DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year
2014

General Departmental Management
Office of Medicare Hearings and Appeals
Office for Civil Rights
National Coordinator for Health Information Technology
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 2014	
	FTE	**Budget Authority**
General Departmental Management	1,361	301,435,000
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	119,841,000
HCFAC[1]	0	8,888,000
GDM Program Level	***1,523***	***559,954,000***
Office of Medicare Hearings and Appeals	514	82,381,000
Office of Civil Rights	233	42,205,000
Office of the National Coordinator for Health IT	191	77,883,000
Service and Supply Fund	*1,262*	0
TOTAL, Departmental Management	**3,723**	**762,423,000**

[1] The reimbursable program (HCFAC) in the General Departmental Management reflects the actual distribution of the allocation amount for FY 2012. For comparability, the FY 2013 Program Level shown here assumes the FY 2012 funding level for HCFAC.

INTRODUCTION

The FY 2014 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 2014 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 2014 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2014 Annual Performance Report and FY 2014 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 $762 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 the National Coordinator for Health IT, to help create a nationwide health information technology infrastructure.

The request also includes grant funding for state and local governments, community organizations and local providers to support minority health and women's health efforts, teen pregnancy prevention and assistance activities and minority HIV/AIDS programs from alternate sources of funding.

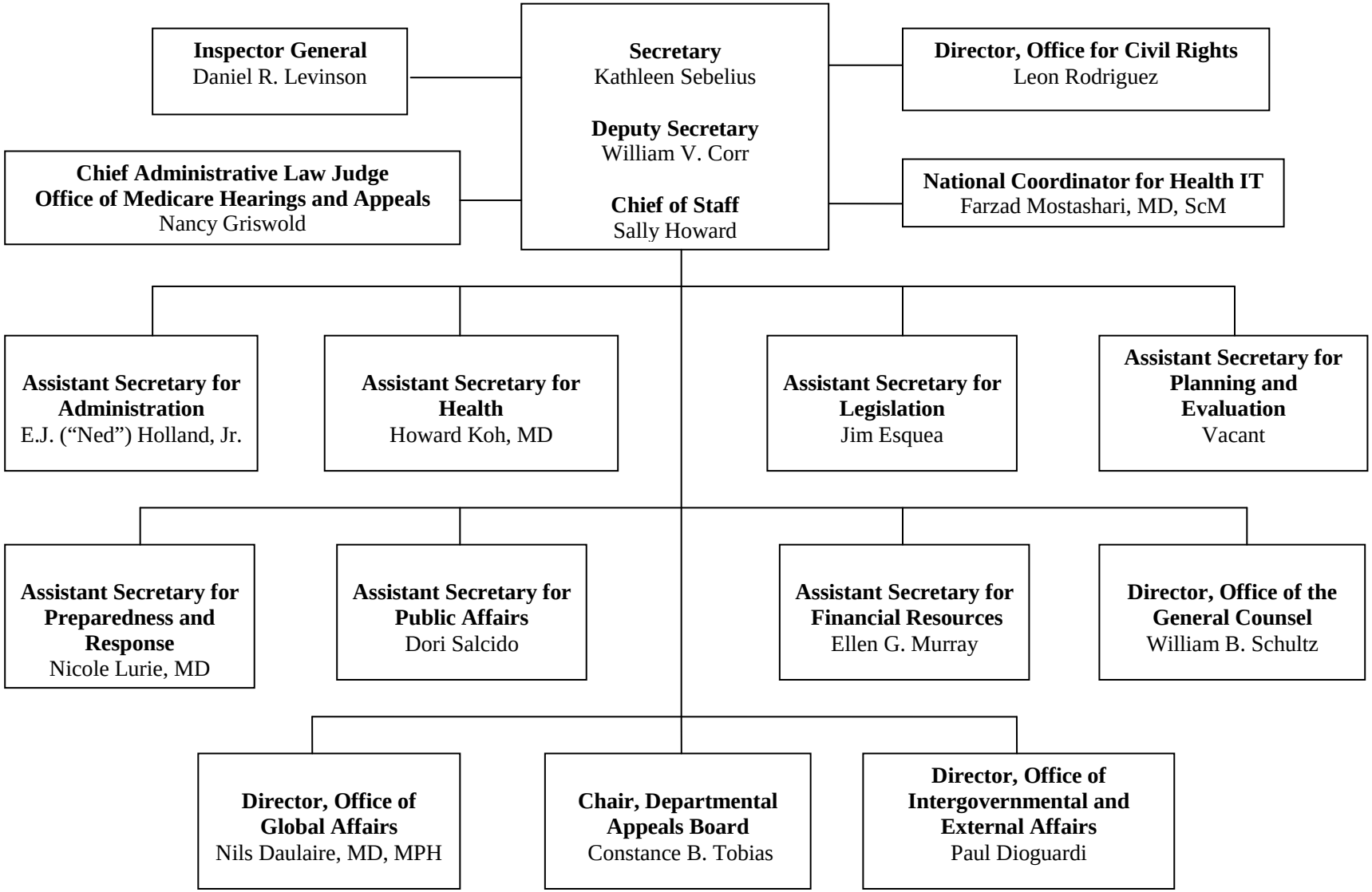
The Secretary looks forward to working with the Congress toward the enactment and implementation of an FY 2014 Budget that advances the Nation's health and supports families.

Ellen G. Murray
Assistant Secretary for Financial Resources

Departmental Management Overview

TABLE OF CONTENTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY



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 2014 program level budget for DM totals $762,423,000 in appropriated budget authority including 3,723 full-time equivalent (FTE) positions. The FY 2014 request is $19,103,000 less than the FY 2012 Enacted Level.

Please see the DM Budget by Appropriation table on the following pages.

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 Affairs; General Counsel; Global Affairs; and Assistant Secretary for Health. For FY 2014, the GDM Budget includes a total of $301,435,000 in budget authority and 1,523 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 FY2014, OMHA is requesting a total of $82,381,000 and 514 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 FY2014, OCR is requesting a total of $42,205,000 in budget authority and 233 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 2014, ONC requests $77,882,675 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 2014, the SSF is projecting total revenue of $1,102,861 and usage of 1,262 FTE.

DEPARTMENTAL MANAGEMENT

BUDGET BY APPROPRIATION
(Dollars in thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
General Departmental Management	$474,253	$477,225	$301,435
Pregnancy Assistance Fund……	$25,000	$25,000	$25,000
Prevention & Public Health Fund[2]……	$30,000	N/A	$104,790
PHS Evaluation Funds …….	$69,211	$69,635	$119,841
HCFAC Funds[3]…….……	$8,888	$8,888	$8,888
**Subtotal, GDM Program Level..... **	**$607,352**	**$580,748**	**$559,954**
Office of Medicare Hearings and Appeals	$72,011	$72,451	$82,381
Office of Civil Rights.....	$40,938	$41,189	$42,205
Office of the National Coordinator for Health Information Technology	$61,225	$61,600	$77,883
Service and Supply Fund	$0	$0	$0
[Trust Fund transfers included above, GDM + OMHA]	[$72,011]	[$72,451]	[$82,381]
**TOTAL, Departmental Management..... **	**781,526**	**755,988**	**762,423**

[2] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

[3] The reimbursable program (HCFAC) in the General Departmental Management reflects the actual distribution of the allocation amount for FY 2013. For comparability, the FY 2014 Program Level shown here assumes the FY 2013 funding level for HCFAC.

General Departmental Management

TABLE OF CONTENTS

APPROPRIATIONS LANGUAGE

GENERAL DEPARTMENTAL MANAGEMENT

For necessary expenses, not otherwise provided, for general departmental management, including hire of passenger motor vehicles, and for carrying out titles *II*, III, XVII, and XXI of the PHS Act, the United States-Mexico Border Health Commission Act, and research studies under section 1110 of the Social Security Act, **[$305,054,000]** *$301,435,000*, together with **[$116,841,000]** *$119,841,000* 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 the funds made available under this heading, **[$3,500,000]** *$1,750,000* is for strengthening the Department's acquisition workforce capacity and capabilities: Provided further, That with respect to the previous proviso, such funds shall be available for training, recruitment, retention and hiring members of the acquisition workforce as defined by **[the Office of Federal Procurement Policy Act, as amended (41 U.S.C. 401 et seq.)]** *41 U.S.C. 1703*: Provided further, That, with respect to the second proviso, such funds shall be available for information technology in support of acquisition workforce effectiveness or for management solutions to improve acquisition management: Provided further, That of the amounts provided under this heading from amounts available under section 241 of the PHS Act, no less than $4,232,000 shall be available to carry out evaluations (including longitudinal evaluations) of teenage pregnancy prevention approaches, and $53,891,000 shall be for minority AIDS prevention and treatment activities. Note.--A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

LANGUAGE ANALYSIS

Language Provision	Explanation
"$53,891,100 shall be available for minority AIDS and treatment activities."	HHS shall make amounts available for this activity under section 241 of the PHS Act in FY2014.
"For necessary expenses, not otherwise provided, for general departmental management, including hire of passenger motor vehicles, and for carrying out titles *II*, III, XVII, and XXI …"	Section 229 of Title II of the PHS Act establishes an Office on Women's Health in the Office of the Secretary (Section 3509 of the Patient Protection and Affordable Care Act, Public Law 111-148).
Provided further, That with respect to the previous proviso, such funds shall be available for training, recruitment, retention and hiring members of the acquisition workforce as defined by **[**the Office of Federal Procurement Policy Act, as amended(41 U.S.C. 401 et seq.)**]** *41 U.S.C. 1703*:	To further document the reason for the funds request.

AUTHORIZING LEGISLATION

(Dollars in Thousands)

	2013 Authorized	2013 CR	2014 Authorized	2014 President's Budget
General Departmental Management:				
except accounts below:				
Reorganization Plan No. 1 of 1953	Indefinite	$242,966	Indefinite	$190,656
Office of the Assistant Secretary for Health:				
Public Health Service Act,				
Title III, Section 301	Indefinite	$129,033	Indefinite	$28,961
Title II, Section 229 (OWH)	1	$33,888	1	$26,808
Title XVII, Section 1701 (ODPHP)	2	$7,230	2	$7,200
Title XVII, Section 1707 (OMH)	3	$56,124	3	$40,560
Title XVII, Section 1708 (OAH)	4	$1,105	4	$1,000
Title XXI, Section 2101 (NVPO)	5	$6,879	5	$6,250
Subtotal		$234,259		$110,779
Total appropriation		$477,225		$301,435
Grand Total appropriation		$477,225		$301,435

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 Section 1707 of the PHS Act expires September 30, 2016.

4) Authorizing legislation under Section 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.

BUDGET BY APPROPRIATION
(Dollars in thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
General Departmental Management	$474,253	$477,225	$301,435
Pregnancy Assistance Fund……	$25,000	$25,000	$25,000
Prevention & Public Health Fund[4]……	$30,000	N/A	$104,790
PHS Evaluation Funds …….	$69,211	$69,635	$119,841
HCFAC Funds[5]……..……	$8,888	$8,888	$8,888
**Total, Program Level.....	**$607,352**	**$580,678**	**$559,954**

[4] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.
[5] The reimbursable program (HCFAC) in the General Departmental Management reflects the actual distribution of the allocation amount for FY 2013. For comparability, the FY 2014 Program Level shown here assumes the FY 2013 funding level for HCFAC.

AMOUNTS AVAILABLE FOR OBLIGATION

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
General funds:			
Annual appropriation	$475,221,000	$477,225,000	$301,435,000
Rescission	-$898,000	$0	$0
Transfers:			
Ryan White - ADAP Transfer	-$70,000	$0	$0
Subtotal, adjusted general funds	$474,253,000	$477,225,000	$301,435,000
Trust funds:			
Annual appropriation	$0	$0	$0
Subtotal, adjusted budget authority	$474,253,000	$477,225,000	$301,435,000
Unobligated balance lapsing	$0	$0	$0
Total Obligations	**$474,253,000**	**$477,225,000**	**$301,435,000**

FY 2014 General Departmental Management Summary of Changes (Dollars in Thousands)		
	Dollars	**FTE's**
FY 2012 Actual	$474,253	1,083
Total Adjusted Budget Authority	**$474,253**	1,083
FY 2014 Current Request	$301,435	1,072
Total Estimated Budget Authority	**$301,435**	1,072
Net Change	**$172,818**	**(11)**
	FY 2012 Actual	**Change from Base**
	FTE	**FTE**
Program Increases		
ASFR - Acquisition Reform	$700	$1,050
OGC	$40,274	$2,826
Shared Services	$16,062	$6,961
Other Direct Funding Increases	$74,316	$3,084
Immediate Office of the ASH	$12,476	$5,624
President's Council Fitness, Sports, and Nutrition	$1,248	$1,002
OASH - Other Direct Funding Increases	$8,684	$16
Total Increases	**$153,760.00**	**$20,563**
Decreases		
Other Direct Funding Decreases	$48,302	-$2,750
Office on Disability	$1,267	-$1,267
OASH Non-PPAs	$16,369	-$2,008
Teen Pregnancy Prevention	$104,592	-$104,592
Minority Health	$55,782	-$15,222
Women's Health	$33,682	-$6,874
Embryo Adoption Awareness Campaign	$1,996	-$1,996
Abstinence Education	$4,991	-$4,991
Minority HIV/AIDS	$53,681	-$53,681
Total Decreases	**$320,662**	**-$193,381**
Built-in		
Inflation factors		**$1,425**
Total Built-in		**$1,425**
Absorption of Current Services		-$1,425
Total Increases	$153,760	$21,988
Total Decreases	$320,493	-$194,806
Net Change	1,083 **$474,253**	(11) **-$172,818**

BUDGET AUTHORITY BY ACTIVITY - DIRECT

(Dollars in Thousands)

	FY 2012 Actual		FY 2013 CR		FY 2014 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
Immediate Office of the Secretary	72	$11,289	72	$11,358	72	$11,300
Secretarial Initiatives and Innovations	-	$2,738	-	$2,824	-	$2,000
Assistant Secretary for Administration	116	$19,463	116	$19,582	116	$18,500
Assistant Secretary for Financial Resources	152	$29,590	149	$29,771	149	$29,700
Acquisition Reform	-	$700	1	$704	1	$1,750
Assistant Secretary for Legislation	27	$3,893	27	$3,916	26	$4,300
Assistant Secretary for Public Affairs	54	$8,983	56	$9,038	56	$9,800
Office of General Counsel	238	$40,274	238	$40,520	236	$43,100
Departmental Appeals Board	75	$10,730	80	$10,795	80	$11,700
Office on Disability	-	$1,098	-	$1,105	-	-
Office of Global Affairs	24	$6,438	24	$6,477	24	$6,400
Office of Intergovernmental and External Affairs	60	$9,831	60	$9,892	60	$10,600
Office of the Assistant Secretary for Health	268	$232,833	268	$234,259	252	$110,779
Embryo Adoption Awareness Campaign	-	$1,996	-	$2,008	-	-
HIV-AIDS in Minority Communities	-	$53,681	-	$54,010	-	-
Shared Operating Expenses	-	$16,062	-	$16,162	-	$23,023
Rent, Operations, Maintenance and Related Services	-	$18,665	-	$18,779	-	$18,483
Abstinence Education	-	$4,991	-	$5,021	-	-
Transportation Assistance	-	$998	-	$1,004	-	-
Total, Budget Authority	**1,086**	**474,253**	**1,091**	**477,225**	**1,072**	**301,435**

BUDGET AUTHORITY by OBJECT CLASS - DIRECT
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	92,222	92,861	92,440
Other than full-time permanent (11.3)	11,873	11,947	11,680
Other personnel compensation (11.5)	3,045	3,063	2,959
Military personnel (11.7)	3,525	3,546	3,761
Subtotal, Personnel compensation	**110,665**	**111,417**	**110,840**
Civilian personnel benefits (12.1)	28,447	28,642	27,619
Military benefits (12.2)	1,651	1,661	1,711
Benefits for former personnel (13.0)	0	0	0
Total Pay Costs	**140,763**	**141,720**	**140,170**
Travel and transportation of persons (21.0)	4,839	4,868	3,977
Transportation of things (22.0)	185	186	179
Rental payments to GSA (23.1)	17,624	17,732	19,493
Communications, utilities, and miscellaneous charges (23.3)	3,616	3,638	3,204
Printing and reproduction (24.0)	853	858	568
Other Contractual Services:			
Advisory and assistance services (25.1)	29,188	29,981	21,170
Other services from non-Federal sources (25.2)	39,390	39,719	30,845
Other goods and services from Federal sources (25.3)	75,129	75,678	48,234
Operation and maintenance of facilities (25.4)	6,750	6,791	5,226
Research and development contracts (25.5)	0	0	0
Medical care (25.6)	0	0	0
Operation and maintenance of equipment (25.7)	4,154	4,179	3,972
Subsistence and support of persons (25.8)	106	107	5
Subtotal, Other Contractual Services	**154,717**	**156,385**	**109,452**
Supplies and materials (26.0)	1,450	1,459	1,225
Equipment (31.0)	447	450	799
Land and Structures (32.0)	0	0	0
Grants, subsidies, and contributions (41.0)	149,755	149,855	22,366
Refunds (44.0)	0	0	0
Insurance claims and indemnities (42.0)	4	4	2
Total Non-Pay Costs	**333,490**	**335,505**	**161,265**
Total Budget Authority by Object Class	**474,253**	**477,225**	**301,435**

BUDGET AUTHORITY by OBJECT CLASS - REIMBURSABLE

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	50,925	44,981	45,720
Other than full-time permanent (11.3)	3,590	3,601	3,635
Other personnel compensation (11.5)	1,083	1,021	1,085
Military personnel (11.7)	1,722	1,739	1,760
Subtotal, Personnel compensation	**57,320**	**51,342**	**52,200**
Civilian personnel benefits (12.1)	10,570	9,740	9,903
Military benefits (12.2)	822	808	816
Benefits for former personnel (13.0)	0	0	0
Subtotal Pay Costs	**68,712**	**61,890**	**62,919**
Travel and transportation of persons (21.0)	1,382	1,391	1,913
Transportation of things (22.0)	89	89	92
Rental payments to GSA (23.1)	4,208	4,212	4,282
Communications, utilities, and miscellaneous charges (23.3)	154	146	149
Printing and reproduction (24.0)	56	68	69
Other Contractual Services:			
Advisory and assistance services (25.1)	40,407	40,971	45,476
Other services from non-Federal sources (25.2)	15,622	17,582	19,809
Other goods and services from Federal sources (25.3)	43,640	43,384	72,774
Operation and maintenance of facilities (25.4)	843	851	851
Research and development contracts (25.5)	776	776	636
Medical care (25.6)	5	5	5
Operation and maintenance of equipment (25.7)	1,049	2,879	3,145
Subsistence and support of persons (25.8)	0	0	0
Subtotal, Other Contractual Services	**102,342**	**106,448**	**142,696**
Supplies and materials (26.0)	1,007	1,247	1,249
Equipment (31.0)	1,142	1,165	1,162
Land and Structures (32.0)	18	53	54
Grants, subsidies, and contributions (41.0)	2,835	2,837	16,383
Refunds (44.0)	0	0	0
Insurance claims and indemnities (42.0)	0	0	0
Subtotal Non-Pay Costs	**113,233**	**117,656**	**168,049**
Total Budget Authority by Object Class	**181,945**	**179,546**	**230,968**

SALARIES AND EXPENSES

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	92,222	92,861	92,440
Other than full-time permanent (11.3)	11,873	11,947	11,680
Other personnel compensation (11.5)	3,045	3,063	2,959
Military personnel (11.7)	3,525	3,546	3,761
Subtotal, Personnel compensation	**110,665**	**111,417**	**110,840**
Civilian personnel benefits (12.1)	28,447	28,642	27,619
Military benefits (12.2)	1,651	1,661	1,711
Total Pay Costs	**140,763**	**141,720**	**140,170**
Travel and transportation of persons (21.0)	4,839	4,868	3,977
Transportation of things (22.0)	185	186	179
Communications, utilities, and miscellaneous charges (23.3)	3,616	3,638	3,204
Printing and reproduction (24.0)	853	858	568
Other Contractual Services:			
Advisory and assistance services (25.1)	29,188	29,981	21,170
Other services from non-Federal sources (25.2)	39,390	39,719	30,845
Other goods and services from Federal sources (25.3)	75,129	75,608	48,234
Operation and maintenance of facilities (25.4)	6,750	6,791	5,226
Medical care (25.6)	0	0	0
Operation and maintenance of equipment (25.7)	4,154	4,179	3,972
Subsistence and support of persons (25.8)	106	107	5
Subtotal, Other Contractual Services	**154,717**	**156,385**	**109,452**
Supplies and materials (26.0)	1,450	1,459	1,225
Insurance claims and indemnities (42.0)	4	4	2
Total Salaries and Expenses	**306,427**	**309,118**	**258,777**

APPROPRIATION HISTORY				
	Budget Estimates to Congress	**House Allowance**	**Senate Allowance**	**Appropriations**
2004				
Appropriation	348,100,000	343,284,000	344,808,000	357,358,000
Rescission	0	0	0	-3,209,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
2005				
Appropriation	431,971,000	349,297,000	376,704,000	349,118,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
2006				
Appropriation	353,325,000	338,695,000	353,614,000	352,703,000
Rescission	0	0	0	-3,585,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
2007				
Appropriation	362,568,000	0	0	350,945,000
Rescission	0	0	0	-500,000
Supplemental	13,512,000	0	0	0
Trust Funds	5,851,000	0	0	5,793,000
2008				
Appropriation	386,705,000	342,224,000	386,053,000	355,518,000
Rescission	0	0	0	-6,312,000
Transfers	0	0	0	-983,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,792,000
2009				
Appropriation	374,013,000	361,825,000	361,764,000	391,496,000
Transfers	0	-1,000,000	-1,000,000	-2,571,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
2010				
Appropriation	403,698,000	397,601,000	477,928,000	493,377,000
Transfers	0	-1,000,000	-1,000,000	-1,074,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
2011				
Appropriation	490,439,000	651,786,000	0	651,786,000
Rescission	0	-1,315,000	0	-1,316,000
Transfers	0	-176,551,000	0	-176,551,000
Trust Funds	0	5,851,000	0	5,851,000
2012				
Appropriation	363,644,000	343,280,000	476,221,000	475,221,000
Rescission	0	0	0	-898,000
Transfers	0	0	0	-70,000
2013				
Appropriation	306,320,000	0	466,428,000	0

General Departmental Management
All Purpose Table

Dollars in Thousands

GDM Base Level Program		FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
GDM	BA	474,253	477,225	301,435	-172,818
	FTE	1,086	1,091	1,072	-14
Related Funding (non-add)					
Pregnancy Assistance Fund P.L. (111-148)	PL	*25,000*	*25,000*	*25,000*	*0*
Prevention and Public Health Fund P.L. (111-148) (GDM Allocation [1])[6]	PL	*30,000*	*N/A*	*104,790*	*74,790*
PHS Evaluation Set-Aside – Public Health Service Act	PL	*69,211*	*69,635*	*119,841*	*50,630*
HCFAC[7]	PL	*8,888*	*8,888*	*8,888*	*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 the operating and staff divisions (OPDIVs/STAFFDIVs) of HHS, and ensuring the health and well-being of Americans.

The FY 2014 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 current FY 2010-2015 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, and performance tables that provide performance data for the following GDM components: ASA, DAB, IOS, and OASH.

[6] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.
[7] The reimbursable program (HCFAC) in the General Departmental Management reflects the actual distribution of the allocation amount for FY 2013. For comparability, the FY 2014 Program Level shown here assumes the FY 2013 funding level for HCFAC.

FY 2014 Budget by HHS Strategic Goal
(Dollars in Millions)

HHS Strategic Goals	FY 2012 Actual	FY 2013 CR	FY 2014 PB
1.Strengthen Health Care	**219.9**	**219.9**	**193.5**
1.A Make coverage more secure	2.5	2.5	2.5
1.B Improve health care quality and patient safety	75.6	75.6	65.5
1.C Emphasize primary & preventative care, link to prevention	4.0	4.0	3.0
1.D Reduce growth of health care costs promoting high-value	5.4	5.4	4.2
1.E Ensure access to quality culturally competent care	71.6	71.6	63.8
1.F Promote the adoption of health information technology	60.8	60.8	54.5
2. Advance Scientific Knowledge and Innovation	**18.0**	**18.0**	**15.3**
2.A Accelerate scientific discovery to improve patient care	8.0	8.0	7.3
2.B Foster innovation at HHS to create shared solutions	3.0	3.0	2.5
2.C Invest in sciences to improve food & medical product safety	3.0	3.0	2.5
2.D Increase understanding of what works in health & services	4.0	4.0	3.0
3. Advance the Health, Safety and Well-Being of the American People	**290.4**	**290.4**	**276.9**
3.A Ensure the children & youth safety, well-being & health	117.6	117.6	116.5
3.B Promote economic & social well-being	17.2	17.2	15.9
3.C Improve services for people with disabilities and elderly	3.5	3.5	3.0
3.D Promote prevention and wellness	73.2	73.2	66.1
3.E Reduce the occurrence of infectious diseases	65.4	65.4	63.4
3.F Protect Americans' health and safety during emergencies,	13.5	13.5	12.0
4. Increase Efficiency, Transparency and Accountability of HHS Programs	**36.2**	**36.2**	**35.0**
4.A Ensure program integrity and responsible stewardship	17.2	17.2	16.5
4.B Fight fraud and work to eliminate improper payments	6.8	6.8	6.8
4.C Use HHS data to improve American health & well-being	7.0	7.0	6.5
4.D Improve HHS environmental performance for sustainability	5.2	5.2	5.2
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce	**42.8**	**40.5**	**39.2**
5.A Invest in HHS workforce to meet needs today & tomorrow	18.3	18.3	16.7
5. B Ensure health care workforce meets increased demands.	7.0	7.0	6.3
5.C Enhance ability of the public health workforce to improve health	8.0	8.0	7.5
5.D Strengthen the Nation's human service workforce	8.0	8.0	7.5
5.E Improve national, State & local surveillance capacity	1.5	1.5	1.2
TOTAL GDM Program Level	**607.3**	**607.3**	**559.9**

Overview of Budget Request

The FY 2014 request for General Departmental Management (GDM) includes $301,435,000 in appropriated funds and 1,523 full-time equivalent (FTE) positions. This request is $172,818,000 less than the FY 2012 Enacted Level. Significant reductions to GDM include the following:

- Abstinence Education: (-$4,991,000) Funding for Abstinence Education was appropriated in 2012, but not requested by HHS. HHS is not requesting continuation of funds for this program in FY 2014.
- Embryo Adoption: (-$1,996,000) HHS is not requesting funds for this program for FY 2014. HHS' decision to discontinue funding for this program is a reflection of limited interest in the program as evidenced by awarded grants.
- Minority HIV AIDS: (-$53,681,000) The funding for Minority AIDS initiative (MAI) moved in FY 2014 from General Departmental Management Account to Public Health Service (PHS) Evaluation Fund.
- Teen Pregnancy Prevention: (-$104,592,000) TPP has been funded in GDM historically; in FY 2014 the funding source will change to the Prevention and Public Health Fund of the Patient Protection and Affordable Care Act of 2010.

The GDM appropriation supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department.

In FY 2012 HHS took steps to implement Health Reform and other ongoing public health initiatives through eliminating and reallocating resources and support new and focused strategic partnerships to provide national health leadership. The FY 2014 President's Budget is an extension of the FY 2012 activities.

This justification includes narrative sections describing the activities of each STAFFDIV funded under the GDM account, including the Rent and Common Expenses accounts. (Resource tables reflect only funding provided from the GDM appropriation. FTE figures include full-time, part-time, and temporary employees.) This justification also includes selected performance information.

The FY 2014 Budget for GDM reflects the following significant changes from the FY 2012 Enacted Level.

Acquisition Reform (+$1,050,000) – The requested resources will be used to implement HHS' Acquisition Workforce Development Strategic Plan.

Shared Operating Expenses (+$6,960,000) – This increase is supported by reallocating funds from other programs within the GDM account for the purpose of consolidating shared services in one account.

Office of General Counsel (+$2,826,000) – This funding increase will sustain OGC's FY 2014 operations and continue to enable OGC to provide extensive legal advice to the Department as well as review all rules and guidance related to all provisions of the ACA.

Office of the Assistant Secretary for Health (-$17,463,000) – Decreases to the Office of Minority Health (decrease of $15,222,000), and Office of Women's Health (decrease of $6,874,000) budgets will support continuation of grant programs. An increase of $5,624,000 to the Immediate Office continues the ASH's responsibility as the senior advisor to the Secretary on public health science, by addressing several highly visible public health needs.

IMMEDIATE OFFICE OF THE SECRETARY

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	11,289	11,358	11,300	11
FTE	72	72	72	0

Authorizing Legislation:
FY 2014 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.

Narrative by Activity:

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.

IOS is responsible for Departmental direction for strengthening program integrity by reducing waste, fraud, and abuse and by holding programs accountable.

Funding History

FY 2009	$11,073,000
FY 2010	$10,925,000
FY 2011	$11,108,000
FY 2012	$11,289,000
FY 2013	$11,358,000

Budget Request

IOS' FY 2014 request is $11,300,000, an increase of $11,000 above the FY 2012 Enacted Level. 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, and Workforce Development Strategic Goals. Personnel costs account for 81% of the IOS budget with the remaining 19% allocated for other mission critical operating expenses.

IOS OUTPUTS AND OUTCOMES TABLE

Program/Measure	Most Recent Result	FY 2013 Target	FY 2014 Target	FY 2014 +/- FY 2013
1.1 Increase number of identified opportunities for public engagement and collaboration among agencies (Output)	FY 2011: 334 Target:317 (Target Exceeded)	346	335	-11
1.2 Increase number of high-value data sets and tools that are published by HHS (Output)	FY 2011: 282 Target:122 (Target Exceeded)	288	287	-1
1.3 Increase the number of participation and collaboration tools and activities conducted by the participation and collaboration community of practice (Output)	FY 2011: 8 Target:8 (Target Met)	12	14	+2

Performance Analysis

1.1 In FY 2012, the Department slightly exceeded its target. HHS projected 340 engagement opportunities and identified 343 opportunities in 2012. Based on public comments received through the HHS blog on the HHS Open Government website it appears that HHS's efforts are increasing visibility of participation and collaboration opportunities. Moreover, HHS is continuing to attract new solvers to our challenge, competitions, which provides important mechanisms through which external stakeholders can participate in the co-creation of solutions. During FY 2012, the HHS Innovation Council actively worked with HHS challenge managers across the Department to develop and expand their challenge competition capabilities. In FY2013, we hope to hire a Director of Open Government Challenges and Competitions. This role would be dedicated specifically to working with the HHS operating and staff divisions to further develop challenge competition capabilities as a core competency.

1.2 In FY 2012, HHS published 84 additional datasets bringing the total number of datasets to 366. These results, which exceeded initial projections, were the result of the high quality datasets developed and maintained by HHS agencies; and of HHS Data Council and HHS Chief Technology Officer's (CTO) outreach efforts to the HHS community and review of potential submissions. Moving forward, under the guidance of the CTO, HHS will focus increasingly on data education and stakeholder engagement with the data. In 2012, we began experimenting with new ways of educating our data communities on the content of HHS data through codeathons and on-line chat sessions. We expect to do more of this type of data education and engagement moving forward, and this should result in additional use of our datasets by external stakeholders.

1.3 In FY 2012, all targets were met. Each of the projects is labor-intensive, and thus only a few projects are selected in each year. The ten projects undertaken by the HHS Innovations Staff and its consulting team (in collaboration with relevant HHS operating and staff divisions) were: 1) Identifying a new webcasting resource (the Homeland Security Information Network) that is available to all federal advisory committees (FAC) at no charge and making this resource known to all of the HHS FACs; 2) deploying Yammer, a web-based collaboration tool, across HHS and making it available to all HHS employees for purposes of professional collaboration; 3) launched two additional rounds of the HHS innovates competition to recognize and share promising new approaches developed by HHS employees and as part of this effort included a People's Choice award to engage the public in selecting the best innovations; 4) launched a robust communications effort on the HHS innovation and open government portfolio including a new HHS CTO newsletter called Innovation Update; 5) launched the HHS Innovations Fellow Program in which we on-boarded a group of external entrepreneurs to work with internal HHS innovators on high profile projects; 6) led the development and successful execution of third annual HHS datapalooza, which attracted over 1600 participants, the highest number ever; 7) developed a system whereby the various HHS sharepoint systems that collect data on FAC activities could communicate directly with the HHS Office of the White House Liaison; 8) implemented and utilized a wiki as a new collaborative tool to interact with our stakeholders in the building of Blue Button tool to access HHS health data; 9) revised the HHS social media policy so that use of social media tools is the default, as opposed to the exception; and 10) in partnership with the West Health Institute launched an Innovator in Residence Program to lower the cost and improve the quality of health care. This program acts as a bridge to the entrepreneurial community to further the development of new health care-related applications and services.

SECRETARIAL INITIATIVES AND INNOVATIONS

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	2,738	2,824	2,000	-738
FTE	0	0	0	0

Authorizing Legislation:
FY 2014 Authorization: ……....Indefinite
Allocation method: ……..Direct Federal; Contracts

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.

In FY 2012, several initiatives were addressed that assisted the Secretary in several initiatives protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The Secretary utilized these funds to support data collection related to LGBT health issues; the Elder Justice Coordinating Council, the child welfare study and medical malpractice reform.

Funding History

FY 2009	$0
FY 2010	$1,600,000
FY 2011	$1,600,000
FY 2012	$2,738,000
FY 2013	$2,824,000

Budget Request

The FY 2014 Budget for Secretarial Initiatives and Innovation is $2,000,000, a $738,000 reduction below the FY 12 Enacted Level. The Budget 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

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	19,463	19,582	18,500	-963
FTE	116	116	116	0

Authorizing Legislation:
FY 2014 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 its components: the Immediate Office, Office of Human Resources, Office of Facilities Management and Policy, Office of the Chief Information Officer, Office of Business Management and Transformation and the Program Support Center (which is funded through other sources and not included in this request).

ASA provides Department-wide leadership and direction in leasing and facilities planning and execution, including sustainability (environmental and energy management). ASA is responsible for the HHS Real Property Asset Management program and provides management oversight across HHS to ensure appropriate stewardship and accountability is maintained. ASA also provides technical assistance to HHS OPDIVs in evaluating the effectiveness of their facilities programs and policies, and fosters creativity and innovation in the administration of these functions.

Office of Human Resources (OHR)
OHR provides leadership in planning and developing of personnel policies and human resource programs that support and enhance the Department's mission. OHR also provides technical assistance to HHS Operating Divisions (OPDIVs) to accomplish the OPDIV's mission through improved planning and recruitment of human resources and serves as the Departmental liaison to OPDIV's 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 policy development, oversight, complaint prevention, investigations, outreach, commemorative events, and standardized education and training programs. OHR also provides resource management and equal opportunity service functions for the Department. To accomplish its mission, OHR provides functional oversight and works in collaboration with the Equal Employment Opportunity offices that service each of the Department's OPDIVs. OHR also conducts Department-wide program analysis to determine barriers to diversity and inclusion.

Office of the Chief Information Officer (OCIO)
OCIO advises the Secretary and the ASA 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; performance measurement; strategic development and application of information systems and infrastructure in compliance with the Clinger-Cohen Act. OCIO leads the HHS Records Management

team and provides HHS employee training, policy, processes, and validation of file plans for 11 HHS OPDIVs including 16 Office of the Secretary Staff Divisions. OCIO coordinates activities throughout HHS to implement requirements under the Paperwork Reduction Act (PRA) and Computer Matching and Privacy Protection Act of 1988. OCIO promulgates HHS IT policies supporting enterprise architecture, capital planning and project management, and security. OCIO leads the formulation of the HHS IT portfolio through the Office of IT Budget and Capital Planning, with an approximate annual expenditure of $7 billion: $4 billion in direct IT expenditures and $3 billion in IT grants to state and local entities.

In its leadership role, OCIO coordinates the implementation of IT policy with 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 HHS efforts to improve IT governance and make better use of IT resources, including the PortfolioStat process to annually review the Department's IT portfolio and the TechStat process to review underperforming IT investments. OCIO coordinates the HHS response to federal IT priorities including: data center consolidation; cloud computing; information management, sharing, and dissemination; and shared services. OCIO leads the HHS-wide program for managing telecommunications services under the Networx contract. 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 coordinates the development and evolution of IT domain governance across HHS. This governance change is designed to increase the responsiveness of the organization, better steward IT resources and identify shared service opportunities. 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 initiatives and coordinates the business mechanisms necessary to account for the performance of these initiatives and other objectives as deemed appropriate. OBMT also manages the budget and financial resources for the direct support of the ASA, and 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.

Funding History

FY 2009	$17,390,000
FY 2010	$18,976,000
FY 2011	$19,482,000
FY 2012	$19,463,000
FY 2013	$19,582,000

Budget Request

The Assistant Secretary for Administration's FY 2014 request is $18,500,000, a decrease of $963,000 below the FY 2012 Enacted level. A reduction of administrative functions as well as lowering contract costs will account for this decrease.

ASA OUTPUTS AND OUTCOMES TABLE

Program/Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
1.1 Increase the percent employees on telework or AWS (Output)	FY 2012: 22.0% Target: 14.0% (Target Exceeded)	14.0%	18.0%	+4
1.2 Reduce HHS fleet emissions (Output)	FY 2012: 12,883 MTCO2e Target: 12,708 MTCO2e (Target Not Met)	12,708 MTCO2e	12,205 MTCO2e	-503
1.3 Ensure Power Management is enabled in 100% of HHS computers, laptops and monitors (Output)	FY 2012: 94.0% Target: 100.0% (Target Not Met but Improved)	100.0%	100.0%	Maintain
2.1 Reduce the average number of days to hire (Output)	FY 2012: 65 Average Number of Days Target: 61 Average Number of Days (Target Not Met)	61 Average Number of Days	60 Average Number of Days	-1

Performance Analysis

1.1 Increasing the percentage of teleworking/alternative work schedule (AWS) employees reduces vehicle miles traveled, which in turn reduces emissions of green house gasses and other pollutants that are 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 supports the implementation of the HHS Strategic Sustainability Performance Plan (SSPP) prepared under Executive Order (EO) 13514. This particular measure tracks progress towards the target of 20% of employees using AWS and/or regularly scheduled telework to avoid commuting at least 4 days per pay period. Currently, information on telework is collected manually through HHS-wide data calls. Results for the first year exceeded the target by 1%. Subsequent years' targets have increased to meet the 2015 goal of 20% of employees reducing commute time through telework or Alternative Work Schedule.

1.2 HHS is committed to replacing gasoline-powered vehicles with alternative fuel vehicles (AFV) in accordance with GSA acquisition guidelines. As the fleet's petroleum consumption decreases, so will the amount of harmful carbon dioxide that the fleet releases into the atmosphere. Results are measured in Million Metric Tons of Carbon Dioxide equivalents, or MTCO2e, a standard measure of greenhouse gas emissions. HHS's measure is intended to reflect actual performance values when excluding all fuel products used by HHS law enforcement, protective, emergency response or military

tactical (if any). However, pursuant to Section 4 of the May 24, 2011 Presidential Memorandum "Federal Fleet Performance," the Secretary must formally exclude these law enforcement, protective, emergency response or tactical vehicles from the measure, and implementation of this exclusion has not yet occurred (but is expected). As a result, the FY2012 data currently include data from these to-be-excluded vehicles. When these vehicles are excluded, HHS should easily achieve its FY2012 goal.

1.3 Consistent application of power management strategies will decrease the amount of electricity used by HHS facilities while maintaining work quality. This effort supports the HHS strategic initiative to be a good steward of energy resources, reducing the negative environmental impacts that result from inefficient energy use. To support this effort, HHS IT contracts have been revised to include power-saving configuration requirements. HHS measures the percentage of eligible computers, laptops and monitors with power management, including power-saving protocols in the standard configuration for employee workstations. 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 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 requiring Agencies to streamline processes and decrease timelines. The Assistant Secretary for Administration's Office of Human Resources (OHR) has set aggressive Agency-wide goals that exceed the OPM federal hiring targets. Beginning in FY2012, 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 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 indicated that processing time had increased to 72 days (compared to 61 days during the previous quarter), as activities related to OHR's major transformation efforts in hiring were intensifying. In the final 2012 data call, the average days to hire dropped to 65 days, indicating positive movement towards the FY2015 target of 60 days.

ASSISTANT SECRETARY FOR FINANCIAL RESOURCES

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	29,590	29,771	29,700	110
FTE	152	149	149	-3

Authorizing Legislation:
FY 2014 Authorization……..……..……Indefinite
Allocation Method…….…....Direct Federal; Contracts

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 2012, in addition to meeting its responsibilities for the annual budget process, the OB successfully managed the major budget-related workload of the Affordable Care Act with the OPDIVs and STAFFDIVs to develop spend plans and begin implementing new activities and provisions. The OB also supported the annual performance budget and other program budget analysis and estimates that occurred throughout the year, and implemented new performance management requirements of the GPRA Modernization Act of 2010. Examples of documents produced in high quality and on-time include the FY 2012 HHS Summary of Performance and Financial Information, On-line Performance Appendix and Budget Justifications. The OB managed the quarterly review of progress towards HHS High Priority Performance Goals and other Departmental priorities.

In FY 2012, in compliance with the Federal Managers' Financial Integrity Act, OMB Circular A-123 "Management's Responsibility for Internal Control," the accomplishments include preparation of the annual plan and timelines; completion and submission of the annual risk assessment of the major transaction cycles, etc.

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. In addition, the OF provides Departmental leadership and support to the Secretary for the implementation of the new Program Integrity (PI) initiative, launched in May 2010.

The OF also has responsibility for overseeing HHS' progress in reducing improper payments (as required by the Improper Payments Information Act and the Improper Payments Elimination and Recovery Act). The error rates decreased between 2010 and 2011 for 5 of the 6 programs that reported error rates in both years, yielding an estimated $3.7 billion of reduced improper payments for those programs.

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). In FY 2012, CMS completed the planned deployment of HIGLAS to every Medicare provider.

The FY 2012 appropriation included funding to begin modernizing the Department's COTS software. This multi-year initiative will standardize financial management across HHS, modernize financial reporting to provide timely, reliable and accurate information about Department's finances and enhance, upgrade, secure and simplify financial systems environment. Also in FY 2012, HHS began implementing a new, integrated business intelligence solution to report the Department's finances by leveraging the consolidated financial statement reporting solution and using transactional data captured in the three financial systems.

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.

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. In FY 2012, HHS held its first Purchase Card, Strategic Sourcing and Sustainable "Green" Acquisition Symposium – providing HHS' GPC holders and contract specialists professional development and a venue for cross-agency collaboration. HHS also enhanced its suspension and debarment program by creating the Office of Recipient Integrity Coordination, dedicating staff toward this effort, and developing detailed policies and guidance and referral processes.

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. HHS exceeded its FY 2011 small business goal of 19.5% by awarding 22.5% of its contract dollars to small businesses.

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).

Funding History

FY 2009	$25,781,000
FY 2010	$26,131,000
FY 2011	$28,103,000
FY 2012	$29,590,000
FY 2013	$29,771,000

Budget Request

ASFR's FY 2014 request is $29,400,000, a decrease of $190,000 from the FY 2012 Enacted Level. This request will allow ASFR to maintain its responsibilities associated with: improving financial management and program integrity; improving budget and performance analysis and support; improving grants and acquisition policies and practices, and the transparency of grants and acquisition data; enhancing the budget, acquisition and grants workforce; and improving the use of program, performance, financial and other business data to inform business decisions.

Office of Budget (OB) – In FY 2014, the OB will continue to produce analyses, options, and recommendations on all HHS budget and related policy, and work with OMB and the Congress to accomplish HHS priorities. The request provides funding for staff to support OB functions, including responsibilities related to the Administration's priorities to employ rigorous standards of accountability and transparency throughout the Federal government. The FY 2014 request provides support for OS-wide compliance with the Federal Managers' Financial Integrity Act, OMB Circular A-123 "Management's Responsibility for Internal Control."

Office of Finance (OF) – The FY 2014 request supports the continued implementation of HHS' Program Integrity Initiative. The FY 2014 Budget supports the development of solutions to cross-cutting risks that can be leveraged across programs facing similar challenges and the continued development of an electronic system to manage risk assessment data. FY 2014 funding will enable HHS to build upon its program integrity success to help ensure programs are operating in an effective and efficient manner, spending HHS dollars in the manner for which they w ere intended.

In FY2014, the Office of Finance (OF) will continue to modernize Department wide financial systems (UFMS, HIGLAS and NBS). This effort will continue to receive $1 million first appropriated for this purpose in FY 2012. When completed, this multi-year modernization initiative will standardize financial management across HHS, modernize financial reporting to provide timely, reliable and accurate information about Department's finances and enhance, upgrade, secure and simplify financial systems environment.

Office of Grants and Acquisition Policy and Accountability (OGAPA) – In FY 2014, OGAPA will continue to ensure appropriate grant and acquisition related internal controls and performance measures; provide 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.

ACQUISITION REFORM

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	700	704	1,750	1,050
FTE	0	1	1	1

Authorizing Legislation:
FY 2014 Authorization……Indefinite
Allocation Method……Direct Federal; Contracts

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 FY2012 with its acquisition reform funds, HHS continued this 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

FY 2009	$0
FY 2010	$0
FY 2011	$700,000
FY 2012	$700,000
FY 2013	$704,000

Budget Request:

Acquisition Reform's FY 2014 request is $1,750,000, $1,050 more than the FY 2012 Enacted Level. The requested resources will be used to implement HHS' Acquisition Workforce Development Strategic Plan. FY 2014 funds will be used to build HHS' 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 and Information Technology acquisitions (e.g., recruit, hire, and retain HHS' acquisition workforce). These funds will provide centralized training to enhance the capabilities of the acquisition workforce and close competency gaps through developing or refining HHS' systems to project future acquisition workforce needs.

ASSISTANT SECRETARY FOR LEGISLATION

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	3,893	3,916	4,300	407
FTE	27	27	26	-1

Authorizing Legislation:
FY 2014 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 serves as 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 on Aging (AoA).

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 EconSys) 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

FY 2009	$3,430,000
FY 2010	$3,204,000
FY 2011	$3,423,000
FY 2012	$3,893,000
FY 2013	$3,916,000

Budget Request

The FY 2014 request for ASL is $4,300,000, an increase of $407,000 over the FY 2012 Enacted level. The Budget allows ASL to provide critical support to the legislative healthcare and human services agenda. The Budget will also allow ASL to continue to meet the demands of the increased activity and congressional inquiries.

In FY 2014, ASL will also support the President's commitment to strengthen the systems that protect our food and medical products supply, ongoing activities related to public health emergency preparedness, and other initiatives.

The request for ASL will support facilitating 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

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	8,983	9,038	9,800	817
FTE	54	56	56	2

Authorizing Legislation:
FY 2014 Authorization……Indefinite
Allocation Method……...…….……Direct Federal

Program Description and Accomplishments

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 communications plans in response to national public health emergencies.
- Providing public affairs council in the HHS policymaking process.
- Acting as the central HHS press office handling media requests; overseeing press release development and interview requests; and managing news issues that cut across Agencies; producing electronic clips for the Secretary and the Department.
- Development, management and maintenance of the content and design of the many of the Department's websites including the Department's flagship HHS.gov website, flu.gov, and healthcare.gov.
- Hosting websites that support one or more secretarial or administration initiatives by providing information, transparency, and tools to the public and encouraging involvement in the governing process, while providing public access.
- Developing protocols and strategies to expand Departmental utilization of new 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 because of the Affordable Care Act.

Funding History

FY 2009	$4,432,000
FY 2010	$4,829,000
FY 2011	$5,477,000
FY 2012	$8,983,000
FY 2013	$9,038,000

Budget Request

ASPA's FY 2014 request of $9,800,000 is $817,000 above the FY 2012 Enacted level. 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. Additionally, ASPA will continue to maintain and update healthcare.gov, the nation's leading source of information on health insurance options for consumers and health providers.

ASPA will continue efforts geared toward increased public awareness of HHS tools, resources, and health education initiatives. ASPA also expects to undertake preparatory activities in anticipation of the new statutory provisions of the Affordable Care Act effective in 2014. ASPA continues to update and upgrade HHS websites geared toward the general public. In conjunction with the website modernizations, ASPA expects to continue and where necessary expand activities encouraging public use of HHS websites as means to research health options and make informed decisions. At the same time, ASPA will also lead the HHS effort to consolidate .gov websites.

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 2014 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

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	40,274	40,520	43,100	2,826
FTE	238	238	236	-2

Authorizing Legislation:
FY 2014 Authorization……Indefinite
Allocation Method……..……..Direct Federal

Program Description and Accomplishments

The Office of the General Counsel's (OGC), team of attorneys and comprehensive support staff, is one of the most diverse and talented law offices in the United States. It provides client agencies throughout the Department of 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 Office of the Secretary and 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.

- OGC was involved in a wide range of CMS program integrity efforts that resulted in Government recoveries of over $1.1 billion in judgments, settlements, or other types of recoveries, savings, or receivables.
- On May 7, 2012, DOJ announced a settlement with Abbott Laboratories, Inc. to resolve civil claims and criminal liability regarding the company's marketing practices with respect to the drug, Depakote. Through the coordinated efforts of the Department of Justice, the Office of Inspector General, CMS, FDA, and NAMFCU, Abbott Labs agreed to pay $1.5 billion, including $800 million to resolve its civil allegations that Abbott unlawfully promoted Depakote for unapproved uses, certain of which were not medically accepted indications for which the United States and state Medicaid programs provided coverage for Depakote.
- Saved the Medicare trust funds approximately $1 billion in a heavily discounted settlement with hundreds of hospitals to resolve liability arising from the decision in *Cape Cod Hospital v. Sebelius*, 09-5447, (D.C. Cir.) (finding longstanding error in IPPS hospital rates).
- Assisted CMS in developing and drafting several major regulations implementing Affordable Care Act insurance reforms, including rules requiring insurance companies to rebate over $1 billion in 2012 for failing to meet "medical loss ratio" standards, rules providing for first time ever federal review of insurance premium rates and federal requirements governing student health insurance.
- Worked closely with the Department of Justice to defend an environmental lawsuit filed against the NIH to stop the operation of a maximum containment laboratory constructed to house research for the development of vaccines, treatments, and cures for highly lethal pathogens. NIH has expended approximately $200 million to construct the facility.
- Assisted SAMHSA in complex and successful settlement negotiations with a private entity to settle administrative litigation pending before the Federal Communications Commission (FCC). As a result of the settlement, and based on the prior record, on March 28, 2012, the FCC ordered the permanent reassignment of three toll-free suicide prevention hotline numbers to SAMHSA, noting that making the assignment to SAMHSA will serve the strong public interest in suicide

prevention.

- Advised HRSA and OASH regarding funding options for AIDS drugs in light of continued waiting lists for AIDS medications and cost containment strategies adopted by States that limited availability of critical medications. Assisted HRSA to implement $35 million emergency funding initiative to provide relief for States with waiting lists, which combined with other HIV resources, will impact about 8,000 people waiting for AIDS medications.
- Coordinated and ensured consistency in the negotiation of over 300 Indian Self-Determination and Education Assistance Act (ISDEAA) contracts and compacts which transfer $2 billion annually to Tribes. This effort was particularly important over the past year because of the changes brought about by the newly reauthorized Indian Health Care Improvement Act (IHCIA). OGC was consulted and/or participated in more than 300 Title I and Title V ISDEAA negotiations in FY 2011 and 2012.
- *Commw. of Pa., Dep't of Pub. Welfare v. U.S. DHHS and Sebelius, Sec'y*, the Third Circuit upheld CMS' **$**150 million disallowance in Medicaid dispute re statutorily barred "room and board" costs under PA's Home and Community-Based Services waiver.
- OGC assisted the CDC in negotiating a sole-source contract to obtain Anthrax vaccine valued at approximately $1.3 billion, saving more than $400 million over the life of the contract.
- OGC worked to implement Federal Closed PODs in support of White House Executive Order 13527. Section 4 of the Executive Order directs Federal agencies to develop plans for protecting employees following an anthrax event, and to explore the creation of "Closed Federal Points of Dispensing (closed PODs)" to alleviate the anticipated surge to the local health care system, in the (hopefully-unlikely) event of an anthrax attack.

