U.S. Department of Health and Human Services
FY 2021 Annual Performance Plan and Report

Message from the HHS Performance Improvement Officer

The U.S. Department of Health and Human Services (HHS) supports and implements programs that enhance the health, safety, and well-being of the American people. In accordance with the Government Performance and Results Act (GPRA) of 1993, as amended in the GPRA Modernization Act (GPRAMA) of 2010, I am pleased to present the Fiscal Year 2021 Annual Performance Plan and Report, documenting the Department's performance during the past year. Further information detailing HHS performance is available at Performance.gov.

In FY 2019, HHS monitored over 900 performance measures to manage departmental programs and activities and improve the efficiency and effectiveness of these programs. This report includes a representative set of performance measures to illustrate progress toward achieving the Department's strategic goals. The information in this report spans the Department's 11 operating divisions and 14 staff divisions and includes work done across the country and throughout the world. Each HHS division has reviewed its submission and I confirm, based on certifications from the divisions, that the data are reliable and complete. When results are not available because of delays in data collection, the report notes the date when the results will be available. The results presented here demonstrate that HHS is performing well across a wide range of activities.

Jen Moughalian
Acting Performance Improvement Officer
U.S. Department of Health and Human Services

Overview

The U.S. Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services. Operating Divisions (OpDivs), including agencies in the United States Public Health Service and human service agencies, administer HHS programs. Staff Divisions (StaffDivs) provide leadership, direction, and policy and management guidance to the Department.

Through its programming and other activities, HHS works closely with state, local, and U.S. territorial governments. The Federal Government has a unique legal and political government-to-government relationship with tribal governments and provides health services for American Indians and Alaska Natives consistent with this special relationship. HHS works with tribal governments, urban Indian organizations, and other tribal organizations to facilitate greater consultation and coordination between state and tribal governments on health and human services.

HHS also has strong partnerships with the private sector and nongovernmental organizations. The Department works with industries, academic institutions, trade organizations, and advocacy groups to leverage resources from organizations and individuals with shared interests. By collaborating, HHS accomplishes its mission in ways that are the least burdensome and most beneficial to the American public. Private sector grantees, such as academic institutions and faith-based and neighborhood partnerships, provide HHS-funded services at the local level. In addition, HHS works closely with other federal departments and international partners to coordinate efforts and ensure the maximum benefit for the public.

Mission Statement

The mission of the U.S. Department of Health and Human Services is 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.

HHS Organizational Structure

The Department includes 11 OpDivs that administer HHS programs:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

In addition, 14 StaffDivs and the Immediate Office of the Secretary (IOS) coordinate Department operations and provide guidance to the operating divisions:

- Assistant Secretary for Administration (ASA)
- Assistant Secretary for Financial Resources (ASFR)
- Assistant Secretary for Health (OASH)
- Assistant Secretary for Legislation (ASL)
- Assistant Secretary for Planning and Evaluation (ASPE)
- Assistant Secretary for Preparedness and Response (ASPR)
- Assistant Secretary for Public Affairs (ASPA)
- Departmental Appeals Board (DAB)
- Office for Civil Rights (OCR)
- Office of Global Affairs (OGA)
- Office of Inspector General (OIG)
- Office of Medicare Hearings and Appeals (OMHA)
- Office of the General Counsel (OGC)
- Office of the National Coordinator for Health Information Technology (ONC)

The HHS organizational chart is available at http://www.hhs.gov/about/orgchart/.

Cross-Agency Priority Goals

Per the GPRAMA requirement to address Cross-Agency Priority (CAP) Goals in the agency strategic plan, the annual performance plan, and the annual performance report, please refer to www.Performance.gov for the agency's contributions to those goals and progress, where applicable.

Agency Priority Goals

The HHS FY 2020-2021 Agency Priority Goals (APGs) support multiple objectives across the HHS Strategic Plan. For presentation purposes, the Department has chosen to display these APGs under their most closely aligned strategic objectives. For more information on these goals, go to Performance.gov.

Strategic Goals Overview

The Department has developed the HHS Strategic Plan FY 2018-2022. The HHS Strategic Plan FY 2018-2022 identifies 5 strategic goals and 20 strategic objectives. The full HHS Strategic Plan FY 2018-2022 is located at https://www.hhs.gov/about/strategic-plan/index.html. The five strategic goals are:

Goal 1: Reform, Strengthen, and Modernize the Nation's Health Care System.
Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play.
Goal 3: Strengthen the Economic and Social Well-Being of Americans across the Lifespan.
Goal 4: Foster Sound, Sustained Advances in the Sciences.
Goal 5: Promote Effective and Efficient Management and Stewardship.

Performance Management

Performance goals and measures are powerful tools to advance an effective, efficient, and productive government, while being accountable for achieving program outcomes. HHS regularly collects and analyzes performance data to inform decisions, to gauge meaningful progress towards objectives, and to identify more cost-efficient ways to achieve results. Responding to opportunities afforded by GPRAMA, HHS continues to institute significant improvements in performance management, including:

- Developing, analyzing, reporting, and managing agency priority goals and conducting performance reviews between HHS component staff and HHS leadership to monitor progress towards achieving key performance objectives.
- Conducting the Strategic Reviews process to support decision-making and performance improvement across the Department.
- Overseeing performance measurement, budgeting, strategic planning, and enterprise risk management activities within the Department.
- Fostering a network of component Performance Officers who support, coordinate, and implement performance management efforts across HHS.
- Sharing best practices in performance management at HHS through webinars and other media.

Strategic Review

GPRAMA aligned agency strategic planning cycles to presidential election cycles and administrative transitions. As a result, HHS's FY 2018–2022 Strategic Plan established a new set of strategic priorities that began in FY 2018. In 2019, HHS conducted our first Strategic Review of progress toward the achievement of each objective of the HHS Strategic Plan FY 2018-2022. This approach leveraged existing processes that support the ongoing collection of data and evidence across the enterprise. The performance measures provided here represent one piece of that broader collection of evidence. The description of each objective contains a categorization of progress reflective of the assessment of evidence provided by these processes and associated analyses. Per OMB Circular A-11, HHS has categorized 2 strategic objectives as making Noteworthy Progress, 16 as Progressing, and 2 as a Focus Areas for Improvement. Please refer to the individual goal sections below for additional information.

Annual Performance Plan and Report

The Annual Performance Plan and Report provides information on the Department's progress towards achieving the goals and objectives described in the HHS Strategic Plan FY 2018–2022. The organization of this report aligns with the strategic plan and the information in the report reflects results available at the end of FY 2019.

Goal 1. Objective 1: Promote affordable health care, while balancing spending on premiums, deductibles, and out-of-pocket costs

Affordability is a key component of accessible health care. For individuals and families, high costs of care create economic strain. Americans often have to choose between spending a higher proportion of wages on health care and paying for other household essentials. Without timely access to health care services, Americans risk worsening health care outcomes and higher costs. Yet for many, costs make health care out of reach.

HHS is committed to lowering health care costs for Americans to affordable levels and minimizing the burden of government health care spending. By increasing consumer information, offering lower-cost options and innovation in payment and service delivery models, and promoting preventive care and market competition, HHS is working with its partners to reduce the burden of higher health care costs.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, CMS, and FDA. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 1.1 Table of Related Performance Measures

Reduce the average out-of-pocket share of prescription drug costs while in the Medicare Part D Prescription Drug Benefit coverage gap for non-Low Income Subsidy (LIS) Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap (Lead Agency - CMS; Measure ID - MCR23)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	53.0%	50.0%	48.0%	43.0%	37.0%	28.0%	25%	25%
Result	53.0%	49.0%	48.0%	42.0%	4/30/20	4/30/21	4/30/22	4/30/23
Status	Target Met	Target Exceeded	Target Met	Target Exceeded	Pending	Pending	Pending	Pending

The Medicare Prescription Drug Improvement and Modernization Act of 2003 amends Title XVIII of the Social Security Act by adding a Voluntary Prescription Drug Benefit Program (Medicare Part D). Since its inception, Medicare Part D has significantly increased the number of beneficiaries with comprehensive drug coverage and enhanced access to medicines.

While Medicare Part D offers substantial insurance coverage for prescription drugs, it does not offer complete coverage. Prior to 2010, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the out-of-pocket threshold (or catastrophic limit). Only once the beneficiary reached the catastrophic limit did Medicare coverage recommence. This is known as the coverage gap (or “donut hole”). For 2019, this gap in coverage is above $3,820 in total drug costs, and up until a beneficiary spends $5,100 out-of-pocket.

Public Law No. 115-123, also known as the Bipartisan Budget Act of 2018, enacted on February 9, 2018, increased the manufacturer discount for beneficiaries in the gap from 50 to 70 percent and reduced beneficiary cost sharing to 25 percent in 2019 for applicable drugs. The discount applies at the point of sale, and both the beneficiary cost sharing and the manufacturer discounts count toward the annual

out-of-pocket threshold (known as True Out-of-Pocket Costs). This performance measure reflects CMS's effort to reduce the average out-of-pocket costs paid by non-Low Income Subsidy Medicare beneficiaries while in the coverage gap and to ensure closure of that the coverage gap is closed completely by 2020 as required by law. For 2020 and beyond, the beneficiary, on average, will only be responsible for 25 percent of the costs of both generic and brand name drugs while in the coverage gap, which makes this coverage equivalent to coverage prior to reaching the gap.

Increase the percentage of Medicare Fee-for-Service (FFS) Payments tied to Alternative Payment Models (Lead Agency - CMS; Measure ID - MCR30.1)

	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	
Target	Baseline	26%	30%	40%	50%	Discontinued	
Result	22%	26%	31%	38%	41%	N/A	
Status	Actual	Target Met	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	N/A	

Increase the percentage of Medicare health care dollars tied to Alternate Payment Models incorporating downside risk (Lead Agency CMS; Measure ID - MCR36)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	N/A	Baseline	30%	40%
Result	N/A	N/A	N/A	N/A	N/A	12/15/20	12/15/21	12/15/22
Status	N/A	N/A	N/A	N/A	N/A	Pending	Pending	Pending

CMS identifies, tests, evaluates, and expands, as appropriate, innovative payment and service delivery models that can reduce Medicare, Medicaid, and the Children's Health Insurance Program expenditures and improve or preserve beneficiary health and quality of care. CMS is testing a variety of alternative payment models (APMs) that create new incentives for clinicians to deliver better care at a lower cost. In addition, CMS is implementing payment reforms that increasingly reward quality and efficiency of care.

To encourage alignment, Medicare is leading the way by publicly tracking and reporting payments tied to alternative payment models. Moving payments to more APMs in an aligned fashion and on an aligned timeframe increases the overall likelihood that new payment models will succeed. CMS uses a framework to describe and measure health care payments through the stages of transition from pure FFS to more advanced alternative payment models.

Despite falling short of its 2018 target, CMS continues to make good progress by increasing the percentage of FFS Medicare payments tied to APMs to 41 percent. CMS is discontinuing MCR30 for 2018 and is replacing it with MCR36, which ties FFS Medicare payments to the downside risk of APMs.

Goal 1. Objective 2: Expand safe, high-quality health care options, and encourage innovation and competition

Strengthening the nation's health care system is not achievable without improving health care quality and safety for all Americans. The immediate consequences of poor quality and safety include health care-associated infections, adverse drug events, and antibiotic resistance.

Health care safety is a national priority. HHS investments in prevention have yielded both human and economic benefits. From 2010 to 2014, efforts to reduce hospital-acquired conditions and infections have resulted in a decrease of 17 percent nationally, which translates to 87,000 lives saved, $19.8 billion in unnecessary health costs averted, and 2.1 million instances of harm avoided.[1]

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, AHRQ, CDC, CMS, HRSA, OCR, ONC, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 1.2 Table of Related Performance Measures

Increase the percentage of hospitals reporting implementation of antibiotic stewardship programs fully compliant with CDC Core Elements of Hospital Antibiotic Stewardship Programs (Lead Agency - CDC; Measure ID - 3.2.5)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	Baseline	N/A	50.0%	61.3%	68.8%	84.4%	100.0%	Discontinued
Result	40.9 %	N/A	64%	76.4%	84.8%	11/30/20	11/30/21	N/A
Status	Actual	N/A	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending	N/A

Antibiotics have been a critical public health tool since the discovery of penicillin in 1928, which saved the lives of millions of people around the world. Today, however, CDC estimates that drug-resistant bacteria cause two million illnesses and approximately 23,000 deaths each year in the United States alone. In 2018, about 84.8 percent of U.S. acute care hospitals reported having an antibiotic stewardship program that incorporates all of the CDC Core Elements for Hospital Antibiotic Stewardship Programs. CDC is retiring measure 3.2.5 because it expects to reach 100 percent of acute care hospitals in 2020.

Reduce all-cause hospital readmission rate for Medicare-Medicaid Enrollees (Lead Agency - CMS; Measure ID - MMB2)

	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Target	N/A	N/A	N/A	N/A	Prior Result -1.0%	Prior Result -1.0%	Prior Result - 0.5%	Prior Result - 0.25%
Result	83.4%	84.0%	83.7%	84.5%	4/30/20	4/30/21	4/30/22	4/30/23
Status	Actual	Actual	Actual	Actual	Pending	Pending	Pending	Pending

[1] https://www.ahrq.gov/professionals/quality-patient-safety/pfp/2014-final.html

A “hospital readmission" occurs when a patient who has recently been discharged from a hospital is once again readmitted to a hospital. A thirty-day period for readmission data has been standard across the quality measure industry for several years. Discharge from a hospital is a critical transition point in a patient’s care. Incomplete handoffs at discharge can lead to adverse events for patients and avoidable readmissions. Hospital readmissions may indicate poor care, missed opportunities to better coordinate care, and result in unnecessary costs.

The rate of readmissions for individuals who are dually eligible for both Medicare and Medicaid (also referred to as Medicare-Medicaid Enrollees) is often higher than for Medicare beneficiaries overall. In 2017, an estimated 12 million beneficiaries were dually eligible for Medicare and Medicaid.

CMS calculates this measure using the number of readmissions per 1,000 eligible beneficiaries. Eligible beneficiaries are dually eligible individuals of any age.

Based on national trends, which reflect a slowing in readmissions reductions for all Medicare beneficiaries after a number of years of larger declines, CMS has selected a more modest target reduction rate for CY 2021 of 0.25 percent.

Improve hospital patient safety by reducing preventable patient harms (Lead Agency – CMS; Measure ID – QIO11)[2,3,4,5]

	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Target	N/A	N/A	N/A	86 harms	82 harms	78 harms	TBD	TBD
Result	98 harms	92 harms	88 harms	86 harms	4/30/20	1/31/21	1/31/22	1/31/23
Status	Actual	Actual	Actual	Pending	Pending	Pending	Pending	Pending

Preventable harms can cause additional pain, stress, and costs to the patient and their family during intended treatment and increase spending on the part of payers. This measure utilizes the AHRQ National Scorecard, which includes abstraction from a nationally representative sample of approximately 20,000 hospital charts per year that yields clinical relevant yet highly standardized national hospital safety metrics. This represents an enormous contribution to the government’s ability to measure, monitor, and improve patient safety at a national scale. As a composite of many different harms, the AHRQ National Score Card also includes data from the CDC’s National Healthcare Safety Network and AHRQ’s Healthcare Cost and Utilization Project databases.

Beginning in 2016, CMS is calculating the all cause harm metric differently due to two significant events that affected the calculation: Hospital Inpatient Quality Reporting Program changes and International Classification of Diseases, 9th Revision, to International Classification of Diseases, 10th Revision, conversions. As a result, CMS adjusted the previously reported targets and results for this performance

[2] The purpose of this measure is to determine the national impact of patient safety efforts by counting the number of preventable patient harms that take place per 1,000 inpatient discharges.
[3] Data are preliminary based on partial data from this calendar year combined with data from prior years to fill gaps. The estimates are subject to change after all data from this calendar year are available and all quality control procedures have been completed.
[4] Targets and results for this performance goal have been revised since the release of the FY 2019 President’s Budget due to significant revisions in methodology that impacted the calculation. (See performance narrative).
[5] Examples of some of the preventable patient harms included in this measure are: adverse drug events, catheter-associated urinary tract infections, central line-associated bloodstream infections, falls, pressure ulcers, surgical site infections, ventilator-associated pneumonia/events, venous thromboembolism, and hospital readmissions.

goal. CMS anticipates that other changes to the sampling methodology will need to occur after 2019 based on improved definitions and sampling methodology, which may require the realignment of targets for 2020 and beyond. CMS is expecting to reduce patient harm by 10 percent between CY 2019 and CY 2024. CMS will set new annual targets based on 2 percent decrease per year.

Using this new sampling methodology, CMS observed an 11 percent decline from the 2014 revised baseline to 2016, which resulted in an estimated 530,000 fewer hospital acquired conditions, 13,100 lives saved from harms avoided, and $4.7 billion in costs saved.[6]

Reduce the standardized infection ratio (SIR) central line-associated bloodstream infection (CLABSI) in acute care hospitals (Lead Agency - CDC; Measure ID - 3.3.3) [7,8]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	0.4	Baseline	0.90	0.80	0.70	0.60	.50	.45
Result	0.5	1.0	0.89	0.81	0.74	11/30/20	11/30/21	11/30/22
Status	Target Not Met but Improved	Actual	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending	Pending

Reducing health care-associated Infections (HAIs) across all health care settings supports the HHS mission to prevent infections and their complications as well as reduce excess health care costs in the U.S. These efforts also align with the National Action Plan to Prevent Health Care Associated Infections: Roadmap to Elimination (National HAI Action Plan),[9] National Action Plan for Combatting Antibiotic Resistance Bacteria (CARB), and Healthy People 2020 Goals. With a SIR of 0.74 for FY 2018, CDC continues to reduce CLABSI infections. This is an improvement over FY 2017 and a 26 percent decrease as compared to the 2015 baseline. In FY 2020 and FY 2021, CDC will continue to monitor HAIs and to develop strategies for prevention.

