil Rights (OCR), an executable and downloadable security risk analysis tool for health IT professionals, which incorporated feedback from the provider community. This tool has been downloaded over 40,000 times since its release at the end of March 2014.
  - Disaster planning and recovery video in conjunction with Hurricane Awareness week.
  - Privacy and Consumer Fact Sheet on How to Keep Health Information Private and Secure.
- Coordinated with NIST and facilitated health care sector participation in the development of the Framework for Improving Critical Infrastructure Cybersecurity.

Provider and Patient Identity Management

In close coordination with the ONC federal advisory committees, ONC investigates and identifies potential means for providing a high level of assurance for identity management when providers and patients are accessing and exchanging health information. Accomplishments include:

- ONC's Standards Committee, Privacy and Security Workgroup held a public hearing in March regarding the National Strategy on Trusted Identities in Cyberspace (NSTIC) to assess the progress of using a federated approach to provider and patient ID management in the health sector. The need for active health care involvement with the NSTIC community was emphasized.
- Continued to work closely with NIST to promote National Strategy on Trusted Identities in Cyberspace in the health care sector by serving as technical advisor on NIST grant-funded pilots, four of which have a focus on health IT. ONC has given technical assistance to both the NSTIC National Program Office and grant awardees.
- Continued to work with NSTIC to promote the Consumer Information Exchange protocols initially defined within the Blue Button Plus Restful API to address the multiple patient portal issues created by Meaningful Use Program Stage 2.

Patient Control over Use and Disclosure of Personal Health Information (PHI)

ONC continues to carry out efforts to ensure that patients are able to exercise control over their health information pursuant to existing law. Accomplishments include:

- Successfully completed phase 1 of the Data Segmentation for Privacy (DS4P) project to develop and pilot standards to facilitate the integration of behavioral health-related information into the primary care setting. The standards have been incorporated into the products offered by at least two major Health IT vendors. Phase 2 of the project has been launched, and will identify evolving issues with being able to record and track patient preferences at a granular level for control over sensitive information.
- Launched the Data Provenance S&I Framework initiative to enable consistent recording and tracking of the source of electronic health information as it is exchanged among parties. This functionality should increase the willingness of providers to accept and use patient generated health data.
- In coordination with OCR, ONC released customizable paper model notices in September 2013. They have been viewed over 240,000 times as of November, 2014. ONC used a low-cost innovation challenge to develop an interactive digital version of the plain language model Notices of Privacy Practices for use by health care providers and health plans that can be used with mobile devices such as cell phones.

Health IT Safety and Usability

ONC is committed to ensuring that health information technologies are safely designed and implemented and that they are used in ways that help improve the safety and quality of health care. To achieve these aims, ONC provides leadership and coordinates activities and resources to help all

stakeholders with responsibility for health IT safety implement the shared improvement strategies and actions described in the HHS Health IT Patient Safety Action and Surveillance Plan (Health IT Safety Plan). Accomplishments include:

- Examined the role of health IT in patient safety events, the results of which will help inform priorities for the Health IT Safety Center. This included analysis of:
    - Health IT-related events from The Joint Commission's de-identified database under its Sentinel Event Program.
    - Health IT-related events in two large Patient Safety Organization adverse event databases.
    - Challenges and effective strategies for health IT-related risk management interventions from an ONC funded RAND study.
- Published the Safety Assurance Factors for EHR Resilience (SAFER) Guides, which offer evidence-based recommended practices on health IT safety in nine areas of known risks.
- In collaboration with FDA and FCC, published a report and recommendations for Congress on an appropriate risk-based regulatory framework for health IT safety, as required by the FDA Safety and Innovation Act (FDASIA). Held a three-day public workshop to solicit feedback on the report and recommendations, and convened a Health IT Safety Task Force within the Policy Committee to provide input on the report's recommendations for a Health IT Safety Center.

Clinical Quality Improvement (CQI)

ONC is working to help providers use interoperable health IT and electronic health information exchange (HIE) to drive improvements in care quality, safety, and value. Providers use health IT and HIE to identify high risk conditions, implement solutions, and measure impact. Through such health IT-enabled improvement tools as clinical decision support (CDS) and quality measurement, providers and their patients benefit from up to date clinical best practices knowledge. CDS encompasses a variety of tools designed to enhance decision-making. Clinical quality measurement tools such as electronically specified clinical quality measures (eCQMs) allow providers to assess their performance in terms of clinical best practices and monitor health outcomes in more actionable timeframes than are possible without health IT. ONC provides subject matter expertise and technical assistance to federal programs that are working to improve clinical quality. Accomplishments include:

- Enhancing clinical quality measure (CQM) development and implementation processes, ensuring availability of health IT-enabled measures needed for the Meaningful Use Program and other quality-reporting and quality-incentive programs, in coordination with CMS.
- Increasing the availability and use of standards-based CDS tools that health care providers can use to help them achieve performance goals for the Million Hearts initiative and other priority clinical topics such as HIV, Hepatitis C, Ebola, and immunizations. This work was done in partnership with the Centers for Disease Control and Prevention (CDC) and CMS.
- Established an S&I Framework Initiative that is supporting progress toward harmonization and alignment of standards used to express clinical decision support and clinical quality measures for implementation in certified health IT.

Funding History

Fiscal Year	Amount
FY 2011	$11,200,000
FY 2012	$11,616,000
FY 2013	$10,301,000
FY 2014	$13,308,000
FY 2015	$12,474,000
FY 2016	$27,000,000

Budget Request

ONC requests $27.0 million for policy development and coordination activities, an increase of $14.5 million from FY 2015 enacted. The request includes funding for 56 FTEs. Increased funding supports building consensus around and implementing the Federal Health IT Strategic Plan, fostering innovation with a new cross-Departmental initiative targeting prescription drug overdoses, ensuring that the governance of our nation's health data supports equity, scalability, integrity and sustainability of information sharing for everyone in the United States, and inspiring confidence and trust in health IT through ensuring the privacy and security of patient data. Increased funds will also be used to launch the Health IT Safety Center, a public-private partnership focused on integrating health IT into a culture of safety in healthcare. This Center is expected to be operational in FY 2017.

This request supports Federal Health IT Strategic Plan 2015-2020 Goals 1: Expand Adoption of Health IT; 2: Advance Secure and Interoperable Health Information; 3: Strengthen Health Care Delivery; 4: Advance the Health and Well-Being of Individuals and Communities, and 5: Advance Research, Scientific Knowledge, and Innovation.

Health IT Policy and Governance ($9.1 million)

In FY 2016, ONC will continue working on the expansion of the Certification Program's regulatory guidance for health care providers – such as mental and behavioral health and long term care facilities – that are ineligible under the Meaningful Use Program. ONC will also continue to collaborate with its federal partners and interested stakeholders to align activities outlined in the updated Federal Health IT Strategic Plan 2015-2020. ONC will engage state and local governments, public health stakeholders, payers, and other interested parties through regional meetings which will build consensus around and implement key outcomes and drivers included in the plan. ONC will also convene a national working group on e-health and telemedicine to coordinate and collaborate with federal agencies regarding e-health needs, standards, federal goals, and federal efforts. This working group will promote interoperability by ensuring that ONC's federal partners are working together to increase e-health compatibility. To support an interoperable, learning health system, ONC will identify the "rules of the road" necessary for information to flow efficiently across networks and will transition to a governance approach for health information exchange that will involve both policy collaboration and development across industry and government. Funding for ONC's two FACA committees, the Policy Committee and Standards Committee, is also included in this request.

Cross Departmental Strategy: Prescription Drug Overdose Initiative ($5.0 million)

In FY 2016, ONC will demonstrate best practices and scalability of innovations to integrate Prescription Drug Monitoring Programs (PDMPs) with health information technology as part of a Cross Departmental Strategy. This effort builds off of ONC's recent work increasing the implementation and enhancement of PDMPs. However, opportunities exist to increase utilization among providers, improve clinical decision-

making, and strengthen PDMPs through the use of health IT. In FY 2016 ONC will fund a series of small challenge awards to innovate the design and use of health IT products to access PDMPs in live clinical applications. Through these challenge awards, ONC will leverage the expertise and creativity of IT developers to make workflow enhancements, such as single sign on and defining trigger events. Additionally, ONC will accelerate and improve the connectivity between state PDMPs and authorized healthcare providers by focusing on technical barriers based on evaluation of previous federal PDMP/health IT integration efforts.

Privacy and Security ($4.8 million)

In FY 2016, ONC will continue to inspire consumer and provider confidence and trust in health IT by ensuring that electronic health information is private and secure wherever it is transmitted, maintained, or received. Work on privacy and security will include:

- Development of Health IT Privacy and Security Policy, Standards, and Adoption Strategies: ONC will continue to engage with the advisory committees, federal partners, the states, foreign countries, and other stakeholders to coordinate, formulate, and prioritize privacy and security policies by evaluating emerging health IT and health information exchange environments, assessing policy gaps and weaknesses, and developing appropriate policy solutions.
- Safeguarding Health Information: ONC will provide technical assistance through the development of tools resources, and standards for vendors, providers, consumers, and other stakeholders to ensure that health information technology and workflows are protected by adequate safeguards. ONC will continue to monitor breaches and other security vulnerabilities in the health sector, including cyber-attacks, to prioritize areas of focus.
- Patient and Provider Identity Management: To further interoperability, ONC will continue its work on patient and provider identity management to assure that patients and providers are who they say they are when accessing and exchanging information electronically.
- Patient Control over Use and Disclosure of Protected Health Information (PHI): ONC will continue its focus on encouraging the development and implementation of standards, technology, and efficient workflow practices to enable the electronic recording and management of consent, and the segmentation, receipt, integration, and proper re-disclosure of health information whose use and disclosure is restricted under current law, such as certain behavioral health information. ONC will continue to work on facilitating patients' receipt of their electronic health information from providers (including laboratories) as well as furnishing patient generated information to providers and other caretakers.

Health IT Safety, Usability and Clinical Quality Improvement ($8.1 million)

In FY 2016, ONC will work to support use of interoperable health IT by launching a Health IT Safety Center that engages public and private stakeholders and ensures health IT helps deliver safer care. Additionally, ONC will also continue using a comprehensive approach to health IT supported quality improvement and progress on the National Quality Strategy objectives, with a focus on advancing: 1) the reliability of CQM data captured, calculated, and reported through certified health IT; 2) the availability and effective use of CDS; and 3) the ability to use data captured through routine clinical care to support the development and dissemination of new knowledge on care outcomes. In FY 2017, the Health IT Safety Center will be operational.

- Health IT Safety Center: In FY 2016, ONC will launch a Health IT Safety Center. The Health IT Safety Center will greatly improve ONC's ability to effectively coordinate implementation of the Health IT Safety Plan. In FY 2016, ONC will fund the Center at $5.0 million. The Center and activities related to Center development will generate substantial efficiencies by enhancing coordination and alignment of resources between ONC, AHRQ, FDA, and other federal agencies, any by encouraging greater

levels of private investment in health IT safety. In 2016, Center development will be informed by public/private stakeholder roadmap. As part of this initiative, ONC intends to conduct analysis to help prioritize Center activities and to align those activities with broader patient safety goals, as well as the development of standards, guidance, best practices and tools to support Center use and effectiveness. The Health IT Safety Center will help ensure that non-regulatory approaches to health IT safety are properly implemented and evaluated, thereby promoting more effective and less burdensome regulation of health IT safety.

- Usability: ONC will work to support use of interoperable health IT by developing and implementing methods to assess the usability of health IT products including the features critical to participating in exchanging information to improve care delivery and coordination. ONC will develop and implement methods to assess the usability of health IT products including the features critical to participating in exchanging information to improve care delivery and coordination. ONC will create and disseminate usability guidance for purchasers of health IT, to assist them in making informed decisions about the interoperability of health IT products.
- Clinical Quality Improvement: ONC will continue using a comprehensive approach to ensure that health IT advances quality improvement with a focus on electronic reporting of CQMs and measurement gaps outlined in the National Quality Strategy.

Outputs and Outcomes Table

ONC uses the following national measures to monitor trends related to provider EHR adoption, consumer access to EHRs, and consumer attitudes about health IT. ONC has set a target for the EHR adoption measure (1.A.2) that cascades into the HHS strategic plan, however the other measures are provided for monitoring purposes only.

Program/Measure	Most Recent Result / Target / Summary	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
1.A.1 Percent of office-based physicians who have adopted electronic health records (basic) [2]	FY 2013: 48% Target: 50% (Target Not Met but Improved)	Not Set	Not Set	--
1.A.2 Increase the percent of office-based primary care physicians who have adopted electronic health records (basic) [2]	FY 2013: 53% Target: 55% (Target Not Met but Improved)	Not Set	70%	+17 percentage points from 2013
1.A.3 Percent of non-federal acute care hospitals that have adopted electronic health records [3]	FY 2013: 59% Target: 55% (Target Exceeded)	Not Set	Not Set	--
1.F.1 Percent of Americans who have been given electronic access to any part of their health care record by their health care provider [4]	FY 2013: 23% (Baseline)	Not Set	Not Set	--
1.F.2 Percent of Americans who strongly or somewhat agree that the privacy and security measures taken by providers establish reasonable protections for their electronic health records [3]	FY 2013: 84% (Baseline)	Not Set	Not Set	--

[2] National Electronic Health Records Survey (NEHRS) formerly entitled NAMCS Electronic Medical Records Supplement. Most recent results are from 2013 and 2014 survey results are expected in March 2015.

[3] American Hospital Association (AHA) Annual Survey, IT Supplement. Most recent results are from 2013 and 2014 survey results are expected in March 2015.

[4] ONC Privacy and Security Attitudes Survey

Standards, Interoperability, and Certification

Budget Summary

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 (+/-) FY 2015
Budget Authority	7.836	15.230	0.000	-15.230
PHS Evaluation Funds	7.901	0.000	33.667	+33.667
Total, Program Level	15.737	15.230	33.667	+18.437
FTE	27	32	39	+7

Authorizing Legislation:

Enabling Legislation Citation……PHS Act 42 U.S.C. 201
Enabling Legislation Status……Permanent
Authorization of Appropriations Citation……No Separate Authorization of Appropriations
Allocation Method……Direct Federal, Contract, Cooperative Agreement, Grant

Program Description and Accomplishments

Advancing the interoperability of health IT is a critical role for HHS in fulfilling its mission to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves. A nationwide interoperable health IT infrastructure means all individuals, their families and their health care providers have consistent, secure and timely access to standardized health information that facilitates informed decision-making, effective health management, allows patients to be active partners in their care, and benefits the overall health of our population. The use of this health information will support improved models of care delivery, value based purchasing, and scientific advancement.

Through investments in standards development and harmonization, ONC engages health care, technology, and standards stakeholders to accelerate industry consensus by focusing on core standards, principles, vocabularies, and technical components that will enable interoperable health IT. To maximize the impact of these investments, ONC convenes federal agencies and other partners to implement nationwide solutions to HIE, and provides direct technical and financial assistance to states and communities who have committed to developing interoperable health IT infrastructures that support national priorities. By providing reliable testing tools and data for the Certification Program, ONC is building trust in the health IT marketplace supporting providers' efforts to achieve interoperability, meaningful use, and the optimization of health IT.

<u>Standards and Technology</u>

ONC makes strategic investments in standards harmonization, implementation guidance and pilots in order to accelerate industry progress in specific areas that require interoperability, and works with standards development organizations to develop and publish standards. ONC also administers the Health IT Certification program, which outlines the processes by which health IT developers can demonstrate that their health IT conforms to specific certification criteria and interoperability standards. These investments address interoperability requirements in support of clinical care, patient engagement, research, clinical quality improvement, privacy and security, and population health.

Standards-based technology enables health information to be consistently recorded and securely exchanged to another party. In the long term, coordinated standards-based innovation, combined with appropriate payment and care delivery policies, will reinforce the national health IT infrastructure, a foundational component for transforming health care and developing a learning health system. In coordination with the Standards Committee and federal partners, ONC engages a diverse community of stakeholders to rapidly advance the adoption of consensus-based standards to solve core interoperability issues of data capture and exchange.

ONC also invests resources to assist the stakeholder community to implement and test standards adopted through regulation. ONC funded the development of reference implementations and specific "companion guides" for standards to improve health IT developers' implementation consistency. In collaboration with NIST and the health IT community, ONC supports the development of testing tools, test procedures, and data that is ultimately used by Accredited Testing Labs (ATLs) to test health IT products to specific criteria. ONC strives to maintain an innovative health IT environment by continuing to support entrepreneurs, public health advocates, and developers as they seek to find ways to make health information more accessible and usable. ONC will continue to play a key role as a leader and convener of the health IT community as the industry as a whole works towards an interoperable ecosystem with health IT as an enabler.

Standards and Interoperability Framework

The Standards & Interoperability (S&I) Framework convenes health IT stakeholders to accelerate standards harmonization, provide implementation guidance in defined health domain use cases, and works with standards development organizations to develop standards for adoption by the health industry. The S&I Framework has successfully accelerated the timeframe for harmonized standards guidance development by convening a broad community of health industry stakeholders working to accelerate industry consensus on the standardization of health data for health information exchange. ONC has instituted a rigorous process for developing clinically-oriented scenarios and use cases; harmonizing interoperability specifications and implementation guidance; and providing real-world experience and implementer support through pilot projects. Accomplishments include:

- Structured Data Capture (SDC) Initiative: This initiative is focused on standardization of how data is captured in an EHR. Ensuring that content and structure for incoming health information is standardized is crucial to data being available and usable for patient care, clinical research, patient centered outcomes research and public health. Standards for SDC were developed that build upon common data elements and data directory standards to improve core data interoperability.
- Clinical Quality Framework (CQF) Initiative: This initiative extends the work of HealtheDecisions (HeD), focusing on the scalability of clinical decision support (CDS) by creating standardized data definition and libraries that support real time access and updating.
- Data Access Framework Initiative: This initiative aims to develop standardized ways for local and distributed queries to be made about data for a potentially broad range of analytics purposes, while maintaining patient privacy and security by keeping protected health information safely behind health care organization firewalls.

Standards Implementation and Testing Environment

ONC provides a pre-certification testing environment that allows health IT developers to verify that their systems have implemented interoperability standards in a consistent manner. The Standards Implementation and Testing Environment (SITE) has substantially reduced the timeframe for implementation and testing of health IT systems. Modeled on the successful S&I Framework concept, SITE provides rapid resolution of standards implementation issues by working closely with the standards

community and IT developers. SITE provides an established venue to disseminate identified solutions to a broad community of health IT developers and users. Accomplishments include:

- Advanced Secure Transport Standards for Query based Exchange: Provided implementation support to enable developers' use of advanced technical standards for secure query based exchanges, including Fast Health Interoperable Resources (FHIR).
- Patient Matching: Implementation and testing support for enabling the use of patient matching standards and methods to enable patients to securely collect and link their data from multiple providers. This will improve patients' ability to use their entire health information in support of better health care.