Funding History

FY 2009	$37,581,000
FY 2010	$38,692,000
FY 2011	$39,911,000
FY 2012	$40,274,000
FY 2013	$40,520,000

Budget Request

The Office of General Counsel (OGC)'s FY 2014 budget request of $43,100,000 is $2,826,000 more than the FY 2012 Enacted level. The $2,826,000 increase directly results from a foreseeable increase in OGC-wide operating costs and anticipatory pay and non-pay inflationary factors.

This funding increase will sustain OGC's FY 2014 operations and continue to enable OGC to provide extensive legal advice to the Department as well as review all rules and guidance related to all provisions of the ACA.

OGC will continue to provide the Department and the Federal Government with the highest quality legal representation.

DEPARTMENTAL APPEALS BOARD

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	10,730	10,795	11,700	970
FTE	75	80	80	5

Authorizing Legislation:
FY 2014 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 2012, the Board/Appellate Division closed 140 cases (78 by decision). Ninety-eight percent of Board decisions issued in FY 2012 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).

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. 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 the 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 2012 CRD received 408 CTP cases.

In FY 2102, CRD received 1,311 new appeals and closed 1,232 cases (189 by decision).

Medicare Appeals Council – Medicare Operations Division (MOD)

With support from MOD attorneys and staff, Administrative Appeals Judges (AAJs) on the Medicare Appeals Council review decisions involving Medicare coverage or entitlement issued primarily by ALJs in Office of Medicare Hearing and Appeals. Medicare Appeals Council review strengthens Medicare management by:

- Improving patient access to health services by ensuring that Medicare requirements are applied correctly nationwide;
- Protecting parties' due process rights;
- Ensuring that interpretations applied to individual claims conform to the statute, regulations, and policy guidance; and
- Avoiding costly court review by ensuring that the administrative record is complete and that the administrative decision is sound and is clearly communicated.

The majority of cases that the Medicare Operations Division (MOD) handles must be decided within a 90-day statutory deadline. In FY 2012, MOD received 3,086 cases and closed 2,513 (32,000 claims).

Alternative Dispute Resolution (ADR) Division

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. 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.

The DAB Chair is the Dispute Resolution Specialist for HHS and oversees ADR activities under the HHS policy issued under the Act. ADR Division staff provide mediation services in DAB cases, provide or arrange for mediation services in other HHS cases (including workplace disputes and claims of employment discrimination filed under the HHS Equal Employment Opportunity program), and provide policy guidance, training, and information on ADR techniques (including negotiated rulemaking – a collaborative process for developing regulations with interested stakeholders).

In FY 2012, the ADR Division undertook several initiatives, including: (1) continuing an IHS training project begun in FY 2010 by conducting conflict management and mediation training for senior managers and EEO staff at IHS' Northwest Regional Service Area in Portland; (2) conducting several large group workplace interventions for various DHHS agencies, including the Office of Refugee Resettlement, Office of Community Services, and the Office of Intergovernmental and External Affairs; (3) beginning a "Conflict Coaching Project" introducing coaching services as a new conflict management tool for managers and employees; (4) continuing to leverage limited resources by promoting video conferencing in place of in-person mediations which requires travel, and by partnering with other Federal ADR programs to share resources.

Workload Statistics

Board Members – Appellate Division

Chart A shows total historical and projected caseload data for this Division. FY 2012 data are actual results, and FY 2013 and FY 2014 data is projected based on certain assumptions, including:

- No new appeals under Early Retiree Reinsurance Program in FY 2013 and FY 2014 (received 40 appeals and disposed of 35 in FY 2012);
- Increased appeals of CRD ALJ decisions in FY 2013 and FY 2014, due to increases in the number of such decisions in FDA tobacco cases issued in each of those years; and
- Review of cases arising under various newly implemented provisions of the Affordable Care Act (ACA) in FY 2013 and FY 2014.

APPELLATE DIVISION CASES – Chart A

	FY2012	FY 2013	FY 2014
Open/start of FY	49	44	49
Received	135	125	125
Decisions	78	80	80
Total Closed	140	120	120
Open/end of FY	44	49	54

Administrative Law Judges – Civil Remedies Division

Chart B shows total historical and projected caseload data for this Division. FY 2012 data are actual results, and FY 2013 and FY 2014 data is projected based on certain assumptions, including:

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

- New and increasing FDA workload;

CIVIL REMEDIES DIVISION CASES -- Chart B

	FY 2012	FY2013	FY 2014
Open/start of FY	298	377	477
Received	1,311	1,400	1,500
Decisions	189	250	250
Total Closed	1,232	1,300	1,300
Open/end of FY	377	477	677

Medicare Appeals Council – Medicare Operations Division

Chart C contains historical and projected caseload data for this Division. FY 2012 data are actual results. Projections for FY 2013 and FY 2014 are based on information and projections from other HHS Operating and Staff Divisions (OMHA). DAB reports data about those 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 receipt in FY 2013 and FY 2014, as OMHA's disposition rate increases (including increased number and complexity of Recovery Audit Contractors cases); and
- New ACA workload.

MEDICARE OPERATIONS DIVISION CASES

	FY 2012	FY 2013	FY 2014
Open/start of FY	2,095	2,668	3,668
Received	3,086	3,500	4,000
Cases Closed (claims closed)	2,513 (32,000 claims)	2,500 (40,000 claims)	2,200 (51,961 claims)
Open/end of FY	2,668	3,668	5,468

Alternative Dispute Resolution Division

In FY 2012, ADR provided 15 conflict resolution seminars and ADR services in 80 cases. In 2013 and FY 2014, ADR projects that it will:

- Provide 15 ADR conflict resolution seminars for DHHS to enhance ADR capacity at DHHS and to encourage ADR use in HHS disputes;
- Use ADR in 80 DHHS cases to increase cost savings, decrease contentiousness, and enhance party satisfaction in case resolution;
- Leverage limited resources for DHHS cases through efficient management of the OPM award-winning Shared Neutrals Program, employing interns and detailees, and encouraging video conferencing of mediations that would otherwise require travel costs;
- Collaborate with other Federal departments and agencies to advance joint ADR goals by participating in interagency initiatives and organizations, such as the Attorney General's ADR Working Group and the Interagency ADR Steering Committee (comprised of representatives of most Federal departments and agencies); and

- Support the goals of the President's Directive on Transparency and Open Government by providing training for DHHS FOIA professionals in conflict management techniques related to responding to public inquiries.

Funding History

FY 2009	$9,981,000
FY 2010	$10,549,000
FY 2011	$10,583,000
FY 2012	$10,730,000
FY 2013	$10,795,000

Budget Request

DAB's FY 2014 request is $11,700,000, $970,000 above the FY 2012 Enacted Level. The funding request for DAB is justified by the increasing Medicare and other workloads (including new ACA cases), additional FTE needed to keep up with those workloads, workload statistics for each Division (see above), DAB e-Government needs, and the potential fiscal and legal consequences of not meeting statutory and regulatory deadlines for hearings and appeals and submitting certified administrative records in cases appealed to Federal court.

Outputs and Outcomes Table

Measure	Most Recent Results	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
1.1: Percentage of Board decisions with net case age of six months or less.	86% (target met)	86%	86%	maintain
2.1: Percentage of Board decisions meeting applicable statutory and regulatory deadlines for issuance of decisions.	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.	100% (target met)	100%	100%	maintain
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.	100% (target met)	100%	100%	maintain
3.3: Percentage of decisions issued with 180 days of filing of provider or supplier enrollment appeal.	100% (target met)	100%	100%	maintain
4.1: Percentage of cases closed in a fiscal year compared to the percentage of cases received that same fiscal year.	80% (target met)	80%	80%	maintain
Proposed 4.1: Cases closed in a fiscal year as a percentage of total cases open in the fiscal year.	NA	NA	65%	NA
5.1: Number of conflict resolution seminars conducted for HHS employees.	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.	80 (target met)	80	80	maintain
6.1: Average time to complete action on Part B Requests for Review measured from receipt of case folder. (FY 2001 and following Fiscal Years) Note: Results for FY 05 determined after excluding outlier cases in which delays related to court proceedings beyond DAB's control.	155 days (target met)	170days	170days	maintain
7.1: Number of dispositions.	2500 (target met)	2500	2500	maintain
Appropriated Amount ($ Million)	**$10.730**	**$11.700**	**$11.700**	**maintain**

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.

Board/Appellate Division

In FY 2012, the Board/Appellate Division closed 140 cases (78 by decision). Ninety-eight percent of Board decisions issued in FY 2012 had a net case age of six months or less, exceeding the target of 86% for Measure 1.1. The Board was able to substantially exceed the target in part because decisions in appeal under the Early Retiree Reinsurance Program did not have complex issues.

The regulatory deadline for issuing a decision was met in 100% of the appeals with a regulatory deadline in FY 2012, thus achieving the target for Measure 2.1.

Appellate projects that it will continue to meet performance targets for Measures 1 and 2 in FY 2013 and FY 2014.

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 and 180 days for CMS provider/supplier enrollment cases). The targets for FY 2012 were 100%, and CRD met those targets. CRD expects to continue to meet the targets for Measures 3.1, 3.2, and 3.3 in FY 2013 and FY 2014.

CRD met its performance target for measure 4.1 in FY 2012 and will meet it in FY 2013.

In order to account for a growing backlog of cases, CRD proposes changing Measure 4.1 in FY 2014. The proposed change would measure cases closed as a percentage of all cases open during the fiscal year (including cases carried over from prior fiscal years). Previously, DAB measured cases closed as a percentage of cases received during the fiscal year, which did not account for the backlog from year to year. CRD believes this new methodology will more accurately measure the Division's capacity and provide a better tool with which to analyze and project staffing needs. DAB expects to meet the new target of 65% in FY 2014.

To ensure that CRD continues to meet its performance objectives, the DAB recently backfilled an open ALJ position. Initially, the new ALJ was assigned provider/supplier enrollment and FDA Center for Tobacco Products (CTP) cases, and he has gradually assumed a full case load. Additionally, CRD used CTP user fees to hire temporary staff for the CTP casework.

Medicare Operations Division

In FY 2012, MOD did not meet its target for Objective 6.1, to constrain the growth in case age by reducing the average time to complete action on Medicare Part B cases (as measured from the date MOD received the claim file). Instead, Part B average case age increased by 28 days because of the increased case complexity of the cases, the loss of five experienced attorneys and the onboarding and training of their replacements. In FY 2012, MOD met its target for Objective 7.1 by closing 2,500 cases.

In both FY 2013 and FY 2014, MOD expects sharply higher case receipts, due to increases in ACA and Recovery Audit Contractor (RAC) workloads (based on projections from CMS and OMHA). Since the RAC and overpayment statistical sampling caseload is also increasing in both the complexity of issues and number of claims per case, the overall target of 2500 cases closed will remain the same in FY 2013 and FY 2014 as in FY 2012. In FY 2013 and FY 2014, MOD will face challenges in meeting its performance targets due to the combination of increased complexity and numbers of claims per case.

Alternative Dispute Resolution (ADR) Division

In FY 2012, the ADR Division met its Performance Measures 5.1 and 5.2 . The ADR Division accomplished this by leveraging its limited resources through: (1) video tele-conferencing in place of in-person mediations (saving travel funds and staff time), (2) partnering with DOT to share training resources, and (3) supplementing a small staff with a Stay-in-School Program intern and a law school intern.

For FY 2013 and 2014, the ADR Division projects workload and staffing to continue at levels comparable to FY 2012. The Division is on track to meet its FY 2013 performance targets and projects meeting its performance targets in FY 2014.

OFFICE ON DISABILITY

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	1,098	1,105	0	-1,098
FTE	0	0	0	0

Funding History

FY 2009	$805,000
FY 2010	$864,000
FY 2011	$862,000
FY 2012	$1,098,000
FY 2013	$1,105,000

Budget Request

The former Office on Disability will not be requesting funds for FY 2014. 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

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	6,438	6,477	6,400	-38
FTE	24	24	24	0

Authorizing Legislation:
FY 2014 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 serves as the focal point within HHS for coordinating international activities, and develops and strengthens relationships with USG agencies, foreign ministries of health, multilateral partners, civil society, academia and the private sector.

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, including representing the Department in the governing structure of major crosscutting global health initiatives. OGA's USG partners include the National Security Staff, the Department of State, the Department of Defense and the U.S. Agency for International Development. 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 GAVI Alliance.

OGA's services to the HHS Operating and Staff Divisions (OPDIVS/STAFFDIVS) include the representation and protection of their domestic and global interests within multilateral organizations and in areas in which a global component, multilaterally or bilaterally, could enhance or contribute to HHS domestic programs and benefit the American people, including at-risk populations. Working collaboratively with the OPDIVs and STAFFDIVs, OGA represents, advances, and protects HHS programs, legislative mandates and regulatory requirements in the international context.

More specifically OGA:

- Provides staff support for the direct involvement of the Secretary, Deputy Secretary, Assistant Secretaries and the Surgeon General in international activities, including through drafting briefing papers and background materials; and by making logistical and diplomatic preparations for their international travel. OGA also often provides the same services to heads of HHS Operating Divisions;
- Staffs the Secretary in international venues and events such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Assembly, the Directing Council of the Pan American Health Organization, the U.S.- México Border Health Commission (USMBHC), the World Economic Forum, and meetings with Ministers of Health and other senior foreign officials;

- Chairs and provides staff support for the HHS Exchange Visitor Waiver Review Board, which has a statutory responsibility for reviewing requests for waivers of the two-year foreign-residence requirement for exchange visitors on J-1 visas in areas of interest to HHS, defined as biomedical and behavioral research and primary health care in underserved areas; and
- Represents U.S. and HHS health interests abroad through assignment of Health Attachés in countries where the US-host country relationship is particularly complex, and where foreign policy or economic or trade issues affect global health programs. Historically, Health Attachés have played critical global health diplomacy roles. HHS currently has Attachés assigned in Brazil, China, India, South Africa, and Geneva, Switzerland, as well as staff on the U.S. – México border and a liaison in Afghanistan.

The following are some of the more significant accomplishments of OGA in 2012:

- Helped to host 144 USMBHC events along both sides of the border, engaging over 160 partners, and providing over 32,000 free health screenings financial and in-kind support came from federal, State, local, private and community stakeholders.
- Led the USG effort to push for and successfully gained global approval for the retention of smallpox stockpiles for research in the U.S.
- Coordinated and managed the international aspects of HHS and USG policy on research on H5N1 mutations which could have dual use and bio safety and security consequences. OGA supported the high-level negotiations with the WHO and the government of the Netherlands.
- Led the HHS and USG participation in ground-breaking and high-profile global workshops on non-communicable diseases, including at the UN High Level Meeting; secured high-visibility speaking opportunities for the Secretary and other HHS senior officials to underscore the USG leadership role on these issues.
- Spearheaded HHS efforts to push for policy consistency across public health and international trade, resulting in inter-agency agreement to put forward a new USG trade policy approach to protect tobacco control efforts.
- Developed the first-ever HHS Global Health Strategy, unveiled by the Secretary as a framework for the department's activities going forward, and supported her health diplomacy efforts during trips to China, India, Kenya, Tanzania, Brazil, and Haiti.
- Led interagency collaboration efforts on behalf of HHS, enhancing our communications and coordination with the Department of Defense, the Department of State, and USAID (among others), and improving working relationships in areas of the Global Health Initiative, Global Health Security, and health diplomacy.
- Coordinated USG inter-departmental coordination and led technical and diplomatic outreach in international negotiations surrounding the sharing of influenza viruses, resulting in a ground-breaking international agreement on virus sample sharing and benefits, the World Health Organization's Pandemic Influenza Preparedness Framework (PIP-FW).

To accomplish this mission, OGA has an International Relations Division (IRD) containing regionally focused branches, and a Policy and Program Coordination Division (PPCD) comprising a policy branch, an agency coordination branch, and two programmatic branches.

Each of the regional branches within the IRD serves as the Department’s focal point for the coordination of activities with countries and international organizations in that region. The branch chiefs and their staff provide technical expertise, diplomatic guidance, and recommendations for policy direction for HHS leadership, OPDIVS/STAFFDIVS, and other relevant USG agencies for bilateral and regional health and social-welfare issues.

Within the IRD, OGA performs in the key role as executive director of the United States-México Border Health Commission of the U.S. Section. Based in El Paso, this office serves to provide a U.S. domestic

focus on border health, and create an effective binational venue to address the public health challenges that impact border populations.

The Policy and Programming Coordination Division (PPCD) is responsible for coordinating all crosscutting global health and human services policy efforts of the Department. The division works closely with OPDIVS and STAFFDIVS to ensure Departmental alignment on key issues as well as working with other USG Agencies on broader policy work. Because the global issues that the Policy and Programming Division works on understandably have regional implication, its work applies both a global policy perspective and country/regional expertise. For instance, the PEPFAR team works closely with the Africa Region.

Funding History

FY 2009	$6,451,000
FY 2010	$6,350,000
FY 2011	$6,329,000
FY 2012	$6,438,000
FY 2013	$6,477,000

Budget Request

The FY 2014 request for the Office of Global Affairs (OGA) of $6,400,000 is $38,000 below the FY 2012 Enacted Level. This decrease will be offset by a reduction in contract services. As the Secretary's central coordinator for international engagement, OGA's request is directly tied to the wide range of global activities described above which contribute to the overall execution of the HHS Global Health Strategy and the Secretary's priorities.

This request continues OGA's ability to represent the U.S. and HHS health interests abroad in countries where the US-host country relationship is particularly complex, and where foreign policy or economic or trade issues affect global health programs. OGA currently has Health Attachés assigned to US embassies in Brazil, China, India, South Africa, and Geneva, Switzerland. These officers have proven their value to health diplomacy, access and coordination of travel and in-country presence.

Grants

Size of Awards (whole dollars)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	4	4	4
Average Award	$331,500	$338,063	$338,063
Range of Awards	$280,000 - $445,000	$290,000 - $455,000	$290,000 - $455,000

The Office of Global Affairs and the border health offices of the four U.S. border-states (Arizona, California, New Mexico and Texas) are engaged in four cooperative agreements to implement the objectives of the United States-Mexico Border Health Commission (USMBHC). The USMBHC strives to optimize the health and quality of life for those living in the border region. The activities supported via these grants raise awareness about public health issues and challenges faced by border populations; the majority of whom are medically underserved, have high uninsured rates, inequitable health conditions and a high rate of poverty.

OFFICE OF INTERGOVERNMENTAL and EXTERNAL AFFAIRS

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	9,831	9,892	10,600	769
FTE	60	60	60	0

Authorizing Legislation:
FY 2014 Authorization……...…Indefinite
Allocation Method…….……...……..Direct Federal

Program Description and Accomplishment

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, most recently, non-governmental stakeholders. The mission of IEA 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 an IGA Specialist who is 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. RDs will lead and implement the recommendations and findings of the Secretary's *Regions Together Initiative* which is an effort designed to analyze and improve regional operations across the Department. IEA will also serve as point of contact between the Secretary's Regional Representatives (SRR) and the Regional Offices. The Regional Director's serve as the Secretary's sole representative for HHS at the local level with the ability to work on cross-cutting and complex issues with local elected officials, non-governmental stakeholders and key business leaders.

The Office of Tribal Affairs coordinates and manages tribal and native policy issues, assists tribes in navigating through HHS programs and services, and coordinates the Secretary's policy development for Tribes and national Native organizations.

IEA provides executive direction for the Secretary's Intradepartmental Council on Native American Affairs (ICNAA) and the Secretary's Tribal Advisory Committee (STAC). The ICNAA is an internal council that brings together all HHS Operating Divisions and Staff Divisions to help frame HHS policy and initiatives on American Indians, Alaska Natives, and Native Americans while the STAC is composed of external Tribal representatives.

IEA tracks HHS region-specific, Federal and State legislative actions, and serves as a surrogate for the Secretary and Deputy Secretary in the regions, informing state, local, territorial and tribal officials, the media and public of the Administration's and Department's program initiatives and priorities. IEA

provides Departmental leadership in the field in several areas, including all top Secretarial priorities and initiatives.

Funding History

FY 2009	$6,244,000
FY 2010	$7,049,000
FY 2011	$9,688,000
FY 2012	$9,831,000
FY 2013	$9,892,000

Budget Request

The FY 2014 request for IEA is $10,600,000, $769,000 above the FY 2012 Enacted Level. This supports annualized staffing of regional offices that previously had vacant positions.

IEA has been tasked with increased responsibility for coordination and communication activities with state, local, tribal and territorial governments related to understanding health reform. IEA's mission has also expanded to include establishing and supporting relationships with non-governmental organizations, groups and private institutions such as labor unions, academia, private sector and national organizations.

IEA regional staff will be responsible for developing and maintaining external communication strategies across all regional offices. They will ensure the development and oversight of short and long-range external communications plans. The regional staff will develop a master external communications plan encompassing state, local, tribal and territorial governments, non-governmental groups and organizations. IEA will develop a process to map major stakeholder groups and develop strategies to effectively reach and engage them.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH
Executive Summary

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	232,833	234,259	110,779	-122,054
FTE	268	268	252	-16

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 provided provides professional 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
- 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.
- 11 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

Strategy 2.B.1: Ensure that the *Office on Women's Health Resource Center* and the *Office of 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: Ensure the Commissioned Corps is a mobile, organized, ready, and responsive force that ensures the preparedness of the Nation for emergency response.

Strategy 3.E.2: Consider engaging the Commissioned Corps in health diplomacy missions to provide critically needed medical and public health services beyond our borders.

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

Strategy 3.E.4: 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.

Outputs and Outcomes

Long Term Objective: Creating better systems of prevention.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
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 2012: 22,330 (Target Not Met)	35,200	40,292[1]	+5,092
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 3: new, targeted educational materials/campaigns; Measure 4: media coverage of OASH-supported prevention efforts (including public affairs events).	FY 2012: 67,661,059 (Target Exceeded)	38,270,500	33,939,393[2]	-4,331,107
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 2012: 1,694 (Target Exceeded)	960	363	-597

[1] The increase is due to PCFSN's release of the new Presidential Youth Fitness Program and the expected adoption of the new initiative in schools.
[2] The decrease is due to OWH updating its performance data collection system to more accurately capture the activities of the office.

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
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 2012: 419 (Target Exceeded)	340	61[3]	-279
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 2012: 1,241 (Target Exceeded)	575	163[4]	-412

Long Term Objective: Eliminating health disparities and achieving health equity

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
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 2012: 174 (Target Exceeded)	130	228	+98

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
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 2012: 8,334,202 (Target Exceeded)	2,232,180	1,487,614	-744,566
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 2012: 948 (Target Exceeded)	330	408	+78
2.d: Strengthen the science base (Outcome) Measure 1: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally; Measure 2: number of research, demonstration, or evaluation studies completed and findings disseminated; Measure 3: number of promising practices identified in research, demonstration, evaluation, or other studies.	FY 2012: 205 (Target Exceeded)	113	49[5]	-64
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 2012: 134[6] (Target Exceeded)	58	57	-1

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

[6] The difference between FY 2012 and the FY 2013/2014 targets is due to OWH updating its performance data collection system to more accurately capture the activities of the office.

Long Term Objective: Making *Healthy People* come alive for all Americans

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
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 2012: 3,049 (Target Exceeded)	1,020	10,179[7]	+9,159
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 2012: 11,014,974 (Target Exceeded)	3,394,691	3,334,220 [8]	-60,471
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 2012: 684 (Target Exceeded)	485	307	-178

[7]The increase is due to the Office of the Surgeon General updating its performance measures for the Civilian Volunteer Medical Reserve Corps to better reflect the activities directly related to the accomplishment of this objective (i.e., # of new units and # of activities reported).

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

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
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 2012: 428 (Target Exceeded)	425	49 [9]	-376
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 2012: 1,650 (Target Not Met but Improved)	6,234	6,122	-112

FY2013-FY2014 High Priority Performance Goal

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
1.4 Reduce annual adult's cigarette consumption in the United States (per capita) (Outcome)	FY 2011: 1,281.0 (Target Met)	1,150	--[10]	--

FY2013-FY2014 HHS Online Performance Appendix Measure

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
6.1.5: Enhance the Department's capability to rapidly and appropriately respond to medical emergencies and urgent health needs, through maintaining response teams. (baseline – 2007: 46) (Outcome)	FY 2012: 41 (Target Met)	41	41	--

[9] The decrease is due to OWH updating its performance data collection system to more accurately capture the activities of the office.
[10] Departmental Priority Goal ends in FY 2013.

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 to make progress in targeted key measures 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. As footnoted, many of the significant decreases are due to the Office of Women's Health updating its performance data collection system to more accurately capture the activities of the office. This will not only enable OWH, but all of OASH to better forecast and report on expected performance measures moving forward.

OASH Summary Table - Direct

(Dollars in Thousands)

	FY 2012 Actual		FY 2013 CR		FY 2014 President's Budget	
OASH:	FTE	Amount	FTE	Amount	FTE	Amount
Immediate Office of the Assistant Secretary for Health	55	$13,474	55	$13,558	55	$18,100
Office of HIV AIDS and Infectious Disease Policy	6	$1,498	6	$1,507	6	$1,500
Office of Disease Prevention and Health Promotion	23	$7,186	23	$7,230	23	$7,200
President's Council on Fitness, Sports and Nutrition	6	$1,248	6	$1,255	6	$2,250
Office for Human Research Protections	33	$6,937	33	$6,979	33	$6,711
National Vaccine Program Office	17	$6,837	17	$6,879	17	$6,250
Office of Adolescent Health	4	$1,098	4	$1,105	4	$1,000
Public Health Reports	2	$499	2	$502	2	$400
Subtotal, OASH Non-PPA	146	$38,777	146	$39,015	146	$43,411
OASH PPAs						
Teen Pregnancy Prevention	16	$104,592	16	$105,232	0	$0
Office of Minority Health	63	$55,782	63	$56,124	63	$40,560
Office on Women's Health	43	$33,682	43	$33,888	43	$26,808
Subtotal, OASH PPAs	122	$194,056	122	$195,244	106	$67,368
Other GDM						
Office of Research Integrity (non add)	[24]	[$9,027]	[24]	[$9,027]	[24]	[$9,027]
HIV-AIDS in Minority Communities	0	$53,681	0	$54,010	0	$0
Embryo Adoption Awareness Campaign	0	$1,996	0	$2,008	0	$0
Abstinence Education	0	$4,991	0	$5,021	0	$0
Subtotal, Other GDM	0	$60,668	0	$61,039	0	$0
Total, OASH	**268**	**$293,501**	**268**	**$295,298**	**252**	**$110,779**
Prevention & Public Health Fund						
Teen Pregnancy Prevention (FTE non add)	[0]	$0	[0]	$0	[16]	$104,790
Subtotal, PPHF	0	$0	0	$0	0	$104,790
PHS Evaluation Set-Aside						
OASH	0	$4,510	0	$4,538	0	$4,285
Teen Pregnancy Prevention Initiative	0	$8,455	0	$8,507	0	$4,232
HIV AIDS in Minority Communities	0	$0	0	$0	0	$53,891
Subtotal, PHS	0	$12,965	0	$13,045	0	$62,408
GRAND TOTAL	**268**	**$306,466**	**268**	**$308,343**	**252**	**$277,977**

OASH
IMMEDIATE OFFICE
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	13,474	13,558	18,100	4,626
FTE	55	55	55	0

Authorizing Legislation……...……...Title III, Section 301 of the Public Health Service Act
FY 2014 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 direction to policy offices within OASH.

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.

In March 2012, OASH released the Surgeon General's Report – *Preventing Tobacco Use among Youth and Young Adults*. This report details the scope, health consequences and influences that lead to youth tobacco use and proven strategies that prevent its use. Additionally, OASH leads implementation of HHS' *Ending the Tobacco Epidemic, A Tobacco Control Strategic Action Plan*, and serves as the chair of the HHS Tobacco Control Working Group.

Eliminating health disparities and achieving health equity
National planning and implementation efforts led by the Immediate Office of the ASH promote 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 will contribute to areas such as improving adolescent health and reducing teen pregnancy; addressing care and prevention related to chronic viral hepatitis; and using health information technology to reduce health disparities.

In February 2012, OASH released the HHS 2012 Environmental Justice Strategy and Implementation Plan. Environmental Justice is "the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations and policies". The Plan builds on collaborative efforts across the Department and proposes a set of strategic elements, goals, strategies and actions that are coordinated and led by OASH.

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.

Making Healthy People come alive for all Americans
OASH continues implementation of *Healthy People 2020,* which has established health goals for the Nation, tracked progress toward meeting targets, and aligned national efforts to guide action for public health. Now in its fourth decade, *Healthy People* offers an opportunity to assess health status in a host of focus areas and objectives. A new, user-centered website, with an up-to-date library of best practices and community planning tools has been unveiled for *Healthy People 2020*. This reflects the Department's commitment to make data available at the community level, and it will advance the goal of making *Healthy* People come alive for all Americans.

In October 2011, as part of *Healthy People 2020,* OASH released the Leading Health Indicators (LHI) – critical health priorities for the Nation – a tool useful to policymakers and public health professionals at the local, state, and national level for tracking progress toward meeting key national health goals. LHIs will assist in focusing efforts to reduce some of the leading causes of preventable deaths and major illnesses.

Funding History

FY 2009	$8,820,000
FY 2010	$9,495,000
FY 2011	$12,495,000
FY 2012	$13,474,000
FY 2013	$13,558,000

Budget Request

The FY 2014 request of $18,100,000 is $4,626,000 above the FY 2012 Enacted level. The budget continues the ASH's responsibility as the senior advisor to the Secretary on public health and science by addressing several highly visible public health needs, such as: the Action Plan for the Prevention and Treatment of Viral Hepatitis (APPTVH); foster greater coordination among the various HHS entities to develop and implement a new Environmental Justice Strategic Plan; and coordinate the implementation of HHS's *Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan*. The request will also continue support for the Office of the Surgeon General and the Regional Health Administrators. Additionally, efforts will continue to reduce various administrative costs as outlined by the President's Executive Order 13589 – Promoting Efficient Spending: travel, information technology devices, printing, promotional items, and other opportunities.

OASH
NATIONAL VACCINE PROGRAM OFFICE
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	6,837	6,879	6,250	-587
FTE	17	17	17	0

Authorizing Legislation……..……Title XXI of the Public Health Service Act
FY 2014 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 as they work together to carry out the goals of the National Vaccine Plan. The development of this plan was mandated in P.L. 99-660. 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 to:

- 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 2011, NVPO coordinated a revision of the Plan (initially published in 1994) with all relevant agencies and offices in HHS, and with the Departments of Defense and Veterans Affairs and the U.S. Agency for International Development. In September 2012, NVPO released the National Vaccine Implementation Plan, which identifies the key indicators which will be used to measure progress on the Plan going forward. The National Vaccine Advisory Committee has been charged to review progress and conduct a mid-course review of the plan in 2015. In 2012, NVPO began coordinating the development of an annual *State of the National Vaccine Plan* report with interagency partners.

- *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 is currently developing recommendations on improving immunization infrastructure, maternal immunization and on the USG role in global immunization.

- *Adult Immunization Coordination.* 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 will consider NVAC recommendations on adult immunizations and will work in partnership with the National Adult Immunization Summit.. Key activities include provider and patient education; expanding access to adult vaccines; reducing health disparities in adult immunization; and refining metrics by which we can measure progress. NVPO supports the interagency process through a contract managed by the HHS Regional Health Administrators (RHA); better integrating RHAs into the interagency process.
- *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. As a key element of the National Vaccine Plan, current priorities in vaccine safety include enhancing the timely detection and verification of vaccine signals and the development of a vaccine safety scientific agenda. NVPO is also supporting an evaluation by the Institute of Medicine to determine the feasibility of determining whether alternative vaccine schedules are associated with different health outcomes.
- *Pandemic Influenza Preparedness.* The occurrence of seasonal influenza (and its response) provides an annual opportunity to assess pandemic influenza preparedness. In that capacity 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 creating of an "adult vaccine finder" web site, with geo-located sites where adult vaccines are administered.

- *Vaccine Financing and the application of the Affordable Care Act to the national vaccination strategy.* NVPO coordinates interagency and external partners on vaccine financing and its implications for access and vaccine coverage rates.

- *Vaccine Communications.* NVPO works with HHS OPDIVs and STAFFDIVs to ensure that communications strategies and tactics are well coordinated and leveraged to the fullest extent possible. Key activities include operating vaccines.gov and the recently launched Spanish language version: http://es.vaccines.gov/; 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 leader and the office of the Assistant Secretary for Public Affairs are leading an interagency group refine our internal communications in the setting of emerging vaccine-related issued (e.g., vaccine shortage, vaccine safety signal, etc).

- *Vaccine Research and Development Priorities.* The National Vaccine Plan identified the need to develop a catalogue of priority vaccine targets of domestic and global health importance. NVPO is supporting a multiphase project conducted by the Institute of Medicine to develop a model for decision makers. The first phase of this project was released May 2012. Feedback from stakeholders on the prototype model being developed will inform the next phase of this effort.

Funding History

FY 2009	$6,879,000
FY 2010	$6,839,000
FY 2011	$6,839,000
FY 2012	$6,837,000
FY 2013	$6,879,000

Budget Request

The FY 2014 request of $6,250,000 is $587,000 below the FY 2012 Enacted level. The reduction will be accomplished primarily through absorption of previously funded activities within the base budget of other divisions in HHS. Additionally, efforts will continue to reduce various administrative costs as outlined by the President's Executive Order 13589 – Promoting Efficient Spending: travel, information technology devices, printing, promotional items, and other opportunities.

OASH
OFFICE OF ADOLESCENT HEALTH
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	1,098	1,105	1,000	-98
FTE	4	4	4	0

Authorizing Legislation……..……...Section 1708 of the Public Health Service Act
FY 2014 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, and training of healthcare professionals. 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 36 states and the District of Columbia. Additionally, OAH manages the Pregnancy Assistance Fund, 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 2010-2013, the program supported 17 grants to States and Tribal organizations.

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.

Funding History

FY 2009	$0
FY 2010	$500,000
FY 2011	$1,098,000
FY 2012	$1,098,000
FY 2013	$1,105,000

Budget Request

The FY 2014 request of $1,000,000 is $98,000 below the FY 2012 Enacted level. Additionally, efforts will continue to reduce various administrative costs as outlined by the President's Executive Order 13589 – Promoting Efficient Spending: travel, information technology devices, printing, promotional items, and other opportunities.

OASH
OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	7,186	7,230	7,200	14
FTE	23	23	23	0

Authorizing Legislation…….....……..Title XVII, Section 1701 of the PHS Act
FY 2014 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 of 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 2012, ODPHP continued the development of the online version of *Healthy People 2020* aimed at making *Healthy People* 2020 come alive to all Americans. 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 gives users a platform from which to learn, collaborate, plan, and implement objectives. Version 1.0 of the site was launched in FY 2011and has been continually updated and improved since then. In FY 2012, healthypeople.gov received the Gold Health Web Award, recognizing the site as a leader among all health websites.

In FY 2012, ODPHP released the Leading Health Indicators (LHI). A subset of the Healthy People 2020 objectives, the LHIs are used to communicate high-priority health issues and actions that can be taken to address them. The indicators will be used by health professionals and policymakers to track progress at national and community levels as the work to achieve the national health objectives. With the launch of the LHIs, ODPHP initiated a monthly e-bulletin and Webinar series that features organizations using

evidence-based approaches to addressing the LHI topics. In addition, ODPHP and the Office of the National Coordinator for Health IT co-sponsored an LHI mobile app challenge to developers and public health experts to co-design an application that makes the LHIs customizable and easy to use.

Dietary Guidelines for Americans
ODPHP plays a leadership role on behalf of HHS in co-coordinating the development, review, and promotion of the recommendations from 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. 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.

The DGAs are informed in part by the Dietary Reference Intakes (DRIs), a system of nutrition recommendations from the Institute of Medicine (IOM). The DRI system is used in the U.S and Canada for development of diets by schools, prisons, hospitals and nursing homes; of new food products by industries; and of policy by public health officials. ODPHP continues its leadership role in the development and review of the DRIs by coordinating with many HHS agencies and with USDA and Department of Defense.

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 PAGs served as the primary basis for physical activity recommendations of the 2010 DGA and the physical activity objectives in *Healthy People 2020* as well as support for the Secretary's initiative to Help Americans Achieve and Maintain Healthy Weight.

In FY 2013, ODPHP continues to focus on outreach by coordinating and managing the online Physical Activity Supporters Network (over 4,500 members), posting weekly PAG blog updates, and developing consumer information for the Spanish-speaking population. In addition, ODPHP coordinates the review of consumer information to be published by the Department related to physical activity to ensure that materials are consistent with the evidence-based messages of the PAGs. The PAG collaborators within the Department have coordinated a literature review of effective strategies for achieving the PAG among youth and young adults to be completed by the end of CY 2012 and will communicate the findings of that scientific report to the American public and re-emphasize the recommended levels of physical activity for health promotion and disease prevention in the PAG.

National Health Information Center
ODPHP is congressionally mandated to provide reliable prevention and wellness information to the public through the National Health Information Center. ODPHP supports four websites: Healthfinder.gov, Healthypeople.gov, Health.gov, and the ODPHP website. Collectively, these websites received 20 million visits in FY 2012.

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 2012, healthfinder received a Bronze Web Health Award for healthfinder in Español and two Health Literacy Innovator Awards in the

2012 Leonard G. Doak Health Literacy Innovator Award contest. These were gold medals for the healthfinder.gov Quick Guide to Healthy Living – in English and Spanish. In FY 2012, 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 2012, and now has approximately 180,000 followers. A Facebook page was launched at the beginning of FY 2012 and has over 3,500 "likes" to date. These outreach channels have contributed to increased website traffic, and healthfinder.gov surpassed the 1 million visits/month mark in October 2012. Currently, ODPHP is working on design comps and usability testing for a website refresh, which will make the prevention and wellness brand easier for consumers to identify.

The Quick Guide to Healthy Living
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. A Spanish version of the Quick Guide was launched in the fall of 2011 and reached about 70,000 visits in the year since its launch. 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 36,000 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). Winners will be chosen in March of 2013.

Healthcare Quality
In FY2012, healthcare quality activities were added to ODPHP's portfolio to coordinate departmental efforts to reduce Hospital Acquired Conditions, including Healthcare Associated Infections and, most recently, Adverse Drug Events (ADEs). Through these activities ODPHP support the ACA's new public private partnership: *The Partnership for Patients: Better Care, Lower Costs.* The Partnership for Patients aims to improve the quality, safety and affordability of health care for all Americans through two core goals: keeping patients from getting injured or sicker in the health care system and helping patients heal without complication by improving transitions from acute-care hospitals to other care settings, like home or a skilled nursing facility.

Funding History

FY 2009	$7,232,000
FY 2010	$7,200,000
FY 2011	$7,200,000
FY 2012	$7,186,000
FY 2013	$7,230,000

Budget Request

The FY 2014 request of $7,200,000 is $14,000 above the FY 2012 Enacted level. The proposed increase will restore funding to activities in support of key ODPHP initiatives including *Healthy People*, Dietary Guidelines for Americans (DGAs), and Physical Activity Guidelines for Americans (PGAs) and cover the expected inflation costs. Specifically, the increase will help ensure that ODPHP can 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 PGAs. Additionally, efforts will continue to reduce various administrative costs as outlined by the President's Executive Order 13589 – Promoting Efficient Spending: travel, information technology devices, printing, promotional items, and other opportunities.

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
I.b Visits to ODPHP-supported websites (Output)	FY 2012: 20.23 Million (Target Exceeded)	17.6 Million	18.2 Million	+0.6
I.c Consumer Satisfaction with healthfinder.gov, measured every three years (Output)	FY 2010: 76% (Target Not Met)	N/A[18]	N/A	N/A
II.a Percentage of States that use the national disease prevention and health promotion objectives in their health planning process (Outcome)	FY 2012: 76% (Target Exceeded)	25%[19]	80%	+55%

Performance Analysis

ODPHP has a Congressional mandate to manage the National Health Information Center (NHIC). Over the past two years, ODPHP has begun consolidating and moving a substantial amount of program activities online, enhancing the value to the NHIC for 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, and have already exceeded its FY 2014 target of 18.2 million visits by 2 million visits. We met our ROI for ACA related decision support at healthfinder.gov and expect to continue to improve our ROI over the next two years.

The request allows 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. All content is evidence based and reviewed by subject matter experts across HHS. Additionally

[18] Consumer satisfaction with healthfinder.gov will be measured in 2013 and continuing every three years.
[19] Healthy People 2020 launched in FY2011 and the FY2013 target reflects initial expectations for the early stages of implementation of the new decade. The FY2012 results, however, far exceeded expectations and the target for FY14 is adjusted accordingly. Uptake will continue to increase in each subsequent year.

the content is presented using the latest science regarding health literacy and plain language dissemination.

ODPHP expect 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.

The request allows 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 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Contracts			
National Health Information Center	1,658,000	1,658,000	1,658,000
Communication Support	700,000	700,000	700,000
Subtotal, Contracts	2,358,000	2,358,000	2,358,000
Grants/Cooperative Agreements			
Disease Prevention and Health Promotion Scholarship Program	400,000	400,000	400,000
Subtotal Grants/Coop	400,000	400,000	400,000
Inter-Agency Agreements (IAAs)			
Performance measures collection, outreach management, website infrastructure	111,000	111,000	111,000
Operating Costs	4,317,000	4,361,000	4,331,000
Total	**7,186,000**	**7,230,000**	**7,200,000**

Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	1	1	1
Average Award	400,000	400,000	400,000
Range of Awards	--	--	--

OASH
OFFICE OF HIV AIDS AND INFECTIOUS DISEASE POLICY
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	1,498	1,507	1,500	2
FTE	6	6	6	0

Authorizing Legislation…….Title III, Section 301 of the Public Health Service Act
FY 2014 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:

- Provide strong, responsive, and accountable administrative structure to HIV/AIDS related issues for OASH and OS to ensure the success of the Department's HIV/AIDS programs, policies, and activities, while maintaining fiscal accountability and promoting sound evaluation.
- Develop and share policy information and analysis to the Department's OPDIVs and STAFFDIVs. OHAIDP ensures that senior Department officials are fully briefed on HIV/AIDS-related matters and that they are able to provide information on HIV/AIDS policies, programs, and activities to the White House or to members of Congress. With both internal and external partners, OHAIDP promotes awareness, understanding, and implementation of HHS policies on HIV/AIDS.
- 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 coordinating HHS activities with other federal departments.
- Coordinate the implementation of the Action Plan for the Prevention, Care & Treatment of Viral Hepatitis (Viral Hepatitis Action Plan) within HHS and across other federal departments.
- Support the ongoing activities of the Presidential Advisory Council on HIV/AIDS (PACHA).
- Coordinate, integrate, and direct the Department's policies, programs and activities related to blood 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.

HIV/AIDS
Following the release of the NHAS and the Federal Implementation Plan, 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 FY 2012, OHAIDP worked with HHS OPDIVs to develop common core indicators for HHS-funded HIV prevention, treatment, and care services; develop operational plans to implement these

indicators; streamline HIV data collection, and reduce undue reporting burden by at least 20 – 25%; and fully deploy these system improvements in a manner that preserves accountability for program outcomes by FY 2014.

OHAIDP coordinates the Department's participation in a wide variety of HIV/AIDS-related conferences and events to ensure cost-effective use of resources, broad participation and outcome-driven results. OHAIDP organizes information and activities around national HIV and viral hepatitis awareness days, and coordinates both inter- and intra-agency HIV/AIDS and viral hepatitis activities.

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 the last quarter of FY 2012, OHAIDP released the summary of the HHS progress toward accomplishing NHAS goals for calendar year 2011 (*Implementation Progress Report*).

Throughout FY 2012, OHAIDP worked closely with its OPDIV partners to improve HIV program planning and coordination, especially in the 12 U.S. jurisdictions that bear the highest AIDS burden in the country (12 Cities Project). During FY 2012, a cross-agency work group met to identify specific opportunities to further support and extend cross-program collaboration at the local level. As part of HHS efforts to better leverage new and existing federal investments and more effectively coordinate federally funded HIV/AIDS activities in those jurisdictions, NIH engaged nine of its Centers for AIDS Research (CFARs) in focused partnerships with local health departments. SAMHSA provided resources to 11 of the 12 jurisdictions to develop and expand networks of primary care, HIV/AIDS, and behavioral health service providers serving racial and ethnic minorities living with or at high risk for HIV/AIDS. OHAIDP engaged an outside evaluator to assess progress toward improving coordination, collaboration, and program integration in these 12 jurisdictions. Results from this qualitative evaluation were shared broadly and the lessons learned will help inform ongoing technical assistance efforts in other jurisdictions, beyond the original 12.

AIDS.gov

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

- Information on HIV/AIDS and referral to individual agency websites and resources which support the Department's HIV prevention, testing, and treatment objectives and improving access to Federal information about HIV/AIDS;
- Training and information to federal, state, local, tribal and non-governmental partners on the use of new media in response to HIV/AIDS; and
- Links to HIV/AIDS and viral hepatitis resources (including both Federal and non-Federal partners).

Viral Hepatitis

In FY 2012, OHAIDP improved the coordination of viral hepatitis activities across HHS and other federal departments through regular meetings of the Viral Hepatitis Implementation Group and summarizing cross-governmental progress toward implementing the Viral Hepatitis Action Plan in the *Interagency Implementation Progress Report Year One*. As part of its efforts to support implementation of the Viral Hepatitis Action Plan, OHAIDP coordinated the compilation of a web-based inventory of federal viral hepatitis materials; provided outreach and communication across the government to support for Hepatitis Awareness Month in May and the first National Viral Hepatitis Testing Day; and convened a day-long,

multi-disciplinary consultation to examine various program approaches for testing for hepatitis B virus (HBV) and hepatitis C virus (HCV). In FY 2012 OHAIDP also initiated a one-year evaluation of implementation of the Viral Hepatitis Action Plan at the state and local level and in FY 2013 convened a multiagency workgroup as a first step in addressing the emerging epidemic of HCV in young injection drug users.

Blood and Tissue Safety

Through the Senior Advisor on Blood Policy, OHAIDP manages the HHS Federal Advisory Committee on Blood and Tissue Safety & Availability which provides public and private sector advice on blood safety and availability. In addition, OHAIDP provides internal coordination of policies, programs and resources related to blood, organs and tissues, through the Blood Organ and Tissue Senor Executive Council (BOTSEC), a cross-department council comprised of representatives from CDC, FDA, NIH, CMS, HRSA, ASPR, and ASPE. BOTSEC members are actively engaged in a number of important policy and program issues and activities, including the biennial HHS National Blood Collection & Utilization Survey; the HHS Donor-based Hemovigilance System; the HHS Blood Availability & Safety Information System; and developing a research agenda to review current policies pertaining to blood donor deferral of men who have sex with men.

Funding History

FY 2009	$919,000
FY 2010	$929,000
FY 2011	$1,429,000
FY 2012	$1,498,000
FY 2013	$1,507,000

Budget Request

The FY 2014 request of $1,500,000 is $2,000 above the FY 2012 Enacted level. The proposed increase will restore funding for activities in support of the President's Advisory Council on HIV/AIDS (PACHA), as well as cover the expected inflation costs. In addition to PACHA's four subcommittees, the Council recently established a new subcommittee on Expanding Access to HIV Care. It is charged with providing advice and developing recommendations to HHS related to planning for changes in the categorical Ryan White Care Act Program in light of the full implementation of the Affordable Care Act (ACA). In FY 2014, PACHA will continue to make significant progress in meeting the goals of the National HIV/AIDS Strategy and provide advice and consultation to ensure the powerful impact that ACA health reforms can have on the health outcomes for people living with HIV.

Additionally, efforts will continue to reduce various administrative costs as outlined by the President's Executive Order 13589 – Promoting Efficient Spending: travel, information technology devices, printing, promotional items, and other opportunities.

OASH
OFFICE FOR HUMAN RESEARCH PROTECTIONS
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	6,937	6,979	6,711	-226
FTE	33	33	33	0

Authorizing Legislation……..……Title III, Section 301 of the PHS Act
FY 2014 Authorization……..Indefinite
Allocation Method……..Direct Federal, Contracts, and Other

Program Description and Accomplishments

The Office for Human Research Protections (OHRP) is the lead federal office 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's mission is to assure those volunteers that the federal government is strongly protecting their well-being. 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 has oversight of more than 10,000 institutions conducting clinical and other research, both in the U.S. and throughout the world, including research funded or conducted by the National Institutes of Health (NIH). Any incident in which research subjects appear to have been inappropriately harmed can result in a large and immediate drop in the numbers of people volunteering for clinical trials, jeopardizing the research enterprise.

OHRP has taken the lead in reforming the protection of human research subjects by examining every aspect of the regulations, and proactively removing bureaucratic requirements that do little or nothing to increase the well-being of research subjects. In July 2011, OHRP published 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 Meetings, invited presentations at educational events, educational videos, and other

communications. 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

FY 2009	$6,959,000
FY 2010	$6,949,000
FY 2011	$6,949,000
FY 2012	$6,937,000
FY 2013	$6,979,000

Budget Request

The FY 2014 request of $6,711,000 is $226,000 below the FY 2012 Enacted level. Additional efforts will continue to reduce various administrative costs as outlined by the President's Executive Order 13589 – Promoting Efficient Spending: travel, information technology devices, printing, promotional items, and other opportunities.

The proposed request will support the following activities through FY 2014:

- Draft a Notice of Proposed Rulemaking (NPRM) proposal on human subjects research protections in follow-up to the ANPRM HHS published in July 2011
- Co-sponsor three Division of Education and Development (DED) Research Community Forums in distinct regions reaching approximately 1,100 people
- Host five DED 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 100 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

- Issue two Federal Register Notices in compliance with the Requirement of the Paperwork Reduction Act of 1995
- Issue two Guidance documents
- Open four Division of Compliance Oversight not-for-cause evaluations of institutions' human subject protections program; this program provides an important complement to the performance-based quality improvement programs (workshops and consultations) conducted by DED
- Open six new compliance oversight investigations; close three compliance oversight investigations
- 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.
- Support three Secretary Advisory Committee on Human Research Protections (SACHRP) meetings and five meetings of SACHRP's subcommittees

OASH
OFFICE OF RESEARCH INTEGRITY
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	9,027	9,027	9,027	0
FTE	24	24	24	0

**Reimbursable Funding

Authorizing Legislation……Title III, Section 301 and Title IV Section 493 of the PHS Act
FY 2014 Authorization……..……..……..…….……...Indefinite
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 Public Health Service (PHS). ORI is required by federal regulation (42 CFR Part 93) to protect taxpayer funding, and the scientific record, through monitoring investigations of allegations of research misconduct involving PHS funds by applicant and awardees' institutions and through its own independent oversight review of institutional reports to ensure thoroughness and fairness. To accomplish this mission, the key responsibilities of ORI are to:

- receive assurances annually from the more than 5,000 institutions worldwide that receive PHS funds for research that they have policies compliant with the PHS research misconduct regulation in place for handing allegations of research misconduct, and fostering an environment that promotes research integrity
- monitor institutional investigations of research misconduct and conduct an independent oversight review of those investigations
- create educational resources on the responsible conduct of research for researchers and research educators
- provide instruction to institutional administrators in up-to-date methods for conducting inquires and investigations of alleged research misconduct
- encourage credible allegations and protect whistleblowers
- advise research journal publishers and editors on forensic analysis of images and other data submitted or already published.

