Blueprint

AcademyHealth

Modernizing Federal Health Evidence: A Blueprint

A proposal for the statutes, standards, and safeguards that would make the federal health evidence enterprise durable across administrations.

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Revision History

This is a living document. The version and date on the cover identify the edition you are reading, and the change log below records what has changed since first release, newest first. Each time we revise a recommendation, a responsible entity, a mechanism, or a timeline, we publish a new edition with a new version number, date, and log entry. Corrections that do not change meaning, such as replaced dead links or fixed typos, are rolled into the next edition and noted as a batch. The copy posted on blueprint.academyhealth.org is always the current edition.

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Contents

A Call to Action 1

How to use this document 2
The five goals 2
Three structural moves 2
Agency Sections 4
Office of the Assistant Secretary for Planning and Evaluation (ASPE) 4
National Institutes of Health 4
Centers for Disease Control and Prevention 5
Food and Drug Administration 5
Centers for Medicare & Medicaid Services 6
Agency for Healthcare Research and Quality 6
National Center for Health Statistics 7
Department of Veterans Affairs 7
Brief agency entries 8
Cross-Cutting Issues 8
Data Infrastructure Modernization 8
Evidence Workforce Development 9
Research Integrity and Scientific Freedom 9
Trust and Communications Preparedness 10
Emergency Evidence Preparedness 10
State Evidence Capacity 10
Align and Coordinate the Federal Evidence Enterprise 11
Office of the Secretary 11

A Call to Action

The United States federal government operates one of the world's most productive health evidence-generation systems. It involves tens of billions of dollars in research funding, surveillance, statistics, program evaluation, and guidance on which clinicians, state officials, and policymakers rely. Yet recent events, including deep cuts to research funding whose effects will run for years, have revealed a significant structural flaw: the evidence infrastructure has historically rested more on norms than on statute. We believe that must change.

Most people never see the evidence infrastructure that holds this system up, but everyone depends on it. It's what helps your doctor recommend when to get your first colonoscopy, helps a drug company learn what needs to be on a label for the medicines you take, helps a county health official decide which outbreak to pursue, and helps Medicare leaders figure out what gets paid for. Generating evidence through research is only the first step. That evidence has to move into practice, programs, and policy, and what practice and policy teach in return needs to shape what gets studied next. The federal government has world-class capacity for that first step of evidence generation, but its capacity for every step that follows has long been improvised and underbuilt. This gap is what Modernizing Federal Health Evidence: A Blueprint addresses.

For nearly a decade, AcademyHealth has been working to address the underlying systemic factors that limit the policy and real-world impact of health and health services research, work that began under the auspices of our Paradigm Project. This Blueprint is the next step. A nonpartisan agency-by-agency plan, it proposes statutes, institutional designs, and operating practices that would make the federal health evidence enterprise (the agencies, funding streams, and rules that generate and use health evidence) more efficient, more effective, and more resilient to disruption, regardless of who holds the relevant authority. The goal is a set of systems and policies steady enough that each administration, of either party, can stand behind them, because iterative, long-term work is impossible without that stability.

What you hold is our attempt to start a conversation rather than end one. We do not claim to have all the answers, and waiting for consensus will take forever. Policy is about tradeoffs, and no recommendation comes without them. We are fully prepared for groups to support, oppose, or honestly question our recommendations. We welcome that debate. We are also agnostic about which party acts on any recommendation. This Blueprint is nonpartisan. It calls for plenty of policy change, but all of it is about the machinery of evidence: how it is generated, protected, funded, and used. It takes no position on what the evidence should say or what health policy should follow from it.

We invite readers to interrogate our recommendations with a shared goal of answering the question: *what would be better?* We expect this to be a living document, and we will treat it as such. We are absolutely wedded to the idea that we need to take action, and we believe this Blueprint offers a starting point, along with specific instructions for implementing any recommendations that get traction.

