Blueprint

AcademyHealth

Modernizing Federal Health Evidence: Full Report

The detailed recommendations, mechanisms, and supporting analysis behind the Blueprint.

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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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Opening Frame

Over the better part of a century, the United States built one of the most productive health evidence systems in the world. Federal agencies funded the research, ran surveillance, maintained vital records, evaluated programs, and turned primary studies into guidance that clinicians and policymakers relied on. That system has saved lives, lowered costs, and answered questions that no single state, university, or company could answer alone.

Most people never see it, and everyone depends on it. The age at which a doctor recommends a first colonoscopy, the label on a prescription that says who the drug was tested in, the county overdose count a health officer uses to decide where to send help, the Medicare coverage decision that determines whether a new treatment is paid for, the death certificate that tells a family and a nation what happened: each rests on a federal evidence function, and each is only as good as that function is allowed to be. When the system works, it is invisible. When it fails, the failure arrives as a guideline no one trusts, a shortage no one saw coming, a treatment approved for patients unlike the ones who take it, or a public health emergency that the country learns about at the speed of its slowest data system. The case for this Blueprint is that ordinary people are better off, and the country safer and richer, when the evidence system is strong, yet that strength has never been guaranteed, and should be.

The stakes reach past health care. Federal health evidence underwrites the largest purchaser of medical care in the world, so the quality of evidence about what works drives the quality of the country's spending. It is the foundation of biosecurity: the surveillance and laboratory networks that detect an outbreak are national security infrastructure, whether or not they are described that way. The federal government does formally designate health care as critical infrastructure. And federal health evidence is the basis of the research enterprise that has made American medicine what it is, an enterprise strong enough that when other countries see it falter, they move to recruit its researchers.

That system is under strain, because much of what protected it rested on norms rather than law. The record of 2025 and 2026, stated once here so the rest of the document need not repeat it: research awards were canceled mid-stream and appropriated funds went unspent while a court considered the matter; grantmaking at the Agency for Healthcare Research and Quality (AHRQ) stopped for months; an entire federal immunization advisory committee was dismissed in a day and its replacement later blocked by a court for violating the statute that governs such committees; the release of important statistical data was delayed and a survey office was eliminated by reduction in force; and rules were changed so that career scientific positions could be stripped of their job protections and more easily replaced. Taken singly, each action might pass as routine administration. Together, they reveal how much of the evidence system depends on choices no law requires anyone to make. The same record shows what held: the appropriations rider that had fixed indirect-cost rates since 2018 stopped a cap within days, the courts enforced the advisory-committee statute within months, and the agencies' career staff kept vital statistical data running through all of it. The Blueprint treats the whole record as a diagnosis. Where a protection held, it was written into law with no discretion to exercise; where one failed, it had been left to custom or to a duty someone could decline to perform. The recommendations

that follow are built to that pattern, irrespective of who produced the record and who might produce the next one.

The weaknesses now on display are not new, and no single administration made them. Biomedical research at NIH has been funded reliably for decades, and it shows. The parts of the system that produce data and evaluation were not. Federal data systems were fragmented and slow before the current pressure arrived, built on one-time supplemental appropriations rather than a base sized to the work. Funding for the evaluation and statistical functions has swung with the appropriations cycle under both parties. The evidence workforce inside government was under-supported for years. The state and local systems that collect most of the country's health data contracted through the 2010s and were only partly and temporarily rebuilt. Prior administrations had their own false starts: a 2023 proposal to move Medicare and Medicaid research data into a single enclave without the research community's involvement had to be walked back, and a decade of declining survey response rates went unaddressed by anyone. What looked like a solid structure had been assembled over decades with what was available at the time.

The lesson is not that something unimpeachable was broken and should be restored exactly as it was. The lesson is that the system was more fragile than it looked, because it ran on convention. And a system that ran on convention also ran without the accountability a durable one needs; the recommendations that follow pair protection with evaluation, scorecards, and sunsets, because the case for rebuilding is also a case for building better. Historically, Congress appropriated funding for research, career scientists decided what got funded, the evidence showed what it showed, administrations left those judgments alone, and almost none of that was written down where it could be enforced. Writing a custom down does not make it a requirement; a statute that leaves the executive discretion to comply is still a custom with a citation. The work of this document is to convert what custom left to good faith into obligations that bind, with the discretion removed and a consequence attached: to move the federal evidence enterprise from arrangements that held because everyone honored them to arrangements that hold because the law leaves no one the option, under administrations of any party. The Blueprint is a proposal for what that law should say.

The scope is the federal health evidence enterprise as it centers on the Department of Health and Human Services, together with the Department of Veterans Affairs research enterprise, which serves as a vital foundation for the whole system. The Indian Health Service and the Defense Department's health system will be addressed in a follow-on set of recommendations, for reasons the shorter agency entries explain, and federal health-evidence functions outside these departments await a committed second stage. The work runs across the National Institutes of Health, the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the Agency for Healthcare Research and Quality, the Office of the Assistant Secretary for Planning and Evaluation, the National Center for Health Statistics, and the Food and Drug Administration. It reaches the Department of Veterans Affairs, whose research and data systems are part of the national evidence base, and the health resources, behavioral health, and social services agencies whose program data is evidence infrastructure of the same kind and whose clinical guidance, like the Preventive Services Task Force's recommendations, carries coverage consequences. It depends on the states, territories, and tribes that collect most of the data the federal system relies on. The Blueprint addresses the enterprise as a whole because its strengths and its failures cross agency lines. It gives the most space to the agencies where the evidence functions are most concentrated and

least protected, which is where the field AcademyHealth represents has its deepest knowledge. Focusing on these areas simply matches where the problems are, rather than ranking which agencies are most important.

The Blueprint is organized around five goals:

1. Protect the independence of federal health research
2. Modernize the nation's health data infrastructure
3. Secure sustainable and accountable funding for evidence generation
4. Build and sustain the evidence workforce, and
5. Embed evidence in policy and practice.

Each agency section and each cross-cutting section serves one or more of these goals. Every recommendation that follows names who must act, by what mechanism, and on what timeline, and each one leads with what it does in plain English before it names the statute. The recommendations sort into three categories:

1. What officials can do now under existing authority
2. What requires a leadership decision under authority the department already holds, and
3. What requires Congress to act

Leadership, in the second category, means action that turns on a leadership decision, at any point. Agency heads turn over within administrations, and the category does not wait for an election.

How to read this document

The *Modernizing Federal Health Evidence: A Blueprint* is the short proposal and can stand alone. This document, *Modernizing Federal Health Evidence: Full Report*, contains the detailed recommendations, mechanisms, and supporting analysis behind the Blueprint. Part I takes the agencies one at a time; Part II takes the problems that cross them; Part III is the legislative agenda, with a table at the end that lists every ask, its statutory hook, and the committees that would carry it. We refer to all the recommendations as The Blueprint. Two principles apply throughout and are stated once here. First, the Blueprint is a floor, not a ceiling: nothing in it preempts state laws that protect specially protected health information more strongly than federal law does, and where a state law restricts what flows onward, the recommendations are built to work within it. Second, the consequences the recommendations attach to failure are consolidated into one annual Federal Health Evidence Report to Congress rather than a separate filing for each; where a recommendation says a matter is recorded in the annual report, that is the report it means, and the Legislative Proposals section describes it.

Funding recommendations are carried within each agency section, where the mechanisms attach to specific statutory contexts; the consolidated budget case, covering cost, priority, and the multi-year and floor-based funding authorities, is presented in the Legislative Proposals section. Several recommendations converge on a reauthorized Agency for Healthcare Research and Quality (AHRQ) as their institutional home. Each names the fallback that operates if that reauthorization does not pass, and the Legislative Proposals section names the minimum durable core that can move on another vehicle if the whole does not, so no part of the Blueprint depends on a single legislative outcome. The document says little about artificial intelligence by design; the Data Infrastructure Modernization section states

why, and the AHRQ reauthorization carries the statutory authority the enterprise needs to evaluate the tools as they arrive.

This is a standing prescription, not a transition memo. It is meant to be useful to whoever holds the relevant authority now and to those who will hold it later, and to the state officials, researchers, funders, and advocates who can press for its implementation from outside government. The aim is a federal evidence enterprise that does its job well and keeps doing it through changes of administration and leadership. The Blueprint is deliberately about infrastructure rather than about how research itself should change; the questions of open science, research incentives, and new ways of producing and sharing evidence that a stronger enterprise would make possible are taken up in AcademyHealth's previously published Paradigm Project reports, which this document treats as the horizon it is building toward.

How the protections are built

A reader will notice that the diagnosis is, in substantial part, a record of codified protections that did not hold: advisory-committee requirements violated, anti-impoundment provisions outrun by litigation, workforce protections removed by rule. The prescription relies heavily on codification. The question this raises is why new statutes would hold when existing ones were overridden.

The answer is not that a statute enforces itself against an actor determined to ignore it, because none does. The answer is that a statutory requirement is far harder to override than a general expectation, and that statutes themselves differ in how readily they are overridden; the protections proposed here are built toward the forms that resist it. Three commitments run through the recommendations that follow. Protections are written as fixed requirements rather than as discretionary duties, because a duty administered at discretion can be administered away. Breaches carry consequences that attach automatically rather than depending on case-by-case litigation that runs slower than the harm. Enforcement is routed, where the structure allows, through institutions that answer to Congress rather than to the officials whose conduct is at issue. These commitments do not make independence guaranteed, and this document does not claim they do. They make its erosion costly, visible, and reversible, and where a protection can still be overridden by an actor willing to bear that cost, the recommendation is built so the override leaves a durable public record and a surviving reference standard. The Research Integrity and Scientific Freedom section sets out the commitments in full and applies them.

A fair question about these commitments is who they leave in charge. The president heads the executive branch, and the officials who run these agencies answer to elected leadership. Nothing in this Blueprint changes that, and nothing in it authorizes any official to defy the leadership the country elected. Every binding protection proposed here is a request to Congress, the branch the Constitution charges with writing the rules agencies operate under, and a statute passed by the people's representatives is the ordinary constitutional way an executive duty becomes fixed. Where the Blueprint routes enforcement to Inspectors General, the Government Accountability Office, or the committees of jurisdiction, it routes it to institutions Congress created and oversees. And most of the consequences proposed here are transparency: written reasons, published reports, records transmitted to Congress. Requirements like those add to what the public can see and hold officials to. Policy priorities will change with elections, and

they should. The infrastructure that measures whether any administration's policies work should serve them all, and preserving that is what these protections are for.

About this Blueprint

Modernizing Federal Health Evidence: A Blueprint (and this companion full report) is issued by AcademyHealth, the professional home of health services research and health policy in the United States, with support from the Robert Wood Johnson Foundation. It was drafted by AcademyHealth staff and reviewed in full by seven external reviewers with backgrounds in congressional relations, public health law, federal agency leadership, public health practice, and philanthropy, whose comments shaped the document. The recommendations are AcademyHealth's. They are offered to the field, to the agencies, and to Congress as a starting point for the work, and the organizations that choose to endorse or act on them will do so on their own terms.

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, and this companion full report, 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 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 content 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. 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 document'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 document. 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 document.

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 document 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]**

Part I. Agency Sections

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

The ASPE portfolio (data governance, program evaluation, Learning Agenda stewardship, and policy analysis) gives the office the right functions but not the authority, resources, or structural protections to execute them. Reform should convert coordination into governance, build durable evaluation capacity, link evidence to the budget process, and codify the independence on which credible analysis depends.

Diagnosis

When HHS decides whether to expand a Medicaid demonstration, redesign a payment model, or surge resources during a public health emergency, ASPE is the office responsible for making sure the supporting evidence exists, that it is rigorous, and that it reaches decision-makers in time to matter. It houses the department's Chief Data Officer and Evaluation Officer. It sets the HHS Learning Agenda, the published list of what the department needs most to learn about its own programs, which the Evidence Act of 2018 requires every major agency to produce and which is meant to guide what gets evaluated. It conducts and commissions the policy analyses that inform the Secretary's most consequential choices. No other office within HHS combines these analytic, evaluative, and coordinating functions. When ASPE is weakened, the department flies blind.

The Foundations for Evidence-Based Policymaking Act of 2018 (the "Evidence Act") formalized much of this role. The law required federal agencies to designate Evaluation Officers, Chief Data Officers, and Statistical Officials, and it mandated Learning Agendas and annual evaluation plans. ASPE was assigned department-wide coordinating responsibility for HHS implementation, but the Evidence Act gave ASPE that responsibility without corresponding authority or resources. Three structural conditions follow.

Authority without enforcement. The Chief Data Officer (CDO) can convene meetings and make recommendations. The CDO cannot compel operating divisions (the major service and research components of HHS, CMS, CDC, NIH, FDA, HRSA, and others) to adopt common data standards, share data assets, or align practices with department-wide priorities. Implementation of the Evidence Act across HHS has been uneven. Of 23 federal agencies reviewed by GAO in 2024, 18 had difficulty interpreting OMB guidance and conducting the statutorily required capacity assessments, and HHS's published evaluation plans have historically captured only a fraction of the evidence-building activity inside its largest operating divisions. Some operating divisions treat Learning Agenda requirements as compliance exercises rather than strategic tools. **The impact: department-wide data governance depends on the goodwill of operating divisions whose incentives do not consistently align with cross-cutting standards, and basic analytic tasks (linking Medicare claims to CDC surveillance data, for example) remain harder than they should be.**

Evaluation capacity that fluctuates with the appropriations cycle. ASPE's evaluation capacity is thin and fragile. The office has relied heavily on contract evaluators rather than maintaining a deep bench of career evaluation staff. When budgets tighten, evaluation contracts are among the first to be cut. **The**

impact: the federal government's ability to learn whether its own programs are working fluctuates with the appropriations cycle. Evaluation operates as a discretionary contract line, not as a standing institutional capability.

Analytic independence without structural protection. ASPE reports directly to the Secretary. That arrangement makes its work product useful precisely when it is candid, but the same reporting line creates vulnerability: analyses can be suppressed, delayed, redirected, or edited when findings prove politically inconvenient. Unlike federal statistical agencies that operate under OMB Statistical Policy Directive No. 1 and the October 2024 binding Final Rule (89 FR 82454) (which formalize their fundamental responsibilities to produce relevant, accurate, objective statistics and protect the trust of information providers) ASPE is not a Recognized Statistical Agency or Unit and operates without a comparable firewall between its analytic function and political leadership. **The impact: the analyses that should most inform difficult decisions are the most vulnerable to being delayed, edited, or shelved.**

The March 27, 2025 HHS reorganization proposed merging ASPE and AHRQ into a new Office of Strategy. The FY 2026 President's Budget expanded that proposal, consolidating ASPE, AHRQ, the National Center for Health Statistics, and the Office of Research Integrity into the Office of Strategy as a single staff division. Congress declined to enact the consolidation in the FY 2026 enacted appropriations (P.L. 119-75, Feb. 3, 2026). The FY 2027 President's Budget renewed the proposal, again consolidating ASPE, AHRQ, and NCHS into an Office of Strategy. This institutional instability strengthens rather than undermines the case for the recommendations below. The functions described above require protection regardless of where they sit on an org chart, and the repeated proposals to reorganize ASPE underscore the case for statutory codification: if these functions can be restructured by administrative action or a budget rider, they are only as durable as the current org chart.

Recommendations

The four recommendations below build outward from the structural conditions identified above. They are organized to first repair ASPE's authority over data governance (Rec 1), then establish durable evaluation capacity (Rec 2), then link evidence priorities to the budget process (Rec 3), then codify analytic independence (Rec 4). Recs 1 and 3 are designed to begin under existing administrative authority and to be codified by Congress over time. Rec 2 requires legislation. Rec 4 has a strong administrative component and a stronger statutory codification track.

1. Strengthen the authority of the HHS Chief Data Officer: binding by statute now for a defined core of data governance functions, phased for the rest.

The CDO's current coordinating role has not produced consistent data practices across HHS. The Blueprint proposes moving the CDO from coordination to governance, implemented in stages.

In the first phase, the Secretary should issue a department-wide directive establishing minimum required data governance standards that all operating divisions must meet. These should cover metadata documentation, data inventory maintenance, data-sharing protocols for cross-agency requests, and demographic data quality sufficient for subpopulation analysis. Operating divisions should

be required to submit annual compliance reports to the CDO. This phase can be implemented under existing secretarial authority and should be among the first administrative actions taken by any incoming HHS leadership team.

In the second phase, the CDO's authority should expand to include review and approval of operating division data management plans, with compliance tied to the Office of Management and Budget (OMB) budget processes. Operating divisions that fail to meet minimum standards should be required to address deficiencies in their budget justifications.

To make this durable, Congress should codify the CDO's governing authority in statute. The Foundations for Evidence-Based Policymaking Act establishes the agency Chief Data Officer at 44 U.S.C. § 3520 and enumerates 14 functions but uses coordination-and-functions language rather than authority-over-components language; binding authority therefore requires additional legislation. Federal precedent for that architecture exists. The Department of Defense Chief Data Officer / Chief Digital and Artificial Intelligence Officer is authorized under DoD Directive 5105.89 and the May 5, 2021 Deputy Secretary memorandum "Creating Data Advantage" to issue binding data policy across DoD components, to have access to all DoD data, and to adjudicate access disputes. HHS-specific legislation should specify that operating divisions must comply with CDO-issued data governance policies and should anchor the HHS CDO's authority on comparable terms, adapted for HHS's civilian mission and the statistical-agency-head deference required for data acquired under applicable statistical law (44 U.S.C. § 3520(d)).

The statutory step should not wait for the phases to finish. Congress should make the CDO's authority binding now for a defined core of functions where administrative precedent already exists and the case is not contested: metadata documentation standards, data inventory maintenance, and data-sharing protocols for cross-agency requests. For that core, the statute should provide that operating divisions may not adopt data policies inconsistent with CDO-issued standards, and that a data-sharing request meeting the CDO protocol is deemed approved if not acted on within a defined period, with the requesting office's dated written request constituting the record of the request and of the lapse; requests for data acquired under CIPSEA or other applicable statistical law are excluded from the deemed-approval default and remain subject to the statistical-agency-head deference that law requires. The broader functions (review and approval of data management plans; demographic data quality standards; budget linkage) follow the phased path above and are codified as the track record accumulates. The split makes binding now what can be made binding under existing precedent and phases in the rest, rather than leaving every element to wait on the full sequence of directive, OMB linkage, and eventual statute.

Responsible entity: HHS Secretary (Phase 1 directive); the HHS Chief Data Officer; the Office of Management and Budget (Phase 2 budget linkage); Congress (statutory codification: the defined core now, the remainder as phased). **Mechanism:** Department-wide secretarial directive establishing minimum data governance standards and annual compliance reporting; statutory binding authority for the defined core (metadata standards, data inventory, data-sharing protocols) with a deemed-approval default; expanded CDO review and approval authority over operating division data management plans, tied to OMB budget processes; statutory codification of the remaining functions adapted from the DoD model. **Timeline:** Phase 1 can be issued under existing authority in the first year under new leadership. Phase 2 requires OMB coordination and should follow within twelve to eighteen months. Statutory

codification of the core can be introduced immediately; the remainder requires legislation following the phased track record.

Cross-cutting connection: Coordinate with the Data Infrastructure Modernization cross-cutting section, which carries the technical content on data standards, interoperability, and linkage. This recommendation establishes the institutional governance framework; the cross-cutting section develops the substance. The architecture of the Defense Department's Chief Digital and Artificial Intelligence Office (CDAO) is a candidate exemplar for that section alongside the FDA Sentinel System pattern. The Phase 1 directive belongs in the early-action agenda in the Office of the Secretary section. The OMB-linked Phase 2 question is coordinated with the Align and Coordinate the Federal Evidence Enterprise cross-cutting section.

2. Establish a permanent, dedicated HHS evaluation fund administered by ASPE with methodological standards and quality review by the reauthorized AHRQ.

Congress should create a dedicated budget line for HHS-wide evaluation, administered by ASPE with a defined methodological-standards-and-quality-review role for the reauthorized AHRQ; if the reauthorization is not adopted, the Secretary designates an alternative federal research authority with comparable methodological independence for that role, on the model CMS Recommendation 5 uses, so the fund's quality architecture is never unassigned and never self-reviewed. This fund should support the Evaluation Officer's annual evaluation plan with stable, multi-year resources that do not depend on individual operating division cooperation or annual appropriations volatility.

The fund is not a duplicate of the Public Health Service Evaluation set-aside (the "PHS Tap," the authority under Section 241 of the Public Health Service Act, 42 U.S.C. § 238j, to reserve a share of certain appropriations for evaluation, with the percentage set each year in the appropriations act), and the difference is the point. The Tap is undirected: it funds ASPE's own operations, appropriators redirect it to stay within discretionary caps, and the agencies whose appropriations it draws on have historically resisted it. The dedicated fund provides specific direction for the use of the money (the Evaluation Officer's plan, the AHRQ methodological standards, the public release requirement in Recommendation 4) and a stable multi-year base that does not move with the annual redirection of the Tap. Where the two overlap, the overlap adds stability and room to expand the evaluation portfolio rather than waste. The phase-in relationship between the fund and the Tap's evaluation share is for the appropriations committees to set; the fund's arrival gives them the first structural occasion to revisit how much evaluation the Tap should continue to carry, and this document does not prejudge that choice. The shared structure reflects what each agency is best positioned to do. ASPE administers the fund because the evaluation question the fund is designed to answer (whether HHS programs are using evidence effectively and whether their designs produce the outcomes Congress intended) sits at the Secretary's analytic remit and depends on the kind of department-wide visibility into program operations that ASPE is structurally positioned to provide. The reauthorized AHRQ holds the methodological-standards-and-quality-review role because the operational expertise on evaluation methodology, the existing infrastructure for evidence-synthesis standards, and the statistical-unit protections established in AHRQ Recommendation 2 are at AHRQ, not ASPE. The division gives the fund administrative coherence at ASPE and methodological discipline at the reauthorized AHRQ without forcing either agency outside its institutional competence.

The fund should support both career evaluation staff within ASPE and a standing contract vehicle for rigorous program evaluations across HHS. The reauthorized AHRQ's methodological-standards-and-quality-review role attaches to both: published methodological standards for evaluations funded through the program, and an evidence-quality review process for evaluation products before they are released. The Office of Planning, Research, and Evaluation (OPRE) at ACF is the operational federal benchmark for embedded evaluation capacity outside the health sector and informs the fund's design (see the ACF/OPRE recommendation in the Brief Agency Entries section).

A reasonable starting target would be on the order of one percent of HHS discretionary program spending, at FY 2026 enacted levels, roughly $115 to $116 billion in discretionary appropriations through the Labor-HHS-Education appropriations bill (P.L. 119-75), implying roughly $1 billion at full implementation. This level approximates the share of budget that high-performing federal agencies have devoted to research and evaluation under Results for America's Invest in What Works Federal Standard of Excellence, and remains modest in proportion to total HHS spending including mandatory programs.

Responsible entity: Congress (appropriators and authorizers); HHS Secretary; the ASPE Evaluation Officer; the reauthorized AHRQ for the methodological-standards-and-quality-review role. **Mechanism:** Dedicated, multi-year appropriation for HHS-wide evaluation administered by ASPE; standing contract vehicle paired with a career evaluation corps within the office; AHRQ-side authority for methodological standards and evidence-quality review codified in the AHRQ reauthorization vehicle and in the authorizing legislation establishing the evaluation fund. **Timeline:** Requires legislation. Appropriations language is the minimum vehicle; authorizing legislation is preferred and should be coordinated with the AHRQ reauthorization.

Cross-cutting connection: The ASPE-administers / AHRQ-holds-methodological-standards-and-quality-review division of labor is one application of the principal-federal-statistical-and-evaluation-agency-and-coordination-rule framework articulated in AHRQ Recommendation 7. The reauthorized AHRQ's methodological-standards role connects to AHRQ Recommendation 2 (CIPSEA recognition for AHRQ's statistical activities), AHRQ Recommendation 4 (statutory consideration links tying AHRQ evidence products to federal decisions), and AHRQ Recommendation 5 (federal health services research (HSR) coordination body). The CMS section's Recommendation 2 on CMMI evaluation infrastructure and the Align and Coordinate the Federal Evidence Enterprise cross-cutting section on the broader federal funding-for-evidence-without-commercial-sponsor question are the other principal cross-section partners.

3. Make the HHS Learning Agenda consequential by linking it to the budget process.

The Learning Agenda should drive evidence-building priorities across HHS rather than sit in a filing cabinet. The Secretary should direct ASPE to review operating division budget justifications for alignment with Learning Agenda priorities. Where ASPE identifies misalignment, ASPE should flag those findings in a formal memo to OMB during the budget formulation process.

This review is distinct from the department's internal budget council, the final formulation step before the request goes to OMB, on which ASPE already sits and which reviews operating division budgets for priorities and costs. The Council's review is internal, undocumented outside the Department, and framed around the Secretary's priorities for the year. The review proposed here is evidence-specific, framed around the statutory Learning Agenda, documented in a memo that travels to OMB, and made

public through the scorecard below. What it adds is a record. An operating division that declines to fund the evidence its own Learning Agenda identifies has to say so somewhere Congress and the public can read.

OMB should be directed, through a joint OMB-HHS memorandum, to consider ASPE's alignment assessments during budget passback (the stage at which OMB returns marked-up budget proposals to agencies before transmission to Congress). This arrangement formalizes an existing federal practice and specifies it for HHS. Since OMB Memorandum M-21-27 (June 2021) and continuing through subsequent annual budget guidance, OMB has directed agencies to tie their evidence-building proposals to annual budget requests, and OMB Circular A-11 Part 6 invokes the agency Learning Agenda as the framework for performance review. What does not currently exist is a department-specific layer that gives the HHS-wide Learning Agenda steward (ASPE) a structured channel to communicate alignment assessments of operating-division budget justifications to OMB during passback. The recommendation establishes that layer. Operating divisions that consistently ignore Learning Agenda priorities would need to justify that choice to OMB rather than only to ASPE.

The public-accountability mechanism that completes this linkage is transparency. ASPE should publish an annual public scorecard reporting each operating division's progress against Learning Agenda priorities, including which planned evaluations were completed, which were deferred, and why. The scorecard converts the internal alignment review and the OMB passback memo into information that Congress, the research community, and the public can use, which is the protection against the OMB linkage becoming a bureaucratic paper requirement without operational impact.

Responsible entity: HHS Secretary; ASPE; the Office of Management and Budget. **Mechanism:** Secretarial directive requiring ASPE alignment review of operating division budget justifications; joint OMB-HHS memorandum directing OMB to consider ASPE's alignment assessments during passback; annual public Learning Agenda scorecard. **Timeline:** The secretarial directive and the joint OMB-HHS memorandum can be issued under existing authority in the first year under new leadership. Implementation requires sustained leadership commitment and OMB cooperation.

Cross-cutting connection: This recommendation belongs on the Secretary's early-action agenda in the Office of the Secretary section. Coordinate with the Align and Coordinate the Federal Evidence Enterprise cross-cutting section on the broader OMB-evidence-enterprise interface question. The guidance-driven foundation of the existing OMB practice (M-21-27, Circular A-11) is itself an instance of the recurring Blueprint pattern in which federal-evidence-infrastructure architectures depend on administrative guidance subject to discontinuation; durability requires codification.

4. Establish transparency, publication norms, and workforce protections for ASPE's policy-relevant analysis, and codify them in statute.

ASPE's analytic credibility depends most directly on the durability of its career analytic workforce. Unlike the principal federal statistical and evaluation agencies, ASPE sits structurally close to the Secretary, who uses it to develop and implement Administration policy and priorities; a Senate-confirmed leader who serves the Secretary is the right architecture for the office. The political vulnerability sits not at the leader but at the career analytic staff who produce the work, where politically motivated reassignment, reductions in force targeting analysts for the content of their

analytic work, and compelled-resignation patterns can hollow out analytic capacity without ever touching the leader's appointment. The closest functional comparator is the Office of Management and Budget, which combines a politically accountable Senate-confirmed Director with a statutorily protected career analytic workforce; ASPE shares that basic architecture without needing to replicate OMB's full statutory portfolio. The four protection layers below build that architecture for ASPE.

The Secretary should establish a formal policy governing ASPE-commissioned evaluations, policy analyses, and the career analytic workforce that produces them. The policy should establish four layers of protection under existing authority, and it preserves political accountability: the Secretary sets ASPE's priorities and directs what is studied, and the protections govern methods, findings, and release. First, completed evaluations and analyses should be publicly released within a fixed period (for example, 90 days of completion), with any decision to delay or withhold requiring written justification subject to Inspector General review. Second, ASPE's analytic agenda should be developed through a transparent, documented process protected from ad hoc political direction. Third, ASPE analysts and contractors should be protected from inappropriate political interference in methods, analysis, and conclusions, with departures from documented methodology requiring written justification. Fourth, any reclassification of ASPE analytic positions out of competitive-service career status, any reduction in force affecting ASPE analytic offices, and any pattern of compelled resignations among ASPE analytic staff should trigger Inspector General review, with a public report to the Secretary, the HHS Inspector General's office of record, and the relevant congressional committees, and with the affected positions held in their prior status pending the committees' review.

Administrative action establishes the starting layer; statute supplies the structural protection ASPE's role requires. Congress should codify the four administrative protections and add five protections that require legislation. First, ASPE analytic positions should receive statutory protection against reclassification out of competitive-service career status by executive order, addressing the Schedule F vehicle reinstated as "Schedule Policy/Career" by Executive Order 14171 (January 2025). This is the model the Blueprint asks its other codification recommendations to meet: it does not direct the executive to protect the positions, it removes the executive's authority to reclassify them. The protection should be proposed at two scales: a government-wide version covering analytic and scientific positions across the federal evidence enterprise and an HHS-specific version covering ASPE and the department's evidence agencies, so that the principle finds allies beyond health while the narrower vehicle remains achievable on its own. Second, involuntary separation or reassignment of ASPE analytic staff should require cause and notice on terms parallel to the protections under 5 U.S.C. Chapter 75 (Adverse Actions) and the prohibited personnel practices framework in 5 U.S.C. Chapter 23 (Merit System Principles), with statutory cause-and-notice extended to cover reassignment within the same grade where existing Chapter 75 protections do not reach. Third, the Inspector General should have explicit statutory jurisdiction to review reclassification, reduction-in-force, and compelled-resignation patterns affecting ASPE analytic staff, with a reporting requirement on a defined cadence and public release. Personnel actions are traditionally the Office of Special Counsel's lane, and the Inspector General's authority to review them as patterns cannot be presumed; the statute should confer it. Fourth, the Office of Special Counsel (OSC) should have an explicit investigation-and-report channel for personnel actions tied to the content of an ASPE analyst's analytic work, paralleling existing whistleblower-reprisal protections but indexed to analytic content rather than to whistleblowing as a triggering act; because the Office's current capacity to act on such channels is limited, the Inspector General jurisdiction in the

third element is the primary route and this channel is the secondary one. Fifth, a finding by the Inspector General that a reclassification, reduction in force, or compelled-resignation pattern was tied to analytic content should carry an automatic consequence: the affected positions are restored to their prior status and the finding is recorded in the annual Federal Health Evidence Report to the committees of jurisdiction at the time it is made. The statutory mechanisms in this paragraph are drafting proposals for legal expert review to settle before any vehicle is introduced, a sequencing the Legislative Proposals section states.

The workforce-protection architecture is reinforced by an outside-review layer for major analytic work. For analytic projects above a defined threshold (by cost, by scope of Secretary's office attention, or by inclusion of cross-administration legacy questions), an external standing review panel should review the analytic plan, methodological design, and final product. The function of outside review is to give analysts cover when their work is at risk of political pressure: a methodological design endorsed by an external standing panel and a final product reviewed by the same panel give the analytic team a defensible position that ad hoc political direction cannot easily override. The panel's composition, scope, and operating procedures should be specified in the same statutory codification that establishes the other workforce protections, with administrative implementation feasible under existing authority as a precursor.

Responsible entity: HHS Secretary (administrative policy for the four layers); ASPE leadership; the HHS Inspector General (review of analytic-product delays or withholdings, and, under conferred statutory jurisdiction, of analytic-position reclassifications, reduction-in-force (RIF) actions, and compelled-resignation patterns); the Office of Special Counsel (analytic-content-related personnel actions, secondary statutory channel); Congress (statutory codification of the four administrative protections and the five additional protections requiring legislation, at two scales). **Mechanism:** Secretarial policy governing release timelines, agenda-setting transparency, analytic-content insulation, and workforce-protection administrative measures; statutory codification covering reclassification protection at government-wide and HHS scales, cause-and-notice for involuntary separation or reassignment, conferred IG jurisdiction with reporting cadence, the OSC analytic-content channel, the automatic-restoration consequence, and the external standing review panel. **Timeline:** The four administrative-policy layers can be established under existing authority in the first year under new leadership; statutory codification requires legislation. Administrative implementation builds the track record that makes statutory protection politically tractable.

Cross-cutting connection: ASPE sits in the policy-analysis tier (Tier 3) of the three-tier federal evidence-function protection architecture articulated in the cross-cutting Research Integrity and Scientific Freedom section, paired with no other agency on this protection structure. The architecture differs from the statistical-and-evaluation tier (AHRQ Director, NCHS Director; a fixed term with the layered removal design) and from the research-administrative tier (NIH Director, CDC Director, VA research leadership; the same layered design without a fixed term) because ASPE's structural position close to the Secretary makes leader-tenure protection inapt; the protection axis is workforce, not leader. The GAO Comptroller General and Congressional Budget Office (CBO) Director architectures, while structurally instructive as historical illustrations of analytic-office independence design (GAO long tenure plus high removal bar; CBO appointment-nonpartisanship), are legislative-branch architectures and are not the right comparators for an executive-branch policy-analysis office. The statutory codification component belongs in the consolidated Legislative Proposals section.

National Institutes of Health

The structural problem at NIH is not its 27-Institute architecture but the cross-cutting weaknesses that constrain it: the absence of agency-wide priority-setting, the burden and bias of its peer review system, the chronic instability of its funding base, and a scientific independence that rests on practice rather than law. Reform should preserve what sustains decades of bipartisan support for biomedical research and fix what limits it.

Diagnosis

NIH is the world's largest public funder of biomedical research. Its annual budget, $48.7 billion in discretionary funding for FY 2026, flows through 27 disease- and discipline-focused Institutes and Centers, plus an intramural program on the NIH campus. In each of the two most recent complete fiscal years, NIH awarded more than 64,000 extramural research and training grants to universities, medical centers, and other institutions. The system rests on competitive peer review: scientists submit proposals, panels of other scientists evaluate them, and the highest-rated proposals receive grants. When NIH works well, it produces the evidence that doctors, public health officials, and policymakers rely on.

NIH's structural problems are not new and predate any single administration. They cluster in four areas.

No agency-wide priority-setting. What NIH funds is largely the sum of what each institute decides separately. There is no deliberate process for balancing the portfolio across safe incremental science, high-risk bets, and research that responds to urgent public health needs. The Office of the Director and the Common Fund (**a pool of money the Director controls for research that crosses institute boundaries**) provide some cross-cutting tools, but they are small relative to the scale of the challenge. The 27-Institute structure itself creates coordination challenges, but it is not the binding constraint. Proposals to merge institutes into as few as 8 or 15 (most recently the House Energy and Commerce Committee's June 2024 framework) would dissolve the advisory councils, patient communities, and Congressional relationships that have sustained bipartisan investment over decades. The NIH Reform Act of 2006 (P.L. 109-482) capped the number of institutes and centers at 27, created the cross-institute coordination mechanisms the Common Fund operates through, and established the Scientific Management Review Board to advise on organizational change. When past advisory recommendations have proposed merging institutes (notably the drug abuse and alcohol institutes, NIDA and NIAAA, in 2010), implementation has come through cross-institute initiatives like the Collaborative Research on Addiction at NIH (CRAN) rather than structural consolidation.

A peer review system with well-documented problems. Studies find bias based on the gender, career stage, and institutional affiliation of applicants. Reviewers evaluating the same application frequently disagree. Research has documented a specific risk-taking penalty: proposals that try something genuinely new are systematically scored lower than safe extensions of established work, even when the novel proposals go on to produce higher-impact science (Azoulay and Greenblatt 2025; Azoulay 2023). The finding holds across four independent measures of risk-taking and is larger for novel research areas

and earlier-career investigators. The R01-equivalent success rate has been at or below approximately 20 percent for most of the past decade. Application preparation and post-award administration consume a large share of researchers' working time: the Federal Demonstration Partnership's Faculty Workload Surveys (2005 and 2012, the latter covering more than 13,000 federally funded principal investigators) found that approximately 42 percent of researcher time on federally funded projects is spent on administrative tasks rather than on research, with the figure stable across both survey waves. Funding is also concentrated geographically and institutionally: four states (California, New York, Massachusetts, and North Carolina) receive nearly half of NIH research funding, and the top 50 institutions account for a disproportionate share of awards across the country. This concentration narrows the questions asked, the methods used, and the populations studied. During COVID-19, NIH compressed grant review from nine months to three and stood up new programs like RADx (Rapid Acceleration of Diagnostics) within weeks. Those capabilities should not be reserved for emergencies.

Chronic funding instability. Because Congress appropriates NIH's budget one year at a time, the agency cannot plan with confidence. When budgets are flat or cut in real terms, the damage falls hardest on early-career researchers, on institutions without large endowments, and on long-running investments (longitudinal cohorts, clinical trials networks, shared data systems) that lose most of their value if interrupted. Layered on top is the contest over "indirect costs" (facilities and administrative, or F&A, reimbursement), the share of federal grants covering laboratories, safety systems, compliance, and utilities. Transparency in how these funds are spent is a legitimate goal; arbitrary caps that do not reflect actual research costs are not. Any reform should be grounded in auditable cost data.

Scientific independence that rests on practice rather than law. The separation between political appointees and the scientists who review and score grant applications is real, and it is a norm rather than a rule. NIH maintains it through internal practice and professional expectation, not through written policy with documented procedures, disclosure requirements, or any external check. 42 U.S.C. § 282 establishes the office of the NIH Director and is silent on removal. The statutory bodies meant to provide structural oversight can also be left unused. The Scientific Management Review Board, chartered under the NIH Reform Act of 2006 to advise the Director on NIH's organizational authorities and required to convene at least once every seven years, was dormant from 2015 to 2024, and had not been convened since 2015 as of that inquiry; the reconvening that followed has not produced a sustained meeting cadence. Nothing in that sequence required anyone to act improperly. A requirement carrying no consequence for inaction is a requirement in name only, and protections that hold only when officeholders choose to honor them are not what a national research enterprise can rely on.

The impact. If these problems persist, the federal biomedical research enterprise will fund less of the best science (peer review filters out novelty), fail to act decisively on cross-cutting questions (no one is empowered to do so), waste prior investment (long-horizon assets are subject to annual disruption), and leave the credibility of what it does fund resting on protections no statute secures. The recommendations that follow address these four problems directly.

Recommendations

This section presents eight recommendations. The first three address NIH's research-management functions: agency-wide priority-setting, the ARPA-H relationship, and the peer review system. Recommendations 4 through 8 address the funding architecture, scientific independence, and the agency's capacity to mobilize when conditions demand it. Most can be initiated under existing administrative authority. Three (statutory codification of the institute structure, multi-year budget authority, and scientific integrity protections) require legislation; those are marked.

1. Protect NIH's institute structure and give the NIH Director better tools to set research priorities across the whole agency.

Congress should resist proposals to split, consolidate, or block-grant NIH. The institute structure works because it creates durable relationships between scientists, patients, and lawmakers that sustain public investment in research; administrative elegance is beside the point. Dismantling it would cost more than proponents acknowledge.

At the same time, NIH needs a better way to set priorities that cut across individual institutes. The NIH Director should have the authority and dedicated funding to identify agency-wide research priorities and direct resources toward questions that no single institute would fund on its own, including health data infrastructure, **implementation science (the study of how to put proven interventions into routine practice)**, and emerging public health threats. This should happen through a regular, public priority-setting process led by the Office of the Director, with input from institute leaders and outside experts.

The Scientific Management Review Board (SMRB), whose dormancy the diagnosis describes, provides a statutory venue for one part of this work, namely the periodic structural review of institutes, centers, and offices within the Office of the Director. Restoring it to its statutory cadence (at least once every seven years per P.L. 109-482, with sustained working-group activity between full meetings) is a precondition for the broader priority-setting process recommended here. The priority-setting process itself is broader than the SMRB's structural-review mandate and should be conducted through the Office of the Director, with input from the SMRB on structural questions and from the Advisory Committee to the Director on scientific portfolio questions. If the Board fails to convene on its statutory cadence, the miss, its reason, and the date by which the Board will meet are recorded in the annual Federal Health Evidence Report to the committees of jurisdiction.

The main funding tools are an expanded Common Fund and new dedicated funding lines that the Director controls for cross-cutting research. These should be new money for coordination, not redirected institute appropriations.

The National Center for Advancing Translational Sciences already coordinates translational science across institutes and is one model for how a Director's cross-cutting priorities can be organized without displacing institute programs. Two safeguards make the cross-cutting authority accountable. First, the Director's allocations from the Common Fund and any new cross-cutting lines should be reviewed

annually by the Advisory Committee to the Director and published in an annual report identifying each cross-cutting investment, its rationale, and its relationship to institute portfolios, so the Director's discretion operates in public rather than on trust. Second, institute base appropriations should be insulated from repurposing into cross-cutting lines by two instruments: appropriations report language directing that cross-cutting funds be new money rather than transfers from institute lines, and continued congressional control of the amount reserved for the Common Fund, which the NIH Reform Act requires the Director to reserve each year subject to the appropriations acts, setting a floor rather than a ceiling; any ceiling on the cross-cutting share would be new appropriations language and should be written as such.

Responsible entity: NIH Office of the Director; the Scientific Management Review Board; Congress (appropriations committees and authorizers; statutory protection against structural dismemberment). **Mechanism:** Administrative priority-setting process and Common Fund expansion under existing authority; appropriations language; authorizing legislation to codify the institute structure and the cross-cutting funding lines. **Timeline:** Priority-setting process and Common Fund expansion can be initiated under existing authority within the first year under new leadership. Statutory protection of the institute structure requires legislation.

Cross-cutting connection: Coordinate with the Research Integrity cross-cutting section. The SMRB's dormancy pattern (statutorily required body, allowed to lapse for nine years, reconvened under Congressional pressure, then de facto dormant again under leadership change) is a concrete example of the structural-protection problem that section addresses, and is carried in this section's diagnosis as the fourth structural problem.

2. Keep ARPA-H as a complement to NIH, not a replacement, and fund it separately.

The Advanced Research Projects Agency for Health (ARPA-H) was created to fund a different kind of research than NIH typically supports: high-risk, milestone-driven projects aimed at translating scientific discoveries into practical health solutions, with hands-on program management rather than traditional grants. Congress placed it within NIH as an independent entity: its Director reports to the Secretary rather than the NIH Director, it is exempt from NIH policies, and its appropriation is carried separately. The recommendation preserves that arrangement rather than changing it. **ARPA-H's milestone-driven, top-down model serves a different problem than NIH's investigator-initiated portfolio: replacing one with the other would leave a permanent gap in the fundamental science base that produces the discoveries ARPA-H exists to translate. Where ARPA-H sits matters less than that the function exists at all. Its budget should be a separate, additive appropriations line, structurally protected from being offset against NIH's main research budget.** Whether ARPA-H should eventually stand as its own agency reporting to the Secretary, on the model of the Defense Advanced Research Projects Agency, is a structural question the Blueprint notes but does not resolve; without a permanent home an agency competes with its host for funds, and the separate appropriations line proposed here is the near-term protection against that outcome.

Responsible entity: Congress (appropriations committees); the Office of Management and Budget; the NIH Director. **Mechanism:** Appropriations practice and budget request structure that maintains ARPA-H as a separate, additive line. **Timeline:** Sustained appropriations oversight in every budget cycle. No single legislative vehicle.

3. Test new ways of deciding which research gets funded.

NIH should run structured experiments with its grant review process. The current system has well-documented problems: reviewer disagreement, bias against innovative work, and an application and reporting process whose cost is measurable. Grant periods of three to five years, combined with the administrative requirements described in the diagnosis, mean researchers spend a large share of funded time on administration rather than research. Longer grant periods for more researchers and a lighter administrative load would yield better research and a better return on the public's money; the experiments below are how NIH finds out which changes do that. **During COVID-19, NIH proved that faster, simpler review processes can work. Those approaches were not retained because they relied on emergency authorities and ad hoc improvisation rather than standing procedure.**

The NIH Director should direct the Center for Scientific Review (CSR, the office that manages NIH's peer review system) to design and evaluate a set of pilot programs testing alternative approaches, **including disruptive ones**. These could include shorter initial applications, with full proposals requested only from competitive applicants; a system where proposals that clear a quality threshold are selected from a pool rather than finely ranked; fast-track review for time-sensitive public health, clinical, and health care delivery questions; and approaches that ensure NIH funds a wider range of research methods, institutions, and populations. **Each pilot should specify outcome measures in advance, be subject to independent evaluation, and report results publicly. Congress should require NIH to submit a summary report on pilot outcomes within three years of program launch.** CSR has the authority to run these pilots without new legislation.

Responsible entity: NIH Director; Center for Scientific Review (CSR); Congress (reporting requirement). **Mechanism:** Pilot programs under existing administrative authority, with pre-specified outcome measures, independent evaluation, public reporting, and a Congressional summary report. **Timeline:** Pilot design within the first year under new leadership; initial results within two to three years.

4. Fund researchers for longer and spread funding to more institutions.

NIH should give more researchers longer grants with fewer administrative requirements, so that funded time goes to the work the grant was made for rather than to reapplying for it. International funders like the Wellcome Trust (UK) and the Howard Hughes Medical Institute have used this model successfully. At NIH, these longer awards should be targeted especially at early- and mid-career researchers, who face the steepest odds in the current system.

Separately, NIH should take concrete steps to spread its funding more broadly across institutions and regions. A small number of universities receive a disproportionate share of NIH grants. **This pattern is self-reinforcing: established institutions have the staff to write competitive applications, the infrastructure to host major awards, the prior funding that signals capacity to reviewers, and the networks that connect investigators to grant-review communities.** When funding flows to the same institutions, the research enterprise asks a narrower range of questions, uses a narrower set of methods, and studies a narrower slice of the population. Broadening access produces better science, beyond a more equitable distribution.

To ensure these goals are more than aspirational, NIH should be required to report annually and publicly on where its grant money goes: which institutions, which states, and which populations are represented in NIH-funded research. **This report should draw on NIH RePORTER data, presented in a structured public format that allows year-over-year comparison rather than ad hoc query.**

Responsible entity: NIH Director and individual Institutes and Centers; Congress (to make annual reporting durable). **Mechanism:** New grant announcements and modifications to existing award programs; structured public annual report drawn from RePORTER data; statutory reporting requirement to make the practice durable. **Timeline:** Award changes and reporting can be initiated under existing authority within the first year under new leadership. Statutory reporting requirement requires legislation.

5. Protect the independence of NIH science, make the Director's removal accountable to Congress, and hold the agency accountable for filling leadership vacancies.

NIH's decisions on individual grant applications should be protected from political interference. **Administrative protections and statutory protections work together: the first sets a floor any Director can implement immediately; the second makes that floor durable across administrations.** The NIH Director should put in place formal internal policies that create a firewall between political appointees and the scientists who review and decide on grant applications. Political leadership properly sets research priorities and portfolio allocations, as the priority-setting recommendation above provides; the firewall applies to the review and selection of individual applications. **The firewall concept exists informally at NIH today, as the diagnosis describes; the recommendation is to formalize it as written internal policy with documented procedures.** The policy should include randomized assignment of applications to reviewers within a study section, mandatory disclosure of any contact between political appointees and review panel leadership, and recusal requirements where such contact concerns a pending application. Any changes to how grants are reviewed, or to who sits on review panels, should be documented and explained publicly. These are administrative actions that can be taken immediately. Written policy can also be rescinded by the next Director, so the durability of the firewall depends on the statutory layer below: the disclosure and documentation requirements should be attached to a statutory reporting obligation to Congress, so that a Director who withdraws the policy must also stop filing a report the law requires.

Congress should go further by writing scientific integrity protections into law, establishing clear standards for keeping the scientific process independent; the cross-cutting Research Integrity and Scientific Freedom section's Recommendation 1, a statutory prohibition on viewpoint discrimination and appointee vetoes in award decisions with sampling-based Inspector General audit, is the government-wide version of that standard and the NIH firewall is its agency-specific application. Congress should also require NIH to publicly report on vacancies and delays in filling its top leadership positions, with a fixed clock: when the office of the Director or of any Institute or Center director has been vacant or filled only in an acting capacity for more than 210 days, the vacancy, its cause, and the plan to fill it are recorded in the annual Federal Health Evidence Report to the committees of jurisdiction. Congress should prioritize reconstituting the advisory bodies that are required by law but often left unfilled, on the same reporting clock.