In the last decade, pursuant to ORI's mission as stated in the Federal Register notice (FR 12 May 2000), ORI has placed greater emphasis on education, research, evaluation, and prevention activities. 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, and
- evaluates the effect of research training on improving the quality of research, preventing research misconduct, and increasing the reporting 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. Since clinical trials, human studies, animal studies, and basic research lead to new drugs, devices, and medical interventions, confidence in the integrity of the research record, which leads to such improvements in health, is intertwined closely with the beneficial products of the research. 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 performance include finding research misconduct in approximately 12-15 cases annually, the ORI website visited by more than 115,000 people annually, the ORI blog and Twitter account, support of world, national and regional conferences on promoting research integrity, "boot camps" for the training of institutional Research Integrity Officers and their legal counsel to handle allegations, support of research on research integrity, and creation of innovative educational materials, including an award winning interactive educational video on research misconduct.

Funding History

FY 2009	$8,909,000
FY 2010	$9,118,000
FY 2011	$9,027,000
FY 2012	$9,027,000
FY 2013	$9,027,000

Budget Request

The FY 2014 request of $9,027,000 is equal to the FY 2012 Enacted level.

OASH
PRESIDENT'S COUNCIL ON FITNESS, SPORTS AND NUTRITION
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	1,248	1,255	2,250	1,002
FTE	6	6	6	0

Authorizing Legislation……..……..…….…….Title III, Section 301 of the PHS Act
FY 2014 Authorization.....Indefinite
Allocation Method.....Direct Federal

Program Description and Accomplishments

The President's Council on Fitness, Sports and Nutrition (PCFSN) was established by Executive Order 13545. Originally chartered in 1956 by President Eisenhower as the President's Council on Youth Fitness, the scope of the Council expanded over the years 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 pleasure of the President.

PCFSN advises the President, through the Secretary of HHS, and develops programs and partnerships with the public, private, and non-profit sectors to promote healthy lifestyles through regular physical activity, and good nutrition.

PCFSN coordinates programmatic activities in consultation with the Departments of Agriculture, State, Interior, Education, 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 PCFSN's President's Challenge Physical Activity and Fitness Awards program (President's Challenge). Established in 1966, the President's Challenge provides low-cost, easy-to-use tools that educators, organizational leaders, families, and individuals can use to track participation in physical and fitness-enhancing activities.

In FY 2012, PCFSN successfully launched an enhanced version of its Presidential Active Lifestyle Award (PALA) called PALA+ (Activity + Nutrition), which emphasizes physical activity and healthy eating. More than 250 partners pledged to promote PALA+ through their programs and communications. Promotion of and enhancements to PALA+ and the other awards programs of the President's Challenge will continue through FY 2014.

In FY 2012, the Council led a coordinated effort, along with CDC and leaders in the youth fitness industry, to evaluate and inform improvements to modernize its Youth Fitness Test, which was based on fitness standards developed in 1985. In September 2012, PCFSN launched the Presidential Youth Fitness Program (PYFP) with CDC and industry partners, creating one national youth fitness assessment program for schools across America. The Council's Youth Fitness Test will be completely phased out by the end of FY 2013, and PYFP will be the only nationally recognized program in FY 2014 (coinciding with the 2013-2014 school year). PYFP partners have established a five-year plan, which includes goals for implementation, tracking, and evaluation of the program.

Evidence shows that parents and caregivers have limited awareness of the physical and cognitive health benefits of 60 minutes of daily physical activity for youth. To help educate that population about the importance of regular physical activity, PCFSN launched a Physical Activity Outreach Initiative to

coincide with National Childhood Obesity Awareness Month in September 2012, which will continue through FY 2014. The initiative promotes the recommendations of HHS' *2008 Physical Activity Guidelines for Americans,* and includes two television, two radio, and four print public service announcements (PSAs) featuring Council co-chairs Drew Brees and Dominique Dawes.
In FY 2012, in collaboration with the Office of Disease Prevention and Health Promotion (ODPHP), CDC and NIH, PCFSN convened a subcommittee of experts to review the science and make recommendations on effective strategies to help youth meet the recommendations of the *Physical Activity Guidelines for Americans* and achieve PALA+. The subcommittee, chaired by Council member Dr. Risa Lavizzo-Mourey, will present its findings in a *Physical Activity Guidelines for Americans Mid-Course Review Report* scheduled for release in early 2013. Promotion of the Guidelines and the recommendations of the subcommittee will continue in FY 2014 and beyond.

It is estimated that nearly nine million American youth (ages 6-21) 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 its evaluation and implementation of the *I Can Do It, You Can Do It!* (ICDI) program. ICDI promotes physical activity and healthy eating to youth with disabilities in school, university and community-based settings. In FY 2012, the Council convened a subcommittee of experts to evaluate the ICDI program. The recommendations of the panel, which include expanding the program to serve adults with disabilities as well as youth, will inform future implementation of this program. PCFSN expects to launch the new ICDI program in Q3 or Q4 of FY 2013 with FY 2014 serving as the inaugural year for new sites.

Funding History

FY 2009	$1,228,000
FY 2010	$1,225,000
FY 2011	$1,225,000
FY 2012	$1,248,000
FY 2013	$1,255,000

Budget Request

The FY 2014 request of $2,250,000 is $1,002,000 above the FY 2012 Enacted level. PCFSN will partner with the HHS Office of Disease Prevention and Health Promotion to increase wide-spread adoption of the Physical Activity Guidelines (PAGs). 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 for FY 2014 motivating health officials and decision makers 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.

The added resources will also allow PCFSN to fully implement current programs such as the Presidential Youth Fitness Program and the *I Can Do It, You Can Do It* program for kids with disabilities.

Efforts will continue to reduce various administrative costs as outlined by the President's Executive Order 13589 – Promoting Efficient Spending: travel, information technology devices, printing, promotional items, and other opportunities. PCFSN will continue to leverage partnerships across federal agencies as well as with national nonprofits and community-based organizations to scale current programs and achieve the greatest impact for the American public.

OASH
PUBLIC HEALTH REPORTS
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	499	502	400	-99
FTE	2	2	2	0

Authorizing Legislation……Title III, Section 301 of the Public Health Service Act
FY 2014 Authorization……...…….…….Indefinite
Allocation Method……..…….…….……..Direct federal; Contract, Cooperative Agreement

Program Description and Accomplishments FY14

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 and/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: *Applying Social Determinants of Health to Public Health Practice, Program Collaboration and Service Integration, Public Health Laboratories; and Sexual Health.*

Recent webcasts have covered the topics of the Affordable Care Act, Smoking and Youth, and Oral Health Care for Persons Living with HIV/AIDS.

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/

In order to accomplish its mission, PHR works with several different partners, using a variety of allocation methods to distribute funds:

- Contracts to secure design and layout services; an online manuscript submission service; technical editors; and consultants to the editor.
- Grant to provide furnish services related to printing, mailing, subscriptions, and other *PHR* tasks.

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

FY 2009	$450,000
FY 2010	$448,000
FY 2011	$448,000
FY 2012	$499,000
FY 2013	$502,000

Budget Request

The FY 2014 request of $400,000 is $99,000 below the FY 2012 Enacted level. For FY 2014, PHR will limit funds for technical editing and targeted marketing and outreach and professional development.

The FY 2014 request will allow PHR to continue providing a platform for publishing the latest science which influences policy and practice covering a broad spectrum of current public health research, practice, and policy topics. PHR utilizes its limited resources extremely efficiently to yield a high quality product; similar government-sponsored journals have a much larger budget and production staff.

Efforts will continue to reduce various administrative costs as outlined by the President's Executive Order 13589 – Promoting Efficient Spending: travel, information technology devices, printing, promotional items, and other opportunities.

OASH
TEEN PREGNANCY PREVENTION
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	104,592[1]	105,232	0	-104,592
FTE	16	16	0	-16

[1]The funding for the Teen Pregnancy Prevention (TPP) program moved in FY 2012 from the General Departmental Management Account to the Prevention and Public Health Fund (PPHF) of the Patient Protection and Affordable Care Act of 2010. Please refer to the PPHF fund section for information on the TPP program.

OASH
OFFICE OF MINORITY HEALTH
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	55,782	56,124	40,560	-15,222
FTE	63	63	63	0

Authorizing Legislation…….……..…Title XVII, Section 1707 of the PHS Act
FY 2014 Authorization……..…….……..…P.L. 111-148; Expires 2016
Allocation Method…….Direct Federal; Competitive Grant/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 led the development of the first-ever *HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS Disparities Action Plan)*, which outlines goals and actions HHS will take to reduce health disparities among racial and ethnic minorities. A second important leadership effort for OMH was the development 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 Presidential initiatives such as *Healthy People 2020*, the *Let's Move* initiative, and the President's National HIV/AIDS Strategy.

During FY 2012, OMH played an ongoing leadership role in coordinating policies, programs, and resources to support implementation and monitoring of both plans. OMH funds support the implementation and evaluation of both of these initiatives. Additionally, OMH provides guidance to, and convenes, HHS Operating and Staff Divisions as well as other Federal departments to identify health disparity and health equity policy actions. The targeted leadership improves performance through better coordination on cross-cutting issues, minimizes duplication, and leverages funds aimed at reducing health disparities. OMH led the following in FY 2012:

- HHS Health Disparities Council
- Federal Interagency Health Equity Team (FIHET)
- HHS American Indian and Alaska Native (AI/AN) Health Research Advisory Council (HRAC)
- HHS Workgroup on Asian, Native Hawaiian, and Pacific Islander Issues

- National Promotores de Salud Steering Committee

OMH supports programs and initiatives that raise awareness about health disparities and help 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 provides technical assistance to community organizations researchers, policymakers, public health professionals, and other stakeholders on how to assemble accurate and comprehensive information and articles for use in program development, training 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 health providers with the cultural and linguistic competencies required to improve the quality of care for diverse communities. The e-learning programs use case studies, pre- and post-tests, and self-assessment exercises. These e-learning programs have over 125,000 registrants total, and Think Cultural Health has over 600,000 continuing education credits.

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. OMH grants empower individuals and communities to develop targeted solutions that eliminate health disparities, achieve health equity, and promote prevention and wellness across the lifespan.

- The **State Partnership Grant Program (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.
- 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 access data and use it to facilitate evidence-based health care decision making and address health disparities planning. The AI/AN Partnership Program supports the HHS Secretary's strategic initiative to leverage data for maximum public good. In FY 2012, an estimated 1,526 individuals received services and/or training.
- **The Partnerships Active in Communities to Achieve Health Equity (PAC) Program** seeks to improve health outcomes among racial and ethnic minorities through community-based networks using evidence-based disease management and preventive health activities.
- **The Curbing HIV/AIDS Transmission Among High Risk Minority Youth and Adolescents (CHAT)**, using a peer-to-peer outreach model grantees provided HIV prevention services and education to approximately 14,000 high risk youth in alternative living and education settings, conducted HIV tests for 2,629 youth, and linked 95 percent of participating youth to social and supportive services in FY 2012.

- The **National Minority Male Health Project**, which reached more than 33,000 young men in FY 2012, implements community-focused strategies to deliver culturally appropriate male health services to minority male populations.
- **The Youth Empowerment Program (YEP*)*** reached nearly 83,000 at-risk minority youth and their families in FY 2012. They received tutoring, mentoring, career, social skill and life skill development services. The rate of promotion to the next grade was 17 percent higher among YEP participants than local comparison groups and school suspension rates are 2.5 times higher in comparison groups than among YEP participants.
- **The HIV/AIDS Health Improvement for Re-Entering Ex-Offenders Initiative (HIRE)** is an approach to improve the HIV/AIDS health outcomes of ex-offenders re-entering the mainstream population from federal and state prisons. In FY 2012, more than 38,000 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 Texas.
- **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. During FY 2012, more than 33,000 received services.
- **Turn the Beat Around: Improving Heart Health for African Americans Living in Alabama by Empowering Communities** is a program developed by the Center for Medicare and Medicaid Services' Office of Minority Health (CMS OMH) in partnership with OASH/OMH to support and align with the Million Hearts™ initiative, the *HHS Disparities Action Plan*, and the *NPA*. This program focuses on Alabama, which has the third highest heart disease rate in the nation and is firmly situated in the area commonly referred to as "the Stroke Belt."
- **The Promotores de Salud Health Services Project** uses a community health worker model to improve health outcomes among minority and underserved communities. Promotores will expand the implementation of evidence-based, culturally and linguistically appropriate health education programs, including the Million Hearts ™ Initiative; Affordable Care Act outreach and education; and share strategies, methods, and lessons learned in promoting community health. This program will provide training to at least 100 promotores who will in turn reach thousands of people.
- **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 2012, more than 130,000 individuals were served through the 22 projects implemented by national organizations.

Funding History

FY 2009	$52,956,000
FY 2010	$55,900,000
FY 2011	$55,888,000
FY 2012	$55,782,000
FY 2013	$56,124,000

Budget Request

The FY 2014 request of $40,560,000 is $15,222,000 below the FY 2012 Enacted level. This reduction will be primarily accomplished by funding only the continuations of the current OMH program activities. OMH will continue its Departmental leadership role, coordinating policy development and initiatives impacting minority health across HHS.

OMH takes seriously its responsibility for stewardship of funding for and coordination of federal efforts related to health disparities. This includes ensuring that the programs HHS is supporting are improving the health of individuals affected by health disparities. OMH is charged with advising the Secretary and the Department on the effectiveness of community-based programs and policies impacting health disparities. OMH funds various initiatives to develop, test, and implement evidence-based interventions to reduce health disparities. The results from these various initiatives play a critical role in supporting the HHS Action Plan to Reduce Racial and Ethnic Health Disparities and the Assistant Secretary for Health's priority goal to eliminate health disparities and achieve health equity. Continued grant funding of these programs is necessary to meet this challenge and to reduce health disparities among individuals, communities, states and, tribes.

In FY 2014, OMH will continue programs that address health disparities, including:

- The 44 *State Partnership Grant Program (SPG)* States/projects engaged approximately 525,000 partner organizations and citizens during FY 2012 and will engage more than 550,000 organizations and citizens at the FY 2014 funding level.
- The *American Indian and Alaska Native (AI/AN) Partnership Program* through grantees and their partner organizations provided an estimated 1,526 individuals with services and/or training in FY 2011. This program is expected to similarly impact more than 1,600 individuals in FY 2014.
- *The Partnerships Active in Communities to Achieve Health Equity (PAC) Program* will serve nearly 20,000 individuals at the FY 2014 funding level.
- The *Youth Empowerment Program (YEP)* will serve approximately 28,000 at-risk minority youth and their families at the FY 2014 funding level.
- *The HIV/AIDS Health Improvement for Re-Entering Ex-Offenders (HIRE) Initiative* is expected that more than 40,000 re-entrants and their partners will benefit from the program at the FY 2014 funding level.
- *The Linkage to Life Program: Rebuilding Broken Bridges for Minority Families Impacted by HIV/AIDS (L2L)* is expected to assist more than 35,000 individuals/families at the FY 2014 funding level.

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
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 2012: 556,000 Baseline	N/A	15%	--
4.3.1 Increased average number of persons participating in OMH grant programs per $1 million in OMH grant support (Efficiency)	FY 2012: 30,569[20] (Target Exceeded)	15,980	16,593	+613
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 2012: 27,151 Baseline	27,151	28,804	+1,653
4.4.1 Unique visitors to OMH-supported websites (Output)	FY 2012: 850,530[21] (Target Exceeded)	580,000	590,000	+10,000
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 2012: 14% Baseline	14%	34%	+20
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 2012: 30% Baseline	30%	34%	+ 4

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. Providers can take the first step to improve the quality of health care services given to diverse populations. By learning to be more aware of their own cultural beliefs and more responsive to those of their patients, providers can think in ways they might not have before. That can lead to self-awareness and, over time, changed beliefs and attitudes that will translate into better health care. OMH expects to see a 5% to 10% increase in the number 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

[20] Based on data collected 9/1/2011–8/31/2011 from OMH grantees entering participant data into the online Performance Data System of the OMH Performance Improvement and Management System.

[21] This figure is based on data collected by the OMH Resource Center. An uptick was noted for this measure in FY 12 Quarter 4 as a new Director (Acting) of the Division of Information and Education was brought on board, along with new staff to support OMH communications efforts and drive Resource Center and website activities.

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. OMH grants empower individuals and communities to develop targeted solutions that eliminate health disparities, achieve health equity, and promote prevention and wellness across the lifespan. In FY 2014, OMH will continue a number of vital grant programs that address health disparities and expect to see a 3% increase in the average number of people participating in OMH grant programs per $1 million in OMH grant support and through partnerships established by grantees to implement funded interventions.

4.4.1: The OMH supported websites are administered by the Office of Minority Health Resource Center (OMHRC) which houses minority health and health disparities data and literature, helping community organizations and health disparities researchers assemble accurate and comprehensive information and articles for use in program development and grant writing. The OMHRC supports the HHS Disparities Action Plan, National Partnership for Action to End Health Disparities (NPA), and the National HIV/AIDS Strategy, along with many other Federal initiatives. The websites serve as an information dissemination tool for the Disparities Action Plan and 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 800,000 times since it was unveiled and OMHRC keeps NPA partners connected through its web page, electronic newsletter, blog, and related media. OMH expects to see an increase of approximately 590,000 unique visitors to these websites in the next year.

4.5.1: OMH is charged with leading key policy initiatives to improve the health of racial and ethnic minorities through the development of policies and programs that help eliminate health disparities. As such, OMH builds strategic partnerships and provides leadership and coordination for State and Territorial Offices of Minority Health/Health Equity. OMH expects to see a 7% 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.

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 therefore 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 Action Plan to Reduce Racial and Ethnic Health Disparities 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 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Contracts			
OMH Resource Center (Includes *A Healthy Baby Begins with You Campaign*)	3,700,000	3,700,000	2,500,000
Logistical Support Contract	2,000,000	2,000,000	1,300,000
Center for Linguistic and Cultural Competency in Health Care	1,600,000	1,600,000	1,100,000
Promotores de Salud Initiative	1,000,000	1,000,000	1,000,000
HHS Disparities Action Plan	1,500,000	1,500,000	850,000
Evaluation	1,000,000	1,000,000	800,000
Subtotal, Contracts	10,800,000	10,800,000	7,550,000
Grants/Cooperative Agreements			
Health Disparities Programs:			
State Partnership Programs	6,000,000	6,000,000	6,000,000
American Indian/Alaska Native Partnership	1,200,000	1,200,000	1,200,000
Community Partnership	4,550,000	4,550,000	1,300,000
Youth Empowerment Program	1,800,000	1,800,000	1,800,000
Conference Support	400,000	400,000	300,000
Tobacco Cessation	1,000,000	1,000,000	1,000,000
Delta Region Institute (*Formerly Health Disparities – Mississippi*)	4,000,000	4,000,000	0
Specified Project – Lupus	1,000,000	1,000,000	0
National Minority Male Health Project	1,000,000	1,000,000	1,000,000
Minority Community HIV/AIDS Partnership	1,150,000	1,150,000	0
National Umbrella Cooperative Agreements	3,675,000	3,675,000	3,025,000
Subtotal, Grants/Coop	25,775,000	25,775,000	15,625,000
Inter-Agency Agreements (IAA)			
Other IAAs	4,887,000	4,887,000	3,729,000
Operating Expenses	14,320,000	14,662,000	13,656,000
Total	**55,782,000**	**56,124,000**	**40,560,000**

Size of Awards

(whole dollars)	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
Number of Awards	112	101	91
Average Award	243,250	163,613	171,703
Range of Awards	125,000-4,000,000	125,000-1,000,000	125,000-1,000,000

OASH
OFFICE ON WOMEN'S HEALTH
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	33,682	33,888	26,808	-6,874
FTE	43	43	43	0

Authorizing Legislation……Title II, Section 229 of the PHS Act
FY 2014 Authorization ..... Indefinite
Allocation Methods..... .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 government 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 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 recommendations 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 Steering Committee on Violence Against Women, OWH convenes this committee and collaborates with HHS agencies and offices in the development and implementation of programs and research related to violence against women. .
- 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.
- White House Working Group on the Intersection of HIV/AIDS, Violence against Women and Girls, and Gender-Related Health Disparities, a member of the working group , and participates in both domestic violence and HIV/AIDS- related efforts and the. 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 helping women of all ages live healthier lives.

For example, OWH continues to implement Project Connect, 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 $3 million 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*. 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.

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 2011, there were 12,260,859 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 994,354 visits in 2011.
- **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.
- **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 2011, there were 38,135 phone calls to the call center.
- **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. OWH has more than 500,000 Twitter followers, the second highest number for any HHS agency or office.

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 2011, OWH launched the *Make the Call. Don't Miss a Beat* media campaign, in collaboration with the National Heart, Lung, and Blood Institute, the Centers for Disease Control and Prevention, and 10 outside organizations. The two-year public service campaign alerts women to the seven symptoms of a heart attack and encourages them to call 911 if they have symptoms. In FY 2013, OWH will release the Spanish version of the campaign in collaboration with major national Hispanic organizations.

The office is also committed to 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

FY 2009	$33,746,000
FY 2010	$33,746,000
FY 2011	$33,679,000
FY 2012	$33,682,000
FY 2013	$33,888,000

Budget Request

The FY 2014 request of $26,808,000 is $4,874,000 below the FY 2012 Enacted level. OWH will 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. The FY 2014 request will not affect funding for Violence against Women's activities.

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. As of July 31, 2012, OWH has a total of 20,249 Facebook subscribers and 882,462 Twitter subscribers across multiple social media channels. The FY 2014 budget request will directly provide support to maintain this level and develop new social media efforts.

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
5.1.2 Increase the Percentage of women-specific Healthy People 2020 objectives and sub-objectives that have met their target or are moving in the right direction. (Outcome)	N/A	N/A	N/A	N/A
5.2.1 Number of users of OWH's social media channels. (Output)	FY 2012: 810,175 Baseline	810,175	1,000,000	+189,825
5.3.1 Number of users of OWH communication resources (Output)	FY 2012:18,456,696 (Target Not Met)	21,500,000 user sessions	22,500,000 user sessions	+1,000,000
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 2012: 11,865,153 (Target Exceeded)	770,461	829,727	+59,266

Performance Analysis

OWH is no longer able to collect data for measure 5.1.2. In the upcoming fiscal year OWH will aggressively work to develop a new outcome measure to be presented in the FY 2015 budget justification.

Funding 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 26 million women 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.

Funding of OWH's social media efforts will ensure the availability of reliable women's health information to the public in a format they want 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). 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 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Contracts			
Regional Women's Master Contract	2,300,000	2,300,000	2,100,000
Program Evaluation	1,000,000	1,000,000	800,000
Nat'l Women's Health Information Center	3,200,000	3,200,000	3,000,000
Print Materials	600,000	600,000	500,000
Communications (Fulfillment)	300,000	300,000	100,000
Meeting Logistics Contract	1,000,000	1,000,000	1,000,000
Adolescent Health & Osteoporosis	3,150,000	3,150,000	800,000
Incarcerated Women in Transition & Trauma	240,000	240,000	500,000
Cardiovascular Disease Programs	1,750,000	1,750,000	518,000
Workplace Breastfeeding	415,000	415,000	375,000
Quick Health Data	500,000	500,000	500,000
National Women's Health Week[1]	250,000	250,000	250,000
HIV/AIDS–Minority Communities[2]	800,000	800,000	600,000
Violence Against Women[2]	895,000	895,000	895,000
Subtotal, Contracts	**$16,400,000**	**$16,400,000**	**$11,938,000**
Grants/Cooperative Agreements			
Coalitions for Health Community[3]	3,000,000	3,000,000	2,900,000
HIV/AIDS–Minority Communities[2]	1,400,000	1,400,000	0
Minority Women's Health	680,000	680,000	0
Violence Against Women[2]	2,115,000	2,115,000	2,115,000
Subtotal, Grants/Coops	**$7,195,000**	**$7,195,000**	**$5,015,000**
Inter-Agency Agreements			
Co-sponsorships (includes IAAs & others)	500,000	500,000	500,000
Operating Expenses	9,587,000	9,793,000	9,355,000
Total	**$33,682,000**	**$33,888,000**	**$26,808,000**

1 Misidentified as grant/cooperative agreement in previous budget submissions
2 Previous budget justifications misidentified initiatives as only grant awards; includes both competitive contracts and grant awards
3 Previously Titled Gender-Focused Health Systems Change

Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	39	32	15
Average Award	184,487	221,719	334,333
Range of Awards	25,000-1,650,000	25,000-1,650,000	25,000-1,650,000

OASH
HIV/AIDS IN MINORITY COMMUNITIES
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	53,681	54,010	0[1]	-53,681
FTE	0	0	0	0

[1]The funding for the Minority AIDS Initiative (MAI) was proposed in the FY 2013 President's Budget from the General Departmental Management Account to the Public Health Service (PHS) Evaluation Fund. Please refer to the PHS Evaluation fund section for information on MAI.

OASH
EMBRYO ADOPTION AWARENESS CAMPAIGN
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	1,996	2,008	0	-1,996
FTE	0	0	0	0

Authorizing Legislation .....Public Health Service Act, Section 1704
FY 2014 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

FY 2009	$4,200,000
FY 2010	$4,200,000
FY 2011	$2,004,000
FY 2012	$1,996,000
FY 2013	$2,008,000

Budget Request

HHS is not requesting funds for this program for FY 2014.

RENT, OPERATIONS, MAINTENANCE AND RELATED SERVICES

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	18,665	18,779	18,483	-182
FTE	0	0	0	0

Rent/Operations and Maintenance and Related Services

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

FY 2009	$16,850,000
FY 2010	$16,935,000
FY 2011	$16,616,000
FY 2012	$18,665,000
FY 2013	$18,779,000

Budget Request

The FY 2014 request for Rent, O&M, and Related Services is $18,483,000, $13,000 below the FY 2012 Enacted level. A reduction in administrative functions will account for this decrease.

SHARED OPERATING EXPENSES

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	16,062	16,162	23,023	6,961
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.

The following services, in support of HealthCare.gov, will be provided by the Web Communications in FY 2013. The services provide a full scope of activity for the site from contracts supporting development, hosting, data base delivery, content management systems, Spanish translation, surge protection and graphics:

- Manage, design and maintain the user interface of Healthcare.gov and the Insurance Finder database section of that site.
- Manage and collaborate with offices across the department related to the user interface, operations and content for the Healthcare.gov Website. Provide managing editor function for healthcare content related to healthcare programs, activities and information across the department.
- Manage with appropriate contracts the maintenance of the infrastructure to include the servers and surge protection for Healthcare.gov.
- Manage site translation.

- Manage and maintain the user interface, data import from Medicaid and HIOS/CMS systems the systems logic, system interface, system hosting and infrastructure for Finder.HealthCare.gov.
- Develop, manage and maintain additional representations of data collected through HIOS/CMS for consumer consumption on HealthCare.gov for business areas such as Rate Review, Medical Loss Ratio, Consumer Assistance and the Federally Facilitated Exchanges. These are new and expanding areas of HealthCare.gov in 2013.

FY 2014 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

The GDM will use $526,268 of its FY 2014 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 2014 E-Gov Initiatives and Lines of Business*	
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	$193,450
FY 2014 E-Gov Initiatives Total	**$526,268**

* 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. Improving sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Funding History

FY 2009	$17,698,000
FY 2010	$14,520,000
FY 2011	$15,999,000
FY 2012	$16,062,000
FY 2013	$16,162,000

Budget Request

The FY 2014 request for other Shared Operating Expenses is $23,023,000, $6,961,000 above the FY 2012 Enacted level. This increase is supported by reallocating funds from other programs within the GDM account for the purpose of consolidating shared services in one account. The increase will be used to support expected growth in regulation of the Affordable Care Act as it is implemented in FY 2014. This will include support for Healthcare.gov and subsequent tools developed in connection with Healthcare.gov such as Small business Finder, which is part of the system where individuals and small business can go to find health coverage options; Options Finder, Individual Plan Finder, Rate Review/Company Profile and Partnership for Patients.

PHS EVALUATION SET-ASIDE

(Dollars in Thousands)

Program Level	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
ASPE	53,993	54,323	56,305	2,312
OASH	4,510	4,538	4,285	-225
HIV AIDS in Minority Communities	0	0	53,891	53,891
Teen Pregnancy Prevention Initiative	8,455	8,507	4,232	-4,223
ASFR	2,253	2,267	1,128	-1,125
Total	**69,211**	**69,635**	**119,841**	**50,630**
FTE	**144**	**144**	**144**	**0**

PHS EVALUATION
OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

(Dollars in Thousands)

Program Level	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
ASPE	41,493	41,746	43,805	2,312
Health Reform	12,500	12,577	12,500	0
Total	**53,993**	**54,323**	**56,305**	**2,312**
FTE	144	144	144	0

Authorizing Legislation..... ….42 U.S.C. 241 Public Health Service Act
FY 2014 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:

1) Assessments of the effectiveness of programs and strategies used to achieve public health and human service goals and objectives;
2) Assessments of the health and human services environment to understand how changes in the environment affect public programs and strategies;
3) Evaluations to improve the management of public health and human services programs;
4) 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,
5) 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, 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

FY 2009	$41,343,000
FY 2010	$54,743,000
FY 2011	$54,743,000
FY 2012	$53,993,000
FY 2013	$54,323,000

ASPE Budget Request

The FY 2014 request for ASPE is $56,305,000. This number includes $12,500,000 for Healthcare Reform activities. 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. Additional funding will allow ASPE to also to do some specific evaluations related to the impact of health insurance coverage and benefit expansions among beneficiaries of HHS direct service programs. $300,000 in additional funding for the Strong Cities, Strong Communities Initiative will help to foster new partnerships between the Department and localities to spark economic development in communities that have faced significant long-term economic challenges.

ASPE will continue its analyses of alternative enrollment and eligibility policies for expansion of health insurance coverage which relies on sophisticated statistical modeling; research on health care workforce supply and distribution, which is designed to address the enhanced need for health care services that is expected to follow the 2014 expansion insurance coverage; cross-cutting research and analysis on medical product development, patient safety, and research translation policy to inform science policy and priority-setting; policy research and evaluation activities that ultimately inform and lay the groundwork for strategic policy initiatives and interagency collaborations; and projects to foster Open Government, which would allow us to release health data to the public in accessible formats that allow and encourage the fullest use of data.

Goal 1: Strengthen Health Care

Priority projects for FY2014 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, 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 FY2014 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 FY2014 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.

Goal 4: Increase Efficiency, Transparency and Accountability of HHS Programs
Priority projects in FY 2014 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, and ensure effective long-range planning for surveys and other investments in major data collection; 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 2014 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 may 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.

ASPE Grant Awards Table

Description	FY 2012	FY 2013	FY 2014
Number of Awards	4	4	4
Average Award	$750,000	$750,000	$750,000
Range of Awards	$700,000 - $800,000	$700,000 - $800,000	$700,000 - $800,000

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. Beginning in FY 2012, ASPE reduced the number of grants from five to four while essentially maintaining total support for the research center program in an effort to ensure that each center received sufficient funding to carry out a robust research agenda.

ASPE's grants for academic research institutes range from $700,000 to $800,000 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.

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 2014, 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.

PHS EVALUATION
OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH
(Dollars in Thousands)

Program Level	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	4,510	4,538	4,285	-225
FTE	0	0	0	0

Authorizing Legislation ..... Section 241 PHS Act
FY 2014 Authorization ..... Indefinite
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 2012 evaluation funds are listed below by HHS Strategic Goal:

Strategic Goal 1: Strengthen Health Care

- Evaluating New Federal Guidance on Quality Family Planning Services – Assess the impact of the nation's first evidence-based guidance on providing comprehensive quality family planning services to women, men, and adolescents. Conduct a nationally-representative assessment of clinicians to establish baseline estimates of provider knowledge, attitudes, and practices related to the clinical provision of reproductive health care and clinic procedures in order to describe differences between various types of service providers and identify gaps between evidence and practice that can inform the design of educational interventions and tools.

- Healthcare Associated Infections (HAI) in Long-Term Care Facilities (LTCF) – Assess LTCF needs regarding HAI data definition and collection and staff training. Build collaborative partnerships to address infection and prevention management needs. Improve discharge planning and reduce HAI rates as residents move between acute care and LTCF settings.

Strategic Goal 2: Advance Scientific Knowledge and Innovation

- National Blood Collection and Utilization Survey – Evaluate the cognitive validity and behavioral effectiveness of the current U.S. blood-donor Universal Donor History Questionnaire (UDHQ). Provide essential sub-assessment to current Department-wide policy evaluation of the 27-year regulation requiring lifetime deferral for blood donation from men who have had sex with another man,even once since 1977.

- OMH Patient Centered Care Collaboration Dissemination and Adoption Evaluation – Evaluate the unique and relative impacts of community engagement in the dissemination and adoption of

evidence-based practices/interventions for the management of diabetes, hypertension, and obesity in targeted racial/ethnic minority communities.

- HIV Open Data Project – Evaluate the strategies to streamline the collection of program and fiscal data from HHS-funded HIV prevention, treatment, and care services. Assess the feasibility of a resource modeled after the NIH's Electronic Research Administration tool, which securely parses data for external sharing and internal monitoring purposes.

- Application of Quality Concepts to Public Health Practice and Research – Evaluate methodologies to put into operation the public health quality concepts into public health practice at the state and local level. Identify a set of potential quality measures and utilize the results to develop time sensitive research to empirically test the measures for validity and reliability.

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

- Dietary Guidelines for America (DGA) 2015, Phase 1 – Evaluate the most recent nutrition science and develop report to Secretary forming the basis for development of DGA 2015. Support Dietary Guidelines Advisory Committee (DGAC) to ensure the DGAs 2015 represent high-caliber scientific expertise and broad public input. Initiate development of next edition of DGA, as mandated by Congress.

- Healthy People 2020: Building the Foundation for a Healthy Nation – Evaluate multiple components of the Healthy People 2020 to ensure Healthy People 2020 remains current; aligns with other high-priority prevention initiatives; and delivers information, resources and tools needed and requested by users in the most effective manner. Draw on expertise and input from diverse stakeholders including Federal partners; State and local health officials; academia; businesses; and community, voluntary and professional organizations.

- Public Health Aims and Leading Health Indicators – Evaluate the feasibility of using the nine aims for quality in public health and six Priority Areas as a framework to identify and map existing quality measures from sources such as Healthy People 2020 to the Leading Health Indicators. Emphasize on quality measures appropriate for implementation at the state and local levels.

- Physical Activity Guidelines (PAG) for Americans Midcourse Review - Evaluate scientific literature and develop a report on effective strategies for achieving the PAG among children, youth, and young adults. Develop a communication campaign to promote the core messages of the PAG and the recommendations that emerge from the midcourse review.

Strategic Goal 4: Increase the Efficiency, Transparency, and Accountability of HHS Programs

- Pregnancy Assistance Fund – Evaluate the Pregnancy Assistance Fund grantees and the implementation of their projects to assist pregnant and parenting teens and women. Use a three-pronged approach to describe the implementation of grantee programs: (1) a descriptive analysis of all projects, (2) an analysis of performance measures reported by the grantees, and (3) a case study analysis of up to three grantees.

- Viral Hepatitis Program Implementation – Evaluates the implementation of the Viral Hepatitis Action Plan by non-federal organizations to enable HHS to better understand the Action Plan's impact on the national response. Inform effective implementation by augmenting periodic Action Plan status updates, engaging community partners and developing a framework to assess progress toward national viral hepatitis goals.

Strategic Goal 5: Strengthen the Nation's Health and Human Service Infrastructure and Workforce

- Strengthen Healthcare Associated Infection (HAI) Prevention in Rural, Small, and Critical Access Hospitals Region IX – Continue development of a model program to enhance infection prevention policies and practices in California hospitals. Develop and expand HAI prevention expertise through three collaborative projects; promulgate best practices and support culture change.

Funding History

FY 2009	$8,465,000
FY 2010	$8,965,000
FY 2011	$4,510,000
FY 2012	$4,510,000
FY 2013	$4,538,000

Budget Request

The FY 2014 request of $4,285,000 is $225,000 below the FY 2012 Enacted level. OASH will continue its established operations at this level.

PHS EVALUATION
HIV/AIDS IN MINORITY COMMUNITIES
(Dollars in Thousands)

Program Level	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	0	0	53,891	53,891
FTE	0	0	0	0

Authorizing Legislation .....Title III, Section 301 of the PHS Act
FY 2014 Authorization .....Indefinite
Allocation Methods.....Grants, Cooperative Agreements and Contracts

Program Descriptions 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 (OHAP), administers the Secretary's Fund (SMAIF) on behalf of the Office of the Assistant Secretary for Health (OASH). SMAIF funds are competitively awarded to HHS agencies and offices to support activities related to HIV prevention, care and treatment, outreach and education, technical assistance, and demonstration projects. 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). In FY 2012 and FY 2013, OHAIDP continued to restructure and transition the SMAIF to align with the goals, objectives, and priorities of the NHAS. OHAIDP works with HHS agencies and offices to enhance the targeting and the effectiveness of SMAIF funds supporting HIV prevention and care services provided for high risk racial and ethnic minority communities. This was accomplished through program and process directives, including the development of a formal internal Funding Opportunity Announcement (FOA) in FY 2012. The internal FOA designates four priority project areas, including: preventing HIV; improving health outcomes; mobilization to reduce HIV-related health disparities; and capacity development in support of NHAS goals. Approximately $35 million was awarded in FY 2012 through the FOA.

In addition, guidance provided by OHAIDP now requires the use of standardized HIV testing and 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 in the U.S. (CAPUS), supported through the SMAIF is an HHS-wide demonstration project. This project is designed to build capacity of non-governmental organizations and health departments to reduce HIV-related health disparities among racial/ethnic minorities in areas of the country with high case fatality rates and in other underserved areas of the United States. Approximately $14.5 million has been allocated to fund this new demonstration project which began in the fall of 2012.

Administration of the SMAIF is more collaborative, accountable, and transparent. 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, future projects funded under the SMAIF in FY 2013 and FY 2014 WILL design demonstration projects and build community capacity to deliver the needed services along that continuum.

The following are additional examples of activities that have been supported with the SMAIF in the recent past and are also in alignment with the National HIV/AIDS Strategy:

- *Capacity Development*: increasing the opportunities for the training of clinical and non-clinical staff to provide HIV/AIDS-related services;
- *Preventing HIV*: developing or expanding prevention efforts for sub-populations, including ex-offenders; at-risk female adolescents/youth; sexual partners of incarcerated or recently released heterosexuals; and African American and Hispanic Men Who Have Sex with Men;
- *Improving Health Outcomes*: developing retention and re-engagement interventions for HIV-positive 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.

Funding History

FY 2009	$0
FY 2010	$0
FY 2011	$0
FY 2012	$0
FY 2013	$0

Budget Request

The FY 2014 budget request of $53,891,000 is the same as the FY 2012 Enacted level. In addition, the Office of HIV/AIDS and Infectious Disease Policy will continue to work with partnering agencies and offices to develop a plan to better identify and disseminate "promising practices" in FY 2013. This "promising practice" plan will better track positive outcomes and improvements or progress in reaching targets and goals, as well as highlight effective and innovative strategies. These efforts will continue through FY 2014.

FUNDING ALLOCATION[1]
(Dollars in thousands)

Agency	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY 09	FY 10	FY 11	FY 12
CDC	15,641	15,641	10,500	9,850	8,500	8,745	7,875	2,740	3,822	10,380	17,650
SAMHSA	12,000	12,000	11,000	11,345	9,500	10,235	8,735	9,600	8,673	5,900	3,400
HRSA	6,200	5,600	6,900	8,205	8,637	8,641	7,190	6,348	5,292	7,722	4,550
NIH	-	-	-	-	-	-	-	-	-	-	-
IHS	1,450	1,450	1,500	2,096	1,963	1,913	2,300	3,210	4,380	4,225	3,990
OS	14,700	14,384	19,644	20,919	23,255	22,357	24,883	29,993	31,723	25,556	24,091
OASH:											
OAH	-	-	-	-	-	-	-	-	-	200	200
OHAIDP	3,200	1,863	2,914	2,956	6,335	3,932	2,523	3,958	3,681	4,359	3,385
OMH	7,900	7,900	8,000	7,650	7,000	6,760	8,800	8,900	8,948	5,468	4,800
OPA	3,000	3,000	6,000	6,000	6,100	6,500	7,100	8,070	7,942	7,200	6,800
OWH	600	600	1,640	3,055	2,655	4,000	4,000	6,125	6,983	3,425	4,100
RHA	-	-	-	-	-	-	1,300	1,780	1,744	2,000	1,900
Eval Set-aside	-	1,021	1,090	1,258	1,165	1,165	1,160	1,160	1,078	-	1,342
Admin Fees (PSC)	-	-	-	-	-	-	-	-	1,347	2,904	1,564
TOTAL	**49,991**	**49,075**	**49,544**	**52,415**	**51,855**	**51,891**	**50,983**	**51,891**	**53,890**	**53,783**	**53,681**

[1]Prior year funding for the Minority AIDS Initiative (MAI) was in General Departmental Management Account no the Public Health Service (PHS) Evaluation Fund.

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
7.1.12a: Increase the number of racial and ethnic minority clients who are tested through the Secretary's MAI fund programs. (Outcome)	FY 2010: 298,498 (Target Exceeded)	209,578	328,348	+118,770
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: 201.0 (Target Met)	221	255	+34
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 Met)	95%	98%	+3
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 Met)	73%	77%	+4
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 Met)	5,585	6,157	+572
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 Met)	133	160	+27

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

PHS EVALUATION
TEEN PREGNANCY PREVENTION
(Dollars in Thousands)

Program Level	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	8,455	8,507	4,232	-4,223
FTE	0	0	0	0

Authorizing Legislation……..……..…….Section 241 of the PHS Act
FY 2014 Authorization……..…..……..Indefinite
Allocation Methods……..……...Direct Federal, Contracts

Program Descriptions and Accomplishments

The request includes funds for: two ongoing Federal evaluations of teen pregnancy prevention programs; an ongoing systematic evidence review; and ongoing evaluation training and technical assistance for Teen Pregnancy Prevention (TPP) program grantee-led evaluations.

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.
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 9 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.
3. 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 23 of these model programs. In April 2012, the review was updated and three additional programs were added. 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 will contribute funds to update the evidence review in FY14.
4. OAH TPP grantees receive intensive evaluation training and technical assistance 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.

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.

Funding History

FY 2009	$0
FY 2010	$4,455,000
FY 2011	$4,455,000
FY 2012	$8,455,000
FY 2013	$8,507,000

Budget Request

The FY 2014 budget request of $4,232,000 is $4,223,000 less than the FY 2012 Enacted Level. Funds will be used to continue to carry out evaluations (including 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 updates to the HHS TPP Research Evidence Review. OASH works with the Assistant Secretary for Planning and Evaluation (ASPE) and evaluation experts at OMB during the planning, design, and implementation of these evaluation studies, and the TPP evidence review. OASH is committed to promoting strong evaluations that can inform policy and program management decisions and will post the status and findings of these and other important evaluations on the OAH website.

PHS EVALUATION
OFFICE OF THE ASSISTANT SECRETARY FOR FINANCIAL RESOURCES
(Dollars in Thousands)

Program Level	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	2,253	2,267	1,128	-1,125
FTE	0	0	0	0

Authorizing Legislation……...Section 241 of the PHS Act
FY 2014 Authorization…….Indefinite
Allocation Methods…….Direct Federal, Contracts

Program Description and Accomplishments

These funds will cover staff costs focused on program evaluation activities in the preparation of performance reports for OMB, the Congress, and the public, such as the Summary of Performance and Financial Information and the Agency Financial Report. Funds will also go towards the continued development and operation of the electronic Program Performance Tracking System.

Funding History

FY 2009	$503,000
FY 2010	$1,503,000
FY 2011	$1,503,000
FY 2012	$2,253,000
FY 2013	$2,267,000

Budget Request

The FY 2014 request for the Assistant Secretary for Resources (ASFR) is $1,428,000, $825,000 below the FY2012 Enacted level. The FY 2014 Budget will be used to fund program evaluation activities within the ASFR Office of Budget. These funds will cover staff costs focused on program evaluation activities in the preparation of performance reports for OMB, the Congress, and the public, such as the Summary of Performance and Financial Information and the Online Performance Appendix. Funds will also go towards the continued development and operation of the electronic Program Performance Tracking System.

PREVENTION AND PUBLIC HEALTH FUND

(Dollars in Thousands)

Program Level	FY 2012 Actual	FY 2013 CR[1]	FY 2014 President's Budget	FY 2014 +/- FY 2012
Tobacco (ASPA)	10,000	N/A	0	-10,000
Teen Pregnancy Prevention (OASH)	0	N/A	104,790	104,790
Emerging Public Health Issues	20,000	N/A	0	-20,000
Total	**30,000**	**N/A**	**104,790**	**74,790**
FTE	0	0	16	16

Authorizing and Appropriations Legislation.....Section 4002 of the Affordable Care Act
FY2014 Authorized…….……..Pub. L. 111-148; Indefinite
Allocation Methods.....Competitive Grants/Cooperative Agreements, Contracts, and Intramural

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 2014.

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 for the Federal costs associated with administration and evaluation. OAH coordinates its efforts with other HHS offices and OPDIVs.

The TPP is a key component of the Secretary's strategic initiative in 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 models and demonstration programs to identify new effective approaches. OAH is currently funding 75 grants to replicate one or more evidence-based program models identified by HHS through an independent systematic review of the existing literature. OAH is partnering with ASPE to support an ongoing review of the evidence base. Another 19 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

[1] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

supporting eight grants to implement and test multi-component, community-wide initiatives to prevent teen pregnancy. OAH is engaged in collaborations in implementing TPP program and evaluation activities with ASPE, ACF, and CDC. The TPP projects are located in 36 States and the District of Columbia. 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.

Funding History

FY 2009	$0
FY 2010	$0
FY 2011	$0
FY 2012	$0
FY 2013	$0

Budget Request

The FY 2014 request of $104,790,000 is equal to the FY 2012 Enacted level. Expected pay and inflationary costs will be absorbed through reductions in various administrative costs as outlined by the President's Executive Order 13589 – Promoting Efficient Spending: travel, information technology devices, printing, promotional items, and other opportunities.

Program Data Chart

Activity	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Contracts			
Training, technical assistance , and other program support	1,789,000	1,789,000	1,789,000
Grants/Cooperative Agreements			
Teen Pregnancy Prevention Grants (Discretionary)			
Tier I – Replication Projects	75,000,000	75,000,000	75,000,000
Tier II – Research and Demonstration Projects	25,000,000	25,000,000	25,000,000
Subtotal, Grants/Coops	100,000,000	100,000,000	100,000,000
Operating Costs	2,803,000	3,443,000	3,001,000
Total	**104,592,000**	**105,232,000**[1]	**104,790,000**

Size of Awards

(whole dollars)	FY 2012 Enacted	FY 2013 CR	FY 2014 President's Budget
Number of Awards	102	102	102
Average Award	980,392	980,392	980,392
Range of Awards	400,000-4,000,000	400,000-4,000,000	400,000-4,000,000

[1]The funding for the Teen Pregnancy Prevention (TPP) program moved in FY 2012 from the General Departmental Management Account to the Prevention and Public Health Fund (PPHF) of the Patient Protection and Affordable Care Act of 2010. Please refer to the PPHF fund section for information on the TPP program.

PREGNANCY ASSISTANCE FUND

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
OASH	25,000	25,000	25,000	0

Authorizing Legislation……...…..……Patient Protection and Affordable Care Act, Section 10214
Authorization……FY 2019
Allocation Method……Direct Federal Competitive Contract

Program Description and Accomplishments

The Office of Adolescent Health (OAH) is responsible for implementing and administering the Pregnancy Assistance Fund, a competitive program of grants to States and Indian Tribes to develop and implement projects to assist pregnant and parenting teens and women. 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 a Pregnancy Assistance Fund for the purpose of awarding competitive grants to assist pregnant and parenting teens and women. A network of supportive services help pregnant and parenting teens and women complete high school or postsecondary degrees and gain access to health care, child care, family housing, and other critical support. In addition, states may use the funds to address violence against pregnant and parenting women.

A total of $25 million was available in FY 2010 to support pregnant and parenting teens and women in States and Tribes across the country. Of the funds awarded, $24 million was awarded to 17 States and Tribes for a three-year project period (FY 2010-2012) and $1 million for administrative expenses. New competitive awards are expected in FY 2013.

The program will support 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 will support the OASH's priority goals of creating better systems of prevention and eliminating health disparities and achieving health equity.

Funding History

FY 2009	$0
FY 2010	$25,000,000
FY 2011	$25,000,000
FY 2012	$25,000,000
FY 2013	$25,000,000

Budget Request

The FY 2014 request of $25,000,000 is equal the FY 2012 Enacted level. Expected pay and inflationary costs will be absorbed through reductions in various administrative costs as outlined by the President's Executive Order 13589 – Promoting Efficient Spending: travel, information technology devices, printing, promotional items, and other opportunities. Reductions to programs and services to the public will be as minimal as possible to accommodate the funding level.

FY 2014 Discretionary State/Formula Grants

Pregnancy Assistance Fund (PAF)

(Dollars in Thousands)

State Territory	FY 2012 Estimate	FY 2013 Estimate*	FY 2014 Estimate*	Difference +/- FY 2013
Arkansas	1,123			
California	2,000			
Connecticut	2,000			
Indiana	2,000			
Massachusetts	1,648			
Minnesota	2,000			
Montana	1,000			
New Mexico	1,300			
North Carolina	1,768			
Oregon	800			
Tennessee	1,400			
Vermont	934			
Virginia	1,500			
Washington	1,567			
Subtotal	21,041			
Indian Tribes	1,400			
District Of Columbia	1,559			
Subtotal	2,959			
Total States/Territories	24,000			
Technical Assistance	1,000	1,000	1,000	0
Subtotal Adjustments	1,000	1,000	1,000	0
Total Resources	25,000			

* PAF Grants are competed on a three year cycle; FY 2013 is the start of a new competition cycle.

Detail of Positions

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
Executive level I	1	1	1
Executive level II	1	1	1
Executive level III	0	0	0
Executive level IV	2	2	2
Executive level V	1	1	1
Subtotal	5	5	5
Total - Exec. Level Salaries	$845,900	$845,900	$845,900
SES	110	109	109
Total - ES Salary	$18,040,330	$17,926,275	$17,926,275
GS-15	212	212	212
GS-14	220	215	214
GS-13	182	176	176
GS-12	341	327	327
GS-11	177	163	162
GS-10	12	12	12
GS-9	127	118	117
GS-8	62	55	55
GS-7	41	41	41
GS-6	7	7	7
GS-5	10	10	10
GS-4	9	9	9
GS-3	11	11	11
GS-2	2	2	2
GS-1	0	0	0
Subtotal	1413	1358	1355
Commissioned Corps	67	54	54
Total Positions	1595	1526	1523
Total FTE	1595	1526	1523
Average ES salary	$164,003	$164,461	$164,461
Average GS grade	13.4	13.5	13.5
Average GS Salary	$100,760	$101,974	$102,390

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT									
	FY 2012 Actual			FY 2013 CR			FY 2014 President's Budget		
	Civilian	**Military**	**Total**	**Civilian**	**Military**	**Total**	**Civilian**	**Military**	**Total**
Direct:	1,043	40	1,083	1,054	37	1,091	1,035	37	1,072
Reimbursable:	485	27	512	418	17	435	434	17	451
FTE Total	**1,528**	**67**	**1,595**	**1,472**	**54**	**1,526**	**1,469**	**54**	**1,523**

Statement of Personnel Resources

	Total Full-Time Equivalents			
	FY 2012		FY 2013	FY 2014
	Budget Target	Estimate	President's Budget	Request
Direct:				
Program, Project or Activity:				
Total, Direct Ceiling FTE	**1,083**	**1,083**	**1,091**	**1,072**
Reimbursable:				
Program, Project or Activity:				
Total, Reimbursable Ceiling FTE	**512**	**512**	**435**	**451**
Total Ceiling FTE	**1,595**	**1,595**	**1,526**	**1,523**
Total, Civilian FTE	**1,528**	**1,528**	**1,472**	**1,469**
Total, Military FTE	**67**	**67**	**54**	**54**

FTE Pay Analysis FY 2012 – FY 2014[1]

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 Pres. Budget
Total FTE	1,595	1,526	1,523
Number change from previous year		-69	-3
Funding for object classes 11	167,985	162,759	163,040
Average cost per FTE	$101	$102	$102
Percent change in average cost from previous year		-3.11%	0.17%
Average GS Grade	13.4	13.5	13.5

[1] Includes direct and reimbursable funding and FTE levels.

