American Recovery and Reinvestment Act Implementation Plans

U.S. Department of Health and Human Services

June 2010

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Broad Recovery Goals:

HHS has been entrusted with carefully investing $145.7 billion of taxpayer's funds over 10 years for these purposes and the Department is committed to making every dollar count. HHS Recovery Act activities are creating jobs, expanding early care and educational opportunities for children and providing immediate relief to States and local communities. In addition, HHS Programs supported by the Recovery Act serve as the foundation upon which the new Affordable Care Act will be implemented. Taken together, these two landmark pieces of legislation will help bring down healthcare costs for families and businesses, raise the quality of care in this country and give Americans more control over their own health care. The early investments made in health information technology, prevention and wellness, scientific research, training for health care professionals, and resources directed towards maintaining and expanding access to care in the Recovery Act are already paying dividends.

HHS Recovery Act activities touch the lives of Americans by:

- Increasing the number of health care professionals through additional grants to health care workforce training initiatives;
- Computerizing Americans' health records, which will improve the quality of health care, reduce medical errors, and prevent unnecessary health care spending;
- Advancing biomedical research;
- Promoting economic and social well-being of individuals, families, and communities;
- Expanding services for the early care and education of children;
- Strengthening necessary health care services for medically underserved individuals, and as part of the unique relationship between Tribes and the Federal government, providing health care services to American Indians and Alaska Natives;
- Promoting patient-centered research, so that scientifically-valid information on the relative strengths of various medical interventions will be available to clinicians and patients so that they can make informed decisions about their care;
- Expanding access to vaccines and vaccination services and preventing healthcare-associated infections;
- Promoting prevention of disease and improving healthy lifestyles through a large-scale community-oriented prevention initiative, which expands the use of evidence-based strategies and mobilizes local resources at the community level to reduce rates of chronic disease, increase physical activity, improve nutrition, decrease obesity rates and decrease tobacco use.
- Identifying and managing risk to ensure that all Recovery Act funds achieve the goals of the Act and specific program goals.

List of Recovery Programs within HHS:

Improving and Preserving Health Care

- Temporary Increase in Medicaid Federal Medical Assistance Percentage (FMAP)
- Relief to States on payments to Medicare for Part D.
- Medicaid FMAP Implementation
- Temporary Increase in Disproportionate Share Hospital (DSH) Allotments
- Transitional Medical Assistance (TMA) Extension
- Qualified Individuals (QI) Program Extension
- Protections for Indians Under Medicaid and the Children's Health Insurance Program (CHIP)
- Health Professions Training Programs

Accelerating the Adoption of Health Information Technology

- Medicare and Medicaid Incentives for Adoption of Health Information Technology
- The Office of the National Coordinator for Health Information Technology

Strengthening Scientific Research and Facilities

- Scientific Research
- Extramural Lab Construction and Renovation
- Buildings and Facilities
- Shared Instrumentation Grants/Contracts Program

Improving Children and Community Services

- TANF - Emergency Fund
- TANF - Supplemental Grants
- Child Support Enforcement
- Temporary Increase in Foster Care Permanency (FMAP)
- Child Care and Development Fund (CCDF)
- Early Head Start
- Head Start
- Community Services Block Grant
- Strengthening Communities Fund
- Congregate Nutrition Services
- Home-Delivered Nutrition Services
- Native American Nutrition Services

Strengthening Community Healthcare Services

- Health Centers -- Construction, renovation and equipment, and Health Information Technology
- Health Centers -- Services
- Health Professions Training Programs -- National Health Service Corps
- Indian Health Services -- Health Care Facilities Construction
- Indian Health Services-- Sanitation
- Indian Health Services -- Facilities Maintenance and Improvement
- Indian Health Services -- Equipment
- Indian Health Services -- Health Information Technology

Supporting Comparative Effectiveness Research

- NIH
- AHRQ
- Office of the Secretary

Promoting Prevention and Wellness

- "Communities Putting Prevention to Work"
- Section 317 Immunization Program
- Healthcare Associated Infection Reduction Strategies in States

Improving Accountability and Information Technology Security

- HHS Information Technology Security
- Office of the Inspector General

Funding Table:

	Program Level (dollars in billions)
Improving and Preserving Health Care *	$91.6
Accelerating the Adoption of Health IT	25.8
Improving Children & Community Services	13.3
Supporting Scientific Research and Facilities	10.0
Strengthening Community Health Care Services	2.8
Supporting Patient-Centered Research	1.1
Promoting Prevention & Wellness	1.0
Improving Accountability and IT Security	0.1
HHS Total	**$145.7**

* This includes an estimated $4.3 billion in financial relief to States by reducing the amount they would have to pay the Federal government to offset the cost of Medicare coverage for prescription drugs for their residents eligible for both Medicare and Medicaid.

Competition of Contracts (excludes contracts under grants):

Baseline Competition Performance: HHS has achieved great success awarding its contract dollars competitively. In fiscal years 2007 and 2008, HHS awarded 80 percent and 84 percent of its available dollars competitively. Similarly, in fiscal years 2009 and 2010 (to date), HHS awarded 80 percent and 89 percent of its available dollars competitively. The funds that were not available for competition were obligated through statutorily exempt processes, such as the SBA 8(a) Business Development Program and Indian Self-Determination and Education Assistance Act (Section 638).

Recovery Act Competition: HHS issued Department-wide guidance emphasizing its commitment to competitive procedures for Recovery Act-funded acquisitions and its intention to strengthen internal controls to maximize competition. Representatives from HHS's acquisition community meet regularly to share information and lessons, to reinforce the need for contracting officials to be business advisers to their program offices, and to reemphasize the need to steward public funds responsibly. As of April 29, 2010, HHS had awarded 65 percent of its Recovery Act contract dollars competitively. A single $302 million Recovery Act-funded sole-source contract between the National Cancer Institute and its Federally Funded Research and Development Center (FFRDC) accounts for the difference in competition between HHS contracts using all appropriations and its Recovery Act-funded contracts.

Increased Scrutiny of Non-Competitive Recovery Act Contracts: For actions that will not be competed, program and contracting officials have been put on notice that their justifications for other than full and open competition must demonstrate the soundness of limiting competition and withstand public scrutiny. Each of HHS's Justifications for Other than Full and Open Competition is published on the Federal Business Opportunities (FedBizOpps) website.

Periodic Updates: This plan will be updated annually to reflect actual levels of competition, achievements against plans, and issuance of additional competition-related policy.

Contract Type (excludes contracts under grants):

Baseline Contract Type: For fiscal years 2007 and 2008, HHS awarded 45 percent and 38 percent, respectively, of its contract actions on a fixed price basis. In FY 2009 and 2010 (to date) 62 percent and 70 percent, respectively, were fixed price contracts.

Recovery Act Contract Type The Acting Senior Procurement Executive issued, through the Office of Recovery Act Coordination, Department-wide guidance emphasizing HHS' commitment to using fixed price type contracts to award Recovery

Act-funded acquisitions. Representatives from HHS's contracting community meet weekly to share information and lessons, to reinforce the need for contracting officials to be business advisers to their program offices, and to reemphasize the need to steward public funds responsibly. As a result, as of April 29, 2010, 86 percent of HHS Recovery Act-funded contract actions were fixed price.

Increased Scrutiny of Other Than Fixed Price Recovery Act Contracts: For actions that will not be fixed price, program and contracting officials have been put on notice that they must demonstrate the basis for determining the contract type. Accordingly, HHS has developed a standard template to document the basis for determining that a contract using Recovery Act funds could not be fixed price. In addition, non-fixed priced Recovery-funded contract actions must be justified in FedBizOpps.

Periodic Updates: This plan will be updated annually to reflect actual contract types, achievements against plans, and issuance of additional contract type-related policy.

Description of Agency Accountability Mechanisms:

HHS has been moving quickly and carefully to award Recovery Act funds in an open and transparent manner that will achieve the objectives of each Recovery Act program and meet the statute's and President's mandate for accountability and transparency. A Recovery Act Implementation Team, comprised of the heads of the Department's Operating Divisions and Staff Divisions, meets monthly to review specific program plans and Recovery Act policies being implemented in HHS. The Implementation Team's work was refocused in January 2010 from the initial planning phrase to concentrate on:

- Tracking and accelerating obligations and outlays;
- Measuring program performance, such as by the number of new patients served at health centers, the number of meals delivered to seniors, or the number of additional children benefiting from Head Start;
- Informing the public about results;
- Identifying and managing risks;
- Collaborating with other Departments on the Vice President's "Impact Communities" initiative; and
- Reviewing and improving quarterly recipient reporting.

Ensuring accountability has been a key HHS objective from the very beginning of implementation of the Recovery Act. HHS established new policy and technical processes to implement the Recovery Act's transparency and accountability requirements. The Department continues to refine them and establish new ones as necessary. In addition to the Implementation Team, HHS created a Recovery Act Technical Council consisting of senior management officials from the Department's Operating Divisions and the heads of business functions across the Office of the Secretary that meets regularly to address operational issues. The Office of Recovery Act Coordination was established in March 2009 to ensure that HHS fully implements the Act's requirements and OMB's guidance, and provides staff support to these groups.

Examples of ongoing activities to minimize risk and ensure accountability include:

- The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department.
- Focusing, from the very beginning, on designing our programs to identify and mitigate the risks of non-performance and waste, fraud, and abuse in each step of program implementation.
- Working proactively with the Office of Inspector General on the design of our programs to prevent fraud, waste, and abuse.
- Incorporating accountability measures for Recovery Act programs in personnel performance appraisal systems.
- Conducting risk assessments, establishing risk mitigation strategies, and monitoring results.
- Monitoring of program performance reports and financial reports for individual programs by program project officers and contracting officer technical representatives.

Summary of Significant Changes:

The current plan updates the funding chart to take into account actuarial changes in calculating mandatory spending. In addition, the chart reflects new financial relief for States by reducing the amount they would have to pay the Federal government to offset the cost of Medicare coverage for prescription drugs for their residents eligible for both Medicare and Medicaid.

Centers for Medicare & Medicaid Services: Temporary Increase of the Medicaid Federal Medical Assistance Percentage (FMAP)

A. Funding Table

(Outlays in Millions)

Project/Activity	Program Level Estimate	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate	FY 2012 – FY 2019
FMAP Increase	$84,511	$31,511	$38,100	$14,900	$0

*These amounts represent OACT cost estimates of the temporary increase in the Medicaid FMAP provided in the Recovery Act.

B. Objectives

The goal of the increased FMAP provision of the Recovery Act is to provide an increase in the required Federal portion and a corresponding decrease in the non-Federal portion of States' medical assistance expenditures during the recession period; therefore, the general objective is to provide additional Federal support for States during the recession period. The increased Medicaid funding made available under the Recovery Act will prevent health coverage loss and stabilize the system.

Medicaid is a medical assistance program, authorized under title XIX of the Social Security Act, which furnishes medical assistance on behalf of families with dependent children and aged, blind and disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services. The Medicaid program is implemented by each State, under Federal guidelines, and the State's Medicaid expenditures are jointly funded by the State and the Federal government. The Federal government's percentage share of each State's medical assistance expenditures under Medicaid is determined by a formula specified in Medicaid law referred to as the Federal Medical Assistance Percentage (FMAP).

Traditionally under the Medicaid law, each State's FMAP is determined by a formula based on the relationship of each State's per capita income to the national per capita income; the lower a State's per capita income the higher its FMAP. The FMAP is determined for each fiscal year and applies for States' expenditures during that fiscal year. The Recovery Act provides a temporary increase in the State FMAPs during a 9 calendar quarter recession adjustment period beginning October 1, 2008 and ending December 31, 2010.

C. Activities

Additional Federal funds are provided to each State for medical assistance expenditures under the Medicaid program during the recession period. Federal funds for States' medical assistance expenditures are typically provided to States on a quarterly basis through a grant process; the amount of additional funds related to the increased FMAP provision will be provided through a separate grant. CMS provided guidance to States in a series of State Medicaid Director letters, fact sheets

and question and answers that provided guidance on the process for accessing the increased FMAP, expenditures for which the increased FMAP is available, the eligibility "maintenance of effort" (MOE) requirements and the prompt pay requirements.

D. Characteristics

There are three components of the increased FMAP. First, the level of each States' FMAP for Federal Fiscal Years (FFY) 2009, 2010, and the first quarter of FFY 2011 is maintained so it is at least equal to the level from the previous fiscal year. Second, each State will receive a general increase in its FMAP of 6.2 percent. Finally, certain States with relatively high unemployment rates during the recession may receive additional increases in their FMAPs. States' FMAPs will be established for each quarter of the recession period, based on updated unemployment statistics.

The increased FMAP provision applies differently for the five Territories (Puerto Rico, Virgin Islands, Guam, the Northern Mariana Islands and the American Samoas). Each Territory was given the choice of receiving the indicated increase in its FMAP and a 15 percent increase in its cap on the amount of total Federal funds it may receive, or alternatively, to receive a 30 percent increase in its cap with no increase in its FMAP. All Territories opted to receive the 30 percent cap increase.

Increased FMAP funds are provided to States through a grant process on a quarterly basis. States will report to CMS on the use of such funds on a quarterly basis.

To be eligible and to retain eligibility for the increased FMAP, States must meet several conditions, including the following:

- Use increased FMAP for certain allowable Medicaid expenditures.
- Maintain eligibility requirements for Medicaid as in effect on June 30, 2008.
- Comply with prompt payment provisions.
- Report to the Department on the use of these funds.

States may not:

- Deposit or credit the increased funds (directly or indirectly) into a rainy day or reserve fund.
- Require local political subdivisions to contribute to the non-Federal share of States' Medicaid expenditures at a percentage greater than was required on September 30, 2008.

E. Delivery Schedule

Funds are awarded quarterly for FY 2009, FY 2010 and first quarter of FY 2011. Section 5001 of Recovery Act does not specify a fixed amount of funds for these grants. The grant amounts are calculated and obligated quarterly based on the amounts of States' medical assistance expenditures for which the increased FMAP are available.

F. Environmental Review Compliance

The CMS and Department of Health and Human Services are committed to sustainable operations of its activities and facilities through sound environmental stewardship including preferential procurement of environmentally preferred products and electronic stewardship of IT and data center operations.

As programs are developed, CMS will incorporate contract and/or grant language to mitigate the environmental impacts of acquisition of IT and other products and equipment and services and provide guidance to encourage the following:

- Green procurement' based on the HHS Affirmative Procurement Plan and similar guidance from the Environmental Protection Agency (EPA) and the President's Council on Environmental Quality (CEQ)

- Electronic Stewardship including the use of electronic products that are Energy Star® compliant and Electronic Product Environmental Assessment Tool (EPEAT) Silver registered or higher when available; the activation of Energy Star® features on all equipment, when available; environmentally sound 'end-of-life' management practices (including reuse, donate, sell, or recycle 100% of electronic products;) and best operation and management practices for energy efficient data centers.

G. Measures

Outcome / Achievement	FY 09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	Program End
Percentage of increased FMAP dollars claimed by States with respect to the Recovery Act's Prompt Pay Provision. Reported Quarterly	99.84%	99.88%	Pending				
Number of beneficiaries enrolled in the Medicaid program. Reported Quarterly	48,753,871	*Pending	Pending				

*At this time reports have not been received from all States. CMS continues to work with States in order to obtain full reports from every State. An Access database is being developed to store this information. It is in the development and testing stage.

H. Monitoring and Evaluation

The CMS programs are assessed for risk to ensure that appropriate internal controls are in place. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B & C).

CMS' risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team (SAT) ensures that risk assessment objectives are clearly communicated throughout the Department. The CMS has a risk management and Financial Oversight committee, comprised of cross-functional senior leadership, to oversee and manage program implementation, and to address risk across the agency, including risk that impacts financial management. It meets monthly to monitor and assess the effectiveness of mitigation strategies, identify emerging risks and ensure the correction of program weaknesses. The CMS SAT performs an annual assessment in accordance with HHS' guidance regarding OMB circular A-123, Appendix A, Internal Control Over Financial Reporting.

In addition, CMS will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact their success.

States' expenditures are monitored on a quarterly basis by both the States' and CMS. In accordance with the guidelines established by OMB the grant awards being issued will be in a separate account specifically designated by the Treasury for the Recovery Act funds and the States will have to draw these funds from that account. The handling of these grant awards follow the processes CMS has established for issuance of regular Medicaid grant awards as well as reconciliation at the end of the quarter to actual allowable Medicaid expenditures. These processes are well documented in the Medicaid Cycle memo which documents the processes as well as details internal controls in place to mitigate risk.

In addition, States are required to submit quarterly reports on the use of these funds. CMS is working with States that have not submitted the required quarterly reports. In this regard, we have set up a web mail box to which these reports are sent directly. If a State fails to meet requirements with respect to use of the funds, CMS can withhold the increased FMAP funds. In the finalization process, CMS will reconcile the total grants and expenditures following receipt and review of the States' expenditure reports.

In addition to the established CMS monitoring, extensive internal monitoring and external evaluation is conducted around this provision. CMS uses its existing financial management oversight mechanisms to require the return of any Federal funds to which a State was not entitled. CMS works extensively with its Regional Offices to conduct reviews where appropriate and to validate information reported by the States on the use of the increased FMAP funds.

Further, the Office of Inspector General (OIG) has 15 completed audits and 28 ongoing audits related to section 5001, including review of States' compliance with the requirements that must be followed to be eligible for the increased FMAP, and other areas of high risk. For the completed audits, in general, the OIG found that the States reviewed were in compliance with the Recovery Act requirements outlined in section 5001.

Finally the Government Accountability Office is required to report to Congress every 60 days on implementation of the increased FMAP provisions. The stated objectives for these reviews are to examine:

- The extent to which the Federal matching assistance percentage has changed for States under the Recovery Act 2)
- States experiences under the Recovery Act in terms of Medicaid expenditures and enrollment;
- Any programmatic adjustments States have made to their Medicaid programs in light of new funding provided through the Recovery Act; and
- CMS plans to monitor and report on States' use of Recovery Act funds for Medicaid.

Results from these ongoing studies can be found at http://www.recovery.gov/Accountability/Pages/GAOFindings.aspx

I. Transparency

CMS is open and transparent in all of its contracting and grant activities involving Recovery Act funding; the Agency is in compliance with statute and OMB guidance on transparency.

States are the recipients of these funds. As part of the funds draw process, States must attest that they are in compliance with the Recovery Act provisions and are eligible for the increased FMAP.

Regular FMAP funds are deposited by the Federal government into a Payment Management System (PMS) account and are available for States to draw upon for eligible Medicaid expenditures. The increased FMAP funds available to States through the Recovery Act are held in a separate PMS account. States draw the increased funds through a separate transaction and track the funds separately from non-Recovery funds. The amount of State draws of the increased FMAP available through the Recovery Act will be posted on the Recovery.gov website.

An All-State Medicaid Directors' call was held in which States were provided an overview of the Recovery Act Medicaid provisions and written guidance specific to section 5001 was issued to States describing the availability of the fund. During the All-State call, CMS described the reporting requirements and told them that more guidance would be issued once the reporting form and method for collection was finalized.

States report quarterly on the use of the increased funds. States also have to report to CMS on their compliance with the Prompt Payment Provisions. CMS developed a

methodology that States use in calculating their compliance with these provisions. CMS issued the guidance and methodology to all States and provides ongoing technical assistance.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, CMS has built upon and strengthened existing processes. Senior CMS Center for Medicaid, CHIP and Survey and Certification officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

In terms of States' accountability, if States do not report required information or if a State were not to meet the Recovery Act requirements with respect to use of the funds, CMS can withhold increased FMAP funds. Further, CMS will utilize its existing financial management oversight mechanisms to require the return of any Federal funds to which a State was not entitled. Such mechanisms include the disallowance of Medicaid expenditures funded by the increased FMAP. This disallowance action would involve formal notice to the State as well as provide the State an opportunity for a hearing to the Departmental Appeals Board.

K. Barriers to Effective Implementation

CMS and States have identified barriers to effective implementation of this provision. One of those barriers is the requirement that States maintain "eligibility standards, methodologies, or procedures" under its Medicaid Program that are not more restrictive during the defined recession period than those in effect on July 1, 2008. Any more restrictive eligibility precludes a State from accessing the increased FMAP funds until the State had restored eligibility standards, methodologies or procedures to those in effect on July 1, 2008. Some States initially delayed the draw of the increased funds due to difficulty meeting this requirement or assessing whether they currently meet this requirement. As of June 15, 2009, all States met these requirements and were able to draw the increased funds.

Another barrier to effective implementation is that some States had to change claims payment and reporting systems to meet these statutory requirements. States have to report quarterly information to CMS that it never reported previously (e.g., compliance with Prompt Payment Provisions). In addition, States have to report to CMS information on how the funding associated with the increased FMAP were used at the State which will include documentation that no funds were directly or indirectly placed in a rainy day or reserve account as well as detailed information on what the funds were used for which may include non-Medicaid related expenses. Many of these reporting requirements are resource issues for States. Changes were made to the Federal Medicaid Expenditure reporting system (Medicaid Budget and Expenditure System (MBES)) to allow for separate expenditure reporting of the increased FMAP funds.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

- Updated Section A to reflect actual 09 outlays and estimated FY10 and first quarter FY11 outlays (program ends 12/31/10).
- Added a chart to Section G to identify the actual percentage of increased FMAP dollars claimed by States with respect to the Recovery Act's Prompt Pay Provision and the number of beneficiaries enrolled in the Medicaid program.
- Updated Section H to include the audit work already performed by both OIG and GAO.
- Updated Sections F, H and I to reflect updated HHS policies on Environmental Review Compliance, Monitoring and Evaluation, and Transparency.

Office of the Secretary: Funding for Oversight and Implementation – Implementation of Increased Federal Medical Assistance Percentage (FMAP)

A. Funding Table for Mandatory Programs:

(Dollars in millions)

Project/Activity	Program Level	FY 2009	FY 2009 Actual Obligations	FY 2010 Estimate	FY 2011 Estimate	FY 2012-2019 Estimate
CMS	$4.27	$1.52	$1.52	$2.43	$.40	$0
ACF	$.67	$.26	$.26	$.27	$.07	$0
ASPE	$.06	$.02	$.02	$.03	$0	$0
Total Amount	$5.00	$1.81	$1.80	$2.72	$.48	$0

B. Objectives

The purpose of these funds is to implement section 5001- Temporary Increase of the Federal Medical Assistance Percentage (FMAP) for Medicaid, Foster Care, and Adoption Assistance. Generally, Section 5001 of the Recovery Act provided for an increase in the States' FMAPs during a 9-calendar quarter recession adjustment period beginning October 1, 2008 and ending December 31, 2010. The Recovery Act provided $5 million to the Office of the Secretary of HHS for implementation of the increased FMAP provision. The Secretary will allocate funds to the Centers for Medicare & Medicaid Services (CMS), the Administration for Children and Families (ACF), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) for costs associated with implementing the provision on a quarterly basis for FY 2010 and FY 2011.

C. Activities

Estimates for FY 2010 (dollars in thousands)

Agency	Project/Activity	FY 2010
CMS	FTEs	$2,374
	Systems Changes	$55
CMS Total Amount		**$2,429**
ACF	FTEs	$153.5
	IT, Grant Making, and Reporting	$107
	PSC Charges	$6.5
ACF Total Amount		**$267**
ASPE	FTEs	$30
ASPE Total Amount		**$30**

The following activities will be performed to implement section 5001. For ACF, funds will be needed for staff and overhead (1 FTE in 2009 & 2010; .5 FTE in 2011), IT, grant making (the GATES system), reporting, and PSC Charges. PSC Charges are based on current rates for Payment Management Services and the estimated # of grants (10% inflation). In FY 2010, ACF anticipates that systems costs will decline and therefore, funds will be

used to pay the federal FTE costs for the grants and program offices. Staff time will be spent providing training and technical assistance to States, as well as reviewing expenditure reports and awarding FY 2010 funds. ACF also will be continuing to ensure that systems can provide support for awarding grants and reporting on the FMAP funds. Fees based on the number of documents processed through the PMS system will also be paid.

For CMS, funds will be used for the costs of employees working on the implementation of provisions of the Recovery Act related to Medicaid and CHIP; for the costs of employees (16.5 FTEs in FY 2010) needed for continued oversight and reporting on the increased FMAP; and to make the systems changes to CMS accounting/payment systems necessary to make the increased FMAP grant awards. CMS has the additional responsibility of working with States to ensure that they meet the requirements of Section 5001(f) (Maintenance of Eligibility) and Section 5001(f)(2) (States Prompt-Pay for Providers).

ASPE obtains annual State and National per capita income data and quarterly unemployment data from other Federal agencies in order to calculate the Federal Medical Assistance Percentages for each State. Funds will be needed for staff to coordinate the receipt of this information (e.g., BLS for unemployment data). ASPE is also responsible for publishing the rates in the Federal Register. Funds will be needed for the calculations and reporting of adjustments on a quarterly basis (FTE in each year of ARRA).

D. Characteristics

Section 5007 of the Recovery Act appropriated $5 million to the Secretary. Funds from the Secretary will be allocated to CMS, ACF, and ASPE for costs of implementation activities.

E. Delivery schedule

Funds will be allocated to ASPE, CMS, and ACF upon submission and approval of request for funds to carry out Section 5007(b) of the Recovery Act for FY 2010 and FY 2011.

F. Environmental Review Compliance

In general, the use of these funds: (1) mitigates social and environmental impacts; (2) does not include facility construction or alterations of the human environment; and (3) have no anticipated individual or cumulative significant effect on natural or cultural assets.

The environmental impact for acquisition and use of IT and other products and equipment will be mitigated by compliance with criteria described in Executive Orders 13514, 13423 and the HHS Sustainable Building Implementation Plan and the HHS Affirmative Procurement Plan (APP).

Both E.O.s are complementary in that they require federal agencies to take steps to reduce environmental impacts. E.O. 13514 specifically addresses Green House Gas and the role of advancing sustainable acquisitions and electronic stewardship in mitigating impacts from emissions. The E.O. 13423 requires that preference be given to the purchase of EPEAT-registered electronic products and at least 95 percent of electronic products be EPEAT-registered unless there is no EPEAT standard. When available, the purchase of EPEAT Silver-rated electronic products or higher is required.

The APP has five major objectives: 1) Inform all appropriate HHS employees on the requirements of the Federal green procurement preference programs, their roles and responsibilities relevant to these programs and the

opportunities to purchase green products and services; 2) Promote purchase of green products and services to the maximum extent practicable, consistent with the demands of mission, efficiency, cost-effectiveness, and performance with continual improvement toward meeting federally established procurement goals; 3) Reduce the amount of solid and hazardous waste generated; 4) Reduce the consumption of energy and natural resources; and, 5) Expand markets for green products and services.

The distribution of additional funds for FMAP as a result of the Recovery Act is determined to be categorically excluded based on a Category 2.f - :Functional Exclusion: Grants for Social Services" and Category 2.c "Functional Exclusion: Information Technology Management" under Chapter 30-20-30 of the HHS General Administration Manual.

To fulfill the environmental review process, the program manager under consultation with the DHHS Environmental Program Manager, will document the categorical exclusions through a memorandum to the record.

This activity is funded under the Recovery Act Division B and is not subject to Section 1609(c) reporting requirements.

G. Measures

Compliance with the implementation of Section 5001 will be evaluated on a quarterly basis. A report that will provide specific detail on how the operating divisions are using these funds and ensuring they are meeting all applicable requirements of the Recovery Act will be produced quarterly.

Outcome / Achievement	**Units**	**Type**	**9/30 /09**	**12/31/ 09**	**3/31/ 10**	**6/30/ 10**	**9/30/ 10**	**12/31/ 10**	**3/31/ 11**	**6/30/ 11**	**9/30/ 11**	**Program End**
Number of quarters that the FMAP is calculated and published in the Federal Register in a timely fashion.	# of quarters	TARGET	1	2	3	4	5	6	7	8	9	9
		ACTUAL	1	2	3							
The number of quarters in which the increased FMAP is implemented and recovery funds provided to States for relief to State budgets by increasing the Federal payments to States.		TARGET	1	2	3	4	5	6	7	8	9	9
		ACTUAL	1	2	3							

H. Monitoring/Evaluation

All Recovery Act programs will be assessed for risk and to ensure that appropriate internal controls are in place throughout the entire funding cycle. These assessments will be done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B & C).

ACF, APSE, and CMS's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. ACF, ASPE, and CMS's Senior Assessment Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets weekly/monthly/quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, ACF, ASPE, and CMS has presented/will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success."

The recipient organizations involved will provide to ASFR periodic reports of staff work needed to implement the increased FMAP provisions. ASFR will analyze the reports and determine whether the fund allocation is appropriate and adjust it as necessary.

I. Transparency

ASPE, CMS, and ACF will be open and transparent in all of its expenditures that involve spending of Recovery Act funding consistent with statutory and OMB guidance.

- Quarterly reporting on the use of the funds related to the implementation from ASPE, CMS, and ACF

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, ASPE, ACF, and CMS will build on and strengthen existing processes. Senior ASPE, CMS, and ACF officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system will also incorporate Recovery Act program stewardship responsibilities for program and business function managers.

ASPE, CMS, and ACF will continue to use their existing internal control infrastructure to implement this provision. Standard FTE accountability measures will apply to the use of these funds. To the extent that ASPE, CMS, and ACF find expenditures that are not allowable or in excess of what is needed for implementation, ASPE, CMS, and ACF will initiate recovery of any unallowable funds.

K. Barriers to Effective Implementation

Not applicable

L. Federal Infrastructure investments

The agency plans to spend funds effectively to comply with energy efficiency and to demonstrate Federal leadership in sustainability, energy efficiency and reducing the agency's environmental impact. The acquisition and use of IT and other products and equipment will be compliant with criteria described in Executive Orders 13514 and 13423 the Sustainable Buildings Implementation Plan and the HHS Affirmative Procurement Plan (APP).

E.O. 13514 specifically addresses Green House Gas and the role of advancing sustainable buildings, sustainable acquisitions, and electronic stewardship in mitigating impacts from emissions. The E.O. 13423 requires that preference be given to the purchase of EPEAT-registered electronic products and at least 95 percent of electronic products be EPEAT-registered unless there is no EPEAT standard. When available, the purchase of EPEAT Silver-rated electronic products or higher will be required. The EPEAT is intended to help purchasers in the public and private sectors evaluate, compare, and select desktop computers, notebooks and monitors based on their environmental attributes. The EPEAT website is: http://www.epeat.net/.

The APP has five major objectives: 1) Inform all appropriate HHS employees on the requirements of the Federal green procurement preference programs, their roles and responsibilities relevant to these programs and the opportunities to purchase green products and services; 2) Promote purchase of green products and services to the maximum extent practicable, consistent with the demands of mission, efficiency, cost-effectiveness, and performance with continual improvement toward meeting federally established procurement goals; 3) Reduce the amount of solid and hazardous waste generated; 4) Reduce the consumption of energy and natural resources; and, 5) Expand markets for green products and services.

The HHS Affirmative Procurement Plan (APP) applies to: a) All agency acquisitions, including micro-purchases and purchase card transactions, in which an EPA-designated item is acquired; b) Contractor Operated, Government-owned (GOCO) HHS facilities; and c) State and local recipients of assistance funding. The latest version (April 2009) of the HHS' APP is available from Division of Acquisition Program Support.

The HHS grants policy emphasizes sustainable design considerations should be included to the maximum extent feasible in construction or modernization grants or activities funded at $1 million or more (AAGAM Chapter 6.99.106-3). Implementing sustainable design principles serves to mitigate health, social and environmental impacts and further the National commitment to reducing energy, and green house gas and related emissions.

Summary of Significant Changes

- Updated Section A to reflect actual 09 outlays, estimated FY10 outlays, estimated FY11 outlays, and estimated FY12-19 outlays.
- Updated Section C with a chart showing activities by Operating Division.
- Updated Sections F, H and I to reflect updated HHS policies on Environmental Review Compliance, Monitoring and Evaluation, and Transparency.
- Updated Section G with additional measure.

Centers for Medicare & Medicaid Services: Extension of Transitional Medical Assistance (TMA)

A. Funding Table

(Outlays in Millions)

Project/Activity	Program Level Estimate	FY 2009 Estimate	FY 2010 Estimate	FY 2011 Estimate	FY 2012 – FY 2019 Estimate
TMA Extension	$915	$30	$480	$395	$10

*Cost impacts for this provision are actuarial estimates

B. Objectives

This provision of the Recovery Act provides low-income families with the ability to maintain their Medicaid health care coverage as they transition into employment and increase their earnings. This allows for continued medical care as individuals return to the workforce, which will preserve continuity of care. The Recovery Act provides new options to States to simplify Transitional Medical Assistance (TMA) and make it easier for families to keep TMA's extended Medicaid coverage for a full 12 months after an increase in earnings would make them ineligible for Medicaid. The sunset date for TMA coverage is extended from June 30, 2009 to December 31, 2010.

C. Activities

Implementation of this provision is accomplished through State Medicaid Director's Letter (SMD) and State Plan Amendments. State Plan Amendments are used when a State selects options offered by the Recovery Act related to TMA eligibility requirements. No action from States is required related to the extension of the sunset date for this mandatory Medicaid coverage.

CMS works with States to modify their Medicaid State plans. Guidance for States was issued in the form of a State Medicaid Director letter and guidance from the CMS Regional Offices was issued about the policy changes.

CMS makes grants to States as part of the regular Medicaid grant awards.

D. Characteristics

Awards are made to States. Transitional medical assistance (TMA) is an integral part of a State's Medicaid grant award. As such, TMA overlaps with one or more of the other ARRA provisions affecting Medicaid. Amounts displayed in Section A are based on actuarial estimates of the aggregate Federal cost of extending TMA through December 2010 as provided by section 5004 of the ARRA.

E. Delivery Schedule

CMS issued a letter to State Medicaid Directors explaining the TMA provisions in the Recovery Act on April 6, 2009. Additional guidance related to the data elements to

be reported and the manner and frequency of reporting was issued by each CMS Regional Office to the States in its region.

F. Environmental Review Compliance

The CMS and Department of Health and Human Services are committed to sustainable operations of its activities and facilities through sound environmental stewardship including preferential procurement of environmentally preferred products and electronic stewardship of IT and data center operations.

As programs are developed, CMS will incorporate contract and/or grant language to mitigate the environmental impacts of acquisition of IT and other products and equipment and services and provide guidance to encourage the following:

A. Green procurement' based on the HHS Affirmative Procurement Plan and similar guidance from the Environmental Protection Agency (EPA) and the President's Council on Environmental Quality (CEQ)

B. Electronic Stewardship including the use of electronic products that are Energy Star® compliant and Electronic Product Environmental Assessment Tool (EPEAT) Silver registered or higher when available; the activation of Energy Star® features on all equipment, when available; environmentally sound 'end-of-life' management practices (including reuse, donate, sell, or recycle 100% of electronic products;) and best operation and management practices for energy efficient data centers.

G. Measures

Outcome / Achievement	FY 09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	Program End
Number of States streamlining eligibility for the newly employed/1	12	12	12				
Number of people enrolled in Transitional Medical Assistance/2							

/1 Medicaid State plan amendment submissions to implement these options are reviewed by CMS Central Office and Regional Office staff prior to approval. The number of States submitting State Plan Amendments (SPAs) applying the streamlined procedures to their TMA program will be reported.

The number of approved SPAs are tracked via the State Plan and Waiver database and will be reported quarterly until the first quarter following the expiration of the TMA authority in December 31, 2010, i.e. March 31, 2011. The SPAs will be available publicly via the Electronic-State Plan Amendment (eSPA) system on a gradual basis, as the system is fully implemented

/2 Data for measure 2 will not be available until the end of 2010 due to retroactive eligibility and the lag time for extracting data from the eligibility files in MMIS by the States.

H. Monitoring and Evaluation

The CMS programs are assessed for risk to ensure that appropriate internal controls are in place. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B & C).

CMS' risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team (SAT) ensures that risk assessment objectives are clearly communicated throughout the Department. The CMS has a risk management and Financial Oversight committee, comprised of cross-functional senior leadership, to oversee and manage program implementation, and to address risk across the agency, including risk that impacts financial management. It meets monthly to monitor and assess the effectiveness of mitigation strategies, identify emerging risks and ensure the correction of program weaknesses. The CMS SAT performs an annual assessment in accordance with HHS' guidance regarding OMB circular A-123, Appendix A, Internal Control Over Financial Reporting.

In addition, CMS will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact their success.

The risk could be mitigated in this mandatory eligibility group due to the simplified eligibility requirements. However, CMS will continue to use its existing internal controls to implement these provisions, i.e., CMS will examine actual expenditures claimed for appropriateness within the Medicaid program requirements.

In addition, CMS will work on an ongoing basis with the Office of Inspector General (OIG) to coordinate oversight and audit activity and focus on performance.

I. Transparency

CMS is open and transparent in all of its contracting and grant activities involving Recovery Act funding; the Agency is in compliance with statute and OMB guidance on transparency.

Guidance in the form of a State Medicaid Director's letter is posted online.
The implementation of eSPA, a web-based application that will automate the current paper-based Medicaid State Plan amendment process, will make approved Medicaid State plan amendments will be available online.

The Recovery Act requires all States to collect and submit to the Department of Health and Human Services (HHS) and to make publicly available, information on the average monthly enrollment and average monthly participation rates for adults and children covered under TMA. Guidance related to this reporting was issued to States.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, CMS has built upon and strengthened existing processes. Senior CMS Center for Medicaid, CHIP, and Survey & Certification officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

K. Barriers to Effective Implementation

No barriers were identified. States currently operate transitional medical assistance. The Recovery Act reduces requirements rather than adds to them.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

- Updated Section A to reflect estimated FY09 and FY10 outlays.
- Updated Sections F, H and I to reflect updated HHS policies on Environmental Review Compliance, Monitoring and Evaluation, and Transparency.

Centers for Medicare & Medicaid Services: Temporary Increase in Medicaid DSH Allotments

A. Funding Table

(Outlays in Millions)

Project/Activity	Program Level Estimate	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate	FY 2012 – FY 2019
DSH Allotment Increase	$595	$75	$520	$0	$0

* These amounts represent HHS Office of the Actuary cost estimates of the temporary increase in Medicaid DSH allotments.

B. Objectives

The purpose of the temporary increase in Medicaid Disproportionate Share Hospital (DSH) payment allotments is to provide additional State fiscal relief through easing the strain on hospitals that provide uncompensated care to vulnerable populations. Eligible hospitals that serve a disproportionate share of low-income or uninsured individuals are entitled to receive DSH payments. States receive an annual allotment to make payments to DSH hospitals to account for higher costs associated with treating uninsured and low-income patients. This annual allotment is calculated by law and includes requirements to ensure that the DSH payments to hospitals are not higher than the actual costs incurred by the hospitals to provide the uncompensated care. These payments are in addition to the regular payments such facilities receive for providing care to Medicaid beneficiaries.

C. Activities

Prior to the Recovery Act, the FY 2009 Federal Medicaid DSH allotments for all States totaled approximately $11.1 billion. After the 2.5% increase authorized by the Recovery Act, the total DSH allotments increased by $268.8 million to a total of $11.3 billion. Notice of State allotments for FY 2010 were issued on April 23, 2010, through the Federal Register notice CMS-2300-N.

D. Characteristics

Section 5002 provides additional fiscal relief to States by increasing most States Federal fiscal year (FFY) 2009 and 2010 Medicaid DSH allotments by 2.5 percent. The Medicaid DSH allotment calculation is based upon a statutory formula in section 1923 of the Social Security Act. Increased DSH allotments are provided to States through a grant process on an annual basis. States will continue to report to CMS on the use of such funds as usual though submission of the quarterly expenditure reports.

E. Delivery Schedule

HHS announced the revised preliminary calculations for the FY 2009 Medicaid DSH allotments in March 2009. CMS announced the revised preliminary DSH allotments

for FY09 and FY10 through Federal Register Notice CMS-2300-N, issued on April 23, 2010. Any additional funds requested by States for Medicaid DSH payments are handled through separate Medicaid grant awards.

States will have to first exhaust their original FY 2009 and FY 2010 Federal Medicaid DSH allotments (un-adjusted by the Recovery Act) before they can access the increased portion of their Federal Medicaid DSH allotments as authorized under the Recovery Act.

F. Environmental Review Compliance

The CMS and Department of Health and Human Services are committed to sustainable operations of its activities and facilities through sound environmental stewardship including preferential procurement of environmentally preferred products and electronic stewardship of IT and data center operations.

As programs are developed, CMS will incorporate contract and/or grant language to mitigate the environmental impacts of acquisition of IT and other products and equipment and services and provide guidance to encourage the following:

- Green procurement' based on the HHS Affirmative Procurement Plan and similar guidance from the Environmental Protection Agency (EPA) and the President's Council on Environmental Quality (CEQ)

- Electronic Stewardship including the use of electronic products that are Energy Star® compliant and Electronic Product Environmental Assessment Tool (EPEAT) Silver registered or higher when available; the activation of Energy Star® features on all equipment, when available; environmentally sound 'end-of-life' management practices (including reuse, donate, sell, or recycle 100% of electronic products;) and best operation and management practices for energy efficient data centers.

G. Measures

Outcome / Achievement	FY 09	12/31/09	3/31/10	6/30/10	9/30/10	Program End
Number of States drawing temporary increase in Medicaid DSH funds. Reported quarterly.	14	16	22			

*Data source: Payment management system. States' expenditures are reported on a quarterly basis to CMS. States report to CMS through the quarterly expenditure process how much of the increased Medicaid DSH allotment they expended. States have to first demonstrate that they expended the full amount available under the regular Medicaid DSH allotments before drawing Recovery Act DSH funds.

H. Monitoring and Evaluation

The CMS programs are assessed for risk to ensure that appropriate internal controls are in place. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B & C).

CMS' risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team (SAT) ensures that risk assessment objectives are clearly communicated throughout the Department. The CMS has a risk management and Financial Oversight committee, comprised of cross-functional senior leadership, to oversee and manage program implementation, and to address risk across the agency, including risk that impacts financial management. It meets monthly to monitor and assess the effectiveness of mitigation strategies, identify emerging risks and ensure the correction of program weaknesses. The CMS SAT performs an annual assessment in accordance with HHS' guidance regarding OMB circular A-123, Appendix A, Internal Control Over Financial Reporting.

In addition, CMS will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact their success.

States' expenditures will be monitored on a quarterly basis by both the States' and CMS. In accordance with the guidelines established by OMB, any funding to States related to the increased DSH allotment will be issued in a separate account specifically designated by the Treasury for the Recovery Act funds and the States will have to draw these funds from that separate account. The handling of these grant awards will follow the processes CMS has established for issuance of regular Medicaid grant awards as well as reconciliation at the end of the quarter to actual allowable Medicaid DSH expenditures. These processes are well documented in the Medicaid Cycle memo which documents the processes as well as details internal controls in place to mitigate risk.

As part of the regular quarterly expenditure reporting process, CMS evaluates which portion of Medicaid DSH expenditures are a result of the increased Medicaid DSH allotments. Further, in order to access the additional increased DSH allotment, States have to demonstrate through their quarterly budget and expenditure reporting mechanism that they have fully expended their regular DSH allotment.

CMS uses its existing internal control infrastructure to implement these provisions, i.e., CMS examines actual expenditures claimed for appropriateness within the

Medicaid DSH program requirements. To the extent CMS finds Medicaid DSH expenditures that are not allowable under the Medicaid statute; CMS will initiate recovery of any unallowable funds.

I. Transparency

CMS is open and transparent in all of its contracting and grant activities involving Recovery Act funding; the Agency is in compliance with statute and OMB guidance on transparency.

The actual increased DSH allotments are published through the Federal Register. The actual amounts of funding made available to States as a result of the increased DSH allotments are also available on www.hhs.gov/recovery/.

Finally, States must report to CMS on a quarterly basis their Medicaid expenditures, including expenditures related to Medicaid DSH payments. In accordance with the guidelines established by OMB, any funding to States related to the increased DSH allotment will be issued in a separate account specifically designated by the Treasury for the Recovery Act funds and the States will have to draw these funds from that separate account.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, CMS has built upon and strengthened existing processes. Senior CMS Center for Medicaid, CHIP and Survey & Certification officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

In addition, CMS uses its existing financial management oversight mechanisms to require the return of any Federal funds to which a State was not entitled. Such mechanisms include the disallowance of Medicaid DSH expenditures funded under the increased DSH allotment. This disallowance action would involve formal notice to the State as well as provide the State an opportunity for a hearing to the Departmental Appeals Board.

K. Barriers to Effective Implementation

Changes were made to the Federal Medicaid Expenditure reporting system (Medicaid Budget and Expenditure System MBES) to allow for separate expenditure reporting of the increased DSH funds. In addition, States are required to separately document and justify the need for the funding available under the increased Medicaid DSH allotment in their routine budget request. Any additional reporting for States is a resource issue for them.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

- Updated Section A to reflect actual 09 outlays and estimated FY10 outlays.
- Added a chart to Section G to identify the actual Number of States drawing temporary increase in Medicaid DSH funds per quarter.
- Updated Sections F, H and I to reflect updated HHS policies on Environmental Review Compliance, Monitoring and Evaluation, and Transparency.

Centers for Medicare & Medicaid Services: Extension of the Qualified Individual (QI) Program

A. Funding Table

(Outlays in Millions)

Project/Activity	Program Level Estimate	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate	FY 2012 – FY 2019
QI Program Extension	$562.5	$0	$412.5	$150	$0

B. Objectives

The purpose of the funds is to extend the Qualified Individuals (QI) program. The QI program pays the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 and 135 percent of the Federal poverty level. States receive 100 percent Federal funding for the QI program. The Recovery Act provided funding through a normal extension of the QI program from its previous expiration of January 1, 2010 for twelve months to December 31, 2010. CMS estimates a total of $562.5 million will be needed by the States for this 12 month period.

This provision is the continuation of the historical practice of handling the QI program. The program is routinely continued, under the authorization of Congress, for certain time-limited periods. Congress periodically extends the program when necessary. The most recent Congressional action with respect to the QI program was through the Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110–275) and the QI Supplemental Funding Act of 2008 (P.L. 110-379).

C. Activities

The regular actions taken for all QI extensions apply to this funding. Notice of State allotments were published in the Federal Register. As part of this process, CMS works with States to understand what each States' projected funding needs for the QI program will be. CMS then bases the individual State allotments on this information.

D. Characteristics

The States are notified of their QI allotments through the Federal Register Process. CMS also solicits relevant expenditure information from States in order to properly determine the actual allotments. In 1997, the Medicaid statute was amended to require States to provide for Medicaid payment of the Medicare Part B premiums for two additional eligibility groups of low-income Medicare beneficiaries, referred to as QIs; however, since 2002, only one eligibility group has been continued. The statute limits the total amount of Federal funds available for payment of part B premiums for QIs each fiscal year and specifies the formula that is to be used to determine an allotment for each State from this total amount. The Federal medical assistance percentage for Medicaid payment of Medicare Part B premiums for QIs, is 100 percent for expenditures up to the amount of the State's allotment.

States receive the available Federal funding for payment of these premiums through the regular Medicaid grant award process.

E. Delivery Schedule

This funding available to States is applicable for the period January 1, 2010 through December 31, 2010. CMS announced the State 2009 and 2010 QI allotments through its regular Federal Register QI notice and actual funds are made available to States through the regular quarterly grant award process.

F. Environmental Review Compliance

The CMS and Department of Health and Human Services are committed to sustainable operations of its activities and facilities through sound environmental stewardship including preferential procurement of environmentally preferred products and electronic stewardship of IT and data center operations.

As programs are developed, CMS will incorporate contract and/or grant language to mitigate the environmental impacts of acquisition of IT and other products and equipment and services and provide guidance to encourage the following:

- Green procurement' based on the HHS Affirmative Procurement Plan and similar guidance from the Environmental Protection Agency (EPA) and the President's Council on Environmental Quality (CEQ)

- Electronic Stewardship including the use of electronic products that are Energy Star® compliant and Electronic Product Environmental Assessment Tool (EPEAT) Silver registered or higher when available; the activation of Energy Star® features on all equipment, when available; environmentally sound 'end-of-life' management practices (including reuse, donate, sell, or recycle 100% of electronic products;) and best operation and management practices for energy efficient data centers.

G. Measures

Outcome / Achievement	FY 09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	Program End
Maintain the QI Program: Number of individuals who receive QI benefits	4,563,815	5,626,407	5,626,407				

*Data Source: Centers for Medicaid, CHIP and Survey & Certification. CMS generally receives a monthly report from States indicating who is on the QI program. CMS will report the number of individuals who receive QI benefits for the period 1/1/2010 through 12/31/2010.

H. Monitoring and Evaluation

The CMS programs are assessed for risk to ensure that appropriate internal controls are in place. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B & C).

CMS' risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team (SAT) ensures that risk assessment objectives are clearly communicated throughout the Department. The CMS has a risk management and Financial Oversight committee, comprised of cross-functional senior leadership, to oversee and manage program implementation, and to address risk across the agency, including risk that impacts financial management. It meets monthly to monitor and assess the effectiveness of mitigation strategies, identify emerging risks and ensure the correction of program weaknesses. The CMS SAT performs an annual assessment in accordance with HHS' guidance regarding OMB circular A-123, Appendix A, Internal Control Over Financial Reporting.

In addition, CMS will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact their success.

States' expenditures will be monitored on a quarterly basis by both States and CMS. In accordance with the guidelines established by OMB, any funding to States related to continuation of the QI allotments will be issued in a separate account specifically designated by the Treasury for the Recovery funds and the States will have to draw these funds from that separate account. The handling of these grant awards will follow the processes CMS has established for issuance of regular Medicaid grant awards as well as reconciliation at the end of the quarter to actual expenditures. These processes are well documented in the Medicaid Cycle memo which documents the processes as well as details internal controls in place to mitigate risk.

CMS will continue to use its existing internal control infrastructure to implement these provisions, i.e., CMS will examine actual expenditures claimed for appropriateness within the Medicaid program requirements and will monitor State compliance with statutory requirements. To the extent CMS finds expenditures that are not allowable or in excess of the State's specific allotment, CMS will initiate recovery of any unallowable funds. In addition, CMS will work on an ongoing basis with the Office of Inspector General (OIG) to coordinate oversight and audit activity.

I. Transparency

CMS is open and transparent in all of its contracting and grant activities involving Recovery Act funding; the Agency is in compliance with statute and OMB guidance on transparency. CMS reports weekly all of its financial activity by Program and by State. This information is posted weekly at http://www.hhs.gov/recovery/reports/index.html.

Finally, States must report to CMS on a quarterly basis their Medicaid expenditures, including expenditures related to QI payments (note that QI is funded separately from the Medicaid program as a whole). In accordance with the guidelines established by OMB, any funding to States related to the QI allotment will be issued in a separate account specifically designated by the Treasury for the Recovery Act funds and the States will have to draw these funds from that separate account.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, CMS has built upon and strengthened existing processes. Senior CMS Center for Medicaid, CHIP and Survey & Certification officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

In addition, CMS will utilize its existing financial management oversight mechanisms to require the return of any Federal funds to which a State was not entitled. Such mechanisms include the disallowance of expenditures funded under the QI allotment. This disallowance action would involve formal notice to the State as well as provide the State an opportunity for a hearing to the Departmental Appeals Board.

K. Barriers to Effective Implementation

No barriers were identified. The Recovery Act included a normal continuation of the QI allotments and the processes of allotting and disbursing the funds is the same. Congress authorizes the allotments for a set period of time and then periodically extends the applicable periods.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

- Updated Section A to reflect actual FY09 outlays and estimated FY10 and first quarter FY11 outlays (QI extension ends 12/31/10).

- Added a chart to Section G identifying the actual Number of individuals who receive QI benefits.

- Updated Sections F, H and I to reflect updated HHS policies on Environmental Review Compliance, Monitoring and Evaluation, and Transparency.

Centers for Medicare & Medicaid Services: Protections for Indians Under Medicaid and CHIP

A. Funding Table

(Outlays in Millions)

Project/Activity	Program Level Estimate*	FY 2009 Estimate*	FY 2010 Estimate*	FY 2011 Estimate*	FY 2012 – FY 2019*
Protections for American Indians/Alaskan Natives under Medicaid	$150.0	$5.0	$10.0	$10	$125.0

*Cost impacts for this provision are actuarial estimates

B. Objectives

The purpose of these provisions is to offer protections to Indian populations covered under Medicaid and the Children's Health Insurance Program (CHIP). This section prohibits State Medicaid programs from imposing cost-sharing on Medicaid-eligible American Indians and Alaska Natives (AIANs) for services that are provided directly or upon referral by Indian Health programs. This prohibits the collection of premiums, co-payments, or deductibles. Also, States may not consider the value of certain property when determining the Medicaid or CHIP eligibility of AI/ANs. Finally, certain income, resources, and property must be exempted from Medicaid estate recoveries.

In Medicaid managed care programs, AIANs are guaranteed the right to choose an Indian heath care provider (as a primary care provider or outside of the managed care network). Access to sufficient numbers of Indian health care providers must be guaranteed. Special payment provisions are provided for Indian health care providers and clinics. Also, Indian Medicaid managed care programs may exclude non-Indians from enrollment with them.

The CMS Tribal Technical Advisory Group (TTAG) is officially recognized in law, to consult with CMS on policies impacting the tribes. Also, States are required to seek advice from Indian Health Programs and Urban Indian Organizations prior to submitting a Medicaid State plan amendment, waiver, or other proposal that would directly impact Indian populations.

C. Activities

CMS is working with States to incorporate these changes into their Medicaid State plans. Guidance for States was issued in the form of a State Medicaid Director letter and collaborative public/private development of regulations about the policy changes.

D. Characteristics

There are no grant awards or funds associated with this provision.

E. Delivery Schedule

The effective date of these provisions was July 1, 2009. The guidance on these provisions was issued on January 22, 2010. The prohibition of cost-sharing for Indians is being included in the final rule entitled "Medicaid Program; Premiums and Cost Sharing." The rule was reopened for comments between March 26 and April 27, 2009. The effective date of the final rule is delayed until July 1, 2010. The delay of the effective date of this regulation does not delay the implementation of the requirements of this legislation.

F. Environmental Review Compliance

The CMS and Department of Health and Human Services are committed to sustainable operations of its activities and facilities through sound environmental stewardship including preferential procurement of environmentally preferred products and electronic stewardship of IT and data center operations.

As programs are developed, CMS will incorporate contract and/or grant language to mitigate the environmental impacts of acquisition of IT and other products and equipment and services and provide guidance to encourage the following:

- Green procurement' based on the HHS Affirmative Procurement Plan and similar guidance from the Environmental Protection Agency (EPA) and the President's Council on Environmental Quality (CEQ)

- Electronic Stewardship including the use of electronic products that are Energy Star® compliant and Electronic Product Environmental Assessment Tool (EPEAT) Silver registered or higher when available; the activation of Energy Star® features on all equipment, when available; environmentally sound 'end-of-life' management practices (including reuse, donate, sell, or recycle 100% of electronic products;) and best operation and management practices for energy efficient data centers.

G. Measures

CMS will report the number of approved SPAs implementing the requirement to solicit advice from individuals who represent the interests of AI/AN populations. The number of SPAs that are submitted by States having at least one Indian Health Program or Urban Indian Organization will be compared to the total number of such States.

Outcome / Achieve-ment	FY 09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
Number	N/A*									

Outcome / Achieve-ment	FY 09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
of States soliciting advice from AI/AN communities										

* The number of approved SPAs are tracked via the State Plan and Waiver database and will be reported quarterly. Guidance including the required State Plan page was issued January 22, 2010 which does not require States to submit a State Plan amendment until the Paperwork Reduction Act process is completed. The process is estimated to be completed during the summer of 2010 and CMS anticipates that States will submit their plans following that date. Consequently no States have completed the State plan amendment process to date.

H. Monitoring and Evaluation

The CMS programs are assessed for risk to ensure that appropriate internal controls are in place. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B & C).

CMS' risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team (SAT) ensures that risk assessment objectives are clearly communicated throughout the Department. The CMS has a risk management and Financial Oversight committee, comprised of cross-functional senior leadership, to oversee and manage program implementation, and to address risk across the agency, including risk that impacts financial management. It meets monthly to monitor and assess the effectiveness of mitigation strategies, identify emerging risks and ensure the correction of program weaknesses. The CMS SAT performs an annual assessment in accordance with HHS' guidance regarding OMB circular A-123, Appendix A, Internal Control Over Financial Reporting.

In addition, CMS will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact their success.

States will submit State Plan Amendments to implement the provisions of the Recovery Act. These SPA submissions will be reviewed by CMS Central Office and

Regional Office staff before approval. The number of approved SPAs will be tracked via the State Plan and Waiver database. These will be available publicly via the Electronic State Plan Amendment (eSPA) system.

I. Transparency

CMS is open and transparent in all of its contracting and grant activities involving Recovery Act funding; the Agency is in compliance with statute and OMB guidance on transparency.

The implementation of eSPA, a web-based application that will automate the current paper-based Medicaid State Plan amendment process, will make approved Medicaid State plan amendments will be available online.

Rules will be promulgated using the standard notice and comment procedures.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, CMS has built upon and strengthened existing processes. Senior CMS Center for Medicaid, CHIP, and Survey & Certification officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

K. Barriers to Effective Implementation

No implementation barriers have been identified at this time.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

- Updated Section A to reflect estimated FY09 FY10, and FY11 outlays, and estimated FY12-19 outlays.

- Updated section E to reflect issuance of guidance.

- Added a chart to Section G to capture the number of States soliciting advice from AI/AN communities and added a footnote indicating when we would have the data to report. .

- Updated Sections F, H and I to reflect updated HHS policies on Environmental Review Compliance, Monitoring and Evaluation, and Transparency.

Health Resources and Services Administration: Health Professions Programs

A. Funding Table

The table below provides an overview of the plan for the use of the $200 million for Health Professions Programs in ARRA funding. All obligations will be made in FY2009 or FY2010 as indicated in the table. The ARRA provides for 0.5% of the total appropriated amount to be used to support the administrative costs of implementation; this totals $1 million across the two years of implementation.

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Training in Primary Care Medicine & Dentistry	$47.600	$0	$47.6
Public Health Traineeships	3.000	3.0	0.0
Preventive Medicine; Dental Public Health	7.500	0.815	6.685
Nursing Education Loan Repayment Program	26.997	26.997	0.0
Scholarships for Disadvantaged Students	40.000	19.34	20.66
Nurse Faculty Loan Program	12.000	5.33	6.67
Faculty Loan Repayment	1.182	1.182	0.0
Centers for Excellence	4.924	4.924	0.0
Health Careers Opportunity Program	2.517	2.517	0.0
Nursing Workforce Diversity	2.756	2.756	0.0
Licensure Portability Special Initiative	1.008	0.0	1.008
Equipment to Enhance Training of Health Professionals	50.516	0.0	50.516
Total	$200.000	$66.861	$133.139

B. Objectives

The objective of the Health Professions Programs as supported through ARRA is to address health professions workforce shortages. Programs funded promote training in nursing and public health, help educational institutions, assist in the recruitment and retention of nurses and faculty, and increase the diversity of the health professions workforce. These programs will also help disadvantaged individuals who might otherwise have to delay their entry into, or drop out of, training programs or teaching. The program efforts funded by these awards support the U.S. Department of Health and Human Services (HHS) Strategic Plan focus on ensuring the health care workforce meets the Nation's health needs.

C. Activities

Several types of activities will be funded with ARRA dollars including direct student support/training, loan repayment, system change, and support for the purchase of equipment. The grant programs will help increase the diversity of students entering health professions programs, support the training of disadvantaged students, provide training in primary care disciplines where shortages exists, and improve training programs by providing access to better equipment. The individual awards for loan repayment will assist trained health professionals in the repayment of qualifying educational loans in exchange for serving in underserved facilities or for serving as faculty in health professions training programs. HRSA will manage this program consistent with changes to eligibility and program structure as a result of the Affordable Care Act.

D. Characteristics

	Training in Primary Care Medicine & Dentistry	***Public Health Traineeships***	***Preventive Medicine; Dental Public Health***
Type of Award	Grant	Grant	Grant
Non-Federal Recipients	$47.362	$2.985	$7.463
Federal Administration and Support (0.5%)	$0.238	$0.015	$0.037
Total Funding Amount (Million)	$47.600	$3.000	$7.500
Recipients	Educational Institutions	Educational Institutions	Educational Institutions
Beneficiaries	Institutions and Students	Institutions and Students	Institutions and Residents
Methodology for Award Selection	New FY2010 competitions and continuation awards	Fund from 2009 applications	New FY2010 competition and fund from 2009 applications

	Nursing Education Loan Repayment Program	***Scholarships for Disadvantaged Students***	***Nurse Faculty Loan Program***
Type of Award	Service Agreement Contract	Grant	Grant
Non-Federal Recipients	$26.862	$39.800	$11.940
Federal Administration and Support (0.5%)	$0.135	$0.200	$0.060
Total Funding Amount (Million)	$26.997	$40.000	$12.000
Recipients	Registered Nurses	Educational Institutions	Educational Institutions
Beneficiaries	Facilities with a critical shortage of nurses	Students	Students

	Nursing Education Loan Repayment Program	***Scholarships for Disadvantaged Students***	***Nurse Faculty Loan Program***
Methodology for Award Selection	Fund from 2009 applications	Fund from 2009 applications and new FY2010 competition	Fund from 2009 applications and new FY2010 competition

	Faculty Loan Repayment	***Centers for Excellence***	***Health Careers Opportunities Program***
Type of Award	Service Agreement Contract	Grant	Grant
Non-Federal Recipients	$1.176	$4.899	$2.504
Federal Administration and Support (0.5%)	$0.006	$0.025	$0.013
Total Funding Amount (Million)	$1.182	$4.925	$2.517
Recipients	Health Professions Faculty from a disadvantaged background	Educational Institutions	Educational Institutions
Beneficiaries	Health Professions schools/programs	Institutions and Students	Institutions and Students
Methodology for Award Selection	Fund from 2009 applications	Fund from 2009 applications	Fund from qualified 2008 applications

	Nursing Workforce Diversity	***Licensure Portability Special Initiative***	***Equipment to Enhance Training of Health Professionals***
Type of Award	Grant	Grant	Grant
Non-Federal Recipients	$2.742	$1.003	$50.263
Federal Administration and Support (0.5%)	$0.014	$0.005	$0.253
Total Funding Amount (Million)	$2.756	$1.008	$50.516
Recipients	Educational Institutions	State Licensing Boards/Professional Organizations of Licensing Boards	Educational Institutions
Beneficiaries	Institutions and Students	Health Professionals	Institutions and Students
Methodology for Award Selection	Fund from 2009 applications	New FY2010 Competition	New FY2010 Competition

E. Delivery Schedule

Training In Primary Care Medicine & Dentistry

Guidance Released: April 22, 2010

Award Date: July 1, 2010
Project Period: July 1, 2010 - June 30, 2015
Quarterly Reports: October 1, 2010 - October 1, 2015

Public Health Traineeships
Guidance Released: March 6, 2009
Award Date: September 1, 2009
Project Period: September 1, 2009 - August 31, 2012
Quarterly Reports: October 1, 2010 - October 1, 2012

Preventive Medicine
Guidance Released: December 21, 2009
Award Date: June 15, 2010
Project Period: July 1, 2010 - June 30, 2013
Quarterly Reports: October 1, 2010 - October 1, 2013

Residency Training in Dental Public Health
Guidance Released: June 17, 2009
Award Date: July 1, 2009
Project Period: July 1, 2009 - June 30, 2012
Quarterly Reports: October 1, 2009 - October 1, 2012

Nursing Education Loan Repayment Program
Guidance Released: February 2, 2009
Award Date: September 30, 2009
Project Period: N/A
Quarterly Reports: N/A

Scholarships for Disadvantaged Students
Guidance Released: May 3, 2009
Award Date: August 1, 2009
Project Period: September 1, 2009 - June 30, 2010
Project Period: July 1, 2010 - June 30, 2011
Quarterly Reports: October 1, 2009 - October 1, 2010

Nurse Faculty Loan Program
Guidance Released: April 17, 2009
Award Date: September 1, 2009
Project Period: August 1, 2009 - June 30, 2010
Quarterly Reports: N/A

Faculty Loan Repayment
Guidance Released: May 19, 2009
Award Date: September 21, 2009
Project Period: N/A
Quarterly Reports: N/A

Centers for Excellence
Guidance Released: June 15, 2009
Award Date: July 1, 2009
Project Period: September 1, 2009 - August 31, 2012
Quarterly Reports: October 1, 2009 - October 1, 2012

Health Careers Opportunity Program
Guidance Released: June 15, 2009
Award Date: August 1, 2009
Project Period: September 1, 2009 - August 31, 2012
Quarterly Reports: October 1, 2009 - October 1, 2012

Nursing Workforce Diversity
Guidance Released: June 13, 2009
Award Date: September 1, 2009
Project Period: September 1, 2009 - August 31, 2012
Quarterly Reports: October 1, 2009 - October 1, 2012

Licensure Portability Special Initiative
Guidance Released: October 5, 2009
Award Date: March 1, 2010
Project Period: March 1, 2010 - February 28, 2012
Quarterly Reports: June 1, 2010 - June 1, 2012

Equipment to Enhance Training of Health Professionals
Guidance Released: February 26, 2010
Application Start Date: February 26, 2010
Award Date: September 1, 2010
Project Period: September 1, 2010 - August 31, 2011
Quarterly Reports: October 1, 2010 - October 1, 2011

F. Environmental Review Compliance

HRSA has reviewed this activity in accordance with the HHS GAM 30 and discussed the program with the HHS Environmental Program Manager. From this review,

HRSA has concluded that it qualifies for a Category 2.a. Function Exclusion and there are no additional extraordinary circumstances that may cause significant effects. HRSA will maintain written documentation of all environmental reviews and they will be reported on the Section 1609(c) report.

G. Measures

Organizations receiving ARRA Division A[1] funds will submit section 1512 required data centrally through federalreporting.gov on a quarterly basis. This data is available to the public on Recovery.gov. The Nursing Education Loan Repayment Program and the Faculty Loan Repayment Program provide direct assistance to individuals who are not required to submit reports in accordance with section 1512. For these two programs, financial data required by section 1512 will be consolidated and reported by HRSA to Recovery.gov.

All grantees will report to HRSA through the normal reporting systems on the measures and schedule defined in the following table. Details are provided through guidance to the applicants for competitive programs and through terms and conditions on the Notice of Grant Award for the other programs. Grantees are also expected to fulfill the normal reporting requirements for each specific program. Data on ARRA measures will be consolidated and reported by HRSA to Recovery.gov.

[1] The American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law by President Obama on February 17, 2009. Division A of ARRA appropriates substantial funding for construction, alteration and repair of federal buildings and for infrastructure projects, such as roads, bridges, public transit, water systems, and housing.

Training in Primary Care Medicine and Dentistry			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
Outputs/Jobs			
# of students trained	Quarterly	Recovery.gov, HHS website	Quarterly
Outcome			
# of residents/, students/trainees and faculty in clinical training with health service organizations serving underserved areas	Quarterly	Recovery.gov, HHS website	Quarterly
Data Sources and Validation: BHPr Data Collection System for Grants and Cooperative Agreements. Data are entered through a web-based system that incorporates extensive validation checks. Grantees are also required to describe methods and systems they use to collect and submit data. Those with deficient systems are required to submit a corrective action plan.			

Public Health Traineeships			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
Outputs/Jobs			
# of traineeships funded	Quarterly	Recovery.gov, HHS website	Quarterly
Outcome			
# of graduates	Quarterly	Recovery.gov, HHS website	Quarterly
Data Sources and Validation: BHPr Data Collection System for Grants and Cooperative Agreements. Data are entered through a web-based system that incorporates extensive validation checks. Grantees are also required to describe methods and systems they use to collect and submit data. Those with deficient systems are required to submit a corrective action plan.			

Preventive Medicine; Dental Public Health			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
Outputs/Jobs			
# of residents funded	Quarterly	Recovery.gov, HHS website	Quarterly
Outcome			
# of residents training in underserved areas # of preventive medicine residents practicing preventive medicine	Quarterly	Recovery.gov, HHS website	Quarterly
Data Sources and Validation: BHPr Data Collection System for Grants and Cooperative Agreements. Data are entered through a web-based system that incorporates extensive validation checks. Grantees are also required to describe methods and systems they use to			

Preventive Medicine; Dental Public Health			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
collect and submit data. Those with deficient systems are required to submit a corrective action plan.			

Nursing Education Loan Repayment Program (NELRP)			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
Outputs/Jobs			
# of new NELRP Loan repayment awards (jobs created/preserved)	Quarterly	Recovery.gov, HHS website	Quarterly
Outcome			
Increase in NELRP field strength	Annually	Recovery.gov, HHS website	Annually
Data Sources and Validation: Nursing Information System for NELRP service agreement contract awards. Application data is entered through a web-based system that incorporates consistency and completeness edits. Applicants are also required to supply supporting documentation. Application information is checked with appropriate sources, including lenders.			

Scholarships for Disadvantaged Students			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
Outputs/Jobs			
# of scholarships awarded	Academic Year	Recovery.gov, HHS website	Yearly
Outcome			
# of Underrepresented Minority (URM) students	Academic Year	Recovery.gov, HHS website	Yearly
Data Sources and Validation: Data provided by Annual Performance Report completed by each grantee in August. Electronic report system has rigorous validation modules to eliminate error. Additionally, all reports are reviewed by program staff.			

Nurse Faculty Loan Program			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
Outputs/Jobs			
# of schools funded	Academic Year	Recovery.gov, HHS website	Yearly
Outcome			
#of students awarded loans to become nurse faculty	Academic Year	Recovery.gov, HHS website	Yearly
Data Sources and Validation: Data provided by Annual Operating Report completed by each grantee in August. Report process uses rigorous validations to eliminate error.			

Faculty Loan Repayment Program (FLRP)			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
Outputs/Jobs			
# of new FLRP loan repayment awards (jobs created/preserved)	Quarterly	Recovery.gov, HHS website	Quarterly
Outcome			
Increase in FLRP field strength	Annually	Recovery.gov, HHS website	Annually
Data Sources and Validation: Application data is entered through a web-based system that incorporates consistency and completeness edits. Applicants are also required to supply supporting documentation. Application information is checked with appropriate sources, including lenders, and validated.			

Centers of Excellence			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
Outputs/Jobs			
# of students trained	Quarterly	Recovery.gov, HHS website	Quarterly
Outcome			
% of URM students	Quarterly	Recovery.gov, HHS website	Quarterly
Data Sources and Validation: BHPr Data Collection System for Grants and Cooperative Agreements. Data are entered through a web-based system that incorporates extensive validation checks. Grantees are also required to describe methods and systems they use to collect and submit data. Those with deficient systems are required to submit a corrective action plan.			

Health Careers Opportunity Program			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
Outputs/Jobs			
# of student participants	Quarterly	Recovery.gov, HHS website	Quarterly
Outcome			
# of matriculants to health and allied health schools	Academic Year	Recovery.gov, HHS website	Yearly
Data Sources and Validation: BHPr Data Collection System for Grants and Cooperative Agreements. Data are entered through a web-based system that incorporates extensive validation checks. Grantees are also required to describe methods and systems they use to collect and submit data. Those with deficient systems are required to submit a corrective action plan.			

Nursing Workforce Diversity			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
Outputs/Jobs			
# of students trained	Quarterly	Recovery.gov, HHS website	Quarterly
Outcome			
# of graduates	Quarterly	Recovery.gov, HHS website	Quarterly
Data Sources and Validation: BHPr Data Collection System for Grants and Cooperative Agreements. Data are entered through a web-based system that incorporates extensive validation checks. Grantees are also required to describe methods and systems they use to collect and submit data. Those with deficient systems are required to submit a corrective action plan.			

Licensure Portability Special Initiative			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
Outputs/Jobs			
# of statutes/ regulations/policies/ expedited processing systems implemented	Semi-annually	Recovery.gov, HHS website	Semi-annually
Outcome			
Increase the number of individuals holding multiple licenses in each state per discipline	Annually	Recovery.gov, HHS website	Annually
Data Sources and Validation: Progress report will be issued, completed by grantee, and submitted back to the Project Officer. The PO will ensure that data is complete and accurate by contacting the various States participating in the respective consortium for verification.			

Equipment to Enhance Training of Health Professionals Program			
Measure	**Reporting Period**	**How data made available to public**	**Frequency of making data available to public**
Outputs/Jobs			
Proportion of equipment purchases completed by target date	Quarterly	Recovery.gov, HHS website	Quarterly
Outcome			
Proportion of equipment purchases put in service by target date	Quarterly	Recovery.gov, HHS website	Quarterly
Data Sources and Validation: BHPr Data Collection System for Grants and Cooperative Agreements. Data are entered through a web-based system that incorporates extensive validation checks. Grantees are also required to describe methods and systems they use to collect and submit data. Those with deficient systems are required to submit a corrective action plan.			

Goals

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
TPCMD - # of residents/, students/trainees training in PCMD	Residents/ Students/ Trainees	TARGET	N/A	N/A	N/A	N/A	1013	1013	1603	1603	1603	1603
		ACTUAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
TPCMD - # of residents/, students/trainees and faculty in clinical training with health service organizations serving underserved areas	Residents/ Students/ Trainees	TARGET	N/A	N/A	N/A		810	810	1282	1282	1282	1282
		ACTUAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
PHT- # of Traineeships funded	Trainee-ships	TARGET	N/A	30	30	30	30	30	30	30		30
		ACTUAL	21	62	134	N/A	N/A	N/A	N/A	N/A	N/A	
PHT - # of graduates	Graduates	TARGET	N/A	N/A	0	N/A	N/A	N/A	N/A	720	N/A	720
		ACTUAL	N/A	0	1	N/A	N/A	N/A	N/A	N/A	N/A	
PM; DPH - # of residents funded	Residents	TARGET	N/A	5	5	5	191	191	191	N/A	N/A	191
		ACTUAL	4	4	4	N/A	N/A	N/A	N/A	N/A	N/A	
PM; DPH - # of residents training in underserved areas # of preventive medicine residents practicing preventive medicine	Residents	TARGET	N/A	5- DPH	5- DPH	5- DPH	42	42	42	42	42	42
		ACTUAL	4	4	4	N/A	N/A	N/A	N/A	N/A	N/A	
NELRP - Increase in NELRP Awards	Awards	TARGET	N/A	427	427	N/A	N/A	N/A	N/A	N/A	N/A	
		ACTUAL	N/A	427	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
NELRP - Increase in NELRP field strength	Field Strength	TARGET	N/A	427	427	N/A	N/A	N/A	N/A	N/A	N/A	
		ACTUAL	N/A	427	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
SDS - # of Scholarships Awarded	Scholar-ships	TARGET	N/A	N/A	N/A	N/A	825	N/A	N/A	N/A	275	1,100
		ACTUAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
SDS-# of Underrepresented Minority (URM) students	Students	TARGET	N/A	290	290	290	290	290	290	290	290	290
		ACTUAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
NFLP- # of Schools Funded	Schools	TARGET	N/A	66	66	66	66	66	66	66	66	66
		ACTUAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
NFLP - #of students awarded loans to become nurse faculty	Awards	TARGET	N/A	495	495	495	495	495	495	495	495	495
		ACTUAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
FLRP- # of new FLRP loan repayment awards	Awards	TARGET	N/A	22	22	22	22	22	22	22	22	22
		ACTUAL	22	22	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
FLRP - Increase in FLRP field strength	Field Strength	TARGET	N/A	22	22	22	22	22	22	22	22	22
		ACTUAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
COE- Number of students trained	Students	TARGET	N/A	335	335	335	335	335	335	335	335	335
		ACTUAL	235	306	306	N/A	N/A	N/A	N/A	N/A	N/A	
COE - % of URM students	Students	TARGET	N/A	271	271	271	271	271	271	271	271	271
		ACTUAL	183	188	206	N/A	N/A	N/A	N/A	N/A	N/A	
HCOP - # of student participants	Students	TARGET	N/A	41	41	41	41	41	41	41	41	41
		ACTUAL	N/A	96	216	N/A	N/A	N/A	N/A	N/A	N/A	
HCOP - # of matriculants to health and allied health schools	Students	TARGET	N/A	18	18	18	18	18	18	18	18	18
		ACTUAL	N/A	0	31	N/A	N/A	N/A	N/A	N/A	N/A	
NWD-# of students trained	Students	TARGET	N/A	450	450	450	450	450	450	450	450	450
		ACTUAL	72	173	180	N/A	N/A	N/A	N/A	N/A	N/A	

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
NWD - # of graduates	Graduates	TARGET	N/A	108	108	108	108	108	108	108	108	108
		ACTUAL	0	9	9	N/A	N/A	N/A	N/A	N/A	N/A	
LPSI - Increase the number of regulations designed to expedite multi-state licensing	States	TARGET	N/A	N/A	N/A	N/A	N/A	N/A	1	1	1	1
		ACTUAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
LPSI - Increase the number of individuals holding multiple licenses in each state per discipline	% individuals	TARGET	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1%	2%
		ACTUAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
Equipment - Proportion of equipment purchased by target date	Equip proporion	TARGET	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	50%	100%
		ACTUAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
Equipment - Proportion of equipment purchases put in service by target date	Equip proportion	TARGET	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	50%	100%
		ACTUAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire life cycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

HRSA's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. HRSA's Senior Assessment Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets monthly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, HRSA will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

Monitoring and evaluation of grants will follow existing HRSA grants management processes which includes a financial integrity assessment prior to award (i.e., review of HRSA alert lists and OMB Circular A-133 audit reports to ensure organizations are viable entities). All grant applications will be subject to an objective review and receive a score in accordance with existing HRSA policy. Upon award, conditions and terms will be associated with awards to ensure compliance with financial and performance reporting requirements. Both grants management as well as program staff will monitor awards to ensure compliance with requirements and will quickly identify potential issues and track corrective actions when needed.

I. Transparency

HRSA is open and transparent in all of its contracting and grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance including, where appropriate, the use of Grants.gov and FedBizOps.

HRSA ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. HRSA informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations,

and other program guidance. In addition, HRSA provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

Every ARRA funded program in HRSA is being structured so that HRSA can track all ARRA financial and performance information separately from existing programs as required by the ARRA, OMB, and HHS guidance. Financial and performance data will be reported through the HRSA website as well as through the government-wide website.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, HRSA has built upon and strengthened existing processes. Senior HRSA/BHPr officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

K. Barriers to Effective Implementation

Overall Recovery Act implementation is not compromised by any regulatory impediment. To help ensure that HRSA met established timelines and monitoring requirements, additional staff was temporarily hired using the administrative funds set-aside by the Recovery Act. However, some of the temporary staff have found permanent jobs and the funding for the temporary hires will end on 9/30/2010. While the available resources will be sufficient to complete the award activities associated with the Recovery Act, monitoring activities will continue for several years without the staff support provided under the Recovery Act. HRSA is working to implement automated solutions as well as hiring staff in order to continue to monitor grants and activities appropriately.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

At the time the original May 2009 Implementation Plan was issued, the final plan had not yet been approved. This updated plan now reflects all activities which will be implemented under this program and includes performance measures for these activities.

Centers for Medicare & Medicaid Services: Medicare and Medicaid Incentives and Administrative Funding

A. Funding Table

(Dollars in Millions)

Project/Activity	Program Level Estimate	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate	FY 2012 – FY 2019 Estimate
Incentives (including Medicare penalties)/1					
Medicare Incentives (High scenario)	$16,600.0	$0.0	$0.0	$2,700.0	$13,900.0
Medicare Incentives (Low scenario)	6,800.0	0.0	0.0	1,800.0	5,000.0
Medicaid Incentives (High scenario)	10,600.0	0.0	0.0	2,300.0	8,400.0
Medicaid Incentives (Low scenario)	7,300.0	0.0	0.0	1,300.0	5,900.0
Subtotal, Medicare and Medicaid Incentives (High Scenario)	27,200.0	0.0	0.0	5,000.0	22,300.0
Subtotal, Medicare and Medicaid Incentives (Low Scenario)	14,100.0	0.0	0.0	3,100.0	10,900.0
State Medicaid Administration	2,308.0	0.2	151.7	282.6	1,874.0
CMS Administrative Costs /2					
Medicare	745.0	3.0	74.3	TBD	TBD
Medicaid	300.0	1.0	48.5	TBD	TBD
Subtotal, CMS Administrative Costs	1,045.0	4.0	122.8	TBD	TBD

/1 Estimates for Medicare and Medicaid incentives are from the proposed regulation (CMS-2009-0117-0002) impact analysis. Physician impact assumes current law physician updates from FY 2010 President's Budget.

/2 For Medicare, from FY 2009 through FY 2015, CMS is appropriated $100 million per year for administrative spending. For FY 2016, the amount is $45 million. For Medicaid, CMS is appropriated $40 million per year for FY 2009 through FY 2015 and $20 million in FY 2016. Funds for each fiscal year are available until expended.

B. Objectives

The Recovery Act authorized bonus payments for eligible professionals (EPs) and hospitals participating in Medicare and Medicaid as an incentive to become meaningful users of certified EHRs. The law established maximum annual incentive amounts and includes Medicare penalties for EPs and hospitals who fail to demonstrate meaningful use of certified EHRs beginning in 2015.

The statute includes three broad criteria for demonstrating one is a "meaningful EHR user" which will be defined as the implementation process moves forward: (1) Meaningful use of certified EHR technology; (2) information exchange; and (3) reporting on measures using EHR. The statute grants the Secretary discretion in defining these terms.

Medicare Payments
Sections 4101 and 4102 of the Recovery Act provide Medicare bonus payments to EPs between calendar years 2011 to 2016 and for hospitals that meaningfully use certified EHRs by fiscal years 2011 to 2016. Starting in 2015, eligible professionals and hospitals failing to demonstrate meaningful use of certified EHRs will receive reduced Medicare payments.

Medicaid Payments
Section 4201 of the Recovery Act established 100 percent Federal Financial Participation (FFP) to States for incentives to eligible Medicaid providers to purchase, implement, and operate certified electronic health records (EHR) technology and established 90 percent FFP for State administrative expenses related to carrying out this provision. Many States have been moving toward interoperable health care technology and information exchange for the last several years. This provision affords States and their Medicaid providers with a unique opportunity to leverage these existing efforts to achieve the vision of interoperable information technology for health care with State Medicaid agencies playing a critically important role in fulfilling that vision.

Adoption of EHRs corresponds to the HHS strategic objective to improve health care quality, safety, cost and value.

C. Activities

The Recovery Act appropriated to CMS $140 million for each of fiscal years (FY) 2009 through 2015 and $65 million for FY 2016 for administrative funding, and made these funds available until expended. Initially CMS used part of these funds to assess existing systems to determine whether or not modifications can be made to accommodate the requirements of the incentive program. The funding is now being used to modify and/or develop, implement, operate and maintain all systems necessary to support payment of incentives to hospitals and eligible professionals, such as systems for registration, attestation, payment, reporting, and accounting/monitoring.

In coordination with the Office of the National Coordinator for Health Information Technology (ONC), CMS published the proposed rule (CMS-2009-0117-0002) on January 13, 2010, including a proposed definition of "meaningful use." The final rule for the EHR incentive program is expected to be issued in late spring 2010. Implementing the incentive programs will require an extensive provider education and outreach effort. This outreach will ensure providers understand all policies and requirements related to the EHR incentive program including provider eligibility, selection of Medicare or Medicaid incentive programs for eligible providers, incentive

payments, and the demonstration of "meaningful use." CMS' outreach efforts will complement ONC's efforts to inform providers about HIT adoption and EHR certification and standards.

State payment of Medicaid incentive payments will require each State to determine how it will implement, oversee, and monitor incentive payments, within CMS guidelines, as well as require modification to CMS Medicaid reporting and data systems. CMS and State verification of payment accuracy and audits to preclude improper payment of Medicare and Medicaid incentives will be critical. Complying with Recovery Act reporting guidance will involve Federal and State staff time and require modification of accounting and payment data reporting systems.

CMS Administrative Funds

Below is a brief description of the overall activities necessary for implementation of the EHR incentive payments program. Except where indicated, we expect the activities to be performed through FY 2016:

Regulatory Work

This effort will include ongoing support for development of regulations for implementing Medicare and Medicaid incentive payments as well as technical information and guidance to the States on the implementation of HITECH. Subsequent rulemaking will be required for stage two and stage three of meaningful use.

Planning and Business Analysis

This includes overall program coordination and planning. Business process modeling support to develop audit and appeals models, help desk models, Medicaid State interaction models, etc. are planned. Systems engineering support involving planning, architecture and development of new systems as well as leveraging existing systems to implement requirements for HITECH.

Plan/Provider Registration/Attestation

CMS will develop a national level repository (NLR) to compile registration, attestation and payment activity for EPs and Hospitals. CMS will leverage the Provider Enrollment Chain and Ownership System (PECOS) and the National Plan and Provider Enumeration System (NPPES) functionality and data.

Plan/Provider Payment

CMS intends to use a Payment File Development Contractor to assist in preparing and processing Medicare incentive payments and to ensure proper funds control and accounting related to these payments.

Control/Oversight

CMS has been working on developing audit and appeals functions as well as integration with other HITECH systems to ensure incentive payments are not made to ineligible providers and that payments are made appropriately and accurately.

Education and Outreach
CMS has developed an extensive outreach and education plan and timeline. Outreach will focus on educating providers about the Medicare and Medicaid EHR programs and on educating States about how to avoid the risk of making improper incentive payments under Medicaid. Outreach and education efforts will inform providers of the requirements of the EHR incentive program. CMS has forged a strong relationship with ONC to coordinate and strengthen education efforts. ONC is responsible for recognizing the standards, implementation specifications, and certification criteria for EHR technology as well as establishing certification programs for HIT. CMS manages the Medicare and Medicaid EHR incentive program which provides incentives for the meaningful use of certified EHR technology.

D. Characteristics

The administrative funding provided by the legislation will be used for both Federal in-house activities and contracting with non-Federal entities. The Federal in-house funding will be used to hire additional Federal staff, as well as pay a portion of the costs for existing staff working on HIT related activities. The non-Federal entities will be provided with funding primarily through the use of contract vehicles under the standard Federal Acquisition Regulations (FAR) requirements.

State Medicaid Agencies will receive Federal matching rates of 90 percent for their administrative costs of the HIT activities through the existing FMAP grant payment process. To qualify to receive 90 percent FFP for administering the incentive program, States must develop a State Medicaid Health Information Technology Plan (SMHP), a Health Information Technology Planning Advance Planning Document (HIT PAPD), and a Health Information Technology Implementation Advance Planning Document (HIT IAPD).

Medicare and Medicaid incentive payments to eligible professionals will be made using existing or newly developed Federal and State payment systems. Medicare hospital incentive payments will be made using the existing cost report based process.

The HIT legislation provided CMS with $1,045 million in administrative funding - $745 million for Medicare and $300 million for Medicaid - for the FY 2009-2019 period. It is anticipated that approximately 10 percent of that funding will be used for Federal in-house activities with the remaining balance going to non-Federal entities.

State Administrative Costs for Medicaid HIT Implementation
Federal matching funds are provided to States for administering payments for certified EHR technology. To be eligible for funding, States must demonstrate:

- Appropriate use of funds including tracking of meaningful use by Medicaid providers.
- Adequate oversight of the program is being conducted, including routine tracking of meaningful use attestations and reporting mechanisms,

- Other initiatives are being pursued to encourage the adoption of certified EHR technology for the promotion of health care quality and the exchange of health care information.

Incentive Payments

Medicare

- Medicare EPs may receive incentives for the meaningful use of certified EHR technology. The incentive payment will be calculated as 75 percent of the allowable charges for services furnished by the EP during the payment year, not to exceed payment maximums set by law. Payments will be made from 2011 through 2016. For example, the maximum payment for 2011 is $18,000 with a maximum of $44,000 paid over 5 years if an EP continues to demonstrate meaningful use of certified EHRs. Incentive payment maximums are increased by 10 percent for those EPs providing services in a health professional shortage area. EPs must choose whether to receive an incentive under Medicare or Medicaid.
- Medicare will also pay incentives to subsection 1886(d) hospitals and critical access hospitals. Eligible hospitals that are meaningful EHR users by 2015 for a reporting period specified by the Secretary could receive up to four years of incentive payments beginning in FY 2011. The payments will be based on the statutory formula which includes a $2 million base payment that is adjusted based on the number of discharges, the Medicare share of inpatient bed days, and charity care. Hospitals that become meaningful users after 2015 would not receive these incentives.
- Medicare may also pay EHR incentives to certain Medicare Advantage (MA) organizations that employ or contract with certain EPs and hospitals. For EPs, EHR incentives will only be paid under the fee-for-service (FFS) program if the EP qualifies for the maximum incentive payment under that provision. For hospitals, incentives will be paid only under the fee-for-service program if at least one-third of a hospital's Medicare discharges (or bed days) of Medicare patients for the year are covered under Medicare FFS Part A, otherwise MA organizations can be reimbursed directly for hospitals that are under common ownership and control and that serve MA plan enrollees of such organizations.

Medicaid

- The Medicaid statute provides for a 100 percent FFP for State expenditures for provider incentive payments to encourage Medicaid providers to implement, operate, and meaningfully use certified EHR technology.
  Medicaid incentive payments can cover up to 85 percent of the federally-determined "net average allowable costs" of EHR technology, including support and training for staff, up to a statutory maximum level. Eligible professionals can receive up to $21,250 for the first year of payment for the initial purchase and adoption of certified EHR technology, and up to $8,500 annually over 5-years for costs relating to the operation, maintenance and demonstration of meaningful use of such technology. Incentive payments are available for no more than a 6-year period, and initial incentive payments are not available after 2016.
- Hospital incentive payments are statutorily defined by formula. Full reimbursement of incentive payments must occur over a minimum 3-year and

maximum 6-year period. The last year that a hospital can begin receiving incentive payments is 2016.

- States must assure that payments are being made directly to Medicaid providers without any deduction or rebate.
- Certified EHR technology must be, to the extent possible as specified by the Secretary, compatible with State or Federal administrative management systems.
- Medicaid EPs must waive the right to receive incentive payments under Medicare for certified EHR technology. An EP that participates in both Medicare and Medicaid and meets the respective eligibility requirements cannot receive incentive payments from both Medicare and Medicaid.

E. Delivery Schedule

September 1, 2009	Released State Medicaid Directors (SMD) letter providing guidance to States on development of plans for administrative funding (HIT PAPD and SMHPs)
November 30, 2009	Published Paperwork Reduction Act Notice State Medicaid HIT Plan and Template for Implementation of Section 4201 of ARRA (CMS-10292).
January 13, 2010	Publication of Medicare and Medicaid Programs: Electronic Health Record Incentive (CMS-2009-0117-0002) proposed regulation defining “meaningful use” and other incentive payments policies.
February 2010	2nd Annual Multi-State Collaborative for HIT Conference
February 2010	External and Internal training calls and webinars to provide outreach on the proposed regulation
April 1, 2010	Registration and Attestation design and development Award-PECOS and National Plan and Provider Enumeration System (NPPES) modifications contract
May 2010	Development and validation environments available
May 1, 2010	Contract award for design and development of NLR
June 2010	Final Rule on Medicare and Medicaid Programs: Electronic Health Record Incentive on display
July 2010	Expected date of Paperwork Reduction Act approval of State Medicaid HIT Plan template and template for the abbreviated HIT Planning Advance Planning document to implement Section 4201 of ARRA (CMS-10292)
July 2010	Outreach on EHR incentive program registration and participation requirements
Aug - Dec 2010	Testing of HITECH systems
Q4 FY 2010	Complete Paperwork Reduction Act process for the Registration and Attestation modules
Q4 FY 2010	Obtain approval for the system of Records for the EHR incentive program
Q4 FY 2010	Publish and distribute to State Medicaid agencies Implementation Guidance on Implementing the Incentive Program end of 3rd quarter or early 4th quarter. Based upon approval timelines for SMHPs, it is expected that the

	Implementation APD's will be approved after guidance has been issued
September 2010	Award Payment File Development Contractor (PFDC)
November 2010	Production environment available
January 2011	Hospitals and eligible professionals may begin registration for incentive payments
January 2011	State Medicaid agencies may begin making incentive payments to hospitals and eligible professionals
April 2011	Medicare hospitals may begin attestation for incentive payments
April 2011	Medicare EPs may begin attestation for incentive payments
May 2011	CMS begins making Medicare Hospital incentive payments
May 2011	CMS begins making Medicare EP incentive payments
2011-2016	CMS makes EP and hospital incentive payments for Medicare and monitor payments (monitoring will be ongoing beyond 2016)
2011-2021	State Medicaid Agencies make Medicaid incentive payments to EPs and Hospitals and monitor payments
2015	Initiate payment reductions to Medicare hospitals and eligible professionals that fail to demonstrate "meaningful use"

F. Environmental Review Compliance

The CMS and Department of Health and Human Services are committed to sustainable operations of its activities and facilities through sound environmental stewardship including preferential procurement of environmentally preferred products and electronic stewardship of IT and data center operations.

As programs are developed, CMS will incorporate contract and/or grant language to mitigate the environmental impacts of acquisition of IT and other products and equipment and services and provide guidance to encourage the following:

- Green procurement' based on the HHS Affirmative Procurement Plan and similar guidance from the Environmental Protection Agency (EPA) and the President's Council on Environmental Quality (CEQ)

- Electronic Stewardship including the use of electronic products that are Energy Star® compliant and Electronic Product Environmental Assessment Tool (EPEAT) Silver registered or higher when available; the activation of Energy Star® features on all equipment, when available; environmentally sound 'end-of-life' management practices (including reuse, donate, sell, or recycle 100% of electronic products;) and best operation and management practices for energy efficient data centers.

