DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR

2012

General Departmental Management
Office of Medicare Hearings and Appeals
National Coordinator for Health Information Technology
Health Insurance Reform Implementation Fund
World Trade Center Health Program
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 2012	
	FTE	Program Level
General Departmental Management	1,439	$663,351,000
Office of Medicare Hearings and Appeals	424	$81,019,000
Office of the National Coordinator for Health IT	189	$78,413,000
Service and Supply Fund	1384	$0
TOTAL, Departmental Management	3,436	$822,783,000

INTRODUCTION

The FY 2012 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 2012 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 2012 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2010 Annual Performance Report and FY 2012 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The Summary of Performance and Financial Information summarizes key past and planned performance and financial information.

Message from the Assistant Secretary for Financial Resources

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

The Budget request supports the Secretary in her role as chief policy officer and general manager of HHS. The request totals $823 million and includes 3,436 full-time equivalent (FTE) staff in FY 2012. These levels 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 2012 Budget for Departmental Management requests funding for the teen pregnancy prevention and minority HIV/AIDS programs from alternate program level sources – Public Health and Prevention Fund and 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 clients with unfettered access. The request also increases funding for the Office of the National Coordinator for Health IT, to support the planned revision of the ONC-Coordinated Federal Health IT Strategic Plan and to carry out Recovery Act responsibilities.

The Secretary looks forward to working with the Congress toward the enactment and implementation of an FY 2012 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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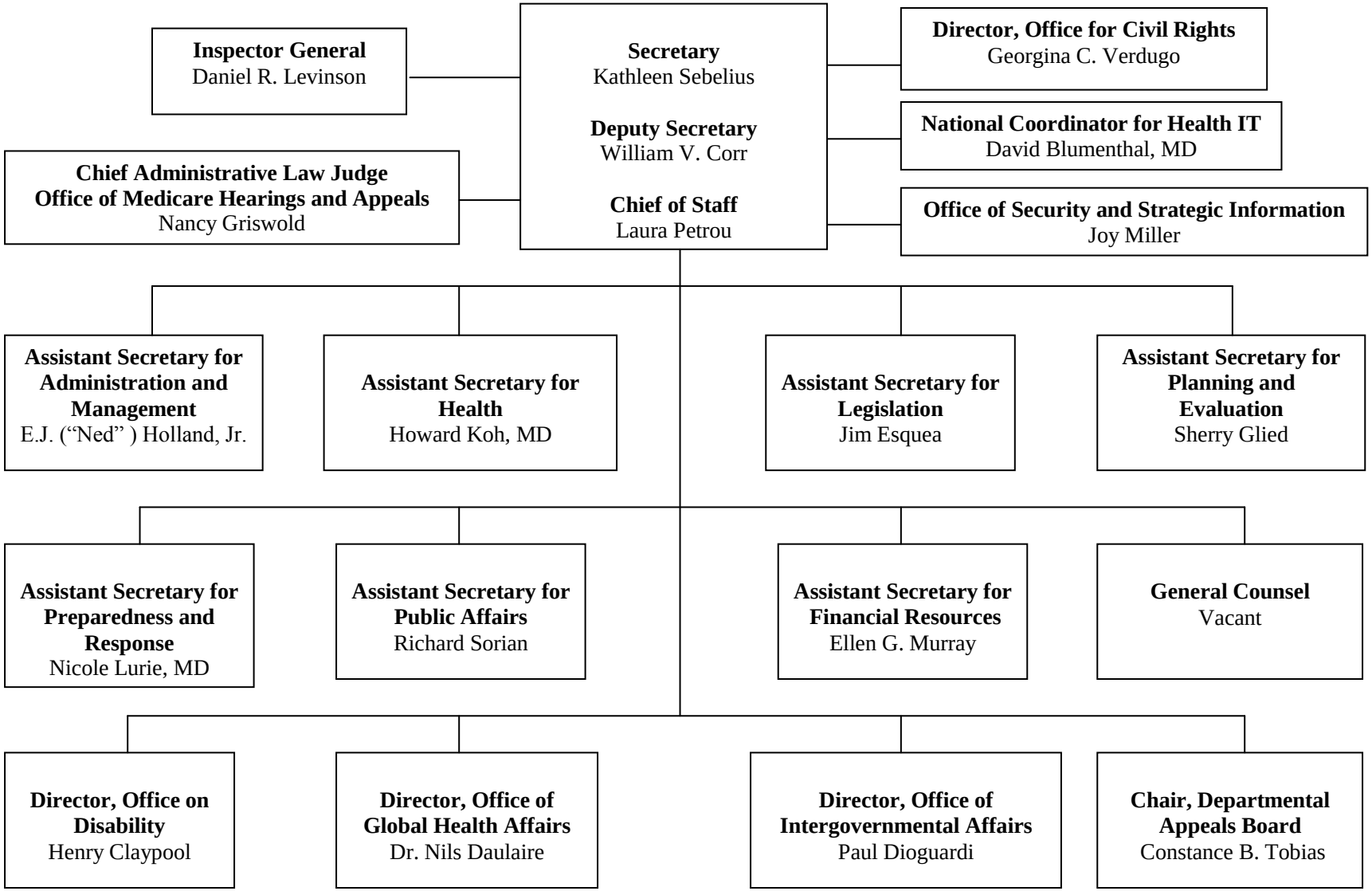
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY



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 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 2012 program level budget request for DM totals $822,783,000 in appropriated budget authority, and 3,436 full-time equivalent (FTE) positions – an increase of $87,269,000 (or 11.9%) above the comparable FY 2010 enacted level. Please see the DM Budget by Appropriation table on the following pages.

The **General Departmental Management** (GDM) appropriation supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department in administering and overseeing the organization, programs, and activities of HHS. These activities are carried out through 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 Health Affairs; Disability; and Assistant Secretary for Health. For FY 2012, GDM is requesting a total of $363,644,000 in budget authority and 1,439 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 $81,019,000 and 424 FTE in FY 2012.

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 2012, HHS requests $78,413,000 and 189 FTE, to coordinate national efforts related to the implementation and use of electronic health information exchange. This includes $21,400,000 in PHS Evaluation Funds. By encouraging providers to adopt health information technology, both the quality of care and the efficiency with which health IT is delivered can be improved.

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 2012, the SSF is projecting total revenue of $1,109,075,000 and usage of 1384 FTE.

NOTE:

The HHS Nonrecurring Expenses Fund (NEF) was established in the Office of the Secretary by the Consolidated Appropriations Act, 2008 (P.L. 110-161). This authority permits expired unobligated balances from discretionary accounts in fiscal years 2008 and later to be transferred into the no-year NEF account, prior to cancellation. HHS currently has no plans to transfer funds to the NEF during FY 2012.

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APPROPRIATIONS LANGUAGE

GENERAL DEPARTMENTAL MANAGEMENT

For necessary expenses, not otherwise provided, for general departmental management, including hire of six sedans, and for carrying out titles III, IV, XVII, XXI, and XXVII of the Public Health Service Act (``PHS Act''), the United States-Mexico Border Health Commission Act, and research studies under section 1110 of the Social Security Act, $363,644,000 and $126,702,000 from the amounts available under section 241 of the PHS Act to carry out national health or human services research and evaluation activities: Provided, That of the amounts provided under this heading from amounts available under section 241 of the PHS Act, $8,455,000 shall be available to carry out evaluations (including longitudinal evaluations) of teenage pregnancy prevention approaches, and $53,891,100 shall be available for minority AIDS prevention and treatment activities: Provided further, That of the funds made available under this heading, $7,000,000 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 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) . Note.-- A full-year 2011 Appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 111-242, as amended). The amounts included for 2011 reflect the annualized level provided by the continuing resolution.

LANGUAGE ANALYSIS

Language Provision	Explanation
"together with $5,851,000 to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund"	HHS is proposing that annual Trust Fund transfers from CMS be deleted from GDM (and OCR) appropriation language, and that the Trust Funds amount be replaced by regular Budget Authority, so that GDM's bottom-line total is not reduced. The numerous accounting intricacies associated with these Trust Fund transfers now outweigh whatever benefit that may have been present when the transfers were initiated years ago. HHS is not aware of any legislative requirement mandating these transfers, or of any prohibition against ending them. Deleting the transfers should also make appropriations scorekeeping easier.
"$5,789,000 shall be to assist Afghanistan in the development of maternal and child health clinics, consistent with section 103(a)(4)(H) of the Afghanistan Freedom Support Act of 2002;"	HHS is proposing that this Afghanistan program be permanently moved to CDC. CDC already participates substantially in this program. This will also move an operational program out of the Office of Global Health Affairs (OGHA), so that OGHA can better focus on policy leadership and coordination.
"That of the funds made available under this heading for carrying out title XX of the Public Health Service Act shall be for activities specified under section 2003(b)(1), of such title XX:"	HHS is proposing that this language be revised in future appropriation bills to read "That none of the funds made available under this heading shall be available for carrying out activities specified under section 2003(b)(2) or (3) of title XX of the PHS Act:". This revision will allow for the provision of demonstration projects for care services.
"That none of the funds made available shall be available for carrying out activities specified under section 2003(b) (2)or (3) of Title XX of the PHS Act:"	HHS is proposing to delete this language in future appropriations bills because the Adolescent Family Life Program will be discontinued in FY 2012.

"$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.
"Provided further, That $10,000,000 of the funds made available under this heading shall be available for health and wellness pilot initiatives for Federal employees, of which up to $5,000,000 may be transferred to other agencies, with the approval of the Director of the Office of Management and Budget, to assist those agencies in the implementation of such initiatives.	HHS is proposing to delete this language. The Federal employee wellness initiative program will not be transferred from OPM to HHS.

AMOUNTS AVAILABLE FOR OBLIGATION

(Dollars in Thousands)

	FY 2010 Actual [1]	FY 2011 CR [1]	FY 2012 President's Budget [1]
General funds:			
Annual appropriation	$493,377	$493,377	$363,644
Actual transfer to:			
NIMH for Interagency Autism Coordinating Cmte	-$1,000	-$1,000	$0
HRSA under the Secretary's One-Percent Transfer Authority	-$74	$0	$0
Comparable transfers to:			
CDC for Afghanistan Health Initiative (OGHA)	-$5,789	-$5,789	$0
CDC for Health Diplomacy Initiative (OGHA)	-$2,000	-$2,000	$0
Subtotal, adjusted general funds	$484,514	$484,588	$363,644
Trust funds:			
Annual appropriation	$5,851	$5,851	$0
Subtotal, adjusted budget authority	$490,365	$490,439	$363,644
Unobligated balance lapsing	$0	$0	$0
Total obligations	$490,365	$490,439	$363,644

1 Excludes amounts for reimbursable activities carried out by this account

SUMMARY OF CHANGES

2010 General Funds appropriation	490,365
Total adjusted budget authority	490,365
2012 Request - General Funds	363,644
Total estimated budget authority	363,644
Net Changes	**-126,721**

	FY 2010 Estimate		FY 2012 Change from Base	
	(FTE)	Budget Authority	(FTE)	Budget Authority
Increases:				
A. Built-In:				
1. Costs of Pay Adjustments	0	99,373	0	18,685
2. Cost of Personnel Benefits Adjustments	0	25,926	0	5,019
3. Within-grade Increases and Career Ladder Promotions	0	641	0	754
4. FTE Position Increases and Decreases	1281	0	60	713
5. SSF Payment/Common Expenses	0	14,520	0	6,081
6. Enterprise IT	0	347	0	78
7. Travel and transportation of persons	0	5,011	0	0
8. Transportation of things	0	1,028	0	0
9. Communications, utilities, and miscellaneous charges	0	24,076	0	0
10. Printing and reproduction	0	1,794	0	0
11. Other contractual services	0	94,211	0	0
12. Supplies and materials	0	1,919	0	0
13. Equipment	0	2,930	0	0
14. Research & Development Contracts	0	955	0	0
15. Grants, subsidies, and contributions	0	8,266	0	0
Subtotal, Built-In Increases	**1,281**	**279,203**	**60**	**31,330**
B. Programs:				
1. OGHA Health Diplomacy Initiative	0	0	4	1,150
2. ASPA Web Portal & Studio	0	0	22	14,608
3. Increased Legislation, Financial Transparency & Policy Review	0	0	28	15,340
4. ASFR Program Integrity	0	0	12	1,900
5. IOS Additional Senior Advisors	0	0	4	900
6. IGA External Affairs	0	0	5	1,200
7. Acquisition Reform	0	0	0	7,000
8. Rent, Operations, and Related Services Mandatory Increases	0	0	0	2,000
Subtotal Program Increases	**0**	**0**	**75**	**44,098**
Total Increases	**1,281**	**279,203**	**135**	**75,428**
Decreases:				
B. Programs:				
1. OASH Embryo Adoption Awareness	0	4,200	0	-2,200
2. Adolescence Family Life	12	16,658	-12	-16,658
3. Commissioned Corps Transformation	31	14,813	-8	-7,800
4. Federal Employee Health & Wellness Initiative	0	10,000	0	-10,000
5. Teen Pregnancy Prevention Initiative	13	110,000	-13	-110,000

6. HIV/AIDS in Minority Communities	0	53,891	0	-53,891
7. IOM Study on Mental Health Workforce	0	900	0	-900
8. Project Earmarks	0	700	0	-700
Subtotal Program Decreases	**56**	**211,162**	**-33**	**-202,149**
Total Decreases	**56**	**211,162**	**-33**	**-202,149**
Net Change	**1,337**	**490,365**	**102**	**-126,721**

BUDGET AUTHORITY BY ACTIVITY

(Dollars in Thousands)

	FY 2010 Actual		FY 2011 CR		FY 2012 PB	
	FTE	Amount	FTE	Amount	FTE	Amount
SSF Payment/Common Expenses	-	$14,521	-	$14,595	-	$19,101
Rent, Operations, Maintenance and Related Services	-	$16,935	-	$16,935	-	$21,425
Immediate Office of the Secretary	71	$10,925	69	$10,925	73	$13,368
Assistant Secretary for Administration	120	$18,976	121	$18,976	126	$21,757
Assistant Secretary for Financial Resources	159	$26,131	182	$26,131	192	$31,425
Assistant Secretary for Legislation	23	$3,204	25	$3,204	34	$4,912
Assistant Secretary for Public Affairs	25	$4,829	24	$4,829	46	$19,922
Office of General Counsel	354	$38,692	321	$38,692	329	$43,531
Departmental Appeals Board	69	$10,549	69	$10,549	81	$13,343
Office on Disability	5	$864	7	$864	8	$1,370
Office of Global Health Affairs	22	$6,350	24	$6,350	28	$8,602
Office of Intergovernmental Affairs	28	$7,049	34	$7,049	45	$10,538
Office of External Affairs	-	-	-	-	5	$1,200
Office of the Assistant Secretary for Health	320	$264,702	337	$264,702	319	$137,125
Embryo Adoption Awareness Campaign	-	$4,200	-	$4,200	-	$2,000
Healthcare-associated Infections	-	$5,000	2	$5,000	2	$5,000
HIV/AIDS in Minority Communities	-	$53,891	3	$53,891	3	-
Secretarial Initiatives and Innovations	-	$1,600	-	$1,600	-	$1,600
Acquisition Reform	-	-	-	-	-	$7,000
Enterprise IT	-	$347	-	$347	-	$425
IOM Study on Mental Health Workforce	-	$900	-	$900	-	-
Project Earmarks	-	$700	-	$700	-	-
PHS Evaluation Set-Aside	141	-	152	-	148	-
Subtotal, Budget Authority	1,337	$490,365	1,370	$490,439	1,439	$363,644
Total, Budget Authority	**1,337**	**$490,365**	**1,370**	**$490,439**	**1,439**	**$363,644**

BUDGET AUTHORITY by OBJECT CLASS - DIRECT

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 CR	FY 2012 PB
Personnel compensation:			
Full-time permanent (11.1)	82,663	82,163	93,879
Other than full-time permanent (11.3)	8,918	8,368	8,073
Other personnel compensation (11.5)	3,014	8,814	8,910
Military personnel (11.7)	4,046	8,946	7,196
Special personal services payments (11.8)	732	0	0
Subtotal, Personnel compensation	99,373	108,291	118,058
Civilian personnel benefits (12.1)	23,003	26,140	26,941
Military benefits (12.2)	2,923	4,923	4,004
Benefits for former personnel (13.0)	0	0	0
Total Pay Costs	125,299	139,354	149,003
Travel and transportation of persons (21.0)	5,011	7,011	6,859
Transportation of things (22.0)	1,028	0	0
Rental payments to GSA (23.1)	0	24,780	23,980
Communications, utilities, and miscellaneous charges (23.3)	24,076	5,684	1,053
Printing and reproduction (24.0)	1,794	5,330	5,083
Rental payments to others (23.2)	0	0	0
Other Contractual Services:			
Advisory and assistance services (25.1)	49,204	58,044	44,154
Other services (25.2)	31,003	50,103	42,263
Other purchases of goods and services from Government Accounts (25.3)	50,966	58,060	34,130
Operation and maintenance of facilities (25.4)	3,971	9,871	10,971
Research and development contracts (25.5)	955	0	0
Medical care (25.6)	0	0	0
Operation and maintenance of equipment (25.7)	838	3,009	3,998
Subsistence and support of persons (25.8)	0	0	0
Subtotal, Other Contractual Services	136,937	179,087	135,516
Supplies and materials (26.0)	1,919	2,919	7,966
Equipment (31.0)	2,930	5,930	6,039
Land and Structures (32.0)	0	0	0
Investments and Loans (33.0)	0	0	0
Grants, subsidies, and contributions (41.0)	193,015	122,015	28,145
One-time Appropriation for Treasury (43.0)	0	0	0
Refunds (44.0)	0	0	0
Total Non-Pay Costs	366,710	352,756	214,641
Total Budget Authority by Object Class	**492,009**[1]	**492,110**	**363,644**[2]

1) FY 2010 & FY 2011 includes $1.6 million for CHIPRA & FMAP program level
2) FY 2012 Does not include $135 thousand for Prevention & Public Health Fund

BUDGET AUTHORITY by OBJECT CLASS - REIMBURSABLE

(Dollars in Thousands)

Object Class	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 PB
Reimbursable Obligations			
Personnel compensation:			
Full-time permanent (11.1)	48,770	48,770	53,561
Other than full-time permanent (11.3)	2,199	2,199	2,252
Other personnel compensation (11.5)	831	831	849
Military personnel (11.7)	3,125	3,125	3,010
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	54,924	54,924	59,670
Civilian benefits (12.1)	13,150	13,150	14,201
Military benefits (12.2)	1,282	1,282	1,247
Benefits to former personnel (13.0)	-	-	-
Subtotal Pay Costs	69,356	69,356	75,118
Travel and transportation of persons (21.0)	866	866	1,187
Transportation of things (22.0)	29	29	62
Rental payments to GSA (23.1)	1,809	1,809	1,619
Communication, utilities, and misc. charges (23.3)	1,760	1,760	2,726
Printing and reproduction (24.0)	166	166	163
Other Contractual Services:	-	-	-
Advisory and assistance services (25.1)	55,501	55,501	47,643
Other services (25.2)	4,249	4,249	6,253
Purchase of goods and services from	-	-	-
government accounts (25.3)	10,785	10,785	22,850
Operation and maintenance of facilities (25.4)	531	531	549
Research and Development Contracts (25.5)	2,271	2,271	1,702
Medical care (25.6)	2	2	12
Operation and maintenance of equipment (25.7)	274	274	325
Subsistence and support of persons (25.8)	-	-	-
Subtotal Other Contractual Services	73,613	73,613	79,333
Supplies and materials (26.0)	139	139	254
Equipment (31.0)	179	179	306
Land and Structures (32.0)	-	-	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	17,278	17,278	66,469
Interest and dividends (43.0)	-	-	-
Refunds (44.0)	-	-	-
Subtotal Non-Pay Costs	95,839	95,839	152,119
Total Direct Obligations	**165,195**	**165,195**	**227,237**

SALARIES AND EXPENSES

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 CR	FY 2012 PB
Personnel compensation:			
Full-time permanent (11.1)	82,663	82,163	93,879
Other than full-time permanent (11.3)	8,918	8,368	8,073
Other personnel compensation (11.5)	3,014	8,814	8,910
Military personnel (11.7)	4,046	8,946	7,196
Special personal services payments (11.8)	732	0	0
Subtotal, Personnel compensation	99,373	108,291	118,058
Civilian personnel benefits (12.1)	23,003	26,140	26,941
Military benefits (12.2)	2,923	4,923	4,004
Total Pay Costs	125,299	139,354	149,003
Travel and transportation of persons (21.0)	5,011	7,011	6,859
Transportation of things (22.0)	1,028	0	0
Communications, utilities, and miscellaneous charges (23.3)	24,076	5,684	1,053
Printing and reproduction (24.0)	1,794	5,330	5,083
Other Contractual Services:			
Advisory and assistance services (25.1)	49,204	58,044	44,154
Other services (25.2)	31,003	50,103	42,263
Other purchases of goods and services from Government Accounts (25.3)	50,966	58,060	34,130
Operation and maintenance of facilities (25.4)	3,971	9,871	10,971
Research and development contracts (25.5)	955	0	0
Operation and maintenance of equipment (25.7)	838	3,009	3,998
Subtotal, Other Contractual Services	136,937	179,087	135,516
Supplies and materials (26.0)	1,919	2,919	7,966
Investments and Loans (33.0)	0	0	0
Total Non-Pay Costs	170,765	200,031	156,477
Total Salaries and Expenses	**296,064**	**339,385**	**305,480**

AUTHORIZING LEGISLATION

(Dollars in Thousands)

	2011 Amount Authorized	2011 Continuing Resolution	2012 Amount Authorized	2012 President's Budget
General Departmental Management:				
except accounts below:				
Reorganization Plan No. 1 of 1953	Indefinite	$225,737	Indefinite	$226,519
Office of the Assistant Secretary for Health:				
Public Health Service Act,				
Title III, Section 301	Indefinite	$178,105	Indefinite	$63,655
Title XVII, Section 1701 (ODPHP)	1	$7,200	1	$7,929
Title XVII, Section 1701 (OMH)	2	$55,900	2	$57,980
Title XX, Section 2010 (AFL)	3	$16,658	3	$0
Title XXI (NVPO)	4	$6,839	4	$7,561
Subtotal		$264,702		$137,125
Subtotal Request Level		$490,439		$363,644
Unfunded Authorizations		$0		$0
Total Request Level		$490,439		$363,644
Total Request Level Against Definite Authorizations		$0		$0

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

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

3) Authorizing legislation under Section 2001 of the PHS Act expired September 30, 1985. Reauthorization will be proposed.

4) Authorizing legislation under Title XXI, Subtitle 1 of the PHS Act expired September 30, 1995. Reauthorization will be proposed.

APPROPRIATIONS HISTORY TABLE

(Non-Comparable)

(Dollars in Thousands)

	Budget Estimate to Congress	House Allowances	Senate Allowance	Appropriation
FY 2002				
Appropriation	$415,348	$333,036	$416,361	$341,703
Rescission	-	-	-	-$1,667
Trust Funds	$5,851	$5,851	$5,851	$5,851
FY 2003				
Appropriation	$387,880	$352,600	$368,535	$361,364
Rescission	-	-	-	-$2,349
OER Transfer	-	-	-	-$13,856
Trust Funds	$5,851	$5,851	$5,851	$5,851
Rescission	-	-	-	-$38
FY 2004				
Appropriation	$348,100	$343,284	$344,808	$357,358
Rescission	-	-	-	-$3,174
Trust Funds	$5,851	$5,851	$5,851	$5,851
Rescission	-	-	-	-$35
FY 2005				
Appropriation	$431,971	$349,298	$376,704	$371,975
Rescissions	-	-	-	-$3,530
Trust Funds	$5,851	$5,851	$5,851	$55,851
Rescission	-	-	-	-$447
SSA Transfer	-	-	-	-$49,600
FY 2006				
Appropriation	$353,325	$338,695	$353,614	$352,703
Rescission	-	-	-	-$3,527
Trust Funds	$5,851	$5,851	$5,851	$5,851
Rescission	-	-	-	-$58
FY 2007				
Appropriation	$362,568	-	-	$350,945
Rescissions	-	-	-	-$500
KLL Supplemental	$13,512	-	-	-
Trust Funds	$5,851	-	-	$5,793

APPROPRIATIONS HISTORY TABLE

(Continued)

	Budget Estimate to Congress	House Allowances	Senate Allowance	Appropriation
FY 2008				
Appropriation	$386,705	$342,224	$386,053	$355,518
Rescissions	-	-	-	-$6,211
NIMH Transfer	-	-	-	-$983
Trust Funds	$5,851	$5,851	$5,851	$5,792
Rescissions	-	-	-	-$101
FY 2009				
Appropriation	$374,013	$361,825	$361,764	$389,925
NIMH Transfer	-	-$1,000	-$1,000	-$1,000
Trust Funds	$5,851	$5,851	$5,851	$5,851
CHIPRA (PL 111-3)	-	-	-	$15,000
ARRA (PL 111-5)	-	-	-	$5,000
FY 2010				
Appropriation	$403,698	$397,601	$477,928	$493,377
NIMH Transfer	-	-$1,000	-$1,000	-$1,000
Trust Funds	$5,851	$5,851	$5,851	$5,851
One Percent Transfer Authority	-	-	-	-$74
Pregnancy Assistance Fund	-	-	-	$25,000
Prevention and Public Health Fund	-	-	-	$12,045
FY 2011 Continuing Resolution				
Appropriation	$490,439	$0	$0	$490,439
NIMH Transfer	-	-	-	-$1,000
Trust Funds	-	-	-	$5,851
Pregnancy Assistance Fund	-	-	-	$25,000
FY 2012				
Appropriation	$363,644	-	-	-
Pregnancy Assistance Fund	$25,000	-	-	-
Prevention and Public Health Fund	$134,900	-	-	-

GENERAL DEPARTMENTAL MANAGEMENT

All Purpose Table

Dollars in Thousands

Base Level Program		FY 2010 Actual	FY 2011 Continuing Res	FY 2012 PB	Difference +/- 2010
GDM	BA	490,365	490,439	363,644	-126,721
	FTE	1,337	1,370	1,439	102
Related Funding (non-add)					
Pregnancy Assistance Fund (P.L. 111-148)	PL	*25,000*	*25,000*	*25,000*	0
Prevention and Public Health Fund P.L. (111-148) (GDM Allocation[1])	PL	*12,045*	*19,100*	*134,900*	122,855
PHS Evaluation Set- Aside - Public Health Service Act	PL	*65,211*	*65,211*	*126,702*	61,491
HCFAC	PL	*10,455*	*13,105*	*13,105*	2,650

[1] Represents the GDM allocation of funds from the Prevention and Public Health Fund – Section 4002 of the Patient Protection and Affordable Care Act, Pub. L. 111-148. FY 2010 $500,000,000; FY 2011 $750,000,000, FY 2012, $1,000,000,000.

Overview of Budget Request

The FY 2012 budget request for General Departmental Management (GDM) includes $363,644,000 in appropriated funds and 1,439 full-time equivalent (FTE) positions. This request is a decrease of $126,721,000 (-26 percent) lower than the FY 2010 Actual or the FY 2011 full year CR appropriations.

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 this request with a funding table is included at the end of the GDM request. In FY 2012, $1 billion is available, which is +$250 million above the FY 2011 appropriation. The HHS allocation for FY 2012 reflects a balanced portfolio of investments among several HHS agencies and offices to improve health and to help restrain the growth of health care costs. The proposed FY 2012 GDM allocation is $134,900,000.

As Health Reform and other ongoing public health initiatives evolve, the Department has made a concerted effort to examine programs which can be reduced or eliminated to move resources and support new and focused efforts in the area of strategic partnering and national health leadership. Increases in targeted areas in GDM were funded by making significant reductions in duplicative or ineffective programs.

The GDM appropriation supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department. 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 Health Affairs; Disability; and Assistant Secretary for Health.

The largest single STAFFDIV within GDM is the Office of the Assistant Secretary for Health (OASH). OASH serves as the focal point for leadership and coordination across the Department in public health and science, and provides advice and counsel to the Secretary on public health and science issues. OASH also exercises management responsibility for thirteen cross-cutting program offices, including: Surgeon General; HIV/AIDS Policy; Disease Prevention and Health Promotion; President's Council on Fitness, Sports and Nutrition; Minority Health; Women's Health; Human Research Protections; Commission Corps Initiatives; National Vaccine Program Office; Public Health Reports; Research Integrity; and the newly established Adolescent Health office.

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.

The FY 2012 request for GDM reflects the following significant changes from previous years:

SSF Payment (+$3,815,000) – The increase in the SSF payment covers increased charges attributable to GDM based on a projection of the SSF Board approved FY 2011 Budget Request.

Rent (+$4,490,000) – The increase is requested to fund the following four mandatory increases, none of which can be reduced without a major impact on HHS operations: Rent in the Humphrey, Switzer, Cohen, and 801 N. Capitol Street buildings; security increases imposed for the Federal Protective Service; labor rate increases on service contracts; and increased utility costs.

Immediate Office of the Secretary (+$2,443,000) – The increase supports additional senior staff advisors and visiting fellows reporting directly to the Secretary who support the tracking and coordination of departmental inquiries at a strategic level.

Office of the Assistant Secretary for Administration (+$2,781,000) – The request allows for an increase in required facilities support and to promote and manage the new HHS federal efforts related to the President's sustainability initiatives. An Integrated Project Team will coordinate the evolution of the health data model across the Department and ensure a standardized approach to information exchange.

Office of the Assistant Secretary for Financial Resources (+$5,294,000) – This increase supports ASFR in providing all aspects of budget, grants, acquisition and financial management required by new government transparency requirements, program integrity, and the coordination of HHS' financial reporting regarding the Affordable Care Act (ACA) accounts and initiatives. Program Integrity efforts include providing effective oversight to programs through rigorous standards of accountability and transparency in responsible Federal funding. This is accomplished through enhancing oversight of and policy guidance for acquisitions; strengthening legal review and oversight; improving financial reporting and financial controls; and implementing robust budgetary oversight execution controls, risk management and performance tracking. This request includes salaries and expenses to employ the necessary staff with the diverse and unique skill-sets required to execute these functions.

Office of the Assistant Secretary for Legislation (+$1,708,000) – The increase supports ASL, in responding to the increased congressional inquiries related to Health Reform as a result of the implementation and review of the legislation.

Office of the Assistant Secretary for Public Affairs (+$15,093,000) – 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 communication. ASPA ensures that comprehensive health information is available and understandable to the public through continued work on HealthCare.gov and conducting educational outreach campaigns designed to help Americans to understand and to help access their benefits and information related to those benefits.

Office of the General Counsel (+$4,839,000) – The 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. Additionally, OGC will provide extensive legal advice and litigation support and defend CMS in potential actions related to Medicare payment policies and/or to final agency actions applying these provisions.

Departmental Appeals Board (+$2,794,000) – This increase continues DAB's mission 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 addition, the increase supports the efforts of DAB to review decisions on Medicare benefits eligibility and claims and coverage issues, and conduct hearings on the record.

Office of Disability (+$506,000) – The increase supports continuing modernization efforts of the Department's 508 compliance and Disability Hiring Initiative, in addition to the Office of Disability's instrumental role in implementing the Community Living Initiative. Working groups are involved with the provision that relates 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.

Office of Global Health Affairs (+$2,252,000) – The increase continues the support and expansion of the Health Diplomacy Initiative, with the overall goal of strengthening health systems and improving ties with partner countries. Additional funding will also implement improvement actions identified in the HHS Stakeholder Study. Study results outlined OGHA's requirements, programs, people, and funds necessary to strengthen OGHA operations, enabling it to fulfill its core functions of policy coordination, representation and diplomacy, supporting the HHS Secretary and including a limited-but-strategic engagement in program coordination and other special initiatives.

Office of Intergovernmental Affairs (+3,489,000) – This increase expands efforts to support the various state and tribal, as well as commercial and health association partners necessary to successfully improve the health of the American public. This enhanced mission and scope of IGA requires additional resources to carry-out the responsibilities of improving efficiency, effectiveness and productivity of external outreach.

Office of External Affairs (+$1,200,000) – The increase requested will allow the newly formed OEA to establish coordination of policy and technical communications at senior strategic levels. In addition OEA staff will develop a master external communications plan engaging partners such as academia, private sector, labor unions, profit and not-for profit groups and national organizations around the implementation of ACA. OEA will develop a process to map major stakeholder groups key to the success of health reform and develop strategies to effectively reach and engage them.

Office of the Assistant Secretary for Health (-$183,668,000) – There are three major areas of change in OASH including 1) an increase of $6,881,000 at the various program office levels supporting the review and development of policies and strategies by providing resources to analyze and coordinate departmental efforts related to the growing list of public health concerns facing the Nation such as Disease Prevention, Vaccines, HIV/AIDS, pregnancy prevention and adolescent, minority and women's health; 2) transfers from GDM of $110,000,000 to Prevention and Public Health Fund for ongoing Teen Pregnancy Prevention program grants and $53,891,000 to the Public Health Service Evaluation Funds for Minority HIV/AIDS; and finally 3) - $26,658,000, reductions in lower priority duplicative, ineffective or concluding programs such as Adolescent Family Life (-$16,658,000); Commission Corps Transformation ($-7,800,000) which is nearing completion; and Embryo Adoption Awareness Campaign (-$2,200,000) a program in transition from an awareness campaign to implementing models developed in FY 2010 for supporting actual embryo adoptions.

PERFORMANCE OVERVIEW

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. These activities are carried out through the following Staff Divisions (STAFFDIVs), include the Immediate Office of the Secretary, the Departmental Appeals Board, and the Office of: Administration; Financial Resources; Public Affairs; Legislation; Planning and Evaluation; General Counsel; Intergovernmental Affairs; Global Health Affairs (OGHA); Disability and Assistant Secretary for Health (OASH).

OASH is the largest single STAFFDIV within GDM, managing thirteen cross-cutting program offices, including: Surgeon General, HIV/AIDS Policy, Adolescent Family Life, Disease Prevention and Health Promotion, President's Council on Fitness and Sports and Nutrition, Minority Health, Women's Health, Human Research Protections, Commissioned Corps Initiatives, National Vaccine Program Office, Public Health Reports, and Research Integrity, and the newly established Adolescent Health office.

OGHA and several OASH components participated in a program assessment that resulted in the development of individual performance measures for some of their programs.

This justification includes individual program narratives that describe accomplishments, for most of the GDM components. The justification also includes performance tables that provides performance data for specific GDM components (OASH, OGHA, DAB, and OD). Detailed analysis for their performance data can be found in the GDM Online Performance Appendix.

Summary of Performance Targets and Results Table

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2007	103	103	100%	92	91%
2008	103	103	100%	83	81%
2009	92	92	100%	83	90%
2010	89	43	48%	38	43%
2011	75				
2012	75				

NOTE: The FY 2007 and FY 2008 targets include the following Departmental Management (DM) programs: OMHA, ONC, OGHA, ASPR, DAB, OD, OASH and specific OASH programs offices with measures developed during their program assessment. The targets in FY 2009 were reduced because the Public Health and Social Services Emergency Fund which includes ASPR, is now published as a separate Justification. Targets for the remaining fiscal years reflect the following DM programs: OMHA, ONC, DAB, OD, OGHA and OASH.

OVERHEAD & SSF PAYMENT

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	14,521	14,595	19,101	4,580
FTE	0	0	0	0

RENT, OPERATIONS, MAINTENANCE AND RELATED SERVICES

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	16,935	16,935	21,425	4,490
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 (ASA), administers the Rent, Operations and Maintenance (O&M), and Related Services funding and requirements for all headquarters facilities occupied by the Office of the Secretary (OS), plus other assigned space. OFMP ensures mission-enabling facilities and a safe, secure work environment for the Hubert H. Humphrey (HHH) Building and the rest of the Southwest complex in Washington DC. OFMP also provides stewardship and fiscal responsibility in managing the Department's real property assets; monitors the amount and type of space occupied by each STAFFDIV; coordinates efforts to achieve the most efficient use of space while maintaining a quality work environment; manages and maintains physical security requirements; provides event management services; and ensures the continuous operation of assigned Federal buildings and leased space.

- Rental Payments (Rent): OFMP manages and administers the space assigned to HHS by the General Services Administration (GSA), including office space, non-office space and parking facilities in owned or leased buildings.

- O&M: OFMP manages and administers the operation, maintenance and repair of the HHH Building, which is HHS Headquarters, under a delegation of authority from GSA, which owns the building. O&M services include heating, lighting, air conditioning, other utilities, and upkeep on building systems and facility equipment.

- Related Services: OFMP manages and administers non-rent activities in GSA-owned buildings, including space management, events management, guard services and other security, as well as building repairs and renovations.

OFMP is committed to a high level of performance in the management of the HHH Building through the improvement of operational efficiency and reductions in operating costs, in accordance with best practices and industry standards. Examples include implementing and maintaining traffic and security improvements to control building access, modernizing lighting systems to improve energy efficiency while minimizing costs, and completing other building improvement projects.

From FY 2001 to FY 2010, OFMP achieved all of its performance targets. OFMP's current practices and procedures adhere to GSA guidelines for responding to building services complaints within 72 hours of receipt. To verify performance, an independent analysis of computer-generated data from the contractor's service call system is conducted regularly. To ensure accuracy, individual work orders (issued as a result of estimates for service) are randomly pulled and reviewed on a periodic basis. These reviews have consistently supported the automated reports.

In FY 2011, OFMP also implemented new security changes to the two main entrances of the HHH Building, to increase effectiveness of building and personal security; and began enhancements to security monitoring equipment to improve controlled access to the building.

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.

Budget Request

The FY 2012 budget request for Rent, O&M, and Related Services is $21,425,000, an increase of $4,490,000 over the FY 2010 Appropriation level. The increase covers GSA-mandated Rent increases; mandatory security increases imposed by the Department of Homeland Security (DHS); mandatory statutory contract labor rate increases for nine service contracts (under the McNamara-O'Hara Service Contract Act of 1965, as amended, and Collective Bargaining Agreements mandated by the Department of Labor); and utility cost increases (steam and electricity) billed by utility providers. None of the mandatory increases can be reduced without a major impact on HHS operations and personnel.

- Rent costs have been formulated based on published GSA rates. HHH building space re-measurement by GSA increased GDM rentable square footage (RSF) in the HHH Building by 20% and the rate per RSF billed by GSA increased by 11%. Other GSA RSF rate increases include the Switzer building (60% increase), Cohen building (10% increase) and 800 N. Capitol Street building (10% increase).

- Security increases will be imposed by DHS for the Federal Protective Service (FPS). FPS costs are estimated to increase 15%, due to anticipated mandatory wage determinations under FPS guard services contracts for managed buildings.

- Service contract labor rates are projected to increase across all contracts, as a result of pre-negotiated firm-fixed pricing and/or anticipated wage increases mandated by statute. These increases include services for CAD, movers, events management, X-ray maintenance and card key access, all projected to increase by an estimated 5%. Physical security service contracts will similarly increase by 7%, due to wage increases mandated by statute. Commercial facilities maintenance contracts are estimated to increase by 9% as noted by the assigned contracting officials.

- Utility cost increases (steam and electricity) billed by utility providers to maintain existing minimum levels for occupied facilities are projected to increase by 10%, based on historical cost increases. In addition, GSA fire alarm and high-voltage electrical maintenance fees are increasing by 50%, due to a new GSA contract providing these services.

RENT AND COMMON EXPENSES

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	Difference +/- 2010
Rent:				
GDM	10,470	10,470	12,493	+2,023
OGC	2,194	2,194	2,267	+73
OPHS	8,035	8,035	8,229	+194
IGA	689	689	729	+40
DAB	312	312	294	-18
Total	21,700	21,700	24,012	+2,312
Operations and Maintenance:				
GDM	3,375	3,375	5,045	+1,670
Related Services:				
GDM	3,090	3,090	3,886	+796
OGC	359	359	345	-14
Total	3,449	3,449	4,231	+782
Subtotal, GDM only	*16,935*	*16,935*	*21,424*	+4,489
Common Expenses:				
GDM	3,182	3,349	4,026	+844
OGC	2,244	2,244	2,131	-113
OPHS	1,941	1,941	1,862	-79
Total	7,367	7,534	8,019	+652
Service and Supply Fund:				
GDM	10,685	10,592	14,500	+3,815
Web Communications	1,000	1,000	1,000	-
OGC	1,010	1,010	1,044	+34
OPHS	9,986	9,986	10,333	+347
Total	22,681	22,588	26,877	+4,196
Subtotal, GDM only	*13,867*	*13,941*	*18,526*	+4,659
Totals:				
GDM	30,802	30,876	39,950	+9,148
Web Communications	1,000	1,000	1,000	-
OGC	5,807	5,807	5,787	-20
OPHS	19,962	19,962	20,424	+462
IGA	689	689	729	+40
DAB	312	312	294	-18
Total	**58,572**	**58,646**	**68,184**	**+9,612**

IMMEDIATE OFFICE OF THE SECRETARY

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	10,925	10,925	13,368	2,443
FTE	71	69	73	2

Authorizing Legislation:

FY 2012 Authorization……..…….. Indefinite
Allocation Method……..……Direct Federal

Overview of Budget Request

In FY 2012 the Immediate Office of the Secretary (IOS) budget request supports agency policy direction, effective oversight, and management on issues that the Secretary and Health and Human Services (HHS) confront daily in leading more than 300 programs covering a wide spectrum of activities. The FY 2012 budget also supports overseeing the operations and functions of IOS components including: Deputy Secretary's Office, Scheduling and Advance, the Executive Secretariat, and the White House Liaison's Office.

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 2007	$9,959,000
FY 2008	$10,728,000
FY 2009	$11,073,000
FY 2010	$10,925,000
FY 2011	$10,925,000

Budget Request

The FY 2012 budget request for IOS is $13,368,000, an increase of $2,443,000 above the FY 2010 Appropriation. This increase is needed to maintain personnel costs and increases in other services to support achieving the Department's Health Care, Human Services, Scientific Research, and Workforce Development Strategic Goals. Personnel costs account for 80% of the IOS budget with the remaining 20% allocated for other mission critical operating expenses. Finally, increases support an increased level of tracking and coordination of departmental correspondence and inquiries at a strategic level in regards to implementation and review of new and proposed laws.

ASSISTANT SECRETARY FOR ADMINISTRATION

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	18,976	18,976	21,757	2,781
FTE	120	121	126	6

Authorizing Legislation:

FY 2012 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, Office of Diversity Management and Equal Employment Opportunity, 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.

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 and physical security for 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.

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 security and enterprise project lifecycle management. OCIO leads the HHS IT CPIC process, through the Office of IT Capital Planning and Investment Control, with an approximate annual portfolio of $6 billion: $3 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 CPIC guidance from OMB and 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 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. This reduces redundant OPDIV-level functions and obtains economies of scale through pooling and managing of HHS requirements, usage volumes, and quantity discounts to control costs. OCIO represents HHS in support of GSA through membership and participation in the Interagency Management Council. Additionally, OCIO staff members act as co-chairs of the OMB-mandated Trusted Internet Connection (TIC) Initiative working group with the intent to bolster IT security across the federal government. OCIO staff members also represent HHS at the Council of Principles (COP) in support of maintaining critical infrastructure and in support of the Government Emergency Telecommunications System, Telecommunications Service Priority.

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.

Office of Diversity Management and Equal Employment Opportunity (ODME)
ODME provides leadership in creating and sustaining a diverse workforce and an environment free of discrimination at HHS. ODME 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. ODME also provides resource management and equal opportunity service functions for the Department. To accomplish its mission, ODME provides functional oversight and works in collaboration with the Equal Employment Opportunity offices that service each of the Department's OPDIVs. ODME also conducts Department-wide program analysis to determine barriers to diversity and inclusion.

Funding History

FY 2007	$15,458,000
FY 2008	$16,855,000
FY 2009	$17,390,000
FY 2010	$18,976,000
FY 2011	$18,976,000

Budget Request Overview

The ASA FY 2012 budget request is $21,757,000, an increase of $2,781,000 over the FY 2010 Appropriation. The increase is needed to officially establish the Office of Sustainability in accordance with Executive Order 13514 – Federal Leadership in Environmental, Energy and Economic Performance. Centralized oversight and leadership are critical for establishing, implementing and evaluating an integrated Departmental strategy for this cross cutting initiative.

An Integrated Project Team will coordinate the evolution of the health data model across the Department and ensure a standardized approach to information exchange. The team will develop a coordinated view of key health business processes necessary to support health care reform in general; ensure that all architectural approaches and IT investments adequately consider security requirements; and that any risks associated with the architecture or IT investment are mitigated adequately. This will greatly enhance evolving interoperable, secure and effective information systems that are able to share information since each project will utilize a Departmental plan.

Finally, ASA will establish a standardized set of online training courses that meet the Equal Employment Opportunity Commission (EEOC) mandatory training requirements, and acquire licenses to improve compliance reporting and analysis to the EEOC.

ASSISTANT SECRETARY FOR FINANCIAL RESOURCES

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	26,131	26,131	31,425	5,294
FTE	159	182	192	33

Authorizing Legislation:
FY 2012 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, 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 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 2010, 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 Office of Consumer Information and Insurance Oversight (OCIIO) and 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. 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 2010 HHS Summary of Performance and Financial Information, On-line Performance Appendix and Budget Justifications. The Office of Budget coordinated the establishment of the HHS High Priority Goals for the Department and the submission of required materials regarding those goals to OMB.

The FY 2011 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) – 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 $141 billion to HHS to support approximately 40 programs managed by eight Operating Divisions, the Office of the Secretary, and the Office of Inspector General. The ORAC was created in March 2009 using a small cadre of staff detailed from within HHS, which allowed the Office to begin functioning immediately.

In FY 2010, ORAC provided staff support for the Recovery Act Implementation Team composed of HHS OPDIV and Staff Division heads and chaired by the Deputy Secretary, coordinated the development of Agency presentations on program operations and performance at monthly Implementation Team meetings, and collaborated with the Vice President's Recovery Implementation Office and the Recovery Act Accountability and Transparency Board on numerous projects and information requests. Major accomplishments included:

- Cumulative outlays of over $85 billion through the end of FY 2010 providing financial assistance to State and local communities for jobs, health and social services, and 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 Recovery Act): reporting compliance of over 99% was achieved from more than 21,000 grantees and contractors.

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. 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). In addition, the OF provides Departmental leadership and support to the Secretary for the implementation of the new Program Integrity initiative.

Consistent with the Reports Consolidation Act and GPRA, OF prepared the Agency Financial Report which includes consolidated financial statements, the auditor's opinion and other statutorily required annual reporting. For the twelfth consecutive year, HHS earned an unqualified or "clean" opinion on the HHS' audited financial statements. In addition to maintaining its external reporting responsibilities, the OF developed and implemented a consolidated reporting solution in FY2010 that supports both the financial statement consolidation process and the consolidated Healthcare Reform reporting requirements in FY2011 and forward.

The OF develops HHS-wide policies and standards for financial and mixed financial system portfolios, including the development and business management of UFMS. UFMS is an integrated financial management system that operates across the OPDIVS and six HHS accounting centers. In FY2010, HHS successfully executed its annual financial reporting closing across all HHS OPDIVs. HHS continues its UFMS stabilization efforts and is focusing significant resources to improve the financial management and reporting services across the HHS. The Healthcare Integrated General Ledger Accounting System contractor conversion and implementation continues on schedule. As one of HHS' six accounting centers, NIH Business System continues its integration of accounting and legacy systems to improve and ensure comprehensive financial management practices.

Office of Grants and Acquisition Policy and Accountability (OGAPA) – This office provides Department-wide leadership and management in the areas of grants and acquisition management 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 and acquisition functions throughout the Department.

Within the *Division of Acquisition*, the Office of Acquisition Policy develops Department-wide acquisition policies; publishes and maintains the HHS Acquisition Regulation (HHSAR); manages the Department's training and certification programs; manages the Departmental Contracts Information System and related contract system initiatives; and participates in government-wide acquisition rule-making through the Civilian Agency Acquisition Council. The Office of Acquisition Program Support establishes appropriate acquisition-related internal controls and performance measures; conducts procurement management reviews; responds to acquisition-oriented GAO and IG audits; leads the Department's Strategic Sourcing, Green Procurement, and Purchase Card programs.

Within the *Division of Grants*, the Office of Grants Policy, Oversight, and Evaluation develops Department-wide grant administration policies; establishes appropriate grants-related internal controls; and provides technical assistance and oversight to foster stewardship and accountability in HHS' grants and financial assistance programs. The Office for Grants Systems Modernization works to ensure that the electronic grants management systems employed by HHS efficiently promote grant policies and optimize departmental resources; ensures that HHS fulfills its role as managing partner of Grants.gov; and coordinates HHS' implementation and reporting regarding the Federal Funding Accountability and Transparency Act (FFATA).

OGAPA also provides administrative leadership and support to the *Office of Small and Disadvantaged Business Utilization* (OSDBU), established in 1979 under Public Law 95-507, the

Small Business Act. The Office provides Department-wide leadership, strategy, and policy direction for the HHS Small Business Program to: ensure that small businesses are given a fair opportunity to compete for contracts that provide goods and services to HHS; establish, manage and track small business goal achievements for the OPDIVs and the Department as a whole; provide technical assistance and Small Business Program training to OPDIV contracting and program officials; and conduct outreach and provide marketing and technical guidance to small businesses on contracting opportunities with HHS.

Funding History

FY 2007	$20,662,000
FY 2008	$23,162,000
FY 2009	$25,781,000
FY 2010	$26,131,000
FY 2011	$26,131,000

Budget Request

The FY 2012 budget request is $31,425,000, an increase of $5,294,000 over the FY 2010 Appropriation level. This request will allow ASFR to maintain its responsibilities associated with: improving financial management; 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. It would also allow the full-year implementation of the program integrity initiative, funded partially through other GDM resources in FY 2010 and FY 2011. It would also support the budget formulation and execution of the new funding and functions related to Health Reform, which were financed through other one-time sources in FY 2010 and FY 2011.

As part of HHS' efforts to support risk mitigation efforts for ongoing HHS activities, these resources will also help ASFR keep pace with the increased demands that have been placed upon it by the growth in HHS programs, 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, as requested in the FY2011 Budget.

Office of Budget (OB)

In FY 2012, 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 of Budget 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 of Budget 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 address increased workload requirements and responsibilities, as well as increasing requirements related to the Administration's priorities to employ rigorous standards of accountability and transparency throughout the Federal government.

Office of Recovery Act Coordination (ORAC)

In FY 2012, ORAC will continue its principal functions: coordinating program implementation; measuring program performance; ensuring compliance with Sec. 1512 recipient reporting

requirements and improving data quality; monitoring and evaluating agency risk management activities; informing the public about the accomplishments and benefits of Recovery Act programs; and collaborating with the Vice President's Recovery Implementation Office, OMB, and other Federal Agencies on Recovery Act policy and program implementation.

In this phase of Recovery Act implementation, ORAC will lead HHS efforts to monitor the implementation of $23 billion in Medicare and Medicaid incentive payments for the adoption and meaningful use of health information technology by hospitals and eligible health care providers. CMS and the Office of the National Coordinator will coordinate implementation of this program beginning in FY 2011. In addition, ORAC will continue oversight of the $22 billion in discretionary program funds awarded in the first two years of the Recovery Act to over 21,000 grantees and contractors.

Office of Finance (OF)

In FY 2012, OF will provide continued support for financial management and reporting needs under the management initiatives for Improving Financial Management and Eliminating Improper Payments across the Department with specific efforts to continue to resolve outstanding financial statement audit findings. The request will also sustain management's Department-wide process for assessing controls across HHS. The FY2012 request also continues to support OF's role as HHS' central audit liaison, and enables OF to participate as key members of Recovery Act and Healthcare Reform implementation and execution teams as subject matter experts. 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. Additionally, OF will lead the efforts of the CFO Community to maximize the UFMS' technical capabilities and utilize its financial information for decision-making.

The FY 2012 request also supports the continued implementation of the Secretary's Program Integrity (PI) Initiative. The PI Initiative seeks to ensure that every program and office in HHS prioritizes the identification of systemic vulnerabilities and opportunities for waste and abuse, and implements heightened oversight. HHS has created a first-time ever Secretary's Council on Program Integrity to oversee this Initiative. The Council on Program Integrity is looking at all areas within the Department, from Medicare and Medicaid, to Head Start and LIHEAP, to medical research and public health grants, to conduct risk assessments of programs or operations most vulnerable to waste, fraud, or abuse; enhance existing program integrity initiatives or create new ones; share best program integrity practices throughout HHS; and measure the results of our efforts. We will also work closely with the Office of Inspector General and other stakeholders to leverage our collective experience and success. Funding will enable the work of the PI Initiative to continue.

The Office of Grants and Acquisition Policy and Accountability (OGAPA)

The *Division of Acquisition* and *Division of Grants* will continue to: (a) standardize and modernize HHS' acquisition and grants administration policies, processes, and systems; (b) enhance their oversight, accountability, program integrity, and knowledge management roles; and (c) continue to contribute expertise in the development of government-wide acquisition and grant administration and management policies, standards, and systems. The *Division of Acquisition* will work with the Department's contracting offices to: increase the use of full and open competition; reduce the use of high-risk contracts; increase the use of performance-based

contracts; issue critical HHS-wide acquisition policies; expand its acquisition training and certification programs to include intern and rotation initiatives; ensure HHS-wide training of program and acquisition staff regarding adherence to appropriations law; implement new government-wide efforts (e.g., prepare service contract inventories, rebalance the multi-sector workforce, ensure optimum use of the Federal Awardee Performance & Integrity Information System). The *Division of Grants* will work with the Department's grant management officials to: provide training and technical assistance related to grant administration; and support the intensified grant and sub-award reporting requirements required by statute and regulation. The *Office of Small and Disadvantaged Business Utilization* (OSDBU) will continue to increase HHS' use of mechanisms, programs and training initiatives that maximize opportunities for small businesses. OSDBU will continue to expand the HHS Mentor Protégé Program; providing a greater avenue for small businesses to achieve entrepreneurial success while supporting the programmatic needs of the Department. Current training initiatives will be enhanced to reach out to Minority Institutions of Higher Education and associated small businesses in order to provide training on preparing and submitting government contract proposals and improve their ability to be responsive to HHS' solicitations.

ASSISTANT SECRETARY FOR LEGISLATION

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	3,204	3,204	4,912	1,708
FTE	23	25	34	11

Authorizing Legislation:

FY 2012 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 2007	$3,187,000
FY 2008	$3,379,000
FY 2009	$3,430,000
FY 2010	$3,204,000
FY 2011	$3,204,000

Budget Request

The FY 2012 request for ASL is $4,912,000, an increase of $1,708,000 over the FY 2010 Appropriation. The request 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 and the Older Americans Act. Increased activity and congressional inquiries are expected related to Health Reform as a result of the review and implementation of the legislation.

