Goal Two: Advance Scientific Knowledge and Innovation

HHS is expanding its scientific understanding of how best to advance health care, public health, human services, biomedical research, and to ensure the availability of safe medical and food products. Chief among these efforts is the identification, implementation, and rigorous evaluation of new approaches in science, health care, public health, and human services that encourage efficiency, effectiveness, sustainability, and sharing or translating that knowledge into better products and services.

Goal Two includes four objectives:

- Accelerate the process of scientific discovery to improve health
- Foster and apply innovative solutions to health, public health, and human services challenges
- Advance the regulatory sciences to enhance food safety, improve medical product development, and support tobacco regulations
- Increase our understanding of what works in public health and human service practice
- Improve laboratory, surveillance, and epidemiology capacity

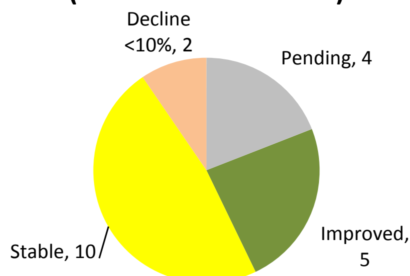
Whole Genome Sequencing

CDC now has almost two years of data on the impact of Advanced Molecular Detection (AMD) technologies (specifically, whole genome sequencing, or WGS) on foodborne listeriosis. Since the adoption of WGS, the number of outbreaks detected has increased by 50% while the number of cases per outbreak has decreased by 50%. Outbreaks are being detected earlier and the number of cases linked to specific food sources has increased 15-fold.

About one-third of breast cancer patients eventually develop metastases, or tumors formed by cancer cells that have spread to other organs. Screening is an important aspect of follow-up care for breast cancer patients, and early detection of recurrence is critical in tailoring appropriate and effective treatments. The earliest signs of cancer spread are called micrometastases, which are often too small to be detected with standard screening. However, there is a promising development based on recent NIH-funded research. Using a biochemical approach researchers developed a probe that combined with magnetic resonance imaging (MRI) successfully detected very tiny tumors of just a few hundred cells, or as small as one-hundredth of an inch, in mice. This technique also has the potential to differentiate aggressive tumors from low-risk tumors. The researchers are conducting additional work with the goal of testing this technique in human trials. If successful, this technique may offer an improved way to detect early metastatic spread, which would allow adaptation of treatment more quickly and lead to better outcomes for patients.

FDA microbiologists are evaluating and integrating commercially available instrumentation into its microbiological testing workflow that is vastly improving the ability of FDA to more quickly and effectively detect and characterize foodborne pathogens such as Salmonella directly from the food supply. Improvements in sample throughput, along with the high degree of sensitivity and specificity built into new pathogen detection technologies, will dramatically improve FDA's foodborne response and traceback capabilities. When fully deployed, technologies such as next-generation whole-genome sequencing (WGS) and others will reduce the time to conduct these analyses from 14 days originally to just a few days. One updated technology which provides highly accurate and rapid Salmonella serotype results for FDA, known as the flow cytometry/fluorescence platform, has been validated extensively and is now deployed in nearly all FDA field laboratories, as well as in CFSAN and CVM laboratories. In FY 2015, FDA exceeded the target of four working days, reducing the average number of days to serotype priority pathogens in foods to three working days, which is the minimum amount of time required. The proposed target for FY 2016 and FY 2017 is three working days, which will maintain the level achieved in FY 2015.

Goal 2: Summary of Measure Progress (number of measures)



For this goal, 88 percent of measures with available data showed stable or improved performance.

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

HHS strives to promote the health, economic, and social well-being of children, people with disabilities, and older adults while improving wellness for all. To meet this goal, the Department is employing evidence-based strategies to strengthen families and to improve outcomes for children, adults, and communities. Underlying each objective and strategy associated with this goal is a focus on prevention.