G. Measures

The Department is working to develop a suite of measures on meaningful use to gauge participation of eligible providers and hospitals participating in the Medicare and Medicaid Incentive Programs when the regulation is finalized and CMS begins making these incentive payments. It is intended for data to be collected and reported quarterly at earliest May 2011. CMS and ONC will work together to ensure that measures are coordinated and reflect common goals. Such measures may include the ones identified below:

Goal	**Measure**	**Type**	**Target**	**Reporting Frequency**
Meaningful Use of certified EHRs by EPs (Medicare)	# of EPs qualifying as meaningful users under the Medicare incentive program	Outcome	2011 target will be set after the regulation has been finalized.	Quarterly
Meaningful Use of certified EHRs by EPs (Medicaid)	# of EPs qualifying as meaningful users under the Medicaid incentive programs	Outcome	2011 target will be set after the regulation has been finalized.	Quarterly
Meaningful Use of certified EHRs by Hospitals (Medicare)	# of Hospitals qualifying as meaningful users under the Medicare incentive program	Outcome	2011 target will be set after the regulation has been finalized.	Quarterly
Meaningful Use of certified EHRs by Hospitals (Medicaid)	# of Hospitals qualifying as meaningful users under the Medicaid incentive program	Outcome	2011 target will be set after the regulation has been finalized.	Quarterly

In the interim, the following performance measures will help track the achievement of critical implementation milestones:

Goal	Measure	Type	Target	Reporting Frequency
Approval of State Medicaid Planning documents	Submittal and approval of State Medicaid planning documents including SMHP, HIT PAPD, and HIT IAPD.	Process	Review and approval of SMHPs and IAPDs within 60 business days post-States' submission	Ongoing
Successfully establish registration processes	Hospitals and EPs can begin registering for the incentive program	Process	Accomplish 6 months after the regulation has been finalized	NA
Successfully establish attestation processes	Medicare hospitals and EPs can begin submitting attestations	Process	Accomplish 9 months after the regulation has been finalized	NA
Successfully establish payment processes	CMS begins making payments to Medicare hospitals and EPs	Process	Accomplish 11 months after the regulation has been finalized	NA
Successfully establish payment processes	CMS begins making incentive funding available to participating State Medicaid agencies for provider incentive payments	Process	Accomplish 11 months after the regulation has been published	NA

H. Monitoring and Evaluation

The CMS programs are assessed for risk to ensure that appropriate internal controls are in place. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B and C).

CMS' risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team (SAT) ensures that risk assessment objectives are clearly communicated throughout the Department. The CMS has a risk management and Financial Oversight committee, comprised of cross-functional senior leadership, to oversee and manage program implementation, and to address risk across the agency, including risk that impacts financial management. It meets monthly to monitor and assess the effectiveness of mitigation strategies, identify emerging risks and ensure the correction of program weaknesses. The CMS SAT performs an annual assessment in accordance with HHS' guidance regarding OMB circular A-123, Appendix A, Internal Control Over Financial Reporting.

In addition, CMS will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact their success.

CMS will develop policies and procedures to ensure proper and accurate identification of providers to determine program eligibility and to prevent duplicate payments. CMS will track payments to ensure that maximum payment limits are not exceeded. We will develop mechanisms to help ensure correct payments and account for and recover any overpayments.

In the Medicaid program, to ensure the proper use of funds, States must demonstrate to the satisfaction of the Secretary that the State is using the funds provided for the purposes of administering payments, conducting adequate oversight, and pursuing initiatives to encourage the adoption of certified EHR technology. CMS expects to conduct periodic reviews to assess the State's progress described in its approved HIT PAPD and HIT IAPD. Regularly scheduled meetings are conducted between CMS and ONC, and both CMS and ONC will evaluate SMHPs on an on-going basis. A portal is being established so State APDs, SMHPs and correspondence will be accessible to CMS and ONC.

I. Transparency

CMS is open and transparent in all of its contracting and grant activities involving Recovery Act funding; the Agency is in compliance with statute and OMB guidance on transparency. All Recovery Act activities are either posted in Federal Business Opportunities (www.fbo.com) (contracts) or Grants.gov (grants) to highlight to the public the actions being undertaken by the Agency in support of the Recovery Act. In addition, CMS ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. CMS informs recipients of their reporting requirements and defines these requirements in both its contracts and grants terms and conditions. CMS will continue its transparency activities including

implementation of new requirements effective October 2010 regarding subcontract reporting.

CMS will provide information for posting on Recovery.gov. In addition, CMS will post the names of those receiving Medicare incentives online. States will be encouraged to share similar information. The Secretary of HHS will submit reports to the Congress on the status, progress, and oversight of payments paid under the Medicaid incentive program. These reports will also describe the extent of adoption of certified EHR technology among Medicaid providers resulting from the incentives and any improvement in health outcomes, clinical quality, or efficiency resulting from adoption. Note that Medicare incentives will not be paid prior to October 2010.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, CMS has built upon and strengthened existing processes. CMS has forged a strong relationship with ONC to coordinate and strengthen overall efforts. The CMS Program Management Office (PMO) for HITECH is located in the Office of E-Health Standards and Systems and is in consultation and close collaboration with ONC and other senior Department officials on a regular basis. Senior CMS Center for Medicaid, CHIP and Survey and Certification officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

State Responsibilities:
States are responsible for tracking and verifying the activities necessary for a Medicaid EP or eligible hospital to receive an incentive payment for each payment year. Under the proposed rule, the State would submit a State Medicaid HIT Plan to CMS that includes: (1) A detailed plan for monitoring, verifying and periodic auditing of the requirements for receiving incentive payments; and (2) A description of the how the State will collect and report on provider meaningful use of certified EHR technology.

K. Barriers to Effective Implementation

Effective implementation is heavily dependent on getting the basic framework and criteria for the programs established as soon as possible. There are a number of critical factors that will create barriers to effective implementation if not implemented early enough including:

1. EHR certification criteria. Payment is based on meaningful use of a certified EHR. The Recovery Act instructs the ONC to revisit the current criteria for certification, a process has been proposed but needs to be finalized so that EHRs can be certified for the incentive program.
2. Meaningful EHR user criteria. Working with ONC, CMS proposed, and is in the process of finalizing, the definition of meaningful use. Providers must successfully demonstrate meaningful use to receive an incentive payment.

Extensive outreach will be conducted to educate providers about the meaningful use requirements.

3. State systems to support the incentive programs. Sufficient lead time is necessary to conduct a gap analysis of current systems and to develop a Health Information Exchange (HIE) infrastructure in the near-term to enable the States to make incentive payments.
4. Accurate State and provider reporting. An analysis of existing reporting systems will be necessary to properly execute, accurately record and issue in a timely manner, transactions made by States to their providers.
5. Federal systems to support incentive payments. Compressed timeline for the systems development and testing for registration, attestation, payment and other systems

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

- Revised estimates in Section A so they are consistent with the NPRM published on January 13, 2010. All other estimates reflect the FY2011 President's Budget.
- Added language about providers (Hospital and EP's) registration and attestation requirements to Section C.
- Updated the Administrative funds section under Section C to be consistent with planning approach as outlined in both Operating Plan and Spend Plan.
- Added a chart to Section G to identify the actual Number of States drawing temporary increase in Medicaid DSH funds per quarter.
- Added language to Section D about how providers (Hospitals and EP's) will be paid an incentive payment.
- Updated Section E to be consistent with planning approach as outlined in Spend Plan.
- Updated Sections F, H and I to reflect updated HHS policies on Environmental Review Compliance, Monitoring and Evaluation, and Transparency.
- Updated Section J to reflect CMS re-alignment structure and added a paragraph about State responsibility.
- Updated Section K to reflect progress made to date.

Office of the National Coordinator for Health Information Technology: Health Information Technology

A. Funding Table

Dollars in Millions

Program/Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations	FY 2011 Estimated Obligations	FY 2012 Estimated Obligations
NIST	20.00	0	16.371	3.525	1.04
Privacy and Security – Enforcement	16.16	0.57	15.59	0	0
Privacy and Security – Regulations, Guidelines and Studies	8.13	0	8.13	0	0
State Health Information Exchange Cooperative Agreements	564.00	0	564.00	0	0
Health Information Technology Research Center and Regional Extension Center Cooperative Agreements	774.00	0	726.20	0	47.80
Health IT Workforce Cooperative Agreements	118.00	0	83.73	34.27	0
Beacon Communities Cooperative Agreements	265.38	0	265.38	0	0
Other Initiatives/Omnibus	203.77	0	201.77	2	0
Public Health	30.58[1]	0	30.58	0	0
Totals	**2,000.00**	**0.57**	**1911.75**	**39.79**	**48.84**

[1] Funds in the Recovery Act Section 317 Immunization Program will support related activities.

B. Objectives

Program Purpose

Signed into law on February 17, 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act represents a historic opportunity to improve American health care delivery and patient care through an unprecedented investment in health information technology (HIT). ONC has undertaken a major effort to successfully implement and oversee HITECH programs. ONC has established eight entirely new major grants programs, issued new regulations, created new Federal Advisory Committee Act (FACA) workgroups, awarded many new contracts to support implementation, and built the federal capacity to manage these efforts. ONC's efforts have resulted in the implementation of key provisions of the HITECH Act and the obligation of a significant portion of the $2,000,000,000 appropriated for HIT activities.

ONC is pleased to have the opportunity to provide the public greater insight on the depth and rapid development of our HIT efforts.

Public Benefits
The HIT initiative is a critical component of health reform as health professionals and health care institutions, both public and private, leverage the full potential of digital technology to prevent and treat illnesses and to improve our nation's healthcare. The Office of the National Coordinator for Health Information Technology (ONC) is charged with leading and coordinating the efforts to facilitate that nationwide adoption of HIT.

HITECH sets an ambitious path to ensure health care transformation through HIT and provides incentives to Medicare and Medicaid providers and hospitals for the meaningful use of certified electronic health record (EHR) technology. To implement Recovery Act provisions, ONC has implemented swiftly, yet judiciously, a wide array of grant programs; contracts supporting evaluations and studies; privacy and security and communication activities; and published regulations supporting standards and certification, and a certification accreditation program all with the goal of supporting meaningful use. ONC has also contributed greatly to a proposed regulation on the meaningful use of electronic health records (developed by CMS). Each of these initiatives were conducted in a manner that achieved ambitious deadlines while assuring that ONC's decisions and actions supported the law's fundamental, long-term purposes: improving health and health care through the application of HIT. Meeting the long-term goals of the Recovery Act will continue to require thorough planning while delivering to the American people quick action and effective investment of committed funds.

C. Activities

The Office of the National Coordinator for Health Information Technology (ONC), under the authority delegated to it by the Secretary of the Department of Health and Human Services, (74 FR 41702, 74 FR 64086), is implementing the HITECH Act as outlined in the American Recovery and Reinvestment Act of 2009. Current activities are detailed below:

Privacy and Security Program - To carry out the Secretary's statutory responsibilities under Subtitle D of the HITECH Act, $24.3 million has been and will continue to be used to draft regulations, guidance, and reports, and to conduct studies and audits to strengthen privacy protections and security safeguards.

To implement HITECH Act improvements to the Health Insurance Portability and Accountability Act's (HIPAA's) privacy and security rules, HHS will use $16.2 million of the $24.3 million for HIPAA enforcement. For example, Section 13411 of the HITECH Act requires the Secretary to conduct periodic audits to ensure compliance with HIPAA. To implement this requirement, HHS has begun to assess, evaluate and develop an appropriate audit program. An audit study has commenced, the results of which are anticipated in July. Findings and recommendations resulting from the study will be evaluated and will serve as the basis for designing an audit program. In addition, the Secretary is required under Section 13410 to formally investigate any complaint where the preliminary facts indicate the possibility of a violation resulting from willful neglect. The Secretary has begun to establish standards for such investigations through the rule making process.

Section 13402 of HITECH requires entities that experience a breach in the privacy or security of health information to notify the individual involved as well as the Secretary. In addition to developing rules establishing standards for the breach notification process, the Secretary has also developed and is maintaining a web site list that identifies each covered entity involved in a breach involving the information of more than 500 individuals. The remaining funds will be directed towards studies and the drafting of regulations, guidance, and reports that the HITECH Act requires and will fund studies and the development of best practices for protecting health information in an electronic environment.

State Health Information Exchange Grants - The State HIE Cooperative Agreement Program provides $564 million to fund states' efforts to rapidly build capacity for exchanging health information across the health care system. Awardees are responsible for enabling increased connectivity for patient-centric information flow to improve the quality and efficiency of care and enable meaningful use of HIT. Key to this is the continual evolution and advancement of necessary governance, policies, technical infrastructure and financing for HIE across each state, territory, and State Designated Entities (SDEs) during a four-year performance period. This program is building on existing efforts to advance regional and state-level health information exchange while moving toward nationwide interoperability.

Health Information Technology Extension Program - The Regional Extension Center (REC) Cooperative Agreements will offer $721 million to fund technical assistance, guidance, and information to support and accelerate health care providers' efforts to become meaningful users of EHRs. Specifically, the RECs are designed to ensure that primary care clinicians who need help are provided with an array of on-the-ground support to meaningfully use EHRs. Providing training and support services, the RECs will assist doctors and other providers in the adoption and meaningful use of EHR systems. The REC program has coverage in virtually every geographic region of the United States, which ensures sufficient community-based support. The goal of the program is to provide outreach and support services to at least 100,000 priority primary care providers within two years. Priority primary-care providers are individuals and small group practices (fewer than 10 physicians and/or other health care professionals with prescriptive privileges) primarily focused on primary care as well as physicians, physician assistants, or nurse practitioners who provide primary care services in public and critical access hospitals, community health centers, rural health clinics, and in other settings that predominantly serve uninsured, underinsured, and medically underserved populations. The Health Information Technology Research Center (HITRC), funded at $53 million, will be responsible for gathering relevant information on effective practices and helping the RECs collaborate with one another and with relevant stakeholders to identify and share best practices in EHR adoption, effective use, and provider support.

Health IT Workforce Cooperative Agreements - Awards totaling $84 million to 16 universities and 70 junior colleges will support training and development of more than 50,000 new health IT professionals. An additional $34 million is available for two year funding under the Community College Consortia program after successful completion of a mid-project evaluation. The institutions receiving awards will help health care providers and hospitals implement and effectively use electronic health records. Specific Health IT workforce cooperative agreement programs are identified as follows:

- Community College Consortia - Provide assistance to institutions of higher education, or consortia thereof, to establish or expand health information technology education programs. Training is designed to be completed within six months or less. The programs offer flexibility to provide each trainee with skills and competencies that he/she does not already possess - either health care or information technology.
- Curriculum Development Centers Program - Provides funding to institutions of higher education, or consortia thereof, to support health information technology curriculum development. The materials developed under this program will be used by the member colleges of the regional Community College Consortia and will also be available to institutions of higher education across the country.
- University-Based Training Program - Produce trained professionals for vital, highly specialized health IT roles. Most trainees in these programs will complete intensive courses of study in 12-months or less and receive a university-issued certificate of advanced training. Other trainees supported by these grants will study toward masters' degrees.

- Competency Examination Program - Supports the development and initial administration of a set of health IT competency examinations. The program will create an objective measure to assess basic competency for individuals trained in short-term, non degree health IT programs and for members of the workforce seeking to demonstrate their competency in certain health IT workforce roles.

Beacon Communities – Cooperative Agreements totaling an estimated $250 million will provide funding to create demonstration communities in which clinicians, hospitals, and consumers show how the meaningful use of EHRs can achieve measurable improvements in health care quality, safety, efficiency, and population health in a given geographic area. An additional $5M will be funded to provide technical assistance to cooperative agreement award recipients.

National Institute of Standards and Technology (NIST) – The Recovery Act mandated the transfer of $20 million from ONC to NIST, a component within the Department of Commerce, to continue health care information enterprise integration. Specific efforts include accelerating the development and harmonization of standards through collaboration with ANSI (American National Standards Institute), Healthcare Information Technology Standards Panel (HITSP), Standards Developing Organizations, Federal agencies, professional societies, and industry; creating a healthcare information technology testing infrastructure to ensure that standards are implemented consistently as part of certification,; engaging NIST experts to plan and lead technical and programmatic activities which includes developing the architecture for testing infrastructure; developing advanced security technologies and guidance; prioritizing standards harmonization (in collaboration with industry); accelerating implementation specifications; engaging in research and development on usability; consulting on conformity assessment; and implementation assistance.

Other Initiatives/Omnibus – Other Initiatives include the Strategic Health IT Advanced Research Projects (SHARP) Cooperative Agreements. This program, funded at $60M, will support research projects focused on specific areas where breakthrough improvements can greatly enhance the transformational effects of health IT and address well-documented problems that have impeded adoption and the pathway to meaningful use. Each awardee will implement a collaborative, inter-disciplinary program of research addressing a specific focus area. The four focus areas for the SHARP awardees are security of health information technology, patient-centered cognitive support, healthcare application and network platform architectures; and secondary use of EHR data.

Another large key initiative will advance standards development and interoperability. These activities, estimated to total $64M, are designed to develop the standards, tools, policies, governance, interoperability framework, and technical infrastructure to support the Nationwide Health Information Network and create standards-based interoperability for health information exchange.

Public Health – These programs, funded at an estimated $30.5 million, will advance the capability of public health agencies to receive electronic reporting information from eligible professionals and hospitals, which will prepare eligible professionals and hospitals in becoming meaningful users of EHR technology. Funding supports interoperability of EHRs and immunization registries and electronic laboratory reporting between public health agencies and clinical care settings. These projects are critical to building the capacity of public health agencies to receive the electronic information from eligible professionals and hospitals that are working towards becoming meaningful users of EHRs.

D. Characteristics

Program	Award Type	Type of Recipients	Dollars (M)
Total			**$2000M**
NIST Health Care Information Enterprise Integration	Transfer	Transfer	$20M
Privacy and Security (Subtitle D) Enforcement	Contracts	Private Industry	$16.16M
Privacy and Security Regulations, Guidance, and Studies	Contracts	Private Industry	$8.125M
Regional Extension Centers	Cooperative Agreements	US-based nonprofit institution or group thereof	$721M
HIT Research Center	Contracts	Private Industry	$53M
State Health Information Exchange	Cooperative Agreements	State or State-Designated Entity	$564M
Community College-Based Training	Cooperative Agreements	Public, State controlled, and private institutions of higher education	$70M
Curriculum Development	Cooperative Agreements	Domestic non-profit institutions of higher education (or consortia thereof)	$10M
University-Based Training	Grants	US-based public or private, four year institutions of higher education or consortia of institutions of higher education that are led by a four-year institution of higher education	$32M
Competency Examination	Cooperative Agreement	Domestic institutions of higher education, or consortia thereof	$6M
Beacon Communities Grants and Evaluation and Technical Assistance Contracts	Cooperative Agreements and Contracts	State, county, local government; public &private institutions of higher education; nonprofits; tribes; private industry of higher education	$265.375
Public Health: Interoperability of EHRs & Immunization Registries	Cooperative Agreements	State and local governments	$12.1M[2]
Public Health -Laboratory Technical Implementation Assistance	Cooperative Agreements	State and local governments	$2.0M
Public Health – Infrastructure & Interoperability for Hospital Labs	Cooperative Agreements	State and local governments	$5.0M
Public Health -Infrastructure for Laboratory Results to Clinical Care from Public Health Laboratories	Cooperative Agreements	State and local governments	$5.0M
Public Health – Laboratory Interoperability Solutions and Enterprise Coordination; Technical and Clinical Decision Support Services	Contracts	Private Industry	$6.4M[3]
Other Initiatives/Omnibus			
SHARP	Cooperative Agreements	Public or private institution of higher education or public or private institution or organization with a research mission	$60M
Innovation	Cooperative Agreements and Contract	Non-profit research institutions and Private Industry	$5M
Clinical Decision Support	Contract	Private Industry	$4M

Program	Award Type	Type of Recipients	Dollars (M)
Standards and Interoperability	Contracts	Private Industry	$64.3M
Technical Assistance to State HIEs	Contract	Private Industry	$8.5M
Evaluations and Studies	Contracts	Private Industry	$28.3M
Communications	Contracts	Private Industry	$19.1M
Privacy and Security Best Practices and Meaningful Use	Contracts	Private Industry	$14.565M

[2] The $12.1 million included in this plan is part of a larger cooperative agreement program totaling $21.41 million. The other $9.35 million is financed through the Recovery Act Section 317 Immunization Program administered by the Centers for Disease Control and Prevention.
[3] Funds in the Section 317 Immunization Program will support similar contract activities.

E. Delivery Schedule

Program	Dollars (M)	Announcement Issued	Awards
Total	**$2000M**		
NIST Health Care Information Enterprise Integration	$20M	N/A	September 1, 2009
Privacy and Security (Subtitle D) Enforcement	$16.16M	FY2010	$3.8M Awarded. Remaining awards FY2010.
Privacy and Security Regulations, Guidance, and Studies	$8.125M	FY2010	$1.3M Awarded. Remaining awards FY2010.
Regional Extension Centers	$721M	Cycle 1 Aug. 20, 09 Cycle 2 Nov. 23, 09 Supplements March 29, 2010	$375M Cycle 1 (Feb. 12 2010) $267M Cycle 2 (April 6 2010) $25M suppl. (June 2010) $45M second budget period (2012) $9M award modifications (as needed)
HIT Research Center	$53M	January 28, 2010	March 31, 2010
State Health Information Exchange	$564M	August 20, 2009	$547M Wave 1(Feb. 12, 2010) Wave 2 (March 15, 2010) $17M supplemental funding to grantees for customized technical assistance and to states facing significant challenges related to enabling health information exchange.
Community College-Based Training	$70M	Nov. 25, 2009	$36M budget period one (Apr. 2, 2010) $34M budget period two (Apr. 2011)
Curriculum Development	$10M	Dec. 2, 2009	April 2, 2010
University-Based Training	$32M	Dec. 17, 2009	April 2, 2010
Competency Examination	$6M	Dec. 17, 2009	April 2, 2010

Program	Dollars (M)	Announcement Issued	Awards
Beacon Communities Grants and Evaluation and Technical Assistance Contracts	$265.375	Cycle 1 Dec. 2, 2009 Cycle 2 June 2010 Evaluation/ Technical Assistance June 2010	$220M Cycle 1 May 4, 2010 $30.375M Cycle 2 Fall 2010 Evaluation/ Technical Assistance August 2010
Public Health: Interoperability of EHRs & Immunization Registries	$12.1M[4]	May 7, 2010	August 2010
Public Health: Laboratory Technical Implementation Assistance	$2.0M	March 5, 2010	June 2010
Public Health: Infrastructure & Interoperability for Hospital Labs	$5.0M	May 6, 2010	August 2010
Public Health: Infrastructure for Laboratory Results to Clinical Care from Public Health Laboratories	$5.0M	March 19, 2010	June 2010
Public Health: Laboratory Interoperability Solutions and Enterprise Coordination; Technical and Decision Support Services	$6.4M[5]	March 9, 2010 - May 6, 2010	July 2010 - August 2010
Other Initiatives/Omnibus			Approved $203.765
SHARP	$60M	Dec. 17, 2009	April 2, 2010
Innovation	$5M	FY2010	Fall 2010-FY 2011
Clinical Decision Support	$4M	February 2010	April 2010
Standards and Interoperability	$64.3M	FY2010	CY 2010
Tech. Assistance to State HIEs	$8.5M	February 2010	March 2010
Evaluations and Studies	$28.3M	February 2010	March 2010, September 2010
Communications	$19.1M	February 2010	March 2010
Privacy and Security Best Practices and Meaningful Use	$14.565M	FY2010	$9.5 Awarded FY 2010 for remaining awards

[4] The $12.1 million included in this plan is part of a larger cooperative agreement program totaling $21.41 million. The other $9.35 million is financed through the Recovery Act Section 317 Immunization Program administered by the Centers for Disease Control and Prevention.

[5] Funds in the Section 317 Immunization Program will support similar contract activities.

Regulations

Standards Rulemaking: Recovery Act §3004 (B) (1) states that, no later than December 31, 2009, HHS shall adopt and publish an initial set of standards, implementation specifications, and certification criteria for certified EHR technology. The rulemaking for this initial set of standards, implementation specifications, and certification criteria may be issued on an interim, final basis. Under this authority, ONC issued an Interim Final Rule on December 30, 2009 that specifies the Secretary's adoption of an initial set of standards and certification criteria for electronic health record (EHR) technology. The Interim Final Rule became effective 30 days after publication and was open for public comment for 60 days after publication. The final rule will be issued in summer 2010.

Certification Programs - Section 3001(c)(5) of the Public Health Service Act (PHSA) as added by the Health Information Technology for Economic and Clinical Health (HITECH) Act, requires the National Coordinator, in consultation with the Director of the National Institute of Standards and Technology, to keep or recognize a program or programs for the voluntary certification of health information technology

as being in compliance with applicable certification criteria. Under this authority ONC issued a Notice of Proposed Rulemaking (NPRM) on March 10, 2010 proposing the establishment of two certification programs for the purposes of testing and certifying health IT, one temporary and one permanent. The public comment period for the temporary certification program was open for 30 days after publication. The public comment period for the permanent certification program was open for 60 days after publication. While two certification programs are described in this proposed rule, ONC anticipates issuing separate final rules for each of the programs in calendar year 2010.

Meaningful Use - On December 30, 2009, CMS, based on significant input from ONC, announced a NPRM to implement provisions of the Recovery Act that provide incentive payments for the meaningful use of certified EHR technology. The proposed rule outlines provisions governing the EHR incentive programs, including defining the central concept of "meaningful use" of certified EHR technology. The goal is to provide a definition of meaningful use consistent with applicable provisions of Medicare and Medicaid law while continually advancing the contributions certified EHR technology can make to improving health care quality, efficiency, and patient safety. To accomplish this, the proposed rule suggests an approach to phase in more robust criteria for demonstrating meaningful use over time through future rulemaking. A 60-day comment period was provided on the proposed rule, which concluded on March 15, 2010 and issuance of a final rule is anticipated in summer 2010.

Privacy and Security – The Office for Civil Rights (OCR) is currently working on a notice of proposed rulemaking to implement many of the provisions included in Subtitle D of the HITECH Act such as business associate liability; new limitations on the sale of protected health information, marketing, and fundraising communications; and stronger individual rights to access electronic health records and restrict the disclosure of certain information. OCR has issued new regulations covering breach notification and has amended the HIPAA Enforcement Rule to include more robust penalties as mandated by the HITECH Act. The breach notification regulation requires covered entities to notify the Secretary whenever there is a breach of data that impacts more than 500 individuals, and annually to notify the Secretary of any breach that impacts less than 500 individuals. A proposed rule on additional changes to the HIPAA Privacy Rule is expected in 2010.

F. Environmental Review Compliance

The activities described in this Implementation Plan do not trigger the requirements of the National Environmental Policy Act (NEPA), National Historic Preservation Act (NHPA) or related statutes.

The ONC and Department of Health and Human Services are committed to sustainable operations of its activities and facilities through sound environmental stewardship including preferential procurement of environmentally preferred products and electronic stewardship of IT and data center operations.

As programs are developed, ONC will incorporate contract and/or grant language to mitigate the environmental impacts of acquisition of IT and other products and equipment and services and provide guidance to encourage the following:

- Green procurement' based on the HHS Affirmative Procurement Plan and similar guidance from the Environmental Protection Agency (EPA) and the President's Council on Environmental Quality (CEQ)
- Electronic Stewardship including the use of electronic products that are Energy Star® compliant and Electronic Product Environmental Assessment Tool (EPEAT) Silver registered or higher when available; the activation of Energy Star® features on all equipment, when available; environmentally sound 'end-of-life' management practices (including reuse, donate, sell, or recycle 100% of electronic products;) and best operation and management practices for energy efficient data centers.

G. Measures

Program: State Health Information Exchange (four year program – ending approx March 2014)

Outcome/measure: Community pharmacies able to receive and process electronic prescriptions. *Electronic prescriptions are both safer and more convenient for consumers because they are transmitted directly to the pharmacy avoiding delays in filling and transcriptions errors. They can also be efficiently refilled saving time for doctors, pharmacists, and patients. This measure represents an important activity that requires States' involvement in the HIE program.*
Unit: Percent
Frequency: Annually
Direction: Increasing
Type: Outcome
Data Source: Surescripts annual report; state grantee progress reports.

Measure	6/30/ 10	9/30/ 10	12/31/ 10	3/31/ 11	6/30/ 11	9/30/ 11	12/31/ 11	3/31/ 12	6/30/ 12	9/30/ 12	12/31/ 12	12/31/ 13	12/31/ 14	12/31/ 15	Prog. End
TARGET	N/A	N/A	87%	87.5%	88%	89%	90%	92%	94%	97%	100%	100%	100%	100%	
ACTUAL															

Program: Community College Consortia (two year program – ending approx March 2012)

Outcome/measure: Students completing training programs at community colleges to become HIT professionals. *There is high demand for HIT professionals from health providers and from ONC's Regional Extension Centers (see below) which are helping doctors and hospitals adopt or upgrade electronic records systems. Community colleges will be issuing certificates to students completing programs of study in HIT. The ultimate goal is for these students to gain employment in the HIT sector.*
Unit: Number
Frequency: Quarterly
Direction: Increasing
Type: Output
Data Source: Grantee progress reports

Measure	6/30/ 10	9/30/ 10	12/31/ 10	3/31/ 11	6/30/ 11	9/30/ 11	12/31/ 11	3/31/ 12	6/30/ 12	9/30/ 12	12/31/ 12	12/31/ 13	12/31/ 14	12/31/ 15	Prog. End
TARGET	0	0	0	0	700	700	3500	4200	7000	7000	10,500	N/A	N/A	N/A	
ACTUAL															

Program: Regional Extension Centers (four year program – ending approx March 2014)

Outcome/measure: Providers registered to receive services from Regional Extension Centers.
Unit: Number of providers registered
Frequency: Quarterly
Direction: Increasing (Note: Program is funded to register and work with a total of 100,000 providers.)
Type: Output
Data Source: Customer Relationship Management Tool.

Measure	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	12/31/11	3/31/12	6/30/12	9/30/12	12/31/12	12/31/13	12/31/14	12/31/15	Prog. End
TARGET	3,000	30,000	50,000	75,000	90,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	100,000	N/A	
ACTUAL															

Outcome/measure: Adoption of EHRs among providers who have registered with Regional Extension Centers for at least 10 months.
Unit: Percent adoption of EHRs among providers registered with Regional Extension Centers
Frequency: Quarterly
Direction: Increasing
Type: Outcome
Data Source: Extension Center Customer Relationship Management Tool.

Measure	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	12/31/11	3/31/12	6/30/12	9/30/12	12/31/12	12/31/13	12/31/14	12/31/15	Prog. End
TARGET	N/A	N/A	N/A	20%	30%	40%	45%	50%	55%	60%	65%	75%	80%	N/A	
ACTUAL															

H. Monitoring and Evaluation

ONC, recognizing the health information technologies' critical contribution to health reform and duty to ensure the appropriate use of taxpayers dollars, has assumed numerous opportunities to monitor and evaluate programs which include, but are not limited to:

Grants

ONC's grants programs are implemented through Cooperative Agreements, thereby affording the Federal Government an opportunity to assume a more substantial role and work collaboratively with grantees with respect to their implementation endeavors. Consistent with this premise, the majority of ONC's cooperative agreements included funding restrictions which are removed upon the grantee's demonstrated achievement of established milestones. In addition to Government-wide financial, program, and Recovery Act reporting requirements, ONC is in the process of developing a Customer Relationship Management (CRM) tool providing a forum through which ONC and grantees can exchange information including successes and challenges.

Evaluations, Reports, and Studies

Consistent with ARRA mandates and ONC's priorities, a series of evaluations and studies have been commissioned to assess program implementation. Studies include a global evaluation of ONC's ARRA efforts, as well as Regional Extension Center, State Health Information Exchanges, Beacon Communities, Workforce, and SHARP grant program evaluations. In addition, a series of Privacy and Security studies have been initiated including de-identification of protected health information and utilizing technology for online dispute resolution and error corrections.

Internal Review of ONC Operations

ONC continually seizes opportunities to proactively prevent, detect, and mitigate risks. These opportunities include evaluating internal controls, assessing the degree to which ONC's grant award activities comply with Government-wide and Department-wide regulations, policies, and procedures; and determining whether grantees are achieving intended performance objectives.

Participation in Department-wide Endeavors

All ONC Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control."

ONC's risk management process aligns with the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. The Office of the Secretary's Senior Assessment Team, of which ONC is an active member, carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated

with selecting recipients, awarding and overseeing funds, and achieving program goals. Meetings are conducted every two weeks to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, ONC will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

I. Transparency

ONC maintains a robust website (http://healthit.hhs.gov) through which the status of our efforts are made readily available to the public including funding opportunity announcements, names and amounts awarded to cooperative agreement recipients, notification of Federal advisory committee meetings, and status of regulatory efforts including opportunities for public comment. In addition, ONC maintains a Health IT Buzz Blog and Twitter account through which the exchange of ideas and viewpoints are encouraged. A List-Serv is also maintained through which subscribers are advised of important events and milestones.
ONC is open and transparent in all of its contracting and grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance.

ONC ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors. ONC informs recipients of their reporting obligation through educational sessions, resources posted on ONC's website, standard terms and conditions, grant announcements, and other program guidance. In addition, ONC provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, ONC has built upon and strengthened existing processes. Senior ONC officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

The HITECH Act requires the ONC to update the Federal Health IT Strategic Plan developed in June 2008 and identified a wide-breadth of areas that must be encompassed. To meet this mandate, ONC continues to pursue development of a plan encompassing the roles, viewpoints, and attributes of both the public and private HIT enterprise. Within this framework, themes, goals, principles, objectives, and strategies have been drafted and continue to be refined in view of public input. Once finalized, the plan will serve as a mechanism through which performance is assessed, results are documented, and accountability, for both successes and weaknesses, is determined.

K. Barriers to Effective Implementation

While staffing levels in ONC have increased, consistent with the FY 2011 President's Budget, resources are necessary to effectively manage the breadth and complexity of programs under ONC's purview. Ambitious goals have been established, with respect to ONC's grant program, interoperability initiatives, and other massive endeavors and having the resources to help ensure attainment of these goals is vital. To that end, recruitment efforts will continue.

One of the most critical implementation issues is maintaining an open and transparent process. This has required a significant investment of time and resources. To that end, ONC must continue robust outreach efforts to ensure public understanding and support of health information technology efforts including the contribution such efforts will make to overall health care reform. This is currently achieved thorough a variety of forums including speaking engagements, blogs, invitations to the public to participate in stakeholder meetings, and opportunities for the public to comment on proposed regulations.

In addition, ARRA provided for the creation of an HIT Policy Committee and the HIT Standards Committee under the auspices of the Federal Advisory Committee Act (FACA). The HIT Policy Committee is charged with making policy recommendations to the National Coordinator and the HIT Standards Committee is charged with making recommendations to the National Coordinator regarding standards, implementation specifications, and certification criteria for the electronic exchange and use of health information. All HIT Policy and HIT Standards Committees meetings are open to the public both in-person and available for listening on the telephone and on the web. The public are invited to make comments at the close of each meeting and are also encouraged to submit written comments on issues before the Committees.

To ensure that the National Coordinator is well informed on the issues, the Committees have also formed Workgroups (or subcommittees). The HIT Policy Committee and HIT Standard Committee each have three to seven workgroups at any given point of time to discuss and develop policies on particular areas of interest such as meaningful use, certification, information exchange, privacy and security, and clinical operations and quality. All of the Workgroups operate in public and there is an opportunity during each Workgroup meeting for the public to comment.

In a number of instances, the Workgroups have held public, in-person hearings on topics which they wish to explore further. For example, Certification and Adoption workgroup of the HIT Policy Committee held a hearing on HIT Safety to explore patient-safety issues related to the use of electronic health records – both risks and approaches to mitigating those risks. The Implementation Workgroup held a hearing on "Implementation Starter Kits: Lessons & Resources to Accelerate Adoption," which included a discussion on the Federal contribution, implementation among providers and their vendors discussing the process and tools to meet meaningful use, and an innovations panel which discussed novel, alternative uses of implementation strategies for HIT. Also, a FACA Blog has been set up on the ONC website to ensure even greater public participation.

The HIT Policy and HIT Standards Committees have been meeting for one year and have each held 12 public meetings. The Workgroups, to date, have held more than 150 teleconference calls and/or public meetings.

Many of the challenges to successful advancement of HIT have been existence before the introduction of ARRA such as privacy and security considerations, adoption, and interoperability across state and regional boundaries. That said, ARRA funding has afforded ONC the opportunity to direct additional resources to these efforts in pursuit of these challenges.

L. Federal Infrastructure

The activities described in this Implementation Plan are not related to building requirements or construction environmental impact issues.

Summary of Significant Changes:

At the time the original May 2009 Implementation Plan was issued, Privacy and Security Guidance and Enforcement initiatives were underway while other ARRA endeavors for brand-new programs were under development. The focus of the May 2009 Implementation Plan was largely targeted towards the Privacy and Security activities and commensurate timeframes. Over the course of the past year, many additional ARRA initiatives have been implemented including, but not limited to, eight new grant programs, issuance of standards and certification regulations, and pursuit of public health programs, all of which, and more, are now detailed in this updated Implementation Plan (May 2010). This updated plan now reflects all activities which will be implemented under the full $2 billion appropriated to the Office of the National Coordinator for Health Information Technology under ARRA/HITECH and includes new performance measures for these activities.

National Institutes of Health: Scientific Research

The Recovery Act directly provided $10 billion to the National Institutes of Health (NIH). This Implementation Plan focuses on the $8.2 billion of Recovery Act funds provided to NIH to support the Scientific Research program.

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
National Cancer Institute	$1,256.5	$830.0	$426.5
National Heart, Lung and Blood Institute	$762.6	$415.1	$347.5
National Institute of Dental and Craniofacial Research	$101.8	$53.2	$48.6
National Institute of Diabetes and Digestive and Kidney Diseases	$445.4	$196.3	$249.1
National Institute of Neurological Disorders and Stroke	$402.9	$223.7	$179.2
National Institute of Allergy and Infectious Diseases	$1,113.3	$526.1	$587.2
National Institute of General Medical Sciences	$505.2	$303.7	$201.5
National Institute of Child Health and Human Development	$327.4	$136.0	$191.4
National Eye Institute	$174.1	$93.3	$80.8
National Institute of Environmental Health Sciences [1]	$187.4	$102.9	$84.5
National Institute on Aging	$273.3	$149.4	$123.9
National Institute of Arthritis and Musculoskeletal and Skin Diseases	$132.7	$73.7	$59.0
National Institute on Deafness and Other Communication Disorders	$103.0	$73.5	$29.5
National Institute of Mental Health	$366.8	$200.9	$165.9
National Institute on Drug Abuse	$261.2	$135.9	$125.3
National Institute on Alcohol Abuse and Alcoholism	$113.9	$57.5	$56.4
National Institute of Nursing Research	$35.9	$17.0	$18.9
National Human Genome Research Institute	$127.0	$68.7	$58.3
National Institute of Biomedical Imaging and Bioengineering	$77.9	$41.5	$36.4
National Center for Research Resources	$310.1	$240.1	$70.0
National Center for Complementary and Alternative Medicine	$31.7	$16.8	$14.9
National Center on Minority Health and Health Disparities	$52.1	$32.1	$20.0
Fogarty International Center	$17.4	$10.3	$7.1
National Library of Medicine	$83.6	$37.7	$45.9
Common Fund	$136.8	$68.3	68.5
Office of the Director	$800.0	$215.2	$584.8
Total	$8,200.0	4,318.9	$3,881.1

[1] Includes Superfund

B. Objectives:

Program Purpose: The National Institutes of Health (NIH) accomplishes its mission through one overarching program: research. NIH probes the unknown to gain new knowledge; communicates and transfers new knowledge to health care providers and the public; trains investigators; and manages and supports the people, systems, and facilities necessary to carry out this work. These activities are integral elements of the research enterprise with the goal of adding to the body of knowledge that will help prevent, detect, diagnose, and treat disease and disability. The NIH research mission is pursued by its Institutes and Centers (ICs), which support and conduct research in partnership with an extensive extramural research community and the NIH intramural research program.

Public Benefits: Recovery Act funds will produce benefits to the economy, to scientific knowledge, and ultimately aid in improving the health of the Nation through the award of grants, contracts and other activities that support biomedical research. The NIH Recovery Act Implementation Plan was developed to accomplish these objectives through a three-tiered approach; 1) NIH has developed new Recovery Act funding opportunity announcements to target specific areas of health research which exploit new technologies and other timely opportunities for growth and to cultivate a stronger biomedical research infrastructure; 2) additional resources have been devoted to NIH's established research programs, including meritorious research programs that previously could not be supported by NIH's base appropriation, to accelerate the pace of ongoing research; and 3) new investments have been made in programs that offer potentially transformative approaches to address major challenges in biomedical research.

C. Activities:

The three-tiered approach outlined above allowed NIH to begin distributing the Recovery Act appropriation in a thoughtful and deliberate manner within only four months of the Act's passage, achieving immediate economic relief for the biomedical research community and the vendors, manufacturers and other technical professionals reliant upon the Nation's thriving biomedical research industry for their livelihoods. The American biomedical research community responded to a series of ARRA funding announcements issued by the NIH Office of the Director with an overwhelming number of meritorious grant applications. NIH included in each of the funding announcements, and in the FY 2009 implementation plan, a conservative estimate of the minimum amount that would be awarded under each of these funding announcements from the ARRA funds appropriated to the Office of the Director (OD). In many cases, because of the large number of highly meritorious applications, the individual Institutes also elected to pay applications relevant to their specific missions. As a result, the funds awarded surpassed the original conservative estimates, particularly for the Competitive Revisions and Administrative Supplements, Summer Research Experiences for Students and Science Educators, Challenge Grants, and Grand Opportunity grants programs..

In March 2009, NIH announced four programs to provide immediate benefits through Recovery Act funds:

- ARRA Payline Extension: Awarding highly meritorious applications (approximately $1.4 billion awarded in FY 2009; additional awards will be made in FY 2010): NIH has provided funding support for peer-reviewed and approved, highly meritorious grant applications from investigators across the nation that were not funded in FY 2008, as well as grant applications that were not otherwise likely to be funded in FY 2009 or FY 2010.
- Competitive Revisions (NOT-OD-09-058) and Administrative Supplements (NOT-OD-09-056) (approximately $1.7 billion awarded in FY 2009; additional awards will be made in FY 2010): NIH is expanding the scope and accelerating the tempo of ongoing science via NIH's supplement programs, through support of additional infrastructure (e.g., equipment costing less than $100,000) and personnel support for new types of activities that fit into the structure of the Recovery Act.
- Summer Research Experiences for Students and Science Educators (NOT-OD-09-060) (approximately $45 million awarded in FY 2009): This program provides summer jobs for high school/college students and teachers to work in science labs.

NIH also worked to develop new research programs specifically tailored to foster new research infrastructure and to achieve high-impact results within the short timeline of the Recovery Act initiative. Examples of the newly developed activities supported through the NIH Recovery Act programs include:

- Challenge Grants (RC1: RFA-OD-09-003) ($371 million awarded in FY 2009; additional awards will be made in FY 2010): The NIH Recovery Act Challenge Grant program focuses on health and science problems, to include cancer and autism, where significant progress can be made in a two-year time frame.

- Grand Opportunity Program, or "GO grants" (RC2: RFA-OD-09-004) ($550 million awarded in FY 2009; additional awards will be made in FY2010): The purpose of this program is to support high-impact ideas that require significant resources for a discrete period of time to lay the foundation for new fields of investigation.

- New Faculty Recruitment to Enhance Research Resources through Biomedical Research Core Centers (RFA-OD-09-005) ($80 million awarded in FY 2009; additional awards will be made in FY 2010): NIH will support the recruitment of new faculty to conduct research at institutions across the country.

- Enabling National Networking of Scientists and Resource Discovery (U24: RFA-RR-09-009; $14 million awarded in FY 2009; additional awards will be made in FY 2010): NIH is developing, enhancing, or extending infrastructure for connecting people and resources to facilitate national discovery of individuals and of scientific resources by scientists and students to encourage interdisciplinary collaboration and scientific exchange.

- Small Business Catalyst Awards for Accelerating Innovative Research (R43: RFA-OD-09-009; $5 million to be awarded in FY 2010): NIH will support entrepreneurs of exceptional creativity, drawn from scientific and technological environments beyond NIH, who propose pioneering and possibly transformative approaches to addressing major biomedical or behavioral challenges with the potential for downstream commercial development.

- NIH Directors Opportunity for Research in Five Thematic Areas (RC4: RFA-OD-10-005; at least $80 million to be awarded in FY 2010): NIH will develop and implement critical research innovations in five thematic areas.

- Academic Research Enhancement Award (R15: RFA-OD-09-007; at least $20 million to be awarded in FY 2010): NIH is stimulating research in educational institutions that provide baccalaureate or advanced degrees for a significant number of the Nation's research scientists, but that have not been major recipients of NIH support.

- The NIH Director's ARRA Funded Pathfinder Award to Promote Diversity in the Scientific Workforce (DP4: RFA-OD-10-013; at least $10 million to be awarded in FY 2010): NIH will encourage exceptionally creative individual scientists to develop highly innovative and possibly transforming approaches for promoting diversity within the biomedical research workforce.

- Biomedical Research, Development, and Growth to Spur the Acceleration of New Technologies (BRDG-SPAN) Pilot Program (RC3: RFA-OD-09-008; at least $35 million to be awarded in FY 2010): NIH will address the funding gap between promising research and development (R&D) activities and transitioning to the market by contributing to the critical funding needed by applicants to pursue the next appropriate milestone(s) toward ultimate commercialization; i.e. to carry out later stage research activities necessary to that end.

Signature Initiatives: NIH also identified a number of Signature Initiatives to support exceptionally creative and innovative projects and programs that represent potentially transformative approaches to major challenges in biomedical research. The initiatives cover new scientific opportunities in nanotechnology, genome-wide association studies, health disparities, arthritis, diabetes, autism, the genetic risk for Alzheimer's disease, regenerative medicine, oral fluids as biomarkers, and HIV vaccine research.

Contract Actions: NIH also is funding similar scientific research through contracts to help achieve the objectives of the Recovery Act, including accelerating the advance of scientific knowledge, achieving economic benefits and ultimately improving the health of the Nation. In FY 2009 NIH awarded $360 million in competitive contracts, with additional contracts to be awarded in FY 2010.

D. Characteristics

NIH exploited a diverse array of funding mechanisms to execute the Recovery Act funds. The table below shows the estimated allocation of Recovery Act funding by mechanism.

(Note that this table includes only NIH Recovery Act funding related to scientific research.) NIH will obligate a significant amount through research project grant mechanisms and contracts. Over $8 billion will be awarded extramurally by the end of FY 2010, primarily to universities, medical centers, hospitals and for-profit and non-profit research institutions throughout the country. NIH will allocate approximately $335 million for administrative and intramural projects.

The NIH uses the peer review system to determine meritorious awards. NIH's peer-review policy is intended to ensure that grant applications submitted to the NIH are evaluated on the basis of merit. Various levels of review are utilized to show relevance to the scientific issue and the IC oversight.

Allocation of Recovery Act funding by Mechanism[1]

	FY 2009/FY 2010	
	No.	**Amount**
Research Grants		
Research Projects		
Noncompeting	4,543	$2,035,989
Administrative Supplements	(9,669)	1,459,433
Competing	5,472	2,746,347
Subtotal	**10,015**	**6,241,769**
SBIR/STTR	159	64,624
Subtotal, RPG	**10,174**	**6,306,393**
Research Centers		
Specialized/Comprehensive	440	515,043
Clinical Research	3	77,307
Biotechnology	6	32,506
Comparative Medicine	2	24,712
Res. Centers in Minority Instit.	2	22,861
Subtotal, Centers	**453**	**672,429**
Other Research		
Research Careers	87	42,324
Cancer Education	0	1,292
Cooperative Clinical Research	43	35,270
Biomedical Research Support	6	1,464
Minority Biomed. Res. Support	0	16,163
Other	128	121,891
Subtotal, Other Research	**264**	**218,404**
Total Research Grants	**10,891**	**7,197,226**
Training	**FTTPs:**	
Individual	177	6,935
Institutional	213	23,522
Total Training	**390**	**30,457**
R&D Contracts	**47**	**637,487**

	FY 2009/FY 2010	
	No.	Amount
Intramural Research **Res. Management & Support**		**81,594** **253,236**
TOTAL		**8,200,000**

E. Delivery Schedule:

NIH published several major Funding Opportunity Announcements (FOAs) related to the Recovery Act by May 12, 2009. NIH began making Recovery Act awards for meritorious applications that were not funded in prior years beginning in April 2009, and will continue to make awards as meritorious applications are identified. NIH awarded Challenge Grants, GO grants and awards in August and September 2009. About half of the funding available for this activity was obligated in FY 2009, with the rest to be obligated in FY 2010.

March 2009	NIH began publishing Recovery Act-specific funding announcements
April 2009	NIH began awarding Recovery Act payline extension grants, supplements and competitive revisions
May-July 2009	Peer review was conducted for Challenge and GO Grants
August-Sept 2009	Council Review and awards issued for Challenge and GO Grants
January 2010	Council Review was carried out for the following Funding Opportunities: • BRDG-SPAN Pilot Program • Small Business Catalyst Awards • Recovery Act AREA Awards
Ongoing after March 2010	Awards issued for council reviewed and meritorious applications. Progress reports received and reviewed for non-competing Recovery Act renewals; non-competing continuation awards obligated prior to the expiration of the initial award segment
May 2010 Council	Council Review for the following Funding Opportunities: • Building Sustainable Community-Linked Infrastructure
August 2010	Council Review for the following Funding Opportunities: • NIH Director's Pathfinder Award • NIH Director's Research in Five Thematic Areas

September 2010	Awards issued to obligate all remaining Recovery Act funds under the Scientific Research Appropriation

F. Environmental Review Compliance

Consistent with the provisions of the National Environmental Policy Act (NEPA), NIH has procedures in place to ensure that Federal officials properly take into account potential environmental consequences when taking actions. Section 1609 (c) of the Recovery Act requires that the President report to the Senate Environment and Public Works Committee and the House Natural Resources Committee every 90 days following the date of enactment until September 30, 2011 on the status and progress of projects and activities funded by the Act with respect to compliance with NEPA requirements and documentation. The Council on Environmental Quality (CEQ) promulgated reporting requirements in a March 11, 2009 document that described specific procedures and a reporting template that NIH completes regularly and provides to the HHS Office of Facilities Management and Policy (OFMP).

Most research grants qualify for a categorical exclusion from detailed NEPA review, as promulgated in the Federal Register on January 19, 2000: "NIH is providing notice of the actions that will normally be categorically excluded from further environmental review because individually and cumulatively they will not have a significant effect on the human environment. If a proposed action is included in one of the categories but extraordinary circumstances as described in section D of this notice apply, an environmental review will be performed." In other words, whereas most research grants qualify for the categorical exclusion, NIH is required to conduct oversight to ensure that all proposals are reviewed for extraordinary circumstances or triggers that might warrant additional environmental review. To meet this responsibility, NIH has included NEPA related reviews in its award and progress reporting processes.

NIH has determined that the following are potential extraordinary circumstances:

1. Greater scope or size than other actions included within a category.
2. A threatened violation of a Federal, State, or local law established for protection of the environment or for public health and safety.
3. Potential effects of the action are unique or highly uncertain.
4. Use of especially hazardous substances or processes for which adequate and accepted controls and safeguards are unknown or not available.
5. Overload existing waste treatment plants due to new loads (volume, chemicals, toxicity, additional hazardous wastes, etc)
6. Possible impact on endangered or threatened species.
7. Introduce new sources of hazardous/toxic wastes or require storage of wastes pending technology for safe disposal.
8. Introduce new sources of radiation or radioactive materials.
9. Substantial and reasonable controversy exists about the environment effects of the action.

In order to ensure a heightened awareness of the environmental aspects of Recovery Act, the Director of the Office of Research Facilities briefed the Extramural Program Management Committee on April 2, 2009; the Grants Management Advisory Committee

on June 17, 2009; and NIH Extramural Staff at large on July 31, 2009. The Categorical Exclusion is used for routine research grants, and we expect ARRA awards to follow a similar pattern.

G. Measures

This information will be available to the public on the Recovery Act website.

NIH is using the following measures for this program:

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	Program End
Number of New and Competing Research	#	TARGET	6,722	5,053	5,116	5,315	7,679	
Project Grants (RPGs) awarded.		ACTUAL	5,071	5,079	5,159			
Number of administrative	#	TARGET	2,076	7,095	7,838	9,125	3,983	
supplement awards made.		ACTUAL	7,005	7,416	8,086			
Number of competitive.	#	TARGET	539	409	414	431	661	
revision awards made		ACTUAL	414	417	423			
Number of non competing.	#	TARGET			72	2,177	4,801	
continuation awards made		ACTUAL			61			
Number of Jobs Created or Retained	#	TARGET	6,722				7,679	
		ACTUAL	4,921	12,338	16,953			

The actual number of awards reported above reflect data on awards made by the specific issuance date in NIH's Information for Management, Planning, Analysis and Coordination System v.2 (IMPAC2) database. Targets reflect analysis of actual awards made to date by type of grant award, as well as detailed reporting by individual Institute/Center on anticipated awards by grant type for the remainder of FY 2010. The actual average size of ARRA awards made in FY 2009 was larger than the standard award size NIH used when calculating the original targets, resulting in a downward adjustment in the number of awards anticipated for research project grants and competing revision awards. The increased average size of ARRA awards acknowledges

the loss of purchase power experienced in prior years when NIH experienced increasing differences between the inflation rate and annual budget increases. NIH will obligate all ARRA funds by 9/30/10 by issuing new and competing awards in response to the FY 2010 FOAs, continuing to award highly meritorious applications received in response to non-ARRA FOA's, as well as making additional administrative supplement and competing revision awards.

NIH has also developed the following outcome performance objectives, set forth in GPRA plans, to assess the performance of Recovery Act activities beyond 2010. Given the breadth of science covered in the Scientific Research program, these outcome measures are illustrative of the program.

Performance Objectives				**FY 2010**	**FY 2011**
	Type	**Frequency**	**Unit**	**Target**	**Target**
Take advantage of advances in genomics research and high-throughput technologies to understand the fundamentals of biology and the causes of specific diseases.	Outcome	Yearly	GPRA Performance Target	Develop tools and resources for the study of prevalent diseases using genetic and genomic methods.	Use the newly developed tools and resources to advance the research into the underlying causes of prevalent diseases.
Use new discoveries about health and disease to develop diagnostics, prevention, and therapies.	Outcome	Yearly	GPRA Performance Target	Identify therapeutic strategies and initiate characterization of stem cell models for the treatment of major diseases such as diabetes, cardiovascular disease, autism spectrum disorders and neurodegenerative diseases.	Demonstrate the therapeutic feasibility of the identified strategies and refine the stem cell models for future use in therapeutics.
Put science to work for the benefit of health care and reform	Outcome	Yearly	GPRA Performance Target	Initiate development of at least five tools and resources to facilitate health care throughout the course of a patient's life.	Finalize development and begin testing the tools and resources identified in 2010.

Examples of specific performance targets related to the performance objective listed under advances in genomics include:

- Initiate genome sequencing of 10,000 well-phenotyped patients with various diseases and their matched controls (12/31/10);
- Deposit the results of the high-throughput genome sequencing for 10,000 patients and their matched controls in a publicly accessible database (12/31/11);
- Begin identification of genomic alterations in nine tumor types (12/31/10);

- Complete the identification of the genomic alterations in the nine tumor types 12/31/11);
- Create an image library (e.g., images, videos and animations) of cells from a variety of organisms (12/31/10); and,
- Populate the image library with approximately 15,000 cell images (12/31/11).

Examples of specific performance targets listed under the performance objective related to using new discoveries to develop diagnostics, prevention and therapies include:

- Identify at least four therapeutic strategies and initiate characterization of two stem cell models for the treatment of major diseases (12/31/10);
- Demonstrate the therapeutic feasibility of the identified strategies and refine the stem cell models for future use in therapeutics (12/31/11);
- Characterize two stem cell models (12/31/10); and,
- Refine two stem cell models (12/31/11).

Examples of specific performance targets listed under the performance objective related to putting science to work for the benefit of health care reform include:

- Design an IT system to support exchange of medical images and another to evaluate behavioral interventions (12/31/10);
- Demonstrate sharing of medical images among at least four medical centers and develop the IT infrastructure resource to support secure information sharing (12/31/11);
- Expand a study aimed at developing a national standard for normal fetal growth study (12/31/11);
- Recruit at least 50 percent of the participants required for the fetal growth study (12/31/11);
- Expand studies aimed at gathering information to be used in curtailing the HIV pandemic (12/31/10);
- Identify at least one new strategy to target residual HIV in treated patients (12/31/11);
- Identify at least one new strategy for improving end-of-life and/or palliative care (12/31/10); and,
- Complete the development and/or testing of at least one strategy for enhancing quality of life through improved end-of-life and/or palliative care 12/31/11).

More complete descriptions of each measure and corresponding targets are available on the web at http://officeofbudget.od.nih.gov/pdfs/FY11/FY11_Online_Performance_Appendix-NIH.pdf.

H. Monitoring/Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B & C).

NIH's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. NIH's Senior Assessment Team in coordination with the NIH Risk Management Program carries out comprehensive annual assessments of its Recovery Act programs to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, NIH has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

The National Institutes of Health through the Extramural Grants Management Advisory Committee (GMAC), and the Contract Management Advisory Committee (CMAC), has established policies and procedures to assure a consistent and integrated approach to oversight practices that monitor extramural grantee activities for NIH contracts, grants, and cooperative agreements. These committees meet approximately twice a month. Guidance for progress tracking, financial management, and administrative management of NIH grants and contracts includes OMB Circular A-110, OMB Circular A-123, *Management's Responsibility for Internal Control*, sections of the Recovery Act including Section 1512, the *Federal Acquisition Regulations* and the *Updated Implementing Guidance for the Recovery Act of 2009.*

In addition, the NIH Office of Management Assessment (OMA) and the Office of Financial Management (OFM) have established the NIH risk management framework for identifying, assessing, and testing of operational and financial risks and internal controls associated with implementing Recovery Act requirements. OFM and OMA conduct risk and control assessments in compliance with the statutory requirements of the Federal Managers' Financial Integrity Act, the Improper Payments Information Act, and OMB's Circular A-123 *Management's Responsibility for Internal Control*. OMA will work with NIH offices that are responsible for implementing programs receiving Recovery Act funding to: identify and score the Recovery Act risks, assess controls related to the identified the Recovery Act risks, remediate controls as needed, monitor the inventory of Recovery Act

risks, and report on the risks and controls to NIH and HHS leadership. OFM uses its existing process for assessing internal control over financial reporting related to using and tracking Recovery Act funds and take into account any control deficiencies.

Progress reports are usually required for all active projects annually and report on scientific progress as well as administrative and fiscal compliance. The reports are reviewed by both program and grants management staff as required in the respective NIH Manual Chapters. The review process includes a project officer completing a review checklist for each project that covers: progress, scope, planning, any project changes, safety, outputs, and reporting requirement. The checklist requires additional information for identified compliance or risk areas. Mitigating or corrective actions are documented and trigger additional review as required. Outputs are reviewed by program officials to confirm appropriate progress. Progress standards are based on planned activities and milestones established by the terms of award of the funded grant application.

Grants management staff monitors the fiscal and administrative status using the progress report, the Financial Status Report and/or disbursements from the grantee project accounts as reported in the quarterly SF425 (Cash Transaction Report), and other pertinent information and correspondence. The administrative review is also documented through the completion of a checklist. When disbursements are materially outside of the parameters of the project, grants management staff contact the grantee for additional information, and confer with NIH program staff to determine whether the project may be at risk. Enforcement actions such as limiting disbursements based on actual charges to the project may be required, if project funds are determined to be at risk. Additional funds may be withheld if progress is not satisfactory, and continued concerns may lead to suspension or termination of award.

NIH routinely provides technical assistance and conducts technical assistance visits for oversight of grantee organizations when deemed necessary. Criteria that may trigger site visits include challenges or risk factors for progress, financial, or administrative management and other concerns regarding compliance the terms of award. Site visits and reviews are tailored to the specific circumstance of use for each Grantee Institution, with the participation of grant and / or program management as needed.

Although science validates itself statistically, other forms of evaluations occur on a regular or as needed basis. The findings from evaluability assessments, evaluations and system assessments are used to improve or to eliminate activities. Assessment type activities often are conducted by external contractors; however, trained evaluation NIH staff separate from a project or program can conduct the assessment as well.

I. Transparency

NIH is open and transparent in all of its contracting and grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance. All funding opportunities for grant awards are available at Grants.gov and notification of contract request for proposals are available through FedBizOps.gov.

NIH ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. NIH informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, NIH provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements. NIH provides technical assistance to grantees and contractors, and fully utilizes Project Officers to ensure compliance with reporting requirements. To ensure recipient cost and performance requirements are reported, all awards issued with Recovery Act funds have special accounting numbers and codes to track the funds and awards. All Recovery Act funds must be awarded separately from the normal appropriation funds. The awards must comply with both existing NIH reporting requirements and the Recovery Act reporting requirements. Grants awards include special terms and conditions based on guidance provided by OMB and HHS.

NIH has a link to Recovery.gov on its website. Also, NIH provides a searchable summary of all funding awards, including ARRA awards at report.nih.gov.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, NIH has built upon and strengthened existing processes. Senior NIH and Science Implementation officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system has incorporated Recovery Act program stewardship responsibilities for program and business function managers.

The NIH staff annual review of progress reports is designed to identify risk or challenge areas. Mitigating factors or corrective actions are documented and may trigger more frequent progress and financial reports or special terms of award as required. Project outputs are reviewed by program officials to confirm appropriate progress. Grants Management reviews for fiscal and administrative compliance. Progress is assessed based on planned activities and milestones within the grant application. Grants management can limit disbursement of funds or withhold awards for non-compliance with the terms of award or if progress is not satisfactory.

The NIH Office of Management Assessment and Office of Financial Management are coordinating efforts to ensure that existing risk management processes are fully used as NIH implements the provisions of the Recovery Act. Terms and conditions of award notices have been amended so that awardees are fully aware of the reporting requirements associated with Recovery Act funds.

K. Barriers to Implementation

NIH anticipates no significant barriers to implementation.

L. Federal Infrastructure Investments

This program does not include construction or renovations of federally owned assets or grant funded facilities.

Summary of Significant Changes:

- Expanded funding table to show three year obligations and outlays (Section A. Funding Table)
- Expanded "Public Benefits" to document focal areas for research (Section B. Objectives)
- Expanded discussion of planned activities to include actual funding in 2009 and additional areas of focus (Section C. Activities)
- Updated allocation of Recovery Act funding by mechanism (Section D. Characteristics)
- Expanded delivery schedule and updated accomplishments since inception (Section E. Delivery Schedule)
- Replacement of the listing of environmental review compliance "extraordinary circumstances" and efforts made to communicate compliance efforts to-date (May 2009) within NIH with the addition of National Environmental Policy Act (NEPA)-related reviews in awards and progress reports (F. Environmental Review Compliance)
- Updated performance *output* measures and added *outcome* performance measures (Section G. Measures)
- Added information on NIH's proactive risk assessment and mitigation efforts and their connection to OMB required internal controls (Section H. Monitoring and Evaluation)
- Expanded transparency efforts by making contractors and awardees aware of their transparency requirements under the Recovery Act; added link to recovery website (Section I. Transparency)
- Added explanation on the delays caused by added clearance levels to issue ARRA FOAs in publishing funding opportunities and the use of an accelerated awards process to offset the delay (Section K. Barriers to Implementation)

National Institutes of Health: Extramural Construction

The Recovery Act directly provided $10 billion to the National Institutes of Health (NIH). This Implementation Plan focuses on the $1.0 billion of Recovery Act funds provided to the National Center for Research Resources (NCRR), a component of the National Institutes of Health (NIH), for the Extramural Construction program.

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Extramural Construction	$1000.0	$52.1	$947.9

B. Objectives

The objective of the Recovery Act Extramural Construction program is to build capacity to conduct biomedical and behavioral research by supporting the costs of improving non-Federal basic research, clinical research, and animal facilities to meet the biomedical or behavioral research, research training, or research support needs of an institution. It is expected that all awards will be expended expeditiously and that applicants will consider the use of "green" technologies and design approaches. Awards are expected to create and/or maintain American jobs. The citizens of the United States will benefit from these awards through improved biomedical and behavioral research capacity.

The objective of the Recovery Act Extramural Construction program is to facilitate and enhance the conduct of biomedical and behavioral research by supporting the costs of designing and constructing non-Federal basic and clinical research facilities to meet the biomedical or behavioral research, research training, or research support needs of an institution or a research area at an institution.

C. Activities

The Extramural Construction program consists of two main activities:

1. **Extramural Research Facilities Improvement Program (RFIP) (approximately $800 million)**: The RFIP activity awards grants to public and nonprofit private entities to expand, remodel, renovate, or alter existing research facilities or construct new research facilities for biomedical and behavioral research.
2. **Core Facility Renovation, Repair, and Improvement (approximately $200 million)**: The Core Facility activity awards grants to public and nonprofit private entities to renovate, repair, or improve core facilities. A core facility is defined as a centralized shared resource that provides access to instruments or technologies or services, as well as expert consultation to investigators

supported by the core. Applicants may request support to alter and renovate (A&R) the core facility as well as to improve the general equipment in the core facility or to purchase general equipment for specialized groups of researchers. Specialized equipment over $100,000 in cost cannot be requested. Such equipment can instead be requested under a separate announcement for shared instrumentation (PAR-09-028). In situations when similar core facilities exist in different departments at an institution, funding can be requested in support of centralizing these core facilities.

D. Characteristics

Eligible recipients include 1) Public/State Controlled Institution of Higher Education; 2) Private Institution of Higher Education; and 3) Nonprofit with or without 501(c)(3) IRS Status (Other than Institution of Higher Education).

Awards are made to public and non-profit domestic institutions only, including health professional schools, other academic institutions, hospitals, health departments, and research organizations. The current obligations were $52.1 million in FY 2009 and will be $947.9 million in FY 2010. FY 2009 obligations were initially lower than expected due to a rigorous construction grant award process; however, FY 2010 obligations far exceed aggregate schedule. Aggregate obligations scheduled for completion by June 2010.

Institutions submit grant applications which are selected using NIH's standard, competitive, peer-reviewed process – a two level review process. Briefly, the first level of review for scientific and technical merit is conducted by expert peer review study sections convened by the NIH and comprised of external reviewers. The second level of review is conducted by the NCRR National Advisory Research Resources Council (NARRC). The final decisions are based on the scientific and technical merit of the application as determined by first and second level of peer review, the availability of funds, the relevance of the application to the NCRR/NIH program priorities, the national geographic distribution of awards, and the priorities specified in the Recovery Act, such as energy efficiency and job creation.

The table below provides a summary of key information about the Extramural Construction Program.

Characteristics:	**Extramural Research Facilities Improvement Program**	**Core Facilities Renovation, Repair, and Improvement Program**
Funding Opportunity Announcement (FOA) #	RFA-RR-09-008	RFA-RR-09-007
Types of awards	Grants	Grants
Estimated size of awards	$2-15M	$1-10M
Targeted recipients/beneficiaries	Public & non-profit private, domestic institutions & organizations	Public & non-profit private, domestic institutions & organizations
Methodology for award Selection	Competitive, 2-tiered peer review	Competitive, 2-tiered peer review

E. Delivery Schedule

The following table depicts major milestones and their associated timelines for the Extramural Construction program.

Milestones:	Extramural Research Facilities Improvement Program (C06)	Core Facilities Renovation, Repair, and Improvement Program (G20)
Funding Opportunity Announcement (FOA) #	RFA-RR-09-008	RFA-RR-09-007
FOA Released	March 5, 2009	March 5, 2009
Applications Due (award size/due date)	• $2-5 M/May 6, 2009 • $10-15 M/June 17, 2009 • $5-10 M/July 17, 2009	$1-10 M/September 17, 2009
Application Review	July – October 2009	December 2009
Earliest Awards	August 2009	March 2010

Additionally, to help speed the economic impact of the Recovery Act funds, NIH made a limited number of awards to previously peer-reviewed, meritorious (but unfunded) applications for the Extramural Construction program.

F. Environmental Review Compliance

National Environmental Policy Act (NEPA) Compliance under the Recovery Act in the area of Research Grants: Consistent with the provisions of NEPA in place since 1970, NIH has procedures in place to ensure that federal officials properly take into account potential environmental consequences when taking actions. Section 1609 (c) of Recovery Act requires that the President report to the Senate Environment and Public Works Committee and the House Natural Resources Committee every 90 days following the date of enactment until September 30, 2011 on the status and progress of projects and activities funded by the Act with respect to compliance with National Environmental Policy Act requirements and documentation. The Council on Environmental Quality (CEQ) promulgated reporting requirements in a March 11, 2009 document that described specific procedures and a reporting template that NIH fills in regularly and provides to the HHS Office of Facilities Management and Policy (OFMP).

Most research grants qualify for a categorical exclusion from detailed NEPA review, as promulgated in the Federal Register on January 19, 2000: “NIH is providing notice of the actions that will normally be categorically excluded from further environmental review because individually and cumulatively they will not have a significant effect on the human environment. If a proposed action is included in one of the categories but extraordinary circumstances as described in section D of this notice apply, an environmental review will be performed.” In other words, whereas most research

grants qualify for the categorical exclusion, NIH is required to conduct oversight to ensure that all proposals are reviewed for extraordinary circumstances or triggers that might warrant additional environmental review. NIH has determined that the following are potential extraordinary circumstances:

1. Greater scope or size than other actions included within a category.
2. A threatened violation of a Federal, State, or local law established for protection of the environment or for public health and safety.
3. Potential effects of the action are unique or highly uncertain.
4. Use of especially hazardous substances or processes for which adequate and accepted controls and safeguards are unknown or not available.
5. Overload existing waste treatment plants due to new loads (volume, chemicals, toxicity, additional hazardous wastes, etc)
6. Possible impact on endangered or threatened species.
7. Introduce new sources of hazardous/toxic wastes or require storage of wastes pending technology for safe disposal.
8. Introduce new sources of radiation or radioactive materials.
9. Substantial and reasonable controversy exists about the environment effects of the action.

In order to ensure a heightened awareness of the environmental aspects of Recovery Act, the Director of the Office of Research Facilities briefed Program Officials on April 2, 2009 and also briefed the Extramural Program Management Committee. The Categorical Exclusion is used for routine research grants, and we expect Recovery Act awards to follow a similar pattern.

G. Measures

Outcome / Measure		9/30 2009	12/31 2009	3/31 2010	6/30 2010	9/30 2010	12/31 2010	3/31 2011	6/30 2011	9/30 2011	Program End
Number of extramural construction grants awarded.	Target	58	63	120	174	174	174	174	174	174	174
	Actual	37	48	142							
Number of grantees that have completed the final design phase.	Target	0	0	0	0	0	25	78	146	146	146
	Actual	0	0	0							

This information will be available to the public on the Recovery Act website.

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B & C).

NIH's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. NIH's Senior Assessment Team in coordination with the NIH Risk Management Program carries out comprehensive annual assessments of its Recovery Act programs to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, NIH has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

The National Institutes of Health through the Extramural Grants Management Advisory Committee (GMAC), and the Contract Management Advisory Committee (CMAC), has established policies and procedures to assure a consistent and integrated approach to oversight practices that monitor extramural grantee activities for NIH contracts, grants, and cooperative agreements. These committees meet approximately twice a month. Guidance for progress tracking, financial management, and administrative management of NIH grants includes OMB Circular A-110, OMB Circular A-123, *Management's Responsibility for Internal Control*, sections of the Recovery Act including Section 1512, and the *Updated Implementing Guidance for the Recovery Act of 2009*.

In addition, the NIH Office of Management Assessment (OMA) and the Office of Financial Management (OFM) have established the NIH risk management framework for identifying, assessing, and testing of operational and financial risks and internal controls associated with implementing Recovery Act requirements. OFM and OMA conduct risk and control assessments in compliance with the statutory requirements of the Federal Managers' Financial Integrity Act, the Improper Payments Information Act, and OMB's Circular A-123 *Management's Responsibility for Internal Control*.

OMA will work with NIH offices that are responsible for implementing programs receiving Recovery Act funding to: identify and score the Recovery Act risks, assess controls related to the identified the Recovery Act risks, remediate controls as needed, monitor the inventory of the Recovery Act risks, and report on the risks and controls to leadership. OFM uses its existing process for assessing internal control over financial reporting related to using and tracking Recovery Act funds and take into account any control deficiencies.

NCRR is responsible for administering and overseeing the extramural construction program, while each grantee is responsible for ensuring that the awarded grant funds are used properly and as specified. NCRR works closely with the grantee, which is ultimately responsible for the activity of the contractors, to make sure the federal funds maximize research capacity and that adequate progress is being made. Additionally, NCRR is employing management tools to mitigate program risk through all program phases including grant review, award, and post-award monitoring.

I. Transparency

NIH will be open and transparent in all of its contracting and grant competitions and regulations that involve spending of Recovery Act funding consistent with statutory and OMB guidance ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. NIH will inform recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. NIH will provide technical assistance to grantees and contractors and fully utilize Project Officers to ensure compliance with reporting requirements.

To ensure recipient cost and performance requirements are reported, all awards issued with Recovery Act funds have special accounting numbers and codes to track the funds and awards. All Recovery Act funds must be awarded separately from the normal appropriation funds. The awards must comply with both existing NIH reporting requirements and the Recovery Act reporting requirements. More specifically, grants will include special terms and conditions based on guidance provided by OMB and HHS.

NIH has a link to Recovery.gov on its web site.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, NIH will build on and strengthen existing processes. Senior NIH and Extramural Construction officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system will also incorporate Recovery Act program stewardship responsibilities for program and business function managers.

The extramural construction program has a database that provides a data collection and monitoring tool that allows NCRR to track required documents, monitor progress, and monitor proper usage of the facility. Reports generated from the database show progress of individual projects and in turn facilitate more effective program management. The database enables NCRR staff to make adjustments to the program and implement corrective actions with grantees as needed.

The NIH Office of Management Assessment and Office of Financial Management are coordinating efforts to ensure that existing risk management processes are fully used as NIH implements the provisions of the Recovery Act. Terms and conditions of award notices will also be amended so that awardees are fully aware of the reporting requirements associated with these funds.

K. Barriers to Effective Implementation

NIH anticipates no significant barriers to implementation.

L. Federal Infrastructure

The Division of Environmental Protection in the Office of Research Facilities at NIH has been reviewing the environmental plans and monitoring compliance for all awards. Thirteen awards are still undergoing review. Most of the awards have been certified as having no negative environmental consequences following the initial review. In the cases where there are questions (25), the awardees have been notified about the issues and are now undertaking the necessary environmental assessments. The information from those assessments will be reviewed before the awardee is permitted to begin construction.

The National Historic Preservation Act is one of the terms and conditions for all NIH major construction awards. Very few of the awards fund renovation projects in building that has been deemed worthy of preservation. For those awards that are occurring in historic buildings, clearance has been or is being obtained from the State Historic Preservation Office.

This program does not support Federally-owned assets. However, HHS grants policy emphasizes sustainable design considerations should be included to the maximum extent feasible in construction or modernization grants or activities funded at $1 million or more (AAGAM Chapter 6.99.106-3). Implementing sustainable design principles serves to mitigate health, social and environmental impacts and further the National commitment to reducing energy, and green house gas and related emissions. NIH included the requirement to incorporate sustainable design practices in the grants announcement. In addition to incorporating the primary elements of improvements and repair projects, all improvements and repair projects that have a total project cost equal to or greater than $10 million and/or impacting 40 percent or more of the overall floor area, must obtain certification from the U.S. Green Building Council's Leadership in Energy and Environmental Design (LEED) or

the Green Building initiative's Green Globes System Certification rating system. Information about the level of sustainability will come to NIH during the design review process. That process is just beginning and will last for 14 months from the start of each award.

Summary of Significant Changes:

- Expanded funding table to show three year obligations and outlays (Section A. Funding Table)
- Updated funding for activities obligations (Section C. Activities)
  - Extramural Research Facilities Improvement from $700 million to $800 million
  - Core Facility Renovation, Repair, and Improvement from $300 million to $200 million
  - These changes occurred in response to the number of applications in each program. More applications were received in the Extramural Research Facilities Improvement than were expected.
- Updated funding for award obligations (Section D. Characteristics, respectively)
  - Awards to public and non-profit domestic institutions from $132 million to $52.1 million in FY 2009
  - Awards to public and non-profit domestic institutions from $868 million to $948 million in FY 2010 The complexity of making construction grant awards resulted in fewer awards being made than expected in FY2009.
- Updated delivery schedule, obligations made in 2009 and planned for 2010, milestones and potential plans for additional projects contigent upon available funding from ARRA project proposals-in-progress (Section E. Delivery Schedule)
- Reported results of National Environmental Policy Act (NEPA) review activities (Section F. Environmental Review Compliance)
- Updated program measures (Section G. Measures)
- Added information on NIH's proactive risk assessment and mitigation efforts and their connection to OMB required internal controls (Section H. Monitoring and Evaluation)

National Institutes of Health: Buildings and Facilities Program

The Recovery Act directly provided $10 billion to the National Institutes of Health (NIH). This Implementation Plan focuses on the $500 million of funds for NIH's Buildings and Facilities program in the Recovery Act.

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Buildings and Facilities	$500.0	$49.7	$450.3

B. Objectives

The Office of Research Facilities (ORF) is responsible for the planning, design, construction, acquisition, maintenance and operations of NIH facilities. The ORF's Buildings and Facilities (B&F) program provides safe, secure, sound, and healthy facilities to support NIH's scientific objectives.

To provide facilities that support state-of-the-art biomedical research, the ORF B&F program uses several processes in concert to anticipate and articulate NIH's facility needs. These processes include:

1. The strategic facilities planning process that focuses on long-term facility needs,
2. The annual Buildings and Space Plan to identify current and emerging facility requirements,
3. The design and construction program to deliver new facilities and major repairs and improvements to existing facilities, and
4. The Facilities Condition Assessment (FCA) program that validates the condition of existing facilities and helps develop a strategy to mitigate deficiencies.

The ORF B&F program objectives specifically support the HHS Strategic Plan Goal of advancing scientific and biomedical research and development related to health and human services.

The Recovery Act program is enhancing the capability of NIH to perform biomedical research by providing additional research space; improving NIH facility energy efficiency to reduce operating costs and refurbishing infrastructure condition to support existing scientific research programs. Moreover, the program is creating jobs for the local and national economies. The public will benefit from this program because of the economic improvements that result from jobs that are created when contracts are awarded. Additionally, these contract awards will contribute to enhancing the health of the Nation because they will result in improving the facilities that NIH uses to support biomedical research.

C. Activities

NIH originally planned to distribute Recovery Act Buildings and Facilities funds among five construction projects and several repair and improvement projects. However, the downturn in the construction market has increased competition among contractors, driving down overall construction prices. Because of this, many of these proposed projects are coming in under budget, which will enable NIH to accomplish more high-priority construction, repair, and improvement projects than originally anticipated with Recovery Act funds.

Recovery Act funds are being used to make contract awards on projects that will enhance NIH's ability to conduct biomedical research. The Recovery Act funds support the following projects:

1. **John Edward Porter Neuroscience Research Center Phase II (PNRCII) ($175.72 million)**: This project will complete the consolidation of researchers from 10 Institutes and multiple disciplines comprising most of the neuroscience research community at the NIH into one facility. The Center will support bench-to-bedside research by basic and clinical neuroscientists, engineers, mathematicians, and computer scientists under one roof. The achievement of future advances in translational Neuroscience research requires a cross-discipline approach that necessitates housing researchers from multiple Institutes and areas of scientific expertise in a central location as provided for by the PNRC complex. The PNRC II is being built using cutting edge energy efficient technologies, such as chilled beam technology, and employing many green features, including photovoltaic technologies and the use of local and low pollutant emitting materials. As a result, it is expected that the PNRC II will achieve both a Leadership in Energy and Environmental Design (LEED) certification at the Gold Level and a Green Globes certification of 3 Globes.

2. **Building 10 F Wing Renovations ($160.33 million):** Building 10, NIH's original Clinical Research hospital was completed in 1955 and the oldest wings are no longer capable of supporting biomedical research and training without extensive renovation.

   Phase A (The Anatomical Pathology Lab) - This is the first of a four phased project to convert mothballed patient care areas in Building 10 to laboratories and support space. This project converts 64,000 gross square feet of former patient care unit**s** on floors 2 through 5 to accommodate the NCI laboratory of Anatomical Pathology. This project allows for the immediate repairs and improvements that are required to retain lab accreditation. This project also provides for the installation of new utilities infrastructure required to support future renovation efforts in Building 10. When completed this project is expected to attain a 'Certified' level of compliance using the LEED rating system.

Phase B - The conversion of F Wing, Phases B1-B2, Floors 6-13 from hospital to laboratory space will support translational research for 9 of the 12 Institutes and Centers (ICs) that have Clinical Research programs in the new Clinical Research Center. When completed it is expected that this renovation will achieve a certified level of compliance using the Leadership in Energy and Environmental Design (LEED) rating system. Additionally, this renovation will decrease NIH's Backlog of Maintenance and Repairs by $80.4 million.

3. **Build-Out of Building 3 ($21.00 million)**: The build-out of Building 3 will transform an unused, vacant building into useable space that is able to provide offices for Scientific Directors and their administrative staff. Building 3 provides the best location given its close proximity to the clinical/research program which is largely located in Building 10, the Clinical Research Center, and the surrounding buildings. . Building 3 is eligible for designation as a historic building on the Federal Register as part of NIH's historic core; NIH considers this building to have historic relevance to the campus and regards its reuse a high priority. Studies showed that Building 3 could not be reoccupied as laboratory space, but could effectively be repurposed as office space– thus avoiding its demolition and the associated destruction of valuable building material with historical preservation status and the energy and resources required to erect a new building. The use/reuse of an existing facility is environmentally sensitive and conserves energy, and when completed, Building 3 will achieve a Silver Level of compliance using the Leadership in Energy and Environmental Design (LEED) rating system.

4. **Conversion of Building 7 ($6.22 million)**: This project at the Rocky Mountain Laboratories (RML) in Hamilton, Montana will convert formerly unused industrial space into laboratories that provide critical additional space for National Institute of Allergy and Infection Diseases (NIAID) research program. This building is part of the RML Historic District and this project preserves the historic nature of Building 7 while enhancing productivity by allowing research personnel to operate in close proximity to each other and existing animal facilities, Additionally the unoccupied space in Building 7 is currently heated during the winter in order to protect building systems; . following renovations, operational energy efficiency will increase because the heated space will be used. Additionally, as a result of this renovation activity, these labs will attain a Silver Level Leadership in Energy and Environmental Design (LEED) certification.

5. **The West Utility Tunnel ($22.30 million):** This project is a design/build effort that increases the size and capacity of the chilled water and steam distribution systems available to support future renovations in the F and Distal-Wings of Building 10. These F-Wing utilities will contribute to the continued certification and accreditation of the Anatomical Pathology Lab in Building 10 that is crucial to the mission of providing clinical pathology services to the NIH.

6. **Renovation of Building 4 ($11.30 million):** Building 4 is 67 years old and located on a historic site on NIH's Bethesda campus; it is a candidate for registration as a Historic Building. This interior renovation project leaves the building envelope intact and does not impact this building's historic status. This project allows for the design and renovation of the first and second floors so obsolete laboratories can be replaced and aging building systems can be improved to ensure compliance with current NIH and HHS Guidelines as well as regulatory codes and accreditation requirements. The renovation of Building 4 in order to house NIAID support functions will ensure efficiencies due to its proximity to the Clinical Research Center and NIAIDS's new research lab in Building 33. When completed this project is expected to attain a 'Certified' level of compliance using the LEED rating system for Commercial Interiors.

7. **Other R&I Projects ($103.13 million)**:A variety of smaller projects are aimed at improving the reliability and condition of NIH facilities such as:

	Amount
Rehabilitate Electrical Vaults	$43,822,000
Improve Building 12 Center for Information Tech Electrical Reliability	7,496,400
Repair Tube Nest and Condensate Lines, Bldg. 10	100,000
Building 10 Repair Laboratory Pathology HVAC	2,992,000
Correct Cell Processing Area Deficiencies	643,300
Barrier, Door and Security Repairs to Main JCAA Accreditation	2,194,000
Renovate Building 16A	2,150,000
Building 31 Emergency Generator for Life Safety Systems	4,780,000
Repair ACRF East Bldg. Fin Tube System	1,894,000
Repairs to Mechanical Systems in Bldgs. 1, 8, 8A, 31, and 45	303,300
Install Dedicated Electrical Feeder to RML	1,394,000
Bldg 12 Continuous Power Phase 3	8,000,000
Repair Cyclotron Exhaust System	4,386,000
Replace ACRF Lab/Clinic Air Handling Units	4,500,000
Replace Steam line and Manhole	4,000,000
Bldg 60 Chilled Water and Steam	3,500,000
Repair Roofs	6,743,000
Program Support Services Contracts	589,000
Project Contingency	3,642,000
TOTAL	$103,129,000

D. Characteristics:

The execution and completion of these projects is being accomplished via contracts awarded by NIH's Buildings and Facilities program for NIH campus Federal facilities. Awards are made through new competitive processes or, where appropriate, by tasks under existing contracts. When existing contracts are used, Recovery Act funds are separately identified in the contracts by use of a unique Treasury symbol and separate accounting numbers and codes. The intended recipients of these awards are construction contractors.

E. Delivery Schedule:

B&F will obligate a total of $500 million for these awards; $49.7 million of which was obligated in FY 2009 and the remaining $450.3 million is being obligated in FY 2010. Of the 15 original Building and Facilities ARRA projects , five projects – PNRCII, Building 10 F Wing, Building 3, RML Building 7, and the Electrical Vaults (under Other R&I), require awarding via newly competitive contracts. One project – the RML Installation of a Dedicated Electrical Feeder – was executed through collaboration with the local utility. Three projects in Building 10- The Tube Nest Condensate Line Repair, The Cell Processing Deficiency Corrections, and The Anatomical Pathology HVAC Repair- were awarded as task orders to existing contracts that had previously been awarded to participants in the 8(a) small disadvantaged business program (FAR 19). Existing competitive contracts can be used to implement the remaining projects.

The appropriate contract award mechanisms is still being determined for the new or additional projects; but, it is anticipated new awards will be made using processes similar to those that were employed when awarding the original 15 projects.
The following are key milestones already achieved by NIH's Recovery Act Buildings and Facilities Activities:

- 4/2009 – Began repairing electrical vaults and correcting cell processing area deficiencies

- 9/2009 – Started Building 12 Center for Information Technology improvements and began repairing the mechanical systems and the Building 10 laboratory pathology HVAC and tube nest and condensate lines.

- 11/2009 – Started the Building 7 conversion

- 3/2010 – Awarded contract to install RML dedicated electrical feeder and repair barrier doors and the ACRF fin tube system

Below are a few milestones that are planned as part of NIH's Recovery Act Buildings and Facilities Program:

- 5/2010 – The Porter Neuroscience Research Center Phase II construction contract and the Building 31 Emergency Generators installation contract will be awarded.

- 6/2010 - Contract awards will be made for the West Utility Tunnel, the Building 3 renovation and both Phase A (the Anatomical Pathology Lab) and Phase B of the Building 10 F Wing.
- 8/2010 – Award the Building 4 renovation contract
- 9/2010 - Award the contract for the Building 12 Continuous Power and Data Center Upgrade

F. Environmental Review Compliance

For every major action, Federal agencies are required to review projects for potential environmental impacts. NIH representatives follow the National Environmental Policy Act regulations to review the proposed action and determine whether the preparation of an Environmental Assessment (EA) or Environmental Impact Statement (EIS) is required before making a final decision regarding the project. In some cases, the review may result in the project being Categorically Excluded from further NEPA review.

For the 15 original ARRA projects/activities that made up NIH's Building and Facilities program 14 have received NEPA approval decisions and one awaits a SHPO decision. Categorical exclusions (CE) were issued for 12 projects, one project has a completed environmental assessment (EA) and there are two projects covered by a Master Plan completed Environmental Impact Statements (EISs).

Consistent with Recovery Act requirements, NIH reports compliance with environmental requirements on the NEPA ARRA 1609(C) report that is submitted to the Office of the Federal Environmental Executive.

G. Measures:

NIH is using the following measures for this program:

Outcome / Achievement [1/]	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
Percent of construction projects complete in accordance with 10% variance of contract schedules[2/]	%	TARGET	100	100	100	100	100	100	100	100	100	100
		ACTUAL	100	100	100							

Percent of construction projects complete in accordance with 10% variance of contract cost[3/ 4/]	%	TARGET	100	100	100	100	100	100	100	100	100	100
		ACTUAL	100	100	100							
Number of capital facility project awards completed. (cumulative)	#	TARGET	6	7	10	17	24	24	24	24	24	
		ACTUAL	6	7	10							
Condition Index (weighted average) of NIH facilities. This measure is designed to reflect the effect of ARRA activity on both the Target and Actual CI. [5/]	#	TARGET	74.5	74.5	74.5	77.3	77.7	77.7	77.7	77.7	77.7	77.7
		ACTUAL	74.1	74.1	74.1							
Reduction in the Backlog of Maintenance and Repairs. [6/]	$s M	TARGET	23.0	23.2	24.4	162.7	180.7	180.7	180.7	180.7	180.7	180.7
		ACTUAL	23.0	23.2	24.4							

1/ For all measures, performance targets and actuals reported here represent the total Building and Facilities ARRA program, which is comprised of both the initial 15 approved ARRA projects and the additional projects added during 3QFY10

2/ This measure derived by taking the total number of projects completed with a 10% or less variance to the contract schedule (based on the number of days in the period of performance) and dividing it by the cumulative number of projects completed.

3/ This measure derived by taking the total number of projects completed with a 10% or less variance to contract cost (based on the dollar value of the contract award) and dividing it by the cumulative number of projects completed.

4/ This measure excludes performance on Line Item projects and only reports cost variance for the R&I projects

5/ The Condition Index is the ratio the cost of needed facility repairs to the replacement value of the facility. Many ARRA projects lead to a reduction in the cost of needed facility repairs. This measure tracks the impact that ARRA projects have on NIH's condition index.

6/ Many ARRA projects lead to a reduction in the cost of needed facility repairs. This measure tracks the impact that ARRA projects have on reducing NIH's Backlog of Maintenance and Repairs.

H. Monitoring/Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B & C).

NIH's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. NIH's Senior Assessment Team in coordination with the NIH Risk Management Program carries out comprehensive annual assessments of its Recovery Act programs to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, NIH has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

In addition, the NIH Office of Management Assessment (OMA) and the Office of Financial Management (OFM) have established the NIH risk management framework for identifying, assessing, and testing of operational and financial risks and internal controls associated with implementing Recovery Act requirements. OFM and OMA conduct risk and control assessments in compliance with the statutory requirements of the Federal Managers' Financial Integrity Act, the Improper Payments Information Act, and OMB's Circular A-123 *Management's Responsibility for Internal Control*. OMA works with NIH offices that are responsible for implementing programs receiving Recovery Act funding to: identify and score the Recovery Act risks, assess

controls related to the identified Recovery Act risks, remediate controls as needed, monitor the inventory of the Recovery Act risks, and report on the risks and controls to leadership. OFM uses its existing process for assessing internal control over financial reporting related to using and tracking Recovery Act funds and take into account any control deficiencies.

NIH uses a Facility Project Approval Agreement (FPAA) form to document risk and put into place measures to manage it. The FPAA process involves 1) clear scope identification; 2) economic analysis of alternatives; 3) identification of best acquisition methodology; 4) sustainability; 5) identification of risk areas such as historic preservation, utilities limitations, environmental issues and other factors that could cause cost escalations or jeopardize construction schedules.

Contracts funded with Recovery Act appropriations are monitored by an Integrated Project Team (IPT) of federal acquisition and project management professionals who have obtained and maintain certification as Contracting Officers (COs) or Contract Officer Technical Representatives (COTRs). For larger projects, this team meets weekly with the contractor to review progress.

For the Recovery Act “line item” projects (PNRCII, Building 10 F wing, Building 3, and RML Building 7) NIH has established an Executive Steering Committee (ESC) for each of these projects that is comprised of members of the IPT and senior ORF and NIH management. The ESC provides close monitoring by senior management of progress and associated corrective actions.

H. Transparency

NIH will be open and transparent in all of its contracting and grant competitions and regulations that involve spending of Recovery Act funding consistent with statutory and OMB guidance. All Recovery Act funds must be awarded separately from the normal appropriation funds. The projects funded with Recovery Act money will comply with both existing NIH reporting requirements and the reporting requirements outlined in the Recovery Act. NIH ensured that recipient reporting required by Section 1512 of the Recovery Act and OMB guidance was made available to the public on Recovery.gov by October 10, 2009 and that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. Recovery Act recipients must report on a quarterly basis and NIH will inform recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. NIH will provide technical assistance to grantees and contractors and fully utilize Project Officers to ensure compliance with reporting requirements.

NIH has a link to Recovery.gov on its website.

I. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, NIH will build on and strengthen existing processes. Senior NIH and Building and Facilities officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system will also incorporate Recovery Act program stewardship responsibilities for program and business function managers.

The NIH Office of Management Assessment and Office of Financial Management are coordinating efforts to ensure that existing risk management processes are fully used as NIH implements the provisions of the Recovery Act. Terms and conditions of award notices will also be amended so that awardees are fully aware of the reporting requirements associated with these funds. Any NIH facilities projects that exceed OPDIV approval authority, the project scope, budget, and schedule will be documented in an FPAA, HHS Form 300.