Health Information Exchange

An interoperable health system makes the right data available to the right people at the right time across products and organizations in a way that can be relied upon and meaningfully used by recipients. The ability to exchange health information electronically is at the core of efforts to improve health care through the use of interoperable health IT. A system where individuals, care providers, communities, and researchers have access to interoperable health IT products and services that will enable lower health care costs, and improved population health, truly empowering consumers and driving innovation.

In order for health IT to continue to improve population health and support new care and payment models, a widespread HIE infrastructure must be in place so that health information can follow patients between care settings and be exchanged across organizational, vendor, and geographic boundaries. ONC provides the leadership needed to accelerate the nationwide adoption and utilization of HIE. This work includes a focus on the standards, protocols, legal agreements, specifications, and services that can be readily deployed by health information organizations and other entities to manage the exchange of health information or provide exchange-related services and solutions. ONC engages the range of HIE participants and assists them implement health information exchange services in ways that meet their specific goals and constraints. Accomplishments include:

- Continued a widespread outreach and education campaign with vendors, providers and HIE implementers to increase their understanding of and help to achieve Stage 2 of Meaningful Use requirements under the Transitions of Care objective and certification criteria. The campaign included in person meetings and webinars as well as dissemination of ONC developed informational resources.
- The State HIE Program, a Recovery Act funded cooperative agreement program that mobilized the efforts of states and territories to increase the use of HIE, ended in March 2014. Over the course of the program, 52 state and territory participants implemented directed exchange including 47 with services available state-wide; 44 participants have implemented query-based exchange, including 34 participants that have services available state-wide. Over 43,000 healthcare related organizations are enabled for directed exchange nationally and over 12,000 healthcare related organizations are enabled for query-based exchange nationally[1].

Certification

ONC administers the ONC Health IT Certification Program, which outlines the processes by which health IT developers can demonstrate that their health IT conforms to specific certification criteria and interoperability standards. Working cooperatively with NIST, the ONC Health IT Certification Program includes test methods that constitute testing procedures, data, and tools in accordance with the standards and certification criteria adopted by regulation. The ONC Health IT Certification Program as a

[1] http://healthit.gov/policy-researchers-implementers/state-hie-program-measures-dashboard

whole provides comprehensive, independent mechanisms for health IT to be evaluated for conformance to standards and functional requirements adopted in regulation. ONC also maintains the Certified Health IT Product List (CHPL), a publicly available list on ONC's website of all the health IT products certified through the ONC Health IT Certification Program. The CHPL is also used to generate a CMS EHR ID number that is representative of the Certified EHR Technology they used to demonstrate meaningful use under the Meaningful Use Program. To date, there are 1,405 health IT developers with 1,815 unique products that have been certified against 2014 Edition Certification Criteria and 1,948 unique products against the 2011 Edition. Accomplishments include:

- ONC, in collaboration with NIST, completed development and deployed the 2014 Edition Test Method for the adopted 2014 Edition certification criteria, which includes test procedures, test data, and test tools for use by ATLs. The 2014 Edition adheres to more rigorous conformance criteria than were used for the prior 2011 edition. ONC developed standardized test data for twice as many of the certification criteria compared to the previous edition (59 percent vs. 33 percent). Automated testing was also improved in the 2014 Edition with 31 percent of the certification criteria that can be tested using nine testing tools including the new Cypress tool for electronic clinical quality measures (eCQMs)s and the Transport Testing Tools for interoperability.
- Fall 2014, Certification Criteria 2014 Edition, Release 2 finalized additional optional certification criteria. These criteria are optional, meaning developers and purchasers are not required to certify products against nor adopt. These were added to increase flexibility and in response to market and end-user needs. The test methods (tools and procedures) will be finalized January 2015—and thereby ready for developers if they wish to certify to the optional criteria.
- As a requirement of ONC-Authorized Certification Bodies (ACBs), ONC works closely with the ONC-Approved Accreditor (AA) and ONC-ACBs in an active surveillance program to ensure products maintain conformance to the criteria for which they are certified and appropriate use of the certification mark.

Innovation

ONC leads efforts designed to encourage a vibrant health IT marketplace, where systems are interoperable and consumers have the ability to obtain "best-of-breed" solutions from among a plethora of choices. ONC works to encourage the development of innovative solutions to health IT challenges, and also to find ways to better support the innovation community through educational materials, live in-person training events, prize challenges and code-a-thons (live events that occur over the course of one or more days, bringing together developers, designers, innovators and entrepreneurs to build exciting new applications and tools), and information exchange. By engaging with vendors, startups, the venture capital community, incubators and accelerators, providers, and researchers at the leading edge of health IT, ONC is working to find the best ways to use health IT to meet the goals of better health, better care, and greater value. Accomplishments include:

- Launched the "Innovation Engagement Program" to facilitate bidirectional learning and mutual understanding between the ONC and the entrepreneurial and developer communities. This includes enhancements to HealthIT.gov and the creation of an Innovate Health Classroom to expose the external innovation community, especially entrepreneurs and developers, to ONC resources and opportunities.
- Developed and hosted the United Kingdom (UK)-US Bilateral Summit on Health IT and Open Data, and completed the Roadmap for the US-EU Memorandum of Understanding, establishing international collaboration around standards and workforce development. This is intended to open marketplace opportunities for health IT vendors by reducing trade and standards barriers.

- Launched the Market R&D Pilot Challenge Program to encourage early testing, user-centered design and use of new Health IT products in clinical and public health settings.

Federal Health Architecture

An E-Government Line of Business, the Federal Health Architecture (FHA) is a partnership among federal agencies, including the Office of Management and Budget (OMB), Department of Health and Human Services (HHS), Department of Defense (DoD), Department of Veterans Affairs (VA), and the Social Security Administration (SSA). On behalf of the federal partners, ONC acts as the managing partner for FHA. Through the FHA, federal agencies have joined together to implement government-wide solutions to health IT that address agency business priorities while protecting citizen privacy. FHA has successfully supported multiple federal partner priorities to address barriers to interoperability and identify potential solutions. The FHA serves the needs of more than 20 federal agencies in domains as diverse as military and veterans' health care, long-term care and disability services, research, and tribal health services. Accomplishments include:

- Continued development of CONNECT 4.4, an open source platform for enabling the secure exchange of patient information, which provides enhanced system administration capabilities, additional Direct features, capabilities that support CORE X12 specifications, and enhanced security features. Convened federal partners such as the DoD (including the Defense Health Agency, Air Force, Army and Navy), VA, SSA, FCC and Indian Health Service (IHS) to develop guidelines and recommendations for the use of Direct in federal health information exchange environments. This effort resulted in the publication of multiple documents that highlight the group's findings and serve as guidelines for federal agencies looking to use Direct for the exchange of health care data.
- Supported the DoD Defense Health Agency (DHA) in their acquisition of the DoD Healthcare Management System Modernization (DHMSM) Program and their TRICARE managed care support contracts (MCSC) in 2017 (T2017). ONC, through FHA, assisted in improving the quality of the Draft Request for Proposal to industry for the DHMSM and provided language to include in the T2017.
- Convened federal partners to review and provide input into the Interoperability Roadmap and the Federal Health IT Strategic Plan. Input from the Department of Homeland Security (DHS), IHS, CMS, DoD, SSA, VA, and other agencies were provided through FHA.

Funding History

Fiscal Year	Amount
FY 2011	$16,809,000
FY 2012	$16,291,000
FY 2013	$19,757,000
FY 2014	$15,737,000
FY 2015	$15,230,000
FY 2016	$33,667,000

Budget Request

ONC requests $33.7 million to support standards, interoperability, and certification activities, an increase of $18.4 million from FY 2015 enacted. The request includes funding for 39 FTEs. Increased funding will be used to advance interoperability among health IT systems to support clinical care, precision medicine, patient engagement, research, clinical quality improvement, privacy and security, and population health. ONC will engage the public and private sectors to identify and fill gaps in current health IT infrastructure. ONC will also enhance standards, and ensure that the governance of our

nation's health data supports equity, scalability, integrity and sustainability of information sharing for everyone in the United States.

This request supports Federal Health IT Strategic Plan 2015-2020 Goals 1: Expand Adoption of Health IT; 2: Advance Secure and Interoperable Health Information; 3: Strengthen Health Care Delivery; 4: Advance the Health and Well-Being of Individuals and Communities, and 5: Advance Research, Scientific Knowledge, and Innovation.

Standards and Technology ($30.7 million)

In FY 2016, ONC will continue to support the Standards & Interoperability Framework as a venue through which accelerated and coordinated standards work can be accomplished. This funding and work is not only critical for ONC, but also for the many other HHS agencies with which we have collaborated in the past, including the Assistant Secretary for Planning and Evaluation (ASPE), the Substance Abuse and Mental Health Service Administration (SAMHSA), CMS, AHRQ, CDC, and as well as DoD, VA, and other federal agencies with which ONC collaborates as part of the FHA.

In 2016 ONC's efforts will build upon recent accomplishments and ensure continued progress toward modernizing the nation's health IT infrastructure in order to support transformed, interoperable learning health care. In FY 2016, ONC will standards work will include:

- Summary care records: This standard is used most often for transitions of care. In FY 2016, ONC will continue coordinating with the industry to enable the consistent implementation of the standard for this purpose in order to enable interoperability.
- Medication-related standards: FY 2016 funding will be used to further improve the specificity, implementation, and use with which medication standards are applied. Medication standards include the consistent representation of drugs, medication instructions ("structured sig"), and medication transactions for refill, cancel, and medication history. The consistent use of medication standards also can support clinical decision support and drug-drug/drug-allergy interactions, one of the most often cited patient safety issues.
- Laboratory data exchange: ONC will continue coordinating in FY 2016 on a suite of laboratory standards for ordering, results, and lab service directories that require further implementation and testing by the field. The implementation of all of these standards can improve patient safety and provide efficiencies for health care providers.

Precision Medicine

In FY 2016, ONC will fund standards coordination and development to advance the basis on which precision based medicine can be practiced. This $5.0 million in funding will lay the ground work to achieve many of the milestones included in the Interoperability Roadmap's 6-year and 10-year milestones for how health IT can support a learning health system. ONC will engage industry stakeholders to identify the standards, technology, and policy necessary to support big data analyses and precision medicine. Working closely with our many partners, ONC will aggressively pursue a portfolio of standards and technology initiatives that support precision medicine and protect user privacy, consistent with final revisions to the Common Rule, such as:

- The standardization and use with consent of patient-generated health data from non-clinical settings
- The incorporation of genomic data into health IT with appropriate protections
- Patient identity management and matching with consent to permit linked analyses
- New platforms for clinical trial recruitment through the use of health IT

Standards Implementation and Testing Environment
In 2016, ONC will continue engaging the developer community through SITE improvements to the pre-certification testing environment, linking policy to real world and future state tools that support the market, providers, and consumers. ONC will provide implementation and testing support for real-life implementation of standards (via SITE) adopted for Certification and Meaningful Use Program Stage 2 and 3, and develop and maintain test tools supporting the Certification Program. These test tools enable interoperability by allowing health IT developers to verify that their systems have implemented the standards correctly before they reach the marketplace.

Health Information Exchange
In FY 2016, ONC will strive for the health care delivery system to achieve the same steep adoption curve for standards-based HIE that has occurred for EHRs. ONC will continue to leverage the lessons, insights and tools developed during the past six years to support nationwide interoperability and meaningful use. Additionally, ONC will build upon the existing health IT infrastructure across the system by filling service gaps, especially in underserved areas, enhancing standards and ensuring that the infrastructure of our nation's health data supports access, equity, and sustainable sharing of health information for all Americans. ONC will continue expanding strategic relationships with states, communities and the private sector to support health information exchange implementation and adoption efforts that enabled health transformation initiatives. Additionally, ONC will conduct robust "real world" pilots of the standards to reveal unforeseen weaknesses and provide feedback to the standards development process before standards get integrated into health IT certification.

Certification and Accreditation
In FY 2016, ONC will expand the Health IT Certification Program aimed at improved efficiency for health IT developers as well as more rigorous testing requirements to provide greater assurance relative to product functionality. ONC will continue to refine and enhance the testing tools necessary for certification and work with the industry to coordinate the development of test methods to ensure products conform to the technical standards. The certification program is expected to broaden its support in some areas to cover certain health information exchange functionality and other capabilities that are used by specific types of service providers. Enhancing testing tools and test methods with a greater focus toward interoperability in addition to basic standards conformance will help ensure certified products interoperate and provide individuals and health care providers with the functionality needed to coordinate care and implement care delivery transformation. The Program will continue its monitoring of already certified products for ongoing adherence to technical, security, and regulatory requirements for interoperability.

Science and Innovation ($1.7 million)
In FY 2016, ONC will continue to coordinate federal efforts to accelerate progress toward a vibrant health IT marketplace with interoperable solutions for providers and consumers from which to choose. These outreach programs serve three purposes, focusing on receiving feedback from implementers on the ground. Through these programs, ONC is able to:

- Quickly gauge consumer and developer interest through collaborative outreach, allowing ONC to target our approach,
- Accelerate consensus on interoperable solutions using open code-a-thons that bring developers together to quickly converge on shared solutions, and
- Understand where ONC efforts should end and the private sector should take over.

In FY 2016, ONC will hold approximately four Innovation Challenges focusing on interoperability, and additional outreach programs such as code-a-thons and webinars.

Federal Health Architecture ($1.2 million)

In FY 2016, ONC will continue to act as the managing partner of the FHA. The request, required by OMB, will ensure continued coordination and alignment of HHS and ONC health IT investments in support of the FHA. The FHA will continue to support multiple federal partners, including the VA and DoD, by addressing barriers to interoperability and identifying potential solutions. This includes continuing to work with the DoD Healthcare Management System Modernization Program on modernizing the military health system and making it interoperable with Department of Veterans Affairs and private provider electronic medical records. ONC will also work with the DoD and the VA to identify and pilot potential shared service opportunities. The FHA will continue to provide standards support and a shared repository of standards, service descriptions, and interoperability specifications within the S&I Framework.

Outputs and Outcomes

ONC uses the following national measures to monitor trends related to health care providers' health information exchange capabilities and activities. These measures are presently in monitoring and in baseline years for consideration prior to target setting. Out year targets have not been set because only one year of baseline data is presently available.

Program/Measure	Most Recent Result / Target / Summary	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
1.E.2 Percent of providers prescribing through an electronic health record [4]	FY 2014: 93% Target: 92% (Target Met)	Discontinue	Discontinue	N/A
1.E.3 Percent of office-based physicians who are electronically sharing any patient health information with other providers[5]	FY 2013: 39% (Baseline)	Not Set	Not Set	--
1.E.4 Percent of office-based physicians who are electronically sharing patient information with any providers outside their organization[5]	FY 2013: 14% (Baseline)	Not Set	Not Set	--
1.E.5 Percent of physicians with capability for patients to view online, download, or transmit information from their medical record[5]	FY 2013: 42% (Baseline)	Not Set	Not Set	--
1.E.6 Percent of office-based physicians who are electronically sharing patient information using a Summary Care Record[5]	FY 2013: 11% (Baseline)	Not Set	Not Set	--

[5] National Electronic Health Records Survey (NEHRS) formerly entitled NAMCS Electronic Medical Records Supplement. Most recent results are from 2013 and 2014 survey results are expected in March 2015.

Program/Measure	Most Recent Result / Target / Summary	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
1. E.7 Percent of non-federal acute care hospitals that are electronically exchanging patient health information with any providers outside their organization[6]	FY 2013: 62% (Baseline)	Not Set	Not Set	--
1.E.8 Percent of non-federal acute care hospitals that are electronically sharing clinical/summary care records with any providers outside their organization[6]	FY 2013: 42% (Baseline)	Not Set	Not Set	--
1.E.9 Percent of non-federal acute care hospitals with capability for patients to view online, download, or transmit information from their medical record[6]	FY 2013: 10% (Baseline)	Not Set	Not Set	--
1.E.10 Percent of non-federal acute care hospitals that are electronically sharing any patient health information with ambulatory providers that are outside their organization[6]	FY 2013: 57% (Baseline)	Not Set	Not Set	--

[6] American Hospital Association (AHA) Annual Survey, IT Supplement. Most recent results are from 2013 and 2014 survey results are expected in March 2015.

Adoption and Meaningful Use

Budget Summary

(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 (+/-) FY 2015
Budget Authority	0.000	11.139	0.000	-11.139
PHS Evaluation Funds	10.711	0.000	13.000	+13.000
Total, Program Level	10.711	11.139	13.000	+1.861
FTE	43	49	50	+1

Authorizing Legislation:

Enabling Legislation Citation……PHS Act 42 U.S.C. 201
Enabling Legislation Status……Permanent
Authorization of Appropriations Citation……No Separate Authorization of Appropriations
Allocation Method……Direct Federal, Contract, Cooperative Agreement, Grant

Program Description and Accomplishments

To achieve a learning health system, interoperable health IT tools must be adopted and used to improve health and lower costs. Prior to the HITECH Act, significant barriers — such as lack of financing, gaps in a trained workforce, and difficulties integrating health IT tools with traditional provider workflows — threatened to slow adoption of EHR systems and prevent their use. With more than 65 percent of health care professionals and more than 90 percent of hospitals adopting certified EHRs, ONC has made substantial progress towards overcoming these barriers. Through strategic investments, effective leadership, and direct engagement with the health IT community, ONC has developed a nationwide network of organizations that are focused on supporting individual providers and consumers adopt and meaningfully use health IT. Through innovative techniques, ONC diffuses best practices and resources such as guides, training, and technical assistance to these organizations.

Through ONC's adoption and meaningful use efforts, ONC engages consumers and patients; monitors and evaluates economic data and market trends concerning the adoption, meaningful use, and optimization of health IT, as well as the collection, use, and sharing of health information. Furthermore, ONC engages providers, consumers, and other stakeholders to increase awareness of the benefits of health IT and ONC's programs, which can help them adopt interoperable health IT tools and meaningfully use them to improve health outcomes.

Provider Adoption Support

ONC designs and implements a variety of methods to accelerate and support providers' ability to collect, share and use health data. ONC also works directly with health care providers to identify barriers to adoption of interoperable health IT and develop strategies to mitigate those barriers. ONC provides a full range of services to meet the challenges of utilizing and meaningfully using health IT tools, including EHR systems. In particular, ONC convenes providers, shares best practices nationally through its National Learning Consortium (NLC), and monitors their progress with a robust web-based customer relationship management (CRM) tool. When synched with patient engagement efforts to affect a change in behavior, favorable impacts on health status and costs are achieved.