Goal Three includes six objectives:

- Promote the safety, well-being, and healthy development of children and youth
- Promote economic and social well-being for individuals, families, and communities
- Improve the accessibility and quality of supportive services for people with disabilities and older adults
- Promote prevention and wellness across the life span
- Reduce the occurrence of infectious diseases
- Protect Americans' health and safety during emergencies, and foster resilience in response to emergencies

Improving the Quality of Head Start Programs

The Improve the Quality of Early Childhood Education Priority Goal calls for actions to improve the quality of programs for children of low-income families, including the Head Start program. One indicator for this Priority Goal is to decrease the proportion of grantees receiving a score in the low range of the Classroom Assessment Scoring System (CLASS: Pre-K). The CLASS measures teacher-child interaction in three broad domains: Emotional Support, Classroom Organization, and Instructional Support. During the FY 2014-15 school year, 22 percent of grantees scored in the low range, thus exceeding the target of 26 percent. All grantees scoring in the low range did so for the Instructional Support domain.

While smoking among adults in the U.S. has decreased significantly from a decade ago, the decline in adult smoking rates has slowed, concurrent with reductions in state investments in tobacco control programs. However, the coordinated efforts of the Agency Priority Goal to reduce tobacco use have resulted in reductions in adult cigarette consumption. The latest FY 2014 data shows that the annual per capita adult cigarette consumption fell to 1,216; missing the FY 2014 target of 1,212 by only four cigarettes. This reduction represents an approximate 9% decrease from the FY 2012 baseline of 1,342. The FY 2015 results will be available in July of 2016. The FY 2014 results of other combustible tobacco use indicators are tracking lower usage across both adults and youth:

- Percentage of adult smokers - 16.8%; exceeding the FY 2014 target of 18% (National Health Interview Survey)
- Percentage of adult smokers last smoked 6 months to 1 year ago – 7.6%; exceeding the FY 2014 target of 7.2% (National Health Interview Survey)
- Percentage of children/adolescents initiation – 3.8%; exceeding the FY 2014 target of 4.7% (National Survey on Drug Use and Health)
- Percentage of young adults initiation – 6.6%; exceeding the FY 2014 target of 7.2% (National Survey on Drug Use and Health)

These national trends and the continued plans of the Department to address combustible tobacco use make the continuation of the APG into FY 2016-FY 2017 achievable.

Salmonella is the leading known cause of bacterial foodborne illness and death in the U.S. Each year in the U.S., Salmonella causes an estimated 1.2 million illnesses and between 400 and 500 deaths. Salmonella serotype enteritidis (SE), a subtype of Salmonella, is now the most common type of salmonella in the U.S. and accounts for approximately 20 percent of all salmonella cases in humans, and reducing its prevalence is an HHS Priority Goal to reduce foodborne

illness in the population. The most significant sources of foodborne SE infections are shell eggs (regulated by the Food and Drug Administration) and broiler chickens (regulated by the United States Department of Agriculture). Therefore, reducing SE illness from shell eggs is the most appropriate strategy for reducing illness from SE. Preventing Salmonella infections depends on actions taken by regulatory agencies, the food industry, and consumers to reduce contamination of food, as well as actions taken for detecting and responding to outbreaks. CDC estimated that, for 2007-2009, 40 percent of domestically-acquired, foodborne SE illnesses were from eating shell eggs and 28 percent of total SE illnesses (foodborne, non-foodborne, and international travel-associated) were from shell eggs. CDC completed an evaluation of a "food product" model to estimate annual change in percentage of SE illnesses from shell eggs, but determined that necessary data about contamination of shell eggs was not available. CDC concluded that this model could not be used unless new sources of egg data were obtained. Therefore, as of January 2014, CDC began collecting exposure data from persons with SE infection in FoodNet sites, a network that conducts surveillance for infections diagnosed by laboratory testing of samples from patients. CDC will conduct a preliminary evaluation of this data to assess its quality and determine its usefulness in updating CDC's exposure model for estimating the proportion of total SE illnesses attributable to shell eggs during 2014-2015. As of June 2015, the SE rate was 2.9 infections per 100,000.