The monitoring activities described in the monitoring section will ensure that NIH management and the Integrated Project Team are aware of deviations of contract performance from requirements. If such deviation from requirements occurs, the Integrated Project Team will use a variety of tools outlined in the Federal Acquisitions Regulations to promote correction by the contractor. These tools range in severity from approving smaller progress payments than requested to formal cure notices, and if necessary as a last resort, termination of the contract for default.

J. Barriers to Implementation

NIH anticipates no significant barriers to implementation.

K. Federal Infrastructure Investments

All projects will incorporate the requirements of the HHS Sustainable Buildings Implementation Plan dated December 2008. To monitor and ensure that energy and “green” building requirements are effectively incorporated into all of NIH’s federal infrastructure investments funded by Recovery Act, NIH is documenting the specific project methodologies to be employed in the HHS Project Sustainable Buildings Checklist. This Sustainability tracking tool is a requirement of the HHS Form 300 – Facility Project Approval Agreement, which is required for projects which fall above given cost thresholds. NIH is using the Sustainable Buildings Checklist even for projects which fall below the FPAA thresholds in order to document the features that are evaluated for lifecycle cost effectiveness. Use of this Checklist also documents compliance with Executive Order 13423, EPAct 2005, and the EISA2007. The NIH operates mainly energy intensive facilities that have no industry baseline so we are working closely with USGBC and Labs 21 on the most appropriate strategies. All six ARRA funded building construction /renovations projects are designed to meet or exceed the Leadership in Energy and Environmental Design (LEED) certification level. Three projects (Bldg 4 and Phases A and B of Bldg 10) that will achieve a

LEED certification level involve the complicated task of renovating a portion of an older occupied building . Two projects where NIH is renovating unoccupied historic structures (RML Bldg 7 and Bldg 3) will result in LEED certifications at the Silver level. One ARRA project is for the construction of a new building (PNRC II) that, when completed, will reach the Gold level of LEED certification as well as achieve a Green Globes certification level of 3 Globes.

Summary of Significant Changes:

- Modified portfolio (Section C. Activities) due market – proposals were lower than anticipated allowing for additional dollars
    - Added: West Utility Tunnel ($22.3M); Renovation of building 4 ($11.3M)
    - Revised/added verbiage on PNRCII, Bldg 10, 3, and 7
    - Added projects to Other R&I table: Bldg 12, Repair Cyclotron Exhaust System, Lab/clinic, Steam line, repair roof, etc.

- Updated program measures (Section G. Measures)

- Revised delivery schedule (Section E. Delivery Schedule)

- Revised federal infrastructure investment (Section L. Federal Infrastructure Investments)

National Institutes of Health: Shared Instrumentation

The Recovery Act directly provided $10 billion to the National Institutes of Health (NIH). This Implementation Plan focuses on the $300 million of Recovery Act funds provided to the National Center for Research Resources (NCRR), a component of the National Institutes of Health (NIH), for the Shared Instrumentation program.

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Shared Instrumentation	$300.0	$52.7	$247.3

B. Objectives

The Shared Instrumentation program provides grants to NIH-supported research institutions to purchase research instruments that will serve multiple researchers. It is a cost-effective mechanism to provide multiple investigators with technologically sophisticated equipment to support federally-sponsored research. The citizens of the United States will benefit from these awards through improved biomedical and behavioral research capacity.

The objectives of the Recovery Act Shared Instrumentation program align with the existing Shared Instrumentation program, in order to facilitate state of the art research as technologies advance to enable better images, diagnostics, data analysis, and new discovery tools. Innovative biomedical research requires access to the newest and most advanced technology.

C. Activities

The Shared Instrumentation program consists of two main activities:

1. **Shared Instrumentation Grants (SIG) (approximately $140 million)**: The SIG program supports grants to groups of three or more NIH-supported investigators at public and non-profit domestic institutions for the purchase of commercially available instruments costing from $100,000 to $500,000. Types of instruments supported include confocal and electron microscopes, biomedical imagers, mass spectrometers, DNA sequencers, biosensors, cell sorters, X-ray diffraction systems, and NMR spectrometers among others.
2. **High-End Instrumentation Grants (HEI) (approximately $160 million)**: The HEI program supports grants to groups of three or more NIH-supported investigators at public and non-profit domestic institutions for the purchase of a single major item of biomedical research equipment costing from $600,000 to $8,000,000. Examples of equipment that could be funded under this program are structural and functional imaging systems, macromolecular NMR spectrometers,

high-resolution mass spectrometers, cryoelectron microscopes, and supercomputers.

D. Characteristics

Eligible recipients include 1) Public/State Controlled Institution of Higher Education; 2) Private Institution of Higher Education; and 3) Nonprofit with or without 501(c)(3) IRS Status (Other than Institution of Higher Education).

Awards are made to public and non-profit domestic institutions only, including health professional schools, other academic institutions, hospitals, health departments, and research organizations. About $52.7 million was obligated in FY 2009, with the remaining $247.3 million to be obligated in FY 2010.

Institutions submit grant applications which are selected using NIH's standard, competitive, peer-reviewed process – a two level review process. Briefly, the first level of review for scientific and technical merit is conducted by expert peer review study sections convened by the NIH and comprised of external reviewers. The second level of review is conducted by the NCRR National Advisory Research Resources Council (NARRC). The final decisions are based on the scientific and technical merit of the application as determined by first and second level of peer review, the availability of funds, the relevance of the application to the NCRR/NIH program priorities, the national geographic distribution of awards, and the priorities specified in the Recovery Act, such as energy efficiency and job creation.

The table below provides a summary of key information about the Shared Instrumentation program.

Characteristics:	Shared Instrumentation Grant Program	High End Instrumentation Program
Funding Opportunity Announcement (FOA) #	PAR-09-028/ NOT-RR-09-008	PAR-09-118
Types of awards	Grants	Grants
Estimated size of awards	$100 - $500K	$600K - $8M
Targeted recipients/beneficiaries	Public and non-profit domestic institutions only	Public, private, and non-profit domestic institutions only
Methodology for award selection	Competitive, 2-tiered peer review	Competitive, 2-tiered peer review

E. Delivery Schedule

The following table depicts major milestones and their associated timelines for the Shared Instrumentation Program.

Milestones:	Shared Instrumentation Grant Program	High-End Instrumentation Program
Funding Opportunity Announcement (FOA) #	PAR-09-028/ NOT-RR-09-008	PAR-09-118

Milestones:	Shared Instrumentation Grant Program	High-End Instrumentation Program
FOA Released	March 5, 2009*	March 5, 2009
Applications Due (award size/due date)	March 23, 2009	May 6, 2009
Application Review	June – December 2009	June - October 2009
Earliest Anticipated Awards	September 2009	September 2009

* In addition, a FOA was released on November 14, 2008 and these applications will be considered for Recovery Act support.

Additionally, NIH funded a small number of previously peer-reviewed, meritorious (but unfunded) applications for the Shared Instrumentation Program. All of the Shared Instrumentation applications will have gone through two levels of peer-review.

F. Environmental Review Compliance

National Environmental Policy Act (NEPA) Compliance under the Recovery Act in the area of Research Grants: Consistent with the provisions of NEPA in place since 1970, NIH has procedures in place to ensure that federal officials properly take into account potential environmental consequences when taking actions. Section 1609 (c) of Recovery Act requires that the President report to the Senate Environment and Public Works Committee and the House Natural Resources Committee every 90 days following the date of enactment until September 30, 2011 on the status and progress of projects and activities funded by the Act with respect to compliance with National Environmental Policy Act requirements and documentation. The Council on Environmental Quality (CEQ) promulgated reporting requirements in a March 11, 2009 document that described specific procedures and a reporting template that NIH fills in regularly and provides to the HHS Office of Facilities Management and Policy (OFMP).

Most research grants qualify for a categorical exclusion from detailed NEPA review, as promulgated in the Federal Register on January 19, 2000: “NIH is providing notice of the actions that will normally be categorically excluded from further environmental review because individually and cumulatively they will not have a significant effect on the human environment. If a proposed action is included in one of the categories but extraordinary circumstances as described in section D of this notice apply, an environmental review will be performed.” In other words, whereas most research grants qualify for the categorical exclusion, NIH is required to conduct oversight to ensure that all proposals are reviewed for extraordinary circumstances or triggers that might warrant additional environmental review. NIH has determined that the following are potential extraordinary circumstances:

1. Greater scope or size than other actions included within a category.
2. A threatened violation of a Federal, State, or local law established for protection of the environment or for public health and safety.
3. Potential effects of the action are unique or highly uncertain.

4. Use of especially hazardous substances or processes for which adequate and accepted controls and safeguards are unknown or not available.
5. Overload existing waste treatment plants due to new loads (volume, chemicals, toxicity, additional hazardous wastes, etc)
6. Possible impact on endangered or threatened species.
7. Introduce new sources of hazardous/toxic wastes or require storage of wastes pending technology for safe disposal.
8. Introduce new sources of radiation or radioactive materials.
9. Substantial and reasonable controversy exists about the environment effects of the action.

In order to ensure a heightened awareness of the environmental aspects of Recovery Act, the Director of the Office of Research Facilities briefed Program Officials on April 2, 2009 and briefed the Extramural Program Management Committee. The Categorical Exclusion is used for routine research grants, and we expect Recovery Act awards to follow a similar pattern.

G. Measures

NIH will use the following performance measures:

Outcome / Measure		9/30 2009	12/31 2009	3/31 2010	6/30 2010	9/30 2010	12/31 2010	3/31 2011	6/30 2011	9/30 2011	Program End
Number of shared equipment and instrumentation grants awarded.	Target	75	130	190	270	450	450	450	450	450	450
	Actual	84	110	215							
Shared Instrumentation projects complete [1]	Projected	0	0	40	50	55	60	65	70	150	450
	Actual	0	0	44							

[1] This information will be available to the public on the Recovery Act website. The data for the number of awards comes from the QVR system at NIH. The data for the number of awards that are complete come from recipient reporting required by section 1512 of the Recovery Act. The projections for the number of awards that are at various stages of completion take into account the date that each award was made as well as the quarterly reporting cycle for the section 1512 reports.

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as

well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B & C).

NIH's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. NIH's Senior Assessment Team in coordination with the NIH Risk Management Program carries out comprehensive annual assessments of its Recovery Act programs to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, NIH has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

The National Institutes of Health through the Extramural Grants Management Advisory Committee (GMAC), and the Contract Management Advisory Committee (CMAC), has established policies and procedures to assure a consistent and integrated approach to oversight practices that monitor extramural grantee activities for NIH contracts, grants, and cooperative agreements. These committees meet approximately twice a month. Guidance for progress tracking, financial management, and administrative management of NIH grants includes OMB Circular A-110, OMB Circular A-123, *Management's Responsibility for Internal Control*, sections of the Recovery Act including Section 1512, and the *Updated Implementing Guidance for the Recovery Act of 2009*.

In addition, the NIH Office of Management Assessment (OMA) and the Office of Financial Management (OFM) have established the NIH risk management framework for identifying, assessing, and testing of operational and financial risks and internal controls associated with implementing Recovery Act requirements. OFM and OMA conduct risk and control assessments in compliance with the statutory requirements of the Federal Managers' Financial Integrity Act, the Improper Payments Information Act, and OMB's Circular A-123 *Management's Responsibility for Internal Control*. OMA will work with NIH offices that are responsible for implementing programs receiving Recovery Act funding to: identify and score Recovery Act risks, assess controls related to the identified Recovery Act risks, remediate controls as needed, monitor the inventory of the Recovery Act risks, and report on the risks and controls to NIH and HHS leadership. OFM uses its existing process for assessing internal control over financial reporting related to using and tracking Recovery Act funds and take into account any control deficiencies.

NCRR is responsible for administering and overseeing the shared instrumentation program, while each grantee is responsible for ensuring that the awarded grant funds are used properly and as specified. NCRR works closely with the grantee to make sure the federal funds are expended appropriately. Additionally, NCRR is employing management tools to mitigate program risk through all program phases including grant review, award, and post-award monitoring.

I. Transparency

NIH is open and transparent in all of its contracting and grant competitions and regulations consistent with statutory and OMB guidance. To ensure recipient cost and performance requirements are reported on a quarterly basis, all awards issued with Recovery Act funds have special accounting numbers and codes to track the funds and awards. All Recovery Act funds must be awarded separately from the normal appropriation funds. The awards must comply with both existing NIH reporting requirements and the Recovery Act reporting requirements. More specifically, grants will include special terms and conditions based on guidance provided by OMB and HHS. NIH ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. NIH will inform recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. NIH will provide technical assistance to grantees and contractors and fully utilize Project Officers to ensure compliance with reporting requirements.

NIH has a link to Recovery.gov on its website.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, NIH will build on and strengthen existing processes. Senior NIH and Shared Instrumentation officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system will also incorporate Recovery Act program stewardship responsibilities for program and business function managers.

The Project officer's annual review requires additional information from the grantee for any identified risk or challenge areas. Mitigating or corrective actions are documented and trigger additional review as required. Outputs are reviewed by program officials to confirm appropriate progress. Progress standards are based on planned activities and milestones within the grant application. Grants management can limit disbursement of funds for any funding improprieties and if progress is not satisfactory.

The NIH Office of Management Assessment and Office of Financial Management are coordinating efforts to ensure that existing risk management processes are fully used

as NIH implements the provisions of the Recovery Act. Terms and conditions of award notices will also be amended so that awardees are fully aware of the reporting requirements associated with these funds.

K. Barriers to Effective Implementation

NIH anticipates no significant barriers to implementation.

L. Federal Infrastructure

This program does not include construction or renovations of federally owned assets or grant funded facilities.

Summary of Significant Changes:

- Expanded funding table to show three year obligations and outlays (Section A. Funding Table)
- Adjusted activities funding (Section C. Activities)
    - Shared Instrumentation Grants from $200 million to $140 million
    - High- End Instrumentation Grants from $100 million to $160 million
    - These changes occurred in response to the relative number of applications submitted for each program.
- Updated award obligations (Section D. Characteristics)
    - Awards to public and non-profit domestic institutions from $50 million to $53 million in FY 2009
    - Awards to public and non-profit domestic institutions from $250 million to $247 million in FY 2010
- Updated program measures (Section G. Measures)
- Added information on NIH's proactive risk assessment and mitigation efforts and their connection to OMB required internal controls (Section H. Monitoring and Evaluation)

TANF – Emergency Contingency Fund

American Recovery and Reinvestment Act Implementation Plan

A. Funding Table

(Outlays in millions)					
Temporary Assistance for Needy Families (TANF)	**Program Level Estimate**	**FY 2009 Actual**	**FY 2010 Estimate**	**FY 2011 Estimate**	**FY 2012-2019 Estimate**
TANF Emergency Contingency Fund	5,000.0	251.0	2,000	1,486	263
Total	5,000.0	251.0	2,000	1,486	263

B. Objectives and Public Benefits

Under the American Recovery and Reinvestment Act (Recovery Act), $5 billion was appropriated for the Temporary Assistance for Needy Families (TANF) Emergency Contingency Fund (known as the Emergency Fund). Up to $5 billion is available over fiscal years 2009 and 2010 for jurisdictions (states, territories, and tribes) that have an increase in assistance caseloads and basic assistance expenditures, or an increase in expenditures related to short-term benefits or subsidized employment. The new Emergency Fund is in addition to the existing TANF Contingency Fund that qualifying states (but not territories or tribes) can access during an economic downturn.

C. Activities

TANF is designed to help needy families achieve self-sufficiency. TANF funds are spent on cash assistance and various non-cash services including work activities, child care, transportation and work supports, and a wide range of other benefits and services. The purposes of the TANF program are:

- to provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;
- end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
- to prevent and reduce the incidence of out-of-wedlock pregnancies; and
- to encourage the formation and maintenance of two-parent families.

A jurisdiction may use Emergency Fund monies in the same way that annual federal TANF block grant funds are spent, except a jurisdiction may not transfer emergency funds to either the Child Care and Development Block Grant (CCDBG) or the Social Services Block Grant (SSBG)

programs. This means that it may use the funds in any manner reasonably calculated to meet a TANF purpose.

D. Characteristics

Purpose	Type of Award	Funding Amount	Recipients
TANF Emergency Contingency Fund	Grants to states, territories, and tribes	$5 billion appropriation	States, territories, and tribes
TOTAL = $5 billion			

E. Delivery Schedule

TANF Emergency Fund:

- Issue Policy Announcement (PA) to potential grantees describing Emergency Fund with explanation of interpretation of statute regarding adjustments, accountability, and type of expenditure data – completed (April 3, 2009)
- States, territories, and tribes notified of their ability to apply for and receive TANF Emergency Fund immediately – completed (April 3, 2009)
- Issue grant awards as requests are received – most requests to be approved within 2 weeks of receipt unless data submitted requires follow-up.
- Publish Federal Register notice on emergency processing request, which notifies the public that the application form and instructions have been submitted to OMB for review and are available for public comment – five days after forms and instructions are cleared by HHS – completed (July 20, 2009)
- Once approved by OMB, provisional form and instructions distributed to states, territories, and tribes (within five days after data collection forms and instructions are approved under emergency clearance by OMB) – completed (July 20, 2009)
- After stakeholder comments received and reviewed, submit updated final application forms and instructions under the regular review and comment process – completed (October 29, 2009).
- Distribute final form and instructions to states, territories, and tribes – completed (March 3, 2010.

F. Environmental Review

The distribution of the TANF Emergency Fund as a result of the Recovery Act is categorically excluded from environmental review based on Category 2 section F - Functional Exclusion: Grants for Social Services under Chapter 30-20-30 of the HHS General Administration Manual. By definition, the use of these funds: (1) mitigates social and environmental impacts; (2) does not include construction or alterations of the human environment; and (3) have no anticipated

individual or cumulative significant effect on natural or cultural assets. Therefore the TANF Emergency Fund qualifies for a Categorical Exclusion from National Environmental Protection Act (NEPA). This activity is funded under the Recovery Act Division B and is not subject to Section 1609(c) reporting requirements.

G. Measures

The following is the proposed set of performance measures for the TANF Emergency Fund, which includes measures of the number of states receiving reimbursement in each of the three funding categories, as well as the number of individuals in subsidized employment for which the state received reimbursement from the TANF Emergency Funds. Each of these measures will be updated quarterly.

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
Number of states providing additional cash assistance with TANF Emergency Funds. (*Quarterly Output)*	# of states	TARGET										
		ACTUAL	11	29	36							
Number of states providing additional non-recurrent short-term benefits with TANF Emergency Funds. *(Quarterly Output)*	# of states	TARGET										
		ACTUAL	6	15	24							
Number of states creating or expanding subsidized employment programs with TANF Emergency Funds. *(Quarterly Output)*	# of states	TARGET										
		ACTUAL	7	18	27							
Number of individuals in subsidized jobs funded in whole or in part by the TANF Emergency Fund. *(Developmental Quarterly Outcome)*	# of states	TARGET										
		ACTUAL										

Data Source	Data Validation
Measures 1, 2, 3: Approved application information maintained by ACF	Comparison of approved TANF Emergency Fund applications with financial reports listing awarded funds
Measure 4: Form OFA [TBD], TANF Emergency Fund Subsidized Employment Report	ACF is in the process of drafting a data collection tool and Paperwork Reduction Act (PRA) clearance package. ACF anticipates the package being completed in summer 2010.

Information on the number of approved TANF Emergency Fund applications by category is listed on the website for ACF's Office of Family Assistance (available here: http://www.acf.hhs.gov/programs/ofa). Obligation and expenditure data for the TANF Emergency Fund is posted as part of the HHS weekly financial and activity reports (found under "Plans and Reports") on the HHS Recovery web site at http://www.hhs.gov/recovery. Information on the number of individuals in subsidized employment for which the state received reimbursement from the TANF Emergency Fund will be published on the website for ACF's Office of Family Assistance (available here: http://www.acf.hhs.gov/programs/ofa/data-reports/index.htm).

H. Monitoring/Evaluation

All Recovery Act programs will be assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

ACF's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. ACF's Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, ACF has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act program and address the obstacles and risks that could impact on their success.

The Office of Family Assistance (OFA) will follow its existing internal control structure in implementing the Emergency Fund. States, territories, and tribes may submit estimated caseload and qualified expenditure data when applying for emergency funding. OFA will reconcile their submitted estimates with actual expenditure data on an on-going basis to ensure the jurisdictions receive the proper amount of funding; a final reconciliation will occur during FY 2011. States, territories, and tribes will be required to report all expenditures of emergency funds after the end of each quarter, and these expenditure amounts will be subject to review under the single state audit.

Current procedures for reviewing state expenditure reports will continue and states, territories, and tribes are subject to the Single Audit Act of 1984.

I. Transparency

ACF is open and transparent in all of its grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance. ACF ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. ACF informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, ACF provides key award information to recipients and other

technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

Jurisdictions have to submit information on caseloads and expenditures. Jurisdictions receiving Emergency Funds will account for and report on these funds separately from other TANF funds on agency financial reports. However, the reporting burden for the TANF Emergency Fund should be minimal, as expenditure reporting requirements and timelines will be the same as for other TANF funds already reported to ACF. Funded jurisdictions must submit reports as required by Section 1512 of the Recovery Act. Audits shall be conducted by the Inspector General and the jurisdictions under Chapter 75 of Title 31, United States Code.

Performance information on the performance measures is available in the annual ACF Budget Justification and Online Performance Appendix (available here: http://www.acf.hhs.gov/programs/olab/budget/index.html). These measures are also published on the website for ACF's Office of Family Assistance (available here: http://www.acf.hhs.gov/programs/ofa/data-reports/index.htm).

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, ACF has built upon and strengthened existing processes. Senior ACF and OFA officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers. ACF program managers, specialists, and senior managers are accountable for the oversight of performance results and improvement actions through the Performance Management Appraisal Program (PMAP). Annual performance appraisals rate each employee on their effectiveness in meeting the goals of the agency, as well as identify the employee's contributions to the mission of the programs administered by their office.

The HHS Office of Inspector General (OIG) conducts reviews of TANF programs to determine whether the state agencies expended funds in accordance with federal and state requirements, as demonstrated by adequate documentation of eligibility and payment determinations.

K. Barriers to Effective Implementation

ACF did not collect the data needed to award these funds before ARRA was enacted. As a result, ACF has issued a new data collection instrument and instructions. In addition, the statute allows jurisdictions to submit estimates and gives HHS the authority to make adjustments (e.g. for changes in program configuration) to ensure comparability between quarters for the request year and the corresponding quarters in the base years. These provisions also require new data and introduce uncertainty into the process of awarding funds. Finally, the statute did not specify procedures for reconciling estimates with actual data and for remitting funds resulting from overpayments due to estimated data. ACF has developed these

procedures, and they have been reviewed by HHS and provided to jurisdictions with the OMB approval of our form and instructions.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

Updated with new performance measures to more clearly communicate the impact of Recovery Act funding for this program noting the pending status of approval for the subsidized employment measure per the PRA clearance process.

TANF – Supplemental Grants

American Recovery and Reinvestment Act Implementation Plan

A. Funding Table

(Outlays in millions)					
Temporary Assistance for Needy Families (TANF)	**Program Level Estimate**	**FY 2009 Actual**	**FY 2010 Estimate**	**FY 2011 Estimate**	**FY 2012-2019 Estimate**
Supplemental Grants for Population Increases	319.5	0.0	255.0	64.5	0
Total	319.5	0.0	255.0	64.5	0

* Seventeen states will receive a total of $319 million. Funds will be made available in FY 2010.

B. Objectives and Public Benefits

The American Recovery and Reinvestment Act (Recovery Act) extended for one year the $319 million awarded annually in Temporary Assistance for Needy Families (TANF) Supplemental Grants. This extension allows 17 states to continue to receive $319 million in supplemental funds in FY 2010 as a result of high population growth in the early 1990s, historic (1994) welfare grants per poor person lower than 35 percent of the national average, or a combination of above average population growth and below average welfare grants per poor person. Eligibility and funding for the supplemental grants has remained constant at FY 2001 levels.

C. Activities

TANF is designed to help needy families achieve self-sufficiency. TANF funds are spent on cash assistance and various non-cash services including work activities, child care, transportation and work supports, and a wide range of other benefits and services. The purposes of the TANF program are:

- to provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;
- end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
- to prevent and reduce the incidence of out-of-wedlock pregnancies; and
- to encourage the formation and maintenance of two-parent families.

Supplemental Grant funds can be used in the same way as annual federal TANF block grant funds (in any manner reasonably calculated to meet a TANF purpose), including transfers to the

Child Care and Development Block Grant (CCDBG) and/or the Social Services Block Grant (SSBG) programs.

D. Characteristics

Purpose	Type of Award	Funding Amount	Recipients
Supplemental grants	Supplemental grants for selected states beyond the TANF family assistance grant	$319 million	17 qualifying states that experienced high population growth and/or had low welfare spending per poor person
TOTAL = $319 million			

E. Delivery Schedule

TANF Supplemental Grants:

- The TANF Supplemental grant awards were set to expire at the end of FY 2009. The Recovery Act extended these grants through September 30, 2010, and will be released in quarterly installments (as is done currently).

F. Environmental Review

The distribution of the TANF Supplemental funds as a result of the Recovery Act is categorically excluded from environmental review based on Category 2 section F - Functional Exclusion: Grants for Social Services under Chapter 30-20-30 of the HHS General Administration Manual. By definition, the use of these funds: (1) mitigates social and environmental impacts; (2) does not include construction or alterations of the human environment; and (3) have no anticipated individual or cumulative significant effect on natural or cultural assets. Therefore the TANF Supplemental funds qualify for a Categorical Exclusion from National Environmental Protection Act (NEPA). This activity is funded under the Recovery Act Division B and is subject to Section 1609(c) reporting requirements.

G. Measures

Targets for the following performance measures have been developed based on historical data, analysis of current trends in TANF programs, and the projected impact of Recovery Act funds. The first measure will be reported on quarterly, thus quarterly projections are provided. The second measure is an annual outcome measure, thus only annual targets are provided for relevant ARRA funding years.

Table 1:

Outcome / Achievement	**Units**	**Type**	**9/30/09**	**12/31/09**	**3/31/10**	**6/30/10**	**9/30/10**	**12/31/10**	**3/31/11**	**6/30/11**	**9/30/11**	**Program End**
Cumulative amount of supplemental funds expended by states. *(Output)*	$ million	TARGET	$0M	$64M	$133M	$200M	$255M	$271M	$287M	$303M	$319M	$319M
		ACTUAL	$0M	$35M	$62M							
Increase the percentage of adult TANF recipients who become newly employed. *(outcome)*	%	TARGET	38%	n/a	n/a	n/a	38.4%	n/a	n/a	n/a	FY09 actual +0.3 percent points	n/a
		ACTUAL	Avail. Oct-10	n/a	n/a	n/a	Avail. Oct-11	n/a	n/a	n/a	Avail. Oct-12	n/a

Table 2:

Data Source	Data Validation
National Directory of New Hires (NDNH)	Beginning with performance in FY 2001, the job entry measure is based solely on performance data obtained from the NDNH. Data are updated by states, and data validity is ensured with normal auditing functions for submitted data. Prior to use of the NDNH, states had flexibility in the data source(s) they used to obtain wage information on current and former TANF recipients under HPB specifications for performance years FY 1998 through FY 2000. ACF moved to this single source national database (NDNH) to ensure equal access to wage data and uniform application of the performance specifications.
TANF Financial Report	Data are validated via single state audits.

The outcome measure is reported annually according to statutory and regulatory guidelines. Financial data for the purpose of the output measure are reported quarterly to the Department. The financial data is posted annually on ACF's website (available here: http://www.acf.hhs.gov/programs/ofs/data/), and obligation and expenditure data will be posted as part of the HHS weekly financial and activity reports (found under "Plans and Reports") on the HHS Recovery web site (http://www.hhs.gov/recovery). Information on the employment outcome measure is available in the annual ACF Budget Justification and Online Performance Appendix (available here: http://www.acf.hhs.gov/programs/olab/budget/index.html). This measure is also published on the website for ACF's Office of Family Assistance (available here: http://www.acf.hhs.gov/programs/ofa/data-reports/index.htm).

H. Monitoring/Evaluation

All Recovery Act programs will be assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

ACF's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. ACF's Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, ACF has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act program and address the obstacles and risks that could impact on their success.

The Office of Family Assistance (OFA) will follow its existing internal control structure in implementing the extension of Supplemental Grants for population increases. States will be required to report all expenditures of supplemental grants after the end of each quarter, and these expenditure amounts will be subject to review under the single state audit.

Current procedures for reviewing state expenditure reports will continue and states are subject to the Single Audit Act of 1984.

I. Transparency

ACF is open and transparent in all of its grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance.

States have to submit information on caseloads and expenditures. Audits shall be conducted by the Inspector General and the states under Chapter 75 of Title 31, United States Code.

Performance information is available in the annual ACF Budget Justification and Online Performance Appendix (available here: http://www.acf.hhs.gov/programs/olab/budget/index.html). The performance measures are also

published on the website for ACF's Office of Family Assistance (available here: http://www.acf.hhs.gov/programs/ofa/data-reports/index.htm).

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, ACF has built upon and strengthened existing processes. Senior ACF and OFA officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers. ACF program managers, specialists, and senior managers are accountable for the oversight of performance results and improvement actions through the Performance Management Appraisal Program (PMAP). Annual performance appraisals rate each employee on their effectiveness in meeting the goals of the agency, as well as identify the employee's contributions to the mission of the programs administered by their office.

The HHS Office of Inspector General (OIG) conducts reviews of state TANF programs to determine whether the state agencies expended funds in accordance with federal and state requirements, as demonstrated by adequate documentation of eligibility and payment determinations.

K. Barriers to Effective Implementation

None identified.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

Provided timely updates regarding funding levels and performance results.

Child Support Enforcement

American Recovery and Reinvestment Act Implementation Plan

A. Funding Table

(Outlays in millions)					
Child Support Enforcement & Family Support Programs	**Program Level Estimate**	**FY 2009 Actual**	**FY 2010 Estimate**	**FY 2011 Estimate**	***FY 2012-2019 Estimate***
Total	*1,817*	*274*	*1,300*	*243*	*0*

B. Objectives and Public Benefits

State Child Support Enforcement (CSE) agencies enhance the well-being of children by obtaining support, including financial and medical, for children through locating parents, establishing paternity, establishing support obligations, and monitoring and enforcing those obligations.

C. Activities

A federal open-ended match of 66 percent is available for state administrative costs of carrying out activities required under title IV-D of the Social Security Act. In addition, the federal government provides states with incentive payments based on their success in meeting certain performance measures. In 2009 and 2010, incentive payments are capped by statute at $504 million per year. States must spend these incentive payments on required CSE activities. The Deficit Reduction Act of 2006 eliminated longstanding Federal authority to match state CSE expenditures paid for with incentive funds. The American Reinvestment and Recovery Act (Recovery Act) temporarily restored federal authority to match state expenditures paid for with incentive funds. This restored authority is effective October 1, 2008 through September 30, 2010.

D. Characteristics

The federal matching funds covered by this authorization will be awarded through existing mandatory grants to states based on state expenditure claims. The Recovery Act temporarily restored authority to match state expenditures made with incentive funds authorized under section 458a. Section 458a authorizes an incentive payment pool of $504 million in each of fiscal years 2009 and 2010. Each state receives incentive funds allocated based upon its performance rates. These funds can be spent on activities eligible for a federal match.

The Recovery Act did not appropriate a fixed sum. The Recovery Act-related spending is the amount of the federal match for expenditures paid for with incentive funds through September 30, 2010 as authorized by the Recovery Act. The estimated Recovery Act incentive match is $1.8 billion.

E. Delivery Schedule

Grant awards are issued quarterly to each state CSE agency based on expenditures reported by the state. Reports are reviewed for accuracy and allowability of expenditures. Specific dates regarding the ultimate provision of funds to states are dependent on state expenditures and thus cannot be estimated here. The following milestones will ensure timely awarding of funds:

- Issue program guidance advising states how to report their expenditures and make any. needed adjustments to quarterly expenditure reports: Completed (March 26, 2009).
- Issue grant awards for 1st quarter actual expenditures reflecting new provision for states that have submitted their first quarter expenditure reports: Completed (March 26, 2009).
- Issue grant awards for 2nd and 3rd quarter estimates and actual adjustments: Completed within one week of receiving revised estimates from states.
- Issue grant awards for future periods and adjustments for actual expenditures: Quarterly.

F. Environmental Review

The distribution of additional funds to Child Support Enforcement (CSE) as a result of the Recovery Act is categorically excluded from environmental review based on Category 2 section F - Functional Exclusion: Grants for Social Services under Chapter 30-20-30 of the HHS General Administration Manual. By definition, the use of these funds: (1) mitigates social and environmental impacts; (2) does not include construction or alterations of the human environment; and (3) have no anticipated individual or cumulative significant effect on natural or cultural assets. Therefore CSE qualifies for a Categorical Exclusion from National Environmental Protection Act (NEPA). This activity is funded under the Recovery Act Division B and is not subject to Section 1609(c) reporting requirements.

G. Measures

Table 1:

The first measure will be reported quarterly, thus quarterly projections are provided for relevant ARRA funding years. The additional measures are annual outcome measures, thus only annual targets are provided for relevant ARRA funding years.

Outcome/ Achievement	**Unit**	**Type**	**9/30/ 09**	**12/31/ 09**	**3/31/ 10**	**6/30/ 10**	**9/30/ 10**	**12/31/ 10**	**3/31/ 11**	**6/30/ 11**	**9/30/ 11**	***Prgm End***
Total amount of distributed child support collections.	$B	Target	$6.1	$12.6	$19.7	$26.5	n/a	n/a	n/a	n/a	n/a	
		Actual	$6.4[1]									
Maintain the paternity establishment percentage (PEP) among children born out-of-wedlock.	%	Target	94%	n/a	n/a	n/a						
		Actual	Avail. Nov-10									
Maintain the percentage of child support cases having support orders.	%	Target	77%	n/a	n/a	n/a						
		Actual	Avail. Nov-10									
Maintain the child support collection rate for current support.	%	Target	62%	n/a	n/a	n/a						
		Actual	Avail. Nov-10									
Maintain the percentage of paying cases among child support arrearage cases.	%	Target	62%	n/a	n/a	n/a						
		Actual	Avail. Nov-10									
Total number of cases with orders established.	# million cases	Target		n/a	n/a	n/a	12.3					
		Actual	*Avail. Nov-10*									

[1] The FY 2009 actual results for this measure are preliminary, pending completion of data reliability audits.

Table 2:

Data Source	Data Validation
Office of Child Support Enforcement (OCSE) Form 157	As part of OCSE's review of performance data, OCSE Auditors review each state and territories' ability to produce valid data. Data reliability audits are conducted annually.

These performance measures are reported annually in OCSE's Annual Report to Congress, which is published on the OCSE website (http://www.acf.hhs.gov/programs/cse/). The annual targets for the outcome measures in Table 1 were revised in previous years as maintenance goals due to the end of federal matching of state expenditures using incentive payments attributable to the Deficit Reduction Act. Given the current economic situation, states may still have difficulty maintaining these performance goals. However, the Recovery Act funds will make it possible to maintain levels of effort to support these performance goals. The economic situation has had a more pronounced impact on collections performance than anticipated, due to the higher than expected unemployment rate of parents with child support obligations – significantly reducing wage withholding and federal tax offset collections. In addition, state budget deficits and resulting across-the-board cutbacks in state funds and staff have been more severe and prolonged than expected. State child support programs have not been immune from the impact of state budget deficits, and have experienced significant resource cutbacks. However, ACF has consistently been told by state child support directors that, had this additional funding not become available, their programs would be in appreciably worse shape than they are, and staff lay-offs and other cutbacks would have been deeper. In addition, some state child support directors have been reluctant to depend upon ARRA matching funds for ongoing staffing needs, with uncertainty about permanent restoration.

In addition to the measures in the table, OCSE will provide quarterly distributed collections data. However, states may change the quarterly data up to 90 days after the end of the fiscal year. In addition, data is not considered final until after annual data reliability audits are complete.

H. Monitoring/Evaluation

All Recovery Act programs will be assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

ACF's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. ACF's Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, ACF has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act program and address the obstacles and risks that could impact on their success.

ACF has assessed the OCSE program as "low" risk for improper payments based on an evaluation of the risk factors against the criteria in the risk assessment. This conclusion is based on effectiveness of the numerous existing federal monitoring controls, data reliability audits, state plan review, the insignificant amounts of questioned costs in A-133 audits, the state single audit, and the fact that child support funds are paid to custodial parents as a result of judicial or administrative actions of courts.

OCSE will follow its existing monitoring controls to implement the Recovery Act. Additional funds provided as the result of the Recovery Act will be subject to existing program accountability requirements which include financial and data reliability audits.

Each year OCSE produces an annual report that includes statistical and financial information on the Child Support program for the fiscal year. The information is taken from reports submitted by states on a quarterly basis for financial data and annually for statistical data. The report also includes program achievement on five performance measures that were established as a result of the Child Support Performance and Incentive Act of 1998 (CSPIA). OCSE staff compiles and reviews the data in an effort to control and monitor the risk of erroneous payments. Administrative expenditures including automated data processing expenditures are also evaluated for accuracy.

Since the passage of the Personal Responsibility and Work Opportunities Act of 1996 (PRWORA), states must submit a "Self-Assessment Report" after a twelve month review period.

The self-assessment process helps states evaluate their program and performance, along with giving them an opportunity to ensure they are meeting federal requirements for providing child support services. The process is used to identify problem areas, and develop and implement actions to correct the noted deficiencies, leading to measurable improved program performance and service delivery to families. The federal role is to analyze the reports, make recommendations, assist with corrective action, and identify best practices that can be shared among the states.

I. Transparency

ACF is open and transparent in all of its grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance.

In addition to providing expenditure reporting instructions, (see http://www.acf.hhs.gov/programs/cse/pol/AT/2009/at-09-02.htm), states were informed of the "Updated Implementing Guidance for the Recovery Act" and specifically, its direction that current Recovery Act reporting requirements apply to discretionary appropriations, not entitlements.

The performance measures are reported annually, in OCSE's Annual Report to Congress, which is published on the OCSE website (http://www.acf.hhs.gov/programs/cse/). Annual performance results are available in the annual ACF Budget Justification and Online Performance Appendix (available at: http://www.acf.hhs.gov/programs/olab/budget/index.html).

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, ACF has built upon and strengthened existing processes. Senior ACF officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers. ACF program managers and senior managers are accountable for the oversight of performance results and improvement actions through the Performance Management Appraisal Program (PMAP). The PMAP plans, in many instances, tie national program goals into the individual performance expectations against which managers are rated.

At the state level, as a condition of receiving federal financial participation, the state CSE agency must submit an approved state plan describing the nature and scope of its CSE program. Activities contained in the plan must be allowable under the Child Support statute (Title IV-D of the Social Security Act, as amended). ACF has the authority to reject elements of the Plan that do not meet the guidelines of the Child Support statute. State plans contain eligibility criteria for recipients the state intends to serve in the program for the fiscal year. While states are not required to submit their plan every year, they are required to submit any pages

that have become required due to new legislation or regulations and to resubmit pages that have changed since the original submission.

For automation, OCSE requires that each state CSE agency have a single statewide CSE system that encompasses all political subdivisions and electronically interfaces with other agencies and organizational entities. Each state is required to submit an annual information technology planning and procurement document for federal prior approval. OCSE also conducts periodic on-site reviews to ensure that statewide CSE systems meet minimum standards that address intake, locate, paternity and order establishment, enforcement, and financial functions such as collection, distribution and disbursement of child support.

K. Barriers to Effective Implementation

As mentioned previously, additional funds provided as the result of the Recovery Act will be issued as part of the title IV-D program and will be subject to existing program accountability requirements which include financial and data reliability audits. In addition, the funds covered by this authorization will be awarded through existing grants to states. Therefore, OCSE anticipates no barriers to effective implementation.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

Provided timely updates regarding funding levels and performance results.

FMAP Foster Care/Adoption Assistance

American Recovery and Reinvestment Act Implementation Plan

A. Funding Table

For complete ACF Funding Table, please see Appendix 1 (dollars in millions).

(Outlays in millions)					
FMAP Foster Care/Adoption Assistance	**Program Level Estimate**	**FY 2009 Actual**	**FY 2010 Estimate**	**FY 2011 Estimate**	**FY 2012-2019 Estimate**
Total	929.0	258.0	500.0	154.0	17.0

B. Objectives

The Children's Bureau seeks to provide for the safety, permanency and well being of children through leadership, support for necessary services, and productive partnerships with states, tribes, and communities. Under the American Recovery and Reinvestment Act (Recovery Act), an estimated additional $929 million will be provided to states to increase the federal match for state maintenance payments for foster care, adoption assistance, and guardianship assistance.

C. Activities

A federal match equal to the Medicaid match rate for medical assistance payments (FMAP) is provided for state maintenance payments for foster care, adoption assistance, and guardianship assistance care under Title IV-E of the Social Security Act. Beginning in FY 2010, tribes also are eligible for these funds. The Recovery Act temporarily increases the FMAP rate for state title IV-E entitlement programs by at least 6.2 percentage points.[1] This matching rate increase is effective October 1, 2008 through December 31, 2010.

D. Characteristics

Funds are awarded to states at the beginning of each quarter based on state estimates and then are adjusted after the end of the quarter when states report actual expenditures.

[1] Not all states received the same rate increase. In addition to the 6.2 percentage point increase, the Recovery Act provides for application of a "base" FMAP rate calculated for the current fiscal year or the one calculated in a previous fiscal year (hold harmless provision), if that rate is higher. There were 17 states in fiscal years 2009 and 2010 whose Recovery Act portion of the FMAP rate exceeded the 6.2 percentage points, and 27 states will exceed that rate in FY 2011.

The Recovery Act does not appropriate funds for this purpose, but rather changes the FMAP rate for Title IV-E maintenance payments. The funding for this change is appropriated annually. Funds will be awarded quarterly for FY 2009, FY 2010 and first quarter of FY 2011. ACF issued initial grants to increase the first and second quarter awards to states for FY 2009 and then began applying the new FMAP rates to subsequent quarterly awards. This process will continue through the first quarter of FY 2011 as required by the statute. It is estimated that states will receive $929 million in additional funding through the end of the first quarter of FY 2011. The final amounts for these quarters will depend on the actual state expenditures matched at the higher rate.

E. Delivery Schedule

Federal payments to states for foster care, adoption and guardianship subsidies are reimbursement for "services" rendered. The Recovery Act simply increases the rate of reimbursement states receive from the federal government for statutorily prescribed items of cost related to a child's board and care.

- Grants for 1st and 2nd quarter state estimates – issued March 16, 2009
- Program guidance advising states how to report their expenditures and make any needed adjustments to quarterly expenditure reports – issued March 16, 2009
- Grants for 3rd quarter state estimates – issued for Adoption Assistance on April 7, 2009 and issued for Foster Care on April 14, 2009
- Grants for 1st quarter actual expenditures – completed May 15, 2009
- Grants for 4th quarter state estimates – completed July 1, 2009
- Grants for future periods and adjustments for actual expenditures – will occur ongoing on a quarterly basis

F. Environmental Review

The distribution of additional funds for FMAP as a result of the Recovery Act is categorically excluded from environmental review based on Category 2 section F - Functional Exclusion: Grants for Social Services under Chapter 30-20-30 of the HHS General Administration Manual. By definition, the use of these funds: (1) mitigates social and environmental impacts; (2) does not include construction or alterations of the human environment; and (3) have no anticipated individual or cumulative significant effect on natural or cultural assets. Therefore FMAP qualifies for a Categorical Exclusion from National Environmental Protection Act (NEPA). This activity is funded under the Recovery Act Division B and is not subject to Section 1609(c) reporting requirements.

G. Measures

Table 1: The first performance measure below is a quarterly reporting output measure. The additional three measures will report annually, thus only annual targets are included.

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
Amount of Recovery Act FMAP funds expended by	$ million	TARGET		$349	$496	$614	$758	$797	$836	$876	$912	$929
states, and states and tribes starting in FY 2010. *(Output)*		ACTUAL	$258 million	$358 million	$466 million							
For those children who had been in care less than 12 months, maintain the	%	TARGET	80%	n/a	n/a	n/a	80%	n/a	n/a	n/a	80%	n/a
percentage that has no more than two placement settings. *(Outcome)*		ACTUAL	Oct-10	n/a	n/a	n/a	Oct-11	n/a	n/a	n/a	Oct-12	n/a
Increase the adoption	%	TARGET	10.1%	n/a	n/a	n/a	10.2%	n/a	n/a	n/a	10.3%	n/a
rate. *(Outcome)*		ACTUAL										
Number of adoptions from	#	TARGET	55,000	n/a	n/a	n/a	55,000	n/a	n/a	n/a	55,000	n/a
foster care. *(Output)*		ACTUAL										

Table 2:

Data Source	Data Validation
Adoption and Foster Care Analysis Reporting System (AFCARS)	States report child welfare data to ACF through the Adoption and Foster Care Analysis Reporting System (AFCARS). All state semi-annual AFCARS data submissions undergo extensive edit-checks for internal reliability. The results of the AFCARS edit-checks for each of the six-month data submissions are automatically generated and sent back to each state, to help the state to improve data quality. Many states submit revised data to insure that accurate data are submitted, often for more than one prior submission period. The Children's Bureau conducts several AFCARS compliance reviews each year, which typically result in a comprehensive AFCARS Improvement Plan (AIP). Also, states' Statewide Automated Child Welfare Information Systems (SACWIS) systems are undergoing reviews to determine the status of their operation and the automated system's capability of meeting the SACWIS requirement to report accurate AFCARS data. To speed improvement, the agency funds the National Resource Center for Child Welfare Data and Technology. This Resource Center provides technical assistance to states to improve reporting to AFCARS, improve statewide information systems, and to make better use of their data. Finally, ACF has recently implemented the AFCARS Project that includes a detailed review of all aspects of AFCARS by federal staff and participation of the field in identifying possible changes to improve the system. All of these activities should continue to generate additional improvements in the data over the next few years.
Monthly Treasury Department Reports	The Treasury Department consolidates the financial information from each state/grantee and publishes the aggregate information on a monthly basis. These reports are generally available within 15 days after the end of each month.

The outcome measures are reported on annually, as well as the first output measure in Table 1. The last output measure in Table 1 related to amount of Recovery Act funds expended will be reported quarterly.

The annual targets for the outcome measures in Table 1 are expressed as maintenance goals because states have discretion over how to spend the state dollars that are freed up by the increased federal share provided by the Recovery Act. Therefore, it is unclear what impacts, if any, this change may have on the Foster Care program performance measures.

H. Monitoring/Evaluation

All Recovery Act programs will be assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

ACF's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. ACF's Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, ACF has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act program and address the obstacles and risks that could impact on their success.

ACF will follow its existing internal control structure in implementing the FMAP provision, as described below. The major source of financial risk in the title IV-E program is state claims submitted on behalf of ineligible children. ACF has successfully reduced the program's error rate associated with claiming for ineligible children through its title IV-E eligibility reviews.

Title IV-E eligibility reviews are a two stage process whereby a team of federal and state reviewers assess a sample of cases to determine whether claims are being made on behalf of eligible children and for appropriate expenditures. States that do not meet the threshold for the first stage of the review implement a program improvement plan and then are assessed during a second stage review using a larger sample. In both review stages unallowable costs associated with the sample cases are disallowed. States that fail to meet the thresholds in a second stage review are subject to a disallowance that is extrapolated to the universe of title IV-E cases. The reviews and the attendant program improvement efforts associated with continuing to reduce the IV-E error rate are ongoing. In addition, ACF will work on an ongoing basis with the OIG to coordinate oversight and audit activity.

ACF does not anticipate any financial risk associated directly with the increase in FMAP. Under the regulatory review promulgated at 45 CFSR 1356.71, Foster Care Eligibility Reviews are conducted systematically in each state (the 50 states, the District of Columbia, and Puerto Rico)

every three years.[2] Corrective action plans instituted by ACF to address improper payments in the foster care program have been designed to address those eligibility errors and other payment errors (e.g. underpayments) that have contributed most to improper payments.

I. Transparency

ACF is open and transparent in all of its grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance. The Recovery Act funds are an increase in the percentage of reimbursement states receive based on the claims they submit for foster care, adoption and guardianship subsidies. States will receive one grant award using the base FMAP and a separate award for the increase under the Recovery Act.

ACF will ensure that all title IV-E funds, including the Recovery Act enhanced match are expended on eligible children and for allowable costs using the monitoring protocol described in the "Monitoring" section. In addition, the expenditure of these funds will be carefully monitored by Children's Bureau regional staff and by ACF Office of Administration (OA) grants specialists with strong oversight from the national office.

Performance results on the outcome and output measures in Table 1 are available in the annual ACF Budget Justification and Online Performance Appendix (available at: http://www.acf.hhs.gov/programs/olab/budget/index.html).

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, ACF has built upon and strengthened existing processes. Senior ACF officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers. ACF program managers and senior managers are accountable for the oversight of performance results and improvement actions through the Performance Management Appraisal Program (PMAP). Managers are assessed on the extent to which their oversight of state programs results in state compliance with applicable federal law and regulations and/or areas of noncompliance are addressed expeditiously.

K. Barriers to Effective Implementation

None identified.

[2] While tribes are eligible for direct FMAP funding beginning in FY 2010, ACF has not yet received any tribal title IV-E plans. It is possible that even if a tribe submits a plan in FY 2010, the program may not be running in time to benefit from the Recovery Act FMAP increase.)

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

Provided timely updates regarding funding levels and performance results.

Child Care and Development Fund

American Recovery and Reinvestment Act Implementation Plan

A. Funding Table

(Dollars in millions)			
Child Care and Development Block Grant (CCDBG)	**FY 2009 Actual Obligations**	**FY 2010 Estimate Obligations**	**FY 2011 Estimate Obligations**
Grants	1,995.0	0	0
Technical Assistance	2.0	3.0	0
Total	1997.0	3.0	0

B. Objectives and Public Benefits

The American Recovery and Reinvestment Act (Recovery Act) provided $2 billion in supplemental funding to the Child Care and Development Fund (CCDF)[1] for grants to states, territories, tribes, and tribal organizations for child care assistance for low-income families and to: (1) allow each state maximum flexibility in developing child care programs and policies that best suit the needs of children and parents within such state; (2) promote parental choice to empower working parents to make their own decisions on the child care that best suits their family's needs; (3) encourage states to provide consumer education information to help parents make informed choices about child care; (4) assist states to provide child care to parents trying to achieve independence from public assistance; and (5) assist states in implementing the health, safety, licensing, and registration standards established in state regulations.

C. Activities

The purpose of these funds is to provide additional funds to current state, tribe, and territorial grantees for the purpose of providing child care financial assistance to low-income working families. In addition, the Recovery Act specifies that states must use approximately $255 million of the $2 billion total funds for quality activities, of which approximately $94 million must be used to improve the quality of infant and toddler care.

D. Characteristics

[1] The Recovery Act funds for CCDF are designated for the Child Care and Development Block Grant, which provides discretionary funding for states to allow maximum flexibility in developing child care programs.

All but one-quarter of one percent ($5 million) of the total $2 billion in funding will be supplemental funds distributed in the form of formula grants to state, tribe, and territorial grantees. The $5 million is reserved as allowed under current program regulations to support the Child Care Technical Assistance Network to provide technical assistance to grantees. One hundred percent of the technical assistance funds will be distributed in the form of contracts or through modifications to existing contracts. Child care funds are distributed to grantees under the existing statutory formula.

Purpose	Type of Award	Funding Amount	Recipients
Expand child care services, including direct services and quality improvement	Supplemental funding via formula grants	Approximately $1.7 billion	States, tribes and territories
Improve quality of services	Supplemental funding via formula grants	$255 million of which $93.6 million for infant and toddler care	States and territories
Technical Assistance	Funding via modifications to existing contracts	$5 million (1/4 of 1%)	Existing Child Care Technical Assistance Network
TOTAL = $2 billion			

E. Delivery Schedule

Child Care and Development Fund (CCDF) for grantees:

- Announcement of supplemental grant awards available to states, tribes, and territories – April 9, 2009
- Guidance provided to grantees (PI #CCDF-ACF-PI-2009-03) regarding additional CCDF Discretionary funding made available (http://www.acf.hhs.gov/programs/ccb/law/guidance/current/pi2009-03/pi2009-03.htm) – April 9, 2009
    - (As Needed): Grantees that decided to make a programmatic or administrative change to the child care program in FY 2009 as a result of the availability of Recovery Act funding – submitted amendment to existing CCDF plan within 60 days of making the change. (Plan amendments may be approved retroactively.)
    - (As Needed): Child Care Bureau (CCB) reviewed and approved CCDF Plan amendments submitted by grantees – within 90 days of receipt
- Funds made available for use by states, tribes, and territories – April 13, 2009
- Information memorandum provided to grantees (CCDF-ACF-IM-09-01) regarding flexibility and uses of CCDF Recovery Act funding (http://www.acf.hhs.gov/programs/ccb/law/guidance/current/im2009-01/im2009-01.htm) – June 2, 2009
- Provided guidance to CCDF Lead Agencies on recipient reporting requirements under section 1512 of the Recovery Act

(http://www.acf.hhs.gov/programs/ccb/initiatives/arra/1512/index.htm) —September 30, 2009

- Issued revised CCDF expenditure reporting forms (ACF-696 and 696T) to include ARRA funds (http://www.acf.hhs.gov/programs/ccb/law/guidance/current/pi2009-08/pi2009-08.htm; http://www.acf.hhs.gov/programs/ccb/law/guidance/current/pi2009-09/pi2009-09.htm)--October 29, 2009
- Ongoing: Monitor grantee expenditure of funds through review of quarterly ACF-696 and annual ACF-696T Financial Reports (from tribes), and review 1512 Report submissions. Confirm compliance with grant award terms and conditions. – Quarterly and Ongoing

Child Care Bureau (CCB) technical assistance funds:

- Modify existing technical assistance contracts and award supplemental funds – September 23, 2009
- Review and approve contract deliverables – September 30, 2009 and ongoing
- Modify existing technical assistance contracts for FY 2010 awards, develop new contracts, and award funds – May 31, 2010

F. Environmental Review

The distribution of additional funds to the Child Care and Development Fund (CCDF) as a result of the Recovery Act is categorically excluded from environmental review based on Category 2 section F - Functional Exclusion: Grants for Social Services under Chapter 30-20-30 of the HHS General Administration Manual. By definition, the use of these funds: (1) mitigates social and environmental impacts; (2) does not include construction or alterations of the human environment; and (3) have no anticipated individual or cumulative significant effect on natural or cultural assets. Any funding that includes construction or alterations will not fall under this categorical exclusion and will be subject to an environmental assessment. Therefore CCDF qualifies for a Categorical Exclusion from National Environmental Protection Act (NEPA) and will be reported under Section 1609(c) report form for ACF.

G. Measures

Regarding the first measure in the performance measures table below, HHS does not require states to separately report on the number of children with child care services funded by ARRA, but rather allows for these children to be reported in combination with children served by other funding sources. Therefore the data in this measure are estimates based on each state's use of ARRA child care funds for direct services and its subsidy cost per child. The measure is based on information provided by states on the ACF-696 Financial Report. CCB added "Column D" to the ACF-696 to capture the categorical expenditure of ARRA funds separately from other CCDF funding streams. States report how much of the ARRA funds are spent on direct services, which could include providing subsidies to additional families (such as those on a waiting list), but also includes supporting direct services for families already receiving a subsidy. States have reported using ARRA funds to lower co-payments for families, extend subsidy eligibility for longer periods of job search, and to provide higher reimbursement to child care providers serving subsidized children. Therefore, this measure does not indicate the number of children new to CCDF served using ARRA funds because it includes expenditures on families already receiving services.

Regarding the second and third performance measures, targets are based on expectations set by States based on the resources available and priorities of the grantees. Barriers to reaching targets may include changes to state budgets and priorities and changes to the needs of families in the states.

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
Estimated number of children receiving subsidies in the CCDF program supported by Recovery Act funds.[2] *(quarterly output)*	Number of Children	TARGET			132,000	156,000	180,000	190,000	200,000	210,000	220,000	220,000
		ACTUAL	60,000	108,000								
Increase the number of states implementing policy	Number of States	TARGET			25	27	27	30	33	35	35	35
		ACTUAL		24								

[2] This measure makes the assumption that children receive services over a 12-month period (i.e., this is the number of children that could have been supported in a year with ARRA funds).

changes to increase access to child care.[3] *(quarterly output)*												
Increase the number of States investing in systemic quality changes.[4] *(quarterly output)*	Number of States	TARGET			12	13	15	18	20	20	20	20
		ACTUAL		10								

Data Source	Data Validation
Measure 1: ACF-696 Financial Report, Column D, ARRA Expenditures	States submit the ACF-696 on a quarterly basis, however it is not due until 30 days after the end of the quarter. CCB will be able to provide actual data on whether the targets for this measure have been met approximately 2 months after the end of each quarter. Expenditure data is subject to automated systems checks and review by ACF Regional Office staff.
Measures 2 and 3: Quarterly Section 1512 Reports	Information provided by states and Regional Offices. CCB will be able to provide actual data on whether the targets for this measure have been met approximately 2 months after the end of each quarter. Data are from Section 1512 reports that are reviewed by CCB Central Office staff and from information provided and verified by CCB Regional Office staff.

[3] Policy changes may include increasing provider payment rates, decreasing parental co-payments, increasing income eligibility levels, expanding the definition of work, and decreasing or avoiding waiting lists.

[4] Systemic quality changes may include Quality Rating and Improvement System creation or expansion, child care provider professional development plans or systems, training registries for child care providers.

H. Monitoring/Evaluation

All Recovery Act programs will be assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 —Management's Responsibility for Internal Control" (including Appendices A, B, and C).

ACF's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. ACF's Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, ACF has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act program and address the obstacles and risks that could impact on their success.

Funded grantees must submit quarterly financial and programmatic reports required by Section 1512 of the Recovery Act. In addition, as specified in 45 CFR Part 98, states must report to ACF annually aggregate data on the number of families and children receiving services, the number and types of providers serving families, payment methods, and consumer education efforts. Quarterly case-level reports are required to provide data on the characteristics of families and children receiving subsidies and payments to providers. States also must submit quarterly expenditure reports, which include separate reporting for ARRA expenditures. Quarterly financial reports are reviewed by ACF Regional staff for compliance with CCDF regulations.

The Child Care and Development Fund (CCDF) has been identified by OMB in Circular A-11, Section 57, as one of the programs that is required under the Improper Payments Information Act of 2002 (IPIA) to report annually on the extent of the erroneous payments and the actions to reduce erroneous payments. ACF issued a final rule in October 2007 adding error rate reporting to CCDF regulations. ACF employs a case record review process to determine whether child care subsidies were authorized correctly for eligible families. States select a random statewide sample of cases for each month of the fiscal year.

CCDF funds for grantees: Existing accountability measures for CCDF formula grant awards are outlined in the terms and conditions of grant awards and include compliance with OMB Circular A-133 and the Single Audit Act of 1984; compliance with 45 CFR Part 98 and 99; compliance

with CCDF regulations at 45 CFR 98.100 which require states, D.C., and Puerto Rico to report on error rates and improper payments made in the CCDF program; and compliance with CCDF regulations at 45 CFR 98.65 to submit quarterly financial status reports (tribes submit reports annually) until all grant award funds have been liquidated.

CCDF funds for technical assistance: A Federal Project Officer within CCB is assigned to each technical assistance contract to oversee project activities, ensure contractor performance, and provide technical direction. Each Federal Project Officer works closely with the Federal Contracting Officer (in the HHS Program Support Center) to ensure accountability and compliance with Federal Acquisition Regulations (FAR) and other requirements.

I. Transparency

ACF is open and transparent in all of its grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance. ACF issued guidance for CCDF Lead Agencies on recipient reporting required by Section 1512 of the Recovery Act, and informed recipients of their reporting obligation through standard terms and conditions, contract documents, and other program guidance. ACF provides technical assistance to grantees and contractors to ensure compliance with reporting requirements.

ACF ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. ACF informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, ACF provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

In addition, as specified in 45 CFR Part 98, states must submit to ACF on a quarterly basis reports documenting categorical expenditures from the CCDF grant award including spending on administrative activities, quality activities, direct services, non-direct services. Grantees also are required to submit administrative data reports, both aggregate and case-level, indicating the number and characteristics of families and children receiving CCDF subsidies as well as other programmatic information. ACF posts data tables which display information for each grantee on its website for public viewing. These reporting mechanisms ensure that both financial and programmatic activities undertaken by grantees are transparent to the public.

The Child Care Bureau has centrally located all Recovery Act information specific to CCDF on its website at: http://www.acf.hhs.gov/programs/ccb/initiatives/arra/index.htm. This information includes program guidance and funding allocations and will include links to program and financial data. Annual performance results are available in the annual ACF Budget Justification and Online Performance Appendix (available at: http://www.acf.hhs.gov/programs/olab/budget/index.html).

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, ACF has built upon and strengthened existing processes. Senior ACF and Child Care Bureau officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers. Program and senior managers are accountable for the oversight of performance results and improvement actions through the Performance Management Appraisal Program (PMAP). The PMAP evaluates employee performance in key areas related to organizational goals, and is linked to both incentives that reward successful performance and compliance action against unacceptable performance.

States described a range of corrective actions they have taken or planned to take to reduce the amount of improper authorizations for payment. Corrective action strategies included training, more frequent case record reviews, improved monitoring or audits, increased awareness through review of results, and targeted corrective actions to managers. States reported action steps to hold staff accountable at both the agency and staff level. Agency accountability steps included performance improvement plans, decisions whether or not to contract with local agencies based on payment accuracy performance, and annual management reviews with corrective action plans if case reviews fail to meet targets.

K. Barriers to Effective Implementation

None identified.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

Updated with new performance measures to more clearly communicate the impact of Recovery Act funding for this program.

Early Head Start

American Recovery and Reinvestment Act Implementation Plan

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Grants	982.0	0.0	982.0
Technical Assistance	85.0	0.0	85.0
Monitoring	33.0	8.0	25.0
Total	1,100.0	8.0	1,092.0

B. Objectives and Public Benefits

Under the American Recovery and Reinvestment Act (Recovery Act), $1.1 billion will be provided to the Office of Head Start to increase the number of children participating in Early Head Start. The objective of the Early Head Start program is to enhance the cognitive, social and emotional development of low-income children, including children on federally-recognized reservations and children of migratory farm workers, through the provision of comprehensive health, educational, nutritional, social and other services and to involve parents in their children's learning and to help parents make progress toward their educational, literacy and employment goals. Head Start also emphasizes the significant involvement of parents in the administration of their local Head Start programs.

C. Activities

The purpose of this funding is to increase the number of children participating in Early Head Start (with up to ten percent of these funds to be used for training and technical assistance and up to three percent for monitoring the operations of these additional programs). Conference report language that accompanied the Recovery Act bill stated: *The conferees expect the Department of Health and Human Services (HHS) to work with Head Start grantees in order to manage these resources in order to sustain fiscal year 2009 awards through fiscal year 2010.*

D. Characteristics

The Recovery Act appropriates $1.1 billion to increase the number of Early Head Start (EHS) children.

Purpose	Type of Award	Funding Amount	Recipients
Expand Early Head Start services	Competitive discretionary grants	$982 million	Community based organizations, local government, higher education institutions, American Indian tribes and migrant and seasonal grantees
Monitoring	Contract	$33 million	Private Industry
Training and technical assistance (T/TA)	Included in awards to grantees who receive expansion funding, modifications to existing contracts and award of new grants/contracts	$85 million	Provided to EHS grantees who receive expansion funding, current state-based T/TA system to work with new grantees, new contracts to work on Child Development Associate (CDA) credential and other training issues
TOTAL = $1.1 billion			

E. Delivery Schedule

- Synopsis of Grant Opportunity published online – completed (April 2, 2009)
- Announcement published in grants.gov – completed (May 8, 2009)
- Applications due – due by July 9, 2009
- Panel the EHS expansion proposals – completed (August 2009)
- Select successful applicants for EHS expansion – completed (September 2009)
- Allocate T/TA funding, including direct awards to grantees, contract modifications to existing recipients, and new contracts to provide T/TA support – ongoing (September 2009 – May 2010)
- Modify contracts to enhance Head Start monitoring activities (completed September 2009 and award new contract (May 2010)
- Award EHS expansion grants – completed (November 2009 - April 2010)
- Award second expansion and T/TA grant – August – September, 2010

F. Environmental Review

The distribution of Early Head Start funds as a result of the Recovery Act is categorically excluded from environmental review based on Category 2 section F - Functional Exclusion: Grants for Social Services under Chapter 30-20-30 of the HHS General Administration Manual. By definition, the use of these funds: (1) mitigates social and environmental impacts; (2) does not include construction or alterations of the human environment; and (3) have no anticipated

individual or cumulative significant effect on natural or cultural assets. Any funding that includes construction or alterations will not fall under this categorical exclusion and will be subject to an environmental assessment. To date, there have been 561 Environmental Assessments completed for Early Head Start grantees receiving Recovery Act funds. All reviews and documents were completed, and have been finalized and reported under in the Section 1609(c) report form for ACF under the National Environmental Protection Act (NEPA).

G. Measures[1]

This funding is expected to provide services to approximately 45,000 more pregnant women, infants, toddlers, and their families. An additional 10,000 Early Head Start (EHS) children will be served through the EHS portion of $1 billion in Head Start Recovery Act funding, in total nearly doubling the total number of Early Head Start participants.

Targets for the following performance measures have been developed based on historical data, analysis of current trends in Early Head Start programs, and the projected impact of Recovery Act funds. The first three measures will be reported on quarterly, thus quarterly projections are provided for relevant ARRA funding years. The fourth measure is an annual outcome measure, thus only annual targets are provided.

Table 1:

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
Number of additional classrooms used to serve the increased Early Head Start enrollment. *(Quarterly Output)*	# classrms	TARGET		0	1,350	3,000	4,000	n/a	n/a	n/a	n/a	
		ACTUAL		439	2,358							
Number of additional Early Head Start children served as a result of Recovery Act funds. *(Quarterly Output)*	# EHS kids	TARGET		0	11,000	33,000	48,000	n/a	n/a	n/a	n/a	
		ACTUAL		625	18,467							
Increase the percentage of EHS teachers with AA, BA, Advanced Degree, or degree in a field related to early childhood education. *(Annual Outcome)*	%	TARGET	57%	n/a	n/a	n/a	60%	n/a	n/a	n/a	60%	57%
		ACTUAL	56%									56%

[1] All EHS expansion grantees will receive two awards – the first to expand and the second to sustain that expansion. Targets will be achieved after the first award and then sustained with the second award made in September 2010.

Table 2:

Data Source	Data Validation
Program Information Report (PIR)	Data collection for the PIR is automated to improve efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The Office of Head Start also engages in significant monitoring of Head Start grantees through monitoring reviews of Head Start and Early Head Start grantees, which examine and track Head Start Program Performance Standards compliance at least every three years for each program. Teams of ACF Regional Office and Central Office staff, along with trained reviewers, conduct more than 500 on-site reviews each year. The automated data system provides trend data so that the team can examine strengths and weaknesses in all programs.

The Office of Head Start (OHS) will track the above output measures in a number of ways. Data on the number of classrooms and enrollment is collected monthly in the Head Start Enterprise System. Grantees report their expenditure data through 1512 reporting on Grants.gov. Risk Management calls, which occur quarterly for all new Early Head Start programs, are used to discuss progress on the grantee's expansion, including enrollment and expenditures. The Office of Head Start works closely with Regional Office staff to review and validate the data.

H. Monitoring/Evaluation

All Recovery Act programs will be assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

ACF's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. ACF's Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, ACF has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act program and address the obstacles and risks that could impact on their success.

ACF will follow its existing internal control structure in implementing this Early Head Start expansion. The expenditure of these funds will be carefully monitored by Office of Head Start (OHS) regional staff and by ACF Office of Administration (OA) grants specialists with strong oversight from the national office. On-going Risk Management Meetings conducted with each grantee will focus on the use of these funds and the frequency will be increased to quarterly with all grantees receiving these funds. All Early Head Start programs are subject to regular monitoring visits where their records, including fiscal records will be carefully reviewed to assure an appropriate use of these funds. New Early Head Start programs will be visited after completion of their first year of program operations. The fiscal monitoring tools will be revised to ensure that the use of these funds is thoroughly and separately examined. All new Early Head Start grantees will be monitored at the end of their first year of operation. In addition, all Head Start grantees must submit an annual audit to OHS.

I. Transparency

ACF is open and transparent in all of its grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance. ACF ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. ACF informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other

program guidance. In addition, ACF provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

OHS will post on its website (http://www.acf.hhs.gov/programs/ohs/) quarterly information about the spending of Recovery Act funds, including such information as the number of successful EHS expansion applicants, how many new children are being served, how many new staff have been hired, and how many new EHS centers have been opened (see Table 1 output measures). Annual performance results are available in the annual ACF Budget Justification and Online Performance Appendix (available at: http://www.acf.hhs.gov/programs/olab/budget/index.html).

J. Accountability

Head Start is legislatively required to perform reviews of each Head Start program every three years and to review all newly funded programs after its first years of operation. Erroneous Payment reviews are conducted to determine whether documentation demonstrated that a Head Start child was income eligible. In the case of errors, Head Start grantees are required to develop corrective action plans. ACF has also issued a memorandum reminding all grantees of documentation requirements, developed a standard signed statement template form, increased oversight of documentation activities being performed by ACF Regional Offices, and increased grantee emphasis for on-going monitoring through training and development of a monitoring protocol to review management systems. Head Start Regional program managers are charged with assuring all programs in their regions are providing appropriate services to enrolled children and families and using their grants funds as required by statute and regulation. Grantees that are not must correct their problems or face de-funding.

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, ACF has built upon and strengthened existing processes. Senior ACF and Head Start officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers. Both senior and program managers are held accountable for assuring quality grantee performance through their Performance Management Appraisal Program (PMAP) plans. PMAP plans define clear expectations for managerial performance related to ACF-wide goals, the HHS Strategic Plan, and other key performance measures.

K. Barriers to Effective Implementation

None identified.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

Provided timely updates regarding funding levels and performance results.

Head Start

American Recovery and Reinvestment Act Implementation Plan

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
COLA/Quality	475.0	474.0	1.0
HS/EHS Expansion	400.0	94.0	306.0
State Advisory Councils	100.0	0.0	100.0
Technical Assistance	25.0	2.0	23.0
Total	1,000.0	570.0	430.0

B. Objectives and Public Benefits

Under the American Recovery and Reinvestment Act (Recovery Act), $1 billion will be provided to the Office of Head Start to promote the school readiness of low-income children, including children on federally-recognized reservations and children of migratory farm workers, by enhancing their cognitive, social and emotional development of low-income children, through the provision of comprehensive health, educational, nutritional, social and other services and to involve parents in their children's learning and to help parents make progress toward their educational, literacy and employment goals. Head Start also emphasizes the significant involvement of parents in the administration of their local Head Start programs.

C. Activities

Recovery Act funds must be used in a manner consistent with the detailed requirements for the allocation of funds included in the Head Start Act. Additionally, Conference report language that accompanied the Recovery Act bill stated: *The conferees expect the Department of Health and Human Services (HHS) to work with Head Start grantees in order to manage these resources in order to sustain fiscal year 2009 awards through fiscal year 2010.*

D. Characteristics

The Recovery Act appropriates $1 billion to be allocated according to the funding formula set out in the Head Start Act. In order to determine the distribution of the funding provided in the Recovery Act, the Recovery Act must be considered in the context of the FY 2009

Appropriation. With an appropriation of $7.1 billion in FY 2009, the funds will be distributed in the following manner:

Purpose	Type of Award	Funding Amount	Recipients
Cost of living allowance (COLA) (4.9%)	Supplemental funding to existing grantees	$122 million in FY 2009 in Recovery Act funds and $204 million from FY 2009 appropriation	Existing Head Start grantees
Quality funds	Supplemental funding to existing grantees	$354 million in FY 2009 in Recovery Act funds	Existing Head Start grantees
Head Start expansion	Competitive grants involving existing grantees	$100 million in FY 2009 and $100 million in FY 2010 in Recovery Act funds	Existing Head Start grantees
Early Head Start expansion	Competitive discretionary grants	$100 million in FY 2009 and $100 million in FY 2010 in Recovery Act funds	Competitive grant process open to all entities eligible under statute, including all current Head Start/Early Head Start grantees
State Advisory Councils	Awarded to states following submittal of application with a 3-year plan	$100 million in FY 2009 in Recovery Act funds	State governments
Training and technical assistance (T/TA)	Supplemental funding to existing grantees and competitive grants to existing grantees	$10 million in FY 2009 in Recovery Act funds, $6 million from FY 2009 appropriation, and $15 million in FY 2010 in Recovery Act funds	Head Start grantees
TOTAL = $1 billion			

COLA and quality funds will be awarded through supplemental funding to existing grantees. Head Start expansion funding will be awarded through a competitive grant process involving existing grantees and will be distributed by formula to each state (including DC, Puerto Rico, and Trust Territories [i.e. Guam. Palau, American Samoa, the Northern Mariana Islands and the Virgin Islands]). The State Advisory Council funds will be awarded to those states that submit acceptable applications, consistent with the requirements of Section 642B of the Head Start Act.

Training and technical assistance funds will be provided to supplement existing Head Start grantees and to fund Office of Head Start (OHS) technical assistance contracts.

The funds for Head Start expansion, quality improvement, and COLA will be awarded to current Head Start grantees, including community-based organizations, local governments, Indian tribes and higher education institutions. The funds for State Advisory Councils will be awarded to state governments.

E. Delivery Schedule

- Issue program instruction on how to apply for COLA and quality – completed (April 2, 2009)
- Synopsis of Grant Opportunity for Head Start expansion funds published online – within one week after approval by OMB – completed (April 2, 2009)
- Expansion announcement published in grants.gov – completed (May 8, 2009)
- Begin issuing COLA, and quality funds to grantees – completed (June - September, 2009)
- Expansion applications due – June 26, 2009
- Panel reviews – completed (July 2009)
- Award Head Start expansion grants and T/TA funds – completed (September 2009)
- Award State Advisory Council grants to states – December 2009-August 2010[1] (in progress - awarded on rolling basis as soon as applications are submitted by Governors and reviewed)
- Announcement of Head Start Expansion Fund availability (in 11 states and the Territories) – applications due by March 8, 2010. Anticipate awarding expansion and T/TA funds in May 2010.
- Award competitive T/TA grants to existing Head Start programs – July-August, 2010
- Award second year expansion and T/TA funds – August-September, 2010

F. Environmental Review

The distribution of Head Start funds as a result of the Recovery Act is categorically excluded from environmental review based on Category 2 section F - Functional Exclusion: Grants for Social Services under Chapter 30-20-30 of the HHS General Administration Manual. By definition, the use of these funds: (1) mitigates social and environmental impacts; (2) does not include construction or alterations of the human environment; and (3) have no anticipated individual or cumulative significant effect on natural or cultural assets. Any funding that includes construction or alterations will not fall under this categorical exclusion and will be subject to an environmental assessment. To date, there have been 2,078 Environmental Assessments completed for Head Start grantees receiving Recovery Act funds. All reviews and documents

[1] OHS received seven applications by mid May; five applications are under review totaling $8.5 million and two applicants have been awarded funding totaling $6.6 million.

were completed, and have been finalized in the Section 1609(c) report form for ACF under the National Environmental Protection Act (NEPA).

G. Measures[2]

Please note that the additional children being served in Early Head Start as a result of the $1 billion funding increase are shown in the Early Head Start Recovery Act Implementation Plan. Targets for the following performance measures have been developed based on historical data, analysis of current trends in Head Start programs, and the projected impact of Recovery Act funds. The first three measures will be reported on quarterly, thus quarterly projections are provided for relevant ARRA funding years. The fourth measure is an annual outcome measure, thus only annual targets are provided.

Table 1:

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
Number of additional classrooms used to serve the increased Head Start enrollment. *(Quarterly Output)*	# class-rooms	TARGET		175	580	700	825	n/a	n/a	n/a	n/a	n/a
		ACTUAL		221	653							
Number of Head Start children served by Recovery Act funds. *(Quarterly Output)*	# HS kids	TARGET		3,000	10,000	12,000	13,000	n/a	n/a	n/a	n/a	n/a
		ACTUAL		3,500	10,375							
Increase the	%	TARGET	75%	n/a	n/a	n/a	85%	n/a	n/a	n/a	100%	n/a

[2] All Head Start expansion grantees will receive two awards – the first to expand and the second to sustain that expansion. Target, will be achieved after the first award and then sustained with the second award made in September 2010

percentage of teachers with AA, BA, Advanced Degree, or a degree in a field related to early childhood education.[3] *(Annual Outcome)*		ACTUAL	77.1%	n/a	n/a	n/a	Data avail. Jan-11	n/a	n/a	n/a	Data avail. Jan-12	n/a

Table 2:

Data Source	Data Validation
Program Information Report (PIR)	Data collection for the PIR is automated to improve efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The Office of Head Start also engages in significant monitoring of Head Start grantees through monitoring reviews of Head Start and Early Head Start grantees, which examine and track Head Start Program Performance Standards compliance at least every three years for each program. Teams of ACF Regional Office and Central Office staff, along with trained reviewers, conduct more than 500 on-site reviews each year. The automated data system provides trend data so that the team can examine strengths and weaknesses in all programs.

The Office of Head Start (OHS) will, through quarterly risk management calls with its grantees, track the above output measures related to the number of new children enrolled, the number of new jobs created and the number of new centers opened. This information will be updated and available on the OHS website (http://www.acf.hhs.gov/programs/ohs/).

[3] This is an existing performance measure that is calculated based on all Head Start staff, which includes both Head Start and Early Head Start teachers.

H. Monitoring/Evaluation

All Recovery Act programs will be assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

ACF's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. ACF's Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, ACF has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act program and address the obstacles and risks that could impact on their success.

The Office of Head Start (OHS) will follow its existing internal control structure in implementing the new discretionary grants. The expenditure of these funds will be carefully monitored by OHS regional staff and by OA grants specialists with strong oversight from the national office. On-going Risk Management Meetings conducted with each grantee at a minimum once each year will focus on the use of these funds and the frequency of these meetings will be increased to quarterly for all grantees receiving any recovery funds. All Head Start programs are subject to on-site monitoring reviews at least once during every three year period where their records, including fiscal records will be carefully reviewed to assure an appropriate use of these funds. Additionally, new grantees are reviewed on-site after their first year of operation. OHS also conducts targeted reviews in response to information obtained from the field or if there are concerns. OHS is beginning to revise the fiscal monitoring tool, taking into consideration aspects that need to be revised, such as cost allocation to ensure the separation of Recovery Act and appropriated funds. In addition, all Head Start grantees must submit an annual audit to the Office of Head Start. The Head Start Enterprise System provides management reports that will assure that grants are being awarded on time and consistent with the requirements of the Head Start Act.

I. Transparency

ACF is open and transparent in all of its grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent

with statutory and OMB guidance. ACF ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. ACF informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, ACF provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

The Office of Head Start (OHS) will post on its website (http://www.acf.hhs.gov/programs/ohs/) quarterly information about the spending of Recovery Act funds, including updates on the output measures from Table 1, including how many new children are being served, how many new staff have been hired, and how many additional centers have been established to serve new Head Start participants. Annual performance results are available in the annual ACF Budget Justification and Online Performance Appendix (available at: http://www.acf.hhs.gov/programs/olab/budget/index.html).

J Accountability

The Office of Head Start (OHS) is legislatively required to perform reviews of each Head Start program every three years. Erroneous Payment reviews are conducted to determine whether documentation demonstrated that a Head Start child was income eligible. In the case of errors, Head Start grantees are required to develop corrective action plans. ACF has also issued a memorandum reminding all grantees of documentation requirements, developed a standard signed statement template form, increased oversight of documentation activities being performed by ACF Regional Offices, and increased grantee emphasis for on-going monitoring through training and development of a monitoring protocol to review management systems. Head Start Regional Program managers are charged with assuring all programs in their regions are providing appropriate services to enrolled children and families and using their grants funds as required by statute and regulation. Grantees that are not must correct their problems or face de-funding.

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, ACF has built upon and strengthened existing processes. Senior ACF and Head Start officials will meet regularly (at least once a month) with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers. Managers are held accountable for assuring quality grantee performance through their Performance Management Appraisal Program (PMAP) plans. PMAP plans define clear expectations for managerial performance related to ACF-wide goals, the HHS Strategic Plan, and other key performance measures.

K. Barriers to Effective Implementation

None identified.

L Federal Infrastructure

Not applicable.

Summary of Significant Changes:

Provided timely updates regarding funding levels and performance results.

Community Services Block Grant (CSBG)

American Recovery and Reinvestment Act Implementation Plan

A. Funding Table

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Grants	985.0	985.0	0
Technical Assistance	15.0	7.0	8.0
Total	1,000.0	992.0	8.0

B. Objectives and Public Benefits

Under the American Recovery and Reinvestment Act (Recovery Act), $1 billion is provided to the Community Services Block Grant (CSBG) program for CSBG community services and for state-level benefits enrollment coordination activities. The CSBG Recovery Act funds will provide assistance to states and local communities, working through a network of community action agencies and other neighborhood-based organizations, for the reduction of poverty, revitalization of low-income communities, and empowerment of low-income families and individuals in rural and urban areas to become fully self-sufficient (particularly families who are attempting to transition off a state program carried out under part A of Title IV of the Social Security Act).

C. Activities

The Recovery Act provides an additional $1 billion for the existing CSBG program to provide funds to states to alleviate the causes and conditions of poverty in communities. In addition, the Recovery Act included two temporary modifications to CSBG. First, states can retain only one percent of all stimulus funds, and these funds are to be used for benefits enrollment coordination activities relating to the identification and enrollment of eligible individuals and families. By contrast, under the ongoing CSBG program, states may retain up to 10 percent of grant funds for discretionary state-level activities, with the limitation that administrative expenses may not exceed the greater of $55,000 or five percent of the total state award. For example, under the ongoing CSBG program, if a state receives a CSBG allocation of $10 million, the state may retain up to $1 million for discretionary activities, but may not use more than $500,000 of these funds for administrative expenses. Under the Recovery Act, the same state would retain only $100,000, and these funds must be used only for benefits enrollment coordination, not for general administrative expenses.

All remaining funds must be distributed by statute to eligible entities (e.g., community action agencies). Second, states may increase individual eligibility for services furnished by the CSBG program during fiscal years 2009 and 2010 to up to 200 percent of the official poverty guidelines as set by the HHS. This eligibility adjustment reflects an increase from 125 percent of the poverty guidelines as currently provided in Section 673(2) of the CSBG Act and applies to all CSBG services furnished during fiscal years 2009 and 2010.

D. Characteristics

All funds are distributed to states ($980 million) after making reservations for territories ($5 million) and training and technical assistance (T/TA) ($15 million) per the authorizing formula in the underlying statute. From the $15 million for T/TA, $7.5 million will be awarded directly to eligible entities and statewide and local organizations and associations to provide T/TA on improving program quality (including financial management), management information and reporting systems, measurement of program results, and responsiveness to identified local needs. ACF will use the remaining funds for federal T/TA activities as provided in the authorizing language for this program. These T/TA activities include federal support for planning, monitoring, data collection, performance measurement and reporting, as well as support for travel, salaries and benefits.

Purpose	Type of Award	Funding Amount	Recipients
Funds to states	Supplemental funding via formula grants	$980 million	All states, the District of Columbia, and Puerto Rico
Funds to territories	Supplemental funding via formula grants	$5 million	U.S. territories and tribal organizations
Training and technical assistance (T/TA): improving program quality (including financial management), management information and reporting systems, measurement of program results, and responsiveness to identified local needs	Supplemental grant and contract awards	$10.3 million	Eligible entities and statewide and local organizations and associations
Training and technical assistance (T/TA): travel, salaries and benefits, and T/TA as provided in the authorizing language	Supplemental grant and contract awards	$4.7 million	National technical assistance grantees, financial monitoring contracts, reimbursable federal expenses.

TOTAL = $1 billion

E. Delivery Schedule

Block Grants:

- Issued Information Memorandum (IM) outlining the purpose of funds and special items to consider with the Recovery Act funding – complete (April 10, 2009)
- Issue state grants – complete (April 10, 2009)
- Receipt of state plans – complete (May 29, 2009)
- Acceptance of state plans – complete (August 20, 2009)

Training and Technical Assistance:

- Issue supplemental grant and contract awards for current projects – round one by September 30, 2009 and round two by September 30, 2010
- Issue supplements to national technical assistance organizations and competitive supplements to statewide associations to document and sustain exemplary practices by September 30, 2010.

F. Environmental Review

The distribution of additional CSBG funds as a result of the Recovery Act is categorically excluded from environmental review based on Category 2 section F - Functional Exclusion: Grants for Social Services under Chapter 30-20-30 of the HHS General Administration Manual. By definition, the use of these funds: (1) mitigates social and environmental impacts; (2) does not include construction or alterations of the human environment; and (3) have no anticipated individual or cumulative significant effect on natural or cultural assets. Any funding that includes construction or alterations will not fall under this categorical exclusion and will be subject to an environmental assessment. Therefore CSBG qualifies for a Categorical Exclusion from National Environmental Protection Act (NEPA) and will be reported under Section 1609(c) report form for ACF.

G. Measures

Targets for the following performance measures have been developed based on historical data, analysis of current trends in CSBG programs, and the projected impact of Recovery Act funds.

Table 1:

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
Increase the number of conditions of poverty[1] reduced or eliminated for low-income individuals, families and communities as a result of community action interventions in areas such as employment, education, healthcare, housing, energy assistance, transportation, childcare support, and community improvement and revitalization projects.[2] *(Annual Outcome)*	# mill	TARGET	30 million	n/a	n/a	n/a	30 million	n/a	n/a	n/a	26 million	n/a
		ACTUAL	Avail. Oct-10	n/a	n/a	n/a	Avail. Oct-11	n/a	n/a	n/a	Avail Oct-12	n/a
Assure that the total amount of sub-grantee CSBG administrative funds expended each year remains below 20 percent.[3] *(Annual Efficiency)*	%	TARGET	19%	n/a	n/a	n/a	19%	n/a	n/a	n/a	19%	n/a
		ACTUAL	Avail. Oct-10	n/a	n/a	n/a	Avail. Oct-11	n/a	n/a	n/a	Avail Oct-12	n/a
Number of individuals served with the Recovery Act funds. *(Annual Output)*	# mill	TARGET		n/a	n/a	n/a	1.6 million	n/a	n/a	n/a	n/a	n/a
		ACTUAL										

[1] Indicators that can be directly related to reducing conditions of poverty may include gainful employment, obtaining safe and stable housing, and the creation of accessible "living wage" jobs in the community.

[2] The FY 2011 target appears to decline because the FY 2009 and FY 2010 targets were increased per the award of ARRA funds. The FY 2011 target is lower because ARRA funds will not be available after FY 2010.

[3] This outcome measure is calculated as an annual percentage, thus it is not possible to present as cumulative.

Table 2:

Data Source	Data Validation
CSBG Information System (CSBG/IS) survey administered by the National Association for State Community Services Programs (NASCSP) collects outcome specific data for the CSBG Network in the National Performance Indicators based upon the Results Oriented Management and Accountability (ROMA) requirements as stated in Section 678E of the CSBG Act.	The Office of Community Services (OCS) and NASCSP have worked to ensure that the survey captures the required information. The CSBG Block Grant allows states to have different program years (States operate and may use calendar year, State fiscal year, or Federal fiscal year). Likewise, local eligible entities may have differing program years. This can create a substantial time lag in preparing annual reports. States and local agencies are working toward improving their data collection and reporting technology. In order to improve the timeliness and accuracy of these reports, NASCSP and OCS are providing states better survey tools and reporting processes.

State CSBG Lead Agencies are responsible for providing statewide data based on data provided from eligible entities. States do not receive additional support for data or administrative expenses under the Recovery Act. The first performance measure in Table 1 is reported on quarterly, and the following three performance measures will be reported annually. Annual reporting is consistent with current performance measurement systems in place within the network of nearly 1,100 eligible entities. OCS is working with its national data partner, NASCSP, to include and collect annual performance data on the fourth measure. Currently, data on the fourth measure is being submitted only by States that are able to provide this specific information with existing data systems. As a result, the total number reported for the fourth measure may not reflect the total number of individuals served nationally with Recovery Act funds. The FY 2009 and FY 2010 targets for the second measure reflect expected increases in positive service outcomes due to new service interventions and populations served as a result of CSBG Recovery Act funding.

H. Monitoring/Evaluation

All Recovery Act programs will be assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B, and C). In addition, ACF will assess the existing historical performance of this program and apply results to Recovery Act funds. ACF management will assist the HHS Office of the Inspector General in the review of ACF operations related to CSBG.

ACF's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. ACF's Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, ACF has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act program and address the obstacles and risks that could impact on their success.

On December 31, 2009, the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG) issued a memorandum to alert the Administration for Children and Families (ACF) that Community Service Block Grant program funds made available under the American Recovery and Reinvestment Act of 2009 (P.L. No. 111-5, Recovery Act), may be at risk for fraud, waste, and abuse at certain community action agencies that State agencies have designated as "vulnerable" or "in crisis." Twenty such agencies were identified at the time of the alert and assessment of risks is an ongoing process. ACF has issued guidance memoranda individuating that agencies must be required to correct identified deficiencies in compliance with the CSBG Act. ACF Office of Community Services (OCS) Information Memorandum 116 outlines the steps for corrective actions, reduction, or termination of funding in compliance with the CSBG Act. States do not have the authority to decline to award Recovery Act funds to eligible entities for cause without first notifying the entity of deficiencies, requiring corrective action, and conducting a public hearing.

While the CSBG Act specifies that a federal review of state documentation for terminating the designation or reducing funding to an eligible entity must be completed within 90 days, an expedited federal review may be possible in some instances. In some instances, particularly those involving potential waste, fraud and abuse, an on-site federal review may be arranged to expedite the review of documentation and assist with CSBG procedures and requirements. A

documentation tool outlining information required for federal review is has been provided to states, and ACF has conducted recorded conference calls and other training events on the required procedures.

Existing accountability measures for CSBG formula grant awards are outlined in the terms and conditions of the grant awards and include compliance with OMB Circular A-133 and the Single Audit Act of 1984 and compliance with CSBG regulations. In addition, the Office of Community Services (OCS) will provide supplemental funding to an existing financial monitoring contract. In addition to the State Assessment process required under the CSBG Act, OCS will conduct reviews with a selected subset of approximately 10 – 20 states to assure compliance with CSBG Act and Recovery Act program and financial monitoring requirements. OCS will provide technical assistance and support to state CSBG Lead Agencies in risk assessment among eligible entities and prioritization of on-site monitoring and assessment.

OCS developed and issued on April 10, 2009, initial Information Memoranda (IMs) summarizing financial monitoring, accounting, and risk assessment requirements, as well as outlining relevant OMB circulars. Additional IMs will be issued requiring all states to submit by a specified deadline to OCS a summary of the following: 1) existing risk assessment procedures for monitoring eligible entities; 2) perceived areas of risk identified with Recovery Act funds; 3) current plans to mitigate risk; and 4) technical assistance needed from the federal government. OCS will review state risk assessment summaries and will provide feedback to states, including suggestions for additional risk assessment approaches and information on OCS' assessment of risk utilizing single audit results for grantees and sub-grantees with three or more findings.

Section 678D of the CSBG Act (the Act) pertaining to "Fiscal Controls, Audits, and Withholding" requires states to establish fiscal control and accounting procedures necessary to assure that states make proper payments and account for federal funds paid to the state. The section also ensures that OMB's cost and accounting standards are met. Additionally, the section requires that appropriate books, documents and records are made available to the Department for examination upon request. Section 678E of the Act addresses the accountability and reporting requirements of the states and sub-recipients' performance. The Act mandates that each state and its sub-recipients must participate in a performance measurement system. This system should establish goals and outcomes expected in service areas and in the expenditure of funds.

Each year states prepare and submit to HHS a report on the measured performance of the state and the state sub-recipients. The report includes an accounting of the expenditure of funds received, including an accounting of funds spent on administrative costs by the state and the state sub-recipients, and funds spent by state sub-recipients on the direct delivery of local services. The report also includes information on the number and characteristics of clients served.

Over the past decade, states and local eligible entities have been working to achieve six national Community Action goals: (1) low-income people become more self-sufficient; (2) the conditions in which low-income people live are improved; (3) low-income people own a stake in their community; (4) partnerships among supporters and providers of services to low-income people are achieved; (5) agencies increase their capacity to achieve results; and (6) low-income

people, especially vulnerable populations, achieve their potential by strengthening family and other supportive systems.

To enable aggregation and national reporting of progress on the most universal and significant CSBG results, 16 common categories, or indicators of Community Action performance, known as National Performance Indicators (NPI), are collected through the Results Oriented Management and Accountability (ROMA) system. These indicators are used to measure the impact of CSBG programs and activities on families and communities as follows: Employment; Employment Supports; Economic Asset Enhancement and Utilization; Community Improvement and Revitalization; Community Quality of Life and Assets; Community Engagement; Employment Growth from ARRA Funds; Community Enhancement through Maximum Feasible Participation; Community Empowerment through Maximum Feasible Participation; Expanding Opportunities through Community-wide Partnerships; Agency Development; Broadening the Resource Base; Independent Living; Emergency Assistance; Child and Family Development; Family Supports; and Service Counts. The NPI are related to the six national Community Action goals in that they measure incremental progress toward achieving each of the larger goals, which require specific steps along the way to success.