SIGNIFICANT ITEMS

ASSISTANT SECRETARY FOR GLOBAL AFFAIRS

Item

Global Health Threats.— The Committee acknowledges the urgent need for new technologies in the fight against global health threats as well as the need to sustain and protect U.S. investment in this important research. The Committee urges the FDA, CDC, and NIH to each create metrics to measure progress and to develop concrete plans to prioritize and incorporate global health research, product development, and regulation into the U.S. global health and development strategies, in line with the new HHS Global Health Strategy.

Action taken or to be taken

Today, the health of Americans and the health of people around the world are more closely linked than ever before. Global health threats are numerous and are continuing to evolve and emerge, whether they are naturally occurring, accidental, or deliberate. The U.S. Department of Health and Human Services (HHS) protects the health security of all people with:

- Global surveillance to detect, control and prevent diseases;
- Prevention of infectious diseases and other health threats from crossing borders;
- Preparedness for and response to international outbreaks and public health emergencies;
- Increased safety and integrity of global manufacturing and supply chains for medical products, food and feed;
- Development and implementation of science-based international health and safety standards;
- Biomedical and public health research and innovation for new interventions that improve health and well-being;
- Identification and exchange of best practices to improve health strategies and health systems;
- Recognition of the changing global patterns of death, illness and disability; and
- Advancement of health diplomacy through scientific and technical expertise.

A focus in all of these is tangible results, and thus the importance of a metric by which threats and the U.S. and health sector response can be measured. It is evident that some of our activities are more measurable than others. In addition, President Obama's 2010 Presidential Policy Directive on Development identifies global health as a key focus area tightly linked to international development and security strategies, so HHS is rarely the only USG player, which make measuring and attributing responses a further challenge.

HHS global health programs, research, product development, and regulation implement the HHS Strategic Plan FY 2010-2015 and the January 2012 HHS Global Health Strategy, but also relate directly to or contribute to the National Health Security Strategy and the National Strategy for Countering Biological Threats.

HHS agencies have a long and successful history of development and use of metrics and methods of monitoring and evaluation in many areas of their international work. Some examples of how the metric measure progress and contribute to priority-setting and strategy development:

U.S. Centers for Disease Control and Prevention (CDC)

Emergence of new influenza viruses and the threat of a new influenza pandemic continue to be major threats to global health and to the health of Americans. CDC has developed and implemented a National Inventory of Core Capabilities for Pandemic Influenza Preparedness and Response (National Inventory)

in 36 countries systematically and quantitatively measure national capabilities to respond to an influenza pandemic in 12 distinct core capabilities (e.g. laboratory diagnosis, infection control, rapid response, etc.). Each capability is assigned a composite score based on the quality, coverage and timeliness of four indicators. Administered every two years with the support of CDC, the 2008 baseline assessments helped countries to identify and target areas for preparedness improvement which in turn strengthened their ability to respond to the 2009 H1N1 pandemic. Repeated assessments show concrete results of investments made to prepare for an influenza pandemic.

Global implementation of the World Health Organization's International Health Regulations in all countries is the cornerstone of detection and response to public health emergencies of international concern, regardless of cause. In 2011, CDC worked in consultation with other USG agencies, including the Department of State and United States Agency for International Development, to develop four core metrics around human resources, surveillance, laboratory, and outbreak response related to countries' implementation of the International Health Regulations. These indicators have served as a basis for prioritizing and measuring progress of USG's support of global health security activities in key countries (e.g. Thailand, Kenya, South Africa, Uganda).

CDC research has led to the development of effective and low-cost options for diagnosis and prevention of important global health threats:

- CDC developed new diagnostic assays for HIV/AIDS that have reduced the cost of testing by at least 50 percent compared to commercial test kits, and have made nationwide testing feasible in resource-constrained settings;
- CDC has worked with international partners to develop a rapid bedside test for the plague that is inexpensive to produce and can yield results in just hours, as well as new assays for diagnosis of malaria and various neglected tropical diseases;
- CDC has worked with public health partners to develop and perform targeted *Cryptococcus* screening in HIV clinics, using a point-of-care dipstick screening test ($2.00 USD per test) that is simple, quick, and effective. If screening detects the presence of *Cryptococcus*, beginning treatment before meningitis develops is affordable;
- CDC research in Kenya has examined the combined effects of indoor residual spraying and insecticide-treated bed nets, leading to global adoption of bed nets as a standard intervention against malaria;
- In Botswana, CDC conducted ground-breaking research that provided the first evidence that a daily oral dose of antiretroviral drugs used to treat HIV infection can reduce HIV acquisition among uninfected individuals exposed to the virus through heterosexual sex.

National Institutes of Health (NIH)

NIH pursues research that relates to objective 6 of the Department of Health and Human Services (HHS) global health strategy to catalyze health research globally. The key HHS priorities, in brief, are to address research areas that are linked to scientific opportunity, public health needs, and the evolving burden of disease; support the rapid translation of research results into new or improved preventive, diagnostic and treatment products and processes; and encourage research that identifies causative pathways of the spread of infectious disease and other health threats. Consistent with the Government Performance and Results Act (GPRA), NIH reports performance, including for its global health research activities, using representative trans-NIH measures. NIH reports progress on these measures as part of the budget process.

NIH Institutes and Centers prepare global research and technology development priorities that are disease-focused and tailored to unique functions or specific needs. Using a wide net for soliciting stakeholder input along with following guidelines established by HHS and NIH expert panel committees has allowed NIH to establish and implement priorities and key success criteria, leading to successful

global bio-medical research, product development, and technology priorities and strategies as evidenced by outcome measures such as decreases in otherwise higher rates of communicable diseases (e.g., HIV, influenza) and burdens of non-communicable disorders (e.g., diabetes).

Because of gains in treatment prevention strategies made possible through research advancement, including those made possible through partnerships in Brazil, Africa, India, and Southeast Asia, it has become possible for the first time in more than 30 years to anticipate an end to the HIV/AIDS pandemic. NIH also supports collaborative diabetes research projects in India, a country that has the highest number of diabetics in the world. In South Africa, NIH-supported researchers are looking at cost-effective ways to screen for heart disease. Ongoing research in Asia on the effects of household air pollution may lead to a reduction in chronic respiratory disease. Egyptian and American investigators are working together to find new drug pathways to treat inflammatory breast cancer.

Food and Drug Administration (FDA)
The recent enactments of the Food Safety Modernization Act (FSMA) and the Food and Drug Administration Safety and Innovation Act (FDASIA), among others, has provided FDA with the tools to make marked progress against global health threats as it applies to food and medical products. FDA has developed or is developing metrics to measure implementation of each statute as well as progress against global health threats. FDA is developing concrete plans to prioritize and incorporate global health research and regulation into US global health and development strategies.

A report describing FDA's activities, including global health research and regulatory actions, can be found in the "Pathway to Global Product Safety and Quality Report" dated July 2011 (http://www.fda.gov/AboutFDA/CentersOffices/OfficeofGlobalRegulatoryOperationsandPolicy/GlobalProductPathway/default.htm).

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Item
Biovigilance Network.— The Committee recognizes the leadership of ASH and the Office of Blood Safety and Availability in coordinating efforts between CDC, FDA, NIH, AHRQ, HRSA, and CMS, as well as experts in transfusion medicine and blood banking, in the development and implementation of surveillance systems to track medical errors and adverse events occurring at any point in the collection, processing, distribution, or transfusion of blood. The Committee urges ASH to further these biovigilance efforts as a public/private collaboration allowing for in-depth analysis of the data collected as well as the development of interventions and best practices that can be implemented to eliminate errors and waste, thus improving patient health and safety and reducing costs.

Action taken or to be taken
The Division of Blood and Tissue Safety and Availability (DBTSA) is a component of the Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) within the Office of the Assistant Secretary for Health (OASH). DBTSA manages public health programs, coordinates internal and external federal advisory committees, and provides Department level consultation and advice on issues pertaining to the safety and availability of blood and tissue products and concerns related to infectious diseases in organs used for transplantation. DBTSA fosters public-private-partnerships with stakeholders, such as the American Association of Blood Banks (AABB), the American Association of Tissue Banks (AATB), the United Network for Organ Sharing (UNOS), and The Joint Commission. For example, DBTSA partners with AABB to manage the biennial HHS National Blood Collection and Utilization Surveys – the leading data source for information on adverse events and safety concerns of the U.S. blood supply. DBTSA recently launched a partnership with AATB and UNOS to provide a similar program aimed at collecting

data on the prevalence and incidence rates of infectious diseases in the donated organ and tissues within the U.S. DBTSA is working with The Joint Commission to produce and disseminate education and outreach materials to hospitals and health care providers on appropriate patient blood management practices. OHAIDP/DBTSA serves as the HHS representative on AABB's blood product Quarantine Release Error (QRE) Inter-organizational Task Force. This task force develops data elements, definitions, and outreach material to improve patient safety, as well as identifies best practices for averting adverse events. Additionally, OHAIDP/DBTSA partnered with the Department of Defense Telemedicine and Advanced Technology Research Center under a joint Phase II+ Small Business Innovative Research (SBIR) contract for blood donor based Hemovigilance Research and Development of the Donor Hemovigilance Analysis and Reporting Tool (DonorHARTTM) System, a commercially available, surveillance software product.

Internally, OHAIDP/DBTSA provides leadership among HHS Operating and Staff Divisions involved in the safety and availability of blood, organ, and tissue products. For example, DBTSA manages and convenes the Federal Advisory Committee on Blood and Tissue Safety and Availability (ACBTSA) to provide expert advice and recommendations to the Secretary and Assistant Secretary for Health on a range of public health concerns related to blood and tissue products; organ transplantation safety concerns. The DBTSA also manages the HHS Blood, Organ, and Tissue Senior Executive Council (BOTSEC) which identifies and recommends action on emerging issues related to blood, organ, and tissue safety and availability.

The DBTSA serves as the Department liaison to internal and external stakeholders and convenes and participates in national and international symposia, seminars, and other decisional meetings, including policy development and policy reviews. OHAIDP/DBTSA also serves as the U.S. government representative to meetings of national and International organizations on blood and tissue safety. Examples of these meetings include the 2013 International Haemovigilance Network meeting in (IHN), for adverse events related to transfusions and which provides an opportunity for sharing best practice and benchmarking of data, as well as a resource for information on new and existing haemovigilance systems; the Pan American Health Organization summit, "Surveillance for transparency in transplantation in the Americas" and the 14th Congress of the IHN. Nationally, DBTSA serves as the HHS representative to The Joint Commission's ongoing National Summit on Overuse of blood products, the 2012 AABB Meeting and Transfusion Expo. DBTSA also coordinated with NIH on the 2012 annual researchers' meeting of the Red Blood Cell Lesion R&D group and with the FDA on their inaugural symposium on statistical modeling of the U.S. blood supply.

Item

Traumatic Brain Injury [TBI].— The Committee notes that TBI is a leading cause of death and disability worldwide, especially in children and young adults ages 1 to 44. Due to the high prevalence of TBI, the Committee believes there is a need for multidisciplinary approaches to rapid evaluation and diagnosis of injured patients who have the potential for the development of TBI, as well as the development of early intervention and treatment protocol for use in preventing TBI and improving patient outcomes. The Secretary is encouraged to support a competitively awarded program of academic centers focused on developing and implementing multidisciplinary approaches to the early diagnosis and innovative treatment models for TBI victims.

Action taken or to be taken

The Centers for Disease Control and Prevention (CDC) serves as a national leader for preventing, recognizing, and responding to TBIs. CDC competitively funds11 multidisciplinary Injury Control Research Centers (ICRC), several of which conduct research related to TBI. For example, the ICRC at Nationwide Children's Hospital in Columbus, Ohio has conducted research on sports concussion among youth. One such project is designed to examine the relationship between clinical and epidemiological

TBI-related variables so that in the future coaches and athletic trainers will better recognize and respond to symptoms of TBI. In addition to the ICRCs, CDC supports other TBI research projects through grants and contracts. One example is a project that is examining strategies to appropriately triage older adults with potential TBIs who are taking anticoagulants and platelet inhibitors. The goal of this research is to ensure these potential high-risk patients are taken to an appropriate treatment facility for timely and effective care. Finally, CDC is developing tools for preventing and mitigating TBI such as the Heads Up initiative, which provides education and training to physicians, coaches, parents, and athletes on appropriate recognition and response to concussions in sports.

Item

Urban-Based Network.— The Committee continues to encourage the Secretary and other agencies within the Department such as HRSA, AHRQ, CDC, CMS, and OMH to partner with NIMHD in supporting a network of urban-based institutions focused on, and with demonstrated commitment and capacity to, 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 Office of Minority Health (OMH) continues to work collaboratively across HHS to better align its strategic priorities and policy initiatives, including the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, National Partnership for Action to End Health Disparities, and National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care. OMH funds and supports a number of urban-based institutions focused on addressing recruitment and training needs of minority and urban underserved populations and reducing health disparities in urban communities. Examples of those projects include:

- The Charles Drew University of Medicine and Science Graduate Medical Education Project addresses health disparities among racial and ethnic minorities by increasing the availability of graduate medical education and the number of cultural, linguistic and socially competent healthcare professionals practicing and/or serving in medically underserved urban areas. The Charles Drew GME Project aids in addressing national and local health professional shortages, improves the retention of minority health professionals in federally designated Health Professional Shortage Areas and/or Medically Underserved Areas, and improves the availability and quality of healthcare services provided to medically underserved communities.

- The Satcher Health Leadership Institute (SHLI) at Morehouse School of Medicine provides postdoctoral professionals with the specific skills, knowledge, and experiences needed to prepare them for leadership roles in promoting and implementing policies and practices to reduce and ultimately eliminate disparities in health. The SHLI's mission is consistent with the HHS and OMH strategic focus to develop a diverse group of exceptional health leaders as a critical strategy to reducing and ultimately eliminate health disparities. The Fellowship is designed to build workforce capacity among minority serving professionals through extensive training in leadership, health systems, health disparities, and health policy.

- The National Minority Male Health Project, headquartered at Morehouse College, is a multidisciplinary, multi-institutional collaborative dedicated to promoting healthy lifestyles specifically among minority males through a comprehensive program of research, education, and service. The consortium builds on community-focused health promotion strategies that include: health education and intervention programs, population specific health information, and targeted outreach to males attending consortium member campuses to include Historically Black Colleges and Universities, Hispanic Serving Institutions and Tribal Colleges and Universities, and training professionals and paraprofessionals to deliver and/or enhance the delivery of culturally appropriate

male health services to the target population. The project brings together researchers from a wide range of disciplines to share perspectives, ideas, knowledge, skills and strategies. An advisory board of community leaders and national experts in risky behavior assessment, healthy lifestyles promotion and program implementation supplements the collective expertise of this group.

- The National Network of Public Health Institutes (NNPHI) represents 35 public health institutes and affiliates in 28 states. NNPHI addresses the lack of data and resources for identifying health disparities in minority populations by updating, enhancing and disseminating the Tool for Health and Resilience in Vulnerable Environments (THRIVE) to NNPHI member organizations and affiliates who serve minority individuals and communities. This tool was developed to help people understand and prioritize the factors that can help improve health and safety within their own communities. NNPHI will continue to partner with the public health institutes to increase the capacity of members of the NNPHI network to address social determinants of health to achieve health equity for minority populations.

In FY 2013 OMH entered into a partnership with Nā Limahana o Lonopūhā Native Hawaiian Consortium to improve the overall health of Native Hawaiians over the next five years. Native Hawaiians are underrepresented in the healthcare workforce, which exacerbates the lack of culturally competent patient services. In partnership with the University of Hawaii System, this program will create a pipeline of health care professionals and health care leaders to increase Native Hawaiians representation in the health care workforce and provide internships, fellowships, and cooperative education opportunities for students and faculty at Asian American Native American Pacific Islander Serving Institutions. Additionally, the program will develop a Community Health Worker/Patient Navigator program that will educate and train health care providers, community health workers, and outreach workers on health insurance exchanges, Medicaid, and other health insurance programs under the Affordable Care Act.

Item

Chronic Kidney Disease [CKD].— The Committee continues to prioritize early detection and treatment of CKD in minority communities to improve health outcomes and eliminate health disparities. In particular, the Committee urges the Department to focus on the prevention of CKD in Filipino populations, who have one of the highest rates of incidence per capita. The Committee encourages OMH to partner with minority health professions schools to educate providers on the benefits and opportunities for early detection and treatment of CKD.

Action taken or to be taken

Racial and ethnic minorities are almost two to four times more likely than non-minorities to develop Chronic Kidney Disease (CKD). Diabetes and high blood pressure are the major contributing factors to 75 percent of the cases of CKD. The Institute of Medicine has highlighted initiatives that target these conditions as important factors for reducing the rate of kidney failure, improving health outcomes, and eliminating these disparities. OMH established the Partnerships Active in Communities to Achieve Health Equity (PAC) Program to improve health outcomes among racial and ethnic minorities through the establishment of community-based networks that collaboratively employ evidence-based disease management and preventive health activities; build the capacity of communities to address social determinants and environmental barriers to healthcare access; and increase access to and utilization of preventive health care, medical treatment, and supportive services. This program directly targets the main risk factors for CKD in minority communities (diabetes, hypertension) and by building community networks and emphasizing prevention takes aim at the complications of these diseases such as chronic kidney failure.

Item

Cancer in Asian/Pacific Islanders.— Asian and Pacific Islanders [API] have a high incidence of stomach cancer and liver cancers compared to Caucasians. The Committee continues to urge the Department to focus on the unique and pressing needs regarding cancer in the API population.

Action taken or to be taken

The HHS Workgroup on Asian American, Native Hawaiian, and Pacific Islander Issues (WANHPII) was established to raise the visibility of Asian American, Native Hawaiian, and Pacific Islander (AANHPI) health issues, health care and human services disparities. Under the leadership of the Office of Minority Health (OMH), the department-wide workgroup played a critical role in the development and release of the HHS Plan for AANHPI Health in March 2011. The plan outlines measureable goals and elevates AANHPI issues across HHS. One key goal of the plan is to address critical health issues—including cancer, diabetes, cardiovascular diseases, hypertension, and infant mortality—that impact AANHPI populations.

Given that AANHPIs experience certain cancers at higher rates than other populations, OMH collaborates with the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the National Institutes of Health's National Cancer Institute (NIH/NCI), and community based organizations to address the unique and pressing needs of the AANHPI population through screening and prevention as well as in the clinical setting and in cancer control planning. The increased rate of liver cancer is directly tied to higher rates of Hepatitis B in AANHPI populations; efforts to lower the rate of Hepatitis B will significantly impact its most devastating effects; liver cancer. OMH will continue to provide support for AANHPI community based organizations to develop targeted outreach programs designed to reach specific populations at risk with Hepatitis B through culturally-sensitive and linguistically appropriate evidence-based interventions aimed at increasing education to providers and communities, improving testing and linkage to care to prevent Hepatitis B-related liver disease and cancer, and eliminating mother-to-child transmission of Hepatitis B. Through OMH's partnership agreement with the Association of Asian Pacific Community Health Organizations, mini grants will be awarded to organizations with existing efforts focused on Hepatitis B programs for AANHPI communities in 2013 and 2014. These local efforts are aligned to advance the Hepatitis B goals within the HHS National Viral Hepatitis Action Plan.

Item

Health Disparities in Women.— Women of racial and ethnic minorities face higher rates of obesity, cancer, diabetes, heart disease, HIV/AIDS, and other diseases when compared with white women. A disproportionately higher rate of preterm birth exists among African-American women that cannot be accounted for by known risk factors. The Committee encourages HHS to conduct research into the causes of these health disparities and develop and evaluate interventions to address these causes.

Action taken or to be taken

The Department of Health and Human Services shares the Committee's concerns about the higher rate of pre-term birth and infant mortality in minority communities. OMH supports the initiative A Healthy Baby Begins with You, a national campaign to raise awareness about infant mortality with an emphasis on the African American community. The goal of the campaign is to continue a broad infant mortality and low birth weight awareness campaign and expand it to include pre-conception and inter-conception health messages. Activities focus on strengthening OMH leadership at both the national and local levels through the establishment of working partnerships with national organizations, such as City Match, Association of Maternal and Child Health Professionals, March of Dimes, as well as Healthy Start Programs, state/city health departments, State OMHs, and community based organizations. Activities also focus on increasing OMH involvement with colleges, universities, and institutions such as

Historically Black Colleges and Universities through targeted health messages emphasizing preconception health and healthcare and training for minority college students to be health ambassadors.

The Preconception Peer Educators Program addresses sexual health in minority women by training college students as peer educators to disseminate essential preconception health messages, including health disparities and minority health. This initiative targets minority students to be trained as peer educators. A recent evaluation of the program indicates a positive change in health behaviors among trained peer educators including an increase in vitamin (including Folic Acid) consumption and stress reduction. The program will be expanded to include an electronic format in an effort to reach more schools and peer educators.

Additionally, two projects funded through OMH's Partnerships Active in Communities (PAC) to Achieve Health Equity program address health disparities among women. The PAC project at the Health Promotion Council of Southeastern Pennsylvania, Inc. provides the only patient navigation services in the Philadelphia area targeting Latino/Hispanic women and breast cancer. This grantee won the 2012 Case In Point Platinum Award in the category of Women/Children Case Management, recognizing the most successful and innovative case management programs and individuals working to improve healthcare across the care continuum. The Downtown Women's Center PAC project focuses on providing diabetes, nutrition and mental health services for homeless individuals in the Los Angeles area. The purpose of the (PAC) is to improve chronic disease health outcomes among racial and ethnic minorities through the establishment of community-based networks that employ evidence-based disease intervention strategies; address social determinants and environmental barriers to healthcare access; and increase access to and utilization of preventive health care, medical treatment, and supportive services

The Office of Minority Health (OMH) has developed a number of initiatives targeting diseases that disproportionately affect minority women. For instance, OMH leads the Eliminating Lupus Health Disparities Initiative or, The Lupus Initiative (TLI), which is a national lupus program to educate health professionals and students in training regarding early diagnosis and treatment of patients disproportionately affected by lupus.

OMH convened a national consortium of lupus experts representing research, education, and health care practice. The TLI Consortium members collaborated with the American College of Rheumatology (OMH Grantee) on the development of an educational curriculum and tools, as well as the promotion and dissemination of these tools to academic institutions and practicing health care professionals. TLI Consortium participates in medical meetings and conferences as well as electronic media. Continuing medical education units are provided to health care practitioners to motivate and encourage use and participation. OMH works in partnership with the Office on Women's Health, and the Office of the Surgeon General to plan and carry out TLI activities. Examples of accomplishments include:

- Presentations at national meetings and conferences, thousands of visits to the TLI website to view or participate in online events and trainings, and distribution of THI toolkits and other resources through the website and at conferences.
- Delivery of presentations to over 5,000 racial, ethnic minority youth, and approximately 700 youth participating in the Not on Tobacco Program (N-O-T).
- Placement of the National Asian Quit line phone number in the China Tribune and MN Times newspaper to promote the Asian quit lines; 500 copies of the THI toolkits and other resources were distributed in MN.

Item

Hepatitis B.— The Committee urges OMH to expand hepatitis B outreach and preventive programs specific to API and other groups disproportionately affected by this disease.

Action taken or to be taken
The Hep B United (HBU) National Coalition was launched May 2012 through an Office of Minority Health (OMH) grant awarded to the Association of Asian Pacific Community Health Organizations. HBU will raise awareness amongst healthcare providers, political leaders, students, and individuals living with Hepatitis B in 14 metropolitan cities (Philadelphia, Boston, Rockville, New York City, Las Vegas, Columbus, Houston, Dallas, Chicago, Seattle, Washington, DC, Honolulu, San Diego, and San Francisco). Through this OMH/HBU partnership, mini grants of up to $10,000 will be awarded to organizations with existing efforts focused on Hepatitis B programs for AANHPI communities in 2013 and 2014. These local efforts are aligned to advance the Hepatitis B strategic goals within the HHS National Viral Hepatitis Action Plan.

OMH also funded San Francisco Hep B Free (SFHBF) to support six health care organizations that provide care to insured and uninsured individuals living in San Francisco. In 2013, SFHBF and its local partners will develop an electronic health system to track and capture outcome data of patients to ensure Hepatitis B positive individuals are screened and receive timely care, treatment and follow-up.

OMH implemented two HIV/AIDS demonstration programs that serve priority populations. One demonstration project, the HIV/AIDS Health Improvement for Re-entering Ex-offenders Initiative (HIRE) serves federal and state reentrants that are living with or at high risk for HIV/AIDS. Services provided by these grantees include HIV and viral hepatitis prevention, counseling, testing, and treatment services. The L2L Health and Social Service Resource Network demonstration program serves families living with HIV/AIDS that are in transition from incarceration and substance abuse treatment. Both the HIRE and L2Lgrantees provide hepatitis screening as part of their outreach and intake efforts. In some cases, the Health Resource and Services Administration -funded or other network partners (HIRE and L2L grantees are primarily CBOs) provided Hepatitis vaccines.

Item
Offices of Minority Health.— The Committee continues to be encouraged by 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 strongly supports the Offices of Minority Health in the Office of the Secretary, AHRQ, CDC, CMS, FDA, HRSA, and SAMHSA, which are charged with leading the strategy. The Secretary is encouraged to work closely with communities, as well as the public and private sectors, in this effort.

Action taken or to be taken
The Office of Minority Health (OMH) leads and coordinates monthly meetings with the Directors of all HHS agency-specific Offices of Minority Health to ensure coordination of health disparities efforts relative to the Affordable Care Act, the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS Action Plan), and the National Partnership for Action to End Health Disparities (NPA). In addition, OMH staffs the Assistant Secretary for Health who co-leads, with the Assistant Secretary for Planning and Evaluation (ASPE), monthly HHS Health Disparities Council meetings – with representation across the Department, including the Staff Divisions within the Office of the Secretary and all HHS agencies -- to further coordinate, foster, and monitor progress on addressing actions in the HHS Action Plan and other departmental minority health and health disparities priorities. In FY 2013, a new web-based tool is being employed to monitor and track progress on the HHS Action Plan.

OMH leads the Federal Interagency Health Equity Team (FIHET) which includes representation from 11 other Federal cabinet-level departments and agencies, coordinates efforts of the FIHET's five subcommittees aligned with the goals of the NPA, and coordinates efforts with the Regional Health Equity Councils (RHECs) across the country to address the social determinants of health and to promote collaboration, coordination, and engagement of multiple sectors at multiple levels. In FY 2012, OMH

hosted 10 RHEC Technical Assistance Meetings. OMH also held 10 regional workshops, two webinars, and one national conference on the HHS data standards and collection/use of data for community-based organizations. OMH has well-established partnerships with community-based organizations, faith-based organizations, national organizations, academic institutions, and State Offices of Minority Health that continues to promote the goals and objectives of the HHS Action Plan and the NPA. For example, OMH has established partnership agreements with the following: Association of State and Territorial Health Officials, National Hispanic Council on Aging, National Baptist Convention, USA, United Way Worldwide, the American Diabetes Association, and the HHS Center for Faith-based and Neighborhood Partnerships. In FY 2013 and FY 2014, OMH will continue to work with its grantees as well as its diverse group of stakeholders to educate racial and ethnic minority communities and individuals on the provisions of the Affordable Care Act.

FOOD AND DRUG ADMINISTRATION

Item

Drug Shortages.— The Committee urges the Secretary, in consultation with FDA, to establish an interagency and intra-agency task force to address drug shortages. The task force should have stakeholder input, including an expert in how shortages affect pediatric patients. The study should examine whether other countries have experienced drug shortages, the extent and effect of the shortages, as well as any steps these countries are taking to mitigate or prevent such shortages.

Action taken or to be taken

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

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Item

Overdose Prevention.— 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 strongly encourages the Secretary to launch a public awareness campaign to educate the public and health professionals about the signs, symptoms, and risk factors for overdose, as well as how individuals can make linkages to recovery and treatment services. The Committee urges the Secretary to develop the campaign with the participation of Federal agencies including SAMHSA, NIDA, HRSA, FDA, and the Office of National Drug Control Policy.

Action taken or to be taken

Please see the Substance Abuse and Mental 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: Grants.gov may not receive sufficient funding to complete project milestones. 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 typical timing of the e-Gov Benefits Report, and the subsequent 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) and OMB. Grants.gov, being an e-Gov initiative, is not able to collect funding from agencies until the e-Gov report is sent by OMB to Congress for approval. If this report were sent to Congress earlier in the fiscal year, rather than the customary February or March timeframe, the Grants.gov PMO would be able to collect funding earlier, and thereby reduce the risk of delayed funding collection substantially.

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.

Risk 3: The Grants.gov system's centralized architecture increases the impact of system failure and performance issues.

Risk mitigation response: The PMO has incorporated off-line forms that can be submitted through alternate paths (e.g., e-mail, mail, or fax) and that distribute the computational load. The PMO also ran pilot electronic applications in parallel with paper submissions during it initial operational phases. The Grants.gov system uses a high-availability configuration for central system and has implemented effective monitoring & restoration procedures. The PMO routinely measures system performance and forecasts application loads and recommends that agencies spread opportunity closing dates to spread system loads. In times of heavy system loads the PMO gives a higher priority to application receipt processing and defers back-end processing to after peak capacity periods. The PMO deployed upgraded hardware and redesigned system network architecture that has removed most single points of failure within the Grants.gov system and provided what is virtually a private-cloud environment within the Grants.gov architecture that allows for rapid (and in many cases automatic) redeployment of system resources to respond to spikes in system demand. The system has been running at between 25 and 50 percent of current system capacity since the upgrade. In 2013, a disaster recovery site was created to mitigate the impact of a total system outage. Risk of system failure or performance issue has been significantly reduced and is no longer considered a major risk."

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 2014.

Grants.gov FY12-14 Agency Funding Contributions			
Agency	**Total FY 2012**	**Total FY 2013**	**Total FY 2014**
HHS	5,125,765	4,985,005	4,710,238
DOT	357,566	449,503	404,959
ED	705,947	475,731	547,513
HUD	412,146	299,068	407,186
DHS	389,508	413,272	300,929
NSF	481,957	370,923	467,754
USDA	483,380	552,402	509,443
DOC	330,894	344,532	326,901
DOD	640,107	715,348	752,274
DOE	508,215	540,740	439,604
DOI	927,758	1,113,310	1,335,972
DOL	174,821	213,702	211,895
EPA	427,636	379,828	373,002
USAID	332,549	402,565	429,166
USDOJ	545,812	398,441	510,553
NASA	215,549	155,066	173,346
CNCS	63,939	59,756	64,809
DOS	186,191	362,137	289,976
NEH	186,191	223,429	213,889
SBA	78,958	71,580	69,120
IMLS	70,197	84,236	76,594
NEA	169,437	203,324	182,161
VA	33,162	39,794	47,753
NARA	54,865	47,975	40,623
SSA	37,713	30,308	36,370
USDOT	41,439	49,727	59,672
Grand Total	**12,981,702**	**12,981,702**	**12,981,702**

PHYSICIANS' COMPARABILITY ALLOWANCE (PCA)

Office of the Assistant Secretary for Planning and Evaluation

		PY 2012 (Actual)	CY 2013 (Estimates)	BY 2014* (Estimates)
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)		$400,769	$415,600	$458,875
5) Average Annual PCA Payment		$40,000	$40,000	$40,000
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	0	0	0
	Category II Research Position	2	2	2
	Category III Occupational Health	0	0	0
	Category IV-A Disability Evaluation	0	0	0
	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 $40,000. 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 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 IPSs with 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 assists to obtain 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 2013 Funding
Dept-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.	$15,167,000
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
Upgrade to Unified Financial Management System (UFMS) Accounting System	These funds will be used to continue to enhance the UFMS financial management performance across the Department by enhancing functionality, eliminating duplication, streamlining processes, and establishing a unified information technology (IT) infrastructure.	$6,002,000
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 NSABB.	$2,771,000
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

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.	$636,242
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.	$558,000
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 provide consumer-based information about bullying prevention and intervention. Together in a multi-office collaboration effort, all HHS bullying websites will be brought into this new website, assuring optimal quality, accuracy and relativity of the site content.	$200,000

Office of Medicare Hearings and Appeals

TABLE OF CONTENTS

Appropriations Language

(Office of Medicare Hearings and Appeals)

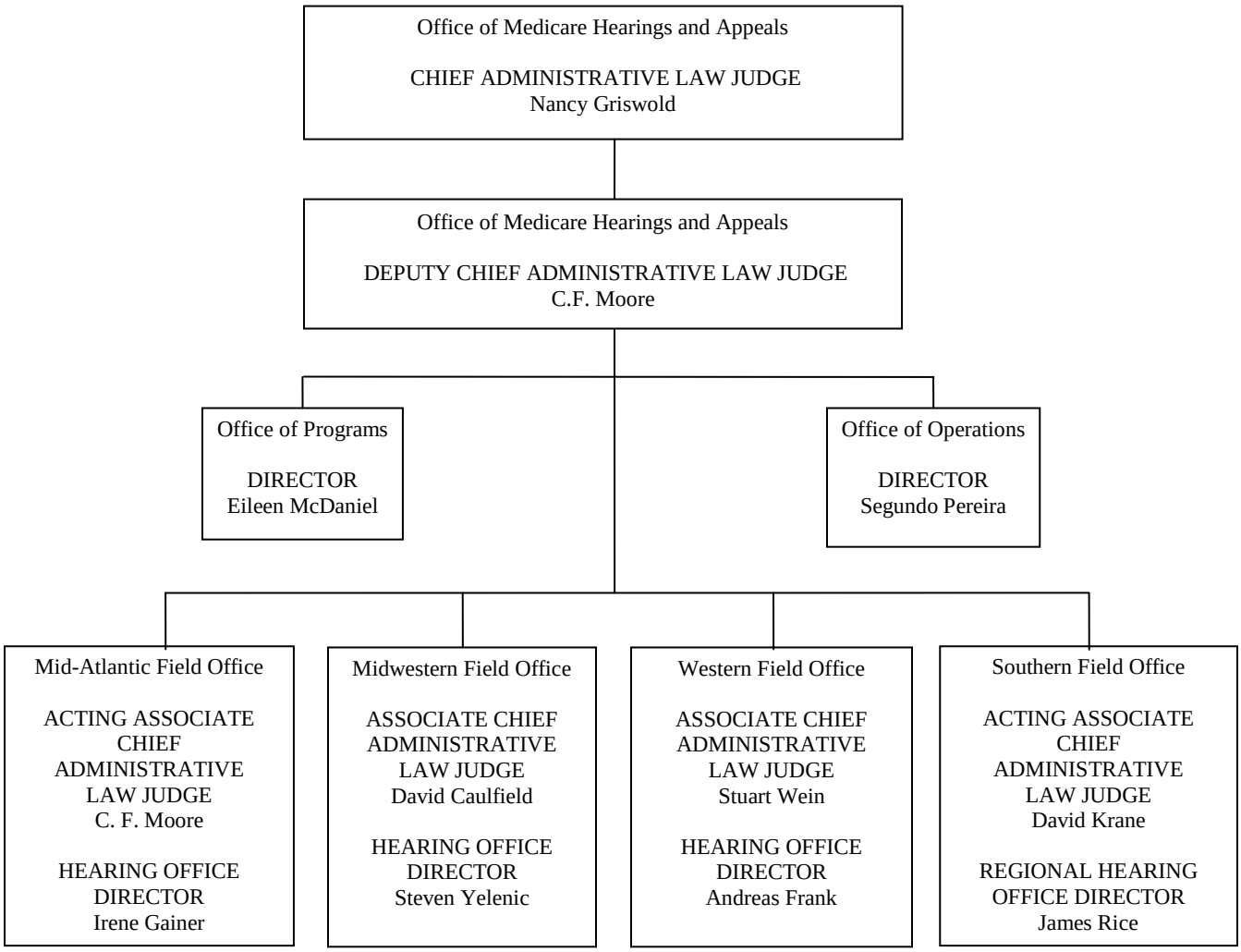
For expenses necessary for **[administrative law judges for hearing cases under title XVIII of the Social Security Act (and related provisions of title XI of such Act)]** *the Office of Medicare Hearings and Appeals*, **[$72,011,000]** *$82,381,000,* to be transferred in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

(Department of Health and Human Services Appropriations Act, 2012.)

Language Analysis

Language Provision	Explanation
"administrative law judges for hearing cases under title XVIII of the Social Security Act (and related provisions of title XI of such Act"	HHS is proposing to simplify OMHA's appropriations language and to make it clear that this appropriation covers all of OMHA's costs, and no other costs.

OMHA ORGANIZATIONAL CHART



INTRODUCTION

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 to make such appeals and can exercise their rights for health care quality and access. On behalf of the Secretary of HHS, the Administrative Law Judges (ALJs) within OMHA conduct impartial hearings and issue decisions on claims determination appeals involving Medicare Parts A, B, C and D, as well as Medicare entitlement and eligibility appeals.

Mission

OMHA is a responsive forum for the 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.

AMOUNTS AVAILABLE FOR OBLIGATION

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
Trust Fund Discretionary Appropriation:			
Annual appropriation	$72,147,000	$72,451,000	$82,381,000
Rescission	-$136,358	$0	$0
Subtotal, adjusted trust fund discretionary appropriation	$72,010,642	$72,451,000	$82,381,000
Unobligated Balance, Discretionary Appropriation	$551,404	$0	$0
Total Obligations	**$71,459,238**	**$72,451,000**	**$82,381,000**

SUMMARY OF CHANGES

2012 Office of Medicare Hearings and Appeals appropriation	72,011
Total adjusted budget authority	72,011
2014 Request – Office of Medicare Hearings and Appeals	82,381
Total estimated budget authority	82,381
Net Changes	**10,370**

	FY 2012 Actual		FY 2014 President's Budget Change From Base	
	FTE	**Amount**	**FTE**	**Amount**
Increases:				
A. Built-In:				
1. Other services	0	$0	0	$0
2. Other purchases of goods and services from Government accounts	0	$0	0	$0
3. Full-Time Permanent	466	$38,643	48	$6,433
4. Other than full-time permanent	0	$0	0	$0
5. Other Personnel Compensation	0	$389	0	$39
6. Civilian personnel benefits	0	$11,711	0	$2,263
7. Military benefits	0	$0	0	$0
8. Benefits for former personnel	0	$0	0	$0
9. Transportation of things	0	$413	0	$564
10. Rental payments to GSA	0	$6,759	0	$655
11. Communications, utilities, and miscellaneous charges	0	$1,327	0	$2,572
12. Printing and Reproduction	0	$31	0	$223
13. Operation and maintenance of facilities	0	$417	0	$244
14. Research & Development Contracts	0	$0	0	$0
15. Medical care	0	$0	0	$0
16. Operation and maintenance of equipment	0	$287	0	$747
17. Subsistence and support of persons	0	$0	0	$0
18. Supplies and materials	0	$541	0	$151
19. Equipment	0	$156	0	$1,463
20. Land and Structures	0	$0	0	$0
21. Investments and Loans	0	$0	0	$0
22. Grants, subsidies, and contributions	0	$0	0	$0
23. Interest and dividends	0	$0	0	$0
24. Refunds	0	$0	0	$0
Subtotal, Built-In Increases	**466**	**+$60,674**	**48**	**+$15,354**
B. Programs:				
Subtotal, Program Increases			**0**	**$0**

	FY 2012 Actual		FY 2014 President's Budget Change From Base	
Total Increases	**466**	**+$60,674**	**48**	**+$15,354**
Decreases:				
A. Built-In:				
1. Travel and transportation of persons	0	$252	0	-$52
2. Advisory and Assistance Services	0	$1,340	0	-$1,340
3. Other services from non-Federal sources	0	$1,144	0	-$193
4. Other goods and services from Federal sources	0	$8,601	0	-$3,399
Subtotal, Built-In Decreases	**0**	**+$11,337**	**0**	**-$4,984**
Total Decreases	**0**	**+$11,337**	**0**	**-$4,984**
Net Change	**466**	**+$72,011**	**48**	**+$10,370**

BUDGET AUTHORITY by OBJECT CLASS

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	38,643	42,111	45,076
Other than full-time permanent (11.3)	0	0	0
Other personnel compensation (11.5)	389	259	428
Military personnel (11.7)	0	0	0
Subtotal, Personnel compensation	**39,032**	**42,370**	**45,504**
Civilian personnel benefits (12.1)	11,711	13,214	13,974
Military benefits (12.2)	0	0	0
Benefits for former personnel (13.0)	0	0	0
Total Pay Costs	**50,743**	**55,584**	**59,478**
Travel and transportation of persons (21.0)	252	121	200
Transportation of things (22.0)	413	309	977
Rental payments to GSA (23.1)	6,759	6,333	7,414
Communications, utilities, and miscellaneous charges (23.3)	1,327	2,611	3,899
Printing and reproduction (24.0)	31	111	254
Other Contractual Services:			
Advisory and assistance services (25.1)	1,340	0	0
Other services from non-Federal sources (25.2)	1,144	770	951
Other goods and services from Federal sources (25.3)	8,601	4,606	5,202
Operation and maintenance of facilities (25.4)	417	664	661
Research and development contracts (25.5)	0	0	0
Medical care (25.6)	0	0	0
Operation and maintenance of equipment (25.7)	287	294	1,034
Subsistence and support of persons (25.8)	0	0	0
Subtotal, Other Contractual Services	**11,789**	**6,334**	**7,848**
Supplies and materials (26.0)	541	415	692
Equipment (31.0)	156	633	1,619
Land and Structures (32.0)	0	0	0
Investments and Loans (33.0)	0	0	0
Grants, subsidies, and contributions (41.0)	0	0	0
One-time Appropriation for Treasury (43.0)	0	0	0
Refunds (44.0)	0	0	0
Total Non-Pay Costs	**21,268**	**16,867**	**22,903**
Total Budget Authority by Object Class	**72,011**	**72,451**	**82,381**

SALARIES AND EXPENSES

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	38,643	42,111	45,076
Other personnel compensation (11.5)	389	259	428
Subtotal, Personnel compensation	**39,032**	**42,370**	**45,504**
Civilian personnel benefits (12.1)	11,711	13,214	13,974
Total Pay Costs	**50,743**	**55,584**	**59,478**
Travel and transportation of persons (21.0)	252	121	200
Transportation of things (22.0)	413	309	977
Communications, utilities, and miscellaneous charges (23.3)	1,327	2,611	3,899
Printing and reproduction (24.0)	31	111	254
Other Contractual Services:			
Advisory and assistance services (25.1)	1,340	0	0
Other services from non-Federal sources (25.2)	1,144	770	951
Other goods and services from Federal sources (25.3)	8,601	4,606	5,202
Operation and maintenance of facilities (25.4)	417	664	661
Operation and maintenance of equipment (25.7)	287	294	1,034
Subtotal, Other Contractual Services	**11,789**	**6,334**	**7,848**
Supplies and materials (26.0)	541	415	692
Total Salaries and Expenses	**65,096**	**65,485**	**73,348**

AUTHORIZING LEGISLATION

(Dollars in Thousands)

	FY 2013 Amount Authorized	FY 2013 CR	FY 2014 Amount Authorized	FY 2014 President's Budget
Office for Medicare Hearings and Appeals Social Security Act, Titles XI and XVIII	Indefinite	$72,451	Indefinite	$82,381
Total:		**$72,451**		**$82,381**

Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2006				
Trust Fund Appropriation:				
Base	80,000,000	60,000,000	75,000,000	60,000,000
Rescission (P.L. 109-149)……				(600,000)
Transfer (P.L. 109-148)……				41,000
Subtotal	80,000,000	60,000,000	75,000,000	59,359,000
FY 2007				
Trust Fund Appropriation:				
Base	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
FY 2008				
Trust Fund Appropriation:				
Base	70,000,000	67,500,000	70,000,000	65,000,000
Rescission (P.L. 110-161)…...				(1,136,000)
Subtotal	70,000,000	67,500,000	70,000,000	63,864,000
FY 2009				
Trust Fund Appropriation:				
Base	65,344,000		63,864,000	64,604,000
Subtotal	65,344,000		63,864,000	64,604,000
FY 2010				
Trust Fund Appropriation:				
Base	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
FY 2011				
Trust Fund Appropriation:				
Base	77,798,000		77,798,000	71,147,000
Rescission (P.L. 112-10)				(142,000)
Subtotal	77,798,000		77,798,000	71,005,000
FY 2012				
Trust Fund Appropriation:				
Base	81,019,000	71,147,000	71,147,000	72,147,000
Rescission (P.L. 112-74)				(136,000)
Subtotal	81,019,000	71,147,000	71,147,000	72,011,000

FY 2013

Trust Fund Appropriation:		
Base.....	84,234,000	79,908,000
Subtotal.....	84,234,000	79,908,000

FY 2014

Trust Fund Appropriation:	
Base.....	82,381,000
Subtotal.....	82,381,000

All Purpose Table Office of Medicare Hearings and Appeals Dollars in Thousands				
	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Discretionary BA	72,011	72,451	82,381	10,370
FTE	466	490	514	48

OVERVIEW OF BUDGET REQUEST

The FY 2014 Request for OMHA of $82.4 million represents a $10.4 million (14%) increase over the FY 2012 Enacted Level. OMHA's budget request makes investments to support HHS Strategic Goals to Strengthen Healthcare and Increase Efficiency, Transparency and Accountability of HHS Programs. This will be accomplished by maximizing its organizational adjudicatory and legal capacity to address OMHA's increasing workload and enhancing adjudicative business processes to meet the needs of Americans, particularly Medicare beneficiaries, providers and the tax-paying public.

The FY 2014 Request funds a new field office in the Central time zone supported by seven new Administrative Law Judge (ALJ) teams comprised of an ALJ, attorney, paralegal and hearing clerk and ten junior attorneys to expand OMHA's organizational legal capacity for case review, decision writing, and case adjudication, as well as eight operational personnel. This positions OMHA to hear more Medicare appeals than ever before and slows down the growth of the backlog in case processing.

OVERVIEW OF PERFORMANCE

OMHA's core mission and performance budget support HHS Strategic Goal 1B: Strengthen Health Care: Improve health care quality and patient safety and HHS Strategic Goal 4A: Increase Efficiency, Transparency and Accountability of HHS Programs: Ensure program integrity and responsible stewardship of resources.

By providing an independent forum for the timely and legally sufficient adjudication of Level III Medicare appeals, OMHA helps to transform health care access by ensuring Medicare beneficiaries receive the services to which they are entitled and contributes to control of Medicare costs by ensuring that inappropriate claims are properly denied. OMHA's budget request is driven strictly by claims receipt levels with 96% of its budget dedicated to direct workload support through staffing and required operational costs.

OMHA experienced an unprecedented 119% increase in the number of appeals in FY 2012 compared to FY 2011. Despite this increase, ALJ teams adjudicated more appeals than ever before (an increase from 898 per team in FY 2011 to 987 in FY 2012). OMHA met or exceeded only one agency performance goal due to increasing volume and complexity of workload. 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 2012, OMHA achieved a 4.1 level of appellant satisfaction nationwide, exceeding the FY 2012 target of 3.6 by 0.5.

OMHA leadership has taken proactive steps to achieve a more complete analysis of projected case disposition rates, case backlogs and staffing resource needs. For example, beginning in FY 2011, OMHA strengthened its methodology for calculating the number of cases closed within 90 days by counting all appeals closed during a fiscal year, regardless of when the appeals were received. Previously, OMHA counted only appeals received and closed in a fiscal year. By not counting OMHA's entire caseload, this methodology understated OMHA's true staffing needs by overstating its ability to meet its statutory 90-day performance goal, as stipulated in the Benefits Improvement and Protection Act (BIPA). The revised methodology has increased the accuracy and transparency of OMHA's measures and more accurately reflected our adjudicatory capacity.

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 continues to face challenges in meeting past successes for adjudicating claims within 90 days due to increasing workload. Performance targets for FY 2012 were adjusted to reflect the increasing challenges caused by rising workloads. OMHA fell short of its 56% performance target by adjudicating only 53% of its BIPA claims in 90 days. Most ALJs exceeded their sustainable capacity for case adjudication as OMHA's FY 2012 claims increased by 34% compared to FY 2011. OMHA projects that its FY 2014 claims alone will further increase by 25% over FY 2012.

The President's Budget funding level of $82.4 million will allow OMHA to implement measures to mitigate the growing backlog experienced over the past two years and improve its ability to process the increasing caseload, while still maintaining program integrity.

FY 2014 Budget by HHS Strategic Goal

(Dollars in Millions)

Office of Medicare Hearings and Appeals

HHS Strategic Goals	FY 2012	FY 2013 CR	FY 2014 PB
1.Strengthen Health Care			
1.A Make coverage more secure			
1.B Improve health care quality and patient safety	47.95	47.95	54.61
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 Promote 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	24.05	24.05	27.39
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 meet needs today & tomorrow			
5.B Ensure health care workforce meets increased demands.			
5.C Enhance ability public health workforce to improve health			
5.D Strengthen the Nation's human service workforce			
5.E Improve national, State & local surveillance capacity			
TOTAL	**72.00**	**72.00**	**82.00**

BUDGET AUTHORITY BY ACTIVITY

(Dollars in thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 Request
Office of Medicare Hearings and Appeals (OMHA)…..	$72,011	$72,451	$82,381
OMHA FTE	466	490	514
TOTAL, OMHA Budget Authority.....	**$72,011**	**$72,451**	**$82,381**
TOTAL, OMHA FTE.....	**466**	**490**	**514**

NARRATIVE BY ACTIVITY

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	72,011	72,451	82,381	10,370
FTE	466	490	514	48

Authorizing Legislation……Titles XVIII and XI of the Social Security Act
FY 2014 Authorization…….Indefinite
Allocation Method……..…….Direct Federal

Program Description

OMHA was established in July 2005 in response to the delays in processing of Medicare appeals that existed at the Social Security Administration (SSA). According to the GAO, SSA ALJs took on average 368 days to resolve appeals in 2003. Unlike other agencies, OMHA was created to administer only one program, the adjudication of the third level of Medicare appeals. While SSA had no statutory timeframe for case adjudication, OMHA was mandated by the Benefits Improvement and Protection Act (BIPA) to adjudicate the third level of Medicare appeals within 90 days.

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 our 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. OMHA utilizes video-teleconferencing (VTC) and telephone hearings to provide appellants with hearings which are timely and accessible. VTC technology, which is now commonly used throughout the country in courtrooms and for telemedicine, offers expanded access for appellants to ALJ hearings.

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 Payer (MSP) claims, as well as non-MSP claims. The demonstration project was designed to determine whether the use of RACs would be a cost-effective means of adding resources to ensure correct payments are made to providers and suppliers, thereby protecting the Medicare Trust Funds. As a result of the 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 approximately 43,000 RAC claims in FY 2012.

OMHA's caseload has also increased due to dual beneficiary claims. In FY 2011, OMHA received approximately 14,000 dual beneficiary claims from State agencies in Connecticut, Massachusetts and New York seeking Medicare reimbursement for services that would otherwise be covered under

Medicaid. Since State agencies now have infrastructures in place for appealing Medicare denials, OMHA will continue to receive dual beneficiary claims.