National Learning Consortium (NLC)

The NLC uses HealthIT.gov as the primary method of educating the nation about best practices and solutions to common challenges that providers face related to achieving meaningful use of interoperable health IT. In 2014 approximately 200,000 visitors accessed healthit.gov and over 23,000 health IT tools and resources were downloaded. Through Communities of Practice (CoPs) and the Health IT Vanguard program, individuals share stories from the perspective of health care providers, office staff, and administrators on how they have leveraged health IT to transform delivery of care to underserved populations. CoPs and working groups bring together over 6,600 health IT implementers and ONC technical experts as they identify issues and discover solutions to common pressing challenges. They address topics as diverse as education and outreach, implementation and project management, workflow redesign, vendor selection and management, meaningful use, privacy and security, workforce issues, and public health. The NLC provides a virtual platform to disseminate the more than 600 best practice guides and tools to the broader health IT community. Accomplishments include:

- Provider reported challenges to the Meaningful Use Program included incorporating the Clinical Summary into practice workflow, impacting providers across all practice settings. To address these challenges via NLC resources, trainings and tools were tested, revised, and disseminated among all RECs, then made publically available on HealthIT.gov.
- Providers also reported challenges in completing the Security Risk Analysis (SRA) and mitigating findings that could put patient data privacy or security at risk. In partnership with ONC's Office of the Chief Privacy Officer and OCR, and in conjunction with the NLC and Privacy and Security Community of Practice, resources, trainings and tools were tested, revised, and disseminated among all RECs, then made publically available on HealthIT.gov.
- Additional resources have been developed on topics such as Change Management, Vendor Selection and Management, Health Workforce Issues, Workflow Redesign, Health Information Exchange, Rural Health, Consumer Engagement and Public Health.

Customer Relationship Management (CRM) Tool

The CRM is a nimble, cloud-based business intelligence tool that serves approximately 1,000 users at ONC, partner organizations and grantees. A large number of users throughout the United States who are "on the ground" helping health care providers adopt and optimize their IT systems enter near real-time data into the system. This helps to inform ONC about the adoption and meaningful use of EHR technology. To assist ONC programs with data analytics and situational awareness, the CRM data set is merged regularly with several other data sources. Combined with ONC's internal analytical capacity, this data provides feedback that goes beyond the realm of anecdotal evidence and can be turned into concrete lessons learned that are used to focus policy and program efforts. Accomplishments include:

- Leveraging the more than 11 million data elements from the over 155,000 providers currently enrolled with RECs, ONC uses CRM data to identify barriers and best practices to health IT adoption and meaningful use. Approximately half of all Primary Care Providers in the nation are represented in the CRM tool.
- Expanding the use of CRM to federal partners working with the Health Resources and Services Administration (HRSA), deploying the CRM tool to track the progress of over 960 (over 80 percent) of the approximately 1,200 Federally Qualified Health Centers in achieving Meaningful Use, and incorporated data from the Meaningful Use Programs to allow for better analysis of how providers are moving through Meaningful Use Program Stage 1. For instance, ONC is able to identify providers who are registered for Meaningful Use program who are working with an REC but who have not achieved Meaningful Use. This information can be used to target outreach.

Regional Extension Center (REC)

The REC Program is an ONC Recovery Act-funded grant program whose primary mission is to provide on-the-ground assistance to individual and small health care provider practices, critical access hospitals, community health centers, and other underserved settings that require assistance with implementing and maintaining EHRs. RECs assist in transforming physician practices to achieve specific, measured clinical, quality, safety, and cost outcomes. There are 62 federally funded RECs that support over 155,000 providers in practice transformation and change management activities to achieve these outcomes. An October 2013 GAO report found that Medicare providers working with an ONC regional extension center were over 1.9 times more likely to receive an EHR incentive payment than those who were not partnered with an extension center. With over two years of building this level of trust, ONC funded programs have become an essential community asset serving solo, small group and underserved settings. Leveraging this existing, nationwide infrastructure, RECs are poised to further build physician practice competencies and spread best practices necessary to manage the health and health care of patients in every state and territory in the nation. Accomplishments include:

- Actively working with over 155,000 providers (including over 45 percent of all primary care providers in the country and 13,000 specialists) in over 30,000 small practices, including 83 percent of Federally Qualified Health Centers and 80 percent of the nation's Critical Access Hospitals (CAHs).[7] This far surpasses the initial program goal of partnering with 100,000 primary care providers.
- As of December 2014, over 90 percent of these primary care providers adopted an EHR system and over 70 percent of these providers are demonstrating Meaningful Use through ONC supported programs.[8] This support resulted in over 100 million patients having access to electronic prescriptions, resulting in reduced medication related errors; patient visit summaries, allowing patients to more fully understand and participate in their health; and evidence-based care recommendations based on quality measures and indicators.

Consumer eHealth

ONC advances Consumer eHealth by acting as a catalyst and convener, providing strategic direction and support to patients, providers, technology developers and others who are working to empower consumers with health IT to improve their health and health care. ONC leads a three-prong national strategy for advancing Consumer eHealth: (1) increase patients' access to their digital health data; (2) make that data actionable via innovative apps and tools; and (3) shift attitudes regarding consumer engagement. ONC's Consumer eHealth work streams include evolving and enhancing the Blue Button Initiative to build consumer awareness and allow patients to access and use data in a meaningful way; convening diverse stakeholders, influencing policy and standards, building public-private partnerships, supporting providers, showing how patient-generated health data is being used, and catalyzing innovation in the development of apps and tools. Accomplishments include:

- Increased consumers' ability to access their health information online from a variety of sources. ONC worked with the White House to bring eight of the nation's leading pharmacies and associations into the Blue Button Initiative. These pharmacy chains will provide patients with easy and secure access to their own pharmacy prescription history.

[7] Customer Relationship Management (CRM) Tool, maintained by the Office of Programs and Engagement at ONC, data as of December 2, 2014. CMS Data as of August 31, 2014. Hospital denominators based on national CAH database maintained by The Flex Monitoring Team, and the Small Hospital Improvement Program (SHIP) maintained by Health Resources and Services Administration (HRSA) ; Provider denominators obtained from the SK&A Office-based Providers Database, Q4, 2011.

[8] Customer Relationship Management (CRM) Tool, maintained by the Office of Programs and Engagement at ONC, data as of December 2, 2014. CMS Data as of August 31, 2014.

- Expanded the ability of consumers to take action with their health data by releasing and continuing to evolve Blue Button+ technical guidelines to help organizations that hold patient data to release it in a structured way consistent with Meaningful Use Program Stage 2 requirements.
- ONC developed PSAs and other materials for three consumer segments, and secured commitments from influential private sector organizations in April 2014 as well as federal partners (CMS, VA, DoD, and IHS) to share and or distribute these materials this fall. Also launched a new website called the Blue Button Connector which helps consumers and patients to find their own health information online from various health data holders.

Planning, Evaluation and Monitoring

ONC develops the Federal Health IT Strategic Plan, which reflects the collective efforts of 35+ federal entities to appropriately collect, share, and use interoperable health information to improve health care, individual, community and public health, and advance research in collaboration with private industry. ONC uses economic analysis and modeling to describe and understand the factors driving the adoption and meaningful use of health IT, including the costs and benefits of health IT implementation. Studies and reports generated from these activities inform policies and decisions not only within ONC, but also by Congress, the White House, other federal agencies, state and local governments, and the private sector. ONC uses statistical methods to analyze data from numerous internal and external sources in order to provide accurate and reliable information. To ensure that up-to-date data is available, ONC sponsors and advises the development of health IT data elements for a number of surveys including the American Hospital Association Information Technology Supplement, the National Electronic Health Records Survey, and the Privacy and Security Attitudes Survey. Further, ONC uses data from internal operations, Recovery Act Programs, the CRM Tool, and the Meaningful Use Program. Accomplishments include:

- Published The Federal Health IT Strategic Plan 2015 – 2020, representing the collaborative efforts across the federal government, with more than 35 federal entities to its development. In May 2014, ONC established the Federal Health IT Advisory Council, an internal federal body with the mission of coordinating federal health IT policy decisions and creating a forum to discuss program alignments for existing and emerging health and health IT matters. The inaugural task of this body was to coordinate and prioritize strategies and define implementation accountabilities to update the federal health IT strategy.
- Published analyses of progress toward and barriers to the use of health IT to improve the health and health care of all Americans, including: a Congressional Report on Health IT Adoption ; a systematic review on the impacts of Meaningful Use functionalities on safety, quality of care, and efficiency; ONC Data Briefs and Quick Stats; and regular reports to ONC's Health IT FACAs. Conducted program evaluations of HITECH programs to assess contextual factors, implementation approaches, and effectiveness and impacts of program interventions.
- Expanded capabilities of the public Health IT Dashboard web site. This innovative platform provides ONC, its stakeholders, and the American public with access to thousands of data points presented as user-interactive graphs and maps.

Provider and Stakeholder Outreach

ONC maintains a coordinated public affairs and communications strategy to reach decision-makers, stakeholders, and consumers. Core communications functions include planning, implementation, media relations, legislative and public affairs, and stakeholder engagement. In addition, ONC supports its various programs and initiatives by coordinating announcements, developing messaging, and other support materials, including specific content posted on HealthIT.gov to help key audiences including

eligible providers, consumers, health IT developers and innovators, policymakers and researchers learn about the use of health IT. Key accomplishments include:

- Issued a call-to-action for a nationwide interoperable health IT infrastructure through the development and dissemination of a vision paper, Connecting Health and Care for the Nation: A 10 year Vision to Achieve and Interoperable Health IT Infrastructure. This process included extensive stakeholder outreach and support.
- Coordinated the publication of The Federal Health IT Strategic Plan 2015 – 2020 which was released for public comment on December 8 This plan was developed in collaboration with private industry and was supported by extensive stakeholder outreach, education, and informational activities and resources.

Funding History

Fiscal Year	Amount
FY 2011	$10,657,000
FY 2012	$10,943,000
FY 2013	$9,340,000
FY 2014	$10,711,000
FY 2015	$11,139,000
FY 2016	$13,000,000

Budget Request

ONC requests $13.0 million in FY 2016 for activities relating to the adoption and meaningful use of health IT, an increase of $1.9 million from the FY 2015 Enacted. The request includes funding for 50 FTEs. Increased funding supports gathering data and evaluating progress toward achieving interoperability.

In 2016, ONC will continue its core work supporting a national support network of implementers to support the appropriate collection, use, and sharing of data. ONC will continue consumer engagement efforts by leveraging existing consumer organizations and through direct outreach efforts. Supporting these efforts are analytical, performance, and communication services that work throughout ONC to assess the current market, measure program outcomes, and provide a framework for disseminating technical materials to the widest audience.

This request supports Federal Health IT Strategic Plan 2015-2020 Goals 1: Expand Adoption of Health IT; 2: Advance Secure and Interoperable Health Information; 3: Strengthen Health Care Delivery; and 4: Advance the Health and Well-Being of Individuals and Communities.

Provider Adoption Support and Consumer e-Health ($5.5 million)

In FY 2016, ONC will continue to support provider adoption through innovative means by addressing critical barriers to the collection, sharing and use of health information. These innovative means include pilot programs, communities of practice, and other peer learning collaboratives, along with the development of impactful tools and resources.. ONC will continue to support the NLC, Health IT Vanguards, and CRM tool. Through these tools, ONC will continue convening providers to develop, share, and spread innovative best practices, support workforce needs, and provide national provider-level situational awareness. The request supports a strong national network of organizations working to assist nearly 150,000 providers, including over 44 percent of the country's total primary care providers,

to meaningfully use health IT. The network is also working with over 80 percent of HRSA-funded federally qualified health centers (FQHCs) and over 50 percent of the practices enrolled in the CMMI Comprehensive Primary Care initiative (CPCi).

To support ONC's Consumer e-Health program, ONC will convene stakeholders, identify barriers, and develop strategies so consumers can electronically send, receive, find and use their health information. ONC will focus on supporting consumer access to electronic health information, enabling the development of interoperable mobile and other tools that help consumers to use their health information effectively, and increasing consumer awareness of and demand for digital health information and tools. ONC will support providers in their efforts to engage and share data with patients as required by the Meaningful Use Program, and, via the Blue Button Pledge Program, support other organizations such as pharmacies, labs, and health insurance companies in data sharing via contract based pilot programs, community collaboratives, and/or challenge grants. ONC will continue to evolve a portfolio of recommended national standards for structured health data sharing in order to encourage the technology developer community to build useful tools, and will work with federal partners and the private sector on an ongoing consumer education and awareness campaign. ONC will also continue to enhance the resources it has created to help consumers better locate their health data electronically, and articulate policies that make it easier for patients to contribute their own health data to their doctors.

Planning, Evaluation and Monitoring ($5.1 million)

In FY 2016, ONC will gather data and evaluate progress toward achieving interoperability. ONC will also fund a consumer survey to monitor trends at a national level that measure the extent to which Americans have access to their essential health information in a format that allows them to better manage their health; how consumers are using their health information; the impact their providers' use of EHRs and exchange is having on them; how consumer mediated exchange is evolving as a means to reduce ineffective and potentially costly health data silos; as well as evaluate consumers' confidence and trust in health IT, including the privacy, security and confidentiality of their data, as well as how they are informed of their rights and use of their health information. ONC will maintain and enhance the Health IT Dashboard, a tool for synthesizing and communicating results of these analyses and providing open data to stakeholders and the public at large.

Provider and Consumer Engagement and Outreach ($2.4 million)

In FY 2016, ONC's communications activities will provide policy-focused content development, stakeholder outreach and dissemination support to meet the health IT policy information needs of audiences, in keeping with the vision, mission, and goals of ONC. In addition to partnering and informing stakeholders, ONC will continue to use traditional and social media to educate and inform consumers, providers, developers and decision makers. Funding for monitoring tools as well as HealthIT.gov operations is included in the request.

Outputs and Outcomes Table

ONC uses the following national measures to monitor trends related to electronic health record adoption and HITECH programs, including the EHR Incentive Programs and the REC Program. Measure 1.2, related to office-based primary care physician adoption of basic EHRs, cascades from ONC's President's Budget into the HHS Strategic Plan (goal 1.F) and is used for monitoring overall health IT adoption. Measures in the 1.B. series are part of the HHS Health IT Priority Goal measure set, with measure 1.B.4 serving as the key indicator and the others as contextual and supporting indicators used for in-depth monitoring.

Program/Measure	Most Recent Result / Target / Summary	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
1.A.1 Percent of office-based physicians who have adopted electronic health records (basic)[9]	FY 2013: 48% Target: 50% (Target Not Met but Improved)	Not Set	Not Set	--
1.A.2 Increase the percent of office-based primary care physicians who have adopted electronic health records (basic)[9]	FY 2013: 53% Target: 55% (Target Not Met but Improved)	Not Set	70%	+17 percentage points from FY 2013
1.A.3 Percent of non-federal acute care hospitals that have adopted electronic health records [10]	FY 2013: 59% Target: 55% (Target Exceeded)	Not Set	Not Set	--
1.B.1 Percent of eligible hospitals receiving meaningful use incentive payments[3,11]	FY 2014: 94% Target: 85% (Target Met)	TBD	TBD	TBD

[9] National Electronic Health Records Survey (NEHRS) formerly entitled NAMCS Electronic Medical Records Supplement. Most recent results are from 2013 and 2014 survey results are expected in March 2015.

[10] American Hospital Association (AHA) Annual Survey, IT Supplement. Most recent results are from 2013 and 2014 survey results are expected in March 2015.

[11] Targets for measures 1.B.1 and 1.B.2 are marked "TBD" because ONC is awaiting updated provider eligibility estimates from CMS. Updates are being made in response to recently implemented flexibilities and timelines for the EHR Incentive Programs.

Program/Measure	Most Recent Result / Target / Summary	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
1.B.2 Percent of eligible professionals receiving meaningful use incentive payments[3, 11]	FY 2014: 74% Target: 65% (Target Met)	TBD	TBD	TBD
1.B.4 Increase the number of eligible providers who receive an incentive payment from the CMS Medicare and Medicaid EHR Incentive Programs for the successful adoption or meaningful use of certified EHR technology[3]	FY 2014: 414,914 Target: 375,000 (Target Met)	450,000	455,000	+5,000
1.B.5 The percentage of EHR Incentive Program participating hospitals that are eligible to attest to Stage 2 EHR Incentive Program milestones that do.	FY 2014: 11% Target: n/a (baseline)	Not set	Not set	--
1.B.6 The percentage of EHR Incentive Program participating professionals that are eligible to attest to Stage 2 EHR Incentive Program milestones that do. [3]	FY 2014: 2% Target: n/a (baseline)	Not set	Not set	--
1.C.3 Electronic health record adoption rate among providers registered and working with ONC Regional Extension Centers for at least 10 months	FY 2014: +90% Target: 76% (Target Met)	Discontinue (Program Over)	Discontinue (Program Over)	N/A
1.C.4 Number of providers registered with ONC RECs that achieve Meaningful Use	FY 2014: 100,427 Target: 100,000 (Target Met)	Discontinue (Program Over)	Discontinue (Program Over)	N/A

Agency-wide Support

Budget Summary
(Dollars in Thousands)

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 (+/-) FY 2015
Budget Authority	7.720	21.524	0.000	-21.524
PHS Evaluation Funds	12.891	0.000	18.133	+18.134
Total, Program Level	20.611	21.524	18.133	-3.390
FTE	55	55	55	--

Authorizing Legislation:
Enabling Legislation Citation……PHS Act 42 U.S.C. 201
Enabling Legislation Status……Permanent
Authorization of Appropriations Citation……No Separate Authorization of Appropriations
Allocation Method……Direct Federal, Contract, Cooperative Agreement, Grant

Program Description and Accomplishments
ONC launched a number of crosscutting efforts to improve customer service, enhance management controls, and increase efficiency in its program support partnership activities:

- *Procurement and Grants Management*: ONC enhanced its grants management and procurement efforts, implementing best practices to optimize grantee and contractor performance. Using a risk-based financial monitoring framework for grants and contracts, ONC fosters program success and financial accountability. ONC has built a strong monitoring and analysis and systems and data management capability and established nimble procurement and grants training programs to ensure proper stewardship of federal funds.

- *Program Oversight*: ONC carries out financial and programmatic oversight responsibilities, employing a robust internal review methodology to achieve high-impact results and fostering data-driven and risk-based decision making.

- *Human Capital*: ONC's human capital experts provide leadership, oversight, and guidance to ONC in hiring a talented workforce. ONC optimizes its strong and high-performing organization through strategic workforce planning, innovative recruitment and retention strategies, including those for students and Veterans, and professional development planning.

- *Budget and Operational Services*: ONC's Budget and Operational Services functions include budget formulation and execution and space and facilities management. ONC initiated improvements in its annual budget processes and budget/performance integration. ONC's telecommunications initiatives are yielding positive results and improved value. ONC has plans underway to move into a consolidated facility in FY 2015.

Funding History

Fiscal Year	Amount
FY 2011	$19,502,000
FY 2012	$22,830,000
FY 2013	$20,896,000
FY 2014	$20,611,000
FY 2015	$21,524,000
FY 2016	$18,133,000

Budget Request

ONC requests $18.1 million in FY 2016 for activities related to agency wide support, a decrease of $3.4 million from the FY 2015 enacted. The request includes funding for 55 FTEs. ONC has been actively working to reduce agency-wide support costs and will continue to realize savings from improved efficiencies and in-sourcing.

