DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2015

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 2015	FTE	Budget Authority
General Departmental Management	1103	286,204,000
Pregnancy Assistance Fund	2	25,000,000
Prevention and Public Health Fund	16	104,790,000
PHS Evaluation Set-Aside – Public Health Service Act	144	118,728,000

FY 2015	FTE	Budget Authority
HCFAC[1]	0	13,000,000
GDM Program Level	***1265***	***547,722,000***

FY 2015	FTE	Budget Authority
Office of Medicare Hearings and Appeals	651	100,000,000
Office of Civil Rights	198	41,205,000
Office of the National Coordinator for Health IT	191	74,688,000

FY 2015	FTE	Budget Authority
Service and Supply Fund	1,324	0
TOTAL, Departmental Management	**3,629**	**763,615,000**

[1] The reimbursable program (HCFAC) in the General Department Management (GDM) account reflects estimates of the allocation account for 2015. Actual allocation will be determined annually.

INTRODUCTION

The FY 2015 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 2015 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 2015 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2015 Annual Performance Report and FY 2015 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 $764 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 request also increases funding for the Office of Civil Rights to support centralized case management operations.

The Secretary looks forward to working with the Congress toward the enactment and implementation of an FY 2015 Budget that advances the Nation's health and supports families.

Ellen G. Murray
Assistant Secretary for Financial Resources

Departmental Management Overview

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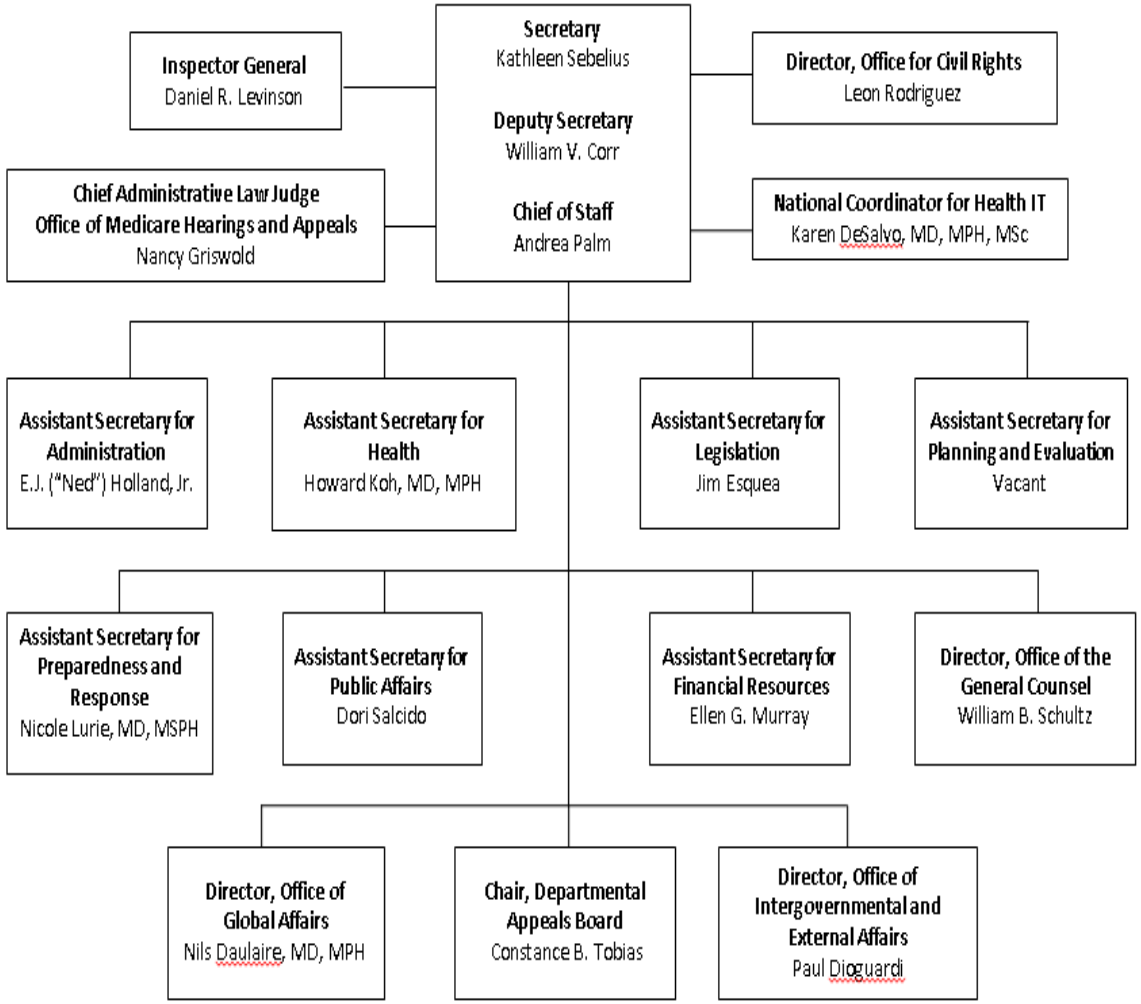
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY ORGANIZATIONAL CHART



ORGANIZATIONAL CHART: TEXT VERSION

Department of Health and Human Services

- Secretary Kathleen Sebelius
  - Deputy Secretary William V. Corr
  - Chief of Staff Andrea Palm

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
  - Leon Rodriguez
- National Coordinator for Health Information Technology
  - Karen DeSalvo, MD, MPH, MSc
- Assistant Secretary for Administration
  - E.J. “Ned” Holland
- Assistant Secretary for Health
  - Howard Koh, MD, MPH
- Assistant Secretary for Legislation
  - Jim Esquea
- Assistant Secretary for Planning and Evaluation
  - Vacant
- Assistant Secretary for Preparedness and Response
  - Nicole Lurie, MD, MSPH
- Assistant Secretary for Public Affairs
  - Dori Salcido
- 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
  - Nils Daulaire, MD, MPH
- 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 2015 President's Budget for DM totals $763,615,000 in program level funding, including 3,629 full-time equivalent (FTE) positions a $18,602,000 increase above the FY 2014 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 2015, the GDM Budget includes a total of $286,204,000 in budget authority and 1,119 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 entirely from the Medicare Hospital Insurance and Supplemental Medical Insurance Trust Funds. For FY 2015 President's Budget, OMHA is requesting a total of $100,000,000 and 651 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 2015 President's Budget, OCR is requesting a total of $41,205,000 in budget authority and 198 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 2015 President's Budget, ONC requests $74,688,000 and 191 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 2015 President's Budget, the SSF is projecting total revenue of $1,143,786,000 and usage of 1,324 FTE.

DEPARTMENTAL MANAGEMENT
BUDGET BY APPROPRIATION

(Dollars in thousands)

Details	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
General Departmental Management	**$447,402**	**$458,056**	**$286,204**
Pregnancy Assistance Fund	**$23,725**	**$23,200**	**$25,000**
Prevention & Public Health	**$0**	**$0**	**$104,790**
PHS Evaluation Funds	**$69,211**	**$69,211**	**$118,728**
HCFAC Funds[1]	**$8,888**	**$13,000**	**$13,000**
Subtotal, GDM Program Level	***$549,226***	***$563,467***	***$547,722***
Office of Medicare Hearings and Appeals	**$69,444**	**$82,381**	**$100,000**
Office of Civil Rights	**$38,615**	**$38,798**	**$41,205**
Office of the National Coordinator for Health Information Technology	**$60,294**	**$60,367**	**$74,688**
Total, Departmental Management	**$717,579**	**$745,013**	**$763,615**

[1] The reimbursable program (HCFAC) in the General Department Management (GDM) account reflects estimates of the allocation account for 2015. Actual allocation will be determined annually.

General Departmental Management

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APPROPRIATIONS LANGUAGE
GENERAL DEPARTMENTAL MANAGEMENT

For necessary expenses, not otherwise provided, for general departmental management, including hire **[**six**]** of passenger motor vehicles, and for carrying out titles III, XVII, XXI , and section 229 of the PHS Act, the United States-Mexico Border Health Commission Act, and research studies under section 1110 of the Social Security Act, **[**$458,056,000**]***$286,204,000* together with **[**$69,211,000**]** *$118,728,000* from the amounts available under section 241 of the PHS Act to carry out national health or human services research and evaluation activities: **[**Provided , That of this amount, $52,224,000 shall be for minority AIDS prevention and treatment activities: Provided further, That of the funds made available under this heading, $104,790,000 shall be for making competitive contracts and grants to public and private entities to fund medically accurate and age appropriate programs that reduce teen pregnancy and for the Federal costs associated with administering and evaluating such contracts and grants, of which not less than $75,000,000 shall be for replicating programs that have been proven effective through rigorous evaluation to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors, of which not less than $25,000,000 shall be available for research and demonstration grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy, and of which any remaining amounts shall be available for training and technical assistance, evaluation, outreach, and additional program support activities:**]** Provided further, That of the amounts provided under this heading from amounts available under section 241 of the PHS Act, **[**$8,455,000**]** *$6,800,000* shall be available to carry out evaluations (including longitudinal evaluations) of teenage pregnancy prevention approaches, *and $53,900,000 shall be for minority AIDS prevention and treatment activities: Provided further,* That of the funds made available under this heading, $1,750,000 is for strengthening the Department's acquisition workforce capacity and capabilities*, including***[** Provided further, That with respect to the previous proviso, such funds shall be available**]** for training,**[** recruitment**]***recruiting*,**[**retention**]***retaining*, and hiring members of the acquisition workforce as defined by 41 U.S.C. 1703 **[**and**]** for information technology in support of acquisition workforce effectiveness, **[**or**]** *and* for management solutions to improve acquisition management**[**: Provided further that of the funds made available under this heading, $5,000,000 shall be for making competitive grants to provide abstinence education (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)**]**.

(Department of Health and Human Services Appropriations Act, 2014.)

LANGUAGE ANALYSIS

Language Provision	Explanation
"That of the funds made available under this heading $104,790,000 shall be for…"	HHS shall make amounts available for this activity under the Prevention and Public Health Fund in FY2015.

AUTHORIZING LEGISLATION

(Dollars in Thousands)

Details	2014 Authorized	2014 Enacted	2015 Authorized	2015 Enacted
General Departmental Management: except account below:	Indefinite	$175,886	Indefinite	$177,409
Reorganization Plan No. 1 of 1953	-	-	-	-
Office of the Assistant Secretary for Health: Public Health Service Act,	-	-	-	-
Title III, Section 301	Indefinite	$176,292	Indefinite	$28,795
Title, II Section 229 (OWH)	1	$34,050	1	$29,500
Title XVII Section 1701 (ODPHP)	2	$6,999	2	$7,000
Title XVII, Section 1707 (OMH)	3	$56,670	3	$36,000
Title XVII, Section 1708 (OAH)	4	$1,500	4	$1,500
Title XXI, Section 2101 (NVPO)	5	$6,659	5	$6,000
Subtotal	-	*$282,170*	-	*$108,795*
Total Appropriation	**-**	**$458,056**	**-**	**$286,204**

1) Authorizing legislation under Section 229 of the PHS Act expires September 30, 2014
2) Authorizing legislation under Section 1701 of the PHS Act expired September 30, 2002. Reauthorization will be proposed.
3) Authorizing legislation under 1707 of the PHS Act expires September 30, 2016.
4) Authorizing legislation under 1708 of the PHS Act expired September 30, 2000. Reauthorization will be proposed.
5) Authorizing legislation under Section 2101 of the PHS Act expired September 30, 2005. Reauthorization will be proposed.

AMOUNTS AVAILABLE FOR OBLIGATION

Detail	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Annual appropriation	$474,323,000	$458,056,000	$286,204,000
Rescission	-$949,000	-	-
Sequestration	-$23,861,000	-	-
Transfers	-$2,112,000	-	-
Subtotal, adjusted general funds	***$447,402,000***	***$458,056,000***	***$286,204,000***
Trust fund annual appropriation	-	-	-
Subtotal, adjusted budget authority	***$447,402,000***	**$458,056,000**	***$286,204,000***
Unobligated balance lapsing	-	-	-
Total Obligations	**$447,402,000**	**$458,056,000**	**$286,204,000**

SUMMARY OF CHANGES

(Dollars in Thousands)

Budget Year and Type of Authority	Dollars	FTE
FY 2014 Enacted Level	458,056	1,088
Total Adjusted Budget Authority	458,056	1,088
FY 2015 Current Request	286,204	1,103
Total Estimated Budget Authority	286,204	1,103
Net Changes	**171,852**	**+15**

Increases	FY 2014 Enacted Level	FY 2015 Request Change from Base
Immediate Office of the Secretary	10,995	+5
Assistant Secretary for Administration	17,958	+42
Assistant Secretary for Legislation	3,791	+9
Departmental Appeals Board	10,450	+2,050
ASFR, Financial Systems Integration and Acquisition Reform	30,724	+1,226
Office of Intergovernmental and External Affairs	9,576	+1,024
Rent, Operations and Maintenance	16,429	+71
Shared Operating Services	13,982	+3,407
Office of the Assistant Secretary for Health	37,225	+6,068
Other Direct Funding Non-Add	*6,270*	*0*
Total	**157,402**	**+13,902**

Decreases	FY 2014 Enacted Level	FY 2015 Request Change from Base
Secretary's Initiative/Innovations	2,735	-1,235
Assistant Secretary for Public Affairs	8,749	-49
Office of the General Counsel	39,226	-26
Teen Pregnancy Prevention	101,000	-101,000
Office of Minority Health	56,670	-20,670
Office of Women's Health	34,050	-4,550
Embryo Adoption Awareness Campaign	1,000	-1,000
Abstinence Education	5,000	-5,000
Minority HIV/AIDS	52,224	-52,224
Total	**300,654**	**-185,754**

Total Changes	FY 2014 Enacted Level	FY 2014 FTE	FY 2015 Request Change from Base	FY 2015 FTE Change from Base
Total Increase Changes	157,402	-	13,902	19
Total Decrease Changes	300,654	-	-185,754	-4
Total	**458,056**	**1,088**	**171,852**	**+15**

BUDGET AUTHORITY BY ACTIVITY - DIRECT

(Dollars in Thousands)

Activity	FY 2013 FTE	FY 2013 Final	FY 2014 FTE	FY 2014 Enacted	FY 2015 FTE	FY 2015 President's Budget
Immediate Office of the Secretary	79	10,995	72	10,995	72	11,000
Secretarial Initiatives and Innovations	-	2,735	-	2,735	-	1,500
Assistant Secretary for Administration	117	17,958	116	17,958	114	18,000
Assistant Secretary for Financial Resources	150	28,820	149	28,974	149	30,200
Acquisition Reform	1	681	1	1,750	1	1,750
Assistant Secretary for Legislation	26	3,791	26	3,791	27	3,800
Assistant Secretary for Public Affairs	44	22,754	56	8,749	56	8,700
Office of General Counsel	227	39,226	236	39,226	236	39,200
Departmental Appeals Board	76	10,450	80	10,450	90	12,500
Office on Disability	-	1,041	-	-	-	-
Office of Global Affairs	25	6,270	24	6,270	22	6,270
Office of Intergovernmental and External Affairs	52	9,576	60	9,576	60	10,600
Office of the Assistant Secretary for Health	274	207,698	268	228,946	276	108,795
Embryo Adoption Awareness Campaign	-	1,000	-	1,000	-	-
HIV/AIDS in Minority Communities	-	50,354	-	52,224	-	-
Shared Operating Expenses	-	12,943	-	13,982	-	17,389
Rent, Operations, Maintenance and Related Services	-	16,429	-	16,429	-	16,500
Abstinence Education	-	4,681	-	5,000	-	-
Transportation Assistance	-	-	-		-	
Total, Budget Authority	**1,071**	**447,402**	**1,088**	**458,056**	**1,103**	**286,204**

BUDGET AUTHORITY BY OBJECT CLASS - DIRECT

(Dollars in Thousands)

Object Class Code	Description	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
11.1	Full-time permanent	90,329	91,920	92,878
11.3	Other than full-time permanent	13,827	11,827	11,907
11.5	Other personnel compensation	2,045	3,045	3,006
11.7	Military personnel	3,153	3,773	5,645
Subtotal	***Personnel Compensation***	***109,353***	***110,564***	***113,436***
12.1	Civilian personnel benefits	28,371	28,333	28,495
12.2	Military benefits	1,559	1,651	2,088
13.0	Benefits for former personnel	-	-	-
Total	***Pay Costs***	***139,283***	***140,548***	***144,019***
21.0	Travel and transportation of persons	4,839	4,832	4,258
22.0	Transportation of things	185	185	182
23.1	Rental payments to GSA	18,535	17,541	16,551
23.3	Communications, utilities, and misc. charges	3,616	3,610	3,537
24.0	Printing and reproduction	853	853	842
25.1	Advisory and assistance services	26,789	28,118	14,731
25.2	Other services from non-Federal sources	42,978	37,573	30,505
25.3	Other goods and services from Federal sources	78,187	70,092	35,557
25.4	Operation and maintenance of facilities	2,242	2,410	5,476
25.5	Research and development contracts	-	-	-
25.6	Medical care	-	-	-
25.7	Operation and maintenance of equipment	5,154	4,154	4,154
25.8	Subsistence and support of persons	106	106	106
26.0	Supplies and materials	2,450	1,449	1,436
31.0	Equipment	1,847	1,247	420
32.0	Land and Structures	-	-	-
41.0	Grants, subsidies, and contributions	120,333	145,334	24,426
42.0	Insurance claims and indemnities	4	4	4
44.0	Refunds	-	-	-
Total	***Non-Pay Costs***	***308,119***	***317,507***	***142,184***
Total	**Budget Authority by Object Class**	**447,402**	**458,056**	**286,204**

BUDGET AUTHORITY BY OBJECT CLASS - REIMBURSABLE

(Dollars in Thousands)

Object Class Code	Description	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
11.1	Full-time permanent	47,921	47,070	47,681
11.3	Other than full-time permanent	2,886	2,876	2,905
11.5	Other personnel compensation	857	931	994
11.7	Military personnel	1,496	1,491	892
Subtotal	***Personnel Compensation***	***53,160***	***52,369***	***52,472***
12.1	Civilian personnel benefits	10,327	9,864	9,738
12.2	Military benefits	435	444	507
13.0	Benefits for former personnel	-	-	-
Total	***Pay Costs***	***63,922***	***62,677***	***62,717***
21.0	Travel and transportation of persons	1,591	1,139	1,649
22.0	Transportation of things	124	106	109
23.1	Rental payments to GSA	6,121	6,109	6,109
23.3	Communications, utilities, and misc. charges	141	144	147
24.0	Printing and reproduction	25	34	44
25.1	Advisory and assistance services	37,968	40,490	40,893
25.2	Other services from non-Federal sources	16,513	15,931	16,258
25.3	Other goods and services from Federal sources	125,023	90,134	119,547
25.4	Operation and maintenance of facilities	2,464	2,549	2,549
25.5	Research and development contracts	-	-	-
25.6	Medical care	-	-	-
25.7	Operation and maintenance of equipment	2,863	3,129	3,129
25.8	Subsistence and support of persons	-	-	-
26.0	Supplies and materials	402	391	394
31.0	Equipment	262	257	257
32.0	Land and Structures	53	54	54
41.0	Grants, subsidies, and contributions	2,837	3,107	21,376
42.0	Insurance claims and indemnities	-	-	-
44.0	Refunds	-	-	-
Total	***Non-Pay Costs***	***196,387***	***163,574***	***212,515***
Total	*Budget Authority by Object Class*	**260,309**	**226,251**	**275,232**

SALARY AND EXPENSES

(Dollars in Thousands)

Object Class Code	Description	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
11.1	Full-time permanent	90,329	91,920	92,878
11.3	Other than full-time permanent	13,827	11,827	11,907
11.5	Other personnel compensation	2,045	3,045	3,006
11.7	Military personnel	3,153	3,773	5,645
Subtotal	***Personnel Compensation***	***109,353***	***110,564***	***113,436***
12.1	Civilian personnel benefits	28,371	28,333	28,495
12.2	Military benefits	1,559	1,651	2,088
13.0	Benefits for former personnel	-	-	-
Total	***Pay Costs***	***139,283***	***140,548***	***144,019***
21.0	Travel and transportation of persons	4,839	4,832	4,258
22.0	Transportation of things	185	185	182
23.3	Communications, utilities, and misc. charges	3,616	3,610	3,537
24.0	Printing and reproduction	853	853	842
25.1	Advisory and assistance services	26,789	28,118	14,731
25.2	Other services from non-Federal sources	42,978	37,573	30,505
25.3	Other goods and services from Federal sources	78,187	70,092	35,557
25.4	Operation and maintenance of facilities	2,242	2,410	5,476
25.5	Research and development contracts	-	-	-
25.6	Medical care	-	-	-
25.7	Operation and maintenance of equipment	5,154	4,154	4,154
25.8	Subsistence and support of persons	106	106	106
26.0	Supplies and materials	2,450	1,449	1,436
Subtotal	***Non-Pay Costs***	***167,400***	***153,381***	***100,783***
Total	**Salary and Expenses**	**306,683**	**293,929**	**244,803**
23.1	Rental payments to GSA	18,535	17,541	16,551
Total	**Salaries, Expenses, and Rent**	**325,218**	**311,470**	**261,354**
Total	**Direct FTE**	**1,071**	**1,088**	**1,103**

APPROPRIATION HISTORY TABLE

(Dollars in Thousands)

2004

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
Appropriation	348,100,000	343,284,000	344,808,000	357,358,000
Rescission	-	-	-	-3,209,000
Trust Funds	**5,851,000**	**5,851,000**	**5,851,000**	**5,851,000**

2005

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
Appropriation	431,971,000	349,297,000	376,704,000	371,975,000
Rescission	-	-	-	-3,977,000
Trust Funds	**5,851,000**	**5,851,000**	**5,851,000**	**5,851,000**

2006

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
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

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
Appropriation	362,568,000	-	-	350,945,000
Rescission	-	-	-	-500,000
Supplemental	13,512,000	-	-	-
Trust Funds	**5,851,000**	**-**	**-**	**5,793,000**

2008

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
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

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
Appropriation	374,013,000	361,825,000	361,764,000	391,496,000
Transfers	-	-	-1,000,000	-2,571,000
Trust Funds	**5,851,000**	**5,851,000**	**5,851,000**	**5,851,000**

2010

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
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

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
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

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
Appropriation	363,644,000	343,280,000	476,221,000	475,221,000
Rescission	-	-	-	-898,000
Transfers	**-**	**-**	**-**	**-70,000**

2013

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
Appropriation	306,320,000	-	466,428,000	474,323,000
Rescission	-	-	-	-949,000
Sequestration	-	-	-	-23,861,000
Transfers	**-**	**-**	**-**	**-2,112,000**

2014

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
Appropriation	301,435,000	-	477,208,000	458,056,000

General Departmental Management
All Purpose Table

(Dollars in Thousands)

GDM	FY 2013 Actual	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	**$447,402**	**$458,056**	**$286,204**	**-$171,852**
FTE	1,071	1,088	1,103	+15

Related Funding (non-add)	FY 2013 Actual	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Pregnancy Assistance Fund P.L. (111-148)	*$23,725*	*$23,200*	*$25,000*	*+$1,800*
Prevention and Public Health Fund P.L. (111-148) (GDM Allocation)	*$0*	*$0*	*$104,790*	*+$104,790*
PHS Evaluation Set-Aside – Public Health Service Act	*$69,211*	*$69,211*	*$118,728*	*+$49,517*
HCFAC[1]	*$8,888*	*$13,000*	*$13,000*	*$0*

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 2015 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).

[1] The reimbursable program (HCFAC) in the General Department Management (GDM) account reflects estimates of the allocation account for 2015. Actual allocation will be determined annually.

FY 2015 BUDGET BY HHS STRATEGIC GOAL

(Dollars in Millions)

HHS Strategic Goals	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
1.Transform Health Care	**187.4**	**191.4**	**187.7**
1.A Make coverage more secure	1.0	1.3	1.0
1.B Improve health care quality and patient safety	62.8	63.5	62.5
1.C Emphasize primary & preventative care, link to prevention	3.0	3.2	3.2
1.D Reduce growth of health care costs promoting high-value	4.3	4.5	4.5
1.E Ensure access to quality culturally competent care	63.8	64.6	63.7
1.F Promote the adoption of health information technology	52.5	54.3	52.8
2. Advance Scientific Knowledge and Innovation	**14.8**	**15.7**	**14.5**
2.A Accelerate scientific discovery to improve patient care	7.3	8.2	7.0
2.B Foster innovation at HHS to create shared solutions	2.0	2.0	2.0
2.C Invest in sciences to improve food & medical product safety	2.5	2.5	2.5
2.D Increase understanding of what works in health & services	3.0	3.0	3.0
3. Advance the Health, Safety and Well-Being of the American People	**276.7**	**283.9**	**273.9**
3.A Ensure the children & youth safety, well-being & health	116.5	120.2	118.0
3.B Promote economic & social well-being	15.7	16.8	15.1
3.C Improve services for people with disabilities and elderly	3.0	3.0	2.8
3.D Promote prevention and wellness	65.6	66.4	64.2
3.E Reduce the occurrence of infectious diseases	63.4	64.5	62.3
3.F Protect Americans' health and safety during emergencies	12.5	13.0	11.5
4. Increase Efficiency, Transparency and Accountability of HHS Programs	**32.8**	**34.3**	**33.8**
4.A Ensure program integrity and responsible stewardship	16.5	17.5	17.5
4.B Fight fraud and work to eliminate improper payments	6.3	6.3	6.3
4.C Use HHS data to improve American health & well-being	5.5	6.0	5.5
4.D Improve HHS environmental performance for sustainability	4.5	4.5	4.5
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce	**37.5**	**38.2**	**37.8**
5.A Invest in HHS workforce to help meet America's health and human service needs today & tomorrow	16.3	16.8	16.6
5.B Ensure health care workforce meets increased demands.	6.0	6.0	6.0
5.C Enhance the ability of the public health workforce to improve health at home.	7.0	7.0	7.0
5.D Strengthen the Nation's human service workforce	7.0	7.2	7.0
5.E Improve national, State & local surveillance capacity	1.2	1.2	1.2
Total GDM Program Level	**549.2**	**563.5**	**547.7**

OVERVIEW OF BUDGET REQUEST

The FY 2015 President's Budget for General Departmental Management (GDM) includes $286,204,000 in appropriated funds and 1,103 full-time equivalent (FTE) positions. This request is $171,852,000 less than the FY 2014 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 2013 HHS took steps to continue implementation of Health Reform and other ongoing public health initiatives through eliminating or reallocating resources and supporting new and focused strategic partnerships to provide national health leadership. The FY 2015 Congressional Justification is an extension of the FY 2014 activities. 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.

While not a request for budget authority, the Affordable Care Act (ACA) established a mandatory appropriation for prevention and public health activities. The FY 2015 Budget funding of $104,790,000, shifts from GDM budget authority to the Prevention and Public Health Fund. A section on Prevention and Public Health Fund allocations with a funding table is included at the end of the GDM justification.

This Budget funds HIV/AIDS in Minority Communities in the amount of $53,900,000. The FY 2015 CJ suggests a shift from GDM budget authority to the PHS Evaluation Fund.

Funding for Abstinence Education ($5,000,000), was appropriated in 2014, but not requested by HHS. HHS is not requesting continuation of funds for this program in FY 2015.

HHS is not requesting $1,000,000 in funds for Embryo Adoption for the FY 2015 President's Budget.

The FY 2015 Budget for GDM reflects the following significant changes from the FY 2014 Enacted Level.

Departmental Appeals Board (+$2,050,000) - The increase supports DAB's Medicare Operations Division (MOD) in meeting the needs of Medicare beneficiaries by addressing the growing number of cases appealed from the Office of Medicare Hearings and Appeals (OMHA). Similar to OMHA, MOD is experiencing a growing backlog, as its caseload is projected to increase 93% from FY 2013 to FY 2015.

IEA (+$1,024,000) – The increase of $1,024,000 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.

Secretary's Initiatives and Innovations (-$1,235,000) – The budget will allow the Secretary to continue to fund innovative programs to address new and existing critical health issues.

Office of the Assistant Secretary for Health (-$19,150,000) – 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. The Office of Minority Health FY 2015 President's Budget is $20,670,000 less than the FY 2014 Enacted Level. This reduction will be primarily accomplished through

streamlining contract support for the Office of Minority Health Resource Center (OMHRC), Center for Linguistic and Cultural Competency in Health Care (CLCCHC), implementation of the National Partnership for Action (NPA), and logistics support. The FY 2015 Office of Women's Health request is $4,550,000 less than the FY 2014 Enacted Level. OWH will continue to focus on its Departmental leadership role, coordinating policy development and initiatives impacting women's health across HHS and will fund the continuation of current grants and cooperative agreements for women's health.

IMMEDIATE OFFICE OF THE SECRETARY

Budget Summary
(Dollars in Thousands)

Immediate Office of the Secretary	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	10,995	10,995	11,000	+5
FTE	79	72	72	0

Authorizing Legislation: ……..Title III of the PHS Act
FY 2015 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 leads the Administration's health and human services agenda and drives the Department's policy formulation. 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 achieves these objectives by ensuring key issues are brought to leadership's attention in a timely manner, facilitating discussions on policy issues, reviewing documents requiring Secretarial action for policy consistent with that of the Secretary and the Administration, and coordinating the appropriate release of regulatory documents. 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.

IOS provides the advisory management and executive leadership essential for the Secretary to manage and direct the myriad of HHS programs. This includes the Executive Secretariat which coordinates and facilitates HHS policy decisions by ensuring that appropriate decision makers contribute relevant information into the decision making process and policy implementation.

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 policy decisions. IOS provides assistance, direction, and coordination to the White House and other Cabinet agencies regarding HHS issues.

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 2010	$10,925,000
FY 2011	$11,108,000
FY 2012	$11,289,000
FY 2013	$10,995,000
FY 2014	$10,995,000

Budget Request

The FY 2015 budget request for IOS is $11,000,000, $5,000 above the FY 14 Enacted. Current funding levels will be utilized to maintain personnel costs and other services to support achieving the Department's Health Care, Human Services, Scientific Research, Health Data, and Workforce Development Strategic Goals. The increased funding will assist with development of Health Data initiatives, tracking and coordination of Departmental correspondence and inquiries at a strategic level in regards to implementation and review of new and proposed laws

Immediate Office of the Secretary - Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
1.1 Increase number of identified opportunities for public engagement and collaboration among agencies (Output)	FY 2013: 496 Target: 346 (Target Exceeded)	500	510	+10
1.2 Increase number of high-value data sets and tools that are published by HHS (Output)	FY 2013: 1025 Target: 288 (Target Exceeded)	1200	1440	+240
1.3 Increase the number of participation and collaboration tools and activities conducted by the participation and collaboration community of practice (Output)	FY 2013: 12 Target: 12 (Target Met)	13	14	+1

Performance Analysis for 2013

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

In 2013, HHS exceeded its targets. The Department projected 346 engagement opportunities and identified 496 opportunities in that year. To advance our open government aims and increase participation in federal advisory committee meetings by the public, HHS leadership requested that all HHS Federal Advisory Committees use webcasting technologies or other means to engage the public in open meetings. As of September 30, 2013 all 270 HHS FACs are complying with this request. On the challenge competition front, HHS is continuing to attract new solvers to our challenge competitions, which provides an important mechanism through which external stakeholders can participate in the co-creation of solutions. Over 30 challenges were released by HHS during 2013, totaling more than $1 million in prize money and focusing on solving a broad range of health and health data problems. During 2013, HHS hired a new Director of Open Government Challenges and Competitions and are ramping up outreach and assistance to challenge managers across HHS. The digital strategy has continued to call attention to the development of API's as an important mechanism for allowing the public to access HHS

data. During 2013 HHS added more than a hundred new API's. During 2014, HHS expect to further increase opportunities for public collaboration and engagement. HHS are exploring ways in which the Department can simplify the acquisition of challenge management services as HHS is increasing options for use of flexible platform that HHS challenge managers could run challenges on. HHS is also exploring ways to upgrade webcasting technologies across the Office of the Secretary to encourage further adoption of these technologies. Finally, HHS expect the number of APIs to grow as more data sets become available.

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

In 2013, HHS published 727 additional datasets bringing the total number of datasets to 1025 (while HHS are doing a lot of data federation, the measure only reflects HHS datasets). Passing the symbolic 1000 dataset milestone, which significantly exceeded initial projections, was the result of more focused efforts by every HHS division's Health Data Lead to locate and catalog the high quality datasets developed and maintained by HHS agencies. The HHS chief Technology Officer's office began more robust outreach efforts to the HHS community and review of potential submissions. Moving forward, under the guidance of the CTO, HHS will execute its first ever Strategic and Execution plan which articulates a clear mission and goals with a specific set of planned actions to achieve those goals. The goals are: improving the usability of HealthData.gov; highlighting datasets that support HHS' strategic plan (Strategically Relevant Data Assets (SRDA)); educating new and existing users about data assets; incentivizing the data's use; and implementing administration and departmental open data policies. In 2013, HHS began experimenting with new ways of educating 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 Health Datapalooza. HHS expect to do more of this type of data education and engagement moving forward, and this should result and 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 2013, 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 12 projects. Each of the projects is labor-intensive, and thus only a few projected are selected in a given year. In 2013, the following 12 projects HHS successfully executed: 1) HHS launched a new innovation program called HHS Ignite that provides seed funding and mentoring to HHS employees for the purpose of incubating and testing new ideas. In response to our call, HHS employees submitted 66 applications, and among these 13 were chosen for funding. 2) HHS continued efforts to roll out 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, create collaborative workgroups, and serve as a knowledge repository. 3) HHS launched a sixth 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) HHS launched a second round of HHS Entrepreneurs, a program that pairs internal and external expertise to solve high priority problems. In this second round HHS brought to HHS a total of 10 external entrepreneurs on 9 projects, across six different Operating and Staff Divisions. 5) HHS held 10 HHS Innovation Council meetings in which HHS invited speakers from inside and outside of government to engage HHS leadership and staff on innovation topics such social networking and behavior Insight theory. 6) IOS developed an HHS working group on crowd funding in which HHS explored new ways to engage the public in co-creating solutions. As part of the workgroup, IOS assisted two units within HHS (NIH and ODPHP) to run challenge competitions that included crowd

funding components. 7) IOS led the development and successful execution of the fourth annual HHS Datapalooza, an event that attracted over 2000 participants and showcased 250 exciting new health applications and products; 8) IOS launched in 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 2013 developed and helped to release the first set of standard for Blue Button Data Sharing. 9) HHS held a public meeting in collaboration with HRSA to receive public input on new methodologies and potential applications HHS text libraries. 10) IOS held an HHS-wide telecast event in collaboration with the Partnership for Public Service at which IOS engaged the six HHS teams that won the Samuel J. Heyman Awards for excellence in Public Service to share their innovation experiences with HHS employees. 11) In collaboration Health 2.0 and a number of HHS divisions, HHS supported the second annual Cajun CodeFest, which brought together 350 people to develop tools that could encourage and support patients to "support their own health" through data-driven applications. 12) Our staff actively participated in DC-to-VC events, which are geared toward engaging entrepreneurs from across the country to find the best venture-backable start-up ideas.

In 2014, the Office of the Secretary will be launching the IDEA Lab (representing Innovation, Design, Entrepreneurship, and Action) is an HHS-wide concept being launched to transform the current structure of government to make it more modern and effective in service to the public. The IDEA Lab is both a new philosophy and a program that will provide government employees and members of the public, new means of engaging to problem solve and innovate.

SECRETARIAL INITIATIVES AND INNOVATIONS

Budget Summary
(Dollars in Thousands)

Secretarial Initiatives and Innovations	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	2,735	2,735	1,500	-1,235
FTE	0	0	0	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2015 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 they continue 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 2010	$1,600,000
FY 2011	$1,600,000
FY 2012	$2,738,000
FY 2013	$2,735,000
FY 2014	$2,735,000

Budget Request

The FY 2015 Budget for Secretarial Initiatives and Innovation is $2,700,000, which reflects a $1,235,000 reduction from the FY 2014 Enacted. The funding will continue to allow the Secretary to be prepared 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	17,958	17,958	18,000	+42
FTE	117	116	114	0

Authorizing Legislation: ……..Title III of the PHS Act
FY 2015 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 through eight components. Five are ASA GDM funded entities, 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. Facilities and Logistics Services are provided pm a fee-for-service basis through the PSC. The Office of Security and Strategic Information and the Program Support Center 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 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.

OHR provides leadership in creating and sustaining a diverse workforce and an environment free of discrimination at HHS. OHR works proactively to enhance the employment of women, minorities, veterans, and people with disabilities through efforts that include policy development, oversight, complaint prevention, investigations and processing, outreach, commemorative events, and standardized education and training programs.

OHR continues to implement the *Human Resource Information Technology End to End Strategy*. In FY 2013, OHR in conjunction with the HR Centers selected the National Finance Center as the provider, completed the requirements gathering and recruited subject matter experts from the Operating and Staff Divisions to support the effort.

The Department received approval to decentralize Human Resource operations in 2012. OHR worked with HR Centers and Operating/Staff Division points of contact to establish an HR specific accounting structure to electronically capture HHS HR costs. Automated reporting will begin in FY 2014.

In support of the President's hiring reform initiative, OHR convened a hiring process assessment team of senior level hiring managers to identify major pain points in the current hiring process and develop solutions to address these department-wide impediments. The results of this initiative have included

policy modifications that clarify the role of hiring managers; including their designation as subject matter experts (SMEs) in the recruitment and selection and a more active role in the position classification process. In addition, OHR has developed a detailed hiring checklist for use by hiring managers and HR specialists to help our hiring managers more easily navigate the federal hiring process.

Equal Employment Opportunity Compliance and Operations Division (EEOCO)

EEOCO provides services to every HHS employee and applicant ensuring equal access to EEO services, timely resolution of complaint as well as an equitable remedy. The Compliance Team provides leadership, oversight, technical guidance and engages in policy development for the complaint processing units in the HHS Operating Division (OPDIV) EEO Offices. Recent Accomplishments include processing Remands, Appeals and Conflict Cases; writing Commission Corp decisions, Final Orders and Final Agency Decisions. Further, 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.

Facilities and Logistics Service (FLS)

Functions of the former Office for Facilities Management and Policy (OFMP) have been reassigned to the Facilities and Logistics Service (FLS), a component of the Program Support Center. The critical Departmental policy and oversight functions originally assigned to OFMP continue to be provided through FLS. FLS is responsible for the HHS Real Property Asset Management program, and in this role provides management oversight across the HHS portfolio of real property assets to ensure appropriate stewardship and accountability is maintained. In addition, FLS is responsible for the operation of the HHS headquarters facility, the Hubert H. Humphrey Building, and oversight of HHS-occupied space in the Southwest Complex of Washington, DC.

Office of the Chief Information Officer (OCIO)

OCIO advises the Department on matters pertaining to the use of information and related technologies to accomplish Departmental goals and program objectives. OCIO establishes and provides assistance and guidance 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 promulgates HHS IT policies supporting enterprise architecture, capital planning and project management, and security.

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

OCIO is responsible for compliance, service level agreement management, delivery of services, service and access optimization, technology refreshment, interoperability and migration of new services. OCIO works to develop a coordinated view to ensure optimal value from IT investments by addressing key agency-wide policy and architecture standards, maximizing smart sharing of knowledge, sharing best practices and capabilities to reduce duplication and working with OPDIVs and STAFFDIVs on the implementation and execution of an expedited investment management process.

Office of Business Management and Transformation (OBMT)

OBMT provides results-oriented strategic and analytical support for key management and various HHS components' improvement initiatives and coordinates the business functions necessary to enable the supported initiatives and organizations to achieve desired objectives. OBMT also oversees Department-wide multi-sector workforce management activities. OBMT provides business process reengineering services, including the coordination of the review and approval process for reorganization and delegation of authority proposals that require the Secretary's or designees' signature. Finally, OBMT leads Departmental and cross-government initiatives that promote innovation or implement effective management practices within the Department.

Funding History

Fiscal Year	Amount
FY 2010	$18,976,000
FY 2011	$19,482,000
FY 2012	$19,463,000
FY 2013	$17,958,000
FY 2014	$17,958,000

Budget Request

The Assistant Secretary for Administration FY 2015 request is $18,000,000, $42,000 more than the FY 2014 Enacted level. This request will allow ASA to continue its established mission of policy and oversight.

ASSISTANT SECRETARY FOR ADMINISTRATION – Outputs and Outcomes Table

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
1.1 Increase the percent employees on telework or AWS (Output)	FY 2013: 38.0% Target: 16.0% (Target Exceeded)	18.0%	40.0%	+24
1.2: Reduce HHS fleet emissions	FY 2013: 11,129 MTCO2e Target: 12,708 MTCO2e (Target Exceeded)	12454 MTCO2e	11961 MTCO2e	-493
1.3: Ensure Power Management is enabled in 100% of HHS computers, laptops and monitors	FY 2013: Data Pending Target: 100.0%	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.

This goal was established in FY 2010. 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 to meet the 2015 goal of 40% of employees reducing commute time through telework or Alternative Work Schedule.

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 Presidential 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.

The target for 2010 was far exceeded, as HHS used Recovery Act funds to replace conventionally (petroleum based) powered vehicles with alternative fuel vehicles, reducing the amount of HHS greenhouse gas emissions. In 2011 and 2012, HHS added vehicles to its fleet, resulting in a nominal net gain of CO2e emissions. HHS's CO2e emissions are expected to stabilize and 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 100% of HHS eligible computers, laptops and monitors have power management. HHS has 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%, representing significant progress to achieving the final 100% goal.

2.1: Reduce the average number of days to hire

Prompt turn-arounds for recruitment requests are not only necessary for hiring highly qualified candidates in today's competitive market, but are also required under several Office of Personnel Management (OPM) directives that oblige Agencies to streamline processes and decrease timelines. Serving as the Department’s strategic lead on Human Resources (HR) policies and practices, the Assistant Secretary for Administration’s Office of Human Resources (OHR) set aggressive Agency-wide

goals that significantly 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. Beginning in FY 2012, HHS began transitioning the Department's HR services to a mission-based, fully-integrated operating environment.

Over the past three years, transaction reports have shown steady progress and an overall dramatic decrease in the hiring cycle time as measured from receipt of a complete job requisition package to job offer to a qualified candidate. Nevertheless, preliminary data for the second quarter of FY2012 indicate that processing time has increased to 72 days (compared to 61 days during the previous quarter) as activities related to that year's major transformation efforts were intensifying. In 2012, the average days to hire dropped to 65 days, indicating positive movement towards the FY2015 target of 60 days. 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.

ASSISTANT SECRETARY FOR FINANCIAL RESOURCES

Budget Summary
(Dollars in Thousands)

Assistant Secretary for Financial Resources	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	28,820	28,974	30,200	+1,226
FTE	150	149	149	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2015 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

Office of Budget (OB) – The Office of Budget (OB) manages the performance budget and prepares the Secretary to present the budget to 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 (OPDIVs) and Staff Divisions (STAFFDIVs). The OB prepares analyses, options, and recommendations on budget and related policy issues for HHS, and works with OMB and the Congress to accomplish the Secretary's objectives. It reviews rules and regulations for mandatory and discretionary spending policies and manages the budget process for the Office of the Secretary (OS) and the Service and Supply Fund. The office oversees, coordinates and convenes resource managers and financial accountability officials within OS to share information about Department-wide and OS policies, procedures, operations and priorities for the future, ensures that Department-wide financial management and budget policies are implemented and issues guidance to assist STAFFDIVs with implementing such policies. OB supports multiple STAFFDIVs by providing budget formulation support, budget analysis and presentation, budget execution, account reconciliations, reporting, status of funds tracking and certification of funds availability. The OB also manages the implementation of the Government Performance and Results Act (GPRA) and other performance improvement activities, and manages OPDIV integration of performance information into all phases of their performance budgets.

In FY 2013, in addition to meeting its responsibilities for the annual budget process, the OB continued to produce analyses, options, and recommendations on all HHS budget and related policy, and worked with OMB and the Congress to accomplish HHS priorities.

Office of Finance (OF) – This office provides financial management leadership to the Secretary through the CFO and the Departmental CFO Community. In accordance with the CFO Act, OMB Circulars, the Federal Accounting Standards Advisory Board (FASAB) and other Federal financial management legislation, OF manages and directs work in the development and implementation of financial policies, standards and internal control practices (as required by FMFIA and OMB Circular A 123). The OF prepares HHS' annual consolidated financial statements and coordinates the HHS' financial statement audit. The OF oversees HHS' financial management systems portfolio, and also has business ownership responsibilities for the Unified Financial Management System (UFMS). The OF has HHS-wide responsibility for ensuring that grantee audit findings (under OMB Circular A-133) are resolved in a timely and appropriate manner.

OF prepares the Agency Financial Report which includes the Department's consolidated financial statements, the auditor's opinion and other statutorily required annual reporting. For the fourteenth consecutive year, 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. OF successfully produced the Agency Financial Report on time in compliance with the federal requirements.

The 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).

The 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), the Council consisting of OS and OPDIV senior leaders that meet monthly and provide strategic direction and oversight for the Initiative. The OF also works closely with OS and OPDIVs to implement the Initiative using a standard approach and tools.

In FY 2013, the Office of Finance continued the implementation of HHS' Program Integrity Initiative supporting the development of solutions to minimize risks across programs facing similar challenges and develop systems to manage risk assessment data. The OF initiated Financial Systems Improvement Program (FSIP) to enhance, upgrade, standardize and simplify Department-wide financial systems environment. This program would allow HHS to maintain a secure and reliable financial systems environment, strengthen internal controls and improve financial reporting. The new functionality would increase efficiencies, simplify operations, eliminate customizations and improve compliance with the Federal Financial Management Improvement Act (FFMIA). The standard accounting practices would improve data integrity, enhance the accuracy of financial reporting and reduce the need for burdensome, manual reconciliations. Finally, the transition to commercial shared service provider for managed cloud/hosting services would reduce operating costs, increase efficiencies and promote standardization.

In addition, the office initiated Financial Business Intelligence Program (FBIP) to develop comprehensive business intelligence capabilities that would transform data from disparate business domains (e.g., finance, grants, acquisition and travel) into meaningful information. This would result in increased transparency; improved compliance with Federal Financial Management Information Act (FFMIA); more effective strategic and tactical decision-making; and, enhanced capability to efficiently provide information to external stakeholders, such as Congress, OMB and Treasury. The OF implemented the first phase of FBIP that provides a limited set of reports and Department-level executive dashboards using UFMS data.

Office of Grants and Acquisition Policy and Accountability (OGAPA) – OGAPA provides Department-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 the Department.

OGAPA publishes and maintains the HHS Grants Policy Statement, Grants Administration Manual and Acquisition Regulation; manages the Department's acquisition workforce training and certification programs; and participates in government-wide grants policy through the Counsel on Financial Assistance Reform and acquisition rule-making through the Civilian Agency Acquisition Council. The office also establishes appropriate grant and acquisition related internal controls and performance measures; provides technical assistance and oversight to foster stewardship and accountability in HHS'

grants, financial assistance and contracting programs; responds to grants or acquisition-oriented GAO and IG audits; and leads the Department's Strategic Sourcing, Green Procurement, and Government Purchase Card (GPC) programs.

OGAPA ensures that small businesses are given a fair 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.

OGAPA fulfills HHS' 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' Tracking Accountability in Government Grants System and Departmental Contract Information System. OGAPA also ensures that the electronic grants management systems employed by HHS efficiently promotes grant policies and optimizes departmental resources and serves as the business owner of the HHS Consolidated Acquisition System (HCAS).

In FY 2013, OGAPA continued to ensure appropriate grant and acquisition related internal controls and performance measures; provided technical assistance and continued their stewardship in HHS' grants, financial assistance and contracting programs; responded to grants or acquisition-oriented GAO and IG audits; and leads the Department's Strategic Sourcing, Green Procurement, and Government Purchase Card (GPC) programs.

Funding History

Fiscal Year	Amount
FY 2010	$26,131,000
FY 2011	$28,103,000
FY 2012	$29,771,000
FY 2013	$28,820,000
FY 2014	$28,974,000

Budget Request

ASFR's FY 2015 request is $30,200,000, $1,226,000 more than the FY 2014 Enacted. 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. The request reflects a shift in program level resources. In prior years, ASFR was allocated approximately $2 million in PHS Evaluation funding. ASFR will not be requesting PHS Evaluation funding in FY 2015.

ACQUISITION REFORM

Budget Summary
(Dollars in Thousands)

Acquisition Reform	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	681	1,750	1,750	0
FTE	1	1	1	0

Authorizing Legislation: ……..Title III of the PHS Act
FY 2015 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. Subsequent guidance from the Office of Management and Budget (including the memorandum *Improving Government Acquisition,* issued July 29, 2009; the memorandum *Acquisition Workforce Development Strategic Plan for Civilian Agencies, FY 2010-2014*, issued October 27, 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 specialists, procurement analysts, 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, and improve the effectiveness of that workforce, in order to maximize value in Federal contracting. The Office of 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 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.

In FY2013 with its acquisition reform funds, HHS continued its centralized training program, enabled its Office of the General Counsel to hire an additional attorney with expertise in appropriation law to support the Department's contract funding compliance efforts, and added staff to its Office of Recipient Integrity to enhance its suspension and debarment program.

Funding History

Fiscal Year	Amount
FY 2010	$0
FY 2011	$700,000
FY 2012	$700,000
FY 2013	$681,000
FY 2014	$1,750,000

Budget Request

Acquisition Reform's FY 2015 request is $1,750,000, the same as the FY 2014 enacted level. The requested resources will be used to implement HHS' Acquisition Workforce Development Strategic Plan. HHS will continue to build its acquisition workforce through internships under the Pathways federal career program as well as rotational and mentor programs to increase the capacity of the workforce and support succession planning and developing specialized cadres in cost and price analysis.

ASSISTANT SECRETARY FOR LEGISLATION

Budget Summary
(Dollars in Thousands)

Assistant Secretary for Legislation	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	3,791	3,791	3,800	+9
FTE	26	26	27	+1

Authorizing Legislation: ……..Title III of the PHS Act
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 the Department on Congressional activities; and maintains communications with executive officials of the White House, OMB, other Executive Branch Departments, Members of the Congress and their staffs, and the Government Accountability Office (GAO).

ASL informs the Congress of the Department'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 Departmental 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 the Department'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 the Department's legislative and administrative agenda; coordinating meetings and communications of the Secretary and other Department 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 the Department's initiatives and provides guidance on the development and analysis of Departmental legislation and policy.

The Office of the Deputy Assistant Secretary for Congressional Liaison (CLO) -Maintains the Department'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 Econosys) made by the Department;
- providing technical assistance regarding grants to Members of Congress and their staff; and
- Facilitating informational briefings relating to Department programs and priorities.

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

Funding History

Fiscal Year	Amount
FY 2010	$3,204,000
FY 2011	$3,423,000
FY 2012	$3,893,000
FY 2013	$3,791,000
FY 2014	$3,791,000

Budget Request

The FY 2015 request for ASL is $3,800,000, an increase of $9,000 above the FY 2014 Enacted level. The Budget allows ASL to provide critical support to the legislative healthcare and human services agenda that, among others includes the Older Americans Act, and the President's Early Learning Initiative. The Budget will also allow ASL to continue to meet the demands of the increased congressional activities and inquiries related to the broad range of HHS programs.

In FY 2015, 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 request for ASL will support facilitating increased communication between the Department 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 Department nominees; preparing witnesses and testimony for Congressional hearings; coordinating Department 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	22,754	8,749	8,700	-49
FTE	54	56	56	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2015 Authorization.....Indefinite
Allocation Method.....Direct Federal; Contracts

Program Description and Accomplishments

The Office of the Assistant Secretary for Public Affairs (ASPA) serves as the Department's principal Public Affairs office, leading Departmental 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 Department's 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 the Department's transparency and public accountability efforts through improved communications and new and innovative communication 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.
- Serving the Secretary in advising and preparing public communications and developing strategic plans for the Department.
- 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.
- Providing public affairs counsel in the HHS policymaking process.
- Acting as the central HHS press office handling media requests; overseeing development of press releases and other communications materials; and managing news issues that cut across Agencies; producing electronic clips for the Secretary and the Department.
- Developing protocols and strategies to expand Departmental utilization of social media and the web.
- Overseeing and producing special events that highlight top Departmental issues.
- Supporting television, Web, and radio appearances for the Secretary and top Department 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 top Departmental officials; and researching and preparing op-ed pieces, blogs, features, articles, and stories for the media.
- Maintaining HHS FOIA/Privacy Act operations and activities.
- Increasing focus on public education efforts surrounding benefits of the Affordable Care Act.

Funding History

Fiscal Year	Amount
FY 2010	$4,829,000
FY 2011	$5,477,000
FY 2012	$8,983,000
FY 2013	$22,754,000
FY 2014	$8,749,000

Budget Request

ASPA's FY 2015 Budget request is $8,700,000, $49,000 less than the FY 2014 Enacted. ASPA will conduct Department-wide public affairs programs; support the rollout of new programs and laws; increase public access to information; enhance transparency and accountability; synchronize Departmental policy and activities with communications; oversee the planning, management and execution of communication activities throughout HHS; and administer Open Government programs, the Freedom of Information Act (FOIA), and Privacy Act programs on behalf of the Department.