As part of the President's Global Health Security Agenda (GHSA), the Office of Global Affairs (OGA) led coordination with international partners to accelerate progress toward a world safe and secure from infectious disease threats. Through this effort, the U.S. has committed to assisting 30 countries to build their capacity to prevent, detect and respond to such threats, and is partnering with over 50 countries and international organizations to strengthen health systems and to protect public health.

The 2014-15 Ebola virus disease outbreak, centered in West Africa but with global impacts and ramifications, devastated families and communities, compromised essential civic and health services, weakened economies and isolated affected populations. The outbreak also placed enormous strain on national and international response capacities and emergency response structures. HHS's Ebola response included staff from across the Department, who worked domestically and were deployed as team members to the affected West African countries, supported the World Health Organization, Ministries of Health and other partners around the world, and undertook critical research and development domestically and overseas for new countermeasures. HHS coordinated closely with the US interagency and other governmental and nongovernmental donors, and contributed substantially to the US and global response, resulting in both control of the epidemic, and great progress in the development of countermeasures.

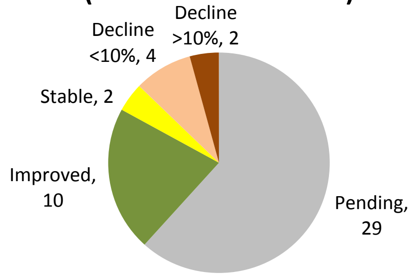
The Administration for Children and Families' (ACF) Child Care and Development Fund (CCDF) program provides funding to help low-income families pay for child care and to improve the overall quality of child care programs. States continue to implement quality rating and improvement systems (QRIS) that meet benchmarks, such as providing financial support to providers and making quality information available to parents. This is also part of the Improve the Quality of Early Childhood Education Priority Goal. The number of states with QRIS that meet these benchmarks increased from 17 states in FY 2011 to 29 states in FY 2014, with FY 2015 data expected in June 2016. Targeted technical assistance provided by the new National Center on Early Childhood Quality Assurance, as well as other technical assistance partners funded by ACF, helps states work toward their goals to improve their QRIS through small group peer-to-peer interactions, national webinars, and topical learning tables related to quality benchmarks.

ACL in partnership with the Assistant Secretary for Planning and Evaluation (ASPE) developed and tested the first national, voluntary system in which states can report data collected through their APS investigations: The National Adult Maltreatment Reporting Systems (NAMRS). The most recent data on the prevalence of elder abuse, neglect and exploitation suggest that at least 10 percent or approximately 5 million, older Americans experience abuse each year. In addition, adults with disabilities are at increased risk of experiencing abuse and neglect. An absence of federal stewardship in Adult Protective Services (APS) has led to a host of challenges including inconsistent data systems and non-uniform reporting requirements that prevent APS programs from evaluating their services or conducting

meaningful program evaluation. NAMRS was developed to address this challenge. The new system along with competitive grants to states to enhance state APS programs and services including reporting capacity is on track to have all states submitting data in FY 2017.

For this goal, 67 percent of measures with available data showed stable or improved performance.

Goal 3: Summary of Measure Progress (number of measures)



Goal Four: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

As the largest grant-awarding agency in the Federal Government and the nation's largest health insurer, HHS places a high priority on ensuring the integrity of its expenditures. HHS manages hundreds of programs in basic and applied science, public health, income support, child development, and health and social services, which award over 75,000 grants annually. The Department has robust processes in place to manage the resources and information employed to support programs and activities.