This request includes funding for critical central costs such as information technology, space, human capital, acquisition, and other shared services. These shared services, which are not attributed to a specific office, but rather are used by ONC as a whole, include financial and grants management systems, as well as contract management fees and legal counsel. This request also funds the personnel costs for the Immediate Office of the National Coordinator.

By providing ONC's offices and programs with essential agency-wide support services, this request supports Federal Health IT Strategic Plan 2015-2020 Goals 1: Expand Adoption of Health IT; 2: Advance Secure and Interoperable Health Information; 3: Strengthen Health Care Delivery; 4: Advance the Health and Well-Being of Individuals and Communities, and 5: Advance Research, Scientific Knowledge, and Innovation.

SUPPORTING EXHIBITS

Crosswalk of Budget Activity by Office

(Dollars in Thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 Request	
	FTE	$	FTE	$	FTE	$
Policy Development & Coordination						
Office of Policy	20	5.640	21	4.848	25	13.564
Office of the Chief Privacy Officer	11	3.916	12	3.690	13	4.797
Office of Clinical Quality and Safety	11	3.103	12	3.030	14	8.064
Office of Care Transformation	4	0.649	4	0.905	4	0.574
Total, Policy Development & Coordination	**46**	**13.308**	**49**	**12.474**	**56**	**27.000**
Standards, Interoperability, & Certification						
Office of Standards and Technology	21	13.454	24	13.309	31	31.919
Office of the Chief Scientist	6	2.283	8	1.921	8	1.747
Total, Standards, Interoperability, & Certification	**27**	**15.737**	**32**	**15.230**	**39**	**33.667**
Adoption & Meaningful Use						
Office of Programs	24	5.275	28	6.023	28	5.509
Office of Planning, Evaluation and Analysis	12	2.809	13	2.792	14	5.133
Office of Public Affairs and Communications	7	2.628	8	2.324	8	2.358
Total, Adoption & Meaningful Use	**43**	**10.711**	**49**	**11.139**	**50**	**13.000**
Agency-Wide Support						
Agency-Wide Support	**55**	**20.611**	**55**	**21.524**	**55**	**18.133**
Total, Agency-Wide Support	**55**	**20.611**	**55**	**21.524**	**55**	**18.133**
Total, Program Level	**171**	**60.367**	**185**	**60.367**	**200**	**91.800**

Budget Authority By Object Class - Program Level

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
11.1	Full-time permanent	14,874	15,065	16,778
11.3	Other than full-time permanent	3,884	5,340	5,569
11.5	Other personnel compensation	539	540	540
11.7	Military personnel	105	0	0
Subtotal	***Personnel Compensation***	**19,402**	**20,946**	**22,887**
12.1	Civilian personnel benefits	5,568	5,785	6,157
12.2	Military benefits	50	0	0
13	Benefits for former personnel	0	0	0
Total	***Pay Costs***	**25,020**	**26,731**	**29,044**
21	Travel and transportation of persons	274	382	382
22	Transportation of things	2	2	2
23.1	Rental payments to GSA	2,588	3,619	5,121
23.3	Communications, utilities, and misc. charges	551	551	552
24	Printing and reproduction	106	106	106
25.1	Advisory and assistance services	1,336	1,336	1,336
25.2	Other services from non-Federal sources	16,249	14,096	36,351
25.3	Other goods and services from Federal sources	12,803	11,815	17,174
25.4	Operation and maintenance of facilities	253	253	254
25.5	Research and development contracts	0	0	0
25.6	Medical care	356	356	356
25.7	Operation and maintenance of equipment	36	36	36
25.8	Subsistence and support of persons	424	424	424
26	Supplies and materials	136	128	128
31	Equipment	81	81	82
32	Land and Structures	0	0	0
41	Grants, subsidies, and contributions	152	452	452
42	Insurance claims and indemnities	0	0	0
44	Refunds	0	0	0
Total	***Non-Pay Costs***	**35,347**	**33,637**	***62,756***
Total	***Total by Object Class***	**60,367**	**60,367**	***91,800***

Budget Authority By Object Class - Direct

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
11.1	Full-time permanent	0	15,065	0
11.3	Other than full-time permanent	0	5,340	0
11.5	Other personnel compensation	0	540	0
11.7	Military personnel	0	0	0
Subtotal	***Personnel Compensation***	***0***	**20,946**	***0***
12.1	Civilian personnel benefits	145	5,785	0
12.2	Military benefits	0	0	0
13	Benefits for former personnel	0	0	0
Total	***Pay Costs***	***145***	**26,731**	***0***
21	Travel and transportation of persons	0	382	0
22	Transportation of things	2	2	0
23.1	Rental payments to GSA	2,588	3,619	0
23.3	Communications, utilities, and misc. charges	551	551	0
24	Printing and reproduction	104	106	0
25.1	Advisory and assistance services	1,121	1,336	0
25.2	Other services from non-Federal sources	5,077	14,096	0
25.3	Other goods and services from Federal sources	4,796	11,815	0
25.4	Operation and maintenance of facilities	253	253	0
25.5	Research and development contracts	0	0	0
25.6	Medical care	356	356	0
25.7	Operation and maintenance of equipment	36	36	0
25.8	Subsistence and support of persons	375	424	0
26	Supplies and materials	86	128	0
31	Equipment	65	81	0
32	Land and Structures	0	0	0
41	Grants, subsidies, and contributions	0	452	0
42	Insurance claims and indemnities	0	0	0
44	Refunds	0	0	0
Total	***Non-Pay Costs***	***15,411***	**33,637**	***0***
Total	***Total by Object Class***	***15,556***	**60,367**	***0***

Budget Authority By Object Class - Reimbursable

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
11.1	Full-time permanent	14,874	0	16,778
11.3	Other than full-time permanent	3,884	0	5,569
11.5	Other personnel compensation	539	0	540
11.7	Military personnel	105	0	0
Subtotal	***Personnel Compensation***	***19,402***	**0**	**22,887**
12.1	Civilian personnel benefits	5,423	0	6,157
12.2	Military benefits	50	0	0
13	Benefits for former personnel	0	0	0
Total	***Pay Costs***	***24,875***	**0**	**29,044**
21	Travel and transportation of persons	274	0	382
22	Transportation of things	0	0	2
23.1	Rental payments to GSA	0	0	5,121
23.3	Communications, utilities, and misc. charges	0	0	552
24	Printing and reproduction	2	0	106
25.1	Advisory and assistance services	214	0	1,336
25.2	Other services from non-Federal sources	11,172	0	36,351
25.3	Other goods and services from Federal sources	8,007	0	17,174
25.4	Operation and maintenance of facilities	0	0	254
25.5	Research and development contracts	0	0	0
25.6	Medical care	0	0	356
25.7	Operation and maintenance of equipment	0	0	36
25.8	Subsistence and support of persons	49	0	424
26	Supplies and materials	50	0	128
31	Equipment	15	0	82
32	Land and Structures	0	0	0
41	Grants, subsidies, and contributions	152	0	452
42	Insurance claims and indemnities	0	0	0
44	Refunds	0	0	0
Total	***Non-Pay Costs***	***19,936***	**0**	***62,756***
Total	***Total by Object Class***	***44,811***	**0**	***91,800***

Salary & Expenses

(Dollars in Thousands)

Object Class Code		FY 2014 Enacted	FY 2015 Enacted	FY 2016 Request
11.1	Full-time permanent	14,874	15,065	16,778
11.3	Other than full-time permanent	3,884	5,340	5,569
11.5	Other personnel compensation	539	540	540
11.7	Military personnel	105	0	0
Subtotal	***Personnel Compensation***	***19,402***	**20,946**	**22,887**
12.1	Civilian personnel benefits	5,568	5,785	6,157
12.2	Military benefits	50	0	0
13	Benefits for former personnel	0	0	0
Total	***Pay Costs***	***25,020***	**26,731**	**29,044**
21	Travel and transportation of persons	274	382	382
22	Transportation of things	2	2	2
23.3	Communications, utilities, and misc. charges	551	551	552
24	Printing and reproduction	106	106	106
25.1	Advisory and assistance services	1,336	1,336	1,336
25.2	Other services from non-Federal sources	16,249	14,096	36,351
25.3	Other goods and services from Federal sources	12,803	11,815	17,174
25.4	Operation and maintenance of facilities	253	253	254
25.5	Research and development contracts	0	0	0
25.6	Medical care	356	356	356
25.7	Operation and maintenance of equipment	36	36	36
25.8	Subsistence and support of persons	424	424	424
Subtotal	***Other Contractual Services***	***32,390***	**29,357**	***56,973***
26	Supplies and materials	136	128	128
Subtotal	***Non-Pay Costs***	***32,526***	**29,485**	***57,101***
Total	***Salary and Expenses***	***57,546***	**56,216**	***86,145***
23.1	Rental payments to GSA	2,588	3,619	5,121
Total	**Salaries, Expenses, and Rent**	**60,134**	**59,835**	**91,266**
Total	**Direct FTE**	**171**	**185**	**200**

Detail Of Full-Time Equivalent (FTE) Employment

Detail	FY 2014 Civilian	FY 2014 Military	FY 2014 Total	FY 2015 Civilian	FY 2015 Military	FY 2015 Total	FY 2016 Civilian	FY 2016 Military	FY 2016 Total
Direct	170	1	171	185	0	185	200	0	200
Reimbursable									
Total FTE	170	1	171	185	0	185	200	0	200

Average GS Grade

	Grade:	Step:
FY 2012.....	13	4
FY 2013.....	13	5
FY 2014.....	13	6
FY 2015.....	13	6
FY 2016.....	13	6

Detail Of Positions

Detail	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget
Executive level	0	0	0
Total - Exec. Level Salaries	0	0	0
SES	7	7	7
Total - SES Salaries	1,263,530	1,276,165	1,288,927
Total - ES Salary	1,263,530	1,276,165	1,288,927
GS-15	43	52	52
GS-14	46	55	55
GS-13	47	55	55
GS-12	18	24	24
GS-11	7	15	15
GS-10	--	1	1
GS-9	2	2	2
GS-8	--	--	--
GS-7	--	--	--
GS-6	--	--	--
GS-5	--	1	1
GS-4	--	--	--
GS-3	--	--	--
GS-2	--	--	--
GS-1	--	--	--
Subtotal	163	205	205
Total, GS Salary	16,830,379	18,562,981	19,356,589
Commissioned Corps	1	--	--
Total, Commissioned Corps Salary	124,995	--	--
Total Positions	171	212	212
Total FTE	171	185	200

FY 2016 Budget By HHS Strategic Goal

(Dollars in Millions)

HHS Strategic Goals	FY 2014 Enacted	FY 2015 Enacted	FY 2016
1.Strengthen Health Care	**45.026**	**45.026**	**71.706**
1.A Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured			
1.B Improve health care quality and patient safety	8.045	8.045	14.375
1.C Emphasize primary and preventive care, linked with community prevention services			
1.D Reduce the growth of health care costs while promoting high-value, effective care	22.496	22.496	42.068
1.E Ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations			
1.F Improve health care and population health through meaningful use of health information technology	14.485	14.485	15.264
2. Advance Scientific Knowledge and Innovation	**15.341**	**15.341**	**20.094**
2.A Accelerate the process of scientific discovery to improve health			
2.B Foster and apply innovative solutions to health, public health, and human services challenges	9.005	9.005	10.124
2.C Advance the regulatory sciences to enhance food safety, improve medical product development, and support tobacco regulation			
2.D Increase our understanding of what works in public health and human services practice	6.336	6.336	9.970
2.E Improve laboratory, surveillance, and epidemiology capacity			
3. Advance the Health, Safety and Well-Being of the American People			
3.A Promote the safety, well-being, resilience, and healthy development of children and youth			
3.B Promote economic and social well-being for individuals, families, and communities			
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults			
3.D Promote prevention and wellness across the life span			
3.E Reduce the occurrence of infectious diseases			
3.F Protect Americans' health and safety during emergencies, and foster resilience to withstand and respond to emergencies			
4. Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs			
4.A Strengthen program integrity and responsible stewardship by reducing improper payments, fighting fraud, and integrating financial, performance, and risk management			
4.B Enhance access to and use of data to improve HHS programs and to support improvements in the health and well-being of the American people			
4.C Invest in the HHS workforce to help meet America's health and human services needs			
4.D Improve HHS environmental, energy, and economic performance to promote sustainability			
TOTAL	**60.367**	**60.367**	**91.800**

Significant Items In Appropriations Committee Reports

FY 2015 L-HHS Appropriations Committee Report Language (PL 113-235)

Item 1:

Information Blocking- The Office of the National Coordinator for Health Information Technology (ONC) is urged to use its certification program judiciously in order to ensure certified electronic health record technology (CEHRT) provides value to eligible hospitals, eligible providers and taxpayers. ONC should use its authority to certify only those products that clearly meet current meaningful use program standards and that do not block health information exchange. ONC should take steps to decertify products that proactively block the sharing of information because those practices frustrate congressional intent, devalue taxpayer investments in CEHRT, and make CEHRT less valuable and more burdensome for eligible hospitals and eligible providers to use. The agreement requests a detailed report from ONC no later than 90 days after enactment of this act regarding the extent of the information blocking problem, including an estimate of the number of vendors or eligible hospitals or providers who block information. This detailed report should also include a comprehensive strategy on how to address the information blocking issue.

Action Taken or To Be Taken

This report is forthcoming and will be submitted no later than 90 days after the enactment of FY 2015 appropriations.

Item 2:

Interoperability- The agreement directs the Health IT Policy Committee to submit a report to the House and Senate Committees on Appropriations and the appropriate authorizing committees no later than 12 months after enactment of this act regarding the challenges and barriers to interoperability. The report should cover the technical, operational and financial barriers to interoperability, the role of certification in advancing or hindering interoperability across various providers, as well as any other barriers identified by the Policy Committee.

Action Taken or To Be Taken

This report is forthcoming and will be submitted no later than 12 months after the enactment of FY 2015 appropriations.

Physicians' Comparability Allowance

		PY 2014 (Actual)	CY 2015 (Estimates)	BY 2016* (Estimates)
1) Number of Physicians Receiving PCAs		1	3	3
2) Number of Physicians with One-Year PCA Agreements		1	2	2
3) Number of Physicians with Multi-Year PCA Agreements		0	1	1
4) Average Annual PCA Physician Pay (without PCA payment)		$155,500	$155,500	$155,500
5) Average Annual PCA Payment		$13,000	$13,333	$13,333
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	0	0	0
	Category II Research Position	0	0	0
	Category III Occupational Health	0	0	0
	Category IV-A Disability Evaluation	0	0	0
	Category IV-B Health and Medical Admin.	1	3	3

** FY 2016 data will be approved during the FY 2017 Budget cycle*

In 2015 and 2016, ONC needs physicians with strong medical backgrounds to work in ONC's Office of the Clinical Quality and Safety as they engage with a wide array of clinical stakeholders and provide a clinically based perspective on ONC policies and activities. This includes clinical issues around EHR safety, usability, clinical decision support, and quality measures.

Without PCA, it is unlikely that ONC could have recruited its current physicians, nor is it likely that ONC will be able to recruit without PCAs in future years.

Health Insurance and Implementation Fund

HEALTH INSURANCE REFORM IMPLEMENTATION FUND

Budget Summary
(Dollars in Thousands)

	FY 2014	FY 2015	FY 2016
Obligations*	70,205	26,014	0

* $1,000,000,000 was appropriated in the Health Care and Education Reconciliation Act of 2010

Authorizing Legislation:
Authorization……Health Care and Education Reconciliation Act, Section 1005, FY 2010
Allocation Method……Direct Federal, Competitive Contract

Program Description and Accomplishments

Section 1005 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) appropriates $1,000,000,000 to the Health Insurance Implementation Fund within the Department of Health and Human Services (HHS). The Fund shall be used for Federal administrative expenses necessary to carry out the requirements of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010.

HHS has used implementation funds to primarily support salaries, benefits, contracts, and infrastructure for various health reform initiatives, including supporting the rate review and medical loss ratio provisions. A portion of these funds have also gone to support the establishment of the Federally Facilitated Marketplace, including the building of IT systems to continue expanding access to health care going forward.

The Department of Treasury required funding to implement multiple tax changes, including the Small Business Tax Credit, expanded adoption credit, W-2 changes for loan forgiveness, charitable hospital requirements, and planning for Marketplaces. The Department of Labor required funds to conduct compliance assistance; modify or develop IT systems that support data collection, reporting, policy and research; and develop infrastructure for the newly required Multiple Entity Welfare Arrangements reporting and registration within the Affordable Care Act.

The Office of Personnel Management (OPM) required funding to plan for implementing and overseeing Multi-State Plan Options for the Marketplaces and allowing Tribes and Tribal organization to purchase Federal health and life insurance for their employees. At least two Multi-State Plans will be offered on each Marketplace. OPM is also assisting HHS by implementing an interim Federal external appeals process prior to the establishment of a permanent Federal appeals process.

Budget Allocation

In FY 2014, $70,205,000 of this funding was obligated by agencies within HHS and external federal partners. In FY 2015, HHS estimates that the remaining funds will be allocated to support ACA implementation efforts.

Nonrecurring Expenses Fund

Nonrecurring Expenses Fund

Budget Summary

(Dollars in Thousands)

	FY 2014[1]	FY 2015	FY 2016
Notification*	$600,000	TBD	TBD

*Pursuant to Section 223 of Division G of the Consolidated Appropriation Act, 2008, notification is required of planned use.

Authorizing Legislation:

Authorization……Section 223 of Division G of the Consolidated Appropriations Act, 2008
Allocation Method……..Direct Federal, Competitive Contract

Program Description and Accomplishments

The Nonrecurring Expenses Fund (NEF) permits HHS to transfer unobligated balances of expired discretionary funds from FY 2008 and subsequent years into the NEF account. Congress authorized use of the funds for capital acquisitions including information technology (IT) and facilities infrastructure.

In FY 2014, HHS allocated NEF funds to invest in an electronic case processing system for the Office of Medicare Hearings and Appeals. HHS also allocated funds to continue development of Department-wide financial systems. HHS invested in data management systems to support enhanced and streamlined access to the Centers for Medicare & Medicaid Services data resources and implementation of new legislative and regulatory requirements. These investments provided more secure access to consumers, states, and partnering agencies to Medicare and Medicaid data. Additional investments were made in Marketplace infrastructure development to support services for consumers, insurance issuers, states, small businesses, and other stakeholders. HHS also used NEF funds to invest in the modernization of the Resource and Patient Management System in the Indian Health Service (IHS).

Additionally, HHS allocated FY 2014 NEF funds to the Centers for Disease Control and Prevention (CDC) for IT infrastructure supporting public health programs and enhanced information systems and cybersecurity capabilities. These investments support increased capacity for CDC to respond to emerging infectious disease threats. HHS also allocated NEF funds towards investments in the Grants Center of Excellence at the Administration for Children and Families; these funds support government-wide data standardization, interoperability, and data quality enhancements for grants. Finally, HHS invested in IT infrastructure related to oversight responsibilities within the Office of Inspector General.

