DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR

2013

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

Justification of Estimates for
Appropriations Committees

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENTAL MANAGEMENT

	FY 2013	
	FTE	**Budget Authority**
General Departmental Management	1,289	306,320,000
Pregnancy Assistance Fund	0	25,000,000
Prevention and Public Health Fund	16	109,790,000
PHS Evaluation Set-Aside – Public Health Service Act	141	116,841,000
HCFAC[1]	0	8,888,000
GDM Program Level	***1,446***	***566,839,000***
Office of Medicare Hearings and Appeals	518	84,234,000
Office of Civil Rights	256	38,966,000
Office of the National Coordinator for Health IT	191	66,257,000
Service and Supply Fund	1489	0
TOTAL, Departmental Management	**3,900**	**756,296,000**
Alzheimer's Disease Initiative	0	100,000,000

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

INTRODUCTION

The FY 2013 Congressional Justification is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 (GPRA) and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2013 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Citizens' Report. These documents are available at http://www.hhs.gov/budget.

The FY 2013 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2011 Annual Performance Report and FY 2013 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The Summary of Performance and Financial Information summarizes key past and planned performance and financial information.

Message from the Assistant Secretary for Financial Resources

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

The Budget request supports the Secretary in her role as chief policy officer and general manager of HHS. The request totals $756 million. The request will ensure the Secretary's ability to successfully manage the Department while increasing accountability in oversight functions and improving the transparency of information and decision-making. It also includes resources needed to guide nationwide implementation of interoperable health information technology, including secure electronic health records.

The FY 2013 Budget for Departmental Management requests funding for the teen pregnancy prevention and minority HIV/AIDS programs from alternate program level sources – the Prevention and Public Health Fund and the Public Health Service Evaluation Set-Aside, respectively. In addition, the request increases funding for the Office of Medicare Hearings and Appeals, to ensure its continued ability to process cases within legally mandated timeframes while providing beneficiaries with unfettered access to coverage. The request also increases funding for the Office of the National Coordinator for Health IT, to help create a nationwide health information technology infrastructure.

The Secretary looks forward to working with the Congress toward the enactment and implementation of an FY 2013 Budget that advances the Nation's health and supports families.

Ellen G. Murray
Assistant Secretary for Financial Resources

Departmental Management Overview

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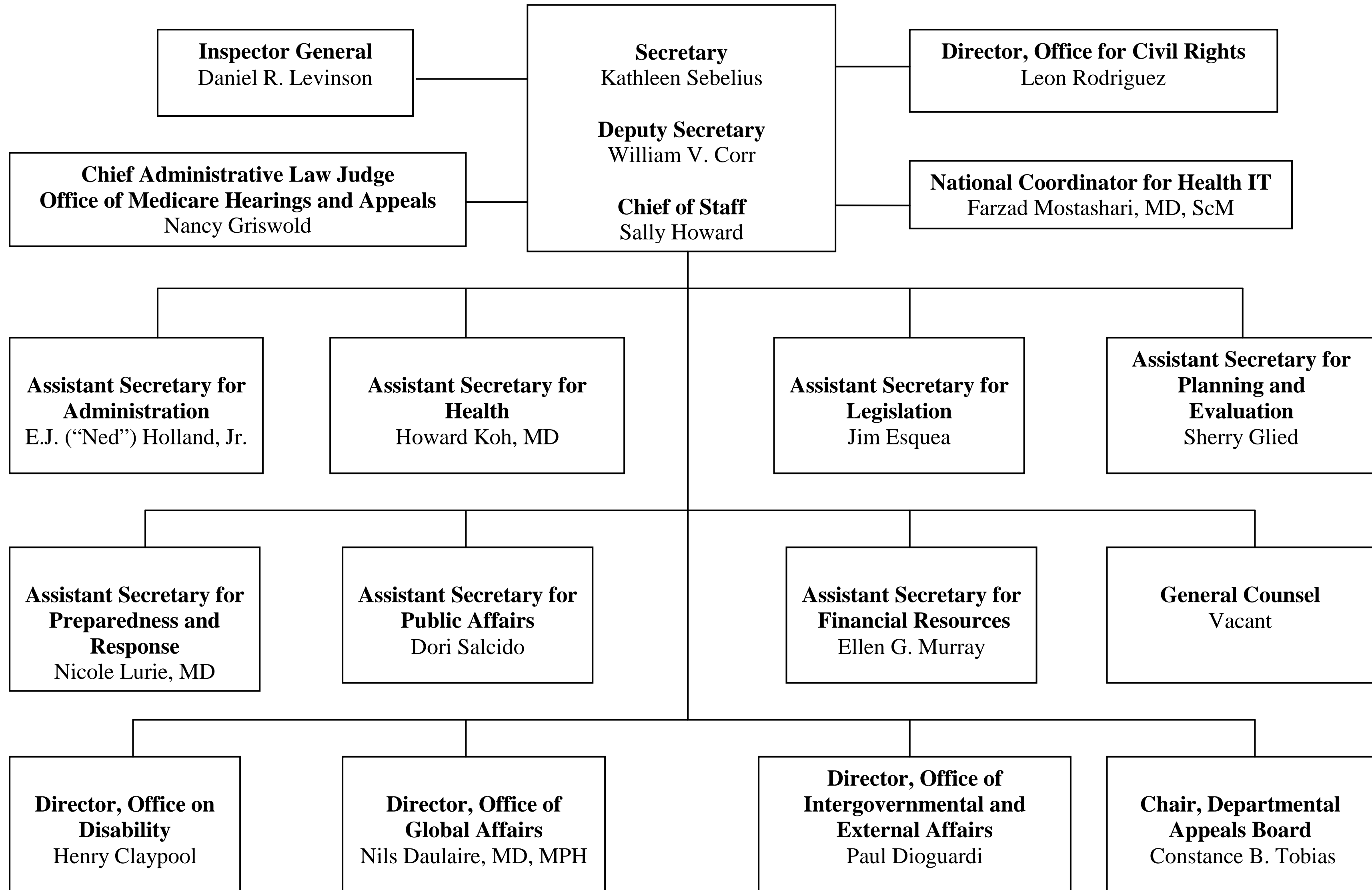
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY



DEPARTMENTAL MANAGEMENT
OVERVIEW

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

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

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

The overall FY 2013 program level Budget for DM totals $756,296,000 in appropriated budget authority including 3,900 full-time equivalent (FTE) positions – a decrease of $5,367,000 (or .7%) below the comparable FY 2012 Enacted level. Additionally the FY 2013 Budget includes $100 million for Alzheimer's Research through the Prevention fund. Please see the DM Budget by Appropriation table on the following pages.

The **General Departmental Management** (GDM) appropriation supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department in administering and overseeing the organization, programs, and activities of HHS. These activities are carried out through twelve Staff Divisions (STAFFDIVs), including the Immediate Office of the Secretary, the Departmental Appeals Board, and the Offices of: Public Affairs; Legislation; Planning and Evaluation; Financial Resources; Administration; Intergovernmental Affairs; General Counsel; Global Affairs; Disability; and Assistant Secretary for Health. For FY 2013, the GDM Budget includes a total of $306,320,000 in budget authority and 1,446 FTE.

The **Office of Medicare Hearings and Appeals** (OMHA) was created in response to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). As mandated by MMA, OMHA opened its doors on July 1, 2005, to hear Medicare appeals at the Administrative Law Judge level, for cases under titles XVIII and XI of the Social Security Act. OMHA is funded entirely from the Medicare Hospital Insurance and Supplemental Medical Insurance Trust Funds, and requests $84,234,000 and 518 FTE in FY 2013.

The **Office of Civil Rights** (OCR) is the primary defender of the public's right to privacy and security of protected health information and the public's right to non-discriminatory access to Federally-funded health and human services. For FY2013, OCR is requesting a total of $38,966,000 in budget authority and 256 FTE.

The **Office of the National Coordinator for Health Information Technology** (ONC) was authorized by the Health Information Technology for Economic and Clinical Health Act, signed by President Obama on February 17, 2009. ONC became operational on August 19, 2005, in response to Executive Order 13335, signed on April 27, 2004. For FY 2013, HHS requests $66,257,000 and 191 FTE, to coordinate national efforts related to the implementation and use of electronic health information exchange.

The **Service and Supply Fund** (SSF), the HHS revolving fund, is composed of two parts: the Program Support Center (PSC) and the Non-PSC activities. For FY 2013, the SSF is projecting total revenue of $1,131,483,000 and usage of 1,489 FTE.

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APPROPRIATIONS LANGUAGE

GENERAL DEPARTMENTAL MANAGEMENT

For necessary expenses, not otherwise provided, for general departmental management, including hire of **[six]** passenger motor vehicles, and for carrying out titles III, XVII, and XXI of the PHS Act, the United States-Mexico Border Health Commission Act, and research studies under section 1110 of the Social Security Act, **[$475,221,000]** *$306,320,000*, together with **[$69,211,000]** *$116,841,000* from the amounts available under section 241 of the PHS Act to carry out national health or human services research and evaluation activities: *Provided,* [**That of this amount, $53,783,000 shall be for minority AIDS prevention and treatment activities: Provided further, That of the funds made available under this heading, $104,790,000 shall be for making competitive contracts and grants to public and private entities to fund medically accurate and age appropriate programs that reduce teen pregnancy and for the Federal costs associated with administering and evaluating such contracts and grants, of which not less than $75,000,000 shall be for replicating programs that have been proven effective through rigorous evaluation to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors, of which not less than $25,000,000 shall be available for research and demonstration grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy, and of which any remaining amounts shall be available for training and technical assistance, evaluation, outreach, and additional program support activities:]** *That of the funds made available under this heading, $3,500,000 is for strengthening the Department's acquisition workforce capacity and capabilities: Provided further, That with respect to the previous proviso, such funds shall be available for training, recruitment, retention and hiring members of the acquisition workforce as defined by the Office of Federal Procurement Policy Act, as amended (41 U.S.C. 401 et seq.): Provided further, That, with respect to the second proviso, such funds shall be available for information technology in support of*

acquisition workforce effectiveness or for management solutions to improve acquisition management: Provided further, That of the amounts provided under this heading from amounts available under section 241 of the PHS Act, **[$8,455,000]** *no less than $4,232,000* shall be available to carry out evaluations (including longitudinal evaluations) of teenage pregnancy prevention approaches, *and $53,891,000 shall be for minority AIDS prevention and treatment activities*[: ***Provided further,*** **That of the funds made available under this heading, $5,000,000 shall be for making competitive grants to provide abstinence education (as defined by section 510(b)(2)(A)-(H) of the Social Security Act) to adolescents, and for Federal costs of administering the grant: Provided further, That grants made under the authority of section 510(b)(2)(A)-(H) of the Social Security Act shall be made only to public and private entities that agree that, with respect to an adolescent to whom the entities provide abstinence education under such grant, the entities will not provide to that adolescent any other education regarding sexual conduct, except that, in the case of an entity expressly required by law to provide health information or services the adolescent shall not be precluded from seeking health information or services from the entity in a different setting than the setting in which abstinence education was provided: Provided further, That funds provided in this Act for embryo adoption activities may be used to provide to individuals adopting embryos, through grants and other mechanisms, medical and administrative services deemed necessary for such adoptions: Provided further, That such services shall be provided consistent with 42 CFR 59.5(a)(4)**].

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

LANGUAGE ANALYSIS

Language Provision	Explanation
"$53,891,100 shall be available for minority AIDS and Treatment Activities."	HHS is proposing to make amounts available for this activity under section 241 of the PHS Act in FY2013.
"*Provided further,* That funds provided in this Act for embryo adoption activities may be used to provide, to individuals adopting embryos, through grants and other mechanisms, medical and administrative services deemed necessary for such adoptions: *Provided further*, That such services shall be provided consistent with 42 CFR 59.5(a)(4): "	HHS is proposing to delete this language in future appropriations bills because the Embryo Adoption program will be discontinued in FY2013.
" *Provided further,* That of the funds made available under this heading, $104,790,000 shall be for making competitive contracts and grants to public and private entities to fund medically accurate and age appropriate programs that reduce teen pregnancy and for the Federal costs associated with administering and evaluating such contracts and grants, of which not less than $75,000,000 shall be for replicating programs that have been proven effective through rigorous evaluation to reduce teenage pregnancy, behavioral risk factors underlying teenage pregnancy, or other associated risk factors, of which not less than $25,000,000 shall be available for research and demonstration grants to develop, replicate, refine, and test additional models and innovative strategies for preventing teenage pregnancy, and of which any remaining amounts shall be available for training and technical assistance, evaluation, outreach, and additional program support activities:"	HHS is proposing to make amounts available for this activity under the Prevention and Public Health Fund.

"*Provided further*, That of the funds made under this heading, $5,000,000 shall be for making competitive grants to provide abstinence education (as defined by section 510(b) (2) (A)-(H) of the social Security Act) to adolescents, and for Federal costs of administering the grant: *Provided further*, That grants made under the authority of section 510(b) (2) (A)-(H) of the social Security Act shall be made only to public and private entities that agree that, with respect to an adolescent to whom the entities provide abstinence education under such grant, the entities will not provide abstinence to that adolescent any other education regarding sexual conduct, except that, in the case of an entity expressly required by law to provide health information or services the adolescent shall not be precluded from seeking health information or services from the entity in a different setting than the setting in which abstinence education was provided:"

HHS is proposing to delete this language in future appropriations bills because the Abstinence Education program will be discontinued in FY2013.

AMOUNTS AVAILABLE FOR OBLIGATION

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Request
General funds:			
Annual appropriation	$651,786,000	$475,221,000	$306,320,000
Rescission	-$1,304,000	-$898,000	$0
Transfers:			
NIMH for Interagency Autism Coordinating Cmte	-$998,000	$0	$0
Secretarial Responsibility Transfer	-$175,553,000	$0	$0
Ryan White - ADAP Transfer	$0	-$70,000	$0
Subtotal, adjusted general funds	$473,931,000	$474,253,000	$306,320,000
Trust funds:			
Annual appropriation	$5,839,000	$0	$0
Subtotal, adjusted budget authority	$479,770,000	$474,253,000	$306,320,000
Unobligated balance lapsing	$0	$0	$0
Total Obligations	$479,770,000	$474,253,000	$306,320,000

SUMMARY OF CHANGES

2012 General funds appropriation	$474,253
Total adjusted budget authority	$474,253
2013 Request - General funds	$306,320
Total estimated budget authority	$306,320
Net Changes	**$167,933**

	FY 2012 Enacted		FY 2013 Request Change from Base	
Increases:				
A. Built-In:	**FTE**	**Amount**	**FTE**	**Amount**
1. Full-Time Permanent	1,386	$96,718	5	$29
2. Special personal services payments	0	$0	0	$32
3. Civilian personnel benefits	0	$23,346	0	$634
4. Rental payments to GSA	0	$17,939	0	$813
Subtotal, Built-In Increases	**1,386**	**138,003**	**5**	**$1,508**
B. Programs:				
1. OGC Health Care Workload	-	$0	-	$2,800
2. ASPA Expand OS Web Operations	-	$0	-	$6,100
3. Financial Systems Integration	-	$0	-	$1,000
Subtotal Program Increases	-	$0	-	**$9,900**
Total Increases	**1,386**	**$138,003**	**5**	**$11,408**
Decreases:				
A. Built-In:				
1. Other than full-time permanent	0	$2,517	0	-$183
2. Other Personnel Compensation	0	$2,531	0	-$958
3. Military personnel	60	$5,484	-5	-$596
4. Military benefits	0	$1,645	0	-$179
5. Travel and transportation of persons	0	$6,289	0	-$3,773
6. Transportation of things	0	$165	0	-$30
7. Communications, utilities, and miscellaneous charges	0	$5,045	0	-$925
8. Printing and Reproduction	0	$1,246	0	-$153
9. Advisory and Assistance Services	0	$36,341	0	-$3,011
10. Other services from non-Federal sources	0	$69,125	0	$57,982
11. Other goods and services from Federal sources	0	$47,235	0	-$24,711
12. Operation and maintenance of facilities	0	$4,886	0	-$1,010
13. Operation and maintenance of equipment	0	$4,398	0	-$2,414
14. Supplies and materials	0	$7,881	0	-$5,649
15. Equipment	0	$6,039	0	-$4,458
16. Grants, subsidies, and contributions	0	$135,423	0	-$4,361
Subtotal, Built-In Decreases	**60**	**$336,250**	-5	**$5,571**
B. Programs:				
1. Minority Health - Maintain existing grants	-	-	-	-$14,682
2. Women's Health - Maintain existing grants	-	-	-	-$4,562
3. Teen Pregnancy - Funding move to PPHF	-	-	-	-$104,790
4. HIV/AIDS in Minority Comm. - Funding move to PHS	-	-	-	-$53,891
5. Abstinence Education	-	-	-	-$4,991
6. Embryo Adoption	-	-	-	-$1,996
Subtotal Program Decreases	-	**-**	-5	**-$184,912**
Total Decreases	**60**	**$336,250**	**-5**	**-$179,341**
Net Change	**1,446**	**$474,253**	**0**	**-$167,933**

BUDGET AUTHORITY BY ACTIVITY - DIRECT

(Dollars in Thousands)

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request	
	FTE	Amount	FTE	Amount	FTE	Amount
Immediate Office of the Secretary	72	$11,108	72	$11,289	72	$11,300
Secretarial Initiatives and Innovations	-	$1,600	-	$2,740	-	$2,042
Assistant Secretary for Administration	118	$19,482	116	$19,463	116	$18,500
Assistant Secretary for Financial Resources	164	$28,103	164	$29,591	164	$28,400
Acquisition Reform	-	$700	-	$699	-	$3,500
Assistant Secretary for Legislation	27	$3,423	27	$3,893	27	$4,300
Assistant Secretary for Public Affairs	41	$5,477	46	$8,983	41	$9,800
Office of General Counsel	312	$39,911	282	$40,274	283	$43,100
Departmental Appeals Board	69	$10,583	69	$10,730	69	$11,700
Office on Disability	6	$862	6	$1,098	6	$1,100
Office of Global Affairs	22	$6,329	23	$6,438	23	$6,000
Office of Intergovernmental and External Affairs	42	$9,688	48	$9,831	48	$10,600
Office of the Assistant Secretary for Health	310	$252,560	269	$232,833	273	$112,020
Embryo Adoption Awareness Campaign	-	$2,004	-	$1,996	-	-
Healthcare-associated Infections	2	$1,542	-	-	-	-
HIV-AIDS in Minority Communities	-	$53,783	-	$53,681	-	-
Enterprise IT	-	-	-	-	-	-
Shared Operating Expenses	-	$15,999	-	$16,060	-	$27,708
Rent, Operations, Maintenance and Related Services	-	$16,616	-	$18,665	-	$16,250
Abstinence Education	-	-	-	$4,991	-	-
Transportation Assistance	-	-	-	$998	-	-
Total, Budget Authority	**1,185**	**479,770**	**1,122**	**474,253**	**1,122**	**306,320**

BUDGET AUTHORITY by OBJECT CLASS - DIRECT

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Personnel compensation:			
Full-time permanent (11.1)	96,718	96,747	29
Other than full-time permanent (11.3)	2,517	2,334	-183
Other personnel compensation (11.5)	2,531	1,573	-958
Military personnel (11.7)	5,484	4,888	-596
Special personal services payments (11.8)	0	32	32
Subtotal, Personnel compensation	107,250	105,574	-1,676
Civilian personnel benefits (12.1)	23,346	23,980	634
Military benefits (12.2)	1,645	1,466	-179
Benefits for former personnel (13.0)	0	0	0
Total Pay Costs	132,241	131,020	-1,221
Travel and transportation of persons (21.0)	6,289	2,516	-3,773
Transportation of things (22.0)	165	135	-30
Rental payments to GSA (23.1)	17,939	18,752	813
Communications, utilities, and miscellaneous charges (23.3)	5,045	4,120	-925
Printing and reproduction (24.0)	1,246	1,093	-153
Other Contractual Services:			
Advisory and assistance services (25.1)	36,341	30,258	-6,083
Other services from non-Federal sources (25.2)	69,125	50,453	-18,672
Other goods and services from Federal sources (25.3)	47,235	32,424	-14,811
Operation and maintenance of facilities (25.4)	4,886	3,876	-1,010
Operation and maintenance of equipment (25.7)	4,398	1,984	-2,414
Research and development contracts (25.5)	0	0	0
Medical care (25.6)	0	0	0
Subsistence and support of persons (25.8)	0	0	0
Subtotal, Other Contractual Services	161,985	118,995	-42,990
Supplies and materials (26.0)	7,881	2,232	-5,649
Equipment (31.0)	6,039	1,581	-4,458
Grants, subsidies, and contributions (41.0)	135,423	25,876	-124,034
Land and Structures (32.0)	0	0	0
Investments and Loans (33.0)	0	0	0
One-time Appropriation for Treasury (43.0)	0	0	0
Refunds (44.0)	0	0	0
Total Non-Pay Costs	342,012	175,300	-166,712
Total Budget Authority by Object Class	474,253	306,320	-167,933

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

	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Personnel compensation:			
Full-time permanent (11.1)	27,340	29,926	2,586
Other than full-time permanent (11.3)	774	785	11
Other personnel compensation (11.5)	547	518	-29
Military personnel (11.7)	1,550	1,311	-239
Special personal services payments (11.8)	0	0	0
Subtotal, Personnel compensation	**30,211**	**32,540**	**2,329**
Civilian personnel benefits (12.1)	6,288	6,910	622
Military benefits (12.2)	356	301	-55
Benefits for former personnel (13.0)	0	0	0
Subtotal Pay Costs	**36,855**	**39,751**	**2,896**
Travel and transportation of persons (21.0)	555	613	58
Transportation of things (22.0)	39	60	21
Rental payments to GSA (23.1)	2,910	3,424	514
Communications, utilities, and miscellaneous charges (23.3)	26	26	0
Printing and reproduction (24.0)	24	24	0
Other Contractual Services:			
Advisory and assistance services (25.1)	31,295	28,455	-2,840
Other services from non-Federal sources (25.2)	26,141	84,959	58,818
Other goods and services from Federal sources (25.3)	21,434	16,994	-4,440
Operation and maintenance of facilities (25.4)	386	400	14
Operation and maintenance of equipment (25.7)	1	1	0
Research and development contracts (25.5)	1,045	794	-251
Medical care (25.6)	27	27	0
Subsistence and support of persons (25.8)	0	0	0
Subtotal, Other Contractual Services	**80,329**	**131,630**	**51,301**
Supplies and materials (26.0)	76	61	-15
Equipment (31.0)	27	46	19
Grants, subsidies, and contributions (41.0)	3,460	3,458	-2
Land and Structures (32.0)	4	14	10
Investments and Loans (33.0)	0	0	0
One-time Appropriation for Treasury (43.0)	0	0	0
Refunds (44.0)	0	0	0
Subtotal Non-Pay Costs	**87,450**	**139,356**	**51,906**
Total Budget Authority by Object Class	**124,305**	**179,107**	**54,802**

SALARIES AND EXPENSES

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Personnel compensation:			
Full-time permanent (11.1)	96,718	96,747	29
Other than full-time permanent (11.3)	2,517	2,334	-183
Other personnel compensation (11.5)	2,531	1,573	-958
Military personnel (11.7)	5,484	4,888	-596
Special personal services payments (11.8)	0	32	32
Subtotal, Personnel compensation	107,250	105,574	-1,676
Civilian personnel benefits (12.1)	23,346	23,980	634
Military benefits (12.2)	1,645	1,466	-179
Total Pay Costs	132,241	131,020	-1,221
Travel and transportation of persons (21.0)	6,289	2,516	-3,773
Transportation of things (22.0)	165	135	-30
Communications, utilities, and miscellaneous charges (23.3)	5,045	4,120	-925
Printing and reproduction (24.0)	1,246	1,093	-153
Other Contractual Services:			
Advisory and assistance services (25.1)	36,341	30,258	-6,083
Other services from non-Federal sources (25.2)	69,125	50,453	-18,672
Other goods and services from Federal sources (25.3)	47,235	32,424	-14,811
Operation and maintenance of facilities (25.4)	4,886	3,876	-1,010
Research and development contracts (25.5)	0	0	0
Operation and maintenance of equipment (25.7)	4,398	1,984	-2,414
Subtotal, Other Contractual Services	161,985	118,995	-42,990
Supplies and materials (26.0)	7,881	2,232	-5,649
Total Non-Pay Costs	182,611	129,091	-53,250
Total Salaries and Expenses	314,852	260,111	54,741

AUTHORIZING LEGISLATION

(Dollars in Thousands)

	2012 Authorized	2012 Enacted	2013 Authorized	2013 Budget
General Departmental Management:				
except accounts below:				
Reorganization Plan No. 1 of 1953	Indefinite	$241,420	Indefinite	$194,300
Office of the Assistant Secretary for Health:				
Public Health Service Act,				
Title III, Section 301	Indefinite	$161,930	Indefinite	$56,620
Title XVII, Section 1701 (ODPHP)	1	$7,186	1	$6,800
Title XVII, Section 1707 (OMH)	2	$55,782	2	$41,100
Title XVII, Section 1708 (OAH)	3	$1,098	3	$1,000
Title XX, Section 2010 (AFL)	4	$0	4	$0
Title XXI, Section 2016 (NVPO)	5	$6,837	5	$6,500
Subtotal		$232,833		$112,020
Total appropriation		$474,253		$306,320
Grand Total appropriation		$474,253		$306,320

1) Authorizing legislation under Section 1701 of the PHS Act expired September 30, 2002. Reauthorization will be proposed.

2) Authorizing legislation under Section 1707 of the PHS Act expired September 30, 2016.

3) Authorizing legislation under Section 1708 of the PHS Act expired September 30, 2000. Reauthorization will be proposed.

4) Authorizing legislation under Section 2010 of the PHS Act expired September 30, 1985. Reauthorization will be proposed.

5) Authorizing legislation under Section 2016 of the PHS Act expired September 30, 2005. Reauthorization will be proposed.

APPROPRIATION HISTORY (Dollars in Millions)				
	Budget Estimates to Congress	**House Allowance**	**Senate Allowance**	**Appropriations**
2002	421,199,000	338,887,000	422,212,000	345,887,000
2003	393,731,000	358,451,000	374,386,000	350,971,000
2004	353,951,000	349,135,000	350,659,000	360,000,000
2005	437,822,000	355,148,000	382,555,000	374,249,000
2006	359,176,000	344,546,000	359,465,000	354,969,000
2007	381,931,000	0	0	356,238,000
2008	392,556,000	348,075,000	391,904,000	354,015,000
2009	379,864,000	366,676,000	366,615,000	381,987,000
2010	409,549,000	402,452,000	482,779,000	498,154,000
2011	490,439,000	479,771,000	0	479,770,000
2012	363,644,000	0	0	0
2013	306,320,000	0	0	0

General Departmental Management
All Purpose Table

Dollars in Thousands

GDM **Base Level Program**		FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
GDM	BA	479,770	474,253	306,320	-167,933
	FTE	1,185	1,122	1,122	0
Related Funding (non-add)					
Pregnancy Assistance Fund P.L. (111-148)	PL	*25,000*	*25,000*	*25,000*	*0*
Prevention and Public Health Fund P.L. (111-148) (GDM Allocation)	PL	*19,100*	*30,000*	*109,790*	*79,790*
PHS Evaluation Set-Aside – Public Health Service Act	PL	*65,211*	*69,211*	*116,841*	*47,630*
HCFAC[1]	PL	*8,888*	*8,888*	*8,888*	*0*

The FY 2011 BA shown here does not include the $176 million transferred outside GDM.

GENERAL DEPARTMENTAL MANAGEMENT
Overview of Performance

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

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

The FY 2013 Congressional Justification (CJ) reflects recent decisions to streamline performance reporting and improve HHS performance-based management. In accordance with this process GDM STAFFDIVs have focused on revising measures that depict the main impact or benefit of the program and support the rationale articulated in the budget request. This approach will also be reflected in the Department's Online Performance Appendix (OPA). The Department's OPA will focus on key HHS activities. Two GDM offices (ASA and OASH) are highlighted in the OPA.

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

[1] The reimbursable program (HCFAC) in the General Department Management reflects the actual distribution of the allocation account for 2012. Future allocation will be determined annually. FY 2013 is estimated at the current rate.

FY 2013 Budget by HHS Strategic Goal
(Dollars in Millions)

HHS Strategic Goals	FY 2011	FY 2012 Enacted	FY 2013
1. Strengthen Health Care	**221.3**	**218.1**	**249.7**
1.A Make coverage more secure for those who have insurance and extend affordable coverage to the uninsured	2.7	2.5	3.5
1.B Improve health care quality and patient safety	71.6	71.6	77.0
1.C Emphasize primary & preventative care, linked with community prevention	3.5	3.0	4.5
1.D Reduce growth of health care costs while promoting high-value, effective care	5.4	5.4	6.5
1.E Ensure access to quality culturally competent care for vulnerable populations	69.8	68.1	78.8
1.F Promote the adoption and meaningful use of health information technology	68.3	67.5	79.4
2. Advance Scientific Knowledge and Innovation	**16.2**	**15.0**	**17.0**
2.A Accelerate the process of scientific discovery to improve patient care	6.0	5.0	6.0
2.B Foster innovation at HHS to create shared solutions	3.0	3.0	3.0
2.C Invest in the regulatory sciences to improve food & medical product safety	3.0	3.0	3.5
2.D Increase our understanding of what works in public health and human services	4.2	4.0	4.5
3. Advance the Health, Safety and Well-Being of the American People	**279.4**	**277.3**	**308.7**
3.A Promote the safety, well-being, resilience, and healthy development of children and youth	115.5	107.5	125.8
3.B Promote economic and social well-being for individuals, families, and communities	17.5	17.2	18.5
3.C Improve the accessibility and quality supportive services for people with disabilities and older adults	3.0	3.5	4.5
3.D Promote prevention and wellness	66.5	71.2	75.5
3.E Reduce the occurrence of infectious diseases	64.4	65.4	70.9
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies	12.5	12.5	13.5
4. Increase Efficiency, Transparency and Accountability of HHS Programs	**37.6**	**35.2**	**43.5**
4.A Ensure program integrity and responsible stewardship of resources	17.3	16.2	19.7
4.B Fight fraud and work to eliminate improper payments	7.1	6.8	8.8
4.C Use HHS data to improve American health and well-being of the American people	8.0	7.0	8.5
4.D Improve HHS environmental, energy, and economic performance to promote sustainability	5.2	5.2	6.5
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce	**43.4**	**41.8**	**47.9**
5.A Invest in HHS workforce to meet America's health and human service needs today and tomorrow	17.5	17.3	19.6
5. B Ensure health care workforce meets increased demands.	7.4	7.0	8.3
5.C Enhance the ability of the public health workforce to improve health at home and abroad	9.0	8.0	9.0
5.D Strengthen the Nation's human service workforce	8.0	8.0	8.5
5.E Improve national, State & local surveillance and epidemiology capacity	1.5	1.5	2.5
TOTAL includes GDM, PHS Evaluation Funds, Prevention & Public Health Funds, and HCFAC	**597.9**	**587.4**	**666.8**

Overview of Budget Request

The FY 2013 budget request for General Departmental Management (GDM) includes $306,320,000 in budget authority and 1,289 full-time equivalent (FTE) positions. This request is a decrease of $167,933,000 (-35.4 percent) lower than the FY 2012 enacted appropriation.

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

In FY 12 HHS took steps to implement Health Reform and other ongoing public health initiatives through eliminating or reallocating resources and support new and focused strategic partnerships to provide national health leadership. The FY 13 President's Budget is an extension of the FY 12 activities.

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

While not a request for budget authority, the Affordable Care Act (ACA) established a mandatory appropriation for prevention and public health activities. A section on Prevention and Public Health Fund allocations with a funding table is included at the end of the GDM justification. In FY 2013, $1.25 billion is available, which is +$250 million above the FY 2012 appropriation. The proposed FY 2013 GDM allocation is $109,790,000.

This Budget funds HIV/AIDS in Minority Communities in the amount of $53,891,000 in the PHS Evaluation Fund.

The FY 2013 Budget for GDM reflects the following significant changes from the FY 2012 enacted appropriation:

Assistant Secretary for Legislation (+$407,000) – This increased funding will be used to support the President' commitment to protect food and medical product supply as well as increase communication between the Department and Congress.

Assistant Secretary for Public Affairs (+$817,000) – This increase maintains efforts to promote transparency, accountability and access to critical public health and human services information to the American people through multiple channels of non-web related communication. ASPA will continue efforts toward increased public awareness and access to HHS tools, resources and health education initiatives.

Assistant Secretary for Financial Resources (-$1,191,000) – This decrease reduces ASFR efforts in enhancing oversight of and policy guidance for acquisitions and strengthening legal review and oversight connected with contracting practices. These efforts are necessary to address identified areas of risk that have resulted in anti-deficiency violations.

Intergovernmental and External Affairs (+$769,000) – IEA has been tasked with increasing the Departments coordination and communication with state, local, tribal, and territorial governments as it relates to health reform. This funding level will support the annualized costs of previously vacant positions.

Office of the General Counsel (+$2,826,000) – This increase supports OGC's efforts to review proposed legislation and related regulations; engage in legislative drafting; and consult and advise on wide-ranging legal issues that emerge from the policies and programs of the Department, Administration, and Congress. In FY 2013, OGC is specifically addressing gaps in employment and labor law services, covering costs of legal services previously paid for from other sources, and expanding services to all HHS components.

Departmental Appeals Board (+$970,000) – The funding increase is needed to support the increasing workload generated by increasing Medicare cases and implementation of information technology initiatives.

Web Communications (+$6,102,000) – The increase in the web communications budget reflects the transfer of $6,100,000 of operational Web activities that had previously been funded by a different funding source.

Office of the Assistant Secretary for Health (-$120,813,000) – Most of this change is the transfer of the Teen Pregnancy Prevention program ($104.790M) from the GDM account to the Prevention and Public Health Fund. Other reductions include the Office of Minority Health and the Office of Women's Health grant resources (-$14.7M and -$4.6M, respectively). The Immediate Office of the ASH has reallocated funding among the various OASH sub-program offices to support the review and development of policies and strategies for the coordination of departmental efforts related to the growing list of public health concerns facing the Nation, including Tobacco Cessation, Obesity, Hepatitis, Autism, and other evolving or ongoing efforts such as in health disparities in minority populations, violence against women and vaccine safety.

IMMEDIATE OFFICE OF THE SECRETARY

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	11,108	11,289	11,300	11
FTE	72	72	72	0

Authorizing Legislation:

FY 2013 Authorization…………………….……………………………………………………..……Indefinite
Allocation Method…………………………………………………………………………..………Direct Federal

Program Description and Accomplishments

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

IOS leads the Administration's health and human services agenda and drives the Department's formulation of policy. The IOS mission involves coordinating all HHS documents, developing regulations requiring Secretarial action, mediating issues among Departmental components, communicating Secretarial decisions, and ensuring the implementation of those decisions. IOS achieves these objectives by ensuring key issues are brought to leadership's attention in a timely manner, facilitating discussions on policy issues, reviewing documents requiring Secretarial action for policy consistent with that of the Secretary and the Administration, and coordinating the appropriate release of regulatory documents. IOS works with other Departments to coordinate analysis of and input on healthcare policy decisions impacting activities within their purview.

Narrative by Activity:

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

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

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

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

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

with particular emphasis on reducing the regulatory burden.

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

Funding History

FY 2008	$10,728,000
FY 2009	$11,073,000
FY 2010	$10,925,000
FY 2011	$11,108,000
FY 2012	$11,289,000

Budget Request

The FY 2013 Budget for IOS is $11,300,000, which reflects an increase of $11,000 above the FY 2012 Enacted level. Current funding levels will be utilized to maintain personnel costs and other services to support achieving the Department's Health Care, Human Services, Scientific Research, and Workforce Development Strategic Goals. Personnel costs account for 78% of the IOS budget with the remaining 22% allocated for other mission critical operating expenses. Finally, the increased funding level will assist with tracking and coordination of departmental correspondence and inquiries at a strategic level in regards to implementation and review of new and proposed laws.

IOS OUTPUTS AND OUTCOMES TABLE

Program/Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
1.1 Increase number of identified opportunities for public engagement and collaboration among agencies (Output)	FY 2011: 334 Target:317 (Target Exceeded)	340	346	+6
1.2 Increase number of high-value data sets and tools that are published by HHS (Output)	FY 2011: 282 Target:122 (Target Exceeded)	285	288	+3
1.3 Increase the number of participation and collaboration tools and activities conducted by the participation and collaboration community of practice (Output)	FY 2011: 8 Target:8 (Target Met)	10	12	+2

SECRETARIAL INITIATIVES AND INNOVATIONS

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	1,600	2,740	2,042	-698
FTE	0	0	0	0

Authorizing Legalization:
FY 2013 Authorization: ……………………………………………………………………………………...Indefinite
Allocation method: ………………………………………………………………………..Direct Federal; Contracts

Program Description and Accomplishments

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

This modest amount of funding allows the Secretary to proactively respond to the needs of the Office of the Secretary (OS) component offices as they continue to implement programs intended to improve and ensure the health and welfare of Americans. These funds will be directed to the Secretary's highest priorities and are implemented and monitored judiciously. As with any appropriation, execution of these funds will be tracked in the financial management system, including monthly status of funds reports, at a minimum, and more frequently if the nature of response or project necessitates. Additionally, the impact of these resources will be monitored based on the Secretary's stated goals and objectives for their use.

In FY 2011, several initiatives were addressed that assisted the Secretary in effectively mitigating emerging risks within a second year of stagnant funding. These include transparency and organizational issues related to program performance tracking, budget and finance data; Replacing aging capital equipment in the Secretary’s studio; Accelerating DAB’s ability to use e-filing for adjudication records; and create a Grants Management Community Strategic Plan, as well as encourage innovation through a department-wide incentive program.

Funding History

FY 2008	$0
FY 2009	$0
FY 2010	$1,600,000
FY 2011	$1,600,000
FY 2012	$2,740,000

Budget Request

The FY 2013 Budget for Secretarial Initiatives and Innovation is $2,042,000, which reflects a reduction of $698,000 from the FY 2012 Enacted level. The Budget will continue to allow the Secretary to be prepared to support HHS component offices as they respond to new and ongoing legislative requirements and seek to implement innovative programs to address new and existing critical health issues.

ASSISTANT SECRETARY FOR ADMINISTRATION

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	19,482	19,463	18,500	-963
FTE	118	116	116	0

Authorizing Legislation:

FY 2013 Authorization…………………………………………………………………...……………Indefinite
Allocation Method………………………………………………………………………….………Direct Federal

Program Description and Accomplishments

The Office of the Assistant Secretary for Administration (ASA) advises the Secretary on all aspects of administration; provides leadership, policy, oversight, supervision, and coordination of long and short-range planning for HHS; and supports the agency's strategic goals and objectives. ASA also provides critical Departmental policy and oversight in the following major areas through its components: the Immediate Office, Office of Human Resources, Office of Facilities Management and Policy, Office of the Chief Information Officer, Office of Business Management and Transformation and the Program Support Center (which is funded through other sources and not included in this request).

Office of Human Resources (OHR)

OHR provides leadership in the planning and development of personnel policies and human resource programs that support and enhance the Department's mission. OHR also provides technical assistance to the HHS Operating Divisions (OPDIVs) to most effectively and efficiently accomplish the OPDIV's mission through improved planning and recruitment of human resources and serves as the Departmental liaison to central management agencies on related matters.

OHR provides leadership in creating and sustaining a diverse workforce and an environment free of discrimination at HHS. OHR works proactively to enhance the employment of women, minorities, veterans, and people with disabilities through efforts that include policy development, oversight, complaint prevention, investigations and processing, outreach, commemorative events, and standardized education and training programs. OHR also provides resource management and equal opportunity service functions for the Department. To accomplish its mission, OHR provides functional oversight and works in collaboration with the Equal Employment Opportunity offices that service each of the Department's OPDIVs. OHR also conducts Department-wide program analysis to determine barriers to diversity and inclusion.

Office for Facilities Management and Policy (OFMP)

OFMP provides Department-wide leadership and direction in master planning, facilities planning, design and construction, leasing, capital program budget management, space utilization, sustainable buildings, operations and maintenance, environmental and energy management, historic preservation, and occupational health and safety. OFMP is responsible for the HHS Real Property Asset Management program, and in this role provides management oversight across the HHS portfolio of real property assets to ensure appropriate stewardship and accountability is maintained. In addition, OFMP is responsible for the operation of the HHS headquarters facility, the Hubert H. Humphrey Building, and oversight of HHS-occupied space in the Southwest Complex of Washington, DC.

OFMP also provides technical assistance to HHS OPDIVs in evaluating the effectiveness of their

facilities programs and policies, and fosters creativity and innovation in the administration of these functions. Establish the Office of Sustainability in accordance with Executive Order 13514 – Federal Leadership in Environmental, Energy and Economic Performance.

Office of the Chief Information Officer (OCIO)
OCIO advises the Secretary and the ASA on matters pertaining to the use of information and related technologies to accomplish Departmental goals and program objectives. OCIO establishes and provides assistance and guidance on the use of technology-supported: business process reengineering; investment analysis; performance measurement; strategic development and application of information systems and infrastructure in compliance with the Clinger-Cohen Act. OCIO leads the HHS Records Management team and provides HHS employee training, policy, processes, and validation of file plans for 11 HHS OPDIVs including 18 Office of Secretary Staff Divisions. OCIO coordinates activities throughout HHS to implement requirements under the Paperwork Reduction Act (PRA) and Computer Matching and Privacy Protection Act of 1988. OCIO promulgates HHS IT policies supporting enterprise architecture, capital planning and project management, and security. OCIO leads the formulation of the HHS IT portfolio through the Office of IT Budget and Capital Planning, with an approximate annual expenditure of $7 billion: $4 billion in direct IT expenditures and $3 billion in IT grants to state and local entities.

In its leadership role, OCIO coordinates the implementation of IT policy from the Office of Management and Budget (OMB) and guidance from the Government Accountability Office (GAO) throughout HHS OPDIVs and ensures the IT investments remain aligned with HHS' strategic goals and objectives and the Enterprise Architecture. OCIO coordinates the HHS response to federal IT priorities including: Data Center consolidation; cloud computing; information management, sharing, and dissemination; and shared services. OCIO leads the HHS-wide program for managing telecommunications services under the Networx contract. OCIO is responsible for compliance, service level agreement management, delivery of services, service and access optimization, technology refreshment, interoperability and migration of new services.

OCIO coordinates the development and evolution of IT domain governance across HHS. This governance change is designed to increase the responsiveness of the organization, better steward IT resources and identify shared service opportunities. OCIO works to develop a coordinated view to ensure optimal value from IT investments by addressing key agency-wide policy and architecture standards, maximizing smart sharing of knowledge, sharing best practices and capabilities to reduce duplication and working with OPDIVs and STAFFDIVs on the implementation and execution of an expedited investment management process.

Office of Business Management and Transformation (OBMT)
OBMT provides results-oriented strategic and analytical support for key management initiatives and coordinates the business mechanisms necessary to account for the performance of these initiatives and other objectives as deemed appropriate. OBMT also manages the budget and financial resources for the direct support of the ASA, and oversees Department-wide multi-sector workforce management activities. OBMT provides business process reengineering services, including the coordination of the review and approval process for reorganization and delegation of authority proposals that require the Secretary's or designees' signature. In addition, the office oversees project management responsibilities for HSPD-12.

Funding History

FY 2008	$16,855,000
FY 2009	$17,390,000
FY 2010	$18,976,000
FY 2011	$19,482,000
FY 2012	$19,463,000

Budget Request

The Assistant Secretary for Administration FY 2013 Budget is $18,500,000, a decrease of $963,000 below the FY 2012 Enacted level. A reduction of FTE through attrition and/or in administrative functions as well as lowering contract costs will account for this decrease.

ASA OUTPUTS AND OUTCOMES TABLE

Program/Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
1.1 Increase the percent employees on telework or AWS (Output)	FY 2011: 13.0% Target: 12.0% (Target Exceeded)	14.0%	16.0%	+2
1.2 Reduce HHS fleet emissions (Output)	FY 2011: 9,375 MTCO2e Target: 12,968 MTCO2e (Target Exceeded)	12,708 MTCO2e	12,454 MTCO2e	-254
1.3 Ensure Power Management is enabled in 100% of HHS computers, laptops and monitors (Output)	FY 2011: 85.0% Target: 100.0% (Target Not Met but Improved)	100.0%	100.0%	Maintain
2.1 Reduce the average number of days to hire (Output)	FY 2011: 61 Average Number of Days Target: 80 Average Number of Days (Target Exceeded)	70 Average Number of Days	65 Average Number of Days	-5

ASSISTANT SECRETARY FOR FINANCIAL RESOURCES

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	28,103	29,591	28,400	-1,191
FTE	164	164	164	0

Authorizing Legislation:

FY 2013 Authorization…………………….…………………………………...………….…Indefinite
Allocation Method…………………………………………………………...Direct Federal, Contracts

Program Description and Accomplishments

The Office of the Assistant Secretary for Financial Resources (ASFR) advises the Secretary on all aspects of budget, grants, acquisition, program performance, and financial management, and provides for the direction of these activities throughout HHS. ASFR also coordinates HHS' implementation and reporting regarding the American Recovery and Reinvestment Act of 2009 (Recovery Act).

In carrying out these functions, the Assistant Secretary has several formal and informal roles, including Chief Financial Officer, Chief Acquisition Officer, Chief Performance Improvement Officer, HHS audit follow-up official, and lead official for budget, grants, program integrity and reducing improper payments. The Assistant Secretary is also a close advisor to the Secretary on policy issues.

ASFR accomplishes its work in 2012 through its four component offices:

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

In FY 2011, in addition to meeting its responsibilities for the annual budget process, the Office of Budget successfully managed the major budget-related workload of the Affordable Care Act with the OPDIVs and STAFFDIVs to develop spend plans and begin implementing new activities and provisions. The Office of Budget continued support of the implementation of the Recovery Act through the development of spend plans, funding announcements and obligations reports. The Office of Budget also supported the annual performance budget and other program budget analysis and estimates that occurred throughout the

year, and implemented new performance management requirements of the GPRA Modernization Act of 2010. The office met its responsibilities for issuing guidance, providing technical assistance and submitting budget proposals in each of these areas that were high quality and complete in a timely manner. Examples of documents produced in high quality and on-time include the FY 2011 HHS Summary of Performance and Financial Information, On-line Performance Appendix and Budget Justifications. The Office of Budget managed the quarterly review of progress towards nine HHS High Priority Performance Goals and other Departmental priorities. The Office of Budget also coordinated submission of required materials regarding the High Priority Performance Goals to OMB.

The FY 2012 HHS Summary of Performance and Financial Information, the HHS Performance Appendices and the HHS Congressional Justifications were submitted on time.

Office of Recovery Act Coordination (ORAC) – Created in March 2009, this office is responsible for meeting performance goals and objectives related to the timely and effective implementation of the Recovery Act and related Executive Orders and Presidential memoranda. The Recovery Act provided $138 billion to HHS to support approximately 40 programs managed by eight Operating Divisions, the Office of the Secretary, and the Office of Inspector General.

In FY 2011, ORAC provided staff support to the Deputy Secretary, the Assistant Secretary and the Recovery Act Implementation Team composed of HHS OPDIV and Staff Division heads, tracked program spending, performance, and agency risk management strategies, facilitated the development of solutions for specific program challenges and collaborated with OMB and the Recovery Accountability and Transparency Board on numerous projects and information requests. Major accomplishments include:

- Cumulative outlays of over $111 billion or 80% of total Recovery Act resources available to HHS through the end of FY 2011. These funds provided financial assistance to State and local communities for health and social services and for jobs, which averaged over 50,000 per quarter. They also supported investments in biomedical and patient-centered research, health information technology and prevention and wellness programs.

- A very successful collaboration with HHS agencies managing quarterly recipient reporting (Sec. 1512 of the Recovery Act): more than 99% of 20,000 grantees and contractors complied with reporting requirements each quarter.

Office of Finance (OF)– This office provides financial management leadership to the Secretary through the CFO and the Departmental CFO Community. In accordance with the CFO Act, OMB Circulars, the Federal Accounting Standards Advisory Board (FASAB) and other Federal financial management legislation, OF manages and directs work in the development and implementation of financial policies, standards and internal control practices (as required by FMFIA and OMB Circular A-123). The OF prepares HHS' annual consolidated financial statements and coordinates the HHS' financial statement audit. The OF oversees HHS' financial management systems portfolio, and also has business ownership responsibilities for the Unified Financial Management System (UFMS). The OF has HHS-wide responsibility for ensuring that grantee audit findings (under OMB Circular A-133) are resolved in a timely and appropriate manner. In addition, the OF provides Departmental leadership and support to the Secretary for the implementation of the new Program Integrity (PI) initiative, launched in May, 2010.

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

Consistent with the Reports Consolidation Act and GPRA, OF prepares the Agency Financial Report which includes consolidated financial statements, the auditor's opinion and other statutorily required annual reporting. For the thirteenth consecutive year, HHS earned an unqualified or "clean" opinion on the HHS audited Consolidated Balance Sheet, and Statements of Net Cost and Changes in Net Position, and Combined Statement of Budgetary Resources. In addition to maintaining its external reporting responsibilities, the OF implemented a consolidated reporting solution in FY2011 that supports the financial statement consolidation process, the consolidated Healthcare Reform and other managerial reporting requirements in FY2011 and forward. This reporting solution was key in the Department's efforts reducing in FY 2011 one of its two material weaknesses identified by the external auditors. In addition, OF develops and establishes financial management policies and procedures across HHS.

The OF develops HHS-wide policies and standards for financial and mixed financial system portfolios. HHS' financial management systems portfolio operates on the same commercial-off-the-shelf platform that consists of three major components: (1) UFMS, which is the integrated financial management system that operates across most HHS OPDIVs; (2) the Healthcare Integrated General Ledger Accounting System (HIGLAS) at the Centers for Medicare & Medicaid Services (CMS); and (3) NIH's Business System (NBS). In FY 2011, in addition to successfully implementing a financial reporting solution across the HHS financial management systems portfolio, HHS continues its integration of accounting and legacy systems (particularly at Medicare providers) to improve comprehensive financial management practices.

The OF leads HHS' Program Integrity Initiative which seeks to ensure that every program operates in an effective and efficient manner, spending HHS dollars in the manner for which they were intended. During FY 2010, the OF created an office, the Office of Program Integrity Coordination (OPIC), to implement this Initiative. OF supports the Program Integrity Coordinating Council (PICC), the Council consisting of OS and OPDIV senior leaders that meet monthly and provide strategic direction and oversight for the Initiative.

The FY2012 appropriation includes $998,000 for the Office of Finance (OF) to begin implementing a new, integrated system that can accurately track and report the Department's finances, including by source year of the appropriation. The OF will use these funds to begin developing a Department wide financial systems modernization plan. When completed, this multi-year modernization initiative will standardize financial management across HHS, modernize financial reporting to provide timely, reliable and accurate information about Department's finances and enhance, upgrade, secure and simplify financial systems environment.

Office of Grants and Acquisition Policy and Accountability (OGAPA) – This office provides Department-wide leadership, management, and strategy in the areas of grants, acquisition, and small business through policy development, performance measurement, oversight and workforce training, development and certification. OGAPA also fosters collaboration, innovation, and accountability in the administration and management of the grants, acquisition, and small business functions throughout the Department. In FY 2011, HHS held its first Acquisition, Grants and Small Business Symposium – providing HHS' grants and acquisition communities with two days of professional development and a venue for cross-agency collaboration.

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

accountability in HHS' grants, financial assistance and contracting programs; responds to grants or acquisition-oriented GAO and IG audits; and leads the Department's Strategic Sourcing, Green Procurement, and Purchase Card programs. In FY 2011, OGAPA also produced HHS' Service Contract Inventory, coordinated an assessment of HHS' spending on service contracts, and developed and implemented additional controls to review prospective acquisitions for services. In FY 2012, HHS is enhancing its suspension and debarment program by creating the Office of Recipient Integrity Coordination, dedicating staff toward this effort, and developing detailed policies and guidance and referral processes.

The office ensures that small businesses are given a fair opportunity to compete for contracts that provide goods and services to HHS; establishes, manages and tracks small business goal achievements; provides technical assistance and Small Business Program training to OPDIV contracting and program officials; and conducts outreach and provides marketing and technical guidance to small businesses on contracting opportunities with HHS. In FY 2010, HHS exceeded its small business goal and earned an "A" on the Small Business Procurement Scorecard Report. HHS exceeded its FY 2011 small business goal of 19.5% by awarding 22.5% of its contract dollars to small businesses.

Finally, this office fulfills HHS' role as managing partner of Grants.gov and supports the Federal Funding accountability and Transparency Act (FFATA) and Open Government Directive by maintaining and operating HHS' Tracking Accountability in Government Grants System and Departmental Contract Information System. OGAPA also ensure that the electronic grants management systems employed by HHS efficiently promote grant policies and optimize departmental resources; and serves as the business owner of the HHS Consolidated Acquisition System.

Funding History

FY 2008	$23,162,000
FY 2009	$25,781,000
FY 2010	$26,131,000
FY 2011	$28,103,000
FY 2012	$29,591,000

Budget Request

The FY 2013 Budget is $28,400,000, a decrease of $1,191,000 compared with the FY 2012 Enacted level. This request will allow ASFR to maintain its responsibilities associated with: improving financial management and program integrity; improving budget and performance analysis and support; improving grants and acquisition policies and practices, and the transparency of grants and acquisition data; and enhancing the budget, acquisition and grants workforce. The request reflects savings from discontinuation of ASFR's coordinated Recovery Act activities, which will be completed in FY2012.

As part of HHS' efforts to support risk mitigation efforts for ongoing HHS activities, ASFR will work to keep pace with the increased demands that have been placed upon it, allowing it to create guidance, policies, and controls crucial to the effective management of HHS programs, and achieve the Administration's accountability, Open Government, and transparency goals.

Office of Budget – In FY 2013, the Office of Budget will continue to manage the preparation of HHS' annual performance budget, and prepare the Secretary to support the budget to the public, the media, and Congressional committees. The office will also continue to improve the analyses, options, and recommendations on all budget and related policy for HHS, and work with OMB and the Congress to

accomplish HHS priorities. The budget request will also allow the office to continue its other responsibilities associated with GPRA, including quarterly program performance reviews, and to support the Program Performance Tracking System. In addition, the request provides funding for staff to support Office of Budget functions, including responsibilities related to the Administration's priorities to employ rigorous standards of accountability and transparency throughout the Federal government. Although workload has increased significantly in recent years, the Office of Budget is not requesting additional staff resources, but will make management and technology improvements to increase the efficiency and effectiveness of existing resources.

Office of Finance (OF) – In FY 2013, the OF will provide continued support to enhance financial management and reporting needs under the management initiatives for Improving Financial Management and Eliminating Improper Payments across the Department. Specific efforts include continuing to resolve outstanding financial statement audit findings and improve financial management processes across HHS. The request will also sustain management's Department-wide process for assessing and strengthening controls across HHS and continuing to support the OF's role as HHS' central audit liaison. Further, the OF will continue participating as subject matter experts as new programs are implemented in HHS to ensure that appropriate financial management controls and reporting considerations are addressed early in the implementation process. In response to the Executive Order *Reducing Improper Payments and Eliminating Waste in Federal Programs and the Improper Payments Information Act (IPIA)*, OF will continue to support HHS efforts to reduce error rates for all program components under the Eliminating Improper Payments initiative.

Within the construct of the CFO Community Strategic Planning activities, OF will continue to develop updated financial management and systems policies and procedures to standardize HHS' approach to financial management across HHS. The OF will lead the efforts of the CFO Community to maximize the utility of its financial management systems portfolio by implementing in FY 2013 additional tools to enhance HHS' reporting capabilities beyond external reports so that financial and related information may be more accessible to HHS personnel for decision-making. The FY 2013 Budget will also support the OF's capability to lead, plan, and oversee technical enhancements and upgrades of its financial management systems portfolio platform to meet information technology security requirements and support the Department's critical financial management business needs.

The FY 2013 request also supports the continued implementation of HHS' Program Integrity Initiative. The OF will continue working with OS and OPDIVs to integrate program integrity into all HHS programs and activities over time. The OF will do this by sharing best practices and continuing to oversee the program integrity lifecycle for risk assessed programs and measure progress. The FY 2013 Budget supports the development of solutions to cross-cutting risks that can be leveraged across programs facing similar challenges. The OF will also oversee single audit findings for those grantees at risk of potentially misusing federal funds. FY 2013 funding will enable HHS to build upon its program integrity success to help ensure programs are operating in an effective and efficient manner, spending HHS dollars in the manner for which they were intended.

In FY2013, the Office of Finance (OF) will continue to modernize Department wide financial systems. HHS' financial systems portfolio consists of three major components: (1) UFMS, which is the integrated financial management system that operates across most HHS Operating Divisions; (2) the Healthcare Integrated General Ledger Accounting System (HIGLAS) at the Centers for Medicare & Medicaid Services (CMS); and (3) NIH's Business System (NBS). When completed, this multi-year modernization initiative will standardize financial management across HHS, modernize financial reporting to provide timely, reliable and accurate information about Department's finances and enhance, upgrade, secure and simplify financial systems environment.

The Office of Grants and Acquisition Policy and Accountability (OGAPA) – In FY 2013, OGAPA will continue to: (a) standardize and modernize HHS' grants, acquisition, and small business administration policies, processes, programs, and systems; (b) enhance its oversight, accountability, program integrity, and knowledge management roles; and (c) continue to contribute expertise in the development of government-wide grant, acquisition, and small business administration and management policies, standards, and systems.

The FY 2013 Budget will also support OGAPA's efforts to expand its acquisition training and certification programs to include mentor, intern, and rotation initiatives; ensure HHS-wide training of program and acquisition staff regarding adherence to appropriations law and the identification of contract fraud; implement new government-wide efforts such as those to reduce high-risk contracting, promote efficient spending, increase the use of strategic sourcing, and improve transparency and data quality; and implement grant and contract sub-award reporting requirements required by statute and regulation. The office will also continue to increase HHS' use of analytical techniques, outreach programs and training to identify and maximize opportunities for small businesses such as by expanding the HHS Mentor Protégé Program and Minority Institutions of Higher Education training program.

ACQUISITION REFORM

Dollars in Thousands

	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	700	699	3,500	2,801
FTE	0	0	0	0

Authorizing Legislation:
FY 2013 Authorization…………………………………………………………………...…………….…Indefinite
Allocation Method…………………………………………………………………...................Direct Federal

<u>Program Description and Accomplishments:</u>

Stemming from a government-wide initiative to advance contracting reform, HHS is requesting $3,500,000 within the General Departmental Management account to further improve the capability, capacity and effectiveness of HHS' acquisition workforce.

In Fiscal Year (FY) 2011, HHS launched, with its acquisition reform funds ($700,000), a centralized training program. Through this program, HHS has been able to assess and meet the most critical, Department-wide training needs, enable HHS' acquisition workforce to meet certification and recertification requirements, enhance levels of proficiency that currently exist, and ensure a highly trained and efficient workforce. As a side benefit, this approach provides an opportunity for greater networking among and sharing by HHS' acquisition workforce across organizational boundaries.

The Federal acquisition workforce includes contract specialists, procurement analysts, program and project managers, and contracting officer representatives (CORs). This funding is requested in order to mitigate the risks associated with gaps in the capacity and capability of the acquisition workforce government-wide, and improve the effectiveness of that workforce, in order to maximize value in Federal contracting. The Office of the Assistant Secretary for Financial Resources (ASFR) will continue to lead this initiative.

The requested resources will be used to:

- increase the <u>capacity</u> of the acquisition workforce in the contracting and cost/price analysis functional areas, plus any necessary changes for program managers and CORs;
- increase the <u>capability</u> of the acquisition workforce by investing in training to close identified gaps in such areas as project management, negotiations, requirements development, appropriations law, contract management and other related areas; and
- increase the <u>effectiveness</u> of the acquisition workforce by enhancing the department-level oversight of HHS' contracting practices (including added controls over contracting for support services and reviews for compliance with appropriation law).