On the Director's tenure, the Blueprint proposes the design set out in Legislative Proposal 2. The NIH Director is a Senate-confirmed principal officer, and after the Supreme Court's June 29, 2026 decision in *Trump v. Slaughter* a principal officer cannot be given for-cause removal protection; the design for this office therefore never touches the removal power itself. 42 U.S.C. § 282 establishes the office of the NIH Director and is silent on removal. Congress should amend it to add statutory qualification requirements for the office; a requirement that any removal be accompanied by a written statement of specific reasons transmitted to the committees of jurisdiction and published, with a defined notice period before the removal takes effect; and an interim rule providing that, while a removal is contested or the office is vacant, the acting Director may not alter the firewall policy, review panel membership, or funding decisions already made on peer-review rankings. Each element operates on its own. The NIH Director sits in the research-administrative tier of the protection architecture articulated in the cross-cutting Research Integrity and Scientific Freedom section, paired with the CDC Director and VA research leadership; that tier carries no fixed term, because NIH's research-administrative function does not have the periodic-release-schedule and principal-federal-estimate-production responsibilities that anchor the fixed-term protection for the AHRQ and NCHS Directors. It differs from the policy-analysis tier (ASPE; politically accountable leader with statutory workforce protections) because the NIH Director is not used to develop and implement Administration policy in the way that ASPE's leader is.

Responsible entity: NIH Director (administrative protections); Congress (statutory protections, amendment of 42 U.S.C. § 282, advisory body reconstitution, leadership vacancy reporting). **Mechanism:** Internal scientific integrity policies and disclosure requirements; statutory amendment to 42 U.S.C. § 282 establishing qualifications, reasons-to-Congress removal reporting, and the interim rule; statutory codification of integrity standards; appointment and reconstitution of statutorily required advisory bodies. **Timeline:** Administrative protections can be implemented within the first year under new leadership. Statutory protections require legislation.

Resilience note: In a cooperative environment, the administrative firewall and disclosure policy do most of the work on their own. In a noncooperative one, the statutory reporting obligation and the vacancy clock are what survive: a Director who rescinds the policy must still file the report, and a vacancy left open past 210 days produces a record the committees of jurisdiction hold whether or not the Department wishes to explain it.

Cross-cutting connection: The NIH Director protection structure sits in the research-administrative tier (Tier 2) of the three-tier federal evidence-function protection architecture, paired with the CDC Director and VA research leadership; the removal design follows Legislative Proposal 2. The cross-cutting Research Integrity and Scientific Freedom section carries the federal-evidence-enterprise-wide articulation of the tiered architecture and the statutory award-protection standard (Recommendation 1). The statutory codification component belongs in the consolidated Legislative Proposals section. This recommendation is anchored in the fourth structural problem of this section's diagnosis.

6. Tie NIH funding to a real benchmark for research costs, pair growth with accountability, and make the case for stable investment.

At minimum, NIH funding should be evaluated against the Biomedical Research and Development Price Index (BRDPI), the federal government's own measure of how much it costs to conduct research. When appropriations fall behind BRDPI, NIH loses purchasing power even if its nominal budget stays flat. **The**

Congressional Budget Office (CBO) or the Government Accountability Office (GAO) should periodically evaluate how far current funding has fallen behind this benchmark and report findings to the appropriations committees.

BRDPI is not without controversy. Two counter-arguments deserve acknowledgment: that the index does not fully capture the actual costs of contemporary biomedical research (a measurement question), and that any benchmarked floor adds to federal spending (a budget question). The Blueprint treats BRDPI as an evaluation benchmark for the appropriations process, not as an automatic escalator.

Stable, predictable funding growth is necessary to support research that takes years or decades to pay off, to keep trained scientists in the pipeline, and to maintain the shared infrastructure (computing systems, biobanks, data networks) that the whole research enterprise depends on.

The case for growth is strongest when paired with accountability for how current money is spent. NIH should be subject to periodic, independent external review of how its budget is divided among direct research costs, administrative overhead, and institutional support, with results reported publicly and to Congress. Congress should authorize and fund such reviews on a defined cadence (e.g., every five years) and direct the National Academies of Sciences, Engineering, and Medicine, or a panel of comparable independence convened for the purpose, to conduct them. Each review should be scoped to address budget composition and the cost benchmarks against which appropriations should be evaluated, including BRDPI.

Responsible entity: Congress (appropriations committees and authorizers); the Office of Management and Budget; the Congressional Budget Office or the Government Accountability Office (BRDPI tracking); NIH (BRDPI tracking and reporting); the National Academies of Sciences, Engineering, and Medicine or a comparably independent panel (commissioned periodic budget composition review). **Mechanism:** Appropriations practice and report language tying evaluation to BRDPI; periodic commissioned external review of the budget composition on a defined cadence; possible authorizing legislation to make the BRDPI benchmark formal and to authorize the review cadence. **Timeline:** Can be advanced in any appropriations cycle. Establishing BRDPI as a formal benchmark and a standing review cadence may require authorizing legislation or appropriations report language.

7. Give NIH multi-year funding authority for research that only works if it continues without interruption.

Some NIH investments only pay off if they run for years or decades without disruption. Longitudinal studies that follow patient populations over time, clinical trials networks, core data systems, and national research resources like biobanks and shared computing platforms all fall into this category. When Congress disrupts these assets mid-cycle, it does more than pause progress. It risks destroying the value of everything already invested.

Recommendation 4 addressed the duration of individual investigator grants. This recommendation addresses a different category: long-horizon research investments that are designated, by their nature, as multi-year commitments at the program or platform level.

Congress should authorize multi-year budget authority for these specific categories of NIH investment, protecting them from the annual appropriations cycle. If full multi-year authority is too heavy a legislative lift, advance appropriations offer an alternative.

Multi-year authority should pair with proportional oversight. The accountability standard should be process- and milestone-based (adherence to research protocols, public release of data and findings, peer-reviewed publication, responsible spend-down) not long-horizon health outcomes that the investment is not designed to produce within the funding window. The recommendation also acknowledges that some long-horizon investments will not achieve their stated aims; those investments can still produce unanticipated value (validated methods, datasets, infrastructure) that justifies the sustained commitment.

Responsible entity: Congress (authorizers and appropriators). **Mechanism:** Multi-year budget authority or advance appropriations for designated categories of long-horizon research investment; process- and milestone-based accountability. **Timeline:** Requires legislation.

8. Build permanent capacity for rapid research mobilization, in emergencies and outside them.

During the COVID-19 pandemic, NIH showed it could move fast: deploying money through existing clinical research networks, compressing grant review timelines, and standing up entirely new programs like RADx within weeks. **Those capabilities currently rely on emergency authorities and ad hoc improvisation rather than standing procedure, which is why they have not persisted between emergencies.** They should exist because the system is designed for it, not because people improvised under pressure.

The NIH Director should make these rapid-response capabilities permanent and routine by establishing standing procedures for fast grant solicitation, expedited review, deployment through existing research networks, and surge funding during public health emergencies and other situations where the evidence need is time-sensitive.

Responsible entity: NIH Director. **Mechanism:** Standing administrative procedures codified as formal NIH policy; pre-positioned authorities for fast solicitation, expedited review, and surge funding through existing clinical research networks. **Timeline:** Can be initiated within the first year under new leadership.

Cross-cutting connection: Coordinate with the Emergency Evidence Preparedness cross-cutting section.

Centers for Disease Control and Prevention

The country needs a federal public health agency that produces timely data, generates evidence about what works, and issues guidance the public can trust. CDC has built capacity to do all three at a world-leading scale. The question is whether the structural conditions under which that capacity operates have kept pace with what the country now asks of it.

Diagnosis

CDC remains one of the most consequential public health institutions in the world. The agency led the global eradication of smallpox, and its global health infrastructure, built in part through the President's Emergency Plan for AIDS Relief, now operates through on-the-ground experts in more than 60 countries. The Epidemic Intelligence Service has trained more than 4,100 applied epidemiologists who staff health departments across the country and ministries of health on every continent. CDC's role runs across infectious and non-infectious disease alike: the National Healthcare Safety Network (more than 38,000 reporting facilities), with more than 70,000 hospital-acquired infections prevented in 2024, the Behavioral Risk Factor Surveillance System, the Tips From Former Smokers campaign, associated with an estimated 16 million quit attempts and about one million sustained quits between 2012 and 2018, and the agency's overdose surveillance and prevention work are all foundational to the federal evidence enterprise. Recent reorganization proposals to divide CDC's mission between infectious and chronic disease would fragment surveillance systems, workforce, and state relationships that operate as one system at the federal, state, and local levels. The Blueprint's recommendations are designed to strengthen the standing capacity, not to substitute for it.

That capacity has never been resourced to match what the country asks of it. CDC's appropriation is directed, through bill text and the accompanying report language, into more than a hundred separately specified program lines, with little authority to move funds toward emerging threats or to sustain data systems between emergencies. The Data Modernization Initiative has been funded largely through one-time supplemental appropriations rather than a base line sized to the work. State and local public health capacity, which federal surveillance depends on, contracted through the 2010s and was rebuilt only partially and temporarily during the COVID-19 response: local health departments lost an estimated 16 percent of their staff between 2008 and 2019 and state agencies about 10 percent between 2012 and 2019, and an estimated 80,000 additional positions are needed to deliver basic services. The structural conditions below come in addition to that baseline. The Legislative Proposals section addresses CDC's funding architecture directly.

Public trust in CDC has fallen in two stages and has not recovered from either. In March 2020, 85 percent of the public, including 90 percent of Republicans, trusted the agency for health information; trust among Republicans fell sharply during the pandemic response, rose briefly in 2025, and by January 2026 stood at about four in ten, where it had been in 2023. Trust among Democrats, which sat at 88 percent for vaccine information in September 2023, fell to 55 percent by January 2026 following the 2025 change in agency leadership. Overall trust in CDC for vaccine information reached 47 percent in January 2026, the lowest level measured since the pandemic, and by July 2026 had steadied near half,

with the partisan gap narrowed because Democratic trust fell rather than because Republican trust returned. Public confidence in the agency now moves with leadership transitions more than with institutional performance. Structural changes that make CDC's evidence outputs more transparent, more methodologically protected, and more clearly distinguished from policy judgments are necessary for trust to recover, even if they are not sufficient. The recommendations that follow address what can be made durable across administrations.

Five structural conditions limit how far CDC's capacity reaches.

- **Surveillance authorities are fragmented and rest on state cooperation without a federal legal framework.** Notifiable disease reporting (the system by which states report cases of designated diseases to CDC) is a state function. CDC sets case definitions and depends on states to report; it has no authority to set enforceable timeliness standards, and Section 308(d) of the Public Health Service Act constrains cross-agency data sharing. State cooperation will always be part of the design, and the Council of State and Territorial Epidemiologists, a professional association of state health-department epidemiologists, has produced substantial harmonization of case definitions through consensus position statements that CDC and states adopt voluntarily. What is missing is a federal framework that makes reporting standards, timeliness, and cross-agency exchange legally routine rather than negotiated case by case. Current technology permits a provider to transmit a report simultaneously to the state and local health department and to CDC with confidentiality protections intact; the legal architecture has not caught up with the technical one. Between 2021 and 2022, twenty-five states enacted laws narrowing public health emergency authorities, widening the variation in what jurisdictions are positioned to report and how quickly. Those laws had two sources, and both matter for the design of the recommendations below. Some were a reaction to pandemic-era measures that states experienced as federal overreach. Others, after *Dobbs*, were written to keep reproductive health information from flowing to a federal system and from there to other states where that care is a crime. A federal framework that simply removed those constraints would be read as a threat by the states that enacted them, and would deserve to be; the framework below is built as a floor (a minimum every jurisdiction must meet, not a limit) that leaves state protections for special classes of information in place. **The country learns about emerging threats at the speed of the slowest jurisdiction.**
- **Data, science, and guidance functions are organizationally integrated in ways that produce both speed and risk.** A single CDC center can run a surveillance system, conduct studies on the resulting data, draft publications, and develop public guidance, sometimes with the same staff on the same topic. **Under contested conditions, external audiences cannot see where the science ends and the policy choice begins.**
- **The advisory bodies that translate CDC evidence into policy carry consequences their statutory protection does not match.** ACIP, the Healthcare Infection Control Practices Advisory Committee (HICPAC), and the Advisory Committee to the Director (ACD) operate under the same enabling authority, Section 222 of the Public Health Service Act (42 U.S.C. § 217a), governed by the Federal Advisory Committee Act, but the downstream legal consequence of their recommendations is sharply unequal. ACIP recommendations trigger coverage under Section 2713 of the Affordable Care Act, the Vaccines for Children program, and state immunization requirements; they also anchor no-cost coverage requirements for nearly every payer, Section 317 purchasing, nearly 600 statutes and regulations across 49 states, three

territories, and the District of Columbia that reference ACIP, including pharmacist scope-of-practice authority, and additions to the Vaccine Injury Compensation Program table. HICPAC and ACD recommendations carry no comparable statutory weight. The 2025 to 2026 sequence made the gap concrete: in June 2025 all seventeen ACIP members were dismissed at once, and in March 2026 the U.S. District Court for the District of Massachusetts issued a preliminary injunction staying the appointments and votes of the reconstituted committee, finding the reconstitution likely to violate the Federal Advisory Committee Act's fairly-balanced requirement (*American Academy of Pediatrics v. Kennedy*, No. 1:25-cv-11916 (D. Mass. Mar. 16, 2026)). While the committee's recommendations were stayed, professional societies issued their own schedules, ending three decades in which the pediatric schedule had been harmonized with CDC's. In the end, the evidence reviews behind the societies' schedules came from a philanthropically funded project at the University of Minnesota, and clinicians and parents must now navigate several national schedules where there had been one, produced by bodies whose funding and governance sit outside public accountability. **When consequence outruns protection, the failure is not confined to the committee.**

- **Coordination across the federal evidence enterprise is not allocated on the merits.** CDC's evidence functions sit alongside adjacent work at other HHS agencies and the VA. The cross-cutting *Align and Coordinate the Federal Evidence Enterprise* section carries the diagnosis and the remedy for the enterprise as a whole; CDC's part of it is addressed there rather than here.
- **CDC surveillance does not consistently make visible the populations most affected by what it tracks, and its surveys are not consistently aligned with what their users need.** Race, ethnicity, geography, occupation, and primary-language data are uneven in completeness across NHSN (the National Healthcare Safety Network), BRFSS (the Behavioral Risk Factor Surveillance System), the National Notifiable Diseases Surveillance System, and vital statistics, and completeness operates as an agency value rather than as an architectural requirement of federal-state surveillance. At the same time, non-federal efforts to assemble timelier and more granular population health data, such as Yale's PopHIVE platform, are a market signal that CDC's survey content and release cadence have drifted from policymaker and practitioner demand. **Where surveillance fails to make populations visible, or arrives after the decision it should inform, downstream evidence and guidance cannot serve them.**

Recommendations

The four recommendations below address the five structural conditions identified above. Two operate primarily through administrative action; all four have legislative components that extend their durability. Recommendation 1 addresses surveillance authority, survey alignment, and CMS-linked reporting. Recommendation 2 addresses advisory committee protections. Recommendation 3 addresses the separation of evidence summary from policy recommendation in CDC guidance. Recommendation 4 addresses pre-registration and analytic transparency. Timelines marked "under new leadership" mean a decision new agency leadership can make at any point. Leadership changes within administrations; these actions do not wait for an election.

1. Modernize federal-state public health surveillance through incentive-based standards, a federal legal framework for reporting, and CMS payment-linked requirements.

The HHS Secretary should direct CDC and CMS to jointly establish a federal-state surveillance modernization framework operating across four levers:

- **Standards with incentives.** CDC publishes minimum timeliness and completeness standards for designated notifiable conditions (diseases that state and local jurisdictions report). Federal funding through the Public Health Infrastructure Grant and the Data Modernization Initiative is tied to jurisdictional progress against those standards, with milestone-based disbursement replacing formula-based allocation for the modernization-eligible portion, and with each jurisdiction's milestone status published annually. Differential disbursement and public reporting are the consequences; the framework does not add sanctions beyond them. Congress can reinforce the incentive through spending-power conditions on public health program funding, which apply pressure without legal compulsion. Completeness standards include race, ethnicity, geography, primary language, and occupation thresholds. Completeness is treated as an architectural requirement of federal-state surveillance, not as a values commitment that can be set aside under pressure.
- **Payment-linked reporting.** CMS expands the use of Conditions of Participation, the Hospital Inpatient Quality Reporting Program, and analogous payment-linked reporting requirements to standardize submission of designated public health data through NHSN and other CDC systems for facilities receiving Medicare and Medicaid payment. This is the federal government's strongest existing lever for securing timely data flows from clinical settings. Payment-linked reporting adds compliance burden for facilities; the framework should sequence new requirements against the reporting hospitals already perform through NHSN and the Hospital Inpatient Quality Reporting Program, so the marginal burden is incremental rather than duplicative.
- **Technical interoperability through ONC.** ONC (the Office of the National Coordinator for Health Information Technology) publishes the United States Core Data for Interoperability (USCDI) standard and administers the Health IT Certification Program, including FHIR-based API certification criteria (FHIR, Fast Healthcare Interoperability Resources, is the standard for exchanging health data between systems). CDC publishes the public-health-side implementation specifications for electronic case reporting, electronic laboratory reporting, and syndromic surveillance, in alignment with USCDI and FHIR. The two jointly lead federal public health interoperability work. The recommendation is that ONC's certification authority be used directly: electronic case reporting and electronic laboratory reporting conformance become certification criteria for the systems hospitals and laboratories already must use, so that public health reporting rides the same rails as clinical interoperability rather than a parallel track. A formal memorandum of understanding between ONC and CDC should specify mutual obligations on standards alignment, certification criteria, and conformance assessment timelines.
- **Survey alignment.** CDC establishes a recurring, public process for reviewing the content, sampling, and release cadence of its major surveys against the needs of the state officials, clinicians, and policymakers who use them, and publishes the resulting changes. Where non-federal initiatives are meeting demand the federal surveys do not, the review treats that as a signal about survey design rather than as competition.

Congress should enact a federal legal framework for public health reporting. The statute should authorize CDC to receive electronic submission of designated notifiable disease data from state and local public health programs and from health care facilities and laboratories. It should state the permitted purposes, limited to detecting, investigating, controlling, and evaluating designated public health threats and to administering public health programs the statute expressly identifies, and it should name the prohibited uses, including immigration enforcement, benefits-eligibility and other adverse individual determinations, employment screening, and law enforcement unrelated to the identified public health response. It should require role-based and minimum-necessary access, disclosure logging, limits on redisclosure and secondary use, retention and destruction rules, independent audit, breach notice, and civil and administrative penalties enforced by the HHS Inspector General and scaled to negligent, knowing, and willful conduct. The framework is a floor. It does not preempt state laws that give reproductive health, substance use, HIV, mental health, or other specially protected information stronger protection than federal law; where such a law restricts onward transmission, the report stays with the state or moves in de-identified form, and the statute says so in terms. These safeguards adapt the specificity of the confidentiality model of CIPSEA (the Confidential Information Protection and Statistical Efficiency Act, which governs federal statistical agency data) under the Public Health Service Act. CIPSEA itself restricts covered data to exclusively statistical uses and cannot govern data that must support case investigation and outbreak response; the framework adapts its rigor without importing its use restriction. The legislation should clarify the relationship between Section 308(d) and cross-agency data sharing for surveillance purposes, removing the friction that constrains routine exchange while preserving confidentiality protections, and should provide that a report transmitted to a state or local health department in conformance with the standard is deemed transmitted to CDC. The same framework should make routine the exchange between CDC and CMS that surveillance and coverage both need, and should let Congress and HHS align the incentives Medicaid agencies and public health departments face within a state, so that the two are rewarded for sharing data rather than for holding it. Multi-year authorization for CDC's data modernization functions should replace the current annual cycle. The framework itself can be established under existing authority; the direct receipt authority, the Section 308(d) clarification, and multi-year authorization require legislation.

Responsible entity: HHS Secretary; CDC Director; ONC (for USCDI, certification criteria, and the Health IT Certification Program); CMS Administrator (for payment-linked reporting requirements); Congress for the statutory framework and multi-year authorization. **Mechanism:** Administrative action under existing CDC, ONC, and CMS authorities for standards, funding, certification, and CMS payment-linked elements; authorizing legislation for the federal reporting framework, Section 308(d) clarification, and multi-year authorization. **Timeline:** Administrative elements within the first year under new leadership; legislative elements require congressional action.

Cross-cutting connection: The federal-state minimum standards architecture and technical interoperability components belong to the Data Infrastructure Modernization cross-cutting section. The state-side capacity dimension belongs to the State Evidence Capacity cross-cutting section.

2. Codify statutory protections for ACIP and establish minimum methodological standards across CDC committees governed by the Federal Advisory Committee Act (FACA).

The CDC Director should issue **and publicly publish** a CDC-wide policy establishing minimum methodological and transparency standards across all CDC FACA committees (advisory committees chartered under the Federal Advisory Committee Act). The standards should require five elements:

- A published methodological framework specifying how evidence is identified, assessed, and translated into recommendations;
- Pre-meeting publication of the full evidence packet under review, with a defined advance notice period;
- Published conflict-of-interest policies and disclosures;
- Documented composition standards ensuring methodological breadth and stakeholder representation;
- A public docket for each recommendation, including the evidence summary, deliberative materials, and a documented rationale.

These standards apply uniformly across ACIP, HICPAC, the Advisory Committee to the Director, and other CDC FACA committees, with adaptation as needed for differences in subject matter and decision consequence.

Congress should enact statutory protections for ACIP and HICPAC that match the consequence their recommendations carry: for ACIP, coverage under Section 2713 of the Affordable Care Act, the Vaccines for Children program, Section 317 purchasing, Medicaid coverage, state immunization requirements, pharmacist scope-of-practice authority, and Vaccine Injury Compensation Program liability protections; for HICPAC, the infection-control standards that hospitals, accreditors, and payers adopt as practice requirements. The protections should cover five elements, written so that each forecloses a discretionary act rather than describing a duty:

- Statutory codification of each committee's existence, scope, and core functions, with the consequence-bearing recommendations identified by cross-reference to the statutes that rely on them;
- Fixed, staggered terms for members; statutory qualification requirements tied to the committee's mandate; and a requirement that any removal before the end of a term be accompanied by a written statement of specific reasons transmitted to the committees of jurisdiction and published, with a defined notice period before the removal takes effect. This design follows the Supreme Court's 2025 holding in *Kennedy v. Braidwood Management* that members of comparable bodies are inferior officers subject to Secretarial supervision, and its 2026 holding in *Trump v. Slaughter* narrowing for-cause removal protection: it preserves the supervision the Constitution requires while ending unexplained, at-will dismissal. The Legislative Proposals section sets out the full post-*Slaughter* enactment strategy that this element applies;
- Statutory codification of each committee's methodological framework, with any departure requiring public notice and comment before a recommendation made under the departed-from method carries statutory effect;

- A published timeline for recommendation review and update, with GAO reporting to the committees of jurisdiction when the timeline is missed, identifying the cause and the responsible decision-maker, the cause signed by that official on the attribution design of the Research Integrity and Scientific Freedom section;
- Statutory continuity: where a committee cannot act because of vacancy, suspension, or a stayed reconstitution, its most recent recommendations remain in effect for the statutes that rely on them until superseded by a recommendation made in conformance with the codified framework, the conformance certified at publication by the committee's designated federal officer, so that the consequence-bearing functions do not lapse while the committee is contested.

The methodological standards in the first part of this recommendation are the administrative floor; the statutory elements make the floor durable. Membership criteria and the charter for each committee should be revised to reflect the codified framework once enacted.

Responsible entity: CDC Director for the administrative standards; Congress for ACIP and HICPAC statutory protections. **Mechanism:** Administrative action for the methodological and transparency standards; authorizing legislation for the statutory protections. **Timeline:** Administrative standards within the first year under new leadership; statutory protections require legislation.

Cross-cutting connection: The statutory codification parallels the AHRQ section's treatment of the U.S. Preventive Services Task Force (Recommendation 3), which faces the same legal vulnerability after Braidwood. The removal design follows the template in Research Integrity and Scientific Freedom Recommendation 4 and the enactment strategy in Legislative Proposal 2. The statutory-continuity element is the interim rule the Research Integrity section asks every protection to carry.

3. Make visible, in every major CDC guidance document, what the evidence says and who decided what to do about it.

The CDC Director should establish a guidance document standard requiring every major CDC guidance document to separate two things and name who is responsible for each.

- A **named scientific lead**, identified by name and title, owns the evidence summary: what is known, what is uncertain, what is unknown, the methodological framework used to weigh the evidence, and a stated confidence level tied to the strength of that evidence. The scientific lead's authority over the evidence summary is documented in agency policy, and the lead is drawn from the career scientific staff.
- The **policy recommendation** that follows from the evidence summary is attributed to the politically accountable official who approved it, at whatever level the decision was actually taken: the CDC Director, the Secretary, or an official the Secretary designates. CDC guidance decisions are frequently made or revised above the agency, at the Department or the White House. The standard does not pretend otherwise, and it does not ask a career scientist to own a policy choice; the Constitution's accountability principle, which the Supreme Court applied to the Preventive Services Task Force in *Braidwood*, runs the other way. It requires that the guidance state who approved the decision and publish the rationale, so that a recommendation that departs from the evidence summary is attributable to a named, accountable decision rather than absorbed into the agency's scientific voice.

The evidence summary and the policy recommendation appear as distinct sections in the guidance itself, not as integrated text. Where a recommendation departs from the evidence summary, the departure and its rationale are stated in the guidance and in a public change log. Science sometimes points in more than one direction; the standard requires that the evidence considered be visible, not that a single reading of it be imposed. The public record is the enforcement mechanism: a directed change becomes attributable rather than deniable.

Congress should codify the transparency obligations as statutory requirements for major CDC guidance, specifying required elements (evidence basis, confidence level, named scientific lead, decision attribution, change log, review date) rather than wording or format, so that a guidance document lacking them does not carry the agency's imprimatur.

Responsible entity: CDC Director; Congress for statutory codification. **Mechanism:** Administrative action for the standard; authorizing legislation for codification. **Timeline:** Administrative action within the first year under new leadership; codification requires legislation.

Cross-cutting connection: The standard parallels the emergency guidance template in the Emergency Evidence Preparedness section. The attribution design applies the Research Integrity and Scientific Freedom section's method: where a directed change cannot be prevented, make it visible and attributable.

4. Establish pre-registration and analytic transparency requirements for designated CDC studies and analyses.

Pre-registration is the practice of publicly recording a study's design, primary and secondary outcomes, and analytic approach before the study begins, so that subsequent changes are visible and selective reporting is constrained. CDC interventional clinical trials are registered on ClinicalTrials.gov per HHS final rule; the broader category of CDC epidemiologic studies, intervention evaluations, and analytic projects that inform CDC guidance does not have a uniform pre-registration standard. The CDC Director should extend pre-registration and analytic transparency requirements to designated categories of those CDC-conducted studies and analyses.

The requirements apply to prospective epidemiologic studies, intervention evaluations, and analytic projects that will inform CDC guidance, advisory committee deliberations, or other consequential CDC outputs. The pre-registration record specifies the research question, study design, primary and secondary outcomes, analytic approach, and criteria for interpreting results. Modifications made after pre-registration are publicly documented with stated rationale at the time the change is made. Final results are published in a publicly accessible registry within a defined timeline, regardless of whether peer-reviewed publication proceeds.

The standard does not apply to all CDC analytic work. Routine surveillance reporting, descriptive epidemiologic summaries, and exploratory analyses are excluded. The standard includes an equity evaluation requirement for any emerging data source CDC integrates into surveillance or analytic work. The evaluation specifies which populations the source represents well, which it under-represents, and how integration with existing surveillance affects the disaggregated statistics that public health practice requires.

Designation of the categories subject to pre-registration is made by published agency policy, reviewed publicly at a fixed interval, rather than by rulemaking, so that the standard can keep pace with analytic practice. The standard includes an emergency provision: where a public health emergency requires analytic work on a timeline pre-registration cannot accommodate, the analysis may proceed under a documented waiver, and the study record is registered retrospectively within 60 days with the waiver rationale attached. The same designation and waiver rule applies to CMMI model evaluations under the CMS section's Recommendation 1, and the Research Integrity and Scientific Freedom section carries it as the federal-evidence-wide standard.

Responsible entity: CDC Director; HHS Chief Data Officer for the secure environment integration. **Mechanism:** Administrative action under existing CDC authority. **Timeline:** Standard published within the first year under new leadership; full implementation across designated categories within two years.

Cross-cutting connection: Pre-registration parallels recommendations in the NIH, FDA, and CMS sections. The Research Integrity and Scientific Freedom cross-cutting section addresses pre-registration as a principle that applies across the whole federal evidence system.

Food and Drug Administration

The challenge for FDA is to build the evidence infrastructure that lets regulatory decisions be both fast and rigorous: transparent decision criteria, continuous post-market learning, and clinical trial designs that generate evidence the full patient population can rely on.

Diagnosis

FDA occupies a unique position in the federal evidence ecosystem (the network of agencies, data systems, and research programs that generate and use health evidence). FDA is a regulatory body whose decisions depend on evidence generated by others; it funds little research and collects little data of its own. This section sets aside FDA's approval pathways, fee structures, and organizational authorities and addresses a more specific structural problem: whether the evidence infrastructure surrounding FDA's decisions is strong enough to support the weight placed on them.

Three structural vulnerabilities weaken that infrastructure today.

First, the framework for deciding when real-world evidence is sufficient remains underspecified. As real-world evidence (clinical data drawn from routine health care rather than controlled trials) assumes a larger role in regulatory decisions, FDA has published substantial technical guidance on data quality and analytic methods but has not yet established a transparent framework for matching evidentiary standards to different categories of regulatory questions. The 21st Century Cures Act of 2016 directed FDA to develop such a framework, and FDA has issued guidance in response, including the Framework for FDA's Real-World Evidence Program (December 2018) for drugs and biologics and parallel guidance for medical devices. The gap between methodological guidance and a clear set of public rules for when real-world evidence is sufficient for a given type of decision remains open. **The gap is not about methods; it is about the framework for deciding when those methods are sufficient.**

Second, the institutional separation between pre-market review and post-market surveillance creates a break in the evidence lifecycle. Pre-market review (the process for deciding whether to approve a product) and post-market surveillance (the process for monitoring a product's safety and effectiveness after it reaches patients) operate as largely separate functions. Pre-market teams accept residual uncertainty at the point of approval, but the post-market system that is supposed to manage that uncertainty operates on a separate institutional track with limited formal connection to the decisions it inherits. A 2015 Government Accountability Office review of postmarket surveillance (Section 522) studies found the majority were classified as "inactive," a category that included both studies consolidated with related orders and studies inactive because the device was no longer marketed. Only 12 percent of ordered 522 studies were ongoing or completed as of the cutoff. The same review found a more favorable picture for postapproval studies ordered through the premarket approval pathway, with most making adequate progress. FDA updated its postmarket surveillance guidance and tracking categories in 2022 and now publishes ongoing study status in a public database, but peer-reviewed analyses since then continue to find that mandated postmarket evidence for high-risk

devices remains thin: a 2022 *JAMA Internal Medicine* study of high-risk cardiovascular devices approved between 2015 and 2019 found that the 21st Century Cures Act had not produced the more rigorous postmarket evidence base its drafters envisioned. **A successor audit of comparable scope to the 2015 GAO review has not been issued.**

Third, clinical trials continue to underrepresent the populations and clinical conditions in which approved products will actually be used, producing evidence whose external validity falls short of what sound regulatory decisions require. This is representativeness, and it is a long-standing structural issue rather than a new one: women were not required to be included in NIH-funded clinical research until the NIH Revitalization Act of 1993, and representation gaps persist in some trial populations today.

Recommendations

1. Publish clear, public rules for when real-world evidence is strong enough to support specific types of FDA decisions.

FDA has issued considerable guidance on the methodological considerations for using real-world data in regulatory decisions, including the August 2023 final guidance for drugs and biologics and the December 18, 2025 final guidance for medical devices. These documents address data relevance, reliability, and analytic standards. They do not, however, provide a transparent framework for when those methods produce evidence sufficient to support a specific type of regulatory action. The December 2025 device guidance states explicitly that it does not offer specific criteria for determining suitability for a particular regulatory decision. That is the gap this recommendation addresses.

FDA should publish and maintain a decision architecture (a structured set of public criteria governing which types of evidence are sufficient for which types of decisions), governed by five principles. First, some FDA decisions are easier to reverse than others, and the evidentiary bar should reflect that. Second, as the expected number of patients exposed to a product grows, the tolerance for residual uncertainty in the evidence base should decrease. Third, real-world evidence has the strongest scientific justification for long-term safety monitoring and rare-event detection, a genuine but more limited role in initial efficacy determinations, and a natural fit for comparative effectiveness questions. Fourth, the fitness of the specific data source for the specific question should be assessed transparently and made part of the public record. Fifth, real-world evidence should be relied upon most heavily when stronger study designs are not feasible, not merely less convenient. Feasibility here includes cost and practicability: a randomized design that cannot be funded, enrolled, or completed within the time the decision allows is not feasible in the sense that matters, and the framework should say so rather than leave the term to argument.

FDA has historically resisted publishing rigid decision criteria, in part because specificity can constrain future discretion and create litigation exposure. The framework proposed here is designed as structured guidance, not as a mechanical scoring system, preserving the agency's scientific judgment while making the principles governing that judgment visible to the public.

Responsible entity: FDA Commissioner; the Center for Drug Evaluation and Research (CDER); the Center for Devices and Radiological Health (CDRH). **Mechanism:** Guidance development and publication building on the 2018 RWE Framework (drugs and biologics), the August 2023 final guidance on drugs and biologics, and the December 18, 2025 final guidance on devices. **Timeline:** Can be initiated under existing authority.

Cross-cutting connection: The upstream data quality and interoperability challenges that affect real-world evidence belong in the Data Infrastructure Modernization section, not here. This recommendation addresses FDA's decision criteria, not the data plumbing.

2. Connect FDA's approval process to its post-market safety monitoring so that uncertainties accepted at the point of approval are tracked and resolved afterward, with real consequences when they are not.

The current organizational structure within FDA treats pre-market review and post-market surveillance as largely separate functions, with different staffing, data systems, and institutional cultures. Within CDER (which reviews drugs), the Office of New Drugs handles pre-market review; the Office of Surveillance and Epidemiology handles post-market safety. Within CDRH (which reviews medical devices), parallel divisions operate with similar separation. When a pre-market review team approves a product, it implicitly accepts a level of residual uncertainty that the post-market system is supposed to manage. But the pre-market team has no formal accountability for whether the post-market system can detect the specific risks it has accepted, and the post-market team inherits a surveillance burden shaped by decisions it had limited input into.

FDA should establish a formal evidence lifecycle protocol. At the point of each approval, the pre-market review team and the post-market surveillance team should jointly specify: what residual uncertainties remain, what post-market evidence plan will address them, and what findings would trigger specific regulatory actions. The protocol should extend to generics and biosimilars, whose approval rests on demonstrated equivalence rather than independent efficacy trials and whose post-market performance in populations and formulations not covered by the reference product's evidence is a residual uncertainty of the same kind.

Where approval rests on material residual uncertainty, FDA should require time-bound milestones for post-market evidence generation, public reporting on study status, and predefined regulatory consequences if post-market commitments are not completed or fail to resolve the key question. Those consequences should be proportionate and specified in advance: restricting the approved indication to the population for which adequate evidence exists, requiring updated labeling that discloses unresolved uncertainties, imposing or modifying a Risk Evaluation and Mitigation Strategy, or initiating proceedings to withdraw or narrow the approval.

The evidence lifecycle protocol and the CMS section's Recommendation 6 (the joint CMS-AHRQ technology-assessment process) and Recommendation 4 (Coverage with Evidence Development thresholds) address the same products at adjacent points in their life: FDA accepts residual uncertainty at approval, and CMS decides whether to pay while that uncertainty is resolved. The two agencies' methodological standards for what counts as sufficient post-market evidence should be harmonized through the Align and Coordinate section's Recommendation 2, so that a post-market study designed to

satisfy an FDA commitment can also inform a Medicare coverage determination rather than being run twice.

Responsible entity: FDA Commissioner; CDER; CDRH. **Mechanism:** Internal organizational guidance and process redesign for the evidence lifecycle protocol; budget request to bring active device surveillance (currently being built through the National Evaluation System for health Technology Coordinating Center (NESTcc)) to comparable scale and operational maturity with the drug-side Sentinel System (FDA's distributed active surveillance system, established under Section 905 of the FDA Amendments Act of 2007, which covers more than 100 million patient lives); legislation for mandatory structured adverse event reporting for high-risk device categories. **Timeline:** The institutional design change can be initiated under existing authority. The active device surveillance expansion requires a budget request sized to bring device surveillance to the scale the drug-side system has reached. Mandatory structured adverse event reporting for high-risk device categories may require legislation (flagged for the Legislative Proposals section).

Cross-cutting connection: Coordinate with the CMS section on coverage with evidence development. A coverage decision that requires ongoing evidence generation is only as strong as the post-market data system feeding it. Coordinate also with the Research Integrity cross-cutting section for the broader principle of evidence lifecycle accountability, and with the Data Infrastructure Modernization cross-cutting section on unique device identifier integration into electronic health records, which the 2024 GAO assessment identified as a binding constraint on active device surveillance.

3. Ensure clinical trials generate evidence that reflects the patients who will actually use the product.

Clinical trials that systematically exclude or underrepresent patients defined by age, sex, body composition, genetic variation, organ function, comorbidity burden, or concomitant medication use produce evidence that may not hold for the patients who will take the product. A treatment tested largely in one population can be less effective, or cause more harm, in the populations that actually use it, and the approval will not say so because the trial never asked. A drug approved on the basis of a trial that enrolled 5 percent of patients over age 75, when 40 percent of prescribing will be to that population, has a known evidence gap with known clinical stakes. The scientific question is whether the trial evidence reflects the populations and clinical conditions in which the product will actually be used.

The statutory framework for addressing this problem is in place but has never taken legal effect. The Food and Drug Omnibus Reform Act of 2022 (FDORA), Section 3601 added sections 505(z) and 520(g)(9) to the Federal Food, Drug, and Cosmetic Act, requiring sponsors to submit clinical study enrollment plans disaggregated by clinically relevant demographic characteristics for pivotal trials. FDA published draft implementing guidance on June 26, 2024, and FDORA Section 3602 directed FDA to issue final guidance within nine months of the close of the comment period. The comment period closed September 26, 2024, placing the statutory deadline at June 26, 2025. Final guidance had not been issued as of September 2026, more than a year past that deadline. Under the statute, the substantive requirement applies only to clinical investigations whose enrollment begins 180 days after final guidance publishes. The requirement Congress enacted in 2022 has therefore never become operative, and no date can be fixed for when it will. FDA has nonetheless reported that hundreds of drug and

device sponsors have voluntarily submitted enrollment plans alongside their applications, indicating continued attention to the underlying scientific question of trial representativeness.

This sequence is the clearest illustration in the Blueprint of a structural pattern that recurs across the federal evidence enterprise. Congress can enact a substantive evidence requirement and condition its effective date on a discretionary implementing step, and where no default trigger exists, the requirement can remain indefinitely inoperative without anyone having repealed it.

The Blueprint recommends that FDA issue final guidance implementing FDORA Section 3601, making the substantive enrollment-plan requirement operative; publish annual reports on sponsor compliance once the requirement is in effect; and develop enforcement mechanisms proportionate to the regulatory leverage available at each stage of product review. Where future statutes condition substantive evidence requirements on discretionary implementing guidance, the Blueprint recommends that Congress consider statutory architectures that include default operational triggers (substantive provisions that become effective on a date certain if implementing guidance is not issued by then), so that the operative effect of an enacted requirement does not depend on a separate discretionary step that can be withheld indefinitely.

The scientific rationale for these provisions extends beyond the demographic categories named in the statute to the full range of biological and clinical variables that affect how products perform in practice. Where a sponsor enrolls a narrow population, the approved indication and labeling should reflect that narrowness, and claims about broader applicability should require supporting evidence.

Responsible entity: FDA Commissioner; CDER; CDRH. **Mechanism:** Issuance of final guidance to make FDORA Section 3601 operative; enforcement guidance; legislative strengthening on default-operative statutory architectures. **Timeline:** Final guidance can be issued under existing authority. Statutory architecture refinements for future evidence requirements are candidates for the consolidated Legislative Proposals section.

Cross-cutting connection: Coordinate with the NIH section on representativeness in federally funded trial design. The Evidence Workforce section addresses who conducts research; this recommendation addresses whose experience the evidence reflects. The dormant-statute pattern in this recommendation parallels the SMRB pattern flagged from the NIH section and is a concrete example case for the Research Integrity and Scientific Freedom cross-cutting section's structural-protection analysis. The default-operative-trigger drafting principle is coordinated with the AHRQ and NIH reauthorizations, and is consolidated in the Legislative Proposals section.

Centers for Medicare & Medicaid Services

CMS generates evidence unavoidably, every day, through the programs it administers. The question is whether to build the evaluation infrastructure, methodological discipline, and data systems that turn that activity into evidence the country can rely on.

Diagnosis

CMS administers the country's largest health insurance programs (**Medicare** (approximately 68 million older adults and people with disabilities), **Medicaid and the Children's Health Insurance Program (CHIP)** (approximately 74.3 million people, as of March 2026, in low-income coverage administered jointly with states), and the **Health Insurance Marketplace** (23.1 million plan selections in the 2026 open enrollment, most with subsidized individual coverage)) covering, in total, more Americans than at any prior point in the agency's history, with substantial overlap among the three populations (notably the approximately 12 million people dually eligible for Medicare and Medicaid). It is simultaneously a payer, a regulator, a coverage decision-maker, and one of the most consequential evidence-generating instruments in the federal government. Its data systems were built for payment but are increasingly relied on for evidence purposes (comparative effectiveness research, payment-model evaluation, and health services research) the original design did not anticipate. Three structural problems follow.

A model-testing authority that has outrun its evaluation infrastructure

The **Center for Medicare and Medicaid Innovation (CMMI)** tests new ways of paying for and delivering care, for example, paying primary care practices a flat monthly fee per patient, or making accountable care organizations financially responsible for the total cost of their patients' care. Section 1115A of the Social Security Act authorizes the Secretary to test such models; Section 1115A(c) authorizes nationwide expansion once a model is found to reduce spending without reducing the quality of care, or to improve quality without increasing spending, with the Office of the Actuary certifying the spending test. This is one of the few statutory mechanisms in federal health policy that conditions program-wide change on evidence. The Congressional Budget Office found in 2023 that CMMI's activities increased direct federal spending by **$5.4 billion** between 2011 and 2020, against a 2010 baseline projection of $2.8 billion in net savings over that period, a reversal CBO attributes to a lower-than-anticipated rate of model certification and expansion, which the agency has now encoded into its updated projection methodology. The Government Accountability Office reported in March 2026 that of the 70 models tested between 2011 and January 2025, CMS has certified four for expansion, and that the Center committed $11.4 billion across that period. Certification is not the only route by which model policies reach the full program: elements of several uncertified models have been carried into the Medicare Shared Savings Program and Medicare Advantage through ordinary rulemaking. That pathway has produced real improvements; it has also meant program-wide change without the evidentiary certification the statute envisioned, which is part of the gap the recommendations below address. **The structural problem is that the evaluation infrastructure has not been built to match the authority the statute created.** Protocols have been inconsistently specified, often after launch; most evaluations

are conducted by contractors funded by and reporting to CMS, creating institutional incentives difficult to separate from the agency's interest in model success; and models have frequently tested multiple interventions simultaneously over durations and sample sizes too small to detect the effects certification requires. The CBO methodological revision is the most authoritative external corroboration of this gap: a federal scoring agency has formally encoded into its baseline the assumption that CMMI will not produce certifications at the rate the statute envisioned. **The impact:** one of the few federal mechanisms tying delivery-system change to evidence will fade through disuse, without anyone ever deciding to end it.

A coverage-with-evidence architecture without enforceable triggers

CMS conditions or expedites Medicare coverage of new services through the **National Coverage Determination (NCD)** process, **Coverage with Evidence Development (CED)** (under which Medicare covers a product or service contingent on ongoing data collection), and newer pathways including **Transitional Coverage for Emerging Technologies (TCET)** and the recently announced **Recovery, Access, and Pathway Innovation Decisions (RAPID)** pathway. CED in particular is the agency's effort to balance access to medical advances against the need for evidence sufficient to make durable coverage decisions. Updated CED guidance was issued in August 2024. Of 27 CED determinations issued from 2005 through 2022, four have had the CED requirement removed following reconsideration leading to national coverage. **The structural problem is that the architecture lacks enforceable thresholds for when CED ends, when reviews must occur, and what to do when no adequate commercial sponsor exists. The impact:** coverage that was supposed to be conditional on evidence becomes permanent in practice, and the evidence is never produced.

A data infrastructure built for payment, increasingly relied on for evidence

CMS administrative data, in research-grade form, would constitute the most consequential health services research resource in the country. Decades of investment have produced traditional Medicare fee-for-service claims, the Chronic Conditions Data Warehouse (linking Medicare and Medicaid for dual-eligible beneficiaries), and the Virtual Research Data Center (VRDC), the secure environment where most researchers actually work with these data, whose fees and onboarding timelines are set without published standards. Three gaps now limit what can be studied, each requiring a different fix. **Medicare Advantage (MA), the private-plan alternative to traditional Medicare and now covering 55 percent of Medicare beneficiaries who are eligible to enroll, 35.2 million people as of 2026, generates encounter data less complete, less timely, and less accessible than traditional Medicare claims.** Because MA plans are paid by capitation (a fixed per-person monthly payment), many data elements carry no payment consequence and arrive incomplete. That is a design artifact of how capitation differs from fee-for-service billing rather than uniform noncompliance, but it degrades both research and the risk adjustment of MA payments, and the standards below account for it rather than assume fee-for-service billing behavior. **Medicaid and CHIP data remain incomplete despite years of investment in the Transformed Medicaid Statistical Information System (T-MSIS)**, the federal repository of state Medicaid claims data; here the problem is variation across states in what is submitted and in operational quality. **The Health Insurance Marketplace, which recorded 23.1 million plan selections for the 2026 Open Enrollment Period, has no individual-level claims data resource for**

researchers comparable to Medicare or Medicaid. The impact: the federal evidence enterprise cannot equally evaluate the programs that cover most of the country's publicly insured population.

Recommendations

The section makes eight recommendations organized into three groups: three on CMMI evaluation infrastructure (Recommendations 1-3); three on the coverage-with-evidence architecture and the federal evidence-funding gap behind it (Recommendations 4-6); and two on the data infrastructure that the entire CMS evidence enterprise rests on (Recommendations 7-8). Recommendations 3 and 8 are achievable administratively in the first year under new leadership. Recommendations 1, 2, 4, 6, and 7 combine administrative action available now with legislative components carried in the Legislative Proposals section. Recommendation 5 requires legislation.

1. Require CMMI to publicly commit to its evaluation plan before a model launches, disclose any later changes, and make an unregistered launch consequential.

CMMI should require, for every new model, that an evaluation protocol be specified and publicly registered before model launch. The protocol should identify the primary outcomes the evaluation will measure, the comparison-group methodology (a known difficulty for models now so widespread that untouched comparison populations are scarce, which is itself a reason the method should be stated in advance), the evidentiary thresholds the model is designed to meet, and the timeline for interim and final analyses. To prevent pre-registration from becoming a procedural formality, modifications must be publicly documented with stated rationale at the time the change is made. Amendment is expected rather than exceptional: models now run five to ten years, and mid-course corrections, such as adjusting attribution and benchmarks for beneficiaries who die during a performance year, are part of running a model honestly. Registration governs disclosure, never rigidity. Designation of which model elements must be pre-registered is made by published CMMI policy, reviewed publicly at a fixed interval; the same designation-and-waiver rule applies to CDC analytic work under the CDC section's Recommendation 4, and the Research Integrity and Scientific Freedom section carries it as the federal-evidence-wide standard. Where a model responds to a declared public health emergency on a timeline pre-registration cannot accommodate, the protocol may be registered retrospectively within 60 days under a documented waiver.

As internal policy, pre-registration has no consequence for a model launched without a registered protocol; a future CMMI Director can drop it. The durable version attaches to the statute CMMI already operates under: Congress should provide that a model launched without a registered evaluation protocol cannot proceed to expansion or actuarial certification under Section 1115A(c) until the protocol is registered and the interval between launch and registration is disclosed. That gives the requirement a self-executing consequence without new enforcement machinery. The consequence attaches at expansion by design: a model that never seeks expansion or actuarial certification is governed by the administrative registration policy alone, because the decision the statute protects is program-wide change.

Responsible entity: CMMI Director; Congress for the Section 1115A(c) linkage. **Mechanism:** Administrative action and internal CMMI policy now; amendment to Section 1115A conditioning

expansion and certification on registration. **Timeline:** Administrative policy can be implemented within the first year under new leadership using existing authority; the statutory linkage requires legislation and is carried in the Legislative Proposals section.

Cross-cutting connection: The pre-registration discipline applied here parallels recommendations in the NIH and CDC sections (and is being scoped for FDA). The Research Integrity and Scientific Freedom cross-cutting section addresses pre-registration as a federal-evidence-wide principle.

2. Separate the people who design and operate CMMI models from the people who evaluate them, with the evaluation function placed in a formal independent structure protected from direction by the teams that run the models.