Reduce standardized infection ratio for hospital-onset Clostridioides difficile infections (Lead Agency - CDC; Measure ID - 3.2.4b) [10]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	Baseline	Baseline	0.84	0.76	0.75	0.70	.70	.60
Result	1.00	1.00	0.92	0.80	0.71	3/31/20	3/31/21	3/31/22
Status	Actual	Actual	Target Not Met but Improved	Target Not Met but Improved	Target Exceeded	Pending	Pending	Pending

Clostridioides difficile infection (CDI)[11] is a preventable, life-threatening bacterial infection that can occur in both inpatient and outpatient health care settings. CDC provides data-driven strategies and tools for targeted intervention to the health care community to help prevent CDI, as well as resources to help the public safeguard its own health. CDI prevention is a national priority, with a 2020 target to reduce CDI

[6] https://www.ahrq.gov/news/newsroom/press-releases/declines-in-hacs.html
[7] The baseline for this measure was updated in FY 2015 and will affect future targets and data reporting for FY 2016 onward.
[8] CDC uses a standardized infection ratio (SIR), the ratio of the observed number of infections to the number of predicted infections, to measure progress in reducing HAIs compared to the baseline period (FY 2015). In 2015, CDC developed a new baseline for all HAIs including CLABSI to better assess national and local prevention progress and identify gaps for tailored prevention.
[9] https://health.gov/hcq/prevent-hai-action-plan.asp
[10] CDC rebaselined measure 3.2.4b in 2015, and subsequent targets were adjusted to align to changes in the current HHS HAI Action Plan.
[11] https://www.nejm.org/doi/full/10.1056/NEJMoa1408913

by 50 percent in the National Action Plan for CARB and the 2015 National HAI Action Plan.[12] In FY 2016, the SIR for hospital-onset CDI was 0.80. Although the target of 0.76 was not met, CDC did make progress in reducing CDIs in these health care settings.

[12] https://health.gov/hcq/prevent-hai-action-plan.asp

Goal 1. Objective 3: Improve Americans' access to health care and expand choices of care and service options

Accessing health services involves gaining entry into the health care system, usually through payment; gaining access to diverse options for receiving treatment, services, and products, including physical locations and online options; and having a trusted relationship with a health care provider. Efforts to improve access to care are not limited to physical health care. Improving access to behavioral and oral health care, including through innovative solutions that use health information technology, also is critical, especially for populations experiencing disparities in access. HHS has removed regulatory barriers, created incentives for increased access to newly developed drugs and devices, expanded patient access and choice through Health Reimbursement Arrangements, and launched the Rural Health Strategy to improve access to care in Medicare and Medicaid. To improve outcomes in this objective, HHS continues to address the high cost of care, lack of availability of services, and lack of culturally competent care.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, CMS, HRSA, IHS, IOS, OCR, OGA, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is making noteworthy progress. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 1.3 Table of Related Performance Measures

Improve patient and family engagement by improving shared decision-making (Lead Agency - CMS; Measure ID - MCR31)[13, 14]

	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	
Target	Baseline	N/A	N/A	76%	Baseline	Discontinued	
Result	74.6%	75.2%	75.4%	75.85%	Baseline not established	N/A	
Status	Actual	Actual	Actual	Target Not Met but Improved	Target Not Met	N/A	

The purpose of this performance goal was to help assess an important component of patient experience of care with their provider. Shared decision making between patient, caregiver, and provider is a fundamental component of a patient-centered health care system that leads to improved health outcomes for patients. This measure reports survey results from the Shared Decision Making Summary Survey Measure (SSM). The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Physician Quality Reporting programs collects and reports SSM data.

CMS set the CY 2017 target for this goal at 76 percent, which is between the 80th and 90th percentiles for all Shared Savings Program Accountable Care Organizations (ACOs) that used the CY 2015 Shared Savings Program quality measure benchmarks. The mean performance on this measure was 75.40 percent in CY 2016 and was 75.85 percent in CY 2017.

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[13] The methodology for this measure changed in CY 2018.

[14] A new baseline cannot be established due to the lack of available, stable, and trend data resulting from the recent CAHPS survey update.

HHS did not set targets for CY 2019 and CY 2020 and discontinued this goal due to data reporting issues. The methodology for this measure changed in CY 2018. A new baseline cannot be established due to the lack of available, stable, and trend data from the recent CAHPS update. The agency implemented a revised shortened version of the survey in CY 2018 for both ACOs and Merit-based Incentive Payment System (MIPS). The CY 2018 performance period was a developmental year.

Increase tele-behavioral health encounters nationally among American Indians and Alaska Natives (Lead Agency - IHS; Measure ID - MH-1)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	8,600	8,901	10,359	11,600	13,600	21,860	26,647
Result	8,298	9,773	10,388	12,212	13,204	17,933	12/31/20	12/31/21
Status	Actual	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Telehealth services have proven effective in providing access to care where there are provider shortages or other barriers to care. IHS has increased its efforts to expand access to care through the integration of telemedicine with community-based services. Behavioral health services are important services delivered through the telehealth option. Expanding access to telehealth services may include increased access to specialty care, such as child psychiatry and addiction psychiatry. This measure shows that demand for these services exceeds expected targets. The target increase between FY 2018 and FY 2021 is close to 40 percent. IHS exceeded its FY 2019 target by 32 percent. In FY 2020 and FY 2021, IHS will expand access to care for telehealth behavioral services.

Goal 1. Objective 4: Strengthen and expand the health care workforce to meet America's diverse needs

Whether people access health care in a doctor's office, in a health center, in a pharmacy, at home, or through a mobile device, they depend on a qualified, competent, responsive workforce to deliver high-quality care. HHS regularly produces reports projecting growth or deficits in the supply and demand of various occupations in the health care workforce. At a national level, by 2025, demand is expected to exceed supply for several critical health professions, including primary care practitioners, geriatricians, dentists, and behavioral health providers, including psychiatrists, mental health and substance abuse social workers, mental health and substance use disorder counselors, and marriage and family therapists. At a state level, the picture is more complex, with some states projected to experience greater deficits in certain health care occupations. For example, rural areas experience greater shortages in the oral and behavioral health workforces. HHS works in close partnership with academic institutions, advisory committees, research centers, and primary care offices. These collaborations help HHS make informed decisions on policy and program planning to strengthen and expand the workforce.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: CDC, CMS, HRSA, IHS, OCR, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 1.4 Table of Related Performance Measures

Support field strength (participants in service) of the National Health Service Corps (NHSC) (Lead Agency - HRSA; Measure ID - 4.I.C.2)[15, 16,17]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	7,522	8,495	9,153	9,219	8,705	11,410	13,700	14,338
Result	9,242	9,683	10,493	10,179	10,939	13,053	12/31/20	12/31/21
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

The National Health Service Corps addresses the nationwide shortage of health care providers in health professional shortage areas by providing recruitment and retention incentives in the form of scholarship and loan repayment support to health professionals committed to a career in primary care and service to underserved communities. The NHSC field strength indicates the number of providers actively serving with the NHSC in underserved areas in exchange for scholarship or loan repayment support.

As of September 30, 2019, 13,053 primary care medical, dental, and mental and behavioral health practitioners were providing service nationwide through the following programs: NHSC Scholarship Program, NHSC Loan Repayment Program, NHSC Students to Service Loan Repayment Program, and the State Loan Repayment Program. These programs collectively serve the immediate needs of

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[15] This measure reports on the number of people who received assistance through the NHSC scholarship and loan programs who are currently in the field. NHSC field strength data include awards made from the FY 2017 Zika Supplemental, which supported providers in the U.S. territories.

[16] Field disciplines include: allopathic/osteopathic physicians, dentists, dental hygienists, nurse practitioners, physician assistants, nurse midwives, mental and behavioral health professionals, and clinicians.

[17] Previously HRSA reported an FY 2019 target of 8,810 NHSC participants in the field. Since the publication of the FY 2019 APP/R, HRSA has received additional FY 2019 funding and has increased its targets accordingly.

underserved communities and support the development and maintenance of a pipeline of health care providers capable of meeting the needs of these communities in the future. In FY 2020 and FY 2021, NHSC will continue to assist students through scholarships and loan repayments and professionals through loan repayment awards as incentives to practice in underserved communities.

Goal 2. Objective 1: Empower people to make informed choices for healthier living

Health promotion and wellness activities involve providing information and education to motivate individuals, families, and communities to adopt healthy behaviors, which ultimately can improve overall public health. However, the lack of access to and understanding of health information can lead people to make uninformed decisions and engage in risky behavior. The Department supports a series of programs and initiatives aimed at improving nutrition; increasing physical activity; reducing environmental hazards; increasing access to preventive services; and reducing the use of tobacco, alcohol, and illicit drugs and prescription drug abuse. HHS achieves these outcomes are achieved through culturally competent and linguistically appropriate health education, services, and supports made possible through strategic partnerships.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ATSDR, CDC, FDA, HRSA, IHS, NIH, OASH, OCR, OGA, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 2.1 Table of Related Performance Measures

Reduce the annual adult per-capita combustible tobacco consumption in the United States (Lead Agency - CDC; Measure ID - 4.6.2a)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	1,145	1,128	967	903	838	817
Result	1,216	1,211	1,164	1,114	1,061	7/31/20	7/31/21	7/31/22
Status	Actual	Actual	Target Not Met but Improved	Target Exceeded	Target Not Met but Improved	Pending	Pending	Pending

Although cigarette smoking remains the leading cause of tobacco-related disease, tobacco users are increasingly shifting consumption to other tobacco products and dual use with other combusted tobacco, which include cigars, cigarillos and little cigars, pipe tobacco, roll-your-own tobacco, and hookah. This has resulted in a slowing of the decline in the consumption of all combustible tobacco, and indicates that the use of non-cigarette combustible products has become more common in recent years and that some smokers may be switching to other combustible tobacco products rather than quitting smoking cigarettes completely. Per capita combustible tobacco product consumption declined from 1,114 cigarette equivalents in FY 2017 to 1,061 cigarette equivalents in FY 2018. In FY 2020 and FY 2021, CDC will continue to monitor combustible tobacco consumption to inform its strategies on reducing tobacco-related disease.

Reduce the age-adjusted proportion of adults (age 20 years and older) who are obese (Lead Agency - CDC; Measure ID - 4.11.10a)[18,19]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	34.4%	N/A	33.2%	N/A	33%	N/A	32.3%	N/A
Result	37.7%	N/A	39.6%	N/A	5/30/20	N/A	5/30/22	N/A
Status	Target Not Met	N/A	Target Not Met	N/A	Pending	N/A	Pending	N/A

National Health and Nutrition Examination Survey (NHANES) data for FY 2016 show that 39.6 percent of adults are obese, which is an increase compared to the proportion of obese adults reported in FY 2014. Some community factors that affect diet and physical activity. These factors include the affordability and availability of healthy food options (e.g. fruits and vegetables), peer and social supports, marketing and promotion, and policies that determine whether a community's design to supports physical activity. In FY 2020 and FY 2021, CDC will continue to implement evidence-based strategies and increase healthy eating and active living through its support for states and communities throughout the United States.

[18] Data for this measure are collected and reported every other year.

[19] There was a delay in publication of CDC's NHANES data, and FY 2018 results will not be available until spring 2020. CDC anticipates that subsequent NHANES data may also be delayed and has adjusted the reporting dates.

Goal 2. Objective 2: Prevent, treat, and control communicable diseases and chronic conditions

Communicable diseases and chronic conditions affect the lives of millions of Americans every day. The emergence and spread of infectious diseases—such as HIV/AIDS, hepatitis, tuberculosis, measles, and human papillomavirus—can quickly threaten the stability of public health for communities and place whole populations at risk. The rise of globalization and ease of travel also has made it easier for domestic and international outbreaks—such as recent outbreaks of measles, pandemic influenza A, Ebola, Zika, and chikungunya—to create public health challenges. Moreover, the prevalence of chronic conditions—such as diabetes, heart disease, stroke, and cancer—in the United States continues to contribute to the daily struggles of Americans. The occurrence of multiple chronic conditions also exacerbates the adverse health impacts and health care costs associated with chronic conditions and their associated health risks. HHS programs and initiatives focus on promoting partnerships, educating the public, improving vaccine development and uptake, advancing early detection and prevention methods, and enhancing surveillance and response capacity.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, ASPA, ASPR, CDC, CMS, FDA, HRSA, IHS, NIH, OASH, OGA, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 2.2 Table of Related Performance Measures

Increase the percentage of Ryan White HIV/AIDS Program clients receiving HIV medical care and at least one viral load test who are virally suppressed (Lead Agency - HRSA; Measure ID - 16.III.A.4)[20]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	83%	83%	83%	83%
Result	N/A	83%	85%	86%	87%	10/31/21	10/31/22	10/31/23
Status	N/A	Actual	Actual	Actual	Target Exceeded	Pending	Pending	Pending

The Ryan White HIV/AIDS Program (RWHAP) works to improve health outcomes by preventing disease transmission or slowing disease progression for disproportionately impacted communities. One way RWHAP accomplishes its mission is through the provision of medications that help patients reach HIV viral suppression. People living with HIV who use medications designed to virally suppress the disease are less infectious, which reduces the risk of their transmitting HIV to others. In FY 2020 and FY 2021, RWHAP will continue to play a central role in ending the HIV epidemic by ensuring that persons living with HIV have access to regular care, receive antiretroviral medications, and adhere to a regular schedule for taking their medications.

[20] Changes in the Ryan White Services Report on how viral suppression data derived before 2015 used a different data collection methodology and are not comparable to data collected using the current methodology.

Increase the percentage of adults aged 18 years and older who are vaccinated annually against seasonal influenza (Lead Agency - CDC; Measure ID - 1.3.3a)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	50%	53%	56%	59%	62%	66%	70%	70%
Result	44%	42%	43%	38%	45.3%	9/30/20	9/30/21	9/30/22
Status	Target Not Met but Improved	Target Not Met	Target Not Met but Improved	Target Not Met	Target Not Met but Improved	Pending	Pending	Pending

In the United States, on average 5-20 percent of the population contracts the flu, more than 200,000 people are hospitalized from seasonal flu-related complications, and approximately 36,000 people die from seasonal flu-related causes. This measure reflects the universal influenza vaccination recommendation and aligns with the Advisory Committee on Immunization Practices' updated recommendation (as of 2010) for the seasonal influenza vaccine. Seasonal influenza vaccination rates for adults aged 18 and older increased from 38 percent in FY 2017 to 45.3 percent in FY 2018. Interpretation of these results should take into account limitations of the survey, which include reliance on self-reporting of vaccination status and a decrease in response rates. Preliminary estimates from claims-based data systems showed no decreases in flu vaccination coverage. Four in ten adults report receiving a flu vaccination. In FY 2020 and FY 2021, CDC will continue to monitor the percentage of adults aged 18 and older who receive annual are vaccination against seasonal influenza to inform its strategies for improving adult vaccination coverage rates.

Measure 1.3.3a reflects the universal influenza vaccination recommendation and aligns with the Advisory Committee on Immunization Practices' recommendation (as of 2010) for the seasonal influenza vaccine. Interpretation of these results should take into account limitations of the survey, including reliance on self-report of vaccination status and decreasing response rates. No decreases in flu vaccination coverage were seen in preliminary estimates from claims-based data systems. Flu vaccination coverage among adults remains at about 4 in 10 adults reporting receipt of a flu vaccination.

CDC's efforts to improve adult vaccination coverage rates include:

- Increasing patient and provider education.
- Funding state and local health departments to implement the Standards for Adult Immunization Practice.
- Partnering with professional organizations to develop and implement strategies to improve adult immunization at provider, practice, and systems levels.
- Enhancing evidence-based communication campaigns to increase public awareness.
- Expanding the reach of vaccination programs including new venues such as pharmacies and other retail clinics.
- Designing and funding investigations into the factors associated with disparities in adult vaccination among racial and ethnic populations.

Continue advanced research and development initiatives for more effective influenza vaccines and the development of safe and broad-spectrum therapeutics for use in seriously ill and/or hospitalized patients, including pediatric patients (Lead Agency - ASPR; Measure ID - 2.4.15b)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	Baseline	2	2	2	2
Result	N/A	N/A	N/A	2	7	6	12/31/20	12/31/21
Status	N/A	N/A	N/A	Actual	Target Exceeded	Pending	Pending	Pending

It is estimated that a highly contagious and virulent airborne pathogen, such as a new influenza virus (the "flu"), could kill tens of millions of people globally in less than a year. Influenza and other emerging infectious diseases with pandemic (global epidemic) potential continue to change, evolve, spread geographically, and infect large numbers of animals and humans. Vaccination is a very effective way to prevent these kinds of diseases and prepare for a possible pandemic. Influenza vaccines are generally very safe and serious reactions are uncommon. Effective treatments for those who are severely ill with influenza are critical for pandemic preparedness and effective response. Efforts to prepare for pandemics promote significant benefits during annual flu seasons. HHS continues to expand the national vaccine manufacturing capacity. In addition, partnerships between HHS and private companies has led to improved and modernized influenza vaccine technologies. Such technologies increase vaccine supplies and improve vaccine effectiveness. ASPR supports production of more effective vaccines that have a stronger response and provide more protection to the vaccinated person.

During 2019, ASPR supported manufacturing efficiency improvements expected to achieve an increase in the number of pandemic influenza vaccine doses produced, which led to the incorporation of improved vaccines into the national supplies for seasonal influenza. ASPR assisted programs designed to support the development of improved influenza vaccines or next generation vaccines. In addition, ASPR assisted programs for late stage development of influenza antivirals and therapeutics. These programs include support for antiviral drugs with new and unique novel mechanisms of action. Development of these products improves our pre-pandemic preparedness and supports use of products that address seasonal influenza. In FY 2020 and FY 2021, ASPR will continue to support many initiatives designed to increase our ability to respond to a pandemic response capability and improve the quality of treatments available for response to seasonal influenza. A key component of ASPR's strategy is to speed-up vaccines production. To do this, ASPR supports modern, egg-independent, cell or recombinant-based approaches so that the right vaccine is available in the right place and at the right time.

HHS FY 2020-2021 Agency Priority Goals

The HHS FY 2020-2021 APGs support multiple objectives across the HHS Strategic Plan. For presentation purposes, the Department has chosen to display these APGs under their most closely aligned strategic objectives. For more information on these goals, go to Performance.gov.

Ending the HIV Epidemic. Ending the HIV Epidemic. End the HIV epidemic by reducing new HIV infections through 1) linking people to HIV medical care as quickly as possible so that treatment can be initiated; and 2) preventing HIV through prescribing pre-exposure prophylaxis (PrEP) to those who have indications for PrEP. Starting from the baselines for December 31, 2017, by September 30, 2021:

- Reduce by 15 percent new HIV infections among persons aged 13 or older.
- Increase by 15 percent linkage to HIV medical care within one month of diagnosis among persons aged 13 or older.
- Increase by 15 percent the number of persons with indications for PrEP who are prescribed PrEP.