<u>Background:</u>

Successful acquisition outcomes are the direct result of having the appropriate personnel with the requisite skills managing various aspects of the acquisition process. Increased workload for the acquisition workforce has left less time for effective planning and contract administration, which can then lead to diminished acquisition outcomes. This lack of capacity and capability in the acquisition

workforce also results in tradeoffs during the acquisition lifecycle, which can reduce the chance of successful outcomes while increasing costs and impacting schedule.

In his March 4, 2009 memorandum on Government Contracting, the President mandated that all Federal agencies improve their acquisition practices and performance by maximizing competition and value, minimizing risk, and reviewing the ability of the acquisition workforce to develop, manage, and oversee acquisitions appropriately. Subsequent guidance from the Office of Management and Budget (including the memorandum *Improving Government Acquisition,* issued July 29, 2009; the memorandum *Acquisition Workforce Development Strategic Plan for Civilian Agencies, FY 2010-2014*, issued October 27, 2009; and the *Guidance for Specialized Information Technology Acquisition Cadres*, issued July 13, 2011*)* directed agencies to strengthen the acquisition workforce and increase the civilian agency workforce, to more effectively manage acquisition performance.

Funding History

FY 2008	$0
FY 2009	$0
FY 2010	$0
FY 2011	$700,000
FY 2012	$699,000

Budget Request:

The $3,500,000 Budget would be a meaningful expansion over the investments made by HHS in FYs 2010 and 2011, and would enable the Department to make further improvements. Such improvements would continue to be managed as part of a multi-year staged effort, with additional resources in future fiscal years.

HHS will invest the Acquisition Reform funds in the following actions (in priority order), to implement HHS' Acquisition Workforce Development Strategic Plan:

- Building or expanding HHS' acquisition workforce through intern, rotational, and mentor programs to increase the capacity of the workforce and support succession planning and developing specialized cadres in cost and price analysis and Information Technology acquisitions (e.g., recruit, hire, and retain HHS' acquisition workforce).

- Providing a centralized training fund to enhance the capabilities of the acquisition workforce and close competency gaps (e.g., train HHS' acquisition workforce).

- Developing or refining HHS' systems to project future acquisition workforce needs and conduct data-driven analysis to support HHS acquisition workforce planning activities (e.g., measure HHS' acquisition workforce).

Strengthening and expanding HHS' acquisition management resources, programs and strategies to improve acquisition planning and oversight (e.g., increase management oversight and compliance reviews, lower program risks and improve HHS' acquisition outcomes).

ASSISTANT SECRETARY FOR LEGISLATION

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	3,423	3,893	4,300	407
FTE	27	27	27	0

Authorizing Legislation:

FY 2013 Authorization……………………….…………………………………………..……Indefinite

Allocation Method……………………………………………………….…………..………Direct Federal

Program Description and Accomplishments

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

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

ASL is organized into six divisions:

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

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

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

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

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

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

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

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

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

- responding to Congressional inquiries and notifying Congressional offices of grant awards (via Econosys) made by the Department;
- providing technical assistance regarding grants to Members of Congress and their staff; and
- facilitating informational briefings relating to Department programs and priorities.

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

Funding History

FY 2008	$3,379,000
FY 2009	$3,430,000
FY 2010	$3,204,000
FY 2011	$3,423,000
FY 2012	$3,893,000

Budget Request

The FY 2013 Budget for ASL is $4,300,000, an increase of $407,000 over the FY 2012 Enacted level. The Budget allows ASL to provide critical support to the legislative healthcare and human services agenda that, among others, includes reauthorization of the Temporary Assistance to Needy Families (TANF) Program, the Older Americans Act, and the Head Start program. The Budget will also allow ASL to continue to meet the demands of the increased activity and congressional inquiries.

In FY 2013, ASL will also support the President's commitment to strengthen the systems that protect our food and medical products supply, ongoing activities related to public health emergency preparedness, the reauthorization of the Substance Abuse and Mental Health Services Administration, the Safe and Stable Families program and others.

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

ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	5,477	8,983	9,800	817
FTE	41	46	41	-5

Authorizing Legislation:

FY 2013 Authorization…………………….………………………………………..……Indefinite

Allocation Method…………………………………………………….……………..………Direct Federal

Program Description and Accomplishments

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

- Overseeing efforts to expand the Department's transparency and public accountability efforts through improved communications and new and innovative communication tools and technology.
- Providing timely, accurate, consistent and comprehensive public health information to the public and ensuring the information is easy to find and understand.
- Serving the Secretary in advising and preparing public communications and developing strategic plans for the Department.
- Coordinating public health and medical communications across all levels of government and with international and domestic partners.
- Developing and managing strategic communications plans in response to national public health emergencies.
- Providing public affairs council in the HHS policymaking process.
- Acting as the central HHS press office handling media requests; overseeing press release development and interview requests; and managing news issues that cut across Agencies; producing electronic clips for the Secretary and the Department.
- Development, management and maintenance of the content and design of the many of the Department's websites including the Department's flagship HHS.gov website, flu.gov, and healthcare.gov.
- Hosting websites that support one or more secretarial or administration initiatives by providing information, transparency, and tools to the public and encouraging involvement in the governing process, while providing public access.
- Developing protocols and strategies to expand Departmental utilization of new media and the web.
- Overseeing and producing special events that highlight top Departmental issues.
- Supporting television, Web, and radio appearances for the Secretary and top Department officials; managing the HHS studio and providing photographic services; producing and distributing internet, radio, and television outreach materials.
- Writing speeches, statements, articles, and related material for the Secretary, Deputy Secretary and Chief of Staff and other top Departmental officials; and researching and preparing op-ed pieces, blogs, features, articles, and stories for the media.
- Maintaining HHS FOIA/Privacy Act operations and activities

Funding History

FY 2008	$4,453,000
FY 2009	$4,432,000
FY 2010	$4,829,000
FY 2011	$5,477,000
FY 2012	$8,983,000

Budget Request

The FY 2013 Budget for ASPA is $9,800,000, an increase of $817,000 over the FY 2012 Enacted level. This increase will be used to conduct Department-wide public affairs programs; support the rollout of new programs and laws; increase public access to information; enhance transparency and accountability; synchronize Departmental policy and activities with communications; oversee the planning, management and execution of communication activities throughout HHS; and administer Open Government programs, the Freedom of Information Act (FOIA), and Privacy Act programs on behalf of the Department. Additionally, ASPA will continue to maintain and update healthcare.gov, the nation's leading source of information on health insurance options for consumers and health providers.

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

ASPA utilizes all methods of mass communication to accomplish its mission of ensuring that all Americans have access to critical public health and human services information in a timely and transparent manner, including vulnerable populations outreach. The FY 2013 funds will be used to provide citizens, in the most transparent and accessible manner possible, with the critical information they need about health and human services programs that are designed to help them achieve economic and health security.

OFFICE OF THE GENERAL COUNSEL

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	39,911	40,274	43,100	2,826
FTE	312	282	283	+1

Authorizing Legislation:
FY 2013 Authorization…...……………………………………………………………………………Indefinite
Allocation Method…………………………………………...……………………………………Direct Federal

Program Description and Accomplishments

OGC, with a team of approximately 600 attorneys and support staff, is one of the largest, most diverse and talented law offices in the United States. It provides client agencies throughout the Department with representation and legal advice on a wide range of highly visible national issues. OGC's goal is to support the strategic goals and initiatives of the Office of the Secretary and the Department by providing high quality legal services, including sound and timely legal advice and counsel. As such, this budget request aims to enable OGC to continue to provide the Secretary with the highest level of legal services required to effectively achieve and implement the goals and initiatives of the agency.

OGC Accomplishments

- During FY 2010, OGC was involved in a wide range of CMS program integrity efforts that resulted in Government recoveries of over $1.2 billion in judgments, settlements, or other types of recoveries, savings, or receivables.
- *Supreme Court Ruling re 340B Drug Discount Program.* On March 29, 2011, the U.S. Supreme Court issued its opinion in *Astra USA, Inc. v. County of Santa Clara*, 131 S. Ct. 1342 (2011). In a unanimous 8 - 0 opinion, consistent with the position put forth by OGC and argued by the U.S. Government in its *amicus* brief, the Supreme Court concluded that 340B Drug Pricing Program participating safety-net entities do not have the right to pursue claims against drug manufacturers pursuant to the 340B pharmaceutical pricing agreement.
- *Supreme Court Ruling re Vaccine Liability.* On February 22, 2011, the Supreme Court issued its decision in *Bruesewitz v. Wyeth,* 562 U.S. In a 6-2 opinion, consistent with the position put forth by OGC and argued by the U.S. Government in its amicus brief, the Court ruled that the National Childhood Vaccine Injury Act of 1986 preempts all design-defect claims against vaccine manufacturers brought by plaintiffs seeking compensation for injury or death caused by a vaccine's side effects.
- *Supreme Court Ruling re Protection and Advocacy for Individuals with Mental Illness.* On April 19, 2011, the Supreme Court issued its decision in *Virginia Office of Protection and Advocacy (VOPA) v. Stewart*, (No. 09-529) holding that Eleventh Amendment sovereign immunity does not prohibit an independent state agency designated as the protection and advocacy (P & A) provider under the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act and the Developmental Disabilities (DD) Act from enforcing its right to records in an abuse investigation from a state hospital in Federal court under the Ex parte Young exception to sovereign immunity. The position of the United States in this case was consistent with OGC's recommendation to the Justice Department.
- Secured a very gratifying settlement at the First Circuit in *Massachusetts Executive Office of Health and Human Services (EOHHS) v. CMS*, when the State agreed to withdraw its appeal of

CMS' disallowance of $86.6 million FFP in targeted case management (TCM) services provided by the Massachusetts Department of Social Services (DSS) during fiscal years 2002 and 2003.

- In *Maine Dep't of Health and Human Services v. CMS,* the District Court recently upheld CMS' similar disallowance of $29.7 million FFP in TCM claims for direct social services rendered by a separate bureau of child welfare services within the State agency.
- In *New Hampshire Dep't of Health and Human Services v. CMS*, at the DAB, our office is defending CMS' disallowance of $35.3 million FFP claimed as the Federal share of disproportionate share (DSH) payments during Federal fiscal year 2004 contrary to Federal provisions.
- Reviewed and approved for legal sufficiency, numerous proposed Medicaid disallowances, such as the more than $28 million FFP claimed by Massachusetts for supplemental payments made to public facilities beyond the two-year timely filing period established under statute and regulation; $4.9 million FFP claimed in administrative costs associated with Medicaid-eligible participants in Massachusetts school-based health programs; $104 million FFP claimed by Connecticut for retroactive rate adjustments for State-operated ICF/MR providers that were outside the State plan rate-setting methodology and were beyond the two-year timely filing period; and $8.8 million FFP claimed by Connecticut for services provided in a State-run psychiatric facility that was ineligible to participate in the program.
- Yielded $976,848 in MSP recoveries for the first half of FY 2011, and $4,308,598 in MSP recoveries for FY 2010.
- Provided legal support for Departmental response to public health emergencies arising from the oil spill in the Gulf of Mexico, the earthquake in Haiti, the earthquake and tsunami in Japan, flooding in upper Midwest States, tornados and flooding in south central states, advising on legal issues related to public health emergency declarations, deployment of personnel, provision of medical care, negotiation of privileges and immunities for medical personnel working in Haiti, and deployment of medical countermeasures domestically and abroad.
- Advised and worked closely with the Health Resources and Services Administration (HRSA) and its HIV/AIDS Bureau leaders to implement a $25 million emergency funding initiative to provide relief for States with waiting lists for HIV/AIDS medications. This life-saving initiative will impact approximately 3,000 individuals.
- Aggressively pursued collection of outstanding debt owed under HRSA's Health Education Assistance Loan Program, National Health Service Corps Programs and other health profession scholarship and loan repayment programs resulting in collections of $17.6 million over the past year (April 2010-March 2011).
- Actively assisted the Department with legal matters associated with response to the Deepwater Horizon oil spill as well as legal implications of the ensuing litigation hold and current multidistrict litigation. Helped negotiate gift from British Petroleum to support mental health services to individuals affected by the spill.
- Provided legal support to NIH and HHS to accelerate private sector development of new vaccines, drugs, and medical technology in the area of technology transfer and intellectual property, including the execution and enforcement of over 850 patent license agreements; collection and administration of more than $91 million dollars in royalty funds; and protection of HHS intellectual property against infringement.
- Provided legal support for successful outcomes to date in HHS human embryonic stem cell research litigation in several courts.
- Defended IHS against Indian tribes and tribal organizations seeking additional CSC under the ISDEAA. More than forty tribal contractors have filed claims for additional CSC funding, and the litigation currently includes 33 ongoing cases in which more than $187 million is in controversy. Received a favorable ruling in litigation involving claims by the Arctic Slope Native Association, Ltd. (ASNA) for additional CSC funding under its ISDEAA contracts from

FYs 1996-1998, thus saving the US $4,879,081.

- OGC has reviewed hundreds of proposed contracts under the ISDEAA, which transfer over $2 billion on an annual basis to nearly 300 tribes. OGC has reviewed tribal proposals, advised the Federal negotiation team, and ensured agreements are within the Agency's statutory authority. OGC has also defended IHS in Federal and administrative actions challenging ISDEAA contracts, including litigation regarding contract support costs (CSC).
- Collected approximately $6 million for CMS, including Trinity Hospices Delaware Insolvency, 43,611,400; Tyrone Hospital, $798,029; IHS Peake, $790,387; CHAMA, $434,234; Eagle/Hope, $410,763; Brownsville, $97,470.
- Commw. of Pa., Dep't of Pub. Welfare v. U.S. DHHS and Sebelius, Sec'y, No. 1:08-cv-791 (M.D. PA): received a favorable district court decision in this $150 million Medicaid dispute regarding statutorily barred "room and board" costs under PA's Home and Community-Based Services waiver.
- In West Virginia v. U.S. Dep't of HHS, Nos. 09-2327, 2261 (4th Cir.): negotiated $180 million settlement with WVA of long-standing cost allocation litigation and received program approval of settlement.
- In *Louisiana Department of Health & Hospitals v. HHS*, DAB No. A-10-11, OGC successfully defended CMS' disallowance in the amount of $362,053,628 in federal financial participation (FFP) for DSH payments to certain public hospitals in excess of the hospitals' actual uncompensated care costs for state fiscal years 1996 through 2006.
- In *America's Health Choice Medical Plans, Inc.,* a lawsuit was brought by the United States in the U.S. District for the Southern District of Florida alleging that owners of America's Health Choice (AHC) violated the False Claims Act by causing AHC to falsely increase the severity of beneficiary diagnoses to obtain higher Medical payments. Through the coordinated efforts of the Department of Justice, the Office of Inspector General, CMS, OGC Region VI, and the Immediate Office, the Medicare Advantage owners agreed to pay $22.6 million to settle claims of falsifying diagnoses.
- In *Anne Sanders, CEO, P.T. v. Department of Health and Human Services, et al*., Civ. Action No. 10-172 (E.D. Tex), OGC successfully defended a FTCA suit with a claim for damages in the amount of $20,000,000.
- OGC played a key role in advising and defending CMS in challenges to its authority to impose sanctions against nursing homes that fail to comply with federal health and safety standards. As a result of OGC's outstanding efforts in this area, most nursing homes no longer litigate the sanctions imposed by CMS; they simply pay them. This improves patient safety at a reduced cost (through the avoidance of litigation) to the public.

Funding History

FY 2008	$36,617,000
FY 2009	$37,581,000
FY 2010	$38,692,000
FY 2011	$39,911,000
FY 2012	$40,274,000

Budget Request

The Office of the General Counsel (OGC) Budget of $43,100,000 is an increase of $2,826,000 over the FY 2012 Enacted level. This increase supports OGC's efforts to review proposed legislation and related regulations; engage in legislative drafting; and consult and advise on wide-ranging legal issues that emerge from the policies and programs of the Department, Administration, and Congress. In this particular year, OGC is specifically addressing gaps in legal support of HHS-wide personnel policy and actions.

This Budget funds six positions for the FY 2013 operation of employment and labor law services. An in-depth analysis of OGC's workload, including backlog and pending matters, indicates these added positions will significantly reduce the backlog of employment and labor matters, address the Department's annual employment and labor law needs as they arise, and provide the best services for the Department. Moreover, as the Department's responsibilities and programs increase, its employment and labor law needs will likewise expand with an increased demand for legal advice. Failing to increase staff resources will result in decreased capacity to provide timely and quality legal advice and to effectively defend the Department's position in litigation.

OGC's onboard positions previously funded from other sources will also need to be funded in FY 2013. This funding increase will ensure that OGC maintains its current level of support and commitment to the Department's ACA goals and initiatives.

Specifically, OGC will provide extensive advice to the Centers of Medicare and Medicaid Services (CMS) as it prepares to implement the numerous Medicare and Medicaid provisions of ACA; provide legal assistance to the National Institute of Health (NIH) to establish and operate the Cures Acceleration Network for the purpose of accelerating the development of new drugs and other medical products; provide legal assistance to the Centers for Disease Control (CDC) and Prevention to establish and/or expand health education activities related to the health care reform legislation; provide legal assistance to the Office of the Assistant Secretary for Health (OASH) in the areas of grants, malpractice coverage, and the highly regulatory initiative of discounted drug pricing; provide legal assistance to the Agency for Healthcare Research and Quality (AHRQ) and NIH in the areas of quality measurement activities, quality improvement efforts, and significantly expanded comparative effectiveness research programs; and provide legal assistance to the Indian Health Services (IHS) to carry out the legislation to make changes to health care delivery and tribal contracting as well as new funding priorities and rulemaking

DEPARTMENTAL APPEALS BOARD

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	10,583	10,730	11,700	970
FTE	69	69	69	0

Authorizing Legislation:
FY 2013 Authorization……………………………………….........................……………………………Indefinite
Allocation Method…………………………………………………….……………………………...Direct Federal

Program Description and Accomplishments

The Departmental Appeals Board (DAB) provides impartial, independent hearings and appellate reviews, and issues Federal agency decisions under more than 60 statutory provisions governing Department of Health and Human Services (DHHS) programs. Unlike most other Staff Divisions (STAFFDIVs) in the Office of the Secretary, DAB performs functions that are mandated by statute or regulation. Cases are initiated by outside parties who disagree with a determination made by a DHHS agency or its contractor. Outside parties include States, universities, Head Start grantees, nursing homes, clinical laboratories, doctors, medical equipment suppliers, and Medicare beneficiaries. Disputes heard by the DAB may involve over $1 billion in Federal funds in a single year. DAB decisions have nation-wide impact. In addition, DAB decisions on certain cost allocation issues in grant programs have government-wide impact, because DHHS is the agency whose decisions in this area legally bind other Federal agencies.

DAB's mission is to provide fast, low-cost, high-quality adjudication and other conflict resolution services in administrative disputes involving DHHS, and to maintain efficient and responsive business practices. In general, DAB contributes to the improved management and integrity of DHHS programs, and to the quality of health care, by:

- Ensuring compliance with program requirements;
- Promoting consistency in decision-making across DHHS;
- Issuing timely decisions that are well-founded, well-reasoned, and clearly communicated;
- Resolving disputes administratively, thereby avoiding costly court proceedings.

DAB is organized into four Divisions:

- the Appellate Division supports the Board Members, who preside in various types of cases;
- the Civil Remedies Division (CRD) supports DAB Administrative Law Judges (ALJs), who conduct evidentiary hearings;
- the Medicare Operations Division (MOD) supports DAB Administrative Appeals Judges, who review decisions by ALJs from the DHHS Office of Medicare Hearings and Appeals (OMHA) or (in some older cases) by Social Security Administration ALJs; and
- The Alternate Dispute Resolution Division, which provides mediation services in DAB cases and provides policy guidance and information on the use of dispute resolution methods throughout DHHS to reduce administrative and management costs.

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

Performance analyses for each Division are based on FY 2010 data to date, extrapolated to the end of the fiscal year. Workload assumptions are explained in the charts under the Budget Request section.

Board Members – Appellate Division

The Secretary appoints the DAB Board Members; the Board Chair is also the STAFFDIV Head of DAB. All Board Members are judges with considerable experience who, acting in panels of three, issue decisions with the support of Appellate Division staff. In some cases (such as Head Start terminations and Medicaid disallowances), Board Members conduct *de novo* reviews and hold evidentiary hearings if needed. In other cases, Board Members provide appellate review of decisions by DAB ALJs or other ALJs. Board review ensures consistency of administrative decisions, as well as adequacy of the record and legal analysis before court review. For example, Board decisions in grant cases promote uniform application of OMB cost principles. Board decisions are posted on the DAB Website and provide precedential guidance on ambiguous or complex requirements.
Board jurisdiction affecting Medicare and Medicaid includes:

- Appellate review of DAB ALJ decisions in cases for which a healthcare provider or supplier has a hearing right under section 1866(h)(1) of the Social Security Act and/or 42 C.F.R. Part 498, including cases that raise important quality of care issues such as nursing home enforcement and Clinical Laboratory Improvement Amendments (CLIA) cases;
- Review of Medicare National Coverage Determination policies and review of DAB ALJ decisions on Local Coverage Determinations that may affect whether Medicare beneficiaries get timely access to new medical technology/procedures, without jeopardizing safety or wasting funds;
- Appellate review of DAB ALJ decisions in civil money penalty (CMP) and exclusion cases brought by the DHHS Office of Inspector General (OIG) or Centers for Medicare & Medicaid Services (CMS) to improve program integrity;
- Review of DAB ALJ decisions in cases involving the imposition of CMPs on covered entities that violate standards adopted by the Secretary to implement the Administrative Simplification provisions of HIPAA;
- *De novo* review of Medicaid disallowances (*i.e.*, the loss of Medicaid funding) appealed by States pursuant to statute;
- Review of cases arising under various new provisions of the Affordable Care Act (ACA).

States may also request Board review of TANF (welfare) penalties, penalties based on ACF child and family welfare and services reviews, foster care eligibility disallowances, and some other determinations related to financial or program management.

Performance Analysis: In FY 2011, the Board/Appellate Division closed 139 cases (90 by decision). Ninety percent of Board decisions issued in FY 2011 had a net case age of six months or less, exceeding the target for Measure 1, which tracks the percentage of total Board decisions issued in cases with a net age of six months or less. The regulatory deadline for issuing a decision was met in one hundred percent of the 16 appeals with a regulatory deadline in FY 2011, thus achieving the target for Measure 2, which tracks the percentage of Board decisions with statutory or regulatory deadlines for issuing decisions in which the deadline was met. (There were no appeals with statutory deadlines in FY 2011.) Appellate will continue to meet performance targets for Measures 1 and 2 in FY 2012 and FY 2013.

Administrative Law Judges – Civil Remedies Division (CRD)

CRD staff support DAB ALJs, who conduct adversarial hearings in proceedings that are critical to HHS healthcare program integrity efforts, as well as quality of care concerns. Hearings in these cases may last

a week or more. Cases may raise complex medical or clinical issues. Some cases require presentation of evidence to prove allegations of complicated fraudulent schemes. Cases may also raise legal issues of first impression. For example, appeals of enforcement cases brought under the Health Insurance Portability and Accountability Act (HIPAA) are likely to raise new issues.

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

In FY 2012, CRD began providing ALJ hearings in Food and Drug Administration (FDA) cases. Most of these will be enforcement actions, involving the regulation of tobacco products, initiated by the Center for Tobacco Products (CTP). DAB review of the CTP cases will be funded through tobacco product user fee funds, which must be used to pay for tobacco regulation pursuant to Section 919 of the FD&C Act, 21 U.S. C. § 387. These funds will be transferred to the DAB via Interagency Agreement (IAA). FDA recently projected 300 CTP cases for FY 2012, and DAB will hire staff to handle them with the CTP funds. FDA has indicated that the non-CTP caseload is projected to be low, so as not to significantly impact DAB costs, but FDA will provide a separate IAA to fund the non-CTP caseload by separate IAA to the extent they exceed five per year.

Performance Analysis: CRD received 835 new appeals in FY 2011 and closed 836 appeals. CRD met its FY 2011 targets for Measure 3 and 4.

Measure 3 relates to OIG actions to impose civil money penalties or to exclude individuals from participating in Federal programs. The measure for this goal is the percentage of OIG cases in which DAB ALJs issue decisions within 60 days of the close of the record. The target for FY 2011 was 100%. CRD expects to continue to meet Objective 3 in FY2012 and FY2013, despite the fact that the CRD and OIG anticipate more enforcement actions.

Measure 4 ensures that increases in case receipts do not result in a greater number of aged cases. The measure is the number of cases open at the end of the fiscal year that had been received in prior fiscal years. CRD reduced this number to 11 in FY 2011, in part because of the efforts of a new ALJ, who has gradually assumed a full caseload. Nevertheless, a senior ALJ will retire at the end of calendar year 2011, and a term attorney will be leaving in March 2012. Since CRD anticipates more provider/supplier enrollment cases and ACA cases, it will need to at least backfill the retiring ALJ position in FY2012 to ensure that CRD can continue to meet its performance objectives in FY 2013. Due to the anticipated influx of FDA cases, CRD believes Measure 4 should be changed to a percentage comparing "cases closed" to "cases received" during the fiscal year. CRD believes it can reasonably expect to close 80% of appeals received in any given fiscal year, and expects to meet this new proposed measure for FY 2012 and FY 2013.

Medicare Appeals Council – Medicare Operations Division (MOD)

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

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

The majority of cases that the Medicare Operations Division (MOD) handles must be decided within a 90-day statutory deadline.

Performance Analysis: In FY 2011, MOD exceeded its FY 2011 target for Objective 6.1 to constrain the growth in case age by reducing the average time to complete action on Medicare Part B cases to 132 days (as measured from the date MOD received the claim file). In FY 2011, MOD fell 54 cases short of its Objective 7.1 target of 2,100 dispositions. In both FY 2012 and FY 2013, MOD projects sharply higher case receipts, due to projected ACA and RAC workloads, and this will present challenges in both timeliness and number of case dispositions. To address the growing workload, DAB added four new staff to MOD in FY 2012, will add 5 more staff (principally GS 9 and GS 11 staff attorneys) in FY 2013, and will meet its performance targets for Objectives 6.1 and 7.1.

Alternative Dispute Resolution (ADR) Division

Under the Administrative Dispute Resolution Act, each Federal agency must appoint a dispute resolution specialist and must engage in certain activities to resolve disputes by informal methods, such as mediation, that are alternatives to adjudication or litigation. Using ADR techniques decreases costs and improves program management by reducing conflict and preserving relationships that serve program goals (*e.g.*, between program offices and grantees, or among program staff). Using ADR also furthers compliance with the Administration's directive of January 24, 2009, entitled "Memorandum to the Heads of Executive Departments and Agencies on Transparency and Open Government." The President called on the Executive Branch to: (1) provide increased opportunities for the public to participate in policymaking; and (2) use innovative tools, methods and systems to cooperate with other Federal Departments and agencies, across all levels of government, and with non-profits, businesses and the private sector.

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

DAB has a small ADR staff, and leverages its reach through a variety of innovative programs. For example, DAB's Sharing Neutrals Program won an award from the Office of Personnel Management for the innovative use of collateral duty mediators to resolve workplace disputes. The Shared Neutrals Program is designed so that Federal employees who are already trained mediators can occasionally mediate disputes for Federal agencies other than their home agency, in exchange for similar services to their home agency from mediators employed by other Federal agencies. DAB also participates in the Federal Interagency ADR Workgroup and partners with the ADR office at the Department of Transportation (DOT) to provide conflict management seminars to DHHS and DOT staff. DAB attorneys encourage parties to mediate DAB cases, and many staff members are trained mediators.

Performance Analysis: In FY 2011, the ADR Division met its performance Measure 5.1 and 5.2 by conducting 15 conflict resolution seminars and providing ADR services in 80 DHHS cases. In FY 2011, the ADR Division successfully undertook several initiatives, including: (1) supplementing a small ADR staff with a Presidential Management Intern and unpaid law school intern; (2) delivering a new course ("Conflict Management for FOIA professionals") to support goals of President Obama's Directive on Transparency and Open Government; and (3) training a cadre of Indian Health Service (IHS) employees to become mediators for workplace and EEO disputes arising in Northwest IHS Service Area.

In FY 2012 and FY 2013, the ADR Division will meet its performance goals and will undertake various cost-saving initiatives, including: (1) continuing IHS training for another cadre of Indian Health Service (IHS) employees to become mediators for workplace and EEO disputes, but this time in the Southwest IHS Service Area; (2) training IHS Service Area supervisors and managers in how to use mediation to effectively avoid litigation in appropriate workplace and EEO disputes; (3) training executives and managers from 14 NIH institutes and from FOIA staff across DHHS in conflict management; and (4) promoting increased use of video-conferencing for mediation in DAB cases.

Workload Statistics

Board Members – Appellate Division

Chart A shows total historical and projected caseload data for this Division. FY 2011 data is historical, and FY 2012 and 2013 data is based on certain assumptions, including:

- Increased appeals of Early Retiree Reinsurance Program cases in FY 2012; and
- Increased appeals of CRD ALJ decisions in both FY 2012 and FY 2013, due to increases in the number of such decisions issued in each of those years.

APPELLATE DIVISION CASES

	FY 2011	FY 2012	FY 2013
Open/start of FY	65	49	54
Received	123	145	130
Decisions	90	90	90
Total Closed	139	140	140
Open/end of FY	49	54	44

Administrative Law Judges – Civil Remedies Division

Chart B shows total historical and projected caseload data for this Division. FY 2011 data is historical, and FY 2012 and 2013 data is based on certain assumptions, including:

- A continued upward trend in certain case types, such as provider/supplier enrollment cases, due to heightened enforcement and oversight efforts by DHHS OIG, CMS, and OCR;
- New FDA workload, resulting from the retirement of the FDA ALJ;
- New cases from OIG related to employee salary overpayments; and
- New ACA workload.

CIVIL REMEDIES DIVISION CASES

	FY 2011	FY 2012	FY2013
Open/start of FY	298	297	397
Received	835	1,100	1,150
Decisions	176	190	210
Total Closed	836	1,000	1,050
Open/end of FY	297	397	497

Medicare Appeals Council – Medicare Operations Division

Chart C contains case data for this Division, based on actual numbers received to date for FY 2011. Projections for FY 2012 and 2013 are based on information and projections from other HHS Operating and Staff Divisions (OMHA). DAB reports data about those cases requiring individual determinations, while noting the associated individual claims (a single case may represent hundreds of Medicare claims and more than one Medicare contractor denial).

Assumptions on which the data are based include:

- Increased case receipt in FY 2012 and FY 2013, as OMHA's disposition rate increases (including increases in appeals originating with Recovery Audit Contractors); and
- New ACA workload.

MEDICARE OPERATIONS DIVISION CASES

	FY 2011	FY 2012	FY 2013
Open/start of FY	835	1,229	1,729
Received	2,440	3,000	3,500
Cases Closed (claims closed)	2,046 (25,700 claims)	2,500 (38,000 claims)	3,100 (59,047 claims)
Open/end of FY	1,229	1,729	2,129

Alternative Dispute Resolution Division

In FY 2012 and FY 2013, ADR will strive to meet the following goals:

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

Funding History

FY 2008	$9,641,000
FY 2009	$9,981,000
FY 2010	$10,549,000
FY 2011	$10,583,000
FY 2012	$10,730,000

Budget Request

DAB's FY 2013 Budget is $11,700,000, an increase of $970,000 over the FY 2012 Enacted level. The funding request for DAB is justified by the increasing Medicare and other workloads (including new ACA cases), workload statistics for each Division, DAB e-Government needs, and the potential fiscal and legal consequences of not meeting statutory and regulatory deadlines for hearings and appeals and submitting certified administrative records in cases appealed to Federal court.

DAB's Budget includes funding for increased personnel and other costs (such as IT costs) associated with the increases in staff to the MOD, CRD, and Appellate divisions.

DAB's Budget also supports the President's information technology initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process.

DAB Outcome/Outputs Table

Measure	Most recent result (FY 2011)	FY 2012 Target	FY 2013 Target	FY 2012 +/- FY 2011
1.1: Percentage of Board decisions with net case age of six months or less.	90% (target exceeded)	86%	86%	Maintain
2.1: Percentage of Board decisions meeting applicable statutory and regulatory deadlines for issuance of decisions.	100%	100%	100%	Maintain
3.1: Percentage of decisions issued within 60 days of the close of the record in HHS OIG enforcement, fraud and exclusion cases.	100% (target met)	100%	100%	Maintain
3.2: Percentage of decisions issued within 60 days of the close of the record in SSA OIG CMP cases and other SSA OIG enforcement cases.	100% (target met)	100%	100%	Maintain
3.3: Percentage of decisions issued with 180 days of filing of provider or supplier enrollment appeal.	100% (target met)	100%	100%	Maintain
4.1: Percentage of cases closed in a fiscal year compared to the percentage of cases received that same fiscal year.	NA	80%	80%	Maintain
5.1: Number of conflict resolution seminars conducted for HHS employees.	15 sessions (target met)	15 sessions	15 sessions	Maintain
5.2: Number of DAB cases (those logged into ADR Division database) requesting facilitative ADR interventions prior to more directive adjudicative processes.	80 (target met)	80	80	Maintain
6.1: Average time to complete action on Part B Requests for Review measured from receipt of case folder. (FY 2001 and following Fiscal Years) Note: Results for FY 05 determined after excluding outlier cases in which delays related to court proceedings beyond DAB's control.	132 days (target exceeded)	155 days	155 days	Maintain
7.1: Number of dispositions.	2,046(target not met)	2,500	3,100	+1,054

OFFICE ON DISABILITY

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	862	1,098	1,100	2
FTE	6	6	6	0

Authorizing Legislation:
FY 2013 Authorization…………………………………………………………………………Indefinite
Allocation Method……………………………………………………………………Direct Federal; Contracts

Program Description and Accomplishments

The Office on Disability (OD) supports initiative organized around the following three themes: a) Improve Access to Community Living Services and Supports; b) Integrate Health Services and Social Supports; and, c) Provide Strategic Support on Disability Matters. The Office on Disability also has new strategic goals/objectives under each of the three themes described above that will support our initiatives and programs. These strategic goals also support Presidential and Secretarial priorities in health care and community living. The Office on Disability's Budget covers operational and personnel costs. Our personnel are involved in coordinating efforts across HHS, which is dependent upon other agencies budgets.

Implementation of the Affordable Care Act
OD works closely with agencies in the Department that have program authority for existing health care programs and related services benefiting people with disabilities. The Office on Disability plays an instrumental role in implementing the law. The Community Living Initiative working groups are involved with provision that relate to the health care workforce, Medicaid home and community based services and the creation of access to private health insurance options as well as the establishment of a new voluntary, self-financing long term services and supports program. OD is leading the implementation of a provision of the law that calls for the removal of barriers to providing home and community-based services.

Community Living Initiative
On the 10th year anniversary of the Supreme Court Olmstead v. L.C. Decision, President Obama announced the Year of Community Living. Secretary Sebelius formed a Coordinating Council to guide the Department's work on this initiative. OD leads the Coordinating Council which is comprised by the heads of the following Federal partners: AoA, CMS, SAMHSA, HRSA, ACF, OCR, and ASPE. Activities under this initiative are carried on through the work of 5 working groups. The initiative will now focus on adding value to the implementation of the provisions of the Patient Protection and Affordable Care Act (ACA). It is poised to monitor the progress of the health reform efforts and communicate the roll out of provisions related to community living to disability and aging stakeholders through the its website.

Comparative Effectiveness Research
OD is leading a Comparative Effectiveness Research project that was awarded on May 5 2010, under a contract mechanism to Mathematical Policy Research Inc. in the amount of $7 million to establish a Center of Excellence in Research on Disability Services, Care Coordination, and Integration. This two-year project, funded under the American Recovery and Reinvestment Act of 2009, will create data infrastructure to support and conduct comparative effectiveness research on health services and supports

for people with disabilities. This initiative directly links to health reform provisions related to improving health care quality programs through the development of a national strategy for quality improvement in health care and the expansion of health care delivery system research including person centered outcomes research. This initiative may also provide relevant information that can be used to improve community living for people with disabilities.

Improving care coordination and integration for people with disabilities
Office on Disability will be working with CMS to develop innovations in health care delivery system to better serve people with disabilities. Of particular interest is the population with multiple chronic conditions that require assistance in performing activities of daily living and/or instrumental activities of daily living. This population tracks closely with the roughly 5% of the Medicaid population that accounts for approximately 50% of the program's cost.

The Department, working with partners across the Federal government, will explore strategies to improve the effectiveness of disability programs through better coordination and alignment of priorities and strategies. The focus of this effort is to work with agencies authorized to run disability-specific programs and those programs that impact and affect people with disabilities to explore how they can achieve better results for this population.

Creating Sustainable Housing for Vulnerable Populations
HUD Secretary Donovan and HHS Secretary Sebelius jointly convened three working groups to identify ways to better link HUD's housing resources with HHS's health and human service resources. The three working groups focus on: (1) Homelessness, (2) Community living (persons with disabilities, aging), and (3) Livable communities (macro level housing and community planning, design and health). The Office on Disability leads working group 2, which is directly linked to the Community Living Initiative. In its role, the office is charged with overseeing the three following major tasks: a) Providing or targeting Public Housing Authorities (PHAs) and appropriate housing stakeholder groups with information designed to develop a better understanding of how certain HHS programs operate; b) Providing expert knowledge to health and human services agencies and key stakeholders on federally funded housing programs; c) Identifying and promoting best practices in which federally-funded housing resources are coordinated with health and human services programs to better serve people with disabilities and seniors.

Creating Better Alignment between the Medicaid & Medicare Benefits
The financial misalignment between Medicare and Medicaid has been a longstanding barrier to improvements and cost savings. Medicaid has little incentive to make needed investments because Medicare reaps much of the savings, a situation worsened by the current state fiscal environments. The Office on Disability is working with the Federal Coordinated Health Care Office is working on shared savings methodologies that would align the incentives between Medicaid and Medicare to promote improvements in the quality, coordination and costs of care for dual eligibles. Immediate opportunities include initiatives related to health homes, care transitions and hospital readmissions.

Funding History

FY 2008	$779,000
FY 2009	$805,000
FY 2010	$864,399
FY 2011	$862,000
FY 2012	$1,098,000

Budget Request

The Office on Disability's FY 2013 Budget is $1,100,000, an increase of $2,000 over the FY 2012 Enacted level. The Budget for the Office on Disability provides cost effective support to the Secretary and Department's disability initiatives and programs. Moreover, the Office on Disability must effectively monitor work being lead by various agencies within the Department to streamline processes and avoid redundant efforts. Finally, the Office on Disability plays an instrumental role for HHS by working closely with agencies in the Department that have program authority for existing health care programs and related services benefiting people with disabilities.

OFFICE OF GLOBAL AFFAIRS

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	6,329	6,438	6,000	-438
FTE	22	23	23	0

Authorizing Legislation:
FY 2013 Authorization……………………….……………………………………………………..……Indefinite
Allocation Method……………………………………………………………………….…………….Direct Federal

Program Description and Accomplishments

The Office of Global Affairs (OGA) promotes the health of the world's population by advancing HHS's global strategies and partnerships and working with HHS Divisions and other U.S. Government agencies in the coordination of global health policy, security and programs.

Much of what HHS does domestically has international impact and connections. Likewise, health issues around the world offer opportunities for U.S. leadership, collaboration and benefit. OGA is the lead coordinating Office in making those global health connections.. It performs these duties for the HHS Secretary and for the HHS Operating and Staff Divisions (OPDIVS / STAFFDIVS). OGA provides policy advice to the Secretary, and HHS senior leaders in the areas of international health, family, and social affairs, including health diplomacy in support of U.S. foreign policy. OGA is the Department's key link in advancing U.S. foreign affairs priorities.

To accomplish this mission, OGA has an international relations division containing regionally focused branches, and a policy and programs division comprising a policy branch, an agency coordination branch, as well as additional programmatic branches. The international relations division has health attachés in six countries and personnel on the U.S. – México border.

HHS can be most effective outside the borders of the United States by partnering with others to maximize impact and sustainability of global health efforts. Among the key actors with which HHS engages are:

- *U..S. Government Agencies:* Key partners are the U.S. Agency for International Development (USAID), the Department of State (DOS), the Department of Defense (DOD) and other agencies engaged globally to improve healthy lives, development, health security, food and drug safety and security, nutrition and environmental health.
- *National Governments*: HHS has long-standing peer-to-peer relationships with more than 190 national Ministries of Health and scientific and regulatory agencies. As our goals abroad require cooperation beyond the health sector, HHS also engages counterpart and relevant authorities in related fields.
- *Multilateral Organizations:* Key health-related agencies include the World Health Organization (WHO) and its regional offices, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund); the Joint United Nations Program on HIV/AIDS (UNAIDS); the United Nations Children's Fund (UNICEF); and the World Bank.
- *Civil Society and Non-Governmental Groups:* Global health is the textbook example of a national priority in which government and non-government actors need to agree on goals, share information, harmonize their actions and learn from each other. International humanitarian service organizations, academic institutions, private philanthropies, civil society and private sector organizations as well as

advocacy groups that conduct research, operate programs, and raise awareness and funding for specific health concerns are essential partners.

In FY 2011, OGA deployed one new health attaché to Brazil, which is at the center of diplomatic issues relating to intellectual property protection, food and drug safety, and international cooperation. This new position, along with HHS attachés in China, India, South Africa and Geneva makes clear OGA's engagement with emerging global powers on health issues in support of Department and Administration bilateral and multilateral priorities.

These interactions require international travel in order to engage these bilateral and multi-lateral organizations to meet the OGA mission objectives

Funding History

FY 2008	$3,951,000
FY 2009	$6,451,000
FY 2010	$6,350,000
FY 2011	$6,329,000
FY 2012	$6,438,000

Budget Request

The FY 2013 Budget for the Office of Global Affairs (OGA) of $6,000,000 is a decrease of $438,000 from the FY 2012 Enacted level. This decrease is offset by a reduction in FTE realized through a re-alignment of the executive office administrative functions creating more efficient and effective resource utilization and task allocation.

HHS and its agencies devote more than $3 billion annually to global health efforts. As the Secretary's central coordinator for this wide range of activities, OGA's request is directly tied to the execution of the President's $63 billion Global Health Initiative; to the Administration's Global Health Security efforts; and to the expansion of global health diplomacy activities.

Within the past year OGA filled positions in the Policy and Program Coordination Division, to take the lead in defining and addressing critical policy issues (biosecurity, emerging threats, trade, and Intellectual Property) and conducting bilateral and multilateral negotiations to further the U.S. position on these issues. Funding has supported the full development of the Global Health Strategy, which will enable a thorough alignment and rationalization of HHS activities in furthering a policy-driven whole-of-government approach to global health.

Funding has also supported the Global Health Diplomacy program which assists countries in this hemisphere to strengthen health systems, improving prevention, detection and treatment of diseases of public health importance.

OGA continues to inform and contribute to scaling up promising activities even without accompanying budget increases. OGA remains the Department's focal point for the development and coordination of international policy.

Initiatives

U.S. – Mexico Border Health Commission

The United States México Border Health Commission (USMBHC), established as a binational entity in 2000, provides international leadership to optimize health and quality of life along the United States–

México border. Its primary goals are to institutionalize a U.S. domestic focus on border health, and create an effective binational venue to address the public health challenges that impact border populations in sustainable and measurable ways. The Office of Global Affairs is the Secretary's focal point of coordination for the USMBHC; and the HHS Secretary is the Commissioner for the U.S. Section.

The USMBHC promotes:

(1) Sustainable partnerships which engage international, federal, state and local public health entities in support of strategic border health priorities for FY 2012 - 2013. The priority areas include: Tuberculosis, obesity, Diabetes, infectious disease and public health emergencies, strategic planning, access to care, research, data collection, and academic alliances. The USMBHC leverages public and private resources through these partnerships.

(2) The development of a comprehensive border health research agenda to inform policy makers, researchers and entities which fund research where research gaps, needs and opportunities lay;

(3) The annual National Infant Immunization Week/Vaccination Week of the Americas (NIIW/VWA) that promotes the benefits of infant immunization in an approach unmatched by any region anywhere in either country. Annual Border Binational Health Week events along the entire U.S.-México border bring together local communities for health screenings, health education interventions, training and education.

In Fiscal Year 2012, the Commission will host binational forums on infectious disease coordination and cooperation; on tuberculosis through the newly established Border TB Consortium, with added focus on multi-drug resistant tuberculosis and a special added sub-group on legal issues surrounding interstate and binational co-management of tuberculosis cases.

USMBHC OUTPUTS AND OUTCOMES TABLE

Program/Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
1.1: Reduce the percent of indirect spending on border health activities (Efficiency)	FY 2010: 3.6% (Target Exceeded)	6%	Maintain	Maintain
1.2: The percentage of Healthy Border 2010 population level health outcome objectives with baseline data that have been achieved. (Outcome) (New Measure 2008)	FY 2009: 5.3% (19 of 21 with baseline; 1 obj. achieved) (Using 2003, 2004 & 2005 data and reported in the Healthy Border 2010 Midterm Review published in 2009) (Target Unmet)	50%	Maintain	Maintain
1.3: The incidence of tuberculosis cases per 100,000 inhabitants on the U.S. side of the border. (Outcome)	FY 2009: 10.3 (2003 data) (Target Unmet)	8	Maintain	Maintain
1.4: The incidence of HIV cases per 100,000 inhabitants on the U.S. side of the border. (Outcome)	FY 2009: 4.1 (2004 data) (Target Exceeded)	4.2	Maintain	Maintain
1.5: The diabetes death rate per 100,000 inhabitants on the U.S. side of the border (Outcome)	FY 2009: 26.8 (2005 data) (Target Unmet)	23.7	N/A	N/A
1.6: The number of U.S. border residents who receive public health education or health screenings during Border Binational Health Week (BBHW) celebrated on both sides of the U.S.-Mexico Border. (Output)	FY 2010: 15,708 (Target Exceeded)	13,000	N/A	N/A
1.7: Cumulative number of health related organizations that have adopted population-level health outcome objective of the BHC-Healthy Border 2010 Strategy into their planning, programming or funding process. (Output) (New Measure-2008)	FY 2008: 57% (Target Unmet) New survey to be conducted in 2010.	100%	Maintain	Maintain

OFFICE OF INTERGOVERNMENTAL and EXTERNAL AFFAIRS

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	9,688	9,831	10,600	769
FTE	42	48	48	0

Authorizing Legislation:
FY 2013 Authorization………………………………………………………………………………..…Indefinite
Allocation Method……………………………………………………...……………………………..Direct Federal

Program Description and Accomplishment

The Office of Intergovernmental and External Affairs (I EA) serves the Secretary as the primary link between the U.S. Department of Health and Human Services (HHS) and state, local, territorial and tribal governments and most recently non-governmental stakeholders. The mission of IEA is to facilitate communication regarding HHS initiatives as they relate to state, local, territorial and tribal governments; and non-governmental stakeholders. IEA serves the dual role of representing the state, territorial and tribal perspective in the federal policymaking process as well as clarifying the federal perspective to state, territorial and tribal representatives.

The IEA is composed of a headquarters team that works on policy matters within HHS Operating Divisions and serves as liaison with state, territorial and local governments and related public policy groups and non-governmental stakeholders. In addition to the Headquarters team, IEA has ten regional offices which include the Secretary’s Regional Directors, Executive Officer, Outreach Specialist and an IGA Specialist who is responsible for public affairs, business outreach and media activities. Within the IEA Office of Tribal Affairs, IEA coordinates and manages tribal and native policy issues, assists tribes in navigating through HHS programs and services, and coordinates the Secretary's policy development for Tribes and national Native organizations.

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

The mission and functions of the IEA are to:

- Advise HHS on state, local, territorial and tribal issues:
    - advise Departmental officials on state, local, territorial and tribal perspectives regarding HHS policies and programs.
    - facilitate the coordination and implementation of Administration and Secretarial initiatives at the headquarters, regional, state, tribal, local, territorial and community levels.
    - formulate and recommend Department policies on the delivery of services to states, territories and communities.
    - ensure that HHS services are consistent in approach on state, local, territorial and tribal levels of government.

- Facilitate communication between HHS and state, local, territorial and tribal governments and non-governmental stakeholders.
  - Serve as the Departmental liaison to state, local, territorial and tribal governments and the organizations that represent them.
  - Represent the Secretary and Deputy Secretary in communications with intergovernmental officials of other Federal agencies, officials of state, territorial, tribal and local governments, and non-governmental organizations, including national advocacy groups and national associations that represent state, local, and tribal governments.
  - develops, maintains, and enhances relationships with a wide range of national and non-governmental stakeholders to promote an understanding of HHS policies and activities related to health reform.
- Coordinate the HHS Regional Office.
  - Direct the Regional Directors (RDs) and their offices in their role in planning, development and implementation of Departmental policy.
  - RDs will lead and implement the recommendations and findings of the Secretary's *Regions Together Initiative* which is an effort designed to analyze and improve regional operations across the Department.
  - Serve as point of contact between the SRRs and the Regional Offices.

IEA tracks HHS region-specific, Federal and State legislative actions, and serves as a surrogate for the Secretary and Deputy Secretary in the regions, informing state, local, territorial and tribal officials, the media and public of the Administration's and Department's program initiatives and priorities. IEA provides Departmental leadership in the field in several areas, including all top Secretarial priorities and initiatives. IEA also represents the Secretary and the Deputy Secretary in contacts with officials from other Federal agencies, the White House, state, local, territorial and tribal governments, their representative organizations, and other outside parties; as well as specific representation with non-governmental stakeholders. IEA solicits a full range of viewpoints from stakeholders; including state, local, territorial and tribal officials, district Congressional staffs, business coalitions, interest groups, advocacy groups, the media and other regional constituents to be shared with headquarters and the Office of the Secretary.

Funding History

FY 2008	$5,978,000
FY 2009	$6,244,000
FY 2010	$7,049,000
FY 2011	$9,688,000
FY 2012	$9,831,000

Budget Request

The FY 2013 Budget for IEA is $10,600,000, an increase of $769,000 over the FY 2012 Enacted level. This supports annualized staffing of regional offices that previously had vacant positions.

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

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

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Executive Summary

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	252,560	232,833	112,020	-120,813
FTE	310	269	273	4

Agency Overview

The Office of the Assistant Secretary for Health (OASH), headed by the Assistant Secretary for Health (ASH), is a staff division of the Office of the Secretary in the U.S. Department of Health and Human Services (HHS). OASH provides leadership to the Nation on public health and science, and communicates on these subjects to the American people. The mission of OASH is "mobilizing leadership in science and prevention for a healthier Nation."

OASH consists of 14 essential public health offices – including the Office of the Surgeon General and the U.S. Public Health Service Commissioned Corps – as well as 10 Regional Health Administrators, and 10 Presidential and Secretarial advisory committees. The ASH serves as the senior advisor for public health and science to the Secretary and provides professional leadership on population-based public health and clinical preventive services. OASH coordinates public health policy and programs across the operating and staff divisions of HHS, ensuring the health and well-being of all Americans. In particular, OASH is charged with leadership in development of policy recommendations "on population-based public health and science" and, at the direction of the Secretary, with coordination of "initiatives that cut across agencies and operating divisions" of HHS.

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

OASH has identified three priorities to enhance the health and well-being of the Nation:

1) Creating better systems of prevention
2) Eliminating health disparities and achieving health equity
3) Making *Healthy People* come alive for all Americans.

Creating Better Systems of Prevention

OASH is mobilizing leadership in prevention throughout HHS focusing on many Secretarial and intra-departmental initiatives. Since FY 2010, OASH has led a senior-level Steering Committee for the Prevention of Healthcare-Associated Infections. Healthcare-associated infections (HAIs) are among the leading causes of morbidity and mortality in the U.S. The Steering Committee released the *HHS Action Plan to Prevent HAIs*, which establishes national five-year goals (e.g., a 50 percent reduction in central line-associated bloodstream infections by the end of 2013), and outlines key actions for enhancing and coordinating HHS activities and opportunities for collaboration with external partners. The plan will continue through FY 2013 into its third tier efforts to reduce and prevent HAIs in long-term care facilities.

As the Chair of the HHS Tobacco Control Working Group, OASH developed and released in November 2010 – *Ending the Tobacco: A Tobacco Control Strategic Action Plan.* OASH continues to lead and coordinate the action plan by mobilizing HHS's expertise and resources in support of proven, pragmatic, achievable interventions that can be aggressively implemented at the federal, state, and local level.

In February 2011, OASH unveiled the first update of the 1994 National Vaccine Plan. Despite the success of vaccines in reducing death and disability over the last century, many Americans still suffer from infectious diseases that can be prevented by vaccines. The plan enhances the coordination of all aspects of Federal vaccine and immunization activities, working to ensure that all Americans have access to the preventive benefits of vaccine. It addresses such issues as research and development, supply, financing, distribution, safety, global cooperation, and informed decision-making among consumers and health care providers. The National Vaccine Plan is the product of an extensive stakeholder feedback process, which will include a series of regional meetings and the final implementation plan to be completed by the end of 2011.

In May 2011, OASH released *Combating the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care and Treatment of Viral Hepatitis*. An estimated 3.5-5.3 million persons in the U.S. are living with viral hepatitis; 65%-75% remain unaware and do not receive proper and timely treatment. Viral Hepatitis, which is largely preventable, is the leading cause of liver cancer – 1 in 4 persons without proper care will develop liver cirrhosis or liver cancer. The Viral Hepatitis Action Plan presents robust and dynamic steps for improving the prevention and treatment of Viral Hepatitis.

Eliminating Health Disparities and Achieving Health Equity

Numerous national planning and implementation efforts led by OASH/ promote health equity by raising awareness; strengthening leadership; improving the health care and health system experience for racial, ethnic, gender, and other minorities; improving cultural and linguistic competency; and improving the use of research and evaluation outcomes.

In April 2011, OASH released the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities,* which promotes integrated approaches, evidence-based programs and best practices to reduce health disparities. The leading health indicators have demonstrated little improvement in disparities over the past decade, according to recent analyses of progress on *Healthy People 2010* objectives. The Action Plan enables the Department to continuously assess the impact of all policies and programs on racial and ethnic health disparities, working ultimately to create a nation free of disparities in health and healthcare

Making *Healthy People* Come Alive for All Americans

In FY 2011 OASH launched *Healthy People 2020*. For over 30 years, *Healthy People* has established health goals for the Nation, tracked progress toward meeting targets and aligned national efforts to guide action for public health. The launch marked the release of the new decade's 10-year objectives and targets.

As a part of *Healthy People 2020,* OASH continued its partnership with the Institute of Medicine (IOM) to develop and report on a sub-set of leading health indicators. The IOM report, *Leading Health Indicators for Healthy People 2020*, singles out 12 indicators as immediate, major health concerns that should be monitored and 24 objectives that warrant priority attention in the plan's implementation. The report updates and expands on the 10 leading health indicators that served as priorities for *Healthy People 2010*.

Discussion of Strategic Plan

The following three goals and associated objectives and strategies are the methods to reach the vision which states: The OASH sees a Nation in which healthy people live in healthy communities, sustained by effective, efficient, and coordinated public health systems.

Over the next four years, OASH leadership will concentrate resources and management efforts on achieving these goals:

Goal 1: Prevention – Creating better systems of prevention

Goal 2: Disparities – Eliminating health disparities and achieving health equity

Goal 3: Public Health Infrastructure – Making Healthy People come alive for all Americans

As a framework, this Plan is specific enough to fit within the more expansive goals of the HHS Strategic Plan. This framework also remains sufficiently broad that programs and activities of individual OASH offices will fit within the structure.

Discussion of OASH Performance Plan

Associated with each of the three goals are five objectives:

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

They are complex national challenges and reach beyond the control and responsibility of the Federal government. Achievement is dependent on various health programs and providers, all levels of government, and the efforts of the private sector as well as individual contributions. In some instances, OASH's contributions act as a catalyst for action; in other instances OASH provides the leadership and "glue" that makes the difference in collective efforts.

Specific strategies associated with each goal and each objective further define the actions OASH will take today and in the future to ultimately reach the vision. The three goals will be achieved through implementation of the explicit strategies which follow.

Goal 1: Creating better systems of prevention

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

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

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

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

Objective B: Communicate Strategically

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

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

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

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

Objective C: Promote Effective Partnerships

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

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

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

Objective D: Build a Stronger Science Base

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

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

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

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

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

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

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

Strategy 1.E.4: Lead the *President's Council on Physical Fitness & Sports (PCPFS)* in efforts to significantly increase physical activity in this country.

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

Goal 2: Eliminating health disparities and achieving health equity

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

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

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

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

Objective B: Communicate strategically

Strategy 2.B.1: Ensure that the *Office on Women's Health Resource Center* and the *Office of Minority Health Resource Center* become the nation's pre-eminent gateways for women's health and minority health information.

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

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

Objective C: Promote effective partnerships

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

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

Objective D: Build a stronger science base

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

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

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

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

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

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

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

Goal 3: Making Healthy People come alive for all Americans

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

Strategy 3.A.1: Promote emergency preparedness by strengthening the capacity and capability of Medical Reserve Corps (MRC) units in local communities across the country.

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

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

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

Objective B: Communicate strategically

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

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

Objective C: Promote effective partnerships

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

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

Objective D: Build a stronger science base

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

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

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

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

Strategy 3.E.1: Ensure the Commissioned Corps is a mobile, organized, ready, and responsive force that ensures the preparedness of the Nation for emergency response.

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

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

Strategy 3.E.4: Lead HHS initiatives to enhance transfusion and transplantation safety and to improve blood availability through collaboration and coordination with relevant stakeholders internal and external to HHS.

OASH revised some of its performance measures for FY 2012 to improve the usefulness of its performance data, and create a stronger alignment between the specific program and budgetary decision making. Such changes in measures are designed to improve program stewardship and accountability and increase program transparency.

Outputs and Outcomes

Long Term Objective: Creating better systems of prevention.