Budget Allocation

For FY 2015 and FY 2016, HHS has not determined the final allocations. The amount allocated will depend on total resources available and the infrastructure needs of HHS. HHS will notify Congress before obligating funds towards projects, consistent with prior years. HHS anticipates making continued investments that support information technology and capital acquisitions across the Department, including facilities infrastructure. The Department will continue to evaluate eligible projects based on funds availability and Administration priority.

[1] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on October 18, 2013.

Service and Supply Fund

Service and Supply Fund

TABLE OF CONTENTS

SERVICE AND SUPPLY FUND

(Dollars in Thousands)

SSF	FY 2014 Actual	FY 2015 Board Approved	FY 2016 Board Approved	FY 2016 +/- FY 2015
BA	$1,030,821	$1,186,925	$1,201,716	+$14,793
FTE	1,329	1,307	1,311	+4

Authorizing Legislation: 42 U.S.C. 231
2015 Authorization……Indefinite
Allocation Method ……Contract, Other
* Additional details on the 2016 SSF Board approved budgets are found in the narrative

Statement of the Budget

The FY 2016 budget for the Service and Supply Fund (SSF) is $1,201,716, which is an increase of $14,791 above the FY 2015 SSF Board-approved level of $1,186,925. The overall increase in the budget from FY 2015 to FY 2016 is the result of projected new business, inflationary increases, and allows the activities to maintain their current operations.

The Program Support Center's (PSC) budget request for FY 2016 is $776,281, which is an increase of $11,585 above the FY 2015 current budget request of $764,696. This increase is attributable to projected new business and inflationary increases. The PSC continues efforts of the PSC SMART (Save, Manage and Assess our Resources Together), which was implemented in FY 2013. Additional information about savings incurred thru the SMART Program can be found in the PSC's narrative.

The total FY 2016 request for the non-PSC SSF Activities is $425,435, which is an increase of $3,206 above the FY 2015 current budget request of $422,229. Increases in non-PSC activities are due in part to increased personnel, administrative, and contract-related costs.

Program Description – Service and Supply Fund Overview and Activity Narratives

This section describes the activities funded through the HHS' Service and Supply Fund (SSF), which is a revolving fund authorized under 42 U.S.C. 231. The SSF provides consolidated financing and accounting for business-type operations which involve the provision of common services to customers. The SSF is governed by a Board of Directors, consisting of representatives from each of the Department's ten (10) Operating Divisions (OPDIV), the PSC and the Office of the Secretary. A representative from the Office of Inspector General (OIG) serves as a non-voting member of the SSF Board.

The SSF does not have its own annual appropriation but is funded entirely through charges to its customers (HHS' Operating Divisions (OPDIV) and Staff Divisions (STAFFDIV) in addition to other federal departments and agencies) for their usage of goods and services. The SSF is comprised of two categories of activities: the Program Support Center and those activities which are performed by other OS components. Each activity financed through the SSF is billed to the Fund's customers by either fee-for-service billing, which is based upon actual service usage or by an allocated methodology. Details of the FY 2016 SSF activities are described below.

Program Support Center

The Program Support Center organizationally resides under the Assistant Secretary for Administration, Office of the Secretary and operates under authorizing legislation 42 USC §231 as amended.
The Program Support Center (PSC) is committed to providing the best value in terms of cost and service quality to its customers. In a proactive effort to contain costs, the PSC again deployed its SMART (*S*ave, *M*anage and *A*ssess our *R*esources *T*ogether) Program for the FY15/16 budget formulation process. This comprehensive, "bottom-up" analysis of PSC's operations identified areas for additional cost reductions, efficiencies, cost avoidance and opportunities for revenue growth.

PSC tracks performance in terms of its strategic goals. These goals focus primarily on delivering products and services that are recognized both as high quality, and as providing value. The organization strives to achieve three primary outcomes: higher service quality, lower operating costs and reduced rates for customers. By working to reach these outcomes, PSC supports the Department's efforts for responsible stewardship and effective management. Details are outlined in the performance review section.

PSC continues to evolve as a shared service provider, as it continues to seek business growth, both inside and outside the HHS, when it makes business sense. PSC growth is important to: (1) meet the HHS mission's need for program support, and (2) reduce our unit costs to all customers through economies of scale.

To better concentrate efficiencies and expertise, PSC has re-aligned some of its services as described in the following sections.

Program Support Center Activities

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The Program Support Center's FY 2016 Board Approved budget of $776,281 represents a net increase of $11,584 from the FY 2015 Board Approved Budget of $764,696, and is attributable to projected new business, or salary increases.

Administrative Operations Portfolio (AOP): AOP provides a wide range of administrative and technical support services to customers within HHS and to other federal agencies. Major services include: Publishing Services (graphic arts, digital conversion services, print procurement, Departmental Forms Management, and, HHS Printing Policy); Mail Services (mail screening, mail operations for the National Capital, Kansas City and New York City Regions, and HHS Mail Policy); Customer Care Services (payroll customer services, OS ITAS support, liaison between DFAS and HHS on all pay-related issues, assist role for transition to National Finance Center (HHS-wide HR, payroll and time and attendance systems), Customer Contact Center, and HHS Toll Free Hotline); Freedom of Information Act Services (tracking appeals and requests, coordinating searches for responsive records, reviewing documents for responsiveness, identifying whether sensitive information can be protected from public disclosure, including conducting research and proper documentation to support the decisions; reviewing appeals and making final appeal HHS recommendations regarding disclosure decisions; and Transportation Services (transit subsidy program management, executive drivers, travel policy, travel program management, travel charge card management, purchase card management, fleet card management, fleet policy, OS Travel assistance, child care subsidies, child care liaison, vehicle leasing services, and, primary role for transition to ETS2 (travel system.))

Financial Management Portfolio (FMP): FMP serves as a major part of the foundation of the Department's finance and accounting operations through: the administration of grant payment management services; accounting and fiscal services; debt management services; rate review/negotiation and approval services. FMP provides these services on behalf of the Department and other Federal agencies. Fiscal, technical, and policy guidance is offered to assist in implementing new initiatives across HHS and other agencies and to ensure compliance with regulatory requirements. FMP continues to be a leader in supporting the Departments' clean audit opinions from independent audit firms.

Federal Occupational Health Portfolio (FOH): FOH provides comprehensive, high-quality, customer-focused occupational health services in strategic partnership with Federal agencies nation-wide to improve the health, safety, and productivity of the Federal workforce. Approximately 92% of FOH's

services are provided to Federal agencies outside of HHS. In FY 2015, FOH re-structured operations into four Service Lines. Clinical Health Services (CHS) (formerly part of Clinical Services Division) provides services which include: medical employability, medical surveillance exams/follow-up, medical clearances, FedStrive Advantage and workers compensation programs, and on-site and shared health center services.

Procurement Portfolio (PMP): The Procurement Management Portfolio (PMP) is responsible for providing fully integrated acquisition and strategic support services to HHS and other Federal agencies. PMP streamlines procurement operations in HHS through activities such as the reduction of duplicate contracts, the use of consolidated contracts and the implementation of new procurement practices designed to provide higher quality procurement services at reduced cost. The major divisions: *Acquisition Management*, which includes negotiated contracts, simplified acquisitions, and purchase card management services; *Quality Assurance*, which provides analytical and quality assurance support to contracting staff and PMP customers, and *Acquisition Development and Support*, which includes customer liaison support, contract closeout and cost/price analysis activities.

Real Estate and Logistics Portfolio (REL): Three costs centers that comprise REL provide policy guidance to HHS entities, and real estate, logistics and related services to HHS and other federal agencies. Real Property Management Services provide real property and logistics oversight and policy development, Department-wide property asset management system, space design planning, utilization and compliance, management for transfer of surplus real property to non-profit entities (McKinney-Vento Homeless Assistance Act), regional support services and conference room reservation tool services. Warehouse and Logistics Services provide personal property management, warehousing, distribution, medical supply distribution, property disposal and labor services. Facilities Management Services provide facilities operations, maintenance, shredding and parking services.

Non-PSC Activities

Non-PSC activities differ from those provided by the PSC in their predominate focus, which is helping HHS components comply with law, regulations, or other federal management guidelines, as well as targeted workforce management. The non-PSC activities support all components of HHS, providing support in areas such as acquisitions management, audit resolution, responding to and processing Federal tort claims, collecting and managing grants data to ensure HHS' ability to respond to regulatory requirements, providing human resources and equal employment opportunity services, and providing IT support and devices.

Acquisition Integration and Modernization (AIM): The AIM program was created to capture knowledge, create standardization and provide one source for the HHS Acquisition Workforce (HHSAW) to access policies, guidance, and other acquisition tools. The program supports the acquisition related mission needs of the Department, providing tools to insure that the acquisition lifecycle processes are efficiently executed and complies with statutory requirements. The AIM program is managed by the

Office of Acquisition Policy within the Division of Acquisition, under the Office of Grants and Acquisition Policy and Accountability, which is within the office of the Assistant Secretary for Financial Resources.

Audit Resolution and Improper Payments: OS Audit Resolution, along with resolution officials in HHS Operating Divisions/Staff Divisions (OPDIVs/STAFFDIVs), is required to resolve Single Audit findings within a six-month time frame in accordance with OMB Circular A-133, Audit of States, Local Governments, and Non-Profit Organizations, which implements the Single Audit Act Amendments of 1996. On behalf of the OPDIVs/STAFFDIVs, OS Audit Resolution resolves cross-cutting findings resulting from OMB Circular A-133 audits that affect the awards of multiple OPDIVs/STAFFDIVs.

In addition to its responsibilities related to the resolution of audit findings, OS Audit Resolution also coordinates HHS' implementation of the *Improper Payments Information Act of 2002* (IPIA), as amended, and related OMB implementing guidance contained in Appendix C of OMB Circular A-123, "*Management's Responsibility for Internal Control*." Specifically, the improper payments team works with OPDIVs/STAFFDIVs to complete risk assessments under the Department's Program Integrity initiative and works to help OPDIVs/STAFFDIVs comply with the IPIA and OMB implementing guidance.

Commissioned Corp Force Management (CCFM): CCFM provides personnel support to active-duty and retired Public Health Service (PHS) Commissioned Officers, and force management activities for the Corps Officers in over 25 federal agencies. CCFM is comprised of two offices, the Division of Commissioned Corps Personnel and Readiness (DCCPR) and the Division of Systems Integration (DSI). DCCPR manages the human resource and officer related activities for Corps officers, provides advice on matters related to the day-to-day management of the Corps, and provides for the delivery of training and career development of Corps members. DSI manages the Information Technology (IT) personnel administration systems for assignment, pay, appointment, promotion, assimilation, and awards for Corps members and retirees, both DCCPR and DSI active duty officers, the agencies and Departments to which the officers are assigned, and retired officers. CCFM is managed within the Office of the Surgeon General.

Departmental Contracts Information System: The Department of Health and Human Services (HHS) collects, tracks, reports, and transmits contract data using the Departmental Contracts Information System (DCIS). The DCIS program supports the acquisition related mission needs of the Department and ultimately assures compliance with various open government and transparency initiatives.

The DCIS program supports HHS compliance with various reporting requirements from the Office of Federal Procurement Policy (OFPP), the FAR, and various other sources; HHS compliance with Open Government Initiatives; assuring HHS contract data is available for use by internal stakeholders; HHS compliance with the Federal Financial Accountability and Transparency Act (FFATA); and a complimentary set of tools to optimize each user session. The DCIS program is managed by the Office of Acquisition Business Systems within the Division of Acquisition, under the Office of Grants and Acquisition Policy and Accountability (OGAPA) which is within the Office of the Assistant Secretary for Financial Resources.

Departmental IT Management (DITM): The four main activities within DITM are Portfolio Management, Vendor Management, Enterprise Architecture, and Enterprise Infrastructure Engineering. Previously, services supplied by DITM have been supported through a combination of the Service & Supply Fund, the Legislatively Mandated Initiatives, and Emerging Technologies (LMIE) Joint Funding Agreement (JFA). Services provided by DITM are managed within the Office of the Chief Information Officer, Office of the Assistant Secretary for Administration.

Digital Communications Division (Web): The Digital Communications Division (DCD) leads the Department's digital communication efforts (policy, web development, mobile, social media, Sec. 508 compliance) and is comprised of two SSF cost centers (OS Web Communications and Web Crawler). DCD develops and maintains HHS.gov, the Intranet, and numerous OS Office websites as well as eleven priority websites which include Flu.gov, BeTobaccofree.gov, Stopbullying.gov, Foodsafety.gov, in addition to HHS.gov. The DCD is managed within the Office of the Assistant Secretary for Public Affairs.

The Equal Employment Opportunity (EEO): The EEO Cost Center consists of two activity centers: (1) EEO Services and (2) EEO Investigations. The goal of the EEOCO is to ensure every HHS employee/applicant for employment has equal access to EEO services, timely resolution of their complaint and equitable remedy. The EEO Compliance and Operations Division consist of two components: (1) EEO Compliance and (2) EEO Operations.

The EEO Compliance component manages the Department's EEO complaint investigations program, prepares and issues final Departmental decisions on the merits for complaints of discrimination filed by employees and applicants and prepares merit decisions on complaints of discrimination filed by members of the Commissioned Corps for issuance by the Surgeon General. EEO Compliance also processes conflict of interest complaints, appeals and remands from the EEOC. The EEO Operations component of EEOCO provides EEO services to the Office of the Secretary (OS). Serving as the EEO office, this unit: assigns EEO Counselors, facilitates Alternative Dispute Resolution sessions, handles phases of EEO complaint processing at the OPDIV level, processes requests for reasonable accommodation and monitors and tracks efforts to improve representation of women and minorities.

EEO cost center is managed by the EEO Compliance and Operations Division (EEOCO), which is a part of the Office of the Secretary (OS), Office of the Assistant Secretary for Administration (ASA), and is a non-PSC activity.

E-Government (E-GOV): The E-Government (E-Gov) Office provides a central funding point for OMB-mandated contributions to EGov initiatives, including: Budget Formulation and Execution (Education), Disaster Assistance Improvement Plan (FEMA), E-Rulemaking (EPA), Federal Health Architecture LoB (HHS), Financial Management LoB (Treasury), Geospatial LoB (FGDC), GovBenefits.gov (Labor), Human Resource Management LoB (OPM), IAE - Loans and Grants (GSA), and Integrated Award Environment (GSA).

Grants.gov: The Grants.gov system (www.grants.gov) is the federal government's single site for the public to find and apply for federal discretionary grants. The Grants.gov program manages the Grants.gov system including associated operations, maintenance, enhancement, user support, and stakeholder communications. Grants.gov provides all potential applicant organizations a single website where they can find and apply for over $153 billion worth of grants distributed annually. The Grants.gov program is governed by the 26 federal grant-making agencies through the Financial Assistance Committee on eGovernment (FACE) and the Council on Financial Assistance Reform (COFAR), and HHS serves as the managing partner. The program operates within HHS's Office of the Assistant Secretary for Financial Resources.

Grants Solution Center of Excellence: The Grant Solutions Center of Excellence (GS COE) is a shared service among HHS and other federal agencies that is managed by the Department's Administration for Children and Families. It serves as one of three consortia leads under the grants management line of business e-gov initiative, delivering end-to-end grants management services to more than forty federal customers. The GS COE is new to the SSF Fund in FY 2015. The GS COE is responsible for awarding, monitoring, and financially reporting on grants to states, tribes, territories, and other non-profit organizations. The GS COE is comprehensive, supporting both discretionary and mandatory awards through all 14 stages of the grants' lifecycle.

HHS Consolidated Acquisition Solution (HCAS): HCAS provides the iProcurement-based requisitioning process and the contract writing, administration, and management application, and is therefore critical to the operation of, seven of the Department's Contracting Activities: ASPR, AHRQ, HRSA, FDA, IHS, PSC/SAS, and SAMHSA. HCAS allows contracting professionals to formulate, administer and distribute contractual documents that comply with the Federal Acquisition Regulation.

The HCAS Program is managed by the Office of Acquisition Business Systems within the Division of Acquisition, under the Office of Grants and Acquisition Policy and Accountability (OGAPA) which is within the Office of the Assistant Secretary for Financial Resources.

High Performing Organizations, Commercial Services Management Reporting & Insourcing: HPO&CMS supports HHS-wide Commercial Services Management reporting (CSM), the inventory and reporting of the Federal Activities Inventory Reform (FAIR) Act inventory, the active sponsorship of High Performing Organizations (HPO), and insourcing through central service activities. Additionally, this program offers organizational redesign services to the Department to promote mission effectiveness, cost-savings and increase efficiencies.

The Office of Information Technology Infrastructure and Operations (ITIO): ITIO manages the purchase and maintenance of technology-based equipment, including Blackberrys, monitors, laptop/desktop computers, printers, and other end user devices; provides access to VPN remote access accounts, Microsoft Outlook, and other proprietary systems; and purchases, installs, and maintains agency-approved software. ITIO provides management of several IT services critical to Department's infrastructure including shared services (Blackberry and e-mail), infrastructure services (network devices and enterprise security monitoring), e-mail services (Outlook and customer e-mail), HHSNet

(applications and internet access), business application hosting (secure offsite database and applications hosting), telecommunications services and management (WITS and telecommunications support), and Networx. The ITIO is managed within the Office of the CIO, Office of the Assistant Secretary for Administration.

Office of the Enterprise Application Development (OEAD): OEAD provides high-quality enterprise systems operations and management services including application development, project management and enterprise systems management. OEAD is comprised of two cost centers, HRSS and ESS

In support of OHR, HRSS will provide high-quality enterprise systems operations and management services including application development, project management and HR enterprise systems management. The ESS is a reformed cost center to support non-HR systems. It will provide enterprise systems support for current projects, including HHS OCIO and ASA SharePoint, OMHA ECAPE, PMT, and HEAR.

OEAD is managed within the Office of the CIO, Office of the Assistant Secretary for Administration.

Office of the General Counsel – Claims: The Office of the General Counsel (OGC) receives all tort claims filed against the Department. These torts can range from “slips” and “falls” in Departmental facilities, to motor vehicle accidents involving Departmental vehicles, or medical malpractice in health clinics. OGC reviews and processes all of these claims. Two clients typically account for approximately ninety-six percent of the Claims Activity workload: the Health Resources and Services Administration (74%) and the Indian Health Service (22%).

Office of Human Resources (OHR): OHR provides strategic leadership and operational services for a variety of Human Capital Management functions across the Department including the planning and development of personnel policies and human resource programs supporting the Department's mission. OHR also provides technical assistance to the HHS Operating Divisions (OPDIVs) to most effectively and efficiently accomplish the OPDIV’s mission through improved planning and recruitment of human resources and serves as the Departmental liaison to central management agencies on related matters.

Office of Information Security (OIS): The mission of HHS’ Office of Information Security (OIS) is to increase the baseline cybersecurity posture across HHS, and to maintain HHS' ability to provide mission-critical services while protecting HHS systems and the public’s personal information in the interest of privacy. The OIS provides critical services to the Department to ensure the security of departmental systems and applications through services such as HHSNET, TIC, HSPD-12, and CSIRC.