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 effective in 2014, thus increasing FOIA and privacy inquiries. As a result this will increase staffing levels to support these activities, while cutting contract costs through collaboration with other HHS agencies whenever practicable.

ASPA utilizes all methods of mass communication to accomplish its mission of ensuring that all Americans have access to critical public health and human services information in a timely and transparent manner, including vulnerable populations outreach. The FY 2015 funds will be used to provide citizens, in the most transparent and accessible manner possible, with the critical information they need about health and human services programs that are designed to help them achieve economic and health security.

OFFICE OF THE GENERAL COUNSEL

Budget Summary
(Dollars in Thousands)

Office of the General Counsel	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	39,226	39,226	39,200	-26
FTE	227	236	236	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2015 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, provides client agencies throughout Health and Human Services (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 Department by providing high quality legal services, including sound and timely legal advice and counsel. As such, this budget request aims to enable OGC to continue to provide the Secretary with the highest level of legal services required to effectively achieve and implement the goals and initiatives of the agency.

Accomplishments:

- On December 19, 2012, DOJ announced a settlement with Amgen of $612,100,000 plus interest for violations of the Anti-kickback Statute, resulting from the coordinated efforts of the DOJ, TRICARE, OPM, and the Office of the Inspector General, CMS, and OGC.
- Assisted CMS as it prepares to implement the Marketplace provisions of the Affordable Care Act, which will open soon for individuals and small businesses to purchase affordable health insurance offered by private health insurance issuers. This year, OGC provided advice and counsel to CMS as it issued regulations and guidance to stakeholders regarding standards and procedures that will govern the Marketplaces, both federally-facilitated and State-based, including policies and agreements governing Marketplace assisters such as Navigators and Certified Application Counselors, health insurance issuers offering qualified health plans through the Marketplaces and the SHOP. OGC attorneys developed the legal analysis to permit agencies to charge user fees in a variety of situations, including user fees that will be charged to support the exchanges, as well as other related ACA programs.
- Won a unanimous Supreme Court decision in Auburn Regional Medical Center v. Sebelius, in which the Court upheld the Secretary's interpretation of statutory provisions on jurisdiction of the Provider Reimbursement Review Board, afforded Chevron deference to her regulations, and held that equitable tolling was not available. The D.C. Circuit had held that hospital cost report appeals were subject to equitable tolling. OGC worked with the Solicitor General's Office to seek certiorari, as well as during the merits briefing stage. Under an equitable tolling theory, claims totaling more than $700 million dollars could have been at issue.
- OGC played an instrumental role in helping HHS to develop its position and in assisting the Department of Justice (DOJ) to successfully litigate several landmark patent cases before the United States Supreme Court including one that involving human genes, Assoc. for Molecular Pathology ("AMP") v. USPTO and Myriad Genetics, 133 S.Ct. 2107 (June 13, 2013) and provided litigation support to DOJ in preparation for the Supreme Court case United States Agency for

- In the contracting arena, OGC represented the agency in a host of bid protests filed against acquisitions awarded by Program Support Center, CMS, and ASPR. In particular, during FY 2013 OGC successfully defended all bid protests filed against the Medicare Administrative Contract awards. These contracts are among the largest awarded by the agency, and are crucial to the efficient operation of the Medicare program.

Funding History

Fiscal Year	Amount
FY 2010	$38,692,000
FY 2011	$39,911,000
FY 2012	$40,274,000
FY 2013	$39,226,000
FY 2014	$39,226,000

Budget Request

The Office of the General Counsel (OGC) requests $39,200,000, $26,000 less than the FY 2014 Enacted. In addition to the activities financed through the GDM, OGC will continue to provide reimbursable services to HHS Operating and Staff Divisions (OPDIVs/STAFFDIVs).

This Budget is intended to fund the salaries, benefits, and operating costs incurred by OGC as a result of providing the Department with legal representation on key social, economic, and healthcare issues. Specifically this Budget will enable the OGC Divisions/Regions to provide the following legal services to HHS OPDIVs.

In FY 2015, Affordable Care Act (ACA) implementation will continue to be a priority, with legal advice requirements pertaining to fiscal law, grants, and procurements related to ACA programs and initiatives. OGC will continue to provide support to all department 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; claims processing and adjudication for medical malpractice claims and other claims against the agency; and labor and employment law advice and litigation support. In the labor and employment law area specifically, OGC will continue litigating a large number of cases.

In regard to ACA, OGC anticipates providing substantial support to Centers for Medicare and Medicaid (CMS)/Center for Consumer Information and Insurance Oversight (CCIIO) in providing legal advice regarding the operation, funding and administration of Health Care Insurance exchanges. OGC also anticipates providing additional support to CMS relating to the CMS Centers for Medicare and Medicaid Innovation (CMMI), which is a CMS organization that has been established to test various service and delivery models. OGC expects to provide legal advice regarding new models, assisting CMMI with drafting agreement terms in models, as well as questions that may arise during the administration of models.

OGC will continue to work with the Health Resources and Services Administration (HRSA)'s health professions programs to develop programs and initiatives to respond to the need for a continually developing health professions workforce in light of changing care delivery models and community's needs, and with the Ryan White HIV/AIDS Program as it is expected to undergo a major transformation in order to mesh seamlessly with the ACA.

OGC will also continue to advise the President's Council on Fitness, Sports and Nutrition (PCFSN) in its campaign to combat childhood obesity, in partnership with the First Lady's "Let's Move!" initiative, and will advise the Secretary and Office of the PCFSN on issues related to the National Foundation on Fitness, Sports, and Nutrition.

Additionally, OGC will continue to provide legal advice to clients seeking to revise and update regulations. OGC also expects to continue advising and assisting the National Institutes of Health (NIH) on numerous 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, bio-defense research, and diversity initiatives.

Likewise, OGC expects to continue advising the Centers for Disease Control and Prevention (CDC) on ACA related public health programs and activitiesand enhanced preventive services guidance; continue to advise CDC on international issues that present for CDC in the complex challenging legal, diplomatic, and cultural environments faced by its overseas offices when working on matters of critical public health significance and to continue to advise CDC on the implementation of President Obama's Now IS the Time on gun violence prevention research. OGC also expects to participate in meetings and provide advice on multiagency preparedness efforts related to pandemic influenza, MERS-CoV and other chemical, biological, radiological, and nuclear threats.

Moreover, OGC expects to continue to 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. This effort is particularly important because of the changes brought about by the Affordable Care Act, the newly reauthorized Indian Health Care Improvement Act (IHCIA), and the recent Supreme Court decision in Salazar v. Ramah Navajo Chapter.

OGC will also be 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 a major rulemaking by the Office of Child Support Enforcement (OCSE) and the Office of Child Care. In addition, OGC will continue to provide defense of likely challenges to the final round of competition under new Designation Renewal System rules for the Head Start program.

Additionally, OGC anticipates continuing to serve as a principal legal advisor to the Assistant Secretary of Preparedness and Response (ASPR) (including the Biomedical Advanced Research and Development Authority (BARDA)) regarding a host of matters. While difficult to predict, OGC also expects to provide rapid legal advice to ASPR on various procurement and other authorities that may be used by the Secretary to fulfill her duties in a public health emergency or other similar situation.

DEPARTMENTAL APPEALS BOARD

Budget Summary
(Dollars in Thousands)

Departmental Appeals Board	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	10,450	10,450	12,500	+2,050
FTE	76	80	90	+10

Authorizing Legislation:.....Title III of the PHS Act
FY 2015 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 Department of Health and Human Services (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 2013, the Board/Appellate Division received 117 cases and closed 109 (68 by decision). Ninety-five percent of Board decisions issued in FY 2013 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 Health Insurance Portability and Accountability Act (HIPAA) 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 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). Additionally, DAB 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.

Through reimbursable inter-agency agreements, 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 2012, CRD began providing ALJ hearings in enforcement actions initiated by the Center for Tobacco Products (CTP) involving the regulation of tobacco products. DAB review of CTP cases are funded through tobacco product user fee funds, which must be used to pay for tobacco regulation pursuant to Section 919 of the FD&C Act, 21 U.S. C. § 387.

In FY 2013, CRD received 1,396 new cases and closed 1,281 (250 by decision). 571 of these new cases were appealed under the FDA reimbursable inter-agency agreements.

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. 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).

The Council supports the overall Medicare program by ensuring that Medicare coverage and payment requirements are applied appropriately nationwide. This helps guarantee that Medicare trust fund monies are being disbursed properly. The Council protects parties' due process rights through its *de novo* review standard and ensures that interpretations of existing regulatory and program guidance conform to the law. Further, the Council helps avoid costly Federal court review by providing a final

administrative decision that is legally sound and by preparing and certifying the administrative record for Federal court.

In FY 2013, MOD received 4,411 new cases and closed 2,592 (12,960 claims).

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

The ADR Division provides ADR services in DAB cases and supports the Chair in her role as DHHS' Dispute Resolution Specialist. The Division 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: (1) provide increased opportunities for the public to participate in policymaking; and (2) 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 2013, ADR received 90 requests for ADR services and closed 83.

Workload Statistics:

Board Members – Appellate Division

Chart A shows total historical and projected caseload data for this Division. FY 2013 data are actual, and FY 2014 and FY 2015 data are projected based on certain assumptions, including:

- Review of cases arising under various newly implemented provisions of the Affordable Care Act (ACA) in FY 2014 and FY 2015.

APPELLATE DIVISION CASES – Chart A

Cases	FY 2013	FY 2014	FY 2015
Open/start of FY	43	51	66
Received	117	125	125
Decisions	68	70	70
Total Closed	109	110	110
Open/end of FY	51	66	81

Administrative Law Judges – Civil Remedies Division

Chart B shows total historical and projected caseload data for this Division. FY 2013 data are actual, and FY 2014 and FY 2015 data projected is based on certain assumptions, including:

- A continued upward trend in certain types of cases, such as provider/supplier enrollment cases, due to heightened enforcement and oversight efforts by DHHS OIG, CMS, and OCR;
- New and increasing FDA workload; and

- Receipt of new cases arising under various newly implemented ACA provisions in FY 2014 and FY 2015.

CIVIL REMEDIES DIVISION CASES – Chart B

Cases	FY 2013	FY 2014	FY 2015
Open/start of FY	377	492	592
Received	1,396	1,400	1,450
Decisions	250	250	250
Total Closed	1,281	1,300	1,300
Open/end of FY	492	592	742

Cases received include the FDA Tobacco CMP cases funded through a reimbursable agreement. These cases account for 571 receipts in FY 2013, 575 receipts in FY 2014, and 600 receipts in FY 2015.

Medicare Appeals Council – Medicare Operations Division

Chart C contains historical and projected caseload data for this Division. FY 2013 data are based on cases received to date and projections for FY 2014 and FY 2015 are based on information from other HHS Operating and Staff Divisions (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 2014 and FY 2015, as OMHA's case receipt and disposition rate increases;
- Increased overpayment (including Recovery Audit Contractor (RAC)) and statistical sampling cases;
- 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 2013	FY 2014	FY 2015
Open/start of FY	3,078	4,897	9,805
Received	4,411	7,500	8,500
Cases Closed (claims closed)	2,592 (12,960 claims)	2,592 (12,960 claims)	3,392 (16,960 claims)
Open/end of FY	4,897	9,805	14,913

Alternative Dispute Resolution Division

In FY 2013, the ADR Division provided services in 90 cases and provided 15 conflict resolution seminars. In FY 2014 and FY 2015, ADR projects it will continue at approximately the same level of productivity.

In FY 2013, the Division began a new 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.

Funding History

Fiscal Year	Amount
FY 2010	$10,549,000
FY 2011	$10,583,000
FY 2012	$10,730,000
FY 2013	$10,450,000
FY 2014	$10,450,000

Budget Request

DAB's FY 2015 request is $12,500,000, which is $2,050,000 above the FY 2014 Enacted level. The increase supports DAB's Medicare Operations Division (MOD) in meeting the needs of Medicare beneficiaries by addressing the growing number of cases appealed from the Office of Medicare Hearings and Appeals (OMHA).

Like OMHA, MOD is experiencing a dramatic increase in caseload since the nationwide implementation of CMS' RAC audit program in FY 2010 and the rise in Medicare enrollee numbers. While the number of MOD staff has remained constant, case receipts increased by more than 36% from FY 2012 to FY 2013 (from 3,245 to 4,411 cases) and are projected to increase an additional 93% from FY 2013 to FY 2015. At this rate of growth, MOD projects its backlog of cases to increase to over 14,000 by the end of FY 2015. Aside from the sheer volume of case receipts, this burgeoning backlog is exacerbated by the technical complexity of the new workload and the greater number of claims per case. MOD has been advised by OMHA to expect sharply higher receipts of technically complex statistical sampling cases and multi-claim overpayment cases (such as RAC audits). In FY 2013, RAC cases made up approximately 37% of total MOD cases. In addition, MOD cases often generate voluminous administrative records, and when cases are appealed to Federal court MOD staff must undertake the time-consuming task of preparing and certifying the accuracy of the record for the court. In order to manage the workload and backlog, MOD will add approximately 10 new staff (Administrative Appeals Judges (MOD currently has only four AAJs), staff attorneys, paralegals, and support staff), enabling MOD to increase case closures by approximately 31%.

DEPARTMENTAL APPEALS BOARD - Outputs and Outcomes Table

Measure	Year and Most Recent Result/Target for Recent Result (Summary of Result)	FY 2014 President's Budget	FY 2015 Request	FY 2015 Request +/- FY 2014 PB
1.1 Percentage of Board Decisions with net case age of six months or less	FY 2013: 95% Target: 86% (Target Exceeded)	86%	86%	Maintain
2.1 Percentage of Board decisions meeting applicable statutory and regulatory deadlines for issuance of decisions.	FY 2013: 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 2013: 100% Target: 100% (Target Met)	100%	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 2013: 100% Target: 100% (Target Met)	100%	90%	-10%
3.3 Percentage of decisions issued within 180 days from the date appeal was filed in provider/supplier enrollment cases.	FY 2013: 100% Target: 100% (Target Met)	100%	100%	Maintain
4.1 Cases closed in a fiscal year as a percentage of total cases open in the fiscal year.	FY 2013: 65% Target: 65% (Target Met)	65%	60%	-5%
5.1 Number of conflict resolution seminars conducted for HHS employees.	FY 2013: 15 Sessions Target: 15 Sessions (Target Met)	15 Sessions	15 Sessions	Maintain
5.2 Number of DAB cases (those logged into ADR Division database) requesting facilitative ADR interventions prior to more directive adjudicative processes.	FY 2013: 90 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 2013: 235 days Target: 170 days (Target Not Met)	185 days	500 days	+315 days
7.1 Number of dispositions	FY 2013: 2,592 Target: 2,500 (Target exceeded)	3,280	3,392	+112

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 2013, the Board/Appellate Division closed 110 cases (70 by decision). Ninety-five percent of decisions issued in FY 2013 had a net case age of six months or less, exceeding the Measure 1.1 target of 86%. The Board is not increasing the FY 2014 or FY 2015 targets because it anticipates turnover in two Board Member positions in those years.

The regulatory deadline for issuing a decision was met in 100% of appeals with a regulatory deadline in FY 2013, thus achieving the target for Measure 2.1. Appellate projects that it will meet FY 2014 and FY 2015 targets for both measures.

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 met the FY 2013 targets of 100%. However, it does not expect to meet the FY 2014 targets due to the October FY 2013 government shutdown. For FY 2015, targets for Measures 3.1 and 3.2 have changed due to an increase in caseload. CRD expects to meet targets for all three measures in FY 2015.

In order to account for a growing case backlog, CRD changed the methodology for calculating Measure 4.1 to measure cases closed as a percentage of all cases open during the fiscal year (including backlog). Previously, DAB measured cases closed as a percentage of cases received during the fiscal year, which did not account for the backlog. This new methodology more accurately measures the Division's capacity and provides a better tool for analyzing and projecting staffing needs. DAB met its target of closing 65% of open cases in FY 2013, and expects to meet its FY 2014 and FY 2015 targets. For FY 2015, the target has changed due to an increase in caseload.

Medicare Operations Division

In FY 2013, MOD did not meet its target of 170 days for Measure 6.1. Because of the growing case backlog, Part B average case age increased by approximately 315 days. MOD did, however, exceed its output target for Measure 7.1.

In FY 2014, MOD will not meet its targets for Measures 6.1 or 7.1, as those targets assumed new staff for which DAB did not receive funding. Average case age will increase as the backlog grows, and case closures will remain the same or possibly decrease due to the time required to process the influx of 7,500 new cases projected for FY 2014.

With additional staff in FY 2015, MOD expects to close 31% more cases. Nevertheless, due to the high volume of cases projected (8,500) and a significant backlog, MOD expects average case age is to increase from the current 235 days to approximately 500 days.

Alternative Dispute Resolution (ADR) Division

In FY 2013, the ADR Division met Measure 5.1 and exceeded 5.2 by leveraging its limited resources through: (1) ramping up the use of VTC in place of all in-person mediations which would otherwise require travel; (2) continuing its DOT partnership to share training resources; and (3) supplementing its small staff with an unpaid law school intern and part-time college intern.

At this time, it is not clear that the increase in mediations will continue into FY 2014 and FY 2015, as the spike in FY 2013 may be attributable to the new VTC mediation initiative with the IHS. Therefore, for FY 2014 and FY 2015, the ADR Division is projecting workload, staffing, and output to continue at FY 2013 levels. The Division is on track to meet its FY 2014 and FY 2015 performance targets.

OFFICE ON DISABILITY

Budget Summary

(Dollars in Thousands)

Office on Disability	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	1,041	0	0	0
FTE	0	0	0	0

Funding History

Fiscal Year	Amount
FY 2010	$864,000
FY 2011	$862,000
FY 2012	$1,098,000
FY 2013	$1,041,000
FY 2014	$0

Budget Request

The former Office on Disability will not be requesting funds for FY 2015. Per the reorganization on April 18, 2012, the Administration for Community Living (ACL) will manage budget execution and formulation responsibilities for existing OD activities.

OFFICE OF GLOBAL AFFAIRS

Budget Summary
(Dollars in Millions)

Office Of Global Affairs	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	6,270	6,270	6,270	0
FTE	25	24	22	-2

Authorizing Legislation: .....Title III of the PHS Act
FY 2015 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 Department in the governing structure of major crosscutting global health initiatives.

OGA takes advantage of capacities present in HHS to address needs and opportunities overseas, while at the same time, providing knowledge and analysis of international developments for the benefit of the Secretary, and HHS as a whole.

HHS has a range of relationships with most U.S. 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 Global Alliance for Vaccines and Immunisation (GAVI). Additionally, the new State Department Office of Global Health Diplomacy will be a valuable ally in this effort, recognizing and tracking on the State side the role OGA has played in HHS.

OGA's International Relations Division (IRD) includes regional and functional global health experts on Africa, the Americas, the Middle East, Asia, and Europe on multilateral affairs. They provide the backbone for global health diplomacy, the Department's focal point for the coordination of HHS activities with other governments and international organizations.

OGA's Policy and Program Coordination Division (PPCD) includes global health experts on a range of policy issues, including non-communicable 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 IRD staff lead regional efforts on these issues, the PPCD staff address from a cross-cutting perspective, ensuring a consistent and comprehensive approach.

The staff from OGA's Africa Region facilitated gains achieved by the African Vaccine Manufacturing Initiative (AVMI) since its conception in 2010. OGA advocacy efforts brought AVMI to the attention of the African Union, resulting in the inclusion of vaccine manufacturing on the African continent as part of

its Pharmaceutical Plan for Africa. Additionally, OGA convened meetings between AVMI and the African Development Bank to get the latter to support vaccine manufacturing capacity in Africa.

Also in Asia, 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 Ministry of Health and industry partners to launch the China-U.S. Smoke-free Worksite partnership. Nearly 70 U.S. and Chinese employers agreed to limit or ban smoking in their workplaces, a huge change from previous norms and practices.

Multilateral work at the U.S. Mission in Geneva, enables HHS to lead the US Government representation at the literally hundreds of meetings annually of the World Health Organization and other international health bodies. The WHO uses its global convening authority to help set health norms and standards across the full spectrum of health issues. The multilateral staff and the OGA attaché played a pivotal role in promoting U.S. positions through engagement with WHO secretariat staff and support and the Secretary's role as head of the U.S. delegation to the annual week-long World Health Assembly. In 2013, the agenda had over 80 items, which is a record number. The U.S. achieved its goals and won endorsement of its positions with a level of cooperation and respect for U.S. leadership rarely seen in the recent past.

The most vivid recent example of the WHO adopting policies reflecting U.S. domestic goals was on non-communicable diseases in 2013. Active diplomacy, led by OGA resulted in the approval of an action plan, targets and indicators entirely consistent with USG priorities. This outcome resulted from HHS' leadership role in the WHO negotiations to fulfill responsibilities under the United Nations General Assembly Political Declaration on the Prevention and Control of non-communicable diseases.

OGA's agency liaison team strengthened the ability of HHS OPDIVs and Staff Divisions to undertake global health work, through ongoing information sharing and communications, and through special initiatives. One initiative developed a new process for the clearance of international arrangements through the State Department, leading to streamlined timelines and clearer processes. Another achievement involved the establishment of a new HHS policy on details to other organizations; OGA ensured that the new policy reflected the Department's priority on global health activities and that the instructions were appropriate for international circumstances.

Funding History

Fiscal Year	Amount
FY 2010	$6,350,000
FY 2011	$6,329,000
FY 2012	$6,438,000
FY 2013	$6,270,000
FY 2014	$6,270,000

Budget Request

The FY 2015 request for the Office of Global Affairs (OGA) of $6,270,000 represents no change from the FY 2014 Enacted. OGA's method of operation, convening interagency teams, formulating positions and options on global health questions, engaging external stakeholders and consulting with international colleagues and multilateral institutions, is even more central to achieving HHS-desired results in the era of instant communications and social media. OGA is working with the OPDIVs to explore whether there may be opportunities to strengthen/improve career tracks for global health work across the OPDIVs

OGA will continue to facilitate the involvement of OPDIVs and Staff Divisions with the WHO and the Organization for Economic Co-operation and Development's (OECD) related to non-communicable diseases, mental health, and reducing tobacco and alcohol consumption. In addition, OGA will lead the

Department's engagement on the Trans-Atlantic Trade and Investment Partnership (TTIP), an ambitious undertaking to strengthen trade ties with the European Union, with significant impact on food safety, intellectual property, and other health issues.

In FY 2015, OGA will intensify efforts to promote access to health care for lesbian, gay, bisexual, and transgender (LGBT) populations, especially in Africa. OGA will raise these issues in WHO and its African region and with Ministers of Health and diplomatic missions. OGA foresee this outreach to be challenging, but necessary, as African customs and laws result in LGBT individuals stigmatized and even criminalized in health facilities.

In South Africa, Brazil, China and India, OGA health attachés will also continue to work with other government agencies, NGOs and industry on research, regulation, information sharing and multilateral issues – important to pandemic preparedness, safety of products, intellectual property and to clinical trials, among many other goals. Smoke-free workplaces are one deliverable in each of these, and other, bilateral relationships.

Health cooperation with Russia contains much unfulfilled potential because of Russian-motivated setbacks in the overall bilateral relationship. There is already a delay to implement joint proposals outlined in 2013-2015 work plan, and much of this work will inevitably slide to 2015.

Office of Global Affairs – Proposed Outputs and Outcomes Table

Proposed Program/Measure	Proposed Measures	Indicator Type
1.1 USMBHC development and implementation of strategies that are directly related to HHS and/or Secretary's priorities	Cumulative number of key identified stakeholders on both sides of the U.S.-Mexico border that have adopted at least one of the population-level health outcome objectives of the Healthy Border 2020 Strategy into their planning, programming or funding process	Intermediate Outcome
1.2 The implementation of USMBHC priorities (which are linked to the Department's priorities)	The number of border residents who receive public health education or health screenings each year through the Community-Based Healthy Border Initiatives that are celebrated on both sides of the U.S.-Mexico border	Output
1.3 The effectiveness of OGA's communication and outreach activities	Increase the number of unique visitors to OGA-supported websites	Output

Program Data Chart

Activity	FY 2013 Enacted	FY 2014 President's Budget	FY 2015 President's Budget
Contracts	$1,133,000	$1,160,000	$1,150,000
Grants/Cooperative Agreements	$1,700,000	$1,300,000	$1,300,000
Inter-Agency Agreements (IAAs)	$180,500	$180,000	$180,000
Operating Costs	$475,000	$480,000	$500,000
Total	$3,488,500	$3,120,000	$3,130,000

Grants

Grants (whole dollars)	FY 2013 Enacted	FY 2014 President's Budget	FY 2015 President's Budget
Number of Awards	4	4	4
Average Award	$338,063	$338,063	$338,063
Range of Awards	$290,000 - $455,000	$290,000 - $455,000	$290,000 - $455,000

OFFICE OF INTERGOVERNMENTAL AND EXTERNAL AFFAIRS

Budget Summary
(Dollars in Thousands)

Office of Intergovernmental and External Affairs	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	9,576	9,576	10,600	+1,024
FTE	52	60	60	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2015 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 U.S. Department of Health and Human Services (HHS) and state, local, territorial and tribal governments and non-governmental stakeholders. The mission of IEA's mission is to facilitate communication regarding HHS initiatives as they relate to state, local, territorial and tribal governments and non-governmental stakeholders. IEA serves the dual role of representing the state, territorial and tribal perspective in the federal policymaking process by advising Departmental officials as well as clarifying the federal perspective to state, territorial and tribal representatives.

The IEA is composed of a headquarters team that works on policy matters within HHS Operating Divisions and serves as liaison with state, territorial and local governments and related public policy groups and non-governmental stakeholders. In addition to the Headquarters team, IEA has ten regional offices which include the Secretary's Regional Directors, Executive Officer, Outreach Specialist and IGA Specialists who are responsible for public affairs, business outreach and media activities. IEA coordinates the HHS Regional office by directing the Regional Directors (RDs) and their offices in their role in planning, development and implementation of Departmental policy. The Office of Tribal Affairs, 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 American organizations.

IEA has led a Departmental communications and outreach effort that has achieved considerable results. IEA undertook the challenge of leading, drafting and coordinating with the Centers for Medicare and Medicaid Services (CMS) and other HHS divisions a department-wide strategy to communicate, educate and actively engage with all governmental and non-governmental stakeholders around the implementation of the ACA. To that end, IEA has conducted over 6,300 ACA outreach activities, reaching over 250,000 individuals nationwide with governmental and non-governmental stakeholders between Oct. 1, 2012 and December 31, 2013.

These unprecedented efforts have gone a long way to increase the awareness and understanding of states, local, tribal and territorial governments; organizations, groups, private institutions, academia, private sector and labor unions around 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 2010	$7,049,000
FY 2011	$9,688,000
FY 2012	$9,831,000
FY 2013	$9,576,000
FY 2014	$9,576,000

Budget Request

The request for FY 2015 for $10,600,000 is $1,024,000 above the FY2014 Enacted. The budget request for IEA will be used to support personnel costs, continue coordination of a wide range of outreach activities, and facilitate cross-cutting initiatives in the field such as ongoing support of the Affordable Care Act along with Tribal activities. ACA and Tribal will require a significant increase in communication, coordination, and outreach activities with state, local, tribal and territorial governments and non-governmental stakeholders.

The budget will be used to conduct a wide variety of outreach and communication activities such as speaking engagements, Brown Bag sessions, conference calls, meetings, training sessions, and consultations with state, local, tribal and territorial governments, and external stakeholders.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Budget Summary
(Dollars in Thousands)

Office of the Assistant Secretary for Health	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	272,017	295,289	173,780	+78,491
FTE	274	268	276	+8

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.1: Promote emergency preparedness by strengthening the capacity and capability of Medical Reserve Corps (MRC) units in local communities across the country.

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 2013 FTE	FY 2013 Final	FY 2014 FTE	FY 2014 Enacted	FY 2015 FTE	FY 2015 President's Budget
Immediate Office of the Assistant Secretary for Health	61	12,151	55	12,151	85	17,995
Office of HIV/AIDS and Infectious Disease Policy	6	1,459	6	1,459	6	1,500
Office of Disease Prevention and Health Promotion	23	6,999	23	6,999	23	7,000
President's Council on Fitness, Sports and Nutrition	6	1,215	6	1,215	6	2,100
Office for Human Research Protections	33	6,756	33	6,756	33	6,800
National Vaccine Program Office	17	6,659	17	6,659	17	6,000
Office of Adolescent Health	4	1,070	4	1,500	4	1,500
Public Health Reports	2	486	2	486	2	400
Teen Pregnancy Prevention	16	98,367	16	101,000	-	-
Office of Minority Health	63	39,533	63	56,670	57	36,000
Office on Women's Health	43	33,002	43	34,050	43	29,500
Office of Research Integrity (Non-Add)	*24*	*8,588*	*24*	*8,588*	*24*	*8,588*
HIV-AIDS in Minority Communities	-	50,354	-	52,224	-	-
Embryo Adoption Awareness Campaign	-	1,000	-	1,000	-	-
Subtotal, GDM	*274*	*259,052*	*268*	*282,170*	*276*	*108,795*
PHS Evaluation Set-Aside	-	-	-	-	-	-
OASH	-	4,510	-	4,664	-	4,285
Teen Pregnancy Prevention Initiative	-	8,455	-	8,455	-	6,800
HIV AIDS in Minority Communities	-	-	-	-	-	53,900
Subtotal, PHS Evaluations	-	*12,965*	-	*13,119*	-	*64,985*
Total, OASH	**274**	**272,017**	**268**	**295,289**	**276**	**173,780**

Immediate Office of the Assistant Secretary for Health

Budget Summary
(Dollars in Thousands)

Immediate Office of the Assistant Secretary for Health	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	12,151	12,151	17,995	+5,844
FTE	61	55	85	+30

Authorizing Legislation: ……Title III of the PHS Act
FY 2015 Authorization……Indefinite
Allocation Method……Direct Federal

Program Description and Accomplishments

The Office of the Assistant Secretary for Health (OASH) is led by the Assistant Secretary for Health (ASH), who serves as the senior advisor 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, advice and counsel to the Secretary and Administration on various priority initiatives including climate change and LGBT health.

Senior public health officials within the Immediate Office ensure a public health perspective on all Secretarial and Presidential priorities. These officials establish and strengthen 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 Secretarial and inter- and intra-departmental initiatives. Coordinating the activities of Federal partners enables HHS to leverage the scientific, evaluative, or programmatic findings of one agency for replication and dissemination through other agencies.

OASH continues to lead department efforts regarding implementation of the HHS' *Ending the Tobacco Epidemic, A Tobacco Control Strategic Action Plan*, and serves as the chair of the Tobacco Control Implementation Steering Committee and the lead for the HHS priority goal to reduce 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 institutions in FY 2013.

Healthcare Associated Infections

Through the OASH Office of Disease Prevention and Health Promotion (ODPHP) continued its leadership on healthcare associated infections through the *National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination.* In FY 2013, progress continued in reducing 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. The ADE Action Plan is scheduled for release mid-2014. Efforts to implement components of the action plan have already been initiated by the OASH Office of Disease Prevention and Health Promotion.

OASH also partners and leads Departmental initiatives and strategic action plans to address various other public health priorities, 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;* FDA procedures to limit exclusion of co-morbidities in clinical research; Informed Medicare payment rule on complex chronic care management services; and released epidemiological data on the MCC population
- 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 Immediate Office of the ASH promotes health equity by raising awareness; strengthening leadership; improving the health care and health system experience for racial, ethnic, gender, and other minorities; improving cultural and linguistic competency; and improving the use of research and evaluation outcomes. These efforts contribute to areas such as adolescent health and reducing teen pregnancy; addressing care and prevention related to chronic viral hepatitis; and using health information technology to reduce health disparities.

OASH continues implementation of 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 the Department 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. In FY 2013, HHS released the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care – a blueprint to help organizations improve health care quality in serving our nation's diverse communities, a major milestone of the action plan.

Making Healthy People Come Alive for All Americans

OASH continues implementation of *Healthy People 2020*, which established health goals for the nation, tracks progress toward meeting targets, and aligns national efforts to guide action for public health. As part of *Healthy People 2020,* OASH continues the Leading Health Indicators (LHI) initiative – critical health priorities for the Nation – which highlights to 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 10 Regional Health Administrators (RHAs) perform essential functions to promote Departmental and OASH priorities, including:

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

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

Funding History

Fiscal Year	Amount
FY 2010	$9,495,000
FY 2011	$12,495,000
FY 2012	$13,474,000
FY 2013	$12,151,000
FY 2014	$12,151,000

Budget Request

The FY 2015 President's Budget request of $17,995,000 is $5,844,000 more than the FY 2014 Enacted Level. 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 - Outputs and Outcomes Table

Long Term Objective: Creating Better Systems of Prevention

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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 2013: 29,645 Target: 23,357 (Target Exceeded)	40,292	312[1]	-39,980
1.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, consultations with professional and institutional associations; Measure	FY 2013: 42,617,687 Target: 34,849,243 (Target Exceeded)	33,939,393	24,770,771[2]	-9,168,622

[1] The decrease is due to PCFSN's change in unit measurement from individual schools to school districts adopting policies and recommendations.

[2] The decrease is due to OWH updating its performance data collection system to more accurately capture the activities of the office.

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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 203: 1,578 Target: 861 (Target Exceeded)	363	355	-8
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 2013: 865 Target: 372 (Target Exceeded)	61	68	+7
1.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 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.	FY 2013: 259 Target: 173 (Target Exceeded)	163	120	-43

Long Term Objective: Eliminating Health Disparities and Achieving Health Equity

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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 2013: 208 Target: 222 (Target Not Met but Improved)	228	152	-76
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-supported disparities efforts (including public affairs events); and estimated number of broadcast media outlets airing Closing the Health Gap messages.	FY 2013: 14,037,013 Target: 2,257,220 (Target Exceeded)	1,487,614	1,494,114	+6,500
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 2013: 767 Target: 322 (Target Exceeded)	408	241	-167
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:	FY 2013: 117 Target: 167 (Target Not Met)	49	39	-10

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
number of promising practices identified in research, demonstration, evaluation, or other studies.				
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 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.	FY 2013: 108 Target: 67 (Target Exceeded)	57	61	+4

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

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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. [OSG]: M2: # New MRC units [OSG] M3: # of MRC activities reported	**FY 2013: 4,024 Target: 1,116 (Target Exceeded)**	**10,179**	**11,153**	**+974**

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 2013: 5,634,818 Target: 2,094,676 (Target Exceeded)**	**3,334,220**	**3,550,397**	**+216,177**
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 2013: 244 Target: 471 (Target Not Met)**	**307**	**91**	**-216**
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 2013: 87 Target: 421 (Target Not Met)**	**49**	**67**	**+18**
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: specific outcomes of the efforts in measure 1 that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc. [OSG] M3: # Activation days [OSG] M\4: # Officers trained	**FY 2013: 13,063 Target: 6,220 (Target Exceeded)**	**6,122**	**6,436**	**+314**

FY2012-FY2013: Priority Goal

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
1.4 Reduce annual adult's cigarette consumption in the United States (per capita) (Outcome)	FY 2012: 1,196 Target: 1,150 (Target Not Met)	NA*	NA	NA

***** Priority goal closed in FY 2013.

FY2014-FY2015: Priority Goal

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
1.5 Reduce the annual adult combustible tobacco consumption in the United States (cigarette equivalents per capita)	FY 2012: 1,259 (Baseline)	1,212	1,174	-38

Performance Analysis

The above 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 can continue progress in targeted key measures related to the implementation of the HHS strategic plan and OASH programs and 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 Infectious Disease Policy	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	1,459	1,459	1,500	+41
FTE	6	6	6	0

Authorizing Legislation: ……..Title III of the PHS Act
FY 2015 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 HIV/AIDS through the following activities:

- Support Department-wide planning, internal assessments, and evaluation activities covering such areas as hepatitis screening, HIV testing, technical assistance, prevention strategies, and gaps in necessary HIV/AIDS services. In working with all OPDIVs and STAFFDIVs, OHAIDP identifies opportunities to collaborate, properly align resources, eliminate redundancy, fill vital gaps and recommend best practices.
- Coordinate HHS implementation of the National HIV/AIDS Strategy (NHAS) and coordinate HHS activities with other federal departments.
- Follow the principles of the NHAS, emerging epidemiological trends and other guidance to allocate funds from the Secretary's Minority AIDS Initiative Fund (SMAIF) to specific demonstration projects and competitively to high priority projects proposed by OPDIVs and STAFFDIVs.
- Coordinate the implementation of recommendations developed in response to the Executive Order to "Accelerate Improvements in HIV Prevention and Care in the United States through the HIV Care Continuum Initiative" (July 15,2013).
- Coordinate the implementation and ongoing dissemination of the updated Action Plan for the Prevention, Care & Treatment of Viral Hepatitis (Viral Hepatitis Action Plan) within HHS and across other federal departments.
- Support the Presidential Advisory Council on HIV/AIDS (PACHA).
- Develop and share policy information and analysis with HHS OPDIVs and STAFFDIVs. OHAIDP ensures that senior Department officials are fully briefed on HIV/AIDS, viral hepatitis, and blood and tissue safety-related matters. OHAIDP promotes awareness, understanding, and implementation of HHS policies on HIV/AIDS and viral hepatitis with internal and external partners.
- Utilize AIDS.gov to disseminate information on federal domestic programs, resources and policies on HIV/AIDS and key departmental policies and initiatives, including NHAS, VHAP, and the Affordable Care Act (ACA).
- Coordinate, integrate, and direct the Department's policies, programs and activities related to blood and tissue safety and availability through managing a variety of programs, committees and working groups, including the federal Advisory Committee on Blood and Tissue Safety and

Availability (ACBTSA); the internal HHS-wide Blood, Organs and Tissues Senior Executive Council (BOTSEC); and the HHS Emergency Management Group (ASPR liaison).

- Provide strong, responsive, and accountable administrative structure to HIV/AIDS related issues for OASH and OS to ensure the success of HHS HIV/AIDS programs, policies, and activities, while maintaining fiscal accountability and promoting sound evaluation.

HIV/AIDS

Following the release of the NHAS and the Federal Implementation Plan, in July 2010, HHS was delegated the responsibility to coordinate HIV/AIDS-related programs and activities across other federal departments. The Implementation Plan identifies specific tasks and activities that HHS must perform through calendar year 2015. In FY2013, OHAIDP coordinated the cross-departmental development of operational plans to implement these indicators; streamline HIV data collection, and reduce undue reporting burden by at least 20 – 25%; and by 2014 HHS OPDIVs will fully deploy these system improvements 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 will use this information, in FY 2014 and FY 2015, to expand efforts 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.

Efforts to improve coordination of HIV/AIDS Programs across HHS include periodic meetings of senior HIV/AIDS leadership to discuss HIV/AIDS-related activities and policies; review of all HIV/AIDS funding opportunity announcements for consistency with the goals/strategies of the NHAS, and hosting one or more technical consultations on strategic issues related to NHAS implementation. For example, in FY 2013, OHAIDP hosted a cross-departmental consultation with black LGBT leaders to discuss HIV prevention, care, and treatment priorities. In both FY 2012 and FY 2013, OHAIDP has released summaries of the HHS progress toward accomplishing NHAS goals for the previous two calendar years (*Implementation Progress Report*).

Throughout FY 2013, OHAIDP worked across HHS and other federal partners to improve HIV program planning and coordination. For example, OHAIDP worked with colleagues from the Departments of Housing and Urban Development, Justice, Labor, Veterans Affairs and the Social Security Administration to complete a review and update the HIV/AIDS information available on Benefits.gov. This resulted in an expansion of the "benefits finder" to include several HIV specific questions to assess individual eligibility and more effectively direct users to the appropriate programs. OHAIDP chaired a cross-departmental working group with representatives from the Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), National Institutes of Health (NIH), Substance Abuse and Mental Health Services Administration (SAMHSA), The Office on Minority Health (OMH) and the Office on Women's Health (OWH). The group collected and reviewed data from 56 HHS-funded HIV prevention programs and initiatives serving African Americans and released a report in FY 2013 suggesting areas where the targeting of services might be enhanced. In FY 13, OHAIDP collaborated with the CDC and the Office of National AIDS Policy (ONAP) to pilot test an HIV prevention resource allocation model in three U.S. jurisdictions. Findings from this project will be used to support technical assistance and dissemination of this model to other U.S. jurisdictions in support of informed local decision making about HIV prevention resource allocation. To better align SMAIF priorities with the goals of the NHAS, OHAIDP led the development of a unique 3 year demonstration project, "Care and Prevention of HIV in the United States", which was funded at the end of FY 2012. OHAIDP worked in collaboration with CDC, HRSA, SAMHSA, and OWH to develop the principles of this demonstration project which is aimed at reducing racial/ethnic disparities in HIV/AIDS related morbidity and mortality by addressing social, economic, clinical and structural factors that influence HIV outcomes. A new SMAIF demonstration project was awarded to enhance collaboration among CDC-funded state health

departments and HRSA-funded community health centers so as to expand the provision of HIV testing, care, and treatment services within racial/ethnic minority communities most impacted by HIV.

AIDS.gov

AIDS.gov, is managed by OHAIDP and is the premier information gateway for federal domestic HIV/AIDS information and resources across the federal government. AIDS.gov provides:

- Up-to-date information on HIV/AIDS resources, programs and policies and key policies and initiatives that impact those living with or at risk for HIV, including the NHAS, the VHAP, the ACA, and the HIV Care Continuum Initiative with targeted information for populations most at risk, such as Black MSM;
- Training and information to federal, state, local, tribal and non-governmental partners on the use of new media in response to HIV/AIDS; and
- Information on viral hepatitis and HIV for the general public, including regular blog posts on these issues and the ongoing implementation of the VHAP.

Viral Hepatitis

Throughout FY 2013, OHAIDP continued to improve the coordination of viral hepatitis activities across HHS and other federal agencies through regular meetings of the Viral Hepatitis Implementation Group (VHIG) which includes twenty-three representatives from across HHS, the Departments of Veterans Affairs, Justice and Housing and Urban Development. In the second quarter of FY 2013, OHAIDP planned and hosted a national, multi-disciplinary, technical consultation addressing the emerging public health problem of new HCV infections among young injection drug users. Scientists from CDC, NIH, and SAMHSA were joined by researchers from academia, health department leaders, and community providers to probe the complexities of this emerging epidemic and to explore potential interventions. OHAIDP coordinated cross-departmental activities to support Hepatitis Awareness Month in May, 2013 and World Hepatitis Day in July 2013. These efforts included promoting and actively disseminating CDC-developed educational materials across HHS and to other federal partners, as well as posting and cross-posting multiple blogs on various aspects of hepatitis B and hepatitis C virus infection on AIDS.gov. Additionally, in FY 2013, OHAIDP undertook a process to renew/update the VHAP, collaborating with the VHIG and soliciting public input through a Request for Information published in the Federal Register as well as a series of webinars and teleconferences to seek input from various non-federal stakeholders on priority activities that should be included in a renewal of the National Viral Hepatitis Action Plan. In both FY 2012 and FY 2013, OHAIDP released reports on the progress toward implementing the goals of the VHAP.

Blood and Tissue Safety

Through the Senior Advisor on Blood & Tissue Policy, OHAIDP manages the HHS Federal Advisory Committee on Blood and Tissue Safety & Availability which provides both public and private sector advice on blood and tissue safety and availability as well as infectious disease concerns related to organ transplantation. In addition, 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 CDC, FDA, NIH, CMS, HRSA, ASPR, and ASPE. OHAIDP is actively engaged in a number of important policy and program issues and activities, including the biennial HHS National Blood Collection & Utilization Survey (NBCUS); the HHS Donor-based Hemovigilance System (DonorHART); the HHS Blood Availability & Safety Information System (BASIS); the Tissue and Organ Donor Epidemiology Study (TODES); and has implemented a number of research activities to review current policies pertaining to blood donor deferral of men who have sex with men. OHAIDP is engaged in the Department's preparedness and response activities, addressing the safety and availability of blood and tissues during national emergencies via various HHS

working groups and councils within the Office of the Assistant Secretary for Preparedness & Response (ASPR) and the HHS Biomedical Advanced Research & Development Authority (BARDA).

Funding History

Fiscal Year	Amount
FY 2010	$929,006
FY 2011	$1,429,000
FY 2012	$1,498,000
FY 2013	$1,459,000
FY 2014	$1,459,000

Budget Request

The FY 2015 President's Budget request of $1,500,000 is $41,000 more than the FY 2014 Enacted. The proposed request will fund baseline activities in support of the President's Advisory Council on HIV/AIDS (PACHA). In addition to PACHA's four subcommittees, the Council established a new subcommittee on Expanding Access to HIV Care. It is charged with providing advice and developing recommendations to HHS related to changes in the Ryan White Care Act Program in light of the full implementation of the Affordable Care Act (ACA). In FY 2013, PACHA released a comprehensive report on "Achieving and AIDS-Free Generation." In FY 2015, PACHA will continue to make significant progress in meeting the goals of the National HIV/AIDS Strategy, specifically addressing ways to reduce HIV-related health disparities and improve outcomes along each step of the HIV Care Continuum and it will continue to provide advice and consultation to ensure the powerful impact that ACA health reforms can have on the 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	6,999	6,999	7,000	+1
FTE	23	23	23	0

Authorizing Legislation: ……..Title XVII, Section 1701 of the PHS Act
FY 2015 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, which underpin 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. The fourth iteration of the 10-year objectives, Healthy People 2020, was released in December 2010.

The *Healthy People 2020* objectives are designed to drive action and help individuals to make healthy lifestyle choices; for health professionals to put prevention into practice; for policy makers, communities and businesses to support health-promoting policies in schools, worksites and other settings; and for scientists to pursue new research. The priorities identified by the National Prevention Strategy mandated by the Affordable Care Act, the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, and other Administration health initiatives align with specific *Healthy People 2020* objectives and overarching goals to increase quality and years of life for all Americans.

In FY 2013, ODPHP continued the development of the online version of *Healthy People 2020* 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 designing a user-centric, web-based resource that expands the reach and usefulness of the national objectives. This new website, which gives users a platform from which to learn, collaborate, plan, and implement objectives, has been continually updated and improved since its launch in FY 2011. In FY 2012, healthypeople.gov received the Gold Health Web Award, recognizing the site as a leader among all health websites and continues to receive consumer satisfaction scores of about 85%, which is well above the average of 73% for public websites (ForeSee Results American Customer Satisfaction Index (ACSI).

In FY 2013, ODPHP initiated a series of bi-monthly public Webinar-based progress reviews of the Healthy People 2020 objectives, 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.

A subset of the Healthy People 2020 objectives, the Leading Health Indicators (LHIs) are used to communicate high-priority health issues and actions that can be taken to address them. The indicators are used by health professionals and policymakers to track progress at national and community levels as the work to achieve the national health objectives. In FY 2013, ODPHP continued the monthly e-bulletin and bi-monthly Webinar series that features organizations using evidence-based approaches to addressing the LHI topics. In FY 2013, participation in the LHI Webinars grew from about 400 sites to an average of nearly 800.

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 DGAs are the basis of Federal nutrition policy and programs. ODPHP is managing and supporting the 2015 Dietary Guidelines Advisory Committee which was established to provide the Departments with independent, science-based advice and recommendations for development of the *DGA 2015*. Based on the preponderance of current scientific evidence, the DGAs provide 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. They also serve as the basis of the nutrition and food safety objectives in *Healthy People 2020* and support 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, NIH, and CDC, led the Department's development and release of the first-ever comprehensive Federal *Physical Activity Guidelines* (PAG), a set of evidence-based recommendations for types and amounts of physical activity for individuals 6 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 March 2013, ODPHP and the President's Council on Fitness, Sports & Nutrition released the Physical Activity Guidelines for Americans Midcourse Report which is supporting health professionals and policymakers in implementing the *PAG*. The Midcourse Report: *Strategies to Increase Physical Activity Among Youth* describes intervention strategies for increasing physical activity among youth aged 3 to 17 years, including evidence-based practices, emerging evidence, and opportunities for additional research.

ODPHP is developing consumer information on both the DGA and PAG for the Spanish-speaking populations. In addition, ODPHP coordinates the review of consumer information to be published by the Department related to nutrition and physical activity to ensure that materials are consistent with the evidence-based messages of the PAG.

healthfinder.gov

ODPHP is congressionally mandated to provide reliable prevention and wellness information to the public. ODPHP fulfills this mandate 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 2013, healthfinder® received two Bronze Web Health Awards: one for the myhealthfinder tool (in the Web-based Resource/Tool category) and the other for healthfinder®'s

responsive design (in the "Mobile Website (Large Mobile Device)" category). Also in FY2013, healthfinder® won a ClearMark award for plain language in the public sector website category. In FY 2013, healthfinder.gov extended the reach of actionable prevention information by disseminating content via Twitter, email newsletters, widgets, and e-cards. The healthfinder® Twitter following grew by about 25,000 new followers in FY 2013, and now has approximately 220,000 followers. A Facebook page was launched at the beginning of FY 2012 and has over 9,000 “likes” to date. The website underwent a refresh in December 2012, which highlights the prevention and wellness brand, making it easier for consumers to identify. Part of this refresh included responsive design (for which it won the Web Health Award) and page tagging. The use of page tagging (instead of log files) enables healthfinder® (as well as the Healthy People and health.gov sites) to report a more meaningful number in terms of people who visit the site.

Health Topics A-Z

A key feature of healthfinder.gov uses everyday language and examples to explain how taking small steps to improve health can lead to big benefits; there are now over 100 featured topics and tools. The website also includes the myhealthfinder tool, developed in a joint effort with AHRQ, to provide personalized recommendations for clinical preventive services from the U.S. Preventive Services Task Force and the Bright Futures Guidelines for preventive services for children. This interactive tool provides personalized decision support for all of the preventive services covered under the Affordable Care Act. In FY 2010, healthfinder.gov launched a content syndication program and tool that provides a way for healthfinder® content to be placed onto other website; healthfinder.gov content was viewed on other sites approximately 43,000 times in FY 2012. For FY 2013, ODPHP launched a mobile app challenge to help consumers make informed health decisions based on healthfinder.gov’s information about services covered under the Affordable Care Act (ACA). The challenge was conducted in two phases and included a component, called crowdsourcing, to gather feedback from end users during the development of the app. The winning app, called myfamily, helps people take action to improve and maintain their family's health by accessing customized prevention information and tips for each family member. To date there have been over 5,000 downloads of the app on the iOS platform; the app will be available both in Spanish and on the Android platform in the coming months.

Funding History

Fiscal Year	Amount
FY 2010	$7,200,000
FY 2011	$7,200,000
FY 2012	$7,186,000
FY 2013	$6,999,000
FY 2014	$6,999,000

Budget Request

The FY 2015 President’s Budget request of $7,000,000 is $1,000 greater than the FY 2014 Enacted Level. The proposed budget request will maintain ODPHP initiatives including *Healthy People*, Dietary Guidelines for Americans (DGAs), and Physical Activity Guidelines for Americans (PAGs) and healthfinder®. ODPHP will focus on continuing to deliver high-quality, user-test tools and resources to health professionals and the public to help achieve the *Healthy People* 2020 goals and implement the DGAs and PAGs.

ODPHP - Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
I.b Visits to ODPHP-supported websites (Output)	FY 2013: 12.59 Million Target: 17.85 Million (Target Not Met)	18.2 Million	6.7 Million[1]	-11.5M
I.c Consumer Satisfaction with healthfinder.gov, measured every three years (Output)	FY 2013: 75% Target: 80% (Target Not Met)	N/A	N/A[2]	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)	80%	84%	+4%

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 will be 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. Over the past two years, ODPHP has begun consolidating and moving 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 (the Physical Activity Supporters Network), currently supporting over 4,500 members. Outreach for The Dietary Guidelines for Americans, for which HHS will have the lead in 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 upon 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, for 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. Additionally the content is presented using the latest science regarding health literacy and plain language dissemination.

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 state's used Healthy People 2010 to inform their health planning processes.

Continued funding will allow ODPHP to expand and 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:

- A relational database integrating objectives with evidence-based practices and demographic data, which will make implementation significantly more targeted and actionable.
- Community planning tools designed by and for Healthy People 2020 stakeholders seeking to establish and maintain health promotion and disease prevention programs at all levels.
- An up-to-date library of best and promising practices to improve outcomes.
- An online collaborative workspace designed by and for stakeholders, across disciplines and geographic locations, to network, to learn, and to plan together.
- A suite of social media tools designed to help Healthy People stakeholders take advantage of the latest, most effective communication and ehealth practices.
- Increase access to Healthy People materials to a greater number of people.
- Reduce disparities by extending access of Healthy People materials to a much broader, more diverse range of users.