Kidney Care. Reduce morbidity and mortality associated with end-stage renal disease and increase patient choice by improving access to alternatives to center-based dialysis. Starting from the baseline for the calendar year ending December 31, 2018, by September 30, 2021:

- Increase by 10 percent the number of new end-stage renal disease patients on home dialysis.
- Increase by 10 percent the number of kidney transplants performed.

Goal 2. Objective 3: Reduce the impact of mental and substance use disorders through prevention, early intervention, treatment, and recovery support

Mental illness and substance abuse create health risks and place a heavy burden on affected individuals and their families. Substance use disorders arise from the recurring use of alcohol and/or drugs, which lead to clinically and functionally significant impairments. Mental disorders are health conditions that involve significant changes in thinking, emotion, and/or behavior and lead to distress and/or problems functioning in social, work, or family activities. Mental and substance use disorders are illnesses that impact people's ability to go about their daily lives in family, social, and professional settings and place individuals at risk of additional health problems. HHS works closely with federal, state, tribal, local, territorial, and community partners, including faith-based and community organizations, to help identify and address mental health problems and substance use disorders.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, AHRQ, CDC, CMS, FDA, HRSA, IHS, IOS, OCR, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 2.3 Table of Related Performance Measures

Increase the number of substance abuse treatment admissions with Medication-Assisted Treatment (MAT) planned as part of Opioid Use Disorder Treatment (Lead Agency - SAMHSA; Measure ID - 2.3.19K) [21]

	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Target	N/A	N/A	N/A	N/A	200,000	220,000	242,000	280,000
Result	N/A	224,389	218,092	263,600	8/31/20	8/31/21	8/31/22	8/31/23
Status	N/A	Actual	Actual	N/A	Pending	Pending	Pending	Pending

SAMHSA expects the number of people receiving MAT and the number of admissions to substance abuse treatment with MAT to increase. States are continuing to develop their systems with increased resources from grant programs, such as the State Opioid Response grants, Tribal Opioid Response grants, and Targeted Capacity Expansion: Medication-Assisted Treatment Prescription-Drug and Opioid Addiction grants. Medicaid systems have increased their focus on opioid-related technical assistance, and outreach efforts from across HHS promote the use of MAT. SAMHSA uses data from the Treatment Episode Dataset (TEDS) to track the provision of substance abuse treatment for opioid use disorders, which includes tracking the planned use of MAT at admission.[22] In CY 2015, 224,389 treatment admissions had MAT as a planned part of the treatment plan. In CY 2016, 218,092 admissions had MAT planned in CY 2016, and 263,600 opioid admissions had MAT planned in CY 2017. MAT data for CY 2018

[21] TEDS Annual Report, which is based on calendar year data, can be found at: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/TEDS-2017.pdf

[22] MAT consists of provision of methadone, buprenorphine or extended-release naltrexone, in combination with counseling and behavioral therapies. TEDS is a compilation of client-level data routinely collected by the individual state administrative data systems to monitor their substance use treatment systems. TEDS records do not represent individuals; rather, each record represents a treatment episode. Thus, an individual admitted to treatment twice within a calendar year counts as two admissions. TEDS does not include all substance use treatments. It includes treatment admissions and discharges at facilities licensed or certified by a state substance abuse agency to provide care for people with a substance use disorder (or at facilities that are administratively tracked for other reasons). In general, facilities reporting TEDS data are those that receive state alcohol and/or drug agency funds (including federal block grant funds) for the provision of alcohol and/or drug treatment services.

will be available in 2020. SAMHSA will continue to monitor the use of MAT in CY 2018, 2019, and 2020.

Increase the availability of electronic clinical decision support tools related to safe pain management and opioid prescribing (Lead Agency - AHRQ; Measure ID - 2.3.8)

Fiscal Year	Target	Result	Status
FY 2014	N/A	N/A	N/A
FY 2015	N/A	N/A	N/A
FY 2016	N/A	N/A	N/A
FY 2017	N/A	N/A	N/A
FY 2018	Develop at least one new electronic clinical decision support tool related to safe pain management and opioid prescribing.	Developed and tested a dashboard that aggregates pain-related information into one consolidated view for clinicians. Information includes data such as pain medications, pain assessments, pain-related diagnoses, and relevant lab test results.	Target Met
FY 2019	1) Test, revise, and disseminate at least one new electronic clinical decision tool related to safe pain management and opioid prescribing and 2) Partner with stakeholders to identify additional evidence-based electronic clinical decision tools related to safe pain management and opioid prescribing and make them publicly available.	Worked with CDC to test, revise, and disseminate two opioid clinical decision support (CDS) tools using the Connect web platform	Target Met
FY 2020	Develop, test, and disseminate at least one electronic clinical decision support tool related to opioids or safe chronic pain management.	9/30/20	In Progress
FY 2021	Evaluate electronic clinical decision support tools related to chronic pain management and disseminate the results of the evaluation	9/30/21	Not Started

Addressing the nation's opioid epidemic is an ongoing focus of AHRQ's Health Services Research, Data, and Dissemination portfolio. In FY 2017, AHRQ launched a new initiative to ensure that health care professionals have access to evidence supporting safe pain management and opioid prescribing at the point of care through electronic CDS. CDS Connect is the infrastructure for developing and sharing these CDS tools.[23]

In FY 2018, AHRQ developed a dashboard that aggregates pain-related information from the Electronic Health Records (EHR) into one consolidated view for clinicians. The information includes data such as pain medications, pain assessments, relevant diagnoses, and lab test results. ARHQ tested the dashboard in partnership with Oregon Community Health Information Network, a network of community health centers. The dashboard uses the Health Level Seven Fast Healthcare Interoperability Resources standard, which allows for interoperability and implementation in different EHRs.

[23] https://cds.ahrq.gov.

In FY 2019, AHRQ disseminated safe pain management and opioid-related CDS tools through CDS Connect. These tools included the pain management dashboard developed in FY 2018. AHRQ continued to present its work in CDS at national meetings of key organizations, such as the American Medical Informatics Association and the Healthcare Information and Management Systems Society.

In FY 2020, AHRQ will develop and test clinician and patient-facing CDS applications for chronic pain management. AHRQ will disseminate the new CDS through AHRQ's CDS Connect platform. In FY 2021, each of the CDS applications will undergo evaluations of their development and dissemination for chronic pain management. AHRQ will conduct a separate evaluation of the agency's overall CDS initiative.

By 2020, evaluate the efficacy of new or refined interventions to treat opioid use disorders (OUD) (Lead Agency - NIH; Measure ID - SRO-4.9)

Fiscal Year	Target	Result	Status
FY 2014	N/A	N/A	N/A
FY 2015	N/A	N/A	N/A
FY 2016	N/A	N/A	N/A
FY 2017	N/A	N/A	N/A
FY 2018	Initiate at least one study to improve identification of OUD or evaluate the comparative effectiveness of available pharmacotherapies for OUD treatment.	A Phase 3 clinical trial to test a non-opioid medication for managing symptoms of opioid withdrawal was completed.	Target Met
FY 2019	Conduct one preclinical study and one clinical trial to develop non-opioid based medications to treat OUD that may avoid the risks of opioid dependence and overdose.	A pre-clinical study of a novel opiate withdrawal therapy was conducted, and a clinical trial of a therapy for both opioid withdrawal and associated insomnia was also conducted.	Target Met
FY 2020	Conduct one pre-clinical and one clinical study of a longer acting formulation of a medication for the treatment of opioid use disorders or opioid overdose.	12/31/20	In Progress

The misuse of and addiction to opioids such as heroin and prescription pain medicines is a serious national problem. This issue has become a public health epidemic with devastating consequences, which include increases in OUDs and related fatalities from overdoses; rising incidence of newborns who experience neonatal abstinence syndrome because their mothers used these substances during pregnancy; and increases in the spread of infectious diseases, such as HIV and hepatitis C. This measure highlights one facet of NIH-funded research in providing scientific evidence to inform the public health response to the opioid crisis.

In FY 2019, a research team established that a novel chemical compound, known as ITI-333, shows promise as an OUD medication with low abuse potential. The research team is now completing additional tests in order to secure FDA approval to begin evaluating ITI-333 in humans. Also in FY 2019, another research team began studying suvorexant as a treatment for opioid withdrawal and insomnia in OUD patients. Suvorexant is an approved drug for insomnia. Preliminary evidence also suggests that the type of brain cells targeted by suvorexant may play a role in addiction itself. Suvorexant has the potential to lessen withdrawal symptoms and sleep problems that occur during supervised opioid withdrawal (detoxification). These problems often lead OUD patients to drop out of addiction

treatment programs. If proven effective, suvorexant is expected to increase the likelihood of OUD patients completing addiction treatment.

In FY 2020, NIH is supporting research on a longer-acting formulation of a medication for treating OUD or opioid overdose. Although this measure is scheduled to discontinue beginning in FY 2021, the search for new or improved strategies for treating OUD will remain a top priority for NIH.

Increase the percentage of youth ages 12-17 who experienced major depressive episodes with severe impairment in the past year receiving treatment for depression (Lead Agency - SAMHSA; Measure ID - 2.3.19O) [24]

	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Target	N/A	N/A	N/A	N/A	48.0%	48.5%	50.0%	55.0%
Result	N/A	N/A	46.7%	47.5%	46.9%	12/31/20	12/31/21	12/31/22
Status	N/A	N/A	Actual	Actual	Target Not Met	Pending	Pending	Pending

With states and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) driving efforts to address the needs of children and youth with serious emotional disturbances, SAMHSA expects to see increases in the percentage of youth with a past year major depressive episode who receive mental health treatment. The National Survey on Drug Use and Health (NSDUH) defines treatment for depression as 1) Seeing or talking to a medical doctor or other professional, or 2) Using prescription medication for depression in the past year. In CY 2017, 47.5 percent of youth ages 12-17 who experienced major depressive episodes with severe impairment in the past year received mental health treatment. SAMHSA has funded a number of programs to increase access to treatment, which include Healthy Transitions continuation grants and contracts for technical assistance and evaluation. The prevalence of receiving depression care among youth with major depressive episode and severe impairment in the past year remained stable between 2006 and 2018. In 2018, the rate was 46.9 percent, narrowly not meeting the target. In FY 2018, in addition to supporting contracts for technical assistance and evaluation, SAMHSA continued support for 14 continuation grants and supported 4 new grants. SAMHSA will work to improve this result in CY 2020 and CY 2021 by providing technical assistance to grantees and by continuing to monitor major depressive episodes in youth ages 12-17. The agency anticipates that these efforts made to improve access to services will lead to identifying reductions in the percentage of youth who report major depressive episodes.

Increase the percentage of adults with Serious Mental Illness (SMI) receiving mental health services (Lead Agency - SAMHSA; Measure ID - 2.3.19L) [25]

	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Target	N/A	N/A	N/A	N/A	67.0%	68.0%	71.0%	75.0%
Result	N/A	N/A	64.8%	66.7%	12/31/19	12/31/20	12/31/21	12/31/22
Status	N/A	N/A	Actual	Actual	Pending	Pending	Pending	Pending

With states and ISMICC driving efforts to address the needs of individuals with serious mental illness (SMI), SAMHSA expects to see increases in the percentage of adults with SMI who receive mental health services.[26] The most recent NSDUH data available show that in CY 2017, 66.7 percent of adults aged 18

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[24] NSDUH full 2017 report available at https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH.

[25] Ibid.

[26] In NSDUH, SMI is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. SMI was assessed using the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID) which is based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). These mental illness estimates are based on a predictive model. Additionally, 'Mental Health Services' in the NSDUH is defined as having received inpatient treatment/counseling or outpatient treatment/counseling or having used prescription medication for problems with emotions, nerves, or mental health.

or older with SMI received mental health services in the past year. For this measure, SAMHSA defines mental health services as inpatient treatment/counseling, outpatient treatment/counseling, or the use of prescription medication for mental health problems. In CY 2020 and CY 2021, SAMHSA will continue to provide guidance to agencies on how to administer mental health services to individuals with SMI. Federal efforts, including ISMICC, discretionary grant programs, and SAMHSA's Clinical Support Services for SMI Technical Assistance Center will enable agencies to provide coordinated efforts and resources to individuals with SMI.

HHS FY 2020-2021 Agency Priority Goals

The HHS FY 2020-2021 APGs support multiple objectives across the HHS Strategic Plan. For presentation purposes, the Department has chosen to display these APGs under their most closely aligned strategic objectives. For more information on this goal, go to Performance.gov.

Reducing Opioid Morbidity and Mortality. Reduce opioid-related morbidity and mortality through: 1) improving access to prevention, treatment and recovery support services; 2) targeting the availability and distribution of overdose-reversing drugs; 3) strengthening public health data and reporting; 4) supporting cutting-edge research; and 5) advancing the practice of pain management. Starting from the baseline of September 30, 2019, by September 30, 2021:

1. Treatment—Increase uptake of medications for the treatment of opioid use disorder:
    a. By 15 percent the number of unique patients receiving prescriptions for buprenorphine in U.S. outpatient retail pharmacies (excluding implantable or long-acting injection products).
    b. By 100 percent the number of prescriptions for long-acting injectable or implantable buprenorphine from retail, long-term care, and mail-order pharmacies in the U.S.
    c. By 25 percent the number of prescriptions for extended-released naltrexone from retail, long-term care, and mail-order pharmacies in the U.S.
    d. By 57 percent the number of providers with a DATA 2000 waiver authorizing buprenorphine prescribing for opioid use disorder treatment.
2. Overdose intervention—Increase availability and access to overdose-reversing drugs:
    a. By 50 percent the number of prescriptions dispensed for naloxone in U.S. outpatient retail and mail-order pharmacies.

Goal 2. Objective 4: Prepare for and respond to public health emergencies

The health of Americans during public health emergencies and other incidents depends on the effectiveness of preparedness, mitigation, response and recovery efforts. Threats in an increasingly interconnected, complex, and dangerous world include naturally emerging infectious diseases; frequent and severe weather events; state and non-state actors that have access to chemical, biological, radiological, or nuclear agents; non-state actors who commit acts of mass violence; and cyber-attacks.

HHS is engaged in the research, development, and procurement of medical countermeasures, which include vaccines, drugs, therapies, and diagnostic tools. HHS collaborates with others to ensure that the appropriate number of safe and effective medical countermeasures are developed and stockpiled and can be easily distributed to save lives during an incident. HHS also invests in building the capacity of other countries to detect, prevent, and respond to incidents.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, ASA, ASPA, ASPR, CDC, CMS, FDA, HRSA, IHS, IOS, NIH, OASH, OCR, OGA, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 2.4 Table of Related Performance Measures

Maintain the percentage of CDC-funded Public Health Emergency Preparedness (PHEP) state and local public health agencies that can convene, within 60 minutes of notification, a team of trained staff that can make decisions about appropriate response and interaction with partners (Lead Agency - CDC; Measure ID - 13.5.3) [27]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	95%	95%	96%	96%	96%	96%	96%	96%
Result	96%	100%	95%	85%	2/28/20	2/28/21	2/28/22	2/28/23
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Pending	Pending	Pending	Pending

Public health agencies must be able to rapidly convene key management staff (within 60 minutes of notification) to appropriately respond to an emergency. This effort includes the integration of information and the prioritization of resources to ensure timely and effective coordination within the public health agency and key response partners.

In FY 2016, 95 percent of PHEP-funded public health agencies convened trained staff within 60 minutes of notification to make decisions regarding partner engagement and incident response. This is slightly below the target of 96 percent. The result is mostly due to two PHEP-funded public health agencies that provided data based on responding to real incidents (hurricane and Zika responses), which resulted in longer assembly times from staff.

In FY 2017, the PHEP program transitioned to the Operational Readiness Review, which caused a change in the data collection process and may have affected FY 2017 performance. In that year, 85 percent of PHEP-funded public health agencies convened trained staff within 60 minutes of notification to make

[27] CDC results are based on jurisdictions (N) that allocated PHEP funding for pulsed-field gel electrophoresis E.coli activities.

decisions regarding partner engagement and incident response, which is below the target of 96 percent. The new process and system requires recipients to provide detailed records to a PHEP specialist for review to determine if the staff assembly met all requirements. The program will provide additional training and technical assistance to recipients during this transition to improve results and achieve future targets.

Increase the number of new licensed medical countermeasures within Biomedical Advanced Research and Development Authority (BARDA) (Lead Agency - ASPR; Measure ID - 2.4.13a)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	3	3	3	3	3	3
Result	N/A	N/A	3	5	9	7	12/31/20	12/31/20
Status	N/A	N/A	Target Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Medical countermeasures (MCMs) are federally regulated products used during a public health emergency. Examples of emergencies include chemical, biological, radiological and nuclear agents, pandemic influenza, and emerging (or re-emerging) infectious diseases. Through the BARDA program, ASPR develops and makes available MCMs to prepare for and respond to national emergencies. Each of APSR's products is designed to address a particular gap in our ability to address these emergencies. In addition, ASPR oversees purchases of MCMs for storage in the Strategic National Stockpile.

ASPR's approach to advanced research and development has a proven track record of success due to continuous collaboration with NIH, CDC, FDA, and the Departments of Defense, Homeland Security, Veteran Affairs, and Agriculture. HHS sets research and development priorities under a five-year strategy and implementation plan. In FY 2019, BARDA completed the licensure process for a Zika vaccine and took steps to address the threat of the Ebola virus spreading within the United States. In FY 2020 and FY 2021, ASPR will continue to support the development of critical MCMs to increase national preparedness.

Goal 3. Objective 1: Encourage self-sufficiency and personal responsibility, and eliminate barriers to economic opportunity

Strong, economically stable individuals, families, and communities are integral components of a strong America. Many Americans currently experience or are at risk for economic and social instability. The social and health impacts of poverty can include reduced access to nutritious food; fewer educational opportunities, and poor educational outcomes; a lack of access to safe and stable housing; increased risk of poor health outcomes including obesity and heart disease; and difficulty obtaining work opportunities. The Department coordinates safety-net programs across the Federal Government; state, local, tribal, and territorial governments; and faith-based and community organizations.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, and CMS. In consultation with OMB, HHS has highlighted this objective as a focus area for improvement. The Department is progressing in this objective, but HHS would like to enhance that progress moving forward. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 3.1 Table of Related Performance Measures

Increase the percentage of adult Temporary Assistance for Needy Families (TANF) work-eligible individuals who entered employment (Lead Agency - ACF; Measure ID - 22B) [28, 29]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	N/A	Baseline	TBD	TBD
Result	N/A	N/A	N/A	17.9%	1/30/20	1/30/21	1/30/22	1/30/23
Status	N/A	N/A	N/A	Actual	Pending	Pending	Pending	Pending

TANF provides states with block grants to design and operate programs that help needy families reach self-sufficiency, with a focus on preparing parents for work. This program measure assesses how effectively recipients transition from cash assistance to employment. Full success requires not only that recipients be employed, but also that they remain employed, increase their earnings, and demonstrate a reduction in dependency on cash assistance.