We invite others to engage in good faith. The evidence infrastructure requires input from a wide range of stakeholders, and we welcome their debate as well as their ideas. If another group proposes a

superior alternative, we will adopt it. We will consider and respond to serious counterarguments, and as we learn from others we will refine the document.

How to use this document

The Blueprint is a standing prescription for those who currently hold the relevant authority and those who will hold it in the future. Every recommendation is tagged with who can act on it and when. If you lead an agency, the [Now] items are yours. They require no new laws, and nothing stands between you and change. If you staff a committee, the Legislative Proposals section of the Full Report is written as drafting specifications. It's our hope that you treat it that way. If you fund, study, or advocate in this field, feel free to pick the section you know best and tell us where we are wrong.

Find your tag, and let's begin.

The five goals

All of our recommendations serve five goals. The Full Report is organized into a section on each covered agency, a section on cross-cutting issues, and a closing part on the Secretary's agenda and the legislative and budget case; the section names below refer to that document. Every section serves at least one of the five goals.

1. *Protect the independence of federal health research* runs through the Research Integrity section, the tenure and firewall provisions in the NIH, CDC, AHRQ, NCHS, VA, and Office of the Secretary sections, and Legislative Proposals 2 and 3 (in the Full Report's closing section of numbered bill specifications).
2. *Modernize the nation's health data infrastructure* runs through Data Infrastructure Modernization, the National Center for Health Statistics (NCHS) and CDC surveillance recommendations, the ONC (Office of the National Coordinator for Health Information Technology) entry, and State Evidence Capacity.
3. *Secure sustainable and accountable funding* runs through the AHRQ floor, the NIH funding structure, the CMS (Centers for Medicare & Medicaid Services) evidence fund, the HHS evaluation fund, and Legislative Proposal 5.
4. *Build and sustain the evidence workforce* runs through Evidence Workforce Development, the ASPE (Office of the Assistant Secretary for Planning and Evaluation) and Research Integrity workforce protections, and the state-placement commitments.
5. *Embed evidence in policy and practice* runs through the CMS coverage and CMMI (the Center for Medicare and Medicaid Innovation) recommendations, the CDC guidance standard, the Learning Agenda and scorecard, Align and Coordinate, Trust and Communications Preparedness, and Emergency Evidence Preparedness.

Three structural moves

Three decisions organize the whole Blueprint. First, a **tiered protection architecture** for the people who lead evidence functions, written after the Supreme Court's 2026 decision in *Trump v. Slaughter*

narrowed for-cause removal protection. The point of the tiers is stability with accountability: leaders hired on qualifications, able to serve across administrations, and removable in ways that are visible rather than silent, so that long-term research is not re-litigated at every transition and elected leadership still answers for the agencies it runs. The heads of the statistical and evaluation agencies (the AHRQ and NCHS Directors) get a fixed term of office, statutory qualifications for the job, and removal only for cause; they stay Secretary-appointed because that is what lets the protection stand. The Senate-confirmed NIH and CDC Directors get statutory qualifications, removal only on published reasons transmitted to Congress with notice, and an interim rule for filling vacancies. VA research leadership, the emergency council chair, and the Chief Science Officer get for-cause protection without a fixed term. Policy analysis (ASPE) gets statutory workforce protections with political accountability preserved. For-cause removal is proposed as the top layer of each design with its constitutional risk stated. The protection matches the function.

Second, an **AHRQ reauthorization** that gives health services research and the department's core health data functions an institutional home: an expanded statutory mandate, an authorized funding floor, and the receipt of NCHS, the National Center for Health Workforce Analysis, and the National Survey on Drug Use and Health into the reauthorized agency. Each of those recommendations names the fallback that operates if reauthorization does not pass, and the Legislative Proposals identify the smallest set of provisions that can move on another vehicle, so no part of the Blueprint depends on a single legislative outcome.