In FY 2012, 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 request for ASL will support facilitating increased communication between the Department and Congress. This requires continued work on several mission critical areas with Members of Congress, Congressional Committees and staff including: managing the Senate confirmation process for Department nominees; preparing witnesses and testimony for Congressional hearings; 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 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	4,829	4,829	19,922	15,093
FTE	25	24	46	21

Authorizing Legislation:
FY 2012 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 counsel in the HHS policymaking process.
- Acting as the central HHS press office handling media requests; clearing all press releases and interviews; and managing news issues that cut across Agencies; producing electronic clips for the Secretary and the Department; and distributing a Department-wide report on each day's media affairs.
- Managing and maintaining the content of the HHS web site and several Departmental and governmental cross-agency websites such as healthcare.gov, flu.gov, foodsafety.gov, stopmedicarefraud.gov, and AIDS.gov.
- Developing protocols and strategies to expand Departmental utilization of new media and the web.
- Overseeing and producing special events that highlight top Departmental officials.
- 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.

- Producing 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, features, articles, and stories for the media.
- Maintaining HHS FOIA/Privacy Act operations and activities.

Funding History

FY 2007	$4,008,000
FY 2008	$4,453,000
FY 2009	$4,432,000
FY 2010	$4,829,000
FY 2011	$4,829,000

Budget Request

The FY 2012 budget request for ASPA is $19,922,000, an increase of $15,093,000 over the FY 2010 Enacted Appropriation.

$14,608,000 will be utilized to continue work on HealthCare.gov and to conduct an educational outreach campaign designed to help Americans understand and access their benefits and information under the law. These efforts were funded in FY 2010 and FY 2011 in the Affordable Care Act (ACA).
The FY 2012 budget request for ASPA will also be used to conduct Department-wide public affairs programs; support the rollout of new programs and legislation; increase consumer access and information; enhance transparency and accountability; synchronize Departmental policy and activities with communications; oversee the planning, management and execution of communication activities throughout HHS; and administer Open Government programs, the Freedom of Information Act (FOIA), and Privacy Act programs on behalf of the Department.

ASPA leverages all methods of mass communication, including vulnerable populations outreach, stakeholder outreach, audience research, and message and materials development 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. ASPA will use the FY 2012 funds to provide citizens with the critical information they need, in the most transparent and accessible manner possible, 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 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	38,692	38,692	43,531	4,839
FTE	354	321	329	-25

Authorizing Legislation:
FY 2012 Authorization……..……..……Indefinite
Allocation Method……..……..…Direct Federal

Program Description and Accomplishments

The Office of the General Counsel (OGC) supports the development and implementation of the Department's programs by providing legal services to the Secretary of HHS, the Operating Divisions (OPDIVs), and the Staff Divisions (STAFFDIVs). OGC lawyers review proposed legislation and 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.

OGC lawyers are heavily involved in litigation before administrative bodies and the federal courts. OGC attorneys independently represent the Secretary in proceedings before administrative bodies such as the Departmental Appeals Board (DAB). In cases before federal courts, OGC works closely with the Department of Justice (DOJ) and offices of United States Attorneys to provide necessary representation.

OGC's litigation caseload has increased dramatically in recent years and that trend is expected to continue. OGC's long-term goal is to continue to consistently provide effective and efficient legal support to the Department. The measures of performance toward this goal are in the quantity of work, timeliness, accuracy, and clarity of the legal support provided to the Office of the Secretary and program client operations and initiatives.

Funding History

FY 2007	$37,347,000
FY 2008	$36,617,000
FY 2009	$37,581,000
FY 2010	$38,692,000
FY 2011	$38,692,000

Budget Request

The FY 2012 budget request is for $43,531,000, an increase of $4,839,000 over the comparable FY 2010 Appropriation. This additional funding will annualize staff brought on via the Health Insurance Reform Implementation Funding provided in ACA. OGC will provide substantive and extensive legal advice and litigation support. The majority of the request is for FTE (salaries and benefits of federal employees).

OGC's goal is to support the strategic goals of the Office of the Secretary and the Department by providing high quality legal services, including sound and timely legal advice and counsel. The budget request for OGC will be used to continue to effectively manage the legal challenges and provide support for the Secretary and Department's initiatives and programs. In addition to the activities financed through the General Departmental Management appropriation, the Office of the General Counsel also provides reimbursable services to HHS components.

In FY 2012, OGC will continue to focus on supporting the Department's highest priorities. Select OGC initiatives and programs are outlined below:

Medicare & Medicaid Services

- *Consumer Choice and Access to Quality Services for Medicare Beneficiaries.* Assist CMS efforts to expand health care coverage options available through the Medicare Advantage program, and continue to address numerous legal issues involving Medicare Advantage Private Fee-for-Service plans.
- *Financial Integrity of Medicare and Medicaid Programs.* Continue to advise Centers for Medicare and Medicaid Services (CMS) with respect to payment system changes, anti-fraud initiatives, and financial integrity of the Medicare and Medicaid programs. Specifically, OGC will work closely with the Health Care Fraud Prevention and Enforcement Action Team (HEAT) members to combat and prevent fraud, waste, and abuse in the Medicare and Medicaid programs. OGC will work to assist the Department of Justice in prosecuting those seeking to defraud the Medicare and Medicaid programs and defending any federal court challenges that are brought as a result of this initiative. OGC will also work with CMS as the recovery audit contractors (RACs) identify Medicare overpayments, including defending these overpayment determinations that are reviewed in federal court.
- *Medicare Advantage and the Part D Benefit.* Medicare Part D benefit and the Medicare Advantage program will continue to generate a significant amount of litigation challenging various aspects of these programs and will generate new litigation as CMS' enforcement/compliance initiatives against these entities increases.
- *Children's Health Insurance Program (CHIP) Reauthorization Act of 2009.* OGC has provided considerable advice to CMS in its development of initial interpretive guidance and will need to provide a substantial amount of advice and guidance as CMS moves to rulemaking to implement significant expansions in CHIP and Medicaid, which will result in expanded coverage of children and pregnant women, as well as increased enrolment of current populations.
- *Medicare Secondary Payer (MSP) Provisions.* Leads efforts to recover conditional payments made under MSP provisions. This work takes place in many individual and some class action cases filed nationwide. OGC has worked closely with CMS to craft innovative MSP settlements in major products liability cases.

Children, Families, and Aging

- *Improving Head Start Grantee Performance.* Assist Administration for Children and Families (ACF) in implementing changes to the Head Start Act resulting from legislation reauthorizing the program which was enacted in December 2007. OGC is also assisting with American Recovery and Reinvestment Act (ARRA) legislation which doubled the size of the Early Head Start program and added the largest increase in funding ever made

to the Head Start Program. Final regulations are expected to be issued in FY 2011 and OGC will assist ACF in their development and clearance.

Ethics

- *Ethics Redesign Initiative.* Administer the Department's ethics program including public and confidential financial disclosure systems. OGC will focus on completion of ongoing program reviews and implementing enforcement and compliance systems, and reinitiate audits after an appropriate interval to measure improvement.

General Law

- *Employment and Labor Legal Activities.* OGC attorneys defend management decisions with respect to employee misconduct, poor performance or claims of unlawful discrimination before various arbitrators, the Merit Systems Protection Board (MSPB), the Equal Employment Opportunity Commission (EEOC), and the Federal Labor Relations Authority (FLRA), and assist DOJ with employment and labor litigation. OGC attorneys also advise management regarding civil service regulations, labor relations and assist in negotiating collective bargaining agreements.
- *TANF Reauthorization.* Assist ACF in answering multiple questions concerning reauthorization of the TANF program in 2010 including providing extensive advice concerning public outreach and Federal Advisory Committee Act (FACA) issues.
- *Oversight of Biomedical and Behavioral Research and Research Misconduct.* Assist the Office for Human Research Protections (OHRP) and the Office of Research Integrity (ORI) in their oversight of HHS-conducted or supported biomedical and behavioral research and research misconduct. OGC also assists NIH in carrying out its own intramural programs to ensure research integrity and appropriate human subject protection in research.
- *Physician Quality Reporting Initiative.* Counsel CMS in the implementation and expansion of the Physician Quality Reporting Initiative (PQRI).
- *President's Health Centers Initiative, and Tort Claims and Tort Litigation.* OGC has issued legal opinions about tort coverage to various clients and has provided assistance to IHS and HRSA in the area of "risk management" activities designed to prevent, respond to, or minimize the effects of any alleged medical malpractice in federally funded facilities. OGC projects a significant growth in tort claims and tort litigation, especially regarding claims arising from the expansion in the number of HRSA-funded Community Health Centers.
- *William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008.* Work closely with ACF in interpreting provisions of this legislation which reauthorizes the Trafficking Victims Protection program and also transfers new responsibilities for the care and custody of Unaccompanied Alien Children who may be victims of Trafficking from DHS to HHS.
- *Health Information Technology*. Work with CMS on transparency initiatives; work with CMS on the rules effectuating the e-prescribing provisions for the Part D program under the Medicare Modernization Act (MMA); work with Office of the National Coordinator (ONC) on the development of the Nationwide Health Information Network; work with IHS on data-sharing agreements for tribally-operated epidemiology centers; and work with OCR and other Department components to address privacy and security issues.

Health Reform

- *Medicare and Medicaid.* Defend CMS in potential actions related to Medicare payment policies and/or to final agency actions applying those new provisions. Because the legislation contains numerous provisions designed to enhance the financial integrity of the Medicare and Medicaid programs, we expect CMS to undertake comprehensive rulemaking addressing these issues and we will advise CMS in conjunction with that rulemaking.
- *Inquiries.* Respond to inquiries pertaining to agency organization and delegations of authority, rulemaking, and various provisions of the new legislation. Respond to administrative law issues requiring involvement of OGC managers in the areas of grants and procurement. Provide legal advice related to the Federal Security Management Act (FISMA), the Privacy Act, computer matching, and the Freedom of Information Act (FOIA).
- *Legal Advice.* Provide legal assistance pertaining to agency organization and delegations of authority, rulemaking, and other Administrative Procedure Act issues, FACA, and various provisions of the new legislation. Provide legal advice and guidance to the Office of Health Insurance (OHI) as it maintains and refines operations. Provide legal advice with respect to the implementation of all Title I provisions. Provide advice and review rules and guidance documents related to all provisions of PPACA.

Public Health

- *Public Health Emergency Preparedness.* Legal preparedness activities, including advising HHS officials on HHS legal authorities and ability to support state, local and tribal officials in public health emergencies (e.g., quarantine, public health emergency declarations, distribution of medical countermeasures, licensing and liability of health care providers, deployment of HHS personnel, and surge capacity).
- *Pandemic Influenza Preparedness and Response.* Advise relevant HHS agencies in pandemic preparedness and response, including for the current H1N1 influenza pandemic, on issues such as countermeasure procurement, distribution and dispensing, vaccine development and distribution, medical surge capacity, international cooperation, liability protections, injury compensation, emergency declarations, emergency authorization of investigational products, and surveillance.
- *Indian Health Care Improvement Act Reauthorization.* Assist Assistant Secretary for Legislation (ASL) and Indian Health Service (IHS) in providing technical assistance to the Congress (including legislative drafting assistance) on Congressional bills to update IHS program authorities to respond to changing health care needs of the American Indian/Alaska Native population.
- *Indian Self-Determination Act.* OGC reviews hundreds of proposed contracts under this Act, which transfer over $2 billion on an annual basis to nearly 300 tribes through these agreements. OGC reviews tribal proposals, advises the federal negotiation team, and ensures agreements are within the agency's statutory authority. OGC also defends IHS in federal and administrative actions challenging Indian Self-Determination Act contracts.
- *Global and Domestic HIV/AIDS and Emerging Infections Programs.* Advise both CDC and HRSA on the numerous legal issues associated with HHS's expanding international programs including those focused on emerging infections and those focused on HIV/AIDS and tuberculosis. OGC will work with key personnel implementing the reauthorization of the Ryan White Comprehensive AIDS Resources Emergency (CARE)

Act. In addition, OGC will work with the Department of State to provide advice on the development of bilateral agreements with host countries.

- *Strategic National Stockpile.* Advise regarding a number of significant issues involving the purchase, stockpiling, and deployment of vital vaccines, drugs, and other medical supplies, including negotiation of deployment agreements, and the management and contracts administration of current and new contracts.
- *The Pandemic and All-Hazards Preparedness Act (PAHPA), P.L. 190-417.* Advise Assistant Secretary for Preparedness and Response (ASPR) on a myriad of issues regarding the return of the National Disaster Medical System (NDMS) to HHS, employment issues, licensing and credentialing issues, use of Federal property when NDMS teams have not been activated by the Federal government and storage of pharmaceuticals and other equipment.
- *Patient Safety and Quality Improvement Act of 2005 (Medical Malpractice).* Continue to advise and assist AHRQ, OCR, and HHS clients in connection with drafting of regulations and other tasks connected with implementation of the recently enacted patient safety legislation, designed to encourage reporting of medical errors in order to facilitate correction of systemic problems, by ensuring that such reports cannot be used in adversarial proceedings.

DEPARTMENTAL APPEALS BOARD

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	10,549	10,549	13,343	2,794
FTE	69	69	81	12

Authorizing Legislation:
FY 2012Authorization…….....…….……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 2010, the Board/Appellate Division closed 113 cases (71 by decision). In FY 2010, 86% of Board decisions had a case age of six months or less, meeting the target for Objective 1, which measures the percentage of total Board decisions issued in cases with a net age of six months or less. Objective 2 for the Appellate Division measures the number of Board decisions reversed or remanded in Federal court, as a percentage of all Board decisions.

In FY 2010, the Board continued to meet this Objective which requires that no more than 2% of total decisions be overturned by Federal court.

Despite an increase in the number of appeals filed in FY 2011, the Board will meet Objective 1. Also, the Board will issue more decisions in FY 2011 than FY 2010. For FY 2011, the Appellate Division changed Objective 2. This is because court decisions are usually issued more than a year after the Board decision has been appealed, so the performance standard is not an accurate measure of current performance. The Appellate Division instead measured the percentage of Board decisions with regulatory deadlines for issuing decisions in which the deadline was met. In FY 2012, Appellate will hire five new staff to handle projected new Affordable Care Act (ACA) workload.

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).

Performance Analysis: CRD received 1,014 new appeals in FY 2010 (30% more than in FY 2009) and closed 1,109 appeals. Despite the tremendous increase in cases, CRD met its FY 2010 targets for Objective 3 and 4. Objective 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 2010 was 100%. Objective 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 year that had been received in prior years. By the end of FY 2010, CRD had only 34 cases that were open in previous fiscal years.

In FY 2010, CRD noted a significant increase in the number of appeals filed under 42 C.F.R. Part 498 by providers and suppliers whose enrollment, reenrollment, or revalidation application for Medicare billing privileges were denied or revoked. The increase was due to amendments that changed previous regulations for physician and non-physician organizations and individual practitioners with respect to effective date of Medicare billing privileges. These provider/supplier enrollment cases increased CRD's workload by the 30% percent noted above. In addition,

heightened enforcement and oversight efforts by DHHS OIG, CMS, and the DHHS Office for Civil Rights (OCR) have resulted in additional new appeals.

CRD has been able to handle this increasing workload by creating a team specifically devoted to the provider/supplier enrollment cases. The Chair detailed a Board Member and Appellate Division senior attorney to lead this initiative. In addition, CRD hired two two-year term attorneys to work exclusively on these cases. In FY 2011, CRD plans to hire an ALJ to lead the team and two one-year term attorneys to work on the team and in FY 2012 will hire five new staff members to handle projected new ACA cases.

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. At its current staffing and workload levels, MOD has successfully managed its caseload within this timeframe and will continue to do so for FY 2011 and 2012.

Performance analysis: In FY 2010, MOD exceeded its FY 2010 target for Objective 6 to constrain the growth in case age by reducing the average time to complete action on Medicare Part B cases to 155 days (as measured from the date MOD received the case folder). For FY 2009, MOD took an average of 147 days to complete action on Medicare Part B cases and reduced this to 132 days in FY 2010. In FY 2010, MOD issued the majority of cases prior to the 90-day deadline. MOD should continue to meet its Objective 6 targets in FY 2011 and FY 2012.

In FY 2010, MOD did not meet its target for Objective 7 of issuing 2,350 dispositions (instead issuing 1,834 dispositions). MOD had fewer dispositions than projected, because it did not receive as many cases as projected from data received from other agencies and because of the changing nature of the overall workload. A significant portion of the casework has become increasingly complex, involving larger overpayment and statistical sampling cases, which generally feature multiple volumes/boxes of beneficiary files and medical records. In addition, the loss of two experienced and highly productive legal analysts during FY 2010 contributed to the shortfall. MOD also had to devote significantly more resources to preparing certified court records for Federal district courts. While the percentage of cases appealed to Federal court has not increased, the overall size (number of beneficiaries/documents submitted) and complexity of the cases has resulted in creating an additional full-time area of responsibility for our paralegal staff. This trend will continue into FY 2011 and FY 2012. MOD anticipates that appeals

originating from overpayments that the Recovery Audit Contractor (RAC) identifies will be particularly burdensome since the cases typically involve thousands of pages. In FY 2011 and FY 2012, DAB will hire new staff for this work, and in FY 2012 DAB will hire five additional staff members for projected new ACA cases. The increase in the FY 2012 target for closed cases (performance measure #7) is attributable to projected ACA workload and resources.

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 Department's 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 2010, the ADR Division met its performance Objective 5.1 and 5.2 by conducting 15 conflict resolution seminars and providing ADR services in 80 DHHS cases. In FY 2010, the ADR Division successfully undertook several initiatives, including: co-sponsoring a Department-wide ADR Forum designed to promote the use of ADR in EEO cases; supplementing a small ADR staff with two unpaid law school interns; and developing a new course ("Conflict Management for FOIA professionals") to support goals of President Obama's Directive on Transparency and Open Government. In FY 2011and FY 2012, the ADR Division will meet its performance goals and will undertake various new initiatives, including: supporting DHHS efforts to implement new Executive Order 13522 on Labor Management Relations by facilitating the formation of labor-management councils, by being available to provide training to labor–management councils in interest-based negotiation and by facilitating labor-management

council meetings; and promoting increased use of video conferencing for mediation in DAB cases to save travel costs.

Funding History

FY 2007	$9,600,000
FY 2008	$9,641,000
FY 2009	$9,981,000
FY 2010	$10,549,000
FY 2011	$10,549,000

Budget Request

DAB's FY 2012 request is $13,343,000, an increase of $2,794,000 over the comparable FY 2010 Appropriation. In FY 2010, DAB began receiving additional work generated by the ACA. The ACA established new or expanded already existing, administrative appeals and other conflict resolution procedures, including hearings on the record and final administrative decisions. Resources will be used for cases expected under numerous new ACA provisions, including Reinsurance of Early Retirees, which requires new appeals processes for claims employment-based plans. Additional staff will include: (1) an Administrative Judge (2) ten attorneys to provide legal support to judges; (3) two paralegal specialists to provide case processing, case management and scheduling, and preparing final administrative records in appeals to Federal court; and (3) two legal assistants to provide case docketing, filing and copying, records management and travel support to judges and attorneys.

The funding request for DAB is fully justified by the increasing Medicare and other caseloads (including new ACA cases), caseload statistics for each Division (see below), increased personnel and other costs (such as IT costs and rent), 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.

Board Members – Appellate Division

Chart A shows total historical and projected caseload data for this Division. FY 2010 data is extrapolated from actual case receipts to date and FY 2011 and 2012 data is based on certain assumptions, including:

- Increases in appeals from CRD ALJ decisions in FY 2011 due to increases in number of such decisions, including some with regulatory deadlines for Board review;
- Higher levels of appeals in discretionary grant cases due to increased number of grants awarded with stimulus funds; and
- New ACA caseload.

Chart A
APPELLATE DIVISION CASES

	FY 2010	FY 2011	FY 2012
Open/start of FY	65	65	80
Received	108	145	165
Decisions	71	80	105
Total Closed	113	130	155
Open/end o FY	65	80	90

Administrative Law Judges – Civil Remedies Division

Chart B shows total historical and projected caseload data for this Division. FY 2010 data is extrapolated from actual case receipts to date and FY 2011 and 2012 data is based on certain assumptions, including:

- A continued upward trend in certain case types, due to heightened enforcement and oversight efforts by DHHS OIG, CMS, and OCR (including increased receipts of provider/supplier enrollment appeals); and
- New ACA caseload.

Chart B
CIVIL REMEDIES DIVISION CASES

	FY 2010	FY 2011	FY 2012
Open/start of FY	391	296	346
Received	1014	1000	1200
Decisions	190	192	156
Total Closed	1109	950	909
Open/end of FY	296	346	637

Medicare Appeals Council – Medicare Operations Division

Chart C contains case data for this Division, based on actual numbers for FY 2010 and trends in case receipts at lower levels of appeals. 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 2011 and FY 2012, as OMHA's disposition rate increases (including increases in appeals originating with Recovery Audit Contractors); and
- New ACA caseload.

Chart C
MEDICARE OPERATIONS DIVISION CASES

	FY 2010	FY 2011	FY 2012
Open/start of FY	707	835	835
Received	1962	2,100	2,500
Cases Closed(claims closed)	1,834 (22,815 claims)	2,100 (24,000 claims)	2,500 (26,000 claims)
Open/end of FY	835	835	835

Alternative Dispute Resolution Division

In FY 2011 and FY 2012, 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 whenever appropriate in disputes involving DHHS;
- 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 and encouraging video conferencing of mediations that would otherwise require travel costs; and
- 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; and
- Support new Executive Order 13522 on Labor Management Relations, by facilitating the formation and operation of DHHS labor-management councils.

Outcome and Outputs Table

Measure	Most Recent Result (2010)	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
1.1: Percentage of Board decisions with net case age of six months or less.	86%	86%	86%	Maintain
2.1: Number of Board decisions reversed or remanded on appeals to Federal court as a percentage of all Board decisions issued.	2%	2%	N/A	N/A

The Appellate Division proposes the following revision to Objective 2.1

2.1: Percentage of Board decisions meeting applicable statutory and regulatory deadlines for issuance of decisions.	Revised in FY 2010	0%	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%	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%	100%	100%	Maintain
3.3: Percentage of decisions issued with 180 days of filing of provider or supplier enrollment appeal.	100%	100%	100%	Maintain
4.1: Number of cases open at end of Fiscal Year that was opened in previous Fiscal Years.	≥2009	≥2009	≥2011	Maintain
5.1: Number of conflict resolution seminars conducted for HHS employees.	15 Sessions	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.	75	75	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	155 days	155 days	Maintain
7.1: Number of dispositions.	1,834	2,350	2,500	400
Appropriated Amount ($ Million)	**$10.549**	**$10.549**	**$13.343**	**Maintain**

OFFICE ON DISABILITY

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	864	864	1,370	506
FTE	5	7	8	3

Authorizing Legislation:
FY 2012 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 discretionary 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 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.

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.

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 programs cost.

Funding History

FY 2007	$739,000
FY 2008	$779,000
FY 2009	$805,000
FY 2010	$864,399
FY 2011	$864,399

Budget Request

The Office on Disability's FY 2012 budget request figure is $1,370,000 an increase of $506,000

over the comparable FY 2010 Appropriation. This increase supports the annualized salary of additional FTEs and related expenses. The budget request 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 HEALTH AFFAIRS

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	6,350	6,350	8,602	2,252
FTE	22	24	28	6

Authorizing Legislation:
FY 2012 Authorization……..……..……Indefinite
Allocation Method…….…….…….Direct Federal

Program Description and Accomplishments

The Office of Global Health Affairs (OGHA) provides advice and counsel to the Secretary on global health policy, planning, and programming. OGHA coordinates global health and human services policies within the Department and represents HHS to other federal agencies, foreign governments, international organizations, non-governmental organizations and the private sector. OGHA is the department's principal proponent on matters affecting Presidential and Secretarial global health initiatives, providing policy and staffing support to HHS.

Various funded projects include:

- Health Diplomacy Training to support the development of the Health Workforce in West Africa, Latin America, Panama and the Caribbean.
- Strengthening National Immunization Programs and Regional Networks in the Latin America and Caribbean region
- Contributing to the Office of Force Readiness and Deployment (OFRD)/USPHS Commissioned Corps
- Establishing best practices for Global Health Diplomacy through the inclusion of women in health training programs in Muslim areas; providing cost effective virtual versus on-site training of health care workers; and comparing one-dimensional versus multi-dimensional approaches to health issues
- Evaluating methodology and results subject to peer review
- Ensuring evaluations will feed back into health systems and facilitate data use at country-level and regional execution

Initiatives

The **Global Health Diplomacy (GHD) Program** was first funded in FY 2009, with the goal of improving health care in underserved areas while helping to create and improve bridges between the United States and other countries. The GHD Program achieves this by engaging bilaterally and regionally to strengthen health systems and health-care infrastructure, thereby improving the prevention, detection and treatment of diseases of public health importance.

Implementation planning has been based upon the World Health Organization (WHO)'s Health Systems Strengthening (HSS) building blocks, including service delivery; health workforce strengthening; medical products, vaccines and technologies; and health information systems. Activities are developed based on needs assessments and coordination with other existing programs. Results-based evaluation methods, an integral component of the activities, are used to

assess the Program's impact. Specific projects are designed with the objectives of establishing best practices which can be expanded to other areas of need.

Global Health Program Coordination Initiative allows for more coordinated HHS efforts ensuring the President's and Secretary's global health programs are seamlessly supported through de-conflicting, and appropriate prioritizing. Currently, five agencies of the HHS, Food & Drug Administration (FDA), Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), National Institutes of Health (NIH), and Substance Abuse and Mental Health Services Administration (SAMHSA) have significant overseas activities operating independently.

Global Health Regional Coordination Initiative monitors, consolidates, and integrates the multiple HHS centers of excellence engaged in global health and infectious disease monitoring. The initiative will *not* be an operations, watch, or collection center; rather it will consolidate the vital data into a single, coordinated, and digestible format enabling senior decision-makers in HHS and other Executive Departments to respond to emerging threats with appropriate courses of action. This initiative will also allow for the exchange of information among other Executive Departments, specifically, State, Agriculture, and Homeland Security. Moreover, the initiative will allow for a single point-of-entry by other agencies and departments of the federal government enabling them to ask for and acquire vital information.

Global Policy and Strategy Initiative similar to the Global Health Program Coordination Initiative, which focuses on the present and near-term, the Global Policy and Strategy Initiative will focus on the longer-term, out-year budget development, coherent policy focus, and resource management. This will allow the Secretary to have an independent voice providing counsel for out-year budget development and submission.

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 USMBHC facilitates identification of public health issues of mutual significance; supports studies and research on border health; and, brings together effective federal, state and local public/private resources by forming dynamic partnerships and alliances to improve the health of the border populations through creative, multi-sectoral approaches. The Office of Global Health 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 annual initiatives around critical border health priorities that for 2011 that will focus on tuberculosis, obesity and diabetes and infectious disease as impacted by public health emergencies; (2) leads the development of a comprehensive border health research agenda that will inform policy makers, researchers and entities which fund research where research gaps, needs and opportunities lay; (3) hosts the annual National Infant Immunization Week/Vaccination Week of the Americas (NIIW/VWA) that promotes the benefits of infant immunization in a regional and binational approach unmatched by any region anywhere in either country and the annual Border Binational Health Week events along the entire U.S.-México border, which bring together local communities for health screenings, health education interventions and other unique training and education forums. In FY 2010 for Border Binational Health Week, the USMBHC helped to host 130 events along both sides of the border, engaging over 160 partners, and providing over 32,000 free health screenings and educational opportunities

to U.S. and México border residents (U.S. side nearly 16,000 and México side nearly 17,000), reflecting a composite of various resources (including financial and in-kind support) from federal, State, local and community stakeholders.

In Fiscal Year 2011, 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. In FY 2010, the Commission published the following key reports and white papers:

1. The first-ever report on *Health Status in the U.S.-Mexico Border Region*
2. White paper on *U.S.-Mexico Children's Health Issues*
3. White paper on *U.S.-Mexico Border Health Research Agenda*

USMBHC OUTPUTS AND OUTCOMES TABLE

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
1.1: Reduce the percent of indirect spending on border health activities (Efficiency)	FY 2010: 3.6% (Target Exceeded)	6%	6%	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%	50%	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	8	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	4.2	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)	24.2	23.7	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	13,000	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%	100%	Maintain
Program Level Funding ($ in millions)	N/A			

Funding History

FY 2007	$3,763,000
FY 2008	$3,951,000
FY 2009	$6,451,000
FY 2010	$6,350,000
FY 2011	$6,350,000

Budget Request

The FY 2012 request for the Office of Global Health Affairs (OGHA) $8,602,000 is an increase of $2,252,000 over the comparable FY 2010 Appropriation. HHS and its agencies devote more than $3 billion annually to global health efforts. As the Secretary's central coordinator for HHS's wide range of activities, OGHA's request for a $2,252,000 increase 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.

Funds allow for incremental staffing of the Global Strategy and Policy Initiative, which will allow HHS/OGHA to take the lead in defining and addressing critical policy issues (biosecurity, emerging threats, trade and health) and in conducting bilateral and multilateral negotiations to further the U.S. position on these issues. It will also allow full development of the Global Health Program Coordination initiative, which will enable a thorough alignment and rationalization of HHS activities in furthering a policy-driven whole-of-government approach.

OGHA will also fully staff and lead the key thematic areas within Strategy and Policy, and deploy and support up to three new critical health attaches: one to Brazil which is increasingly at the center of priority diplomatic issues relating to intellectual property protection, food and drug safety, and international cooperation; a second to Southeast Asia, which is the epicenter of emerging concerns related to pandemic disease and to emerging biotechnologies; and a third to Brussels/EU for tighter global health coordination on critical issues. This expanded range of bilateral and multilateral engagements with Health Ministries around the world is at the heart of the broadened Global Health Diplomacy Initiative.

The foundation for the formulation of this request was based on the recommendations from an internal HHS Stakeholder Study conducted in 2010. OGHA's mission vibrancy and agility is strained by the recent speed with which influenza, pandemic, and infectious disease issues have evolved as well as the associated Presidential and Secretarial policy responses. For example, OGHA has as its primary mission; to support the HHS Secretary on global issues. This requires more proactive and comprehensive utilization of the HHS Secretary to further US global health objectives. OGHA must be invigorated to ensure its competencies, capabilities, and the President's and Secretary's global initiatives are attained.

The Stakeholder Study defined, clarified, and articulated OGHA's valid needs. The organizations represented in the HHS Stakeholder Study included: Operating/Staff Division (OP/STAFFDIV) heads and senior global health staff members throughout HHS as well as the U.S. Department of State (DOS), including the Office of the U.S. Global AIDS Coordinator (OGAC) and the Bureau of International Organizations, and the National Security Council (NSC).

Quoting from the Stakeholder Study:

> "OGHA is operating in a time of remarkable new activity in global health, does critical work for HHS and its Agencies, and has many capable and committed staff members. Its effective functioning is vital to the expanded and meaningful presence and impact of HHS and its OP/STAFFDIVS in the global arena and USG interagency process.

Policy development and coordination constitute a particularly large percentage of the OGHA work-load. OGHA also plays a key role representing the USG, HHS Secretary and HHS OP/STAFFDIVS with domestic and international agencies, organizations, and foreign governments. This representation involves communicating official positions and negotiating agreements with other parties on behalf of HHS and/or USG. [As currently staffed and structured, OGHA cannot meet] the substantial workload of critical policy issues, along with high-level representational duties, and diplomatic and negotiating tasks for the Secretary and HHS."

OFFICE OF INTERGOVERNMENTAL AFFAIRS

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	7,049	7,049	10,538	3,489
FTE	28	34	45	17

Authorizing Legislation:
FY 2012 Authorization……..…Indefinite
Allocation Method…….……...……..Direct Federal

Program Description and Accomplishment

The Office of Intergovernmental Affairs (I GA) serves the Secretary as the primary link between the U.S. Department of Health and Human Services (HHS) and state, local, and tribal governments. The mission of IGA is to facilitate communication regarding HHS initiatives as they relate to state, local, and tribal governments. IGA serves the dual role of representing the state and tribal perspective in the federal policymaking process as well as clarifying the federal perspective to state, and tribal representatives.

The IGA is composed of a headquarters team that works on policy matters within HHS Operating Divisions and serves as liaison with state and local governments and related public policy groups. In addition to the Headquarters team, IGA has ten regional offices which include the Secretary's Regional Directors, Executive Officer, and an IGA Specialist who is responsible for public affairs and media activities. Within the IGA Office of Tribal Affairs, IGA 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.

IGA 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 IGA 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.
  - 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.
- 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.

IGA 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. IGA provides Departmental leadership in the field in several areas, including all top Secretarial priorities and initiatives. IGA 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. IGA 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 2007	$5,762,000
FY 2008	$5,978,000
FY 2009	$6,244,000
FY 2010	$7,049,000
FY 2011	$7,049,000

Budget Request

The FY 2012 budget request for IGA is $10,538,000, an increase of $3,489,000 over the FY 2010 Enacted Appropriation. This supports annualized staffing of regional offices that had previously had vacant positions.

IGA has been tasked with increased responsibility for coordination and communication activities with state, local, tribal and territorial governments related to understanding health reform. IGA'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. The enhanced mission and scope of IGA requires additional staff to carry-out the responsibilities of improving efficiency, effectiveness and productivity of external outreach including the launch of the Department's first ever external outreach program at the regional level designed to address health reform in addition to all policy and program areas within the Department.

IGA 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. IGA will develop a process to map major stakeholder groups and develop strategies to effectively reach and engage them.

OFFICE OF EXTERNAL AFFAIRS

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	0	0	1,200	1,200
FTE	0	0	5	5

Authorizing Legislation:
FY 2012 Authorization……..……..…Indefinite
Allocation Method……..……Direct Federal

Program Description

The Department of Health and Human Services is working to enhance communication and coordination activities with a variety of external partners such as, academia, private sector, labor unions, profit and not-for profit groups and national organizations. The Office of External Affairs (OEA) has been created to establish and support relationships and communication with non-governmental organizations, groups and private institutions. The newly established mission and scope of OEA requires staff to carry-out the full responsibilities of improving the efficiency, effectiveness and productivity of external outreach with non-governmental organizations.

OEA will also coordinate with IGA Regional staff to build more fully effective and collaborative relationships with HHS external partners. OEA staff will also 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 outreach and engagement plans. OEA staff will develop a master external communications plan encompassing non-governmental groups and organizations.

Funding History

FY 2007	$0
FY 2008	$0
FY 2009	$0
FY 2010	$0
FY 2011	$0

Budget Request

The FY 2012 budget request for the OEA is $1,200,000. This funding represents funding for the recently created office of External Affairs. While this office was originally created to field non-governmental inquiries related to the health reform initiatives, it revealed a gap in some important stakeholder communication and coordination activities that this office now fills.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH
Executive Summary

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	264,702	264,702	137,125	-127,577
FTE	320	337	319	-1

Agency Overview

The Office of the Assistant Secretary for Health (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 performs both policy and program roles. Authorized in 1995[3], OASH, headed by the Assistant Secretary for Health (ASH), is a division in the Office of the Secretary (OS). This role encompasses responsibilities as senior advisor for public health and science to the Secretary thereby providing senior professional leadership on population-based public health and clinical preventive services, directing a variety of program offices housing essential public health activities, providing senior professional leadership across HHS on White House and special Secretarial initiatives involving public health and science, and guiding and providing technical assistance to the ten Regional Health Administrators. By providing valuable coordination within and across the divisions of HHS, OASH helps HHS achieve greater success in enhancing the health and well-being of Americans.

In its authorizing regulation, the ASH, through OASH, is given as a primary function the coordination of public health and science activities across HHS components. Specifically, 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. In fulfillment of this function, OASH works closely with the various operating divisions of HHS on implementation of programs and policies at the convergence of public health and science.

OASH has outlined three priorities that are of primary focus in enhancing the health and well-being of our Nation. The three priorities include creating better systems of prevention, eliminating health disparities and achieving health equity, and making *Healthy People* come alive for all Americans.

Priority: Creating better systems of prevention

OASH/ASH is mobilizing leadership in prevention throughout HHS focusing on many Secretarial and intradepartmental initiatives. Major examples include a new Department strategic plan on

[3]"Office of the Secretary and Public Health Services: Statement of Organization, Functions, and Delegations of Authority", Federal Register, Vol. 60, No. 217. Thursday, November 9, 1995, p. 56605-56606.

Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan which outlines actions, based on scientific evidence and extensive real-world experience that will serve as a roadmap for reaching the Healthy People objective of reducing the adult smoking rate to 12 percent by 2020. This strategic action plan proposes a comprehensive approach designed to mobilize HHS's expertise and resources in support of proven, pragmatic, achievable interventions that can be aggressively implemented not only at the federal level, but also within states and communities. The activities described in the plan are meant to serve as a guideline for future development, are conditional, and are subject to the availability of resources.

Second, the ASH, along with the Secretary and the FDA Commissioner, unveiled a new comprehensive tobacco control strategy that includes proposed new bolder health warnings on cigarette packages and advertisements. Once final, these health warnings on cigarettes and in cigarette advertisements will be the most significant change in more than 25 years. These actions are part of a broader strategy that will help tobacco users quit and prevent children from starting.

By June 22, 2011, FDA will select the final nine graphic and textual warning statements after a comprehensive review of the relevant scientific literature, the public comments, and results from an 18,000 person study. Implementation of the final rule (September 22, 2012) will ultimately prohibit companies from manufacturing cigarettes without new graphic health warnings on their packages for sale or distribution in the United States. In addition, manufacturers, importers, distributors and retailers will no longer be allowed to advertise cigarettes without the new graphic health warnings in the United States. By October 22, 2012, manufacturers can no longer distribute cigarettes for sale in the United States that do not display the new graphic health warnings.

Lastly, on December 2, 2010, the Office of Disease Prevention and Health Promotion released the goals and objectives for *Healthy People 2020*. *Healthy People 2010* presents a comprehensive set of disease prevention and health promotion objectives developed to improve the health of all people in the United States during the first decade of the 21st century, with 10-year targets to guide national health promotion and disease prevention efforts. The objectives and targets are used to measure progress for health issues in specific populations, and serves as (1) a foundation for prevention and wellness activities across various sectors and within the federal government, and (2) a model for measurement at the state and local levels.

This launch included a *Healthy People* (version 1.0) website, which will be interactive and used as the main vehicle for information dissemination. The launch had over 9,000 participants online and over 200 participants in person. There are 42 topic areas in *Healthy People 2020*, 13 of which are new.

Priority: Eliminating health disparities and Achieving health equity

Numerous national planning and implementation efforts led by OASH/ASH promote health equity by raising awareness; strengthening leadership; improving the health care and health system experience for racial, ethnic, gender, and other minorities; improving cultural and linguistic competency; and improving the use of research and evaluation outcomes. Implementing these plans will have impact in areas ranging from improving adolescent health and reducing teen pregnancy, addressing care and prevention related to chronic viral hepatitis, and utilizing health information technology to reduce health disparities (with the Office of the National Coordinator).

Priority: Making *Healthy People* come alive for all Americans

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 conclusion of *Healthy People 2010* this year and the launch of *Healthy People 2020* 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, will be unveiled for *Healthy People 2020*. Ongoing Department efforts to make data available at the community level will advance the goal of making *Healthy People* come alive for the all Americans.

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.

OASH
Summary Table
(Dollars in Thousands)

Program	FY 2010 Actual FTE	FY 2010 Actual AMOUNT	FY 2011 Continuing Resolution FTE	FY 2011 Continuing Resolution AMOUNT	FY 2012 President's Budget FTE	FY 2012 President's Budget AMOUNT
OASH:						
Immediate Office	44	9,495	52	9,495	53	11,338
Office of HIV/AIDS Policy	6	929	8	929	8	1,526
Office of Disease Prev & Hlth Promo	23	7,200	23	7,200	23	7,929
Pres Council on Fitness, Sports & Nutrition	6	1,225	6	1,225	6	1,323
Office for Human Research Protections	33	6,949	33	6,949	33	7,007
National Vaccine Program Office	17	6,839	17	6,839	17	7,561
Office of Adolescent Health	3	500	3	500	4	1,250
Public Health Reports	2	448	2	448	2	452
Subtotal, OASH Non-PPA	**134**	**33,585**	**144**	**33,585**	**146**	**38,386**
OASH PPAs						
Adolescent Family Life	12	16,658	12	16,658	---	---
Teen Pregnancy Prevention	13	110,000	17	110,000	---	---
Mandatory State Teen Preg Grants (non-add)	---	---	---	---	---	---
Office of Minority Health	63	55,900	63	55,900	63	57,980
Office on Women's Health	43	33,746	43	33,746	43	33,746
Commissioned Corps	31	14,813	31	14,813	23	7,013
Subtotal, OASH PPAs	**162**	**231,117**	**166**	**231,117**	**129**	**98,739**
Other GDM:						
Office of Research Integrity ...(Non-Add)	*24*	*9,118*	*24*	*9,118*	*24*	*9,709*
Healthcare Associated Infections	---	5,000	2	5,000	2	5,000
Minority AIDS Initiative	---	53,891	3	53,891	---	---
Embryo Adoption	---	4,200	---	4,200	---	2,000
Subtotal, Other GDM	**24**	**63,091**	**29**	**63,091**	**26**	**7,000**
TOTAL, GDM	**320**	**327,793**	**339**	**327,793**	**301**	**144,125**
Prevention & Public Health Fund						
OASH	---	2,825	---	-	---	5,700
Teen Pregnancy Prevention	---	---	---	-	17	110,000
Subtotal, PPHF	-	2,825	-	-	17	115,700
PHS Evaluation Set-Aside						
OASH	---	4,510	---	4,510	---	5,510
Teen Pregnancy	---	-	---	-	---	4,000
Teen Pregnancy Prevention	---	4,455	3	4,455	*3*	4,455
Minority AIDS Initiative	---	---	---	---	3	53,891
Subtotal, PHS	-	8,965	3	8,965	6	67,856
GRAND TOTAL	**320**	**339,583**	**342**	**336,758**	**324**	**327,681**

OASH CJ Performance Measures Table

Program: Office of the Assistant Secretary for Health

Long Term Objective: Creating better systems of prevention.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.a: Shape policy at the local, State, national and international levels (Outcome)	FY 2009: 32,145 (Target Not Met)	35,000[4]	35,200	+200
1.b: Communicate strategically (Outcome)	FY 2009: 40,268,111 (Target Not Met)	41,230,280[5]	38,270,500	-2,959,780
1.c: Promote effective partnerships (Outcome)	FY 2009: 1044 (Target Exceeded)	546	960	+414
1.d: Strengthen the science base (Outcome)	FY 2009: 363 (Target Exceeded)	50	340	+290
1.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome)	FY 2009: 1,840 (Target Exceeded)	1,390[6]	575	-815

Long Term Objective: Eliminating health disparities and Achieving health equity

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.a: Shape policy at the local, State, national and international levels (Outcome)	FY 2009: 328 (Target Exceeded)	98	130	+32
2.b: Communicate strategically (Outcome)	FY 2009: 265,695,094 (Target Exceeded)	2,410,400	2,232,180	-178,220
2.c: Promote Effective Partnerships (Outcome)	FY 2009: 623 (Target Exceeded)	136	330	+194
2.d: Strengthen the science base (Outcome)	FY 2009: 197 (Target Exceeded)	60	1600	+1,540
2.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome)	FY 2009: 549 (Target Exceeded)	70	60	-10

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

[4] OASH has consistently not met this target. We are changing our target to keep it more in line with our actual performance.

[5] The Office of HIV/AIDS Policy (OHAP) was a big contributor to this measure. OHAP's Mobilization Campaign has ended and they collected a lot of web visitors to their campaign site. As a result, OASH had to decrease their target for this measure. A significant drop in OHAP's numbers in FY'10 can be explained due to: (1) the end of the National HIV/Testing Mobilization Campaign (NHTMC) which produced considerable numbers for both preventing disease and addressing health disparities and (2) a reduction in OHAP-generated programs and projects to focus more on HIV/AIDS policy and program review and analysis.

[6] OWH is the greatest contributor for this measure. In prior years, OWH had the National Centers of Excellence and the Community Centers of Excellence (established programs). OWH restructured those programs (new competition,etc) and they now have a new coordinated program linked to Healthy People which is the ASIST 2010 program. Their data also changed, therefore they submitted new and more realistic targets for this measure.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
3.a: Shape policy at the local, State, national and international levels (Outcome)	FY 2009: 3,575 (Target Exceeded)	951[7]	1,020	+69
3.b: Communicate strategically (Outcome)	FY 2009: 1,568,751 (Target Exceeded)	1,615,473	1,444,660	-170,813
3.c: Promote Effective Partnerships (Outcome)	FY 2009: 486 (Target Exceeded)	40	485	+445
3.d: Strengthen the science base (Outcome)	FY 2009: 7,512 (Target Exceeded)	1,103	1,940	+837
3.e: Lead and coordinate key initiatives within and on behalf of the Department (Outcome)	FY 2009: 3,149 (Target Not Met but Improved)	4,600[8]	6,234	+1,634

[7] OSG is the greatest contributor for this measure. They have increased their target as a result of prior performance.

[8] OASH has consistently not met this target. We are changing our target for this measure to be more realistic with our progress in this area.

Program: Adolescent Family Life

Long Term Objective: Encourage adolescents to postpone sexual activity by developing and testing abstinence interventions.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.5: Increase the scientific understanding of adolescent sexual health and family relationships through the production and dissemination of peer reviewed publications and presentations at regional and national conferences. This measure will enable OAPP to assess activities related to the office's long term goals of promoting rigorous research and increasing the scientific understanding of adolescent sexual behavior. (Outcome)	N/A	N/A	N/A	N/A

Long Term Objective: Ameliorate the effects of too-early-childbearing by developing and testing interventions with pregnant and parenting teens.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.2.1: Demonstrate lower rates of repeat pregnancy among participants receiving enhanced services (intervention) as compared to participants receiving standard services (comparison) at 12-month follow-up. Results will be reported by AFL grantee cohort. (Outcome)	FY 2009: 90% (Target Not Met)	92%	92%	Maintain
2.2.3: Demonstrate increased positive educational outcomes among participants receiving enhanced services (intervention) as compared to participants receiving standard services (comparison) at 12-month follow-up. Results will be reported by AFL grant cohort. (Outcome)	FY 2009: 81% (Target Exceeded)	79%	81%	+2
2.5: Increase the scientific understanding of adolescent sexual health and family relationships through the production and dissemination of peer reviewed publications and presentations at regional and national conferences. Results will be reported by AFL grantee cohort. (Outcome)	N/A	N/A	N/A	N/A

Long Term Objective: (1) Identify interventions that have demonstrated their effectiveness to promote premarital abstinence for adolescents. (2) Identify interventions that have demonstrated their effectiveness to ameliorate the consequences of adolescent pregnancy and childbearing.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.3.2: Improve the quality of the Title XX independent evaluations through the provision of technical assistance and related training. Results will be reported by AFL grantee cohort. (Outcome)	FY 2009: 41% (Target Not Met)	58.8%	67.2%	+8.4

Long Term Objective: Improve the efficiency of the AFL program.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.4.2: Sustain the cost to encounter ratio in care demonstration projects. (Outcome)	FY 2009: $91 (Target Exceeded)	$110	$110	Maintain

Long Term Objective: Increase the scientific understanding of adolescent sexual health and family relationships through the production and dissemination of peer reviewed publications and presentations at regional and national conferences. This measure will enable OAPP to assess activities related to the office's long term goals of promoting rigorous research and increasing the scientific understanding of adolescent sexual behavior.

Program: Office of Disease Prevention and Health Promotion

Long Term Objective: Communicate strategically by increasing the reach of ODPHP disease prevention and health promotion information and communications

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
I.a: Awareness of Dietary Guidelines for Americans (will be measured at least two times between 2005 and 2010) (Outcome)	FY 2007: 45% (Target Exceeded)	N/A	N/A[9]	N/A
I.b: Visits to ODPHP-supported websites (Output)	FY 2010: 14.83 Million (Target Not Met but Improved)	15.75 Million	17.6 Million	+1.85
I.c: Consumer Satisfaction with healthfinder.gov, measured every three years at a minimum (Output)	FY 2010: 76% (Target Not Met but Improved)	78%	78%	Maintain
I.d: Increase the percentage of Healthy People 2010 focus area progress review summaries that have been written, cleared, and posted on the internet within 16 weeks of the progress review date (Efficiency)	FY 2008: 92% (Target Exceeded)	98%	N/A[10]	N/A

Long Term Objective: Shape prevention policy at the local, State and national level by establishing and monitoring National disease prevention and health promotion objectives

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
II.a: Percentage of States that use the national disease prevention and health promotion objectives in their health planning process (Outcome)	FY 2009: 100% (Target Exceeded)	98%	25%[11]	-73
II.b: Increase the percentage of Healthy People 2010 objectives that have met the target or are moving in the right direction (Outcome)	FY 2005: 42.2% (Baseline)	60.0%	N/A[12]	N/A

[9]In 2004, 2005 and 2007, ODPHP supported fielding a
[10]This measure may be reinstated in FY 2012 pending the initiation of monthly topic area progress reviews for Healthy People 2020.
[11]The FY2012 target reflects the FY 2011 launch of Healthy People 2020. All previous years' targets apply to Healthy People 2010.
[12]This measure's first long-term target is FY 2015, when a mid-decade assessment of progress on achieving the Healthy People 2020 objectives/targets will be conducted.

Program: Office of Minority Health

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
4.3.1: Increased average number of persons participating in OMH grant programs per $1 million in OMH grant support (2006 Baseline: 18,960) (Efficiency)	FY 2010: 18,376 (Target Exceeded)[13]	15,063[14]	15,980[15]	+917
4.4.1: Unique visitors to OMH-supported websites (Output)	FY 2010: 573,732.0 (Target Exceeded)[16]	420,000.0	580,000.0[17]	+160,000

Long Term Objective: Increased percentage of measurable racial/ethnic minority-specific Healthy People 2010 objectives and sub-objectives that have met the target or are moving in the right direction

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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

[13] In early May 2010, OMH launched its Performance Data System (PDS) which replaced the Uniform Data Set (UDS) previously used to obtain OMH grantee and program activity data. The PDS, unlike the UDS, is designed to reflect the logical approach used in the Strategic Framework and the Evaluation Planning Guidelines developed by OMH; enable collection of more performance–oriented data tied to OMH–wide performance measurement and reporting needs (including relevant OASH GPRA measures and the objectives of the National Partnership for Action to End Health Disparities and Healthy People 2010/2020); and reduce respondent burden through improved layout, logical flow, etc.). All data quality and integrity issues experienced with the UDS have been corrected, and OMH can now systematically document and track grantee and grant program progress. The first grantee reporting period (for the first half of FY 2010) using the PDS occurred throughout May 2010, and the reporting period for the second half of FY 2010 occurred throughout November 2010. The current FY 2010 estimates include the final results of the May 2010 collection and PRELIMINARY results of the November 2010 collection. Data for the second half of FY 2010 are currently being reviewed and validated and are not yet complete (i.e., OMH is awaiting data from a couple of grantees whose reporting deadlines have been extended). Final results are expected by the end of December 2010.

[14] The footnote concerning the resets for the FY 2009 baseline and results also noted that, in reviewing its methodology for calculating the efficiency estimates, OMH determined that the denominator for these calculations should be a PORTION of the annual total funding available, rather than the TOTAL annual funding available, based on the number of reporting periods (bi–annual or quarterly) during which the participant date are collected. This will enable more accurate estimates and tracking of OMH's performance on this measure throughout the year. Thus, using the reset FY 2009 baseline/result (7312) to recalculate a target for FY 2010, during which data continued to be collected on a bi–annual basis, the total annual funding available in FY 2010 for grantees reporting PDS data (previously used as the denominator) would be divided by half for each data reporting period, effectively doubling the basis for setting the FY 2010 target to 14,624. A 3 percent increase over this baseline result would be 15,063 as the recalculated FY 2010 target. The target–setting methodology has not changed, but all previous targets have now been adjusted to reflect the revised calculation procedures.

[15] 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.

[16] Due to increases in referrals from Google, OMH realized a substantial increase in unique visitors to its Resource Center website in FY 2010. These increases resulted from steps taken by OMH during the year to improve results in Google searches and also convert to a new URL (www.minorityhealth.hhs.gov), which identifies the OMH web site as part of a trusted source, the HHS family of web sites. Given this success, OMH is raising the targets for FY 2011 and beyond to reflect an expectation of sustained increases on this measure.

[17] The original FY 2012 target of 450,000 was raised relative to the FY 2010 actual result. See footnote for the FY 2010 result for further information.

Long Term Objective: Increased awareness of racial/ethnic minority health status and health care disparities in the general population

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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% (Target Not Met)[18]	60.7%[19]	63.1%[20]	+2.4

[18] 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 previous year's target 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.

[19] See note for 2007 target.

[20] See note for 2007 target.