ACF is committed to helping the states identify innovative and effective employment strategies and offering a range of targeted technical assistance efforts. As one example, ACF provides research on potential areas for employment and skill-building. In FY 2020 and FY 2021, ACF will continue to support state, tribal, and community partners' efforts to design and implement programs that focus simultaneously on adult employment and family well-being.

[28] These data exclude territories but include the District of Columbia.
[29] ACF has revised the performance measure since the FY 2020 APPR.

Increase the percentage of refugees who are self-sufficient (not dependent on any cash assistance) within the first six months of the service period (Lead Agency - ACF; Measure ID - 16.1LT and 16C)[30]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	69.76%	76.84%	83.01%	85.26%	84.84%	82.88%	81.80%	Prior Result +1%
Result	76.08%	82.19%	84.42%	84%	82.06%	80.99%	11/30/20	11/30/21
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Target Not Met	Target Not Met	Pending	Pending

In FY 2019, 189 locations offered ACF Matching Grant Program services. This is a decrease from 236 locations in FY 2018. ACF expects additional site closings and consolidations in FY 2020. Since the program provides $2,500 in funds for each individual served, program funding is directly linked to the number of eligible participants. Grantees access funds only when serving eligible participants. While providing services, grantees must match federal funds by at least 50 percent. ACF encourages grantees to experiment in the delivery of services at one or more sites to improve efficiencies and outcomes.

ACF expects to complete enhanced on-site monitoring of each grantee's local service provider site at least once every three years. As the number and quality of these monitoring meetings increases, ACF expects that an analysis of the monitoring data will yield information useful to performance improvement efforts. ACF continues to enforce the Performance Improvement Plan (PIP) requirement that affects each site expecting to serve at least 50 clients in the fiscal year, performing 10 percentage-points or more below the network's self-sufficiency average, and performing at least 5 percentage-points below the annual national program average. Each PIP must include concrete measures such as enhanced monitoring, professional development training, reassignment of personnel, and reductions in funding. Grantees report on the progress of their PIPs every six months.

[30] In spite of generally robust economic conditions, grantees continue to note the difficulties inherent with decreasing and uneven arrival numbers and the corresponding adjustments in funding. Nonetheless, outcomes remain commendable and ACF expects positive growth to resume as the agency works towards achieving FY 2020 goals.

Goal 3. Objective 2: Safeguard the public against preventable injuries and violence or their results

Injuries and violence affect all Americans regardless of an individual's age, race, or economic status. Preventable injuries and violence—such as falls, homicide stemming from domestic violence, and gang violence—kill more Americans ages 1 to 44 than any other cause, including cancer, HIV, or the flu.[31] Hospitalizations, emergency room visits, and lost productivity caused by injuries and violence cost Americans billions of dollars annually.

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. The Department supports multiple trauma-informed care initiatives to integrate a trauma-informed approach into health, behavioral health, and related systems to reduce the harmful effects of trauma and violence on individuals, families, and communities.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, CDC, IHS, OASH, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 3.2 Table of Related Performance Measures

Maintain the percentage of domestic violence program clients who have a safety plan (Lead Agency - ACF; Measure ID - 14D)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	90%	90%	90%	90%	90%	90%	90%	90%
Result	93%	91.9%	89.6%	92.8%	93.4%	5/31/20	5/31/21	5/31/22
Status	Target Exceeded	Target Exceeded	Target Not Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Family Violence Prevention and Services Act grantee data for fiscal years 2017 and 2018 show that more than 90 percent of domestic violence program clients reported improved knowledge of safety planning as a result of grantee efforts. These data correlate with other indices of longer-term client safety and well-being.[32] Since many program participants receive short-term crisis assistance and would not expect to report significant change, consistently achieving a higher than 90 percent benchmark is unrealistic. In FY 2021, ACF will continue to implement its improved data quality checks to ensure data accuracy as well as work with the grantees to identify ways to promote domestic violence safety.

[31] https://www.cdc.gov/injury/wisqars/overview/key_data.html

[32] Bybee, D. I., and Sullivan, C. M. (2002). Strengths-based intervention resulted in positive change for battered women over time. American Journal of Community Psychology, 30(1), 103-132.

Decrease the percentage of children with substantiated or indicated reports of maltreatment that have a repeated substantiated or indicated report of maltreatment within six months (Lead Agency - ACF; Measure ID - 7B)[33]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	6.10%	6.30%	6.20%	6.30%	6.74%	6.50%	Prior Result - 0.2PP	Prior Result -0.2PP
Result	6.50%	6.40%	6.50%	6.90%	6.70%	10/31/20	10/31/21	10/31/21
Status	Target Not Met	Target Not Met but Improved	Target Not Met	Target Not Met	Target Met	Pending	Pending	Pending

In FY 2017, the rate of repeat child maltreatment increased from 6.5 percent to 6.9 percent. In FY 2018, the rate decreased to 6.7 percent. In FY 2020 and FY 2021, ACF will continue to identify and implement ways to support states in their efforts to care for children and families who are experiencing a crisis, while ensuring the safety of children. The renewed emphasis on prevention efforts may also lead to improved performance in this area.

Increase Intimate Partner (Domestic) Violence screening among American Indian and Alaska Native (AI/AN) females (Lead Agency – IHS; Measure ID – 81)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	41.6%	41.6%	41.5%	37.5%
Result	N/A	N/A	N/A	N/A	38.1%	36.3%	1/31/20	1/31/21
Status	N/A	N/A	N/A	N/A	Target Not Met	Target Not Met	Pending	Pending

Domestic and intimate partner violence has a disproportionately large impact on AI/AN communities. AI/AN women experience intimate partner violence at higher rates than any other single race or ethnicity in the United States. Screening for intimate partner (domestic) violence provides the ability to identify victims and those at risk for injury. The Intimate Partner (Domestic) Violence screening measure supports improved processes for identification, referral, and treatment for female victims of domestic assault. In FY 2018, IHS began reporting the Intimate Partner (Domestic) Violence screening measure using the IHS Integrated Data Collection System Data Mart (IDCS DM). FY 2019 represents the second year of IDCS DM reporting; IHS continues to monitor and adjust to reporting system changes. Although several IHS Areas met or exceeded the FY 2018 and FY 2019 targets, IHS did not meet the national target of 41.6 percent. IHS is reviewing FY 2019 data and will reach out to the Areas and sites that met or exceeded the target to identify what is working well, capture lessons learned, and cultivate knowledge sharing across the Agency. IHS will also provide technical assistance and training to IHS health care providers and sites in completing the appropriate screening and injury assessments and IDCS DM reporting. IHS will provide outreach and assistance to tribal sites as requested.

In FY 2020 and FY 2021, IHS will offer additional Intimate Partner (Domestic) Violence trainings for health care providers for screening and injury assessment. IHS will also provide technical assistance to sites that did not meet the FY 2019 screening target and improve the data collection process for reporting results. In FY 2021, IHS will continue to support screening improvements for domestic violence among AI/AN females.

[33] The program updated the FY 2016 actual result for this performance measure based on a technical correction to calculate the data based on the national population, which is consistent with previous results. The program updated the FY 2017 target due to this change.

Goal 3. Objective 3: Support strong families and healthy marriage, and prepare children and youth for healthy, productive lives

Families are the cornerstone of America's social fabric. People live longer, have less stress, and are more financially stable in a healthy family environment where both parents are present, share the responsibility of the household, and raise the children. Additionally, in these households, children tend to be healthier, both mentally and physically, and are better able to have their fundamental needs met. The Department supports healthy families and youth development through collaborations across the Federal Government and with states, territories, community partners, tribal governments, and faith-based organizations.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, CDC, HRSA, IHS, OASH, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 3.3 Table of Related Performance Measures

Reduce the proportion of Head Start preschool grantees receiving a score in the low range on any of the three domains on the basis of the Classroom Assessment Scoring System (CLASS: Pre-K) (Lead Agency - ACF; Measure ID - 3A)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	27%	26%	25%	24%	15%	17%	15%	Prior Result - 1PP
Result	23%	22%	24%	16%	18%	16%	1/31/21	1/31/22
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Not Met	Target Exceeded	Pending	Pending

The ACF Office of Head Start (OHS) strives to increase the percentage of Head Start children in high-quality classrooms. ACF measures progress by reducing the proportion of Head Start grantees scoring in the low range (below 2.5) in any domain of the Classroom Assessment Scoring System (CLASS: Pre-K). This research-based tool measures teacher-child interaction on a seven-point scale in three broad domains: Emotional Support, Classroom Organization, and Instructional Support. Research findings underscore the importance of teacher-child interactions as a demonstrated measure of classroom quality. OHS assesses each Head Start grantee using the CLASS instrument during onsite monitoring reviews. The most recent data from FY 2019 CLASS reviews indicate that 16 percent of grantees scored in the low range. In FY 2020 and FY 2021, ACF plans to reduce the proportion of grantees scoring in the low range by at least one percentage-point, year over year.

Reduce the proportion of children and adolescents ages 2 through 19 who are obese (Lead Agency - CDC; Measure ID - 4.11.10b)[34,35]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	15.7%	N/A	15.2%	N/A	14.7%	N/A
Result	17.2%	N/A	18.5%	N/A	5/30/20	N/A	5/30/20	N/A

[34] The data for this performance goal are collected and reported every other year.

[35] There was a delay in publication of CDC's NHANES data, and FY 2018 results will not be available until spring 2020. CDC anticipates that subsequent NHANES data may also be delayed and has adjusted the reporting dates.

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Status	Actual	N/A	Target Not Met	N/A	Pending	N/A	Pending	N/A

CDC funds a number of interventions that target obesity as well as related chronic diseases. The percentage of all children and adolescents (ages 2 to 19 years) that have obesity increased from 16.8 percent in FY 2008 to 18.5 percent in FY 2016. In children ages 2 to 5, the prevalence of obesity has fluctuated over time. Research shows behaviors that influence excess weight gain include eating high-calorie, low-nutrient foods and beverages and not getting enough physical activity. Public health practitioners can educate individuals about healthy lifestyle choices and ways to improve their diet and increase physical activity. Places such as child care centers, schools, or communities can affect diet and activity through the foods and drinks offered and the opportunities provided for physical activity. In FY 2020 and FY 2021, CDC will continue promoting good nutrition and physical activity in children and adolescents to help prevent childhood obesity.

Maintain the proportion of youth living in safe and appropriate settings after exiting ACF-funded Transitional Living Program (TLP) services. (Lead Agency - ACF; Measure ID - 4A)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	86%	86%	86%	87%	90%	90%	90%	91%
Result	87.8%	88.2%	91.6%	90.7%	90%	1/30/20	12/30/20	12/30/21
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Met	Pending	Pending	Pending

The Transitional Living Program (TLP) supports community-based, adult-supervised residences for youth ages 16 to under 22 who cannot safely live with their own families, or for whom living with their families provides undue hardships. This long-term shelter program offers otherwise homeless youth housing for up to 18 months and provides the educational, employment, health care and life skills necessary for youth to transition into self-sufficient living. The TLP safe and appropriate exit rate is the percentage of TLP youth discharged during the year who find immediate living situations that are consistent with independent living. The vast majority of youth (70 percent) were between the ages of 18 and 20 when they entered the program. Approximately 25 percent of these youth had been in the child welfare system and almost 11 percent had been involved in the juvenile justice system.

Because safe and stable housing is one of the core outcomes for the TLP program, ACF proposes to keep this performance standard and increase the annual target to 90 percent. In FY 2020 and FY 2021, ACF will continue to work with grantees to ensure that appropriate service delivery and technical assistance systems are in place to provide increased support to at-risk youth.

(For adult-serving programs) Increase the proportion of participants who, at program exit, express positive attitudes towards marriage (Lead Agency – ACF; Measure ID – 22G) [36]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	N/A	Baseline	TBD	TBD
Result	N/A	N/A	N/A	87.52%	87.38%	3/31/20	3/31/21	3/31/22
Status	N/A	N/A	N/A	Actual	Actual	Pending	Pending	Pending

[36] This is a new measure. ACF is in the process of collecting data and determining targets.

(For adult-serving programs) Increase the proportion of married couples who, at program exit, view their marriage as lifelong (Lead Agency – ACF; Measure ID – 22H) [37]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	N/A	Baseline	TBD	TBD
Result	N/A	N/A	N/A	94.9%	94.2%	3/31/20	3/31/21	3/31/22
Status	N/A	N/A	N/A	Actual	Actual	Pending	Pending	Pending

(For youth-serving programs) Increase the proportion of youth who express attitudes supportive of the success sequence (Lead Agency – ACF; Measure ID – 22I) [38]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	N/A	Baseline	TBD	TBD
Result	N/A	N/A	N/A	61.33%	65.15%	3/31/20	3/31/21	3/31/22
Status	N/A	N/A	N/A	Actual	Actual	Pending	Pending	Pending

The Healthy Marriage Relationship Education Grant Program (HMRE) is part of HHS's community-based efforts to promote strong, healthy relationships; family formation; and maintenance of economically secure, two-parent, married families. ACF HMRE grants fund 46 organizations that provide comprehensive healthy relationship and marriage education services and job and career advancement activities.

These are new measures for the Healthy Marriage program that better address the core goals of the program. ACF will establish future performance targets once trend data are established.

[37] This is a new measure. ACF is in the process of collecting data and determining targets.
[38] This is a new measure. ACF is in the process of collecting data and determining targets.

Goal 3. Objective 4: Maximize the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers

Older adults and people with disabilities face a complex set of difficulties. About 1 in every 7, or 14.9 percent, of the population is an older American. Approximately 12 percent of working-age adults in the United States have some type of disability. Of these adults, 51 percent had a mobility disability, and 38.3 percent had a cognitive disability.

To support older adults, people with disabilities, and the system of friends, family, and community members that support them, the Department collaborates across the Federal Government and, with states, tribes, territories , and faith-based and community organizations. Aging and Disability Resource Centers provide a gateway to a broad range of services and supports for older adults and people with disabilities. Centers for Independent Living are community-based centers that offer services to empower and enable people with disabilities to stay in their communities. Every state and territory has an Assistive Technology Act program that can help people find, try, and obtain assistive technology devices and services. Assistive technology includes resources ranging from "low tech" helping tools—like utensils with big handles—to higher-tech solutions like talking computers.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, CDC, CMS, HRSA, IHS, OASH, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 3.4 Table of Related Performance Measures

Demonstrate improvement in nursing home health care quality by reducing the number of one-star nursing homes (Lead Agency - CMS; Measure ID - QIO7.2)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019		
Target	N/A	N/A	Baseline	N/A	6.0%			
Result	N/A	N/A	8.0%	4.6%	4.4%			
Status	N/A	N/A	Actual	Actual	Target Exceeded			

Demonstrate improvement in nursing home health care quality by reducing the number of one-star nursing homes (Lead Agency - CMS; Measure ID - QIO7.3)[39]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	N/A	Baseline	TBD	TBD
Result	N/A	N/A	N/A	N/A	N/A	4/30/20	TBD	TBD
Status	N/A	N/A	N/A	N/A	N/A	Pending	Pending	Pending

To protect more than 3 million nursing home residents, CMS provides strategies to guide local, state, and national efforts to improve the quality of care in nursing homes. In December 2008, CMS added a star rating system to the Nursing Home Compare website to track nursing home quality. This rating system serves three purposes: 1) to provide residents and their families with an assessment of nursing home quality, 2) to distinguish between high and low performing nursing homes, and 3) to provide

[39] CMS will use the baseline to determine future targets.

incentives for nursing homes to improve their performance. The one-star rating is the lowest rating and the five star rating is the highest.

In April 2019, CMS made improvements to each of the rating system domains under the Five Star Quality Rating System. These revisions are part of an ongoing effort to improve information available to the public and drive quality improvement amongst nursing homes. Due to the change in the methodology of how data is collected for the quality component of the Five Star Quality Rating System, the current reporting methodology is no longer valid and a new measure, baseline and future targets are expected to be developed for this goal Spring 2020.

CMS included new Quality Measure (QM) rating thresholds which increase every six months in the new ratings methodology. CMS provides the new QM weights, scoring, and changes to certain measures in the Quality, Safety and Oversight Group Memo QSO-19-08-NH and the Nursing Home Compare Five-Star Quality Rating System: Technical User's Guide.

Decrease the percentage of long-stay nursing home residents receiving an antipsychotic medication (Lead Agency - CMS; Measure ID - MSC5)

	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Target	19.1%	17.9%	16.7%	16%	16%	15.5%	15.4 %	15.3%
Result	19.1%	17.1%	16.7%	15.4%	14.6%	4/30/20	4/30/21	4/30/22
Status	Target Met	Target Exceeded	Target Met	Target Exceeded	Target Exceeded	Pending	Pending	Pending

Antipsychotic medications have common and dangerous side effects when used for the behavioral and psychological symptoms of dementia. National scientists and thought leaders have review a number of evidence-based non-pharmacological interventions and approaches have been reviewed through the National Partnership to Improve Dementia Care. The Advancing Excellence website (in the public domain) at www.nhqualitycampaign.org posts clinical practice guidelines and various tools and resources. State coalitions are reaching out to providers in every state and encouraging the use of these resources, as well as Hand in Hand, which is a CMS-developed training program for nursing home staff.

Success varies by state and CMS region, with some states and regions seeing a reduction of greater than 40 percent. CMS continues to have quarterly national calls with the public on aspects of good dementia care and the use of non-pharmacological approaches. CMS is conducting focused dementia care surveys on those facilities that continue to have high rates of antipsychotic use, and has modified the regulations limiting the use of antipsychotic medications on an as needed basis.

Improve dementia capability of long-term support systems to create dementia-friendly, livable communities (Lead Agency ACL; Measure ID – ALZ.3)[40,41]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	Baseline	28%	33%	35%
Result	N/A	N/A	N/A	N/A	22%	1/31/20	1/31/21	1/31/22
Status	N/A	N/A	N/A	N/A	Actual	Pending	Pending	Pending

Of the community dwelling individuals living with Alzheimer's Disease and Related Dementias (ADRD), approximately one-third live alone, exposing them to numerous risks, which include unmet needs, malnutrition and injury, and various forms of neglect and exploitation.[42] With the number of people living with ADRD in the United States projected to grow by almost 300 percent by 2050[43], it is important to develop effective and coordinated service delivery and health care systems that are responsive to the needs of these individuals and their caregivers.