The Recovery Act output measures will be measured based on data collected through the ROMA system. Currently, CSBG state agencies and eligible entities annually report data on the number of clients served and on employment data including the number of unemployed low-income people obtaining a job, the number of low-income people with jobs that obtained an increase in salary and the number of low-income people who got “living wage” jobs with benefits. CSBG state agencies do not receive additional support for data or administrative expenses under the Recovery Act. However, OCS is working with its national data collection and reporting grantee, the National Association for State Community Services Programs (NASCSP), to issue instructions and procedures to states and eligible entities to ensure that states and eligible entities know how to collect and report data using the ROMA system. OCS is working to ensure that data will be collected to enable at least quarterly reporting on the Recovery Act measure concerning the number of jobs created or saved, as a result of Recovery Act funds, in the community.

I. Transparency

ACF is open and transparent in all of its grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance. ACF ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. In instances where material omissions or significant errors are noted in review, ACF provides official comment during the Federal review period and requests that the grantee make necessary corrections. ACF informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, ACF provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

The CSBG Act requires that all state plans be made available for public inspection within the state in such a manner as will facilitate review of, and comment, on the plan. ACF will review state plans to confirm that this requirement has been met. In addition, grant funding for training and technical assistance will be announced publicly, through the ACF website, Grants.gov, or Federal Register notices.

States are required to keep records sufficient to permit preparation of the required reports and to permit tracking of funds to a level of expenditure adequate to ensure that funds have not been spent unlawfully. On April 10, 2009, OCS issued Information Memorandum #109. This memorandum sets forth to states and U.S. territories the requirement to track and report Recovery Act fund expenditures separately.

Information on programmatic results, program operations and decisions will be routinely disclosed and regularly updated on the program website, which can be accessed through the ACF OCS website (located at: http://www.acf.hhs.gov/programs/ocs/). Annual performance results are available in the annual ACF Budget Justification and Online Performance Appendix (available at: http://www.acf.hhs.gov/programs/olab/budget/index.html).

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, ACF has built upon and strengthened existing processes. Senior ACF officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

ACF program and senior managers are accountable for the oversight of performance results and improvement actions through the Performance Management Appraisal Program (PMAP). PMAP plans define clear expectations for managerial performance related to Recovery Act objectives, the HHS Strategic Plan, ACF-wide goals, and other key measures. Program managers oversee collective efforts and monitor team and individual performance to accomplish organizational goals, insure ethics, integrity and accountability, and document performance.

K. Barriers to Effective Implementation

The Administration will continue improvements in monitoring processes and accountability measures to mitigate the possibility of misuse of funds.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes

Provided timely updates re: funding levels and performance results. Added narrative to discuss the 12/31/09 OIG memo to the Monitoring/Evaluation section.

Strengthening Communities Fund

American Recovery and Reinvestment Act Implementation Plan

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Grants	46.0	46.0	…
Grant Support	4.0	2.3	1.7
Total	50.0	48.3	1.7

B. Objectives

Under the American Recovery and Reinvestment Act (Recovery Act), $50 million will be provided for a new initiative called the Strengthening Communities Fund. The purpose of this initiative is to enable nonprofit organizations to contribute to the economic recovery and help federal, state, and local governments ensure that the information and services described in the Recovery Act reach disadvantaged and hard-to-serve populations.

C. Activities

The Strengthening Communities Fund (SCF) supports two Capacity Building programs. The first program is for state, local, and tribal governments, and the second for nonprofit social service providers, which focus on expanding service delivery, increasing community access to public benefits (including Recovery Act benefits), and helping low- and moderate-income people secure and retain employment. Neither program funds direct social service provision, and both programs require grantees to provide at least 20 percent of the total approved project costs.

<u>SCF State, Local, and Tribal Government Capacity Building program:</u>
ACF will make an estimated 48 grants to state, local, and tribal governments to build their capacity to partner with community-based and faith-based non-profits, to provide training and technical assistance to help nonprofit faith-based and community organizations better serve those in need and to increase nonprofit involvement in the economic recovery.

SCF state, local, and tribal governmental grantees will use program funds to:

- Conduct outreach and education aimed at increasing the involvement of nonprofit organizations in the economic recovery.

- Provide training and technical assistance aimed at building the capacity of nonprofit organizations to address the broad economic recovery issues present in their communities.
- Build the capacity of state, local or Native American/Tribal government office or designee to better involve nonprofit organizations in the economic recovery.

SCF Nonprofit Capacity Building program:
The goal of the SCF Nonprofit Capacity Building program is to maximize the social impact of nonprofit organizations providing services which address economic recovery issues at the community level.

ACF will make an estimated 34 awards to support experienced lead organizations providing nonprofit project partners with capacity building training and technical assistance in **five** critical areas:

- Organizational development,
- Program development,
- Collaboration and community engagement,
- Leadership development, and
- Evaluation of effectiveness.

Capacity building activities in the five areas are designed to increase an organization's sustainability and effectiveness, enhance its ability to provide social services, to create collaborations to better serve those in need, and to increase the partners' ability to address the broad economic recovery issues present in their communities.

At least 55 percent of the total federal funds requested must be issued through competitive financial assistance to project partners for investments which will help equip partners to assist low-income individuals secure and retain employment, earn higher wages, obtain better-quality jobs, and gain greater access to state and federal benefits and tax credits.

D. Characteristics

Ninety-two percent ($46 million) of the Recovery Act funding will be for discretionary cooperative agreement awards with a required 20 percent match. The remaining $4 million (eight percent) will be used for grant support. This support includes a modification to an existing panel review contract, a modification to an existing training and technical assistance (T/TA) contract, and a new task order for program evaluation.

ACF will award a contract for an independent evaluation of the Strengthening Communities Program in FY 2009. The contract will first produce evaluation design options that address the specific features of the Strengthening Communities Program before the evaluation is undertaken.

Technical assistance (TA) topics covered by program and resource center staff generally fall into the following categories:

- Compliance with grant award requirements, terms and conditions, program guidelines and federal laws and regulations;
- Grant actions/changes (budget modification, change of authorizing official, carryover funds from previous budget period, no cost extensions);
- Obtaining required prior approval (changes in approach, partners, key personnel, service area); or
- Management and reporting (tracking and evaluating training/TA delivery and outcomes; project, progress, financial and human resources management and associated reporting).

Grantees receive regular newsletters, e-mail correspondence and telephone follow up from both Program Office and Resource Center staff on a variety of topics. Each grantee is notified of the assignment of individual specialists in both Program and Grants Management Offices, and provided with contact information for each. Program Specialists make initial phone and e-mail contact with grantees to introduce themselves and explain the distribution of responsibilities among federal offices. Telephone and e-mail support may be by grantee request at any time. In the absence of grantee requests, program staff initiates personal contact a minimum of once a quarter.

Purpose	Type of Award	Funding Amount	Recipients
Nonprofit and Government Capacity Building Programs	Discretionary cooperative agreements	$46 million	Nonprofit organizations and state, local and tribal government offices (e.g. offices responsible for community initiatives, community outreach, or those interested in initiating such an initiative)
Panel review, training and technical assistance, and evaluation in FY 2009	Supplements to existing contracts and a new task order contract (program evaluation)	$3 million	Existing panel review and T/TA support contractors; new task order award for evaluation
Ongoing training and technical assistance and evaluation in FY 2010	Supplements to existing contracts and a new task order contract (program evaluation)	$1 million	Existing T/TA support contractors; new task order award for evaluation
TOTAL = $50 million			

E. Delivery Schedule

- Synopses of two Grant Opportunities completed – OMB approved April 30, 2009
- Two Program Synopses and Announcements published – May 11, 2009
- Request for Proposal for evaluation contract issued – June 2009
- Applicant training(s) –Completed June 4 & 5, 2009
- Application due date – received by July 7, 2009
- Panel reviews of applications – within 30 days after final due date (July 7, 2009) for applications
- Funding decisions – completed September 2009
- Grant awards issued – completed by September 30, 2009
- Task order contract for evaluation awarded – completed October 2009
- Awardees submit partnering plans to ACF for review and approval – SCF Non-Profit plans submitted by November 30, 2009 and SCF Government plans submitted by December 31, 2009
- Grantee orientation and training conference – completed January 25-27, 2010
- Program office review and approval of grantee work plans to ensure proper compliance – 98% completed as of May 2010. (Remainder being approved on case-by-case basis as compliance is achieved.)
- Training and technical assistance (T/TA) conference calls and/or webinars – monthly for the first 6 months, then quarterly thereafter.

F. Environmental Review

The distribution of funds to create the Strengthening Communities Fund (SCF) as a result of the Recovery Act is categorically excluded from environmental review based on Category 2 section F - Functional Exclusion: Grants for Social Services under Chapter 30-20-30 of the HHS General Administration Manual. By definition, the use of these funds: (1) mitigates social and environmental impacts; (2) does not include construction or alterations of the human environment; and (3) have no anticipated individual or cumulative significant effect on natural or cultural assets. Any funding that includes construction or alterations will not fall under this categorical exclusion and will be subject to an environmental assessment. Therefore SCF qualifies for a Categorical Exclusion from National Environmental Protection Act (NEPA) and will be reported under Section 1609(c) report form for ACF.

Program participants are encouraged to participate in community recycling and recycling awareness programs, and to adopt cost-effective waste reduction and recycling of reusable materials compatible with applicable state and local requirements whenever feasible. Participants are encouraged to emphasize procurement of recycled and environmentally preferable products and services that meet performance standards and are available at a reasonable price and within the time required.

G. Measures

1. The Strengthening Communities Fund (SCF) **Nonprofit Capacity Building** program will increase the capacity of small nonprofit organizations to address the broad economic recovery issues present in their local communities. The following three sub-goals support this overarching goal.

Outcome / Achievement	Units	Type	9/30/ 09	12/31/ 09	3/31/ 10	6/30/ 10	9/30/ 10	12/31/ 10	3/31/ 11	6/30/ 11	9/30/ 11	Program End
1a. The number of hours of T/TA provided to organizations by SCF **Nonprofit** grantees.* *(quarterly output)*	%	TARGET	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	Baseline Established
		ACTUAL					Interim baseline avail. Dec-10				Establish baseline Dec-11	
1b. Increase the number of capacity building activities completed by organizations receiving financial assistance or intensive TA from SCF **Nonprofit** grantees.* *(annual intermediate outcome)*	%	TARGET	n/a	n/a	n/a	n/a	TBD	n/a	n/a	n/a	TBD	Baseline Established
		ACTUAL					Interim baseline avail. Dec-10				Establish baseline Dec-11	
1c. Increase the number and percent of organizations receiving financial assistance through the SCF **Nonprofit Capacity Building** Program that expand or enhance services addressing economic recovery issues. *(annual end outcome)*	%	TARGET	n/a	n/a	n/a	n/a	TBD	n/a	n/a	n/a	TBD	Baseline Established
		ACTUAL					Interim baseline avail. Dec-10				Establish baseline Dec-11	

* Training and technical assistance are designed to develop recipient organizations' organizational , leadership , and program capacity, enhance evaluation of effectiveness, and promote collaboration and community engagement, expand service delivery, increase access to public benefits, and/or help low- and moderate-income people secure and retain employment. Interim baseline data will be available by the end of December 2010, and a baseline will be established by the end of December 2011, in order to have two years of data to establish baselines.

2. The Strengthening Communities Fund (SCF) **Government Capacity Building** program will increase the involvement of nonprofit organizations in economic recovery:

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
2a. The number of hours of T/TA assistance provided to organizations by SCF **Government Capacity Building** grantees.* *(quarterly output)*	%	TARGET	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	Baseline Established
		ACTUAL					Interim baseline avail. Dec-10				Establish baseline Dec-11	
2b. Increase the number of nonprofit organizations receiving TA through the State, Local, and Tribal SCF **Government Capacity Building** program that contribute staff time, money, or volunteers to a new inter-organizational referral system, data collection/evaluation system, program, service, or community engagement campaign.* *(annual outcome)*	%	TARGET	n/a	n/a	n/a	n/a	TBD	n/a	n/a	n/a	TBD	Baseline Establish
		ACTUAL					Interim baseline avail. Dec-10				Establish baseline Dec-11	

Table 2:

Data Source	Data Validation
Financial reports from grantees	All Strengthening Communities Fund grantees will provide regular financial reports. The data reported will be reviewed by federal Office of Community Services (OCS) staff for consistency, completeness and conformance with approved grant plans. OCS staff regularly examine each grantee's progress in relation to approved plans.
Performance Progress Report from grantees	All grantees will provide regular program reports on a quarterly basis. These reports will be reviewed by federal OCS staff for consistency, completeness, and conformance with approved grant plans.

Quarterly updates for the output data will be made available through the Recovery Act website (available at: http://www.hhs.gov/recovery).

H. Monitoring/Evaluation

All Recovery Act programs will be assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

ACF's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. ACF's Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, ACF has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act program and address the obstacles and risks that could impact on their success.

The Office of Community Services (OCS) will follow established internal control structures in implementing the new discretionary grants. OCS will use its experience with the existing intermediary program to provide upfront technical assistance to applicants and new grantees to prevent ineffective spending or waste, fraud, and abuse. OCS' rigorous post-award monitoring and oversight protocol includes remote review and assessment (desk monitoring) of grantee program progress and financial reports and quarterly cash transaction reports and site visits by program office staff. Program office monitoring site visits entail programmatic and financial oversight to determine that managerial and financial capability is sufficient for proper planning, management, and completion of the project. Targets may be selected based on perceived need for additional monitoring or identification of practices whose replication is to be encouraged.

To ensure that obligations and costs comply with applicable law; assets are safeguarded against waste, loss, unauthorized use or misappropriation; and revenues and expenditures are properly recorded and accounted for, grantee activities, progress and financial activity are reported quarterly. Required quarterly submissions will be reviewed and assessed by program office and resource center staff. Program, operational, and administrative areas will be evaluated in accordance with OMB Circular A-102 for state and local governments and 2 CFR Part 215 for institutions of higher education and non-profit organizations. Accounting and financial management will be assessed for compliance with Financial Accounting Principles and Standards established by OMB Circular A-134 and Audit requirements established in OMB Circular A-133 as well as Cost Principles codified in 2 CFR, Part 220 (for Educational

Institutions) Part 225 (for state, local and Indian tribal governments) and Part 230 (for non-profit organizations).

Award recipients will receive individual follow up and technical assistance from program staff, who will work cooperatively to identify and correct problems resulting from inadequate, excessive, or poorly designed controls; and establish appropriate controls; and resolve any identified issues. Grantees receive regular newsletters, e-mail correspondence and telephone follow up from both Program Office and Resource Center staff on a variety of topics. Each grantee is notified of the assignment of individual specialists in both Program and Grants Management Offices, and provided with contact information for each. Program Specialists make initial phone and e-mail contact with grantees to introduce themselves and explain the distribution of responsibilities among federal offices. Telephone and e-mail support may be by grantee request at any time. In the absence of grantee requests, program staff initiates personal contact a minimum of once a quarter.

Uncorrected deficiencies deemed to be material will be addressed through successive levels of intervention including requests for corrective action, funding restrictions, and, where appropriate, disallowance, suspension, and termination.

I. Transparency

ACF is open and transparent in all of its grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance. ACF ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. ACF informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, ACF provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements. ACF will make use of technological advances, innovative applications and electronic media to optimize transparency and satisfy the Recovery Act's accountability objectives. This is an efficient and economical approach to improving the exchange of information and foster collaboration among government, nonprofits, businesses, and private citizens.

Information on programmatic results, program operations and decisions will be routinely disclosed and regularly updated on the program website, which can be accessed through the ACF OCS website (located at: http://www.acf.hhs.gov/programs/ocs/). Annual performance results will be made available in the annual ACF Budget Justification and Online Performance Appendix (available at: http://www.acf.hhs.gov/programs/olab/budget/index.html). In addition, the website will encourage and facilitate feedback to identify information of greatest public interest and suggestions on increasing and improving program impact.

After evaluation of quarterly report content, the program office will prepare accounts of current program status, management controls and program improvement initiatives, and other pertinent information (including financial updates) for release on the previously noted ACF OCS website.

ACF will ensure that recipient reporting required by Section 1512 of the Recovery Act and OMB guidance is made available to the public on Recovery.gov by October 10, 2009. ACF will inform recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance, and will provide technical assistance to grantees and contractors and fully utilize Project Officers to ensure compliance with reporting requirements. In addition, funded grantees are required to submit Performance Progress Reports, and semi-annual financial status reports using the required standard form (SF-269).

In accordance with the provisions of OMB Circular No. A-133 on audits of states, local governments, and nonprofit organizations, non-federal entities that receive financial assistance of $500,000 or more in federal awards will have a single or a program-specific audit conducted for that year. Non-federal entities that expend less than $500,000 a year in federal awards are exempt from the federal audit requirements for that year, except as noted in Circular No. A-133.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, ACF has built upon and strengthened existing processes. Senior ACF officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

ACF program managers and senior managers are accountable for the oversight of performance results and improvement actions through the Performance Management Appraisal Program (PMAP). PMAP plans define clear expectations for managerial performance related to Recovery Act objectives, the HHS Strategic Plan, ACF-wide goals, and other key measures, including those identified by customers/stakeholders. Program managers oversee collective efforts and monitor team and individual performance to accomplish organizational goals, insure ethics, integrity and accountability, and document performance.

Experience with existing OCS programs will inform pre-and post-award development of guidance and provision of technical assistance. Pre-award guidance and technical assistance for applicants will be provided through teleconferences, web-based learning, and help desk support. In order to prevent ineffective spending or waste, fraud, and abuse, grantees will be provided on-going post-award technical assistance through web-based seminars, e-newsletters, an interactive grantee website and personal follow up by program office and resource center staff in addition to annual conference training.

In addition, OCS' customized database captures program activities and outcomes and allows the program manager to collect, analyze, and summarize program data. For each budget period, grantees will identify organizations receiving training, technical assistance (TA), or financial assistance, describe the programs benefiting from capacity building efforts, and identify

the beneficiary's affiliation with other federal initiatives (e.g. Weed and Seed, AmeriCorps VISTA). Grantees will cite target and actual values for project milestones, and identify unduplicated organizational recipients, the number of service hours and type of capacity-building service (TA, training or financial assistance), and the amount of financial assistance provided through program funding.

For training and technical assistance, grantees will describe delivery methods, dates and locations, and provide recipient identities along with critical areas of need identified. For financial awards to subrecipients, grantees will identify benefiting organizations, describe each expenditure and its purpose, estimate total expenditures and cite funding expended to date.

Data is requested about the benefiting organization's increases in persons served, expansion or improved effectiveness of service, improved financial sustainability, and improvements in interagency collaboration (new/improved service, interagency data collection/evaluation or referral systems, community engagement/awareness campaign). Grantees are also requested to note concerns/problems, request needed assistance and identify promising practices.

Grant specialists review performance progress reports and financial status reports using required standard forms SF-269. Follow-up consultation and requests for corrective action are recorded in the database along with e-copies of reports, audit materials and other source documents. The system permits identification of high risk programs and entities which are then given priority for additional technical assistance or intervention. The system supports real-time program manager oversight, and allows tracking of grant actions such as budget or program modifications, personnel updates, and required prior approvals, and improvement efforts.

K. Barriers to Effective Implementation

None identified.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

Updated to reflect restructuring of performance measures to more clearly communicate the impact of this Recovery Act program. Provided timely updates re: funding levels and performance results.

Administration on Aging: Congregate Nutrition Services

A. Funding Table

(Dollars in Millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Congregate Nutrition Services	$65.0	$65.0	$0.0
Total	$65.0	$65.0	$0.0

B. Objectives

The American Recovery and Reinvestment Act (Recovery Act) provides $65 million for Congregate Nutrition Services. Established in 1972 under the Older Americans Act (OAA), the program provides meals to older Americans in congregate facilities such as senior centers, adult day centers, and faith-based settings.

In line with the HHS Strategic Objective "Promote the Economic Independence and Social Well-being of Individuals and Families Across the Lifespan," Congregate Nutrition Services help seniors to maintain their health and avoid hospitalization and nursing home placement. Fifty-eight percent of congregate meal recipients who responded to AoA's national survey of elderly clients reported that the meals enabled them to continue living independently in their own homes.

Congregate meal programs are faced with the dual challenge of rising food and other costs in addition to an increased demand for services because of the growing elderly population. The economic downturn has forced many local senior programs to close meal sites or scale back meal services. Funding provided under the Recovery Act will help local senior programs to offset these cutbacks and contribute to the provision of more than 10 million meals to more than 500,000 vulnerable older adults.

C. Activities

Funds have been used to augment existing resources, replace revenue lost from local sources due to the economic downturn, reduce waiting lists, and support the continued delivery of meals to vulnerable older Americans. In addition, congregate meal sites help to reduce isolation, provide nutrition screening, and offer health assessments for diseases such as hypertension and diabetes. In many sites older participants receive training in how to prepare meals that are economical and enhance their health and well-being.

D. Characteristics

AoA distributed $65 million in Congregate Nutrition Services funding under the Recovery Act to 56 States and Territories in accordance with the statutory formula established under the OAA. The formula allocation is based on each State's share of the population age 60 and older. As with funds provided under regular OAA appropriations, States have distributed funds to Area Agencies on Aging or local providers, which coordinate the provision of meals to elderly individuals. No Recovery Act funding is being used to pay for AoA administrative costs associated with this program.

A person must be 60 years of age or older to be eligible to participate in the Congregate Nutrition Services program under the OAA. While there is no means test for participation, services are targeted to those in greatest economic and social need, with special attention given to low-income minorities and people living in rural areas. Approximately 34 percent of congregate meal participants live at or below the poverty level compared to 10 percent of the overall population 60 and older.

E. Delivery Schedule

On March 19, 2009, AoA obligated $65 million in Congregate Nutrition Services funding under the Recovery Act to 56 States and Territories in accordance with the statutory formula established under the OAA. On March 18, 2009, AoA posted to its website Frequently-Asked Questions about the implementation of the Recovery Act, and the agency participated in conference calls with State officials on March 30, 2009 and April 23, 2009 to answer questions. Each State has been responsible for developing its own schedule for expeditiously allocating funds to Area Agencies on Aging or local providers.

As of March 31, 2010, $38.8 million (60% of the $65 million distributed) has been expended, with a target of having all funds expended for this program by the end of FY2010. AoA continues to comply with the requirements under the Recovery Act legislation and OMB Guidance concerning monitoring and reporting.

F. Environmental Review Compliance

This program has undergone NEPA review and a Categorical Exclusions (CE) has determined to be the appropriate level of NEPA review.

F. Measures

Table 1

Measure Type	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Number of Congregate meals served	Output	Quarterly	Quarterly	Quarterly
Unduplicated count of people provided congregate meals.	Output	Quarterly	Quarterly	Quarterly

Measure T	ype	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Improve well-being and prolong independence for elderly individuals as a result of AoA's Title III home and community-based services.	Outcome	Annually	Annually	Annually

Table 2

Measure	Data Source	Data Validation
Number of Congregate meals served. *(Output)*	State Program Report and National Survey	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and state staff. AoA staff follow-up with states to assure validity and accuracy. After revisions, states certify the accuracy of their data.
Unduplicated count of people provided congregate meals. *(Output)*	State Program Report and National Survey	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and state staff. AoA staff follow-up with states to assure validity and accuracy. After revisions, states certify the accuracy of their data.
Improve well-being and prolong independence for elderly individuals as a result of AoA's Title III home and community-based services. *(Outcome)*	State Program Report and National Survey.	This is a composite measure that utilizes data from multiple sources. One source is the State Program Report. Another source is the National Survey. State Program Report data is annually submitted by states. The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and state staff. AoA staff follow-up with states to assure validity and accuracy. After revisions, states certify the accuracy of their data. The National Survey draws a sample of Area Agencies is used to obtain a random sample of clients receiving selected services. Trained staff administers telephone surveys. Results are analyzed and compared to client population to assure representative sample.

To minimize the reporting burden on States and territories, AoA tracks performance under the Recovery Act using three existing measures. These include the outcome measure "improve the well-being and prolong independence for elderly individuals as a result of AoA's Title III home and community-based services" and the output measures 1) "the number of congregate meals provided" and 2) "the unduplicated count of people provided congregate meals."

Outcome Measure

Data for Congregate Nutrition Services measures is collected annually from AoA's State Program Report and the National Survey of Older Americans Act Participants. The outcome measure "improve the well-being and prolong independence for elderly individuals as a result of AoA's Title III home and community-based services" is a composite measure of four nursing home predictors. These are:

- Increase the percentage of caregivers reporting that services help them provide care longer.
- Increase the percentage of transportation clients who are transportation disadvantaged (defined as unable to drive or use public transportation).
- Increase the percentage of congregate meal recipients who live alone.
- Increase the percentage of home delivered meal recipients with 3 or more limitations of Independent Activities of Daily living.

Since FY 2005, AoA has demonstrated the Aging Network's progress toward preventing nursing home placement and prolonging viable community living opportunities. Actual scores in FY 2005 and FY 2006 were 51.0 and 52.2 respectively. In 2007 the actual score was 60.17, 7 points above the target. AoA develops its targets based on trends rather than a single data point. For FY 2008, AoA set a target of 54.5 to take into account the rising costs faced by congregate meal programs. AoA will increase the FY 2009 target to 56.0 because of the additional Recovery Act funding and an increase in AoA's FY 2009 budget for the congregate meal program. AoA will work to develop targets based strictly on the Recovery Act funding. AoA will report this data annually and will make the results public via press release and at www.recovery.gov and http://www.aoa.gov.

Output Measures
This outcome measure is supported by corresponding OAA output measures 1) "the number of congregate meals provided" and 2) "the unduplicated count of people provided congregate meals." AoA will report this data quarterly for Recovery Act funds and will make the results public via press release and at http://www.recovery.gov and http://www.aoa.gov. To date, more than 580,000 persons aged 60 and over have been served 9 million meals with Recovery Act funding. The following is a summary of the program's target goals and output measures as of March 31, 2010:

Outcome / Achievement	Type	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	Program End
People Served	TARGET	63,213	106,108	128,685	142,230	144,488	146,746	146,746
	ACTUAL	453,037	582,743					
Meals Served	TARGET	3,590,525	6,026,952	7,309,283	8,078,681	8,206,914	8,335,147	8,335,147
ACTUAL		6,886,561	9,142,206					

G. Monitoring and Evaluation

All Recovery Act programs are assessed for risk and to ensure the appropriate internal controls are in place throughout the entire funding cycle. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Managers' Financial Integrity Act and the Improper

Payments Information Act, as well as OMB's Circular A-123 "Managements' Responsibility for Internal Control" (including Appendices A, B, and C).

AoA's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. AoA's Senior Assessment Team carries out comprehensive annual assessments of its Recovery Act programs to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, AoA has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

Congregate Nutrition Services is a long-established program with a proven track record of delivering results. Internal control assessments conducted under the Federal Managers' Financial Integrity Act have consistently found AoA mandatory grants programs (including Congregate Nutrition Services) to be low risk and to have a sound internal control structure. Financial statement and other programmatic audits have not identified any significant deficiencies in OAA nutrition programs and there are no uncorrected weaknesses or deficiencies associated with these activities. Primary recipients are State governments that have their own established control structures and State audits of these programs under Circular A-133 have not generated significant systemic findings. In addition, risk assessments conducted specifically for the Recovery Act found that these activities are generally low risk and that appropriate mitigation strategies have been put in place.

Congregate Nutrition Services also has an established system for collecting and validating financial data and program data on both outputs, such as numbers of meals and individuals served, as well as client outcomes, such as ability to remain independent and in the community. AoA data collection systems and controls have been assessed by external entities, including the Office of Management and Budget, which found that the program had both credible and effective performance data and strong financial management systems in place.

In addition to routine performance measurement activities, AoA conducts in-depth program evaluations on a 10-year basis. The Recovery Act has coincided with the evaluation cycle for Congregate Nutrition Services. An evaluation design contract has been completed and a contract to conduct the evaluation is under development. AoA's comprehensive evaluation framework assesses all levels of the Aging Network

(State and Local) as well as program participant outcomes and impacts. The current design for this evaluation includes three interconnected studies: cost, process and client outcome. The cost study will examine the use of multiple funding streams for congregate meals and will be amended to include the Recovery Act. AoA's data collection systems, including evaluation, provide a robust assessment of program efficiency and effectiveness. The results of the evaluation will be posted on the AoA website in FY 2012.

To ensure that recipients understand and can meet the objectives, outcomes and accountability expectations associated with the provision of Recovery Act funds to OAA nutrition programs, AoA provides additional technical assistance to States, along with enhanced monitoring and reporting as required under the Act. On March 18, 2009, AoA posted to its website Frequently-Asked Questions about the implementation of the Recovery Act, and the agency participated in conference calls with State officials on March 30, 2009 and April 23, 2009 to answer questions. AoA also utilizes existing technical assistance mechanisms, such as State Planning Grant Projects, the Area Agency Capacity Assessment Grant Project, and the State Unit Regional Program Analysis Forum Project. These projects provide ongoing support of communication and technical assistance needs of AoA and its OAA grantees, and enhances assurances of full program compliance for Recovery Act funding. AoA will not use Recovery Act funds to provide technical assistance under these existing mechanisms.

H. Transparency

AoA is open and transparent in all grant activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance. AoA ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. AoA informs recipients of their reporting obligations through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, AoA provides key award information to recipients and other technical assistance to grantees and fully utilizes Project Officers to ensure compliance with reporting requirements

AoA collects OAA performance outcome data via the web-based State Program Report. AoA Headquarters and Regional Office staff check the data for consistency and follow-up with the states to assure validity and accuracy. State performance data is available via the Aging Integrated Database (AGID), AoA's online data query system, at www.data.aoa.gov.

AoA's data community website also helps to ensure that recipients meet Recovery Act reporting requirements. The website includes resources and documentation related to the Recovery Act and a listserv with 120 performance specialists who are responsible for collecting and reporting Recovery Act data for their states. AoA uses this website to offer technical assistance, promote information sharing, and provide reminders regarding data requirements. AoA utilizes the technical assistance

methods described above to ensure that recipients understand and comply with the statutory, OMB, and HHS reporting requirements.

I. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, AoA has built upon and strengthened existing processes. Senior AoA officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

AoA performance plans for both Senior Executives and managers align individual and organizational performance with results-oriented goals that are linked to the HHS and AoA Strategic Plans. These goals, which include objectives related to effective program management and proper stewardship of Federal funds, are cascaded to subordinate supervisors and staff throughout each executive's portion of the organization.

J. Barriers to Effective Implementation

Because Recovery Act funds will be used to augment existing programs that already have service delivery structures in place, there are some barriers to effective implementation of these programs. States have needed to change from an annual reporting system to a quarterly reporting system for some key elements. While reporting data within 10 days of the end of each fiscal quarter was a difficult challenge for States that have multiple sub-grantees' reports to compile, all States and territories were able to meet the quarterly reporting deadline following the first three reporting periods with a 100% success rate. To ensure that recipients understand and can meet the objectives, outcomes and accountability expectations associated with the provision of Recovery Act funds to OAA nutrition programs, AoA has provided ongoing technical assistance to States, along with enhanced monitoring and reporting as required under the Act.

K. Federal Infrastructure

Not applicable.

Summary of significant changes:

No major revisions were required. Expenditures are at or above projected levels for this period of time and are on track to be fully expended by the end of the fiscal year. Outcomes, in terms of meals provided and persons served, are well above targets -- with three-fifths of the funds expended, both the number of persons and meals served already exceed what the projections had been for all of the funding.

Administration on Aging: Home-delivered Nutrition Services

A. Funding Table

(Dollars in Millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Home-Delivered Nutrition Services	$32.0	$32.0	$0.0
Total	$32.0	$32.0	$0.0

B. Objectives

The American Recovery and Reinvestment Act (Recovery Act) provides $32 million for Home-Delivered Nutrition Services. Established in 1978 under the Older Americans Act (OAA), the program provides meals and related nutrition services to seniors who are homebound.

In line with the HHS Strategic Objective "Promote the Economic Independence and Social Well-being of Individuals and Families Across the Lifespan," Home-Delivered Nutrition Services help seniors to maintain their health and avoid hospitalization and nursing home placement. Ninety-three percent of home-delivered meal recipients who responded to AoA's national survey of elderly clients reported that the meals enabled them to continue living independently in their own homes.

Home-delivered meal programs are faced with the dual challenge of rising food and other costs in addition to an increased demand for services because of the growing elderly population. The economic downturn has forced many local senior programs to close meal sites or scale back meal services. Funding provided under the Recovery Act helps local senior programs to offset these cutbacks and contribute to the provision of 5 more than million meals to an estimated 250,000 homebound older adults and their caregivers.

C. Activities

Funds augment existing resources, replace revenue lost from local sources due to the economic downturn, and support the continued delivery of meals to vulnerable older Americans. In addition to meals, services include nutrition screening and education and nutrition assessment and counseling as appropriate. Home-delivered meals also represent an essential service for many caregivers by helping them to maintain their own health and well-being.

D. Characteristics

AoA distributed $32 million in Home-Delivered Nutrition Services funding under the Recovery Act to 56 States and Territories in accordance with the statutory formula established under the OAA. The formula grant allocation is based on each State's share of the population age 60 and older. As with funds provided under regular OAA appropriations, States distribute funds to Area Agencies on Aging or local providers, which coordinate the provision of meals to elderly individuals. No Recovery Act funding will be used to pay for AoA administrative costs associated with this program.

A person must be 60 years of age or older to be eligible to participate in the Home-Delivered Nutrition Services program under the OAA. While there is no means test for participation, services are targeted to those in greatest economic and social need, with special attention given to low-income minorities and people living in rural areas. Almost 43 percent of recipients of home-delivered meal participants live at or below the poverty level compared to 10 percent of the overall population 60 and older.

E. Delivery Schedule

On March 19, 2009, AoA distributed $32 million in Home-Delivered Nutrition Services funding under the Recovery Act to 56 States and Territories in accordance with the statutory formula established under the OAA. On March 18, 2009, AoA posted to its website Frequently-Asked Questions about the implementation of the Recovery Act, and the agency participated in conference calls with State officials on March 30, 2009 and April 23, 2009 to answer questions. Each State is responsible for developing its own schedule for expeditiously allocating funds to Area Agencies on Aging or local providers.

As of March 31, 2010, $20.2 million (63% of the $32 million distributed) has been expended, with a target of having all funds expended for this program by the end of FY2010.

AoA continues to comply with the requirements under the Recovery Act legislation and OMB Guidance concerning monitoring and reporting.

F. Environmental Review Compliance

This program has undergone NEPA review and a Categorical Exclusions (CE) has determined to be the appropriate level of NEPA review.

G. Measures

Table 1: Data-Gathering Schedule

Measure	Type	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Number of home-delivered meals served.	Output	Quarterly	Quarterly	Quarterly

Measure T	ype	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Unduplicated count of people provided home-delivered meals.	Output	Quarterly	Quarterly	Quarterly
Increase the number of older persons with severe disabilities who receive home-delivered meals.	Outcome	Annually	Annually	Annually

Table 2: Data Source and Validation

Measure	Data Source	Data Validation
Number of home-delivered meals served. *(Output)*	State Program Report data is annually submitted by states.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and state staff. AoA staff follow-up with states to assure validity and accuracy. After revisions, states certify the accuracy of their data.
Unduplicated count of people provided home-delivered meals. *(Output)*	State Program Report data is annually submitted by states.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and state staff. AoA staff follow-up with states to assure validity and accuracy. After revisions, states certify the accuracy of their data.
Increase the number of older persons with severe disabilities who receive home-delivered meals. *(Outcome)*	State Program Report data is annually submitted by states.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and state staff. AoA staff follow-up with states to assure validity and accuracy. After revisions, states certify the accuracy of their data.

To minimize the reporting burden on States and territories, AoA tracks performance under the Recovery Act using three existing measures. These include the outcome measure "increase the number of older persons with severe disabilities who receive home-delivered meals" and the output measures "number of home-delivered meals served" and "the unduplicated count of people provided home-delivered meals."

Outcome Measure

The outcome measure "increase the number of older persons with severe disabilities who receive home-delivered meals" captures the effectiveness of AoA efforts to target services to vulnerable elderly individuals. This measure is in line with the intent of the OAA, which specifically requires AoA and the aging services network to target services to the most vulnerable elders, and the mission of AoA, which is to help vulnerable elders maintain their independence in the community.

The most recent year for which this outcome data is available is FY 2007. In that year AoA's home delivered meal programs served 359,143 seniors with severe disabilities, 8,575 more than the target. AoA increased the target marginally in FY 2008 to 364,590 to take into account the rising costs faced by home delivered meals

programs. AoA will increase the FY 2009 target to 378,613 because of the additional Recovery Act appropriations and an increase in AoA's FY 2009 budget for the home-delivered meal program. AoA will work to develop targets based strictly on the Recovery Act funding. AoA will report this data annually and will make the results public via press releases and at http://www.recovery.gov and http://www.aoa.gov.

Output Measures
This outcome measure is supported by corresponding OAA output measures 1) "the number of congregate meals provided" and 2) "the unduplicated count of people provided congregate meals." AoA will report this data quarterly for Recovery Act funds and will make the results public via press release and at http://www.recovery.gov and http://www.aoa.gov. To date, more than 230,000 persons aged 60 and over have been served 5.8 million home-delivered meals with Recovery Act funding. The following is a summary of the program's target goals and output measures as of March 31, 2010:

Outcome / Achievement	Type	12/31/ 09	3/31/ 10	6/30/ 10	9/30/ 10	12/31/ 10	3/31/ 11	Program End
People Served	TARGET	15,762	23,643	27,583	30,538	31,031	31,524	31,524
	ACTUAL	143,974	230,284					
Meals Served	TARGET	2,536,074	3,804,111	4,438,129	4,913,643	4,992,895	5,072,147	5,072,147
	ACTUAL	3,881,698	5,829,708					

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk and to ensure the appropriate internal controls are in place throughout the entire funding cycle. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Managers' Financial Integrity Act and the Improper Payments Information Act, as well as OMB's Circular A-123 "Managements' Responsibility for Internal Control" (including Appendices A, B, and C).

AoA's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. AoA's Senior Assessment Team carries out comprehensive annual assessments of its Recovery Act programs to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, AoA has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

Home-Delivered Nutrition Services is a long-established program with a proven track record of delivering results. Internal control assessments conducted under the Federal Managers Financial Integrity Act have consistently found AoA mandatory grants programs (including Home-Delivered Nutrition Services) to be low risk and to have a sound internal control structure. Financial statement and other programmatic audits have not identified any significant deficiencies in OAA nutrition programs and there are no uncorrected weaknesses or deficiencies associated with these activities. Primary recipients are State governments that have their own established control structures and State audits of these programs under Office of Management and Budget Circular A-133 have not generated significant systemic findings. In addition, risk assessments conducted specifically for the Recovery Act found that these activities are generally low risk and that appropriate mitigation strategies have been put in place.

Home-Delivered Nutrition Services also has an established system for collecting and validating financial data and program data on both outputs and outcomes. Existing AoA performance outcome measures as well as the ongoing measurement of program outputs are applicable to Recovery Act funding activities as described above. These data collection systems and controls have been assessed by external entities, including the Office of Management and Budget, which found that the program had both credible and effective performance data and strong financial management systems in place.

In addition to routine performance measurement activities, AoA conducts in-depth program evaluations on a 10-year basis. The Recovery Act has coincided with the evaluation cycle for Home-Delivered Nutrition Services. An evaluation design contract has been completed and a contract to conduct the evaluation is under development. AoA's comprehensive evaluation framework assesses all levels of the Aging Network (State and Local) as well as program participant outcomes and impacts. The current design for this evaluation includes three interconnected studies: cost, process and client outcome. The cost study will examine the use of multiple funding streams for home delivered meals and will be amended to include the Recovery Act. AoA's data collection systems, including evaluation, provide a robust assessment of program efficiency and effectiveness. The results of the evaluation will be posted on the AoA website in FY 2012.

To ensure that recipients understand and can meet the objectives, outcomes and accountability expectations associated with the provision of Recovery Act funds to OAA nutrition programs, AoA provides additional technical assistance to States, along with enhanced monitoring and reporting as required under the Act. On March 18, 2009, AoA posted to its website Frequently-Asked Questions about the

implementation of the Recovery Act, and the agency participated in conference calls with State officials on March 30, 2009 and April 23, 2009 to answer questions. AoA also utilizes existing technical assistance mechanisms, such as State Planning Grant Projects, the Area Agency Capacity Assessment Grant Project, and the State Unit Regional Program Analysis Forum Project. These projects provide ongoing support of communication and technical assistance needs of AoA and its OAA grantees, and enhances assurance of full program compliance for Recovery Act funding. AoA will not use Recovery Act funds to provide technical assistance under these existing mechanisms.

I. Transparency

AoA is open and transparent in all grant activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance. AoA ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. AoA informs recipients of their reporting obligations through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, AoA provides key award information to recipients and other technical assistance to grantees and fully utilizes Project Officers to ensure compliance with reporting requirements

AoA collects OAA performance outcome data via the web-based State Program Report. AoA Headquarters and Regional Office staff check the data for consistency and follow-up with the states to assure validity and accuracy. State performance data is available via the Aging Integrated Database (AGID), AoA's online data query system, at www.data.aoa.gov.

AoA's data community website also helps to ensure that recipients meet Recovery Act reporting requirements. The website includes resources and documentation related to the Recovery Act and a listserv with 120 performance specialists who will be responsible for collecting and reporting Recovery Act data for their states. AoA will use this website to offer technical assistance, promote information sharing, and provide reminders regarding data requirements. AoA utilizes the technical assistance methods described above to ensure that recipients understand and comply with the statutory, OMB, and HHS reporting requirements.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, AoA has built upon and strengthened existing processes. Senior AoA officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

AoA performance plans for both Senior Executives and managers align individual and organizational performance with results-oriented goals that are linked to the

HHS and AoA Strategic Plans. These goals, which include objectives related to effective program management and proper stewardship of Federal funds, are cascaded to subordinate supervisors and staff throughout each executive's portion of the organization.

K. Barriers to Effective Implementation

Because Recovery Act funds are being used to augment existing programs that already have service delivery structures in place, there are some barriers to effective implementation of these programs. States have needed to change from an annual reporting system to a quarterly reporting system for some key elements. Reporting data within 10 days of the end of each fiscal quarter will be difficult for States that have multiple sub-grantees' reports to compile. Sub-grantees, many of which have multiple contracts for delivery of meals, will face challenges in obtaining information within the expected timeframes. To ensure that recipients understand and can meet the objectives, outcomes and accountability expectations associated with the provision of Recovery Act funds to OAA nutrition programs, AoA provides additional technical assistance to States, along with enhanced monitoring and reporting as required under the Act.

L. Federal Infrastructure

Not applicable.

Summary of significant changes:

No major revisions have been made. Expenditures are at or above projected levels for this period of time and are on track to be fully expended by the end of the fiscal year. Outcomes, in terms of meals provided and persons served, are well above targets -- with three-fifths of the funds expended, both the number of persons and meals served already exceed what the projections had been for all of the funding.

Administration on Aging: Nutrition Services for Native Americans

A. Funding Table

(Dollars in Millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Nutrition Services for Native Americans	$3.0	$3.0	$0.0
Total	$3.0	$3.0	$0.0

B. Objectives

The American Recovery and Reinvestment Act (Recovery Act) provides $3 million for Nutrition Services for Native Americans. Established in 1978 under the Older Americans Act (OAA), this program provides congregate and home-delivered meals and related nutrition services to American Indian, Alaskan Native and Native Hawaiian elders.

In line with the HHS Strategic Objective "Address the Needs, Strengths, and Abilities of Vulnerable Populations," these programs are responsive to the cultural diversity of American Indian, Alaskan Native, and Native Hawaiian communities and represent an important part of the communities' comprehensive services. Performance data indicate that these nutrition services are an efficient means to help Native American elders remain independent and in their own homes.

Nutrition services for Native Americans are faced with the dual challenge of rising food and other costs in addition to an increased demand for services because of the growing population of older Native Americans. The economic downturn has forced many Tribal senior programs to scale back or eliminate nutrition services and staff. Funding provided under the Recovery Act will help Tribal programs to offset these cutbacks and contribute to the provision of nearly 400,000 meals to more than 2,300 vulnerable Native American seniors and their caregivers.

C. Activities

Funds augment existing resources, replace revenue lost from local sources due to the economic downturn, and support the continued delivery of meals to vulnerable Native Americans. In addition to meals, services include nutrition screening and education and nutrition assessment and counseling as appropriate. Home-delivered meals also represent an essential service for many caregivers by helping them to maintain their own health and well-being.

D. Characteristics

AoA distributed $3 million in Nutrition Services for Native Americans funding under the Recovery Act to the 244 Tribal organizations and two Native Hawaiian organizations currently funded under the OAA. Formula allocations are based on the population of elders aged 60 and older within each Tribal service area. Tribal organizations directly provide, or arrange for, congregate and home delivered meals and related nutrition services. Tribes may decide the age at which a member is considered an elder and thus eligible for services. No Recovery Act funding will be used to pay for AoA administrative costs associated with this program.

E. Delivery Schedule

On April 2, 2009, AoA distributed $3 million in Nutrition Services for Native Americans funding under the Recovery Act to 244 Tribal organizations and two Native Hawaiian organizations under a formula based on each Tribal organization's share of the elderly. On March 18, 2009, AoA posted to its website Frequently-Asked Questions about the implementation of the Recovery Act, and on April 28, 2009 the agency hosted a plenary session on the topic at the Title VI National Training and Technical Assistance Forum. Tribal organizations directly provide, or arrange for, congregate and home delivered meals and related nutrition services. AoA will comply with the requirements under the Recovery Act legislation and OMB Guidance concerning monitoring and reporting.

F. Environmental Review Compliance

This program has undergone NEPA review and a Categorical Exclusions (CE) has determined to be the appropriate level of NEPA review.

G. Measures

Table 1: Data-Gathering Schedule

Measure	Type	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
Home-Delivered Nutrition meals.	Output	Quarterly	Quarterly	Quarterly
Congregate Nutrition meals.	Output	Quarterly	Quarterly	Quarterly
For Title VI Services, increase the number of units of services provided to native Americans per thousand dollars of AoA funding.	Outcome	Annually	Annually	Annually

Table 2: Data Source and Validation

Measure	Data Source	Data Validation
Home-Delivered Nutrition meals *(Output)*	State and Tribal Program Report data is annually submitted.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and state staff. AoA staff follow-up with states to assure validity and accuracy. After revisions, states certify the accuracy of their data.

Measure	Data Source	Data Validation
Congregate Nutrition meals *(Output)*	State and Tribal Program Report data is annually submitted.	The web-based submissions include multiple data checks for consistency. Multi-year comparison reports are reviewed by AoA and state staff. AoA staff follow-up with states to assure validity and accuracy. After revisions, states certify the accuracy of their data.
For Title VI Services, increase the number of units of service provided to Native Americans per thousand dollars of AoA funding. *(Outcome)*	Title VI Reporting System, Budget amounts as appears in the Congressional Justification.	Annual reports submitted by grantees, reviewed by AoA staff who follow-up with questions. Tribal officials certify report is accurate. AoA staff review record keeping system during regular on-site monitoring.

To minimize the reporting burden on Tribes, AoA tracks performance under the Recovery Act using two existing measures. These include the outcome measure "increase the number of units of service provided to Native Americans per thousand dollars of AoA funding" and output measure "the number of meals provided."

The outcome measure "increase the number of units of service provided to Native Americans per thousand dollars of AoA funding" demonstrates the efficiency of AoA in providing services to Native Americans. Program efficiency is a necessary and important measure of the performance of AoA programs. OAA intends Federal funds to act as a catalyst in generating capacity for these program activities at the Tribal level. It is the expectation of the OAA that Tribal organizations increasingly improve their capacity to serve Native American elders efficiently and effectively with both Federal and Tribal funds.

Outcome Measure
The most recent year for which this outcome data is available is FY 2007. In that year AoA's target for this measure was 264 units of service provided per thousand dollars of OAA funding, which was exceeded with an actual rate of 312 units per thousand dollars of funding. AoA develops its targets based on trends rather than a single data point. Given that the actual FY 2005 measure was 254 and the one in FY 2006 was 281, AoA increased the target in FY 2008 to 273. AoA also selected this target to take into account the rising costs faced by Native American nutrition programs. AoA will increase the FY 2009 target to 277 because of the additional Recovery Act appropriations and an increase in AoA's FY 2009 budget for the Native American Nutrition & Supportive Services program. AoA will work to develop targets based strictly on the Recovery Act funding. AoA will report this data annually and will make the results public via press releases and at http://www.recovery.gov and http://www.aoa.gov.

Output Measures
This outcome measure is supported by the corresponding OAA output measure "the number of meals provided." The most recent year for which this output data is available is FY 2007. In that year Tribal organizations provided 4.37 million meals,

270,000 more than the target. In FY 2008 AoA decreased the target to 4.05 million meals to take into account the rising costs faced by Native American nutrition programs. In FY 2009 AoA anticipates serving 4.37 million meals given Recovery Act funding and the increase in AoA's FY 2009 budget for the Native American Nutrition & Supportive Services program.

Outcome / Achievement	Type	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	Program End
Home-Delivered Nutrition meals	TARGET	200,000	325,000	452,563	678,844	678,844	678,844	678,844
	ACTUAL	113,871	125,270					
Congregate Nutrition meals	TARGET	125,000	200,000	254,566	381,849	381,849	381,849	381,849
	ACTUAL	72,596	100,226					

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk and to ensure the appropriate internal controls are in place throughout the entire funding cycle. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Managers' Financial Integrity Act and the Improper Payments Information Act, as well as OMB's Circular A-123 "Managements' Responsibility for Internal Control" (including Appendices A, B, and C).

AoA's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. AoA's Senior Assessment Team carries out comprehensive annual assessments of its Recovery Act programs to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, AoA has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

Nutrition Services for Native Americans is a long-established program with a proven track record of delivering results. Internal control assessments conducted under the Federal Managers Financial Integrity Act have consistently found AoA grants programs (including Nutrition Services for Native Americans) to be low risk and to have a sound internal control structure. Financial statement and other programmatic audits have not identified any significant deficiencies in OAA nutrition programs and there are no uncorrected weaknesses or deficiencies associated with these activities. Primary recipients are Tribal governments that have their own established control structures and Tribal audits of these programs under Office of Management and Budget Circular A-133 have not generated significant systemic findings. In addition, risk assessments conducted specifically for the Recovery Act found that these activities are generally low risk and that appropriate mitigation strategies have been put in place.

Nutrition Services for Native Americans also has an established system for collecting and validating financial data and program data on both outputs, such as numbers of meals and individuals served. Existing AoA performance measures of efficiency and targeting, as well as the ongoing measurement of program outputs, are applicable to Recovery Act funding activities as described above.

To ensure that recipients understand and can meet the objectives, outcomes and accountability expectations associated with the provision of Recovery Act funds to OAA nutrition programs, AoA provides additional technical assistance to Tribal organizations, along with enhanced monitoring and reporting as required under the Act. On March 18, 2009, AoA posted to its website Frequently-Asked Questions about the implementation of the Recovery Act, and on April 28, 2009 the agency hosted a plenary session on the topic at the Title VI National Training and Technical Assistance Forum. AoA also utilizes existing technical assistance mechanisms, such as such as Native American Resource Centers and training and technical assistance contracts, to support the efforts of Tribal organizations and ensure full program compliance for Recovery Act funding. AoA will not use Recovery Act funds to provide technical assistance under these existing mechanisms.

I. Transparency

AoA is open and transparent in all grant activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance. AoA ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. AoA informs recipients of their reporting obligations through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, AoA provides key award information to recipients and other technical assistance to grantees and fully utilizes Project Officers to ensure compliance with reporting requirements

AoA collects OAA performance outcome data via the web-based State Program Report. AoA Headquarters and Regional Office staff check the data for consistency

and follow-up with the states to assure validity and accuracy. State performance data is available via the Aging Integrated Database (AGID), AoA's online data query system, at www.data.aoa.gov.

AoA's data community website also helps to ensure that recipients meet Recovery Act reporting requirements. The website includes resources and documentation related to the Recovery Act and a listserv with 120 performance specialists who will be responsible for collecting and reporting Recovery Act data for their states. AoA uses this website to offer technical assistance, promote information sharing, and provide reminders regarding data requirements. AoA utilizes the technical assistance methods described above to ensure that recipients understand and comply with the statutory, OMB, and HHS reporting requirements.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, AoA has built upon and strengthened existing processes. Senior AoA officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

AoA performance plans for both Senior Executives and managers align individual and organizational performance with results-oriented goals that are linked to the HHS and AoA Strategic Plans. These goals, which include objectives related to effective program management and proper stewardship of Federal funds, are cascaded to subordinate supervisors and staff throughout each executive's portion of the organization.

K. Barriers to Effective Implementation

Because Recovery Act funds are being used to augment existing programs that already have service delivery structures in place, there are barriers to effective implementation of these programs. Many of the Tribal and Native Hawaiian organizations that will receive a portion of the $3 million in Recovery Act funding are in rural areas and have small numbers of staff, with more than half having one or less full time employee equivalents. Most of the Tribal and Native Hawaiian organizations will receive less than $13,000 in Recovery Act funding. To prevent undue burden, AoA is requesting that Tribal and Native Hawaiian organizations report on the effects and use of Recovery Act funds when funding has been expended. This effort to reduce reporting burden has resulted in some challenges for monitoring the implementation of the funding. It is likely that many more meals have been served to date than have been reported because the majority of tribes still have Recovery Act funding available in their accounts and have not been required to report any outcomes to date. AoA is undertaking follow-up outreach activities with the Tribal organizations to make sure that all recipients which have expended all their funds are reporting their outcomes. To ensure that recipients understand and can meet the objectives, outcomes and accountability expectations associated with

the provision of Recovery Act funds to OAA nutrition programs, AoA is providing additional technical assistance to Tribal organizations.

L. Federal Infrastructure

Not applicable.

Summary of significant changes:

All of recipients of these grants receive less than $25,000 in funding. As such, they are not required to provide AoA with any outcome measures (numbers of meals served) until all the funding is expended. We had not projected in our original implementation plans that so many of the grantees would have unexpended funds at this point in time, so fewer meals have been reported as being served than we had projected. It is likely that any more meals have been served to date than have been reported because the majority of Tribal organizations still have ARRA funding available in their accounts and haven't reported their outcomes to us yet. AoA is undertaking follow-up outreach and technical assistance with the tribes to make sure that all those which have expended all their funds have reported their outcomes.

Health Resources and Services Administration: Community Health Centers - Capital (Construction, Renovation, and Equipment, and for the Acquisition of Health Information Technology (HIT))

A. Funding Table

The table below provides an overview of the plan for the use of the $1.5 billion for Community Health Center Capital programs in Recovery Act funding. The Recovery Act provides for 0.5% of the total appropriated amount to be used to support the administrative costs of implementation, which totals $7.5 million across the two years of implementation. These amounts are included the program totals listed below.

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Capital Improvement Program (CIP) Grants	$857.7	852.9	4.8
Facility Investment Program (FIP) Grants	$521.8	0	521.8
Health Information Technology (HIT) Systems/Networks Grants	$120.5	36.1	84.4
Total	1,500.0	889.0	611.0

B. Objectives

The Health Center Capital Recovery Act funding is preserving and creating jobs, promoting economic recovery, and helping people most impacted by the recession. These funds support new and improved health center facilities and equipment, including the acquisition of health information technology systems, in many of the nation's most underserved communities.

The objectives of the Capital Improvement Program (CIP), Health Information Technology (HIT) Systems/Networks, and Facility Investment Program (FIP) grants are consistent with the objectives and requirements of the Recovery Act as well as the mission of the Health Center Program.

Together, all capital funding opportunities support health center efforts to modernize facilities and systems, and in turn improve access to quality, comprehensive, culturally competent and affordable primary and preventive health care for medically underserved populations.

1,127 CIP grants are funding capital improvements in health centers including construction, repair, and renovations as well as equipment/health information technology systems.

To date, 53 HIT systems/networks grants are supporting Electronic Health Record (EHR) and HIT systems for health centers. HRSA anticipates awarding the remaining grants in June 2010.

86 FIP grants are funding major facility investments in health centers including construction and major renovations.

All capital funding opportunities support health center efforts to modernize facilities and systems, and in turn improve access to quality, comprehensive, culturally competent and affordable primary and preventive health care for medically underserved populations.

The objectives of these awards also support multiple objectives of the U.S. Department of Health and Human Services (HHS) Strategic Plan, including ensuring access to high quality health care, particularly for vulnerable populations..

C. Activities

The CIP, HIT systems/networks, and FIP grants support the development of health center infrastructure. Projects including construction, alteration/repair/renovation, purchase of equipment/HIT as well as the adoption and expansion of EHR systems that will enhance access to comprehensive, culturally competent and quality primary and preventive health care services for medically underserved populations.

D. Characteristics

	Capital Improvement Program	***HIT Systems/ Networks***	***Facility Investment***
Types of Award	Grant	Grant	Grant
Non-Federal Recipients, Federal Support	$853.4	$119.9	$520.4
Administration (0.5%)	$ 4.3	$ 0.6	$ 1.4
Total Funding Amount (Millions)	$857.7	$120.5	$521.8
Recipients	Private and Nonprofit Institution/ Organizations, Public and Nonprofit Institutions (existing section 330-funded health centers[1])	Private Nonprofit and Institution/ Organizations, Public and Nonprofit Institutions (existing section 330-funded health centers and health center controlled networks[1])	Private Nonprofit and Institution/ Organizations, Public and Nonprofit Institutions (existing section 330-funded health centers[1])

	Capital Improvement Program	*HIT Systems/ Networks*	*Facility Investment*
Beneficiaries	general public (medically underserved populations)	general public (medically underserved populations)	general public (medically underserved populations)
Methodology for Award Selection	Grants to existing health centers based on number of patients served and described project	Health Center Network/ Supplemental Grants; current FY 2009 HIT competitions; new competition for EHR and other HIT adoption support	Limited Grant Competition

[1]Health centers that receive operating grants under section 330 of the Public Health Service Act

E. Delivery Schedule

Capital Improvement Program Awards
Guidance Released: May 1, 2009
Application Phase: May 1 – June 2, 2009
Award Date: June 29, 2009
Project Period: June 29, 2009 – June 28, 2011
Quarterly Reports: October 1, 2009 through July 1, 2011
Monitoring: Ongoing

HIT Systems/Networks Awards: Includes supplements, current FY 2009 competition and new competition
HIT/Noncompeting:
Guidance Released: February 25, 2009
Application Phase: February 25, 2009 – April 15, 2009
Award Date: September 1, 2009
Project Period: September 1, 2009 – August 31, 2011
Quarterly Reports: October 1, 2009 through October 1, 2011
Monitoring: Ongoing

HIT/Current FY 2009 Competition (includes two separate competitions):
Guidance Released: January 6, 2009 and February 5, 2009
Application Phase: January 6 – March 4, 2009 and February 5 – April 1, 2009
Award Date: September 29, 2009
Project Period: September 29, 2009 – August 31, 2011
Quarterly Reports: October 1, 2009 through October 1, 2011
Monitoring: Ongoing

HIT/New Competition:
Guidance Released: December 9, 2009
Application Phase: December 9 – February 5, 2009
Award Date: July 1, 2010

Project Period: July 1, 2010 – June 30, 2012
Quarterly Reports: October 1, 2010 through July 1, 2012

Facility Investment Program Awards
Guidance Released: June 19, 2009
Application Phase: June 19, 2009 – August 6, 2009
Award Date: December 9, 2009
Project Period: December 9, 2009 through December 10, 2011
First Quarterly Report: January 1, 2010 through January 1, 2012
Monitoring: Ongoing

F. Environmental Review Compliance

Working with HHS and the Council on Environmental Quality, HRSA established a protocol and a set of procedures that ensure all activities funded under the Recovery Act will comply with the National Environmental Policy Act (NEPA), National Historic Preservation Act (NHPA), and related statutes. All applicants are required to submit environmental information and documentation with projects, as applicable. HRSA reviews submissions and conducts additional review and monitoring as needed. Compliance status is regularly reported on the Section 1609(c) report.

HRSA was able to obtain a categorical exclusion for HIT System/Network grants.

For CIP and FIP, HRSA conducts reviews on a project-specific basis. Many grants include more than one project.

HRSA obtained a categorical exclusion for CIP equipment-related projects. For the majority of CIP construction and alteration/repair/renovation projects, HRSA has completed programmatic environmental assessments or reviewed and approved standard environmental assessments. As of March 30, 2011, 67 standard environmental assessments and 105 programmatic environmental assessments are still pending. Pending projects are due to revisions to projects, reviews currently occurring, or grantees that are still preparing necessary documentation to submit to HRSA.

For FIP construction and alteration/renovation projects, HRSA has completed many programmatic environmental assessments or reviewed and approved standard environmental assessments. As of March 30, 2011, 66 standard environmental assessments and 7 programmatic environmental assessments are still pending. Pending projects are due to reviews currently occurring or grantees that are still preparing necessary documentation to submit to HRSA.

For all grants, compliance status is regularly reported on the Section 1609(c) report.

G. Measures

Measurement for these grants focuses on the number of health center sites with new/improved space, the number of health center sites with new equipment, and the number of health centers with new or upgraded/expanded certified electronic health records. Outcomes are measured by grantees based on the completion status of

their project(s) as proposed in their grant applications. Grantees report on each project that they complete, using existing HRSA electronic reporting and information systems. Through the quarterly progress reports, grantees are asked to report on the percent of each project completed (e.g., not started; less than 50 percent; more than 50 percent completed; fully completed). They are also asked to include major accomplishments and/or progress made as well as any factors that may have impeded progress to date, where appropriate.

In the table below, actual data may not meet targets due to grantees' updated project timelines for meeting program requirements and schedules

Outcome/ Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End*
Number of Health Center sites with new space (construction)	Sites	TARGET	2	25	20	30	40	60	80	100	200	491
		ACTUAL	2	10								
Number of Health Center sites with improved space (alteration/repair/renovation)	Sites	TARGET	15	60	100	150	200	300	400	500	600	1,181
		ACTUAL	16	63								
Number of Health Centers with new equipment	Health Centers	TARGET	5	25	40	65	85	125	175	225	275	490
		ACTUAL	5	27								
Number of Health Centers with new health information technology	Health Centers	TARGET	1	10	15	20	25	35	50	75	100	176
		ACTUAL	1	8								
Number of Health Centers with a new certified Electronic Health Record	Health Centers	TARGET	0	5	10	20	30	40	50	75	100	295
		ACTUAL	0	3								
Number of Health Centers w/upgraded/expanded certified Electronic Health Record	Health Centers	TARGET	0	4	10	15	20	25	35	45	65	89
		ACTUAL	0	2								
Earned Value Management: Percent of Projects On Schedule and On Budget (construction and alteration/repair/renovation over $1M)	Percent Projects	TARGET	NA	NA	NA	80%	80%	80%	80%	80%	80%	80%
		ACTUAL	NA	NA	NA							

***Program End: CIP Project Periods conclude on June 28, 2011. FIP project periods conclude on December 10, 2011.**

Data Sources and Validation: The Outcomes are measured by grantees based on the completion status of their project(s) as proposed in their grant applications.

All measures:

Frequency : Quarterly

Direction : Increasing

Type : Outcome

Explanation : The Health Centers Capital Recovery Act funding preserves and creates jobs, promotes economic recovery, and helps people most impacted by the recession. These funds support new and improved health center facilities and equipment, including the acquisition of health information technology systems, in many of the nation's most underserved communities.
The Health Center Capital program includes three major components: the Capital Improvement Program (CIP), Health Information Technology (HIT) Systems/Networks, and Facility Investment (FIP) grants. Together, all capital funding opportunities support health center efforts to modernize facilities and systems, and in turn improve access to quality, comprehensive, culturally competent and affordable primary and preventive health care for medically underserved populations.
CIP grants fund capital improvements in health centers including construction, repair, and renovations as well as equipment/health information technology systems. HIT systems/networks grants support Electronic Health Record (EHR) and HIT systems for health centers. FIP grants fund major facility investments in health centers, including construction and renovation.

Number of Health Center sites with new space (construction):
Unit : Sites

Number of Health Center sites with improved space (alteration/repair/renovation):
Unit : Sites

Number of Health Centers with new equipment:
Unit : Health Centers

Number of Health Centers with new Health Information Technology:
Unit : Health Centers

Number of Health Centers with a new certified Electronic Health Record:
Unit : Health Centers

Number of Health Centers with a upgraded/expanded certified Electronic Health Record:
Unit : Health Centers

Percent of Projects On Schedule and On Budget (Earned Value Management for construction and alteration/repair/renovation over $1 million):
Unit: Projects

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire life cycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

HRSA's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. HRSA's Senior Assessment Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. The team met weekly during the first year of ARRA and continues to meet biweekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, HRSA has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

Only existing section 330-funded grantees are eligible to apply for CIP, HIT systems, and FIP grants.

Pre-award: Applications for CIP and HIT grants undergo internal HRSA review to ensure applicants propose to use funding as intended by the Recovery Act. Applications for competitive grants are reviewed by an Objective Review Committee. HRSA also conducts additional levels of review (e.g., environmental assessment, architectural and engineering review, etc.) on applicable proposals through the use of qualified environmental, architectural and engineering experts.

Post-award: HRSA continues to follow established policies and procedures for health center program training, technical assistance, reporting, data verification, documentation and corrective actions. Ongoing monitoring and evaluation occur through at least quarterly communication between grantees and Project Officers, quarterly progress reports, site visits as necessary, annual applications and annual performance reports, including audits. For construction-related projects, HRSA utilizes architectural and engineering consultants to review project progress and budget expenditures, quarterly. Additionally, HRSA utilizes an early alerts monitoring process to quickly identify potential issues and track corrective actions when needed.

I. Transparency

HRSA is open and transparent in all of its contracting and grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance.

HRSA ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. HRSA informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, HRSA provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, HRSA has built upon and strengthened existing processes. Senior HRSA Health Center Program officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. HRSA's personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

Existing processes ensure that HRSA managers are held to high standards of accountability in terms of achieving program goals and facilitating improvement. As part of their Employee Performance Plans, HRSA program managers are required to assist health center grantees with implementation of program requirements and to improve program performance. HRSA managers are held accountable to ensure the timely awarding and appropriate management of funds, and, as appropriate, HRSA Performance Management and Assessment Plans may be modified to incorporate the stewardship of Recovery Act funds.

HRSA has also implemented senior level governance boards, focused on accountability and internal controls, and a thorough and comprehensive A-123 internal controls testing and evaluation process that tests and ensures appropriate internal controls are in place throughout the entire funding cycle. The Health Center Program is also subject to a complete improper payments risk assessment on a regular basis by the HRSA CFO, with the last assessment performed during FY 2009.

K. Barriers to Effective Implementation

HRSA has a history of working successfully with health center grantees that provide primary and preventive health care services to medically underserved populations. However, full implementation may be impeded by construction delays, cost overruns, and insufficient health information technology system readiness. HRSA mitigates these risks via thorough review of all proposals, quarterly reporting, ongoing monitoring and technical assistance, regular grantee updates, and site visits.

Available resources are sufficient to complete the awarding and monitoring activities associated with the Recovery Act. However, to help ensure that HRSA meets established timelines and monitoring requirements, additional staff were hired. To decrease the hiring timeframe for Recovery Act positions, HRSA worked closely with the Rockville HR Center (RHRC) to make one announcement to cover approximately 100 vacant positions. HRSA also met weekly with RHRC to ensure selections met OPM requirements and job offers were made in a timely manner.

L. Federal Infrastructure

This program does not support Federally-owned assets. However, HHS grants policy emphasizes sustainable design considerations should be included to the maximum extent feasible in construction or modernization grants or activities funded at $1 million or more (AAGAM Chapter 6.99.106-3). Implementing sustainable design principles serves to mitigate health, social and environmental impacts and further the National commitment to reducing energy, and green house gas and related emissions. HRSA included the requirement to incorporate sustainable design practices in the grants announcement. Approximately 7% of proposed CIP projects and more than 95% of proposed FIP projects are implementing major renovation or construction projects with total costs of $1 million or more. In their applications, 73% of all CIP recipients and 99% of all FIP recipients indicated that they will implement green/sustainable design practices for their proposed project(s), including using low-impact materials, ensuring energy efficiency, maximizing reuse/recycling capabilities, and building LEED-certified structures.

Summary of Significant Changes:

- Specific award phase dates have been added.
- Updated status of Environmental Review Compliance and added information on sustainable design considerations
- Actual measures data through 12/31/10 have been added.
- Targets for measures have been updated to reflect the anticipated completion date of Capital grant projects. These targets have been adjusted to reflect the grantees' updated project timelines for meeting program requirements and schedules.

Health Resources and Services Administration: Community Health Centers - Services

A. Funding Table

The table below provides an overview of the plan for the use of the $500 million for Health Centers Services in Recovery Act funding. The Recovery Act provides for 0.5% of the total appropriated amount to be used to support the administrative costs of implementation; this totals $2.5 million across the two years of implementation. These amounts are included in program totals listed below.

(Dollars in Millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
New Access Point (NAP) Grants	$156.7	155.0	1.7
Increased Demand for Services (IDS) Grants	$343.3	341.9	1.4
Total	500.0	496.9	3.1

B. Objectives

The Health Center Services Recovery Act funding preserves and creates jobs, promotes economic recovery, and helps people most impacted by the recession. These funds support new sites and service areas, increase services at existing sites, and provide supplemental payments for spikes in uninsured populations.

The objectives of the New Access Point (NAP) and Increased Demand for Services (IDS) grants are consistent with the objectives and requirements of the Recovery Act as well as the mission of the Health Center Program.

NAP awards support health centers' new service delivery sites to significantly increase the number of medically underserved and uninsured people with access to comprehensive primary and preventive health care services.

IDS grants support health centers' response to increases in demand for services, including addressing increases in uninsured populations and increasing services at existing sites. IDS grants increase health center staffing (i.e., full-time equivalents), extend hours of operations and expand existing services.

Together, NAP and IDS grants will provide services to an estimated 2,870,000 new health center patients, including approximately 1,340,000 new uninsured patients.

These awards also support multiple objectives of the U.S. Department of Health and Human Services (HHS) Strategic Plan, including ensuring access to high quality health care, particularly for vulnerable populations, and promoting preventive care.

C. Activities

Both NAP and IDS grants support the direct provision of comprehensive, culturally competent and quality primary and preventive health care services, regardless of an individual's ability to pay. New and existing health center grantees are using NAP funds to support new service delivery sites around the country, in areas where more primary and preventive health care is needed. Existing health centers are using IDS grants to implement strategies to expand services that include adding new providers, expanding hours of operations and expanding services at existing health center sites.

D. Characteristics

	New Access Point (NAP)	***Increased Demand for Services (IDS)***
Type of award	Grant	Grant
Non-Federal Recipients, Federal Support	$155.9	$341.7
Administration (0.5%)	$ 0.8	$ 1.6
Total Funding Amount (Millions)	$156.7	$343.3
Recipients	Private and Nonprofit Institution/Organizations, Public and Nonprofit Institutions	Private and Nonprofit Institution/Organizations, Public and Nonprofit Institutions
Beneficiaries	general public (medically underserved populations)	general public (medically underserved populations)
Methodology for Award Selection	Former competition: FY 2008 NAP Grant Competition (HRSA-08-077); approved but unfunded applicants	Grants (HRSA-09-218) to existing health centers based on number of patients and uninsured patients served

E. Delivery Schedule

NAP Awards
Planning Phase: 2007
Application Phase: September 28 – December 18, 2007
Award Date: March 2, 2009
Project Period: March 2, 2009 – February 28, 2011
Quarterly Reports: July 1, 2009 through April 1, 2011
Monitoring: Ongoing

IDS Awards
Planning Phase: February 17 – March 6, 2009
Application Phase: March 9 – March 16, 2009
Award Date: March 27, 2009
Project Period: March 27, 2009 – March 26, 2011
Quarterly Reports: July 1, 2009 through April 1, 2011
Monitoring: Ongoing

F. Environmental Review Compliance

Working with HHS and the Council on Environmental Quality, HRSA established a protocol and a set of procedures that ensure all activities funded under the Recovery Act will comply with the National Environmental Policy Act (NEPA), National Historic Preservation Act (NHPA), and related statutes. All NAP applicants are required to submit environmental information and documentation checklists with projects, as applicable. HRSA reviewed submissions and conducted additional review and monitoring as needed. Of the 127 NAP grants, 119 were classified under a categorical exclusion (HCHCBIDS-H8A) obtained by HRSA, and 8 required HRSA to conduct an environmental assessment. All reviews have been completed.

HRSA has obtained a categorical exclusion (HCHBIDS-H8B) for compliance with environmental statutes for activities carried out using IDS funds.

For NAP and IDS grants, compliance status is regularly reported on the Section 1609(c) report.

G. Measures

Measurement for both NAP and IDS grants focuses on number of new patients served and number of new uninsured patients served. Grantees will report on measures using their existing patient data collection and personnel systems. All job data are reported, on a quarterly basis, directly by grantees to federalreporting.gov. All outcome measures are reported, on a quarterly basis, directly by grantees to HRSA via the HRSA Electronic Handbook system. Through the quarterly progress reports, grantees are asked to report on major accomplishments and/or progress made as well as any factors that may have impeded progress to date, where appropriate.

Outcome/ Achievement	Units	Data Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	Program End
Number of new patients served	New Patients	TARGET	1,000,000	1,320,000	1,630,000	1,940,000	2,250,000	2,560,000	2,870,000	2,870,000
		ACTUAL	1,014,237	1,579,532						
Number of new uninsured patients served	New Uninsured Patients	TARGET	600,000	740,000	860,000	980,000	1,100,000	1,220,000	1,340,000	1,340,000
		ACTUAL	619,575	915,815						

New health center patients served
Frequency: Quarterly
Direction: Increasing
Type: Outcome
Explanation: The Health Center Services Recovery Act funding will preserve and create jobs, promote economic recovery, and help people most impacted by the recession. These funds will support new sites and service areas, increase services at existing sites, and provide supplemental payments for spikes in uninsured populations.

NAP awards will support health centers' new service delivery sites to significantly increase the number of medically underserved and uninsured people with access to comprehensive primary and preventive health care services. IDS grants will support health centers' response to increases in demand for services, including addressing increases in uninsured populations and increasing services at existing sites. IDS grants will extend hours of operations and expand existing services. ***Together, NAP and IDS grants will provide services to an estimated 2,870,000 new health center patients.***
Unit: New Patients

New uninsured patients served
Frequency: Quarterly
Direction: Increasing
Type: Outcome
Explanation: The Health Center Services Recovery Act funding will preserve and create jobs, promote economic recovery, and help people most impacted by the recession. These funds will support new sites and service areas, increase services at existing sites, and provide supplemental payments for spikes in uninsured populations.

NAP awards will support health centers' new service delivery sites to significantly increase the number of medically underserved and uninsured people with access to comprehensive primary and preventive health care services. IDS grants will support health centers' response to increases in demand for services, including addressing increases in uninsured populations and increasing services at existing sites. IDS grants will increase health center staffing (i.e., full-time equivalents), extend hours of operations and expand existing services. ***Together, NAP and IDS grants will provide services to an estimated 1,340,000 new uninsured patients.***

Unit: Uninsured Patients

Data Source for all measures is reporting from grantees; all measures are currently collected in the Health Center Program's quarterly submission of the Health Center Quarterly Report (HCQR). Data will be validated quarterly in comparison with application projections and annual reports sent by grantees to HRSA. The HCQR is validated using edit checks, including checks for missing data and outliers, and checks against history and norms. HRSA's annual Primary Health Care Online Performance Appendix contains targets and actual results for the existing outputs and outcomes.

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire life cycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

HRSA's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department.

HRSA's Senior Assessment Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. The Team met weekly during the first year of ARRA and continues to meet biweekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, HRSA will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

Pre-award: NAP awards were made to prior applicants that received high scores from an Objective Review Committee as part of a competitive application process, but were not previously funded. IDS awards were made to existing section 330-funded health center grantees, with each IDS proposal undergoing internal HRSA review to ensure funds would be used as the Recovery Act and HRSA intended.

Post-award: HRSA is continuing to follow established policies and procedures for health center program training, technical assistance, reporting, data verification, documentation and corrective actions. Ongoing monitoring and evaluation is continuing through at least quarterly communication between grantees and Project Officers, quarterly progress reports, site visits as necessary, annual applications and annual performance reports, including audits. For the 51 new health center organizations that received NAP funding, two on-site visits will be conducted. Additionally, HRSA utilizes an early alerts monitoring process to quickly identify potential issues and track corrective actions when needed.

I. Transparency

HRSA is open and transparent in all of its contracting and grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance.

HRSA ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. HRSA informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, HRSA provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements. HRSA utilizes existing electronic reporting and information systems to organize program cost and performance information.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, HRSA has built upon and strengthened

existing processes. Senior HRSA Health Center Program officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. HRSA's personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

Existing processes ensure that HRSA managers are held to high standards of accountability in terms of achieving program goals and facilitating improvement. As part of their Employee Performance Plans, HRSA program managers are required to assist health center grantees with implementation of program requirements and improve program performance. HRSA managers ensure the timely award and appropriate management of funds, and, as appropriate, HRSA Performance Management and Assessment Plans are modified to incorporate oversight of use of Recovery Act funds.

HRSA has implemented senior level governance boards, focused on accountability and internal controls, and a thorough and comprehensive OMB A-123 internal controls testing and evaluation process that tests and ensures appropriate internal controls are in place throughout the entire funding cycle. The Health Center Program is also subject to a complete improper payments risk assessment on a regular basis by the HRSA CFO, with the last assessment performed during FY 2009.

K. Barriers to Effective Implementation

HRSA has a history of working successfully with health center grantees to provide primary and preventive health care services to medically underserved populations. As the objectives and activities of the NAP and IDS awards are consistent with ongoing HRSA objectives and activities, HRSA has not encountered significant barriers to effective implementation.

Available resources will be sufficient to complete the awarding and monitoring activities associated with the Recovery Act. However, to help ensure that HRSA meets established timelines and monitoring requirements, additional staff were hired. To decrease the hiring timeframe for Recovery Act positions, HRSA worked closely with the Rockville HR Center (RHRC) to make one announcement to cover approximately 100 vacant positions. HRSA also met weekly with RHRC to ensure selections met OPM requirements and job offers were made in a timely manner.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

- Updated status of Environmental Review Compliance
- Actual measures data through 12/31/10 have been added

Health Resources and Services Administration: Health Professions Training Programs - National Health Service Corps (NHSC)

A. Funding Table

The table below provides an overview of the plan for the use of the $300 million for the National Health Service Corps (NHSC) Health Professions Training Programs in Recovery Act funding. Within the $300 million, the Recovery Act provides for 80 percent ($240 million) to be used for recruitment of primary care clinicians; the remaining 20 percent to be used for NHSC field operations ($60 million). The recruitment line is comprised of three programs: the NHSC Loan Repayment Program ($191.5 million), NHSC Scholarship Program ($37.3 million), and State Loan Repayment Program ($11.2 million). Column 1 identifies the specific programs that will be funded, column 8 provides the total appropriated amount, and columns 2, 4, and 6 provide the distribution of funds across programs and years. In addition, columns 3, 5, and 7 provide the distribution of outlays of funds cumulatively across programs and years. NHSC expects making outlays until 2014 since scholarship recipients are supported up to 4 years. The Recovery Act provides for 0.5% of the total appropriated amount to be used to support the administrative costs of implementation; this totals $1.5 million across the three years of implementation. These amounts are included in the program totals listed below.

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations	FY 2011 Estimated Obligations
NHSC Loan Repayment Program	$191.50	$37.5	$98.0	$56.0
NHSC Scholarship Program	$37.30	$8.5	$28.8	$0.0
State Loan Repayment Program	$11.20	$5.8	$5.4	$0.0
NHSC Field	$60.00	$14.7	$28.0	$17.3
Total	$300.00	$66.5	$160.2	$73.3

B. Objectives

The objective of the NHSC Recovery Act funding is to increase public access to affordable primary health care by providing an incentive to primary health care clinicians/students to serve in underserved areas and thus increasing the number of NHSC primary health care clinician jobs. The NHSC program encourages primary health care clinicians/students to serve vulnerable populations (e.g., uninsured, Medicaid, Medicare) within health professional shortage areas (HPSAs).

Prospective placement sites must be located in a HPSA and provide health care services to all individuals, regardless of the ability to pay. The NHSC provides incentives to primary care clinicians/students by offering loan repayment and scholarships. In doing so, it can create or preserve primary health care clinician jobs in communities with greatest need. It is estimated that the health workforce would be strengthened by more than 4,000 new/preserved primary health care clinician jobs supported through the NHSC, including 332 clinicians supported through the State Loan Repayment Program.

The objectives of these awards support objectives of the U.S. Department of Health and Human Services (HHS) Strategic Plan, relating to increasing access to health care and strengthening the primary care workforce.

C. Activities

The NHSC will award service contracts to primary health care clinicians/students through the loan repayment and scholarship programs (service contracts are not subject to the Federal Acquisition Regulation), and award administrative contracts and supplements for support services. The State Loan Repayment Program (SLRP) will award grants to States.

D. Characteristics

	NHSC Loan Repayment	***NHSC Scholarship***	***SLRP***
Type of Award	Direct Payment for Specified Use (Service Contract)	Direct Payment for Specified Use (Service Contract)	Grant
Non-Federal Recipients	$190.54	$37.11	$11.15
Federal Administration and Support (0.5%)	$0.96	$0.19	$0.05
Total Funding Amount (Million)	$191.5	$37.3	$11.2
Recipients	Individuals (Primary health care clinicians)	Individuals (Primary health care students)	States
Beneficiaries	Anyone/general public (medically underserved in HPSAs, e.g., Medicaid, uninsured)	Anyone/general public (medically underserved in HPSAs, e.g., Medicaid, uninsured)	Individuals
Methodology for Award Selection	New competitions; amendments	New competitions; continuations	New competitions

E. Delivery Schedule

NHSC Scholarship
Application Open/Due:
FY09: March 5, 2009/April 6, 2009

FY10: May 4, 2010/June 3, 2011
Service Contracts Awarded: starting Summer 2009

NHSC Loan Repayment
New Application Open/Period: Summer 2009/Open and Continuous for 18 months
Service Contracts Awarded: Summer 2009

SLRP
Application Open/Due: Spring 2009
Grants Awarded: Summer 2009

To date, NHSC has made over 3,000 loan repayment awards and 70 scholarship awards.

F. Environmental Review Compliance

HRSA has reviewed this activity in accordance with the HHS GAM 30 and discussed the program with the HHS Environmental Program Manager. From this review, HRSA has concluded that it qualifies for a Category 2.a. Function Exclusion and there are no additional extraordinary circumstances that may cause significant effects. HRSA will maintain written documentation of all environmental reviews and they will be reported on the Section 1609(c) report.

G. Measures

Measurement under this program will focus on jobs created or retained, including:

- Number of new NHSC loan repayment awards (jobs created/preserved)
- Number of new State Loan Repayment Program awards (jobs created/preserved)
- Number of new NHSC scholarship awards (future jobs created)

The program outcome measure will be the increase in NHSC field strength (total). Since awards under the NHSC program are made to individuals, not to grantees, direct reporting from those individuals is not required. Program performance information will be collected through the existing program data systems. Data will be consolidated and reported by HRSA to a Recovery Act central system, such as www.hhs.gov/recovery or recovery.gov.

Outcome/ Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
Number of new NHSC loan repayment service contract awards (jobs created/preserved)	Awards	**TARGET**	829	1504	2494	3000	3000	3500	4000	4000	4000	4000
		ACTUAL	829	1602	2538							
Number NHSC scholarship service contract awards (jobs created)	Awards	**TARGET**	70	70	70	70	214	214	214	214	214	214
		ACTUAL	70	72	72							
Increase in NHSC field strength	Field Strength	**TARGET**	829	1504	2494	3332[2]	3332	3832	4332	4332	4083[1]	4083
		ACTUAL	829	1602	2586							
Number new State Loan Repayment Program contract awards (jobs created/preserved) 18 Grants to States	Awards	**TARGET**			332	332	332	332	332	332	332	332
		ACTUAL			26							

[1] Decrease in Field Strength due to an estimated 249 FY 2009 loan repayers who will have fulfilled their service obligation and are no longer counted in the Field Strength

[2] SLRP Awards made in one quarter were expected to appear in the NHSC Field Strength in the next quarter.

Measure	Reporting Period	How data made available to public	Frequency of making data available to public
Outputs/Jobs			
# new NHSC loan repayment service contract awards (# new Direct Payments for Specified Use Awards) (jobs created/preserved)	Quarterly	Recovery.gov, HHS website	Quarterly
# new State loan repayment (SLRP) contracts awarded (jobs created/ preserved)	Quarterly	Recovery.gov, HHS website	Quarterly
# NHSC scholarship service contract awards (#new Direct Payments for Specified Use Awards) (future jobs created)	Quarterly	Recovery.gov, HHS website	Quarterly
# NHSC loan repayment service contract amendment awards (Direct Payments for Specified Use Amendment Awards) (jobs preserved beginning 2011)	Quarterly	Recovery.gov, HHS website	Quarterly
Outcome			
Increase in NHSC field strength	Quarterly	Recovery.gov, HHS website	Annually
Data Sources: NHSC – Award package, BMISS is a database containing information collected from: individual scholarship and loan repayment applications, recruitment and retention assistance applications, and monitoring data and compliance data. **Validation:** NHSC – Application data is entered through a web-based system that incorporates extensive validation checks. Applications also include many hard copy documents that are reviewed for completeness. **Data Sources:** SLRP – Semi-Annual Report. **Validation:** Grantees must report the number of new contracts awarded, the amount of the contract, and the HPSA site where the practitioner is completing his/her service obligation in their semi-annual report. Program staff validates this data by reviewing each report and contact State to verify when a discrepancy exists.			

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper

Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

HRSA's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. HRSA's Senior Assessment Team carries out comprehensive annual assessments of its Recovery Act programs to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets biweekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, HRSA will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

NHSC: To ensure compliance and minimize exposure to risk, HRSA requires that the Office of the General Counsel review all application materials associated with the Recovery Act, performs a National Practitioner Data Bank check on all applicants as one determination of eligibility for the NHSC loan repayment, requires completion of a 6-month verification form confirming full-time service for all NHSC clinicians, and is taking steps to modify and compete contracts which will allow the program to uniquely report on Recovery Act activities. HRSA program staff work closely with the HRSA budget and finance organizations associated with managing and monitoring Recovery Act expenditures.

SLRP: To ensure compliance and minimize exposure to risk, HRSA will work with the Office of the General Counsel to review all application materials associated with the Recovery Act, and staff will perform SLRP database checks against NHSC Loan Repayment Program applicants to avoid dual program participation. In addition, all HRSA budget and finance offices work closely together to manage and monitor Recovery Act activities.

I. Transparency

HRSA is open and transparent in all its contracting and grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance.

HRSA ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. HRSA informs recipients of their reporting obligation

through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, HRSA provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes staff to ensure compliance with reporting requirements.

The NHSC will report for NHSC loan repayment and scholarship programs on an aggregate level; SLRP will report the amount of funds expended and number of awards by State. HRSA will utilize existing reporting and information systems to organize program cost and performance information.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, HRSA has built upon and strengthened existing processes. Senior HRSA and BCRS officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

HRSA program managers will monitor program outputs on a weekly basis. HRSA program managers will be held accountable to ensure the timely awarding and appropriate management of funds, and, as appropriate, HRSA Performance Management and Assessment Plans may be modified to incorporate the stewardship of Recovery Act funds. HRSA has also implemented senior level governance boards, and a thorough and comprehensive A-123 internal controls testing and evaluation process, which tests, and ensures appropriate internal controls are in place throughout the entire funding cycle. The NHSC program is also subject to a complete improper payments risk assessment on a regular basis, with the last one performed during FY 2010.

K. Barriers to Effective Implementation

Overall Recovery Act implementation is not compromised by any regulatory impediment. Available resources will be sufficient to complete the awarding and monitoring activities associated with the Recovery Act.

The following implementation challenges have been identified:

- Securing an adequate number of applicants for the NHSC loan repayment program. Recovery Act funding represents a twofold increase above the program's annual appropriation base resulting in an increase in the number of needed NHSC clinician applicants. Recruiting for positions in underserved areas has proved challenging. To address this challenge, the program has developed an aggressive recruitment and technical assistance protocol to expand the pool of applicants for positions in health professional shortage areas. HRSA is expanding the number of positions that can be filled by sites with NHSC

clinicians, and extending the application period to increase the application pool.

- Complying with all program support contracting requirements in a timely manner is challenging and directly impacts the speed of the award process. For example, the program is hoping to receive no less than 6,000 but as many as 8,000 applications for Recovery Act award consideration. These applications must be processed for completeness, eligibility, and ranking for a funding determination. HRSA continues to work on identify timely and viable options for expediting the application review. For example, HRSA decreased the required documentation for NHSC LRP application by 50 percent to streamline the process. In addition, Recovery Act funding will be used for additional program support contract and temporary Federal staff to assist in processing these applications. Since the beginning of FY 2010, HRSA has increased hiring of temporary staff to support the recruitment; application review; and monitoring of awardees.

- Monitoring the compliance of new NHSC clinic sites and clinicians stretches the programs' current capability. NHSC will monitor service contract obligations from a minimum of 2 years to as long as 8 years from the date of award (e.g., in school, in service, suspension of service for pregnancy or illness). To respond to the significant increase in the NHSC monitoring caseload over the next 2-8 years, HRSA is reengineering business processes to efficiently handle the additional case load. Furthermore, HRSA is reviewing contractor support to ensure that both federal and contractor resources are leveraged efficiently and effectively in a synergetic effect.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

- Changes have been made to the funding allocation based on program implementation.
- Increased NHSC Loan Repayment and NHSC Scholarship Program funds. Decreased State Loan Repayment Program funds.
- Targets for measures have been updated to reflect distribution of obligations and outlays.

Indian Health Service: Health Care Facilities Construction

The Recovery Act funds will complete the replacement of two Indian Health Service (IHS) healthcare facilities with more technologically advanced state-of-the-art facilities. The specified $227 million for IHS Health Care Facilities Construction will complete the replacement of the hospital and staff quarters at Eagle Butte, South Dakota, and complete the replacement of the hospital facility at Nome, Alaska. The two funded construction projects were determined by criteria in the Recovery Act requiring up to two facilities from IHS' current construction priority list for which work had already been initiated. Construction of the Nome replacement facility has been implemented by a direct Federal open competition contract, meeting all respective and applicable laws. A Public Law (P.L.) 93-638 Title-V tribal self-determination construction project agreement has been entered into with the Norton Sound Health Corporation (NSHC) for the provision of all equipment and furnishings, architect/engineer (A/E) construction administration services, and off-site utilities. The Eagle Butte replacement facility and quarters construction is being completed through a P.L. 93-638 Title-I self-determination construction contract, whereby the Tribe will implement construction contracts.

A. Funding Table

(Dollars in Millions)

	Total Appropriated	Actual Obligations FY 2009	Planned Obligations FY 2010
Replacement Facility – Nome, Alaska	$142.5	$90.25	$52.25
Replacement Facility – Eagle Butte, South Dakota	$84.5	$43.0	$41.5
Total	$227.0	$133.25	$93.75

B. Objectives

- Complete the replacement facilities at Nome, Alaska, and at Eagle Butte, South Dakota (including the quarter units at Eagle Butte)
- Expand service capacity by increasing access to modern health care services at state-of-the-art medical facilities for surrounding American Indian and Alaska Native communities.
- Provide economic stimulus through the creation of jobs.

C. Activities

Categories for Health Facilities Construction include:

- Completion of the Nome direct federal contract for construction of the new 150,000 SF hospital.
- Completion of the Norton Sound Health Corporation P.L. 93-638 Title-V Construction Project Agreement for architect/engineer construction contract administration, equipment, and furnishings, and off-site utilities.

- Award and initiation of the Nome Direct Federal contract for Commissioning. The Commissioning Agent will ensure completion and verification of all building systems as well as operator training and O&M manuals.
- Completion of the Eagle Butte P.L. 93-638 Title-I contract for construction of the new 138,000 SF hospital and design/build of 133 Quarters units.

D. Characteristics

Types of Recipients

- Tribal governments and/or Tribal Organizations
- Private-sector construction vendors

Types of Financial Awards

- Federal construction contracts and purchase orders
    - Nome: $99.75M
    - Eagle Butte: $0M
- Tribal P.L. 93-638 construction contracts
    - Nome: $42.75M
    - Eagle Butte: $84.5M

Methods of Selection

- These facilities replacement projects were highly ranked on the IHS facilities priority list (a nation-wide assessment of facility condition, capacity, and need). Design was already complete and initial stages of construction had begun. In accordance with Congressional direction, these were the highest ranking facilities replacement projects that met criteria specified in the Recovery Act for these funds.
- The Nome facility construction is being completed by a direct Federal contract that met all respective and applicable laws. A direct Federal contract will be issued for the provision of commissioning services.
- The Norton Sound Health Corporation (NSHC) will provide all equipment and furnishings, A/E construction contract administration services, and off-site utilities through a P.L. 93-638 Title-V self-determination construction project agreement.
- The Eagle Butte healthcare facility and quarters units construction is being completed through a P.L. 93-638 Title-I self-determination construction contract. The Tribe has implemented construction contracts for the healthcare facility and the design and construction of the staff quarters (design build).