Program: Office On Women's Health

Long Term Objective: Advance superior health outcomes for women

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
5.1.1: Increase the percentage of women-specific Healthy People 2010 objectives and sub-objectives that have met their target or are moving in the right direction. (Outcome)	FY 2009: 63.4% (Target Not Met)	74.0%	75.0%	+1
5.1.2: Increase the Percentage of women-specific Healthy People 2020 objectives and sub-objectives that have met their target or are moving in the right direction. (Outcome)	N/A	N/A	N/A	N/A

Long Term Objective: Increase heart attack awareness in women

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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 Not Met)	70.0%	75.0%	+5

Long Term Objective: Expand the number of users of OWH communication resources

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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 2009: 26,508,685 user sessions (Target Not Met)	26,000,000 user sessions	26,000,000 user sessions	Maintain

Long Term Objective: Increase the number of people that participate in OWH-funded programs per million dollars spent annually

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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 Not Met)	770,461	770,461	Maintain

Program: Commissioned Corps: Readiness and Response Program

Long Term Objective: Increase the size and operational capability of the Commissioned Corps.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
6.1.1: Increase the percentage of Officers that meet Corps readiness requirements, thus expanding the capability of the individual Officer. (Outcome)	FY 2009: 94.4% (Target Exceeded)	95%	97.5%	+2.5
6.1.2: Increase the percentage of Officers that are deployable in the field, thus expanding the capability of the Corps.(Baseline - 2005: 40%) (Outcome)	FY 2009: 79.4% (Target Exceeded)	82.5%	85%	+2.5
6.1.3: Increase the percent of individual responses that meet timeliness, appropriateness, and effectiveness requirements.(Baseline - 2007: 77%) (Outcome)	FY 2009: 92.5% (Target Exceeded)	93%	97.5%	+4.5
6.1.4: Increase the percent of team responses that meet timeliness, appropriateness, and effectiveness requirements.(Baseline - 2007: 89%) (Outcome)	FY 2009: 95% (Target Met)	97.5%	99%	+1.5
6.1.5: Increase the number of response teams formed, thus enhancing the Department's capability to rapidly and appropriately respond to medical emergencies and urgent public health needs.(Baseline - 2005: 0) (Outcome)	FY 2009: 41 (Target Exceeded)	46	46	Maintain
6.1.6: Increase the number of response teams which have met all requirements, including training, equipment, and logistical support, and can deploy in the field when needed as fully functional teams, thus enhancing the Department's capability to appropriately respond to medical emergencies and urgent public health care needs.(Baseline - 2006: 0) (Outcome)	FY 2009: 21 (Target Exceeded)	26	36	+10
6.1.7: Cost per Officer to attain or maintain readiness requirements. (Efficiency)	FY 2009: $91.14 (Target Exceeded)	$90	$90	Maintain

Program: HIV/AIDS in Minority Communities

Long Term Objective: Long-Term Outcome Goals

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
7.1.1: Increase the number of ethnic and racial minority individuals surviving 3 years after a diagnosis of AIDS (Outcome)	FY 2009: 82% (Target Not Met)	87.75%	88.25%	+0.5
7.1.2: Reduce the percentage of AIDS diagnosis within 12 months of HIV diagnosis among racial and ethnic minority communities (Outcome)	FY 2009: 32.75% (Target Exceeded)	35.25%	34%	-1.25
7.1.3: Reduce the rate of new HIV infections among racial and ethnic minorities in the United States (Outcome)	FY 2009: 48.8% (Target Not Met but Improved)	46%	43%	-3
7.1.4: Increase the number of African American individuals surviving 3 years after a diagnosis of AIDS (Outcome)	FY 2009: 80% (Target Not Met but Improved)	88%	89.5%	+1.5
7.1.5: Increase the number of Hispanic individuals surviving 3 years after a diagnosis of AIDS (Outcome)	FY 2009: 85% (Target Not Met)	90%	91.5%	+1.5
7.1.6: Increase the number of Asian/Pacific Island individuals surviving 3 years after a diagnosis of AIDS (Outcome)	FY 2009: 85% (Target Not Met)	93%	94.5%	+1.5
7.1.7: Increase the number of American Indian/Alaskan Native individuals surviving 3 years after a diagnosis of AIDS (Outcome)	FY 2009: 77% (Target Not Met but Improved)	80%	81.5%	+1.5
7.1.8: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among African American communities (Outcome)	FY 2009: 32% (Target Exceeded)	34%	32.5%	-1.5
7.1.9: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among Hispanic communities (Outcome)	FY 2009: 37% (Target Exceeded)	38%	36.5%	-1.5
7.1.10: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among Asian/Pacific Islander communities (Outcome)	FY 2009: 33.5% (Target Exceeded)	35%	33.5%	-1.5
7.1.11: Reduce percentage of AIDS diagnosis within 12 months of HIV diagnosis among American Indian/Alaskan (Outcome)	FY 2009: 38% (Target Not Met)	36%	34.5%	-1.5
7.1.12: Increase the number of individuals who learn their HIV status for the first time through MAI Fund programs (Outcome)	FY 2008: 147,726 (Target Not Met but Improved)	167,662	185,000	+17,338
7.1.13: Maintain the actual cost per MAI Fund HIV testing client below the medical care inflation rate (Efficiency)	FY 2007: $88 (Target Exceeded)	$101.71	$102.5	+0.79
7.1.14: Maintain the actual cost per MAI Fund physician and other clinical staff trained below the medical care inflation rate (Efficiency)	FY 2006: $795.7 (Target Exceeded)	$1,670.78	$1,500	-170.78

OASH
IMMEDIATE OFFICE
Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	9,495	9,495	11,338	1,843
FTE	44	52	53	9

Authorizing Legislation……...……...Title III, Section 301 of the Public Health Service Act
FY 2012 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 on these issues, and provides direction to policy offices within OASH.

The OASH mission is to mobilize leadership in science and prevention for a healthier Nation. Led by the ASH, senior public health officials within OASH work to 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; and 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 our Federal partners will enable HHS to leverage the scientific, evaluative, or programmatic findings of one agency for replication and dissemination through other agencies to reach the State and local levels. Recent accomplishments by Immediate Office staff in this area include:

- Coordinating a national strategic plan on tobacco cessation titled *Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan for the U.S. Department of Health and Human Services*.
- Leading collaboration with AHRQ, CDC, and CMS, to develop an online portal for consumers, clinicians, and decision makers on prevention of Healthcare-Associated Infections.

Other examples of OASH Offices' leadership in prevention include:

- The National Vaccine Program Office (NVPO) is completing the second draft of the National Vaccine Plan.
- The Office of Disease Prevention and Health Promotion (ODPHP) and the USDA's Center for Nutrition Policy jointly hosted the 5th meeting of the Dietary Guidelines Advisory Committee on April 13 and 14, 2010. The Committee reviewed the evidence/conclusions of the final set of questions underpinning the Advisory Committee Report and discussed draft elements of the report.

- ODPHP participated in the Health Resources and Services Administration's all-Advisory Board Meeting and the Council on Graduate Medical Education (COGME). COGME will be issuing recommendations on restructuring physician training to better reflect the prevention and primary care-oriented healthcare system mandated by health reform legislation.
- The Office of Minority Health (OMH) collaborated with the Public Health Service's Oral Health coordinating Committee to develop the HHS Oral Health Initiative 2010. The ASH is the Department's co-lead with the HRSA Administrator in the effort and jointly launched the initiative at the 2010 National Oral Health Conference on April 26 in St. Louis, MO.

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. Recent accomplishments in this domain include:

- Immediate Office staff, in coordination with representatives from the CDC, is developing an HHS strategic action plan to improve the coordination of viral hepatitis activities within HHS. This plan will address policy questions raised in a recent IOM report, *"Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C."* The group will seek to establish goals for the prevention, care, and treatment of viral hepatitis and associated disease in the U.S.
- An intra-agency workgroup has been working to develop a proposal for an Institute of Medicine study on the public health dimensions of the epilepsies. Immediate Office staff are pooling experts from the OpDivs and leveraging financial contributions for commissioning the study. OASH has also leveraged funds from *Vision 20:20*, a non-governmental coalition of epilepsy advocates and professional organizations that has generated approximately $250,000 for the study.
- In Region III, the Regional Health Administrator (RHA) is actively coordinating representatives from Federal agencies located within metropolitan Philadelphia to provide support to the City of Philadelphia, Department of Public Health Community Coalition for the *Communities Putting Prevention to Work, Nutrition & Physical Activity and Tobacco Policy and Control Initiatives.* The RHA will convene Federal agencies located within the metropolitan area to discuss how we can provide coordinated support to this major Federal initiative.
- The HHS Advisory Committee on Blood Safety and Availability prepared for their June 2010 meeting, which will deal with the prohibition of men who have had sex with other men since 1977 from donating blood. Members of Congress and external organizations have contacted the Department in regard to this matter.
- The *Healthy People 2020* Federal Interagency Workgroup has approved the establishment of a *Healthy People 2020* Lesbian, Gay, Bisexual, and Transgender (LGBT) Workgroup whose mission is to reduce health disparities for populations by improving data collection and sharing expertise on LGBT health needs within the Healthy People program.

Other examples of OASH Offices' leadership in eliminating health disparities and achieving health equity include:

- ODPHP launched The National Action Plan to Improve Health Literacy. The plan is aimed at making health information and services easier to understand and use. It calls for improving the jargon-filled language, dense writing, and complex explanations that often fill patient handouts, medical forms, health web sites, and recommendations to the public.

- OMH funded and collaborated with the Joint Center for Political and Economic Studies Health Policy Institute's Commission on Paternal Involvement in Pregnancy Outcomes. Together they released recommendations on best and promising practices for improving research policy and practice on strengthening the role of men and fathers in achieving healthy pregnancies.
- The Office of Human Research Protections (OHRP) is part of an OMB working group, including FDA and NIH, working to revise portions of the human subjects protection regulations. This review will seek to facilitate valuable health research while increasing protections for human subjects.
- The Office on Women's Health (OWH) marked the observance of National Women's Health Week 2010, capped by the first-ever Presidential Proclamation recognizing the Week. Senior OASH staff conducted 11 radio interviews reaching over a million people about women's health. A 5 minute segment aired on The *Today Show* on National Women's Check Up Day.

Making Healthy People come alive for all Americans - 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 conclusion of *Healthy People 2010* and the launch of *Healthy People 2020* later this year 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, will be unveiled for *Healthy People 2020*. Ongoing Department efforts to make data available at the community level will advance the goal of making *Healthy* People come alive for all Americans. To preview the unveiling of this vital prevention tool, the ASH authored "*A 2020 Vision for Healthy People*," an article about the Healthy People 2020 initiative published in the May 6, 2010 issue of the New England Journal of Medicine. Examples of OASH leadership in Making Healthy People come alive include:

- ODPHP launched the *The Quick Guide to Healthy Living*, a new feature of healthfinder.gov, which recently won the ClearMark Public Web Award. The ClearMark Awards are for clear communication documents and websites in private, public and non-profit sectors.
- ODPHP and the USDA's Center for Nutrition Policy jointly hosted the 5th meeting of the Dietary Guidelines Advisory Committee on April 13 and 14. The Committee reviewed the evidence/conclusions of the final set of questions underpinning the Advisory Committee Report and discussed draft elements of the report.

Funding History

FY 2007	$8,165,000
FY 2008	$7,927,000
FY 2009	$8,820,000
FY 2010	$9,495,000
FY 2011	$9,495,000

Budget Request

The FY 2012 budget request of $11,338,000 is an increase of $1,843,000 over the comparable FY 2010 Appropriation. This request provides a program increase needed to keep pace with the growing list of public health concerns facing the Nation.

The ASH needs to draw upon skilled experts from a multitude of backgrounds. OASH also needs to develop the capacity for clear and action-oriented communications. Whether the audience is other HHS and Federal entities, or HHS partners, effective communications can reduce the time from discovery of a potential solution to actual delivery of that solution for urgent public health needs. OASH strives to balance programmatic expertise, communication, and coordination with the efforts of HHS agencies

working in their respective areas of public health, science, and or medicine. With a broader view of how HHS resources are used by the public and by our Federal, state, and local partners, OASH sees the knowledge and expertise of human resources as a key component to creating systems of prevention that will eliminate health disparities and achieve health equity as well as maximize the benefits of *Healthy People 2020* for all Americans. OASH is requesting these programmatic dollars to support and expand the coordination and collaboration efforts established within HHS over the past two years.

OASH
NATIONAL VACCINE PROGRAM OFFICE
Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	6,839	6,839	7,561	722
FTE	17	17	17	0

Authorizing Legislation……..……Title XXI of the Public Health Service Act
FY 2012 Authorization…….…….……....Expires 2012
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 values, goals, objectives, and strategies for pursuing the prevention of infectious diseases through immunization. The four goals of the National Vaccine Plan are to:

- Develop new and improved vaccines;
- Ensure the optimal safety and effectiveness of vaccines and immunization;
- Better educate the public and health professionals about the benefits and risks of immunizations; and
- Achieve better use of existing vaccines to prevent disease, disability, and death.

NVPO coordinates interaction between the Department of Health and Human Services (HHS) agencies and interacts with stakeholders in these areas through regular communication on issues including vaccine safety, vaccine supply, vaccine coverage, vaccine adverse events, vaccine financing and international vaccine and immunization issues. NVPO advances the Secretary's priority on prevention from the work done to promote safe and effective vaccines, and enhance delivery of these preventive medical services, as well as being deeply involved in pandemic influenza preparedness, thereby contributing to the Secretary's priority on preparedness. Highlights include:

- *Updating the National Vaccine Plan.* The National Vaccine Plan identifies priority activities to improve the safety and effectiveness of disease prevention through immunization. NVPO is coordinating the revision of the Plan (initially published in 1994) with all relevant agencies and offices in HHS, and with the Departments of Defense and Veterans Affairs, and the U.S. Agency for International Development. Input is also being obtained from the Institute of Medicine, interested stakeholders, and the general public.
- *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 Agencies with assets in immunization safety (NIH, FDA, CDC, HRSA, CMS, IHS) and VA and DoD. The dual goals of this Task Force report are to: 1) enhance federal scientific capacity to detect, understand, and prevent adverse events following immunization; and 2) enhance communications and maintain public confidence in vaccines through sound science, trust and transparency.
- *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.

- *National Vaccine Advisory Committee (NVAC)*. NVPO serves as Executive Secretariat for NVAC which advises and makes vaccine-related recommendations to the Assistant Secretary for Health. NVAC meets at a minimum of three times per year and is funded through the NVPO budget.
  - *Seasonal Influenza Coordination.* NVPO leads an interagency process to coordinate seasonal influenza delivery across HHS OPDIVS and other Federal agencies. Key activities include assessing current activities, identifying gaps in vaccine delivery, assuring coordination across agencies, and reporting progress.
  - *Vaccine Communications*. NVPO works with HHS operating and staff divisions to ensure that communications strategies and tactics are well coordinated and leveraged to the fullest extent possible. Key activities include 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 2007	$6,980,000
FY 2008	$6,781,000
FY 2009	$6,879,000
FY 2010	$6,839,000
FY 2011	$6,839,000

Budget Request

The FY 2012 budget request of $7,561,000 is an increase of $722,000 over the comparable FY 2010 Appropriation. This request enables the continued support of existing projects and implementation of new activities such as:

- Coordinate and integrate activities of all Federal agencies involved in vaccine and immunization efforts such as: minimizing gaps that may exist in Federal planning of vaccine and immunization activities; developing and implementing strategies for prevention of human diseases through immunization and prevention of adverse reactions to vaccines;
- Enhance interagency collaboration, so that vaccine and immunization-related activities are carried out in an efficient, consistent, and timely manner. NVPO uses the monthly Flu Risk Management Meeting and weekly Departmental Influenza Conference Call to specifically coordinate influenza information across the Federal government;
- Contribute to pandemic preparedness by finalizing national guidance on the use of medical countermeasures, supporting other vaccine and pandemic preparedness initiatives, and coordinating an update of the HHS Pandemic Influenza Preparedness and Response Plan;
- Complete the Revised National Vaccine Plan;
- Coordinate communications for routine and pandemic vaccination. This includes ongoing coordination with agencies on routine vaccination and seasonal flu, informing the public through Vaccines.gov, and pandemic communications.
- Enhance the effectiveness and value of NVAC by supporting their efforts in authoring timely and topical recommendations on critical vaccine policy issues; and more closely align its activities with the priorities of the ASH.

OASH
OFFICE OF ADOLESCENT HEALTH
Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	500	500	1,250	750
FTE	3	3	4	1

Authorizing Legislation……..……...Section 1708 of the Public Health Service Act
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. OAH will place particular emphasis on the most vulnerable populations, those in low socio-economic areas and areas where adolescents are likely to be exposed to emotional and behavioral stress that can lead to substance abuse.

OAH is responsible for implementing and administering the Teen Pregnancy Prevention discretionary grant program to support evidence-based teen pregnancy prevention approaches. OAH coordinates its efforts with other HHS offices and operating divisions 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 Administration for Children and Families' Personal Responsibility Education Program and the Centers for Disease Control and Prevention's Safe Motherhood Program. The Secretary has designated Reducing Teen and Unintended Pregnancy as one of her key Inter-agency Collaboration areas. OAH is also responsible for implementing and administering the Pregnancy Assistance Fund, Support for Pregnant and Parenting Teens and Women, authorized in the Affordable Care Act (ACA).

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 2007	$0
FY 2008	$0
FY 2009	$0
FY 2010	$500,000
FY 2011	$500,000

Budget Request

The FY 2012 budget request of $1,250,000 is an increase of $750,000 over the comparable FY 2010 Appropriation. This request will provide continued support for existing activities as well as initiate the Second Decade Project. The Second Decade Project will maximize health and healthy development among persons in the second decade of life (ages 10-19) through enhanced coordination and integration of the many health-relevant interventions and activities that affect persons in this age group.

During the second decade of life, a wide variety of personal decisions are made and lifelong patterns of behavior are established that affect the health of each individual for the rest of his or her life. As noted in the Senate Appropriations Committee report accompanying HR 3293, "health problems that emerge during adolescence have important consequences for adult morbidity and mortality." Many programs exist to promote health and healthy development during adolescence, but these programs are not optimally coordinated or integrated. The Affordable Care Act (ACA) added a number of programs that impact the health of adolescents; while some required coordination in statute, others did not. Even those with statutory requirements were limited to requiring HHS agencies to coordinate with each other or with other Federal departments, not at the local level.

This effort is in keeping with the focus of the newly enacted ACA's focus on health promotion and disease prevention. It supports the Secretary's Key Inter-agency collaborations to Reduce Teen and Unintended Pregnancy and Support the National HIV/AIDS Strategy, as well as several HHS Strategic Initiatives such as Prevent and Reduce Tobacco Use and Help Americans Achieve and Maintain a Healthy Weight. It also builds upon Promoting Early Childhood Health and Development by continuing these efforts into the adolescent years.

These funds would build on a project under development in HHS Region X that will seek to identify governmental programs, campaigns, and initiatives currently funded/implemented in the Region that affect the health and healthy development of this age group. Due to the influx of new funds, the project would be expanded to several other regions, seeking to develop coordination at the early stages of implementation. Funds would be used to award a contract to support the effort across the chosen regions. Examples of activities supported include:

- Summit meeting bringing together federal, state and local stakeholders in the selected Regions;
- Review research, current practices, and effective frameworks related to the coordination of services for this age group;
- Identify communities to implement integrative services;
- Provide implementation assistance to the communities; and
- Evaluate the overall efforts.

The project would engage communities to define the parameters of a community-level project that integrated and coordinated a variety of federal investments to create an environment to optimally foster health and healthy development for persons 10-19 years of age. Communities that participate would be well-positioned to prioritize applications for Federal funding. Eventually, results of the project would add to the evidence base and could be disseminated nationally for other communities to use as a model.

OASH
OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	7,200	7,200	7,929	729
FTE	23	23	23	0

Authorizing Legislation…….……..…….Title XVII, Section 1701 of the PHS Act
FY 2012 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 for the Department of Health and Human Services (HHS) through collaboration with HHS agencies and other partners in prevention. ODPHP's central mandates are to assist the Assistant Secretary for Health and the Office of the Secretary in:

- leading and coordinating health promotion and disease prevention activities, including *Healthy People*, *Dietary Guidelines for Americans*, and *Physical Activity Guidelines for Americans*;
- developing, evaluating, and promoting innovative approaches to communicating health information, increasing health literacy, and operating the National Health Information Center; and
- addressing cross-cutting and gap-filling issues in public health, prevention and science.

Healthy People
ODPHP meets its Congressional mandate to establish health goals for the Nation by leading the development and implementation of *Healthy People* on behalf of the Department. *Healthy People* underpins many of HHS' priorities and strategic initiatives and provides a framework for prevention and wellness programs for a diverse array of stakeholders.

Through measurable, evidence-based objectives, *Healthy People* provides the metrics and tools that support programs necessary to achieve health care reform and the vision of a healthier nation. The priorities identified by the Affordable Care Act–mandated National Prevention and Health Promotion Strategy will align with specific *Healthy People 2020* objectives and the overarching goals of increasing quality and years of life for all Americans; achieving health equity and eliminating health disparities; promoting healthy development and healthy behaviors across life stages; and creating social and physical environments that promote good health.

The *Healthy People* 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.

In FY 2011, the Assistant Secretary for Health launched *Healthy People 2020* at the George Washington University, with more than 450 individuals attending in person and another 9,000 via live Web streaming. The launch marked the release of the new decade's 10-year objectives and targets and the redesigned healthypeople.gov website.

In FY 2009 and FY 2010, leading up to the launch, ODPHP completed the public comment elements of the development of the *Healthy People 2020* objectives. Representatives from academia and each state and territory were invited to attend a stakeholders' workshop in Washington, DC. Public meetings were held in Kansas City, MO; Philadelphia, PA; and Seattle, WA. Comments from the public were also collected via an online database, through which the Department received more than 8,000 submissions. In FY 2010, and again in FY 2011, a 12-member Secretary's Advisory Committee on National Disease Prevention and Health Promotion Objectives for 2020 convened public meetings, either in person or via the Internet, and continued to provide guidance on the development and implementation of Healthy People 2020. In FY2010, the *Healthy People Consortium*, a group of organizations sharing the *Healthy People* vision of a healthier nation, grew to more than 2,200 members.

In FY2010, OPDHP continued its assessment of state use of the *Healthy People 2020* framework, which was approved by the Secretary in late FY 2009. Under this project, ODPHP is supporting assessments in 11 states, 1 territory, and 1 Tribal organization, with each entity receiving an average of $35,000. This project, which will inform development of user resources and other implementation activities, is expected to be completed in FY 2011. In FY 2010, ODPHP initiated additional projects that will expand the state assessment plus evaluate community organizations' use of *Healthy People 2020*.

In FY2010 and FY 2011, ODPHP continued the development of the online version of *Healthy People 2020* aimed at making *Healthy People* 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 of *Healthy People 2020*. This new website will give users a platform from which to learn, collaborate, plan, and implement *Healthy People 2020* objectives. Version 1.0 of the site was launched in FY2010; version 2.0 is planned for release in FY2012.

In addition, ODPHP, in collaboration with CDC and the Office of the National Coordinator for Health Information Technology, has led the development of Healthy People 2020 objectives for health communication and health IT.

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). 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.

In preparation for the publication on the 2010 DGAs, in FY2009 and FY2010, the 13-member Dietary Guidelines Advisory Committee (DGAC) convened public meetings, either in person or via the Internet, and reviewed current scientific evidence regarding nutrition and health in preparation of their report to the Secretaries of HHS and USDA in FY2010. Although USDA has the administrative lead for this iteration of the DGAs, ODPHP contributed considerable staff time in FY 2009-2010 to supporting the committee, and in FY 2010-2011, to writing the 2010 DGA policy document, coordinating focus group testing and developing consumer materials, and developing and implementing a strategic plan for communicating the 2010 Dietary Guidelines for Americans to be released in FY2011. For the 2015 edition, HHS will have the administrative lead for chartering the DGAC and publishing the 2015 DGAs in partnership with USDA. Appropriate resources for ODPHP, including staffing, will need to be in place by FY2013.

ODPHP will continue to coordinate with other HHS offices/agencies and other departments to develop communications, educational information and resources that are research-tested, audience-appropriate, actionable, and consistent with the DGAs. ODPHP is focusing its resources on nutrition outreach efforts that are based on results of consumer research that provides data on health literacy principles in communicating nutrition information. Communication of information that is understandable and actionable is critical not only in increasing awareness but also in effecting behavior change related to diet.

The DGAs are informed in part by the Dietary Reference Intakes (DRIs), a system of nutrition recommendations from the Institute of Medicine (IOM) of the National Academy of Sciences. The DRI system is used by the general public and health professionals in the United States and Canada in the following applications:

- Composition of diets for schools, prisons, hospitals or nursing homes
- Industries developing new food products
- Healthcare policy makers and public health officials

ODPHP continues its leadership role in the development and review of the DRIs by co-sponsoring nutrition-related studies by the IOM. Dietary Reference Intakes for Calcium and Vitamin D were released in November of FY 2011. Data from these studies provide critical information to strengthen the science base of disease prevention and health promotion efforts for the Department.

Physical Activity Guidelines for Americans

ODPHP led the Department's development and release of the first-ever comprehensive Federal Physical Activity Guidelines (PAGs), a set of evidence-based recommendations for types and amounts of physical activity for individuals ages 6 years and older to improve health and reduce disease. Released in FY 2009, the 2008 PAGs served as the primary basis for physical activity recommendations for the 2010 *Dietary Guidelines for Americans.* They are also the basis for the physical activity objectives in *Healthy People 2020* and support the Secretary's initiative to Help Americans Achieve and Maintain Healthy Weight.

In leading the PAG effort, ODPHP collaborated with the President's Council on Fitness, Sports, and Nutrition (PCFSN), formerly named the President's Council on Physical Fitness and Sports, the National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC). In FY 2010 and FY 2011, ODPHP continued to focus on outreach by coordinating and managing the online Physical Activity Supporters Network, which currently has over 4,500 members. A series of increasingly popular webinars were offered to members of the Supporters Network, and a new Physical Activity Guidelines blog was introduced (including weekly posts from ODPHP and designated partners). ODPHP continues to promote the PAGs through a variety of creative mechanisms, including a PAG widget, PAG blog, and scientific presentations in multiple venues and will continue these efforts in FY 2012. In FY 2011, ODPHP began to increase the reach of PAGs by developing consumer information for the Hispanic population. ODPHP plans to continue these efforts in FY 2012.

In addition, ODPHP continues to coordinate the review of consumer information developed by the Department related to physical activity. This team of physical activity experts from PCFSN, NIH and CDC reviews all consumer materials related to physical activity that are published within HHS to ensure that materials are consistent with the evidence-based messages of the PAGs. ODPHP is committed to ensuring the PAGs and the DGAs build from one another and provide parallel information for consumers over time. It will be important to ensure the PAGs continue to reflect the preponderance of current scientific evidence for the 2015 DGAs as well.

Disease Prevention and Health Promotion Scholarship Program
The goal of this initiative is to advance prevention/public health education, research, knowledge and application in health promotion and disease prevention - two basic tenants of prevention and public health and critical to health reform- for students, medical residents, practicing physicians, and other health professionals. The Scholarship Program supports the Luther Terry Fellowship, health policy fellowships, residency rotations for preventive medicine/primary care residents, ODPHP Visiting Scholars Program, the Paul Ambrose Health Promotion Student Leadership Symposium, and facilitates opportunities for other departmental prevention education initiatives. ODPHP has had twelve Luther Terry Fellows since the inception of the program. ODPHP has provided eleven health policy fellowships of approximately one-to-two years' duration for public health professionals to support ODPHP teams and initiatives and gain education and experience in health policy development. ODPHP hosts approximately six resident physicians and eight Visiting Scholars per year. In addition 40-50 health professionals-in-training participate in the Ambrose Symposium each year.

Health Communication and eHealth

ODPHP is congressionally mandated to provide reliable prevention and wellness information to the public through the National Health Information Center. Products include:

healthfinder.gov. Since 1997, healthfinder.gov has been recognized as a key resource for finding the best government and non-profit health online information. It has received numerous awards and has gained top billing among health information websites by NBC, the *New York Times* and *Health Magazine*. In FY2010 it won the ClearMark Award for best public website**.** This year healthfinder.gov extended the reach of actionable prevention information by disseminating content via content syndication, Twitter, widgets, and e-cards. Healthfinder.gov has been incorporated into healthcare.gov, providing the prevention content for the site. The healthfinder® Twitter following grew from 3,000 to over 86,000 followers in 2010.

Healthfinder.gov launched a content syndication program and tool in 2010 that provides a way for healthfinder® content to be placed onto other websites. Rather than linking to healthfinder.gov, users can pull content directly from healthfinder® while keeping visitors on their site. Users don't have to monitor the content or copy updates. The syndicated content is automatically updated in real-time requiring no maintenance from staff of other sites to keep the pages up to date.

In addition to adding syndicated prevention content to the healthcare.gov site, the tool was first piloted in HHS at NHLBI and with other partners including the Vermont Department of Public Health and the Howard County (Maryland) Health Department. There is additional interest from other federal partners including the Department of Veteran's Affairs and the Office of Personnel Management as well as others in non-profit organizations including the Public Broadcasting Service.

The Quick Guide to Healthy Living. ODPHP designed, consumer-tested, and launched a new online prevention information resource that uses everyday language and examples to communicate to users how taking small steps to improve health can lead to big benefits. A Spanish version is currently under development, ***myhealthfinder.*** This tool provides personalized recommendations for clinical preventive services. ODPHP developed this tool as a joint effort with the Agency for Healthcare Research and Quality (AHRQ). It provides evidence-based recommendations from the U.S. Preventive Services Task Force sponsored by AHRQ. Thirty-one new Quick Guide to Healthy Living topics and tools were added in 2010. **Health Literacy Online: A guide to writing and designing easy-to-use health websites.** In FY2010, ODPHP will launch a research-based guide for creating health websites and Web content for Americans with limited health literacy skills and limited Web experience. The guidance includes how to

deliver online health information that is actionable and engaging; create a health website that is easy to use; and improve and evaluate health websites using iterative design.

***A National Action Plan to Improve Health Literacy*.** This plan offers a vision and goals, innovative approaches, and a review of health literacy research for creating and sustaining national action to improve health literacy. It was informed by a 2007 Surgeon General's Workshop on Improving Health Literacy, four regional town hall meetings in 2007 and 2008, and with input from the HHS Health Literacy Workgroup members. It was launched in FY2010. Four health literacy improvement webinars and one in-person workshop was held in 2010. The average webinar attendance was approximately 600.

Funding History

FY 2007	$7,305,000
FY 2008	$7,106,000
FY 2009	$7,232,000
FY 2010	$7,200,000
FY 2011	$7,200,000

Budget Request

The FY 2012 budget request of $7,929,000 is an increase of $729,000 over the comparable FY 2010 Appropriation. This request will maintain ODPHP's current level of support, coordination, and outreach for several activities including: *Healthy People 2020; Dietary Guidelines for Americans 2010; Physical Activity Guidelines for Americans;* health communication and eHealth activities; and training for public health and prevention policy professionals. These programs all focus on preventing disease; improving the health of individuals and communities; reducing and ultimately eliminating health disparities; and promoting effective, sustainable, and consistent public health systems.

In FY2012, ODPHP will use the requested increase to initiate the process of updating the 2008 Physical Activity Guidelines for Americans (to be published in 2013). The updating process calls for the establishment of a Physical Activity Federal Advisory Committee to convene public meetings, either in person or via the Internet, to review current evidence on physical activity and health, to provide guidance on updating the Guidelines and integrating them with the National Physical Activity Plan. In FY 2013, ODPHP expects to continue to support the development process, materials development and launch activities. Supporting the Advisory Committee activities within the FY 2012 Planning Level will necessitate significantly scaling back other Web and communication support activities currently covered within ODPHP's existing communication contracts.

Outputs and Outcomes

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.1**:** Number of clients served. *(Outcome)*	FY 2007: 88,000 (Target Exceeded)	89,000	109,000	+20,000
Long Term Objective: Communicate strategically by increasing the reach of ODPHP disease prevention and health promotion information and communications				
I.a: Awareness of Dietary Guidelines for Americans (measured at least two times between 2005 and 2010) *(Outcome)*	FY 2007: 45% (Target Exceeded)	N/A[1]	N/A	N/A
I.b: Visits to ODPHP-supported websites *(Output)*	FY 2009: 12.569 Million (Target Not Met)	14 Million	17.6 Million	3.6 Million
I.c: Consumer Satisfaction with healthfinder.gov, measured every three years at a minimum *(Output)*	FY 2009: 76% (Target Not Met)	N/A	78%	78%

Program Data

	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 Request
PREVENTION FRAMEWORK:			
Healthy People, Dietary Guidelines for Americans, Physical Guidelines for Americans	455,800	455,800	1,067,800
PREVENTION COMMUNICATION:			
National Health Information Center	1,658,000	1,658,000	1,658,000
Communication Support	700,000	700,000	700,000
SCIENCE:			
Disease Prevention and Health Promotion Scholarship Program	400,000	400,000	400,000
OPERATING EXPENSES:			
Operating Costs	3,986,200	3,986,200	4,103,200
TOTAL	7,200,000	7,200,000	7,929,000

OASH
OFFICE OF HIV/AIDS POLICY
Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	929	929	1,526	597
FTE	6	8	8	2

Authorizing Legislation……Title III, Section 301 of the Public Health Service Act
FY 2012 Authorization……Indefinite
Allocation Method……Direct Federal

The Department of Health and Human Services (HHS) Secretary has delegated the Assistant Secretary for Health (ASH) responsibility for coordinating, integrating, and directing the Department's policies, programs, and activities related to HIV/AIDS. 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 engaging in outcome evaluation.
- Serving as the senior advisory agency on HIV/AIDS issues to the Secretary, the Deputy Secretary and the ASH, OHAP provides policy information and analysis to the Department's Operating Divisions (OPDIV) and Staff Divisions (STAFFDIV). 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 in an expeditious manner. With both internal and external partners, OHAP promotes awareness, understanding, and implementation of HHS policies on HIV/AIDS.
- Supporting Department-wide planning, internal assessments, evaluation activities covering such areas as HIV testing, technical assistance and prevention strategies, and gaps in necessary AIDS services. In working with all OPDIVs and STAFFDIVs with an HIV/AIDS portfolio, OHAP seeks areas for future collaboration, proper alignment of resources, elimination of redundancy, and filling of vital gaps and recommendations on best practices.
- Coordinating the implementation of the National HIV/AIDS Strategy within HHS and across Federal Departments.
- In FY 2012 the HHS Budget proposes that up to one percent of HHS discretionary funds be appropriated for domestic HIV/AIDS activities, or approximately $60 million, be provided to foster collaborations across HHS agencies and finance high priority initiatives in support of the National HIV/AIDS Strategy. Such initiatives could focus on improving the linkage between prevention and care, coordinating Federal resources within targeted high-risk populations, enhancing provider capacity to care for persons living with HIV/AIDS, and increasing capacity to monitor key Strategy targets.

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 the Department of Health and Human Services as one of the lead agencies for implementing the NHAS and tasked HHS with coordinating program planning and administration of 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, i.e. on December 9, 2010. The Implementation Plan identifies 32 specific tasks and activities that HHS must perform within calendar year 2010, by the end of calendar year 2011, and 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. OS, OASH and OHAP have been tasked with improving and enhancing coordination within HHS and outside HHS with other lead agencies. The NHAS calls for a change in the approach to addressing the domestic HIV/AIDS epidemic. OHAP has been delegated many of the day-to-day responsibilities of coordinating the implementation of the NHAS within HHS and across 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. Activities in the recent past have included an OHAP led comprehensive evaluation and assessment of the Minority AIDS Initiative (MAI) Fund, a subset of programs and activities under the MAI. HHS will be able to significantly expand HIV testing, prevention and other services for minority populations and communities that are particularly hard-hit by HIV/AIDS

OHAP will continue hosting lectures and in-service forums to keep executive senior staff and mid-level agency managers apprised of cutting edge issues and topics on the HIV/AIDS horizon, especially as they relate to implementation of the NHAS. These forums will provide information on major advances in science, technology and behavioral studies which will have a significant impact of the delivery of HIV care and treatment and the positioning of HIV prevention interventions and programs. These forums will increase Departmental transparency and enable staff to develop a heightened appreciation for the "front-line" issues related to achieving the goals of the NHAS.

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.

In addition, 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's performance goals have been based on OHAP's responsibility to advise Department officials on all HIV/AIDS-related issues and to coordinate the Department's internal and external HIV/AIDS programs, policies, and activities. Those goals have been met and recognized, as evidenced by the HHS Secretary, the White House, the HHS OPDIVs and STAFFDIVs, and other Federal agencies reliance on the information and support that OHAP provides. In the last year, OHAP increased the number of projects and events it manages by some 35 percent and its scope of activities and responsibilities will increase even further as a result of the NHAS.

OHAP will continue to serve as 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. As of June 2010 OHAP has gained additional high level expertise and capacity through the appointment of a Deputy Assistant Secretary for Health, Infectious Diseases (DASH-ID). This appointment paves the way for broader leadership roles to achieve greater coordination efforts across a wider array of health conditions and events. The Office will continue to coordinate the Department's participation in a wide variety of HIV/AIDS-related conferences and meetings, domestic and international, as well as activities related to National HIV Awareness Days and World AIDS Day observances.

Funding History

FY 2007	$930,000
FY 2008	$904,000
FY 2009	$919,000
FY 2010	$929,000
FY 2011	$929,000

Budget Request

The FY 2012 budget request of $1,526,000 is an increase of $597,000 the comparable FY 2010 Appropriation. This request will increase OHAP's ability to support the White House Office on National AIDS Policy Director with the implementation of the NHAS. The NHAS identified the ASH as the primary leader for the coordination and collaboration to ensure the full implementation of the NHAS, and named DASH-ID as playing a "lead role" in supporting the implementation of the NHAS. As such, OHAP is requesting funding to scale up staffing to achieve the 32 specific tasks and responsibilities that are outlined in the NHAS Implementation Plan framework.

The NHAS has three goals: reduce the incident of new HIV infections; increase access to care and treatment, and reduce HIV-related health disparities. The NHAS will target all racial and ethnic populations, especially men who have sex with men, substance abusers and their partners, and individuals who have multiple sexual partners but do not consistently avoid behaviors that put them at risk for contracting HIV disease. The ultimate goal is a dramatic reduction in new HIV infections, improved access to high quality HIV care and treatment, significantly improved health outcomes, and reduction in health disparities and inequities.

OHAP provides administrative support for the Presidential Advisory Council on HIV/AIDS (PACHA). The White House Office on National AIDS Policy in conjunction with the Secretary has amended the PACHA Charter to expand the Council's scope of work to include a monitoring and reporting role on the NHAS. There are four specific task referenced in the Implementation Plan for the PACHA to accomplish within the next 12 months and over the course of the next 5 years. The PACHA's role in the implementation of the NHAS does not displace the traditional activities and function this Council will continue to perform during its chartered period. OHAP staff will collaborate with PACHA staff to coordinate public outreach and communications activities to keep the public informed about the implementation efforts by all Federal departments and agencies conducting this work.

OASH
OFFICE FOR HUMAN RESEARCH PROTECTIONS
Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	6,949	6,949	7,007	58
FTE	33	33	33	0

Authorizing Legislation……..……Title III, Section 301 of the PHS Act
FY 2012 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 ten thousand institutions conducting clinical research, both in the U.S. and throughout the world, including the tens of billions of dollars of research funded or conducted by the National Institutes of Health. 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. Through guidance and changes in the regulations, OHRP is making sure that the current system never inappropriately leads to delays in the advancement of medical knowledge.

OHRP is organized into three functional Divisions headed by the Office of the Director. Each Division contributes to these responsibilities in numerous ways. The following narrative provides a brief description of each organizational component and some of OHRP's recent accomplishments and future expectations.

Office of the Director (OD) – The OD supervises and manages the development and promulgation of policies, procedures, and plans for meeting the responsibilities set forth above and the activities of the Divisions as described below. Specific responsibilities and accomplishments include:

- Taking a lead role in partnering with the Office of Management and Budget (OMB) in proposing a major reform of the regulations—which have undergone virtually no change over several decades—that will reduce inappropriate regulatory burdens while increasing protections for research subjects participating in the riskiest studies.
- Advising the Secretary, Assistant Secretary for Health, and other HHS officials on ethical issues pertaining to medical, biomedical, public health and other forms of research.

- Serving as liaison to Presidential, Departmental, Congressional, interagency and international commissions and boards to examine ethical issues in medicine and research.
- Serves as Executive Secretary and Executive Director of the Secretary's Advisory Committee on Human Research Protections (SACHRP) and co-chair of Human Subject Research Subcommittee (HSRS) of the National Science and Technology Council's Committee on Science. In FY 2012, the OD will support up to three SACHRP meetings, approximately five SACHRP subcommittee meetings, as necessary; and lead approximately six meetings of the HSRS.
- Manages the International Activities Program which provides leadership for HHS in the global effort to improve human research protections through developing policies, procedures and practices for the monitoring and protection of human research participants in studies conducted outside the US, and to enhance the global capacity for protecting human research participants.
- Supports and increases public understanding of the role of human subject protections in advancing biomedical and behavioral knowledge, by providing information and clarification to reporters who disseminate this knowledge to the research community and the general public.

Division of Policy and Assurances (DPA) – DPA is responsible for developing policy and guidance documents related to HHS regulations for the protection of human subjects (45 CFR part 46). These policy and guidance documents address topics that the research community has indicated warrant further clarification, an alternative regulatory interpretation, or regulatory change. The central goal of these documents are to help ensure that human research subjects are appropriately protected from harm, and to reduce unnecessary regulatory burden. Critical to meeting these goals is an active partnership with the Food and Drug Administration (FDA), the HHS agencies that conduct or support human subjects research, and the other federal departments and agencies that have adopted the Federal Policy for the Protection of Human Subjects (known as the Common Rule). Policy and guidance documents are widely disseminated both in draft and final form to the research community and the public more broadly--reaching thousands of individuals and institutions both in the public and private sectors--that are involved in safeguarding the rights and welfare of human research subjects.

DPA also plays a more direct role in implementing the HHS regulations for the protection of research subjects. DPA organizes and coordinates consultations with experts for certain research involving children, pregnant women, fetuses, neonates and prisoners; and determines whether proposed research that involves prisoners meet one of the permissible categories as required by the HHS regulations. In addition, DPA administers assurances of compliance with research institutions and implements a registration system for institutional review boards (IRB).

Specifically, the DPA contributes to the OHRP mission by carrying out the following responsibilities:

- Prepares policy and guidance documents regarding regulatory requirements and ethical issues for biomedical and behavioral research involving human subjects. DPA issued six guidance documents in FY 2010 and expects to issue up to 7 guidance documents both in FY 2011 and 2012.

  Guidance Published in FY 2010
  - Guidance on OHRP's Compliance Oversight Process for Evaluating Institutions [posted on October 13, 2009]
  - OHRP Frequently Asked Questions and Answers on Exempt Research Determination [October 15, 2009]
  - Draft Guidance on IRB Continuing Review of Research [posted on November 6, 2009; public comments by January 5, 2010]
  - Draft Guidance on IRB Approval of Research with Conditions Research [posted on November 6, 2009; public comments by January 5, 2010]

- FAQs on IRB Registration [posted on March 29]
- Guidance on Withdrawal of Subjects from Research: Data Retention and Other Related Issues [Posting Pending, anticipated before September 30, 2010]

- Develops FR notices, including notices related to the issuance of OHRP guidance, requests for information (RFI), advance notices of proposed rulemaking, notices of proposed rulemaking, final rules and notices requesting comment on information collections. DPA published three FR notices in FY 2010 and expects to publish up to seven notices in both FY 2011 and FY 2012.

  FR notices published in FY 2010
  - November 6, 2009, FR Notice announcing availability of OHRP Draft Guidance on IRB Continuing Review of Research
  - November 6, 2009, FR Notice announcing availability of OHRP Draft Guidance on IRB Approval of Research with Conditions
  - March 29, 2010, 60-day PRA FR notice, Proposing Evaluation of OHRP Outreach Pamphlet on Public Participation in Research

- Coordinates responses to requests for information, technical assistance, and guidance from Congress, other HHS agencies, other Federal agencies, and non-governmental entities. In FY 2010, DPA completed approximately 75 correspondences and expects to complete a sustained number of correspondences in FY 2011 and FY 2012.
- Negotiates Assurances of Compliance with research entities, registers IRBs, and maintains a database of Assurances of Compliance and registered IRBs. Starting in July 2009, in addition to processing the IRB registration submissions required by the HHS human subject protection regulations, DPA staff – 4 dedicated individuals - began processing IRB registration submissions on behalf of FDA. In FY 2010, DPA reviewed and accepted 3,373 new, renewed, or updated IRB registrations and 4,124 new, renewed or updated Assurances of compliance and expects to sustain approximately the same level of activity in FY 2011 and 2012.
- Reviews and approves certifications for HHS conducted or supported research involving prisoners. DPA completed approximately 125 prisoner certification requests in FY 2010, and expects to complete approximately 125 in both FY 2011 and FY 2012.
- Prepares submissions to the OMB for forms that require OMB approval under the Paperwork Reduction Act (PRA). In 2010, DPA issued three PRA notices, and expects to issue approximately four PRA notices in both FY 2011 and FY 2012.
- In conjunction with the FDA, DPA convenes a panel of experts to provide recommendations to the Secretary, as set forth in the HHS human subject protection regulations at 45 CFR 46.407, regarding whether HHS should support a certain research study involving children. DPA convened no panels in FY 2010, but expects to convene up to one panel in both FY 2011 and FY 2012.

Division of Compliance Oversight (DCO) – DCO evaluates written substantive indications of non-compliance with HHS regulations (45 CFR 46) and conducts inquiries and investigations into alleged non-compliance. These activities include conducting and preparing investigative reports, and recommending remedial or corrective action as necessary. DCO also conducts compliance oversight site visits related to the DCO investigations. They include extensive record reviews and numerous interviews with institution staff in order to evaluate specific noncompliance concerns as well as the institution's overall system for protecting human subjects. In FY 2010, DCO opened four new compliance oversight investigations and closed six compliance oversight investigations. So far in FY 2011, DCO has opened six new compliance oversight investigations and closed one compliance oversight investigations.

The Division also conducts a program of not-for-cause surveillance evaluations of institutions. This program provides an important complement to the performance-based quality improvement programs described below. DCO conducted four not-for-cause compliance oversight evaluations in FY 2010.

The Division also receives, reviews, and responds to incident reports from Assured institutions. These reports include reports of suspensions or terminations of IRB approval of research, serious or continuing non-compliance, and unanticipated problems involving risks to subjects or others. DCO has reviewed and closed about 978 incident reports in FY 2010.

Division of Education and Development (DED) –The critical elements of human subjects' protection—informed consent, equitable selection of subjects, research designed to maximize benefits and minimize risks, as well as the development and maintenance of the appropriate administrative infrastructure to support sound and ethical research—are not "taught" in medical school, business school, or other academic programs. DED fills this critical gap in the furtherance of sound and ethical research by providing technical assistance to institutions engaged in HHS-conducted or sponsored research involving human subjects through developing and maintaining educational guidance materials related to protection of human research subjects. With more than 10,000 Federal-wide Assurance (FWA) - holders and more than 6,000 registered IRBs, DED has an enormous mandate. In a system based largely on trust and the delegation of responsibilities, education of all the stakeholders involved in research involving human subjects is essential. A strong educational foundation is the single most important element in helping to ensure that the safety and welfare of the most precious and valued resource--the human volunteers indispensable to the research enterprise--are protected adequately and appropriately.

- In FY 2010, DED helped organize three OHRP Research Community Forums attended by more than 1,100 people from across the country and abroad. These national conferences provide in-depth and focused human subject protections education across the spectrum of issues, from very basic regulatory education to high-level discussions of advanced topics, and are provided to the regulated community for a fraction of the cost of similar programs provided by non-governmental entities in the field.
- DED staff present at large professional, academic, and association conferences across the country. DED gave approximately 50 presentations in FY 2010, and expects to do the same in FY 2011 and FY 2012.
- DED provides hands-on support to institutions through quality improvement workshops. Originally piloted to reach about 40-50 individuals working in FWA-holding institutions, this program has grown to reach up to 200 people over the course of a two-day program. The program provides regulatory information and focused on the development of compliant written policies and procedures, IRB minutes, IRB membership, and other issues of concern. In FY 2010, DED conducted eight of these programs across the country, and looks to conduct up to six in FY 2011 and 2012. DED has evaluated the current two day program and plans to take the most pertinent topics of the two day workshop and, in order to reduce costs, will combine them into a one day workshop which will provide educational opportunities for approximately 100 institutional staff.

OHRP activities contribute directly to Goal 4 of the HHS Strategic Plan, which is to *Advance scientific and biomedical research and development related to health and human services.* 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 2007	$6,897,000
FY 2008	$6,701,000
FY 2009	$6,959,000
FY 2010	$6,949,000
FY 2011	$6,949,000

Budget Request

The FY 2012 budget request of $7,007,000 is an increase of $58,000 over the comparable FY 2010 Appropriation. Funds will allow OHRP to maintain the same level of activity as described above. OHRP well recognizes the importance of the two key aspects of its activities to the well-being of the Nation's clinical research enterprise assuring the integrity of the system for protecting research subjects; and assuring that that system works in an efficient and effective manner, and does not inappropriately delay or burden the conduct of research.

In FY 2012, OHRP will update the DCO's web-based Compliance Activities Tracking System (CATS database). The current CATS database is housed on a server that is not accessible through the internet and must be maintained by a sole-source contractor. The new web-based database will assist the Division in tracking compliance oversight investigations, not-for-cause evaluations, FDA inspection reports, No Action reports, miscellaneous reports, and incident reports (research institution's reports of incidents that occur within the context of HHS-funded or -supported research studies, which are required by HHS regulations.). The new web-based system could potentially allow for the DCO database to communicate with other systems being developed for adverse event reporting, reducing reporting burden. One of the goals of the Federal Adverse Event Task Force (FAET) is to determine how agencies collect and use data in promoting the safety and integrity of their clinical research activities, and identify opportunities for greater interagency harmonization.

OASH
OFFICE OF RESEARCH INTEGRITY
Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	9,118	9,118	9,709	591
FTE	24	24	24	0

Authorizing Legislation……..……Title III, Section 301 and Title IV Section 493 of the PHS Act
FY 2012 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). To accomplish this mission, key, long standing, primary, and sustained responsibilities of ORI are to: 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.

Unfortunately, some researchers will behave irresponsibly and temptation for misbehaving increases with global competition for funding and prestige. The public must know that effective systems are in place to protect them from research misconduct. Those systems include the regulation, forensic tools, and education that ORI has provided for more than 20 years. 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, which were found under HHS regulations, has resulted in more people 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 maintain 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. Key components of this plan were: 1) the establishment of a research program to study the factors influencing research integrity; 2) 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.

ORI's budget, resources, and programs are relevant directly to the Department's interest in prevention of disease and promotion of health. 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 receive PHS research funding must submit an assurance statement and their policies and procedures for handling allegations of research misconduct, thus 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.

Over the past three years (2007-2009), ORI has accomplished the following:[21]

- Reviewed more than 800 allegations of misconduct, opened more than 80 formal inquiries and investigations, and made 29 findings of research misconduct.
- Reviewed more than 100 institutional policies and procedures for regulatory compliance and responded to over 15 incidents of possible retaliation against good faith whistle blowers or non-compliance with regulatory requirements.
- Sponsored or participated in more than 50 workshops and conferences with research institutions, scientific societies, and others on research misconduct, the responsible conduct of research, and the promotion of research integrity.
- Engaged in the development of more than 10 educational products in Responsible Conduct in Research (RCR).
- Funded 15 grants to support research on misconduct, education in research integrity, conflicts of interest, and institutional practices that affect the integrity of research.
- Provided on-site or telephonic technical assistance to approximately 150 research institutions in handling allegations of misconduct.
- Received and managed the Annual Report on Possible Research Misconduct for approximately 5000 institutes per year.
- Prepared quarterly newsletters for distribution through postal service
- Updated and modified ORI website, which was visited more than 100,000 times during the period
- Adopted a sample misconduct policy in 2007 to assist institutions in implementing the new PHS misconduct regulation, 42 CFR Part 93, Subpart E, that requires the accused scientist to provide

[21] All ORI data are reported on a calendar year, rather than fiscal year, basis.

specific factual evidence during inquiries and investigations of research misconduct.
- Funded 78 awards to 72 societies through a cooperative agreement with Association of American Medical Colleges (AAMC) resulting in 20 educational products related to research integrity and the responsible conduct of research.
- Funded development of five model RCR programs at leading research universities.
- Created universal objectives and learning topics for the core areas of responsible conduct of research.
- In partnership with NIH, ORI has funded 53 projects that have resulted in 91 publications in 30 journals.
- Completed two intramural research studies and published the findings in peer reviewed journals.
- Awarded three contracts for research about Research Integrity Officers, mentoring, and researcher's knowledge about research integrity
- Awarded funds to the National Postdoctoral Association to facilitate the creation of RCR programs specific for post docs.
- Focused 3 conferences for RCR educators and for RCR researchers so that the professionals were enabled to interact and learn from each other.
- ORI staff made presentations at more than 167 conferences to more than 10,000 total attendees
- Increased staff involved in making presentations at conferences

ORI supports the following OASH performance measures:

- Increase the number of substantive commitments to prevention on the part of governmental and non-governmental organizations.
- Increase knowledge about disease prevention and health promotion, including effective interventions and research needs.
- Increase the reach and impact of OASH communications related to strengthening the public health and research infrastructures.
- 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 2007	$8,172,000
FY 2008	$8,571,000
FY 2009	$8,909,000
FY 2010	$9,118,000
FY 2011	$9,118,000

Budget Request

The FY 2012 budget request of $9,709,000 is an increase of $591,000 over the comparable FY 2010 Appropriation. The FY 2012 budget will be used for operational expenses, to support staff for misconduct investigation oversight and responsible conduct of education, and to maintain existing ORI Initiatives.

The ORI Initiatives are categorized broadly into these programs: 1) Research Integrity Officer Training; 2) Extramural Research on Research Integrity; 3) Conferences and Workshops; 4) Educational Resources Development; and 5) Communications. Some of the major projects under the category Research Integrity Officer Training include conducting three or more week-long intensive "boot camps." Research Integrity Officers (RIO) often bring the institution's counsel with them to learn how to conduct research

misconduct inquiries and investigations properly and in conformance with federal regulation 42 CFR 93. In addition, the funds in this category support a website for RIOs.

The Extramural Research Program will continue to be conducted in partnership with NIH to provide funds for research on research integrity and has resulted in more than 53 publications in refereed journals.

The Conferences and Workshops Program will continue to enable participants to gather regionally, nationally, and internationally to hear renowned speakers and have discussions on research integrity.

The Educational Resources Development Program will include projects to develop modules for young scientists to learn about research integrity, a documentary on safeguarding research integrity, and development of a computer interactive learning exercise for learning about research integrity.

The communications program will include further development of social networking tools as a means of educating users about research integrity, as well as further development of ORI publications such as books, the ORI newsletter, and website. Together these programs continue to support an expanded national education campaign, begun in 2009, to promote research integrity and quality research. ORI intends to continue this nationwide program designed to help educate graduate students, postdoctoral scholars, faculty, and other researchers in the responsible conduct of research. The RCR curriculum will continue to be updated and expanded. Regional workshops used effectively in the past and described in such prestigious journals as *Science* and *Nature* will continue to be a primary means of delivering the curriculum. The workshops will be facilitated by the ten HHS regional offices, the more than 40 Clinical Translational and Science Centers, and scientific professional and administrative associations. The national campaign also will continue to engage scientists, administrators, and the public through use of research integrity posters, enacting live scenarios that help develop ethical decision making skills, use of interactive video scenarios that enable learners to navigate through ethical dilemmas, and use of the ORI web site and social networking technologies to encourage discussion between ORI and the research community about research integrity issues.

Demand for research has never been greater as the nation, indeed the world, face global crises that require research responses; yet there is a general shortage of U.S. researchers to meet research demand—*per capita* fewer students in the U.S. are choosing research as a career. These shortages of U.S. researchers result in an increasing reliance on researchers from outside the U.S., who may need additional training in their scientific discipline and in conducting research in a culture different from their own. As researchers are a limited resource and their innovation and productivity is vital to our nation's health and welfare, the ORI national campaign centers on their continued development through education in research integrity.