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
1.a: Shape policy at the local, State, national and international levels (Outcome)	FY 2011: 25882 (Target Not Met)	35200	23350	-11,850
1.b: Communicate strategically (Outcome)	FY 2011: 60,136,573 (Target Exceeded)	38,270,500	34,849,240	-3,421,260
1.c: Promote effective partnerships (Outcome)	FY 2011: 480 (Target Not Met)	960	860	-100
1.d: Strengthen the science base (Outcome)	FY 2011: 298 (Target Exceeded)	340	370	+30
1.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome)	FY 2011: 116 (Target Not Met)	575	170	-405

Long Term Objective: Eliminating health disparities and achieving health equity

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
2.a: Shape policy at the local, State, national and international levels (Outcome)	FY 2011: 83 (Target Not Met)	130	220	+90
2.b: Communicate strategically (Outcome)	FY 2011: 153,770,257 (Target Exceeded)	2,232,180	2,250,200	+18,020
2.c: Promote Effective Partnerships (Outcome)	FY 2011: 219 (Target Exceeded)	330	320	-10
2.d: Strengthen the science base (Outcome)	FY 2011: 21 (Target Not Met)	1600	170	-1,430
2.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome)	FY 2011: 83 (Target Exceeded)	60	60	Maintain

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

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
3.a: Shape policy at the local, State, national and international levels (Outcome)	FY 2011: 1,052 (Target Exceeded)	1,020	1,100	+80
3.b: Communicate strategically (Outcome)	FY 2011: 8,865,817 (Target Exceeded)	1,444,660	2,095,600	+650,940

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
3.c: Promote Effective Partnerships (Outcome)	FY 2011: 381 (Target Exceeded)	485	470	-15
3.d: Strengthen the science base (Outcome)	FY 2011: 382 (Target Not Met)	1,940	420	-1,520
3.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome)	FY 2011: 265 (Target Not Met)	6,234	6,220	-14

FY2012-FY2013 High Priority Performance Goal

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
1.4 Reduce annual adult's cigarette consumption in the United States (per capita) (Outcome)	FY 2010: 1,281.0 Target: 1,281.0 (Baseline)	1,150.0	1,062.0	-88

OASH Summary Table - Direct

(Dollars in Thousands)

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Budget Request	
OASH:	FTE	Amount	FTE	Amount	FTE	Amount
Immediate Office of the Assistant Secretary for Health	52	$12,495	55	$13,475	55	$18,100
Office of HIV AIDS Policy	8	$1,429	6	$1,497	9	$1,300
Office of Disease Prevention and Health Promotion	23	$7,200	23	$7,186	23	$6,800
President’s Council on Fitness, Sports and Nutrition	6	$1,225	7	$1,248	8	$1,100
Office for Human Research Protections	33	$6,949	33	$6,937	33	$6,600
National Vaccine Program Office	17	$6,839	17	$6,837	17	$6,500
Office of Adolescent Health	3	$1,098	4	$1,098	4	$1,000
Public Health Reports	2	$448	2	$499	2	$400
Subtotal, OASH Non-PPA	144	$37,683	147	$38,777	151	$41,800
OASH PPAs						
Adolescent Family Life	12	$12,449	-	-	-	-
Teen Pregnancy Prevention	17	$104,790	16	$104,592	-	-
Office of Minority Health	63	$55,888	63	$55,782	63	$41,100
Office on Women’s Health	43	$33,679	43	$33,682	43	$29,120
Commissioned Corps Initiatives	31	$8,071	-	-	-	-
Subtotal, OASH PPAs	166	$214,877	122	$194,056	106	$70,220
Other GDM						
Office of Research Integrity (non add)	24	$9,027	24	$9,027	24	$9,027
Healthcare-associated Infections	2	$1,542	-	-	-	-
HIV-AIDS in Minority Communities	-	$53,783	-	$53,681	-	-
Embryo Adoption Awareness Campaign	-	$2,004	-	$1,996	-	-
Subtotal, Other GDM	2	$57,329	0	$55,677	0	$0
Total, GDM	**312**	**$309,889**	**269**	**$288,510**	**257**	**$112,020**
Prevention & Public Health Fund						
Teen Pregnancy Prevention	-	-	-	-	16	$104,790
Subtotal, PPHF	0	$0	0	$0	16	$104,790
PHS Evaluation Set-Aside						
OASH	-	$4,510	-	$4,510	-	$4,285
Teen Pregnancy Prevention Initiative	-	$4,455	-	$8,455	-	$4,232
HIV AIDS in Minority Communities	-	-	-	-	-	$53,891
Subtotal, PHS	0	$8,965	0	$12,965	0	$62,408
GRAND TOTAL	**312**	**$318,854**	**269**	**$301,475**	**273**	**$279,218**

OASH
IMMEDIATE OFFICE
Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	12,495	13,475	18,100	4,625
FTE	52	55	55	0

Authorizing Legislation……………………...……………...Title III, Section 301 of the Public Health Service Act
FY 2013 Authorization……………………………………….....………………………………………Indefinite
Allocation Method……………………………………………...…………………………………...Direct federal

Program Description and Accomplishments
The Office of the Assistant Secretary for Health (OASH) is under the direction of the Assistant Secretary for Health (ASH), who serves as the senior advisor to the Secretary on issues of public health and science. The Immediate Office of the ASH serves as the focal point for leadership and coordination across the Department in public health and science, provides advice and counsel to the Secretary, and provides direction to policy offices within OASH.

The OASH mission is to mobilize leadership in science and prevention for a healthier Nation. Senior public health officials within OASH ensure a public health perspective on all Secretarial and Presidential priorities by establishing and strengthening effective networks, coalitions, and partnerships that identify public health concerns and undertake innovative projects that solve them. Three key priorities established by the ASH provide a framework for addressing public health concerns:

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

Creating better systems of prevention
OASH mobilizes leadership in prevention throughout HHS by coordinating many Secretarial and inter- and intra-departmental initiatives. Coordinating the activities of Federal partners will enable HHS to leverage the scientific, evaluative, or programmatic findings of one agency for replication and dissemination through other agencies.

Eliminating health disparities and achieving health equity
Numerous national planning and implementation efforts led by the ASH and other OASH senior staff promote health equity by raising awareness; strengthening leadership; improving the health care and health system experience for racial, ethnic, gender, and other minorities; improving cultural and linguistic competency; and improving the use of research and evaluation outcomes. Implementing these plans will have impact in areas such as improving adolescent health and reducing teen pregnancy; addressing care and prevention related to chronic viral hepatitis; and using health information technology to reduce health disparities.

Making Healthy People come alive for all Americans
OASH launched *Healthy People 2020*, marking the release of the new decade's 10-year objectives and targets. For over 30 years, *Healthy People* has established health goals for the Nation, tracked progress toward meeting targets, and aligned national efforts to guide action for public health. *Healthy People* offers an opportunity to assess health status in a host of focus areas and objectives. A new, user-centered website, with an up-to-date library of best practices and community planning tools has been unveiled for

Healthy People 2020. This will continue the efforts of the Department to make data available at the community level will advance the goal of making *Healthy* People come alive for all Americans.

OASH has led many Department-wide initiatives achieving the three priority goals mentioned above and fulfilling the OASH mission. For instance, since FY 2010, OASH has continued to lead a senior-level Steering Committee for the Prevention of Healthcare-Associated Infections and developed the HHS Action Plan to Prevent HAIs, which establishes national five-year goals (e.g., a 50 percent reduction in central line-associated bloodstream infections by the end of 2013), and outlines key actions for enhancing and coordinating HHS activities and opportunities for collaboration with external partners. The plan will continue through FY 2013 into its third tier efforts to reduce and prevent HAIs in long-term care facilities.

In February 2011, OASH unveiled the first update of the 1994 National Vaccine Plan. The plan enhances the coordination of all aspects of Federal vaccine and immunization activities, working to ensure that all Americans have access to the preventive benefits of vaccine. The National Vaccine Plan is the product of an extensive stakeholder feedback process, which will include a series of regional meetings and the final implementation plan to be completed by the end of 2011.

In April 2011, OASH released the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities,* which promotes integrated approaches, evidence-based programs and best practices to reduce health disparities. The Action Plan enables the Department to continuously assess the impact of all policies and programs on racial and ethnic health disparities, working ultimately to create a nation free of disparities in health and healthcare

In May 2011, OASH released *Combating the Silent Epidemic of Viral Hepatitis: Action Plan for the Prevention, Care and Treatment of Viral Hepatitis*. An estimated 3.5-5.3 million persons in the U.S. are living with viral hepatitis; 65%-75% remain unaware and do not receive proper and timely treatment. Viral Hepatitis, which is largely preventable, is the leading cause of liver cancer – 1 in 4 persons without proper care will develop liver cirrhosis or liver cancer. The Viral Hepatitis Action Plan presents robust and dynamic steps for improving the prevention and treatment of Viral Hepatitis

Funding History

FY 2008	$7,927,000
FY 2009	$8,820,000
FY 2010	$9,495,000
FY 2011	$12,495,000
FY 2012	$13,475,000

Budget Request

The FY 2013 Budget of $18,100,000 is $4,625,000 more than FY 2012 Enacted level. The Budget solidifies the ASH's responsibility as the senior advisor to the Secretary on public health and science by addressing several highly visible public health needs such as: the Action Plan for the Prevention and Treatment of Viral Hepatitis (APPTVH); foster greater coordination among the various HHS entities to develop and implement a new Environmental Justice Strategic Plan; coordinate the implementation of HHS's *Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan*; and enhance the healthcare workforce to best support healthcare-associated infection prevention activities through innovative approaches. The FY 2013 Budget will solidify funding for the Office of the Surgeon General to provide leadership for the Public Health Service's Commissioned Corps.

OASH
NATIONAL VACCINE PROGRAM OFFICE

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	6,839	6,837	6,500	-337
FTE	17	17	17	0

Authorizing Legislation…..…………………………..……………….Title XXI of the Public Health Service Act
Authorization…………………………………….....…...…..………………………………………….Expired
Allocation Method…….……….…...…………………….………………………...Direct federal; Contracts

Program Description and Accomplishments

The National Vaccine Program Office (NVPO) was created by Congress in 1987, to provide leadership and coordination among Federal agencies as they work together to carry out the goals of the National Vaccine Plan. The development of this plan was mandated in P.L. 99-660. The Plan includes goals, objectives, and strategies for pursuing the prevention of infectious diseases through immunization. The five goals of the National Vaccine Plan are to:

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

NVPO coordinates interaction between the HHS agencies and across the federal government (DoD, VA, USDA and USAID) and interacts with stakeholders through regular communication on issues including vaccine research and development, vaccine coverage, vaccine supply, vaccine financing, vaccine safety, education and communications, and international vaccine and immunization initiatives. NVPO advances the Secretary's priority on prevention and health promotion by enhancing the vaccine enterprise. Highlights include:

- *Coordination and Implementation of the National Vaccine Plan.* The National Vaccine Plan identifies priority activities to improve the safety and effectiveness of disease prevention through immunization. In 2011, NVPO coordinated a revision of the Plan (initially published in 1994) with all relevant agencies and offices in HHS, and with the Departments of Defense (DoD) and Veterans Affairs (VA), and the U.S. Agency for International Development (USAID). NVPO is currently coordinating the development of an implementation plan which will be released in late 2011.

- *National Vaccine Advisory Committee (NVAC).* NVPO serves as Executive Secretariat for NVAC which advises and makes vaccine-related recommendations to the ASH. NVAC meets at a minimum of three times per year and is supported by NVPO.

- *Seasonal Influenza Coordination.* NVPO leads an interagency effort across HHS OPDIVs and other Federal agencies to coordinate seasonal influenza vaccine delivery. Key activities include assessing current activities, identifying gaps and disparities in vaccination, and assuring coordination across agencies so federal resources are used effectively.

- *Coordination and Enhancement of Immunization Safety.* In April 2008, the Secretary formed a cross-government, Federal Immunization Safety Task Force. The Task Force includes HHS OPDIVs with assets in immunization safety (NIH, FDA, CDC, HRSA, CMS, IHS) and VA and DoD and led by the Assistant Secretary for Health. It is charged with: Ensuring that all federal assets relevant to immunization safety are coordinated and synergies identified; coordinating vaccine safety strategic planning, including development of a vaccine safety scientific agenda; and ensuring a coordinated response to emerging immunization safety issues.
- *Adult Immunization.* NVPO coordinates efforts across federal and non-federal partners to improve delivery and coverage for adult vaccines. Key activities include co-chairing with CDC and AMA the first National Adult Immunization Summit to facilitate action by partners on identified interventions toward sustainable gains in adult immunizations.

- *Pandemic Influenza Preparedness.* NVPO provides scientific direction to HHS pandemic influenza planning and preparedness activities coordinating with the Office of the Assistant Secretary for Preparedness and Response, HHS OPDIVs, and other Federal agencies. Key activities include developing national guidance on prioritization of pandemic and pre-pandemic influenza vaccines, guidance on antiviral drug use strategies, and coordination in updating the HHS pandemic influenza preparedness and response plan.

- *Vaccine Financing.* NVPO coordinates interagency and external partners on vaccine financing. In 2011, an interagency working group on Vaccine Financing and Immunization Access was formed to facilitate awareness of and coordinate agency efforts on vaccine access and financing of delivery, focusing on public and private insurance programs.

- *Vaccine Communications*. NVPO works with HHS OPDIVs and STAFFDIVs to ensure that communications strategies and tactics are well coordinated and leveraged to the fullest extent possible. Key activities include operating Vaccines.gov, supporting short-term and long-term public education activities, establishing and maintaining strong working relationships with communications staff from across the Department, and providing strategic counsel to senior leadership on key programs and initiatives relating to vaccines and immunization

Funding History

FY 2008	$6,781,000
FY 2009	$6,879,000
FY 2010	$6,839,000
FY 2011	$6,839,000
FY 2012	$6,837,000

Budget Request

The FY 2013 Budget of $6,500,000 is a reduction of $337,000 from the FY 2012 Enacted level. NVPO will reduce operational costs to maintain the current level of services and programs, and this will generate additional savings by focusing on high priority areas, phasing out lower priority activities, and focusing on the core activity of inter-agency coordination.

The NVPO budget will focus on immunization activities consistent with the Assistant Secretary for Health's priorities, implementing the 10 priorities in the recently released (February 2011) National Vaccine Plan, inter-agency coordination of seasonal influenza vaccination, and increasing the reach of

messages and information about the benefits and risks of vaccination. Through this work NVPO will accomplish progress towards each of the 10 priorities in the National Vaccine Plan, a 10% increase in the number of visitors to Vaccines.gov, and a 3% increase in the number of high risk adults age 18-64, pregnant women, and health care personnel who are vaccinated against seasonal influenza

OASH
OFFICE OF ADOLESCENT HEALTH

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	1,098	1,098	1,000	-98
FTE	3	4	4	0

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

Program Description and Accomplishments

The Office of Adolescent Health (OAH) is responsible for coordinating the activities of the Department with respect to adolescent health, including program design and support, evaluation, trend monitoring and analysis, research projects, and training of healthcare professionals. OAH is charged with carrying out demonstration projects to improve adolescent health as well as implementing and disseminating information on adolescent health. OAH coordinates with other HHS agencies to reduce the health risk exposure and risk behaviors among adolescents, placing particular emphasis on the most vulnerable populations (i.e., those in low socio-economic areas and areas where adolescents are likely to be exposed to emotional and behavioral stress).

OAH administers the Teen Pregnancy Prevention discretionary grant program to support evidence-based and innovative approaches to teen pregnancy prevention. OAH coordinates its efforts with other HHS offices and OPDIVs to make competitive grants to public and private entities to fund medically accurate and age appropriate programs that reduce teenage pregnancy. In FY 2010, OAH issued joint funding opportunity announcements with both the ACF's Personal Responsibility Education Program and the CDC's Safe Motherhood Program. The Secretary has designated Reducing Teen and Unintended Pregnancy as one of the Key Inter-agency Collaboration areas. Additionally, OAH manages the Pregnancy Assistance Fund, a program of competitive grants to States and Tribes to support pregnant and parenting teens and women, as authorized by the Affordable Care Act (ACA). Currently, the program supports 17 grants to States and Tribal organizations.

OAH leads the HHS Adolescent Health work group, which brings together representatives from across the Department to strategically plan across adolescent health and related programs.

Funding History

FY 2008	$0
FY 2009	$0
FY 2010	$500,000
FY 2011	$1,098,000
FY 2012	$1,098,000

Budget Request

The FY 2013 Budget of $1,000,000 is a reduction of $98,000 from the FY 2012 Enacted level. OAH will reduce operational costs to maintain the current level of services and programs.

OASH
OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	7,200	7,186	6,800	-386
FTE	23	23	23	0

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

Program Description and Accomplishments

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

Healthy People
ODPHP meets its Congressional mandate to establish health goals for the Nation by leading the development and implementation of *Healthy People* for the last 30 years. *Healthy People* provides science-based, 10-year national objectives for improving the health of all Americans, which underpin many of HHS' priorities and strategic initiatives and provide a framework for prevention and wellness programs for a diverse array of Federal and non-Federal stakeholders. The updated health objectives for the next decade were released in December 2010 with *Healthy People 2020.*

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

In FY 2011, ODPHP continued the development of the online version of *Healthy People 2020* aimed at making *Healthy People* 2020 come alive to all Americans. ODPHP collaborated with the National Center for Health Statistics and other partners in designing a user-centric, web-based resource that will expand the reach and usefulness. This new website will give users a platform from which to learn, collaborate, plan, and implement objectives. Version 1.0 of the site was launched in FY 2011; version 2.0 is planned for release in FY 2012.

In FY 2012, ODPHP released the Leading Health Indicators (LHI). Selected from among the Healthy People 2020 objectives, the LHIs will be used to communicate high-priority health issues and actions that can be taken to address them.

Dietary Guidelines for Americans
ODPHP plays a leadership role on behalf of HHS in co-coordinating the development, review, and promotion of the recommendations from the *Dietary Guidelines for Americans* (DGAs) as required by Congress (P.L. 101-445). Published jointly every five years by HHS and the U.S. Department of

Agriculture (USDA), the DGAs are the basis of Federal nutrition policy and programs. Based on the preponderance of current scientific evidence, the DGAs provide information and advice for choosing a nutritious diet that will reduce the risk of chronic disease, meet nutrient requirements, maintain a healthy weight, and keep foods safe to avoid food-borne illness. They also serve as the basis of the nutrition and food safety objectives in *Healthy People 2020* and support the Secretary's initiative to Help Americans Achieve and Maintain Healthy Weight.

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

Physical Activity Guidelines for Americans

ODPHP, in collaboration with the President's Council on Fitness, Sports, and Nutrition, NIH, and CDC, led the Department's development and release of the first-ever comprehensive Federal Physical Activity Guidelines (PAG), a set of evidence-based recommendations for types and amounts of physical activity for individuals 6 years and older to improve health and reduce disease. The PAGs served as the primary basis for physical activity recommendations of the 2010 DGA and the physical activity objectives in *Healthy People 2020* as well as support for the Secretary's initiative to Help Americans Achieve and Maintain Healthy Weight.

In FY 2011, ODPHP continued to focus on outreach by coordinating and managing the online Physical Activity Supporters Network (over 4,500 members), offering webinars, developing a new PAG blog, and developing consumer information for the Hispanic population. In addition, ODPHP coordinates the review of consumer information to be published by the Department related to physical activity to ensure that materials are consistent with the evidence-based messages of the PAGs. The PAG collaborators within the Department are planning a substantial communication campaign at the end of FY 2012 that reminds Americans of the recommended levels of physical activity for health promotion and disease prevention.

National Health Information Center

ODPHP is congressionally mandated to provide reliable prevention and wellness information to the public through the National Health Information Center. ODPHP supports four websites: Healthfinder.gov, Healthypeople.gov, Health.gov, and the ODPHP website. Collectively, these websites had 17 million visits in FY 2011.

healthfinder.gov.

Since 1997, healthfinder.gov has received numerous awards as a key resource for finding the best government and non-profit online health information. In FY 2011, healthfinder.gov extended the reach of actionable prevention information by disseminating content via Twitter, widgets, and e-cards. The healthfinder® Twitter following grew from 3,000 to over 140,000 in one year. A Facebook page was launched at the beginning of FY 2012.

The Quick Guide to Healthy Living

A key feature of healthfinder.gov, uses everyday language and examples to explain how taking small steps to improve health can lead to big benefits; 40 new Quick Guide to Healthy Living topics and tools were recently added. A Spanish version of healthfinder.gov was launched in the fall of 2011. The website also includes the **myhealthfinder** tool, developed in a joint effort with AHRQ, to provide personalized recommendations for clinical preventive services from the U.S. Preventive Services Task Force and the Bright Futures Guidelines for preventive services for children. This interactive tool

provides personalized decision support for all of the preventive services covered under the Affordable Care Act. In FY 2010, healthfinder.gov launched a content syndication program and tool that provides a way for healthfinder® content to be placed onto other website; healthfinder.gov content has been placed on other sites approximately 18,000 times in FY 2011.

Funding History

FY 2008	$7,106,000
FY 2009	$7,232,000
FY 2010	$7,200,000
FY 2011	$7,200,000
FY 2012	$7,186,000

Budget Request

The FY 2013 Budget of $6,800,000 is $386,000 less than the FY 2012 Enacted level. The FY 2013 Budget will reduce operational costs to maintain the current level of services and programs. The FY 2013 Budget decrease will be accomplished by consolidating existing contracts, decreasing some of the contract management costs, and reducing meeting support, publications development, and media relations.

The budget will be used to initiate, coordinate, and support disease prevention and health promotion activities, programs, policies, and information as outlined above for HHS through collaboration with HHS agencies, other Departments, and a wide variety of non-Federal partners. Almost 40% of the current budget is used to contract for support in the development and implementation of *Healthy People*, Dietary Guidelines, Physical Activity Guidelines, and the National Health Information Center products and services.

ODPHP supports the Administration's Open Government initiative by applying plain language and health literacy principles to translation of prevention science and policy so that it is transparent and easy to use for all Americans. Additionally, OPHP's Open Data program publishes datasets and content produced via content syndication and encourages developers and health professionals to build solutions using the data and tools.

All of the major products of the office, websites, social media, and other outreach activities will be continued. The support for their development and implementation will be prioritized to remain within the appropriated budget. Many of the current activities of ODPHP are supported by PHS Evaluation Funds on an annual, non-recurring basis; this level of support will continue to be sought.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
I.a. Awareness of Dietary Guidelines for Americans (will be measured at least two times between 2005 and 2010) (Outcome)	FY 2007: 45% Target: 39% (Target Exceeded)	Maintain	Maintain	Maintain
I.b Visits to ODPHP-supported websites (Output)	FY 2011: 17.27 Million Target: 16 Million (Target Exceeded)	17.6 Million	17.85 Million	+0.25
I.c Consumer Satisfaction with healthfinder.gov, measured every three years at a minimum (Output)	FY 2010: 76% Target: 78% (Target Not Met but Improved)	78%	80%	+2
II.a Percentage of States that use the national disease prevention and health promotion objectives in their health planning process (Outcome)	FY 2011: 100% Target: 99% (Target Exceeded)	25% [2]	35% [3]	+10

Program Data Chart

Activity	FY 2011 Actual	FY 2012 Enacted	FY 2013 Request
Contracts			
National Health Information Center	1,658,000	1,658,000	1,658,000
Communication Support	700,000	700,000	300,000
Subtotal, Contracts	2,358,000	2,358,000	1,958,000
Grants/Cooperative Agreements			
Disease Prevention and Health Promotion Scholarship Program	400,000	400,000	400,000
Subtotal Grants/Coop	400,000	400,000	400,000
Inter-Agency Agreements (IAAs)			
Performance measures collection, outreach management, website infrastructure	111,000	111,000	111,000
Operating Costs	4,331,000	4,317,000	4,331,000
Total	**7,200,000**	**7,186,000**	**6,800,000**

[2] The FY2012 target reflects the FY 2011 launch of Healthy People 2020. All previous years & targets apply to Healthy People 2010. Based on OMB comments in the 2012 OPA, ODPHP increased this target to 25%.

[3] The FY2013 target reflects the FY 2011 launch of Healthy People 2020. All previous targets apply to Healthy People 2010.

OASH
OFFICE OF HIV/AIDS POLICY

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	1,429	1,497	1,300	-197
FTE	8	6	9	3

Authorizing Legislation……………………….……………Title III, Section 301 of the Public Health Service Act
FY 2013 Authorization……………………………….……………………………………………………Indefinite
Allocation Method…………………………………………….……………………………………Direct Federal

Program Description and Accomplishments

The HHS Secretary has delegated the ASH responsibility for coordinating, integrating, and directing the Department's policies, programs, and activities related to HIV/AIDS and viral hepatitis. The Office of HIV/AIDS Policy (OHAP) works with the ASH to meet HHS' needs by supporting its mission and goals in the following areas:

- Providing strong, responsive, and accountable administrative structure to HIV/AIDS related issues for OASH and OS to ensure the success of the Department's HIV/AIDS programs, policies, and activities, while maintaining fiscal accountability and promoting sound evaluation.
- OHAP develops and/or shares policy information and analysis to the Department's OPDIVs and STAFFDIVs. OHAP ensures that senior Department officials are fully briefed on HIV/AIDS-related matters and that they are able to provide information on HIV/AIDS policies, programs, and activities to the White House or to members of Congress. With both internal and external partners, OHAP promotes awareness, understanding, and implementation of HHS policies on HIV/AIDS.
- Supporting Department-wide planning, internal assessments, and evaluation activities covering such areas as hepatitis screening, HIV testing, technical assistance, prevention strategies, and gaps in necessary HIV/AIDS services. In working with all OPDIVs and STAFFDIVs OHAP seeks areas for collaboration, proper alignment of resources, elimination of redundancy, and filling of vital gaps and recommendations on best practices.
- Coordinating the implementation of the Action Plan for the Prevention, Care & Treatment of Viral Hepatitis (Viral Hepatitis Action Plan) within HHS and across other Federal Departments. Successful implementation of the Action Plan will promote improved coordination and integration of existing activities, as well as needed policy- and system changes.

On July 13, 2010 the White House released The National HIV/AIDs Strategy (NHAS) and the Federal Implementation Plan. A Presidential Memorandum to the Heads of Executive Departments and Agencies identified HHS as responsible for coordinating HIV/AIDS-related programs and activities across other Federal Departments. HHS and the other lead Federal agencies submitted detailed operational plans to the Office of National AIDS Policy and OMB 150 days after the release of the NHAS (December 9, 2010). The Implementation Plan identifies specific tasks and activities that HHS must perform through calendar year 2015. These activities include on-going coordination efforts, budget and program analysis, policy development, and meetings and consultations with subject matter experts, professional health and science organizations, state and local government health leadership, national and regional HIV/AIDS groups and organizations, as well as service providers and advocates at the state and local levels. OHAP has been delegated responsibility for day-to-day oversight of the implementation of the NHAS within HHS and for coordinating HHS activities with other Federal Departments. In coordinating the

implementation of the NHAS, OHAP provides leadership to senior advisors and principals from all of the HHS agencies and offices with key HIV/AIDS portfolios.

OHAP coordinates the Department's participation in a wide variety of HIV/AIDS-related conferences to ensure cost-effective and outcome-driven participation and successes. OHAP organizes information and activities around numerous National HIV Awareness Days, and coordinates both inter-agency and intra-agency HIV/AIDS activities. OHAP works to keep front-line and senior-level staff informed about the Department's HIV goals and objectives and how they affect communities, as well as to demonstrate effective ways to disseminate information about those policies inside and outside the Department.

AIDS.gov, which is managed by OHAP, is now the premier information gateway for Federal domestic HIV/AIDS information and resources. AIDS.gov provides:

- basic HIV/AIDS information and drives traffic to individual agency websites and resources—supporting the Department's HIV prevention, testing, and treatment objectives and improving access to Federal information about HIV/AIDS
- training and information to Federal colleagues, state and local health departments, and AIDS service organizations on using new media in response to HIV/AIDS
- links to HIV/AIDS resources (including both Federal and non-Federal partners)
- weekly blogs on Federal HIV/AIDS programs and resources
- management of the NHAS website for the White House

OHAP will continue to serve as the HHS central coordinating office for the Minority HIV/AIDS Initiative and as the convener of various work groups, committees, and consultations necessary to promote and support the goals of the NHAS and the Viral Hepatitis Action Plan.

Funding History

FY 2008	$904,000
FY 2009	$919,000
FY 2010	$929,000
FY 2011	$1,429,000
FY 2012	$1,497,000

Budget Request

The FY 2013 Budget of $1,300,000 is $197,000 less than the FY 2012 Enacted level. OHAP will reduce operational costs to maintain the current level of services and programs

OASH
OFFICE FOR HUMAN RESEARCH PROTECTIONS

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	6,949	6,937	6,600	-337
FTE	33	33	33	0

Authorizing Legislation……………………………………………….………Title III, Section 301 of the PHS Act
FY 2013 Authorization……………………………………………………………………………………..Indefinite
Allocation Method…………………………………………………………..Direct Federal, Contracts, and Other

Program Description and Accomplishments

The Office for Human Research Protections (OHRP) is the lead federal office assuring the integrity of the clinical research enterprise, an enterprise dependent on the willingness of millions of people to volunteer as human research subjects. OHRP's mission is to assure those volunteers that the federal government is strongly protecting their well-being. OHRP's mission plays a crucial role in supporting the Secretary's Strategic Initiative to Accelerate the Process of Scientific Discovery to Improve Patient Care, and the strategy under that objective to support comprehensive and efficient regulatory review of new medical treatments.

OHRP has oversight of more than 10,000 institutions conducting clinical and other research, both in the U.S. and throughout the world, including the tens of billions of dollars of research funded or conducted by NIH. Any incident in which research subjects appear to have been inappropriately harmed can result in a large and immediate drop in the numbers of people volunteering for clinical trials, jeopardizing the research enterprise.

OHRP has taken the lead in reforming the protection of human research subjects by examining every aspect of the regulations, and proactively removing bureaucratic requirements that do little or nothing to increase the well-being of research subjects. On behalf of the Secretary and in coordination with the White House's Office of Science and Technology Policy, OHRP published an advance notice of proposed rulemaking (ANPRM) titled "Human Subjects Research Protections: Enhancing Protections for Research Subjects and Reducing Burden, Delay, and Ambiguity for Investigators," on July 26, 2011. This is the beginning of a groundbreaking effort to strengthen protections and adjust the regulatory system to changes in the evolving research enterprise. Through guidance and changes in the regulations, OHRP is ensuring that the current system avoids inappropriate delays in the advancement of medical knowledge.

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

communications. OHRP also supports the Secretary's Advisory Committee on Human Research Protections.

OHRP activities contribute directly to Goal 2 of the HHS Strategic Plan, *Advance Scientific Knowledge and Innovation.* Scientific and biomedical research will only continue so long as the rights and welfare of human subjects in scientific and biomedical research are protected, so that people continue to trust the research community and agree to participate in research in sufficient numbers. Advancing scientific and biomedical research in turn supports Goals 1, 2, and 3 of the HHS Strategic Plan, since the findings of scientific and biomedical research enable us to improve health care (Goal 1), prevent or control medical conditions and protect public health (Goal 2), and promote the economic and social well-being of individuals, families, and communities (Goal 3).

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

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

Funding History

FY 2008	$6,701,000
FY 2009	$6,959,000
FY 2010	$6,949,000
FY 2011	$6,949,000
FY 2012	$6,937,000

Budget Request

The FY 2013 Budget of $6,600,000 is $337,000 less than the FY 2012 Enacted level. OHRP will reduce operational costs to maintain the current level of services and programs.

OHRP's publication of the (ANPRM) titled "Human Subjects Research Protections: Enhancing Protections for Research Subjects and Reducing Burden, Delay, and Ambiguity for Investigators" and aligns with the President's Executive Order of January 18, 2011, *Improving Regulation and Regulatory Review,* which requires Federal Agencies to review existing regulations to determine whether they should be modified, streamlined, expanded, or repealed to make the agency's regulatory program more effective or less burdensome in achieving the regulatory objective

OASH
OFFICE OF RESEARCH INTEGRITY

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	9,027	9,027	9,027	0
FTE	24	24	24	0

**Reimbursable Funding

Authorizing Legislation…………………………...……Title III, Section 301 and Title IV Section 493 of the PHS Act
FY 2013 Authorization……………………….……….....……………………………………………...Indefinite
Allocation Method ……………………………………………………………….Direct federal; Contracts; Grants

Program Description and Accomplishments

The mission of the Office of Research Integrity (ORI) is to promote research integrity, reduce research misconduct, and maintain the public confidence in research supported by funds of the Public Health Service (PHS). ORI is required by federal and department policies to protect taxpayer funding, and the scientific record of PHS research, through oversight of allegations of research misconduct. To accomplish this mission, the key responsibilities of ORI are:

1. receive assurance statements annually from the more than 5,000 institutions that receive PHS funds for research in which policies are in place for handing allegations of research misconduct, and fostering an environment that promotes research integrity
2. oversee institutional investigations of research misconduct
3. create educational resources on the responsible conduct of research for researchers and research educators
4. provide instruction to institutional administrators in up-to-date methods for conducting inquires and investigations of research misconduct
5. encourage credible allegations and protect whistleblowers; and
6. advise research journal publishers and editors on forensic analysis of images and other data submitted or already published.

Before regulatory protection few were willing to come forward and report an alleged incident of research misconduct for fear of retaliation or a lack of confidence that a good faith allegation could be proven. Now with regulations in place, and a few recent notable cases of research misconduct found under HHS regulations, more people are willing to come forward to report allegations of research misconduct when they feel justified in doing so. Increasing stressors on researchers demand strong regulation and superb education, not just to prevent maliciousness, but to enhance the abilities of researchers to be innovative and productive. This is particularly essential during economic downturns when increased pressures are placed on research faculty and staff members to accept additional responsibilities, decreasing their time for research, and when much of their time must be spent trying to maintain a stream of funding to continue their research program and staff.

In recent years, ORI has placed greater emphasis on education, research, evaluation, and prevention activities. In response to these changes, ORI adopted an action plan, approved by the Assistant Secretary for Health (ASH), to increase resources in these areas:

1. establishing a research program to study the factors influencing research integrity
2. developing an education program on the responsible conduct of research; and
3. fostering ongoing collaborations with ORI's teaching and research partners, including the Association

of American Medical Colleges, The Council of Graduate Schools, National Academies, American Association for the Advancement of Science, and other research associations, academic and scientific societies, and numerous individual institutions.

The work of ORI directly supports the Secretary's Strategic Initiatives and Key Inter-Agency Collaborations; specifically, prevention of disease and health promotion. ORI's overall mission supports the integrity of research and the public confidence in such research. Since clinical trials, human studies, animal studies, and basic research lead to new drugs, devices, and medical interventions, confidence in the science base, which leads to such improvements in health, is intertwined closely with the beneficial products of the research. ORI also emphasizes prevention in its programs by developing educational resources to support best practices and by supporting extramural studies through its research program on the indicators of research integrity and the causes of misconduct. Only through the development of this science base can PHS identify effective and cost efficient means of promoting integrity and preventing misconduct.

ORI's mission to identify and take action in response to research misconduct also provides primary and secondary prevention by removing from research those who commit misconduct and reinforcing the scientific norms of honest scientists who conduct research responsibly.

Each institution (currently more than 5,000) that receives PHS research funding must submit an assurance statement and their policies and procedures for handling allegations of research misconduct, demonstrating to their faculty, students, scholars, and staff the importance of honesty in research.

ORI's efforts to prevent misconduct and promote integrity and responsible research practices strengthen the public's trust in researchers, research institutions, and the process of scientific research essential for the progress of new health care products and treatments, which can prevent disease and illness. ORI also supports the public health infrastructure by helping ensure a trustworthy science database, upon which decisions are made, and which support public confidence in the use of science-based medical discoveries.

Key highlights of ORI's performance include finding research misconduct in approximately 20 cases annually, the ORI website visited by more than 115,000 people annually, the ORI blog and Twitter account, and the creation of an award winning interactive educational video.

Funding History

FY 2008	$8,571,000
FY 2009	$8,909,000
FY 2010	$9,118,000
FY 2011	$9,027,000
FY 2012	$9,027,000

Budget Request

The FY 2013 Budget of $9,027,000 is the same as the FY 2012 Enacted level. ORI will maintain the current level of services and programs.

OASH
PRESIDENT'S COUNCIL ON FITNESS, SPORTS AND NUTRITION

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	1,225	1,248	1,100	-148
FTE	6	7	8	1

Authorizing Legislation………………………………...…….……………Title III, Section 301 of the PHS Act
FY 2013 Authorization..Indefinite
Allocation Method...Direct Federal

Program Description and Accomplishments

The President's Council on Fitness, Sports and Nutrition (PCFSN) was established by Executive Order 13545. Originally chartered in 1956 by President Eisenhower as the President's Council on Youth Fitness, the scope of the Council expanded over the years to address people of all ages and to include the promotion of good nutrition. The PCFSN is a federal advisory committee of 25 volunteer citizens who serve at the pleasure of the President.

The PCFSN advises the President through the Secretary of HHS about physical activity, fitness, sports, and nutrition. Through programs and partnerships with the public, private, and non-profit sectors the Council serves as a catalyst to promote health, physical activity, and fitness for people of all ages, backgrounds, and abilities by participating in a variety of physical activities and the development and maintenance of healthy eating habits.

The PCFSN coordinates programmatic activities in consultation with the Departments of Agriculture and Department of Education to highlight the importance of quality physical education and physical activity in schools. The Council supports HHS efforts to help Americans achieve and maintain a healthy weight through continued promotion and enhancements to the PCFSN's President's Challenge Physical Activity and Fitness Awards program (President's Challenge). Established in 1966, the President's Challenge provides a low-cost, easy-to-use tool that educators, organizational leaders, families, and individuals can use to track participation in a variety of physical activities and/or fitness improvements.

In September 2011, the PCFSN celebrated achievement of the Million PALA Challenge (MPC), an initiative to get one million individuals to earn their PALA award as part of the President's Challenge. At the MPC celebration, the Council announced the release of PALA+, an upgraded version of PALA that continues to promote regular physical activity, but also emphasizes the importance of healthy eating habits in alignment with the Dietary Guidelines for Americans. The Council continues to support the *Let's Move* initiative and promote actions that further the achievement of relevant *Healthy People 2020* goals.

Funding History

FY 2008	$1,195,000
FY 2009	$1,228,000
FY 2010	$1,225,000
FY 2011	$1,225,000
FY 2012	$1,248,000

Budget Request

The FY 2013 Budget of $1,100,000 is $148,000 less than the FY 2012 Enacted level. PCFSN will reduce operational costs to maintain the current level of services and programs. Speaking opportunities at conferences and other public venues are the primary means by which the PCFSN disseminates its messages and works towards accomplishing its mission. PCFSN will rely heavily on more social media and other technologies that lessen the need for in-person appearances or meeting participation.

In FY 2013, the PCFSN will leverage partnerships with federal and non-federal entities to accomplish the following activities:

- Address health disparities by extending reach to other special populations including further collaboration with appropriate agencies to target people with disabilities and underserved communities.
- Increase coordination and collaboration across federal, state, and local government programs to ensure effective awareness of and participation in healthy lifestyle programs
- Work in conjunction with the CDC, NIH, and ODPHP to review and update the Physical Activity Guidelines for Americans (PAG) as dictated by new science and further communications efforts associated with the PAG.
- Elevate National Physical Fitness and Sports Month (annually in May).
- Recognize achievement in promoting physical activity, fitness, and sports participation through the Council's Lifetime Achievement and Community Leadership Awards.
- Continue to co-lead with CDC the Physical Activity Topic Area of *Healthy People 2020.*

OASH
PUBLIC HEALTH REPORTS
Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	448	499	400	-99
FTE	2	2	2	0

Authorizing Legislation……………………………………Title III, Section 301 of the Public Health Service Act
FY 2013 Authorization………………………………………….………………………………Indefinite
Allocation Method……..…………………………..……….……….Direct federal; Contract, Cooperative Agreement

<u>Program Description and Accomplishments</u>

Public Health Reports (PHR), is the official peer-reviewed journal of the U.S. Public Health Service and the Surgeon General, and is believed to be the longest continuously published journal of public health in the U.S. and the world, published continuously since 1878. PHR is published in collaboration with the Association of Schools of Public Health, and brings important research and discussion of key issues to the public health community. Each bi-monthly issue examines subject matter necessary to understand the issues of public health and disease prevention of the Nation.

In addition to the six regular issues, three or more supplemental and/or special issues are published annually. About two to three science-based webcasts are also produced each year. Regular columns in the issues include: *Surgeon General's Perspective*, *Recommendations and Reports*, *Global Health Matters*, *Law and the Public's Health*, *Public Health Chronicles*, *Local Acts, Focus on Environmental Health, NCHS Dataline*, and *From the Schools of Public Health* that address important national and international public health issues. The *Surgeon General's Perspective* highlights and discusses timely and emerging public health issues identified by the Surgeon General.

Special supplements each year bring focus to topics of interest to the public health community; recent examples include: *Oral Health Care for People with HIV Sexual Health, and Social Determinants of Health.*

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

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

- Contract with an external partner to provide the design and layout for six regular journal issues per year and with an electronic manuscript ion submission company.
- Professional services in the form of purchase orders are contracted annually, including technical editors, photo journalism, and special topic peer-review.
- A grant is awarded annually to provide support costs related to printing, mailing, subscriptions, and other PHR tasks.

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

Funding History

FY 2008	$443,000
FY 2009	$450,000
FY 2010	$448,000
FY 2011	$448,000
FY 2012	$499,000

Budget Request

The FY 2013 Budget of $400,000 is $99,000 less than the FY 2012 Enacted Level. PHR will reduce operational costs to maintain the current level of services and programs.

OASH
TEEN PREGNANCY PREVENTION

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request[4]	FY 2013 +/- FY 2012
Budget Authority	104,790	104,592	0	-104,592
FTE	17	16	0	-16

[4] The funding for the Teen Pregnancy Prevention (TPP) program moved in FY 2013 from the General Departmental Management Account to the Prevention and Public Health Fund (PPHF) of the Patient Protection and Affordable Care Act of 2010. Please refer to the PPHF fund section for information on the TPP program.

OASH
ADOLESCENT FAMILY LIFE

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	12,449	0	0	0
FTE	12	0	0	0

Authorizing Legislation……………………………………………..…...…Title XX of the Public Health Service Act
Authorization……………………………………...…...….………………………………………………Expired
Allocation Method………………………….…………………………….Competitive Grant; Contract; Direct Federal

Program Description and Accomplishments

The Adolescent Family Life (AFL) program, Title XX of the Public Health Service Act, supported demonstration grants to test innovative strategies for pregnant and parenting adolescents and their families to enable them to become healthy productive adolescent parents and to assist their families in addressing the societal factors associated with adolescent pregnancy.

The AFL legislation also authorizes support for basic and applied research focusing on the causes and consequences of adolescent pregnancy and parenting.

Funding History

FY 2008	$29,778,000
FY 2009	$29,778,000
FY 2010	$16,658,000
FY 2011	$12,449,000
FY 2012	$0

Budget Request

HHS is not requesting funds for the AFL program for FY 2013. Mandatory funding for the Pregnancy Assistance Fund (PAF) was included in the Patient Protection and Affordable Care Act. The PAF directs resources to similar populations and activities.

Program Data Chart

Activity	FY 2011 Actual	FY 2012 Enacted	FY 2013 Request
Contracts			
Technical Assistance Activities	1,240,000	0	0
Research	0	0	0
Subtotal, Contracts	1,240,000		
Grants/Cooperative Agreements			
Care Demonstration Grants	8,430,440	0	0
Inter-Agency Agreements (IAA)			
Research IAAs & Related Activities	0	0	0
Operating Costs	2,778,560	0	0
Total	**12,449,000**	**0**	**0**

OASH
OFFICE OF MINORITY HEALTH

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	55,888	55,782	41,100	-14,682
FTE	63	63	63	0

Authorizing Legislation…………………………………………………..…Title XVII, Section 1707 of the PHS Act
FY 2013 Authorization………………………………………………………………………P.L. 111-148 of 2016
Allocation Method................ …………. Direct Federal; Competitive Grant/Cooperative Agreement; & Contract

Program Description and Accomplishments

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

OMH's mission is to improve the health of racial and ethnic minority populations through the development of policies and programs that help eliminate disparities. Policy and program activities focus on improving the health status and health outcomes for African Americans, Hispanic Americans, American Indians, Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders. The poor health outcomes for racial and ethnic minorities are reflected in the health status and health care disparities that are apparent when comparing health indicators for minorities against those of the rest of the U.S. population.

OMH provides guidance to, and convenes, HHS divisions as well as other Federal departments to identify health disparity and health equity policy actions. The targeted leadership improves performance through better coordination on cross-cutting issues, minimizes duplication, and leverages funds aimed at reducing health disparities. OMH led activities include:

- HHS Health Disparities Council, which includes directors of the various HHS Offices of Minority Health and works to improve harmonization of HHS-wide minority health policies, assures successful implementation of the first ever *HHS Strategic Action Plan to Reduce Racial and Ethnic Health Disparities*, and leverages policies, programs, and resources in support of HHS health disparity reduction goals. The work of the Councils is responsive to the President's performance management strategy focused on strengthening problem-solving networks.

- Federal Interagency Health Equity Team (FIHET), which is comprised of 12 Federal departments/agencies whose collective missions contribute to achieving health equity. It works to identify opportunities for Federal collaboration, partnership, and coordination; and, leverage national, regional, state, and local efforts funded by respective FIHET agencies. The FIHET guided the development of the first ever community-driven *National Stakeholder Strategy for Achieving Health Equity* to improve coordination and action across sectors.

- HHS American Indian and Alaska Native Health Research Advisory Council, which is comprised of elected Tribal officials and provides a venue for HHS to consult with Tribes about health research priorities, needs in American Indian and Alaska Native communities, and collaborative approaches to

address issues and needs. It also provides a forum through which HHS divisions can better coordinate their AI/AN health research activities.

- HHS Workgroup on Asian, Native Hawaiian and Pacific Islander Issues, which is comprised of representatives from HHS divisions and works to improve communication and coordination of policies, programs, and evaluations that are unique to Asian American, Native Hawaiian, and Pacific Islander (AANHPI) communities. The Workgroup developed the *HHS AANHPI Action Plan* which outlines top departmental priorities and goals for improving the health and well-being of AANHPIs.

Additionally, OMH provides grant funds to State offices of minority health; multicultural health and health equity; community and faith-based organizations; tribes and tribal organizations; and institutions of higher education. OMH grants empower individuals and communities to develop targeted solutions that eliminate health disparities and promote prevention and wellness across the lifespan. OMH also funds demonstration grants to develop, test, and implement interventions to reduce health disparities, all of which play a critical role in supporting the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* and the ASH's priority goal to eliminate health disparities and achieve health equity. The grants also facilitate improvement of State, tribal, and local policies and programs to improve collaboration and reduce redundancy and increase availability of all forms of data.

In FY 2013, OMH will continue a number of vital grant programs that address health disparities, including:

- The Youth Empowerment Program (YEP) provides at-risk minority youth opportunities to learn about positive life styles and enhance their capacity to make healthier life choices. Nearly 80,000 youth (and their families) received tutoring, mentoring, social and educational skills development, life skills, and career development services in FY 2011. At the FY 2013 funding level, this program will serve no more than 28,000 at-risk minority youth and their families.

- The Partnerships Active in Communities to Achieve Health Equity (PAC) Program seeks to improve health outcomes among racial and ethnic minorities through the establishment of community-based networks that collaboratively employ evidence-based disease management and preventive health activities. In FY 2011, 37,000 individuals received preventive and improved access to health care and supportive services. At the FY 2013 funding level, this program will serve fewer than 20,000 individuals.

- The Curbing HIV/AIDS Transmission Among High Risk Minority Youth and Adolescents (CHAT) by Utilizing a Peer-to-Peer Outreach Model and New Application Technologies seeks to improve the HIV/AIDS health outcomes of high risk minority youth by supporting community-based efforts to increase HIV/AIDS prevention/ education efforts, testing, counseling and referrals. In FY 2011, 18,000 youth received HIV prevention education, counseling, and were linked to testing. At the FY 2013 funding level, this program will serve fewer than 9,000 high-risk minority youth.

- The *State and Territorial Partnership Program* (STTP) strengthens coordination of health disparities and health equity efforts and policies intended to improve outcomes for minority communities and responds to the Secretary's strategic initiatives to advance the health, safety, and well-being of the American people and promote economic and social well-being for individuals, families, and communities The 44 projects funded under the STPP engaged approximately 680,000 partner organizations and citizens during FY 2011.

- The *American Indian and Alaska Native (AI/AN) Partnership Program* provides support to tribal epidemiology centers and their respective tribal leaders to better access data, engage in data

development activities, and/or use a broad array of data to facilitate evidence-based health care decision-making and address health disparities planning. The AI/AN Partnership Program supports the Secretary's strategic initiative to leverage data for maximum public good. In FY 2011, an estimated 1,950 individuals received services and/or training from grantees and their partner organizations.

Funding History

FY 2008	$49,118,000
FY 2009	$52,956,000
FY 2010	$55,900,000
FY 2011	$55,888,000
FY 2012	$55,782,000

Budget Request

The FY 2013 Budget of $41,100,000 is $14,682,000 less than the FY 2012 Enacted level. This reduction will be primarily accomplished by funding only the continuations of the current OMH program activities. Additionally, the Delta Region Institute and Minority Community HIV/AIDS Partnership grant programs will be discontinued, for which the current funding cycle is ending in FY 2012.

This budget includes funding for continuation grants of the following OMH programs and services: *The Office of Minority Health Resource Center; Center for Linguistic and Cultural Competence in Health Care; State and Territorial Partnership Grant Program; Partnerships Active in Communities to Achieve Health Equity; Curbing HIV/AIDS Transmission among High Risk Minority Youth and Adolescents; Youth Empowerment Program; Minority Youth Tobacco Elimination Project; National Minority Male Health Project; and, National Umbrella Cooperative Agreement Program.* These programs continue to support improvements in the health status and health outcomes for African Americans, Hispanic Americans, American Indians, Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders. The requested funds are vital to ongoing initiatives and multi-year efforts.

The FY 2013 budget includes funds for the HHS promotores de salud (community health workers) initiative to strengthen outreach and education on the availability of health services and insurance coverage to underserved Hispanic/Latino communities. The FY 2013 Budget also includes funding to improve the availability of critical health information in the primary languages spoken by monolingual and limited English proficient populations. These efforts and the programs described in the Program Data table support the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities* released in April 2011 (for which OMH is the departmental coordinating office) and the ASH's priority goal to eliminate health disparities and achieve health equity

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2012 Target
4.1.2 Increased percentage of measurable racial/ethnic minority-specific Healthy People 2020 objectives and sub-objectives that have met the target or are moving in the right direction. (Outcome)	N/A	N/A	N/A	N/A
4.2.1 Increased awareness of racial and ethnic health status and health care disparities in the general population, measured every 3 years at a minimum (1999 Baseline: 54.5%) (Outcome)	FY 2010: 58.9% [5] Target: 60.7% (Target Not Met)	63.1%	64.3%	+1.2
4.3.1 Increased average number of persons participating in OMH grant programs per $1 million in OMH grant support (Efficiency)	FY 2011: 26,038 Target: 15,515 (Target Exceeded)	15,980[6]	16,459	+479
4.4.1 Unique visitors to OMH-supported websites (Output)	FY 2011: 668,888.0[7] Target: 575,000.0[8] (Target Exceeded)	580,000[9]	585,000	+5,000

[5] The fielding of the 2010 general household survey was completed in June 2010 and final analyses and reporting were completed in September 2010, with scientific presentations of results at the annual meeting of the American Public Health Association in November 2010. OMH has submitted these results to peer–reviewed journals for publication, to be linked to the official release of the study results by the Department. No statistical difference in the level of public awareness of health disparities between the 2010 and 2009 survey results was found. Given the trends in performance, the 2 percent annual increase over the target for the previous year may be too ambitious and unrealistic to achieve across the country as a whole, and may suggest the need to reduce the increases in annual targets and expected results to 1 percent every year or two. This change will be considered and, if needed, proposed for future performance plans and reports.

[6] While the target–setting methodology has not changed, the FY 2012 target was adjusted at the end of FY 2010 to reflect revised calculation procedures as described in the footnote for the FY 2010 target. The change in the target is simply a reflection of the change in the calculation procedure rather than a material change in efficiency.

[7] The degree to which the target was exceeded is assumed to be an anomaly, likely due to the large number of hits based on this year and launch of the HHS Disparities Action Plan and National Stakeholders Strategy under the National Partnership for Action to End Health Disparities (NPA); targets for subsequent years have not been increased.

[8] The original FY 2011 target of 430,000 was raised relative to the FY 2010 actual result.

[9] The original FY 2012 target of 450,000 was raised relative to the FY 2010 actual result. The target has not been further increased based on the FY 2011 actual result due to current budget restrictions and program plans.

Program Data Chart

Activity	FY 2011 Actual	FY 2012 Enacted	FY 2013 Request
Contracts			
OMH Resource Center (Includes *A Healthy Baby Begins with You Campaign*)	3,300,000	3,700,000	2,500,000
Logistical Support Contract	1,400,000	2,000,000	1,300,000
Center for Linguistic and Cultural Competency in Health Care	1,600,000	1,600,000	1,100,000
Promotores and Translation Services	0	1,000,000	1,000,000
HHS Disparities Action Plan	0	1,500,000	850,000
Evaluation	850,000	1,000,000	800,000
Subtotal, Contracts	7,150,000	10,800,000	7,550,000
Grants/Cooperative Agreements			
Health Disparities Programs:			
State and Territorial Partnership	6,100,000	6,000,000	6,000,000
American Indian/Alaska Native Partnership	1,200,000	1,200,000	1,200,000
Community Partnership	6,250,000	4,550,000	2,200,000
Youth Empowerment Program	5,300,000	1,800,000	1,800,000
Conference Support	350,000	400,000	300,000
Tobacco Cessation	1,000,000	1,000,000	1,000,000
Delta Region Institute (*Formerly Health Disparities – Mississippi*)	4,000,000	4,000,000	0
Specified Project – Lupus	1,000,000	1,000,000	0
National Minority Male Health Project	1,000,000	1,000,000	1,000,000
Minority Community HIV/AIDS Partnership	1,150,000	1,150,000	0
National Umbrella Cooperative Agreements	2,725,000	3,675,000	3,025,000
Subtotal, Grants/Coop	30,075,000	25,775,000	16,525,000
Inter-Agency Agreements (IAA)			
Other IAAs	4,879,000	4,887,000	3,369,000
Operating Expenses	13,784,000	14,320,000	13,656,000
Total	**55,888,000**	**55,782,000**	**41,100,000**

OASH
OFFICE ON WOMEN'S HEALTH

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	33,679	33,682	29,120	-4,562
FTE	43	43	43	0

Authorizing Legislation……………………………………………………Title III, Section 301 of the PHS Act
FY 2013 Authorization... . Indefinite
Allocation Methods .... .Direct Federal; Competitive grants; Contracts

Program Description and Accomplishments

The Office on Women's Health (OWH) was established in 1991 to improve the health of American women and girls by advancing and coordinating a comprehensive women's health; recently, it was authorized in the Affordable Care Act of 2010 (ACA). OWH has four goals: 1) develop and impact national health policy; 2) develop, adapt, implement, and evaluate and/or replicate model programs; 3) educate, influence, and collaborate with health and human service organizations, health care professionals, and the public; and 4) increase organizational efficiency and performance.

OWH provides departmental leadership on women's health by collaborating with federal agencies and offices and developing partnership opportunities with the private sector. OWH promotes health equity for women and girls through gender-specific approaches and fulfills this mission through competitive contracts and grants to community, academic, and other organizations at the national, state, and local levels. OWH instituted a Strategic Plan for FY 2010 - FY 2015. Under this plan, OWH funds evidence-based interventions to address gaps in women's health areas that are not addressed at the national level by any other public or private entity. These interventions focus on disparities in women's health.

Impact National Health Policy as it relates to Women and Girls

OWH continues leadership and management of the Chronic Fatigue Syndrome Advisory Committee (CFSAC). In addition to private individuals, membership includes ex-officio representatives from CDC, FDA, HRSA, NIH, AHRQ, CMS, and SSA. The CFSAC met in May and November 2011, and plans to meet again in the Spring of 2012. The committee advises, consults with, and makes recommendations to the Secretary on a broad range of topics including the current state of the science and the relevant gaps about the epidemiology, etiologies, biomarkers and risk factors. Additional topics include the impact and implications of current and proposed diagnosis and treatment methods, development and implementation of communication strategies about CFS advances, and partnering to improve the quality of life of CFS patients.

The HHS Coordinating Committee on Women's Health (CCWH), chaired by OWH, was established to advise the ASH on current and planned activities across HHS that safeguard and improve the physical and mental health of women and girls. The CCWH includes representatives from NIH, FDA, CDC, HRSA, AHRQ, and other agencies and offices. The CCWH will continue to monitor implementation of ACA recommendations that relate to women's health. Specifically, OWH is working with HRSA to lead a HHS Working Group for Worksite Lactation Support.

OWH is engaged in efforts that address violence against women (VAW) and is a leader in bringing awareness to the health impact of gender-based violence. As the convener for the HHS Steering

Committee on VAW, OWH collaborates with agencies and offices in the development and implementation of violence-related programs and research. The HHS Secretary is the co-chair for the National Advisory Committee on VAW with the Attorney General; OWH collaborates with DOJ OVW on activities for this committee.

OWH continues to work collaboratively with the White House Office of National AIDS Policy, the President's Advisory Council on HIV/AIDS, and the Secretary's Office of HIV/AIDS Policy in the implementation of a national strategy on HIV/AIDS that addresses the critical needs of women and girls. In FY 2011, OWH continued development of a HIV Prevention Gender Toolkit for US Women and Girls for OWH grantees.

Model Programs on Women's and Girls' Health

In FY 2011, OWH launched the *Make the Call. Don't Miss a Beat* media campaign, in collaboration with the National Heart Lung and Blood Institute (NHLBI), CDC, and 10 outside organizations. The two-year public service campaign alerts women to the seven symptoms of a heart attack and encourages them to call 911 if they have symptoms. The campaign includes TV, radio, billboard, print, internet, and social media advertising. The launch of the campaign was featured on the cover of USA Today on February 2, 2011 and on numerous TV, radio, print, and web media outlets. In addition, over 250 million persons have seen or heard the ads since the launch.

In 2009, OWH launched the Coalition for a Healthier Community (CHC) program and awarded a total of $1.6 million in grants to 16 coalitions comprised of local, regional, and national organizations; academic institutions, and public health departments. Each grantee developed a strategic plan to address health conditions that adversely affected the health of women and girls in their specific community. In September 2011, OWH launched Phase II of the CHC and ten sites were selected to implement their 5-year strategic plans, which have goals and objectives linked to *Healthy People* 2020.

Education and Collaboration on Women's and Girls' Health

OWH maintains www.womenshealth.gov, which provides health information and referrals to consumers of health services, health professionals, researchers, educators, and students. From January 1, 2011 to September 30, 2011, there were 9,631,113 user sessions and over 31,000 phone calls to OWH's call center.

OWH's www.girlshealth.gov website is the number one Google return when searching on "girls health." The intent of the site is to motivate girls ages 10-16 to choose healthy behaviors by providing information on fitness, nutrition, stress management, relationships with friends and family, peer pressure, suicide, drugs, and self-esteem. The www.girlshealth.gov website had 833,530 user sessions from January 1, 2011 – September 30, 2011.

Three key programs focus on girl's health and are the backbone of OWH efforts for girls and young women. The *BodyWorks* toolkit for the prevention of obesity focuses on the family as the most important institution to prevent obesity. The toolkit helps parents and caregivers of girls and young adolescents (ages 9-13) to improve their eating and activity habits. An extensive evaluation of *Bodyworks* is planned for FY 2012- 2015.

OWH contracted with the Advertising Council to develop the first ever *National Lupus Awareness Campaign*. This campaign is dedicated to increasing awareness of lupus to improving early diagnosis and treatment among those who are at increased risk for this disease, especially young minority women. The campaign included TV and radio public service announcements, billboards and a website (www.couldihavelupus.gov). It reached more than 30 million people after the launch and from January 1 – July 31, 2011 had over 243,854 user sessions on the website. For $2.3M, the campaign has gained

more than $60M in donated advertising. This campaign led in the Ad Council's outdoor billboard, number two in network cable TV and number three in total cable TV.

OWH sponsors National Women's Health Week, a weeklong observance that promotes women's health and empowers women to make their health a top priority. For 2011, over 2,000 events and outreach activities occurred all across the U.S. and its territories; the second ever Presidential Proclamation was issued along with various governors', mayoral, tribal, and congressional proclamations; OWH's first-ever NWHW social media campaign was launched that resulted in an increase of more than 1,000 "likes" on the OWH Facebook page, 5,000 new followers on the OWH Twitter account and NWHW being a top trending Tweet on National Women's Checkup Day (Monday, May 9, 2011); and over 256 million media impressions occurred.

Funding History

FY 2008	$31,033,000
FY 2009	$33,746,000
FY 2010	$33,746,000
FY 2011	$33,679,000
FY 2012	$33,682,000

Budget Request

The FY 2013 Budget of $29,120,000 is $4,562,000 less than the FY 2012 Enacted level. The Budget includes funding for continuation grant programs within the Office on Women's Health. The FY 2013 Budget will not affect funding for Violence Against Women activities.

OWH, and its HHS Coordinating Committee, will continue to serve as the focal point for women on the ACA health care reform legislation. Significant effort will go towards educating women about the various provisions.