E. Delivery Schedule

Activities	Initiation Dates	Completion Dates
Nome facility direct federal Request for Proposal (RFP) solicitation and award	4/3/09	8/19/09
Norton Sound Health Corporation (NSHC) Title-V Construction Project Agreement (CPA) for A/E construction contract administration services, partial equipment, and furnishings – Modification No. 4	5/13/09	12/28/09

Activities	Initiation Dates	Completion Dates
NSHC Title V CPA Modification No. 5 for off-site utilities	1/1/10	6/30/10
NSHC Title V CPA Modification No. 6 for remaining equipment and furnishings and occupancy by NSHC	6/1/10	8/31/10
Nome ARRA direct Federal Construction Start and Complete	4/5/10	12/31/12
Eagle Butte Title-I contract for Phase-I construction with non-Recovery Act funding construction start and complete	4/20/09	11/30/09
Eagle Butte Title-I contract for Phase-II remaining facility construction w/Recovery Act funding – Negotiate, execute, and complete all construction	5/1/09	12/31/11
Eagle Butte Title-I contract for design/build of the 133 quarters units	4/6/10	12/31/11
Eagle Butte Title-I contract for disposition of existing hospital and out-buildings – Negotiate, execute, complete all design and construction	4/6/10	12/31/12

F. Environmental Review Compliance

- All Recovery Act projects have been reviewed for environmental compliance. The Nome and Eagle Butte projects currently comply with National Environmental Policy Act and National Historic Preservation Act and other environmental regulations.
- To satisfy Section 1609(c) reporting requirements of the Recovery Act, the IHS will report the status and progress of the environmental review of all Recovery Act funded projects using the prescribed President's Council on Environmental Quality format.

G. Measures

Measure	Type	Frequency Measured	Available for Public Access
Percent of construction funds expended by direct Federal and tribal Title-I and Title-V contractors.	Output	Quarterly for direct Federal contractors and quarterly for the tribal contractors	Recovery Act reports on Recovery.Gov; Supplemental information on HHS.gov/Recovery

Explanation of Measure: The tangible outputs produced by the facility construction projects are two state-of-the-art health care facilities located at Nome, Alaska and Eagle Butte, South Dakota. The new facilities replace older facilities and will expand

capacity to serve the current patient population. The percent of funds expended will be determined quarterly from the direct Federal contractor's monthly progress payment submissions as determined from the schedule of values, quarterly from the Title-I tribal contractor, and semi-annually from the Title-V tribal contractor from their respective financial reports. The percent of funds expended will be compared to the respective actual construction progress to determine the overall project cost status.

Measure	Type	Frequency Measured	Available for Public Access
Progress schedule monitoring actual progress vs. the Contractor's submitted schedule	Output	Quarterly for the direct Federal contractor and tribal Title-I contractor	Recovery Act reports on Recovery.Gov; Supplemental information on HHS.gov/Recovery

Explanation of Measure: The general contractors for both the Eagle Butte and Nome hospital construction projects are required to submit a construction schedule in a CPM (critical path method) format. Each contract has a stipulated completion date. This measure will note actual construction progress on a quarterly basis for the direct Federal contractor and for the tribal contractor, and will be compared to their CPM schedules. The actual completion progress for each project will be compared to the respective CPM schedules to determine the overall project completion status. This measure will be reported quarterly for federal and tribal contracts.

Outcome / Achievement	Type	Units	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	12/31/11	3/31/12	6/30/12	9/30/12	12/31/12
Percent of total Recovery Act facility construction funds expended (both Nome and Eagle Butte projects)	TARGET	Percent	15%	22%	22%	37%	59%	63%	72%	75%	79%	82%	91%	94%	98%	100%
	ACTUAL		15%	22%	17%*											
Nome Health Center direct federal contract. Progress schedule monitoring actual progress vs. the Contractor's submitted schedule	TARGET	Percent	2%	10%	17%	25%	32%	40%	47%	55%	62%	70%	77%	84%	92%	100%
	ACTUAL		2%	11%	19%											
Eagle Butte Health Center P.L. 93-638 contract Progress schedule monitoring actual progress vs. the Contractor's submitted schedule	TARGET	Percent	15%	25%	34%	43%	53%	62%	72%	81%	91%	100%				
	ACTUAL		20%	16%	36%											
Eagle Butte Quarters P.L. 93-638 contract Progress schedule monitoring actual progress vs. the Contractor's submitted schedule	TARGET	Percent	NA	NA	NA	Schedule to be provided to IHS by the Cheyenne River Sioux Tribe in May 2010										
	ACTUAL		NA	NA	NA											

* Note: The actual percent of expenditures went down from $22% to 17% from December 09 to March 10 due to an overpayment to NSHC for the Nome project. $16.8M was paid to NSHC when $5M should have been paid. NSHC returned $11.8M shortly after this error was identified.

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

The IHS risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. The IHS Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets bi-weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, IHS has presented/will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

I. Transparency

IHS will be open and transparent in all of its contracting competitions and regulations that involve spending of Recovery Act funding consistent with statutory and OMB guidance.

IHS ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. IHS has informed recipients of their reporting obligations through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. IHS has provided technical assistance to grantees and contractors and has fully utilized Project Officers to ensure compliance with reporting requirements.

- Post Recovery Act reports on Recovery.Gov and supplemental information on HHS.Gov/Recovery.
- Post reports enabling the public to see how much Recovery Act funding has been awarded and to whom.
- Recipients submit Recovery Act reports to a web-based central data portal which routes raw reports to a central national data repository and to the IHS.
- IHS submits consolidated reports assembled from raw individual recipient reports, e.g., overview of progress of multiple vendors working on a single project.

- Types of data available to the public:
    - Recovery Act financial data for IHS
    - Recovery Act implementation plans
    - Recovery Act award data
    - Recovery Act program and project level status reports - individually by recipient and collectively synthesized as appropriate.
- No agency contact or oral communications with registered lobbyists regarding particular Recovery Act projects are allowed.
- Post any written agency communications with lobbyists to Recovery.Gov
- All tribal and commercial contracts will include applicable reporting requirements for use of Recovery Act funds.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, IHS has built on and strengthened existing processes. Senior IHS Office of Environmental Health and Engineering program officials have met regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system has also been incorporated the Recovery Act program stewardship responsibilities for program and business function managers.

- Incorporate Recovery Act implementation into IHS fiscal year 2009 and 2010 Management Control Plan
- Track quantifiable outcomes and outputs for funded projects
- Track Recovery Act projects & funds in Unified Financial Management System
- Track Construction Projects for:
    - Construction schedule, scope, costs, disbursements
    - Facilities performance measures
- Incorporate Recovery Act implementation in:
    - Director's Performance Plan and cascade to responsible Recovery Act managers
- Health Facility Construction Projects comply with rigorous national planning, design, and selection criteria in advance of selection for construction
- Health Facility Construction Projects comply with:
    - National design standards for health care facilities
    - worker health and safety standards and coverage standards
    - right-of-way and tribal permissions
    - documented scope, budget, and schedule in Facility Project Approval Agreement (HHS Form 300)
- Projects comply with procurement standards and quality assurance
- Track and report use of funds for administration

K. Barriers to Effective Implementation

Health Facility construction projects are complex, multi year projects which include many interdependent sub-projects. Both construction sites are located in remote areas where progress can be limited by logistical bottlenecks and severe climate. Ordinarily, IHS facilities construction funding obligations are staged over the entire

period of construction. However, the Recovery Act requires that all Recovery Act funding be obligated no later than September 30, 2010. Funding for equipment and furnishings and a contingency reserve amount for unforeseen costs are normally not obligated this early. This unusual challenge continues to require special project management, financial, and acquisition steps to comply with the Recovery Act and assure that construction is conducted according to standards.

- The Nome construction schedule could be extended due to uncertainty with procurement, shipping, arctic construction, labor, and other risks at this very remote site located on the Bering Sea.
- The Eagle Butte construction schedule could be extended due to severe winters, labor, and other project risks at this remote site in rural South Dakota.
- The Nome facility will be owned by NSHC on land owned by NSHC.
- The Eagle Butte facility will be Government owned on trust land.

L. Federal Infrastructure

- Design for both projects was initiated prior to the requirement to meet the Guiding Principles for High Performance and Sustainable Buildings in EO 13423. However, the IHS design criteria for both replacement facilities include many energy efficiency features; and the Tribes have incorporated sustainable design features into the projects. In an effort to meet the requirements of Energy Policy Act (EPAct) of 2005 and some of the requirements of EO 13423 it was decided to incorporate a geothermal heat pump system into the new Eagle Butte Heath Care facility. Also the EISA storm water migration will be addressed.
- The Nome facility was designed to meet current energy efficiency criteria. The facility completed its design prior to consideration of Leadership in Energy and Environmental Design (LEED) certification being required, however, the facility will still meet many of the LEED criteria.
- The Eagle Butte facility will meet many of the current energy efficiency criteria, including utilizing a renewable energy ground source heat pump system for heating and cooling, which will meet ASHRAE 90.1 (2004) and the facility is targeted to be 30% more efficient. The Sustainable Buildings Checklist will be utilized to document all energy and sustainability features of the design at the completion of construction.
- The Eagle Butte facility was targeted to meet current pre site development storm water runoff condition regulations.

Summary of significant changes:

The original Implementation Plan for Health Care Facilities continues to be accurate for this update. The only major change was replacing the FTE performance outcome with a progress schedule monitoring outcome and modifying the Outcome/Achievement Table to add this measure.

Indian Health Service: Sanitation Facilities Construction Program

The Recovery Act (ARRA) funds are used to construct essential sanitation facilities including water supply, sewage, and solid waste disposal facilities to American Indian and Alaska Native (AI/AN) homes and communities. Through Interagency Agreement DW-75-95766001-0 the US Environmental Protection Agency provided the Indian Health Service with $30 million of Drinking Water Infrastructure Grants Tribal Set Aside funds. The EPA also provided $60 million of Clean Water Act Indian Set Aside funds through Interagency Agreement DW-75-95765901-0. Funds were distributed to the 12 IHS Areas (IHS regional organizational level) based on relative need considering both the dollar amount of sanitation need and the sanitation need measured in the number of homes lacking facilities. The projects within each Area are prioritized to serve existing homes, based on an established formula that considers, among other factors, health impact, cost effectiveness, and ability to expeditiously complete the projects. Projects were executed using Public Law (P.L.) 86-121 authorities including the Memorandum of Agreement (MOA) and P.L. 93-638 instruments. Sanitation Facilities Construction (SFC) projects can be managed by the IHS directly (Direct Service) or they can be managed by Tribes that elect to use authorities under P.L. 93-638, the Indian Self-Determination and Education Assistance Act. The IHS will use up to $1 million of the funds for administrative costs, finance activities, and transparency reporting required by the Recovery Act. The overall SFC goals, eligibility criteria, and project funding priorities remain the same, regardless of the delivery methods chosen by a Tribe.

A. Funding Table

Program/ Project/Activity	(Dollars in Millions)		
	Total Appropriated	**FY 2009 Actual**	**FY 2010 Estimate**
		Obligations	Obligations
Sanitation Facilities	$68	$37	$31
Transfer from EPA	$90	$41	$49
Total	$158	$78	$80

B. Objectives

As of the end of fiscal year (FY) 2008, there were about 220,000 American Indian and Alaska Native (AI/AN) homes in need of sanitation facilities, including nearly 35,000 AI/AN homes without potable water. As of April 24, 2009, the total cost of sanitation facilities needs for existing Indian homes totaled almost $3 billion. Safe drinking water supplies and adequate waste disposal facilities are essential preconditions for most health promotion and disease prevention efforts, as well as being a major factor in the quality of life of AI/AN people. The SFC Program is a preventative health program that yields positive benefits in excess of the program

costs. The Recovery Act funding was expended on sanitation facilities construction projects that accomplish IHS objectives including:

- Developing public health infrastructure with Tribes to support AI/AN communities mediate sub-standard conditions and upgrade to modern fire-life safety standards,
- Preventing the spread of infectious diseases,
- Protecting the public against injuries and environmental threats, and
- Providing economic stimulus and jobs.

C. Activities

Projects by Categories

Category	# of Projects Provided Funding*	Cost ($)*
Sanitation Facilities Projects, including: • provisions of water supplies; • sewage disposal facilities; • development of solid waste treatment sites; • provision of technical assistance to Indian water and sewer utility organizations.	161	$67,000,000
IHS Administrative cost		$1,000,000**
EPA Clean Water Sanitation Facilities Projects, including: o sewage treatment and disposal facilities; o provision of technical assistance to Indian sewer utility organizations.	96	$60,000,000
EPA Drinking Water Sanitation Facilities Projects, including: o provisions of water supplies; o water treatment and distribution facilities; o provision of technical assistance to Indian water utility organizations.	63	$30,000,000

* Some projects are jointly funded by IHS and EPA for a total of 292 projects.
**Any excess admin funds will address cost and/or scope changes on current projects or fund additional priority SFC projects.

D. Characteristics

Types of Recipients

Sanitation Facilities Construction Projects by Recipient Type

Recipient Type	Number of Projects*	Cost ($)
Tribal governments and/or Tribal Organizations	292	158,000,000

* Some projects are jointly funded by IHS and EPA for a total of 292 projects.

Types of Financial Awards

- Public Law (P.L.) 86-121 Memorandum of Agreement (MOA) -- estimated funding: $140 million. Approximately 10% will be funded through Buy-Indian or Commercial Contracts
- Tribal self-determination contracts -- estimated funding: $18 million

Methods of Selection

The 12 IHS Areas, in consultation with Tribes, selected high priority sanitation facilities construction projects to be funded by the Recovery Act. Projects for water and sanitation services are ranked in priority using measures collected in the IHS Sanitation Deficiency System (SDS) which is an inventory of the sanitation deficiencies of AI/AN communities. Sanitation deficiencies include needed water, sewer, and solid waste facilities for existing AI/AN homes. The sanitation deficiency data is continually updated and annually reported to Congress as required by the Indian Health Care Improvement Act, Public Law 94-437, as amended (25 U.S.C. 1601 et seq). Potential construction projects are prioritized considering measures of health impact, deficiency level, previous service, capital cost, operations and maintenance capability, Tribal contribution, Tribal priority and other considerations. The Recovery Act funding favored projects that could be started and completed expeditiously. The SDS scoring criteria were supplemented to comply with the Recovery Act by focusing on projects that could be delivered expeditiously and by lowering priority for projects where conditions and circumstances could impede completion on schedule. Tribal involvement has been a keystone of the Sanitation Facilities Program since its inception in FY 1959. Tribal project proposals are funded through agreements which specify Tribal ownership responsibilities, including operation and maintenance.

Sanitation Facilities Construction ARRA Projects by Area

IHS Regional Area	Number of Projects by State	Number of Projects by Area	Cost (in Dollars)
Aberdeen	Iowa – 1 Nebraska – 4 North Dakota – 1 South Dakota - 7	13	5,907,000
Alaska	Alaska - 14	14	14,291,000
Albuquerque	New Mexico - 6	6	3,053,000
Bemidji	Michigan – 2 Minnesota – 4 Wisconsin - 2	8	1,918,000

IHS Regional Area	Number of Projects by State	Number of Projects by Area	Cost (in Dollars)
Billings	Montana – 4 Wyoming - 1	5	1,827,000
California	California - 16	16	4,068,000
Nashville	Florida 1 Maine -1 Mississippi -1 New York - 5	8	3,083,000
Navajo	Arizona - 14 New Mexico - 16	30	15,078,000
Oklahoma	Oklahoma - 28 Kansas - 6	34	8,074,000
Phoenix	Arizona - 6 California - 3 Nevada - 4	13	5,750,000
Portland	Washington - 9 Idaho - 1 Oregon – 1	11	2,237,000
Tucson	Arizona – 3	3	1,714,000
Totals		**161**	**67,000,000**

SFC ARRA Projects by Area
Funded with EPA Clean Water Contributions

IHS Regional Area	State	Number of Projects		Cost ($)
		By Area	By State	
Aberdeen	South Dakota	1	1	$3,210,000
Alaska	Alaska	20	20	$19,979,950
Albuquerque	Colorado	6	6	$3,995,990
	New Mexico			
Bemidji	Michigan	6	1	$1,590,010
	Minnesota		3	
	Wisconsin		2	
Billings	Montana	3	3	$2,166,000
California	California	5	5	$7,548,000
Nashville	Alabama	5	1	$3,390,000
	Maine		1	
	New York		1	
	North Carolina		2	
Navajo	Arizona	30	8	$10,176,030
	New Mexico		22	
Oklahoma	Oklahoma	5	4	$1,344,010

SFC ARRA Projects by Area *Funded with EPA Clean Water Contributions*				
		Number of Projects		
	Kansas		1	
Phoenix	Arizona	10	8	
	California		1	$3,714,000
	Utah		1	
Portland	Washington	3	3	$1,884,000
Tucson	Arizona	2	2	$1,002,010
		96		$60,000,000

SFC ARRA Projects by Area *Funded with EPA Drinking Water Contributions*				
IHS Regional Area	State	Number of Projects		Cost ($)
		By Area	By State	
Aberdeen	Nebraska	4	1	
	South Dakota		3	$2,844,100
Alaska	Alaska	11	11	$7,965,800
Albuquerque	New Mexico	4	4	$1,845,200
Bemidji	Michigan	6	1	
	Minnesota		2	$1,692,700
	Wisconsin		3	
Billings	Montana	2	2	$602,600
California	California	1	1	$753,100
Nashville	Florida	12	1	
	Maine		5	
	New York		2	
	North Carolina		2	$2,667,800
	Rhode Island		1	
	Texas		1	
Navajo	Arizona	1	1	$3,187,000
Oklahoma	Oklahoma	6	2	
	Kansas		4	$1,084,100
Phoenix	Arizona	9	7	
	California		1	$3,775,300
	Nevada		1	
Portland	Washington	4	3	
	Oregon		1	$2,655,300
Tucson	Arizona	3	3	$927,000

		63	$30,000,000

Each SFC project to be funded by the Recovery Act, including EPA ARRA funding, is listed in a separate IHS report that consolidates all Recovery Act funded projects. Many IHS SFC projects are funded by multiple contributors including EPA ARRA programs, States, other Federal Agencies, and Tribes. All funds for ARRA SFC projects are tracked and accounted for separately by funding type in the Unified Financial Management System (UFMS).

E. Delivery Schedule

The projects will be implemented through September 30, 2013.

F. Environmental Review Compliance

- All Recovery Act projects conform to standard IHS procedures that require documentation of an environmental review of each construction project to identify any exceptional or extraordinary circumstances and to ensure compliance with all environmental laws, regulations, and executive orders.
- To satisfy Section 1609(c) reporting requirements of the Recovery Act, the IHS will is reporting the status and progress of the environmental review of all Recovery Act SFC funded projects using the prescribed President's Council on Environmental Quality format.
- SFC projects comply with National Environmental Policy Act (NEPA) and the National Historic Preservation Act (NHPA) and other environmental regulations.

G. Measures

SFC projects provide potable water, wastewater disposal and solid waste systems to AI/AN homes and communities. Each project is different in size, scope and purpose with a variety of tangible, overlapping infrastructure items such as water storage tanks, microfiltration water treatment plants, slow sand filtration water treatment plants, pressure filter water treatment plants, water wells, water transmission lines, water distribution systems, individual service lines, creek intakes, infiltration galleries, septic tank drain fields systems, wastewater lagoons, solar powered systems, gravity sewer systems, pressure sewer systems, sewage lift stations, solid waste transfer stations , open dump closures, wetland wastewater disposal systems, sewage treatment plants and pump houses.

Measure	Type	Frequency Measured	Available for Public Access
Percentage of SFC Recovery Act projects completed.	Output	Quarterly	Supplemental information on HHS.gov/Recovery

Explanation of Measure: The percentage of SFC Recovery Act projects completed is the number of completed construction projects relative to the total number of sanitation projects funded by the Recovery Act. Progress is tracked quarterly using milestone data from the IHS-SFC Program's Project Data system (PDS). Projects

are considered fully complete when all phases of construction at a site are completed and the facilities are certified to begin serving the community. The goal is to complete 100% of Recovery Act projects by the 4th quarter of FY 2013.

Measure	Type	Frequency Measured	Available for Public Access
Number of existing AI/AN homes provided with sanitation facilities on Recovery Act SFC funded projects.	Output	Quarterly	Supplemental information on HHS.gov/Recovery

Explanation of Measure: The outcome measure is number of currently deficient AI/AN homes that will be served by Recovery Act funded water and sanitation projects. Progress is tracked quarterly using data gathered for the IHS-SFC Program's Project Data system (PDS). As projects are completed and certified to begin serving the community, counts of additional homes served by each completed project will be added to the cumulative total of homes served by all Recovery Act funded projects.

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
SFC Recovery Act projects completed	%	TARGET		5	7	10	15	20	25	50	90	100%
		ACTUAL	1	4	6							
Existing AI/AN homes provided with sanitation	#	TARGET		800	1,120	1,600	2,400	3,200	4,000	8,000	14,000	16,000
		ACTUAL	367	436	1036							

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

The IHS risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. The IHS Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets bi-weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, IHS has presented/will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

I. Transparency

IHS is open and transparent in all of its contracting competitions and regulations that involve spending of Recovery Act funding consistent with statutory and OMB guidance.IHS ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. IHS informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. IHS provides technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

- Post Recovery Act reports on Recovery.Gov and supplemental information on HHS.Gov/Recovery
- All tribal and commercial contracts and tribal agreements, including MOUs, include relevant reporting requirements for use of Recovery Act funds.
- Post reports enabling the public to see how much Recovery Act funding has been awarded and to whom.
- Recipients submit Recovery Act reports to a web-based central data portal which routes raw reports to a central national data repository and to the IHS.
- IHS generates consolidated reports assembled from raw individual recipient reports.

- Types of data available to the public:
    - Recovery Act financial data for IHS
    - Recovery Act implementation plans
    - Recovery Act award data
    - Recovery Act program and project level status reports - individually by recipient and collectively synthesized as appropriate.
- No agency contact or oral communications with registered lobbyists regarding particular Recovery Act projects are allowed.
- Post any written agency communications with lobbyists to Recovery.Gov

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, IHS is building on and strengthening existing processes. Senior IHS Office of Environmental Health and Engineering program officials meet regularly with senior Department and USEPA officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system incorporates Recovery Act program stewardship responsibilities for program and business function managers.

- Incorporate Recovery Act into IHS FY 2009/2010 Management Control Plan
- Track quantifiable outcomes and outputs for funded projects
- Track Recovery Act projects and funds in UFMS
- Incorporate Recovery Act implementation in the Director's Performance Plan and cascade to responsible Recovery Act managers.
- Projects comply with procurement standards and quality assurance
- SFC Projects comply with established design standards and value engineering criteria and with worker health and safety standards
- Track and report use of funds.

K. Barriers to Effective Implementation

The availability or materials and contractors at sites where some of the projects are located may potentially impede completion on schedule. The potential for delays is minimized by the selection of projects with lower risks - fewer conditions and circumstances that could impede the schedule.

L. Federal Infrastructure

- SFC projects incorporate green materials and designs that meet the Environmental Protection Agency's definition of Green Projects.
- SFC projects have always integrated low operation and maintenance systems and energy efficient practices into facilities because they are transferred to tribes and/or tribal organizations with limited economic resources to manage the facilities.

Summary of significant changes:

In our initial implementation plan we had 169 sanitation facilities projects. After further review of project scope and documentation, it was determined that 8 projects could be combined with similar projects to streamline the overall project execution.

Indian Health Services: Maintenance & Improvement

The Recovery Act funds are being used for infrastructure projects to improve the condition, fire-life safety, energy conservation, and operational efficiency of existing Indian Health Service (IHS) and Tribal healthcare facilities. IHS health care services are provided in over 700 IHS and tribal health care sites throughout 36 states, mostly in rural and isolated areas. Total space (IHS and tribal) is over 1.6 million square meters (17.2 million square feet) with a replacement cost in excess of $3.1 billion. Funds were targeted to facility maintenance and improvement (M&I) projects in IHS Areas based on detailed assessments of facility age, conditions, and deficiencies. These deficiencies are identified as the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) for IHS and reporting Tribal facilities, and totaled $476,052,000 as of April 24, 2009. Projects are being executed using a combination of federal construction contracts and Indian self-determination (P.L. 93-638) construction project agreements. High priority projects were selected in partnership with tribes and tribal organizations. The IHS is using up to 3% of the funds for administrative costs, project management, and transparency reporting required by the Recovery Act.

A. Funding Table

(Obligations in Millions)

Program/Activity	Program Level Estimate	FY 2009 Actual	FY 2010 Estimate
M&I/Repair, alteration and improvement of IHS and Tribal health care facilities	$97.2	$45.1	$52.1
M&I/Administration	2.8	0.5	2.3
Total	100.0	45.6	54.4

B. Objectives

Some IHS and Tribal facilities are old, overcrowded, and hampered by outdated designs that can impair efficient modern healthcare delivery practices. The Recovery Act funding is being used for facility infrastructure projects to:

- Maintain and improve deteriorating facilities.
- Mediate sub-standard conditions and upgrade to modern fire-life safety standards.
- Modify outdated facilities to improve patient flow, capacity, facilitate modern medical practices.
- Enhance energy conservation.
- Provide economic stimulus and jobs.
- Reduce the system-wide backlog of essential maintenance needed in facilities.

C. Activities

Maintenance & Improvement Projects by Categories

Category	# of Projects	Cost ($M)*
Improve Facility Condition	161	49.4
Energy Conservation	70	22.3
Program Enhancements	46	18.0
Fire-Life-Safety 23		5.9
Security 2		0.2
Sustainability 1		0.1
Total	303 95.9	

*Remaining balance of $1.3 million is held in reserve pending actual award amounts which may differ from current projections. Additional projects or contingency for awarded projects will be funded with any unused reserve funds.

- Projects may address multiple categories of work; however one category was selected for reporting purposes.

D. Characteristics

Types of Recipients

- Tribal governments and/or Tribal Organizations
- Private-sector construction vendors

Types of Financial Awards

Project awards are managed though the IHS Area Offices.

- Federal construction contracts (approximately: $42.9 million).
- Tribal P.L. 93-638 construction project agreements (approximately: $53 million).

Maintenance & Improvement Projects by Recipient Type

Category	# of Projects	Cost ($M)
Federal Contracts - New	88	36.7
Federal Contracts - Existing	16	6.2
Tribes/Tribal Organizations	199	53.0
Total	303	95.9

Methods of Selection

Recipients were selected in accordance with applicable contracting solicitation requirements under the Federal Acquisition Regulations (FAR) or under P.L. 93-638, the Indian Self-Determination Act. New and existing contracts and compacts were used.

Maintenance & Improvement Projects by Area

Area (States Covered)	# of Projects	Cost ($M)
Aberdeen (IA, ND, NE, SD)	39	15.2
Alaska (AK)	37	19.5
Albuquerque (CO, NM, TX, UT)	14	5.3
Bemidji (IL, MI, MN, WI)	40	4.9
Billings (MT, WY)	27	4.3

Area (States Covered)	# of Projects	Cost ($M)
California (CA)	29	3.0
Nashville (AL, CT, FL, LA, MA, ME, MS, NC, NS, NY, RI, SC, TN, TX)	7 3.4	
Navajo (AZ, NM)	27	13.3
Oklahoma (KS, OK, TX)	24	8.2
Phoenix (AZ, CA, NM, NV, UT)	24	11.8
Portland (ID, OR, UT, WA)	27	4.4
Tucson (AZ)	8	2.6
Total	303 95.9	

E. Delivery Schedule

- The projects will be completed between the 2nd Qtr of FY 2010 and the end of FY 2012.
- If significant events occur during the implementation of these projects that impact attainment of one or more projects, the schedule will be amended accordingly.

F. Environmental Review Compliance

- All Recovery Act projects were/are being reviewed for environmental compliance. Maintenance and Improvement projects comply with National Environmental Policy Act (NEPA) and National Historic Preservation Act (NHPA) and other environmental regulations.
- To satisfy Section 1609(c) reporting requirements of the Recovery Act, the IHS reports quarterly the status and progress of the environmental review of all Recovery Act funded projects using the prescribed President's Council on Environmental Quality format.

G. Measures

Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) is an indication of the overall condition at IHS and tribal facilities and of the repair need in these facilities. Approximately 300 projects will be funded.

Measure	Type	Frequency Measured	Available for Public Access
Percent of Recovery Act projects completed	Output	Quarterly	Supplemental information on HHS.gov/Recovery

Explanation of Measure: M&I projects improve the condition, fire-life safety, and efficiency of existing healthcare facilities and enhances energy conservation. The percentage of Maintenance and Improvement (M&I) projects completed is the number of completed construction projects (numerator) divided by the total number of M&I projects funded by the Recovery Act (denominator). Projects are considered fully complete when all phases of construction are certified as complete. Progress will be monitored and reported quarterly. The goal is to complete 100% of M&I projects by the by the end of FY 2012. Many less complex projects are anticipated to be completed in FY 2010 and FY 2011.

Measure	Type	Frequency Measured	Available for Public Access
Percentage reduction in the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) through Recovery Act funding	Output	Quarterly	Supplemental information on HHS.gov/Recovery

Explanation of Measure: The Backlog of Maintenance and Repair (BEMAR) is an IHS-wide inventory of needed maintenance and repair projects. As maintenance and repair projects are completed the BEMAR deficiency is reduced (improved). As BEMAR is reduced, system-wide capacity for safe and efficient patient care is increased. The percentage reduction measure is the amount the system-wide BEMAR is reduced by completion of Recovery Act projects (numerator) divided by the original system-wide baseline BEMAR (denominator).

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End: 9/30/12
Percent of Recovery Act projects completed	%	TARGET		5.2%	10.3%	20.6%	41.2%	61.9%	72.2%	77.3%	82.5%	100%
		ACTUAL	0%	3.0%	4.9%							
Percentage reduction in the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) through Recovery Act funding	%	TARGET		0.8%	1.6%	3.3%	6.7%	10.1%	11.8%	12.9%	13.7%	16.7%
		ACTUAL	0%	0.2%	0.3%							

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

The IHS risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. The IHS Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets bi-weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, IHS has presented/will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

I. Transparency

The IHS is open and transparent in all of its contracting that involve spending of Recovery Act funding consistent with statutory and OMB guidance.
The IHS ensures that recipient reporting required by Section 1512 of the Recovery Act and OMB guidance is made available to the public on Recovery.gov.
All Tribal and Federal contracts include/will include relevant reporting requirements for use of Recovery Act funds.
The IHS informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance.
The IHS provides technical assistance to recipients and fully utilizes Project Officers

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, IHS builds on and strengthens existing processes. Senior IHS Office of Environmental Health and Engineering program officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system

also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

- IHS Health Care Facilities officials meet regularly to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions.
- The personnel performance appraisal system incorporates Recovery Act program stewardship responsibilities for program and business function managers.
- Incorporate the Recovery Act into the IHS FY 2010 Management Control Plan.
- Track Recovery Act projects and funds in the Unified Financial Management System.
- M&I Projects comply with:
    - National design standards.
    - Worker health and safety standards and coverage standards.
    - Project approval processes.
- Track and report use of funds for administration.

K. Barriers to Effective Implementation

- Recovery Act funding is approximately twice the annual funding level for maintenance and improvement creating a surge which affects IHS and tribal finance, acquisition, and facilities operations. IHS is working to effectively balance Recovery Act workload with healthcare requirements.
- Due to the many remote IHS and tribal facility sites, the availability of contractors and skilled labor impacts construction works and contractors. The IHS is monitoring this situation.

L. Federal Infrastructure

- Approximately $22 million will be invested in major energy and sustainability related projects.
- All projects at Federal sites will comply with the Department of Health and Human Services Sustainable Buildings Implementation Plan, which outlines the guidance on incorporating of sustainability principles into the existing and new buildings.
- Projects will reduce ongoing energy usage.

Summary of changes:

There were no major changes to the implementation plan. Update to the plan reflects minor context changes (e.g., “will” to “is”) and minor adjustments on the summary number on awards/amounts. M&I-Project additions and deletions were the result of healthcare needs, tribal priorities, bid savings, etc.

Indian Health Services: Equipment

The Recovery Act funds are being used to purchase essential medical equipment and ambulances for Indian Health Service (IHS) and Tribal health programs. The IHS assesses equipment conditions and needs in all Areas (regions) considering condition, workload volume, and safety. Medical equipment at some IHS and Tribal health care sites is out of date or inadequate, especially at sites with high volumes of patients. Recovery Act funds are being used to mitigate some of the most pressing needs. Funds for medical equipment were distributed to Areas using the existing equipment replacement formula which considers workload volume and facility space. Funds also were used for replacement ambulances among the 94 Tribal and IHS emergency medical services (EMS) programs. The IHS supports a fleet of approximately 175 General Services Administration (GSA) leased ambulances nationwide.

A. Funding Table

(Obligations in Millions)

Program/Activity	**Program Level Estimate**	**FY 2009 Actual**	**FY 2010 Estimate**
Equipment/Medical Equipment Purchases (various types)	$8.75	$5.4	$3.35
Equipment/Computer Tomography (CT) Scanner	6.25	1.25	5.0
Equipment/Ambulance Replacements	5.0	2.7	2.3
Total	20.0	9.35	10.65

B. Objectives

Recovery Act funding is being used to purchase new and replacement medical equipment and ambulances to:

- Increase access to health care, quality of care, and to expand health services received.
- Enhance capacity to provide modern diagnostic and treatment and ability to adapt to innovations and new technology in medical equipment.
- Improve diagnostic capability by installing new CTs and upgrading existing units in emergency departments, which will result in lives saved, as well as reducing unnecessary patient transports. CT scanners play an important diagnostic role for providers, especially in treating trauma patients. Having a CT allows expanded diagnostic services to be provided on-site that are otherwise referred out, thus reducing the dependence on care provided outside the Indian health system though contracts with other local providers.
- Replace ambulances that have exceeded their useful life by contracting with the GSA lease program, which is more affordable than outright purchase of ambulances.

C. Activities

Equipment Acquisition by Category

Equipment Category	No. of Activities Tracked
Medical Equipment Purchases (various types)	211
Computed Tomography (CT) Scanner Purchases	9
Ambulance Replacements	71

- For medical equipment, an activity tracked may be an individual piece of equipment or consist of a system that contains a number of individual pieces of equipment meant to work together to meet a medical need. An example of a system would be a dental operatory that consists of a dental chair, dental x-ray, and associated dental implements.
- For ambulances, the number of activities tracked represents an approximate number that can be purchased given an average cost for replacement. EMS programs in different communities will require a different body type of ambulance or a four-wheel versus a two wheel drive, thus changing the cost. The FY 2009 list identified 35 ambulances for replacement. The FY 2010 ambulance list identified an additional 36 ambulances for replacement.

D. Characteristics

Types of Recipients

Intended award recipients are IHS service units, Tribes, Tribal organizations, contractors, and other Federal Agencies (GSA and Veterans Affairs). Contract actions take place at the IHS Area (regional) level. All contract actions are publicized and reported in accordance with the requirements of the Recovery Act.

Types of Recipients

- Tribal governments and/or Tribal Organizations
- Private-sector vendors

Methods of Selection

- A total of $8.25 million was distributed to purchase medical equipment for Tribal and IHS healthcare facilities. The funding was distributed to the IHS Areas (regions) using the existing equipment replacement funding priority formula. Facilities scheduled to receive new equipment through new construction, or sites identified to receive a new CT scanner, were not included in the distribution formula. Each IHS Area (region) developed a list prioritizing medical equipment needs among its sites considering a variety of factors, including repair frequency and cost, age of devices, reliability, obsolescence, program changes/needs, upgrade versus replacement cost, ability to integrate with electronic medical records, and safety. The cost threshold is a minimum of $10,000 for each piece of equipment.
- A feasibility assessment among 41 Tribal and IHS hospitals yielded a list of 9 priority sites to receive a CT scanner, one site in each IHS Area (region) with a hospital. The assessment addressed the readiness of sites, including space requirements, utility requirements, information technology infrastructure, and their

ability to sustain the maintenance and operation of a CT. For sites requiring site preparation, power, and information technology upgrades to accommodate the CT, the upgrades will be made prior to the delivery of the CT to the site.

- Replacement of ambulances leased through GSA that have exceeded their useful life: 35 ambulances in FY 2009 and an additional 36 ambulances in FY 2010. Funding is transferred to GSA through an interagency agreement to acquire the ambulances through existing contracts. The ambulances will be delivered to communities as they become available from the vendors.

Equipment Acquisitions by IHS Area (region)

Area (States)	Medical Equipment	CT Scanners	Ambulance Replacements
Aberdeen (ND, SD, NE, IA)	9	1	30
Alaska (AK)	20	1	0
Albuquerque (NM, CO, TX)	13	1	4
Bemidji (MN, WI, MI)	19	0	0
Billings (MT, WY)	14	1	10
California (CA)	30	0	3
Nashville (AL, CT, FL, LA, MA, ME, MS, NC, NY, PA, TN)	12	1	1
Navajo (AZ, NM, UT, CO, TX)	14	1	2
Oklahoma (OK, KS, TX)	33	1	6
Phoenix (AZ, CA, NV, UT)	12	1	14
Portland (OR, WA, ID)	31	0	1
Tucson (AZ)	4	1	0
Total	**211**	**9**	**71**

E. Delivery Schedule

Activities	Initiation Dates	Milestones Dates	Delivery Dates
Medical Equipment	Priority List – April 2009	Acquisition process – Summer 2009 to Summer 2010	Summer 2009 to Summer 2011
Computed Tomography (CT) scanners including site-prep and installation	Contract for renovations, upgrades – as necessary CT Purchase Process – May 2009	Awards for the CT equipment – September 2009 to June 2010 Renovations and Upgrades – as necessary	1st Quarter 2010: 2 4th Quarter 2010: 4 4th Quarter 2011: 3

Activities	Initiation Dates	Milestones Dates	Delivery Dates
Ambulance Replacement	GSA Agreement 2009 – May 2009	Start orders to ambulance vendors – Summer 2009	August 2009: 34 October 2010: 37
	GSA Agreement 2010 – April 2010		

F. Environmental Review Compliance

- All Recovery Act purchases were/are being reviewed for environmental compliance.
- Ambulances and most equipment purchases not requiring installation will qualify as exempt under the National Environmental Protection Act (NEPA) requirements.
- Environmental reviews will be documented in writing and reported on the quarterly Section 1609(c) report.

G. Measures

Output	Frequency Measured	Will be posted for public access at
Percentage of Recovery Act funds expended	Quarterly	Supplemental information on HHS.gov/Recovery

Explanation of Measure: Hundreds of individual pieces of health care equipment and ambulances will be delivered and installed at health care sites throughout the IHS system. Because payment is closely tied to order delivery, expenditure of funds is a practical overall progress indicator for tracking installation of equipment IHS-wide. The percentage measure is defined as the cumulative expended funds (numerator) divided by the total Recovery Act Equipment funds available (denominator -- $20 million). Progress will be reported quarterly.

Output	Frequency Measured	Will be posted for public access at
The number of ambulances over mileage (>100K mi) or over 10 yrs old is expected to decrease from 81 to 19 by October 2010.	Quarterly	Supplemental information on HHS.gov/Recovery

Explanation of Measure: Vehicles beyond their useful life have higher maintenance costs, lower availability, and lower reliability for emergency transport. Conversely, newer units have lower maintenance costs, higher availability, and better reliability for meeting communities' most urgent needs. The replacement ambulances will contribute to more efficient more reliable emergency transport services in Indian communities.

Output	Frequency Measured	Will be posted for public access at
Increased access to diagnostic services with new CT scanners	Quarterly	Supplemental information on HHS.gov/Recovery

Explanation of Measure: The number of diagnostic CT diagnostic services will increase at the 2 sites receiving a new CT scanner. This output indicator measures additional services performed due to Recovery Act funding. CT scanners play an important diagnostic role for providers, especially in treating trauma patients. The purchase and installation of CTs at IHS and tribal emergency departments will enhance quality of care and access to care, and will reduce expensive patient transports to other facilities for services.

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End: 9/30/2012
Percentage of Recovery Act funds expended	%	TARGET	[redacted]	53.5%	58.5%	63.5%	71.0%	73.5%	86.6%	88.5%	100%	100%
		ACTUAL	30.7	37.0%	60.4%							
The number of ambulances over mileage (>100K mi) or over 10 yrs old	#	TARGET	[redacted]	81	81	81	62	62	62	62	46	19
		ACTUAL	47	47	47							
Increased access to diagnostic services with new CT scanners*	#	TARGET	[redacted]	0	0	450	900	1300	1300	1300	1300	1300
		ACTUAL	0	0	0							

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

The IHS risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. The IHS Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets bi-weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, IHS has presented/will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

I. Transparency

IHS is open and transparent in all of its contracting competitions and regulations that involve spending of Recovery Act funding consistent with statutory and OMB guidance.

IHS ensures that recipient reporting required by Section 1512 of the Recovery Act and OMB guidance is made available to the public. IHS informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. IHS provides technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

- The Recovery Act requires reporting by Federal agencies and prime recipients of funds.
- Post Recovery Act reports on Recovery.Gov and supplemental information on HHS.Gov/Recovery
- Post reports enabling the public to see how much Recovery Act funding has been awarded and to whom.
- Recipients submit Recovery Act reports to a web-based central data portal which routes raw reports to a central national data repository and to the IHS.

- Types of data available to the public:
    - Recovery Act financial data for IHS
    - Recovery Act implementation plans
    - Recovery Act award data
    - Recovery Act program and project level status reports - individually by recipient and collectively synthesized as appropriate.
- No agency contact or oral communications with registered lobbyists are allowed about particular Recovery Act projects.
- All tribal and Federal contracts include relevant reporting requirements for use of Recovery Act funds.
- Post any written agency communications with lobbyists to Recovery.Gov.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, IHS builds on and strengthens existing processes. Senior IHS Office of Environmental Health and Engineering program officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

- Incorporate Recovery Act implementation into IHS FY 2010 Management Control Plan.
- Track quantifiable outcomes and outputs for funded projects.
- Track Recovery Act projects and funds in the Unified Financial Management System (UFMS).
- Track Recovery Act funded equipment and ambulances in the Agency's Property Management Inventory System (PMIS).
- Incorporate Recovery Act implementation in:
    - Director's Performance Plan and cascade to responsible Recovery Act managers
    - Annual Budget Process
    - IHS Strategic Plan
- Projects comply with procurement standards and quality assurance.

K. Barriers to Effective Implementation

None.

L. Federal Infrastructure

United States Environmental Protection Agency (EPA) Energy Star products will be purchased if available.

Summary of significant changes:

Update to the plan reflects minor context changes (e.g., “will” to “is”), minor adjustments on the summary number on awards/amounts, the projected number of FY-2010 replacement ambulances, and the procurement of nine rather than the original estimate of ten CT scanners. No change in schedule. Rather the updated Implementation Plan better define the projected delivery schedule in lieu of the more general statement “starting in Summer 2009” listed in the original Implementation Plan.

Recovery Act (ARRA) Funded Projects for the Indian Health Service Consolidated by State

PROJECT LIST — Equipment, Construction, Maintenance, and Sanitation Projects

This supplemental document provides additional project details for the following: (1) IHS Sanitation Facilities Plan, (2) IHS Maintenance and Improvement Plan, (3) IHS Health Care Facilities Construction Plan, and (4) IHS Equipment Significant changes to this list are not anticipated; however there may be minor adjustments to the list (project additions or withdraws) until the end of the fiscal year in order to meet healthcare requirements, changes in tribal priorities, pressing facilities needs, unforeseen conditions, bid savings, increases in the construction cost, etc.

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
AK	Anchorage	Alaska Native Tribal Health Consortium	Equipment – Hospital CT Scanner	Replacement CT scanner	PL 93-638 Agreement	Computed Tomography (CT) Scanner
AK	Anchorage	South Central Foundation	Equipment - Medical Various	Portable Dental Equipment Suite	PL 93-638 Agreement	Portable Dental Equipment Suite
AK	Anchorage	Aleutian Pribilof Island Association	Equipment - Medical Various	Exam Tables for Urgent Care Program	PL 93-638 Agreement	Exam Tables for Urgent Care Program
AK	Bethel	Yukon Kuskokwim Helath Corporation	Equipment - Medical Various	Cardiac Monitor System for ER	PL 93-638 Agreement	Cardiac Monitor System for ER
AK	Chistochina	Mt. Sanford Tribal Consortium	Equipment - Medical Various	New Dental Operatory Suite/Systems	PL 93-638 Agreement	New Dental Operatory Suite/Systems
AK	Cold Bay, Akutan, Nelson Lagoon	Multiple Tribes	Equipment - Medical Various	Automatic Sterilizers	Federal Contact-New	Automatic Sterilizers
AK	Dillingham	Bristol Bay Area Health Corporation	Equipment - Medical Various	Optical Coherence Tomogropher	PL 93-638 Agreement	Optical Coherence Tomogropher
AK	Fairbanks	Tanana Chiefs Conference	Equipment - Medical Various	Replacement 23 Exam Tables	PL 93-638 Agreement	Replacement 23 Exam Tables
AK	Ft. Yukon	Council of Athabaskan Tribal Gov.	Equipment - Medical Various	Dental Delivery System + Dental Chair replacement	PL 93-638 Agreement	Dental Delivery System + Dental Chair replacement
AK	Glennallen	Copper River Native Association	Equipment - Medical Various	Digital Dental X-Ray System (4 Operatories)	PL 93-638 Agreement	Digital Dental X-Ray System (4 Operatories)
AK	Haines	Southeast Alaska Regional Helath Corp.	Equipment - Medical Various	New X-ray System	PL 93-638 Agreement	New X-ray System
AK	Kenai	Kenaitze Indian Tribe	Equipment - Medical Various	Chemistry system Analyser.	PL 93-638 Agreement	Chemistry system Analyser.
AK	Kenai	Kenaitze Indian Tribe	Equipment - Medical Various	Clinic Lab Hematology analysis equipment.	PL 93-638 Agreement	Clinic Lab Hematology analysis equipment.
AK	Kodiak	Kodiak Area Native Association	Equipment - Medical Various	Colposcope	PL 93-638 Agreement	Colposcope
AK	Kotzebue and Selawik	Maniilaq Association	Equipment - Medical Various	Telepharmacy Automated Dispensing Unit	PL 93-638 Agreement	Telepharmacy Automated Dispensing Unit
AK	Metlakatla	Metlakatla	Equipment - Medical Various	Ambulance Strectchers (3)	PL 93-638 Agreement	Ambulance Strectchers (3)
AK	Metlakatla	Metlakatla	Equipment - Medical Various	Defibrillators (2) for Ambulances	PL 93-638 Agreement	Defibrillators (2) for Ambulances
AK	Sand Point	Eastern Aleutian Tribes	Equipment - Medical Various	Portable Dental Equipment Suite System	PL 93-638 Agreement	Portable Dental Equipment Suite System
AK	Seward	Chugachmiut	Equipment - Medical Various	Village Chemstat replacements (5)	PL 93-638 Agreement	Village Chemstat replacements (5)
AK	St George	Aleutian Pribilof Island Association	Equipment - Medical Various	Emergency Defibulator	PL 93-638 Agreement	Emergency Defibulator
AK	Tanana	Tanana IRA Tribal Council	Equipment - Medical Various	Complete Hematology analysis system.	PL 93-638 Agreement	Complete Hematology analysis system.
AK	Anchorage	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	SCF - Repair Elevators and Remote Monitoring	PL 93-638 Agreement	CI Improvement
AK	Anchorage	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	ANMC - Replace Medical Office Building Server HVAC system	PL 93-638 Agreement	CI Improvement
AK	Anchorage	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	ANMC - Hospital Radiology Server HVAC Renovation	PL 93-638 Agreement	CI Improvement

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
AK	Anchorage	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	SCF - HVAC Energy Conservation Project	PL 93-638 Agreement	Energy
AK	Anchorage	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	ANMC - Renovate and Expand Space for Medical Center Oncology Program	PL 93-638 Agreement	Program Enhancement
AK	Anchorage	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	ANMC - Urgent Care Center and Behavioral Health Rapid Response Team	PL 93-638 Agreement	Program Enhancement
AK	Anchorage	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	SCF - Anchorage Native Primary Care Center Women's Clinic and Laboratory Renovations	PL 93-638 Agreement	Program Enhancement
AK	Anchorage	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	ANMC - Convert Medical Center Administration Space into New Birth Postpartum Rooms	PL 93-638 Agreement	Program Enhancement
AK	Barrow	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	ASNA - Energy Efficient Window Replacement	PL 93-638 Agreement	Energy
AK	Bethel	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	YKHC - Replace Hospital ADA Entrance Ramp Grating	PL 93-638 Agreement	CI Improvement
AK	Bethel	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	YKHC - Hospital Ambulance Bay Extension	PL 93-638 Agreement	CI Improvement
AK	Bethel	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	YKHC - Replace Outdated Hospital Roof	PL 93-638 Agreement	CI Improvement
AK	Bethel	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	YKHC - Hospital Oxygen Generator and Installation Project	PL 93-638 Agreement	Program Enhancement
AK	Bethel	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	YKHC - Renovate Hospital Delivery Area to Add Room for C-Section Delivery's	PL 93-638 Agreement	Program Enhancement
AK	Bethel	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	YKHC - Hospital Emergency Room Renovation	PL 93-638 Agreement	Security
AK	Copper River	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	CRNA - Correction of Deficiencies at the Wrangell Mountain Dental Clinic	PL 93-638 Agreement	CI Improvement
AK	Dillingham	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	BBAHC - Replace Hospital Clean Steam Generator	PL 93-638 Agreement	CI Improvement
AK	Dillingham	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	BBAHC - Hospital Exterior Building Insulation Repair	PL 93-638 Agreement	CI Improvement
AK	Dillingham	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	BBAHC - Hospital Campus Emergency Generator and Electrical Distribution System Renovation	PL 93-638 Agreement	CI Improvement
AK	Dillingham	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	BBAHC - Install new Hospital Medical Waste Disposal System	PL 93-638 Agreement	Program Enhancement
AK	Dillingham	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	BBAHC - Hospital Medical Gas and Vacuum System Repair	PL 93-638 Agreement	Program Enhancement
AK	Fairbanks	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	TCC - Replace Fire Alarm Panel and Detectors at Adolescent Treatment Facility	PL 93-638 Agreement	Fire-Life Safety
AK	Ketchikan	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	KIC - Health Center Optometry/Laboratory Renovation	PL 93-638 Agreement	Program Enhancement
AK	Kodiak	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	KANA - Replace Clinic Floor to Reduce Infection Control	PL 93-638 Agreement	CI Improvement
AK	Kotzebue	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	Maniilaq - Hospital HIPAA Security/Emergency Room Renovation	PL 93-638 Agreement	CI Improvement

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
AK	Kotzebue	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	Maniilaq - Hospital Ambulance Access Road and Drainage Repair	PL 93-638 Agreement	CI Improvement
AK	Kotzebue	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	Maniilaq - Hospital Energy Conservation and Heating System Repair	PL 93-638 Agreement	Energy
AK	Kotzebue	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	Maniilaq - Hospital HIPAA Compliance Renovation and Stair Case Safety Project	PL 93-638 Agreement	Fire-Life Safety
AK	Kotzebue	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	Maniilaq - Install new Hospital Oxygen Generator & Medical Waste Autoclave	PL 93-638 Agreement	Program Enhancement
AK	Metlakatla	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	AISU-MIC - Service Unit HVAC System Modifications	PL 93-638 Agreement	CI Improvement
AK	Metlakatla	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	AISU-MIC - Service Unit, Oxygen Storage, Correct Cement Flooring	PL 93-638 Agreement	Fire-Life Safety
AK	Seldovia	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	SVT - Health Center Dental Clinic Renovation	PL 93-638 Agreement	Program Enhancement
AK	Sitka	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	SEARHC - Hospital Roof Repair and Replacement	PL 93-638 Agreement	CI Improvement
AK	Sitka	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	SEARHC - Replace Hospital Exterior Insulation and Install Energy Efficient Windows	PL 93-638 Agreement	Energy
AK	St. Paul	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	APIA - Health Center Mechanical and Electrical Repairs	PL 93-638 Agreement	CI Improvement
AK	St. Paul	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	APIA - Repair/Replace Roof Deficiencies at Health Center	PL 93-638 Agreement	CI Improvement
AK	Tanana	Alaska Native Tribal Health Consortium	Facility Maintenance & Improvement	TTC - Replace Health Center Exterior Insulation to reduce energy costs	PL 93-638 Agreement	Energy
AK	Nome	Norton Sound Health Corporation	Hospital Replacement Construction	State-of-the-Art Hospital in Nome AK	Federal Contract/PL 93-638 Agreement	New Hospital
AK	ANGOON	ANGOON COMMUNITY ASSOCIATION, AK	Water and Sanitation Facilities	Angoon WTP SWTR Upgrades	Tribal Agreement	128 homes served
AK	ATKA	ATKA, NATIVE VILLAGE OF ATKA, AK	Water and Sanitation Facilities	Atka - Water Treatment Plant	Tribal Agreement	31 homes served
AK	BUCKLAND	BUCKLAND, NATIVE VILLAGE OF BUCKLAND, AK	Water and Sanitation Facilities	Buckland Lift Station, Sewer & Forcemain	Tribal Agreement	105 homes served
AK	CHIGNIK	CHIGNIK, NATIVE VILLAGE OF CHIGNIK, AK	Water and Sanitation Facilities	Chignik Water and Sewer	Tribal Agreement	23 homes served
AK	CHUATHBALUK	CHUATHBALUK, VILLAGE OF CHUATHBALUK, AK	Water and Sanitation Facilities	CHUATHBALUK - Piped W&S & LS Work	Tribal Agreement	27 homes served
AK	DEERING	DEERING, NATIVE VILLAGE OF DEERING, AK	Water and Sanitation Facilities	Deering - Raw Water Transmission Main	Tribal Agreement	45 homes served
AK	FORT YUKON	FORT YUKON, NATIVE VILLAGE OF FORT YUKON, AK	Water and Sanitation Facilities	FT YUKON Water and Sewer	Tribal Agreement	82 homes served
AK	GAMBELL	GAMBELL, NATIVE VILLAGE OF GAMBELL, AK	Water and Sanitation Facilities	Gambell - WTP Upgrade	Tribal Agreement	163 homes served
AK	GOODNEWS BAY	GOODNEWS BAY, NATIVE VILLAGE OF GOODNEWS BAY, AK	Water and Sanitation Facilities	Goodnews Bay Water and Sewer	Tribal Agreement	68 homes served
AK	GULKANA	AHTNA, INC., AK	Water and Sanitation Facilities	Gulkana Community Lagoon	Tribal Agreement	31 homes served
AK	HOONAH	HOONAH INDIAN ASSOCIATION, AK	Water and Sanitation Facilities	Hoonah - WTP Upgrade / Water Mains	Tribal Agreement	95 homes served
AK	HOOPER BAY	HOOPER BAY, NATIVE VILLAGE OF HOOPER BAY, AK	Water and Sanitation Facilities	Hooper Bay Booster/Vac Building	Tribal Agreement	244 homes served
AK	HUGHES	HUGHES VILLAGE, AK	Water and Sanitation Facilities	Hughes - Sewer & Water	Tribal Agreement	23 homes served
AK	HUSLIA	HUSLIA VILLAGE, AK	Water and Sanitation Facilities	Huslia - Water Main & Services/ Garage	Tribal Agreement	63 homes served

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
AK	KAKE	KAKE, ORGANIZED VILLAGE OF KAKE, AK	Water and Sanitation Facilities	Kake - WTP SWTR Upgrades	Tribal Agreement	222 homes served
AK	KASIGLUK	KASIGLUK, NATIVE VILLAGE OF KASIGLUK, AK	Water and Sanitation Facilities	KASIGLUK WTP, WST, and lagoon	Tribal Agreement	62 homes served
AK	KIPNUK	KIPNUK, NATIVE VILLAGE OF KIPNUK, AK	Water and Sanitation Facilities	Kipnuk WTP, Washeteria, raw water	Tribal Agreement	132 homes served
AK	KIPNUK	KIPNUK, NATIVE VILLAGE OF KIPNUK, AK	Water and Sanitation Facilities	KIPNUK Wastewater System	Tribal Agreement	132 homes served
AK	KIVALINA	KIVALINA, NATIVE VILLAGE OF KIVALINA, AK	Water and Sanitation Facilities	Kivalina - WWTP Completion	Tribal Agreement	55 homes served
AK	KONGIGANAK	KONGIGANAK NATIVE VILLAGE, AK	Water and Sanitation Facilities	Kongiganak - Phase I, Sewer Mains, LS &	Tribal Agreement	38 homes served
AK	KWIGILLINGOK	KWIGILLINGOK, NATIVE VILLAGE OF KWIGILLINGOK, AK	Water and Sanitation Facilities	KWIGILLINGOK - Water Core Facilities	Tribal Agreement	84 homes served
AK	KWIGILLINGOK	KWIGILLINGOK, NATIVE VILLAGE OF KWIGILLINGOK, AK	Water and Sanitation Facilities	KWIGILLINGOK - Reservoir	Tribal Agreement	84 homes served
AK	NEW STUYAHOK	NEW STUYAHOK VILLAGE, AK	Water and Sanitation Facilities	New Stuyhaok - Lagoon Completion	Tribal Agreement	90 homes served
AK	NULATO	NULATO VILLAGE, AK	Water and Sanitation Facilities	Nulato - WTP Upgrades, Lift Station Impr	Tribal Agreement	78 homes served
AK	PORT LIONS	PORT LIONS, NATIVE VILLAGE OF PORT LIONS, AK	Water and Sanitation Facilities	Port Lions Lift Station & Force Main	Tribal Agreement	25 homes served
AK	QUINHAGAK	KWINHAGAK, NATIVE VILLAGE OF KWINHAGAK (aka QUINHAGAK), AK	Water and Sanitation Facilities	QUINHAGAK - Service Area 3 Mains	Tribal Agreement	28 homes served
AK	QUINHAGAK	KWINHAGAK, NATIVE VILLAGE OF KWINHAGAK (aka QUINHAGAK), AK	Water and Sanitation Facilities	Quinhagak - WTP Upgrades/Water Storage T	Tribal Agreement	111 homes served
AK	SCAMMON BAY	SCAMMON BAY, NATIVE VILLAGE OF SCAMMON BAY, AK	Water and Sanitation Facilities	Scammon Bay Wastewater Project	Tribal Agreement	94 homes served
AK	ST.MICHAEL	ST. MICHAEL, NATIVE VILLAGE OF ST. MICHAEL, AK	Water and Sanitation Facilities	St. Michael - Water Treatment Plant	Tribal Agreement	75 homes served
AK	ST.PAUL	ALEUTIAN PRIBLOF	Water and Sanitation Facilities	St Paul - South Old Town Sewer Supp	Tribal Agreement	53 homes served
AK	STATE WIDE	Unspecified	Water and Sanitation Facilities	Statewide Energy Diminution	Tribal Agreement	1000 homes served
AK	STEBBINS	STEBBINS COMMUNITY ASSOCIATION, AK	Water and Sanitation Facilities	Stebbins Washeteria Improvements	Tribal Agreement	113 homes served
AK	STEVENS VILL	STEVENS, NATIVE VILLAGE OF STEVENS, AK	Water and Sanitation Facilities	Stevens Village -LAGOON-LIFT STN & FORCE	Tribal Agreement	23 homes served
AK	TULUKSAK	TULUKSAK NATIVE COMMUNITY, AK	Water and Sanitation Facilities	Tuluksak - Basic Sewer Infrastructure	Tribal Agreement	59 homes served
AL	ATMORE	POARCH BAND OF CREEK INDIANS OF ALABAMA	Water and Sanitation Facilities	CREE - Wastewater Treatment Plant	Tribal Agreement	187 homes served
AZ	Kykotsmovi	Hopi Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
AZ	Kykotsmovi	Hopi Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
AZ	Kykotsmovi	Hopi Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
AZ	Maricopa	AK-CHIN INDIAN COMMUNITY	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
AZ	Maricopa	AK-CHIN INDIAN COMMUNITY	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
AZ	Peach Springs	Hualapai Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
AZ	San Carlos	San Carlos Apache Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
AZ	San Carlos	San Carlos Apache Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
AZ	Whiteriver	White Mountain Apache	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
AZ	Whiteriver	White Mountain Apache	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
AZ	Whiteriver	White Mountain Apache	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
AZ	Whiteriver	WHITE MOUNTAIN APACHE	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
AZ	Hopi	Hopi Tribe	Equipment – Hospital CT Scanner	Replacement CT scanner	Federal Contact-New	Computed Tomography (CT) Scanner
AZ	Sells	Tohono O'odham Nation	Equipment – Hospital CT Scanner	New CT scanner	Federal Contact-New	Computed Tomography (CT) Scanner

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
AZ	Chinle	Navajo Nation	Equipment - Medical Various	Pateint Monitors and Gas monitors	Federal Contact-New	Pateint Monitors and Gas monitors
AZ	Fort Defiance	Navajo Nation	Equipment - Medical Various	Fetal Monitors	Federal Contact-New	Fetal Monitors
AZ	Ganado	Navajo Nation	Equipment - Medical Various	Patient Monitor System	Federal Contact-New	Patient Monitor System
AZ	Inscription House	Navajo Nation	Equipment - Medical Various	Defibrillators (2)	Federal Contact-New	Defibrillators (2)
AZ	Phoenix	Multiple Tribes	Equipment - Medical Various	Large Steam Sterilizer	Federal Contact-New	Large Steam Sterilizer
AZ	Phoenix	Multiple Tribes	Equipment - Medical Various	Small Steam Sterilizer	Federal Contact-New	Small Steam Sterilizer
AZ	San Simon	Tohono O'odham Nation	Equipment - Medical Various	Visual Field Analyzer	Federal Contact-New	Visual Field Analyzer
AZ	San Xavier	Tohono O'odham Nation	Equipment - Medical Various	Film Digitizer	Federal Contact-New	Film Digitizer
AZ	San Xavier	Tohono O'odham Nation	Equipment - Medical Various	Tabletop Laser Imager	Federal Contact-New	Tabletop Laser Imager
AZ	Santa Rosa	Tohono O'odham Nation	Equipment - Medical Various	Optometry Eye Lane Equipment	Federal Contact-New	Optometry Eye Lane Equipment
AZ	Tuba City	Navajo Nation Tuba City Regional Health Care Corp	Equipment - Medical Various	Bariatric Bed	PL 93-638 Agreement	Bariatric Bed
AZ	Tuba City	Navajo Nation Tuba City Regional Health Care Corp	Equipment - Medical Various	Holter Monitor	PL 93-638 Agreement	Holter Monitor
AZ	Tuba City	Navajo Nation Tuba City Regional Health Care Corp	Equipment - Medical Various	Ultrasound Unit	PL 93-638 Agreement	Ultrasound Unit
AZ	Whiteriver	White Mountain Apache Tribe Of The Fort Apache Indian Reservation, Arizona	Equipment - Medical Various	Digital X-Ray Unit	Federal Contact-New	Digital X-Ray Unit
AZ	Window Rock	Navajo Tribe Of Arizona, New Mexico And Utah	Equipment - Medical Various	Defibrillators (6)	Federal Contact-New	Defibrillators (6)
AZ	Winslow	Navajo Nation Winslow Health Care Corp	Equipment - Medical Various	Ultrsound Unit	PL 93-638 Agreement	Ultrsound Unit
AZ	Winslow	Navajo Nation Winslow Health Care Corp	Equipment - Medical Various	Ultrsound Unit	PL 93-638 Agreement	Ultrsound Unit
AZ	Chinle	Navajo Nation	Facility Maintenance & Improvement	Chinle Quarters Roof Replacement Phase II	Federal Contact-New	CI Improvement
AZ	Chinle	Navajo Nation	Facility Maintenance & Improvement	Chinle Adolescent Treatment Center	Federal Contact-New	CI Improvement
AZ	Chinle	Navajo Nation	Facility Maintenance & Improvement	Chinle Site Drainage	Federal Contact-New	CI Improvement
AZ	Chinle	Navajo Nation	Facility Maintenance & Improvement	Repair by Replacement Chinle CHR	Federal Contact-New	CI Improvement
AZ	Crownpoint	Navajo Nation	Facility Maintenance & Improvement	Crownpoint Adolescent Treatment Center Roof and Exterior Repairs	Federal Contact-New	CI Improvement
AZ	Dennehotso	Navajo Nation	Facility Maintenance & Improvement	Repair by Replacement Dennehotso CHR	Federal Contact-New	CI Improvement
AZ	Dilkon	Navajo Nation	Facility Maintenance & Improvement	Repair by Replacement Dilkon CHR	Federal Contact-New	CI Improvement
AZ	Fort Defiance	Navajo Nation	Facility Maintenance & Improvement	Fort Defiance CHR Maintenance & Improvement	Federal Contact-New	CI Improvement
AZ	Fort McDowell	Fort McDowell Tribe	Facility Maintenance & Improvement	Energy Conservation/Sustainability Upgrade Wassaja Memorial Health Clinic	PL 93-638 Agreement	Energy
AZ	Greasewood	Navajo Nation	Facility Maintenance & Improvement	Greasewood Clinic Repairs	Federal Contact-New	CI Improvement
AZ	Kayenta	Navajo Nation	Facility Maintenance & Improvement	Kayenta Outpatient Treatment Center Interior & Exterior Repairs	Federal Contact-New	CI Improvement
AZ	Keams Canyon	Hopi Tribe	Facility Maintenance & Improvement	Water Main Replacement at KC IHS Housing Compound	Federal Contact-New	Fire-Life Safety

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
AZ	Many Farms	Navajo Nation	Facility Maintenance & Improvement	Dental Clinic Repair by Replacement	Federal Contact-New	Program Enhancement
AZ	Page	Navajo Nation	Facility Maintenance & Improvement	Page Adolescent Treatment Center Repairs	Federal Contact-New	CI Improvement
AZ	Pascua	Pascua Yaqui Tribe	Facility Maintenance & Improvement	Yaqui Pharmacy	PL 93-638 Agreement	Program Enhancement
AZ	Peach Springs	Hualapai Tribe	Facility Maintenance & Improvement	Clinic and Maintenance Building Roof Replacement	Federal Contact-New	CI Improvement
AZ	Phoenix	Multiple Tribes	Facility Maintenance & Improvement	Boiler #1 Replacement	Federal Contact-New	CI Improvement
AZ	Phoenix	Multiple Tribes	Facility Maintenance & Improvement	Replace/Upgrade Seven Packaged A/C Units (WC, Spec Svcs, Bldg 4)	Federal Contact-New	CI Improvement
AZ	Phoenix	Multiple Tribes	Facility Maintenance & Improvement	Cooling Tower Replacement	Federal Contact-New	CI Improvement
AZ	Phoenix	Multiple Tribes	Facility Maintenance & Improvement	South Campus Pavement Replacement	Federal Contact-New	CI Improvement
AZ	Phoenix	Multiple Tribes	Facility Maintenance & Improvement	PIMC Electrical Upgrades	Federal Contact-New	CI Improvement
AZ	Phoenix	Multiple Tribes	Facility Maintenance & Improvement	Replace Air Handling Units on Hospital	Federal Contact-New	CI Improvement
AZ	Phoenix	Multiple Tribes	Facility Maintenance & Improvement	Emergency Department Renovation	Federal Contact-New	Program Enhancement
AZ	Phoenix	Multiple Tribes	Facility Maintenance & Improvement	Emergency Generator Addition	Federal Contact-New	Program Enhancement
AZ	Phoenix	Multiple Tribes	Facility Maintenance & Improvement	Access Control Upgrades	Federal Contact-New	Security
AZ	Sacaton	Gila River Indian Community	Facility Maintenance & Improvement	Desert Visions HVAC Units Replacement	Federal Contact-New	Energy
AZ	Sacaton	Gila River Indian Community	Facility Maintenance & Improvement	GRHC - Hu Hu Kam Hospital Chiller Replacement	PL 93-638 Agreement	CI Improvement
AZ	Sacaton	Gila River Indian Community	Facility Maintenance & Improvement	GRHC - Fire Alarm Upgrades	PL 93-638 Agreement	Fire-Life Safety
AZ	Sacaton	Gila River Indian Community	Facility Maintenance & Improvement	GRHC- Upgrade Fire Protection Water Pressure	PL 93-638 Agreement	Fire-Life Safety
AZ	San Xavier	Tohono O'odham Nation	Facility Maintenance & Improvement	San Xavier Xeriscape and Drainage	Federal Contact-New	Sustainability
AZ	Sells	Tohono O'odham Nation	Facility Maintenance & Improvement	Sells Interior Waterline	Federal Contact-New	CI Improvement
AZ	Sells	Tohono O'odham Nation	Facility Maintenance & Improvement	Tohono O'odham Nation Department Health Roof Replacement	Federal Contact-New	CI Improvement
AZ	Sells	Tohono O'odham Nation	Facility Maintenance & Improvement	Sells HVAC	Federal Contact-New	Energy
AZ	Sells	Tohono O'odham Nation	Facility Maintenance & Improvement	Sells Main Entrance and Waiting Room Renovation	Federal Contact-New	Program Enhancement
AZ	Sells	Tohono O'odham Nation	Facility Maintenance & Improvement	Sells Signage	Federal Contact-New	Program Enhancement
AZ	Sells	Tohono O'odham Nation	Facility Maintenance & Improvement	Sells CT Building	Federal Contact-New	Program Enhancement

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
AZ	Tohatchi	Navajo Nation	Facility Maintenance & Improvement	Tohatchi Roof Replacement	Federal Contact-New	CI Improvement
AZ	Tuba City	Navajo Nation Tuba City Regional Health Care Corp	Facility Maintenance & Improvement	Repair by Replacement Tuba City Outpatient Treatment Center	Federal Contact-New	CI Improvement
AZ	Tuba City	Navajo Nation Tuba City Regional Health Care Corp	Facility Maintenance & Improvement	Repair by Replacement Tuba City CHR	Federal Contact-New	CI Improvement
AZ	Tuba City	Navajo Nation Tuba City Regional Health Care Corp	Facility Maintenance & Improvement	Tuba City Electrical Repairs	PL 93-638 Agreement	CI Improvement
AZ	Tuba City	Navajo Nation Tuba City Regional Health Care Corp	Facility Maintenance & Improvement	Tuba City Fire Alarm Replacement	PL 93-638 Agreement	Fire-Life Safety
AZ	Whiteriver	White Mountain Apache Tribe Of The Fort Apache Indian Reservation, Arizona	Facility Maintenance & Improvement	Boiler Replacement	Federal Contact-New	CI Improvement
AZ	Whiteriver	White Mountain Apache Tribe Of The Fort Apache Indian Reservation, Arizona	Facility Maintenance & Improvement	Water Main to Modular Office Buildings	Federal Contact-New	Fire-Life Safety
AZ	Whiteriver	White Mountain Apache Tribe Of The Fort Apache Indian Reservation, Arizona	Facility Maintenance & Improvement	Hospital Signage	Federal Contact-New	Program Enhancement
AZ	Winslow	Navajo Nation Winslow Health Care Corp	Facility Maintenance & Improvement	Winslow Laboratory Repair by Replacement	PL 93-638 Agreement	CI Improvement
AZ	Yuma	Cocpah and Quecehan Tribes	Facility Maintenance & Improvement	Boiler Replacement	Federal Contact-New	CI Improvement
AZ	7-MILE WASH	SAN CARLOS APACHE TRIBE OF THE SAN CARLOS RESERVATION OF ARIZONA	Water and Sanitation Facilities	7 Mile Lift Station Replacement	Tribal Agreement	120 homes served
AZ	AK CHIN	AK CHIN INDIAN COMM. OF PAPAGO INDIANS OF MARICOPA, AK CHIN RESERVATION, AZ	Water and Sanitation Facilities	Greasewood Grinder Pump Replacement	Tribal Agreement	126 homes served
AZ	BACABI	HOPI TRIBE OF ARIZONA	Water and Sanitation Facilities	Bacavi Scattered & Plumbing (W)	Tribal Agreement	12 homes served
AZ	BACABI	HOPI TRIBE OF ARIZONA	Water and Sanitation Facilities	Bacavi Scattered & Plumbing (S)	Tribal Agreement	12 homes served
AZ	BYLAS	SAN CARLOS APACHE TRIBE OF THE SAN CARLOS RESERVATION OF ARIZONA	Water and Sanitation Facilities	Bylas-WWTF Lagoon Revetment	Tribal Agreement	479 homes served
AZ	CARRIZO	WHITE MOUNTAIN APACHE TRIBE OF THE FORT APACHE INDIAN RESERVATION, ARIZONA	Water and Sanitation Facilities	CARRIZO - GWUDI Study	Tribal Agreement	32 homes served
AZ	CASA BLANCA	GILA RIVER PIMA MARICOPA IND COMM OF THE GILA RIVER INDIAN RES. OF ARIZONA	Water and Sanitation Facilities	GRIC Casa Blanca Storage Tank/wmain	Tribal Agreement	540 homes served
AZ	CHILCHINBETO	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Chilch. Well Power and WL Upgrades	Tribal Agreement	403 homes served
AZ	CHINLE	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Chinle S. U. Failed Drainfields	Tribal Agreement	63 homes served
AZ	CHINLE	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Ventana Mesa Waterline D18/Q48	Tribal Agreement	55 homes served
AZ	CHUICHU	TOHONO O'ODHAM NATION,AZ	Water and Sanitation Facilities	2009 Open Dump Closures	Tribal Agreement	259 homes served
AZ	CHUICHU	TOHONO O'ODHAM NATION,AZ	Water and Sanitation Facilities	CHUICHU - Well Development	Tribal Agreement	104 homes served
AZ	COPPERMINE	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Coppermine Porcupine Mesa P89	Tribal Agreement	61 homes served
AZ	COTTONWOOD	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Cottonwood East Q23	Tribal Agreement	48 homes served
AZ	COVE	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Cove Waterline Blending Y04	Tribal Agreement	221 homes served

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
AZ	DILKON	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	WINSLOW SU DRAINFIELD REPLACEMENT	Tribal Agreement	97 homes served
AZ	FT.DEFIANCE	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Ft Def. Failed Drainfields Stimulus	Tribal Agreement	56 homes served
AZ	FT.MCDOWELL	FT. MCDOWELL MOHAVE-APACHE IND COMM, FT MCDOWELL INDIAN RESERVATION	Water and Sanitation Facilities	Fort McDowell Solid Waste Phase II	Tribal Agreement	375 homes served
AZ	GUNSIGHT	TOHONO O'ODHAM NATION,AZ	Water and Sanitation Facilities	Gunsight Water Supplemental	Tribal Agreement	20 homes served
AZ	JEDDITO	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Jeddito Member Extension N41	Tribal Agreement	49 homes served
AZ	KAYENTA-ARIZ	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Kayenta Lagoon Sludge Removal	Tribal Agreement	967 homes served
AZ	KAYENTA-ARIZ	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Kayenta Lagoon Dechlorination	Tribal Agreement	967 homes served
AZ	KAYENTA-ARIZ	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Kayenta Tank	Tribal Agreement	148 homes served
AZ	KEAMS CANYON	HOPI TRIBE OF ARIZONA	Water and Sanitation Facilities	Spider Mound NTUA Connection	Tribal Agreement	28 homes served
AZ	LA PAZ-CO	CO RIVER IND. TRIBES OF THE CO RIVER IND. RES., AZ AND CA	Water and Sanitation Facilities	CRIT Old Parker Dump Close - Study	Tribal Agreement	1850 homes served
AZ	MANY FARMS	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Many Farm Septic Replacement	Tribal Agreement	32 homes served
AZ	MIDDLE VERDE	YAVAPAI-APACHE IND COMM, AZ	Water and Sanitation Facilities	Middle Verde Arsenic Treatment	Tribal Agreement	161 homes served
AZ	NAVAJO MT-A	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Navajo Mountain Phase I	Tribal Agreement	247 homes served
AZ	PEACH SPRGS	HUALAPAI TRIBE OF THE HUALAPAI INDIAN RESERVATION, ARIZONA	Water and Sanitation Facilities	Grand Canyon West Solar Pump	Tribal Agreement	75 homes served
AZ	PERIDOT HGTS	SAN CARLOS APACHE TRIBE OF THE SAN CARLOS RESERVATION OF ARIZONA	Water and Sanitation Facilities	SCAT Region Water Sys Improvement	Tribal Agreement	1055 homes served
AZ	POLACCA	HOPI TRIBE OF ARIZONA	Water and Sanitation Facilities	North Sewage Lagoon Wash	Tribal Agreement	100 homes served
AZ	ROCK POINT	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	ROCK PT. NORTH PHASE 2 P83	Tribal Agreement	88 homes served
AZ	ROUND ROCK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Round Rock SW Waterline Q28	Tribal Agreement	38 homes served
AZ	SALT RIVER	SALT RIVER PIMA-MARICOPA IND. COMM., OF THE SALT RIVER RESERVATION, ARIZONA	Water and Sanitation Facilities	SALT RIVER WATER MAIN EXTENSION	Tribal Agreement	683 homes served
AZ	SAN LUCY VIL	TOHONO O'ODHAM NATION,AZ	Water and Sanitation Facilities	SAN LUCY VIL - Water Sys	Tribal Agreement	94 homes served
AZ	SANTA ROSA	TOHONO O'ODHAM NATION,AZ	Water and Sanitation Facilities	Test Well Drilling Supplemental	Tribal Agreement	293 homes served
AZ	SANTA ROSA R	TOHONO O'ODHAM NATION,AZ	Water and Sanitation Facilities	Santa Rosa Ranch - Community Sewer	Tribal Agreement	49 homes served
AZ	SAWMILL	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	SAWMILL NE WL EXT P79	Tribal Agreement	57 homes served
AZ	SELLS	TOHONO O'ODHAM NATION,AZ	Water and Sanitation Facilities	Sells LS Replacement Supplemental	Tribal Agreement	123 homes served
AZ	SHUNGOPOVI	HOPI TRIBE OF ARIZONA	Water and Sanitation Facilities	Shungopavi Lagoon Expansion	Tribal Agreement	48 homes served
AZ	SHUNGOPOVI	HOPI TRIBE OF ARIZONA	Water and Sanitation Facilities	Shungopavi Water Project Shortfall	Tribal Agreement	225 homes served
AZ	SIKUL HIMATK	TOHONO O'ODHAM NATION,AZ	Water and Sanitation Facilities	SIKUL HIMATK WATER EXTENSION	Tribal Agreement	10 homes served
AZ	ST.MICHAELS	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	St. Michaels Summit Ph. 1 P80	Tribal Agreement	48 homes served

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
AZ	SUPAI	HAVASUPAI TRIBE OF THE HAVASUPAI RESERVATION, ARIZONA	Water and Sanitation Facilities	Supai - Dump Cover	Tribal Agreement	122 homes served
AZ	SWEETWATER	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Shiprock to Sweetwater Phase 1	Tribal Agreement	1958 homes served
AZ	SWEETWATER	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Shiprock to Sweetwater Phase 2	Tribal Agreement	1958 homes served
AZ	TUBA CITY	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	TUBA CITY - DRAINFIELD REPLACEMENT	Tribal Agreement	54 homes served
AZ	TUBA CITY	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	TUBA CITY - LAGOON LINER	Tribal Agreement	1290 homes served
AZ	WHITERIVER	WHITE MOUNTAIN APACHE TRIBE OF THE FORT APACHE INDIAN RESERVATION, ARIZONA	Water and Sanitation Facilities	WHITERIVER - Alchesay Flat SM Ext.	Tribal Agreement	35 homes served
AZ	WHITERIVER	WHITE MOUNTAIN APACHE TRIBE OF THE FORT APACHE INDIAN RESERVATION, ARIZONA	Water and Sanitation Facilities	WMAT SWTP EPA Core Shortfall	Tribal Agreement	1667 homes served
AZ	WHITERIVER	WHITE MOUNTAIN APACHE TRIBE OF THE FORT APACHE INDIAN RESERVATION, ARIZONA	Water and Sanitation Facilities	WHITERIVER - 7 Mile Lagoon Abandon.	Tribal Agreement	35 homes served
AZ	WIDE RUINS	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Wide Ruins South Ph 1 P81	Tribal Agreement	48 homes served
CA	Hoopa	Hoopa Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
CA	Hoopa	Hoopa Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
CA	Hoopa	Hoopa Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
CA	Alpine, Campo	Southern Indian Health Council, Inc.	Equipment - Medical Various	Bone Dexa Scanner for osteoporosis scanning	PL 93-638 Agreement	Bone Dexa Scanner for osteoporosis scanning
CA	Arcata	California Rural Indian Health Board	Equipment - Medical Various	ScanX ILE Digital Phosphor Developer and digital x-ray sensor assembly	PL 93-638 Agreement	ScanX ILE Digital Phosphor Developer and digital x-ray sensor assembly
CA	Auburn	Chapa De Indian Health Program, Inc.	Equipment - Medical Various	Chair delivery system dental Operatory Suite	PL 93-638 Agreement	Chair delivery system dental Operatory Suite
CA	Banning	Riverside/San Bernardino Indian Health	Equipment - Medical Various	Ultra Sound	PL 93-638 Agreement	Ultra Sound
CA	Burney	Pit River Health Services, Inc	Equipment - Medical Various	Dental Chair Delivery System	PL 93-638 Agreement	Dental Chair Delivery System
CA	Clovis	Central Valley Indian Health, Inc	Equipment - Medical Various	Digital Diagnostic Dental X-ray equipment	PL 93-638 Agreement	Digital Diagnostic Dental X-ray equipment
CA	Covelo	Round Valley Indian Health Center, Inc.	Equipment - Medical Various	LifePack AED	PL 93-638 Agreement	LifePack AED
CA	El Cajon	Sycuan Band of Mission Indians	Equipment - Medical Various	Pharmacy dispensing machine	PL 93-638 Agreement	Pharmacy dispensing machine
CA	Ft. Bidwell	California Rural Indian Health Board	Equipment - Medical Various	Crash Cart	PL 93-638 Agreement	Crash Cart
CA	Ft. Jones	Quarts Valley Indian Reservation	Equipment - Medical Various	Dental Vacuum/air	PL 93-638 Agreement	Dental Vacuum/air
CA	Greenville	Greenville Rancheria Clinic	Equipment - Medical Various	Digital Diagnostic Dental X-ray equipment	PL 93-638 Agreement	Digital Diagnostic Dental X-ray equipment
CA	Hoopa	Hoopa Valley Tribe	Equipment - Medical Various	Laboratory equipment Vitros 250	PL 93-638 Agreement	Laboratory equipment Vitros 250
CA	Lone Pine	Toiyabe Indian Health Project, Inc	Equipment - Medical Various	Dental X-Ray Machine	PL 93-638 Agreement	Dental X-Ray Machine
CA	Mariposa	California Rural Indian Health Board	Equipment - Medical Various	Crash Cart	PL 93-638 Agreement	Crash Cart
CA	Oroville	Feather River Tribal Health, Inc.	Equipment - Medical Various	Digital Dental Panorex Machine	PL 93-638 Agreement	Digital Dental Panorex Machine
CA	Oroville	Feather River Tribal Health, Inc.	Equipment - Medical Various	Pharmacy automation machine	PL 93-638 Agreement	Pharmacy automation machine
CA	Pauma Valley	Indian Health Council, Inc	Equipment - Medical Various	Automated Tablet/Capsule Counting Machine	PL 93-638 Agreement	Automated Tablet/Capsule Counting Machine

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
CA	Pauma Valley	Indian Health Council, Inc	Equipment - Medical Various	Portable Ultra Sound Imaging System	PL 93-638 Agreement	Portable Ultra Sound Imaging System
CA	Pauma Valley	Indian Health Council, Inc.	Equipment - Medical Various	Dental Vacuum/air	PL 93-638 Agreement	Dental Vacuum/air
CA	Porterville	California Rural Indian Health Board	Equipment - Medical Various	Crash Cart	PL 93-638 Agreement	Crash Cart
CA	Redding	Redding Rancheria Indian Health Clinic	Equipment - Medical Various	Bladder Scanner	PL 93-638 Agreement	Bladder Scanner
CA	Redwood Valley	Consolidated Tribal Health Project, Inc.	Equipment - Medical Various	Chair delivery system dental Operatory Suite	PL 93-638 Agreement	Chair delivery system dental Operatory Suite
CA	Santa Rosa	California Rural Indian Health Board	Equipment - Medical Various	Crash Cart	PL 93-638 Agreement	Crash Cart
CA	Santa Rosa	California Rural Indian Health Board	Equipment - Medical Various	Podiatry/OB Chair	PL 93-638 Agreement	Podiatry/OB Chair
CA	Santa Rosa	California Rural Indian Health Board	Equipment - Medical Various	Powered Bariatric multi position exam table	PL 93-638 Agreement	Powered Bariatric multi position exam table
CA	Santa Ynez	Santa Ynez Band of Mission Indians	Equipment - Medical Various	Dermatology table	PL 93-638 Agreement	Dermatology table
CA	Shingle Springs	California Rural Indian Health Board	Equipment - Medical Various	Crash Cart	PL 93-638 Agreement	Crash Cart
CA	Susanville	Susanville Indian Rancheria	Equipment - Medical Various	Dental Vacuum/air	PL 93-638 Agreement	Dental Vacuum/air
CA	Tuolumne	Tuolumne Me-Wuk Indian Health Center	Equipment - Medical Various	Portable Ultrasound Equipment	PL 93-638 Agreement	Portable Ultrasound Equipment
CA	Willows	Northern Valley Indian Health, Inc	Equipment - Medical Various	Digital Panoramic X-Ray	PL 93-638 Agreement	Digital Panoramic X-Ray
CA	Winterhaven	Cocpah and Quecehan Tribes	Equipment - Medical Various	Ultrasound	Federal Contact-New	Ultrasound
CA	Alpine	Southern Indian Health Council, Inc.	Facility Maintenance & Improvement	Repaving	PL 93-638 Agreement	CI Improvement
CA	Alturas	Modoc Indian Health Project, Inc.	Facility Maintenance & Improvement	Paving Repair	PL 93-638 Agreement	CI Improvement
CA	Arcata	California Rural Indian Health Board	Facility Maintenance & Improvement	Solar PV	PL 93-638 Agreement	Energy
CA	Auburn	Chapa-de Indian Health Program, Inc.	Facility Maintenance & Improvement	Lighting and HVAC Upgrade	PL 93-638 Agreement	Energy
CA	Banning	Riverside/San Bernardino Indian Health	Facility Maintenance & Improvement	Energy Upgrades	PL 93-638 Agreement	Energy
CA	Bishop	Toiyabe Indian Health Project, Inc.	Facility Maintenance & Improvement	HVAC Upgrade	PL 93-638 Agreement	CI Improvement
CA	Burney	Pit River Health Services, Inc.	Facility Maintenance & Improvement	Entrance Vestibule	PL 93-638 Agreement	CI Improvement
CA	Clovis, Lemoore	Central Valley Indian Health Project, Inc.	Facility Maintenance & Improvement	Archived Records Rm Conversion, Change Entrance Doors to automatic, Clinic Insulation, Window Replacement	PL 93-638 Agreement	Program Enhancement
CA	Colusa	Colusa Indian Health Community Council	Facility Maintenance & Improvement	Interior/exterior finishes	PL 93-638 Agreement	CI Improvement
CA	Covelo	Round Valley Indian Health Center, Inc.	Facility Maintenance & Improvement	Yuki Trails Solar - Phase 1	PL 93-638 Agreement	Energy
CA	El Cajon	Sycuan Band of Mission Indians	Facility Maintenance & Improvement	Interior Finishes	PL 93-638 Agreement	CI Improvement
CA	Fresno	Sierra Tribal Consortium	Facility Maintenance & Improvement	HVAC Upgrade	PL 93-638 Agreement	Energy
CA	Ft. Bidwell	California Rural Indian Health Board	Facility Maintenance & Improvement	Parking resurface	PL 93-638 Agreement	CI Improvement
CA	Ft. Jones	Quartz Valley Indian Reservation	Facility Maintenance & Improvement	Paving	PL 93-638 Agreement	CI Improvement

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
CA	Greenville, Red Bluff	Greenville Rancheria Clinic	Facility Maintenance & Improvement	Bldg Insulation, Exam Room Renovation, Bldg Shade Project, Bathroom Flooring, IT Rm Cooling, and Replace Base Boards	PL 93-638 Agreement	CI Improvement
CA	Happy Camp	Karuk Tribe of California	Facility Maintenance & Improvement	Generator and HVAC Upgrade	PL 93-638 Agreement	Program Enhancement
CA	Hoopa	Hoopa Valley Tribe, K'ima:w Medical Center	Facility Maintenance & Improvement	Interior Finishes	PL 93-638 Agreement	CI Improvement
CA	Lakeport	Lake County Tribal Health Consortium	Facility Maintenance & Improvement	Solar System	PL 93-638 Agreement	Energy
CA	Oroville	Feather River Tribal Health, Inc.	Facility Maintenance & Improvement	Emergency Generator	PL 93-638 Agreement	Program Enhancement
CA	Pauma Valley	Indian Health Council, Inc.	Facility Maintenance & Improvement	Solar PV	PL 93-638 Agreement	Energy
CA	Porterville	California Rural Indian Health Board	Facility Maintenance & Improvement	HVAC Upgrade	PL 93-638 Agreement	CI Improvement
CA	Porterville	California Rural Indian Health Board	Facility Maintenance & Improvement	Parking lot renovation	PL 93-638 Agreement	CI Improvement
CA	Redwood Valley	Consolidated Tribal Health Project, Inc.	Facility Maintenance & Improvement	HVAC Upgrade	PL 93-638 Agreement	Energy
CA	Santa Rosa	California Rural Indian Health Board	Facility Maintenance & Improvement	Solar power	PL 93-638 Agreement	Energy
CA	Santa Ynez	Santa Ynez Band of Mission Indians	Facility Maintenance & Improvement	Solar	PL 93-638 Agreement	Energy
CA	Sonora, Mariposa, and Jackson	California Rural Indian Health Board	Facility Maintenance & Improvement	HVAC Upgrade, alternative power generator,	PL 93-638 Agreement	Energy
CA	Susanville	Lassen Indian Health Center	Facility Maintenance & Improvement	Receptionist Area Remodel	PL 93-638 Agreement	Program Enhancement
CA	Tuolumne	Tuolumne Me-Wuk Indian Health Center	Facility Maintenance & Improvement	IT Rm Upgrade	PL 93-638 Agreement	Program Enhancement
CA	Willows	Northern Valley Indian Health, Inc.	Facility Maintenance & Improvement	Solar System	PL 93-638 Agreement	Energy
CA	AUB-BIG SAND	BIG SANDY RANCHERIA OF MONO INDIANS OF CALIFORNIA	Water and Sanitation Facilities	Big Sandy - Uranium Treatment	Tribal Agreement	35 homes served
CA	BIG VALLEY	BIG VALLEY RANCHERIA OF POMO & PIT RIVER INDIANS OF CALIFORNIA	Water and Sanitation Facilities	Big Valley-W & S Feasibility Study	Tribal Agreement	33 homes served
CA	BISHOP RESV.	PAIUTE-SHOSHONE INDIANS OF THE BISHOP COMM. OF THE BISHOP COLONY, CA	Water and Sanitation Facilities	Bishop Secondary Wells	Tribal Agreement	723 homes served
CA	BISHOP RESV.	PAIUTE-SHOSHONE INDIANS OF THE BISHOP COMM. OF THE BISHOP COLONY, CA	Water and Sanitation Facilities	Bishop Pa Me VFD	Tribal Agreement	723 homes served
CA	CAHUILLA RSV	CAHUILLA BAND OF MISSION INDIANS OF THE CAHUILLA RESERVATION, CALIFORNIA	Water and Sanitation Facilities	CAHUILLA Failed Septic System	Tribal Agreement	1 homes served
CA	CAMPO RESV.	CAMPO BAND OF DIEGUENO INDIANS OF THE CAMPO INDIAN RESERVATION, CALIFORNIA	Water and Sanitation Facilities	CAMPO Old System Uranium Project	Tribal Agreement	29 homes served
CA	CAPPEL CREEK	YUROK TRIBE OF THE YUROK RESERVATION, CA	Water and Sanitation Facilities	Ke'pel/Nochco Water Supp. ph2	Tribal Agreement	21 homes served