OMHA has undertaken a number of successful initiatives focused on improving the quality and timeliness of its services. These include:

- A redefined five year strategic plan that codifies OMHA's objectives and establishes the foundation for organizational performance.
- A best practices initiative that shared and implemented efficient operational approaches across offices.
- A unified workload measurement system (UWMS) that established a methodology for balancing caseload across the agency.
- A national data standardization initiative to promote data quality.
- An Adjudicative Business Practice (ABP) Initiative to develop OMHA-wide common business practices for the adjudicative process.
- A National Substantive Legal Training Program for new Administrative Law Judges and attorneys.
- A Centralized Operations initiative to establish a uniform case docketing process agency-wide.
- The development and implementation of technology enhancements to create an electronic case file.
-

Funding History

FY 2009	$64,604,000
FY 2010	$71,147,000
FY 2011	$71,005,000
FY 2012	$72,011,000
FY 2013	$72,451,000

Budget Request

The FY 2014 Request for OMHA of $82.4 million is an increase of $10.4 million (or 14%) over FY 2012 Enacted Level. The request allows OMHA to address the ever growing and changing workload by increasing OMHA's adjudicatory capacity and staffing levels, above its current 65 ALJ teams (comprised of an ALJ, attorney, paralegal and hearing clerk).

Growth in Workload

OMHA's workload has increased 195% between FY 2006 (106,000 claims received) and FY 2012 (313,000 claims received). As shown in the table below, OMHA anticipates its workload will increase by an additional 25% from its FY 2012 claim level (313,000) to its projected claim level of (392,000) in FY 2014. OMHA attributes this significant increase in workload volume in large part to the ongoing influx in Medicare enrollees.

OMHA Claims Received					OMHA Claims Projected	
FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
186,000	216,000	194,000*	234,000	313,000	368,000	392,000

*Decrease in claims received due to delay in CMS implementation of RAC program.

Workload Complexity

In FY 2012, OMHA also experienced a significant increase in the complexity of its workload. In comparison to FY 2011, the number of Complex Part A appeals more than doubled in FY 2012. This increase in complexity is related to higher-intensity care involving multiple care givers often over an extended period of time with voluminous medical records, including hospitals, Inpatient Rehabilitation Facilities (IRF), Skilled Nursing Facilities (SNF), and home healthcare settings. All of this requires more time to review the record, the applicable rules, conduct the hearings, and write the decisions.

Backlog Reduction Initiative (BRI)

Although OMHA's workload volume and complexity significantly increased since its inception, the number of ALJs has remained relatively constant. OMHA must expand its adjudicatory and legal capacity to achieve a more manageable workload per ALJ team and increase its decision writing capacity in order to minimize the backlog of unheard claims. In addition, OMHA's workload is now subject to greater shifts and variability in demographics. Thirty-percent of all appellants are located in the Central time zone. With three of the four OMHA field offices located in the Eastern time zone, OMHA needs to maximize its ability to schedule hearings for a significant number of appellants located within the boundaries of the Central time zone.

This critical initiative will establish a new field office in the Central time zone supported by seven additional ALJ teams, ten additional junior attorney, and eight additional operational personnel. This strategy will allow OMHA to increase flexibility to schedule hearings in an additional time zone, increase decision writing capability, mitigate the regression of backlog of unheard cases, and facilitate more efficient service to Medicare service providers and suppliers and individual Medicare beneficiaries.

The requested funding also will support critical staffing and operational investments:

- Seventy-two 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.

- Maintenance of 45 on-site adjudication hearing rooms and the associated VTC equipment and telecommunications infrastructure, along with access to external hearing room facilities via commercial vendors.

- Maintaining information technology systems, including the Medicare Appeals System (MAS). MAS is shared by the Centers for Medicare & Medicaid and OMHA.

OMHA Outputs and Outcomes Table

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
1.1.1: Increase the number of Benefits Improvement and Protection Act of 2000 (BIPA) cases closed within 90 days. (Outcome)	FY 2012: 53% (Target Not Met)	56%	39%	-17
1.1.4: Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council. (Outcome)	FY 2012: 1.8% (Target Not Met)	1%	1%	Maintain
1.1.5: Improve the average survey results from appellants reporting good customer service on a scale of 1 – 5 at the Administrative Law Judge Medicare Appeals level (Outcome)	FY 2012: 4.1 (Target Exceeded)	3.6	3.6	Maintain

Performance Analysis

HHS implemented several initiatives to improve the usefulness of the Department's performance measures by streamlining the performance management process by only tracking key performance measures within an agency's mandate and control.

In FY 2012, OMHA met or exceeded only one agency performance goal as follows:

- *Increase the number of BIPA cases closed within 90 days* - In FY 2012, OMHA processed 53% of the BIPA cases within the statutory timeframe. OMHA fell short of its performance target of 56% for FY 2012 as a direct result of the overall increase in workload. Although the FY 2012 performance target was missed, OMHA reached higher levels of efficiency with each Administrative Law Judge team adjudicating more Medicare appeals than ever before. In FY 2012, performance targets were adjusted to reflect the increasing challenges caused by rising workloads.

- *Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council* - The legal accuracy of OMHA decisions remains of paramount importance to the agency. OMHA is committed to providing accurate decisions that are not reversed or remanded on appeals to the Medicare Appeals Council (MAC), which provides the fourth level of Medicare appeals. This goal focuses on maintaining the overall quality and accuracy of OMHA decisions. OMHA fell slightly short of its 1% performance target by having 1.8% of its decisions reversed or remanded on appeals to the MAC.

- *Maintain the average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level* - OMHA evaluates 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. The survey measures the overall appellant experience, hearing scheduling and format, and interactions with OMHA staff. The measure aims to assure that appellants and related parties are satisfied with their Medicare appeals experience with OMHA. On a scale of 1 – 5, 1 represents the lowest score (very dissatisfied) and 5 represents the best score (very satisfied). In FY 2012, OMHA achieved a 4.1 level of appellant satisfaction nationwide, exceeding the FY 2012 target of 3.60 by 0.5. This result indicates the vast majority of appellants were either somewhat or very satisfied with OMHA services, from initiation of cases through closure, as well as with hearing formats used to adjudicate their cases.

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT

	FY 2012 Actual			FY 2013 CR			FY 2014 President's Budget		
	Civilian	**Military**	**Total**	**Civilian**	**Military**	**Total**	**Civilian**	**Military**	**Total**
Direct:	466	0	466	490	0	490	514	0	514
Reimbursable:	0	0	0	0	0	0	0	0	0
FTE Total	**466**	**0**	**466**	**490**	**0**	**490**	**514**	**0**	**514**

Detail of Positions

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
AL-1	1	1	1
AL-2	2	3	3
AL-3	65	64	71
Subtotal	68	68	75
Total - AL Salary	$9,693,749	$10,750,715	$11,174,153
ES-1	2	5	5
Subtotal	2	5	5
Total - ES Salary	$345,356	$495,356	$645,356
GS-15	12	12	13
GS-14	25	26	27
GS-13	25	25	25
GS-12	122	124	126
GS-11	80	77	79
GS-10			
GS-9	21	22	47
GS-8	71	72	72
GS-7	33	44	52
GS-6	35	28	28
GS-5			
GS-4	5	5	5
GS-3	20	15	15
GS-2			
GS-1			
Subtotal	449	450	489
Total - GS Salary	$28,603,895	$30,864,929	$33,256,491
Commissioned Corps	0	0	0
Total Positions	519	523	569
Total FTE	466	490	514
Average AL Salary	$156,996	$158,099	$160,039
Average ES salary	$172,678	$165,119	$159,071
Average GS grade	11/3	11/5	11/5
Average GS Salary	$63,706	$68,585	$68,009

Office for Civil Rights

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Director
Office for Civil Rights
Washington, DC 20201

Dear Reader:

I am pleased to present the Office for Civil Rights' (OCR) Fiscal Year 2014 Congressional Justification. This budget reflects OCR's resolute commitment to ensuring equal, non-discriminatory access to all health care services and an equally vigorous commitment to protecting individually identifiable health information from unauthorized disclosure.

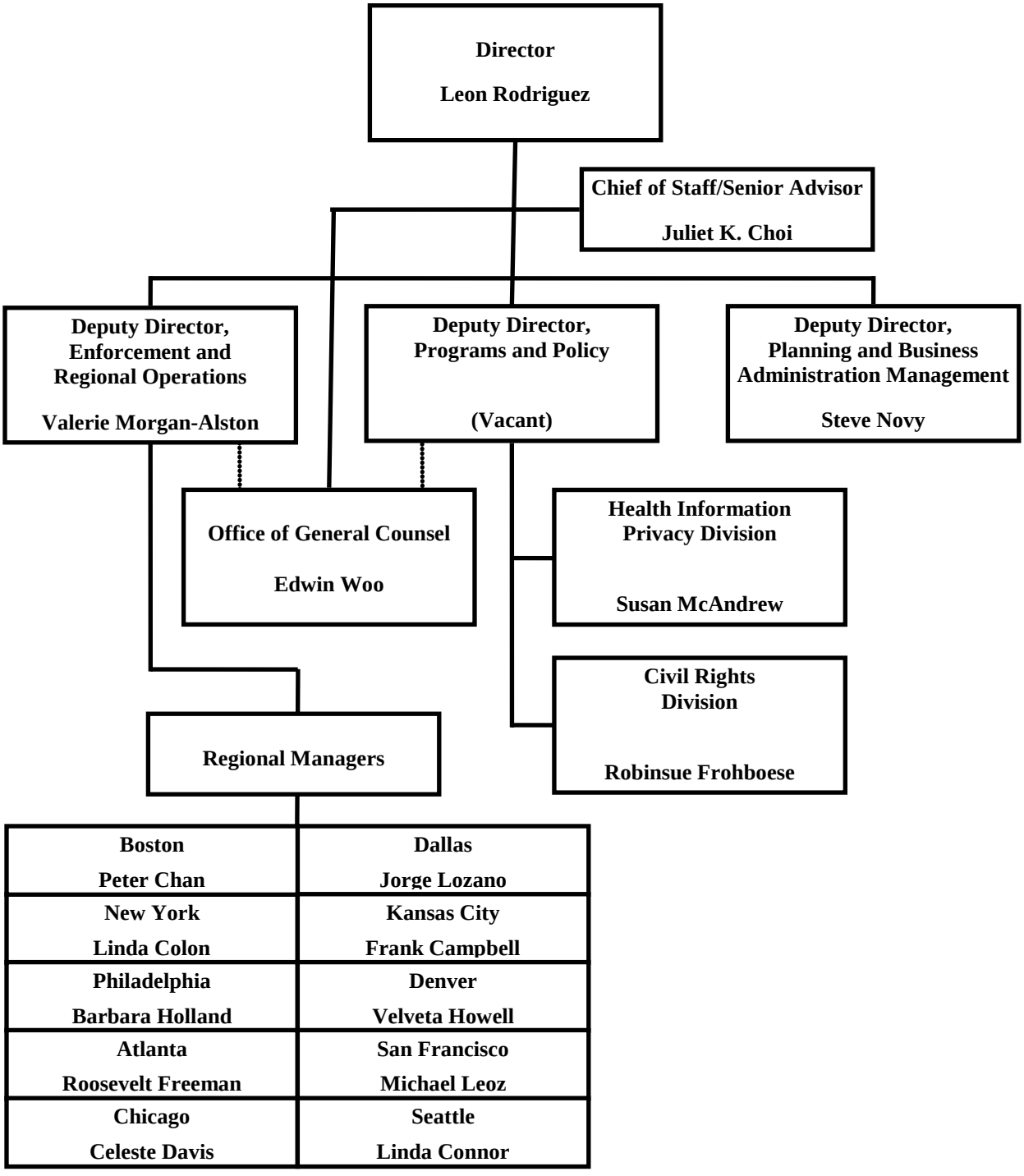
The FY 2014 budget will provide OCR the ability to protect the public's right to equal access and the opportunity to participate in and receive services from all Department of Health and Human Services' (HHS) programs without facing unlawful discrimination. It likewise supplies the means for OCR to maintain its energetic enforcement of the privacy and security provisions for personal health information. In addition to striving for constant improvement in all its core mission areas, OCR continues to enhance and expand enforcement activities in areas such as the Affordable Care Act, Limited English Proficiency, and community living (Olmstead). Similarly, great strides have been achieved in the privacy arena, namely publication of the final HIPAA Omnibus Rule, dramatically increased collection of monetary settlements, and a more robust breach notification program. These enhancements as well as the establishment of a central complaint intake unit illustrate how OCR seeks efficiencies, exploits technology, and leverages human capital to provide the best possible service.

This budget request supports the President's and Secretary's priority initiatives and reflects the goals and objectives of the Department. In an era of ever-increasing needs and constrained resources, OCR continues to protect health care consumers from civil rights infringements as well as to aggressively implement the privacy and security protections for all American citizens.

Leon Rodriguez

TABLE OF CONTENTS

Organization Chart
(February 2013)



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 nearly 13,000 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 Office for Civil Rights' (OCR) budget request for FY 2014 is $42,205,000, an increase of $1,267,000 from the FY 2012 Enacted Level of $40,938,000. This request supports OCR's activities 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.

The FY 2014 request supports:

- Continued operations to further OCR's civil rights and health information privacy mission
- Civil rights enforcement enhancements; specifically, ensuring non-discriminatory access to health care under the ACA, reducing racial and ethnic health disparities and ensuring language access, and promoting the right of individuals with disabilities to live in their own communities, pursuant to the Supreme Court's *Olmstead* decision and the Secretary's Community Living Initiative
- Vital HIPAA Security Rule efforts to ensure continued program activities

Program increases:

Enforcement of the HIPAA Security Rule (+$1M)
In 2009, the Secretary delegated authority for the administration and enforcement of the Security Standards for the Protection of Electronic Protected Health Information (HIPAA Security Rule) to the Director of OCR.

Performance Overview

Both of OCR's overarching goals encompass multiple supporting objectives that align to the Department's Strategic Plan:

OCR Goal			OCR Supporting Objectives	HHS Goal/Objectives*
1	Raise awareness, increase understanding, and ensure compliance 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	Provide information and training to representatives of health and human service providers, other interest groups, and consumers (Civil rights and health information privacy mission activities)	#1 E #3 B
		D	Increase the number of covered entities that take corrective action, including making substantive policy changes or developing new policies as a result of review and/or intervention	#1 E
2	Enhance operational efficiency	A	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

[* As reflected on the "FY 2014 Budget by HHS Strategic Goal Table" included herein.]

The following is a synopsis of current OCR performance measures:

Measure	Most Results (Summary of Result)	FY 2014 Target	FY 2014 +/- FY 2012 Target
1.1.1 # Covered Entities taking corrective action as a result of OCR intervention / year (Outcome)	FY 2012: 4,807 Target: 4,300 (Target Exceeded)	5,900	+1,600
1.1.2 # Covered Entities making substantive policy changes as a result of OCR intervention / year (Outcome)	FY 2012: 1,172 Target: 2,800 (Target Not Met)	3,600	+800
1.1.3A % of closure for civil rights cases / cases received each year (Outcome)	FY 2012: 109% Target: 108% (Target Exceeded)	86%	N/A
1.1.3B % of closure for health information privacy cases / cases received each year (Outcome)	FY 2012: 96% Target: 108% (Target Not Met)	66%	N/A
1.1.3C % of closure for Medicare application reviews / reviews received each year (Output)	FY 2012: 112% Target: 108% (Target Exceeded)	100%	N/A
1.1.4 % CR cases and MED application reviews resolved per received per year	FY 2012: 110% Target: 105% (Target Exceeded)	93%	N/A

1.1.6 # individuals whom OCR provides information and training annually (Output)	FY 2012: 11,108 Target: 213,500 (Target Not Met)	213,500	Maintain
1.1.7 % of civil rights complaints requiring formal investigation resolved within 365 days (Output)	FY 2012: 35% Target: 42% (Target not met)	52%	+10%
1.1.8 % of civil rights complaints not requiring formal investigation resolved within 180 days (Output)	FY 2011: 87% Target: 81% (Target Exceeded)	100%	+19%
1.1.9 % of health information privacy complaints requiring formal investigation resolved within 365 days (Output)	FY 2012: 68% Target: 52% (Target Exceeded)	65%	+13%
1.1.10 % of health information privacy complaints not requiring formal investigation resolved within 180 days (Output)	FY 2012: 78% Target: 72% (Target Exceeded)	100%	+28%

[1.1.5 eliminated as duplicative to 1.1.3B when 1.1.3 was expanded to category to A-C]

*Prior to FY 2013, the methodology for computing Measures 1.1.3A-C and 1.1.4 did not account for backlog. Beginning in FY 2013, targets were revised based on new methodology which captures total receipts (backlog in addition to complaints received).

OCR continues to make great strides in serving the American public when they encounter potential discrimination and health information privacy issues and violations. Despite increases in caseloads received of 12% and 4% in the past two years, OCR has made significant progress in reducing backlog, and in particular, closing stagnant cases (those open for 2-3 years). This concentration on older cases, however, has repercussions. In FY 2012, OCR exceeded seven out of the eleven performance goals. OCR has thus demonstrated less than anticipated improvement in areas such as the rate of closure for current cases and reviews as well as reduced outreach efforts. Additionally, significant improvements to OCR's case management reporting system have caused a learning curve that temporarily decreased timely entries of case data, thus inaccurately reflecting annual closure numbers.

Leadership is taking proactive steps to revamp and reinvigorate the performance management process and achieve a more representative picture of OCR's mission, goals, and accomplishments. In addition to the performance measures overall nearing completion, OCR is also focused on the constant improvement of its data management system that contains all case information.

In 2011, OCR completed major modification to its automated Performance Information Management System (PIMS) to strengthen the completeness, validity, and accuracy of the data captured and reported and has seen improvements in 2012. Additionally, OCR awarded a large-scale contract to further enhance PIMS by adding capability modules to allow for the capture and storage of additional information (compliance audits, breach notifications, etc) as well as the development of a management dashboard and reporting feature. This is a two-year effort that will further improve OCR's capability to gather, access, and report data and information.

The FY14 initiative and other enhancements contained herein will dramatically improve OCR's output and outcome measures by providing additional manpower in the form of civilian FTEs and contractor staff augmentation in combination with a streamlined complaint receipt process that allows current Equal Opportunity Specialist (EOS) staff to focus on investigative work and case resolution rather than administrative tasks. Although the requested FY14 level restores OCR's previous level of funding, OCR will face challenges in addressing its continually growing civil rights and health information privacy responsibilities in the long-term.

Budget by HHS Strategic Goal

(Dollars in Millions)

HHS Strategic Goals	FY 2012 Enacted	FY 2013 CR	FY 2014
1. Strengthen Health Care	**$ 21.3**	**$ 19.5**	**$ 20.4**
1.A Make coverage more secure for those who have insurance, and extend affordable coverage to the uninsured			
1.B Improve health care quality and patient safety			
1.C Emphasize primary and preventive care linked with community prevention			
1.D Reduce the growth of health care costs while promoting high-value, effective care			
1.E Ensure access to quality, culturally competent care for vulnerable populations	$ 11.3	$ 9.9	$ 10.8
1.F Promote the adoption and meaningful use of health information technology	$ 10.0	$ 9.6	$ 9.6
2. Advance Scientific Knowledge and Innovation	**$ -**	**$ -**	**$ -**
2.A Accelerate the process of scientific discovery to improve patient care			
2.B Foster innovation to create shared solutions			
2.C Invest in the regulatory sciences to improve food and medical product safety			
2.D Increase our understanding of what works in public health and human service practice			
3. Advance the Health, Safety and Well-Being of the American People	**$ 19.6**	**$ 21.2**	**$ 21.0**
3.A Ensure the safety, well-being, and healthy development of children and youth	$ 1.8	$ 1.8	$ 1.9
3.B Promote economic and social well-being for individuals, families, and communities	$ 17.8	$ 17.8	$ 17.4
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults		$ 1.3	$ 1.7
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 and foster resilience in response to emergencies			
4. Increase the Efficiency, Transparency, and Accountability of HHS Programs	**$ -**	**$ 0.3**	**$ 0.5**
4.A Ensure program integrity and responsible stewardship of resources		$ 0.1	$ 0.2
4.B Fight fraud and work to eliminate improper payments		$ 0.1	$ 0.1
4.C Use HHS data to improve the health and well-being of the American people			
4.D Improve HHS environmental, energy, and economic performance to promote sustainability		$ 0.1	$ 0.2
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce	**$ -**	**$ 0.2**	**$ 0.3**
5.A Invest in the HHS workforce to meet America's health and human services needs today and tomorrow		$ 0.2	$ 0.3
5.B Ensure that the Nation's health care workforce can meet increased demands			
5.C Enhance the ability of the public health workforce to improve public health at home and abroad			
5.D Strengthen the Nation's human services workforce			
5.E Improve national, state, local, and tribal surveillance and epidemiology capacity			
TOTAL	**$ 40.9**	**$ 41.2**	**$ 42.2**

Discretionary All Purpose Table

(Dollars in Thousands)

Program	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Enforcement and Regional Operations	26,908	27,073	27,180	272
Programs and Policy	9,217	9,273	10,162	945
Planning and Business Administration Management	4,813	4,843	4,863	50
Total, Office for Civil Rights	40,938	41,189	42,205	1,267

Appropriations Language

For expenses necessary for the Office for Civil Rights, **[$40,938,000]** *$42,205,000***.**

AMOUNTS AVAILABLE FOR OBLIGATION

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
General Fund Discretionary Appropriation:			
Appropriation (L/HHS)	$41,016,000	$41,189,000	$42,205,000
Across-the-board reductions (L/HHS)	-$78,000	$0	$0
Subtotal, appropriation (L/HHS)	$40,938,000	$41,189,000	$42,205,000
Unobligated balance lapsing	$64,000	$0	$0
Total Obligations	**$40,874,000**	**$41,189,000**	**$42,205,000**

Summary of Changes

(Dollars in Thousands)

2012 General funds appropriation	40,938
Total adjusted budget authority	40,938
2014 Request - General funds	42,205
Total estimated budget authority	42,205
Net Changes	**1,267**

	FY 2012 Actual		FY 2014 President's Budget Change From Base	
	FTE	Amount	FTE	Amount
Increases:				
A. Built-In:				
1. Costs of pay adjustments	0	$0	0	$0
2. Other services	0	$0	0	$0
3. Other purchases of goods and services from Government accounts	0	$0	0	$0
4. Insurance claims and indemnities	0	$0	0	$0
5. Full-Time Permanent	225	$21,727	6	$1,401
6. Other than full-time permanent	0	$554	0	$9
7. Other Personnel Compensation	0	$574	0	$14
8. Military personnel	1	$67	1	$1
9. Special personal services payments	0	$0	0	$0
10. Civilian personnel benefits	0	$5,072	0	$469
11. Military benefits	0	$26	0	$0
12. Benefits for former personnel	0	$21	0	$0
13. Travel and transportation of persons	0	$340	0	$4
14. Transportation of things	0	$20	0	$0
15. Rental payments to GSA	0	$3,152	0	$74
16. Rental payments to others	0	$0	0	$0
17. Communications, utilities, and miscellaneous charges	0	$359	0	$2
18. Printing and Reproduction	0	$50	0	$0
19. Advisory and Assistance Services	0	$0	0	$0
20. Other services from non-Federal sources	0	$2,747	0	$0
21. Other goods and services from Federal sources	0	$3,061	0	$0
22. Operation and maintenance of facilities	0	$1,246	0	$7
23. Research & Development Contracts	0	$0	0	$0
24. Supplies and materials	0	$250	0	$3
25. Equipment	0	$75	0	$0
26. Land and Structures	0	$0	0	$0
27. Investments and Loans	0	$0	0	$0
28. Grants, subsidies, and contributions	0	$0	0	$0

	FY 2012 Actual		FY 2014 President's Budget Change From Base	
Subtotal, Built-In Increases	**226**	**+$39,341**	**7**	**+$1,984**
B. Programs:				
Subtotal, Program Increases			**0**	**$0**
Total Increases	**226**	**+$39,341**	**7**	**+$1,984**
Decreases:				
A. Built-In:				
1. Operation and maintenance of equipment	0	$1,597	0	-$717
Subtotal, Built-In Decreases	**0**	**+$1,597**	**0**	**-$717**
B. Programs:				
Subtotal, Program Decreases			**0**	**$0**
Total Decreases	**0**	**+$1,597**	**0**	**-$717**
Net Change	**226**	**+$40,938**	**7**	**+$1,267**

BUDGET AUTHORITY BY ACTIVITY - DIRECT

(Dollars in Thousands)

	FY 2012 Actual		FY 2013 CR		FY 2014 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
Enforcement and Regional Operations	165	$26,908	163	$27,073	166	$27,180
Programs and Policy	40	$9,217	41	$9,273	44	$10,162
Planning and Business Administration Management	19	$4,813	18	$4,843	20	$4,863
Subtotal, Budget Authority	224	40,938	222	41,189	230	42,205
Total, Budget Authority	**224**	**40,938**	**222**	**41,189**	**230**	**42,205**

AUTHORIZING LEGISLATION

(Dollars in Thousands)

	FY 2013 Amount Authorized	FY 2013 Appropriations Act	FY 2014 Amount Authorized	FY 2014 President's Budget
Office for Civil Rights:				
	Indefinite	$41,189	Indefinite	$42,205
Total:		$41,189		$42,205

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 Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 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
FY 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
FY 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	3,000
FY 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

FY 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

FY 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

FY 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

FY 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

FY 2013

General Fund Appropriation:				
Base…….	38,966,000		38,966,000	
Subtotal……	38,966,000		38,966,000	

FY 2014

General Fund Appropriation:				
Base.....	42,205,000			
Subtotal.....	42,205,000			

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 2014, OCR requests $42,205,000, an increase of $1,267,000 from the FY12 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.

- $27,180,000 for Enforcement and Regional Operations – an increase of $272,000
- $10,162,000 for Programs and Policy – an increase of $945,000
- $4,863,000 for Planning and Business Administration Management – an increase of $50,000

Enforcement and Regional Operations
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	26,908	27,073	27,180	272
FTE	165	163	166	1

Program Description and Accomplishments

The Division of Enforcement and Regional Operations is charged with prevention and elimination of unlawful discrimination as well as protecting the privacy and security of individually identifiable health information. In fulfilling that mission, it supports the American public. The office consists of a small headquarters staff and personnel located at 10 regional HHS offices throughout the United States as indicated on the organization chart. 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 in the ten regions spread across the nation are at the forefront of OCR's enforcement efforts and responsible for responding to complainants and investigation of alleged violations of civil rights and health information privacy laws. The regional manager in each of the ten Regions is responsible for operations within his/her geographical area of responsibility.

Region	Location	Satellite Office	Geographical Responsibility
I	Boston		CT,ME,MA,NH,RI,VT
II	New York		NJ,NY,PR,Virgin Islands
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	American Samoa,AZ,CA,Guam,HI,NV
X	Seattle		AK,ID,OR,WA

Since implementation of the Privacy Rule in 2003, the number of complaints filed with OCR per year has grown six-fold, from 1,948 in FY 2002 to approximately 16,000 in FY 2012. In an effort to keep pace with an ever increasing case workload, OCR instituted a number of efficiencies from FY 2002 through FY 2010, including a reorganization effort, improved staff skill sets, a centralized intake study, and ongoing improvements in case management techniques. These efficiency measures produced an increase in the number of cases resolved per FTE per year, although these measures did not fully offset the robust growth in complaint receipts.

Highlights of recent civil rights enforcement accomplishments:

- As a result of a settlement agreement entered into between Citizen's Medical Center (CMC) in Victoria, Texas and OCR (Region VI) in March 2012, children with disabilities will now have the same rights as other American children to access child care programs. The settlement followed an OCR investigation into a complaint filed on behalf of a complainant's child who was denied an

opportunity to participate in a CMC child care program, based on the child's disability, autism spectrum disorder. OCR's investigation into the complaint revealed that CMC violated Section 504 and the ADA when it rejected the child for enrollment based on its perception that the child would need one-on-one care as a reasonable modification. The settlement agreement required CMC to establish a non-discrimination policy and provide notice to its staff and program participants of the policy. In addition, CMC agreed to staff receiving comprehensive training concerning their obligations to provide services without discrimination to qualified persons with disabilities and specific training on autism spectrum disorder; implement a patient grievance procedure; inform patients of their right to file a complaint with OCR; appoint a Section 504 Coordinator who will be responsible for CMC's efforts to comply with Section 504 and Title II of the ADA; and report to OCR for an 18 month period.

- In August 2011, OCR (Region VI) entered into a resolution agreement with the East Texas Medical Center Regional Healthcare System (ETMC) to ensure that deaf or hard of hearing patients receiving care will be screened and provided with sign language interpreter services when necessary for effective communication. After investigating the complaint of a deaf patient who alleged she had not been provided a sign language interpreter while receiving prenatal care at ETMC Crocket Hospital, OCR issued a letter of concern to ETMC stating that deficiencies in their policies could result in the provision of auxiliary aids and services to deaf patients in an arbitrary or inconsistent manner. Under Section 504 of the Rehabilitation Act of 1973, recipients of federal financial assistance must provide auxiliary aids and services to individuals who are deaf or hard of hearing.

- In January 2011, OCR (Region I) entered into a state-wide voluntary resolution agreement with the Rhode Island Department of Human Services (RIDHS) that provides limited English proficiency (LEP) clients improved access to RIDHS programs and services, including Medicaid and other social service programs. Under the agreement, RIDHS will ensure that the language access needs of its LEP clients are properly assessed and that appropriate language services are provided to clients in all RIDHS programs. RIDHS will improve its policies and procedures for assessing translation needs and ensure that current and new staff receives comprehensive training on providers' duties under Title VI of the Civil Rights Act of 1964.

Highlights of recent HIPAA Privacy and Security Rule enforcement accomplishments:

- Phoenix Cardiac Surgery (PCS) Monetary Settlement (Region X). In April of 2012, PCS agreed to pay $100,000 and take corrective action to implement policies and procedures to safeguard the protected health information of its patients. The settlement with the physician practice follows an extensive investigation by the HHS Office for Civil Rights (OCR) for potential violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules. The incident giving rise to OCR's investigation was a report that the physician practice was posting clinical and surgical appointments for its patients on an Internet-based calendar that was publicly accessible. On further investigation, OCR found that PCS had implemented few policies and procedures to comply with the HIPAA Privacy and Security Rules, and had limited safeguards in place to protect patients' electronic protected health information (ePHI).

- Blue Cross Blue Shield of Tennessee (BCBST) Monetary Settlement (Region IV). In March of 2012, BCBST agreed to pay $1,500,000 to settle potential violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules. BCBST has also agreed to a corrective action plan to address gaps in its HIPAA compliance program. The enforcement action is the first resulting from a breach report required by the Health Information Technology for Economic and Clinical Health (HITECH) Act Breach Notification Rule. The investigation followed a notice

submitted by BCBST to HHS reporting that 57 unencrypted computer hard drives were stolen from a leased facility in Tennessee. The drives contained the protected health information (PHI) of over 1 million individuals, including member names, social security numbers, diagnosis codes, dates of birth, and health plan identification numbers. OCR's investigation indicated BCBST failed to implement appropriate administrative safeguards to adequately protect information remaining at the leased facility by not performing the required security evaluation in response to operational changes. In addition, the investigation showed a failure to implement appropriate physical safeguards by not having adequate facility access controls; both of these safeguards are required by the HIPAA Security Rule.

- University of California at Los Angeles Health System (UCLAHS) Monetary Settlement (Region IX). In July of 2011, UCLAHS agreed to settle potential violations of the HIPAA Privacy and Security Rules for $865,500 and has committed to a corrective action plan aimed at remedying gaps in its compliance with the rules. The resolution agreement resolves two separate complaints filed with OCR on behalf of two celebrity patients who received care at UCLAHS. The complaints alleged that UCLAHS employees repeatedly and without permissible reason looked at the electronic protected health information of these patients. OCR's investigation into the complaints revealed that from 2005-2008, unauthorized employees repeatedly looked at the electronic protected health information of numerous other UCLAHS patients. Through policies and procedures, entities covered under HIPAA must reasonably restrict access to patient information to only those employees with a valid reason to view the information and must sanction any employee who is found to have violated these policies.

- The General Hospital Corporation and Massachusetts General Physicians Organization, Inc. ("Mass General") Monetary Settlement (Region I). In February of 2011, Mass General agreed to pay $1,000,000 to settle potential violations of the HIPAA Privacy Rule. Mass General, one of the nation's oldest and largest hospitals, signed a Resolution Agreement with HHS that requires it to develop and implement a comprehensive set of policies and procedures to safeguard the privacy of its patients. The settlement follows an extensive investigation by OCR. The incident giving rise to the agreement involved the loss of protected health information (PHI) of 192 patients of Mass General's Infectious Disease Associates outpatient practice, including patients with HIV/AIDS. OCR opened its investigation of Mass General after a complaint was filed by a patient whose PHI was lost. OCR's investigation indicated that Mass General failed to implement reasonable, appropriate safeguards to protect the privacy of PHI when removed from Mass General's premises and impermissibly disclosed PHI potentially violating provisions of the HIPAA Privacy Rule.

- Cignet Health of Prince George's County, MD (Cignet) Civil Monetary Penalty (CMP) (Region III). In February of 2011, HHS OCR issued a Notice of Final Determination finding that a covered entity, Cignet, violated the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HHS has imposed a civil money penalty (CMP) of $4.3 million for the violations, representing the first CMP issued by the Department for violations of the HIPAA Privacy Rule. The CMP is based on the violation categories and increased penalty amounts authorized by Section 13410(d) of the Health Information Technology for Economic and Clinical Health (HITECH) Act. OCR found that Cignet violated 41 patients' rights by denying them access to their medical records. These patients, each of whom made a request to obtain their record between September 2008 and October 2009, individually filed complaints with OCR initiating investigations of each complaint. The HIPAA Privacy Rule requires that a covered entity provide a patient with a copy of their medical records within 30 (and no later than 60) days of the patient's request. The CMP for these violations is $1.3 million. During the investigations, Cignet refused to respond to OCR's repeated demands to produce the records. Additionally, Cignet failed to cooperate with OCR's investigations of the complaints, including failure to produce the records in response to OCR's subpoena. OCR filed a

petition to enforce its subpoena in United States District Court and obtained default judgment against Cignet on March 30, 2010. On April 7, 2010, Cignet produced the medical records to OCR, but otherwise made no efforts to resolve the complaints through informal means. Covered entities are required under law to cooperate with the Department's investigations. OCR found that Cignet's failure to cooperate with OCR's investigations was due to willful neglect.

- In FY 2012, OCR collected an aggregate of $3.6 million in monetary settlements and civil monetary penalties. OCR anticipates recovering $5.5 million and $6.5 million in FY 2013 and FY 2014, respectively.

Funding History

FY 2013	$27,073
FY 2012	$26,908
FY 2011	$26,961
FY 2010	*
FY 2009	*

* An OCR reorganization occurred in 2010 so funding by activity is not available prior to FY 2011.

Budget Request

The FY 2014 request for Enforcement and Regional Operations (E&RO) is $27,180,000 and reflects an increase of $272,000 from the FY 2012 Enacted Level. The increase is for one additional FTE and additional contractors to carry out investigations and compliance reviews to enforce the HIPAA Security Rule.

Programs and Policy
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	9,217	9,273	10,162	945
FTE	40	41	44	3

Program Description and Accomplishments

The Division of Programs and Policy is charged with prevention and elimination of unlawful discrimination as well as protecting the privacy and security of individually identifiable health information. In fulfilling that mission, it supports the American public. The Division consists of two components, Civil Rights and Health Information Privacy, with the vast majority of personnel working within the HHS headquarters in Washington, DC. The Deputy Director for Programs and Policy is responsible for all aspects of the operations and performance of this area and reports through the Chief of Staff to the Director of OCR.

Civil Rights Division:

The Civil Rights (CR) Division 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 OCR component responsible for leading OCR's civil rights activities, CR provides strategic planning for national priorities and oversees OCR's nationwide program for civil rights enforcement, outreach, and policy development through headquarters and regional operations. In particular, CR provides direction and subject matter expertise to regional staff and assistance in their activities to ensure legal and policy coordination and consistency 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, CR is responsible for all civil rights rulemaking and policy guidance in the Department's activities, including implementation of the civil rights mandates in the Affordable Care Act, and developing and overseeing national outreach efforts.

CR also oversees a nationwide civil rights pre-grant review program for new Medicare applicants to ensure their compliance with Federal civil rights laws, including 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, CR provides technical assistance to new and existing Medicare providers, reviews health care facilities' policies and procedures for civil rights compliance, and sends clearance letters to the facilities after they have demonstrated compliance.

Through the pre-grant review program, CR 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.

The Civil Rights Division is establishing three focused teams to implement the priority civil rights enforcement areas of Equal Access to Health Care under the Affordable Care Act (Section 1557),

Reducing Racial and Ethnic Health Disparities (Limited English Proficiency), and Community Living (Olmstead)

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 (LEP)), disability, age, or sex. Significantly, this is the first time that sex discrimination in health care is prohibited by a national civil rights law. OCR is currently drafting a regulation and intends to issue an NPRM in 2013. During 2014, we will conduct listening sessions to enhance public participation in the rulemaking process and issue a final rule. We also intend to conduct outreach and provide technical assistance to educate stakeholders about the new obligations and rights under the law. Even without a regulation in place, OCR is currently receiving complaints under this provision and OCR investigates and resolves those complaints.

In the HHS Strategic Plan for 2010-2015, one of the key strategies for implementing the objective of providing quality, culturally and linguistically competent care to vulnerable populations is "the prevention and correction of discriminatory actions and practices." OCR team personnel will implement this strategy by: addressing the language access issues identified in the HHS Disparities Action Plan; and rigorously enforcing Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color and national origin, including LEP populations, in programs receiving Federal financial assistance, which is an integral part of the ACA. Currently, OCR is conducting compliance reviews in ten states to ensure that Critical Access Hospitals in rural areas provide meaningful access to LEP persons. The team will initiate complaint investigations and compliance reviews in additional states and expand the reviews to other health care providers. Finally, they will work to ensure that underserved populations have equal access to health services and insurance as health reform is implemented and to identify ways to help recipients comply with their legal obligation to provide meaningful access by LEP persons to their programs and activities.

OCR will create a team to implement the Administration's and Secretary's priority to promote community living for persons with disabilities through vigorous enforcement of the Americans with Disabilities Act (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 must provide 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. Team personnel will collaborate with the Department of Justice, The Department of Housing and Urban Development, the Administration on Community Living, the Centers for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration. OCR will work with these agencies to develop policy and technical assistance opportunities for States, people with disabilities, and others.

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 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 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. 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 field testing and evaluation process will continue into FY2013.

HIP staff provides significant input into the development of compliance and enforcement strategies as well as expert advice to regional staff in their formulation of investigative plans, letters of investigative 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, 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.

Highlights of recent civil rights accomplishments:

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

- CR partnered with the Office on Disability and the Office of the National Coordinator (ONC) to improve accessibility of health information technology for people with disabilities to address complaints by disability advocates that materials were not accessible to individuals with vision impairments. CR provided technical assistance materials and information on civil rights laws and accessibility of electronic information to ONC. In the March 7, 2012 notice of proposed rulemaking on standards and certification criteria to support meaningful use, ONC noted in the preamble that it had worked with OCR and was proposing accessibility standards so patients with disabilities can view their health information online.

- CR also recently posted guidance on OCR's and ASPA's web pages on the intersection of Sections 504 and 508 of the Rehabilitation Act as applied generally to information technology.

- CR 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 CR's efforts, there are now 42 Agreements covering over 3,900 healthcare providers who serve more than 8.6 million patients.

- To respond to a series of complaints which found lack of communication with deaf and hard of hearing in hospitals as a widespread problem, CR recently identified and posted to OCR's website 20 promising practices for hospitals to communicate effectively with LEP individuals and deaf or hard of hearing individuals.

- In response to an OCR finding that a Dialysis Center in Maryland violated Section 504 of the Rehabilitation Act, OCR (Region III) initiated a technical assistance project with the Mid-Atlantic Renal Coalition (MARC) and the End Stage Renal Disease Network to ensure that these organizations understand their providers' Section 504 obligations to ensure effective communication with persons who are deaf or hard of hearing. As a result, MARC included information regarding the importance of providing effective communication in their monthly E-alert to their hundreds of providers throughout Maryland, Washington, D.C., Virginia, and West Virginia.

- The Civil Rights Division has worked with the Joint Commission to recently issue a publication that urges hospitals to create safe and inclusive environments to improve health care for LGBT patients and their families: *Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care for the Lesbian Gay, Bisexual and Transgender (LGBT) Community: A Field Guide.* For several years now, the CRD has worked cooperatively with the Joint Commission, serving on its expert advisory panel and collaboration of the Commission's publication: *Advancing Effective Communication, Cultural Competence and Patient- and Family-Centered Care: A Roadmap for Hospitals.* The *Roadmap's* law and regulations section was drafted by CRD staff.

- In April 2012, OCR (Region I) entered into a voluntary resolution agreement with the Town of Simsbury, Connecticut mandating that the town recreation department allow children with diabetes to attend its summer camp program. This agreement has served as a critical model to providers of public programs, services and activities that cannot screen out or exclude individuals because of disabilities, including diabetes.

Highlights of recent health information privacy accomplishments:

- HIP issued an Interim Final Rulemaking in October 2009 to implement the tiered penalty structure under the HITECH Act, significantly increasing the amount of civil money penalties that could be imposed for violations of the HIPAA Privacy and Security Rules. Since that time, OCR has imposed its first civil money penalty in February 2011, and has negotiated corrective active plans and monetary settlements in 6 cases, resulting in $3.8 million to put towards furthering health information privacy and security enforcement efforts.

- Based on new authority in the HITECH Act, HIP launched a major initiative to design, test, and evaluate a program for the 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 and tested in audits of 20 covered entities of

varying types and sizes. Based on feedback from this initial test, the remaining audits (up to a total of 115) will be conducted and the program and its results evaluated through FY 2013.

- In 2011, HIP completed a nation-wide training of State Attorneys General (SAG) on HIPAA and HITECH. The HITECH Act authorized State Attorneys General to bring civil actions to enforce the HIPAA Privacy and Security Rules. Training was provided to SAG staff at four sites across the country and copies of computed-based training materials were subsequently provided to each SAG office to facilitate continuous training of staff. OCR will continue to work with the State Attorneys General as they begin to pursue actions within their new jurisdiction.

- HIP has led extensive rulemaking efforts to implement the first statutorily mandated changes to the HIPAA Privacy, Security, and Enforcement Rules. A Notice of Proposed Rulemaking was issued in October 2009 under the Genetic Information Nondiscrimination Act to recognize genetic information as protected health information and to prevent its use by health plans for underwriting purposes. HIP also promulgated Interim Final Rules on 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. In July 2010, HIP issued another Notice of Proposed Rulemaking to address most of the remaining changes from the HITECH Act, 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. HIP will be completing these extensive rulemaking activities in January of 2013.

- 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 those proposed for Phase 2 and future phases.

- HIP also partnered with ONC to design and implement an initial 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. As part of this effort, OCR launched its first privacy videos oriented toward the public on the internet and is otherwise improving and expanding its abilities to reach healthcare consumers across America.

Funding History

FY 2013	$9,273
FY 2012	$9,217
FY 2011	$9,235
FY 2010	*
FY 2009	*

* An OCR reorganization occurred in 2010 so funding by activity is not available prior to FY 2011.

Budget Request

The FY 2014 request for Programs and Policy (P&P) is $10,162,000 and reflects an increase of $945,000 from the FY 2012 Enacted Level.

Program Increases:

Enforcement of the HIPAA Security Rule (+$945,000)
On July 27, 2009, the HHS Secretary delegated authority for the administration and enforcement of the Security Standards for the Protection of Electronic Protected Health Information (HIPAA Security Rule) to the Director of OCR. Combining the authority for administration and enforcement of the Federal standards for health information privacy and security called for in HIPAA improves HHS' ability to protect individuals' health information. OCR has been conducting this activity for nearly three years without any added funding. OCR requests that funding be reflected in the HHS budget. Additional funding will be used to adequately staff the HIPPAA security rule program, including a full-time permanent Program Manager to oversee and administer the program, and contractor support staff (2 subject matter experts). Funding will cover personnel costs and other indirect costs such as travel and supplies.

Planning and Business Administration Management

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	4,813	4,843	4,863	50
FTE	19	18	20	1

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 processing intra-HHS and external agency clearance requests, processing Congressional and other high-level correspondence, handling Freedom of Information Act (FOIA) requests, and other general administrative duties.
Human Resources	OCR operates in a dynamic environment which requires highly motivated and trained professionals to respond to citizen complaints involving complex circumstances. The Human Resources Section conducts the recruitment of all staff personnel as well as coordinating the personnel action support for all-board employees, both at the headquarters and throughout the Regions. The section's key responsibilities include coordination with the Office of Human Resources within the HHS Office of the Assistant Secretary of Administration, interpretation and application of human resources policy, and interfacing with the labor union.
Information Technology	With a wide dispersion of personnel spread across the nation, the Information Technology (IT) Section has the challenging task of ensuring that all operating locations receive superb and timely automation support to enable seamless operations. The Director of IT, with the assistance of three other personnel, performs a variety of tasks in support of that mission, including conducting inventories, trouble-shooting equipment, planning upgrades, reviewing invoices, letting contracts to support systems, monitoring interagency support services, administering the Performance Information Management System (PIMS), and acquiring replacement hardware.
Budget and Performance	The Budget and Performance Section is accountable for working with the OCR leadership to formulate requirements, both funding and personnel. Specific focus areas are: entering budget data into applicable systems, submitting budget justification exhibits, supporting overall headquarters and regional operations, contributing to the overall HHS Performance Appendix, monitoring budget execution spending and targets, setting and gauging progress on established performance measures, answering HHS and OMB data calls, and responding to all resource matters that affect ongoing OCR efforts to provide quality support to all citizens.

Additional personnel include the Director of OCR and his immediate office staff as well as the Deputy Director of PBAM.

To facilitate accomplishment of the OCR mission, PBAM staff members are focused on continuous operational and process improvement to support OCR programs and staff. Key initiatives designed to

improve overall operational efficiency within the last two years include centralized complaint intake for Regions IV and V that eliminated the backlog and now provides timely assistance and responses to complainants, targeted hiring designed to close skill gaps across the organization, development of enhanced programmatic training, upgrades to OCR's proprietary case management system, and more focus on information security.

Highlights of recent PBAM accomplishments:

- Currently leading an OCR-wide project to identify new performance measures that more accurately gauge OCR's overall performance across the entire organization
- Managed a centralized intake pilot study that demonstrated two key findings: a possible 53% decrease in the amount of time it takes to close complaints and discovery that transferring case workload between regional offices could result in a 78% reduction in overall case workload backlogs
- 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
- Reconfigured PIMS to more accurately reflect performance thereby providing additional capability to leaders in managing their operations
- Established a comprehensive IT inventory control plan to more efficiently safeguard all OCR equipment
- Completed a Continuity of Operations Plan (COOP) ensuring that, in the event of an emergency, OCR will continue to perform its critical mission functions

With an emphasis on improving the level of service provided to the public, these initiatives, coupled with programmatic enhancements to HIPAA compliance and enforcement operations have enabled OCR to make solid gains in reducing the inventory of open complaints. Funding at the requested level will allow OCR's compliance and enforcement operations to continue this renewed focus on being more responsive to the American public.

Funding History

FY 2013	$4,843
FY 2012	$4,813
FY 2011	$4,821
FY 2010	*
FY 2009	*

* An OCR reorganization occurred in 2010 so funding by activity is not available prior to FY 2011.

Budget Request

The FY 2014 request for Planning and Business Administration Management (PBAM) is $4,863,000 and reflects an increase of $50,000 from the FY 2012 Enacted Level. Funding will allow PBAM to provide administrative guidance and support to the program and enforcement staff (i.e. supplies, travel, printing services, etc.).

Budget Authority by Object Class
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	21,727	22,062	23,128
Other than full-time permanent (11.3)	554	557	563
Other personnel compensation (11.5)	574	577	588
Military personnel (11.7)	67	67	68
Special personal services payments (11.8)	0	0	0
Subtotal, Personnel compensation	**22,922**	**23,263**	**24,347**
Civilian personnel benefits (12.1)	5,072	5,185	5,541
Military benefits (12.2)	26	26	26
Benefits for former personnel (13.0)	21	21	21
Total Pay Costs	**28,041**	**28,495**	**29,935**
Travel and transportation of persons (21.0)	340	341	344
Transportation of things (22.0)	20	20	20
Rental payments to GSA (23.1)	3,152	3,171	3,226
Rental payments to others (23.2)	0	0	0
Communications, utilities, and miscellaneous charges (23.3)	359	361	361
Printing and reproduction (24.0)	50	50	50
Other Contractual Services:			
Advisory and assistance services (25.1)	0	0	0
Other services from non-Federal sources (25.2)	2,747	2,728	2,747
Other goods and services from Federal sources (25.3)	3,061	2,836	3,061
Operation and maintenance of facilities (25.4)	1,246	1,253	1,253
Research and development contracts (25.5)	0	0	0
Operation and maintenance of equipment (25.7)	1,597	1,607	880
Subtotal, Other Contractual Services	**8,651**	**8,424**	**7,941**
Supplies and materials (26.0)	250	252	253
Equipment (31.0)	75	75	75
Land and Structures (32.0)	0	0	0
Investments and Loans (33.0)	0	0	0
Grants, subsidies, and contributions (41.0)	0	0	0
Insurance claims and indemnities (42.0)	0	0	0
Total Non-Pay Costs	**12,897**	**12,694**	**12,270**
Total Budget Authority by Object Class	**40,938**	**41,189**	**42,205**

Salaries and Expenses
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	21,727	22,062	23,128
Other than full-time permanent (11.3)	554	557	563
Other personnel compensation (11.5)	574	577	588
Military personnel (11.7)	67	67	68
Subtotal, Personnel compensation	**22,922**	**23,263**	**24,347**
Civilian personnel benefits (12.1)	5,072	5,185	5,541
Military benefits (12.2)	26	26	26
Benefits for former personnel (13.0)	21	21	21
Total Pay Costs	**28,041**	**28,495**	**29,935**
Travel and transportation of persons (21.0)	340	341	344
Transportation of things (22.0)	20	20	20
Communications, utilities, and miscellaneous charges (23.3)	359	361	361
Printing and reproduction (24.0)	50	50	50
Other Contractual Services:			
Other services from non-Federal sources (25.2)	2,747	2,728	2,747
Other goods and services from Federal sources (25.3)	3,061	2,836	3,061
Operation and maintenance of facilities (25.4)	1,246	1,253	1,253
Operation and maintenance of equipment (25.7)	1,597	1,607	880
Subtotal, Other Contractual Services	**8,651**	**8,424**	**7,941**
Supplies and materials (26.0)	250	252	253
Total Non-Pay Costs	**9,670**	**9,448**	**8,969**
Total Salaries and Expenses	**37,711**	**37,943**	**38,904**

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT									
	FY 2012 Actual			FY 2013 CR			FY 2014 President's Budget		
	Civilian	**Military**	**Total**	**Civilian**	**Military**	**Total**	**Civilian**	**Military**	**Total**
Direct:	223	1	224	220	2	222	228	2	230
Reimbursable:	2	0	2	3	0	3	3	0	3
FTE Total	**225**	**1**	**226**	**223**	**2**	**225**	**231**	**2**	**233**

Detail of Positions

	FY 2012 Actual	FY 2013 CR	FY 2014 President's Budget
Executive level I			
Executive level II	4	4	4
Executive level III	4	4	4
Executive level IV	1	1	1
Executive level V			
Subtotal	9	9	9
Total - Exec. Level Salaries	$1,452,097	$1,459,357	$1,472,587
SES			
ES-6			
ES-5			
ES-4			
GS-15	25	26	26
GS-14	30	29	28
GS-13	39	39	42
GS-12	76	76	76
GS-11	14	14	14
GS-10			
GS-9	7	7	7
GS-8	3	4	4
GS-7	19	19	19
GS-6	5	5	5
GS-5	3	2	2
GS-4	7	6	5
GS-3			
GS-2			
GS-1			
Subtotal	228	227	228
Total - GS Salary	$20,212,991	$20,314,056	$20,489,826
Total Positions	237	236	237
Total FTE	225	223	231
Average ES salary	$161,344	$162,151	$163,621
Average GS grade	12/7	12/8	12/9
Average GS Salary	$88,653	$89,489	$89,868

*Excludes OCR's one military employee, "Other personnel compensation (11.5)," and "Civilian personnel benefits (12.1)." Includes reimbursable FTEs for FY 2013 and 2014.