Third, a **consolidated legislative and funding agenda**. Funding mechanisms live in the agency sections where they attach to statutory context; the consolidated budget case, covering cost, priority, and the multi-year and floor-based funding authorities, is presented in the Legislative Proposals section that closes the Full Report.

We encourage readers to weigh the following recommendations knowing where our inherent biases are. AcademyHealth is the professional home of health services and health policy research, and many of our members' jobs rely on the agencies referenced in this Blueprint, especially AHRQ. We lead the Friends of AHRQ and consider ourselves among AHRQ's most vocal defenders. But we have tried to rest our case for reform on structural arguments a skeptic can check rather than on our affection for the agency.

We also want to make sure that we are honest and straightforward about costs. We estimate that the Blueprint's proposed new authorized spending totals about $1.7 billion a year. Most of it funds the raised AHRQ floor and a dedicated HHS evaluation fund. That is about 1.5 percent of HHS discretionary spending (and three-hundredths of one percent of national health care spending). We believe that is a fair price to pay for knowing whether the rest of our spending is actually buying improved health. Each proposal names its cost and what happens if Congress doesn't act. These figures are authorization totals, checkable against the proposals themselves. We have not modeled administrative or other implementation costs; official cost estimates will come from the Congressional Budget Office (the office that scores legislation for Congress) when bills are introduced. Authorized money still needs to be appropriated every year, and nothing in the document pretends otherwise.

The following is a summary of all the recommendations made in the Blueprint, starting with the agencies and moving into sections on cross-cutting issues. Please refer to the Full Report for more details. Each one-liner carries a tag: **[Now]** means action available under existing authority;

[Leadership] means action department or agency leadership can begin under existing authority, generally within the first year; **[Congress]** means legislation is required. An arrow, as in **[Now → Congress]**, means the work starts administratively and Congress makes it durable.

Agency Sections

Office of the Assistant Secretary for Planning and Evaluation (ASPE)

ASPE is the Secretary's analytic arm and the department's evaluation policy lead. It is meant to give the Secretary straight answers about whether HHS programs work; under current conditions its analysts can be reassigned or reclassified for what they find rather than judged on the quality of their work. The recommendations make its work binding, funded, and protected.

1. Give the HHS Chief Data Officer binding data governance authority: by statute now for a defined core set of functions, phased in for the rest. **[Leadership → Congress]**
2. Create a permanent HHS evaluation fund run by ASPE to evaluate HHS programs, with the reauthorized AHRQ reviewing the quality of the evaluations. **[Congress]**
3. Link the HHS Learning Agenda (the department's published research priorities) to the budget request the department sends to OMB, so that what the department says it needs to learn shapes what it asks to spend. **[Leadership]**
4. Establish transparency, publication norms, and workforce protections for ASPE analysis, then codify them. **[Leadership → Congress]**

National Institutes of Health

NIH funds most of the nation's foundational biomedical research, the work behind the treatments Americans use. Its structural weaknesses cut across its 27 Institutes: no agencywide process for setting priorities across them, a peer review system that penalizes novel research and consumes researchers' time in administration, and chronic funding instability. The reforms in this Blueprint preserve what has sustained bipartisan support for NIH and fix what limits the agency.

1. Keep NIH's Institute structure, which statute sets, and give the Director real tools to set priorities across the whole agency. **[Leadership → Congress]**
2. Keep ARPA-H (the Advanced Research Projects Agency for Health) as a complement to NIH with its own separate funding. **[Congress]**
3. Test new ways of deciding which research gets funded, with results in two to three years. **[Leadership]**
4. Fund researchers for longer periods and spread funding across more institutions. **[Leadership → Congress]**
5. Protect the independence of NIH science, require published reasons, transmitted to Congress, for the Director's removal, and hold the agency to a clock on filling leadership vacancies. **[Leadership → Congress]**