ACL's Alzheimer's Disease Program provides funding for the development and enhancement of dementia-capable, person-centered systems of services and supports through partnerships with public and private entities. In 2017, ACL developed a new tool to measure the program's success at improving the dementia capability of long-term services and support systems. Through the tool, program grantees and their partners assess organizational activities in the following three areas:

- Identification of people with possible cognitive impairment or dementia and their primary caregiver;
- Staff training about cognitive impairment, dementia and dementia care, and
- Provision of specialized services for people with a cognitive impairment or dementia and their caregivers.

ACL ensures the quality of the assessment results through frequent contact with grantees, clear guidance for grantees regarding their grant activities and reporting expectations, and timely review of grantee performance data. If grantees appear to be underperforming based on the data provided, grant officers provide technical assistance.

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[40] Program participants report annually on program progress in advancement of the dementia-capability of program partners and provide appropriate technical assistance to address areas of concern. Data reported include changes in the range of services and supports each grantee provides to people with dementia, grantee capacity to provide specialized services to people with a cognitive impairment or dementia and their caregivers, and the degree to which the grantee organizations have standardized their procedures or assessing dementia among their consumers. ACL uses grantee responses to calculate grantee level of improvement between reporting periods.

[41] This is a developmental measure. ACL is currently collecting sufficient data to establish a baseline. To set a baseline, the agency relies on 3 years of data. This process ensures that the data are stable and show a clear trend.

[42] Gould, E., Maslow, K., Yuen, P., Wiener, J. *Providing Services for People with Dementia Who Live Alone: Issue Brief.* Accessed April 14, 2014.

[43] Alzheimer's Association. *2017 Alzheimer's Disease Facts and Figures.* Accessed May 9th, 2017 at http://www.alz.org/alzheimers_disease_facts_and_figures.asp

Increase the success rate of the Protection and Advocacy Program's individual or systemic advocacy, thereby advancing individuals with developmental disabilities right to receive appropriate community based services, resulting in community integration and independence, and have other rights enforced, retained, restored and/or expanded (Lead Agency ACL; Measure ID – 8F)[44]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	N/A	TBD	TBD	TBD
Result	N/A	N/A	N/A	78.1%	78.9%	1/31/21	1/31/22	1/31/23
Status	N/A	N/A	N/A	Actual	Actual	Pending	Pending	Pending

Under the Developmental Disabilities Assistance and the Bill of Rights Act of 2000 (DD Act), each state and territory has a Developmental Disabilities Protection and Advocacy (P&A) program designated by the state's governor. The DD Act and other authorizing statutes give the P&A the authority to advocate for the rights of individuals with disabilities. The DD Act states that each P&A has the authority to "pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of such individuals within the State."[45] P&As provide a range of legal services and use a range of remedies, including self-advocacy assistance, negotiation, investigation, and litigation, to advocate for traditionally unserved or underserved individuals with developmental disabilities. P&A authorities are critical to preventing abuse and neglect of people with disabilities and safeguarding individuals' right to live with dignity and self-determination.

In FY 2019, grant officers worked with ACL's Office of Performance and Evaluation to develop or improve logic models and performance measures for this program. ACL staff are working on developing standard methods for analyzing the data to identify trends and results.

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[44] This is a developmental measure. ACL is currently collecting sufficient data to establish a baseline. To set a baseline, the agency relies on 3 years of data. This process ensures that the data are stable and show a clear trend. The agency will set targets for this measure once a baseline is established.

[45] 42 U.S.C. 15043

Goal 4. Objective 1: Improve surveillance, epidemiology, and laboratory services

The Department is dedicated to conducting and funding scientific research that leads to evidence-based, high-quality care and responsive interventions to mitigate health crises. Data and information from surveillance, epidemiology, and laboratory services can aid in the prevention and early intervention of foodborne illnesses, such as listeria and norovirus, and infectious disease outbreaks, such as Zika and Ebola. To achieve this objective, the Department is working to facilitate information exchange to identify risks quickly and efficiently, strengthen the quality and safety of our nation's laboratories, and strengthen the alignment of surveillance, epidemiology, and laboratory services.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ASPR, CDC, CMS, FDA, NIH, OCR, OGA, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is making noteworthy progress. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 4.1 Table of Related Performance Measures

Maintain the percentage of laboratory reports on reportable conditions that are received through electronic means nationally (Lead Agency - CDC; Measure ID - 3.5.2)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	65%	70%	75%	80%	82%	90%	90%	90%
Result	69%	69%	75%	80%	86%	90%	12/31/20	12/31/21
Status	Target Exceeded	Target Not Met	Target Met	Target Met	Target Exceeded	Target Met	Pending	Pending

Advancing national implementation of Electronic Laboratory Reporting (ELR) is a priority in CDC's efforts to protect the public's health. ELR replaces paper-based reporting, which accelerates reporting to public health labs; reduces the reporting burden on clinicians, hospitals, and commercial laboratories; and decreases errors and duplicate reporting. As of FY 2019, electronic laboratory reports accounted for nearly 90 percent of laboratory reports for reportable conditions received, which met the target and was an improvement over FY 2018. These results continue the upward trend begun FY 2012.

Since there are diminishing returns after reaching an ELR volume higher than 90 percent, the program considers moving from 62 percent in 2013 to 90 percent a success. In FY 2020 and FY 2021, CDC will continue to monitor the implementation of ELR as part of its efforts to protect the public health.

Increase the percentage of notifiable disease messages transmitted in HL7 format to improve the quality and streamline the transmission of established surveillance data (Lead Agency – CDC; Measure ID - 8.B.1.4)[46]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	Baseline	10%	40%	40%	40%	40%	40%
Result	1%	1%	3%	5%	5%	7.24%	2/1/21	2/1/22
Status	Actual	Actual	Target Not Met but Improved	Target Not Met but Improved	Target Not Met but Improved	Target Not Met but Improved	Pending	Pending

[46] The initially reported FY 2018 result of seven percent reflected only a segment of these data. The FY 2018 result has been revised to reflect final data.

During FY 2019, CDC advanced the modernization of infectious disease surveillance by producing technology upgrades to the Message Validation, Processing and Provisioning System, which receives production data from the states using the new Health Level Seven (HL7) based messages. This system reduces development time to implement a new condition from months to weeks and ensures that CDC programs can access their data within an hour of receipt at CDC. When CDC completes implementation of new HL7 messages for all diseases, the new strategy will allow the retirement of older, less efficient legacy systems, and will increase the number of HL7 messages received at CDC. In 2019, 7.24 percent of notifiable disease messages received at CDC were in the HL7 format, which is an increase over the FY 2018 result. Data transmissions continue to improve and remain stable, which indicates that CDC has achieved a more routine and reliable mode. The FY 2020 and FY 2021 focus will be on completion of the modernization process and transitioning to efficient long-term operations with continuous improvement and enhancement.

The National Notifiable Diseases Surveillance System (NNDSS) Modernization Initiative involved updating infrastructure, data standards, and state and programmatic capabilities to provide more complete, accurate, and timely data for public health awareness and action. CDC prioritized upgrading and developing technology and data standards to streamline the receipt and processing of information from states. CDC worked with state partners to develop capacity to utilize the modernized system.

CDC is now focused on full implementation of the improved technology and standardized formats. CDC anticipates meeting the current target of 40 percent of all messages being transmitted in the HL7 format no later than end of FY 2022.

Number of medical product analyses conducted through the FDA's Sentinel Active Risk Identification and Analysis (ARIA) system (Lead Agency – FDA; Measure ID – 292203)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	N/A	50	55	60
Result	N/A	N/A	N/A	N/A	74	68	1/31/21	1/31/22
Status	N/A	N/A	N/A	N/A	Actual	Target Exceeded	Pending	Pending

FDA has developed a new Sentinel performance measure that focuses on using the system to generate high quality evidence about the use of medical products and their risks and benefits. The new measure leverages Sentinel's Active Risk Identification and Analysis system. This system is comprised of pre-defined, parameterized, and reusable routine querying tools, which are combined with the multi-site electronic data in the Sentinel Common Data Model. This enables FDA to conduct safety analyses more efficiently using a trusted distributed database that undergoes continuous quality checks and refreshes. FDA has used the results of these analyses to present at FDA Advisory Committee meetings, highlight potential ways to intervene in the opioid crisis, inform responses to Citizen Petitions, and influence numerous regulatory decisions.

FDA has framed the new goal as the number of analyses conducted using the ARIA system. This is a new goal and the analyses conducted each year can vary greatly in the number, timing, complexity, and character of the safety issues. FDA set the initial target at 50 analyses for FY 2019. FDA will reassess these targets periodically. These targets reflect the trend toward more complex analyses that employ more sophisticated analytical methods and yield more meaningful inputs to public health and regulatory decision making.

Goal 4. Objective 2: Expand the capacity of the scientific workforce and infrastructure to support innovative research

Tomorrow's scientific breakthroughs depend on a highly trained and ethical scientific workforce, working in facilities and with tools that foster innovation. Efforts to expand the capacity of the scientific workforce and infrastructure can better prepare the nation for global health emergencies, extend the reach and impact of scientific investigations, and contribute to research of national or global significance.

Through various initiatives and programs, HHS recruits and trains students, recent graduates, and other professionals to conduct rigorous and reproducible research. HHS provides research training and career development opportunities to ensure that highly trained investigators will be available across the range of scientific disciplines necessary to address the nation's biomedical and scientific research needs. Scientific integrity is a priority for the Department. Divisions responsible for research have developed policies and procedures to ensure the highest degree of scientific integrity in the research HHS conducts, funds, and supports—to ensure that our research is credible and worthy of the public's confidence.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: AHRQ, CDC, FDA, NIH, OASH, OGA, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 4.2 Table of Related Performance Measures

By 2021, develop, validate, and/or disseminate 3-5 new research tools or technologies that enable better understanding of brain function at the cellular and/or circuit level (Lead Agency - NIH; Measure ID - SRO-2.12)

Fiscal Year	Target	Result	Status
FY 2014	N/A	N/A	N/A
FY 2015	N/A	N/A	N/A
FY 2016	N/A	N/A	N/A
FY 2017	N/A	N/A	N/A
FY 2018	Develop four novel neurotechnologies for stimulating/recording in the brain to enable basic studies of neural activity at the cellular level	Projects funded through the BRAIN Initiative led to novel innovations in four neurotechnologies to enable basic studies of neural activity at the cellular level.	Target Met
FY 2019	Test new and/or existing brain stimulation devices for two new therapeutic indications in humans through the BRAIN Public-Private Partnership.	The BRAIN Initiative Public-Private Partnership Program initiated testing of brain stimulation devices for six new therapeutic indications in humans and continued to enable current and potential BRAIN investigators to gain access to medical device tools and	Target Met

Fiscal Year	Target	Result	Status
		technologies from some of the top medical device manufacturers.	
FY 2020	Provide broad access to new research approaches and techniques for acquiring fundamental insight about how the nervous system functions in health and disease	12/31/20	In Progress
FY 2021	Expand our understanding of brain function at the cellular or circuit level using three to five new tools and technologies	12/31/21	In Progress

The NIH-funded Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative® accelerates the development and application of new neurotechnologies that will enable researchers to gain deeper understanding of how the human brain functions in normal conditions as well as states of disease or dysfunction. One of the BRAIN Initiative programs is the BRAIN Public-Private Partnership Program. This program facilitates partnerships between clinical investigators and manufacturers of the latest-generation invasive brain stimulation and recording devices. These partnerships conduct clinical research on the human central nervous system. In FY 2019, BRAIN investigators initiated testing of brain stimulation devices in humans for six medical conditions: loss-of-control eating; neuropathic pain; essential tremor; freezing of gait from Parkinson's disease; epilepsy; and post-traumatic stress disorder. By increasing collaborations between researchers and industry partners, the BRAIN Initiative is able to accelerate the dissemination of tools and technologies to its investigators and spur research progress.

In FY 2020 and FY 2021, NIH plans to 1) provide broad access to new research approaches and techniques for acquiring fundamental insight about how the nervous system functions in health and disease and 2) expand our understanding of brain function at the cellular or circuit level using newly developed tools and technologies.

Increase the percentage of scientists retained at FDA after completing the Fellowship or Traineeship programs (Lead Agency- FDA; Measure ID – 291101)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	45%	40%	40%	40%	50%	50%	50%	20%
Result	78%	80%	81%	72%	53%	86%	2/28/21	2/28/22
Status	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

To support the Department's mission and FDA's scientific expertise, FDA is launching a new FDA Traineeship Program while continuing other Fellowship programs. This performance goal focuses on FDA's efforts to retain a targeted percentage of the scientists who complete these programs. The size and focus of the new agency-wide Traineeship Program will be greater in number and scope than the current Fellowship Program. Since the scope of the program will increase, FDA will reset the retention target to 20 percent for FY 2021 to reflect the new program's expected baseline. Whether "graduates" from these programs continue to work for FDA or choose to work in positions in related industry and academic fields, they are trained in an FDA-presented understanding of the complex scientific issues in emerging technologies and innovation, which furthers the purpose of this strategic objective. In FY 2020 and FY 2021, FDA will continue to monitor its ability to retain scientists who have participated in the Fellowship or Traineeship Programs.

Goal 4. Objective 3: Advance basic science knowledge and conduct applied prevention and treatment research to improve health and development

HHS conducts, funds, and supports a broad and diverse portfolio of biomedical research in a range of scientific disciplines, including basic and translational research, to augment scientific opportunities and innovation for public health needs. HHS works to strengthen basic and applied science and treatment pipelines to assess potential health threats and bolster the fundamental science knowledge in these risk areas to expedite the development of therapies. As described in Strategic Objective 4.2, Expand the capacity of the scientific workforce and infrastructure to support innovative research, HHS conducts research is conducted ethically and responsibly.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACL, AHRQ, CDC, FDA, NIH, and OASH. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 4.3 Table of Related Performance Measures

By 2023, develop, optimize, and evaluate the effectiveness of nano-enabled immunotherapy (nanoimmunotherapy) for one cancer type (Lead Agency - NIH; Measure ID - SRO-2.1)

Fiscal Year	Target	Result	Status
FY 2014	N/A	N/A	N/A
FY 2015	N/A	N/A	N/A
FY 2016	N/A	N/A	N/A
FY 2017	N/A	N/A	N/A
FY 2018	Optimize properties of three nanoformulation for effective delivery and antigen-specific response in immune cells.	Developed, tested, and optimized, in animal models, three unique nanodelivery systems for effective anti-cancer immunotherapeutics	Target Met
FY 2019	Further optimize top two candidate nanoformulation for co-delivery of multiple antigens to enhance anti-tumor response in one animal model.	Further optimized two unique nanodelivery systems for effective anti-cancer immunotherapeutics in different animal models and showed promising results for consideration in clinical trials	Target Met
FY 2020	Further optimize the top candidate nanoformulation for co-delivery of antigens, adjuvants and immuno-modulators and evaluate its efficacy and long-lasting immunity (over 3 months) in preclinical models with established tumors.	12/31/20	In Progress
FY 2021	Further optimize the top candidate nanoformulation for co-delivery of antigens, adjuvants and immuno-modulators and evaluate its efficacy towards near and	12/31/21	In Progress

Fiscal Year	Target	Result	Status
	distance metastatic lesions in preclinical models with established tumors.		

Nanoparticles are extremely tiny particles that can coat, attach to, or encapsulate drugs. Scientists use nanoparticles in drug delivery systems to enhance the effectiveness of cancer drugs, which include immunotherapies. NIH supports research to enhance existing immunotherapies with nanotechnologies and facilitate the development of new, more efficacious nano-based immunotherapies.

Results from recent studies have shown that optimizing nanoparticle drug delivery systems improves the effectiveness of cancer immunotherapy. The optimization process of both drugs and delivery systems involves many different steps, which include testing the drug systems in different animal models and in different stages of disease (e.g., localized tumors and tumors that have spread to other parts of the body). In FY 2019, two NIH-funded research teams further optimized two unique nanoparticle drug delivery systems. Their work provides additional evidence that these systems are effective in delivering drugs to different tumor types and at different stages of disease, which include stages when the tumors have spread to other parts of the body.

In FY 2020 and FY 2021, NIH will support the optimization and evaluation of the top-candidate nanoparticle drug delivery system in animal models of advanced stages of cancer. These efforts will lay the groundwork for obtaining FDA approval to begin evaluating the system in human studies.

By 2022, evaluate the safety and effectiveness of 1-3 long-acting strategies for the prevention of HIV (Lead Agency - NIH; Measure ID - SRO-2.9)

Fiscal Year	Target	Result	Status
FY 2014	N/A	N/A	N/A
FY 2015	N/A	N/A	N/A
FY 2016	N/A	N/A	N/A
FY 2017	Strategy 1: Continue enrolling participants into two studies to test the safety, tolerability, and effectiveness of VRC01 as an intravenous prevention strategy.	Enrollment of participants continued for both studies.	Target Met
FY 2018	Strategy 2: Analyze primary results of a Phase 2a study examining the long-acting injectable, cabotegravir, for the prevention of HIV	Analysis of primary results has been conducted and results are in press.	Target Met
FY 2019	Strategy 3: NIH-funded investigators complete final analysis of an open-label extension study that builds on the findings of an earlier trial and aims to assess the continued safety of the dapivirine vaginal ring in a more real-world context and study participants' adherence	NIH-funded investigators completed final analysis of an open-label extension study that built on the findings of an earlier trial and aimed to assess the continued safety of the dapivirine vaginal ring and study participants' adherence to its use.	Target Met
FY 2020	Strategy 1: Complete follow-up of participants in studies testing the safety, tolerability, and effectiveness of VRC01.	12/31/20	In Progress

Fiscal Year	Target	Result	Status
FY 2021	Strategy 1: Analyze data of two studies testing the safety, tolerability, and effectiveness of VRC01 broadly neutralizing antibody (bnAb).	12/31/21	In Progress

NIH-funded research has led to the identification of highly effective, non-vaccine prevention strategies that have the potential to significantly reduce HIV infection rates around the world. However, adhering to daily or near-daily dosing has proved challenging for both HIV-infected and uninfected individuals. Women in particular have limited HIV prevention options that they can initiate and that are discreet and long-acting. To address this issue, NIH funded a study to gather additional data on the safety of a vaginal ring infused with a drug to prevent HIV, as well as new data on whether and how women used it in a real-world setting. The ring is inserted once a month and slowly releases the antiviral drug. Overall, the ring was found to be safe and have moderate levels of HIV protection. Additionally, the majority of study participants accepted and were willing to use the ring to protect themselves against HIV infection. These and related efforts represent some of the building blocks that NIH is laying toward the goal of providing women with a range of HIV prevention tools from which they can make informed choices.