The CMS Administrator should establish a formal structure ensuring independence between the entities designing and operating models and the entities evaluating them. Independence requires: evaluation contractors funded and overseen through a structure separate from CMMI's model operations; no contractual relationship between evaluators and model designers; and findings reported publicly without modification. The evaluation function may be housed in AHRQ under the authority of Section 1142 of the Social Security Act, in an independent CMS evaluation unit reporting separately from CMMI, in an external evaluation consortium, or in another structure that meets these independence requirements. The separation is structural rather than a judgment of the people doing the work now: proximity, not integrity, is the risk it manages. And the independent layer above the agency already exists in this Blueprint's architecture: the HHS evaluation fund places department-wide evaluation under ASPE, with the reauthorized AHRQ reviewing evaluation quality, which answers the concern that any unit inside CMS ultimately reports to the Administrator. Three of these elements are the ones an administrative structure cannot make durable and that statute should anchor: the funding separation (evaluation funds may not be obligated through the model-operations account), the contract provision barring contractual relationships between evaluators and model designers, and publication without modification, with any departure from a final evaluation report before release required to be documented and published alongside it. A structure that lacks any of the three is reversible by the next Administrator; a statute that names them is not.

Responsible entity: CMS Administrator; AHRQ Director if AHRQ is the chosen vehicle; Congress for codification of the three independence elements. **Mechanism:** Administrative action under existing authority; codification of the funding separation, contract provision, and publication-without-modification elements in the Legislative Proposals section. **Timeline:** Structure established within the first year under new leadership; codification requires legislation.

Cross-cutting connection: The institutional vehicle is the reauthorized AHRQ, following the AHRQ section. Where AHRQ serves as that vehicle, the Section 1142 authority described in Recommendation 6 and AHRQ Recommendation 4 governs. The independence elements named here parallel the evidence-synthesis firewall in Research Integrity and Scientific Freedom Recommendation 3.

3. Document how CMMI's program-evaluation findings translate into the actuarial certification the Office of the Actuary uses to decide whether a model can be expanded.

CMMI evaluators ask whether a model improved care or reduced spending compared with a counterfactual; the Office of the Actuary asks whether expanding a model would raise or lower federal program spending relative to current-law baselines. These are different questions answered with different methods, and the translation from one to the other has not been systematically documented. The CMS Administrator should direct that, for every model evaluation that proceeds to consideration for expansion, a formal documented translation be produced and publicly released alongside the certification decision, showing how evaluation findings were converted into the form the actuarial certification under Section 1115A(c) requires. The Office of the Actuary and the CMMI evaluation function should establish an annual joint methodological review examining where the two methodologies converge and where they diverge.

Responsible entity: CMS Administrator; Chief Actuary; CMMI Director. **Mechanism:** Administrative directive and joint working process. **Timeline:** Within the first year under new leadership. Does not require legislation.

Cross-cutting connection: The Align and Coordinate the Federal Evidence Enterprise cross-cutting section addresses the broader pattern of federal analytical processes that need to become more permeable to health services research findings. CMMI–Office of the Actuary translation is a concrete instance of that pattern.

4. Strengthen Coverage with Evidence Development by setting clear thresholds for when coverage requirements end, and by sunsetting conditions that are not affirmatively renewed.

The CMS Administrator should issue supplemental CED guidance that operationalizes the pre-specified-threshold principle adopted in the August 2024 framework with three additional requirements. First, every new CED determination must include pre-specified primary outcomes, evidentiary thresholds, and an explicit statement of what results will trigger retirement of the CED condition, continuation, or NCD reconsideration. Second, every CED determination must include a preliminary review date no later than three years from study initiation. Third, where commercial sponsorship is unavailable or conflicted, CMS should issue clear guidance on alternative evidence-generation pathways (see Recommendation 5). The CMS Administrator should also establish a regular process for evaluating CMS's portfolio of evidence-coverage pathways (CED, TCET, RAPID, and successor mechanisms) against common questions: evidence sufficiency, resolution rates, population representativeness, commercial-sponsorship adequacy, and coordination with AHRQ's technology-assessment role under Section 1142.

Pre-specified thresholds discipline the front end of a CED determination. They do not, on their own, discipline the back end: of 27 CED determinations issued from 2005 through 2022, only four have had the requirement retired with national coverage retained, after four to twelve years each, because once a condition is in place nothing forces a decision about it. The remedy is a default that operates without a decision. Every CED condition should sunset (automatically expire) five years after issuance unless CMS affirmatively re-issues it after a public review that considers an AHRQ technology assessment of the accumulated evidence under Section 1142. Re-issuance is available; inaction is not. At sunset, the

evidence-development condition expires and the underlying national coverage determination enters mandatory reconsideration, with a decision due within twelve months and existing coverage continuing during reconsideration, so that inaction can neither convert conditional coverage into unconditional coverage nor end coverage without a reviewable decision. The public review considers an AHRQ technology assessment under Section 1142 where one is available within the review window; where none is available, CMS conducts the review on the record before it and states the assessment's absence and its cause in the decision memorandum, so that defunding the assessment function cannot operate the default. The reconsideration docket is a real addition to the coverage staff's workload, spread by the staggered five-year anniversaries; that is the price of ending drift, and it appears in the fiscal accounting this document owes appropriators. The design is the same default-operative form the FDA section applies to statutory requirements left unimplemented: whether an evidence-development requirement should end stops being a question CMS may take up and becomes one CMS must answer by a date certain.

Responsible entity: CMS Administrator; Congress for the sunset default. **Mechanism:** Guidance development and administrative action for the thresholds and review date; statutory amendment establishing the five-year sunset with affirmative re-issuance, carried in the Legislative Proposals section. **Timeline:** Supplemental guidance within the first year under new leadership; first portfolio evaluation within two years; sunset requires legislation.

Cross-cutting connection: This recommendation addresses CMS's decision criteria for evidence-conditional coverage. The upstream data systems connect to the FDA section's evidence-lifecycle recommendation and to Data Infrastructure Modernization.

5. Establish federal funding for evidence generation when no commercial sponsor is available or when commercial interests conflict with the question Medicare needs answered.

Some of the evidence Medicare needs to make coverage decisions cannot be generated by industry sponsors, either because no commercial sponsor with adequate capacity exists for a question (for example, comparative effectiveness of two already-marketed drugs, or evidence on long-standing technologies that no manufacturer has commercial incentive to study) or because the sponsor's commercial interest conflicts with the question Medicare needs answered. Congress should establish a dedicated federal funding mechanism for these cases, administered through AHRQ's Evidence-based Practice Center program or through a designated alternative federal research authority with comparable methodological independence and capacity. The mechanism should be invoked at the CMS Administrator's request, with criteria for use published in advance and decisions to invoke made public.

Responsible entity: Congress (authorizing legislation); HHS Secretary, AHRQ Director, and CMS Administrator (implementation). **Mechanism:** Authorizing legislation. **Timeline:** Flagged for the Legislative Proposals section.

Cross-cutting connection: The pattern this recommendation addresses appears across CMMI, CED, FDA post-market surveillance, and other federal evidence functions. The Align and Coordinate the Federal Evidence Enterprise cross-cutting section should consider whether a consolidated federal funding mechanism would serve this function more efficiently than agency-by-agency patches.

6. Make the long-standing statutory partnership between CMS and AHRQ operational for technology assessments and for the quality measures that payment models depend on.

The CMS Administrator and the AHRQ Director should establish a formal annual process for identifying and prioritizing technology-assessment topics connected to the projected NCD and CED pipeline. The process should include public input and a published joint work plan. Section 1142 of the Social Security Act provides the statutory foundation for this relationship and has not been given sustained operational content since the 1990s; the August 2024 CED guidance describes direct collaboration between the agencies but does not give that collaboration institutional content. Topic selection should begin from the identification by the Healthcare Cost and Utilization Project (HCUP) of the most common and costly conditions among Medicare beneficiaries, as the AHRQ section's Recommendation 4 proposes.

The same partnership should carry a second workstream: quality-measure development and validation for Alternative Payment Models (APMs, the CMMI models that pay providers for value rather than volume). A payment model rises or falls on its measures, because the measures determine both the payment adjustments and whether the model can be evaluated at all, and CMS's measure-development capacity, which has produced many of the measures hospitals are judged by, depends heavily on contractors and has no standing research arm for what comes next: digital measures drawn from electronic health record data, broader access to clinical data, and measurement that can keep pace with artificial intelligence in care delivery. AHRQ is the federal government's measurement-science home; its Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient-experience surveys are already embedded in Medicare payment and the Star Ratings. Under this workstream, AHRQ develops and validates the outcome and quality measures that CMMI models pre-register under Recommendation 1, on a joint work plan with CMS parallel to the technology-assessment process. Whether this workstream sits within Section 1142's existing outcomes-research and technology-assessment authority or requires a modest amendment is carried in the Legislative Proposals section, which confirms or amends the statutory hook; the recommendation proceeds administratively either way.

Responsible entity: CMS Administrator and AHRQ Director jointly; the Center for Medicare and Medicaid Innovation for the APM measure workstream. **Mechanism:** Administrative action by both agency heads; a joint work plan covering technology assessments and APM quality-measure development. A companion legislative proposal codifies the joint process, provides dedicated appropriations for Section 1142 technology assessments, placed at AHRQ, with a mandatory appropriation from the Medicare Trust Funds presented as the financing option (Section 1142 authorized such Trust Fund appropriations through fiscal year 1994, when they helped pay for the predecessor agency's Medicare technology assessments; that authority lapsed with the 1999 reauthorization and would be restored by amending 42 U.S.C. § 1320b-12(i)), and confirms or amends the statutory hook for the measure workstream. **Timeline:** Administrative process within the first year under new leadership. Companion legislation carried in the Legislative Proposals section.

Cross-cutting connection: This is an instance of the broader question the Align and Coordinate the Federal Evidence Enterprise cross-cutting section addresses: how to give long-standing statutory coordination authorities operational content. The APM measure workstream reinforces Recommendations 1 and 2 (a pre-registered evaluation plan is only as strong as its measures) and connects to the AHRQ section's measurement assets (CAHPS, HCUP).

7. Bring Medicare Advantage encounter data up to research quality, with statutory authority to enforce data quality standards on participating plans.

The CMS Administrator should publish, within the first 100 days, a formal plan specifying timelines for quarterly data refreshes; completeness standards (defined as low rates of missing values on data elements MA plans are required to submit) comparable to those applied to traditional Medicare claims; and ongoing data-quality monitoring. The completeness standards should include the demographic and clinical elements necessary to support analysis at the level of the populations the program serves. Demographic elements such as race and ethnicity, primary language, and disability status have no field on the claim itself (the X12 transaction standard, the standard electronic format for insurance claims, which governs claims does not carry them), so the standards should route those elements through the sources that can: enrollment data, where those elements are still collected, and the FHIR-based exchange standards now being developed to carry demographic data consistently. Dual-eligibility status and geographic granularity sufficient for sub-state analysis can ride on existing administrative data. Plan-level data-quality reporting should include completeness and timeliness cuts by these subgroups, matched against enrollment records. Congress should provide statutory authority for CMS to enforce encounter-data quality standards as a condition of Medicare Advantage participation, structured as escalating remediation requirements.

Responsible entity: CMS Administrator; Congress for the enforcement authority. **Mechanism:** Administrative action for the data plan and access governance; authorizing legislation for the participation-conditional enforcement authority. **Timeline:** Plan within first 100 days; implementation within the first year under new leadership. Legislation flagged for the Legislative Proposals section.

Cross-cutting connection: The data-architecture work this recommendation depends on belongs in the Data Infrastructure Modernization cross-cutting section. The disparities-relevant subgroup reporting principle applied here is the same principle the cross-cutting section should apply to other federal health data systems.

8. Establish standardized researcher access for Medicaid (T-MSIS) data, improve T-MSIS data quality and comparability across states, and develop a comparable framework for Health Insurance Marketplace data.

Quality comes first: T-MSIS's documented weaknesses in completeness and cross-state comparability limit what any access process can deliver, so the quality and comparability work in this recommendation is the precondition, and standardized access is what makes the improved data usable. The CMS Administrator, through the Medicaid and CHIP function, should establish a standardized researcher access process for T-MSIS data with consistent data-use agreement terms across states, supported by regular public reporting. The same discipline applies to Medicare data access: CMS should publish fee schedules and onboarding-timeline standards for VRDC research access and report performance against them annually, an administrative action available in the first year on state-level data quality. In parallel, CMS should publish state-level data-quality benchmarks and a remediation framework for states whose T-MSIS submissions fall below those benchmarks, building on existing CMS work, including the DQ Atlas data quality assessment tool, the T-MSIS Priority Items (TPI) framework, and the Outcomes Based Assessment (OBA) methodology. CMS should also develop a framework for researcher access to Marketplace data, in consultation with the Research Data Assistance Center (ResDAC), ASPE, qualified health plan issuers, and state-based marketplace operators.

Responsible entity: CMS Administrator. **Mechanism:** Administrative action; architecture-level standards and any mandatory data-submission authority for Marketplace data are flagged for cross-section coordination. **Timeline:** Within the first year under new leadership.

Cross-cutting connection: The Marketplace data framework depends on architecture-level decisions that belong in the Data Infrastructure Modernization cross-cutting section. The federal-state dimension of T-MSIS data quality connects to the State Evidence Capacity cross-cutting section.

Agency for Healthcare Research and Quality

The country needs a federal locus for health services evidence and patient safety. The question is whether the statutory architecture around that locus has been built for the work it is being asked to carry.

Diagnosis

The Agency for Healthcare Research and Quality (AHRQ) is the only federal agency whose primary mission is health services research. Since Congress reauthorized it in 1999 (Healthcare Research and Quality Act of 1999, Public Law 106-129), AHRQ has been an Operating Division of the Department of Health and Human Services with a mandate to produce evidence about how the health care system functions. The agency's products underpin federal decisions made outside the agency itself. The U.S. Preventive Services Task Force (USPSTF, a federal panel of independent experts convened and staffed by AHRQ) issues recommendations that determine private-insurance coverage requirements under Section 2713 of the Affordable Care Act. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient-experience surveys are embedded in Medicare payment and public reporting, including the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey used in the Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing programs, and CAHPS-based measures used in the Medicare Advantage and Part D Star Ratings. The Medical Expenditure Panel Survey (MEPS) and the Healthcare Cost and Utilization Project (HCUP) are the principal federal data assets on health care spending, insurance coverage, and hospital encounters, and the analytic foundation for federal and state hospital-quality measurement.

Three structural vulnerabilities recur across AHRQ's history.

1. AHRQ has faced elimination, consolidation, or substantial budgetary reduction in every decade of its existence. Since the agency's creation as the Agency for Health Care Policy and Research (AHCPR) in 1989, three episodes have been most consequential. First, in 1995, AHCPR published clinical practice guidelines on acute low back pain; organized opposition from affected specialty interests followed; the agency's budget was cut by approximately 20 percent and AHCPR exited the guidelines business. The evidentiary-standard question the agency was asked to resolve in 1995 has since been answered consistently by international and U.S. guidelines that converged on the framework AHCPR proposed, but the agency did not have the institutional protections to defend the work in real time. Second, the 2017–2018 budget cycle proposed folding AHRQ into NIH. Most recently, since early 2025, AHRQ's workforce has been substantially reduced through a reduction in force that targeted the Office of Extramural Research, Education, and Priority Populations, the unit responsible for grant peer review; new grantmaking has been halted since April 1, 2025; and the agency has been unable to obligate the bulk of its FY2025 grant appropriations before the September 30, 2025 expiration. Amid legal action and public outcry, Congress enacted the FY2026 appropriation on February 3, 2026 (Further Consolidated Appropriations Act, 2026, P.L. 119-75), funding AHRQ at $345.4 million as a distinct line item and

declining to enact the President's FY2026 Budget proposal to consolidate AHRQ with ASPE, the Office of Research Integrity, and the National Center for Health Statistics into a new Office of Strategy. The enacted bill directed HHS to support staffing sufficient to carry out the agency's statutory responsibilities. **The pattern across three decades is that congressional direction alone has not kept the agency operational when executive branch priorities have shifted.**

2. AHRQ is small relative to the agencies it is said to duplicate, and its scale feeds unproven perceptions of duplication. The duplication argument fails on the analytic record, but it persists, and it surfaces as political pressure. The congressionally directed Health Services and Primary Care Research Study, which AHRQ commissioned and RAND conducted (RR-A1503-1, 2021; the final report to the House and Senate Appropriations Committees, superseding the initially released RR-3229-AHRQ), found that agency-funded research on similar topics is largely complementary, with the operative weakness being that portfolio overlap is detected only sporadically and by happenstance rather than systematically. The study's mandate expressly included assessing potential consolidation of research agendas, and it concluded in favor of coordination rather than consolidation. The 2024 GAO review of biomedical research collaboration practices (GAO-24-106757) did not identify AHRQ as a source of wasteful duplication; the 2024–2025 GAO documentation of the partnership between AHRQ and PCORI (the Patient-Centered Outcomes Research Institute) (GAO-25-107462) is consistent with this picture. NIH funds substantial health services research across its institutes, but that work is largely disease-specific and investigator-initiated, organized within the institutes' broader portfolios rather than as a defining cross-institute mission. The complementary system-level evidence AHRQ is structured to produce does not have an obvious NIH counterpart. **The duplication claim has driven recurring elimination proposals across administrations of both parties despite the analytic record, and AHRQ has lacked the structural authorities to convert the analytic case into political durability.**

3. AHRQ's statutory authorities do not match the scope of the work the federal evidence enterprise now requires. AHRQ holds regulatory authority in one narrow domain: under the Patient Safety and Quality Improvement Act of 2005 it lists Patient Safety Organizations and administers the Network of Patient Safety Databases, a reporting regime rather than a decision lever. Outside that domain, it has no regulatory or purchasing levers that tie its research, data, and synthesis outputs to consequential federal decisions. Its core data programs operate without the principal-federal-statistical-activity protections (data confidentiality, publication integrity, methodological independence) that insulate comparable federal data systems. Its director serves at the Secretary's pleasure, with no term and no statutory qualifications. Its grantmaking operates without mandatory timelines or anti-impoundment provisions that would make continuity enforceable. Its cross-cutting coordination role across HHS rests on persuasion rather than directive authority. The USPSTF illustrates the same pattern from a different angle: the Supreme Court's June 27, 2025 ruling in *Kennedy v. Braidwood Management, Inc.*, 606 U.S. 748, preserved the Task Force's recommendations and the Section 2713 coverage trigger but grounded them in Secretarial supervision rather than structural autonomy, leaving methodological independence subject to Secretarial discretion unless codified. **The architectural features that make AHRQ administratively easy to pause, relocate, or defund are the same features that leave its consequential outputs undefended when they antagonize entrenched interests.**

Restoration of AHRQ's pre-2025 operations is necessary but does not address the recurring mismatch between the scope of the work and the scope of the authorities. The current moment creates the opportunity to build the statutory architecture the agency was never given.

Recommendations

The seven numbered recommendations below propose a single package. Each addresses a specific element of the mismatch between AHRQ's work and its statutory authorities identified in the diagnosis, and the elements are designed to be adopted together. Structural protections without consequential outputs leave the agency durable but peripheral. Consequential outputs without structural protections invite the kind of organized opposition the 1995 back pain episode illustrated and produce political pressure the agency cannot withstand. The reauthorization package proposed here pairs protection with consequence, deliberately. Recommendations 1 through 6 establish the AHRQ-side architecture. Recommendation 7 receives selected principal federal statistical and evaluation functions into that architecture through three sub-recommendations: 7a receives NCHS and is structurally dependent on the NCHS section's Recommendation 2; 7b receives the National Center for Health Workforce Analysis and the Area Health Resources Files and is paired with the HRSA recommendation of the Brief Agency Entries section; 7c receives the National Survey on Drug Use and Health and is paired with the SAMHSA recommendation of the Brief Agency Entries section.

The package combines actions that can proceed under existing executive authority with actions that require congressional legislation. Three elements can begin in the first year under existing authority: OMB recognition of AHRQ's statistical activities encompassing HCUP, MEPS, and CAHPS as a CIPSEA statistical unit (Recommendation 2), Section 1142 operationalization between AHRQ and CMS (Recommendation 4), and interagency convening of the federal HSR coordination body (Recommendation 5). The administrative elements should not wait on the legislative vehicle.

1. Reauthorize AHRQ with an expanded statutory mandate, an authorized funding floor, and the governance stature the mission requires.

Congress should enact a reauthorization bill that resets AHRQ's statutory foundation for the work the federal evidence enterprise now requires. The reauthorization should establish six elements.

First, the statutory mandate should expand beyond the agency's current authorities to include, as core functions, evidence synthesis and dissemination, implementation science, health data stewardship, patient safety, primary care research, disparities and priority-population research, and the convening and support of independent federal evidence bodies including the U.S. Preventive Services Task Force. Two of these need statutory modernization rather than addition. Primary care research is a function unique to AHRQ that the Senate Labor-HHS bill has funded consistently and for which the FY 2026 explanatory statement specified $2 million for the Center for Primary Care Research; naming it as a core function protects a function whose statutory footing is thinner than its appropriations history suggests. Patient safety is one of the agency's largest lines of work but is codified as "reducing medical errors"; the statute should be updated to reflect the field's expansion to healthcare-associated infections and diagnostic safety, with authority for research centers in diagnostic excellence and infection prevention.

Second, the reauthorization should establish a director appointed by the Secretary for a fixed term of five years, with statutory qualification requirements in health services research, health statistics, or evaluation, and removable by the Secretary only for cause. The statute should state that the office is an inferior one. Appointment by the Secretary is what makes the protection possible: an inferior officer appointed by a Secretary who serves at will may be given for-cause protection as a single layer, which is the structure the Court left standing in *Trump v. Slaughter*, whereas a Senate-confirmed office would move toward principal-officer status and lose the protection. The Blueprint chooses the protection over the hearing. The five-year term breaks alignment with the four-year presidential cycle and follows the Census Director (5-year term under 13 U.S.C. § 21) as the primary comparator, with the Bureau of Labor Statistics Commissioner (4-year term under 29 U.S.C. § 1) as a secondary reference. The rest of the design follows Legislative Proposal 2. Any removal requires a written statement of specific reasons transmitted to the committees of jurisdiction and published, with a defined notice period before it takes effect; during any period in which a removal is contested, the deputy director serves as acting director without authority to alter methodology, release schedules, review panels, or grantmaking timelines. The for-cause standard is the operative protection; the notice and interim layers stand on their own if it is ever narrowed.

Third, the reauthorization should establish an authorized funding floor of $1 billion annually, indexed to inflation. The Friends of AHRQ coalition has identified $500 million as the level required to sustain the agency's current portfolio; this reauthorization expands the mandate well beyond that portfolio, and the floor is sized to the work it authorizes. The floor covers the agency's core functions; budget lines for the statistical and evaluation units received under Recommendation 7 are preserved separately and sit on top of it. An authorized floor is a statement of intent that does not bind annual appropriators. It provides the baseline against which subsequent appropriations are judged and is the kind of statutory anchor that can be cited in future impoundment litigation.

Fourth, the reauthorization should establish mandatory timelines for grantmaking and review following appropriation, with default procedures that trigger automatically if the agency fails to act within specified windows: when quarterly obligation falls below a benchmark computed and recorded by the Government Accountability Office, awards issue in peer-review rank order from the most recent completed review cycle as a nondiscretionary duty of the agency's grants management officials, and funds appropriated for extramural research count toward the benchmark only when obligated to extramural awards. This addresses the 2025 pattern in which appropriated funds went unspent because grantmaking was administratively halted; the full trigger design is in the Legislative Proposals. Interim implementation through HHS administrative guidance is feasible in the first year under new leadership ahead of statutory codification.

Fifth, the reauthorization should include anti-impoundment provisions specific to AHRQ's core functions. The Impoundment Control Act provides general protections against the withholding of appropriated funds, but the 2025 experience demonstrated that general protections require case-by-case litigation to enforce. Agency-specific anti-impoundment provisions tied to identified core functions provide faster and more enforceable protection. Because the 2025 lapse ran through capacity rather than withholding, the reauthorization should also direct the agency to maintain the personnel capacity necessary to execute the grantmaking timelines, stated as functions (peer-review convening, award issuance, grants management) rather than headcount, and place reductions in force and reassignment

patterns affecting those functions within the conferred Inspector General jurisdiction of Legislative Proposal 3.9; the workforce protections are the anti-impoundment provisions that reach what a funds-withholding bar cannot.

Sixth, the reauthorization should replace the current Section 914(a) authority for "Information Systems for Health Care Improvement" with a digital health provision. The provision should authorize AHRQ to conduct and support research on whether digital health technologies, including artificial intelligence applications, mobile health tools, telehealth, digital therapeutics, and wearable devices, are safe and improve health outcomes, and to generate real-world evidence on their implementation in clinical settings. "Digital health" here means the tools that reach patients and clinicians through software rather than through a drug or a physical device: clinical decision support, diagnostic and triage software, remote and asynchronous care, and the AI systems embedded in each. The provision authorizes research on whether these tools work, not regulation of them; FDA's device authority, and the exclusion of most clinical decision support from it under Section 3060 of the 21st Century Cures Act, is unchanged, and the research this provision funds is the evidence that FDA, CMS, and clinicians can use where their own authorities apply. This is the Blueprint's principal statutory vehicle on artificial intelligence in health care evidence; the Data Infrastructure Modernization section states why the document otherwise says little on the subject.

Responsible entity: Congress, with implementing roles for the HHS Secretary and the AHRQ Director. **Mechanism:** Reauthorization legislation, with HHS administrative guidance for interim grantmaking-timeline implementation. **Timeline:** Requires legislation. Can be introduced at the start of the next congressional session. Interim grantmaking-timeline guidance feasible in the first year under new leadership.

Cross-cutting connection: The anti-impoundment provisions and the firewall and procedural protections proposed for the AHRQ Director connect to the broader theme of statutory protection for federal evidence functions addressed in the Research Integrity and Scientific Freedom cross-cutting section. The authorized funding floor and anti-impoundment provisions are consolidated with the Blueprint's other funding-architecture proposals in the Legislative Proposals section.

2. Codify and extend statistical-unit protections for AHRQ's core data programs.

HCUP, MEPS, and CAHPS function as foundational federal data assets, as established in the diagnosis: each one carries decisions that other federal agencies make about coverage, payment, public reporting, and patient-experience measurement. They operate today under a patchwork of protections that does not provide the full statutory architecture that insulates federal data systems administered by CIPSEA-recognized statistical agencies and units. MEPS carries confidentiality protections under Sections 308(d) and 903(c) of the Public Health Service Act, but the AHRQ Center for Financing, Access, and Cost Trends (which administers MEPS) is not among the principal federal statistical agencies or the three additional units recognized under the Confidential Information Protection and Statistical Efficiency Act (CIPSEA) of 2018. HCUP and CAHPS lack comparable named confidentiality statutes.

OMB should recognize the AHRQ statistical activities encompassing HCUP, MEPS, and CAHPS as a statistical unit under CIPSEA 2018, with the data confidentiality, publication integrity, and methodological independence protections that recognition carries. This action requires no new

legislation; the procedural pathway is the OMB Chief Statistician recognition process specified in the CIPSEA implementation guidance. Congress should subsequently codify the recognition in the AHRQ reauthorization and amend CIPSEA as necessary to secure the protections against future administrative reversal.

The reauthorization should also set timeliness standards for AHRQ's data programs: a statutory interval from the completion of data collection to public dissemination, with the interval published for each program and GAO reporting when it is missed. Data that arrive years after the period they describe are read by policymakers as a reason to discount the program; a published clock is the answer.

Responsible entity: Office of Management and Budget for recognition, with implementing roles for the AHRQ Director; Congress for statutory codification. **Mechanism:** OMB recognition under existing CIPSEA 2018 authority; full statutory protection requires legislative action. **Timeline:** OMB recognition in the first year under existing authority. Legislative codification through reauthorization.

Cross-cutting connection: The CIPSEA-recognition asymmetry between NCHS (currently a principal federal statistical agency) and AHRQ's statistical activities (currently unrecognized) is part of what the AHRQ-NCHS data-asset integration proposed in Recommendation 7 and in the NCHS section's Recommendation 2 is designed to resolve. The cross-cutting Align and Coordinate the Federal Evidence Enterprise section is the venue for the broader statutory-architecture argument.

3. Codify the methodological independence and operational protections of the U.S. Preventive Services Task Force.

The Supreme Court's June 27, 2025 ruling in *Kennedy v. Braidwood Management, Inc.* resolved the constitutional question about the Task Force's appointment structure by holding that Task Force members are inferior officers because the HHS Secretary directs and supervises them. This sharpens, rather than diminishes, the case for statutory codification, and it also sets the limit of what codification can do. The Court upheld the Task Force because the Secretary can review its recommendations before they take effect and remove its members; that political accountability is what the Constitution requires, and the Blueprint does not propose to remove it. What it proposes to protect is method, not decision: the evidence-grading framework, the recommendation development process, and the operational protections. A Secretary who disagrees with a grade may act on that disagreement through the review authority the Court described, on the record; what a Secretary should not be able to do is quietly change how the grades are produced. The appointment-clause architecture cannot be the source of methodological independence after Braidwood. If the Task Force's evidence-grading methodology, recommendation development process, and operational protections are not codified in statute, they are subject to revision at Secretarial discretion.

Congress should codify three elements of Task Force operations in the AHRQ reauthorization, each written so that a consequence attaches to non-compliance rather than leaving compliance to Secretarial discretion. First, the Task Force's methodological independence should be established in statute. Departures from established methodology require public notice and comment, and a recommendation issued under a departed-from methodology without that process does not carry statutory effect under Section 2713 until the process is completed. Second, AHRQ's obligation to provide staff, research support, and evidence synthesis capacity for the Task Force should be established in statute, with

dedicated funding authority that cannot be redirected to other uses. Third, procedural changes to Task Force operations require public notice and comment rather than agency discretion. The Task Force's grades carry the Section 2713 cost-sharing consequence for private insurance and are among the most consequential federal decisions in preventive care; any future question of where the Task Force sits institutionally must weigh that consequence first.

Responsible entity: Congress, with implementing roles for the HHS Secretary and the AHRQ Director. **Mechanism:** Legislation, within the AHRQ reauthorization bill. **Timeline:** Requires legislation. Urgency is elevated because Secretarial discretion over methodological process is currently unconstrained by statute.

Cross-cutting connection: The Task Force protections proposed here connect to the broader theme of statutory protection for federal evidence functions addressed in the Research Integrity and Scientific Freedom cross-cutting section. The structural argument for codifying methodological independence of federal advisory bodies is shared with the CDC section's recommendation on ACIP/HICPAC protections; the two sections address parallel problems at different agencies and the cross-cutting Research Integrity section is the venue for the shared structural argument.

4. Create statutory links tying AHRQ evidence products to specific federal decisions.

The diagnosis identified the informal relationship between AHRQ's outputs and consequential federal decisions as a source of structural weakness. The remedy is to require that specified AHRQ products be formally considered, with consideration documented in the administrative record, when federal agencies make related decisions. Consideration requirements preserve agency discretion while making AHRQ outputs part of the formal decision architecture.

Congress should establish three such links. First, CMS National Coverage Determinations (NCDs, the formal Medicare-wide decisions on whether and how a particular technology or service is covered) should be statutorily required to formally consider AHRQ Evidence-based Practice Center (EPC) reports when EPC evidence is available on the technology, service, or procedure under consideration. Second, AHRQ patient safety measures should be integrated into CMS quality reporting and payment programs through a joint AHRQ-CMS measure development and maintenance process established in statute. Third, where Coverage with Evidence Development (CED) determinations (the CMS mechanism for covering items conditional on participation in evidence generation) require evidence generation that no commercial sponsor can credibly provide, a dedicated federal funding mechanism should be available through AHRQ's EPC program. The statutory authority for AHRQ's role in CED is Section 1142 of the Social Security Act (42 U.S.C. § 1320b-12), and the operational architecture is described in the 2024 CMS CED Guidance; the recommendation here is to develop this authority into an operating program. The precedent is direct, and so is its funding history: AHRQ's predecessor, the Agency for Health Care Policy and Research, conducted technology assessments at the Health Care Financing Administration's request for Medicare coverage decisions, financed in part by an authorization of appropriations from the Medicare Trust Funds that ran through fiscal year 1994 (42 U.S.C. § 1320b-12(i)); the 1999 reauthorization moved the agency to annual appropriations and the Trust Fund authority lapsed. Even then, fewer than ten assessments were conducted each year (GAO, 1994). Topic selection for the EPC reports feeding coverage determinations should be anchored in AHRQ's own data: the Healthcare Cost

and Utilization Project identifies the most common and costly conditions among Medicare beneficiaries, and the statute should direct that prioritization begin there.

These are consideration requirements, not substantive constraints on CMS decisions. They preserve agency discretion by design and are weaker than the anti-impoundment and default-grantmaking provisions in Recommendation 1. The Blueprint states that distinction rather than letting the weaker provisions inherit the stronger ones' force.

The relationship between AHRQ's evidence-generation authority and PCORI's comparative clinical effectiveness research mandate warrants explicit statutory clarification. The reauthorization should clarify the division: AHRQ as the federal authority for systematic evidence synthesis supporting federal coverage, payment, and quality decisions; PCORI as the funder of patient-centered comparative clinical effectiveness research generating the evidence inputs that AHRQ syntheses draw on. Some in the field propose the larger step of receiving PCORI and its work into AHRQ to consolidate the federal comparative-effectiveness function under one oversight structure. The Blueprint does not adopt that proposal. PCORI's trust-fund financing has made it resilient through the 2025 disruptions in a way that appropriated agencies were not, and that financing design is the lesson worth carrying into the AHRQ reauthorization rather than the consolidation itself.

Responsible entity: Congress, with implementing roles for CMS and AHRQ. **Mechanism:** Legislation, with supporting joint administrative guidance from the two agencies. **Timeline:** Administrative coordination on Section 1142 operationalization can begin in the first year under existing authority. Durable statutory links require legislation.

Cross-cutting connection: The three statutory links above are addressed from complementary angles in the CMS section. The AHRQ section establishes the evidence-generation authority and the agency's obligations; the CMS section establishes the consideration and incorporation requirements on the decision side.

5. Establish AHRQ as the chair of a formal interagency health services research coordination body.

The federal government funds health services research through multiple agencies: NIH Institute and Center HSR portfolios, CMS through CMMI and the Office of Minority Health, the Department of Veterans Affairs through HSR&D (its Health Services Research and Development Service), CDC, the Department of Defense, HRSA, and AHRQ itself. The appropriate response to this fragmentation is coordination of the portfolio as a portfolio, not consolidation under a single agency.

Congress should establish a formal federal health services research coordination body, chaired by AHRQ, with statutory authority to identify cross-agency research priorities, coordinate solicitations where coordination serves the field, identify gaps no single agency is addressing, and report to Congress annually on the federal HSR portfolio as a whole. Participating agencies should include NIH, CMS, VA HSR&D, CDC, DoD, and HRSA, with OMB participation as a non-voting member. The HHS Secretary has existing authority to convene an interagency body of this kind administratively, and the Blueprint recommends that the Secretary do so in the first year under new leadership as an interim step. A fair question is why a body chaired by AHRQ would do what other federal coordinators have not; agencies guard their authorities, and coordination by convening has a thin record across government. The answer is not the chair. It is the consequences the Align and Coordinate section attaches: a gap the body

identifies that goes unaddressed across two budget cycles produces a mandatory finding in OMB's passback that the agency must answer in its budget justification, and a body that misses its cadence is recorded in the annual Federal Health Evidence Report. Coordination that reaches the budget is different in kind from coordination that issues a plan.

Responsible entity: Congress for statutory creation; HHS Secretary for interim administrative convening; AHRQ Director as chair. **Mechanism:** Legislation for codification; HHS Secretary administrative action for interim standup. **Timeline:** Interim convening in the first year under new leadership. Legislative codification through the AHRQ reauthorization.

Cross-cutting connection: The Align and Coordinate the Federal Evidence Enterprise cross-cutting section should address the coordination body in the broader context of federal evidence coordination, with the AHRQ section establishing the specific statutory mechanism.

6. Codify the National Healthcare Quality and Disparities Report and codify AHRQ's disaggregation methodology role.

The federal evidence enterprise increasingly requires disaggregated data and disparities-focused analysis to inform policy decisions affecting populations whose outcomes have historically been obscured in aggregate measures. AHRQ has produced the National Healthcare Quality and Disparities Report (NHQDR) for more than two decades and has maintained a priority-population research portfolio. These functions operate today as administrative programs rather than as fully codified statutory functions. They are administratively organized and therefore administratively dismantled.

Congress should establish two elements in the AHRQ reauthorization. First, the NHQDR should be codified as a single statutory product with a defined cadence, reflecting the combination of the two reports the statute currently names. The codification includes expansion of the categories of disaggregation beyond the racial and socioeconomic factors currently named at 42 U.S.C. § 299a-1, to include primary language, disability status, sexual orientation and gender identity, geography, and other priority-population categories aligned with the broader AHRQ priority-populations definition at 42 U.S.C. § 299(c)(1) and with OMB Statistical Policy Directive No. 15, as revised in 2024. Second, AHRQ's role in supporting disaggregation methodology development across federal health programs should be codified. The priority-population research function itself already exists in law at 42 U.S.C. § 299(c); Recommendation 1 carries it as a named core function rather than proposing a duplicate authorization.

Responsible entity: Congress, with implementing roles for the HHS Secretary, the AHRQ Director, and CMS for measurement alignment. **Mechanism:** Legislation, within the AHRQ reauthorization bill. **Timeline:** Requires legislation. Administrative continuation of NHQDR and priority-population research can proceed in the first year under new leadership.

Cross-cutting connection: The methodological-leadership role on disaggregation across federal health programs connects to the Data Infrastructure Modernization cross-cutting section.

7. Receive principal federal statistical and evaluation functions into the reauthorized AHRQ where the structural-protection test is met.

The reauthorization should consolidate selected federal statistical and evaluation functions that meet a structural-protection test into the reauthorized AHRQ. A function meets the test when it (a) produces principal federal estimates or evidence syntheses on a national scale, (b) is methodologically continuous with AHRQ's existing portfolio or with functions already received into the reauthorized agency, and (c) does not have an essential operational linkage at its current home that consolidation would disrupt. The receiving-side commitment in each case is the same: the reauthorized AHRQ takes on the function under statutory preservation conditions and a five-element transition plan covering brand and identity, methodological independence, cooperative relationships, workforce, and budget line. The federation-versus-consolidation question that this approach implies is addressed at the federal-evidence-enterprise scale in the cross-cutting Align and Coordinate the Federal Evidence Enterprise section.

On the surface, this proposal resembles the Office of Strategy consolidation that Congress declined to enact in the FY 2026 appropriations, and the resemblance deserves a direct answer. Three features distinguish it. The Office of Strategy proposal moved functions by administrative and budget action; this proposal moves them by statute, with preservation conditions Congress must affirmatively enact. The administrative consolidation submerged the receiving functions' identities and budget lines; this proposal preserves name, methodological independence, cooperative relationships, workforce, and appropriation line as statutory conditions of the transfer. And the administrative consolidation was designed to shrink the functions it combined; this proposal consolidates to protect functions whose current homes have already demonstrated the vulnerability the structural-protection test screens for.

Three sub-recommendations apply the test to three specific functions: NCHS (7a), the National Center for Health Workforce Analysis together with the Area Health Resources Files (7b), and the National Survey on Drug Use and Health (7c). Each is a self-contained statutory proposal; the three are designed to be adopted together within the reauthorization vehicle but can be modified independently in legal expert review.

The package pairs provisions of different strength, and the Blueprint distinguishes them. The provisions written as fixed requirements are the anti-impoundment and default-grantmaking elements of Recommendation 1 and the CIPSEA and Statistical Policy Directive protections the received functions already carry. The preservation conditions in 7a through 7c are written as statutory conditions of transfer, and each is drafted to foreclose an act rather than to state a duty: a transfer executed without the conditions in force does not take effect; funds appropriated to a received unit's line may not be reprogrammed to other agency purposes; positions transferred may not be reclassified out of competitive service or reassigned outside the unit for five years following transfer unless the action and its reason are recorded in the annual Federal Health Evidence Report to the committees of jurisdiction before it takes effect; and cooperative agreements with state partners carry over by operation of law rather than by renegotiation. Where a condition cannot be written that way, the text says so.

On resources: the concern that merging two chronically under-resourced organizations compounds rather than relieves the problem deserves a direct answer. AHRQ's total budget grew $76 million in nominal terms between 2010 and 2026, a decline after inflation, and NCHS's appropriation has been nearly flat in nominal terms over the same period; there is no evidence that NCHS has fared better as a

component of CDC than it would within a newly authorized agency carrying an indexed funding floor and separately preserved budget lines. The relocation does not solve the resource problem on its own, and the Blueprint does not claim it does; the funding floor in Recommendation 1 and the multi-year authority in NCHS Recommendation 3 are the resource instruments.

Fallback if the reauthorization does not advance. The receipt of functions in Recommendation 7 requires the reauthorization vehicle. If that vehicle does not advance, the received functions remain at their source agencies under the coordination-and-standards overlay the document already prescribes for the functions that stay put, the Uniform Data System (UDS, the health-center reporting system) at HRSA and N-SUMHSS (the national survey of treatment facilities) at SAMHSA. That overlay does not itself depend on the reauthorization: the interagency coordination body in Recommendation 5 can be convened in the first year under existing authority, so the coordinating and standards-setting function is available in the interim even if the vehicle stalls. Relocation is therefore an integration measure rather than the mechanism of protection, and a delay in the vehicle does not, by itself, leave any received function more exposed than it is today. What holds each function in the interim differs by the protection it already carries.

NCHS, under 7a, retains the principal-statistical-agency protections that attach to its function under CIPSEA and the Statistical Policy Directives, as set out in the NCHS section's Recommendation 2 fallback, and remains in place with those protections intact.

The National Survey on Drug Use and Health (NSDUH), under 7c, retains the same class of protection, because SAMHSA's Center for Behavioral Health Statistics and Quality is a recognized statistical unit under CIPSEA and that recognition attaches to the function rather than to its organizational parent. The interim commitment for NSDUH must address operational continuity and not only legal protection. The April 2025 reduction in force eliminated the SAMHSA Office of Population Surveys that historically oversaw the survey, so the protection is intact on paper while the capacity to exercise it is not. The first-year commitment should restore and protect the staffing and contractor continuity necessary to sustain the survey on its established methodology and release schedule.

The workforce functions under 7b are the exception, because the National Center for Health Workforce Analysis and the Area Health Resource Files are not a recognized statistical unit and carry no independent statistical-agency protection to fall back on. If the vehicle does not advance, these functions remain at HRSA under the coordination-and-standards overlay, with interim source-agency protections written in: methodological independence and a protected release schedule for the workforce estimates, established administratively in the first year and drafted for later codification. This interim protection should be conformed to the fallback language of the Evidence Workforce Development section's Recommendation 1, which draws on the same workforce-data foundation.

The severable durable core of this reauthorization (Recommendation 1's anti-impoundment provision and mandatory grantmaking timelines with automatic defaults; Recommendation 3's Task Force codification on its own *Braidwood*-driven vehicle) is stated once, in the Legislative Proposals section, as enactment strategy.

7a. Receive NCHS into the reauthorized AHRQ as proposed in the NCHS section, with statutory preservation conditions for NCHS's methodological identity and state cooperative relationships.

The NCHS section of this Blueprint proposes relocating NCHS into the reauthorized AHRQ at the time of the reauthorization, on the grounds that NCHS-AHRQ data asset integration is the location of the federal evidence enterprise's most consequential research and that the methodological communities operating those assets are stronger together than separately. The case from the receiving side is the obverse: AHRQ's statutory data programs (HCUP, MEPS, CAHPS), the patient-safety measurement work, and the evidence-synthesis infrastructure are operated by methodological communities whose work has long been functionally dependent on NCHS surveys, vital records, and statistical methodology. The four linkage examples the diagnosis sections name (MEPS sampling drawn from the National Health Interview Survey (NHIS); mortality follow-up linking HCUP to the National Death Index (NDI); condition-encounter linkage between the National Health and Nutrition Examination Survey (NHANES) and HCUP; patient-experience linkage between CAHPS and NHIS) are not abstractions. The MEPS relationship is a standing operational dependency today: the survey's sample is drawn from the NHIS frame, so its reliability and cadence already depend on an NCHS counterpart. HCUP-to-NDI mortality follow-up happens project by project rather than as standing infrastructure; NHANES-to-HCUP comparison depends on bespoke linkage agreements; and the CAHPS-NHIS product does not yet exist as a routine joint product. Integration would make the existing linkages routine and the prospective one feasible, subject to the statutory and state-agreement limits named below. Receiving NCHS into the same institutional home does not change what either side produces. It removes the bespoke-linkage tax that the methodological communities currently pay. A linkage can stall for two reasons today: the agencies run different intake and review processes, and statutes or state agreements restrict sharing. The tax therefore has an organizational component and a statutory one: relocation reduces the organizational component where the transition law supplies shared intake, a review clock, and common governance; the enabling legislation's data-sharing and transition provisions address the federal statutory component while preserving CIPSEA, Section 242m(d), and applicable state-agreement restrictions; neither instrument alone reaches both, and neither eliminates every linkage cost. The consolidation also creates the operational conditions for integrated statistical products that the federal health services research community has called for over many years.

The CIPSEA-recognition asymmetry described in Recommendation 2 is part of what this integration resolves. NCHS is one of the thirteen principal federal statistical agencies recognized under CIPSEA 2018; AHRQ's statistical activities encompassing HCUP, MEPS, and CAHPS currently are not. Receiving NCHS into the reauthorized AHRQ creates the operational adjacency for a coherent statutory-protection argument for the integrated statistical unit, building on the OMB recognition proposed in Recommendation 2.

The transition mechanics matter as much as the affirmative case. The NCHS section names three non-negotiable preservation conditions: NCHS name and brand, methodological independence (including CIPSEA recognition, Statistical Policy Directive protections, and the Director's authority over methodology and release timing), and state vital records cooperative relationships. Each preservation condition needs an operational instrument. (a) Brand and identity: NCHS continues as a named principal federal statistical agency unit within the reauthorized AHRQ, with its publication imprint, methodological standards, and external identity preserved in statute. (b) Methodological independence

and appointment: the NCHS Director retains statutory authority over methodology, release schedule, and statistical-data confidentiality, with the AHRQ Director excluded from those decisions; the NCHS Director reports to the AHRQ Director on administrative matters and to OMB on statistical-policy matters consistent with current OMB Statistical Policy Directive arrangements; and the NCHS Director is appointed and removable by the Secretary, not by the AHRQ Director, so that the for-cause protections of the two offices sit side by side under an at-will Secretary rather than one on top of the other, the stacked structure the Court has held unconstitutional. (c) State vital records relationships: existing cooperative agreements, funding flows, data-sharing protocols, and methodological consultation arrangements between NCHS and the state, territorial, and city vital records jurisdictions are preserved through statutory transition language; the transition must not be the occasion for renegotiation of those relationships, which the states would correctly read as a threat to the federation coordinated through NAPHSIS (the National Association for Public Health Statistics and Information Systems). (d) Workforce: NCHS staff carry their grade, classification, and methodological assignments into the reauthorized AHRQ without administrative reclassification. (e) Budget: NCHS funding is preserved as a separate appropriation line within the reauthorized AHRQ, with the funding floor for vital statistics modernization (NCHS Recommendation 3) carrying over into the consolidated agency.

Responsible entity: Congress, with implementing roles for HHS, CDC, AHRQ, the NCHS Director, and state vital records jurisdictions. **Mechanism:** Legislation, within the AHRQ reauthorization vehicle proposed in Recommendation 1. **Timeline:** Requires legislation. Administrative transition planning, including engagement with state vital records officers and NAPHSIS, can and should begin before legislation moves.

Cross-cutting connection: The state vital records preservation language is shared with the State Evidence Capacity cross-cutting section.

7b. Receive the National Center for Health Workforce Analysis (NCHWA) and the Area Health Resources Files (ARF/AHRF) into the reauthorized AHRQ, with statutory preservation conditions and a five-element transition plan.

The National Center for Health Workforce Analysis (NCHWA) produces the federal estimates of supply, demand, and distribution for physicians, nurses, behavioral health workers, and other clinicians. The Area Health Resources Files (ARF/AHRF) combine workforce, facility, and population data at the county level for federal programs and research. NCHWA estimates and ARF/AHRF county-level files are the federal workforce-data counterparts to NCHS's vital statistics, NHIS, and NHANES, produced on the same kind of recurring, methodologically-disciplined cadence, used by the same federal-state-academic analytic community, and answering the same kind of national-and-subnational distributional questions. The methodological case for receiving NCHWA and ARF/AHRF into the reauthorized AHRQ alongside NCHS is the workforce-data equivalent of the NCHS-AHRQ integration argument in 7a: the analytic communities operating these assets are already functionally dependent on the surveys, vital records, and statistical methodology that NCHS and AHRQ produce, and the bespoke-linkage tax those communities currently pay is the same. The Uniform Data System (UDS) does not meet the structural-protection test and stays at HRSA; UDS is operationally tied to the federally qualified health center grant-administration function and receiving it would disrupt that linkage.