Goal Four includes four objectives:

- Strengthen program integrity and responsible stewardship by reducing improper payments; fighting fraud; and integrating financial, performance, and risk management
- Enhance access to and use of data to improve HHS programs and to support improvements in the health and well-being of the American People
- Invest in the HHS workforce to help meet America's health and human services needs
- Improve HHS environmental, energy, and economic performance to promote sustainability

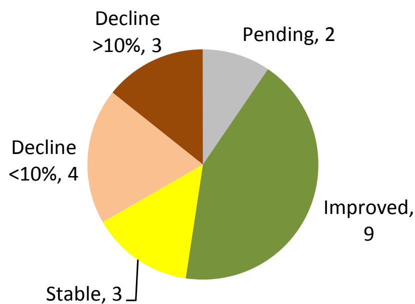
HHS University and the VA

HHS University partnered with the Department of Veterans Affairs (VA) to share common training and development requirements for the Department's medical, science and research practitioners. The technical trainings are in various formats, including web-based, simulations, video, etc. To-date, HHS has acquired 89 trainings from VA for the IHS, CDC, FDA, NIH and HRSA workforces. The Department has realized a total cost avoidance of $7.9M based upon Department of Veterans Affairs' costs to develop the courses in various formats.

The President's Now Is the Time initiatives support new activities to expand the behavioral health workforce. In FY 2015, new workforce investments provided support for approximately 3,500 new behavioral health professionals. To ensure that the existing workforce investments would achieve the desired outcomes, SAMHSA workforce activities in FY 2015 included $1.0 million to collaborate with HRSA in the establishment of a Behavioral Health Workforce Research Center. This cooperative agreement supports the conduct of workforce based projects including the development of white papers, data collection and analysis, and targeted research projects on the U.S. Behavioral Health Care Workforce. In FY 2016, SAMHSA is continuing to work with HRSA to expand this research centers impact and to develop clear goals and objectives that meet national behavioral health workforce needs in America.

This Office of Security and Strategic Information, in collaboration with the Office of the Chief Information Officer, established the Cyber Threat Analysis Center (CTAC). The mission and focus of the CTAC is to integrate the technical identification and response capabilities related to cyber intrusions and exfiltrations. This partnership will allow a Department-wide situational awareness of threats and the ability to synthesize and analyze areas of concern stemming from cyber-related activities.

One of CMS's key goals is to pay Medicare claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable, and necessary services provided to eligible beneficiaries. Paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable dollars. The Medicare fee-for-service improper payment rate in FY 2015 was 12.09 percent. The primary cause of improper payments is lack of documentation to support the services or supplies billed to Medicare, or insufficient documentation to determine proper payment. The other causes of improper payments are classified as medical necessity errors and administrative or process errors made by other parties, due to incorrect coding errors. CMS continues to implement corrective actions to address the agency vulnerabilities.



For this goal, 63 percent of measures with available data showed stable or improved performance.

Summary of Financial Statements and Stewardship Information

The financial statements were prepared in accordance with federal accounting standards and audited by the independent accounting firm of Ernst & Young LLP under the direction of our Inspector General. The Chief Financial Officers Act requires the preparation and audit of these statements, which are part of our efforts for continuous improvement of financial management. Accurate, timely and reliable financial information is necessary for making sound decisions, assessing performance and allocating resources.

Financial Condition: The following table summarizes trend information concerning components of HHS financial condition—assets, liabilities, and net position. The Consolidated Balance Sheet presents a snapshot of HHS financial condition as of September 30, 2015 compared to FY 2014, and displays assets, liabilities, and net position.

Table 1: Summary of Financial Condition Trends
(*in Billions)*

Assets and Liabilities	2012	2013	2014	2015	$ Change (2014-15)	% Change (2014-15)
Fund Balance with Treasury	$197.3	$159.2	$177.0	$219.5	$42.5	24
Investments, Net	306.4	281.7	278.9	269.7	(9.2)	(3)
Other Assets	27.0	29.3	26.4	22.9	1.4	9
Total Assets	**$530.7**	**$470.2**	**$482.3**	**$528.8**	**$46.5**	**10**