The Department of Health and Human Services (HHS) Office of Information Security (OIS) is one of only seven Federal agencies that have been designated as a Center of Excellence represented by the Department of Homeland Security (DHS), and endorsed by the Office of Management and Budget (OMB), to support any federal agency that requires assistance in developing certification & accreditation packages in accordance with federal requirements. Specifically, the Information Systems Security Line of Business (ISS LOB) program provides services to assist system owners throughout the system lifecycle.

The Office of Security and Strategic Information (OSSI): OSSI has two business lines for the Personnel Security Cost Center: Background Investigations (Personnel Security), and National Security Adjudications. Background Investigations provide customer agencies with support in processing suitability and national security investigations. Billable units are based upon a customer's request for a background investigation. National Security Adjudications provide support including: adjudication, tracking, and management of national security clearances.

Office of Small and Disadvantaged Business Utilization (OSDBU): OSDBU is the focal point for the Department's policy formulation, implementation, coordination, and management of small business programs. Organizationally, OSDBU is administratively supported by the OGAPA Immediate Office, but reports directly to the Deputy Secretary of HHS. The office ensures that small businesses are given a fair and transparent opportunity to compete for contracts that provide goods and services to HHS; establishes, manages and tracks small business goal achievements; provides technical assistance and small business program training to OPDIV contracting and program officials; and conducts outreach and provides marketing and technical guidance to small businesses on contracting opportunities with HHS.

The Strategic Planning System (SPS): SPS is a web-based application that centralizes information about strategic plans that agencies within HHS are implementing. The SPS was built in response to a request from the HHS Deputy Secretary and is supported by a contract managed by Assistant Secretary for Planning and Evaluation (ASPE). The HHS Strategic Plan FY 2014-2018 and more than 150 other strategic plans are currently included in the SPS. The SPS has multiple purposes that benefit all agencies in the Department.

The Strategic Sourcing Program (SSP): SSP provides departmental leadership in developing acquisition strategies that leverage the Department's contract spending for common supplies and services. The SSP also manages the HHS conference request review process and enables the Department to achieve efficiencies and savings on conference spending through strategic sourcing and vendor management. The SSP is managed by the Office of Acquisition Program Support within the Division of Acquisition, under the Office of Grants and Acquisition Policy and Accountability (OGAPA) which is within the Office of the Assistant Secretary for Financial Resources.

Tracking Accountability in Government Grants System (TAGGS): Since 1995, the Department of Health and Human Services (HHS) has tracked and reported grant spending online via its Tracking Accountability in Government Grants System (TAGGS). TAGGS is overseen by the Office of Grants Systems Management within the Division of Grants, under the Office of Grants and Acquisition Policy and Accountability (OGAPA), which is within the Office of the Assistant Secretary for Financial Resources.

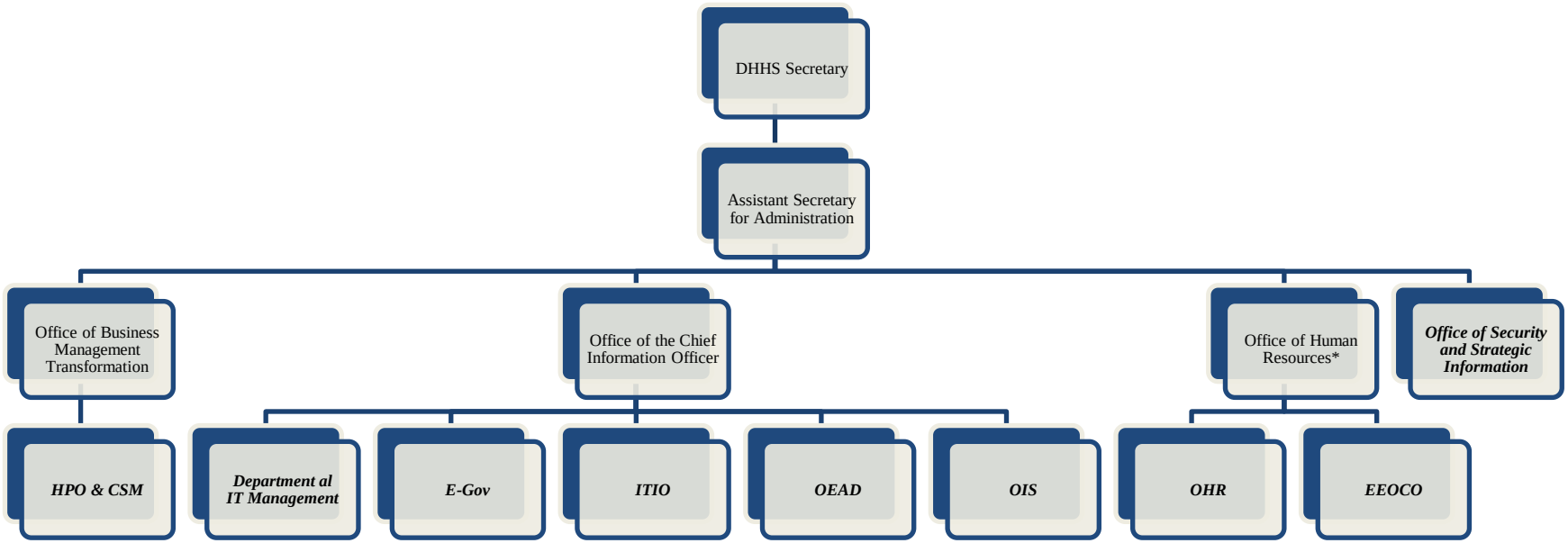
TAGGS is maintained in a manner that supports the Open Government Initiative and adherence to federal reporting requirements, and ensures the availability of HHS data for internal and external stakeholders use. TAGGS also maintains a roadmap for continued security compliance, updates and

assessment requirements set forth by the Office of the Chief Information Officer (OCIO). TAGGS continues to serve as the central repository and reporting system for grant award data generated by HHS' Staff Divisions and Operating Divisions. TAGGS grant data is made available to the public on the TAGGS Website (http://taggs.hhs.gov) and in accordance with the Federal Financial Accountability and Transparency Act (FFATA), HHS's grant award data is submitted to USASpending.gov twice a month.

Unified Financial Management Systems (UFMS): UFMS environment offers the Department a platform for effectively processing and tracking its financial and accounting transactions with the Unified Financial Management System (UFMS) at its core.

The UFMS environment consists of three essential components. The Consolidated Financial Reporting System (CFRS) performs the important function of generating accurate, Department-wide financial statements on a consistent and timely basis. The Financial Business Intelligence System (FBIS) serves as a powerful business intelligence platform for integrated, timely, and accurate reporting and analysis. The Property Management Information System (PMIS) is the HHS accountable personal property system of record used to account for and track over 225,000 assets valued at approximately $1.2 billion. The PSC/REL Asset Management team is responsible for managing PMIS on behalf of all activities in HHS, and for tracking OS capitalized personal property to ensure proper capitalization and depreciation of HHS assets. UFMS is managed within the Office of Finance, Office of the Assistant Secretary for Financial Resources.

Service and Supply Fund Organizational Chart
Non-PSC Activities Under the Purview of the
Assistant Secretary for Administration



Acronym Key:
EEOCO – Equal Employment Opportunity Compliance and Operations
HPO & CMS – High Performing Organizations and Commercial Services Management
HSPD-12 – Homeland Security Presidential Directive 12
ITIO – Information Technology Infrastructure and Operations
OEAD – Office of Enterprise Application Development
OHR – Office of Human Resources
OIS – Office of Information Security
*Organizationally, the Office of Human Resources (OHR) is part of the Office of the Assistant Secretary for Administration (ASA) as is the Program Support Center (PSC). However, so that our budget tables remain comparable from year to year, OHR is reflected under the PSC in the budget.
SSF Activities are italicized

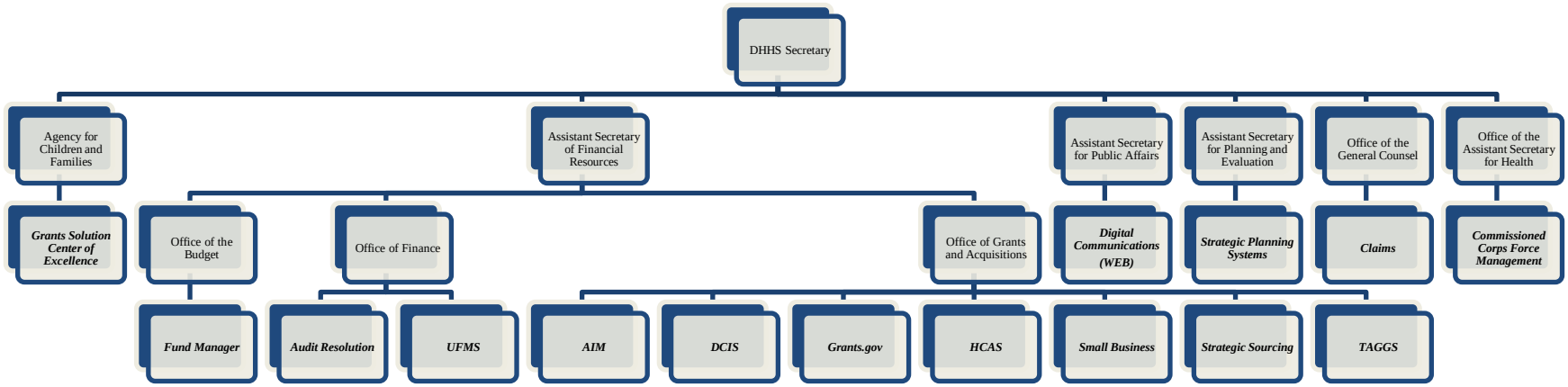
Service and Supply Fund Organizational Chart
Non-PSC Activities Under the Purview of the
Assistant Secretary for Administration

- Office of the Secretary
- The Office of the Assistant Secretary for Administration (ASA)

The following offices report directly to the ASA:

- Office of Business Management Transformation
    - High Performing Organizations and Commercial Services Management
- Office of the Chief Information Officer
    - Departmental IT Management
    - E-Gov
    - Office of Enterprise Application Development
    - Office of Information Security
    - Information Technology Infrastructure and Operations
- Office of Human Resources
    - Human Resource Centers
    - Equal Employment Opportunity Compliance and Operations
- Office of Security and Strategic Information
    - Homeland Security Presidential Directive 12

Service and Supply Fund Organizational Chart
Non-PSC Activities



Acronym Key:

AIM – Acquisition Integration and Modernization

DCIS – Departmental Contracts Information System

HCAS – HHS Consolidated Acquisition Solution

TAGGS – Tracking Accountability in Government Grants System

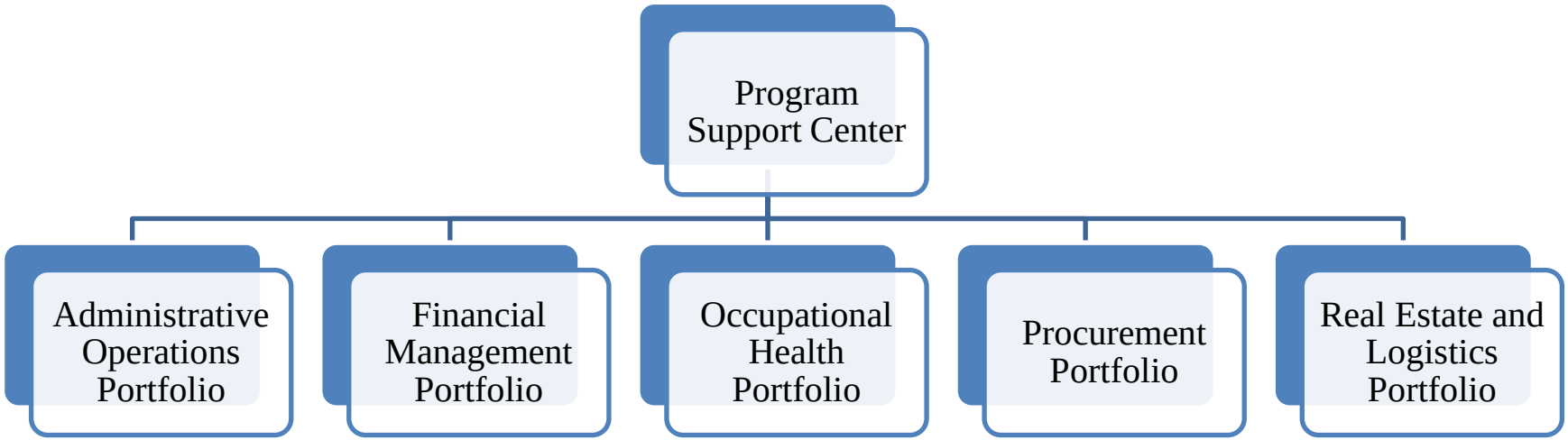
UFMS – Unified Financial Management System

SSF Activities are italicized

Service and Supply Fund Organizational Chart
Non-PSC Activities

- Office of the Secretary
- Agency for Children and Families
    - Grants Centers of Excellence
- Office of the Assistant Secretary for Financial Resources
    - Office of Budget
        - SSF Fund Manager's Office
    - Office of Finance
        - OS Audit Resolution
        - Unified Financial Management System
        - UFMS Governance and Program Management
    - Office of Grants and Acquisition
        - Acquisition Integration and Modernization
        - Departmental Contracts Information System
        - HHS Consolidated Acquisition System
        - Small Business Program
        - Strategic Sourcing Program
        - Tracking Accountability in Government Grants
- Office of the Assistant Secretary for Public Affairs
    - Digital Communications Division (Web)
- Office of the General Counsel
    - OGC Claims
- Office of the Assistant Secretary for Health
    - Commissioned Corp Force Management

Program Support Center
Service and Supply Fund Organizational Chart



Service and Supply Fund Organizational Chart
Program Support Center

- Office of the Secretary
- The Office of the Assistant Secretary for Administration (ASA)

The divisions of the Program Support Center report directly to the ASA:

- Program Support Center Office of the Director
    - Administrative Operations Portfolio
    - Occupational Health Portfolio
    - Financial Management Portfolio
    - Real Estate and Logistics Portfolio
    - Procurement Portfolio

Department of Health and Human Services
Service and Supply Fund
(Dollars in Thousands)

Service and Supply Fund Activities	FY 2014 Actuals	FY 2015 Board Approved	FY 2016 Board Approved	FY 2016 +/- FY 2015
PSC				
Administrative Operations Portfolio	71,028	80,787	81,903	1,118
Financial Management Portfolio	54,561	65,969	66,319	350
Occupational Health Portfolio	146,484	166,174	171,774	5,600
Procurement Portfolio	335,053	361,013	368,233	7,220
Real Estate and Logistics Portfolio	68,987	90,753	88,050	(2,703)
PSC Reserves	7,996			
PSC Subtotal	***684,109***	***764,695***	***776,279***	***(11,583)***
Non-PSC				
AIM	1,134	992	992	-
Audit Resolution	1,402	1,812	1,845	33
CCFM	23,341	25,166	24,456	(710)
DCIS	1,793	1,999	1,999	-
DITM	30,092	10,941	12,090	1,149
EEO Services	2,509	3,261	3,261	-
Governmentwide E-Gov Initiatives	-	12,959	12,959	-
Grants.gov		4,965	5,162	197
Grants Solutions Center of Excellence		42,632	44,140	1,508
HCAS	4,655	7,877	7,877	-
HPO & Commercial Services Mgmnt	196	262	262	-
ITIO	85,581	89,609	89,609	-
OEAD	29,928	36,874	35,289	(1,585)
OGC Claims	1,378	1,477	1,491	14
OHR	21,074	25,014	25,014	-
OIS	8,840	40,012	40,898	886
OSSI	36,597	43,572	43,572	-
Small Business Consolidation	2,626	2,871	2,932	61
Strategic Sourcing	830	959	959	-
Strategic Planning System		338	338	-
TAGGS	2,256	2,832	3,550	718
UFMS	40,277	45,598	46,534	936
Web Communications	23,243	20,209	20,209	-
Non-PSC Reserves	28,960	-	-	-
Non-PSC Subtotal	***346,713***	***422,229***	***425,438***	***3,207***
Total SSF Revenue	***1,030,821***	***1,186,925***	***1,201,717***	***14,791***

Department of Health and Human Services
Service and Supply
Object Classification – Reimbursable Obligations
(Dollars in Thousands)

Object Class	FY 2014 SSF Board Actuals	FY 2015 SSF Board Approved	FY 2016 SSF Board Approved
Reimbursable Obligations			
Personnel Compensation:			
Full – Time Permanent (11.1)	102,509	105,762	107,962
Other Than Full – Time Permanent (11.3)	2,497	2,324	2,310
Other Personnel Compensation (11.5)	2,587	2,538	2,504
Military Personnel (11.7)	7,627	7,508	7,504
Special Personnel Services Payments (11.8)	1,032	1,276	1,256
Subtotal, Personnel Compensation	**116,252**	**119,408**	**121,536**
Civilian Personnel Benefits (12.1)	28,583	29,017	30,855
Military Personnel Benefits (12.2)	1,879	2,437	2,367
Benefits to Former Personnel (13.0)	652	689	681
Subtotal, Pay Costs	**31,114**	**32,143**	**33,903**
Travel (21.0)	1,681	1,857	1,824
Transportation of Things (22.0)	3,539	3,688	3,693
Rental Payments to GSA (23.1)	21,799	22,041	23,524
Rental Payments to Others (23.2)	359	359	359
Communications, Utilities and			
Miscellaneous Charge (23.3)	5,743	6,108	6,079
Printing and Reproduction (24.0)	2,745	2,570	2,525
Other Contractual Services:			
Advisory and Assistance Services (25.1)	27,059	31,579	31,043
Other Services (25.2)	656,472	744,719	752,719
Purchases from Govt. Accounts (25.3)	51,374	70,012	71,337
Operation & Maintenance of Facilities (25.4)	15,562	16,497	16,342
Research & Development Contracts (25.5)	-	-	-
Medical Services (25.6)	23,889	28,704	28,534
Operation & Maintenance of Equipment (25.7)	49,047	71,322	72,589
Subsistence& Support of Persons (25.8)	-	-	-
Subtotal, Other Contractual Services	**859,269**	**1,002,456**	**1,011,104**
Supplies and Materials (26.0)	32,432	32,441	32,289
Equipment (31.0)	3,041	3,439	3,472
Grants (41.0)	-	-	-
Other (32), (42), (61)	-	-	-
Subtotal, Non – Pay Costs	**35,473**	**35,918**	**35,709**
Total, Reimbursable Obligations	**1,042,108**	**1,186,925**	**1,201,716**

Retirement Pay & Medical Benefits for Commissioned Officers

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

	FY 2014	FY 2015	FY 2016	FY 2016 +/-FY 2015
Retirement Payments	407,083,423	423,828,557	$441,977,420	18,148,863
Survivor's Benefits	27,129,978	27,759,722	28,603,471	843,750
Medical Care Benefits	106,192,026	110,609,935	115,607,901	4,997,966
Accrued Health Care Benefits	27,335,980	27,958,911	29,189,669	1,230,758
Total	**$567,741,408**	**$590,157,125**	**$615,378,461**	**$25,221,337**

Authorizing Legislation 42 U.S.C., Chapter 6A; 10 U.S.C., Chapter 73; 10 U.S.C., Chapters 55; and Section 229(b) of the Social Security Act.