The five-element transition plan parallels the NCHS and AHRQ-side plans:

(a) **Brand and identity.** NCHWA continues as a named federal workforce-analytic unit within the reauthorized agency, with its publication imprint, methodological standards, and external identity preserved in statute. The State of the Primary Care, Behavioral Health, Maternal Health, and Health Care Workforce publication series; the National Sample Survey of Registered Nurses (NSSRN); and the recurring physician-supply projections continue under the NCHWA imprint.

(b) **Methodological independence.** NCHWA leadership retains statutory authority over methodology, release schedule, and analytic-product confidentiality, with the reauthorized agency's Director excluded from those decisions. Methodological independence protections parallel those proposed for NCHS in 7a and in NCHS Recommendation 1.

(c) **Cooperative relationships.** NCHWA's existing data-stewardship and methodological-consultation arrangements with HRSA's Bureau of Health Workforce program offices, with state workforce data centers, with the Census Bureau, with the Bureau of Labor Statistics, and with VA workforce-data partners are preserved through statutory transition language. HRSA retains operational responsibility for the workforce program functions (clinician training, scholarship and loan repayment, shortage-area designation) that NCHWA data informs; the data-stewardship function moves and the program-administration function stays.

(d) **Workforce.** NCHWA staff carry their grade, classification, and analytic assignments into the reauthorized agency without administrative reclassification. ARF/AHRF data-stewardship staff at HRSA carrying the file's compilation, documentation, and release functions move with the asset.

(e) **Budget line.** NCHWA funding and ARF/AHRF compilation funding are preserved as a separate appropriation line within the reauthorized agency. The multi-year funding authority for NCHWA established in the HRSA recommendation of the Brief Agency Entries section carries into the reauthorized agency.

The annual federal health workforce report proposed in the HRSA recommendation of the Brief Agency Entries section is convened by the reauthorized AHRQ following the transition; HRSA, ASPE, the Bureau of Labor Statistics (BLS), and VA remain participating agencies.

Responsible entity: Congress, with implementing roles for HHS, HRSA, AHRQ, and state workforce data centers. **Mechanism:** Legislation, within the AHRQ reauthorization vehicle proposed in Recommendation 1. **Timeline:** Requires legislation. Administrative transition planning, including engagement with HRSA's Bureau of Health Workforce and state workforce data center directors, can and should begin before legislation moves.

Cross-cutting connection: The federal workforce-data foundation NCHWA and ARF/AHRF provide is the analytic substrate for the Evidence Workforce Development cross-cutting section. The data-stewardship-versus-program-administration distinction this sub-recommendation draws is one application of the federation-versus-consolidation argument carried at the federal-evidence-enterprise scale in the Align and Coordinate the Federal Evidence Enterprise section.

7c. Receive the National Survey on Drug Use and Health (NSDUH) into the reauthorized AHRQ, with statutory preservation conditions and a five-element transition plan.

The National Survey on Drug Use and Health (NSDUH), run by SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ), is the federal government's primary source of national estimates on substance use, mental illness, and treatment access. NSDUH is the structural counterpart on the behavioral health side to what NHIS and NHANES are on the general population side: a national

household survey producing principal federal estimates on a recurring, methodologically-disciplined cadence, with sample design, instrumentation, and weighting maintained as a long-running federal statistical infrastructure. The methodological case for receiving NSDUH into the reauthorized AHRQ alongside NCHS is the behavioral-health-data equivalent of the NCHS-AHRQ integration argument in 7a. The structural-protection case is sharpened by the April 2025 reduction in force at SAMHSA, which eliminated the Office of Population Surveys, the team that historically oversaw NSDUH. SAMHSA reports that CBHSQ technical staff continue to work with the NSDUH contractor to maintain uninterrupted data collection, and the 2024 NSDUH was released on schedule, but the durable institutional anchor for NSDUH's methodological independence at SAMHSA has been removed and the open question is what replaces it. Receiving NSDUH into the reauthorized AHRQ supplies the durable institutional anchor that the SAMHSA configuration no longer provides. The National Substance Use and Mental Health Services Survey (N-SUMHSS) does not meet the structural-protection test and stays at SAMHSA; N-SUMHSS is a provider survey operationally tied to SAMHSA's program-administration functions and receiving it would disrupt that linkage.

The five-element transition plan parallels the NCHS and NCHWA plans:

(a) **Brand and identity.** NSDUH continues as a named federal household-survey program within the reauthorized agency, with its publication imprint, methodological standards, and external identity preserved in statute. The NSDUH brand has substantial recognition value in the behavioral health analytic community and in state and local response operations, and is itself part of the response-rate-and-trust infrastructure on which the survey depends.

(b) **Methodological independence.** NSDUH leadership retains statutory authority over methodology, release schedule, and statistical-data confidentiality, with the reauthorized agency's Director excluded from those decisions. The methodological-continuity protections established when reweighted 2021 estimates were released in January 2024 to restore comparability with 2022 and later carry into the reauthorized agency; the 2019-to-2022 trend break that the reweighting did not resolve is the kind of disruption the protections are designed to prevent recurring. The statutory protection vehicle, whether designation under the Confidential Information Protection and Statistical Efficiency Act of 2018 (CIPSEA) or another mechanism, should be identified through legal review and codified in the reauthorization.

(c) **Cooperative relationships.** NSDUH's existing data-stewardship and methodological-consultation arrangements with the NSDUH contractor, with state behavioral health agencies, with CDC for overdose surveillance integration, with CMS for treatment-utilization integration, and with NIH-funded behavioral health research programs are preserved through statutory transition language. SAMHSA retains operational responsibility for the behavioral health program functions (treatment funding, the Treatment Locator, N-SUMHSS, opioid response, and crisis services) that NSDUH data informs; the survey-stewardship function moves and the program-administration function stays.

(d) **Workforce.** Remaining CBHSQ technical staff supporting NSDUH carry their grade, classification, and analytic assignments into the reauthorized agency without administrative reclassification. The NSDUH contractor relationship transfers with the survey, and the workforce-continuity question raised by the April 2025 RIF is the question the receiving-agency configuration is designed to answer: a durable federal-statistical-infrastructure home rebuilds the analytic team around the contractor relationship rather than around an operational team that has already been removed.

(e) **Budget line.** NSDUH funding is preserved as a separate appropriation line within the reauthorized agency, with funding adequate to maintain the survey at full sample size and methodological continuity. A consolidated appropriation that gives the reauthorized agency's Director discretion to reallocate funds between NSDUH and the rest of the agency would reproduce the durability-vulnerability pattern that the receive-into-AHRQ proposal is designed to resolve.

Responsible entity: Congress, with implementing roles for HHS, SAMHSA, AHRQ, and the NSDUH contractor. **Mechanism:** Legislation, within the AHRQ reauthorization vehicle proposed in Recommendation 1. **Timeline:** Requires legislation. Administrative transition planning, including engagement with SAMHSA, CBHSQ, the NSDUH contractor, and state behavioral health agencies, can and should begin before legislation moves.

Cross-cutting connection: NSDUH is the household-survey leg of the integrated behavioral health data architecture that the SAMHSA recommendation of the Brief Agency Entries section establishes; the recommendation's directive on linking NSDUH estimates with claims-based treatment utilization and overdose surveillance is unaffected by the relocation and is operationalized through the reauthorized AHRQ's CMS partnership established in Recommendation 4. The April 2025 SAMHSA RIF is a cross-section flag for the Research Integrity and Scientific Freedom cross-cutting section as an institutional-scale instance of the structural-protection problem; the receive-into-AHRQ proposal is the agency-specific application of the cross-cutting section's structural-protection argument.

National Center for Health Statistics

NCHS produces the foundational data on which the federal evidence enterprise depends. The resources and institutional architecture supporting that work have not kept pace.

Diagnosis

The National Center for Health Statistics (NCHS) is the federal government's principal health statistics agency. It produces vital statistics on every birth and death in the United States, runs the National Health Interview Survey (NHIS, the country's primary source of self-reported health and access information) and the National Health and Nutrition Examination Survey (NHANES, the only federal survey that combines interviews with physical examinations and laboratory tests), maintains the National Death Index (NDI, the standing infrastructure researchers use to follow study cohorts to mortality outcomes), and runs federal surveys of hospitals, ambulatory care providers, and long-term care providers. NCHS is one of the thirteen principal federal statistical agencies recognized by the Office of Management and Budget under the Confidential Information Protection and Statistical Efficiency Act of 2018 (CIPSEA, the federal statute that protects statistical data from non-statistical uses), and the Statistical Policy Directives, particularly OMB Directive No. 1 and the binding October 2024 Final Rule that codified it, apply to NCHS alongside the Bureau of Labor Statistics, the Census Bureau, and the National Center for Education Statistics, giving statistical-agency releases methodological independence and release-schedule integrity.

The most important questions about American health are answered by combining what NCHS measures about the population with what other federal agencies measure about the care system. How long do people live, and what care did they receive before they died? How does a population's self-reported health relate to what its hospital system records? How do measured rates of chronic disease compare to what insurance claims show as treated? Each requires NCHS data on one side of the linkage and Agency for Healthcare Research and Quality (AHRQ) or Centers for Medicare & Medicaid Services (CMS) data on the other.

NCHS sits in an unusual posture relative to the other agencies in this Blueprint. Its technical reputation has historically been preserved across administrations, and policymakers do not debate it the way they debate the Centers for Disease Control and Prevention (CDC) or the National Institutes of Health (NIH). The August 2025 dismissal of the Bureau of Labor Statistics Commissioner and active proposals on CDC reorganization and statistical-agency restructuring have shifted NCHS's political risk profile from purely derivative to partly direct. The diagnosis is therefore about an agency whose foundational role in the federal evidence enterprise has outgrown the structural conditions in which it currently operates, and whose protections have not kept pace with the evolving political environment.

Three structural conditions warrant attention.

1. The integration of NCHS and AHRQ data assets is where the most consequential federal health research happens, and the institutional architecture has not caught up. The Medical Expenditure

Panel Survey (MEPS), AHRQ's flagship survey of health care use and expenditures, draws its sample from NHIS respondents. The Healthcare Cost and Utilization Project (HCUP), AHRQ's hospital encounter database, is linked to the NDI project by project to produce post-discharge mortality outcomes, but the linkage is not standing infrastructure. NHANES measures conditions in a representative population sample; HCUP records hospital encounters for the same conditions; comparative analyses connecting them depend on bespoke linkage agreements rather than routine joint products. **None of these linkages is impossible today, but each is slower, more resource-intensive, and less methodologically integrated than the federal evidence enterprise increasingly requires, and the methodological communities operating these assets pay an ongoing bespoke-linkage tax that integrated infrastructure would remove.**

2. NCHS has been chronically underfunded, and survey response rate decline compounds the funding problem. The agency's FY 2024 enacted budget was $187,397,000, flat with FY 2022 and FY 2023, making NCHS the fifth-largest of the thirteen principal federal statistical agencies but small relative to the scope of what it operates. The American Statistical Association documents a 16 percent decline in NCHS purchasing power from FY 2009 to FY 2025, with the FY 2026 President's Budget Request implying a 24 percent decline from the FY 2009 baseline if enacted, alongside a 10 percent staff reduction through September 2025. Survey response rates have declined sharply: the NHANES interview response rate fell from 51.0 percent in the 2017-March 2020 pre-pandemic cycle to 34.6 percent in the August 2021-August 2023 cycle, with the examination response rate falling to 25.7 percent, and NHIS final Sample Adult response rates have stabilized in the high-40-percent range (47.7% in 2022, 47.9% in 2024) after dropping during the early COVID-19 period from the roughly 60 percent achieved before the 2019 questionnaire redesign. The decline is broader than NCHS, a pattern ASPE documented across seven major HHS surveys through 2014 and that peer-reviewed analyses show worsened sharply in the early pandemic period, with the steepest declines among lower-income and lower-education populations. The surveys remain irreplaceable for questions emerging data sources cannot answer: subgroup-level prevalence in populations not captured in clinical encounters, physical examination measurements, dietary intake, and directly measured environmental exposures. **Sustaining the value of what the surveys produce now depends on both adequate funding for the surveys themselves and integration with complementary data sources, which has shifted from a forward-looking opportunity to a methodological necessity.**

3. NCHS depends on cooperative relationships with state, territorial, and city vital records jurisdictions, and those relationships are under-resourced for the work the modern federal evidence enterprise asks of them. The National Vital Statistics System (NVSS) is the oldest cooperative federal-state data system in the country. NCHS does not collect birth and death records directly. It receives them from fifty-seven jurisdictions, each operating on its own statutory framework, technology, and budget. The federal vital statistics system is only as current and complete as its slowest contributing jurisdiction. NCHS, working with the Office of the National Coordinator for Health Information Technology (ONC), has invested in modern technical infrastructure including Fast Healthcare Interoperability Resources (FHIR, the technical standard for exchanging health data) implementation guides for vital records exchange. State implementation remains uneven. The bottleneck is funding, governance, and incentive structures, not technical knowledge. **Without sustained funding, a national governance framework, and durable adoption incentives, the**

federal vital statistics system continues to produce uneven data on the slowest jurisdictions' timeline.

Recommendations

The four recommendations below respond to the three structural conditions in sequence: protect current NCHS functions and funding (Recommendation 1); relocate NCHS into the reauthorized Agency for Healthcare Research and Quality so its data assets can be operationally integrated with AHRQ's (Recommendation 2); establish the funding authority and federal-state architecture required to modernize vital statistics at scale (Recommendation 3); and give NCHS an explicit mandate and dedicated resources to integrate emerging data sources with the traditional survey and vital statistics infrastructure (Recommendation 4). Recommendation 1 can begin under existing executive authority in the first year under new leadership, with statutory protections following through legislation. Recommendations 3 and 4 combine administrative action that can begin in the first year under existing authority with statutory authority that follows. Recommendation 2 requires legislation and is bound to the AHRQ reauthorization vehicle established in the AHRQ section. Because the protections in Recommendation 1 are drafted to advance independently of the AHRQ reauthorization vehicle, a delay in the reauthorization postpones the data integration that Recommendation 2 secures without leaving NCHS's statistical-agency protections unaddressed.

1. Keep NCHS staffed and funded, and protect its statistical releases from pre-publication political review.

The HHS Secretary, the CDC Director, and the NCHS Director should ensure that NCHS staffing is at the level required to operate the agency's statistical programs, that appropriated funds reach NCHS in full, and that the publication schedule and methodological integrity of NCHS releases are protected from pre-publication political review or delay.

NCHS does not face the documented political vulnerability that justifies expansive appointment-protections regimes at agencies like AHRQ or NIH, but the political environment for federal statistical agencies has shifted. The August 2025 dismissal of the Bureau of Labor Statistics Commissioner and active proposals on CDC reorganization and statistical-agency restructuring make targeted statutory protections appropriate.

Four statutory protections deserve consideration, drawing on the framework in the American Statistical Association's *The Nation's Data at Risk: 2025 Report*. First, codify NCHS's release schedule, with a requirement that releases occur within their announced windows; any departure must be accompanied by a published statement of methodological cause at the time the window is missed, so that the cause is on the record rather than asserted afterward. Second, establish an NCHS Director appointed by the Secretary for a fixed term of five years, with statutory qualification requirements in statistics or a related field and removable by the Secretary only for cause, with the statute stating that the office is an inferior one; appointment by an at-will Secretary is what allows the for-cause protection to stand as a single layer after *Trump v. Slaughter*, and the position is therefore not made Senate-confirmed. The term is anchored to the Census Director (5-year term under 13 U.S.C. § 21) as the primary comparator and the Bureau of Labor Statistics Commissioner (4-year term under 29 U.S.C. § 1) as a secondary reference. The

rest of the design follows Legislative Proposal 2: any removal requires a written statement of specific reasons transmitted to the committees of jurisdiction and published, with a defined notice period; during any contested removal, the deputy director serves as acting director without authority over methodology, release schedules, or statistical-data confidentiality decisions. After relocation under Recommendation 2, the Director remains appointed and removable by the Secretary rather than by the AHRQ Director, so the two offices' protections sit side by side rather than stacked. This structure parallels the AHRQ Director design in the AHRQ section's Recommendation 1 and sits in the statistical-and-evaluation tier of the protection architecture in the cross-cutting Research Integrity and Scientific Freedom section. Third, require that any release that slips outside its announced window without a published methodological cause be recorded, with the cause and the responsible decision-maker identified, in the annual Federal Health Evidence Report to the committees of jurisdiction and reported to the Chief Statistician of the United States, with Government Accountability Office (GAO) review available on the committees' request. Fourth, protect the senior NCHS scientific staff with delegated authority over methodological decisions and statistical release content through the competitive-service and whistleblower protections the Research Integrity and Scientific Freedom section proposes for the federal science workforce (Recommendation 5), rather than through removal protections of the kind *Slaughter* has narrowed.

The National Death Index warrants specific protection. NDI access is the standing infrastructure that researchers across federal agencies, academic institutions, and federally funded studies rely on to follow cohorts to mortality outcomes. Disruption of NDI access cascades into every long-running clinical and observational study that depends on it. Continuity of NDI operations, including standard turnaround times for researcher requests, should be an explicit operational priority.

Responsible entity: HHS Secretary; CDC Director; NCHS Director; Congress for the statutory protections. **Mechanism:** Administrative action under existing authority and agency policy in the near term; statutory amendment to the Public Health Service Act for the codified release schedule, the Director's term and removal design, GAO reporting, and staff protections. **Timeline:** Administrative action within the first year under new leadership; statutory protections require legislation.

Cross-cutting connection: The release-integrity and statistical-agency-protection elements here are part of the broader pattern of statistical-agency-release protections that applies across the federal evidence enterprise. The NCHS Director protection structure (second element above) sits in the statistical-and-evaluation tier of the three-tier federal evidence-function protection architecture, paired with the AHRQ Director on the same fixed-term layered removal design and the same Census Director comparator. The cross-cutting Research Integrity and Scientific Freedom section carries the federal-evidence-enterprise-wide articulation of the tiered architecture.

2. Move NCHS into the reauthorized Agency for Healthcare Research and Quality, with the NCHS name, methodological identity, principal-federal-statistical-agency protections, and cooperative relationships preserved by statute.

Recommendations 3 and 4 stand on their own merits regardless of where NCHS sits and should not depend on this recommendation succeeding. The funding architecture, the federal-state vital records modernization program, the integration mandate, and the equity-evaluation requirement operate on their own merits and on their own statutory paths.

The AHRQ section of this Blueprint proposes legislation that reauthorizes the Agency for Healthcare Research and Quality with a substantially expanded statutory mandate: Secretary-appointed director with a fixed term and for-cause protection under the post-*Slaughter* design, authorized funding floor, mandatory grantmaking timelines, anti-impoundment provisions, CIPSEA recognition for the agency's statistical activities, and codified United States Preventive Services Task Force protections. NCHS should be received into the reauthorized agency at the time of the reauthorization, with statutory protections for the principal-federal-statistical-agency function carried forward through the same enabling legislation.

The affirmative case for relocation, on data-asset-integration grounds. NCHS and AHRQ data assets are already complementary as described in the diagnosis. The four named linkage examples (NHIS-MEPS sampling; HCUP-NDI mortality follow-up; NHANES-HCUP condition-encounter comparison; CAHPS-NHIS patient-experience integration) are not abstractions: the diagnosis describes their present state, one standing dependency and three bespoke or prospective linkages, and integration replaces negotiation with routine joint production for all four. The methodological communities that operate these surveys are stronger together than separately. Receiving NCHS into the same institutional home does not change what either NCHS or AHRQ produces. It removes the bespoke-linkage tax that the methodological communities currently pay and creates the operational conditions for integrated statistical products that the field has called for across the 2023 National Academies *Toward a 21st Century National Data Infrastructure* series.

Receiving NCHS into the reauthorized agency also creates operational adjacency for a coherent statutory-protection architecture across the integrated data assets. NCHS is one of the thirteen principal federal statistical agencies recognized under CIPSEA; AHRQ's Center for Financing, Access, and Cost Trends is not among the sixteen CIPSEA-recognized agencies and units. The reauthorization extends CIPSEA recognition to AHRQ's statistical activities, and consolidating NCHS into the agency at the same legislative moment unifies the statistical-data-confidentiality architecture across NHIS, MEPS, NHANES, HCUP, CAHPS, NDI, and the federal-state vital records data the agency would receive. This is an integration that has not previously existed in the federal statistical system at this scale.

The affirmative case that principal-federal-statistical-agency independence is preserved under the reauthorized agency. The most consequential structural concern about the relocation is that NCHS would lose the protections that make it a principal federal statistical agency: CIPSEA designation, Statistical Policy Directive protections, methodological independence over data collection design and release schedule, statistical-data confidentiality firewalls between statistical and administrative uses. The concern is reasonable and the answer is structural, not aspirational. Principal-federal-statistical-agency designation under CIPSEA attaches to the agency function under OMB rules, not to its organizational parent. The OMB Statistical Policy Directives apply to the statistical activity itself. The Bureau of Labor Statistics sits within the Department of Labor; the Census Bureau sits within the Department of Commerce; the National Center for Education Statistics sits within the Department of Education. None of these placements compromises the statistical-agency protections of the unit. NCHS's protections do not depend on its position within CDC. They depend on its CIPSEA designation under the Confidential Information Protection and Statistical Efficiency Act of 2018, on its Statistical Policy Directive No. 1 recognition, and on the October 2024 binding Final Rule that codifies the fundamental responsibilities of recognized statistical agencies and units across the federal statistical system.

Relocation into the reauthorized agency, with the protections preserved by statute in the enabling legislation, is structurally equivalent on these dimensions. The enabling legislation must do this work explicitly, not implicitly: the bill must affirmatively preserve NCHS's CIPSEA designation, Statistical Policy Directive recognition, statistical-data confidentiality protections, and the Director's authority over methodology and release timing, with statutory language at least as protective as what governs NCHS today.

Five-element transition plan. The transition mechanics required to honor the preservation conditions must be specified in the enabling legislation rather than delegated to administrative implementation. Where administrative implementation has carried the burden at recent federal-data-agency transitions, the consequences have been documented losses of methodological capacity, workforce attrition, and disrupted cooperative relationships. The most visible recent instance is the 2019 attempted relocation of the Economic Research Service to Kansas City, during which most ERS staff did not move and methodological-capacity losses were sustained across the agency. Specifying the transition mechanics in statute is the structural protection that the cooperative-federal-state vital records relationships, the principal-federal-statistical-agency function, and the NCHS workforce all require. The five elements below parallel the AHRQ-side transition mechanics in the AHRQ section Recommendation 7.

(a) **Brand and identity.** NCHS continues as a named principal federal statistical agency unit within the reauthorized agency, with its publication imprint, methodological standards, and external identity preserved in statute. NCHS has a sixty-five-year reputation as the nation's principal health statistics agency, and the brand is itself part of the response-rate-and-trust infrastructure on which the surveys depend.

(b) **Methodological independence.** The NCHS Director retains statutory authority over methodology, release schedule, and statistical-data confidentiality, with the reauthorized agency's Director excluded from those decisions. The NCHS Director reports to the reauthorized agency's Director on administrative matters and to OMB on statistical-policy matters consistent with current OMB Statistical Policy Directive arrangements. CIPSEA designation, Statistical Policy Directive recognition, and the firewall between statistical and administrative uses of NCHS data carry into the reauthorized agency without modification.

(c) **State, territorial, and city vital records cooperative relationships.** Existing cooperative agreements, funding flows, data-sharing protocols, and methodological consultation arrangements between NCHS and the fifty-seven vital records jurisdictions are preserved through statutory transition language. The transition cannot be the occasion for renegotiation of those relationships, which state vital records officers and the National Association for Public Health Statistics and Information Systems (NAPHSIS) would correctly read as a threat to NAPHSIS-coordinated federation. Transition design must engage NAPHSIS and individual state vital records officers from the outset.

(d) **Workforce.** NCHS staff carry their grade, classification, statistical-agency-specific personnel arrangements, and methodological assignments into the reauthorized agency without administrative reclassification. The reauthorization cannot be the occasion for restructuring NCHS positions.

(e) **Budget line.** NCHS funding is preserved as a separate appropriation line within the reauthorized agency, with the multi-year funding authority for vital statistics modernization established in Recommendation 3 carrying over into the consolidated agency. A consolidated appropriation that gives the reauthorized agency's Director discretion to reallocate funds

between NCHS and the rest of the agency would reproduce the chronic-underfunding pattern the diagnosis identifies.

Census Bureau operational role. The Census Bureau's operational role in conducting NHIS data collection on behalf of NCHS under Title 13 U.S.C. Section 8(b) should carry forward without disruption. Where MEPS sample selection draws on NHIS respondents, the corresponding Census operational role on the MEPS side should likewise carry forward. The reauthorization is an opportunity to make these inter-agency operational relationships more durable through standing statutory recognition rather than continued reliance on memoranda of understanding alone.

Fallback if the reauthorization does not advance. The relocation proposed here is an integration and efficiency measure. It removes the bespoke-linkage tax and unifies the statistical-data-confidentiality architecture across the combined assets. It is not the mechanism that protects NCHS. The protections that make NCHS a principal federal statistical agency attach to the statistical function under CIPSEA, Statistical Policy Directive No. 1, and the October 2024 Final Rule, not to the agency's organizational parent, and they remain in force whether or not the reauthorization advances. Three things therefore hold NCHS in the interim, none of them contingent on the AHRQ vehicle. First, the statutory protections in Recommendation 1 (a codified release schedule with a published cause required at the time of any departure, a Secretary-appointed Director serving a fixed term with for-cause protection under the design in Legislative Proposal 2, GAO reporting that names the responsible decision-maker when a release slips outside its announced window, and competitive-service and whistleblower protection for senior scientific staff with delegated authority over methodology and release content) should be drafted as freestanding amendments to the Public Health Service Act rather than as provisions of the reauthorization, so that they can advance on any available legislative path and are not forfeited if the reauthorization stalls. Second, the release-schedule integrity, the obligation of appropriated funds in full, and continuity of National Death Index operations in Recommendation 1 can be established administratively in the first year under existing authority and hold regardless of the vehicle. Third, the data-integration benefit that relocation would secure can be pursued in the interim through a standing NCHS-AHRQ data linkage agreement and jointly published linked products under existing interagency authority, converting the bespoke, project-by-project linkages into routine infrastructure without waiting on statutory relocation. Under this structure, the reauthorization changes where the integration happens and how cleanly the confidentiality architecture is unified. If it is delayed, it does not leave NCHS more exposed than it is today.

Responsible entity: Congress, with implementing roles for HHS, CDC, the reauthorized agency, the NCHS Director, OMB (for the CIPSEA and Statistical Policy Directive carryover), and state vital records jurisdictions and NAPHSIS. **Mechanism:** Legislation; the same vehicle that reauthorizes AHRQ in the AHRQ section. **Timeline:** Requires legislation. Administrative transition planning, including engagement with state vital records officers and NAPHSIS, can and should begin before legislation moves.

Cross-cutting connection: The data-asset-integration argument that anchors this recommendation belongs in the Align and Coordinate the Federal Evidence Enterprise cross-cutting section. The state vital records preservation language belongs in coordination with the State Evidence Capacity cross-cutting section. The principal-federal-statistical-agency-independence-preserved-under-relocation argument is a federal-evidence-enterprise-wide question and may also belong in the Align and Coordinate section.

3. Establish multi-year funding authority for NCHS modernization and a national governance framework for vital statistics, with milestone-based federal-state funding and direct support for cause-of-death data quality.

Modernization at the scale the federal evidence enterprise requires cannot be sustained on year-by-year appropriations. Congress should establish multi-year funding authority for NCHS modernization, covering the agency's internal infrastructure (statistical computing, data processing, dissemination platforms, data linkage capability) and the federal-state vital records modernization program.

A national governance framework is the structural complement to multi-year funding. NCHS, NAPHSIS, state vital records jurisdictions, and ONC should operate within a defined governance structure with shared roadmaps, harmonized data and software standards, common interoperability requirements, and published progress reporting. The governance framework should be tasked with setting the milestones the federal-state funding program rewards. The 2023 National Academies report on building a 21st century national data infrastructure and the companion report on enhancing survey programs using multiple data sources provide the substantive template, building on the 2009 NRC workshop on the Vital Statistics Cooperative Program.

The federal-state vital records modernization program should pay state, territorial, and city jurisdictions meaningful dollars for hitting specified milestones: nationwide electronic registration of births, deaths, and fetal deaths; FHIR-based exchange using the Vital Records Death Reporting and Birth and Fetal Death Reporting Implementation Guides; sub-30-day provisional mortality reporting from event to release as a programmatic milestone, building on the timeliness gains NCHS demonstrated during the COVID-19 pandemic provisional-mortality response; and specified completeness thresholds for race, ethnicity, geography, occupation, and cause-of-death coding. The program should pair the milestone-incentive structure with floor-level capacity grants for jurisdictions in the bottom quartile of vital records system capacity, including U.S. territories and historically under-resourced jurisdictions.

Cause-of-death data quality deserves direct attention as a distinct workstream. NCHS should fund standardized cause-of-death certification training for clinicians and certifiers, support modernization of medical examiner and coroner case management systems, and run systematic quality assurance and validation against the resulting mortality data.

Responsible entity: Congress for multi-year funding authority and conditional funding alignment; HHS Secretary, CDC Director, NCHS Director, ONC for program design and operation, in coordination with NAPHSIS and state vital records jurisdictions. **Mechanism:** Authorizing legislation for multi-year funding authority and conditional funding alignment; budget request and administrative action for program design, certification training, federal technical assistance, and the governance framework; agency policy for the state scorecard. **Timeline:** Administrative action and budget request in the first year under new leadership; multi-year authority and conditional funding alignment require legislation.

Cross-cutting connection: This recommendation operates in concert with the vital statistics modernization recommendation in the Data Infrastructure Modernization cross-cutting section. The state-incentives architecture and federal technical assistance corps belong in coordination with the State Evidence Capacity cross-cutting section.

4. Establish a clear NCHS mandate and dedicated funding for integrating emerging data sources with the traditional survey and vital statistics infrastructure.

The mandate is to evaluate, develop, and operate the integration of electronic health records, claims data, and other emerging data sources with the traditional survey and vital statistics infrastructure NCHS already runs. The mandate is not a replacement for the surveys; it gives NCHS the authority and the resources to do at scale the linkage and integration work the agency has demonstrated on a project-by-project basis for years. It also directs the agency to modernize how it collects: NHANES in particular is an irreplaceable resource whose examination component is costly and slow to field, and the mandate should include a published plan, on a fixed timeline, for lower-burden designs that combine administrative records, multimode interviewing, and targeted examination components without sacrificing the representativeness that gives the survey its authority.

The mandate should include five specific functions. First, expanded operation of the existing NCHS data linkage portfolio (linkages to Medicare and Medicaid claims, Social Security Administration records, the NDI, Department of Housing and Urban Development (HUD) records, Department of Veterans Affairs (VA) records, and others), shifting from project-by-project resource allocation to standing program infrastructure. Second, methodological evaluation of the representativeness, validity, and bias characteristics of emerging data sources relative to nationally representative surveys, published as a public research agenda. Third, equity evaluation as a routine condition of integration: every emerging data source NCHS proposes to integrate carries a published bias assessment by race, ethnicity, age, geography, and insurance status before being used in NCHS releases. Fourth, expanded data-sharing authorities, governed by privacy protections at a level of specificity at least equivalent to CIPSEA, that allow NCHS to integrate appropriate data sources without case-by-case legal review of every linkage. Fifth, partnership with the HHS Chief Data Officer and the Office of the Assistant Secretary for Planning and Evaluation (ASPE, the HHS office responsible for cross-departmental evaluation, planning, and Evidence Act implementation) on the Federal Statistical Research Data Center model and the National Secure Data Service architecture.

The accuracy-and-timeliness tension that runs through all data modernization deserves direct acknowledgment. Faster data sometimes means less complete data; complete data sometimes means slow data. NCHS has historically chosen accuracy. The integration mandate does not require NCHS to abandon that choice. It requires NCHS to develop the methodological judgment about when faster, less complete, complementary data is the right input and when the slower, more complete survey or vital statistics data remains irreplaceable.

Responsible entity: NCHS Director; HHS Chief Data Officer; ASPE. **Mechanism:** Administrative action and budget request for program expansion and the public research agenda; authorizing legislation for expanded data-sharing authorities and the CIPSEA-equivalent privacy regime. **Timeline:** Administrative action and budget request can begin in the first year under new leadership; statutory data-sharing authorities require legislation.

Cross-cutting connection: The privacy-preserving record linkage architecture and the relationship to the Federal Statistical Research Data Centers and the National Secure Data Service belong in the Data Infrastructure Modernization cross-cutting section. The methodological evaluation of emerging data sources relative to traditional surveys connects to the Research Integrity and Scientific Freedom cross-cutting section.

Department of Veterans Affairs

The federal government operates only one health system at scale, and that system has spent decades building the research infrastructure required to learn from its own care. The Blueprint's task is to specify what it will take to keep that capacity intact and to make what it produces available to the rest of the federal evidence enterprise.

Diagnosis

The Department of Veterans Affairs operates the largest integrated health care delivery system in the United States, with approximately 9.1 million veterans enrolled and care delivered through 170 medical centers and roughly 1,200 outpatient sites. The VA is the only federal entity that is simultaneously a payer, a provider, and an evidence generator at scale, with a research enterprise embedded inside the delivery system it studies. That structural position makes the VA the federal government's only at-scale operational *learning health system* (a system in which data from routine care continuously informs how that care is delivered, with research, implementation, and quality improvement integrated as a single function).

The federal evidence enterprise depends on the VA for evidence other agencies cannot generate: long-horizon effectiveness studies in a stable enrolled population, embedded pragmatic trials in routine clinical operations, and implementation evidence about how findings move into practice at scale. Two intramural programs make this function operational. The Health Services Research and Development Service (HSR&D, recently renamed Health Systems Research) is the VA's principal health services research program; it funds research on how the delivery system performs. The Quality Enhancement Research Initiative (QUERI) is the VA's implementation science program, the study of how proven interventions are adopted into routine practice; it translates findings into clinical care. The Million Veteran Program (MVP, the VA's biorepository linked to clinical care data, with one million participating veterans) and the Cooperative Studies Program (the VA's clinical trials infrastructure) extend the loop to genomic and prospective evidence generation.

Four structural conditions weaken that infrastructure today.

- **HSR&D is funded as a discretionary line, not as a federal evidence function.** HSR&D operates within the Veterans Health Administration's Research and Development account, with annual appropriations set at the account level rather than at the service level. The Senate Appropriations Committee's FY2025 bill provided $878 million for Medical and Prosthetic Research across the four research services, with VA setting internal allocation. HSR&D's intramural budget has been characterized by senior VA leadership as approximately $100 million in 2018, with the broader Health Systems Research portfolio at approximately $127 million by 2024. The configuration that funds HSR&D was not designed to protect a federal evidence function and treats the program as a candidate for reallocation when operational priorities compete with research, even when the research is the operational priority's own evidence base. **The impact: the only embedded federal learning-health-system research**

program operates without a budget structure that recognizes the federal interest in what it produces.

- **The electronic health record (EHR) transition puts the continuity of the longitudinal research record at risk unless it is managed for research as well as for care.** The Veterans Health Administration is mid-transition from its long-standing Vista EHR to a commercial Oracle Health platform (formerly Cerner Millennium), with repeated implementation pauses and a programmatic reset reflected in the FY2025 EHR appropriations reduction. VA research has historically depended on a longitudinal record stretching back decades through the Corporate Data Warehouse (CDW, the VA's enterprise repository of clinical data) and the VA Informatics and Computing Infrastructure (VINCI, the secure research computing environment that gives investigators access to that data). **The impact: at every site where the new platform is deployed, the longitudinal record breaks, putting decades of accumulated evidence-generation capacity at risk.**
- **VA research operates on time horizons that are a feature of its value and a target of political pressure.** Long-horizon studies of treatment effectiveness, implementation outcomes, and chronic-disease trajectories in a stable enrolled population are part of what makes VA evidence valuable to the rest of the federal evidence base. Senior HSR&D leadership has characterized the resulting tension: VA research is driven by long-term issues rather than the needs of the moment, even though the system is often under public and oversight scrutiny on timelines policymakers do not align with research timelines (see also Garrido and Kilbourne 2024 on QUERI as the VA's learning health system). **The impact: the long-horizon studies that produce some of the most distinctive federal evidence assets have no structural protection against short-horizon redirection.**
- **VA research authority under 38 USC sits outside the protections proposed for federal research agencies operating under 42 USC.** The Blueprint proposes three kinds of protection for HHS research agencies: appointment and removal protections for research leadership, procedural protections for peer review and agenda-setting, and public-access requirements that do not depend on case-by-case clearance. None has a parallel in Title 38 of the U.S. Code, which governs veterans' programs (HHS research agencies operate under Title 42, the public health title). The asymmetry matters because the VA is the federal entity where the case for research-independence protections is most acute: an integrated delivery system whose research is operationally embedded in the system it studies needs structural insulation that arms-length research relationships do not require to the same degree. **The impact: the only federal entity that conducts research inside an integrated delivery system at scale operates with the weakest formal protections for the independence of that research.**

These four conditions are shaped by a structural reorganization announced in December 2025. Per subsequent reporting on the plan, it consolidates the Veterans Integrated Service Networks (VISNs, the regional structures that oversee groups of VA medical centers) from 18 to 5 and introduces Health Service Areas and a Medical Operations Center as new layers between Central Office and the field, eliminates the Chief Operating Officer role, and routes Central Office staff to the Under Secretary for Health or one of two deputies. Implementation runs over 18 to 24 months beginning in early 2026. The recommendations below are designed against the post-reorganization Veterans Health Administration and assume the VA keeps providing care directly. Recommendations 1, 2, 5, and 6 address evidence functions that would need protection under any feasible configuration, including the one that emerges

as Health Service Areas and the Medical Operations Center come online. Recommendations 3 and 4 assume direct provision and would need restructuring if the VA's role shifted toward purchasing care.

Recommendations

Six recommendations follow. Three are essential structural protections: Recommendation 1 protects HSR&D's institutional foundations as a federal evidence function, Recommendation 2 protects the data assets and the longitudinal research record through the EHR transition, and Recommendation 5 establishes the statutory protections required to address the 38 USC / 42 USC asymmetry. Three are operational extensions: cross-system data linkage for dual-eligible veterans, formal participation in federal evidence coordination architecture, and standing mechanisms for transferring portable VA evidence to non-VA settings. The structural protections are what make the operational extensions worth building. Recommendations 2, 3, 4, and 6 can be initiated under existing executive authority; Recommendations 1 (codification), 4 (joint funding authority), and 5 (statutory protections) require legislation.

1. Protect HSR&D's budget, organizational placement, and operational independence so the only at-scale federal learning health system can keep functioning.

The Secretary of Veterans Affairs and the Under Secretary for Health should establish a structural designation for HSR&D that ties its resourcing and operational independence to the federal evidence functions it performs. The designation should specify three things. First, a base funding level for HSR&D adequate to sustain its investigator-initiated portfolio, its career development award infrastructure, and its embedded research operations across VA medical centers. Second, an organizational placement within the post-reorganization Veterans Health Administration that maintains a direct reporting line for the HSR&D director to the Chief Research and Development Officer and the Under Secretary for Health, not routed through Health Service Areas, the Medical Operations Center, or any intermediate operational layer, with operational independence from program offices whose performance HSR&D research evaluates. Third, procedural protections for the HSR&D director's authority to set the research agenda, award peer-reviewed funding, and report findings publicly, including a firewall between political appointees and the scientists who serve on HSR&D merit review panels and a requirement that any modification of HSR&D findings prior to public release be documented and explained. Political leadership properly sets the priorities of the research agenda; the firewall applies to the review of individual studies and the integrity of findings.

Congress should codify the structural designation in authorizing legislation, including the funding floor, the reporting structure, and the procedural protections, so that the protections do not depend on any single administration maintaining them. Two things hold the line before codification and after it. Before: the designation should be issued as a published directive that names the reporting line by title and provides that any reorganization altering it takes effect only after 90 days' notice to the House and Senate Veterans' Affairs Committees with a written statement of the reason, so that rerouting cannot happen quietly. After: the statute should provide that a reorganization which routes the HSR&D director's reporting line through any intermediate operational layer is without effect for the purposes of HSR&D's funding floor and agenda-setting authority until Congress has been notified and the notice

period has run. The VA is the setting where research independence is most acute, because the research is embedded in the system it evaluates, and it is also where the protections are most deferred to legislation; the notice-and-effect design closes that gap in the interim.

Responsible entity: Secretary of Veterans Affairs; Under Secretary for Health; Chief Research and Development Officer; Congress (for codification). **Mechanism:** Administrative action under existing authority for the structural designation, reporting line, procedural protections, and the published notice requirement; budget request for the funding floor; authorizing legislation for codification and the reorganization notice-and-effect provision. **Timeline:** Designation established within the first year under new leadership. Codification carried in the Legislative Proposals section.

Resilience note: In a cooperative environment, the directive and the funding floor do the work. In a noncooperative one, the notice requirement is what survives: a reorganization that reroutes HSR&D must be announced to the Veterans' Affairs Committees before it takes effect, which converts a quiet administrative change into a public one the committees can act on.

Cross-cutting connection: The procedural protections for the HSR&D director's authority parallel protections proposed for NIH and AHRQ leadership and belong in the Research Integrity and Scientific Freedom cross-cutting section. The clinician-investigator pipeline question is flagged to the Evidence Workforce Development cross-cutting section.

2. Treat VA data assets as a national research resource, with continuity through the EHR transition and external access governance fit to the federal evidence enterprise.

The Secretary of Veterans Affairs, the Under Secretary for Health, and the Chief Research and Development Officer should formally designate VA's research data infrastructure as a national research resource, with structured access for federally funded researchers outside the VA. That infrastructure includes the Corporate Data Warehouse, the VA Informatics and Computing Infrastructure, the Million Veteran Program data channels, and the research data layer being built on the new Oracle Health record.

The designation should be paired with an **EHR transition bridging plan** that protects the longitudinal research record at every transition site.

EHR transition bridging plan

The bridging plan should include three operational components: (a) **legacy-to-new common data model mappings** between Vista-era and Oracle Health-era data within CDW and VINCI, with validated crosswalks for the variables that carry the heaviest research load (longitudinal pharmacy, laboratory, problem list, vital signs, and outcomes data); (b) **funded bridging tools** for investigators whose active studies span the transition, including a published technical architecture for the research data substrate and a designated office responsible for transition-period research data integrity (GAO-25-106874, Mar. 2025; GAO-25-108091, Feb. 2025); and (c) **a published timeline for research-grade data availability through Oracle Health at each site**, with pre-transition validation studies, post-transition data quality assessment, and a milestone-based commitment that does not slip silently as deployment dates shift.

External access governance should be redesigned to address three specific problems: project-by-project access negotiation, the absence of standardized agreements for federal researcher access, and the lack of

a published service-level commitment for data access timelines. The community care fragmentation that has accelerated under the VA MISSION Act of 2018 (the law that expanded veterans' access to community care outside VA facilities) means a growing share of veteran utilization does not appear in the VA's own data systems; CBO estimated that VHA community care costs grew from $7.9 billion in 2014 to $17.6 billion in 2021, in 2021 dollars, and post-MISSION Act growth has continued across most service lines. The data infrastructure designation should specify how the longitudinal record is reconstructed for the share of veteran care delivered through community providers. MVP enrollment representativeness should be reported routinely against the corresponding distributions in the enrolled veteran population (sex, race and ethnicity, era of service, rurality, clinical priority group), framed as a structural data-validity question.

Responsible entity: Secretary of Veterans Affairs; Under Secretary for Health; Chief Research and Development Officer; the office responsible for VA Informatics and Computing Infrastructure. **Mechanism:** Administrative action for the designation, continuity plan, bridging plan, and access governance redesign; budget request for the data infrastructure work that the EHR transition continuity plan will require. **Timeline:** Designation and access governance redesign within the first year under existing authority. Bridging plan and continuity plan implementation aligned with the EHR transition timeline at each site.

Cross-cutting connection: The Oracle Health EHR transition is part of the broader pattern of federal health data continuity risk and belongs in the Data Infrastructure Modernization cross-cutting section. The MVP representativeness reporting connects to the broader pattern of disparities-relevant data infrastructure.

3. Establish a standing VA-CMS data linkage governance framework for the dual-eligible veteran population.

The Secretary of Veterans Affairs, the CMS Administrator, and the Under Secretary for Health should establish, within the first year under existing authority, a standing governance framework for VA-CMS data linkage covering the population of veterans who are also Medicare beneficiaries. The framework should be a joint program between the VA's research data infrastructure (Health Systems Research and the VA Informatics and Computing Infrastructure) and the CMS Office of Enterprise Data and Analytics. It has three components: a standing linked dataset covering veterans enrolled in both systems, available to federally funded researchers under standardized agreements; a governance committee with representation from VA, CMS, AHRQ, and ASPE; and a published research agenda focused on questions that span both systems.

Responsible entity: Secretary of Veterans Affairs; CMS Administrator; Under Secretary for Health. **Mechanism:** Memorandum of understanding between VA and CMS; administrative action under existing data-sharing authorities. **Timeline:** Governance framework and standing linked dataset within the first year under existing authority. Research agenda development in parallel.

Cross-cutting connection: The dual-eligible linkage parallels the Medicare-Medicaid linkage in the CMS section's Recommendation 7 and belongs in cross-section integration.

A parallel data relationship runs between the VA and the Department of Defense, and it already operates at scale. The Joint Longitudinal Viewer gives clinicians at every VA and DoD facility a read-only integrated view of a patient's record across both departments, and the joint Health Information

Exchange, in operation since 2020, is the secure gateway that connects those records to community providers. These systems are built for clinical care rather than research, and the research-grade governance of cross-departmental data, why the link exists, what it should support, and how it should be improved for evidence generation, is the most operationally substantial cross-departmental coordination question outside HHS. The Align and Coordinate the Federal Evidence Enterprise section addresses that question; this section notes the existing infrastructure and the dependency rather than duplicating the discussion.

4. Establish formal VA participation in HHS-led federal evidence coordination structures and joint funding authority for cross-system research questions.

The Secretary of Health and Human Services and the Secretary of Veterans Affairs should establish, within the first year under existing authority, formal VA participation in defined HHS-led research coordination structures. The current architecture includes three bodies. The HHS Data Council is the Secretary's principal internal advisory body on data policy, co-chaired by the Assistant Secretary for Planning and Evaluation and the Director of the National Center for Health Statistics. The HHS Evidence and Evaluation Policy Council coordinates evaluation across HHS operating and staff divisions. The HHS Data Governance Body is chaired by the HHS Chief Data Officer. For comparative effectiveness research specifically, the Federal Coordinating Council established under the 2009 Recovery Act was wound down in March 2010 and its coordinating role passed to the Patient-Centered Outcomes Research Institute. VA participation should be structured against PCORI as it exists today and the ASPE-coordinated bodies above, not against the dormant 2009 council.

Congress should establish joint funding authority that allows VA, NIH, AHRQ, CDC, and other federal research entities to pool resources for research questions that span systems and that no single agency can fund on its own. The VA-NCCIH (National Center for Complementary and Integrative Health) pain management collaboratory provides a documented model: two agencies jointly funding pragmatic trials larger than the VA could fund on its own. The authority should specify the mechanism for proposing topics, the governance structure for jointly funded portfolios, and the standards for evaluating cross-system research.

Responsible entity: Secretary of Health and Human Services; Secretary of Veterans Affairs; Congress (for joint funding authority). **Mechanism:** Administrative action for participation in coordination structures; authorizing legislation for joint funding authority. **Timeline:** Participation in coordination structures within the first year under existing authority. Joint funding authority flagged for the Legislative Proposals section.

Cross-cutting connection: The broader argument about how the federal evidence enterprise coordinates across departmental lines belongs in the Align and Coordinate the Federal Evidence Enterprise cross-cutting section. The Federal Coordinating Council's termination is an additional instance of the SMRB dormancy pattern described in the NIH section, part of the broader set of lapsed statutorily chartered bodies the Research Integrity and Scientific Freedom cross-cutting section addresses.

5. Establish statutory protections for VA research authority under 38 USC that match those proposed for HHS research agencies under 42 USC.

Congress should enact statutory protections for VA research authority that address the embedded-research configuration directly. The protections should cover three structural elements. First, tenure protection for the Chief Research and Development Officer, an inferior officer appointed by the Secretary, written to the design in Legislative Proposal 2 after the Supreme Court's June 29, 2026 decision in *Trump v. Slaughter*: statutory qualification requirements, a fixed term, and removal by the Secretary only for cause, with the statute stating that the office is inferior. The protection sits at that one level deliberately. The directors of HSR&D, QUERI, MVP, and the Cooperative Studies Program report to the Chief Research and Development Officer; giving them for-cause protection as well would stack one protected inferior officer beneath another, the structure the Court struck down in *Free Enterprise Fund*, and would put the whole design at risk. Those directors are protected instead by the procedural and publication elements below and by the competitive-service protections in the Research Integrity and Scientific Freedom section. Any removal of the Chief Research and Development Officer must be accompanied by a written statement of specific reasons, transmitted to the Veterans' Affairs Committees and published, with a defined notice period before it takes effect. And during any vacancy in that office, the acting official may not alter the research agenda, peer-review panel composition, or findings pending release; a challenge to a removal neither creates a vacancy nor confers acting authority. Second, procedural protections for the conduct of research, including peer review composition, agenda-setting authority, and reporting requirements. Third, public access to research findings, including standards for publication, data sharing, and reporting that do not depend on case-by-case clearance. The second and third elements are the durable core of this recommendation: they operate on the research itself rather than on who holds the office, and they survive any narrowing of tenure protection.