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

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	1,225	1,225	1,323	98
FTE	6	6	6	0

Authorizing Legislation……..…….……Title III, Section 301 of the PHS Act
FY 2012 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 Health and Human Services about physical activity, fitness, sports, and good nutrition. Through its 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 through participation in a variety of physical activities and the development and maintenance of healthy eating habits. The PCFSN is directed to coordinate programmatic activities in consultation with the Departments of Agriculture and Education.

Among its key activities, the Council will continue to promote and enhance its 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. An inter-agency agreement with the Centers for Disease Control and Prevention-Division of Adolescent and School Health will lead to improvements in the long-standing youth fitness test, which is central to the President's Challenge program. Launched September 2010, the year-long Million PALA Challenge (MPC) initiative aims to get one million individuals to earn their Presidential Active Lifestyle Award (PALA), one of the awards offered through the President's Challenge. Key to MPC success is the partners who have pledged to engage their respective audiences and members in the PALA. In addition, the Council continues to support various elements of the *Let's Move* initiative and promote actions that further the achievement of relevant *Healthy People 2020* goals.

Funding History

FY 2007	$1,230,000
FY 2008	$1,195,000
FY 2009	$1,228,000
FY 2010	$1,225,000
FY 2011	$1,225,000

Budget Request

The FY 2012 budget request of $1,323,000 is an increase of $98,000 over the comparable FY 2010 Appropriation. The PCFSN will support the additional costs of the Council which was expanded in FY 2010 to include five additional members.

Outputs and Outcomes

OASH Goal: Prevent disease and improve the health of individuals

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
1a: Number of schools and organizations that adopt the President's Challenge	FY 2009: 32,000 Target Not Met	30,000	35,000	+ 5,000
1b: Increase reach of PCPFS messages through Website, participation in conferences or consultations with professional groups, education materials/campaigns, and media coverage of PCPFS events/initiatives.	FY 2009: 796,867 Target exceeded	800,000	850,000	+50,000
1c: Promote effective partnerships (MOUs, LOUs)	FY 2009: 22 Target not met	30	40	+10
1d: Increase physical activity and fitness knowledge through peer-reviewed texts	FY 2009: 4 Target met	4	4	No Change
1e: Chair or staff prevention-oriented initiatives in HHS or across Federal agencies and non-duplicative outcomes from those efforts	FY 2009: 24 Target Exceeded	18	18	No Change

OASH Goal: Reduce and eliminate health disparities

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
2a: Number of communities that adopt policies or recommendations targeting health disparities that are promoted by PCPFS	FY 2009: 2 Target not met	5	7	+ 2
2b: New, targeted educational materials/camaigns	FY 2009: 0 Target not met	1	3	+ 2
2c: Promote effective partnerships (MOUs, LOUs) that address health disparities	FY 2009: 5 Target exceeded	5	10	+5
2e: Chair or staff disparities-oriented initiatives in HHS or across Federal agencies and non-duplicative outcomes from those efforts	FY 2008: 3 Target Not Met	2	2	No Change

OASH Goal: Strengthen the public health infrastructure

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
3e: Chair or staff relevant initiatives in HHS or across Federal agencies and non-duplicative outcomes from those efforts	FY 2008: 7 Target Exceeded	5	6	No Change
Program Level Funding ($ in millions)	**N/A**	**$1,235,000**	**$1,423,000**	**$12,000**

OASH
PUBLIC HEALTH REPORTS
Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	448	448	452	4
FTE	2	2	2	0

Authorizing Legislation……Title III, Section 301 of the Public Health Service Act
FY 2012 Authorization……Indefinite
Allocation Method……..Direct federal; Contract, Cooperative Agreement

Program Description and Accomplishments

The journal *Public Health Reports* (*PHR*), the oldest journal of public health in the U.S., has published continuously since 1878. *PHR* is the public health journal of the U.S. Public Health Service and the Surgeon General, and is produced in collaboration with the Association of Schools of Public Health. *Public Health Reports* 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 three to four science-based webcasts are also produced each year. Each issue includes columns such as the *Surgeon General Perspective*, *International Observer*, *Law and the Public's Health*, *Public Health Chronicles*, and *From the Schools of Public Health* that address important national and international public health issues. The *Surgeon General Perspective* highlights and discusses timely and emerging public health issues identified by the Surgeon General.

The Journal also has a special interest in emphasizing public health history, not only in the *PHR* Public Health Chronicles column but also in supplements and yearly premiums. For example, *Public Health Reports: Historical Collection 1878-2005* is a supplement containing 35 seminal articles with added historical commentary that have appeared over the years. *Vaccination* is a *PHR* CD that contains a history of vaccine use in America from the 18th century to the present day. This *PHR* end-of-year premium explores the history of this essential public health tool through an audio presentation with historical timelines, photographs, and archived articles. Recently, the entire set of *PHR* journal articles from 1878 has been digitized and is currently available on the internet at: http://www.pubmedcentral.nih.gov/tocrender.fcgi?journal=333&action=archive .

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

- Contract with Capital Communications Systems Inc. (CCSI) –CCSI provides the design and layout for six regular journal issues per year.
- Professional Services in the form of purchase orders are contracted annually including technical editors, photo journalism, special topic peer-review, and web-cast coordination.
- A grant is awarded annually to the Association of Schools of Public Health to provide support costs related to printing, mailing, subscriptions, and other public health report tasks.

PHR supports the Secretary's Strategic Initiatives by accelerating the process of scientific discovery to improve patient care.

Funding History

FY 2007	$455,000
FY 2008	$443,000
FY 2009	$450,000
FY 2010	$448,000
FY 2011	$448,000

Budget Request

The FY 2012 budget request of $452,000 is an increase of $4,000 over the comparable FY 2010 Appropriation. The FY 2012 Request provides funds to continue operations at the established levels.

Outputs and Outcomes

End-of-year	# of Manuscript Submissions
2005	320
2006	323
2007	416
2008	410
2009 (12/10/09)	424

Key Outcomes	Most Recent Results	FY 2010 Estimate	FY 2012 Estimate	FY 2012 +/- FY 2010
Increase the number of submissions for consideration by Public Health Reports	424 (CY 2009)	450	475	+5%
Publish two or more supplements or special issues to add even more focus to important public health matters	2 (CY2009)	5 or 6	3 or 4	0%
Improve the desirability and outreach of the journal that will increase the frequency that PHR is referenced	3 webcasts (CY2009)	3	3	0%

OASH
TEEN PREGNANCY PREVENTION
Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	110,000	110,000	0	-110,000
FTE	13	20	0	-13

PL –Prevention & Public Health Fund	0	0	110,000	110,000
FTE	0	0	20	20

Authorizing Legislation..... Consolidated Appropriation Act, FY 2010
Allocation Method..... Direct federal, Competitive Grants, Contracts

Program Description and Accomplishments

The Teen Pregnancy Prevention (TPP) program is a new discretionary grant program to support evidence-based teen pregnancy prevention approaches and is under the direction of the Office of Adolescent Health (OAH). These funding supports 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. The OAH coordinates its efforts with other HHS offices and operating divisions.

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 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. The Office is engaged in collaborations in implementing TPP program and evaluation activities with ASPE, ACF and CDC. OAH has begun work to develop appropriate program performance measures for the TPP program as well as design a system for collecting and reporting annual performance data. OAH is also partnering with ASPE supporting an ongoing annual review of the evidence base. TPP grantees are currently engaged in a planning, piloting and readiness period, and are expected to achieve a series of milestones that will allow them to fully and successfully implement their projects.

Funding History

FY 2007	$0
FY 2008	$0
FY 2009	$0
FY 2010	$110,000,000
FY 2011	$110,000,000

Budget Request

The FY 2012 request has been included with the Prevention and Public Health Fund.

Program Data

RESOURCE DATA	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Request
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
Total, TPP Grants	100,000,000	100,000,000	100,000,000
Training and Technical Assistance, Outreach, and other program support*	10,000,000	10,000,000	10,000,000
Evaluation	---	---	4,000,000
Prevention	4,455,000	4,455,000	4,455,000
Total Resources	114,455,000	114,455,000	118,455,000
PROGRAM DATA			
Number of Teen Pregnancy Prevention Grants			
Discretionary Grants			
New starts	110		
Continuations		110	110
Contracts	9	10	10

*Program support – includes funding for space, equipment, information technology, grants panel review costs, conference fees, program monitoring, travel, printing, staff salaries and benefits, and associated operating costs.

OASH
ADOLESCENT FAMILY LIFE
Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	16,658	16,658	0	-16,658
FTE	12	12	0	-12

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, supports 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.

AFL demonstration grants are awarded to public or private nonprofit organizations for up to a five-year project period. The AFL program serves pre-adolescents, adolescents, families, infants of parenting teens, and teen fathers. All AFL demonstration projects are community-based and focus on ways to build and strengthen families. Demonstration projects funded by the "Care" component of AFL are designed to ameliorate the negative effects of too-early childbearing on teen parents, their infants and their families. These services include prenatal and postnatal care, nutrition counseling, parenting workshops, GED education, tutoring, vocational training, child care, family planning counseling, individual/couples/family counseling, child care and transportation.

The AFL legislation also authorizes support for basic and applied research focusing on the causes and consequences of adolescent pregnancy and parenting. FY 2011 funding will support the AFL Care demonstration grants and the program's research components.

Funding History

FY 2007	$30,229,000
FY 2008	$29,778,000
FY 2009	$29,778,000
FY 2010	$16,658,000
FY 2011	$16,658,000

Budget Request

HHS is not requesting funds for the AFL program for FY 2012. Mandatory funding for the Pregnancy Assistance Fund was included in the Patient Protection and Affordable Care Act. This new program directs resources to similar populations and activities-making the AFL program duplicative. Therefore HHS has not provided funding to continue the AFL program.

Outputs and Outcomes

Measure	Most Recent Result (FY 2008)	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Long-Term Objective 1: Encourage adolescents to postpone sexual activity by developing and testing abstinence interventions.				
1.1 Increase communication among parents and adolescents on topics relating to puberty, pregnancy, abstinence, alcohol, and/or drugs.	43%	N/A	N/A	N/A
1.2 Increase adolescents' understanding of the positive health and emotional benefits of abstaining from premarital sexual activity.	57.5%	N/A	N/A	N/A
Long-Term Objective 2: Ameliorate the effects of too-early-childbearing by developing and testing interventions with pregnant and parenting teens				
2.1 Maintain the incidence of clients in AFL Care demonstration projects who do not have a repeat pregnancy.	90%	92%	N/A	N/A
2.2 Increase infant immunization among clients in AFL Care demonstration projects.	65%	82%	N/A	N/A
2.3 Increase the educational attainment of clients in AFL Care demonstration projects.	79%	80%	N/A	N/A
Long-Term Objective 3: Identify interventions that have demonstrated their effectiveness to: 1) promote premarital abstinence for adolescents and 2) ameliorate the consequences of adolescent pregnancy and childbearing.				
3.1 Improve the quality of the Title XX independent evaluations (prevention/care)	48.5%/ 55.5%	N/A / 58.8%	N/A	N/A
Long-Term Objective 4: Improve the efficiency of the AFL program.				
4.1 Sustain the cost to encounter ratio in Title XX prevention and care demonstration projects (prevention/care)	$25/ $72	N/A / $110	N/A	N/A
Program Level Funding ($ in millions)		$16.658	$0	-$16.658

ADOLESCENT FAMILY LIFE
Program Data

Activity	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget	
PROGRAM FUNDING	No.	Amount	No.	Amount	No.	Amount
Care Demonstration Grants						
Continuations	17	6,186,264	18	8,435,052	0	0
New	11	5,812,712	8	2,563,970	0	0
Subtotal, Care	28	11,998,976	26	10,999,022	0	0
Research						
Continuations	0	0	0	0	0	0
New	0	0	4	1,000,000	0	0
Subtotal, Research	0	0	4	1,000,000	0	0
Technical Assistance Activities		1,240,000		1,240,000		0
Research IAAs & Related Activities		640,418		640,418		0
Support Costs		2,778,606		2,778,560		0
TOTAL		**16,658,000**		**16,658,000**		**0**

OASH
OFFICE OF MINORITY HEALTH
Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	55,900	55,900	57,980	2,080
FTE	63	63	63	0

Authorizing Legislation……..…Title XVII, Section 1707 of the PHS Act
FY 2012 Authorization……P.L. 111-148 of 2010
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), reauthorized under the Health Professions Education Partnerships Act of 1998 (PL 105-392), and most recently reauthorized under the Patient Protection and 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.

The primary recipients of OMH grant funds include 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 makes approximately 149 grant awards per year which are intended to foster informed, empowered individuals and communities as a means for promoting community solutions to eliminate health disparities; promote prevention and wellness across the lifespan; improve the diversity and cultural competency of the health-related workforce; and, ensure access to quality, culturally competent care. 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.

Funding History

FY 2007	$53,455,000
FY 2008	$49,118,000
FY 2009	$52,956,000
FY 2010	$55,900,000
FY 2011	$55,900,000

Budget Request

The FY 2012 President's budget request of $57,980,000 is an increase of $2,080,000 over the comparable FY 2010 Appropriation. The FY 2012 budget request will support the following projects and support the priorities of the Secretary:

The following offices and programs continued to be funded at their previous levels including*: The Office of Minority Health Resource Center;* The *Healthy Baby Begins with You* campaign; the hosting of a World Hepatitis Day; *The Center for Linguistic and Cultural Competence in Health Care (CLCCHC); the Partnerships Active in Communities to Achieve Health Equity (PAC - formerly Community Partnership to Eliminate Health Disparities Demonstration Grant Program - CPEHD); Bilingual/Bicultural Demonstration Grant Program; Minority Community HIV/AIDS Partnership: Preventing Risky Behaviors Among Minority College Students (formerly the HIV/AIDS Cooperative Agreement Program); National Umbrella Cooperative Agreement Program (NUCA); State Partnership Program; and the Youth Empowerment Program (YEP).* These programs continue to make strides in supporting and improving the health status and health outcomes for African Americans, Hispanic Americans, American Indians, Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders. These funds are important to ongoing initiatives and completing continuation grants and multi-year efforts.

While an ongoing program, the FY 2012 request supports an expansion of the following program - *Curbing HIV/AIDS Transmission Among High Risk Minority Youth and Adolescents by Utilizing a Peer-to-Peer Outreach Model and New Application Technologies (CHAT)* - Through the CHAT Program, OMH seeks to improve the HIV/AIDS health outcomes of high risk minority youth by supporting community-based efforts (10 grantees) to increase HIV/AIDS prevention and education, testing, counseling and referrals. It is expected that CBOs will ensure that their efforts will enhance current programs and strategies and expand established capacity by federal agencies, and public and private youth service providers to engage youth who are currently in alternative education settings, alternative living arrangements ordered by the courts, and juvenile detention facilities. This project encourages partnerships among traditional service providers targeting high risk adolescents, such as substance abuse prevention centers for youth; foster care agencies working with youth; youth serving organizations; youth runaway shelters; and peer-to-peer education programs. More than 4,383 youth/young adults were screened for HIV and more than 5,000 were provided HIV prevention education via peer educators and new media during FY 2010 through this program.

Outputs and Outcomes

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
4.3.1: Increased average number of persons participating in OMH grant programs per $1 million in OMH grant support(2006 Baseline: 18,960) (Efficiency)	FY 2010: 18,376[22]	15,515	15,980	+465
4.4.1: Increased unique visitors to OMH-supported websites (Output)	FY 2010: 573,732[23] (Target Exceeded)	575,000.0	580,000.0	+5,000

Long Term Objective: Increased percentage of measurable racial/ethnic minority-specific Healthy People 2010 objectives and sub-objectives that have met the target or are moving in the right direction

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2011
4.1.1: Increased percentage of measurable racial/ethnic minority-specific Healthy People 2010 objectives and sub-objectives that have met the target or are moving in the right direction. (2005 Baseline: 62.4%) (Outcome)	FY 2008: 67.8% (Historical Actual)[24]	N/A	N/A	N/A

[22] In early May 2010, OMH launched its Performance Data System (PDS) which replaced the Uniform Data Set (UDS) previously used to obtain OMH grantee and program activity data. The PDS, unlike the UDS, is designed to reflect the logical approach used in the Strategic Framework and the Evaluation Planning Guidelines developed by OMH; enable collection of more performance-oriented data tied to OMH-wide performance measurement and reporting needs (including relevant OASH GPRA measures and the objectives of the National Partnership for Action to End Health Disparities and Healthy People 2010/2020; and reduce respondent burden through improved layout, logical flow, etc.). All data quality and integrity issues experienced with the UDS have been corrected, and OMH can now systematically document and track grantee and grant program progress. The first grantee reporting period (for the first half of FY 2010) using the PDS occurred throughout May 2010, and the reporting period for the second half of FY 2010 occurred throughout November 2010. The current FY 2010 estimates include the final results of the May 2010 collection and PRELIMINARY results of the November 2010 collection. Data for the second half of FY 2010 are currently being reviewed and validated and are not yet complete (i.e., OMH is awaiting data from a couple of grantees whose reporting deadlines have been extended.) . Final results are expected by the end of January 2011.

[23] Due to increases in referrals from Google, OMH realized a substantial increase (over its 2010 target of 420,000) in unique visitors to its Resource Center website in FY 2010. These increases resulted from steps taken by OMH during the year to improve results in Google searches and also convert to a new URL (www.minorityhealth.hhs.gov), which identifies the OMH web site as part of a trusted source, the HHS family of web sites. Given this success, OMH has raised the target for FY 2011 and beyond to reflect an expectation of sustained increases on this measure.

[24] Although not required, OMH was able to calculate an interim result by using Healthy People DATA 2010 and NCHS calculations of the progress quotient, obtained in April 2010. The data analysis indicates that the Nation continues to be on track to reach the long-term target by the end of 2010. As of mid-December 2010, the most recent data available in the Healthy People DATA 2010 database remains that from 2008. This measure will be retained until results of progress for the decade ending in 2010 are available.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2011
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[25]	N/A	N/A	N/A

Long Term Objective: Increased awareness of racial/ethnic minority health status and health care disparities in the general population

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2011
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: 47.5%) (Outcome)	FY 2010: 58.9% (Target Exceeded)[26]	61.9%	63.1%	+1

Grant Awards

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Request
Number of Awards	120	120	157
Average Award	$198,483	$198,483	$201,443
Range of Awards	$130,000-$900,000	$130,000-$900,000	$125,000-$1,000,000

[25] The target for 2020 will be determined after analyses and reports of actual results for the first decade of the 21st century ending in 2010 have been completed. The baseline data will be available in FY 2015, after the mid-decade assessment of progress has been conducted.

[26] 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 were found.

Program Data Chart

Activity	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Request
OMH Resource Center	3,700,000	3,700,000	3,700,000
Logistical Support Contract	1,400,000	1,400,000	2,000,000
Center for Linguistic and Cultural Competency in Health Care	1,600,000	1,600,000	1,600,000
Evaluation	700,000	700,000	1,000,000
Tobacco Cessation	0	0	2,000,000
Comparative Demonstrations	0	0	2,700,000
Other Contracts & IAAs	4,879,000	4,879,000	4,879,000
Subtotal, Contracts	12,279,000	12,279,000	17,879,000
National Minority Male Health Project	1,000,000	1,000,000	1,000,000
Minority Community HIV/AIDS Partnership (formerly the HIV/AIDS Cooperative Agreements)	1,150,000	1,150,000	1,150,000
Umbrella Cooperative Agreements	2,725,000	2,725,000	3,225,000
Subtotal, Coop Agreements	4,875,000	4,875,000	5,375,000
Bilingual/Bicultural Demonstrations	0	0	1,200,000
Health Disparities Program:			
State Partnership Grants	6,600,000	6,600,000	7,100,000
American Indian/Alaska Native Partnership Grants	1,600,000	1,600,000	2,000,000
Community Partnership Grants	6,250,000	6,250,000	6,250,000
Youth Empowerment Program	5,300,000	5,300,000	3,500,000
Conference Support Program	200,000	200,000	350,000
Subtotal, Demonstration Projects	19,950,000	19,950,000	20,400,000
Health Disparities – Mississippi	4,000,000	4,000,000	0
Specified Project – Lupus	1,000,000	1,000,000	0
Operating Expenses	13,796,000	13,796,000	14,326,000
TOTAL	**55,900,000**	**55,900,000**	**57,980,000**

OASH
OFFICE ON WOMEN'S HEALTH
Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	33,746	33,746	33,746	0
FTE	43	43	43	0

Authorizing Legislation……..……Title III, Section 301 of the PHS Act
FY 2012 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 agenda throughout the Department of Health and Human Services (HHS) and was authorized in the Patient Protection and Affordable Care Act of 2010 (PPACA). The office has four goals: 1) Develop and impact national women's and girl's health policy; 2) Develop, adapt, implement and evaluate and/or replicate model programs on women's and girls' health; 3) Educate, influence and collaborate with health and human service organizations, health care professionals, and the public; and 4) Increase OWH's organizational efficiency and performance.

OWH provides departmental leadership on women's health, while developing partnership opportunities across agencies and with the private sector. OWH promotes health equity for women and girls through sex/gender-specific approaches and fulfills this mission through competitive contracts and grants to an array of community, academic and other organizations at the national, state and local levels. National educational campaigns provide information about the important steps women can take to improve and maintain their health. This approach maximizes efficiency and minimizes costs. OWH has experienced success in all of its program goals.

OWH instituted a Strategic Plan for FY 2010 - FY 2015, which became effective in October 2008. 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, in which minority status, disabilities, geography, family history, low socioeconomic status (SES), chronic conditions, and infectious diseases are contributing risk factors.

FY 2008 Appropriations Language directed OWH to fund the Institute of Medicine to conduct a study of progress in women's health research. Details of the *Women's Health Research: Progress, Pitfalls, and Promise* study, the committee membership, and related materials can be found at http://www.iom.edu/CMS/3793/61343.aspx. The results were announced on September 23, 2010 and outlined key findings and recommendations to address these findings.

Impact National Health Policy as it relates to Women and Girls

OWH continues leadership and management of the following committees: Chronic Fatigue Syndrome Advisory Committee (CFSAC); and the HHS Coordinating Committee on Women's Health (CCWH), and is working to establish a Federal Advisory Committee (FAC) on Women's Health to provide expert advice and evidence-based recommendations to the Secretary and Assistant Secretary for Health on a

broad range of issues including prevention, education, policy and programmatic approaches to improving the status of women's and girls' health. This advisory committee will assist OWH with expert consultation on emerging women's health issues, preventive and behavioral programs, and identification of relevant partnering and collaborative opportunities. OWH also works collaboratively with the White House Office of National AIDS Policy and the President's Advisory Council on HIV/AIDS in the implementation of a national strategy on HIV/AIDS that addresses the critical needs of women and girls.

OWH is highly engaged in efforts that address the following: the Surgeon General's Call to Action to Support Breastfeeding; *Violence Against Women* (VAW); the HHS Oral Health Initiative; young women's breast health awareness and support of young women diagnosed with breast cancer; and is a leader in programs to address these issues.

Funding History

FY 2007	$28,219,000
FY 2008	$31,033,000
FY 2009	$33,746,000
FY 2010	$33,746,000
FY 2011	$33,746,000

Budget Request

The FY 2012 President's Budget Request is $33,746,000 the same as the FY 2010 Appropriation. OWH will continue its established operations at this level. Specific FY 2012 activities include ongoing programs including the following:

OWH has two adolescent programs that seek to affect public policy, *Best Bones Forever* (BBF) and *Bodyworks*. The BBF campaign is partnering with the American Academy of Pediatrics (AAP) to change the way pediatricians interact with adolescent girls around increasing exercise as well as calcium and vitamin D consumption. The *Bodyworks* program is also working with the AAP to include *Bodyworks* as a resource for obesity prevention with adolescents and their parents. The *BodyWorks* toolkit for the prevention of obesity focuses on the family as the most important environment to prevent obesity in girls and the rest of the family. The toolkit helps parents and caregivers of young adolescent girls and boys (ages 9-13) improve family eating and activity habits. An extensive evaluation of Bodyworks is planned for FY 2011-FY 2013.

OWH will continue with Phase II of the *Coalition for a Healthier Community* (CHC) a new gender-based national program that enables communities to implement evidence based or evidence influenced prevention interventions. For Phase II, OWH supports the implementation of health interventions targeting women/girls that are gender-based, cost effective, community driven and sustainable. This new initiative builds on the lessons learned and strengths of the *Advancing System Improvements to Support Targets for Healthy People 2010* (ASIST 2010) model to provide support to communities to implement evidence-based gender specific programs to address health issues identified by the community. The CHC cooperative agreement is a two phased approach allowing one year for planning and up to five years for implementation and evaluation. The first phase assessed the community to determine issues that have a devastating impact on the health of women and girls and to develop a strategic action plan to address the issue(s). The communities are then required to link their Phase II program to Healthy People (HP) 2020 objectives and to set SMART objectives to meet the HP 2020 objectives.

The multi-agency program to reduce smoking rates in young, low socioeconomic status (SES) women, will be expanded to Medicare patients in FY 2012.

OWH plans to develop and implement a series of women's health seminars that will provide the public with easily accessible and accurate health information. The seminars will be conducted using webcast, webinar, podcast and web forum technologies. The goals of this initiative are to increase the number of women and girls accessing free health information; and increase the understanding and knowledge of federal activities. The seminars will also enhance OWH's current communication tools i.e. women's health websites, Facebook and Twitter pages. The women's health seminars align with Secretary Sebelius' initiatives to foster open government, ensure timely and effective communications, and disseminate health information to the public.

OWH proposed to build on the successes of the National Lupus Awareness Campaign and the Lupus Provider Education Program to engage the public and health providers in a pilot project to address all autoimmune diseases which primarily impact woman and girls.

Grants will be funded to conduct a Health and Wellness Initiative for women attending minority serving institutions (Historically Black Colleges and Universities, Hispanic-Serving Institutions, and Tribal Colleges and Universities). The health promotion initiative is a multi-level (community, group, and individual level) approach designed to address the health needs and concerns of women of color (African American, Hispanic/Latina, and Native Americans and Alaska Natives) through student-driven, gender-responsive health education activities. This initiative is a 3-year pilot project.

OWH will assess and evaluate the Spanish adaptation (expected for release in FY 2011) of the women's mental health consumer publication, *Women's Mental Health: What it means to you*. This publication is the companion, consumer booklet to *Action Steps for Improving Women's Mental Health*, a report that outlines specific action steps for policy-makers, health care providers, researchers, and others to take to address the burden of mental illness on women's lives and increase their capacity for recovery. Additionally, mental health education and outreach materials will be developed for military and veteran women.

Outputs and Outcomes

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
Long-Term Objective 1: Increase the percentage of women-specific Healthy People 2010 objectives and sub-objectives that have met their target or are moving in the right direction				
1.1 Increase the percentage of women-specific *Healthy People 2010* objectives and sub-objectives that have met their target or are moving in the right direction.	63.4% (target not met)	74.0% (245/338)	N/A	N/A
1.1 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. (Updated)		N/A	Baseline	N/A
Long-Term Objective 2: Increase heart attack awareness in women				
2.1 Increase the percentage of women who are aware of the eight early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911. (Baseline: FY05 54.5%)	53% (target not met)	70%	72.5%	+2.5
Long-Term Objective 3: Expand the number of users of OWH communication				
3.1 Number of users of OWH communication resources (e.g. NWHIC, womenshealth.gov website; and girlshealth.gov website).	15.2m sessions (target not met)	32.0m sessions	33.0m sessions	1.0m sessions
Long-Term Objective 4: Increase the number of people that participate in OWH-funded programs per million dollars spent annually				
4.1 Number of girls ages 9-17 and women ages 18-85+ that participate in OWH-funded programs (e.g. information sessions, websites, and outreach) per million dollars spent annually.	1,603,451 (exceeded target)	770,461	740,828	-29,433
Program Level Funding ($ in millions)		**$33.746**	**$33.746**	**---**

OASH
COMMISSIONED CORPS INITIATIVES

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	14,813	14,813	7,013	-7,800
FTE	31	31	23	-8

Authorizing Legislation ..... Title III, Section 301 & Title XXVIII, Section 206 of PHS Act
FY 2012 Authorization ..... Indefinite
Allocation Method ..... Direct Federal; Contracts

Program Description and Accomplishments

This request provides funding to support the Office of the Surgeon General (OSG) and its component organizations including the Office of Force Readiness and Deployment, Office of Reserve Affairs, and the Office of Science and Communication. The Office of Commissioned Corps Operations is supported through the HHS Service and Supply Fund.

Readiness and Response: The Office of Force Readiness and Deployment (OFRD), a division in the OSG, was established in 2003 to manage the Commissioned Corps Readiness and Response Program.

The mission of the Commissioned Corps Readiness and Response Program is to provide a timely, appropriate, and effective response by U.S. Public Health Service officers to:

- public health and medical emergencies,
- urgent public health needs and challenges, and
- National Special Security Events.

US Public Health Service Commissioned Corps (Corps) officers are deployable assets and must meet requirements for physical fitness, height and weight standards, immunizations, basic life support certification, and the completion of training related to emergency response and humanitarian assistance. OFRD executes this program by ensuring individual Corps officers are trained for deployment; that the Corps deploys the appropriate team(s) and/or individual(s); and that once deployed, they function in a timely and effective manner.

Active duty commissioned officers are assigned to one of three Tiers. Tier 1 and Tier 2 consist of preconfigured response teams. Tier 3 consists of active duty officers not assigned to response teams. The tiers are further distinguished by the rapidity with which responses can be mounted: Tier 1 response teams deploy within 12 hours of notification; Tier 2 response teams do so within 36 hours of notification; and Tier 3 officers deploy within 72 hours of notification.

All the members of the above teams as well as all Tier 3 officers are comprised of active duty commissioned officers assigned to agencies of the US government, within and external to the Department of Health and Human Services. Thus, their response duties are in addition to their day-to-day agency-specific duties. The following is a summary of the Corps' current Tiered response system:

Assets	Tier	# Currently Available	Officers per Team	Arrival On Scene	Deployment Duration
Rapid Deployment Forces	1	5	125	<24 Hours	15-30 days
National Incident Support Teams	1	5	72	<24 Hours	15-30 days
Regional Incident Support Teams	1	11	12-30	<24 Hours	1-3 days
Applied Public Health Teams	2	5	47	<48 hours	15 days
Mental Health Teams	2	5	26	<48 Hours	15 days
Services Access Teams	2	5	10	<48 Hours	15 days
PHS Capitol Area Provider Teams	2	5	5	<48 Hours	1-3 days
Remaining Active Duty Corps Officers	3	----	~4,400	<72 hours	15 days

In addition to the use of this tiered approach for responding to public health emergencies, OFRD deploys pre-positioned teams of officers and individuals for National Special Security Events and high-profile mass gatherings, such as the annual State of the Union Address.

Performance goals, measures and targets have been established to assure progress is made in achieving the operational goals established by the Corps. These goals define the Corps' staffing requirements, readiness, public health, isolated/ hardship and other clinical requirements, as well as its management, research, and other functions. The established performance goals have already facilitated the following:

- Collaborative arrangements with a broad variety of federal and private partners to obtain readiness training at no-cost or low-cost, including Advanced Cardiac Life Support, training on the Federal Medical Station platform, and humanitarian assistance training .
- For the past three years, OFRD has successfully and dramatically increased the readiness numbers and standards of Corps officers and teams to match performance. In FY2008, the percent of officers meeting readiness standards *exceeded* the target, as did the percentage of officers that are were fully deployable, and the percentage of both deployed officers and teams that met timeliness, appropriateness and effectiveness. Furthermore, OFRD exceeded its efficiency measure. The target cost per officer to attain or maintain readiness requirements was $100; and the actual cost to OFRD was $93.87.
- Development and application of deployment assessment tools to effectively assess performance measures for timeliness, effectiveness and appropriateness of activations and deployments.
- Active Duty Officers are provided both didactic and field training by OFRD to achieve and maintain compliance with force readiness standards as well as to increase operational capability.

The Commissioned Corps continues to protect the health of the American people by maintaining its commitment to respond rapidly to emerging public health crises. Efforts to transform the Commissioned Corps by updating recruiting, training and immunizations have been completed.
In its day-to-day role, the Corps will remain an essential national resource within HHS to meet mission critical requirements and to address health care needs in isolated, hardship, hazardous, and other hard-to-fill positions. A large part of this modernization includes employing reengineered business processes integrated information technology solutions. Better human resources (HR) information empowers HHS and the Corps to fulfill core public health missions and enables centralized force management for the first time. As such, the Corps has began utilizing the United States Coast Guard's Direct Access HR Solution for Uniformed Personnel, a PeopleSoft-based program.

Officer HR data has been transferred to Direct Access, which was released to Corps officers on June 1, 2009. HHS and the Corps incorporated a comprehensive list of public health skill sets into Direct Access to enable leadership to match officers with positions and deployments. Direct Access collects validated, searchable information that previous systems had not captured in the past.

Officers are using Direct Access to proactively maintain compliance with Readiness standards for public health response, search for jobs, and capture multiple licenses and certifications, education, and security clearance information. Integration of HR data allows HHS to better utilize the skill sets of the Corps to improve accessibility of health care, respond to natural and manmade disasters, and foster scientific research and development in the United States.

For the first time, agencies and other public health entities will be able to post jobs for Corps officers in Direct Access and can search for officers meeting the job criteria. The collection and characterization of searchable, standardized, descriptive billet (officer positions) information is underway and will be completed by the end of the 2010. It will serve as the basis for Corps force management based upon public health needs.

Funding History

FY 2007	$9,926,000
FY 2008	$4,119,000
FY 2009	$14,813,000
FY 2010	$14,813,000
FY 2011	$14,813,000

Budget Request

The FY Request of $7,013,000 is a decrease of $7,800,000 below the comparable FY 2010 Appropriation. This reduction reflects a decrease in funding for the transformation of the Commissioned Corps. Continued support will be provided for the following Commissioned Corps activities at the direction of the Surgeon General:

- Deployment Readiness Training – Training will continue to be both didactic and field-based in FY 2011. Field-based training will encompass exercises in austere settings designed to familiarize teams and individual officers with deployment and operational scenarios consistent with the National Planning Scenarios and to enhance the resilience of all participants. Field based training in FY 2011 will also build upon the development of domestic medical readiness training exercises that will provide training as well as deliver services to underserved communities.
- Direct Access - Direct Access functionality will be further developed focusing on the adaptation of current data and applications to the PeopleSoft 9.0 environment. In addition, the Corps will continue to develop systems and import data to support increased functionality within Direct Access.
- Operating Costs and Salaries and Benefits and the day-to-day operations to manage the Corps as well as overhead and other operating costs.

Outputs and Outcomes

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2011
6.1.1: Increase the percentage of Officers that meet Corps readiness requirements, thus expanding the capability of the individual Officer. (Baseline – 2004: 50%) *(Outcome)*	FY 2009: 94.37% (Target Exceeded)	95%	97.5%	+2.5%
6.1.2: Increase the percentage of Officers that are deployable in the field, thus expanding the capability of the Corps. (Baseline - 2005: 40%) *(Outcome)*	FY 2009: 79.37% (Target Exceeded)	82.5%	85%	+2.5%
6.1.3: Increase the percent of individual responses that meet timeliness, appropriateness, and effectiveness requirements. (Baseline - 2007: 77%) *(Outcome)*	FY 2009: 92.5% (Target Exceeded)	95%	97.5%	+2.5%
6.1.4: Increase the percent of team responses that meet timeliness, appropriateness, and effectiveness requirements. (Baseline - 2007: 89%) *(Outcome)*	FY 2009: 95% (Target Met)	98%	99%	+1%
6.1.5: Increase the number of response teams formed, thus enhancing the Department's capability to rapidly and appropriately respond to medical emergencies and urgent public health needs. (Baseline - 2005: 0) *(Outcome)*	FY 2009: 41 (Target Exceeded)	40	46	+6
6.1.6: Increase the number of response teams which have met all requirements, including training, equipment, and logistical support, and can deploy in the field when needed as fully functional teams, thus enhancing the Department's capability to appropriately respond to medical emergencies and urgent public health care needs. (Baseline - 2006: 0) *(Outcome)*	FY 2009: 21 (Target Exceeded)	36	41	+5
6.1.7: Cost per Officer to attain or maintain readiness requirements. *(Efficiency)*	FY 2009: $91.14 (Target Exceeded)	$100	$100	---
Program Funding Level ($ in millions)	**N/A**	**$14.813**	**$7.013**	**-$1.3**

OASH
HEALTHCARE-ASSOCIATED INFECTIONS

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	5,000	5,000	5,000	0
FTE	0	2	2	2

Authorizing Legislation……..……...……..Title III, Section 301 of the Public Health Service Act
FY 2012 Authorization…...……..…..……Indefinite
Allocation Method……...……...……..……Direct Federal

Program Description and Accomplishments

Healthcare-associated infections (HAIs) are among the leading national causes of morbidity and mortality and the most common type of adverse event in the field of healthcare today. They are defined as localized or systemic adverse events, resulting from the presence of an infectious agent or toxin, occurring to a patient in a healthcare setting. An epidemiologic study by the Centers for Disease Control and Prevention (CDC) revealed that HAIs accounted for 1.7 million infections annually and were associated with 99,000 deaths in 2002. The fiscal cost is steep creating an additional $28 to $33 billion dollars in excess healthcare expenditures annually.

OASH established a Steering Committee for the Prevention of Healthcare-Associated Infections to improve and expand prevention efforts. Their initial Action Plan focuses on reducing the burden of HAIs occurring in acute care hospitals. OASH is primarily responsible for building and maintaining a national level infrastructure, through the Steering Committee, its Action Plan, and monitoring of national progress towards achieving the plan's goals. This infrastructure expands the national network across a broad range of public and private sector groups.

In FY 2010, OASH began raising awareness of the importance of addressing HAIs with a variety of audiences. The campaign focuses on engaging patients and family members, as well as healthcare providers. The campaign includes public service announcements. Strategies to reduce the burden of HAIs in non-English speaking populations are proposed for FY 2011 and FY 2012. In addition, a computer-based interactive training has been developed to raise the importance of HAI prevention with health professional students and newly practicing clinicians.

OASH also coordinates and directs the multi-year, iterative evaluation of the Department's activities related to the Action Plan. In FY 2010 and 2011, the evaluation will be broadened to include data on the regional and state levels, as well as to assess the impact of the national media campaign.

In FY 2010 and FY 2011, OASH supported a variety of inter-agency projects including:

- A toolkit or bundle approach to prevent ventilator-associated pneumonia (VAP) in intensive care units, including a reliable, objective VAP definition for consistent use and national adoption;
- Collaborations with stakeholders that influence patient care in facilities including projects studying the impact of healthcare personnel policy changes on increased vaccination rates;
- National awards program recognizing notable improvement in preventing HAIs;

- Strategy to engage hospital and health system leadership and incentivizing support/involvement at the facility level in HAI reduction;
- Establishing effective networks across States and Regional levels, exploring how federal HAI prevention policy can be informed by local efforts;
- Project to assess defined strategies for catheter-associated urinary tract infection (CAUTI) prevention to create a "packaged" program or bundle approach for facility implementation;
- Assessment of hand hygiene practices in a variety of healthcare settings and impact of data feedback provided by lost cost sensors on improved hygiene;
- Assessment of the dynamics of contamination of the healthcare environment as well as cleaning and disinfection methods to reduce environmental contamination; and,
- Information technology projects designed to integrate HAI service, quality, process, and outcome data across disparate HHS systems.

In FY 2011, the Steering Committee will begin its third tier efforts to reduce and prevent HAIs in long-term care facilities while continuing Action Plan strategies to reduce infections in acute care hospitals, ambulatory surgical centers, and ESRD facilities, building a system and culture of HAI prevention across the continuum of care.

Funding History

FY 2007	$0
FY 2008	$0
FY 2009	$5,000,000
FY 2010	$5,000,000
FY 2011	$5,000,000

Budget Request

The FY 2012 budget request of $5,000,000 is the same as the comparable FY 2010 Appropriation. The FY 2012 proposed funding level enables the continued support of the existing projects as described above, specifically continuation and expansion of the national media campaign and the comprehensive evaluation of all the Department's activities linked to the Action Plan, as well as on-going maintenance and revision to the Action Plan and expansion of the Action Plan's scope to non-hospital settings.

In addition, OASH plans to expand the national awards program to recognize teams of professionals and healthcare institutions that have achieved excellence or notable improvements in HAI prevention. These professionals, teams, programs, and institutions will serve as models for others. Thus, the program's broader goal is to further motivate other clinicians, hospital executives, and facilities to improve clinical practice patterns in order to achieve similar or superior results. The initial phase of the program focused on achievements in central line-associated bloodstream infections and ventilator-associated pneumonia prevention. The program's expansion will allow recognition of achievements in other HAI priority areas (e.g., catheter-associated urinary tract infections, surgical site infections, methicillin-resistant Staphylococcus aureus (MRSA) infections, Clostridium difficile infections) and in non-hospital settings.

OASH and the Steering Committee seeks to build effective partnerships for HAI prevention at the regional, state, and local/community levels, as well as support the continued implementation of the 52 State Action Plans to Prevent HAIs. Continued funding will be used to support the establishment of this multi-level, accountability infrastructure (e.g., additional regional projects, State HAI Coordinator and other stakeholder meetings) for achieving the Action Plan goals.

OASH
HIV/AIDS IN MINORITY COMMUNITIES

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	53,891	53,891	0	-53,891
FTE	0	3	0	0

PL – PHS Evaluation Set Aside	0	0	53,891	53,891
FTE	0	0	3	3

Authorizing Legislation..... Title III, Section 301 of the PHS Act
FY 2012 Authorization..... Indefinite
Allocation Methods.....Grants, Cooperative Agreements and Contracts

Program Description and Accomplishments

Since FY 1999, Congress has appropriated $50 million or more each year to support the Minority AIDS Initiative (MAI). The following issues have been identified:

- developing more effective prevention education interventions;
- increasing access to HIV counseling and testing services; and
- ensuring that comprehensive and quality health care and drug abuse treatment services are available in these communities.

Utilizing these funds, significant steps have been taken to respond to this unfolding crisis through capacity enhancements to mount a community-based response, delivering prevention and treatment services, and providing guided and informed technical assistance and research. A sustained commitment to these goals will ensure a durable response with a flexible resource pool that can be quickly targeted to respond to newly emerging problems and to capitalize on lessons learned. Since most minority communities have disproportionately high rates of HIV/AIDS infection, these targeted investments have been successful in identifying and addressing key barriers to allowing the Department's programs to effectively reach and serve minority communities.

Funds received by the Office of the Secretary for the MAI are disbursed on a competitive basis to several offices within the Office of the Assistant Secretary for Health (OASH) as well as several HHS agencies, including the Centers for Disease Control and Prevention (CDC); Health Resources and Services Administration (HRSA); Substance Abuse and Mental Health Services Administration (SAMHSA); and Indian Health Service (IHS). Project proposals are subject to three levels of review, including peer review by fellow agency representatives who comprise the MAI Steering Committee; secondary review committee of senior OASH staff led by the Office of HIV/AIDS Policy (OHAP); and final review team comprised of the Assistant Secretary for Health (ASH), and a few of his key advisors, including the Deputy Assistant Secretary for Health, Infectious Diseases. Following approval from the ASH, agencies then award the funds through grants, cooperative agreements, and/or contracts to support scores of organizations and entities across the country.

Following are examples of activities that have been supported with MAI funds.

Outreach and Partnership Building. An integral part of the OASH national prevention strategy is to educate, motivate and mobilize local and national minority leaders in the fight against HIV/AIDS. The goal is to leverage the credibility and influence of community leaders, and to place resources (information and technical) in the hands of those who know and can reach vulnerable racial and ethnic communities. This strategy also strives to improve health outcomes in general for these populations, while promoting HIV testing and early medical treatment for those who are HIV-infected. Several efforts are underway which have facilitated the creation of new partnerships and initiatives. At the national level, dialogues with the YWCA and the National Medical Association have resulted in these organizations adopting HIV awareness, education and/or prevention activities which target their employees, clients and members.

Concurrently, the HHS Regional Health Administrators have reached hundreds of community- and faith-based groups and leaders in first-time engagements with HHS on HIV/AIDS awareness and education. Some of these groups have now become advocates of HIV prevention education, while others have stepped forward to become providers of HIV/AIDS services. Grants for outreach and partnership activities are awarded to not-for-profit community- and faith-based organizations, local health departments and clinics, health care providers, and universities and colleges, including Historically Black Colleges and Universities (HBCUs), Hispanic Serving Colleges and Universities (HSCUs), and Tribal Colleges and Universities (TCUs), research institutions, local government agencies, tribal government and for-profit organizations and companies. With the awarding of these grants, many influential and well-positioned entities educate and mobilize local communities through a variety of venues and mediums to engage the HIV epidemic. From sponsoring health fairs to town hall meetings and prayer breakfasts, local leaders become federal partners. Similarly, through the use of their own internal publications, training, listservs and e-mail blasts, community leaders provide additional media for outreach to vulnerable communities.

Technical Assistance and Training Activities. MAI funds are being used to expand technical assistance and capacity building activities for organizations serving racial and ethnic minorities disproportionately impacted by HIV/AIDS. Grants are awarded to not-for-profit community- and faith-based organizations, local health departments and clinics, health care providers, and universities and colleges, including HBCUs, HSCUs, and TCUs, research institutions, local government agencies, tribal government and for-profit organizations and companies.

Training centers from the HRSA, SAMHSA, CDC, and Office of Population Affairs (OPA) have continued a formal partnership to collaborate among these providers. These collaborative efforts have significantly reduced duplication of efforts, and have fostered more rigorous and comprehensive training both across and within the areas of HIV/AIDS prevention, care and treatment. Currently, training centers in the HHS regions are developing curricular and training modules that reflect the many advances in preventing and treating HIV, as well as aiding HHS in activities which promote and support the Department's policies.

Prevention. With a focus on at-risk and high-risk ethnic and racial minority populations, CDC, SAMHSA, IHS, and several OASH offices receiving MAI funds continue to make HIV testing central to their prevention efforts. Routine HIV testing and rapid HIV testing have been consistently integrated in the kinds of programs and activities developed over the last few years to reach youth, ex-offenders, rural and frontier populations, immigrants, college students, MSM, and substance abusers.

In general, grants to fuel prevention work have been awarded to not-for-profit community-based and faith-based organizations, local health departments and clinics, health care providers, and universities and colleges, including HBCUs, HSCUs, and TCUs, research institutions, local government agencies, tribal government and for-profit organizations and companies. Multi-ethnic, evidence-based behavioral

interventions remain essential to the MAI prevention efforts. The Office of Minority Health's Pacific Project and African Immigrant Project are just two examples of this expanded prevention effort.

Assessment and Evaluation. In 2007, the MAI Fund underwent a program assessment in which OHAP coordinated the data collection and reporting and was responsible for its completion. As a result, OHAP developed and implemented an improvement plan for the MAI Fund. The plan consists of improving four performance objectives and one management objective. Specifically, the improvement plan consists of: (1) establishment of baselines and ambitious targets for long-term performance measures; (2) development of a comprehensive evaluation plan for MAI Fund activities; (3) development of a formal process to document the use of performance information in managing the MAI Fund and making funding allocation decisions; (4) establishment of procedures that get grantees to commit to measures and report on performance related to the program's goals; and (5) arrangement for the inventory of programs with related missions or activities and document their complimentary relationship to the activities of the MAI Fund.

In addition, OHAP developed and completed an inventory of MAI programs and activities that were funded during 2006 -2008. This comprehensive inventory captures program, budget, and award distribution information for all activities supported under the MAI. The inventory provides a means to catalog HIV/AIDS activities in support of the President's National HIV/AIDS Strategy.

By working with the MAI Steering Committee, OHAP has integrated the five improvement objectives outlined in the Improvement Plan. All process or procedural fixes are now in place and the establishment of baselines and ambitious targets are complete. An 18 month assessment and evaluation of the MAI Fund was completed in the fall of 2010. Performance measures have been included as one of the variables to consider when assessing the merit of new proposals, and most agencies have quickly aligned their proposals to the Department's efforts to increase testing and knowledge of HIV status; decrease new HIV infections; improve frequency of early HIV diagnosis; decrease AIDS mortality; and improve the cost efficiency of both HIV testing and the training of clinical staff—all goals consistent with the National HIV/AIDS Strategy.

MAI Accomplishments in FY 2008 through FY 2010

The National HIV Testing Mobilization Campaign outreached to over 5 million Americans through direct contact and social marketing activities. Memorandums of Agreement were established with 7 national HIV/AIDS organizations across a broad spectrum of HIV/AIDS demographics to expand HIV testing. A "legacy document" on the Campaign was completed "Lessons Learned to Inform Future Social Marketing Efforts which captures best practices and promising strategies. Also completed is the "HIV/AIDS: Building Capacity to Better Serve Your Community" *A Guide to Strengthening HIV/AIDS Services*. This primer details the strategic thinking, organizational background and lessons learned that can help enable community organizations to better work in the HIV/AIDS arena.

Through the MAI, a number of projects are designed to promote increased access to, continuity of, and quality of HIV/AIDS care, including: expanded recruitment and training of clinical staff; refining referral and linkage strategies; development of chronic care initiatives; promotion of telemedicine; and exploration of additional retention and patient navigation programs.

Through the AIDS.gov portal and the use of new media tools we have significantly broadened the outreach capacities of all of the HHS agencies and offices with HIV portfolios. MAI-funded projects have increasingly integrated new media tools and strategies in their activities.

Funding History

FY 2007	$51,891,000
FY 2008	$50,984,000
FY 2009	$51,891,000
FY 2010	$53,891,000
FY 2011	$53,891,000

Budget Request

The FY 2012 budget request for this program has been moved to the PHS Evaluation Set Aside. The program will be funded at the same level as previous years, $53,891,000.

OASH
EMBRYO ADOPTION AWARENESS CAMPAIGN

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 20107
Budget Authority	4,200	4,200	2,000	-2,200
FTE	0	0	0	0

Authorizing Legislation ..... Public Health Service Act, Section 1704
FY 2012 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 donation/ adoption by individuals or couples. Estimates of how many frozen embryos are stored in fertility clinics in the United States vary, reaching as high as 400,000. It is estimated that about 88% are still being considered for future use by the creating couples. The program is premised on the belief that frozen embryos might be donated by couples if they were informed about the option of releasing them for "adoption" by other infertile couples.

The program focuses on educating couples with available frozen embryos that they have the option to donate them. The program also informs infertile couples of the alternative of embryo adoption. Information and educational activities are directed at potential donors and recipients, as well as to professionals such as physicians, IVF clinic personnel, attorneys, and/or social workers, who may have a positive influence on the process of embryo donation/adoption.

A key challenge for the program is to help couples with the decision-making process that could lead to them to allow their frozen embryos to be made available for adoption. Funded projects, which include Bethany Christian Services, Nightlight Christian Adoption Services, and the National Embryo Donation Center have used both traditional and new media techniques (e.g. podcasting and social networking) to reach the general public as well as professionals. Outreach to professionals is based on the concept that the information they acquire will be transmitted to their clients and thereafter to the general public. These projects have equipped professionals with the knowledge, skills and abilities necessary to provide useful counsel to their clients.

Funding History

FY 2007	$1,980,000
FY 2008	$3,930,000
FY 2009	$4,200,000
FY 2010	$4,200,000
FY 2011	$4,200,000

Budget Request

In FY 2012 the budget requests is $2,000,000 a decrease of $2,200,000 below the comparable FY 2010 Appropriation. This level will allow current grantees the ability to continue program activities in support of embryo donations/adoption. Since its inception, the narrowly drawn Embryo Adoption Awareness Campaign had a limited number of applicants/awardees, with grants awarded to a very small pool of applicants, many of whom are repeat recipients. The reduction represents an appropriate use of resources given the historical interest in the program.

Embryo Adoption Awareness	FY 2009	FY 2010	FY 2011 (est.)	FY 2012 (est.)
Total Number of Awards	8	8	8 est.	8 est.
Average Award	$460,000	$414,000	$414,000	$200,000
Range of Awards	$367,000-$500,000	$300,000-$500,000	$300,000-$500,000	TBD

SECRETARIAL INITIATIVES AND INNOVATIONS

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	1,600	1,600	1,600	0
FTE	0	0	0	0

Authorizing Legalization:
FY 2012 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 legislatives 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 minimal 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 will be 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.

Funding History

FY 2007	$0
FY 2008	$0
FY 2009	$0
FY 2010	$1,600,000
FY 2011	$1,600,000

Budget Request

The FY 2012 budget request for Secretarial Initiatives and Innovation is $1,600,000, which reflects no change from the comparable FY 2010 budget request. The budget request 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.

ACQUISITION REFORM

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	0	0	7,000	7,000
FTE	0	0	0	0

Authorizing Legislation:
FY 2012 Authorization……..……..……Indefinite

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

Program Description and Accomplishments:

As part of a government-wide initiative to advance contracting reform, HHS is requesting $7,000,000 within the General Departmental Management account to further improve the capability, capacity and effectiveness of HHS's acquisition workforce.

The Federal acquisition workforce includes contract specialists, program and project managers, and contracting officer technical representatives (COTRs). 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 lead this initiative.

The requested resources will be used to:

- increase the capacity of the acquisition workforce in the contracting functional area, plus any necessary changes for program managers and COTRs;
- increase the capability of the acquisition workforce by investing in training to close identified gaps in such areas as project management, negotiations, requirements development, contract management and other key topics; and
- increase the effectiveness of the acquisition workforce by investing in improvements to systems that support the contracting function.

Background:

Successful acquisition outcomes are the direct result of having the appropriate personnel with the requisite skills managing various aspects of the acquisition process. Between FY 2000 and FY 2008, acquisition spending by civilian agencies increased by 56% (in inflation-adjusted dollars), while the number of contract specialists grew by only 24%. This increased workload 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 will also result in tradeoffs during the acquisition lifecycle, which may 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, and the memorandum *Acquisition Workforce Development Strategic Plan for Civilian Agencies, FY 2010-2014*, issued October 27, 2009*)* directed agencies to strengthen the acquisition workforce and increase the civilian agency workforce, to more effectively manage acquisition performance.

Budget Request:

The $7,000,000 request would be a meaningful expansion over the investments started by HHS in FY 2010, and would enable the Department to make further improvements. Such improvements would best 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's acquisition workforce through intern, rotational, and mentor programs to increase the capacity of the workforce and support succession planning (e.g., recruit, hire, and retain HHS' acquisition workforce).

- Developing 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's systems to track acquisition workforce metrics (e.g., educational/certification data), 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., improve HHS' acquisition outcomes).