OWH will continue to expand the use of social media as a method for interacting with women and girls across the nation. From January 1 – July 31, 2011, OWH has interacted with more than 2,028,029 Twitter users, and more than 374,922 Facebook users. The FY 2013 Budget will maintain this level and develop new social media efforts by OWH.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
5.1.2 Increase the Percentage of women-specific Healthy People 2020 objectives and sub-objectives that have met their target or are moving in the right direction. (Outcome)	N/A	Maintain	Maintain	Maintain
5.2.1 Increase the percentage of women who are aware of the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911. (Outcome)	FY 2009: 53.0% Target: 67.5% (Target Not Met)	75.0%	77.5%	+2.5
5.3.1 Number of users of OWH communication resources (e.g., National Women's Health Information Center; womenshealth.gov website; and girlshealth.gov website). (Output)	FY 2010: 21,476,422 Target: 26,000,000 (Target Not Met)	21,500,000 user sessions	22,000,000 user sessions	+500,000
5.4.1 Number of girls ages 9-17 and women ages 18-85+ that participate in OWH-funded programs (e.g., information sessions, web sites, and outreach) per million dollars spent annually. (Efficiency)	FY 2009: 785,536 Target:1,216,046 (Target Not Met)	770,461	800,095	+29,634
5.1.2 Increase the Percentage of women-specific Healthy People 2020 objectives and sub-objectives that have met their target or are moving in the right direction. (Outcome)	N/A	Maintain	Maintain	Maintain

Program Data Chart

Activity	FY 2011 Actual	FY 2012 Enacted	FY 2013 Request
Contracts			
Regional Women's Master Contract	2,200,000	2,300,000	2,100,000
Program Evaluation	900,000	1,000,000	800,000
Nat'l Women's Health Information Center	3,200,000	3,200,000	3,000,000
Print Materials	700,000	600,000	500,000
Communications (Fulfillment)	300,000	300,000	100,000
Meeting Logistics Contract	1,000,000	1,000,000	1,000,000
Adolescent Health & Osteoporosis	2,465,000	3,150,000	800,000
Incarcerated Women in Transition & Trauma	0	240,000	500,000
Cardiovascular Disease Programs	1,742,393	1,750,000	518,000
Workplace Breastfeeding	415,000	415,000	375,000
Quick Health Data	500,000	500,000	500,000
Subtotal, Contracts	13,422,393	14,455,000	10,193,000
Grants/Cooperative Agreements			
Action Agenda for Women's Health	350,000	0	0
Gender-Focused Health Systems Change	1,600,000	3,000,000	2,900,000
Gender Focused Outreach	1,135,000	0	0
Sustainability Consensus Conference	200,000	0	0
Mental Health	300,000	0	0
HHS Women's Health Advisory Committee	250,000	0	0
HIV/AIDS–Minority Communities	2,230,048	2,200,000	2,000,000
Minority Women's Health	400,000	680,000	680,000
Violence Against Women	3,000,000	3,010,000	3,010,000
National Women's Health Week	250,000	250,000	250,000
Subtotal, Grants/Coops	9,715,048	9,140,000	8,840,000
Inter-Agency Agreements			
Co-sponsorships (includes IAAs & others)	500,000	500,000	500,000
Operating Expenses	10,041,559	9,587,000	9,587,000
Total	**$33,679,000**	**$33,682,000**	**$29,120,000**

OASH
COMMISSIONED CORPS INITIATIVES

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	8,071	0	0	0
FTE	31	0	0	0

Authorizing Legislation .... Title III, Section 301 & Title XXVIII, Section 206 of PHS Act
FY 2013 Authorization .... Indefinite
Allocation Method .... Direct Federal; Contracts

Program Description and Accomplishments

This activity supported the modernization and reengineering of the U.S. Public Health Service Commissioned Corps' (Corps) business processes and integrating needed human resources (HR) information into a single information system. Better information empowers HHS and the Corps to fulfill core public health missions and enables centralized force management for the first time. The Corps in 2009 began utilizing the United States Coast Guard's Direct Access HR Solution for Uniformed Personnel, a PeopleSoft-based HR program that will consolidate a broad set of information on Corps officers that was unavailable before.

Funding History

FY 2008	$4,119,000
FY 2009	$14,813,000
FY 2010	$14,813,000
FY 2011	$8,071,000
FY 2012	$0

Budget Request

HHS is not funding the Commissioned Corps Initiatives for FY 2013. Beginning in FY 2012 and continuing in FY 2013, the Direct Access activities will be funded through the Department's Service and Supply Fund instead of General Departmental Management. Support for the Office of the Surgeon General will be funded through the OASH Immediate Office for FY 2012 and FY 2013.

Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
6.1.5: Enhance the Department's capability to rapidly and appropriately respond to medical emergencies and urgent health needs, through maintaining response teams. (baseline – 2007: 46) (Outcome)	FY 2011: 41 (Target Not Met)	46	41	-5

OASH
HEALTHCARE-ASSOCIATED INFECTIONS

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	1,542	0	0	0
FTE	2	0	0	0

Authorizing Legislation……………………….……...……..Title III, Section 301 of the Public Health Service Act
FY 2013 Authorization……..…………………………………..…..……………………………………Indefinite
Allocation Method……..…..………………………………………………...……..……………….Direct Federal

Program Description and Accomplishments

OASH began a coordinated national effort to address healthcare-associated infections (HAI) by establishing the senior-level Steering Committee for the Prevention of Healthcare-Associated Infections in order to improve and expand prevention efforts in 2008. The Steering Committee, chaired by the Deputy Assistant Secretary for Healthcare Quality, is charged with developing and implementing the National Action Plan to Prevent HAIs: Roadmap to Elimination. The Action Plan established national five-year goals (e.g., a 50 percent reduction in central line-associated bloodstream infections by the end of 2013), and outlined key actions for enhancing and coordinating HHS activities and opportunities for collaboration with external partners. The Steering Committee also coordinated the use of HAI-related American Recovery and Reinvestment Act (ARRA) funds provided to CDC and the Centers for Medicare and Medicaid Services (CMS).

In FY 2011, the Steering Committee began its third phase efforts to reduce and prevent HAIs in long-term care facilities. The Steering Committee plans to continue to implement the existing Action Plan strategies focused on reducing infections in acute care hospitals, ambulatory surgical centers, and ESRD facilities, as well as build a system and culture of HAI prevention across the continuum of settings where healthcare is provided.

Funding History

FY 2008	$0
FY 2009	$5,000,000
FY 2010	$5,000,000
FY 2011	$1,542,000
FY 2012	$0

Budget Request

HHS is not funding for the HAI program for FY 2013. OASH will support implementation of the HAI-related reforms as well as the Departmental Steering Committee from resources provided directly to the Assistant Secretary for Health.

OASH
HIV/AIDS IN MINORITY COMMUNITIES

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request[10]	FY 2013 +/- FY2012
Budget Authority	53,783	53,681	0	-53,681
FTE	0	0	0	0

[10] The funding for the Minority AIDS Initiative (MAI) moved in FY 2013 from the General Departmental Management Account to the Public Health Service (PHS) Evaluation Fund. Please refer to the PHS Evaluation fund section for information on MAI.

OASH
EMBRYO ADOPTION AWARENESS CAMPAIGN

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	2,004	1,996	0	-1,996
FTE	0	0	0	0

Authorizing Legislation .... Public Health Service Act, Section 1704
FY 2013 Authorization .... Indefinite
Allocation Method .... Competitive grants, Contract Inter-Agency Agreement

Program Description and Accomplishments

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

In the last year, program funds have been used to support an interagency agreement with the Centers for Disease Control and Prevention's National Center for Health Statistics designed to document the extent of awareness of embryo donation/adoption among infertile couples in the United States. This will be accomplished through the inclusion of measures within the National Survey of Family Growth (NSFG). In May 2011, the program published a Funding Opportunity Announcement requesting applications for projects to increase public awareness for embryo donation and/or adoption or for projects designed to facilitate embryo donation and/or adoption by providing medical or administrative services, including counseling, to couples who are currently involved in or considered embryo donation and/or adoption.

Funding History

FY 2008	$3,930,000
FY 2009	$4,200,000
FY 2010	$4,200,000
FY 2011	$2,004,000
FY 2012	$1,996,000

Budget Request

HHS is not requesting funds for this program for FY 2013. HHS' decision to discontinue funding for this program is a reflection of the limited interest in the program as evidenced by grants being awarded to a very small pool of applicants, many of whom are repeat recipients.

RENT, OPERATIONS, MAINTENANCE AND RELATED SERVICES

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	16,616	18,665	16,250	-2,415
FTE	0	0	0	0

Program Description and Accomplishments

The Office for Facilities Management and Policy (OFMP), in the Office of the Assistant Secretary for Administration, administers both Rent/Operation and Maintenance (O&M) and Related Services funds for all headquarters facilities occupied by the Office of the Secretary. OFMP provides stewardship and fiscal responsibility in managing the Department's real property assets, monitors the amount and type of space occupied by each STAFFDIV, and coordinates efforts to achieve the most efficient use of space, while maintaining a quality work environment.

Descriptions of each area follow:

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

- O&M*:* (formerly known as Delegated Authority) includes funds to cover the operation, maintenance and repair of HHS Headquarters and buildings for which management authority has been delegated to HHS by GSA. Note: All Rent amounts are shown in object class 23.1, Rental Payments to GSA; however, O&M amounts are spread across other object classes.

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

    - Provides mission-enabling facilities and a safe, secure and healthy work environment for the Southwest Complex and the Humphrey Building.
    - Implements and maintains HSPD-12 Badge Program for SW Complex
    - Improves surveillance in and around the Humphrey Building
    - Improves security in the Humphrey main lobby through installation of new turnstiles.

- Building Management: OFMP is committed to a high level of performance in the management of the HHH Building.

    - Applies best practices to execute various repair and improvement projects to sustain acceptable building conditions.
    - Upgrades building controls to reduce energy through installation of variable frequency drives on AHU's.
    - Installs UV lights in ventilation system return plenums to maximize indoor air quality.

In FY 2001 - FY 2012, all performance targets in this area were achieved. OFMP's current practices and procedures adhere to GSA guidelines that building services complaints are responded to within 72 hours of receipt. To verify performance, an independent analysis of computer generated data from the contractor's service call system is regularly performed. In order to ensure accuracy, individual work

orders (issued as result of estimates for service) are manually pulled on a random and periodic basis, and performance verified. These reviews have consistently supported the data in automated reports

Funding History

FY 2008	$16,882,000
FY 2009	$16,850,000
FY 2010	$16,935,000
FY 2011	$16,616,000
FY 2012	$18,665,000

Budget Request

The FY 2013 Budget for Rent, O&M, and Related Services is $16,250,000, a reduction of $2,415,000 below the FY 2012 Enacted Level. The decrease reflects significant efforts to ensure that for Rent, O&M, and Related Services bills were charged to the correct agencies and Staff Divisions.

SHARED OPERATING EXPENSES

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	15,999	16,060	27,708	11,648

Common Expenses/ Service and Supply Fund (SSF) Payment

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

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

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

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

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

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

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

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

Funding History

FY 2008	$17,698,000
FY 2009	$17,698,000
FY 2010	$14,520,000
FY 2011	$15,999,000
FY 2012	$16,060,000

FY 2013 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

STAFFDIV Allocation Statement:
The GDM will use $659,785 of its FY 2013 budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. Staff Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, $383,936.00 is allocated to developmental government-wide E-Government initiatives for FY 2013. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$2,551
Line of Business - Grants Management	$3,174
Line of Business - Financial	$8,981
Line of Business - Budget Formulation and Execution	$6,685
Disaster Assistance Improvement Plan	$1,356
Federal Health Architecture (FHA)	$0
Integrated Acquisition Environment-Grants and Loans	$2,216
Line of Business - Geospatial	$433
Line of Business – Performance Management	$358,000
FY 2013 Developmental E-Gov Initiatives Total	**$383,396**

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

Prospective benefits from these initiatives are:

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. The Administration for Children and Families (ACF) is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users.

Additionally, NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business - Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Lines of Business - Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

Lines of Business - Geospatial: Promotes coordination and alignment of geospatial data collection and maintenance among all levels of government: provides one-stop web access to geospatial information through development of a portal; encourages collaborative planning for future investments in geospatial data; expands partnerships that help leverage investments and reduce duplication; and, facilitates partnerships and collaborative approaches in the sharing and stewardship of data. Up-to-date accessible information helps leverage resources and support programs: economic development, environmental quality and homeland security. HHS registers its geospatial data, making it available from the single access point.

Line of Business – Performance Management: Supports development of government wide performance management capabilities to meet transparency requirements of the GPRA Modernization Act. HHS performance information will be reported through a Federal website that will include advanced data display and reporting capabilities, the ability to extract raw data, and, over time, will integrate other government-wide data, such as program, human capital, and spending information. All information

currently provided publicly will be updated more frequently and will be provided in user-friendly formats that the public can more easily access and analyze.

In addition, $276,389 is allocated to ongoing government-wide E-Government initiatives for FY 2013. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Ongoing E-Gov Initiatives*	
E-Rule Making	$5,956
Integrated Acquisition Environment	$29,451
GovBenefits	$4,149
Grants.Gov	$236,833
FY 2013 Ongoing E-Gov Initiatives Total	**$276,389**

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

Budget Request

The FY 2013 Budget for other Shared Operating Expenses is $27,708,000; an increase of $11,648,000 over the FY 2012 Enacted level.

The $6,000,000 results from the reallocation of funding from prior sources to support the expected growth, and regulations of the Affordable Care Act that will need to be implemented in FY 2013 and are supported through Healthcare.gov. The substantial support services required for HealthCare.gov includes Small Business Finder which is a part of the system where individuals and small businesses can go to find health coverage options. Options Finder, Individual Plan Finder, Rate Review/Company Profile, and Partnership for Patients are other major support services required for the site. The $5,000,000 increase results from the reallocation of funding from within the GDM account to support new and focused strategic health partnerships.

PHS EVALUATION SET-ASIDE

Dollars in Thousands

Program Level	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request
ASPE	41,243	41,493	40,505
Health Reform	13,500	12,500	12,500
OASH	4,510	4,510	4,285
HIV AIDS in Minority Communities	0	0	53,891
Teen Pregnancy Prevention Initiative	4,455	8,455	4,232
ASFR	1,503	2,253	1,428
Autism	0	0	0
Total	**65,211**	**69,211**	**116,841**
FTE	**141**	**141**	**141**

PHS EVALUATION
OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

Dollars in Thousands

Program Level	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
ASPE	41,243	41,493	40,505	-988
Health Reform	13,500	12,500	12,500	0
Total	**54,743**	**53,993**	**53,005**	**-988**

Authorizing Legislation.. 42 U.S.C. 241 Public Health Service Act
FY 2013 Authorization..Indefinite
Allocation Method……..Direct federal/Intramural; Contracts; Competitive Grants, Cooperative Agreement; Other (Salaries and Expenses, etc.)

Program Description and Accomplishments

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

1. assessments of the effectiveness of programs and strategies used to achieve public health and human service goals and objectives;
2. assessments of the health and human services environment to understand how changes in the environment affect public programs and strategies;
3. evaluations to improve the management of public health and human services programs;
4. development of performance measures and data systems for measuring progress toward achieving the public health and human services goals and objectives of the Department; and,
5. maintenance and improvement of the infrastructure needed to evaluate PHS programs.

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

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

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

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

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

- Research and Evaluation – ASPE's policy research and evaluation program has a significant impact on the improvement of policies, programs and services of HHS, by systematically collecting information on program performance, assessing program effectiveness, improving performance measurement, performing environmental scans and assessments, and providing program management.
- Data Collection Coordination – ASPE leads the planning and coordination of data collection investments and statistical policy across HHS and co-chairs the HHS Data Council, which promotes communication and planning for data collection from an HHS-wide perspective, assures coordination and cost efficiencies in addressing interagency data needs, and serves as a forum to address priority interagency, Departmental, and national data needs in a coordinated fashion.
- Research Coordination – ASPE also has the lead role in ensuring that HHS' investment in health and human services research supports the Secretary's Strategic Initiatives and Departmental priorities in the most efficient and effective manner.

Funding History

FY 2008	$41,243,000
FY 2009	$41,243,000
FY 2010	$42,243,000
FY 2011	$41,243,000
FY 2012	$41,493,000

ASPE Budget Request

The FY 2013 Budget for ASPE is $53,005,000 including $12,500,000 for Health Reform activities. The FY 2013 funding level will allow ASPE to continue a variety of independent policy research and evaluation activities across the spectrum of the HHS's programs, with particular attention to strategic plan goals, Secretarial strategic initiatives, priorities, key interagency collaborations, and crosscutting initiatives. Funds are used to conduct research and evaluation studies, collect data, and estimate the costs, benefits and impacts of policies and programs under consideration by HHS or the Congress. ASPE's work supports HHS' mission and achievement of the Strategic Goals.

Goal 1: Strengthen Health Care

Priority projects for FY2013 under this goal include providing analysis and developing data to measure and evaluate the implementation and impact of the Affordable Care Act, improving health care and nursing home quality, developing innovative payment and delivery systems, identifying the best ways to serve individuals who are dually eligible for Medicare and Medicaid, modernizing Medicaid, and improving prevention efforts as well as public health infrastructure and financing.

ASPE evaluation studies will identify key strategies to reduce the growth of healthcare costs while promoting high-value, effective care. Priority projects will produce the measures; data, tools, and evidence that healthcare providers, insurers, purchasers, and policymakers need to improve the value and affordability of health care and to reduce disparities in costs and quality between population groups and regions.

Goal 2: Advance Scientific Knowledge and Innovation

Priority projects for FY2013 under this goal include research and analysis to support regulatory risk assessment and management, the translation of the fruits of biomedical research into every day health and health care practice, the development and adoption of innovation in health care, and food, drug, and medical product safety and availability.

ASPE projects are providing substantial contributions in making HHS more open and innovative, supporting projects that promote agency transparency and public participation, exploring the development and use of Web-based tools to improve surveillance, monitoring, analysis, and reporting.

Goal 3: Advance the Health, Safety and Well-being of our People

Priority projects for FY2013 under this goal will include studying ways to enhance the economic security, stability and well-being of families and communities; evaluating methods to improve the coordination of physical and behavioral health services; fostering innovative approaches to delivering integrated care; conducting research to promote healthy development, early learning, school readiness and comprehensive services for young children; and examining potential strategies to improve the safety and well-being of children involved with the child welfare system.

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

Goal 4: Increase Efficiency, Transparency and Accountability of HHS Programs
Priority projects in FY 2013 under this goal include developing measures and metrics for performance measurement and conducting research in support of efforts to develop strategies for reducing improper payments, understanding disability, and Medicare quality improvement. ASPE will coordinate HHS data collection and analysis activities, and ensure effective long-range planning for surveys and other investments in major data collection; will proactively identify opportunities for transparency, data sharing, and dissemination through electronic posting of datasets on data.gov and other means.

Goal 5: Strengthen the National Health and Human Services Infrastructure and Workforce
Priority projects for FY 2013 in this goal area will include policy research and evaluation related to the direct care workforce, the recruitment and retention of a qualified, stable and geographically well-distributed health workforce, and improving the effectiveness and efficiency of the health system through adoption of health information technology. ASPE will also continue to develop and integrate HHS data capabilities for public health surveillance and health system change.

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

ASPE Grant Awards Table

Description	FY 2011	FY 2012	FY 2013
Number of Awards	4	4	4
Average Award	$750,000	$750,000	$750,000
Range of Awards	$500,000 - $800,000	$500,000 - $800,000	$500,000 - $800,000

ASPE maintains a grants program to support research and evaluation by academically based research centers of important and emerging social policy issues associated with income dynamics, poverty, individual and family functioning, marriage and family structure, transitions from welfare to work, child well-being, and special populations. Federal support for the poverty center program has been continuous since 1968, and Federal support for a family and marriage research program was instituted by ASPE in FY 2007. Beginning in FY 2011, ASPE reduced the number of grants from five to four while essentially maintaining total support for the research center program in an effort to ensure that each center received sufficient funding to carry out a robust research agenda.

ASPE's grants for academic research institutes range from $500,000 to $800,000 per year. The poverty center program conducts a broad range of research to describe and analyze national, regional and state environments (e.g., economics, demographics) and policies affecting the poor, particularly families with children who are poor or at-risk of being poor. It also focuses on expanding our understanding of the causes, consequences and effects of poverty in local geographic areas, especially in states or regional

areas of high concentrations of poverty, and on improving our understanding of how family structure and function affect the health and well-being of children, adults, families and communities. All of the centers develop and mentor social science researchers whose work focuses on these issues.

Health Reform Related Activities

As the U.S. Government's lead health agency, HHS is responsible for the implementation of many of the provisions of the ACA. ASPE will undertake a variety of policy development, research, analysis, evaluation and data development activities in support of ACA implementation in FY 2013, including:

- Internal policy development and technical assistance projects. ASPE will continue to serve as a source of information and data to other parts of the Federal government and track changes as the ACA is implemented. Reviews, data analysis, and options papers will be developed as needed.
- Reviews, studies, and evaluations to identify effective prevention strategies and associated benefits, especially in the area of community-based and clinical preventive service integration.
- Research and developing the design of the "essential health benefits" package required of insurance providers for the individual and small group markets.
- Modeling and evaluation models to support innovation Center activities including ACO and post acute care payment activities.

PHS EVALUATION
HIV/AIDS IN MINORITY COMMUNITIES

Dollars in Thousands

Program Level	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	0	0	53,891	53,891
FTE	0	0	0	0

Authorizing Legislation.. Title III, Section 301 of the PHS Act
FY 2013 Authorization.. Indefinite
Allocation Methods ....Grants, Cooperative Agreements and Contracts

<u>Program Descriptions and Accomplishments</u>

The Minority AIDS Initiative (MAI) was established in 1999 in response to growing concern about the impact of HIV/AIDS on racial and ethnic minorities in the United States. The year before, the President had declared HIV/AIDS to be a severe and on-going health crisis in racial and ethnic minority communities. Subsequently, the Administration, HHS, the Congressional Black Caucus, and the Congressional Hispanic Caucus collaborated to develop the MAI. Beginning in FY 1999, the MAI provided new funding with the principal goals of improving HIV-related health outcomes for racial and ethnic minority communities disproportionately affected by HIV/AIDS and reducing HIV related health disparities. These resources are intended to complement, rather than replace, other Federal HIV/AIDS funding and programs.

The MAI allocates resources to four HHS Operating Divisions (OPDIVs), as well as the Office of the Secretary through the Secretary's MAI Fund (SMAIF). In turn, those SMAIF resources are distributed on a competitive basis to HHS agencies and staff offices to support HIV prevention, care and treatment, outreach and education, technical assistance, and demonstration activities. The Office of HIV/AIDS Policy (OHAP) administers the Secretary's Fund on behalf of the Office of the Assistant Secretary for Health (OASH), and the awards are approved and made by the Assistant Secretary for Health.

In addition to the SMAIF, MAI funds (estimated $367 million in FY 2011) are congressionally appropriated directly on a non-competitive basis to three OPDIVs within HHS, including CDC, HRSA, and SAMHSA and two Staff Divisions, OMH and OWH. These agencies then provide funds to community-based organizations, faith communities, research institutions, minority-serving colleges and universities, health care organizations, state and local health departments, and correctional institutions, among others, to help them address the HIV/AIDS epidemic within the minority populations they serve.

With the release of the National HIV/AIDS Strategy (NHAS) in July 2010 and acting upon recommendations from the Office of Management and Budget, OASH/OHAP began steps in FY 2011 to better target MAI resources in alignment with the NHAS. Continuing with the FY 2012 cycle, OHAP has successfully restructured and transitioned the SMAIF to align with the goals, objectives, and priorities of the National HIV/AIDS Strategy (NHAS). Over the last year, through program and process directives, including for the first time, the development of a formal internal funding opportunity announcement (FOA), OHAP has worked with HHS agencies and offices to enhance the targeting and the effectiveness of HIV prevention and care services provided for high risk racial and ethnic minority communities through the SMAIF. Specifically, the internal FOA has designated four priority project areas, from which agencies and offices will develop new proposals, including: *preventing HIV; improving health outcomes*; *mobilization to reduce HIV-related health disparities*; and *capacity development in*

support of NHAS goals. Approximately $35M is available for this competitive portion of the FY 12 SMAIF.

In addition, guidance provided by OHAP now requires the use of standardized HIV testing and training metrics for all SMAIF projects. There is also a much greater emphasis on projects done in collaboration across agencies and offices with collaboration now one of four scored criteria in the review process. Through the SMAIF, we are also embarking on the development of a cross-agency demonstration project designed to build capacity of non-governmental organizations and health departments to reduce HIV-related health disparities in the South and in other underserved areas of the United States. Approximately $15M will be targeted to fund this new demonstration project.

The “new” SMAIF is more collaborative, accountable, and transparent, and these changes should bode well for impacting the lives and communities devastated by HIV/AIDS. In addition to a renewed commitment to funding capacity building activities, projects funded under the SMAIF will continue to consider the latest behavioral and biomedical strategies for more impactful results, including “treatment as prevention” and PrEP, as well as, expanded HIV testing and active linkage to care. As research has helped us to better understand the “HIV Cascade” from HIV diagnosis to viral suppression----and where serious challenges persist, future projects funded under the SMAIF in FY 12 and FY 13 will have the opportunity to design demonstration projects and build community capacity to deliver the needed services along that continuum.

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

- Preventing HIV: developing or expanding prevention efforts for sub-populations, including ex-offenders; at-risk female adolescents/youth; sexual partners of incarcerated or recently released heterosexuals; and African American and Hispanic Men Who Have Sex with Men
- Improving Health Outcomes: developing retention and re-engagement interventions for HIV-positive patients and expanding tele-health opportunities in rural and tribal locations
- Mobilization to Reduce Health Disparities: use of emerging technologies and social marketing campaigns, including AIDS.gov, new and social media to broaden reach

Funding History

FY 2008	$0
FY 2009	$0
FY 2010	$0
FY 2011	$0
FY 2012	$0

Budget Request

The FY 2013 Budget of $53,891,000 is available to be distributed accordingly. MAI funds were previously appropriated to General Departmental Management, but will now be funded through Public Health Service Evaluation funds.

Outputs and Outcomes

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
7.1.12a: Increase the number of racial and ethnic minority clients who are tested through the Secretary's MAI fund programs. (Outcome)	FY 2010: 298,498 (Target Exceeded)	209,578[11]	220,057[12]	+10,479
7.1.12b: Increase the diagnosis of HIV-positive racial and ethnic minority clients through HIV testing programs supported by the Secretary's MAI Fund programs. (Outcome)	FY 2011: 201.0 (Target Met)	221.0[13]	243.0[14]	+22
7.1.12c: Increase the proportion of HIV-positive racial and ethnic minority clients who learn their test results through the Secretary's MAI Fund programs. (Outcome)	FY 2011: 93% (Target Met)	95%	96%	+1
7.1.15: Increase the proportion of newly diagnosed and re-diagnosed HIV-positive racial and ethnic minority clients linked to HIV care, as defined by attendance of at least one appointment, within three months of diagnosis, through the Secretary's MAI Fund programs. (Outcome)	FY 2011: 63% (Target Met)	73%	75%	+2
7.1.17: Increase the proportion of clinical and program staff who are provided HIV-related training through the Secretary's MAI Fund programs in one or more of the following areas: (1) HIV testing and risk counseling; (2) patient navigation and medical case management; (3) adherence assessment and counseling; (4) alternative models for delivering HIV care (task shifting, telemedicine, etc.); or (5) cultural competency (racial/ethnic, gender, and sexual orientation). (Outcome)	FY 2011: 5,319 (Target Met)	5,585[15]	5,864[16]	+279

[11] Reflects a 25% increase over the newly established baseline of 167,662 for 2011.

[12] Reflects a 5% increase over the 2012 target.

[13] Reflects a 10% increase over the baseline.

[14] Reflects a 10% increase over the 2012 Target.

[15] Reflects a 5% increase over the baseline.

[16] Reflects a 5% increase over the 2012 Target.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
7.1.18: Increase the proportion of SMAIF community-based and faith-based organizations that adopt new or enhanced organizational policies, programs, or protocols in one or more of the following capacity building areas: (1) targeting HIV testing in community settings; (2) increasing the rate of receipt of HIV test results; (3) improving active linkage to, or re-engagement in, care for infected clients; and (4) facilitating effective patient navigation that improves retention in continuous care. (Outcome)	FY 2011: 121 (Target Met)	133[17]	146[18]	+13

[17] Reflects a 10% increase over the baseline.

[18] Reflects a 10% increase over the 2012 target.

PHS EVALUATION
OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Dollars in Thousands

Program Level	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
OASH	4,510	4,510	4,285	-225

Authorizing Legislation .... Section 241 PHS Act
FY 2013 Authorization .... Indefinite
Allocation Method .... Direct Federal, Contracts

Program Description and Accomplishments

The Office of Public Health and Science (OASH) exhibits an essential role in the Public Health Evaluation Set-Aside program at HHS. Within OASH, the Immediate Office of the Assistant Secretary for Health (ASH) coordinates the Evaluation Set-Aside program for the ASH. Each fiscal year, OASH program offices submit proposals in an effort to improve and evaluate programs and services of the U.S. Public Health Service, and identify ways to improve their effectiveness. Studies supported by these Set-Aside funds serve decision makers in federal, state, and local government, and the private sector of the public health research, education, and practice communities by providing valuable information about how well programs and services are working. Projects that were approved for 2010 evaluation funds are listed below by HHS Strategic Goal:

Effectiveness of Programs and Strategies

Strategic Goal 2: Public Health Promotion, Disease Prevention and Emergency Preparedness – *Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.*

- Evaluate the National Blood Collection and Utilization Survey (NBCUS), a unique bi-annual industry-wide survey of 3,000 blood collection facilities and blood centers. Data collection of more than 325 data elements for blood, plasma, tissue, and cellular products are analyzed to determine the current trends in blood safety and availability, cellular therapies, and tissue transplantation. The NBCUS data and analysis survey report draws evaluative data for policy and program effectiveness. The report is also essential to the Advisory Committee on Blood Safety and Availability in assessing past and future recommendations.

- Physical Activity Guidelines Supporter Network Evaluation will determine the effectiveness of current outreach to Physical Activity Guidelines (PAG) partners via the online PAG Supporters network in order to inform future offerings/activities and evaluate this mechanism as a potential outreach tool for Dietary Guidelines for Americans (DGA) supporters (through the establishment of an online DGA Supporters Network) and *Healthy People Consortium* members. Key informant interviews and survey research will be conducted with Physical Activity Guidelines Supporters and current ODPHP Dietary Guidelines partners to identify the following: benefits, utility, and level of satisfaction with the PAG Supporters network; partner requests for offerings/activities; identify gaps between current offerings and partner requests; potential for using the PAG Supporters network as a model for forming other online supporters networks for our office. Results of this evaluation will be used to inform future physical activity and nutrition offerings and determine whether to establish a

DGA Supporters Network.

- Evaluation of HIV Prevention Programs for Young Women Attending Minority Institutions - In 2003, the OWH through the Minority AIDS Initiative initiated HIV Prevention for Young Women Attending Minority Institutions program. OWH believes these programs are an innovative approach to HIV prevention for young women and will help to reduce the risk and spread of HIV among women in the U.S. This evaluation should provide OWH with an understanding of effective gender-specific interventions, both process and outcome. This is the final year of this project.

Strategic Goal 3: Human Services – *Promote the economic and social well-being of individuals, families and communities.*

- As part of the Administration's government-wide initiative to strengthen program evaluation, the request includes $4,232,000 to continue a Federal evaluation of the projects funded under the discretionary teen pregnancy prevention program. This study is one of 23 evaluation proposals specifically approved by the Office of Management and Budget for 2011 to strengthen the quality and rigor of Federal program evaluation. To ensure the study is well designed and implemented, OAH will work with the Assistant Secretary for Planning and Evaluation (ASPE), evaluation experts at OMB and the Council of Economic Advisers during the planning, design, and implementation of the study. OAH is committed to promoting strong, independent evaluation that can inform policy and program management decisions and will post the status and findings of this and other important evaluations publicly available online.

Environmental Assessments

Strategic Goal 2: Public Health Promotion, Disease Prevention and Emergency Preparedness – *Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.*

- Community Assessment of Rosebud Sioux Tribe Suicide Prevention Initiatives – Evaluation of prevention strategies and tribal policies on reservation communities, such as Rosebud Sioux, which has epidemic levels of suicide. This project will assess the extent to which recent suicide prevention initiatives have influenced community awareness and perceptions of suicide risk, and access to services, in local communities. This formative evaluation will be the first community-based approach aimed at providing tribal officials with feedback on measurable progress toward the reduction of suicide.

Improving Program Management

Strategic Goal 2: Public Health Promotion, Disease Prevention and Emergency Preparedness – Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.

- Evaluation of the Integration of Preparedness Indicators throughout Healthy People 2020 – This project will evaluate proposed public health preparedness indicators for Healthy People 2020. The Mid-Atlantic Public Health Preparedness Coalition will serve as a technical consultant on choosing an appropriate set of preparedness indicators. This project will evaluate the utility at state and local levels for program development and strategic planning for statewide preparedness and response. It will also evaluate the utility of these indicators for assessing state and local preparedness.

- Physical Activity and Nutrition Community Moderators' Guide/Curriculum project will develop, implement and evaluate a community-based curriculum for adults with limited health literacy, in an effort to promote use of the 2008 *Physical Activity Guidelines for Americans* (PAG) and the 2010 *Dietary Guidelines for American* (DGA). In the first phase, a community moderators' guide/ curriculum will be developed according to the PAG and DGA and refined for the intended audience, building upon existing physical activity and nutrition materials and evidence-based communication principles. The community moderators' guide/ curriculum will be pilot-tested locally and in the second phase be implemented in a select number of sites nationwide and evaluated for usability and effectiveness in promoting positive behavior change.

- Building a Healthier Heartland (BHH) – BHH will evaluate, further develop and enhance a multi-stakeholder community collaboration that can amplify a consistent health message across four key community channels (Business, Schools, Organizations, Government) and model it around chronic disease risk factors (poor nutrition, physical inactivity, tobacco use). Programs would focus on such actions/issues as: Coalition Building, Measurement, Education, Messaging, Policy Change, and Social Networking. BHH strives to develop a coalition of local and national stakeholders working to strengthen partners' efforts to promote the health of Kansas City Metropolitan Area residents and employees. The goals of BHH are to improve nutrition, increase physical activity, and reduce exposure to tobacco and secondhand smoke.

Supporting an Evaluation Infrastructure

Strategic Goal 4: Scientific Research and Development - *Advance scientific and biomedical research and development related to health and human services.*

- Developing, Implementing, and Evaluating a Web-Based Performance Information Management System (PIMS). This project, led by OMH, will implement Phase II, and is intended to primarily support implementation, further integration, and evaluation of the effectiveness of system components, including use of performance and evaluation tools and resources by broader audiences in the longer term. The purpose of PIMS is to improve the Office's ability to demonstrate meaningful results in return for the public's investment in OMH-funded programs. The result of this initiative will enable OMH and its partners within OASH, HHS, and across the Nation to more effectively and efficiently produce and demonstrate more meaningful progress towards the health of racial/ethnic minorities and reduction of racial/ethnic health disparities.

- Improving Medication Assisted Substance Abuse Treatment in the U.S. Caribbean Jurisdictions – Puerto Rico and the Virgin Islands requested assistance from SAMHSA to provide technical assistance for improving their drug treatment programs. SAMHSA has gathered partners from a variety of federal programs to serve as an advisory group to seek broader assistance. There is significant substance abuse treatment need (health gap) within the territories, which this project seeks to provide strategies to ameliorate. The goals of the project are to develop a long term strategy for capacity and infrastructure development with specific actionable goals, map deliverables for SAMHSA and other Federal partners, and establish reasonable performance metrics for system improvement.

Strategic Goal 2: Public Health Promotion, Disease Prevention and Emergency Preparedness – Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.

- Developments of Health Indicators for the Nation – Evaluation of the current and past Healthy People objectives and implementation activities that will help ensure that the next generation of objectives – Healthy People 2020 – represents national health priorities, reflects extensive stakeholder input, and is relevant to a wide variety of users. The project will reach beyond the traditional public health sector to engage stakeholders from other areas not directly connected with health. This input will be gathered, evaluated, and synthesized.

- Building a Healthier Nation – State by State – will evaluate the effectiveness of national Healthy People 2020 goals and objectives in guiding the development of state action plans and their corresponding policies and programs. The components of project include: 1) an analysis of formal plans developed by states to advance Healthy People 2020, 2) an open competition for funds to develop and implement a state Healthy People 2020, and 3) the development of a Web-based Healthy People action plan toolkit.

- Evaluating Healthy People 2020 – Healthy People, Places, and Practices in the Community – will: 1) evaluate and support community-based translation of the HP 2020 goals, objectives, including the social determinants of health into practice; 2) assess community-developed health promotion and disease prevention activities identified on the HP2020 relational database as potential models for achieving the HP2020 objectives; 3) evaluate factors that contribute to community-based health promotion and disease prevention program sustainability; and 4) assess and promote effective partnerships that can sustain local-level activities.

Funding History

FY 2008	$5,010,000
FY 2009	$8,465,000
FY 2010	$8,965,000
FY 2011	$4,510,000
FY 2012	$4,510,000

Budget Request

The FY 2013 Budget for OASH is $4,285,000, a decrease of $225,000 below the FY 2012 Enacted level. OASH will continue its established operations at this level.

PHS EVALUATION
TEEN PREGNANCY PREVENTION
Dollars in Thousands

Program Level	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
OASH	4,455	8,455	4,232	-4,223

Authorizing Legislation..........Section 241 of the PHS Act
FY 2013 Authorization.......... Indefinite
Allocation Methods..........Direct Federal, Contracts

Program Descriptions and Accomplishments

As part of the Administration's govern-wide initiative to strengthen program evaluation, the request also includes $4,000,000 for a Federal evaluation of the projects funded under the discretionary TPP program. This study is one of 23 evaluation proposals specifically approved by the Office of Management and Budget (OMB) for FY 2011 to strengthen the quality and rigor of Federal program evaluation. To ensure that the study is well designed and implemented, OAH will work with the HHS Assistant Secretary for Planning and Evaluation (ASPE), evaluation experts at OMB, and the Council of Economic Advisers during the planning, design and implementation of the study. OAH is committed to promoting strong, independent evaluation that can inform policy and program management decisions and will post the status and findings of this and other important evaluations publicly available online.

Funding History

FY 2008	$0
FY 2009	$0
FY 2010	$0
FY 2011	$4,455.000
FY 2012	$8,455,000

Budget Request

The FY 2013 Budget includes $4,232,000 a reduction of $4,223,000 in Public Health Service (PHS) Act evaluation funds "to carry out evaluations (including longitudinal evaluations) of teen pregnancy prevention approaches." Most of the PHS evaluation funds support the Evaluation of Adolescent Pregnancy Prevention Approaches (PPA) study being conducted and this support will continue through the end of the contract in FY 2016. Additional PHS evaluation funds are used to support the Teen Pregnancy Prevention (TPP) Replication study that began in FY 2010 and will end in FY 2015. OASH is committed to promoting strong, independent evaluation that can inform policy and program management decisions and will post the status and findings of this and other important evaluations publicly available online.

PHS EVALUATION
THE OFFICE OF THE ASSISTANT SECRETARY FOR FINANCIAL RESOURCES

Dollars in Thousands

Program Level	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	1,503	2,253	1,428	-825
FTE	0	0	0	0

Authorizing Legislation.......................................Section 241 of the PHS Act
FY 2013 Authorization....................................... Indefinite
Allocation Methods.......................................Direct Federal, Contracts

Program Description and Accomplishments

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

Funding History

FY 2008	$503,000
FY 2009	$503,000
FY 2010	$1,503,000
FY 2011	$1,503,000
FY 2012	$2,253,000

Budget Request

The FY 2013 Budget for the Assistant Secretary for Financial Resources (ASFR) is $1,428,000 which is a reduction of $825,000 from the FY 2012 Enacted level. The FY 2013 Budget will be used to fund program evaluation activities within the ASFR Office of Budget.

PREVENTION AND PUBLIC HEALTH FUND

Funding by Agency

(Dollars in Thousands)

Program Level	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request
Obesity Prevention and Fitness (ASPA)	**9,100**	**0**	**0**
Tobacco (ASPA)	**10,000**	**10,000**	**5,000**
Teen Pregnancy Prevention (OASH)	**0**	**0**	**104,790**
OS Subtotal	***19,100***	***10,000***	***109,790***
Emerging Public Health Issues	**0**	**20,000**	**0**
Alzheimer's Disease Activities	**0**	**0**	**100,000**
Total	**19,100**	**30,000**	**209,790**

Authorizing and Appropriations Legislation............Section 4002 of the Affordable Care Act, Pub. L. 111-148 (2010)
Allocation Methods......................................Competitive Grants/Cooperative Agreements, Contracts, and Intramural

Program Description and Accomplishments

Section 4002 of the Affordable Care Act establishes a mandatory appropriation for prevention and public health activities. The Act appropriated $500 million beginning in FY 2010. The appropriated levels increase each fiscal year to $2 billion in FY 2015 and remain at $2 billion in the out-years. For FY 2013, the law appropriates $1.25 billion into the Fund. The purpose of the Fund is to "expand and sustain national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs." The Act provides the Secretary with the authority to transfer appropriated amounts to accounts within HHS.

The HHS activities funded in FY 2013, from the Prevention and Public Health Fund, are focused on promoting wellness and preventing chronic disease. The FY 2013 investments support activities such as prevention research, community and State prevention, public health infrastructure, the health care workforce, targeted investments for tobacco and obesity, and health care surveillance.

Funding Allocation

The FY 2013 HHS allocation for the $1.25 billion available in the Prevention and Public Health Fund reflects a balanced portfolio of investments to improve health and to help restrain the growth of health care costs. The FY 2012 allocation aligns with the risk factors and behaviors associated with the leading causes of death, as described in the National Prevention, Health Promotion and Public Health Council's status report for FY 2010.

In FY 2013, the HHS allocation supports public health infrastructure and workforce, a community and State prevention activities, and critical areas in prevention research, health screenings, tobacco and obesity prevention, and health care surveillance. The FY 2013 HHS allocation includes the agencies and offices shown in the following tables. For more information on activities funded within each allocation, please refer to the agency's or staff division's FY 2013 budget justification.

PREVENTION AND PUBLIC HEALTH FUND
OBESITY PREVENTION AND FITNESS

Dollars in Thousands

Program Level	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
ASPA	9,100	0	0	0

Authorizing Legislation…………………………………………………..……....Affordable Care Act, Section 4002
Authorization………………………………………………………………………………………….FY 2015
Allocation Method…………..……………………………………..………...Direct Federal Competitive Contract

Program Description and Accomplishments

ASPA

In FY 2011 funding supported public awareness campaigns targeting at-risk populations for anti-obesity and healthy lifestyle initiatives. The initiatives developed and executed innovative communication campaigns, both print and on-line materials. These health initiatives included breast-feeding campaigns, as well as the opportunity to support the Surgeon General's Call to Action on Breastfeeding. Each campaign was responsible for:

- Marketing research
- Media analyses
- Message development and testing
- Focus group testing
- Monitoring the progress and success of these campaigns

Funding History

FY 2008	$0
FY 2009	$0
FY 2010	$9,120,000
FY 2011	$9,100,000
FY 2012	$0

Budget Request

ASPA

HHS is not requesting funds for this program for FY 2013.

PREVENTION AND PUBLIC HEALTH FUND
TOBACCO

Dollars in Thousands

Program Level	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
ASPA	10,000	10,000	5,000	-5,000

Authorizing Legislation…………………………………….…………..Affordable Care Act, Section 4002
Authorization……………………………………………………….………………………………FY 2015
Allocation Method…………..………………...……………………………Direct Federal Competitive Contract

Program Description and Accomplishments

The Department has invested heavily in the regulatory and scientific aspects of tobacco control. There is a need to accelerate the implementation and funding of tobacco control interventions, particularly for vulnerable populations (women, minorities, low socio-economic status) to reduce the disparities and diseases that plague these groups as a result of widespread tobacco use.

The allocation is in direct support of the Secretary's Strategic Initiatives to prevent and reduce tobacco use and to ensure program integrity and responsible stewardship of Federal funds. Additionally, these funds will support the Secretary's priority goals of creating better systems of prevention and eliminating health disparities and achieving health equity.

ASPA

ASPA will continue its work related to the tobacco cessation campaign:

- Develop creative outreach ideas and strategies. Conduct market research and consumer testing as appropriate.
- Promote and market educational tools available for public use
- Execute innovative health marketing campaigns at the national, regional, and local level
- Provide substantive expertise on effective strategies to segment target audience groups and engage in public awareness activities
- Collaborate on the creation of public education tools, such as websites, action kits, etc.
- Monitor the ongoing progress and media coverage of the campaign
- Report at regular intervals the impact of campaign activities

Funding History

FY 2008	$0
FY 2009	$0
FY 2010	$900,000
FY 2011	$10,000,000
FY 2012	$10,000,000

Budget Request

ASPA

ASPA's FY 2013 Budget for tobacco prevention of $5,000,000 to $5,000,000 less than the FY 2012 Enacted level. ASPA will continue its work related to the tobacco prevention and cessation campaign. ASPA will collaborate on the creation of public education tools such as websites, and action kits, to help consumers find more key resources. ASPA will conduct market research and consumer testing as appropriate and continue to monitor ongoing media campaigns to promote HHS' public health goals for tobacco prevention and cessation.

PREVENTION AND PUBLIC HEALTH FUND
TEEN PREGNANCY PREVENTION

Dollars in Thousands

Program Level	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
OASH	0	0	104,790	104,790

Authorizing Legislation……………………………………………………..Affordable Care Act, Section 4002
Authorization………………………………………………………………………………………FY 2015
Allocation Method…………..…………………..………………………………Direct Federal Competitive Contract

Program Description and Accomplishments

The Teen Pregnancy Prevention (TPP) program is a discretionary grant program to support evidence-based and innovative approaches to teen pregnancy prevention, and is under the direction of the Office of Adolescent Health (OAH). These funds support competitive grants to public and private entities to fund medically accurate and age appropriate programs that reduce teen pregnancy and for the Federal costs associated with administration and evaluation. OAH coordinates its efforts with other HHS offices and OPDIVs.

The TPP is a key component of the Secretary's Key Inter-Agency Collaboration to *Reduce Teen and Unintended Pregnancy.* These funds support both the replication of evidence-based models and demonstration programs to identify new effective approaches. OAH is currently funding 75 grants to replicate one or more of 28 evidence-based program models. The 28 evidence-based teen pregnancy prevention program models were identified by HHS through an independent systematic review of the existing literature. Another 19 grants are being funded to develop, refine, and test additional models and innovative strategies for preventing teen pregnancy. In collaboration with CDC, the program is supporting eight grants to implement and test multi-component community-wide initiatives to prevent teen pregnancy. OAH is engaged in collaborations in implementing TPP program and evaluation activities with ASPE, ACF, and CDC. OAH developed performance measures for the TPP program and grantees will be expected to begin collecting performance measure data in September, 2011. OAH is also partnering with ASPE to support an ongoing review of the evidence base. In the first year, TPP grantees were engaged in a planning, piloting and readiness period and are expected to fully implement their projects in October, 2011.

Funding History

FY 2008	$0
FY 2009	$0
FY 2010	$0
FY 2011	$0
FY 2012	$0

Budget Request

Teen Pregnancy Prevention has been funded in General Departmental Management but the funding source will change to the Prevention and Public Health Fund of the Patient Protection and Affordable Care Act of 2010. The FY 2013 Budget is $104,790,000. The program structure will remain unchanged.

Program Data Chart

Activity	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget
Contracts			
Training, technical assistance , and other program support	1,789,000	1,789,000	1,789,000
Grants/Cooperative Agreements			
Teen Pregnancy Prevention Grants (Discretionary)			
Tier I – Replication Projects	75,000,000	75,000,000	75,000,000
Tier II – Research and Demonstration Projects	25,000,000	25,000,000	25,000,000
Subtotal, Grants/Coops	100,000,000	100,000,000	100,000,000
Operating Costs	3,001,000	2,803,000	3,001,000
Total	**104,790,000**	**104,592,000**	**104,790,000**

PREVENTION AND PUBLIC HEALTH FUND
ALZHEIMER'S DISEASE INTIATIVES

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Budget Authority	0	0	100,000	100,000
FTE	0	0	0	0

Program Description and Accomplishments

Alzheimer's disease is a brain disease that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks. Memory problems are one of the first signs of Alzheimer's. People may have trouble remembering things that happened recently or names of people they know. Over time, symptoms will most often get worse, and problems can include getting lost, repeating questions, and taking longer than normal to finish daily tasks. As the disease progresses, people may have trouble learning new things, recognizing family and friends, and communicating. Eventually, they need total care.

In December 2011, HHS unveiled an ambitious proposal to eliminate the national burden of Alzheimer's disease and related dementias by 2025. It also released the National Institutes of Health's (NIH's) annual review of Alzheimer's-related research. The draft *National Plan to Address Alzheimer 's disease* outlines specific steps to accelerate research on treatment and prevention of the disease. It also lays out ways to improve care, services, and support for patients, families and caregivers.

Recent studies have demonstrated that the burden to caregivers of dementia patients can be reduced by effective evidence-based programs and that institutionalization of care recipients can be delayed by these programs. These programs are now "scaled up" and are being used in community settings. The stage is now set for studies that will identify the most effective of interventions, giving clinicians information to tailor care appropriate to patients, given the cost, effectiveness and acceptability of these programs

Funding History

FY 2008	$0
FY 2009	$0
FY 2010	$0
FY 2011	$0
FY 2012	$0

Budget Request

The FY 2013 Budget includes $100,000,000 for research and other activities related to Alzheimer's Disease.

PREGNANCY ASSISTANCE FUND

Dollars in Thousands

Program Level	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
OASH	25,000	25,000	25,000	0

Authorizing Legislation………………..……………..…Patient Protection and Affordable Care Act, Section 10214
FY 2013 Authorization……..……..………………………………………………………………FY 2019
Allocation Method…………………..…………………………………..……Direct Federal Competitive Contract

Program Description and Accomplishments

The Office of Adolescent Health (OAH) is responsible for implementing and administering the Pregnancy Assistance Fund, a competitive program of grants to States and Indian Tribes to develop and implement projects to assist pregnant and parenting teens and women. The program is authorized by Sections 10211- 10214 of the Affordable Care Act (Public Law 111-148); specifically, the Act appropriates $25,000,000 for each of fiscal years 2010 through 2019 and authorizes the Secretary of HHS, in collaboration and coordination with the Secretary of Education (as appropriate) to establish and administer a Pregnancy Assistance Fund for the purpose of awarding competitive grants to assist pregnant and parenting teens and women. A network of supportive services help pregnant and parenting teens and women complete high school or postsecondary degrees and gain access to health care, child care, family housing, and other critical support. In addition, states are encouraged to use the funds to address violence against pregnant and parenting women.

A total of $25 million was available in FY 2010 and again in FY 2011 to support pregnant and parenting teens and women in States and Tribes across the country. Of the funds awarded, $24 million was awarded to 17 States and Tribes and $1 million for administrative expenses.

The Budget is in direct support of the Secretary's key interagency collaboration to reduce teen and unintended pregnancy. This program will also support the Secretary's Strategic Initiative to Promote Early Childhood Health and Development. Additionally, these funds will support the OASH's priority goals of creating better systems of prevention and eliminating health disparities and achieving health equity.

Funding History

FY 2008	$0
FY 2009	$0
FY 2010	$25,000,000
FY 2011	$25,000,000
FY 2012	$25,000,000

Budget Request

The FY 2013 Budget of $25,000,000 is equal to the FY 2012 Enacted Level. Activities will be continued at the established levels in FY 2012.

DETAIL OF FULL-TIME EQUIVALENT (FTE)

	FY 2011 Actual			FY 2012 Enacted			FY 2013 Budget Request		
	Civilian	**Military**	**Total**	**Civilian**	**Military**	**Total**	**Civilian**	**Military**	**Total**
Direct:	1,137	48	1,185	1,072	50	1,122	1,082	40	1,122
Reimbursable:	387	11	398	314	10	324	309	15	324
FTE Total	**1,524**	**59**	**1,583**	**1,386**	**60**	**1,446**	**1,391**	**55**	**1,446**

Average GS Grade

FY 2007…………… GS 12/2
FY 2008…………… GS 12/3
FY 2009…………… GS 12/3
FY 2010…………… GS 12/4
FY 2011…………… GS 12/4
FY 2012…………… GS 12/6

Detail of Positions

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Estimate
Executive level I	1	1	1
Executive level II	1	1	1
Executive level III			
Executive level IV	9	9	9
Executive level V			
Subtotal	11	11	11
Total - Exec. Level Salaries	$1,779,000	$1,779,000	$1,779,000
SES	98	98	98
Total - ES Salary	$16,942,900	$16,942,900	$16,942,900
GS-15	144	145	145
GS-14	176	177	177
GS-13	202	194	194
GS-12	325	276	278
GS-11	201	196	199
GS-10	37	25	25
GS-9	193	158	158
GS-8	63	29	29
GS-7	52	55	55
GS-6	9	9	9
GS-5	13	13	13
GS-4			
GS-3			
GS-2			
GS-1			
Subtotal	1,415	1,277	1,282
Commissioned Corps	59	60	55
Total Positions	1,583	1,446	1,446
Total FTE	1,583	1,446	1,446
Average ES level	2	3	3
Average ES salary	$169,429	$169,429	$169,429
Average GS grade	12/4	12/6	12/6
Average GS Salary	$82,359	$87,350	$87,350

SIGNIFICANT ITEMS

ASSISTANT SECRETARY FOR FINANCIAL RESOURCES

Item
Anti-deficiency Act -- The Committee is aware that the Department recently reported 47 violations of the Anti-deficiency Act which involved several agencies and occurred over multiple fiscal years dating back at least to 2002. Contributing causes of the problems were inconsistent acquisition guidance regarding multi-year contracts and the lack of a legal review process for large contracts. While the Department has taken corrective action, including revising its guidance and providing appropriations law training, the Committee remains deeply concerned that these violations indicate a widespread lack of understanding of appropriations law by departmental staff. Accordingly, the Committee directs the Secretary to institute a process by which all large contracts above a certain dollar threshold are sent to the Office of the General Counsel for legal review to ensure sufficiency of available funds and compliance with appropriations law. The thresholds may vary from agency to agency. The Committee directs the Department to perform follow up sampling of contracts to ensure that improper funding practices have been corrected.

Action taken or to be taken
In July, 2011, the Secretary notified the President, Congress, and the Comptroller General of a series of violations of the Anti-deficiency Act (ADA); the deficiencies were identified by the Department through an internal review of its contract funding practices. The Department determined that the deficiencies were caused by a combined lack of understanding throughout the Department of the legal limits on funding contracts and the failure of HHS' guidance to clearly set forth the legal parameters of funding contracts, or in some instances, the misapplication of the Department's guidance.

As noted by the Committee, the Department's corrective actions taken include: sharing the results of the review across HHS and across the functional disciplines involved in the acquisition process (i.e., budget, program, contracting, and finance), revising the HHS Acquisition Regulation provisions regarding contract funding, and issuing a detailed and extensive Acquisition Policy Memorandum to explain how contracting officials should apply the new guidance. The Department has also conducted intensive training (trained over 12,000 staff) on appropriation law. Further, the Department has provided technical assistance to Heads of Contracting Activity and their staff, conducted continuous education and outreach sessions across the Department, shared pertinent legal advice with the acquisition community, and identified, tailored and adopted best practices from other federal agencies.

HHS has also developed an on-line Reference Tool for Contract Funding, Formation and Appropriations Law Compliance. The reference tool was designed to: a) help HHS staff members – program, finance/budget, and contracting – understand contract funding and formation strategies; and b) promote compliance with federal appropriation laws, regulations and policies (http://www.hhs.gov/asfr/ogapa/acquisition/contractfunding/index.html).

Regarding processes for reviewing contracts prospectively, HHS issued an Acquisition Policy Memorandum in October, 2011 which requires appropriations law compliance reviews of planned acquisitions over $5 million or $10 million, depending on the HHS Agency, by HHS' Office of Grants and Acquisition Policy and Accountability and Office of the General Counsel. These reviews are an additional safeguard to ensure the planned acquisitions for HHS' most challenging service requirements – research and development, studies, and data collection with contract performance greater than 12 months – receive the necessary oversight to ensure compliance with appropriation laws and regulations.

With respect to follow up sampling of contracts, the Department conducts annual Procurement Management Reviews (PMRs) in support of the Acquisition Assessment/Oversight process and to promote sound contracting practices and documentation. Teams of contracting experts review and assess the operations, organization structure, workforce, and contracting practices of the individual contracting offices through a structured interview and file/documentation review process. Samples of contracts are reviewed for compliance with appropriation law as part of this process. These PMRs began in FY2010 and the level of attention toward appropriation law compliance increased in FY2011. Since FY2010, six PMRs have been conducted and the reviews have shown that the sampled contracts have been funded in compliance with appropriation law. The Department will continue this practice to ensure continued compliance and has two additional reviews scheduled in FY2012.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Item
Viral Hepatitis -- The Committee commends the Secretary for developing the HHS Action Plan for the Prevention, Care and Treatment of Viral Hepatitis and urges her to increase the staff capacity at the Office of the Assistant Secretary for Health [OASH] to implement the plan. The Committee notes that hepatitis B and hepatitis C testing guidelines are not aligned across HHS operating divisions, and expects OASH to work expeditiously with CDC, AHRQ and the U.S. Preventive Services Task Force to develop a consistent national testing guideline by early 2012 to improve testing rates.

Action take or to be taken
The Agency for Healthcare Research and Quality (AHRQ) provides scientific, technical, administrative, and dissemination support to the U.S. Preventive Services Task Force (USPSTF), an independent, voluntary panel of experts in prevention and evidence-based medicine. In 2009, the USPSTF gave “high” priority to updating its recommendation on screening for Hepatitis C virus (HCV). In collaboration with the Effective Health Care Program, AHRQ commissioned a systematic evidence review on screening and treatment of HCV. Subject matter experts from the U.S. Centers for Disease Control and Prevention (CDC) were consulted throughout the process.

The results of the systematic evidence review will be presented to the USPSTF in the spring of 2012. The Task Force will deliberate the evidence and develop draft a recommendation in March 2012. After meeting in March, the Task Force will take approximately 6-8 months to complete drafting its full recommendation statement and to publish a manuscript based on the systematic evidence review in a peer-reviewed journal. The draft recommendation statement will be posted for public comment in late Fall 2012 and will be open four weeks. Approximately six months after the public comment period, the Task Force will publish the final recommendation statement in a peer-reviewed journal and post it on its website.

CDC is currently in the process of updating its HCV testing recommendations. To consider the merits and limitations of a birth cohort approach to HCV screening, CDC conducted a systematic review on the prevalence of HCV among persons born from 1945-1965 and evaluated the evidence using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) methodology. CDC convened an external consultation to review and evaluate the quality of evidence discovered by the systematic review. Since the consultation, a first draft of the recommendations has been completed and is currently under review and is expected to be finalized in early 2012.

CDC has worked closely with AHRQ to harmonize the development process for the respective HCV testing recommendations. AHRQ staff participated in the external working group and in the expert consultation for the CDC recommendations. AHRQ has included CDC staff on their Technical Expert

Panels for both HCV testing and treatment and CDC staff will serve as a peer reviewer of these final documents. Both CDC and AHRQ are using a similar processes for policy development that includes a transparent evidence review and grading to evaluate the quality of evidence and the strength of subsequent recommendations.

There are no current efforts to update CDC's recommendations for the identification and public health management of persons with chronic hepatitis B virus (HBV) infections. In July 2011, the USPSTF gave "high" priority to updating its recommendation on screening for HBV in the general asymptomatic population. AHRQ has commissioned a systematic evidence review. However, given the current workload of USPSTF topics, this review will not begin until July 2012.