The named VA research positions sit in the research-administrative tier (Tier 2) of the three-tier federal evidence-function protection architecture articulated in the cross-cutting Research Integrity and Scientific Freedom section, paired with the NIH Director and the CDC Director, without a fixed term. The architecture differs from the statistical-and-evaluation tier (AHRQ Director, NCHS Director; fixed term anchored to the Census Director comparator) because VA research leadership does not have periodic-release-schedule and principal-federal-estimate-production responsibilities. It differs from the policy-analysis tier (the ASPE model: a politically accountable leader with statutory workforce protections) because VA research leadership is structurally distant from Secretary-level policy development. The tenure design protects the named positions against unexplained dismissal while preserving the appointment accountability appropriate to research-administrative leadership embedded in an operating health system.

The diagnosis identifies the structural reason this asymmetry matters: the VA is the federal entity where the case for research-independence protections is most acute. The protections in this recommendation translate the operational and procedural protections of Recommendation 1 into statute.

Responsible entity: Congress (authorizing legislation amending 38 USC research authority, including the tenure design for the named positions); Secretary of Veterans Affairs and Chief Research and Development Officer (implementation). **Mechanism:** Authorizing legislation amending 38 USC research authority, with qualifications, reasons-to-Congress removal reporting, the interim rule, and the procedural and publication protections codified for the Chief Research and Development Officer and the

directors of HSR&D, QUERI, MVP, and the Cooperative Studies Program. **Timeline:** Requires legislation; carried in the Legislative Proposals section, including the question of how parallel statutory protections move through structurally separate congressional committees of jurisdiction.

Cross-cutting connection: The named VA research positions sit in the research-administrative tier (Tier 2) of the three-tier federal evidence-function protection architecture, paired with the NIH Director and the CDC Director; the tenure design follows Legislative Proposal 2. The cross-cutting Research Integrity and Scientific Freedom section carries the federal-evidence-enterprise-wide articulation of the tiered architecture. The statutory codification component belongs in the consolidated Legislative Proposals section, where the question of how parallel statutory protections move through structurally separate congressional committees of jurisdiction (Veterans' Affairs for VA research positions under 38 USC; Health, Education, Labor, and Pensions and Energy and Commerce for HHS research positions under 42 USC) sits.

6. Build standing mechanisms for transferring VA-generated evidence to non-VA care settings, anchored in QUERI's implementation infrastructure and honest about what does and does not translate.

The Secretary of Veterans Affairs, the Under Secretary for Health, and the AHRQ Director should establish, within the first year under existing authority, standing mechanisms for transferring VA-generated evidence to non-VA care settings. The mechanisms should include three components. First, a standing joint working group between QUERI and AHRQ's implementation science portfolio, with comparable working relationships developed with CMS's Center for Medicare and Medicaid Innovation evaluation function, HRSA's quality improvement programs, and the Indian Health Service. Second, a published portfolio of QUERI implementation findings and tools, with explicit characterization of which findings depend on VA-specific institutional features (salaried clinician workforce, integrated formulary, single payer-provider structure, stable patient population, operational EHR data substrate) and which are transferable to other federal programs and non-VA care settings. Third, a dissemination mechanism for findings determined to be transferable, including plain-language summaries sufficient for clinical and operational adoption outside the VA, building on AHRQ's evidence dissemination infrastructure.

Responsible entity: Secretary of Veterans Affairs; Under Secretary for Health; AHRQ Director; CMS, HRSA, and Indian Health Service (IHS) leadership for partner roles. **Mechanism:** Administrative action under existing authorities; budget request for any expansion of QUERI's cross-system function and for AHRQ's role in the joint working group. **Timeline:** Working group and portfolio established within the first year under existing authority. Dissemination mechanism in parallel.

Cross-cutting connection: This recommendation connects to the AHRQ section's evidence dissemination function and belongs partly in the cross-cutting section on embedding evidence in policy and practice. The implementation science capacity building dimension is flagged to the Evidence Workforce Development cross-cutting section.

Brief Agency Entries: ONC, HRSA, SAMHSA, ACF/OPRE

Section Opening

The agencies covered in full sections above are not the only federal entities that hold evidence-relevant authorities. Four others operate functions the Blueprint depends on: standards-setting for health information technology, federal health workforce analysis, behavioral health surveillance and provider data, and evaluation of social services programs. Each has been affected by structural changes in 2025 and 2026 that compound long-standing institutional vulnerabilities, and each entry below is written with both the durable structural problem and the current operational disruption in view. One principle runs through the four entries and connects them to the CMS section: the administrative data of the programs through which Americans actually receive care, Medicaid, community health centers, behavioral health services, and child and family services, is evidence infrastructure, and the Blueprint treats it that way consistently rather than only where the program is large.

The Indian Health Service and the Department of Defense Military Health System will be addressed in a follow-on set of recommendations. Tribal data sovereignty is a foundational principle that conditions the federal data architecture rather than a sub-question of "other federal evidence functions," and a substantive IHS entry requires formal tribal consultation that AcademyHealth has not yet initiated. The Military Health System holds substantial evidence-relevant data (the Defense Health Agency, the Military Health System Data Repository, and the longitudinal records that flow to the VA) but the Blueprint does not yet rest on the operational understanding required to make specific recommendations. Both entries are identified as high-priority follow-on tasks. The DoD-VA evidence interface is addressed in the VA section and the Align and Coordinate the Federal Evidence Enterprise section; this deferral concerns DoD's internal evidence functions. The Data Infrastructure Modernization and Legislative Proposals sections develop the foundational principles that the IHS entry, when drafted, will operationalize.

ONC (Office of the National Coordinator for Health Information Technology)

Diagnosis

ONC sets the federal standards that determine whether electronic health record data can move between systems and be used for research, public health, and quality measurement. It is a staff division in the Office of the Secretary, and the National Coordinator reports to the Secretary. Three federal building blocks do different jobs: one defines the data, one moves it, and one governs exchange across networks. The United States Core Data for Interoperability (USCDI) defines what data elements every certified

electronic health record (EHR) must capture. Fast Healthcare Interoperability Resources (FHIR) standards define how systems exchange it through programming interfaces, one of several ways data moves. The Trusted Exchange Framework and Common Agreement (TEFCA) is the network-of-networks framework for nationwide exchange. Information blocking rules under the 21st Century Cures Act prohibit the developers of certified health IT, health information networks and exchanges, and health care providers from interfering with the access, exchange, or use of electronic health information when the disclosure is not prohibited by law. When these standards lag or go unenforced, the consequences are concrete: clinical data captured during a pandemic or overdose wave cannot reach the public health agencies that need it, and quality measures cannot detect the disparities they are designed to surface.

The standards exist. Federal enforcement of information blocking entered an active phase in 2025–2026, with HHS Office of Inspector General (OIG) civil monetary penalties of up to $1 million per violation against developers and information networks effective since September 2023, provider disincentives under Medicare payment programs effective since July 2024, and the first letters of nonconformity to EHR developers issued in February 2026. Two different problems sit here and should not be confused. The first is enforcement: OIG and CMS, which enforce the rule, have not made public health, research, or quality reporting a stated priority, so interference with those disclosures carries little risk. The second is standards: the data elements public health reporting needs have been added to the federal content standard more slowly than clinical ones, which is ONC's work, not OIG's. A third gap is research access to clinical data itself. TEFCA (the Trusted Exchange Framework and Common Agreement), the national network-of-networks ONC oversees, defines the purposes for which participants exchange data, and research is not yet an operational exchange purpose. ONC should define one, with privacy protections consistent with the Data Infrastructure recommendations, within the first year of a leadership decision to act; Congress can make the pathway durable when it codifies the information blocking rule. Recent federal rulemaking has moved toward reducing certification burden on health IT developers. **Certification streamlining and stronger use-case-specific enforcement can and should proceed in parallel.** Streamlining certification for health IT developers and enforcing more firmly against vendors and providers who frustrate public health, research, and quality measurement are complementary, not in tension. The public bears the cost of underenforcement on these use cases; the vendor community does not.

Recommendation

The Secretary should direct OIG and CMS, which decide what to enforce, to make interference with public health, research, and quality measurement disclosures a stated enforcement priority under the existing rule. ONC, which does not enforce, should do the two things within its own authority: publish worked examples of what such interference looks like, under its education mandate, and keep adding the public health and research data elements CDC and the statistical agencies need to the United States Core Data for Interoperability on its existing schedule, which has produced seven versions in six years and works. Congress should codify the information blocking prohibition and its exceptions as they now stand in regulation, so that the standard cannot be narrowed by a future rulemaking; it should not write the update schedule into statute, where a floor becomes a ceiling. The Data Infrastructure Modernization section's Recommendation 4 carries the full design.

Responsible entity: HHS Secretary for enforcement direction; OIG and CMS as enforcing agencies; ONC for standards and education; CDC for the public health data elements; Congress for codification. **Mechanism:** Secretarial direction under existing authorities; ONC's standards and education functions; authorizing legislation codifying the existing prohibition and exceptions. **Timeline:** Administrative action can proceed under current authority; codification requires legislation.

Cross-cutting connection: The Data Infrastructure Modernization section establishes the broader federal health data architecture; this entry specifies the ONC role within it. ASPE Recommendation 1 names the HHS Chief Data Officer without reference to an office, so the post-March 2026 division of technology functions between ONC and the Office of the Chief Information Officer (OCIO) of HHS technology functions does not affect it.

HRSA (Health Resources and Services Administration)

Diagnosis

HRSA holds three federally important evidence assets. The National Center for Health Workforce Analysis (NCHWA), housed within HRSA's Bureau of Health Workforce, produces the federal estimates of supply, demand, and distribution for physicians, nurses, behavioral health workers, and other clinicians. The Uniform Data System (UDS) is the annual data report from every federally qualified health center, covering patients, services, outcomes, and costs for the safety-net population. The Area Health Resource Files combine workforce, facility, and population data at the county level for federal programs and research. When these assets are weak, federal and state policymakers cannot answer basic questions about whether enough providers are entering specific specialties, where shortages are worst, or whether federal investment is reaching the populations the safety net is designed to serve.

Federal workforce data is fragmented across HRSA, the Bureau of Labor Statistics, the Department of Veterans Affairs, and academic data sources, with no recurring interoperable reporting structure that produces a usable picture of the workforce as a system. UDS captures federally qualified health center patients, and the UDS Modernization Initiative (UDS+) now requires de-identified patient-level data submitted via HL7 FHIR R4 standards aligned with CMS electronic clinical quality measures. UDS+ does not, however, establish a standing data-linkage protocol with Medicare or Medicaid claims for outcomes analysis; linkages remain project-specific and require case-by-case data use agreements. Workforce analytic capacity at HRSA was thin relative to the magnitude of the workforce decisions that depend on it before the 2025 federal workforce reductions further eroded it, with approximately a quarter of HRSA's roughly 2,700 staff departing between February and August 2025. The FY 2026 President's Budget proposed eliminating HRSA and the March 2025 HHS reorganization proposed folding HRSA and SAMHSA into a new Administration for a Healthy America; the FY 2026 omnibus (P.L. 119-75, February 3, 2026) declined to enact those changes and provided approximately $8.95 billion in discretionary funding for HRSA.

HRSA's evidence functions extend beyond workforce data, and three of them carry consequences the Blueprint's framework treats as consequential federal decisions. First, HRSA is the statutory locus for

two sets of clinical preventive-service standards that trigger coverage. The HRSA-supported Women's Preventive Services Guidelines determine, under Section 2713 of the Affordable Care Act, what private insurance must cover for women without cost sharing. The Bright Futures periodicity schedule for children and adolescents, which HRSA supports, is incorporated the same way at 42 U.S.C. § 300gg-13(a)(3). These guidelines sit in the same consequence class as U.S. Preventive Services Task Force grades and ACIP recommendations, and they carry none of the methodological-independence protections the Blueprint proposes for those bodies. Second, the 340B Drug Pricing Program and the Organ Procurement and Transplantation Network are two of the largest federal health programs about which the evidence base is thinnest relative to the stakes. GAO has repeatedly found that HRSA lacks the data to assess how 340B savings are used or whether the program reaches the patients it was designed for (GAO-18-480 and its successors). The OPTN modernization Congress authorized in 2023 (Securing the U.S. Organ Procurement and Transplantation Network Act, P.L. 118-14; HRSA's OPTN Modernization Initiative) rests on performance data whose independence from the contractor being evaluated is itself a design question. Third, continued research access to UDS data is a live concern for those who study underserved populations: UDS public-use files and researcher access are administrative choices, not statutory guarantees, and a program that stops releasing them would end a decade of safety-net research overnight.

Recommendation

Two coordinated actions establish the federal workforce-data foundation. First, NCHWA and the Area Health Resources Files are received into the reauthorized AHRQ under Recommendation 7b of the AHRQ section, with the five-element transition plan (brand and identity, methodological independence, cooperative relationships, workforce, budget line) preserved by statute and the multi-year funding authority for NCHWA established as part of the AHRQ reauthorization vehicle. The Uniform Data System (UDS) stays at HRSA; UDS is operationally tied to the federally qualified health center grant-administration function and receiving it would disrupt that linkage. The reauthorized AHRQ provides coordination and standards for UDS without custody. Second, the reauthorized AHRQ convenes the recurring interoperable reporting structure that produces an annual federal health workforce report covering supply, demand, distribution, and equity dimensions for the major clinical and evidence workforce categories, with HRSA, ASPE, BLS, and VA as participating agencies. Equity reporting should meet, at minimum, the seven reporting categories under OMB Statistical Policy Directive No. 15 (2024 revision): American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; Middle Eastern or North African; Native Hawaiian or Pacific Islander; and White. The directive's default requirement to collect detail beyond the minimum applies, with sub-state geographic resolution where sample sizes permit. HRSA and CMS should jointly establish a standing data linkage protocol between UDS and Medicare and Medicaid claims for approved research, with privacy protections consistent with the Data Infrastructure recommendations.

Third, three HRSA evidence functions should be given the protections the Blueprint proposes for their counterparts elsewhere. The methodological framework for the Women's Preventive Services Guidelines and the Bright Futures schedule should be documented publicly, with departures requiring notice and comment before a revised guideline carries Section 2713 effect, on the design the AHRQ section's Recommendation 3 applies to the Task Force. Research access to UDS data, including public-use files and a standing linkage protocol to Medicare and Medicaid claims, should be codified as a

program requirement rather than left to administrative discretion. And HRSA should be directed to commission, through the reauthorized AHRQ's evidence-synthesis function (or, absent reauthorization, through that function at its current statutory home), standing evidence programs on 340B program performance and OPTN outcomes, using the administrative data both programs already generate, so that the two largest programs HRSA administers are evaluated on a cadence rather than by episodic GAO review.

Responsible entity: Congress for the receipt of NCHWA and ARF/AHRF into the reauthorized AHRQ and for multi-year funding authority; HHS Secretary, HRSA, AHRQ, and CMS for the UDS-claims data linkage protocol and for convening the federal health workforce report with ASPE, BLS, and VA as participating agencies. **Mechanism:** Legislation within the AHRQ reauthorization vehicle for the receipt of NCHWA and ARF/AHRF and for the multi-year funding authority; joint agency protocol and Secretarial directive for the UDS-claims data linkage protocol and the federal workforce report. Congress for codification of UDS research access and the guideline methodological framework; HRSA and AHRQ for the 340B and OPTN evidence programs. **Timeline:** The joint agency protocol and the federal workforce report convening can proceed in the first year under existing authority; legislative action follows through the AHRQ reauthorization.

Cross-cutting connection: The Evidence Workforce Development section addresses the broader pipeline questions; this entry establishes the federal workforce-data foundation that section will draw on. The data-stewardship-versus-program-administration distinction that produces the NCHWA-and-ARF-receive / UDS-stay split is one application of the federation-versus-consolidation argument carried at the federal-evidence-enterprise scale in the Align and Coordinate the Federal Evidence Enterprise section.

SAMHSA (Substance Abuse and Mental Health Services Administration)

Diagnosis

SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) runs the National Survey on Drug Use and Health (NSDUH), the federal government's primary source of national estimates on substance use, mental illness, and treatment access. SAMHSA also operates the Treatment Locator and the National Substance Use and Mental Health Services Survey (N-SUMHSS), which in 2021 merged the legacy N-SSATS and N-MHSS facility surveys. These data sources are what federal, state, and local officials use to size the behavioral health crisis and target resources. When overdose mortality spikes or youth mental health deteriorates, behavioral health data has to be timely, integrated, and granular enough for officials at every level to act. Currently it is none of those things consistently.

NSDUH provides national estimates annually rather than in real time, and methodological breaks in 2020 (partial-year collection plus introduction of web-based interviewing) and 2021 (full-year multimode collection) interrupted trend continuity at the moment overdose mortality and youth mental health were both at historic levels. Reweighted 2021 estimates released in January 2024 restored comparability with 2022 and later, but the 2019-to-2022 trend break remains. Provider data is

fragmented across program-specific surveys. Overdose surveillance through CDC is not integrated with treatment access data through SAMHSA or claims data through CMS. The April 2025 reduction in force at SAMHSA included the entire Office of Population Surveys, the team that historically oversaw NSDUH, making the methodological-continuity question more urgent. SAMHSA reports that CBHSQ technical staff continue to work with the NSDUH contractor to maintain uninterrupted data collection, and the 2024 NSDUH was released on schedule, but the durability of NSDUH's methodological independence under this configuration is an open question.

SAMHSA's second evidence function is standard-setting. The agency's certification criteria for Certified Community Behavioral Health Clinics (CCBHCs), its treatment improvement protocols and practice guidelines, and its Evidence-Based Practices Resource Center define what counts as adequate mental illness and addiction care for the programs states run with federal money. The evidence basis for those standards is documented unevenly, the process for revising them is not public, and the April 2025 reduction in force eliminated the internal policy lab and evaluation capacity that would have produced the evidence on which revisions depend. A standard that guides care in every state, set by a process no one outside the agency can see, is the same exposure the Blueprint identifies for clinical guidance at CDC and preventive-service grades at AHRQ.

Recommendation

Two coordinated actions establish a durable behavioral health data architecture. First, NSDUH is received into the reauthorized AHRQ under Recommendation 7c of the AHRQ section, with the five-element transition plan (brand and identity, methodological independence, cooperative relationships, workforce, budget line) preserved by statute and methodological-independence protections attaching to the new institutional home. The statutory protection vehicle, whether designation under the Confidential Information Protection and Statistical Efficiency Act of 2018 (CIPSEA) or another mechanism, should be identified through legal review and codified in the AHRQ reauthorization. N-SUMHSS stays at SAMHSA; the provider survey is operationally tied to SAMHSA's program-administration functions and receiving it would disrupt that linkage. The methodological independence of N-SUMHSS should be protected at SAMHSA against administrative redirection of methodology and publication schedule. Second, the HHS Secretary should direct SAMHSA, in coordination with the reauthorized AHRQ, CDC, and CMS, to establish an integrated behavioral health data architecture that links NSDUH estimates (now produced through the reauthorized AHRQ), claims-based treatment utilization, and overdose surveillance, with timeliness and disaggregation standards consistent with the Data Infrastructure recommendations. Disaggregation should meet, at minimum, the seven minimum reporting categories under OMB Statistical Policy Directive No. 15 (2024 revision) with the default requirement to collect additional detail beyond the minimum, with sub-state geographic resolution where sample sizes permit.

Third, SAMHSA's care standards should carry a documented methodological framework. The evidence basis for CCBHC certification criteria and for published practice guidelines should be stated publicly with each edition, and revisions should proceed through public notice and comment. The agency's evaluation and policy-analysis capacity, eliminated in April 2025, should be restored as a named function with a budget line, so that the standards are revised on evidence rather than on assertion. The

interim operational commitment for NSDUH under AHRQ Recommendation 7c, which covers staffing and collection continuity and not only the legal protection CBHSQ already holds, applies here as well.

Responsible entity: Congress for the receipt of NSDUH into the reauthorized AHRQ and for the methodological-independence statutory vehicle; HHS Secretary, SAMHSA, AHRQ, CDC, and CMS for the integrated behavioral health data architecture and the SAMHSA-side N-SUMHSS protections. **Mechanism:** Legislation within the AHRQ reauthorization vehicle for the receipt of NSDUH and the statutory protections; Secretarial directive and joint agency protocol for the integrated data architecture; SAMHSA-side administrative action for N-SUMHSS methodological-independence protections, with legislation as the durable mechanism. SAMHSA and Congress for the care-standards methodological framework and the restored evaluation function. **Timeline:** The integrated data architecture and the SAMHSA-side N-SUMHSS protections can proceed in the first year under existing authority; legislative action follows through the AHRQ reauthorization.

Cross-cutting connection: The integrated behavioral health data architecture connects to the surge-capacity arguments in the Emergency Evidence Preparedness section and to the broader federal health data architecture the NCHS section anchors. The April 2025 SAMHSA RIF also eliminated the internal policy lab, the Office of Minority Health, the Office of Behavioral Health Equity, and the ten regional offices. The Research Integrity and Scientific Freedom section treats it as an institutional-scale instance of the structural-protection problem; AHRQ Recommendation 7c is the agency-specific application of that argument. The data-stewardship-versus-program-administration distinction that produces the NSDUH-receive / N-SUMHSS-stay split is one application of the federation-versus-consolidation argument carried at the federal-evidence-enterprise scale in the Align and Coordinate the Federal Evidence Enterprise section.

ACF/OPRE (Office of Planning, Research, and Evaluation, Administration for Children and Families)

Diagnosis

OPRE is the evaluation office for the Administration for Children and Families, which administers Temporary Assistance for Needy Families (TANF), Head Start, child welfare, child care, and refugee assistance programs. **OPRE has been a federally recognized model of embedded evaluation capacity outside the health sector.** Results for America's 2024 Federal Standard of Excellence recognized ACF as a top-performing federal agency for evidence and data, for the ninth consecutive year. The Data Foundation's November 2024 survey found that 83 percent of federal evaluation officials reported the Evidence Act was helping achieve their missions. OPRE's randomized-evaluation portfolio, multi-year evaluation funding structure, and Learning Agenda implementation bear directly on the ASPE Recommendation 2 evaluation-fund design and the AHRQ-section work on department-wide evaluation infrastructure.

OPRE's evaluation portfolio has run almost entirely through contracts and grants rather than career evaluation staff, which is the same vulnerability the ASPE section identifies department-wide. Health-

services-research integration with OPRE's social services research is informal: programs that affect health outcomes (Head Start, child welfare, TANF) are evaluated separately from health programs that serve overlapping populations (Medicaid, CHIP). The Foundations for Evidence-Based Policymaking Act of 2018 applies directly to HHS as a cabinet-level agency, and ACF voluntarily participates through its own 2020 Research and Evaluation Agenda, program-specific learning agendas, and a September 2024 ACF data strategy. The February 2026 OPRE restructuring illustrates precisely the vulnerability this recommendation is designed to prevent from recurring. It transferred research portfolios to ACF program offices. Under a December 2025 HHS policy change, it moved final authority over program evidence ratings from career staff to the political-appointee Assistant Secretary. And it is expected to cut central research-office staffing from about 120 to about 20. The FY 2026 omnibus largely supported OPRE's functions as written, raising questions about the restructuring's consistency with congressional intent.

Recommendation

The HHS Secretary should direct OPRE and ASPE to jointly develop a set of priority research questions at the intersection of ACF programs and health outcomes, with corresponding data-linkage authority across ACF, CMS, and CDC datasets. Data linkage should operate within the privacy framework the Data Infrastructure section establishes, with explicit protections against use of linked data for eligibility redetermination or enforcement purposes. Congress should establish multi-year evaluation funding authority for OPRE on the model proposed for ASPE, with appropriations language that prevents evaluation budgets from being absorbed into program operations during fiscal pressure.

Responsible entity: HHS Secretary; OPRE; ASPE; CMS, ACF, and CDC for data linkage; Congress for multi-year evaluation funding authority. **Mechanism:** Secretarial directive and joint priority-setting under future leadership; authorizing legislation for multi-year evaluation funding. **Timeline:** Administrative action under future leadership; multi-year authority requires legislation.

Cross-cutting connection: The OPRE recommendation is the operating-division-level analog of ASPE Recommendation 2 (dedicated evaluation funding), not a duplicate. The Align and Coordinate section is the appropriate venue for the broader structural argument: the federal government currently evaluates health and social interventions in separate silos even though the populations they serve experience them as one system.

Part II. Cross-Cutting Sections

Data Infrastructure Modernization

Diagnosis

Modern federal health data infrastructure makes the rest of the evidence enterprise possible. Complete, timely, interoperable, and well-governed federal data lets agencies detect emerging health threats while there is still time to act on them; lets clinicians, insurers, researchers, and state and local public health officials work from the same factual base; and lets the public hold federal decisions accountable to the evidence behind them. The data systems the country needs already exist in pieces, and the pieces are the product of real progress. Digital claims data, built for payment, became the backbone of health services research. The Meaningful Use program that hospitals and clinicians resented in the 2010s put an electronic record in nearly every hospital and most physician offices, which is why the interoperability questions below are questions at all. The Cures Act information blocking rules gave the exchange of that data legal force, and federal enforcement of them is now active under two administrations. Officials from other countries study this infrastructure with envy. What the pieces require is integration, modernization, and durable governance.

The current federal health data infrastructure falls short in four related ways.

Completeness. Large gaps persist in federal health surveys and surveillance systems for populations that federal data has long undercounted. Behavioral health data, covering mental health and substance use, runs years behind clinical reality. Maternal mortality reporting varies by state in ways that make national estimates unstable. Cause-of-death data often arrives months after the public health question has moved on. Completeness is not only about which populations are counted; it also requires consistent capture of the demographic and social variables that allow valid analysis of how federal programs perform across different groups. The causes differ and the remedies must too: some gaps come from surveys that were not designed to reach a population, some from systems too slow to matter, and some, as with race and ethnicity fields that health plans are required to ask about and that most people decline to answer, from non-response that no reporting requirement can cure. A standard that penalized a state or a health system for what people choose not to say would be unjust and would not produce the data.

Timing. Data that arrives six months late cannot guide a response to an overdose cluster, a maternal health crisis, or a respiratory outbreak. State and local officials responding to real-time events routinely make decisions without current federal data; reporting practices vary widely across jurisdictions (Pew Charitable Trusts, December 2024).

Interoperability and access. Different data systems often cannot share and use each other's information because they were never built to a common standard. Access to federal datasets is often slow, and the cause is worth stating precisely, because it is not HIPAA: HIPAA already permits disclosure to public health authorities and, with the required protections, for research. The delay comes from data use agreements negotiated one at a time, review boards that each start from scratch, agency policies written for paper, and state laws that vary in what they let flow onward. You cannot link, share, or analyze data that does not exist, and you cannot act on data that arrives too late.

Privacy protection is the foundation on which these investments rest. Public trust in federal data systems depends on clear, enforceable rules about who can access identifiable information, under what conditions, and for what purposes. State laws are part of that foundation as well: many states give reproductive health, substance use, HIV, and mental health information stronger protection than federal law does, and a federal data architecture that treated those protections as obstacles would lose the trust it depends on and the states whose data it needs. Tribal data sovereignty is a distinct governance question: Tribal nations hold authority over data collected about their citizens and communities, including decisions about collection, access, reuse, and secondary linkage. Federal practice should reflect the CARE Principles for Indigenous Data Governance and formal Tribal consultation processes. Decisions made in this section about access controls, linkage architecture, and governance composition must be designed to accommodate Tribal authority as specified in the Legislative Proposals section and, once tribal consultation concludes, the IHS entry, alongside specific reforms to statutes such as HIPAA.

Artificial intelligence raises the stakes. Every AI system used in health research, regulation, or clinical care runs on data. When the training data is incomplete, biased, or poorly documented, the resulting system reproduces and scales those defects, often without detection until real harm has occurred. Trustworthy AI requires what this section prescribes: complete, timely, and well-governed data; clear documentation of where each dataset came from and how it was built; ways for independent parties to test how a system performs across populations and conditions; and transparency about what a system can and cannot do. These requirements do not belong to any particular type of technology and will outlast the current tools. Modernizing data infrastructure is the prerequisite for responsible deployment of AI in health research, regulation, and clinical care.

What Modernization Requires

Modern federal health data infrastructure rests on six building blocks: common content standards that define what a data element means and how it is coded; common exchange standards that let systems move data between each other; identity and matching approaches that allow records from different sources to be connected to the same person; provenance and metadata standards that document where each dataset came from and how it was built; privacy and governance controls that determine who can see what, under what conditions, and with what oversight; and secure analytic environments where approved users can work with sensitive data without the data leaving federal control. Current federal work on these includes standards like USCDI, the FHIR exchange format, and TEFCA; progress across the six categories is uneven (Data Foundation, 2024).

Recommendations

The six recommendations build outward from the four shortfalls. Rec 1 sets federal minimum standards for timeliness, completeness, and demographic disaggregation. Rec 2 modernizes vital statistics and surveillance. Rec 3 enables privacy-protected linkage of sensitive federal data, anchored on the reauthorized AHRQ as the federal statistical-and-evaluation core. Rec 4 extends the now-active information blocking enforcement architecture to public health, research, and quality measurement use cases and makes federal data publicly available and usable by default. Rec 5 sets rules for new kinds of health data and for data that trains AI systems used in federal research and administration. Rec 6

establishes a governance structure that keeps modernization on track. All six operate through a combination of administrative action and legislation.

1. Set federal minimum standards for how fast federal health data arrives, how completely it represents the population, and how consistently it disaggregates by demographic category, with the post-2024 OMB Statistical Policy Directive No. 15 categories as the federal floor for federally administered and federally funded data systems.

Federal health data should meet a floor for timeliness and completeness. Complete data means more than broad population coverage; it includes consistent capture of the demographic and social variables needed for valid analysis across populations. A workable content floor exists: USCDI supplies the electronic health record baseline, and the six core public health data sources defined by the CDC Advisory Committee to the Director's Data and Surveillance Workgroup, 2022 supply the public health analog. HHS should use existing authorities to set thresholds through grant conditions, cooperative agreements, procurement standards, program guidance, and Medicare and Medicaid Conditions of Participation and quality-reporting measures (Pew Charitable Trusts, December 2024). Payment-linked measures have been effective where other tools have stalled, because they align reporting with revenue. ASPE, working with ONC and CDC, should issue guidance within the first year that sets specific thresholds tied to Medicaid, public health grant programs, and Public Health Emergency Preparedness funding. CMS should extend the thresholds through Conditions of Participation and quality measures that rise over time.

The recommendation also establishes a federal floor for demographic disaggregation. The agency sections raise the disaggregation question in parallel: the Brief Entries HRSA paragraph and Evidence Workforce Development Recommendation 1 apply OMB Statistical Policy Directive No. 15 to the federal workforce-data foundation; the Brief Entries SAMHSA paragraph applies it to the integrated behavioral health data architecture; the NCHS and CDC sections rely on it implicitly. A uniform federal floor avoids regulatory fragmentation. The floor is the seven minimum reporting categories under the 2024 revision to OMB Statistical Policy Directive No. 15: American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; Middle Eastern or North African; Native Hawaiian or Pacific Islander; and White. The floor includes the directive's default requirement to collect additional detail beyond the minimum, with sub-state geographic resolution where sample sizes permit. The floor applies to federally administered and federally funded data systems covered by this section; broader application to privately held health data is governed by Rec 4 (information blocking enforcement) and would otherwise require separate legislation. The Evidence Act provides the existing data governance framework these standards extend.

Congress should codify minimum timeliness, completeness, and disaggregation standards (disaggregation meaning the ability to report results separately for the population groups the standards name) for federally held and federally funded data systems. The standards stop at the edge of federal money and federal programs. Reaching further would require Congress to preempt state privacy law, including the protections many states give reproductive health and other specially protected information, and the Blueprint does not propose that.

Responsible entity: ASPE; ONC; CDC; CMS; HHS Secretary; Congress for codification. **Mechanism:** HHS guidance, CMS payment-linked measures, and funding conditions, followed by authorizing legislation. **Timeline:** Administrative action within the first year under new leadership; statutory codification requires legislation.

Cross-cutting connection: The OMB SPD 15 federal floor is inherited by reference by AHRQ Rec 7b, the Brief Entries HRSA and SAMHSA paragraphs, and the NCHS, CDC, and CMS sections.

2. Modernize the systems that track births, deaths, and disease outbreaks.

These systems, known as vital statistics and surveillance, still rely on paper-and-PDF workflows in many states and agencies. NCHS and CDC should accelerate the shift to real-time electronic reporting for births, deaths, and diseases that must be reported to public health authorities. Modernization requires three concrete moves. First, standardize the electronic reporting pathways so states and providers can submit data through consistent interfaces rather than building one-off connections for each system. That work anchors on common content and exchange standards, including current federal efforts on USCDI, FHIR, and electronic case reporting. Second, modernize the state-federal interfaces that move data from jurisdictional systems into national ones, because the slowest link in the chain sets the speed of the whole chain. Third, use funding and technical assistance to bring lagging jurisdictions forward, recognizing that state capacity varies widely and that the federal system is only as current as its weakest feed. The Secretary of HHS should request multi-year budget authority for this modernization in the next budget cycle, because one-year funding cannot sustain a multi-year technology upgrade. Congress should grant multi-year budget authority and codify timeliness standards so modernization does not restart every appropriations cycle.

Responsible entity: HHS Secretary; NCHS; CDC; state health agencies as partners; Congress for multi-year budget authority and codified timeliness standards. **Mechanism:** Agency action and budget request, followed by authorizing legislation. **Timeline:** Administrative action and budget request within the first year under new leadership; multi-year authority and timeliness standards require legislation.

Cross-cutting connection: See the NCHS section for institutional detail on vital statistics modernization, the CDC section for surveillance modernization, and the State Evidence Capacity section for the state role, including the workforce dimension.

3. Enable researchers to combine and analyze sensitive federal data while protecting privacy, with the reauthorized AHRQ as the federal statistical-and-evaluation core of the linkage architecture and CIPSEA-grade protections as the privacy floor.

Researchers trying to answer basic questions about how federal programs perform often spend years negotiating access to data held by different agencies (Data Foundation, 2024). The HHS Chief Data Officer, now housed within OCIO following the March 31, 2026 HHS technology realignment, should expand secure environments where approved researchers can work with linked federal data without exposing identifiable records. These environments should include privacy-preserving linkage methods that match records across datasets without revealing identities, auditable access logs, role-based controls, and documented data provenance.

A constraint conditions the linkage architecture. A federal appropriations rider in place since 1999 prohibits the use of federal funds to develop or implement a unique patient identifier. Record linkage across federal health data therefore depends on probabilistic matching methods, privacy-preserving linkage techniques, and programmatic identifiers specific to individual systems. Operational standards developed under this recommendation should quantify expected match rates and error tolerances and publish them so downstream users can interpret linked-data analyses accurately.

The reauthorized AHRQ provides the federal statistical-and-evaluation core of this architecture. Under AHRQ Recommendation 7, NCHS, NCHWA, ARF/AHRF, and NSDUH are received into the reauthorized AHRQ with statutory preservation conditions; UDS stays at HRSA with coordination-and-standards from the reauthorized AHRQ; N-SUMHSS stays at SAMHSA with methodological-independence protections; and under ASPE Rec 2, the HHS-wide evaluation fund is administered by ASPE with a defined methodological-standards-and-quality-review role for the reauthorized AHRQ. The linkage architecture this recommendation calls for is designed around that asset map: the reauthorized AHRQ is the natural hub for cross-program federal health data linkage because the principal federal statistical functions and the evidence-synthesis methodology now sit at the same agency. The design has a recent negative precedent to learn from: in 2023 CMS proposed to move Medicare and Medicaid research files into a single virtual enclave and to end the physical data files researchers had relied on for decades, and the research community, AcademyHealth among them, pushed back because the proposal would have raised costs, cut off established workflows, and narrowed access without a governance process researchers could see. The lesson is not that enclaves are wrong; it is that an enclave imposed on researchers fails and an enclave built with them, with affordable access, published fee schedules, and a transition that preserves what works, can succeed. Access cost is part of the design, not an afterthought: a linked dataset no one but the largest institutions can afford to use is not public infrastructure. The Federal Statistical Research Data Centers provide a model that should be adapted for health data and scaled for broader research use, with the reauthorized AHRQ as the federal partner anchoring the health-data implementation. The National Secure Data Service, authorized as a demonstration at NSF under the CHIPS and Science Act, provides the operational precedent across the federal statistical system; the health-specific implementation should extend and complement the NSDS rather than duplicate it. The National COVID Cohort Collaborative (N3C), an NIH-stewarded multi-institutional EHR analytic platform that aggregated and de-identified data from more than 90 contributing institutions during the pandemic, is a documented operational precedent for federated, privacy-protected analytic environments at national scale. If the AHRQ reauthorization is not adopted, ASPE should anchor the linkage architecture as the interim federal statistical-and-evaluation hub, on the strength of its existing Evidence Act statistical-coordination role, rather than leave the hub function unassigned across agencies.

Access controls, linkage architecture, and governance composition should be designed from the start to accommodate Tribal authority over data about Tribal citizens, as specified in the Legislative Proposals section and, once tribal consultation concludes, the IHS entry. The substantive operational floor is set in those sections; this recommendation commits the federal linkage architecture to designing around that authority rather than retrofitting around it.

The Office of the Secretary should direct implementation within the first year. Congress should clarify data-sharing authorities across federal health programs so approved linkages do not require case-by-

case legal review, and should extend the same clarification to sharing with state, local, tribal, and academic partners under defined governance, because the current limits on sharing outside the federal government push partners toward adversarial Freedom of Information Act requests for data a governed channel would provide, and should establish a uniform federal privacy floor at a level of specificity at least comparable to CIPSEA. The CIPSEA-grade floor is the privacy standard the agency sections invoke in parallel (NCHS, AHRQ, the Brief Entries SAMHSA paragraph); the linkage architecture inherits that floor uniformly. The floor governs statistical and research uses. Operational copies, for public health response, payment, and program administration, remain governed by the Public Health Service Act, HIPAA, the Privacy Act, and program-specific statutes, and the statistical side of the architecture may not serve as a back channel for administrative data supply; the firewall between statistical and administrative uses that governs NCHS data is the model.

Responsible entity: HHS Secretary; HHS Chief Data Officer; reauthorized AHRQ as federal statistical-and-evaluation core, or ASPE as interim hub if reauthorization is not adopted; participating federal statistical agencies; Congress for cross-program data-sharing clarification and the CIPSEA-grade privacy floor. **Mechanism:** Administrative expansion of existing infrastructure, followed by statutory clarification of cross-program data-sharing authorities and codification of the CIPSEA-grade privacy floor. **Timeline:** Administrative action within the first year under new leadership; broader cross-program linkage and the CIPSEA-grade statutory privacy floor require legislation.

Cross-cutting connection: The AHRQ-hub framing inherits the consolidated asset map established at AHRQ Recommendation 7 and ASPE Recommendation 2; the CIPSEA-grade floor is the federal privacy floor inherited by the NCHS, AHRQ, and SAMHSA-side recommendations. Configuration-dependency: designation of the reauthorized AHRQ as the linkage hub is contingent on AHRQ Recommendation 7 and degrades gracefully to ASPE as interim hub, consistent with the fallback pattern in Evidence Workforce Development Recommendation 1.

4. Make federal health data publicly usable by default, and get information blocking enforcement to cover the data public health, research, and quality measurement depend on.

Access should not depend on which institution an analyst works for or which administration holds office. The OPEN Government Data Act, enacted as Title II of the Evidence Act, requires federal agencies to make their data publicly available by default. CMS and AHRQ should implement that requirement fully by streamlining data use agreements for lower-sensitivity data, reducing fees that exclude smaller institutions and state agencies, publishing on predictable schedules, and investing in cloud-based tools that let users analyze large public datasets without downloading them.

These are two different problems and the recommendation treats them separately. The first, above, is about data the federal government already holds. The second is about data that should flow to public health agencies, researchers, and quality programs from the private systems that hold it, and the federal tool for that is the information blocking rule under the 21st Century Cures Act. The rule already covers this ground. It prohibits health IT developers of certified products, health information networks and exchanges, and health care providers from interfering with the access, exchange, or use of electronic health information, and a request from a public health agency, a quality measurement program, or a researcher whose disclosure is permitted by law is already within it. Fees are already governed by the

rule's Fees exception. Enforcement is now real: the HHS Office of Inspector General has had authority since September 2023 to impose civil monetary penalties of up to $1 million per violation on developers and networks, and CMS has applied payment disincentives to providers since July 2024. The problem is not the rule. It is that enforcement has concentrated on clinical exchange between providers, that neither OIG nor CMS has made public health, research, or quality reporting a stated priority, and that the standards public health reporting depends on have lagged behind the clinical ones.

The recommendation therefore asks for three things, each within an authority that exists. First, the Secretary should direct OIG and CMS, which choose what to enforce, to make interference with public health, research, and quality measurement disclosures a stated enforcement priority, and ONC, which does not enforce but does educate, should publish worked examples of what such interference looks like so that developers and providers cannot claim surprise. Second, ONC should continue adding the public health and research data elements that CDC and the statistical agencies need to the United States Core Data for Interoperability on its existing schedule, which has produced seven versions in six years and should not be written into statute, where a floor becomes a ceiling. Third, Congress should codify the rule's core prohibition and its exceptions as they now stand in regulation, so that the standard cannot be narrowed by a future rulemaking; that is the purpose of codification here, stated plainly, and it changes nothing about what the rule requires. The federal government cannot make anyone disclose what state or federal law prohibits disclosing, and this recommendation does not try.

Responsible entity: CMS and AHRQ for federal data access; the HHS Secretary for enforcement direction; the HHS Office of Inspector General and CMS as the enforcing agencies; ONC for standards and education; Congress for codification of the existing rule. **Mechanism:** Agency action under the OPEN Government Data Act; Secretarial direction of enforcement priorities under existing OIG and CMS authorities; ONC's existing standards and education functions; authorizing legislation codifying the information blocking prohibition and exceptions as they stand. **Timeline:** Administrative action within the first year under new leadership; codification requires legislation.

Cross-cutting connection: The CDC section's Section 308(d) clarification, the AHRQ and CMS sections' streamlined data access, and the ONC entry in the Brief Agency Entries all rely on the enforcement priority set here. The ONC entry carries ONC's standards role; this recommendation carries the enforcement architecture, which belongs to OIG and CMS.

5. Set rules for new kinds of health data and for the data that trains AI systems used in federal research and administration.

Wearable devices, mobile health apps, data purchased from commercial brokers, and information gathered from social media and other online activity already shape health research and practice. Rules for how this data is collected, used, and documented have not kept up. The Secretary of HHS should convene a standing body to set governance standards for data used in federally funded research and federal programs: how the origin and construction of each dataset is documented, how consent for its use was obtained and can be verified, how accuracy is validated, and how performance is tested across population subgroups. The body should draw on the agencies that actually hold the relevant authority and expertise: NCHS and ONC for statistical and interoperability standards; the HHS Office for Civil Rights, which administers HIPAA; the Office for Human Research Protections, which administers the Common Rule; and the Federal Trade Commission, which regulates consumer health data outside HIPAA

and whose Health Breach Notification Rule already reaches the apps and wearables in question. FDA has no jurisdiction over privacy or consent and does not belong in that part of the work; it belongs in the AI lifecycle standards below only where a system is a regulated device.

Governance should cover the full lifecycle of AI systems, not only pre-deployment standards. After an AI system is put into use, the operating agency should monitor performance across population subgroups on a defined schedule, report when subgroup performance degrades below specified thresholds, and decommission systems that cannot be repaired (Duke-Margolis Institute for Health Policy, 2024). The standing body should publish post-deployment monitoring requirements, auditable performance criteria, and decommissioning triggers that apply to AI used in federally supported research, administrative decision-making in federal benefit programs, and public health decision support. Existing frameworks for digital health research ethics provide a starting point (Nebeker, Torous, and Bartlett Ellis, *BMC Medicine*, 2019). The standards apply to AI used in federally supported research, in administrative decisions in federal benefit programs, and in public health decision support, which are federal activities the Secretary can govern. FDA's authority reaches only AI that is a medical device; Section 3060 of the 21st Century Cures Act excludes most clinical decision support, wellness software, and the administrative and record-keeping functions of electronic health records from that authority, and those limits are statutory, not discretionary. ONC's algorithm transparency requirements apply to certified health IT. This recommendation coordinates with both frameworks and claims authority for neither. Subgroup-performance monitoring should align with the OMB SPD 15 federal floor established in Recommendation 1.

Congress should codify the standards for federally funded research and federal programs. Extending them to consumer health data outside federal programs would put HHS in territory that twenty-three states and the Federal Trade Commission already regulate, would require preempting those state laws and their consent requirements, and is not realistic; the Blueprint instead proposes that the Secretary's standards govern what data federally funded projects may use and how its provenance and consent must be documented, which reaches the same data through the federal money that pays for the research.

Why the Blueprint says little else about artificial intelligence. AI will change how federal health evidence is generated, synthesized, and used, and the pace of that change is the reason this document does not attempt to govern it. Recommendations written to a specific generation of tools would be stale before enactment; recommendations written generally would add nothing to the frameworks FDA, ONC, and OMB already administer. The Blueprint therefore confines itself to what durable evidence infrastructure requires of AI regardless of the tools: the lifecycle governance and subgroup-performance standards in this recommendation, the statutory authority for AHRQ to evaluate whether digital health technologies including AI applications are safe and improve outcomes (AHRQ Recommendation 1, sixth element), and the principle that the obligation to use these tools responsibly rests on the agencies and vendors that deploy them, not on the tools. Where AI touches a recommendation elsewhere in the document, it is because the underlying evidence function would need the same protection with or without it.

Responsible entity: HHS Secretary; the standing governance body; NCHS; ONC; the Office for Civil Rights; the Office for Human Research Protections; the Federal Trade Commission as a participating agency; FDA for regulated devices only; Congress for codification. **Mechanism:** Secretarial directive

establishing the standing body and its standards for federally funded research and federal programs; authorizing legislation to codify them. **Timeline:** Administrative action within the first year under new leadership; codification requires legislation.

Cross-cutting connection: Coordinate with the Align and Coordinate the Federal Evidence Enterprise section for the broader interagency AI governance framework.

6. Establish a cross-HHS data modernization governance body with the authority to set milestones, coordinate budgets, review architecture decisions across agencies, and publish progress, with statutory protection against suspension and a consolidation-and-replacement analysis up front.

Standards and statutes do not implement themselves. The previous five recommendations depend on a governance structure with the authority to set milestones, coordinate budgets across participating agencies, review architecture decisions, and report progress publicly. The Secretary of HHS should establish a cross-HHS data modernization governance body, chaired by the HHS Chief Data Officer (housed at OCIO following the March 31, 2026 HHS technology realignment) and including ASPE, ONC, CDC, NCHS, CMS, AHRQ, and FDA.

Several federal coordination bodies already exist in this space: the HHS Data Council, the HHS Evidence and Evaluation Policy Council, the HHS Data Governance Body, the HHS AI Council, the National Committee on Vital and Health Statistics, and the Federal CDO Council. Within six months of standing up, the new body should publish a consolidation and replacement analysis identifying what functions of existing bodies it absorbs, what functions those bodies retain, and what net change in coordination infrastructure and staffing results, and the statute should require that the functions the analysis identifies for absorption are in fact transferred within the following year. Consolidation is a condition of the body's authorization, not a study the body may commission; without it, modernization becomes an additive layer of bureaucracy and the new body one more perfunctory member of the set it was meant to replace.

The body's design should be informed by the recent operational record of statutorily chartered federal advisory bodies that have proven vulnerable to administrative suspension. The Health Information Technology Advisory Committee (HITAC), established by 21st Century Cures Act § 4003(e) and governed by the Federal Advisory Committee Act, was placed on indefinite suspension in January 2025; meetings resumed by January 2026 with four 2026 meetings scheduled in a Federal Register notice. The HITAC pattern shows that a statutory charter alone does not guarantee operating continuity. The governance body proposed here is designed against that pattern. Its statutory authorization should specify a minimum operating cadence and a published consolidation-and-replacement analysis as a precondition of standing up, and it should say what happens by operation of law if the body is suspended, defunded, or ignored, because a constraint on suspension that names no consequence is an intention rather than a mechanism. Three consequences should attach automatically. If the body does not meet on its statutory cadence, the failure, its cause, and the date of the next meeting are recorded in the annual Federal Health Evidence Report to the committees of jurisdiction. Funds appropriated for the body's operations and for the modernization milestones it sets may not be reprogrammed to other purposes. And a milestone missed across two successive annual reports without a published corrective plan is transmitted to GAO for review, with the review report going to the committees of jurisdiction.

The funding restriction is self-executing; the reporting and referral duties are mandatory oversight, whose force is that ignoring them is a second visible breach. The HITAC pattern is one instance of a broader structural-protection family carried in the Research Integrity and Scientific Freedom section.