Healthy People 2020 objectives are data driven, and based on the best available scientific and knowledge. All tools and resources are evidence based and reviewed by subject matter experts across HHS and other federal departments, as appropriate. Additionally material is developed and presented according to the latest science regarding health literacy and plain language.

Program Data Chart

Activity	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Contracts	-	-	-
National Health Information Center	0	0	0
ODPHP Web and Communication Support[1]	1,672,000	1,672,000	2,358,000
Communication Support	0	0	0
Subtotal, Contracts	1,672,000	1,672,000	2,358,000
Grants/Cooperative Agreements	-	-	-
Disease Prevention and Health Promotion Scholarship Program[2]	200,000	200,000	200,000
Subtotal Grants/Coop	200,000	200,000	200,000
Inter-Agency Agreements (IAAs)			
Disease Prevention and Health Promotion Scholarship Program[2]	200,000	200,000	200,000
Performance measures collection, outreach management, website infrastructure	111,000	111,000	111,000
Subtotal Inter-Agency Agreements (IAAs)	311,000	311,000	311,000
Operating Costs	4,816,000	4,816,000	4,131,000
Total	**6,999,000**	**6,999,000**	**7,000,000**

[1] Includes both the National Health Information Center and Communication Support
[2] In FY13 program was split between a cooperative agreement and an IAA; will continue same practice into FY15

Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	1	1	1
Average Award	$200,000	$200,000	$200,000
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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	1,215	1,215	2,100	+885
FTE	6	6	6	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2015 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 President Dwight D. Eisenhower in 1956 by Executive Order 13545. Over the years, the scope of the Council expanded and changed its name through Executive Orders to address people of all ages, backgrounds, and abilities and to include the promotion of good nutrition. 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 all Americans to adopt a healthy lifestyle that includes regular physical activity and good nutrition. PCFSN advises the President, through the Secretary of HHS, 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 HHS 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 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 via a co-sponsorship agreement with the Amateur Athletic Union. 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 2013, approximately 300 organizations signed on to promote and/or administer the Presidential Active Lifestyle Award (PALA+) program through their networks.

The Presidential Youth Fitness Program (PYFP) (www.presidentialyouthfitnessprogram.org) 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% of U.S. public and private schools by 2020. Within the first year of implementation (September 2012-September 2013), PYFP:

- Educated 5,696 individuals through the free webinar series, a number that continues to grow through the PYFPLive YouTube channel.
- Hosted 116,769 unique visitors on the program website.
- Supplied 10,015 individuals with the Physical Educator Resource Guide.
- Recognized more than 400 schools as program participants

- Enhanced 511 schools' fitness education programming through the Inaugural Funding Opportunity. This includes 20 full school districts.

The *Physical Activity Guidelines for Americans Midcourse Report: Strategies to Increase Physical Activity Among Youth* was released by HHS in March 2013. Over the course of a year, PCFSN convened a subcommittee to review the evidence on effective strategies to increase physical activity opportunities for youth between the ages of 3 and 17 where they live, learn, and play. Promotion of the Guidelines and the recommendations of the subcommittee will continue in FY 2015.

In FY 2013, PCFSN partnered with the Alliance for Health, Physical Education, Recreation & Dance (AAHPERD) and the Alliance for a Healthier Generation (AHG) to launch *Let's Move!* Active Schools (LMAS). This sub-initiative focuses on creating active school environments to ensure that all students achieve at least 60 minutes of physical activity per day where they live, learn and play based on the recommendations of PAG and PAG Midcourse Report. Within the program, participating schools gain access to free opportunities such as activation grants, professional development and technical assistance in the following program areas: physical education, physical activity during school, physical activity before and after school, staff involvement, as well as family and community engagement. 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. As the lead federal office, PCFSN oversees the implementation, communications, and strategic direction for the program with support from AAHPERD and AHG.

It is estimated that 56 million Americans have a disability that requires special services. HHS' *Healthy People 2020* and CDC report that notable disparities in health and healthcare exist for this population. 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 FY 2013, PCFSN launched Phase II of the ICDI program which now served children and adults with disabilities. FY 2014 will serve as the inaugural year for new sites 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 nationwide by 2018.

PCFSN partnered with the Food and Nutrition Service (FNS) at the U.S. Department of Agriculture to launch an outreach campaign for the 2013-2014 academic year, emphasizing the importance of eating a healthy breakfast and highlighting the national School Breakfast Program. This promotion includes two PSAs featuring Council co-chair Dominique Dawes and Council member Allyson Felix as well as posters featuring various Council members for display in school cafeterias.

PCFSN's continued partnership with the American Council on Exercise and the International Health, Racquet & Sportsclub Association has provided free fitness benefits for the families of deployed active duty National Guard and Reserve members. As of FY 2013, 130,000 hours of complimentary personal training and 50,000 gym memberships have been pledged to help those family members start or maintain a healthy lifestyle. In FY 2014 and FY 2015, PCFSN will evaluate the need for diversifying these fitness offerings and expanding the eligibility requirements to include more service members and their families.

Funding History

Fiscal Year	Amount
FY 2010	$1,225,000
FY 2011	$1,225,000
FY 2012	$1,248,000
FY 2013	$1,215,000
FY 2014	$1,215,000

Budget Request

The FY 2015 President's Budget request of $2,100,000 is $885,000 more than the FY 2014 Enacted. PCFSN will partner with the OASH Office of Disease Prevention and Health Promotion to increase wide-spread adoption of the *Physical Activity Guidelines* (PAG) and the PAG Midcourse Report. This includes raising awareness of the most effective intervention strategies to encourage America's youth to be physically active for at least 60 minutes per day. 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, play, and learn.

In FY 2015, PCFSN expects to engage at least 55 percent of U.S. schools (66,000) and secure their adoption of the Presidential Youth Fitness Program. The Council expects to provide physical activity opportunities to at least 28 million students (K-12) nationwide through the program in FY 2015. PCFSN projects that it will reach 90 percent of schools by 2020, with approximately 45 million students participating in the program.

PCFSN - Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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)**	**85% of students served by the PEP grant engage in 60 minutes of daily physical activity**	**90% percent of students served by the PEP grant engage in 60 minutes of daily physical activity**	**+5 percent**
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)**	**1,344,000**	**1,800,000**	**+456,000**
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)**	**100 million media impressions**	**300 million media impressions**	**+200 million**

Performance Analysis

The PCFSN performance measures tracks 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. 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 FY 2015. In addition, PCFSN has raised its direct outreach and engagement targets via online assets, including a 456,000 increase in the number of website visitors to the dedicated PAG website and a 200 million increase in social and traditional media impressions for FY 2015.

OFFICE FOR HUMAN RESEARCH PROTECTIONS

Budget Summary
(Dollars in Thousands)

Office for Human Research Protections	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	6,756	6,756	6,800	+44
FTE	33	33	33	0

Authorizing Legislation: .....Title III, Section 301 of the PHS Act
FY 2015 Authorization.....Indefinte
Allocation Method.....Direct Federal, Contracts, and Other

Program Description and Accomplishments

The Office for Human Research Protections (OHRP) is the lead federal office assuring the integrity of the clinical research enterprise, an enterprise dependent on the willingness of millions of people to volunteer as human research subjects. OHRP has oversight over more than 10,000 institutions in the US and world-wide, which conduct clinical and other research.

OHRP's mission is to assure those volunteers that the federal government is strongly protecting their well-being since any harm, real or perceived can reduce the pool of volunteers for scientific studies and clinical research trials and 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.

OHRP efforts to reform and ensure the protection of human research subjects includes review of current regulation, and proactively reviewing requirements that do little or nothing to protect research subjects. In July 2011, OHRP completed the work enabling HHS, in coordination with the Office of Science and Technology Policy, 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". More than 1,000 public comments were submitted. This is the beginning of a groundbreaking effort to strengthen protections and adjust the regulatory system to changes in the evolving research enterprise. Through guidance and changes in the regulations, OHRP is ensuring that the current system avoids inappropriate delays in the advancement of medical knowledge.

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 documents 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 provides educational opportunities through sponsored Research Community Forums and Quality Assessment Workshops, invited presentations at educational events, educational videos and webinars, and educational assistance to constituents through phone calls and emails. 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 2010	$6,949,000
FY 2011	$6,949,000
FY 2012	$6,937,000
FY 2013	$6,756,000
FY 2014	$6,756,000

Budget Request

The FY 2015 President's Budget request of $6,800,000 is $44,000 more than the FY 2014 Enacted. The proposed increase will support program activities and allow OHRP to expand its educational activities, 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 2015:

- Co-sponsor three Division of Education and Development (DED) Research Community Forums in distinct regions reaching approximately 1,100 people
- Host four Quality Assessment Workshops across the country; free, hands-on, intensive one-day events reaching more than 500 individuals
- Provide education to more than 2,000 individuals through webinars, videoconferences, and other forms of "virtual" education
- Provide more than 90 presentations to groups and institutions in the regulated community, reaching more than 5,000 individuals
- Process more than 3,300 Institutional Review Board Registrations and approve over
- 4,000 Federal wide Assurances of Compliance
- Process and close more than 600 incident reports from institutions; these include reports of any unanticipated problems involving risks to subjects or others or 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.

NATIONAL VACCINE PROGRAM OFFICE

Budget Summary
(Dollars in Thousands)

National Vaccine Program Office	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	6,659	6,659	6,000	-659
FTE	17	17	17	0

Authorizing Legislation: .....Title XXI of the Public Health Service Act
FY 2015 Authorization.....Expired
Allocation Method.....Direct Federal; Contracts

Program Description and Accomplishments

The National Vaccine Program Office (NVPO) was created by Congress in 1987, to provide leadership and coordination among Federal agencies to carry out the goals of the National Vaccine Plan. The Plan includes goals, objectives, and strategies for pursuing the prevention of infectious diseases through immunization. The five goals of the National Vaccine Plan are:

- Develop new and improved vaccines;
- Enhance the vaccine safety system;
- Support communications to enhance informed vaccine decision-making;
- Ensure a stable supply of, access to and better use of recommended vaccines in the United States;
- Increase global prevention of death and disease through safe and effective vaccination.

NVPO coordinates interaction between the HHS agencies and across the federal government and interacts with stakeholders through regular communication on issues including vaccine research and development, vaccine coverage, vaccine supply, vaccine financing, vaccine safety, education and communications, and international vaccine and immunization initiatives. NVPO advances the Secretary's priority on prevention and health promotion by enhancing the vaccine enterprise. Highlights 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 Report, which identifies the key indicators which will be used to measure progress on the National Vaccine Plan going forward. A progress report is posted at: http://www.hhs.gov/nvpo/vacc_plan/annual-report-2013/nvp-2013.html

The National Vaccine Advisory Committee (NVAC) will conduct a mid-course review of the plan in FY 2015.

- *National Vaccine Advisory Committee (NVAC)*. NVPO serves as Executive Secretariat for NVAC which advises and makes vaccine-related recommendations to the ASH. NVAC meets at a minimum of three times per year and is supported by NVPO. NVAC has recently developed a report and recommendations on HHS' role in global immunization and is in the process of developing recommendations on maternal immunization, HPV vaccine coverage, and addressing vaccine hesitancy/confidence in parents of young children. NVPO will continue to strengthen our support of all NVAC initiatives and is increasing the visibility and transparency of the Committee through webcasts of its meetings.

- *Adult Immunization.* Following the 2009 H1N1 pandemic, NVPO led an interagency review of seasonal influenza in an effort to strengthen existing systems for vaccine delivery. Following this effort, in 2012, the interagency group expanded the scope of the review to focus on adult immunizations. This effort works to support NVAC recommendations on adult immunizations in partnership with multiple stakeholders as part of the National Adult and Influenza Immunization Summit, which is led by NVPO along with CDC and the Immunization Action Coalition. Key activities include provider and patient education; expanding access to adult vaccines; reducing health disparities in adult immunization; and establishing standards for adult immunization quality measurements by which we can measure progress. In addition, NVPO leads and coordinate the Assistant Secretary for Health's Adult Immunization Task Force designed to support adult immunization activities and collaborate among our federal partners. NVPO continues to work with the Inter-Department task force to identify gaps and barriers to improving adult immunization rates. NVPO will continue to expand and improve this effort.
    - During the H1N1 pandemic, the role of pharmacists in improving vaccine access was highlighted. NVPO has implemented an effort to explore how pharmacists can facilitate collaboration, coordination and communication amongst the healthcare community as it pertains to adult immunization. This effort includes data collection, analysis, education and communication of information to guide immunizing pharmacists and other stakeholders in meeting Healthy People 2020 goals.
    - Reducing vaccine preventable diseases in adults is a national health priority. Adult vaccination coverage rates remain low for most routinely recommended vaccines and are well below Healthy People 2020 targets. NVPO has contracted with RAND to develop a National Adult Immunization Plan that will identify priority areas for program efforts and identify and develop targets for performance indicators. NVPO will also develop an implementation plan outlining discrete activities with measurable milestones to monitor progress on improving adult immunization.
    - NVAC recently released its updated Standards for Adult Immunization Practices (http://www.hhs.gov/nvpo/nvac/reports/nvacstandards.pdf). These are now being adopted by a number of medical professional societies whose members provide health care services for adults. It is envisioned that these will become the standards for adult immunization practice in the United States.

- *Coordination and Enhancement of Immunization Safety.* In April 2008, the Secretary formed a cross-government, Federal Immunization Safety Task Force. The Task Force includes HHS OPDIVs with assets in immunization safety (NIH, FDA, CDC, HRSA, CMS, IHS) and VA and DoD and led by the Assistant Secretary for Health. It is charged with: ensuring that all federal assets relevant to immunization safety are coordinated and synergies identified; coordinating vaccine safety strategic planning, including development of a vaccine safety scientific agenda; and ensuring a coordinated response to emerging immunization safety issues.

- *Pandemic Influenza Preparedness*. NVPO provides scientific direction to HHS pandemic influenza planning and preparedness activities coordinating with the Office of the Assistant Secretary for Preparedness and Response, HHS OPDIVs, and other Federal agencies. Key activities include developing national guidance on prioritization of pandemic and pre-pandemic influenza vaccines, guidance on antiviral drug procurement and use strategies, and coordination in updating the HHS pandemic influenza preparedness and response plan. Using influenza vaccination as the platform for a broader adult immunization effort, including the creation of an "adult vaccine finder" web site, with geo-located sites where adult vaccines are administered.

- *Pertussis*: The resurgence of pertussis (whooping cough) has required a broad examination of the root cause(s) of the problem. NVPO, with NIH, FDA and CDC, organized and hosted a small meeting of relevant stakeholders to examine this problem. This served as the basis for a special session at the annual Infectious Diseases Society of America meeting in 2013 and the summary and recommendations will be published in a supplement to the Journal of Infectious Diseases in March 2014.

- *Vaccine Communications*. NVPO and the office of the Assistant Secretary for Public Affairs led an interagency group to refine internal communications in the setting of emerging vaccine-related issued (e.g., vaccine shortage, vaccine safety signal, etc.) that has provided valuable lessons for improved communication coordination going forward. Key activities include operating vaccines.gov and working to re-establish a Spanish-language version of that site; supporting short-term and long-term public education activities; establishing and maintaining strong working relationships with communications staff from across the Department; and providing strategic counsel to senior leaders.

- *Health Information Technology and Immunizations.* Immunization Information Systems/Registries continue to surface as a viable solution to improving uptake and tracking of adult immunization. Partnering with ONC, NVPO is convening HHS partners and others to improve the functionality and use of immunization information systems (registries) to improve vaccine and vaccination tracking.

Funding History

Fiscal Year	Amount
FY 2010	$6,839,000
FY 2011	$6,839,000
FY 2012	$6,837,000
FY 2013	$6,659,000
FY 2014	$6,659,000

Budget Request

The FY 2015 President's Budget request of $6,000,000 is $659,000 less than the FY 2014 Enacted Level. The reduction will be accomplished primarily through absorption of previously funded activities within the base budget of other divisions in HHS.

In FY 2015, NVPO will engage in efforts related to preventive or educational or wellness services supported through academic health care or community health care settings, focused on projects (pilot/demonstration projects) to include children, pregnant, diverse, and adult populations designed to decrease infectious diseases by stimulating immunization rate improvements.
Projects include:

1. Examine evidence-based practices relating to prevention, with a particular focus on high priority areas as identified in the National Prevention Strategy or Healthy People 2020
2. Analyze the translation of interventions from academic settings to real world settings, and
3. Identify effective strategies for organizing, accessing, or delivering immunization education and services in community settings.

OFFICE OF ADOLESCENT HEALTH

Budget Summary
(Dollars in Thousands)

Office of Adolescent Health	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	1,070	1,500	1,500	0
FTE	4	4	4	0

Authorizing Legislation: ……..Section 1708 of the Public Health Service Act
FY 2015 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).

OAH administers the Teen Pregnancy Prevention (TPP) discretionary grant program to support evidence-based and innovative approaches to teen pregnancy prevention. OAH coordinates its efforts with other HHS offices and OPDIVs to make competitive grants to public and private entities to fund medically accurate and age appropriate programs that reduce teenage pregnancy. In FY 2010, OAH issued joint funding opportunity announcements with both the ACF's Personal Responsibility Education Program and the CDC's Safe Motherhood Program. The TPP program supports a total of 102 grant projects for a five year project period (FY 2010-2014) in 39 states and the District of Columbia. Additionally, OAH manages the Pregnancy Assistance Fund (PAF), a program of competitive grants to States and Tribes to support pregnant and parenting teens and women, as authorized by the Affordable Care Act (ACA). In FY 2013, the PAF program awarded 17 new grants to States and Tribal organizations for a four year project period (FY 2013-2016).

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 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 2010	$500,000
FY 2011	$1,098,000
FY 2012	$1,098,000
FY 2013	$1,070,000
FY 2014	$1,500,000

Budget Request

The FY 2015 President's Budget request of $1,500,000 is equal to the FY 2014 Enacted Level. These funds will be used to coordinate with key stakeholders efforts to reduce the health risk exposure and risk behaviors among adolescents. This includes support for the implementation of a national health agenda on adolescent health, Adolescent Health: Think, Act, Grow.

PUBLIC HEALTH REPORTS

Budget Summary
(Dollars in Thousands)

Public Health Reports	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	486	486	400	-86
FTE	2	2	2	0

Authorizing Legislation: .....Title III of the PHS Act
FY 2015 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 continuously since 1878. It is published in partnership with the Association of Schools of Public Health (ASPH). 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. The overall goal is to facilitate the movement of science into public health policy and practice in order to positively affect the health and wellness of the American public.

Public Health Reports is published six times per year. In addition, each year, three or more supplemental or special issues are published and two to three science-based webcasts are produced. Columns in the regular issues include: *Surgeon General's Perspective*, *Executive Perspective*, *Recommendations and Reports*, *Global Health Matters*, *Law and the Public's Health*, *Public Health Chronicles*, *Local Acts, Focus on Environmental Health, NCHS Dataline*, and *From the Schools of Public Health*. Supplements bring focus to topics of interest to the public health community; recent topics include: *Social Determinants of Health, Program Collaboration and Service Integration, Tobacco, and Public Health Laboratories.*

The entire set of *PHR* journal articles from 1878 has been digitized and is currently available on the internet at: http://www.ncbi.nlm.nih.gov/pmc/journals/333/

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 2010	$448,000
FY 2011	$448,000
FY 2012	$499,000
FY 2013	$486,000
FY 2014	$486,000

Budget Request

The FY 2015 President's Budget request of $400,000 is $86,000 less than the FY 2014 Enacted Level. For FY 2015, PHR will limit funds for technical editing and targeted marketing and outreach and professional development.

OFFICE OF MINORITY HEALTH

Budget Summary
(Dollars in Thousands)

Office of Minority Health	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	39,533	56,670	36,000	-20,670
FTE	63	63	57	-6

Authorizing Legislation: .....Title XVII, Section 1707 of the PHS Act
FY 2015 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's mission is to improve the health of racial and ethnic minority populations through the development of policies and programs that help eliminate disparities. Program activities focus on improving the health status and health outcomes for African Americans, Hispanics/Latinos, American Indians, Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders.

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 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 crosscutting initiatives, minimizes programmatic duplication, and leverages funds to reduce health disparities.

OMH leads and oversees the implementation of the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS Disparities Action Plan). The HHS Disparities Action Plan is the most comprehensive federal commitment on health disparities and charges all HHS operating and staff divisions to heighten the impact of HHS policies and programs to reduce health disparities, builds on the foundation of the Affordable Care Act, and leverages other key national initiatives. A key component of the HHS Disparities Action Plan is the enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards), which were released by HHS in April 2013. The CLAS Standards are intended to advance health equity, improve quality, and eliminate health care disparities by establishing a blueprint for health and health care organizations to implement and provide culturally and linguistically appropriate services.

A second important leadership effort for OMH is 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. A key product of the NPA, the National Stakeholder Strategy for Achieving Health Equity provides a common set of goals and objectives for public and private sector initiatives and partnerships to help racial and ethnic minorities, and other underserved populations, reach their full health potential. Both plans build on the strong foundation of the Affordable Care Act

and are aligned with programs and key initiatives such as Healthy People 2020, the Let's Move initiative, and the President's National HIV/AIDS Strategy.

In FY 2013, OMH led the following workgroups and committees, which will continue in FYs 2014 and 2015:

- **Advisory Committee on Minority Health (ACMH) -** The ACMH advises the Deputy Assistant Secretary for Minority Health on ways to improve the health of racial and ethnic minority populations, and on the development of goals and program activities within the Office of Minority Health.
- **HHS Health Disparities Council -** The HHS Health Disparities Council is an important, departmental coordinating body on minority health and health disparities. Chaired by the Assistant Secretary for Health and the Assistant Secretary for Planning and Evaluation, the Council is comprised of senior-level representatives from operating and staff divisions across HHS, including the Deputy Assistant Secretary for Minority Health, the directors of the individual Offices of Minority Health, and the director of the National Institute on Minority Health and Health Disparities.
- **Federal Collaboration on Health Disparities Research (FCHDR)** - FCHDR was established to engage a wide range of federal agencies in cross-agency research partnerships to promote more coordinated efforts that target health improvement in populations disproportionately affected by disease, injury, and/or disability. FCHDR supports the NPA and the HHS Disparities Action Plan goals for improved coordination and use of research and evaluation outcomes.
- **Federal Interagency Health Equity Team (FIHET)** - The FIHET provides guidance for the implementation of the National Stakeholder Strategy and implement the NPA. The FIHET is comprised of representatives from 12 federal departments and agencies: Health and Human Services, Agriculture, Commerce, Defense, Education, Housing and Urban Development, Homeland Security, Justice, Labor, Transportation, Veterans Affairs, as well as the Environmental Protection Agency. The FIHET's goals are to: (1) identify opportunities for federal agency collaboration, partnership, and coordination on efforts that are relevant to the NPA; (2) provide leadership and guidance for national, regional, state, tribal, and local efforts that address health equity; and (3) leverage any opportunities for integrating health disparities into their policies, practices, and initiatives.
- **HHS American Indian and Alaska Native (AI/AN) Health Research Advisory Council (HRAC)** - The HRAC was established to provide a venue for the department to consult with tribes about health research priorities and needs in AI/AN communities, and collaborative approaches in addressing these issues and needs. The HRAC is comprised of elected tribal officials from each of the 12 Indian Health Service Areas, and Washington based tribal organizations that have been designated by elected tribal officials, in their official capacity, to act on behalf of the elected officials. The HRAC serves three primary functions: (1) obtaining input from tribal leaders on health research priorities and needs for their communities; (2) providing a forum through which HHS operating and staff divisions can better communicate and coordinate AI/AN health research activities; and (3) providing a conduit for disseminating information to Tribes about research findings from studies focusing on the health of AI/AN populations.
- **HHS Workgroup on Asian, Native Hawaiian, and Pacific Islander Issues -** This workgroup is comprised of representatives from HHS operating and staff Divisions and works to improved communication and coordination of programs and activities related to Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPI). The workgroup oversees the implementation of the HHS Plan for AANHPI Health which outlines departmental priorities and goals for improving the health and well-being of the AAHNHPI population.
- **HHS Promotores de Salud Steering Committee -** HHS Promotores de Salud Steering Committee is comprised of community health workers, peer leaders, patient navigators and health advocates. The goal of this initiative is to recognize the important contributions of promotores in reaching

vulnerable, low income, and underserved members of Latino/Hispanic populations, and promote the increased engagement of promotores to support health education and prevention efforts and access to health insurance programs.

OMH supports efforts to raise awareness about health disparities and disseminate tools and other relevant information to communities whose populations are affected. These programs include:

- OMH's Performance Improvement and Management System (PIMS) is used to improve the quality of the planning, implementation, and evaluation of programs.
- Office of Minority Health Resource Center (OMHRC) is the nation's largest repository of information on minority health issues, health disparities data and literature, and health equity. OMHRC serves as a key resource for health professionals, researchers, policymakers, and consumers nationwide seeking information on minority health and related issues. The resource center acts as the mechanism for the development and dissemination of outreach activities and communications vehicles for the agency. This includes implementing national health campaigns and disseminating useful information to public health professionals and community-based organizations. OMHRC also provides technical assistance and capacity building services and training to minority focused, community-based organizations, health departments, tribal organizations, and other stakeholders regarding all aspects of organizational development, program development, cultural competency and grant writing.
- The Center for Linguistic and Cultural Competence in Health Care (CLCCHC) promotes the delivery of culturally and linguistically appropriate health care services to racially and ethnically diverse populations in collaboration with Federal, public, and private partners. CLCCHC hosts Think Cultural Health (TCH), an online clearinghouse of information pertaining to cultural and linguistic competency. TCH features e-learning programs that equip physicians, physicians assistants, and nurse practitioners; other nursing professionals and social workers; disaster mental health workers, first responders (including Emergency Medical Technicians and firefighters), and emergency managers with the cultural and linguistic competencies required to improve the quality of care for diverse communities. In FY 2013 and FY 2014, TCH will develop and launch additional e-learning programs for oral health professionals, Promotores de Salud (on food insecurity and its relationship to obesity in Latino communities), and health care policy- and decision-makers. These e-learning programs have over 135,000 registrants total, and Think Cultural Health has awarded over 675,000 credits to date.

OMH program support plays a critical role in supporting the Department's strategic goals and empowering individuals and communities to develop targeted evidence-based solutions that eliminate health disparities, achieve health equity, and promote prevention and wellness across the lifespan. This includes support for:

- **The American Indian and Alaska Native (AI/AN) Partnership Program** provides support to tribal epidemiology centers and their respective tribal leaders, and to Urban Indian Health Programs to collect and manage more effectively and facilitate evidence-based health care decision making, address health disparities planning and create a pipeline program for students to increase ethnic diversity in the public health and biomedical sciences professions. The AI/AN Partnership Program support the HHS Secretary's strategic initiative to leverage data for maximum public good. In FY 2013, an estimated 1,600 individuals received services and/or training. This program is expected to similarly impact almost 1,700 individuals in FY 2014 and FY 2015.
- **The Curbing HIV/AIDS Transmission Among High Risk Minority Youth and Adolescents (CHAT) Project** used a peer-to-peer outreach model and social media grantees provided HIV prevention education, counseling/testing and social services to approximately 15,000 high risk youth in alternative and court ordered living and education settings to conduct HIV tests for an estimated

2,800 youth, and linked 95 percent of participating youth to social and supportive services. This program will serve nearly 16,000 high risk minority youth in FY 2014. The CHAT project period will end in FY 2014.

- **The HIV/AIDS Health Improvement for Re-Entering Ex-Offenders Initiative (HIRE) Project** is designed to improve the HIV/AIDS health outcomes of ex-offenders re-entering the mainstream population from federal and state prisons. In FY 2013, more than 30,000 HIRE participants received services (HIV counseling and testing, linkages to health care and linkages to social/supportive services including housing) in New York, Florida and Georgia. It is expected that 31,000 HIRE reentrants and their partners will benefit from the HIV services, comprehensive medical care and social/supportive services in FY 2014. The HIRE project period will end in FY 2014.
- **The Linkage to Life Program: Rebuilding Broken Bridges for Minority Families Impacted by HIV/AIDS (L2L)** addresses gaps in healthcare, social, and supportive services for high-risk minority families living with HIV/AIDS or at risk for HIV infection who are in transition from domestic violence, substance abuse treatment and incarceration, and their dependent children. During FY 2013, more than 23,000 received services (HIV CTR, linkages to health care, social and supportive services including housing) provided by L2L grantees. It is expected that more than 24,000 individuals/families will be similarly assisted in FY 2014. The L2L project period will end in FY 2014.
- **The Minority Youth Tobacco Elimination Project (MYTEP)** will identify the most promising smoking cessation and prevention strategies in racial and ethnic minority groups and increase the number of minority youth, young adults, and low SES women of child bearing are that access and use evidence-based tobacco cessation and preventive services. FY 2013 MYTEP activities involved full-scale implementation of culturally appropriate strategies and activities, wide-scale support and guidance provided to grantees by national tobacco experts, and collection of detailed data needed to track and evaluate MYTEP outputs, outcomes, and accomplishments. The MYTEP project period will end in FY 2014.
- **The Youth Empowerment Program (YEP*)*** reached nearly 16,000 at-risk minority youth and their families in FY 2013. They received tutoring, mentoring, career, social and life skill development services through innovative and multi-partnership collaborative approaches. 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. This program will serve 25,000 at-risk minority youth and their families in FY 2014 and FY 2015.
- The **State Partnership Grant to Improve Minority Health (SPG)** strengthens coordination of health disparity and health equity efforts and policies intended to improve outcomes for minority communities by supporting state offices of minority health across the country. STPP responds to Secretary Sebelius' strategic initiatives to advance the health, safety, and well-being of the American people and promote economic and social well-being for individuals, families, and communities. It is estimated that the SPG will engage more than 220,000 organizations and citizens in FY 2014. The SPG project period will end in FY 2014.
- **The National Umbrella Cooperative Agreements** demonstrate that partnerships between Federal agencies and national organizations can efficiently and effectively: (1) improve access to care for targeted racial and ethnic minority populations; (2) address social determinants of health to achieve health equity for targeted minority populations through projects of national significance; (3) increase the diversity of the health-related work force; and (4) increase the knowledge base and enhance data availability for health disparities and health equity activities. The use of the cooperative agreement funding mechanism facilitates the ability of HHS and other Federal agencies to work with OMH funded grantees to carry out a broad range of projects. In FY 2013, nearly 130,000 individuals were served through the 22 projects

implemented by national organizations. It is expected more than 130,000 individuals will be served by this program in FY 2014. The NUCA project period will end in FY 2014.

Funding History

Fiscal Year	Amount
FY 2010	$55,900,000
FY 2011	$55,888,000
FY 2012	$55,782,000
FY 2013	$39,533,000
FY 2014	$56,670,000

Budget Request

The FY 2015 President's Budget request of $36,000,000 is $20,670,000 less than the FY 2014 Enacted Level. This reduction will be primarily accomplished through streamlining contract support for the OMHRC, CLCCHC, implementation of NPA, and logistics support.

In FY 2015, 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. OMH will scale implementation and evaluation activities for both of these initiatives to meet the FY 2015 funding level. 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 Health Insurance Marketplace through its many national, regional, State and Territorial, Tribal, and community-based partnerships and networks across the nation. In FY 2015, OMH will fund targeted new grants to reduce health disparities and increase awareness of minority health issues to the most at-risk populations.

In FY 2014 OMH initiated My Brother's Keeper which supports the Administration's My Brother's Keeper Initiative through a Violence Interrupters Training Demonstration Program to implement strategies to decrease youth violence in targeted communities; and the Black and Latino Male Health Education Teaching and Mentoring Surge which aims to build the capacity of communities to identify the social and community risks for youth violence.

OMH - Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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 2013: 28% Target: 10% (Target Exceeded)**	**15%**	**20%**	**+5%**
4.3.1 Increased average number of persons participating in OMH grant programs per $1 million in OMH grant support (Efficiency)	**FY 2013: 27,299 (Target Exceeded)**	**16,953**	**12,928**	**-4,025**
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 2013: 34,134 Target: 27,965 (Target Exceeded)**	**28,804**	**4,533**	**-24,271**
4.4.1 Unique visitors to OMH-supported websites (Output)	**FY 2013: 2,249,202 Target: 585,000 (Target Exceeded)**	**590,000**	**595,000**	**+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 (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)	**FY 2013: 38% Target: 27% (Target Exceeded)**	**34%**	**37.5%**	**+3.5%**
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: 34% Target: 32% (Target Exceeded)**	**34%**	**35%**	**+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 20% 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 Assistant Secretary for Health's priority goal to eliminate health disparities and achieve health equity. In FY 2014, OMH will continue a number of grant programs 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.

4.4.1: The OMH supported websites are administered by the OMHRC. The main website, minorityhealth.hhs.gov, houses a digital database of the knowledge center collection, minority health and health disparities data and literature, resources for CBOs and FBOs 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 Disparities Action Plan and NPA (minorityhealth.hhs.gov/npa), conducting media and educational outreach to 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 approximately 600,000 unique visitors to these websites in the next year.

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 2015 funding level and OMH's grant policy.

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 ASH's priority goal to eliminate health disparities and achieve health equity. 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 2% increase in the percentage of promising approaches, models, and evidence-based practices produced by OMH-funded grantees and cooperative agreement partners per year.

Program Data Chart

Activity	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Contracts			
OMH Resource Center	3,450,000	3,500,000	2,200,000
Logistical Support Contract	2,400,000	1,600,000	900,000
National Partnership for Action to End Health Disparities	0	4,045,000	1,000,000
Center for Linguistic and Cultural Competency in Health Care	1,700,000	1,700,000	1,300,000
Promotores de Salud Initiative	0	0	0
HHS Action Plan to Reduce Racial and Ethnic Health Disparities	600,000	680,000	0
Evaluation	900,000	1,100,000	600,000
State Minority Health Task Force	0	2,500,000	0
Subtotal, Contracts	9,050,000	15,125,000	6,000,000
Grants/Cooperative Agreements			
Health Disparities Programs:			
State Partnership Programs	3,250,000	3,231,471	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]	1,300,000	1,300,000	0
Youth Empowerment Program	2,100,000	2,100,000	2,100,000
Conference Support	0	400,000	0
Minority Youth Tobacco Elimination Project	1,000,000	1,000,000	0
Delta Region Institute (*Formerly Health Disparities – Mississippi*)	0	0	0
Specified Project – Lupus	0	2,000,000	0
National Minority Male Health Project	0	0	0
Minority Community HIV/AIDS Partnership	0	0	0
National Umbrella Cooperative Agreements	3,825,000	5,175,000	2,400,000
My Brother's Keeper	0	5,500,000	5,500,000
Partnership to Increase Coverage for Communities of Color	0	2,550,000	0
Partnership Active Communities to Achieve Health Equity	0	1,500,000	1,500,000
Subtotal, Grants/Coop	12,675,000	25,906,471	15,700,000
Inter-Agency Agreements (IAAs)	4,150,000	2,750,000	800,000
Operating Costs	13,658,000	12,838,529	13,500,000
Total	39,533,000	55,670,000	36,000,000

[1]Formerly titled: Community Partnership

Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	68	82	71
Average Award	$186,397	$315,216	$221,127
Range of Awards	$100,000-$300,000	$100,000-$2,000,000	$150,000-$1,100,000

OFFICE ON WOMEN'S HEALTH

Budget Summary
(Dollars in Thousands)

Office on Women's Health	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	33,002	34,050	29,500	-4,550
FTE	43	43	43	0

Authorizing Legislation: ……..Title II, Section 229 of the PHS Act
FY 2015 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 in 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. In addition to the national office, OWH supports Regional Women's Health Coordinators (RWHCs) in each of the 10 HHS Regional Offices; these Coordinators administer programs and lead initiatives at the regional, state, and local level related to women's and girls' health.

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), OWH chairs this committee which advises the Assistant Secretary for Health on current and planned activities across HHS that safeguard and improves the health of women and girls. The CCWH and OWH continue to monitor implementation of ACA provisions that relate to women's health, particularly with regard to promoting screening and counseling for interpersonal and domestic violence in health care settings as a part of the ACA's preventive health services for women.

- HHS VAW Steering Committee (VAW-SC) was established in 1996 to work collaboratively and collectively on issues involving violence against women and girls. OWH chairs the committee which works strategically to improve awareness, increase collaboration, advance evidence-based programs and policies. It is comprised of senior-level representatives from each of the Federal agencies and offices within the Department. The VAW-SC representatives foster critical linkages among research, education, training, prevention, safety, and care and service systems to improve the Department's response to violence against women and girls.

- Chronic Fatigue Syndrome Advisory Committee (CFSAC), in accordance with the Federal Advisory Committee Act, OWH leads the CFSAC which is composed of non-federal researchers, clinicians, a patient representative, and federal *ex-officio* representatives. This committee meets semiannually and 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.

- OWH is an official HHS representative to 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. A report of recommendations has been developed to show how federal agencies can work together to address the intersection of these issues. OWH also continues to work collaboratively with the White House Office of National AIDS Policy, the President's Advisory Council on HIV/AIDS, and the HHS Office of HIV/AIDS and Infectious Disease Policy in the implementation of the National HIV/AIDS Strategy to ensure that it addresses the critical needs of women and girls.

Model Programs on Women's and Girls' Health

OWH supports culturally appropriate activities and programs through grants and contracts aimed at gathering evidence on effective strategies to help women and girls of all ages live healthier lives.

For example, OWH continues to implement Project Connect, in 2014, a multi-state initiative started in 2010 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 programs also focus on advancing the science on effective women's health interventions.

- OWH launched Phase II of the Coalition for a Healthier Community (CHC) program in September 2011. During Phase I, 16 coalitions comprised of local, regional, and national organizations, academic institutions, and public health departments across the country were asked to develop a strategic plan to address health conditions that adversely affected the health of women and girls in their community. During Phase II, 10 of the original 16 grantees were selected to implement their five year strategic plans, which have goals and objectives linked to *Healthy People 2020*. Two years into the program, CHC grantees have facilitated policy changes at the local and state level. In FY 2012, OWH awarded a contract for a three year, multi-site evaluation of CHC.
- OWH awarded five contracts in FY 2012 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 such as healthcare systems and physical activity/nutrition environments. In the United States, lesbian and bisexual women are known to have substantially higher prevalence rates of obesity than women overall. OWH plans to award a contract in FY 2013 to establish a data coordinating for the program. The contractor will manage the program evaluation and support the publication of article on the outcome of the project.
- OWH continues its efforts to educate underserved and minority women and girls about HIV/AIDS. In FY 2014, OWH plans to launch the *Know the Facts First* campaign. This social marketing campaign targets teen girls with the goal of empowering teen girls to make informed decisions about sexual activity to reduce sexually transmitted infection among teen girls. The campaign was developed in collaboration with the Centers for Disease Control and Prevention, Office of the Assistant Secretary's Office of HIV/AIDS and Infectious Disease Policy and, the Office of Adolescent Health, and Office of Population Affairs.

Education and Collaboration on Women's and Girls' Health

As directed by the ACA, OWH administers the National Women's Health Information Center, which utilizes websites, social media, print materials, and a helpline to provide information to women across the nation. These resources allow women and girls to find reliable health information online and by phone in English and Spanish.

- Womenshealth.gov provides reliable, easy-to-understand, and commercial-free health information that has been reviewed by the federal government on hundreds of topics ranging from reproductive health to healthy aging. In FY 2012, there were 16,098,475 visits to womenshealth.gov. Girlshealth.gov targets girls ages 10–16 and provides them with reliable, easy-to-understand, and commercial-free information that has been reviewed by the federal government on health issues they face such as puberty and peer pressure. This website had 1,134,787 visits in FY 2012.
- Quick Health Data Online is an interactive system that provides reliable, easily accessible state- and county-level health data to help assess needs, develop programs, and inform policies. The system allows anyone to access U.S. health data and is used by the public health community, policymakers, grant writers, researchers, and students. This website had 101,944 visits in FY 2012.
- OWH Helpline offers a toll-free telephone number for health information Monday through Friday, 9 a.m. to 6 p.m. EST. English and Spanish speaking information and referral specialists find and order free health information or make referrals to relevant websites and health organizations. In addition, trained breastfeeding peer counselors are available to provide technical assistance and support. In FY 2012, there were 18,737 phone calls to the call center. The call center was closed April 15-September 30.
- Social Media helps OWH engage the public via Facebook, Twitter, and YouTube. Visitors receive accurate, timely, and educational women's health information using these mechanisms from across the government. At the end of FY2012, OWH had more than 800,000 subscribers to its social media channels, a number that continues to increase each month.
- OWH coordinates two national observances each year: National Women and Girls HIV/AIDS Awareness Day and National Women's Health Week.
- National Women and Girls HIV/AIDS Awareness Day is held every year on March 10 to raise awareness of the increasing impact of HIV/AIDS on the lives of women and girls and to educate them about prevention, the importance of getting tested, and how to live with and manage HIV/AIDS.
- National Women's Health Week begins on Mother's Day each year. This national effort raises awareness about manageable steps all women can take to improve their health. Thousands of events are held across the country to promote women's health and provide access to important health information and screenings. As part of National Women's Health Week, OWH also celebrates National Women's Checkup Day to encourage women to visit health care professionals to receive regular, preventive checkups and screenings.

In FY 2013, OWH supported the launch of the It's Only Natural campaign which helps African American women to overcome the barriers they face in starting and continuing breastfeeding. OWH, in partnership with CMS, worked to supplement their Health Insurance Marketplace Public Education and Outreach Campaign with a focus on mothers of uninsured young adults.

In FY 2014, OWH plans to initiate a partnership with WebMD and Medscape to provide information to women and healthcare providers, especially providers who specialize in treating women, on the impact of the ACA and the Marketplaces. Also in FY 2014, OWH will fund a collaborative effort with ACF to initiate a pilot project that will educate health care providers on human trafficking and build their capacity to deliver culturally appropriate, and trauma informed care to trafficking victims. The overarching goal is a coordinated system of response by health care organizations, which will include protocols to manage and provide services to human trafficking victims; training to educate health care providers on human trafficking at the undergraduate and professional levels; creation of a systems guidance to healthcare professionals to aid in collaboration with law enforcement agencies, social

services and other pertinent resources; and the promotion of effective, culturally relative, and trauma informed care to improve the short and long term health of victims.

Additionally, OWH will continue working with policy partners to ensure that women with HIV/AIDS or at risk are included in future efforts to control the epidemic, as well as raising awareness among the public and professionals regarding the importance of healthy aging and the health effects associated with key issues for women such as care giving and trauma.

Funding History

Fiscal Year	Amount
FY 2010	$33,746,000
FY 2011	$33,679,000
FY 2012	$33,682,000
FY 2013	$33,002,000
FY 2014	$34,050,000

Budget Request

The FY 2015 President's Budget request of $29,500,000 is $4,550,000 less than the FY 2014 Enacted Level. OWH will continue to focus on its Departmental leadership role, coordinating policy development and initiatives impacting women's health across HHS and OWH will fund the continuation of current grants and cooperative agreements for women's health and the evaluation of these programs. OWH will continue the funding for Violence Against Women Initiatives, which will include a new grant to support education and training for healthcare providers to promote the assessment and prevention of IPV in healthcare settings.

Additionally, OWH will fund new grants in support of the Secretary's strategic initiative to reduce health disparities among women in underserved communities and disproportionally affected by gender-related health disparities. These grants will be aimed at model programs which have demonstrated success at addressing systemic issues that lead to health disparities.

OWH, along with the HHS Coordinating Committee on Women's Health, will continue to serve as the focal point for women on the Affordable Care Act. Significant effort will go towards educating and motivating women and health care providers about the Health Insurance marketplace and how to enroll and its provisions especially counseling and screening for domestic violence.

OWH will continue to expand the use of social media as a method for interacting with women and girls across the nation. In 2013, OWH had a total of 1,108,080 Facebook and Twitter subscribers. The FY 2015 budget request will directly provide support to maintain this level and develop new social media efforts.

OWH - Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
5.2.1 Number of users of OWH's social media channels. (Output)	FY 2013: 1,068,089 Target: 810,175 (Target Exceeded)	1,000,000	1,150,000	+150,000
5.3.1 Number of users of OWH communication resources (Output)	FY 2013: 24,201,973 user sessions Target: 22,000,000 (Target Exceeded)	22,500,000 user sessions	18,000,000 user sessions 18,000,000	-4,500,000[1]
5.4.1 Number of girls ages 9-17 and women ages 18-85+ that participate in OWH-funded programs (e.g., information sessions, web sites, and outreach) per million dollars spent annually. (Efficiency)	FY 2013: 2,294,828 Target:800,095 (Target Exceeded)	829,727	1,000,000	+170,273

1 In alignment with the Federal digital strategy, OWH website reporting methodology has been changed from using "log files" to "page tagging" resulting in fewer but more meaningful numbers.

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 will have to find other sources for reliable 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 includes monthly user sessions to the OWH websites and public inquiries through the OWH call center and email accounts.

OWH's social media efforts will ensure the availability of reliable women and girl's health information to the public in a format they want (e.g., desktop, mobile, or tablet) whenever and wherever they are. Data from the Pew Research Center shows that 75% of online women use social media on a typical day (http://pewinternet.org/Commentary/2012/March/Pew-Internet-Social-Networking-full-detail.aspx). As of June 2013, 55% of users access womenshealth.gov via tablet or mobile phone. The evidence base includes monthly followers to OWH's Twitter feeds and Facebook pages. OWH has the #2 (@womenshealth) and #3(@girlshealth) most popular Twitter channels at HHS.

Program Data Chart

Activity	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Contracts	-	-	-
Regional Women's Master Contract	21,350	2,100,000	0
Program Evaluation	1,000,000	800,000	1,395,000
Health Communications[1]	3,990,500	4,065,000	3,000,000
Print Materials	0	500,000	0
Communications (Fulfillment)	0	100,000	0
Logistical Meeting Support[2]	200,000	1,000,000	500,000
Adolescent Health[3]	0	800,000	0
Incarcerated Women in Transition & Trauma	519,323	500,000	1,000,000
Health Disparities[4]	400,000	518,000	0
Breastfeeding[5]	375,000	375,000	600,000
Quick Health Data	499,000	500,000	500,000
National Women's Health Week	0	250,000	0
HIV/AIDS	1,095,000	1,095,000	1,500,000
Violence Against Women	895,000	895,000	810,000
Affordable Care Act	0	0	2,000,000
Subtotal, Contracts	8,995,173	13,498,000	11,305,000
Grants/Cooperative Agreements	-	-	-
Affordable Care Act Enrollment	0	2,000,000	0
Coalitions for Health Community	3,000,000	3,000,000	3,000,000
HIV/AIDS	300,000	300,000	0
Health Disparities	0	0	2,000,000
Violence Against Women	1,995,000	2,115,000	2,200,000
Subtotal, Grants/Cooperative Agreements	5,295,000	7,415,000	7,200,000
Inter-Agency Agreements (IAAs)	-	-	-
Co-sponsorships (includes IAAs & others)	8,331,167	3,551,340	1,745,000
Operating Costs	10,380,660	9,585,660	9,250,000
Total	33,002,000	34,050,000	29,500,000

1 Previously titled: Nat'l Women's Health Information Center; expanded to more accurately represent the range of activities by OWH

2 Previously titled: Meeting Logistics Contract

3 Previously titled: Adolescent Health & Osteoporosis. In FY13, OWH reprioritized funds through an IAA to support a Health Insurance Marketplace Public Education and Outreach Campaign

4 Previously titled: Cardiovascular Disease Programs; expanded to more accurately represent the range of activities by OWH

5 Previously titled: Workplace Breastfeeding

Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	23	11	16
Average Award	$230,217	$646,818	$450,000
Range of Awards	$30,000-$1,715,000	$300,000-$1,715,000	$300,000-$2,200,000

OFFICE OF RESEARCH INTEGRITY

Budget Summary
(Dollars in Thousands)

Office of Research Integrity	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	8,558	8,558	8,558	0
FTE	24	24	24	0

Authorizing Legislation: ……Section 493 of the PHS Act
FY 2015 Authorization……Indefintie
Allocation Method……Direct federal, Contracts, Grants

Program Description and Accomplishments

The mission of the Office of Research Integrity (ORI) is to promote research integrity, reduce research misconduct, and maintain the public confidence in research supported by funds of the U.S. Public Health Service (PHS). ORI is required by Federal regulation (42 CFR Part 93) to promote the responsible conduct of research, protect taxpayer funding, and ensure the integrity of the research record, through monitoring investigations of allegations of research misconduct involving PHS funds by applicants' and awardees' institutions and through its own independent oversight review of institutional reports to ensure "thoroughness, objectivity and competence." To accomplish this mission, the key responsibilities of ORI's mission includes:

- Receiving annual reports from the more than 5,500 institutions worldwide that receive Federal funds for research and ensuring that they have policies in place for handing allegations of research misconduct
- Fostering an environment of research integrity that complies with Federal regulations regarding research misconduct
- Monitoring institutional investigations of research misconduct and conducting independent oversight reviews of those investigations
- Creating educational resources on the responsible conduct of research for researchers and research educators
- Facilitating skill-based training for Research Integrity Officers (RIOS) responsible for fostering an environment for research integrity within their institution while simultaneously conducting inquires and investigations of alleged research misconduct.
- Creating an environment that encourages the reporting of credible allegations and protects whistleblowers
- Advising research journal publishers and editors on forensic analysis of images and other data submitted or already published.

ORI has placed greater emphasis on education, research, evaluation, and prevention activities. Therefore, ORI adopted an action plan, approved by the Assistant Secretary for Health (ASH) that:

- Establishes a research program to study the factors influencing research integrity
- Develops innovative educational resources for teaching the responsible conduct of research
- Fosters ongoing collaborations with ORI's teaching and research partners, including research associations, academic and scientific societies, and numerous individual research universities and hospitals
- Evaluates the effect of research training on improving the quality of research, preventing research misconduct, and increasing the reporting of research misconduct.

The work of ORI directly supports the Secretary's Strategic Initiatives and Key Inter-Agency Collaborations, specifically, prevention of disease and health promotion. ORI's overall mission supports the integrity of research and the public confidence in that research. Confidence in the integrity of the research record is intertwined closely with the beneficial products of the research including clinical trials, human and animal studies, and basic research, which lead to new drugs, devices, and medical interventions and improvements in health. ORI also emphasizes prevention in its programs by developing educational resources to support responsible research practices. ORI's mission to identify and take action in response to research misconduct also provides primary and secondary prevention by removing from research those who commit misconduct and reinforcing the scientific norms of honest scientists who conduct research responsibly.

Key highlights of ORI's accomplishments include closing 35 cases of alleged research misconduct; 14 of these cases were closed with findings of research misconduct. With information and resources, over 200,000 visits were conducted to the ORI website this past year. Additionally, ORI has an active social media effort with a bi-weekly blog and Twitter account used to disseminate information on research integrity.

The ORI Research Integrity Officer (RIO) training program provides subject matter expertise to build skills in RIOs, promotes research integrity, provides training "boot camps" for institutional RIOs and their legal counsel to handle allegations of research misconduct, supports research on research integrity, and has led to the creation of innovative educational materials, including an award winning interactive educational video on research misconduct.

Funding History

Fiscal Year	Amount
FY 2010	$9,118,000
FY 2011	$9,027,000
FY 2012	$9,027,000
FY 2013	$8,558,000
FY 2014	$8,558,000

Budget Request

The FY 2015 President's Budget request of $8,558,000 is equal to the FY 2014 Enacted Level. The FY 2015 funding level will support staff for misconduct investigation oversight, responsible conduct of research education, and maintenance of existing ORI initiatives. The ORI request includes:

- *RIO Training*. This includes conducting intensive "boot camps" and advanced "boot camps," at which RIOs often bring the institution's counsel with them to learn how to conduct research misconduct inquiries and investigations properly and in conformance with Federal regulation 42 CFR Part 93.
- *Educational Material/Communications Development.* The Educational Resources Development Program will include projects to develop modules for young scientists to learn about research integrity, a documentary on safeguarding research integrity, and development of a computer interactive learning exercise for learning about research integrity.
- *Communications.* The Communications program includes development of social networking tools as a means of educating users about research integrity as well as further development of ORI publications such as books, the ORI Newsletter, and ORI website.

EMBRYO ADOPTION AWARENESS CAMPAIGN

Budget Summary
(Dollars in Thousands)

Embryo Adoption Awareness Campaign	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	1,000	1,000	0	0
FTE	0	0	0	0

Authorizing Legislation:.....Public Health Service Act, Section 1704
FY 2015 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 2010	$4,200,000
FY 2011	$2,004,000
FY 2012	$1,996,000
FY 2013	$1,000,000
FY 2014	$1,000,000

Budget Request

HHS is not requesting funds for this program for FY 2015.

RENT, OPERATIONS, MAINTENANCE AND RELATED SERVICES

Budget Summary
(Dollars in Thousands)

Rent, Operations, Maintenance and Related Services	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	16,429	16,429	16,500	+71
FTE	0	0	0	0

Authorizing Legislation: ……..Title III of the PHS Act
FY 2015 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 2010	$16,935,000
FY 2011	$16,616,000
FY 2012	$18,665,000
FY 2013	$16,429,000
FY 2014	$16,429,000

Budget Request

The FY 2015 total GDM Rent request for $16,500,000 is an increase of $71,000 from the FY 14 Enacted. In FY 2015, HHS will maintain its Rent and Facility Operation as established.