Item

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

Action take or to be taken

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

Given that AANHPIs experience certain cancers at higher rates than other populations, OMH works with the CDC, NIH/NCI, and community organizations to address the unique and pressing needs in this population through screening and prevention as well as in the clinical setting and in cancer control planning. The increased rate of liver cancer is directly tied to higher rates of Hepatitis B in AAPI populations; efforts to lower the rate of Hepatitis B will significantly impact its most devastating sequel liver cancer. OMH will continue to provide support for AANHPI community based organizations to develop targeted outreach programs designed to reach specific populations at risk with hepatitis B through culturally-sensitive and linguistically appropriate evidence-based interventions. In addition, the higher rates of stomach cancer in AAPI populations have been linked to dietary factors. As noted in the AAPI plan, OMH will work with the Office on Women's Health (OWH) and HRSA as part of a national program on prevention education and train AANHPIs to become ambassadors in their communities using the "train the trainer" model for prevention education. Programs like these will highlight the importance of diet and exercise in reducing cancer risk in AANHPI populations.

Item

Chronic Kidney Disease (CKD) --The Committee recognizes that African Americans represent nearly 29 percent of all those treated for kidney failure and have an end-stage renal disease rate nearly three times that of their non-minority counterparts. Asian and Pacific Islanders experience a higher than average rate of CKD, with Filipinos having one of the highest rates of incidence per capita. The Committee encourages OMH to prioritize the early detection of CKD in minority communities in order to improve health outcomes and eliminate these disparities.

Action take or to be taken

Minorities in the United States are almost two to four times more likely than non-minorities to develop CKD. Diabetes and high blood pressure cause 75 percent of the cases of CKD. The Institute of Medicine has highlighted initiatives that target these disorders as important for reducing the rate of kidney

failure, improving health outcomes, and eliminating these disparities. The Office of Minority Health established the Partnerships Active in Communities to Achieve Health Equity (PAC) Program to improve health outcomes among racial and ethnic minorities through the establishment of community-based networks that collaboratively employ evidence-based disease management and preventive health activities; build the capacity of communities to address social determinants and environmental barriers to healthcare access; and increase access to and utilization of preventive health care, medical treatment, and supportive services. This program directly targets the main risk factors for CKD in minority communities (diabetes, hypertension) and by building community networks and emphasizing prevention takes aim at the complications of these diseases such as chronic kidney failure.

As an example, St. Vincent Mercy Medical Center, in Toledo OH, is being supported by this program to develop and mobilize community partnerships of integrated health, social and supportive services for diabetes prevention and care in African American communities. They will also develop and implement evidence-based diabetes management and preventive health programs inclusive of screening programs for kidney diseases.

Item

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

Action take or to be taken

The Office of Minority Health (OMH) has developed a number of initiatives targeting diseases that disproportionately affect minority women. For instance, OMH leads disparities in lupus through the Lupus Education and Training for Health Professionals Program. This program emphasizes education and training in the medical professions to improve the diagnosis and treatment of lupus, which disproportionately affects minority women. OMH also works with a number of other agencies to address health disparities in minority women.

For example, the Office on Women's Health (OWH) has developed targeted programs and services to address specific health conditions, including:

- HIV/AIDS – OWH funds HIV prevention education for women living in the continental United States, the U.S. Virgin Islands, and Puerto Rico. OWH also funds programs directed at various minority groups, such as In Community Spirit, an HIV prevention program for Native American women living in rural and frontier Indian country; and Straight Talk on Preventing HIV, a program that develops gender and age-specific, culturally, and linguistically-appropriate HIV/AIDS prevention education to reach at-risk racial and ethnic minorities.
- Cardiovascular Health – OWH funded various projects aimed at reducing cardiovascular disease among African American women, including Generations and a project with the National Black Nurses Foundation.
- Sexual Health, Pregnancy and Breastfeeding – The Preconception Peer Educators Program addresses sexual health in minority women by training college students as peer educators to disseminate essential preconception health messages, including health disparities and minority health. The initiative targets minority students to be trained as peer educators. OWH has also partnered with the African-American Breastfeeding Alliance, Inc. to educate the African American community about the benefits of breastfeeding through education, counseling, training, and advocacy.

The Department also shares the Committee’s concerns about the higher rate of pre-term birth and infant mortality in minority communities, that is why a number of programs have been launched including:

- ***A Healthy Baby Begins with You***, a national campaign to raise awareness about infant mortality with an emphasis on the African American community. The goal of the campaign is to continue a broad infant mortality awareness campaign and expand it to include preconception and inter-conception health messages. Activities focus on strengthening OMH leadership at the local level through the establishment of working partnerships with Healthy Start Programs, state/city health departments, State OMHs and community based organizations. Activities also focus on increasing OMH involvement with colleges and universities, and institutions such as Historically Black Colleges and Universities, through targeted health messages emphasizing preconception health and healthcare and training for minority college students to be health ambassadors.
- The Health Resources and Services Administration’s (HRSA) ***Text4baby*** is a free mobile information service designed to promote healthy birth outcomes and to reduce infant mortality among underserved populations. Women who sign up for the service by texting BABY (or BEBE for Spanish) to 511411 will receive three free SMS text messages each week, timed to their due date or baby’s date of birth. Since its launch in February 2010, over 100,000 subscribers have enrolled in the program. An evaluation funded by HHS is underway to examine the characteristics of women who utilize the text4baby mobile phone-based program, assess their experience with the program, and determine whether text4baby is associated with timely access to prenatal care and healthy behaviors during pregnancy and through the first year of the infant's life.

Other programs targeting women include:

- OMH’s Minority Youth Tobacco Elimination Project promotes tobacco prevention and cessation strategies in Young Racial and Ethnic Minorities (ages 11 – 18), and Low Socioeconomic Status (LSES) Women of childbearing age (19-26). MYTEP grantees are funded to design and implement culturally and linguistically appropriate evidence-based smoking prevention and cessation strategies among these targeted groups. MYTEP will involve the examination, implementation, and evaluation of a range of smoking prevention and cessation strategies including smoking quit lines, smoking prevention, and effective environmental, system, and policy change strategies. A key feature of MYTEP is the inclusion of a technical support and evaluation center to provide grantees with technical guidance and evaluation support to ensure proposed strategies and interventions are appropriately selected, targeted, and tailored to target communities and populations.
- The Food and Drug Administration’s (FDA) campaign on Safe Medication Use features four video (Spanish with English subtitles) projects (under development) uses an engaging “novella” infotainment format to raise awareness and educate underserved Hispanic/Latino women on safe medication use. Issues addressed include: record keeping of prescribed or over-the-counter medicines, reading the label, skipping doses or sharing medications, safe ways to take medications, and the importance of consulting your health provider (doctor, nurse, or pharmacist) to learn more about safe use of these products.

HHS’ efforts to continue and expand collection of data capturing racial and ethnic information include the following:

The Affordable Care Act (ACA) includes several provisions aimed at eliminating health disparities in America. Section 4302 (Understanding health disparities: data collection and analysis) of the ACA focuses on the standardization, collection, analysis, and reporting of health disparities data.

In October 2011, new data standards were developed to improve our ability to highlight disparities in health status and to help target research and tailor interventions for underserved and minority communities. New categories for specific groups have been disaggregated based on the recommendations

from the 1997 Office of Management and Budget Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. They include:

- Pacific Islanders – Guamanian and Chamorro, Samoan and "other Pacific Islander" have been added as explicit categories for data collection.
- Asian populations – Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese and "Other Asian" have been added as explicit categories.
- Hispanics – Mexican, Mexican American and Chicano/a, Puerto Rican, Cuban, and other Hispanic Latino/a or Spanish origin have been added as explicit categories.
- The National "progression plan" announced in June allows questions on lesbian, gay, bisexual and transgender health to be integrated into national HHS data collection efforts.

Item

Hepatitis B --The Committee notes that Asian Americans, Native Hawaiians and other Pacific Islanders (AANHPI) comprise more than 1.5 million of the 2 million estimated hepatitis B carriers in the United States and consequently have the highest rate of liver cancer among all ethnic groups. The Committee urges OMH to expand outreach and preventive hepatitis B programs specific to Asian and Pacific Islanders and other groups disproportionately affected by hepatitis B. The Committee believes that the recently completed HHS Action Plan for the Prevention and Treatment of Viral Hepatitis will inform and guide this expanded effort.

Action take or to be taken

In May 2011, HHS released *Combating the Silent Epidemic of Viral Hepatitis*, an action plan for the prevention, care, and treatment of viral hepatitis. The plan seeks to raise awareness among public and health care professionals and to encourage opportunities for prevention, diagnosis, and treatment. The plan will be carried out by improving coordination of viral hepatitis activities across HHS operating divisions, and mobilizing stakeholders at all levels of government, private sector, and the impacted populations.

The Viral Hepatitis plan calls for providers to better recognize the diversity of patients at risk for viral hepatitis such as AANHPIs. The plan will also help to reduce morbidity and mortality of hepatitis B by strengthening the capacity of state and local health departments to collect a core set of viral hepatitis surveillance data. In addition, the plan will reduce prenatal Hepatitis B by ensuring that hospitals and birthing centers administer a "birth dose" of Hepatitis B vaccine to all neonates prior to discharge; improve prevention for infants born to Hepatitis B-infected mothers with high viral load; and ensure that children who were not vaccinated at birth and who have parents born in countries with high rates of Hepatitis B are tested and vaccinated as needed.

In addition, the Goals and Strategies to Address Chronic Hepatitis B in Asian American Native Hawaiian and Other Pacific Islander Populations, which presents the recommendations of the National Task Force on Hepatitis B Expert Panel, convened by the HHS Office of Minority Health (OMH). The report includes 5 strategies for addressing Hepatitis B inequities in AAPIs.

OMH will work in conjunction with the HHS Action Plan implementation team to ensure its activities are consistent with and guided by the Plan's key goals. OMH will focus on increasing Hepatitis B education and help to improve community-based interventions to prevent Hepatitis B-related liver disease in the high-risk AANHPI community through the following activities:

- Continuing to support the promotion of the San Francisco Hep B Free Campaign, a community-based viral Hepatitis B prevention model that collaborates with city government, private healthcare, community organizations and businesses to make high risks AANHPI communities free of Hepatitis B. Replications of this model will be promoted in three to four other U.S. cities with high concentrations of AANHPIs through the development of a Hep B Free Strategic Plan.

- Increasing capacity of community based organization (CBO) to advocate for programs for early detection and prevention of Hepatitis B infection in medically underserved AANHPI communities. OMH will provide support for AANHPI CBOs to develop targeted outreach programs designed to reach specific populations at risk with Hepatitis B through culturally-sensitive and linguistically appropriate evidence based interventions in 2012.
- Partnering with national partners to continue promoting a national campaign to raise awareness of the epidemic of chronic hepatitis B in AANHPI communities. The focus of the campaign is a television public service announcement (PSA) that encourages AANHPIs to get tested for hepatitis B. The public service announcement titled "Silent Killer" has been translated into Chinese, Vietnamese, and Korean and aired on television networks and community stations in metropolitan areas with significant AANHPI populations, including Houston, Los Angeles, New York City, Philadelphia, Seattle and Washington, DC.

GRANTS.GOV

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

The Assistant Secretary for Financial Resources (ASFR) manages the Grants.gov program. Grants.gov is the Federal government's "one-stop-shop" for grants information, providing information on over 1,000 grant programs and $450 billion awarded by the 26 grant-making agencies and other Federal grant-making organizations. The initiative enables Federal agencies to publish grant funding opportunities and application packages online, while allowing the grant community of over one million organizations (State, local, and tribal governments, education and research organizations, non-profit organizations, public housing agencies, and individuals) to search for opportunities and download, complete, and electronically submit applications.

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

The initiative provides benefits to the following agencies:

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

From its inception, Grants.gov has transformed the Federal grants environment by streamlining and standardizing public-facing grant processes, thus facilitating an easier application submission process for

our applicants. The Grants.gov Program Management Office (PMO) works with agencies on system adoption, utilization, and customer satisfaction.

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

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

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

Risk 1: Grants.gov may not receive sufficient funding to complete project milestones. The Grants.gov PMO operations are funded entirely by agency contributions, including salaries and expenses for full-time staff, and support contracts for system integration, hardware platforms, upgrades, software licenses, Independent Verification and Validation, outreach and liaison, contact center, performance metrics monitoring, and office support. If the PMO does not receive sufficient funding, or if the agency contributions are not provided in a timely manner, the PMO would have to limit or stop providing the services it offers to its stakeholders.

Risk mitigation response: Grants.gov risk mitigation is a multifaceted approach that includes internal actions as well as external entities. Internally, the PMO incrementally funds contract requirements when adequate funds are not available, and when funds becomes available it will fully fund requirements. The PMO closely monitors contract expenditures and PMO activities such as training and travel expenditures to ensure the available budget will cover the actual expense. Externally at the beginning of the fiscal year the PMO develops and sends documentation to each funding agency to initiate funding transfers and then reports the status of agency contribution to the Grants Executive Board (GEB) and OMB. Another mitigation activity is that the GEB is currently working on a long term funding strategy for Grants.gov. In FY 2010 Grants.gov will transition to a Fee-for-Service based fee structure that was approved by the GEB in FY 2008. This structure will distribute agency costs amongst agencies on usage basis, however it does not alleviate the current funding process of executing 26 funding agreements each fiscal year to transfer operating funds to HHS for Grants.gov. The GEB will explore ways to transfer the funding without having to execute 26 separate agreements.

Risk 2: Grants.gov receives and distributes grants applications that contain proprietary information that must be safeguarded.

Risk mitigation response: Grants.gov mitigates this risk through the use of policy /procedure and by physical means. Grants.gov has specific policy on the creation of system super user accounts and provides these users recommended authentication procedures. Grants.gov uses encrypted channels and limits the time that application data is retained on the Grants.gov system.

Risk 3: A fundamental concept of electronic commerce is the standardization of a common set of terms to be used by trading partners during business communications. Grants.gov requires common data processes in order to function. The inability to define common data and processes could delay system adoption or impede program goals.

Risk mitigation response: The Grants.gov system was developed in accordance with the electronic standards for core grants data, Transaction Set 194, which were developed by the Inter-Agency Electronic Grants Committee (IAEGC). The Grants.gov PMO worked with the PL 106/107 workgroup and IAEGC to build consensus, and continues to work to minimize the required changes to agency and applicant processes, to minimize agency-specific forms, and to publish existing forms and encourage agencies to use them.

Risk 4: The Grants.gov system's centralized architecture increases the impact of system failure and performance issues.

Risk mitigation response: The PMO has incorporated off-line forms that can be submitted through alternate paths (e.g., e-mail, mail, or fax) and that distribute the computational load. The PMO also ran pilot electronic applications in parallel with paper submissions during it initial operational phases. The Grants.gov system uses a high-availability configuration for central system and has implemented effective monitoring & restoration procedures. The PMO routinely measures system performance and forecasts application loads and recommends that agencies spread opportunity closing dates to spread system loads. In times of heavy system loads the PMO gives a higher priority to application receipt processing and defers back-end processing to after peak capacity periods. In FY 2010, the PMO deployed upgraded hardware and redesigned system network architecture that has removed most single points of failure within the Grants.gov system and provided what is virtually a private-cloud environment within the Grants.gov architecture that allows for rapid (and in many cases automatic) redeployment of system resources to respond to spikes in system demand. The system has been running at between 25 and 50 percent of current system capacity since the upgrade. Risk of system failure or performance issue has been significantly reduced and is no longer considered a major risk."

FUNDING: The total development cost of the Grants.gov initiative by fiscal year -- including costs to date, estimated costs to complete development to full operational capability, and estimated annual operations and maintenance costs -- are included in the table below. Also included are the sources and distribution of funding by agency, showing contributions to date and estimated future contributions through FY 2012.

Grants.gov
FY10-12 Agency Funding Contributions

Agency	FY 2010	FY 2011	Total FY 2012
HHS	5,304,638	5,351,254	5,125,765
DOT	326,220	341,215	357,566
ED	693,539	693,539	705,947
HUD	409,327	414,422	412,146
DHS	330,895	333,118	389,508
NSF	475,294	486,442	481,957
USDA	520,732	529,802	483,380
DOC	333,740	335,476	330,894
DOD	676,559	680,529	640,107
DOE	438,664	441,866	508,215
DOI	733,176	835,507	927,758
DOL	179,472	180,930	174,821
EPA	479,847	479,847	427,636
USAID	251,360	251,360	332,549
USDOJ	594,241	594,241	545,812
NASA	198,038	198,038	215,549
CNCS	60,419	60,419	63,939
DOS	155,159	155,159	186,191
NEH	155,159	155,159	186,191
SBA	68,730	68,730	78,958
IMLS	55,127	63,224	70,197
NEA	155,159	155,159	169,437
VA	40,583	44,617	33,162
NARA	52,774	52,774	54,865
SSA	39,300	39,300	37,713
USDOT	39,575	39,575	41,439
Grand Total	**12,767,727**	**12,981,702**	**12,981,702**

PHYSICIANS' COMPARABILITY ALLOWANCE (PCA)

Office of the National Coordinator for Health Information Technology

		PY 2011 (Actual)	CY 2012 (Estimates)	BY 2013* (Estimates)
1) Number of Physicians Receiving PCAs		1	2	3
2) Number of Physicians with One-Year PCA Agreements		1	2	3
3) Number of Physicians with Multi-Year PCA Agreements		0	0	0
4) Average Annual PCA Physician Pay (without PCA payment)		$123,758	$114,485	$114,485
5) Average Annual PCA Payment		$14,000	$13,000	$14,000
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	0	0	0
	Category II Research Position	0	0	0
	Category III Occupational Health	0	0	0
	Category IV-A Disability Evaluation	0	0	0
	Category IV-B Health and Medical Admin.	1	2	3

*FY 2013 data will be approved during the FY 2014 Budget cycle.

In 2011 the Office of the National Coordinator for Health Information Technology (ONC) needed a qualified individual with a strong medical background to take the lead on implementing the Meaningful Use of Electronic Health Records. In 2012 ONC will need an additional individual with a strong medical background to assist with ONC's E-measures initiative. In 2013 ONC will likely need to utilize the PCA as there is a strong possibility ONC will recruit for a chief medical officer position to report directly to the National Coordinator.

In 2011 ONC lost a physician to non-federal agency. It is likely ONC would have lost this employee sooner were it not for the use of PCA. While the use of PCAs does not guarantee retention or recruitment of qualified physicians, it is the only tool ONC currently has to incentivize public service for physicians who can make much more outside of the Federal Government.

In all these cases the PCAs were awarded at the maximum $10,000.

CENTRALLY-MANAGED PROJECTS

The GDM Staff Divisions are responsible for administering certain centrally-managed projects on behalf of all Operating Divisions in the Department. Authority for carrying out these efforts is authorized by either specific statute or general transfer authority (such as the Economy Act, 31 USC 1535). The costs for centrally-managed projects are allocated among the Operating Divisions in proportion to the estimated benefit to be derived.

Project	Description	FY 2011 Funding	FY2012 Funding
Dept-wide CFO Audit of Financial Statements	These funds cover the costs of auditing the HHS financial statements annually (as required by the CFO Act of 1990), producing the Department-wide financial statements, and coordinating the HHS audit process.	$15,021,000	$14,864,000
Bilateral and Multilateral International Health Activities	These funds support activities by the Office of Global Affairs to develop and coordinate the department's crosscutting interactions with multilateral organizations and foreign governments, necessitated by the increasing intersections between domestic health priorities and international engagement	$5,811,294	$5,811,294
Upgrade to UFMS Accounting System	These funds will be used to expand the usefulness of the UFMS software with modernization projects to achieve significant improvements with regard to financial management functions.	$8,377,000	$6,002,000
Regional Health Administrators	The RHA's provide senior-level health leadership and infrastructure in HHS's ten Regions, particularly in the areas of prevention, preparedness, coordination and collaboration. The RHA's represent the Secretary, Assistant Secretary for Health and Surgeon General in the Regions, and are key players in managing ongoing public health challenges.	$2,772,090	$2,772,090
National Science Advisory Board for Bio-Security	Funds will be used by the NSABBS for providing guidance on ways to enhance the culture of responsibility among researchers, developing strategies for enhancing interdisciplinary bio-security, recommending outreach strategies, engaging journal editors on policies for review, continuing international engagement, and develop Federal policy for oversight of life sciences research at the local level based on recommendations of the NSABB.	$2,772,000	$2,771,000
Departmental Ethics Program	These funds will be used to support attorneys and other legal staff under the direction of HHS's Designated Agency Ethics Official, who provide ethics-related program services, financial disclosure reviews, training programs and audits, as required by the Ethics in Government Act and the Office of Government Ethics.	$3,334,000	$3,200,000
Secretary's Advisory Committee on Blood Safety and Availability	The Committee advises the Secretary on a broad range of public health, ethical and legal issues related to blood transfusion and transplantation safety. Such issues require coordination across many of the Operating Divisions. Funds support Committee meetings, workshops, staff, and subject matter experts.	$1,500,000	$1,500,000
President's Commission for the Study of Bioethical Issues	The Commission was created by Executive Order 13521 on November 24, 2009, replacing the President's Council on Bioethics. Its purpose is to advise the President on bioethical issues that may emerge as a consequence of advances in biomedicine and related areas of science and	$3,000,000	$3,000,000

	technology. Funding for the Council comes entirely from HHS.		
HSPD-12 Implementation	These funds are used to fund the HHS Program management Office for Homeland Security Presidential Directive 12 (HSPD-12), which requires Federal agencies to issue and maintain PIV-2 compliant ID cards to all HHS contractors and employees.	$650,000	-0-
Media Monitoring and Analysis	These funds permit the office of the Assistant Secretary for Public Affairs to provide coordinated, succinct daily monitoring services of all agency-relevant media coverage for the entire department, thus preventing duplication and overlap by the individual Operating Divisions.	$579,820	$603,013
NIH Negotiation of Indirect Cost Rates	At the request of Operating Divisions, NIH has expanded its capacity to negotiate indirect cost rates with commercial (for-profit) organizations that receive HHS contract and/or grant awards, to ensure that such indirect costs are reasonable, allowable, and allocable.	$558,000	$558,000
HHS Health and Wellness Center	These funds are used to provide a portion of the ongoing operating coasts of a health facility which promotes physical fitness for all HHS employees located in the Southwest DC complex.	$362,291	-0-
Intradepartmental Council on Native American Affairs	These funds will be used for continued support of HHS-wide tribal consultation; support new initiatives such as tribal emergency preparedness, suicide prevention and the HHS American and Alaska native health Research Advisory Council and to continue to serve as the HHS focal point for native American health and human services.	$101,430	$175,000
Chronic Fatigue Syndrome Advisory Committee	CFSAC provides expertise in biomedical research in the area of CFS, health care delivery services, insurers and voluntary organizations concerned with the problems of individuals with CFS. They meet on research, patient care, education, and quality of life for persons with CFS.	$100,000	$100,000
Motor Vehicle Management Information System	MVMIS funds are used to support a web-based tool which allows the Department to manage its motor vehicle fleet and be in compliance with all applicable Federal and HHS policies, laws and regulations.	$64,000	-0-
SES Leadership Development Program	This program establishes a high-impact, low-cost investment in the effectiveness of our government and specifically HHS SES Leadership is the goal of the investment. It will link senior executives into national assets and connects them via modern networking technology. The program will link all senior executives via a state of the art portal to connect them as a true “corps” and help them grow as leaders.	-0-	$1,000,000
HHS Broadcast Studio	These funds will be used to give Staff and Operating divisions the ability to utilize the studio as a lead component in their communication strategies both to internal and external audiences.	-0-	$1,500,000
HHS Web Site Development	These funds will be used to provide consumer-based information about bullying prevention and intervention. Together in a multi-office collaboration effort, all HHS bullying websites will be brought into this new website, assuring optimal quality, accuracy and relativity of the site content.	-0-	$200,000

I am pleased to present the Office of Medicare Hearings and Appeals (OMHA's) Fiscal Year 2013 Congressional Justification. This budget request reflects OMHA's strong commitment to providing an independent forum for the fair and efficient adjudication of Medicare appeals for beneficiaries and other parties.

Since beginning operations in July 2005, OMHA has been committed to continuous improvement in the timely adjudication of Medicare appeals decisions through responsible stewardship. This commitment has benefitted Medicare appellants nationwide and continues to inspire OMHA's mission, accountability, and progress.

The FY 2013 budget reflects OMHA's efforts not only to build upon the operational success achieved during its first six years, but also to implement a strategic new initiative critical to addressing OMHA's growing workload. OMHA's vision is to perform "World class adjudication for the public good," by becoming a fully electronic, efficiently managed and well-respected quasi-judicial agency capable of delivering high quality and timely public service. In FY 2011, dramatic increases in workloads resulted in a backlog of unheard appeals despite record productivity by Administrative Law Judge teams hearing more appeals than ever before. OMHA's Backlog Reduction Initiative builds upon our experience and is supported by key performance metrics.

Above all, this FY 2013 budget reflects OMHA's efforts to focus on the agency's mission and meet statutory deadlines given increasing workloads, by increasing efficiency through staffing and technology.

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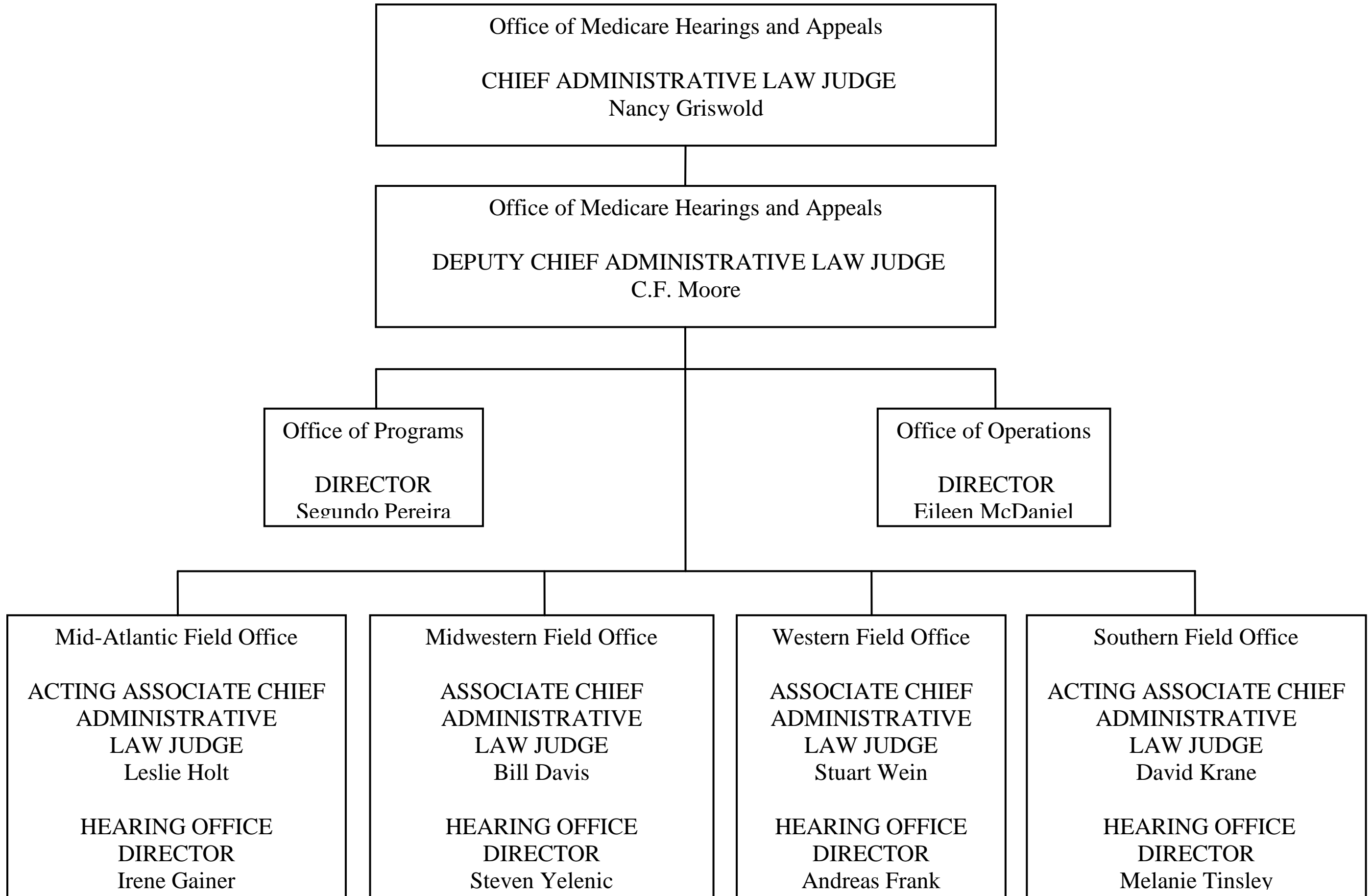
Appropriations Language

(Office of Medicare Hearings and Appeals)

For expenses necessary for administrative law judges responsible for hearing cases under title XVII of the Social Security Act (and related provisions of title XI of such Act), [$72,147] *$84,234,000,* to be transferred in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

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

OMHA ORGANIZATIONAL CHART



EXECUTIVE SUMMARY

Agency Overview

The Office of Medicare Hearings and Appeals (OMHA), an agency of the U.S. Department of Health and Human Services (HHS), administers hearings and appeals nationwide for the Medicare program. OMHA ensures that the American people have equal access and opportunity to make such appeals and can exercise their rights for health care quality and access. On behalf of the Secretary of HHS, the Administrative Law Judges (ALJs) within OMHA conduct impartial hearings and issue decisions on claims determination appeals involving Medicare Parts A, B, C and D, as well as Medicare entitlement and eligibility appeals.

Vision

World class adjudication for the public good.

Mission

OMHA is a responsive forum for the fair, credible, and timely decision-making through an accomplished, innovative, and resilient workforce. Each employee makes a difference by contributing to shaping American health care.

AMOUNTS AVAILABLE FOR OBLIGATION

(Dollars in Millions)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Request
Trust Fund Discretionary Appropriation:			
Annual appropriation	$71,147,000	$72,147,000	$84,234,000
Rescission	-$142,294	-$136,358	$0
Subtotal, adjusted trust fund discretionary appropriation	$71,004,706	$72,010,642	$84,234,000
Total, Appropriation	$71,004,706	$72,010,642	$84,234,000
Unobligated Balance, Discretionary Appropriation	$639,256	$0	$0
Total Obligations	$70,365,450	$72,010,642	$84,234,000

SUMMARY OF CHANGES

2012 Office of Medicare Hearings and Appeals appropriation[1]	72,011
Total adjusted budget authority	72,011
2013 Request – Office of Medicare Hearings and Appeals	84,234
Total estimated budget authority	84,234
Net Changes	**12,223**

	FY 2012 Enacted Base		FY 2013 Request Change From Base	
	FTE	**Amount**	**FTE**	**Amount**
Increases:				
A. Built-In:				
1. Full-Time Permanent	466	$42,332	52	$4,266
2. Other Personnel Compensation	0	$290	0	$176
3. Civilian personnel benefits	0	$12,700	0	$1,280
4. Travel and transportation of persons	0	$200	0	$132
5. Transportation of things	0	$200	0	$355
6. Rental payments to GSA	0	$6,200	0	$624
7. Communications, utilities, and miscellaneous charges	0	$1,010	0	$642
8. Printing and Reproduction	0	$20	0	$4
9. Other services from non-Federal sources	0	$400	0	$1,337
10. Other goods and services from Federal sources	0	$6,522	0	$1,589
11. Operation and maintenance of facilities	0	$506	0	$1,216
12. Operation and maintenance of equipment	0	$0	0	$195
13. Supplies and materials	0	$300	0	$121
14. Equipment	0	$228	0	$719
Subtotal, Built-In Increases	**466**	**+$70,908**	**52**	**+$12,656**
B. Programs:				
Subtotal, Program Increases			**0**	**$0**
Total Increases	**466**	**+$70,908**	**52**	**+$12,656**
Decreases:				
A. Built-In:				
1. Advisory and Assistance Services	0	$1,103	0	-$433
Subtotal, Built-In Decreases	**0**	**+$1,103**	**0**	**-$433**
B. Programs:				
Subtotal, Program Decreases			**0**	**$0**
Total Decreases	**0**	**+$1,103**	**0**	**-$433**
Net Change	**466**[1]	**+$72,011**	**52**	**+$12,223**

[1] Includes conversion of contractor positions to federal positions.

BUDGET AUTHORITY by OBJECT CLASS - DIRECT

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Personnel compensation:			
Full-time permanent (11.1)	42,332	46,598	4,266
Other than full-time permanent (11.3)	0	0	0
Other personnel compensation (11.5)	290	466	176
Military personnel (11.7)	0	0	0
Special personal services payments (11.8)	0	0	0
Subtotal, Personnel compensation	42,622	47,064	4,442
Civilian personnel benefits (12.1)	12,700	13,980	1,280
Military benefits (12.2)	0	0	0
Benefits for former personnel (13.0)	0	0	0
Total Pay Costs	55,322	61,044	5,722
Travel and transportation of persons (21.0)	200	332	132
Transportation of things (22.0)	200	555	355
Rental payments to GSA (23.1)	6,200	6,824	624
Communications, utilities, and miscellaneous charges (23.3)	1,010	1,652	642
Printing and reproduction (24.0)	20	24	4
Other Contractual Services:			
Advisory and assistance services (25.1)	1,103	670	-433
Other services from non-Federal sources (25.2)	400	1,737	1,337
Other goods and services from Federal sources (25.3)	6,522	8,111	1,589
Operation and maintenance of facilities (25.4)	506	1,722	1,216
Research and development contracts (25.5)	0	0	0
Medical care (25.6)	0	0	0
Operation and maintenance of equipment (25.7)	0	195	195
Subsistence and support of persons (25.8)	0	0	0
Subtotal, Other Contractual Services	8,531	12,435	3,904
Supplies and materials (26.0)	300	421	121
Equipment (31.0)	228	947	719
Land and Structures (32.0)	0	0	0
Investments and Loans (33.0)	0	0	0
Grants, subsidies, and contributions (41.0)	0	0	0
One-time Appropriation for Treasury (43.0)	0	0	0
Refunds (44.0)	0	0	0
Total Non-Pay Costs	16,689	23,190	6,501
Total Budget Authority by Object Class	72,011	84,234	12,223

SALARIES AND EXPENSES

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Personnel compensation:			
Full-time permanent (11.1)	42,332	46,598	4,266
Other personnel compensation (11.5)	290	466	176
Subtotal, Personnel compensation	42,622	47,064	4,442
Civilian personnel benefits (12.1)	12,700	13,980	1,280
Total Pay Costs	55,322	61,044	5,722
Travel and transportation of persons (21.0)	200	332	132
Transportation of things (22.0)	200	555	355
Communications, utilities, and miscellaneous charges (23.3)	1,010	1,652	642
Printing and reproduction (24.0)	20	24	4
Other Contractual Services:			
Advisory and assistance services (25.1)	1,103	670	-433
Other services from non-Federal sources (25.2)	400	1,737	1,337
Other goods and services from Federal sources (25.3)	6,522	8,111	1,589
Operation and maintenance of facilities (25.4)	506	1,722	1,216
Operation and maintenance of equipment (25.7)	0	195	195
Subtotal, Other Contractual Services	8,531	12,435	3,904
Supplies and materials (26.0)	300	421	121
Total Non-Pay Costs	10,261	15,419	5,158
Total Salaries and Expenses	65,583	76,463	10,880

All Purpose Table Office of Medicare Hearings and Appeals Dollars in Thousands			
	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request
Discretionary BA	**71,005**	**72,011**	**84,234**
FTE	**418**	**466**	**518**

OVERVIEW OF BUDGET REQUEST

The FY 2013 Request for OMHA of $84,234,000 represents a $12.2 million (17%) increase over the FY 2012 Enacted Level. OMHA's budget request makes investments to support HHS Strategic Goals to Strengthen Healthcare and Increase Efficiency, Transparency and Accountability of HHS Programs. This will be accomplished by maximizing its organizational legal capacity to address OMHA's increasing workload and enhancing adjudicative business processes to meet the needs of Americans, particularly Medicare beneficiaries, providers and the tax-paying public.

The FY 2013 Request:

- Addresses OMHA's workload balancing and adjudicative business processes – by sustaining a centralized docket as a stand-alone office to standardize processes and equitably distribute case assignments across OMHA's four field offices.

- Funds four new Administrative Law Judge (ALJ) teams comprised of an ALJ, attorney, paralegal and hearing clerk, and thirty-six junior attorneys to expand OMHA's organizational legal capacity for case review, decision writing, and case adjudication.

- Positions OMHA to hear more Medicare appeals than ever before and slows down the growth of the backlog in case processing.

OVERVIEW OF PERFORMANCE

OMHA's core mission and performance budget support HHS Strategic Goal 1B: Transform Health Care: Improve health care quality and patient safety (OMHA Performance Measure 1.1) and HHS Strategic Goal 4A: Increase Efficiency, Transparency and Accountability of HHS Programs: Ensure program integrity and responsible stewardship of resources (OMHA Performance Measure 1.5).

By providing an independent forum for the timely and legally sufficient adjudication of Level III Medicare appeals, OMHA helps to transform health care access by ensuring Medicare beneficiaries receive the services to which they are entitled and contributes to control of Medicare costs by ensuring that inappropriate claims are properly denied.

In FY 2011, OMHA met or exceeded four out of the seven agency performance goals. OMHA continues to evaluate its customer service through an independent evaluation that captures the scope of the Level III appeal experience by randomly surveying selected appellants and appellant representatives. Measure 1.5 aims to ensure appellants and related parties are satisfied with their Medicare appeals experience with OMHA regardless of the outcome of their appeal. The measure is evaluated on scale of 1 – 5, 1 representing the lowest score (very dissatisfied) and 5 representing the best score (very satisfied). In FY 2011, OMHA achieved a 4.2 level of appellant satisfaction nationwide, exceeding the FY 2011 target of 3.40 by 0.8. As case processing times slow in response to increasing receipts, it is anticipated that this measure will begin to drop.

OMHA leadership has taken proactive steps to achieve a more complete analysis of projected case disposition rates, case backlogs and staffing resource needs. For example, beginning in FY 2011, OMHA strengthened its methodology for calculating the number of cases closed within 90 days (Measures 1.1 and 1.2) by counting all appeals closed during a fiscal year, regardless of when the appeals were received. Previously, OMHA counted only appeals received and closed in a fiscal year. By not counting OMHA's entire caseload, this methodology understated OMHA's true staffing needs by overstating its ability to meet its statutory 90-day performance goal, as stipulated in the Benefits Improvement and Protection Act (BIPA). This more stringent methodology increased the accuracy and transparency of OMHA's measures and more accurately reflects our capacity.

OMHA continues to implement methods to increase efficiency in case processing such as the recent establishment of a centralized docketing division. The implementation of the centralized docket will help ensure a single consistent docketing process agency-wide and more equitable workload distribution across ALJ teams nationwide. Despite the efficiencies incorporated in case processing, OMHA continues to face challenges in meeting past successes for adjudicating claims within 90 days due to increasing caseload. Although ALJ teams adjudicated more cases than ever before in FY 2011, OMHA still fell short of its performance target for case adjudication. Most ALJs exceeded their sustainable capacity for case adjudication as OMHA's FY 2011 caseload increased by 21% compared to FY 2010. For the first time in OMHA's history, a backlog of unheard claims formed in FY 2011. OMHA projects that its FY 2013 caseload will increase 57% over FY 2011.

With the President's Budget funding level of $84 million, OMHA can implement measures to mitigate the growing backlog and strive to process the increasing number of ALJ appeals within the statutory timeframe, while still maintaining program integrity.

FY 2013 Budget by HHS Strategic Goal

(Dollars in Millions)

HHS Strategic Goals	FY 2011	FY 2012 Enacted	FY 2013
1.Strengthen Health Care			
1.A Make coverage more secure for those who have insurance and extend affordable coverage to the uninsured			
1.B Improve health care quality and patient safety	47.29	47.95	55.94
1.C Emphasize primary & preventative care, linked with community prevention			
1.D Reduce growth of health care costs while promoting high-value, effective care			
1.E Ensure access to quality, culturally competent care for vulnerable populations			
1.F Promote the adoption and meaningful use of health information technology			
2. Advance Scientific Knowledge and Innovation			
2.A Accelerate the process of scientific discovery to improve patient care			
2.B Foster innovation at HHS to create shared solutions			
2.C Invest in the regulatory sciences to improve food & medical product safety			
2.D Increase our understanding of what works in public health and human services			
3. Advance the Health, Safety and Well-Being of the American People			
3.A Promote the safety, well-being, resilience, and healthy development of children and youth			
3.B Promote economic & social well-being for individuals, families and communities			
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults			
3.D Promote prevention and wellness			
3.E Reduce the occurrence of infectious diseases			
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies			
4. Increase Efficiency, Transparency and Accountability of HHS Programs			
4.A Ensure program integrity and responsible stewardship of resources	23.71	24.05	28.06
4.B Fight fraud and work to eliminate improper payments			
4.C Use HHS data to improve American health and well-being of the American people			
4.D Improve HHS environmental, energy, and economic performance to promote sustainability			
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce			
5.A Invest in HHS workforce to meet America's health and human service needs today & tomorrow			
5.B Ensure that the Nation's health care workforce meets increased demands.			
5.C Enhance the ability of the public health workforce to improve health at home and abroad			
5.D Strengthen the Nation's human service workforce			
5.E Improve national, State & local surveillance and epidemiology capacity			
TOTAL	**71.00**	**72.00**	**84.00**

NARRATIVE BY ACTIVITY

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	71,005	72,011	84,234	12,223
FTE	418	466[2]	518	52

[2] Includes conversion of contractor positions to federal positions.

Authorizing Legislation…………………………..……………………Titles XVIII and XI of the Social Security Act

Allocation Method……………………………………………………………..………………………Direct Federal

NARRATIVE BY ACTIVITY

Program Description

OMHA was established in July 2005 to administer the adjudication of Level III Medicare Appeals. OMHA is the only agency that hears Level III appeals, and has a legislative mandate to adjudicate them within 90 days. OMHA serves a broad sector of the public, including Medicare service providers and suppliers and Medicare beneficiaries who are often elderly and disabled and among our most vulnerable populations. OMHA administers its program in four field offices, including the Southern Field Office in Miami, Florida; the Midwestern Field Office in Cleveland, Ohio; the Western Field Office in Irvine, California; and the Atlantic Field Office in Arlington, Virginia. OMHA utilizes video-teleconferencing (VTC) and telephone hearings to provide appellants with hearings which are timely and accessible. VTC technology, which is now commonly used throughout the country in courtrooms and for telemedicine, plays a critical role in OMHA's ability to meet the BIPA timeframes and offers expanded access for appellants to ALJ hearings.

At the time of OMHA's establishment, it was envisioned that OMHA would receive a traditional Medicare Part A and Part B workload. However, OMHA has seen an increased caseload due to the expansion of its original jurisdiction over Medicare Part A and Part B to include areas not originally envisioned to be within its authority. Specifically, in January 2006, OMHA began hearing appeals arising from the new Medicare Part D Prescription Drug Plan. In January 2007, OMHA began hearing Medicare Part B Income-Related Monthly Adjustment Amount (IRMAA) appeals.

In 2007, OMHA began receiving new cases as a result of the Centers for Medicare & Medicaid Services (CMS) pilot Recovery Audit Contractor (RAC) program. This program includes RACs for Medicare Secondary Payer (MSP) claims, as well as non-MSP claims. The demonstration project was designed to determine whether the use of RACs would be a cost-effective means of adding resources to ensure correct payments are made to providers and suppliers, thereby protecting the Medicare Trust Funds. CMS selected California, New York and Florida as the three initial States under the pilot program, and later expanded the program to include Massachusetts and South Carolina. As a result of the RAC pilot program, OMHA received more than 20,000 RAC claims through FY 2009. In January 2010, the RAC program became permanent and was expanded to all 50 States. Although OMHA originally expected to start receiving additional RAC claims in FY 2010 from the permanent expansion, CMS' implementation was delayed for more than a year. OMHA expects to start receiving this increased RAC caseload in early FY 2012.

OMHA's caseload has also increased due to the dual beneficiary claims. In FY 2011, OMHA received approximately 15,000 dual beneficiary claims from State agencies in Connecticut, Massachusetts and New York seeking Medicare reimbursement for services that would otherwise be covered under Medicaid. California, Texas and Florida are expected to follow suit. Since State agencies now have infrastructures in place for appealing Medicare denials, OMHA will continue to receive dual beneficiary claims.

In the FY 2013 President's Budget, OMHA acknowledges the importance of building upon what has worked well for the agency such as increasing the number of attorneys on a limited number of ALJ teams to increase adjudicatory efficiency, and making changes in areas where strategic information technology investments are needed and opportunities for improvement exist.

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

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

OUTPUTS AND OUTCOMES TABLE

Measure	Year and Most Recent Result Target for Recent Result Summary of Result	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
1.1: Increase the number of BIPA cases closed within 90 days *(Output)*	FY 2011: 73% Target: 88% Target Unmet	56%***	44%***	-12%
*1.2: Increase the number of non-BIPA cases closed within 90 days *(Output)*	FY 2011: 52% Target: 55% Target Unmet	57%	N/A	N/A
**1.3: For cases that go to hearing, increase the percentage of decisions rendered in 30 days *(Output)*	FY 2011: 64% Target: 85% Target Unmet	N/A	N/A	N/A
1.4: Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council *(Output)*	FY 2011: 1.5% Target: 2% Target Exceeded	1%	1%	0
1.5: Improve the average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level *(Output)*	FY 2011: 4.21 Target: 3.4% Target Exceeded	3.6	3.2	-0.4
*1.6: Decrease the cost per claim adjudicated *(Efficiency)*	FY 2011: -19% Target: 2% Target Exceeded	3%	N/A	N/A
*1.7: Increase number of claims processed per ALJ team *(Efficiency)*	FY 2011: 40% Target: 1% Target Exceeded	2%	N/A	N/A
Program Level Funding ($ in millions)	**N/A**	**$72**	**$84**	**+$12**

*Measure to be retired at the end of FY 2012 in accordance with HHS' initiative to streamline performance management by only tracking key targets within an agency's mandate and control.
**Measure retired at the end of FY 2011.
*** OMHA is modifying its performance targets in FY 2012 and FY 2013 to count all BIPA appeals closed during a fiscal year, regardless of when the appeals were received. This more accurately accounts for OMHA's case backlog due to OMHA's increasing caseload.

Funding History

FY 2008	$63,864,000
FY 2009	$64,604,000
FY 2010	$71,147,000
FY 2011	$71,005,000
FY 2012	$72,011,000

Budget Request

The FY 2013 Request for OMHA of $84,234,000 is an increase of $12.2 million (or 17%) over the FY 2012 funding level. As shown in the table below, OMHA anticipates its caseload will increase by 57% from its FY 2011 claim level (234,000) to its projected claim level of 368,000 in FY 2013. In large part, OMHA attributes this significant increase in workload to the influx in Medicare enrollees. The request allows OMHA to increase its adjudicatory capacity and staffing levels, above its current 65 ALJ teams (comprised of an ALJ, attorney, paralegal and hearing clerk.) The request enables OMHA to hire more ALJs and attorneys to expand the number of mega teams capable of adjudicating more Medicare appeals annually.

OMHA Claims Received					OMHA Claims Projected	
FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
137,000	186,000	216,000	194,000*	234,000	314,000	368,000

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

Although OMHA continues to become more efficient, OMHA is currently operating over capacity for the number of manageable claims ALJ teams can adjudicate within 90 days. OMHA believes the most viable way to address the caseload and meet its statutory timeline for case adjudication is to begin expanding its organizational legal capacity, expertise and infrastructure. Specifically, to support HHS Strategic Goals to Strengthen Healthcare and Increase Efficiency, Transparency and Accountability of HHS Programs, the FY 2013 President's Budget will support:

Backlog Reduction Initiative (BRI)

OMHA's organizational legal capacity, specifically the number of ALJ teams has remained relatively constant for the past four years. OMHA must expand its organizational legal capacity to achieve a more manageable workload per ALJ team and increase its decision writing capacity in order to prevent a significant backlog of unheard claims. The purpose of this initiative is to address the increasing workload in two hiring strategies. Under Strategy A, OMHA would hire four additional ALJ teams to assist in achieving a more manageable number of claims per ALJ team and continuing to meet its legislative mandate.

Under Strategy B, OMHA would incrementally increase the number of attorneys on each ALJ team to two by bringing thirty-six additional junior attorneys on board in FY 2013, thereby creating thirty-six

additional mega teams. Currently, a standard ALJ team is comprised of an ALJ, attorney, paralegal and hearing clerk. Adding an additional attorney to a standard ALJ team would increase the ALJ to legal staff ratio and increase OMHA's case review and decision writing capacity. Workload analysis indicates ALJs are capable of adjudicating more cases than attorneys can review and prepare for them. Based on six years of operational experience, OMHA has found having one additional attorney on ALJ teams will increase efficiency by 30% and enable incumbent ALJs to hear more claims (i.e., 3,500 claims adjudicated per standard team vs. 4,550 claims adjudicated per mega team). It is only by balancing the ability of ALJs to hear and decide cases with the ability of legal staff to review and draft legal decisions, that the use of both resources can be maximized.

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

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

- Maintenance of 46 on-site adjudication hearing rooms and the associated VTC equipment and telecommunications infrastructure, along with access to external hearing room facilities via commercial vendors.

- Maintaining information technology systems, including the Medicare Appeals System (MAS), intranet expansion, and planning for MAS enhancements. MAS is the primary business system used to track and support the adjudication of the second and third levels of the Medicare appeals process. MAS is shared by the Centers for Medicare & Medicaid and OMHA.

PERFORMANCE NARRATIVE

HHS implemented several initiatives to improve the usefulness of the Department's performance measures by streamlining the performance management process by only tracking key performance measures within an agency's mandate and control. In response to these initiatives, OMHA proposes retiring three performance measures as highlighted below.

In FY 2011, OMHA met or exceeded four out of the seven agency performance goals as follows:

- *Increase the number of BIPA cases closed within 90 days* - In FY 2011, OMHA processed 73% of the BIPA cases within the statutory timeframe. OMHA fell short of its performance target of 88% for FY 2011 by 15% due to the overall increase in workload. Although the FY 2011 performance target was missed, OMHA reached higher levels of efficiency with each Administrative Law Judge team adjudicating more Medicare claims than ever before. OMHA is modifying its performance targets in FY 2012 and FY 2013 to count all BIPA appeals closed during a fiscal year, regardless of when the appeals were received. This more accurately accounts for OMHA's case backlog due to OMHA's increasing caseload.

- *Increase the number of non-BIPA cases closed within 90 days* - Although there is no statutory requirement to decide non-BIPA cases within 90 days, OMHA makes a concerted effort to adjudicate non-BIPA cases expeditiously. In FY 2011, OMHA processed 52% of the non-BIPA cases within 90 days. OMHA fell short of its performance target of 57% for FY 2011 by 5% primarily due to the overall increase in workload. OMHA's number of non-BIPA cases continues to represent a small percentage of its caseload. This measure can be construed as competing with OMHA's statutory mandate to adjudicate BIPA cases within 90 days which is OMHA's highest priority. This measurement is proposed for retirement at the end of FY 2012. OMHA will continue to track this outcome internally.

- *For cases that go to hearing, increase the percentage of decisions rendered in 30 days* - OMHA's primary mission is to adjudicate cases within required timelines (i.e., 90 days). During OMHA's first year of operation, rendering decisions within 30 days of when a hearing is held was expected to be a leading indicator of the likelihood of meeting the 90-day timeframe. The percentage represents the cases where a decision was rendered within 30 days of completing the ALJ hearing. In FY 2011, OMHA issued 64% of its decisions for cases that went to hearing within 30 days. This fell short of the performance target of 85%. After five years of operations, however, the data confirmed this is not an accurate indicator of meeting the 90-day adjudicatory timeframe or any other performance goal. There is little correlation between the time when a hearing is held and when the decision is rendered, and the likelihood of meeting the 90-day timeframe. OMHA believes this measure should serve more as a management tool instead of an external performance measure. As a result, OMHA retired this performance measure at the end of FY 2011.

- *Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council* - The legal accuracy of OMHA decisions remains of paramount importance to the agency. OMHA is committed to providing accurate decisions that are not reversed or remanded on appeals to the Medicare Appeals Council (MAC), which provides the fourth level of Medicare appeals. This goal focuses on maintaining the overall quality and accuracy of OMHA decisions. The performance target for FY 2011 was 2% which OMHA exceeded by having only 1.5% of its decisions reversed or remanded on appeals to the MAC.

- *Maintain the average survey results from appellants reporting good customer service on a scale of 1 – 5 at the ALJ Medicare Appeals level* **-** OMHA is evaluating its customer service through an independent evaluation that captures the scope of the Level III appeal experience by randomly surveying selected appellants and appellant representatives. The survey measures the overall appellant experience, the quality of OMHA materials, hearing scheduling and format, and interactions with OMHA staff. The measure aims to assure that appellants and related parties are satisfied with their Medicare appeals experience with OMHA. On a scale of 1 – 5, 1 represents the lowest score (very dissatisfied) and 5 represents the best score (very satisfied). In FY 2011, OMHA achieved a 4.21 level of appellant satisfaction nationwide, exceeding the FY 2011 target of 3.40 by .81. This result indicates the vast majority of appellants were either somewhat or very satisfied with OMHA services, from initiation of cases through closure, as well as with hearing formats used to adjudicate their cases.

- *Decrease the cost per claim adjudicated* - OMHA seeks to gain efficiencies and cost savings through reduced case processing timeframes despite rising costs for staffing, rent, contracts and other services needed to support the appeals process. In FY 2011, OMHA exceeded this performance target. The average cost per claim in FY 2011 was $313 compared to $388 in FY 2010. The average cost per claim is driven by the number of claim receipts, which is an external factor not in OMHA's control. In addition, the cost per claim does not account for the claims that are unheard as a result of OMHA's workload exceeding its adjudicatory capacity. To streamline the performance management process by focusing on key performance measures within OMHA's mandate and control, OMHA proposes to retire this measure at the end of FY 2012. OMHA will continue to track this outcome internally.

- *Increase the number of claims processed per ALJ team* – ALJ teams (comprised of an ALJ, attorney, paralegal and hearing clerk) strive to meet statutory timeframes and increasing workloads while also maintaining the quality and accuracy of OMHA decisions. The FY 2011 performance target was to increase the number of claims processed by each ALJ team by 2%. OMHA exceeded this performance target. The average number of claims processed per ALJ in FY 2011 was 3,896 compared to 2,789 in FY 2010. The average number of claims processed per ALJ team is also impacted by the number of claim received, which is an external factor not in OMHA's control. Although OMHA continues to increase adjudicative efficiency, this measure correlates directly to the number of ALJ teams which can vary by funding levels. To streamline the performance management process by focusing on key performance measures within OMHA's mandate and control, OMHA proposes to retire this measure at the end of FY 2012. OMHA will continue to track this outcome internally.

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT									
	FY 2011 Actual			FY 2012 Estimate			FY 2013 Estimate		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Office of Medicare Hearings and Appeals	418	0	418	466	0	466*	518	0	518**

* Includes conversion of contractors positions to Federal positions
** Includes FTE to support Backlog Reduction Initiative

Average GS Grade:

FY 2009……….11/5
FY 2010……….11/1
FY 2011……….11/3
FY 2012……….11/6
FY 2013……….11/6

Office of Medicare Hearings and Appeals
Detail of Positions

	FY 2011 Actual*	FY 2012 Estimate	FY 2013 Estimate
AL-1...	2	2	2
AL-2...	4	4	4
AL-3...	63	63	67
Subtotal	69	69	73
Total - AL Salary	9,749,749	10,163,474	10,885,108
ES-1...	2	2	2
Subtotal	2	2	2
Total - ES Salary	345,356	352,265	359,274
GS-15...	11	12	12
GS-14...	28	28	28
GS-13...	16	18	18
GS-12...	109	111	111
GS-11...	95	96	96
GS-10...			
GS-9...	19	19	63
GS-8...	52	52	52
GS-7...	37	38	42
GS-6...	33	52	52
GS-5...			
GS-4...	5	8	8
GS-3...			
GS-2...			
GS-1...			
Subtotal	405	434	482
Total - GS Salary	26,279,647	31,816,261	35,353,618
Average ES salary..........................	172,678	176,133	179,637
Average GS grade...........................	11/3	11/6	11/6
Average GS salary..........................	64,888	73,309	73,348

* total positions

FY 2013 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

STAFFDIV Allocation Statement:

The **OMHA** will use **$7,826.00** of its **FY 2013** budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. Staff Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, **$736.00** is allocated to developmental government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$736.00
Line of Business - Grants Management	$0.00
Line of Business - Financial	$0.00
Line of Business - Budget Formulation and Execution	$0.00
Disaster Assistance Improvement Plan	$0.00
Federal Health Architecture (FHA)	$0.00
Integrated Acquisition Environment-Grants and Loans	$0.00
Line of Business - Geospatial	$0.00
FY 2013 Developmental E-Gov Initiatives Total	**$736.00**

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

In addition, **$7,126.00** is allocated to ongoing government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Ongoing E-Gov Initiatives*	
E-Rule Making	$0.00
Integrated Acquisition Environment	$7,126.00
GovBenefits	$0.00
Grants.Gov	$0.00
FY 2013 Ongoing E-Gov Initiatives Total	**$7,126.00**

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

DEPARTMENT OF HEALTH & HUMAN SERVICE OFFICE OF THE SECRETARY

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Director
Office for Civil Rights
200 Independence Ave., SW Rm 506F
Washington, DC 20201

Dear Reader:

I am pleased to present the Office for Civil Rights' (OCR) Fiscal Year 2013 Congressional Justification. This budget request provides support for the President's and Secretary's priority initiatives and reflects the goals and objectives of the Department.

OCR's requested budget will support our ability to protect the public's right to equal access and the opportunity to participate in and receive services from all Department of Health and Human Services' (HHS) programs without facing unlawful discrimination, and to protect the privacy and security of an individual's identifiable health information. OCR's performance objectives align with HHS' objectives, particularly in the area of ensuring access to quality, culturally competent care for vulnerable populations to strengthen the overall healthcare system. Through its work in assisting individuals with ensuring access to care and in protecting all citizens' health information privacy, OCR also contributes to each of the other HHS strategic objectives, with the exception of the area of scientific research.

In a dynamic environment with scarce resources, OCR continues to protect health care consumers from civil rights infringements as well as to aggressively implement the privacy and security protections provision of the Health Information Technology for Economic and Clinical Health (HITECH) Act. OCR seeks efficiencies, exploits technology, and leverages human capital and intergovernmental resources to provide the best possible service to the American people.