National Coordinator for Health Information Technology

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Fiscal Year

2014

Office of the National Coordinator for Health Information Technology

Justification of Estimates for Appropriations Committee

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH IT
TABLE OF CONTENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the National Coordinator
for Health Information Technology
Washington, D.C. 20201

LETTER FROM THE NATIONAL COORDINATOR

I am pleased to present the fiscal year (FY) 2014 budget request for the Office of the National Coordinator for Health Information Technology (ONC). Health information technology (health IT) is a critical component of the Administration's efforts to improve our Nation's health care and move from a transaction-based system to one that emphasizes quality and value. As the National Coordinator for Health IT, I am extremely proud of the role that ONC's programs and its dedicated workforce play in facilitating the adoption and use of health IT in ways that help improve care, improve community health, and make care more efficient.

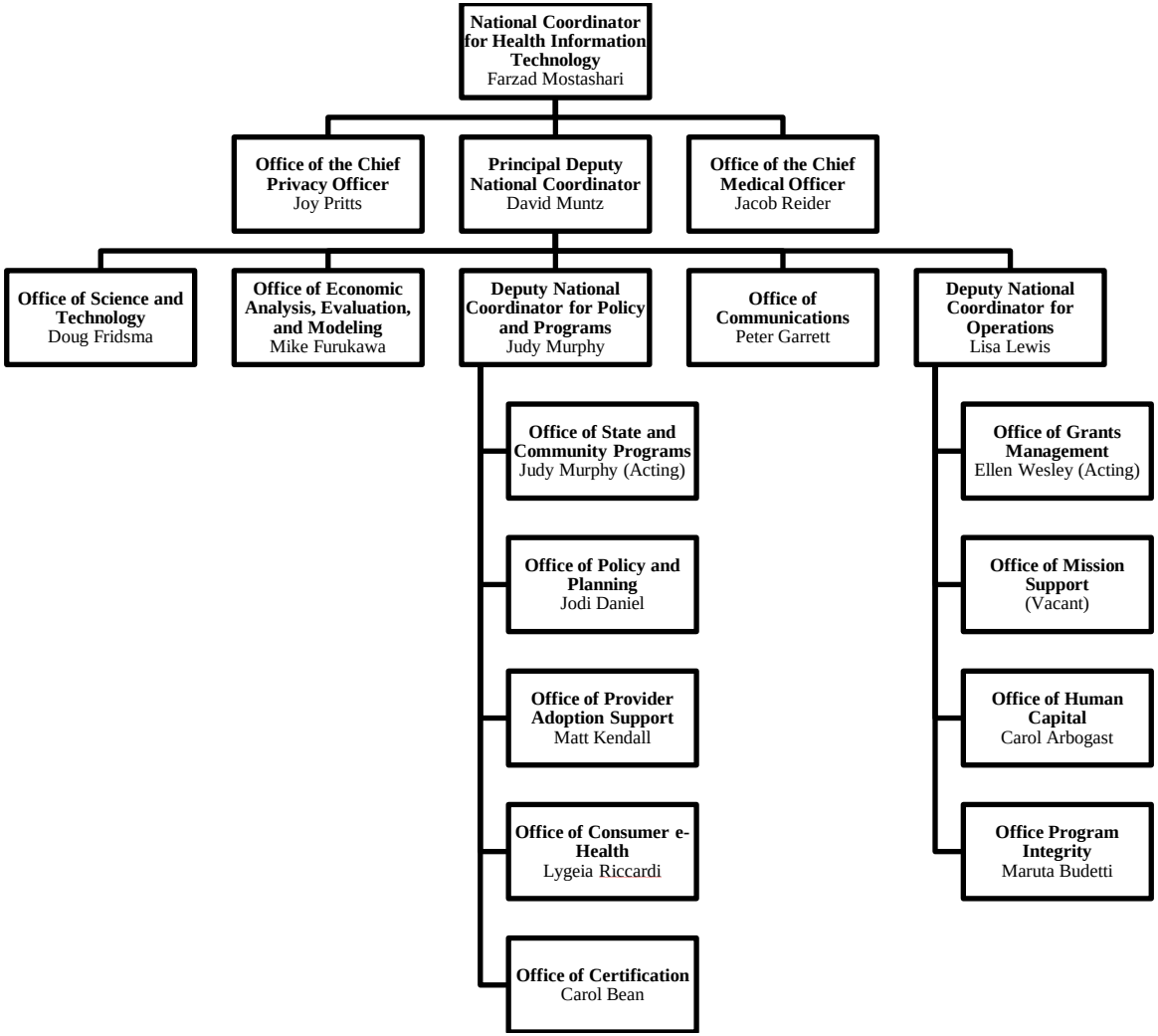
The FY 2014 budget request for ONC reflects a continued commitment to maximizing the positive impact of health IT in a fiscally responsible way. The Health Information Technology for Economic and Clinical Health (HITECH) Act, which is part of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5, Recovery Act), was a landmark moment in American health care. In investing $2 billion in key health IT infrastructure projects at ONC and creating the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, the legislation responded to President Obama's call to move from a paper-based to a digital health care system. The Department's investments in health IT have begun to pay great dividends, as the rate of EHR use by hospitals and providers throughout the country has risen sharply since the legislation was enacted, and we have started to see evidence of improved outcomes through the effective use of health IT.

ONC's budget reflects the level of resources necessary to both maintain and advance the health IT activities created by the HITECH Act and continue to provide value to the health IT marketplace. For example, the budget will allow ONC to continue activities that ensure health IT products follow consensus-based standards and policies which promote coordination of care through interoperable information exchange. The budget provides continued support for programs that directly support the Medicare and Medicaid EHR Incentive Programs, including EHR testing and certification and a National Learning Collaborative that helps providers adopt and meaningfully use EHRs. The budget provides resources for critical projects that help ensure that patient health information remains private and secure. The budget also takes steps to promote the safety and usability of health IT products and supports initiatives that make it easier for patients and consumers to engage in their own care through health IT.

ONC's budget request represents an increase over past years. With HITECH funding ending in FY 2013, the proposed funding is needed to ensure that progress towards secure, interoperable health IT systems is continued. ONC's budget will ensure that investments such as the EHR Incentive Programs continue to yield meaningful results, and that health IT fulfills its important role in modernizing and transforming the Nation's health care system.

Farzad Mostashari, M.D., Sc.M.
National Coordinator for Health IT

ORGANIZATIONAL CHART



The ONC organizational chart has been realigned to reflect the reorganization published in the Federal Register (Volume 77, Number 96) on May 17, 2012.

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, 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 and meaningful use of health IT. These efforts will make health information available 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 many patient activities outside of the clinical setting generate health information that can be used to support a range of clinical processes. For this information to be useful, however, it must be structured and formatted in a way that can be understood. Moreover, providers and other consumers of health information must be able to exchange and use that information seamlessly and securely across different information systems, care settings, and organizational and geographic boundaries.

These are the goals of health IT and the policies and programs supporting its acceptance and use. Health IT comprises the technologies — from electronic health records (EHRs) and personal health records (PHRs) to remote monitoring devices and mobile health applications — that can collect, store, and transmit health information. By enabling health information to be used more effectively and efficiently throughout our health system, health IT has the potential to empower providers and patients; make health care and the health system more transparent; enhance the study of care delivery and payment systems; and drive substantial improvements in care, efficiency, and population health.

Despite recent progress in achieving these goals, substantial work remains to be done. While recent years have seen a dramatic increase in the number of U.S. providers using health IT, interoperability and patient engagement continue to lag behind. As a result, health information can be costly and difficult to collect, preventing it from being available where and when providers and patients need it most.

ONC provides the collaborative framework through which policy-makers and stakeholders address critical health IT issues and barriers. Working directly with the health IT community, ONC develops consensus-based standards and technologies that facilitate interoperability and health information exchange (HIE). At the same time, ONC inspires confidence and trust in health IT by protecting the privacy and security of health information and ensuring the safe use of health IT in every phase of its development and implementation.

To ensure that health IT is widely and effectively implemented, ONC provides expertise, guidance, and resources to implementers and consumers, and administers a reliable Health IT Certification Program. ONC also works closely with the Centers for Medicare & Medicaid Services (CMS) to establish the criteria governing the Medicare and Medicaid EHR Incentive Programs (Meaningful Use Programs), which provide incentive payments to eligible providers who adopt and meaningfully use certified EHR technology (CEHRT).

ONC carries out the above activities through the following offices:

Deputy National Coordinator for Programs and Policy (DNC-PP): DNC-PP supports the adoption, utilization, and meaningful use of health IT among providers and consumers by guiding policy development and adoption support through the following offices:

- *Office of Policy and Planning (OPP):* OPP develops and coordinates policies that support market optimization and provides proactive and forward-thinking strategies that reflect open and transparent processes.
- *Office of Consumer e-Health (OCEH):* OCEH works to empower patients and caregivers to be partners in their health care through the adoption and utilization of health IT.
- *Office of State and Community Programs (OSCP):* OSCP coordinates the efforts of states and communities in adopting HIE and develops governance mechanisms to ensure the efficient exchange of health information.
- *Office of Provider Adoption Support (OPAS):* OPAS assists providers in adopting and utilizing health IT through a national network of organizations that are focused on supporting individual providers by identifying barriers and effective adoption strategies.
- *Office of Certification (OCERT):* OCERT accredits the testing and certification bodies that ensure health IT is certified for use by federal agencies and partners and as required for attestation by providers participating in the Meaningful Use Programs.

Office of the Chief Privacy Officer (OCPO): OCPO develops and coordinates privacy, security, and data stewardship policy across the federal government, state and regional agencies, and foreign countries by providing subject matter expertise and technical support.

Office of the Chief Medical Officer (OCMO): OCMO engages with a wide array of clinical stakeholders and provides a clinically based perspective on ONC policies and activities. This includes clinical issues around health IT safety, usability, clinical decision support, and quality measures.

Office of Science and Technology (OST): OST promotes the adoption of interoperable, open, standards-based technologies and architectures that ensure information can flow seamlessly and securely between interoperable health IT. By engaging a range of stakeholders through a standardized framework, OST accelerates the development and harmonization of health IT standards.

Office of Economic Analysis, Evaluation, and Modeling (OEAM): OEAM provides ONC policy and program leaders with reliable, systematic studies and data analysis related to ONC programs as well as the U.S. health system and economy at large.

Office of Communications (OCOMM): OCOMM provides ONC with comprehensive communication strategies for public outreach, media relations, and public affairs.

Deputy National Coordinator for Operations (DNC-OPS): DNC-OPS provides agency wide support functions for ONC, including grants management, budget formulation and execution, procurement, human capital, and program integrity.

All Purpose Table

(Dollars in Thousands)

Program	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Budget Authority	16,415	16,515	20,576	+4,161
PHS Evaluation Funds	44,811	45,086	56,307	+11,496
User Fee	0	0	1,000	+1,000
Total, Program Level	61,226	61,601	77,883	+16,657

Overview of Budget Request

The Fiscal Year (FY) 2014 Budget Request for ONC is $77.9 million, including $20.6 million in budget authority, $56.3 million in Public Health Service (PHS) Evaluation Funds, and $1.0 million in CEHRT fees to support program activities. This represents an increase of $16.7 million above the FY 2012 enacted level.

ONC provides the leadership, program resources, and services needed to guide nationwide implementation and meaningful use of health IT. ONC establishes the policies, standards, and certification that support the federal health IT infrastructure; and supports the efforts of states, communities, providers, and consumers to adopt and meaningfully use health IT. These efforts will improve care to patients, improve population health, and increase the value of every health care dollar.

Recognizing the need to overcome significant barriers that were slowing the acceptance of health IT and HIE, Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (Recovery Act). The HITECH Act aimed to improve health care quality, safety, and efficiency through the promotion of health IT and HIE. The HITECH Act reaffirmed the vital role of the federal government in optimizing the health IT market and strengthening the nation's health IT infrastructure.

Over the past three years, $2 billion in HITECH funding for ONC has supported grant programs and investments in standards and security that have dramatically accelerated the adoption and meaningful use of CEHRT. With the end of HITECH funding in FY 2013, the FY 2014 Budget will allow ONC to leverage vital HITECH Act investments and continue to support the growing number of consumers, health care providers, and vendors engaged in modernizing the nation's health care system. Since 2009, ONC has focused on reaching a critical mass in the use of health IT through steep adoption of CEHRT, PHRs, and interoperable standards. As a result of these efforts, providers and consumers are increasingly realizing the benefits of health IT and HIE.

In the coming years, providers and consumers will seek to leverage health IT to improve care coordination, clinical decision-making, quality improvement, and population health. As this occurs, ONC will continue to forge consensus among stakeholders and coordinate effective policies and programs that promote the meaningful use of health IT while protecting the privacy and security of health information and advancing patient safety. ONC will continue to enable innovation in the health IT market by maintaining and establishing core standards, and will inspire trust and confidence in health IT through a robust Certification Program. ONC will establish good governance rules that will ensure that 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, at lower cost.

This Budget builds on the momentum gained over the past few years through the following activities:

Policy Development and Coordination – $16.0 million ($4.9 million increase)
These funds will support ONC's regulatory, policy, convening, and analysis activities, including priority policy initiatives in the areas of HIE governance, privacy and security, and patient safety and usability.

- The increased funding will support implementation of the *Health IT Patient Safety Action and Surveillance Plan* including enhancements to the AHRQ common formats for patient safety event reporting and development of corresponding certification criteria to ensure that CEHRT can be used to report safety events.
- The increased funding will also support nationwide health IT governance efforts by funding emerging private-sector governance collaboratives, publishing a series of governance guides, and launching a monitoring program to ensure that governance goals are being addressed.

Standards, Interoperability, and Certification – $26.3 million ($10.0 million increase)
These funds will allow ONC to maintain and develop standards that support an interoperable and secure health IT infrastructure. The increased funding will support standards development and harmonization surrounding *Structured Data Capture, Data Spigot, Patient Data Portability,* and *Data Provenance*. With the end of Recovery Act funding, this request will allow ONC to hire additional technical staff in order to maintain its core standards capacity while transitioning away from reliance on contractual support. ONC will continue to provide the leadership, technical expertise, and tools required by implementers to enable sustainable and robust HIE throughout the nation. This request will also ensure continued operation of the ONC Health IT Certification Program, inspiring confidence, trust, and innovation in health IT.

Adoption, Utilization, and Meaningful Use of Health IT – $14.5 million ($3.6 million increase)
These funds will enable ONC to continue to support providers in successfully adopting and implementing health IT systems; monitor and evaluate economic data and market trends concerning the adoption and meaningful use of EHRs; empower consumers through the use of health IT; and inform stakeholders, media, and the public. The increased funding will transition the infrastructure of the Health Information Technology Research Center (HITRC) and the Customer Relations Management (CRM) Tool, developed with Recovery Act funding, to a permanent infrastructure in support of adoption activities. As adoption rates accelerate, ONC will begin focusing on developing and distributing best practices to providers and consumers in order to help them make the most of their health IT investments to improve patient care, population health, and increase the value of every health dollar.

Agency-Wide Support – $21.1 million ($1.8 million decrease)
These funds will be used to provide central services and operational support to ONC's program offices. The decrease reflects improved administrative efficiencies.

Overview of Performance

ONC monitors a number of health system research and performance measures that contextualize and inform the government's strategic planning and performance evaluation of the national health care infrastructure and Federal health IT programs. The performance measures presented in the Performance Appendix (page 43) demonstrate some key trends showing the:

Section 1 – Trends in EHR adoption and Health Information Exchange (HIE) activity

- 1.1 EHR adoption is accelerating health IT-enabled delivery system reform, as exemplified by major increases in EHR adoption statistics. ONC estimates that by 2014, 65 percent of non-federal acute care hospitals and primary care physicians will have at least basic electronic health records.
- 1.2 EHR systems that are being implemented now include more functionalities, as evidenced by growth in adoption of "comprehensive" EHRs as compared to "basic" EHRs.
- 1.3 Stakeholder networks are being leveraged to enable HHS to govern at the pace of technology, as shown through the work of ONC's Federal Advisory Committees.
- 1.4 EHR and HIE market places are robust and active, as shown by vendor participation in the EHR Certification Program, which reached 1,758 unique products in March 2013.

Section 2 – Success of ONC and HITECH programs as health system modernization change agents

- 2.1 CMS EHR Incentive Programs have had strong starts, with more than two thirds of eligible professionals and over 80 percent of eligible hospitals already on the pathway to demonstrating Meaningful Use.
- 2.2 RECs are accelerating the drive towards Meaningful Use by reaching out to priority groups of the nation's primary care providers. As of March 2013, the RECs have assisted over 107,000 primary care providers with adopting an EHR and working towards Meaningful Use.
- 2.3 State HIE Program is improving collaboration and capacity to promote information exchange by States their health systems.
- 2.4 Health IT Workforce have helped strengthen the nationwide infrastructure for providing technical assistance and leadership to the health care community as it transitions towards the greater and more meaningful use of EHRs. Almost 17,000 health IT professionals have completed ONC workforce training programs by December 2012.
- 2.5 Strategic Health IT Advanced Research Projects (SHARP) Program is developing innovative solutions to address major challenges in the use of EHRs.
- 2.6 Beacon Communities are showing real-life examples of how greater health IT adoption can contribute to improvements in quality of care for patients.

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, [$26,246,000] *$20,576,000: Provided, That in addition to amounts provided herein,* [$40,011,000] *$56,307,000 shall be available from amounts available under section 241 of the PHS Act: Provided further, That health information technology user fees collected in FY 2014, as provided in this Act, shall be credited to this appropriation as offsetting collections to this account, to remain available until expended.*

Note.--A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

Language Analysis

Language Provision	Explanation
Provided further, That health information technology user fees collected in FY 2014, as provided in this Act, shall be credited to this appropriation as offsetting collections to this account, to remain available until expended.	Provides ONC the authority to collect and spend user fees authorized in the general provision below.
SEC. 223. (a) Health Information Technology User Fees. The Secretary of HHS shall prescribe by regulation, for application in the current fiscal year and in subsequent fiscal years, a schedule of fees for certification of health information technology as established by Section 300jj-11(c)(5) of Title 42. The fees shall be paid by health information technology vendors based on the fee structure established by the Secretary and published in the Federal Register. The Secretary shall periodically update this schedule of fees through a notice in the Federal Register. This fee structure shall be designed to be sufficient to recover costs associated with the administration of certification programs authorized by Section 300jj-11(c)(5) of Title 42, including the costs for health information technology standards, testing and certification, and improving the efficiency of certification programs. *(b) Collection Procedures. The Secretary shall prescribe procedures to collect the fees. The Secretary may, for the purpose of collecting fees, use the services of a department, agency, or instrumentality authorized by the National Coordinator to perform the certification of health information technology in accordance with Section 300jj-11(c)(5) of Title 42, and may reimburse such department, agency, or instrumentality a reasonable amount for its services.* *(c) Collection, Deposit, and Use.* *(1) Fees collected under this section shall be deposited in the HHS Office of the National Coordinator for Health Information Technology account as offsetting collections.* *(2) Such fees shall be collected and available only to the extent and in such amounts as provided in advance in appropriations acts.*	Authorizes the Certified Electronic Health Record Technology user fee collections to the Office of the National Coordinator for Health Information Technology to use for EHR certification and standards development.

Amounts Available for Obligation

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
General Fund Discretionary Appropriation:			
Appropriation (L/HHS, Ag, or, Interior).....	61,257,000	61,225,917	77,883,000
Across-the-board reductions (L/HHS, Ag, or Interior)	-31,083		
Across-the-board increase (P.L. 112-175).....		374,703	
Subtotal, Appropriation (L/HHS, Ag, or Interior)....	61,225,917	61,600,620	77,883,000
Total, Discretionary Appropriation.....	61,225,917	61,600,620	77,883,000
Unobligated Balances:			
Unobligated balance, Recovery Act start of year.....	3,740,000	1,526,277	0
Unobligated balance, Recovery Act end of year.....	1,526,277	0	0
Total obligations.....	64,965,917	63,126,897	77,883,000
Obligations less ARRA.....	61,225,917	61,600,620	77,883,000

Summary of Changes

dollars in thousands

2012

Total estimated budget authority 16,415

2014

Total estimated budget authority 20,576

Net Change budget authority ..... +4,161

	FY 2012 Enacted		FY 2014 PB		FY 2014 +/- FY 2012	
	FTE	BA	FTE	BA	FTE	BA [1]
Increases:						
A. Program:						
1. Standards, Interoperability, and Certification.....	39	5,784	50	9,167	+11	+3,383
2. Agency Wide Support.....	50	10,631	59	11,409	+9	+778
Subtotal, Program Increases.....	**89**	**16,415**	**109**	**20,576**	**+20**	**+4,161**

1/ totals may not add due to rounding.

Budget Authority by Activity

(dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
1. Policy Development and Coordination			
Budget Authority	-	-	-
PHS Evaluation Funds	11,161	14,210	16,014
Total, Policy Development and Coordination	**11,161**	**14,210**	**16,014**
2. Standards, Interoperability, and Certification			
Budget Authority	5,784	6,054	9,167
PHS Evaluation Funds	10,507	10,730	16,090
User Fee	-	-	1,000
Total, Standards, Interoperability, and Certification	**16,291**	**16,784**	**26,257**
3. Adoption, Utilization, and Meaningful Use			
Budget Authority	-	-	-
PHS Evaluation Funds	10,943	10,287	14,535
Total, Adoption, Utilization, and Meaningful Use	**10,943**	**10,287**	**14,535**
4. Agency-Wide Support			
Budget Authority	10,631	10,361	11,409
PHS Evaluation Funds	12,199	9,959	9,668
Total, Agency-Wide Support	**22,830**	**20,320**	**21,077**
Total, ONC			
Total Budget Authority	16,415	16,415	20,576
Total PHS Evaluation Funds	44,810	45,186	56,307
User Fee	-	-	1,000
Total, Program Level	**61,225**	**61,601**	**77,883**
FTE	159	191	191

Authorizing Legislation

(dollars in thousands)

	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2014 Amount Authorized	FY 2014 Pres. Budget
Health Information Technology Activity:				
1. Health Information Technology PHS Act 42 U.S.C. 201.....	Indefinite	$16,415	Indefinite	$20,576
2. PHS Evaluation Funds (non-add) PL 111-117.....	Indefinite	$44,811	Indefinite	$56,307
3. User Fee		$0	Indefinite	$1,000
Total request level.....		$61,226		$77,883

Appropriations History Table

(dollars in thousands)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2006				
General Fund Appropriation:				
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
FY 2007				
General Fund Appropriation:				
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
FY 2008				
General Fund Appropriation:				
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
FY 2009				
General Fund Appropriation:				
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
FY 2010				
General Fund Appropriation:				
Base	$42,331	$0	$42,331	$42,331
PHS Evaluation Funds	$19,011	$61,342	$19,011	$19,011
Subtotal	$61,342	$61,342	$61,342	$61,342
FY 2011				
General Fund Appropriation:				
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

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2012				
General Fund Appropriation:				
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
FY 2013				
General Fund Appropriation:				
Base	$26,246	$16,415	$16,415	
PHS Evaluation Funds	$40,011	$44,811	$49,842	
Subtotal	$66,257	$61,226	$66,257	
FY 2014				
General Fund Appropriation:				
Base	$20,576			
PHS Evaluation Funds	$56,307			
User Fee	$1,000			
Subtotal	$77,883			

NARRATIVE BY ACTIVITY

Policy Development and Coordination

(dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 (+/-) FY 2012
Budget Authority	-	-	-	+0
PHS Evaluation Funds	11,161	14,210	16,014	+4,853
Total Program Level	11,161	14,210	16,014	+4,853
FTE	27	35	35	+8

Authorizing Legislation: PHS Act 42 U.S.C. 201

Allocation Method: Contract, Cooperative Agreement, Grant

Program Description and Accomplishments

ONC coordinates the policies and activities necessary to develop a robust and interoperable health IT infrastructure that will enable the transformation of health care delivery in the United States. In consultation with a broad range of health IT stakeholders, ONC sets the direction of federal health IT policy and provides a policy framework for emerging activities that emanate from the use of electronic health information.

ONC ensures that health IT policies promote confidence and trust in health IT by protecting the privacy and security of health information and integrating clinical best practices in every phase of health IT development and implementation. ONC carries out these functions through its Chief Privacy Officer (CPO) and Chief Medical Officer (CMO). CPO has the statutory role of coordinating and implementing privacy and security protections found in the Health Insurance Portability and Accountability Act (HIPAA) as well as the HITECH Act. CMO ensures that federal policies on health IT incorporate a clinical perspective that promotes patient safety and health IT usability. Within their respective areas of expertise, CPO and CMO monitor current and emerging issues; identify weaknesses and gaps in existing policies; formulate solutions; and provide guidance to federal agencies and stakeholders.

Health IT Policy

ONC ensures a coordinated and effective approach to federal health IT policy. ONC maintains the *Federal Health IT Strategic Plan*, monitors progress towards the plan's objectives, and works with its partners to align their activities with national goals and priorities. Using its unique convening authority, ONC brings together diverse stakeholders to forge consensus-based solutions to key health IT policy issues. ONC provides analysis and subject-matter expertise to leaders and policy-makers at all levels of government, and supports a variety of White House, Congressional, and inter-departmental initiatives to leverage health IT to meet government-wide goals and objectives.

ONC ensures that federal health IT policies are transparent and responsive to input from the private and non-profit sector stakeholders in the health IT and health care communities. To this end, ONC maintains two Federal Advisory Committee Act (FACA) bodies (advisory committees), the Health IT Policy Committee (HITPC) and Health IT Standards Committee (HITSC). The members of the HITPC are appointed by the Comptroller General of the United States, the Secretary of HHS, the Majority and Minority leaders of the Senate, and the Speaker and Minority leader of the House of Representatives. The

HITECH Act further specified that the HITSC include providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant federal agencies, and individuals with technical expertise on health care quality, privacy and security, and HIE. To further enrich the advice they provide, each advisory committee maintains several workgroups that incorporate the perspectives of additional stakeholders from government and the private sector. ONC solicits recommendations from the HITPC in order to inform its 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 HITSC to ensure that the standards, implementation specifications, and certification criteria established by the Secretary through regulation support federal health IT policies and are responsive to the needs of the health IT community and marketplace.

Accomplishments include:

- In August 2012, the Secretary promulgated final rules governing Stage 2 of the Meaningful Use Programs (MU Stage 2), including the 2014 Edition Standards, Implementation Specifications, and Certification Criteria for EHR Technology. These rules, developed jointly by ONC and CMS, were heavily informed by the work of the advisory committees, CPO, and CMO. MU Stage 2 represents a major step forward in advancing the secure exchange of health information between providers and patients to support better care across the nation. Highlights of MU Stage 2 include:
    - Common standards and implementation specifications that will facilitate greater and more robust HIE. By 2014, providers will have to demonstrate, and vendors will have to support, the actual exchange of structured care summaries with other providers — including across vendor boundaries — and with patients.
    - New and enhanced clinical quality measures for the capture, calculation, and reporting of clinical quality measure data.
    - A new focus on patient safety that will require vendors to publicly identify a method of ensuring user-centered design of eight certification criteria that have a high likelihood of helping to prevent medical errors.
    - Enhanced privacy and security protections, including a new emphasis on encryption and securing mobile devices.
    - Greater patient access to health information through the requirement that patients be able to view, download, and transmit their health data electronically.
- In collaboration with the HITPC Meaningful Use Workgroup, ONC explored methods for integrating patient generated health data with CEHRT. ONC recently commissioned a report to better understand this emerging landscape.
- In 2012, ONC convened experts in the Long Term and Post Acute Care (LTPAC) community to assess and subsequently publish a whitepaper on the applicability of MU Stage 2 functionality for these providers and health IT vendors.

<u>Governance of Health Information Exchange</u>

Effective governance “rules of the road” are essential to enabling trusted exchange of information to emerge. As providers and patients increasingly engage and seek benefit from interoperable health IT, governance and oversight entities will have a critical role in aligning regional and state exchange initiatives with national priorities; reducing implementation costs; ensuring privacy and security of electronic health information; and establishing the policies, interoperability requirements, and business practices that will allow information to follow patients between care settings and across organizational, vendor, and geographic boundaries. ONC works with states and communities, health information organizations (HIOs), and other entities currently serving in governance and oversight roles to promote emerging good governance practices.

Accomplishments include:

- Issued a request for information (RFI) to stakeholders seeking input on whether ONC should establish a regulatory framework for HIE governance. Based on responses that there are already organizations engaged in HIE governance activities, ONC decided to work with these entities rather than pursue a regulatory approach to governance.
- Issued a Funding Opportunity Announcement (FOA) that will allow ONC to work collaboratively with existing HIE governance entities to develop and adopt policies and practices that support robust, secure, and interoperable exchange.
- Hosted open listening sessions on governance of HIE to provide opportunities for a wide range of stakeholders to describe their issues, experience, priorities, and critical concerns.
- The HITPC and HITSC held a joint hearing to further discuss the current state of governance of HIE. The hearing highlighted, among other topics, the nature and scope of existing governance policies and practices, the impact of governance on HIE, and the opportunities to strengthen governance at multiple levels.

Privacy and Security

Privacy and security are the foundation upon which trust in health information and participation in HIE is built. [1] Anticipating the need for clear and coordinated federal policy with respect to the privacy and security of electronic health information, Congress established the position of CPO to advise the National Coordinator and coordinate privacy, security, and data stewardship policy with state and regional efforts, federal agencies, and foreign countries. These entities frequently solicit CPO's expertise and assistance in navigating the multifarious legal and regulatory issues surrounding the privacy and security of electronic individually identifiable health information.

Privacy and security protections are a key component in the development of health IT policy, standards, and adoption strategies. Accordingly, CPO has developed a flexible, iterative process for assessing, prioritizing, and implementing privacy and security-related initiatives on behalf of ONC. CPO receives consensus recommendations on privacy and security from a broad range of stakeholders, including the advisory committees, the HHS Inter-Division Privacy and Security Task Force, and the Federal Interagency Health IT Task Force. CPO receives input from ONC's grantees; solicits feedback on emerging issues through public roundtables; and determines privacy and security priorities through the analysis of public surveys and government data. CPO prioritizes its privacy and security work to meet statutory deadlines for implementing the Meaningful Use Programs as well as Patient Protection and Affordable Care Act (ACA) initiatives.

To ensure that privacy and security policies are consistently and effectively implemented, ONC develops plain language guidance and toolkits that assist vendors, providers, and consumers in adopting and utilizing privacy and security practices. These efforts are supported by an aggressive communications campaign designed to educate providers, vendors, patients, business associates, and other stakeholders on important aspects of health IT privacy and security.

Accomplishments include:

- Contributed to HHS rulemaking on Modifications to the HIPAA Privacy and Security Rules. The final rule was promulgated in January 2013 and implements statutory amendments under the

[1] Privacy refers to policies and practices that may restrict the use and disclosure of health information, such as requiring individuals' permission to share their health information. Privacy also encompasses individuals' rights to access their information, request corrections, and to have notice of how their information is being used and disclosed. Security refers to protecting information and information systems from unauthorized access, use, disclosure, disruption, modification, perusal, inspection, recording, or destruction. Information security is primarily focused on ensuring the confidentiality, integrity, and availability of data, however and wherever it is transmitted, maintained, or received.

HITECH Act to strengthen the HIPAA privacy and security protections for individuals' health information maintained in EHRs.

- Worked closely with CMS to incorporate privacy, security, and data stewardship policies in the final rules governing new modes for exchanging and analyzing health information under the ACA.
- Provided input from the health sector perspective to the National Science & Technology Committee Subcommittee on Privacy and Internet Policy into the White House Internet Privacy Policy, *Consumer Data Privacy in a Networked World.*
- Coordinated with the State Department and the HHS Office of Global Affairs to provide input on the U.S. response to the European Commission draft Data Protection Regulation. HHS suggested a number of revisions that addressed the impact of proposed regulation on health research and public health efforts, which were incorporated in the final draft regulation.

Safeguarding Health Information

ONC is charged with ensuring 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:

- Working with the HITPC, CPO identified lost and stolen unencrypted mobile devices as a major source of health information breaches. To address this vulnerability, ONC undertook a multi-pronged approach designed to ensure the privacy and security of health information stored or accessed through mobile devices.
- Launched an initiative to educate clinicians on how to protect and secure health information when using a mobile device. To support this initiative, ONC developed a resource center[2] comprising educational videos, tips, and tools about HIPAA Privacy and Security Rule safeguards and other good privacy and security practices for mobile devices.
- Developed protocols to test the security of health information stored in popular mobile devices and determine what additional security measures are needed. This analysis was used to develop guidelines for configuring mobile devices to improve "out of the box" security. These device-specific guidelines were presented to stakeholders and made publicly available on HealthIT.gov.
- Fielded a national survey to measure consumer privacy and security concerns and analyze changes in consumer perception over time.

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 that providers and patients are who they represent they are (identity management) when they are accessing and exchanging health information. Accomplishments include:

- Hosted a hearing on patient credentialing, the process by which a patient's identity in an electronic environment is verified. To meet MU Stage 2 requirements, providers will need to give their patients the ability to electronically view, download, and transmit relevant parts of their health record stored in CEHRT. Protecting and securing patients' health information through electronic access and email is therefore a priority. ONC will address trusted remote access to health information and identify methods for implementing digital credentials without burdening providers or consumers.

[2] Available at https://www.HealthIT.gov/mobiledevices.

Patient Control over Use and Disclosure of PHI

To mitigate the risk of sharing information a patient does not want shared, CEHRT must be able to record patients' choices concerning the health information they wish to share, and must be able to segment patients' health records in order to effect those choices. As policies in this area evolve, ONC funds pilots to demonstrate the feasibility of proposed policy and technical solutions that have not been proven in the marketplace, and conducts an annual survey to measure consumer confidence. These activities bolster consumer confidence in the privacy and security of health IT and health information. Accomplishments include:

- Through the *eConsent Trial* initiative, ONC developed, piloted, and evaluated innovative ways to meaningfully inform individuals about their choices regarding how their health information is shared, and to electronically capture individuals' choices. Findings were incorporated in educational materials and tools distributed to providers and health IT implementers.
- Launched a *Data Segmentation for Privacy* initiative through the Standards and Interoperability (S&I) Framework to explore the ability of EHRs to segment health information (i.e., isolate and send only specific parts of a medical record). The initiative identified current standards that could be used to "tag" sensitive information protected by law or patient choices. Using these standards, ONC launched a pilot to exchange sensitive information (i.e., information related to substance and alcohol abuse treatment, protected by 42 CFR Part 2) that had been tagged to alert the receiving system not to further disclose the information without patient consent.

Patient Safety and Health IT Usability

When fully integrated into health care delivery organizations, health IT has enormous potential to reduce medical errors and increase health care quality and safety. However, as with other new technologies, health IT creates new risks of harm that must be identified and mitigated. Using a comprehensive approach, ONC works to ensure that health IT is safely designed and implemented, that medical staff are properly informed and trained to use their health IT systems, and that processes are in place to identify and correct unsafe conditions or unsafe uses of health IT.

Patient Safety Interventions

The Institutes of Medicine (IOM) published a report in November 2011 in which it presented recommendations on the roles of federal agencies and the private sector in ensuring the safety of EHRs and HIE. In response to the this report, ONC worked with its HHS partners to develop the *Health IT Patient Safety Action and Surveillance Plan* (Health IT Safety Plan). The plan seeks to expand and strengthen patient safety efforts across government programs and the private sector. Accomplishments include:

- Launched the SAFER project to develop checklists (SAFER Guides) for safe and efficient health IT implementations based on existing research, expert opinion, stakeholder engagement, and field work. The Guides will enable everyone responsible for safety in health systems and ambulatory settings to implement safety programs for health IT in critical areas.
- Launched an S&I Framework initiative to refine and expand the AHRQ common formats, a technical standard for data capture, for capture of patient safety events related to health IT.

Health IT Usability

Usability is an essential component of any safe system. The usability of health IT must be at the forefront of ONC's policy, program, and coordination activities as the agency begins implementing the Health IT Safety Plan. ONC works with NIST and other federal partners to better define the boundaries of usability measurement and methods for the enhancing the usability of CEHRT. Accomplishments include:

- Incorporated new "Safety-Enhanced Design" and "Good Manufacturing Process" requirements in the standards and certification criteria for MU Stage 2.

- Co-sponsored the Annual Usability and Human Factors stakeholder meeting with NIST with goal of facilitating improvement of usability and safety of health IT.
- Funded a *Strategic Health IT Advanced Research Projects (SHARP)* initiative that enabled the creation of usability metrics, EHR usability assessment tools, and example toolkits to demonstrate optimal user experience to EHR developers.

Clinical Quality Improvement

Health IT has the potential to drive enormous improvements in clinical quality by providing the tools providers need to identify high priority or high risk conditions, implement solutions, and measure impact. In particular, through clinical decision support (CDS) and 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. Electronically generated quality measures make it possible to quantify defined outcomes in terms of clinical best practices so that providers can monitor health outcomes. CDS encompasses a variety of tools to improve health outcomes by enhancing decision-making in the clinical workflow. ONC provides subject matter expertise and technical assistance to various federal programs that are working to improve the availability and utility of CDS and CQM. ONC also promotes the development and widespread implementation of interactive data technologies that will make it easier for providers to share CDS interventions and CQMs. Accomplishments include:

- Launched the "Health-eDecisions" initiative through the S&I Framework. This initiative will support efforts by ONC and AHRQ to standardize the publication of clinical guidance so that it can be readily consumed by CEHRT, thereby accelerating the delivery of knowledge from the bench to the bedside.
- Completed the "Advancing CDS" project to accelerate implementation and effective use of CDS interventions by improving CDS functionality and usability, sharing successful CDS interventions, and identifying CDS-related gaps and goals across specific clinical specialties.
- Developed a *Roadmap for National Action on Clinical Decision Support*, which recommends a series of activities to improve CDS development, implementation, and use throughout the United States.
- Collaborated with the National Library of Medicine (NLM) to create the Quality Data Element Catalog, which provides clear guidance to EHR developers on the data elements that they are required to capture so that providers can accurately measure their quality of care.
- Developed Cypress,[3] an open-source tool for certification and pre-certification testing of clinical quality measures in EHRs.

Funding History

FY 2010	$10,856,000
FY 2011	$11,200,000
FY 2012	$11,616,000
FY 2013	$14,210,000

Budget Request

ONC requests $16.0 million for policy development and coordination activities, an increase of $4.9 million above the FY 2012 enacted level. The request includes funding for 35 FTEs, an increase of 8 above the FY 2012 enacted level.

[3] Available at http://projectcypress.org.

This request provides funding for continued support of the advisory committees and their work groups, as well as resources to support ONC's core regulatory, convening, and analysis activities. This request will also support emerging priority initiatives in the areas of HIE governance, privacy and security, and patient safety and usability.

Health IT Policy

In FY 2014, the advisory committees will continue to focus their efforts on ensuring widespread adoption of health IT and HIE, optimizing health IT systems for meaningful use, and advancing interoperability. As adoption rates continue to accelerate, the advisory committees will focus on pursuing policy and standards solutions that ensure privacy and security, increase consumer engagement, and promote widespread exchange of health information between providers, public health agencies, and payers. These policies will also provide the data infrastructure to increase patient safety, improve the effectiveness of health interventions and research, and provide for accountable payment models.

In FY 2014, ONC will be developing the notice of proposed rulemaking (NPRM) and final rule for MU Stage 3 standards, implementation specifications, and certification criteria for EHRs. MU Stage 3 will focus on transforming health care and population health through health IT and demonstrating improvements in care, efficiency, and population health.

Governance of Health Information Exchange

In FY 2014, ONC will convene key stakeholder governance entities through the National eHealth Collaborative to identify key issues and common problems in the governance of HIE and the best ways to address them. ONC will fund a number of emerging private-sector governance collaboratives, and publish a series of governance guidelines for effective and trusted HIE. Through these efforts, ONC will guide emerging governance models on the policies and practices that should be considered as part of their approach to governance. ONC will also launch a monitoring program to ensure the governance goals are being addressed. ONC will continue to use its existing authorities and convening powers to create consensus and provide guidance and tools to address specific barriers to interoperability and exchange, while continuing to evaluate how and what consumer protections can be appropriately applied to HIE through existing regulatory frameworks.

Privacy and Security

In FY 2014, ONC will continue to inspire confidence and trust in health IT by ensuring that electronic health information is private and secure wherever it is transmitted, maintained, or received. Through this request, ONC will continue working with the advisory committees and other federal partners, the states, and foreign countries to formulate and prioritize privacy and security policies by evaluating and addressing emerging privacy and security policy concerns. In FY 2014, ONC's work on Privacy and Security will include:

- *Safeguarding Health Information:* ONC will provide technical assistance to vendors, providers, consumers, and others on safeguarding health information through education and technical assistance to help them ensure that their health IT systems and workflows are protected by adequate safeguards.
- *Patient and Provider Identity Management:* ONC will continue its work on patient and provider identity management to assure that the correct health information is associated with the correct patients. 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 work on data segmentation policies and standards that give consumers control over use and disclosure of their health information when it is stored and exchanged. This includes educating patients about their rights, and HIOs about their duties when participating in HIE.

Patient Safety and Health IT Usability

In FY 2014, ONC will continue using a comprehensive approach to ensure that health IT is safely designed and implemented, that it is safely integrated into clinical workflows, and that processes are in place to identify and correct unsafe conditions or uses of CEHRT. Activities will include:

- *Patent Safety Interventions:* ONC will develop and administer policies and programs to enable health IT developers, implementers, and users to ensure that the use of health IT advances patient safety.
- *Health IT Usability:* ONC will continue to work with NIST, AHRQ, and other federal partners to better define the boundaries of usability measurement and methods for optimizing the usability, safety, and efficiency of health IT.
- *Clinical Quality Improvement:* ONC will continue to advance CQI with a focus on electronic reporting of CQMs and measurement gaps outlined in the *National Quality Strategy*.

Outputs and Outcomes Table

Measure	Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 Target +/-FY 2012 Target
1.A.1 Percent of office-based physicians who have adopted electronic health records (basic)[4]	FY 2012: 40% (Target Met)	40%	60%	+20 Percentage Points
1.A.2 Increase the percent of office-based primary care physicians who have adopted electronic health records (basic) (NAMCS)	FY 2012: 44% (Target Not Met but Improved)	45%	65%	+20 Percentage Points
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 (ONC)	FY 2012: 19%	Baseline	35%	+16 Percentage Points
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 (ONC)[5]	FY 2012: 80%	Baseline	82%	+2 Percentage Points

[4] National Electronic Health Records Survey (NEHRS) formerly entitled NAMCS Electronic Medical Records Supplement.
[5] ONC Privacy and Security Attitudes Survey.

Standards, Interoperability, and Certification

(dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 (+/-) FY 2012
Budget Authority	5,784	6,054	9,167	+3,383
PHS Evaluation Funds	10,507	10,730	16,090	+5,583
User Fee	-	-	1,000	+1,000
Total Program Level	16,291	16,784	26,257	+9,966
FTE	39	50	50	+11

Authorizing Legislation: PHS Act 42 U.S.C. 201

Allocation Method: Contract, Cooperative Agreement, Grant

Program Description and Accomplishments

ONC leads a variety of efforts designed to accelerate progress towards the interoperability of health IT systems. Interoperability refers to the ability of two or more health IT systems or components to not only exchange information, but to be able to meaningfully incorporate and use the information that has been exchanged. Through investments in standards development and harmonization, ONC engages health care, technology, and standards stakeholders to accelerate industry consensus on the standardization of health data and HIE and establish the core standards, principles, vocabularies, and technical components that will enable the electronic exchange and use of health information. 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. Finally, by providing a reliable testing and certification program for EHR technology, ONC builds trust in the health IT marketplace and supports providers' efforts to achieve interoperability and the meaningful use of health IT.

Standards Development and Harmonization

The health IT community looks to ONC to bring together stakeholders to develop scalable, consensus-based standards that solve core data capture, exchange, and interoperability issues. As health IT advances, so do the expectations that ONC will continue and expand its role as a leader and convener. ONC enables scientific innovation while promoting the adoption of interoperable, open, standards-based technologies and architectures that enable health IT users to capture and securely exchange 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, providing the foundation for transforming health care.

Through the S&I Framework, ONC has successfully reduced the timeframe for developing standards in some cases as dramatically as from three years to under one year. Using the S&I Framework, ONC regularly convenes a broad community of almost 1,000 stakeholders from across the United States who are working to accelerate industry consensus on the standardization of health IT and HIE. Each year, a number of critical standards and interoperability challenges are resolved through this 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:

- Developed, balloted, and tested the *Transitions of Care* standard in 12 months, working with over 150 different organizations. This standard enables providers to exchange core summary data as patients move to different care settings when they leave hospitals.
- Launched the *Health-eDecisions* initiative to develop a set of standards to promote the interoperability and scalability of clinical decision support technology. The goal of this project is to allow clinical guidance to be published in a standardized form that EHR technologies can use, saving many thousands of hours and errors associated with manual entry and accelerating the delivery of new clinical knowledge to health providers.
- Developed a single standard for laboratory reporting that enables an EHR technology to accept data directly from reporting laboratories in a common format. This standard was included in the MU Stage 2 regulations.
- Launched the *Automate Blue Button Initiative (ABBI)* initiative that will result in standards and specifications that give patients and vendors access to structured health information for use in developing health IT solutions. CPO will ensure this standard incorporates applicable HIPAA regulations.
- Developed standards for exchanging Prescription Drug Monitoring Program (PDMP) data as well as tools for incorporating electronic PDMP data into prescriber and dispenser workflows.

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 (DoD), the Department of Veterans Affairs (VA), and the Social Security Administration (SSA). ONC acts as the managing partner, providing technical and administrative support. Through the FHA, federal agencies have joined together to rapidly and efficiently implement government-wide solutions for interoperable and secure HIE 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, tribal health services, and many other critical federal priorities.

Accomplishments include:

- Restructured governance to facilitate strategic and operational alignment within and across federal partner agencies, and development of a strategic plan that articulates the vision of the FHA into the future and the specific program outcomes that will be achieved.
- Integrated standards to support the following federal programs through specification development and updates: DoD/VA Virtual Lifetime Electronic Record (VLER); SSA Disability Determination; CMS End Stage Renal Disease Program; and Electronic Signature for Medical Documentation.
- Implemented a new operating model for the CONNECT program with distinct software development, code maintenance, and community development functions in order to position the program for migration of the CONNECT gateway to full community-development engagement in the open source software community.

Nationwide Health Information Network (NwHIN)

The NwHIN is a "toolkit" developed by ONC comprising standards, policies, specifications, and legal arrangements that facilitate secure, trusted, and interoperable HIE. The NwHIN features a robust set of

implementable specifications and vendor-neutral test cases that allow for rapid deployment by HIOs and other entities that implement exchange services.

Using the NwHIN policies and standards, ONC partnered with other federal agencies and non-federal organizations to create a nationwide HIE network called the NwHIN Exchange. The Exchange has allowed participants to improve patient care, streamline disability benefit claims, and improve public health reporting, thus demonstrating the viability of nationwide HIE and serving as a model and source of practical lessons for states and organizations that are planning and implementing their own exchange services. In FY 2013, the Exchange transitioned to a public-private partnership that will manage exchange services going forward.

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 toolkits comprise 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 also administers two cooperative agreement programs under the Recovery Act that provide direct assistance to states and communities to build and strengthen their health IT infrastructure and exchange capabilities.

Accomplishments include:

- Issued a joint request for information (RFI) with CMS seeking input on ways to further accelerate and advance interoperability and HIE beyond what is currently being done through ONC programs and the Meaningful Use Programs. The RFI will allow ONC to explore potential policy and programmatic changes using existing HHS authorities in order to further drive HIE to support more person-centered, coordinated, and value-driven care.
- Increased the proportion of hospitals that have access to a health information exchange organization from 51 to 58 percent in FY 2012.
- Participated in an interagency project sponsored by the Office of National Drug Control Policy (ONDCP) to develop health IT solutions that can reduce prescription drug misuse and overdose. In partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), ONC launched a PDMP pilot to demonstrate the viability of real-time, electronic coordination among primary care providers, behavioral health specialists, and pharmacies. In order to implement this pilot, ONC developed standards for exchanging PDMP data as well as tools for incorporating electronic PDMP data into prescriber and dispenser workflows. An evaluation of the PDMP pilot will be published in Summer 2013.
- Commissioned and published five detailed reports on various technical and business-related HIE topics in order to provide HIE implementers and policy-makers with a heightened understanding of several high-impact services that can support the sustainability of HIE organizations.
- In collaboration with CPO, developed guidance on a common set of privacy and security rules that will ensure provider and public trust as states pursue rapid progress towards HIE.
- Promoted international HIE through a common set of standards between the U.S. and other countries and continued development of a health data interoperability implementation strategy with ONC's European counterparts, pursuant to a 2010 Memorandum of Understanding between

HHS and the European Commission on Cooperation Surrounding Health Related Information and Communication Technologies.

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. Accomplishments include:

- Assisted 21 states to address exchange disparities by providing much needed assistance to critical access hospitals, long-term care facilities, rural providers, independent labs, and others participants in HIE.
- To date, 43 states have implemented directed exchange; 32 states have implemented query-based exchange (with 20 states achieving state-wide adoption); and 94 percent of the nation's pharmacies have implemented technologies that enable them to actively e-prescribe.[6]

Beacon Community Program
Beacon Communities are areas where clinicians, hospitals, and consumers commit to using health IT and related care delivery tools, such as clinical decision support technologies. ONC has supported 17 Beacon Communities across the United States since 2010. Beacon Communities exchange information across affiliated practices to demonstrate the advantages and barriers to using interoperable EHR systems. Recovery Act funding for this program will end in FY 2013. Accomplishments include:

- All Beacon Communities demonstrated improvements in care in at least two key measures of population health (e.g., increases in blood pressure control or improvements in cancer screenings), thereby enhancing understanding of how health IT-enabled interventions can support better health at lower cost.
- Beacon Communities extended existing interoperability and HIE infrastructure at the community level to include non-traditional care partners such as public health agencies, LTPAC providers, and schools. Seven communities implemented entirely new exchange solutions. In total, Beacon Communities served over eight million individuals and over 8,500 providers[7].
- Insights from the Beacon Communities were widely disseminated through published materials, including 150 on-line media clips highlighting Beacon work, nearly 50 in-person and on-line speaking events, and fact sheets for each community published on HealthIT.gov.

<u>Certification and Accreditation</u>
ONC administers the ONC Health IT Certification Program, a critical step in the rule and standards making process. The use of CEHRT is required in order for providers to demonstrate meaningful use and receive incentive payments under the Meaningful Use Programs. The Certification Program provides vendors and developers with clear criteria for developing their products and provides them with tools for testing their products prior to submitting them for certification.

The Certification Program develops testing procedures and data in accordance with the standards and certification criteria adopted by regulation. ONC accredits separate certification and testing bodies that provide an independent mechanism for vendors to determine if their EHR systems meet the standards and technical requirements for payments under the Meaningful Use Programs. ONC also maintains the Certified Health IT Product List (CHPL)[8], a public website that uniquely identifies all certified health IT

[6] ONC Performance Metric
[7] ONC Performance Metric
[8] Available at http://oncchpl.force.com/ehrcert?q=chpl

products. As of March 2013, the CHPL includes over 1,750 unique certified EHR products from 945 vendors and developers.

Accomplishments include:

- ONC issued the final rule establishing the Permanent Certification Program (PCP) for Health Information Technology. The PCP accredited five test labs and five certifying bodies through which vendors and developers can test and obtain certification for their health IT products.
- ONC collaborated with NIST to develop testing procedures and data for the certified testing bodies, allowing vendors to ensure their EHR technology is compliant with the regulatory requirements of MU Stage 2.