SHARED OPERATING EXPENSES

Budget Summary
(Dollars in Thousands)

Shared Operating Expenses	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	12,941	13,982	17,389	+3,407
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

Funding to pay for computer service charges remain in the individual STAFFDIV budgets, to ensure the proper alignment of incentives in ordering services and in paying these bills.

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

The GDM will use $367,025 of its FY 2015 request to support Department-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*	Amount
Budget Formulation and Execution LoB	$6,685
E-Rulemaking (moved from FFS)	$41,570
Financial Management LoB	$17,736
Geospatial LoB	$619
GovBenefits.gov	$4,296
Grants.gov	$152,492
Human Resources Management LoB	$2,551
IAE – Loans and Grants	$106,869
Integrated Acquisition Environment	$34,207
FY 2015 E-GOV Initiatives Total	**$367,025**

* 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 2010	$14,520,000
FY 2011	$15,999,000
FY 2012	$16,062,000
FY 2013	$13,457,000
FY 2014	$13,982,000

Budget Request

The FY 2015 request for other Shared Operating Expenses is $17,389,000, $3,407,000 more than the FY 2014 Enacted Level. The Budget reflects an increase in GDM's contribution to the shared services fund.

PHS EVALUATION SET-ASIDE

Budget Summary
(Dollars in Thousands)

Program Level	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
ASPE	53,993	53,993	53,743	-250
OASH	4,510	4,664	4,285	-379
HIV/AIDS in Minority Communities	0	0	53,900	+53,900
Teen Pregnancy Prevention Initiative	8,455	8,455	6,800	-1,655
ASFR	2,253	2,099	0	-2,099
Total	69,211	69,211	118,728	+51,866
FTE	139	144	144	0

ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

Budget Summary
(Dollars in Thousands)

ASPE	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
ASPE	41,493	41,493	41,243	-250
Health Reform	12,500	12,500	12,500	0
FTE	139	144	144	0

Authorizing Legislation……42 U.S.C. 241 Public Health Service Act
FY 2015 Authorization……Indefinite
Allocation Method……Direct Federal/Intramural; Contracts; Competitive Grants, Cooperative Agreement; Other (Salaries and Expenses, etc.)

Program Description and Accomplishments
HHS' Public Health Service (PHS) Evaluation Set-Aside program is authorized by Section 241 of the U.S. Public Health Service Act. Through the systematic collection of information on program performance, this program has a significant impact on the improvement of activities and services provided by HHS. Projects supported by these funds serve decision makers in federal, state, and local governments, and private sector public health research, education, and practice communities by providing valuable information on how well programs are working. These funds support:

- Assessments of the effectiveness of programs and strategies used to achieve public health and human service goals and objectives;
- Assessments of the health and human services environment to understand how changes in the environment affect public programs and strategies;
- Evaluations to improve the management of public health and human services programs;
- Development of performance measures and data systems for measuring progress toward achieving the public health and human services goals and objectives of the Department; and,
- Maintenance and improvement of the infrastructure needed to evaluate PHS programs.

The Assistant Secretary for Planning and Evaluation (ASPE) serves as the principal policy advisor to the Secretary of HHS on issues related to health, disability, aging, human services, and science policy. ASPE conducts research and evaluation studies, provides critical policy analysis, development, and advice; provides policy planning, coordination, and management; coordinates research, evaluation, and data collection across the Department; and estimates the costs and benefits of policies and programs under consideration by HHS or the Congress. ASPE has a long history of leading special initiatives on behalf of the Secretary (e.g., health care and welfare reform), serving as a temporary implementation office when requirements emerge which are not supported by existing Department programs, infrastructure, or processes, and providing direction for HHS-wide strategic, evaluation, legislative and policy planning.

Four policy offices within ASPE (Health Policy, Science and Data Policy, Human Services Policy, and Disability, Aging and Long-Term Care Policy) perform these functions with a focus on their primary population or issue of interest. ASPE develops and reviews issues with a perspective that is broader in scope than that of any one Operating Division (OPDIV) or Staff Division (STAFFDIV). When appropriate, ASPE policy offices collaborate with HHS OPDIVs and STAFFDIVs, other federal agencies, state and local partners, and non-governmental groups, in performing these functions.

ASPE's contributions provide objective and reliable information for policy development and program decision-making. ASPE's policy analysis, evaluation and policy development activities in health, science, human services, disability, aging and long-term care, and human services have contributed substantial information to senior policy makers in HHS and throughout the federal government.

ASPE continues to build a strong analytical capacity, including making substantial investments in the creation and analysis of nationally representative data to inform critical policy issues. ASPE provides policy support services including microsimulation modeling, statistical analysis, actuarial support and other technical and analytic services. ASPE also supports internal HHS-wide coordination in data policy, including interagency data collection and data standards, and collaborative efforts between HHS, the health industry, and the philanthropic sectors for both health and human services programs.

In addition to the activities of the four policy offices, ASPE performs the following primary activities:

Research and Evaluation – ASPE's policy research and evaluation program has a significant impact on the improvement of policies, programs and services of HHS, by systematically collecting information on program performance, assessing program effectiveness, improving performance measurement, performing environmental scans and assessments, and providing program management.

Data Collection Coordination – ASPE leads the planning and coordination of data collection investments and statistical policy across HHS and co-chairs the HHS Data Council, which promotes communication and planning for data collection from an HHS-wide perspective, assures coordination and cost efficiencies in addressing interagency data needs, and serves as a forum to address priority interagency, Departmental, and national data needs in a coordinated fashion.

Research Coordination – ASPE also has the lead role in ensuring that HHS' investment in health and human services research supports the Secretary's Strategic Initiatives and Departmental priorities in the most efficient and effective manner.

Funding History

Fiscal Year	Amount
FY 2010	$54,743,000
FY 2011	$54,743,000
FY 2012	$53,993,000
FY 2013	$53,993,000
FY 2014	$53,993,000

Budget Request

The FY 2015 request for ASPE is $53,743,000, which is a decrease of $250,000 from the FY 2014 Enacted level. The FY 2015 request includes $12,500,000 for ASPE to continue Affordable Care Act related studies. ASPE's request supports the continuation of research and evaluation studies, collection of data, and assessments of the costs, benefits and impacts of policies and programs under consideration by HHS or the Congress. ASPE will continue to seek economies of scale and opportunities to leverage and reduce costs whenever possible in order to maintain the established level of performance. The following outlines ASPE's programs and goals in FY 2015.

Goal 1: Strengthen Health Care

Priority projects for FY 2015 under this goal include providing analysis and developing data to measure and evaluate the implementation and impact of the Affordable Care Act, 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 evaluation studies will identify key strategies to reduce the growth of healthcare costs while promoting high-value, effective care. Priority projects will produce the measures, data, tools, and evidence that healthcare providers, insurers, purchasers, consumers and policymakers need to improve the value and affordability of health care and to reduce disparities in costs and quality between population groups and regions.

ASPE will also identify information that will be 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.

Goal 2: Advance Scientific Knowledge and Innovation

Priority projects for FY 2015 under this goal include research and analysis to support regulatory risk assessment and management, the translation of the fruits 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 projects are providing substantial contributions in making HHS more open and innovative, supporting projects that promote agency transparency and public participation, exploring the development and use of Web-based tools to improve surveillance, monitoring, analysis, and reporting.

Additionally, ASPE's projects will examine various micro-simulation models used for health and human services policy to develop systematic methods to further improve the transparency of model estimates, better understand model assumptions, comparisons of alternative models, and opportunities to improve models.

Goal 3: Advance the Health, Safety and Well-being of our People
Priority projects for FY 2015 under this goal will include studying ways to enhance the economic security, stability and well-being of vulnerable individuals, families and communities; evaluating methods to improve the coordination of physical and behavioral health services; fostering innovative approaches to delivering integrated health care and long-term support and services; conducting research to promote healthy development, early learning, school readiness and comprehensive services for young children; and examining potential strategies to improve the safety and well-being of children involved with the child welfare system.

Priority projects will also include research, data development and analysis to examine residential care alternatives for the aged, caregiver support, evidence-based clinical and community-based preventive services, mental health and substance abuse programs, and disparities in health. Activities under this goal include collaboration across systems to promote access for individuals with disabilities to inclusive, integrated services and supports. ASPE will also conduct research and evaluation of important initiatives such as HIV/AIDS prevention and treatment, tobacco prevention and control, obesity prevention and reducing health disparities. ASPE will 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.

HHS is working with other agencies across the Federal government, is exploring ways to strengthen data capacity and conduct rigorous evaluations to understand the impacts of Promise Zones and other important cross-sector initiatives designed to improve outcomes for high-poverty communities and individuals living in those communities. A key focus will be on utilizing reliable administrative data sources at the Federal, State, and local level for measuring common outcomes across multiple sites, an approach that can enhance the quality of the evaluations while minimizing their costs.

Goal 4: Increase Efficiency, Transparency and Accountability of HHS Programs
Priority projects in FY 2015 under this goal include developing measures and 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.

Goal 5: Strengthen the National Health and Human Services Infrastructure and Workforce
Priority projects for FY 2015 in this goal area will include policy 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 also 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 provide the necessary data for HHS to monitor and assess 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-Related Activities

As the U.S. Government's lead health agency, HHS is responsible for the implementation of many of the provisions of the ACA. ASPE will undertake a variety of policy development, research, analysis, evaluation and data development activities in support of ACA implementation in FY 2015, including:

- Internal policy development, data development and technical assistance projects. ASPE will continue to serve as a source of information and data to other parts of the Federal government and improve data to track changes as the ACA is implemented.
- Actuarial analysis and modeling to support the development of policy alternatives relating to ACA provisions regarding coverage, affordability, and market reforms.
- Reviews, data analysis, and options papers will be developed as needed.
- Reviews, studies, and evaluations to identify effective prevention strategies and associated benefits, especially in the area of community-based and clinical preventive service integration.
- Developing data and analytic capability to support outreach and enrollment activities for Medicaid and Exchange coverage expansion.
- Modeling and evaluation methods to support CMS Innovation Center activities including post-acute care payment activities.
- Evaluations of 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.

Size of Awards

Grants (whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 Request
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

ASPE maintains a grants program to support research and evaluation by academically based research centers of important and emerging social policy issues associated with income dynamics, poverty, transitions from welfare to work, child well-being, and special populations. Federal support for the poverty center program has been continuous since 1968.

ASPE's grants for academic research institutes range from $800,000 to $1,300,000 per year. 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.

PHS EVALUATION

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Budget Summary
(Dollars in Thousands)

PHS Evaluation - OASH	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	4,510	4,664	4,285	-379
FTE	0	0	0	0

Authorizing Legislation: .....Section 241 PHS Act
FY 2015 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 at 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 2013 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.

- Enhancing Native Hawaiian and Other Pacific Islander and American Indian/Alaska Native (NHPI and AI/AN) Data Collection in HHS surveys – Evaluate the use of the American Community Survey for collecting information from NHPI and AI/AN respondents for the National Health Interview Survey. Assess the feasibility of this Survey as a means of increasing sample size for these two population subgroups.

- Assessing the Impact of the National Partnership for Action to End Health Disparities Regional Health Equity Council (RHEC) Efforts to Promote Enrollment of Uninsured Racial and Ethnic Minorities through the Affordable Care Act – Collect, analyze, and report data to determine the impact of RHEC-sponsored, regional, state, tribal and/or community-based education, outreach, and enrollment events on knowledge of the Affordable Care Act and insurance enrollment options as well as on opportunities to enroll among uninsured and underinsured individuals.

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.

- Tissue and Organ Epidemiology Study (TODES) – Identify and collect information on infectious disease screening results from potential United States organ and tissue donors. Determine estimates of infectious disease prevalence of HIV, Hepatitis B, Hepatitis C, and incidence in potential organ and tissue donors.

- 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.

- HIV Open Data Project Phase – Develop and design a system to integrate multiple electronic reporting systems with a secure, user-friendly, reliable method of collecting data for analysis, and ad hoc report generation, with built-in internal quality controls, including alerts for inconsistencies or other errors. Develop a flexible and easy to use tool to produce tables, graphs, and maps that will enable the contractor to replicate and enhance the array of charts, maps, and graphical options available to the public.

- 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.

- Health.gov Website Refresh and Update – Evaluate and update the Health.gov website. Ensure the website provides accurate and user-friendly health information related to nutrition and physical activity for policymakers, healthcare professionals, practitioners, educators, and consumers.

- 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.

- Integrating Healthy People 2020 Goals into Community Benefit Plans by Non-Profit Hospitals – Assess ways in which Healthy People 2020 Goals can be integrated into Community Benefit Plans and help ensure coordination across efforts between hospitals and local health departments. Provide technical assistance related to areas of need.

- Content Repository for the National Health Information Center for Healthfinder.gov's Covered Prevention Decision Support – Assess and develop content repository for healthfinder.gov prevention & wellness content. Make digital prevention content reusable and personalized for multiple users and on multiple platforms so that it's ready to go anywhere, at any time, and in any format.

- 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.

- 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.

Strategic Goal 4

- Evaluating Healthcare Workforce Education and Training on Multiple Chronic Conditions– Assess training and educational materials for key healthcare works 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.
- Evaluating Pilot Design – Evaluate strategies to improve quality in public health workforce and education. Evaluate models for curriculum development and articulation in areas of public health workforce need

Funding History

Fiscal Year	Amount
FY 2010	$8,965,000
FY 2011	$4,510,000
FY 2012	$4,510,000
FY 2013	$4,510,000
FY 2014	$4,664,000

Budget Request

The FY 2015 President's Budget request of $4,285,000 is $379,000 less than the FY 2014 Enacted Level. In FY 2015, OASH program offices will submit proposals to improve and evaluate public health programs and identify ways to improve their effectiveness. The funds will support evaluations of community based activities supporting the health of individuals affected by health disparities. OASH will support evaluation projects in-line with the FY 2015 budget request. 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.

PHS EVALUATION
HIV/AIDS IN MINORITY COMMUNITIES

Budget Summary
(Dollars in Thousands)

PHS Evaluation – HIV/AIDS in Minority Communities	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	0	0	53,900	+53,900
FTE	0	0	0	0

Authorizing Legislation:…… Title III of the PHS Act
FY 2015 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 allocated resources to CDC, HRSA, and SAMHSA and the Office of the Secretary MAI Fund (SMAIF). The Office of HIV/AIDS and Infectious Disease Policy (OHAIDP), formerly the Office of HIV/AIDS Policy , administers the Secretary's Fund (SMAIF) on behalf of the Office of the Assistant Secretary for Health (OASH). SMAIF is used to support cross-agency demonstration initiatives that are competitively awarded through HHS agencies and offices to fund 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.

In FY 2011, OHAIDP undertook efforts to better target SMAIF resources in alignment with the National HIV/AIDS Strategy (NHAS). OHAIDP continues to restructure and transition the SMAIF in FY 2014 to 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 include seeking input from various community leaders and providers about unmet HIV/AIDS prevention and care needs and pressing 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, including: 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 $33 million was awarded in FY 2013 through the FOA.

In addition, 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. For example, Care and Prevention of HIV in the U.S., 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) have begun 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

In addition to a renewed commitment to funding capacity building activities, the SMAIF continues to require that funding proposals consider 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 2013 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. In that same regard, the SMAIF will fund a new three-year demonstration project beginning in FY 2014 involving CDC, HRSA/BPHC and HRSA/HAB 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.

The following are additional examples of activities that have been supported with the SMAIF in FY 2013 and are also in alignment with the NHAS:

- *Capacity Development*: increasing the opportunities for the training of clinical and non-clinical staff to provide HIV/AIDS-related services, including increasing the capacity of Ryan White grantees and providers for outreach and enrollment to racial and ethnic minority people living with HIV/AIDS;
- *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, and adolescent African American and Latino males;
- *Improving Health Outcomes*: developing retention and re-engagement interventions for HIV-positive racial/ethnic minority patients and expanding tele-health opportunities in rural and tribal locations; and
- *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.

Funding History

Fiscal Year	Amount
FY 2010	$0
FY 2011	$0
FY 2012	$0
FY 2013	$0
FY 2014	$0

Budget Request

The FY 2015 President's Budget request of $53,900,000 to fund the MAI program through the Public Health Service Evaluation Fund is $1,676,000 more than the FY 2014 Enacted Level. Projects funded in

FY 2015 will include both the aforementioned cross-agency demonstration project 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 as well as competitively-funded projects developed by the participating OPDIVs and STAFFDIVs. The FY 2015 request will also support the continuation of several ongoing projects, including the following:

- Improving HIV prevention and treatment outcomes among HIV infected persons by integrating community pharmacists and clinical sites into a model patient-centered HIV care
- Linkage to Care and Retention in Care: Improving the Weak Links in the Continuum of Care for Minority Youth Newly Diagnosed with HIV
- Prevention of Substance Abuse and HIV/AIDS and the Promotion of Behavioral Health in High-Risk Populations Using Emerging Technologies.
- HIV testing initiatives and HIV Continuum of Care efforts.
- Expansion of a webinar series following the successful Patient Navigation webinar in FY 13, focused on critical questions, issues and strategies, including how best to improve the health outcomes of black MSM along the HIV care continuum.
- Diagnosis and linkage to care for racial/ethnic minority substance users who are co-infected with HIV and HCV.
- The NHAS through 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 2015 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 FY 13 Black MSM Technical Consultation. The identification and dissemination of promising practices will accelerate progress in reaching targets and goals.

MAI - Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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)**	**328,348**	**338,198**	**+9,850**
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)**	**255**	**263.**	**+8**
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%**	**Maintain**
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)**	**77%**	**79%**	**+2%**

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 and counseling; (4) alternative models for delivering HIV care (task shifting, telemedicine, etc.); or (5) cultural competency (racial/ethnic, gender, and sexual orientation). (Outcome)	**FY 2011: 5,319 Target: 5,319 (Target Met)**	**6,157**	**6,772**	**+615**
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)**	**160**	**165**	**+5**

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 20% of those who are infected do not know their status. More critically, knowledge of status anchors our prevention and care/treatment efforts. 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 are 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.

PHS EVALUATION
TEEN PREGNANCY PREVENTION

Budget Summary
(Dollars in Thousands)

PHS Evaluation – Teen Pregnancy Prevention	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	8,455	8,455	6,800	-1,655
FTE	0	0	0	0

Authorizing Legislation: ……..Section 241 of the PHS Act
FY 2015 Authorization……..Indefinte
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. The request includes funds for:

- three Federal evaluations of teen pregnancy prevention approaches
- a cost study of the evidence-based teen pregnancy prevention program models
- evaluation training and technical assistance for the Teen Pregnancy Prevention (TPP) program evaluation grantees
- ongoing collection and analysis of performance measures from both OAH grant programs, and
- ongoing support for the HHS Pregnancy Prevention Research Evidence Review

In FY 2013 these funds supported various activities, including:

1. The Pregnancy Prevention Approaches (PPA) evaluation is an experimental evaluation study focused on assessing the implementation and impacts of innovative strategies and untested approaches for preventing teenage pregnancy. There are three OAH TPP Research and Demonstration grantees, three ACYF-funded Personal Responsibility Education Program Innovative Strategies (PREIS) grantees, and one non-federally funded site included in the evaluation representing a mix of TPP programs including an abstinence until marriage curriculum, a clinic-based program, a mobile unit that visits youth, group-based and peer-led programs, and curriculums for both pregnancy prevention and pregnant and parenting teens. The first three of 22 expected reports from this project have been posted on OAH's website. Five additional implementation reports and seven short-term impact reports are expected in 2014, and seven long-term impact reports are expected in 2015/2016.
2. The TPP Replication Evaluation, being managed in coordination with ASPE, 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 can achieve impacts with different populations and settings. The implementation report is expected in 2014, short-term impact reports across the sites are anticipated in 2015, and long-term impact reports are anticipated in 2016.
3. In FY 2013 OAH contracted for a feasibility and design study for conducting a rigorous evaluation of the Pregnancy Assistance Fund (PAF) Grant Program. This work will provide the ground work for a future rigorous Federal evaluation of the program, which will determine the effectiveness of the selected grantees' programs in strengthening access to and completion of education (secondary and postsecondary), improving child and maternal health outcomes, reducing the likelihood of repeat teen pregnancies, increasing parenting

and co-parenting skills, decreasing intimate partner violence, and raising awareness of available resources. The evaluation is expected to be awarded in FY 2014 and to be conducted through FY 2018.

4. In FY 2013 OAH contracted for a cost study of the evidence-based teen pregnancy prevention programs currently being replicated by OAH Teen Pregnancy Prevention (TPP) grantees. The cost study will include three components: (1) a cost analysis to determine the cost of implementing select evidence-based TPP programs, (2) an economic evaluation to determine the economic impact of select evidence-based TPP programs, and (3) the development of guidance and tools for OAH to use to collect and evaluate cost data from future TPP grantees in a systematic, standardized way. Reports are expected in 2014 and 2015 and tools to collect cost data from future TPP grant cohorts are expected in 2015.
5. Forty OAH TPP evaluation grantees receive 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 evidence review standards. Grantees are primarily conducting randomized controlled trials. The contractor also provides ongoing technical assistance to the grantees and their federal project officers on conducting, analyzing, and reporting on their evaluations as well as develops evaluation resources utilized by grantees and the larger evaluation field.
6. In FY 2013, OAH awarded a contract to maintain a web-based data repository that uploads and stores standardized performance measure data for OAH's Teen Pregnancy Prevention (TPP) grantees and Administration for Children, Youth and Families, Family Youth Services Bureau (ACF/FYSB) Personal Responsibility Education Program Innovative Strategies (PREIS) grantees, as well as for OAH Pregnancy Assistance Fund (PAF) grantees to upload their performance measures data. The data system facilitates electronic data collection and reporting among the three grant programs. The contractor also provides ongoing technical assistance to these grantees as well as their project officers, with their data reporting related to the performance measures. Grantees utilize this web-based system for continuous quality improvement in delivering their programming, for reporting back to partners and stakeholders, and for their sustainability efforts.
7. In 2010, HHS conducted a systematic review of the literature and identified a list of 28 TPP program models considered evidence-based, making up the HHS List of Evidence-Based TPP Programs. OAH TPP Replication grantees are replicating 24 of these evidence-based programs. In April 2012, the review was updated and three additional programs were added for a total of 31. A current update will be released in early 2014. The list includes programs that use a number of approaches—abstinence, sexual health education, youth development, and programs for delivery in clinical settings and for special populations—all of which show positive results in at least one rigorous program evaluation. In collaboration with ASPE and ACF/FYSB, OAH currently contributes funds to update the evidence review annually and enhance the implementation reports for use by community-based providers.

OAH is committed to promoting strong, independent evaluation that can inform policy and program management decisions and will post the status and findings of these evaluations on our website. Consistent with the Administration's commitment to transparency in our work, a detailed full final report and an executive summary are made available on the OAH website as they are available. The contracts for Federally-led evaluations include tasks for creating papers to be submitted to peer-reviewed journals. We encourage and support grantees to publish evaluation findings by providing them with guidance on writing and disseminating scientific program evaluation reports. And finally, OAH has committed to disseminating the work of both the federal evaluations and the grantee evaluations by publishing special issues in peer-reviewed academic journals, the first of which is expected in March 2014.

Funding History

Fiscal Year	Amount
FY 2010	$4,455,000
FY 2011	$4,455,000
FY 2012	$8,455,000
FY 2013	$8,455,000
FY 2014	$8,455,000

Budget Request

The FY 2015 President's Budget request of $6,800,000 is $1,655,000 less than the FY 2014 Enacted Level. Funds will be used to continue to carry out longitudinal evaluations of teen pregnancy prevention approaches. Evaluation funds support the Evaluation of Adolescent Pregnancy Prevention Approaches study which assesses the implementation and impacts of innovative strategies and untested approaches for preventing teen pregnancy. Funds are also used to support the Teen Pregnancy Prevention (TPP) Replication Evaluation which examines whether evidence-based program models commonly chosen for replication can achieve impacts with different populations and settings. The funds also support a rigorous implementation and impact evaluation of the Pregnancy Assistance Fund grant projects that develop and implement programs to improve the educational, health, and social outcomes for expectant and parenting teens, women, fathers, and their families. Additionally, OAH is leading the field towards obtaining a better understanding of the most efficient investments in TPP programs and contributing to the evidence-base of what works by using these funds to support a cost study of the TPP evidence-based replication grants, collection and analysis of TPP and PAF program performance measures, and updates to the HHS TPP Research Evidence Review. OAH is committed to promoting and supporting the strongest evaluation designs and most useful and relevant evaluation projects to inform policy and program management decisions. OAH will be disseminating the findings from both the federal and grantee evaluations on the OAH website and in peer reviewed journals as well as supporting the grantees in disseminating on their own.

PREVENTION AND PUBLIC HEALTH FUND

Budget Summary
(Dollars in Thousands)

Prevention and Public Health Fund	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Teen Pregnancy Prevention (OASH)	0	0	104,790	+104,790
Total	0	0	104,790	+104,790
FTE	0	0	16	+16

Authorizing Legislation: .....Section 4002 of the Affordable Care Act
FY 2015 Authorization.....Indefinite
Allocation Method.....Direct federal, Contract, Grants

Section 4002 of the Affordable Care Act establishes a mandatory appropriation for prevention and public health activities. The purpose of the Fund is to "expand and sustain national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs." The Act provides the Secretary with the authority to transfer appropriated amounts to accounts within HHS.

Funding Allocation
Not requesting funds for Emerging Public Health Issues or Tobacco media efforts in FY 2015.

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, and is under the direction of the Office of Adolescent Health (OAH). These funds support competitive grants 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. OAH coordinates its efforts with other 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. These funds support both the replication of evidence-based program models and demonstration programs to identify new effective approaches. The TPP program currently funds 75 grants to replicate one or more diverse evidence-based program models identified by HHS through an independent systematic review of the existing research. OAH is partnering with the Assistant Secretary for Planning and Evaluation (ASPE) to support an ongoing review of the evidence base. Another 18 grants are being funded to develop, refine, and test additional models and innovative strategies for preventing teen pregnancy. In collaboration with CDC, the program is supporting eight grants to implement and test multi-component, community-wide initiatives to prevent teen pregnancy. OAH also collaborates with ASPE, ACF, and CDC to implement TPP program and evaluation activities. A new cohort of TPP grantees will be selected through a competitive application and objective review process to receive funding in FY 2015.

OAH developed a performance measurement system for the TPP program that was implemented in 2012 for all TPP grantees and will continue through FY 2014. Each year, OAH TPP grantees reach 121,000 youth each year in 39 States and the District of Columbia and partner with over 1,700 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; 34% are Black, non-Hispanic, 30% are Hispanic/Latino, and 26% are White, non-Hispanic. High fidelity, quality, and attendance are essential to ensuring that youth served experience the outcomes expected from receiving an evidence-based program. OAH grantees implement evidence-based programs with a rate of 94% fidelity or adherence overall; and a rate of 91% for quality or observed sessions are rated as very good or excellent A recent white paper developed by the Bridgespan Group, a nonprofit organization focused on a case study of the TPP program and the importance of focusing on implementation with fidelity and quality.

OAH launched the Teen Pregnancy Prevention (TPP) Resource Center. This is 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 Resource Center also features success stories describing some of the accomplishments of the TPP grantees.

Funding History

Fiscal Year	Amount
FY 2010	$0
FY 2011	$0
FY 2012	$0
FY 2013	$0
FY 2014	$0

Budget Request

The FY 2015 President's Budget request of $104,790,000 to fund the TPP program through the Prevention and Public Health Fund is $3,790,000 more than the FY 2014 Enacted Level. The budget request will be used to fund a new cohort of competitively selected TPP grantees, which is expected to have at least the same reach as in FY 2013. The total reach is dependent on the size and type of specific programs funded through the new, competitive announcement. The funding level will also support the competitive grant review process and provide program support for the grantees, to include:

- Reviewing materials for medical accuracy
- Providing programmatic and evaluation training and technical assistance
- Covering program administrative and operating costs of the grant program

In FY 2015, additional flexibility beyond the current statutory language is needed for program operating costs to support competition of the new cohort of five-year grants, which includes training and technical assistance for grantees and other program support costs associated with processing grant applications. Of the funds requested in the PPHF, it is anticipated that not more than 10% will be used for operational expenses including the aforementioned support for the new cohort of 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.

TPP - Outputs and Outcomes Table

Measure	Year and Most Recent Result/ Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
9.1 Number of youth served by the TPP Program	FY 2013: 121,196 (Baseline)	121,196	121,196	0
9.2 Number of TPP Program formal or informal partners	FY 2013: 1,762 (Baseline)	1,762	1,762	0
9.3 Number of Intervention Facilitators provided new or follow-up training	FY 2013: 3,709 (Baseline)	3,709	3,709	0
9.4 Number of youth receiving at least 75% of available TPP programming	FY 2013: 60,711 (Baseline)	60,711	60,711	0
9.5 Mean percentage of the evidence-based model being implemented as intended	FY 2013: 95% (Baseline)	95%	95%	0

Performance Analysis

In FY 2013, the Teen Pregnancy Prevention Program served over 121,000 youth with evidence-based programs and promising strategies to reduce teen pregnancy. In total, ninety-four grantees partnered with over 1,700 organizations and trained over 3,700 people to deliver the TPP programs. Ninety-four 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 grantee program complete implementation and a new cohort of competitive grant awards are made by the end of FY 2015. It is expected that the current cohort will maintain the current performance levels.

Program Data Chart

Activity	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Contracts	-	-	-
Training, technical assistance , and other program support	1,338,028	1,600,000	2,789,000
Subtotal, Contracts	1,338,028	1,600,000	2,789,000
Grants/Cooperative Agreements			
Tier I – Replication Projects	70,489,700	72,200,000	74,000,000
Tier II – Research and Demonstration Projects	23,393,961	24,000,000	24,000,000
Subtotal, Grants/ Cooperative Agreements	93,883,661	96,200,000	98,000,000
Operating Costs	3,145,311	3,200,000	4,001,000
Total	98,367,000	101,000,000	104,790,000

Size of Awards

(whole dollars)	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	102	102	130
Average Award	920,428	$943,137	$753,846
Range of Awards	$400,000-$4,000,000	$400,000-$4,000,000	$400,000-$4,000,000

PREGNANCY ASSISTANCE FUND

Budget Summary
(Dollars in Thousands)

Pregnancy Assistance Fund	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	23,725	23,200	25,000	+1,800
FTE	0	0	2	+2

Authorizing Legislation: ……..Patient Protection and Affordable Care Act, Section 10214
FY 2015 Authorization……FY 2019
Allocation Method……..Direct Federal; Competitive Contracts, Grants

Program Description and Accomplishments

The Office of Adolescent Health (OAH) is responsible for implementing and 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 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; decrease domestic and increase sexual assault prevention ; and raise awareness of available resources.

In July 2013, OAH awarded a new cohort of grants to 17 States and Tribes (14 states and 3 tribes) to support expectant and parenting teens, women, fathers and their families for a four year project period (FY 2013-2016). OAH is planning a rigorous feasibility and design study evaluation of at least two grantee projects in the upcoming fiscal years. All grants 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. In FY 2014, all grantees will collect baseline data on these performance measures. 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. Grantees utilized various communication strategies such as texting to share critical health information to pregnant and parenting young mothers, and TV and radio advertising to inform the public about the text messaging service. Others involved youth and program participants in the development of educational materials on intimate partner violence that resonant with the audiences being served.

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 2010	$25,000,000
FY 2011	$25,000,000
FY 2012	$25,000,000
FY 2013	$23,725,000
FY 2014	$23,200,000

Budget Request

The FY 2015 budget request of $25,000,000 is $1,800,000 more than the FY 2014 Enacted. In FY 2015, PAF will continue to serve young fathers and partners through their programs, assist participants in accessing information about health care coverage available in the Health Marketplace, and support participants in completing their education.

FY 2015 Discretionary State Grants

Pregnancy Assistance Fund (PAF)

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	Difference FY 2015 +/- FY 2014
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
Subtotal States/Territories	***$22,019,937***	***$22,019,937***	***$22,019,937***	***0***
Program Support	**$1,705,063**	**$1,180,063**	**$2,980,063**	**$1,180,000**
Total Resources	**$23,725,000**	**$23,200,000**	**$25,000,000**	**0**

SUPPORTING EXHIBITS

DETAIL OF POSITIONS

Detail	FY 2013 Final	FY 2014 Enacted	FY 2015 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**	**$862,818**	**$854,359**
SES	110	109	109
Total - ES Salary	**$18,040,330**	**$17,926,275**	**$17,926,275**
GS-15	210	212	212
GS-14	220	220	220
GS-13	222	188	190
GS-12	297	341	341
GS-11	177	177	177
GS-10	12	12	12
GS-9	127	127	127
GS-8	61	55	55
GS-7	40	40	40
GS-6	6	6	6
GS-5	9	9	9
GS-4	8	8	8
GS-3	10	10	10
GS-2	1	1	1
GS-1	-	-	-
Subtotal	***1,400***	***1,406***	***1,408***
Commissioned Corps	62	54	52
Total Positions	**1,577**	**1,574**	**1,574**
Average ES salary	$156,872	$157,248	$157,248
Average GS grade	13.6	13.6	13.6
Average GS Salary	$103,038	$101,438	$102,843

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT

Detail	FY 2013 Civilian	FY 2013 Military	FY 2013 Total	FY 2014 Civilian	FY 2014 Military	FY 2014 Total	FY 2015 Civilian	FY 2015 Military	FY 2015 Total
Direct	1032	39	1071	1051	37	1088	1060	43	1103
Reimbursable	483	23	506	469	17	486	462	9	471
Total FTE	**1515**	**62**	**1577**	**1520**	**54**	**1574**	**1522**	**52**	**1574**

FTES FUNDED BY THE AFFORDABLE CARE ACT

(Dollars in Thousands)

Program	Section	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FTEs
Pregnancy Assistance Fund Discretionary P.L. (111-148)	Section 10214	25,000	25,000	25,000	25,000	25,000	2
Prevention & Public Health Fund Discretionary P.L. (111-148) (GDM Allocation)	Section 4002	-	-	-	-	104,790	16

STATEMENT OF PERSONNEL RESOURCES

Resource	FY 2013 Budget Target	FY 2013 Estimate	FY 2014 Estimate	FY 2015 Estimate
Direct Ceiling FTE	1091	1071	1088	1103
Reimbursable Ceiling FTE	499	506	486	471
Total Ceiling FTE	**1590**	**1577**	**1574**	**1574**
Total Civilian FTE	1536	1515	1520	1522
Total Military FTE	54	62	54	52

FTE PAY ANALYSIS

Detail	FY 2013	FY 2014	FY 2015
Total FTE	**1,071**	**1,088**	**1,103**
Number change from previous year	-20	17	15
Funding for object classes 11	$110,353	$110,364	$113,436
Average cost per FTE	$103	$101	$103
Percent change in average cost from previous year	1.0%	-1.5%	1.5%
Average grade/step of GS employee	13.6	13.6	13.6

RENT AND COMMON EXPENSES

(Dollars in Thousands)

Rent

Detail	FY 2013 Final	FY 2014 Enacted	FY 2105 President's Budget	FY 2015 +/- FY 2014
GDM[1]	8,524	8,524	8,524	-
ASFR	150	150	150	-
DAB	-	-	245	+245
OGA	700	700	700	-
OGC	2,821	2,827	2,827	-
OASH	4,340	4,340	4,106	-235
Subtotal	*16,535*	*16,541*	*16,551*	*+10*

Operations and Maintenance

Detail	FY 2013 Final	FY 2014 Enacted	FY 2105 President's Budget	FY 2015 +/- FY 2014
GDM[1]	7,906	7,906	7,976	+71
ASA	268	268	268	-
ASFR	290	290	290	-
DAB	40	40	40	-
OGA	222	231	231	-
OGC	1,520	1,571	1,571	-
OASH	1,618	1,688	1,680	-8
Subtotal	*11,863*	*11,993*	*12,056*	*+63*

Service and Supply Fund

Detail	FY 2013 Final	FY 2014 Enacted	FY 2105 President's Budget	FY 2015 +/- FY 2014
GDM Shared Services	9,472	9,472	13,889	+4,417
ASA	1,498	1,757	1,757	-
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***	***24,248***	***28,665***	***+4,417***

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

SIGNIFICANT ITEMS IN CONFERENCE AND SENATE APPROPRIATIONS COMMITTEES REPORTS

FY 2014 Senate Appropriations Committee Report Language (Senate Report 113-71)

Item

Alzheimer's Disease - *The Committee strongly supports the National Plan to Address Alzheimer's Disease and its goal of preventing and effectively treating Alzheimer's disease by 2025. The Committee encourages the Department to include specific annual milestones as well as measures to assess progress within each annual report authorized by the National Alzheimer's Project Act. To ensure all appropriate Federal departments and agencies are informing the plan, the Department should consider adding representatives from NCATS and the Office of Science and Technology Policy to the Advisory Council on Alzheimer's Research, Care and Services. The Committee also encourages the Department to ensure the perspectives of patients with Alzheimer's disease are represented by establishing a patient representative position to the council.*

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

Item

Chronic Fatigue Syndrome [CFS].--*The Committee endorses the Department's continued support of the CFS Advisory Committee and urges accelerated progress to enact its recommendations to strengthen research, education, training, care, and services to better address the needs of one million Americans living with CFS.*

Action Taken or To Be Taken
HHS continues support for efforts to better address myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) through multiple activities across the Department including research, education, training, care, and service aspects of this disease.

In 2013, HHS initiated an 18-month study with the Institute of Medicine (IOM) to comprehensively evaluate the clinical criteria for the diagnosis of ME/CFS. This study will produce a consensus report in 2015 with recommendations for criteria and will include an outreach strategy to disseminate the results of the study to health professionals nationwide.

In 2012 and 2013, the Food and Drug Administration hosted a series of activities to explore the burden of disease which impacts quality of life for ME/CFS patients; the measures or endpoints that determine whether disease symptoms improve with intervention; and how drug efficacy should be tested based on these measures or endpoints. The agency held a teleconference and webinar with ME/CFS patients and advocates, as well as a drug development workshop to explore what is needed to facilitate development of safe and effective treatments for ME/CFS.

The National Institutes of Health is taking action to stimulate ME/CFS clinical research with the help of its Trans-NIH ME/CFS Research Working Group. The agency has also implemented a process for using biological samples obtained from ME/CFS patients who participated in a recent NIH-funded study. These samples from well-characterized ME/CFS cases provide a valuable resource for research on ME/CFS biomarkers moving forward. Additionally, NIH is planning an Evidence-based Methodology

Workshop on ME/CFS. This effort will include a thorough, unbiased evidence review of the literature related to clinical research outcomes compared across various definitions and will culminate in a workshop with experts and patients. The workshop participants and panel members will use the evidence review to evaluate the strength of evidence for case definitions with the goal of identifying the most consistent outcomes for ME/CFS.

The Centers for Disease Control and Prevention (CDC) has completed data collection for the first stage of an ongoing seven-site study of the clinical characteristics of ME/CFS. This study was launched in September 2011 to collect standardized data from clinical practices with expertise in ME/CFS. The data will be used to evaluate variation in the illness among clinics, to characterize all aspects of illness in ME/CFS patients, and to provide data that could be used in evaluation of a research case definition and diagnostic criteria. Data analysis is underway, and initial findings will be available to the IOM committee in February 2014.

In addition to prioritizing research and patient care, HHS has made educating health care providers on ME/CFS a priority. The Agency for Healthcare Research and Quality provided technical support to the International Association for CFS/ME for the dissemination of a primer for clinical practitioners that has been added to the National Guideline Clearinghouse. The Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration both hosted webinars to educate providers in their networks about ME/CFS. A free, web-based continuing medical education course on ME/CFS was also launched by the CDC in collaboration with MedScape Live. The course has reached over 5,000 health care providers thus far. The Administration on Children and Families has also identified networks to disseminate information relevant to children and adolescents on the epidemiology and diagnosis of ME/CFS for laypersons.

Item

Federal E-Health Working Group *- The Committee encourages the Secretary to convene a national working group on e-health and telemedicine to improve communication, coordination and collaboration among relevant Federal agencies regarding e-health needs, standards, Federal goals, and Federal efforts. Such a working group should seek to reduce duplication and e-health incompatibility, as well as improve health quality, effectiveness, and outcomes*.

Action Taken or To Be Taken

ONC will convene a meeting with relevant HHS OPDIVs/STAFFDIVs to determine their e-Health and telemedicine activities and interests. After this meeting, ONC will contact other Federal agencies to convene a working group and will consider whether recommendations from the HIT Policy Committee and HIT Standards Committee would be useful.

Item

Hiring Individuals with Disabilities *- The Committee is very supportive of Executive Order 13548 and the Department's goal to raise the representation of individuals with disabilities in its workforce from 9 percent in fiscal year 2011 to 11 percent by fiscal year 2015. However, the Committee understands that the Department is not on pace to meet this target. The Committee encourages the Department to accelerate its efforts toward achieving the goals of this important executive order.*

Action Taken or To Be Taken

In fiscal year (FY) 2013, the Department of Health and Human Services (HHS) participated in close to 100 career fairs targeting veterans, veterans with disabilities, and persons with disabilities. In addition, the Department held more than 350 combined (individual and group) resume writing sessions for persons interested in HHS positions, including veterans and veterans with disabilities. These career fairs and resume writing sessions contributed greatly in aiding HHS Operating Divisions (OpDivs) to hire more than 350 persons with disabilities in FY2013. This number represents close to eight percent of all hires by the Department. The overall representation of persons with disabilities at HHS at the end of FY2013 is 8.3 percent.

HHS utilizes USAjobs to post vacancy announcements which include information specifically related to Special Hiring Authorities for veterans and persons with disabilities. HHS continues to market and implement the Non-Paid Work Experience Program (NPWE) and the Operation Warfighter Program (OWF) that enables rehabilitating servicemen and women to acquire on-the-job training within the federal government.

HHS consults with hiring managers to ensure that targeted advertisements (e.g., professional journals, websites, and professional events) are distributed to a broad and diverse population. Additionally, HHS' Office of Human Resources (OHR) developed a comprehensive "Hiring Guide for Managers," which lays out the entire recruitment process and associated actions from beginning to end. This guide provides all OpDiv managers with information on available hiring flexibilities, including Schedule A hiring authorities for persons with disabilities and those targeted to veterans, such as the Veterans' Recruitment Appointments (VRA), Appointment of Veterans who are 30 percent or more disabled, and the Veterans Employment Opportunities Act (VEOA) appointments. Managers are trained to consider volunteer, unpaid work experiences for individuals with disabilities who need to develop viable work skills, knowledge, and abilities for future paid employment.

Item

Immunotherapy and Asthma *- The Committee notes that an AHRQ review published earlier this year concluded that allergy immunotherapy is an effective treatment for allergic rhinitis, reduces asthma symptoms, lowers the use of asthma medications, and improves patient quality of life. Studies have also shown that allergy immunotherapy is highly cost-effective and severely underutilized. The Committee encourages the Secretary to develop a multi-agency initiative involving the NIH, AHRQ, CMS, and CDC to support research that will identify patient, healthcare provider, and systems barriers to initiation and adherence to allergy immunotherapy and develop interventions to address these problems.*

Action Taken or To Be Taken

Please see the National Institute of Health's President's Budget for a narrative on this item.

Item

Overdose Prevention *- The Committee notes that accidental deaths from overdose, particularly from prescription drugs such as opioids, are on the rise and have become the leading cause of preventable death for individuals under the age of 65 in the United States. The Committee is concerned that many healthcare professionals, treatment providers and at-risk populations are unaware of overdose prevention and reversal strategies. The Committee urges the Secretary, in collaboration with other agencies such as SAMHSA and CDC, to raise awareness of the symptoms and risk factors of overdose,*

how to deploy naloxone, rescue breathing and emergency services for someone experiencing an overdose, and how to help individuals make the linkage to treatment and recovery services.

Action Taken or To Be Taken
Please see Substance Abuse and Mental Health Services Administration's President's Budget for a narrative on this item.

Item

Prescriber Education *- The administration's `Prescription Drug Abuse Plan' called on the Department to work with the Department of Justice and the Office of National Drug Control Policy on ways to educate practitioners on safe and proper prescribing of opioid painkillers as a prequalification for those individuals obtaining a Drug Enforcement Administration license to prescribe and dispense controlled substances. The Committee requests an update on these efforts in next year's congressional justification.*

Action Taken or To Be Taken
Please see the Food and Drug Administration's President's Budget for a narrative on this item.

Item

Urban-Based Network – *The Committee continues to support the efforts of the Secretary and other agencies within the Department, such as HRSA, AHRQ, CDC, CMS, NIMHD, and the Office of Minority Health (OMH), to support a network of urban-based institutions focused on addressing recruitment and training needs of minority and urban underserved populations and reducing health disparities in these urban communities.*

Action Taken or To Be Taken
The Department continues to engage in efforts to develop and support a network of urban-based institutions focused on addressing recruitment and training needs of minority and urban underserved populations and reducing health disparities in these communities. The *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* (*HHS Disparities Action Plan*) specifically calls for increasing the diversity of the healthcare and public health workforces as a strategy to reduce health disparities in minority and underserved communities. Examples of key initiatives include, but are not limited to:

OMH funds the *American Indian/Alaska Native Health Disparities Grant Program* (*AI/AN Program*) that is directed at Tribal Epidemiology Centers and Urban Indian Health Programs supported by the Indian Health Service. The AI/AN Program supports internships, fellowships, and graduate student and faculty development programs that encourage underrepresented populations' pursuit of careers in healthcare, science, technology, engineering, and mathematics (STEM), and research fields; develop leadership capacity within academic, health, and public health professions; and increase the number of culturally and linguistically appropriate professionals practicing in medically underserved communities.

HRSA funds programs through the *National Health Service Corps (NHSC) and Nurse Corps (NC) programs* which help underserved communities and facilities experiencing critical shortages of health care providers recruit and retain clinicians through scholarship and educational loan repayment programs in exchange for clinical service. The NHSC and NC programs operate by awarding direct contracts to individuals who practice in a variety of clinical practice settings across the nation. In FY 2013 NHSC Field Strength consists of 8,899 primary care medical, dental and behavioral and mental health providers with

56 percent serving in urban areas. The FY 2013 NURSE Corps Field Strength consists of 2,559 registered and advanced practiced nurses with 81 percent fulfilling their service obligation in urban settings.

NIMHD funds the Urban Universities for HEALTH Program, a partnership effort of the Coalition of Urban-Serving Universities/Association of Public and Land-grant Universities with the Association of American Medical Colleges, to create urban medical centers of excellence. *The Health Equity through Alignment, Leadership and Transformation of the Health Workforce Program* recognizes the critical role that urban universities and their academic medical centers play in driving change in their communities and in innovating and implementing workforce solutions with an eye toward health equity. The partnership aims to improve the health of urban communities by developing their health workforce through education and training, institutional capacity building, research, and outreach and community engagement. Five demonstration sites will work together with a broader group of university leaders over the next four years to pursue the partnership's goals.

For example, the University of Missouri – Kansas City (UKMC) developed "Transformation of the Health Care Workforce to Combat Disparities", a program designed to increase underrepresented populations in healthcare fields. To date the program has successfully incorporated cultural competency content in its curriculum and began using the AAMC-endorsed Tool for Assessing Cultural Competence Training (TACCT) in August 2012. In 2011, at least 20% of graduates from Health Science Schools were from underrepresented populations, and UMKC placed more than 1,500 health sciences students in high disparities environments in urban Kansas City.

Item

Office of Minority Health *– The Committee recommendation includes $2,000,000 to continue the national health education program on lupus for healthcare providers, with the goal of improving diagnosis for those with lupus and reducing health disparities. The Committee continues to strongly support 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 to be taken

The Department continues its commitment to improve the diagnosis for individuals with lupus and reducing health disparities. Since FY 2012, OMH worked in partnership through a competitive cooperative agreement with the American College of Rheumatology (ACR) to implement the following key strategies and produce modular learning tools for students of medicine, nursing and other health professions:

1. Maintained an active consortium of medical schools, medical professional associations, federal partners, nationally known lupus scientific experts and medical curriculum experts.
2. Developed curriculum instruction that prepares medical and other health professions students to effectively apply knowledge and skills needed to reduce morbidity and mortality among populations disproportionately impacted by lupus.
3. Recruited schools of medicine, nursing, and allied health to use and adopt the Eliminating Lupus Health Disparities Initiative (ELHDI) curriculum or curriculum components.
4. Provided opportunities for practicing health care professionals to receive lupus training and education through a variety of modalities including face to face, electronic media, social media, etc.

5. Disseminated Toolkit to over 1800 providers and community health clinics nationwide. The toolkit is a compilation of resources providers can use for their own education in lupus and health disparities and materials designed to help improve interactions with patients.
6. Patient DVD viewed in over 400 practitioner waiting rooms.
7. Beta-tested curriculum as a grand rounds lecture at an Ohio community hospital and pilot tested the curriculum in a wide range of health professions schools including Meharry Medical College's autoimmunity lecture for first year students.
8. Developed resources for health professions practitioners designed to promote understanding of the impact of health disparities in outcomes of patients with lupus; testing and accurate diagnosis of at-risk patients; and improved physician/patient communication. The Department and ACR are working with Georgetown University's National Center for Cultural Competence (NCCC) to create a web-based, interactive, distance learning tool for health care professionals that addresses conscious and unconscious bias in the provision of health care, with an emphasis on those patients diagnosed with Lupus.
9. Recorded three Lupus CME lectures that were added to the Lupus Initiative website.
10. Produced short teaching videos to offer access to expert content in brief segments.

In FY 2014, OMH will include continuation and broader dissemination of curriculum and materials to health professions schools and expanding opportunities to local health systems in selected geographic areas with infrastructure in place to adopt the recommendations.

Item

Chronic Kidney Disease (CKD) – *The Committee continues to encourage OMH to prioritize early detection and treatment of CKD in minority communities to improve health outcomes and eliminate these severe health disparities.*

Action take or to be taken

OMH is dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs to eliminate health disparities. OMH's work to eliminate health disparities includes health disparities related to Chronic Kidney Disease (CKD) through a focus on prevention of diabetes and hypertension (high blood pressure), the two leading causes of CKD which are responsible for up to two-thirds of the cases of CKD.

OMH continues to prioritize diabetes awareness, education, outreach, program, and research activities to reduce disparities in diabetes and diabetes-related complications, such as CKD, in minority communities. For example, OMH has a co-sponsorship agreement with the American Diabetes Association which focuses on the prevention of late stage diabetes complications. The agreement also includes a component on increasing diabetes awareness of preventive self-care behaviors through access to culturally competent community awareness and patient education programs. Further, OMH is a member of the Diabetes Mellitus Interagency Coordinating Committee (DMICC), which is comprised of HHS, Department of Defense, and U.S. Department of Agriculture representatives. The DMICC meets regularly to review and discuss current and emerging research projects that allow the committee to develop recommendations for prevention and treatment best practices, future funding, and programming that address diabetes and its known adverse impact on metabolic and cardiovascular conditions that include chronic and end-stage renal disease.

Translating knowledge into practice, OMH works closely with the Centers for Medicare & Medicaid Services to ensure science-based information and actionable steps to hypertension control are

disseminated among communities at highest risk, including individuals with high incidence of cardiovascular disease, stroke, diabetes, and CKD. In FY13, a joint initiative, "100 Congregations for Million Hearts", was launched in five cities across the country – Baltimore, Chicago, Philadelphia, San Diego, and Tulsa. The initiative enlists the support of local congregations in increasing awareness of disease prevention by focusing on hypertension reduction and control. OMH is actively pursuing a range of outreach activities to promote effective interventions related to the prevention, treatment, and management of CKD.

In addition, OMH supports outreach and awareness activities stemming from the National Kidney Disease Education Program, a program led by the National Institute of Diabetes and Digestive and Kidney Disease (NIDDK). Through collaboration, OMH reviews, provides feedback, assists in the dissemination of program literature to help promote awareness of chronic kidney disease among racial and ethnic minority populations.

Item

Office of Minority Health *- The Committee continues to support the Department's implementation of the Action Plan to Reduce Racial and Ethnic Health Disparities, as well as the National Stakeholder Strategy for Achieving Health Equity. The Committee notes that the Offices of Minority Health in the Office of the Secretary, AHRQ, CDC, CMS, FDA, HRSA, and SAMHSA are charged with leading the strategy.*

Action Taken or To Be Taken

The ***HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS Disparities Action Plan)*** and the National Stakeholder Strategy for Achieving Health Equity continues to provide visible and accountable federal leadership for addressing health disparities while also promoting collaborations across the Department and with other stakeholders to more effectively reduce health disparities and achieve health equity. The Office of Minority Health in the Office of the Secretary oversees the implementation of HHS Disparities Action Plan and works with the HHS Health Disparities Council to oversee Departmental Plan progress.