In FY 2020 and FY 2021, NIH will continue to support studies that assess whether giving uninfected people an infusion of VRC01, a "broadly neutralizing" (capable of stopping a wide range of HIV strains from infecting human cells) antibody, every eight weeks is an effective way to protect them against HIV infection.

By 2023, identify risk and protective alleles that lead to one novel therapeutic approach, drug target, or pathway to prevention for late-onset Alzheimer's disease (Lead Agency - NIH; Measure ID - SRO-5.3)

Fiscal Year	Target	Result	Status
FY 2014	Complete Discovery Phase whole genome sequencing and analysis of 582 family members from 111 families with late onset AD to identify genomic regions associated with increased risk of AD; sequencing of the coding regions of the DNA (whole exome sequencing) of 5,000 cases / 5,000 controls for both risk raising and protective loci; and whole exome sequencing and analysis of one individual from ~1,000 additional AD families to identify regions associated with increased risk or protection from AD.	Sequencing and an initial level of analysis were completed.	Target Met
FY 2015	Initiate Replication Phase to validate genes / regions of interest identified from case-control and family sequencing in ~50,000 samples from well phenotyped individuals by targeted sequencing and/or genotyping.	Sample selection for whole genome sequencing on additional multiply affected families was initiated. Planning of the Replication Phase has begun.	Target Met
FY 2016	Begin confirmation of genomic regions of interest identified in the Discovery Phase using samples from the Replication phase. Begin harmonization of data from Discovery	Sample selection/sequencing Discovery Extension phases completed (4,000 additional whole genomes). Data analysis for Extension Phase initiated. Genomic Center for Alzheimer's	Target Met

Fiscal Year	Target	Result	Status
	phase datasets with data from Replication Phase for confirmation of regions of interest.	Disease funded (all ADSP quality control and data harmonization).	
FY 2017	Continue confirmation of genomic regions of interest in the Discovery and Replication phase datasets. Continue harmonization of Discovery Phase and Replication Phase datasets.	NIH met its target of confirming genomic regions of interest in the Discovery and Replication phase data sets and continues to harmonize the Discovery Phase and Replication Phase data sets.	Target Met
FY 2018	Continue confirmation of genomic regions of interest in the Discovery phase using samples from the Replication phase. Continue harmonization of Discovery Phase and Replication Phase datasets. Begin analysis of genomic regions of interest in the genomes of minority cohorts.	NIH continued confirmation of genomic regions of interest in the Discovery Phase using samples from the Replication Phase, continued harmonization of Discovery Phase and Replication Phase datasets, and began analysis of genomes of minority cohorts.	Target Met
FY 2019	Begin analysis of genomic regions of interest in the ADSP Discovery Follow-Up Phase using whole genome sequence data from ethnically diverse cohorts. Continue confirmation of genomic regions of interest in the Discovery Phase using samples from the Follow-Up phase. Continue harmonization of Discovery Phase and Follow-Up Phase datasets.	The ADSP Discovery Follow-Up Phase has begun to analyze genomic regions of interest using whole genome sequence data from ethnically diverse cohorts. The ADSP has continued its confirmation of genomic regions identified in the Discovery Phase of the project. Genetic data for all phases of the ADSP have been harmonized.	Target Met
FY 2020	Continue analysis of ADSP Discovery Follow-Up Phase in ethnically diverse cohorts. Continue confirmation of genomic regions of interest from Discovery Phase and Discovery Follow-Up Phase in ethnically diverse datasets. Compare data on genomic regions of interest by ethnicity.	12/31/20	In Progress
FY 2021	Continue analysis of ADSP Discovery Follow-Up Study in ethnically diverse cohorts. Continue confirmation of genomic regions of interest from Discovery Phase and Discovery Follow-Up Phase in ethnically diverse datasets. Begin harmonization of phenotypic data with ADSP genetic data across multiple types of study approaches from large epidemiology and clinical cohorts that are outside of the ADSP.	12/31/21	In Progress

There is an urgent need for effective interventions to prevent, delay, and treat Alzheimer's disease (AD). As many as 5.5 million Americans age 65 and older are living with AD. Available treatments do not target the underlying molecular pathways believed to be involved in AD's development; thus, they neither halt nor reverse disease progression.

The overall goal of the NIH-supported Alzheimer's Disease Sequencing Project (ADSP) is to identify genetic variants associated with risk of and protection from AD. In FY 2019, the ADSP continued to reveal the complexity of the genetics of AD, and the challenges involved in genetic data analysis. The data have helped researchers understand why it has been so challenging to find and develop potential treatments. Once the ADSP has identified and confirmed genes associated with AD, their next step is to determine the genes' function and whether these genes interact to modify how the disease manifests. The availability of large amounts of data from multi-ethnic populations, made possible by the ADSP, is bringing the project closer to identifying genetic variants associated with risk of and protection from AD within specific populations.

In FY 2020 and FY 2021, the NIH-supported ADSP will continue its efforts to identify and confirm genes associated with AD and examine them in ethnically diverse populations. NIH will use this information to explore new, promising pathways for treating AD.

Goal 4. Objective 4: Leverage translational research, dissemination and implementation science, and evaluation investments to support adoption of evidence-informed practices

Translational research, dissemination, and implementation science help increase understanding about how best to support knowledge, adoption, and faithful implementation of best practices in the community. Selecting and adopting evidence-based approaches to tackle health, public health, and human services challenges can be a complex undertaking. HHS programs balance requirements to implement high-quality programs with fidelity, while acknowledging the unique needs of specific individuals or target populations, recognizing differences in program and community settings and resources, and respecting linguistic or cultural differences. Understanding threats to successful implementation of a promising practice can help the Department prevent and mitigate those risks early.

The Office of the Secretary leads this objective. The following divisions are responsible for implementing programs under this strategic objective: ACF, ACL, AHRQ, CDC, FDA, HRSA, NIH, OASH, and SAMHSA. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 4.4: Table of Related Performance Measures

Increase the percentage of Community-Based Child Abuse Prevention (CBCAP) total funding that supports evidence-based and evidence-informed child abuse prevention programs and practices (Lead Agency - ACF; Measure ID - 7D)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	71.4 %	64.1 %	62.4 %	57.3%	56.4%	64.5%	Prior Result +3PP	Prior Result +3PP
Result	61.1 %	59.4 %	53.4%	53.4%	61.5%	10/31/20	10/30/21	10/30/22
Status	Target Not Met	Target Not Met	Target Not Met	Target Not Met	Target Exceeded	Pending	Pending	Pending

Currently, the Children's Bureau and its National Center for CBCAP are working closely with the states to promote more rigorous evaluations of their funded programs. The Children's Bureau defines evidence-based and evidence-informed programs and practices along a continuum. The continuum includes four categories of programs or practices: Emerging and Evidence Informed; Promising; Supported; and Well-Supported.

The FY 2018 result represented an increase with grantees reporting 61.5 percent of funds directed at evidence-based practices. ACF will continue to promote evaluation and innovation to expand the availability and use of evidence-informed and evidence-based practice over time. In FY 2020 and FY 2021, ACF is committed to continuing to work with CBCAP grantees to invest in known evidence-based practices, as well as to focus on one-on-one and peer learning technical assistance on increased accuracy of data reporting for this measure.

By 2020, develop and test the effectiveness of two strategies for translating cancer knowledge, clinical interventions, or behavioral interventions to underserved communities in community-based clinical settings (Lead Agency - NIH; Measure ID - SRO-5.1)

Fiscal Year	Target	Result	Status
FY 2014	N/A	N/A	N/A
FY 2015	N/A	N/A	N/A
FY 2016	N/A	N/A	N/A
FY 2017	Develop two strategies for translating validated basic knowledge, clinical interventions, or behavioral interventions to diverse communities and clinical practice through establishing the Partnerships to Advance Cancer Health Equity (PACHE) program between Minority Serving Institutions (MSI) and NCI-designated Cancer Centers (CC).	Several U54 PACHE Partnerships have developed and/or validated evidence-based interventions and tools to help reduce the burden of cancer disparities in underserved communities across the United States. They are working with various community-based organizations (including faith-based organizations and community-based clinical practices and organizations) to disseminate/translate the interventions and tools in the diverse communities.	Target Met
FY 2018	Develop and support two partnerships to test validated basic cancer knowledge, clinical or behavioral interventions to diverse communities in clinical practice.	The U54 PACHE Partnerships, through 2 new efforts, developed and/or validated evidence-based interventions and tools to help reduce the burden of cancer disparities in underserved communities across the United States. These partnerships continued to work with various community-based organizations (including faith-based organizations and community-based clinical practices and organizations) to disseminate/translate the interventions and tools for use in diverse communities.	Target Met
FY 2019	Finalize testing and validating the strategies to translate basic cancer knowledge, clinical or behavioral interventions to underserved communities and into clinical practice.	Two U54 PACHE partnerships finalized testing and validating evidence-based interventions and tools to help translate basic cancer knowledge and clinical or behavioral interventions to underserved communities across the United States. They continue to work with various community-based organizations to disseminate these interventions and tools.	Target Met
FY 2020	Finalize testing and validating the strategies to translate basic cancer knowledge, clinical or behavioral interventions to underserved communities and into clinical practice.	12/31/20	In Progress

NIH's Partnerships to Advance Cancer Health Equity (PACHE) is a program that fosters partnerships among institutions serving underserved health disparity populations, underrepresented students, and

National Cancer Institute-designated Cancer Centers. PACHE partnerships train scientists from diverse backgrounds in cancer research and to effectively deliver knowledge on cancer to underserved communities.

PACHE partnerships continued to flourish in FY 2019. For example, one partnership promoted cancer screening awareness and recruitment in several clinical trials in African American and Latino communities in the South Los Angeles area. This partnership continues to develop a cancer survivorship and caregiving program to equip nursing students with tools to assist aging underrepresented minority cancer survivors. Another example involves a different partnership that conducted community training and worked with community-based organizations to disseminate educational materials on cancer prevention and screening and HPV vaccination to underserved Micronesian and Pacific Islander populations. This partnership developed a training curriculum and provided informational tools to help healthcare providers serving these populations. These efforts resulted in raised awareness about cancer and cancer prevention related topics of regional relevance.

In FY 2020 PACHE partnerships are finalizing the testing and validation of strategies for translating basic cancer knowledge, and clinical or behavioral interventions to underserved communities and into clinical practice. Although this measure is scheduled to discontinue beginning in FY 2021, NIH is committed to funding future projects to develop and assess new strategies to help bring cancer advances to underserved communities.

Goal 5. Objective 1: Ensure responsible financial management

HHS is responsible for almost a quarter of federal outlays and administers more grant dollars than all other federal agencies combined. Ensuring the integrity of direct payments, grants, contracts, and other financial transactions requires strong business processes, effective risk management, and a financial management workforce with the expertise to comply with legislative mandates, which include the Federal Managers' Financial Integrity Act of 1982 (Pub. L. 97–255), the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109–282), and the Improper Payments Elimination and Recovery Improvement Act of 2012 (Pub. L. 112–248).

HHS co-leads the government-wide Getting Payments Right Cross-Agency Priority (CAP) Goal. Through this CAP goal, HHS aims to better understand the nature of improper payments and their relationship to payment integrity and to demonstrate stewardship of taxpayer dollars. By identifying root causes of monetary loss, strategic uses of data, and mitigation strategies to avoid monetary loss for its large programs (e.g., Medicare, Medicaid, and the Child Health Insurance Program (CHIP)), HHS improves agency and government-wide results. This focus on getting government payments right the first time and preventing monetary loss allows HHS to build public trust in the government.

All divisions contribute to the achievement of this objective. The Office of the Secretary leads this objective. In consultation with OMB, HHS has determined that performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 5.1 Table of Related Performance Measures

Reduce the percentage of improper payments made under Medicare Part C, the Medicare Advantage (MA) Program (Lead Agency - CMS; Measure ID – MIP5)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018 [47]	FY 2019	FY 2020	FY 2021
Target	9%	8.5%	9.14 %	9.5 %	8.08%	7.9%	7.77%	TBD
Result	9%	9.5%	10%	8.3%	8.10%	7.87%	11/15/20	11/15/21
Status	Target Met	Target Not Met	Target Not Met	Target Exceeded	Target Met	Target Exceeded	Pending	Pending

The Part C Medicare Advantage program payment error estimate reflects the extent to which plan-submitted diagnoses for a national sample of enrollees are substantiated by medical records. CMS performs a validation of diagnoses in medical records for sampled beneficiaries during CMS's annual Medical Record Review process, where two separate coding entities review medical records in the process of confirming discrepancies for sampled beneficiaries. To calculate the Part C program's error estimate rate, divide the dollars in error by the overall Part C payments for the year measured.

In FY 2019, CMS reported an actual improper payment estimate of 7.87 percent, or $16.73 billion. The submission of more accurate diagnoses by MA organizations for payment drove the decrease from the prior year's estimate of 8.10 percent. The FY 2020 target is 7.77 percent. The FY 2021 target will be established in the FY 2020 Agency Financial Report (AFR). Per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year.

[47] CMS uses Improper Payments Elimination and Reduction Act (IPERA) standards, rather than GPRAMA standards, for performance reporting on improper payments. According to A-123 guidance on IPERA, programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

Reduce the percentage of improper payments made under the Part D Prescription Drug Program (Lead Agency - CMS; Measure ID - MIP6)

	FY 2014	FY 2015	FY 2016 [48]	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	3.6%	3.5%	3.4%	3.3%	1.66%	1.65%	0.74%	TBD
Result	3.3%	3.6%	3.41%	1.67%	1.66%	0.75%	11/15/20	11/15/21
Status	Target Exceeded	Target Not Met	Target Met	Target Exceeded	Target Met	Target Exceeded	Pending	Pending

The purpose of this measure is to reduce the percentage of improper payments in the Part D Prescription Drug program. Measuring Part D payment errors protects the integrity of the Part D program by ensuring that CMS has made correct payments to contracting private health plans for coverage of Medicare-covered prescription drug benefits. The Medicare Prescription Drug Program (Part D) payment error estimate reflects the extent to which Prescription Drug Event (PDE) records submitted by Part D sponsors for a national sample of PDEs are substantiated by supporting documentation such as prescription record hardcopies, long-term care medication orders, and claims information from Part D sponsors. CMS validates PDEs during CMS's annual Payment Error Related to Prescription Drug Event Data Validation process, where two separate clinicians review supporting documentation. To calculate the Part D program's error estimate, divide the dollars in error by the overall Part D payments for the year measured.

In FY 2019, CMS exceeded its target of 1.65 percent, reporting an actual improper payment estimate of 0.75 percent, or $607.94 million. The decrease from the prior year's estimate of 1.66 percent resulted from errors being smaller in magnitude.

Reduce the improper payment rate in the Medicare Fee-for-Service Program (Lead Agency - CMS; Measure ID - MIP1)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	9.9%	12.5%	11.5%	10.4%	9.4%	8.0%	7.15%	TBD
Result	12.7%	12.1%	11.0%	9.5%	8.12%	7.25%	11/15/20	11/15/21
Status	Target Not Met	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

CMS calculates the Medicare FFS improper payment estimate under the Comprehensive Error Rate Testing (CERT) program and reports the result in the HHS AFR. CMS initiated the CERT program in FY 2003 and produced a national Medicare FFS improper payment rate for each year since its inception. Please refer to the FY 2019 HHS AFR for information on the Medicare FFS improper payment methodology.

CMS exceeded its CY 2019 target. The Medicare FFS improper payment estimate for CY 2019 is 7.25 percent or $28.91 billion. The CY 2020 target is 7.15 percent and the CY 2021 target will be established in the FY 2020 AFR.

CMS developed a number of preventive and detective measures for specific service areas with high improper payment rates, which include Skilled Nursing Facility, hospital outpatient, Inpatient Rehabilitation Facility, and home health claims. CMS believes implementing targeted corrective actions will continue to prevent and reduce improper payments in these areas and reduce the overall improper

[48] Ibid.

payment rate. Please refer to the FY 2019 HHS AFR for detailed information on corrective actions.

Reduce the improper payment rate in the Medicaid Program (Lead Agency - CMS; Measure ID - MIP9.1)[49]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	5.6%	6.70%	11.5 %	9.57%	7.93%	N/A	N/A	N/A
Result	6.7%	9.78%	10.48%	10.10%	9.79%	14.90%	N/A	N/A
Status	Target Not Met	Target Not Met	Target Exceeded	Target Not Met but Improved	Target Not Met but Improved	Actual	N/A	N/A

Reduce the improper payment rate in the Children's Health Insurance Program (Lead Agency - CMS; Measure ID - MIP9.2)[50]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	6.50%	6.81%	7.38%	8.20%	N/A	N/A	N/A
Result	N/A	6.80%	7.99%	8.64%	8.57%	15.83%	N/A	N/A
Status	N/A	Target Not Met	Target Not Met	Target Not Met	Target Not Met but Improved	Actual	N/A	N/A

The Payment Error Rate Measurement program measures improper payments in the FFS, managed care, and eligibility components of both Medicaid (MIP9.1) and CHIP (MIP9.2). CMS measures improper payments in 17 states each year to calculate a rolling, three-year national improper payment rate for both Medicaid and CHIP. CMS based the national Medicaid and CHIP improper payment rates reported in the FY 2019 HHS AFR on measurements that CMS conducted in FYs 2017, 2018, and 2019. Please refer to the FY 2019 HHS AFR for information on the Medicaid and CHIP statistical sampling process and review period.

Since FY 2014, errors due to state noncompliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements have driven the Medicaid improper payment rate. Most improper payments cited on claims are those where a newly enrolled provider was appropriately screened by the state, did not have the required NPI on the claim, or was not enrolled. While the screening errors described above are for newly enrolled providers, states also must revalidate the enrollment and rescreen all providers at least every 5 years. States were required to complete the revalidation process of all existing providers by September 25, 2016. In FY 2019, HHS measured the second cycle of states for compliance with requirements for provider screening at revalidation. Improper payments cited on claims where a provider had not been appropriately screened at revalidation is a new major error source in the Medicaid improper payment rate. Another area driving the FY 2019 Medicaid improper payment estimate is the reintegration of the PERM eligibility component. This is the first time in the history of the program that the eligibility component measurement has been conducted by a federal contractor; previously states conducted the measurement and self-reported results to HHS for reporting the national rate.