FY 2016 Authorization……Indefinite.

Rationale for Budget

This appropriation provides for retirement payments to Public Health Service (PHS) Commissioned Corps officers who are retired for age, disability, or a specific length of service as well as payments to survivors of deceased retired officers who had elected to receive reduced retirement payments.

This appropriation also funds the provision of medical care to active duty and retired members of the Corps under the age of 65, dependents of active duty and retired members, and dependents of deceased members. This account includes payments to the Department of Defense (DoD) Medicare-Eligible Retiree Healthcare Fund for the accrued costs of health care for beneficiaries over the age of 65.

The Accrual Health Care Benefits amount is a per officer estimate provided by the DoD Office of the Actuary, multiplied by the estimated total number of active duty positions (6,899 in FY 2016), for a baseline contribution of $29,189,669. The FY 2016 baseline estimate is a net increase of $1,230,758 over the FY 2015 level. Additionally, this budget assumes $1,474,000 in savings in FY 2016 associated with the Department of Defense legislative proposals.

The overall request reflects increased costs in medical benefits, an average increase of 4.3% over the past five years in Retired Pay, and a net increase in the number of retirees and survivors during FY 2016.

Out Year Projections

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Retirement Payments	460,903,440	480,639,895	501,221,490	522,684,414	545,066,408
Survivor's Benefits	29,472,866	30,368,687	31,291,735	32,242,839	33,222,852
Medical Care Benefits	120,831,703	126,291,545	131,998,093	137,962,494	144,196,399
Accrued Health Care Benefits	28,151,000	29,767,000	31,484,000	33,288,000	35,200,000
Total	**$639,359,009**	**$667,067,127**	**$695,995,318**	**$726,177,748**	**$757,685,660**

[1] Baseline Totals; does not include DoD legislative proposals.

HHS General Provisions

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROPOSED GENERAL PROVISIONS
FOR FISCAL YEAR 2016

The President's Budget recommends that a number of general provisions be included in the FY 2016 Departments of Labor, Health and Human Services and Education Appropriations Act. These provisions follow appendix schedules for the Department of Health and Human Services (Title II General Provisions) and the Departments of Labor, Health and Human Services and Education (Title V General Provisions).

TITLE II

SEC. 201. Funds appropriated in this title shall be available for not to exceed $50,000 for official reception and representation expenses when specifically approved by the Secretary.

[SEC. 202. The Secretary shall make available through assignment not more than 60 employees of the Public Health Service to assist in child survival activities and to work in AIDS programs through and with funds provided by the Agency for International Development, the United Nations International Children's Emergency Fund or the World Health Organization.**]**

SEC. **[**203**]***202*. None of the funds appropriated in this title shall be used to pay the salary of an individual, through a *discretionary* grant or other extramural mechanism, at a rate in excess of Executive Level II.

SEC. [204]*203*. None of the funds appropriated in this Act may be expended pursuant to section 241 of the PHS Act, except for funds specifically provided for in this Act, or for other taps and assessments made by any office located in HHS, prior to the preparation and submission of a report by the Secretary to the Committees on Appropriations of the House of Representatives and the Senate detailing the planned uses of such funds.

SEC. **[**205**]***204*. Notwithstanding section 241(a) of the PHS Act, such portion as the Secretary shall determine, but not more than **[**2.5**]** *3.0* percent, of any amounts appropriated for programs authorized under such Act shall be made available for the evaluation (directly, or by grants or contracts) and the implementation and effectiveness of programs funded in this title.

(TRANSFER OF FUNDS)

SEC. **[**206**]***205*. Not to exceed 1 percent of any discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) which are appropriated for the current fiscal year for HHS in this Act may be transferred between appropriations, but no such appropriation shall be increased by more than 3 percent by any such transfer: *Provided*, That the transfer authority granted by this section shall not be used to create any new program or to fund any project or activity for which no funds are provided in this Act: *Provided further*, That the

Committees on Appropriations of the House of Representatives and the Senate are notified at least 15 days in advance of any transfer.

(TRANSFER OF FUNDS)

SEC. **[**207**]***206*. The Director of the NIH, jointly with the Director of the Office of AIDS Research, may transfer up to 3 percent among institutes and centers from the total amounts identified by these two Directors as funding for research pertaining to the human immunodeficiency virus: *Provided*, That the Committees on Appropriations of the House of Representatives and the Senate are notified at least 15 days in advance of any transfer.

(TRANSFER OF FUNDS)

SEC. **[**208**]***207*. Of the amounts made available in this Act for NIH, the amount for research related to the human immunodeficiency virus, as jointly determined by the Director of NIH and the Director of the Office of AIDS Research, shall be made available to the "Office of AIDS Research'' account. The Director of the Office of AIDS Research shall transfer from such account amounts necessary to carry out section 2353(d)(3) of the PHS Act.

SEC. **[**209**]***208*. None of the funds appropriated in this Act may be made available to any entity under title X of the PHS Act unless the applicant for the award certifies to the Secretary that it encourages family participation in the decision of minors to seek family planning services and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.

SEC. **[**210**]***209*. Notwithstanding any other provision of law, no provider of services under title X of the PHS Act shall be exempt from any State law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.

SEC. **[**211**]***210*. None of the funds appropriated by this Act (including funds appropriated to any trust fund) may be used to carry out the Medicare Advantage program if the Secretary denies participation in such program to an otherwise eligible entity (including a Provider Sponsored Organization) because the entity informs the Secretary that it will not provide, pay for, provide coverage of, or provide referrals for abortions: *Provided*, That the Secretary shall make appropriate prospective adjustments to the capitation payment to such an entity (based on an actuarially sound estimate of the expected costs of providing the service to such entity's enrollees): *Provided further*, That nothing in this section shall be construed to change the Medicare program's coverage for such services and a Medicare Advantage organization described in this section shall be responsible for informing enrollees where to obtain information about all Medicare covered services.

SEC. **[**212**]***211*. In order for HHS to carry out international health activities, including HIV/AIDS and other infectious disease, chronic and environmental disease, and other health activities abroad during fiscal year **[**2015**]***2016*:

(1) The Secretary may exercise authority equivalent to that available to the Secretary of State in section 2(c) of the State Department Basic Authorities Act of 1956. The Secretary shall consult with the Secretary of State and relevant Chief of Mission to ensure that the authority provided in this section is exercised in a manner consistent with section 207 of the Foreign Service Act of 1980 and other applicable statutes administered by the Department of State.

(2) The Secretary is authorized to provide such funds by advance or reimbursement to the Secretary of State as may be necessary to pay the costs of acquisition, lease, alteration, renovation, and management of facilities outside of the United States for the use of HHS. The Department of State shall cooperate fully with the Secretary to ensure that HHS has secure, safe, functional facilities that comply with applicable regulation governing location, setback, and other facilities requirements and serve the purposes established by this Act. The Secretary is authorized, in consultation with the Secretary of State, through grant or cooperative agreement, to make available to public or nonprofit private institutions or agencies in participating foreign countries, funds to acquire, lease, alter, or renovate facilities in those countries as necessary to conduct programs of assistance for international health activities, including activities relating to HIV/AIDS and other infectious diseases, chronic and environmental diseases, and other health activities abroad.

(3) *The Centers for Disease Control and Prevention may acquire, lease, construct, alter, renovate, equip, furnish, or manage facilities outside of the United States, as necessary to conduct such programs, in consultation with the Secretary of State, either directly for the use of the United States Government or for the use, pursuant to grants, direct assistance, or cooperative agreements, of public or nonprofit private institutions or agencies in participating foreign countries.*

(**[**3**]***4*) The Secretary is authorized to provide to personnel appointed or assigned by the Secretary to serve abroad, allowances and benefits similar to those provided under chapter 9 of title I of the Foreign Service Act of 1980, and 22 U.S.C. 4081 through 4086 and subject to such regulations prescribed by the Secretary. The Secretary is further authorized to provide locality-based comparability payments (stated as a percentage) up to the amount of the locality-based comparability payment (stated as a percentage) that would be payable to such personnel under section 5304 of title 5, United States Code if such personnel's official duty station were in the District of Columbia. Leaves of absence for personnel under this subsection shall be on the same basis as that provided under subchapter I of chapter 63 of title 5, United States Code, or section 903 of the Foreign Service Act of 1980, to individuals serving in the Foreign Service.

SEC. **[**213**]***212*.

(a) AUTHORITY.—Notwithstanding any other provision of law, the Director of NIH (''Director'') may use funds available under section 402(b)(7) or 402(b)(12) of the PHS Act to enter into transactions (other than contracts, cooperative agreements, or grants) to carry out research identified pursuant to such section 402(b)(7) (pertaining to the Common Fund) or research and activities described in such section 402(b)(12).

(b) PEER REVIEW.—In entering into transactions under subsection (a), the Director may utilize such peer review procedures (including consultation with appropriate scientific experts) as the Director determines to be appropriate to obtain assessments of scientific and technical merit. Such procedures shall apply to such

transactions in lieu of the peer review and advisory council review procedures that would otherwise be required under sections 301(a)(3), 405(b)(1)(B), 405(b)(2), 406(a)(3)(A), 492, and 494 of the PHS Act.

SEC. **[**214**]***213*. Funds which are available for Individual Learning Accounts for employees of CDC and the Agency for Toxic Substances and Disease Registry (''ATSDR'') may be transferred **[**to**]** *between* appropriate accounts of CDC, to be available only for Individual Learning Accounts: *Provided*, That such funds may be used for any individual full-time equivalent employee while such employee is employed either by CDC or ATSDR.

SEC. **[**215**]***214*. Not to exceed $45,000,000 of funds appropriated by this Act to the institutes and centers of the National Institutes of Health may be used for alteration, repair, or improvement of facilities, as necessary for the proper and efficient conduct of the activities authorized herein, at not to exceed $3,500,000 per project.

(TRANSFER OF FUNDS)

SEC. **[**216**]***215*. Of the amounts made available for NIH, 1 percent of the amount made available for National Research Service Awards (''NRSA'') shall be made available to the Administrator of the Health Resources and Services Administration to make NRSA awards for research in primary medical care to individuals affiliated with entities who have received grants or contracts under sections 736, 739, or 747 of the PHS Act, and 1 percent of the amount made available for NRSA shall be made available to the Director of the Agency for Healthcare Research and Quality to make NRSA awards for health service research.

[SEC. 217. None of the funds made available in this title may be used, in whole or in part, to advocate or promote gun control.**]**

[SEC. 218.

(a) The Secretary shall establish a publicly accessible Web site to provide information regarding the uses of funds made available under section 4002 of the Patient Protection and Affordable Care Act of 2010 (''ACA'').
(b) With respect to funds provided under section 4002 of the ACA, the Secretary shall include on the Web site established under subsection (a) at a minimum the following information:
    (1) In the case of each transfer of funds under section 4002(c), a statement indicating the program or activity receiving funds, the operating division or office that will administer the funds, and the planned uses of the funds, to be posted not later than the day after the transfer is made.
    (2) Identification (along with a link to the full text) of each funding opportunity announcement, request for proposals, or other announcement or solicitation of proposals for grants, cooperative agreements, or contracts intended to be awarded using such funds, to be posted not later than the day after the announcement or solicitation is issued.

(3) Identification of each grant, cooperative agreement, or contract with a value of $25,000 or more awarded using such funds, including the purpose of the award and the identity of the recipient, to be posted not later than 5 days after the award is made.

(4) A report detailing the uses of all funds transferred under section 4002(c) during the fiscal year, to be posted not later than 90 days after the end of the fiscal year.

(c) With respect to awards made in fiscal years 2013 and 2014, the Secretary shall also include on the Web site established under subsection (a), semi-annual reports from each entity awarded a grant, cooperative agreement, or contract from such funds with a value of $25,000 or more, summarizing the activities undertaken and identifying any sub-grants or sub-contracts awarded (including the purpose of the award and the identity of the recipient), to be posted not later than 30 days after the end of each 6-month period.

(d) In carrying out this section, the Secretary shall:

(1) present the information required in subsection (b)(1) on a single webpage or on a single database;

(2) ensure that all information required in this section is directly accessible from the single webpage or database; and

(3) ensure that all information required in this section is able to be organized by program or State.**]**

[(TRANSFER OF FUNDS)**]**

[SEC. 219.

(a) Within 45 days of enactment of this Act, the Secretary shall transfer funds appropriated under section 4002 of the Patient Protection and Affordable Care Act of 2010 ("ACA") to the accounts specified, in the amounts specified, and for the activities specified under the heading "Prevention and Public Health Fund" in the explanatory statement described in section 4 (in the matter preceding division A of this Consolidated Act) accompanying this Act.

(b) Notwithstanding section 4002(c) of the ACA, the Secretary may not further transfer these amounts.

(c) Funds transferred for activities authorized under section 2821 of the PHS Act shall be made available without reference to section 2821(b) of such Act. **]**

SEC. **[**220**]***216*.

(a) The Biomedical Advanced Research and Development Authority ("BARDA") may enter into a contract, for more than one but no more than 10 program years, for purchase of research services or of security countermeasures, as that term is defined in section 319F-2(c)(1)(B) of the PHS Act (42 U.S.C. 247d-6b(c)(1)(B)), if—

(1) funds are available and obligated—

(A) for the full period of the contract or for the first fiscal year in which the contract is in effect; and

(B) for the estimated costs associated with a necessary termination of the contract; and

(2) the Secretary determines that a multi-year contract will serve the best interests of the Federal Government by encouraging full and open competition or promoting economy in administration, performance, and operation of BARDA's programs.

(b) A contract entered into under this section:

(1) shall include a termination clause as described by subsection (c) of section 3903 of title 41, United States Code; and

(2) shall be subject to the congressional notice requirement stated in subsection (d) of such section.

[SEC. 221.

(a) The Secretary shall publish in the fiscal year 2016 budget justification and on Departmental Web sites information concerning the employment of full-time equivalent Federal employees or contractors for the purposes of implementing, administering, enforcing, or otherwise carrying out the provisions of the Patient Protection and Affordable Care Act of 2010 (''ACA''), and the amendments made by that Act, in the proposed fiscal year and the 4 prior fiscal years.

(b) With respect to employees or contractors supported by all funds appropriated for purposes of carrying out the ACA (and the amendments made by that Act), the Secretary shall include, at a minimum, the following information:

(1) For each such fiscal year, the section of such Act under which such funds were appropriated, a statement indicating the program, project, or activity receiving such funds, the Federal operating division or office that administers such program, and the amount of funding received in discretionary or mandatory appropriations.

(2) For each such fiscal year, the number of full-time equivalent employees or contracted employees assigned to each authorized and funded provision detailed in accordance with paragraph (1).

(c) In carrying out this section, the Secretary may exclude from the report employees or contractors who:

(1) Are supported through appropriations enacted in laws other than the ACA and work on programs that existed prior to the passage of the ACA;

(2) spend less than 50 percent of their time on activities funded by or newly authorized in the ACA;

(3) or who work on contracts for which FTE reporting is not a requirement of their contract, such as fixed-price contracts.**]**

[SEC. 222. In addition to the amounts otherwise available for "Centers for Medicare and Medicaid Services, Program Management'', the Secretary of Health and Human Services may transfer up to $305,000,000 to such account from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to support program management activity related to the Medicare Program: *Provided*, That except for the foregoing purpose, such funds may not be used to support any provision of Public Law 111–148 or Public Law 111–152

(or any amendment made by either such Public Law) or to supplant any other amounts within such account.**]**

SEC. **[**223**]***217*. In lieu of the timeframe specified in section 338E(c)(2) of the PHS Act, terminations described in such section may occur up to 60 days after the execution of a contract awarded in fiscal year **[**2015**]** *2016* under section 338B of such Act.

[Sec. 224 Title IV of the PHS Act is amended by:

(1) Striking "National Center for Complementary and Alternative Medicine" in each place it appears and replacing it with "National Center for Complementary and Integrative Health";

(2) Striking "alternative medicine" in each place it appears and replacing it with "integrative health";

(3) Striking all references to "alternative and complementary medical treatment" or "complementary and alternative treatment" in each place either appears and inserting "complementary and integrative health";

(4) Striking references to "alternative medical treatment" in each place it appears and inserting "integrative health treatment"; and

(5) Striking section 485D(c) and inserting:

"(c) In carrying out subsection (a), the Director of the Center shall, as appropriate, study the integration of new and non-traditional approaches to health care treatment and consumption, including but not limited to non-traditional treatment, diagnostic and prevention systems, modalities, and disciplines.". **]**

SEC. **[**225**]***218*. In addition to amounts provided herein, payments made for research organisms or substances, authorized under section 301(a) of the PHS Act, shall be retained and credited to the appropriations accounts of the Institutes and Centers of the NIH making the substance or organism available under section 301(a). Amounts credited to the account under this authority shall be available for obligation through September 30, **[**2016**]** *2017*.

[Sec. 226. The Secretary shall publish, as part of the fiscal year 2016 budget of the President submitted under section 1105(a) of title 31, United States Code, information that details the uses of all funds used by the Centers for Medicare and Medicaid Services specifically for Health Insurance Marketplaces for each fiscal year since the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148) and the proposed uses for such funds for fiscal year 2016. Such information shall include, for each such fiscal year—

(1) the amount of funds used for each activity specified under the heading "Health Insurance Marketplace Transparency" in the explanatory statement described in section 4 (in the matter preceding division A of this Consolidated Act) accompanying this Act; and

(2) the milestones completed for data hub functionality and implementation readiness. **]**

[Sec. 227. None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the" Centers for Medicare and Medicaid Services—

Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridors). **]**

[Sec. 228. (a) Subject to the succeeding provisions of this section, activities authorized under part A of title IV and section 1108(b) of the Social Security Act shall continue through September 30, 2015, in the manner authorized for fiscal year 2014, and out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated such sums as may be necessary for such purpose. Grants and payments may be made pursuant to this authority through September 30, 2015, at the level provided for such activities for fiscal year 2014, except as provided in subsections (b) and (c).

(b) In the case of the Contingency Fund for State Welfare Programs established under section 403(b) of the Social Security Act—

(1) the amount appropriated for section 403(b) of such Act shall be $608,000,000 for each of fiscal years 2015 and 2016;

(2) the requirement to reserve funds provided for in section 403(b)(2) of such Act shall not apply during fiscal years 2015 and 2016; and

(3) grants and payments may only be made from such Fund for fiscal year 2015 after the application of subsection (d).