PHS EVALUATION SET-ASIDE

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
Program Level	Actual	Continuing Res	PB	+/- 2010
ASPE	41,243	41,243	44,843	3,600
Health Reform	12,500	12,500	12,500	0
OASH	4,510	4,510	9,510	5,000
HIV/AIDS in Minority Communities	0	0	53,891	53,891
Teen Pregnancy Prevention Initiative	4,455	4,455	4,455	0
ASFR	1,503	1,503	1,503	0
Caroline P. Walker Cancer Act	1,000	1,000	0	-1,000
Total	**65,211**	**65,211**	**126,702**	**61,491**

Office of the Assistant Secretary for Planning and Evaluation

Authorizing Legislation..... 42 U.S.C. 241 Public Health Service Act
FY 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) support 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, actuarial support and other technical and analytic services. ASPE also supports internal HHS-wide coordination in data policy, including interagency data collection and data standards, and collaborative efforts between HHS, the health industry, and the philanthropic sectors for both health and human services programs.

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

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

Medicaid Evaluation

The expansion of the Medicaid program to cover all of the lowest income Americans is a central component of the ACA. The coverage expansion will in large measure extend coverage to low income adults that are not currently eligible for Medicaid. By 2014 Medicaid coverage will be expanded to people with income at or below 133% of the federal poverty line ($14,404 for an individual in 2009).

The coverage expansion will extend coverage and access to care for a population with significant health care needs that frequently go unmet for years at a time. Effective implementation of the coverage expansions will require enrolling the target population into the Medicaid program, understanding the health needs of the target population and matching them to appropriate services. The anticipated results would be to observe a) expanded access to care; b) more appropriate care; c) improved health status and management of chronic conditions; and d) in some specific cases reduced use of ER, hospital and other human services (e.g., jails and shelters for people with severe and persistent mental and addictive disorders).

The study design is by necessity quasi experimental because the entire population of potentially eligible people in a state will be subject to the coverage expansions. This means that we can rely on some form of pre-post-comparison group design. There are several potential comparison groups possible. One set could be drawn from within the same state and consist of a matched sample of adults that are either already eligible for Medicaid because of their family circumstances or because they have qualified for receipt of SSI. A second potential comparison group could be based on a matched group of people drawn from a state in the same region that already experienced a Medicaid expansion to single childless adults. A third group could consist of low income people matched on demographic and health status characteristics that are just above 133% of poverty and are covered by private health insurance. In each case a differences in differences approach to analysis of the data could be taken.

The Medicaid expansions target populations that frequently suffer from extreme poverty and can be hard to locate and engage. In addition because the study design relies on quasi-experimental methods, it is important to test key assumptions of such designs prior to making large investments in prospectively collected data. It will therefore be important to refine and expand HHS data infrastructure in a number of ways.

Health Homes Evaluation

ACA Section 2703: Medicaid State Option to provide Health Homes

Starting January 1, 2011 states may adopt a state plan amendment that permits recipients with chronic conditions to designate a provider or a team of providers as their health home. The focus is on individuals with multiple chronic conditions, and severe and persistent mental disorders. The health homes are a central component of the department's approach to coordinated care. It is expected that states will establish pilot programs for early adopters and that the programs will phase in across the states that make the changes to their state plans.

Initial steps have been taken by HHS. ASPE is working with a contractor and CMS to conduct an environmental scan, develop an evaluation design, and determine approaches to data collection for an evaluation. Because of the nature of how the program is likely to operate, a randomized design is not practical. However, because states will phase in the program and/or establish a set of criteria that providers must meet, there will be opportunities to use a quasi experimental approach to evaluation. Two such approaches include a) practices that enter the program earlier (due to geography or capacity to set up the program) compared to practices that phase in later or never; and b) practices that meet all program requirements versus those that "just miss" meeting criteria. In one case a differences in differences (DID) approach to analysis could be taken. In the other, a so-called regression discontinuity approach can be adopted. Both represent rigorous quasi-experimental approaches. The evaluation end points would include: avoidable hospitalizations, avoidable ER visits, costs, indicators of care coordination, receipt of evidence based treatments, quality of care and some patient outcomes.

ASPE is investing funds to initiate the evaluation of the take-up of the state plan option. Funds are being requested to fully implement a rigorous evaluation of the health home option.

Falls Evaluation

Falls constitute one of the most significant and common causes of injury and disability for the elderly. One in every three people age 65 and older living in the community falls during a year and fall-related injuries cost an estimated $17 billion annually. Falls are also associated with subsequent admission to a nursing home and use of long-term care services.

While there are numerous studies identifying the major risk factors associated with falling (e.g., muscle strength/gait and balance, cognitive impairment, polypharmacy, and physical environment), there is virtually no research demonstrating the cost-effectiveness of comprehensive programs designed to reduce the incidence and impact of falls. ASPE therefore began a demonstration to determine the cost-effectiveness of a fall prevention program for older Americans. The demonstration uses a classic experimental design where a random sample of private long-term care insurance policy holders age 75 and older receive the full assessment and intervention (treatment) and others do not (control). Additional control groups will be evaluated to test for biased selection. After further refinement of the intervention, methodological approach and assessment instruments, ASPE began data collection in FY 2006.

The U.S. Preventive Services Task Force is about to release a report giving falls screenings and interventions a grade high enough that the Secretary of Health and Human Services has the authority to have Medicare cover a benefit for screening and intervention. The demonstration will provide definitive evidence that intervening at the right time and in the right way could prevent older people from having costly, injurious falls. The demonstration will fill a significant policy research gap and answer a critical question posed by policymakers: can an affordable falls prevention program reduce the incidence of falls in the elderly and lower spending for acute health and long-term care services? The funding being requested will be used to analyze the longitudinal data that will be available shortly.

ASPE Budget Request

The FY 2012 request for ASPE is $57,343,000 (excluding the Children's Health Insurance Program and the Prevention and Public Health activities discussed below). The FY 2012 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. Set-aside 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. Detail on these activities is provided below.

Goal 1: Transform health care

Priority projects for FY2012 under this goal include providing analysis and developing data to support the implementation of the Affordable Care Act, measuring state and national progress in meeting the CHIPRA Challenge, improving health care and nursing home quality, developing innovative payment and delivery systems, modernizing Medicaid, and improving public health infrastructure and financing.

Goal 2: Advance Scientific Knowledge and Innovation

Priority projects for FY2012 under this goal include research and analysis to support regulatory risk assessment and management, the translation of the fruits of 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.

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

Priority projects for FY2012 under this goal will include assessing challenges to implementing evidence-based policy and strategies for scale-up and replication; studying ways to enhance the economic security, stability and well-being of families and communities; 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. ASPE will also conduct research and evaluation of important initiatives such as the Community Resilience and Recovery Initiative, HIV/AIDS prevention and treatment, tobacco prevention and control, and obesity prevention.

Goal 4: Increase Efficiency, Transparency and Accountability of HHS Programs
Priority projects in FY 2012 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, assessing the health implications of climate change, and Medicare quality improvement. Priority projects will also include conducting comparative effectiveness research and dissemination of data and results.

Goal 5: Strengthen the National Health and Human Services Infrastructure and Workforce
Priority projects for FY 2012 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.

ASPE Grant Awards Table:

Description	FY 2010	FY 2011	FY 2012
Number of Awards	5	5	5
Average Award	$565,000	$565,000	$565,000
Range of Awards	$500,000 - $850,000	$500,000 - $850,000	$500,000 - $850,000

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.

ASPE's grants for academic research institutes range from $350,000 to $750,000 per year. All of the centers develop and mentor social science researchers whose work focuses on these issues. 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.

Establish Hold-Harmless for Federal Poverty Guidelines

This proposal establishes a permanent hold-harmless provision to adjust the poverty guidelines only when there is an increase in the Consumer Price Index for All Urban Consumers (CPI-U). To protect program

access for low-income families and individuals, this proposal would treat the CPI-U adjustment for the poverty guidelines similarly to the treatment of the annual cost-of-living adjustments for Social Security benefits.

Affordable Care Act-Related Activities

As the U.S. Government's lead health agency, HHS is responsible for the implementation of many of the provisions of the ACA. ASPE will undertake a variety of policy development, research, analysis, evaluation and data development activities in support of ACA implementation in FY 2012, including the following:

- Conducting actuarial analysis and modeling to support the development of three actuarially sound benefit options from which the Secretary may select a CLASS benefit plan. In addition, conducting extensive research to support development of marketing campaigns for employers, individuals and other key stakeholders as the CLASS plan is rolled out.
- Conducting 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.

Office of the Assistant Secretary for Health

Authorizing Legislation ..... Section 241 PHS Act
FY 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 an increase of $4,000,000 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.

Minority AIDS Initiative (MAI)

Since FY 1999, Congress has appropriated $50 million or more each year to support the Minority AIDS Initiative (MAI). Utilizing these funds, significant steps have been taken to respond to this unfolding crisis through capacity enhancements to mount a community-based response, delivering prevention and treatment services, and providing guided and informed technical assistance and research. A sustained commitment to these goals will ensure a durable response with a flexible resource pool that can be quickly targeted to respond to newly emerging problems and to capitalize on lessons learned. Since most minority communities have disproportionately high rates of HIV/AIDS infection, these targeted investments have been successful in identifying and addressing key barriers to allowing the Department's programs to effectively reach and serve minority communities.

Budget Request

HIV/AIDS in Minority Communities

In July 2010, the Administration released the first comprehensive *National HIV/AIDS Strategy for the United States*. The NHAS was the result of unprecedented public input, including 14 HIV/AIDS community discussions held across the country, as well as an online suggestions process, various expert meetings and other inputs. Senior officials in the Office of the Assistant Secretary for Health were involved in the Federal interagency working group that reviewed recommendations from the public and worked with the Office of National AIDS Policy to develop the NHAS.

The National Strategy focuses on three population-based goals: reducing the number of new HIV infections, increasing access to care for people living with HIV, and reducing HIV-related health disparities.

The FY 2012 President's Budget supports the goals of the National HIV/AIDS Strategy to reduce new HIV infections, increase access to care, and improve health outcomes for people living with HIV. The request focuses resources on high-risk populations and allocates funds to State and local health departments to align resources to match the burden of the epidemic across the United States.

Meeting these goals will require a new level of coordination and collaboration across agencies and among the Federal Government, States, tribes, and localities. OASH therefore has a central role to play in meeting these goals as the office responsible for coordinating HIV/AIDS activities across the Federal government and for working directly with states and localities to implement comprehensive and coordinated HIV/AIDS activities on the ground.

In addition, the Budget proposes that up to one percent of HHS discretionary funds appropriated for domestic HIV/AIDS activities, or approximately $60 million, be provided to foster collaborations across HHS agencies and finance high priority initiatives in support of the National HIV/AIDS Strategy. Such initiatives could focus on improving the linkages between prevention and care, coordinating Federal resources within targeted high-risk populations, enhancing provider capacity to care for persons living with HIV/AIDS, and increasing capacity to monitor key Strategy targets.

Prevention and Linkage to Services

In 2012, these funds will be used to continue our expansion of HIV testing opportunities as the cornerstone of prevention and our efforts to find the more than 225,000 individuals who are positive but do not know their status. Our prevention efforts must also involve getting those who test positive into ongoing care and returning to care those that have left. In addition to the medical benefits of early intervention, there is strong evidence that those individuals who know their positive status are more likely to take steps to modify unsafe behaviors, thus, reducing transmission. Finally, prevention cannot lose sight of those who are at great risk of becoming infected. Their linkage to effective and appropriate prevention services is critical. Whether it is high risk youth, women, or minorities, our prevention efforts must continue to evolve and stay relevant and meaningful. The MAI Fund provides this opportunity.

Capacity Development in Urban, Rural and Remote Areas

One of the keys to having an impact on this epidemic is to develop sustainable capacity in urban, rural and remote areas where an HIV/AIDS prevention and treatment infrastructure may be weak or non-existent. Given these infrastructure challenges, it is incumbent upon federal offices and agencies to think creatively about how best to address these needs. The MAI Fund in FY 2012 represents an important opportunity to provide indigenous organizations within these communities the capacity development around service delivery and the management of HIV/AIDS. During times of tightened resources but an

ongoing epidemic, sustainable and proactive efforts are needed. From the rural South to tribal country to some small cities in the Midwest and southwest to some neglected urban enclaves, there are places where carefully targeted resources from the MAI Fund can have a significant impact on the epidemic.

Technical Assistance and Training Activities
Innovations in technology and new media or new perspectives on the use of traditional media, has broadened our understanding of how the federal government can provide invaluable technical assistance and training to organizations and other entities. From podcasts to text messaging to PSAs, there is a new and exciting way the MAI Fund can provide the tools to our local partners to assist them to carry awareness and prevention messages to their constituents, encourage HIV testing or refer for treatment and care. Given the well-recognized challenges of reaching youth and other populations, often excluded from traditional public health campaigns and messages, it's important to use every tool we have in our arsenal to reverse this epidemic.

Outreach and Partnership Building and Stigma Reduction
In FY 2012, these funds will be used to continue our outreach and partnerships with non-traditional and under-served community-based and faith-based entities. Programs and activities designed to address HIV-related stigma will be encouraged. While the primary focus will be on those communities and populations that are disproportionately impacted by HIV/AIDS, we will continue to target appropriate resources to those communities that have lower incidence levels but are at risk for increasing transmission and prevalence. Outreach to youth and those individuals over 50 will play an increasingly important role as prevalence increases in both of these population segments. Within our partnerships we will explore new ways to communicate and forge relationships through the use of innovative technology and new media.

OASH PHS Evaluation Funds
The FY 2012 Request of $9,510,000 is the $5,000,000 above the FY 2010 Appropriation. OASH will continue its established operations at this level as well as implement an evaluation of the Teen Pregnancy Prevention grants issued in FY 2010. This project will be in addition to the existing $4,455,000 longitudinal evaluation of teen pregnancy prevention approaches.

Evaluation of Teen Pregnancy Prevention Grants
As part of the Administration's government-wide initiative to strengthen program evaluation, the request includes $4,000,000 to support a Federal evaluation of the projects funded under the discretionary teen pregnancy prevention program. This study is one of 23 evaluation proposals designed 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 other HHS agencies 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.

Longitudinal Study of Teen Pregnancy Projects
The FY 2012 request is $4,455,000 million 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 2013. This study is one of 23 evaluation proposals to strengthen the quality and rigor of Federal program evaluation. To ensure the study is well designed and implemented, OASH 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. 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.

The Office of the Assistant Secretary for Financial Resources

The FY 2012 request for the Office of the Assistant Secretary for financial Resources (ASFR) is $1,503,000. The FY 2012 request will be used to fund program evaluation activities within the ASFR Office of Budget. These funds will cover additional staff costs focused on program evaluation activities in the preparation of performance reports to OMB and the Congress such as the Performance and Accountability Report pilot. Funds will also go towards the continued development and operation of the electronic Program Performance Tracking System.

Funding History

FY 2007	$39,013,000
FY 2008	$46,756,000
FY 2009	$46,756,000
FY 2010	$65,211,000
FY 2011	$65,211,000

PREVENTION AND PUBIC HEALTH FUND

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Program Level	12,045	19,100	134,900	122,855

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 2012, the law appropriates $1 billion into the Fund. The purpose of the Fund is to "expand and sustain national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs." The Act provides the Secretary with the authority to transfer appropriated amounts to accounts within HHS.

The HHS activities funded in FY 2010, from the Prevention and Public Health Fund, are focused on promoting wellness and preventing chronic disease. The FY 2010 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 2012 HHS allocation for the $1 billion available in the Prevention and Public Health Fund reflects a balanced portfolio of investments to improve health and to help restrain the growth of health care costs. The FY 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 2012, approximately a third of the allocation supports public health infrastructure and workforce, a third supports community and State prevention activities, and a third supports critical areas in prevention research, health screenings, tobacco and obesity prevention, and health care surveillance. The FY 2012 HHS allocation includes the agencies and offices shown in the table below. For more information on activities funded within each allocation, please refer to the agency's or staff division's FY 2012 budget justification.

Prevention and Public Health Fund
Funding by Agency
(Dollars in Millions)

	FY 2010	FY 2011	FY 2012
Program Level	Actual	Continuing Res	PB
Obesity Prevention & Fitness			
ASPA	9,120	9,100	9,100
ASPE	100	-	100
OASH	925	-	3,800
Tobacco			
ASPA	-	10,000	10,000
OASH	900	-	900
Healthcare Surveillance & Planning			
OASH	1,000	-	1,000
Teen Pregnancy Prevention			
OASH	-	-	110,000
Total	**12,045**	**19,000**	**134,900**

PREVENTION AND PUBLIC HEALTH FUND
OBESITY PREVENTION AND FITNESS

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
Program Level	Actual	Continuing Res	PB	+/- 2010
ASPA	9,120	9,100	9,100	-20
ASPE	100	0	100	0
OASH	925	0	3,800	2,875

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

Program Description and Accomplishments

OASH through the President's Council on Fitness, Sports and Nutrition will be able to increase the number of schools and organizations that adopt the President's Challenge through increased outreach, participation in conferences/consultations with professional groups, education materials/campaigns, and media coverage of the Council events/initiatives.

The President's Challenge is a physical activity and fitness awards program. It 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.

Increased funding will increase the number of communities that adopt policies or recommendations targeting health disparities that are promoted by the Council, and achieve *Healthy People 2020* goals.

The budget request is in direct support of the *President's Challenge* and the first lady's *Let's Move* initiatives as well as the Secretary's strategic initiative to help Americans achieve and maintain a healthy weight. These funds also support the ASH's three priority goals of: creating better systems of prevention; eliminating health disparities and achieving health equity; and making *Healthy People* come alive for all Americans.

Budget Allocation

OASH

The FY 2012 allocation is $3,800,000 for OASH. These funds are requested in addition to the GDM appropriated funds for PCFSN. Funds provided through the Affordable Care Act (ACA) will be used to expand the programmatic outreach and offerings of the President's Council on Fitness, Sports and Nutrition, particularly as they relate to the expansion of the Council's mission to include nutrition. With these funds, more focus will be directed towards minority youth who experience the greatest disparities relative to physical activity and good nutrition. One of the mechanisms through which this work will be accomplished is a Youth Empowerment Program to be established in FY 2011. Specifically, this program will build upon a targeted public affairs campaign, includes a National Summit on Youth Physical Activity and Sports Participation (with additional messaging relative to good nutrition), creation of a

national youth advisory board and continued promotion of the updated and enhanced President's Challenge Physical Activity and Fitness Awards program.

ASPE

The allocation of $100,000 for ASPE will provide funds to evaluate the obesity prevention and fitness activities funded with resources from the Prevention Fund. ASPE will also coordinate The Healthy Living Innovation Awards to acknowledge innovative health promotion initiatives within the last three years that have demonstrated a significant impact on the health status of a community. Activities would be coordinated with OASH.

Innovation in health promotion can be defined as the introduction of something entirely new (e.g. a product, program, process, system, service, or model) or a new and unusual application of an existing tool to improve the health and well-being of others. These awards will provide an opportunity to increase public awareness of creative approaches to develop and expand innovative health promotion programs and duplicate successful strategies in various settings.

The Healthy Living Innovation Awards will provide a platform to celebrate and share innovative health promotion practices across organizations, professions, and communities through an HHS website. The Awards website will feature tools, services, and programs that provide innovative solutions to encourage people to include healthy living activities into their daily lives. While some innovations will be cutting-edge others will be non-technical community-based programs or services that have significant health impacts. In addition to a year-round website, awardees will exhibit or provide an oral presentation to highlight their innovations at a national meeting.

ASPA

ASPA Activities allocated under the Prevention and Public Health Fund in the amount of $9,100,000 are intended to support disease prevention efforts, education to consumers and patients about programs and procedures to help them live healthier lives like smoking cessation classes, vaccination and immunization and chronic disease. Educational campaigns will also be designed to promote existing materials, programs and websites that help consumers find more information and key services.

HHS will employ a comprehensive approach that includes both clinical and public health strategies to reverse the obesity epidemic in the United States and stem tobacco usage. ASPA will manage targeted media campaigns funded through the Prevention and Public Health Fund which seek to promote HHS' public health goals for obesity and tobacco cessation. Some specific campaigns that will be supported include: educational outreach around the health benefits of breastfeeding, especially with minority communities, education and outreach around the President's Council on Nutrition and Physical Fitness and the President's Challenge for Fitness, promotion of resources and websites like Let's Move, healthcare.gov, and flu.gov.

PREVENTION AND PUBLIC HEALTH FUND
TOBACCO

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
Program Level	Actual	Continuing Res	PB	+/- 2010
ASPA	-	10,000	10,000	10,000
OASH	900	0	900	-

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

Program Description and Accomplishments

Affordable Care Act (ACA) funds are needed to enhance the ASH's role in leading and coordinating the implementation of the *HHS Tobacco Control Strategic Action Plan* and its related activities. OASH developed the *HHS Tobacco Control Strategic Action Plan* in the Spring of 2010 and will begin implementation of the Plan in June 2010. OASH also funded the implementation of a demonstration project focused on implementing comprehensive tobacco cessation services for low income women in federally-funded clinics administered by IHS and HRSA.

The Department has invested heavily in the regulatory and scientific aspects of tobacco control. However, there is need to accelerate the implementation and funding of tobacco control interventions, particularly for vulnerable populations (women, minorities, low socio-economic status) as doing so would continue 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 ASH's priority goals of creating better systems of prevention and eliminating health disparities and achieving health equity.

OASH is supported by the ASPA organization in promoting these efforts.

Budget Request

OASH

The FY 2012 allocation is $900,000, to address public health concerns related to tobacco. Funding for OASH to coordinate tobacco cessation activities will help to further the success of Secretarial and ASH initiatives and will ensure that the Department has a comprehensive and sustainable tobacco control strategy.

FY 2012 funds will be used to: 1) provide leadership and implementation of strategic actions in the *HHS Tobacco Control Strategic Action Plan*, coordinating key tobacco control policies and program activities across HHS; 2) support FDA's newly acquired role to regulate tobacco products; 3) coordinate key tobacco policies and activities across the federal government; 4) fund demonstration projects with HRSA and IHS to integrate and enhance tobacco cessation through their health care and service delivery settings.

ASPA

ASPA Activities allocated under the Prevention and Public Health Fund in the amount of $10,000,000 are intended to support disease prevention efforts, education to consumers and patients about programs and procedures to help them live healthier lives like smoking cessation classes, vaccination and immunization and chronic disease. Educational campaigns will also be designed to promote existing materials, programs and websites that help consumers find more information and key services.

HHS will employ a comprehensive approach that includes both clinical and public health strategies to stem tobacco usage. ASPA will manage targeted media campaigns funded through the Prevention and Public Health Fund which seek to promote HHS' public health goals for tobacco cessation. Some specific campaigns that will be supported include: educational outreach around the new tobacco cessation consumer website.

PREVENTION AND PUBLIC HEALTH FUND
HEALTHCARE SURVEILLANCE AND PLANNING

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
Program Level	Actual	Continuing Res	PB	+/- 2010
OASH	1,000	0	1,000	0

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

Program Description and Accomplishments

Section 4001 of the ACA directed the President to establish a National Prevention, Health Promotion and Public Health Council (Council) to be chaired by the Surgeon General. The Council will oversee twelve Departments in the coordination and implementation of National Prevention and Health Promotion Strategy. The Strategy will be developed based on the Council's input that incorporates the most effective means to prevent illness and disabilities to the Nation. The Strategy will set goals and objectives to be implemented by specific agencies and establish specific timelines to carry out the Strategy and provide measures for accountability.

The Council will report to the President and relevant Congressional committees on all activities and achievements, with emphasis on specific science based initiatives regarding nutrition, exercise and smoking cessation and focusing on the five leading causes of death in the United States. The Council will outline specific countermeasures to reduce diseases and evaluate the evidence-based models and policies use to formulate the Strategy. The Council will establish a process for continual public input from all relevant stakeholders including Indian Tribes and Tribal organizations.

In addition to supporting the functions of the National Prevention Council, funding will support a national conference that will bring together individuals, agencies, organizations, and programs that are putting into practice activities that will advance prevention per the *Healthy People 2020 (HP2020)* initiative. This conference can be regarded as part of the Council's essential work by building on the 3 decades of public health prevention strategies develop by *Health People.* Complete the development and promotion of Leading Health Indicators that will underpin the work of the National Prevention Council and strategies.

In addition to supporting several of the secretary's Strategic Initiatives, this initiative will serve as the basis for all Federal Departments and Agencies to bring public health strategies into their programs. By implementing public health prevention strategies in other Departments and Agencies, the Council will be supporting the ASH's priority areas of creating better systems of prevention.

Funding Allocation

OASH

The OASH FY 2012 allocation is $1,000,000. Funds will be used to maintain the operations of the Council.

PREVENTION AND PUBLIC HEALTH FUND
TEEN PREGNANCY PREVENTION

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Program Level	0	0	110,000	110,000

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 new discretionary grant program launched in FY 2010 to support evidence-based teen pregnancy prevention approaches and is under the direction of the Office of Adolescent Health (OAH). The funding supports 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. The OAH coordinates its efforts with other HHS offices and operating divisions.

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 literature. Another 19 grants are being funded to develop, refine and test additional models and innovative strategies for preventing teen pregnancy. In collaboration with the Centers for Disease Control and Prevention (CDC), the program is supporting eight grants to implement and test multi-component community-wide initiatives to prevent teen pregnancy. The Office is engaged in collaborations in implementing TPP program and evaluation activities with the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Administration for Children and Families (ACF), and CDC. OAH has begun work to develop appropriate program performance measures for the TPP program as well as design a system for collecting and reporting annual performance data. OAH is also partnering with ASPE in support of ongoing annual review of the evidence base. TPP grantees are currently engaged in a planning, piloting and readiness period, and are expected to achieve a series of milestones that will allow them to fully and successfully implement their projects.

Budget Request

The FY 2012 President's Budget Request is the same as the FY 2010 Appropriation of $110,000,000 using Prevention and Public Health Funds for FY 2012. The proposed funding level enables the continued support of the existing projects funded under the Teen Pregnancy Prevention Program.

PREGNANCY ASSISTANCE FUND

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Enacted	PB	+/- 2010
Program Level	25,000	25,000	25,000	0

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

Program Description and Accomplishments

The Office of Adolescent Health (OAH) was assigned the responsibility for implementing and administering a new competitive program of grants to States, and Indian Tribes or reservations, to develop and implement projects to assist pregnant and parenting teens and women. This new program is authorized by Sections 10211- 10214 of the Affordable Care Act (Public Law 111-148). 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 States 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 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. In addition $3 million in Affordable Care Act funds was awarded to 13 tribes, tribal organizations, and urban Indian organizations through the Tribal Maternal, Infant, and Early Childhood Home Visiting Grant Program.

The request 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 to prevent and reduce tobacco use and to ensure program integrity and responsible stewardship of Federal funds. 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 Allocation

The FY 2012 allocation is $25,000,000. Activities will be continued at the established levels in FY 2012.

OTHER FUNDING SOURCES

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
Program Level	Actual	Continuing Res	PB	+/- 2010
CHIPRA	10,000	0	0	-10,000

Authorizing Legislation……..……...Unauthorized

Program Description and Accomplishments

Evaluation of Express Lane Eligibility Option under CHIP
The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 created a new option for States to rely on an Express Lane agency finding when determining eligibility for medical assistance, through September 30, 2013. Each State must annually provide an eligibility error rate on children enrolled in Medicaid or CHIP using these findings. If a State's error rate exceeds three percent, corrective actions will be undertaken and continued noncompliance may lead to a reduction in payments. The Secretary must conduct an effectiveness evaluation of this option and report to Congress by the end of FY 2012. The Assistant Secretary for Planning and Evaluation will be conducting this evaluation.

Funding History

FY 2007	$0
FY 2008	$0
FY 2009	$5,000,000
FY 2010	$10,000,000
FY 2011	$0

Budget Request

There is no FY2012 funding request for this activity.

General Departmental Management
Detail of Full Time Equivalents (FTE)

	2010 Actual Civilian	2010 Actual Military	2010 Actual Total	2011 Est. Civilian	2011 Est. Military	2011 Est. Total	2012 Est. Civilian	2012 Est. Military	2012 Est. Total
GDM.....									
Direct:.....	894	84	978	943	73	1016	999	73	1072
Reimbursable:.....	359		359	354		354	367		367
Total:.....									
FTE Total.....	**1253**	**84**	**1337**	**1297**	**73**	**1370**	**1366**	**73**	**1439**

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

Detail of Positions

	FY 2010 Actual	FY 2011 CR	FY 2012 PB
Executive level I	1	1	1
Executive level II	1	1	1
Executive level III			
Executive level IV	9	9	9
Executive level V			
Total - Exec. Level Salaries	$1,779,000	$1,779,000	$1,779,000
Subtotal	0	0	0
SES	98	100	100
Total - ES Salary	$16,604,042	$16,942,900	$16,942,900
GS-15	134	143	145
GS-14	166	172	177
GS-13	180	186	194
GS-12	251	263	276
GS-11	179	182	192
GS-10	17	17	17
GS-9	115	117	138
GS-8	37	39	39
GS-7	43	45	55
GS-6	9	9	9
GS-5	13	13	13
GS-4			
GS-3			
GS-2			
GS-1			
Subtotal	1,144	1,186	1,255
Commissioned Corps	84	73	73
Total Positions	1,337	1,370	1,439
Total FTE	1,337	1,370	1,439
Average ES salary	$164,429	$169,429	$169,429
Average GS grade	12/4	12/4	12/5
Average GS Salary	$82,253	$84,695	$86,079

SIGNIFICANT ITEMS IN APPROPRIATIONS COMMITTEE REPORTS

FY 2010 Senate Appropriations Committee Report Language (Senate Report 111-117)

Item

Asian and Pacific Islanders -The Committee notes that Asian and Pacific Islanders [API] have a high incidence of stomach and liver cancers compared to Caucasians. Overall, cancer data are limited for this population. In addition, the API population experiences a higher than average rate of chronic kidney disease, with one person in seven afflicted with this disease, compared to a national average of one person in nine. Among API population groups, Filipinos have one of the highest rates of incidence per capita. The Committee urges the OMH to focus on the unique and pressing needs of this at-risk population."

Action Taken or to be Taken

The Office of Minority Health (OMH) recognizes the unique and pressing need to address the high incidence of stomach and liver cancers in Asian Americans, Native Hawaiians, and Pacific Islanders. Specifically, OMH has been working to address chronic hepatitis B as the leading cause of liver cancer in these populations. OMH has collaborated with community partners and across the Department to elevate the level of awareness of this great health disparity for Asian Americans, Native Hawaiians, and Pacific Islanders. In addition to support of activities through grant funding across the country to address chronic hepatitis B and liver cancer, OMH has co-hosted annual World Hepatitis Day events, endorsed a public service announcement targeting the Asian American, Native Hawaiian, and Pacific Islander communities regarding hepatitis B, and is involved in an interagency collaboration to comprehensively address viral hepatitis disparities.

OMH works with the National Diabetes Education Program, a joint initiative of the National Institutes of Health and the Centers for Disease Control and Prevention to address diabetes disparities and its complications, including heart disease and chronic kidney disease in Asian Americans, Native Hawaiians, and Pacific Islanders. OMH also will reach out to other partner agencies and community organizations to more fully assess chronic kidney disease disparities in these populations.

Item

Hepatitis B and C - The Committee is pleased that the Secretary has convened and established an inter-departmental task force to address the public health challenge of viral hepatitis. The Committee urges the task force to review and consider the Institute of Medicine report released in January 2010 titled "Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis Band C," which documents the problem and highlights a course of action to address it. The Committee looks forward to an update on the task force's recommendations and actions. (p. 170)

Action Taken or to be Taken

In response to the IOM report, the Assistant Secretary for Health convened a Viral Hepatitis Interagency Working Group comprised of subject matter experts from various HHS agencies. This group was charged with determining how to best respond to the IOM comments; the chief recommendation of the Working Group was to develop a comprehensive strategic viral hepatitis action plan that would:

- Address IOM recommendations for viral hepatitis prevention, care, and treatment;
- Set forth the actions needed to improve the prevention of viral hepatitis and ensure that infected persons are identified and provided with care and treatment; and
- Improve coordination of all viral-hepatitis-related activities within HHS and promote collaborations with other government agencies and non-governmental organizations.

The HHS Action Plan for the Prevention and Treatment of Viral Hepatitis will be completed in Spring 2011.

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Item

Office of Women's Health – The Committee understands the importance of advancing the health of women by promoting health screening and prevention; improving access to care; and cultivating women's health research, professional development and education of new providers. From 1996 to 2006, the National Centers of Excellence in Women's Health served as a resource for clinical, education and outreach programs, and achieved these goals in a cost-effective manner before the elimination of their funding in 2007. The Committee urges OWH to re-examine the benefits of the Centers of Excellence in Women's Health and their potential to reduce health disparities. (p.162)

Action Taken or to be Taken

OWH has worked hard to reduce health disparities in women and girls. The OWH Centers of Excellence in Women's Health program was but one mechanism to achieve this goal. During FY 2008, OWH underwent a rigorous strategic planning process and developed a comprehensive plan. Under this new plan, OWH began funding evidence-based interventions to acknowledge women's health areas that were not currently addressed at the national level by any other public or private entity. The OWH model program, *Advancing System Improvements to Support Targets for Health People 2010* (ASISAT 2010) funds gender-focused, public health systems approaches that adapt evidence-based strategies for use in diverse populations and geographic areas to promote behavior change that leads to improvements in health outcomes for patients with chronic diseases and prevention of these diseases. ASIST 2010 programs are working to help counties and States meet or improve progress toward meeting their Health People 2010 objectives. ASISAT 2010 grantees are implementing system and policy changes to expand and improve delivery systems and to support program sustainability. A national evaluation of the ASIST 2010 program is underway to assess the effectiveness of a gender-focused, public health systems approach on service delivery and behavioral change. In FY 2010, OWH will continue an assessment of its former multidisciplinary models of women's health programs, including the former Centers of Excellence program, in an effort to identify the characteristics of programs that have sustained themselves after federal funding has expired. The assessment will generate examples of acceptably sustained federal programs and guidelines for sustaining a federal program that may be included in future grant/contract announcements.

Item

Adolescent Health – The Committee expects that, in the context of national health reform and the renewed commitment to health promotion and disease prevention, the Secretary will place this office within the Office of Public Health and Science, as authorized. The Committee expects the Director of the Office to coordinate efforts among HRSA, CMS, CDC, and SAMHSA to reduce health risk exposure and behaviors among adolescents, particularly low-income adolescents, and to better manage and treat their health conditions. The Committee has also tasked OAH with implementing a new initiative supporting evidence-based teen pregnancy prevention approaches. (p.158)

Action Taken or to be Taken

A new Office of Adolescent Health (OAH) is being established within the Office of Public Health and Science. The OAH will be responsible for implementing and administering the new teen pregnancy prevention initiative as well as for coordination with other HHS agencies on issues affecting adolescent health and well-being. In late February, the Department will submit a report to the House and Senate Appropriations Committees with more detailed information about the status of the OAH and the implementation of the new teenage pregnancy prevention program.

Item

Office of Adolescent Health - The Committee notes that adolescents have morbidity and mortality rates twice those of younger children. Many are vulnerable to poor health outcomes as a result of risk-taking behaviors and exposure to environmental risks. Despite their high rates of mental health conditions, sexually transmitted diseases, obesity, asthma, and other chronic conditions, adolescents are not receiving the care they need. The Committee strongly urges the Secretary, through the Office of Adolescent Health, to fund demonstrations of primary care models staffed by an interdisciplinary team of professionals who provide integrated preventive care, primary care, sexual health, and mental health services. These models should

include care management and communication strategies for adolescents at significant risk of poor health outcomes, as well as opportunities for teen and parent involvement and linkages to community prevention efforts.

Action Taken or to be Taken: The Office of Adolescent Health (OAH) within the Office of the Assistant Secretary for Health coordinates adolescent health programs and initiatives across HHS related to adolescent health promotion and disease prevention. Should funding become available, OAH will implement and administer demonstrations of primary care models staffed by an interdisciplinary team of professionals who provide integrated preventive care, primary care, sexual health, and mental health services. These models would include care management and communication strategies for adolescents at significant risk of poor health outcomes, as well as opportunities for teen and parent involvement and linkages to community prevention efforts.

SPECIAL REQUIREMENTS

FY 2012 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

STAFFDIV Allocation Statement:

General Departmental Management will use **$522,715.00** of its **FY 2012** 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, **$23,555.00** is allocated to developmental government-wide E-Government initiatives for **FY 2012**. This amount supports these government-wide E-Government initiatives as follows:

FY 2012 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$2,700.00
Line of Business - Grants Management	$4,757.00
Line of Business - Financial	$8,980.00
Line of Business - Budget Formulation and Execution	$6,685.00
Disaster Assistance Improvement Plan	$0.00
Federal Health Architecture (FHA)	$0.00
Line of Business - Geospatial	$433.00
FY 2012 Developmental E-Gov Initiatives Total	**$23,555.00**

* 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-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-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, **$178,560.00** is allocated to ongoing government-wide E-Government initiatives for **FY 2012**. This amount supports these government-wide E-Government initiatives as follows:

FY 2012 Ongoing E-Gov Initiatives*	
E-Rule Making	$15,851.00
Integrated Acquisition Environment	$43,935.00
IAE – Loans & Grants	$6,938.00
GovBenefits	$3,541.00
Grants.Gov	$108,295.00
FY 2012 Ongoing E-Gov Initiatives Total	**$178,560.00**

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

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 with out 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**

I am pleased to present the Office of Medicare Hearings and Appeals (OMHA's) Fiscal Year 2012 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 despite significant increases in caseloads. This commitment has benefitted Medicare appellants nationwide and continues to inspire OMHA's mission, accountability, and progress.

The FY 2012 budget reflects OMHA's efforts not only to build upon the operational success achieved during its first five years but also to implement strategic new initiatives critical to OMHA's future. The Electronic Records and Mega Team initiatives address issues identified by experience and verified by meaningful metrics. OMHA's vision is to become a fully electronic, efficiently managed, and well-respected quasi-judicial agency, while continuing to deliver high quality and timely service to the public. This vision is consistent with the enabling legislation which envisioned OMHA as an agency operating in a fully electronic environment.

Above all this FY 2012 budget reflects OMHA's efforts to focus on the agency's mission and meet statutory deadlines given increasing caseloads, by increasing efficiency through our people and technology.

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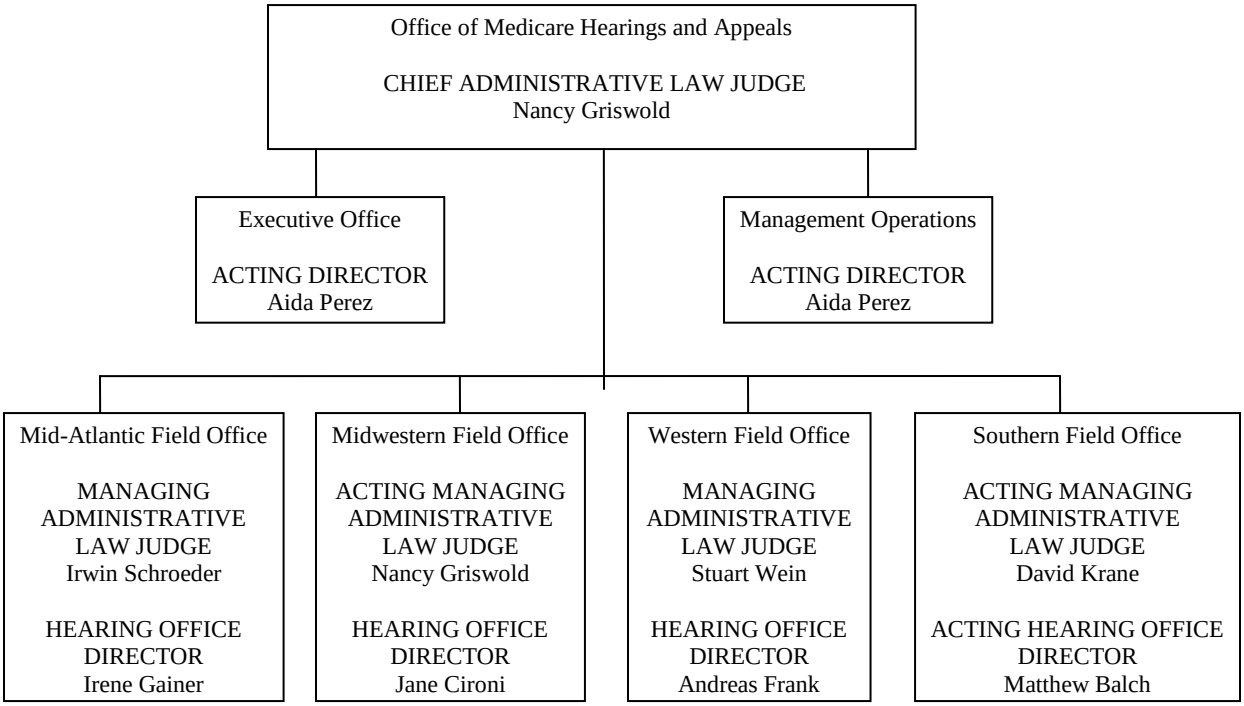
OMHA ORGANIZATIONAL CHART



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.

DISCRETIONARY ALL PURPOSE TABLE

Office of Medicare Hearings and Appeals
(Dollars in Thousands)

	FY 2010 Actual	FY 2011 CR	FY 2012 Request
Total Funding	71,147	71,147	81,019
FTE	368	395*	424

* Includes conversion of contractor positions to federal positions.

OVERVIEW OF BUDGET REQUEST

The FY 2012 President's Budget request for OMHA is $81,019,000 – an increase of $9,872,000 or 13.9 % above the FY 2010 level. OMHA's budget request makes investments to support HHS Strategic Goals to Transform Healthcare and Increase Efficiency, Transparency and Accountability of HHS Programs, by maximizing its organizational capacity and implementing technology enhancements to address OMHA's increasing workload and meet the needs of the public (Medicare beneficiaries and providers).

The FY 2012 Request:

- Addresses OMHA's increasing workload – projected to double from FY 2007 to FY 2012 – by funding a Mega Team Initiative that expands OMHA's organizational legal capacity for case review and decision writing capacity to further maximize the ALJ resource. A Mega Team includes an ALJ, two attorneys (versus one in a traditional team), one paralegal and one hearing clerk.

- Sustains OMHA's Health Care Reform efforts initiated in FY 2011, including an Electronic Records Initiative for development and enhancements within the shared Medicare Appeals Systems (MAS). OMHA has a critical need to transform its case file process from paper to a fully electronic environment.

- Maintains focus on meeting OMHA's 90-day statutory deadline for adjudicating cases.

The FY 2011 figures displayed throughout this document represent the annualized Continuing Resolution level. Allocation of funds to programs and activities represent policies consistent with the enacted FY 2010 appropriations.

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 and Strategic Goal 4A: Increase Efficiency, Transparency and Accountability of HHS Programs: Ensure program integrity and responsible stewardship of resources. By providing an independent forum for the timely and legally sufficient adjudication of Level III Medicare appeals, OMHA helps to transform health care access by ensuring that Medicare beneficiaries receive the services to which they are entitled. In addition, OMHA's performance targets independently and jointly serve to support OMHA's core mission and statutory requirement to efficiently and effectively adjudicate Level III Medicare appeals within 90 days.

In FY 2010, OMHA met or exceeded four out of the seven agency performance goals as follows: (See Outputs and Outcomes Table below for additional detail.)

- *Increase the number of Benefits Improvement and Protection Act (BIPA) cases closed within 90 days* - In FY 2010, OMHA processed 95% of the BIPA cases within the statutory timeframe. OMHA exceeded its performance target of 88% for FY 2010 by 7% primarily due to the continued nationwide implementation of best practices identified in OMHA field offices, increased efficiencies and standardization, and the implementation

of a workload measurement system for balancing national caseloads across offices through case transfers.

- *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 identified the timely closure of non-BIPA cases as an important long-term goal. OMHA makes a concerted effort to adjudicate non-BIPA cases expeditiously and adopted many of the same process improvements for non-BIPA cases. This measure assures OMHA meets or exceeds all mandated case processing timelines throughout the Medicare appeals process. OMHA expects the number of non-BIPA cases to decrease in the out years. In FY 2010, OMHA processed 72% of the non-BIPA cases within 90 days, thereby exceeding its performance target of 55% for FY 2010 by 17% primarily due to the continued nationwide implementation of best practices identified in OMHA field offices and other process improvements and efficiencies that support reduced case processing timeframes.

- *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 2010, OMHA issued 73% of its decisions for cases that went to hearing within 30 days. This fell short of the performance target of 84%. After five years of operations, however, the data has 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 will retire 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 2010 was 1% which OMHA exceeded by having only 0.2% 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 2010, OMHA achieved a 4.30 level of appellant satisfaction nationwide, exceeding the FY 2010 target of 3.20 by 1.10. 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 2010, OMHA fell short of this performance target. The average cost per claim in FY 2010 was $388 compared to $300 in FY 2009. The average cost per claim is driven by claim receipts. The projected number of claims processed per ALJ for FY 2012 was based on the full implementation of the CMS Recovery Audit Contractor (RAC) program during FY 2010. The RAC program was delayed several months, resulting in fewer claim receipts per ALJ. OMHA expects the cost per claim adjudicated to decrease in FY 2012.

- *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 2010 performance target was to increase the number of claims processed by each ALJ team by 1%. OMHA fell short of this performance target. The average number of claims processed per ALJ in FY 2010 was 2,789 compared to 3,336 in FY 2009. The projected number of claims processed per ALJ for FY 2012 also was based on the full implementation of CMS RAC program during FY 2010. However, the RAC program was delayed by several months, resulting in fewer claim receipt per ALJ. OMHA expects the average number of claims adjudicated per ALJ team to increase in FY 2012.

OMHA is improving its methodology for calculating the number of cases closed with 90 days (Measure 1.1 and Measure 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. This more stringent methodology will increase the accuracy and transparency of these measures. These changes resulted in a new FY 2010 baseline. The FY 2011 targets are based on this new baseline.

SUMMARY OF TARGETS AND RESULTS

The summary of Targets and Results Table provides an overview of all targets established for each corresponding fiscal year.

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2007	6	6	100%	2	33%
2008	7	7	100%	7	100%
2009	7	7	100%	6	86%
2010	7	7	100%	4	57%
2011	7	N/A	N/A	N/A	N/A
2012	6*	N/A	N/A	N/A	N/A

* Measure 1.3 (See Outputs and Outcomes Table) will be retired at the end of FY 2011.

AMOUNTS AVAILABLE FOR OBLIGATION

	FY 2010 Actual	FY 2011 CR	FY 2012 PB
Trust Fund Discretionary Appropriation:			
Annual Appropriation	71,147,000	71,147,000	81,019,000
Subtotal, adjusted trust fund discretionary appropriation.....	71,147,000	71,147,000	81,019,000
Total, Discretionary Appropriation.....	71,147,000	71,147,000	81,019,000
Unobligated Balance.....	1,000,000		
Total Obligations.....	70,000,000	71,147,000	81,019,000

SUMMARY OF CHANGES

2010 General Funds appropriation	$71,147
HI/SMI trust funds transfer	$0
Total adjusted budget authority	$71,147
2012 Request - General Funds	$81,019
Request - HI/SMI trust funds Transfer	$0
Total estimated budget authority	$81,019
Net Changes	**9,872**

	FY 2010 Actual		Change from Base	
	(FTE)	Budget Authority	(FTE)	Budget Authority
Increases:				
A. Built-In:				
1. Costs of pay adjustments	368	$34,433	56	$7,206
2. Benefits for former personnel	0	$0	0	$0
3. Land and Structures	0	$0	0	$0
4. Personnel benefits	0	$8,731	0	$3,083
5. Travel and transportation of persons	0	$185	0	$165
6. Transportation of things	0	$216	0	$72
7. Communications, utilities, and miscellaneous charges	0	$8,008	0	$492
8. Printing and reproduction	0	$26	0	$4
9. Advisory and assistance services	0	$9,136	0	-$3,361
10. Other services	0	$3,518	0	$962
11. Working Capital Fund	0	$5,958	0	$542
12. Operation and maintenance of facilities	0	$470	0	$130
13. Job Corps FECA	0	$0	0	$0
14. Operation and maintenance of equipment	0	$73	0	$20
15. Supplies and materials	0	$338	0	$112
16. Equipment	0	$55	0	$445
17. Research & Development Contracts	0	$0	0	$0
18. Grants, subsidies, and contributions	0	$0	0	$0
Subtotal, Built-In Increases	**368**	**+$71,147**	**56**	**+$9,872**
B. Programs:				
Subtotal Program Increases			**0**	**$0**
Total Increases	**368**	**+$71,147**	**56**	**+$9,872**

	FY 2010 Actual		Change from Base	
Decreases:				
B. Programs:				
Subtotal Program Decreases			**0**	**$0**
Total Decreases	**0**	**$0**	**0**	**$0**
Net Change	**368**[1]	**+$71,147**	**56**	**+$9,872**

[1] Includes conversion of contractor positions to federal positions.

BUDGET AUTHORITY BY ACTIVITY

(Dollars in Thousands)

	FY 2010 Actual		FY 2011 CR		FY 2012 PB	
	FTE	Amount	FTE	Amount	FTE	Amount
Office of Medicare Hearings and Appeals	368	$71,147	395	$71,147	424	$81,019
Total, Budget Authority	368	$71,147	395[2]	$71,147	424	$81,019

[2] Includes conversion of contractor positions to federal positions.

AUTHORIZING LEGISLATION

	FY 2011 Amount Authorized	FY 2011 CR	FY 2012 Amount Authorized	FY 2012 Pres. Budget
Medicare Prescription Drug, Improvement, and Modernization Act of 2003	Indefinite	$71,147,000	Indefinite	$81,019,000

APPROPRIATION HISTORY (Dollars in Thousands)				
	Budget Estimates to Congress	**House Allowance**	**Senate Allowance**	**Appropriations**
2002	$0	$0	$0	$0
2003	0	0	0	0
2004	0	0	0	0
2005	0	0	0	0
2006	0	0	0	0
2007	74,250,000	70,000,000	75,000,000	59,727,000
2008	74,250,000	70,000,000	75,000,000	63,864,000
2009	64,604,000	64,604,000	64,604,000	64,604,000
2010	71,147,000	71,147,000	71,147,000	71,147,000
2011	0	0	0	71,147,000[3]

[3] 2011 CR

NARRATIVE BY ACTIVITY

Dollars in Thousands

	FY 2010	FY 2011	FY 2012	Difference
	Actual	Continuing Res	PB	+/- 2010
Budget Authority	71,147	71,147	81,019	9,872
FTE	368	395[4]	424	56

[4] Includes conversion of contractor positions to federal positions.

Authorizing Legislation…….……..Titles XVIII and XI of the Social Security Act

Allocation Method…….…….Direct Federal

Program Description and Accomplishments

OMHA administers its adjudicative 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 extensively utilizes video-teleconferencing (VTC) and telephone hearings, in order 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 both meet the BIPA timeframes and offer expanded access for appellants to ALJ hearings.

Since opening its doors in July 2005, OMHA's caseload has nearly doubled as shown below:

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
137,442	185,665	209,002	194,000	235,000*	274,000*

*Projected

OMHA's original jurisdiction over Medicare Part A and Part B cases has been expanded to include areas not originally within its authority. 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 Medicare 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 that 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. Under Title III, Section 302, of the Tax Relief and Health Care Act of 2006, the RAC program has become permanent and is being expanded to all 50 States in FY 2010. The actual implementation of the RAC program was delayed and CMS is now using a staggered implementation plan that results in some uncertainty regarding the timing and number of RAC cases that CMS and OMHA will actually receive. In discussions with CMS leadership, CMS reinforced the difficulty in making RAC projections but concurred that OMHA's projected receipts of 41,000 RAC specific claims by the end of FY 2012 is realistic.

In addition, OMHA expects that a portion of its caseload will also increase due to the enactment of the Patient Protection and Affordable Care Act. For example, Section 1104 amends Health Insurance Portability and Accountability (HIPPA) to require increased use of electronic exchanges of information by HIPAA covered entities. OMHA expects the provision to result in increased appeals at the CMS-contractor level as appeals become easier to file. This provision will therefore result in increased appeals at the third level of the Medicare appeals process as lower reviews become more accessible and therefore more plentiful.

In July 2010, OMHA commemorated five years of successful agency operations. For OMHA, reaching this milestone also presents some new challenges as OMHA fully comes into its own as an independent agency and adapts to new leadership under its second Chief Judge. Specifically, OMHA faces an increasing caseload and the need to make some critical management refinements (e.g., ALJ staffing ratios composition, strategic technological investments so OMHA can continue to maximize efficiencies and position itself to introduce electronic record files). In the FY 2012 Request, OMHA acknowledges the importance of building upon what has worked well for the agency and making changes in areas where strategic investments are needed and opportunities for improvement exist.

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

- A five year strategic plan that codifies OMHA's objectives and establishes the foundation for organizational performance.
- A best practices initiative that shared and facilitated 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 enhanced, citizen-centric internet presence based on usability testing to clearly communicate the Medicare appeals process to citizens.
- The establishment of a decision template resource database.
- An Adjudicative Business Process (ABP) Initiative to develop OMHA-wide common business practices for the adjudicative process.

Funding History

FY 2007	$59,727,000
FY 2008	$63,864,000
FY 2009	$64,604,000
FY 2010	$71,147,000
FY 2011	$71,147,000

Budget Request

The FY 2012 Request for OMHA of $81,019,000 is an increase of $9,872,000 (or 13.9%) over FY 2010. Although OMHA projects that its receipt levels will double over the five year period from FY 2007 to FY 2012 (137,442 actual claims received) to 274,000 projected claims in FY 2012, its adjudicatory staff to judge ratio has not. Although OMHA continues to become more efficient, expanding its organizational legal capacity and expertise and developing and implementing technology enhancements is the only assured method to address the caseload volume and meet performance measures. The FY 2012 Request will support:

Mega Team Initiative:

- This entails hiring twelve junior attorneys to add one additional attorney to twelve traditional ALJ teams thereby creating twelve additional mega teams. Currently, a traditional ALJ team is comprised of an ALJ, attorney, paralegal and hearing clerk. Based on five years of operational experience, OMHA recognizes having an additional

attorney on an ALJ team will enable ALJs to hear more appeals. This would increase the ALJ to legal staff ratio and increase OMHA's case review and also decision writing capacity to address periodic delays in decision writing and prepare for the increasing caseload. It is projected that team efficiency will increase by 30% with the additional attorney.

Electronic Records Initiative:

- This Initiative will move OMHA move from a paper case file to a fully electronic environment through continued development and enhancements within the shared Medicare Appeals System (MAS). The authorizing legislation for OMHA envisioned it using electronic case files. However, OMHA is currently operating in an unwieldy system driven by paper case files, whereby documents must be individually scanned into the case record. Operating in a fully electronic environment will conserve costlier human resources for performing more complex tasks, and provide a direct benefit to CMS, DAB and Medicare beneficiaries through operational efficiencies. This initiative also will provide long term savings.