Leon Rodriguez
Director
Office for Civil Rights

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Office for Civil Rights

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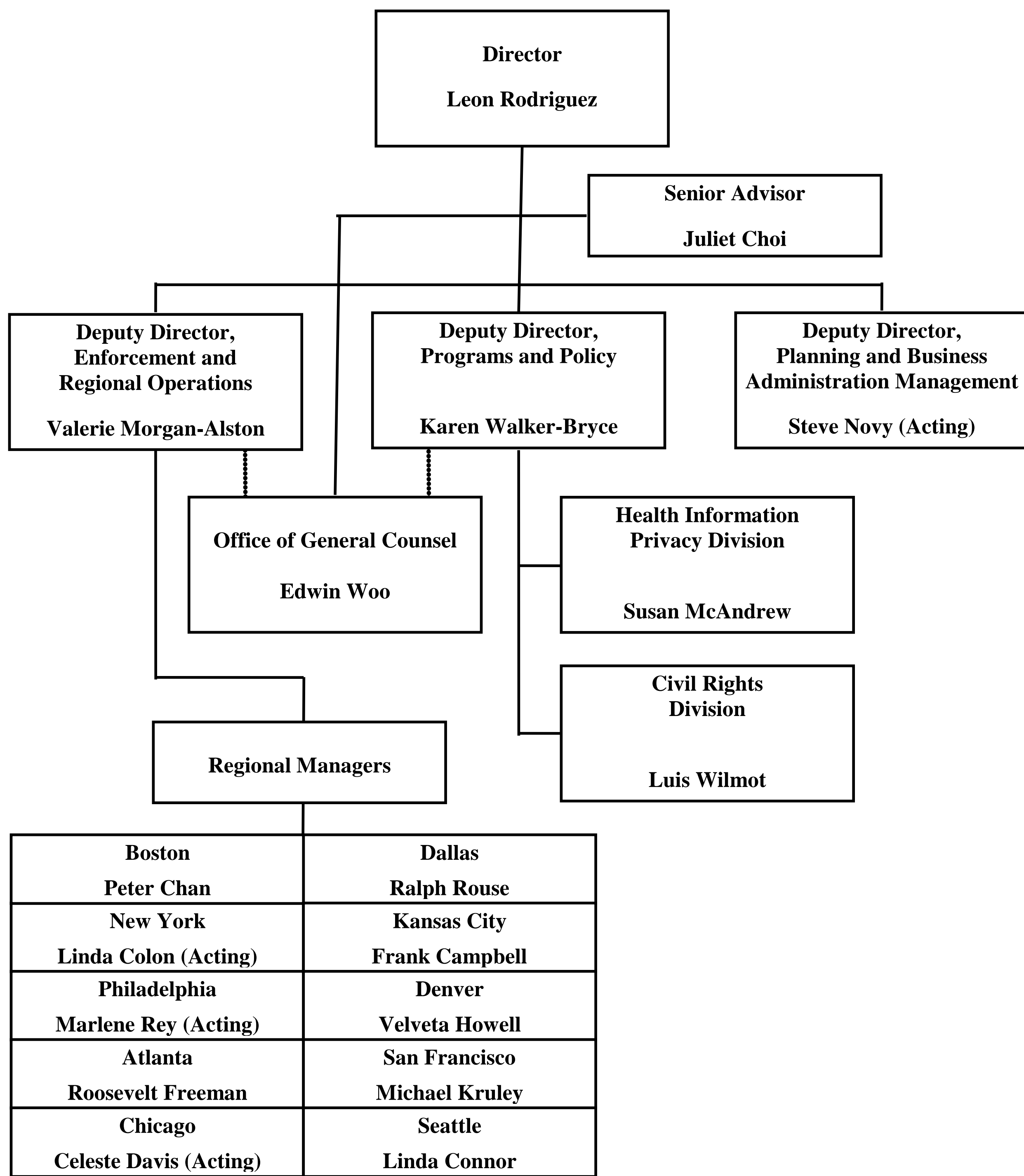
Office for Civil Rights

Organization Chart



Introduction and Mission

Agency Overview
The Office for Civil Rights (OCR), a staff division of the U.S. Department of Health and Human Services (HHS), ensures that people have equal access to and the opportunity to participate in and receive services from all HHS-funded programs without facing unlawful discrimination, and that the privacy and security of their health information is protected. Through prevention and elimination of unlawful discrimination and by protecting the privacy and security of individually identifiable health information, OCR helps HHS carry out its overall mission of improving the health and well-being of all people affected by its many programs.

Vision
Through investigations, voluntary dispute resolution, enforcement, technical assistance, policy development and information services, OCR will protect the civil rights of all individuals who are subject to discrimination in health and human services programs and protect the health information privacy and security rights of consumers.

Mission
As the Department's civil rights and health information privacy and security protection law enforcement agency, OCR:

- Ensures that the estimated 4,500,000 recipients of Federal financial assistance comply with our Nation's civil rights laws
- Enforces the civil rights protections of Title VI of the Civil Rights Act of 1964 (Title VI); Section 504 of the Rehabilitation Act of 1973 (Section 504); Title II of the Americans with Disabilities Act of 1990 (Title II); Titles VI and XVI of the Public Health Service Act (Hill-Burton Act); the Multi-Ethnic Placement Act (MEPA); the Age Discrimination Act of 1975 (Age Act); Title IX of the Education Amendments of 1972 (Title IX); and the Church Amendments, Section 245 of the Public Health Service Act and the Weldon Amendment (which prohibits discrimination against those who decline to participate in abortions or sterilization procedures)
- Ensures the practices of several million health care providers, health plans, healthcare clearinghouses, and their business associates adhere to Federal privacy and security requirements under the Health Insurance Portability and Accountability Act (HIPAA)
- Implements and enforces the privacy protections under the Genetic Information Nondiscrimination Act of 2008; the privacy and security provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act contained in the American Recovery and Reinvestment Act (ARRA) of 2009; and the confidentiality provisions of the Patient Safety and Quality Improvement Act of 2005
- Annually resolves nearly 12,000 citizen complaints alleging discrimination or a health information privacy or security violation

Budget Overview

The FY 2013 President's Budget request for OCR is $38,966,000 – a decrease of $1,972,000 from FY 2012 funding of $40,938,000. This FY 2013 budget proposal maintains the essential programmatic focus of the previous request and continues to support OCR's activities as the primary defender of the public's right to nondiscriminatory access to and receipt of Federally funded health and human services and the privacy and security protections for individually identifiable health information.

Program decreases:

Civil Rights and Health Information Privacy Staffing Efficiencies (-$2.0 million)
The recent OCR reorganization as well as achieved and projected business practice improvements have and will lead to efficiencies allowing for the reduction of enforcement personnel, both government and contract, and associated support staff. Attained efficiencies allow for the reduction of permanent staff in addition to a reduction in contract support augmentation. Specifically, this decrease in funding corresponds to a reduction of 10 government civilian full time equivalents (FTEs) and approximately 4 contractor work-year equivalents (CWEs). Decreased levels of funding will be incurred in the categories of full time permanent compensation, other personnel compensation, civilian benefits, other contractor services, and other related support costs.

Office for Civil Rights

Appropriations Language

For expenses necessary for the Office for Civil Rights, **[**~~$41,016,000~~**]** *$38,966,000***.**

AMOUNTS AVAILABLE FOR OBLIGATION

(Dollars in Millions)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget
General Fund Discretionary Appropriation:			
Appropriation (L/HHS)……	$37,785,000	$41,016,000	$38,966,000
Across-the-board reductions (L/HHS)……	-$75,000	-$78,000	$0
Subtotal, Appropriation (L/HHS)……	$37,710,000	$40,938,000	$38,966,000
Trust Fund Discretionary Appropriation:			
Appropriation Lines……	$3,314,000	$0	$0
Rescission……	-$7,000	$0	$0
Subtotal, adjusted trust fund disc. Appropriation……	$3,307,000	$0	$0
Total Obligations……	$41,017,000	$40,938,000	$38,966,000

SUMMARY OF CHANGES

2012 General funds appropriation	$40,938
Total adjusted budget authority	$40,938
2013 Request - General funds	$38,966
Total estimated budget authority	$38,966
Net Changes	**-$1,972**

	FY 2012 Enacted Base		FY 2013 Request Change From Base	
	FTE	**Amount**	**FTE**	**Amount**
Increases:				
A. Built-In:				
Subtotal, Built-In Increases	**0**	**$0**	**0**	**$0**
B. Programs:				
Subtotal, Program Increases			**0**	**$0**
Total Increases	**0**	**$0**	**0**	**$0**
Decreases:				
A. Built-In:				
1. Full-Time Permanent	265	$22,789	-10	-$917
2. Other Personnel Compensation	0	$574	0	-$22
3. Civilian personnel benefits	0	$5,532	0	-$207
4. Travel and transportation of persons	0	$340	0	-$35
5. Communications, utilities, and miscellaneous charges	0	$359	0	-$78
6. Operation and maintenance of equipment	0	$1,597	0	-$688
7. Equipment	0	$75	0	-$25
Subtotal, Built-In Decreases	**265**	**+$31,266**	**-10**	**-$1,972**
B. Programs:				
Subtotal, Program Decreases			**0**	**$0**
Total Decreases	**265**	**+$31,266**	**-10**	**-$1,972**
Net Change	**265**	**+$31,266**	**-10**	**-$1,972**

Office for Civil Rights

BUDGET AUTHORITY BY ACTIVITY - DIRECT
(Dollars in Thousands)

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
Enforcement and Regional Operations	186	$26,961	186	$26,908	180	$25,621
Programs and Policy	51	$9,235	51	$9,217	48	$8,747
Planning and Business Administration Management	26	$4,821	26	$4,813	25	$4,598
Subtotal, Budget Authority	263	$41,017	263	$40,938	253	$38,966
Total, Budget Authority	**263**	**$41,017**	**263**	**$40,938**	**253**	**$38,966**

Office for Civil Rights

Authorizing Legislation

	FY 2012 Amount Authorized	FY 2012 Estimate	FY 2013 Amount Authorized	FY 2013 Budget Request
Office for Civil Rights:				
Program operations: P.L. 88-352; 42 U.S.C. 300s, P.L. 91-616; P.L. 92-157; P.L. 92-158; P.L. 92-255; P.L. 93-282; P.L. 93- 348 P.L. 94-484; P.L. 95-567; P.L. 97-35; P.L. 103-382; P.L. 104-188; P.L. 92-318; P.L. 93-112; P.L. 94-135; P.L. 101-336; P.L. 104-191; P.L. 109-41; P.L. 110-233; P.L. 111-5; P.L. 111-148	Indefinite	40,938,000	Indefinite	38,966,000
Total:	Indefinite	40,938,000	Indefinite	38,966,000

Office for Civil Rights

Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY2004				
General Fund Appropriation:				
Base	30,936,000	30,936,000	30,936,000	30,936,000
Rescission				-133,000
Rescission				-182,000
Subtotal……………………………….	30,936,000	30,936,000	30,936,000	30,621,000
Trust Fund Appropriation:				
Base	3,314,000	3,314,000	3,314,000	3,314,000
Rescission				-14,000
Rescission				-19,000
Subtotal……………………………….	3,314,000	3,314,000	3,314,000	3,281,000
FY2005				
General Fund Appropriation:				
Base	32,042,000	32,042,000	32,042,000	32,043,000
Rescission				-61,000
Rescission				-255,000
Subtotal……………………………….	32,042,000	32,042,000	32,042,000	31,727,000
Trust Fund Appropriation:				
Base	3,314,000	3,314,000	3,314,000	3,314,000
Rescission				-27,000
Subtotal……………………………….	3,314,000	3,314,000	3,314,000	3,287,000
FY2006				
General Fund Appropriation:				
Base	31,682,000	31,682,000	31,682,000	31,682,000
Rescission				-317,000
Subtotal……………………………….	31,682,000	31,682,000	31,682,000	31,365,000
Trust Fund Appropriation:				
Base	3,314,000	3,314,000	3,314,000	3,314,000
Rescission				-33,000
CMS Transfer				-24,000
Subtotal……………………………….	3,314,000	3,314,000	3,314,000	3,257,000
FY2007				
General Fund Appropriation:				
Base	32,696,000	31,365,000	31,365,000	31,628,000
Subtotal……………………………….	32,696,000	31,365,000	31,365,000	31,628,000
Trust Fund Appropriation:				
Base	3,314,000	3,281,000	3,281,000	3,281,000
Subtotal……………………………….	3,314,000	3,281,000	3,281,000	3,281,000

Office for Civil Rights

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY2009				
General Fund Appropriation:				
Base	36,785,000	36,785,000	36,785,000	36,785,000
Subtotal…………………………….....	36,785,000	36,785,000	36,785,000	36,785,000
Trust Fund Appropriation:				
Base	3,314,000	3,314,000	3,314,000	3,314,000
Subtotal……………………………….	3,314,000	3,314,000	3,314,000	3,314,000
FY2010				
General Fund Appropriation:				
Base	37,785,000	37,785,000	37,785,000	37,785,000
Rescission				-76,000
Subtotal……………………………….	37,785,000	37,785,000	37,785,000	37,709,000
Trust Fund Appropriation:				
Base	3,314,000	3,314,000	3,314,000	3,314,000
Subtotal……………………………….	3,314,000	3,314,000	3,314,000	3,314,000
FY2011				
General Fund Appropriation:				
Base	44,382,000	44,382,000	44,382,000	37,785,000
Rescission				-75,000
Subtotal…………………………….....	44,382,000	44,382,000	44,382,000	37,710,000
Trust Fund Appropriation:				
Base	3,314,000	3,314,000	3,314,000	3,314,000
Rescission				-7,000
Subtotal……………………………….	3,314,000	3,314,000	3,314,000	3,307,000
FY2012				
General Fund Appropriation:				
Base	46,717,000			41,016,000
Rescission				-78,000
Subtotal…………………………….....	46,717,000			40,938,000

BUDGET AUTHORITY by OBJECT CLASS - DIRECT

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Personnel compensation:			
Full-time permanent (11.1)	22,789	21,872	-917
Other than full-time permanent (11.3)	554	554	0
Other personnel compensation (11.5)	574	552	-22
Military personnel (11.7)	67	67	0
Special personal services payments (11.8)	0	0	0
Subtotal, Personnel compensation	23,984	23,045	-939
Civilian personnel benefits (12.1)	5,506	5,299	-207
Military benefits (12.2)	26	26	0
Benefits for former personnel (13.0)	21	21	0
Total Pay Costs	29,537	28,391	-1,146
Travel and transportation of persons (21.0)	340	305	-35
Transportation of things (22.0)	20	20	0
Rental payments to GSA (23.1)	3,152	3,152	0
Communications, utilities, and miscellaneous charges (23.3)	359	281	-78
Printing and reproduction (24.0)	50	50	0
Other Contractual Services:			
Advisory and assistance services (25.1)	0	0	0
Other services from non-Federal sources (25.2)	2,036	2,036	0
Other goods and services from Federal sources (25.3)	2,276	2,276	0
Operation and maintenance of facilities (25.4)	1,246	1,246	0
Research and development contracts (25.5)	0	0	0
Operation and maintenance of equipment (25.7)	1,597	909	-688
Subtotal, Other Contractual Services	7,155	6,467	-688
Supplies and materials (26.0)	250	250	0
Equipment (31.0)	75	50	-25
Land and Structures (32.0)	0	0	0
Investments and Loans (33.0)	0	0	0
Grants, subsidies, and contributions (41.0)	0	0	0
Total Non-Pay Costs	11,401	10,575	-826
Total Budget Authority by Object Class	40,938	38,966	-1,972

SALARIES AND EXPENSES

(Dollars in Thousands)

	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Personnel compensation:			
Full-time permanent (11.1)	22,789	21,872	-917
Other than full-time permanent (11.3)	554	554	0
Other personnel compensation (11.5)	574	552	-22
Military personnel (11.7)	67	67	0
Subtotal, Personnel compensation	23,984	23,045	-939
Civilian personnel benefits (12.1)	5,506	5,299	-207
Military benefits (12.2)	26	26	0
Benefits for former personnel (13.0)	21	21	0
Total Pay Costs	29,537	28,391	-1,146
Travel and transportation of persons (21.0)	340	305	-35
Transportation of things (22.0)	20	20	0
Communications, utilities, and miscellaneous charges (23.3)	359	281	-78
Printing and reproduction (24.0)	50	50	0
Other Contractual Services:			
Other services from non-Federal sources (25.2)	2,036	2,036	0
Other goods and services from Federal sources (25.3)	2,276	2,276	0
Operation and maintenance of facilities (25.4)	1,246	1,246	0
Operation and maintenance of equipment (25.7)	1,597	909	-688
Subtotal, Other Contractual Services	7,155	6,467	-688
Supplies and materials (26.0)	250	250	0
Total Non-Pay Costs	8,174	7,373	-801
Total Salaries and Expenses	37,711	35,764	-1,947

Office for Civil Rights

All Purpose Table

Activity	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget	FY 2013 + / - FY 2012
Enforcement and Regional Operations	26,961,000	26,908,000	25,621,000	(1,287,000)
Programs & Policy	9,235,000	9,217,000	8,747,000	(470,000)
Planning and Business Administration Management	4,821,000	4,813,000	4,598,000	(215,000)
Total, Office for Civil Rights	41,017,000	40,938,000	38,966,000	(1,972,000)
FTE	226	266	256	(10)

Summary of Request

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) is the primary defender of the public's right to privacy and security of protected health information and the public's right to non-discriminatory access to Federally-funded health and human services. Through prevention and elimination of unlawful discrimination and by protecting the privacy and security of individually identifiable health information, OCR helps HHS carry out its overall mission of improving the health and well-being of all people affected by the Department's many programs. To most effectively accomplish this enormously important undertaking, OCR activities partner with government and private sector entities at the local, state, and national levels.

In FY 2011, OCR completed the change of its operating structure to better manage staff in order to provide superior support throughout its organization. Three Deputy Director level activities were established: Enforcement and Regional Operations, Programs and Policy, and Planning and Business Administration Management. Although each has unique functions and objectives, they each collaborate with one another, other HHS agencies, the Department of Justice, and other organizations to fully protect citizen rights. The OCR reorganization was published in the Federal Register (Vol. 75, No. 190) on October 1, 2010. This budget submission marks the first break-out of the OCR by these discrete activities.

For FY 2013, the Administration requests $39.0 million to fund its nation-wide health care anti-discrimination and privacy duties performed by OCR's three activities. The following decreases reflect OCR-wide staffing reductions:

- $25.6 million for Enforcement and Regional Operations – a decrease of $1.3 million
- $8.7 million for Programs and Policy – a decrease of $.5 million
- $4.6 million for Planning and Business Administration Mgmt – a decrease of $.2 million

Performance Overview

Both of OCR's overarching goals encompass multiple supporting objectives that link to the Secretary's Strategic Initiatives and the HHS Strategic Plan:

OCR Goal		OCR Supporting Objectives		HHS Goal/Objectives*
1	Raise awareness, increase understanding, and ensure compliance of all federal laws requiring non-discriminatory access to HHS programs and protection of the privacy and security of personal health information	A	Increase access to and receipt of non-discriminatory quality health and human services while protecting the integrity of HHS federal financial assistance (Title VI enforcement, public education activities, access via TANF program, Section 504 ADA, *Olmstead* activities, HIV/AIDS access enforcement)	#1 E #3 A,B,C,E
		B	Protect the privacy and security of personally identifiable health information for healthcare consumers (HIPPA rule activities and enforcement)	#1 E,F
		C	Provide information and training to representatives of health and human service providers, other interest groups, and consumers (Civil rights and health information privacy mission activities)	#1 E #3 B
		D	Increase the number of covered entities that take corrective action, including making substantive policy changes or developing new policies as a result of review and/or intervention (Medicare application review process)	#1 E
2	Enhance operational efficiency	A	Advance human capital management (Provide training, develop and mentor subordinates, promote effectiveness)	#5 A
		B	Improve financial management and the integration of budget and performance data (Increase resource management process oversight, strengthen internal controls, overhaul performance objectives)	#4 A,B,D

[* As reflected on the HHS Strategic Goals and Objectives Table]

Office for Civil Rights

The primary OCR outcome measures are the following:

- # covered entities that take corrective action as a result of OCR intervention
- # covered entities that make substantive policy changes as a result of OCR intervention
- % of actions (civil rights cases, Medicare reviews, privacy cases) resolved
- # people made aware of applicable OCR federal laws
- % of complaints that require formal investigation resolved within 365 days
- % of complaints that do not require formal investigation resolved with 180 days

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

The following is a synopsis of our overall OCR-wide performance measures:

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
1.1.1 # Covered Entities taking corrective action as a result of OCR intervention / year (Outcome)	FY 2011: 3479 Target: 4200 (Target Not Met)	4300	4300	Maintain
1.1.2 # Covered Entities making substantive policy changes as a result of OCR intervention / year (Outcome)	FY 2011: Not able to assess based on systems change Target: 2750 (No Status)	2800	2800	Maintain
1.1.3 % of closure for civil rights cases, health information privacy cases, and Medicare reviews / cases and reviews received each year (Outcome)	FY 2011: 92% Target: 107% (Target Not Met)	108%	108%	Maintain
1.1.6 # individuals whom OCR provides information and training annually (Output)	FY 2011: 19226 Target: 201200 (Target Not Met)	213500	213500	Maintain

Additional specific performance results are contained in the narratives for both Enforcement and Regional Operations and Programs and Policy.

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OCR has just completed major modification to our automated Performance Information Management System (PIMS) which was intended to revamp and reinvigorate the process of performance management as well as to strengthen the completeness, validity, and accuracy of the data capture and reporting. We expect to see improvement of our data in 2012.

Finally, OCR is currently in the process of initiating a review of its goals and objectives as well as its performance measures and the methods by which those measures are calculated and reported. Since OCR now has a reliable and versatile system in PIMS, our intention is to comprehensively reevaluate our current metrics which may not be optimal in order to arrive at current, representative, and quantifiable measures that reflect and evaluate OCR's true performance.

OCR estimates that break-outs of its FY budget requests by HHS strategic goal and objective are as follows:

HHS Strategic Goals	**FY 2011**	**FY 2012 Enacted**	**FY 2013**
1. Strengthen Health Care	$21.3	$21.3	$18.5
1.A Make coverage more secure for those who have insurance and extend affordable coverage to the uninsured			
1.B Improve health care quality and patient safety			
1.C Emphasize primary & preventative care, linked with community prevention			
1.D Reduce growth of health care costs while promoting high-value, effective care			
1.E Ensure access to quality culturally competent care for vulnerable populations	$11.3	$11.3	$9.9
1.F Promote the adoption and meaningful use of health information technology	$10.0	$10.0	$8.6
2. Advance Scientific Knowledge and Innovation			
2.A Accelerate the process of scientific discovery to improve patient care			
2.B Foster innovation at HHS to create shared solutions			
2.C Invest in the regulatory sciences to improve food & medical product safety			
2.D Increase our understanding of what works in public health and human services			
3. Advance the Health, Safety and Well-Being of the American People	$19.7	$19.7	$20.0
3.A Promote the safety, well-being, resilience, and healthy development of children and youth	$1.8	$1.8	$1.8
3.B Promote economic and social well-being for individuals, families, and communities	$17.9	$17.9	$16.8
3.C Improve the accessibility and quality supportive services for people with disabilities and older adults			$1.1
3.D Promote prevention and wellness			
3.E Reduce the occurrence of infectious diseases			$.3
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies			
4. Increase Efficiency, Transparency and Accountability of HHS Programs			$.3
4.A Ensure program integrity and responsible stewardship of resources			$.1
4.B Fight fraud and work to eliminate improper payments			$.1
4.C Use HHS data to improve American health and well-being of the American people			
4.D Improve HHS environmental, energy, and economic performance to			$.1

promote sustainability			
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce			$.2
5.A Invest in HHS workforce to meet America's health and human service needs today and tomorrow			$.2
5. B Ensure health care workforce meets increased demands.			
5.C Enhance the ability of the public health workforce to improve health at home and abroad			
5.D Strengthen the Nation's human service workforce			
5.E Improve national, State & local surveillance and epidemiology capacity			
TOTAL includes GDM, PHS Evaluation Funds, Prevention & Public Health Funds, and HCFAC	$41.0	$40.9	$39.0

Enforcement and Regional Operations

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	26,961	26,908	25,621	-1,287
FTE	186	186	180	-6

<u>Program Description and Accomplishments</u>

The Division of Enforcement and Regional Operations is charged with prevention and elimination of unlawful discrimination as well as protecting the privacy and security of individually identifiable health information. By fulfilling that mission, it supports all United States citizens. The office is made up by ten field offices and a small headquarters staff, consisting of 186 FTEs located at HHS regional offices throughout the United States, as indicated on the organization chart. Although the functions performed by this activity have been an integral part of the Office of Civil Rights' mission for years, the Division of Enforcement and Regional Operations was only recently established in the FY 2010-2011 reorganization. The Deputy Director for Enforcement and Regional Operations is responsible for all aspects of the operations and performance of the ten regions and reports directly to the Director of OCR.

The personnel in the ten regions spread across the nation are at the forefront of OCR's enforcement efforts and responsible for responding to citizen complainants and investigation of alleged violations of civil rights and health information privacy laws. The regional manager in each of the ten Regions is responsible for operations within his/her geographical area of responsibility.

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

Since implementation of the Privacy Rule in 2003, the number of complaints filed with OCR per year has grown six-fold, from 1,948 in FY 2002 to approximately 12,000 in FY 2011. In an effort to keep pace with an ever increasing case workload, OCR instituted a number of efficiencies from FY 2002 through FY 2010, including a reorganization effort, improved staff skill sets, a centralized intake study, and ongoing improvements in case management techniques. These efficiency measures produced an increase in the number of cases resolved per FTE per year.

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Highlights of recent civil rights enforcement accomplishments:

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

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

Highlights of recent HIPAA Privacy and Security Rule enforcement accomplishments:

- In February 2011, OCR imposed a civil money penalty of $4.3 million on Cignet Health of Prince George's County, MD (Cignet) for violations of HIPAA Privacy and Enforcement Rules. Cignet was fined $1.3 million for failing to provide 41 individuals with access to their medical records as required and $3 million for refusing to cooperate with OCR in the course of its investigation into the complaints about the failure to provide access. This is the first civil money penalty imposed for a HIPAA violation and clearly evidences that OCR is serious about enforcing individual rights guaranteed by the HIPAA Privacy Rule and ensuring providers cooperate with all enforcement and compliance efforts. [Region III]

- Massachusetts General Hospital (Mass General) has agreed to pay $1 million to settle potential violations of the Privacy Rule arising from sensitive hospital records of 192 individuals being left on a subway train by a billing manager in the Infectious Disease Associates outpatient practice of the hospital. As part of the February 2011 resolution, Mass General also agreed to a three year corrective action plan to develop and implement a comprehensive set of policies and procedures to safeguard both paper and electronic records when removed from the hospital by its employees for work-related reasons. [Region I]

Funding History

FY 2011	$26,961
FY 2012	$26,908

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

Budget Request

The FY 2013 request for Enforcement and Regional Operations (E&RO) is $25.6 million and reflects a decrease of $1.3 million from the FY 2012 enacted amount. The reduction is due to E&RO staffing reduction of 6 government civilian FTEs and approximately 2.5 contractor work-year equivalents.

Outputs and Outcomes Table

Performance measure results were largely exceeded in FY11, specifically in 4 of 6 measures outlined below. While 1 of 2 targets were attained in the area of closing civil rights and health information privacy cases, 3 of 4 metrics were exceeded in closing complaints not requiring investigation within 180 days and closing investigative actions within 365 days. The latter instances in particular illustrate strong performance on the part of the regions in receiving, processing, and closing citizen complaint actions promptly.

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
1.1.3A % of closure for civil rights cases / cases received each year (Outcome)	FY 2011: 91% Target: 107% (Target not met)	108%	108%	Maintain
1.1.3B % of closure for health information privacy cases / cases received each year (Outcome)	FY 2011: 112% Target: 107% (Target Exceeded)	108%	108%	Maintain
1.1.7 % of civil rights complaints requiring formal investigation resolved within 365 days (Output)	FY 2011: 37% Target: 40% (Target not met)	42%	42%	Maintain
1.1.8 % of civil rights complaints not requiring formal investigation resolved within 180 days (Output)	FY 2011: 90% Target: 79% (Target Exceeded)	81%	83%	+2%
1.1.9 % of health information privacy complaints requiring formal investigation resolved within 365 days (Output)	FY 2011: 68% Target: 50% (Target Exceeded)	52%	55%	+3%
1.1.10 % of health information privacy complaints not requiring formal investigation resolved within 180 days (Output)	FY 2011: 81% Target: 69% (Target Exceeded)	72%	75%	+3%

Programs and Policy

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	9,235	9,217	8,747	-470
FTE	51*	51*	48*	-3

* Does not include 3 reimbursable FTE

Program Description and Accomplishments

The Division of Programs and Policy is charged with preventing and eliminating unlawful discrimination as well as protecting the privacy and security of individually identifiable health information. By fulfilling that mission, it supports all United States citizens. The Division consists of two components, Civil Rights and Health Information Privacy. The Division consists of 54 FTEs (3 of whom are reimbursable) who work in the HHS headquarters in Washington, DC. Although the functions and activities performed by this component have been an integral part of the Office of Civil Rights' mission for years, the Division of Programs and Policy was only recently established in the FY 2011 reorganization. The Deputy Director for Programs and Policy is responsible for all aspects of the operations and performance of this area and reports directly to the Director of OCR.

The Civil Rights (CR) Division performs a wide variety of functions to support both citizens and health organizations directly as well as the ten regional offices. CRD is responsible for rulemaking, the pre-grant program, review of settlement agreements, strategic development, and providing subject matter expertise to regional staff.

CR oversees a nationwide civil rights pre-grant review program for new Medicare applicants to ensure their compliance with Federal civil rights laws, including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. Through this program, CR provides technical assistance to new and existing Medicare providers, reviews health care facilities' policies and procedures for civil rights compliance, and sends clearance letters to the facilities after they have demonstrated compliance.

CR also enters into civil rights settlement agreements with major health care corporations to develop model civil rights policies and procedures at all facilities under corporate ownership and control, extending their reach to facilities beyond the scope of Medicare Part A program requirements. In this way, OCR is attaining voluntary compliance by health care organizations on a large scale, maximizing its impact and civil rights compliance efforts within the Medicare provider community.

CR staff members perform other measures including development of compliance and enforcement strategies as well as providing expert advice to regional staff in their formulation of investigative plans for complaints and compliance reviews, corrective action closure letters, voluntary compliance agreements, violation letters of finding, settlement agreements and enforcement actions.

Highlights of recent CR accomplishments:

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

The Health Information Privacy (HIP) Division performs a wide variety of functions to support both citizens and health organizations directly as well as OCR's ten regional offices. HIP is responsible for policy development, including proposing regulatory and legislative modifications to the HIPAA Privacy and Security Rules, rulemaking activities (including promulgating regulations for new statutory authorities), reviewing settlement agreements and enforcement actions, providing subject matter expertise to regional staff on both privacy and security matters, and investigating violations of patient safety work product confidentiality.

Since September 2009, HIP staff has overseen a nationwide breach reporting system, required by the HITECH Act, that enables covered entities and business associates to electronically file reports with the Secretary of all breaches that create a significant risk of harm to the confidentiality or integrity of the protected health information. The covered entity is also required to provide prompt notification to the individuals affected by the breach. For breaches affecting 500 or more individuals, HIP is responsible for maintaining a listing of such breaches on the HHS web site and referring the breach report to the regional offices for validation and investigation.

HIP staff provide significant input into the development of compliance and enforcement strategies and expert advice to regional staff in their formulation of investigative plans, letters of investigative findings, and resolution agreements or notices of the imposition of civil monetary penalties following compliance reviews or complaint investigations. HIP also coordinates with the Department of Justice on criminal referrals under the HIPAA. As a result of the HITECH Act, civil money penalties for HIPAA violations have increased significantly, from $100 per violation to up to $50,000 per violation. OCR has leveraged these higher penalty amounts to strengthen and expand its compliance and enforcement program. In addition to breach notification, discussed above, other HITECH Act compliance and enforcement achievements include:

- The launch of a pilot project to provide for periodic audits to ensure compliance by covered entities and business associates with the HIPAA Privacy and Security Rules and their obligations under the HITECH Act. Audit protocols will be developed and tested for covered entities of varying types and sizes. Audits will be performed in FY 2012 and the evaluation of their effectiveness across covered entities will be completed in FY 2013.
- In 2011, HIP completed a nation-wide training of State Attorneys General on HIPAA and HITECH. The HITECH Act authorized State Attorneys General to bring civil actions to enforce the HIPAA Privacy and Security Rules. OCR will continue to work with the State Attorneys General as they begin to pursue actions within their new jurisdiction.

HIP staff is also responsible for policy development and rule making activities, including analyzing the need for modifications to privacy and security regulations implementing HIPAA, proposing regulatory modifications when necessary, and promulgating regulations for new statutory authorities, such as the Genetic Information Nondiscrimination Act of 2008 (GINA) and the Health Information Technology for

Economic and Clinical Health (HITECH) Act contained in the American Recovery and Reinvestment Act of 2009 (ARRA). In addition, HIP is responsible for national policy and regulatory activities related to the confidentiality of information concerning patient safety events and for the enforcement of those confidentiality protections under the Patient Safety and Quality Improvement Act of 2005. Through these efforts, OCR plays a leading role in other health reform efforts, including patient safety in personalized medicine based on genetic breakthroughs, and in ensuring the appropriate flow of health information under the HIPAA Privacy and Security Rules during emergencies situations.

HIP's primary policy activities center on regulatory and technical assistance work necessary to implement the provisions of the HITECH Act to strengthen HIPAA Privacy and Security protections, enhance enforcement efforts, and provide public education about privacy protections. These activities directly support the President's goal of increasing the use of electronic health records. HIP staff closely coordinates implementation of these more robust privacy and security protections with the Office of that National Coordinator's (ONC) work to advance the adoption of electronic health records in two ways: (1) by developing privacy and security protections for electronic health records that will promote their adoption and meaningful use; and (2) by designing and rolling out the initial public education campaign during FY 2012 to increase Americans' confidence in the use of electronic health records and the privacy and security of their health information. In FY 2010 and FY 2011, HIP published two Notices of Proposed Rulemaking to implement the major provisions of the HITECH Act strengthening the HIPAA Privacy and Security Rules and expanding their scope to include the direct enforcement of these protections against business associates, and expects to complete its rulemaking efforts in FY 2013.

Funding History

FY 2011	$9,235
FY 2012	$9,217

[*] The OCR reorganization occurred in 2010 so funding by activity is not available prior to FY 2011

Budget Request

The FY 2013 request for Programs and Policy (P&P) is $8.7 million and reflects a decrease of $.5 million from the FY 2012 enacted amount. The decrease is due to P&P staffing reduction of 3 government civilian FTEs and approximately 1 contractor work-year equivalent.

Outputs and Outcomes Table

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/- FY 2012 Target
1.1.3C % of closure for Medicare application reviews / reviews received each year (Output)	FY 2011: 95% Target: 107% (Target Not Met)	108%	108%	Maintain

Planning and Business Administration Management

Dollars in Thousands

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY2012
Budget Authority	4,821	4,813	4,598	-215
FTE	26	26	25	-1

Program Description and Accomplishments

The Division of Planning and Business Administration Management (PBAM) is focused on supporting the overall efforts of OCR's mission. The office consists of several sections (Executive Secretariat, Outreach and Education, Human Resources, Information Technology, Budget and Performance) and provides direct support to the operations of OCR's other two activities (E&RO and P&P). It consists of 26 FTEs located at HHS headquarters in Washington, DC. Although the functions performed by this activity have been an integral part of the Office for Civil Rights' mission for years, PBAM was only recently established in the FY 2011 reorganization. The Deputy Director for Planning, Business Administration Management is responsible for all aspects of the operations and performance of his/her five sections and reports directly to the Director of OCR.

The Executive Secretariat Section consists of five staff members responsible for processing intra-HHS and external agency clearance requests, processing Congressional and other high-level correspondence, handling Freedom of Information Act (FOIA) requests, and other general administrative duties. In FY 2011, the Executive Secretariat also sponsored a "Central Intake Unit" (CIU) pilot whereby Region V cases were received and assigned through a centralized approach via the headquarters office. Once this pilot is completed and analyzed for effectiveness, it may lead to the establishment of an office-wide CIU approach being implemented to attain staffing efficiencies.

The Outreach and Education Section is critical to the success of the OCR mission of educating the public on the laws, regulations, and policies that protect citizen rights in the areas of equal access to health care and health information privacy. The three-person Outreach and Education Team works closely with the OCR Director and collaborates on all activities within OCR and other partner government agencies to formulate a cohesive strategic outreach plan. The Section also supports Enforcement and Regional Operations with their local outreach efforts, assists Programs and Policy promulgate new law and resultant implementing policy, prepares Director and key leader public event messaging, and plans all media events and interactions.

OCR operates in a dynamic environment that requires highly motivated and trained professionals to respond to citizen complaints involving complex circumstances. The Human Resources Section conducts the recruitment of all staff personnel and coordinates the personnel action support for all-board employees, both at the headquarters and throughout the Regions. The section consists of three staff members whose other key responsibilities include coordination with the Office of Human Resources within the HHS Office of the Assistant Secretary of Administration, interpreting and applying human resources policy, and interfacing with the labor union.

With a wide dispersion of personnel spread across the nation, the Information Technology (IT) Section has the challenging task of ensuring that all operating locations receive superb and timely automation support to enable seamless operations. The Director of IT, with the assistance of three other staff, performs a variety of tasks in support of that mission, including conducting inventories, trouble-shooting equipment, planning upgrades, reviewing invoices, letting contracts to support systems, monitoring

interagency support services, administering the Performance Information Management System (PIMS), and acquiring replacement hardware.

The Budget and Performance Section is accountable for working with the OCR leadership to formulate requirements, both funding and personnel. Specific focus areas are: entering budget data into applicable systems, submitting budget justification exhibits, supporting overall headquarters and regional operations, contributing to the overall HHS Performance Appendix, monitoring budget execution spending and targets, setting and gauging progress on established performance measures, answering HHS and OMB data calls, and responding to all resource matters that affect ongoing OCR efforts to provide quality support to all citizens.

To effectively achieve OCR's mission, operations staff members are focused on continuous operational and process improvement. Several key initiatives designed to improve overall operational efficiency in FY 2010 and FY 2011 included centralized intake, targeted hiring designed to close skill gaps across the organization, development of enhanced programmatic training, upgrades to case management systems, and transferring case workload between regional offices. Results from the centralized intake pilot study demonstrated a possible 53% decrease in the amount of time it takes to close complaints and transferring case workload between regional offices could result in a 78% reduction in regional office case backlogs. With an emphasis on improving the level of service provided to the public, these initiatives, coupled with programmatic enhancements to HIPAA compliance and enforcement operations, have enabled OCR to make solid gains in reducing the inventory of open complaints. Funding at the requested level will allow OCR's compliance and enforcement operations to continue this renewed focus on being more responsive to the American public.

In addition to these process improvements, OCR continuously works to improve budget and performance integration and increase performance accountability. Results-oriented performance plans are established for all employees with goals cascaded down from OCR's organization-wide performance objectives. By continuously evaluating performance against established measures and goals, OCR works to achieve maximum resource efficiency.

Highlights of recent PBAM accomplishments:

- Modernizing PIMS to streamline the administrative burden associated with the regional casework thereby allowing Equal Opportunity Specialists to dedicate additional time to complainant response
- Reconfiguring PIMS to more accurately reflect performance, thereby providing additional capability to leaders in managing their operations
- Establishing a comprehensive IT inventory control plan to more efficiently safeguard all OCR equipment

Funding History

FY 2011	$4,821
FY 2012	$4,813

[*] The OCR reorganization occurred in 2010 so funding by activity is not available prior to FY 2011

Budget Request

The FY 2013 request for Planning and Business Administration Management (PBAM) is $4.6 million and reflects a decrease of $.2 million from the FY 2012 enacted amount. The decrease is due to PBAM reduction in staffing of 1 government civilian FTE and approximately .5 contractor work-year equivalents.

Office for Civil Rights
Detail of Full Time Equivalents (FTE)

	2011 Actual Civilian	2011 Actual Military	2011 Actual Total	2012 Est. Civilian	2012 Est. Military	2012 Est. Total	2013 Est. Civilian	2013 Est. Military	2013 Est. Total
Enforcement and Regional Operations									
Direct[1]:…………………	158	1	159	185	1	186	179	1	180
Reimbursable:………….	0	0	0	0	0	0	0	0	0
Total:………………..	158	1	159	185	1	186	179	1	180
Programs and Policy									
Direct[2]:…………………	46	0	46	51	0	51	48	0	48
Reimbursable:………….	3	0	3	3	0	3	3	0	3
Total:………………..	49	0	49	54	0	54	51	0	51
Planning and Business Administration Management									
Direct[3]:…………………	18	0	18	26	0	26	25	0	25
Reimbursable:………….	0	0	0	0	0	0	0	0	0
Total:………………..	18	0	18	26	0	26	25	0	25
OCR FTE Total………..	225	1	226	265	1	266	255	1	256

[1] Consists of personnel in the regions, OGC lawyers supporting regions, and the Deputy Director's staff at the HQ
[2] Consists of the HIP Division, the CR Division, OGC lawyers supporting HQ, and the Deputy Director
[3] Consists of Executive Secretariat, Outreach and Education, Human Resources, IT, Budget, and the Director's staff

Enforcement and Regional Operations: Decrease of authorized FTEs from 186 (FY 2012) to 180 (FY 2013); hiring temporarily reduced due to management change; aggressive hiring will take place in FY 2012 to fill vacant leadership positions and other key positions up to 180 ceiling.

Programs and Policy: Decrease of authorized FTEs from 54 (FY 2012) to 51 (FY 2013); leadership is intent on filling all remaining vacant positions in FY 2012.

Planning and Business Administration management: Decrease of authorized FTEs from 26 (FY 2012) to 25 (FY 2013); reduced support staffing.

Average GS Grade

FY 2008……………….. 13/4
FY 2009……………….. 13/5
FY 2010……………….. 13/2
FY 2011……………….. 13/2
FY 2012……………….. 12/8

Office for Civil Rights
Detail of Positions

	2011 Actual	2012 Estimate	2013 Estimate
Executive level I	0	0	0
Executive level II	3	2	2
Executive level III	1	1	1
Executive level IV	3	4	4
Executive level V	1	1	1
Subtotal	8	8	8
Total - Exec. Level Salaries	$1,106,000	$1,204,000	$1,204,000
GS-15	20	25	25
GS-14	37	40	40
GS-13	40	45	45
GS-12	80	87	87
GS-11	15	28	28
GS-10	0	0	0
GS-9	11	14	14
GS-8	2	2	2
GS-7	4	4	4
GS-6	2	3	3
GS-5	5	5	5
GS-4	1	2	2
GS-3	1	2	2
GS-2	0	0	0
GS-1	0	0	0
Subtotal	218	257	257
Total - GS Salary	$21,730,000	$24,462,000	$25,420,000
Average ES level	III	III	III
Average ES salary	$167,000	$164,000	$164,000
Average GS grade	12/7	12/8	12/9
Average GS salary	$90,000	$93,000	$94,000

* Reflects the number of positions encumbered at of the end of FY 2011 and projections for the number of positions that will be encumbered as of the end of FY 2012 and FY2013. Excludes OCR's 1 military employee and includes 3 reimbursable FTEs. Excludes "Other personnel compensation" (11.5) and "Civilian Benefits" (12.1) object classes.

FY 2013 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

STAFFDIV Allocation Statement:

The **OCR** will use **$20,562.00** of its **FY 2013** budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. Staff Divisions help finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, **$2,154.00** is allocated to developmental government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$495.00
Line of Business - Grants Management	$0.00
Line of Business - Financial	$925.00
Line of Business - Budget Formulation and Execution	$689.00
Disaster Assistance Improvement Plan	$0.00
Federal Health Architecture (FHA)	$0.00
Integrated Acquisition Environment-Grants and Loans	$0.00
Line of Business - Geospatial	$45.00
FY 2013 Developmental E-Gov Initiatives Total	**$2,154.00**

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

Prospective benefits from these initiatives are:

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital

Lines of Business–Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Lines of Business-Geospatial: Promotes coordination and alignment of geospatial data collection and maintenance among all levels of government: provides one-stop web access to geospatial information through development of a portal; encourages collaborative planning for future investments in geospatial data; expands partnerships that help leverage investments and reduce duplication; and, facilitates partnerships and collaborative approaches in the sharing and stewardship of data. Up-to-date accessible information helps leverage resources and support programs: economic development, environmental quality and homeland security. HHS registers its geospatial data, making it available from the single access point.

In addition, **$18,408.00** is allocated to ongoing government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Ongoing E-Gov Initiatives*	
E-Rule Making	$17,868.00
Integrated Acquisition Environment	$540.00
GovBenefits	$0.00
Grants.Gov	$0.00
FY 2013 Ongoing E-Gov Initiatives Total	**$18,408.00**

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2013

Office of the National Coordinator for Health Information Technology

Justification of Estimates for Appropriations Committee

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

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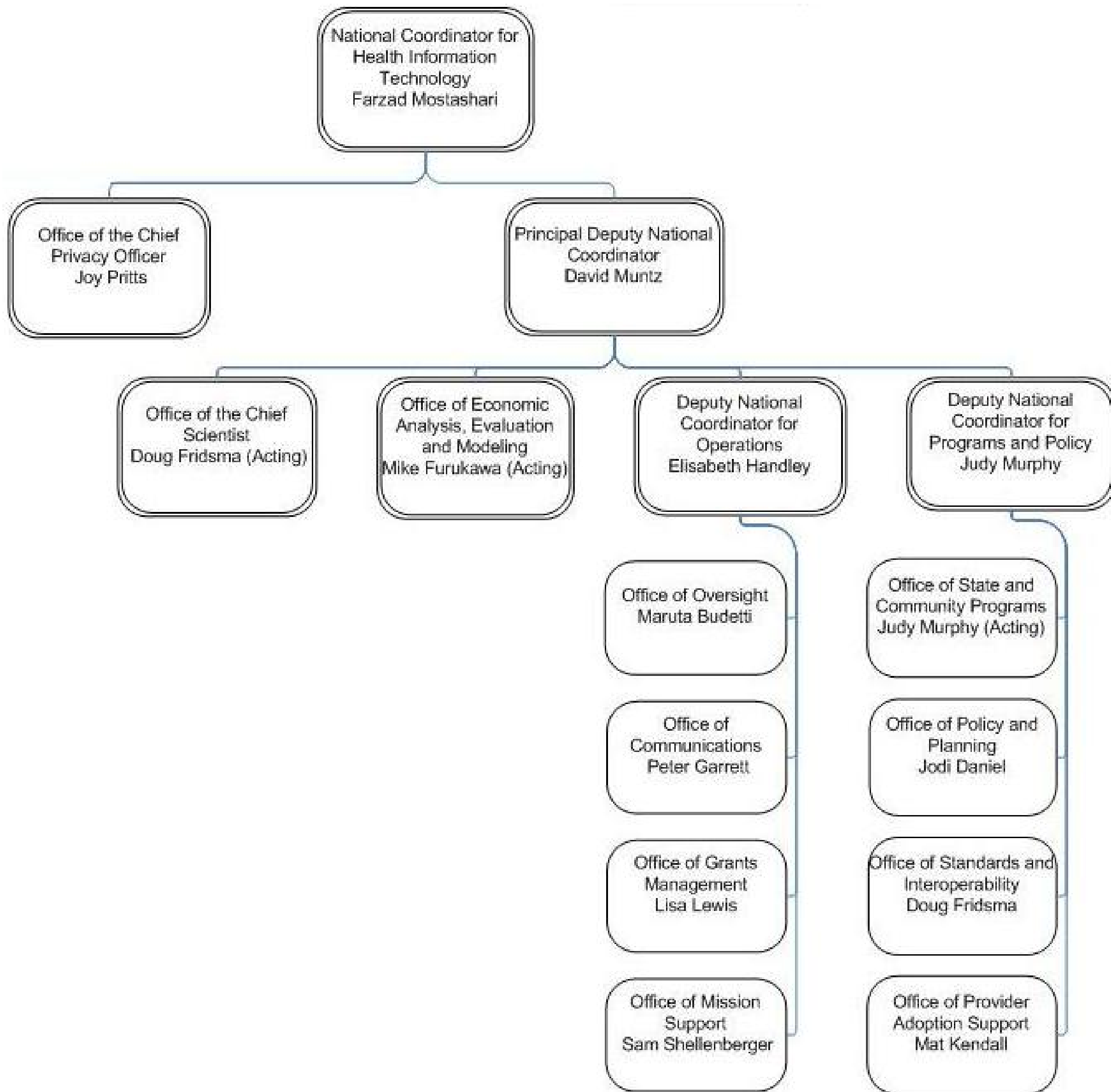
DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

ORGANIZATIONAL CHART[1]



[1] The ONC organizational chart has been realigned to reflect the reorganization published in the Federal Register (Volume 76, Number 203) on October 20, 2011.

VISION

A health system that uses information to empower individuals and to improve the health of the population.

MISSION

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

INTRODUCTION

Information is the lifeblood of modern medicine, and improving the flow of information is foundational to transforming health care. The U.S. Department of Health and Human Services' (HHS) Office of the National Coordinator for Health Information Technology (ONC) was created through Executive Order 13335, *Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator* and established in law through the American Recovery and Reinvestment Act of 2009 (Public Law 111-5, "Recovery Act"), and particularly, its Health Information Technology for Economic and Clinical Health (HITECH) provisions. ONC's goal is to pursue the modernization of the American health care system through the implementation and meaningful use of health information technology (health IT).

A high performing health system must take full advantage of the information technologies that have transformed every aspect of modern life. To enable health information to flow more effectively and efficiently throughout our health system, health IT advancements and the related efforts of ONC broadly support all of the HHS Secretary's priority goals.

In particular, ONC provides critical support to HHS' mission and particularly the HHS Secretary's priority to *Transform Health Care*. Information about patient care, population health, and health system performance are essential to improving outcomes of care, the health of populations, and the effective deployment and conservation of health care resources. Right now, such information is costly and difficult to collect and often completely unavailable. The goal of "meaningful use" of electronic health records (EHRs) and other forms of health IT promises to make critical data available for better decision-making by consumers, clinicians, health care managers, and policy-makers at all levels of our health care system and of government.

ONC has collaborated with the Centers for Medicare & Medicaid Services (CMS) to encourage the meaningful use of health IT, the Medicare and Medicaid EHR Incentive Programs. These programs provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. In establishing these programs through a final rule, ONC and CMS worked together to define Stage 1 of meaningful use. The initial stage outlines measures, which seek to:

- Improve the health care quality, safety, and efficiency while reducing health disparities;
- Engage patients and their families in their health care;
- Improve healthcare coordination;
- Improve population and public health; and,
- Ensure adequate privacy and security protections for personal health information.

Subsequent meaningful use stages will build off of these measures to further improve advanced care processes and health outcomes. Stage 1 of meaningful use was focused on data capture and sharing. This includes accelerated adoption of EHRs, capture of critical information in EHRs, and health information

exchange. Stage 2 of meaningful use will be focused on demonstrating health system improvement, which includes more widespread adoption, data exchange, and process improvement. Stage 3 of meaningful use will be focused on transforming health care, and population health through health IT. This includes demonstrating improvements in care, efficiency, population health, and breakthrough examples of delivery and payment reform.

ONC provides leadership, program resources and services needed to guide nationwide implementation and meaningful use of health IT. The programmatic activities of ONC are carried out by the following offices:

The *Office of the Deputy National Coordinator for Programs & Policy* is responsible for: implementing and overseeing grant programs that advance the nation toward universal meaningful use of interoperable health IT in support of health care and population health; coordinating among HHS agencies, offices as well as relevant executive branch agencies; the public health IT programs and policies; developing the mechanisms for establishing and implementing standards necessary for nationwide health information exchange; and, formulating plans, policies and regulations related to the mission of ONC. These activities are carried out by:

- The Office of Policy and Planning;
- The Office of Standards and Interoperability;
- The Office of State and Community Programs; and,
- The Office of Provider Adoption Support.

The *Office of the Chief Scientist* is responsible for identifying, tracking and supporting innovations in health IT; promoting applications of health IT that support basic and clinical research; collecting and communicating knowledge of health care informatics from and to international audiences; and, advising the National Coordinator on the educational needs of the field of health IT.

The *Office of the Chief Privacy Officer* is responsible for advising the National Coordinator on privacy, security, and stewardship of electronic health information and coordinating ONC's efforts with similar privacy officers in other Federal agencies, state and regional agencies, and foreign countries. The Office of the Chief Privacy Officer also supports privacy and security efforts in ONC's programs.

The *Office of Economic Analysis, Evaluation, and Modeling* utilizes advanced quantitative modeling to simulate the microeconomic and macroeconomic effects of investing in health IT; provides advanced policy analysis of health IT strategies and policies to the National Coordinator; and, applies research methodologies to perform evaluation studies of health IT grant programs.

The *Office of the Deputy National Coordinator for Operations* is responsible for activities that support ONC's numerous programs. These include: budget formulation and execution; contracts and grants management; facilities and internal IT management; human capital planning; stakeholder communications; policy coordination; and, financial and programmatic oversight. These activities are carried out through:

- The Office of Mission Support;
- The Office of Communications;
- The Office of Grants Management; and,
- The Office of Oversight.

DISCRETIONARY ALL-PURPOSE TABLE

(Dollars in thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 (+/-) FY 2012
Budget Authority	42,246	16,415	26,246	+9,831
PHS Evaluation Funds	19,011	44,811	40,011	-4,800
Total Program Level	61,257	61,226	66,257	+5,031
FTE	147	172	191	+19

OVERVIEW OF BUDGET REQUEST

The FY 2013 Budget Request for ONC is $66.3 million, including $40.0 million in Public Health Service (PHS) Evaluation Funds to support program activities and carry out Recovery Act responsibilities. This represents an increase of $5.0 million above the FY 2012 Enacted Level, and includes a decrease in PHS Evaluation Funds of $4.8 million.

This Budget request supports the implementation of the *Federal Health IT Strategic Plan 2011 – 2015* and HHS Strategic Plan, Goal 1: Transform Health Care. The FY 2013 budget request supports efforts that will contribute to advancing the following five priorities:

- Achieve Adoption and Information Exchange through Meaningful Use of Health IT;
- Improve Care, Improve Population Health, and Reduce Health Care Costs through the Use of Health IT;
- Inspire Confidence and Trust in Health IT;
- Empower Individuals With Health IT to Improve their Health and the Health Care System; and,
- Achieve Rapid Learning and Technological Advancement.

The Budget request provides resources that enable ONC to continue supporting, and further advancing, the progress it has achieved in creating a nationwide health IT infrastructure in response to the mandates set forth in HITECH. ONC is recognized as the lynchpin between Federal and state governments as well as the private market that ensures the standards, policy coordination, and certification supporting the health IT infrastructure are upheld.

OVERVIEW OF PERFORMANCE

The performance measures reported in this document track progress towards ONC's overarching goal to promote the nationwide implementation of health IT along with specific measures of key HITECH programs. Accordingly, the nationwide measures track the rate of EHR adoption, and meaningful use among professionals, hospitals, and priority groups, while separate measures track the performance of individual grant programs against their stated mission and goals.

During FY 2011, important strides were made in accelerating the development and diffusion of an interoperable nationwide health IT infrastructure. ONC continued to conduct and participate in a wide range of Federal planning and coordination efforts, further implemented HITECH grant programs, and assisted HHS by filling new and important roles required to support recently enacted health care reforms. Among recent accomplishments are the following highlights:

- *Increases in EHR Adoption:* EHR adoption statistics among non-Federal acute care hospitals, office-based physicians, and office-based primary care providers all increased markedly in FY 2011. Among office-based primary care providers, the nationwide rate of EHR adoption continued showing significant increases for a second year, this year increasing from 30 percent to 39 percent.

- *Federal Coordination and Advisory Activities:* ONC made progress in coordinating Federal health IT endeavors through leadership roles on the Federal Health IT Task Force by sustaining and forging key partnerships with HHS agencies – such as the Health Resources and Services Administration (HRSA) – and through coordination with other Federal agencies – such as the Federal Communications Commission – to ensure that the implementation of health and IT-related programs are mutually supporting.

- *Meaningful Use:* During FY 2011, health IT stakeholders in HHS collaborated extensively to establish the definition and implementation parameters for Stage 1 of the CMS Medicare and Medicaid EHR Incentive Program. As a result, initial incentives reached nearly 11,000 eligible providers, and provided almost $900 million in incentives to transition health care practices to EHRs. In further support of meaningful use, ONC also established the EHR Certification Program in FY 2011, another key milestone towards creating a transparent market for certified EHR products.

- *HITECH Program Implementation:* ONC's implementation of HITECH programs proceeded as expected in the first half of FY 2011. Notably, since the Health Information Technology Extension Program's establishment, more than 100,000 providers have signed up to receive implementation support. Moreover, in the Program of Assistance for University-Based Training and Community College Consortia to Educate health IT professionals, more than 5,500 students completed training in critical health IT workforce roles during FY 2011. This is around one fifth of the estimated shortfall of approximately 51,000 that was forecasted in 2009 based on available data from the Bureau of Labor Statistics (BLS), U.S. Department of Education (ED), and independent studies.

ONC'S PERFORMANCE MANAGEMENT PROCESS

The performance management process at ONC is a dynamic and on-going part of all program and policy management activities. The process includes embedded and discrete activities that provide ONC executives, managers and staff an opportunity to develop clear and common goals, monitor progress towards goal attainment, and when necessary, revise established plans appropriately.
The ONC performance process, which is largely enabled by a common government-wide framework of performance processes and standards, includes targeted activities that focus ONC performance management around: (A) priority-setting; (B) measurement and analysis; (C) regular performance reviews; and, (D) priority, strategic, and operational updates based on findings from performance reviews.

A. *Priority-setting*

ONC's authorizing legislation, appropriations, and operating budgets form the basis for the multi-year and annual priority setting processes. In addition, requests from Congress that pertain to updates on ONC activities or for renewed or reformed focus on certain aspects of health IT promotion and implementation are regularly received and integrated into ONC's priority set.

1. Strategic Plan (Fiscal Years 2011 to 2015)

Establishing multi-year strategic plans is a critical step in the process for establishing the medium and long-term visions for ONC. Accordingly, HITECH directs ONC to maintain the *Federal Health IT Strategic Plan*. Recently published, the Federal Health IT Strategic Plan is the result of extensive collaboration among health IT stakeholders; it represents an ambitious plan to coordinate the nation's efforts to accelerate the development and proliferation of health IT throughout the United States health care system.

HITECH requires the *Federal Health IT Strategic Plan* to address the following priority areas:

- Use of electronic exchange, health information, and the enterprise integration of such information;
- Utilization of an EHR for each person in the United States;
- Incorporation of privacy and security protections for the electronic exchange of an individual's individually identifiable health information;
- Use of security methods to ensure appropriate authorization and electronic authentication of health information and specifying technologies or methodologies for rendering health information unusable, unreadable, or indecipherable;
- Specification of a framework for coordination and flow of recommendations and policies under this subtitle among the Secretary, the National Coordinator, the HIT Policy Committee (HITPC), the HIT Standards Committee (HITSC), and other health information exchanges and other relevant entities;
- Use of methods to foster the public understanding of health IT;
- Employment of strategies to enhance the use of health IT to improve health care quality, reduce medical errors, reduce health disparities, improve public health, increase prevention and coordination with community resources, and improve the continuity of care among health care settings; and,
- Implementation of specific plans for ensuring that populations with unique needs, such as children, are appropriately addressed in the technology design, which may include technology that automates enrollment and retention for eligible individuals.[2]

Following the best practices established in the Government Performance and Results Act Modernization Act of 2011, partners will begin a process for reviewing and, if necessary, revising the strategic plan beginning in FY 2013, which is 3 years into the current plan's implementation. The process for updating the plan will necessarily include extensive planning within ONC; consultation with Federal partners; and, outreach to providers and the health care community.

2. Annual Plans

While multi-year, strategic plans are important to establishing a clear and common plan for the accomplishment of the nation's health IT adoption goals, so too is the establishment of annual processes for articulating in greater detail the specific performance expectations for the organization, senior executive, and staff levels.

The organizational and National Coordinator's annual plans are established according to the Department's senior executive service performance planning schedule, which is aligned to the fiscal year calendar. In practice, the method for establishing these plans is a collaborative, yet personally led, disciplined, and detailed-oriented series of conversations. The National Coordinator, ONC's executives, and subject

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

matter experts work together to define ambitious milestones, and goals for accomplishing the upcoming fiscal year's program, policy and operational objectives.