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CA	CAPPEL CREEK	YUROK TRIBE OF THE YUROK RESERVATION, CA	Water and Sanitation Facilities	Ke'Pel Water Treatment Monitoring	Tribal Agreement	26 homes served
CA	CHICO	MECHOOPDA INDIAN TRIBE OF CHICO RANCHERIA, CHICO, CALIFORNIA	Water and Sanitation Facilities	Chico Wastewater Upgrade (4-plex)	Tribal Agreement	4 homes served
CA	FORKS OT SAL	KARUK TRIBE OF CALIFORNIA	Water and Sanitation Facilities	FOS - Crapo Creek Indiv. Supp. ph2	Tribal Agreement	2 homes served
CA	GRINDSTONE	GRINDSTONE INDIAN RANCHERIA OF WINTUN-WAITAKI INDIANS OF CALIFORNIA	Water and Sanitation Facilities	Grindstone Sewer Laterals	Tribal Agreement	10 homes served
CA	HOOPA VALLEY	HOOPA VALLEY TRIBE OF THE HOOPA VALLEY R	Water and Sanitation Facilities	Hoopa Scattered Water and Sewer 09	Tribal Agreement	11 homes served
CA	IMPERIAL-CO	QUECHAN TRIBE OF THE FORT YUMA INDIAN RESERVATION, CALIFORNIA	Water and Sanitation Facilities	Sewer Line F - Quechan	Tribal Agreement	15 homes served
CA	IMPERIAL-CO	QUECHAN TRIBE OF THE FORT YUMA INDIAN RESERVATION, CALIFORNIA	Water and Sanitation Facilities	Yuma Lift Station Upgrade	Tribal Agreement	324 homes served
CA	KERN-CO	TULE RIVER INDIAN TRIBE OF THE TULE RIVER INDIAN RESERVATION, CALIFORNIA	Water and Sanitation Facilities	White Blanket PDA Ph. II	Tribal Agreement	8 homes served
CA	REDDING	REDDING RANCHERIA OF POMO INDIANS OF CALIFORNIA	Water and Sanitation Facilities	Redding Swr Extension-stimulus proj	Tribal Agreement	13 homes served
CA	REDWOOD VAL	REDWOOD VALLEY RANCHERIA OF POMO INDIANS OF CALIFORNIA	Water and Sanitation Facilities	Redwood Valley WWTS Improvements II	Tribal Agreement	32 homes served
CA	REQUA	YUROK TRIBE OF THE YUROK RESERVATION, CA	Water and Sanitation Facilities	REQUA-Water Sys Supp. ph2	Tribal Agreement	25 homes served
CA	REQUA	YUROK TRIBE OF THE YUROK RESERVATION, CA	Water and Sanitation Facilities	Requa Water Main Extension	Tribal Agreement	10 homes served
CA	ROUND VALLEY	COVELO INDIAN COMMUNITY OF THE ROUND VALLEY RESERVATION, CALIFORNIA	Water and Sanitation Facilities	Round Valley WWTF Expansion Ph II	Tribal Agreement	132 homes served
CA	SMITH RIVER	SMITH RIVER RANCHERIA OF CALIFORNIA	Water and Sanitation Facilities	Smith River Wtr Plant Imp Supp Ph2	Tribal Agreement	50 homes served
CA	TULE RIVER	TULE RIVER INDIAN TRIBE OF THE TULE RIVER INDIAN RESERVATION, CALIFORNIA	Water and Sanitation Facilities	Tule River WWTP	Tribal Agreement	268 homes served
CA	TULE RIVER	TULE RIVER INDIAN TRIBE OF THE TULE RIVER INDIAN RESERVATION, CALIFORNIA	Water and Sanitation Facilities	Tule River-Apple Vly Water Ph. II	Tribal Agreement	9 homes served
CA	WEITCHPEC	YUROK TRIBE OF THE YUROK RESERVATION, CA	Water and Sanitation Facilities	Yurok Water Monitor Imp Supp. ph2	Tribal Agreement	44 homes served
CO	TOWAOC UTE	UTE MOUNTAIN TRIBE OF THE UTE MOUNTAIN RESERVATION, CO, NM, & UTAH	Water and Sanitation Facilities	UMU Towaoc Lag. No. 1 Repair Ph II	Tribal Agreement	157 homes served
CO	TOWAOC UTE	UTE MOUNTAIN TRIBE OF THE UTE MOUNTAIN RESERVATION, CO, NM, & UTAH	Water and Sanitation Facilities	UMU Towaoc Lag No.2 Exp. PH II	Tribal Agreement	94 homes served
FL	MICCOUSUKEE	MICCOSUKEE TRIBE OF INDIANS OF FLORIDA	Water and Sanitation Facilities	MICC-LOOP ROAD WATER STORAGE TANK	Tribal Agreement	185 homes served
IA	SAC AND FOX	SAC AND FOX TRIBE OF THE MISSISSIPPI IN IOWA	Water and Sanitation Facilities	S&F-Spring Road Lift Station Repl.	Tribal Agreement	270 homes served
ID	Fort Hall	Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho	Equipment - Medical Various	Colposcope	Federal Contact-New	Colposcope
ID	Fort Hall	Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho	Equipment - Medical Various	Laboratory Analyzers - Hematology & Urine	Federal Contact-New	Laboratory Analyzers - Hematology & Urine
ID	Lapwai	Nez Perce Tribe of Idaho	Equipment - Medical Various	Examination; Table/Chair (3)	PL 93-638 Agreement	Examination; Table/Chair (3)
ID	Plummer	Coeur d'Alene Tribe of the Coeur d'Alene Reservation	Equipment - Medical Various	Diagnostic Equipment System (10)	PL 93-638 Agreement	Diagnostic Equipment System (10)

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
ID	Plummer	Coeur d'Alene Tribe of the Coeur d'Alene Reservation	Equipment - Medical Various	Upgrade Packages for X-ray CR System	PL 93-638 Agreement	Upgrade Packages for X-ray CR System
ID	Fort Hall	Multiple Tribes	Facility Maintenance & Improvement	Not-Tsoo Gah Nee Health Center Renovation	Federal Contact-New	Energy
ID	Fort Hall	Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho	Facility Maintenance & Improvement	Four Directions Treatment Center Heating System	PL 93-638 Agreement	Energy
ID	Fort Hall	Multiple Tribes	Facility Maintenance & Improvement	Not-Tsoo Gah Nee Health Center Facility Alterations to Accommodate Digital Radiography Unit	Federal Contact-New	Program Enhancement
ID	Plummer	Coeur d'Alene Tribe of the Coeur d'Alene Reservation, Idaho	Facility Maintenance & Improvement	Diabetes and Community Health Outreach Program Building Roof	PL 93-638 Agreement	CI Improvement
ID	Plummer	Coeur d'Alene Tribe of the Coeur d'Alene Reservation, Idaho	Facility Maintenance & Improvement	Benewah Medical Center Roof	PL 93-638 Agreement	CI Improvement
ID	Plummer	Coeur d'Alene Tribe of the Coeur d'Alene Reservation, Idaho	Facility Maintenance & Improvement	Benewah Medical Center HVAC Improvement	PL 93-638 Agreement	CI Improvement
ID	KAMIAH	NEZ PERCE TRIBE OF IDAHO, NEZ PERCE RESERVATION, IDAHO	Water and Sanitation Facilities	NEZ PERCE-KAMIAH WATER IMPROVE	Tribal Agreement	53 homes served
ID	LAPWAI	NEZ PERCE TRIBE OF IDAHO, NEZ PERCE RESERVATION, IDAHO	Water and Sanitation Facilities	Nez Perce - Lapwai Valley Sewer Int	Tribal Agreement	389 homes served
KS	Haskell	Prairie Band Pottawatomie, Kickapoo, Iowa, and Sac and Fox	Equipment - Medical Various	Coagulation Analyzer	Federal Contact-New	Coagulation Analyzer
KS	Haskell	Prairie Band Pottawatomie, Kickapoo, Iowa, and Sac and Fox	Equipment - Medical Various	Dental Fiber Optic Hnd Pcs	Federal Contact-New	Dental Fiber Optic Hnd Pcs
KS	Mayetta	Prairie Band Potawatomi Nation	Equipment - Medical Various	Dental Hnd Pcs	PL 93-638 Agreement	Dental Hnd Pcs
KS	Mayetta	Prairie Band Potawatomi Nation	Equipment - Medical Various	Ultrasound Probe Upgrade	PL 93-638 Agreement	Ultrasound Probe Upgrade
KS	White Cloud	Iowa Tribe Of Kansas And Nebraska	Equipment - Medical Various	EKG w/Cart	Federal Contact-New	EKG w/Cart
KS	Lawrence	Kickapoo Tribe In Kansas	Facility Maintenance & Improvement	Haskell IHC Flooring	Federal Contact-New	CI Improvement
KS	Mayetta	Prairie Band Potawatomi Nation	Facility Maintenance & Improvement	Drainage Remediation	PL 93-638 Agreement	CI Improvement
KS	BROWN-CO	IOWA TRIBE OF KANSAS AND NEBRASKA	Water and Sanitation Facilities	Iowa/Water System Improvements	Tribal Agreement	60 homes served
KS	BROWN-CO	KICKAPOO TRIBE IN KANSAS	Water and Sanitation Facilities	KICKAPOO KS / TANKS REHAB	Tribal Agreement	200 homes served
KS	BROWN-CO	KICKAPOO TRIBE IN KANSAS	Water and Sanitation Facilities	KS KICKAPOO DISTR. SYSTEM UPGRADE	Tribal Agreement	200 homes served
KS	BROWN-CO	KICKAPOO TRIBE IN KANSAS	Water and Sanitation Facilities	KICKAPOO KS / Valve&Hyd. Replace	Tribal Agreement	200 homes served
KS	BROWN-CO	KICKAPOO TRIBE IN KANSAS	Water and Sanitation Facilities	KS Kickapoo/ Weir Raise & Rehab	Tribal Agreement	200 homes served
KS	BROWN-CO	KICKAPOO TRIBE IN KANSAS	Water and Sanitation Facilities	KS Kickapoo/ K-20 Cell#1 Aerator	Tribal Agreement	125 homes served
KS	DONIPHAN-CO	IOWA TRIBE OF KANSAS AND NEBRASKA	Water and Sanitation Facilities	IOWA KS/ EAST WATER SYSTEM EXT.	Tribal Agreement	6 homes served
ME	PERRY	Passamaquoddy Tribe Pleasant Point	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
ME	Houlton	Houlton Band of Maliseet	Equipment - Medical Various	Exam tables (3)	PL 93-638 Agreement	Exam tables (3)
ME	Old Town	Penobscot Indian Nation	Equipment - Medical Various	Dental X-ray units	PL 93-638 Agreement	Dental X-ray units
ME	Old Town	Penobscot Indian Nation	Equipment - Medical Various	Dynomap monitors/Vital Signs Equip	PL 93-638 Agreement	Dynomap monitors/Vital Signs Equip
ME	Old Town	Penobscot Indian Nation	Equipment - Medical Various	Exam tables (3)	PL 93-638 Agreement	Exam tables (3)
ME	Presque Isle	Micmac (Aroostook Band)	Equipment - Medical Various	AFHCAN Cart Telemedicine Station	Federal Contact-New	AFHCAN Cart Telemedicine Station
ME	Princeton	Passamaquoddy Indian Township	Equipment - Medical Various	Replace dental operatories	PL 93-638 Agreement	Replace dental operatories

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
ME	Houlton	Houlton Band of Maliseet Indians	Facility Maintenance & Improvement	New HBMI Health Clinic - Repair by Replacement	PL 93-638 Agreement	CI Improvement
ME	Old Town	Penobscot Indian Nation	Facility Maintenance & Improvement	Roof Replacement with Pitched Roof	PL 93-638 Agreement	CI Improvement
ME	Perry	Passamaquoddy Pleasant Point Tribe of Maine	Facility Maintenance & Improvement	Health Center Repairs	PL 93-638 Agreement	CI Improvement
ME	INDIAN ISLND	PENOBSCOT TRIBE OF MAINE	Water and Sanitation Facilities	PENO - Hydrant Replacement	Tribal Agreement	229 homes served
ME	INDIAN ISLND	PENOBSCOT TRIBE OF MAINE	Water and Sanitation Facilities	PENO - Metering / Leak Detection	Tribal Agreement	229 homes served
ME	PLEASANT PT	PASSAMAQUODDY TRIBE OF MAINE-PLEASANT POINT	Water and Sanitation Facilities	PASP-METER ENCLOSURE AND HYD STUDY	Tribal Agreement	280 homes served
ME	PLEASANT PT	PASSAMAQUODDY TRIBE OF MAINE-PLEASANT POINT	Water and Sanitation Facilities	PASP - Water Source Study	Tribal Agreement	1030 homes served
ME	PLEASANT PT	PASSAMAQUODDY TRIBE OF MAINE-PLEASANT POINT	Water and Sanitation Facilities	PASP - Metering/Leak Detection	Tribal Agreement	278 homes served
ME	THE STRIP	PASSAMAQUODDY TRIBE OF MAINE -INDIAN TOWNSHIP	Water and Sanitation Facilities	PASI-LIFT STATION RENOVATION	Tribal Agreement	50 homes served
MI	Baraga	Keweenah Bay	Equipment - Medical Various	Dental Delivery System -2	PL 93-638 Agreement	Dental Delivery System -2
MI	Fulton	Huron Potawatomi	Equipment - Medical Various	Dental Delivery System -2	PL 93-638 Agreement	Dental Delivery System -2
MI	Sault Ste. Marie	Lombart Instruments	Equipment - Medical Various	Retinal Camera	PL 93-638 Agreement	Retinal Camera
MI	Sault Ste. Marie	Vendor : Claflin Medical Equipment	Equipment - Medical Various	Medical Exam Table and Chair	PL 93-638 Agreement	Medical Exam Table and Chair
MI	Wilson	Hannaville	Equipment - Medical Various	Dental Delivery System -2	PL 93-638 Agreement	Dental Delivery System -2
MI	Baraga	Keweenaw Bay	Facility Maintenance & Improvement	Cooling System Replacement	PL 93-638 Agreement	Energy
MI	L'anse	Keweenaw Bay	Facility Maintenance & Improvement	Safety, Accessibility, and Facility Repairs	PL 93-638 Agreement	CI Improvement
MI	Manistee	Little River Band	Facility Maintenance & Improvement	Structural Repairs	PL 93-638 Agreement	CI Improvement
MI	Manistee	Little River Band	Facility Maintenance & Improvement	Health Center Renovation for Pharmacy/ and Dental Services.	PL 93-638 Agreement	Program Enhancement
MI	Manistique	Sault Ste. Marie Tribe	Facility Maintenance & Improvement	Facility Exit	PL 93-638 Agreement	CI Improvement
MI	Mount Pleasant	Saginaw Chippewa	Facility Maintenance & Improvement	Life-Safety and Facility Repairs	PL 93-638 Agreement	Fire-Life Safety
MI	Munising	Sault Ste. Marie tribe	Facility Maintenance & Improvement	Installation of Fire rated doors	PL 93-638 Agreement	Fire-Life Safety
MI	Petoskey	Little Traverse	Facility Maintenance & Improvement	Renovation of dental registration and install of electrical powered handicap door.	PL 93-638 Agreement	Program Enhancement
MI	Sault Ste. Marie	Sault Ste. Marie	Facility Maintenance & Improvement	Health Center Renovation for acute care appointments.	PL 93-638 Agreement	Program Enhancement
MI	Suttons Bay	Grand Traverse Band Ottawa/Chippewa	Facility Maintenance & Improvement	Health Center Renovation for Dental Wing (combine with BE010)	PL 93-638 Agreement	Program Enhancement
MI	Suttons Bay	Grand Traverse Band Ottawa/Chippewa	Facility Maintenance & Improvement	Health Center Renovation for Dental Wing (combine with BE009)	PL 93-638 Agreement	Program Enhancement
MI	Watersmeet	Lac Vieux Desert	Facility Maintenance & Improvement	Safety, Accessibility, and Facility Repairs	PL 93-638 Agreement	CI Improvement
MI	Watersmeet	Lac Vieux Desert	Facility Maintenance & Improvement	Lighting, Accessibility, and Facility Repairs	PL 93-638 Agreement	CI Improvement

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
MI	BAY MILLS	BAY MILLS IND COMM OF THE SAULT STE. MARIE BAND OF CHIPPEWA INDIANS	Water and Sanitation Facilities	BM - Pumphouse Upgrades - ARRA	Tribal Agreement	153 homes served
MI	HARBOR SPGS	LITTLE TRAVERSE BAY BAND OF ODAWA INDIANS	Water and Sanitation Facilities	Harbor Springs Pumphouse - ARRA	Tribal Agreement	19 homes served
MI	MT PLEASANT*	SAGINAW CHIPPEWA INDIAN TRIBE OF MICHIGAN, ISABELLA RESERVATION, MICHIGAN	Water and Sanitation Facilities	Sag Chip WWTP RPZ - ARRA	Tribal Agreement	280 homes served
MI	WILSON	HANNAHVILLE INDIAN COMMUNITY WISCONSIN POTAWATOMIE INDIANS OF MICHIGAN	Water and Sanitation Facilities	Hannaville Ex. Scattered - ARRA	Tribal Agreement	1 homes served
MN	Cloquet	Fond du Lac	Equipment - Medical Various	CBC Analyzer	PL 93-638 Agreement	CBC Analyzer
MN	Ogema	White Earth	Equipment - Medical Various	General X-Ray with PACS	Federal Contact-New	General X-Ray with PACS
MN	Red Lake	Red Lake	Equipment - Medical Various	Blood Pressure Vital Signs Monitors	Federal Contact-New	Blood Pressure Vital Signs Monitors
MN	Red Lake	Red Lake	Equipment - Medical Various	Cardiac monitoring System	Federal Contact-New	Cardiac monitoring System
MN	Red Lake	Red Lake	Equipment - Medical Various	Defibrillators - 2	Federal Contact-New	Defibrillators - 2
MN	Vineland	Mille Lacs	Equipment - Medical Various	Replacement of Dental Suction System	PL 93-638 Agreement	Replacement of Dental Suction System
MN	Ball Club	Leeech Lake	Facility Maintenance & Improvement	Safety, Accessibility, and Facility Repairs	PL 93-638 Agreement	CI Improvement
MN	Cass Lake	Leech lake	Facility Maintenance & Improvement	Masonry, Asphalt, and Facility Repairs	PL 93-638 Agreement	CI Improvement
MN	Cass Lake	Leech Lake	Facility Maintenance & Improvement	Safety, Accessibility, and Facility Repairs	PL 93-638 Agreement	CI Improvement
MN	Duluth	Fond du Lac	Facility Maintenance & Improvement	Building Structural Repairs	PL 93-638 Agreement	CI Improvement
MN	Grand Portage	Grand Portage	Facility Maintenance & Improvement	Health Center Life Safety Project	PL 93-638 Agreement	Fire-Life Safety
MN	Inger	Leech Lake	Facility Maintenance & Improvement	Safety, Accessibility, and Facility Repairs	PL 93-638 Agreement	CI Improvement
MN	Ponsford	White Earth Tribe	Facility Maintenance & Improvement	Safety, Accessibility, and Facility Repairs	PL 93-638 Agreement	CI Improvement
MN	Red Lake	Red Lake	Facility Maintenance & Improvement	Boiler Replacement (Combine with BE030)	PL 93-638 Agreement	Energy
MN	Red Lake	Red Lake	Facility Maintenance & Improvement	Boiler Replacement (Combine with BE029)	PL 93-638 Agreement	Energy
MN	Red Lake	Red Lake	Facility Maintenance & Improvement	Basement Exit	PL 93-638 Agreement	Fire-Life Safety
MN	Tower	Bois Forte	Facility Maintenance & Improvement	Misc. Facility Repairs	PL 93-638 Agreement	CI Improvement
MN	Vineland	Mille Lacs	Facility Maintenance & Improvement	Health Center Renovation for Pharmacy/Medical records	PL 93-638 Agreement	Program Enhancement
MN	White Earth	White Earth	Facility Maintenance & Improvement	Safety, Accessibility, and Facility Repairs	PL 93-638 Agreement	CI Improvement
MN	White Earth	White Earth Tribe	Facility Maintenance & Improvement	Fire Sprinkler system repairs	PL 93-638 Agreement	Fire-Life Safety
MN	BOIS FORT	MINNESOTA CHIPPEWA TRIBE,MN- BOIS FORTE BAND (NETT LAKE)	Water and Sanitation Facilities	Nett Lake Water System Repairs-ARRA	Tribal Agreement	77 homes served

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
MN	CARLTON-CO	MINNESOTA CHIPPEWA TRIBE,MN- FOND DU LAC BAND	Water and Sanitation Facilities	Fond Du Lac Scattered - ARRA	Tribal Agreement	11 homes served
MN	LITTLE ROCK	RED LAKE BAND OF CHIPPEWA INDIANS OF THE RED LAKE RESERVATION, MINNESOTA	Water and Sanitation Facilities	Little Rock Water Main Ext.-ARRA	Tribal Agreement	97 homes served
MN	LOWER SIOUX	LOWER SIOUX IND COMM OF THE MA MDEWAKANTON SIOUX INDIANS	Water and Sanitation Facilities	Act. Sludge Treatment Plant-ARRA	Tribal Agreement	142 homes served
MN	NETT LAKE	MINNESOTA CHIPPEWA TRIBE,MN- BOIS FORTE BAND (NETT LAKE)	Water and Sanitation Facilities	Nett Lake AC water Main PhI-ARRA	Tribal Agreement	77 homes served
MN	RED LAKE	RED LAKE BAND OF CHIPPEWA INDIANS OF THE RED LAKE RESERVATION, MINNESOTA	Water and Sanitation Facilities	Transfer Stn. Upgrade-ARRA	Tribal Agreement	686 homes served
MN	SQUAW POINT	MINNESOTA CHIPPEWA TRIBE,MN- LEECH LAKE BAND	Water and Sanitation Facilities	Oak Pt. Tubbs Repl Ph.I-ARRA	Tribal Agreement	14 homes served
MN	VERMILLION L	MINNESOTA CHIPPEWA TRIBE,MN- BOIS FORTE BAND (NETT LAKE)	Water and Sanitation Facilities	Vermillion Addl. Water Source-ARRA	Tribal Agreement	66 homes served
MN	VINELAND	MINNESOTA CHIPPEWA TRIBE,MN- MILLE LACS BAND	Water and Sanitation Facilities	Nekemigaag Drive Sewer - ARRA	Tribal Agreement	3 homes served
MN	WHITE EARTH	MINNESOTA CHIPPEWA TRIBE,MN- WHITE EARTH BAND	Water and Sanitation Facilities	White Earth Scattered - ARRA	Tribal Agreement	13 homes served
MN	WHITE EARTH	MINNESOTA CHIPPEWA TRIBE,MN- WHITE EARTH BAND	Water and Sanitation Facilities	WE Lagoon Riprap - Ph. 2-ARRA	Tribal Agreement	122 homes served
MS	Choctaw	Mississippi Band of Choctaw Indians	Equipment – Hospital CT Scanner	Replacement CT scanner	PL 93-638 Agreement	Computed Tomography (CT) Scanner
MS	Philadelphia	Mississippi Band of Choctaw Indians	Facility Maintenance & Improvement	Roof and HVAC System Replacement	PL 93-638 Agreement	Energy
MS	Philadelphia	Mississippi Band of Choctaw Indians	Facility Maintenance & Improvement	Replace Fire Alarm System	PL 93-638 Agreement	Fire-Life Safety
MS	CONEHATTA	MISSISSIPPI BAND OF CHOCTAW INDIANS, MISSISSIPPI	Water and Sanitation Facilities	CHOC-CONEHATTA STP Replacement	Tribal Agreement	243 homes served
MT	BOX ELDER	CHIPPEWA-CREE INDIANS OF THE ROCKY BOY'S RESERVATION	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
MT	BROWNING	Blackfeet Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
MT	BROWNING	Blackfeet Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
MT	BROWNING	Blackfeet Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
MT	BROWNING	BLACKFEET TRIBE	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
MT	BROWNING	BLACKFEET TRIBE	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
MT	Harlem	FORT BELKNAP INDIAN COMMUNITY	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
MT	Lame Deer	Northern Cheyenne Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
MT	Lame Deer	Northern Cheyenne Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
MT	Lame Deer	Northern Cheyenne Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
MT	Blackfeet	Blackfeet Tribe, The (Inc)	Equipment – Hospital CT Scanner	Replacement CT scanner	Federal Contact-New	Computed Tomography (CT) Scanner
MT	Crow Agency	Crow Tribe	Equipment - Medical Various	Fluid and blanket warmer	Federal Contact-New	Fluid and blanket warmer
MT	Crow Agency	Crow Tribe	Equipment - Medical Various	OR Sterilizer	Federal Contact-New	OR Sterilizer
MT	Crow Agency	Crow Tribe	Equipment - Medical Various	Urinalysis Analyzer	Federal Contact-New	Urinalysis Analyzer
MT	Flathead	Confederated Salish & Kootenai Tribes	Equipment - Medical Various	Digital dental x-ray unit	PL 93-638 Agreement	Digital dental x-ray unit
MT	Fort Belknap	Fort Belknap Tribes	Equipment - Medical Various	Ultrasound Unit	Federal Contact-New	Ultrasound Unit

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
MT	Lame Deer	Northern Cheyenne Tribe	Equipment - Medical Various	Defibrillator	Federal Contact-New	Defibrillator
MT	Lame Deer	Northern Cheyenne Tribe	Equipment - Medical Various	Fetal heart monitor	Federal Contact-New	Fetal heart monitor
MT	Lame Deer	Northern Cheyenne Tribe	Equipment - Medical Various	X-ray scanner and software	Federal Contact-New	X-ray scanner and software
MT	Rocky Boy	Rocky Boy Health Board	Equipment - Medical Various	Hematology analyzer	PL 93-638 Agreement	Hematology analyzer
MT	Rocky Boy	Rocky Boy Health Board	Equipment - Medical Various	Life Pak 12	PL 93-638 Agreement	Life Pak 12
MT	Rocky Boy	Rocky Boy Health Board	Equipment - Medical Various	Urinalysis Analyzer	PL 93-638 Agreement	Urinalysis Analyzer
MT	Wolf Point	Fort Peck Tribe	Equipment - Medical Various	Dental Operatory and (x-ray=non-ARRA)	Federal Contact-New	Dental Operatory and (x-ray=non-ARRA)
MT	Browning	Blackfeet Tribe, The (Inc)	Facility Maintenance & Improvement	Renovate Conference/Chapel	PL 93-638 Agreement	CI Improvement
MT	Browning	Blackfeet Tribe, The (Inc)	Facility Maintenance & Improvement	Energy Efficiency Upgrades Quarters	PL 93-638 Agreement	Energy
MT	Browning	Blackfeet Tribe, The (Inc)	Facility Maintenance & Improvement	Chiller Replacement	PL 93-638 Agreement	Energy
MT	Browning	Blackfeet Tribe, The (Inc)	Facility Maintenance & Improvement	Replace EIFS	PL 93-638 Agreement	Energy
MT	Crow Agency	Crow Tribe	Facility Maintenance & Improvement	Exterior Light Repairs	Federal Contact-New	CI Improvement
MT	Crow Agency	Crow Tribe	Facility Maintenance & Improvement	Chiller AHU1 Upgrade	Federal Contact-New	CI Improvement
MT	Crow Agency	Crow Tribe	Facility Maintenance & Improvement	Entrance Repairs	Federal Contact-New	CI Improvement
MT	Crow Agency	Crow Tribe	Facility Maintenance & Improvement	Refurbish Chillers	Federal Contact-New	Energy
MT	Elmo	Confederated Salish & Kootenai Tribes	Facility Maintenance & Improvement	Pave Parking Area	PL 93-638 Agreement	CI Improvement
MT	Fort Belknap	Fort Belknap Tribes	Facility Maintenance & Improvement	Replace Hydraulic Lift	PL 93-638 Agreement	CI Improvement
MT	Lame Deer	Northern Cheyenne Tribe	Facility Maintenance & Improvement	Install Variable Speed Drives	Federal Contact-New	Energy
MT	Lame Deer	Northern Cheyenne Tribe	Facility Maintenance & Improvement	Carpet Replace	PL 93-638 Agreement	CI Improvement
MT	Poplar	Fort Peck Assiniboine & Sioux Tribes, Inc	Facility Maintenance & Improvement	Water Line Replacement	PL 93-638 Agreement	CI Improvement
MT	Poplar	Fort Peck Assiniboine & Sioux Tribes, Inc	Facility Maintenance & Improvement	Repair by Replacement Storage Building	PL 93-638 Agreement	CI Improvement
MT	Poplar	Fort Peck Assiniboine & Sioux Tribes, Inc	Facility Maintenance & Improvement	Roof Top HVAC Units Replacement	PL 93-638 Agreement	Energy
MT	Rocky Boy	Rocky Boy Health Board	Facility Maintenance & Improvement	Ambulance Garage Repairs	PL 93-638 Agreement	CI Improvement
MT	Rocky Boy	Rocky Boy Health Board	Facility Maintenance & Improvement	EH Building Safety and Site Improvements	PL 93-638 Agreement	CI Improvement
MT	Rocky Boy	Rocky Boy Health Board	Facility Maintenance & Improvement	Quarters Repairs	PL 93-638 Agreement	Energy
MT	St. Ignatius	Confederated Salish & Kootenai Tribes	Facility Maintenance & Improvement	Renovate Tribal Clinic Space	PL 93-638 Agreement	CI Improvement
MT	St. Ignatius	Confederated Salish & Kootenai Tribes	Facility Maintenance & Improvement	Pave Parking Area	PL 93-638 Agreement	CI Improvement

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
MT	St. Ignatius	Confederated Salish & Kootenai Tribes	Facility Maintenance & Improvement	Renovate Health Center (Neil Charlo), replace Lighting	PL 93-638 Agreement	Energy
MT	Wolf Point	Fort Peck Assiniboine & Sioux Tribes, Inc	Facility Maintenance & Improvement	Boiler Replacement	PL 93-638 Agreement	Energy
MT	Wolf Point	Fort Peck Assiniboine & Sioux Tribes, Inc	Facility Maintenance & Improvement	Chiller Replacement	PL 93-638 Agreement	Energy
MT	BROCKTON	ASSINIBOINE & SIOUX TRIBES OF THE FORT PECK INDIAN RES., MONTANA - SIOUX	Water and Sanitation Facilities	Brockton-sew1: lagoon bank stabiliz	Tribal Agreement	105 homes served
MT	BROWNING	BLACKFEET TRIBE OF THE BLACKFEET INDIAN RESERVATION, MONTANA	Water and Sanitation Facilities	BCWP - BROWNING WATER MAIN	Tribal Agreement	1501 homes served
MT	CROW AGENCY	CROW TRIBE OF MONTANA	Water and Sanitation Facilities	CROW AGENCY-sewer ph I-lagoon	Tribal Agreement	564 homes served
MT	FT BELKNAP-A	FORT BELKNAP INDIAN COMMUNITY OF THE FORT BELKNAP RES. OF MT - ASSINBOINE	Water and Sanitation Facilities	Ft Belknap WaterTreatment Plant PH2	Tribal Agreement	426 homes served
MT	GLACIER-CO	BLACKFEET TRIBE OF THE BLACKFEET INDIAN RESERVATION, MONTANA	Water and Sanitation Facilities	BLACKFEET: Landfill closure ph III	Tribal Agreement	2219 homes served
MT	LODGE GRASS	CROW TRIBE OF MONTANA	Water and Sanitation Facilities	LODGE GRASS:water ph 3-telemetry	Tribal Agreement	239 homes served
MT	ROCKY BOY AG	CHIPPEWA-CREE INDIANS OF THE ROCKY BOY RESERVATION, MONTANA	Water and Sanitation Facilities	Rocky Boys Agency Lagoon	Tribal Agreement	130 homes served
Multiple States	Area Wide (NV, AZ, UT)	Multiple Tribes	Facility Maintenance & Improvement	Fire Sprinklers at Various Locations	Federal Contact-New	Fire-Life Safety
Multiple States	Fort Berthold, Pine Ridge, Rapid City, Rosebud (NE, ND, SD)	Multiple Tribes	Facility Maintenance & Improvement	Replace Underground Storage Tanks, Multiple Sites	Federal Contact-New	CI Improvement
Multiple States	Macy, Newtown, Lower Brule, Belcourt, Winnebago, Ft Yates, McLaughlin, Wagner (SD, ND)	Multiple Tribes	Facility Maintenance & Improvement	Sprinkler Health Stations and Residences-Multiple Sites	Federal Contact-New	Fire-Life Safety
NC	Cherokee	Eastern Band of Cherokee Indians	Equipment - Medical Various	Alt Pressure mattresses (9)	PL 93-638 Agreement	Alt Pressure mattresses (9)
NC	Cherokee	Eastern Band of Cherokee Indians	Equipment - Medical Various	BiPAP Ventilator	PL 93-638 Agreement	BiPAP Ventilator
NC	Cherokee	Eastern Band of Cherokee Indians	Equipment - Medical Various	Dynomap monitors/Vital Signs Equip	PL 93-638 Agreement	Dynomap monitors/Vital Signs Equip
NC	Cherokee	Eastern Band of Cherokee Indians	Equipment - Medical Various	I-stat Lab Analyzer	PL 93-638 Agreement	I-stat Lab Analyzer
NC	Cherokee	Eastern Band of Cherokee Indians	Equipment - Medical Various	Patient bathing tubs	PL 93-638 Agreement	Patient bathing tubs
NC	Cherokee	Eastern Band of Cherokee Indians	Facility Maintenance & Improvement	HMD Administration Roof Replacement	PL 93-638 Agreement	CI Improvement
NC	Cherokee	Eastern Band of Cherokee Indians	Facility Maintenance & Improvement	Alternate Water Source for Hospital	PL 93-638 Agreement	Fire-Life Safety
NC	BIRDTOWN	EASTERN BAND OF CHEROKEE INDIANS OF NORTH CAROLINA	Water and Sanitation Facilities	CHER-ADAMS CREEK SEWER REHAB, PH. 1	Tribal Agreement	250 homes served
NC	BIRDTOWN	EASTERN BAND OF CHEROKEE INDIANS OF NORTH CAROLINA	Water and Sanitation Facilities	CHER - Adams Crk Inv Syphon Replace	Tribal Agreement	557 homes served
NC	PAINTTOWN	EASTERN BAND OF CHEROKEE INDIANS OF NORTH CAROLINA	Water and Sanitation Facilities	CHER-OLD MISSION ROAD BOOSTER REPACEMENT	Tribal Agreement	152 homes served

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
NC	YELLOWHILL	EASTERN BAND OF CHEROKEE INDIANS OF NORTH CAROLINA	Water and Sanitation Facilities	CHER-Leaking Storage Tank Repair	Tribal Agreement	1826 homes served
ND	Belcourt	Turtle Mountain Band of Chippewa	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
ND	Belcourt	Turtle Mountain Band of Chippewa	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
ND	Belcourt	Turtle Mountain Band of Chippewa	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
ND	Ft Totten	Spirit Lake Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
ND	Ft Yates	Standing Rock Sioux Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
ND	Ft Yates	Standing Rock Sioux Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
ND	Ft Yates	Standing Rock Sioux Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
ND	Ft Yates	Standing Rock Sioux Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
ND	Ft Yates	Standing Rock Sioux Tribe	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
ND	Belcourt	Turtle Mountain Band of Chippewa	Equipment – Hospital CT Scanner	Replacement CT scanner	Federal Contact-New	Computed Tomography (CT) Scanner
ND	Trenton	Turtle Mountain Band of Chippewa	Equipment - Medical Various	Dental Delivery System Replacement (2) (in conjunction with M&I ARRA Project)	PL 93-638 Agreement	Dental Delivery System Replacement (2) (in conjunction with M&I ARRA Project)
ND	Trenton	Turtle Mountain Band of Chippewa	Equipment - Medical Various	New X-ray unit with wall bucky	PL 93-638 Agreement	New X-ray unit with wall bucky
ND	Belcourt	Turtle Mountain Band of Chippewa	Facility Maintenance & Improvement	Interior and HVAC Renovations/Repairs	Federal Contact-Existing	CI Improvement
ND	Belcourt & Dunseith	Turtle Mountain Band of Chippewa	Facility Maintenance & Improvement	Fire-Life-Safety, Interior, and Exterior Repairs	PL 93-638 Agreement	Fire-Life Safety
ND	Ft Totten	Spirit Lake Sioux Nation	Facility Maintenance & Improvement	Siding, Windows, and Floor Covering Replacement	Federal Contact-Existing	Energy
ND	Ft Totten	Spirit Lake Sioux Nation	Facility Maintenance & Improvement	EMS Building Repair by Replacement and Exterior Repairs to Alcohol and Substance Abuse Building	PL 93-638 Agreement	CI Improvement
ND	Ft Yates	Standing Rock Sioux Tribe	Facility Maintenance & Improvement	Sewer Lines, Lighting, Roof Vents/Access, and Other Repairs	Federal Contact-Existing	CI Improvement
ND	Ft Yates	Standing Rock Sioux Tribe	Facility Maintenance & Improvement	Boilers Replacement-Energy Efficient Heating & Cooling System	Federal Contact-New	Energy
ND	Ft Yates	Standing Rock Sioux Tribe	Facility Maintenance & Improvement	EMS Building Repair by Replacement	PL 93-638 Agreement	CI Improvement
ND	New Town	Three Affiliated Tribes	Facility Maintenance & Improvement	Flooring, Roofing, and Ceiling Replacement	Federal Contact-Existing	CI Improvement
ND	New Town	Three Affiliated Tribes	Facility Maintenance & Improvement	HVAC, Roofing, Electrical and Lighting System, and Sewer Line Replacement	Federal Contact-Existing	CI Improvement
ND	New Town	Three Affiliated Tribes	Facility Maintenance & Improvement	Interior Repairs at Staff Quarters	Federal Contact-New	CI Improvement
ND	Trenton	Turtle Mountain Band of Chippewa	Facility Maintenance & Improvement	Renovate Ambulance Department/Exam Rooms, Roof Replacement, and HVAC Replacement	PL 93-638 Agreement	CI Improvement
ND	TRENTON	TURTLE MOUNTAIN BAND OF CHIPPEWA INDIANS, TURTLE MOUNTAIN INDIAN RES., ND	Water and Sanitation Facilities	Trenton Lift Station Replacement	Tribal Agreement	163 homes served
NE	MACY	Omaha Tribe Nebraska	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
NE	MACY	Omaha Tribe Nebraska	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
NE	Macy	Omaha Tribe of Nebraska	Equipment - Medical Various	Dental Delivery System Replacement (2)	Federal Contact-New	Dental Delivery System Replacement (2)

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
NE	Macy	Omaha Tribe of Nebraska	Equipment - Medical Various	Dental PACS System	Federal Contact-New	Dental PACS System
NE	Macy	Omaha Tribe of Nebraska	Equipment - Medical Various	Digital Dental Panoramic X-ray	Federal Contact-New	Digital Dental Panoramic X-ray
NE	Omaha (Ponca)	Northern Ponca Tribe of Nebraska	Equipment - Medical Various	Replace (1) Dental Delivery System	Federal Contact-New	Replace (1) Dental Delivery System
NE	Macy	Omaha Tribe of Nebraska	Facility Maintenance & Improvement	HVAC, Electrical, Grounds & Building Repairs	Federal Contact-New	CI Improvement
NE	Omaha	Omaha Tribe	Facility Maintenance & Improvement	Roof Replacement, Flooring, & Fire Alarm System	PL 93-638 Agreement	CI Improvement
NE	Winnebago	Winnebago Tribe of Nebraska	Facility Maintenance & Improvement	HVAC Phase II Retro-Commissioning Actions	PL 93-638 Agreement	Energy
NE	SANTEE	SANTEE SIOUX TRIBE OF THE SANTEE RESERVATION OF NEBRASKA	Water and Sanitation Facilities	Santee - Lift Station Replacement	Tribal Agreement	169 homes served
NE	SANTEE	SANTEE SIOUX TRIBE OF THE SANTEE RESERVATION OF NEBRASKA	Water and Sanitation Facilities	Santee - Storage Tank	Tribal Agreement	192 homes served
NE	SANTEE	SANTEE SIOUX TRIBE OF THE SANTEE RESERVATION OF NEBRASKA	Water and Sanitation Facilities	Santee - Pump House Replacement	Tribal Agreement	192 homes served
NE	THURSTON-CO	OMAHA TRIBE OF NEBRASKA	Water and Sanitation Facilities	Omaha - PRV Renovation & Relocation	Tribal Agreement	450 homes served
NE	WINNEBAGO	WINNEBAGO TRIBE OF THE WINNEBAGO RESERVATION OF NEBRASKA	Water and Sanitation Facilities	Vil. of Winnebago AC Water Main Prj	Tribal Agreement	392 homes served
NM	Magdalena	ALAMO NAVAJO	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
NM	Magdalena	Alamo Navajo School Board	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
NM	San Fidel	ACOMA-CANONCITO-LAGUNA IHS HOSPITAL	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
NM	Shiprock	Navajo Nation	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
NM	Shiprock	Navajo Nation	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
NM	ZUNI	Zuni Pueblo	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
NM	Gallup	Navajo Nation	Equipment – Hospital CT Scanner	Replacement CT scanner	Federal Contact-New	Computed Tomography (CT) Scanner
NM	Zuni	Zuni	Equipment – Hospital CT Scanner	New CT scanner	Federal Contact-New	Computed Tomography (CT) Scanner
NM	Alamo	Navajo Nation	Equipment - Medical Various	X-ray CR Reader	Federal Contact-New	X-ray CR Reader
NM	Albuquerque	Multiple Tribes	Equipment - Medical Various	Laser X-ray printer	Federal Contact-New	Laser X-ray printer
NM	Albuquerque	Multiple Tribes	Equipment - Medical Various	Local PACS (Picture and Archving System)	Federal Contact-New	Local PACS (Picture and Archving System)
NM	Crownpoint	Navajo Nation	Equipment - Medical Various	1 CR and cassetts	Federal Contact-New	1 CR and cassetts
NM	Dulce	JICARILLA APACHE TRIBE	Equipment - Medical Various	Local PACS (Picture and Archving System)	Federal Contact-New	Local PACS (Picture and Archving System)
NM	Mescalero	MESCALERO APACHE TRIBE OF THE MESCALERO RESERVATION, NEW MEXICO	Equipment - Medical Various	Local PACS (Picture and Archving System)	Federal Contact-New	Local PACS (Picture and Archving System)
NM	Pine Hill	Ramah Navajo School Board	Equipment - Medical Various	X-ray CR Reader	Federal Contact-New	X-ray CR Reader
NM	San Fidel	ACOMA, LAGUNA & CANONCITO TRIBES	Equipment - Medical Various	Local PACS (Picture and Archving System)	Federal Contact-New	Local PACS (Picture and Archving System)
NM	Santa Clara	SANTA CLARA PUEBLO	Equipment - Medical Various	X-ray CR Reader	Federal Contact-New	X-ray CR Reader
NM	Santa Fe	Multiple Tribes	Equipment - Medical Various	Central Nurses Station	Federal Contact-New	Central Nurses Station
NM	Santa Fe	Multiple Tribes	Equipment - Medical Various	Laser X-ray printer	Federal Contact-New	Laser X-ray printer
NM	Santa Fe	Multiple Tribes	Equipment - Medical Various	Local PACS (Picture and Archving System)	Federal Contact-New	Local PACS (Picture and Archving System)
NM	Shiprock	Navajo Nation	Equipment - Medical Various	Audiology Equipment	Federal Contact-New	Audiology Equipment
NM	Shiprock	Navajo Nation	Equipment - Medical Various	Labor Delivery beds	Federal Contact-New	Labor Delivery beds

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
NM	Taos	Taos	Equipment - Medical Various	X-ray	Federal Contact-New	X-ray
NM	Taos	Taos	Equipment - Medical Various	X-ray CR Reader	Federal Contact-New	X-ray CR Reader
NM	Albuquerque	Multiple Tribes	Facility Maintenance & Improvement	Roof Replacement	Federal Contact-Existing	CI Improvement
NM	Crownpoint	Navajo Nation	Facility Maintenance & Improvement	Repair by Replacement Crownpoint CHR	Federal Contact-New	CI Improvement
NM	Crownpoint	Navajo Nation	Facility Maintenance & Improvement	Crownpoint Health Center Roof Repairs	Federal Contact-New	CI Improvement
NM	Crownpoint	Navajo Nation	Facility Maintenance & Improvement	Emergency Generator Replacement and UPS Installation	Federal Contact-New	Program Enhancement
NM	Gallup	Navajo Nation	Facility Maintenance & Improvement	Gallup CHR Maintenance & Improvement	Federal Contact-New	CI Improvement
NM	Gallup	Navajo Nation	Facility Maintenance & Improvement	Boiler Replacement	Federal Contact-New	Energy
NM	Huerfano (Nageezi)	Navajo Nation	Facility Maintenance & Improvement	Dzilth Na O Dilth Hle Health Center Roof Replacement	Federal Contact-New	CI Improvement
NM	Jemez	Jemez Pueblo Health & Human Services	Facility Maintenance & Improvement	Tribal Health Center Improvements	PL 93-638 Agreement	CI Improvement
NM	Magdalena	Navajo Alamo Chapter	Facility Maintenance & Improvement	Emergency Engine Generator & Electrical Upgrade	PL 93-638 Agreement	CI Improvement
NM	Mescalero	MESCALERO APACHE TRIBE OF THE MESCALERO RESERVATION, NEW MEXICO	Facility Maintenance & Improvement	HVAC Improvements	Federal Contact-Existing	Energy
NM	Mescalero	MESCALERO APACHE TRIBE OF THE MESCALERO RESERVATION, NEW MEXICO	Facility Maintenance & Improvement	Electrical Energy Improvements	Federal Contact-Existing	Energy
NM	Pine Hill	Ramah Navajo School Board	Facility Maintenance & Improvement	HVAC Improvements	PL 93-638 Agreement	CI Improvement
NM	Pine Hill	Ramah Navajo School Board	Facility Maintenance & Improvement	Electrical System Improvements	PL 93-638 Agreement	CI Improvement
NM	Pine Hill	Ramah Navajo School Board	Facility Maintenance & Improvement	Roof Repairs	PL 93-638 Agreement	CI Improvement
NM	San Fidel	ACOMA, LAGUNA & CANONCITO TRIBES	Facility Maintenance & Improvement	Steam to Hot Water Boiler Replacement & HVAC Improvements	Federal Contact-New	Energy
NM	San Fidel	ACOMA, LAGUNA & CANONCITO TRIBES	Facility Maintenance & Improvement	Patient Service Area Renovations & Improvements (Courtyard Enclosure)	Federal Contact-New	Program Enhancement
NM	Santa Fe	Multiple Tribes	Facility Maintenance & Improvement	Dental Clinic Replacement	Federal Contact-New	CI Improvement
NM	Santa Fe	Multiple Tribes	Facility Maintenance & Improvement	Metal Building Renovation	Federal Contact-New	CI Improvement
NM	Santa Fe	Multiple Tribes	Facility Maintenance & Improvement	Steam to Hot Water Boiler Replacement &HVAC Improvements	Federal Contact-New	Energy
NM	Shiprock	Navajo Nation	Facility Maintenance & Improvement	Building Renovations and Code Compliance Upgrades	Federal Contact-New	CI Improvement
NM	Shiprock	Navajo Nation	Facility Maintenance & Improvement	Shiprock Adolescent Treatment Center	Federal Contact-New	CI Improvement
NM	Shiprock	Navajo Nation	Facility Maintenance & Improvement	Shiprock CHR Maintenance & Improvement	Federal Contact-New	CI Improvement
NM	Zuni	Zuni	Facility Maintenance & Improvement	Steam to Hot Water Boiler Replacement & HVAC Improvements	Federal Contact-New	Energy

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
NM	ACOMA	PUEBLO OF ACOMA, NEW MEXICO	Water and Sanitation Facilities	Old Acoma Waterless Toilet Pilot	Tribal Agreement	33 homes served
NM	ALAMO	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Alamo Failed ST/DF Replacements	Tribal Agreement	8 homes served
NM	ANZAC	PUEBLO OF ACOMA, NEW MEXICO	Water and Sanitation Facilities	ACOMA McCartys Abeita Rd WL Repl.	Tribal Agreement	30 homes served
NM	BACA	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Baca Failed ST-DF Replacements	Tribal Agreement	4 homes served
NM	BLANCO	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Blanco Waterline Replacement	Tribal Agreement	38 homes served
NM	BREAD SPRGS	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Bread Springs Failed ST/DF	Tribal Agreement	7 homes served
NM	CASAMERO LK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	CASAMERO CUP EXT P65	Tribal Agreement	30 homes served
NM	CASAMERO LK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Casamero Lk W. Central Extens P66	Tribal Agreement	17 homes served
NM	CASAMERO LK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	CASAMERO LAKE SOUTH EXT N59	Tribal Agreement	33 homes served
NM	CASAMERO LK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	CHAPO EXTENSION P67	Tribal Agreement	30 homes served
NM	CHURCHROCK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Church Rock Failed ST/DF Repl	Tribal Agreement	9 homes served
NM	COYOTE CNYN	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Coyote Canyon Failed ST/DF	Tribal Agreement	6 homes served
NM	CROWNPOINT	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	CROWNPOINT SCTD R04/Y54	Tribal Agreement	11 homes served
NM	CROWNPOINT	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	CROWNPOINT SEWER RENOV PH2	Tribal Agreement	748 homes served
NM	CROWNPOINT	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Crownpoint Failed ST/DF	Tribal Agreement	13 homes served
NM	CROWNPOINT	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	CROWNPOINT NE Tsai Yanal Kedi Q88	Tribal Agreement	30 homes served
NM	FARMINGTON	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	FARMINGON FAILIED DRAINFIELD III	Tribal Agreement	35 homes served
NM	IYANBITO	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Iyanbito Failed ST/DF	Tribal Agreement	7 homes served
NM	JONES RANCH	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Chichiltah Failed ST/DF	Tribal Agreement	3 homes served
NM	MANUELITO	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Manuelito TseDeTah Ph 1 P98-Y19-D60	Tribal Agreement	17 homes served
NM	MANUELITO	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Manuelito TseDeTah Ph 2 Q69-Y31	Tribal Agreement	18 homes served
NM	MESCALRO RES	MESCALERO APACHE TRIBE OF THE MESCALERO RESERVATION, NEW MEXICO	Water and Sanitation Facilities	MESECALERO Windmill Watermain Ph II	Tribal Agreement	612 homes served
NM	MESCALRO RES	MESCALERO APACHE TRIBE OF THE MESCALERO RESERVATION, NEW MEXICO	Water and Sanitation Facilities	MESCALERO I & I Rehabilitation	Tribal Agreement	412 homes served
NM	MESITA	PUEBLO OF LAGUNA, NEW MEXICO	Water and Sanitation Facilities	LAGUNA-MESITA Water Storage TankPh2	Tribal Agreement	210 homes served
NM	MEXICAN SPGS	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Mexican Sprgs Failed STDF	Tribal Agreement	15 homes served

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
NM	NAMBE	PUEBLO OF NAMBE, NEW MEXICO	Water and Sanitation Facilities	NAM WWT Impr Lagoons#1 (Church)	Tribal Agreement	41 homes served
NM	NASCHITTI	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Naschitti Failed STDF	Tribal Agreement	8 homes served
NM	PICURIS	PUEBLO OF PICURIS, NEW MEXICO	Water and Sanitation Facilities	PIC Wastewater Treatment Imp. P2	Tribal Agreement	74 homes served
NM	PICURIS	PUEBLO OF PICURIS, NEW MEXICO	Water and Sanitation Facilities	PIC Water Service Line Replacement	Tribal Agreement	2 homes served
NM	PINEDALE	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Pinedale Failed STDF Repl	Tribal Agreement	3 homes served
NM	POJOAQUE	PUEBLO OF POJOAQUE, NEW MEXICO	Water and Sanitation Facilities	POJ 100,000 Gallon Tank Replacement	Tribal Agreement	150 homes served
NM	RAMAH RESERV	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Ramah Failed ST/DF Replacements	Tribal Agreement	4 homes served
NM	RED ROCK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Red Rock Scattered N34	Tribal Agreement	18 homes served
NM	RED ROCK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Red Rock Failed STDF	Tribal Agreement	6 homes served
NM	RED ROCK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	CHURCHRCK S II - B P49	Tribal Agreement	25 homes served
NM	RED ROCK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	TWIN BUTTES NORTH P43	Tribal Agreement	19 homes served
NM	RED ROCK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	RED RCK S. SCT EPA P28	Tribal Agreement	19 homes served
NM	RED ROCK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	RED RCK E. SCT EPA P27	Tribal Agreement	13 homes served
NM	ROCK SPRINGS	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Rock Sprgs Scat Q60 D62 Y22	Tribal Agreement	10 homes served
NM	SAN JUAN	PUEBLO OF SAN JUAN, NEW MEXICO	Water and Sanitation Facilities	SJ Kennedy Raw Water Main Phase 2	Tribal Agreement	492 homes served
NM	SANDIA	PUEBLO OF SANDIA, NEW MEXICO	Water and Sanitation Facilities	SANDIA Sewer Lift Station Rehab	Tribal Agreement	192 homes served
NM	SHIPROCK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	SHIPROCK SU FAILIED DRAINFIELD	Tribal Agreement	101 homes served
NM	SHIPROCK	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Shiprock Blueberry Hill EPA Q46	Tribal Agreement	25 homes served
NM	SKYLINE	PUEBLO OF ACOMA, NEW MEXICO	Water and Sanitation Facilities	ACOMA Anzac to Skyline WL PH 1B	Tribal Agreement	811 homes served
NM	SMITH LAKE	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Smith Lake Failed ST/DF	Tribal Agreement	1 homes served
NM	THOREAU	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Thoreau Failed STDF Repl	Tribal Agreement	4 homes served
NM	TOHATCHI	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Tohatchi Failed STDF Repl	Tribal Agreement	12 homes served
NM	TSAYATOH	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Tsayatoh Failed ST/DF Repl	Tribal Agreement	12 homes served
NM	TSAYATOH	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Defiance Scatt N23	Tribal Agreement	62 homes served
NM	TWIN LAKES	NAVAJO TRIBE OF ARIZONA, NEW MEXICO AND UTAH	Water and Sanitation Facilities	Twin Lakes Failed STDF	Tribal Agreement	25 homes served
NM	ZIA	PUEBLO OF ZIA, NEW MEXICO	Water and Sanitation Facilities	ZIA Lift Station Modifications	Tribal Agreement	35 homes served
NM	ZIA	PUEBLO OF ZIA, NEW MEXICO	Water and Sanitation Facilities	ZIA Community Well Upgrades	Tribal Agreement	178 homes served
NV	SCHURZ	FORT MCDERMITT PAIUTE AND SHOSHONE TRIBES	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
NV	SCHURZ	Ft McDermitt Paiute and Shoshone Tribes	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
NV	Duckwater	Duckwater Shoshone Tribe	Equipment - Medical Various	Defibrillator	PL 93-638 Agreement	Defibrillator
NV	McDermitt	FT MCDERMITT INDIAN (PAIUTE & SHOSHONE) TRIBES	Equipment - Medical Various	Dental & Medical Equipment	Federal Contact-New	Dental & Medical Equipment
NV	Pyramid Lake	Pyramid Lake Tribe	Equipment - Medical Various	Digital X-Ray Unit	PL 93-638 Agreement	Digital X-Ray Unit
NV	Reno	Reno Sparks Indian Colony	Equipment - Medical Various	Veloscope	PL 93-638 Agreement	Veloscope
NV	Washoe	Washoe Tribe	Equipment - Medical Various	Pharmacy Counting Machine	PL 93-638 Agreement	Pharmacy Counting Machine
NV	Yerrington	Yerington Paiute Tribe	Equipment - Medical Various	Ultrasound	PL 93-638 Agreement	Ultrasound
NV	McDermitt	FT MCDERMITT INDIAN (PAIUTE & SHOSHONE) TRIBES	Facility Maintenance & Improvement	Ft McDermitt Clinic Replacement Facility	Federal Contact-New	CI Improvement
NV	Schurz	Multiple Tribes	Facility Maintenance & Improvement	Walker River Clinic Parking Lot Resurfacing	Federal Contact-New	CI Improvement
NV	Schurz	Multiple Tribes	Facility Maintenance & Improvement	Walker River Clinic Roof Replacement	Federal Contact-New	CI Improvement
NV	FALLON	PAIUTE-SHOSHONE INDIANS OF THE FALLON RESERVATION & COLONY, NEVADA	Water and Sanitation Facilities	Fallon - Replace LS Controls	Tribal Agreement	117 homes served
NV	HUMBOLDT-CO	FORT MCDERMITT PAIUTE & SHOSHONE TRIBES, FORT MCDERMITT INDIAN RES., NV	Water and Sanitation Facilities	Ft McDermitt Electrical Control	Tribal Agreement	132 homes served
NV	SCHURZ	WALKER RIVER PAIUTE TRIBE OF THE WALKER RIVER RESERVATION, NEVADA	Water and Sanitation Facilities	Schurz - SW compactor truck	Tribal Agreement	313 homes served
NV	SCHURZ	WALKER RIVER PAIUTE TRIBE OF THE WALKER RIVER RESERVATION, NEVADA	Water and Sanitation Facilities	SCHURZ - Lift station upgrade	Tribal Agreement	93 homes served
NV	YERINGTON	YERINGTON PAIUTE TRIBE OF THE YERINGTON COLONY & CAMBELL RANCH, NEVADA	Water and Sanitation Facilities	Yerington As/U supplement	Tribal Agreement	71 homes served
NY	BURNINGSPRG	SENECA NATION OF NEW YORK	Water and Sanitation Facilities	SENE - BURNING SPRG WATER LOOP	Tribal Agreement	165 homes served
NY	CATTARAUGUS	SENECA NATION OF NEW YORK	Water and Sanitation Facilities	SENE - RICHARDSON RD WELL EXP (SUP)	Tribal Agreement	428 homes served
NY	ELMA	SENECA NATION OF NEW YORK	Water and Sanitation Facilities	SENE - TIS WWTP EXPANSION (SUP)	Tribal Agreement	228 homes served
NY	LEWISTON	TUSCARORA NATION OF NEW YORK	Water and Sanitation Facilities	TUSC-Ind. Water/Wastewater Ser-PH 2	Tribal Agreement	22 homes served
NY	ST REGIS RES	ST. REGIS BAND OF MOHAWK INDIANS OF NEW YORK	Water and Sanitation Facilities	STRE - PHASE 1-SEWER (SUPPLEMENTAL)	Tribal Agreement	86 homes served
NY	ST REGIS RES	ST. REGIS BAND OF MOHAWK INDIANS OF NEW YORK	Water and Sanitation Facilities	STRE - WTP UPGRADE	Tribal Agreement	1146 homes served
NY	STEAMBURG	SENECA NATION OF NEW YORK	Water and Sanitation Facilities	SENE -STEAMBURG WWTP (SUP)	Tribal Agreement	97 homes served
OK	Ada	Chickasaw Nation	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
OK	Ada	CHICKASAW NATION	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
OK	Okmulgee	Creek Nation	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
OK	Tahlequah	Cherokee Nation of Oklahoma	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
OK	Tahlequah	Cherokee Nation of Oklahoma	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
OK	Tahlequah	Cherokee Nation of Oklahoma	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
OK	Claremore	Multiple Tribes	Equipment – Hospital CT Scanner	Replacement CT scanner	Federal Contact-New	Computed Tomography (CT) Scanner
OK	Clinton	Cheyenne & Arapaho Tribes	Equipment - Medical Various	Colposcope w/Accessories	Federal Contact-New	Colposcope w/Accessories
OK	El Reno	CHEYENNE & ARAPAHO TRIBES	Equipment - Medical Various	5-Dental Operatory Chairs	Federal Contact-New	5-Dental Operatory Chairs
OK	Lawton	Multiple Tribes	Equipment - Medical Various	Local PACS	Federal Contact-New	Local PACS
OK	McLoud	Kickapoo Tribe of Oklahoma	Equipment - Medical Various	Dental CR System	PL 93-638 Agreement	Dental CR System
OK	McLoud	Kickapoo Tribe of Oklahoma	Equipment - Medical Various	Dental Panoramic X-ray-Digital	PL 93-638 Agreement	Dental Panoramic X-ray-Digital

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
OK	Miami	Northeastern Tribal Health System	Equipment - Medical Various	Medical Ultrasond System	PL 93-638 Agreement	Medical Ultrasond System
OK	Newkirk	Kaw Nation of Oklahoma	Equipment - Medical Various	5-Exam Tables	PL 93-638 Agreement	5-Exam Tables
OK	Oklahoma City	Multiple Tribes	Equipment - Medical Various	Area PACS	Federal Contact-New	Area PACS
OK	Oklahoma City	Multiple Tribes	Equipment - Medical Various	Auto Refractometer	Federal Contact-New	Auto Refractometer
OK	Pawhuska	OSAGE NATION OF OKLAHOMA	Equipment - Medical Various	Retina Camera	Federal Contact-New	Retina Camera
OK	Pawnee	PAWNEE INDIAN TRIBE OF OKLAHOMA	Equipment - Medical Various	2-Basic Laboratory Instrument Starter Package #4	Federal Contact-New	2-Basic Laboratory Instrument Starter Package #4
OK	Perkins	Iowa Tribe of Oklahoma	Equipment - Medical Various	X-Ray Film Digitizer	PL 93-638 Agreement	X-Ray Film Digitizer
OK	Sapulpa	Muscogee Creek Nation	Equipment - Medical Various	Laboratoy Microscope	PL 93-638 Agreement	Laboratoy Microscope
OK	Sapulpa	Muscogee Creek Nation	Equipment - Medical Various	Vascular Doppler	PL 93-638 Agreement	Vascular Doppler
OK	Shawnee	Absentee Shawnee Tribe of Oklahoma	Equipment - Medical Various	Colposcope w/Accessories	PL 93-638 Agreement	Colposcope w/Accessories
OK	Shawnee	Absentee Shawnee Tribe of Oklahoma	Equipment - Medical Various	Dental Surgical Laser	PL 93-638 Agreement	Dental Surgical Laser
OK	Shawnee	Citizen Potawatomi Nation	Equipment - Medical Various	Hematology Analyzer	PL 93-638 Agreement	Hematology Analyzer
OK	Stroud	Sac & Fox	Equipment - Medical Various	7-Medical Suite Equipment Packages	PL 93-638 Agreement	7-Medical Suite Equipment Packages
OK	Tahlequah	Cherokee Nation	Equipment - Medical Various	2-Funduscopic Camera	PL 93-638 Agreement	2-Funduscopic Camera
OK	Talihina	Choctaw Nation of Oklahoma	Equipment - Medical Various	2-Infant Warmer w/Scale	PL 93-638 Agreement	2-Infant Warmer w/Scale
OK	Tishomingo	Chickasaw Nation	Equipment - Medical Various	Coagulation Analyzer	PL 93-638 Agreement	Coagulation Analyzer
OK	Tishomingo	Chickasaw Nation	Equipment - Medical Various	Glidescope Video Larynscope	PL 93-638 Agreement	Glidescope Video Larynscope
OK	Tulsa	Multiple Tribes	Equipment - Medical Various	Ultrasound Unit	Federal Contact-New	Ultrasound Unit
OK	Watonga	CHEYENNE & ARAPAHO TRIBES	Equipment - Medical Various	3-Dental Operatory Chairs	Federal Contact-New	3-Dental Operatory Chairs
OK	Wewoka	CHEYENNE & ARAPAHO TRIBES	Equipment - Medical Various	2-Complete Dental Delivery/Op. Systems	Federal Contact-New	2-Complete Dental Delivery/Op. Systems
OK	White Eagle	Ponca Tribe of Oklahoma	Equipment - Medical Various	Dental Fiber Optic Hnd Pcs	PL 93-638 Agreement	Dental Fiber Optic Hnd Pcs
OK	Wyandotte	Wyandotte Tribe of Oklahoma	Equipment - Medical Various	EKG w/Cart	PL 93-638 Agreement	EKG w/Cart
OK	Ardmore	Chickasaw Nation	Facility Maintenance & Improvement	Ardmore HC Remodel	PL 93-638 Agreement	Program Enhancement
OK	Claremore	Multiple Tribes	Facility Maintenance & Improvement	Design & Replace Roof	Federal Contact-New	CI Improvement
OK	Clinton	Cheyenne & Arapaho Tribe	Facility Maintenance & Improvement	ASAP Renovations	PL 93-638 Agreement	CI Improvement
OK	Clinton	Cheyenne & Arapaho Tribes	Facility Maintenance & Improvement	Clinton - additional exam rooms	Federal Contact-New	Program Enhancement
OK	Hugo	Choctaw Nation of Oklahoma	Facility Maintenance & Improvement	Hugo Health Center	PL 93-638 Agreement	CI Improvement
OK	Lawton	Multiple Tribes	Facility Maintenance & Improvement	LIH Roof Replacement	Federal Contact-New	CI Improvement
OK	Lawton	Multiple Tribes	Facility Maintenance & Improvement	LIH Construction of Boiler Replacement	Federal Contact-New	Energy
OK	Mayetta, KS	Prairie Band Potawatomi Nation	Facility Maintenance & Improvement	Geothermal heating and air conditioning improvements	PL 93-638 Agreement	Energy
OK	Mcloud	Kickapoo Tribe of Oklahoma	Facility Maintenance & Improvement	Operating Cost Reduction and Safety Improvements	PL 93-638 Agreement	Energy
OK	Newkirk	Kaw Nation of Oklahoma	Facility Maintenance & Improvement	Health Center Renovation	PL 93-638 Agreement	Energy
OK	Okmulgee	Creek Nation	Facility Maintenance & Improvement	Okmulgee Indian Health Ctr Renovation	PL 93-638 Agreement	Program Enhancement

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
OK	Pawnee	PAWNEE INDIAN TRIBE OF OKLAHOMA	Facility Maintenance & Improvement	Repair Roof Project #OK4PAS01C6	Federal Contact-New	CI Improvement
OK	Perkins	Iowa Tribe of Oklahoma	Facility Maintenance & Improvement	Perkins Family Clinic	PL 93-638 Agreement	CI Improvement
OK	Ponca City	Ponca Tribe of Oklahoma	Facility Maintenance & Improvement	WEHC Renovation	PL 93-638 Agreement	Energy
OK	Shawnee	Absentee Shawnee Tribe of Oklahoma	Facility Maintenance & Improvement	Absentee Shawnee Clinic Remodel	PL 93-638 Agreement	CI Improvement
OK	Shawnee	Citizen Potawatomi Nation	Facility Maintenance & Improvement	CPN Targeted Deficiency-- Flooring	PL 93-638 Agreement	CI Improvement
OK	Shawnee	Citizen Potawatomi Nation	Facility Maintenance & Improvement	CPN Geothermal Retrofit	PL 93-638 Agreement	Energy
OK	Tahlequah	Cherokee Nation	Facility Maintenance & Improvement	WWH Roof Replacement	PL 93-638 Agreement	CI Improvement
OK	Tahlequah	Cherokee Nation	Facility Maintenance & Improvement	WW Hastings Direct Digital Control Upgrade	PL 93-638 Agreement	Energy
OK	Tishomingo	Chickasaw Nation	Facility Maintenance & Improvement	Tishomingo Electrical	PL 93-638 Agreement	CI Improvement
OK	Wyandotte	Wyandotte Nation	Facility Maintenance & Improvement	Prepare and Paint interior of existing facility	PL 93-638 Agreement	CI Improvement
OK	Wyandotte	Wyandotte Nation	Facility Maintenance & Improvement	Remodel & Renovate Health Center	PL 93-638 Agreement	Program Enhancement
OK	ADAIR-CO	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	CHEROKEE / Adair RWD #3 Improvement	Tribal Agreement	930 homes served
OK	ADAIR-CO	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	Cherokee/Adair #2 Storage	Tribal Agreement	612 homes served
OK	ATOKA-CO	CHOCTAW NATION OF OKLAHOMA	Water and Sanitation Facilities	Choctaw/Atoka Co Ind. W & S	Tribal Agreement	97 homes served
OK	BRYAN-CO	CHOCTAW NATION OF OKLAHOMA	Water and Sanitation Facilities	Choctaw/Bennington Water Engineer	Tribal Agreement	6 homes served
OK	CACHE	KIOWA INDIAN TRIBE OF OKLAHOMA	Water and Sanitation Facilities	Comanche / RWD 1 Water Improvement	Tribal Agreement	400 homes served
OK	CADDO-CO	CADDO TRIBE INDIAN OF OKLAHOMA	Water and Sanitation Facilities	Caddo / Scattered W&S	Tribal Agreement	70 homes served
OK	CHEROKEE-CO	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	CHEROKEE/Gourd Lane WL Replacement	Tribal Agreement	52 homes served
OK	CHEROKEE-CO	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	CHEROKEE / RWD 3 VANCE SPRINGS WTP	Tribal Agreement	573 homes served
OK	CHEROKEE-CO	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	Cherokee/Cher RWD#8 Improvements	Tribal Agreement	275 homes served
OK	CHEROKEE-CO	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	CHEROKEE/RWD #3 Sparrowhawk WL	Tribal Agreement	30 homes served
OK	COMANCHE-CO	COMANCHE INDIAN TRIBE OF OKLAHOMA	Water and Sanitation Facilities	Comanche/ RWD 4 Water Improvement	Tribal Agreement	2200 homes served
OK	CONCHO	CHEYENE-ARAPAHO TRIBES OF OKLAHOMA	Water and Sanitation Facilities	C&A \ Concho \ Water System - Study	Tribal Agreement	24 homes served
OK	CUSTER-CO	CHEYENE-ARAPAHO TRIBES OF OKLAHOMA	Water and Sanitation Facilities	C&A Multi County Ind. W&S Project	Tribal Agreement	11 homes served
OK	DELAWARE	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	CHEROKEE / Delaware WTP Upgrade	Tribal Agreement	198 homes served
OK	DELAWARE-CO	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	CHEROKEE / Bradley WL Ext	Tribal Agreement	9 homes served
OK	FAIRLAND	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	CHEROKEE / Fairland WWTP Imp	Tribal Agreement	424 homes served
OK	KAY-CO	PONCA TRIBE OF INDIANS OKLAHOMA	Water and Sanitation Facilities	Ponca / Kay Co. Ind. W&S	Tribal Agreement	10 homes served
OK	MCLOUD	KICKAPOO TRIBE OF OKLAHOMA	Water and Sanitation Facilities	Kickapoo Frye Road WL EXT-PH2	Tribal Agreement	17 homes served
OK	MILL CREEK	CHICKASAW NATION OF OKLAHOMA	Water and Sanitation Facilities	Chickasaw/Mill Creek Lagoon Upgrade	Tribal Agreement	160 homes served
OK	MUSKOGEE-CO	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	CHEROKEE / Muskogee #7 Sys Imp Ph I	Tribal Agreement	901 homes served
OK	NOBLE-CO	OTOE-MISSOURIA TRIBE OF OKLAHOMA	Water and Sanitation Facilities	OTOE/OTOE WATER SYSTEM STANDPIPE REPL.	Tribal Agreement	110 homes served

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
OK	NOBLE-CO	OTOE-MISSOURIA TRIBE OF OKLAHOMA	Water and Sanitation Facilities	Otoe-Missouria Housing Sewer Rehab	Tribal Agreement	50 homes served
OK	OAKS	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	CHEROKEE / Oaks WW Lagoons	Tribal Agreement	85 homes served
OK	OKMULGEE-CO	CREEK NATION OF OKLAHOMA	Water and Sanitation Facilities	Creek/OML Individual W&S (Stimulus)	Tribal Agreement	23 homes served
OK	OTTAWA-CO	EASTERN SHAWNEE TRIBE OF OKLAHOMA	Water and Sanitation Facilities	Eastern Shawnee/Tribe PWS cnx RWD#5	Tribal Agreement	377 homes served
OK	OTTAWA-CO	MODOC TRIBE OF OKLAHOMA	Water and Sanitation Facilities	Modoc/Ottawa Co. Ind Water & Sewer	Tribal Agreement	8 homes served
OK	PAWNEE	PAWNEE INDIAN TRIBE OF OKLAHOMA	Water and Sanitation Facilities	Pawnee\Pawnee City Sewer Svc Lines	Tribal Agreement	150 homes served
OK	PERKINS	IOWA TRIBE OF OKLAHOMA	Water and Sanitation Facilities	IOWA/ LAGOON INLET PIPE REHAB	Tribal Agreement	22 homes served
OK	POTTAWATOMIE	CITIZEN BAND OF POTAWATOMI INDIAN TRIBE OF OKLAHOMA	Water and Sanitation Facilities	CPN Individual Water and Sewer	Tribal Agreement	25 homes served
OK	STROUD	SAC AND FOX TRIBE OF INDIANS OF OKLAHOMA	Water and Sanitation Facilities	Sac And Fox Individual W&S	Tribal Agreement	16 homes served
OK	TAHLEQUAH	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	CHEROKEE/TPWA WTP Tenkiller	Tribal Agreement	15418 homes served
OK	WARNER	CHEROKEE NATION OF OKLAHOMA	Water and Sanitation Facilities	CHEROKEE/Warner WTP Improvements	Tribal Agreement	800 homes served
OR	Chiloquin	Klamath Tribes	Equipment - Medical Various	Laboratory Analyzer (4)	PL 93-638 Agreement	Laboratory Analyzer (4)
OR	Coos Bay	Coquille Tribe of Oregon	Equipment - Medical Various	Examination Tables w/ Accesories (3)	PL 93-638 Agreement	Examination Tables w/ Accesories (3)
OR	Grand Ronde	Confederated Tribes of the Grande Ronde Community of Oregon	Equipment - Medical Various	Diagnostic Testing System (1)	PL 93-638 Agreement	Diagnostic Testing System (1)
OR	Grand Ronde	Confederated Tribes of the Grande Ronde Community of Oregon	Equipment - Medical Various	Tables Exam (3)	PL 93-638 Agreement	Tables Exam (3)
OR	Pendleton	Confederated Tribes of Umatilla Reservaton	Equipment - Medical Various	Dental Chair w/ Delivery System (2)	PL 93-638 Agreement	Dental Chair w/ Delivery System (2)
OR	Roseburg	Cow Creek Band of Umpqua Indians of Oregon	Equipment - Medical Various	Table Examination w/ Accessory (3)	PL 93-638 Agreement	Table Examination w/ Accessory (3)
OR	Siletz	Confederated Tribes of the Siletz Reservation	Equipment - Medical Various	Examination Tables	PL 93-638 Agreement	Examination Tables
OR	Siletz	Confederated Tribes of the Siletz Reservation	Equipment - Medical Various	Hematology Analyzer (1)	PL 93-638 Agreement	Hematology Analyzer (1)
OR	Warm Springs	Confederated Tribes of the Warm Springs Reservation of Oregon	Equipment - Medical Various	Digital X-ray System	Federal Contact-New	Digital X-ray System
OR	Coos Bay	Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians of Oregon	Facility Maintenance & Improvement	Coos, L. Umpqua, Siuslaw CTLUSI Health Ctr. Renovation	PL 93-638 Agreement	CI Improvement
OR	Coos Bay	Coquille Tribe of Oregon	Facility Maintenance & Improvement	Coquille Indian Tribe Community Health Center Energy-HVAC Improvements	PL 93-638 Agreement	Energy
OR	Grand Ronde	Confederated Tribes of the Grand Ronde Community of Oregon	Facility Maintenance & Improvement	Health and Wellness Center Renovation	PL 93-638 Agreement	CI Improvement
OR	Klamath Falls	Klamath Tribes	Facility Maintenance & Improvement	Klamath Tribal Health & Family Services Renovation	PL 93-638 Agreement	CI Improvement
OR	Pendleton	Confederated Tribes of the Umatilla Reservation, Oregon	Facility Maintenance & Improvement	Health Center HVAC Replacement	PL 93-638 Agreement	Energy
OR	Pendleton	Confederated Tribes of the Umatilla Reservation, Oregon	Facility Maintenance & Improvement	Yellowhawk Tribal Health Center X-Ray Lab Renovation	PL 93-638 Agreement	Program Enhancement
OR	Roseburg	Cow Creek Band of Umpqua Indians of Oregon	Facility Maintenance & Improvement	Cow Creek Health and Wellness Center Renovations	PL 93-638 Agreement	Fire-Life Safety
OR	Salem	Multiple Tribes	Facility Maintenance & Improvement	Chemawa Health Center HVAC-Energy Improvements	Federal Contact-New	Energy
OR	Warm Springs	Confederated Tribes of the Warm Springs Reservation of Oregon	Facility Maintenance & Improvement	Warm Springs Health and Wellness Center - Facility Alterations to Accommodate Digital Radiography Unit	PL 93-638 Agreement	Program Enhancement

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
OR	SIELETZ	CONFEDERATED TRIBES OF THE SILETZ RESERVATION, OREGON	Water and Sanitation Facilities	SILETZ - Water Storage Tank & Pump	Tribal Agreement	713 homes served
OR	SIMNASHO ARE	CONFEDERATED TRIBES OF THE WARM SPRINGS RESERVATION, OREGON	Water and Sanitation Facilities	WS - Simnasho&Sidwalter Wtr Meters	Tribal Agreement	202 homes served
RI	Charleston	Narragansett Indian Tribe	Equipment - Medical Various	Optometry Care Delivery System/Unit	PL 93-638 Agreement	Optometry Care Delivery System/Unit
RI	CHARLESTOWN	NARRAGANSETT INDIAN TRIBE OF RHODE ISLAND	Water and Sanitation Facilities	NARR - Corrosion Control	Tribal Agreement	5 homes served
SD	Eagle Butte	CHEYENNE RIVER SIOUX TRIBE	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Eagle Butte	CHEYENNE RIVER SIOUX TRIBE	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Eagle Butte	CHEYENNE RIVER SIOUX TRIBE	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Eagle Butte	CHEYENNE RIVER SIOUX TRIBE	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Eagle Butte	STANDING ROCK SIOUX TRIBE	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Pine Ridge	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Pine Ridge	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Pine Ridge	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Pine Ridge	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Pine Ridge	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Pine Ridge	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Pine Ridge	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	PINE RIDGE	Oglala Sioux Tribe Pine Ridge	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Rosebud	Rosebud Sioux	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Rosebud	Rosebud Sioux	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Rosebud	Rosebud Sioux	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Rosebud	ROSEBUD SIOUX TRIBE	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Rosebud	ROSEBUD SIOUX TRIBE	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Rosebud	ROSEBUD SIOUX TRIBE	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
SD	Ft Yates/McLaughlin	STANDING ROCK SIOUX TRIBE	Equipment - Medical Various	CR/PACS Installation	Federal Contact-New	CR/PACS Installation
SD	Lower Brule	Lower Brule Sioux Tribe	Equipment - Medical Various	Ultrasound Installation	Federal Contact-New	Ultrasound Installation
SD	Rosebud	Rosebud Sioux Tribe	Equipment - Medical Various	CR/PACS Expansion	Federal Contact-New	CR/PACS Expansion
SD	Agency Village	Sisseton-Wahpeton Tribe	Facility Maintenance & Improvement	Tribal Alcohol Treatment Building Renovations	PL 93-638 Agreement	CI Improvement
SD	Fort Thompson	CROW CREEK SIOUX TRIBE OF THE CROW CREEK RESERVATION, SOUTH DAKOTA	Facility Maintenance & Improvement	Health Clinic Fire Alarm Repairs, OP Clinic Exam Room Expansion, and Exterior Repairs	Federal Contact-Existing	Fire-Life Safety
SD	Kyle	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION, SOUTH DAKOTA	Facility Maintenance & Improvement	Kyle Health Center and Quarters Repairs/Renovations	Federal Contact-Existing	CI Improvement
SD	Kyle, Wanblee, Martin and Porcupine, SD	Doug O'Bryan Contracting	Facility Maintenance & Improvement	OST Health Buildings Renovations	PL 93-638 Agreement	CI Improvement

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
SD	Lake Andes	Yankton Sioux Tribe	Facility Maintenance & Improvement	Building Access Road Repairs	PL 93-638 Agreement	CI Improvement
SD	Lower Brule	Lower Brule Sioux Tribe	Facility Maintenance & Improvement	Fire-Life-Safety, Interior and Exterior Repairs	PL 93-638 Agreement	CI Improvement
SD	Lower Brule	Lower Brule Sioux Tribe	Facility Maintenance & Improvement	Replace Doors Ambulance Building	PL 93-638 Agreement	Fire-Life Safety
SD	Pine Ridge	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION, SOUTH DAKOTA	Facility Maintenance & Improvement	Door, HVAC Control, & Oxygen Gas System Repairs/Upgrades	Federal Contact-Existing	CI Improvement
SD	Pine Ridge	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION, SOUTH DAKOTA	Facility Maintenance & Improvement	Water Treatment & Retro-Commissioning	Federal Contact-Existing	Energy
SD	Pine Ridge	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION, SOUTH DAKOTA	Facility Maintenance & Improvement	Install Wind Turbine	Federal Contact-New	Energy
SD	Pine Ridge Manderson Allen	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION, SOUTH DAKOTA	Facility Maintenance & Improvement	Staff Quarters Roof, Basement, Heat Pump, Street Paving/Repairs, and Security Fencing	Federal Contact-Existing	CI Improvement
SD	Rapid City	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION, SOUTH DAKOTA	Facility Maintenance & Improvement	Facility Renovations, Repairs, and Systems Upgrades	Federal Contact-Existing	CI Improvement
SD	Rosebud	Rosebud Sioux Tribe	Facility Maintenance & Improvement	Install Wind Turbine	Federal Contact-New	Energy
SD	Rosebud	Rosebud Sioux Tribe	Facility Maintenance & Improvement	Ambulance Bay, Doors and Roof Access	PL 93-638 Agreement	CI Improvement
SD	Rosebud	Rosebud Sioux Tribe	Facility Maintenance & Improvement	Replace Doors, Siding, Roof, Electrical Systems at Tribal Alcohol, Diabetes, and Ambulance Buildings	PL 93-638 Agreement	CI Improvement
SD	Rosebud	Rosebud Sioux Tribe	Facility Maintenance & Improvement	Rosebud Garage Reroofing	PL 93-638 Agreement	CI Improvement
SD	Rosebud	Rosebud Sioux Tribe	Facility Maintenance & Improvement	HVAC System Repairs/Upgrades	PL 93-638 Agreement	Energy
SD	Rosebud, Pine Ridge	Multiple Tribes	Facility Maintenance & Improvement	Sprinkler Health Stations and Residences-Multiple Sites	Federal Contact-New	Fire-Life Safety
SD	Sisseton	Sisseton-Wahpeton Tribe	Facility Maintenance & Improvement	Replace Existing Storefront Windows	PL 93-638 Agreement	Energy
SD	Wagner	YANKTON & SANTEE SIOUX TRIBES	Facility Maintenance & Improvement	Elevator, Fire Door, Door Hardware, & Lighting Project	Federal Contact-Existing	CI Improvement
SD	Wakpala	STANDING ROCK SIOUX TRIBE	Facility Maintenance & Improvement	Construct French Drain and Pumping System	Federal Contact-New	CI Improvement
SD	Wakpala	STANDING ROCK SIOUX TRIBE	Facility Maintenance & Improvement	Renovation and Reroof Facility	Federal Contact-New	CI Improvement
SD	Wanblee	OGLALA SIOUX (PINE RIDGE) TRIBE	Facility Maintenance & Improvement	Wanblee Health Center Quarters Ground Source Heat Pumps	Federal Contact-Existing	Energy
SD	Eagle Butte	Cheyenne River Sioux Tribe	Hospital Replacement Construction	State of the Art Hospital in Eagle Butte SD	Federal Contract/PL 93-638 Agreement	New Hospital
SD	BIG BEND	CROW CREEK SIOUX TRIBE OF THE CROW CREEK RESERVATION, SOUTH DAKOTA	Water and Sanitation Facilities	Big Bend Lift Station Renovation	Tribal Agreement	24 homes served
SD	ENEMY SWIM	SISSETON-WAHPETON SIOUX TRIBE OF THE TRAVERSE RESERVATION, SOUTH DAKOTA	Water and Sanitation Facilities	Enemy Swim Tank Repairs	Tribal Agreement	62 homes served

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
SD	FT THOMPSON	CROW CREEK SIOUX TRIBE OF THE CROW CREEK RESERVATION, SOUTH DAKOTA	Water and Sanitation Facilities	Ft Thompson WTP Replacement	Tribal Agreement	368 homes served
SD	KYLE	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION, SOUTH DAKOTA	Water and Sanitation Facilities	Pine Ridge Solid Waste Equipment	Tribal Agreement	1282 homes served
SD	KYLE	OGLALA SIOUX TRIBE OF THE PINE RIDGE RESERVATION, SOUTH DAKOTA	Water and Sanitation Facilities	Kyle LS Replacement & Lagoon Improv	Tribal Agreement	419 homes served
SD	MISSION	ROSEBUD SIOUX TRIBE OF THE ROSEBUD INDIAN RESERVATION, SOUTH DAKOTA	Water and Sanitation Facilities	RB-Mission Lift Station Replacement	Tribal Agreement	1149 homes served
SD	PARMELEE	ROSEBUD SIOUX TRIBE OF THE ROSEBUD INDIAN RESERVATION, SOUTH DAKOTA	Water and Sanitation Facilities	RB-Parmelee Lift Station Replace	Tribal Agreement	136 homes served
SD	ROSEBUD	ROSEBUD SIOUX TRIBE OF THE ROSEBUD INDIAN RESERVATION, SOUTH DAKOTA	Water and Sanitation Facilities	Rosebud Lagoon Phase 1	Tribal Agreement	463 homes served
SD	SOUTH DAKOTA	CHEYENNE RIVER SIOUX TRIBE OF THE CHEYENNE RIVER RESERVATION, SOUTH DAKOTA	Water and Sanitation Facilities	Mni Waste WTP Backwash Piping	Tribal Agreement	549 homes served
TX	Eagle Pass	Kickapoo Traditional Tribe of Texas	Equipment - Medical Various	Holter Monitor Starter Kit	PL 93-638 Agreement	Holter Monitor Starter Kit
TX	LIVINGSTON	ALABAMA AND COUSHATTA TRIBES OF TEXAS	Water and Sanitation Facilities	ALAC-WATER LOSS MONITORING	Tribal Agreement	232 homes served
UT	Fort Duchesne	Uintah & Ouray	Equipment - Medical Various	Digital X-Ray Processor	Federal Contact-New	Digital X-Ray Processor
UT	Fort Duchesne	Uintah & Ouray	Equipment - Medical Various	Panoramic Dental X-ray	Federal Contact-New	Panoramic Dental X-ray
UT	Montezuma Creek	Navajo Nation	Equipment - Medical Various	EKGs (3)	PL 93-638 Agreement	EKGs (3)
UT	SKULL VALLEY	SKULL VALLEY BAND OF GOSHUTE INDIANS OF UTAH	Water and Sanitation Facilities	Skull Valley - Water Storage Tank	Tribal Agreement	16 homes served
UT	UINTAH-CO	UTE INDIAN TRIBE OF THE UINTAH AND OURAY RESERVATION, UTAH	Water and Sanitation Facilities	U&O - Restore Old Lagoon Site	Tribal Agreement	70 homes served
WA	WHITE SWAN	Yakima Nation	Equipment - Ambulance	New Ambulance	GSA Contracts	New Ambulance
WA	Arlington	Stillaquamish Tribe of Washington	Equipment - Medical Various	Table Examination w/ Accessory (3)	PL 93-638 Agreement	Table Examination w/ Accessory (3)
WA	Darrington	Sauk-Suiattle Indian Tribe of Washington	Equipment - Medical Various	Patient Examination System (1)	PL 93-638 Agreement	Patient Examination System (1)
WA	Deming	Nooksack Indian Tribe of Washington	Equipment - Medical Various	Moble Diagnostic System (1)	PL 93-638 Agreement	Moble Diagnostic System (1)
WA	Inchelium	Confederated Tribes of Colville Reservation	Equipment - Medical Various	Stryker Beds (3)	PL 93-638 Agreement	Stryker Beds (3)
WA	La Conner	Swinomish Indians of the Swinomish Reservation	Equipment - Medical Various	Dental Care Delivery System (1)	PL 93-638 Agreement	Dental Care Delivery System (1)
WA	LaConner	Swinomish Indians of the Swinomish Reservation	Equipment - Medical Various	EKG Diagnostic System (1)	PL 93-638 Agreement	EKG Diagnostic System (1)
WA	Longview	Cowlitz Indian Tribe	Equipment - Medical Various	Barrier Free Table Exam (3);	PL 93-638 Agreement	Barrier Free Table Exam (3);
WA	Neah Bay	Makah Indian Tribe of the Makah Nation	Equipment - Medical Various	Fetal Monitor (1)	PL 93-638 Agreement	Fetal Monitor (1)
WA	Oakville	Confederated Tribes of the Chehalis Reservation	Equipment - Medical Various	Cardiac/Monitor Systems (1)	PL 93-638 Agreement	Cardiac/Monitor Systems (1)
WA	Sequim	Jamestown S'Klallam Tribe of Washington	Equipment - Medical Various	Mobile Diagnostic Testing System/Unit (2)	PL 93-638 Agreement	Mobile Diagnostic Testing System/Unit (2)
WA	Shelton	Skokomish Indian Tribe of the Skokomish Reservation	Equipment - Medical Various	Dental Xray Unit (2)	PL 93-638 Agreement	Dental Xray Unit (2)
WA	Shelton	Squaxin Island Tribe of Squaxin Island Reservation	Equipment - Medical Various	Cardiac Diagnostic System-Basic(3)	PL 93-638 Agreement	Cardiac Diagnostic System-Basic(3)
WA	Tacoma	Puyallup Tribe of the Puyallup Reservation	Equipment - Medical Various	Examination Tables w/ Accesories (10)	PL 93-638 Agreement	Examination Tables w/ Accesories (10)
WA	Tacoma	Puyallup Tribe of the Puyallup Reservation	Equipment - Medical Various	Pill Counters(3)	PL 93-638 Agreement	Pill Counters(3)
WA	Taholah	Quinault Tribe of the Quinault Reservation	Equipment - Medical Various	Cardiac Transport System(1)	PL 93-638 Agreement	Cardiac Transport System(1)

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
WA	Tulalip	Tulalip Tribes of Tulalip Reservation	Equipment - Medical Various	Otoscopes/Ophthalmoscope (14)	PL 93-638 Agreement	Otoscopes/Ophthalmoscope (14)
WA	Yakama	Multiple Tribes	Equipment - Medical Various	Digital X-ray System	Federal Contact-New	Digital X-ray System
WA	Elma	Squaxin Indian Tribe of the Squaxin Island Reservation, Washington	Facility Maintenance & Improvement	Squaxin Island NW Indian Treatment Center Renovation	PL 93-638 Agreement	Program Enhancement
WA	LaPush	Quileute Tribe of the Quileute Reservation	Facility Maintenance & Improvement	Quileute Health Center Roof Replacement	PL 93-638 Agreement	CI Improvement
WA	LaPush	Quileute Tribe of the Quileute Reservation	Facility Maintenance & Improvement	Quileute Health Center HVAC Replacement	PL 93-638 Agreement	Energy
WA	Neah Bay	Makah Indian Tribe of the Makah Indian Reservation	Facility Maintenance & Improvement	Sophie Trettevick Health Center Renovation	PL 93-638 Agreement	CI Improvement
WA	Nespelem	Confederated Tribes of the Colville Reservation, Washington	Facility Maintenance & Improvement	Nespelem Health Center Renovation	PL 93-638 Agreement	Program Enhancement
WA	Olympia	Nisqually Indian Tribe of the Nisqually Reservation	Facility Maintenance & Improvement	Nisqually Indian Tribe Health Clinic Renovation	PL 93-638 Agreement	CI Improvement
WA	Shelton	Skokomish Indian Tribe of the Skokomish Reservation, Washington	Facility Maintenance & Improvement	Skokomish Health Clinic Repair & Renovation	PL 93-638 Agreement	Program Enhancement
WA	Shelton	Squaxin Indian Tribe of the Squaxin Island Reservation, Washington	Facility Maintenance & Improvement	Squaxin Island Health Clinic Facility Repairs	PL 93-638 Agreement	Energy
WA	Spokane	HEALING LODGE OF THE SEVEN NATIONS	Facility Maintenance & Improvement	Healing Lodge HVAC-Energy	PL 93-638 Agreement	Energy
WA	Toppenish	Multiple Tribes	Facility Maintenance & Improvement	Yakama Health Center HVAC-Chiller Replacement	Federal Contact-New	Energy
WA	Toppenish	Multiple Tribes	Facility Maintenance & Improvement	Yakama Health Center - Facility Alterations to Accommodate Digital Radiography Unit	Federal Contact-New	Program Enhancement
WA	Wellpinit	Multiple Tribes	Facility Maintenance & Improvement	David C. Wynecoop Memorial Clinic Renovation	Federal Contact-New	CI Improvement
WA	CHEHALIS RES	CONFEDERATED TRIBES OF THE CHEHALIS RESERVATION, WASHINGTON	Water and Sanitation Facilities	CHEHALIS RES - Starrville Dfields	Tribal Agreement	5 homes served
WA	LAPUSH	QUILEUTE TRIBE OF THE QUILEUTE RESERVATION, WASHINGTON	Water and Sanitation Facilities	QUILEUTE - WATER SYSTEM IMPROVE	Tribal Agreement	199 homes served
WA	LOWER ELWHA	LOWER ELWHA TRIBAL COMMUNITY OF THE LOWER ELWHA RESERVATION, WASHINGTON	Water and Sanitation Facilities	LOWER ELWHA - VALLEY WATER STORAGE	Tribal Agreement	134 homes served
WA	LUMMI VILL	LUMMI TRIBE, WA	Water and Sanitation Facilities	LUMMI - Slater Rd & Haxton Way Wtr	Tribal Agreement	1053 homes served
WA	NEAH BAY	MAKAH INDIAN TRIBE OF THE INDIAN RESERVATION, WASHINGTON	Water and Sanitation Facilities	MAKAH - Neah Bay CSS Phase I	Tribal Agreement	660 homes served
WA	NESPELEM	CONFEDERATED TRIBES OF THE COLVILLE RESERVATION, WASHINGTON	Water and Sanitation Facilities	COLVILLE - NESP ARSENIC & TANK REHA	Tribal Agreement	569 homes served
WA	PEND OREILLE	KALISPEL INDIAN COMMUNITY OF THE KALISPEL INDIAN RESERVATION, WASHINGTON	Water and Sanitation Facilities	Kalispel - HQ WW Expansion	Tribal Agreement	91 homes served
WA	STEVENS-CO	SPOKANE TRIBE OF THE SPOKANE RESERVATION, WASHINGTON	Water and Sanitation Facilities	SPOKANE-Westend Landfill Close	Tribal Agreement	815 homes served
WA	SWINOMISH IC	SWINOMISH TRIBE, WA	Water and Sanitation Facilities	SWINOMISH - Sewer Main Replcmt	Tribal Agreement	67 homes served
WA	TAHOLAH	QUINAULT TRIBE OF THE QUINAULT RESERVATION, WASHINGTON	Water and Sanitation Facilities	QUINAULT - TAHOLAH AC MAIN REPLACE	Tribal Agreement	264 homes served

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
WA	TULALIP IC	TULALIP TRIBES OF THE TULALIP RESERVATION, WASHINGTON	Water and Sanitation Facilities	TULALIP WATER METERS	Tribal Agreement	1733 homes served
WA	YAKIMA-CO	CONFEDERATED TRIBES & BANDS OF THE YAKIMA INDIAN NATION OF THE YAKIMA RES.	Water and Sanitation Facilities	YAKAMA - Individual Scat W&S	Tribal Agreement	12 homes served
WI	Baraboo	Ho-Chunk Nation	Equipment - Medical Various	Dental Delivery System -4	PL 93-638 Agreement	Dental Delivery System -4
WI	Baraboo	Ho-Chunk Nation	Equipment - Medical Various	Two Digital Dental X-ray Units	PL 93-638 Agreement	Two Digital Dental X-ray Units
WI	Bayfield	Red Cliff	Equipment - Medical Various	Hematology Equipment	PL 93-638 Agreement	Hematology Equipment
WI	Bowler	Stockbridge-Munsee	Equipment - Medical Various	Replacement Chemistry Analyzer	PL 93-638 Agreement	Replacement Chemistry Analyzer
WI	Hayward	Lac Courte Oreilles Band	Equipment - Medical Various	Bone Densitometer	PL 93-638 Agreement	Bone Densitometer
WI	Hayward	Lac Courte Oreilles Band	Equipment - Medical Various	Hermatology Analyzer	PL 93-638 Agreement	Hermatology Analyzer
WI	Keshena	Menominee	Equipment - Medical Various	Coagulation Analyzer	PL 93-638 Agreement	Coagulation Analyzer
WI	Oneida	Oneida	Equipment - Medical Various	Coag Analyzer	PL 93-638 Agreement	Coag Analyzer
WI	Bayfield	Red Cliff	Facility Maintenance & Improvement	Misc. Facility Repairs	PL 93-638 Agreement	CI Improvement
WI	Bayfield	Red Cliff	Facility Maintenance & Improvement	Renovation of reception area	PL 93-638 Agreement	Program Enhancement
WI	Black River Falls	Ho-Chunk	Facility Maintenance & Improvement	Renovation of facility to improve patient care.	PL 93-638 Agreement	Program Enhancement
WI	Bowler	Stockbridge-Munsee	Facility Maintenance & Improvement	Repair roof, roof supports, & flashing; concrete masonry repairs; repair of windows; prep & stain exterior wood logs and siding	PL 93-638 Agreement	CI Improvement
WI	Bowler	Stockbridge-Munsee	Facility Maintenance & Improvement	Renovation of reception and registration area	PL 93-638 Agreement	Program Enhancement
WI	Crandon	Forest County Potawotomi	Facility Maintenance & Improvement	HVAC Repairs	PL 93-638 Agreement	CI Improvement
WI	Gresham	Menominee	Facility Maintenance & Improvement	Sewage-Septic Replacement	PL 93-638 Agreement	CI Improvement
WI	Hayward	Lac Courte Oreilles Band	Facility Maintenance & Improvement	HVAC Repairs	PL 93-638 Agreement	Energy
Wi	Hayward	Lac Courte Oreilles Band	Facility Maintenance & Improvement	Health Center Life Safety Project	PL 93-638 Agreement	Fire-Life Safety
WI	Keshena	Menominee	Facility Maintenance & Improvement	Safety, Accessibility, and Facility Repairs	PL 93-638 Agreement	CI Improvement
WI	Keshena	Menominee	Facility Maintenance & Improvement	Exterior-Interior Repairs	PL 93-638 Agreement	CI Improvement
WI	Keshena	Menominee	Facility Maintenance & Improvement	HVAC DDC Replacement	PL 93-638 Agreement	Energy
WI	Odanah	Bad River	Facility Maintenance & Improvement	Safety, Accessibility, and Facility Repairs	PL 93-638 Agreement	CI Improvement
WI	JACKSON-CO	HO CHUNK	Water and Sanitation Facilities	Ho-Chunk Scattered Site - ARRA	Tribal Agreement	1 homes served
WI	L D FLAMBEAU	LAC DU FLAMBEAU BAND OF LAKE SUPERIOR CHIPPEWA INDIANS	Water and Sanitation Facilities	LDF AC Main Replace - ARRA	Tribal Agreement	117 homes served
WI	L D FLAMBEAU	LAC DU FLAMBEAU BAND OF LAKE SUPERIOR CHIPPEWA INDIANS	Water and Sanitation Facilities	Main & West PH Shortfall-ARRA	Tribal Agreement	532 homes served

STATE	CITY/SITE	TRIBE/TRIBALORGANIZATION	TYPE	DESCRIPTION	METHOD	OUTPUT
WI	MAPLE PLAIN	ST. CROIX CHIPPEWA INDIANS OF WISCONSIN, ST. CROIX RESERVATION, WISCONSIN	Water and Sanitation Facilities	Hydro. tank Isolation/GW study-ARRA	Tribal Agreement	44 homes served
WI	ODANAH	BAD RIVER BAND OF THE LAKE SUPERIOR TRIBE OF CHIPPEWA INDIANS	Water and Sanitation Facilities	Bad River Septic Replace - ARRA	Tribal Agreement	37 homes served
WY	Fort Washakie	SHOSHONE & ARAPAHOE TRIBES	Equipment - Medical Various	Bacteriology ID and sensitivity system	Federal Contact-New	Bacteriology ID and sensitivity system
WY	Fort Washakie	SHOSHONE & ARAPAHOE TRIBES	Equipment - Medical Various	Exam table	Federal Contact-New	Exam table
WY	Arapahoe	NORTHERN ARAPAHOE TRIBE (WIND RIVER)	Facility Maintenance & Improvement	Roof Top HVAC Units Replacement	Federal Contact-New	Energy
WY	Fort Washakie	SHOSHONE & ARAPAHOE TRIBES	Facility Maintenance & Improvement	Cooling Tower Replacement	Federal Contact-New	CI Improvement
WY	Fort Washakie	SHOSHONE & ARAPAHOE TRIBES	Facility Maintenance & Improvement	Boiler Design and Replacement	Federal Contact-New	Energy
WY	Fort Washakie	SHOSHONE & ARAPAHOE TRIBES	Facility Maintenance & Improvement	HVAC Control System Replacement	Federal Contact-New	Energy
WY	FT WASHAKIE	SHOSHONE TRIBE OF THE WIND RIVER RESERVATION, WYOMING	Water and Sanitation Facilities	FT. Washakie water meters phase I	Tribal Agreement	531 homes served

Indian Health Services: Health Information Technology

Recovery Act funds are modernizing and extending electronic health information technology in the Indian Health Service (IHS) thereby improving access, quality, safety and overall health status of American Indian/Alaska Native (AI/AN) patients and populations. Approximately 95% of Recovery Act funded activities are being carried out through commercial contracts and through amendments to contracts with Tribes or Tribal organizations. IHS is using up to 5% of the funds for administrative costs, project management, and Recovery Act transparency reporting. Approximately 44% of the funds are being competitively awarded to acquire new hardware and network services to modernize security, communications, and infrastructure. In addition, acquisitions for software development and related services are being awarded via contract vehicles and through existing Tribal contracts as appropriate. Several existing competitively awarded General Services Administration (GSA) contracts were accelerated to expedite Recovery Act funded activities.