Funding History

FY 2010	$16,417,000
FY 2011	$16,809,000
FY 2012	$16,291,000
FY 2013	$16,784,000

Budget Request

ONC requests $26.3 million to support its standards, interoperability, and certification activities in FY 2014. This represents an increase of $10.0 million from the FY 2012 enacted level. The request includes funding for 50 FTEs, an increase of 11 above the FY 2012 enacted level.

Standards Development and Harmonization

In FY 2014, ONC will continue to develop and update standards that support an interoperable and secure health IT infrastructure. These efforts will build upon recent accomplishments and ensure continued progress towards modernizing the U.S. health IT infrastructure in order to support a transformed health care system. ONC will focus particularly on several high priority areas, including:

- Developing a standard for *Structured Data Capture* that builds on existing data directory standards to improve core interoperability functions;
- Developing a *Data Spigot* standard that will leverage existing standards to allow access to reports and data stored within EHR technology;
- Supporting consumer access through piloting a *Patient Data Portability* standard that allows patients to easily exchange summary level health information, such as immunization, basic medical information, and clinical care summaries; and,
- Continuing work on the *Data Provenance* standards, which allow for health IT to trust the source of information by developing metadata tools that identify the source of the health information (e.g., EHR, PHR).

Federal Health Architecture

ONC will continue to act as the managing partner of the FHA. This 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.

Health Information Exchange

A top priority for ONC and for the healthcare delivery system is to achieve the same steep adoption curve for standards-based HIE that has occurred for EHR adoption. As direct support of state and community programs closes out, ONC will leverage lessons, insights, and tools developed under the State HIE and

Beacon Community programs in order to support improved HIE. ONC will continue supporting nationwide exchange adoption and utilization by developing consensus-based and open source standards and specifications. ONC will package these technologies with relevant policies, guidance, and legal agreements, and publish the resulting exchange building blocks and toolkits through the National Learning Consortium[9] to assist implementers in rapidly deploying and utilizing HIE. ONC will also continue to work with its HHS partners to develop and align policies and programs to further accelerate HIE in support of new payment and delivery models that will deliver more person-centered, coordinated, and value-driven care.

- *State HIE Program:* In FY 2014, ONC will begin close out operations on schedule for the State HIE Program with direct support provided as part of the Recovery Act.

Certification and Accreditation

This request will allow ONC continue to monitor its accredited testing and certification bodies, and support further enhancements to the CHPL. As adoption of health IT has accelerated, ONC has seen a steady increase in both the number of health IT vendors and the volume of health IT products submitted for certification. This trend, coupled with the need to update and guide the development of standards and certification criteria that support new technologies and future stages of meaningful use will substantially increase ONC's workload. ONC, in partnership with NIST, will continue to expand the Certification Program to ensure CEHRT functions in a manner that is compliant with the standards and certification criteria for the Meaningful Use Programs.

Due to ONC's increasing workload, this request includes proposal for a new health IT user fee that would provide ONC with the necessary resources to meet the increasing demands of health IT vendors and sustain the impact of its certification and standards work on the health IT marketplace and the health care system. An initial fee level of $1.0 million is suggested in FY 2014, reflecting the fact that collections would likely begin late in the fiscal year and would be phased in gradually (Appendix B).

Outputs and Outcomes Table

Measure	Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 Target +/-FY 2012 Target
1.E.1 Percent of community pharmacies that are capable of exchanging health information electronically[10]	FY 2012: 94%	89%	97%	+8 Percentage Points
1.E.2 Percent of providers prescribing through an electronic health record (EHR)	FY 2012: 86%	Baseline	92%	+6 Percentage Points
1.E.3 Percent of office-based physicians who are electronically sharing any patient health information with other providers	FY 2012: 36%	Baseline	54%	+18 Percentage Points

[9] The National Learning Consortium is discussed below in connection with ONC's Adoption, Utilization, and Meaningful Use of Health IT activities.

[10] Surescripts.

Measure	Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 Target +/-FY 2012 Target
1.E.4 Percent of office-based physicians who are electronically sharing patient information with any providers outside their organization	FY 2012: 10%	Baseline	40%	+30 Percentage Points
1.E.5 Percent of physicians with capability for patients to view online, download, or transmit information from their medical record	FY 2013: TBD (Baseline)	N/A	TBD	--
1.E.6 Percent of office based physicians who are electronically sharing patient information using a Summary Care Record	FY 2012: 10%	Baseline	30%	+20 Percentage Points
1. E.7 Percent of non-federal acute care hospitals that are electronically exchanging patient health information with any providers outside their organization	FY 2012:58% (Baseline)	Baseline	75%	+17 Percentage Points
1.E.8 Percent of non-federal acute care hospitals that are electronically sharing clinical/summary care records with any providers outside their organization	FY 2012: 35%	Baseline	65%	+30 Percentage Points
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	FY 2012: 51%	Baseline	60%	+9 Percentage Points

Adoption, Utilization, and Meaningful Use of Health IT

(Dollars in Thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 (+/-) FY 2012
Budget Authority	-	-	-	+0
PHS Evaluation Funds	10,943	10,287	14,535	+3,592
Total Program Level	10,943	10,287	14,535	+3,592
FTE	43	47	47	+4

Authorizing Legislation: PHS Act 42 U.S.C. 201

Allocation Method: Contract, Cooperative Agreement, Grant

Program Description and Accomplishments

The widespread adoption and meaningful use of health IT is essential to transforming the American health care system from a system that emphasizes transactions to a system that emphasizes improved care, improved population health, and reduced cost.

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. Today, ONC is making 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 in adopting and meaningfully using health IT. Through coordinated national strategies, ONC works directly with providers and consumers to improve the use of health IT and health information to make better and more coordinated care decisions.

As the trend towards widespread adoption and utilization of health IT continues, ONC continues to engage patients and other consumers of health care; monitors and evaluates economic data and market trends concerning the adoption and meaningful use 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 supports providers' adoption and utilization 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. By convening providers through the Health IT Research Center (HITRC), directly supporting them through the Regional Extension Centers (REC) Program, and monitoring their progress with the Customer Relations Management (CRM) Tool, ONC provides a full range of services to meet the challenges of utilizing and meaningfully using health IT and EHR technology in particular.

REC Program

The REC Program is a Recovery Act-funded grant program serviced by ONC. Recipients of grant funding represent a range of organizations that serve local communities in 62 states and territories throughout the nation. The primary mission of the RECs 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. Accomplishments include:

- As of March of this year, the 62 RECs are actively working with close to 132,000 primary care providers and more than 11,000 specialists, surpassing the goal of recruiting 100,000 primary care providers to achieve meaningful use by 2014. Of the providers working with the RECs, over 107,000 are live on an EHR system that had e-prescribing and quality measurement functionality.
- A Government Accountability Office (GAO) report found that Medicare providers working with RECs were over 2.3 times more likely to receive an EHR incentive payment then those who were not.
- The RECs are also working with over 1,164 critical access hospitals (CAHs) and regional hospitals (RHs) with 50 beds or less, which comprise approximately 67 percent of the practices of this size in the country. Of the CAHs and RHs working with RECs, 19 percent achieved meaningful use by the end of 2013.

HITRC

The HITRC uses data and analysis to identify barriers and convene RECs and relevant stakeholders to identify and share best practices in health IT adoption, utilization, and meaningful use. The HITRC, which is funded by the Recovery Act, supports 20 Communities of Practice (CoPs) that focus on such topics as education and outreach, implementation and project management, workflow redesign, vendor selection and management, meaningful use, privacy and security, workforce issues, and public health. Accomplishments include:

- In 2012, the CoPs had over 6,600 participants, who accessed the HITRC CoP portal over 200,000 times and identified over 200 best practices.
- The HITRC aggregated information from more than 23,000 practice-level barrier reports to identify the major challenges REC providers are experiencing as they work towards meaningful use. These reports were used to identify and address specific trends, such as issues with particular vendors or issues specific to particular practice types.

CRM Tool

The CRM Tool is a nimble business intelligence tool distributed to more than 1,500 partner organizations and grantees that provides near real-time data about the adoption, utilization, and meaningful use of EHR technology. The CRM Tool supplements other provider data sources and tracks program performance and progress towards milestones. Combined with ONC's internal analytical capacity, this data provides feedback that is 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) in deploying the CRM Tool to track the progress of over 960 of the approximately 1,200 Federally Qualified Health Centers in achieving meaningful use.
- CRM data elements were used 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 over 11 million data elements from the over 143,000 providers currently registered with RECs.

Workforce Program

The Workforce Program is a Recovery Act-funded grant program that assists in the establishment and expansion of education programs designed to train a highly skilled workforce of health and IT professionals to effectively establish and utilize secure, interoperable EHR systems. The workforce programs focused on several key resources needed to rapidly expand the availability of skilled health IT professionals who will facilitate the implementation and adoption of health IT in the provider community.

Direct support for the Workforce Program ended on schedule in FY 2013. Convening activities, work groups, and lessons learned were transitioned to the HITRC as a new CoP. Accomplishments include:

- As of December 2012, the program has exceeded its original goals of training more than 16,000 community college students and more than 983 students from the university based program.
- With assistance from CPO, ONC incorporated training exercises that meet the regulatory expectations and requirements for the HIPAA Privacy and Security Rule regulations. These trainings include a series of security-focused interactive games to be provided free of charge to providers and staff throughout the country. These interactive modules depict various real-world scenarios involving potential security breaches of patient health information. The curricula that were developed for the workforce program by 2012 have been downloaded by over 10,000 individuals.

Consumer e-Health

The Consumer e-Health program is designed to increase consumers' engagement with their health information in health IT settings ranging from EHRs to PHRs to smart phone apps. By enabling better communication between consumers and their providers, consumers can be empowered to achieve or maintain better health, resulting in improved population health and reduced costs. ONC uses a number of techniques including sponsored contests and testimonials to spark consumer engagement. A goal of the *Federal Health IT Strategic Plan* is to ensure that consumers have a level of comfort in taking on the role of partner with their healthcare providers in achieving or maintaining better health. In fact, studies show that 90 percent of the actions associated with managing a chronic condition must come directly from the patient (CHCF 2010).

Accomplishments include:

- Supported consumer engagement with health information and tools made available as part of MU Stage 2. Consumers will have direct access to their health information electronically where it can be viewed, downloaded, and transmitted.
- Transitioned the "Blue Button" from the VA to ONC to expand the program into a nationwide effort reaching up to 80 million people in partnership with the public and private sectors. Blue Button provides a simple way for patients to download their health data securely and privately.
- As an outgrowth of "Text4Health" initiative, ONC conducted a series of focus groups in partnership with community based organizations to identify and explore consumer attitudes, concerns, and preferences on the privacy and security of health information via mobile devices. The study focused on underserved populations across the nation and included participants in urban and rural settings as well as in English and Spanish.
- Released an animated video showing the benefits of health IT to Americans in an engaging way.[11] Further engaged consumers by running a series of video contests encouraging consumers to create short videos sharing their stories about how health IT has made a difference in their lives.

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 Survey of Hospitals, National Ambulatory Medical Care Survey,

[11] Available at http://www.HealthIT.gov/4uvideo.

Critical Access Hospital Survey, and the Privacy and Security Attitudes Survey. Further, ONC uses data from internal Operations, HITECH Programs, the CRM Tool, and the Meaningful Use Programs.

Accomplishments include:

- Worked with the REC Program to create data analytics strategies. These reports found that 52 percent of Comprehensive Primary Care Initiative (CPCI) and 82 percent of Advanced Primary Care Initiative (APCI) participants are working with RECs. ONC developed practices in conjunction with the RECs to leverage their meaningful use work to improve their services and monitor the success of providers as they move through the program.
- Launched the ONC Intranet Dashboards and public Health IT Dashboard website.[12] Within the first year of launch, these innovative projects have provided ONC the unique capability to create and multi-purpose hundreds of impactful research datasets as user-interactive graphs and maps covering some of ONC's most-valued information assets.
- Fielded national surveys collecting data on consumers' perception of the privacy and security of their health information. The surveys assess consumer confidence in the handling of their health information and their concerns with the further introduction of health IT.
- Secured cooperation and co-sponsorship from international partners and a U.S.-based charitable foundation to facilitate progress toward the availability and international recognition of health IT adoption and use metrics that will be directly comparable and applicable for benchmarking across nations engaged in health IT. This will support policy research and identification of best practices, which in turn, supports health system performance. These measures will be refined for development of international consensus via the Organization for Economic Cooperation and Development with support from Europe.

Provider and Consumer Engagement and Outreach

ONC maintains a coordinated communication and public outreach strategy. Core communications functions include planning, implementation, media relations, public affairs, stakeholder engagement, legislative affairs, and executive secretariat. In addition, ONC supports its various programs and initiatives by developing messaging, branding, and internet specific content centered on HealthIT.gov, a sophisticated web presence that integrates media outreach, interactive social media, and the National Learning Consortium.

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

FY 2010	$8,874,000
FY 2011	$10,657,000
FY 2012	$10,943,000
FY 2013	$10,287,000

[12] Available at http://dashboard.HealthIT.gov.

Budget Request

ONC requests $14.5 million in FY 2014 for activities relating to the adoption, utilization, and meaningful use of health IT, an increase of $3.6 million from the FY 2012 enacted level. The request includes funding for 47 FTEs, an increase of four above the FY 2012 enacted level.

Provider Adoption Support

In FY 2014, ONC will continue to support provider adoption through innovative means to address critical barriers to adoption and implementation of health IT. With the ending of direct support to the RECs, HITRC, and Workforce programs in FY 2014, ONC will begin building on and expanding the lessons learned from these programs. The investments in adoption support have provided a strong national network of organizations working to provide better health, improved population management, and reduced costs. As ONC continues to develop policies and standards, provider adoption support efforts ensure that the certification specifications, building blocks, and toolkits are successfully distributed to providers.

- *National Learning Consortium (NLC)*: ONC will begin transitioning the HITRC infrastructure into a one stop shop where providers can use an expanded number of CoP and experts from across the health care sector to gain insight and strategies to accelerate adoption and utilization via making the tools and data publically available on the healthIT.gov internet portal.
- *CRM Tool*: ONC will increase support for new users and enhancements that are critical to meet the on-going data collection efforts in ONC and partner organizations. The funding will support continued use of the CRM Tool by federal partners in working to support the adoption and utilization of CEHRT.
- *REC Program*: In FY 2014, ONC will begin close out operations on schedule for the 62 RECs with direct support provided as part of the Recovery Act.
- *HITRC*: In FY 2014, ONC will begin to close out operations of the HITRC and transition existing convening activities, toolkits, and CoPs to the NLC. The HITRC was funded as part of the Recovery Act.

Consumer e-Health

Through this request, ONC will continue to convene stakeholders, identify barriers, and develop strategies to increase consumer adoption and utilization of health IT. ONC will focus on consumers' access to their health information, the actions they can take with their health information, and shifting consumer attitudes about using health IT. ONC will increase consumer access to data through outreach and support to stakeholders, including continued support for the Blue Button. ONC will help consumers take action with their health information by catalyzing the development of innovative consumer health IT tools and resources through application developer contests to spur market innovation in areas that align with federal health priorities. ONC will also work to shift attitudes about the role of consumers as partners in health care by developing tools and guidance on specific ways that consumers can use health IT to manage their health and care.

Health IT Monitoring and Evaluation

This request will maintain ONC's 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 and communicating data to the public and provider community through the health IT dashboard, HealthIT.gov, blog posts, data briefs, and peer-reviewed literature. ONC will enhance the existing HealthIT.gov dashboard to provide a richer information environment that will lead to a better understanding of the role of health IT in delivering better and more cost effective health care. ONC will study and model specific aspects of health IT, including how proposed MU Stage 3 criteria could be used to address barriers to adoption and utilization of HIE. ONC

will also examine market responses to the increasing interoperability of CEHRT and analyze the impact of this trend on HIE and health care delivery.

Provider and Consumer Engagement and Outreach

This request includes funding to develop ONC's communications strategy, enabling ONC to better identify, capture, and cultivate relationships with external stakeholders in a way that extends the ONC message and promotes engagement. In FY 2014, ONC's communications activities will also 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

Measure	Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 Target +/-FY 2012 Target
1.A.1 Percent of office-based physicians who have adopted electronic health records (basic)[13]	FY 2012: 40% (Target Met)	40%	60%	+20 Percentage Points
1.A.2 Increase the percent of office-based primary care physicians who have adopted electronic health records (basic) (NAMCS)	FY 2012: 44% (Target Not Met but Improved)	45%	65%	+20 Percentage Points
1.A.3 Percent of non-federal acute care hospitals that have adopted electronic health records (AHA)[14]	FY 2012: 44% (Target Not Met but Improved)	45%	65%	+20 Percentage Points
1.B.1 Percent of eligible hospitals receiving meaningful use incentive payments (ONC)	FY 2012: 68% (Target Exceeded)	38%	85%	+43 Percentage Points
1.B.2 Percent of eligible professionals receiving meaningful use incentive payments (ONC)	FY 2012: 33% (Target Exceeded)	15 %	65%	+35 Percentage Points
1. B.3 Percent of eligible primary care professionals receiving meaningful use incentive payments[15]	FY 2012: Not calculated	--	Retire	N/A
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 (ONC)	FY 2012: 156,958 (Target Exceeded)	80,000	314,000	+234,000 health care providers
1.C.1 Establish a network of Regional Extension Centers covering 100% of the U.S. population by the end of FY 2010 (ONC)	FY 2012: 100% (Target Met)	100%	Retire	--

[13] National Electronic Health Records Survey (NEHRS) formerly entitled NAMCS Electronic Medical Records Supplement.
[14] American Hospital Association (AHA) Annual Survey, IT Supplement
[15] Eligibility standards are for stage I of the CMS EHR Incentive Program.

Measure	Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2014 Target	FY 2014 Target +/-FY 2012 Target
1.C.2 Number of priority primary care providers registered to receive services from ONC Regional Extension Centers (ONC)	FY 2012: 137,795 (Target Exceeded)	100,000	Retire	--
1.C.3 Electronic health record adoption rate among providers registered and working with ONC Regional Extension Centers for at least 10 months (ONC)	FY 2012: 74% (Target Exceeded)	60%	76%	+16 Percentage Points
1.C.4 Number of providers registered with ONC RECs that achieve Meaningful Use (ONC)	FY 2012: 21,900 (Baseline)	Baseline	100,000	+78,100 health care providers
1.D.1 Number of students enrolled in Health IT training programs at Community College Consortia participants (ONC)	FY 2012: 12,135 (Target Exceeded)	6,500	Discontinue (Goal Achieved)	--
1.D.2 Cumulative number of students completing Health IT training programs at Community College Consortia participants (ONC)	FY 2012: 15,461 (Target Exceeded)	10,500	Discontinue (Goal Achieved)	--
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	FY 2012: 26%	Baseline	55%	+29 Percentage Points
2.A.1 Number of physicians participating in Beacon Community interventions (ONC)	FY 2012: 8,500	7,430	Discontinue (Program Complete)	--
2.A.2 Proportion of eligible providers in Beacon Communities that receive meaningful use incentive payments (ONC)	FY 2012: 24%	60%	Discontinue (Program Complete)	--

Agency-wide Support

(dollars in thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014 (+/-) FY 2012
Budget Authority	10,631	10,361	11,409	+778
PHS Evaluation Funds	12,199	9,959	9,668	-2,531
Total Program Level	22,830	20,320	21,077	-1,753
FTE	50	59	59	+9

Program Description and Accomplishments

ONC's program support offices provide central services and are responsible for the efficient and effective operation of ONC's numerous programs. Activities include budget formulation and execution; procurement and grants management; facilities and internal IT management; human capital planning; and financial and programmatic oversight. Through these activities, the program support offices provide ONC with a dynamic, flexible support system that works to provide ONC's programs with the tools and resources necessary to respond to emerging health IT issues.

Program support activities include:

- *Grants Management*: ONC continues to enhance its grants management efforts by implementing best practices to ensure grantee compliance. ONC uses a risk-based financial monitoring framework to foster program success and financial accountability. In FY 2012, ONC instituted a comprehensive year-in-review process for grantees, bringing together the program offices and the grants management office to assess and document financial and programmatic compliance of every ONC grantee. This process documented grantee performance against milestones, program objectives, and compliance with grants and financial management requirements. ONC also collaborated with its program offices and the budget office to implement OMB Memorandum M-11-34,[16] which requires accelerated spending in Recovery Act Discretionary Grant Programs. ONC has developed and posted more than 15 Grants Management Advisories for its grantees, covering a wide variety of topics. These concise documents, written in plain language, provide clarification to ONC grantees on grants management issues.
- *Program Integrity*: ONC coordinates and tracks Government Accountability Office (GAO) and Office of the Inspector General (OIG) reports and monitors corrective action as necessary. ONC carries out financial and programmatic oversight responsibilities by employing a robust internal review methodology to produce high-impact results using qualitative and quantitative assessment techniques. In FY 2012, ONC conducted two program integrity reviews, identifying risks and risk response strategies. These reviews are designed to increase the overall effectiveness and efficiency of ONC.
- *Human Capital*: ONC's human capital experts provide leadership, oversight, and guidance to ONC in hiring a talented workforce. The hiring of new staff in FY 2012 was performed at a rate consistent with ONC's goals and objectives. In an effort to optimize an already strong, high-performing organization, ONC implemented a reorganization in 2012 that included strategic plan development, talent, and professional development planning, and external review of existing

[16] Available at http://www.whitehouse.gov/sites/default/files/omb/memoranda/2011/m11-34.pdf.

structures. As part of the FY 2012 reorganization, the following offices were created to improve ONC's ability to coordinate and provide meaningful guidance in the area of health IT: OCMO, OST, OCEH, OCert, and OHC. In planning for expiration of the HITECH Act hiring authority, ONC conducted a thorough review of its HITECH Act positions to determine which positions were central to ONC's mission, and utilized traditional hiring authorities to retain those employees.

- *Mission Support*: ONC's mission support staff provides budget formulation and execution functions, facilities and internal IT management, and procurement services for ONC. In FY 2012, ONC established a refined budget baseline in order to meet its dynamic operational needs. A comprehensive study of ONC's procurement activities was conducted and identified opportunities to improve the procurement process. ONC moved several staff to new facilities, arranged internal moves as necessary, and conducted ongoing planning for consolidation of all ONC's staff members in 2013. ONC increased the number of its staff who are certified as Contracting Officer's Technical Representatives to ensure that every ONC contract is monitored with at least one-back-up individual.

Funding History

FY 2010	$5,976,000
FY 2011	$19,502,000
FY 2012	$22,830,000
FY 2013	$20,319,000

Budget Request

In FY 2014, ONC requests $21.1 million for Agency-Wide Support, a decrease of $1.8 million from the FY 2012 enacted level. The request includes funding for 59 FTEs, an increase of nine above the FY 2012 enacted level.

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. ONC has been actively working to reduce agency-wide support costs and realized savings from reduced costs through improved efficiencies, in-sourcing, and consolidation of office space. This request also funds the personnel costs for the Immediate Offices of the National Coordinator and the Deputy National Coordinators.

PHYSICIANS' COMPARABILITY ALLOWANCE (PCA)

Office of the National Coordinator for Health Information Technology

		PY 2012 (Actual)	CY 2013 (Estimates)	BY 2014* (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

*FY 2013 data will be approved during the FY 2015 Budget cycle.

In 2012, Office of the National Coordinator for Health Information Technology (ONC) needed a qualified individual with a strong medical background to take the lead on Health IT innovations and quality measures.

In 2014, ONC will need additional physicians with a strong medical background 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 likely 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.

SUPPORTING EXHIBITS

Budget Authority by Object Class

(dollars in thousands)

Object Class	FY 2012 Enacted	FY 2014 President's Budget	Increase or Decrease
Direct Obligations			
Personnel compensation:			
Full-time permanent (11.1)	2,236		(2,236)
Other than full-time permanent (11.3)	1,309		(1,309)
Other personnel compensation (11.5)	24		(24)
Military personnel (11.7)	22	-	(22)
Special personnel services payments (11.8)			
Subtotal personnel compensation	**3,591**	**-**	**(3,591)**
Civilian benefits (12.1)	944		(944)
Military benefits (12.2)	12		(12)
Benefits to former personnel (13.0)			
Subtotal Pay Costs	**4,547**	**-**	**(4,547)**
Travel and transportation of persons (21.0)			
Transportation of things (22.0)			
Rental payments to GSA (23.1)	1,890	2,349	459
Communication, utilities, and misc. charges (23.3)			-
Printing and reproduction (24.0)			
Other Contractual Services:			
Advisory and assistance services (25.1)		2,450	2,450
Other services (25.2)	1,941	8,344	6,403
Purchase of goods and services from			
government accounts (25.3)	5,808	5,726	(82)
Operation and maintenance of facilities (25.4)	1,769	1,247	(522)
Research and Development Contracts (25.5)			
Medical care (25.6)			
Operation and maintenance of equipment (25.7)			
Subsistence and support of persons (25.8)			
Subtotal Other Contractual Services	**11,408**	**20,116**	**8,708**
Supplies and materials (26.0)			
Equipment (31.0)	460	460	-
Land and Structures (32.0)			
Investments and Loans (33.0)			
Grants, subsidies, and contributions (41.0)			
Interest and dividends (43.0)			
Refunds (44.0)			
Subtotal Non-Pay Costs	**11,868**	**20,576**	**8,708**
Total Direct Obligations	**16,415**	**20,576**	**4,161**

Salaries and Expenses

(dollars in thousands)

Object Class 1/	FY 2012 Enacted	FY 2014 President's Budget	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	2,236		(2,236)
Other than full-time permanent (11.3)	1,309		(1,309)
Other personnel compensation (11.5)	24		(24)
Military personnel (11.7)	22		(22)
Special personnel services payments (11.8)			-
Subtotal personnel compensation	**3,591**	**-**	**(3,591)**
Civilian benefits (12.1)	944		(944)
Military benefits (12.2)	12		(12)
Benefits to former personnel (13.0)			-
Subtotal Pay Costs	**4,547**	**-**	**(4,547)**
Travel and transportation of persons (21.0)			
Transportation of things (22.0)			
Communication, utilities, and misc. charges (23.3)			
Printing and reproduction (24.0)			
Other Contractual Services:	9,518		8,249
Advisory and assistance services (25.1)		2,450	2,450
Other services (25.2)	1,941	8,344	6,403
Purchase of goods and services from			
government accounts (25.3)	5,808	5,726	(82)
Operation and maintenance of facilities (25.4)	1,769	1,247	(522)
Research and Development Contracts (25.5)			
Medical care (25.6)			
Operation and maintenance of equipment (25.7)			
Subsistence and support of persons (25.8)			
Subtotal Other Contractual Services	**9,518**	**17,767**	**8,249**
Supplies and materials (26.0)	-	-	-
Subtotal Non-Pay Costs	**9,518**	**17,767**	**8,249**
Total Salary and Expenses	**14,065**	**17,767**	**3,702**
Rental payments to GSA (23.1)	1,890	2,349	459
Total Salary, & Expenses and Rent	**15,955**	**20,116**	**4,161**

1/ Excludes 'Equipment' Object Class 31.

Detail of Full-Time Equivalent Employment (FTE)

	2012			2013			2014		
	Actual Civilian	Actual Military	Actual Total	Est. Civilian	Est. Military	Est. Total	Est. Civilian	Est. Military	Est. Total
ONC									
Direct:.....	0	0	0	0	0	0	0	0	0
Reimbursable:.....	158	1	159	190	1	191	190	1	191
OPDIV FTE Total.....	**158**	**1**	**159**	**190**	**1**	**191**	**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

Detail of Positions

	2012 Actual	2013 Base	2014 Budget
Total, SES	8	9	9
Total, SES Salary	1,423,383	1,639,620	1,639,620
GS-15.....	38	43	43
GS-14.....	30	42	42
GS-13.....	39	64	64
GS-12.....	22	27	27
GS-11.....	16	6	6
GS-10.....	1	1	1
GS-9.....	11	7	7
GS-7.....	2	0	0
Subtotal	159	191	191
Total - GS Salary	16,325,137	21,490,069	21,682,453
Average SES salary.....	177,923	182,180	182,180
Average GS grade.....	13	13	13
Average GS salary.....	97,936	100,904	103,872

Crosswalk of Budget Activity by Office

(dollars in thousands)

	FY 2012 Actual		FY 2013 Annualized CR		FY 2014 President's Budget	
	FTE	$	FTE	$	FTE	$
1. Policy Development and Coordination						
Office of Policy and Planning	12	4,335	16	5,347	16	3,926
Office of the Chief Privacy Officer	9	5,405	10	5,405	10	5,405
Office of the Chief Medical Officer	6	1,421	9	2,457	9	4,517
Office of State and Community Programs		-	0	1,000	0	2,166
Total, Policy Development and Coordination	**27**	**11,161**	**35**	**14,209**	**35**	**16,014**
2. Standards, Interoperability, and Certification						
Office of Science and Technology	17	10,459	22	10,886	22	20,187
Office of Certification	3	1,750	5	1,242	5	2,520
Office of State and Community Programs	19	4,083	23	4,656	23	3,550
Total, Standards, Interoperability, and Certification	**39**	**16,292**	**50**	**16,784**	**50**	**26,257**
3. Adoption, Utilization, and Meaningful Use						
Office of Provider Adoption Support	23	4,887	24	4,594	24	8,800
Office of Consumer e-Health	3	937	4	1,043	4	1,150
Office of Economic Analysis and Evaluation	11	3,107	11	2,831	11	2,700
Office of Communications	6	2,012	8	1,820	8	1,885
Total, Adoption, Utilization, and Meaningful Use	**43**	**10,943**	**47**	**10,288**	**47**	**14,535**
4. Agency-Wide Support						
Office of Mission Support	27	17,949	34	16,547	34	16,820
Office of Human Capital	4	591	5	722	5	631
Office of Grants Management	16	3,552	17	2,549	17	3,046
Office of Program Integrity	3	740	3	502	3	580
Total, Agency-Wide Support	**50**	**22,832**	**59**	**20,320**	**59**	**21,077**
Total, Program Level	**159**	**61,228**	**191**	**61,601**	**191**	**77,883**

Programs Proposed for Elimination

No programs are proposed for elimination in FY 2014.

APPENDIX A – PERFORMANCE APPENDIX

1. TRENDS IN EHR ADOPTION AND HIE ACTIVITY

1.1 EHR ADOPTION IS ACCELERATING HEALTH IT-ENABLED DELIVERY SYSTEM REFORM

The health care industry is undergoing a transformational, disruptive and over-due shift as health care providers adopt and integrate EHRs and HIE technologies into their health care practice at greater rates than ever before. ONC estimates that by FY 2014 a majority of health care providers will have adopted EHRs, compared to about 20 percent in 2008.

For example, in 2012, nearly 45 percent of office-based physicians had adopted a basic EHR compared to just 12 percent in 2007.[17] ONC estimates that that number will rise to around 60 percent by FY 2014. Showing further evidence that compelling change is underway, 40 percent of rural office-based providers have adopted at least a basic EHR system in 2011, compared to 14 percent in 2009. Adoption patterns among small practices also show marked increases, up to 35 percent in 2011 compared to 15 percent in 2009.

Among hospitals, in 2012 56 percent of non-federal acute care hospitals had implemented at least a basic EHR system, compared to 13 percent in 2008.[18] In 2012, 47percent of rural hospitals had implemented at least basic EHRs, compared to 8 percent in 2008. Respectively, the rate of adoption in small hospitals grew from 9 percent to 48 percent.

1.2 EHR SYSTEMS THAT ARE BEING IMPLEMENTED NOW INCLUDE MORE FUNCTIONALITIES

Alongside the widespread adoption of EHR and HIE technologies, there is also mounting evidence that the EHR systems that are being implemented are becoming more comprehensive in the range of functionalities and benefits that they provide to the patient, provider, and health system users.

The EHR system functionalities being implemented by non-federal acute care hospitals are increasing, including hospital selection of comprehensive EHR systems. Comprehensive systems, in contrast to basic systems, include relatively advanced CDS features that help providers identify risks associated with drug-drug interactions, or provide the ability to order, view, and share lab and imaging results easily with other providers, hospitals, and entities.

Certain HIE activities, enabled by the adoption of increasingly sophisticated EHRs, are taking place at higher rates among office-based providers than before as well. Two particular areas of EHR systems and provider HIE capability that ONC is monitoring are e-prescribing and health information exchange capabilities.

Early adoption of HIE technologies, such as e-prescribing, has had especially strong leadership from the vendor and community pharmacy groups. An established ONC performance measure is related the percentage of community pharmacies that have the capability for e-prescribing, and it is reported in the President's Budget and the ARRA Implementation Plan. From 2008 and 2012, national rates of e-

[17] Office-based provider adoption of basic EHRs includes specific functionalities in the following areas of health care and administrative data: patient demographics, patient problem lists, electronic lists of medication taken by patients, clinical notes, orders for prescriptions, laboratory results viewing, and imaging results viewing.

[18] "Adoption" of an inpatient electronic health record is defined as at least "basic" adoption, without notes, as in Jha et al. 2009 in the New England Journal of Medicine article *Use of Electronic Health Records in U.S. Hospitals* http://www.nejm.org/doi/pdf/10.1056/NEJMsa0900592. This measure excludes federal hospitals, and hospitals located outside of the 50 states and the District of Columbia. It encompasses all non-federal general acute care hospitals in the American Hospital Association annual survey, including critical access hospitals.

prescribing have soared, growing from about 70 percent in the beginning of 2009 to nearly 94 percent in FY 2012. At the community-level, measures of e-prescribing show that the growth in e-prescribing activity is roughly equal across rural and urban boundaries.

What's more, the number of providers using e-prescribing tools has increased significantly since ONC began tracking the activity in 2009. The increases are especially notable among specialist providers, and alongside the increases in provider participation in e-prescribing, providers are most likely to make the decision to begin providing e-prescribing services through an EHR system, as opposed to through stand-alone e-prescribing systems.

Other areas of EHR adoption and HIE activity where ONC will continue promotion and monitoring include: patient engagement through electronic access to health information; provider capability to share patient care summaries between systems; and growth of EHR system features functionalities related to clinical care coordination like ordering and viewing lab and imaging tests and results. Accordingly, beginning in 2012 ONC has established the following performance measures and baselines in this area.

These measures track important facets of HIE activity with regard to EHR functionalities and interoperability and are also closely related to the future of Meaningful Use of EHRs. Finally, these measures are also important candidates because they can inform ONC about the extent that additional regulatory activity may be necessary to further promote HIE or remove its barriers, particularly barriers that inhibit exchange between the various health care provider groups.

1.2 Leveraging Existing Investments and Stakeholder Networks to Enable ONC to Govern at the Pace of Technology

As EHR and HIE technologies evolve, consumers and patients will expect more control and continued protection of their health information. ONC will continue to monitor consumer and provider attitudes and activities with regard to EHRs and HIE activity.

Two ONC-managed FACA committees provide particularly valuable input related to policies promoting the adoption and meaningful use of EHRs as well as Standards & Interoperability (S&I) related to the EHR and HIE market places. The FACAs have over a thousand stakeholders and the following highlights from 2012:

- The HITPC approved recommendations on a security policy framework for EHR, approved recommendations on the initial set of policies developed by ONC to govern its Query Health pilot project, and provided recommendations to the National Coordinator on issues raised by an Advanced Notice of Proposed Rulemaking (ANPRM) (published July 26, 2011, Human Subjects Research Protections) regarding secondary uses of EHR data for research uses. The recommendations were developed by the HITPC Privacy and Security Tiger Team.
- The HITSC has provided recommendations regarding the development of the Certification Process for Stage 2 Meaningful Use, which recommendations were approved on November 16. The HITSC also endorsed recommendations of its Privacy and Security Workgroup on security-related certification criteria, standards and implementation specifications for EHR certification. These recommendations were complementary to those endorsed on September 28. In particular, the recommendations included detail about patient matching.
- The HITPC and the HITSC both assessed and made recommendations related to the need for privacy and security conditions for trusted exchange as elements of a proposed governance model.

1.3 EHR AND HIE MARKETPLACES ARE ROBUST AND ACTIVE

Certified Health Information Technology Product List (CHPL)

Stage 1 of the CMS Medicare and Medicaid EHR Incentive Programs succeeded in motivating large numbers of health care providers to begin implementing EHRs. An important part of the Program's success relates to the establishment of the EHR Certification Program, which implemented a regulatory and technical framework for protecting and standardizing HIE and promoting the interoperability of EHRs. The Certification Program provides also establishes a public listing of certified health IT products through the CHPL website.

A sign that the EHR Certification Program and CHPL were welcomed by the vendor and health care provider communities and effective at defining initial standards upon which the market could build is the strong participation rate in the CMS EHR Certification Program. The expectation among ONC program managers was that approximately 150 products would be submitted for certification to the affiliated and then become part of the CHPL. As of August 2012, there were 2,520 certified EHR products from 800 EHR Vendors/Developers.[19] Of the certified products listed in the CHPL, 1,528 were for unique products (e.g., when a new "version" of an existing EHR product is released it is not double-counted).

Figure: Number of Vendor Products (Versions) on the Certified Health IT Product List, Sept. 2012

	Ambulatory	**Inpatient**	**Total**
Complete EHR	748 (1,266)	99 (291)	847 (1,557)
Modular EHR	461 (799)	450 (707)	911 (1,506)
Total	1,209 (2,065)	549 (998)	1,758 (3,063)

Source: ONC Certification Division

While all of the certified products listed on the CHPL meet criteria for use in the CMS EHR Incentive programs, the market is still newly defined and will likely experience the effects of competitive forces that will result in the market consolidation around certain vendors/products. As this occurs, and providers adopt, update, and change between EHR vendors/products in large numbers, ONC's continued work related to the establishment of regulations and standards for governing interoperability and information exchange standards will be integral and overdue.

Consumer Attitudes and Engagement

In addition to monitoring the development of a robust EHR vendor and product marketplace, ONC is actively monitoring a variety of consumer attitudes and health information engagement measures. Tracking these measures enables the office to give general contextual descriptions about the extent that these EHR technologies are becoming routine parts of patients' personal behaviors as well as the efficacy of government policy and outreach activities of topics related to access to and uses of health information.

Beginning with baseline data obtained in 2012, ONC's consumer attitudes and patient engagement efforts will be evaluated by monitoring the following survey data as reference points:

- percentage of Americans who have been given electronic access to any part of their health care record from the 2012 baseline of 10 percent;

[19] Certified Health IT Products List, April 2012 Program Report

- percentage of Americans who strongly or somewhat agree that the privacy and security measures taken by providers establish reasonable protections for their electronic health records above the 2012 baseline of 80 percent; and
- percentage of Americans who are very concerned about the security of electronic health records from the 2012 baseline of 52 percent.

2. SUCCESS OF ONC AND HITECH PROGRAMS AS HEALTH SYSTEM MODERNIZATION CHANGE AGENTS.

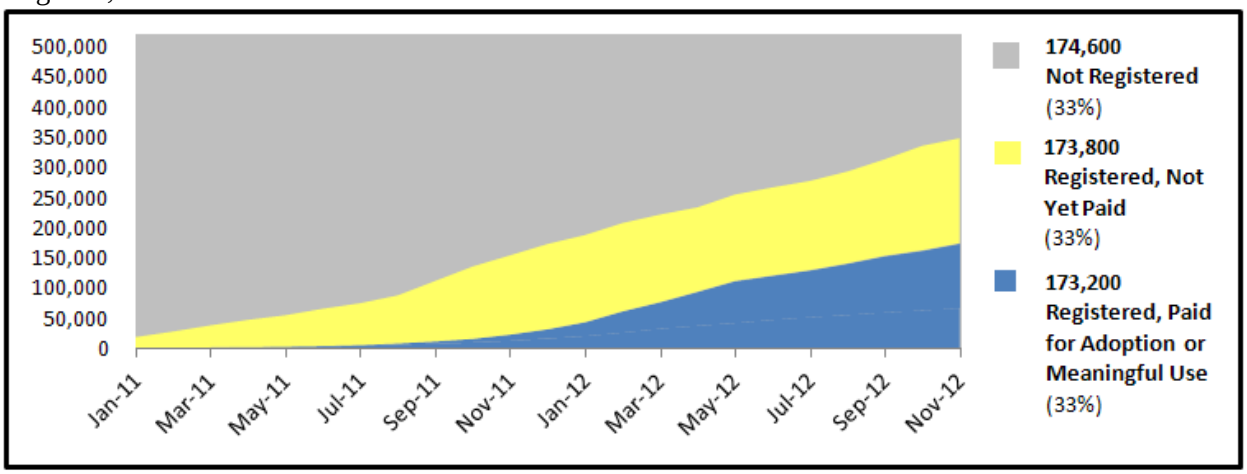
The collective implementations of HITECH Act programs, including the CMS EHR Incentive programs along with ONC grant programs, has contributed to the momentum in the health system transformation movement currently underway.

2.1 CMS MEDICARE AND MEDICAID EHR INCENTIVE PROGRAMS

The initial implementation of the CMS EHR Incentive Programs has shown strong signs of success in terms of provider registration and intent to participate in the programs. As of September 2012, two thirds of eligible professionals (almost half of the estimated total 521,000 eligible professionals) and 3,750 eligible hospitals (almost 75 percent of the estimated total 5011 eligible hospitals) had successfully registered for the EHR Incentive programs.[20] The number of providers who received incentive payments has been steadily increasing – as of June 2012, more than $7.7 billion dollars in financial incentives have been distributed to over 150,000 health care providers for implementing EHRs and achieving meaningful use according to the CMS Medicare and Medicaid EHR Incentive Programs' Meaningful Use criteria.

A large number of providers remain in the pipeline for meaningful use - as of November 2012, about 174,000 providers had successfully registered for the Medicare or Medicaid EHR Incentive Programs but had not yet received payment or attested. The number of providers registered for the incentive programs will continue to grow. Continued investment in outreach, education, and support services will help to ensure these providers successfully implement and meaningfully use certified EHR technology to improve patient care.

Figure: Eligible professionals participating in the CMS Medicare and Medicaid EHR Incentive Programs, November 2012



Source: Centers for Medicare and Medicaid Services, EHR Incentive Programs

[20] Federal programs began AAA. States are implementing the Medicaid programs at various schedules and BBB have implemented as of May 2012.

Between now and FY 2014, HHS/ONC estimates that an additional 15 percent of the eligible providers will meet criteria to receive incentive payments. The HHS/ONC estimate for eligible provider participation in EHR Incentive Programs is that about 85 percent of eligible hospitals and 50 percent of eligible professionals swill qualify for and receive incentive payments from CMS or their state Medicaid program in FY 2014.

2.2 ONC HEALTH IT REGIONAL EXTENSION CENTERS PROGRAM

The REC program has achieved remarkable success since its establishment in FY 2010. Already, more than 140,000 primary care and specialist providers have registered with RECs to receive technical assistance with the steps necessary to implement EHRs and work towards Meaningful Use. With the assistance of RECs, almost 100,000 health care providers have implemented EHRs with important functionalities related to patient quality reporting and e-prescribing, and more than 30,000 had already demonstrated Meaningful Use.

Among the provider groups where the RECs are having particular success, rural primary care providers, Federally Qualified Health Centers (FQHC), and Critical Access Hospital each stand out. RECs are working with 40 percent of primary care providers in the nation; 80 percent of Federally Qualified Health Centers, and 70 percent of the nation's Critical Access Hospitals.

The RECs have been particularly successful in reaching rural providers, reaching over 70 percent of providers in rural areas receiving technical assistance from a REC by the end of FY 2012. A recent Government Accountability Office report found that providers who work with a REC are 2.3 times more likely to obtain an incentive payment from CMS for the successful implementation and meaningful use of an EHR system than those providers that do not work with a REC. The GAO report is available at: http://gao.gov/assets/600/593078.pdf.

Alongside the progress that RECs have had with enrolling and assisting providers to "go-live" with an EHR, the HITRC and NLC projects are leveraging the technical assistance materials so that they have the broadest impact possible. The HITRC and NLC are particularly valuable for assisting providers in rural and remote areas and for ensuring that providers who register for the EHR Incentive Programs have sufficient resources to successfully adopt and become meaningful users of EHRs.

2.3 STATE HEALTH INFORMATION EXCHANGE PROGRAM

The State HIE program is accelerating and improving coordination among states to promote health information exchange and the meaningful use of health IT. Since the State HIE Program's HITECH inception, ONC has assisted all States with their development of comprehensive plans to enable and accelerate the development of their own health IT infrastructures. There is early evidence of momentum and success resulting from the State Plans and coordination efforts. Recent gains in pharmacy capability to e-prescribe, for example, are in part attributable to the initiatives that the State HIE Program has implemented.

Moreover, the State HIE Program has contributed significantly to the effectiveness of collaborations among health care and technology groups within states and nationwide around the effective development of HIE infrastructures and technologies. Some of the innovations programs and monitoring efforts sponsored by the State HIE Program include the "Challenge Grants[21]," the "Program Information Notice (PIN) Priority Measures," and a forthcoming survey to establish the national baseline estimate for laboratory health information exchange capability.

[21] Challenge Grant program has goals to develop scalable solutions in the following key areas: (1) Achieving health goals through health information exchange; (2) Improving long-term and post-acute care transitions; (3) Consumer-mediated information exchange; (4) Enabling enhanced query for patient care; (5) Fostering distributed population-level analytics

2.4 HEALTH IT WORKFORCE PROGRAMS ARE MEETING THE GROWING DEMAND

Popular media outlets and ONC studies examining the job market related to health care and IT have surfaced multiple points of evidence demonstrating a strong demand for health care and IT professionals that are cross-trained and capable to help the health system realize the expected benefits from the meaningful use of EHRs.[22]

The HITECH Workforce Programs have built a solid foundation of curricula and training capacity within a network of over 90 of the nation's community college and universities. Since establishment in August 2012, over 30,000 health care and IT professionals have enrolled in training programs, and more than 15,000 had completed training programs by the end of FY 2012.

The broad interest in the materials developed by the Health IT Workforce Program's Curriculum Development Centers is also remarkable and interesting. In addition to the curricula's pervasive use and adaptation among the Community College Consortia, the materials have also been widely available and distributed publicly over the internet to individuals and educational groups in more than 100 countries across six continents.

Coupled with the development of health IT curriculum materials, HITECH authorized ONC and its grantees to establish a Competency Exam Program that could be used by employers to assess the readiness of employees for the health IT workforce. As of August 2012, more than 3,700 health IT professionals had taken exams across the 6 workforce roles for which competency exams were developed. Among these professionals, the following demographics were observed:

2.5 STRATEGIC HEALTH IT ADVANCED RESEARCH PROJECTS (SHARP) PROGRAM IS DEVELOPING INNOVATIVE SOLUTIONS TO ADDRESS MAJOR CHALLENGES IN THE USE OF EHRS.

The SHARP Program is helping America's universities lead the way in creating a new of generation of innovative technologies to improve health care quality and delivery system performance. The SHARP program is led by major collaborative efforts at the University of Illinois at Urbana-Champaign, the University of Texas at Houston, Harvard University, the Mayo Clinic of Medicine, and Massachusetts General Hospital.

Since the SHARP Program's inception: the University of Illinois at Urbana-Champaign has been helping develop technologies and policy recommendations that reduce privacy and security risks and increase public trust; the University of Texas, Houston is undertaking innovative cognitive research to harness the power of health IT to integrate and support physician reasoning and decision-making as providers care for patients; Harvard University has been leading platform-based research to create new and improved system designs that facilitate information exchange while ensuring the accuracy, privacy, and security of electronic health information; and, the Mayo Clinic of Medicine has been developing strategies to improve the overall quality of healthcare by leveraging existing EHR data to generate new, environmentally appropriate, best practice suggestions.

2.6 BEACON COMMUNITIES PROGRAM

[22] Online job posting data are from the Job Data Mart, a proprietary database of O'Reilly Media, Inc. The database captures weekly snapshots of open jobs from a national job aggregator web site and represents approximately 85-90% of all U.S.-based online job postings. Jobs are uniquely identified and de-duplicated to the extent possible. Persistent postings are recorded only at the date of first post, and companies that advertise multiple positions are counted as a single job. The number of online job postings are reported monthly based on a 3-month moving average. Prior research has shown that job openings correlate with actual employment trends

Since the Beacon Communities were established they have flourished into 17 diverse communities of health care provider networks that are participating in community building and health IT-based clinical interventions across an impressive range of health care areas. In FY 2011, there were 5,678 health care providers participating with Beacon Communities interventions and by FY 2012. Several early successes have been demonstrated among the Beacon Communities and are being reported publicly during the summer 2012. Quarterly performance reviews of grantee data shows that 7 of the 17 Beacons area already reporting improvements in clinical care measures associated with the health IT interventions that are being implemented within their community.

Description of ONC's Performance Management Process

The performance management process at ONC is an embedded and appreciated part of all program and policy 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 largely enabled by a common government-wide framework of performance processes and standards, including targeted activities that focus ONC performance management around: (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.

1. PRIORITY-SETTING

ONC's authorizing legislation, appropriations, and implemented budgets form the basis for the multi-year and annual priority setting processes. In addition, ONC regularly receives and integrates into its priority set requests from Congress that pertain to updates on ONC activities or to renewed or reformed focus on health IT promotion and implementation.

1.1 STRATEGIC PLANNING

Establishing multi-year strategic plans is a critical step in the process for formulating and advancing a long-term vision for the coordination of an EHR- and HIT-enabled health 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 individually 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 under this subtitle among the Secretary, the National Coordinator, the HITPC, the HITSC, 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.[23]

Access the Health IT Strategic Plan here:
http://healthit.hhs.gov/portal/server.pt/community/federal_health_it_strategic_plan_-_overview/1211

Following the best practices established in the Government Performance and Results Act Modernization Act of 2011, partners will begin a process for reviewing and, if necessary, revising the strategic plan beginning in FY 2013, which is 3 years into the current plan's implementation. The process for updating the plan will necessarily include extensive planning within ONC, consultation with Federal partners, and outreach to providers and the health care community. In FY 2014, ONC's strategic direction will be guided by its authorizing legislation and the appropriated budget.

1.2 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 detailed-oriented series of conversations wherein 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.

2. Measurement and Analysis

2.1 Research and Analysis of Priority Health IT Adoption Indicators

Through a variety of research projects into the development and diffusion of a national market around health IT, ONC's teams of 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 change. 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.

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

2.2 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 the: ONC Intranet; Health IT Research Center; 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: http://www.dashboard.healthit.gov
- Health IT Research Council, National Learning Consortium: http://www.healthit.gov/providers-professionals/about-national-learning-consortium

2.3 SUMMATIVE FEEDBACK ON HITECH PROGRAM EFFECTIVENESS THROUGH PROGRAM EVALUATIONS:
According to HITECH requirements and implementation plans, ONC is conducting program evaluations of the: (1) overall implementation of HITECH, (2) Health Information Technology Extension Program, (3) Health IT Workforce Program, (4) State Health Information Exchange (HIE) Program, and (5) Beacon Community Program. In addition to providing summative assessments of ONC's HITECH program implementations, these evaluations also generate useful materials for routine 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.

3. REGULAR PERFORMANCE REVIEWS
The regular review of performance is engrained at all levels of ONC in a number of ways, including the Annual Organizational Assessment and Performance Report; Mid-Year Senior Executive and Employee Performance Reviews; Quarterly Reviews; and, Monthly Meetings.

4. PRIORITY, STRATEGIC AND/OR OPERATIONAL UPDATES BASED ON FINDINGS FROM THE REVIEWS
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 managers meetings, 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.