(c) In the case of research, evaluations, and national studies funded under section 413(h)(1) of the Social Security Act, no funds shall be appropriated under that section for fiscal year 2015 or any fiscal year thereafter.

(d) Of the amount made available under subsection (b)(1) for section 403(b) of the Social Security Act for fiscal year 2015—

(1) $15,000,000 is hereby transferred and made available to carry out section 413(h) of the Social Security Act; and

(2) $10,000,000 is hereby transferred and made available to the Bureau of the Census to conduct activities using the Survey of Income and Program Participation to obtain information to enable interested parties to evaluate the impact of the amendments made by title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(e) Section 413(h)(1) of the Social Security Act (42 U.S.C. 613(h)(1)) is amended, in the matter preceding subparagraph (A), by striking "Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $15,000,000 for fiscal year 2012" and inserting "Funds made available to carry out this section for a fiscal year shall be used".

(f) Section 414 of the Social Security Act (42 U.S.C. 614) is repealed.

(g) Expenditures made pursuant to Public Law 113–164 for section 403(b) of the Social Security Act for fiscal year 2015 shall be charged to the appropriation provided by subsection (b)(1) for such fiscal year. **]**

[Sec. 229. The remaining unobligated balances of the amount appropriated for fiscal year 2015 by section 510(d) of the Social Security Act (42 U.S.C. 710(d)) for which no application has been received by the Funding Opportunity Announcement deadline, shall be made available to States that require the implementation of each element described in subparagraphs (A) through (H) of the definition of abstinence education in section 510(b)(2). The remaining unobligated balances

shall be reallocated to such States that submit a valid application consistent with the original formula for this funding. **]**

[Sec. 230. Hereafter, for each fiscal year through fiscal year 2025, the Director of the National Institutes of Health shall prepare and submit directly to the President for review and transmittal to Congress, after reasonable opportunity for comment, but without change, by the Secretary of Health and Human Services and the Advisory Council on Alzheimer's Research, Care, and Services, an annual budget estimate (including an estimate of the number and type of personnel needs for the Institutes) for the initiatives of the National Institutes of Health pursuant to the National Alzheimer's Plan, as required under section 2(d)(2) of Public Law 111–375. **]**

Sec. 219. In the event of a public health emergency declared under section 319 of the PHS Act, the Secretary may, during the duration of the emergency, transfer discretionary funds (as defined pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) which are appropriated in this Act for the current fiscal year for the Department of Health and Human Services between appropriations for costs of responding to and aiding in recovery from such public health emergency: Provided, That no appropriation may be reduced by more than 10 percent under this section: Provided further, That the Committees on Appropriations of the House of Representatives and the Senate shall be promptly notified of such transfers: Provided further, That this transfer authority is in addition to any other transfer authority.

Sec. 220 (a) The amount appropriated for the Contingency Fund for State Welfare Programs established under section 403(b) of the Social Security Act (42 U.S.C. 603(b)) shall be $608,000,000 for fiscal year 2017.

(b) Of the amount made available by Public Law 113–235 for section 403(b) for fiscal year 2016—

(1) $15,000,000 is hereby transferred to the Children's Research and Technical Assistance account in the Administration for Children and Families of the Department of Health and Human Services and made available to carry out section 413(h) of the Social Security Act (42 U.S.C. 613(h)); and

(2) $10,000,000 is hereby transferred to the Current Surveys and Programs account in the Bureau of the Census of the Department of Commerce and made available to the Bureau of the Census to conduct activities using the Survey of Income and Program Participation to obtain information to enable interested parties to evaluate the impact of the amendments made by title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193).

Sec. 221. Subsection 1864(e) of the Social Security Act (42 U.S.C. 1395aa(e)) is amended to read as follows—

"(e) FEES FOR CONDUCTING REVISIT SURVEYS.—The Secretary may impose fees upon facilities or entities referred to in this section for conducting revisit surveys in cases where such facilities or entities have been cited for deficiencies during initial certification, recertification, or substantiated complaint surveys. Such fees shall be established and collected in accordance with

regulations prescribed by the Secretary that provide for a gradual phase-in of the fee amounts, and collected funds shall be available to supplement funding appropriated for such surveys. Fee amounts assessed upon an entity in an entity class shall not exceed the estimated average cost of performing such surveys for an entity in such class. Such fees shall be collected and available only to the extent and in such amounts as provided in advance in appropriations acts.".

Sec. 222 The following unobligated balances of amounts appropriated prior to fiscal year 2007 for "Department of Health and Human Services, Health Resources and Services Administration" are hereby permanently cancelled:

(a) $281,003 appropriated to carry out section 1610(b) of the PHS Act;

(b) $3,611 appropriated to carry out section 1602(c) of the PHS Act;

(c) $105,576 appropriated in section 167 of Division H of Public Law 108–199; and

(d) $55,793 appropriated to carry out the National Cord Blood Stem Cell Bank Program.

(Department of Health and Human Services Appropriations Act, 2015.)

[Sec. 601. For purposes of preventing, preparing for, and responding to Ebola domestically or internationally, the Secretary of Health and Human Services may use funds provided in this title—

(1) for the CDC to acquire, lease, construct, alter, renovate, equip, furnish, or manage facilities outside of the United States, as necessary to conduct such programs, in consultation with the Secretary of State, either directly for the use of the United States Government or for the use, pursuant to grants, direct assistance, or cooperative agreements, of public or nonprofit private institutions or agencies in participating foreign countries;

(2) for the CDC to obtain by contract (in accordance with section 3109 of title 5, but without regard to the limitations in such section on the period of service and on pay) the personal services of experts or consultants who have scientific or other professional qualifications, except that in no case shall the compensation provided to any such expert or consultant exceed the daily equivalent of the annual rate of compensation for Executive Level II employees; and

(3) to use available resources to provide Federal assistance as necessary for repatriation notwithstanding the limitation on temporary assistance in section 1113(d) of the Social Security Act. **]**

[Sec. 602. The Secretary shall provide notice to the Committees on Appropriations of the House of Representatives and the Senate within 15 days of the use of the provisions in section 601. **]**

[Sec. 603. A grant awarded by the Department of Health and Human Services with funds made available by this title may be made conditional on agreement by the awardee to comply with existing and future guidance from the Secretary regarding control of the spread of the Ebola virus. **]**

[(TRANSFER OF FUNDS)**]**

[Sec. 604. Funds appropriated in this title may be transferred to, and merged with, other appropriation accounts of the Centers for Disease Control and Prevention, the Assistant Secretary for Preparedness and Response, or the National Institutes of Health for the purposes specified in this title following consultation with the Office of Management and Budget: Provided, That the Committees on Appropriations of the House of Representatives and the Senate shall be notified 10 days in advance of any such transfer: Provided further, That, upon a determination that all or part of the funds transferred from an appropriation are not necessary, such amounts may be transferred back to that appropriation: Provided further, That none of the funds made available by this title may be transferred pursuant to the authority in section 206 of this Act or section 241(a) of the PHS Act. **]**

(Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2015.)

TITLE V

(TRANSFER OF FUNDS)

SEC. 501. The Secretaries of Labor, Health and Human Services, and Education are authorized to transfer unexpended balances of prior appropriations to accounts corresponding to current appropriations provided in this Act. Such transferred balances shall be used for the same purpose, and for the same periods of time, for which they were originally appropriated.

SEC. 502. No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year unless expressly so provided herein.

SEC. 503. (a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

(b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, *or* appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative *and State-local* relationships *for presentation to any State or local legislature or legislative body itself,* or *for* participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government. **[**(c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.**]**

SEC. 505. When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state—

(1) the percentage of the total costs of the program or project which will be financed with Federal money;

(2) the dollar amount of Federal funds for the project or program; and

(3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.

SEC. 506. (a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term "health benefits coverage'' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

SEC. 507. (a) The limitations established in the preceding section shall not apply to an abortion—

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

(d) (1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(2) In this subsection, the term "health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

SEC. 508. (a) None of the funds made available in this Act may be used for—

(1) the creation of a human embryo or embryos for research purposes; or

(2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

(b) For purposes of this section, the term "human embryo or embryos'' includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

SEC. 509. (a) None of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act except for normal and recognized executive-congressional communications.

(b) The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

SEC. 510. None of the funds made available in this Act may be used to promulgate or adopt any final standard under section 1173(b) of the Social Security Act providing for, or providing for the assignment of, a unique health identifier for an individual (except in an individual's capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard.

SEC. 511. None of the funds made available in this Act may be obligated or expended to enter into or renew a contract with an entity if—

(1) such entity is otherwise a contractor with the United States and is subject to the requirement in 38 U.S.C. 4212(d) regarding submission of an annual report to the Secretary of Labor concerning employment of certain veterans; and

(2) such entity has not submitted a report as required by that section for the most recent year for which such requirement was applicable to such entity.

[SEC. 512. None of the funds made available in this Act may be transferred to any department, agency, or instrumentality of the United States Government, except pursuant to a transfer made by, or transfer authority provided in, this Act or any other appropriation Act.**]**

[SEC. 514. (a) None of the funds provided under this Act, or provided under previous appropriations Acts to the agencies funded by this Act that remain available for obligation or expenditure in fiscal year 2014, or provided from any accounts in the Treasury of the United States derived by the collection of fees available to the agencies funded by this Act, shall be available for obligation or expenditure through a reprogramming of funds that—

(1) creates new programs;

(2) eliminates a program, project, or activity;

(3) increases funds or personnel by any means for any project or activity for which funds have been denied or restricted;

(4) relocates an office or employees;

(5) reorganizes or renames offices;

(6) reorganizes programs or activities; or

(7) contracts out or privatizes any functions or activities presently performed by Federal employees; unless the Committees on Appropriations of the House of Representatives and the Senate are consulted 15 days in advance of such reprogramming or of an announcement of intent relating to such reprogramming, whichever occurs earlier, and are notified in writing 10 days in advance of such reprogramming.

(b) None of the funds provided under this Act, or provided under previous appropriations Acts to the agencies funded by this Act that remain available for obligation or expenditure in fiscal year 2014, or provided from any accounts in the Treasury of the United States derived by the collection of fees available to the agencies funded by this Act, shall be available for obligation or expenditure through a reprogramming of funds in excess of $500,000 or 10 percent, whichever is less, that—

(1) augments existing programs, projects (including construction projects), or activities;

(2) reduces by 10 percent funding for any existing program, project, or activity, or numbers of personnel by 10 percent as approved by Congress; or

(3) results from any general savings from a reduction in personnel which would result in a change in existing programs, activities, or projects as approved by Congress; unless the Committees on Appropriations of the House of Representatives and the Senate are consulted 15 days in advance of such reprogramming or of an announcement of intent relating to such reprogramming, whichever occurs earlier, and are notified in writing 10 days in advance of such reprogramming.**]**

[SEC. 515. (a) None of the funds made available in this Act may be used to request that a candidate for appointment to a Federal scientific advisory committee disclose the political affiliation or voting history of the candidate or the position that the candidate holds with respect to political issues not directly related to and necessary for the work of the committee involved.

(b) None of the funds made available in this Act may be used to disseminate information that is deliberately false or misleading.**]**

[SEC. 516. Within 45 days of enactment of this Act, each department and related agency funded through this Act shall submit an operating plan that details at the program, project, and activity level any funding allocations for fiscal year 2015 that are different than those specified in this Act, the accompanying detailed table in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act) accompanying this Act, or the fiscal year 2015 budget request.**]**

[SEC. 517. The Secretaries of Labor, Health and Human Services, and Education shall each prepare and submit to the Committees on Appropriations of the House of Representatives and the Senate a report on the number and amount of contracts, grants, and cooperative agreements exceeding $500,000 in value and awarded by the Department on a non-competitive basis during each quarter of fiscal year 2015, but not to include grants awarded on a formula basis or directed by law. Such report shall include the name of the contractor or grantee, the amount of funding, the governmental purpose, including a justification for issuing the award on a noncompetitive basis. Such report shall be transmitted to the Committees within 30 days after the end of the quarter for which the report is submitted.**]**

[(RESCISSION)**]**

[SEC. *520*. Of the funds made available for performance bonus payments under section 2105(a)(3)(E) of the Social Security Act, $1,745,000,000 are hereby rescinded. **]**

SEC. **[**521**]***514*. **[**Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.**]** *None of the funds contained in this Act may be used to distribute any needle or syringe for the purpose of preventing the spread of blood borne pathogens in any location that has been determined by the local public health or local law enforcement authorities to be inappropriate for such distribution.*

[(RESCISSION)**]**

[SEC. 522. Of the funds made available for fiscal year 2015 under section 3403 of Public Law 111–148, $10,000,000 are rescinded.**]**

[SEC. 523. Not later than 30 days after the end of each calendar quarter, beginning with the first quarter of fiscal year 2013, the Departments of Labor, Health and Human Services and Education and the Social Security Administration shall provide the Committees on Appropriations of the House of Representatives and Senate a quarterly report on the status of balances of appropriations: *Provided,* That for balances that are unobligated and uncommitted, committed, and obligated but unexpended, the quarterly reports shall separately identify the amounts attributable to each source year of appropriation (beginning with fiscal year 2012, or, to the extent feasible, earlier fiscal years) from which balances were derived.**]**

Sec. **[**524**]***515*. (a) Federal agencies may use Federal discretionary funds that are made available in this Act to carry out up to 10 Performance Partnership Pilots. Such Pilots shall:

(1) Be designed to improve outcomes for disconnected youth, and
(2) Involve Federal programs targeted on disconnected youth, or designed to prevent youth from disconnecting from school or work, that provide education, training, employment, and other related social services. Such Pilots shall be governed by the provisions of section 526 of **[** the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Act, 2014**]** *division H of Public Law 113–76,* except that in carrying out such Pilots section 526 shall be applied by substituting **[**"fiscal year 2015"**]** *"fiscal year 2016"* for **[**"fiscal year 2014"**]** *"fiscal year 2015"* in the title of subsection (b) and by substituting **[**"September 30, 2019"**]** *"September 30, 2020"* for **[**"September 30, 2018"**]** *"September 30, 2019"* each place it appears.

(b) In addition, Federal agencies may use Federal discretionary funds that are made available in this Act to participate in Performance Partnership Pilots that are being carried out pursuant to the authority provided by Section 526 of **[**the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2014**]** *division H of Public Law 113–76, and section 524 of division G of Public Law 113-235.*

[SEC. 525. Each Federal agency, or in the case of an agency with multiple bureaus, each bureau (or operating division) funded under this Act that has research and development expenditures in excess of $100,000,000 per year shall develop a Federal research public access policy that provides for—

(1) the submission to the agency, agency bureau, or designated entity acting on behalf of the agency, a machine-readable version of the author's final peer reviewed manuscripts that have been accepted for publication in peer-reviewed journals describing research supported, in whole or in part, from funding by the Federal Government;
(2) free online public access to such final peer-reviewed manuscripts or published versions not later than 12 months after the official date of publication; and
(3) compliance with all relevant copyright laws.**]**

SEC. **[**526**]***516*. (a) None of the funds made available in this Act may be used to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.

(b) Nothing in subsection (a) shall limit the use of funds necessary for any Federal, State, tribal, or local law enforcement agency or any other entity carrying out criminal investigations, prosecution, or adjudication activities.

Sec. **[**527**]***517*. For purposes of carrying out Executive Order 13589, Office of Management and Budget Memorandum M-12–12 dated May 11, 2012, and requirements contained in the annual appropriations bills related to conference attendance and expenditures:

(1) the operating divisions of HHS shall be considered independent agencies; and
(2) attendance at and support for scientific conferences shall be tabulated separately from and not included in agency totals.

[(TRANSFER)**]**

[Sec. 528. (a) This section applies to the amounts that–

(1) are made available in this Act–
(A) under the heading “Rehabilitation Services and Disability Research” in title III; or
(B) under the heading “PROGRAM ADMINISTRATION” under the heading “Departmental Management” in title III; and
(2) relate to functions described in subsection (b), (m)(1), or (n)(2) of section 491 of the WIOA.

(b) Amounts described in subsection (a) shall be obligated, expended, and transferred in accordance with that section 491.**]**

Sec. **[**529**]***518*. None of the funds made available under this or any other Act, or any prior Appropriations Act, may be provided to the Association of Community Organizations for Reform Now (ACORN), or any of its affiliates, subsidiaries, allied organizations, or successors.

Sec. 519. WORK INJURY AND DISEASE COMPENSATION FOR NATIONAL DISASTER MEDICAL SYSTEM EMPLOYEES– Section 2812(d)(2) of the Public Health Service Act (42 U.S.C. 300hh-11(d)(2)) is amended–

(a) by redesignating the three sentences as subparagraphs (A), (B), and (C), respectively, and indenting accordingly;

(b) in subparagraph (A), as so redesignated, by striking "An" and inserting "IN GENERAL.–An";
(c) in subparagraph (B), as so redesignated, by striking "With" and inserting "APPLICATION TO TRAINING PROGRAMS. –With";
(d) in subparagraph (C), as so redesignated, by striking "In" and inserting "RESPONSIBILITY OF LABOR SECRETARY.–In"; and
(e) by adding at the end the following new subparagraphs:
"(D) COMPUTATION OF PAY.–In the event of an injury to such an intermittent disaster-response appointee, the position of the employee shall be deemed to be 'one which would have afforded employment for substantially a whole year,' for purposes of section 8114(d)(2) of such title.
"(E) CONTINUATION OF PAY.–The weekly pay of such an employee shall be deemed to be the hourly pay in effect on the date of the injury multiplied by 40, for purposes of computing benefits under section 8118 of such title.".

Sec. 520. EVALUATION FUNDING FLEXIBILITY PILOT–
(a) This section applies to:
(1) the Office of the Assistant Secretary for Planning and Evaluation within the Office of the Secretary and the Administration for Children and Families in the Department of Health and Human Services; and
(2) the Chief Evaluation Office and the statistical-related cooperative and interagency agreements and contracting activities of the Bureau of Labor Statistics in the Department of Labor.
(b) Amounts made available under this Act which are either appropriated, allocated, advanced on a reimbursable basis, or transferred to the functions and organizations identified in subsection (a) for research, evaluation, or statistical purposes shall be available for obligation through September 30, 2010. When an office referenced in subsection (a) receives research and evaluation funding from multiple appropriations, such offices may use a single Treasury account for such activities, with funding advanced on a reimbursable basis.
(c) Amounts referenced in subsection (b) that are unexpended at the time of completion of a contract, grant, or cooperative agreement may be deobligated and shall immediately become available and may be reobligated in that fiscal year or the subsequent fiscal year for the research, evaluation, or statistical purposes for which the amounts are made available to that account.

Sec. 521. Amounts deposited or available in the Child Enrollment Contingency Fund from appropriations to the Fund under section 2104(n)(2)(A)(i) of the Social Security Act and the income derived from investment of those funds pursuant to 2104(n)(2)(C) of that Act, shall not be available for obligation in this fiscal year.

CANCELLATION

Sec. 522. Of any available amounts appropriated under section 108 of Public Law 111 – 3, as amended, $3,330,000,000 are hereby permanently cancelled. (Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2015.)