The body should then publish a shared modernization roadmap with milestones tied to the six building blocks, coordinate budget requests across participating agencies, review architecture decisions that affect more than one agency, and publish annual public progress reports to Congress. The body should not duplicate the authority over data governance that ASPE Rec 1 phases into binding form at the HHS CDO level. The relationship is complementary: ASPE Rec 1 establishes binding department-wide data governance authority at the CDO; this recommendation establishes the cross-agency operating body that implements the modernization roadmap under that authority. Civil service workforce protections for the body's career analytic staff are covered by ASPE Rec 4 (Tier 3 of the three-tier protection architecture).

Congress should codify the governance structure, its operating cadence, the three automatic consequences above, the mandatory consolidation, and its reporting obligations, with a reauthorization requirement so that the body is evaluated and extended or retired on a defined schedule.

Responsible entity: HHS Secretary; HHS Chief Data Officer as chair; ASPE, ONC, CDC, NCHS, CMS, AHRQ, and FDA as members; Congress for codification. **Mechanism:** Secretarial directive establishing the body and requiring the consolidation-and-replacement analysis, followed by authorizing legislation specifying operating cadence, automatic consequences, mandatory consolidation, reporting obligations, and a reauthorization requirement. **Timeline:** Administrative action within the first year under new leadership; consolidation-and-replacement analysis within six months of standing up; statutory codification requires legislation.

Resilience note: In a cooperative environment, the body meets, sets milestones, and publishes progress on its own. In a noncooperative one, the three automatic consequences are what survive: the missed-cadence entry in the annual report to Congress, the non-reprogrammable funds, and the GAO referral on repeated missed milestones each produce a record without requiring anyone inside the Department to want one.

Cross-cutting connection: The Align and Coordinate the Federal Evidence Enterprise section addresses broader federal coordination across the evidence enterprise; this recommendation is the data-modernization-specific layer of it. The HITAC design-rationale pattern is one instance of the structural-protection family articulated in Research Integrity and Scientific Freedom. The CDO-authority and workforce-protection components are inherited from ASPE Recommendations 1 and 4 rather than reargued here.

Configuration-dependency note. This recommendation names existing federal coordination bodies and the post-March 2026 HHS technology architecture (ONC singularly titled; HHS CDO under OCIO; National Coordinator reporting directly to Secretary). The operational status of those bodies and the technology-leadership configuration at publication may differ. The structural argument (no existing body covers the full cross-agency data modernization function; existing bodies should be reviewed for consolidation or replacement) does not depend on the precise configuration and survives reconfiguration. The companion configuration-dependency observation in the Brief Entries ONC paragraph applies.

Implementation Capacity

These recommendations depend on federal, state, and local workforce capacity, informatics expertise, and sustained operational funding. The Evidence Workforce Development and State Evidence Capacity cross-cutting sections address those needs directly.

Evidence Workforce Development

Diagnosis

Federal evidence is not self-executing. Data systems, program evaluations, and surveillance networks produce public value only when skilled people design them, run them, and interpret what they show. The federal government has invested heavily in this evidence infrastructure over decades. It has rarely treated the workforce that operates the infrastructure as a strategic asset in its own right.

This section covers the evidence-generating workforce: the researchers, evaluators, statisticians, epidemiologists, and data scientists inside federal agencies who produce statistics, run evaluations, and synthesize evidence, together with the extramural health services research workforce that federal funding sustains. It does not cover the clinical or health-services delivery workforce, which is a separate policy domain. The argument is specific: the evidence-generating workforce is a binding constraint on the federal government's capacity to know what works. Funding is the other, and the two move together. When the workforce is thin, every other recommendation in this Blueprint becomes a plan with no one to carry it out.

The current workforce falls short in four related ways.

Visibility. The federal government cannot clearly see its own evidence-generating workforce. The data-science series created in 2021 (GS-1560) now identifies data scientists, but evaluators still fall into the catch-all Miscellaneous Administration and Program series (GS-0301), which makes them close to impossible to count as evidence producers. There is no recurring federal picture of how many evaluators, statisticians, and research data scientists the government employs, where they sit, how the workforce is aging, or how fast it is turning over. The extramural health services research workforce is better studied but still hard to size: recent estimates range from roughly 9,600 to 28,000 (Frogner 2022). A workforce the government cannot count is a workforce it cannot plan, defend in a budget request, or rebuild after a loss.

Fragmentation. Agency training grants support doctoral and postdoctoral health services researchers. Applied fellowship programs train epidemiologists and analysts inside agencies. Evaluation contracting builds capacity at policy offices and their partner institutions. These instruments operate agency by agency, with no shared definition of the competencies the federal enterprise needs and no coordinated strategy connecting them. The result is a set of pipelines that do not add up to a pipeline.

Recruitment and retention. Federal pay scales and classification systems were not built for a workforce that now competes directly with technology firms, universities, and consultancies for the same statisticians and data scientists. Expedited hiring authorities exist for some of these roles but are used unevenly, and hiring timelines remain long enough that strong candidates take offers elsewhere. Early-career researchers face long and uncertain paths into federal evidence work, and the government loses many of them before they ever arrive.

State and institutional capacity. The same constraint operates below the federal level. State agencies and the academic and research institutions that supply the pipeline often lack the capacity to train, place, and retain evidence-generating staff. The State Evidence Capacity section addresses the federal-lever question of building state capacity and cross-references here.

These shortfalls predate any single administration. They have been compounded by recent disruption. In 2025, federal restructuring and reductions in force reduced the evidence-generating workforce across several HHS components. The HHS-wide reductions cut roughly 10,000 full-time positions, bringing the department from about 82,000 to about 62,000 employees, with CDC, FDA, and NIH each down about 20 percent (HHS restructuring announcement, March 2025). AHRQ's workforce fell roughly 65 percent, from 298 employees in fiscal 2024 to about 103 by December 2025 (Becker's 2026), and the agency's official FY2026 contingency staffing plan works from a base of 91 staff as of September 2026; the proposed AHRQ-ASPE Office of Strategy merger was not adopted, and Congress funded AHRQ for fiscal 2026 with a directive to maintain the staffing levels necessary to fulfill the agency's statutory responsibilities (Roll Call 2026). Workforce loss tracks funding erosion: by the American Statistical Association's assessment, the principal federal statistical agencies lost about 14 percent of their purchasing power over roughly 15 years, even as non-defense discretionary spending rose about 16 percent (reported January 2025), so staffing cannot be rebuilt by hiring authority alone. The Legislative Proposals section carries the consolidated budget case; this section treats funding as the precondition it is. The task is to build a stronger workforce than the one that existed before the disruption, not to restore the prior state.

What is at stake is implementation of the entire Blueprint. Modernized data systems need people to run them. New evaluation funds need evaluators to spend them well. Statistical agencies protected by new term and removal rules still need staff to do the work those protections exist to safeguard. The recommendations below build capacity, while the Research Integrity and Scientific Freedom section guards that capacity against political interference. Neither substitutes for the other.

Recommendations

A functioning evidence-generating workforce rests on five things: a clear and recurring picture of supply, demand, and turnover; entry pathways that recruit and train new producers; competitive recruitment into federal and federally funded roles; career structures that retain people once trained; and coordination that treats these as one system. The five recommendations map to these requirements and are durable even as specific programs and authorities change. Recommendations 1 and 2 work as a pair: the government has to see the workforce before it can shape it. Most can be initiated under existing administrative authority; several elements require legislation, and those are marked.

1. Make the federal evidence-generating workforce visible by consolidating the federal workforce-data foundation at the reauthorized AHRQ and extending it to cover evidence producers specifically.

The government cannot plan a workforce it cannot count. Under AHRQ Recommendation 7b, the National Center for Health Workforce Analysis and the Area Health Resources Files move into the reauthorized AHRQ, which also takes on the federal workforce-report convening role. That

consolidation gives the enterprise a natural anchor for workforce data. The reauthorized AHRQ should extend this foundation to cover the evidence-generating workforce specifically: federal statisticians, evaluators, epidemiologists, research data scientists, and the extramural health services research workforce. Building the picture requires drawing on Office of Personnel Management federal-employment data, Bureau of Labor Statistics occupational data, and the agency training-grant and fellowship records that show how new producers enter the field. If the AHRQ reauthorization is not adopted, the Secretary of Health and Human Services should designate a lead entity for evidence-workforce monitoring and reporting rather than leave the function distributed across agencies, where it has historically gone unmeasured. In that case the National Center for Health Workforce Analysis and the Area Health Resources Files remain at HRSA under the coordination-and-standards overlay the AHRQ section prescribes for functions that stay at their source agencies, with interim protections written in administratively in the first year and drafted for later codification: methodological independence for the workforce estimates and a protected release schedule. Unlike NCHS and NSDUH, these functions carry no independent statistical-agency protection to fall back on, so the interim protections are the whole of their fallback; this paragraph supplies the workforce-data specifics of the coordination-and-standards overlay that the AHRQ section's Recommendation 7 fallback prescribes generally for functions remaining at their source agencies.

The designated home should publish a recurring federal evidence-workforce report, convening HRSA, ASPE, BLS, and VA as participating agencies. The report should combine administrative data from OPM (the Office of Personnel Management) and BLS with a recurring workforce survey, because administrative records show headcount and demographics but miss the leading indicators of retention loss: attrition intent, burnout, and morale. The Federal Employee Viewpoint Survey and the Data Foundation's annual survey of federal evaluation officials are existing models. The report should disaggregate by demographic category and by career stage, applying the federal demographic floor established in Data Infrastructure Modernization Recommendation 1. Career stage matters because the equity challenge appears to lie less in entry than in advancement: the extramural field is already more racially diverse than the U.S. adult population, though that diversity has not consistently reached its senior ranks (Frogner 2022).

Responsible entity: Reauthorized AHRQ (lead), or an HHS-designated lead entity if reauthorization is not adopted; HRSA, ASPE, BLS, and VA (participating agencies); OPM (federal workforce data); Congress (to codify the recurring report). **Mechanism:** Administrative data integration, a recurring survey, and convening under existing and AHRQ-reauthorization authority; a recurring published report; statutory codification to make the report durable across administrations. **Timeline:** The data foundation and first report can be initiated under existing authority within the first year under new leadership; codifying the recurring report is part of the AHRQ reauthorization legislative vehicle, or a standalone authority if reauthorization does not proceed.

Cross-cutting connection: Inherits the demographic disaggregation floor from Data Infrastructure Modernization Recommendation 1. The workforce-data foundation originates in AHRQ Recommendation 7b and the Brief Entries HRSA paragraph. See State Evidence Capacity for the state-level dimension. Configuration-dependency: designation of the reauthorized AHRQ as home is contingent on AHRQ Recommendation 7 and degrades gracefully to an HHS-designated lead entity.

2. Build a coherent federal pipeline for evidence producers by defining shared competencies and coordinating existing training instruments through the bodies that already coordinate evidence work.

Visibility is necessary but not sufficient. The federal government already pays to train evidence producers; what it lacks is the strategy that connects those investments into a workforce. The pipeline can be strengthened substantially without building a new bureaucracy.

Two moves do most of the work. First, define the competencies. The reauthorized AHRQ should lead an interagency process to define the core competencies the federal evidence-generating workforce needs across its main roles: statistical, evaluative, epidemiologic, and data-science. A shared competency framework gives every training instrument a common target, and read against the workforce picture from Recommendation 1, it shows where the pipeline is thin. Second, coordinate through the bodies that already exist. The Evidence Act created the coordinating spine: agency Evaluation Officers, Statistical Officials, and Chief Data Officers, and the interagency councils that connect them. The Secretary of Health and Human Services, working with OMB, should task those bodies with an interagency pipeline strategy rather than stand up a parallel structure. The Chief Data Officers Council's pooled data-scientist hiring pilot, which let candidates apply once and be assessed by subject-matter experts across agencies, is a proven model the pipeline strategy should adopt and extend (Federal News Network 2021).

The pipeline should widen its entry points. Public-private talent exchanges, technical rotations across agencies, paid internships, and intern-to-hire conversion are established ways to bring technical talent into government, and the federal evidence enterprise uses them less than it could. Existing training instruments should be coordinated against the competency framework: AHRQ health services research training grants, applied agency fellowships such as CDC's Epidemic Intelligence Service (which continued operating through 2025 and into 2026 despite being targeted in successive rounds of cuts, a vulnerability that shows why these pipeline programs need durable footing), and the evaluation contracting and fellowship mechanisms run through ASPE and partner offices. Coordination that becomes overhead should not be kept: the coordinating function should be light, attached to a measurable output (a pipeline that visibly closes the gaps the workforce-data foundation identifies), with a cost estimate and a periodic review.

Responsible entity: Reauthorized AHRQ (competency framework); the Evaluation Officers Council and Chief Data Officers Council, with OMB (interagency coordination); CDC and ASPE (training and fellowship instruments); the HHS Secretary (direction). **Mechanism:** An administrative competency framework and an interagency pipeline strategy tasked to existing councils under existing authority; budget requests to expand training-grant and fellowship capacity; authorizing legislation if a durable, funded pipeline program is warranted. **Timeline:** The competency framework and coordination strategy can be established within the first year under new leadership; capacity expansion proceeds through the budget cycle; a statutory pipeline program requires legislation.

Cross-cutting connection: Applies the federation-not-duplication principle developed in the Align and Coordinate the Federal Evidence Enterprise section. See the AHRQ section for the reauthorized agency's training role.

3. Strengthen recruitment into federal and federally funded evidence-generating roles by using existing hiring authorities and competing on pay.

The barriers to entry are plural, so the response should be too. For physicians, debt is the dominant entry barrier and loan repayment is the natural lever. For statisticians, evaluators, and research data scientists, the evidence points to slow hiring, classification that does not fit the role, and pay that lags the private sector.

Four sets of tools matter, in order of leverage. First, use the hiring authorities that already exist. Two agency-specific authorities are underused and should be named. AHRQ's statute permits the Secretary to obtain the services of up to 50 experts and consultants outside the competitive process, without the duration limit that ordinarily applies to such appointments, and both AHRQ and NIH hold service-fellow authority that supports the same kind of appointment; neither has been used at the scale the workforce gap warrants. Government-wide, the government-wide STEM direct-hire authority, extended through 2028, already covers data-science and mathematical-statistician positions, so for those roles the task is to use it consistently and quickly (OPM Direct Hire Authority). The gap is program evaluation: evaluation roles classified under GS-0301 are not covered by the STEM authority, so OPM should extend direct-hire coverage to them and, per Recommendation 5, give them a proper occupational series. Second, compete on pay and terms: where federal pay cannot match the market for scarce technical skills, agencies should use existing pay-flexibility authorities, with Recommendation 5 carrying the durable classification and pay changes. Third, use targeted service incentives. A loan-repayment or service-incentive option can help recruit specific hard-to-fill roles and early-career entrants who carry debt, but the evidence that debt is the binding barrier for this workforce is weak, and the recommendation does not rest on it. Fellowship pipelines are the fourth tool and the cheapest to restore: the Presidential Management Fellows program and the agency-run fellowships that historically fed the evidence workforce were ended in 2025 (the PMF program was terminated by executive order in February 2025 and its regulations rescinded that August), and rebuilding a named, recurring entry path for early-career evaluators and statisticians does more for recruitment than any single incentive. Any such program should be built from existing authority first (NIH Loan Repayment Programs are one model), with new statutory programs reserved for the Legislative Proposals section. Across all three, the early-career entry point deserves attention, because it is the federal government's thinnest.

Responsible entity: OPM (hiring authorities and direct-hire coverage); the reauthorized AHRQ and component agencies (use of authorities and pay flexibility); the agencies holding existing loan-repayment authority; the HHS Secretary; Congress (for new authority and dedicated funding). **Mechanism:** Consistent use and extension of existing direct-hire authorities and pay-flexibility tools under existing authority; adaptation of existing service-incentive authorities; authorizing legislation for any new standing incentive program. **Timeline:** Use and extension within the first year under new leadership; a new statutory program requires legislation.

Cross-cutting connection: Classification and career-ladder reform are addressed in Recommendation 5. Stronger conditionality and any new statutory service-incentive program are carried by the Legislative Proposals section. See State Evidence Capacity for the state-level recruitment dimension.

4. Build state and institutional capacity by strengthening the pathways from academic and research institutions into public-sector evidence work.

The pipeline does not begin inside the federal government. It begins in the universities and research institutions that train evidence producers, and it has to carry those producers into public-sector evidence roles. The health services research workforce sits across three main settings (universities, government, and health systems) with little overlap in employers for people with competing skill sets (Frogner 2022). The challenge is not that the workforce avoids government. It is that academic training is often misaligned with what public agencies need, rewarding publication over the applied evaluation, surveillance, and data skills that government and state evidence work require (Grant 2021).

The reauthorized AHRQ and HRSA should direct training grants and cooperative agreements to states and to academic and research institutions, structured to address those failures directly: applied training placements that put graduate students and early-career researchers inside state and federal evidence offices, and grant conditions that reward programs producing the applied skills public agencies need. The State Evidence Capacity section keeps the complementary federal-lever question of which existing federal programs build state capacity and cross-references here.

Responsible entity: Reauthorized AHRQ and HRSA; states and academic and research institutions as partners; Congress (for funding). **Mechanism:** Training grants and cooperative agreements structured around applied placements and skills-alignment conditions, under existing authority; a budget request for expansion; capacity conditions tied to existing federal funding streams. **Timeline:** Grants and agreements can be initiated under existing authority within the first year under new leadership; expansion proceeds through the budget cycle.

Cross-cutting connection: This is the substantive counterpart to the State Evidence Capacity section's federal-lever framing. It also answers the implementation-capacity note that closes the Data Infrastructure Modernization section.

5. Retain the federal evidence-generating workforce by modernizing occupational classification, career paths, and pay flexibility.

Recruiting and training evidence producers is wasted effort if the government cannot keep them. Retention is a capacity question, distinct from the protection of evidence staff against political interference, which the Research Integrity and Scientific Freedom section addresses.

Three moves matter. First, finish the classification work that is already underway. The data-science series (GS-1560) was created in 2021. The unfinished work is program evaluation, which has no dedicated occupational series and falls into the GS-0301 catch-all, and the boundary between mathematical statistician and data scientist. OPM should establish a program-evaluation series (or issue formal classification guidance for evaluators) and clarify the statistician/data-scientist boundary, so agencies can hire, grade, and promote these staff correctly. Second, agencies should design clear career ladders that let evidence producers advance without leaving technical work for management as the only path upward. Career ladders should include rotation and detail flexibility across agencies and between federal and state evidence functions, so that advancement does not require leaving the enterprise, and every evidence agency should publish a succession plan for its senior technical positions: a large share of the federal statistical and evaluation workforce is at or near retirement eligibility, and the 2025

departures accelerated a wave that was already coming. Third, where federal pay cannot compete for scarce technical skills, agencies should use existing pay-flexibility authorities, and Congress should provide special pay authority where existing tools fall short. The VA flagged its evidence-workforce questions to this section, and the VA research workforce is one concrete setting where these classification and retention tools should be applied.

Responsible entity: OPM (classification and pay flexibility); the HHS Secretary and component agencies (career-ladder design and use of pay flexibility); the reauthorized AHRQ (coordination with the workforce-data foundation); Congress (for special pay authority where needed). **Mechanism:** OPM classification action (a program-evaluation series or formal guidance) and use of existing pay-flexibility authorities under existing authority; agency career-ladder redesign; authorizing legislation for special pay authority where existing tools are insufficient. **Timeline:** Classification action and career-ladder redesign can be initiated within the first year under new leadership; new special pay authority requires legislation.

Cross-cutting connection: Workforce protection against political interference is carried by the Research Integrity and Scientific Freedom section; this recommendation covers the distinct question of career structure and retention. The VA section flagged its evidence-workforce questions here.

Building the Capacity to Implement

Modernized data systems, new evaluation funds, protected statistical agencies, and faster emergency research all depend on people who can do the work. These five recommendations make that assumption real. They connect to the standing-capacity argument in the Emergency Evidence Preparedness section, which holds that surge capacity is only possible when permanent capacity is already in place, and to the implementation-capacity note in the Data Infrastructure Modernization section.

Research Integrity and Scientific Freedom

Federal health research has historically depended on a quiet division of labor: political leadership decides what to do with the evidence, and scientists determine what the evidence shows. That division rested on norms rather than law. Those norms are being tested and failing under political pressure. The answer is architecture that makes both halves of the division enforceable across administrations of any orientation: scientific independence in determining what the evidence shows, and public accountability for what is done with it.

Scope note: This section addresses the structural protection of research integrity from political interference. Research misconduct in the traditional sense (fabrication, falsification, plagiarism) falls to the Office of Research Integrity under existing mechanisms and is out of scope. Research reproducibility is a question of method rather than political interference and is likewise out of scope.

Diagnosis

Federal health research has historically run on norms more than law. Career scientists decided what got funded and what the evidence showed, and administrations left those judgments alone. The protections that did exist were thin: an information-quality statute that is rarely enforced, and a 2023 government-wide framework, set by executive policy, that directs agencies to maintain scientific integrity policies. Either can be overridden or ignored without consequence. Nothing was built into law in a form that binds when the norms behind it are no longer shared. That test has come, and the norms are giving way.

The Opening Frame sets out the record of 2025 and 2026; this section does not repeat it. What matters here is the shape of it. Each action may appear defensible on its own, and each was taken by an actor holding lawful authority. Together they reroute the flow of evidence from the moment it is generated to the moment it is used: awards decided on priorities rather than on peer review, syntheses whose methods stay published while their findings change, advisory bodies replaced faster than a court can rule, and workforce protections removed by rule for the positions that produce the evidence. The sequence exposed three weaknesses in how the system was built rather than in who ran it. First, a discretionary act (canceling an award, editing a review, dismissing a committee) had no built-in cost. Second, the protections that did exist were enforceable only through litigation that ran slower than the harm. Third, nothing required the change to be attributed to anyone. Those are design defects, and they would be defects under any administration. The case for fixing them does not rest on the current one; it rests on the fact that public confidence in the objectivity of federal science has declined across the political spectrum for a decade, and a system that cannot show its work cannot earn that confidence back from anyone.

A clear line separates the two things at stake. Every administration may set research priorities and policy direction; that is its prerogative. What no administration should be able to do is alter scientific methods or findings, or suppress them, to reach a preferred conclusion. The recommendations below draw that line and make it enforceable.

The test the diagnosis sets

The recommendations in this section, and the statutory protections proposed throughout the Blueprint, are answerable to a test the diagnosis sets for them. Much of what the diagnosis documents is codified protection that failed: the Federal Advisory Committee Act violated, the Impoundment Control Act outrun, civil-service protections removed by rule. A prescription built on codification must therefore say what makes its statutes harder to override than the ones that gave way. The failures are instructive because they are distinct. Advisory-committee protection failed at enforcement, where the remedy ran slower than the harm and cost the violator nothing. Civil-service protection failed at delegation, where the statute left the decision to executive discretion and the executive exercised it. Each failure points to a design response. The pattern is not a paradox. The statutes that gave way were written with discretion in them, and discretion is what was exercised. Where the law left none, it held: the attempt to cap indirect cost recovery at 15 percent was restrained within days and permanently enjoined within two months, in large part because an appropriations rider in force since 2018 had barred any change to the negotiated-rate process, leaving no discretionary hook to pull. The answer to law that buckled is law without the give.

Three design commitments follow, and they should be read as criteria applied to every codification recommendation in this document rather than as aspirations. First, remove the discretionary hook. A protection written as a duty the executive administers can be administered away, because the discretion to perform the duty is also the discretion to neglect it; a protection written to foreclose the discretionary act cannot. The ASPE workforce recommendation models this where it proposes statutory protection against reclassification of analytic positions out of competitive-service status, foreclosing the Schedule Policy/Career vehicle rather than asking the executive to refrain from using it. Second, attach an automatic consequence to the breach. A protection is only as strong as what happens when it is violated without a court: funds that cannot be obligated for other purposes, an appointment that is void rather than merely challengeable, a default procedure that triggers by operation of law, or, where the law permits no self-executing effect, a mandatory report on a fixed clock. These consequences come in two strengths, and the difference should be stated plainly. Self-executing legal effects operate without any executive act: the funds are simply unavailable, the appointment simply void, the default procedure already running. A self-executing effect earns that name only when its statute defines an objective trigger and identifies who records that it occurred; the drafting of each such provision must supply both. Mandatory transparency and oversight duties can be delayed or answered in conclusory form; their force is that evasion is itself a second, visible breach, committed on the record against a separate institution. Administrative commitments, directives and memoranda and internal policy, are a third and weaker class, used in this Blueprint only as interim steps toward codification, never as the durable protection. The FDA representativeness recommendation models this where it proposes that a substantive requirement become effective on a date certain if implementing guidance is withheld; the AHRQ reauthorization's anti-impoundment provision and mandatory grantmaking timelines with automatic defaults are the same design at the scale of an agency. Third, route enforcement through a separate, accountable institution. A protection the executive enforces against itself is weaker than one an Inspector General, the Office of Special Counsel, or Congress is given standing and a duty to enforce, because overriding it requires a second visible act against a separate institution. Recommendation 1 below models this with sampling-based Inspector General audit of award decisions, and

Recommendation 4 models the constitutional form the design must take after *Kennedy v. Braidwood Management* and *Trump v. Slaughter*.

These commitments do not guarantee the outcome, and the Blueprint does not claim they do. Against an actor willing to bear the cost, to remove the auditor, to accept the record, and to outlast the litigation, no drafting guarantees the protection holds. What the commitments do is convert a quiet, cheap, deniable erosion into one that is loud, expensive, attributable, and reversible. The protection of the federal evidence enterprise is therefore layered: administrative measures that establish practice now, statutory measures built to resist reversal, and a transparency-and-attribution floor that holds when the layers above it are breached. Where a recommendation in this document falls short of these commitments, a resilience note says so and states what survives.

A durable framework also has to be able to change. Consensus on formal structure requires agreement not only that it is time for statute but that the statute can be lived with: overseen, adhered to by administrations of any party, and updated as conditions change without reopening the founding fight. Each codified standard in this document should therefore carry its own amendment path, a public review on a fixed cadence with notice and comment, so that revision is routine and visible rather than either impossible or improvised. Breach, enforcement, and evolution are the three parts of the architecture.

Recommendations

These five recommendations build the architecture the diagnosis describes and apply the test above. Three can begin now under existing authority; all five require legislation to become durable. They address peer review in grantmaking, scientific integrity oversight and evidence-function leadership, evidence synthesis, advisory committee governance, and the science workforce.

1. Protect federal research awards from political interference.

Congress should prohibit viewpoint discrimination in federal research funding and bar political appointees from scoring, ranking, or vetoing individual grant applications. Peer review should remain the basis for funding recommendations, and agencies should keep their existing discretion to balance portfolios and to fund high-risk, early-career, or underserved-population research. The statute should require only that any departure from peer-review rankings rest on programmatic criteria published in advance and on a written rationale entered in the administrative record, unrelated to the viewpoint of the research. Compliance should be tested through sampling-based Inspector General audit rather than case-by-case litigation, which protects the principle without inviting a lawsuit over every award. An audit finding that an award decision violated the prohibition should carry an automatic consequence: the affected application returns to its peer-review disposition for a new funding decision on the record, and the finding is recorded in the annual Federal Health Evidence Report to the committees of jurisdiction. A firewall of this kind makes a universal political pre-award gate unlawful and leaves a rule like the proposed Uniform Grants Regulation no ground to stand on. Agencies can act now under existing authority by adopting binding integrity procedures that put any contrary government-wide rule in conflict with their statutory missions; if such a rule is finalized, Congress can reverse it by resolution

of disapproval or supersede it by statute. The NIH section and the Follow the Science Act (H.R. 7173) offer the agency-specific version this framework would generalize.

Responsible entity: Congress for the statutory prohibition and audit mandate; agency heads for binding integrity procedures now; the HHS Inspector General for sampling-based audit. **Mechanism:** Authorizing legislation; agency integrity procedures under existing authority in the interim; appropriations language as the minimum vehicle; a Congressional Review Act resolution or superseding statute if a rule institutionalizing interference is finalized. **Timeline:** Agency procedures within the first year under new leadership; statute requires legislation.

2. Establish scientific integrity officers and tiered protection for evidence-function leadership.

Every HHS agency that funds, conducts, or oversees research should maintain a scientific integrity policy enforced by a Scientific Integrity Officer who reports to the agency head, investigates complaints, protects whistleblowers, and holds the office under statutory qualification requirements, with any removal accompanied by a written statement of specific reasons transmitted to the committees of jurisdiction and published. The 2023 federal scientific integrity framework already directs agencies to designate such officials; the task is to make the role durable and independent rather than a revocable matter of policy, with authority defined to complement the Inspector General and the Office of Special Counsel rather than duplicate them, and with the Inspector General as the primary outside channel given the Office of Special Counsel's present capacity limits. The Secretary should issue an HHS-wide directive within the first 90 days of new leadership, and Congress should codify the structure. The Scientific Integrity Act (H.R. 1106) and the Follow the Science Act (H.R. 7173) offer a useful framework, although neither has made it out of committee as of this writing. The same logic tiers protection for evidence-function leaders, on the removal design set out in Legislative Proposal 2 after *Trump v. Slaughter* (June 29, 2026): statistical and evaluation heads (AHRQ and NCHS Directors), kept as inferior officers appointed by the Secretary, warrant a fixed term off the presidential cycle, statutory qualifications, for-cause removal as a single layer under an at-will Secretary, published reasons for any removal with a notice period, and an interim rule for contested removals; research and guidance heads (NIH and CDC Directors) are principal officers who cannot carry for-cause protection after *Slaughter* and warrant the same design without the for-cause element or a fixed term; the VA Chief Research and Development Officer, the emergency council chair, and the Chief Science Officer are inferior officers and carry for-cause protection without a fixed term; policy-analysis leadership (ASPE) warrants statutory workforce protections within a politically accountable office. The agency sections set the specific selections.

Responsible entity: HHS Secretary for the directive; agency heads for integrity policies; Congress for codification and the tiered leadership design. **Mechanism:** Secretarial directive under existing authority; authorizing legislation codifying the officer and the tier design (Legislative Proposal 2). **Timeline:** Directive within the first 90 days under new leadership; codification requires legislation.

3. Protect the independence of federal evidence synthesis across the government.

Federal evidence synthesis runs through more than one program. The AHRQ Evidence-based Practice Centers, the VA Evidence Synthesis Program, and the Community Preventive Services Task Force all turn

primary research into the conclusions that drive coverage, clinical guidelines, and public health practice. Each should operate under the same protection. Congress should codify the recognized national standards for systematic reviews and trustworthy clinical guidelines as the methodological baseline, and require registered protocols, public comment, and independent methodological review before release. It should establish that no federal funds may be used to suppress, delay, or alter a federal evidence synthesis in a way inconsistent with those standards, on the model of the statutory firewall that protects the Medicare actuary. The protection does not turn on adjudicating whether a claimed methodological justification is genuine, because an actor determined to alter findings can always supply one. It turns on attribution: any alteration to a registered synthesis protocol or to findings after protocol registration must be published as a dated, signed change alongside the original, with the independent methods reviewer's concurrence or objection on the record, and a pattern of unconcurred alterations triggers Inspector General review on the sampling model in Recommendation 1. A synthesis carrying a visible record of directed change no longer carries clean authority, which is the consequence that matters. Program staff may manage scope, timelines, and deliverables, but not methods or findings, and the protection should reach contract terms so payment cannot be used as leverage over results. Any correction process should be held to firm timelines and to the same attribution rule, so that information-quality challenges cannot be used to delay inconvenient findings. Where an emergency requires synthesis on a timeline registration cannot accommodate, the designation-and-waiver rule the CDC and CMS sections apply to pre-registration governs: documented waiver, retrospective registration within 60 days. The AHRQ, VA, and CDC sections address their synthesis functions in detail.

Responsible entity: Congress for the methods baseline and the firewall; AHRQ, VA, and CDC program leadership for protocol registration and contract terms now; the HHS Inspector General for pattern review. **Mechanism:** Appropriations language and contract terms now; authorizing legislation to codify the methods standards, the attribution rule, and the firewall. **Timeline:** Next appropriations cycle; codified independence requires legislation.

4. Reform federal scientific advisory committee governance.

The strongest protections should focus on advisory bodies whose recommendations carry quasi-regulatory weight, such as the Preventive Services Task Force and the immunization committee. For these, Congress should require subject-matter expertise tied to the committee's mandate, fixed staggered terms, a published statement of specific reasons for any removal before the end of a term transmitted to the committees of jurisdiction with a notice period before it takes effect, and transparent records of conflicts and of the evidence considered. The reform must be drafted with care. In 2025 the Supreme Court upheld the Task Force's structure precisely because the Secretary can remove its members and review their recommendations, so a removal protection must preserve enough supervision to keep members inferior officers under the Appointments Clause while still ending at-will, viewpoint-based dismissal. For the wider universe of federal advisory committees, Congress should require baseline transparency (public rosters with areas of expertise, conflict disclosures, meeting materials, and the basis for advice) together with periodic Government Accountability Office review of compliance, with a GAO finding of non-compliance transmitted to the committees of jurisdiction and the committee's charter renewal conditioned on a documented response, rather than a single across-the-board removal standard that would invite constitutional challenge. This recommendation is the template for how the Blueprint's removal protections are written after *Slaughter*: supervision

preserved, unexplained dismissal ended, the reasons on the record. Pending legislation, the Secretary should apply these standards to HHS advisory committees by guidance. The CDC section addresses the immunization committee and the AHRQ section addresses the Preventive Services Task Force; this recommendation sets the framework they share.

Responsible entity: Congress for the statutory framework; HHS Secretary for interim application by guidance; GAO for compliance review. **Mechanism:** Authorizing legislation amending the Federal Advisory Committee Act and the enabling statutes of the consequence-bearing committees; Secretarial guidance in the interim. **Timeline:** Guidance within the first year under new leadership; statute requires legislation.

5. Protect the federal science workforce and scientific communication.

HHS should restore full competitive-service tenure and whistleblower protections for positions at health evidence agencies designated as policy-influencing, and Congress should codify those protections in statute, superseding the February 2026 civil service reclassification rule. Agencies should limit pre-publication review of findings, data releases, and guidance to scientific and legal questions rather than political clearance, and should publish clearance standards with firm timelines, so review cannot become indefinite delay. Congress should codify federal scientists' right to publish and disseminate findings consistent with their agencies' scientific missions, with anti-retaliation protections enforceable through the Merit Systems Protection Board and the Inspector General, and through the Office of Special Counsel as that office's capacity permits, and should direct the Government Accountability Office to audit clearance compliance, with findings transmitted to the committees of jurisdiction and any clearance held past the published timeline deemed complete. The Data Infrastructure section addresses removal of public data, and the Evidence Workforce section addresses the broader pipeline.

Responsible entity: HHS Secretary and agency heads for administrative restoration and clearance standards; Congress for codification; the Merit Systems Protection Board, the HHS Inspector General, and the Office of Special Counsel for enforcement; GAO for audit. **Mechanism:** Administrative restoration of workforce protections and published clearance standards now; statutory codification and anti-retaliation enforcement by Congress. **Timeline:** Available now; codification requires legislation.

Together these recommendations give the Office of the Secretary a concrete first-year agenda: an integrity directive, advisory committee standards, and clearance review limited to scientific and legal questions. The statutory pieces (grantmaking protections, the Scientific Integrity Act, advisory committee reform, and evidence synthesis standards) belong on the consolidated Legislative Proposals list, and can be phased so administrative steps precede the legislation that makes them durable. Each codified standard carries the review cadence the framing above requires, so the framework can be revised on evidence rather than abandoned under pressure. Progress is measurable: the share of funding deviations with published rationales, the time from draft to release for synthesis products, and the disposition of integrity complaints can each be tracked and audited by the Government Accountability Office. These protections also presume the underlying programs survive, which the AHRQ section and the funding recommendations across the agency sections address.

Trust and Communications Preparedness

Federal evidence only works if people receive it and believe it. A guidance document no one trusts changes no behavior; a dataset no one can interpret informs no decision. Trust in the federal evidence system is not produced by a communications strategy, and the three recommendations in this section do not claim to produce it. Trust follows trustworthiness. The whole of this Blueprint is the trust strategy: the firewalls around research awards, the named scientific lead in every CDC guidance document, the published record of who decided what and why, the statistical releases that arrive on schedule with their methods stated. What a communications function adds is two things the structural protections cannot do on their own. It makes a trustworthy system visible as one, by governing how agencies state what they know, admit what they do not, and explain themselves when the answer changes. And it carries back into the agencies what the people they serve are actually asking and experiencing, so that the system earns trust by responding rather than by announcing. The federal government treats communication as a function that activates when a crisis begins. Trust does not work that way. It is built or spent in the years between crises. The Emergency Evidence Preparedness section addresses the emergency application. This section builds the standing base that the emergency function draws on.

The scope here is structural. This section takes no position on what federal health messages should say. It addresses the infrastructure through which evidence reaches people and the operating practices that determine whether it is believed when it arrives.

Diagnosis

Trust is managed as an emergency asset, and it depreciates in peacetime. Communications investment surges when a crisis is declared and recedes when it ends, while trust moves on its own schedule. Trust in CDC for vaccine information reached 47 percent in January 2026, the lowest level measured since the pandemic, and by mid-2026 about half the public trusted federal health agencies for reliable information, continuing a multi-year erosion that no emergency campaign arrested. The pattern parallels a failure the Blueprint addresses elsewhere in data systems and research mobilization: capacity that is stood up during an emergency, then dismantled, is never ready when needed. **The impact: every emergency response begins by borrowing against a trust account that routine practice has been drawing down.**

Routine guidance practice spends credibility. Guidance that overclaims certainty, reverses without explanation, or blends the evidence summary with the policy choice teaches its audience to discount the next guidance. The Blueprint proposes fixes at specific points: the CDC section separates evidence summary from policy recommendation, and the Emergency Evidence Preparedness section requires emergency guidance to state what it knows, how confident it is, and when it will be revisited. No department-wide standard extends those practices to the routine guidance that shapes public expectations between emergencies. **The impact: the credibility available in a crisis is set by the everyday guidance practice that preceded it.**

Federal communication runs one way, through channels the government owns. Survey research consistently finds that people trust their own clinicians and pharmacists more than they trust government health authorities. In the 2026 Edelman Trust Barometer Special Report on Trust and Health, respondents rated their own doctor the most trusted voice on health issues, at 80 percent, against 44 percent for government leaders, and trust in United States national health authorities fell nine points in a single year, to 51 percent. Federal engagement with those messengers is episodic: activated when an emergency is declared, dropped when it ends. And the flow is one-directional. No standing federal capacity exists to learn, quickly and systematically, what questions the public is actually asking or how federal guidance is landing where people live, so guidance is written to the questions agencies assume rather than the questions people have. The community organizations that hold trust on the ground are engaged episodically and rarely paid for the work, and many of them experience federal public health as an entity that takes data and gives little back. **The impact: the messengers people believe are outside the system, and the questions people hold are invisible to it.**

Recommendations

The three recommendations are the communications infrastructure for a trustworthy system, and they should be read alongside the protections elsewhere in the document rather than as a substitute for them. They operate primarily through administrative action, with appropriations sustaining the partnership and listening infrastructure and codification securing the standard so it survives a change of leadership. Each strengthens, and none duplicates, the emergency function established in the Emergency Evidence Preparedness section.

1. Adopt a department-wide standard for how federal health evidence is communicated.

The HHS Secretary should issue a directive establishing four practices as the operating standard for major guidance and evidence communication across the operating divisions. First, state the confidence level: what is established, what is provisional, what is unknown. Second, explain every change: when guidance changes, publish a plain-language statement of what changed, what evidence changed it, and what would change it again. Third, keep the boundary visible: present the evidence summary and the policy recommendation as distinct elements, extending the structure proposed in the CDC section department-wide. Fourth, publish the open questions the agency is working to answer. The directive belongs in the first-100-day package assembled in the Office of the Secretary section, administered by the Chief Science Officer, with compliance reflected in the annual evidence-use scorecard.

Responsible entity: HHS Secretary; the Chief Science Officer as administrator; operating division heads. **Mechanism:** Secretarial directive under existing authority; codification through the same vehicle as the scientific integrity policy, so that a guidance document lacking the four elements does not carry the department's imprimatur. **Timeline:** First 100 days under new leadership; codification requires legislation.

2. Resource trusted-messenger partnerships as routine infrastructure, and build a standing capacity to listen.

CDC and the Office of the Assistant Secretary for Health should maintain standing cooperative agreements with the organizations people already trust: clinician, nursing, and pharmacy associations, community health worker networks, and state and local public health organizations. The partnerships should carry routine work in ordinary times, so the relationships are functioning when an emergency arrives, and the community organizations that do the work should be paid for it through the cooperative agreements rather than asked to volunteer it. The partnerships should also run in both directions, and surveys alone do not accomplish that. The listening function should include a standing rapid-survey capacity anchored in existing federal survey infrastructure; real-time social listening on defined questions, with the methods published; recurring focus groups and community panels; and lived-experience councils with a formal channel into guidance development. On a regular cadence, the agencies should publish what they heard and what changed because of it. Three design rules keep this from becoming a channel for whoever happens to be trusted by whoever happens to be in office. The partnerships are procurement, run through cooperative agreements with published selection criteria, rotating terms, and no exclusivity, so that no organization becomes the government's permanent voice or its permanent ear. Any council that advises the agencies is chartered under the Federal Advisory Committee Act, with the balance, open-meeting, and public-record requirements that Act imposes, and the Act's requirements are treated as the design rather than as an obstacle to it. And what is heard is published in full, not summarized by the agency that heard it, so that capture of the listening function by any interest is visible to everyone else. A federal system that asks and is seen to answer is treated differently from one that announces. The community-messenger, multilingual, and tribal partnership networks specified in the Emergency Evidence Preparedness section activate through the relationships this recommendation maintains.

Responsible entity: CDC Director and the Assistant Secretary for Health; the HHS Office of the Assistant Secretary for Public Affairs for channel coordination; the reauthorized AHRQ for the listening methods. **Mechanism:** Cooperative agreements under existing authority, with partner compensation built in; appropriations to sustain continuity; codification of the standing listening function alongside the communication standard in Recommendation 1. **Timeline:** First year under existing authority; durable funding requires appropriations; codification requires legislation.

3. Measure trust and report it publicly.

What the department measures, it manages. The federal statistical system should produce an annual, methodologically stable, publicly released measurement of trust in federal health evidence and guidance, disaggregated by the population categories used across the Blueprint's data recommendations, with the survey home in the reauthorized AHRQ's statistical activities. The measure gives the communication standard in Recommendation 1 an outcome, gives the scorecard in the Office of the Secretary section a trust line, and replaces anecdote with a tracked series the department cannot ignore.

Responsible entity: The reauthorized AHRQ, drawing on NCHS survey methodology; the Chief Science Officer for scorecard integration. **Mechanism:** Administrative action within existing survey authority; a modest recurring appropriation. **Timeline:** First measurement within two years; annual thereafter.

Cross-cutting connection: The trust argument runs through the whole document, and its structural sources sit elsewhere: CDC Recommendations 2 and 3, the Research Integrity and Scientific Freedom section, and the transparency and public-record provisions throughout. The Emergency Evidence Preparedness section's Recommendation 5 is the emergency application of the standing base built here; the two are designed as one architecture, and the standing listening function lives in this section. The communication standard extends the CDC section's evidence-summary structure (Recommendation 3) and joins the Office of the Secretary's first-100-day package (Recommendation 2) and scorecard (Recommendation 3). The partnership architecture coordinates with the State Evidence Capacity section. The trust measurement joins the statistical portfolio consolidated in the AHRQ section.

Emergency Evidence Preparedness

The next crisis will test the federal evidence system. It may be infectious, climate-driven, a mass casualty event, or a disaster not yet imagined. Whatever its shape, the system's performance will help determine how many lives are lost and how quickly public trust recovers. COVID-19 showed that the system was not ready. Those lessons apply across crisis types. The fixes are structural.

Diagnosis

The federal evidence system entered the COVID-19 emergency without a tested, operating model for managing uncertainty. The federal agencies that issue public guidance under emergency conditions, particularly the CDC, the FDA, and the NIH, have decades of expertise in evidence synthesis and decades more in emergency response. What they lacked, and still lack, is a standing operating framework that distinguishes what is known from what is uncertain from what is unknown, updates that framework on a predictable schedule as evidence accumulates, matches the confidence level of public recommendations to the strength of the evidence, and makes the evidence-summary-to-policy-decision boundary visible at the moment of consequence. Public communication swung between false certainty and apparent reversal. The public lost the ability to tell the difference.

Four related failures compounded this one.

Federal agencies blurred the line between science and policy in ways that left scientists carrying political judgments and let policymakers escape accountability for calls that were theirs to make. Former CDC employees writing in the *New England Journal of Medicine* in July 2020 framed this directly as a question of whether the agency would be allowed to fulfill its pledge to "base all public health decisions on the highest quality scientific data that is derived openly and objectively" (Rasmussen and Jamieson, NEJM, July 29, 2020). The boundary between the evidence summary and the policy decision dissolved at the moment it mattered most.

The system was not designed for speed. The country lacked a nationally coordinated standing research platform at comparable scale to the United Kingdom's RECOVERY trial, which announced practice-changing dexamethasone results on June 16, 2020, less than 100 days after the protocol was first drafted (Glasziou and Tikkinen, *JRSM*, 2021). Hundreds of uncoordinated U.S. studies ran in parallel, most too small to answer the questions they asked. An FDA review by Bugin and Woodcock in *Nature Reviews Drug Discovery* (2021) found that of more than 2,895 unique drugs or drug combinations evaluated worldwide in COVID-19 trials by late 2020, only about five percent of trial arms were randomized and adequately powered.

The system lacked a disciplined framework for acting on imperfect information. Some decisions were delayed while officials waited for evidence that would not arrive in time to matter. Others moved forward on weak evidence without transparent explanation. In neither case did the public see a visible process for revising decisions as evidence changed.

The supporting infrastructure failed at the seams. Federal and state data systems did not produce timely, linked information on cases, hospitalizations, outcomes, and equity, and lacked pre-negotiated legal authorities to move data without improvising privacy questions mid-crisis. Agencies ran research efforts without coordination, producing redundancy and gaps at the same time. The evidence workforce could not deploy across agencies or shift between routine and crisis operations. State, local, tribal, and territorial partners operated with uneven capacity, authorities, and reporting systems. Trust and communications infrastructure required the same advance investment and exercise but did not receive it (Sell et al., Johns Hopkins Center for Health Security, March 23, 2021). The Data Infrastructure, Align and Coordinate, Evidence Workforce, and State Evidence Capacity cross-cutting sections treat each failure in full.

Recommendations

The five recommendations operate through a combination of administrative action and legislation. Recommendation 1 establishes a common federal emergency guidance template with an integrated emergency waiver standard for pre-registration. Recommendation 2 builds a national emergency research commons. Recommendation 3 builds the operational readiness that lets research start in days, not months. Recommendation 4 establishes a standing interagency council with statutory protections for its scientific chair. Recommendation 5 establishes standing trust and communications preparedness as durable infrastructure rather than a campaign reconstructed at the start of each emergency.

1. Require every piece of federal emergency guidance to say what it knows, how confident it is, when it will be revisited, and, when pre-registration is compressed under emergency conditions, what evidentiary trade-offs that compression accepts.

The HHS Secretary should direct the CDC, the FDA, and the NIH to adopt a common emergency guidance template and issue all emergency public guidance in that format. The template should require six elements: a plain-language summary of what is known, uncertain, and unknown; a stated confidence level tied to the strength of the evidence; a named scientific chair supported by a standing scientific team who owns the evidence summary; a named policy official who owns the decision; a next-review date with the triggers that would prompt earlier revision; and, for reissued guidance, a dated change log that states what changed and why. The template should include adaptation pathways so state, local, tribal, and territorial agencies can tailor guidance to local conditions without losing the evidentiary backbone.

The recommendation also establishes a federal standard for pre-registration emergency waivers. Pre-registration is recommended for designated categories of federal evidence work in the CDC, NIH, FDA, and CMS sections; each raises the same question of how the standard operates under declared emergencies. A uniform federal standard avoids both regulatory fragmentation and a race to the weakest waiver. The waiver standard has four elements. First, the trigger is a declared public health emergency under section 319 of the Public Health Service Act, or a parallel statutory emergency declaration, rather than agency-level discretion; the waiver is not available for routine speed pressure. Second, the waiver compresses the pre-registration record to a minimum-viable form (research question, primary outcome, analytic approach), posted before analysis begins, rather than eliminating

pre-registration; the full record is filed within a defined post-hoc window. Third, the agency invoking the waiver posts a brief public explanation at the time of invocation describing why the compressed pathway is necessary, what evidentiary trade-offs it accepts, and what the post-hoc completion timeline is. Fourth, waivers expire with the underlying emergency declaration; continuing analytic work transitions to the standard pre-registration pathway, and the council convened under Recommendation 4 reviews waiver use after each declared emergency and publishes findings.

Congress should codify the transparency obligations of the template as statutory requirements for federal emergency guidance and codify the waiver standard as a uniform federal floor that the agency-section pre-registration recommendations inherit by reference. The statute should specify required elements rather than prescribe wording or format, which would raise compelled-speech questions unnecessary to the durability goal.