6. Tie NIH funding growth to a real benchmark for research costs, paired with accountability. **[Congress]**
7. Give NIH multi-year funding authority for research that loses its value when funding is interrupted, such as clinical trials and long-term cohort studies. **[Congress]**
8. Build permanent capacity to mobilize research rapidly, in emergencies and outside them. **[Leadership]**

Centers for Disease Control and Prevention

CDC is how the country learns what makes people sick, what injures and kills them, and what to do about it, across infectious disease, chronic disease, and injury alike; under current conditions it learns at the speed of its slowest reporting jurisdiction, and public trust in its guidance has fallen since the pandemic and has not recovered. The recommendations modernize surveillance authority and make visible, in every guidance document, what the evidence says and how the agency decided what to do about it.

1. Modernize federal-state surveillance through standards CDC sets and ties to funding, a federal legal framework for reporting, health IT certification for public health data, and CMS payment-linked reporting, with survey content realigned to what users need. **[Leadership → Congress]**
2. Codify statutory protections for ACIP (the Advisory Committee on Immunization Practices) and HICPAC (the infection-control committee) matched to the legal consequences their recommendations carry, with continuity rules, and set minimum methodological standards for CDC advisory committees. **[Leadership → Congress]**
3. Make visible, in every major CDC guidance document, what the evidence says and who decided what to do about it, with the decision attributed to whoever actually made it, career scientists or political leadership. **[Leadership → Congress]**
4. Require CDC to publish the plan for designated studies before the analysis is run (pre-registration) and to publish the analysis code afterward. **[Leadership]**

Food and Drug Administration

FDA decides which drugs and devices may be marketed and on what evidence, and CMS and insurers decide what is paid for. For people, the question is whether the trial that supported approval included patients like them. The recommendations connect the uncertainty the agency accepts at approval to the verification it requires afterward.

1. Publish clear public rules for when real-world evidence can support specific types of FDA decisions. **[Now]**
2. Connect approval decisions to post-market safety monitoring so uncertainties accepted at approval are tracked and resolved. **[Now → Congress]**
3. Ensure clinical trials enroll the people who will actually take the product, by age, sex, race, comorbidity, and where they live. When they do not, the approval and the label must say so. **[Now → Congress]**

Centers for Medicare & Medicaid Services

CMS decides what Medicare and Medicaid pay for, and every payment and delivery model it launches changes care for millions of people and is, in effect, a test of whether the change works. For people, its evidence determines whether a new treatment is covered and whether a payment model that changes their care actually works. The recommendations make its evaluations credible, its data usable, and its coverage-evidence pipeline self-executing.

1. Require CMMI (the Center for Medicare and Medicaid Innovation, which CMS calls the Innovation Center) to publish its evaluation plan before a model launches and disclose any changes, with a model launched without a registered plan barred from expansion until the plan and all changes are published. **[Leadership → Congress]**
2. Separate the people who design and run CMMI models from those who evaluate them. **[Leadership → Congress]**
3. Document how CMMI evaluation findings translate into the Office of the Actuary's certifications. **[Leadership]**
4. Strengthen Coverage with Evidence Development (Medicare coverage conditioned on evidence generation) with clear thresholds for when requirements end and a five-year sunset unless affirmatively renewed: Of 27 such determinations issued from 2005 through 2022, only four had the evidence-development requirement removed while national coverage was retained. **[Leadership → Congress]**
5. Establish federal funding to generate the evidence Medicare needs when no manufacturer has a product to sell and therefore no incentive to fund the study (procedures, care models, and off-patent drugs). **[Congress]**
6. Make the long-standing statutory CMS-AHRQ partnership operational: AHRQ reviews the evidence on treatments and procedures that Medicare is deciding whether to cover (technology assessment), and develops the quality measures payment models depend on. **[Now → Congress]**
7. Bring Medicare Advantage encounter data (the records of services delivered under Medicare Advantage) up to research quality, with enforcement authority and standards that account for differences across payment arrangements. **[Leadership → Congress]**
8. Standardize researcher access to Medicaid data (T-MSIS, the Transformed Medicaid Statistical Information System) and improve data quality and comparability. **[Leadership]**

Agency for Healthcare Research and Quality

AHRQ produces the evidence about how care is delivered, whether it is safe, and what it costs, and it enters this document as the smallest and least protected of the major evidence agencies; in 2025 its grantmaking stopped for months while appropriated funds went unspent. The recommendations rebuild it as the system's institutional anchor.