The current national Medicaid improper payment rate (MIP 9.1) reported in the 2019 HHS AFR is 14.90 percent or $57.36 billion. The national Medicaid component rates are 16.30 percent for Medicaid FFS, 0.12 percent for Medicaid managed care and 8.36 percent for the Medicaid eligibility component.

[49] These measures are being suspended until three years of new eligibility data are gathered and can be inserted into a new baseline in FY 2021. Reduction targets will be reported in FY 2021.
[50] Ibid.

The current national CHIP improper payment rate (MIP 9.2) reported in the 2019 HHS AFR is 15.83 percent or $2.74 billion. The national CHIP component rates are 13.25 percent for CHIP FFS, 1.25 percent for CHIP managed care, and 11.78 percent for the CHIP eligibility component.

One area driving the FY 2019 CHIP improper payment estimate is the FY 2019 reintegration of the Payment Error Rate Measurement eligibility component. This is the first time in the history of the program that a federal contractor has conducted the eligibility component measurement. Previously, states conducted the measurement and self-reported the results to HHS for calculation of the national rate.

HHS resumed the Medicaid and CHIP eligibility component measurements and report updated national eligibility improper payment estimates in FY 2019. After establishing a full baseline, including eligibility, CMS will publish reduction targets in the FY 2021 HHS AFR.

The factors contributing to improper payments are complex and vary from year to year. Each year CMS outlines actions the agency will implement to prevent and reduce improper payments for all error categories. Please refer to the FY 2019 HHS AFR for detailed information on corrective actions.

CMS will receive corrective action plans from states to address their improper payments, and CMS will provide technical assistance to states as needed to help them reduce improper payments. In FY 2018, CMS released a new strategy for Medicaid to address new program integrity challenges associated with the rapid Medicaid spending increase in the last decade due in part to Medicaid expansion. The new initiatives in this strategy that CMS is now implementing include new audits targeting improper claims for federal matching funds, managed care medical loss ratios, rate setting, and state beneficiary eligibility determinations previously found to be high risk by the HHS Office of Inspector General.

Goal 5. Objective 2: Manage human capital to achieve the HHS mission

As the Department looks to FY 2020 and beyond, it imagines all the achievements that can be reached when workforce performance is heightened, efficiencies achieved, and accountability strengthened. The Department must continue to create a flexible and agile workforce that responds and adapts to change: change in technology, change in society, change in expectations, and change in scientific findings. HHS needs the leaders of tomorrow today. To this end, the Department will continue to build a world-class federal management team and a workforce ready to collaborate with colleagues within the Department, among other federal departments, and outside the Federal Government, to seek change that improves and enhances the health and well-being of Americans.

The Office of the Secretary leads this objective. All divisions contribute to the achievement of this objective. In consultation with OMB, HHS has highlighted this objective as a focus area for improvement. The Department is progressing in this objective, but HHS would like to enhance that progress moving forward. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 5.2 Table of Related Performance Measures

Increase HHS employee engagement through Federal Employee Viewpoint Survey (FEVS) (Lead Agency - ASA; Measure ID - 2.6) [51]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	Baseline	67%	68%	69%	72.5%	73%	75%	75%
Result	66%	68%	70%	72%	72.8%	73.5%	9/20/20	9/30/21
Status	Actual	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Employee engagement is foundational to achieving the level of active strategic management needed for building and sustaining the 21st century workforce The Office of Personnel Management (OPM) FEVS measures employee engagement.[52] Employee engagement drives performance. Engaged employees look at the whole of the organization and understand their purpose within the agency's mission. This understanding leads to better decision-making. In FY 2020 and FY 2021, HHS will continue to use FEVS data to monitor the impact of its efforts to support organizational improvement. In FY 2019, the Department reported the highest employee engagement score (74 percent) among very large federal agencies. Also among these agencies, HHS reported the top response rates (72 percent). In FY 2020 and FY 2021, HHS expects to meet and maintain a target of 75 percent for this goal.

Decrease the cycle time to hire new employees (Lead Agency - ASA; Measure ID - 2.8)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	80 days	80 days	80 days	80 days
Result	N/A	N/A	108 days	101 days	94 days	113	12/31/20	12/31/21
Status	N/A	N/A	Actual	Actual	Target Not Met but Improved	Target Not Met	Pending	Pending

HHS is modernizing its federal hiring practices, which includes simplifying and streamlining the hiring

[51] This measure reports employee engagement index results collected through the FEVS.

[52] FEVS assesses whether an employee's sense of purpose is evident in their display of dedication, persistence, and effort in their work or overall attachment to their organization and its mission.

process. In 2010, OPM issued guidance encouraging agencies to implement an 80-day hiring process. These data demonstrate how close HHS is to reaching this target. The Department has determined that it can reduce some duplicative effort through standardization and sharing of efforts across staffing organizations. These enhanced business practices are still emerging and so their impact will not be fully felt until next year.

The FY 2019 result does not reflect HHS's progress with streamlining its hiring process through the HHS ReImagine Maximize Talent initiative. While the shutdown significantly contributed HHS's not meeting the FY 2019 target, other factors played a role. HHS had far higher demand for staffing services in FY 2019 (8,929 hires) than in FY 2018 (6,213 hires). This measure reports on the end-to-end hiring process, not just those parts of the process which HHS controls. One of the efficiencies that HHS has rolled out across several HR Centers is the use of shared certificates in which a certificate of eligible candidates from one recruitment is used to hire new employees in additional areas beyond that initial recruitment. The way HHS calculates time to hire is to count the number of days between when HHS validates an initial recruitment and the time a person physically reports for duty. The existing tracking systems do not yet have the capability to designate an alternative start time for shared certificate hires (i.e. when a hiring manager receives a shared certificate); therefore, a hire from a shared cert will have the same "start time" as the start time for the original recruitment rather than start time when the hiring manager initiated the shared certificate process. The data shows that the shared recruitment takes longer, despite the actual results. HHS seeks to correct this issue with improved tracking systems.

In FY 2020 and FY 2021, HHS will continue using this process and will identify and implement additional ways for streamlining the time-to-hire cycle. Please refer to the ReImagine Maximize Talent initiative in the Major Management Priorities section of this report for more information.

Goal 5. Objective 3: Optimize information technology investments to improve process efficiency and enable innovation to advance program mission goals

HHS information technology investments help achieve the Department's mission by acquiring and managing the technology infrastructure and systems for its health care and human services programs and mission-support programs. From externally facing websites like HHS.gov to internal applications that manage programs and resources, HHS needs information technology solutions to be modernized, secure, and responsive to customer demands. The Department's current modernization investments include cloud computing, data center consolidation and improvements, information technology portfolio reviews, shared services, and a digital strategy that makes it easier to access information using HHS websites and tools. In addition, HHS is working to increase partnerships with industry, academia, and other organizations to leverage their technology expertise as well.

The Office of the Secretary leads this objective. All divisions contribute to the achievement of this objective. HHS believes performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 5.3 Table of Related Performance Measures

Increase the percentage of systems with an Authority to Operate (ATO) (Lead Agency - ASA; Measure ID - 3.3)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	Baseline	96.5%	97%	97.5%
Result	N/A	N/A	N/A	N/A	96%	95%	12/31/20	12/31/21
Status	N/A	N/A	N/A	N/A	Actual	Target Not Met	Pending	Pending

An ATO authorizes a particular information system to connect to or operate within the HHS network for a specified period of time. Prior to issuing an ATO, HHS reviews the system to ensure that it will not compromise network data or cause technical support problems. The HHS Office of Information Security has identified the organizations and systems which are not in compliance with ATO requirements and is diligently working with OpDiv cybersecurity programs and system owners to ensure ATOs are issued for those systems. The HHS cybersecurity program is making investments in technologies to proactively identify, detect and remediate malicious activity on the HHS network while investing in resources to accelerate the implementation of the Department of Homeland Security (DHS) Continuous Diagnostics and Mitigation (CDM) program. The release of resources from DHS to HHS for these purposes was delayed due to the partial government shutdown. This delayed HHS's ability to implement the automation that was planned for this effort, given DHS was shut down during this period. In addition, HHS implemented new training sessions, guidelines, and outreach, and invested in a Transformation project that streamlined the ATO process. The project concluded near the end of the year, and the resulting improvements are expected to be evident in 2020. The application of greater automation to cybersecurity practices across the enterprise and working closely with cybersecurity personnel throughout the Department to provide effective cybersecurity training will continue to reduce the number of non-compliant systems without a valid ATO. In FY 2020, HHS will also continue to implement changes to strengthen its enterprise wide information security program. HHS will work with the OpDivs to enhance enterprise risk management strategy and to integrate governance functions for information security, strategic planning and reviews, internal control activities, and applicable mission/business

areas. This measure links directly to measure 3.4.

Improve the score to an "A" in each of the Federal Information Technology Acquisition Reform Act (FITARA) related Scorecard Metrics, per GAO and the House Oversight and Government Reform Committee (Lead Agency - ASA; Measure ID - 3.4)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	90%	90%	90%	90%
Result	N/A	N/A	64%	64%	89%	70%	12/31/20	12/31/21
Status	N/A	N/A	Actual	Historic Actual	Target Not Met but Improved	Target Not Met	Pending	Pending

FITARA established standards for buying and managing computer technology. The FITARA scorecard reports agency progress towards IT modernization. Scorecard results demonstrate the connection of technology capability to agency leadership and the agency's ability to use technology to drive change. The scorecard reports progress on a biannual basis. The FITARA scorecard contains subcomponents. The main driver for HHS performance was the subcategory of cyber/FISMA (the Federal Information Security Management Act). For detailed actions regarding HHS plan for improvement see https://oig.hhs.gov/oas/reports/region18/181811200.pdf.

The HHS Office of Inspector General identified weaknesses in the following areas: risk management, configuration management, identity and access management, data protection and privacy, security training, information security continuous monitoring, incident response, and contingency planning. To address these findings, HHS will provide technical assistance to the OpDivs as they review and address vulnerabilities discovered, implement account management procedures, and track systems to ensure they are operating with a current and valid Authority to Operate. Additionally, the Department will focus on configuring recently deployed continuous diagnostic monitoring tools to automate the integration of cyber risks into newly developed enterprise risk management programs. These steps will strengthen the program and further enhance the HHS mission.

Goal 5. Objective 4: Protect the safety and integrity of our human, physical, and digital assets

Providing security for HHS involves more than preventing breaches or cybersecurity attacks. The Department's OpDivs and StaffDivs participate in efforts to preserve physical security; personnel security and suitability; security awareness; information security, including the safeguarding of sensitive and classified material; and security and threat assessments. In addition, the Department has established a network of scientific, public health, and security professionals internally, as well as points of contact in other agencies, in the intelligence community, and in the Information Sharing Environment Council. The Department has specialized staff to provide policy direction to facilitate the identification of potential vulnerabilities or threats to security, conduct analyses of potential or identified risks to security and safety, and work with agencies to develop methods to address them.

The Office of the Secretary leads this objective. All divisions contribute to the achievement of this objective. HHS believes performance toward this objective is progressing. The narrative below provides a brief summary of progress made and achievements or challenges, as well as plans to improve or maintain performance.

Objective 5.4 Table of Related Performance Measures

Decrease the Percentage of Susceptibility among personnel to phishing (Lead Agency - ASA; Measure ID - 3.5)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	Baseline	6.8%	6.5%	6.2%
Result	N/A	N/A	N/A	N/A	7%	4.5%	12/31/20	12/31/21
Status	N/A	N/A	N/A	N/A	Actual	Target Met	Pending	Pending

Phishing is a fraudulent attempt to obtain sensitive information, like user names and passwords, to access a system or network. HHS provides training, education, and tools (e.g., email add-in) to reduce the likelihood of staff mistaking phishing email attempts for legitimate communications over time. In order to mitigate future breaches, HHS focuses on vulnerabilities to phishing attacks and other cyber threats. In FY 2020 HHS will continue training and phishing exercises to assess progress.

Maintain the number of days since last major incident of personally identifiable information (PII) breach (Lead Agency - ASA; Measure ID - 3.6)[53]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	Baseline	365	366	365
Result	N/A	N/A	N/A	N/A	365	365	9/20/20	9/20/21
Status	N/A	N/A	N/A	N/A	Actual	Target Met	Pending	Pending

If an employee misuses, loses, or otherwise compromises PII, the action results in steep financial costs and damage to the Department's reputation. The Department is committed to protecting PII from misuse. HHS has developed a privacy program for the protection of personally identifiable information that the Department information systems collect, use, maintain, share, and expunges. [54] This measure tracks the number of days in a fiscal year since a major harm incident. A major data breach has not

[53] HHS has updated the FY 2020 target for this measure to reflect that this is a leap year.

[54] A major harm incident is any incident that is likely to result in demonstrable harm to the national security interests, foreign relations, or economy of the United States or to the public confidence, civil liberties, or public health and safety of the American people.

occurred in more than 730 days. HHS will continue to train staff in protecting and safeguarding PII.

Evidence Building Efforts

OMB Circular A-11, Section 210.11 requires the Annual Performance Reports to describe evaluations or other relevant evidence activities, and how a portfolio of evidence is used to inform decision-making. Evaluation and analysis provide essential evidence for HHS to understand how its programs work, for whom, and under what circumstances. HHS builds evidence through evaluation and analysis in order to inform decisions in the budget, legislative, regulatory, strategic planning, program, and policy arenas. Given the breadth of work supported by HHS, the Department conducts many evaluations and analyses each year. These efforts range in scope, scale, design, and methodology, but all aim to understand the effects of programs and policies and how they can be improved.

Implementation of the Evidence Act: HHS is in the initial stages of implementing the Foundations for Evidence-Based Policymaking Act of 2018 ("the Evidence Act"). The Evidence Act requires the Department to develop and implement a four-year Evidence-Building Plan, with annual evaluation plans. These plans will guide HHS's progress towards addressing the questions and priorities articulated in the Evidence-Building Plan. Per OMB Guidance M-19-23, HHS is presently developing interim Evidence-Building Plans and an evaluation plan for FY 2022. HHS also designated the Assistant Secretary for Planning and Evaluation as the Evaluation Officer for HHS.

Evaluation at HHS: Across HHS, evaluation comes in many forms including:

- Formal program evaluations using the most rigorous designs appropriate;
- Capacity-building initiatives to improve administrative data collection, accessibility, and use for management;
- Exploratory quantitative and qualitative analysis to build preliminary evidence;
- Pilots and demonstrations; and
- Statistical analysis of factors related to the implementation, performance, and outcomes of health and human services programs and policies.

HHS disseminates findings from a variety of evaluations and analyses to the public on HHS agency websites, such as those operated by ACF's Office of Planning, Research, and Evaluation and CMS's Innovation Center at the Centers for Medicare and Medicaid. HHS coordinates its evaluation community by regularly convening the HHS Evaluation and Evidence Policy Council, which builds capacity by sharing best practices and promising new approaches across the department. The Council will be key to implementing the Evidence Act.

Disseminating Evidence: In addition to building evidence through a broad range of rigorous empirical studies, analysis, and evaluations, HHS supports multiple clearinghouses that catalog, review, and disseminate evidence related to programs. Examples include the ACF Research and Evaluation Clearinghouses on Self-Sufficiency, Employment Strategies, Strengthening Families, Home Visiting, and Child Care and Early Education; the AHRQ United States Preventive Services Task Force; the CDC Community Guide; and the SAMHSA Evidence-Based Practices Resource Center.

Cross-Government Collaborations

The Federal Government has a unique legal and political government-to-government relationship with tribal governments and provides health services for American Indians and Alaska Natives consistent with

that special relationship. HHS works with tribal governments, urban Indian organizations, and other tribal organizations to facilitate greater consultation and coordination between states and tribes on health and human services issues.

Regulatory Reform

On January 30, 2017, President Trump issued Executive Order (EO) 13771 *Reducing Regulation and Controlling Regulatory Costs.* This EO requires agencies to identify two deregulatory actions for every new significant regulatory action issued. Deregulatory actions should offset any new incremental costs associated with new regulatory actions. On February 24, 2017, the President issued EO 13777 *Enforcing the Regulatory Reform Agenda*. This EO directed agencies to establish a Regulatory Reform Task Force to review and evaluate existing regulations and to make recommendations for repeal or simplification. On April 28, 2017, the Administration published OMB Memorandum M-17-23, *Regulatory Reform Officers and Regulatory Policy Officers at Executive Departments and Agencies*. This EO provided guidance on the regulatory reform performance indicators that agencies must incorporate into their annual performance plans. HHS tracks progress on regulatory reform through six measures.

Number of evaluations to identify potential EO 13771 deregulatory actions that included opportunities for public input and/or peer review (RR1)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	44	12	6
Result	N/A	N/A	N/A	N/A	111	15	10/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Target Exceeded	Pending

These results include all actions evaluated on a monthly basis by the HHS Regulatory Reform working groups. During FY 2018 and FY 2019, the Department identified 126 deregulatory actions. Since the Department identified such a significant number of deregulatory actions in FY 2018, HHS has fewer actions that it can evaluate. For example, in FY 2020, HHS has set an evaluation target for six actions. Also in FY 2020, the Department will begin conducting evaluations every other month.

Number of EO 13771 deregulatory actions recommended by the Regulatory Reform Task Force to the agency head, consistent with applicable law (RR2)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	19	12	6
Result	N/A	N/A	N/A	N/A	61	14	10/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Target Exceeded	Pending

In FY 2018 and FY 2019, the HHS Regulatory Reform Task Force recommended 94 of the actions that the workgroup submitted. Of the 76 remaining deregulatory actions, HHS predicts that the Task Force will approve 6 actions. Many of the submitted actions are not deregulatory based on Executive Order definitions. Other deregulatory actions will require more detail before the Task Force can make a recommendation.

Number of EO 13771 deregulatory actions issued that address recommendations by the Regulatory Reform Task Force (final/published) (RR3)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	4	4	4
Result	N/A	N/A	N/A	N/A	25	15	10/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Target Exceeded	Pending

The Department expects to finalize four deregulatory actions in FY 2020. The Regulatory Reform Task Force recommended all deregulatory actions appearing on the HHS FY 2019 13771 Cost Allocation table.

Number of EO 13771 regulatory actions issued (final/published) (RR4a)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	6	15	12
Result	N/A	N/A	N/A	N/A	4	11	10/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Target Exceeded	Pending

The Department expects to finalize 12 regulations in FY 2020.