A. Funding Table

(Obligations in millions)

Program/Project Activity	Total Appropriated	FY2009 Actual	FY2010 Estimate
		Obligations	Obligations
Certified Electronic Health Record	$46.3	$34.2	$12.1
Personal Health Record Adoption	$2.3	$0.0	$2.3
Telehealth and Network Infrastructure	$32.3	$3.4	$28.9
Administration	$4.1	$2.1	$2.0
Total	$85.0	$39.7	$45.3

A. Objectives

- Invest in health information technology within IHS, directly benefiting the economy through the expenditure of funds in the private sector for goods and services.
- Contribute to the revitalization of the American economy through a significant expansion in the use of IT service companies and purchases of hardware from U.S. based information technology companies.
- Modernize and enhance network hardware and software capacity so that all Indian health care sites enhance the delivery of care and benefit from new health care information tools and security.
- Improve network infrastructure, including:

  - Network security enhancements to provide additional protection for patient data.
  - Network upgrades to improve speed, reliability, and redundancy of the network.
  - Video conferencing upgrades to support future telehealth initiatives.
- Deploy enhanced electronic health information technology to expand services, improve patient care quality, decrease service disparities, and expand access by Indians to out-of-network services and reimbursements.
- Improve and leverage the capabilities of the Resource and Patient Management System (RPMS), which is the electronic health information technology solution used by IHS, and the associated network infrastructure.
- Continue RPMS ambulatory certification and achieve RPMS patient certification by the non-profit U.S. certification authority.
- Expand use of the RPMS certified solutions in outpatient and inpatient settings; ensure meaningful use, once it has been defined.
- Improve the RPMS application, including:
  - Modernize the RPMS Electronic Health Record (EHR).
  - Acquire a personal health record capability for RPMS.
  - Improve the existing population health application.
  - Acquire a practice management system.
  - Develop a behavioral health EHR.

A. Activities

Expand Use of Certified Electronic Health Record

- **Comprehensive Health Information**. Improving capabilities across the RPMS suite, including clinical care, support services, and practice management, including activities to address the ease of implementation, support, and usability of the system.
- **Provider Order Entry**. Continued improvements to applications that support the communication of orders and consultations among members of the health care team both on site and remotely, including electronic prescribing.
- **Clinical Decision Support**. Creating and acquiring clinical decision support tools that build additional intelligence into RPMS, supporting quality of care and patient safety.
- **Quality and Performance Reporting**. Expanding existing quality and performance reporting capabilities, and ensuring that quality and performance data are transparent and accessible to consumers of IHS health care services.

- **Health Information Exchange**. Activities to ensure that RPMS meets national interoperability standards and those facilities using RPMS are positioned to participate in exchanges such as the Nationwide Health Information Network.
- **Certification**. Ensuring that RPMS receives national certification as a qualified EHR for inpatient use and for behavioral health settings, and continued certification as an outpatient EHR solution.
- **Deployment**. Intensive support for the deployment of RPMS EHR in all Federal and Tribal inpatient facilities, and optimization of implementation in outpatient settings as well.
- **Meaningful Use**. Ensure that RPMS can be used by providers to demonstrate they meet the requirements of "meaningful use" of electronic health records, once defined.

Personal Health Record Adoption

Development and collaborations to create truly consumer-oriented tools for management and portability of personal health information.

Telehealth and Network Infrastructure

The telehealth and network infrastructure activity is comprised of a number of discrete projects. All of these projects are related to improvements to the IHS network or support of future telehealth initiatives. These projects include a complete upgrade of the network routers, upgrade of network domain controllers, improvement and expansion of the storage area network, network security improvements; upgrade of information technology equipment required to support the deployment of an EHR certified for meaningful use, and upgrade and expansion of video conferencing infrastructure and the purchase of video conference devices for provision of telehealth services.

A. Characteristics

Types of Recipients

- Private-sector firms for computer and networking hardware
- Private-sector software development and project management firms
- Tribes, Tribal organizations, and Urban Indian programs offering needed technology products and services

Types of Financial Awards

- Commercial contracts (estimated funding: $51 million)
- Tribal contracts (estimated funding: $3.5 million)
- GSA contracts (estimated funding: $28 million)

Methods of Selection

- **New competition**. Merit based competition among vendors offering products that meet the specified requirements. Approximately 37% (32 million) will be competed for hardware and infrastructure modernization relating to security, networking, communications, and health information technology. Competitive contracts will also be awarded for new software development activities not covered under the scope of existing contracts.
- **Supplements to standing contracts**. Several competitively awarded GSA contract vehicles have accommodated rapid expansions for work in the near term, consistent with the goal of the Recovery Act to stimulate the economy in as timely a manner as possible.

A. Delivery Schedule

Activities	Supplements	Awards	Milestones	
Certified Electronic Health Record: Comprehensive Health Information	April-June, 2009	August-September 2010	Acquire practice management solution (October-December, 2010) Release of EHR Web interface (July-September, 2011)	July-September, 2011
Certified Electronic Health Record: Provider Order Entry	April-June, 2009	August-September 2010	Release pharmacy multiple drug file enhancement (January-March, 2010) Deploy Consolidated Mail Outpatient Pharmacy (April-June, 2010)	January-March, 2011
Certified Electronic Health Record: Clinical Decision Support	April-June, 2009	None	Release care management functionality (April-June, 2010) Implement ER dashboard application (January-March, 2010)	July-September 2011
Certified Electronic Health Record: Quality & Performance Reporting	April-June, 2009	August-September 2010	Add 2 performance measures to the Clinical Reporting System's Selected Measures Report	July-September 2010

Activities	Contract Supplements	New Awards	Work Milestones	Delivery
Certified Electronic Health Record: Health Information Exchange	April-June, 2009	August-September 2010	Deploy Enterprise Master Patient Index (January-March, 2010) Complete connection to Nationwide Health Information Network (July-September, 2010)	July-September 2010
Certified Electronic Health Record: Certification	April-June, 2009	August-September 2010	Complete EHR inpatient certification (July-September, 2010)	July-September 2010
Certified Electronic Health Record: Deployment	April-June, 2009	None	Implement use of RPMS in at least eighty (80) Alaska Village Clinics (July-September, 2010)	July-September 2011
Personal Health Record Adoption	April-June, 2009	August-September 2010	Complete requirements for initial PHR (October-December, 2010)	July-September 2011
Telehealth and Network Infrastructure	April-June, 2009	July-September 2009	Implementation plans complete (July-September, 2009) Begin Implementation May 2010Complete May 2011	December 2009-2011

Note: The above activities are a combination of multiple projects. Many aspects are currently underway through existing contracts.

A. Environmental Review Compliance

All Recovery Act projects are reviewed for environmental compliance. Projects comply with National Environmental Policy Act and National Historic Preservation Act and other environmental regulations as applicable.

A. Measures

Outputs	Frequency Measured	Measures Available for Public Access
Uptime of IHS data center network circuits	Quarterly	Recovery Act reports on http://www.recovery.gov Supplemental information on http://www.HHS.gov/Recovery

Explanation

Data circuit uptime is one of the most common methods used for measuring network reliability and availability to users. Uptime is a measure of the time a circuit is operational and available to carry data communications across the network. This measurement is made as a percentage of time. For example, 99% uptime means the network is non-operational 1% of the time or roughly 87.4 hours per year. By contrast, a 99.9% uptime means the network is only non-operational 8.5 hours per year. IHS plans to reach the goal of 99.9% uptime by the 4th quarter of FY 2010, and reports progress toward achieving this goal on a quarterly basis.

Outcomes	Frequency Measured	Measures Available for Public Access
Percentage of all orders that are electronically entered into the EHR	Quarterly	Recovery Act reports on http://www.recovery.gov Supplemental information on http://www.HHS.gov/Recovery

Explanation of Measure

Electronic order entry (medication, laboratory, and radiology) is an indicator of how completely the EHR is being utilized at a health care facility. It is a proxy outcome measure for the impact of EHR deployment; because it is well established that electronic order entry contributes to quality of care and patient safety. For example, electronic medication orders improve the quality of care by preventing medical errors such as incorrect dosage, medication allergy complications, and unintended drug interactions. An increase in electronic order entry is expected as a result of EHR enhancements and expanded deployment funded by the Recovery Act. IHS plans to reach the goal of 75% of all order that are entered electronically into the EHR by the 4th quarter of FY 2011, and reports progress toward achieving this goal on a quarterly basis.

Outcome/ Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
Increase percentage of all orders that are electronically entered into the EHR	%	TARGET			Release pharmacy multiple drug file enhancement	Deploy Consolidated Mail Outpatient Pharmacy	Complete EHR inpatient certification	Acquire practice management solution	Complete requirements for initial PHR	Release of EHR Web interface	Complete connection of Nationwide Health Information Network	IHS plans to reach the goal of 75% of all order that are entered electronically into the EHR
		ACTUAL	53%	49%								
Increase in uptime of IHS data center network circuits	%	TARGET		Begin Implementation			Implementation plans complete					IHS plans to reach the goal of 99.9% uptime by Q4 FY10
		ACTUAL	99.3524 %	99.73991 %	99.582%							

B. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

The IHS risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. The IHS Recovery Act Coordination Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets bi-weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, IHS has presented/will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

C. Transparency

Indian Health Service Office of Information Technology (IHS-OIT) is open and transparent in all of its contracting activities and regulations that involve spending of Recovery Act funding consistent with statutory and OMB guidance.

All tribal and Federal contracts include relevant reporting requirements for use of Recovery Act funds.

Indian Health Service Office of Information Technology (IHS-OIT) ensures that recipient required by Section 1512 of the Recovery Act and the public. IHS-OIT informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. IHS-OIT provides technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

D. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, Indian Health Service Office of Information Technology (IHS-OIT) builds on and strengthens existing processes. Senior IHS-OIT officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

- Incorporate Recovery Act into IHS FY 2009 Management Control Plan.
- Health Information Technology projects comply with:
  - Expedited reviews by IHS' Information Technology Investment Review Board.
  - Monthly reviews by IHS Capital Planning and Investment Control to detect project variances, including cost and schedule.
  - Centralized equipment purchase and distribution to enhance control, timeliness, and volume.
  - Request for Proposal (RFP) processes will include review of vendor capabilities and ramp-up time.
- Incorporate Recovery Act implementation in:
  - Director's Performance Plan and cascade to responsible Recovery Act managers.
- Track quantifiable outcomes and outputs for Recovery Act projects.
- Track Recovery Act funds in the IHS Unified Financial Management System.
- Track and report use of funds for administration.

E. Barriers to Effective Implementation

- Timely obligation of funding.
- The increase in OIT acquisition requests result in an additional workload. OIT mitigates this risk through the use of multiple avenues for acquisitions. This includes the use of GSA for some acquisitions and the use of existing competitively bid contract vehicles such as the GSA Supply Schedule contract. In addition, OIT has funded the hiring of additional IHS contracting personnel.
- Filling federal vacancies.
- OIT will require additional staff to oversee and manage ARRA activities. OIT minimized this barrier by hiring additional HR support.

- Requirement for specialized skill sets.
- The sudden increase in project activities have resulted in a need for additional qualified personnel. Some of the skill sets required are highly specialized and difficult to find. OIT reduced this risk by using both the federal hiring process and contractors to fill vacancies.

F. Federal Infrastructure

- IHS has implemented a standard life cycle replacement program for desktops and laptops to allow the use of the most energy efficient devices.
- IHS has included language in its contracting mechanisms to require the procurement of energy efficient computer equipment.
- IHS is a partner in the Federal Electronics Challenge (FEC). The FEC is managed by the Environmental Protection Agency and provides partners with resources and technical assistance for improving electronics management practices.
- Computers and monitors purchased by IHS meet the Electronic Product Environmental Assessment Tool (EPEAT) standards, where applicable.
  - EPEAT evaluates electronic products in relation to 51 total environmental criteria, 23 required criteria and 28 optional criteria.
  - Energy Star features and Power management settings are implemented and required to be used on all commodity desktops, monitors and laptops.

Summary of significant changes

Health Information Technology (HIT) updated the Funding table to align with actual implementation of projects. HIT also provided actual performance measure outcomes to gauge progress towards program end targets. Due to the time constraints of the Recovery Act funding and the length and complexity of software development, HIT has modified its initial plan to focus more on the infrastructure improvements that will provide immediate returns and comply with ARRA regulations while still achieving Health Information Technology goals.

National Institutes of Health: Comparative Effectiveness Research

The Department of Health and Human Services (HHS) received funding for comparative effectiveness research (CER) under the American Recovery and Reinvestment Act (Recovery Act) of $1.1 billion, of which $300 million is for the Agency for Healthcare Research and Quality (AHRQ), $400 million is for the National Institutes of Health (NIH), and $400 million is for allocation at the discretion of the Secretary.

This implementation plan focuses on the $400 million of funds in the Recovery Act for NIH as part of a trans-agency research effort in CER.

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Comparative Effectiveness Research	$400.0	$176.5	223.5

B. Objectives

The overarching goal of this program is to improve health outcomes by providing evidence to enhance medical decisions made by patients and their medical providers. NIH uses the definition of comparative effectiveness research as set forth by the Federal Coordinating Council:

> Comparative effectiveness research is the conduct and synthesis of systematic research comparing different interventions and strategies to prevent, diagnose, treat and monitor health conditions. The purpose of this research is to inform patients, providers, and decision-makers, responding to their expressed needs, about which interventions are most effective for which patients under specific circumstances. To provide this information, comparative effectiveness research must assess a comprehensive array of health-related outcomes for diverse patient populations. Defined interventions compared may include medications, procedures, medical and assistive devices and technologies, behavioral change strategies, and delivery system interventions. This research necessitates the development, expansion, and use of a variety of data sources and methods to assess comparative effectiveness. Systematic research methods can include randomized controlled trials, meta-analyses, observational cohort analyses, and other new and emerging methodologies.

NIH's objective is to target funding to support scientific research opportunities that help support the goals of the Recovery Act. The projects support Recovery Act by

conducting CER that aims to enhance patient and clinician decision-making and to improve "real world" health outcomes for the Nation. The NIH objective specifically supports the HHS Strategic Plan.

C. Activities

As a member of the Federal Coordinating Council for Comparative Effectiveness Research (FCC), which was authorized by and established pursuant to the Recovery Act, NIH coordinated its research plan with other agency members and consulted with the FCC to ensure consistency with the HHS-wide plan.

To support scientific research opportunities that help achieve the goals of the Recovery Act, NIH has and will continue to obligate resources across several major activities, including:

1. **Previously Peer-Reviewed and Approved Projects.** NIH is supporting peer-reviewed and approved, highly-meritorious grant applications from investigators across the Nation that were not funded in FY 2008 and grant applications that would not otherwise likely be funded in FY 2009 or FY 2010.
2. **New and Competing Research Efforts**. NIH also is supporting new types of activities that fit into the structure of the Recovery Act. For example, the new NIH Challenge Grant and Grand Opportunities programs focus on health and science problems where significant progress can be made within a two-year time frame.
3. **Continuations.** NIH also is supporting acceleration of ongoing science via NIH's supplement programs known as "administrative supplements" or expansion of the scope of current research through "competitive revisions" for support of additional infrastructure (e.g., equipment costing less that $100,000) and personnel.

As of March 2010, NIH had committed $342 million (M) to the following categories:

- $144.9M for 31 Grand Opportunity Grants;
- $76.5M for 82 Challenge Grants;
- $55.0M for 12 Pay-line Expansions;
- $39.2M for 5 Other Actions (contracts, interagency agreements, etc);
- $7.3M for 7 Competitive Revisions; and,
- $19.1M for 29 Administrative Supplements.

Note that while this represents $342M in commitments, the amount of money actually obligated so far is $207.5M (see table below); the difference relates to the second year of two-year ARRA CER grants. Those funds are already committed, but will not be obligated until later this year.

NIH plans to commit the remaining $58M to the following categories:

- $10M for Methodology Development in CER;
- $15M for CER on Upper Endoscopy in Gastro-Esophogeal Reflux Disease. Eradication Methods for Methicillin-Resistant Staphylococcus Aureus (Staph) Infection, and Dementia Detection and Management Strategies;
- $25M for CER Mentored Career Development Awards; and,
- $8M for Administrative Supplements for CER Workforce Development.

D. Characteristics

In general, NIH is funding competitive awards based on peer review, scientific opportunity and the potential impact of the proposal on biomedical research and public health priorities related to CER. To date, approximately 38% of the recipients are "Institutions of Higher Learning," and 62% are "Non-profit" organizations (these entities include hospital systems, research institutions, centers, foundations, etc.). In order to avoid duplicative databases, each project that involves database establishment, expansion, and/or maintenance must detail the rationale and need for the database work proposed. Senior NIH and Science Implementation officials continue to meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions.

The $400M in CER ARRA funds has allowed NIH to expand its portfolio of landmark CER to fund additional comparisons within ongoing clinical trials, support new CER projects, and bolster CER infrastructure and training—all in a trans-agency context. Some highlights of the ARRA-funded CER include:

1) "SPRINT Senior" adds an older adult population to the original "SPRINT" trial to compare control of systolic blood pressure (BP) to 140 versus 120 for possible beneficial and adverse effects in this age group (over 75) on multiple real-world end-points, including cardiovascular, renal and cognitive function.

2) The Oregon lottery study analyzes how insurance affects health care utilization and health by comparing low income participants selected for enrollment in Oregon's public health insurance program through a lottery with non-participants.

3) A follow-up to the diabetes prevention study, which showed dramatic effects of lifestyle and/or drugs in preventing onset of diabetes, will determine effects on relevant health end-points associated with diabetes complications.

4) Recovery After an Initial Schizophrenia Episode (RAISE) is the first step for transforming treatment for schizophrenia by engineering rapid adoption of an effective early treatment package consisting of both pharmacologic and psychosocial interventions.

5) Additional studies compare the effectiveness of:
   - Breast imaging strategies in community practice;
   - Interventions for chronic pain management;
   - FIT (fecal immunochemical test for occult blood) vs. colonoscopy for cancer screening;
   - Surgery vs. medical management in patients with atrial fibrillation and stroke;
   - Minimally invasive surgical pulmonary vein isolation vs. medical management in patients with atrial fibrillation and stroke; and,
   - Conservative vs. dialytic management in Stage V Chronic Kidney Disease.

6) Multiple registries will allow tracking of populations for variables including outcomes and relationship to treatment:

- Community-based Autism Spectrum Disorders disease registry; and,
- Kaiser Permanente Autoimmune Disease Registry.

7) CER Centers to support research, training and dissemination of evidentiary knowledge:

- Center for CER in Cancer Genomics - "CancerGen;"
- Comparative Effectiveness and Outcomes Improvement Center; and,
- Clinical and Translational Science Awards

E. Delivery Schedule

Status of ARRA CER Obligations [1]
As of 3/31/2010
($ in millions)

Research	Type of Award	Obligations	Unobligated Balance	Total
Previously Peer-Reviewed and Approved Projects	Grants	$16.9	$18.9	$35.8
Challenge Grants	Grants	38.6	37.9	76.5
GO Grants	Grants	76.8	68.2	145.0
Administrative Supplements	Grants	17.6		17.6
Competing Revisions	Grants	7.3		7.3
High Impact Research / Infrastructure	Grants		25.0	25.0
Institutional Mentored Career Development	Grants		25.0	25.0
Administrative Supplements for Workforce Development	Grants		8.9	8.9
Other Activities (interagency agreements, grants, and contracts)	Grants/ Contracts/ IAA	35.3	23.6	58.9
Total CER Recovery Act Obligations		$192.5	$207.5	$400.0

[1] Note that while this represents $342M in commitments, the amount of money actually obligated so far is $207.5M (see table below); the difference relates to the second year of two-year ARRA CER grants. Those funds are already committed, but will not be obligated until later this year.

NIH has accomplished the following milestones over the past 16 months:

- Began publishing Recovery Act specific funding announcements (March 2009)
- Assessed highly meritorious CER applications that expanded the pay-line (May/June 2009)
- Conducted peer review for Challenge and Grand Opportunity Program Grants to determine which were CER-related (May-July 2009)
- Awarded all FY 2009 Challenge and Grand Opportunity Program Grants (August – September 2009)
- Issued four additional CER-specific funding announcements – CER Methodology, CER Research Gaps, and 2 CER Training announcements (October – December 2009)
- Awarded "Administrative supplements for CER Workforce Development" (May 2010)
- NIH plans to award the remaining CER fund by August 2010.

NIH expects to obligate an additional $110.6M by August 2010 and the remaining $96.5M by September 2010. NIH expects to have obligated all $400M by the end of 2010.

Research results with significant impacts are expected to begin being generated in FY 2011-FY 2012 (see Section G—Measures below.)

F. Environmental Review Compliance

Consistent with the provisions of the National Environmental Policy Act (NEPA), NIH has procedures in place to ensure that Federal officials properly take into account potential environmental consequences when taking actions. Section 1609 (c) of the Recovery Act requires that the President report to the Senate Environment and Public Works Committee and the House Natural Resources Committee every 90 days following the date of enactment until September 30, 2011 on the status and progress of projects and activities funded by the Act with respect to compliance with NEPA requirements and documentation. The Council on Environmental Quality (CEQ) promulgated reporting requirements in a March 11, 2009 document that described specific procedures and a reporting template that NIH completes regularly and provides to the HHS Office of Facilities Management and Policy (OFMP).

Most research grants qualify for a categorical exclusion from detailed NEPA review, as promulgated in the Federal Register on January 19, 2000: "NIH is providing notice of the actions that will normally be categorically excluded from further environmental review because individually and cumulatively they will not have a significant effect on the human environment. If a proposed action is included in one of the categories but extraordinary circumstances as described in section D of this notice apply, an environmental review will be performed." In other words, whereas most research grants qualify for the categorical exclusion, NIH is required to conduct oversight to ensure that all proposals are reviewed for extraordinary circumstances or triggers

that might warrant additional environmental review. To meet this responsibility, NIH has included NEPA related reviews in its award and progress reporting processes.

G. Measures

HHS is working to develop cross-cutting outcome measures for comparative effectiveness research activities across the Department. In addition, the measures below will be reported quarterly and help HHS track progress toward the program's goals and objectives. NIH recently developed outcome measures as indicated in the last five measures presented below. NIH will develop targets for these measures over the next few months by analyzing the funded CER projects (which will be finalized in July 2010). The targets will be developed by the end of September 2010. Outcomes are expected to be generated starting in FY 2011.

Each of the targets for the various measures was developed through either evaluating CER efforts in 2009 (i.e., the number of CER Coordinating Committee meetings) or analyzing the portfolio of funded projects in order to determine the likely product/result of each project. Actual outcomes are calculated through tracking actual events, and will be confirmed through communications with the funding recipients. Measures of outcomes, in particular, will be generated based on grantee reporting and validation of those reports; greater measures specificity will be available as the grantees' work progresses and NIH is able to initiate outcome measurements.

NIH is using the following measures for this program:

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
# applications	#	TARGET				445	N/A	N/A	N/A	N/A	N/A	
received[1]		ACTUAL	304	304	395	442	N/A	N/A	N/A	N/A	N/A	
# meritorious	#	TARGET					216	N/A	N/A	N/A	N/A	
grants awarded		ACTUAL	166	166	166	185		N/A	N/A	N/A	N/A	
# of CER-related meetings ,	#	TARGET						33				
including FCC, AHRQ CER, VA CER[2]		ACTUAL	27	27	27	29						
# of NIH CER Coordinating	#	TARGET						23				
Committee meetings		ACTUAL	14	14	16	18						

[1] No targets were estimated for this particular measure. The earliest target developed was 445 – which is the total of applications received in 2009 plus the applications anticipated to be received in 2010. The additional 138 applications in March 2010 include the following:

- (1) 31 applications in response to **RFA-OD-10-008** "Comparative Effectiveness Research on Upper Endoscopy in Gastroesophageal Reflux Disease, Eradication Methods for Methicillin Resistant Staphylococcus aureus and Dementia Detection and Management Strategies," and
- (2) 60 applications in response to **RFA-OD-10-009** "Methodology Development in Comparative Effectivess Research."
- (3) 26 applications in response to **RFA-OD-10-011** "Institutional CER Mentored Career Development Award."
- (4) 21 applications in response to **NOT-OD-10-037** "Administrative supplements for CER Workforce Development."

[2] The measure in the March 2010 FOR, "# of coordinating meetings, including FCC, AHRQ CER, VA CER," has been split into the following two measures: "# of CER-related meetings including FCC, AHRQ CER, VA CER," and "# of NIH CER Coordinating Committee meetings." The measure was split in order to emphasize the difference between the two types of meetings – the first measure represents meetings at the federal level where coordination and information sharing between agencies is occurring, the second measure looks at meetings internal to NIH (these meetings are where the additional review of ARRA-funded CER projects at NIH occurs).

Full Implementation Phase Measures (FY 2011-2012)[3]

Outcome / Achievement	Units	Type	3/31/11	6/30/11	9/31/11	12/31/11	3/31/12	6/30/12	9/30/12	12/31/12	3/31/13	Program End
Number of interventions whose relative effectiveness as		TARGET	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	
compared to other interventions is identified by CER studies		ACTUAL										
Number of dissemination efforts (programs/tools) to translate CER		TARGET	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	
findings to clinicians, consumers, and policy-makers		ACTUAL										
Increase evidence available to		TARGET	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	
policy-makers, providers and consumers		ACTUAL										
Number of sources		TARGET	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	
available for CER		ACTUAL										
Number of research networks		TARGET	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	
developed for CER		ACTUAL										

This information will be available to the public on the Recovery Act website.

[3] This table includes new measures developed by NIH. No targets are reported for these measures until 2011 because significant outcomes, as demonstrated through these measures, are not expected until then. Over the next few months, NIH will develop targets for each of these measures by analyzing the projects funded with the $400 million in CER funds. Until all awards are made, targets representing the full portfolio cannot be established.

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B & C).

NIH's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. NIH's Senior Assessment Team in coordination with the NIH Risk Management Program carries out comprehensive annual assessments of its Recovery Act programs to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, NIH has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

The National Institutes of Health through the Extramural Grants Management Advisory Committee (GMAC), and the Contract Management Advisory Committee (CMAC), has established policies and procedures to assure a consistent and integrated approach to oversight practices that monitor extramural grantee activities for NIH contracts, grants, and cooperative agreements. These committees meet approximately twice a month. Guidance for progress tracking, financial management, and administrative management of NIH grants includes OMB Circular A-110, OMB Circular A-123, *Management's Responsibility for Internal Control*, sections of the Recovery Act including Section 1512, and the *Updated Implementing Guidance for the Recovery Act of 2009*.

In addition, the NIH Office of Management Assessment (OMA) and the Office of Financial Management (OFM) have established the NIH risk management framework for identifying, assessing, and testing of operational and financial risks and internal controls associated with implementing Recovery Act requirements. OFM and OMA conduct risk and control assessments in compliance with the statutory requirements of the Federal Managers' Financial Integrity Act, the Improper Payments Information

Act, and OMB's Circular A-123 *Management's Responsibility for Internal Control*. OMA works with NIH offices that are responsible for implementing programs receiving Recovery Act funding to: identify and score the Recovery Act risks, assess controls related to the identified the Recovery Act risks, remediate controls as needed, monitor the inventory of the Recovery Act risks, and report on the risks and controls to NIH and HHS leadership. OFM uses its existing process for assessing internal control over financial reporting related to using and tracking Recovery Act funds and take into account any control deficiencies.

Progress reports are required for all active projects annually. The reports are reviewed by both program and grants management staff as required in the respective NIH Manual Chapters. The review process includes a project officer completing a review checklist for each project that covers: progress, scope, planning, any project changes, safety, outputs, and reporting requirement. The checklist requires additional information for any identified risk or challenge areas. Mitigating or corrective actions are documented and trigger additional review as required. Outputs are reviewed by program officials to confirm appropriate progress. Progress standards are based on planned activities and milestones within the grant application.

Grants management specialists monitor disbursements from the grantee project accounts as reported in the quarterly SF272 (Cash Transaction Report) to assure that the drawdowns from the Division of Payment Management System are appropriate for the effort described in the application. When disbursements are outside of planned parameters, grants management specialists contact the grantee for additional information, and confer with NIH program staff to determine whether the project may be at risk. Decisions to limit disbursements based on actual charges to the project may be required, if project funds are determined to be at risk. Additional funds may be withheld if progress is not satisfactory, and continued concerns may lead to suspension or termination of award.

NIH conducts technical assistance visits for oversight of grantee organizations when deemed necessary by the grants management specialist based on a GMAC Risk Assessment analysis. Criteria that trigger additional site visits can include challenges or risk factors for progress, financial, or administrative management. Site visits and reviews are tailored to the specific circumstance of use for each Grantee Institution, with the participation of grant and / or program management as needed.

Although science validates itself statistically, other forms of evaluations occur on a regular or as needed basis. The findings from evaluability assessments, evaluations and system assessments are used to improve or to eliminate activities. Assessment type activities often are conducted by external contractors; however, trained evaluation NIH staff separate from a project or program can conduct the assessment as well.

For a current assessment of the risks associated with NIH's CER program, refer to the program's latest Risk-Executive Summary and Detailed Summary available from the NIH Office of Management Assessment.

I. Transparency

NIH is open and transparent in all of its grants competitions that involve spending of Recovery Act funding consistent with statutory and OMB guidance. NIH ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. NIH informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. NIH provides technical assistance to grantees and contractors and fully utilizes project officers to ensure compliance with reporting requirements. To ensure recipient cost and performance requirements are reported, all awards issued with Recovery Act funding have special accounting numbers and codes to track the funds and awards. All Recovery Act funds must be awarded separately from the normal appropriation funds. The awards must comply with both existing NIH reporting requirements and the Recovery Act reporting requirements. Grants include special terms and conditions based on guidance provided by OMB and HHS.

NIH links to Recovery.gov on its website at http://recovery.nih.gov/.

NIH is open and transparent in all of its contracting and grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance.

NIH ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. NIH informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, NIH provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes project officers to ensure compliance with reporting requirements.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, NIH has built upon and strengthened existing processes. Senior NIH officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

The project officer's annual review requires additional information for any identified risk or challenge areas. Mitigating or corrective actions are documented and trigger additional review as required. Outputs are reviewed by program officials to confirm appropriate progress. Progress standards are based on planned activities and milestones within the grant application. Grants management can limit disbursement of funds for any funding improprieties and if progress is not satisfactory.

The NIH Office of Management Assessment and Office of Financial Management are coordinating efforts to ensure that existing risk management processes are fully used as NIH implements the provisions of the Recovery Act. Terms and conditions of award notices also are amended so that awardees are fully aware of the reporting requirements associated with these funds.

K. Barriers to Effective Implementation

NIH does not anticipate any significant barriers to implementation.

NIH participates on the Federal Coordinating Committee for CER and has also reached out to other agencies across the Department and with the Federal Coordinating Council, (including the Food and Drug Administration (FDA) and the Veterans Administration (VA)) to ensure that research efforts are not duplicative and that research is pursued on topics of interest to stakeholders.

L. Federal Infrastructure

The infrastructure that are supported through these funds are primarily data bases, patient registries and other health information technologies, which are not subject to energy efficiency or green building requirements. No construction will be carried out with these funds.

Summary of Significant Changes:

- Expanded funding table to show three year obligations and outlays (Section A. Funding Table)
- Addition of itemized actual and planned commitments (Section C. Activities)
- Shifted emphasis from process description of award review/ control to active process management efforts and listing of CER awards already made (Section D. Characteristics)
- Replacement of delivery schedule development plans with status of obligations by research type to date and plans for remaining obligations (Section E. Delivery Schedule)
- Replacement of the listing of environmental review compliance “extraordinary circumstances” and efforts made to communicate compliance efforts to-date (May 2009) within NIH with the addition of National Environmental Policy Act (NEPA)-related reviews in awards and progress reports (F. Environmental Review Compliance)
- Detailing of Developmental Phase Measures and addition of Full Implementation Phase Measures (Section G. Measures)
- Added information on NIH’s proactive risk assessment and mitigation efforts and their connection to OMB required internal controls (Section H. Monitoring and Evaluation)
- Expanded transparency efforts by making contractors and awardees aware of their transparency requirements under the Recovery Act; added link to recovery website (Section I. Transparency)

Agency for Healthcare Research and Quality: Comparative Effectiveness Research

The American Recovery and Reinvestment Act (Recovery Act) appropriated $1.1 billion for comparative effectiveness research, of which $300 million is for the Agency for Healthcare Research and Quality (AHRQ), $400 million is for the National Institutes of Health, and $400 million is for allocation at the discretion of the Secretary.

This implementation plan describes how AHRQ is using its $300 million in Recovery Act funds to expand and broaden pre-existing comparative effectiveness research activities initiated at the Agency in response to Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This legislation was designed to increase the availability of research that would inform the real-world decisions facing patients and clinicians. AHRQ's investments using Recovery Act funds will expand its Effective Health Care Program. This program supports research activities that use rigorous scientific methods within a previously established process that emphasizes stakeholder involvement and transparency. It is designed to prioritize among pressing health issues, and its products are designed for maximum usefulness for health care decision makers.

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations[1]	FY 2010 Estimated Obligations
Comparative Effectiveness Research	$300.0	$4.9	$295.1

B. Objectives

Program Purpose

The overarching goal of this program is to improve health outcomes by producing evidence to enhance medical decisions made by patients and their medical providers. This goal is achieved by conducting and supporting comparative effectiveness research. Comparative effectiveness studies may compare similar treatments, such as competing drugs, or analyze very different approaches, such as surgery and drug therapy. Study of treatments includes any potential medical intervention under consideration, whether prognostic, preventive, diagnostic, therapeutic, or palliative. Comparative effectiveness research may also address public health or systems interventions that affect health outcomes. Comparative effectiveness research is designed to inform patient and

[1] Please note: The amounts reported for AHRQ CER Obligations and Outlays do not tie to the Treasury Reports as of September 30, 2009. One OS CER Inter-Departmental Delegation of Authority (with an obligation $599,458 and an outlay of $190,747) was mistakenly included in AHRQ's totals. The error has been corrected in subsequent reports.

clinician decisions relevant to the unique circumstances of individual patients. Systematic research methods can include randomized controlled trials, meta-analyses, observational cohort analyses, and other new and emerging methodologies. HHS uses the definition of comparative effectiveness as set forth by the Federal Coordinating Council for Comparative Effectiveness Research:

> *Comparative effectiveness research is the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies to prevent, diagnose, treat and monitor health conditions in "real world" settings. The purpose of this research is to improve health outcomes by developing and disseminating evidence-based information to patients, clinicians, and other decision-makers, responding to their expressed needs, about which interventions are most effective for which patients under specific circumstances. To provide this information, comparative effectiveness research must assess a comprehensive array of health-related outcomes for diverse patient populations and sub-groups. Defined interventions compared may include medications, procedures, medical and assistive devices and technologies, diagnostic testing, behavioral change, and delivery system strategies. This research necessitates the development, expansion, and use of a variety of data sources and methods to assess comparative effectiveness and actively disseminate the results.*

Public Benefits

AHRQ is spending appropriated funds to research and provide information on the relative strengths and weaknesses of various medical interventions. Such research will give clinicians and patients valid information with which to make decisions that will improve the performance of the U.S. health care system. AHRQ's comparative effectiveness research supports the HHS strategic plan goal of improving the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.

Recovery Act funding focuses initially on 14 priority conditions established by the Secretary of HHS under Section 1013 of the Medicare Modernization Act: arthritis and non-traumatic joint disorders; cancer; cardiovascular disease, including stroke and hypertension; dementia, including Alzheimer's disease; depression and other mental health disorders; developmental delays, attention-deficit hyperactivity disorder, and autism; diabetes mellitus; functional limitations and disability; infectious diseases, including HIV/AIDS; obesity; peptic ulcer disease and dyspepsia; pregnancy, including preterm birth; pulmonary disease/asthma; and substance abuse. Funds are being allocated based on additional priorities identified through ongoing research at AHRQ and recommendations from the Federal Coordinating Council for Comparative Effectiveness Research and Institute of Medicine reports.

With Recovery Act funding, AHRQ will fund at least 5 projects in the area of cardiovascular disease that have the potential to affect an estimated 80 million Americans (36.3%). We are concentrating on this priority area, cardiovascular disease, as well as the other 13 priority conditions established by the Secretary of HHS under

Section 1013 of the Medicare Modernization Act. (Reference: Heart Disease and Stroke Statistics - 2009 Update, American Heart Association.)

C. Activities

The following activities, identified in Table 1, are an investment in creating the integrated components of a national comparative effectiveness program in the United States, including the first coordinated, prospective, pragmatic comparative effectiveness clinical studies program. Additional Recovery Act investments support the infrastructure, methods, and capacity necessary to sustain a vigorous national comparative effectiveness research enterprise in the United States.

Table 1: AHRQ CER Spend Plan

Research	Type of Financial Award	FY 09 Obligations (M)	FY 10 Obligations (M)	Total Obligations (M)
I. Identification of New and Emerging Issues for Comparative Effectiveness (Horizon Scanning)	Contracts	$0 M	$9.5 M	**$9.5 M**
II. Evidence Synthesis	Task Order Contract	$2 M	$23 M	**$25 M**
III. Evidence Gap Identification	Task Order Contract	$0 M	$25 M	**$25 M**
IV. Evidence Generation	Grants *CHOICE Studies* *Request for Registries* *Unfunded Meritorious Apps* Task Order Contract *DEcIDE Consortium Support*	$0.3 M *0 M* *.0 M* *0.3 M* $0 M *0 M*	$148.7 M *100 M* *48 M* *0 M* $24 M *24 M*	**$149 *M*** ***100 M*** ***48 M*** ***1 M*** **$24 M** ***24 M***
V. Translation and Dissemination	Grants (R18) Contract	$0 M $2.5 M	$29.5 M $2.5 M	**$29.5 M** **$5 M**
VI. Training and Career Development	Grants (K12, T32)	$0 M	$20 M	**$20 M**
VII. Citizen Forum	Contract	$0 M	$10 M	**$10 M**
Salaries and Benefits for ARRA FTEs	Salary and Benefits	$0.1 M	$2.9 M	**$3 M**
Total		**$4.9 M**	**$295.1 M**	**$300 M**

I. Identification of New and Emerging Issues for Comparative Effectiveness - Horizon Scanning ($9.5 million)

AHRQ is using Recovery Act funding to establish an infrastructure to identify new and/or emerging issues for comparative effectiveness review investments. This investment also addresses emerging technologies and their contextual role in health care.

It establishes and uses an efficient approach to investigate and prioritize areas for investigation relevant to the 14 priority conditions that guide AHRQ's Effective Health Care Program and that can be scaled for a national investment in comparative effectiveness research. This new activity tracks emerging clinical interventions and investigates key issues related to the intervention. AHRQ is initiating a program dedicated to tracking emerging interventions and investigating ways in which these new interventions are likely to fit into current care pathways.

II. Evidence Synthesis ($25 million)

Working with lists of priority topics developed within the Effective Health Care Program, topics generated through the increased horizon scanning and priority setting efforts and other lists of priority topics (such as those to be recommended by the Institute of Medicine through their project on Priority Setting for Comparative Effectiveness Research), AHRQ is using Recovery Act funds to increase support for comparative effectiveness reviews. The goal of this effort is to increase the number of comparative effectiveness reviews conducted through AHRQ's Evidence-based Practice Center (EPC) Program, thereby increasing the information base of research synthesis available to support decisions in clinical and other health care decision settings. The EPCs are 14 institutions that critically examine existing scientific evidence on a clinical topic and summarize what is known and not known from the current science base.

III. Evidence Gap Identification: ($25 million)

With Recovery Act funds, AHRQ is enhancing capacity for identifying and prioritizing evidence needs. A formal process is being developed that will involve stakeholders, including clinicians, funding agencies, and researchers, to consider the gaps identified in systematic reviews. This will help shape future research agendas and set priorities for a national investment in new research based on the findings.

This process brings together the researchers that worked on the individual review, as well as stakeholders with interest in the topic, clinicians with expertise in the topic area, agencies with funds for potential future research, and researchers with expertise in the clinical area and study design to identify evidence needs and to develop new research based on the findings of the comparative effectiveness review. Funding is being used to develop this formal approach to ensure it is transparent, systematic, strategic, and rigorous. This activity builds on and expands current AHRQ Effective Health Care Program efforts to involve stakeholders in the research. Inputs to the process include

stakeholder nominations and recommendations from sources such as the Federal Coordination Council for Comparative Effectiveness Research or the Institute of Medicine's project on Priority Setting for Comparative Effectiveness Research, as well as AHRQ's systematic review process.

IV. Evidence Generation ($173 million)

This proposal is the largest investment in Recovery funds and is intended to establish a coordinated national investment in practical/pragmatic comparative effectiveness research. It focuses on important research questions for the health care system and its users with a concentration in under-represented populations.

a) *CHOICE Studies ($100 million):* The Clinical and Health Outcomes Initiative in Comparative Effectiveness (CHOICE) represents the first coordinated national effort to establish a series of pragmatic clinical comparative effectiveness studies in the United States. These pragmatic studies will be measuring effectiveness – the benefit the treatment produces in routine clinical practice – and will include novel study designs focusing on real-world populations. Each CHOICE study addresses at least one of the 14 priority health conditions. This initiative concentrates on under-represented populations (children, elderly, racial and ethnic minorities, and other under-studied populations) and oversamples or deliberately obtain information on under-represented populations, to make sure that this effort achieves the goals of understanding treatment effects in under-represented populations. Up to 10 grants of up to $10 million each will be awarded, depending on the scope of the study, for a total of $100 million.

b) *Request for Registries ($48 million)*: Disease registries are databases that collect clinical data on patients with a specific disease or keep track of specific medical tests, devices, or surgical procedures (joint replacements, heart valve replacements, etc.). Clinical areas within the 14 priority conditions will be targeted. Ongoing and completed projects on patient registries for studying outcomes in real practice settings funded by AHRQ will inform all future investments in registries by AHRQ. AHRQ will also continue to consult with other agencies across the Department of Health and Human Services on existing registries, registries in need of expansion, and areas where registries are needed but do not exist. It is expected that grantees will develop registries that are sustainable such that the registries will continue once AHRQ funding has ended.

c) *DEcIDE Consortium Support ($24 million):* The DEcIDE (Developing Evidence to Inform Decisions about Effectiveness) Network conducts accelerated practical studies about the outcomes, comparative clinical effectiveness, safety, and appropriateness of health care items and services. The network is comprised of research-based health organizations with access to electronic health information databases and the capacity to conduct rapid turnaround research. AHRQ is enhancing its investments in establishing a learning health care system by funding the DEcIDE Network to expand multi-center research consortia comprised of academic, clinical, and practice-based centers. These centers are studying diabetes, cancer, cardiovascular disease, and other priority conditions. AHRQ is also funding distributed data network models using clinically rich data from electronic health

records and is using Recovery Act funds to continue support for the DEcIDE Network's research to advance study designs and methods for comparative effectiveness research.

d) *Unfunded Meritorious Applications ($1 million):* AHRQ is using the Recovery Act investment to fund meritorious grant applications that were not funded in previous cycles due to limited funding. Research projects selected for funding may have either a clinical or methodological emphasis, but will focus tightly on the study and/or use of comparative effectiveness research. Multiple grant mechanisms are being used.

V. Translation and Dissemination ($34.5 million)

AHRQ has a strong and long-term commitment to bridging the gap between research and practice by translating findings on the comparative effectiveness of interventions for different audiences including consumers, clinicians, and policymakers, and disseminating these findings. This proposal uses Recovery Act funds to expand AHRQ's translation and dissemination activities (and thereby strengthen the infrastructure supporting these activities). Thee activities include the John M. Eisenberg Clinical Decisions and Communications Science Center, whose workload will substantially increase.

The Recovery Act funds are primarily being used to support grantees in developing and implementing innovative approaches to integrating comparative effectiveness research findings into clinical practice and health care decisionmaking. Investments will be in multiple geographically dispersed translation, implementation, and evaluation projects to be carried out by local organizations such as medical societies, State institutions of higher learning, patients, community advocacy organizations, and others to promote education, dissemination, and application of comparative effectiveness research.

VI. Training and Career Development ($20 million)

AHRQ builds the capacity for comparative effectiveness research by providing institutional support to increase the intellectual and organizational capacity for larger scale programs in comparative effectiveness and to allow fellowship training opportunities. Funding supports the career development of clinicians and research doctorates focusing their research on the synthesis, generation, and translation of new scientific evidence and analytic tools for comparative effectiveness research. In particular, the goal is to enhance the research and methodological capacity for conducting and improving the quality of systematic review, retrospective studies, and clinical trials in comparative effectiveness research and the development of data sources and other aspects of the research infrastructure. Mentored Clinical Scientist Development Program Awards are being used to develop independent scientists. Institutional Research Training) are being used to support predoctoral and postdoctoral research training.

VII. Citizen Forum: Total Expenditure ($10 million)

AHRQ is using Recovery Act funds to establish and support a Citizen Forum on Effective Health Care to formally engage stakeholders in the entire Effective Health Care enterprise and to continue to open up and make the program inclusive and transparent. This initiative builds on the smaller initiative that has guided AHRQ's Effective Health Care Program until now and will be an important component for a larger and more sustained national initiative in comparative effectiveness research, translation, and use.

The Citizen Forum on Effective Health Care formally engages stakeholders, through a variety of transparent and inclusive mechanisms, at the critical stages of identifying research needs, study design, interpretation of results, development of products, and research dissemination. Funds are being used to develop formal processes for input, convene citizen panels, and convene a Workgroup on Comparative Effectiveness to provide formal advice and guidance to the Program. Funds are also supporting programs in citizen awareness of the use of comparative effectiveness evidence in health care decisionmaking. These programs, developed under the guidance of the Citizen Forum, may include town hall meetings, Web-based information exchange, and community-based grassroots awareness efforts.

The salaries and benefits for the Recovery Act full-time equivalent staff needed to administer these programs will be $0.1 million in FY 2009 and $2.9 million in FY2 010 for a total of $3 million. This includes up to15 temporary FTE.

D. Characteristics

A total of $5 million of the total funds available (2 percent) has been obligated in FY 2009, and $295 million (98 percent) will be obligated in FY 2010. To achieve the goals of comparative effectiveness research, AHRQ is using a variety of funding mechanisms including grants and contracts. AHRQ anticipates that award recipients will include a combination of researchers, academic institutions, States, community-based organizations, private or non-profit national organizations, and Federal agencies.

Funds also include support for additional activities to be conducted within current AHRQ programs such as the, DEcIDE consortium[2], John M. Eisenberg Clinical Decisions and Communications Science Center communities[3], and the EPC Program[4]. All activities will be coordinated with other AHRQ research networks as well as other research networks and programs across HHS. The specific type and amount of awards are detailed in the previous section and in Table 1.

[2] The DEcIDE (Developing Evidence to Inform Decisions about Effectiveness) Network is a new network of research centers that AHRQ created in 2005 to generate new knowledge. The DEcIDE Network conducts accelerated practical studies about the outcomes, comparative clinical effectiveness, safety, and appropriateness of health care items and services. The network is comprised of research-based health organizations with access to electronic health information databases and the capacity to conduct rapid turnaround research.

[3] The John M. Eisenberg Clinical Decisions and Communications Science Center translates complex scientific research produced in the Effective Healthcare Program into short, clear and actionable materials and products that can be used by three primary audiences: clinicians, consumers and policymakers.

[4] Evidence-based Practice Centers perform comprehensive reviews of existing evidence.

All eligible applications will undergo a competitive review process in order to evaluate scientific and technical merit.

E. Delivery Schedule

The table below includes the anticipated award dates for the items identified in Table 1.

NOFA/RFI issued	Competition Starts	Awards Date	Status
Recovery Act: Identification of New and Emerging Issues for Comparative Effectiveness (Horizon Scanning)	Nov/Dec 2009	June/July 2010	RFP Closed, but not yet awarded
Recovery Act: Comparative Effectiveness Evidence Synthesis (EPC)	Jul 2009	Sept 2009 ($2M); Oct 2009 ($23 M)	Awarded
Recovery Act: Comparative Effectiveness Evidence Gap Identification (EPC)	Jul 2009	Oct 2009 ($25M)	Awarded
Recovery Act: Request for Task Orders for DEcIDE Consortium Support	Oct 2009	Apr/May 2010	RFP Closed, but not yet awarded
AHRQ Clinical and Health Outcomes Initiative in Comparative Effectiveness (CHOICE) (R01)	Sept/Oct 2009	Jul 2010	FOA Closed, but not yet awarded
PROSPECT Studies - Building New Clinical Infrastructure for Comparative Effectiveness Research (R01)	Oct 2009	Aug 2010	FOA Closed, but not yet awarded
Recovery Act Limited Competition: Electronic Data Methods (EDM) Forum (U01)	Oct 2009	Aug 2010	FOA Closed, but not yet awarded
Innovative Adaptation and Dissemination of AHRQ Comparative Effectiveness Research Products (iADAPT) (R18)	Sept/Oct 2009	July 2010	FOA Closed, but not yet awarded
Recovery Act: Contract Modification to John M. Eisenberg Clinical Decisions and Communications Science Center	August 2009 and May 2010	Awarded Sept. 2009 ($2.5M) and Planned Award in June 2010	Partially Awarded
AHRQ Institutional Training Program Grants for Comparative Effectiveness Research (K12)	Oct 2009	Aug 2010	FOA Closed, but not yet awarded
ARRA Limited Competition: NRSA Comparative Effectiveness Development Award (T32)	Nov 2009	Aug 2010	FOA Closed, but not yet awarded
Recovery Act: Citizen Forum on Effective Health Care	Nov/Dec 2009	June/July 2010	RFP Closed, but not yet awarded

*Administrative Support	Sept 2009	Sept 2010	Ongoing Award

F. Environmental Review Compliance

The Implementation Plan for AHRQ's Recovery Act comparative effectiveness research activity has been reviewed in accordance with the Chapter 30-20-40 of the HHS General Administration Manual (http://www.hhs.gov/hhsmanuals/read/gam/part30/) and has been determined that the activity falls under Category 2 Functional Exclusions a., c., d., e., f., and i., and there are no additional extraordinary circumstances that may cause significant effects.

There will be no construction or renovation funded under this activity.

The environmental impact for acquisition of IT and other products and equipment will be mitigated by compliance with criteria described in Executive Order 13423[5] and the HHS Affirmative Procurement Plan (APP)[6] and written guidance to this effect will be provided to grantees as appropriate.

[5] Specifically, E.O. 13423 requires that preference be given to the purchase of EPEAT-registered electronic products and at least 95 percent of electronic products be EPEAT-registered unless there is no EPEAT standard. When available, the purchase of EPEAT Silver-rated electronic products or higher is required. EPEAT is intended to help purchasers in the public and private sectors evaluate, compare and select desktop computers, notebooks and monitors based on their environmental attributes. The EPEAT website is: http://www.epeat.net/.

[6] The HHS Affirmative Procurement Plan (APP) applies to: a) All agency acquisitions, including micro-purchases and purchase card transactions, in which an EPA-designated item is acquired; b) Contractor Operated, Government-owned (GOCO) HHS facilities; and c) State and local recipients of assistance funding. The latest version (April 2009) of the HHS' APP is available by contacting Dennise March, Director, Division of Acquisition Program Support, at (202)205-0722, Dennise.March@hhs.gov or Lydina Battle, Procurement Analyst, at (202) 205-4512, Lydina.Battle@hhs.gov.

G. Measures

Current measures for AHRQ's comparative effectiveness program are below. A new output measure has been established for funding appropriated under the Recovery Act - Number of competitive contracts and grants awarded to support AHRQ's Recovery Act comparative effectiveness research activities (Output).

We will report outcome and outputs, to the extent possible, supported with funding appropriated under the Recovery Act as an incremental change from those supported by regular appropriations. See Table 2 below.

Outcome/ Achievement		**12/31/09**	**3/31/10**	**6/30/10**	**9/30/10**	**12/31/10**	**3/31/11**	**6/30/11**	**9/30/11**	**Program End**
Increase the number of Effective Health Care Program products available for use by clinicians, consumers and policymakers. (AHRQ ARRA 1)	Target	0	0	0	5-15 Research Reviews or Research Gap Reports (RR/RG) and 0-3 Translation and Education Products (TE)	9-23 RR/RG 0 TE	9-25 RR/RG 0 TE	13-33 RR/RG 7-14 TE	17-41 RR/RG 12-23 TE	Cumulative total through 2012 26-54 RR/RG 23-38 TE
	Actual	0	0							
Increase the dissemination of Effective Health Care Program products to clinicians, consumers and	Target	0	0	0	Product Views[7] RR/RG = 1,500 product visits TE = 1,800 product visits	RR/RG = 3,900 TE = 3,600	RR/RG = 6,450 TE = 5,400	RR/RG = 9,900 TE = 15,300	RR/RG = 14,250 TE = 31,500	Cumulative through 2012 RR/RG = 35,500 TE = 124,200

[7] All products will be posted on the Effective Health Care web site, http://www.effectivehealthcare.ahrq.gov/; product views data from the web site.

Outcome/ Achievement		12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
policymakers to promote the communication of evidence about the effectiveness of CER. (AHRQ ARRA 2)	Actual	0	0							
Number of competitive contracts and grants awarded to support AHRQ's Recovery Act comparative effectiveness research activities (AHRQ ARRA 3)	Target	1 grant: 11 contracts	1 grant: 17 contracts	1 grant: 19 contracts	75 grants; 19 contracts	N/A[8]	N/A1[8]	N/A[8]	N/A[8]	N/A[8]
	Actual	1 grant: 11 contracts	1 grant: 11 contracts							

[8] All grants and contract will be awarded by September 30, 2010.

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

AHRQ's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. AHRQ's Senior Assessment Team [or other team/office, if applicable] carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets weekly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, AHRQ has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

From a program standpoint, a potential risk for ineffective spending or waste is through non-performance of funded projects. To minimize this risk, AHRQ will carefully review and select projects for funding. The following criteria may be reviewed for each proposed project: understanding of the purpose and objectives of AHRQ's comparative effectiveness research programs, technical approach, management plan, organizational experience, key personnel, stakeholder engagement, and facilities and database characteristics. AHRQ will also continue to standardize training required for program officials at the Agency working on contracts and grants. This will ensure effective oversight and management of contracts and grants and will decrease the risk of non-performance. AHRQ program officials will implement processes for identifying high and low performance which may include program officials overseeing project management plans and awardees submitting monthly status reports and quarterly self-assessments.

I. Transparency

AHRQ is open and transparent in all of its contracting and grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance. AHRQ publishes all grant funding opportunities on http://www.grants.gov/ and all contract solicitation

opportunities on http://www.FedBizOpps.gov. Both sites include a button that allows you to search for all Recovery Act opportunities.

AHRQ ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. AHRQ informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, AHRQ provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements."

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, AHRQ has built upon and strengthened existing processes. Senior AHRQ and CER officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

K. Barriers to Effective Implementation

One potential barrier/risk to effective implementation is funding projects that do not meet the needs of stakeholders. To minimize this risk, AHRQ will continue to increase the transparency and explicit process for comparative effectiveness research and will continue to engage stakeholders throughout the research process. Currently, there are many ways for stakeholders to get involved in AHRQ's comparative effectiveness research, including:

- Submitting suggestions for research topics.
- Commenting on draft key questions before research has begun.
- Commenting on draft Research Reviews and Comparative Effectiveness Reviews.
- Providing expert input / scientific information to inform a report.
- Participating in a listening session. These sessions allow participants to provide focused comments on issues important to the EHC Program, such as research topics, program structure, and scientific methods.

In addition, all grantees will be required to report quarterly to both AHRQ (through our reporting system) and through Recovery Act channels.

L. Federal Infrastructure

AHRQ will ensure that it complies with energy efficiency and green building requirements, if applicable. Little, if any, Recovery Act funds are expected to be used to fund equipment purchases. No Recovery Act funds will be used to fund construction projects.

Summary of Significant Changes:

- Added Obligation Funding table in Section A.
- Added Public Benefits Section under Section B.
- Added Detailed Delivery Schedule by FOA and Contract Solicitation under Section E.
- Provided Final Performance Measures under Section G.
- Updated Sections F, H and I to reflect updated HHS policies on Environmental Review Compliance, Monitoring and Evaluation, and Transparency.

Funds for Allocation by the Office of the Secretary through the Agency for Healthcare Research and Quality (AHRQ): Comparative Effectiveness Research

The Department of Health and Human Services (HHS) has developed a comprehensive plan and a corresponding funding allocation for dollars appropriated for Comparative Effectiveness Research (CER). The American Recovery and Reinvestment Act (Recovery Act) appropriated $1.1 billion for Comparative Effectiveness Research (CER), of which $300 million is for AHRQ, $400 million is for the National Institutes of Health, and $400 million is for allocation at the discretion of the Secretary.

This implementation plan focuses on the $400 million to be allocated by AHRQ at the discretion of the Secretary.

A. Funding Table—Dollars in millions

Table 1

Program/ Project/Activity:	Comparative Effectiveness Research
Total Appropriated	$400.0
FY 2009 Actual Obligations[1]	$1.6
FY 2010 Estimated Obligations	$398.4

B. Objectives

The overarching goal of this activity is to improve health outcomes by producing evidence to enhance medical decisions made by patients and their medical providers. This goal will be achieved by the Secretary by allocating funds appropriated for comparative effectiveness research (CER) to help produce and provide information and research on the relative strengths and weaknesses of various medical interventions.

The current definition of CER used by HHS as developed by the Federal Coordinating Council is: "Comparative Effectiveness Research" Comparative effectiveness research is the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies to prevent, diagnose, treat and monitor health conditions in "real world" settings. The purpose of this research is to improve health outcomes by developing and disseminating evidence-based information to patients, clinicians, and other decision-makers, responding to their expressed needs, about which interventions are

[1] Please note: The amounts reported for OS CER Obligations and Outlays do not tie to the Treasury Reports as of September 30, 2009. One OS CER Inter-Departmental Delegation of Authority (with an obligation $599,458 and an outlay of $190,747) was mistakenly included in AHRQ's totals. The error has been corrected in subsequent reports.

most effective for which patients under specific circumstances. To provide this information, comparative effectiveness research must assess a comprehensive array of health-related outcomes for diverse patient populations and sub-groups. Defined interventions compared may include medications, procedures, medical and assistive devices and technologies, diagnostic testing, behavioral change, and delivery system strategies. This research necessitates the development, expansion, and use of a variety of data sources and methods to assess comparative effectiveness and actively disseminate the results."

This research will give clinicians and patients' accurate information that can facilitate decision making and improve the performance of the U.S. health care system. This comparative effectiveness research has the potential to improve health outcomes and the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.

C. Activities

The Council developed the priority investment portfolio for OS funds with the purpose of making an unprecedented impact on the foundation and future of comparative effectiveness research. While any single investment in an activity can leave its mark, an investment that crosses activities or builds the foundation for multiple research or dissemination efforts will have a far more profound effect on health outcomes. Proposals that leverage multiple activities or themes will have greater value than those that focus on a single area. For example, OS investments in Human and Scientific Capital are imbedded in many of the specific projects (such as the FDA proposal outlined below). Similarly, projects that emphasize comparative effectiveness for priority populations were targeted for OS investment.

HHS has developed a plan that specifies the kind and scope of activities that will achieve the program's objectives. To facilitate the implementation of this plan, the Secretary developed and implemented the Comparative Effectiveness Research-Coordination and Implementation Team (CER-CIT). The CER-CIT has reviewed and approved HHS funded program applications, thus preventing undue duplication of CER activities within HHS. Additionally, the CER-CIT ensures that, consistent with the Recovery Act, funds will be used to accelerate the development and dissemination of research by assessing the comparative effectiveness of health care treatments and strategies. These efforts will conduct, support, or synthesize research that compares the clinical outcomes, effectiveness, and appropriateness of items, services and procedures that are used to prevent, diagnose, or treat diseases, disorders and other health conditions. Further, the Secretary has allocated funds to encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data.

The funds are allocated into the following categories:

Table 2

Investment (categorization is for primary focus)	FY 09 Funding (M)	FY 10 Funding (M)	Total Funding (M)
A. Data Infrastructure	$0M	$219M	$219M
B. Dissemination and Translation	$0M	$93.1M	$93.1M
C. Research	$0M	$75.5M	$75.5M
D. Inventory and Evaluation	$1.6M	$7.65M	$8.25M
E. Administrative Costs	$0M	$4M	$4M
F. Funds for Future Allocation	$0M	$.150	$.150
Total	**$1.6M**	**398.4M**	**$400M**

Data Infrastructure

HHS CER funds provide a unique opportunity for a meaningful and sustainable investment in building the foundation for CER infrastructure. Significant investment in this activity is unlikely to come from any other source, and will fundamentally change the landscape for CER. Through enhancement of existing infrastructure as well as development of new databases, networks, and registries, both public and private CER endeavors will be sustainable and multiplicative. Importantly, investment in data infrastructure can align with investments in health information technology (HIT), providing a platform for research endeavors that can strongly impact broad populations and conditions. Sub-categories of investment that the Federal Coordinating Council considered essential were:

- Longitudinal Claims Databases—research database that links claims data for single patients over a long period of time
- Distributed Data Networks—clinical electronic health record (EHR) data networks and health information exchanges for CER purposes
- Patient Registries—databases that prospectively collect clinical data on patients with a specific disease or on a specific test or procedure

Dissemination, Translation, and Implementation

The FCC recognized that currently most research funds are directed towards evidence generation rather than the application of evidence “at the bedside.” Without significant investment in evidence dissemination and implementation into practice, the goal of the Comparative Effectiveness Research – improved health outcomes – could go unrealized. Several Federal agencies currently engage in dissemination and translation activities, with inconsistent results. Innovative methods and strategies for these activities are therefore essential, both for patients and providers.

Priority Populations and Interventions

Another core investment for the OS funds is within the cross-cutting themes of priority populations and interventions. Investment in these areas requires coordination of efforts across multiple activities, and can therefore have a broad impact. Priority populations include:

- Racial and Ethnic Minorities
- Elderly
- Children
- People with Disabilities
- People with Multiple Chronic Conditions

These sub-groups have historically been under-represented in research activity to date, and describe a large segment of the U.S. population.

The Council specified the following interventions as lacking in clinical certainty, affecting a large population, and insufficiently addressed by other agencies. Thus, the Council recommended that OS funds could be used to address gaps in research addressing these comparative effectiveness questions:

- Medical and Assistive Devices (e.g., comparing rehabilitative devices)
- Procedures and Surgeries (e.g., evaluating surgical options or surgery versus medical management)
- Medications (e.g., comparing the effectiveness of 2 drugs from different classes on a specific disease)
- Diagnostic Testing (e.g. comparing imaging modalities for evaluating certain types of cancer)
- Behavioral Change (e.g., developing and assessing smoking cessation programs)
- Delivery System Strategies (e.g., testing two different discharge process care models on readmission rates
- Prevention (e.g., comparing two interventions to prevent or decrease obesity)

Research

Another core investment for the OS funds is research. The ARRA will produce an array of new CER findings for physicians.

Many of these topics are larger foci for investment within NIH and AHRQ, and therefore represent supporting investments for the OS spending plan. The Office of the Secretary investments in these CER questions are specifically designed to address these questions in a way to complement the NIH and AHRQ operational plans.

Inventory and Evaluation

The CER inventory analysis outlined in the Federal Coordinating Council's Report to Congress identified current gaps in the CER landscape. This process of cataloguing CE research activities and infrastructure is ongoing, and will be crucial to tracking

investments in CER going forward. Public and private investments across the major activities will need to be assessed collectively, to capture the entire spectrum of this important work. Through an iterative process, current and future CER efforts will be routinely evaluated, so as to rapidly identify gaps in knowledge and inform future priority-setting.

Administrative Costs

Section 804(f) of the Recovery Act addressed the Federal Coordinating Council for Comparative Effectiveness Research and instructed the Secretary to make no more than $4 million available to the Council for staff and administrative support.

D. Characteristics

A total of $1.6 million of the total funds available were obligated in FY 2009, and $398.4 million will be obligated in FY 2010. To achieve the goals of comparative effectiveness research, HHS will use a variety of funding mechanisms including grants and contracts. HHS anticipates that award recipients will include a combination of researchers, academic institutions, States, community-based organizations, private or non-profit national organizations, and Federal agencies. Descriptions of all OS ARRA CER funded programs are as follows:

Data Infrastructure

A1. Enhance Availability and Use of Medicare Data to Support Comparative Effectiveness Research

Centers for Medicare & Medicaid Services

This program will enhance the Chronic Conditions Warehouse to support CER by adding Medicare and Medicaid data back to 1999 with census track and race and ethnicity codes to facilitate study of health disparities. Enhancement of this data warehouse will also enable research on the elderly and persons with multiple chronic conditions, two populations historically under-represented in research.

A2. Build a Medicaid Analytic eXtract (MAX) Data Repository Designed to Support Comparative Effectiveness Research for Medicaid and Children's Health Insurance Program Populations

Centers for Medicare & Medicaid Services

This program will focus on building a parallel Medicaid and Children's Health Insurance Program research database with data dissemination capability to support CER projects.

A3. Clinically Enhanced State Data for Analysis and Tracking of Comparative Effectiveness Impact

Agency for Healthcare Research and Quality

This program will provide organizations that collect statewide all-payer, hospital-based encounter-level data (inpatient, emergency department, and ambulatory surgery) capacity to significantly broaden and supplement existing population-based data for producing the evidence base for comparative effectiveness and evaluating efforts to implement comparative effectiveness where the evidence already exists.

A4. Creation of an All-Payer, All-Claims Database to Enable Innovative Comparative Effectiveness Research

Office of the Assistant Secretary for Planning and Evaluation, Centers for Medicare & Medicaid Services

This program will focus on the creation of an all-payer database that builds on existing claims streams to support research to allow for the greatest power in analysis, ensuring that the data infrastructure is equipped to address the needs of multiple priority populations, multiple priority types of interventions, and a breadth of conditions.

A5. Distributed Data Research Networks, Including Linking Data

Agency for Healthcare Research and Quality

This program will focus on electronic health record-driven distributed research networks along with linking clinical and administrative data to investigate comparative effectiveness of medications, treatments, and strategies to improve health outcomes.

A6. Community Health Applied Research Network

Health Resources and Services Administration

This program will provide funds for research nodes, that will serve as a platform from which to conduct investigations on treatments, interventions, and models of care.

A7. Building Patient Registries to Track Health Outcomes and Measure Quality and Performance

Agency for Healthcare Research and Quality

This program will focus on developing registries for researching health outcomes for effectiveness research and performance measurement and benchmarking.

A8. Enhancing Cancer Registry Data Systems for Comparative Effectiveness Research

Centers for Disease Control and Prevention

This program will focus on the power of cancer surveillance systems that can be significantly enhanced for comparative effectiveness analyses and clinical research by expanding the current infrastructure.

A9. Registry of Patient Registries

Agency for Healthcare Research and Quality

This program will establish a registry of patient registries with research purposes, thus enabling researchers who are considering a new registry to identify similar studies and avoid unnecessary duplication of research questions or populations.

A10. Building U.S. Food and Drug Administration Comparative Effectiveness Research Clinical Data and Standards Infrastructure, Tools, Skills, and Capacity

U.S. Food and Drug Administration

Under this program, the U.S. Food and Drug Administration will develop policies, standards, infrastructure, and tools for standardizing clinical study data to enable analyses across multiple studies. This activity will support scientifically sound assessments of medical interventions consistent with FDA's public health responsibility. Although current FDA regulations generally limit public sharing of the primary data from commercial sponsors, FDA has options for supporting CER including sharing of data with sponsor permission.

A11. Persons with Multiple Chronic Conditions Data and Research

Agency for Healthcare Research and Quality, Indian Health Service

- 11A – Expansion of Research Capability to Study Complex Patients — The Agency for Healthcare Research and Quality will solicit grant applications from organizations that propose to build or enhance partnerships and datasets that will improve the capacity to study comparative effectiveness of different management strategies for patient-centered care of patients with multiple chronic illnesses.
- 11B – Comparative Effectiveness Research to Optimize Prevention and Health Care Management for the Complex Patient — This program will focus on the priority conditions as detailed in Agency for Healthcare Research and Quality's comparative effectiveness program.
- 11C– Creating and Disseminating Public Use Data Sets — This program will address the specific priority population of patients with multiple chronic conditions. Investment in infrastructure should permit performance of high-

quality research on complex patient populations to provide evidence for which interventions are most valuable and how a patient's particular circumstances determine these relative values.

- 11D – Comparative Effectiveness Research to Enhance the Delivery of Services Within the Indian Health Service — This program will be conducted within existing Special Diabetes Program for Indians grantee sites to compare the effectiveness of disease treatment and prevention strategies for diabetes and cardiovascular disease as provided by physicians, nurse practitioners, physician assistants, advanced practice pharmacists, and registered dieticians.
- 11E – Comparative Effectiveness of Quality Improvement Efforts Focused on Chronically Ill Adults among American Indian/Alaska Native Communities — This program focuses on evaluation of prevention and treatment strategies for chronic diseases within American Indian/Alaska Native communities.

A12. Pediatric Care Networks and Comparative Effectiveness Research

Health Resources and Services Administration

This program will enhance the electronic health record infrastructure of pediatric care networks for comparative effectiveness research.

A13. Public Use Data Files

Centers for Medicare & Medicaid Services

Consistent with the confidentiality requirements of the Privacy Act and the Health Insurance Portability and Accountability Act, the Centers for Medicare & Medicaid Services propose to create public use files containing detailed but de-identified data for the Medicare population, including claims (inpatient and outpatient hospital, skilled nursing facilities, home health, hospice, physician/suppliers, durable medical equipment, and prescription drugs), beneficiary-level enrollment/entitlement/demographic information, and data from the Medicare Current Beneficiary Survey.

A14. Strategic Plan for Developing Comparative Effectiveness Research Data Sets

Centers for Medicare & Medicaid Services

This project will be used to develop a strategic plan for the use of all types of Centers for Medicare & Medicaid Services data, including Medicare fee-for-service claims, Medicare Advantage encounter data, and Medicaid claims. The analysis would focus on maximizing Centers for Medicare & Medicaid Services data in all formats for comparative effectiveness research, including the public use files, limited data sets, and research-identifiable files. Contracts will be awarded for this opportunity.

Dissemination and Translation

B1. Dissemination of Comparative Effectiveness Research to Physicians, Providers, Patients, and Consumers Through Multiple Vehicles

Agency for Healthcare Research and Quality, Office of the Assistant Secretary for Planning and Evaluation, Assistant Secretary for Public Affairs

This project includes multiple sub-proposals that seek to bring innovative, effective, and user-friendly methods to advancing the dissemination of comparative effectiveness concepts and content to patients and providers.

B2. Assessing and Accelerating Implementation Strategies in Agency for Healthcare Research and Quality Networks

Agency for Healthcare Research and Quality

This project funds the development and implementation of strategies for promoting the use of comparative effectiveness findings at the delivery system and community levels, along with an evaluation designed to assess the effectiveness of the interventions themselves and their potential for broader spread.

B3. Accelerating Dissemination and Adoption of Comparative Effectiveness Research by Delivery Systems

Office of the Assistant Secretary for Planning and Evaluation

This project will fund both Federal and non-Federal comparative effectiveness research dissemination and translation efforts.

B4. Enhancing the Adoption of Comparative Effectiveness Research in the Treatment of Serious Mental Illnesses in Medicaid

Office of the Assistant Secretary for Planning and Evaluation

This project will identify the combinations of benefit design, payment, and organizational arrangements that best support the use of evidence-based practices for the severely and persistently mentally ill population in Medicaid, recognizing that Medicaid is the single largest payer of services for this population. The study will evaluate State Medicaid programs' use of effective pharmacotherapy to treat serious mental disorders and will be part of evaluating "benefit design."

Research

C1. Optimizing the Impact of Comparative Effectiveness Research Findings through Behavioral Economic Randomized Controlled Trial Experiments

National Institutes of Health, Agency for Healthcare Research and Quality

The National Institutes of Health and Agency for Healthcare Research and Quality will collaborate to develop, apply, and compare behavioral economic approaches to encourage rapid and widespread uptake of CER recommendations.

C2. Comparative Effectiveness Research on Delivery Systems

Agency for Healthcare Research and Quality

The demonstrations and evaluations funded under this initiative will rapidly build and deploy an evidence base for successful, large-scale delivery system transformation and lay the infrastructure for further work in this area.

C3. Effective Use of Regionalized Emergency Care Delivery

Office of the Assistant Secretary for Preparedness and Response

This proposal will focus on the evaluation of established models of regional emergency care delivery, identify best practices and opportunities for networking State-level regionalized services, and identify the limitations of such care delivery systems.

C4. Informing Clinical and Public Health Approaches to Chronic Disease Prevention

Centers for Disease Control and Prevention

This program seeks to enhance clinical and community linkages to perform CER on community interventions that are designed to work in concert with clinical interventions, to perform CER that addresses both primary prevention and secondary prevention and optimum delivery of quality health care in underserved populations, and to leverage the community engagement that Prevention Research Centers possess to advance translation and dissemination of CER findings.

C5. Linked HHS longitudinal claims data sets for comparative effectiveness research on medications and devices (ASPE/CMS)

Office of the Assistant Secretary for Planning and Evaluation, Centers for Medicare & Medicaid Services

Due to ARRA time constraints this program was withdrawn.

C6. Centers for Racial and Ethnic Minority-Focused Comparative Effectiveness Research

Office of Minority Health, National Institutes of Health

The Office of Minority Health will partner with the National Center on Minority Health and Health Disparities, under the aegis of the Federal Collaboration for Health Disparities Research, to create Centers on Comparative Effectiveness Research. These centers will complement existing peer-reviewed Centers of Excellence at the National Institutes of Health and other Federal agencies focusing on the health of racial and ethnic minority populations.

C7. Center of Excellence for Research on Disability Care Coordination

Office of the Director, Office of the Assistant Secretary for Planning and Evaluation

This program will establish the Center of Excellence for Research on Disability Care Coordination.

Inventory and Evaluation

D1. Inventory of Ongoing Comparative Effectiveness Research and Evaluation of Impact

Office of the Assistant Secretary for Planning and Evaluation

This program will focus on an iterative process through which current and future CER efforts will need to be routinely evaluated so as to rapidly identify gaps in knowledge and inform future priority setting.

D2. Evaluation and Impact Assessment

Office of the Assistant Secretary for Planning and Evaluation

The objective of these assessments is to ensure that the complete portfolio of efforts is collectively achieving impact. Its purpose is not to evaluate the performance of specific projects or grants.

D3. Federal Coordinating Council Support for Inventory and Listening Sessions

Office of the Assistant Secretary for Planning and Evaluation

This program provided support for the Federal Coordinating Council for Comparative Effectiveness Research and the development of recommended research priorities for the Office of the Secretary's Comparative Effectiveness Research funds.

D4. Institute of Medicine Report-Initial National Priorities for Comparative Effectiveness Research

Agency for Healthcare Research and Quality

This program provided support for an independent committee convened by the IOM, to develop a report on comparative effectiveness research priority topics. In addition to the FCC findings, this report further informs how the Office of the Secretary's comparative effectiveness research funds are distributed.

E. Delivery Schedule

The table below includes the anticipated award dates for the items identified in Section D.

Table 3

Investment	Primary Division	Type of Award	Est. Date of Award
A. Data Infrastructure			
A1. Medicare claims	CMS	Task Order Contracts	April and June 2010
A2. Medicaid claims	CMS	Task Order Contracts	March (awarded) and Sept 2010
A3. Clinically enhanced state data	AHRQ	Contracts and/or grants, cooperative agreements	July and Sept 2010
A4. All-Payor, All-Claims Design and Implementation	ASPE/CMS	Task Order Contracts	January, April and Sept 2010
A5. Distributed clinical data networks	AHRQ	Grants, Task Order Contracts	Sept 2010
A6. Community Health Applied Research Network	HRSA	Cooperative agreements	Sept 2010
A7. Patient Registries	AHRQ	Task Order Contracts or Grants	Sept 2010
A8. Cancer Registries	CDC	Task Order Contracts, cooperative agreements	May 2010
A9.Registry of Registries	AHRQ	Contract	Sept 2010
A10. Building FDA infrastructure and skills for medication and device CER	FDA	Task Order Contracts,	August and Sept 2010
A11. Persons with multiple chronic conditions Data and Research	AHRQ/IHS	Grants and/or Task Order Contracts	July and Sept 2010
A12. Pediatric care networks and CER	HRSA	Grants and/or cooperative agreements	Sept 2010

Investment	Primary Division	Type of Award	Est. Date of Award
A13. CMS Public Use Data Files	CMS	Task Order Contracts	Sept 2010
A14. Strategic Plan for Developing CER Data Sets	CMS	Task Order Contract	Sept 2010
B. Dissemination and Translation			
B1. Dissemination of CER to Physicians and other Providers, Patients and Consumers	AHRQ/ASPE	Task Order Contracts	May and Sept 2010
B2. Implementation strategies in AHRQ networks	AHRQ	Grants and/or Task Order Contracts	July and Sept 2010
B3. Accelerating Dissemination and Adoption of CER in Delivery Systems	ASPE	Cooperative agreements Grants and/or Task order contracts	May, July, August and Sept 2010
B4. Enhancing the Adoption of CER in the Treatment of Medicaid Patients with Serious Mental Illness	ASPE	Task Order Contract	July 2010
C. Interventions			
C1. Behavioral Economics and Change	NIH/AHRQ	Grants and Contracts	August 2010
C2. Delivery System	AHRQ	Grants, Task Order Contract	June and Sept 2010
C3. Regionalized Emergency Care delivery	ASPR	Task Order Contracts	June 2010
C4. Comparative effectiveness of chronic disease prevention	CDC	Grants	July 2010
C5. Linked administrative claims research on medications and devices	ASPE Withdrawn	Task Order Contract, cooperative agreements	Withdrawn
C6. Centers of Excellence for Racial and Ethnic Minority-focused CER	NIH/OMH	Cooperative agreements	July 2010
C7. Centers of Excellence for Persons with Disabilities	ASPE/OD	Task Order Contracts, cooperative agreements	April 2010
D. Inventory and Evaluation			
D1. Inventory of CER ongoing	ASPE	Task Order Contract	May 2010
D2. Evaluation and Impact Assessment	ASPE	Task Order Contracts	June 2010
D3. FCC support for inventory and listening sessions	ASPE	Task Order Contracts	Awarded
D4. IOM report	AHRQ	Contract	Awarded

Investment	Primary Division	Type of Award	Est. Date of Award
E. Administrative Costs	Across Divisions	Administrative	Ongoing
F. Funds for Future Allocation			

F. Environment Review Compliance[2],[3]

The Implementation Plan for AHRQ's Recovery Act comparative effectiveness research activity has been reviewed in accordance with the Chapter 30-20-40 of the HHS General Administration Manual (http://www.hhs.gov/hhsmanuals/read/gam/part30/) and has been determined that the activity falls under Category 2 Functional Exclusions a., c., d., e., f., and i., and there are no additional extraordinary circumstances that may cause significant effects.

There will be no construction or renovation funded under this activity.

The environmental impact for acquisition of IT and other products and equipment will be mitigated by compliance with criteria described in Executive Order 13423 and the HHS Affirmative Procurement Plan (APP) and written guidance to this effect will be provided to grantees as appropriate.

G. Measures

HHS has developed quantifiable outcomes that will show how execution of this program will improve health outcomes and the quality of health care. Performance indicators are broken into 3 key categories: data infrastructure, dissemination and translation, and research. The AHRQ Program Management Office will collect information to aid HHS with tracking progress toward the program's goals and objectives. The total number of projects on track will indicate the progress towards program completion. Planned measures include the following:

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[2] Specifically, E.O. 13423 requires that preference be given to the purchase of EPEAT-registered electronic products and at least 95 percent of electronic products be EPEAT-registered unless there is no EPEAT standard. When available, the purchase of EPEAT Silver-rated electronic products or higher is required. EPEAT is intended to help purchasers in the public and private sectors evaluate, compare and select desktop computers, notebooks and monitors based on their environmental attributes. The EPEAT website is: http://www.epeat.net/.

[3] The HHS Affirmative Procurement Plan (APP) applies to: a) All agency acquisitions, including micro-purchases and purchase card transactions, in which an EPA-designated item is acquired; b) Contractor Operated, Government-owned (GOCO) HHS facilities; and c) State and local recipients of assistance funding. The latest version (April 2009) of the HHS' APP is available by contacting Dennise March, Director, Division of Acquisition Program Support, at (202)205-0722, Dennise.March@hhs.gov or Lydina Battle, Procurement Analyst, at (202) 205-4512, Lydina.Battle@hhs.gov

Table 4

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
ARRA OS CER 1: Evidence[4] available to policymakers, providers and consumers as a foundation for health care decision making[5]	0	TARGET	TBD	N/A[6]	N/A	N/A	N/A	N/A	N/A	N/A	TBD	By 2013, increase by 10%
		ACTUAL										
ARRA OS CER 2: The number of sources[7] available for comparative effectiveness Research[5]	0	TARGET	TBD	N/A	N/A	N/A	N/A	N/A	N/A	N/A	TBD	By 2013, increase by 10%
		ACTUAL										
ARRA OS CER 3: The number of research networks[8] for comparative effectiveness research[5]	0	TARGET	TBD	N/A	N/A	N/A	N/A	N/A	N/A	N/A	TBD	By 2013, increase by 10%
		ACTUAL										
ARRA OS CER 4: Number of contract and grant applications received	#	TARGET	0	0	154	155	155	N/A	N/A	N/A	N/A	Establishing baseline metrics for applicants received.

[4] The type of evidence of CER to be developed includes, but is not limited to literature reviews, peer reviewed journal articles, websites, and presentations.
[5] Performance data sources for the Data Infrastructure, Research and Dissemination and Translation projects are currently under development. Target measurements will be determined by April 2011 and are reported annually.
[6] N/A indicates that target measures will be reported on or by April 2011
[7] Sources for this measure include, but are not limited to the creation of datasets, registries or files to be utilized for CER.
[8] Research networks are designed to increase the availability of researcher access to data by creating data linkages among research institutions for CER work.

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
		ACTUAL	0	0	168							
ARRA OS CER 5: Number of Federal Coordinating Council Meetings (Annual Target)[9]		TARGET		13				2				
		ACTUAL		13								Completed 100% of all council meetings.
ARRA OS CER 6: Number or people and organizations who provided written or verbal comments for Council's consideration (Annual Target)[9]		TARGET		13				2				
		ACTUAL		412								Exceeded target goal for public comments received on CER for FCC consideration.

[9] The Federal Coordinating Council was terminated in the Affordable Care Act.

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are done consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control." (including Appendices A, B, and C)

The HHS risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. The AHRQ Risk Assessment Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. The AHRQ Risk Assessment Team meets with OPDIV's weekly to assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, AHRQ has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

I. Transparency

The Office of the Secretary is open and transparent in all of its contracting and grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance. Contract solicitations can be found via the Federal Business Opportunity website, http://www.fbo.gov, and funding announcements are available via http://www.grants.gov.

HHS ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. HHS informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, HHS provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, HHS has built upon and strengthened existing processes. Senior OS officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

K. Barriers to Effective Implementation

One potential barrier/risk to effective implementation is funding projects that do not meet the needs of stakeholders. To minimize this risk, HHS will continue to increase the transparency and explicit process for comparative effectiveness research and will continue to engage stakeholders throughout the research process.

L. Federal Infrastructure Investments

The OS does not anticipate any construction or renovation funded under this activity. However, HHS will ensure that it complies with energy efficiency and green building requirements, if applicable.

Summary of Significant Changes:

- Added Obligation Funding table to Section A.
- Added table indicating investment levels for data infrastructure, dissemination and translation, research and inventory and evaluation projects in Section C.
- Revised Characteristics section to include numbers from obligation funding table and previously funded inventory (D3 and D4) projects.
- Revised delivery schedule table to include the correct name for the Registry of Registries project.
- Updated Performance Measures Provided in Section G.
- Updated Sections F, H and I to reflect updated HHS policies on Environmental Review Compliance, Monitoring and Evaluation, and Transparency.

A. Funding Table for Communities Putting Prevention to Work

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Communities Putting Prevention to Work: Community Initiative	449.4	0.0	449.4
Communities Putting Prevention to Work: State and Territory Initiative	125.0	0.0	125.0
Communities Putting Prevention to Work: Chronic Disease Self-Management Initiative	32.3	0.0	32.3
Communities Putting Prevention to Work: National Prevention Media and National Organization Initiatives	40.00	0.0	40.00
Management and Oversight	3.3	0.0	3.3
Total	650.00	0.0	650.00

B. Objectives

The American Recovery and Reinvestment Act of 2009 (Recovery Act) states that "$650,000,000 shall be provided to carry out evidence-based clinical and community-based prevention and wellness strategies authorized by the Public Health Service Act that deliver specific, measurable health outcomes that address chronic disease rates." The Department of Health and Human Services (HHS) is executing a robust initiative in response to the Act. The goal of this collaborative HHS initiative – ***Communities Putting Prevention to Work*** – is to reduce risk factors and prevent/delay chronic disease and promote wellness in both children and adults. ***Communities Putting Prevention to Work*** (CPPW) will expand the use of evidence-based strategies and programs, mobilize local resources at the community-level, and strengthen the capacity of states.

The initiative has a strong emphasis on creating policy and environmental changes at both the state and local levels that will, in the longer term:

- Increase levels of physical activity;
- Improve nutrition;
- Decrease obesity rates; and
- Decrease smoking prevalence, teen smoking initiation, and exposure to second-hand smoke.

Powerful models of success are expected to emerge to be replicated in other communities. For more information, visit: www.cdc.gov/CommunityHealthResources.

C. Activities

There are three major components to the CPPW initiative:

- Community Program
- States and Territories
- National Prevention Media and National Organizations Initiative

Community and State/Territory recipients will select a package of strategies from the following five groups of strategies ("MAPPS Strategies"). These strategies will be described in obesity, physical activity and nutrition and/or a tobacco plan:

- Use **media** to promote healthy foods/drinks and increase activity; restrict advertising and employ counter-advertising for tobacco and unhealthy foods/drinks;
- Increase **access** to healthy food/drink choices and safe locations to be active and improve the built environment; restrict the availability of tobacco and unhealthy food/drinks; smoke free and tobacco free policies
- Use of **point of decision** labeling/signage/placement to discourage consumption of tobacco, increase consumption of healthy foods/drinks, and prompt physical activity;
- Use **price** to discourage consumption of tobacco and to benefit consumption of healthy foods/drinks; and
- Use **social support/services** to promote tobacco cessation, breastfeeding, and increased activity.

Community Program

The Centers for Disease Control and Prevention (CDC) is supporting intensive community approaches to creating supportive policies and environments that will drive changes in risk behaviors and chronic disease prevention and control in selected communities (urban and rural), to achieve the following prevention goals:

- Increased levels of physical activity;
- Improved nutrition (e.g. increased fruit/vegetable consumption, reduced salt and transfats);
- Decreased overweight/obesity prevalence;
- Decreased smoking prevalence and decreased teen smoking initiation; and
- Decreased exposure to secondhand smoke.