Assets and Liabilities	2012	2013	2014	2015	$ Change (2014-15)	% Change (2014-15)
Accounts Payable	$1.1	$1.2	1.0	0.9	$ (0.1)	(10)
Entitlement Benefits Due and Payable	72.5	77.3	91.0	108.1	17.1	19
Accrued Grant Liability	3.7	3.9	3.3	14.3	11.0	333
Federal Employee and Veterans' Benefits	11.0	11.6	12.0	12.1	0.1	1
Other Liabilities	11.2	13.5	16.8	16.0	(0.8)	(5)
Total Liabilities	**$99.5**	**$107.5**	**$124.1**	**$151.4**	**$27.3**	**22**
Net Position	**$431.2**	**$362.7**	**$358.2**	**$377.4**	**$ 19.2**	**5**
Total Liabilities & Net Position	**$530.7**	**$470.2**	**$482.3**	**$528.8**	**$46.5**	**10**

Our Consolidated Net Cost of Operations represents the difference between the costs incurred by our programs less associated revenues. We receive the majority of our funding through Congressional appropriations and reimbursement for the provision of goods or services to other federal agencies. Our Consolidated Net Cost of Operations for the year ended September 30, 2015, totaled $1.0 trillion. The majority of FY 2015 net costs relate to Medicare ($547.1 billion) and the Health budget function ($431.0 billion) which includes Medicaid, or almost 95 percent of our annual net costs.

The following table shows HHS net cost of operations by major component for the last five years. The FY 2015 Net Cost represents an increase of $78.0 billion or 8 percent more than the FY 2014 Net Cost of Operations. Approximately 88.7 percent of the Net Cost of Operations ($913.3 billion) relates to Medicare, Medicaid, CHIP, and other health programs managed by CMS. Further information on the net cost of operations is available in the [FY 2015 Agency Financial Report].

Table 2: Net Cost of Operations
(in Billions)

Segments	2012	2013	2014	2014	$ Change (2013-14)	% Change (2013-14)
Responsibility Segments:						
CMS Gross Cost	$802.3	$848.9	$910.5	$1011.3	$100.8	11
CMS Exchange Revenue	(65.1)	(69.7)	(73.3)	(98.0)	(24.7)	34
CMS Net Cost of Operations	**$737.2**	**$779.2**	**$837.2**	**$913.3**	**$76.1**	**9**
Other Segments:						
Other Segments Gross Cost	$121.5	$121.0	$120.5	$120.7	$0.2	0
Other Segments Exchange Revenue	(3.2)	(3.9)	(5.7)	(4.0)	(1.7)	(30)
Other Segments Net Cost of Operations	$118.3	$117.1	$114.8	$116.7	$1.9	2
Net Cost of Operations	**$855.5**	**$896.3**	**$952.0**	**$1030.0**	**$78.0**	**8**

Summary of Management Challenges

The Department is continually striving to improve efficiency and effectiveness in its programs. Many HHS programs are complex and require long-term strategies for ensuring stable operations. These management challenges, as identified by the HHS Office of the Inspector General, include:

- Protecting an Expanding Medicaid Program from Fraud, Waste, and Abuse
- Fighting Waste, Fraud and Abuse in Medicare Parts A and B
- The Meaningful and Secure Exchange and Use of Electronic Health Information and Health Information Technology
- Administration of Grants, Contracts, and Financial and Administrative Management Systems
- Ensuring Appropriate Use of Prescription Drugs
- Ensuring Quality in Nursing Home, Hospice, and Home- and Community-Based Care
- Implementing, Operating, and Overseeing the Health Insurance Marketplaces
- Reforming Delivery and Payment in Health Care ProgramsEffectively Operating Public Health and Human Services Programs
- Ensuring the Safety of Food, Drugs and Medical Devices

Detailed information about each management challenge can be found in the FY 2015 Agency Financial Report which can be accessed here. In addition, the Government Accountability Office (GAO) has placed four HHS programs on its most recent "High Risk List" that lists programs that may have greater vulnerabilities to fraud, waste, abuse and mismanagement. As a responsible steward of taxpayer resources, HHS is committed to making improvements related to these challenges and high-risk areas.

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