As required by the Affordable Care Act, individual Offices of Minority Health have been established within AHRQ, CDC, CMS, FDA, HRSA, and SAMHSA. In 2012, all of the agencies appointed permanent directors who meet regularly with the Deputy Assistant Secretary for Minority Health/Director of the Office of Minority Health in the Office of the Secretary and who provide important leadership and coordination within their agencies to help implement the *HHS Disparities Action Plan*.

Examples of these agencies' efforts to implement the Disparities Action Plan include:

- HHS Office of Minority Health released the enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) in FY 2013 which serves as a framework for organizations to provide culturally and linguistically appropriate services to our nation's increasingly diverse communities.
- AHRQ has distributed over 3,000 *Aprende a vivir* DVDs and 55,000 consumer publications in Spanish to mostly promotores de salud and community health workers in the United States and Puerto Rico who help Hispanics with type 2 diabetes address challenges related to managing their condition.
- CDC awarded $70 million in 2012 through the *Community Transformation Grant (CTG) Small Communities Program* that will directly impact approximately 9.2 million Americans living in low-income, racial and ethnic minority, and medically underserved communities.

- CMS implemented recommended approaches for collecting and analyzing data on health care disparities using the standards finalized under section *4302(a) of the Affordable Care Act* to better identify and track disparities in health and health care, understand their correlates and consequences, and facilitate greater accountability for reducing them.
- FDA supports minority health related research projects through the *Centers for Excellence in Regulatory Science Universities (CERSI) Minority Health Grants* to integrate health disparities research into the development of new tools to assess the safety, efficacy, quality, and performance of FDA-regulated products.
- HRSA's *National Health Service Corps (NHSC) Loan Repayment and Scholarship Awards Program* resulted in 10.4 million patients being served by NHSC clinicians and in 9,908 scholarship and loan repayment agreements to place NHSC clinicians in communities with limited access to care in fiscal year 2012.
- SAMHSA included language to determine if an activity is making progress on reducing disparities in four grant programs in fiscal year 2012, all of which have shown improved focus on disparities, and expanded the strategy to include requirements to include *Disparity Impact Statements* in all new grants in fiscal year 2013.

*The **National Stakeholder Strategy for Achieving Health Equity (NSS)*** serves as a roadmap for the National Partnership for Action to End Health Disparities (NPA), an initiative led by the Office of Minority Health in the Office of the Secretary. The NPA provides a national platform for increasing cross-sector and multi-level coordination of efforts and activities to eliminate health disparities and promote health equity, and in ways that yield and support policy and systems level changes that ultimately drive organizational and programmatic changes. These changes in turn are expected to promote equity in the social determinants of health (e.g., poverty, housing, access to health care, education), and therefore reductions in health disparities.

Implementation of the NSS occurs through the efforts of 10 non-federal Regional Health Equity Councils (RHECs) that are aligned with the 10 HHS regions, a Federal Interagency Health Equity Team (FIHET), State Offices of Minority Health, and other partners from the public and private sectors. OMH supports and coordinates the efforts of these implementation arms to: identify areas of need nationally and locally; identify state of the art and promising strategies for meeting these needs as well as partners implementing these strategies; educate and raise awareness among leaders of organizations and communities as well as persons under the influence of such leadership about the issues and remedial strategies; foster partnerships to leverage existing resources and maximize the impact of remedial strategies, and support action to implement these promising practices and remedial strategies.

Highlights of NPA activities in FY 2013 included the following:

- Outreach and education to leaders of community and faith-based organizations, individuals and families in several communities on the Affordable Care Act.
- Assessments of the needs of community health workers to effectively support disease prevention efforts broadly and specifically in mental health, given the provisions in the Affordable Care Act.
- Activities to educate and inform state legislators and their staff about the enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care and the Affordable Care Act.
- Engaging young adults (undergraduate and graduate students) through internship experiences in the Office of Minority Health and the Regional Health Equity Councils with the goals of exposing students in the pipeline to health equity policy and programs.

- Convening health and non-health sector practitioners to share state of the art strategies and promising practices at federal, state and county levels for promoting health equity, and identify challenges and needs.

Item

*The Committee is concerned by both the growing backlog of cases at **OMHA** and the high rate of claims overturned by the Office. Over half of the cases sent to OMHA are overturned; of the remaining cases, 37 percent are overturned through the departmental appeal process. The Department is urged to work with providers at the early stages of the audit process so that only a small number of cases are ultimately appealed and the loss of provider time, energy, and resources due to incorrect audit results are limited.*

Action Taken or To Be Taken
The Office of Medicare Hearings and Appeals (OMHA) has established internal workgroups to recommend strategies to address the significant increase in workload volume and mitigate the growth in backlog of unheard cases. The positive impact of these strategies may also reduce future appeals in the current process, but will not eliminate the current need for additional adjudicators and legal support staff to handle the appeals currently pending as well as anticipated receipt levels for 2015.

To potentially reduce the number of hearings and increase adjudicatory efficiency, OMHA seeks to implement Statistical Sampling w/Appellant Consent, as well as grouping cases for efficient processing and strategic assignments of big box cases. OMHA also is examining the use of a Front End Review program for systematic triaging of appeals agency-wide. The program would identify appeals potentially capable of immediate disposition, which would relieve ALJ teams from case processing requirements. In addition, a back-end pool initiative will provide assistance to ALJ teams with the closing process and will create additional case processing efficiencies. All of these strategies have the potential to relieve ALJ teams from considerable case processing tasks and provide more time for adjudicatory functions. In coordination with the Department, OMHA is also exploring the use of alternative adjudication strategies which could expand the number of adjudicators available to handle workloads and is undertaking a holistic review of the appeals process to determine whether possibilities exist for additional processing efficiencies.

Item

***Asthma** - The Committee is concerned that in the 6 years since the release of NIH's Expert Panel Guidelines for the Diagnosis and Management of Asthma, very few children being treated in a primary care setting are receiving in vitro testing or skin testing to manage their asthma more effectively with an increased focus on achieving and maintaining good asthma control over time. The Committee directs the Secretary to report to the Committee within 60 days of enactment of this act on the barriers to primary care adoption of standardized and reproducible allergy tests for children and adults with asthma and related conditions. The report should recommend actions to remove such barriers to testing, which is a critical component of the guidelines.*

Action Taken or To Be Taken
Please see the National Institute of Health'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), GLCE, 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 2013 to FY 2015 Agency Contributions

Agency	Total FY 2013	Total FY 2014	Total FY 2015
HHS	4,985,005	4,710,238	4,964,848
DOT	449,503	404,959	394,724
ED	475,731	547,513	543,914
HUD	299,068	407,186	241,593
DHS	413,272	300,929	361,185
NSF	370,923	467,754	450,354
USDA	552,402	509,443	439,294
DOC	344,532	326,901	289,592
DOD	715,348	752,274	666,561
DOE	540,740	439,604	379,656
DOI	1,113,310	1,335,972	1,603,166
DOL	213,702	211,895	209,386
EPA	379,828	373,002	281,852
USAID	402,565	429,166	398,331
USDOJ	398,441	510,553	435,397
NASA	155,066	173,346	161,725
CNCS	59,756	64,809	57,453
DOS	362,137	289,976	413,404
NEH	223,429	213,889	196,177
SBA	71,580	69,120	49,186
IMLS	84,236	76,594	77,833
NEA	203,324	182,161	174,423
VA	39,794	47,753	57,304
NARA	47,975	40,623	36,160
SSA	30,308	36,370	26,578
USDOT	49,727	59,672	71,606
Grant Total	12,981,702	12,981,702	12,981,702

PHYSICIANS' COMPARABILITY ALLOWANCE (PCA)

Office of the Assistant Secretary for Planning and Evaluation

Physician Categories	FY 2013 Enacted	FY 2014 President's Budget	FY 2015 Request
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)	$163,696	$165,834	$167,657
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 2013 data will be approved during the FY 2015 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. One physician left this year. 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 2014 Funding
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.	$14,265,000
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.	$6,036,193
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.	$2,772,000
Departmental Ethics Program	These funds will be used to support attorneys and 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.	$3,200,000

Project	Description	FY 2014 Funding
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.	$726,580
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.	$980,000
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.	$175,000
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.	$1,500,000
HHS Web Site Development	These funds will be used to continue to deliver online information to citizens and making improvements through effective management. Resources will be used to help make sure our sites deliver the best possible customer service.	$200,000

Office of Medicare Hearings and Appeals

Letter from the Chief Administrative Law Judge

I am pleased to present the Office of Medicare Hearings and Appeals (OMHA's) Fiscal Year 2015 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 despite significant increases in workload. This commitment continues to inspire OMHA's mission. However, due to rapidly increasing receipt levels which far exceed the adjudication capacity of its 65 Administrative Law Judges (ALJ), OMHA is failing to issue Medicare decisions in 90 days as required by statute. In January of 2014, average processing times for the agency had reached 329.8 days. Given current adjudication capacity, OMHA's backlog will approach 1,000,000 claims by the end of FY 2014.

The FY 2015 budget reflects OMHA's efforts not only to build upon the operational success achieved during its first nine years, but also to implement an Adjudication Expansion Initiative to respond to the agency's foremost challenge, its growing backlog of appeals. In January of 2012 OMHA received an average of 1250 appeal receipts per week. Two years later in January of 2014, OMHA is receiving over 15,000 appeals per week. Although OMHA's 65 Administrative Law Judges have doubled their productivity from 632.5 dispositions per ALJ per day in 2010 to 1220 dispositions in 2013, OMHA has been unable to keep pace with the dramatic increase in receipts. The Adjudication Expansion initiative will position OMHA to be able to increase the issuance of dispositions while maximizing the efficiency of our human resources through strategic technology enhancements.

Above all, this FY 2015 budget reflects OMHA's efforts to focus on the agency's mission, by increasing efficiency and further enhancing service to the public.

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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
- Director, Office of Operations
  - Segundo Pereira
- Mid-Atlantic Regional Office
  - Acting Associate Chief Administrative Law Judge, C.F. Moore
  - Hearing Office Director, vacant
- Mid-Western Field Office
  - Acting Associate Chief Administrative Law Judge, Robert Fisher
  - Hearing Office Director, Steven Yelenic
- Western Field Office
  - Associate Chief Administrative Law Judge, Stuart Wein
  - Hearing Office Director, Andreas Frank
- Southern Field Office
  - Associate Chief Administrative Law Judge, David Krane
  - Hearing Office Director, James Rice

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 the American people have equal access and opportunity for hearing on Medicare disputed claims. On behalf of the Secretary of HHS, the Administrative Law Judges (ALJs) within OMHA conduct independent and 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.

OVERVIEW OF BUDGET REQUEST

The FY 2015 Request for OMHA of $100,000,000 represents a $17.6 million (or 21%) increase over the FY 2014 Enacted Level. OMHA's budget request makes investments to support HHS Strategic Goals to Transform Healthcare and Increase Efficiency, Transparency and Accountability of HHS Programs. This will be accomplished by maximizing its organizational adjudicatory capacity to meet the needs of the public (i.e. Medicare beneficiaries, who are among our nation's most vulnerable populations, providers and the tax-paying public).

The FY 2015 Request funds 115 additional FTE's, including 17 new Administrative Law Judge (ALJ) teams and adjudicatory support staff compared to FY 2014 Enacted to expand OMHA's legal capacity for case review, decision writing, and case adjudication, and increases case processing and workload distribution staff. The expansion of adjudicatory capacity will allow OMHA to hear more Medicare appeals and begin to slow the growth of its increasing backlog which will approach 1,000,000 claims by the end of FY 2014.

OVERVIEW OF PERFORMANCE

Although ALJ teams adjudicated more appeals than ever before in FY 2013, doubling their appeal productivity levels from FY10, OMHA met or exceeded only one out of the three agency performance goals due to increasing volume and complexity of workload.

In support of 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 appeal 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 – 5, 1 representing the lowest score (very dissatisfied) and 5 representing the best score (very satisfied). In FY 2013, OMHA achieved a 4.0 level of appellant satisfaction nationwide, exceeding the FY 2013 target of 3.6 by 0.4. However, average scores may decrease as the appeals backlog continues to grow.

OMHA continues to implement methods to increase efficiency in case processing such as the establishment of a centralized docketing division in FY 2012. The implementation of the centralized docket helps ensure a single consistent docketing process agency-wide and more balanced workload distribution across ALJ teams nationwide. Despite the efficiencies incorporated in case processing, OMHA is unable to continue its past successes for adjudicating claims within 90 days, as mandated by the Benefits Improvement and Protection Act (BIPA) 2000. Performance targets for the past two years were adjusted to reflect the increasing challenges caused by rising workloads. In FY 2013, OMHA fell short of its 44% performance target by adjudicating only 28% of its BIPA claims in 90 days.

OMHA experienced a 100% increase in total claims received in FY 2013 compared to FY 2012 levels. ALJs have exceeded their sustainable capacity for case adjudication, and it is currently not possible to meet the 90 day mandate. Furthermore, conservative projections show FY 2015 claims will increase by a minimum of 30% above FY 2013 levels.

ALL PURPOSE TABLE

(Dollars in Thousands)

OMHA	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	69,444	82,381	100,000	+17,619
FTE	492	514	629	+115

Authorizing Legislation……Titles XVIII and XI of the Social Security Act
FY 2015 Authorization…….. Indefinite
Allocation Method……..Direct Federal

APPROPRIATIONS LANGUAGE

For expenses necessary for the Office of Medicare Hearings and Appeals, **[$82,381,000]** *$100,000,000*, to be transferred in appropriate part from the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund.

AMOUNTS AVAILABLE FOR OBLIGATION

Detail	FY 2013 Actual	FY 2014 Enacted	FY 2015 President's Budget
Trust Fund Discretionary Appropriation	68,244,054	82,381,000	100,000,000
Rescission	-	-	-
Transfers	1,200,000	-	-
Subtotal, adjusted trust fund discretionary appropriation	***69,444,054***	***82,381,000***	***100,000,000***
Unobligated balance lapsing	89,882	**-**	**-**
Total Obligations	**69,354,172**	**82,381,000**	**100,000,000**

SUMMARY OF CHANGES

(Dollars in Thousands)

Budget Year and Type of Authority	Dollars	FTE
FY 2014 Enacted	82,381	514
FY 2015 Total Adjusted Budget Authority	100,000	629
Net Changes	**17,619**	**115**

Program Increases	FY 2014 FTE	FY 2014 Enacted	FY 2015 +/- FY 2014 FTE	FY 2015 +/- FY 2014 BA
Full-time permanent	514	45,076	115	9,951
Other personnel compensation	-	428	-	40
Civilian personnel benefits	-	13,974	-	3,384
Travel and transportation of persons	-	200	-	0
Other services from non-Federal sources	-	951	-	670
Others goods and services from Federal sources	-	5,202	-	2,249
Operation and maintenance of facilities	-	661	-	1,934
Operation and maintenance of equipment	-	1,034	-	57
Supplies and materials	-	692	-	198
Equipment	-	1,619	-	236
Total Increases	**-**	**69,837**	**-**	**18,719**

Program Decreases	FY 2014 FTE	FY 2014 Enacted	FY 2015 +/- FY 2014 FTE	FY 2015 +/- FY 2014 BA
Transportation of things	-	977	-	-644
Rental payments to GSA	-	7,414	-	-48
Communications, utilities, and misc. charges	-	3,899	-	-316
Printing and reproduction	-	254	-	-92
Total Decreases	**-**	**12,544**	**-**	**-1100**

Total Changes	FY 2014 FTE	FY 2014 Enacted	FY 2015 +/- FY 2014 FTE	FY 2015 +/- FY 2014 BA
Total Increases	514	69,837	115	18,719
Total Decreases	0	12,544	0	-1100
Total Net Change	**514**	**82,381**	**115**	**17,619**

BUDGET AUTHORITY BY ACTIVITY – DIRECT

(Dollars in Thousands)

Activity	FY 2013 Actual	FY 2014 Enacted	FY 2015 President's Budget
Office of Medicare Hearings and Appeals (OMHA)	69,444	82,381	100,000
OMHA FTE	492	514	629
Total, Budget Authority	**69,444**	**82,381**	**100,000**
Total, FTE	**492**	**514**	**629**

AUTHORIZING LEGISLATION

(Dollars in Thousands)

Authorizing Legislation	2014 Amount Authorized	2014 Appropriations Act	2015 Amount Authorized	2015 President's Budget
Office of Medicare Hearings and Appeals Social Security Act, Titles XI and XIII	Indefinite	$82,381	Indefinite	$100,000
Total	**-**	**$82,381**	**-**	**$100,000**

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	-	-	-	(3,622,567)
Transfers (P.L. 112-74)	-	-	-	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	-	-	-
Subtotal	100,000,000	-	-	-

NARRATIVE BY ACTIVITY

Program Description and Accomplishments
OMHA was established in July 2005 pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) in response to the delays in processing of Medicare appeals that existed at the Social Security Administration (SSA). According to the Government Accountability Office (GAO), SSA ALJs took on average 368 days to resolve appeals in 2003. The appropriation authorization of the MMA provided for the addition of ALJs and staff to insure for the "timely action on appeals before administrative law judges," (MMA § 931(c), 117 Stat. 2398-99).

While SSA had no statutory timeframe for case adjudication, OMHA is mandated by the Benefits Improvement and Protection Act (BIPA) to adjudicate the third level of Medicare appeals within 90 days. Given current and projected receipt levels, it is projected that by the end of FY 2014, OMHA's average processing will continue to increase significantly as the backlog grows.

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. OMHA administers its program in four field offices, including the Southern Field Office in Miami, Florida; the Midwestern Field Office in Cleveland, Ohio; the Western Field Office in Irvine, California; and the Mid-Atlantic Field Office in Arlington, Virginia.

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 January 2006, OMHA began hearing appeals arising from the new Medicare Part D Prescription Drug Plan. In January 2007, OMHA began hearing Medicare Part B Income-Related Monthly Adjustment Amount (IRMAA) appeals.

In 2007, OMHA also began receiving new cases as a result of the Centers for Medicare & Medicaid Services (CMS) pilot Recovery Audit Contractor (RAC) program. This program includes RACs for Medicare Secondary Payee. As a result of the RAC pilot program, OMHA received more than 20,000 RAC claims through FY 2009. In January 2010, the RAC program became permanent and was expanded to all 50 States. OMHA received 192,000 RAC claims in FY 2013. OMHA received no additional funding for handling this burgeoning workload. OMHA projects approximately 250,000 RAC claims annually for the next two years.

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.
- The development of OMHA's Electronic Case Processing Environment (ECAPE) currently underway.
- A best practices initiative that shared and implemented efficient operational approaches across offices.
- 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.

- In coordination with the Department, OMHA is also exploring the use of alternative adjudication strategies which could expand the number of adjudicators available to handle workloads and is undertaking a holistic review of the appeals process to determine whether possibilities exist for additional processing efficiencies.

These initiatives have allowed OMHA to double the productivity of its ALJ teams, increasing the average productivity from 632.5 dispositions per team in FY 2010 to 1220 dispositions per team in FY2013. However, it should be noted that this level of productivity allows for the dedication of less than 2 hours of ALJ time per appeal. Further increases in ALJ productivity may compromise a key aspect of OMHA's mission—its commitment to quality adjudication.

Funding History

Fiscal Year	Amount
FY 2010	$71,147,000
FY 2011	$71,005,000
FY 2012	$72,011,000
FY 2013	$69,444,054
FY 2014	$82,381,000

Budget Request

The FY 2015 Request for OMHA of $100 million represents a $17.6 million (or 21%) increase over the FY 2014 Enacted Level, with $13 million attributed to staffing. The request allows OMHA to address the ever growing and changing workload by increasing OMHA's adjudicatory capacity and staffing levels to 89 ALJ teams, above its current 65 ALJ teams.

Growth in Workload

Appeals:
OMHA received 390,000 appeals (cases) in FY 2013, nearly triple the 131,000 appeals received in FY 2012. OMHA's workload continues to exceed its capacity to adjudicate cases, resulting in an increased average adjudication time.

Claims:
The total number of claims associated with the appeals continues to escalate at unprecedented levels as well. In FY 2013 OMHA received more than 650,000 claims compared to 320,000 claims received in FY 2012. At this rate of growth, OMHA projects FY 2015 claims will escalate to more than 850,000.

The significant growth in workload is primarily driven by the influx in Medicare enrollees due to retirement of baby boomers compounded by the national implementation of the Recovery Audit Contractor (RAC) program. The 200,000 RAC claims received in the FY 2013 represents 30% of total claims received, and significantly exceeds the 42,000 RAC claims received in FY 2012.

Increase in Workload Complexity

Rising receipt levels are exacerbated by the increase 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. OMHA received approximately 263,000 complex Part A appeals, a 317% increase compared to the total 63,000 received in FY 2012. RAC claims currently account for the vast majority of hospital insurance

claims. Recovery Audit claim determinations that are appealed to Administrative Law Judges often present complex factual patterns and are becoming increasingly adversarial many times with multiple parties appearing at hearings. Recent areas of Recovery Audit focus include the reasonableness and necessity of hospital inpatient admissions. These complex factual assessments are made based on varying degrees of documentation by the hospitals, and take considerable time for a thorough review.

Adjudication Expansion Initiative (AEI):

Despite agency-wide initiatives to streamline business processes and significantly increased productivity by ALJ teams as described above, ALJs have exceeded their sustainable capacity for case adjudication. OMHA's workload has increased six fold since 2006, while the number of adjudicatory teams (65) has remained relatively constant. At the current rate of receipts, OMHA is receiving a year's worth of workload for its 65 ALJ teams every six weeks. OMHA currently has over 4 years of work on hand for its existing 65 teams. OMHA must expand its case processing and adjudicatory capacity to respond to its increasing workload and to begin to mitigate the backlog of unheard cases which will approach 1,000,000 claims by the end of FY 2014.

Under this critical Adjudication Expansion Initiative, OMHA would increase its staffing levels by 115 FTE, including 17 new ALJ teams. After gaining experience these ALJ teams collectively will adjudicate approximately 55,000 additional claims annually.

In addition, OMHA would increase its Central Operations case processing and workload distribution staff by 24 positions. In FY 2012, Central Operations was established to facilitate a new, unified workload distribution system and standardized docketing process across all four field offices. In its first year of operation, Central Operations successfully demonstrated that this new approach provides the efficiency, proactivity and flexibility needed for increased case processing. Despite the effectiveness of Central Operations, it was staffed to support 1,500 new appeals per week. The average weekly appeals have increased fivefold in FY 2013, with current weekly receipts of 15,000. Increasing the staff at Central Operations will also allow OMHA to gain processing efficiencies by grouping appeals for adjudication.

This phased strategy in adding resources will allow OMHA to increase decision writing capability and facilitate more efficient service to Medicare service providers and suppliers and individual Medicare beneficiaries.

The requested funding will support critical staff and operational investments including:

- Eighty-nine ALJ teams to adjudicate all Medicare appeals, including Medicare Parts A, B, C, D, Medicare entitlements and eligibility appeals, Income Related Monthly Adjustment Amount (IRMAA) cases and RAC cases.

OUTPUTS AND OUTCOMES TABLE

Measure	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Increase the number of BIPA cases closed within 90 days	FY 2013: 28% Target: 44% (Target Not Met)	21%	15%	-6%
Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council	FY 2013: 1.1% 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 2013: 4.0 Target: 3.6 (Target Exceeded)	3.6	3.4	-0.2

BUDGET AUTHORITY BY OBJECT CLASS-DIRECT

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Enacted	FY 2015 Budget	FY 2015 +/- FY 2014
-	***Personnel Compensation***	-	-	-
11.1	Full-time permanent	45,076	55,027	9,951
11.5	Other personnel compensation	428	468	40
Subtotal	***Personnel Compensation***	***45,504***	***55,495***	***9,991***
12.1	Civilian personnel benefits	13,974	17,358	3,384
Total	**Pay Costs**	**59,478**	**72,853**	**13,375**
21.0	Travel and transportation of persons	200	200	0
22.0	Transportation of things	977	333	-644
23.1	Rental payments to GSA	7,414	7,366	-48
23.3	Communications, utilities, and misc. charges	3,899	3,583	-316
24.0	Printing and reproduction	254	162	-92
-	***Other Contractual Services***	-	-	-
25.2	Other services from non-Federal sources	951	1,621	670
25.3	Other goods and services from Federal sources	5,202	7,451	2,249
25.4	Operation and maintenance of facilities	661	2,595	1,934
25.7	Operation and maintenance of equipment	1,034	1,091	57
Subtotal	***Other Contractual Services***	***7,848***	***12,758***	***4,910***
26.0	Supplies and materials	692	890	198
31.0	Equipment	1,619	1,855	236
Total	**Non-Pay Costs**	**22,903**	**27,147**	**4,244**
Total	**Budget Authority by Object Class**	**82,381**	**100,000**	**17,619**

Office for Civil Rights

Letter from the Director of the Office for Civil Rights

I am pleased to present the Office for Civil Rights (OCR) Fiscal Year 2015 Congressional Justification. This budget reflects OCR's continued commitment to fulfilling its mission. As the Department's civil rights and health privacy rights law enforcement agency, OCR investigates complaints, enforces rights, and promulgates regulations, develops policy and provides technical assistance and public education to ensure understanding of and compliance with non-discrimination and health information privacy laws.

The FY 2015 budget request affords OCR the opportunity to become a) appropriately resourced where it has been historically underfunded in fulfilling its existing mission; and b) adequately equipped and resourced for new mission elements (expanded enforcement in civil rights and health information privacy and security, and expanded and enhanced public education in line with OCR's expanded enforcement) which currently exceed our infrastructure.

This budget request supports the President's and Secretary's priority initiatives and reflects the goals and objectives of the Department.

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Leon Rodriguez
Director, Office for Civil Rights

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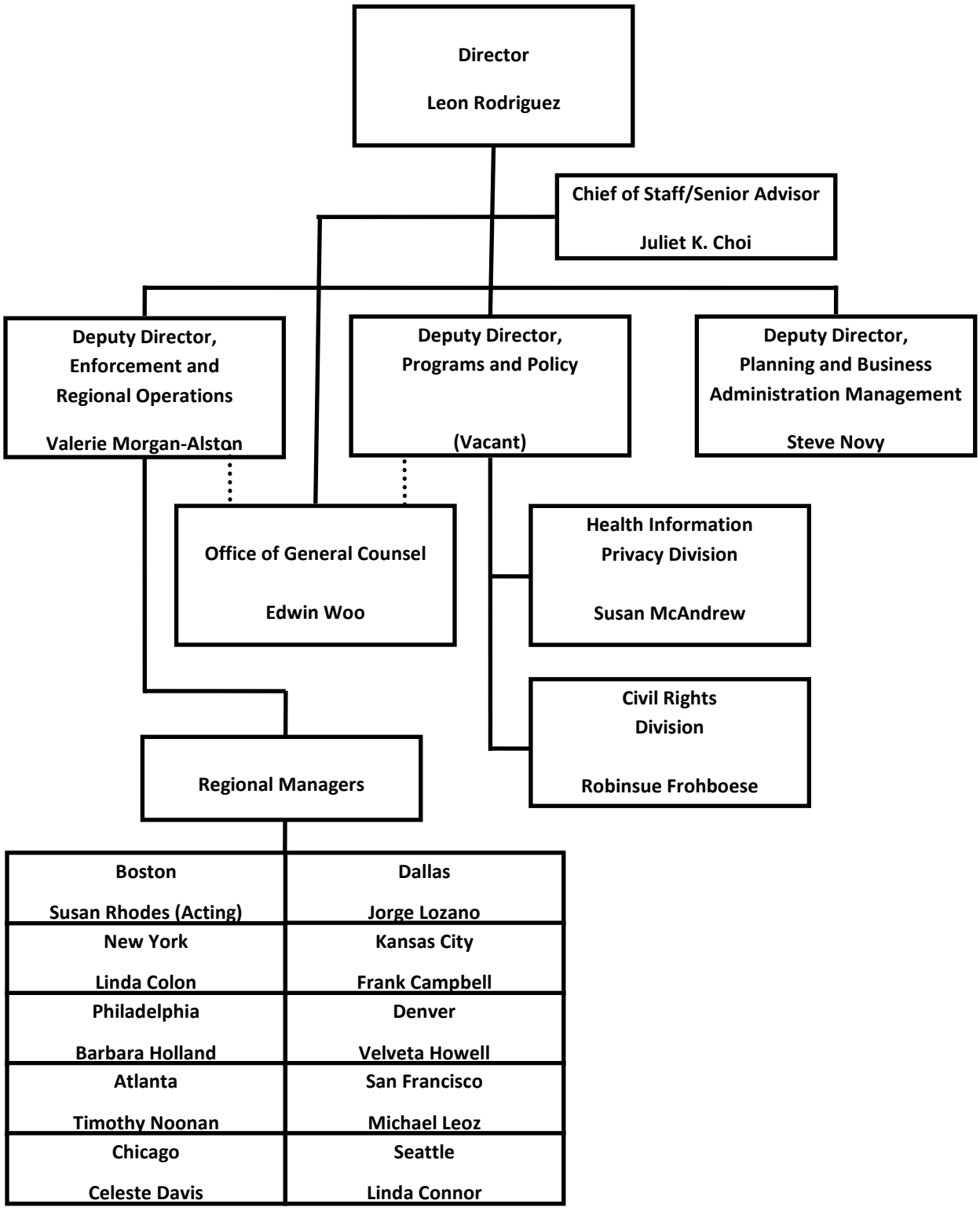
ORGANIZATION CHART

(February, 2013)



ORGANIZATIONAL CHART: TEXT VERSION

Office for Civil Rights

- Director Leon Rodriguez
- Chief of Staff Juliet Choi

The following offices report directly to the Director:

- Deputy Director, Enforcement and Regional Operations
  - Valerie Morgan-Alston
- Deputy Director, Programs and Policy
  - Vacant
- Deputy Director, Planning and Business Administration Management
  - Steve Novy
- Office of General Counsel
  - Edwin Woo

The following regional managers report to the Deputy Director of Enforcement and Regional Operations:

- Susan Rhodes (Acting), Boston
- Linda Colon, New York Regional Office
- Barbara Holland, Philadelphia Regional Office
- Timothy Noonan, Atlanta Regional OFfice
- Celeste Davis, Chicago Regional Office
- Jorge Lozano, Dallas Regional Office
- Frank Campbell, Kansas City Regional Office
- Velveta Howell, 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

- Health Information Privacy Division
  - Susan McAndrew
- Civil Rights Division
  - Robinsue Frohboese

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 people have equal access to and the opportunity to participate in and receive services from all HHS-funded programs without facing unlawful discrimination, and that the privacy and security of their health information is protected. In doing so, OCR helps carry out HHS' overall mission of improving the health and well-being of all people affected by its many programs and promotes integrity in the use of federal funds by removing discriminatory barriers to HHS funded services and programs. OCR annually resolves more than 10,000 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, sex, and religion.
- Enforce new rights under the Affordable Care Act (ACA) which promote access to health care by prohibiting discrimination in health care programs or activities, provider conscience rights, which prohibit discrimination against those who decline to participate in abortions or sterilization procedures, and rights that ensure individuals with disabilities have options to live in their own communities rather than segregated facilities pursuant to the Supreme Court's *Olmstead* decision.
- 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

The FY 2015 request for OCR is $41,205,000 represents a $2.407 million (6%) increase over the FY 2014 Enacted Level.

The FY 2015 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 the privacy and security protections for individually identifiable health information.

Program increases:

Centralized Case Management Operations (+2.407M): 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 invest in a number of proactive efficiencies, such as the Centralized Case Management Operations (CCMO) The CCMO encompasses the following components – Customer Response Center (CRC), Central Intake Unit (CIU), Academy for Civil Rights Investigators (EOS Academy), and the Online Complaint System.

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]
1. Raise awareness, increase understanding, and ensure compliance of all federal laws requiring non-discriminatory access to HHS programs and protection of 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 (Title VI enforcement, public education activities, access via TANF program, Section 504, ADA, *Olmstead* activities, HIV/AIDS access enforcement)	#1 E #3 A, B, 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. information and training to representatives of health and human service providers, other interest groups, and consumers (Civil rights and health information privacy mission activities)	#1E #3B
	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	#1E
1. Enhance Operational Efficiency	A. Advance human capital management (Provide training, develop and mentor subordinates, promote effectiveness)	#5 A
	B. Improve financial management and the integration of budget and performance data (Increase resource management process oversight, strengthen internal controls, overhaul performance objectives)	#4 A,B,D

[1]As reflected on the "FY 2015 Budget by HHS Strategic Goal Table" included herein.

In FY 2013, OCR met or exceeded eight out of its eleven performance measures. In recent years, OCR made efforts to strengthen its performance management process and achieve a more representative picture of OCR's mission, goals, and accomplishments. In FY 2013, OCR revised its method for calculating Measures 1.1.3A-C and 1.1.4 to more accurately reflect case closure rates by accounting for total receipts, including backlog and not just new complaints received. Additionally, OCR has made improvements to its case data management system to strengthen the completeness, validity, and accuracy of the data captured and reported. OCR has also added capability modules to allow for the capture and storage of additional complaint information (compliance audits, breach notifications, etc). The system changes have increased OCR's capability to gather, access, and report performance data and information.

OCR has experienced a steady increase in caseload due to its evolving jurisdictional responsibilities related to health information privacy and security, and civil rights. To address the high volume of complaints, OCR instituted a number of efficiencies, such as Centralized Case Management Operations (CCMO) activities and an on-line complaint receipt system. While the online complaint system is generating a significant number of complaints for the agency, OCR is implementing a case triage and processing practice which allows for better management of incoming complaints and facilitation of case closures. OCR will make more deliberate case processing and investigation decisions at the triage level which should enable OCR to maintain or exceed prior case closure rates despite the increase in complaints.

OUTPUTS AND OUTCOMES TABLE

3	Year and Most Recent Result /Target for Recent Result (Summary of Result)	FY 2014 President's Budget	FY 2015 Request	FY 2015 +/- FY 2014
1.1.1 # Covered Entities taking corrective action as a result of OCR intervention / year (Outcome)	FY 2013: 5,292 Target: 5,900 (Target Not Met)	5900	5900	Maintain
1.1.2 # Covered Entities making substantive policy changes as a result of OCR intervention / year (Outcome)result of OCR intervention / year (Outcome)	FY 2013: 439 Target: 2,800 (Target Not Met)	3600	1000	-2600
1.1.3A % of closure for civil rights cases / cases received each year (Outcome)	FY 2013: 98% Target: 91% (Target Exceeded)	86%	90%	+4%
1.1.3B % of closure for health information privacy cases / cases received each year (Outcome)	FY 2013: 85% Target: 55% (Target Exceeded)	66%	66%	Maintain
1.1.3C% of closure for Medicare application review / reviews received each year (Output)	FY 2013: 92% Target: 90% (Target Exceeded)	90%	90%	Maintain
1.1.4 % CR cases and MED application reviews resolved per received per year	FY 2013: 98% Target: 92% (Target Exceeded)	92%	92%	Maintain
1.1.6 # individuals whom OCR provides information and training annually (Output)	FY 2013: 213,500 Target: 213,500 (Target Met)	213,500	213,500	Maintain
1.1.7 % of civil rights complaints requiring formal investigation resolved within 365 days (Output)	FY 2013: 45% Target: 42% (Target Exceeded)	52%	41%	-11%
1.1.8 % of civil rights complaints not requiring formal investigation resolved within 180 days (Output)	FY 2013: 88% Target: 83% (Target Exceeded)	100%	80%	-20%
1.1.9 % of health information privacy complaints requiring formal investigation resolved within 365 days (Output)	FY 2013: 68% Target: 55% (Target Exceeded)	65%	68%	3%
1.1.10 % of health information privacy complaints not requiring formal investigation resolved within 180 days (Output)	FY 2013: 86% Target: 75% (Target Exceeded)	100%	72%	-28%

[1.1.5 eliminated as duplicative to 1.1.3B when 1.1.3 was expended by category to A-C]
Revised targets reflected, in FY 2013, for Measures 1.1.3A-C and 1.1.4.

BUDGET BY HHS STRATEGIC GOAL

(Dollars in Millions)

HHS Strategic Goals	FY 2013	FY 2014	FY 2015
1.Transform Health Care	**20.1**	**20.1**	**20.4**
1.A Make coverage more secure	-	-	-
1.B Improve health care quality and patient safety	45.78	54.61	66.59
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	10.6	10.6	10.8
1.F Promote the adoption of health information technology	9.5	9.5	9.6
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	**18.5**	**18.6**	**20.0**
3.A Ensure the children & youth safety, well-being & health	1.7	1.8	1.9
3.B Promote economic & social well-being	16.8	16.8	16.5
3.C Improve services for people with disabilities and elderly	-	-	1.3
3.D Promote prevention and wellness	-	-	
3.E Reduce the occurrence of infectious diseases	-	-	0.3
3.F Protect Americans' health and safety during emergencies	-	-	
4. Increase Efficiency, Transparency and Accountability of HHS Programs	**-**	**-**	**0.5**
4.A Ensure program integrity and responsible stewardship	-	-	0.2
4.B Fight fraud and work to eliminate improper payments	-	-	0.1
4.C Use HHS data to improve American health & well-being	-	-	
4.D Improve HHS environmental performance for sustainability	-	-	0.2
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce	**-**	**0.1**	**0.3**
5.A Invest in HHS workforce to help meet America's health and human service needs today & tomorrow	-	0.1	0.3
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 OCR Program Level	**38.6**	**38.8**	**41.2**

DISCRETIONARY ALL PURPOSE TABLE

(Dollars in Thousands)

Office for Civil Rights	FY 2013 Final Level	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Enforcement and Regional Operations	27,030	27,159	28,844	1,685
Programs and Policy	7,723	7,760	8,241	481
Planning and Business Administration Management	3,862	3,879	4,120	241
Total, Office for Civil Rights	38,615	38,798	41,205	2,407

APPROPRIATIONS LANGUAGE

For expenses necessary for the Office for Civil Rights, **[$37,798,000]** *$41,205,000.*

AMOUNTS AVAILABLE FOR OBLIGATION

(Dollars in Thousands)

Detail	FY 2013 Actual	FY 2014 Enacted	FY 2015 President's Budget
General Fund Discretionary Appropriation:	-	-	-
Appropriation (L/HHS, Ag, or, Interior)	40,938	38,798	41,205
Across-the-board reductions (L/HHS, Ag, or Interior)	-82	-	-
Subtotal, Appropriation (L/HHS, Ag, or Interior)	40,856	38,798	41,205
Rescission (PL 113-6)	-2,059	-	-
Subtotal, adjusted appropriation	38,797	38,798	41,205
Real transfer to the Centers for Disease Control	-138	-	-
Real transfer to the Office of Medicare Hearings and Appeals	-44	-	-
Subtotal, adjusted general fund discr. appropriation	38,615	38,798	41,205
Total discretionary appropriation	**38,615**	**38,798**	**41,205**
Offsetting Collections from:	-	-	-
Unobligated balance lapsing	-77	-	-
Total Obligations	**38,538**	**38,798**	**41,205**

SUMMARY OF CHANGES

(Dollars in Thousands)

Budget Year and Type of Authority	Dollars	FTE
FY 2014 Enacted	38,798	207
FY 2015 Total Estimated Budget Authority	41,205	218
Net Changes	**2,407**	**11**

Program Increases	FY 2014 FTE	FY 2014 Enacted	FY 2015 +/- FY 2014 FTE	FY 2015 +/- FY 2014 BA
Other than full-time permanent	5	1,388		14
Military personnel	2	142	0	1
Travel and transportation of persons	-	313	-	6
Rental payments to GSA	-	3,324	-	66
Communication, utilities, and misc. charges	-	242	-	5
Printing and reproduction	-	75	-	2
Other services	-	93	-	1,667
Other purchases of goods and services from Government accounts	-	5,658	18	2,114
Operation and maintenance of facilities	-	622	-	12
Operation and maintenance of equipment	-	366	-	7
Supplies and materials	-	133	-	3
Military benefits	-	61	-	0
Benefits to former personnel	-	21	-	0
Transportation of things	-	5	-	0
Equipment	-	15	-	0
Total Increases	**-**	**12,458**	**-**	**3,897**

Program Decreases	FY 2014 FTE	FY 2014 Enacted	FY 2015 +/- FY 2014 FTE	FY 2015 +/- FY 2014 BA
Full-time permanent	200	19,826	7	-1,034
Other personnel compensation	-	212	-	-10
Civilian benefits	-	6,302	-	-446
Total Decreases	**-**	**26,340**	**-**	**-1,490**

Total Changes	FY 2014 FTE	FY 2014 Enacted	FY 2015 +/- FY 2014 FTE	FY 2015 +/- FY 2014 BA
Total Increases	207	12,458	11	3,897
Total Decreases	-	26,340	-	-1,490
Total Net Change	**207**	**38,798**	**11**	**2,407**

BUDGET AUTHORITY BY ACTIVITY – DIRECT

(Dollars in Thousands)

Activity	FY 2013 FTE	FY 2013 Actual	FY 2014 FTE	FY 2014 Enacted	FY 2015 FTE	FY 2015 President's Budget
Enforcement and Regional Operations	148	27,030	144	27,159	144	28,844
Programs and Policy	38	7,723	38	7,760	29	8,241
Planning and Business Administration Management	23	3,862	23	3,879	25	4,120
Total	**209**	**38,615**	**205**	**38,798**	**198**	**41,205**

AUTHORIZING LEGISLATION

Authorizing Legislation	2014 Amount Authorized	2014 Appropriation's Act	2015 Amount Authorized	2015 President's Budget
Office for Civil Rights	Indefinite	$38,798	Indefinite	$41,205
Total	-	**$38,798**	-	**$41,205**

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	Appropriation
2005	-	-	-	-
General Fund Appropriation:	-	-	-	-
Base	32,043,000	32,043,000	32,043,000	32,043,000
Rescissions (P.L. 108-447)	-	-	-	(317,000)
Subtotal	32,043,000	32,043,000	32,043,000	31,726,000
Trust Fund Appropriation:	-	-	-	-
Base	3,314,000	3,314,000	3,314,000	3,314,000
Rescissions (P.L. 108-447)	-	-	-	(27,000)
Subtotal	3,314,000	3,314,000	3,314,000	3,287,000
2006	-	-	-	-
General Fund Appropriation:	-	-	-	-
Base	31,682,000	31,682,000	31,682,000	31,682,000
Rescissions (P.L. 109-148)	-	-	-	(317,000)
Subtotal	31,682,000	31,682,000	31,682,000	31,365,000
Trust Fund Appropriation:	-	-	-	-
Base	3,314,000	3,314,000	3,314,000	3,314,000
Rescissions (P.L. 109-148)	-	-	-	(33,000)
Transfers (P.L. 109-148)	-	-	-	(22,000)
Subtotal	3,314,000	3,314,000	3,314,000	3,259,000
2007	-	-	-	-
General Fund Appropriation:	-	-	-	-
Base	32,969,000	32,969,000	32,969,000	31,628,000
Subtotal	32,969,000	32,969,000	32,969,000	31,628,000
Trust Fund Appropriation:	-	-	-	-
Base	3,314,000	3,314,000	3,314,000	3,314,000
Rescissions (P.L. 110-5)	-	-	-	(33,000)
Subtotal	3,314,000	3,314,000	3,314,000	3,281,000
2008	-	-	-	-
General Fund Appropriation:	-	-	-	-
Base	33,748,000	33,748,000	33,748,000	31,628,000
Rescissions (P.L. 110-161)	-	-	-	(553,000)
Subtotal	33,748,000	33,748,000	33,748,000	31,075,000
Trust Fund Appropriation:	-	-	-	-
Base	3,314,000	3,314,000	3,314,000	3,281,000
Rescissions (P.L. 110-161)	-	-	-	57,000
Subtotal	3,314,000	3,314,000	3,314,000	3,224,000
2009	-	-	-	-
General Fund 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 Fund Appropriation:	-	-	-	-
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	-	-	-	-
General Fund Appropriation:	-	-	-	-

Base	37,785,000	37,785,000	37,785,000	37,785,000
Transfers (P.L. 111-117)	-	-	-	(6,000)
Subtotal	37,785,000	37,785,000	37,785,000	37,779,000
Trust Fund Appropriation:	-	-	-	
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	-	-	-	-
General Fund Appropriation:	-	-	-	-
Base	44,382,000	44,382,000	44,382,000	37,785,000
Rescissions (P.L. 112-10)	-	-	-	(76,000)
Subtotal	44,382,000	44,382,000	44,382,000	37,709,000
Trust Fund Appropriation:	-	-	-	-
Base	-	-	-	3,314,000
Rescissions (P.L. 112-10)	-	-	-	(7,000)
Subtotal	-	-	-	3,307,000
2012	-	-	-	-
General Fund Appropriation:	-	-	-	-
Base	44,382,000	41,016,000	41,016,000	41,016,000
Rescissions (P.L. 112-74)	-	-	-	(78,000)
Subtotal	44,382,000	41,016,000	41,016,000	40,938,000
2013	-	-	-	-
General Fund Appropriation:	-	-	-	-
Base	38,966,000	-	38,966,000	40,938,000
Sequestration	-	-	-	(2,059,000)
Rescissions (P.L. 113-6)	-	-	-	(82,000)
Transfers (P.L. 112-74)	-	-	-	(182,000)
Subtotal	38,966,000	-	38,966,000	38,615,000
2014	-	-	-	-
General Fund Appropriation:	-	-	-	-
Base	42,205,000	-	42,205,000	37,798,000
Subtotal	42,205,000	-	42,205,000	37,798,000
2014	-	-	-	-
General Fund Appropriation:	-	-	-	-
Base	41,205,000	-	-	-
Subtotal	41,205,000	**-**	**-**	**-**

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 2015, OCR requests $41,205,000, an increase of $2,407,000 from the FY14 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.

- $28,844,000 for Enforcement and Regional Operations – an increase of $1,685,000
- $8,241,000 for Programs and Policy – an increase of $481,000
- $4,120,000 for Planning and Business Administration Management – an increase of $241,000

ENFORCEMENT AND REGIONAL OPERATIONS

(Dollars in Thousands)

Activity	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Enforcement and Regional Operations	27,030	27,159	28,844	1,685
FTE	148	144	144	0

Program Description and Accomplishments

Enforcement and Regional Operations is charged with prevention and elimination of unlawful discrimination and with protecting the privacy and security of individually identifiable health information. In securing discrimination free healthcare and ensuring the protection of health information privacy, the Division directly supports Americans' access to healthcare. It consists of a small headquarters element and personnel located at 10 HHS regional offices. Two regional offices, Philadelphia and San Francisco, are further supported by two satellite offices, in which additional investigators are based. The Deputy Director for Enforcement and Regional Operations is responsible for all aspects of the operations and performance of the regions and reports through the Chief of Staff to the Director of OCR.

The personnel based in OCR's regional offices are at the forefront of OCR's enforcement efforts and responsible for responding to complainants and conducting investigations of alleged violations of civil rights and health information privacy laws. Each region is led by a regional manager who is responsible for operations within the geographical area of responsibility.

Region	Location	Satellite Office	Geographical Responsibility
I	Boston	-	CT,ME,MA,NH,RI,VT
II	New York	-	NJ,NY,PR[1]
III	Philadelphia	Washington, DC	DE,DC,MD,PA,VA,WV
IV	Atlanta	-	AL,FL,GA,KY,MS,NC,SC,TN
V	Chicago	-	IL,IN,MI,MN,OH,WI
VI	Dallas	-	AR,LA,NM,OK,TX
VII	Kansas City	-	IA,KS,MO,NE
VIII	Denver	-	CO,MT,ND,SD,UT,WY
IX	San Francisco	Los Angeles	AZ,CA,HI,NV[2]
X	Seattle	-	AK,ID,OR,WA

Since implementation of the Privacy Rule in 2003, the number of complaints filed with OCR per year has steadily grown. In FY13, OCR received 15,043 complaints compared to 12,705 in FY 2012. The spike in receipts in FY 2013 is partly attributable to the efficiencies OCR has implemented, specifically a complaint web portal that provides stakeholders with a quick and simple method of submitting complaints. OCR anticipates the volume of complaint receipts to increase to 22,996 in CY 2014 and 24,390 in FY 2015.

[1] Includes Virgin Islands

[2] Includes American Samoa, Guam, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Marshall Islands, and the Republic of Palau

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, such as Centralized Case Management Operations (CCMO) activities, the "EOS Academy", and an on-line complaint receipt system.

Centralized Case Management Operations

Customer Response Center (CRC)

Studied and planned for over a year, CCMO activities effectively commenced in August 2012 with the stand-up of the CRC which centralizes the case intake function at OCR headquarters. This is a dramatic shift in one of OCR's core processes that is intended to lead to significant efficiencies over time. The CRC offers nation-wide bilingual (Spanish) capability to receive complaints from all sources (phone, mail, fax, and web) and interact with complainants to educate and advise them on HIPAA and the various civil rights laws as well as OCR's intake and investigation processes. In doing so, it frees up regional resources allowing them to focus primarily on investigation, outreach, and other enforcement activities. OCR expects the CRC to reach its full operating capability in FY2014.

Central Intake Unit (CIU)

The CIU is a follow-on processing unit which evaluates, triages, and distributes cases. Like the CRC, it transfers the responsibility for this function from the regions to a centralized headquarters team. This function requires considerably more expertise than the intake function. While not an original aim, the CIU also allows for early intervention in certain situations to facilitate resolution and prevent escalation to the regions in instances where an individual needs help in attaining a medical record, attaining a sign language interpreter, or simply has a question. While currently performing this function for six regions, OCR leadership is targeting full implementation across all ten regions in FY 2014.

Academy for Civil Rights Investigators

In FY2012 OCR established the "EOS Academy", an intensive program to train its Equal Opportunity Specialists (EOS) and civil rights analysts. The Academy focuses on improving investigative skills by fostering a deeper understanding of Federal civil rights enforcement and the statutes that underpin OCR's civil rights actions. Attendees gain a better understanding of how to create thorough and legally supportable investigative plans, obtain the appropriate information to determine the facts of the case, and apply the law to the facts identified. Continued investment in this program ensures OCR investigators have the knowledge and skills to adequately address the increasing caseload. To encourage cross-agency collaboration, OCR offers the program to civil rights investigators from other Federal entities such as the Department of Justice, Department of Agriculture, Department of the Interior, Department of Health and Human Services, Department of Labor, Department of Veterans Affairs, the National Science Foundation, and NASA.

Online Complaint System

In July 2013, OCR introduced its on-line web portal that provides a customer-friendly and expedient method for filing HIPAA and civil rights complaints as an alternative to the other current options. Online forms on the website 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 81%. The increase resulting from this seamless complaint submission process is likely to continue and will significantly impact OCR's operations moving forward in terms of OCR being able to keep up with the pace of incoming case receipts.

Accomplishments

- In August 2013, based on the evidentiary record compiled by OCR's Region IX, the Departmental Appeals Board (DAB) found that since Dr. San Agustin participated in the joint state/Federal Medicaid program, he is a recipient of Federal financial assistance and he may not discriminate against any qualified person with a disability. On behalf of OCR, the Office of General Counsel brought an action before the DAB under Section 504 of the Rehabilitation Act of 1973 seeking to withdraw federal financial assistance from Winston C. San Agustin, M.D. Having initially been recommended due to back pain, once Dr. San Agustin became aware that the patient was HIV-positive, he refused to perform the surgery. The DAB found that Dr. San Agustin had refused to provide medical services to an individual because of that individual's disability, in violation of Section 504. OCR has been unable to secure Dr. San Agustin's compliance with Section 504 through voluntary means. Therefore, Dr. San Agustin's receipt of federal financial assistance must be terminated until he shows he will comply with the requirements of Section 504. Subject to additional statutory requirements, the DAB ordered that HHS officials suspend, terminate, and refuse to grant or continue Dr. San Agustin's Federal financial assistance until he satisfies those officials that he will comply with Section 504's nondiscrimination provisions. The withdrawal of Dr. San Agustin's funds is the first instance in nearly 30 years in which OCR has undertaken efforts to withdraw a recipient's funds for noncompliance with the nondiscrimination provisions OCR enforces.

- In August 2013, OCR's Region II entered into a settlement agreement with Affinity Health Plan, Inc that included a $1.2 million payment to settle potential violations of the HIPAA Security Rule. Affinity Health Plan is a not-for-profit managed care plan serving the New York metropolitan area. Affinity filed a breach report with OCR as required by the HITECH Act indicating that the new owner of copiers previously leased by Affinity contained confidential medical information on the hard drive. OCR's investigation indicated that Affinity impermissibly disclosed the electronic protected health information (ePHI) of over 344,000 individuals when it returned multiple photocopiers to leasing agents without erasing the data contained on the hard drives. In addition, Affinity failed to incorporate the ePHI stored on photocopier hard drives in its analysis of risks and vulnerabilities as required by the Security Rule and failed to implement policies and procedures when returning the photocopiers to its leasing agents. The settlement includes a corrective action plan requiring Affinity to use its best efforts to retrieve all hard drives that were contained on photocopiers previously leased by the plan that remain in the possession of the leasing agent, and to take certain measures to safeguard all ePHI.