1. Reauthorize AHRQ with an expanded mandate (reviving its primary care research and adding the evaluation of software-based care, such as clinical decision support and AI tools), a $1 billion

indexed funding floor, self-executing grantmaking timelines and anti-impoundment protection, and a Secretary-appointed director with a fixed term and for-cause protection. **[Congress]**

2. Codify statistical-unit protections for AHRQ's core data programs (the Medical Expenditure Panel Survey, the Healthcare Cost and Utilization Project, the Network of Patient Safety Databases, and the CAHPS surveys). **[Now → Congress]**
3. Codify the U.S. Preventive Services Task Force's methodological independence. **[Congress]**
4. Create statutory links that tie AHRQ evidence products to specific federal decisions, such as Medicare coverage determinations and FDA post-market actions. **[Now → Congress]**
5. Make AHRQ the chair of a formal interagency health services research coordination body. **[Leadership → Congress]**
6. Codify the National Healthcare Quality and Disparities Report with expanded disaggregation and AHRQ's disaggregation-methodology role. **[Congress]**
7. Transfer NCHS, the health workforce data functions, and the National Survey on Drug Use and Health to the reauthorized AHRQ, each with statutory preservation conditions written to foreclose reversal and a stated fallback if the vehicle stalls. **[Congress]**

National Center for Health Statistics

NCHS counts the nation's births and deaths and measures its health. For people, it is the source of the numbers on which every other number depends, and its independence currently rests on convention.

1. Keep NCHS staffed and funded, and protect its statistical releases from pre-publication political review, with the protections codified as freestanding law. **[Now → Congress]**
2. Move NCHS into the reauthorized AHRQ, keeping its name, methods, and cooperative relationships intact. **[Congress]**
3. Establish multi-year funding for NCHS modernization and national governance for vital statistics (the birth and death records system). **[Leadership → Congress]**
4. Give NCHS a clear mandate and dedicated funding to integrate new data sources with its traditional surveys. **[Leadership → Congress]**

Department of Veterans Affairs

VA operates the only at-scale federal learning health system. For approximately 9.1 million enrolled veterans and for everyone else, its research infrastructure is a national asset beyond veterans' care.

1. Protect the budget, placement, and operational independence of VA Health Services Research and Development. **[Now → Congress]**
2. Treat VA data as a national research resource, ensuring continuity through the electronic health record transition. **[Now]**
3. Establish standing VA-CMS data linkage governance for veterans enrolled in both systems. **[Now]**
4. Formalize VA participation in HHS-led evidence coordination, with joint funding authority to follow. **[Now → Congress]**

5. Establish statutory protections for VA research authority under Title 38 (the title of the U.S. Code governing veterans' programs) matching those proposed for HHS research agencies, centered on the procedural and publication protections. **[Congress]**
6. Build standing mechanisms for moving VA-generated evidence into non-VA care settings. **[Now]**

Brief agency entries

Four shorter entries complete the agency coverage.