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

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
*1.1: Increase the number of BIPA cases closed within 90 days *(Output)*	FY 2010: 95% (Target Exceeded)	88%	89%	+1%
*1.2: Increase the number of non-BIPA cases closed within 90 days *(Output)*	FY 2010: 72% (Target Exceeded)	55%	57%	+2%
**1.3: For cases that go to hearing, increase the percentage of decisions rendered in 30 days *(Output)*	FY 2010: 73% (Target Unmet)	84%	N/A	N/A

1.4: Reduce the percentage of decisions reversed or remanded on appeals to the Medicare Appeals Council *(Output)*	FY 2010: 0.2% (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 2010: 4.3 (Target Exceeded)	3.2	3.6	+0.4
1.6: Decrease the cost per claim adjudicated *(Efficiency)*	FY 2010: +29% (Target Unmet)	-3%	-3%	0
1.7: Increase number of claims processed per ALJ team *(Efficiency)*	FY 2010:-16% (Target Unmet)	1%	2%	+1%
Program Level Funding ($ in millions)	**N/A**	**$71**	**$81**	**+$10**

*****Starting in FY 2011, the methodology for Measure 1.1 and Measure 1.2 will include counting 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.

****** Measure 1.3 will be retired at the end of FY 2011.

BUDGET AUTHORITY by OBJECT CLASS

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 CR	FY 2012 PB
Personnel compensation:			
Full-time permanent (11.1)	33,764	37,546	41,120
Other than full-time permanent (11.3)	0	0	0
Other personnel compensation (11.5)	669	293	519
Military personnel (11.7)	0	0	0
Special personal services payments (11.8)	0	0	0
Subtotal, Personnel compensation	34,433	37,839	41,639
Civilian personnel benefits (12.1)	8,731	9,988	11,814
Military benefits (12.2)	0	0	0
Benefits for former personnel (13.0)	0	0	0
Total Pay Costs	43,164	47,827	53,453
Travel and transportation of persons (21.0)	185	338	350
Transportation of things (22.0)	216	260	288
Rental payments to GSA (23.1)	6,691	6,700	7,000
Communications, utilities, and miscellaneous charges (23.3)	1,317	1,360	1,500
Printing and reproduction (24.0)	26	23	30
Other Contractual Services:			
Advisory and assistance services (25.1)	9,136	5,444	5,775
Other services (25.2)	3,518	2,090	4,480
Other purchases of goods and services from Government Accounts (25.3)	5,958	6,065	6,500
Operation and maintenance of facilities (25.4)	470	352	600
Research and development contracts (25.5)	0	0	0
Medical care (25.6)	0	0	0
Operation and maintenance of equipment (25.7)	73	82	93
Subsistence and support of persons (25.8)	0	0	0
Subtotal, Other Contractual Services	19,155	14,033	17,448
Supplies and materials (26.0)	338	406	450
Equipment (31.0)	55	200	500
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	27,983	23,320	27,566
Total Budget Authority by Object Class	71,147	71,147	81,019

SALARIES AND EXPENSES

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 CR	FY 2012 PB
Personnel compensation:			
Full-time permanent (11.1)	33,764	37,546	41,120
Other personnel compensation (11.5)	669	293	519
Subtotal, Personnel compensation	34,433	37,839	41,639
Civilian personnel benefits (12.1)	8,731	9,988	11,814
Total Pay Costs	43,164	47,827	53,453
Travel and transportation of persons (21.0)	185	338	350
Transportation of things (22.0)	216	260	288
Communications, utilities, and miscellaneous charges (23.3)	1,317	1,360	1,500
Printing and reproduction (24.0)	26	23	30
Other Contractual Services:			
Advisory and assistance services (25.1)	9,136	5,444	5,775
Other services (25.2)	3,518	2,090	4,480
Other purchases of goods and services from Government Accounts (25.3)	5,958	6,065	6,500
Operation and maintenance of facilities (25.4)	470	352	600
Operation and maintenance of equipment (25.7)	73	82	93
Subtotal, Other Contractual Services	19,155	14,033	17,448
Supplies and materials (26.0)	338	406	450
Total Non-Pay Costs	21,237	16,420	20,066
Total Salaries and Expenses	64,401	64,247	73,519

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT

	FY 2010 Actual			FY 2011 Estimate			FY 2012 Estimate		
	Civilian	**Military**	**Total**	**Civilian**	**Military**	**Total**	**Civilian**	**Military**	**Total**
Office of Medicare Hearings and Appeals	368	0	368	395	0	395	424	0	424
Total, Office of Medicare Hearings and Appeals	368	0	368	395	0	395[5]	424	0	424

[5] Includes conversion of contractor positions to federal positions.

Detail of Positions

	FY 2010 Actual	FY 2011 CR	FY 2012 PB
AL-1	1	1	1
AL-2	4	4	4
AL-3	64	64	65
Subtotal	69	69	70
Total - AL Salary	$10,139,215	$10,699,215	$11,340,739
ES-1	2	2	2
Subtotal	2	2	2
Total - ES Salary	$305,388	$315,466	$325,876
GS-15	7	8	8
GS-14	25	27	29
GS-13	7	7	7
GS-12	107	108	109
GS-11	69	69	69
GS-10			
GS-9	28	33	46
GS-8	42	48	48
GS-7	26	36	37
GS-6	10	16	16
GS-5			
GS-4			
GS-3	5	6	7
GS-2			
GS-1			
Subtotal	326	358	376
Total - GS Salary	$23,319,397	$26,531,319	$29,453,385
Commissioned Corps	0	0	0
Total Positions	397	429	448
Total FTE	368	395	424
Average ES salary	$152,694	$157,733	$162,938
Average GS grade	11/1	11/4	11/5
Average GS Salary	$62,352	$67,168	$69,466

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

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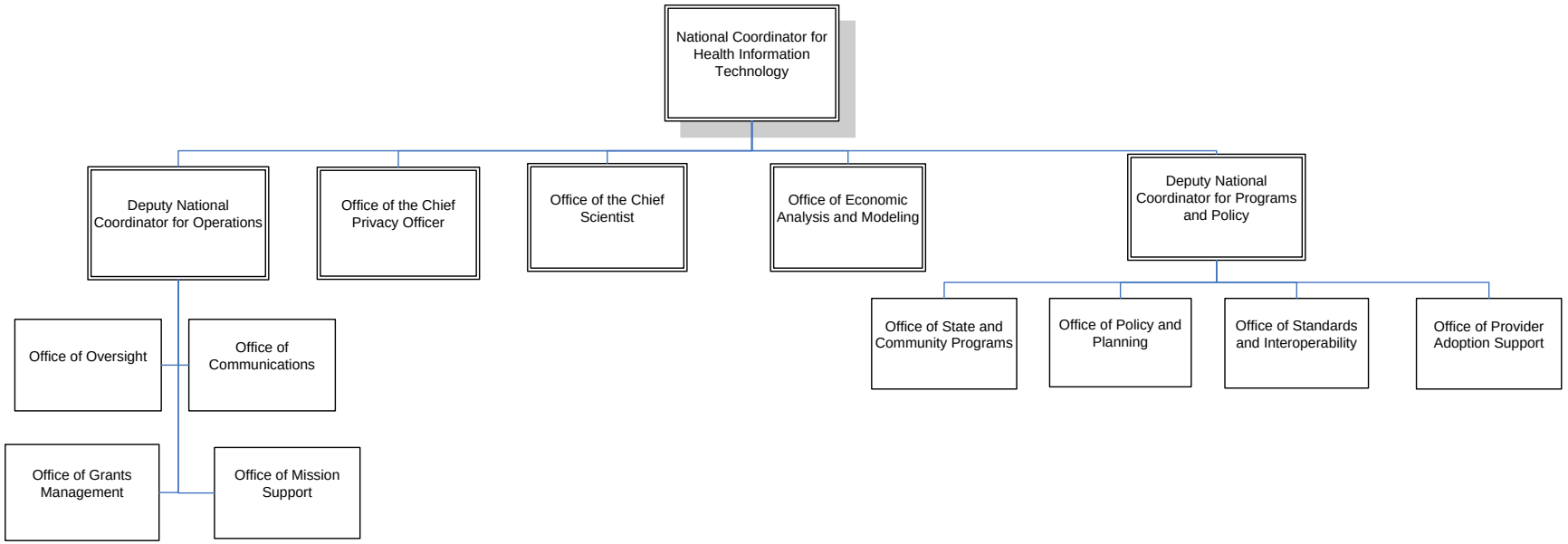
OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

ORGANIZATIONAL CHART



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 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.

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 information technology (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 the Department's aspirations and the HHS Secretary's priority to *Transform Healthcare*. 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 "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 and Medicaid to encourage the meaningful use of health IT through manners such as establishment of 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 healthcare quality, safety, and efficiency while reducing health disparities,
- Engage patients and their families in their healthcare,
- 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.

ONC also 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 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 and offices and among relevant executive branch agencies and the public health IT programs and policies to avoid duplication of efforts and inconsistent activities; 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 through:

- 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 applying research methodologies to perform evaluation studies of health information technology grant programs; identifying, tracking and supporting innovations in health IT; leading research activities mandated under the HITECH Act provisions of Recovery Act; promoting applications of health IT that support basic and clinical research; collecting and communicating knowledge of health care informatics from and to international audiences; collaborating with other agencies and departments on assessments of new health IT programs; and advising the National Coordinator concerning 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 the ONC's efforts with similar privacy officers in other Federal agencies, State and regional agencies, and foreign countries.

The *Office of Economic Analysis and Modeling* utilizes advanced quantitative modeling to simulate the microeconomic and macroeconomic effects of investing in health IT and provides advanced policy analysis of health IT strategies and policies to the National Coordinator.

The *Office of the Deputy National Coordinator for Operations* is responsible for the 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.

DISCRETIONARY ALL-PURPOSE TABLE

(dollars in thousands)

	FY 2010 Actuals	FY 2011 President's Budget	FY 2011 CR	FY 2012 Request
Budget Authority	41,461	78,334	42,325	57,013
PHS Evaluation Funds	19,011	0	19.011	21,400
Total Program Level	60,472	78,334	61,336	78,413
FTE	84	149	149	189

OVERVIEW OF BUDGET REQUEST

The FY 2012 President's Budget Request for ONC is $78.4 million including $21.4 million in Public Health Service (PHS) Evaluation Funds to support program activities and carry out Recovery Act responsibilities. This represents an increase of +$18.0 million above the FY 2010 actual level and includes an increase in PHS Evaluation Funds of +$2.4 million. This budget supports the implementation of the "*ONC-Coordinated Federal Health IT Strategic Plan*" and its planned revision, and HHS Strategic Plan, Goal 1: Transform Health Care. It also provides resources required to administer and manage the $2 billion appropriated to ONC under the Recovery Act and to support ONC's responsibilities as legislated under the HITECH Act, including promoting the meaningful use of health IT.

OVERVIEW OF PERFORMANCE

In FY 2012 ONC grants programs and policy development efforts will be well underway and making significant progress toward meeting the goals of the HITECH Act provisions of the Recovery Act. In so doing, ONC is working toward the goal that all Americans will benefit from secure, interoperable EHR technology. ONC's efforts to encourage the development and adoption of health IT are also critical to achieving the Department's overall goals for health care and delivery system reform.

ONC efforts, as well as corresponding performance goals, are structured according to the following five priority areas of the Administration's health IT strategy:

- Achieve adoption and information exchange through meaningful use of health IT,
- Improve care, population health, and increase efficiency 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.

SUMMARY OF TARGETS AND RESULTS TABLE

Fiscal Year	Total Targets	Targets With Results Reported	Percentage of Targets With Results Reported	Total Targets Met	Percentage of Targets Met
2007	3	3	100%	1	33%
2008	4	3	75%	0	0%
2009	4	2	50%	1	25%
2010	8	8	100%	7	88%
2011	14	TBD	TBD	TBD	TBD
2012	13	TBD	TBD	TBD	TBD

DISCUSSION OF THE STRATEGIC PLAN AND TABLE

ONC is the principal Federal organization charged with coordination of national efforts related to the implementation and use of electronic health information exchange. Although computer technology has changed the way that Americans communicate and share information, for the most part health care data are still available to health care providers and patients only through paper and film records. Leading the public and private sector efforts to improve the quality of health and care through information technology is a key ONC role.

ONC published the "*ONC-Coordinated Federal Health IT Strategic Plan: 2008 - 2012*" in June 2008. In light of the section 3001 (C) 3 of the Recovery Act, this document is being updated and will be re-released in the spring of 2011.

	ONC Goal 1: Encourage Adoption and Meaningful Use of Health IT	ONC Goal 2: Engage Consumers in Health Care Through Health IT	ONC Goal 3:. Inspire Confidence and Trust in Health IT	ONC Goal 4: Enable Rapid Learning, Knowledge Creation and Health Reform
1 Transform 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 and preventive care linked with community prevention services				
1.D: Reduce the growth of health care costs while promoting high-value, effective care				
1:F: Promote the adoption of health information technology	X	X	X	X
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 and medical product safety				
2.D: Increase our understanding of what works in public health and human service practice				
3 Advance the Health, Safety and Well-Being of Our People				
3.A: Ensure the safety, well-being, and healthy development of children and youth				
3.B: Promote economic and social well-being for individuals, families, and communities				
3.C: Improve the accessibility and quality of supportive services for people with disabilities and older adults				
3.D: Promote prevention and wellness				
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 the 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 Services Infrastructure and Workforce				
5.A: Invest in the HHS Workforce to help meet America's health and human service needs today and tomorrow				
5.B: Ensure that the Nation's health care workforce can meet increased demands				
5.C: Enhance the ability of the public health workforce to improve public health at home and abroad				
5.D: Strengthen the Nation's human services workforce				
5.E: Improve national, state, and local, and tribal surveillance and epidemiology capacity				

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

SUMMARY OF RECOVERY ACT OUTLAYS

(dollars in millions)

ARRA Implementation Plan[1]		Outlays		
	Program Total	FY 2009/ FY 2010	FY 2011	FY 2012
Health IT Extension Program	774.0	28.4	192.8	382.5
State Health Information Exchange	564.0	18	144.0	234.7
Beacon Communities	265.3	1.8	67.75	110.4
Workforce	118	3.3	30.1	49.1
Omnibus	203.8	2.6	52.0	74.8
Public Health	30.6	0.5	7.8	12.7
Privacy and Security	24.3	2.1	4.1	10.1
Totals	1980.0	56.7	498.6	874.3[2]

SUMMARY OF RECOVERY ACT PERFORMANCE

Implementation Plan 1: Health Information Technology

Performance Measure	FY 2010 Result	FY 2011 Target	FY 2012 Target
Medical professionals receiving incentive payments for achieving the meaningful use of an electronic health record to: improve	See CMS measure set		
Community pharmacies able to receive and process electronic prescriptions	85% baseline	89%	97%
Students completing training programs at community colleges to become health IT professionals[3]	N/A	6,500	5,250
Providers Registered to receive services from Regional Extension Centers	11,875	50,000	100,000
Adoption of EHRs among providers who have registered with Regional Extension Centers for at least 10 months.	N/A	40%	60%

[1] Does not include $20 million transferred to and managed by the National Institute for Standards and Technology at the Department of Commerce.

[2] Discrepancies between this table and the FY 2012 Budget Appendix are due to the omission of $524,300,000 in end of previous year ARRA balances from the Budget Appendix in FY 2012.

[3] ONC has revised the targets for this measure from original estimates of 700 in FY 2011 and 7,000 in FY 2012 to 6,500 in FY 2011 and 5,250 in FY 2012. These revisions (1) increase the FY 2011 target to reflect the enrollment of 2,287 students in these programs during the final months of FY 2010, which was higher than the 700 originally forecast, and (2) lowering the FY 2012 estimate to reflect the period of the fiscal year that is within the Cooperative Agreement Grant program's period of performance. Note that the purpose of the program is to create a *sustainable increase* in the capacity of the nation's community colleges to train health IT professionals. ONC expects students to continue enrolling in and completing these training programs after the grant's period of performance. Accordingly, the full year estimated target for students trained in FY 2012 is 10,500.

For more information about ONC's Recovery Act Implementation Plan and Government Performance and Results Act performance measures, read the Online Performance Appendix to the FY 2012 President's Budget Request at http://dhhs.gov/asfr/ob/docbudget or in the About ONC section of http://healthit.hhs.gov.

To view the Recovery Act Implementation Plan for health information technology visit http://recovery.gov.

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 $78,413,000 Provided, That in addition to amounts provided herein, $21,400,000 shall be available from amounts available under section 241 of the Public Health Service Act. (Department of Health and Human Services Appropriations Act, 2009.)

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

SUMMARY OF CHANGES

2010

Total estimated budget authority	$41,461,000
(Obligations)	-$60,472,000

2012

Total estimated budget authority	$57,013,000
(Obligations)	-$78,413,000
Net Change obligations	+$17,941,000
Net Change budget authority	+$15,552,000

	FY 2012 Estimate FTE	FY 2012 Estimate Budget Authority	Change from Base FTE	Change from Base Budget Authority
Increases:				
A. Program:				
1. Deputy National Coordinator for Programs and Policy	24	$43,587,000	+13	+$19,055,000
[Including increase in Evaluation Funds of]		[$11,896,000]		[+$4,184,000]
2. Office of the Chief Privacy Officer	6	$5,923,000	+3	$3,578,000
[Including increase in Evaluation Funds of]		[$1,616,000]		[+$879,000]
Total, Program Increases.	**30**	**$49,510,000**	+16	**+$22,633,000**
Decreases:				
A. Program:				
1. Deputy National Coordinator for Operations	57	$22,099,000	+25	-$3,631,000
[Including decrease in Evaluation Funds of].		[$6,031,000]		[-$2,058,000]
2. Office of Economics Analysis and Modeling	6	$3,177,000	+4	-$828,000
[Including decrease in Evaluation Funds of]		[$897,000]		[-$362,000]
3. Office of the Chief Scientist	15	$3,627,000	+6	-$234,000
[Including decrease in Evaluation Funds of].		[$990,000]		[-$224,000]
Total, Program Decreases	**78**	**$28,903,000**	+35	**-$4,693,000**
Net Change	**108**	**$49,510,000**	+51	**+$22,633,000**

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

BUDGET AUTHORITY BY ACTIVITY

	FY 2010 Actual	FY 2011 CR	FY 2012 PB
1. DNC Programs and Policy	24,532,000	26,138,000	43,587,000
Total, DNC Programs and Policy	**24,532,000**	**26,138,000**	**43,587,000**
2. DNC Operations	25,730,000	23,223,000	22,099,000
Total, DNC Operations	**25,730,000**	**23,223,000**	**22,099,000**
3. Office of the Chief Scientist	3,861,000	3,553,000	3,627,000
Total, Office of the Chief Scientist	**3,861,000**	**3,553,000**	**3,627,000**
4. Office of the Chief Privacy Officer	2,345,000	5,070,000	5,923,000
Total, Office of the Chief Privacy Officer	**2,345,000**	**5,070,000**	**5,923,000**
5. Office of Economic Analysis and Modeling	4,005,000	3,352,000	3,177,000
Total, Office of Economic Analysis and Modeling	**4,005,000**	**3,352,000**	**3,177,000**
Total, Budget Authority	**60,473,000**	**61,336,000**	**57,013,000**
FTE	84	149	189

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

AUTHORIZING LEGISLATION

	FY 2011 Amount Authorized	FY 2011 Continuing Resolution	FY 2012 Amount Authorized	FY 2012 Pres. Budget
Health Information Technology Activity:				
1. Health Information Technology PHS Act 42 U.S.C. 201……	Indefinite	$42,332,000	Indefinite	$57,013,000
2. PHS Evaluation Funds (non-add) PL 111-117.....	Indefinite	$19,011,000	Indefinite	$21,400,000
Total request level.....		$61,343,000		$78,413,000

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

APPROPRIATIONS HISTORY TABLE

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2006				
General Fund Appropriation:				
Base	$75,000,000	$58,100,000	$32,800,000	$42,800,000
PHS Evaluation Funds	$2,750,000	$16,900,000	$12,350,000	$18,900,000
Advance				
Rescissions (P.L. 109-148)				($428,000)
Transfer to CMS				($29,107)
Subtotal	$77,750,000	$75,000,000	$45,150,000	$61,242,893
FY 2007				
General Fund Appropriation:				
Base	$89,872,000	$86,118,000	$51,313,000	$42,402,000
PHS Evaluation Funds	$28,000,000	$11,930,000	$11,930,000	$18,900,000
Advance				
Subtotal	$117,872,000	$98,048,000	$63,243,000	$61,302,000
FY 2008				
General Fund Appropriation:				
Base	$89,872,000	$13,302,000	$43,000,000	$42,402,000
PHS Evaluation Funds	$28,000,000	$48,000,000	$28,000,000	$18,900,000
Advance				
Subtotal	$117,872,000	$61,302,000	$71,000,000	$60,561,000

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2009				
General Fund Appropriation:				
Base	$18,151,000	$43,000,000	$60,561,000	$43,552,000
PHS Evaluation Funds	$48,000,000	$18,900,000	$0	$17,679,000
Advance				
ARRA (P.L. 111-5)				$2,000,000,000
Subtotal	$66,151,000	$61,900,000	$60,561,000	$2,061,231,000
FY 2010				
General Fund Appropriation:				
Base	$42,331,000	$0	$42,331,000	$42,331,000
PHS Evaluation Funds	$19,011,000	$61,342,000	$19,011,000	$19,011,000
Advance				
Subtotal	$61,342,000	$61,342,000	$61,342,000	$61,342,000
FY 2011				
General Fund Appropriation:				
Base	$87,113,000	$69,842,000	$78,334,000	$61,343,000
Advance				
Subtotal	$87,113,000	$69,842,000	$78,334,000	$61,343,000

BUDGET NARRATIVES

OFFICE OF THE DEPUTY NATIONAL COORDINATOR FOR PROGRAMS AND POLICY

	FY 2010	FY 2011	FY 2012	FY 2012 +/-
	Actuals	Continuing Resolution (CR)	President's Budget Request	FY 2010
Budget Authority	16,820,000	18,031,000	31,691,000	+14,871,000
PHS Evaluation Funds	7,712,000	8,107,000	11,896,000	+4,184,000
Total Program Level	24,532,000	26,138,000	43,587,000	+19,055,000
FTE	38	79	105	+67

1/Privacy and security activities for FY 2010 and FY 2011 are included in the Office of the Chief Privacy Officer for comparability with the FY 2012 request.

Authorizing Legislation: PHS Act 42 U.S.C. 201
Allocation Method: Contract, Cooperative Agreement, Grant

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Deputy Coordinator 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 support efforts to accomplish the following:

- 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,
- Establish state and community programs to create the infrastructure and demonstrations needed to improve health care efficiency and quality,
- Encourage the adoption of health IT, and
- Coordinate across and outside of the government to expand the use of health IT, and establish standards to govern meaningful use of health IT.

OFFICE OF POLICY AND PLANNING

Within ONC, the Office of Policy and Planning (OPP) has an important role in making progress towards the achievement of the HHS Secretary's priority to *Transform Health Care*. OPP's efforts focus on developing and implementing health IT policies that set the national direction, establish the "rules of the road" and best practices for the use of health IT and health information exchange, and support new requirements of health reform.

Federal Health IT Strategic Plan

As required by HITECH Subtitle A, Part 1 section 3001, ONC, in consultation with other appropriate Federal agencies, updated its Federal Health IT Strategic Plan. The Plan was sent to policy makers for review in CY 2010 and will be released in CY 2011. This effort will continue to be funded via Recovery Act funds through FY 2012.

Health Information Technology Policy Committee and Health Information Technology Standards Committee
As required by the HITECH Act Subtitle A, Part 1 section 3002 and section 3003, in 2009, ONC chartered the Health IT Policy Committee (HITPC) and the Health IT Standards Committee (HITSC), Federal Advisory Committee Act (FACA) bodies, to make policy and technical recommendations to the National Coordinator relating, but not limited to, defining meaningful use criteria for the Medicare and Medicaid EHR Incentive Programs under HITECH, protecting health IT privacy, promoting security in certified EHR technology, utilizing a certified EHR for all United States citizens, improving the quality of health care through use of certified EHRs, and implementing a nationwide health IT infrastructure and Federal Health IT Strategic Plan to support these activities.

Regulations
OPP has worked to increase the alignment of Federal regulations and Federal health IT policies where possible to ensure improved and consistent Federal and state policies.

ONC accomplished major steps toward the goal of facilitating meaningful use of certified health IT. In 2010 ONC issued final rules that established not only the temporary and permanent certification programs, but also the standards, implementation specifications, and certification criteria aligned with the Medicare and Medicaid EHR Incentive Programs. The establishment of these certification programs and the requirements for certified EHR technology sent a clear signal to health care providers to start taking steps to adopt and use EHRs in a meaningful manner; to vendors to start enhancing their products to make them capable of meaningful use; and to vendors, health care organizations and consumers concerning how personal health information must, and can be, kept private and secure.
OPP worked closely with the HITPC and with CMS to develop HHS' definition of the meaningful use of health IT advances. The definition supports five health care goals:

1. Improving quality, safety, efficiency and reducing disparities,
2. Engaging patients and families in their health care,
3. Improving population and public health,
4. Improving care coordination, and
5. Ensuring adequate privacy and security protections for personal health information.

OPP meaningful use efforts to date include working with the:

- Internal Revenue Service to provide guidance on: hospital tax-exempt status and Stark Anti-kickback statutes, Health Information Organizations and tax-exempt status, assuring that health information exchange organizations operating in the public interest were eligible to receive tax-exempt status,
- Drug Enforcement Agency on effective policies and publication of regulations to permit e-prescribing of controlled substances,
- Office of Civil Rights (OCR) and Centers for Medicare and Medicaid on HIPAA regulations and other related activities, and

Centers for Medicare and Medicaid to develop and publish guidance to address real and perceived barriers raised by the Clinical Laboratory Improvement Amendments (CLIA) and to publish the final rule to establish the Medicare and Medicaid EHR Incentive Programs.

State Coordination
States play a critical role in ONC's strategy to support hospitals and health care professionals in attaining meaningful use of health IT and encouraging widespread health information exchange. Efforts to coordinate with states (in addition to the State Health Information Exchange Program) include the State Alliance for e-Health, a consensus-based, executive-level body of state elected and appointed officials (in all levels of state government). State policy makers will play an important role in supporting clinical and public health information exchange necessary for meaningful use of health IT. OPP is supporting the

record number of states going through an administration change by providing a community of practice where best practices are shared and by creating customizable educational materials that states can provide to their new administration officials.

OFFICE OF STANDARDS AND INTEROPERABILITY

The Office of Standards and Interoperability (OSI) works to enable health information to be captured and exchanged among health IT systems – whether small physician practices or large hospital systems. The funding is allocated among several components that allow ONC to:

- Support the life-cycle of standards and implementation specifications for health IT,
- Identify existing or develop new standards, service descriptions and implementation specifications for health IT,
- Develop and maintain certification criteria and a certification process,
- Provide a core set of needed publicly accessible specifications, tools and services that support standardization and information exchange,
- Coordinate Federal participation in health information exchange (i.e., the Federal Health Architecture), and
- Support the Virtual Lifetime Electronic Record (VLER) project, a presidential priority creating a unified electronic record for military personnel and veterans.

OSI has undertaken a wide range of standard and certification criteria-related activities that support ONC's overall mission of meaningful use and the efforts of major grants programs established with Recovery Act funding. The meaningful use requirements progress from a focus on data collection to an increasing requirement for improved processes of care, better care coordination, and demonstration of improved outcomes. This progression of meaningful use depends fundamentally on the specification of standards, services, and policies that support interoperability of EHRs and actual information exchange.

Certification Process

ONC is collaborating 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. This will assure consumers that the products they purchase will meet the requirements necessary to achieve meaningful use of health IT. In FY 2010 OSI implemented a temporary certification program, accredited five Authorized Testing and Certification Bodies, and established the Certified Health IT Products List, which are important advancements for ensuring standardization in health IT—a prerequisite for meaningful use.

Nationwide Health Information Network

The Nationwide Health Information Network is a collection of standards, protocols, legal agreements, specifications, and services that enables the secure exchange of health information over the Internet. The Nationwide Health Information Network is a key component of the nationwide health IT strategy and provides a common platform for health information exchange to achieve the goals of the HITECH Act. The Nationwide Health Information Network's standards, services, and policies will enable health information to follow the consumer, be available for clinical decision making, and support appropriate use of health care information beyond direct patient care so as to improve public health.

Another important part of ONC's Nationwide Health Information Network strategy is to provide a reference implementation of the Nationwide Health Information Network's interoperable standards and specifications for entities to use in exchanging information with each other. A reference implementation is a working software application that meets all the specification criteria for exchanging health information. It is both a quality check of the standards and implementation specifications and a template that Federal and private partners can use to develop their own software. The CONNECT project supports

such a reference implementation. CONNECT is a Federal Health Architecture (FHA) initiative to develop a production-ready open-source software solution that can be adopted by Federal systems as well as private entities to exchange health information. Additionally, ONC efforts include the DIRECT project, which develops specifications for a secure, scalable, standards-based way to establish universal health addressing and transport for participants (including providers, laboratories, hospitals, pharmacies and patients) to send encrypted health information directly to known, trusted recipients over the Internet. The Direct Project will expand the standards and service descriptions available to address the key Stage 1 requirements for meaningful use, and provide an easy "on-ramp" for a wide set of providers and organizations looking to adopt health information exchange. The Direct Project is making a high quality open-source reference implementation available to organizations that want to incorporate Direct Project specifications into their technologies or exchanges. ONC continues to support the CONNECT and Direct project efforts through its leadership role and strategic setting efforts.

ONC also supports the Nationwide Health Information Network's mission through its many programs, including the State HIE and Beacon Communities programs. Grant recipients for both of these programs, for example, are aiming to utilize Nationwide Health Information Network services and capabilities in order to share data and to help demonstrate health improvements.

Federal Health Architecture (FHA)
The FHA is a partnership among Federal agencies, ONC, and the Office of Management Budget (OMB). HHS, through ONC, is the managing partner. As the managing partner, ONC provides annual funding, coordination and oversight, and operationalizes the shared goals and objectives for the Federal partners. The Department of Defense (DOD) and the Department of Veterans Affairs (VA) serve as lead partners. The lead partners provide program funding. In addition, more than 20 agencies, all with health-related responsibilities, contribute time and expertise to participate in specific FHA activities. Through this group, a collaborative Federal voice informs the development of shared Federal standards and protocols, including the Nationwide Health Information Network, and provides a venue for implementing and deploying standards, services and policies that will allow data exchange with all entities across the nation.

OFFICE OF STATE AND COMMUNITY PROGRAMS

The Office of State and Community Programs (OSCP) coordinates the efforts of states in the health care provider adoption of health information exchange to meet requirements for CMS meaningful use financial incentives authorized by the Recovery Act. It also supports communities in applying health IT to demonstrate health care outcomes.

State Health Information Exchange (HIE) Cooperative Agreement Program
In FY 2009, the Deputy National Coordinator for Programs and Policy issued a State Health Information Exchange Cooperative Agreement Program. Public Health Service Act (PHSA) Title 42, Subtitle B, Sec. 3013, as added by American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5) Division A, Title XIII, Subtitle C, section 13301 requires a program to promote the electronic movement and use of health information among organizations. The Recovery Act made $564 million available for a state health information exchange (HIE) grant program. As of March 2010, $300 million was awarded to specifically fund geographic-based regional and sub-national health information exchange efforts and their corresponding governance and policy frameworks. In addition, $247.7 million was awarded to provide technical services in support of national efforts towards health IT interoperability and statewide planning.

During FY 2010, ONC funded all eligible states, the District of Columbia, and five territories for a total of 56 grantees. All recipients were approved for planning grants, and OSCP has provided technical assistance to grantees as they develop their implementation plans. The technical assistance provided to states includes helping states address the grant program's priorities. These priorities include:

- Ensuring that state health information exchange efforts address the needs of small and low capacity providers,
- Enabling the improvement of individual and population health,
- Ensuring the effective deployment and conservation of health care resources, and
- Ensuring that providers in the states have a means of meeting the health information exchange requirements of the meaningful use incentive payments.

An additional $16 million of the Recovery Act funding was awarded in FY 2011 through supplemental awards to current grantees to make breakthrough progress in cross-cutting health information exchange areas including increasing consumer access to health information, improving transitions from acute to long-term care settings, and demonstrating population health applications for health information exchange. The supplemental awards will be made to states working on initiatives that are applicable and scalable to other communities and states.

Beacon Community Grants
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 (e.g., medical homes) to pursue significant improvements in quality, efficiency, and overall population health. As authorized by the HITECH Act, the Beacon Community program represents ONC's strategy for demonstrating health IT's role in accelerating gains in health care quality, efficiency, and population health. The Beacon Community program selected its awardees based on communities with above-average experience with EHRs, health information exchange, or other health IT. The Beacon Communities therefore consist of forward-looking communities judged as national leaders in health IT. Together, these communities are charged with deploying novel solutions and serving as innovation laboratories for the nation. In addition to awarding 17 Beacon cooperative agreements, ONC awarded a $9 million technical assistance contract to support the communities in achieving their objectives, capturing their practices and ideas, and disseminating implementation lessons to other communities.

OFFICE OF PROVIDER ADOPTION SUPPORT

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 health IT Regional Extension Center (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. By providing a comprehensive strategy of support, OPAS is also working to support the President's goal of ensuring that all American's have access to an EHR system.

Health Information Technology Regional Extension Center (REC) Program
As required by the Public Health Service (PHS) Act Title 42, the Deputy National Coordinator for Programs and Policy 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 EHRs. The extension program has established 62 regional centers, each serving a defined geographic area.

In FY 2010, ONC awarded REC cooperative agreements through three objective review cycles. Collectively, these RECs have service areas that cover the entire United States and will assist over 100,000 primary care providers operating in priority settings to achieve successful adoption and meaningful use of a certified EHR system. RECs are expected to work with both priority primary-care

providers who have not yet adopted EHR systems, and with those who already have EHR systems. OPAS also provided supplemental awards, which by the end of February 2011 will support over 1,777 critical access hospitals and rural hospitals with 50 beds or less.

Health Information Technology Research Center (HITRC)
As required by the Recovery Act, ONC established the HITRC. Its responsibilities include gathering relevant information on effective practices as well as helping RECs to collaborate with one another and with relevant stakeholders to identify and share best practices in EHR adoption and meaningful use.

The HITRC awarded task orders in nine key areas to eight organizations in FY 2010. The task orders cover a variety of interrelated tasks that the HITRC is responsible for, including, but not limited to, provision of technical expertise, creation of tools and trainings for ONC programs, regional and annual meeting planning, and creation of an online Customer Relations Management (CRM) tool for REC and ONC use in tracking provider progress in EHR implementation.

The HITRC is also facilitating Communities of Practice (CoPs) for the RECs. The membership is composed of participants from each REC and a subject matter expert for each community whose role is to provide technical assistance. These CoPs connect RECs for the purposes of sharing knowledge and collectively identifying barriers and solutions to the RECs' scope of work. The CoPs make extensive use of the expertise contracted through the HITRC Task Orders. There are currently 13 CoPs.

Community College Workforce Program
As required by the HITECH Act, in FY 2010, OPAS created a community college workforce programs to assist in the establishment and/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. The workforce programs focused on several key resources needed to rapidly expand the availability of skilled health IT professionals who will support broad adoption and use of health IT in the provider community.

In April 2010, ONC awarded approximately $36 million in cooperative agreements to five regional recipients to establish a multi-institutional consortium within each designated region, which includes a total of 84 consortia member schools. The Community College Program is designed to prepare trainees with relevant prior experience in six months of intensive courses. The Community Colleges will train 7,000 graduates per year initially, with a gradual increase to 10,500 graduates per year. As of the end of FY 2010 the Community College Consortium had enrolled 2,287 students, exceeding its initial enrollment target of 300 students.

Additionally, in FY 2010, OPAS collaborated with the Department of Education and Department of Labor, to promote the development of a workforce that can meet the needs of the health IT community. OPAS will also partner with RECs to support the development of REC-focused job placement programs for health IT.

FUNDING HISTORY

FY 2007	47,996,000
FY 2008	45,929,000
FY 2009	48,665,000
FY 2010	26,138,000
FY 2011	26,138,000

BUDGET REQUEST

The FY 2012 Budget request for the Deputy National Coordinator for Programs and Policy is $43.6 million. This amount is an increase of +$14.9 million above the FY 2010 actual level and enables ONC to continue implementing HITECH Act provisions and meet ONC objectives. Funding will support ONC's regulation, standards and certification, and HITECH grant program objectives.

OFFICE OF POLICY AND PLANNING

The FY 2012 Budget request for OPP is $9.5 million, which is +$2 million above the FY 2010 actual level. The Budget request will support a variety of activities including, but not limited to the following items.

Health Information Technology Policy Committee and Health Information Technology Standards Committee

ONC is committed to using the HITPC and HITSC to support open and transparent processes for Federal health IT policy. The FY 2012 Budget request includes funding for continued support of the HITPC and HITSC created under the HITECH Act. In addition to monthly Committee meetings, the FY 2012 Budget will support the work of approximately ten sub-committees that will assess and make recommendations to ONC on critical health IT policy areas such as Stages 2 and 3 of meaningful use of health IT and privacy and security protections for electronic health information. These Committees will also provide recommendations on the standards and implementation specifications and certification criteria that will enable ONC's strategic goal of meaningful use of health IT.

HIT Policy Development

The FY 2012 Budget request will also allow OPP to continue health IT policy development. Funding will sustain OPP's continued coordination with states to facilitate health information exchange and address the unique role of states in the adoption and meaningful use of health IT. In FY 2012, OPP will support the State Health Policy Consortium to work on multi-state projects aimed at addressing more complex inter-state health information exchange issues. This includes harmonization of state laws regarding health information exchange to reduce barriers in achieving future stages of meaningful use of health IT.

In FY 2012 OPP will also continue activities to assess the long-term consequences, including unintended effects, of the adoption and meaningful use of EHRs and other patient safety concerns related to health IT. OPP will use this funding to assess, and take action related to, unintended consequences and patient safety based on the 2011 Institute of Medicine (IOM) report recommendations.

Additionally, OPP's request supports aligning maintenance of medical specialty certification requirements with meaningful use. Maintenance of Certification (MOC) promotes lifelong learning and the enhancement of the clinical judgment and skills essential for high quality patient care, an HHS priority.

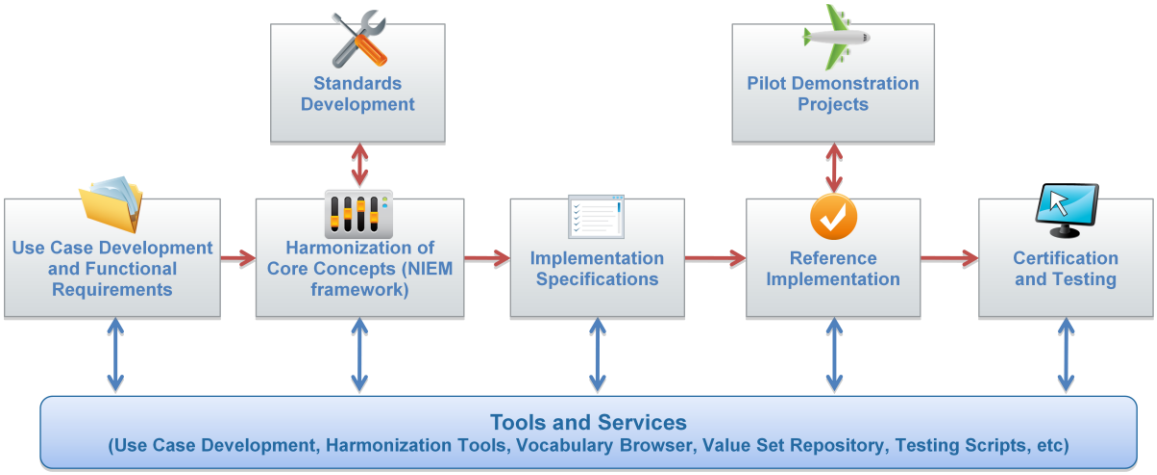
OFFICE OF STANDARDS AND INTEROPERABILITY

The FY 2012 Budget request for OSI is $22.7 million, which is +$12.9 million above the FY 2010 actual level. The Budget request will support a variety of activities including, but not limited to the following items.

Standards Development and Harmonization

The FY 2012 Budget request includes funding for standards development and harmonization to support ONC's strategic goal of achieving meaningful use. This will be focused on continuing the standards development and harmonization processes using the Standard and Interoperability Framework (S&I Framework). The S&I Framework is a set of integrated functions, processes, and tools being guided by the healthcare and technology industry to achieve harmonized interoperability for healthcare information

exchange. Each component of the S&I Framework (represented by the graphic sub-components below) is a process implemented by a team to generate artifacts to enable explicit instantiations of healthcare data exchange scenarios.



OSI will develop vocabulary and terminology extensions to prepare for Stage 2 of meaningful use, and develop the tools and services (in collaboration with the National Library of Medicine) to support Stage 2 meaningful use standards. A significant proportion of our resources will go to support new use cases for meaningful use in Stage 2. These efforts will include continuation of work in progress related to standards development, testing and implementation, expansion of the standards and interoperability framework to enable the repurposing of health data for the purposes of public health, clinical research, and quality improvement. This will include leveraging standards developed as part of the Strategic Health IT Advanced Research Project (SHARP) grants into meaningful use standards to support secondary reuse of data, and modular designs for EHR technology. OSI will also work towards developing and harmonizing standards to facilitate exchange of behavioral health information.

Nationwide Health Information Network Activities

The FY 2012 Budget request will support activities pertaining to the Nationwide Health Information Network, which has been defined as the "standards, services and policies" that enable the Internet to be used for the secure exchange of health information, to improve a patient's health and health care. These activities include operational support and "on-boarding" of new participants through conformance and interoperability testing. Funding is included to continue supporting CONNECT to develop software that instantiates Nationwide Health Information Network specifications, and provides a reference implementation to the Nationwide Health Information Network's standards and specifications. The Nationwide Health Information Network will provide the necessary specifications to enable hospitals and health care professionals to exchange health information and achieve meaningful use. OSI is working to develop an effective governance mechanism for the Nationwide Health Information Network with the goal of it attaining a self-sustaining business model.

Nationwide Health Information Network Governance

The request also funds Nationwide Health Information Network governance activities, which will satisfy statutory requirements set forth in HITECH Subtitle A, Part 1 section 3001. Specifically, the funds will be used for resources and support associated with developing a governance mechanism for health information exchange, which will be accomplished through rulemaking in FY 2011. As more and more physicians and hospitals become meaningful users of certified EHR technology, the need will grow for entities that can provide services to facilitate secure, reliable exchange of electronic health information. As a critical part of that governance mechanism, OSI will support governance processes for policies and

oversight, including establishing a new accreditation program for entities that provide exchange services to support health care professionals and hospitals in being meaningful users of health IT. In addition to meeting a statutory requirement, the Nationwide Health Information Network governance funding will support ONC strategic goals of achieving meaningful use and inspiring confidence in health IT by establishing a secure and reliable exchange.

Federal Health Architecture
The FY 2012 Budget Request will also support the cross government Federal Health Architecture (FHA) program, which is funded by partner agencies and headed by the HHS CIO Office. This funding supports agency coordination and alignment of agency health IT investments, coordination around standards development and support, and the creation of a shared repository of standards, service descriptions and interoperability specifications within the ONC Standards and Interoperability framework to support the Federal agencies. The FHA allows for discussions to occur with existing funding partners, as well as an opportunity to seek out additional partners to secure future funding if required and approved. The FHA is not building a health information exchange system but rather helping to architect solutions. FHA partners reevaluate the lifecycle costs yearly during strategy planning to identify the next year's work plan.

OFFICE OF STATE AND COMMUNITY PROGRAMS

The FY 2012 Budget request for OSCP is $4.9 million, which is +$1.8 million above the FY 2010 actual level. The Budget request will support a variety of activities including, but not limited to the following items.

Beacon Community and State Health Information Exchange (HIE)
The FY 2012 Budget request will enable OSCP to continue implementation of HITECH Act grant programs, specifically the Beacon Community and State Health Information Exchange (HIE) Programs. Funding will provide for additional staff and contract support to implement the following:

- Engaging in oversight activities such as site visits to ensure the grantees are implementing the program according to the requirements;
- Coordinating with grantees to identify best practices for health IT adoption and health information exchange and for using health IT to achieve improved health care outcomes
- Convening states and communities to share lessons learned and communicate program direction;
- Assisting Beacon Communities in the development of health care outcome goals and reporting that will demonstrate health IT's ability to improve population health; and
- Building State capacity to facilitate health information exchange through their health IT Coordinators by communicating Federal health IT policy direction, updating states on current nationwide health IT activities, and receiving feedback from the states on their health IT challenges.

OFFICE OF PROVIDER ADOPTION SUPPORT

The FY 2012 Budget request for OPAS is $6.5 million, which is +$2.4 million above the FY 2010 actual level. The FY 2012 Budget request will allow OPAS to sustain the momentum of HITECH implementation and support the following efforts:

Meaningful Use

- Work with the RECs to understand the challenges of implementation and use this information to shape the development of Stage 2 meaningful use, and
- Revise technical assistance programs and update training systems to reflect Stage 2 of meaningful use.

Heath Information Technology Research Center

- Support CoPs that will facilitate communication among REC and provider groups that are working on achieving meaningful use,
- Support the research, development, and dissemination of best practices, and
- Support programs' integration into health care reform efforts and creation of regional quality measurement integrators.

Adoption Support

- Increase focus on functional interoperability, especially for labs, e-prescribing and public health interfaces,
- Develop systems to assist large hospitals/health care systems to leverage the best practices from the RECs and move towards meaningful use, and
- Work with EHR vendors to support their efforts in promoting meaningful use.

OUTPUTS AND OUTCOMES TABLE

For a complete discussion of ONC's performance measures, view the Online Performance Appendix to the FY 2012 President's Budget request at http://dhhs.gov/asfr/ob/docbudget/.

Key Indicators	Most Recent Result (FY 2010)	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.A.1: Percent of office-based physicians who have adopted electronic health records[4]	25%	25%	40%	+15%
1.A.2: Percent of office-based primary care physicians who have adopted electronic health records[5]	30%	23%	35%	+12%
1.A.3: Percent of acute care hospitals participating in Medicare and Medicaid that have adopted electronic health records[6]	19%	19% Baseline	34% Increasing	+15%
1.B.1: Percent of eligible hospitals receiving meaningful use incentive payments	N/A	TBD Baseline	TBD Increasing	N/A
1.B.2: Percent of eligible professionals receiving meaningful use incentive payments	N/A	TBD Baseline	TBD Increasing	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	100%	100%	100%	--

[4] 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.

[5] 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.

[6] "Adoption" of an electronic health record for this measure is defined as "basic, with notes" adoption, as in DesRoches et al. 2008 in the New England Journal of Medicine article *Electronic Health Records in Ambulatory Care – A National Survey of Physicians* http://www.nejm.org/doi/pdf/10.1056/NEJMsa0802005.

1.C.2: Number of priority primary care providers registered to receive services from a Regional Extension Center	11,875	30,000	100,000	70,000
1.C.3: Electronic health record adoption rate among providers registered and working with ONC Regional Extension Centers for at least 10 months	TBD Baseline	N/A	60%	N/A
1.D.1: Number of students enrolled in health IT training programs at Community College Consortia participants	2,287	300	6,500	6,200
1.D.2: Cumulative number of students completing health IT training programs at community colleges to become HIT professionals[7]	N/A	N/A	12,250	+12,500
1.E.1: Percentage of community pharmacies in the U.S. that are capable of exchanging health information electronically	85%	85%	97%	+12%
1.F.1: Number of organizations using at least once complete NWHIN information component to exchange information	2	10	N/A	N/A
5.A.1: Number of physicians participating in Beacon Community interventions	N/A	N/A	TBD	N/A
5.A.2: Proportion of eligible providers in Beacon Communities that receive meaningful use incentive payments	N/A	N/A	60%	N/A

[7] 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. During the period of FY 2012 within the period of performance, ONC expects 5,250 students to be trained. At the full-year FY 2012 performance level, ONC expects the community colleges associated with the Consortia to have the capacity to train 10,500 students per year, thus resulting in a cumulative total of 17,250 students trained by the end of the fiscal year on September 30, 2012.

OFFICE OF THE CHIEF SCIENTIST

	FY 2010	FY 2011	FY 2012	FY 2012 +/-
	Actuals	Continuing Resolution (CR)	President's Budget Request	FY 2010
Budget Authority	2,647,000	3,861,000	2,637,000	-10,000
PHS Evaluation Funds	1,214,000	1,690,000	990,000	-224,000
Total Program Level	3,861,000	3,603,000	3,627,000	-234,000
FTE	9	14	15	+1

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 U. S. Department of Health and Human Services (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 concerning current and anticipated developments in information science and health information technology.

Evaluation
Working collaboratively with all affected ONC components, and in especially close partnership with the Office of Economic Analysis and Modeling (OEAM), the OCS monitors program performance, evaluates major grant programs, and tracks national progress towards achieving the goals laid out in HITECH.

Historically, ONC tracked and reported on a subset of performance measures directly related to the measurement of adoption of EHRs. ONC is working closely to identify a broader set of performance measures based on the need of health IT to support the Secretary's priority to transform health care. These measures will reflect the scope of programs and products being overseen by ONC. Beyond measures of adoption, this will include high priority performance goals related to technical assistance for priority providers to adopt and become meaningful users of EHRs, measures of the active exchange of clinical information, active participation in the Nationwide Health Information Network, as well as measures related to the certification of EHR products. The breadth of measures will represent a much fuller picture of ONC's responsibilities and collaborative work to accomplish the goals of HITECH and support health reform.

Using one percent of HITECH funds, in 2010, ONC awarded a portfolio of contracts tasked with providing timely, systemic input into program operations and providing an impartial evaluation of the overall success of each of the individual grant programs as well as a global assessment of how these programs interact to achieve widespread adoption and their impact on health outcomes.

Innovation
OCS provides support for health IT innovation efforts both 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*. The ONC'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, 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 purposes 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, because 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.

In FY 2010 ONC funded an Institute of Medicine (IOM) workshop series on the *Digital Infrastructure to Support a Learning Health System.* The workshop series brought together experts from a broad array of stakeholder perspectives to identify opportunities to build upon current innovations in re-purposing of electronic health information as well as to identify significant challenges that need to be addressed in developing the learning system infrastructure.

With FY 2011 funding, working in collaboration with other ONC components and other HHS Operating Divisions, OCS will have 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. Within ONC's FY 2011 funding, work on applicable standards development, architecture development, and the requisite policy framework will begin. For the specific use case, requirements definition, standards, and policy-development projects undertaken with this FY 2011 funding, OCS will have worked in very close partnership with ONC's Office of the Deputy National Coordinator for Programs and Policy, and the Office of the Chief Privacy Officer (OCPO).

FUNDING HISTORY

FY 2007	3,000,000
FY 2008	3,697,000
FY 2009	4,517,000
FY 2010	5,453,000
FY 2011	5,453,000

BUDGET REQUEST

The FY 2012 Budget request for the OCS is $3.6 million. This amount is a reduction of -$1.85 million below the FY 2010 actual level, which represents a decrease in contract activities. This amount will allow OCS to continue evaluation and performance measurement of health IT programs, including:

Monitoring Innovation & International Programs

ONC's FY 2012 Budget request includes $500,000 to continue 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 the provisions of HITECH. In addition, ONC requests $500,000 to continue exploring the international experience of health IT adoption, garner lessons learned from other countries' experiences, and 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. This activity is requested to be funded across 3 program offices in ONC at approximately $864,000 per office.

OFFICE OF THE CHIEF PRIVACY OFFICER

	FY 2010	FY 2011	FY 2012	FY 2012 +/-
	Actuals	Continuing Resolution (CR)	President's Budget Request	FY 2010
Budget Authority	3,499,000	3,499,000	4,307,000	+808,000
PHS Evaluation Funds	1,571,000	1,571,000	1,616,000	+45,000
Total Program Level	5,070,000	5,070,000	5,923,000	+853,000
FTE	3	6	6	0

Authorizing Legislation: PHS Act 42 U.S.C. 201
Allocation Method: Contract, Cooperative Agreement, Grant

PROGRAM DESCRIPTIONS AND ACCOMPLISHMENTS

Electronic health information exchange promises an array of potential benefits for individuals and the U.S. health care system through improved clinical care and reduced cost. At the same time, this environment also poses new challenges and opportunities for protecting individually identifiable health information. Ensuring individuals and providers that personal health information is private and secure is vital to ONC's efforts to increase the adoption of EHRs and electronic health information exchange. Coordinated attention at the Federal and state levels is needed both to develop and implement appropriate privacy and security policies. By engaging all stakeholders, particularly consumers, health information can be protected and electronically exchanged in a manner that respects variations in individuals' views on privacy and access. In 2009, the Health Information Technology for Economic and Clinical Health Act mandated the appointment of a Chief Privacy Officer, recognizing the critical need to give high priority to privacy and security issues. As required by HITECH, the Chief Privacy Officer was appointed in February 2010 and assumed responsibility for privacy and security programs within ONC. In FY 2010, ONC privacy and security functions were consolidated under the Office of the Chief Privacy Officer (OCPO).

As directed by HITECH, OCPO 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 OCPO supports programs to carry out these Congressionally mandated responsibilities as well as the continued implementation of other HITECH privacy and security activities, including secure and privacy-protected meaningful use. In addition, the OCPO will support the Secretary's priority to *Transform Health Care* and the new requirements of health care reform through analysis, development and coordination of privacy and security standards applicable to health benefit exchanges (also known as health insurance exchanges), wellness programs, and patient -centered research institutions, crucial components of health care reform.

Health Information Technology Security and Cybersecurity
HITECH Subtitle A, Part 1 section 3001, directs ONC to ensure that each patient's 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. This program was initiated in 2010 and will continue in FY 2011. ONC, working in close collaboration with nearly 70 different stakeholder groups representing critical segments of IT infrastructure, is part of a cross-agency writing team that developed a National Strategy for Secure Online Transactions. In efforts to coordinate health IT security across Federal agencies, ONC, in conjunction with the Office of Management and Budget, established the Federal health IT Task Force in February 2010, including an interagency cybersecurity workgroup. Thus, OCPO supports security efforts both within ONC programs, as well as on a much broader Federal policy scale.

Privacy and Security Policy and Implementation
Public policy must not only protect the privacy and security of health information, but it must also 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 (FIPPs) to guide policy and technical development across the Federal government, state governments, and the private sector. ONC has also developed a toolkit comprised of the Health Insurance Portability and Accountability Act (HIPAA) guidance related to the Privacy and Security Framework. ONC has conducted an initial examination of technologies that support the segmentation of health information (i.e., the sending of some, but not all, of a patient's health information), in support of Section 3002 of HITECH.