- In July 2013, OCR's Region I entered into a settlement agreement with WellPoint, Inc that included a $1.7 million payment to settle potential violations of the HIPAA Privacy and Security Rules. OCR began its investigation following a breach report submitted by WellPoint which indicated that security weaknesses in an online application database left the ePHI of 612,402 individuals accessible to unauthorized individuals over the Internet. The investigation indicated that WellPoint did not implement appropriate administrative and technical safeguards as required under the HIPAA Security Rule. Specifically, WellPoint: did not adequately implement policies and procedures for authorizing access to the on-line application database; did not perform an appropriate technical evaluation in response to a software upgrade to its information systems; and did not have technical safeguards in place to verify the person or entity seeking access to ePHI maintained in its enrollment database.

- In June 2013, OCR' Region IX entered into a settlement agreement and comprehensive corrective action plan with Shasta Regional Medical Center (SRMC) concerning potential violations of the HIPAA Privacy Rule. As part of that agreement, SRMC paid a monetary settlement of $275,000. OCR opened a

compliance review of SRMC following a Los Angeles Times article that indicated two SRMC senior leaders had met with media to discuss medical services provided to a patient. OCR's investigation indicated that SRMC failed to safeguard a patient's protected health information (PHI) from impermissible disclosure by intentionally disclosing that patient's PHI to multiple media outlets on at least three separate occasions, without a valid written authorization from the patient to do so. OCR's review indicated that senior management at SRMC had also impermissibly shared details about the patient's medical condition, diagnosis, and treatment in an email to the entire SRMC workforce. In addition, SRMC had failed to sanction its workforce members for impermissibly disclosing the patient's records pursuant to its internal sanctions policy. The corrective action plan requires SRMC to update its policies and procedures on safeguarding PHI from impermissible uses and disclosures and to train its workforce members on those policies and procedures. The Corrective Action Plan (CAP) also requires fifteen other hospitals or medical centers under the same ownership or operational control as SRMC to attest to their understanding of permissible uses and disclosures of PHI, including disclosures to the media.

- In February 2013, OCR' Region III entered into a settlement agreement with Genesis HealthCare (Genesis), one of the nation's largest providers of senior care. In the accord, Genesis agreed to implement the agreement's corrective actions at all 400 nursing centers and assisted/senior living communities operated by Genesis. The settlement follows a complaint that Genesis failed to provide a qualified sign language interpreter to a resident at its skilled nursing facility in Randallstown, Maryland. Throughout the resident's stay at the facility, facility staff relied on written notes and gestures to communicate with the resident, even when conducting a comprehensive psychiatric evaluation with him. Moreover, not providing a qualified interpreter negatively affected evaluations of his care and discussions with him regarding the effects of his numerous medications and the risks caused by not following recommended treatments and prescription protocols and ultimately resulted in harmful effects to his overall health status. The agreement also requires Genesis to form an auxiliary aids and services hotline; create an advisory committee to provide guidance and direction on how to best communicate with members of the deaf and hard of hearing community; and designate a monitor to conduct a self-assessment and obtain feedback from deaf and hard of hearing individuals and advocates and conduct outreach to promote awareness of hearing impairments and services that are available for deaf and hard of hearing individuals. In addition, the agreement is significant because it is the first time OCR has included a provision requiring a recipient to pay monetary penalties should the recipient fail to comply with the terms of the agreement. That is, this agreement requires Genesis to pay monetary penalties if it fails to comply with any terms of the agreement.

- In early 2013, OCR's Regions II and III entered into separate agreements with the Cattaraugus County Department of Aging (CCDOA) in New York and the District of Columbia Children and Family Services Agency (DCCFSA) to ensure that deaf and hard of hearing individuals living in New York and the District of Columbia have equal access to public human services programs. The CCDOA provides health care and social services to 5,000 county residents who are 60 and older. DCCFSA is a designated child welfare agency for the District of Columbia and provides services that include adoption, foster care, and protective services to more than 3,600 children under the age of 18 and their families. These agreements emanated from complaints alleging that CCDOA and DCCFSA had failed to provide sign language interpretation services. OCR investigated the complaints pursuant to its authority under Section 504 and Title II, which require that recipients ensure effective communication for persons with disabilities. Both recipients agreed in the settlement agreements to revise their effective communication language policies and redouble their employee training programs. Most importantly,

CCDOA and DCCFSA, pursuant to their agreements with OCR, set in place interpretation services that will ensure equal access to their programs for deaf and hard of hearing individuals.

Funding History

Fiscal Year	Amount
FY 2011	$26,961,000
FY 2012	$26,908,000
FY 2013	$27,030,000
FY 2014	$27,159,000
FY 2015	$28,844,000

Budget Request

The FY 2015 request for Enforcement and Regional Operations (E&RO) is $28,844,000, which is $1,685,000 above the FY 2014 Enacted.

Program Increases:

Investing in the Institution [Regional Operations] (+$1,685,000)

A centralized process frees regional personnel from significant administrative efforts and allows for reinvestment of that labor into case analysis and investigation to improve response time and reduce current case backlogs. Since its inception, the Central Intake Unit (CIU) and Customer Response Center (CRC) have successfully triaged complaints, enhanced efficiency of service, and afforded OCR the ability to connect and respond to the general public at a rapid pace for sixty percent of the regions.

Additionally, OCR created an on-line web portal in July 2013. The average number of complaints received has increased exponentially. OCR is elevating the consciousness and educating the general public on their civil rights and rights under HIPAA; as a result, OCR receives approximately 250 online complaints a week, which averages to 13,000 complaints over the course of a year. Moreover, this is in addition to the complaints we receive through other mediums, ongoing investigations and backlog cases.

The additional resources will afford OCR's ability to: a) hire additional full-time, permanent or contracting staff members in order to support the increased workload, as a result of the on-line web portal; b) expand operations in order to overlay the remaining four regions not covered by the CIU; and c) continue training of our equal opportunity specialists (EOS) and civil rights analysts (CRA) to ensure program integrity and investment in the HHS workforce.

PROGRAMS AND POLICY

(Dollars in Thousands)

Activity	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Programs and Policy	7,723	7,760	8,241	481
FTE	38	38	29	-9

Program Description and Accomplishments

Programs and Policy consists of two components, Civil Rights and Health Information Privacy, 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 through headquarters and regional operations. 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 in his 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.

CRD also oversees a nationwide civil rights pre-grant review program for health care provider covered entities applying to participate in the Medicare program (because they are newly established or have had a recent change in ownership). These civil right reviews of covered entities ensure their compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. Through this program, CRD provides technical assistance to new and existing Medicare providers, reviews covered entities' policies and procedures for civil rights compliance, and sends clearance letters to the covered entities after they have demonstrated compliance. Through the pre-grant review program, CRD also enters into civil rights settlement 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, maximizing its impact and civil rights compliance efforts within the Medicare provider community.

With the advent of the Affordable Care Act, 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 their 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 2014. Afterwards, we will conduct listening sessions to enhance public participation in the rulemaking process and issue a final rule. This legislation significantly expands OCR's enforcement jurisdiction. We have already seen an increase in complainants, many of which raise issues of the first impression and important policy issues and anticipate a continued significant increase in complaints, particularly once full ACA implementation occurs.

OCR also anticipates the likelihood of increased enforcement efforts to implement the Administration's and Secretary's priority to promote community living for persons with disabilities through vigorous enforcement of the ADA as interpreted by the Supreme Court in the Olmstead case. This concept is an integral part of the ACA and the Secretary's Initiative on Community Living. OCR provides technical assistance, policy development, and enforcement of the ADA and Section 504 of the Rehabilitation Act and investigates complaints and initiates compliance reviews to determine if there are violations of these laws. OCR is currently conducting compliance reviews of nursing homes using Centers for Medicare and Medicaid Services (CMS) Minimum Data Set information identifying nursing home residents with disabilities who seek information on living in the community and hopes to expand these reviews. OCR teams with the Department of Justice, the Department of Housing and Urban Development, the Administration on Community Living, the CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA). OCR envisions working with these agencies to develop policy and technical assistance opportunities for States, people with disabilities, and others. This will build on OCR's collaborative work with these agencies on the SAMHSA sponsored 2012 Olmstead state policy academy in which OCR planned a pre-academy day-long session on housing in partnership with HUD.

Accomplishments

- The 2013 HHS Language Access Plan was developed by the HHS Language Access Steering Committee, which is staffed by CR and led by the OCR Director on behalf of the Secretary. In accordance with Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, the 2013 HHS LAP establishes the Department's policy and strategy for serving individuals with LEP and reaffirms the Department's commitment to language access principles. The 2013 HHS LAP serves as a blueprint for HHS staff and operating divisions charged with developing their own agency-specific language access plans.

- As part of its Title VI enforcement activities, OCR recently entered into a voluntary compliance agreement with the North Carolina Department of Health and Human Services (NCDHHS), which administers an annual budget of $18.3 billion, including the State's Medicaid; Early and Periodic Screening, Diagnosis and Treatment; and Children's Health Insurance Programs. To comply with Title VI, NCDHHS agreed to provide timely and competent language access services, including oral interpreters and written translations of vital documents, at no cost to individuals with LEP.

- CRD partnered with the Department of Justice's Civil Rights Division and the Department of Education's Office for Civil Rights to issue a Dear Colleague letter to schools of medicine, dentistry, and nursing and other health-related schools, expressing concern that some health-related schools may be making enrollment decisions based on an incorrect understanding of the hepatitis B virus, resulting in discrimination. The letter updates schools on the latest recommendations from the Centers for Disease Control and Prevention (CDC) regarding the participation of students with hepatitis B in health-related

schools. The issue is particularly important to the Asian American and Pacific Islander community, in light of its high representation among those individuals with hepatitis B. The letter is being widely disseminated.

- CRD entered into a settlement agreement with Genesis HealthCare (Genesis), one of the nation's largest providers of senior care, which covers more than 400 skilled nursing centers and assisted/senior living communities across 29 states. This settlement follows a complaint that Genesis failed to provide a qualified interpreter to a resident throughout his stay at its skilled nursing facility in Randallstown, Maryland. The agreement, which includes several innovative and unique requirements, requires Genesis to form an auxiliary aids and services hotline; create an advisory committee to provide guidance and direction on how to best communicate with the deaf and hard of hearing community; designate a monitor to conduct a self-assessment and obtain feedback from deaf and hard of hearing individuals and advocates and conduct outreach to promote awareness of hearing impairments and services that are available for deaf and hard of hearing individuals. In addition Genesis would be required to pay monetary penalties for noncompliance with any terms of the agreement.

- CRD has achieved corrective action allowing many individuals with disabilities to move from institutional to community settings. For example, a Kentucky woman with Acquired Brain Injury (ABI) was residing in a state psychiatric hospital, but wanted to move into the community. Subsequent to OCR initiating an investigation, the State took corrective action and approved the Affected Party for services under the State's ABI waiver. Under this waiver, the Affected Party moved out of the institution and enrolled with a community residential ABI waiver provider, where she now resides and receives community services.

- CRD partnered with CMS to ensure that the outreach and information provided to consumers about the ACA are accessible to underserved populations, including LEP populations and individuals with disabilities. As a result, the ACA regulations governing key aspects of health care reform ensure that the call center, websites, navigators, applications and notices will be accessible to LEP populations and individuals with disabilities.

- CRD has continued to develop Civil Rights Corporate Agreements to increase the efficiency of the pre-grant program and to promote civil rights compliance among large groups of healthcare providers throughout the country. In the Agreements, the corporations and OCR develop, for the corporate facilities, model civil rights policies and procedures that demonstrate compliance with the civil rights statutes and regulations. As a result of CRD's efforts, there are now 54 Agreements covering over 4,600 healthcare providers who serve more than 11 million patients.

- In support of the National HIV/AIDS Strategy, CRD continued to strengthen enforcement of the civil rights laws affecting people living with HIV/AIDS. For example, in August 2012, OCR secured an order terminating Medicaid payments to a California surgeon who discriminated against an HIV-positive patient by refusing to perform back surgery on him. The order was issued by the HHS Departmental Appeals Board, which 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. In addition, OCR and the New York State Department of Health (NYSDOH) collaborated to address reports that some nursing homes in the state were denying admission to patients who have HIV/AIDS due to the cost of HIV medications. Nursing home care is a critically important service for approximately 120,000 New Yorkers living with HIV/AIDS, and denying admission to individuals based on the cost of their

medications may constitute discrimination that is prohibited by the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, as well as New York state statutes and regulations. As such, OCR and NYSDOH sent a joint letter to all New York nursing home administrators focusing on the requirement to provide equal access to health care for individuals with HIV/AIDS. In the letter, OCR and NYSDOH offered to provide technical assistance to facilities to ensure compliance with anti-discrimination statutes and regulations.

Health Information Privacy Division

The Health Information Privacy (HIP) Division is primarily responsible for leading OCR's national privacy and security 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 proposing regulatory and legislative modifications to the HIPAA Privacy and Security Rules; rule making activities, including promulgating regulations for new statutory authorities; issuing guidance and developing compliance and training tools; providing public education; and raising awareness of privacy rights and protections. Through its efforts to promote robust privacy and security protections, HIP plays a leading role in other health reform efforts, including advancing the adoption and meaningful use of electronic health records, and assuring privacy and security concerns are appropriately addressed by the new delivery mechanisms under the ACA and American Recovery and reinvestment Act (ARRA), in research and patient safety initiatives particularly those involving genetic breakthroughs, and in emergency preparedness and response activities. HIP staff also reviews settlement agreements and enforcement actions, provides subject matter expertise to regional staff on both privacy and security matters, and investigates violations of patient safety work product confidentiality.

Since September 2009, HIP staff has overseen a nationwide breach reporting system required by Section 13402 of the HITECH Act enabling covered entities and business associates to electronically file reports with the Secretary of all breaches that create a significant risk to the confidentiality or integrity of protected health information. The covered entity is also required to provide prompt notification to the individuals affected by the breach. For breaches affecting 500 or more individuals, HIP also refers the breach report to the regional offices for validation and investigation, and is responsible for maintaining a listing of such breaches on the HHS web site. Breach reports that impact fewer than 500 individuals are treated as discretionary and investigated when resources permit. As of March 1, 2012, OCR has received more than 600 reports of breaches affecting 500 or more individuals, and over 55,000 reports of smaller breaches.

In addition, as required by the HITECH Act, HIP staff led the Department's efforts to design, test, and evaluate an audit function to measure compliance with privacy, security and breach notification requirements by healthcare entities and their business associates. The audit program expands and complements other OCR enforcement efforts to ensure individually identifiable health information is kept private and secure, particularly with regard to the exchange of electronic information. Field testing finished in the first quarter of FY2013 and the evaluation process is scheduled to conclude at the end of FY2013. The experience and evaluation of the methods piloted in 2011 and 2012 funded by ARRA provided the Department with an enhanced understanding of current privacy and security risks to health information and a foundation for appropriate enforcement actions. A viable audit program adds value to the compliance and enforcement mission of OCR by its enhancement of proactive, systemic, and preventative measures to achieve compliance rather than the incident response efforts triggered by a complaint process. An audit program can generate analytical tools and methods for entity self-

evaluation and prevention, fostering a culture of compliance throughout the healthcare sector. Through entity adoption, a successful audit program can have a multiplier effect on compliance penetration beyond the number of entities selected for the audit itself.

HIP staff also 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 findings, and resolution agreements or notices of the imposition of civil monetary penalties following compliance reviews or complaint investigations. As a result of the HITECH Act, maximum civil money penalties for HIPAA violations have increased significantly, from $100 per violation to up to $50,000 per violation. 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 the integration with OCR's ongoing privacy enforcement programs. HIP provides subject matter expertise to OCR's regional offices on Security Rule cases, thereby raising the quality of the corrective actions achieved through investigations. HIP also coordinates with the Department of Justice on criminal referrals under the HIPAA.

Accomplishments

- HIP published the Omnibus HIPAA Final Rule in January 2013, which concludes the rulemaking process for many of the HITECH Act changes. The Omnibus Rule finalizes regulatory provisions including extending privacy and security obligations and resulting liabilities to business associates of HIPAA covered entities, strengthening privacy protections in the areas of marketing, fundraising, requests for restrictions and electronic access, and prohibiting the sale of protected health information without authorization from the individual. The rulemaking also finalizes changes related to the October 2009 NPRM requirements of GINA to recognize genetic information as protected health information and to prevent its use by health plans for underwriting purposes. The rulemaking also makes final two IFRs published to implement two new authorities under the HITECH Act, a tiered and strengthened civil money penalty structure for HIPAA violations and breach notification obligations on HIPAA covered entities and business associates.

- 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 and to embed privacy and security principles and functions in the regulatory certification criteria for health information technology and the meaningful use standards for Phase 1 and Phase 2, and future phases.

- HIP has designed and implemented a public education campaign to increase the American public's awareness of and confidence in the privacy and security of their health information, particularly with electronic health records. Highlights of these consumer-focused efforts include the development of eight videos on OCR's YouTube channel which have generated over 600,000 views within one year of posting. Of note is the creation of a Spanish-language video on consumers' health information privacy rights which has over 200,000 views. OCR has created four new factsheets explaining consumer's privacy rights and has translated these materials into 8 languages: Simplified Chinese, Traditional Chinese, Korean, Vietnamese, Tagalog, Russian, Polish and Spanish. In May 2013, OCR partnered with the CDC, Office of the National Coordinator (ONC), and AIDS.gov to launch a campaign targeting HIV positive Black men who have sex with men (BMSM) with messaging on the importance of access to a copy of their medical record in order to be more involved in their care. In addition to national media buys, the campaign will target five cities during Black gay pride events around the country: DC, Chicago, New York City, Atlanta, and Oakland.

• Based on the authority and funding in the ARRA HITECH Act, HIP continued a major initiative to design, test, and evaluate a program for periodic audits to ensure compliance by covered entities and business associates with the HIPAA Privacy and Security Rules and their obligations under the HITECH Act. Comprehensive audit protocols were developed, tested, and used to conduct a total of 115 audits of covered entities of varying types and sizes. The program, its implementation, and the audit results are being evaluated and the program evaluation is scheduled to conclude at the end of FY2013. ARRA funding is no longer available to continue this program.

• 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 a series of three on-line educational modules which are offered for free Continuing Medical Education (CME) and Continuing Education (CE) credits to health care providers on Medscape.org. In less than a year, OCR has educated over 30,000 health care providers through these modules, with 7,323 taking advantage of CME or CE credits. In addition, following the publication of the Omnibus HIPAA Final Rule in January 2013, OCR undertook a paid advertisement targeting health care providers via Medscape with the message "HIPAA Rules Have Changed. You Must Comply by September 23, 2013. Act Now to Learn What You Need to Do." When providers click on the ad, they are brought to OCR's website. The ads generated 37,000 visits to OCR's website from March 15, 2013 through April 1, 2013. OCR developed a video for YouTube to educate HIPAA covered entities and their business associates on compliance with the HIPAA Security Rule which has 155,000 views from June 2012 through June 2013. Finally, OCR has undertaken a series of four free webinars to educate covered entities and business associates on the Omnibus HIPAA Final Rule changes with over 3500 confirmed registrants.

• OCR has been aggressive and consistent in its HIPAA Security and Privacy Rule enforcement. Since July of 2008, OCR has imposed one civil money penalty and negotiated 15 monetary settlements that included detailed corrective active plans. These actions have resulted in monetary receipts that OCR has utilized towards furthering health information privacy and security enforcement efforts.

Funding History

Fiscal Year	Amount
FY 2011	$9,235,000
FY 2012	$9,217,000
FY 2013	$7,723,000
FY 2014	$7,760,000
FY 2015	$8,241,000

Budget Request

The FY 2015 request for Programs and Policy (P&P) is $8,241,000, which is $481,000 above the FY 2014 Enacted. This funding supports the CRC's role in educating callers about HIPAA rights and protections and informing consumers about the resources available to them.

PLANNING AND BUSINESS ADMINISTRATION MANAGEMENT

(Dollars in Thousands)

Activity	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Planning and Business Administration Management	3,862	3,879	4,120	241
FTE	23	23	25	2

Program Description and Accomplishments

The Division of Planning and Business Administration Management (PBAM) is focused on supporting the overall efforts of OCR's mission. The office consists of administration sections which are outlined below and provides 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 Planning, Business Administration Management is responsible for all aspects of the operations and performance of his/her sections and reports through the Chief of Staff to the Director of OCR.

Section	Description
Executive Secretariat	The Executive Secretariat 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	The Human Resources Section provides guidance to leaders, conducts the recruitment of staff personnel, and coordinates personnel support actions for the headquarters and 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	With personnel spread across the nation, the Information Technology (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, trouble-shooting equipment problems, planning upgrades, attaining contracts to support systems, administering the Performance Information Management System (PIMS), and acquiring replacement hardware and software.
Budget	The Budget Section is accountable for working with the leadership to formulate requirements, both funding and personnel. Specific focus areas are: budget formulation, budget execution, management internal controls, supporting overall headquarters and regional operations, answering data calls, and responding to all resource matters that affect ongoing OCR efforts to provide quality support.

Additional personnel include the Director of OCR, the Chief of Staff, and their immediate staff as well as well as the Deputy Director of PBAM.

Accomplishments

- Completed the administrative support actions (facilities, budget, communications, information technology, and human resources) actions required to stand-up and sustain the first two CCMO components (CRC and CIU)

- Completed Certification & Accreditation (C&A) of Program Information Management System (PIMS) and attained renewed Authority to Operate (ATO) that had expired in 2008. Also, established an alternate processing site for PIMS as well as an increased information security awareness throughout OCR

- Implemented a PIMS modernization plan to streamline the administrative burden associated with the regional casework, thereby allowing Equal Opportunity Specialists to dedicate additional time to complainant response

- Completed a Continuity of Operations Plan (COOP) ensuring that, in the event of an emergency, OCR will continue to perform its critical mission functions

Funding History

Fiscal Year	Amount
FY 2011	$4,821,000
FY 2012	$4,813,000
FY 2013	$3,862,000
FY 2014	$3,879,000
FY 2015	$4,120,000

Budget Request

The FY 2015 request for Planning and Business Administration Management (PBAM) is $4,120,000, which is $241,000 above the FY 2014 Enacted. PBAM serves as the premier hub of administrative guidance, expertise and support to the program staff in order for OCR to carry-out its critical mission.

BUDGET AUTHORITY BY OBJECT CLASS

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Enacted	FY 2015 Budget	FY 2015 +/- FY 2014
-	***Personnel Compensation***	-	-	-
11.1	Full-time permanent	19,826	18,792	(1,034)
11.3	Other than full-time permanent	1,388	1,402	14
11.5	Other personnel compensation	212	202	(10)
11.7	Military personnel	142	143	1
Subtotal	***Personnel Compensation***	***21,568***	***20,539***	***(1,029)***
12.1	Civilian benefits	6,152	5,856	(296)
12.2	Military benefits	61	61	0
13.0	Benefits to former personnel	21	21	0
Total	***Pay Costs***	***27,802***	***26,477***	***(1,325)***
21.0	Travel and transportation of persons	313	319	6
22.0	Transportation of things	5	5	0
23.1	Rental payments to GSA	3,324	3,390	66
23.3	Communications, utilities, and misc. charges	242	247	5
24.0	Printing and reproduction	75	77	2
-	***Other Contractual Services***	-	-	-
25.2	Other services from non-Federal sources	243	1,760	1,517
25.3	Other goods and services from Federal sources	5,658	7,772	2,114
25.4	Operation and maintenance of facilities	622	634	12
25.7	Operation and maintenance of equipment	366	373	7
Subtotal	***Other Contractual Services***	***6,889***	***10,539***	***3,650***
26.0	Supplies and materials	133	136	3
31.0	Equipment	15	15	0
Total	***Non-Pay Costs***	***10,996***	***14,728***	***3,732***
Total	***Budget Authority by Object Class***	***38,798***	***41,205***	***2,407***

SALARIES AND EXPENSES

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Enacted	FY 2015 Budget	FY 2015 +/- FY 2014
-	***Personnel Compensation***	-	-	-
11.1	Full-time permanent	19,826	18,792	(1,034)
11.3	Other than full-time permanent	1,388	1,402	14
11.5	Other personnel compensation	212	202	(10)
11.7	Military Personnel	142	143	1
Subtotal	***Personnel Compensation***	***21,568***	***20,539***	***(1,029)***
12.1	Civilian benefits	6,152	5,856	(296)
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23.1	Rental payments to GSA	3,324	3,390	66
23.3	Communications, utilities, and misc. charges	242	247	5
24.0	Printing and reproduction	75	77	2
-	***Other Contractual Services***	-	-	-
25.2	Other services from non-Federal sources	243	1,758	1,515
25.3	Other goods and services from Federal sources	5,658	7,772	2,114
25.4	Operation and maintenance of facilities	622	634	12
25.7	Operation and maintenance of equipment	366	373	7
Subtotal	***Other Contractual Services***	***6,889***	***10,538***	***3,649***
26.0	Supplies and materials	133	136	3
Total	***Non-Pay Costs***	***10,981***	***14,712***	***3,732***
Total	***Salary and Expenses***	**38,783**	**41,190**	**2,407**
Total	***Direct FTE***	***205***	***198***	***-7***

DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT

Detail	FY 2013 Civilian	FY 2013 Military	FY 2013 Total	FY 2014 Civilian	FY 2014 Military	FY 2014 Total	FY 2015 Civilian	FY 2015 Military	FY 2015 Total
Enforcement and Regional Operations	-	-	-	-	-	-	-	-	-
Direct	147	1	148	143	1	144	143	1	144
Reimbursable	0	0	0	0	0	0	9	0	9
Subtotal	***147***	***1***	***148***	***143***	***1***	***144***	***152***	***1***	***153***
Programs and Policy	-	-	-	-	-	-	-	-	-
Direct	37	1	38	37	1	38	28	1	29
Reimbursable	3	0	3	2	0	2	11	0	11
Subtotal	***40***	***1***	***41***	***39***	***1***	***40***	***39***	***1***	***40***
Planning and Business Admin. Management	-	-	-	-	-	-	-	-	-
Direct	23	0	23	23	0	23	25	0	25
Reimbursable	0	0	0	0	0	0	0	0	0
Subtotal	*23*	*0*	*23*	*23*	*0*	*23*	*25*	*0*	*25*
Total FTE	***210***	***2***	***212***	***205***	***2***	***207***	***216***	***2***	***218***

Fiscal Year	Average GS
FY 2011	12.7
FY 2012	12.7
FY 2013	12.9
FY 2014	13.6
FY 2015	12.7

DETAIL OF POSITIONS

Detail	FY 2013 Actual	FY 2014 Enacted	FY 2015 Budget
Executive Level II	4	4	3
Executive Level III	3	3	3
Executive Level IV	1	1	1
Subtotal	**8**	**8**	**7**
Total –Exec. Level Salary	**1,404,963**	**1,419,013**	**1,254,361**
GS-15	24	24	24
GS-14	31	36	37
GS-13	41	38	39
GS-12	74	69	74
GS-11	9	8	9
GS-10	0	0	0
GS-9	9	9	10
GS-8	3	3	4
GS-7	9	6	7
GS-6	2	2	2
GS-5	3	3	3
GS-4	1	3	3
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal	**206**	**201**	**212**
Total – GS Salary	**19,663,430**	**20,580,529**	**19,210,721**
Total Positions	**214**	**209**	**219**
Total FTE	**210**	**205**	**216**
Average ES Level	II	II	II
Average ES Salary	175,620	177,377	179,194
Average GS Grade	12.9	13.6	12.7
Average GS Salary	95,454	102,391	90,617

SALARIES AND EXPENSES

(Dollars in Thousands)

Object Class Code	Description	FY 2014 Enacted	FY 2015 Budget	FY 2015 +/- FY 2014
-	***Personnel Compensation***	-	-	-
11.1	Full-time permanent	45,076	55,027	9,951
11.5	Other personnel compensation	428	468	40
Subtotal	***Personnel Compensation***	***45,504***	***55,495***	***9,991***
12.1	Civilian personnel benefits	13,974	17,358	3,384
Total	**Pay Costs**	**59,478**	**72,853**	**13,375**
21.0	Travel and transportation of persons	200	200	0
22.0	Transportation of things	977	333	-644
23.3	Communications, utilities, and misc. charges	3,899	3,583	-316
24.0	Printing and reproduction	254	162	-92
-	***Other Contractual Services***	-	-	-
25.2	Other services from non-Federal sources	951	1,621	670
25.3	Other goods and services from Federal sources	5,202	7,451	2,249
25.4	Operation and maintenance of facilities	661	2,595	1,934
25.7	Operation and maintenance of equipment	1,034	1,091	57
Subtotal	***Other Contractual Services***	***7,848***	***12,758***	***4,910***
26.0	Supplies and materials	692	890	198
Total	**Non-Pay Costs**	**13,870**	**17,926**	**1,040**
Total	**Salary and Expenses**	**73,348**	**90,779**	**17,431**
Total	**Direct FTE**	**514**	**629**	**115**

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT

Detail	FY 2013 Civilian	FY 2013 Military	FY 2013 Total	FY 2014 Civilian	FY 2014 Military	FY 2014 Total	FY 2015 Civilian	FY 2015 Military	FY 2015 Total
Direct	492	0	492	514	0	514	629	0	629
Reimbursable	0	0	0	0	0	0	0	0	0
Total FTE	**492**	**0**	**492**	**514**	**0**	**514**	**629**	**0**	**629**

Fiscal Year	Average GS
FY 2011	11/3
FY 2012	11/3
FY 2013	11/4
FY 2014	11/5
FY 2015	11/3

DETAIL OF POSITIONS

Detail	FY 2013 Actual	FY 2014 Enacted	FY 2015 Budget
ALJ-1	*1*	*1*	*1*
ALJ-2	*4*	*5*	*5*
ALJ-3	*63*	*70*	*87*
Subtotal	***68***	***76***	***93***
Total –AL Salary	**10,801,317**	**11,109,555**	**14,371,026**
Exec. Level	3	2	2
Subtotal	***3***	***2***	***2***
Total - SES Salaries	**475,241**	**347,935**	**351,414**
GS-15	11	12	12
GS-14	22	27	28
GS-13	23	25	27
GS-12	136	148	167
GS-11	67	58	59
GS-10	0	0	0
GS-9	8	33	70
GS-8	86	91	108
GS-7	34	31	48
GS-6	16	30	58
GS-5	0	1	3
GS-4	4	12	12
GS-3	7	7	7
GS-2	0	0	0
GS-1	0	0	0
Subtotal	***414***	***475***	***599***
Total – GS Salary	**28,842,035**	**33,618,510**	**40,304,560**
Total Positions	**485**	**553**	**694**
Total FTE	**492**	**514**	**629**
Average AL salary	158,843	146,178	154,527
Average ES Salary	158,414	173,968	175,707
Average GS Grade	69,667	70,776	67,286
Average GS Salary	11/4	11/5	11/3

FY 2015 BUDGET BY HHS STRATEGIC GOAL

(Dollars in Millions)

HHS Strategic Goals	FY 2013	FY 2014	FY 2015
1.Transform Health Care	**-**	**-**	**-**
1.A Make coverage more secure	-	-	-
1.B Improve health care quality and patient safety	45.78	54.61	66.59
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	23.22	27.39	33.41
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	**69.00**	**82.00**	**100.00**

DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2015

Office of the National Coordinator for Health Information Technology

Justification of Estimates for Appropriations Committee

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LETTER FROM THE NATIONAL COORDINATOR

I am pleased to present the fiscal year (FY) 2015 Departmental Budget Justification for the Office of the National Coordinator for Health Information Technology (ONC). Health information technology (IT) is a foundational component of the Administration's efforts to improve our Nation's health and health care by moving from a transaction-based system to one that emphasizes quality, value and outcomes. As the National Coordinator for Health IT, I am proud of the role that ONC's dedicated staff, policy efforts and programs have played in supporting more than 60 percent of health care professionals and more than 85 percent of hospitals to adopt certified electronic health records. This illustrates that federal leadership and investments in health IT are beginning to pay dividends and will continue to do so as providers increasingly optimize clinical flows and functionalities to improve patient care. As adoption rates reach a critical mass and key exchange infrastructure comes online, we will have the digital infrastructure necessary to support improved care, at a lower cost and ultimately improve population health.

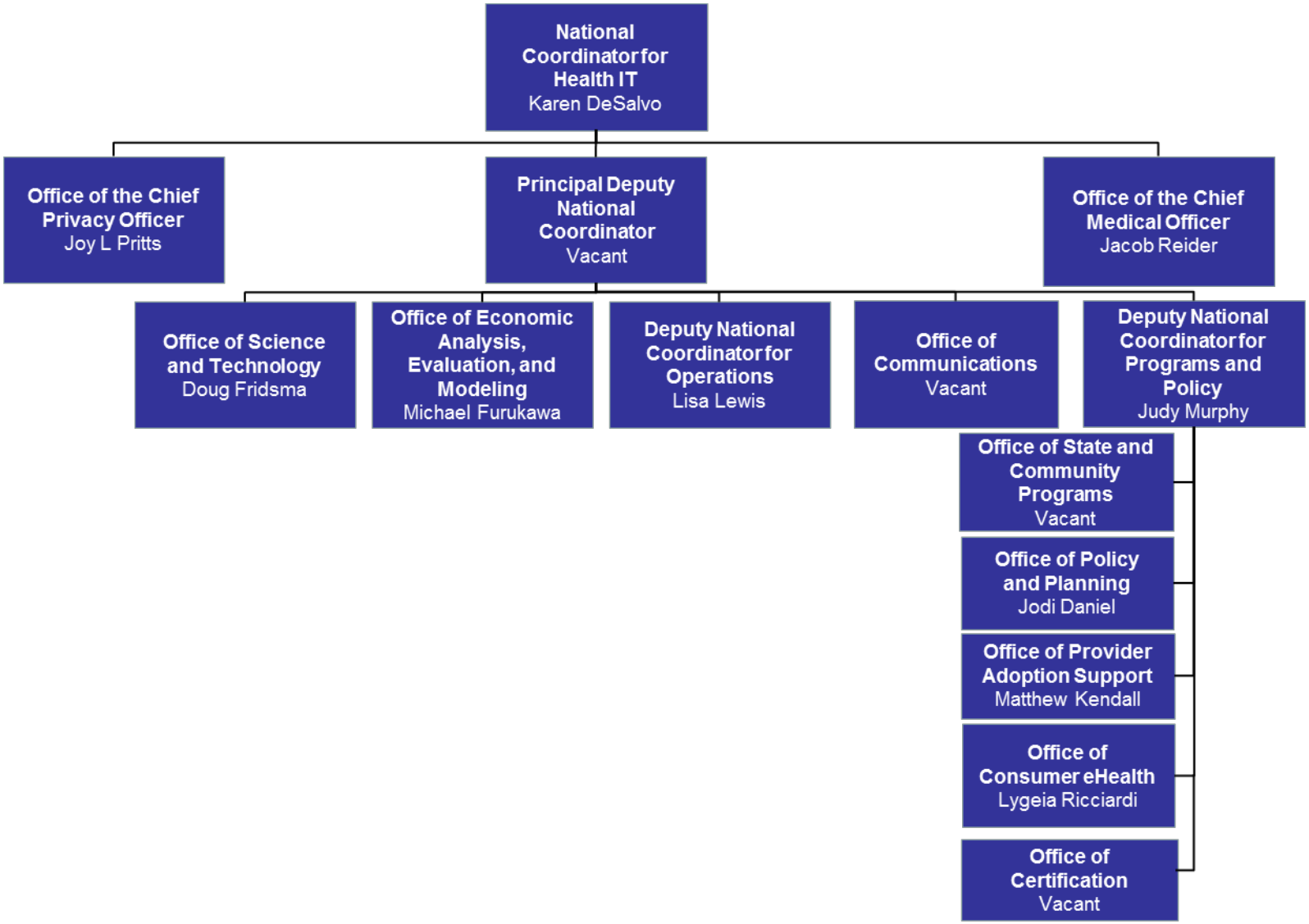
The FY 2015 Budget reflects a continued commitment to maximizing the promise of health IT by focusing on our core responsibilities and increasingly emphasizing interoperability. The Health Information Technology for Economic and Clinical Health (HITECH) Act responded to a national need to move from a paper-based to a digital health care system by authorizing the Health IT Certification Program at ONC and creating the Medicare and Medicaid EHR Incentive Programs (Meaningful Use Programs) at the Centers for Medicare and Medicaid Services. With the blueprint for action that HITECH provided, ONC is at the forefront of evolving standards and policies designed to promote care coordination, patient engagement, and population health management through the optimization and meaningful use of health IT. The Budget reflects the resources necessary to maintain these core activities related to health IT standards, policy, and adoption with an emphasis on consensus based solutions to a broad range of health IT issues. The Budget provides continuing support for programs that directly support the Meaningful Use Programs; the Certification Program testing tools for developers and strengthened surveillance activities; the Blue Button Program, which engages providers, developers, and consumers to create solutions that empower all participants in health care; and a National Learning Consortium that disseminates best health practices to providers on how to optimize health IT and effective guidelines to achieve meaningful use of electronic health records.

New investments would support a new public-private partnership aimed at enhancing patient safety and health IT usability through surveillance and analysis of safety incidents. In addition, ONC's Budget requests funding to support ONC's work providing federal agencies and other partners with the implementation support and assistance needed to integrate health IT standards and policies. This work is crucial to realizing the new payment models necessary for healthcare transformation.

The Budget will allow ONC to continue responding to an evolving health IT landscape and ensure that health IT continues to meet the needs of a diverse set of users that span geographic and organizational boundaries. With the culmination of Recovery Act programs in FY 2015, this Budget proposes funding that is needed to maintain progress towards a digitally transformed health care system that is safe, secure, and interoperable.

/Karen B. Desalvo/
Karen B. DeSalvo, MD, MPH, MSc
National Coordinator for Health IT

ORGANIZATIONAL CHART



ORGANIZATIONAL CHART: TEXT VERSION

National Coordinator for Health Information Technology
- Karen DeSalvo, MD, MPH, MSc

The following offices report directly to the National Coordinator:
- Office of the Chief Privacy Officer
  - Joy L. Pritts, JD
- Office of the Chief Medical Officer
  - Jacob Reider, MD
- Principal Deputy National Coordinator
  - Vacant

The following offices report to the Principal Deputy National Coordinator:
- Office of Science and Technology
  - Doug Fridsma, MD, PhD
- Office of Economic Evaluation and Modeling
  - Michael Furukawa, PhD
- Deputy National Coordinator for Operations
  - Lisa Lewis
- Office of Communications
  - Vacant
- Deputy National Coordinator for Programs and Policy
  - Judy Murphy, RN

The following offices report to the Deputy National Coordinator for Programs and Policy:
- Office of State and Community Programs
  - Vacant
- Office of Policy and Planning
  - Jodi Daniel, JD, MPH
- Office of Provider Adoption Support
  - Matthew Kendall, MPH
- Office of Consumer eHealth
  - Lygeia Ricciardi, EdM
- Office of Certification
  - Vacant

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 the Department's goal to strengthen health care by pursuing the modernization of the American health care system through the adoption, meaningful use, and optimization of health IT. These efforts will make health information available electronically for better decision-making by consumers, clinicians, health care managers, and policy-makers at all levels of our health care system.

Vision

A health system that uses information to empower individuals, improves the health of the population, and supports new models of payment reform.

Mission

To improve health and health care for all Americans through use of information and technology.

Introduction

Information is the lifeblood of modern medicine, and improving the flow of information is foundational to transforming health care. In a modern health care system, every patient encounter and outside patient activities generate health information that can be used to support a wide range of clinical processes. For the health information to be useful, however, it must be interoperable. That means that a common set of structures and formats must be coupled with transport protocols and the appropriate infrastructure to enable various health IT systems to use the health information. The most effective systems incorporate not only providers, but also consumers, researchers, and public health agencies. Moreover, the users of health information must be able to exchange health information seamlessly and securely not only across different information systems, but also between different care settings, organizations, geographic boundaries, and uses.

Health IT comprises technologies — ranging from electronic health records (EHRs) and personal health records (PHRs) to remote monitoring devices and mobile health applications — that collect, store, and transmit health information. By liberating health information from paper and electronic silos, health IT has the potential to transform the health care system from one that emphasizes transactions to one that emphasizes care. By making the health care system more transparent, health IT can enhance the study of health care delivery and support new payment systems. This transformation will empower providers and consumers to drive substantial improvements in care, efficiency, and population health.

These goals guide federal policies and programs that support the wide-spread adoption, meaningful use, and optimization of health IT. ONC provides a collaborative framework through which policy-makers engage stakeholders to address critical health IT issues and barriers. By engaging directly with the health IT community, ONC develops consensus-based policies that facilitate interoperability through technological standards and health information exchange. Further, ONC inspires confidence and trust in health IT by promoting policies that protect the privacy and security of health information, integrate clinical best practices into care processes, and ensure the safe use of health IT. To ensure that health IT

is widely and effectively implemented, ONC provides technical expertise, guidance, and resources to implementers and consumers through the National Learning Consortium (NLC).

ONC administers the Health IT Certification Program (Certification Program) in close cooperation with the Centers for Medicare & Medicaid Services (CMS) and the National Institutes for Standards and Technology (NIST). The Certification Program establishes the technical standards and criteria for certified EHR technology (CEHRT), with input from two Federal Advisory Committee Act (FACA) bodies. In order to attest to receive incentive payments under the Medicare and Medicaid EHR Incentive Programs (Meaningful Use Programs), eligible providers must adopt CEHRT and meaningfully use built in features in ways defined by CMS under the Meaningful Use Programs.

The following activities describe how ONC is working to create a safe, secure, and interoperable health IT infrastructure.

Policy Development and Coordination

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 Certification Program. Ensures a coordinated and consistent approach to the federal regulation 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 treatment impacts.

Standards, Interoperability, and Certification

ONC leads a variety of efforts designed to accelerate nationwide progress towards an interoperable health IT infrastructure. By developing standards 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 validate the efficiency of proposed standards for inclusion in the Certification Program.

- *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.
- *Health Information Exchange:* Develops and disseminates HIE building blocks and toolkits comprising predefined sets of standards, protocols, legal agreements, specifications, and services that can be readily deployed by entities that manage or provide health information exchange services. ONC provides technical assistance to implementers by advising them on how the building blocks and toolkits can meet their specific goals and constraints.
- *Certification and Accreditation:* Provides vendors and developers with clear criteria for developing their products by issuing certification criteria for the Certification Program. Collaborates with 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 (ONC-ACBs) to independently validate the ATLs results and certify the product.

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 CEHRT 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 and Blue Button. Works to ensure consumers are engaged in support of a robust eHealth market.
- *Health IT Monitoring and Evaluation:* 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 Request (+/-) FY 2014 Enacted
Budget Authority	15.483	15.556	0.0	-15.556
PHS Evaluation Funds	44.811	44.811	74.688	+29.877
Total, ONC	60.294	60.367	74.688	+14.321

Overview of Budget Request

The Fiscal Year (FY) 2015 Budget Request for ONC is $74.7 million in Public Health Service (PHS) Evaluation Funds. This request is $14.3 million above the FY 2014 enacted budget. This request includes funds for establishment of a Health IT Safety Center, standards development, and implementation support so that ONC can assist federal agencies integrate health IT standards and policies that support new payment models and enable healthcare reform.

Since the initiation of the Health Information for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act of 2009 (Recovery Act), nationwide EHR adoption and utilization has soared, with over 340,000 health care providers— 60 percent of health care professionals and more than 85 percent of hospitals —receiving more than $19.4 billion in Meaningful Use Program payments. All fifty states have health information exchange services available, and 96 percent of the nation's pharmacies have implemented e-prescribing technologies. Additionally, the market for CEHRT has expanded rapidly, with nearly 1,200 health IT vendors certifying more than 2,400 unique products. ONC expects that the health IT sector will continue to grow, for example, the Bureau of Labor Statistics predicts that health IT employment alone will grow 21 percent by 2020.

ONC has been at the center of national efforts to coordinate and support investments in policies, standards, testing tools, and implementation guides that have dramatically accelerated the adoption and meaningful use of CEHRT. Coupled with Recovery Act grants that provided on-the-ground technical assistance and direct financial support, these efforts have accelerated progress towards a safe, secure, and interoperable health IT infrastructure that will power new health care delivery and payment models, and fundamentally improve the quality and efficiency of health care. As the Recovery Act programs close out, ONC will continue to leverage vital investments and support HITECH as a critical mass of providers and consumers adopt CEHRT, personal health records (PHRs), and interoperable standards. ONC will continue to engage the growing number of consumers, health care providers, and vendors who are realizing the benefits of health IT and health information exchange and, in the process, modernize the nation's health care system.

Although in recent years we have seen a dramatic increase in the number of providers using health IT, ensuring interoperability and patient engagement in their health care are ongoing challenges. As a result, health information can still be costly and difficult to collect, preventing it from being available where and when providers and patients need it most. ONC will continue to enable innovation in the health IT market by maintaining and establishing core standards to support a robust Health IT Certification Program. ONC will provide the policies and tools that will ensure health information can securely follow patients wherever and whenever they seek care. Together, these efforts will ensure that

health IT fulfills its potential to realize the three-part aim of better health, better care, and improved value.

This Budget sustains the momentum of recent nationwide investments to promote adoption of health IT among a critical mass of providers, professionals, and consumers. In FY 2014 and FY 2015, ONC will help vendors to prepare for the 2014 Edition Standards and Certification Criteria (2014 Edition) and ensure that providers are prepared to use CEHRT to achieve Stage 2 of Meaningful Use. With more than 60 percent of health care professionals and more than 85 percent of hospitals adopting certified electronic health records, ONC will place new emphasis on health IT safety and continue to focus on the technical challenges related to interoperability and exchange. ONC also will engage in efforts to show consumers how health IT can empower them to become more active partners in their health. As ONC is focused on achieving care coordination, patient engagement, and population health management through the optimization and meaningful use of health IT, specifically CERHT, the Budget requests the following activities:

Policy, Development, and Coordination ($16.0 million, +$5.6 million from FY 2014 enacted)
These funds support regulatory, policy, convening, and analysis activities, including priority policy initiatives in the areas of privacy, security, and clinical improvement. New investments will support the Health IT Safety Center to analyze patient safety incidents associated with the use of CEHRT. In FY 2015, the Center will begin a robust collection and analysis of health IT-related adverse events, which will facilitate benchmark data on the types and frequencies of events. The Center will work with federal agencies, such as AHRQ and FDA, and patient safety organizations (PSOs), vendors, providers, and patients to ensure that CEHRT is safely developed, deployed, and maintained.

Standards, Interoperability, and Certification ($27.2 million, +$8.5 million from FY 2014 enacted)
These funds will allow ONC to maintain and increase development of standards that support an interoperable and secure health IT infrastructure. ONC will continue to provide the leadership, technical expertise, and implementation tools to enable a national private and secure health IT infrastructure. This request also supports the Certification Program.

Adoption and Meaningful Use of Health IT ($12.9 million, +$2.0 million from FY 2014 enacted)
These funds will continue ONC efforts to support training, technical assistance, and dissemination of guides and best practices. ONC will continue to convene a nationwide community of implementers with an emphasis on optimizing the use of health IT in clinical workflows. New investments will enable ONC to continue support of groups providing technical assistance, and give ONC the ability to provide federal agencies with the implementation support and assistance needed to integrate health IT standards and policies in support of new payment models.

Agency-Wide Support ($18.6 million, -$1.7 million from FY 2014 enacted)
These funds will be used to provide central services and operational support to ONC's program offices. The decrease reflects improved administrative efficiencies and in-sourcing.

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 EHR Incentive Programs gained significant momentum in 2013, and as of December 2013 more than 335,646 (64 percent of) eligible health care professionals and 4,400 (88 percent of) hospitals were participating in the programs and had met the criteria for incentive payments during Stage I of the Meaningful Use Program. The progress substantially exceeded the HHS priority goal for FYs 2012-2013 that 230,000 providers would receive a payment from either the Medicare or Medicaid programs. The Department recommends the same goal, with even more ambitious provider participation targets of 425,000 in the 2014-2015 priority goal portfolio.

The gains in EHR adoption are being supported and accelerated by ONC's implementation of HITECH programs, including the Health IT Regional Extension Center (REC) program, and the Meaningful Use Program. During 2013 a Government Accountability Office (GAO) study demonstrated how RECs are succeeding as change agents in health care. The GAO report found that Medicare providers working with RECs were more than 2.3 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 eligibles 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 2014-2015, 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 (FY 2011-2015) 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 Health IT Strategic Plan.

Following the best practices established in the Government Performance and Results Act Modernization Act of 2011, ONC will revise the Health IT Strategic Plan. The process for updating the plan will include extensive planning within ONC, consultation with Federal partners, and outreach to providers and the

[1] P.L. 111-5, Sec. 3001(c)(3)(A)

health care community. In FY 2015, ONC's strategic direction will be guided by its authorizing legislation and the appropriated budget.

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, 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); Customer Relationship Management Tools; 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 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.

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, **[**$15,556,000: *Provided*, That in addition to amounts provided herein, $44,811,000**]** *$74,688,000* shall be available from amounts available under section 241 of the PHS Act. *(Department of Health and Human Services Appropriations Act, 2014.)*

Language Analysis

Language Provision	Explanation
$74,688,000 shall be available from amounts available under section 241 of the PHS Act.	Provides ONC's entire budget from PHS Evaluation funding.

Amounts Available for Obligation

Detail	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
General Fund Discretionary Appropriation:	-	-	-
Annual appropriation	61,225,917	60,367,000	74,688,000
Across-the-board reductions	-32,829	0	0
Subtotal, Appropriation	61,193,088	60,367,000	74,688,000
Sequestration	-825,769	0	0
Subtotal, Adjusted Appropriation	60,367,319	60,367,000	74,688,000
Transfer	-55,699	-	-
Transfer	-17,636	-	-
Total, Discretionary Appropriation	*60,293,984*	*60,367,000*	*74,688,000*
Unobligated Balances:	-	-	-
Unobligated balance, Recovery Act start of year	3,473,617	0	0
Unobligated balance, Recovery Act end of year	0	0	0
Total Obligations	62,798,085	60,367,000	74,688,000
Obligations less ARRA	59,918,175	60,367,000	74,688,000

Summary of Changes

Summary of Changes*

(Dollars in thousands)

2014

Total estimated program level..... 60,367

2015

Total estimated program level..... 74,688

Net Change program level..... +14,321

	FY 2014 Enacted		FY 2015 President's Budget		FY 2015 +/- FY 2014	
	FTE	Program Level	FTE	Program Level	FTE	Program Level
Increases:						
A. Program:						
1. Policy Development & Coordination.....	39	10,456	40	16,014	+1	+5,558
2. Standards, Interoperability, and Certification..	46	18,710	49	27,202	+3	+8,492
3. Adoption, Utilization, & Meaningful Use.....	45	10,891	47	12,859	+2	+1,968
Subtotal, Program Increases.....	**130**	**40,057**	**136**	**56,075**	**+6**	**+16,018**
Decreases						
A. Program:						
1. Agency Wide Support.....	55	20,310	55	18,613	--	-1,697
Subtotal, Program Decreases.....	**55**	**20,310**	**55**	**18,613**	**--**	**-1,697**
Net Change.....	**185**	**60,367**	**191**	**74,688**	**+6**	**+14,321**

**Table includes both Budget Authority (BA) and Public Health Service (PHS) Evaluation Funds*

Budget Authority by Activity

(Dollars in Thousands)

Activity	FY 2013 Actual	FY 2013 Actual	FY 2014 Actual	FY 2014 Enacted	FY 2015 Actual	FY 2015 President's Budget
Policy Development and Coordination	-	-	-	-	-	-
Budget Authority	0	0	0	0	0	0
PHS Evaluation Funds	32	10,301	39	10,456	40	16,014
Total, Policy Development and Coordination	32	10,301	39	10,456	40	16,014
Standards, Interoperability, and Certification	-	-	-	-	-	-
Budget Authority	0	5,122	0	2,835	0	0
PHS Evaluation Funds	42	14,635	46	15,875	49	27,202
Total, Standards, Interoperability, and Certification	42	19,757	46	18,710	49	27,202
Adoption, Utilization, and Meaningful Use	-	-	-	-	-	-
Budget Authority	0	0	0	0	0	0
PHS Evaluation Funds	42	9,340	45	10,891	47	12,859
Total, Adoption, Utilization, and Meaningful Use	42	9,340	45	10,891	47	12,859
Agency-wide Support	-	-	-	-	-	-
Budget Authority	0	10,361	0	12,721	0	0
PHS Evaluation Funds	55	10,535	55	7,589	55	18,613
Total, Agency-wide Support	55	20,896	55	20,310	55	18,613
Total, Budget Authority	*0*	*15,483*	*0*	*15,556*	*0*	*0*
Total, PHS Evaluation Funding	*171*	*44,811*	*185*	*44,811*	*191*	*74,688*
Total, Program Level	***171***	***60,294***	***185***	***60,367***	***191***	***74,688***

Authorizing Legislation

(Dollars in Thousands)

	2014	2014	2015	2015
Health Information Technology Activity:	Authorized	Enacted	Authorized	President's Budget
Health Information Technology PHS Act 42 U.S.C. 201	Indefinite	15,556	Indefinite	-
PHS Evaluation Funds (non-add)	Indefinite	44,811	Indefinite	74,688
Total Request Level	**-**	**60,367**	**-**	**74,688**

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	$42,331	$0	$42,331	$42,331
Base	$19,011	$61,342	$19,011	$19,011
PHS Evaluation Funds	$61,342	$61,342	$61,342	$61,342
Subtotal	-	-	-	-
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
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

Details	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriations
PHS Evaluation Funds	$56,307	-	$51,307	$44,811
User Fee	$1,000	-	$1,000	$0
Subtotal	$77,883	$0	$72,597	$60,367
2015	-	-	-	-
Base	$0	-	-	-
PHS Evaluation Funds	$74,688	-	-	-
Subtotal	$74,688	-	-	-

Policy Development and Coordination

Budget Summary

(Dollars in Thousands)

Policy Development and Coordination	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	0	0	0	0
PHS Evaluation Funds	10,301	10,456	16,014	+5,558
Total, Program Level	10,301	10,456	16,014	+5,558
FTE	32	39	40	+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

ONC coordinates federal policies and activities necessary to develop a robust and interoperable health IT infrastructure. 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. ONC ensures that federal health IT policies promote patient safety, health IT usability, and clinical quality improvement by integrating a clinical perspective.