ONC (the Office of the National Coordinator for Health Information Technology): get the agencies that enforce the information blocking rule, the HHS Office of Inspector General (OIG) and CMS, to enforce the rule against interference with data sharing for public health, research, and quality reporting, and have Congress write the existing rule into statute so it cannot be quietly narrowed, and have ONC define a research exchange purpose under TEFCA (the Trusted Exchange Framework and Common Agreement, the national network for health information exchange), opening a governed pathway for research access to clinical data. **[Now → Congress]**

HRSA (the Health Resources and Services Administration): move the health workforce data functions (the National Center for Health Workforce Analysis and the Area Health Resources Files) into the reauthorized AHRQ while the Uniform Data System stays with HRSA's grant administration. **[Congress]**

SAMHSA (the Substance Abuse and Mental Health Services Administration): move the National Survey on Drug Use and Health into the reauthorized AHRQ with the federal statistical confidentiality protections (CIPSEA) attached. **[Congress]**

ACF/OPRE (the Administration for Children and Families' research office): Establish joint priority research questions with ASPE, support data linkage with privacy protections and an explicit bar on enforcement uses, and provide multi-year evaluation funding. **[Leadership → Congress]**

Entries for the Indian Health Service (pending tribal consultation) and the Department of Defense are planned and their positions are reserved.

Cross-Cutting Issues

Like any ecosystem, the federal health evidence enterprise is interconnected and overlapping. Many of the most foundational problems do not reside in a single agency. The cross-cutting sections outline issues that affect every part of the system, from data infrastructure modernization to trust and communications.

Data Infrastructure Modernization

The data recommendations set floors: minimum standards defined once and inherited across every program, so that the data a decision needs arrives in time, represents everyone, and can be combined without years of negotiation.

1. Set federal minimum standards for how fast health data arrives, how completely it represents the population, and how consistently it disaggregates by demographic category. **[Leadership → Congress]**
2. Modernize the systems that track births, deaths, and disease outbreaks. **[Leadership → Congress]**
3. Let researchers combine and analyze sensitive federal data under a statutory privacy floor at the level of CIPSEA (the federal statistical confidentiality law). **[Leadership → Congress]**
4. Make federal health data publicly usable by default, with tiered access where privacy requires it, and direct information-blocking enforcement toward the data that public health, research, and quality measurement depend on. **[Leadership → Congress]**
5. Set rules for new kinds of health data and for data that trains AI systems used in federal research and administration. **[Leadership → Congress]**
6. Establish a cross-HHS data modernization governance body with milestone and budget-coordination authority, mandatory consolidation of the bodies it replaces, and consequences that attach by law if it is suspended or ignored. **[Leadership → Congress]**

Evidence Workforce Development

The federal evidence workforce is largely invisible to the systems that manage it; these recommendations make it visible, then build and keep it.

1. Consolidate the federal workforce-data foundation so the evidence workforce can be counted and tracked. **[Leadership → Congress]**
2. Define shared competencies and coordinate existing training programs into a coherent pipeline. **[Leadership]**
3. Strengthen recruitment using hiring authorities that already exist. **[Leadership → Congress]**
4. Build state and institutional capacity through pathways from research institutions into public service. **[Leadership]**
5. Retain the workforce by modernizing occupational classification, career paths, and pay. **[Leadership → Congress]**

Research Integrity and Scientific Freedom

These recommendations convert the norms the recent disruption exposed into law, and they set the test every protection in the document is written to meet: remove the discretionary hook, attach an automatic consequence (self-executing where law permits, mandatory oversight where it does not), route enforcement through institutions that answer to Congress rather than to the officials whose conduct is at issue.

1. Protect federal research awards from political interference, including procedural protections against mid-stream termination. **[Now → Congress]**
2. Establish scientific integrity officers and the tiered leadership protections described above, on the post-*Slaughter* design. **[Now → Congress]**

3. Protect the independence of federal evidence synthesis across the government by making every post-registration change attributable. **[Now → Congress]**
4. Reform federal scientific advisory committee governance. **[Now → Congress]**
5. Protect federal scientists from being reassigned, reclassified, or silenced for what their work finds. **[Now → Congress]**

Trust and Communications Preparedness

Trust follows trustworthiness, and it is built or spent between crises through routine practice. For people, this section determines whether federal guidance arrives honest about its uncertainty, explains itself when it changes, and answers the questions they actually have. It builds the standing base the emergency function draws on.