As noted, the five evidence-based groups of MAPPS strategies (Media, Access, Point of decision information, Price, and Social support), when combined, can have a profound influence on improving health behaviors by changing community policies and environments. Communities will implement a focused set of prescribed interventions related to the MAPPS strategies, as outlined in the funding opportunity announcement, in tobacco and/or obesity and related risk factors to achieve broad reach, high impact, and sustainable change. The specific amount of funding per community was determined by mix of interventions, population size, ability to reduce health disparities, and likelihood of success. The official local, state or tribal health department (or its bona fide agent, equivalent, or other fiscal intermediary as designated by the mayor, county executive, or other equivalent governmental official), will serve as the lead/fiduciary

agent on behalf of an effective community-wide consortium. Consortium partners include local and state health departments and other governmental agencies, health centers, schools, businesses, community and faith-based organizations, academic institutions, and health care providers. Mental health/substance abuse organizations, health plans and other community partners working together to promote health and prevent chronic diseases were encouraged.

Communities were encouraged to coordinate with other US Government-funded Recovery Act efforts in multiple sectors, such as transportation, education, health care delivery, agriculture and others, as well as coordinating with HHS Regional Offices. Funded communities demonstrated, through letters of support, that they have political support and connections with other community development and livability efforts, and that they build on and leverage existing place-based revitalization and reform projects funded by the US Government, including HHS, and programs supported by other agencies such as the US Department of Housing and Urban Development, the Environmental Protection Agency, the US Park Service, US Department of Transportation, US Department of Agriculture, the Corporation for National and Community Service, and the US Department of Education.

The Community component also includes a robust support plan to ensure funded communities are successful, and that the agencies are able to evaluate the impact of their efforts. The plan consists of a three-pronged approach:

(1) Community Programmatic Support – intervention design, expertise, implementation support, and national dissemination and training. These activities will occur before, during, and after the program implementation period. Elements of this support will be embedded in communities based on community needs;

(2) Community Mentoring – fund up to 10 communities to provide mentoring to less experienced communities based on their previous success in specific policy strategies; and

(3) Evaluation – through a multi-component evaluation strategy that includes case studies in funded communities and states, cost tracking, and modeling, community and state level risk factor surveillance, and selected community impact evaluations utilizing biometric data collection. The primary emphasis of the evaluation design is on factors and variables that influence successful enactment of the community-level policy and environmental changes that are expected to drive, in the longer-term, the key behavioral outcomes linked to chronic disease.

States and Territories

Three major State and Territory components together support implementation of key evidence-based strategies and interventions at the state level that are expected to create supportive policies and environments that will make healthier choices easier and more affordable, and assist those living with chronic conditions:

(1) Policy and environmental change – under direction of CDC, States and Territories received funding to promote state-wide policy and environmental changes in support of the goals of this initiative. These activities, applying the five MAPPS strategies, will

support and institutionalize healthy behaviors related to nutrition, physical activity, obesity control and tobacco use. Strategies were grounded in evidence. All states and territories were eligible for a base funding amount determined by population, and in addition, thirteen states received competitive funds for special policy initiatives;

(2) Tobacco cessation – under the direction of CDC, all currently funded states and territories received funding to expand tobacco quit lines, in concert with expanded cessation media campaigns. States and territories received funding based on the number of smokers in their jurisdiction. Additional funds are being used for national efforts to support surge capacity, additional quit line monitoring and quality improvement measures; and

(3) Expansion of the chronic disease self-management program (CDSMP) - AoA competitively awarded 45 states, the District of Columbia, and Puerto Rico cooperative agreements to collectively deliver chronic disease self-management programs to 50,000 people with chronic conditions and to build or enhance state evidence based prevention distribution and delivery systems. AoA competitively awarded the National Council on Aging Center for Healthy Living a cooperative agreement to provide technical assistance to the states and territories that received Recovery Act CPPW Chronic Disease Self-Management Program awards. Two million-five hundred thousand dollars ($2.5M) was allocated to the Center for Medicare and Medicaid Services to develop and test a prototype system for using Medicare claims data to track the health care utilization of CDSMP participants and compare it with claims data of a comparable group of Medicare beneficiaries who did not participate in the program.

National Prevention Media and National Organizations Initiative

To complement and reinforce community and State/Territory activities, these initiatives will foster effective and hard-hitting prevention and wellness messages and advertisements, amplified and extended through national organizations.

(1) National Prevention Media - under the direction of CDC, investments will be made in national media to foster effective and hard-hitting prevention and wellness messages and advertisements and to provide communities with high-quality communications expertise to assist in achieving measurable health outcomes. Prevention media materials will be tailored to address the unique needs of communities and will provide materials and templates to give the initiative a powerful brand. The communications component will draw on the full array of materials available across HHS, the Federal Government, and non-governmental organizations, ensure consistency and quality, provide support, and aggregate outreach materials so that they can be easily and widely accessed.

(2) National Organizations - under the direction of the HHS Office of Public Health and Science (OPHS), national organizations will be funded as part of the effort to support community outcomes and focus on community-linked prevention and wellness media. Additionally national organizations will foster community-based linkages with other federally funded and foundation activities to leverage reach and impact of interventions. Linkages may include efforts funded by the US Department of Health and Human

Services and programs supported by other agencies such as the US Department of Housing and Urban Development, the Environmental Protection Agency, the US Park Service, US Department of Transportation, US Department of Agriculture, the Corporation for National and Community Service, and the US Department of Education.

D. Characteristics

All funds will be awarded in accordance with the applicable provisions of the Recovery Act, and all applicable HHS-specific and government-wide policies related to such actions whether the policies are general or specific to Recovery Act funds.

Program Category	Type of Award	Total Funding Amount	Methodology for Award Selection	Recipients
Community Program	Grants and contracts	$449,412,500	New competitive funding opportunity announcement, new and existing contracts, and supplement to existing funding announcements	Official local, state or tribal health department (or its bona fide agent, equivalent, or other fiscal intermediary as designated by the mayor, county executive, or other equivalent governmental official) on behalf of an established community coalition; contracts; and non-profit organizations]
States and Territories	Grants and contracts	$157,337,500	Supplement to existing funding announcements, and new and existing contracts	States/Territories; contracts; National Institute of Health; Center for Medicare and Medicaid Services; non-profit organizations; and Universities.]
National Prevention Media and National Organizations	Grants and contracts	$40,000,000	New and existing contracts and new funding opportunity announcement	Contracts and non-profit organizations
Management and Oversight	Other	$3,250,000	Other	Other
Total	-	$650,000,000	-	-

Community Program

Community Program - CDC competitively awarded funding to 44 eligible local or state health departments and Tribal Governments, Regional Area Indian Health Boards, Urban Indian organizations, and Inter-Tribal Councils (or their bona fide agent, equivalent, or other fiscal intermediary as designated by the mayor, county executive, or other equivalent governmental official). Eligible states included the 50 states, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Marianna Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

Community Mentoring - awards will be made as competitive supplemental awards within funded communities.

Community Programmatic Support and Evaluation - activities will be funded through a combination of supplemental awards to existing cooperative agreements and new/existing competitive contract solicitations.

States and Territories

Policy and environmental change - CDC awarded supplemental funding through existing cooperative agreements to eligible grantees including all 50 states, the District of Columbia, Puerto Rico, U.S. Virgin Islands, and the Pacific Islands to promote state- and territory-wide policy and environmental change in support of the goals of this initiative.

Tobacco cessation/quitlines - CDC awarded supplemental funding to all states and those territories currently funded for quit line services to expand tobacco quitlines and support tobacco counter-advertising campaigns. The amount of funding was based on the number of smokers in the state. Funding was also allocated to the National Institute of Health for national quitline efforts.

CDC competitively awarded supplemental funds to thirteen states to implement one or more high impact policy, environmental and/or systems change strategies to eliminate health disparities and achieve health equity related to these individual risk factors or a combination thereof. The funded states are as follows: Colorado, Delaware, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New York, North Carolina, Oregon, Rhode Island, Texas, and Wisconsin.

Expansion of the chronic disease self-management program (CDSMP) - AoA competitively awarded new and supplemental cooperative agreement funding to eligible States. Governors will decide through which state government entity the funding would flow (State Units on Aging or State Health Departments). Funding was also allocated to the Center for Medicare and Medicaid Services to develop and test a prototype system for using Medicare claims data to track the health care utilization of CDSMP participants and comparing it with claims data of comparable groups of Medicare beneficiaries who did not participate in the program.

National Prevention Media and National Organizations

National Prevention Media - CDC will award contracts and/or task orders for media production, media buying, earned-media outreach, and social media activities.

National Organizations - OPHS will award competitive funding through cooperative agreements to support earned-media activities; and competitively award funding to National organizations to leverage the strengths of public, private, and industry efforts into collaborative partnerships in support of community outcomes and focus on community-linked prevention and wellness media.

Management and Oversight

A total of $3.25 million will be used for management and oversight of the entire CPPW initiative. This amount is equal to 0.5% of the $650 million appropriated for the initiative: $3,087,500 for CDC and $162,500 for AoA.

E. Delivery Schedule

Program	Milestone	Expected Date	Responsible Agency
Community Program	Post Funding Opportunity Announcement (FOA)	September 2009	CDC
States and Territories	Issue supplemental guidance (environmental and policy change, Quitline)	September 2009	CDC
Chronic Disease Self Management Program	Post FOA	December 2009	AoA
Community Program	Award various contracts and/or cooperative agreements for evaluation components and support	February 2010 - August 2010	CDC
Media Campaign	Post Request for Proposals	January 2010	CDC
States and Territories	“Base” policy and environmental change awards made; Awards made for Quitline efforts	February 2010	CDC
States and Territories	Awards made for supplemental funding to support environmental and policy change	February 2010	CDC
Chronic Disease Self Management Program	Awards made to State Units on Aging or State Health Departments	March 2010	AoA
National Organizations	Post FOA	March 2010	OPHS
Community Programs	Awards made to communities	March 2010	CDC

Program	Milestone	Expected Date	Responsible Agency
Community Programs	Post Supplemental FOA for Community Mentoring	May 2010	CDC
Media Campaign	Awards made for various contracts for media support	May 2010	CDC
National Organizations	Awards made to National Organizations	June 2010	OPHS
Community Programs	Awards made for Community Mentoring	August 2010	CDC

F. Environmental Review Compliance

The grants and contracts addressed in this program are subject to a National Environmental Policy Act (NEPA) categorical exclusion promulgated by HHS [65 FR 10229 (2/25/2000)] and additional NEPA review is not required.

Categorical exclusions (if applicable) and other environmental reviews will be documented in writing and reported on the Section 1609(c) report.

G. Measures:

Outcome / Achievement	Units	Type	9/30/10 10/Q4	12/31/10 11/Q1	3/31/11 11/Q2	6/30/11 11/Q3	9/30/11 11/Q4	Program End 12/Q2
Tobacco: Increase to 85%[1] the percentage of communities funded under the Communities Putting Prevention to Work program that have enacted new smoke-free policies and/or improved the comprehensiveness of their existing policies.	%	TARGET	5	15	25	50	75	85
		ACTUAL						
Obesity (Nutrition): Increase to 85%[1] the percentage of communities funded under the Communities Putting Prevention to Work program that have enacted new policies or improved the comprehensiveness of existing policies to limit the availability of unhealthy food or drink and/or increase the availability of healthy food or drink.	%	TARGET	5	15	25	50	75	85
		ACTUAL						
Obesity (Physical Activity): Increase to 85%[1] the percentage of communities funded under the Communities Putting Prevention to Work program[2] that have enacted new policies or improved the comprehensiveness of existing policies to increase access to physical education in schools or physical activity in afterschool or daycare settings.	%	TARGET	5	15	25	50	75	85
		ACTUAL						

[1] The HHS high priority in this category shows a 75% target to be achieved by the end of Q4 of FY 2011. The 85% target in the implementation plan for this goal correlates to the end of the project/budget period for funded communities.

[2] For the physical activity measures, percentages are of the total number of funded communities that have included the relevant MAPPS strategies in their workplan.

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

CDC, AoA, CMS, HHS/ASPE, and HHS/OPHS's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. CDC, AoA, CMS, HHS/ASPE, and HHS/OPHS Senior Assessment Teams carry out comprehensive annual assessments of this Recovery Act program to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. They meet at least quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, CDC will present this program's high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

CDC

Understanding that funds allocated as part of Recovery Act require additional accountability, CDC has established a centralized oversight function, for agency-wide Recovery Act Coordination (RAC), to oversee and coordinate all Recovery Act-funded activities. Quarterly reviews of Recovery Act programs will be conducted by RAC in collaboration with CDC's Financial Management Office (FMO) and Procurement and Grant's Office (PGO), as well as program managers. Potential risks associated with executing Recovery Act funds have been identified and appropriate mitigation strategies have been instituted to ensure Recovery Act funding is effectively and efficiently utilized to achieve program goals. In addition, assurance of adequate staffing levels within FMO, PGO, and within the program has been addressed to provide appropriate oversight and monitoring of recipient activity.

To ensure Recovery Act grantee accountability and performance and to minimize risks associated with the misuse of Recovery Act funds, CDC will perform the following contract and grant management activities for Recovery Act-funded contractors and grantees:

- Coordinate with the Office of the Inspector General (OIG) to ensure that Recipient Capability Assessments are conducted on funded organizations as needed;

- Ensure ongoing technical assistance is provided to contractors and grantees who need assistance in meeting administrative and program requirements;
- Monitor the receipt of financial reports, and review those reports for the purpose of monitoring compliance with financial requirements;
- Monitor the receipt of recipient progress reports, and review those reports for the purpose of monitoring compliance with program requirements;
- Conduct vigorous post-award monitoring to include site visits to grantees;
- Ensure the unique identification of Recovery Act funds in contractual and grant agreements, to include the use of unique Recovery Act CFDA numbers for grants;
- Refer all known instances of suspected fraud, waste, or abuse to the OIG;
- Ensure that timely enforcement actions are taken on any non-performing contractor or grantee;
- Take appropriate enforcement action, such as the disallowance of costs, the recovery of funds, the referral of suspected fraud to the OIG, the implementation of administrative corrective actions by the contractor or grantee, or the termination of funding if CDC determines that a contractor or grantee has misused Recovery Act funds, CDC will; and
- Support the oversight of the Recovery Accountability and Transparency Board, the OIG, and General Accounting Office, to include taking timely action on inquires and recommendations.

There will be frequent communication between grant and contract recipients and program staff, including regular conference calls. Program staff will ensure site visits are conducted according to Recovery Act requirements, and that technical assistance is provided. Recipients may be allowed to charge increased administrative costs to support the frequent and extensive reporting required by the Recovery Act. Allowable and unallowable expenditures will be clearly communicated to recipients and appropriate penalties for misappropriation or misuse of funds will be enforced. The Office of Management and Budget (OMB) Circular A-133, “Audits of States, Local Governments and Non profit Organizations” will set the administrative requirements for these entities. OMB Circular A-87, “Cost Principles for State, Local and Indian Tribal Governments” will set the Federal principles for determining allowable costs.

Development and submission of grantee plans and quarterly updates on progress towards measures and targets will enhance recipient accountability. Specific financial and program performance measures and the frequency for their reporting have been enumerated regarding measures. These indicators will serve as an evaluation of progress in deploying funds and achieving the intended outcomes. Lack of progress will serve as a warning for early intervention to ensure timely mitigation of issues. Monthly and quarterly reporting by recipients will be monitored by project and contract officers and failures to adhere to performance measures will be elevated to supervisory authorities immediately for troubleshooting.

AoA

All AoA Recovery Act programs will be assessed for risk and to ensure the appropriate internal controls are in place through the entire funding cycle. These assessments will be done consistent with the statutory requirements of the Federal Managers’ Financial Integrity Act and the Improper Payments Information Act, as well as OMB’s Circular A-123 “Managements’

Responsibility for Internal Control." Primary recipients of funds are State governments that have their own established control structures and State audits under Office of Management and Budget (OMB) Circular A-133 "Audits of State, Local Governments and Non profit Organizations" have not generated significant systemic findings.

Cost items are reviewed during the application review process and evaluated for reasonableness, allowability and allocability. Disallowed cost entries are promptly removed from the application prior to issuing an award. All recipients will be governed by the appropriate cost principles (OMB Circular A-87 – "Cost Principles for State, Local and Indian Tribal Governments"). In addition, OMB Circular A-133 requires a stringent audit to be performed with a focus on ARRA expenditures.

AoA has a designated staff person who will coordinate all OPDIV-wide Recovery Act reporting activities. This individual will work with the program officer(s) assigned to manage ARRA recipients, as well as ARRA state level coordinators to ensure reports are submitted in a timely manner and the data is accurate.

AoA's Grants Management Office (GMO) and Recovery Act Program Officer (PO) staff will collect quarterly reports from all ARRA act recipients. This data includes:

- A quarterly quantitative data report, which is accompanied semi-annually by a qualitative narrative; the semi-annual narrative will satisfy the GMO/PO discretionary grants reporting requirements while the quarterly quantitative portion of this report will reflect the program measures required by DHHS and OMB.
- An annual Financial Status Report (FSR 269) to track recipient fiscal expenditures

AoA established and listed the indicators for program development and assessment in the Recovery Act program announcement. Each successful applicant submitted an initial work plan in which the state proposed how it would meet these indicators, which relate to overall programmatic goals. These work plans are undergoing revision in response to AoA's notices of award. States will further refine their work plans in consultation with the technical assistance center and AoA project officers during a grantee meeting in June 2010. The goal is for all states to set their initial target goals no later than November, 2010. Subsequently, AoA project officers and technical assistance center staff will engage in an ongoing assessment of state progress toward meeting their indicators and programmatic goals through periodic conference calls, site visits, and technical assistance calls.

To assist with meeting reporting requirements and program goals, ARRA recipients will have the support of the following types of technical assistance under this funding:

- A national technical assistance center specifically tasked to design and implement tools and strategies to assist the successful implementation of AoA CDSMP grant recipients
- Coordinated AoA Program Officer and Regional Staff technical assistance
- Specific trainings and teleconferences to facilitate timely and accurate ARRA, DHHS and OMB reporting requirements

I. Transparency

CDC, AoA, CMS, ASPE, and OPHS are is open and transparent in all of its contracting and grant competitions and program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance and published on grants.gov and fbo.gov. CDC ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. CDC informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, CDC provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

CDC, AoA, CMS, ASPE, and OPHS will provide technical assistance to grantees and contractors and fully utilize Project Officers to ensure compliance with reporting requirements. CDC will ensure recipient cost and performance requirements are reported on a quarterly basis. All awards issued with Recovery Act will have special accounting numbers and codes to track the funds and awards.

Recipients will report economic indicators of job creation and/or preservation on a quarterly basis directly to a central reporting system in accordance with the provisions of Section 1512. These data will be available at the recipient level. All other indicators will be collected from existing databases, collated by the program staff and then reported to CDC RAC. The customary process for reporting progress on these measures to the Department of Health and Human Services (HHS) and the OMB will be employed. These measures will be reported in aggregate, however the recipient-by-recipient performance on which they are based will be available from the program and its project officers. A CDC point of contact has been established for federalreporting.gov and recovery.gov to receive and answer public inquiries regarding programmatic efforts with Recovery Act funds.

CDC shall ensure merit-based decision-making for Recovery Act grant and contract awards by:

- Promoting competition to the maximum extent practicable;
- Considering the weighting of selection criteria to favor applicants with demonstrated ability to deliver performance;
- Using award methods that allow grantees and contractors to commence activities as quickly as possible;
- Ensuring that receipt of funds is contingent on grantees and contractors agreeing to meet Recovery Act reporting requirements;
- Adapting current applicant evaluation and review processes to reflect Recovery Act needs; and
- Pursuing efforts to overcome impediments to Recovery Act awards.

CDC grant announcements and contract solicitations involving Recovery Act funds shall contain transparent merit-based selection criteria that allow CDC to evaluate an applicant's demonstrated or potential ability to:

- Deliver programmatic results;

- Create economic stimulus, to include the number of jobs created or saved in relation to Federal dollars obligated;
- Achieve long-term public health benefits; and
- Satisfy Recovery Act transparency and accountability objectives, to include all reporting requirements.

CDC shall avoid the funding of imprudent projects by:

- Exercising the formal approval of Agency, Program and Spend Plans;
- Identifying measurable Program and Recovery Act outcomes;
- Reviewing proposed activities and expenditures for imprudent projects; and
- Making the timely obligation of funds.

CDC, AoA, CMS, ASPE, and OPHS will conduct frequent review of the program's progress to identify areas of high risk, high and low performance, and longer-term impact. Performance monitoring in communities and states will focus on effective implementation of the set of chosen interventions/strategies and the status of enactment of the policy/system/environmental changes to be produced by the strategies. In addition, in communities, changes in behavioral outcomes of interest will be monitored through periodic risk factor surveillance, and, in selected communities, community impact evaluations utilizing biometric data collection.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, CDC, AoA, CMS, ASPE, and OPHS has built upon and strengthened existing processes. Senior CDC, AoA, CMS, ASPE, and OPHS officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

Centers for Disease Control and Prevention
The CPPW program has developed a CDC-approved Program Implementation Plan containing management and oversight processes. Additionally, a point of contact has been established for Recovery.gov to receive and answer public inquiry regarding programmatic efforts with Recovery Act funds.

CDC will conduct quarterly reviews between Division Directors/Management Officials and project officers prior to the end of the quarter to evaluate progress to date and discuss grantee performance. This information will be provided to the National Center and ultimately CDC's Recovery Act Coordination unit for review. Additionally, National Center and Division Directors will have accountability and performance measurement objectives included in performance plans. Annual reviews will be conducted with CDC leadership to ensure programmatic objectives and grantee accountability measures are being executed and achieved as stated.

K. Barriers to Effective Implementation

Circumstances that could impede the effective implementation of Recovery Act activities have been evaluated. In each of these circumstances, CDC has developed a strategy to identify and take actions to mediate appropriately.

1. Potential delay in the development and implementation of strategies in some states and communities due to lack of staff with appropriate expertise in some states or communities. This issue will be re-evaluated upon review of the Community Action Plans due in the third quarter of 2010.

2. Potential impediments for communities in hiring staff due to hiring freezes and limitations on contracting with out of state entities. CDC, AoA, and HHS OPHS are mindful of this barrier and have authorized the use of Recovery Act funding and although we are unable to affect state restrictions regarding procurement policies and procedures, program officials will provide technical assistance to the extent possible to help mitigate this risk.

L. Federal Infrastructure

Not applicable

Summary of Significant Changes:

- Developed new Implementation plan in alignment with OMB approved spend plans (September 2009).
- Updated all sections to reflect the current status of planned activities.
- Updated the **Delivery Schedule** with revised completion dates and added the following:
- **Measures** – added performance measures for nutrition and obesity. The HHS high priority in this category shows a 75% target to be achieved by the end of Q4 of FY 2011. The 85% target in the implementation plan for this goal correlates to the end of the project/budget period for funded communities.

Centers for Disease Control and Prevention: Section 317 Immunization Program

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
Vaccine purchase and grantee operations	250	127.4	122.6
Innovative Immunization and Reimbursement Initiatives	18	6.7	11.3
National communication campaign and provider education	9	3.7	5.3
Strengthening the evidence base	21.5	16.4	5.1
Management and oversight	1.5	0.2	1.3
Total	300	154.4	145.6

B. Objectives

The American Recovery and Reinvestment Act appropriated to the Department of Health and Human Services Office of the Secretary $300 million and specified that these funds be transferred to the Centers for Disease Control and Prevention (CDC) for its Section 317 Immunization program (Section 317). The Section 317 Program funds 64 immunization programs that include all 50 states, Washington DC, 5 urban areas, the U.S. Territories, and selected Pacific Island nations. The majority of Section 317 program funds are dedicated to routine childhood programs, with a small portion remaining for adolescent and adult immunization programs. Most children served with Section 317-funded vaccines are under-insured or their parents cannot afford the out-of-pocket costs required to fully vaccinate their children. The Recovery Act program funds will expand access to vaccines and vaccination services by making more vaccines available, increase national public awareness and knowledge about the benefits and risks of vaccines and vaccine-preventable diseases, and strengthen the evidence base for vaccination policies and programs.

Public Benefits

This investment will expand access to vaccines and vaccination services by:

- Making recommended vaccines available in all states through the existing network of private and public immunization providers and supporting and expanding the network of providers as needed;
- Expanding access to the childhood vaccine series and influenza vaccines through using innovative vaccine delivery strategies;

- Providing grants to immunization programs to conduct needs assessments and develop plans that will enable health departments to bill private insurance for immunization services provided to insurance plan members;
- Increasing national public awareness and knowledge about the benefits and risks of vaccines and vaccine-preventable diseases;
- Enhancing assessments of vaccine coverage, vaccine impact, vaccine effectiveness and vaccine adverse events.

C. Activities

Below is a list of activities to be performed, including project scope for each:

Reaching more children and adults: Provides additional vaccine and the means for administering this vaccine through Section 317 grantees and their community partners:

- Vaccine purchase: procurement of additional vaccines for children and adults
- Grant supplements: assistance funding to 64 immunization programs that include all 50 states, Washington DC, 5 urban areas, the U.S. Territories, and selected Pacific Island nations to support programs operations

Innovative initiatives for improving reimbursement and enhancing electronic immunization data exchange: Time-limited projects to develop demonstrate how innovative approaches can successfully and measurably deliver more vaccine to selected target groups, and enhance the interoperability of electronic immunization data exchange between Electronic Health Record (EHR) systems and immunization registries (IR) and to develop specifications to harmonize clinical decision support algorithms. Partnerships will engage national interests such as Medicare, Medicaid and CHIP in assisting with these efforts and forging other important partnerships at the state and local levels with health agencies, healthcare providers, professional organizations, insurers, employers, and other community leaders:

- Improving Reimbursement: Competitive awards to immunization programs for planning grants to develop appropriate mechanisms to bill private health insurance for immunization services provided to plan members.
- Electronic Health Record (EHR) Systems and Immunization Registries (IR): Competitive awards to current immunization grantees to enhance interoperability of electronic immunization data exchange between Electronic Health Record (EHR) systems and immunization registries (IR) and to develop specifications to harmonize clinical decision support algorithms.

National communication campaign and provider education: Purposes include: 1) increase public awareness of vaccine-preventable diseases and CDC's immunization recommendations for Americans of all ages, 2) enhance knowledge among immunization providers about CDC's immunization recommendations, and 3) engage the American public on questions related to U.S. immunization policy:

- Communication and education activities: raise awareness of vaccine availability as well as address public questions about vaccine benefits and risks. Includes the development and provision of training and education resources and tools that increase knowledge of complex immunization schedules and recommendations.

Strengthening the evidence base: Time-limited assessments of vaccine-preventable disease burden trends and vaccine effectiveness, filling selected gaps in current vaccination coverage assessment capability, upgrading the current sentinel immunization registries allowing for more rapid monitoring of vaccination trends, improving existing systems for monitoring vaccine safety, and conducting short term training courses for state health laboratories.

D. Characteristics

Spend Plan Category	Type of Award	Total Funding Amount	Methodology for Award Selection	Recipients
Vaccine purchase and operations	Grants and contracts	$250,000,000	Supplement to existing funding announcements, new and existing contracts	Official state or local health department
Innovative Immunization and Reimbursement Initiatives *	Grants and Contracts	$18,000,000	New competitive funding opportunity, announcement supplement to existing funding announcements, new and existing contracts	Official state or local health department
National Communication Campaign and Provider Education	Grants and contracts	$9,000,000	New competitive funding opportunity, announcement supplement to existing funding announcements, new and existing contracts	Official state or local health departments, Contractors, and national non-profit organizations
Strengthening the Evidence Base	Grants and Contracts	$21,5000,000	New competitive funding opportunity, announcement supplement to existing funding announcements, new and existing contracts	Official state or local health departments, Contractors, and national non-profit organizations
Management and Oversight	Other	$1,5000,000	Other	Other
Total		$300,000,000		

E. Delivery Schedule

Major Milestones	Expected Completion Date
Vaccine Ordering and Forecasting Applications sent to grantees to complete vaccine spend plans	May 2009
Publication of funding opportunity announcement for 50 States,	May 2009

Major Milestones	Expected Completion Date
Washington DC, 5 urban areas, and selected Pacific Island Nations program operations grants	
Publication of funding opportunity announcement Innovative Immunization and Reimbursement Initiatives	June 2009
Finalize State vaccine purchase levels	May 2009
Awards for funding opportunity announcement for 50 States, Washington DC, 5 urban areas, and selected Pacific Island Nations program operations grants	September 2009
Awards for innovative immunization and reimbursement initiatives to bill private health insurance for immunization services to increase total vaccine availability under Section 317	September 2009
Awards for strengthening the evidence base projects	September 2009
Publication of funding opportunity announcement for innovative initiatives to enhance the interoperability of electronic immunization data exchange between Electronic Health Records (EHR) systems and immunization registries	May 2010
Awards for public communication and engagement activities and provider outreach	April 2009 – September 2010
All National Communications Campaign and Provider Education awards will be completed	June 2010
Awards for innovative initiatives to enhance the interoperability of electronic immunization data exchange between Electronic Health Records (EHR) systems and immunization registries	August 2010
All Reaching More operations grants have been awarded to states and all vaccine purchases are on schedule.	August 2010
Innovative Immunization and Reimbursement Initiatives- fourteen (14) grants have been awarded funds for the reimbursement initiatives and awards to grantees to enhance immunization registry and electronic health records linkages are planned for August.	August 2010
All Strengthening the Evidence Base awards will be completed	August 2010

F. Environmental Review Compliance

The CDC grants and contracts addressed in this program are subject to a National Environmental Policy Act (NEPA) categorical exclusion promulgated by HHS [65 FR 10229 (2/25/2000); HHS GAM Part 30-20-40, B.2. (e), (g), (i), (j)] and additional NEPA review is not required. Categorical exclusions and other environmental reviews are documented in writing and reported on the Section 1609(c) report.

G. Measures

Table 1A: ARRA Measures—Type, Polarity, Target, and Frequency

Measure and Explanation	Type	Polarity	Target	Frequency
ARRA-funded vaccine doses providers will administer to	Outcome	Positive	FY09-Q4: 20% FY10-Q1: 40%	Quarterly

Table 1A: ARRA Measures—Type, Polarity, Target, and Frequency

Measure and Explanation	Type	Polarity	Target	Frequency
children (0-18 years) Explanation: Cumulative number of doses of ARRA-funded vaccine ordered by public and private providers for administration to children. Immunization providers are allowed to order only as much vaccine as they intend to administer.			FY10-Q2: 50% FY10-Q3: 60% FY10-Q4: 95% FY11-Q1: 100% FY11-Q2: 100%	
ARRA-funded vaccine doses providers will administer to adults (19 years and older) Explanation: Cumulative number of doses of ARRA-funded vaccine ordered by public and private providers for administration to adults. Immunization providers are allowed to order only as much vaccine as they intend to administer.	Outcome	Positive	FY09-Q4: 20% FY10-Q1: 40% FY10-Q2: 50% FY10-Q3: 60% FY10-Q4: 95% FY11-Q1: 100% FY11-Q2: 100%	Quarterly
% recipients on track with meeting project-specific milestones.	Output	Positive	FY10-Q1: 70% FY10-Q2: 80% FY10-Q3: 80% FY10-Q4: 90%	Quarterly

Table 2A: ARRA Measures—Data Source, Validation, and Reporting

Measure	Data Source and Validation	Reporting System	How Reported to Public
ARRA-funded vaccine doses providers will administer to children (0-18 years)	Source: CDC's Vaccine Central Distribution Ordering and Shipment Data Warehouse Validation: Vaccine orders are submitted by recipients to CDC's Vaccine Management system based on actual vaccine orders they have received from providers. These data are compared against shipping data of the centralized distributor to ensure that ordered doses were	Extracted by Program staff from Data Warehouse, compiled and reported up. No grantee reporting required.	Compiled monthly, but will be reported up quarterly to CDC/FMO and then to designated website(s)
ARRA-funded vaccine doses providers will administer to adults (19 years and older)			

Table 2A: ARRA Measures—Data Source, Validation, and Reporting

Measure	Data Source and Validation	Reporting System	How Reported to Public
	actually shipped.		
Percentage of recipients on track with meeting project-specific milestones	Source: Recipient progress on project-specific milestone checklist Validation: Project Officer review of progress reports + routine TA with grantees will help with report preparation and prior report follow up. Failure to meet reporting requirements will be elevated to supervisory authorities for troubleshooting.	Recipient will develop milestones/checklist in their proposal and complete checklist as part of their progress reporting. PO will assess progress per checklist against targets for progress.	Compiled monthly, but will be reported up quarterly to CDC/FMO and then to designated website(s)

Performance Reporting

Outcome / Achievement	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
ARRA-funded vaccine doses providers will administer to children (0-18 years)	%	Projected	20%	40%	50%	60%	95%	100%	100%			100%
		Actual	-	37%	53%							
ARRA-funded vaccine doses providers will administer to adults (19 years and older	%	Projected	20%	40%	50%	60%	95%	100%	100%			100%
		Actual	-	45%	53%							
% of recipients on track with meeting project-specific milestones	%	Projected	-	70%	80%	80%	90%					90%
		Actual	-	86%	88%							

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire life cycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

CDC's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. CDC's Senior Assessment Team carries out comprehensive annual assessments of its Recovery Act programs to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets at least quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, CDC will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

Understanding that funds allocated as part of Recovery Act require additional accountability, CDC has established a centralized oversight function, for agency-wide Recovery Act Coordination (RAC), to oversee and coordinate all Recovery Act-funded activities. Quarterly reviews of Recovery Act programs will be conducted by RAC in collaboration with CDC's Financial Management Office (FMO) and Procurement and Grant's Office (PGO), as well as program managers. Potential risks associated with executing Recovery Act funds have been identified and appropriate mitigation strategies have been instituted to ensure Recovery Act funding is effectively and efficiently utilized to achieve program goals. In addition, assurance of adequate staffing levels within FMO, PGO, and within the program has been addressed to provide appropriate oversight and monitoring of recipient activity.

To ensure Recovery Act grantee accountability and performance and to minimize risks associated with the misuse of Recovery Act funds, CDC will perform the following contract and grant management activities for Recovery Act-funded contractors and grantees:

- Coordinate with the Office of the Inspector General (OIG) to ensure that Recipient Capability Assessments are conducted on funded organizations as needed;
- Ensure ongoing technical assistance is provided to contractors and grantees who need assistance in meeting administrative and program requirements;

- Monitor the receipt of financial reports, and review those reports for the purpose of monitoring compliance with financial requirements;
- Monitor the receipt of recipient progress reports, and review those reports for the purpose of monitoring compliance with program requirements;
- Conduct vigorous post-award monitoring to include site visits to grantees;
- Ensure the unique identification of Recovery Act funds in contractual and grant agreements, to include the use of unique Recovery Act CFDA numbers for grants;
- Refer all known instances of suspected fraud, waste, or abuse to the OIG;
- Ensure that timely enforcement actions are taken on any non-performing contractor or grantee;
- Take appropriate enforcement action, such as the disallowance of costs, the recovery of funds, the referral of suspected fraud to the OIG, the implementation of administrative corrective actions by the contractor or grantee, or the termination of funding if CDC determines that a contractor or grantee has misused Recovery Act funds, CDC will; and
- Support the oversight of the Recovery Accountability and Transparency Board, the OIG, and General Accounting Office, to include taking timely action on inquires and recommendations.

In accordance with current practice for the Section 317 Immunization Grant Program, there will be frequent communication between grant and contract recipients and program staff, including regular conference calls. Program staff will ensure site visits are conducted according to Recovery Act requirements, and that technical assistance is provided. Recipients may be allowed to charge increased administrative costs to support the frequent and extensive reporting required by the Recovery Act. Allowable and unallowable expenditures will be clearly communicated to recipients and appropriate penalties for misappropriation or misuse of funds will be enforced. The Office of Management and Budget (OMB) Circular A-133, “Audits of States, Local Governments and Non profit Organizations” will set the administrative requirements for these entities. OMB Circular A-87, “Cost Principles for State, Local and Indian Tribal Governments” will set the Federal principles for determining allowable costs.

Development and submission of grantee plans and quarterly updates on progress towards measures and targets will enhance recipient accountability. Specific financial and program performance measures and the frequency for their reporting have been enumerated regarding measures. These indicators will serve as an evaluation of progress in deploying funds and achieving the intended outcomes. Lack of progress will serve as a warning for early intervention to ensure timely mitigation of issues. Monthly and quarterly reporting by recipients will be monitored by project and contract officers and failures to adhere to performance measures will be elevated to supervisory authorities immediately for troubleshooting.

I. Transparency

CDC is open and transparent in all of its contracting and grant competitions and regulations depending on what is appropriate for Section 317 program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance and published on

grants.gov and fbo.gov. CDC ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. CDC informs recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, CDC provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

CDC will provide technical assistance to grantees and contractors and fully utilize Project Officers to ensure compliance with reporting requirements. CDC will ensure recipient cost and performance requirements are reported on a quarterly basis. All awards issued with Recovery Act will have special accounting numbers and codes to track the funds and awards.

Recipients will report economic indicators of job creation and/or preservation on a quarterly basis directly to a central reporting system in accordance with the provisions of Section 1512. These data will be available at the recipient level. All other indicators will be collected from existing databases, collated by the program staff and then reported to CDC RAC. The customary process for reporting progress on these measures to the Department of Health and Human Services (HHS) and the OMB will be employed. These measures will be reported in aggregate, however the recipient-by-recipient performance on which they are based will be available from the program and its project officers. A CDC point of contact has been established for federalreporting.gov and recovery.gov to receive and answer public inquiries regarding programmatic efforts with Recovery Act funds.

CDC shall ensure merit-based decision-making for Recovery Act grant and contract awards by:

- Promoting competition to the maximum extent practicable;
- Considering the weighting of selection criteria to favor applicants with demonstrated ability to deliver performance;
- Using award methods that allow grantees and contractors to commence activities as quickly as possible;
- Ensuring that receipt of funds is contingent on grantees and contractors agreeing to meet Recovery Act reporting requirements;
- Adapting current applicant evaluation and review processes to reflect Recovery Act needs; and
- Pursuing efforts to overcome impediments to Recovery Act awards.

CDC grant announcements and contract solicitations involving Recovery Act funds shall contain transparent merit-based selection criteria that allow CDC to evaluate an applicant's demonstrated or potential ability to:

- Deliver programmatic results;
- Create economic stimulus, to include the number of jobs created or saved in relation to Federal dollars obligated;
- Achieve long-term public health benefits; and

- Satisfy Recovery Act transparency and accountability objectives, to include all reporting requirements.

CDC shall avoid the funding of imprudent projects by:

- Exercising the formal approval of Agency, Program and Spend Plans;
- Identifying measurable Program and Recovery Act outcomes;
- Reviewing proposed activities and expenditures for imprudent projects; and
- Making the timely obligation of funds.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, CDC will build on and strengthen existing processes. Senior CDC Section 317 program officials will meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system will also incorporate Recovery Act program stewardship responsibilities for program and business function managers.

Centers for Disease Control and Prevention

The 317 program has developed a CDC-approved Program Implementation Plan containing management and oversight processes. Additionally, a point of contact has been established for Recovery.gov to receive and answer public inquiry regarding programmatic efforts with Recovery Act funds.

CDC will conduct quarterly reviews between Division Directors/Management Officials and project officers prior to the end of the quarter to evaluate progress to date and discuss grantee performance. This information will be provided to the National Center and ultimately CDC's Recovery Act Coordination unit for review. Additionally, National Center and Division Directors will have accountability and performance measurement objectives included in performance plans. Annual reviews will be conducted with CDC leadership to ensure programmatic objectives and grantee accountability measures are being executed and achieved as stated.

K. Barriers to Effective Implementation

Circumstances that could impede the effective implementation of Recovery Act activities have been evaluated. In each of these circumstances, CDC has developed a strategy to identify and take actions to mediate appropriately.

1. **Some state legislatures may not be in session full time. Passage of state appropriations may not coincide with the timing of implementation of Recovery Act funds, potentially causing a delay in programmatic activities.** CDC monitors program activities to determine if this becomes a factor with effective program implementation. If program activities are impeded, program staff will elevate concerns through CDC management to determine the appropriate course of action.

2. **Some states have implemented hiring freezes due to the current economic environment. This may inhibit the ability of CDC to efficiently execute Recovery Act funded activities**. CDC monitors program activities to determine if this becomes a factor with effective program implementation. If program activities are impeded, program staff will elevate concerns through CDC management to determine the appropriate course of action.

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

- Updated **Public Benefits** and **Activities** section to align with February 2010 spend plan that was approved by OMB.
- Updated **Characteristics** section with additional details in the Type of Award and Recipients column.
- Updated the **Delivery Schedule** with revised completion dates and added the following:
    - Publication and award date for Innovative Initiatives/Electronic Health NOFA
    - Projected award date for National Communication Campaign and Provider Education
- **Measures** – revised targets in child/adult vaccine doses measures based on ARRA-funded vaccine purchase patterns.
- Updated mitigation strategy for each risk identified in the **Barriers to Effective Implementation** section

Appendix A – Additional Information

Does this program align with an existing PART program? Yes

PART Program Code #: 10000250

Does this program align with an existing CFDA program? Yes

CFDA #: 93.712 ARRA Immunization

Related Programs:
93.268 Immunization Grants
93.185 Immunization Research, Demonstration, Public Information and Education-Training
and Clinical Skills Improvement Projects
93.283 Centers for Disease Control and Prevention – Investigations and Technical Assistance
93.217 Family Planning Services
93.185 Varicella Active Surveillance Project

Centers for Disease Control and Prevention: Healthcare-Associated Infections Program

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
State Health Department Efforts to Prevent Healthcare Associated Infections (CDC)	40.00	39.88	0.12
Improvement of State Survey Inspection Capability of Ambulatory Surgery Centers (CMS)	10.00	0.73	9.27
Total	50.00	40.61	9.39

B. Objectives

The American Recovery and Reinvestment Act (Recovery Act) appropriated $50 million to the Department of Health and Human Services (HHS) Office of the Secretary. These funds will be provided to states for the execution and implementation of healthcare-associated infection (HAI) reduction strategies. They will also be used for state prevention activities and enhancing oversight and accreditation at the state level.

This program is aligned to the HHS Action Plan to Prevent Healthcare-Associated Infections (HAIs), which represents a culmination of research, deliberation, and public comment to identify the key actions needed to achieve and sustain progress in protecting patients from the transmission of serious, and in some cases, deadly infections. For more information, visit: http://www.hhs.gov/ophs/initiatives/hai/infection.html.

Traditionally, state health departments have had limited activities or workforce to address HAIs. However, in recent years more than 20 states have passed laws requiring reporting of hospital-specific HAI data to state health departments with public disclosure of hospital infection rates. In 21 states thus far, the CDC's National Healthcare Safety Network (NHSN) has been identified as the tool for reporting and NHSN participation has grown from 300 hospitals nationally to approximately 2,100 hospitals in two and a half years. This program will assist in providing state health departments with the necessary workforce, training, and tools to rapidly scale up to meet this new effort to prevent HAIs, support the dissemination of HHS evidence-based practices within hospitals, support targeted efforts to monitor and investigate the changing epidemiology of HAIs in populations as a result of new prevention collaboratives, and address overall HHS HAI prevention priorities.

This program provided funds for improvement of State Survey Agency (SA) inspection capability of Ambulatory Surgery Centers (ASCs) nationwide. This program will also assist

SAs, enabling them to identify and correct infection control deficiencies in ambulatory surgical centers.

Public Benefits

Healthcare-associated infections occur in all settings of care. It has been estimated that in 2002, 1.7 million infections and 99,000 associated deaths occurred in hospitals alone. The financial burden attributable to these infections is staggering with an estimated $33 billion in added healthcare costs (2009[1,2]). Recent research efforts supported by the CDC and the Agency for Healthcare Research Quality (AHRQ) have shown that implementation of CDC HAI prevention recommendations can reduce some healthcare-associated infections by as much as 70%. Broad implementation of HAI prevention guidelines can result in dramatic reductions in HAIs, which will not only save lives and reduce suffering, but will result in healthcare cost savings.

Investing in state health departments to promote HAI prevention is critical. States currently conduct limited activities on HAI surveillance and prevention activities. Recovery Act funding will fill an essential gap for state health departments and will build capacity for HAI prevention. This funding will allow states to better promote and coordinate HAI prevention activities in all hospitals in their states. States that currently have this leadership and coordination role (e.g. New York) have shown major decreases in HAIs. This funding will enable states to build a sustainable program to decrease HAIs which is expected to lead to a reduction in healthcare costs. Recovery Act funding is restricted to state health department efforts to track and prevent HAIs.

ASCs in the United States have been the fastest growing provider type participating in Medicare, increasing in number by more than 38% between 2002 and 2007. A 2008 Hepatitis C outbreak in Nevada was traced to poor infection control practices at various ASCs (potentially affecting more than 50,000 people). Follow-up surveys throughout Nevada found infection control deficiencies at more than 40% of the ASCs.

C. Activities

Centers for Disease Control and Prevention

CDC competitively awarded funding to eligible state health departments to support efforts to prevent HAIs as part of the HHS Action Plan to Prevent HAIs. Existing Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) and the Emerging Infections Programs (EIP) competitive cooperative agreement programs were utilized to make supplemental competitive awards to state health departments to carry out HAI activities as follows:

Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)

- Coordinating and reporting of state HAI prevention efforts
- Reporting progress toward reductions on two or more of the targets in the HHS Action Plan To Prevent Healthcare-Associated Infections

[1] Scott, R. Douglas. The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention. March 2009. http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf

[2] Klevens RM, Edwards JR, Richards CL, Horan T, Gaynes R, Pollock D, Cardo D. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. Public Health Rep 2007;122:160-166.

- Developing sustainable state HAI reporting using the NHSN and to evaluate NHSN data
- Increasing awareness among healthcare providers
- Estimating the burden of HAI
- Monitoring the impact of prevention programs and reporting using NHSN metrics for progress toward HHS HAI Prevention Targets
- Establishing prevention collaborations with healthcare facilities, healthcare professionals, state Hospital associations, and state-based Medicare Quality Improvement Organizations

Emerging Infections Programs (EIP)
- Monitoring and investigating the changing epidemiology of HAIs in populations as a result of prevention collaboratives
- Quickly expanding the EIP infrastructure to address a broader array of HAI epidemiology
- Providing additional training for EIP state staff on HAI epidemiology and surveillance
- Developing and implementing enhanced surveillance tools and methods, and add staff for targeted two year projects

Centers for Medicare and Medicaid Services
This initiative will significantly expand the awareness of proper infection control technique among ASCs and SAs, increase the extent to which infection control deficiencies are both identified and remedied, and prevent future serious infections in ASCs by:
- Improving SA inspection capability and frequency for onsite surveys of ASCs nationwide,
- Using a new infection control survey tool developed by the CDC and CMS,
- Improving the survey process through the use of a CMS tracer methodology, and
- Using multi-person teams for ASCs over a certain size or complexity.

A CMS pilot program tested the above survey process improvements in three states in 2008 and demonstrated superior results in the identification and remedy of serious infection control deficiencies. The particular focus on ASCs for this funding was chosen because the available tool was developed and tested for ASCs, because ASCs have not been surveyed with the frequency and attentiveness to infection control that is needed (about once every ten years on average nationally), and because of the likely continuing infection control deficiencies in this setting. The Recovery Act funds will enable the application of the above four-component new survey process nationwide. For FY2009, 12 states participated in the ASC-HAI Initiative, utilizing the four-component survey process. For FY2010, 42 states are receiving Recovery Act funding to utilize the new survey process. The new survey process is mandatory for all state agencies as of October 1, 2009.

D. Characteristics

Centers for Disease Control and Prevention
Type of Financial Award: The Code of Federal Domestic Assistance number for HAI is 93.717. CDC utilized Code B – Project Grants to provide funding to state health departments using two existing competitive Cooperative Agreements:

1. **Epidemiology and Laboratory Capacity for Infectious Disease Program**
   - Coordination and Reporting of State HAI Prevention Efforts (Activity A)

Award Amount: up to $200,000 per funded state

- Detection and Reporting of Healthcare Associated Infection Data (Activity B)
  Award Range: $500,000 - $1,000,000 per funded state
- Establishing a Prevention Collaborative (Activity C)
  Award Range: $200,000 - $500,000 per funded state

States applied for ARRA funding to complete one, two, or three of the activities (A, B, C) listed above. If a State applied for A and another activity, they were required to justify in their application their ability to fully complete all requirements described in Activity A in a timely manner so that funds within Category B and C will be fully implemented within the ARRA allotted timeframes. State HAI funds were competitively awarded based on objective evaluation criteria, including sustainability. If a state applied for more than one activity, the state was required to describe how work done in each activity must be coordinated and complimentary. States will also need to discuss how funding supplements existing programs and does not supplant existing efforts. Spending under categories A, B, and/or C was contingent upon the States ability to sustain activities after Recovery Act funding has ceased.

2. Emerging Infections Program

- Resources will support targeted efforts to monitor and investigate the changing epidemiology of HAIs in populations as a result of prevention collaboratives.
  Award Range: $200,000 -$500,000 per funded site
  Type of Recipient: States via the state health departments
  Type of Beneficiary: States

Centers for Medicare and Medicaid Services

Type of Financial Award: The Code of Federal Domestic Assistance number for HAI is 93.720. Payments are made to States separately from but in the same manner as they currently are made to operate the Survey and Certification program described under §1864 of the Social Security Act using funds from the Federal Hospital and Supplementary Medical Insurance Trust Funds. The SAs completed Form CMS-435, State Survey Agency Budget/Expenditure Report for current survey and certification requirements. Form CMS-435 is a multi-purpose form (budget request and approvals, expenditures reports, supplemental funding request, etc.) used in Medicare and Medicaid applications. The SA indicated the specific use of the form by checking the appropriate box. CMS internally assessed an allocation strategy based on the number of ASCs in the State, performance in meeting the prioritization of the objectives, and SA's capability to move forward expeditiously. The use of the funds are captured distinct from other Survey & Certification program funds using a modified version of the standard Form 435 – Expenditure form. Of the total funds, $8.375 million of the $9.95mil available has been allocated to States and $50,000 will be used for Federal administration (e.g., training of States). In both FY 2009 and FY 2010, the Recovery Act funds are separately tracked and monitored from the Federal Administration funds allocated for Survey and Certification program activities
Type of Recipient: State Survey Agencies
Type of Beneficiary: States

E. Delivery Schedule

Centers for Disease Control and Prevention
The table below shows the schedule of milestones for major phases (e.g. the procurement phase, planning phase, project execution phase, etc., or comparable) with planned delivery date(s):

Milestone	Completion Date
CDC Guidance issued for State HAI plans	May 2009
EIP Proposals Due to CDC	June 2009
Supplemental Awards for ELC	September 2009
Supplemental Awards to EIP	September 2009
State HAI plans submitted to CDC for review	January 2010
State Healthcare Collaboratives established	January 2010
State HAI Plans due by HHS	January 2010
States identify HAI coordinators	January 2010
Baseline State reporting measures in NHSN due	May 2010
Reporting of progress toward prevention targets using NHSN	Ongoing

Centers for Medicare and Medicaid Services
The table below shows the schedule of milestones for major phases (e.g. the procurement phase, planning phase, project execution phase, etc) with planned delivery date(s).

Milestone	Completion Date
First Training on new Evidence-based tool	May 2009
Notice to State Survey Agencies	June 2009
Selection of States for 2009 Implementation	July 2009
Implementation in 2009 Volunteer States	July 2009
Second Training – all States	October 2009
Implementation in Remaining States-FY 2010	November 2009
All ASC surveys completed	September 2010

F. Environmental Review Compliance

The grants and contracts addressed in this program are subject to a National Environmental Policy Act (NEPA) categorical exclusion reference 2d, 2e, 2g, 2i, 2j per HHS GAM 30-20-40 as promulgated by HHS [65 FR 10229 (2/25/2000)] and additional NEPA review is not required.

Categorical exclusions and other environmental reviews will be documented in writing and reported on the Section 1609(c) report.

G. Measures

Centers for Disease Control and Prevention

The investments for HAI prevention through December 2011, are historic both in helping states to address HAIs and in their potential for rapidly building capacity in state health departments for promoting HAI prevention long term. CDC provides technical assistance and support as necessary to ensure that states can effectively use these funds. With the successful implementation of this program, we anticipate some reductions in HAIs within two years, and potentially a greater than 50% reduction in HAIs within ten years of initiation of the program.

Table 1A. CDC – Healthcare-Associated Infections Recovery Act Performance Measures: Type, Polarity, Target, and Frequency

Goal/Objective	Measure	Type	Direction of Measure	Target	Frequency
Reduction in (targeted or selected) HAIs	% of states that have a standardized infection ratio (SIR) for central line-associated bloodstream infections (CLABSIs) that is significantly less than 1 (of states submitting enough data to produce a reliable SIR) (CDC)	Outcome	Positive	FY09-Q3: -- FY09-Q4: -- FY10-Q1: -- FY10-Q2: -- FY10-Q3: 40% FY10-Q4: -- FY11-Q1: 50% FY11-Q2: -- FY11-Q3: 60% FY11-Q4: --	Annually
Detection and reporting of Healthcare Associated Infection data [selected states]: Number of new healthcare facilities participating in NHSN. .	% of all hospitals participating in NHSN, among states funded for detection and reporting of Healthcare Associated Infection data (CDC)	Output	Positive	FY09-Q4: 30% FY10-Q1: 40% FY10-Q2: 45% FY10-Q3: 45% FY10-Q4: 50% FY11-Q1: 50% FY11-Q2: 55% FY11-Q3: 60% FY11-Q4: 60%	Quarterly

Table 1B. CDC – Healthcare-Associated Infections Recovery Act Performance Measures: Data Source, Validation, and Reporting

Measure	Data Source	Validation	How Reported to Public
% of states that have a standardized infection ratio (SIR) for central line-associated bloodstream infections (CLABSIs) that is significantly less than 1 (of states submitting enough data to produce a reliable (SIR) (CDC)	National Healthy Safety Network (NHSN) system	NHSN's web application has internal data validity and consistency checks. Data are entered in participating hospitals by trained infection prevention staff using standardized definitions and surveillance methods. Data are reviewed by CDC staff for consistency. ARRA funds will provide States resources to conduct validation studies of data submitted to NHSN; see (http://www.cdc.gov/nhsn/index.html)	Reported by participating hospitals to NHSN. Extracted by Project Officers and Program staff for reporting.
% of all hospitals participating in NHSN, among states funded for Detection and Reporting of Healthcare Associated Infection Data (CDC)			

Centers for Medicare and Medicaid Services

CMS will provide quarterly reporting on what work has been completed including milestones such as training, outreach efforts, allotments to SAs. Using data derived from the data base that supports survey operations, we are monitoring progress on the number of surveys and the survey results on a monthly basis internally, and reporting quarterly on the measure indicated in Table 1C below. To gauge effectiveness of the project overall, CMS will issue an evaluative report on the new ASC survey process. The report shall include SA & CDC input on the value from the enhanced survey infection control tool and other important aspects of the new survey process. CMS will post the report on its Web site at www.cms.hhs.gov.

Table 1C. CMS - Healthcare-Associated Infections Recovery Act Performance Measures: Type, Target, and Frequency

Goal/Objective	Measure	Type	Direction of Measure	Target	Frequency
Improve State Survey Agencies' ability to identify deficient infection control practices during inspection of Ambulatory Surgery Centers (ASCs) as a result of using an infection control surveyor tool.	Increase by 50%, when compared to the first three quarters of FY 2009, the percentage of all ASCs inspected by State Survey Agencies that are cited for an infection control deficiency. (CMS)	Outcome	Positive	FY10-Q1: -- FY10-Q2: -- FY10-Q3: -- FY10-Q4: 50%	Annually – at the end of FY 10

Performance Reporting

Outcome / Measure	Unit	Type	9/30/09 09/Q4	12/31/09 10/Q1	3/31/10 10/Q2	6/30/10 10/Q3	9/30/10 10/Q4	12/31/10 11/Q1	3/31/11 11/Q2	6/30/11 11/Q3	9/30/11 11/Q4	Program End
% of states that have a standardized infection ratio (SIR) for central line-associated bloodstream infections (CLABSIs) that is significantly less than 1 (of states submitting enough data to produce a reliable SIR) (CDC)[1]	%	Target				40%	-	50%	-	60%	-	60%
		Actual	-	-								
% of all hospitals participating in National Healthy Safety Network (NHSN), among states funded for Detection and Reporting of Healthcare Associated Infection Data (CDC)[2]	%	Target	30%	40%	45%	45%	50%	50%	55%	60%	60%	60%
		Actual	42.7%	43.4%								
Increase by 50%, when compared to the first three quarters of FY 2009, the percentage of all ASCs inspected by State Survey Agencies that are cited for an infection control deficiency.. (CMS)[3]	%	Target		-	-	-	50%					50%
		Actual		498%[4]								

[1] The SIR compares the actual number of the specific HAI type in a state with the baseline U.S. experience (i.e., standard population), adjusting for several risk factors that have been found to be associated with differences in infection rates. An SIR of less than 1.0 indicates that fewer HAI events (of that specific type) were observed than expected. The SIR is consistent with the HHS Action Plan to Eliminate HAIs, and is currently used by three states for public reporting. This measure will be reported for states receiving Activity C funding and have identified CLABSI as a prevention target.

[2] Thirty-two states are receiving funding for Activity B. This percentage is calculated by dividing the total number of hospitals participating in NHSN by the number of 2008 American Hospital Association (AHA) facilities. The denominator comes from the 2008 AHA national hospital survey. The numerator comes from the NHSN system and includes all hospital categories. This measure assumes that all NHSN facilities are included in the AHA facilities count. In actuality, NHSN facilities have not been matched to AHA data. There are some AHA facilities that are not participating in NHSN; also, there are some facilities within the NHSN system that are not included in the AHA list. **CDC is working to identify a more accurate denominator. If one can be found, it will be used in subsequent reports.**

[3] The numbers will change in the next reporting quarter as a result of lag time and enforcement activities. Also, as more surveys are uploaded, the performance measures will improve.

[4] The figure represents the percentage increase in the percentage of surveyed ASCs that had an infection control deficiency in the 1st quarter of FY09 versus the 1st quarter of FY10.

H. Monitoring and Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are conducted by operating components to comply with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act as well as OMB Circular A-123, "Management's Responsibility for Internal Control" (including Appendices A, B, and C).

CDC and CMS's risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. The CDC and CMS Senior Assessment Teams carry out comprehensive annual assessments of this Recovery Act program to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. They meet at least quarterly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, CDC will present this program's high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

Centers for Disease Control and Prevention
Understanding that funds allocated as part of Recovery Act require additional accountability, CDC has established a centralized oversight function, for agency-wide Recovery Act Coordination (RAC), to oversee and coordinate all Recovery Act-funded activities. Quarterly reviews of Recovery Act programs will be conducted by RAC in collaboration with CDC's Financial Management Office (FMO) and Procurement and Grant's Office (PGO), as well as program managers. Potential risks associated with executing Recovery Act funds have been identified and appropriate mitigation strategies have been instituted to ensure Recovery Act funding is effectively and efficiently utilized to achieve program goals. In addition, assurance of adequate staffing levels within FMO, PGO, and within the program has been addressed to provide appropriate oversight and monitoring of recipient activity.

To ensure Recovery Act grantee accountability and performance and to minimize risks associated with the misuse of Recovery Act funds, CDC will perform the following contract and grant management activities for Recovery Act-funded contractors and grantees:

- Coordinate with the Office of the Inspector General (OIG) to ensure that Recipient Capability Assessments are conducted on funded organizations as needed;

- Ensure ongoing technical assistance is provided to contractors and grantees who need assistance in meeting administrative and program requirements;
- Monitor the receipt of financial reports, and review those reports for the purpose of monitoring compliance with financial requirements;
- Monitor the receipt of recipient progress reports, and review those reports for the purpose of monitoring compliance with program requirements;
- Conduct vigorous post-award monitoring to include site visits to grantees;
- Ensure the unique identification of Recovery Act funds in contractual and grant agreements, to include the use of unique Recovery Act CFDA numbers for grants;
- Refer all known instances of suspected fraud, waste, or abuse to the OIG;
- Ensure that timely enforcement actions are taken on any non-performing contractor or grantee;
- Take appropriate enforcement action, such as the disallowance of costs, the recovery of funds, the referral of suspected fraud to the OIG, the implementation of administrative corrective actions by the contractor or grantee, or the termination of funding if CDC determines that a contractor or grantee has misused Recovery Act funds, CDC will; and
- Support the oversight of the Recovery Accountability and Transparency Board, the OIG, and General Accounting Office, to include taking timely action on inquires and recommendations.

There will be frequent communication between grant and contract recipients and program staff, including regular conference calls. Program staff will ensure site visits are conducted according to Recovery Act requirements, and that technical assistance is provided. Recipients may be allowed to charge increased administrative costs to support the frequent and extensive reporting required by the Recovery Act. Allowable and unallowable expenditures will be clearly communicated to recipients and appropriate penalties for misappropriation or misuse of funds will be enforced. The Office of Management and Budget (OMB) Circular A-133, “Audits of States, Local Governments and Non profit Organizations” will set the administrative requirements for these entities. OMB Circular A-87, “Cost Principles for State, Local and Indian Tribal Governments” will set the Federal principles for determining allowable costs.

Development and submission of grantee plans and quarterly updates on progress towards measures and targets will enhance recipient accountability. Specific financial and program performance measures and the frequency for their reporting have been enumerated regarding measures. These indicators will serve as an evaluation of progress in deploying funds and achieving the intended outcomes. Lack of progress will serve as a warning for early intervention to ensure timely mitigation of issues. Monthly and quarterly reporting by recipients will be monitored by project and contract officers and failures to adhere to performance measures will be elevated to supervisory authorities immediately for troubleshooting.

Program Specific Risk Mitigation Strategies
EIP and ELC, funds were specifically awarded for HAI activities only. Recipients will outline a plan for reporting progress toward HHS Action Plan Prevention Targets using specified metrics compatible with NHSN. CDC will collaborate with AHRQ and work with grantees to eliminate duplication of effort, and the EIP and ELC supplemental funding opportunity announcements (FOAs) required details on how CDC-funded work will link into existing efforts funded by AHRQ.

HAI state applicants were required to describe state plans for sustaining Recovery Act impact beyond the federal funding provided and demonstrate a continued plan for progress toward meeting HHS Action Plan prevention targets as evidenced through reporting metrics outlined in the Plan.

Tables 2A and 2B includes a full presentation of the Agency specific Recovery Act Risks and Mitigations for Healthcare-Associated Infections.

Development and submission of HAI grantee plans and quarterly updates on progress towards specific economic and performance measures and targets, enumerated in the preceding Measures section, will help minimize the risk of such abuse, These indicators,, including targets for reduction in HAIs will serve as an evaluation of progress, allowing for early intervention to ensure timely mitigation of issues. Lack of progress will serve as a warning for early intervention to ensure timely mitigation of issues.

The HAI proposal was shared with the Office of Inspector General (OIG), and CDC successfully responded to all questions.

Table 2A. CDC-Specific Recovery Act Risks and Mitigations for Healthcare-Associated Infections

Risk Description and Degree	Mitigation Description	Assessment Measure	Trigger for Contingency Plan	Responsible Office and Official
Lack of program-direct support to hire the necessary staff within CDC to oversee grantee performance and reporting. *(High degree of risk)*	CDC is planning to use FY 2009 appropriations funding to hire additional FTE and contract staff.	At least half of the proposed FTEs and contract staff are in place by July 2009.	Inability to hire new staff, and/or to meet RA reporting requirements.	CDC: Joni Young
Potential for NHSN performance to degrade with rapid influx of new users. *(High degree of risk)*	CDC is planning to use FY 2009 appropriations funding to hire additional FTE and contract staff, purchase more servers, and related software.	Through continued monitoring of system performance and feedback from state users.	Unacceptable performance of NHSN	CDC: Dan Pollock

Risk Description and Degree	Mitigation Description	Assessment Measure	Trigger for Contingency Plan	Responsible Office and Official
Potential delay in the developing/ implementing prevention collaboratives and expansion of participation in NHSN due to lack of staff with HAI expertise in some states. *(Medium degree of risk)*	CDC will allow states to contract with outside entities (e.g. CSTE).	CDC will monitor states identifying and/or hiring of HAI coordinators through quarterly progress and financial reports.	State's inability to define needs and address barriers to implementation.	CDC: Joni Young
Potential impediments for state public health departments in hiring HAI Coordinator due to state hiring freezes and limitations of states to contract with out of state entities (e.g. Council of State and Territorial Epidemiologists). *(Medium degree of risk)*	CDC will work with states to define options; technical assistance to states with difficulty identifying a coordinator may receive additional technical assistance, but if an appropriate person is not readily identified, they may lose funding as per the ELC award conditions.	CDC will monitor states hiring of HAI coordinators through quarterly progress and financial reports.	State's inability to define needs and address barriers to implementation.	CDC: Mike Bell
Potential duplicative use of CDC's RA HAI funds for prevention collaboratives currently funded by the Agency for Healthcare Research and Quality (AHRQ). *(Medium degree of risk)*	The ELC supplemental FOA will require details on how CDC-funded work will link into existing efforts funded by AHRQ and reporting will be executed through CDC's systems. CDC will collaborate with AHRQ to ensure grantees are not duplicating efforts with OPDIV funds.	Through continued collaboration and discussion with AHRQ. Also through quarterly progress and financial reports.	State's inability to define their prevention collaboratives or how they complement any existing AHRQ efforts. If they cannot define their needs or address barriers to implementation.	CDC: Arjun Srinivasin

Risk Description and Degree	Mitigation Description	Assessment Measure	Trigger for Contingency Plan	Responsible Office and Official
Delays in EIP reporting due to need for OMB Paperwork Reduction Act (PRA) clearance *(Low to Medium degree of risk)*	Recipients will report via their customary progress reporting; hence we do not anticipate a need for PRA clearance. In the unlikely event PRA clearance is needed, many project milestones that can be completed while awaiting clearance and work can stay on schedule	Reporting of progress milestones is occurring in the first quarter	Judgment by CDC's PRA office that EIP reporting of milestones would require PRA	CDC: Susan Conner

Centers for Medicare and Medicaid Services

CMS will obtain detailed information on the ASC infection control deficiencies identified through onsite surveys. CMS will analyze such information to discern patterns and correlates of such deficient practices. CMS will also evaluate the extent to which States conduct the onsite surveys. Risk mitigation will focus primarily on issues related to addressing State across-the-board personnel restrictions (due to State budget deficits) and obtaining the necessary data on survey results in a timely manner and with sufficient detail.

Table 2B. CMS-Specific Recovery Act Risks and Mitigations for Healthcare-Associated Infections

Risk Description & Degree	Mitigation Description	Assessment Measure	Contingency Plan Trigger	Responsible Official
1. Program Direction: Insufficient allocation of staff within CMS to provide proper direction and oversee grantee performance and reporting. *(High degree of risk)*	CMS examined workload priorities to redeploy FTE resources and to contract for certain support where necessary.	At least half of the proposed FTEs and contract staff are in place by July 2009.	Inability to hire new staff, and/or to meet Recovery Act reporting requirements.	CMS: Marilyn Dahl

Risk Description & Degree	Mitigation Description	Assessment Measure	Contingency Plan Trigger	Responsible Official
2. Training + Guidance: Potential for performance to be impaired if necessary training and guidance is not put in place effectively and timely. *(High degree of risk)*	CMS used webinars or satellite broadcasts to reach surveyors quickly in May 2009, sought assistance from CDC in training surveyors, conducted a second training (face-to-face) for surveyors in October 2009. ,	CMS will monitor system performance and obtain feedback from States and ASCs.	Unacceptable performance of States, lack of attendance at training.	CMS: Marilyn Dahl
3. State Surveyor Staffing: Potential impediments for State survey agencies due to State hiring freezes, furloughs, or other across-the-board limitations imposed due to the generalized budget deficits faced by States. *(High degree of risk)*	CMS communicated the importance and urgency of this infection control initiative to State Governors and Public Health Departments, and encouraged States to permit exceptions for State survey agencies from across-the-board personnel limitations. CMS worked with States to identify options and offer technical assistance.	CMS will monitor State hiring and personnel adjustments granted to State survey agencies.	State's inability to staff the ASC surveys.	CMS: Marilyn Dahl
4. **Evaluation**: Potential difficulties in obtaining results from surveys with the detail and timeliness required for an effective evaluation. *(Medium degree of risk)*	CMS will explore and implement stand-alone data collection strategies to improve the timeliness and detail of survey results, with possible contract assistance and collaboration with CDC.	Through continued collaboration and discussion with CDC. Also through quarterly progress and financial reports.	Delay or lack of necessary detail in survey findings reported.	CMS: Marilyn Dahl

I. Transparency

CDC and CMS is are open and transparent in all contracting and grant competitions that involve spending of Recovery Act funding consistent with statutory and OMB guidance and published on grants.gov and fbo.gov. CDC and CMS ensure that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. CDC and CMS inform recipients of their reporting obligation through standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, CDC and CMS provide key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

CDC and CMS will provide technical assistance to grantees and contractors and fully utilize Project Officers to ensure compliance with reporting requirements. CDC will ensure recipient cost and performance requirements are reported on a quarterly basis. All awards issued with Recovery Act will have special accounting numbers and codes to track the funds and awards.

Recipients will report economic indicators of job creation and/or preservation on a quarterly basis directly to a central reporting system in accordance with the provisions of Section 1512. These data will be available at the recipient level. All other indicators will be collected from existing databases, collated by the program staff and then reported to CDC RAC. The customary process for reporting progress on these measures to the Department of Health and Human Services (HHS) and the OMB will be employed. These measures will be reported in aggregate, however the recipient-by-recipient performance on which they are based will be available from the program and its project officers. A CDC point of contact has been established for federalreporting.gov and recovery.gov to receive and answer public inquiries regarding programmatic efforts with Recovery Act funds.

CDC shall ensure merit-based decision-making for Recovery Act grant and contract awards by:

- Promoting competition to the maximum extent practicable;
- Considering the weighting of selection criteria to favor applicants with demonstrated ability to deliver performance;
- Using award methods that allow grantees and contractors to commence activities as quickly as possible;
- Ensuring that receipt of funds is contingent on grantees and contractors agreeing to meet Recovery Act reporting requirements;
- Adapting current applicant evaluation and review processes to reflect Recovery Act needs; and
- Pursuing efforts to overcome impediments to Recovery Act awards.

CDC grant announcements and contract solicitations involving Recovery Act funds shall contain transparent merit-based selection criteria that allow CDC to evaluate an applicant's demonstrated or potential ability to:

- Deliver programmatic results;
- Create economic stimulus, to include the number of jobs created or saved in relation to Federal dollars obligated;
- Achieve long-term public health benefits; and
- Satisfy Recovery Act transparency and accountability objectives, to include all reporting requirements.

CDC shall avoid the funding of imprudent projects by:

- Exercising the formal approval of Agency, Program and Spend Plans;
- Identifying measurable Program and Recovery Act outcomes;
- Reviewing proposed activities and expenditures for imprudent projects; and

- Making the timely obligation of funds.

Centers for Disease Control and Prevention
The system central to HAI efforts is the National Healthcare Safety Network. Although data are entered by facilities, healthcare facility data are confidential at the federal level. However, some state public health department websites may provide access to specific facility data for facilities in their state. Per Tables 1A and 1B, the proposed performance measures track the number of states with a "threshold" percentage of healthcare facilities meeting the designated benchmark. This does not require reporting data for specific facilities.

The program will pull grantee expenditure data from the quarterly reports and performance data from the grantee progress reports submitted to their Project Officers. CDC will provide the necessary recipient performance and financial data at the aggregate and disaggregated levels for public access on the CDC Web site (www.cdc.gov).

As noted, the program and its project officers will collect and collate this information from databases and grantee progress reports. It will be reported in an existing system to CDC's FMO and PGO, which have can readily provide the recipient financial and performance information required for Recovery Act-funded programs.

Centers for Medicare and Medicaid Services
CMS published on the CMS Web site (www.cms.hhs.gov) the public communications with States (Survey and Certification memoranda) as well as the survey Guidance and protocol documents. Results from the quarterly reporting are available. CMS will also publish the results of the research completed at the end of the project based on results from the onsite surveys. There is frequent communication between grant recipients and program staff, including conference calls addressing costs, performance, and requirements with OMB, CMS, and other applicable guidance documents. All grant funds will be designated to State levels with consideration for the number of ASCs in that specific State.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, CDC and CMS have built upon and strengthened existing processes. Senior CDC and CMS officials will regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

Centers for Disease Control and Prevention
The HAI program has developed a CDC-approved Program Implementation Plan containing management and oversight processes. Additionally, a point of contact has been established for Recovery.gov to receive and answer public inquiry regarding programmatic efforts with Recovery Act funds.

CDC will conduct quarterly reviews between Division Directors/Management Officials and project officers prior to the end of the quarter to evaluate progress to date and discuss

grantee performance. This information will be provided to the National Center and ultimately CDC's Recovery Act Coordination unit for review. Additionally, National Center and Division Directors will have accountability and performance measurement objectives included in performance plans. Annual reviews will be conducted with CDC leadership to ensure programmatic objectives and grantee accountability measures are being executed and achieved as stated.

Centers for Medicare and Medicaid Services
CMS uses its existing internal control fiscal infrastructure to implement this Recovery Act initiative.

CMS also established additional procedures and practices, as necessary, to ensure proper transparency, accountability, and oversight. Training in the new survey process was mandatory for relevant State and federal surveyors, with attendance tracked. Completion of the expected ASC surveys are tracked through CMS' ASPEN surveyor information system. CMS incorporated the ASC-HAI performance expectations for States into CMS' State Performance Standards System (SPSS).

CMS communicated to the SAs the intent, purpose, and process for the State grants consistent with the funding and the requirements of the Recovery Act. CMS also communicated with State officials (such as State Governors) and leadership of state Departments within which the State Survey Agencies are organizationally located, in an effort to address any State gubernatorial or Department-level actions that may be taken to promote fulfillment of the goals of this initiative. SAs progress are monitored and the agencies are held accountable for outcomes through additions to the existing SPSS. CMS uses Regional Office environmental scanning to determine if States have applied the Recovery Act dollars consistent with this program's purpose. CMS will post on the CMS Web site the results of its pilot study as well as progress reports on the Recovery Act implementation and results.

K. Barriers to Effective Implementation

Barriers to effective implementation of Recovery Act-funded activities include: Circumstances that could impede the effective implementation of Recovery Act activities have been evaluated. In each of these circumstances, CDC has developed a strategy to identify and take actions to mediate appropriately.

Centers for Disease Control and Prevention

1. Potential delay in the development and implementation of prevention collaboratives and expansion of participation in NHSN due to lack of staff with HAI expertise in some states. Solution: The ELC supplemental FOA will allow states to use a portion of funds to contract with outside entities [e.g. the Council of State and Territorial Epidemiologists (CSTE)] to place fellows in states to address HAI prevention activities. Nine CSTE HAI fellows have been matched and are currently working with state health departments.

2. Potential impediments for state public health departments in hiring HAI Coordinator due to state hiring freezes and limitations of states to contract with out-of-state entities (e.g. Council of State and Territorial Epidemiologists). Solution: While the HAI program has

offered the use of ELC funding for hiring of an HAI coordinator, CDC is not able to affect state restrictions regarding procurement policies and procedures. CDC's HAI program and the ELC will provide technical assistance to the extent possible to help mitigate this risk. All grantees have identified current staff or hired new staff to serve in this role.

3. Potential impediments for state public health departments receiving activity B funding to enroll healthcare facilities into NHSN. States without mandates for the utilization of NHSN to report HAIs are having difficulty encouraging facilities to join NHSN and/or to share data with the state health department. CDC has encouraged all current NHSN-participating facilities to contact their state health departments to identify themselves and consider sharing their data. Facilities currently have the ability to make their data available to the state health department, but they have to manually identify all of the data that is to be shared. CDC is revising the current NHSN Assurance of Confidentiality parameters so that facilities can opt to share all of their data with the states upon joining NHSN, thus relieving some of the work of the facility. CDC is actively working with the Office of General Council to revise and implement the updated Assurance of Confidentiality. CDC is also partnering with other federal agencies to focus on opportunities to maximize NHSN utilization to everyone's benefit.

Centers for Medicare and Medicaid Services

1. State furloughs and hiring freezes may negatively affect State performance. Mitigation: CMS performed outreach to State officials to inform them of the project, its purpose, and engage them in this mutually beneficial endeavor. CMS communicated with State Governors, State Public Health Commissioners, and national State associations to stress the importance of this initiative and the need to address personnel barriers to enable success. States were able to hire additional surveyors – during FY10Q2, almost 20 surveyors were hired/retained through the Recovery Act dollars.

2. Ineffective staffing. Mitigation: We expect to be able to monitor this by examining the amount of surveyor time and the number of surveyors trained, and assigned to complete the work. We have some comparative data from the ASC pilot that we plan to apply in our analysis. We conducted specialized training to States and, through partnerships with other parties, seek to make physician consultants more readily available to State surveyors.

L. Federal Infrastructure

Not applicable.

Summary of Changes

- Updated all sections to reflect the current status of planned activities.
- Updated the **Delivery Schedule** with revised completion dates for all milestones
- Reduced **performance measures** in the Implementation Plan to highlight top-level measures that are core to the intent ARRA legislation specific to HAI. While CDC will continue to collect and monitor all measures, the two measures included for the purposes of presenting program progress to the American public maintain a good balance between the public health outcome and the process.
- Adjusted targets for performance measures.
- Updated mitigation strategy for each risk identified in the **Barriers to Effective Implementation** section.

HHS Information Technology (IT) Security

A. Funding Table

(Dollars in millions)

Program/ Project/Activity	Total Appropriated	FY 2009 Actual Obligations	FY 2010 Estimated Obligations
HHS Information Technology Security	$50.00	$6.148	$43.852

B. Objectives

Recovery Act funding will accelerate HHS efforts to improve the security of its computer systems, which must protect the sensitive information held by the agencies many health, social, and research programs.

Recent compromises of Federal government computer systems and data require concerted and coordinated actions across HHS that are commensurate with the sustained level of sophisticated cyber attacks targeting Federal government computer systems, including HHS computer systems. Department and Operating Division (OPDIV) security leadership embarked in early FY 2009 on multiple discussions to define the requirements, scope, and desired security capabilities that would substantially improve the IT security posture of HHS as a whole. The initiatives identified here reflect agency-wide collaboration.

A primary objective of HHS IT security efforts is to have the ability to rapidly determine the enterprise security risk posture of operational IT systems and computer networks throughout the Department. Significant enhancements to our key information assurance capabilities will be required to more effectively detect, defend, and mitigate attacks against HHS systems. Current capabilities vary across HHS organizational components. With interconnected computer systems, a weakness in any OPDIV potentially introduces security risks for all OPDIVs. Reviews by the Office of the Inspector General (OIG) and the Government Accountability Office (GAO) recommended a number of HHS computer systems security capabilities for enhancement. This HHS IT security Recovery Act spend plan addresses the issues and recommendations arising from forensics and audit reports.

IT security is a critical issue throughout the Federal government, as nation states, commercial competitors, identity thieves, and computer hackers have significantly ramped up their efforts to attack and penetrate U.S. government computer systems. HHS' ability to continue to fulfill our national health related mission and functions as our budget grows to support economic recovery depends on our ability to maximize the secure use of the powerful computing resources that are available to us today.

C. Activities

Recovery Act funds will be used to purchase hardware, software and IT security related services.

The plan encompasses four initiatives, which streamline the original five developed at the start of the program. The new initiatives reorganize program activities in a more logical and efficient manner:

- **Security Incident Response & Situational Awareness; (CSIRC):** Expand capabilities of the HHS Computer Security Incident Response Center (CSIRC), which is co-located with the CDC Security Operations Center in Atlanta, GA. Provide enhanced Department-wide computer systems intrusion detection capabilities, security information event management systems, and network forensics capabilities.
- **Federal Information Security Management Act (FISMA) - Security Engineering and Technical Staff Support:** Alleviate the current security workload backlog of OPDIV security staffs, allowing OPDIVs to respond in a more timely manner to FISMA program tasks, begin more timely reviews of system audit logs, and reduce the Plan of Action and Milestones (POA&M) backlog.
- **Computing Infrastructure Security Redesign Projects:** Develop or update OPDIV plans for securely architecting our computing environments into secure enclaves; implements a number of network security enhancements at several OPDIVs.
- **Endpoint Protection Security Tools:** Provide OPDIVs with advanced security tools to strengthen end user computer defense mechanisms against malware attacks, and help prevent sensitive data from being extracted from the HHS computer systems and databases.

D. Characteristics

Contracts will be competitively awarded as Fixed-Price (FP) or Firm-Fixed-Price (FFP). Targeted recipients will be hardware and software vendors and contracted service providers.

HHS and the OPDIVs will leverage existing competitive contracts for efficiency purposes as much as possible. In the cases where an existing contract will be modified, HHS will ensure that such contract actions are publicized, justified, and reported accordingly. If new contracts are required, HHS will use competitive processes and publicize such opportunities as required, and report the resulting awards.

Implementation plan characteristics by OPDIV are detailed below.

OS (HHS CSIRC): $25.586M to address risks/vulnerabilities associated with the inability to detect and effectively respond to security incidents in HHS/OPDIV systems. Contracts include labor support, a portion of which will assist OPDIVs in installation of the CSIRC security product deployments. Major contracts include CSIRC IT infrastructure, network forensic solutions, intrusion detection/prevention solutions, and security information and event management solutions. Additional forensics and malware analysis tools will also be purchased.

OS (ITO): $7.055M to strengthen vulnerabilities in security infrastructure and augment endpoint protection. Over 25 projects have been identified including efforts to improve identity management, firewall applications, and network forensics.

OS (OCIO IT Security Program - Secure One): $5.918M to fund staffing support for FISMA compliance, security vulnerability weakness remediation, solutions for endpoint protection, and security architecture planning. Two key contracts include the Enterprise File and E-Mail Encryption Capability Project and the Enhanced Security Architecture Analysis procurement. Additionally, OCIO IT Security will add eight FTE to aid program support.

IHS: $2.240M for security infrastructure and endpoint protection vulnerability projects. Projects include efforts to support multi-factor authentication, vulnerability management, and intrusion detection systems.

CDC: $6.328M for security infrastructure and endpoint protection vulnerability projects. Two contracts include firewall upgrades and software/hardware redundancy, and security engineering support. Funding will also be used for network security upgrade project planning and encryption project, and to procure Department-wide licenses for security solutions for Internet content filtering, malware detection, and data loss prevention.

CMS: $1.187M to fund four FTE for FISMA compliance and security vulnerability weakness remediation support.

FDA: $.679M to fund five FTE for FISMA compliance and security vulnerability weakness remediation support.

HRSA: $.335M to fund two FTE for FISMA compliance and security vulnerability weakness remediation support.

OIG: $.671M to fund two FTE for FISMA compliance and security vulnerability weakness remediation.

The majority of contracts funded with Recovery Act resources will be new contracts. In a small number of instances, new task orders may also be placed against contracts that were previously awarded via competitive procurements. Implementation plan characteristics by contract and investment are included in the table below:

OPDIV	Initiative	Total Value ($M)	Type (in accordance with FAR Part 16)
OS (HHS CSIRC)	FISMA - Security Engineering and Technical Staff Support Security Incident Response & Situational Awareness; (CSIRC)	25.586	Fixed-Price (FP) / Firm-Fixed-Price (FFP)
OS (ITO)	Computing Infrastructure Security Redesign Projects	7.055	Fixed-Price (FP) / Firm-Fixed-Price (FFP)
CDC	FISMA - Security Engineering and Technical Staff Support Security Incident Response & Situational Awareness; (CSIRC) Computing Infrastructure Security Redesign Projects Endpoint Protection Security Tools	6.328	Fixed-Price (FP) / Firm-Fixed-Price (FFP)
OS (OCIO)	FISMA - Security Engineering and Technical Staff Support Endpoint Protection Security Tools	5.918	Fixed-Price (FP) / Firm-Fixed-Price (FFP); Government, Full Time Equivalent Hire
IHS	FISMA - Security Engineering and Technical Staff Support Computing Infrastructure Security Redesign Projects	2.240	Fixed-Price (FP) / Firm-Fixed-Price (FFP)
CMS	FISMA - Security Engineering and Technical Staff Support	1.187	Fixed-Price (FP) / Firm-Fixed-Price (FFP); Government, Full Time Equivalent Hire
FDA	FISMA - Security Engineering and Technical Staff Support	0.679	Government, Full Time Equivalent Hire
OIG	FISMA - Security Engineering and Technical Staff Support	0.671	Government, Full Time Equivalent Hire
HRSA	FISMA - Security Engineering and Technical Staff Support	0.335	Government, Full Time Equivalent Hire

E. Deliver y Schedule

The delivery schedule for IT Security ARRA investments is organized by initiative. All four initiatives will be pursued concurrently. Although there are a variety of deliverables and performance measures associated with each, the primary deliverables are the new or enhanced security capabilities that will be provided. Once the capability is established, (such as the HHS CSIRC, or the procurement and fielding of endpoint security solutions), the initiative will not necessarily be “complete,” as there will be continuing license renewal costs to sustain the capabilities in the outyears.

Following is a preliminary delivery schedule by initiative. HHS will award all IT security contracts by the end of FY 2010.

- **Security Incident Response & Situational Awareness; (CSIRC):** Begin obligations in Q4 FY 2009, complete obligations in Q3 FY 2010, and full operational capability by end of FY 2011.
- **FISMA - Security Engineering and Technical Staff Support:** Begin obligations in Q4 FY 2009, complete obligations by Q4 FY 2010, and contracted support complete by Q4 FY 2011.
- **Computing Infrastructure Security Redesign Projects:** Begin obligations in Q4 FY 2009, complete obligations by Q3 FY 2010, and redesign projects complete by end of FY 2011.
- **Endpoint Protection Security Tools:** Begin obligations in Q1 FY 2009, complete obligations in Q4 FY 2010, partial implementation in Q4 FY 2010 with full tool deployment complete by the end of calendar year (CY) FY 2011.

F. Environmental Review Compliance

HHS does not anticipate that any of the IT security initiatives will introduce extraordinary circumstances or construction projects necessary to support IT infrastructure improvements.

Therefore, this activity qualifies for a Categorical Exclusion under the HHS General Administration Manual (GAM) 30-20-40 Category 2 –Functional Exclusion 2.c. An Environmental Assessment (EA) will not be required in support of the IT security initiatives. A memorandum documenting this exclusion will be entered into the record and the activity is subject to the HHS Section 1609(c) reporting.

G. Measures

The Federal Information Security Management Act (FISMA) has identified a number of security performance measures that HHS and all OPDIVs are already using to monitor the effectiveness of the security controls in HHS enterprise applications and network systems, and also the effectiveness of OPDIV applications and network systems. The existing Department FISMA program reporting processes will be used to monitor for improvements in the security performance of the Department as a result of Recovery Act funds expenditures. The Department FISMA program reporting processes include quarterly and annual formal reporting to the Office of Management and Budget (OMB), and are annually reviewed by the OIG. The HHS Chief Information Officer (CIO) Council and Information Technology Investment Review Board (ITIRB) will also play a role in ensuring accountability.

Specific output performance measures will be used to track the results of Recovery Act funding and will help to enhance and improve the security of HHS computer systems:

Outcome/ Achievement	Frequency	Type	Units	Type	9/30/09	12/31/09	3/31/10	6/30/10	9/30/10	12/31/10	3/31/11	6/30/11	9/30/11	Program End
Percentage of HHS laptops and desktops with sensitive information secured with encryption capabilities.	Quarterly	Output	Percent	TARGET	40	40	40	40	55	65	75	85	100	100
				ACTUAL	40	40	40							
Percentage of HHS enterprise network infrastructure monitored by the CSIRC with automated intrusion detection systems.	Quarterly	Outcome	Percent	TARGET	55	55	55	55	60	70	80	90	90	90
				ACTUAL	55	55	55							
Percentage of HHS IT systems protected with advanced Internet content filtering and anti-malware solutions.	Quarterly	Output	Percent	TARGET	60	60	60	60	60	85	85	85	95	95
				ACTUAL	60	60	60							
Percentage of HHS critical IT systems audit logs analyzed by the CSIRC and OPDIV staffs for intrusions and security attacks	Quarterly	Outcome	Percent	TARGET	60	60	60	60	60	75	80	85	90	90
				ACTUAL	55	55	55							

Currently, the fourth measure, 'Percentage of HHS critical IT systems audit logs analyzed by the CSIRC and OPDIV staffs for intrusions and security attacks', is 5% behind target. This is due to a delayed support contract which has resulted in a delay in acquiring the necessary staff to analyze the audit logs. The HHS IT Security program is working with the Program Support Center (PSC) to ensure the support contract begins as soon as possible, and by Q4 FY 2010. To ensure that OPDIVs understand and can meet the objectives, outcomes and accountability expectations associated with the allocation of Recovery Act funds to OPDIV IT security programs, the HHS Chief Information Security Officer (CISO) will provide additional guidance to the OPDIVs to support the enhanced monitoring and reporting required for Recovery Act funds. All contracts will incorporate the reporting requirements of Section 1512, thereby increasing the level of transparency and accountability on the part of the contractors.

H. Monitoring/Evaluation

All Recovery Act programs are assessed for risk to ensure that appropriate internal controls are in place throughout the entire lifecycle of the program. These assessments are consistent with the statutory requirements of the Federal Manager's Financial Integrity Act and the Improper Payments Information Act, as well as OMB's circular A-123 "Management's Responsibility for Internal Control."

The risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team ensures that risk assessment objectives are clearly communicated throughout the Department. The OCIO Senior Assessment Team carries out comprehensive annual assessments of its Recovery Act program(s) to identify risks and develop strategies to address them, including those associated with selecting recipients, awarding and overseeing funds, and achieving program goals. It meets monthly to monitor and assess the effectiveness of mitigation strategies and identify emerging risks.

In addition, the CISO has presented its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact on their success.

Internal HHS investment review boards, the HHS Recovery Act Oversight Committee, and the HHS Office of the Chief Information Officer (OCIO) staff under the Assistant Secretary for Administration will all be involved in the management and/or oversight of Recovery Act HHS IT Security investments and their associated performance measures and risks. Periodic reviews on at least a monthly basis of the program's progress will be performed by the HHS CIO Council and the ITIRB.

The OCIO will provide oversight and management for the spend plan. Each OPDIV will also be responsible to OCIO for carrying out activities, for providing funds control, and satisfying Recovery Act reporting requirements.

The OCIO will conduct program reviews for each initiative, and will require formal OPDIV reporting to account for Recovery Act funds expenditures.

I. Transparency

HHS is open and transparent in all of its contracting and grant competitions and regulations depending on what is appropriate for program activities that involve spending of Recovery Act funding consistent with statutory and OMB guidance.

HHS ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. HHS informs recipients of their reporting obligation through

standard terms and conditions, grant announcements, contract solicitations, and other program guidance. In addition, HHS provides key award information to recipients and other technical assistance to grantees and contractors and fully utilizes Project Officers to ensure compliance with reporting requirements.

J. Accountability

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, HHS has built upon and strengthened existing processes. Senior IT security program officials meet regularly with senior Department officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

K. Barriers to Effective Implementation

The potential for contracting and award date delays is considerable due to acquisition lifecycle risks, which result in part from the level of effort required in developing approved statements of work and acquisition plans. For instance, the request for proposal (RFP) process could include delays in the release of acquisition paperwork to the public for bids, a lack of adequate response to the RFP, or vendor cost proposals higher than the budgeted amount expected by the Government. Acquisition lifecycle risks are also increased by the large volume of Recovery Act contracts that need to be set in place across the federal government, and overburdened contracting offices (e.g., PSC, NIH etc).

A second barrier to effective implementation will be the significant level of effort required to coordinate and oversee OPDIV Recovery Act activities. To mitigate this risk, the OCIO will follow a centralized reporting and evaluation model for the spend plan investments. Each OPDIV will be responsible to OCIO for carrying out activities, for providing funds control, and satisfying Recovery Act reporting requirements. The OCIO will conduct program reviews for each initiative, and will require formal OPDIV reporting to account for Recovery Act funds expenditures.

L. Federal Infrastructure Investments

For all IT security initiatives, HHS will comply with E.O. 13423 and E.O. 13514 regarding the purchase of energy efficient hardware and related equipment and products and the operation of Data Centers. Annually, 95% of electronic products purchased will meet Electronic Product Environmental Assessment Tool standards, and HHS will enable Energy Star® features on 100% of computers and monitors. In addition, HHS will reuse, donate, sell, or recycle 100% of electronic products using environmentally sound management practices. HHS is developing implementation plans to meet technology energy consumption goals in its data center operations.

Summary of Significant Changes:

- The funding table now reflects actual obligations for FY 2009 and an updated estimate for FY2010 obligations. The program is still on target to obligate all funds by the end of FY10.
- The Activities section is organized using four initiatives, which streamline the original five from the original plan. The initiatives reorganize program activities in a more logical and efficient manner.
- The Characteristics section is reorganized based on OPDIV obligations, rather than initiatives. This better reflects how the program is managed via Intra Departmental Delegations of Authority (IDDAs) and how obligations are tracked.
- The Delivery Schedule, which is organized by initiative, is updated based on actual obligations and projections for the remainder of the fiscal year.
- The number of performance measures was streamlined from five to four. The Measures section now includes target and actual metrics for each measure.