Health IT Policy

ONC develops and coordinates federal health IT policy to achieve national health priorities set forth in the National Quality Strategy and National Prevention Strategy. ONC guides achievement of goals and objectives outlined in the Federal Health IT Strategic Plan through collaboration with federal partners and engagement of stakeholders. ONC monitors progress towards the goals and objectives and works to align federal activities with national priorities, goals, and objectives.

Using our unique convening authority, ONC engages a diverse group of private, non-profit, and public sector stakeholders to identify health IT policy issues and forge consensus-based solutions. By investigating alternative and creative solutions, ONC designs programs to remove barriers that limit market progress in achieving the meaningful use and 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 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. 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:

- Received recommendations from the advisory committees for policies, standards, and certification criteria related to Stage 3 of the Meaningful Use Program, and also the subsequent set of standards, implementation specifications, and criteria for the Certification Program. The recommendations were informed through a Request for Comment process to incorporate public input.
- Released guidance on EHR technology certification for health care providers who are not eligible for incentive payments under the Medicare and Medicaid EHR Incentive Program, and a guide on How to Identify and Address Unsafe Conditions Associated with Health IT.
- Collaborated with the Substance Abuse and Mental Health Services Agency (SAMHSA), the Centers for Disease Control and Prevention (CDC), and the White House Office of National Drug Control Policy (ONDCP) to address the growing problem of prescription drug misuse and overdose through an initiative to enhance prescriber and dispenser access to prescription drug monitoring program (PDMP) data through health IT. Conducted pilots to test multiple approaches using health IT to allow the real-time access to PDMP data.

Governance of Health Information Exchange

Governance of HIE encompasses the appropriate structures, agreements, and business practices that are necessary to ensure that health information is kept private and secure while allowing for efficient HIE between care settings and across organizational, vendor, and geographic boundaries. Using a non-regulatory approach to governance, ONC is working with states, health information organizations (HIOs), health information service providers (HISPs), and other governance entities. Though coordination and convening of key governance entities and grants to test alternative approaches, ONC is supporting nationwide efforts to enhance HIE practices. Accomplishments include:

- Released the Governance Framework for Trusted Electronic Health Information Exchange. This Framework provides a common foundation for all types of HIE governance models. Other entities that set HIE policy can refer to the Framework's principles as a way to align their work with national priorities.
- Launched the National HIE Governance Forum to convene key stakeholders and address crosscutting issues among various exchange approaches. Developed consensus based guidance and tools to enable an effective and efficient approach to governance for exchange based on Direct technology.
- Awarded two cooperative agreements with existing HIE governance entities to collaboratively develop and adopt policies and practices that support robust, secure, and interoperable exchange.

Privacy and Security

Privacy and security are the foundation upon which trust in health IT and participation in HIE is built. The Chief Privacy Officer advises the National Coordinator by contributing health sector-specific subject matter expertise and technical assistance on privacy, security, and data stewardship policies. ONC identifies evolving health IT and health information exchange efforts, assesses gaps and vulnerabilities in

their privacy and security efforts and proposes policy solutions. ONC coordinates with state and regional efforts, federal agencies, and foreign countries on health information privacy and security issues. To make stakeholders aware that the privacy and security of health information is a shared responsibility, ONC develops and disseminates guidance, toolkits, and multimedia technical assistance materials. ONC is committed to developing these materials in formats that are clear, concise, well-organized, varied to meet different users' learning styles, are accessible, and are in plain language.

Development of Health IT Privacy and Security Policy, Standards, and Adoption Strategies
Using a multi-pronged, flexible, iterative process for assessing, prioritizing, and implementing privacy and security-related initiatives, ONC builds consensus recommendations on privacy and security issues. Through specific privacy and security communities on the advisory committees and the NLC, ONC solicits feedback on emerging issues and best practices through public roundtables and engagements. It combines this knowledge with qualitative analysis of public surveys and government data to determine privacy and security priorities in the health care sector. ONC is focused on ensuring that privacy and security are adequately addressed in implementing the Meaningful Use program and the delivery and payment reform. Accomplishments include:

- Worked closely with CMS to incorporate privacy, security, and data stewardship policies in proposed and final rules, and developed supporting guidance and frequently asked questions (FAQs) governing new modes for exchanging and analyzing health information for new delivery and payment models.
- Coordinated with the U.S. Department of State, the Food and Drug Administration (FDA), National Institutes of Health (NIH), and other HHS agencies to provide the U.S. Government's health sector responses to the European Union's (EU) proposed Data Protection Regulation.
- Coordinated the Health IT Policy Committee's Privacy and Security Tiger Team's hearing on the transparency and implementation of the HITECH accounting of disclosures provisions. The HITECH Act requires the Department to issue regulations requiring HIPAA covered entities and business associates to account for disclosures of protected health information to carry out treatment, payment, and health care operations if such disclosures are through an electronic health record.

Safeguarding Health Information
ONC works to ensure that electronic health information is secure and protected. ONC addresses security with multiple strategies, including provider education, assistance, and outreach; threat and vulnerability analysis; mitigation planning and implementation; and identification of breach prevention technology. ONC also monitors changes in consumers' perception of the privacy and security of health information, which is essential to developing trust in health IT and designing programs to safeguard health information. Accomplishments include:

- In coordination with the Office for Civil Rights, developed a security risk analysis tool for health IT professionals. This tool includes feedback from the provider community.
- Released a second cybersecurity video game focused on disaster planning and recovery, and launched the Meaningful Consent online resource to help health care providers effectively engage patients in choosing how they want their electronic patient health information shared.
- Expanded on prior year efforts to protect health information stored or accessed through mobile devices by developing a resource center with information to help health care providers and professionals protect and secure patients' health information when using mobile devices.

Provider and Patient Identity Management

In close coordination with the 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:

- Hosted public hearings on provider and patient identity proofing and authentication related to Stage 2 of Meaningful Use; worked closely with stakeholders to address trusted remote access to health information and implement digital credentials without burdening providers or consumers.
- Conducted research into the landscape of patient identity management and developed an action plan to improve patient matching.
- 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 a NIST grant-funded pilot.

Patient Control over Use and Disclosure of Personal Health Information (PHI)

ONC continues to coordinate pilots to test data tagging for sharing of information, as well as tagging data so that the receiving party is notified that there are restrictions on the data they are receiving (e.g., not re-disclosing data without obtaining the patient's permission). Accomplishments include:

- Provided support to the Data Segmentation for Privacy initiative through the S&I Framework, which demonstrated how current standards could be used to "tag" sensitive information protected by law or patient choice. Five pilots were launched and successfully exchanged sensitive substance and alcohol abuse treatment information and alerted the receiving system not to further disclose the information without patient consent. The standards tested and developed via the pilots are currently being balloted through the standards organizations IHE and HL7.
- Through a landscape analysis, identified evolving issues with being able to record and persistently track the original source of health data (called "data provenance") in clinical records. The ability to determine data provenance has potential patient safety and provider liability implications. As a result of this analysis, ONC initiated an S&I Framework initiative to harmonize standards that enable consistent recording and tracking of the source of health information.
- Created and published sample plain language version of the HIPAA Privacy Rule's Notice of Privacy Practices, in collaboration with the HHS Office of Civil Rights (OCR). This model notice may be customized by health care providers and health plans to fit their needs. The plain language model is intended to improve consumers' understanding of their rights under HIPAA as well as how their information may be used and shared.

<u>Health IT Safety and Usability</u>

ONC is committed not only to promoting the adoption, meaningful use, and optimization of health IT but also to ensuring that these innovative technologies are safely designed and implemented and that they are used in ways that improve patient safety and the quality of patient 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:

- ONC released the final version of the HHS Health IT Safety Plan in July 2013, following significant input from the public and other federal agencies. The Plan builds on existing patient safety programs in the public and private sectors and integrates strategies and actions for advancing patient safety in an increasingly health IT-enabled health care system.
- ONC coordinated and aligned government and private sector activities to promote responsibility for and enhance oversight of health IT safety. Significant activities included issuing regulatory guidance to its ONC-ACBs regarding the surveillance of CEHRT, with a focus on the surveillance of safety-related capabilities as well as the processes through which EHR technology developers address

complaints from users about the safety or performance of CEHRT; coordinating with CMS to provide guidance on adverse event reporting by hospitals subject to Medicare's Conditions of Participation, and with AHRQ to issue guidance related to Patient Safety Organizations (PSOs) and ways in which EHR technology developers can contribute to patient safety improvement activities.

- ONC established a workgroup within the Policy Committee to make recommendations to ONC, the FDA, and the Federal Communications Commission (FCC) regarding an appropriate risk-based regulatory framework for patient safety. The workgroup's recommendations informed the agencies' draft report to Congress, as required by the FDA Safety and Innovation Act (FDASIA). The agencies developed a draft framework for public comment.

Clinical Quality Improvement (CQI)

ONC is working to harness the potential of health IT to drive enormous improvements in clinical quality by providing the tools providers and professional need to identify high risk conditions, implement solutions, and measure impact. In particular, through clinical decision support (CDS) and electronic clinical quality measures (CQMs), providers can benefit from the knowledge of clinical best practices learned from advances in digitally supported clinical, biomedical, and health services research. CDS encompasses a variety of tools designed to enhance decision-making by providers at the most optimal time in the clinical workflow. CQMs allow providers to quantify defined outcomes in terms of clinical best practices and give providers the ability to monitor health outcomes in real time. ONC provides subject matter expertise and technical assistance to federal programs that are working to improve clinical quality. Accomplishments include working with CMS to streamline the CQM development processes and ensure existing measures needed for Stage 2 of Meaningful Use.

Funding History

Fiscal Year	Amount
FY 2010	$10,856,000
FY 2011	$11,200,000
FY 2012	$11,616,000
FY 2013	$10,301,000
FY 2014	$10,456,000
FY 2015	$16,014,000

Budget Request

ONC requests $16.0 million for policy development and coordination activities, an increase of $5.6 million over the FY 2014 enacted. The request includes funding for 40 FTEs, an increase of one above the FY 2014 enacted. The increase includes support for the creation of the new Health IT Safety Center. In FY 2015, ONC will focus on improving coordination and engagement with federal partners and public health agencies. The request continues support of core regulatory, convening, and analysis activities. ONC will continue to address emerging policy with a focus on care transformation and particular attention to privacy, security, CQI, and patient safety.

Health IT Policy ($3.8 million)

In FY 2015, ONC will collaborate with federal partners to align activities outlined in the updated Federal Health IT Strategic Plan 2014-2018, including using policy levers to promote interoperability and electronic health information exchange across all health care providers. ONC will continue to engage stakeholders through the advisory committees to collaborate on updating the 2014 Edition, which will incorporate new and updated standards, implementation specifications, and certification criteria that will further advance HIE, CQM, privacy, security, and patient safety. ONC will support the continued

expansion of the Certification Program's regulatory guidance for health care providers, such as mental health and long term care facilities that are ineligible under the Meaningful Use Program. In addition, ONC will coordinate the health IT policy response to the FDASIA Report to Congress.

Governance of Health Information Exchange

In FY 2015, ONC will transfer the Governance of HIE to the Standards, Interoperability, and Certification activity.

Privacy and Security ($2.9 million)

In FY 2015, 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, and foreign countries, and other stakeholders to coordinate, formulate, and prioritize privacy and security policies by evaluating emerging health IT and HIE, monitoring consumer confidence, and assessing policy gaps and weaknesses and developing appropriate policy solutions.
- Safeguarding Health Information: ONC will provide technical assistance to vendors, providers, consumers, and others on safeguarding health information to ensure that health IT systems and workflows are protected by adequate safeguards. ONC will address the growing need for education and outreach targeted to consumers regarding gaining access to their health information. As Cloud Computing increases in the healthcare industry, there will be growing privacy and security concerns.
- Patient and Provider Identity Management: 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 information electronically by, identifying methods for implementing digital credentials for trusted remote access to health information without burdening providers or consumers. ONC will monitor prevailing and new identity management practices to develop evidence about their effectiveness that will be distributed to stakeholders.
- Patient Control over Use and Disclosure of PHI: ONC will continue to work on data segmentation and other policies and standards that give consumers control over use and disclosure of their electronic health information. This includes educating patients about their rights, and HIOs about their duties when participating in HIE. ONC will also work to develop solutions to the problem of identifying the origin of health information as it moves through the health ecosystem, an issue which affects, among other things, the ability to integrate "sensitive" health information into EHRs as well as providers' confidence in the accuracy of information they receive from PHRs.

Health IT Safety, Health IT Usability and Clinical Quality Improvements ($9.3 million)

In FY 2015, ONC will launch a Health IT Safety Center, and continue implementation of the Health IT Safety Plan to enable health IT developers, implementers, and users to ensure that the use of health IT advances patient safety. ONC will also 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.

The Health IT Safety Center will greatly improve ONC's ability to effectively coordinate implementation of the Health IT Safety Plan. In FY 2015, ONC will fund the center at $5.0 million. The Center will also generate substantial efficiencies by enhancing coordination and alignment of resources between ONC, AHRQ, FDA, and other federal agencies and encouraging greater levels of private investment in health IT safety. The Health IT Safety Center will also 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.

In 2015, the Center will begin a robust collection and analysis of health IT-related adverse events, which will facilitate benchmark data on the types and frequencies of events. This benchmark data will inform research and improvement activities that identify and develop health IT tools, interventions, and usability standards for widespread implementation. Further, the Center will serve to integrate knowledge from public and private sources and will facilitate broad stakeholder engagement and collaboration. A public-private process would be established in order to develop evidence-based health IT patient safety priorities, goals, and measures.

Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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)	60%	2014-04	-
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)	65%	2014-04	-
1.A.3 Percent of non-federal acute care hospitals that have adopted electronic health records [3]	FY 2013: Expected 2014-02 Target: 55%	65%	2014-04	-
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: Expected 2014-04 (Baseline)	35%	2014-04	-
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: Expected 2014-04 (Baseline)	82%	2014-04	-

[2] National Electronic Health Records Survey (NEHRS) formerly entitled NAMCS Electronic Medical Records Supplement.
[3] American Hospital Association (AHA) Annual Survey, IT Supplement
[4] ONC Privacy and Security Attitudes Survey

Standards, Interoperability, and Certification

Budget Summary

(Dollars in Thousands)

Standards, Interoperability, and Certification	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	5,122	2,835	0	-2,835
PHS Evaluation Funds	14,635	15,875	27,202	+11,327
Total, Program Level	19,757	18,710	27,202	+8,492
FTE	42	46	49	+3

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

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. For interoperability to occur, two or more health IT systems or components must not only exchange information, but meaningfully incorporate and use the information that has been exchanged.

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 optimization of health IT.

<u>Standards Development and Harmonization</u>

ONC promotes the adoption of open standards-based technologies and architectures that enable interoperable health IT capture and secure exchange of health information with greater ease and at substantially lower cost. In the long term coordinated standards-based innovation, combined with appropriate policies, will ensure the development of a national health IT infrastructure that is the foundation for transforming health care. In coordination with the Standards Committee and federal partners, ONC engages a diverse group of stakeholders to rapidly develop and harmonize consensus-based and scalable standards that solve core interoperability issues around data capture and exchange while supporting adoption.

Once a standard is approved for the Certification Program, ONC develops reference implementation guides that instruct developers and vendors how to meet the technical specifications. In collaboration with the health IT community, ONC develops testing tools and data that will be validated by NIST and distributed to the Accredited Testing Labs (ATLs). 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 come alive. As health IT continues to advance, ONC will

continue to play a key role as a leader and convener in this community by ensuring the development of robust standards, implementation, and testing infrastructure that substantially reduces the overall cost for health IT users.

Standards and Interoperability Framework

The Standards & Interoperability (S&I) Framework has reduced the timeframe for developing standards in some cases from three years to under one year. The S&I Framework regularly convenes a broad community of more than 2,200 stakeholders, including more than 700 committed members, representing over 500 companies from across the United States who are working to accelerate industry consensus on the standardization of health IT and health information exchange. These committed members collectively provide more than 26,000 hours per year to support efforts that resolve critical standards and interoperability challenges using a rigorous process that involves the development of clinically-oriented scenarios and robust use cases; harmonization of interoperability specifications and implementation guidance; provision of real-world experience and implementer support through new initiatives, workgroups, and pilot projects; and mechanisms for feedback and testing of implementations. Accomplishments include:

- Health-eDecisions Initiative: ONC balloted as a Draft Standard for Trial Use two Clinical Decision Support (CDS) use cases. The use cases allow for clinical guidance to be published in a standardized format that EHR technologies can use, saving many thousands of hours and errors associated with manually integrating the new clinical knowledge into existing systems.
- Blue Button Plus Initiative: Launched in 2013, the initiative seeks to enhance patients' access to their structured health information through enhancements to existing Blue Button standards. These solutions will improve consumer mediated exchange by creating an interoperable platform for providers and vendors to exchange health information.
- Data Segmentation for Privacy Initiative: This initiative seeks to enable the electronic management of patient consent to disclose health information in compliance with applicable privacy statutes and regulations. ONC developed three transport sensitive implementation guides for use with CONNECT, Direct, and during storage.

Standards Implementation and Testing Environment

ONC provides a pre-certification "sandbox" testing environment that allows the health IT developers and vendors to verify that their systems have implemented the standards correctly, before formally going through certification. The Standards Implementation and Testing Environment (SITE) Platform has substantially reduced the timeframe for implementation and testing of health IT systems. Modeled on the successful S&I Framework concept, the SITE Platform provides rapid resolution of issues, by working closely with the standards community. The SITE Platform provides an established venue to disseminate the solutions to the broader community health IT developers, vendors, and users.

Science and 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 integrate health IT within the ecosystem of health related systems. By engaging with vendors, delivery systems, providers, patients, 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, improved population health, and greater value. Accomplishments include:

- Launched the "Innovation Exchange Program" to facilitate bidirectional learning and mutual understanding between the ONC and the entrepreneurial and developer communities. This includes

the Innovator's Guide to Health IT Galaxy website 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.
- Partnered with the Small Business Administration to generate the Small Business Innovation Research grants to aid small businesses commercializing innovative health IT products and services.

Federal Health Architecture

The Federal Health Architecture (FHA) is a partnership among federal agencies, including the Office of Management and Budget (OMB), HHS, the Department of Defense, the Department of Veterans Affairs, and the Social Security Administration. ONC acts as the managing partner, providing subject matter expertise and technical and administrative support. Through the FHA, federal agencies have joined together to implement government-wide solutions to health IT that addresses agency business priorities while protecting citizen privacy. The FHA serves the needs of more than 20 federal agencies in domains as diverse as military and veterans' healthcare, public health monitoring, long-term care and disability services, research, and tribal health services. Accomplishments include:

- Released CONNECT 4.0, an open source platform for enabling the secure exchange of patient information. CONNECT 4.0 supports the 2014 Edition and Stage 2 of Meaningful Use core objectives related to HIE. The latest upgrade offers more flexibility incorporating a smaller and modular platform with higher message throughput, the exchange of large files, and improved logging capabilities.
- Established governance and policy guidelines for the transition of CONNECT to the open source community, enabling more extensive code contribution and testing from the healthcare community. Created a robust open source option for use case contributions by federal, state, local and private organizations in health exchange.

Certification and Accreditation

The Certification Program provides vendors and developers with clear criteria for developing their products. Working cooperatively with NIST, the Certification Program deploys testing procedures, data, and tools in accordance with the standards and certification criteria adopted by regulation. ONC accredits separate authorized certification bodies (ONC-ACBs) and testing bodies that provide independent mechanisms for vendors to determine if their products meet the standards and technical requirements laid out in regulation. ONC also maintains the Certified Health IT Product List (CHPL), a public website that uniquely identifies all certified health IT products. As of January 2014, the CHPL includes over 2,400 unique certified EHR products from nearly 1,200 vendors and developers in the 2011 and 2014 Edition certification programs combined. The use of CEHRT is required in order for providers to attest to and receive incentive payments under the Meaningful Use Programs. Accomplishments include:

- ONC, in collaboration with NIST, completed development and deployed the 2014 Edition that includes test procedures, test data, and test tools for use by ATLs. The 2014 Edition adheres to more rigorous conformance standards than were used for the prior edition and Stage 1 of Meaningful Use. 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 CQMs and the Transport Testing Tools for interoperability.

- Developed a CEHRT surveillance plan to ensure that products continue to meet functionalities that were originally certified and that vendors are appropriately representing their product. Issued regulatory guidance to ONC-ACBs on patient safety surveillance of CEHRT to ensure consistency and reliability in their reporting.

Health Information Exchange

The ability to exchange health information electronically is at the core of efforts to improve health care through the use of interoperable health IT. In order for health IT to continue to advance the goals of Meaningful Use, improve population health, and support new care and payment models, a robust 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 develops the technical components and building blocks for HIE and provides the leadership and resources needed to accelerate the nationwide adoption and utilization of HIE. These building blocks and toolkits are comprised of predefined sets of standards, protocols, legal agreements, specifications, and services that can be readily deployed by HIOs 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 in implementing the building blocks and toolkits in ways that meet their specific goals and constraints. Accomplishments include:

- Launched 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.
- Issued community supported guidance to help develop a common approach to Direct security and trust implementation decisions, and led an interagency initiative with federal partners to develop common security and trust requirements for the use of the Direct Protocol to exchange health information with federal agencies.

State HIE Program

This Recovery Act funded grant program mobilizes the efforts of states to increase the use of HIE by providing a cadre of on-the-ground implementers who are helping to advance and monitor standards adoption across the nation, shorten the timeline to achieve widespread adoption and implementation, and provide a rapid feedback loop to ONC about workflow, policy, and interoperability challenges. The program ends in FY 2014 and close out will occur in FY 2015. Accomplishments include:

- To date, 50 states have implemented Direct, including 44 states with services available state-wide; 38 states have implemented query-based exchange, including 30 states that have services available state-wide. Over 42,000 healthcare related organizations are enabled for Direct exchange nationally and over 9,300 healthcare related organizations are enabled for query-based exchange nationally.
- Identified and disseminated successful implementation practices and approaches through published reports, webinars and in-person meetings.
- Established trusted interstate data exchange in multiple regions throughout the country through the State Health Policy Consortium.

Funding History

Fiscal Year	Amount
FY 2010	$16,417,000
FY 2011	$16,809,000
FY 2012	$16,291,000
FY 2013	$19,757,000
FY 2014	$18,710,000
FY 2015	$27,202,000

Budget Request

ONC requests $27.2 million to support priority areas with its standards, interoperability, and certification activities, an increase of $8.5 million from the FY 2014 enacted. The request includes funding for 49 FTEs, an increase of three above the FY 2014 enacted. This increase will support the development and updating of standards which support interoperable and secure health IT infrastructure.

In FY 2015, ONC will continue to engage stakeholders to facilitate development and harmonization of consensus based standards in coordination with the policy activities and validation by the health IT community. Once a standard is complete, ONC will continue to create testing tools and test data for developers, vendors, and their customers that includes implementation guidance which instruct them on how the meet the technical specifications. ONC strives to maintain an innovative environment through its continued support of entrepreneurs, public health advocates, and developers.

Standards Development and Harmonization ($19.5 million)

In FY 2015, ONC will continue to develop and update standards that support an interoperable and secure health IT infrastructure. The health IT standards and certification criteria regulations, including the 2015 and 2017 Edition certification criteria, will focus on capabilities that enhance interoperability, secure health information exchange, quality improvement, patient engagement, and patient safety. ONC's efforts will build upon recent accomplishments and ensure continued progress towards modernizing the Nation's health IT infrastructure in order to support a transformed health care system. ONC will focus on high priority areas as defined through continued policy and rulemaking activities, including:

- Standards Development and Harmonization: continued support and expanded capacity for the S&I Framework that convenes a community of more than 2,200 stakeholders representing over 500 companies from across the national. Using a rigorous process to develop and harmonize standards through clinically-oriented scenarios and use cases. New and continuing initiatives include:
    - Developing a standard for Structured Data Capture that builds on existing data directory standards to improve core interoperability functions;
    - Health-eDecisions Initiative: continues focus on the scalability of CDS by creating standardized data definition and libraries that support real time access and updating;
    - Automate Blue Button Initiative: continue focus on patients' access to their health information using Blue Button to meet the 2014 Edition "view/download/transmit" criteria.
    - Query Health Initiative: develops distributed queries that provide access to data for analysis purposes, while maintaining patient privacy and security by keeping protected health information safely behind healthcare organization firewalls.
- Standards Implementation and Testing Environment (SITE): 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.

- Science and Innovation: Complete set up of the Health IT Innovation Center to coordinate federal efforts to the accelerate progress towards encouraging a vibrant health IT marketplace with an ecosystem of interoperable solutions for providers and consumers to choose from.

Federal Health Architecture ($1.2 million)
In FY 2015, ONC will continue to act as the managing partner of the FHA. The request will ensure continued coordination and alignment of HHS and ONC health IT investments in support of the FHA, including ongoing standards support and the creation of a shared repository of standards, service descriptions, and interoperability specifications within the S&I Framework to support federal agencies and/or departments.

Health Information Exchange ($3.5 million)
In FY 2015, ONC will continue to strive for the healthcare delivery system to achieve the same steep adoption curve for standards-based HIE that has occurred for EHRs. ONC will leverage the lessons, insights, and tools developed under the State HIE and Beacon Community programs to continue supporting nationwide HIE adoption and meaningful use. ONC will continue to package and update building blocks and toolkits through the NLC.

Certification and Accreditation ($3.0 million)
In FY 2015, ONC will continue to support a robust and flexible Certification Program. ONC will focus on monitoring activities to ensure CERHT remains in compliance and developing easy to use guides to assist providers as they compare the functionality between CEHRTs. ONC, in partnership with NIST, will continue to respond to developer feedback by improving testing methods with a focus on cross-vendor exchange, test scenario libraries, and additional standardized data sets.

Outputs and Outcomes

Program/Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
1.E.1 Percent of community pharmacies that are capable of exchanging health information electronically [5]	FY 2013: 96% Target: 97% (Target Not Met but Improved)	Retire	Retire	-
1.E.2 Percent of providers prescribing through an electronic health record [4]	FY 2013: 91% (Baseline)	92%	2014-04	-
1.E.3 Percent of office-based physicians who are electronically sharing any patient health information with other providers [2]	FY 2013: 39% (Baseline)	54%	2014-04	-
1.E.4 Percent of office-based physicians who are electronically sharing patient information with any providers outside their organization [2]	FY 2013: 14% (Baseline)	40%	2014-04	-

[5] Surescripts

Program/Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
1.E.5 Percent of physicians with capability for patients to view online, download, or transmit information from their medical record [2]	FY 2013: 42% (Baseline)	Second-Year Baseline, No Target	2014-04	-
1.E.6 Percent of office-based physicians who are electronically sharing patient information using a Summary Care Record [2]	FY 2013: 11% (Baseline)	30%	2014-04	-
1. E.7 Percent of non-federal acute care hospitals that are electronically exchanging patient health information with any providers outside their organization[2]	FY 2013: Expected 2014-02 (Baseline)	75%	2014-04	-
1.E.8 Percent of non-federal acute care hospitals that are electronically sharing clinical/summary care records with any providers outside their organization[2]	FY 2013: Expected 2014-02 (Baseline)	65%	2014-04	-
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[2]	FY 2013: Expected 2014-02 (Baseline)	60%	2014-04	-

Adoption, Utilization, and Meaningful Use

Budget Summary

(Dollars in Thousands)

Adoption, Utilization, and Meaningful Use	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	0	0	0	0
PHS Evaluation Funds	9,340	10,891	12,859	+1,968
Total, Program Level	9,340	10,891	12,859	+1,968
FTE	42	45	47	+2

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

Prior to the HITECH Act, significant barriers — such as a lack of financing and a trained IT workforce in healthcare, and difficulties integrating EHR technologies with traditional provider workflows — threatened to slow acceptance of EHRs and prevent their utilization. With more than 60 percent of health care professionals and more than 85 percent of hospitals adopting certified electronic health records, ONC had made substantial progress towards overcoming these barriers. Through strategic investments, effective leadership, and direct engagement with the health IT community, ONC has developed a national network of organizations that are focused on supporting individual providers and consumers in adopting and meaningfully using health IT. Through innovative techniques, ONC disseminates best practices through guides, training, and technical assistance to these organizations.

As part of ONC's adoption, utilization and meaningful use efforts, ONC engages patients and other consumers of health care; monitors and evaluates economic data and market trends concerning the adoption, meaningful use, and optimization of health IT; and works collaboratively with its advisory committees and CMS to raise the bar for subsequent stages of the Meaningful Use Programs by incorporating new objectives and requirements for CEHRT that will drive improvements in outcomes and quality of care.

<u>Provider Adoption Support</u>

ONC engages in a variety of efforts designed to accelerate and support providers' adoption and optimization of health IT and assist them in achieving meaningful use. ONC also works directly with health IT providers to identify barriers to adoption 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 and EHR technology. In particular, ONC convenes providers, sharing best practices nationally through the National Learning Consortium (NLC), and monitoring their progress with the Customer Relationship Management (CRM) Tool. When synched with patient engagement efforts to affect a change in behavior, favorable impacts on health status and costs can be achieved.

National Learning Consortium (NLC)
The NLC uses HealthIT.gov as the primary way of educating the nation about solutions and best practices to common challenges that providers face in achieving meaningful use. Through Communities of Practice (CoPs), the NLC convenes stakeholders to identify and share best practices in health IT adoption, meaningful use, and optimization. Each CoP focuses on specific topics, bringing together over 6,600 health IT implementers and ONC technical experts as they identify issues and discover solutions to common pressing challenges. CoPs 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 200 best practice guides and tools to the broader health IT community. Accomplishments include:

- ONC enhanced functionality by launching a Tool Repository that consolidates resources from across HealthIT.gov, and successfully transitioned the HITRC to the NLC. ONC can better track resource utilization and promotional efforts to ensure stakeholders are generating maximum value from new materials.
- Implemented the Health IT Vanguard program, consisting of Meaningful Use Vanguards and Health IT Fellows. These individuals share stories from the perspective of providers, office staff, and administrators on how they have leveraged health IT to transform delivery of care to underserved populations.

Customer Relationship Management (CRM) Tool
The CRM System is a flexible business intelligence tool being used by more than 1,500 users at ONC, partner organizations, and grantees. Because it collects data from a large number of users throughout the United States who are "on the ground" helping healthcare providers adopt and optimize their IT systems, it provides near real-time data about the adoption, utilization, and meaningful use of EHR technology. The CRM Tool supplements and is regularly merged with other provider data sources and tracks program performance and progress towards milestones. 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:

- Expanded the use of CRM Tool 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.
- Used CRM data elements in multiple analyses and studies designed to identity barriers and best practices to health IT adoption, utilization, and meaningful use. The CRM Tool was used to collect more than 11 million data elements from the nearly 150,000 providers currently enrolled with RECs. Approximately half of all Primary Care Providers in the nation are represented in the CRM tool.

Regional Extension Center (REC)
The REC Program is an ONC Recovery Act-funded grant program. RECs reach out to, organize and transform physician practices toward specific, measured clinical, quality, safety, and cost outcomes. There are 62 federally funded RECs that currently support nearly 150,000 providers in practice transformation and change management activities to achieve these outcomes. The primary mission of the REC program is to provide on-the-ground assistance for individual and small providers, critical access hospitals, community health centers, and public providers that require assistance with implementing and maintaining CEHRT. 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. The funding for this program will end in FY 2015 and close-out operations will continue into FY 2016. Accomplishments include:

- Actively working with over 136,000 primary care providers (over 44 percent of all primary care providers in the country), over 15,000 specialists, and over 1,164 critical access hospitals (CAHs) and regional hospitals (RHs) with 50 beds or less, surpassing the goal of recruiting 100,000 primary care providers to achieve meaningful use by 2014 (as of December 2013).
- Over 90,000 REC providers have demonstrated meaningful use using CEHRT (as of December 2013). Of the CAHs and RHs working with RECs, more than 1,000 have achieved meaningful as of December 2013.
- Partnered with specialists eligible for CMS EHR incentive programs and those not eligible for incentives but still committed to practice transformation and the vision of meaningful use (i.e., behavioral health, long term care providers).

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 the health care system. 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 apps and tools; and (3) shift attitudes regarding consumer engagement. ONC advances consumer eHealth by: providing thought leadership, building consumer awareness, convening diverse stakeholders, influencing policy and standards, building public-private partnerships such as the Blue Button Pledge Program, 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, including health care providers, health plans, labs and pharmacies. Grew the Blue Button Pledge Program to 500 diverse stakeholder organizations which collectively reach at least 50 percent of Americans.
- Expanded the ability of consumers to take action with their health data by releasing and continuing to evolve Blue Button Plus technical guidelines to help organizations that hold patient data to release it in a structured way consistent with MU 2 requirements.
- Advanced our understanding of consumer attitudes toward engaging with their health data online. Developed PSAs and other materials for three consumer segments. Secured commitments from influential organizations to distribute these materials in 2014, and developed a website to help consumers and IT developers identify diverse sources of Blue Button data.
- Provided thought leadership on Consumer eHealth by publishing in a leading peer reviewed journal (Health Affairs); hosting the third Annual Consumer Health IT Summit (with 1,000 live/virtual participants); convening three round tables on emerging policy topics; presenting at 10 major conferences; and had coverage of our work and key themes by media including the Wall Street Journal, Huffington Post, C-SPAN, and Consumer Reports.

Health IT Monitoring and Evaluation

ONC uses economic analysis and modeling to describe and understand the factors driving the adoption, utilization, and meaningful use of health IT, including the costs and benefits of health IT implementation. Studies and reports generated from these activities help to inform policies and decisions not only within ONC, but also by Congress, the White House, 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 conducted by the American Hospital Association Information Technology Supplement, National Electronic Health Records Survey, Critical Access Hospital 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 Programs. Accomplishments include:

- Published a Congressional Report on Health IT Adoption and an updated systematic review on the benefits of health IT, synthesizing statistics on progress, barriers, and Federal initiatives underway to promote greater health IT adoption and meaningful use and reporting on evidence on studies of the impacts of Meaningful Use functionalities on safety, quality of care, and efficiency.
- Expanded capabilities of the public Health IT Dashboard web site. This innovative platform provides ONC and its stakeholders with access to thousands of data points presented as user-interactive graphs and maps.
- Conducted program evaluations of HITECH programs to assess contextual factors, implementation approaches, and effectiveness and impacts of program interventions.

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 eligible providers and consumers learn about the use of health IT. Accomplishments include:

- Developed materials to educate providers on the benefits of and processes for adopting and utilizing health IT as well as ways in which they can use health IT more meaningfully.
- Coordinated with federal partners, including CMS and OCR, to implement a multi-pronged communications strategy to educate patients and caregivers about the ways in which health IT can empower them to become partners in their health care.

Funding History

Fiscal Year	Amount
FY 2010	$8,874,000
FY 2011	$10,657,000
FY 2012	$10,943,000
FY 2013	$9,340,000
FY 2014	$10,891,000
FY 2015	$12,859,000

Budget Request

ONC requests $12.9 million in FY 2015 for activities relating to the adoption and meaningful use of health IT, an increase of $2.0 million from the FY 2014 enacted. The request includes funding for 47 FTEs, an increase of two above the FY 2014 enacted. This increase will give ONC the ability to provide federal agencies with the implementation support and assistance needed to integrate health IT standards and policies in support of new payment models.

In FY 2015, ONC will emphasize and expand efforts aimed at optimizing provider and consumer use of health IT. The request will continue investments from FY 2014 in leveraging the existing national implementers support network as partners to improve health care quality by identifying, orchestrating, and disseminating best practices for providers. The request will support consumer engagement efforts by leveraging existing consumer organizations and through direct outreach efforts. Supporting these

efforts are analytical, performance, and communication services who work throughout ONC to assess the current market, measures program outcomes, and provide a framework for disseminating technical materials to the widest audience.

Provider Adoption Support ($7.3 million)
In FY 2015, ONC will continue to support provider adoption through innovative means by addressing critical barriers to the adoption, meaningful use, and optimization of health IT. ONC will also provide other HHS and federal agencies with essential implementation support and assistance for health IT standards and policies in support of new payment models which enable healthcare reform. This includes supporting the planned substantive investments that will be made in practice transformation programs at AHRQ and CMS.

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). This nimble yet diverse network will inform development of technical materials that optimize health IT to provide better health, improved population management, and reduced costs, which will assist all types of providers to participate in new payment models. Through the NLC, Health IT Vanguards, and the CRM tool, ONC will continue convening providers to develop, share, and spread innovative best practices, support workforce needs, and provide national provider-level situational awareness. As ONC continues to develop policies and standards, provider adoption support efforts ensure that providers have the resources necessary to implement the new certified systems and leverage them to successfully participate in the new payment models.

Consumer e-Health ($0.9 million)
In FY 2015, ONC will convene stakeholders, identify barriers, and develop strategies to increase consumer adoption and meaningful use of health IT. ONC will focus on consumer access to health information, actions that consumers can take to use their health information as active partners in their health care, and shifting consumer attitudes about using health IT.

Health IT Monitoring and Evaluation ($2.3 million)
In FY 2015, ONC will maintain an internal capacity for providing the analytical tools, data, and expertise necessary to measure and analyze the impact of federal health IT efforts and inform decisions about health IT policy. ONC will continue to implement a longitudinal data-collection strategy that exploits low-cost methods of data collection, synthesizing the data into studies and analysis that can be disseminated to the stakeholder community through the Health IT Dashboard, HealthIT.gov, blog posts, data briefs, and peer-reviewed literature.

Provider and Consumer Engagement and Outreach ($2.4 million)
In FY 2015, ONC's communications activities will provide policy-focused content development and dissemination support to meet the health IT policy information needs of varying stakeholder audiences, in keeping with the vision, mission, and goals of ONC. Funding for operating ONC's website, HealthIT.gov, is also included in this request.

Outputs and Outcomes Table

Program/Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
1.A.1 Percent of office-based physicians who have adopted electronic health records (basic)[6]	FY 2013: 48% Target: 50% (Target Not Met but Improved)	60%	2014-04	-
1.A.2 Increase the percent of office-based primary care physicians who have adopted electronic health records (basic)	FY 2013: 53% Target: 55% (Target Not Met but Improved)	65%	2014-04	-
1.A.3 Percent of non-federal acute care hospitals that have adopted electronic health records [7]	FY 2013: Expected 2014-02 Target: 55%	65%	2014-04	-
1.B.1 Percent of eligible hospitals receiving meaningful use incentive payments[3]	FY 2013: 83% Target: 53% (Target Exceeded)	85%	2014-04	-
1.B.2 Percent of eligible professionals receiving meaningful use incentive payments[3]	FY 2013: 61% Target: 26% (Target Exceeded)	65%	2014-04	-
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	FY 2013: 325,124 Target: 230,000 (Target Exceeded)	314,000	425,000	-
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.	N/A	Baseline	Baseline	-

[6] National Electronic Health Records Survey (NEHRS) formerly entitled NAMCS Electronic Medical Records Supplement.
[7] American Hospital Association (AHA) Annual Survey, IT Supplement

Program/Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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.	N/A	Baseline	Baseline	-
1.C.3 Electronic health record adoption rate among providers registered and working with ONC Regional Extension Centers for at least 10 months	FY 2013: 90% Target: 72% (Target Exceeded)	76%	Discontinue (Program Over)	-
1.C.4 Number of providers registered with ONC RECs that achieve Meaningful Use	FY 2013: 75,164 (Baseline)	100,000	Discontinue (Program Over)	-
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[2]	FY 2013: Expected 2014-02 (Baseline)	55%	TBD	-
2.A.1 Number of physicians participating in Beacon Community interventions	FY 2012: 8,500 Target: 7,430	Discontinue (Program Over)	Discontinue (Program Over)	-
2.A.2 Proportion of eligible providers in Beacon Communities that receive meaningful use incentive payments	FY 2012: 30% Target: 60% (Target Not Met)	Discontinue (Program Over)	Discontinue (Program Over)	-

Agency-wide Support

Budget Summary

(Dollars in Thousands)

Agency-wide Support	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Budget Authority	10,361	12,721	0	-12,721
PHS Evaluation Funds	10,535	7,589	18,613	+11,024
Total, Program Level	20,896	20,310	18,613	-1,687
FTE	55	55	55	0

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 reduce costs, 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 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 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 facilities management. ONC initiated improvements in its annual budget process and budget/performance integration. ONC's telecommunications initiatives are yielding cost savings. ONC has plans underway to move into a consolidated facility in FY 2015.

Funding History

Fiscal Year	Amount
FY 2010	$5,976.000
FY 2011	$19,502,000
FY 2012	$22,830,000
FY 2013	$20,896,000
FY 2014	$20,310,000
FY 2015	$18,613,000

Budget Request

ONC requests $18.6 million in FY 2015 for activities related to agency wide support activities, a decrease of $1.7 million from the FY 2014 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. As ONC's grant programs end, further cost savings will be realized in agency-wide support.

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 Offices of the National Coordinator and the Deputy National Coordinators.

SUPPORTING EXHIBITS

Crosswalk of Budget Activity by Office

(Dollars in Thousands)

Crosswalk of Budget Activity by Office	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	FTE	$	FTE	$	FTE	$
Policy Development & Coordination	-	-	-	-	-	-
Office of Policy and Planning	14	4,365	14	3,786	14	3,786
Office of the Chief Privacy Officer	8	3,053	12	2,949	13	2,949
Office of the Chief Medical Officer	10	2,403	13	3,721	13	9,279
Office of State and Community Programs	0	480	0	0	0	0
Total, Policy Development & Coordination	**32**	**10,301**	**39**	**10,456**	**40**	**16,014**
Standards, Interoperability, & Certification	-	-	-	-	-	-
Office of Science and Technology	19	12,923	20	12,165	22	20,682
Office of Certification	3	2,135	3	3,031	4	3,031
Office of State and Community Programs	20	4,699	23	3,514	23	3,489
Total, Standards, Interoperability, & Certification	**42**	**19,757**	**46**	**18,710**	**49**	**27,202**
Adoption, Utilization, & Meaningful Use	-	-	-	-	-	-
Office of Provider Adoption Support	23	3,869	23	5,335	24	7,303
Office of Consumer e-Health	4	937	4	869	4	869
Office of Economic Analysis and Evaluation	9	2,501	10	2,308	11	2,308
Office of Communications	6	2,032	8	2,378	8	2,378
Total, Adoption, Utilization, & Meaningful Use	**42**	**9,340**	**45**	**10,891**	**47**	**12,859**
Agency-Wide Support	-	-	-	-	-	-
Office of Mission Support	32	17,496	32	17,092	32	15,395
Office of Human Capital	5	663	5	673	5	673
Office of Grants Management	15	2,276	15	2,009	15	2,009
Office of Program Integrity	3	460	3	536	3	536
Total, Agency-Wide Support	**55**	**20,896**	**55**	**20,310**	**55**	**18,613**
Total, Program Level	**171**	**60,294**	**185**	**60,367**	**191**	**74,688**

Budget Authority By Object Class - Program Level

(Dollars in Thousands)

Object Class Code	Description	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
11.1	Full-time permanent	13,876	14,396	15,146
11.3	Other than full-time permanent	4,133	4,133	4,174
11.5	Other personnel compensation	278	278	281
11.7	Military personnel	104	105	106
Subtotal	*Personnel Compensation*	18,391	18,912	19,707
12.1	Civilian personnel benefits	5,512	5,529	5,736
12.2	Military benefits	45	217	46
13.0	Benefits for former personnel	-	-	-
Total	*Pay Costs*	23,948	24,658	25,489
21.0	Travel and transportation of persons	404	382	382
22.0	Transportation of things	1	-	-
23.1	Rental payments to GSA	2,814	2,814	3,982
23.3	Communications, utilities, and misc. charges	1,225	1,245	1,424
24.0	Printing and reproduction	20	26	34
25.1	Advisory and assistance services	740	740	500
25.2	Other services from non-Federal sources	17,586	17,523	28,784
25.3	Other goods and services from Federal sources	11,302	11,302	12,456
25.4	Operation and maintenance of facilities	1,322	1,327	1,320
25.5	Research and development contracts	-	-	-
25.6	Medical care	-	-	-
25.7	Operation and maintenance of equipment	-	-	-
25.8	Subsistence and support of persons	-	-	-
26.0	Supplies and materials	128	128	128
31.0	Equipment	222	222	239
32.0	Land and Structures	-	-	-
41.0	Grants, subsidies, and contributions	582	-	-
42.0	Insurance claims and indemnities	-	-	-
44.0	Refunds	-	-	-
Total	*Non-Pay Costs*	36,346	35,709	49,199
Total	***Budget Authority by Object Class***	**60,294**	**60,367**	**74,688**

Budget Authority By Object Class - Direct

(Dollars in Thousands)

Object Class Code	Description	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
11.1	Full-time permanent	-	-	-
11.3	Other than full-time permanent	-	-	-
11.5	Other personnel compensation	-	-	-
11.7	Military personnel	-	-	-
Subtotal	***Personnel Compensation***	**-**	**-**	**-**
12.1	Civilian personnel benefits	171	171	-
12.2	Military benefits	-	-	-
13.0	Benefits for former personnel	-	-	-
Total	***Pay Costs***	171	171	-
21.0	Travel and transportation of persons	-	-	-
22.0	Transportation of things	1	-	-
23.1	Rental payments to GSA	2,814	2,814	-
23.3	Communications, utilities, and misc. charges	1,124	1,1,144	-
24.0	Printing and reproduction	-	-	-
25.1	Advisory and assistance services	295	295	-
25.2	Other services from non-Federal sources	4,995	5,049	-
25.3	Other goods and services from Federal sources	4,572	4,572	-
25.4	Operation and maintenance of facilities	1,307	1,307	-
25.5	Research and development contracts	-	-	-
25.6	Medical care	-	-	-
25.7	Operation and maintenance of equipment	-	-	-
25.8	Subsistence and support of persons	-	-	-
26.0	Supplies and materials	40	40	-
31.0	Equipment	164	164	-
32.0	Land and Structures	-	-	-
41.0	Grants, subsidies, and contributions	-	-	-
42.0	Insurance claims and indemnities	-	-	-
44.0	Refunds	-	-	-
Total	***Non-Pay Costs***	15,312	15,385	-
Total	***Budget Authority by Object Class***	**15,483**	**15,556**	**-**

Budget Authority By Object Class - Reimbursable

(Dollars in Thousands)

Object Class Code	Description	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
11.1	Full-time permanent	13,876	14,396	15,146
11.3	Other than full-time permanent	4,133	4,133	4,174
11.5	Other personnel compensation	278	278	281
11.7	Military personnel	104	105	106
Subtotal	*Personnel Compensation*	18,391	18,912	19,707
12.1	Civilian personnel benefits	5,341	5,529	5,736
12.2	Military benefits	45	46	46
13.0	Benefits for former personnel	-	-	-
Total	*Pay Costs*	23,777	24,487	25,489
21.0	Travel and transportation of persons	404	382	382
22.0	Transportation of things	-	-	-
23.1	Rental payments to GSA	-	-	3,982
23.3	Communications, utilities, and misc. charges	101	101	1,424
24.0	Printing and reproduction	20	26	34
25.1	Advisory and assistance services	445	445	500
25.2	Other services from non-Federal sources	12,591	12,474	28,734
25.3	Other goods and services from Federal sources	6,730	6,730	12,456
25.4	Operation and maintenance of facilities	15	20	1,320
25.5	Research and development contracts	-	-	-
25.6	Medical care	-	-	-
25.7	Operation and maintenance of equipment	-	-	-
25.8	Subsistence and support of persons	-	-	-
26.0	Supplies and materials	88	88	128
31.0	Equipment	58	58	239
32.0	Land and Structures	-	-	-
41.0	Grants, subsidies, and contributions	582	-	-
42.0	Insurance claims and indemnities	-	-	-
44.0	Refunds	-	-	-
Total	*Non-Pay Costs*	21,034	20,324	49,199
Total	***Budget Authority by Object Class***	**44,811**	**44,811**	**74,688**

Salary & Expenses

(Dollars in Thousands)

Object Class Code	Description	FY 2013 Actual	FY 2014 Enacted	FY 2015 President's Budget
11.1	Full-time permanent	13,876	14,396	15,146
11.3	Other than full-time permanent	4,133	4,133	4,174
11.5	Other personnel compensation	278	278	281
11.7	Military personnel	104	105	106
Subtotal	***Personnel Compensation***	18,391	18,912	19,707
12.1	Civilian personnel benefits	5,341	5,529	5,736
12.2	Military benefits	216	217	46
13.0	Benefits for former personnel	-	-	-
Total	***Pay Costs***	23,948	24,658	25,489
21.0	Travel and transportation of persons	404	382	382
22.0	Transportation of things	1	-	-
23.3	Communications, utilities, and misc. charges	1,225	1,245	1,424
24.0	Printing and reproduction	20	26	34
25.1	Advisory and assistance services	740	740	500
25.2	Other services from non-Federal sources	17,586	17,523	28,734
25.3	Other goods and services from Federal sources	11,302	11,302	12,456
25.4	Operation and maintenance of facilities	1,322	1,327	1,320
25.5	Research and development contracts	-	-	-
25.6	Medical care	-	-	-
25.7	Operation and maintenance of equipment	-	-	-
25.8	Subsistence and support of persons	-	-	-
Subtotal	***Other Contractual Services***	32,600	32,545	44,850
26.0	Supplies and materials	128	128	128
Subtotal	***Non-Pay Costs***	32,728	32,673	44,978
Total	***Salary and Expenses***	56,678	57,331	70,467
23.1	Rental payments to GSA	2,814	2,814	3,982
Total	**Salaries, Expenses, and Rent**	59,490	60,145	74,449
Total	**Direct FTE**	**171**	**185**	**191**

Detail Of Full-Time Equivalent (FTE) Employment

Detail	FY 2013 Civilian	FY 2013 Military	FY 2013 Total	FY 2014 Civilian	FY 2014 Military	FY 2014 Total	FY 2015 Civilian	FY 2015 Military	FY 2015 Total
Direct	-	-	-	-	-	-	-	-	-
Reimbursable	170	1	171	184	1	185	190	1	191
Total FTE	170	1	171	184	1	185	190	1	191

Average GS Grade

	Grade:	Step:
FY 2010.....	13	3
FY 2011.....	13	3
FY 2012.....	13	4
FY 2013.....	13	5
FY 2014.....	13	6
FY 2015.....	13	6

Detail Of Positions

Detail	FY 2013 Actual	FY 2014 Enacted	FY 2015 President's Budget
Executive level	0	0	0
Total - Exec. Level Salaries	$0	$0	$0
SES	7	9	9
Total - SES Salaries	$1,404,858	$1,599,823	$1,622,283
Total - ES Salary	**$1,373,743**	**$1,599,823**	**$1,622,283**
GS-15	41	48	48
GS-14	38	47	47
GS-13	36	62	62
GS-12	24	23	23
GS-11	17	17	17
GS-10	2	2	2
GS-9	5	5	5
GS-8	0	0	0
GS-7	0	0	0
GS-6	0	0	0
GS-5	1	1	1
GS-4	0	0	0
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal	***164***	***205***	***205***
Total, GS Salary	**$19,331,531**	**$24,381,842**	**$25,259,160**
Commissioned Corps	1	1	1
Total, Commissioned Corps Salary	$149,400	$156,000	$157,560
Total Positions	**172**	**215**	**215**
Total FTE	171	185	191
Average SES salary	$175,607	$177,758	$180,253
Average GS grade	GS-13	GS-13	GS-13
Average GS Salary	$108,835	$104,538	$108,835

FY 2015 Budget By HHS Strategic Goal

(Dollars in Millions)

HHS Strategic Goals	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
1.Transform Health Care	**-**	**-**	**-**
1.A Make coverage more secure	-	-	-
1.B Improve health care quality and patient safety	-	-	-
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	60.294	60.367	74.688
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	-	-	-
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 ONC Program Level	60.294	60.367	74.688

Significant Items In Appropriations Committee Reports

FY 2013 Senate Appropriations Committee Report Language (Senate Report 113-71)

Item 1:
Federal E-Health Working Group- The Committee encourages the Secretary to convene a national working group on e-health and telemedicine to improve communication, coordination and collaboration among relevant Federal agencies regarding e-health needs, standards, Federal goals, and Federal efforts. Such a working group should seek to reduce duplication and e-health incompatibility, as well as improve health quality, effectiveness, and outcomes.