APPENDIX B – HEALTH INFORMATION TECHNOLOGY USER FEE

The FY 2014 Budget introduces a health IT user fee to support ONC's certification and standards activities. The proposed fee would be assessed on health IT vendors who certify their products through the ONC Health IT Certification Program.[24]

The health IT industry relies on ONC to administer a timely and reliable testing infrastructure and certification process for health IT products. Since the establishment of ONC's Health IT Certification Program, the number of health IT vendors and the volume of health IT products submitted for certification has steadily increased.[25] This trend, coupled with the need to update and guide the prioritization and adoption of standards and certification criteria to support new technologies, future stages of meaningful use, and delivery reform activities has resulted in a substantial increase in ONC's workload. This workload is expected to increase in the coming years as ONC's responsibilities associated with administering the Certification Program expand.

In addition to the expanding marketplace and corresponding increase in workload for ONC, much of the work to date has been funded using Recovery Act funds scheduled to expire at the end of FY 2013. Consequently, a new revenue source is necessary to ensure that ONC can continue to fully administer the Certification Program as well as invest resources to improve its efficiency. Such improvements are envisioned to include, among other improvements, additional testing tools and resources, less time between revisions to testing tools, and other forms of technical assistance. These service level improvements would be expected to reduce the cost and time associated with developing health IT products, preparing products for testing, and completing the certification process, thereby enabling vendors to expeditiously bring their products to market.

The user fee will provide ONC with the resources necessary to meet the increasing demands of health IT vendors and sustain the impact of its certification and standards work on the health IT marketplace and the health care system.

In particular, the proceeds of the user fee could fund:

- Administration of the ONC Health IT Certification Program and maintenance of the Certified Health IT Product List (CHPL).[26]
- Development of implementation guides and other forms of technical assistance for incorporating standards and specifications into products.
- Development of health IT testing tools that are used by both developers, testing laboratories, and certification bodies.
- Development of consensus standards, specifications, and policy documents related to health IT certification criteria.

[24] Section 3001(c)(5) of the Public Health Service Act, as amended by the Recovery Act, directs the National Coordinator to oversee the testing and certification of health IT products as being in compliance with standards, implementation specifications, and other criteria established by the Secretary.

[25] The number of providers using health IT has grown rapidly over the past several years, creating a robust marketplace for health IT products and services. As of March 2013, ONC's Health IT Certification Program had tested and certified more than 1,750 unique EHR products, up from about 250 products certified at the start of 2011. The number of vendors with certified products increased from 200 to 945 over the same period.

[26] The CHPL is a public website maintained by ONC that uniquely identifies all certified health IT products. See http://oncchpl.force.com/ehrcert?q=chpl.

- Post-market surveillance, field testing, and monitoring of certified products to ensure they are meeting applicable performance metrics in the clinical environment.

For FY 2014, a fee level of $1 million is estimated, reflecting the fact that collections would likely begin late in the fiscal year and would be phased in gradually. User fees would be collected from Health IT vendors, who are the primary beneficiaries of ONC's Certification Program, including testing tools, standards, implementation specifications, guidance, and other services that support the program. Fees would be assessed based on a fee structure established by the Secretary and published in the Federal Register. Fees would be collected on ONC's behalf by ONC-Authorized Certification Bodies (ONC-ACBs).[27] In setting fees, the Secretary would have the flexibility to reflect differences among health IT products, vendors, and the number of certification criteria. For example, fees for an electronic prescribing module could be less than fees for a complete EHR system.

[27] Under the ONC Health IT Certification Program, certification is conducted by independent certification bodies that are authorized by ONC.

Health Insurance and Implementation Fund

HEALTH INSURANCE REFORM IMPLEMENTATION FUND

(Dollars in millions)

	FY 2012	FY 2013	FY 2014
Obligations*	$333	$241	$0

* $1,000,000,000 was appropriated in the Health Care and Education Reconciliation Act of 2010.

Authorizing Legislation…….Health Care and Education Reconciliation Act, Section 1005
Authorization……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. Much of these funds have gone to support the establishment of the Federal Marketplace, including the building of IT systems to ensure that health insurance access is reliable and open in 2014.

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 2012, $333 million of this funding was obligated by agencies within HHS and external federal partners. In FY 2013, HHS estimates the remaining funds will be obligated to ensure the Marketplace is operational by October 2013.

Prevention and Public Health Fund

PREVENTION AND PUBLIC HEALTH FUND

(Dollars in millions)

	FY 2012	FY 2013	FY 2014
HHS Total	$1,000	$1,000	$1,000

Authorizing Legislation……Section 4002 of the Affordable Care Act, Pub. L. 111-148 (2010)

Program Description and Accomplishments

Section 4002 of the Affordable Care Act establishes a mandatory appropriation for prevention and public health activities. The Act appropriated $500 million in FY 2010, $750 million in FY 2011, and $1 billion in FY 2012 and FY 2013. For FY 2014, the law appropriates $1 billion into the Fund. 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.

The HHS activities funded in FY 2014, from the Prevention and Public Health Fund, are focused on promoting wellness and preventing chronic disease. The FY 2014 investments support activities such as prevention research, community and clinical prevention, public health infrastructure, and health care surveillance.

Budget Allocation

The FY 2014 HHS allocation for the $1 billion available in the Prevention and Public Health Fund reflects a balanced portfolio of investments to improve health and to help restrain the growth of health care costs.

The FY 2014 HHS allocation supports public health infrastructure and training, community and State prevention activities, clinical prevention including behavioral health screening and integration with primary health, and critical areas in prevention data analysis, tobacco and obesity prevention, and health care surveillance and tracking. For more information on activities funded within each allocation, please refer to the agency's or staff division's FY 2014 budget justification. The FY 2014 Budget reflects the FY 2013 Prevention Fund resources within the Office of the Secretary. Plans for the FY 2013 allocation are being finalized.

Service and Supply Fund

Service and Supply Fund

TABLE OF CONTENTS

Service and Supply Fund
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 Program Level	FY 2014 Board Approved	FY 2014 +/- FY 2013
BA…	$1,002,774,000	*$1,084,491,000	*$1,102,861,000	+$18,370,000
FTE...	1374	1260	1262	+2

Authorizing Legislation: 42 U.S.C. 231
2013 Authorization……..……..……Indefinite
Allocation Method ……..……Contract, Other
* Additional details on the 2014 SSF Board approved budgets are found in the narrative.

Statement of the Budget

The FY 2014 budget for the Service and Supply Fund (SSF) is $1,102,861,000, an increase of $18,370,000 above the FY 2013 SSF program level of $1,084,491,000 (both fiscal year budgets approved August 13, 2012). The overall increase in the budget from FY 2013 to FY 2014 is primarily the result of increased contract support costs, increased civilian and military personnel costs, and additional costs associated with anticipated increases in customer business in both the Program Support Center (PSC) and non-PSC activities.

PSC's budget request for FY 2014 is $784,540,000, which is an increase of $9,502,000 above the FY 2013 program level of $775,038,000. This budget increase is attributable to escalating inflation affecting contract support costs and modest mandatory increases to personnel cost. In addition, a new service within the PSC, Facilities and Logistics Services, is the result of combining the Offices of Facilities Management and Policy. More information on this service can be found in the PSC portion of the narrative.

The total FY 2014 request for the non-PSC SSF Activities is $318,321,000, which is an increase of $8,868,000 above the FY 2013 program level of $309,453,000. Overall, the approved revenue for longstanding non-PSC SSF activities has remained level, with modest increases for contracts and costs associated with full time equivalent (FTE) personnel. In addition, there were several organizational changes that have resulted in realignment within the Fund, which moved activities from the PSC to the non-PSC side of the Fund. Additionally, two activities previously funded via the Joint Funding Agreement (JFA) process have been added to the Service and Supply Fund.

Organizational changes within the Fund include: 1) Freedom of Information Act (FOIA) previously in Information and Systems Management Services (ISMS) is now in Administrative Operation Services (AOS); 2) Division of Security and Emergency Services (DSES) moved from PSC to the non-PSC Office of Security and Strategic Information (OSSI) within the Office of the Assistant Secretary for Administration (ASA); 3) Homeland Security Presidential Directive – 12 (HSPD-12) moved back to OSSI; 4) the remaining ISMS activities moved from the PSC to non-PSC to the Office of the Chief Information Officer (OCIO) within ASA; 5) two formerly Legislatively Mandated Initiatives and Emerging Technologies (LMIE) JFA investments have been moved into the Service and Supply Fund and 6) moved the Commissioned Corp Support Services Group to the Commissioned Corp Force Management activity. Additionally, Office of Human Resources (OHR) will remain a non-PSC activity but has delegated HR operations functions to four Operating Divisions (OPDIV): Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), Food and Drug

Administration (FDA), and Health Resources and Services Administration (HRSA). They have also realigned their HRIT functions within OHR Enterprise Systems Division to ASA/OCIO. 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 2013 SSF activities are described below.

Program Support Center Activities

PSC was established in 1995 to provide a full range of support services to HHS OPDIVs, allowing them to focus on their core missions, and has since expanded its service provision to 31 other federal agencies. PSC pursues continuous efforts to drive cost savings and quality improvement through economies of scale, cost negotiations, standardized business processes, and consistent quality controls in order to gain reductions in rates. The 'SMART' (Save, Manage and Assess our Resources Together) program is an ongoing comprehensive annual review of PSC's operations to identify substantial cost reductions and increased opportunities for revenue growth. This program has resulted in significant billable rate reductions, and is now in its third iteration.

PSC continues to evolve as a shared service provider, adding services to meet customer demands and scaling back or eliminating services that are no longer needed by our customers. PSC also continues to seek business growth, both inside and outside the Department in order to meet customers' need for program support, and to reduce unit costs.

Administrative Operations Service (AOS): AOS provides a wide range of administrative and technical services to customers within HHS and to other federal agencies. The major service areas within AOS are: Payroll Liaison, which ensures that HHS employees are paid accurately and on time; Customer Contact Center services provide modern call center services for HHS and other customers; Travel and Transportation operates the HHS e-Gov Travel Center that provided travel arrangements, reimbursement and support for official travel, motor pool and vehicle rental services for official business, and GO!card® (Transhare/ Mass Transit Benefit) services; Mail Services provides mail support for HHS customers in the National Capital Region and also to New York and Kansas City Regional Offices; Media Services offers graphics arts, photography, printing procurement, Section 508 compliance testing and remediation, and forms management; and Freedom of Information Act Services (FOIA) and Records Management, which processes FOIA requests and appeals.

Facilities and Logistics Service (FLS): FLS is a new service area within PSC that combines OFMP functions with existing building operations, logistics and warehouse activities previously performed by components within PSC/AOS and PSC/SAS. The mission of FLS is to set building management policy efficiently and effectively, and to provide building and logistics operations, such as general storage, regional support, Real Property, and specialized handling for medical supplies and pharmaceuticals, on a fee-for-service basis to the Department and other federal customers.

Financial Management Service (FMS): FMS serves to provide the foundation of HHS' finance and accounting operations through the provision of grant payment management services; accounting and fiscal services; debt management services; and rate review, negotiation, and approvals for departmental and other federal grant and program activities to HHS and other federal agencies. FMS also offers fiscal advice and technical and policy guidance to assist in customers in implementing new initiatives and assuring compliance with regulatory requirements.

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. Services include: health and wellness programs, employee assistance, work/life services, and environmental health and safety services. FOH programs provide strategic prevention and early intervention services to employees and federal agency employers. FOH currently provides services to 352 federal agencies and serves over 1.5 Million federal employees. Approximately 90% of FOH's services are provided to federal agencies outside of HHS.

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 consist of: Acquisition Management, which includes negotiated contracts, simplified acquisitions and purchase card management services, and Quality Assurance, which provides analytical and quality assurance support to contracting staff and SAS customers.

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: The Acquisition Integration and Modernization (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 (OGAPA) 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 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; launching a Recovery Act Acquisition Desk Reference to support statutory compliance; conducting web-based surveys under HHS' Acquisition Balanced Scorecard; creating an on-line acquisition focused appropriations law course; and conducting symposiums providing training opportunities and sharing of best practices.

Audit Resolution: OS Audit Resolution, along with resolution officials in HHS Operating Divisions/Staff Divisions (OPDIV/STAFFDIV), is required to resolve Single Audit findings within a six-month time frame in accordance with OMB Circular A-133, *Audit of States, Local Governments, and Non-Profit Organizations*, which implements the Single Audit Act Amendments of 1996. OS Audit Resolution resolves cross-cutting findings resulting from OMB Circular A-133 audits that affect the awards of multiple OPDIVs/STAFFDIVs. HHS' Office of Inspector General (OIG) closely monitors audit findings to determine if the findings are resolved within the required six-month time frame. In addition to resolving cross-cutting findings, OS Audit Resolution is responsible for providing departmental leadership and policies.

Claims: The Office of the General Counsel (OGC) receives all tort claims filed against the Department. These torts can range from "slips" and "falls" in HHS facilities, to motor vehicle accidents involving HHS vehicles, or medical malpractice in health clinics. OGC reviews and processes all of these claims.

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 as a whole. Two offices within the Office of the Surgeon General (OSG) administer force management for the Corps – 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. DCCPR and DSI's customer base consists of active duty, assigned within various agencies and Departments, and retired officers.

Departmental Contracts Information System (DCIS): The Departmental Contracts Information System (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 (OGAPA) which is within the office of the Assistant Secretary for Financial Resources. DCIS serves as a central repository for Department-wide, post-award contract data. In recent years, DCIS has taken steps to improve efficiency by: pursuing application software upgrades (to expedite delivery of contract data to FPDS); conducting HHS-wide training sessions for DCIS users (to improve the reliability of data input); enhancing systems security; migrating DCIS from its current platform in the Parklawn Computer Center to cloud technology; and deploying robust reporting and business intelligence tools (COGNOS).

Division of Security and Emergency Services: The Division of Security and Emergency Services (DSES) conducts approximately 3,000 personnel suitability investigations and adjudications per year. These services were previously covered under security adjudication, initiation and processing functions within the PSC. DSES resides within the Office of Security and Strategic Information (OSSI), which is

headed by the Deputy Assistant Secretary for Security, now under the Office of the Assistant Secretary of Administration. As the result of two strategic-level security reviews performed by the Office of the Secretary in 2011, security functions were consolidated to strengthen management and streamline programmatic processes, enable greater accountability across the Department, and reduce overall operating costs.

Enterprise Architecture Program: The HHS Enterprise Architecture (EA) Program resides in the Office of the Chief Information Officer. The HHS EA Program provides strategic planning and a roadmap for continuously evolving HHS business processes, services, and supporting systems and technologies in response to changing operational requirements and priorities. The program provides an HHS-wide repository that contains the HHS' authoritative source inventory for all software systems, documents HHS' current environment and defines intended target states to realize the longer-term vision. The program leads planning, execution and reporting on Administration initiatives such as Cloud-First, Data Center Consolidation, and Shared Services.

Equal Employment Opportunity: The Equal Employment Opportunity (EEO) cost center is managed by the EEO Compliance and Operations Division (EEOCO), which is a part of the Office of the Secretary (OS), Office of the Assistant Secretary for Administration (ASA). The goal of the EEOCO is to ensure every HHS employee/applicant for employment has equal access to EEO services, timely resolution of their complaint and equitable remedy. The EEO Compliance and Operations Division consist of two components: (1) EEO Compliance and (2) EEO Operations.

HHS Consolidation Acquisition System: The HHS Consolidated Acquisition (HCAS) is overseen by the Office of Acquisition Policy within the Division of Acquisition, under the Office of Grants and Acquisition Policy and Accountability (OGAPA), which is within the office of the Assistant Secretary for Financial Resources. 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). This system, based on a Commercial-Off-The-Shelf software application, enables users to commit funds to requisitions and for the contracting officers to formulate and administer contracts in compliance with the Federal Acquisition Regulation.

High Performing Organizations, Commercial Services Management Reporting & Insourcing (HPO, CSM & Insourcing): The HPO, CSM & Insourcing program under OBMT, supports HHS in meeting statutory mandates related to ensuring the insourcing of government functions as required by the Federal Activities Inventory Reform Act of 1998 (Public Law 105-270); Section 647 (b) of Division F of the Consolidated Appropriations Act, FY 2004, P.L. 108-109; Section 735, Section 752, and Section 321 of Title VII of the Omnibus Appropriations Act, 2009; and P.L. III-8, Section 735. The program also ensures the Department's compliance with Section 752 of the Omnibus Appropriations Act, which requires Agencies to submit to the Director of OMB a report stating the total size of its workforce, differentiated by number of civilian, military, and contract workforce and Section 321, which mandates a comprehensive analysis and development of single government-wide definition of inherently governmental function and criteria for critical functions by collecting and organizing various data for submission to OMB.

Homeland Security Presidential Directive – 12: The HSPD-12 program implements the Presidential directive to provide greatly enhanced security for physical access to HHS facilities and logical access to systems and applications. The HSPD-12 program encompasses the sponsorship, enrollment, and management of identities and issuance of identity cards. Identity cards are currently issued to all permanent Federal, contractor, and affiliate staff after a rigorous background adjudication process. Identity cards are printed in accordance with the National Institute for Standards and Technology (NIST) standards and contain electronic credentials on the embedded smart chip.

Information Technology Infrastructure & Operations (ITIO): ITIO is a division under the Office of the CIO located within ASA. The mission of the ITIO is to provide high-quality information technology services to a majority of the HHS OPDIVs and STAFFDIVs.

The ITIO provides onsite desktop/laptop support with four year product lifecycle upgrades, 24/7 Service Desk, Blackberry email and wireless solutions, network printer installation and technical support as well as government and commercial off-the-shelf software installation and technical support. Additionally, the ITIO maintains infrastructure services covering: planning, deployment, and maintenance of network devices and servers and enterprise network security monitoring, including incident response. The ITIO provides both LAN and WAN and facilitates business application hosting allowing customers to have mission critical and applications and databases hosted in an offsite, secure and fully redundant facility. The ITIO provides COOP/DR services for our customers. Support includes planning, support, and staging of hardware as well as internet availability and Blackberry services.

Office of IT Portfolio Management: The Office of IT Portfolio Management (OITPM) resides in the Office of the CIO, Office of the Assistant Secretary for Administration (ASA). OITPM combines the functions previously carried out by the Office of IT Budget and Capital Planning and the Domain Management Program Management Office. OITPM provides HHS-wide oversight of information technology investments. This oversight includes analyzing the cost of the IT portfolio, facilitation of decision making on IT investments and support for project and portfolio reviews following the TechStat and PortfolioStat processes. OITPM also provides direct support the domain IT steering committees, which represents a strengthening of IT governance within HHS. The office supports the preparation and submission of HHS's Exhibit 53 and 300s and maintains HHS's Enterprise Performance Lifecycle – a framework for IT project management. Finally, OITPM houses the program management office supporting the Affordable Care Act Health Insurance Exchange (HIX) Steering Committee.

Information Technology Security and Privacy: The Information Technology Security and Privacy Program (ITSP) is managed within the HHS Office of the CIO, Assistant Secretary for Administration. The focus of ITSP is to help protect HHS against potential IT threats and vulnerabilities. The ITSP is an important component of HHS' Cybersecurity Program, which ensures compliance with Federal mandates and legislation, including the Federal Information Security Management Act (FISMA) and the President's Management Agenda. The Program also plays an important role in protecting HHS's ability to provide mission-critical operations.

Networx Program Management Office (NxPMO): The Networx Program Management Office (NxPMO) is organizationally located within the HHS Office of the CIO, Office of the Assistant Secretary of Administration. The Networx program offers comprehensive, best value telecommunications. The NxPMO allows for optimal management and contractual oversight of the Networx contracted telecommunications, IT, and professional services.

Through the NxPMO, HHS will realize cost savings through centralized management of the HHS Networx program as a result of expedited transition, rate validations and corrections, inventory validation and quality control, and overall process improvement including HHS-wide requirements management and continued strategic pricing management. Additionally, NxPMO will ensure HHS compliance of policy, regulatory and statutory requirements.

Office of Enterprise Application Development: The Office of Enterprise Application Development (OEAD) is located within the Office of the Chief Information Officer (OCIO). This organization contains portions of the former ISMS, which was dissolved in May 2012, with several components organizationally relocated within the 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.

Office of Human Resources: The Office of Human Resources (OHR) resides under the Assistant Secretary for Administration, Office of the secretary. 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.

OHR provides leadership in creating and sustaining a diverse workforce and an environment free of discrimination. OHR works proactively to enhance the employment of women, minorities, veterans, and people with disabilities through efforts that include policy development, program oversight, complaint resolution, diversity outreach, commemorative events, and standardized education and training programs. In addition, OHR works in collaboration with the various HHS Equal Employment Opportunity offices OHR on conducting Department-wide program reviews to determine barriers to diversity and inclusion.

Office of Small and Disadvantaged Business Utilization (OSDBU): The Office of Small and Disadvantaged Business Utilization (OSDBU) was established under Public Law 95-507 (Small Business Act). The Office is supported by the Assistant Secretary for Financial Resources (ASFR), the Office of Grants, Acquisition Policy and Accountability. OSDBU is responsible by statute to ensure that small businesses receive the maximum, practicable opportunities to compete for HHS procurements. It serves as the HHS single point of contact for small business matters and is accountable for coordinating and implementing strategies to meet statutory goals for awards to small entities. OSDBU is broadening small business training of acquisition and program staff, leading to increased HHS performance in meeting HHS' socio-economic goals; automating the HHS contract review system and also creating an HHS-wide system for contracting staff to access information on small businesses that can potentially perform on HHS contracts; and enhancing training assistance for internal and external customers through web-based training initiatives that will lower operating costs while reaching a larger audience in a shorter time period. OSDBU continues to revise the Small Business Manual which serves as the primary reference tool for HHS contracting staff, allowing them to be more effective in determining a sound acquisition strategy around HHS' requirements.

Strategic Sourcing Program (SSP): The Strategic Sourcing Program (SSP) provides departmental leadership in conducting spend analysis and developing acquisition strategies that leverage HHS contract spending for common supplies and services. 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 (OGAPA), which is within the office of the Assistant Secretary for Financial Resources.

HHS has leveraged its purchasing power to obtain Department-wide discounts from 6% to 54% (depending on the category) over current HHS pricing for similar items, which is a substantial savings for the Department. To date, HHS has established enterprise-wide Blanket Purchase Agreements (BPAs) to facilitate purchasing of: Custodial Products, Events Management Services, Information Technology, Lab Supplies, Office Equipment, Office Furniture, Office Supplies, Temporary Administrative and Professional Staffing Services, and Temporary Professional and Medical Staffing Services.

Telecommunications: The Office of Telecommunications is managed within the Office of the CIO, Office of the Assistant Secretary of Administration. Telecommunications Services was formerly

managed by the PSC ISMS division. The Office of Telecommunications has the mission of providing flexible, responsive, high quality and cost effective solutions for Federal Agencies located in the National Capital Area (NCA) through the Telecommunications/WITS program. Through the establishment and management of partnerships with customers and vendors, the Telecommunications Team is able to meet customer requirements, manage costs, and improve productivity.

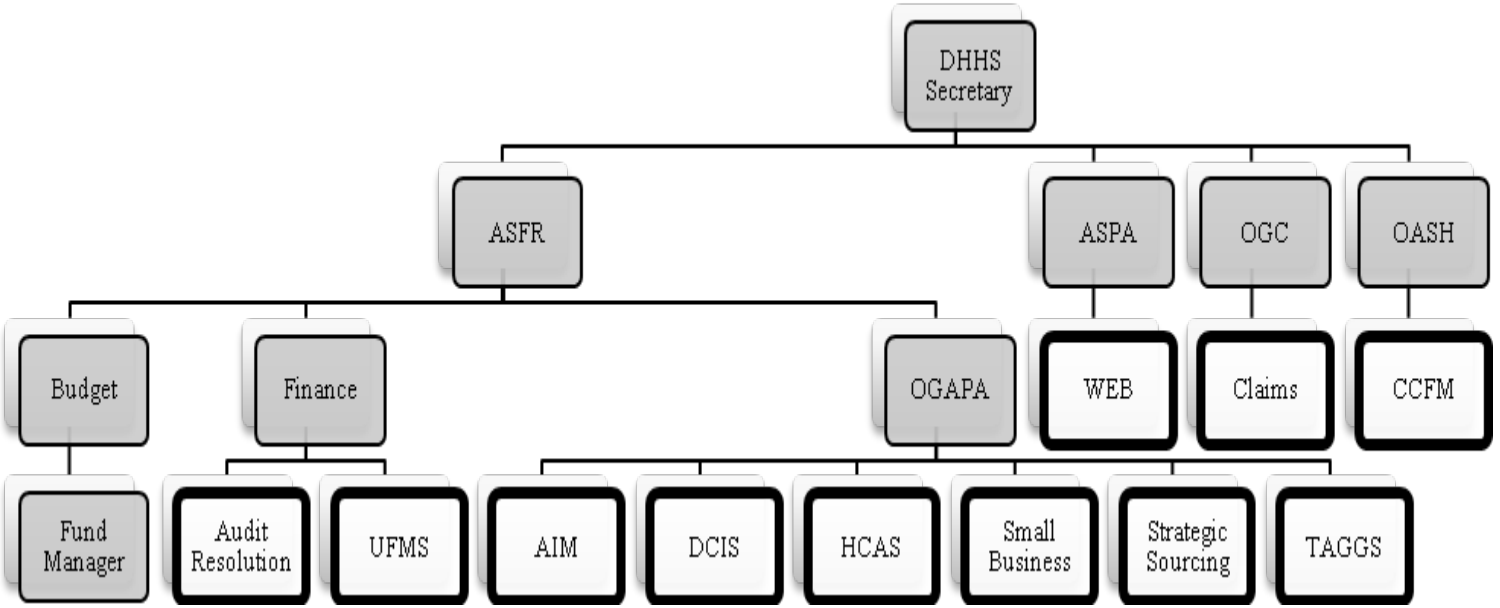
Tracking Accountability in Government Grants (TAGGS): Since 1995, the Department of Health and Human Services (HHS) has tracked and reported grant spending online via its Tracking Accountability in Government Grants System (TAGGS). TAGGS is overseen by the Office of Grants Systems Management within the Division of Grants, under the Office of Grants and Acquisition Policy and Accountability (OGAPA), which is within the office of the Assistant Secretary for Financial Resources. TAGGS continues to serve as the central repository and reporting system for grant award data generated by HHS. TAGGS grant data is made available to the public on the TAGGS Website (http://taggs.hhs.gov) and HHS' grant award data is submitted to USASpending.gov twice a month.

Unified Financial Management System: The Unified Financial Management Systems (UFMS) environment offers HHS a platform for effectively processing and tracking its financial and accounting transactions with the Unified Financial Management System at its core. With the recent implementation of the Consolidated Financial Reporting System (CFRS), the UFMS environment now provides the capability to generate accurate, HHS-wide financial statements on a consistent and timely basis. With the implementation of the core Enterprise Financial Business Intelligence System (FBIS, but also known as OBIEE) in February 2013, the UFMS environment will offer management reports and business analytics that will facilitate the analysis of data across systems and strategic decision-making by management.

Vendor Management Office: The Vendor Management Office (VMO) resigns in the Office of the CIO, Office of the Assistant Secretary for Administration (ASA). VMO was created as a result of the request presented by the Office of Management and Budget in the July 2011, President's Management Advisory Board meeting. The purpose of the VMO will be to provide IT contract development, administrative and technical support services to customers within the HHS.

Web Communications and New Media Division: The Web Communications and New Media Division (WCD) is a part of the Assistant Secretary for Public Affairs (ASPA) that resides in the Office of the Secretary. WCD provides support for the Office of the Secretary by designing and managing HHS.gov, five Departmental priority websites, and nine mandated sites that are required by legislation and Executive Orders. WCD also provides overall HHS-wide policy, standards, guidance, a Section 508 compliance program, shared services with enterprise licenses and support, as well as counsel and assistance on best Web and social media practices.

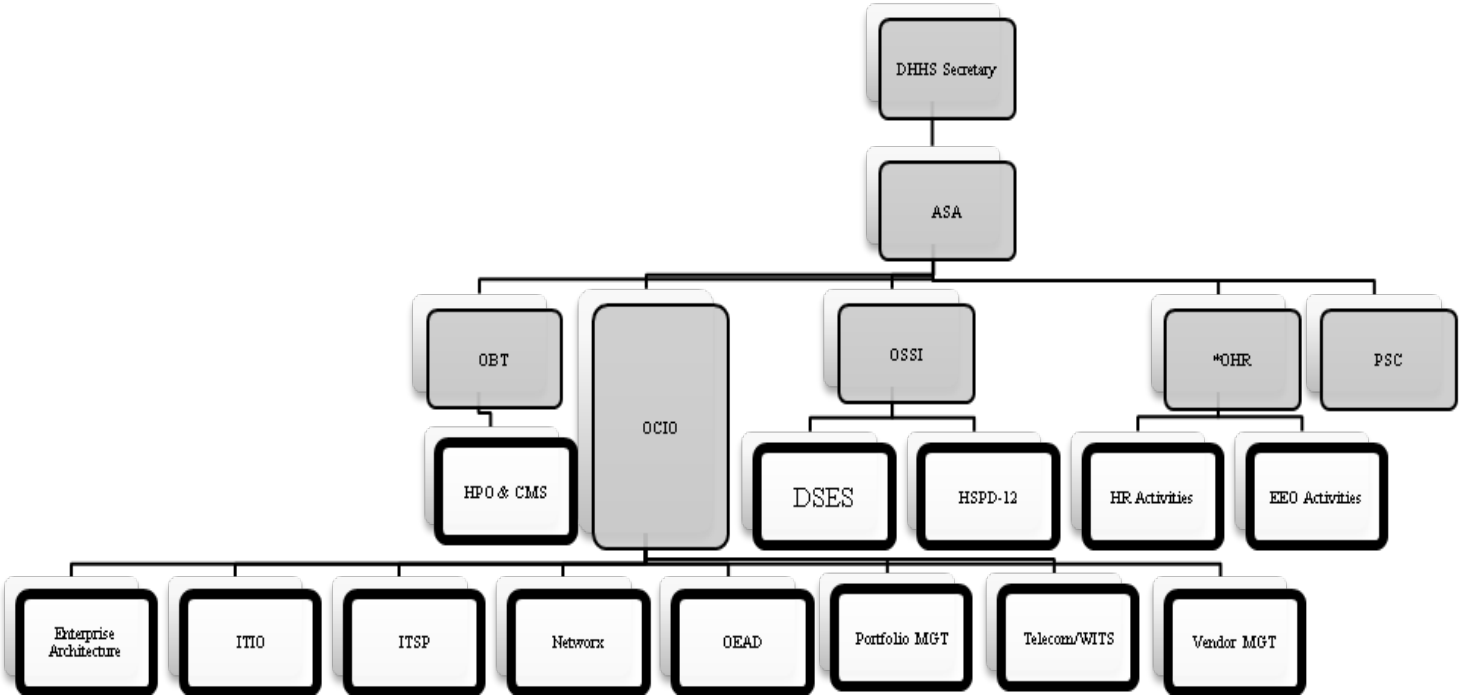
SERVICE AND SUPPLY FUND
NON-PSC ACTIVITIES



Key:
ASFR – Associate Secretary for Financial Resources
ASA – Associate Secretary for Administration
ASPA – Assistant Secretary for Public Affairs
OGC – Office of the General Counsel
OASH – Office of the Assistant Secretary for Health
OGAPA – Office of Grants and Acquisitions Policy and Accountability
CCFM – Commissioned Corps Force Management
AIM – Acquisition Integration and Modernization
DCIS – Departmental Contracts Information System
HCAS – HHS Consolidated Acquisition Solution
TAGGS – Tracking Accountability in Government Grants System

SSF Activities are outlined in bold.

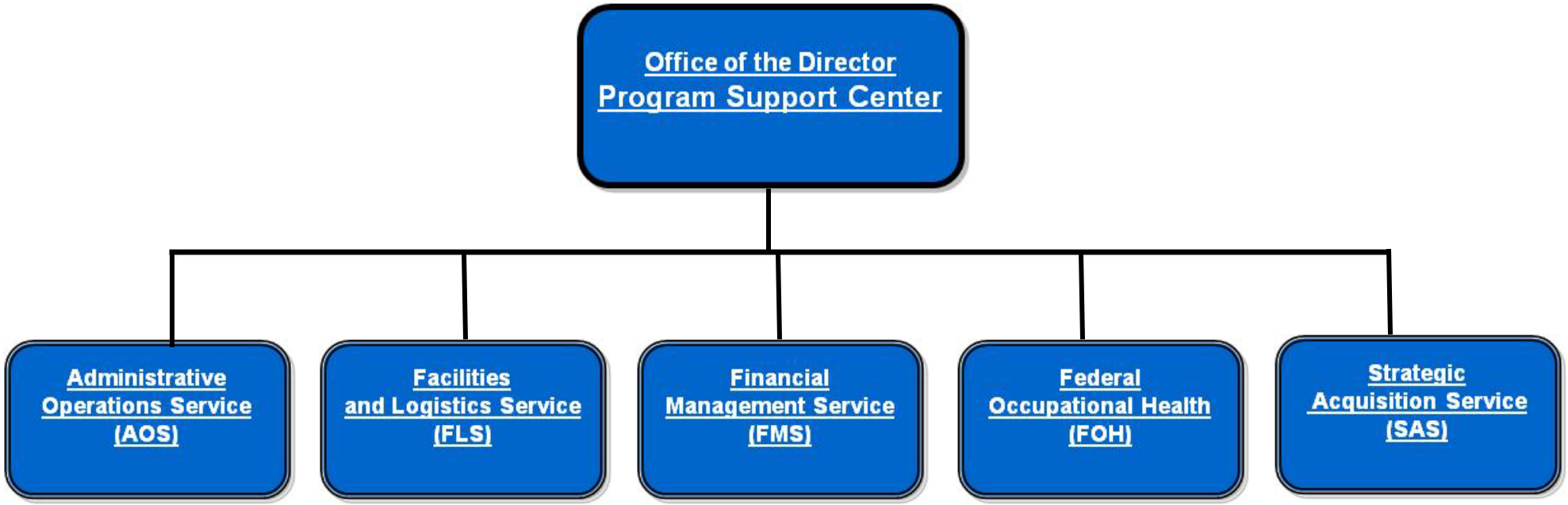
SERVICE AND SUPPLY FUND
NON-PSC ACTIVITIES - Continued



Key:
ASA – Associate Secretary for Administration
OBT – Office of Business Transformation
DSES – Division of Security and Emergency Services
EEO – Equal Employment Opportunity
HPO & CMS – High Performing Organizations and Commercial Services Management
HSPD-12 – Homeland Security Presidential Directive 12
ITIO – Information Technology Infrastructure and Operations
ITSP – Information Technology Security and Privacy
OEAD – Office of Enterprise Application Development
OHR – Office of Human Resources

SSF Activities are outlined in bold.
*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.

Program Support Center Organizational Chart



Department of Health and Human Services
Service and Supply Fund

(Dollars in Thousands)

Service and Supply Fund Activities	FY 2012 Actuals 1/	FY 2013 Program Level	FY 2014 Board Approved	FY 2014+/- FY 2013
PSC				
Administrative Operations Service	63,404	86,294	87,056	762
Facilities and Logistics Service	77,111	69,364	69,474	110
Federal Occupational Health Service	146,650	165,128	167,571	2,443
Financial Management Service	53,615	64,138	64,473	335
Info. & Systems Mgmnt Service	-	-	-	-
Strategic Acquisitions Service	357,192	390,114	395,966	5,852
PSC Reserves	3,613			
PSC Subtotal	701,584	775,038	784,540	9,502
Non-PSC				
AIM	1,019	992	992	-
Audit Resolution	1,384	1,608	1,608	-
CCFM	23,074	31,502	31,033	(469)
DCIS	1,360	1,999	1,999	-
DSES	16,058	17,373	18,538	1,166
Enterprise Architecture	-	3,078	3,078	-
EEO Services	3,060	3,170	3,170	-
HCAS	7,682	7,877	7,877	-
HPO & Commercial Services Mgmnt	179	262	262	-
HSPD-12	12,855	13,926	14,876	950
ITIO	53,836	59,842	61,248	1,406
ITSP	4,006	3,935	3,950	15
Networx	3,765	4,501	4,514	13
OEAD	27,846	45,256	45,317	61
OGC Claims	1,136	1,355	1,376	21
Office of Human Resources	60,063	21,544	21,544	-
Portfolio Management	-	2,875	3,128	252
Small Business Consolidation	2,246	2,842	2,842	-
Strategic Sourcing	621	959	959	-
Telecommunication Services/WITS	28,423	31,576	31,576	-
TAGGS	2,076	2,431	2,431	-
UFMS	28,560	31,586	36,733	5,147
Vendor Management	-	780	1,086	306
Web Communications	16,875	18,184	18,184	-
Non-PSC Reserves	5,068			-
Non-PSC Subtotal	301,190	309,453	318,321	8,867
Total SSF Revenue	**1,002,774**	**1,084,491**	**1,102,861**	**18,370**

1/ Comparable adjustments shown to FY2012 actuals for activities moved from the PSC to the Non -PSC side of Fund resulting from organizational changes.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SERVICE AND SUPPLY FUND
Object Classification - Reimbursable Obligations
(Dollars in Thousands)

Object Class	FY 2012 SSF Board Actual	FY 2013 SSF Board Approved	FY 2014 SSF Board Approved
Reimbursable Obligations			
Personnel Compensation:			
Full-Time Permanent (11.1)	110,265	103,103	103,103
Other Than Full-Time Permanent (11.3)	3,829	2,412	2,438
Other Personnel Compensation (11.5)	1,764	3,068	3,091
Military Personnel (11.7)	8,310	9,600	9,647
Special Personnel Services Payments (11.8)	10,082	-	-
Subtotal Personnel Compensation	**134,250**	**118,183**	**118,279**
Civilian Personnel Benefits (12.1)	31,998	28,582	29,136
Military Personnel Benefits (12.2)	4,412	2,230	2,461
Benefits to Former Personnel (13.0)	158	164	-
Subtotal Pay Costs	**36,568**	**30,976**	**31,597**
Travel (21.0)	1,966	1,891	1,895
Transportation of Things (22.0)	2,836	3,788	3,833
Rental Payments to GSA (23.1)	25,287	22,246	22,413
Rental Payments to Others (23.2)	-	-	-
Communications, Utilities and	-	-	-
Miscellaneous Charges (23.3)	32,105	6,375	6,443
Printing and Reproduction (24.0)	2,172	2,745	2,777
Other Contractual Services:	-	-	-
Advisory and Assistance Services (25.1)	35,952	56,489	56,756
Other Services (25.2)	479,698	612,438	625,262
Purchases from Govt. Accounts (25.3)	127,139	69,048	70,604
Operation & Maintenance of Facilities (25.4)	17,506	6,546	6,642
Research & Development Contracts (25.5)	-	-	-
Medical Services (25.6)	13,620	28,543	29,429
Operation & Maintenance of Equipment (25.7)	50,956	92,053	93,838
Subsistence & Support of Persons (25.8)	-	-	-
Subtotal Other Contractual Services	**789,237**	**902,162**	**919,892**
Supplies and Materials (26.0)	40,960	31,196	31,572
Equipment (31.0)	1,759	1,974	1,521
Grants (41.0)	-	-	-
Other (32), (42), (61)	-	-	-
Subtotal Non-Pay Costs	**42,719**	**33,170**	**33,093**
Total Reimbursable Obligations	**1,002,774**	**$1,084,491**	**1,102,861**

Retirement Pay & Medical Benefits for Commissioned Officers

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

	FY 2012	FY 2013	FY 2014	FY 2014 +/-FY 2013
Retirement Payments	373,736,296	394,207,941	415,330,606	21,122,664
Survivor's Benefits	25,159,362	26,929,696	28,239,057	1,309,361
Medical Care Benefits	93,984,039	101,337,780	106,801,650	5,463,870
Accrued Health Care Benefits	35,991,000	29,061,800	26,476,358	-2,585,442
Total	**$528,870,697**	**$551,537,217**	**$576,847,671**	**$25,310,453**

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 2014 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 an estimate provided by the DoD Office of the Actuary, multiplied by the estimated number of active duty positions (6,746 in FY 2014).

The FY 2014 estimate is a net decrease of $2,585,442 below the FY 2013 level. This Budget assumes savings from FY 2014 Department of Defense Budget proposals, yielding a total of $26,476,358 for the Accrual Health Care Benefits account. The overall request reflects increased costs in medical benefits, an average increase of 5.4% over the past five years in Retired Pay, and a net increase in the number of retirees and survivors during FY 2014.

	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Retirement Payments	437,758,458	461,397,414	486,312,875	512,573,770	540,252,754
Survivor's Benefits	29,622,771	31,074,287	32,596,927	34,194,176	35,869,691
Medical Care Benefits	112,369,779	118,940,917	125,949,598	133,530,877	141,923,701
Accrued Health Benefits	25,284,358	25,098,358	24,906,358	24,701,358	24,483,358
Total	**$605,035,365**	**$636,510,976**	**$669,765,757**	**$705,000,181**	**$742,529,503**

HHS General Provisions

DEPARTMENT OF HEALTH AND HUMAN SERVICES
GENERAL PROVISIONS
FOR FISCAL YEAR 2014

TITLE II

This section uses the FY 2013 President's Budget as a base. Thus, the language changes reflected in this section are compared against the language that was included in the FY 2013 President's Budget.

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 of Health and Human Services 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.]

> Rationale: The President's Budget deletes this provision because it is no longer necessary. A comparable provision was inserted in the 1980's to provide operational authority to HHS and to exempt these staff from FTE caps in place at the time. Since then, changes in HHS' operational authorities have made the authority provided by this provision redundant, and there are no FTE caps in place any longer.

Sec. [203] *202*. None of the *discretionary* funds appropriated in this *title* [Act for the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration] 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.

> Rationale: The Budget applies this limitation to discretionary programs. The Administration added clarifying language to ensure this provision does not apply to mandatory programs such as matching grants for Medicaid.

Sec. [204] *203*. Notwithstanding section 241(a) of the PHS Act, such portion as the Secretary shall determine, but not more than *3.0* [3.2] percent, of any amounts appropriated for programs authorized under such Act shall be made available for the evaluation (directly, or by grants or contracts) of the implementation and effectiveness of such programs.

> Rationale: The modified percentage reflects the proposed uses of funds in the FY 2014 President's Budget.

(Transfer of Funds)

Sec. [205] *204*. 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. [206] *205*. 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. [207] *206*. 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. [208] *207*. 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. [209] *208*. 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. [210] *209*. 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. [211] *210*. 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 [2013] *2014*:

(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. [212] *211*. (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. [213] *212*. 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 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. [214] *213*. Notwithstanding any other provisions of law, discretionary funds made available in this Act may be used to continue operating the Council on Graduate Medical Education established by section 301 of Public Law 102–408.

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. Such portion as the Secretary shall determine, but not more than 1 percent, of any discretionary funds which are appropriated in this Act for the current fiscal year for domestic HIV/AIDS activities in any program, project, or activity carried out by the Department of Health and Human Services shall be made available to the Office of the Assistant Secretary for Health to support the National HIV/AIDS Strategy: Provided, That such support may be provided directly, or by grants or contracts, on a reimbursable basis.]

> Rationale: This provision was proposed in the first two President's Budgets that were proposed after the National HIV/AIDS Strategy was issued in July, 2010. This transfer authority is no longer being requested.

Sec. [218] *216*. (a) A state shall be entitled to receive a grant under section 510 of the Social Security Act (42 U.S.C. 710) for fiscal year [2013] *2014* only if the Department of Health and Human Services receives an application under section 505(a) of such Act (42 U.S.C. 705(a)) for such fiscal year by no later than September 20, [2013] *2014*.

(b) CANCELLATION. The remaining unobligated balances of the amount appropriated for fiscal year [2013] *2014* by section 510(d) of such Act (42 U.S.C. 710(d)) for which no application has been received by September 20, [2013] *2014*, shall be permanently cancelled as of September 27, [2013] *2014*.

(c) APPROPRIATION. There is appropriated to the Department of Health and Human Services, to become available on September 27, [2013] *2014*, and to remain available through September 30, [2014] *2015*, an amount equal to the unobligated balances cancelled pursuant to subsection (b), for carrying out (in addition to any other funds that may be available for such purpose) a program of competitive contracts and grants to State and local governments to develop approaches to reduce pregnancy among youth in foster care and to fund age appropriate evidence-based programs that reduce teenage pregnancy, behavioral risk factors underlying teen pregnancy, or other associated risk factors among youth in foster care and for the Federal costs associated with administering and evaluating such contracts and grants.

Sec. 217. The Director of the CDC, or the Administrator of the Agency for Toxic Substances and Disease Registry, may detail staff without reimbursement for up to 180 days, to support the CDC response to a public health emergency or urgent public health event that involves activation of the Emergency Operations Center at the CDC.

Rationale: This proposed language will ensure that CDC can mobilize quickly to respond to urgent public health needs, and utilize subject matter experts from across the agency during large-scale public health emergencies.

Sec. 218. Funds provided to the National Institutes of Health in this and subsequent acts may be used to support the Sanctuary System for Surplus Chimpanzees authorized by section 404K of the Public Health Service Act, including for the construction, renovation, and funding of current or additional facilities of the sanctuary system as authorized by section 404K, notwithstanding the limitations in subsection (g) of such section.

Rationale: The proposed language will enable the Sanctuary System to continue operating. P.L. 106-551, which was enacted in 2000 to authorize this system, placed a cumulative limit of $30,000,000 on the amount that NIH could spend on this system. This statutory limitation on NIH funding for the sanctuary system for surplus chimpanzees is expected to be reached in the first quarter of FY 2014. Removing the cap is necessary to allow NIH support to continue for the care of these chimpanzees that have been retired from research uses.

Sec. 219. 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.

Rationale: The emergency transfer authority would provide HHS greater flexibility in responding to public health emergencies. While Sec. 204 provides the Secretary authority to transfer funds to address unanticipated needs that arise throughout the fiscal year, it limits the amount of the transfer and the time in which transfers may be made, which could delay and constrain HHS's emergency response activities. For example, that authority cannot be used during the last 15 days of a fiscal year, which is a time that hurricanes often strike, and the amount that can be transferred into a response appropriation is limited. This provision will provide greater flexibility to HHS to respond quickly in the wake of a public health emergency.

Sec. 220. Notwithstanding section 338E(c)(2) of the PHS Act, unless funds have been paid to or on behalf of an individual under section 338B(g) of such Act, the Secretary or the individual with whom the Secretary entered into a contract under section 338B of such Act in this or any subsequent fiscal year may terminate the contract within 60 days of its execution. The party electing to terminate the contract under such section must provide written notice to the other party prior to expiration of the 60-day period, and termination of the contract shall be effective upon verified receipt of the termination notice.

Rationale: Under current law, individuals who sign National Health Service Corps contracts prior to August 17 are allowed to reconsider provided that any amounts disbursed to them are repaid. However, any individuals that sign contracts between that date and the end of the fiscal year have no opportunity to reconsider. Now that funding for the National Health Service Corps is available until expended, the Budget proposes additional authority to allow those individuals a 60 day reconsideration window, as long as no funds are disbursed.

Sec. 221. Health Information Technology User Fees. (a) The Secretary of HHS shall prescribe by regulation, for application in the current fiscal year and in subsequent fiscal years, a schedule of fees for certification of health information technology as established by Section 300jj-11(c)(5) of Title 42. The fees shall be paid by health information technology vendors based on the fee structure established by the Secretary and published in the Federal Register. The Secretary shall periodically update this schedule of fees through a notice in the Federal Register. This fee structure shall be designed to be sufficient to recover costs associated with the administration of certification programs authorized by Section 300jj-11(c)(5) of Title 42, including the costs for health information technology standards, testing and certification, and other related costs for improving the efficiency of certification programs.

(b) Collection Procedures. The Secretary shall prescribe procedures to collect the fees. The Secretary may, for the purpose of collecting fees, use the services of a department, agency, or instrumentality authorized by the National Coordinator to perform the certification of health information technology in accordance with Section 300jj-11(c)(5) of Title 42, and may reimburse such department, agency, or instrumentality a reasonable amount for its services.

(c) Collection, Deposit, and Use. Fees collected under this section shall be deposited in the HHS Office of the National Coordinator for Health Information Technology account as offsetting collections, and shall remain available until expended.

Rationale: Allows ONC to collect user fees from electronic health record vendors to support certification and standards activities.

Sec. 222. (a) The Biomedical Advanced Research and Development Authority (BARDA) may enter into a contract, for more than one but no more than ten 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 Public Health Service 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.

Rationale: Improves the long-term procurement capability of BioShield by allowing BARDA to make multi-year commitments for security countermeasures. This modified authority permits BARDA to apply set aside amounts, if not utilized for termination fees, towards payment of contract invoices.

Note.--A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

TITLE V

This section uses the FY 2013 President's Budget as a base. Thus, the language changes reflected in this section are compared against the language that was included in the FY 2013 President's Budget.

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, 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 [relationships or] 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.

> Rationale: Recommend including language to allow State and local contractors and grantees to present to State and local legislatures or legislative bodies within the realm of normal and recognized State-local relationships.

Sec. 504. The Secretaries of Labor and Education are authorized to make available not to exceed $28,000 and $20,000, respectively, from funds available for salaries and expenses under titles I and III, respectively, for official reception and representation expenses; the Director of the Federal Mediation and Conciliation Service is authorized to make available for official reception and representation expenses not to exceed $5,000 from the funds available for "Federal Mediation and Conciliation Service, Salaries and Expenses"; and the Chairman of the National Mediation Board is authorized to make available for official reception and representation expenses not to exceed $5,000 from funds available for "National Mediation Board, Salaries and Expenses."

Sec. 505. 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. 506. 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. 507. (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. 508. (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. 509. (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. 510. (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. 511. 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. 512. 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. 513. Not applicable to HHS.

Sec. 514. Not applicable to HHS.

Sec. 515. Not applicable to HHS.

Sec. 516. 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. Of the funds made available for performance bonus payments under section 2105(a)(3)(E) of the Social Security Act, [$6,367,964,000] *$3,779,000,000* [are hereby rescinded $6,706,000,000] shall be permanently cancelled as of January [1, 2013] *20, 2014*.

> Rationale: Recommend revising dates to permit timely payment of bonus funds in FY 2014.

Sec. 518. 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 and the Secretary of Education.

(b) Amounts appropriated for the Workforce Innovation Fund—

(1) shall be administered by the Secretary of Labor and the Secretary of Education in accordance with an interagency agreement describing the respective roles and responsibilities of the Secretaries in administering such funds, and, as appropriate, shall be administered in consultation with other heads of departments and agencies; and

(2) may be transferred between the Department of Labor and the Department of Education.

(c) Of the funds appropriated under this Act for the Workforce Innovation Fund, not more than 5 percent shall be available to the Secretary of Labor and to the Secretary of Education for technical assistance and evaluations related to the projects carried out with these funds.

(d) The Secretary of Labor and the Secretary of Education may authorize awardees to use a portion of awarded funds for evaluation, upon approval of an evaluation plan by the Secretaries.

(e) The Secretary of Labor and the Secretary of Education shall establish requirements for the Workforce Innovation Fund to ensure that individuals with disabilities, including those with significant disabilities, benefit substantially from activities supported under the Fund.

(f) Of the funds appropriated under this Act for the Workforce Innovation Fund, $10 million shall be used for innovative and evidence-based approaches to serving disconnected youth.

(g) Of the funds appropriated under this Act for the Workforce Innovation Fund, not to exceed $20 million may be used for Workforce Innovation Fund-related performance-based awards or other agreements under the Pay for Success program: Provided, that any deobligated funds from such projects or agreements shall immediately be available for the Workforce Innovation Fund.

(h) Funds obligated for Workforce Innovation Fund projects may remain available for disbursement until expended, notwithstanding 31 U.S.C. 1552(a).

(i)(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, 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 projects.

(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.

Sec. 519. (a) In General. The Health Education Assistance Loan (HEAL) program under title VII, part A, subpart I of the Public Health Service Act (42 U.S.C. 292–292p), 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 Higher Education Act 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 Higher Education Act 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 Public Health Service Act (42 U.S.C. 292o) is amended by adding at the end the following new paragraph: "(6) The term "Secretary" means the Secretary of Education."