Number of EO 13771 deregulatory actions issued (final/published) (RR4b)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	4	4	4
Result	N/A	N/A	N/A	N/A	25	15	10/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Target Exceeded	Pending

The Department expects to finalize four deregulatory actions in FY 2020.

Total incremental cost of all EO 13771 regulatory actions and EO 13771 deregulatory actions (RR5)

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Target	N/A	N/A	N/A	N/A	-$28.7 million	-$550 million	-$100 million
Result	N/A	N/A	N/A	N/A	-$763.48 million	-$544 million	10/31/20
Status	N/A	N/A	N/A	N/A	Target Exceeded	Target Not Met	Pending

In FY 2020, the Department expects to decrease total incremental cost by $100 million in annualized dollars.

Major Management Priorities

The Department has identified four Major Management Priorities:

- Moving to a 21st Century Workforce
- Restoring Market Forces
- Making HHS More Innovative and Responsive
- Generating Efficiencies through Streamlined Services

Below HHS has provided detailed information on its progress with each initiative, including performance goals, performance indicators, and milestones.

Moving to a 21st Century Workforce

Supporting Initiative: Maximize Talent

The Maximize Talent Initiative aimed to transform HHS's business processes and practices to meet modern-day human capital management and human resources operational challenges now and in the future. Through the Maximize Talent efforts, the Initiative enhanced the Department's most important resource – its people. The transformation focused on three primary goals:

1. Optimizing HR Service Delivery by exploring ways to standardize core HR processes and implementing more efficient, effective, customer-focused, and cost-effective service delivery models.
2. Transforming the Employee Performance and Engagement Culture by taking steps to institutionalize an environment that empowers and engages employees to maximize their talents to their full potential and enhance our performance management program to motivate, reward, and recognize high performance.
3. Modernizing Human Resources Information Technology Infrastructure by upgrading and integrating enterprise IT systems that support the workforce and increase the data available to inform management decision-making.

Salient accomplishments under the Maximize Talent Initiative include:

- Envisioned a culture of accountability and data-driven decision making to improve workforce conditions and took action to achieve that vision:
    - HHS FEVS Employee Participation increased by 14.7 percentage points to 71.9 percent
    - HHS Employee Engagement Index increased by 0.7 percentage points to 73.5 percent;
    - Effective Communication Index increased by 0.8 percentage points to 71.2 percent; and
    - Global Satisfaction increased by 0.5 percentage points to 71.7 percent.
- Implemented a simplified recruitment process in the District of Columbia Health Resources Center, which included sharing certificates with multiple managers with similar hiring needs to expedite the hiring process. The simplified recruitment process reduced the average time to issue a certificate of eligible candidates to hiring officials using the new shared certificates process from 140 calendar days, on average, to 65.5 calendar days, on average and decreased the time-to-hire by saving 74.5 calendar days, on average, in the hiring process. Since February 2019, 80% of candidates were selected from simplified recruitments; with a 200% increase in number of new hires on-boarded.
- Implemented two pilots of Better Assessment Tools for Better Quality Candidates in partnership with OPM, including USA Hire, purchased now for use Enterprise-wide; and Subject Matter Expert Quality Assurance in collaboration with US Digital Services - HHS Office of the Chief Information Officer and Office of the Chief Technology Officer selected 35+ qualified candidates to fill critical vacancies.
- Transitioned SES performance management from manual, paper-based processes to electronic system in October 2018, automating all tracking/reporting for SES HHS-wide.

- Successfully launched the Enterprise Human Capital Management system upgrade from PeopleSoft 8.9 to 9.2 in May 2019, creating a lasting baseline for managing HHS personnel transaction and reporting, using a single enterprise cloud-based solution.

On September 30, 2019, HHS transitioned the work of the Maximize Talent Initiative to the Strategic Initiatives Group (SIG) within the Office of Human Resources (OHR). SIG is responsible for coordination, communication, development, and implementation of transformational and strategic initiatives for OHR. SIG activities focus on Maximize Talent's three primary goals: Optimizing HR Service Delivery; Modernizing HR Information Technology; and Improving the Employee Performance and Engagement Culture at HHS. OHR will continue to identify, pilot, scale improvements and reforms across HHS through the SIG.

Designated Official: Bahar Niakan, Former Initiative Lead, Deputy Chief Human Capital Officer

Performance Goal: Increase overall HHS employee participation in the FEVS survey, as well as the overall Employee Engagement Index Score by August 2019.

Data Source and Validation: Employee Engagement Score and Participation Rate from FEVS Survey. Validated by OPM.

Performance Indicator: FEVS Employee Engagement Index

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	70%	72.5%	73%	75%	75%
Result	N/A	N/A	N/A	72.2%	72.8%	73.5%	9/30/20	9/30/21
Status	N/A	N/A	N/A	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

Performance Indicator: FEVS Employee Participation[55]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	54%	56%	58%	60%	TBD
Result	N/A	N/A	N/A	58.5%	57.2%	71.9%	9/30/20	9/30/21
Status	N/A	N/A	N/A	Target Exceeded	Target Exceeded	Target Exceeded	Pending	Pending

	Milestones	Planned Completion Date	Status
1.	2019 FEVS guidance from the ASA to OPDIV and STAFFDIV Heads and Executive Officers	10/31/2018	Completed
2.	Held Employee Engagement Forum Kickoff	10/17/2018	Completed
3.	Held FEVS Program Managers Best Practice Exchange	11/1/2018	Completed
4.	Provided pre-populated OPM reporting template to FEVS Program Managers	11/6/2018	Completed
5.	Compiled initial report of HHS 20 by 20 by 2020 data for submission to OPM	11/15/2018	Completed

[55] The FY 2021 target will be established upon evaluation of 2019 FEVS results.

6.	Submit HHS Report to OPM	11/23/2018	Completed
7.	ASA/CHCO Endorsement of "Sprint to 2019" and "Marathon to 2020"	11/23/2018	Completed
8.	Set Up EVS ART Training for OpDiv/StaffDiv	1/19/2018	Completed
9.	Leaders at all levels present FEVS data to work units and commit to action.	3/31/2019	Completed
10.	Collect insight on employee engagement from the employee perspective.	2/28/2019	Completed
11.	Release a call for Organization Development services/providers to support SPRINT 2019	2/28/2018	Completed
12.	Managers and supervisors lead work units in action planning for quick sprint improvement.	3/29/2019	Completed
13.	Active, visible, and meaningful action to improve employee engagement.	4/30/2019	Completed
14.	Encourage participation in the FEVS.	6/21/2019	Completed
15.	Employ long term strategies for success including FEVS Program Manager offsite, lessons learned from SPRINT to 2019, assessment of FEVS program metrics (leading and lag indicators), continued engagement of Employee Engagement Community of Practice, and other	6/21/2019 –8/30/2020	Ongoing

Restoring Market Forces

Supporting Initiative: Bring Common Sense to Food Regulation; Enhance state produce safety infrastructure to improve farm compliance with Produce Safety Rule.

The *Bring Common Sense to Food Regulation* Initiative aimed to increase collaboration between food regulatory programs to minimize dual jurisdiction and improve state produce safety infrastructure. To address these issues, this Initiative consisted of two sub-Initiatives: Regulatory Oversight and State Produce Safety Infrastructure. The core objective of the Regulatory Oversight sub-Initiative was to increase regulatory efficiency and advance food safety in the context of "dual jurisdiction establishments," where the Food and Drug Administration and the United States Department of Agriculture's Food Safety and Inspection Service both have jurisdiction to conduct food inspections and exercise oversight. The objective of the State Produce Safety Infrastructure sub-Initiative was to fully develop and implement a state produce safety infrastructure to assist FDA in implementing the Food Safety Modernization Act (FSMA) Produce Safety regulations.

On September 30, 2019, HHS transitioned the work of this Initiative to the Office of Regulatory Affairs and the Center for Food Safety and Applied Nutrition within FDA. In ongoing efforts to implement the FSMA, FDA has provided over $80 million in support to 48 participating states out of 55 (50 states and 5 territories) to conduct training and technical assistance. By working with states to develop these programs and having states conduct their own inspection and compliance/enforcement work, FDA is working towards building an Integrated Food Safety System where states and FDA can mutually rely on each other's work. FDA is also working on joint efforts between USDA and FDA to reduce the duplication of inspections and create efficiencies with regulatory oversight. This includes the consolidation and updating of existing Memorandums of Understanding between the Agencies and the creation of a Field Management Directive.

Designated Official: Erik P. Mettler, Former Initiative Lead, Assistant Commissioner for Partnerships and Policy

Performance Goal: Create a more effective and efficient food safety system by increasing the role of the states in improving produce safety as measured by 85 percent of states and territories (out of 55 total, 50 states and 5 territories) participating in the Produce Safety Implementation Cooperative Agreement Program (State CAP) by September 30, 2019.

Data Source and Validation: State CAP

Performance Indicator: Number of States and Territories (Grantees) Participating in State CAP[56]

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	Baseline	Baseline	47	47	48	48
Result	N/A	N/A	42	43	47	48	7/31/20	7/31/21
Status	N/A	N/A	Actual	Actual	Target Met	Target Exceeded	Pending	Pending

Performance Goal: Create a more effective and efficient food safety system by increasing the role of the states in improving produce safety as measured by an increase in inspections being conducted by state partners participating in State CAP by December 31, 2021.

Data Source and Validation: State inspection reporting.

Performance Indicator: Number of Inspections being conducted by State Partners Participating in State CAP[57,58]

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	Baseline	Result +10%	Result +10%
Result	N/A	N/A	N/A	12/31/19	6/30/20	6/30/21
Status	N/A	N/A	N/A	Pending	Pending	Pending

	Milestones	Planned Completion Date	Status
1.	Complete detailed assessment of state produce regulatory programs, to include projected availability of resources and jurisdictional assessment.	6/2019	Completed
2.	Develop detailed Implementation Plan which may include: potential funding sources, partners for leveraging, outreach opportunities, and measures of success for increasing the role of states in produce safety inspection.	12/2019	On-Track
3.	Execution of Implementation plan	6/2021	On-Track

56 State CAP year runs from July 1 – June 30. Data reported are from that timeframe.

57 Many states did not start inspections until June 2019. HHS anticipates that baseline data will be available once analysis is completed for the period April 2019 through September 2019.

58 State CAP year runs from July 1 – June 30. Data reported are from that timeframe.

Making HHS More Innovative and Responsive

Supporting Initiative: Optimize NIH

The *Optimize NIH* Initiative aimed to increase the efficiency and effectiveness of administrative functions for employees and the agency and improve support for the NIH mission. *Optimize NIH* is focused on administrative areas that could be more effective and efficient if: 1) managed enterprise-wide, 2) managed through service centers, or 3) harmonized.

With regard to managing enterprise-wide, *Optimize NIH* initially focused its efforts on achieving efficiencies in: Committee Management, Freedom of Information Act (FOIA), and Ethics. As the Acquisitions, Information Technology Security, Title 42(f) Processing, Travel, and Property functions continue to evaluate their functions, NIH will determine if functions are best served through enterprise-wide improvements or by the service center model. Salient accomplishments under *Optimize NIH* in managing enterprise-wide include:

- Expanded the Committee Management Module within existing Electronic Research Administration grants systems to develop complete automation of nomination slates and appointments. When fully automated, eliminating Committee Management courier services to HHS has a projected cost savings of $17,000 per year. NIH piloted a human resources onboarding system for Special Government Employees (SGEs), which resulted in saving time and reducing wasteful spending. As such, the pilot is being prepared for a full roll-out to all of NIH.
- Rolled out a customizable commercial off-the-shelf FOIA platform (FOIAXpress) and public access portal in early 2019 to improve FOIA management and standardize processes across all 27 of NIH's Institutes and Centers. Since the launch of FOIAXpress and the portal, the number of requests received through portal has risen to 90 percent, the number of processed FOIA requests increased by 125 percent, and the backlog decreased by 24 percent. FOIAXpress can be leveraged across HHS.
- Expanded the capabilities of the NIH Ethics Enterprise System, including electronic submission of the OGE Form 450 Confidential Financial Disclosure Report for SGEs and 278T Periodic Transaction Report.

Designated Official: Janet Shorback, Initiative Lead

Performance Goal: Increase the efficiency and effectiveness of NIH administrative functions to better support the agency's mission while maintaining support of the workforce, increasing employee engagement, and overseeing the use of taxpayer dollars.[59] HHS will pursue the following performance goal by 2020: Make management of Freedom of Information Act (FOIA) requests more efficient by reducing the number of systems used to track and submit FOIA requests by December 17, 2018.

Data Source and Validation: Tracking system – systems to track and submit FOIA reports. The new, unified system permits data review and validation at the individual FOIA request level to monitor and improve quality of data and process management.

Performance Indicator: Number of Systems Used to Track and Submit FOIA Reports[60]

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[59] Since HHS has met this performance goal, the Department is discontinuing the measure.

[60] The HHS target for FY 2019 was to reduce the number of systems from eight to one. HHS has achieved this target and is discontinuing this performance indicator.

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	
Target	N/A	N/A	N/A	N/A	Baseline	1	Discontinued	
Result	N/A	N/A	N/A	N/A	8	1	N/A	
Status	N/A	N/A	N/A	N/A	Actual	Target Met	N/A	

	Milestones	Planned Completion Date	Status
1.	Due diligence to identify suitable FOIA platform	7/2018	Completed
2.	Finalize FOIA implementation plan	8/2018 - 9/2018	Completed
3.	Begin implementing FOIA plan	9/2018	Completed
4.	Selected platform for FOIA effort and began portal customization	10/2018	Completed
5.	Customize selected FOIA platform and perform user-acceptance testing	11/2018	Completed
6	Train all NIH FOIA staff on selected FOIA platform	12/2018	Completed
7.	Launch selected FOIA platform across NIH	12/2018	Completed
8.	Customize portal and launch customized portal to public	3/2019	Completed

Generating Efficiencies through Streamlined Services

Supporting Initiative: Buy Smarter

The *Buy Smarter* Initiative is transformative and data-driven, leveraging the collective purchasing power of HHS to secure lower prices, achieve operational efficiencies, and generate cost avoidances on goods and services. *Buy Smarter* is creating a leaner, more accountable, and efficient government by using technology to improve underlying business processes and mission outcomes.

Buy Smarter serves the mission and acquisition communities. The immediate beneficiary is the HHS acquisition community through the group purchasing model. This will ultimately benefit HHS's overall mission, through efficiencies gained from the rationalization of duplicative contracts and lower variance on prices paid for similar products and services.

Buy Smarter established an operating model, developed an implementation plan, and created a funding strategy for procurement process improvements that will realize projected cost avoidances. The *Buy Smarter* Operating Model is based on the General Services Administration (GSA) Category Management structure. *Buy Smarter* uses Artificial Intelligence (A.I.) technology to analyze current HHS contract data and the underlying mission requirements. This identifies opportunities to consolidate contract vehicles across HHS to ensure best pricing and smarter buying for the federal government.

Buy Smarter is moving from the planning phase to the implementation phase along the parallel tracks of people, process, and technology, which will result in millions of dollars in savings when the improvements are implemented and realized. *Buy Smarter* leverages new and emerging technologies (e.g., cloud-native technology, A.I., machine learning, etc.) to analyze HHS-wide spend data, identifying an annual savings opportunity of $720 million on goods and services when fully operational across all of the HHS Operating Divisions.

Designated Official: David Dasher, Initiative Lead

Performance Goal: Achieve $720 million in cost savings[61] once fully implemented by September 30, 2025 by utilizing new and emerging technologies to leverage the enormous purchasing power of HHS ($24 billion per year) and enhance and streamline the end-to-end procurement process.

Data Source and Validation: Five HHS contract writing systems. Data from all five contract writing systems will be consolidated in HHS's Accelerate model, which leverages Blockchain Technology and Artificial Intelligence for advanced data analytics.

Performance Indicator: Achieve increased year over year cost savings[62], based on implementation, across the HHS enterprise, of the *Buy Smarter* operating model, in an evolutionary manner. HHS follows category management principles to manage spend.

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Target	N/A	N/A	N/A	N/A	NA	$8 million	$22 million	$25.5 million
Result	N/A	N/A	N/A	N/A	NA	9/30/20	9/30/21	9/30/22
Status	N/A	N/A	N/A	N/A	N/A	Pending	Pending	Pending

	Milestones	Planned	Status
1.	Analyzed 18 months of HHS-wide spend data through an A.I. tool to give never-before visibility into HHS-wide goods and services spending.	3/2018	Completed
2.	Determined initial savings hypotheses based on category benchmarks.	3/2018	Completed
3.	Establish BUYSMARTER Operating Model framework for all GSA Categories, which will cover all HHS spending.	7/2018	Completed
4.	Developed an overview of current spending, including top categories and vendor fragmentation.	12/2018	Completed
5.	Establish Category Collaborative Model to focus on GSA Categories of Spend	1/2019	Completed
6.	Leverage Accelerate block chain data layer for initial BUYSMARTER Operating Model.	3/2020	Ongoing
7.	Conducted initial business-case analysis to focus on understanding current purchasing fragmentation and potential inefficiencies of the current acquisition function (e.g., initial spend analysis, initial acquisition function review).	7/2019	Completed
8.	Conducted additional validation and implementation (e.g., detailed spend analysis, detailed acquisition function review).	10/2019	Completed
9.	Implement A.I. microservices for initial BUYSMARTER Operating Model.	3/2020	Ongoing
10.	Implement e-commerce platform.	12/2020	Pending

[61] Percent of savings is in some part a cost avoidance and some savings will be reallocated back to primary missions.
[62] Ibid.

11.	Share contracts in place for 80 percent of A.I. identified common spend categories. The 80 percent metric covers the majority of HHS's spend while recognizing that there are unique requirements that may not fall under common spend categories.	10/2022	Pending

Lower-Priority Program Activities

The President's Budget identifies the lower-priority program activities, where applicable, as required under the GPRAMA, 31 U.S.C. 1115(b)(10). The public can access the volume at: http://www.whitehouse.gov/omb/budget.

Changed Performance Goals

Please refer to https://www.hhs.gov/about/budget/fy2021/performance/performance-plan-changes-in-performance-measures/index.html?language=es for Information on performance goal changes.

Data Sources and Validation

Please refer to https://www.hhs.gov/about/budget/fy2021/performance/performance-plan-data-sources-and-validation/index.html?language=es for supporting information on the performance goals in the HHS FY 2021 Annual Performance Plan and Report.