Action Taken or To Be Taken
ONC will convene a meeting with relevant HHS OPDIVs/STAFFDIVs to determine their e-Health and telemedicine activities and interests. After this meeting, ONC will contact other Federal agencies to convene a working group and will consider whether recommendations from the HIT Policy Committee and HIT Standards Committee would be useful.

Physicians' Comparability Allowance

Physicians' Comparability Allowance		PY 2013 (Actual)	CY 2014 (Estimates)	BY 2015 (Estimates)
1) Number of Physicians Receiving PCAs		1	3	3
2) Number of Physicians with One-Year PCA Agreements		1	3	3
3) Number of Physicians with Multi-Year PCA Agreements		0	0	0
4) Average Annual PCA Physician Pay (without PCA payment)		$155,500	$155,500	$155,500
5) Average Annual PCA Payment		$13,000	$13,000	$13,000
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

In 2013, ONC needed a qualified individual with a strong medical background to take the lead on Health IT innovations and quality measures.

In 2014 and 2015, ONC will need additional physicians with strong medical backgrounds to work in ONC's Office of the Chief Medical Officer 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 not unlikely that ONC could have recruited its current physician, nor is it likely that ONC will be able to recruit without PCAs in future years. PCAs were awarded at the maximum amount allowed in all of these cases.

Health Insurance and Implementation Fund

HEALTH INSURANCE REFORM IMPLEMENTATION FUND

Budget Summary

(Dollars in Thousands)

	FY 2013	FY 2014	FY 2015
Obligations*	153,167	86,962	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 2013, $153,166,627 of this funding was obligated by agencies within HHS and external federal partners. In FY 2014, HHS estimates the remaining funds will be obligated to support ACA implementation efforts that support the Marketplaces.

Nonrecurring Expenses Fund

Nonrecurring Expenses Fund

Budget Summary

(Dollars in Thousands)

	FY 2013[1]	FY 2014[2]	FY 2015
Notification*	$600,000	$600,000	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

Starting with fiscal year 2008 funds, the Nonrecurring Expenses Fund (NEF) authority permits HHS to transfer unobligated balances of expired discretionary funds into a no-year account for specific purposes. Congress authorized the Department of Health and Human Services (HHS) to use these funds for capital acquisitions such as information technology procurements and facility investments.

HHS invested in data management systems to support enhanced and streamlined access to the Centers for Medicare & Medicaid Services (CMS) data resources and implementation of new legislative and regulatory requirements. These investments will provide more secure access to consumers, states, and partnering agencies to Medicare and Medicaid data. HHS made additional investments in Marketplace infrastructure development for which HHS is responsible to support services for consumers, insurance issuers, states, small businesses, and other stakeholders.

HHS used NEF funds to invest in an electronic processing system for the Office of Medicare Hearings and Appeals moving from a paper-based case processing to a digital system. This investment will better serve Medicare beneficiaries by accelerating the process to adjudicate appeals. HHS has also begun development of Department-wide financial systems that will standardize financial data and significantly enhance core financial systems. This investment will enhance the security and reliability of the financial systems providing stronger internal controls and improve financial reporting. HHS also upgraded components of the cybersecurity infrastructure.

Budget Allocation

HHS has not determined the FY 2015 allocation. The FY 2015 allocation will depend on total resources available and the infrastructure needs of HHS in FY 2015. HHS will notify Congress before obligating funds towards projects, consistent with prior year notifications. HHS anticipates making continued investments that support information technology capital acquisitions within CMS as well as Department-wide financial system upgrades. The Department may also invest NEF resources in facilities infrastructure. For example, the renovation of a currently under-utilized facility within the Jefferson Laboratories Complex located in Jefferson, Arkansas may be an appropriate use of these funds.

[1] Notification submitted to the Committees on Appropriations in the House of Representatives and the Senate on March 29, 2013.

[2] 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

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SERVICE AND SUPPLY FUND

(Dollars in Thousands)

SSF	FY 2013 Actual	FY 2014 Board Approved	FY 2015 Board Approved	FY 2015 +/- FY 2014
BA	$954,419	$1,148,535	$1,143,786	-$4,749
FTE	1,154	1,326	1,324	-2

Authorizing Legislation: 42 U.S.C. 231
2014 Authorization……Indefinite
Allocation Method ……Contract, Other
* Additional details on the 2015 SSF Board approved budgets are found in the narrative

Statement of the Budget

The FY 2015 budget for the Service and Supply Fund (SSF) is $1,143,786,000, which is a decrease of $4,749,000 below the FY 2014 SSF Board-approved level of $1,148,535,000. The overall decrease the in the budget from FY 2014 to FY 2015 is the result of IT system functions being fully migrated to the Coast Guard Direct Access (DA) HR system, movement of the HRESM EHRP system to the USDA National Finance Center and reduction in pass through cost.

The Program Support Center's (PSC) budget request for FY 2015 is $784,466,000, which is a decrease of $11,884,000 below the FY 2014 current budget request of $796,350,000. This decrease is largely attributable to the one –time purchase of furniture for the Parklawn Building and the continued efforts of the PSC SMART (Save, Manage and Assess our Resources Together), which was implemented in FY 2013. The program continues to result in increased savings within PSC.

The total FY 2015 request for the non-PSC SSF Activities is $359,319,000, which is an increase of $7,134,000 above the FY 2014 current budget level of $352,185,000. Increases in non-PSC activities are due in part to increased personnel, administrative, and contract-related costs. Additionally, as in previous fiscal years, the SSF continues to absorb activities previously funded through the Joint Funding Agreement (JFA) process in order to provide increased visibility, transparency and oversight over those activities.

There are organizational/realignment transfers within the Fund including the movement of Office of Enterprise Support Programs from Administrative Operations Service (AOS) to Facilities and Logistic Service (FLS). Other changes within the Fund are intended to align activities and allow for cohesive management. These changes include: 1) Combining three separate cost centers (Enterprise Architecture, Vendor Management Office, and Portfolio Management) into one cost center now called Departmental IT Management; 2) Including the Networx and Telecommunications cost centers in the Information Technology Infrastructure and Operations (ITIO) cost center; and 3) Including HSPD-12 and DSES in the Office of Security and Strategic Information (OSSI). These organizational changes have no direct budgetary affect. Additionally, two formerly Legislatively Mandated Initiatives and Emerging Technologies (LMIE) Joint Funding Agreement (JFA) investments (Government-wide E-Gov Initiatives and Governance, Program Management and System Enhancements) have been moved into the Service and Supply Fund. More information on these activities can be found in their respective narratives.

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 2015 SSF activities are described below.

Program Support Center Activities

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 address the current federal budget challenges, the PSC again leveraged its SMART (Save, Manage and Assess our Resources Together) Program for the FY 2015 budget formulation process. Through the SMART III process, service managers conducted a comprehensive, "bottom-up" analysis of PSC's operations to identify areas for additional cost reductions, efficiencies and cost avoidance. PSC also boosted its efforts to identify opportunities for revenue growth, which resulted in billable rate reductions.

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 unit costs to all customers through economies of scale.

Administrative Operations Service (AOS): AOS provides a wide range of administrative and technical support services to customers within HHS and to other federal agencies. The mission of AOS is to provide high-quality administrative support services at competitive prices by capitalizing on its expertise and leveraging economies of scale. AOS major service areas include publishing services, mail operations, payroll services, FOIA services, travel services and, other administrative support.

Facilities and Logistics Service (FLS): FLS is responsible for all aspects of HHS real property asset management in compliance with Executive Order 13327, oversight and policy development for master planning, facilities planning, design and construction, operations and maintenance (O&M), leasing and space utilization, real estate and capital program budget development, and logistics services. FLS provides Department-wide leadership in environmental management, energy management, occupational safety and health, and historic preservation. FLS also manages for the Federal government the transfer of surplus real property to non-profit entities such as under Stewart B. McKinney-Vento Homeless Assistance Act. FLS provides shared services Department-wide and to other federal agencies, such as recycling, personal property functions including the Department-wide property asset management system, warehousing and distribution, property disposal, and labor services. Included within the warehouse and distribution services are the receipt, processing and distribution of drugs,

medical supplies, and equipment. FLS also manages the O&M functions for any buildings under delegated authority from the General Services Administration (GSA) and the Federal Protective Service (FPS).

The Federal Occupational Health Service (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 other than HHS. FOH Clinical Services Division provides services which includes health and wellness programs, AED management and training, medical employability and medical surveillance exams/follow-up. FOH Employee Assistance and Work/Life Division provides professional services for assessment, short-term counseling, referral, critical incident response to improve the well-being of federal employees and to help employees better manage their personal and professional responsibilities which in turn helps improve productivity. The Division of Environmental Health Services offer a wide variety of services and support including Environmental Regulatory Compliance, Environmental Reference Laboratories, Industrial Hygiene, Emergency Response Management and other Environmental consulting services.

The Financial Management Service (FMS): FMS 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. FMS 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. FMS continues to be a leader in supporting the Departments' clean audit opinions from independent audit firms.

Strategic Acquisition Service (SAS): SAS is responsible for providing fully integrated acquisition and strategic support services to HHS and other Federal agencies. SAS 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 SAS customers, and Acquisition Development and Support, which includes customer liaison support, contract closeout and cost/price analysis activities.

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): AIM program was created to capture knowledge within the acquisition workforce, leverage opportunities to adopt or tailor successful practices, and standardize and modernize acquisition processes. AIM is overseen 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.

The AIM program has taken steps to improve the effectiveness and efficiency of HHS' acquisition functions in the past by: developing a robust, web-enabled decision tree to support compliance with appropriations law; establishing standard HHS-wide templates (e.g., justifications for noncompetitive acquisitions) and checklists (e.g., contract file content); developing statistically reliable workforce projections to support a professional cadre of Contracting Officers, Contracting Officers' Representatives, and Program/Project Managers; and rewriting and reconfiguring the Health and Human Services Acquisition Regulation (HHSAR) to separate guidance housed in a Procurement, Guidance and Information (PGI) portal from policy housed in the HHSAR.

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 within the Office of the Surgeon General (OSG), 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 serve active duty officers, the agencies and Departments to which the officers are assigned and retired officers.

Departmental Contracts Information System (DCIS): DCIS provides procurement data collection and reporting capabilities to enable the HHS' Operating Divisions (OPDIVs) to comply with requirements under Public Law 93-400 and FAR Subpart 4.6 regarding the reporting of contract actions to the Federal Procurement Data System (FPDS). DCIS is overseen 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.

Departmental IT Management: The Departmental IT Management (DITM) is a consolidated cost center within the HHS Office of the Chief Information Officer (OCIO) including Portfolio Management, Vendor Management and Enterprise Architecture. Activities resourced through DITM have been resourced through a combination of the Service & Supply Fund and the Legislatively Mandated Initiatives and Emerging Technologies (LMIE) Joint Funding Agreement (JFA) and have now been transferred to the SSF. DITM provides these services to HHS components Portfolio Management Activities, Vendor Management Activities, and Enterprise Architecture Activities.

Digital Communications Division (DCD) (Web): DCD leads the Department's digital communication efforts (policy, web, mobile, social media). DCD develops and maintains HHS.gov, numerous OS Office websites, nine Secretarial priority websites, HHS Intranet, multiple social media channels, and applications that meet the Federal Digital Strategy (FDS) to make data available for public utilization. DCD builds and maintains applications and databases supporting the Office of Management and Budget (OMB) and other mandated activities. DCD acquires, develops and operates complex system and tools

that are made available on a shared-resource basis. DCD manages the Department's Section 508 digital compliance program, including establishing standards, monitoring and reporting compliance, remediating sites, applications and documents, and providing Department-wide training.

Equal Employment Opportunity (EEO): EEO cost center is managed by the EEO Compliance and Operations Division (EEOCO). 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 EEOCO Division consist of two components: (1) EEO Compliance and (2) EEO Operations.

Government-wide E-Government (e-Gov) Initiatives: E-Gov office directly under the Office of the Chief Information Officer (OCIO) provides a central funding point for the Office of Management and Budget (OMB) mandated contributions to e-Gov initiatives. Every OPDIV and STAFFDIV is assessed charges to support these initiatives, and this change was made to increase transparency and facilitate collection of OPDIV and STAFFDIV contributions. The initiatives included in this cost center are: Grants.gov, E Rulemaking, Integrated Acquisition Environment, Geospatial Line of Business (LoB), Federal Health Architecture, Human Resources LoB, Financial Management LoB, Budget Formulation and Execution LoB, Disaster Assistance Improvement Plan, and GovBenefits.gov.

HHS Consolidated Acquisition System (HCAS): HCAS was launched in 2009 and provides contract writing and administration capabilities to seven of the ten Department's Contracting Activities (ASPR, AHRQ, FDA, HRSA, IHS, PSC/SAS, and SAMHSA). HCAS enables users to commit funds to requisitions and contracting officers to formulate and administer contracts in compliance with the Federal Acquisition Regulation.

The High Performing Organizations, Commercial Services Management Reporting & Insourcing (HPO&CSM): HPO&CSM program supports HHS-wide CSM reporting, the inventory and reporting requirements of the Federal Activities Inventory Reform (FAIR) Act , the active sponsorship of HPO, and insourcing through central service activities. Additionally, this program offers organizational redesign services to and performs reorganizations for the Department to promote mission effectiveness, cost-savings and increases efficiencies.

The Office of Information Technology Infrastructure and Operations (ITIO): ITIO provides expert guidance and knowledgeable professionals to gather requirements, design and develop plans, and implement and manage customer information technology (IT) needs. By providing expanded services within the Department, ITIO enables the HHS Operating and Staff Divisions to focus on their core missions and reap the financial and specialization benefits of sharing services. By expanding business, ITIO both helps meet the administrative support needs of the HHS community, but also is able to spread overhead and fixed costs over a much greater revenue pool, thereby reducing unit costs for all customers.

Office of Enterprise Application Development (OEAD): OEAD has the mission of providing high-quality enterprise systems operations and management services including application development, project management, HR enterprise systems management, financial enterprise systems management, and procurement enterprise system management. In addition to the OEAD Program Management Branch (PMB), which provides project support staff to organizations within HHS on a fully reimbursable, fee-for-service basis, several OEAD components will continue to provide systems operations services in support of critical activities serving SSF and other customers.

Office of the General Counsel (OGC) Claims: OGC receives reviews and processes 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.

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): OIS is one of only seven Federal agency programs that have been designated as a Center of Excellence represented by the Department of Homeland Security 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. OIS supports system owners throughout the Security Assessment and Authorization (SA&A) process, developing documents, conducting security testing and evaluation activities, analyzing risks, and communicating these risks to key stakeholders as appropriate. OIS also provides services that allow all HHS customers the safety of secure operating environments, infrastructure, email and WAN/LAN services.

Office of the Secretary (OS) Audit Resolution: OS Audit Resolution's primary function is to resolve Single Audit findings within a six-month period 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. (Audit findings are also required to be resolved within 6 months under P.L. 96-304, P.L. 98-502, and OMB Circular A-50, *Audit Followup.*) HHS' Office of Inspector General (OIG) reviews grantees' OMB Circular A-133 audit reports and assigns audit findings for resolution to OS Audit Resolution and Operating Divisions/Staff Divisions (OPDIVs/STAFFDIVs). OS Audit Resolution resolves cross-cutting findings reported in OMB Circular A-133 audit reports that affect the awards of multiple OPDIVs/STAFFDIVs. In addition to resolving 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 Contro1*.

Office of Security and Strategic Information (OSSI): The goals of the OSSI are to: (1) effectively/efficiently manage security by consolidating the execution (operations) and policy functions, (2) establish a platform that enables technical training, career advancement and management for security and intelligence professionals, and (3) provide the resource flexibility needed to meet the growing demand for strategic information and counterintelligence capabilities.

Small Business Program: The Department of Health and Human Services' (HHS) Office of Small and Disadvantaged Business Utilization (OSDBU) is the focal point for the Department's Small Business Program's policy formulation, implementation, coordination, and management. 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 HHS' contracting and program officials; and conducts outreach and provides marketing and technical guidance to small businesses on contracting opportunities with HHS.

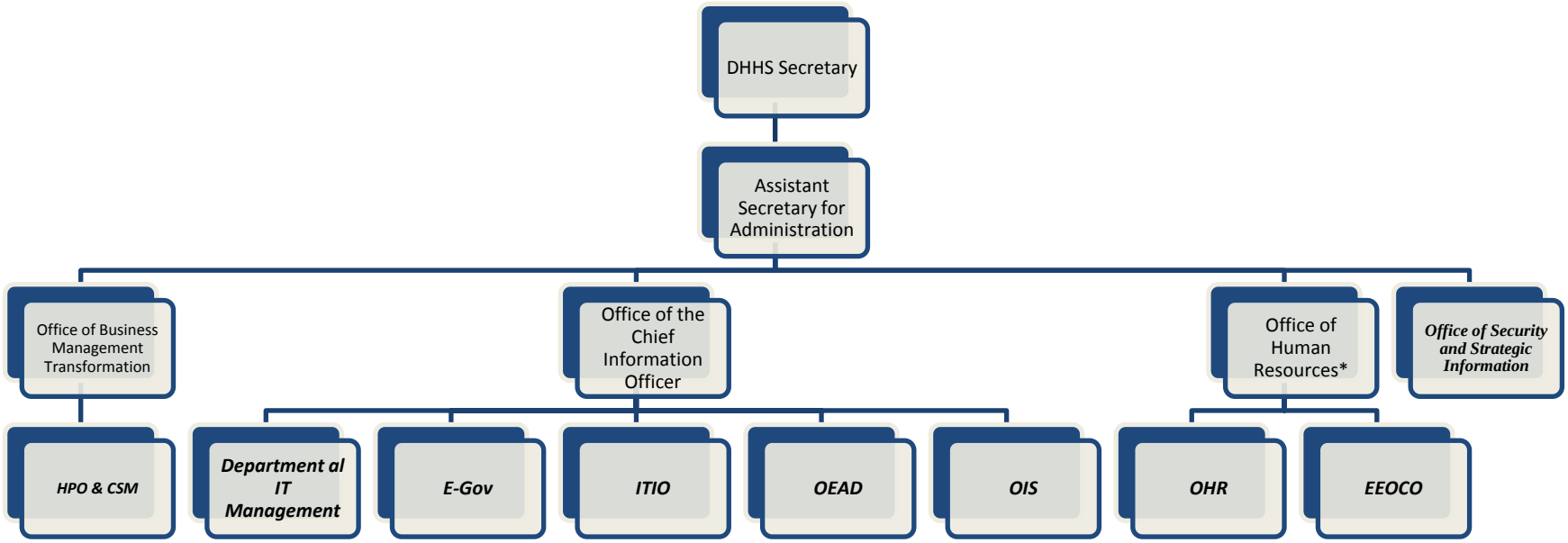
Strategic Sourcing Program: SSP provides departmental leadership in conducting spend analysis and developing acquisition strategies that leverage the Department's contract spending for common supplies and services. SSP also manages the new conference request review process and supports efforts to achieve efficiencies and savings in conference spending through strategic sourcing. The SSP is overseen by the Office of Acquisition Program Support 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.

Tracking Accountability in Government Grants (TAGGS): Since 1995, the Department of Health and Human Services (HHS) has tracked and reported grant spending online via TAGGS. TAGGS serves 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 web site (http://taggs.hhs.gov).

Unified Financial Management Systems (UFMS): UFMS offers HHS a platform for effectively processing and tracking its financial and accounting transactions with UFMS at its core. With the implementation of other systems over the past two years, the capabilities of this environment have greatly expanded. The Consolidated Financial Reporting System (CFRS), which was implemented in early 2012, provides the capability to generate accurate, HHS-wide financial statements on a consistent and timely basis. The Enterprise Financial Business Intelligence System (FBIS), which went live in early 2013, offers management reports and business analytics that facilitate the analysis of data across systems and strategic decision-making by management. UFMS and its related systems support all of the operating and staff divisions of HHS.

UFMS Governance and Program Management: UFMS Governance and Program Management will implement a mature governance and program management framework and provide resources to oversee Department-wide financial systems. UFMS Governance and Program Management will improve change management processes by assessing and prioritizing the existing change request backlog, performing policy reviews and resolving pending change requests. Internal controls will be strengthened by resolving a material weakness and significant deficiency using risk-based approaches for ensuring HHS' compliance with all financial system policies. UFMS Governance and Program Management will provide oversight and governance to the five components of HHS' financial management systems environment.

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.

Note: A text version of the chart appears on the following page.

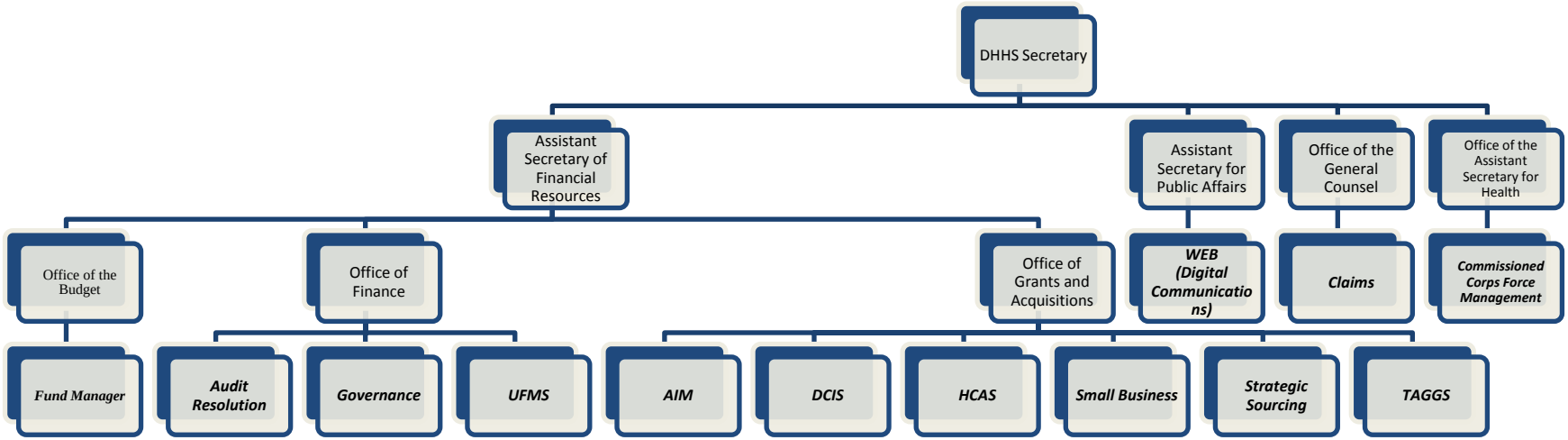
Service and Supply Fund Organizational Chart Non-PSC Activities under the Purview of the Assistant Secretary for Administration

- Office of the Secretary
- The Office of the Assistant Secretary for Administration (ASA)

The following offices report directly to the Office of the Assistant Secretary for Administration:

- 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

Note: A text version of the chart appears on the next page.

Service and Supply Fund Organizational Chart, Non-PSC Activities

- Office of the Secretary
- Office of the Assistant Secretary for Financial Resources

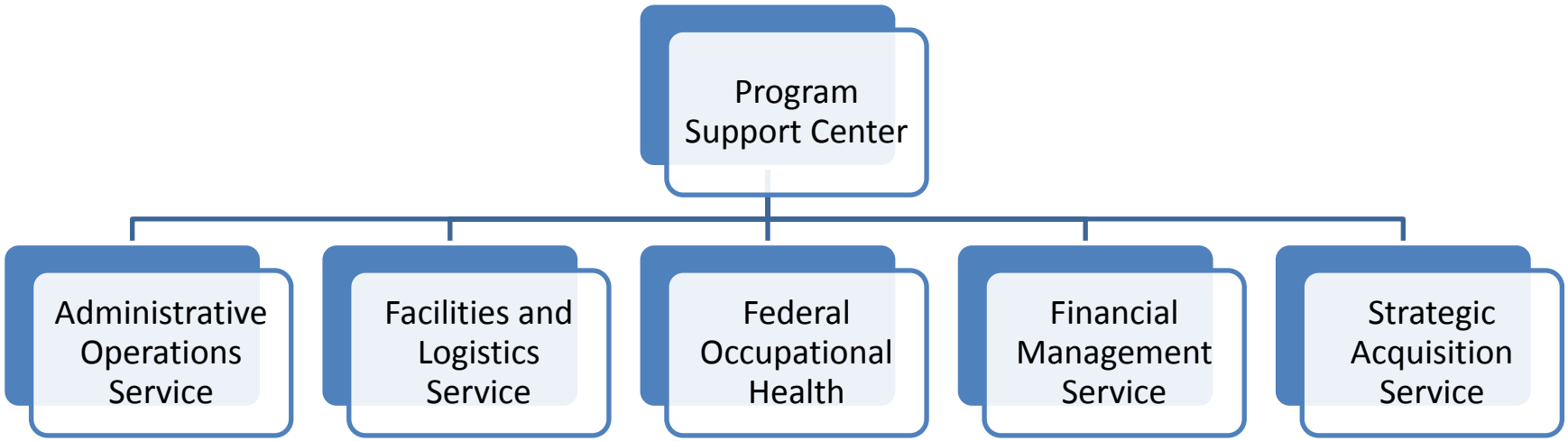
The following offices report directly to the Office of the Assistant Secretary for Financial Resources:

- 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

The following offices report directly to the Office of the Secretary:

- 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

Service and Supply Fund Organizational Chart, Program Support Center



Note: A text version of this chart appears on the next page.

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 Service
    - Facilities and Logistics Service
    - Federal Occupational Health
    - Financial Management Service
    - Strategic Acquisition Service

Department of Health and Human Services
Service and Supply Fund
(Dollars in Thousands)

Service and Supply Fund Activities	FY 2013 Actuals	FY 2014 Board Approved	FY 2015 Board Budget	FY 2015 +/- FY 2014
PSC				
Administrative Operations Service	70,723	100,582	100,669	87
Facilities & Logistics Service	55,012	103,755	83,983	(19,772)
Federal Occupational Health Service	147,305	168,397	168,852	455
Financial Management Service	54,600	65,458	65,639	181
Strategic Acquisitions	317,699	358,157	365,323	7,166
PSC Reserves	8,361			
PSC Subtotal	***653,700***	***796,349***	***784,466***	***(11,883)***
Non-PSC				
AIM	951	992	992	-
Audit Resolution	1,542	1,557	1,557	-
CCFM	25,085	24,730	23,652	(1,078)
DCIS	1,883	1,999	1,999	-
DITM	4,307	11,749	12,182	433
EEO Services	3,066	3,171	3,171	-
Governance	-	6,002	6,002	-
Government wide E-Gov Initiatives	-	20,812	20,812	-
HCAS	6,661	7,877	7,898	21
HPO & Commercial Services Mgmnt	208	262	262	-
ITIO	89,794	92,729	94,545	1,816
OEAD	35,513	40,021	40,229	208
OGC Claims	1,375	1,438	1,449	11
OHR	22,583	21,040	21,040	-
OIS	3,434	11,922	11,971	49
OSSI	29,844	42,711	42,994	283
Small Business Consolidation	2,383	2,842	2,871	29
Strategic Sourcing	930	959	959	-
TAGGS	2,290	2,431	2,474	43
UFMS	34,345	36,733	40,260	3,527
Web Communications	23,002	20,209	22,000	1,791
Non-PSC Reserves	11,523	-	-	-
Non-PSC Subtotal	***300,719***	***352,185***	***359,319***	***7,134***
Total SSF Revenue	**954,419**	**1,148,535**	**1,143,786**	**(4,749)**

Department of Health and Human Services Service and Supply
Object Classification – Reimbursable Obligations
(Dollars in Thousands)

Object Class	FY 2013 SSF Board Actuals	FY 2014 SSF Board Request	FY 2015 SSF Board Request
Reimbursable Obligations	-	-	-
Personnel Compensation:	-	-	-
Full – Time Permanent (11.1)	92,109	102,762	102,562
Other Than Full – Time Permanent (11.3)	3,564	2,324	2,310
Other Personnel Compensation (11.5)	1,587	2,538	2,504
Military Personnel (11.7)	7,047	7,508	7,504
Special Personnel Services Payments (11.8)	1,032	1,276	1,256
Subtotal, Personnel Compensation	**105,339**	**116,408**	**116,136**
Civilian Personnel Benefits (12.1)	27,583	29,017	28,855
Military Personnel Benefits (12.2)	3,879	2,437	2,367
Benefits to Former Personnel (13.0)	652	689	681
Subtotal, Pay Costs	**32,114**	**32,143**	**31,903**
Travel (21.0)	1,681	1,857	1,824
Transportation of Things (22.0)	3,239	3,688	3,693
Rental Payments to GSA (23.1)	21,799	22,041	21,524
Rental Payments to Others (23.2)	359	359	359
Communications, Utilities and	-	-	-
Miscellaneous Charge (23.3)	33,610	6,108	6,079
Printing and Reproduction (24.0)	2,745	2,570	2,525
Other Contractual Services:	-	-	-
Advisory and Assistance Services (25.1)	28,535	31,579	31,081
Other Services (25.2)	554,278	706,367	706,563
Purchases from Govt. Accounts (25.3)	52,316	70,012	69,873
Operation & Maintenance of Facilities (25.4)	12,562	16,497	16,342
Research & Development Contracts (25.5)	-	-	-
Medical Services (25.6)	20,389	28,704	28,534
Operation & Maintenance of Equipment (25.7)	59,547	74,322	72,589
Subsistence& Support of Persons (25.8)	-	-	-
Subtotal, Other Contractual Services	**791,060**	**964,066**	**960,948**
Supplies and Materials (26.0)	24,432	32,441	32,289
Equipment (31.0)	1,474	3,439	2,472
Grants (41.0)	-	-	-
Other (32), (42), (61)	-	-	-
Subtotal, Non – Pay Costs	**25,906**	**35,918**	**34,709**
Total, Reimbursable Obligations	**954,419**	**1,148,535**	**1,143,786**

Retirement Pay & Medical Benefits for Commissioned Officers

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

RPMB	FY 2013	FY 2014	FY 2015	FY 2015 +/-FY 2014
Retirement Payments	392,958,371	$413,751,807	$432,177,493	18,425,686
Survivor's Benefits	26,310,291	27,462,270	28,186,391	724,121
Medical Care Benefits	94,547,851	99,214,529	101,878,091	2,663,562
Accrued Health Care Benefits	27,608,710	27,335,980	*27,946,578	610,598
Total	**$541,425,223**	**$567,764,586**	**$590,188,553**	**$22,423,967**

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 2015 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 (6,798 in FY 2015), for a baseline contribution of $27,946,578. This budget assumes savings from FY 2015 Department of Defense legislative proposals, yielding a total of $25,137,578. The FY 2015 estimate is a net increase of $610,598 above the FY 2014 level.

The overall request reflects increased costs in medical benefits, an average increase of 4.5% over the past five years in Retired Pay, and a net increase in the number of retirees and survivors during FY 2015.

*The FY15 baseline total does not include DoD legislative proposals.

Out Year Projections

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Retirement Payments	451,423,733	471,527,069	492,525,671	514,459,408	537,369,923
Survivor's Benefits	28,929,606	29,692,417	30,475,342	31,278,911	32,103,669
Medical Care Benefits	104,613,160	107,421,656	110,305,551	113,266,867	116,307,685
Accrued Health Care Benefits	29,623,373	31,104,541	32,970,814	34,949,063	37,046,006
Total	**$614,589,871**	**$639,745,684**	**$666,277,378**	**$693,954,249**	**$722,827,284**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROPOSED GENERAL PROVISIONS
FOR FISCAL YEAR 2015

The President's Budget recommends that a number of general provisions be included in the FY 2015 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 *discretionary* funds appropriated in this title shall be used to pay the salary of an individual, through a 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 **[**2014**]***2015*:

(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 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 section 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 2015 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 **[**2014**]** *2015* under section 338B of such Act.

[SEC. 224. The Secretary shall publish, as part of the fiscal year 2015 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 2015. Such information shall include, for each such fiscal year—

(1) the section(s) of such Act under which such funds were appropriated or used;
(2) the program, project, or activity for which such funds were used;
(3) the amount of funds that were used for the Health Insurance Marketplaces within each such program, project, or activity; and
(4) the milestones completed for data hub functionality and implementation readiness.**]**

[SEC. 225. Activities authorized under part A of title IV and section 1108(b) of the Social Security Act (except for activities authorized in section 403(b)) shall continue through September 30, 2014, in the manner authorized for fiscal year 2013, 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.**]**

[SEC. 226. The Secretary shall include in the fiscal year 2016 budget justification an analysis of how section 2713 of the PHS Act will impact eligibility for discretionary HHS programs.**]**

SEC. 218. In the event of a public health emergency declared under section 319 of the PHS Act, the Secretary of HHS may, during the duration of the emergency, transfer discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) which are appropriated in this Act for the current fiscal year for HHS 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. (Department of Health and Human Services Appropriations Act, 2014.)

TITLE V

(Department of Health and Human Services Appropriations Act, 2012)

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.
(c) 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 2014 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 2014 budget request.**]**

SEC. 513. EXTENSION AND AMENDMENT OF AUTHORITY FOR CHIP PERFORMANCE BONUS PAYMENTS.

(*a*) *EXTENSION OF AUTHORITY FOR PERFORMANCE BONUS PAYMENTS. Section 2105(a)(3)(A) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(A)) is amended by striking "ending with fiscal year 2013" and inserting "ending with fiscal year 2014".*

(*b*) *AUTHORITY TO TRANSFER UNOBLIGATED CHIP ALLOTMENTS FOR PERFORMANCE BONUS PAYMENTS. Section 2105(a)(3)(E)(ii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(E)(ii)) is amended—*

(*1*) *in subclause (I) by inserting after item (cc) the following:*

"(dd) FIRST HALF OF FISCAL YEAR 2015.—As of December 31 of fiscal year 2015, the portion, if any, of the sum of the amounts appropriated under section 2104(a)(18)(A) and under section 108 of the Children's Health Insurance

Reauthorization Act of 2009 for the period beginning on October 1, 2014, and ending on March 31, 2015, that is unobligated for allotment to a State under section 2104(m) for such fiscal year.

"(ee) SECOND HALF OF FISCAL YEAR 2015.—As of June 30 of fiscal year 2015, the portion, if any, of the amount appropriated under section 2104(a)(18)(B) for the period beginning on April 1, 2015, and ending on September 30, 2015, that is unobligated for allotment to a State under section 2104(m) for such fiscal year."; and

(*2*) *in subclauses (II) and (III), by striking "2013" and inserting "2015".*

(*c*) *QUALIFYING CHILDREN DEFINED.*

(*1*) *EXCLUSION OF CERTAIN CHILDREN TRANSITIONED FROM CHIP TO MEDICAID UNDER THE AFFORDABLE CARE ACT.—Section 2105(a)(3)(F)(iii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(F)(iii)) is amended—*

(*A*) *by inserting a hyphen after "Such term does not include" and re-designating all text that follows as subclause (I) and indenting it appropriately;*

(*B*) *in subclause (I), as so re-designated, by striking all text after "section 1903(v)" and inserting a semi-colon; and*

(*C*) *by inserting after subclause (I), as so re-designated, the following new subclauses:*

"(II) any children with family income from 100 to 133 percent of the federal poverty line that the Secretary determines are transitioned by the State on or after January 1, 2014, from the program under this title to the program under title XIX, in order to comply with applicable provisions regarding Medicaid coverage for the lowest income populations under section 2001 of Public Law 111–148; or "(III) any children enrolled on or after October 1, 2014.".

(*2*) *CONFORMING AMENDMENT TO DETERMINATION OF PER CAPITA STATE MEDICAID EXPENDITURES.—Section 2105(a)(3)(D) of the Social Security Act (42 U.S.C. 1397ee)(a)(3)(D)) is amended—*

(*A*) *by designating all text after the caption as clause (i) and indenting it appropriately;*

(*B*) *in clause (i), as so designated, by inserting ", and subject to clause (ii)," after "For purposes of subparagraph (B)"; and*

(*C*) *by inserting at the end the following new clause:*

"(ii) For purposes of the determination under clause (i), the average per capita expenditures for children under the State plan shall not include expenditures with respect to children described in subparagraph (F)(iii)(II).".

(*d*) *AMENDMENTS TO CRITERIA FOR STATE RECEIPT OF PERFORMANCE BONUS PAYMENTS.—Section 2105(a) of the Social Security Act (42 U.S.C. 1397ee(a) is amended—*

(*1*) *in paragraph (4), by inserting "and subject to paragraph (5) with respect to fiscal year 2014," after "For purposes of paragraph (3)(A),"; and*

(*2*) *by inserting at the end the following new paragraph:*

"(5) BONUS PAYMENT CONDITION FOR FISCAL YEAR 2014.

"(A) IN GENERAL.—For purposes of paragraph (3)(A), a State meets the condition of paragraph (4) for fiscal year 2014 if it is implementing, throughout the entire

fiscal year, at least 5 of the following provisions, treating each subparagraph as a separate provision:
"(i) subparagraphs (A), (F), (G), and (H) of paragraph (4); and
"(ii) subparagraphs (B) through (E) of this paragraph.
"(B) ELIMINATION OF CHIP WAITING PERIODS.—The State imposes no waiting period for purposes of meeting the requirement under section 2102(b)(3)(C) that the insurance provided under the State child health plan not substitute for coverage under group health plans.
"(C) REPORTING OF CHILDREN'S HEALTH CARE QUALITY MEASURES.—For reporting year 2014, the State reports to the Secretary under section 1139A(a) regarding the quality of care provided to children by the State under the programs under this title an d title XIX, utilizing at least 80 percent of the initial core set of quality measures developed by the Secretary under such section 1139A(a).
"(D) INCREASED REPORTING OF CHILDREN'S HEALTH CARE QUALITY MEASURES FOR FISCAL YEAR 2014.—With respect to a State which reported information under section 1139A(a) for reporting year 2013, the State increases such reporting for reporting year 2014, by using at least 5 initial core quality measures under such section not previously utilized by the State in such reporting.
"(E) ELIMINATING THE 5-YEAR WAITING PERIOD FOR COVERAGE OF LAWFULLY RESIDING IMMIGRANT CHILDREN UNDER MEDICAID AND CHIP.—The State elects the options under sections 1903(v)(4)(A)(ii) and 2107(e)(1)(J) to provide medical assistance and child health assistance, as applicable, to immigrant children lawfully residing in the United States.".

SEC. 514. WORKFORCE INNOVATION FUND.

(*a*) *From funds appropriated under this Act for the Workforce Innovation Fund—*

(*1*) *amounts shall be available to support innovative new strategies and activities, or the replication and expansion of effective evidence-based strategies and activities, that are designed to align programs and strengthen the workforce development system in a State or region, in order to substantially improve education and employment outcomes for adults and youth served by such system, cost effectiveness, and the services provided to employers under such system; and*

(*2*) *amounts shall be available for awards to States or State agencies that are eligible for assistance under any program authorized under the Workforce Investment Act; consortia of States; or partnerships, including regional partnerships, which may include workforce investment boards, public agencies, or other entities, pursuant to criteria established by the Secretary of Labor.*

(*b*) *Amounts appropriated for the Workforce Innovation Fund shall be administered by the Secretary of Labor in consultation with the Secretary of Education and other heads of departments and agencies, as appropriate.*

(*c*) *Funds obligated for Workforce Innovation Fund projects may remain available until expended for disbursement, notwithstanding 31U.S.C. 1552(a).*

(*d*)(*1*) *In the case of any innovation or replication project which, in the judgment of the Secretary of Labor and the Secretary of Education, is likely to substantially improve the education and*

employment outcomes for adults and youth served by such system and the services provided to employers under such system and requires waiver of statutory or regulatory requirements to achieve those improvements, the Secretary of Labor, with respect to title I of the Workforce Investment Act of 1998 and the Wagner-Peyser Act, and the Secretary of Education, with respect to title II of the Workforce Investment Act of 1998 and title I of the Rehabilitation Act of 1973—

(*A*) *may waive compliance with statutory or regulatory requirements under such Acts to the extent and for the period the respective Secretary determines necessary to carry out such project;*

(*B*) *may not waive any requirement related to nondiscrimination, wage and labor standards, or allocation of funds to State and substate levels.*

(*2*) *Waivers may only be provided to projects which include—*

(*A*) *a plan, approved by the relevant Secretary, to effectively evaluate the impact of the strategies being tested on outcomes for program participants, including target populations identified by the Secretaries;*

(*B*) *a strong accountability system, including performance measures which show outcomes for program participants and demonstrate that vulnerable populations, including individuals with disabilities are being appropriately served by the workforce system; and*

(*C*) *other required elements, as established by the Secretaries in regulation or grant solicitation.*

(*3*) *Prior to granting a waiver, the Secretaries of Education and Labor will provide at least 60 days written notice to the Committees on Appropriations and other committees of jurisdiction in the House of Representatives and the Senate.*

Sec. 515. TRANSFER OF OLDER AMERICAN COMMUNITY SERVICE EMPLOYMENT PROGRAM TO DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Older American Community Service Employment (OACSE) program under title V of the Older Americans Act of 1965 (42 U.S.C. 3056), and the authority to administer such program, shall be permanently transferred from the Secretary of Labor to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging.

(b) TRANSFER OF FUNCTIONS, ASSETS, AND LIABILITIES.—The functions, assets, and liabilities of the Secretary of Labor relating to the OACSE program shall be transferred to the Secretary of Health and Human Services.

(c) EFFECTIVE DATE OF TRANSFER.—The transfer under this section shall be effective no later than the last day of the second full fiscal quarter following the quarter in which this section is enacted.

[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 2014, 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.**]**

[SEC. 518. None of the funds appropriated or otherwise made available by this Act may be used to enter into a contract in an amount greater than $5,000,000 or to award a grant in excess of such amount unless the prospective contractor or grantee certifies in writing to the agency awarding the contract or grant that, to the best of its knowledge and belief, the contractor or grantee has filed all Federal tax returns required during the 3 years preceding the certification, has not been convicted of a criminal offense under the Internal Revenue Code of 1986, and has not, more than 90 days prior to certification, been notified of any unpaid Federal tax assessment for which the liability remains unsatisfied, unless the assessment is the subject of an installment agreement or offer in compromise that has been approved by the Internal Revenue Service and is not in default, or the assessment is the subject of a non-frivolous administrative or judicial proceeding.**]**

SEC. 517. None of the funds made available by this Act may be used to enter into a contract, memorandum of understanding, or cooperative agreement with, make a grant to, or provide a loan or loan guarantee to, any corporation that has any unpaid Federal tax liability that has been assessed for which all judicial and administrative remedies have been exhausted or have lapsed, and that is not being paid in a timely manner pursuant to an agreement with the authority responsible for collecting the tax liability, where the awarding agency is aware of the unpaid tax liability, unless a federal agency has considered suspension or debarment of the corporation and made a determination that this further action is not necessary to protect the interests of the Government.

SEC. 518. None of the funds made available by this Act may be used to enter into a contract, memorandum of understanding, or cooperative agreement with, make a grant to, or provide a loan or loan guarantee to, any corporation that was convicted of a felony criminal violation under any Federal law within the preceding 24 months, where the awarding agency is aware of the conviction, unless a federal agency has considered suspension or debarment of the corporation and made a determination that this further action is not necessary to protect the interests of the Government.

(RESCISSION)

SEC. **[**521**]***519*. **[**Of the funds made available for performance bonus payments under section 2105(a)(3)(E) of the Social Security Act, $6,317,000,000are hereby rescinded.**]***Of any amounts provided under section 2105(a)(3)(E) of the Social Security Act and available as of January 15, 2015, $1,751,000,000 are hereby permanently cancelled.*

SEC. 520. 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.

SEC. 521. Of any available amounts appropriated under section 108 of Public Law 111–3, as amended, $1,384,000,000 are hereby permanently cancelled.

(RESCISSION)

SEC. **[**522**]***522*. **[**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.*

[SEC. 523. Of the funds made available for fiscal year 2014 under section 3403 of Public Law 111–148, $10,000,000 are rescinded.**]**

[SEC. 524. 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.**]**

(INCLUDING TRANSFER OF FUNDS)

[SEC. 525.

(a) IN GENERAL.—The Health Education Assistance Loan ("HEAL'') program under title VII, part A, subpart I of the PHS Act, and the authority to administer such program, including servicing, collecting, and enforcing any loans that were made under such program that remain outstanding, shall be permanently transferred from the Secretary of Health and Human Services to the Secretary of Education no later than the end of the first fiscal quarter that begins after the date of enactment of this Act.

(b) TRANSFER OF FUNCTIONS, ASSETS, AND LIABILITIES.—The functions, assets, and liabilities of the Secretary of Health and Human Services relating to such program shall be transferred to the Secretary of Education.

(c) INTERDEPARTMENTAL COORDINATION OF TRANSFER.—The Secretary of Health and Human Services and the Secretary of Education shall carry out the transfer of the HEAL program described in subsection (a), including the transfer of the functions, assets, and liabilities specified in subsection (b), in the manner that they determine is most appropriate.

(d) USE OF AUTHORITIES UNDER HEA OF 1965.—In servicing, collecting, and enforcing the loans described in subsection (a), the Secretary of Education shall have available any and all authorities available to such Secretary in servicing, collecting, or enforcing a loan made, insured, or guaranteed under part B of title IV of the HEA of 1965.

(e) CONFORMING AMENDMENTS.—Effective as of the date on which the transfer of the HEAL program under subsection (a) takes effect, section 719 of the PHS Act is amended by adding at the end the following new paragraph: "(6) The term 'Secretary' means the Secretary of Education.''.**]**

(INCLUDING TRANSFER OF FUNDS)

[SEC. 526

(a) DEFINITIONS.—In this section,

(1) "Performance Partnership Pilot'' (or "Pilot'') is a project that seeks to identify, through a demonstration, cost-effective strategies for providing services at the State, regional, or local level that—

(A) involve two or more Federal programs (administered by one or more Federal agencies)—

(i) which have related policy goals, and

(ii) at least one of which is administered (in whole or in part) by a State, local, or tribal government; and

(B) achieve better results for regions, communities, or specific at-risk populations through making better use of the budgetary resources that are available for supporting such programs.

(3) "To improve outcomes for disconnected youth'' means to increase the rate at which individuals between the ages of 14 and 24 (who are low-income and either homeless, in foster care, involved in the juvenile justice system, unemployed, or not enrolled in or at risk of dropping out of an educational institution) achieve success in meeting educational, employment, or other key goals.

(4) The "lead Federal administering agency'' is the Federal agency, to be designated by the Director of the Office of Management and Budget (from among the participating Federal agencies that have statutory responsibility for the Federal discretionary funds that will be used in a Performance Partnership Pilot), that will enter into and administer the particular Performance Partnership Agreement on behalf of that agency and the other participating Federal agencies.

(c) USE OF DISCRETIONARY FUNDS IN FISCAL YEAR 2014.—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.

(d) PERFORMANCE PARTNERSHIP AGREEMENTS.—Federal agencies may use Federal discretionary funds, as authorized in subsection (b), to participate in a Performance Partnership Pilot only in accordance with the terms of a Performance Partnership Agreement that—

(a) is entered into between—

(A) the head of the lead Federal administering agency, on behalf of all of the participating Federal agencies (subject to the head of the lead Federal administering agency having received from the heads of each of the other participating agencies their written concurrence for entering into the Agreement), and (B) the respective representatives of all of the State, local, or tribal governments that are participating in the Agreement; and

(2) specifies, at a minimum, the following information:

(A) the length of the Agreement (which shall not extend beyond September 30, 2018);

(B) the Federal programs and federally funded services that are involved in the Pilot;

(C) the Federal discretionary funds that are being used in the Pilot (by the respective Federal account identifier, and the total amount from such account that is being used in the Pilot), and the period (or periods) of availability for obligation (by the Federal Government) of such funds;

(D) the non-Federal funds that are involved in the Pilot, by source (which may include private funds as well as governmental funds) and by amount;

(E) the State, local, or tribal programs that are involved in the Pilot;

(F) the populations to be served by the Pilot;

(G) the cost-effective Federal oversight procedures that will be used for the purpose of maintaining the necessary level of accountability for the use of the Federal discretionary funds;

(H) the cost-effective State, local, or tribal oversight procedures that will be used for the purpose of maintaining the necessary level of accountability for the use of the Federal discretionary funds;

(I) the outcome (or outcomes) that the Pilot is designed to achieve;

(J) the appropriate, reliable, and objective outcome-measurement methodology that the Federal Government and the participating State, local, or tribal governments will use, in carrying out the Pilot, to determine whether the Pilot is achieving, and has achieved, the specified outcomes that the Pilot is designed to achieve;

(K) the statutory, regulatory, or administrative requirements related to

1. Federal mandatory programs that are barriers to achieving improved outcomes
2. of the Pilot; and

(L) in cases where, during the course of the Pilot, it is determined that the

3. Pilot is not achieving the specified outcomes that it is designed to achieve,
    (i) the consequences that will result from such deficiencies with respect to the Federal discretionary funds that are being used in the Pilot, and
    (ii) the corrective actions that will be taken in order to increase the likelihood that the Pilot, upon completion, will have achieved such specified outcomes.

(e) AGENCY HEAD DETERMINATIONS.—A Federal agency may participate in a Performance Partnership Pilot (including by providing Federal discretionary funds that have been appropriated to such agency) only upon the written determination by the head of such agency that the agency's participation in such Pilot—
    (1) will not result in denying or restricting the eligibility of any individual for any of the services that (in whole or in part) are funded by the agency's programs and Federal discretionary funds that are involved in the Pilot, and
    (2) based on the best available information, will not otherwise adversely affect vulnerable populations that are the recipients of such services. In making this determination, the head of the agency may take into consideration the other Federal discretionary funds that will be used in the Pilot as well as any non-Federal funds (including from private sources as well as governmental sources) that will be used in the Pilot.

(f) TRANSFER AUTHORITY.—For the purpose of carrying out the Pilot in accordance with the Performance Partnership Agreement, and subject to the written approval of the Director of the Office of Management and Budget, the head of each participating Federal agency may transfer Federal discretionary funds that are being used in the Pilot to an account of the lead Federal administering agency that includes Federal discretionary funds that are being used in the Pilot. Subject to the waiver authority under subsection (f), such transferred funds shall remain available for the same purposes for which such funds were originally appropriated: *Provided*, That such transferred funds shall remain available for obligation by the Federal Government until the expiration of the period of availability for those Federal discretionary funds (which are being used in the Pilot) that have the longest period of availability, except that any such transferred funds shall not remain available beyond September 30, 2018.

(g) WAIVER AUTHORITY.—In connection with a Federal agency's participation in a Performance Partnership Pilot, and subject to the other provisions of this section (including subsection (e)), the head of the Federal agency to which the Federal discretionary funds were appropriated may waive (in whole or in part) the application, solely to such discretionary funds that are being used in the Pilot, of any statutory, regulatory, or administrative requirement that such agency head—
    (1) is otherwise authorized to waive (in accordance with the terms and conditions of such other authority), and
    (2) is not otherwise authorized to waive, provided that in such case the agency head shall—

(A) not waive any requirement related to nondiscrimination, wage and labor standards, or allocation of funds to State and substate levels;

(B) issue a written determination, prior to granting the waiver, with respect to such discretionary funds that the granting of such waiver for purposes of the Pilot—

(h) is consistent with both—

(I) the statutory purposes of the Federal program for which such discretionary funds were appropriated, and

(II) the other provisions of this section, including the written determination by the agency head issued under subsection (d);

(ii) is necessary to achieve the outcomes of the Pilot as specified in the Performance Partnership Agreement, and is no broader in scope than is necessary to achieve such outcomes; and

(iii) will result in either—

(I) realizing efficiencies by simplifying reporting burdens or reducing administrative barriers with respect to such discretionary funds, or

(II) increasing the ability of individuals to obtain access to services that are provided by such discretionary funds; and

(B) provide at least 60 days advance written notice to the Committees on Appropriations and other committees of jurisdiction in the House of Representatives and the Senate.]

SEC. 523. (*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 Appropriations Act, 2014, except that in carrying out such Pilots section 526 shall be applied by substituting "FISCAL YEAR 2015" for "FISCAL YEAR 2014" in the title for subsection (b) and by substituting "September 30, 2019" for "September 30, 2018" each time 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.*

[SEC. 527. 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. **[**528**]***524*.

(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.

(Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2014.)