Responsible entity: HHS Secretary; CDC Director; FDA Commissioner; NIH Director for their respective guidance functions; Congress for codification. **Mechanism:** Secretarial directive establishing the template and waiver standard, followed by authorizing legislation. **Timeline:** Administrative action within the first year under new leadership; statutory codification requires legislation.

Cross-cutting connection: The guidance template parallels and reinforces CDC Recommendation 3 on the separation of evidence summary from policy recommendation, and the waiver standard establishes a federal floor that the pre-registration recommendations in the CDC, NIH, FDA, and CMS sections inherit by reference. The Research Integrity and Scientific Freedom cross-cutting section carries the federal-evidence-enterprise-wide articulation of the evidence-summary-from-policy-decision boundary and the pre-registration framework.

2. Build a national emergency research commons that makes the full evidence effort visible in real time.

NIH and CDC should establish a unified public registry for all federally funded research conducted under declared emergencies, including research funded through the Administration for Strategic Preparedness and Response (ASPR) and the Biomedical Advanced Research and Development Authority (BARDA), which fund a substantial share of emergency research and whose studies should be visible in the same place as everyone else's. The registry should go beyond clinical trials to include observational studies, surveillance protocols, modeling work, and rapid analytic plans. Every entry should post its research question, study design, analysis plan, and, where feasible, common data elements (including population disaggregation standards) and core outcomes before data collection begins. The registry should serve as a prioritization and coordination tool: federal program officers should be able to see when ten small overlapping studies are being launched and consolidate them into one large useful one. Authority to flag overlapping studies and propose consolidation should rest with the lead coordinating agency designated under Recommendation 4, with final funding decisions retained by program officers and grant-making institutes.

A registry without dedicated analytic capacity is a compliance artifact. A standing team of analysts embedded in the lead coordinating agency should actively review entries, identify overlap and gaps, and brief program officers on consolidation opportunities. Pre-negotiated state-federal data sharing agreements should make registry participation compatible with state, local, and health system data

flows. The pre-registration emergency waiver standard established under Recommendation 1 applies to registry entries filed during declared emergencies. Congress should codify the emergency research commons as a statutory condition of federal emergency research funding.

Responsible entity: NIH Director and CDC Director jointly; ASPR and BARDA as participating funders; the lead coordinating agency designated under Recommendation 4; Congress for codification. **Mechanism:** Agency policy, terms of award, pre-positioned data agreements, and standing analytic staffing, followed by authorizing legislation. **Timeline:** Administrative action within the first year under new leadership; statutory codification requires legislation.

Cross-cutting connection: Coordinate with the Data Infrastructure Modernization and Align and Coordinate the Federal Evidence Enterprise cross-cutting sections.

3. Build the operational readiness that lets research start in days, not months.

Rapid evidence generation depends on more than pre-written protocols and fast money. It depends on research operations built in advance: single institutional review board reliance agreements across federal research entities, standing contract and legal templates, provider and health system networks embedded in routine care, community-based trial networks that reach populations outside academic medical centers, common data models, and annual full-pipeline activation drills with published findings. NIH and CDC should maintain this operational stack alongside pre-written adaptive trial protocols and standing funding pathways that can activate within days of a declared emergency. The model is the United Kingdom's RECOVERY trial: flexible study design, rapid enrollment through routine care settings, and a short list of high-priority questions answered at scale. The same infrastructure that answers questions about an emerging pathogen can answer questions about wildfire smoke, heat-related mortality, or the health effects of mass displacement. The operational stack should also be built from what the last emergency taught. The Secretary should commission, within the first year, a methodological review of the emergency authorizations, waivers, and barrier removals used during the COVID-19 response (single-IRB reliance, remote consent, decentralized trial elements, expedited data-use agreements, and emergency-use evidence standards among them) to identify which produced evidence of acceptable quality faster and should become routine, which should remain emergency-only, and which should not be repeated. Applying emergency lessons in peacetime is the point of readiness; the review is how the lessons become the standing design rather than an after-action report.

The NIH-led ACTIV partnership, launched on April 17, 2020 within weeks of the pandemic declaration, supplies a documented operational precedent for rapid public-private research coordination. ACTIV developed and launched nine master protocols between April 14, 2020 and May 31, 2021 and brought together eight U.S. government agencies, twenty biopharmaceutical companies, and four nonprofit partners. ACTIV's operational record, including the trial-specific lessons-learned series subsequently published, is a directly usable design reference for the standing operational stack.

This framework depends on permanent capacity: a trained workforce and interoperable data systems. Those come from the Evidence Workforce Development and Data Infrastructure Modernization cross-cutting sections. Congress should establish a dedicated surge research fund, appropriated on a regular cycle with statutorily defined activation triggers and standing oversight requirements, so activation does not wait for emergency appropriations passed after the crisis has already begun. Pre-positioned

funding is scheduled funding, not off-budget funding; appropriations committees retain authority over the baseline and over activation review.

Responsible entity: NIH Director; CDC Director; HHS Secretary for the emergency-to-peacetime methodological review; Congress for the surge research fund. **Mechanism:** Agency guidance, pre-positioned protocols, and operational infrastructure, with legislation to authorize a surge research fund. **Timeline:** Capacity-building can begin within the first year under existing authority; surge funding requires legislation.

Cross-cutting connection: Coordinate with the Evidence Workforce Development and Data Infrastructure Modernization cross-cutting sections; the surge research fund belongs with the consolidated funding-architecture proposals in the Legislative Proposals section. The standing rapid-response procedures called for in NIH Recommendation 8 are the agency-side counterpart to this operational stack.

4. Create a standing interagency council that maintains readiness between crises, coordinates the federal response during them, and operates with statutory protections for its scientific chair under the federal evidence-function three-tier protection architecture.

Existing coordination bodies serve important but differently scoped functions. The Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) covers medical countermeasure development. The Administration for Strategic Preparedness and Response (ASPR) covers operational response coordination. The White House Office of Pandemic Preparedness and Response Policy (OPPR) covers pandemic-specific strategic coordination. CDC incident command structures cover intra-agency response. None of these bodies covers the full emergency evidence enterprise across crisis types: evidence generation, synthesis, guidance revision, and cross-jurisdictional coordination.

The gap is not abstract. The Health Information Technology Advisory Committee (HITAC), chartered under section 4003(e) of the 21st Century Cures Act and governed by the Federal Advisory Committee Act, was placed on indefinite suspension in late January 2025 and did not resume regular meetings until January 2026, a full year of dormancy in a non-emergency period for a statutorily chartered body in a substantively adjacent domain. The HITAC pattern demonstrates that statutory charter alone is insufficient: a council designed to maintain readiness between crises needs operating-cadence requirements, a defined activated-footing protocol, and a stated consequence for suspension, all written into statute. A constraint on suspension that names no consequence is an intention. The statute should provide that if the council is not convened on its cadence, or is suspended, the vice-chair convenes it by operation of the statute and the failure is recorded in the annual Federal Health Evidence Report to the committees of jurisdiction and the Secretary states the cause; and that during a declared emergency the council's activated-mode authorities run from the declaration itself, not from a Secretarial decision to activate.

The HHS Secretary should convene a council with the broader remit. Members should include NIH, CDC (including NCHS), FDA, AHRQ, ASPE, and the VA, with defined participation from DOD, NSF, BARDA, and representation from state, tribal, and territorial public health agencies. In non-emergency periods the council should meet at least quarterly to maintain data-sharing agreements, run tabletop exercises, and identify evidence gaps. When a public health emergency is declared the council should shift to an

activated footing with defined authorities, a published decision protocol, and a faster meeting schedule. The council should carry explicit responsibility for keeping the evidence summary and the policy decision separate. During emergencies it should also coordinate rumor surveillance and evidence-based communication with state and local public health agencies, working in conjunction with the standing trust and communications infrastructure established under Recommendation 5.

The council should operate with a defined interface to White House coordination functions, including OPPR and relevant National Security Council directorates, without duplicating their authorities. The council's work is evidence generation, synthesis, and guidance. White House coordination is crisis command and interagency response policy. The two functions interact but should remain structurally distinct.

Congress should codify the council in statute to make its authorities durable across administrations, to specify operating cadence and the consequences above, to define the triggers and scope of its activated mode, and to protect the role of the council's scientific chair on the design set out in Legislative Proposal 2 after *Trump v. Slaughter* (June 29, 2026). The chair is an inferior officer, appointed by the Secretary, and the statute should say so: the council recommends and convenes, and binding decisions stay with the officials who already hold the authority, which is what keeps the office inferior and lets it carry for-cause protection as a single layer. The design adds statutory qualifications for the chair; a requirement that any removal be accompanied by a written statement of specific reasons transmitted to the committees of jurisdiction and published, with a notice period before it takes effect; and an interim rule. The interim rule matters most here, because the council exists for the moment when a removal would do the most damage: while a removal of the chair is contested, or the position is vacant, the vice-chair, a career scientist designated in advance, chairs with the council's full authorities intact and without power to alter the published decision protocol. Remove-first-and-litigate-later does not work against a body whose chair is replaced by operation of statute the moment the office is disturbed. Removal by the Secretary is only for cause. The chair sits in Tier 2 of the federal evidence-function three-tier protection architecture articulated in the cross-cutting Research Integrity and Scientific Freedom section, paired with the CDC Director, the NIH Director, and VA research leadership, without a fixed term. Tier 2 differs from the statistical-and-evaluation tier (Tier 1; AHRQ and NCHS Directors) because the chair's evidence-synthesis-and-guidance function does not have the periodic-release-schedule and principal-federal-estimate-production responsibilities that anchor Tier 1's fixed-term protection. It differs from the policy-analysis tier (Tier 3; ASPE) because the chair runs evidence synthesis and guidance rather than the development and implementation of Administration policy.

Responsible entity: HHS Secretary; council members as named above; council scientific chair and designated vice-chair; Congress for codification. **Mechanism:** Secretarial convening authority, followed by authorizing legislation that establishes the chair's qualifications and removal design, the interim rule, operating cadence, automatic consequences on suspension, and activated-mode triggers running from the emergency declaration. **Timeline:** The council can be convened within the first year under existing authority; statutory codification requires legislation.

Resilience note: In a cooperative environment, the council meets quarterly and activates when asked. In a noncooperative one, three things survive by operation of the statute: the vice-chair convenes a council that has not been called, the activated-mode authorities run from the declaration rather than from a decision to use them, and a disturbed chair is replaced in the room before the litigation begins.

Cross-cutting connection: The council scientific chair protection structure sits in Tier 2 of the three-tier federal evidence-function protection architecture, paired with the CDC Director, NIH Director, and VA research leadership; the removal design follows Legislative Proposal 2. The cross-cutting Research Integrity and Scientific Freedom section carries the federal-evidence-enterprise-wide articulation of the tiered architecture. Statutory codification components belong in the consolidated Legislative Proposals section.

5. Build public trust the way trust is built: through a standing, two-way communications infrastructure that is resourced between crises and listens before it speaks.

Trust in the federal evidence system is not produced by a communications strategy. It is produced by a system that behaves in ways that deserve it, and the whole of this Blueprint, from the firewalls around research awards to the attribution of policy decisions in CDC guidance to the published record of who decided what, is the trust strategy. What a communications function can do is make a trustworthy system visible as one, and, at least as important, carry back to the agencies what the people they serve are actually experiencing, so that the system earns trust by responding rather than by asserting. The most consistent finding across COVID-era trust research is that the communications infrastructure needed during an emergency cannot be built during the emergency. Trusted community messengers, multilingual communication capacity, rumor and misinformation surveillance, and pre-tested emergency communication frameworks all require the same kind of advance investment that medical countermeasure stockpiles and laboratory networks receive (Sell et al., Johns Hopkins Center for Health Security, March 23, 2021). They do not currently receive that investment, and they were not in place when the federal evidence system needed to communicate emergency findings to the public during the COVID-19 response.

HHS, through CDC and ASPR and in coordination with the council established under Recommendation 4, should resource and operate trust and communications preparedness as a standing function with six elements, the emergency application of the base built in the Trust and Communications Preparedness section. First, standing relationships with trusted community messengers (faith leaders, community health workers, tribal health departments, community and multilingual media outlets, disability-community organizations) maintained between crises through small recurring grants and joint planning rather than stood up ad hoc when an emergency is declared. Second, multilingual communication capacity built into routine federal health communication, so the muscle is exercised continuously and the communication networks needed in an emergency already exist. Third, standing rumor and misinformation surveillance with defined federal-state-platform information-sharing protocols; the ad hoc arrangements assembled during 2020 to 2022 should be made durable, with the constitutional limits on government speech and federal-platform interaction observed and made transparent. Fourth, pre-tested communication frameworks for high-frequency emergency scenarios (respiratory pathogen outbreak, environmental health emergency, mass casualty event), exercised in the same annual full-pipeline activation drills called for in Recommendation 3. Fifth, integration with the emergency guidance template established under Recommendation 1, so that confidence-level signaling, the evidence-summary-to-policy-decision boundary, and revision protocols translate intelligibly across community channels. Sixth, and running underneath the other five, the standing two-way channel the Trust and Communications Preparedness section builds in its Recommendation 2: the paid messenger partnerships and the listening function (social listening, community panels, lived-experience councils)

that operate in ordinary time. In an emergency this function does not have to be created; it shifts to emergency cadence, and the published record of what was heard and what changed continues.

Congress should codify the standing trust and communications function, including the listening function and the community-partner funding, as a statutory requirement so it survives administration transitions and budget cycles, with defined appropriations on a regular cycle and standing oversight requirements paralleling those for the surge research fund established under Recommendation 3.

Responsible entity: HHS Secretary; CDC; ASPR; the council established under Recommendation 4. **Mechanism:** Secretarial directive establishing the standing function under existing authority, followed by authorizing legislation establishing statutory requirement, appropriations cycle, and oversight architecture. **Timeline:** Administrative action within the first year under new leadership; statutory codification requires legislation.

Cross-cutting connection: The trust argument runs through the whole document; this recommendation is its communications infrastructure. The structural sources of trustworthiness sit in CDC Recommendations 2 and 3 (advisory committee protections; attribution of evidence and decision in guidance), in the Research Integrity and Scientific Freedom section, and in the transparency and public-record provisions throughout. State Evidence Capacity carries the state and tribal partnership architecture; Align and Coordinate carries the cross-agency operating model.

State Evidence Capacity

The federal evidence enterprise is a federal-state system. Vital records arrive at the National Center for Health Statistics from fifty-seven jurisdictions. Notifiable disease reports reach the CDC only insofar as state and local health departments collect, code, and submit them. The Transformed Medicaid Statistical Information System (T-MSIS) is built from data the states report. A substantial share of what the federal health evidence enterprise produces depends on what state, territorial, and local jurisdictions are positioned to deliver, and the federal system can only run as fast and as completely as those partners can run it. The CDC, NCHS, CMS, and brief agency sections each diagnose this dependency from the federal side. This section addresses it from the state side: what limits state evidence capacity, and what the federal government can do to build it.

The Blueprint's federal-state posture follows from a single principle: the federal government should build state capacity by setting meaningful minimum standards tied to federal funding streams and by providing the technical assistance, milestone-based funding, and floor-level investments that allow all jurisdictions, including the smallest and most under-resourced, to meet those standards. State evidence capacity should serve state legislative oversight and state-level program management as well as the federal evidence enterprise; the federal investment is in the underlying analytic and data infrastructure, not in the direction of the evidence that infrastructure produces. The Blueprint is not a directive to states about how to govern themselves.

The recommendations that follow are designed for two operating environments: one in which a federal partner is actively investing in state evidence capacity, and one in which the federal partner is reducing investment or actively disinvesting. Each recommendation distinguishes elements that survive through statutory design from elements requiring active administration support.

Diagnosis

Five structural conditions limit the evidence capacity of state, territorial, and local jurisdictions. None is attributable to a single administration.

State-level data infrastructure for the federal data systems that depend on state submission is variable and, in many jurisdictions, inadequate. The National Vital Statistics System receives birth and death records from fifty-seven jurisdictions, each operating on its own statutory framework, technology, and budget; the federal vital statistics system is only as current as its slowest contributing jurisdiction. Notifiable disease reporting depends on state systems that range from modernized FHIR-based electronic case reporting to legacy systems requiring substantial manual handling. T-MSIS data quality has improved substantially under the CMS DQ Atlas, T-MSIS Priority Items, and Outcomes Based Assessment framework; most state Medicaid agencies now meet the three OBA data-quality targets, with only a small number failing the critical-priority criterion as of mid-2026 (CMS T-MSIS data quality assessment). But variation across states and data elements remains material. Jurisdictions facing the largest gaps, including U.S. territories and historically under-resourced jurisdictions, are systematically least positioned to compete for competitive federal modernization dollars.

State-level evaluation capacity for Medicaid demonstrations and state-administered health programs depends on episodic contractor arrangements rather than standing analytic units. Section 1115 demonstration evaluations are typically conducted by external contractors funded through state Medicaid budgets that face pressure in every fiscal cycle, with no standing analytic units carrying institutional knowledge across demonstration cycles. Where standing state-level analytic capacity exists at scale, it was built through decades of sustained federal-state-academic collaboration. The clearest example is the twenty-five states whose Medicaid agencies maintain active partnerships with thirty public universities through the AcademyHealth State-University Partnership Learning Network (Milbank Memorial Fund); Maryland's partnership with The Hilltop Institute at the University of Maryland, Baltimore County, has run since 1994. That model is the existing implementation form of standing state analytic capacity; the problem is not that it does not exist but that it is not the norm and is not durably funded.

Workforce gaps in state and local health departments, Medicaid agencies, and vital records offices are a binding constraint. Epidemiologists, health-services researchers, biostatisticians, data scientists, evaluators, and informaticists are in chronic short supply across state and local jurisdictions. The state and local governmental public health workforce lost roughly 40,000 jobs between 2008 and 2019. PH WINS data show nearly half of state and local public health staff left between 2017 and 2021, and three-quarters of those thirty-five and younger (Leider et al., *Health Affairs* 2022). The CDC Epidemic Intelligence Service, AHRQ training grants, HRSA workforce programs, and ASPE evaluation contracting each supply some of this workforce; none operates at scale sufficient to meet demand. The Evidence Workforce Development section addresses the substantive policy question.

The federal funding and coordination architecture for state evidence capacity produces wide variation in outcomes from comparable inputs. Federal capacity dollars flow mostly through formula-based grants: the Public Health Infrastructure Grant, the CDC Data Modernization Initiative, AHRQ state-level capacity investments, ASPE-funded state evaluation work, and the cooperative agreements that fund vital records and surveillance. None is consistently tied to measured progress on jurisdictional capacity. Formula allocation produces predictable funding but leaves the federal government with limited tools to address jurisdictions that under-perform for reasons unrelated to baseline resources. Compounding the problem, federal-state coordination is fragmented: CDC, NCHS, CMS, HRSA, SAMHSA, ASPE, and the agencies that pass funds through each maintain their own technical assistance, data-use agreement templates, reporting requirements, and capacity-grant programs. State agencies that interact with multiple federal partners experience federal fragmentation as a capacity tax on top of resource constraints. The Align and Coordinate the Federal Evidence Enterprise section addresses federal coordination in full.

The state evidence capacity these recommendations would build depends on three structural conditions that shape whether the capacity, once built, produces credible evidence. First, federal-state data systems and analytic capacity should be designed with community governance over how data is collected, used, and accessed. The Robert Wood Johnson Foundation National Commission to Transform Public Health Data Systems supplies the framework and the CARE Principles ground tribal data sovereignty; the Data Infrastructure Modernization and Legislative Proposals sections treat both in substance. Second, state-level analytic functions should be protected from state-level political pressure on what they study and what they report, through professional independence standards and pre-

registration requirements consistent with the federal framework. Third, public trust in state and local health departments bears on both the quality of data communities provide and the durability of federal-state investments in capacity. Confidence in state health departments fell about 16 percentage points between early 2020 and mid-2022 and remained depressed through 2024; confidence in local health departments has partially rebounded (survey evidence, *PLOS Global Public Health* 2025). The Network for Public Health Law has separately documented narrowing of state public health emergency authorities in multiple states since 2020, addressed by the Legislative Proposals section.

Recommendations

The five recommendations operate as a coordinated package. Recommendation 1 is the technical backbone: federal-state minimum standards tied to existing funding streams. Recommendation 2 is the operational delivery mechanism: a federal technical assistance corps and unified state-facing federal interface. Recommendation 3 is the floor: capacity grants for jurisdictions below defined infrastructure thresholds. Recommendation 4 is the Medicaid-specific apparatus: enhanced federal matching for state Medicaid evidence functions. Recommendation 5 supplies the people: aligned federal workforce programs with concrete state-placement commitments. The test each note applies, whether the element works only if the responsible agent is already cooperative and, if so, what survives when it is not, is the one the Research Integrity and Scientific Freedom section asks of every protection in the document, and the same notes now appear on the most exposed recommendations elsewhere. Each carries a resilience note distinguishing elements that operate without active administration support, through statutory design, from those that require it.

1. Establish federal-state minimum standards for state-level data infrastructure, tied to existing federal funding streams and structured as incentive-based rather than punitive. The HHS Secretary should direct CDC, NCHS, CMS, and ONC to jointly publish, within the first year, federal-state minimum standards for state submission to the federal data systems on which the federal evidence enterprise depends. The standards should cover timeliness, completeness (including race, ethnicity, geography, primary language, and occupation), and technical interoperability (USCDI and FHIR alignment). Funding through the Public Health Infrastructure Grant, the CDC Data Modernization Initiative, NCHS cooperative agreements, and T-MSIS technical assistance and capacity programs should be tied to jurisdictional progress against those standards, with milestone-based disbursement replacing formula-based allocation for the modernization-eligible portion, while base allocations continue on formula. Milestone-based disbursement trades away some of the funding predictability formula allocation provides; program design should include defined transition periods, and the floor-level grants of Recommendation 3 protect jurisdictions whose baseline capacity cannot yet reach the milestones. The state-side standards operate alongside complementary provider-side levers (CMS payment program incentives such as the Promoting Interoperability Program and the Merit-based Incentive Payment System for electronic case reporting and syndromic surveillance) addressed in the CMS agency section. Congress should codify the federal-state minimum standards through the CDC reporting authority recommended in CDC R1, the multi-year vital-statistics funding authority recommended in NCHS R3, and statutory clarification of T-MSIS quality enforcement.

Mechanism: administrative action under existing CDC, NCHS, CMS, and ONC authorities, followed by authorizing legislation. Timeline: standards publication and milestone-based funding within the first year; statutory codification requires legislation.

Resilience note: The technical standards operate without administration support, through embedded technical practice, once published; they become reference points states, researchers, and Congress can use even if the federal agencies that published them later disinvest. The milestone-based disbursement architecture requires active administration commitment and is vulnerable to reversal absent statutory codification.

Cross-cutting connection: Operates in concert with the federal minimum-standards architecture in the Data Infrastructure Modernization section; receives state-side handoffs from CDC R1, NCHS R3, and CMS R8. The complementary provider-side reporting architecture is owned by the CMS agency section.

2. Establish a federal technical assistance corps for state evidence infrastructure and a unified state-facing federal interface. The HHS Secretary should establish, within the first year, a federal technical assistance corps for state evidence infrastructure, supporting state, territorial, and local jurisdictions on data infrastructure, evaluation, surveillance, and Medicaid analytics under a coordinated federal program. The corps should be staffed through detail and rotation arrangements across CDC, NCHS, CMS, AHRQ, ASPE, and HRSA, with the Office of the Secretary holding coordination authority and ASPE serving as the standing administrative home. Three design specifications, built in from the start, distinguish the corps from inter-agency bodies that dissolved into the fragmentation they were meant to address. The corps reports to the Secretary through ASPE rather than to its component agencies. It is funded through a dedicated appropriation rather than detail-cost reimbursement. And it is subject to a defined review and reauthorization cycle: every five years, with public reporting on performance against published service standards. Technical assistance should be provided under a unified state-facing federal interface: common data-use agreement templates, harmonized reporting requirements, coordinated capacity-grant timelines, and a single federal point of contact for state agencies working across multiple HHS partners. Congress should authorize the corps in statute and appropriate dedicated funding.

Mechanism: administrative action under existing authorities, followed by authorizing legislation. Timeline: corps established within the first year; statutory authorization requires legislation.

Resilience note: The corps requires active administration support to establish and function; an administration that does not want to coordinate technical assistance can simply not establish it or can establish it nominally and disinvest. Statutory authorization with dedicated appropriation and the five-year review cycle is the principal protection against administrative reversal, and the reason Congressional action matters more for this recommendation than for R1.

Cross-cutting connection: The federal-coordination dimension connects to the Align and Coordinate the Federal Evidence Enterprise section. Placement of the unified-state-interface component should be coordinated with that section's lead once identified.

3. Provide floor-level capacity grants to jurisdictions below defined infrastructure thresholds, including U.S. territories, with community governance built in. Milestone-based federal funding is the right structure for jurisdictions positioned to compete for it, but it does not reach jurisdictions

whose baseline capacity is too thin to meet entry-level milestones. The HHS Secretary should establish, within the first year, a floor-level capacity grant program for state, territorial, and city jurisdictions falling below defined infrastructure thresholds, with funding directed to base-level data systems, evaluation staff, and federal-state coordination infrastructure. Initial eligibility should be determined by an interim metric drawn from already-published federal sources (CMS DQ Atlas tiers, NAPHSIS-published EBRS/EDRS implementation status, and CDC surveillance-modernization indicators) so the program can begin disbursing in the first year without waiting for new measurement infrastructure to be built. A composite jurisdictional capacity index, developed by the federal technical assistance corps in coordination with CDC, NCHS, and CMS, should be published within eighteen months of the corps's establishment and updated annually; the composite index replaces the interim metric once published. U.S. territories, which face the largest gaps in vital records modernization, surveillance infrastructure, and Medicaid analytics, warrant dedicated allocations set as a defined percentage in program design. The federal-state architecture should accommodate Tribal data sovereignty under the CARE Principles: federal-state data-use agreements and milestone definitions that touch Tribal-collected data or data about Tribal citizens should require Tribal consultation and consent for federal use, consistent with the Data Infrastructure Modernization and Legislative Proposals sections, and with the IHS entry once tribal consultation concludes. Beyond Tribal data sovereignty, the federal-state architecture should require state and territorial recipients to establish community advisory mechanisms for data collection priorities and data-use decisions, consistent with the RWJF National Commission framework. Congress should authorize multi-year funding and direct the relevant HHS agencies to maintain dedicated territorial allocations.

Mechanism: administrative action under existing authorities, followed by authorizing legislation for multi-year funding. Timeline: program design and initial disbursement within the first year using the interim metric; composite capacity index within eighteen months of corps establishment; multi-year authority requires legislation.

Resilience note: The program depends on active administration commitment to design and fund it; absent that commitment, the architecture survives only as a published proposal. Statutory authorization with multi-year funding and a dedicated territorial allocation in statute is the principal protection. The CARE Principles and community governance requirements, once embedded in federal-state data-use agreements, are harder to remove than to put in place.

Cross-cutting connection: The Tribal data sovereignty dimension is treated in the Data Infrastructure Modernization and Legislative Proposals sections, with the IHS entry to follow tribal consultation. The community governance framework is addressed in full in Data Infrastructure Modernization.

4. Build state-level Medicaid analytic capacity through enhanced federal matching for Medicaid evidence functions, with pre-registration and analytical independence protections. State Medicaid agencies are simultaneously the largest source of state-level health data, the largest state-level health policy decision-makers, and the primary federal-state interface for the largest federal health program. The CMS Administrator should establish, within the first year, a federal-state Medicaid evidence infrastructure program providing enhanced federal matching for Medicaid evidence functions. Three functions qualify: standing state-level Medicaid analytic units; Section 1115 demonstration evaluation capacity that carries across waiver cycles rather than being rebuilt each time; and the federal-state coordination architecture for Medicaid data and evidence. The vehicle should be an enhanced

administrative match under Section 1903(a) of the Social Security Act, at a rate sufficient to make standing analytic capacity affordable for state Medicaid budgets that currently fund evaluation episodically through contractors. The Section 1903(a) match has direct statutory precedent: 90 percent federal matching for design, development, and installation of Medicaid eligibility and enrollment systems, with 75 percent for maintenance and operations. The same logic (federal interest in durable state infrastructure for federal program administration) applies to Medicaid evidence functions.

The existing implementation model for standing state-level Medicaid analytic capacity is the state-university partnership: twenty-five state Medicaid agencies maintain active analytic partnerships with thirty public universities through the AcademyHealth State-University Partnership Learning Network, with multi-state coordinated analyses conducted through the Medicaid Outcomes Distributed Research Network. The enhanced match should support and scale this model, and standing analytic capacity built directly within state Medicaid agencies where state preference and statutory authority support it, rather than require a single organizational form. Federal eligibility should specify standing analytic capacity (minimum staffing, data access, and protected analytic time) rather than a specific institutional arrangement. State-conducted Section 1115 demonstration evaluations supported by the enhanced match are subject to the federal pre-registration framework established in the CDC, NIH, CMS, and FDA agency sections, with evaluation designs registered before data analysis begins and final reports released regardless of findings. State-level Medicaid analytic units supported by the enhanced match should operate under professional independence standards consistent with federal-side standards for CMS-funded evaluations, including protections for analysts and protected publication rights for findings.

The current Medicaid fiscal-federalism environment moves in the opposite direction from this recommendation. The recommendation acknowledges that countercurrent and proposes a capped multi-state pilot of the enhanced administrative match as the realistic near-term pathway, with broader authorization to follow on pilot evidence. The federal-side standardization of T-MSIS researcher access and data-quality benchmarking is handled in CMS R8 and not duplicated here. Congress should authorize the enhanced administrative match for Medicaid evidence functions in statute and provide multi-year funding authority.

Mechanism: administrative action under existing CMS authorities for program design and the capped pilot, followed by authorizing legislation for the enhanced match. Timeline: program design and capped pilot within the first year; statutory authority and the full enhanced match require legislation.

Resilience note: The capped pilot can be initiated under existing CMS administrative authority and is the principal element that operates when political conditions do not favor broader Medicaid investment. The full enhanced administrative match requires legislation and is the most vulnerable to the current fiscal-federalism environment. The pre-registration and independence protections are within CMS administrative authority for federally matched evaluations and can be implemented immediately on the pilot scale.

Cross-cutting connection: Operates in concert with CMS R8 and connects to the Evidence Workforce Development section on state-level Medicaid analytic workforce. The pre-registration provision connects to the federal pre-registration framework established in the CDC, NIH, CMS, and FDA agency sections and inherited from Emergency Evidence Preparedness R1.

5. Align federal workforce programs with state evidence-capacity demand, with concrete state-placement commitments and attention to workforce diversity. The HHS Secretary should direct CDC, AHRQ, HRSA, ASPE, and the relevant offices to jointly publish, within the first year, an aligned strategy for federal workforce programs that build state and local evidence-generation capacity. The strategy should cover the CDC Epidemic Intelligence Service and CDC fellowships, AHRQ training grants for health services researchers, HRSA workforce programs for health-department epidemiologists and informaticists, and ASPE-funded state evaluation contracting. To distinguish this recommendation from a plan to make a plan, the strategy should commit to two concrete actions. First, a state-placement requirement attached to a defined percentage of federally funded fellowship positions (CDC EIS, AHRQ T32 health-services-research training grants, and HRSA-funded fellowships), with the percentage set in the strategy and adjusted as state demand is measured. Second, a joint state-demand survey, conducted within twelve months, whose results bind subsequent allocations of the federal workforce programs the strategy covers. The state-demand survey and the state-placement requirement should address documented diversity gaps in federal fellowship pipelines, including underrepresentation of researchers from communities historically over-surveyed and under-served by public health data systems; substantive treatment of workforce diversity belongs to the Evidence Workforce Development section, but R5 commits to incorporating diversity considerations into the strategy design. Congress should authorize a federal-state evidence workforce program with multi-year funding and statutory protections against arbitrary reduction of workforce-pipeline investments.

Mechanism: administrative action under existing authorities, followed by authorizing legislation. Timeline: aligned strategy and state-demand survey within the first year; state-placement requirement implemented within eighteen months; statutory authority and multi-year funding require legislation.

Resilience note: The aligned strategy and state-demand survey require active administration support and can be reversed by a subsequent administration's decision not to coordinate workforce programs. The state-placement requirement, once embedded in fellowship terms and conditions, is harder to reverse than to put in place but is not statutorily protected absent Congressional action. The diversity provisions are most durable when incorporated into statutory authorization.

Cross-cutting connection: Substantive workforce policy treatment belongs to the Evidence Workforce Development cross-cutting section, including the diversity dimension.

Coordination

The five recommendations should be implemented in parallel, with the Office of the Secretary holding coordination authority. The CDC, NCHS, CMS, and brief agency sections each address the federal-side architecture for the federal data systems that depend on state partners; this section addresses the state-side capacity foundation on which that federal architecture rests. The federal evidence enterprise that the rest of the Blueprint recommends cannot deliver what it promises without state, territorial, and local partners positioned to deliver their part.

Align and Coordinate the Federal Evidence Enterprise

The federal government funds and produces health evidence through more agencies than any single official oversees. NIH institutes, CMS through CMMI and its coverage processes, AHRQ, CDC, the VA through HSR&D, FDA, HRSA, and the statistical agencies each generate evidence inside their own authorities and budgets. This is not a flaw to be eliminated. A diverse enterprise is more resilient than a single point of failure, and proximity to a mission produces evidence a central office would not think to ask for. The problem is that the enterprise has many producers and no architecture: work is allocated by habit and jurisdiction rather than by which agency is best placed to do it, and the seams between agencies are where evidence is lost.

Three coordination failures follow.

The same question can be asked at three agencies, fall between them entirely, or be answered well at one while another duplicates the work. Methodologically adjacent research runs in parallel at CDC, AHRQ, NIH, FDA, ONC, HRSA, and the VA. No standing process allocates the work or names the questions no agency has picked up. The recurring claim that the enterprise is riddled with wasteful duplication does not survive contact with the evidence. The congressionally directed assessment of federally funded health services and primary care research, which AHRQ commissioned and RAND conducted, found that agency-funded research on similar topics is largely complementary, with the real weakness being that overlap is detected only sporadically and by happenstance. That study's mandate expressly included assessing consolidation of research agendas, and it landed on coordination rather than consolidation. The 2024 GAO review of biomedical research collaboration reached a consistent conclusion for the agencies it examined. The case is for coordinating the portfolio as a portfolio, not for consolidating it into fewer agencies. Consolidation would dissolve the proximity and the constituencies that make the evidence worth producing.

Long-standing statutory coordination authorities exist but carry no operational content. Congress has repeatedly created coordination mandates and then left them inert. Section 1142 of the Social Security Act directs coordination between AHRQ and CMS on health-care technology assessment, yet for most of its life it has functioned as words on a page rather than a working process. The same pattern recurs where CMMI evaluation findings reach the CMS Office of the Actuary, where a translation gap routinely separates what was learned from what gets scored. An authority that is never operationalized is indistinguishable from no authority at all.

Health evidence and social-program evidence sit in separate silos, though the people they serve experience one system. Programs that shape health outcomes (Head Start, child welfare, housing, nutrition assistance) are evaluated on tracks that rarely connect to the health programs serving the same families, so the evidence base answers narrow program questions well and cross-program questions poorly. Bodies that might bridge these tracks tend to decay when they rest on persuasion alone: several federal coordinating councils in this space have been allowed to lapse once attention

moved elsewhere. (The structural-protection dimension is developed in the Research Integrity and Scientific Freedom section.)

The recommendations below build a coordinating architecture that allocates work to the agency best placed to do it, gives existing authorities operational content, reaches across departmental lines where the population is shared, and makes the federal research portfolio publicly visible at the project level.

Recommendations

1. Establish a standing federal health services research coordination body, and make its work consequential by linking it to the budget process.

The Secretary of Health and Human Services should convene a standing interagency health services research coordination body in the first year under existing authority, chaired by AHRQ, with participation from NIH, CMS, CDC, the VA's HSR&D, FDA, and HRSA, and with OMB participating. Its charge is to identify cross-agency research priorities, coordinate solicitations where coordination serves the field, name the gaps no single agency is addressing (including which populations and settings are underrepresented), and publish an annual report on the federal HSR portfolio as a whole. The body should be built on AHRQ's existing coordination function with a defined and modest staffing footprint. Congress should then codify it with a five-year reauthorization, giving it durable statutory footing while preserving a regular point at which to assess whether it produces value.

This body does work the existing coordination structures do not. Within HHS, the Data Council, the Evidence and Evaluation Policy Council, and ASPE's Learning Agenda stewardship govern data assets, evaluation practice, and department-wide evidence planning. Across the government, the Evaluation Officer Council, codified under the Foundations for Evidence-Based Policymaking Act and chaired by OMB, coordinates evidence-building practice across the CFO Act agencies. None manages the federal health services research portfolio as a portfolio across producing agencies. The authorizing language should state that remit explicitly, position the body to feed the Evaluation Officer Council rather than parallel it, and route through existing HHS structures rather than around them. A 2024 GAO review found uneven implementation of the Evidence Act capacity assessments across agencies and positioned the Evaluation Officer Council as the mechanism to close those gaps. That is a caution worth heeding: a coordinating body needs more than codification to function.

Codification alone is necessary but not sufficient, because coordination bodies that rest on goodwill decay even when they have statutory footing. The authorizing language should therefore specify the charter: how the annual gap analysis becomes a formal set of recommendations, the threshold at which OMB and the affected agencies must respond in writing rather than note and move on, and what happens when an identified gap goes unaddressed across successive cycles. A written response is a step a reluctant agency completes and ignores, so the charter should name the consequence rather than the paperwork. Where a priority gap identified by the body goes unaddressed across two successive budget cycles without a published rationale, OMB's passback for the affected agency should carry a mandatory alignment finding that the agency must answer in its congressional budget justification, and GAO should review the gap and report to the committees of jurisdiction. The published-rationale safe harbor is available once per gap: the same gap unaddressed in a further cycle goes to GAO review regardless of

further rationales, so a rationale republished annually cannot substitute forever for an answer. Where the body itself fails to meet or to publish its analysis on its statutory cadence, the failure and its cause are recorded in the annual Federal Health Evidence Report to the committees of jurisdiction. The consequences run by operation of the statute; none depends on OMB or the Department choosing to act.

Coordination changes behavior only if it reaches the budget. The body's annual portfolio review and gap analysis should enter budget formulation as a defined product: the body transmits its assessment to OMB during the formulation cycle, and agencies whose portfolios diverge from identified cross-agency priorities respond in writing. This mirrors, at the enterprise level, the mechanism the ASPE section establishes for the HHS Learning Agenda, and the two channels should be designed together, along with the other findings this document routes into passback (the scorecard finding of the Office of the Secretary section and the coordination-body milestones of the Data Infrastructure section): all four should arrive as one consolidated evidence annex, so that they compete for budget attention as one document rather than four, and OMB administers one instrument rather than resisting four mandates on its internal process. The point is to make the gap analysis visible at the moment resources are allocated, without handing OMB a new instrument for directing research. The body should publish its portfolio report, gap list, and agency responses, and report annually against a few outcome measures: the share of major agency initiatives that draw on cross-agency evidence reviews, the number of jointly solicited or co-funded projects, and the time from identifying a priority gap to funding work against it.

The coordination body should also weigh whether the field needs standing network infrastructure, and the operational lessons come from PCORnet, the national patient-centered clinical research network. PCORnet's record teaches three things: a common data model across participating systems cuts the startup time of every subsequent study, a standing network stays usable only if its maintenance is funded between studies rather than rebuilt for each one, and network governance has to resolve data-use questions once, centrally, rather than site by site. Health services and implementation research has no equivalent standing capability. The body's first portfolio review should assess whether the federated, privacy-protected analytic environments described in the Data Infrastructure Modernization section (Recommendation 3) can carry that function for health services and implementation research, and what incremental investment a standing network would require. The assessment belongs to the coordination body because a network serves every producing agency and belongs to none.

This body is distinct from the standing interagency emergency evidence council proposed in the Emergency Evidence Preparedness section, and the two should not be merged. The emergency council is a crisis-activation mechanism with a dormant-to-activated posture; the coordination body is a permanent portfolio-management function operating in ordinary time. They connect at one point: the coordination body's gap analysis identifies the evidence weaknesses the emergency council must be ready to address, and should be a standing input to its preparedness work.

Responsible entity: HHS Secretary (administrative convening); AHRQ (chair); NIH, CMS, CDC, VA HSR&D, FDA, HRSA, and OMB (members); Congress (codification with five-year reauthorization). **Mechanism:** Secretarial convening under existing authority, followed by authorizing legislation specifying the body's charter and decision rules; integration with existing OMB evaluation-and-budget guidance and the ASPE-OMB passback channel. **Timeline:** Convening in the first year under existing authority; codification requires legislation.

Resilience note: In a cooperative environment, the body's gap analysis reaches the budget through OMB's own interest in using it. In a noncooperative one, the mandatory passback finding and the GAO referral on gaps left unaddressed across two cycles are what survive: each produces a record in a place Congress reads whether or not the Department wishes to explain itself.

Cross-cutting connection: The specific statutory mechanism is developed in the AHRQ section (Recommendation 5). The enterprise-level budget channel is the analog of the HHS Learning Agenda budget linkage in the ASPE section (Recommendation 3), and the two should be designed together. The body's gap analysis depends on portfolio-tracking capability developed in the Data Infrastructure Modernization section. The funding question for evidence without a commercial sponsor is addressed in CMS Recommendation 5 and AHRQ Recommendation 4. A body composed of federal officials is not itself an advisory committee under the Federal Advisory Committee Act; if it seeks standing external input, that input should run through a chartered committee or a public comment process so the Act's requirements are met by design.

2. Give existing statutory coordination authorities operational content rather than creating new ones.

Before Congress writes new coordination mandates, the existing ones should be made to work. The lead instance is Section 1142 of the Social Security Act, the statutory foundation for AHRQ-CMS coordination on technology assessment, which has not been given operational content in decades. It once had some: AHRQ's predecessor agency conducted technology assessments for Medicare coverage decisions at the Health Care Financing Administration's request, fewer than ten a year on the resources it had, and the Medicare Trust Fund authorization that helped pay for it (42 U.S.C. § 1320b-12(i)) ran only through fiscal year 1994; after the 1999 reauthorization moved the agency to annual appropriations, the service to the Medicare program did not survive as a routine function. AHRQ and CMS should issue joint guidance, in the first year under existing authority, that converts the statute into a defined process: an annual process for identifying and prioritizing technology-assessment topics tied to the projected National Coverage Determination and Coverage with Evidence Development (CED) pipeline, with public input and a published joint work plan. The timelines and review clocks that give such a process teeth are set out in the CMS section, which calls for pre-specified thresholds and a preliminary review date no later than three years from study initiation. The stakes are concrete, and the CMS section states them with the five-year sunset that answers them (CMS Recommendation 4): a CED condition that is not affirmatively re-issued after public review expires by operation of law, with the underlying coverage determination entering the mandatory reconsideration the CMS section specifies; the AHRQ technology assessment informs the review where one is available rather than gating it, so the assessment function cannot be defunded into a veto. Congress should then attach dedicated appropriations to the joint process. The same operationalize-before-you-create discipline should govern the CMMI evaluation-to-Office-of-the-Actuary translation gap and any comparable dormant authority surfaced during legal review.

Operationalizing Section 1142 will quickly reach a question this section flags but does not resolve: some of the evidence the coordination pipeline identifies as necessary has no commercial sponsor willing or able to produce it. A coordinated gap list is only actionable if paired with a route to fund the gaps it

names. That financing mechanism is developed in CMS Recommendation 5 and AHRQ Recommendation 4 and consolidated in the Legislative Proposals section.

Responsible entity: AHRQ and CMS (joint guidance); Congress (dedicated appropriations and any codification). **Mechanism:** Joint administrative guidance under existing authority; authorizing and appropriations legislation for durability. **Timeline:** Joint guidance in the first year under existing authority; dedicated appropriations require legislation.

Resilience note: Joint guidance under existing authority is the cooperative-environment instrument. What survives in a noncooperative one is the pair of clocks the CMS section sets: the three-year preliminary review date and the five-year sunset on CED conditions, which run whether or not the two agencies are talking to each other.

Cross-cutting connection: Section 1142 operationalization is developed in the AHRQ section (Recommendation 4) and the CMS section (Recommendation 6); the CED thresholds and review clocks are owned by the CMS section (Recommendation 4). The non-sponsored-evidence funding mechanism is owned by CMS Recommendation 5 and AHRQ Recommendation 4. The pattern of statutory authorities left without operational content connects to the Research Integrity and Scientific Freedom section.

3. Extend federal evidence coordination across departmental lines where the population is shared.

Veterans, dual-eligible beneficiaries, and service members move between the VA, CMS, and DoD health systems, but the evidence about their care does not follow them. The populations most affected by these seams are among those with the most at stake: dual eligibles, veterans also enrolled in Medicaid, families served simultaneously by health and social programs, and people moving between active-duty and veteran status. Two steps are available now and do not depend on any unresolved question. First, the Secretary of Health and Human Services and the Secretary of Veterans Affairs should formalize VA participation in the relevant HHS evidence-coordination structures, including the HHS Data Council, the Evidence and Evaluation Policy Council, and the comparative-effectiveness coordination function now carried by the Patient-Centered Outcomes Research Institute. Second, the departments should establish governance for data linkage across the VA, CMS, and DoD for shared populations, so that coordinated evidence can follow patients who move between systems. Both can be done administratively in the first year. The fuller VA-DoD coordination dimension is the most operationally substantial cross-departmental question in the federal health evidence enterprise, and the Blueprint defers standalone DoD treatment to the planned DoD brief entry and will complete the coordination treatment there. The two steps above stand on their own regardless of when that entry is drafted.

Responsible entity: HHS Secretary; Secretary of Veterans Affairs; the named HHS coordination bodies. **Mechanism:** Administrative action for participation; joint funding authority for cross-system research requires legislation. **Timeline:** Participation in the first year under existing authority; joint funding authority flagged for the Legislative Proposals section.

Cross-cutting connection: The substance of VA participation in federal coordination structures is developed in the VA section (Recommendation 4). The DoD dimension is deferred to the planned DoD brief entry, consistent with the Brief Agency Entries section. Joint cross-system funding authority is flagged for the Legislative Proposals section.

4. Extend RePORTER-grade public reporting of research funding to every HHS evidence funder.

Anyone should be able to see what the federal government funds, at the project level, in one place. For much of the enterprise, they already can: NIH RePORTER carries project records for NIH and for several other funders, including AHRQ, CDC, HRSA, ACF, FDA, and the VA. The coverage is uneven. Funding amounts are available for only a subset of the participating agencies, some HHS evidence funders do not report at all, and update practices vary by agency. The task is completion rather than creation: extend the existing RePORTER platform so that every HHS agency that funds evidence generation reports its awards there, with project-level funding amounts, abstracts, and investigator and institution records, on a defined update cadence.

The Secretary should direct participation by all HHS evidence funders, using RePORTER's existing intake pipelines rather than building parallel systems, with onboarding sequenced through the coordination body established in Recommendation 1. Congress should codify the reporting requirement, the funding-amount element, and the update cadence so coverage does not erode when administrative attention moves elsewhere. Complete, single-platform reporting also serves the enterprise directly: the coordination body's portfolio review and gap analysis under Recommendation 1 depends on seeing the whole portfolio, and the public case for evidence funding is easiest to make when the record of what was funded is complete and public.

Responsible entity: HHS Secretary; the health services research coordination body (Recommendation 1); NIH Office of Extramural Research as RePORTER operator; each HHS evidence funder; Congress (codification). **Mechanism:** Secretarial direction and interagency data-sharing agreements under existing authority; authorizing legislation codifying the reporting requirement, funding-amount element, and update cadence. **Timeline:** Direction and initial onboarding in the first year under existing authority; codification requires legislation.

Cross-cutting connection: The Research Integrity and Scientific Freedom section's grantmaking protections (Recommendation 1) draw on this element: complete project-level public reporting is what makes departures from peer-review rankings visible and auditable. The CDC section's analytic transparency requirements (Recommendation 4) connect for CDC's extramural portfolio. The portfolio-tracking capability supporting the coordination body's gap analysis (Recommendation 1) is the internal use of the same data.

The governance map: who decides what

A reader who has met each body in its home section is entitled to see them in one place, with the question every coordination proposal must answer stated plainly: who is accountable when they disagree. The answer is structural. Binding authority in this Blueprint sits with named officials: the Chief Data Officer for data governance, agency heads for their programs, the Secretary for department policy. The coordination bodies convene, prioritize, and report; they are deliberately given visibility consequences instead of command authority, because a coordination body with command authority would be the single point of failure this document is designed to avoid. When coordination fails, the

architecture does not resolve the failure quietly inside the chain; it makes the failure visible outside it, on the non-discretionary triggers each body's statute specifies. Unresolved executive-branch disagreement rests with the official who holds the underlying statutory authority. The external routes, to the Inspector General, GAO, and the committees of jurisdiction, create visibility and review rather than appellate command; their force is the record they compel.