FUNDING HISTORY

FY 2007	0
FY 2008	0
FY 2009	0
FY 2010	5,070,000
FY 2011	5,070,000

BUDGET REQUEST
The FY 2012 Budget request for the OCPO is $5.9 million. This amount is an increase of +$0.83 million above the FY 2010 actual level. The Budget request for the OCPO supports the continued implementation and ongoing requirements of HITECH as directed toward the privacy and security of health information, a high priority issue for HHS that reaches across the spectrum of ONC's health IT efforts. The request supports a variety of ongoing efforts, including:

Health Information Technology Security and Cybersecurity
In 2012, ONC will continue to build on work in the area of health information security through continuing efforts within existing programs, the inception of new, more advanced cybersecurity projects and the development of tools, methodologies, and guidelines to support security in health IT adoption. These projects and tools are expected to be particularly helpful to eligible providers and hospitals seeking to qualify for meaningful use of health IT incentive payments from Medicare and Medicaid under HITECH.

Privacy and Security Policy and Implementation
Federal programs encouraging the meaningful use of health IT and health information exchange will be evolving in FY 2012 to continue the implementation of HITECH. OCPO will continue to provide essential technical support on privacy and security to these programs as new issues emerge. In addition, OCPO will continue to develop and coordinate generally applicable Federal health information privacy and security policies to ensure that they provide adequate protection and can be broadly implemented in an electronic health system environment. OCPO will also examine means of implementing these policies.

OFFICE OF ECONOMIC ANALYSIS AND MODELING

	FY 2010	FY 2011	FY 2012	FY 2012 +/-
	Actuals	Continuing Resolution (CR)	President's Budget Request	FY 2010
Budget Authority	1,002,000	1,002,000	2,310,000	1,308,000
PHS Evaluation Funds	450,000	450,000	867,000	417,000
Total Program Level	1,452,000	1,452,000	3,177,000	1,725,000
FTE	2	4	6	+2

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 of 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; 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 regarding the adoption and benefits of health IT,
- Manages ONC's performance measures and reporting for both governmental and external audiences, and
- Represents ONC in departmental discussions involving health policy, economics, and 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 of ONC's 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 uses 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 enable providers to 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
A critical medium for the ongoing advancement of health IT is peer-reviewed journal articles. 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 conducting and funding studies that can result 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.

ONC Website
OEM works with the ONC Communications team, to produce versions of its 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. It also serves as a strong commitment to information technology for an agency asking almost all health care providers to advance theirs. In addition, an online dashboard that displays program milestones, metrics, and achievements to the general public will be activated in FY 2011. The ONC dashboard will also be used to track interim program activities. The public dashboard communicates important and up-to-date measures of adoption, quality improvement, cost-savings, and as a part of HITECH stimulus funding, job creation.

ONC Program Support Activities
OEM undertook a wide range of activities that supported our overall mission and the efforts of our major grants programs established with HITECH funding. OEM will similarly support ONC's activities implementing The Patient Protection and Affordable Care Act (Affordable Care Act), 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:

- *Beacon Communities*
  OEM supports the Beacon Communities Program in developing ongoing methods and models for the analysis of cost and quality data. These efforts include coordination with CMS around the use of Medicare data for technical assistance and monitoring, evaluation design in conjunction with the Office of the Chief Scientist, and research and development around health care quality and efficiency metrics.

- *State Health Information Exchanges*
  OEM assists 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. Tracking and evaluating the frequency of e-prescribing and other forms of data exchange within and across states will support the development of an important component of meaningful use and help measure the potential to achieve cost-savings and quality improvement through the electronic sharing of health data. Data on exchange and e-prescribing will be collected through the grants reporting process and through collaborations around data collection with the OCS and the external evaluation contractors.

- *Regional Extension Centers (RECs)*
  OEM supports the RECs by providing and analyzing measures of the adoption of EHR systems and the functionalities of those systems. Prospective modeling techniques used by OEM help determine who is likely to adopt and which types of providers or areas may need greater assistance. These analyses support REC grantees in developing strategies for greater health IT implementation in their regions. Retrospective analysis, in collaboration with the OCS, will also help the RECs in targeting and/or refocusing adoption strategies.

- *Health Information Technology Resource Center (HITRC)*
  Many providers remain unclear, skeptical, or uncertain about how to achieve the documented benefits of EHR adoption. OEM supports the HITRC through data gathering, analysis and publication of results that inform the provider community of the effects of EHR implementation. For example, a current study on physician workflow that analyzes the costs and benefits of adopting health IT in different aspects of medical practice and administration will be translated into a comprehensive source of information for providers on how best to achieve the benefits of EHRs and minimize the cost and disruption of implementation to their practices.

FUNDING HISTORY

FY 2007	0
FY 2008	0
FY 2009	0
FY 2010	1,452,000
FY 2011	1,452,000

BUDGET REQUEST

The FY 2012 Budget request for the Office of Economic Analysis and Modeling is $3.2 million. This amount is an increase of +$1.7 million above the FY 2010 actual level. The Budget request for the OEM broadly supports the requirements to measure and analyze the adoption, costs, and benefits of health IT.

Performance Measurement & Tracking
ONC's FY 2012 Budget request for the OEAM includes funding to continue support for ongoing performance measurement and program tracking. Performance measurement and program tracking keep the implementation of HITECH on target. These activities ensure that ONC meets the provisions and requirements of HITECH, and provide a basis for any necessary course correction. This request includes $1.9 million to continue and expand its Physician Adoption Survey, Hospital Adoption Survey, and Report on Nationwide Adoption. These survey vehicles provide vital information to help ONC track progress on adoption of health IT. Following the passage of HITECH, ONC is leveraging these annual surveys to collect more detailed information to inform program and policy operations such as development of criteria for defining meaningful use of health IT.

The goal of this analysis is to inform programs, reduce uncertainty surrounding the benefits, and communicate measures of ONC's progress to governmental and external audiences. The request includes funding for staffing to continue operations and for:

- $500,000 for workflow analysis at Stage 3 meaningful use;
- $200,000 for small hospital health IT;
- $200,000 for efficiency measure specification at Stage 3 meaningful use; and,
- $100,000 for the return on investment tool development at Stage 2 of meaningful use.

OFFICE OF THE DEPUTY NATIONAL COORDINATOR FOR OPERATIONS

	FY 2010	FY 2011	FY 2012 President's	FY 2012 +/-
	Actuals	Continuing Resolution (CR)	Budget Request	FY 2010
Budget Authority	17,641,000	16,034,000	16,068,000	-1,573,000
PHS Evaluation Funds	8,089,000	7,189,000	6,031,000	-2,058,000
Total Program Level	25,730,000	23,223,000	22,099,000	-3,631,000
FTE	32	46	57	+25

Authorizing Legislation: PHS Act 42 U.S.C. 201
Allocation Method: Contracts

PROGRAM DESCRIPTION AND ACCOMPLISHMENTS

The Office of the Deputy National Coordinator 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.

ONC established a new Office of Grants Management in FY 2010 under the Office of the Deputy National Coordinator for Operations because the importance and workload associated with ONC's nine grant programs warrants a single office to effectively manage the programs and to ensure accountability. Previously, ONC utilized the services of three separate grants offices within HHS to issue and monitor grants. This organizational change will further enhance ONC's structure and operations. Similarly, ONC established an Office of Oversight in FY 2010 to meet the requirements of the Federal Managers' Financial Integrity Act (FMFIA); Office of Management and Budget (OMB) Circular A-123; and provide oversight to ONC grant funding, internal controls, and program offices. This office will monitor all audit related activities and track development of any corrective action plans.

Additionally, ONC launched a comprehensive communications initiative in FY 2010 that will support all components of adoption and meaningful use, ONC strategic goals, through the timely dissemination of information through a wide array of tools. These include, but are not limited to, blogs, e-mail alerts, letters, public appearances, speeches, and postings to the ONC and HHS websites. ONC is collaborating with CMS, OCR and other partners to implement the communications and outreach activities needed to promote acceptance of broader goals and to support the specific programs and policies of the HITECH Act. ONC will focus on informing doctors, hospitals, patients, providers, and caregivers about the benefits of EHRs and as well as increasing their knowledge of protections for privacy and security of personal health information. These activities are very closely coordinated with CMS communications focusing on the incentives program for meaningful use. Communications activities will be jointly led by ONC and OCR. OCR's involvement relates to its mandate to educate the public on uses of, and safeguards for, protected health information. This effort is well coordinated within HHS as it is overseen by the interagency HITECH Communications Workgroup, chaired by ONC.

To effectively meet the requirements of HITECH, and to provide the structure needed for developing and overseeing programs, regulations, and policies to successfully accomplish the mandates of the Recovery Act, ONC is increasing Federal staffing levels in FY 2010 and FY 2011. Term, schedule A, and permanent positions continue to be established to provide sound, Federal oversight to new programs and

responsibilities, including grants oversight. In prior years funding for ONC staff was centralized in the Operations section, but for FY 2011 and forward such costs are allocated to the program offices.

FUNDING HISTORY

FY 2007	10,306,000
FY 2008	10,935,000
FY 2009	8,050,000
FY 2010	23,223,000
FY 2011	23,223,000

BUDGET REQUEST

The FY 2012 Budget request for The Office of the Deputy National Coordinator for Operations is $21.3 million. This is approximately -$1.7 million below the FY 2010 actual level and will be used to support the four offices within the DNC Operations. It will also support the central costs of ONC as a whole. In FY 2012, ONC will undergo a significant effort to federalize staff that has historically been supported through contracts, allowing an increase in its FTE level while showing a reduction in the requested amounts.

- The FY 2012 Budget request for the Deputy National Coordinator (DNC) for Operations includes funding for critical central costs such as rent 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 technology, and telecommunications costs. Additionally, the FY 2012 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 2012 Budget request will also fund the personnel costs (salaries and benefits) for the Immediate Offices of the National Coordinator and the Deputy National Coordinators.
- Additionally, the DNC Operations FY 2012 Budget request will allow the DNC for Operations to fully support its following offices:

    - The Office of Mission Support;
    - The Office of Communications;
    - The Office of Oversight; and
    - The Office of Grants Management.

SUPPORTING EXHIBITS

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

FTE PAY ANALYSIS

	FY 2010	FY 2011	FY 2012
Total FTE	84	149	189
Number change from previous year		65	40
Funding for object classes 11(personnel compensation), 12 (personnel benefits), and 13(benefits for former personnel)	11,066,000	21,618,000	27,965,000
Average cost per FTE	132,000	145,000	148,000
Percent change in average cost from previous year		10%	2%
Average grade/step	13 / 4	13 / 8	13 / 8

Notes.
1/ Increase in average costs per FTE from FY 2010 to FY 2011 is due to increased hiring of medical and technical personnel to implement HITECH.
2/ Includes one (1) commissioned corps.

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

ANALYSIS OF FTE CHANGE FY 2009-FY 2012

	On-Board			FTEs		
	Total	Comm. Corps	Civilian	Total	Comm. Corps	Civilian
FY 2009 Actual	**40**	**1**	**39**	**32**	**1**	**31**
FY 2010						
Current Level (based on PSC report as of [Month]	99	1	98	52	1	51
Adjustments						
Anticipated hires remainder of FY 2010	50	0	50	32	0	32
FY 2010 MAX-basis Estimate	**149**	**1**	**148**	**84**	**1**	**83**
Misc Trust Fund employees (+/-)	0	0		0	0	
FY 2010 CJ-basis Estimate	**149**	**1**	**148**	**84**	**1**	**83**
FY 2011 President's Budget						
Maintaining FY 2009 staffing level	149	1	148	84	1	83
FY 2011 Initiatives						
Other	0	0	0	65	0	65
Subtotal, FY 2011 Initiatives	0	0	0	65	0	65
FY 2011 MAX-basis Estimate	**149**	**1**	**148**	**149**	**1**	**148**
Misc Trust Fund employees (+/-)						
FY 2011 CJ-basis Estimate	**149**	**1**	**148**	**149**	**1**	**148**
FY 2012 Estimate						
Maintaining FY 2010 PB staffing level	149	1	148	149	1	148
FY 2012 Initiatives						
Other	40	0	40	40	0	40
Subtotal, FY 2011 Initiatives	40	0	40	40	0	40
FY 2012 MAX-basis Estimate	**189**	**1**	**188**	**189**	**1**	**188**
Misc Trust Fund employees (+/-)						
FY 2012 CJ-basis Estimate	**189**	**1**	**188**	**189**	**1**	**188**

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

FTE DETAIL

	2010 Actual Civilian	2010 Actual Military	2010 Actual Total	2011 Est. Civilian	2011 Est. Military	2011 Est. Total	2012 Est. Civilian	2012 Est. Military	2012 Est. Total
DNC Programs and Policy	38	0	38	79	0	79	105	0	105
Direct:	38	0	38	79	0	79	105	0	105
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	38	0	38	79	0	79	105	0	105
DNC Operations	32	0	32	46	0	46	57	0	57
Direct:	32	0	32	46	0	46	57	0	57
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	32	0	32	46	0	46	57	0	57
Office of the Chief Scientist	9	1	10	14	1	15	15	1	16
Direct:	9	1	10	14	1	15	15	1	16
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	9	1	10	14	1	15	15	1	16
Office of the Chief Privacy Officer	3	0	3	6	0	6	6	0	6
Direct:	3	0	3	6	0	6	6	0	6
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	3	0	3	6	0	6	6	0	6
Office of Economic Analysis and Modeling	2	0	2	4	0	4	6	0	6
Direct:	2	0	2	4	0	4	6	0	6
Reimbursable:	0	0	0	0	0	0	0	0	0
Total:	2	0	2	4	0	4	6	0	6
OPDIV FTE Total	83	**1**	**84**	**148**	**1**	**149**	**188**	**1**	**189**
Recovery Act FTE (non add)									

Average GS Grade	
FY 2007	12 / 8
FY 2008	13 / 2
FY 2009	13 / 4
FY 2010	13 / 4
FY 2011	13 / 8

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

AMOUNTS AVAILABLE FOR OBLIGATION

	FY 2010 Actual	FY 2011 CR	FY 2012 PB
General Fund Discretionary Appropriation:			
Appropriation (L/HHS, Ag, or, Interior).....	42,325,000	42,325,000	57,013,000
Across-the-board reductions (L/HHS, Ag, or Interior).....	-6,000	0	0
Subtotal, Appropriation (L/HHS, Ag, or Interior).....	42,319,000	42,325,000	57,013,000
Total, Discretionary Appropriation.....	42,319,000	42,325,000	57,013,000
Unobligated Balances:			
Unobligated balance, Recovery Act start of year.....	1,979,430,000	158,000,000	0
Unobligated balance, Recovery Act end of year.....	159,370,000	0	0
Total obligations.....	1,862,379,000	200,325,000	57,013,000
Obligations less ARRA.....	41,461,000	42,325,000	57,013,000

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

BUDGET AUTHORITY BY OBJECT CLASS

	2010 Estimate	2012 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	8,393	14,073	+$5,680
Other than full-time permanent (11.3)	135	146	+$11
Other personnel compensation (11.5)	212	438	+$226
Military personnel (11.7)	95	99	+$4
Special personnel services payments (11.8)			
Subtotal personnel compensation	**8,835**	**14,756**	**+$5,921**
Civilian benefits (12.1)	2,057	4,034	+$1,977
Military benefits (12.2)	41	44	+$3
Benefits to former personnel (13.0)			
Total Pay Costs	**10,933**	**18,834**	**+$7,901**
Travel and transportation of persons (21.0)	866	753	-$113
Transportation of things (22.0)	2	22	+$20
Rental payments to GSA (23.1)	1,718	2,879	+$1,161
Communication, utilities, and misc. charges (23.3)	445	485	+$40
Printing and reproduction (24.0)	119	175	+$56
Other Contractual Services:			
Advisory and assistance services (25.1)	24,191	26,734	+$2,543
Other services (25.2)	134	147	+$13
Purchase of goods and services from government accounts (25.3)	2,959	6,000	+$3,041
Operation and maintenance of facilities (25.4)	267	284	+$17
Research and Development Contracts (25.5)			
Medical care (25.6)			
Operation and maintenance of equipment (25.7)			
Subsistence and support of persons (25.8)	37	41	+$4
Subtotal Other Contractual Services	**27,588**	**33,206**	**+$5,618**
Supplies and materials (26.0)	130	93	-$37
Equipment (31.0)	523	566	+$43
Land and Structures (32.0)			
Investments and Loans (33.0)			
Grants, subsidies, and contributions (41.0)			
Interest and dividends (43.0)			
Refunds (44.0)			
Total Non-Pay Costs	**31,391**	**38,179**	**+$6,788**
Total Budget Authority by Object Class	**42,325**	**57,013**	**+$14,688**

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

SALARIES AND EXPENSES

	2010 Estimate	2012 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	8,393	14,073	+$5,680
Other than full-time permanent (11.3)	135	146	+$11
Other personnel compensation (11.5)	212	438	+$226
Military personnel (11.7)	95	99	+$4
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Rental payments to Others GSA (23.2)	1,718	2,879	+$1,161
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Purchase of goods and services from government accounts (25.3)	2,959	6,000	+$3,041
Operation and maintenance of facilities (25.4)	267	284	+$17
Research and Development Contracts (25.5)			
Medical care (25.6)			
Operation and maintenance of equipment (25.7)			
Subsistence and support of persons (25.8)	37	41	+$4
Subtotal Other Contractual Services	**30,738**	**37,520**	**+$6,782**
Supplies and materials (26.0)	130	93	-$37
Total Non-Pay Costs	**30,868**	**37,613**	**+$6,745**
Total Salary and Expenses[1]	**41,801**	**56,447**	**+$14,646**
Direct FTE	**83**	**189**	**+$106**

[1] Table reflects the budget authority by the object classifications displayed above.

Health Insurance Reform Implementation Fund

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HEALTH INSURANCE REFORM IMPLEMENTATION FUND

Dollars in Millions

	FY 2010	FY 2011	FY 2012
	Actual	Continuing Res	PB
Budget Authority	1,000	0	0

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 the funds to primarily support salaries, benefits, contracts, and infrastructure for various health reform initiatives. The funds will allow HHS to improve and enhance its existing programs including quality reporting and incentive payments, health plan oversight, provider and beneficiary outreach, administrative simplification, and information technology infrastructure. This funding will also support implementation of new insurance market reforms and oversight programs, new State and Federally-operated Health Insurance Exchanges that must be built before 2014, and outreach and education for a new and broad cohort of consumers.

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 Office of Personnel Management (OPM) required funding to plan for implementing and overseeing Multi-State Plan Options for the Exchanges. At least two Multi-State Plans will be offered on each Exchange beginning in 2014. 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 2010, $128 million of this funding was obligated by agencies within HHS and by the Department of Treasury. HHS estimates that $790 million will be obligated by agencies within HHS, the Department of Treasury, and the Office of Personnel Management in 2011. The remaining $82 million will be obligated in 2012.

World Trade Center Health Program

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WORLD TRADE CENTER HEALTH PROGRAM

Dollars in Thousands

	FY 2010 Enacted	FY 2011 (4th Quarter)	FY 2012 President's Budget	FY 2012 +/- FY 2010
Mandatory Funds	0	70,000	313,000	313,000

Authorizing Legislation…….…James Zadroga 9/11 Health and Compensation Act of 2010, Pub. L. 111-347 (2011)
Allocation Methods……...Contracts, Competitive Grants/Cooperative Agreements, and Intramural

Program Description and Accomplishments

The James Zadroga 9/11 Health and Compensation Act of 2010 (Zadroga Act) establishes a WTC Health Program in HHS. The WTC Program includes six components: (1) medical monitoring for responders; (2) initial health evaluation for survivors; (3) follow-up monitoring and treatment for WTC-related health conditions for responders and survivors; (4) outreach and education; (5) clinical data collection and analysis; and (6) research on health conditions. In addition, the Zadroga Act mandates that the WTC Program Administrator maintain a health registry of individuals directly affected by the September 11, 2001, World Trade Center Attacks. The Zadroga Act establishes a World Trade Center Health Program Fund, which provides mandatory funding for the program.

Funding History

FY 2011 (4th quarter) mandatory funding: $70 million

*In FY 2011, the FY 2011 Continuing Resolution provided $71 million in discretionary funding to the Centers for Disease Control and Prevention for screening and treatment for first response emergency services personnel, residents, students, and others related to the September 11, 2001 terrorist attacks on the World Trade Center.

Budget Request

The FY 2012 Budget requests $313 million in mandatory funding for HHS, along with the National Institute of Occupational Safety and Health, to implement the James Zadroga 9/11 Health and Compensation Act of 2010. Funds will support medical monitoring and treatment services for eligible responders and non-responders in the community directly affected by the September 11, 2001, World Trade Center Attacks. In addition, funds will support outreach and education, clinical data collection and analysis, research on health conditions, and a health registry to assess the extent and persistence of physical and mental health conditions.

Service and Supply Fund

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HHS SERVICE AND SUPPLY FUND

	FY 2010 Actual	FY 2011 Program Level	FY 2012 Board Approved	FY 2012 +/- FY 2011
Budget Authority	$937,263,000	*$1,167,375,000	*$1,109,075,000	-$58,300,000
FTE	1360	1384	1384	0

Authorizing Legislation: 42 U.S.C. 231
2012 Authorization……..……Indefinite
Allocation Method ……Contract, Other
* Additional details on the 2012 SSF Board approved budgets are found in the narrative.

Statement of the Budget

The FY 2012 budget for the Service and Supply Fund (SSF) is $1,109,075,000, an increase of $28,725,000 from the FY 2011 SSF Board-approved level of $1,080,350,000 (both fiscal year budgets approved July 7, 2010). The overall increase in the budget from FY 2011 to FY 2012 is primarily a reflection of increases in revenue from non-HHS customers. The above header table reflects in FY 2011 a total of $87,025,000 in unfilled customer orders and reserves activities (FY 2010 carryover projects and new FY 2011 projects).

The Program Support Center's (PSC) budget request for FY 2012 is $1,046,402,000, which is an increase of $25,458,000 above the FY 2011 program level of $1,020,944,000. This budget increase is a direct result of Transhare benefits and rent in the Parklawn facility, which increased 115% in FY 2011. Rent in the Parklawn facility increased from $31.89 per square foot in FY 2011 to $36.43 per square foot in FY 2012.

The total FY 2012 request for the Non-PSC SSF Activities is $62,673,000, which is an increase of $3,267,000 above the FY 2011 program level of $59,406,000. The Board approved the following FY 2012 increases: 1) $1,341,000 increase to the budget for the Homeland Security Presidential Directive – 12 (HSPD-12) initiative to continue its efforts in implementing enhancements to secure physical and logical access to HHS facilities Department-wide; $466,000 increase in Commissioned Corp Force Management (CCFM) to reflect increased Commissioned Corp strength and increased calculation factor for annual leave; $1,340,000 (Tracking Accountability in Government Grants Systems(TAGGS)/Departmental Contracts Information System (DCIS)) for support for Open Government Directive.

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 2011 to support Open Government related requirements and system improvements for the DCIS and TAGGS activities. The total approved for use in FY 2011 to fund these activities is $600K and $710K for DCIS and TAGGS respectively.

At the end of FY 2010, a total of $14,739,000 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 2011.

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 2012 SSF activities are described below.

Program Support Center Activities

The PSC FY 2012 SSF Board-approved budget is $1,046,402,000, which is an increase of $25,458,000 above the FY 2011 SSF Board-approved budget of $1,020,944,000. This 2.5% increase is attributable to increases in the areas of rent, parking, TranShare, contracts and other inflationary factors. Effective in FY 2011, Parklawn facilities rent will increase 115% and the lessor will also begin to charge for parking spaces. Fully loaded costs will increase from $15.06 per square foot in FY 2010 to $31.89 in FY 2011 and will increase another $4.54 per square foot for FY 2012. For the most part, the PSC will able to drive down costs in other areas to absorb these increases and by increasing business with other government agencies.

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*, comprised of facilities management, space leasing, disposition of surplus Federal property, logistics services including receiving, asset management, warehouse storage, product distribution and office mover services;
- *Security and Emergency Services*, comprised of personnel and physical security services and HSPD-12 services consisting of background investigations, digital fingerprinting, both HSPD-12 and non-HSPD-12 badging and recertifications;
- *Support Services*, comprised of visual communications, print procurement and publications, graphic arts, Forms Management, the HHS Southwest D.C. Complex Copier Program; Mail Management and Policy Services, the Parklawn Conference Center, Office Hoteling, Regional Administrative Support and Cooperative

Administrative Support Units;
- *Transportation Services*, which includes the Transhare program, parking facilities at the Parklawn building, Office of the Secretary Executive Motor Pool, General Services Administration leased vehicle services, travel policy, travel helpdesk support and training for the GovTrip system;
- *Payroll Services*, which manages all aspects of civilian payroll customer services, liaison between Defense Finance and Accounting Service (DFAS) and HHS on all pay-related issues including HHS pay policy, employee pay records and supporting systems, and monitoring DFAS performance against the Service Level Agreement;
- *Commissioned Corps Support Services*, comprised of Commissioned Corps payroll which administers over $1 Billion annually in a system of basic pay, allowances and special or incentive pay for active duty Commissioned Corps Officers and annuitants of the Public Health Service; Commissioned Corps Systems Branch, which maintains and operates the systems housing current and historical pay and leave records for Commissioned Corp Officers; and Medical Affairs Branch, which provides administrative management and direction concerning medical issues.

The FY 2012 budget for AOS is $392,644,000, which is an increase of $8,179,000 above the FY 2011 budget request of $384,465,000. This increase is attributable to a $2,340,000 increase in rent and parking costs for the Parklawn building lease extension and a $2,966,000 increase in contracts. Additionally, the FY 2012 budget increase reflects $2,873,000 in costs attributable to an organizational transfer of five employees from what was formerly the Office of the Assistant Secretary for Administration and Management (ASAM) and seven employees from the Office of the Secretary, Office of the Secretary Executive Office (OS/OSEO) to AOS.

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. Fiscal advice, as well as technical and policy guidance is also available to assist in implementing new initiatives and assuring compliance with regulatory requirements.

The FY 2012 budget for Financial Management Service is $67,757,000, which is an increase of $3,215,000 above the FY 2011 budget request of $64,542,000. This $3,215,000 increase is attributable to a $1,781,000 increase in contracts, $847,000 increase in space rent and parking costs for the Parklawn building lease extension and $587,000 in utilities, labor costs and intergovernmental support.

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, such as:

- Health screenings for cholesterol, diabetes, blood pressure, and cancer, identifying diseases in early stages where they can be treated or cured and preventing more costly complications and treatment.
- Smoking cessation programs aimed at reducing tobacco use, preventing lung cancer, heart disease and stroke and reducing other health care costs and absenteeism.
- Influenza immunization programs to reduce the incidence of infections among employees which in turn reduces absenteeism, decreases health care costs and improves productivity.
- Critical Incident Stress Management designed to minimize the potential impact of a crisis or traumatic event.
- Environmental assessments for indoor air, water, asbestos and other hazard evaluations of worksites.

FOH currently provides services to 45 federal agencies and serves over 1.5 Million federal employees. Approximately 90% of FOH's services are provided to federal agencies outside of HHS.

The FY 2012 budget for Federal Occupational Health Service is $172,652,000, which is an increase of $5,972,000 above the FY 2011 budget request of $166,680,000. This increase is due to a $4,471,000 increase in contracts, $1,322,000 increase in space rent and parking costs for the Parklawn building lease extension and $179,000 in labor costs and intergovernmental support.

Information and Systems Management Service (ISMS)
The Information and Systems Management Service (ISMS) has the mission of providing high-quality information technology services, including project management, application development, operations and maintenance, infrastructure support services, telecommunications management and services, records management, and requests for access to information from the public.

The ISMS:

- Provides leadership and overall management for information technology resources for which PSC has responsibility;
- Directs the development, implementation, and enforcement of the Office of the Secretary and the PSC's information technology architecture, policies, standards and acquisitions in all areas of information technology;
- Oversees PSC's information systems security program and serves as PSC's Information Technology Security Officer (PSC/ITSO);
- Manages and directs the PSC's IT business functions including business planning, development, budgeting and fiscal planning, establishing service level agreements, assessing customer satisfaction, assuring compliance with the Government Performance Results Act (GPRA) and overseeing capital planning and investment control (CPIC) for IT initiatives, researching emerging technologies and managing business systems initiatives;
- Provides operations and maintenance support services;
- Provides application software development support;

- Provides the Freedom of Information Act (FOIA) and record-keeping services; and
- Provides telecommunications management and services and technical design and support for customer systems.

The FY 2012 budget for the Information and Systems Management Service is $176,499,000, which is an increase of $3,555,000 above the FY 2011 budget request of $172,944,000. This increase is attributable to a $1,822,000 increase in IT support contracts, $1,361,000 increase in space rent and parking costs for the Parklawn building lease extension and $372,000 in labor costs and intergovernmental support.

Office of Human Resources (OHR)

The Office of Human Resource (OHR) is a part of the Office of the Secretary, Office of the Assistant Secretary for Administration. The FY 2012 budget submission for OHR includes activities to support OHR as well as HHS University (HHSU) and the Office of Equal Employment Opportunity (EEO).

OHR provides leadership in the development and assessment of the HHS' human resources programs and policies that support and advance the HHS mission and objectives.
The scope of OHR's activities is HHS-wide, covering all statutes and regulations relating to human resources. 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.

In FY 2010, OHR transformed from a geographically based operation to a functional business model. OHR's centralization and consolidation initiative positioned the organization to operate more efficiently and effectively as mandated by this administration and the agency by transforming it into a more customer-responsive organization.

The HR Centers provide human resources strategic programs, customer service, and workforce relations support for HHS customer organizations. They serve as the principal advisor to the customer organizations' leadership on matters related to human resources management, including strategic human capital planning, recruitment and placement, position classification and management, compensation and pay administration, executive resources, workforce planning, labor and employee relations, employee services, and employee benefits, entitlements and advisory services. HR Centers interpret regulations, directives, and other guidance related to human resources programs. In addition, they provide policy direction, coordination and operational control for human resources programs.

HHSU supports HHS' mission and goals by providing high-quality, cost-effective continued learning and development opportunities. HHSU employs innovative approaches and emerging learning technologies, including on-line training courses. HHSU manages HHS' Learning Management System (LMS). Available to all HHS employees, LMS provides one-stop access to training, and allows tracking and reporting of training activities at any level within HHS. LMS also makes tools available to assist HHS with effective human capital management, through

activities such as talent management, succession planning, and knowledge and content management.

Effective November 22, 2010, the EEO Services Cost Center was realigned into OHR. Previously, the EEO Services Cost Center was managed by the Office of Equal Employment Opportunity (OEEO) within the Administrative Operations Service (AOS).

In addition to providing EEO services the EEO office manages an EEO Investigations Cost Center that provides EEO Investigations, preparation of Final Agency Decisions (merit), as well as EEO Counseling. With the exception of the Centers for Medicare and Medicaid Services (CMS), all HHS EEO Investigations are procured through the EEO Investigations Cost Center.

The FY 2012 budget request for the Office of Human Resources includes funding to support OHR as well as HHSU and EEO activities. The overall FY 2012 OHR budget $68,171,000, which includes FY 2012 budget request of $65,557,000 to support OHR and HHS University and $2,614,000 to support EEO activities. The FY 2012 budget request represents an overall net decrease of $1,885,000.

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. The Strategic Sourcing Division within Acquisition Management was organizationally transferred to the Office of Grants and Acquisition Policy and Accountability (OGAPA) the Office of the Assistant Secretary for Financial Resources (ASFR). (See more detail in the Strategic Sourcing narrative in the Non-PSC section.)

The FY 2012 budget for SAS is $168,679,000 which is an increase of $6,422,000 above the FY 2011 budget request of $162,257,000. This increase is attributable to $4,731,000 in support of new acquisition business with external customers, $1,463,000 increase in space rent and parking costs for the Parklawn building lease extension, and $228,000 in labor costs and intergovernmental support.

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. These non-PSC SSF activities are described in the following narratives.

Acquisition Integration and Modernization (AIM)
This initiative provides acquisition tools to support process standardization, organizational improvement, and the contracting community's compliance with the Federal Acquisition Regulation and other acquisition. These efforts capture knowledge within the acquisition workforce, seize opportunities to share and adopt best practices, and enable consistent approaches, where appropriate, across HHS. Another component of the AIM effort is the HHS Acquisition Dashboard, which provides a stoplight chart of HHS' performance in several critical acquisition functions.

In FY 2012, AIM will continue to pursue opportunities to standardize and modernize acquisition processes. An ongoing objective is to focus on performance measurement, including additional purchase card oversight and procurement management reviews to measure how well HHS manages and conducts its procurement function.

The FY 2012 budget for AIM is $1,127,000, the same as the FY 2011 budget level.

Audit Resolution
Audit Resolution, as mandated by P.L. 96-304 and P.L. 98-502, resolves grantee audit findings within a statutorily mandated six-month period. Based on findings identified by auditors in a grantee's A-133 audit, Audit Resolution reviews and resolves audit findings containing monetary and/or systemic findings of grantee organizations affecting the programs of more than one HHS Operating Division (OPDIV) or federal agency. Audit Resolution makes recommendations and ensures that corrective action is taken on deficiencies in grantee accounting systems, internal controls, or other management systems. Under the authority of OMB Circular A-50, paragraph 7.c., Audit Resolution, as an audit follow-up official, has responsibility for ensuring that timely responses are made to all audit reports, disagreements are resolved, and corrective actions are implemented.

Audit Resolution is responsible, HHS-wide, for identifying and following up with all grantees that have not submitted their annual A-133 audit in a timely manner. Grantees that have not submitted their audit reports after HHS' initial follow-up are reported to the relevant OPDIV or other federal agency for additional follow-up.

The FY 2012 budget for Audit Resolution is $1,568,000, which is an increase of $62,000 above the FY 2011 budget request of $1,506,000. The increase is due to an expected increase in audit findings to be resolved; the continuing importance of ensuring transparency and accountability for grantee expenditures related to the American Recovery and Reinvestment Act (ARRA); efficiencies and expertise gained through the use of contractual assistance.

Claims (Office of the General Counsel)
The Federal Tort Claims Act (FTCA) requires claimants to file administrative claims with the responsible agency before filing suit against the United States in federal court. 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. All federal agencies are given six months to settle or deny administrative claims. If no action is

taken within six months, the claimant may then file suit in federal court. As such, administrative claim processing is mission critical work that is required by federal statute.

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. OGC settles claims where appropriate, and denies claims where not. For claims that are not settled and result in litigation, OGC works with the Department of Justice to defend the agency. At the administrative adjudication level, the work is funded by those HHS clients that use the service via the HHS Service and Supply Fund (e.g., most medical malpractice claims are from HRSA-funded Community Health Centers and from Indian Health Service clinics). Claims that result in litigation go through an additional process and are worked by other OGC personnel (e.g., a secretary, paralegals, and attorneys). Thus all tort claims are processed from beginning to end by OGC personnel.

In FY 2010, the OGC Claims Office received 517 tort claims, 279 of which were related to community health centers. As of February 4, 2011 (FY2011), OGC received 141 tort claims of which 75 were related to community health centers. The FY 2012 budget for OGC Claims is $1,320,000, which is an increase of $57,000 above the FY 2011 budget of $1,263,000.

Commissioned Corps Force Management (CCFM)

CCFM provides personnel support to active-duty and retired Public Health Services (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 (ASH) – the Office of Commissioned Corps Force Management (OCCFM) and the Office of Commissioned Corps Operations (OCCO) within the Office of the Surgeon General (OSG). OCCFM develops policies and proposes regulations in order to carry out a comprehensive force management program for the Corps. The office establishes timelines, performance standards, and measurements of the evaluation of the operations and management of the Corps, and works closely with the OSG to facilitate operations and the implementation of policies and programs. OCCO provides advice on matters related to the day-to-day management of the Corps, and also provides for the delivery of training and career development. OCCO manages the personnel administration systems for the assignment, appointment, promotion, assimilation, and awards for Corps members.

CCFM purchases its payroll, information technology support and management of commissioned officers healthcare from the Office of Commissioned Corps Support Services which is part of the PSC.

In FY 2011 ASH performed a comprehensive review of the management of the Commissioned Corps with specific emphasis on the personnel management entities of the Corps. In conjunction with this review, ASH is in the process of finalizing an action plan for improving operations through an improved accountability structure and a more systematic approach for tracking and managing Commissioned Officers within HHS OPDIVs and outside of HHS. ASH has partnered with the ASA Office of Business Management and Transformation to perform an analysis and make recommendations for improved efficiency of the Commissioned Corps personnel

operations.

The FY 2012 budget request for CCFM is $25,236,000, which is an increase of $466,000 above the FY 2011 request of $24,777,000. Funding increases are attributed to increased projections in Commissioned Corps strength and an increase in the calculation factor for annual leave. There are no new programs or activities requested.

Departmental Contracts Information System (DCIS)
DCIS provides a central repository for HHS contract award data and is a certified feeder system to the Federal Procurement Data System-Next Generation (FPDS-NG). The FPDS-NG is mandated by Public Law 93-400. DCIS collects, stores, and compiles contract award information to produce various critical reports for Freedom of Information Act (FOIA) requestors, the Congress, Government Accountability Office (GAO), HHS senior management and others. DCIS primarily receives HHS OPDIV and STAFFDIV data via the contract writing systems employed by the contracting offices.

In FY 2012, funding to support DCIS will focus on configuring the system to address additional data elements and enhanced reporting capabilities; improving operational, Help Desk and test support functions; and performing an independent Verification & Validation review of HHS' contract data.

The FY 2012 budget for DCIS is $1,865,000, which is an increase of $620,000 above the FY 2011 budget request of $1,245,000. This is due to an increase in costs required to support the Open Government Directive and related data quality improvement efforts.

Homeland Security Presidential Directive-12 (HSPD-12)
The HSPD-12 program implements the Presidential Directive to provide greatly enhanced security for physical access to HHS facilities and logical access to systems and applications. The HSPD-12 program encompasses the sponsorship, enrollment, and management of identities and issuance of identity cards. Identity cards are printed in accordance with the National Institute for Standards and Technology (NIST) standards and contain electronic credentials on the embedded smart chip. The HSPD-12 program has evolved into an identity and access management program, which will enable HHS personnel to use the card for logical as well as physical access. Use of the identity card to access logical systems has been implemented and is in production to support two HHS-wide human capital systems; these are the Enterprise Human Resources Program (EHRP), which serves as the system of record and authoritative source for the HHS civilian workforce and the Enterprise Workflow Information Tracking System (EWITS), which provides workflow management supporting EHRP. Both EHRP and EWITS have been integrated into the HHS' access management system, which requires the use of the HSPD-12 Personal Identity Verification (PIV) card for authentication at level four and may be used for authentication at level three and below. The access management system is in production today. The SSF funding for HSPD-12 is used to support and pay for contracts to support the HSPD-12 program.

Integration of systems such as the Integrated Time and Attendance System (ITAS), Electronic Official Personnel Folder (eOPF), and MyPay (payroll) into HHS' single sign on solution and

use of the HSPD-12 PIV card is underway. Integration of other HHS systems will extend into calendar years 2011 and 2012. Use of the identity card for remote access is in limited production at a number of OPDIVs as is the ability to authenticate to the network from the desktop.

The FY 2012 budget for HSPD-12 is $14,477,000, which is an increase of $1,341,000 above the FY 2011 budget request of $13,136,000. This is due to the costs associated with implementing physical and logical access enhancements Department-wide.

High Performing Organizations, Commercial Services Management Reporting & Insourcing (HPO, CSM & Insourcing)

In response to Section 647(b) of Division F of the Consolidated Appropriations Act, FY 2004, P.L. 108-109, which requires annual commercial services management reports to the Congress, HPO, CSM & Insourcing provides active sponsorship to develop, maintain and report on High Performing Organizations (HPO) for various OPDIVs. The program also oversees all OPDIVs and STAFFDIVs in the collection and submission of the annual Federal Activities Inventory Reform (FAIR) Act inventory as required by the FAIR Act of 1998.

HPO, CSM & Insourcing leads HHS in efforts that ensure compliance with new statutory requirements (including Section 735 and Section 321 of Title VII of the Omnibus Appropriations Act, 2009, P.L. III-8. Section 735) that addresses insourcing and will require central service activities to ensure that consideration is given to using federal employees to perform new functions as well as to ensure that contractors are not performing functions that could be equitably performed by federal employees.

In addition, HPO, CSM & Insourcing spearheads coordination, organization, and timely submittal of the HHS-wide annual Commercial Services Management 647(b) Report to Congress. This is facilitated through active maintenance of the FAIR Act Collection System (FACS) database, which collects and summarizes data and produces various reports.

The FY 2012 budget for HPO, CSM & Insourcing is $287,000, the same as the FY 2011 budget request level.

Office of Small and Disadvantaged Business Utilization (OSDBU)

The OSDBU was established in 1979 under Public Law 95-507, the Small Business Act. OSDBU provides leadership, guidance and oversight to ensure that small businesses are given an equitable opportunity to compete for contracts that provide goods and services to HHS.

In FY 2012, the OSDBU will continue to increase the use of mechanisms and programs that "maximize opportunities for small businesses". It will disseminate best practices and policy that ensure sufficient numbers of small businesses are considered during the procurement process. The OSDBU will continue to expand the HHS Mentor Protégé Program, which provides an avenue for small businesses (Protégés) to achieve greater entrepreneurial success by partnering with larger entities (Mentors) that provide technical and management guidance. HHS will benefit from a growing industry of capable small businesses that can perform and deliver on the programmatic needs of HHS.

The FY 2012 budget for OSDBU is $2,818,000, the same as the FY 2011 budget request level.

Strategic Sourcing
In FY 2011 this activity was transferred from the PSC to ASFR/OGAPA, to better leverage acquisition spending across HHS. Strategic sourcing is the collaborative and structured process of analyzing an organization's spending to make better, enterprise-wide business decisions about acquiring commodities and services.

In FY 2012, HHS' Strategic Sourcing Team will continue to perform spend analysis and provide critical support for the various strategic sourcing efforts conducted by HHS (e.g., office supplies, temporary services, event management services). This team will also participate actively in federal-wide Strategic Sourcing initiatives.

The FY 2012 budget for Strategic Sourcing is $766,000, the same as the FY 2011 budget request level.

Tracking Accountability in Government Grants System (TAGGS)
TAGGS is HHS' central data warehouse and online web repository of federal assistance data. The system transmits grant and other assistance data to USASpending.gov. TAGGS collects, stores, and compiles award information to produce ad hoc reports for a variety of key stakeholders including the Congress, GAO, state governments, HHS senior and executive leadership, FOIA requestors, and other users. The system primarily receives HHS Operating Division and Staff Division data via the Administration for Children and Families' GrantsSolutions.gov and the National Institutes of Health's IMPAC II systems, thus streamlining grants management business processes and solutions for improved efficiency and accountability and improving internal controls for enhancing and monitoring assistance data quality and integrity.

In FY 2012, TAGGS efforts will focus on improving internal controls for submitting USASpending.gov data, enhancing data collection, maintenance, and transmission of loan and aggregated direct payment data, and supporting sub-recipient data collection and reconciliation processes for the Federal Funding Accountability and Transparency Act (FFATA).

The FY 2012 budget for TAGGS is $2,125,000, which is an increase of $720,000 above the FY 2011 budget request of $1,405,000. This is due to an increase in costs required to support the Open Government Directive and related data quality improvement efforts.

Web Communications and New Media Division (WCD)
The WCD is a part of the Office of the Secretary, Office of the Assistant Secretary for Public Affairs. The WCD is responsible for the coordination of HHS communication and outreach activities, including implementing Web 2.0 applications, related to health and human service information, education and public interaction.

The WCD is responsible for creating, launching, and maintaining high profile websites such as HealthCare.gov HHS.gov/Recovery, InsureKidsNow.gov, and FoodSafety.gov as well as other sites such as Data.gov in support of the Open Government. WCD responsibilities in support of

legislation require the maintenance of substantial databases, staff with expertise in graphics and design, and the development of policies and best practices to support HHS' growing social networking practices. The growing use of video public comment and social networking tools, and other outreach mechanisms are driving the work of the WCD and require immediate responsiveness to the fast-paced changes in communication methods and practices.

The FY 2012 budget for Web Communications is $11,084,000, the same as the FY 2011 budget request.

FY 2012 Congressional Justification

Program Support Center
Overview of Key Performance Measures, Outcomes and Outputs

Key Outcomes and Outputs

PSC Key Performance Measures Table

Long Term Objective: ***Improve quality – Provide quality administrative support so that high performance can be maintained in HHS Program Services.***

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.1.1: Increase the percentage of services achieving Service Quality targets. *(Outcome)*	FY 2010: 94% (Set baseline)	95%	95%	Maintain
1.1.2: Increase the percentage of customers responding to PSC comment cards and indicating excellent/good ratings for satisfaction of services. *(Outcome)*	FY 2010: 91% (Target Exceeded)	90%	90%	Maintain
1.1.3: Increase the percentage of cost centers processing billings to coincide with service delivery *(Outcome)*	FY 2010: 97% (Target Exceeded)	95%	95%	Maintain
1.1.4: Increase the percentage of customers positively responding to the Annual Customer Survey with a selection of "Strongly Agree" or "Moderately Agree". *(Outcome)*	FY 2010: 82% (Under development)	80%	85%	N/A

Long Term Objective: ***Increase Cost Savings to HHS by Expanding Market Share or Increasing Size of Customer Base.***

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.2.1: Increase percentage of new customers acquired annually. *(Outcome)*	FY 2010: 2% (Target Exceeded)	2%	2%	Maintain
1.2.2: Increase sales revenue for each of the top 20 cost centers. *(Outcome)*	N/A	N/A	5%	N/A
1.2.3: Increase business from customers outside of HHS. *(Outcome)*	N/A	N/A	5%	N/A

Long Term Objective: ***Increase Cost Savings to HHS through Asset Management***[1]

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.3.1: Participate in Department-wide consolidations. *(Outcome)*	FY 2010: 2 consolidation (Target Exceeded)	1 consolidation	N/A	N/A
1.3.2: Maintain PSC overhead rate to be less than 1.4% of total costs. *(Outcome)*	FY 2010: 1.1% (Target Exceeded)	1.6%	1.4%	-0.2
1.3.4: Increase the percentage of overall employee satisfaction PSC-wide. *(Outcome)*	FY 2010: 69% (Target Not Met but Improved)	75%	75%	Maintain
1.3.5: Increase the percentage of cost centers recovering within an established variance and achieving target Net Operating Result (NOR). *(Outcome)*	FY 2010: 62% (Target Not Met but Improved)	75%	75%	Maintain
1.3.6: Achieve an unqualified audit opinion for the SSF. *(Outcome)*	FY 2010: Unqualified audit opinion, no MW and RC, and measurable progress in correcting existing MW and RC (Target Met)	Unqualified audit opinion, no new MW and RC, and measurable progress in correcting existing MW and RC	Achieve unqualified audit opinion for the SSF.	N/A

[1] Performance Measure 1.3.3 (Intra-service Costs) was removed because it was discontinued in FY 2010 as reported in the FY 2011 OPA.

Improve Quality:

PSC has a long term goal of consistently improving the delivery of quality, timely and efficient services so that HHS OPDIVs may receive superior service while maintaining focus on their mission-related programs. There are four important measures that indicate quality of service – timeliness, customer satisfaction, timely billing and overall satisfaction. Performance Measure 1.1.4 (Overall Satisfaction) is new for FY 2012.

Performance Measure 1.1.1 (Service Quality: Increase the percentage of services achieving Service Quality targets – Reset baseline in FY 2010):

Service quality and responsiveness are critical elements that determine the customer's level of satisfaction with PSC. PSC consistently focuses on service quality in order to maintain and improve the customers' perceptions of PSC as a high-quality service provider. PSC seeks to provide quality, timely, accurate and efficient products and services to all customers through simplified, streamlined processes and procedures and through employment of best practices and standards.

PSC measures the quality of service delivery against the service quality performance standards established for each product and service listed in our comprehensive Directory of Products and Services. Service delivery is considered timely when the requested service is delivered to the customer in a prompt manner and within the time frame published for the timeliness performance standard for that product or service.

The service quality standards exist in order to set clear performance expectations with the customer and to allow the customer to hold PSC accountable. For Performance Measure 1.1.1, PSC tracks performance data to determine the percentage of its products and services that are achieving their individual service quality standards. While these standards are rolled up for high-level reporting, each Cost Center Manager is accountable for meeting the goals for the product or service for which he or she is responsible. Performance responsibilities are assigned and documented under the Performance Management Appraisal Program (PMAP). Results for individual product and service lines are compiled monthly. The data is reviewed, and service issues are remediated and tracked for improvement. PSC Business Operations (PBO) provides monthly training for Cost Center Managers so that they can properly analyze the performance results for their respective areas of responsibility.

In FY 2010, this performance measure is modified from previous years, which only focused on timeliness to include measures of service quality (which encompasses timeliness) of PSC products and services. PSC tracked 198 service quality standards for 83 products and services. There were more products and services in FY 2010 compared to FY 2009 because of the new products and services such as Medical Affairs and Continuity of Operations (COOP) Disaster Recovery and Infrastructure. PSC achieved 94% service quality during the baseline year.

In FY 2011 and FY 2012, the target for Performance Measure 1.1.1 will be 95% which is higher than the 94% achieved during the baseline year to make the target challenging. PSC will

continue to analyze the targets established for each product and service to ensure that appropriate yet challenging targets are established.

Performance Measure 1.1.2 (Customer Satisfaction: Increase the percentage of customers responding to PSC comment cards and indicating excellent/good ratings for satisfaction of services -Target exceeded in FY 2010):

The other factor in measuring quality is overall customer satisfaction. PSC has placed great emphasis on providing quality, value-added services to all customers through reengineered processes and procedures; upgraded infrastructure, tools and systems; transparency; management and employee attention to quality; and through employment of best business practices and standards. PSC will measure the perceived quality of its service delivery as the percentage of customers expressing customer satisfaction with the quality of services provided.

It is clear that customer satisfaction has a direct relationship not only to quality, but also to price for customers. Ensuring high satisfaction ratings, will in turn lead to increased purchasing of PSC products and services, which will have an overall effect on price as PSC customers are able to take advantage of improved economies of scale.

The customer satisfaction measure defines quality as those customers who are highly satisfied with overall service. PSC encourages customers to complete an on-line survey upon delivery of products and services and makes the survey available on PSC's website. Survey responses are collected and analyzed on a monthly basis to calculate the customer satisfaction rating. The monthly performance results are distributed to the cost center managers to resolve issues and to monitor the performance of their respective areas.

In FY 2009, the results of the Customer Satisfaction Survey showed that 1,679 customers completed the PSC On-line Customer Survey with a resulting customer satisfaction rating of 88% based on a four point scale, thus PSC did not achieve the target of 90%. Based on the customer comments, most of the dissatisfaction was due the initial challenges as a result of organizational realignment within the PSC, which disrupted some processes and created some customer frustration as personnel became familiar with new responsibilities. The following table displays the customer satisfaction results by Service Area in FY 2009.

FY 2009 Overall Satisfaction Ratings (# of Comments)	**AOS**	**ISMS**	**FMS**	**FOH**	**SAS**	**OD**	**BCSS**	**BFC**	**PSC Overall**
Very Satisfied	364	270	206	187	115	29	26	3	1200
Satisfied	141	29	32	44	11	3	18		278

FY 2009 Overall Satisfaction Ratings (# of Comments)	AOS	ISMS	FMS	FOH	SAS	OD	BCSS	BFC	PSC Overall
Dissatisfied	29	16	11	12	3	2	6	1	80
Very Dissatisfied	31	26	35	9	6		12	2	121
Total	565	341	284	252	135	34	62	6	1,679
Percentage of Customers Very Satisfied and Satisfied	89%	88%	84%	92%	93%	94%	71%	50%	88%

In FY 2010, there is an increase in percentage of customers responding to PSC comment cards and indicating excellent/good ratings for satisfaction of services received. The results for customer satisfaction showed that 2,023 customers completed the PSC On-line Customer Survey with a resulting customer satisfaction rating of 91% based on a four point scale, thus PSC achieved the target of 90%. The following table displays the customer satisfaction results by Service Area in FY 2010.

FY 2010 Overall Satisfaction Ratings (# of Comments)	AOS	ISMS	FMS	FOH	SAS	OD	BFC	PSC Overall
Very Satisfied	975	135	217	110	106	65	3	1,611
Satisfied	122	22	21	42	8	8		223
Dissatisfied	33	6	17	12	9	2		79

FY 2010 Overall Satisfaction Ratings (# of Comments)	AOS	ISMS	FMS	FOH	SAS	OD	BFC	PSC Overall
Very Dissatisfied	52	5	29	8	14	2		110
Total	1182	168	284	172	137	77	3	2023
Percentage of Customers Very Satisfied and Satisfied	93%	93%	84%	88%	83%	95%	100%	91%

In FY 2011 and FY 2012, targets will remain constant at 90% but the FY 2013 target will be raised if the FY 2011 result exceeds the FY 2011 performance target. PSC expects to continue the achievement of the Customer Satisfaction performance in the coming years.

Performance Measure 1.1.3 (Timely Billing: Increase the percentage of cost centers processing billings to coincide with service delivery - Target exceeded in FY 2010):

In an effort to improve the quality of PSC service delivery, PSC established this performance measure in FY 2008 that strives to achieve timely billings. As a fee-for-service organization, it is important for PSC to process its billings when services are rendered in order to collect revenue from its customers in a timely manner. This performance measure was developed in FY 2007 wherein 87% was established as the baseline. The 87% resulted from the cost centers billing on time 707 instances out of 815 actions in FY 2007.

Timely billing in the PSC Revenue, Invoicing, and Cost Estimation System (PRICES) system is affected by the prompt receipt of billing data from the service providers, the availability of the related Unified Financial Management System (UFMS) reports and the efficient set-up by the Cost Center Managers of the customers' billing information in PRICES. Billing is considered timely when the invoices for the products and services of a certain cost center are entered by the Cost Center Manager into PRICES on or before the monthly cut-off date or deadline.

In both FY 2009 and FY 2010, the PSC exceeded the target of 95% with a rating of 97%. This is a 2% improvement over the FY 2008 performance result. The performance targets will remain at 95% for FY 2011 and FY 2012.

Performance Measure 1.1.4 (Increase in Overall Satisfaction: Increase the percentage of customers positively responding to the Annual Customer Survey with a selection of "Strongly Agree" or "Moderately Agree - New in FY 2012):

As part of our continuing effort to improve product and service delivery, customer satisfaction and service quality, PSC conduct an annual customer survey that targeted customers who can represent their organization's perception and opinion of PSC's overall service performance relative to the service levels, cost of service and demand requirements. These types of customers are usually the budget officers, agency heads or executive officers. PSC conducted the first of these surveys which was the FY 2009 Annual Customer Survey.