After the National Coordinator's plan is finalized, the core performance elements are integrated into the annual performance plans for ONC's senior executives. Each ONC senior executive has a performance plan that includes critical elements of performance that are related to the achievement of the organization's program and policy goals, as well as the on-going exhibition of core management and leadership competencies. Once the National Coordinator and senior executive performance plans are in place, the process of aligning employee performance plans will begin. Staff performance plans will align with the expectations of ONC senior executives as well as the overarching goals of the organization. They will also include specific goal statements expressing the exact contributing actions that the staff will champion during the performance period.

B. Measurement and analysis

1. Research and Analysis of Priority Health IT Adoption Indicators

Through a variety of health IT-related research projects, ONC's teams of researchers, program evaluators, and program and policy analysts support a cross-cutting research, analysis, and adoption modeling agenda targeted to identifying barriers to health IT adoption, patterns of successful implementation, and gaps where additional research is needed to further motivate health systems change. Together, these activities enable ONC to assess nationwide, regional, and state-level patterns of adoption pertaining to priority groups of health care providers.

2. Summative Feedback on HITECH Program Effectiveness through Program Evaluations:

According to HITECH requirements, ONC is to conduct program evaluations of the: (1) overall implementation of HITECH, (2) Health Information Technology Extension Program, (3) Health IT Workforce Program, (4) State Health Information Exchange Program, and (5) Beacon Community Program. In addition to providing a summative assessment of ONC's HITECH program implementation, these evaluations also generate useful materials for routine analyses that can impact the implementation of the programs. For example, several of the HITECH evaluations are developing use-cases and grantee typologies that help ONC project officers and grantees understand and address common problems.

3. Rapid Analysis of Program Performance and Operations Data:

ONC's performance-based program management is supported by numerous information management systems that enable the consistent collection and analysis of performance information. For example, ONC's Office of Provider Adoption and Support uses a customer relationship management (CRM) tool to ensure that all Regional Extension Centers (RECs) are capturing the same information about the providers they are supporting in the path to meaningful use. In addition, ONC is implementing enterprise level analytical tools that harness the recurring flow of information and routine analyses by integrating them into management dashboards and regular dashboard reports. The ONC dashboards will be fully operational during the final three years of HITECH programs implementation.

C. Regular performance reviews

The regular review of national, Federal, ONC-organizational, senior executive and employee performance is engrained in ONC operations through a variety of formal and informal practices, including:

- Annual Organizational Assessment and Performance Report,

- Mid-Year Senior Executive and Employee Performance Reviews, and
- Quarterly Reviews.

In addition, ONC is committed to real-time analysis and review of data. Via the internal ONC performance and management dashboards and the Open Government Dashboard for Health IT, regular performance reviews will be made available to the public according to a pre-set list of key performance indicators that provide insight into how ONC programs are being implemented and the status of health IT adoption.

D. Priority, strategic and/or operational updates based on findings from the reviews

The process for planning, reviewing progress, and re-establishing priorities within an environment in which change is the expectation is necessarily robust and on-going. Through a series of regularly held weekly managers meetings, senior leadership team meetings, cross-cutting priority group meetings, and planning exercises, the Office of the Deputy National Coordinator for Operations and the Office of Policy and Planning shepherd the agency's leadership through the planning exercises needed to ensure that ONC strategic and implantation plans are always focused on the highest priority needs.

HHS Priority Goal for Fiscal Years 2012-2013: Improve Health Care Through Meaningful Use of Health Information Technology

Goal Statement:
By September 30, 2013, increase the number of eligible providers who receive an incentive payment from the CMS Medicare and Medicaid EHR Incentive Programs for the successful adoption or meaningful use of certified EHR technology to 140,000.

Key Indicators:

- Number of eligible providers who receive incentive payments from the CMS Medicare EHR Incentive Program for the successful demonstration of meaningful use of certified EHR technology.
- Number of eligible providers who receive incentive payments from the CMS Medicaid EHR Incentive Program for the successful demonstration of either adopt/implement/upgrade or meaningful use of certified EHR technology.

Discontinued Performance Measures

FY 2011 is the final year in which measure 1.F.1 will be reported.

Disclosure of Assistance by Non-Federal Parties

There was no assistance provided to ONC by non-Federal parties in preparing this performance plan and report.

Agency Support for HHS Strategic Plan

ONC is the principal Federal organization charged with coordination of national efforts related to the implementation and use of electronic health information exchange. The following table crosswalks the goals in ONC's existing strategic plan with the HHS Strategic Plan for 2010 - 2015.

FY 2013 Budget by HHS Strategic Goal
Office of the National Coordinator for Health Information Technology

(dollars in thousands)

HHS Strategic Goals	FY 2011	FY 2012	FY 2013 PB
1 Strengthen Health Care			
1.A Make coverage more secure for those who have insurance and extend affordable coverage to the uninsured			
1.B Improve health care quality and patient safety			
1.C Emphasize primary & preventative care linked with community prevention			
1.D Reduce growth of health care costs while promoting high-value, effective care			
1.E Ensure access to quality, culturally competent care for vulnerable populations			
1.F Promote the adoption and meaningful use of health information technology	61,257	61,226	66,257
2. Advance Scientific Knowledge and Innovation			
2.A Accelerate the process of scientific discovery to improve patient care			
2.B Foster innovation at HHS to create shared solutions			
2.C Invest in the regulatory sciences to improve food & medical product safety			
2.D Increase our understanding of what works in public health and human services			
3. Advance the Health, Safety and Well-Being of the American People			
3.A Promote the safety, well0-being, resilience, and healthy development of children and youth			
3.B Promote economic & social well-being for individuals, families and communities			
3.C Improve the accessibility and quality of supportive services for people with disabilities and older adults			
3.D Promote prevention and wellness			
3.E Reduce the occurrence of infectious diseases			
3.F Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies			
4. Increase Efficiency, Transparency and Accountability of HHS Programs			
4.A Ensure program integrity and responsible stewardship of resources			
4.B Fight fraud and work to eliminate improper payments			
4.C Use HHS data to improve American health and well-being of the American people			
4.D Improve HHS environmental, energy, and economic performance to promote sustainability			
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce			
5.A Invest in HHS workforce to meet America's health and human service needs today & tomorrow			
5. B Ensure that the Nation's healthcare workforce meets increased demands.			
5.C Enhance the ability of the public health workforce to improve health at home and abroad			
5.D Strengthen the Nation's human service workforce			
5.E Improve national, State & local surveillance and epidemiology capacity			
TOTAL	61,257	61,226	66,257

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

APPROPRIATIONS LANGUAGE

For expenses necessary for the Office of the National Coordinator for Health Information Technology, including grants, contracts and cooperative agreements for the development and advancement of interoperable health information technology, [$16,446,000] *$26,246,000*: Provided, That in addition to amounts provided herein, [$44,811,000] *$40,011,000* shall be available from amounts available under section 241 of the Public Health Service Act.

AMOUNTS AVAILABLE FOR OBLIGATION

(Dollars in thousands)

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Request
General Fund Discretionary Appropriation:			
Appropriation (L/HHS, Ag, or, Interior)........................	61,257,000	61,257,000	66,257,000
Across-the-board reductions (L/HHS, Ag, or Interior)	0	-31,083	
Subtotal, Appropriation (L/HHS, Ag, or Interior)....	61,257,000	61,225,917	66,257,000
Total, Discretionary Appropriation.......................	61,257,000	61,225,917	66,257,000
Unobligated Balances:			
Unobligated balance, Recovery Act start of year............	159,370,000	3,740,000	0
Unobligated balance, Recovery Act end of year.............	3,740,000	0	0
Total obligations...	216,887,000	64,965,917	66,257,000
Obligations less ARRA...	61,257,000	61,225,917	66,257,000

SUMMARY OF CHANGES

(dollars in thousands)

2012				
Total estimated budget authority........				16,415
(Obligations)				0
2013				
Total estimated budget authority........				26,246
(Obligations)........				0
Net Change budget authority				+9,831
Net Change obligations........				+0

	FY 2013 Budget FTE	FY 2013 President's Budget Budget Authority	Change from Base FTE	Change from Base Budget Authority /1
Increases:				
A. Program:				
1. Deputy National Coordinator for Programs and Policy	92	12,229	+6	+4,796
Subtotal, Increases	**92**	**12,229**	**+6**	**+4,796**
2. Deputy National Coordinator for Operations	70	10,061	+9	+3,907
Subtotal, Increases	**70**	**10,061**	**+9**	**+3,907**
3. Office of the Chief Scientist	8	722	+0	+154
Subtotal, Increases	**8**	**722**	**+0**	**+154**
3. Office of the Chief Privacy Officer	10	2,141	+4	+692
Subtotal, Increases	**10**	**2,141**	**+4**	**+692**
4. Office of Economic Analysis, Evaluation, and Modeling	11	1,093	+0	+283
Subtotal, Increases	**11**	**1,093**	**+0**	**+283**
Total, Program Increases	**191**	**26,246**	**+19**	**+9,832**
Net Change	**191**	**26,246**	**+19**	**+9,832**

/1 Total may not add due to rounding.

BUDGET AUTHORITY BY ACTIVITY

(dollars in thousands)

	FY 2011 Actual	FY 2012 Enacted /1	FY 2013 Request
1. DNC Programs and Policy	18,570	7,336	12,229
Total, DNC Programs and Policy	18,570	7,336	12,229
2. DNC Operations	15,312	6,262	10,061
Total, DNC Operations	15,312	6,262	10,061
3. Office of the Chief Scientist	1,977	568	722
Total, Office of the Chief Scientist	1,977	568	722
4. Office of the Chief Privacy Officer	3,728	1,449	2,141
Total, Office of the Chief Privacy Officer	3,728	1,449	2,141
5. Office of Economic Analysis and Modeling	2,659	799	1,093
Total, Office of Economic Analysis and Modeling	2,659	799	1,093
Total, Budget Authority	42,246	16,414	26,246
FTE	147	172	191

/1 Total may not add due to rounding.

AUTHORIZING LEGISLATION

(dollars in thousands)

	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2013 Amount Authorized	FY 2013 Pres. Budget
Health Information Technology Activity:				
1. Health Information Technology PHS Act 42 U.S.C. 201……..	Indefinite	$16,415	Indefinite	$26,246
2. PHS Evaluation Funds (non-add) PL 111-117...........................	Indefinite	$44,811	Indefinite	$40,011
Total request level.................		$61,226		$66,257

APPROPRIATIONS HISTORY

(dollars in thousands)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2006				
General Fund Appropriation:				
Base	$75,000	$58,100	$32,800	$42,800
PHS Evaluation Funds	$2,750	$16,900	$12,350	$18,900
Rescissions (P.L. 109-148)				-$428
Transfer to CMS				-$29
Subtotal	$77,750	$75,000	$45,150	$61,243
FY 2007				
General Fund Appropriation:				
Base	$89,872	$86,118	$51,313	$42,402
PHS Evaluation Funds	$28,000	$11,930	$11,930	$18,900
Subtotal	$117,872	$98,048	$63,243	$61,302
FY 2008				
General Fund Appropriation:				
Base	$89,872	$13,302	$43,000	$42,402
PHS Evaluation Funds	$28,000	$48,000	$28,000	$18,900
Rescissions (P.L. 110-160)				-$741
Subtotal	$117,872	$61,302	$71,000	$60,561
FY 2009				
General Fund Appropriation:				
Base	$18,151	$43,000	$60,561	$43,552
PHS Evaluation Funds	$48,000	$18,900	$0	$17,679
ARRA (P.L. 111-5)				$2,000,000
Subtotal	$66,151	$61,900	$60,561	$2,061,231
FY 2010				
General Fund Appropriation:				
Base	$42,331	$0	$42,331	$42,331
PHS Evaluation Funds	$19,011	$61,342	$19,011	$19,011
Subtotal	$61,342	$61,342	$61,342	$61,342
FY 2011				
General Fund Appropriation:				
Base	$78,334	$69,842	$59,323	$42,331
PHS Evaluation Funds	$0	$0	$19,011	$19,011
Rescissions (Secretary's)				-$85
Subtotal	$78,334	$69,842	$78,334	$61,257

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2012				
General Fund Appropriation:				
Base..	$57,013	$0	$42,246	$16,446
PHS Evaluation Funds...	$21,400	$28,051	$19,011	$44,811
Rescissions (P.L. 112-74).................................				-$31
Subtotal..	$78,413	$28,051	$61,257	$61,226
FY 2013				
General Fund Appropriation:				
Base..	$26,246			
PHS Evaluation Funds...	$40,011			
Subtotal..	$66,257			

OFFICE OF THE DEPUTY NATIONAL COORDINATOR FOR PROGRAMS AND POLICY

	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 (+/-) FY 2012
Budget Authority	18,570	7,336	12,229	+4,893
PHS Evaluation Funds	8,357	20,026	18,642	-1,384
Total Program Level	26,927	27,362	30,871	+3,509
FTE	75	86	92	+6

Authorizing Legislation: PHS Act 42 U.S.C. 201
Allocation Method: Contract, Cooperative Agreement, Grant

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Deputy National Coordinator (DNC) for Programs and Policy plays an important role in progressing towards the achievement of the HHS Secretary's priority to *Transform Health Care*. Its four program offices, the Office of Policy and Planning, the Office of Standards and Interoperability, the Office of State and Community Programs, and the Office of Provider Adoption Support, support efforts to:

- Encourage the adoption of health IT;
- Coordinate across and outside the government to expand the use of health IT, and establish standards to govern meaningful use of health IT;
- Develop and implement health IT policies that set the national direction;
- Establish the "rules of the road" and best practices for the use and exchange of health IT; and,
- Establish state and community programs to create the infrastructure and demonstrations needed to improve health care efficiency and quality.

The Office of Policy and Planning (OPP) leads ONC's Federal health IT policy activities and plays a critical role in the Administration's efforts to transform health care. OPP's policy development, coordination and planning activities include identifying and addressing policy opportunities and barriers that affect widespread adoption and meaningful use of health IT; aligning policy levers across the Federal government with health IT programs and objectives; and, developing and setting the policy framework for emerging activities that emanate from the creation and exchange of electronic health information.

In support of ONC's guiding priority principles, OPP advances and implements Federal policy that improves health and health care through the effective use of health IT. Specifically, OPP leads the following activities:

- *HIT PC and HITSC:* ONC chartered the HITPC, and the HITSC, Federal Advisory Committee Act (FACA) bodies, to make policy and technical recommendations to the National Coordinator. Committee work has informed CMS and ONC rulemaking for Stage 2 requirements for the Medicare and Medicaid EHR Incentive Program, Stage 2 standards and certification criteria for EHRs, and governance of the Nationwide Health Information Network (NwHIN). To date, the Committees have made recommendations to the National Coordinator related to all five of ONC's five priorities noted in the Budget Overview.

- *Regulations:* OPP has developed seven regulations to date, including: the initial set of standards, implementation specifications, and certification criteria for EHRs as well as the establishment of the Temporary and Permanent Certification Programs for Health IT. In FY 2011, ONC published an advance notice of proposed rulemaking (ANPRM) to seek public comment on proposed health IT standards related to metadata. In FY 2012, OPP is developing the final rule for Stage 2 meaningful use standards, implementation specifications, and certification criteria for EHRs. This will be completed by FY 2013. Rulemaking for a governance mechanism and criteria for the NwHIN will continue into FY 2013.
- *Federal Health IT Strategic Planning and Policy Development:* OPP published the *Federal Health IT Strategic Plan 2011 – 2015* on September 12, 2011. OPP also conducted a webinar series for the members of the Federal Health IT Task Force – consisting of the National Coordinator for Health IT, administration officials, and other Federal agency leads for health IT. The Federal Health IT Task Force is the key federal committee responsible for coordinating Federal health IT investments, aligning programs to support meaningful use of certified EHR technology, and creating broad understanding of the direction for Federal health IT over the next five years.

The Office of Standards and Interoperability (OSI) works to enable health information to be captured and exchanged among health IT systems, whether they are within small physician practices or large hospitals. OSI plays a critical role in driving ONC's efforts to promote adoption and meaningful use of EHRs; facilitate electronic health information exchange to improve health care quality and delivery; and, enable consumers to play a more central role in directing their care through the use of technology.

OSI has undertaken a wide range of standard and certification criteria-related activities including establishing the Standards and Interoperability (S&I) Framework and the NwHIN's Direct, and health information exchange activities. OSI has also taken a role in establishing the EHR Certification Program and acting as Managing Partner of the Federal Health Architecture (FHA). OSI's role will become more critical as meaningful use requirements progress from a focus on data collection to improved care processes, better care coordination, and demonstration of improved outcomes.

Examples of activities and processes lead by OSI include:

- *Certification Process:* In FY 2010, OSI developed and implemented a temporary certification program, accredited six Authorized Testing and Certification Bodies, and established the Certified Health IT Products List (CHPL) to assure consumers that the EHR products they purchase will meet the requirements necessary to achieve meaningful use of health IT. As of January 2012, the CHPL includes 1,577 certified EHR products, 806 complete EHRs (678 ambulatory, 128 inpatient), and 692 EHR vendors. OSI collaborated with the National Institute of Standards and Technology (NIST) to develop and apply tests to ensure EHRs function in a manner that is compliant with the standards and technical requirements for meaningful use.
- *Standards/S&I Framework:* Through the S&I Framework, OSI has enabled a broad community of participants across the United States to engage positively with our government-led efforts to standardize health information exchange. The first initiative within the S&I was launched in January 2011. Today, the S&I Framework facilitates a community of almost 1,000 entities. As a result of these efforts, the nation, for the first time, has established a single standard for the data that is exchanged in core care transition scenarios.
- *Nationwide Health Information Network:* The NwHIN is a portfolio of standards, protocols, legal agreements, specifications, and services that enables the secure exchange of health information over the Internet. Just like the core standards that support the Internet allow information to be accessible through multiple means, the NwHIN's standards, services, and policies will make it possible for health information to follow the consumer, be available for clinical decision making,

and support appropriate use of health care information beyond direct patient care to improve public health. In FY 2011, ONC leveraged the investments and lessons learned from the NwHIN Direct and Exchange implementations to curate a set of simple modular transport specifications and associated testing guidelines that ensures the ability to exchange health information nationally.

- *Federal Health Architecture:* The FHA is a partnership among Federal agencies, ONC, and the Office of Management and Budget (OMB). HHS, through ONC, is the managing partner. This group is a collaborative Federal voice informs the development of shared Federal standards and protocols, including the NwHIN, and provides a venue for implementing and deploying standards, services and policies that will allow data exchange with all entities across the nation. In 2011, FHA developed requirement specifications and a roadmap for the CONNECT gateway, and successfully released version 3.2 of CONNECT, with work continuing on subsequent releases.

The Office of State and Community Programs (OSCP) supports and manages programs established in HITECH. Specifically, OSCP coordinates the efforts of states in the health care provider adoption of health information exchange to meet requirements for the CMS Medicare and Medicaid EHR Incentive Payment Program. OSCP also supports communities in applying health IT to demonstrate health care outcomes.

OSCP programs incorporate the outcome-oriented use of health IT into state-led care transformation efforts, such as quality reporting and medical home initiatives. OSCP programs will shape health information exchange efforts to address specific, concrete interventions that will have a significant impact on health outcomes, including improved care transitions, reduced readmissions, and reduced adverse drug events.

Activities led by OSCP include:

- *State Health Information Exchange (HIE) Program:* In FY 2011, all states received approval of their implementation plans for achieving statewide health information exchange. These plans guide creation of appropriate governance, policies, and network services to build capacity for connectivity between and among health care providers. Current OSCP efforts that support the State HIE Program are focused on the concentrated and successful Program execution, dissemination of lessons learned, and achieving innovation. State Health Information Exchanges bridge a digital divide, and fill a public need which is not addressed by other government programs.
- *Beacon Community Program:* In FY 2010, ONC awarded funding to 17 Beacon Communities in which clinicians, hospitals, and consumers commit to using health IT and related care delivery tools (e.g., clinical decision support technologies) and interventions, such as medical homes, to pursue significant improvements in quality, efficiency, and overall population health. In FY 2011 OSCP worked with Beacon communities to establish an outline of the specific activities and interventions they would implement to achieve their improvement goals. As a part of this effort, OSCP worked with the Beacon communities to establish a three-part performance measurement strategy, which is comprised of endorsed measures aligned with specific interventions; a common core set of measures aligned with national priorities; and, testing new measure types and measurement data aggregation to inform policy. Additionally, grantees began working to implement key health IT solutions aimed at improving care coordination and providing important clinical information to providers and patients.

The Office of Provider Adoption Support (OPAS) is responsible for helping health care providers utilize health IT effectively to improve the quality and efficiency of the care they deliver to their patients. Through the REC program, the Health IT Research Center (HITRC), and the Community College

Workforce program, OPAS has developed a national network of organizations that are focused on supporting individual providers and assisting them to achieve meaningful use.

Examples of activities and processes led by OPAS include:

- *REC Program:* As required by HITECH, Section 3012, ONC initiated the REC program, which offers technical assistance, guidance, and information on best practices to support and accelerate health care providers' efforts to become meaningful users of certified EHR technology. As of December 2011, the 62 Regional Extension Centers have collectively recruited over 120,000 primary care providers and nearly 8,000 specialists to achieve meaningful use by 2014, surpassing the HHS High Priority Goal of recruiting 100,000 primary care providers to achieve meaningful use by 2014. Of the providers working with the RECs, by the end of 2011 nearly 60,000 were live on an EHR system that had e-prescribing and quality measurement functionality.
- *Community College Workforce:* As required by HITECH, in FY 2010, OPAS created a Community College Workforce Program to assist in the establishment or expansion of education programs designed to train a highly skilled workforce of health and information technology (IT) professionals to effectively establish and utilize secure, interoperable EHR systems. Estimates constructed in 2009 based on available data from the BLS, ED, and independent studies anticipated a shortfall of approximately 51,000 qualified health IT workers that will be required over five years to meet the needs of hospitals and physicians as they move toward meaningful use of certified EHR technology. The workforce programs focused on several key resources needed to rapidly expand the availability of skilled health IT professionals who will facilitate the implementation and adoption of health IT in the provider community. As of November 30, 2011 a total of 7,129 students have successfully completed the program. Currently, 8,936 students are enrolled nationwide. The programs are all fully operational, and are actively recruiting students.
- *HITRC:* As required by HITECH, OPAS established the HITRC. The office's responsibilities include gathering relevant information on effective practices as well as helping RECs collaborate with one another and with relevant stakeholders to identify and share best practices in EHR adoption and meaningful use. The HITRC supports 14 Communities of Practice (CoPs), which focus on topics such as education and outreach, implementation and project management, workflow redesign, vendor selection and management, meaningful use, privacy and security, workforce issues, public health, etc. During the last eight months of 2011, the HITRC portal, which provides a virtual environment for collaboration amongst individuals focused on implementing and using health IT to improve health care, averaged over 40,000 hits per month. Since the launch of the HITRC Portal, more than 895 resources have been posted, including 127 articles, 17 Frequently Asked Questions, 45 reports, 531 tools, 105 trainings and 70 suggested websites. The HITRC also launched a Learning Management System (LMS) to provide on-line training to REC staff on key issues related to EHR implementation and meaningful use.
- *eQuality Measurements/Meaningful Use Policy Support:* OPAS efforts to support meaningful use policy include its work with electronic Clinical Quality Measures (eCQMs) and the meaningful use vanguard (MUV) program. Stage 1 of meaningful use requires reporting existing clinical quality measures, which need to be re-tooled for inclusion within EHRs. Leveraging an interagency agreement with CMS, the OPAS meaningful use team supported the development, testing and validation of the eCQMs that are being developed to support meaningful use. The eCQM subgroup also began to develop open-source tools for providers and vendors to use to facilitate eCQM calculation, reporting, and improvement.

FUNDING HISTORY

FY 2007	47,996
FY 2008	45,929
FY 2009	48,665
FY 2010	26,138
FY 2011	26,927
FY 2012	27,362

BUDGET REQUEST

The FY 2013 Budget request for the DNC for Programs and Policy is $30.9 million. This amount is an increase of $3.5 million above the FY 2012 Enacted Level, and enables ONC to continue implementing HITECH provisions and meet ONC objectives. In FY 2013, ONC will also undergo a significant effort to transition activities that have historically been supported through contracts to Federal staff.

The FY 2013 Budget request will allow HHS to inspire confidence and trust in health IT through its efforts to develop a portfolio of secure, interoperable standards, develop a health IT testing infrastructure, establish certification criteria, provide a public facing CHPL, and support the NwHIN portfolio's "building blocks" of standardized vocabularies, content packages, transportation specification and information exchange services. The FY 2013 Budget request for ONC will also support a strong interoperability foundation upon which meaningful use, health information exchange, and improved patient care quality will be built.

The FY 2013 Budget request includes funding for continued support of the HITECH mandated HITPC and HITSC, and their workgroups. The Committees are charged with making recommendations to the National Coordinator on a policy framework for developing and adopting a nationwide health information infrastructure as well as on standards, implementation specifications, and certification criteria for the electronic exchange and use of health information.

The FY 2013 Budget request will support continued coordination with grantees to identify best practices for health IT adoption and meaningful use to achieve improved health care outcomes during the peak performance period of the grants. This support includes engaging in program management activities for the Beacon Communities, such as site visits, to ensure grantees are implementing the program according to the requirements. Continued program management for the State HIE program is also included in the FY 2013 Budget request, supporting best practice analysis, impact measurement, communication and dissemination of best practices, and engagement of a broad range of stakeholders associated with the program. This investment will produce more effective, easier to implement and lower-cost exchange options.

The FY 2013 Budget request also supports further development and expansion of the HITRC portal and the CRM tool. These tools will assist in the implementation of population health management and planning, and facilitate knowledge sharing among and between the network of over 120,000 REC members through virtual and in-person meetings and workshops to accelerate the exchange of lessons learned from on-going implementation projects. The FY 2013 Budget request assists ONC in breaking down barriers between providers and information systems. The Budget request also supports the development of best practices in guiding provider practices for understanding, selection, implementation and use of EHR systems. The CRM is able to analyze the data by types of provider type, provider setting, and region of the country. This information will assist other providers implement systems and will address the historically low rate of EHR adoption by small practices. This information will also be used

to support ONC's understanding of the factors that are impacting EHR adoption, which is an element of the ONC strategic plan.

OUTPUTS AND OUTCOMES TABLE

The following measures represent ONC's cross-cutting measures of national level indicators of health IT adoption and exchange, and HITECH Act implementation endeavors.

For more information about ONC performance against established goals, visit the ONC website at http://healthit.hhs.gov or the Health IT Dashboard at http://dashboard.healthit.gov.

Measure	Year and Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2011Target
1.A.1 Percent of office-based physicians who have adopted electronic health records (basic)[3]	FY 2010: 25% Target: 25% (Target Met)	40%	50%	+25
1.A.2 Percent of office-based primary care physicians who have adopted electronic health records (basic)	FY 2011: 39% Target: 35% (Target Exceeded)	45%	55%	+20
1.A.3 Percent of non-federal acute care hospitals that have adopted electronic health records[4]	FY 2011: Not Reported Target: 24% (Target Exceeded)	45%	55%	+31
1.B.1 Percent of eligible hospitals receiving meaningful use incentive payments[5]	FY 2011: 14% Target: N/A	38%	53%	+39%

[3] This measure is derived from the NAMCS and reported by the National Center for Health Statistics (NCHS) in the December 2010 publication, "Electronic Medical Record/Electronic Health Record Systems of Office-based Physicians" http://www.cdc.gov/nchs/data/hestat/emr_ehr_09/emr_ehr_09.htm.

[4] "Adoption" of an inpatient electronic health record is defined as at least "basic" adoption, without notes, as in Jha et al. 2009 in the New England Journal of Medicine article *Use of Electronic Health Records in U.S. Hospitals* http://www.nejm.org/doi/pdf/10.1056/NEJMsa0900592. This measure excludes federal hospitals, and hospitals located outside of the 50 states and the District of Columbia. It encompasses all non-federal general acute care hospitals in the American Hospital Association annual survey, including critical access hospitals.

[5] The numerator for this measure, 700 for FY 2011, is the total number of hospitals that receive incentive payments from either of the CMS EHR Incentive Programs. The composite pieces of this measure's numerator are reported in

Measure	Year and Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2011Target
1.B.2 Percent of eligible professionals receiving meaningful use incentive payments[6]	FY 2011: 2% Target: N/A	15%	26%	+26%
1.B.3 Percent of eligible primary care professionals receiving meaningful use incentive payments[7]	FY 2011: Not Reported Target: N/A	N/A	N/A	N/A
1.C.1 Establish a network of Regional Extension Centers covering 100% of the U.S. population by the end of FY 2010	FY 2011: 100% Target: 100% (Target Met)	100%	100%	Maintain
1.C.2 Number of priority primary care providers registered to receive services from	FY 2011: 97,763 Target: 100,000	100,000	100,000	Maintain

the CMS Performance Budget as measures MCR 27.3, MCR 27.4 and MCR27.6. The denominator is the total number of hospitals eligible to participate in the programs, 5,011, which were estimated through the impact analysis of the EHR Incentive Program, stage I meaningful use rule and is available here: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf. The denominator for this measure is not adjusted from the FY 2011 estimated level in FY 2012 or 2013 to account for any potential changes to the size of the eligible population. This is not expected to have significant impact on the measure

[6] The numerator for this measure, 10,000 for FY 2011, is the total number of health care professionals that receive incentive payments from either of the CMS EHR Incentive Programs. The composite pieces of this measure's numerator are reported in the CMS Performance Budget as measures MCR 27.1, MCR 27.2 and MCR27.5. The denominator is the total number of health care professionals eligible to participate in the programs, 521,600, which was estimated through the impact analysis of the EHR Incentive Program stage I meaningful use rule and is available here: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf. The denominator for this measure is not adjusted from the FY 2011 estimated level in FY 2012 or 2013 to account for any potential changes to the size of the eligible professional population. This is not expected to have significant impact on the measure.

[7] This measure's calculation requires a numerator and denominator. The numerator is the number of primary care providers that receive EHR Incentive Program payments, and the denominator is an estimate for the total number of primary care providers that are eligible to participate in the EHR Incentive Programs. Calculating this measure's numerator and denominator depends on the availability of several key data points for defining providers as "primary care" consistent with the EHR Incentive Programs' data collection process, as well as for estimating provider type, specialty, and patient volume against the Incentive Programs' eligibility criteria to estimate the eligibility. At this point, ONC data sources do not enable such estimates to be calculated with sufficient statistical reliability to report the results with confidence. Accordingly, results are not currently being reported for this measure.

Measure	Year and Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2011Target
Regional Extension Centers[8]	(Target Not Met but Improved)			
1.C.3 Electronic health record adoption rate among providers registered and working with ONC Regional Extension Centers for at least 10 months	FY 2011: 47% Target: 40% (Target Exceeded)	60%	72%	+32
1.D.1 Number of students enrolled in Health IT training programs at Community College Consortia participants[9]	FY 2011: 16,111 Target: 6,500 (Target Exceeded)	6,500	Discontinue	N/A
1.D.2 Cumulative number of students completing Health IT training programs at Community College Consortia participants[10]	FY 2011: 5,125 Target: 7,000 (Target Not Met)	12,250	Discontinue	N/A
1.E.1 Percent of community pharmacies that are capable of exchanging health information electronically	FY 2011: 92% Target:89% (Target Met)	97%	99%	+10
1.F.1 Number of organizations using at least one complete	FY 2011: 20 Target:	Discontinue	Discontinue	N/A

[8] As defined in the Funding Opportunity Announcement for the HITECH program for Health Information Technology Extension Centers, priority primary care providers are physicians (Internal Medicine, Family Practice, OB/GYN, Pediatrics) and other healthcare professionals (PA, NP, Nurse Midwife) with prescribing privileges in the following settings: small group practices (10 or less providers); ambulatory clinics connected with a public or critical access hospital; community health centers and rural health clinics; other ambulatory settings that predominantly serve uninsured, underinsured, and medically underserved populations.

[9] The period of performance for the Community College Consortia to Educate Health IT professionals ends April 2, 2012. Accordingly, performance targets reported here are pro-rated for the portion of FY 2012 that includes the grant program's period of performance. At the full 2012 performance level, which includes a portion of FY 2012 which is outside the program's period of performance, ONC expects the community colleges associated with the Consortia to have the capacity to train 10,500 students per year.

[10] *Ibid 8.*

Measure	Year and Recent Result / Target for Recent Result / (Summary of Result)	FY 2012 Target	FY 2013 Target	FY 2013 Target +/-FY 2011Target
NHIN information component to exchange information[11]	15 (Target Exceeded)			
2.A.1 Number of physicians participating in Beacon Community interventions	FY 2011: 5,678 Target: 5,678 (Baseline)	7,430	8,440	+2,762
2.A.2 Proportion of eligible providers in Beacon Communities that receive meaningful use incentive payments[12]	FY 2011: Not Reported Target: 30% (Baseline)	60%	TBD	N/A

[11] The National Health Information Network (NHIN) is a set of conventions that provide the foundation for the secure exchange of health information that supports meaningful use. The foundation includes technical, policy, data use and service level agreements and other requirements that enable data exchange, whether between two different organizations across the street or across the country.

[12] This measure uses a numerator and denominator. The numerator is the number of providers that receive EHR Incentive Program payments, and the denominator is an estimate for the number of providers that are eligible to participate in the EHR Incentive Programs within Beacon Communities. Estimating the denominator requires a zip code-level of granularity in the estimation process, and at this point, ONC data sources do not enable such estimates to be calculated with sufficient statistical reliability to report the results with confidence or reliability. Accordingly, results are not currently being reported for this measure. However, the following information is available: as of year-end FY 2011, approximately 8,856, or 6%, of the EHR Incentive Program-enrolled eligible professionals were from geographic areas overlapping with the Beacon Communities. Of those enrolled providers, 10% had already successfully attested *and* received incentive payments.

Data Validation Table

Measure ID	Data Source	Data Validation
1.A.1	The information for this measure is gathered in partnership between the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) and ONC. Each year since 2008, NCHS has included in its National Ambulatory Medical Care Survey (NAMCS) questions pertaining to electronic health record adoption.	The CDC National Ambulatory Medical Care Survey (NAMCS) is a nationally representative survey of office-based health care providers with a response rate of approximately 68 percent. The survey allows ONC to examine electronic health record adoption by provider specialty and region in detail. Estimates of performance for FYs 2008-11 for this measure derive from the mail supplement to the NAMCS.
1.A.2	The information for this measure is gathered in partnership between the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) and ONC. Each year since 2008, NCHS has included in its National Ambulatory Medical Care Survey (NAMCS) questions pertaining to electronic health record adoption.	The CDC National Ambulatory Medical Care Survey (NAMCS) survey is a nationally representative survey of office-based physicians with a response rate of approximately 68 percent. The survey allows ONC to examine electronic health record adoption by provider specialty and region in detail. Estimates of performance for FYs 2008-2011 for this measure derive from the mail supplement to the NAMCS.
1.A.3	American Hospital Association Annual Survey of Hospitals, Information Technology Supplement	The American Hospital Association (AHA) surveys all non-federal acute care hospitals annually. The survey includes a health IT supplement and the response rate is historically about 60 percent.
1.B.1	The CMS National Level Repository (NLR) is the data source of the meaningful use incentive program registration and payment data.	CMS will make incentive payments to eligible providers through the information that providers input into the CMS/NLR. CMS has procedures in place to ensure the integrity of the EHR incentive program incentive payments and the quality of data in the NLR.
1.B.2	The CMS National Level Repository (NLR) is the data source of the meaningful use incentive program registration and payment data. The denominator, number of eligible professionals, is estimated during rulemaking process for the EHR Incentive Programs. The estimate used for this measure is 521,600 eligible professionals. The numerator, number of eligible professions that receive incentive payments, is reported by CMS in its monthly public reporting of program data.	CMS will make incentive payments to eligible providers through the information that providers input into the CMS/NLR. CMS has procedures in place to ensure the integrity of the EHR incentive program incentive payments and the quality of data in the NLR.
1.B.3	The CMS National Level Repository is the data source of the meaningful use incentive program registration and payment data. The denominator, number of eligible primary care professionals, will be estimated by ONC subsequent to CMS reporting to ONC a dataset listing the population of primary care providers that	CMS will make incentive payments to eligible providers through the information that providers input into the CMS/NLR. CMS has procedures in place to ensure the integrity of the EHR Incentive Programs incentive payments and the quality of data in the NLR.

Measure ID	Data Source	Data Validation
	have successfully attested to meaningful use.	
1.C.1	ONC Office of Provider Adoption and Support, Health Information Technology Extension Program.	ONC Project Officers routinely evaluate the quality of information submitted by REC grantees. In addition, ONC uses an evaluation contractor to validate the data.
1.C.2	Health IT Regional Extension Center Program	ONC Project Officers work closely with grantees and regularly review the quality of information submitted.
1.C.3	ONC Office of Provider Adoption and Support, Regional Extension Center Program	ONC Project Officers work closely with grantees to evaluate and ensure the quality of data that is submitted.
1.D.1	The information for this measure is gathered in partnership between the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) and ONC. Each year since 2008, NCHS has included in its National Ambulatory Medical Care Survey (NAMCS) questions pertaining to electronic health record adoption.	In 2010 the CDC National Ambulatory Medical Care Survey (NAMCS) surveyed more than 10,000 physicians with a response rate of approximately 68 percent. The survey allows ONC to examine electronic health record adoption by provider specialty and region in detail. Estimates of performance for FYs 2008-2010 for this measure derive from the mail supplement to the NAMCS.
1.D.2	ONC Community College Consortia to Educate Health Information Technology Professionals Program, Monthly Grantee Reports	ONC Project Officers work in close coordination with grantees to review and approve the information that is submitted.
1.E.1	National Progress Report on E-Prescribing, Surescripts	This information is obtained from publicly available annual reports published by the industry-leading vendor for e-prescribing. For more information, visit: http://www.surescripts.com/about-e-prescribing/progress-reports/national-progress-reports.aspx
1.F.1	ONC Office of Standards and Interoperability	ONC tracks which organizations have signed on to the NHIN's Data Use and Reciprocal Support Agreements (DURSA) as well as which organizations are using at least one complete NHIN technical component to share information.
2.A.1	ONC Beacon Communities Cooperative Agreement Program	ONC Project Officers routinely evaluate the quality of information submitted by the Beacon Communities.
2.A.2	ONC Beacon Communities Cooperative Agreement Program	ONC Project Officers routinely evaluate the quality of information submitted by the Beacon Communities.

OFFICE OF THE CHIEF PRIVACY OFFICER

	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 (+/-) FY 2012
Budget Authority	3,728	1,449	2,141	+692
PHS Evaluation Funds	1,677	3,956	3,264	-692
Total Program Level	5,405	5,405	5,405	+0
FTE	4	6	10	+4

Authorizing Legislation: PHS Act 42 U.S.C. 201
Allocation Method: Contract, Cooperative Agreement, Grant

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

As directed by HITECH, the Chief Privacy Officer, who was appointed in February 2010, is responsible for advising the National Coordinator on privacy, security, and data stewardship of electronic health information, and coordinating ONC's efforts with similar privacy officers in other Federal agencies, state and regional agencies, and foreign countries with regard to the privacy, security, and data stewardship of electronic, individually identifiable health information. The Office of the Chief Privacy Officer (OCPO) exercises this policy-focused role by conducting research, drafting and disseminating reports that support policy positions, staffing the HITPC and HITSC Privacy and Security workgroups, and guiding those recommendations through the Federal policy making process. OCPO plays an important policy formulation and policy coordination role in HHS, and the Federal government, contributing to a large variety of rules proposed by other operating divisions across the Department and across Federal agencies, particularly those arising out of the Patient Protection and Affordable Care Act (ACA), to help shape the privacy and security of evolving means for sharing health information to improve health care accessibility and quality.

The OCPO is also responsible for supporting the development and coordination of privacy and security implementation efforts within ONC’s HITECH programs including the OSI, OPAS, and OSCP.

Health Information Technology Security and Cybersecurity
HITECH Subtitle A, Part 1 § 3001, directs ONC to ensure that electronic health information is secure and protected. To that end, ONC has developed a comprehensive security and cybersecurity program that addresses both short-term objectives in supporting early gains in health IT adoption, as well as long-term objectives in creating a secure and protected health IT infrastructure for health information exchange. Security policy must constantly be re-assessed as the technological models for maintaining and sharing health information rapidly evolve (e.g. from on-site hardware to mobile devices and cloud computing).

Under this program, ONC has addressed security and cybersecurity with multiple strategies including provider education, assistance, and outreach, threat and vulnerability analysis; mitigation planning and implementation; and, breach prevention technology. OCPO supports security efforts both within ONC programs, as well as on a broader Federal policy scale, by supporting important research and innovations in enhanced security protection technology, which encourages further market innovation in this area. Example projects include:

- *Breach Causal Analysis:* To combat data leakage, it is necessary to know the cause, to apply the appropriate corrections. OCPO performed the first known study of health care electronic data breach, which found that, contrary to common public assumption, nearly 80 percent [13] of data loss stems from the loss or theft of computing devices ranging from server hard drives to flash memory sticks. The study found that external intrusions or "hacking" accounted for less than 10 percent of data loss. This finding and the subsequent HIT Task Force Cybersecurity Work Group recommendations have provided the direction for ONC's data loss prevention efforts. Examples include outreach to RECs to provide tools and training in data loss prevention and a series of online breach prevention training modules which will be available to providers in 2012.
- *Endpoint Security Automation Test Bed:* OCPO has partnered with the Office of Civil Rights (OCR) and NIST to develop methods of automating EHR security from the initial installation through the lifetime of the system. This project's objectives are to reduce the technology burden on providers while simultaneously improving the overall level of security across the health IT ecosystem. ONC is testing advanced technologies for security automation, including NIST's Security Content Automation Protocol, software assurance, anti-theft technology, and hardware-based security. The result will be tested specifications for standard system configurations.
- *Technologies to Render Protected Health Information Unreadable, Unusable, or Indecipherable:* In establishing the basis for a breach notification rule, HITECH requires updates on technologies for breach prevention. OCPO has initiated a series of studies to survey emerging technologies for data protection. Among the advanced technologies recommended for further investigation are hardware-based anti-theft capabilities (e.g. Lojack for Laptops®) and remote destruction programs, which allow system administrators to wipe all data off of a stolen laptop regardless of location. As a result of this study, OCPO has included these emerging technologies in its security automation test bed.
- *REC Cybersecurity Support for Small Providers:* OCPO has supported ONC's core mission to facilitate provider adoption of EHR technology by delivering training and tools for the RECs to use in assisting their provider clients. These include a cybersecurity awareness video, an automated risk assessment tool, a cybersecurity checklist, a technology capability assessment tool, and training in cybersecurity incident response.
- *State Health Information Exchanges Resiliency Plan:* OCPO solicited stakeholder input to determine the impact of disasters on health information exchange regionally and nationally. Based on the findings, OCPO is developing basic resiliency training for grantees and is producing a concept for resiliency.

Privacy and Security Policy and Implementation
Public policy must not only protect the privacy and security of health information, but must do so in a manner that can be implemented broadly in the health system. ONC has established a high-level Privacy and Security Framework based on the fair information practice principles to guide policy and technical development across the Federal government, state governments, and the private sector. OCPO developed, operationalized, and began staffing the HHS department-wide Task Force, which was formed to resolve HITPC and HITSC recommendations on high-priority policy-making to ensure the privacy and security of health information for the nation. OCPO has provided crucial guidance on privacy and security to CMS on the implementation of components of health care reform under ACA, including acting as a liaison with consumer and privacy group stakeholders. On a programmatic level, OCPO has initiated an active campaign to raise health care provider awareness of the importance of incorporating privacy and security from the outset as they begin to adopt health IT. OCPO is developing both traditional and emerging training tools for this process, including game-based training and security "infomercials".

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[13] Lafky, Deborah. HIT Task Force Cybersecurity Workgroup. White House. Washington, DC. July 16 2010. Practical Solutions to Health care Data Loss.

OCPO also played a lead role in privacy and security-related coordination efforts across the Federal government through participation in the National Science & Technology Committee Subcommittee on Privacy and Internet Policy, the Federal Health IT Task Force, Federal Chief Information Officer Privacy Committee, and Credentialing and Access Management Subcommittee and the National Security Staff-led cross-agency working group which produced the National Strategy for Secure Online Transactions. In addition, OCPO has worked in collaboration with OCR to develop a consumer education campaign about health information privacy rights. OCPO hosted a public roundtable to discuss privacy and security requirements for and understand the evolving landscape of entities that maintain health information but are not covered by the Health Insurance Portability and Accountability Act (HIPAA), with a focus on personal health records (PHRs) and related service providers. Thus, OCPO has coordinated efforts to ensure key privacy and security protections are in place to achieve public trust in health IT adoption, health information exchange, and meaningful use.

FUNDING HISTORY

FY 2007	0
FY 2008	0
FY 2009	0
FY 2010	5,070
FY 2011	5,405
FY 2012	5,405

BUDGET REQUEST

The FY 2013 Budget request for OCPO is $5.4 million, which is the same as the FY 2012 Enacted Level.

Privacy and security are the foundation upon which trust in electronic health information and participation in health information exchange will be built. If individuals and health care professionals do not believe that their health information will be protected and remain confidential, the nation will not achieve the level of participation in health information exchange that is needed to improve individual and population health. Bolstering trust by ensuring privacy and security is fundamental to ONC's mission and a basic priority for ONC.

Cybersecurity
Ensuring that health information is secure in an ever-changing environment is a key goal of ONC. Since its creation in FY 2010, OCPO has worked with its FACAs and stakeholders to identify priority security and cybersecurity policy and practical challenges. OCPO's FY 2013 Budget request address these priorities by focusing its work on breach prevention and remediation in key areas including: assessing privacy and security aspects of emerging technologies; developing (with NIST and other partners) technical requirements and good practices for end-to-end healthcare information technology security implementation; reducing the exposure of health care data through advanced technologies such as data federation and de-identification; and continuing to investigate good practices and to provide tools and training to support grantees and healthcare providers in adopting sound security measures.

OCPO will also continue to work on patient identity management issues. Assuring that the correct clinical information is associated with a patient is crucial to providing safe care. In addition, it is essential to verify that patients accessing their health information electronically are who they say they are. OCPO will work on these patient identity management issues, including furthering the goals of the Administration's National Strategy on Trusted Identities in Cyberspace. OCPO will also continue to work on other

security issues arising from the goal of furthering patient-centered health care, such as secure communications with patients.

Privacy & Security Policy and Implementation
OCPO will continue to support the HIT Policy and Security Committees in evaluating the privacy and security policy needs of the evolving nationwide health information network, including governance. As new policies are developed, providers, health information exchanges, consumers, and other stakeholders need to be educated about their rights and responsibilities. In the past, there has been significant confusion over Federal privacy laws (e.g., HIPAA) partially due to the lack of a comprehensive education campaign. The FY 2013 Budget request will also support OCPO's security communications campaign that informs providers of security requirements and best practices, a privacy component will be added to ensure that new policies and best practices are communicated to those on the front line of using health IT, and HIE.

OCPO will also continue its work to further the electronic implementation of existing and evolving privacy and security policies, e.g., electronic consent. As directed by HITECH, OCPO will continue its work on coordinating health privacy policies and data stewardship with other federal partners, the states and foreign countries, for example working with the Federal HIT Taskforce.

Additionally, the report issued by the President's Council of Advisors on Science and Technology envisions accomplishing patient-centered health care through, among other things, embedding a patient's preference with respect to whether and to whom their health information will be shared. OCPO has previously funded preliminary work in developing use cases and standards that would advance this vision. OCPO intends to continue this work in FY 2013, building upon the trials that will have been conducted in FY 2012.

OFFICE OF ECONOMIC ANALYSIS, EVALUATION, AND MODELING

	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 (+/-) FY 2012
Budget Authority	2,659	799	1,093	+293
PHS Evaluation Funds	1,197	2,183	1,666	-516
Total Program Level	3,856	2,982	2,759	-223
FTE	11	11	11	+0

Authorizing Legislation: PHS Act 42 U.S.C. 201
Allocation Method: Contract, Cooperative Agreement, Grant

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Office of Economic Analysis and Modeling (OEM) supports ONC's efforts to achieve cost savings and quality improvement in the health care system through in depth research and analysis of the myriad factors affecting adoption and meaningful use of EHRs. Within the broader context of ONC, OEM

- Uses economic analysis and models to describe and understand the factors driving: a) the adoption and meaningful use of EHRs; and, b) the costs and benefits of health IT implementation;
- Generates reports, data, and strategies, both as internal documents/presentations and external peer-reviewed publications, to inform ONC programs and broader audiences on the adoption and benefits of health IT;
- Manages ONC's performance measures and reporting requirements for both governmental and external audiences; and,
- Represents ONC in departmental discussions involving health policy, economics, data analysis, and policies/reforms that would leverage health IT and in the broader health economics and health services research community.

Performance Measurement & Reporting
OEM is responsible for developing and coordinating ONC performance measures and ensuring their accurate reporting to internal government audiences and the general public. This involves collaboration with all ONC offices. The mechanisms for reporting these data include the government-wide High Priority Performance Measurement website (www.goals.performance.gov) and related documents, the Recovery Act reporting website (www.recovery.gov) and the ONC Performance Appendix (www.hhs.gov/asfr/ob/docbudget/index.html).

Externally-Directed Activities
OEM must use multiple modes of communication to reach a diverse set of audiences. As discussed earlier, benefits of implementing health IT in care settings are well documented but most published studies are limited case studies or narrow reviews. OEM's work to synthesize and communicate what is known about health IT for the public and provider community through ONC's performance reports, website, public dashboard, and peer-reviewed literature helps providers understand the merits of health IT

adoption and ultimately contributes to health care cost-savings and quality improvement through the expanded use health IT.

Peer-reviewed Literature

Peer-reviewed journal articles are a critical medium for the ongoing advancement of health IT. Policy-makers, decision makers, and key industry stakeholders follow closely the documented benefits of health IT, and published studies are an effective and necessary tool for ONC to reach these audiences. As a result, OEM is committed to funding studies resulting in peer-reviewed publications. OEM also strives to publish staff-generated findings so as to make them widely available to the public and scientific community in the spirit of open government.

A study completed by OEM and published in the journal *Health Affairs* found growing evidence of the benefits of health IT. Using methods that were employed by two previous independent reviews, the new study finds that 92 percent of articles on health IT reached conclusions that showed overall positive effects of health IT on key aspects of care including quality, and efficiency of health care.

Another study published by OEM in *Health Affairs* reported that more than four in five office-based physicians could qualify for new Federal incentive payments to encourage the adoption and meaningful use of electronic health records, based on the numbers of their Medicare or Medicaid patients. The incentives are thus likely to accelerate the spread of EHRs. OEM also recently published a study in the *American Journal of Managed Care,* which indicated that Surescripts© (the nation's largest e-prescribing network) transactional data may allow for the ongoing identification of regional trends, and assist policy-makers in identifying and mitigating emerging disparities in EHR adoption. Finally, OEM office developed measures that were published in *American Journal of Managed Care* and which determined that many hospitals have adopted multiple features of EHRs, and tend to use a staged adoption strategy based on logical groupings of functions.

ONC Website

OEM has worked with the ONC Communications team to produce versions of our technical work accessible to multiple audiences and stakeholder groups. In addition, as discussed above, the public portion of the ONC dashboard is intended to be a user-friendly and innovative reporting tool demonstrating progress in health IT. The public dashboard communicates important and up-to-date measures of adoption, quality improvement, and cost-savings.

ONC Program Support Activities

OEM undertook a wide range of activities that supported ONC's overall mission and the efforts of ONC's major grants programs established with HITECH funding. These include: supporting the Beacon Communities Program develop ongoing methods and models for the analysis of cost and quality data; assisting the State HIE program through tracking and evaluating critical measures for information exchange including e-prescribing, which is associated with fewer adverse drug events and medication errors; providing and analyzing measures of the adoption of EHR systems and the functionalities of those systems for the REC program; and, data gathering, analysis and publication of results that inform the provider community of the effects of EHR implementation for the HITRC program.

In addition, OEM contributes to ONC's activities implementing ACA, focusing on creating the basis for value-based payment and electronic means of measuring and reporting quality and cost performance. Additionally, OEM's FY 2012 Budget request includes funding to support the continuing momentum of the provisions of HITECH.

FUNDING HISTORY

FY 2007	0
FY 2008	0
FY 2009	0
FY 2010	1,452
FY 2011	3,856
FY 2012	2,982

BUDGET REQUEST

The FY 2013 Budget request for OEM is $2.8 million, a decrease of $0.2 million below the FY 2012 Enacted Level, and represents a reduction in monitoring activities. The Budget request for OEM broadly supports the requirements to measure and analyze the adoption, costs, and benefits of health IT.

The Budget request broadly supports ONC's requirement to measure, analyze, and evaluate the adoption and value of health IT. OEM works across the ONC programs and priority areas to:

1. Monitor EHR adoption and use;
2. Promote research on and understanding of the value of health IT; and,
3. Evaluate health IT Initiatives.

These three areas of activity link to ONC's strategic plan goals and are described in more detail in the remainder of this section.

Monitor EHR Adoption and Use

OEM has undertaken numerous initiatives to develop and track the adoption and meaningful use of EHRs and the exchange of clinical data. OEM will continue to monitor trends in these areas through its longitudinal data-collection strategy. In doing so, OEM will continue to exploit low-cost ways of collecting data through supplements to existing Federal surveys, research collaborations, and the procurement of data collected by private entities. The results of these monitoring activities will inform strategies to: enhance the use of health IT; improve the quality and efficiency of health care; and, improve public health. OEM is also tracking detailed data on adoption and meaningful use to inform the rulemaking process. Also, OEM is working to assess the number of eligible providers eligible for the meaningful use incentive program by geographic area. Finally, OEM is using procured data to assess the evolution of EHRs and to track the impact of the certification programs and incentives on the marketplace.

Promote Research on and Understanding of the Value of Health IT

OEM continually tracks and disseminates information to stakeholders about the effects of health IT on key aspects of care, including efficiency and effectiveness. OEM's work synthesizes and communicates what is known about health IT for the public and provider community through ONC's performance reports, blog posts, data collection, the ONC website, public dashboard, and peer-reviewed literature to help citizens and providers understand the value of health IT and how it can contribute to health care cost savings and quality improvement. Policy-makers, decision-makers, and key industry stakeholders follow the documented benefits of health IT closely, and published peer-reviewed studies are an effective and necessary tool for ONC to reach these audiences.

OEM also works to advance the literature on health IT and spur research on the effects of health IT on patient health outcomes and costs. For example, OEM's survey of the effects of EHRs on physician workflow will be producing information in FY 2013 on the current costs and benefits of adopting health IT, and how that has changed since the first survey conducted in FY 2011. The results of this three-year study will be translated into a comprehensive set of information for policymakers and providers on how best to achieve the benefits of EHRs and minimize the cost and disruption of implementation to practices. Using procured data, OEM is conducting research on the digital divide and the association of EHR adoption and disparities in underserved areas. Additionally, OEM collaborates with HRSA to assess EHR adoption in rural and underserved areas and to evaluate the impact of EHRs on health care disparities. Finally, OEM is promoting research to reduce health disparities through health IT.

Evaluation

OEM is responsible for developing and coordinating ONC performance measures and ensuring their accurate reporting to internal government audiences and the general public. OEM uses the analyses mentioned above to inform programs, reduce uncertainty surrounding the benefits, and communicate measures of ONC's progress to governmental and external audiences. OEM works with the ONC Communications team to produce versions of its technical work accessible to multiple audiences and stakeholder groups. OEM also serves as a consultant to other parts of ONC and oversees a set of independent evaluations of each of ONC's HITECH-funded grant programs. In addition, OEM conducts internal analyses and commissions work to support the development of methods and models for the analysis of cost and quality data for the Beacon Program and the RECs by providing and analyzing measures of the adoption of EHR systems and the functionalities of those systems. Additionally, OEM assists the State HIE program through the evaluation of critical measures for electronic information exchange. Evaluating the frequency of data exchange within and across states will help measure the potential to achieve cost-savings and improve quality.

OEM's performance reporting, especially through its dashboard project, allows key audiences to track ONC progress with easily accessible and current data. The online dashboard displays program milestones, metrics, and achievements of ONC and to track interim program activities. The public dashboard communicates important and up-to-date measures of health IT initiatives including EHR adoption, meaningful use, grantee milestones, and Federal partner programs, and is a user-friendly and innovative reporting tool demonstrating progress in health IT. It represents OEM's strong commitment to health IT and the principle of open government.

OFFICE OF THE CHIEF SCIENTIST

	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 (+/-) FY 2012
Budget Authority	1,977	568	722	+154
PHS Evaluation Funds	0,889	1,551	1,101	-450
Total Program Level	2,866	2,119	1,823	-296
FTE	8	8	8	+0

Authorizing Legislation: PHS Act 42 U.S.C. 201
Allocation Method: Contract, Cooperative Agreement, Grant

PROGRAM DESCRIPTIONS AND ACCOMPLISHMENTS

The Office of the Chief Scientist (OCS) is responsible for: applying research methodologies to assess progress and trends in health IT science and technology; identifying, tracking and supporting innovations in health IT; leading research activities to support the goals of the HHS Strategic Plan and National Health Care Quality Strategy and Plan; promoting applications of health IT that support basic and clinical research; exchanging knowledge of health informatics and effective practices in health IT application with international audiences; collaborating with Federal agencies on new health IT programs; and, advising the National Coordinator on current and anticipated developments in information science and health IT.

Innovation

OCS provides support for health IT innovation efforts within ONC, HHS, and the Administration as well as the broader health IT development community in an effort to support widespread adoption of health IT through the achievement of meaningful use. While current programs represent the near-term steps towards improved health delivery, substantial innovation is needed to create the foundation for the Secretary's priority to *Transform Health Care*. OCS's innovations and research work supports HHS along three broad themes:

- Monitoring and identifying health IT and related innovations amongst all health care stakeholders;
- Communicating innovations to inform ONC programmatic and policy efforts, as well as other appropriate stakeholders; and,
- Supporting both the development and diffusion of innovative efforts aligned with HHS goals.

Advancing Health IT Science and Technology

ONC plans to develop a learning system infrastructure for healthcare quality improvement and population health. This nationwide health IT infrastructure will build upon adoption and meaningful use of certified EHR technology to support improving outcomes of care and the health of populations as well as the effective deployment and conservation of health care resources. To do so requires careful strategic consideration of the capabilities, technical and policy approaches, and operating principles needed to assiduously protect individuals' privacy while allowing efficient and effective use of data from multiple areas of health care, population health, and clinical, biomedical, and translational research.

The data needed for many of these goals are not currently captured in most EHRs, and often exist in parallel, un-integrated systems. Development of the technical infrastructure to harvest information and generate knowledge from data held across these areas is important to achieve HHS goals. Development of a policy and governance framework is equally crucial to achieving the infrastructure that will support the needed capacities and functionalities. Without a robust trust fabric between patients (in routine clinical care settings or in context of participating in clinical research) and providers/researchers, and amongst the providers and researchers, the needed sharing will not occur.

OCS, in collaboration with other ONC components, and other HHS Operating Divisions, has developed a detailed plan and governance construct for developing the learning system infrastructure for healthcare quality improvement and population health. ONC anticipates that organizations participating in these efforts will include government agencies and entities in the private sector. Additionally, OCS has worked on applicable standards development, architecture development, and the requisite policy framework. For the specific use case, requirements definition, standards, and policy-development projects undertaken, OCS has worked in very close partnership with ONC's Office of the DNC for Programs and Policy, and OCPO.