1. Adopt a department-wide standard for communicating federal health evidence: state the confidence level, explain every change, keep the evidence-policy boundary visible, and publish the open questions. **[Leadership → Congress]**
2. Resource trusted-messenger partnerships as routine, paid infrastructure and build a standing capacity to listen, publishing what was heard and what changed because of it. **[Now → Congress]**
3. Measure trust in federal health evidence annually and report it publicly, housed in the reauthorized AHRQ's statistical activities. **[Now → Congress]**

Emergency Evidence Preparedness

Emergency recommendations build readiness that persists between crises instead of being rebuilt each time.

1. Require every piece of federal emergency guidance to state what it knows, how confident it is, and when it will be revisited. **[Leadership → Congress]**
2. Build a national emergency research commons making the full evidence effort visible in real time. **[Leadership → Congress]**
3. Build the operational readiness that lets research start in days instead of months, with surge funding to match. **[Now → Congress]**
4. Create a standing interagency council that maintains readiness between crises, with statutory vacancy succession for its chair, coordinated with the Federal Vacancies Reform Act. **[Now → Congress]**
5. Establish standing trust and communications preparedness as durable infrastructure. **[Leadership → Congress]**

State Evidence Capacity

The federal evidence system depends on data collected by states, territories, and tribes, and capacity varies widely for reasons federal program design can address.

1. Set federal-state minimum standards for state data infrastructure, tied to existing funding streams and structured as incentives. **[Leadership → Congress]**
2. Establish a federal technical assistance corps for state evidence infrastructure and a single state-facing federal interface. **[Leadership → Congress]**
3. Provide floor-level capacity grants to jurisdictions below defined thresholds, including the territories, with tribal data sovereignty and community governance built in. **[Leadership → Congress]**
4. Build state Medicaid analytic capacity through enhanced federal matching, on the statutory model already used for eligibility systems. **[Leadership → Congress]**
5. Align federal workforce programs with state demand, with concrete state-placement commitments. **[Leadership → Congress]**

Align and Coordinate the Federal Evidence Enterprise

Coordination recommendations follow one discipline: make existing authorities work before creating new ones.

1. Establish a standing federal health services research coordination body, chaired by AHRQ, whose gap analysis reaches OMB passback with mandatory findings when gaps go unaddressed. **[Now → Congress]**
2. Give existing statutory coordination authorities operational content, starting with the long-dormant CMS-AHRQ technology assessment partnership. **[Now → Congress]**
3. Extend evidence coordination across departmental lines where VA, CMS, and Department of Defense populations overlap. **[Now → Congress]**
4. Extend RePORTER-grade public reporting of research funding, with project-level amounts and a defined update cadence, to every HHS evidence funder. **[Now → Congress]**

Office of the Secretary

A small set of actions can only be set in motion from the top. This section consolidates them into one coherent first-100-day agenda, so early action is clear and the department can be held accountable to it.

1. Define a department-wide Chief Science Officer accountable to the Secretary, then codify the office with qualifications, reasons-to-Congress removal reporting, and an interim rule. **[Now → Congress]**
2. Issue the first-100-day evidence agenda as a single package: maintain and strengthen the HHS scientific integrity policy, direct full Evidence Act implementation across the operating divisions (the department's component agencies), and issue the early-action directives routed from other sections together. **[Now]**
3. Require operating division heads to report annually on how evidence informed their decisions, consolidated into a public scorecard with a mandatory passback finding and GAO referral when reports go unanswered. **[Now → Congress]**
4. Inventory the department's statutorily required advisory bodies and keep them staffed and meeting, with annual vacancy reporting. **[Now]**

For how this document was made, including the external review process, the role of AI, and acknowledgments, see "About This Document" in the Full Report, available at blueprint.academyhealth.org.