The FY 2009 Annual Customer Survey was administered online, and was open to customers for five weeks beginning in November 2009. During this time two reminders were sent, and Service Area outreach programs were conducted. The survey was deployed to 2,489 PSC customers. The overall response rate was 24% (588 surveys were completed) and the Overall Satisfaction result was 83%.

The highest performing areas from the FY 2009 survey results were:

Customer's *overall satisfaction* with the PSC – 83%
Would recommend the PSC to others – 82%
PSC staff *knowledge* – 82%
PSC *quality* – 82%

The lowest performing areas from the FY 2009 survey were:

Customer satisfied with the *value* of PSC services - 75%
Customers satisfied with the PSC's *communication of the range of services offered.*
Satisfied with the *communication of the pricing* of PSC services - 64%
Satisfied with the *price* of PSC services - 63%

In FY 2009-FY 2010 the PSC had implemented certain strategies aimed at improvements in the low performing areas:

- Conducted focus group sessions with key customer representatives from HHS Operating Divisions as part of the Customer Experience Management initiative
- Service Area executives and staff assigned to engage each HHS customer contact to review any issues and fill any communication gaps.
- Establish a common performance element for customer satisfaction in the PMAP
- Host customer events designed to educate customers about PSC's service portfolio and support capabilities
- Increase survey participation for each cost center/service and for key customer agencies

The FY 2010 Annual Customer Survey is closed as of February 4, 2011. The target for FY 2010 was re-evaluated taking into account that FY 2009 results were heavily weighted by FOH who had over half of all responses to the survey and scored well above the average. By using the

percentage of positive survey responses *by service area* going forward, instead of the overall number of responses across the PSC, the results will be adjusted for the FOH contribution. The target for FY 2010 was 80% (corresponding to 75% average by service area in FY2009). The actual FY 2010 result was 82%.

The FY 2012 performance target is 85% for overall satisfaction on the Annual Customer Survey. The percentage increase comes in 2012 after PSC has had sufficient time to adjust its business processes and operations schedules to the survey.

Improve Cost Savings to HHS by Expanding Market Share:

The PSC seeks to expand its portion of the Federal shared services market in order to establish itself as the leader in shared services, benefit from economies of scale, achieve operational efficiencies, foster standardization, and free customers to focus on their core missions. As the shared services provider for HHS, it is essential that our prices be competitive and costs be controlled.

One method of controlling price increases is through obtaining new Federal customers, both from HHS and from outside the Department. By doing this, the PSC can spread overhead costs to a greater number of work units and it can achieve economies of scale through volume buys, thus lowering the cost to customers. This is most effective when a greater portion of the expanded market includes external customer agencies, which has a direct effect on HHS customer agencies (i.e. total cost to the Department can be reduced)[2] As a result, we monitor our customer's usage of services (in addition to managing costs, which is discussed in the next series of performance goals).

There are three measures utilized to track customer usage. The first measure, performance measure 1.2.1 (Increase in Number of Customers) tracks the percentage of new customers acquired annually. The second measure, performance measure 1.2.2 (Increase in Revenue for top 20 Cost Centers) will be fully implemented in FY 2012. This performance measure is being utilized to track the increase in sales for the top 20 cost centers. The third measure, performance measure 1.2.3 will be fully implemented in FY 2012. This performance measure is being utilized to track the increase in revenue from customers outside of HHS.

Performance Measure 1.2.1 (Increase in Number of Customers: Increase percentage of new customers acquired annually - Target exceeded in FY 2010):

This performance standard is measured by the increase in the number of customers billed through PRICES. In FY 2010, achieved the Increase Number of Customers performance measure with a result of 2% or an increase of 30 new customers. Eighty-seven percent (87%) of the FY 2010 new customers were new customers of AOS of which 80% were by the CASUs. The other new customers were earned by the SAS's Supply Service Center (7%), FOH's

[2] While expanding the market is one component of the equation, the other component that has an overall effect on total HHS cost is actual cost of service delivery. It is only when market share and total delivery costs are tracked that true savings to the Department can be determined.

Employee Assistance Program (3%) and ISMS's Information Technology Infrastructure and Operations (3%). The bulk of the FY 2010 new customers were 47% from DOD, 10% from GSA and 6% from DOL.

For FY 2011 and FY 2012, PSC has set a target of maintaining 2% growth rates for the number of new customers over the prior year.

Performance Measure 1.2.2 (Increase in Revenue for top 20 Cost Centers: Increase sales revenue for each of the top 20 cost centers – Fully implemented in FY 2012):

In an effort to improve cost savings by expanding market share, PSC has established a new performance measure to achieve an increase in sales revenue for each of the top 20 revenue-producing cost centers.

Below is the table of the top 20 cost centers for FY 2009:

Rank	Product/Service	Service Area	FY 2009 Revenue
1	CLINICAL SERVICES	FOH	$101,024,540
2	KC CASU	AOS	$76,592,352
3	ACQUISITIONS MANAGEMENT	SAS	$72,835,071
4	DENVER CASU	AOS	$51,744,916
5	NY CASU	AOS	$50,508,481
6	SUPPLY SERVICE CENTER (PERRY POINT)	SAS	$45,304,249
7	IT SERVICES (ITO)	ISMS	$44,474,599
8	ENTERPRISE APPLICATIONS	ISMS	$28,893,792
9	ENVIRONMENTAL HEALTH SERVICES	FOH	$28,600,312
10	TELECOMMUNICATIONS MGMT./WITS	ISMS	$28,503,358
11	UFMS O and M	ISMS	$27,933,045
12	EAP	FOH	$23,525,643
13	ACCOUNTING SERVICES	FMS	$21,939,009
14	PERSONNEL/PHYSICAL SECURITY-HSPD12	AOS	$19,885,776
15	PAYMENT MANAGEMENT – GENERAL	FMS	$17,576,461
16	ENTERPRISE EMAIL SYSTEM	ISMS	$14,671,039
17	BUILDING OPERATIONS – DELEGATED	AOS	$13,276,523
18	PAYROLL	AOS	$11,680,752
19	COST ALLOCATION	FMS	$10,109,885

20	DEBT MANAGEMENT	FMS	$9,514,572

Below are the top 20 cost centers for FY 2010:

Rank	Product/Service	Service Area	FY 2010 Revenue
1	KC CASU	AOS	$122,799,710.32
2	CLINICAL SERVICES	FOH	$112,635,867.25
3	ACQUISITIONS MANAGEMENT	SAS	$ 75,948,548.90
4	NEW YORK CASU	AOS	$ 60,702,699.64
5	DENVER CASU	AOS	$ 48,133,285.40
6	SUPPLY SERVICE CENTER (PERRY POINT)	SAS	$ 46,217,003.17
7	IT SERVICES (ITO)	ISMS	$ 31,545,636.65
8	TELECOMMUNICATIONS MGMT./WITS	ISMS	$ 31,232,678.86
9	ENTERPRISE APPLICATIONS	ISMS	$ 30,646,012.67
10	UFMS O and M	ISMS	$ 30,548,803.95
11	ENVIRONMENTAL HEALTH SERVICES	FOH	$ 27,181,472.97
12	EAP	FOH	$ 24,997,236.73
13	ACCOUNTING SERVICES	FMS	$ 24,839,648.91
14	DSES	AOS	$ 22,242,811.95
15	PAYMENT MANAGEMENT - GENERAL	FMS	$ 17,852,111.04
16	BUILDING OPERATIONS - DELEGATED	AOS	$ 13,944,615.21
17	PAYROLL	AOS	$ 12,148,593.32
18	Infrastructure	ISMS	$ 11,361,914.82
19	DEBT MANAGEMENT	FMS	$ 10,461,944.55
20	COST ALLOCATION	FMS	$ 9,664,852.97

Like most businesses, most of PSC's sales come from a small subset of their operating units or products. For PSC, these operating units and products are represented by Cost Centers. The top 20 Cost Centers account for more than 75% of all sales revenue of PSC's 60+ Cost Centers. PSC's intention is to put a greater focus on these sales leaders because of their proven attractiveness and the benefits derived from increasing sales in those areas. Those benefits include reducing prices for customers, creating a larger base against which to spread overhead costs, and the ability to absorb losses from new or struggling cost centers.

This performance measure will be under development in FY 2011 and a baseline will be set. A preliminary target is being established for FY 2011 to strive for 5% increase in total sales revenue from the top 20 PSC revenue-producing cost centers. The sales revenue data for this performance measure will be obtained from the Cost Recovery Reports. In this performance

measure, each CASU, e.g., Kansas City (KC) CASU, will be considered as one cost center because it has a common management structure, similar customer base and the same goals.

This performance measure compares the increase in sales revenue of the top 20 revenue-producing Cost Centers of the current year against the previous year's top 20 producers. For example, Clinical Services which is ranked number 1 in the FY 2009 top 20 cost centers is compared to the cost center ranked number 1 in the FY 2010 top 20 cost centers in sales revenue, which is the KC CASU. This methodology is repeated for the top 20 cost centers for FY 2009 and FY 2010 and the percentage increase for each ranking will be calculated. Then, the percentage increases will be added and divided by the number of rankings. In this case, 20 percentages will be added and then divided by the number of rankings which is 20. The resulting quotient will be the percentage increase in sales revenue for the top 20 revenue-producing cost centers.

In the FY 2009 and FY 2010 comparison, the result came out to be 8% increase in sales revenue for the top 20 revenue-producing cost centers. After the development of this performance measure in FY 2011, we will have a more realistic performance target in FY 2012. At that time, we will be able to validate whether 5% is an attainable and challenging target.

Performance Measure 1.2.3 (Increase in Business from Customers outside of HHS: Increase business from customers outside of HHS – Fully implemented in FY 2012):

In another effort to improve cost savings by expanding market share, PSC has established a new performance measure for FY 2011 to achieve an increase in business from federal customers outside of HHS. This performance measure calculates the share of non-HHS revenue as a percentage of total PSC revenue.

As a shared service provider for HHS, PSC's primary responsibility is the support of HHS's needs. Nonetheless, PSC aggressively markets its services to other Governmental Agencies (OGAs) as well. By selling its services to OGAs, volume discounts can lower the unit price for all PSC's customers. An additional benefit occurs on the costing side because the increase in business is handled without a proportional increase in expenses, ensuring economies of scale. The PSC's overhead expense is spread over a greater base, which reduces rates for HHS customers. For these reasons, PSC is committed to increasing sales from all customers, including those outside of HHS.

This performance measure is under development in FY 2011 in order to establish a baseline. The data for this performance measure will be obtained from the billings by Customer Report and Cost Recovery Reports. A preliminary target is being established for FY 2011 to strive for 5% increase in business from customers outside of HHS. In FY 2009, the revenue from customers outside of HHS was $369 million and in FY 2010, the revenue from customers outside of HHS was $396 million for a 7% increase in business from customers outside of HHS.

After the development period of this performance measure in FY 2011, we will have a more realistic performance target in FY 2012. At that time, we will be able to validate whether the 5% is an attainable and challenging target for the increase in business from non-HHS business.

Improve Cost Savings to HHS through Asset Management:

Two critical factors that influence a customer's decision to purchase services from PSC are quality of the service and the price. PSC's first three performance measures address methods for monitoring quality, timeliness and improving customer satisfaction. The remaining performance measures address factors that influence price, focusing on the overall cost of delivering the products and services. If PSC costs can be maintained or reduced and the volume of services purchased remains steady or increases, there will be a positive result for the customer (i.e., prices remain the same or decrease).

Performance Measure 1.3.1 (Department-wide Consolidations: Participate in Department-wide consolidations - Discontinued starting in FY 2011; Target exceeded in FY 2010):

This performance measure was established in FY 2007 and replaced a retired measure that previously tracked PSC's contributions to the Department's goal for a reduction in administrative staff. This measure is intended to track PSC's participation in Department-wide consolidations which addressed the overall Department goal of reducing administrative costs.

In a calculated effort to reduce costs and minimize duplication of effort across HHS, PSC purchased and deployed 22 HSPD-12 mobile Biometric enrollment and 21 Personal Identity Verification (PIV) card issuance stations across the United States and affiliated US territories. This enterprise offered OPDIV and STAFFDIV field offices the opportunity to enroll and receive the new PIV card without having to procure, install and maintain expensive equipment, as well as staff the effort. These networked systems also eliminated the need for personnel to travel to their headquarters' offices for enrollment and PIV card issuance, saving time and money. This effort achieved an approximate savings of $2.5M for the Department during its first eighteen months of operation. Additional savings and benefits followed when other OPDIVs and STAFFDIVs chose Division of Security Services (DSES) at PSC as an HSPD-12 enrollment and issuance service provider. NIH, NDMS, CMS, IHS, OMHA, and the OIG signed memoranda of understanding governing the provision of these services by PSC.

In FY 2010, PSC participated in Department-wide consolidations and achieved the performance target by incorporating the Learning Management System (LMS) and e-Travel under the simplified sign-on HHSIdentity (which will become Access Management System (AMS@HHS) starting October 11, 2010). Full implementation of LMS occurred on December 9, 2010 and e-Travel soon after. With LMS and e-Travel under HHSIdentity (AMS@HHS), employees can log-on to their LMS or e-Travel accounts with a simplified sign-on (SSO) and will not encounter further prompts when they switch applications during a particular session.

PSC decided to discontinue this performance measure in FY 2011 in order to concentrate on metrics that are more closely aligned with the new ASA goals and strategy and have more direct impact on price, service quality and customer satisfaction. Even though this performance measure is discontinued, PSC will continue to support the Department's goal of reducing

administrative costs. For example, PSC has developed a service portfolio strategy in FY 2010 which identifies strategic-growth services, as well as candidates for divestiture. Services identified for divestiture traditionally absorb a higher portion of the administrative cost. The combined effect of divesting from these services and concentrating available resources to grow the designated growth services will result in lower administrative costs, thereby reducing rates to customers.

Performance Measure 1.3.2 (Overhead Costs: Maintain PSC overhead rate to be less than 1.4% of total costs - Target exceeded in FY 2010):

PSC recognizes that it must be prudent in controlling overhead costs (those not involved directly in the performance of our products and services). To achieve this outcome, PSC originally established a performance measure to reduce the resources consumed by overhead to the extent possible while still maintaining required internal support functions.

For both FY 2009 and FY 2010, the performance targets were to maintain an overhead rate of 1.6%. PSC achieved its targets by maintaining a low overhead rate of 1.2% in FY 2009 and 1.1% in FY 2010 by limiting contract costs under the Office of the Director. For FY 2011 and FY 2012, the target for this performance measure is the reduced rate of 1.4%.

Performance Measure 1.3.4 (Employee Satisfaction: Increase the percentage of overall employee satisfaction PSC-wide - Target was not met but improved for FY 2010):

Studies have shown that there is a direct link between employee satisfaction, productivity, and customer satisfaction. As a result, it is essential that PSC monitor employee satisfaction levels because dips in satisfaction may result in lower levels of productivity, which then has a correlation to a potential increase in costs. PSC recognizes the importance of employee satisfaction with respect to the overall success of the organization.

The results of the FY 2010 Employee Viewpoint Survey (EVS) that were released to PSC in August 2010 revealed an overall job satisfaction rating of 69%. Even though PSC did not meet the target of 75%, the employee satisfaction has been steadily increasing in the last few years. The increase in PSC's employee satisfaction was due to employee-centric policies and numerous proactive actions and initiatives. Aside from the High GEAR Program, PSC also conducted All Hands Meetings, implemented an Awards Program and work-life balance programs

Each quarter, PSC conducted an All-Hands Meeting to share vital organization information with PSC staff, and gathered feedback through a post-meeting survey. According to average survey results, 75-80% of respondents viewed meeting topics favorably, indicating that the meetings were an effective forum for learning and providing feedback to PSC leadership. Approximately 80% responded favorably that leadership is engaged and committed to improving the work environment.

More than one-third of all PSC employees participated in a survey conducted on December 7, 2009, used to ascertain supervisors' and employees' perceptions and knowledgebase about the current Employee Awards Program. Survey results indicated that approximately 80% of

employees and 90% of supervisors have received awards while employed by the PSC. Also, perceptions vary between supervisors and employees on whether awards improve morale and performance. Based on these findings, PSC intends to make changes in management and oversight of the PSC awards program, and institute a robust communications and training program.

PSC implemented the Employee Awards and Recognition Program as a means to ensure that managers are aware of their role in rewarding high performance and motivating their employees as well as providing the tools available to support them. The PSC also provided work-life balance programs such as Alternative Work Schedules (AWS) and Child Care Subsidy which began on October 1, 2000.

PSC implemented its Succession Planning Program to ensure it is proactively planning for the loss of employees in mission-critical positions. The Succession Planning Programs help improve job satisfaction through mentoring and training that prepares personnel to assume the responsibilities of vacated mission critical positions.

PSC will continue to measure employee satisfaction as a critical component of its performance management program. PSC will continue to improve human capital processes by focusing on human capital strategy, workforce planning and recruiting, knowledge management, career development, rewards and recognition, succession planning, work-life balance and change management.

In the end, these efforts will assist the PSC in achieving higher levels of satisfaction across the organization and help it achieve the targets of 75% overall job satisfaction for FY 2011 and FY 2012.

Performance Measure 1.3.5 (Cost Recovery: Increase the percentage of cost centers recovering within an established variance and achieving target Net Operating Result (NOR).**Target not met but improved in FY 2010):**

The Cost Recovery performance measure is one of several performance measures with a long-term objective of increasing cost savings to HHS through asset management. As a working capital fund, PSC must fully recover its operating costs with customer revenue at the agency level. However, in order to ensure that this rolled up information is being managed as effectively as possible, PSC also tracks this information at each individual cost center (product/service) level.

The Cost Recovery performance measure enables PSC management to evaluate the performance, cost, and business results of each product line; identify problem areas; and take appropriate action. PSC monitors cost center performance with an expectation that all costs will be covered by revenue recognition.

While PSC continues to strive for full cost recovery at the organizational level and cost center level each year, it realizes that unforeseen circumstances and business fluctuations may alter its operations during the course of the year. Therefore, PSC established its FY 2009 target to have

75%, instead of 100%, of its cost centers recover costs within an established variance. The PSC did not meet its target on this metric in 2009. The performance result was 56% which was a decline of 5% from 2008 and 19% below target. The decrease was mainly due to the challenges brought by the reorganizational realignment.

The result for FY 2010 showed that the target was not met but improved by 6% compared to FY 2009 due to the High GEAR Program initiatives and Cost Center Manager trainings. The Service Portfolio Manager position was created to assist the Service Director to achieve numerous process improvements and the achievement of key metrics including cost recovery. The target of 75% will remain in effect for FY 2011 and FY 2012.

Performance Goal 1.3.6 (Financial Audit: Achieve unqualified audit opinion for the SSF - SSF Audit met in FY 2010)

A key component in managing PSC's costs is to monitor its financial data and ensure that we meet financial reporting requirements. Achieving an unqualified audit opinion from independent auditors is a significant performance measure of how PSC implements financial and management controls and maintains its financial records. Based on government-wide standards, PSC has adopted a measure that targets a clean, unqualified audit opinion.

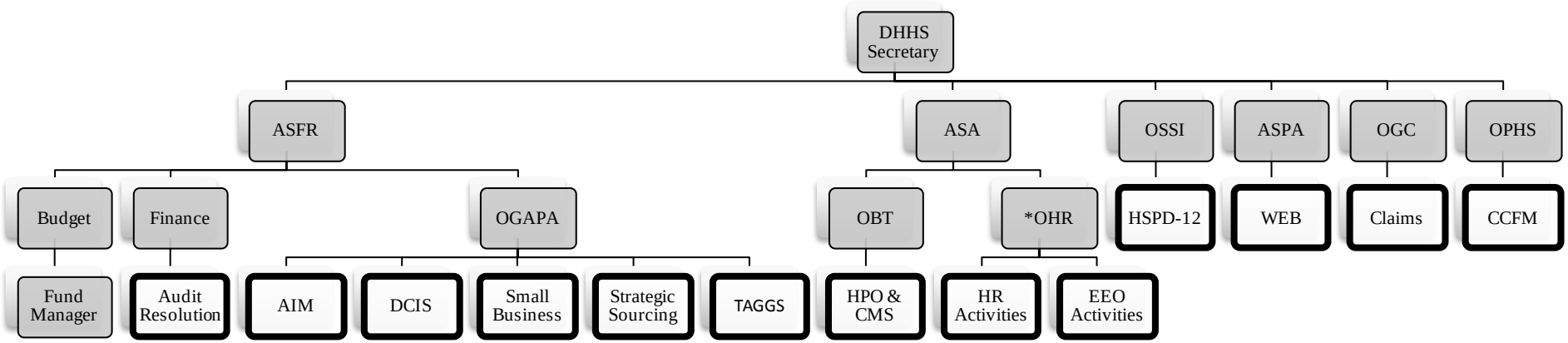
Effective FY 2008, the SSF fund was audited instead of a PSC-specific audit. The Service and Supply Fund Board approved the expansion with the support of the Department's CFO. In FY 2008, PSC received an unqualified "clean" opinion of the SSF balance sheet, with no material weaknesses and reportable conditions. Due to the large scale of PSC's financial operations and fiduciary responsibility, the successful FY 2008 audit results demonstrated PSC's continued commitment to its customers and its ability to manage and achieve positive results.

The FY 2009 SSF Audit completed in March 2010 resulted in a clean opinion of the balance sheet and the related statements of net cost and changes in net position. The clean opinion on FY 2009 SSF financial statements substantiated liquidity, financial flexibility and financial management efficiencies. PSC once again achieved an unqualified audit opinion in FY 2010 for the Service Supply Fund. The successful FY 2010 audit results demonstrated again, PSC's continued commitment to its customers and its ability to manage and achieve positive results. The target for the SSF-wide audit performance measure will remain the same for FY 2011 and FY 2012.

FY 2012 Congressional Justification

Supplementary Materials

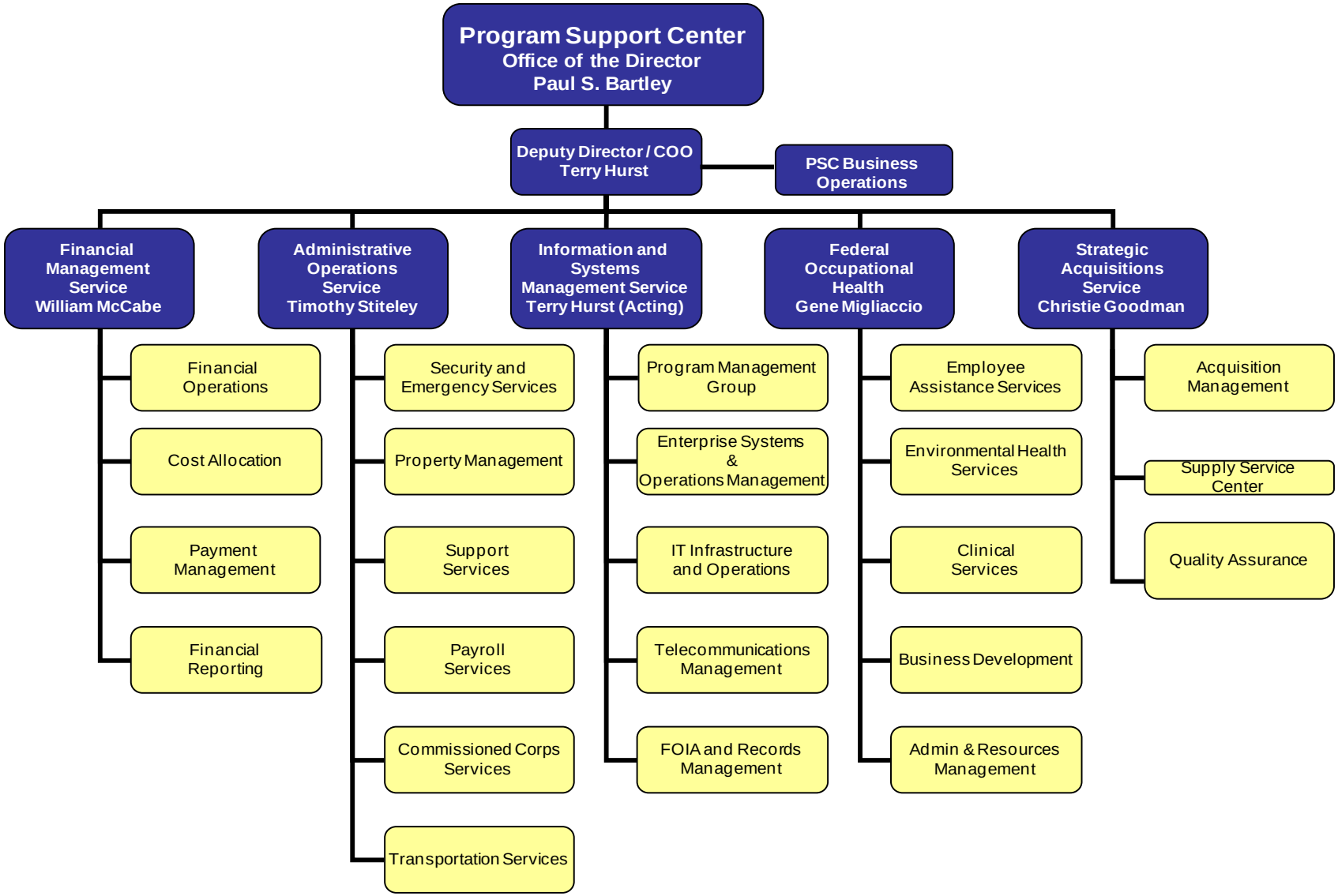
SERVICE AND SUPPLY FUND
NON-PSC ACTIVITIES



Key:
ASFR – Associate Secretary for Financial Resources
ASA – Associate Secretary for Administration
OSSI – Office of Security and Strategic Information
OGC – Office of the General Counsel
OPHS – Office of the Public Health Service
OGAPA – Office of Grants and Acquisitions Policy and Accountability
OBT – Office of Business Transformation
OHR – Office of Human Resources
HSPD-12 – Homeland Security Residential Directive-12
CCFM – Commissioned Corps Force Management
TAGGS – Tracking Accountability in Government Grants System
AIM – Acquisition Integration and Modernization
HPO & CMS – High Performing Organizations and Commercial Services Management
EEO – Equal Employment Opportunity
SSF Activities are outlined in bold.

*Organizationally, the Office of Human Resources (OHR) is part of the Office of the Assistant Secretary for Administration (ASA) as is the Program Support Center (PSC). However, so that our budget tables remain comparable from year to year, OHR is reflected under the PSC in the budget.

Program Support Center Organization Structure



Department of Health and Human Services
Service and Supply Fund
(Dollars in Thousands)

Service and Supply Fund Activities	FY 2010 Actual	FY 2011 Program Level*	FY 2012 Board Approved	FY 2012+/- FY 2011
PSC				
Administrative Operations Service [1/]	332,635	384,465	392,644	8,179
Federal Occupational Health Service	146,833	166,680	172,652	5,972
Financial Management Service	59,094	64,542	67,757	3,215
Info. & Systems Mgmnt Service	164,353	172,944	176,499	3,555
Strategic Acquisitions [2/]	102,233	162,257	168,679	6,422
HR Centers, HHSU & EEO Services [1/]	66,536	70,056	68,171	(1,885)
Unfilled Customer Orders	-	70,976	-	(70,976)
PSC Reserves	22,711	9,932	-	(9,932)
PSC Subtotal	894,395	1,101,852	1,046,402	(55,450)
Non-PSC				
AIM	816	1,127	1,127	-
Audit Resolution	1,321	1,506	1,568	62
CCFM	15,835	24,770	25,236	466
DCIS	1,017	1,245	1,865	620
HPO & Commercial Services Mgmnt	263	287	287	-
IAM@HHS (HSPD-12)	7,896	13,136	14,477	1,341
OGC Claims	1,114	1,263	1,320	58
Small Business Consolidation (OSDBU)	2,178	2,818	2,818	-
Strategic Sourcing [2/]	-	766	766	-
TAGGS	468	1,405	2,125	720
Web Communications	10,263	11,084	11,084	-
Non-PSC Reserves	1,697	6,117	-	(6,117)
Non-PSC Subtotal	42,868	65,523	62,673	(2,850)
Total SSF Revenue	937,263	1,167,375	1,109,075	(58,300)

[1/] Equal Employment Opportunity Cost center moved from the PSC (AOS) to a Non-PSC (ASA) activities in FY 2011. This transfer was approved by the Board on July 7, 2010. Effective November 22, 2010, EEO was realigned into the Office of Human Resources. FY 2010 actuals are reflected in Administrative Operation Services.

[2/] Strategic Sourcing cost center moved from the PSC (SAS) to a Non-PSC (OGAPA) activities in FY 2011. This transfer was approved by the Board on July 7, 2010. FY 2010 actuals are reflected in Strategic Acquisition Services.

*FY 2011 column includes $87.025m in unfilled customer orders and funded reserve activities.

OPDIV Share of SSF Budget

(Dollars in Thousands)

	FY 2011			FY 2012			
	PSC	**Non-PSC**	**Total**	**PSC**	**Non-PSC**	**Total**	**+/- Total FY 2011**
ACF	29,665	3,986	33,651	30,546	3,986	34,532	881
AoA	3,095	375	3,470	3,167	386	3,553	83
AHRQ	6,017	828	6,845	6,161	837	6,998	153
CDC	50,459	24,003	74,462	51,768	23,966	75,734	1,272
CMS	13,717	10,836	24,553	13,858	10,750	24,608	55
FDA	47,653	30,225	77,878	46,595	29,898	76,493	(1,385)
HRSA	30,361	4,912	35,273	31,536	5,106	36,642	1,369
IHS	26,973	16,878	43,851	27,529	17,617	45,146	1,295
NIH	50,556	14,661	65,217	51,831	15,355	67,186	1,969
SAMHSA	9,661	1,976	11,637	9,948	2,052	12,000	363
OS	85,877	11,266	97,143	93,141	11,185	104,326	7,183
PSC	44,309	3,183	47,492	45,869	2,946	48,815	1,323
Non-HHS	552,542	6,336	558,878	566,283	6,759	573,042	14,164
Total Budget			**1,080,350**			**1,109,075**	**28,725**

Object Classification - Reimbursable Obligations
Service & Supply Fund
(Dollars in Thousands)

Object Class	FY 2010 Actual	FY 2011 Program Level	FY 2012 Board Approved
Direct Obligations			
Personnel compensation:			
Full-time permanent (11.1)	105,810	119,750	123,897
Other than full-time permanent (11.3)	3,802	4,850	5,000
Other personnel compensation (11.5)	3,524	3,524	4,252
Military personnel (11.7)	8,698	9,675	10,890
Special personnel services payments (11.8)	10,186	11,253	11,253
Subtotal personnel compensation	**132,020**	**149,052**	**155,292**
Civilian benefits (12.1)	30,289	36,695	38,025
Military benefits (12.2)	4,687	8,175	5,635
Benefits to former personnel (13.0)		325	
Subtotal Pay Costs	**166,996**	**194,247**	**198,952**
Travel and transportation of persons (21.0)	2,274	4,675	4,500
Transportation of things (22.0)	3,907	3,907	3,907
Rental payments to GSA (23.1)	16,787	19,150	19,755
Rental payments to others (23.2)	303	61	63
Communication, utilities, and misc. charges (23.3)	38,670	45,695	45,695
Printing and reproduction (24.0)	2,303	1,000	1,000
Other Contractual Services:			
Advisory and assistance services (25.1)	32,546	44,158	34,175
Other services (25.2)	476,467	598,813	571,715
Purchase of goods and services from			
government accounts (25.3)	52,393	86,100	54,755
Operation and maintenance of facilities (25.4)	5,367	6,370	6,553
Research and Development Contracts (25.5)			
Medical care (25.6)	19,400	24,412	24,412
Operation and maintenance of equipment (25.7)	69,025	88,105	89,123
Subsistence and support of persons (25.8)	6,388		
Subtotal Other Contractual Services	**661,586**	**847,958**	**780,733**
Supplies and materials (26.0)	34,105	37,846	40,733
Equipment (31.0)	9,674	9,674	10,750
Land and Structures (32.0)			
Investments and Loans (33.0)	581	3,162	3,287
Grants, subsidies, and contributions (41.0)	77		
Interest and dividends (43.0)			
Refunds (44.0)			
Subtotal Non-Pay Costs	**770,267**	**973,128**	**910,423**
Total Direct Obligations	**937,263**	**1,167,375**	**1,109,375**

FY 2012 Budget Submission
Service and Supply Fund Activities
Statement of Personnel Resources

	Total Full-Time Equivalents (Workyears)								
	FY 2010 Actuals			FY 2011 Estimate			FY 2012 Estimate		
	Civilian	Military	Total	Civilian	Military	Total	Civilian	Military	Total
Reimbursable:									
PSC Activities:									
Administartive Operations Service	213	8	221	214	8	222	217	8	225
Federal Occupational Health Service	52	53	105	53	53	106	53	53	106
Financial Management Service	202		202	231		231	231		231
Information and Systems Management Service	126		126	136		136	136		136
Strategic Acquisitions Service	105	2	107	108	2	110	108	2	110
Office of the Director	32		32	32		32	32		32
Total Reimbursable PSC FTEs	**730**	**63**	**793**	**774**	**63**	**837**	**777**	**63**	**840**
Non-PSC Activites									
AIM	-		-	-		-	-		-
Audit Resolution	8		8	8		8	8		8
Commissioned Corps Force Management	17	53	70	31	53	84	31	53	84
DCIS	1		1	2		2	2		2
HPO & CSM	3		3	3		3	3		3
HR Services	427		427	375		375	372		372
- EEO Services [1/]	-		-	8		8	8		8
HSPD - 12 O&M	3	1	4	3	1	4	3	1	4
OGC Claims	8		8	8		8	8		8
Small Business Consolidation	12		12	13		13	13		13
Strategic Sourcing	-		-	2		2	2		2
TAGGS	2		2	5		5	5		5
Web Communications Division	25		25	28		28	28		28
Fund Manager	7		7	7		7	7		7
Total Reimbursable Non-PSC FTEs	**513**	**54**	**567**	**493**	**54**	**547**	**490**	**54**	**544**
Total Reimbursable SSF FTEs	**1,243**	**117**	**1,360**	**1,267**	**117**	**1,384**	**1,267**	**117**	**1,384**

[1/] EEO Services realigned with OHR.

Retirement Pay and Medical Benefits for Commissioned Officers

TABLE OF CONTENTS

Appropriation Language

The Program Support Center has responsibility for the administration of the retirement pay for commissioned officers. The appropriations language for that account follows.

Retirement Pay and Medical Benefits for Commissioned Officers

For retirement pay and medical benefits of Public Health Service Commissioned Officers as authorized by law, for payments under the Retired Serviceman's Family Protection Plan and Survivor Benefit Plan, and for medical care of dependents and retired personnel under the Dependent's Medical Care Act (10 U.S.C. ch. 55), such amounts as may be required during the current fiscal year.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Amounts Available for Obligation

Total, Mandatory Appropriation

	FY 2010 Actual	FY 2011 Estimate	FY 2012 President's Budget Request
Mandatory Appropriation [1]	$440,862,268	$ 517,537,000	$564,505,000
Unobligated Balance, start of year			
Unobligated Balance, end of year [2]	20,286,618		
Unobligated Balance, lapsing			
Total Obligations	$461,148,886	$517,537,000	$564,505,000

[1] Includes Retirement Payments, Survivor Benefits, and Medical Care.
[2] This reflects an upward adjustment in the amount of $20M to the FY 2010 end of year actual. This adjustment is needed to pay out any additional FY 2010 medical claims received in FY 2011.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Accrued Medical Amount Available for Obligation

Amounts Available for Obligation

	FY 2010 Actual	FY 2011 Estimate	FY 2012 President's Budget Request
Total, Discretionary Appropriation	$ 35,589,736	$ 38,088,000	$ 38,614,000
Unobligated Balance, start of year			
Unobligated Balance, end of year			
Unobligated Balance, lapsing			
Total Obligations	$ 35,589,736	$ 38,088,000	$ 38,614,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay, Medical Benefits and Accrued Health Care Benefits for Commissioned Officers

Summary of Changes

2011 Estimate……...	$555,625,000
2012 Request…….	$603,119,000
Net change……..	+47,494,000

	FY 2011 Current Estimate Base		Change from Base	
	FTE	BA	FTE	BA
Changes:				
1. Annualization of the FY 2012 COLA, 1.6% COLA in FY 2011, and for the projected net increase of retirees during FY 2011.	---	$386,041,000	---	+$32,041,000
2. Annualization of the FY 2012 COLA, 1.6% COLA in FY 2011, and projected net increase in average costs per survivor in FY 2011	---	27,888,000	---	+3,737,000
3. Will only cover medical benefits for Officers under age 65. Costs do include a projected increase of 11.7% in medical care costs for these Officers.	---	103,608,000	---	+11,190,000
4. Will cover Medicare Eligible Accrual Benefits for Officers under age 65.	---	38,088,000	---	+526,000
Net change			---	+$47,494,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Budget Authority by Activity

	FY 2010 [3] Actual	FY 2011[4] Estimate	FY 2012[5] President's Budget Request
Retirement payments	$343,614,870	$386,041,000	$418,082,000
Survivors' benefits	23,893,143	27,888,000	31,625,000
Medical care [6]	73,354,255	103,608,000	114,798,000
Total Retired Pay	$440,862,268	$517,537,000	$564,505,000
Medicare Eligible Accruals	35,589,736	38,088,000	38,614,000
Total	$476,452,004	$555,625,000	$603,119,000

[3] FY10 – The DoD Office of the Actuary letter dated 7/24/08 set the PHS FY10 per capita amount for the DoD MERHCF at $5642 for full-time members.
[4] FY11 – The DoD Office of the Actuary letter dated 8/19/09 set the PHS FY11 per capita amount for the DoD MERHCF at $5673 for full-time members.
[5] FY12 – The DoD Office of the Actuary letter dated 8/19/10 set the PHS FY12 per capita amount for the DoD MERHCF at $5580 for full-time members.
[6] Medical benefits from FY 2010 were revised from $73M to $93M. This reflects an upward adjustment in the amount of $20M to the FY 2010 end of year actual. This adjustment is needed to pay out any additional medical claims received in FY 2011.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Budget Authority by Object

	FY 2010 Actual	FY 2011 Estimate	FY 2012 President's Budget Request	Increase/ Decrease
Benefits for former Personnel	$461,148,886	$517,537,000	$564,505,000	+$46,968,000
Accrued Health Care Benefits	35,589,736	38,088,000	38,614,000	+526,000
Total budget authority by object	$496,738,622	$555,625,000	$603,119,000	+$47,494,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Authorizing Legislation

	FY 2011 Amount Authorized	FY 2011 Estimate	FY 2012 Amount Authorized	FY 2012 President's Budget Request
1. Retirement payments Chapter 6A of Title 42, U.S.C.	Indefinite	$386,041,000	Indefinite	$418,082,000
2. Survivors' benefits Chapter 73 of Title 10, U.S.C.	Indefinite	27,888,000	Indefinite	31,625,000
3. Medical care Chapter 55 Of Title 10 U.S.C., P.L. 89-614; P.L.106-398; P.L. 107-107.	Indefinite	103,608,000	Indefinite	114,798,000
4. Medicare Eligible Accruals, Chapter 55 Of Title 10 U.S.C., P.L. 108-375	Indefinite	38,088,000	Indefinite	38,614,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Appropriations History Table

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2002	242,577,000	242,577,000	242,577,000	273,478,000
2003	251,039,000	251,039,000	251,039,000	291,471,000
2004	308,763,000	308,763,000	308,763,000	321,083,000
2005	324,636,000	324,636,000	324,636,000	343,885,000
2006	363,029,000	363,029,000	363,029,000	363,029,000
2007	377,982,000	377,982,000	377,982,000	406,967,000
2008	439,907,000	439,907,000	439,907,000	438,053,000
2009	469,472,000	469,472,000	469,472,000	484,685,000
2010	510,147,000	510,147,000	510,147,000	496,738,622
2011	555,007,000	555,625,000	555,625,000	555,625,000
2012	603,119,000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Justification

A. Account Summary

	FY 2010 Actual	FY 2011 Estimate	FY 2012 President's Budget Request	Increase or Decrease
Retirement payments	$343,614,870	$386,041,000	$418,082,000	+$32,041,000
Survivors' benefits	23,893,143	27,888,000	31,625,000	+3,737,000
Medical care [7]	73,354,255	103,608,000	114,798,000	+11,190,000
Medicare Eligible Accruals	35,589,736	38,088,000	38,614,000	+526,000
Total budget authority	$476,452,004	$555,625,000	$603,119,000	+$47,494,000

B. General Statement

This appropriation provides for retirement payments to Public Health Service (PHS) officers who are retired for age, disability, or a specified length of service as well as for payments to survivors of deceased retired officers who had elected to receive reduced retirement payments.

This account also funds the provision of medical care to active duty and retired members of the PHS Commissioned Corps, and to dependents of active duty, retired and deceased members of the PHS Commissioned Corps.

The FY 2012 request is a net increase of $47,494,000 over the FY 2011 level. This amount reflects increased medical benefits costs, an annualization of amounts paid to retirees and survivors in FY 2010, and a net increase in the number of retirees and survivors during FY 2010. The budget request includes a cost-of-living adjustment (COLA) of 1.6 percent.

[7] Medical benefits from FY 2010 were revised from $73M to $93M. This reflects an upward adjustment in the amount of $20M to the FY 2010 end of year actual. This adjustment is needed to pay out any additional medical claims received in FY 2011.

C. Retirement Payments

Authorizing legislation - Chapter 6A of Title 42 U.S.C.

FY 2010 Actual	FY 2011 Estimate	FY 2012 President's Budget Request	Increase or Decrease
$343,614,870	$386,041,000	$418,082,000	+$32,041,000

2012 Authorization..... Indefinite

Purpose and Method of Operation

The purpose of this activity is to provide mandatory payments to Commissioned Officers of the Public Health Service who have been retired for age, disability or specified length of service.

Funding levels for the past five fiscal years were as follows:

2007…….……	292,249,000
2008…….……	303,912,000
2009…….……	333,318,000
2010…….……	343,614,870
2011…….……	386,040,000

Rationale for the FY 2012 Budget Request

The FY 2012 request of $418,082,000 is an increase of $32,041,000 over the FY 2011 level and will support payments to an estimated 5495 annuitants. The increase will fund the annualization costs of the FY 2011 COLA, an FY 2012 COLA of 1.6 percent, and the projected net increase of 105 retirees during FY 2012.

The FY 2012 estimates are based on payments to the following number of retirees:

Period Ending	Total	Net Increase/(Decrease)
September 30, 2010, (act.)	5317	123
September 30, 2011, (est.)	5470	153
September 30, 2012, (est.)	5495	25

D. Survivors' Benefits

Authorizing legislation - Chapter 73 of Title 10 U.S.C.

FY 2010 Actual	FY 2011 Estimate	FY 2012 President's Budget Request	Increase or Decrease
$25,893,143	$27,888,000	$31,625,000	+$3,737,000

2012 Authorization..... Indefinite

Purpose and Method of Operation

This activity provides for the payment of annuities to survivors of retired officers who had elected to receive reduced retirement payments under the Retired Serviceman's Family Protection Plan and Survivor's Benefit Plan. This program is financed by the Federal Government although deductions are made in the retirement payments to the officers who elect the option of survivors' benefits.

Funding levels for the past five years were as follows:

2007…….	18,004,000
2008…….	21,400,000
2009…….	24,247,000
2010…….	23,893,143
2011…….	27,888,000

Rationale for the FY 2012 Budget Request

The FY 2012 request of $31,625,000 is an increase of $3,737,000 from the FY 2011 level and will provide payments for an estimated 985 annuitants. This amount includes funds for the annualization costs of the FY 2011 COLA and the FY 2012 COLA of 1.6 percent, and the projected net increase of 35 annuitants during FY 2012.

The FY 2012 estimates are based on payments to the following numbers of annuitants:

Period Ending	Total	Net Increase/(Decrease)
September 30, 2010, (act.)	945	19
September 30, 2011, (est.)	950	5
September 30, 2012, (est.)	985	35

E. Medical Care

Authorizing legislation - Chapter 55 of Title 10 U.S.C.; P.L. 106-398; and P.L. 107-107.

FY 2010[8] Actual	FY 2011 Estimate	FY 2012 President's Budget Request	Increase or Decrease
$73,354,255	$103,608,000	$114,798,000	+$11,190,000

2012 Authorization..... Indefinite

Purpose and Method of Operation

This program provides for the cost of medical care rendered in non-Federal and in uniformed service facilities to active duty and retired PHS commissioned officers and dependents of eligible personnel.

This activity fulfills the mandatory medical care obligations of the Public Health Service to Commissioned Officers and their dependents. Medical care to eligible beneficiaries is authorized under the Dependents' Medical Care Act, as amended by P.L. 89-614, which allows for an expanded and uniform program of medical care to active duty and retired members of the uniformed services, and dependents of active duty, retired and deceased members. Health care provided in a uniformed service facility is billed directly to the Public Health Service by that organization. When medical care is provided to dependents or retirees in a private facility, the Civilian Health and Medical Program of the Uniformed Services (TRICARE) acts as the Government's agent to arrange payment and, in turn, bills the Public Health Service for the services rendered. In addition, contract medical care is arranged for active duty officers who are not stationed in an area accessible to uniformed facilities.

Funding levels for the past five years were as follows:

	Total Funding Level
2007	65,998,000
2008	76,100,000
2009	92,341,000
2010	73,354,255
2011	103,608,000

[8] Medical benefits from FY 2010 were revised from $73M to $93M. This reflects an upward adjustment in the amount of $20M to the FY 2010 end of year actual. This adjustment is needed to pay out any additional medical claims received in FY 2011.

Rationale for FY 2012 Budget Request

The request of $114,798,000 will provide medical care for under age 65 beneficiaries. The FY 2012 request reflects increases in the cost of drugs and inpatient and outpatient care for all beneficiaries in Federal and non-Federal facilities.

The FY 2012 estimates are based on payments to the following numbers of active duty officers:

Period Ending	Total	Net Increase/(Decrease)
September 30, 2010, (act.)	6,584	273
September 30, 2011, (est.)[9]	6,822	238
September 30, 2012, (est.)	6,920	98

[9] The accrual contribution calculation was based on 6,714 Commissioned Corp active duty officers for FY 2011.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROPOSED GENERAL PROVISIONS
FOR FISCAL YEAR 2012

The President's Budget recommends that a number of general provisions be included in the FY 2012 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. This provision authorizes not to exceed $50,000 in appropriated funds may be used for official reception and representation expenses that are specifically approved by the Secretary.

Sec. 202. This provision enables the Secretary to assign not more than 60 Public Health Service employees 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 Nation's International Children's Emergency Fund or the World Health Organization.

Sec. 203. This provision states that no 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.

(TRANSFER OF FUNDS)

Sec. 204. This provision allows the Secretary to use not more than 3.2 percent of any appropriations authorized under the Public Health Service Act for evaluation (directly, or by grants or contracts) of the implementation and effectiveness of the Public Health Service Act programs.

(TRANSFER OF FUNDS)

Sec. 205. This section provides that not to exceed 1 percent of discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985) appropriated for the current fiscal year for the Department of Health and Human Services in this Act may be transferred between appropriations, with a limitation that no such appropriation may be increased by more than 3 percent, and that an appropriation may be increased by up to an additional 2 percent after notification of the Appropriations Committees in both the House and Senate. The Appropriations Committees of both the House and Senate are to be notified at least 15 days in advance of any transfer.

(TRANSFER OF FUNDS)

Sec. 206. This provision states that the Director of the National Institutes of Health, 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 House and Senate Appropriations Committees are notified at least 15 days in advance of any transfer.

Sec. 207. This section provides that the amount for research related to the human immunodeficiency virus at the National Institutes of Health, as jointly determined by the Director of the National Institutes of

Health and the Director of the Office of AIDS Research, shall be available to the "Office of AIDS Research" account and that the Director of the Office of Aids Research shall transfer from the account amounts necessary to carry out section 2353(d)(3) of the Public Health Service Act.

Sec. 208. This provision states that none of the funds appropriated in this Act may be made available to any entity under title X of the Public Health Service Act unless the award applicant certifies to the Secretary of Health and Human Services that it encourages family participation in decisions of minors to seek family planning services and provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.

Sec. 209. This section allows that no provider of services under title X of the Public Health Service Act shall be exempt from State laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape or incest.

Sec. 210. This provision provides that none of the funds appropriated by this Act, including trust funds, may be used to carry out the Medicare Advantage program if the Secretary of Health and Human Services denies an otherwise eligible entity participation in the program 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), and 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. This provision provides authority to support HHS in carrying out international HIV/AIDS and other infectious disease, chronic and environmental disease and other health activities abroad during fiscal year 2012.

Sec. 212. This provision provides authority for the Office of the Director of the National Institutes of Health (NIH) to enter into transactions (other than contracts, cooperative agreements, or grants) in order to implement the NIH Common Fund, in lieu of the peer review and advisory council review procedures that would otherwise be required. The Director of NIH may utilize such peer review procedures as determined appropriate to obtain assessments of scientific and technical merit.

Sec 213. This provision provides that funds are available for Individual Learning Accounts for employees of the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ASTR) and may be transferred to Disease Control, Research and Training, to be available only for Individual Learning Accounts; provided that the funds are used while such employee is employed by either CDC or ASTR.

Sec. 214. This section allows funds made available in this Act to be used to continue operating the Council on Graduate Medical Education established by section 301 of Public Law102-408.

(TRANSFER OF FUNDS)

Sec. 215. This provision provides authority not to exceed $35,000,000 the amount of funds appropriated by this Act to the Institutes and Centers of the National Institutes of Health that 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 $2,500,000 per project.

Sec. 216. This provision provides that 1 percent of the funds made available for the National Institutes of Health National Research Service Awards (NRSA) will be available to the Administrator of the Health Resources and Services Administration for NRSA awards for research in primary medical care; 1 percent of the amount made available for NRSA is to be available to the Director of the Agency for Healthcare Research and Quality to make NRSA awards for health service research.

Sec. 217. This provision provides that the Health Education Assistance Loan (HEAL) program and the authority to administer such program, shall be permanently transferred from the Secretary of Health and Human Services to the Secretary of Education.

Sec. 218. Hereafter, no funds appropriated in this or any other act, in this or any subsequent fiscal year, shall be available for transfer under section 274 of the Public Health Service Act.

Sec. 219. Hereafter, no funds appropriated in this or any other act, in this or any subsequent fiscal year, shall be subject to the allocation requirements of section 1707A(e) of the Public Health Service Act.

Sec. 220. 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. 221. Of discretionary funds appropriated for the current fiscal year for the Department of Health and Human Services, not to exceed $5,000,000 may be transferred to the Department of Housing and Urban Development to support an interagency neighborhood revitalization program. Note.—A full year 2011 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 111-242, as amended). The amounts included for 2011 reflect the annualized level provided by the continuing resolution.

Title V

Sec. 501. This provision authorizes the Secretaries of Labor, Health and Human Services, and Education to transfer unexpended balances of prior appropriations to accounts corresponding to those included in this Act as long as the balances are used for the same purpose and the same period of time they were originally appropriated.

Sec. 502. This section states that no appropriation contained in this Act shall remain available for obligation for a period beyond the current fiscal year, unless it is expressly stated in this Act.
Sec. 503. This provision provides that:

(a) Except for normal and recognized executive-legislative relationships, no part of any appropriation in this Act shall be used for publicity or propaganda, preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio or TV broadcast or film presentation designed to support or defeat legislation pending before the Congress or any State legislature, except as a presentation to the Congress or any State legislature itself.

(b) No part of any appropriation in this Act be used to pay the salary or expenses of any grant or contract recipient (or their agent) related to activities designed to influence legislation or appropriations pending before the Congress or any State legislature.

Sec. 504. This provision provides the amounts available to the Secretaries of Labor and Education, the Director of the Federal Mediation and Conciliation Service, and the Chair of the National Mediation Board, from their respective Salaries and Expenses accounts, for official reception and representation expenses.

Sec. 505. This provision provides that no funds appropriated under this Act may be used to carry out a program of distributing sterile needles for the hypodermic injection of any illegal drug.

Sec. 506. This provision provides that all Federal grantees (including State and local governments and recipients of Federal research grants) issuing press releases, requests for proposals and other documents describing projects or proposals supplied with Federal money clearly state the following: (1) the percentage of total costs of the program or project financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) the percentage and dollar amount of the total cost to be financed by non-governmental sources.

Sec. 507. This provision provides that none of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, may be expended for abortion or for health benefits coverage that includes coverage of abortion. 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. The limitations established in the preceding section shall not apply to an abortion:

(a) If the pregnancy is the result of an act of rape or incest; or 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 the 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 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) None of the funds may be available to any Federal program, agency or State and local government, if said institution subjects the individual or health care entity to discrimination on the basis that the health care entity does not provide coverage of, or referrals for abortions. Further, the section defines the term "health care entity."

Sec. 509. This section provides that none of the funds made available in this Act to be used for creation of a human embryo, embryos for research, or research in which a human embryo or embryos is destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under the Public Health Service Act. For the purposes of this section, human embryo or embryos include any organism derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

Sec. 510. This provision provides that none of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or controlled substance except when there is significant medical evidence of therapeutic advantage to the use of such drug or other substance, or Federally-sponsored clinical trials are being conducted to determine therapeutic advantage.

Sec. 511. This provision provides that 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. This provision provides that none of the funds made available in this Act may be used to enter into or renew a contract with a contractor with the U.S. Government who is subject to section 4212(d) of title 38, United States Code, but has not submitted the most recent annual report required by that section to the Secretary of Labor, detailing the employment of certain veterans.

Sec. 513. This provision affects the Department of Education and pertains to a library's eligibility for funding under the Library Services and Technology Act, as amended by the Children's Internet Protections Act.

Sec. 514. This provision prescribes that none of the funds made available to carry out part D of title II of the Elementary and Secondary Education Act of 1965 may be made available to elementary or secondary schools covered by paragraph (1) of section 2441(a), 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.

Sec. 515. This provision provides that none of the funds appropriated in this Act may 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 claims for credits for quarters 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. This provision provides that none of the funds made available in this Act may be used for first-class travel by the employees of agencies funded by this Act in contravention of sections 301-10.124 of Title 41, Code of Federal Regulations.

Sec. 517. This provision provides for an additional amount for the "Social Security Administration Limitation on Administrative Expenses account of $1,863,280 to increase the Social Security Administrations acquisition workforce capacity and capabilities provided that such funds may be transferred by the Commissioner to any other account in the Social Security Administration provided herein.

Sec. 518. This provision provides authorities to the Department of Labor and the Department of Education in implementing the Workforce Innovation Fund.

Sec. 519 This provision transfers the Older American Community Service Employment Program from the Department of Labor to the Department of Health and Human Services.