OCS is also working in coordination across HHS and with other Federal agencies active in relevant areas to advance the availability and utility of health IT for quality improvement, including Clinical Decision Support (CDS) and quality measurement. Two keystones for transformational quality improvement are CDS functionality and adaptable, reliable quality measurement functionality. CDS functionality helps healthcare providers deliver care that is timely, safe, high-quality, and sensitive to consumer preferences. Quality measurement helps providers define improvement priorities and track the effectiveness of improvement projects, while allowing for performance accountability. CDS and quality measurement have extensively overlapping needs for data interoperability and system capabilities. Both types of functionality are expected to benefit from the development and widespread implementation of interactive data technology. OCS is currently working through its various programs and with a variety of Federal partners to improve the availability and utility of CDS and quality measures functionality within and compatible with certified EHRs, and to promote development and widespread implementation of the interactive data technologies that will make it easier for providers to share CDS interventions and quality measures for internal improvement use, and for rapid application of quality measures that are developed or refined as our knowledge of clinical best practices is refined by the advances in digitally supported clinical, biomedical, and health services research.

FUNDING HISTORY

FY 2007	3,000
FY 2008	3,697
FY 2009	4,517
FY 2010	5,453
FY 2011	2,866
FY 2012	2,119

BUDGET REQUEST

The FY 2013 Budget request for OCS is $1.8 million, a decrease of $0.3 million below the FY 2012 Enacted Level, which represents a decrease in the Learning System Infrastructure, Health IT Innovation and Utility activities, and the International Health IT Program. This amount, however, will allow OCS to continue performance measurement of health IT programs, including:

Monitoring Innovation & International Programs
OCS's FY 2013 Budget request includes efforts to track health care innovations to understand their potential impact, and ensure that they are being appropriately leveraged by HHS and ONC in implementing health reform and HITECH. In addition, OCS continues to explore the international experience of health IT adoption, garner lessons learned from other countries' experiences, promote the availability and use of internationally recognized standards to facilitate health IT innovation and implementation in support of HHS domestic and global health goals.

Learning System Infrastructure for Healthcare Quality Improvement and Population Health
The Budget request also includes funding to build upon accomplishments in the area of health IT infrastructure to support a transformed health care system. In order to create a learning health system for health care quality improvement and population health, ONC will work with its Federal partners and the private sector to develop a policy framework that enables the repurposing of health data for the purposes of public health, clinical research, and quality improvement.

OFFICE OF THE DEPUTY NATIONAL COORDINATOR FOR OPERATIONS

	FY 2011 Appropriation	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 (+/-) FY 2012
Budget Authority	15,312	6,262	10,061	+3,799
PHS Evaluation Funds	6,891	17,096	15,338	-1,758
Total Program Level	22,203	23,358	25,399	+2,041
FTE	49	61	70	+9

Authorizing Legislation: PHS Act 42 U.S.C. 201
Allocation Method: Contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Office of the Deputy National Coordinator (DNC) for Operations is responsible for the activities that support ONC's numerous programs. These include: budget formulation and execution; procurement and grants management; facilities and internal IT management; human capital planning; stakeholder communications; policy coordination; and, financial and programmatic oversight.

The DNC for Operations has enhanced its grants management efforts to ensure compliance with Federal governing provisions for financial assistance, to implement and follow a defensible grants management process, and to implement robust program integrity measures. Through eight major grant programs, ONC has awarded over $1.7 billion in grants.

To ensure proper stewardship of these Federal grant dollars, the Office of Grants Management (OGM) has institutionalized a robust risk-based financial monitoring program which includes a toolkit of processes and procedures for review of financial status reports, analysis of drawdown reports, comprehensive desk reviews and on-site monitoring at the grantee facility, as well as year-in reviews that analyze every grant in the ONC portfolio to determine the risk level of each grantee and inform the following fiscal year monitoring plan. This risk-based monitoring program is the framework for ensuring both program success and financial accountability in all ONC programs.

OGM moved forward with two innovative grants management efforts, both critical to program integrity. The first, a comprehensive year-in-review tool, brings together the program offices and grants management office to assess financial and programmatic compliance of every ONC grantee. Program offices use program performance reports with milestones/outcomes to gauge grantee performance. The grants management office developed a set of criteria to analyze grantee financial performance. Once these reviews were completed, each grants management specialist and program officer met to discuss the analysis and determine overall grantee performance. In the end, every grantee received an official letter signed jointly by the program manager and grants management officer to document grantee performance against milestones, program objectives, and grantee compliance with grants and financial management requirements.

The second initiative was the development of a financial grants monitoring tool that streamlines the monitoring process. This cutting edge tool uses office software, automating the process for conducting financial monitoring visits. Grounded in grants management regulations, the tool allows for consistency and ease in documenting the financial monitoring visit, generating analytics on grantee performance and compliance, and quickly and easily drafting reports. This tool achieves efficiencies in the monitoring process, while ensuring rigor and accountability.

Moreover, OGM developed and implemented a proactive training and technical assistance program for grantee and internal stakeholders to inform all stakeholders of Federal financial assistance requirements and processes throughout the lifecycle of the grant award. This program has proven to be a successful mechanism for increasing grantee knowledge of grants concepts and rules. Business grants management resources are available on the Internet to assist ONC grantees in understanding Federal, HHS, and ONC business grants management policies and issues. Specifically, OGM developed and posted 11 Grants Management Advisories covering a wide variety of topics. These concise documents provide clarification to ONC grantees on grants management issues. In addition, OGM posted 60 Frequently Asked Questions, held numerous webinars, conducted trainings sessions for grantees at regional meetings, and ONC annual grantee meetings, established a grants questions clearinghouse, and initiated grantee office hours, allowing grantees to ask questions or providing information and updates regarding grants policies.

Further, OGM developed a robust objective review capability and, a comprehensive budget review capability to ensure the integrity of the award process. Specifically, OGM has developed full life cycle policies and standard operating procedures, transitioned all grants into the Grant Solutions System, and fostered program effectiveness through strong partnerships with all the Program Offices and the grantee community.

The Office of Mission Support (OMS) within the DNC for Operations also worked to establish a budget baseline for all of ONC. The baseline establishes a strong foundation for capturing ONC's operational costs, by category, which must be funded to advance the organization's mission. This accomplishment ensures that ONC is building a budget that meets its operational needs. Additionally, the policy coordination team within OMS developed a library of question and answer (Q&A) documents. These Q&As address inquiries that ONC receives, and anticipates receiving regarding ONC programs, ONC programs' impact on health care, and budgetary questions. The Q&A library provides a resource for the organization and the National Coordinator in responding to Congressional, public, or other Federal agency requests for information.

The Office of Oversight (OO) conducted a comprehensive study of ONC grant programs identifying best practices, including an innovative post-award monitoring strategy as well as opportunities for improvement. OO supported the activities of the Secretary's Program Integrity Initiative, and facilitated two ONC program integrity reviews identifying risks and risk response strategies. Additionally, OO conducted two internal control reviews increasing the effectiveness and efficiency of ONC's overall operations. OO is further advancing internal control efforts by developing a robust internal control methodology to produce high-impact results using qualitative and quantitative assessment techniques. Further, OO has an ongoing responsibility serving as the Recovery Act coordinator for ONC, and achieved over a 99 percent compliance rate each quarter with Recovery Act reporting requirements. OO also serves as the central coordinating office during all phases of U.S. Government Accountability Office, and Office of Inspector General studies.

Lastly, the Communications Office (OCOMM) has designed and implemented a communication strategy for provider outreach. The strategy identifies the informational needs of providers and other stakeholders, that vary depending on specialization, location, and other demographic factors, and enables ONC (working with OCR) to tailor important health IT adoption and privacy and security information to

various audiences. The strategy also identifies the elements necessary to provide patients with an understanding of the changes that are coming in health care via health IT in an easily understood, culturally diverse way, *Putting the I in Health IT* as the campaign is entitled.

OCOMM created foundational materials that have been tested to ensure that they meet provider information needs, and a health IT adoption campaign strategy that allows health professionals and consumers alike to see themselves as an integral part of a health care system transformed by health IT. This is in addition to a revised HHS' health IT website, designed to be a one-stop-shop for consumers and providers. ONC established this comprehensive website to provide information on the full spectrum of health IT benefits and activities, including certification regulations and guidance, the CHPL, information on privacy and security, standards and interoperability, and other HITECH programs and resources that links to the CMS website for information on the incentive programs. Importantly, it will also connect providers and hospitals directly to CMS' site on the Medicare and Medicaid EHR Incentive Program, as well as to HIPAA information on OCR's website, and to other relevant agencies such as AHRQ, and NIST.

FUNDING HISTORY

FY 2007	10,306
FY 2008	10,935
FY 2009	8,050
FY 2010	23,223
FY 2011	22,203
FY 2012	23,358

BUDGET REQUEST

The FY 2013 Budget request for the DNC for Operations is $25.4 million, an increase of $2.0 million above the FY 2012 Enacted Level, and will fund increased central cost support for the four offices within the DNC Operations. It will also support the central costs of ONC as a whole. In FY 2013, ONC will also undergo a significant effort to transition activities that have historically been supported through contracts to Federal staff.

The FY 2013 Budget request for the DNC for Operations includes funding for critical central costs such as information technology, space, human capital, acquisition and shared services. These shared services, which are not attributed to a specific office, but are rather used by ONC as a whole, include financial and grants management systems, as well as contract management fees and legal counsel. Additionally, the FY 2013 Budget request includes funding to support increased space and related infrastructure costs, such as furniture, computers, equipment and supplies to accommodate new staff within the DNC for Operations, and ONC as a whole. The FY 2013 Budget request will also fund the personnel costs for the Immediate Offices of the National Coordinator and the Deputy National Coordinators. Lastly, the DNC Operations FY 2012 Budget request will allow the DNC for Operations to fully support its four offices:

- The Office of Grants Management,
- The Office of Mission Support,
- The Office of Oversight, and
- The Office of Communications.

SUPPLEMENTARY TABLES

BUDGET AUTHORITY BY OBJECT CLASS

(Dollars in thousands)

Object Class	FY 2012 Enacted	FY 2013 President's Budget	Increase or Decrease
Direct Obligations			
Personnel compensation:			
Full-time permanent (11.1).......................................	2,236		(2,236)
Other than full-time permanent (11.3)....................	1,309		(1,309)
Other personnel compensation (11.5)...................	24		(24)
Military personnel (11.7)...	22		(22)
Special personnel services payments (11.8)			
Subtotal personnel compensation.............................	**3,591**	**-**	**(3,591)**
Civilian benefits (12.1)...	944		(944)
Military benefits (12.2)...	12		(12)
Benefits to former personnel (13.0)...........................			
Subtotal Pay Costs	**4,547**	**-**	**(4,547)**
Travel and transportation of persons (21.0).............			
Transportation of things (22.0)..................................			
Rental payments to GSA (23.1)..................................	1,890	2,268	378
Communication, utilities, and misc. charges (23.3)...			
Printing and reproduction (24.0)................................			
Other Contractual Services:..			
Advisory and assistance services (25.1)..............		1,500	1,500
Other services (25.2)..	1,941	9,326	7,385
Purchase of goods and services from...................			
government accounts (25.3)...............................	5,808	10,612	4,804
Operation and maintenance of facilities (25.4)......	1,769	1,801	32
Research and Development Contracts (25.5)........			
Medical care (25.6)..			
Operation and maintenance of equipment (25.7)..			
Subsistence and support of persons (25.8)...........			
Subtotal Other Contractual Services.......................	**11,408**	**25,507**	**14,099**
Supplies and materials (26.0)......................................			
Equipment (31.0)...	460	739	279
Land and Structures (32.0)..			
Investments and Loans (33.0)....................................			
Grants, subsidies, and contributions (41.0)...............			
Interest and dividends (43.0)......................................			
Refunds (44.0)..			
Subtotal Non-Pay Costs...	**11,868**	**26,246**	**14,378**
Total Direct Obligations...	**16,415**	**26,246**	**9,831**
Average Cost per FTE			
Civilian FTEs..	146	171	190
Civilian Average Salary..	15	0	-12
Percent change..		-100%	0%
Military FTEs...	1	1	1
Military Average Salary...	22	0	-22
Percent change..		-100%	0%
Total OPDIV FTEs..	147	172	191
Total OPDIV Average Salary.......................................	24	0	-19
Percent change..		-100%	0%

SALARIES AND EXPENSES

(dollars in thousands)

Object Class	FY 2012 Enacted	FY 2013 President's Budget 1/	Increase or Decrease
Personnel compensation:...			
Full-time permanent (11.1)..	2,236		(2,236)
Other than full-time permanent (11.3).....................................	1,309		(1,309)
Other personnel compensation (11.5)....................................	24		(24)
Military personnel (11.7)..	22		(22)
Special personnel services payments (11.8)..........................			-
Subtotal personnel compensation...	**3,591**	**-**	**(3,591)**
Civilian benefits (12.1)..	944		(944)
Military benefits (12.2)...	12		(12)
Benefits to former personnel (13.0)...			-
Subtotal Pay Costs	**4,547**	**-**	**(4,547)**
Travel and transportation of persons (21.0).............................			
Transportation of things (22.0)..			
Communication, utilities, and misc. charges (23.3)..................			
Printing and reproduction (24.0)..			
Other Contractual Services:...	9,518	23,239	13,721
Advisory and assistance services (25.1)...............................		1,500	1,500
Other services (25.2)..	1,941	9,326	7,385
Purchase of goods and services from....................................			
government accounts (25.3)..	5,808	10,612	4,804
Operation and maintenance of facilities (25.4)......................	1,769	1,801	32
Research and Development Contracts (25.5)........................			
Medical care (25.6)...			
Operation and maintenance of equipment (25.7)..................			
Subsistence and support of persons (25.8)..........................			
Subtotal Other Contractual Services.......................................	**9,518**	**23,239**	**13,721**
Supplies and materials (26.0)..	-	-	-
Subtotal Non-Pay Costs...	**9,518**	**23,239**	**13,721**
Total Salary and Expenses..	**14,065**	**23,239**	**9,174**
Rental payments to GSA (23.1)..	1,890	2,268	378
Total Salary, & Expenses and Rent...	**15,955**	**25,507**	**9,552**

1/ Excludes 'Equipment' Object Class 31.

DETAIL OF FULL-TIME EQUIVALENT EMPLOYMENT (FTE)

(dollars in thousands)

	FY 2011	**FY 2012**	**FY 2013**
Total FTE	147	172	191
Number change from previous year		25	19
Funding for object classes 11, 12, and 13	18,587	22,345	24,727
Average cost per FTE	126	130	129
Percent change in average cost from previous year		3%	0%
Average grade/step	13/2	13/2	13/2

Notes.

1/ Includes one (1) commissioned corps officer.

DETAIL OF POSITIONS

(dollars in thousands)

	Total Full-Time Equivalents (Workyears)			
	FY 2011 Target	**FY 2011 Estimate**	**FY 2012 Estimate**	**FY 2013 Estimate**
Direct:				
Program, Project or Activity:				
a. Budget Authority	148	147	172	191
b. Health Care Reform	1	0	0	0
Total, Direct Ceiling FTE	**149**	**147**	**172**	**191**
Reimbursable:				
Program, Project or Activity:				
Total, Reimbursable Ceiling FTE	**0**	**0**	**0**	**0**
Total, Ceiling FTE	**149**	**147**	**172**	**191**
Total, Civilian FTE	148	146	171	190
Total , Military FTE	1.0	1.0	1.0	1.0

Note: While there are no FTE ceilings, there continue to be statutory categorizes of “ceiling exempt” FTE. The tables above include “ceiling exempt” FTE totaling: 0 in FY 2010; 0 in FY 2011; and 0 in FY 2012.

PROGRAMS PROPOSED FOR ELIMINATION

No programs are proposed for elimination in FY 2013.

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Health Insurance Reform Implementation Fund.. 2

HEALTH INSURANCE REFORM IMPLEMENTATION FUND

(Dollars in millions)

	FY 2011	FY 2012	FY 2013
Obligations*	$312	$565	$0

* $1,000,000,000 was appropriated in the Health Care and Education Reconciliation Act of 2010.

Authorizing Legislation…………………………Health Care and Education Reconciliation Act, Section 1005
Authorization…………………………………...……………………………………………FY 2010
Allocation Method…………..…………………………………………Direct Federal, Competitive Contract

Program Description and Accomplishments

Section 1005 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) appropriates $1,000,000,000 to the Health Insurance Implementation Fund within the Department of Health and Human Services (HHS). The Fund shall be used for Federal administrative expenses necessary to carry out the requirements of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010.

HHS has used implementation funds to primarily support salaries, benefits, contracts, and infrastructure for various health reform initiatives, including supporting the rate review and medical loss ratio provisions. These funds also have gone to support the establishment of State and Federal Exchanges, including the building of IT systems to ensure health insurance access in 2014.

The Department of Treasury required funding to implement multiple tax changes, including the Small Business Tax Credit, expanded adoption credit, W-2 changes for loan forgiveness, excise tax on indoor tanning services, charitable hospital requirements, and planning for Exchanges. The Department of Labor required funds to conduct compliance assistance; modify or develop IT systems that support data collection, reporting, policy and research; and develop infrastructure for the newly required Multiple Entity Welfare Arrangements reporting and registration within the Affordable Care Act.

The Office of Personnel Management (OPM) required funding to plan for implementing and overseeing the establishment of at least two Multi-State Plan Options to be offered on each state health insurance exchange beginning in 2014, and allowing Tribes and Tribal organizations to purchase Federal health and life insurance for their employees. OPM is also assisting HHS by implementing an interim Federal external appeals process prior to the establishment of a permanent Federal appeals process.

Budget Allocation

In FY 2011, $312 million of this funding was obligated by agencies within HHS and by the Department of Treasury. HHS estimates that the remaining $565 million will be obligated by agencies within HHS, the Department of Treasury, the Department of Labor, the Social Security Administration, and the Office of Personnel Management in FY 2012.

Service and Supply Fund

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Dollars in Thousands

	FY 2011 Actual	FY 2012 Program Level	FY 2013 Board Approved	FY 2013 +/- FY 2012
Budget Authority	$976,070	$1,077,747	$1,131,483	+$53,736
FTE	1,451	1,538	1,489	-49

Authorizing Legislation: 42 U.S.C. 231
2012 Authorization………………………………………………………………………..……………..……Indefinite
Allocation Method ……………………………………………………………….…………………Contract, Other

Statement of the Budget

The FY 2013 budget for the Service and Supply Fund (SSF) is $1,131,483,000 a decrease of $3,471,000 from the FY 2012 SSF Board-approved level of $1,134,954,000 (both fiscal year budgets approved July 18, 2011). The FY 2012 program level column above reflects the funding approved on the latest Office of Management and Budget (OMB) apportionment and not the Board approved level for FY 2012.

The Program Support Center (PSC) Board approved budget for FY 2013 is $937,837,000, which is a decrease of $2,095,000 below the FY 2012 current Board approved budget of $939,932,000. This budget decrease is a result of continued effort within the PSC to implement their SMART (*S*ave, *M*anage and *A*ssess our *R*esources *T*ogether) Initiative in FY 2012.

The total FY 2013 Board approved budget for the non-PSC SSF Activities is $193,646,000, which is a decrease of $1,376,000 below the FY 2012 current Board approved budget of $195,022,000. Overall, the approved revenue for longstanding non-PSC SSF activities has remained level, with modest increases for contracts. There are four organizational transfers on the non-PSC side of the fund: 1) Information Technology Infrastructure and Operations (ITIO) moved from PSC to non-PSC; 2) IAM@HHS (formerly Homeland Security Presidential Directive-12 (HSPD-12)) moved from Office of Security and Strategic Information (OSSI) to Office of the Secretary (OS)/Assistant Secretary for Administration (ASA); 3) Networx moved from the development stages currently funded from a joint funding arrangement (JFA) to a non-PSC funding activity; and 4) OS Chief Information Officer (CIO) moved to the HHS CIO's office within ASA.

Use of SSF Retained Equity

The SSF Board of Directors approved the use of the Fund's retained equity (also referred to as the "SSF Reserves") in FY 2012 to support system improvements and operation enhancements. The total approved for use in FY 2012 to fund these activities is $23,421,915.

At the end of FY 2011, a total of $7,104,606 in Board approved projects that was not obligated in that fiscal year were reinstated to fund the continuation of these Board approved activities in FY 2012.

Program Description – Service and Supply Fund Overview and Activity Narratives

This section describes the activities funded through the HHS' Service and Supply Fund (SSF), which is a revolving fund authorized under 42 U.S.C. 231. The SSF provides consolidated financing and accounting

for business-type operations which involve the provision of common services to customers. The SSF is governed by a Board of Directors, consisting of representatives from each of the Department's ten (10) Operating Divisions (OPDIV) and the Office of the Secretary. A representative from the Office of Inspector General (OIG) serves as a non-voting member of the SSF Board.

The SSF does not have its own annual appropriation but is funded entirely through charges to its customers (HHS' Operating Divisions (OPDIV) and Staff Divisions (STAFFDIV) in addition to other federal departments and agencies) for their usage of goods and services. The SSF is comprised of two categories of activities: the Program Support Center and those activities which are performed by other OS components. Each activity financed through the SSF is billed to the Fund's customers by either fee-for-service billing, which is based upon actual service usage or by an allocated methodology. Details of the FY 2013 SSF activities are described below.

Program Support Center Activities

PSC is committed to providing the best value in terms of cost and service quality to its customers. PSC continues to evolve as a shared service provider by continuing to meet HHS's need for program support, and by reducing unit costs to all customers through economies of scale. Economies of scale are achieved by providing services both inside and outside HHS.

In a proactive effort to address the current federal budget challenges, PSC launched the SMART (*S*ave, *M*anage and *A*ssess our *R*esources *T*ogether) Initiative in March 2011. Through SMART, service managers conducted a comprehensive review of PSC's operations to identify substantial cost reductions and increased opportunities for revenue growth which should result in billable rate reductions. This review achieved substantial budgetary reductions. The PSC FY12 original budget request ($978,231,000) compared to the Board approved request ($939,932,000) reflecting SMART savings shows a reduction totaling $32,189,000. Comparatively, the FY 2012 PSC original budget request versus the FY 2013 Board approved budget shows a savings of $18,456,000. These savings will be accomplished through workforce adjustments, contract support reassessments, business efficiencies, process streamlining, purchase deferrals and greening initiatives.

Administrative Operations Service (AOS): Administrative Operations Service (AOS) provides a wide range of administrative and technical services to customers within HHS and to other federal agencies. The mission of AOS is to provide high-quality administrative support services at competitive prices by capitalizing on its expertise and leveraging economies of scale. AOS major service areas include property management, security and emergency services, graphic arts and printing, payroll services, transportation services, Commissioned Corps support , and regional services.

Financial Management Service (FMS): The Financial Management Service (FMS) serves as a major part of the foundation of the HHS' finance and accounting operations through the provision of grant payment management services; accounting and fiscal services; debt management services; and rate review, negotiation, and approvals for departmental and other federal grant and program activities to HHS and other federal agencies. FMS also offers fiscal advice, as well as technical and policy guidance is also available to assist in implementing new initiatives and assuring compliance with regulatory requirements. FMS continues to support the Departments' ability to receive "clean" audit opinions, from independent audit firms.

Federal Occupational Health Service (FOH): The Federal Occupational Health Service (FOH) provides comprehensive, high-quality, customer-focused occupational health services in strategic partnership with federal agencies nation-wide to improve the health, safety, and productivity of the

federal workforce. Services include health and wellness programs, employee assistance, work/life services, and environmental health and safety services. FOH programs provide strategic prevention and early intervention services to employees and federal agency employers. FOH currently provides services to 352 federal agencies and serves over 1.5 Million federal employees. Approximately 90% of FOH's services are provided to federal agencies outside of HHS.

Information and Systems Management Service (ISMS): The Information Systems Management Service (ISMS) has the mission of providing high-quality enterprise systems operations and management services including, project management, information security, telecommunications management, HR and financial enterprise systems management, records management, and requests for access to information from the public.

Strategic Acquisition Service (SAS): The Strategic Acquisition Service (SAS) is responsible for providing fully integrated acquisition and strategic support services to HHS and other Federal agencies. SAS streamlines procurement operations in HHS through activities such as the reduction of duplicate contracts, the use of consolidated contracts and the implementation of new procurement practices designed to provide higher quality procurement services at reduced cost. The major divisions consist of: *Acquisition Management*, which includes negotiated contracts, simplified acquisitions and purchase card management services; *Quality Assurance*, which provides analytical and quality assurance support to contracting staff and SAS customers; and *Supply Management*, which provides pharmaceutical, medical and dental supplies to federal agencies and other customers worldwide.

Non-PSC Activities

Non-PSC activities differ from those provided by the PSC in their predominate focus, which is helping HHS components comply with law, regulations, or other federal management guidelines, as well as targeted workforce management. The non-PSC activities support all components of HHS, providing support in areas such as acquisitions management, audit resolution, responding to and processing Federal tort claims, collecting and managing grants data to ensure HHS' ability to respond to regulatory requirements, providing human resources and equal employment opportunity services, and providing IT support and devices.

Acquisition Integration and Modernization (AIM): The AIM program was created to capture knowledge within the acquisition workforce, leverage opportunities to adopt or tailor successful practices, and standardize and modernize acquisition processes. The AIM program works to continuously improve day-to-day contract operations as well as the effectiveness and efficiency of HHS' acquisition functions.

Audit Resolution: On behalf of the OPDIVs, OS Audit Resolution resolves cross-cutting findings resulting from OMB Circular A-133 audits that affect multiple OPDIVs in order to ensure HHS' compliance with OMB Circular A-133, *Audit of States, Local Governments, and Non-Profit Organizations*.

Claims: The HHS Office of the General Counsel (OGC) receives and adjudicates all administrative tort claims (e.g., medical malpractice, vehicle accidents, acts or omissions that cause damages) on behalf of HHS. The General Law Division of OGC is responsible for processing administrative claims. Processing these claims includes logging in matters, creating files, researching the issues, coordinating with claimants and preparing recommendations for the HHS settlement authority, which also resides within OGC.

Commissioned Corp Force Management (CCFM): CCFM provides personnel support to active-duty and retired Public Health Service (PHS) Commissioned Officers, and force management activities for the Corps as a whole. Force management of the Corps is administered by two offices within the Office of the Assistant Secretary for Health (OASH) – the Office of Commissioned Corps Force Management (OCCFM) that reports to the Assistant Secretary for Health (ASH) and the Office of Commissioned Corps Operations (OCCO) within the Office of the Surgeon General (OSG).

Departmental Contracts Information System (DCIS): DCIS serves as a central repository for Department-wide, post-award contract data. DCIS provides procurement data collection and reporting capabilities enabling HHS to comply with requirements under Public Law 93-400 and FAR Subpart 4.6 regarding the reporting of contract actions to the Federal Procurement Data System (FPDS). DCIS ensures HHS compliance with both FPDS changes and Federal Funding Accountability and Transparency Act reporting requirements (Open Government) and improves the quality and timeliness of HHS' acquisition-related analyses and reports to OMB, GAO, and the Congress.

EEO Services: The Equal Employment Opportunity (EEO) Cost Center is managed by the EEO Compliance and Operations Division (EEOCO), which is a part of the Office of the Secretary (OS), Office of the Assistant Secretary for Administration (ASA). The goal of the EEOC is to ensure every HHS employee/applicant for employment has equal access to EEO services, timely resolution of their complaint and equitable remedy. The EEO Compliance component serves as the Departmental level EEO Office and is responsible for providing leadership, oversight, technical assistance and enabling tools to OPDIV EEO Offices in matters related to EEO discrimination complaints management and prevention. The EEO Compliance component also manages the Department's EEO complaint investigations program, prepares and issues final Departmental decisions on the merits for complaints of discrimination filed by employees and applicants and prepares merit decisions on complaints of discrimination filed by members of the Commissioned Corps for issuance by the Surgeon General. Additionally, EEO Compliance processes conflict of interest complaints, appeals and remands from the EEOC.

IAM@HHS (formerly Homeland Security Presidential Directive-12 (HSPD-12)): The IAM@HHS program implements the Presidential directive to provide greatly enhanced security for physical access to HHS facilities and logical access to systems and applications. The IAM@HHS program encompasses the sponsorship, enrollment, and management of identities and issuance of identity cards. Identity cards are printed in accordance with the National Institute for Standards and Technology (NIST) standards and contain electronic credentials on the embedded smart chip.

High Performing Organizations, Commercial Services Management Reporting & Insourcing (HPO, CSM & Insourcing): The HPO, CSM & Insourcing program supports HHS in meeting statutory mandates related to ensuring the insourcing of government functions as required by the Federal Activities Inventory Reform Act of 1998 (Public Law 105-270); Section 647 (b) of Division F of the Consolidated Appropriations Act, FY 2004, P.L. 108-109; Section 735, Section 752, and Section 321 of Title VII of the Omnibus Appropriations Act, 2009; and P.L. III-8, Section 735. The program also ensures the Department's compliance with Section 752 of the Omnibus Appropriations Act, which requires Agencies to submit to the Director of OMB a report stating the total size of its workforce, differentiated by number of civilian, military, and contract workforce and Section 321, which mandates a comprehensive analysis and development of single government-wide definition of inherently governmental function and criteria for critical functions by collecting and organizing various data for submission to OMB.

Information Technology Infrastructure & Operations (ITIO): The ITIO provides onsite desktop/laptop support with four year product lifecycle upgrades, 24/7 Service Desk, Blackberry email and wireless solutions, network printer installation and technical support, government and commercial

off-the-shelf software installation and technical support, etc. Additionally, the ITIO maintains infrastructure services covering: planning, deployment, and maintenance of network devices and servers and enterprise network security monitoring, including incident response. The ITIO manages email services, LAN and WAN capabilities, and facilitates business application hosting. The ITIO provides COOP/DR services through the use of a third-party provider.

Networx Program Management Office (NxPMO): Networx is a series of government-wide contracts utilized by HHS to obtain long distance telecommunications services. Networx will replace the current expiring contact, FTS2001, formerly administered by General Services Administration (GSA). The Networx program offers comprehensive, best value telecommunications providing for new technologies, industry partners and ways to achieve a more efficient, and effective government. Networx allows agencies to focus their resources on building seamless, secure operating environments while ensuring access to the best technology industry has to offer.

Human Resource Services: The scope of the Office of Human Resources' (OHR) activities is HHS-wide, covering all statutes and regulations relating to human resources, including those under 5 USC and Title 5 CFR. This includes assigning responsibility to develop and implement methodologies to measure, evaluate, and improve human capital results to ensure mission alignment, effective HR management programs, efficient business processes and merit-based decision-making in compliance with laws and regulations.

HHS University: HHSU provides high-quality, cost-effective continued learning and development opportunities through innovative approaches and emerging learning technologies.

Office of Small and Disadvantaged Business Utilization (OSDBU): OSDBU was established under Public Law 95-507 (Small Business Act). OSDBU is responsible by statute to ensure that small businesses receive the maximum, practicable opportunities to compete for Department procurements. It serves as the HHS single point of contact for small business matters and is accountable for coordinating and implementing strategies to meet statutory goals for awards to small entities.

Strategic Sourcing Program (SSP): SSP provides departmental leadership in conducting spend analyses and developing acquisition strategies that leverage the Department's contract spending for common supplies and services. The SSP also enables the department to participate in, and affect the outcomes of, Federal-wide Strategic Sourcing Initiatives.

Tracking Accountability in Government Grants (TAGGS): TAGGS is the central repository and reporting system for grant award data generated by HHS' Staff Divisions and OPDIVs. TAGGS grant data is made available to the public on the TAGGS Website (http://taggs.hhs.gov) and in accordance with the Federal Financial Accountability and Transparency Act, HHS' grant award data submitted to USASpending.gov twice a month.

Web Communications and New Media Division (WCD): The WCD is responsible for the coordination and implementation of HHS communication and outreach activities, including priority departmental Websites and implementing Web 2.0 applications, related to health and human service information, education and public interaction

FY 2013 Office of Management and Budget Justification

Supplementary Materials

Department of Health and Human Services
Service and Supply Fund
(Dollars in Thousands)

Service and Supply Fund Activities	FY 2011 Actuals	FY 2012 Program Level	FY 2013 Board Approved	FY 2013+/- FY 2012
PSC				
Administrative Operations Service	325,606	385,286	383,191	(2,095)
Federal Occupational Health Service	160,237	164,327	164,327	-
Financial Management Service	55,443	60,300	60,300	-
Info. & Systems Mgmnt Service	113,970	103,461	103,461	-
Strategic Acquisitions Service	141,633	166,557	226,557	60,000
Unfilled Customer Orders				
PSC Reserves	7,454	446		(446)
PSC Subtotal	804,338	880,378	937,837	57,459
Non-PSC				
AIM	1,165	1,127	992	(135)
Audit Resolution	1,479	1,608	1,631	23
CCFM	15,458	22,306	21,525	(781)
DCIS	1,284	1,915	1,999	84
EEO Services	2,437	2,564	2,564	-
HPO & Commercial Services Mgmnt	278	287	287	-
HR Centers & HHS Univ	68,331	66,018	66,018	-
HSPD-12	12,711	15,945	16,600	655
ITIO	50,989	60,823	59,320	(1,503)
Networx	-		4,312	4,312
OGC Claims (Federal Tort)	1,391	1,252	1,270	18
Small Business Consolidation (OSDBU)	2,578	2,808	2,842	34
Strategic Sourcing	713	758	771	13
TAGGS	1,455	2,215	2,431	216
Web Communications	10,073	11,084	11,084	-
Non-PSC Reserves	1,390	6,659		(6,659)
Non-PSC Subtotal	171,732	197,369	193,646	(3,724)
Total SSF Revenue	**976,070**	**1,077,747**	**1,131,483**	**53,736**

OPDIV Share of SSF Budget SSF Board Approved (Dollars in Thousands)							
	FY 2012			FY 2013			
	PSC	Non-PSC	Total	PSC	Non-PSC	Total	+/- Total FY 2012
ACF	19,715	12,641	32,356	19,560	12,710	32,270	(86)
AoA	1,962	1,322	3,284	1,911	1,336	3,247	(37)
AHRQ	2,717	3,402	6,119	2,619	3,317	5,936	(183)
CDC	41,615	25,467	67,082	41,485	25,749	67,234	152
CMS	11,171	14,002	25,173	11,309	13,967	25,276	103
FDA	31,328	33,171	64,499	30,778	33,380	64,158	(341)
HRSA	32,346	6,432	38,778	32,283	6,143	38,426	(352)
IHS	24,323	16,812	41,135	24,347	16,803	41,150	15
NIH	46,249	17,262	63,511	46,325	17,821	64,146	635
SAMHSA	5,419	5,789	11,207	5,288	5,533	10,821	(386)
OS	59,998	39,172	99,170	59,407	37,738	97,145	(2,025)
PSC	33,407	13,560	46,967	32,841	13,635	46,476	(491)
Non-HHS	629,682	5,989	635,671	629,682	5,515	635,197	(474)
Total Budget			**1,134,954**			**1,131,483**	**(3,471)**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SERVICE AND SUPPLY FUND
Object Classification - Reimbursable Obligations
(Dollars in Thousands)

Object Class	FY 2011 Actuals	FY 2012 Program Level	FY 2013 SSF Board Approved
Reimbursable Obligations			
Personnel Compensation:			
Full-Time Permanent (11.1)	113,790	131,161	130,760
Other Than Full-Time Permanent (11.3)	3,988	6,398	6,379
Other Personnel Compensation (11.5)	2,922	4,799	4,784
Military Personnel (11.7)	7,566	6,595	7,541
Special Personnel Services Payments (11.8)	14,066	7,217	
Subtotal Personnel Compensation	**142,332**	**156,170**	**149,464**
Civilian Personnel Benefits (12.1)	32,195	41,302	41,176
Military Personnel Benefits (12.2)	4,192	6,489	3,660
Benefits to Former Personnel (13.0)	195	367	915
Subtotal Pay Costs	**36,582**	**48,158**	**45,751**
Travel (21.0)	2,579	1,867	1,596
Transportation of Things (22.0)	2,582	4,730	2,926
Rental Payments to GSA (23.1)	26,972	14,982	22,333
Rental Payments to Others (23.2)	156	32	45
Communications, Utilities and			
Miscellaneous Charges (23.3)	33,788	6,886	6,294
Printing and Reproduction (24.0)	808	342	342
Other Contractual Services:			
Advisory and Assistance Services (25.1)	41,595	31,847	38,344
Other Services (25.2)	479,966	624,670	685,348
Purchases from Govt. Accounts (25.3)	62,136	49,236	47,359
Operation & Maintenance of Facilities (25.4)	5,441	5,519	6,647
Research & Development Contracts (25.5)	0		-
Medical Services (25.6)	22,420	21,151	17,869
Operation & Maintenance of Equipment (25.7)	75,185	72,473	70,319
Subsistence & Support of Persons (25.8)			
Reserved for Local Use and Other (25.9)	4,006		
Subtotal Other Contractual Services	**757,634**	**833,735**	**899,422**
Supplies and Materials (26.0)	35,157	35,786	33,187
Equipment (31.0)	3,873	3,899	3,659
Grants (41.0)	0	0	
Other (32), (42), (61)	492	0	
Subtotal Non-Pay Costs	**39,522**	**39,685**	**36,846**
Total Reimbursable Obligations	**$976,070**	**$1,077,747**	**$1,131,483**

FY 2013 Budget Submission
Service and Supply Fund Activities
Statement of Personnel Resources

	Total Full-Time Equivalents (Workyears)								
	FY 2011 Actual			FY 2012 Estimate			FY 2013 Estimate		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Reimbursable:									
PSC Activities:									
Administartive Operations Service	214	8	222	227	8	235	227	8	235
Financial Management Service	230	1	231	208	1	209	208	1	209
Federal Occupational Health Service	55	46	101	57	49	106	57	49	106
Information and Systems Management Service	93		93	98		98	98		98
Strategic Acquisitions Service	109	-	109	157	-	157	157	-	157
Office of the Director	32		32	30		30	30		30
Total Reimbursable PSC FTEs	**733**	**55**	**788**	**777**	**58**	**835**	**777**	**58**	**835**
Non-PSC Activites									
AIM	-		-	-		-	-		-
Audit Resolution	8		8	8		8	8		8
Chief Information Office	10		10	-		-	-		-
Commissioned Corps Force Management	26	49	75	23	40	63	23	40	63
DCIS	2		2	2		2	2		2
EEO Services	8		8	8		8	8		8
HPO & CSM	3		3	3		3	3		3
HR Services	458		458	502		502	454		454
HSPD - 12	-	1	1	7	-	7	7	-	7
ITIO	37		37	47	-	47	47	-	47
Networx	-		-	-		-	-		-
OGC Claims	8		8	8		8	8		8
Small Business Consolidation (OSBDU)	13		13	13		13	13		13
Strategic Sourcing	2		2	2		2	2		2
TAGGS	5		5	5		5	5		5
Web Communications Division	28		28	28		28	28		28
Fund Manager	5		5	7		7	6		6
Total Reimbursable Non-PSC FTEs	**613**	**50**	**663**	**663**	**40**	**703**	**614**	**40**	**654**
Total Reimbursable SSF FTEs	**1346**	**105**	**1451**	**1440**	**98**	**1538**	**1391**	**98**	**1489**

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

	FY 2011	FY 2012	FY 2013	FY 2013 +/- FY 2012
Retirement Payments	$354,655,534	$375,016,378	$395,451,972	+$20,435,594
Survivor's Benefits	25,912,765	28,349,703	31,042,600	+2,692,897
Medical Care Benefits	86,059,887	93,984,039	100,656,480	+6,672,441
Accrued Health Care Benefits	38,088,522	36,392,760	26,061,912	-10,330,848
Total	$504,716,708	$533,742,880	$553,212,964	+$19,470,084

Authorizing Legislation 42 U.S.C., Chapter 6A; 10 U.S.C., Chapter 73; 10 U.S.C., Chapters 55; and Section 229(b) of the Social Security Act.

FY 2013 Authorization…………………………...……………………………………………………Indefinite

Rationale for Budget

This appropriation provides for retirement payments to Public Health Service (PHS) Commissioned Corps officers who are retired for age, disability, or a specific length of service as well as payments to survivors of deceased retired officers who had elected to receive reduced retirement payments.

This appropriation also funds the provision of medical care to active duty and retired members of the Corps under the age of 65, dependents of active duty and retired members, and dependents of deceased members. This account includes payments to the Department of Defense (DoD) Medicare-Eligible Retiree Healthcare Fund for the accrued costs of health care for beneficiaries over the age of 65.

The Accrual Health Care Benefits amount is an estimate provided by the DoD Office of the Actuary, multiplied by the estimated number of Active Duty positions (6,522 in FY 2013), This Budget assumes savings from passage of the National Defense Reauthorization Act in 2011 and FY 2013 Department of Defense Budget proposals, yielding a total of $26,061,912 for the Accrual Health Care Benefits account.

The FY 2013 estimate is a net increase of $19,470,084 over the FY 2012 level. The request reflects increased costs in medical benefits, an annualization of amounts paid to retirees and survivors in FY 2012 and a net increase in the number of retirees and survivors during FY 2013.

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Retirement Payments	$416,843,418	$439,498,551	$463,414,264	$488,740,508	$515,495,966
Survivor's Benefits	33,991,647	37,220,853	40,756,834	44,628,7343	48,868,463
Medical Care Benefits	108,086,386	116,390,595	125,358,664	135,047,404	145,435,482
Accrued Health Ben.	27,569,277	29,154,123	30,830,538	32,605,565	34,479,205
Total	$586,490,728	$622,264,122	$660,360,300	$701,022,211	$744,279,116

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROPOSED GENERAL PROVISIONS
FOR FISCAL YEAR 2013

The President's Budget recommends that a number of general provisions be included in the FY 2013 Departments of Labor, Health and Human Services and Education Appropriations Act. These provisions follow appendix schedules for the Department of Health and Human Services (Title II General Provisions) and the Departments of Labor, Health and Human Services and Education (Title V General Provisions). Following is a summary of the proposed provisions:

Title II

Sec. 201. Funds appropriated in this title shall be available for not to exceed $50,000 for official reception and representation expenses when specifically approved by the Secretary.

Sec. 202. The Secretary shall make available through assignment not more than 60 employees of the Public Health Service to assist in child survival activities and to work in AIDS programs through and with funds provided by the Agency for International Development, the United Nations International Children's Emergency Fund or the World Health Organization.

Sec. 203. None of the funds appropriated in this *Act for the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration* shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.

Sec. *204*. Notwithstanding section 241(a) of the PHS Act, such portion as the Secretary shall determine, but not more than *3.2* percent, of any amounts appropriated for programs authorized under such Act shall be made available for the evaluation (directly, or by grants or contracts) of the implementation and effectiveness of such programs.

(TRANSFER OF FUNDS)

Sec. *205*. Not to exceed 1 percent of any discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) which are appropriated for the current fiscal year for HHS in this Act may be transferred between appropriations, but no such appropriation shall be increased by more than 3 percent by any such transfer: *Provided*, That the transfer authority granted by this section shall not be used to create any new program or to fund any project or activity for which no funds are provided in this Act: *Provided further*, That the Committees on Appropriations of the House of Representatives and the Senate are notified at least 15 days in advance of any transfer.

(TRANSFER OF FUNDS)

Sec. *206*. The Director of the NIH, jointly with the Director of the Office of AIDS Research, may transfer up to 3 percent among institutes and centers from the total amounts identified by these two Directors as funding for research pertaining to the human immunodeficiency virus: *Provided*, That the Committees on Appropriations of the House of Representatives and the Senate are notified at least 15 days in advance of any transfer.

(TRANSFER OF FUNDS)

Sec. *207*. Of the amounts made available in this Act for NIH, the amount for research related to the human immunodeficiency virus, as jointly determined by the Director of NIH and the Director of the Office of AIDS Research, shall be made available to the "Office of AIDS Research" ccount. The Director of the Office of AIDS Research shall transfer from such account amounts necessary to carry out section 2353(d)(3) of the PHS Act.

Sec. *208*. None of the funds appropriated in this Act may be made available to any entity under title X of the PHS Act unless the applicant for the award certifies to the Secretary that it encourages family participation in the decision of minors to seek family planning services and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.

Sec. *209*. Notwithstanding any other provision of law, no provider of services under title X of the PHS Act shall be exempt from any State law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.

Sec. *210*. None of the funds appropriated by this Act (including funds appropriated to any trust fund) may be used to carry out the Medicare Advantage program if the Secretary denies participation in such program to an otherwise eligible entity (including a Provider Sponsored Organization) because the entity informs the Secretary that it will not provide, pay for, provide coverage of, or provide referrals for abortions: *Provided*, That the Secretary shall make appropriate prospective adjustments to the capitation payment to such an entity (based on an actuarially sound estimate of the expected costs of providing the service to such entity's enrollees): *Provided further*, That nothing in this section shall be construed to change the Medicare program's coverage for such services and a Medicare Advantage organization described in this section shall be responsible for informing enrollees where to obtain information about all Medicare covered services.

Sec. *211*. In order for HHS to carry out international health activities, including HIV/AIDS and other infectious disease, chronic and environmental disease, and other health activities abroad during fiscal year 2013:

(1) The Secretary may exercise authority equivalent to that available to the Secretary of State in section 2(c) of the State Department Basic Authorities Act of 1956. The Secretary shall consult with the Secretary of State and relevant Chief of Mission to ensure that the authority provided in this section is exercised in a manner consistent with section 207 of the Foreign Service Act of 1980 and other applicable statutes administered by the Department of State.

(2) The Secretary is authorized to provide such funds by advance or reimbursement to the Secretary of State as may be necessary to pay the costs of acquisition, lease, alteration, renovation, and management of facilities outside of the United States for the use of HHS. The Department of State shall cooperate fully with the Secretary to ensure that HHS has secure, safe, functional facilities that comply with applicable regulation governing location, setback, and other facilities requirements and serve the purposes established by this Act. The Secretary is authorized, in consultation with the Secretary of State, through grant or cooperative agreement, to make available to public or nonprofit private institutions or agencies in participating foreign countries, funds to acquire, lease, alter, or renovate facilities in those countries as necessary to conduct programs of assistance for international health activities, including activities relating to HIV/AIDS and other infectious diseases, chronic and environmental diseases, and other health activities abroad.

(3) The Secretary is authorized to provide to personnel appointed or assigned by the Secretary to serve abroad, allowances and benefits similar to those provided under chapter 9 of title I of the Foreign Service Act of 1980, and 22 U.S.C. 4081 through 4086 and subject to such regulations prescribed by the

Secretary. The Secretary is further authorized to provide locality-based comparability payments (stated as a percentage) up to the amount of the locality-based comparability payment (stated as a percentage) that would be payable to such personnel under section 5304 of title 5, United States Code if such personnel's official duty station were in the District of Columbia. Leaves of absence for personnel under this subsection shall be on the same basis as that provided under subchapter I of chapter 63 of title 5, United States Code, or section 903 of the Foreign Service Act of 1980, to individuals serving in the Foreign Service.

Sec. *212*.
(a) Authority.--Notwithstanding any other provision of law, the Director of NIH (``Director'') may use funds available under section 402(b)(7) or 402(b)(12) of the PHS Act to enter into transactions (other than contracts, cooperative agreements, or grants) to carry out research identified pursuant to such section 402(b)(7) (pertaining to the Common Fund) or research and activities described in such section 402(b)(12).
(b) Peer Review.--In entering into transactions under subsection (a), the Director may utilize such peer review procedures (including consultation with appropriate scientific experts) as the Director determines to be appropriate to obtain assessments of scientific and technical merit. Such procedures shall apply to such transactions in lieu of the peer review and advisory council review procedures that would otherwise be required under sections 301(a)(3), 405(b)(1)(B), 405(b)(2), 406(a)(3)(A), 492, and 494 of the PHS Act.

Sec. *213*. Funds which are available for Individual Learning Accounts for employees of CDC and the Agency for Toxic Substances and Disease Registry (``ATSDR'') may be transferred to appropriate accounts of CDC, to be available only for Individual Learning Accounts: *Provided*, That such funds may be used for any individual full-time equivalent employee while such employee is employed either by CDC or ATSDR.

Sec. *214*. Notwithstanding any other provisions of law, discretionary funds made available in this Act may be used to continue operating the Council on Graduate Medical Education established by section 301 of Public Law 102-408.

Sec. *215*. Not to exceed $45,000,000 of funds appropriated by this Act to the institutes and centers of the National Institutes of Health may be used for alteration, repair, or improvement of facilities, as necessary for the proper and efficient conduct of the activities authorized herein, at not to exceed $3,500,000 per project.

(TRANSFER OF FUNDS)

Sec. *216*. Of the amounts made available for NIH, 1 percent of the amount made available for National Research Service Awards (``NRSA'') shall be made available to the Administrator of the Health Resources and Services Administration to make NRSA awards for research in primary medical care to individuals affiliated with entities who have received grants or contracts under section 747 of the PHS Act, and 1 percent of the amount made available for NRSA shall be made available to the Director of the Agency for Healthcare Research and Quality to make NRSA awards for health service research.

Sec. *217*. *Such portion as the Secretary shall determine, but not more than 1 percent, of any discretionary funds which are appropriated in this Act for the current fiscal year for domestic HIV/AIDS activities in any program, project, or activity carried out by the Department of Health and Human Services shall be made available to the Office of the Assistant Secretary of Health to support the National HIV/AIDS Strategy: Provided, That such support may be provided directly, or by grants or contracts, on a reimbursable basis.*

Sec. 218.

(a) A state shall be entitled to receive a grant under section 510 of the Social Security Act (42 U.S.C. 710 for fiscal year only if the Department of health and human Services receives an application under section 505(a) of such Act (42 U.S.C. 705(a) for such fiscal year by no later than September 20, 2013.
(b) CANCELLATION. The remaining unobligated balances of the amount appropriated for fiscal year 2013 by section 510(d) of such Act (42 U.S.C. 710(d) for which no application has been received by September 20, 2013, shall be permanently cancelled as of September 27, 2013.
(c) APPROPRIATION. There is appropriated to the Department of Health and Human Services, to become available on September 27, 2013, and to remain available through September 30,2014, an amount equal to the unobligated balance cancelled pursuant to subsection (b), for carrying out (in addition to any other funds that may be available for such purpose) a program of competitive contracts and grants to State and local governments to develop approaches to reduce pregnancy among youth in foster care and to fund age appropriate evidence-based programs that reduce pregnancy, behavioral risk factors underlying teen pregnancy, or other associated risk factors among youth in foster care and for the Federal costs associated with administering and evaluating such contracts and grants.

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

Title V

(transfer of funds)

Sec. 501. The Secretaries of Labor, Health and Human Services, and Education are authorized to transfer unexpended balances of prior appropriations to accounts corresponding to current appropriations provided in this Act. Such transferred balances shall be used for the same purpose, and for the same periods of time, for which they were originally appropriated.

Sec. 502. No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year unless expressly so provided herein.

Sec. 503.
(a) No part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat legislation *pending* before the Congress or any State legislature, except in presentation to the Congress or any State legislature itself.
(b) No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriation *pending* before the Congress or any State legislature.

Sec. 504. The Secretaries of Labor and Education are authorized to make available not to exceed $28,000 and $20,000, respectively, from funds available for salaries and expenses under titles I and III, respectively, for official reception and representation expenses; the Director of the Federal Mediation and Conciliation Service is authorized to make available for official reception and representation expenses not to exceed $5,000 from the funds available for ``Federal Mediation and Conciliation Service, Salaries and Expenses''; and the Chairman of the National Mediation Board is authorized to make available for official

reception and representation expenses not to exceed $5,000 from funds available for ``National Mediation Board, Salaries and Expenses''.

Sec. *505. None of the funds contained in this Act may be used to distribute any needle or syringe for the purpose of preventing the spread of blood borne pathogens in any location that has been determined by the local public health or local law enforcement authorities to be inappropriate for such distribution.*

Sec. *506.* When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state--
(1) the percentage of the total costs of the program or project which will be financed with Federal money;
(2) the dollar amount of Federal funds for the project or program; and
(3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.

Sec. *507.*
(a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.
(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.
(c) The term ``health benefits coverage'' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

Sec. *508*.
(a) The limitations established in the preceding section shall not apply to an abortion--
(1) if the pregnancy is the result of an act of rape or incest; or
(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).
(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).
(d)
(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.
(2) In this subsection, the term ``health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

Sec. *509*.
(a) None of the funds made available in this Act may be used for--
(1) the creation of a human embryo or embryos for research purposes; or

(2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).
(b) For purposes of this section, the term ``human embryo or embryos'' includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

Sec. *510.*
(a) None of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act except for normal and recognized executive-congressional communications.
(b) The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

Sec. *511.* None of the funds made available in this Act may be used to promulgate or adopt any final standard under section 1173(b) of the Social Security Act providing for, or providing for the assignment of, a unique health identifier for an individual (except in an individual's capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard.

Sec. *512.* None of the funds made available in this Act may be obligated or expended to enter into or renew a contract with an entity if--
(1) such entity is otherwise a contractor with the United States and is subject to the requirement in 38 U.S.C. 4212(d) regarding submission of an annual report to the Secretary of Labor concerning employment of certain veterans; and
(2) such entity has not submitted a report as required by that section for the most recent year for which such requirement was applicable to such entity.

Sec. *513.* None of the funds made available by this Act to carry out the Library Services and Technology Act may be made available to any library covered by paragraph (1) of section 224(f) of such Act, as amended by the Children's Internet Protection Act, unless such library has made the certifications required by paragraph (4) of such section.

Sec. *514.* None of the funds made available by this Act to carry out part D of title II of the Elementary and Secondary Education Act of 1965 may be made available to any elementary or secondary school covered by paragraph (1) of section 2441(a) of such Act, as amended by the Children's Internet Protection Act and the No Child Left Behind Act, unless the local educational agency with responsibility for such covered school has made the certifications required by paragraph (2) of such section.

(including transfer of funds and *cancellation*)

Sec. *515.* None of the funds appropriated in this Act shall be expended or obligated by the Commissioner of Social Security, for purposes of administering Social Security benefit payments under title II of the Social Security Act, to process any claim for credit for a quarter of coverage based on work performed under a social security account number that is not the claimant's number and the performance of such work under such number has formed the basis for a conviction of the claimant of a violation of section 208(a)(6) or (7) of the Social Security Act.

Sec. *516. TRANSFER OF OLDER AMERICAN COMMUNITY SERVICE EMPLOYMENT PROGRAM TO DEPARTMENT OF HEALTH AND HUMAN SERVICES.*

(a) IN GENERAL.--Notwithstanding any other provision of law, the Older American Community Service Employment (OACSE) program under title V of the Older Americans Act of 1965 (42 U.S.C. 3056), and the authority to administer such program, shall be permanently transferred from the Secretary of Labor to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging.

(b) TRANSFER OF FUNCTIONS, ASSETS, AND LIABILITIES.--The functions, assets, and liabilities of the Secretary of Labor relating to the OACSE program shall be transferred to the Secretary of Health and Human Services.

(c) EFFECTIVE DATE OF TRANSFER.--The transfer under this section shall be effective no later than the last day of the second full fiscal quarter following the quarter in which this section is enacted.

Sec. *517. Of the funds made available for performance bonus payments under section 2105(a)(3)(E) of the Social Security Act, $6,700,000,000 shall be permanently cancelled as of January 1, 2013.*

Sec. *518. WORKFORCE INNOVATION FUND*

(a) *From funds appropriated under this Act for the Workforce Innovation Fund—*
   (1) amounts shall be available to support innovative new strategies and activities, or the replication and expansion of effective evidence-based strategies and activities, that are designed to align programs and strengthen the workforce development system in a State or region, in order to substantially improve education and employment outcomes for adults and youth served by such system, cost effectiveness, and the services provided to employers under such system; and
   (2) amounts shall be available for awards to States or State agencies that are eligible for assistance under any program authorized under the Workforce Investment Act; consortia of States; or partnerships, including regional partnerships, which may include workforce investment boards, public agencies, or other entities, pursuant to criteria established by the Secretary of labor and the Secretary of Education.

(b) Amounts appropriated for the Workforce Innovation Fund—
   (1) Shall be administered by the Secretary of labor and the Secretary of Education in accordance with an interagency agreement describing the respective roles and responsibilities of the Secretaries in administering such funds, and as appropriate, shall be administered in consultation with other heads of department and agencies; and
   (2) May be transferred between the Department of labor and the Department of Education.

(c) Of the funds appropriated under this Act for the Workforce Innovation Fund not more than 5 percent shall be available to the Secretary of labor and to the Secretary of Education for technical assistance and evaluation related to the projects carried out with these funds.

(d) The Secretary of Labor and the Secretary of Education may authorize awardees to use a portion of awarded funds for evaluation upon approval of an evaluation plan by the Secretaries.

(e) The Secretary of Labor and the Secretary of Education shall establish requirements for the Workforce Innovation Fund to ensure that individuals with disabilities, including those with significant disabilities, benefit substantially from activities supported under the Fund

(f) Of the funds appropriated under this Act for the Workforce Innovation Fund, 410 million shal be used for innovative and evidence-based approaches to serving disconnected youth.

(g) Of the funds appropriated under this Act for the Workforce Innovation Fund not to exceed $20 million may be used for Workforce Innovation Fund-related performance-based awards or other agreements under the Pay for success program: Provided, That any funds obligated for such projects or agreements shall remain available for disbursement until expended, notwithstanding 31 U.S.C. 1552(a): Provided further, That any deobligated funds from such projects or agreements shall immediately be available for the Workforce Innovation Fund.

(h)

(1) In the case of any innovation or replication project which, in the judgment of the Secretary of Labor and the Secretary of Education, is likely to substantially improve the education and employment outcomes for adults and youth served by such system and the services provided to employers under such system and requires waiver of statutory or regulatory requirements to achieve those improvements, the Secretary of Labor, with respect to title I of the Workforce Investment Act of 1998 and the Wagner-Peyser Act, and the Secretary of Education, with respect to title II of the Workforce investment Act of 1998 and title I of the Rehabilitation Act of 1973, may waive compliance with statutory or regulatory requirements under such Acts to the extent and for the period the respective Secretary determines necessary to carry out such projects.

(2) Waivers may only be provided to projects which include—

(A) A plan, approved by the relevant Secretary, to effectively evaluate the impact of the strategies being tested on outcomes for program participants, including target populations identified by the Secretaries:

(B) A strong accountability system, including performance measures which show outcomes for program participants and demonstrate that vulnerable populations, including individuals with disabilities, are being appropriately served by the workforce system; and

(C) Other required elements, as established by the Secretaries in regulation or grant solicitation.

Sec. 519.

(a) IN GENERAL. THE HEALTH Education Assistance Loan (HEAL) program under title VII, part A, subpart I of the Public Health Act (42 U.S.C. 292-292p), and the authority to administer such program, including servicing , collecting and enforcing any loans that were made under such program that remain outstanding, shall be permanently transferred from the Secretary of health and Human Services to the Secretary of Education no later than the end of the first fiscal quarter that begins after the date of enactment of this act.

(b) TRANSFER OF FUNCTIONS ASSETS, AND LIABILITIES. The functions, assets and liabilities of the Secretary of Health and Human Services relating to such program shall be transferred to the Secretary of Education.

(c) INTERDEPARTMENTAL COORDINATION OF TRANSFER. The Secretary of Health and Human Services and the Secretary of Education shall carry out the transfer of the HEAL program described in subsection (a), including the transfer of the function, assets, and liabilities specified in subsection (b), in the manner that they determine is most appropriate.

(d) USE OF THE AUTHORITIES UNDER HIGHER EDUCATION ACT OF 1965. In servicing, collecting, and enforcing the loans described in subsection (a), the Secretary of Education shall have available any and all authorities available to such Secretary in servicing,

collecting, or enforcing a loan made, insured, or guaranteed under part B of title IV of the Higher Education Act of 1965.

(e) CONFORMING AMENDMENTS. Effective as of the date on which the transfer of the HEAL program under subsection (a) takes effect, section 719 of the Public Health Service Act (42 U.S.C. 292o) is amended by adding at the end the following new paragraph: "(6) The term "Secretary" means the Secretary of Education".

(Department of Labor, health and Human Services, and Education and Related Agencies Appropriations Act, 2012)