Body or official	Home	What it decides, advises on, or delivers	Where disagreement goes
HHS Chief Science Officer	Office of the Secretary Rec 1	Stewards the integrity policy and the communication standard; advisory and coordinating, with no independent executive power	Secretary
HHS Chief Data Officer	ASPE Rec 1	Binding data governance: an administrative minimum under existing authority, a proposed statutory core, and a phased expansion to the rest	Secretary; the statutory core remains in force unless amended or held invalid, and a departure from it triggers the statute's reporting and review provisions
Evaluation Officer and Learning Agenda	ASPE (Evidence Act)	Evaluation practice and the department's priority evidence questions	Secretary, through ASPE
Agency Scientific Integrity Officers	Research Integrity Rec 2	Complaint investigation and whistleblower protection at each agency	Agency head; the HHS Inspector General and the Office of Special Counsel as separate, accountable channels
Health services research coordination body (AHRQ chair)	Recommendation 1 of this section	Recommends cross-agency portfolio priorities, runs the gap analysis, and links findings to the budget process; final decisions rest with the officials holding statutory authority	Annual report to Congress; missed-cadence consequences in its statute
Standing interagency emergency evidence council	Emergency Evidence Preparedness Rec 4	Crisis activation and readiness between crises; distinct from the coordination body by design	Vice-chair convenes by operation of the statute; suspension reported to the committees within 30 days
Data modernization governance body	Data Infrastructure Rec 6	Modernization milestones and cross-agency budget coordination; complementary to the Chief Data Officer's binding governance	GAO on missed milestones; the committees of jurisdiction
Federal technical assistance corps	State Evidence Capacity Rec 2	Delivery to states and territories through a single federal interface; a service rather than a governance body	The funding agencies it serves

Part III. Secretarial and Legislative

Office of the Secretary

The Secretary is the only official with authority over every part of HHS, and so the only actor who can treat evidence as shared infrastructure rather than the separate concern of each operating division. Early action should define a department-wide steward for scientific integrity and evidence use, set the evidence agenda through a defined package of executive actions, hold operating division heads accountable for whether evidence informs their decisions, and keep the department's scientific advisory bodies staffed.

Diagnosis

Most of the Blueprint's recommendations live inside individual agencies. A smaller set can only be set in motion from the top. The Secretary is the single point in HHS with authority over every operating division at once, and the Secretary's first actions signal whether the department treats evidence as core infrastructure or as discretionary overhead.

The pieces exist but are not held together. HHS has a department scientific integrity policy, finalized in 2024, and its operating divisions designate chief scientists. The Chief Data Officer, the Evaluation Officer, and the HHS Learning Agenda sit in ASPE with coordination responsibility but not governance authority (see the ASPE section). What the department lacks is a single official, accountable to the Secretary, whose defined job is to protect scientific integrity and the use of evidence across all operating divisions at once.

The Foundations for Evidence-Based Policymaking Act of 2018 (the "Evidence Act") built much of the machinery for evidence-based government, but implementation has lagged. Of 23 federal agencies reviewed by GAO in 2024, 18 had difficulty interpreting OMB guidance and conducting the statutorily required capacity assessments. Several HHS operating divisions treat Learning Agenda and evaluation requirements as compliance paperwork. The result: the department's evidence functions depend on the attention each operating division chooses to give them, and no one can set a department-wide expectation and enforce it.

This section consolidates the early-action items that other sections route to the Secretary, so the first 100 days form one coherent agenda, and adds the leadership, accountability, and advisory architecture that only the Secretary can establish.

Recommendations

Rec 1 defines and protects a department-wide steward for scientific integrity and evidence use. Rec 2 sets the evidence agenda through a first-100-day package of executive actions, including the items routed here from the ASPE section and the Brief Agency Entries. Rec 3 holds operating division heads accountable for using evidence. Rec 4 keeps the department's advisory bodies staffed. Recs 1 through 3 begin under existing authority and are built to be codified over time; Rec 4 is administrative with a statutory backstop.

1. Define a department-wide Chief Science Officer for HHS, and codify the office in statute.

The department needs one official, accountable to the Secretary, charged with protecting scientific integrity and the use of evidence across all operating divisions. The role does not have to be invented. The 2023 interagency framework on federal scientific integrity already requires agencies that fund, conduct, or oversee research to designate a Chief Science Officer responsible for ensuring that research programs are well-founded and conducted with integrity (CRS R46614). HHS operating divisions designate chief scientists today. What is missing is a single department-wide Chief Science Officer who sits above the operating divisions and answers to the Secretary.

The Secretary should define the department-wide Chief Science Officer administratively in the first 100 days. The remit: coordinate department-wide scientific integrity policy, oversee Evidence Act implementation, and serve as the Secretary's principal advisor on the integrity and use of evidence. The role coordinates. It does not displace the statutory functions of the Chief Data Officer, the Evaluation Officer, or operating division science leadership.

Definition by directive establishes the role. Statute makes it durable. Congress should codify the office on the design set out in Legislative Proposal 2. The Chief Science Officer is an inferior officer appointed by a Secretary who serves at will, and the statute should say so; that is what allows the office to carry for-cause removal protection as a single layer after *Trump v. Slaughter*, *Seila Law v. CFPB* (2020), and *Collins v. Yellen* (2021), which foreclose such protection for principal officers. The design: statutory qualification requirements for the office; a requirement that any removal be accompanied by a written statement of specific reasons transmitted to the committees of jurisdiction and published, with a notice period before it takes effect; and an interim rule providing that while a removal is contested the deputy holds the office without authority to alter the department's scientific integrity policy or to suspend the evidence-use reporting in Recommendation 3. The office is structured as advisory and coordinating rather than as a holder of independent executive power, which is both its correct function and the structure most defensible under the Court's reasoning. It sits in the research-administrative tier (Tier 2) of the three-tier protection architecture in the cross-cutting Research Integrity and Scientific Freedom section, without a fixed term; unlike the NIH and CDC Directors, who are principal officers, it can carry for-cause protection. ASPE, also close to the Secretary, is protected at the workforce layer rather than the leader layer, because its leader develops and implements Administration policy. The Chief Science Officer's function is integrity stewardship, not policy development, so the leader-tenure design fits the role on the same logic that supports it for the NIH and CDC Directors. Removal is by the Secretary only for cause; the notice and interim layers protect the officer against unexplained dismissal for the content of scientific advice while preserving normal appointment accountability.

Responsible entity: HHS Secretary (definition by directive); the Chief Science Officer (implementation); Congress (codification and the removal design). **Mechanism:** Secretarial directive defining the department-wide role and remit under existing authority; statutory codification with qualifications, reasons-to-Congress removal reporting, and the interim rule, without a fixed term. **Timeline:** Definition in the first 100 days under existing authority; codification requires legislation.

Cross-cutting connection: Tier 2 placement is carried by the Research Integrity and Scientific Freedom section, paired with the NIH and CDC Directors. The removal design follows Legislative Proposal 2, which

carries the post-Slaughter enactment strategy for all three; the constitutional analysis is recorded in the Legislative Proposals section. The officer is the administrative home for the scientific integrity policy in Rec 2 and the evidence-use reporting in Rec 3.

2. Set the evidence agenda in the first 100 days through a defined package of executive actions.

The Secretary's first actions establish whether the department treats evidence as core infrastructure. The Blueprint recommends a defined package, issued together so the agenda is legible and so the department can be held to it. Each action is available under existing authority:

1. **Maintain and strengthen the HHS scientific integrity policy.** HHS finalized a department scientific integrity policy in 2024. The Secretary should keep a department-wide policy in force and confirm its core protections: scientific findings are not altered, suppressed, or delayed for non-scientific reasons; scientists may communicate their findings; and departures from documented methods require written justification. The policy foundation across the government rests on layered administrative authorities (a 2023 interagency framework, agency-level policies, and Executive Order 14303 of May 23, 2025), each revisable by the next administration. That is the reason to codify the core protections, addressed below and in the Research Integrity section.
2. **Direct full Evidence Act implementation across all operating divisions.** Designate the required Evaluation Officers, Chief Data Officers, and Statistical Officials; maintain current Learning Agendas and annual evaluation plans. The 2024 GAO review cited above documents how far implementation has fallen short.
3. **Issue the directives routed here from other sections, as a set.** From ASPE: the Phase 1 directive setting minimum data governance standards for all operating divisions with annual compliance reporting to the Chief Data Officer (ASPE Rec 1); the directive requiring ASPE to review operating division budget justifications against Learning Agenda priorities, paired with a joint OMB-HHS memorandum directing OMB to weigh those assessments at budget passback (ASPE Rec 3); and the policy establishing transparency, publication, and workforce protections for ASPE's career analytic staff (ASPE Rec 4). From the Brief Agency Entries: a directive setting joint evidence-building priorities for OPRE at ACF.
4. **Define the department-wide Chief Science Officer** described in Rec 1.

Each action is reversible by a later administration. That is the reason to issue them as a package: a package creates a public record of the department's evidence commitments and a baseline for measuring progress.

Responsible entity: HHS Secretary; the Chief Science Officer; ASPE; the Chief Data Officer; OMB (joint passback memorandum). **Mechanism:** A coordinated set of secretarial directives and policies under existing authority, as enumerated above. **Timeline:** All actions in the first 100 days under existing authority. Durable effect requires sustained leadership commitment; codification of the underlying functions is handled in the source sections.

Cross-cutting connection: This is the consolidation point for early-action items from ASPE (Recs 1, 3, 4) and the Brief Agency Entries (OPRE). The scientific integrity policy connects to Research Integrity and Scientific Freedom, where codification is anchored. A bipartisan Scientific Integrity Act, which would require

research agencies to maintain enforceable scientific integrity policies, has been introduced in recent Congresses (H.R. 1106 in the 119th, alongside the Follow the Science Act, H.R. 7173) and is the existing bill precedent for that codification. The Evidence Act directive connects to Align and Coordinate the Federal Evidence Enterprise.

3. Hold operating division heads accountable for evidence use through annual reporting and a public scorecard.

Setting an agenda is not the same as ensuring it is followed. The Secretary should require each operating division head to report annually, through the Chief Science Officer, on four things:

1. The major decisions the division made during the year.
2. The evidence that informed them.
3. The division's compliance with the Evidence Act.
4. Its progress against Learning Agenda priorities.

The Secretary should consolidate these into a single public department-wide evidence scorecard. The ASPE Learning Agenda scorecard (ASPE Rec 3) is one input, covering evaluation completion; the department-wide scorecard is the broader instrument, covering evidence use across operating division decisions. Public reporting is the accountability mechanism.

Reporting without consequence becomes paperwork, and a report an operating division files and no one acts on is paperwork with a cover page. The consequence channel already exists: ASPE Rec 3 routes budget-justification alignment findings to OMB at passback. The scorecard supplies public transparency; the passback channel supplies the budgetary consequence, and the two should be joined so that neither depends on anyone choosing to use them. A division whose report is not filed, or is filed and scored non-responsive on published criteria, receives a mandatory alignment finding in OMB's passback that it must answer in its congressional budget justification; a division that carries such a finding across two successive cycles is referred to GAO for review, with the report to the committees of jurisdiction. The Secretary can establish the reporting and the scorecard now; the mandatory finding and the referral are the statutory reporting requirement this recommendation carries to the Legislative Proposals.

Responsible entity: HHS Secretary; the Chief Science Officer (consolidation); operating division heads (reports); OMB and ASPE (passback consequence, via ASPE Rec 3). **Mechanism:** Secretarial directive requiring annual evidence-use reports; an annual public scorecard; linkage to the OMB passback channel in ASPE Rec 3. **Timeline:** Reporting and scorecard in the first year under existing authority. The mandatory passback finding and GAO referral are carried as a statutory reporting requirement in the Legislative Proposals section.

Resilience note: In a cooperative environment, the scorecard is read and the passback channel used because OMB and the Secretary want it. In a noncooperative one, the mandatory finding on an unfiled or non-responsive report and the two-cycle GAO referral are what survive, on the same design as the coordination bodies in Align and Data Infrastructure.

Cross-cutting connection: Extends ASPE Rec 3 (Learning Agenda budget linkage and scorecard); connects to Align and Coordinate the Federal Evidence Enterprise; statutory-reporting option routes to Legislative Proposals.

4. Keep the department's statutorily required advisory bodies staffed and functioning.

Advisory bodies turn independent expertise into department decisions. HHS administers more federal advisory committees than any other department, on the order of 270 (GSA FACA database; CED analysis). In fiscal year 2025 a large share were terminated or became administratively inactive (CED reports 72 terminated and 23 administratively inactive). The contraction reaches statutorily grounded bodies: the Interagency Autism Coordinating Committee, established in statute and required to meet twice a year, met once in 2025, and the Scientific Management Review Board flagged from the NIH section remains dormant. A body that exists on paper but does not meet provides no advice.

In the first year and under existing authority, the Secretary should:

1. Inventory all statutorily required HHS advisory bodies.
2. Identify which are unfilled, lapsed, or meeting below their charter requirement.
3. Set a schedule for reconstituting them, and report annually on vacancies against that schedule.

The Secretary should treat timely appointment to statutorily required bodies as a standing obligation, not a discretionary one.

The department does not need a new department-wide Science Advisory Board. The problem this recommendation addresses is that required bodies are not functioning, not that the department lacks advisory venues; HHS already manages more committees than any other agency, and a new board would add a venue and an administrative burden without curing the failure it would sit beside. The remedy is the one above: keep the statutory bodies staffed and meeting, and give the Chief Science Officer the standing to make that visible.

Responsible entity: HHS Secretary (inventory, schedule, appointments); the Chief Science Officer (support); Congress (only if a new Science Advisory Board is created by statute). **Mechanism:** Secretarial directive to inventory and reconstitute required advisory bodies under existing authority; annual vacancy reporting; statutory establishment of a Science Advisory Board only if a bill's sponsors elect that path. **Timeline:** Inventory and reconstitution schedule in the first year under existing authority; any new statutory body requires legislation.

Cross-cutting connection: The advisory-body-dormancy pattern is carried at the enterprise level by Research Integrity and Scientific Freedom (the SMRB dormancy and parallel instances). This is the Secretary-level application. Coordinate with Align and Coordinate the Federal Evidence Enterprise on the existing-bodies inventory.

Legislative Proposals

This section consolidates the Blueprint's legislative agenda. It adds no new recommendations. Every proposal below appears in an agency or cross-cutting section, where the case for it is argued in full; this section converts those recommendations into a form Congress can act on, organized by legislative vehicle rather than by agency. Statutory citations reflect a recommendation-by-recommendation legislative analysis mapping each proposal to existing authority.

Two congressional processes govern everything in this section, and the distinction matters for reading it. Authorizing legislation creates, changes, or protects programs and authorities; it moves through committees like Senate Health, Education, Labor, and Pensions and House Energy and Commerce. Appropriations legislation provides the money, one year at a time unless the law says otherwise; it moves through the Appropriations Committees. An authorized program with no appropriation cannot operate, and an appropriation with no authorization is vulnerable. Several proposals below therefore appear twice by design: once as authorizing language and once as appropriations language, because durability requires both.

A reading rule for what follows: each proposal leads with what it does in plain English, then names the statute it would amend or the new authority it would create, and points to the section where the full argument lives.

1. The AHRQ reauthorization: the Blueprint's principal legislative vehicle

The largest share of the Blueprint's legislative agenda travels in a single bill: a reauthorization of the Agency for Healthcare Research and Quality. AHRQ's original authorizing statute is the Healthcare Research and Quality Act of 1999 (P.L. 106-129), codified in Title 42, Chapter 6A of the U.S. Code. The reauthorization resets that foundation. Bundling these elements is a deliberate design choice: each element reinforces the others, and a single vehicle gives authorizers one coherent institutional proposal rather than a dozen fragments.

The bill carries twelve titles' worth of content, argued in the AHRQ and NCHS sections:

First, the expanded statutory mandate. Amend 42 U.S.C. § 299b to establish evidence synthesis and dissemination, implementation science, health data stewardship, patient safety, primary care research, disparities and priority-population research, and the convening and support of independent federal evidence bodies as core statutory functions; to modernize the patient-safety authority beyond "reducing medical errors" to healthcare-associated infections and diagnostic safety; and to name primary care research, which the Senate has funded as a line item, as a function the statute protects. The priority-population research function already exists at 42 U.S.C. § 299(c) and is carried here as a named core function rather than as a new authorization. (AHRQ Recommendation 1.)

Second, agency governance. Establish an AHRQ Director appointed by the Secretary for a fixed five-year term, with statutory qualification requirements and removal by the Secretary only for cause, the statute

stating that the office is an inferior one. Director qualifications and protections are not currently in statute; 42 U.S.C. § 299c-5 is where other AHRQ officers are described and is the natural placement. The removal-protection element of this provision is governed by the enactment strategy in Proposal 2 below. (AHRQ Recommendation 1.)

Third, the authorized funding floor: $1 billion annually, indexed to inflation, covering core functions, with the budget lines of received units preserved separately on top. An authorized floor does not bind appropriators. It sets the baseline against which appropriations are judged. (AHRQ Recommendation 1.)

Fourth, mandatory grantmaking timelines with two self-executing triggers and a mandatory reporting duty. The first trigger is scheduling: review meetings convene within 90 days of appropriation. The second is obligation: quarterly obligation is benchmarked to the higher of the agency's trailing three-year average and its rate in the last full fiscal year before enactment, each adjusted proportionally to the size of the current appropriation, with a documented adjustment for a lapse in appropriations or a declared emergency; funds appropriated for extramural research count only when obligated to extramural awards, so obligation to internal task orders cannot satisfy the benchmark; and the Government Accountability Office computes the benchmark from apportionment and obligation data as the recording official. The default procedure that follows a missed benchmark is the issuance of awards in peer-review rank order from the most recent completed review cycle, executed by the agency's grants management officials as a nondiscretionary duty. Funds subject to a triggered default remain available for obligation for one additional fiscal year, so that expiration cannot complete what impoundment began; the 2025 funds lapsed not because they were withheld at the apportionment stage but because the capacity to obligate them was dismantled before the fiscal year closed. The extension is a real ask of the appropriations committees, whose annual discipline it loosens for exactly one case, funds an agency has already been recorded as failing to obligate on its own benchmark, and the document states that trade rather than obscuring it. The reporting duty runs to GAO and the appropriations committees when obligations fall a quarter behind; it is mandatory oversight in the sense this document uses, and calling it anything stronger would overstate it. AHRQ's grantmaking process is codified at 42 U.S.C. §§ 299b and 299c-4; the timeline provisions amend there. (AHRQ Recommendation 1.)

Fifth, statistical-unit protection. Require that the Office of Management and Budget designation of AHRQ's statistical activities under the Confidential Information Protection and Statistical Efficiency Act of 2018 (CIPSEA, 44 U.S.C. § 3562(a)) be made and maintained. CIPSEA names no agency and does not need amendment; the requirement lives in the reauthorization, together with statutory dissemination timelines for AHRQ's data programs: a published interval from the completion of collection to release, with GAO reporting when it is missed. (AHRQ Recommendation 2.)

Sixth, codification of the U.S. Preventive Services Task Force, currently authorized at 42 U.S.C. § 299b-4: methodological independence, AHRQ staffing and support obligations with dedicated funding authority, notice-and-comment for procedural changes, a sixteen-member composition floor with staggered terms, statutory conflict-of-interest standards, and recommendation timelines. The staffing obligation can be supported through appropriations bill text; the remaining elements are authorizing matter. (AHRQ Recommendation 3.)

Seventh, statutory decision links. Amend 42 U.S.C. § 1395y(l) to require that Medicare national coverage determinations formally consider AHRQ Evidence-based Practice Center reports where available;

current law specifies a public process but does not specify what evidence CMS must consider. Establish the joint AHRQ-CMS patient-safety measure development process in statute. Provide a dedicated evidence-generation funding pathway for coverage-with-evidence questions no commercial sponsor will fund. Whether Section 1142 as written supports the evidence-generation funding pathway or new authority is required is a question for legal expert review before introduction. (AHRQ Recommendation 4; CMS Recommendation 5.)

Eighth, the AHRQ-PCORI division of labor, stated in statute: AHRQ as the federal authority for systematic evidence synthesis supporting federal coverage, payment, and quality decisions; the Patient-Centered Outcomes Research Institute as the funder of patient-centered comparative clinical effectiveness research that generates the evidence those syntheses draw on. The Blueprint considered and declined the alternative of receiving PCORI into AHRQ; PCORI's trust-fund financing is the design lesson carried forward, not the consolidation. (AHRQ Recommendation 4.)

Ninth, the federal health services research coordination body, chaired by AHRQ, with statutory authority to identify cross-agency priorities, coordinate solicitations, identify gaps, and report annually to Congress. Interagency communication happens under existing authority; a standing body with directive content requires codification. (AHRQ Recommendation 5; Align and Coordinate Recommendation 1.)

Tenth, the National Healthcare Quality and Disparities Report and disaggregation. The report and its current disaggregation categories already have a statutory basis at 42 U.S.C. § 299a-1, so the legislative delta is specific: expand the disaggregation categories to include primary language, disability status, sexual orientation and gender identity, and geography, aligned with 42 U.S.C. § 299(c)(1) and OMB Statistical Policy Directive No. 15; set the release cadence in statute; and codify AHRQ's methodology-support role for disaggregation across federal health programs. The separate authorization for a priority-population research function that earlier drafts carried is folded into the mandate title, since the function already exists at 42 U.S.C. § 299(c); the statutory delta is the report's codification and the expanded disaggregation. (AHRQ Recommendation 6.)

Eleventh, the receptions. Move the National Center for Health Statistics into the reauthorized agency by amending 42 U.S.C. § 242k, which establishes NCHS and its Director without mandating its current placement; statute is nonetheless the right instrument, given the litigation that followed the 2025 attempt to reorganize HHS unilaterally. Move the National Center for Health Workforce Analysis and the Area Health Resources Files (42 U.S.C. § 294n) and the National Survey on Drug Use and Health stewardship function on the same basis. Each reception carries its five-element transition plan (name and identity, methodological independence, cooperative relationships, workforce, separate budget line) as statutory conditions. (AHRQ Recommendation 7; NCHS Recommendation 2; Brief Agency Entries.)

Twelfth, digital health. Replace the Section 914(a) authority for "Information Systems for Health Care Improvement" with a digital health provision authorizing AHRQ to conduct and support research on whether digital health technologies, including artificial intelligence applications, mobile health tools, telehealth, digital therapeutics, and wearable devices, are safe and improve outcomes, and to generate real-world evidence on their implementation. This is the Blueprint's principal statutory vehicle on artificial intelligence. (AHRQ Recommendation 1, sixth element.)

If Congress does not act. The AHRQ section's administrative recommendations proceed under existing authority in the first year regardless. The minimum durable core above can ride an appropriations rider. The received functions stay at their source agencies under the coordination-and-standards overlay, with the interim protections the AHRQ and NCHS sections specify, and are no more exposed than today. **Responsible entity:** Congress; Senate Health, Education, Labor, and Pensions (HELP) Committee and House Energy and Commerce Committee, with Senate Finance and House Ways and Means jurisdiction over the Medicare-linked titles (the seventh and the Section 1142 elements) and Appropriations Committee action on the funding elements. **Mechanism:** Single reauthorization bill. **Timeline:** Introduction at the start of the next congressional session; the administrative elements identified in the AHRQ section proceed in the first year without waiting for the bill.

Enactment strategy for the AHRQ reauthorization: a minimum durable core. The AHRQ reauthorization is designed to be enacted whole, for the reasons the AHRQ section gives: its structural protections and its consequential outputs reinforce each other, and separating them reproduces the vulnerabilities the diagnosis documents. Enactment strategy should nonetheless account for the possibility that the full reauthorization does not advance in a given Congress. Two provisions form the minimum protective core that can be carried on another vehicle without waiting on the whole, durable in a narrow authorizing bill, interim in an appropriations rider that binds for its fiscal year and must be reenacted until the authorizing version passes: the agency-specific anti-impoundment provision and the mandatory grantmaking timelines with automatic default procedures. These two are singled out for what they preserve, the package's pairing of protection with consequence at the smallest workable scale, and for what they answer, the two failures the 2025 experience documents, the halted grantmaking and the appropriated funds left unobligated before expiration. They are, for the same reason, the two provisions written as fixed requirements rather than as discretionary duties, which is the property that makes a protection hold when it is tested. The codification of USPSTF methodological independence should be treated as a third severable element on its own timetable, because the ruling in *Kennedy v. Braidwood Management* gives it both an independent rationale and an independent legislative path. Naming the durable core here, once, is an enactment contingency, not a retreat from the recommendation that the package be adopted whole. The NCHS protections in Proposal 3 are drafted as freestanding amendments for the same reason, so that a delay in the vehicle leaves no received function more exposed than it is today.

2. Removal protections after Trump v. Slaughter: the enactment strategy

The Blueprint proposes a layered tenure design for the AHRQ Director, the NCHS Director, the NIH Director, the CDC Director, the VA Chief Research and Development Officer, the scientific chair of the emergency evidence council, and the HHS Chief Science Officer. The design differs by the constitutional status of the office. The NIH and CDC Directors are principal officers (the NIH Director by statute; the CDC Director since Senate confirmation was required beginning with the 2025 appointment), and after *Slaughter* a principal officer cannot carry for-cause removal protection; for them the design rests on qualifications, reasons to Congress, the vacancy clock, and the interim rule. The other five are inferior officers appointed by a Secretary who serves at will, and for them explicit for-cause protection is a permitted single layer. The two positions the document protects most, the AHRQ and NCHS Directors,

are therefore kept as Secretary-appointed offices rather than made Senate-confirmed: confirmation would move them toward principal-officer status and cost them the protection that matters. The document trades a Senate hearing for a protection that holds. The Supreme Court's June 29, 2026 decision in *Trump v. Slaughter*, 609 U.S. ___ (2026) overruled *Humphrey's Executor v. United States* and held that statutory removal restrictions on the officers of most independent agencies violate Article II. Any honest legislative strategy has to start from that holding rather than draft around it.

The Blueprint retains the protection architecture, for two reasons. Enacted removal protections state Congress's institutional judgment about how evidence functions should be governed, and that judgment carries weight with appointees, agency counsel, and future Congresses even where judicial enforcement is uncertain. And the architecture was never a single provision; it is a set of layered protections, most of which do not run through the removal power at all.

The drafting strategy has six elements, and the agency sections apply it in consistent form, with one deliberate position-by-position variation. First, appointment follows the office's status: the NIH and CDC Directors remain Senate-confirmed principal officers; the AHRQ and NCHS Directors, the VA Chief Research and Development Officer, the emergency council chair, and the Chief Science Officer are appointed by the Secretary, which is what keeps them inferior officers able to carry for-cause protection, and each enabling statute says so in terms. No inferior officer with for-cause protection may supervise another officer who also has it; the protection sits at one level in each chain, and the NCHS Director, once received into AHRQ, is appointed and removable by the Secretary rather than by the AHRQ Director for that reason. Fixed terms are the variation: positions in the statistical-and-evaluation tier carry a five-year term that sets the maximum period of service and the renomination cadence, and breaks alignment with the presidential cycle to the extent the layered protections hold, while the remaining positions carry the same design without a fixed term, matching the choice each agency section records.

Second, each position carries statutory qualification requirements, so that whoever holds the removal power must fill the office with someone qualified to hold it, and every position, whether or not it carries for-cause protection, is paired with a notice-and-justification requirement: removal before the end of a term requires a written statement of specific reasons transmitted to the authorizing committees and published, with a defined notice period before the removal takes effect. Procedural requirements of this kind, on the model of the Inspector General removal provisions, rest on different constitutional footing than substantive removal restrictions.

Third, protections for senior career scientific staff with delegated methodological authority should be drafted as civil-service protections rather than officer-removal restrictions; *Slaughter* addressed principal officers, and the merit-system framework in Title 5 remains the operative protection for the career workforce.

Fourth, every removal provision should carry a severability clause so that if a court strikes the for-cause element, the term, notice, and reporting elements stand.

Fifth, the architecture leans on protections that never touch removal: statutory release schedules, GAO reporting triggers, budget-line preservation, publication and firewall provisions, randomized panel assignment and mandatory recusal, vacancy reporting on a fixed clock, and the transition conditions in the reception titles.

Sixth, every position carries an interim rule: upon a vacancy, and only upon a vacancy, a designated career deputy performs the office's functions for a bounded period coordinated with the Federal Vacancies Reform Act, without authority to alter methodology, release schedules, review panels, or pending decisions, except to comply with a statute or court order, to address an imminent and documented threat to health or safety, or to correct a newly discovered material factual or methodological error certified in writing by the agency scientific integrity officer. The threat and error exceptions require the integrity officer's written concurrence and lapse thirty days after invocation unless renewed on a published record; the basis, scope, and duration are published before the change takes effect or, where an imminent threat makes advance publication impracticable, within 48 hours after the action taken; and an error certification issued within 60 days of a change in the integrity officer's incumbency is transmitted to the Inspector General for review before the correction takes effect, because an exception certified by the architecture's least-protected officer would otherwise be its widest door. Acting succession runs to positions, never to named designees: the career official serving as deputy, then the senior career officials of the agency's scientific or statistical staff by length of service, three positions deep, so that no reassignment can empty the chain. Filing a challenge to a removal neither creates a vacancy nor confers acting authority, and a court order preserving or restoring an incumbent displaces acting service. The succession rule preserves continuity of lawful operations while any challenge is adjudicated; it does not itself alter the effective date of a removal under otherwise applicable law or predetermine any judicial remedy. The diagnosis records harm outrunning remedy; the interim rule is the continuity answer written into each position.

The constitutional analysis underlying this pattern is consistent with the Congressional Research Service analysis of the decision (LSB11448). The Court's same-day decision in *Trump v. Cook* turned on the Federal Reserve's institution-specific history and is not relied on here; it neither extends to any health office nor makes litigation an automatic stay. The design accordingly treats the notice, interim-governance, and for-cause clauses as distinct, severable questions for position-specific legal expert review. The principal-officer classification above reflects legal expert review conducted in September 2026 (Ernat); the durability of the notice-period and interim-rule elements is the least-settled part of the design, and both are drafted severably, clause by clause, so that the remaining elements stand where they are independently constitutional and operable.

If Congress does not act. Each agency head can adopt the qualification standards, the written-reasons practice, and the interim succession rules as departmental policy now; they bind no successor, but they set the practice a statute would later codify and create the record of a departure from it. **Responsible entity:** Congress, on the drafting pattern above, applied within the AHRQ reauthorization (AHRQ and NCHS Directors), NIH authorizing legislation at 42 U.S.C. § 282 (NIH Director), CDC authorizing legislation (CDC Director), Title 38 legislation (VA research officials), and the Chief Science Officer proposal. **Mechanism:** Uniform drafting pattern across vehicles. **Timeline:** Requires legislation; the principal-officer question should be settled position by position through legal expert review before any vehicle is introduced.

3. Protections for evidence functions and the scientific workforce

Beyond the removal architecture, the Blueprint's protection agenda converts to five freestanding legislative proposals, each drafted so it can move independently or attach to a moving vehicle.

Protect research awards from political interference. Codify limits on the participation of political appointees in individual grant and award decisions at NIH and AHRQ, amending the peer-review requirements at 42 U.S.C. § 289a and the parallel AHRQ provisions. Existing legislative proposals in Congress provide drafting pathways. HHS can formalize firewall policies now under existing authority (42 U.S.C. § 282(b)(16) supports the NIH Director's peer-review authorities); statute makes the firewall durable, and an Inspector General audit finding that an award decision violated the prohibition returns the application to its peer-review disposition and is recorded in the annual Federal Health Evidence Report to the committees of jurisdiction. (Research Integrity Recommendation 1; NIH Recommendation 5.)

Protect federal evidence synthesis with a statutory firewall. Codify recognized national standards for systematic reviews and trustworthy guidelines as the methodological baseline; require registered protocols, public comment, and independent methodological review before release; and provide that no federal funds may be used to suppress, delay, or alter a federal evidence synthesis inconsistently with those standards, on the model of the statutory firewall protecting the Medicare actuary. The protection turns on attribution rather than on adjudicating justifications: any alteration after protocol registration is published as a dated, signed change alongside the original, with the independent methods reviewer's concurrence or objection on the record. The protection should reach contract terms, so payment cannot be used as leverage over findings, and information-quality correction processes should run on firm timelines so they cannot be used to delay inconvenient results. (Research Integrity Recommendation 3.)

Reform advisory committee governance, with ACIP and HICPAC first. Enact statutory protections for the Advisory Committee on Immunization Practices and the Healthcare Infection Control Practices Advisory Committee that match the consequences their recommendations carry: for ACIP, Section 2713 of the Affordable Care Act (42 U.S.C. § 300gg-13(a)(2)) and the Vaccines for Children program (42 U.S.C. § 1396s): Section 317 purchasing, Medicaid coverage, state immunization requirements, pharmacist scope-of-practice laws, and Vaccine Injury Compensation Program protections; for HICPAC, the infection-control standards hospitals, accreditors, and payers adopt. Five elements: codification of existence and scope with the consequence-bearing statutes cross-referenced; fixed staggered terms, qualifications, and the Proposal 2 removal design; codified methodology with departures requiring notice and comment before statutory effect; review timelines with GAO reporting naming the responsible decision-maker; and statutory continuity, so that a committee's most recent recommendations remain in effect for the statutes that rely on them while the committee is vacant, suspended, or stayed. Statutory conflict-of-interest, disclosure, and recusal standards apply to every consequence-bearing committee. ACIP today rests on the Secretary's general committee authority at 42 U.S.C. § 217a, which is what made its 2025 reconstitution possible. Drafting must account for *Kennedy v. Braidwood Management*: protections should attach to process and methodology rather than to appointment structures the decision forecloses. Minimum methodological standards should extend across CDC's advisory committees. (CDC Recommendation 2.)

Protect the analytic and scientific workforce. Enact statutory protection against reclassification of designated analytic and scientific positions out of competitive-service career status; cause-and-notice requirements for involuntary separation or reassignment, on terms parallel to 5 U.S.C. Chapters 75 and 23 and extended to same-grade reassignment where Chapter 75 does not reach; explicit Inspector General jurisdiction to review reclassification, reduction-in-force, and compelled-resignation patterns in analytic offices, conferred rather than presumed, with a finding tied to analytic content restoring the affected positions and going to the committees of jurisdiction within 30 days; and an Office of Special Counsel channel for analytic-content personnel actions as the secondary route. The reclassification protection is proposed at two scales: a government-wide version covering analytic and scientific positions across the federal evidence enterprise and an HHS-specific version, so that the principle finds allies beyond health while the narrower vehicle remains achievable. The ASPE section specifies the model; the same pattern extends to NCHS, NIH, CDC, and AHRQ scientific staff. (ASPE Recommendation 4; Research Integrity Recommendation 5; NCHS Recommendation 1.)

Codify the NCHS protections. Amend 42 U.S.C. § 242k to set the NCHS release schedule in statute with a requirement that any departure carry a published statement of cause at the time the window is missed, and to require GAO reporting when releases slip, identifying the cause and the responsible decision-maker. These provisions are drafted as freestanding amendments so they advance on any available path (the fallback design recorded in NCHS Recommendation 2, protecting Recommendation 1's elements). The legislative analysis found no direct precedent for an automatic GAO trigger of this kind; legal expert review identified no legality concern, and the trigger is drafted as a first instance. Because several provisions in this section route through GAO on fixed clocks, the appropriations for GAO should carry the staffing to act on them within the periods the statutes set. The VA section's parallel protections for research authority under Title 38 convert on the same pattern. (NCHS Recommendation 1; VA Recommendation 5.)

If Congress does not act. Scientific integrity policies, protocol registration, and clearance standards operate as agency policy under existing authority; the Inspector General's existing jurisdiction supports sampling-based award audits without new law; the workforce protections fall back to the merit-system protections in Title 5 as they stand. **Responsible entity:** Congress; committees of jurisdiction by vehicle. **Mechanism:** Freestanding bills or titles attached to moving vehicles; each proposal is drafted to sever cleanly. **Timeline:** Requires legislation. The administrative counterparts identified in each section proceed in the first year.

4. Data infrastructure and interoperability legislation

Codify the information blocking rule as it stands, and direct its enforcement toward public health, research, and quality measurement. The information blocking prohibition in 42 U.S.C. § 300jj-52 and the regulatory exceptions at 45 C.F.R. Part 171 already reach interference with disclosures to public health agencies, quality programs, and researchers when the disclosure is not prohibited by law, and they already govern fees through the Fees exception. The legislative ask is therefore narrow and stated for what it is: write the prohibition and its exceptions into statute as they now stand in regulation, so that a future rulemaking cannot narrow them, and require the Secretary to report annually, as a section of the Federal Health Evidence Report, on OIG and CMS enforcement activity involving public

health, research, and quality measurement disclosures. Enforcement priorities belong to OIG and CMS, not ONC, and the Blueprint asks the Secretary to set them under existing authority rather than asking Congress to write them. The update schedule for the United States Core Data for Interoperability (the federal standard for what data elements certified health IT must exchange, at 42 U.S.C. § 300jj-11(c)(3)) is deliberately not codified; ONC has issued seven versions in six years under the current process, and a statutory cadence would turn that floor into a ceiling. (Data Infrastructure Recommendation 4; Brief Agency Entries, ONC.)

Give CDC surveillance reporting a statutory backbone. Enact authority for CDC to require electronic submission of designated notifiable disease data from federally funded public health programs and from facilities participating in Medicare and Medicaid, with enumerated safeguards adapted from CIPSEA's confidentiality model and fitted to operational purpose under the Public Health Service Act (a statutory purpose test limited to designated threats and expressly identified programs, role-based and minimum-necessary access, disclosure logging, redisclosure limits, retention and destruction rules, independent audit, breach notice, OIG-enforced penalties scaled to culpability, and named prohibited uses including immigration enforcement, adverse individual determinations, employment screening, and unrelated law enforcement; CIPSEA's exclusively-statistical-use rule is not imported). The data modernization authority at 42 U.S.C. § 300hh-33 supports much of the infrastructure work; the reporting requirement, and in particular its extension through Medicare and Medicaid participation conditions, is the new authority. Sufficient appropriations are the binding constraint on the rest. (CDC Recommendation 1.)

Fund and govern vital statistics modernization. Authorize multi-year funding for NCHS modernization and a national governance framework for vital statistics with milestone-based federal-state funding. Multi-year budget authority must exist in authorizing statute before appropriators can use it; the authorization permits rather than compels, which is why the appropriations proposal in Proposal 5 pairs with it. (NCHS Recommendation 3.)

Set federal-state minimum data standards, incentive-based. Establish minimum standards for state-level data infrastructure tied to existing federal funding streams, structured as incentives rather than penalties, with the standards work convened through existing bodies (the HHS Data Council and the Interagency Council on Statistical Policy). Enhanced federal Medicaid matching for state Medicaid evidence functions, with pre-registration and analytic-independence conditions, extends the same logic; the data-collection and reporting foundation sits at 42 U.S.C. § 1396w-8, and the match mechanics follow the established Title XIX pattern for federally supported state administrative systems. The statutory placement for the enhanced match, and the extent of existing CMS grantmaking authority for state analytic capacity, are for legal expert review to settle before any vehicle is introduced. (State Evidence Capacity Recommendations 1 and 4; Data Infrastructure Recommendation 4.)

If Congress does not act. ONC certification criteria and the CMS conditions of participation reach most of the reporting framework administratively; what cannot be done is the Section 308(d) clarification and the deemed-transmission rule, so cross-agency exchange stays agreement by agreement. **Responsible entity:** Congress; Senate HELP and Finance, House Energy and Commerce and Ways and Means by element. **Mechanism:** Authorizing legislation, with appropriations pairing below. **Timeline:** Requires legislation.

5. Funding architecture

These proposals move through the appropriations process, paired with authorizing language where multi-year structures require it. They consolidate the funding elements flagged across the document. Appropriations asks come in two instruments, and each proposal below names its instrument: bill text is binding law that creates accounts, sets periods of availability, and carries enforceable conditions, while report language accompanies the bill and directs agencies without binding them. Durable structures need bill text. Report language is the right instrument for direction an agency is already authorized to follow.

Every funding structure in this proposal is a request to appropriators, holds only as long as they sustain it, and multi-year balances in particular remain subject to rescission; the structures are designed to make disinvestment visible and attributable, not impossible.

The HHS evaluation fund. Create a dedicated budget line for HHS-wide evaluation administered by ASPE, with AHRQ methodological-standards review, at a level on the order of one percent of HHS discretionary program spending (approximately $1 billion). The design question that determines the vehicle: discretionary funding through appropriations bill text is achievable but re-fought annually; mandatory funding requires authorizing-committee action but delivers the stability the proposal exists to provide. A program-integrity framing may support treatment outside discretionary caps, with the caveat that CBO does not score program-integrity savings. (ASPE Recommendation 2.)

NIH funding structure. Authorize multi-year budget authority or advance appropriations for designated long-horizon research categories (longitudinal studies, trials networks, core data systems, national research resources) under 42 U.S.C. § 282a, with process- and milestone-based accountability; the account structure and periods of availability are bill text, enabled by the authorizing amendment. Assign a periodic independent review of NIH funding against the Biomedical Research and Development Price Index, and of the budget's division among research, administration, and institutional support, to GAO or the National Academies on a defined cadence, extending the triennial reporting framework at 42 U.S.C. § 283; report language can direct the first review while the statutory cadence moves. Codify the annual public report on the institutional, geographic, and population distribution of NIH funding, building on the data collection already required at 42 U.S.C. § 282(b)(4). Appropriators should maintain the separate, additive ARPA-H account in bill text; 42 U.S.C. § 290c already requires that budget requests propose a separate ARPA-H appropriation from the other NIH accounts. (NIH Recommendations 2, 4, 6, and 7.)

CDC funding structure. CDC's appropriation is directed, through bill text and the accompanying report language, into more than a hundred separately specified program lines, with little authority to move funds toward emerging threats or to sustain data systems between emergencies. Unlike NIH, CDC has no general authority to reprioritize within its appropriation. The Blueprint proposes that Congress consolidate CDC's data-modernization and surveillance lines into a multi-year account with milestone-based release and a bar on transfer or reprogramming outside the enumerated modernization and surveillance purposes, so that flexibility in timing does not become flexibility in purpose. Release milestones for the account are set in advance for each period of availability, published, and developed through the national governance framework of NCHS Recommendation 3, with amendments published on the same terms, so that milestones the account cannot meet are not a lawful impoundment

instrument; unreleased balances above a stated share of the account at the end of each fiscal year are reported to the appropriations committees with the unmet milestones and the responsible official named; and bill text caps the share of the account chargeable to department-wide overhead and shared-services assessments, so that costs cannot drain what transfers cannot. The Blueprint further proposes and that the authorizing committees take up CDC's expired program authorizations as a package rather than program by program; the specific consolidation belongs to the appropriators, and the Blueprint states the structural problem rather than the account map. (CDC Recommendation 1.)

Cross-system joint funding authority. Establish statutory authority for VA, NIH, AHRQ, CDC, and other federal research entities to pool resources for research questions spanning systems. No existing statute supports pooled cross-department research funding of this kind: the NIH Common Fund (42 U.S.C. § 282a(c)) operates only across NIH, and Economy Act agreements (31 U.S.C. § 1535) support fee-for-service arrangements rather than joint funding. The Common Fund is the design model. (VA Recommendation 4; cross-cutting.)

Medicare evidence generation. Establish the dedicated federal funding mechanism for evidence Medicare needs but no commercial sponsor will generate, as new authorizing and appropriations language, with the fund created in authorizing statute and capitalized through bill text; a notice-of-funding-opportunity under current authority can begin the work but cannot sustain it. The fund's topic selection should be anchored in Healthcare Cost and Utilization Project data identifying the most common and costly conditions among Medicare beneficiaries, and a mandatory appropriation from the Medicare Trust Funds under Section 1142 of the Social Security Act should be presented as the financing option, on the precedent of the technology assessments AHRQ's predecessor agency conducted for Medicare coverage decisions in the 1990s; Section 1142 once did exactly this: its authorization of appropriations from the Medicare Trust Funds (42 U.S.C. § 1320b-12(i)) ran only through fiscal year 1994, and the 1999 reauthorization moved AHRQ to annual appropriations. New authority is required, and the proposal is to amend § 1320b-12(i) to restore the Trust Fund authorization for the assessment work Medicare itself consumes. (CMS Recommendations 5 and 6; AHRQ Recommendation 4.)

Coverage with Evidence Development sunset, and CMMI pre-registration. Amend the coverage authority so that a CED condition expires five years after issuance unless CMS affirmatively re-issues it after public review informed by an AHRQ technology assessment under Section 1142, and amend Section 1115A(c) so that a model launched without a registered evaluation protocol cannot proceed to expansion or actuarial certification until the protocol is registered and the interval disclosed. Both are default-operative designs: inaction produces the consequence. (CMS Recommendations 1 and 4.)

Impoundment enforcement. Withholding appropriated funds at the apportionment stage is already unlawful under the Impoundment Control Act of 1974; the gap the 2025 experience exposed is enforcement, not prohibition. The Blueprint proposes, as a bounded option, a private right of action for grantees, research participants, and institutions injured by unlawful impoundment, together with a congressional right of action, modeled on H.R. 10014 (119th Congress), the Restoring Accountability in Appropriations Act, which amends the Impoundment Control Act to the same effect. The proposal strengthens a bipartisan 1974 statute rather than creating a health-research remedy, and it is the provision that gives the anti-impoundment language in Proposal 1 and the apportionment point above their teeth. The right of action carries fee-shifting for prevailing plaintiffs and an anti-retaliation provision covering future award consideration, so that bringing the claim is not itself the injury. The

tradeoff is stated plainly: a litigation-facing remedy carries a different political profile than a structural one, and the current vehicle has a partisan sponsorship history. (Research Integrity framing; AHRQ Recommendation 1.)

Evaluation and readiness funding. Multi-year evaluation funding authority for ACF's Office of Planning, Research, and Evaluation, with bill text setting the multi-year availability and preventing absorption into program operations; both conditions bind only as bill text. Appropriations for emergency research readiness under the existing rapid-research authority at 42 U.S.C. § 247d(b)(2), so the authority can actually move money in the first days of an emergency; the appropriation itself is bill text, and report language can direct the readiness planning the authority already permits. Floor-level capacity grants for jurisdictions below defined infrastructure thresholds, including territories, under 42 U.S.C. § 300hh-33, and the federal technical assistance corps for state evidence infrastructure, both as bill text. (Brief Agency Entries, ACF/OPRE; Emergency Evidence Preparedness Recommendation 3; State Evidence Capacity Recommendations 2 and 3.)

If Congress does not act. The evaluation fund falls back to the existing set-aside; the CDC account stays as appropriators have structured it; the CED sunset and CMMI linkage can be adopted by CMS as policy without the self-executing force; the Section 1142 work proceeds as far as annual appropriations allow. **Responsible entity:** Appropriations Committees, with authorizing-committee action where multi-year or mandatory structures require it. **Mechanism:** Appropriations bill text and report language, paired with authorizing provisions. **Timeline:** First appropriations cycle of the next Congress; authorizing pairs on the reauthorization timeline.

6. Coordination made consequential: Section 1142 and the reporting spine

Reauthorize and fund Section 1142. Section 1142 of the Social Security Act (42 U.S.C. § 1320b-12) has authorized federal health services research supporting Medicare decisions for more than three decades without ever being operationalized. The Blueprint proposes codifying the joint CMS-AHRQ process the CMS section describes (annual technology-assessment prioritization and the APM quality-measure workstream), providing a dedicated appropriation for it, and confirming or amending the statutory hook for measure development. A reauthorization of the section itself deserves consideration; three decades of dormancy is evidence about durability that new guidance alone will not fix. The dedicated appropriation is placed at AHRQ, which administers the Evidence-based Practice Center program the process draws on; the placement follows the capacity, and the appropriation is justified by the assessment pipeline the CED sunset and coverage processes generate, not by the floor; the Medicare Trust Fund stream under Section 1142 is the financing option, presented in Proposal 5. A CMS placement was considered and rejected because the amount would be marginal within a program management account and invisible to appropriators. (CMS Recommendation 6; Align and Coordinate Recommendation 2.)

Codify the reporting spine. Statutory codification of RePORTER-grade public reporting for every HHS evidence funder, including funding amounts and update cadence (Align and Coordinate Recommendation 4). Codification of the HHS Chief Science Officer (Office of the Secretary Recommendation 1) under the Proposal 2 drafting pattern. **One report, not thirty.** The

recommendations in this document attach consequences to many failures, and in earlier versions of this document too many of those consequences took the form of a separate report to a committee. Congress does not want thirty reports and would not read them. The Blueprint therefore proposes a single statutory vehicle: an annual Federal Health Evidence Report from the Secretary to the committees of jurisdiction, with required sections that are triggered by the events the agency sections specify (a statistical release outside its announced window, a body that missed its cadence, a leadership vacancy past 210 days, an Inspector General finding, a coordination gap unaddressed across two cycles, a passback alignment finding). A triggered event goes into the next report; nothing requires a separate filing. Three kinds of notice stay outside the report because their timing is the point: the written reasons that precede a removal, which run on the notice period; GAO reviews, which GAO issues on its own schedule; and Inspector General findings that restore positions, which take effect when made. Everything else in this document that says a matter is "recorded in the annual report" means this report. The evidence-use scorecard in Office of the Secretary Recommendation 3 becomes a statutory section of that report with a mandatory oversight consequence: an operating division report that is not filed or is scored non-responsive draws a mandatory alignment finding in OMB's passback that the division must answer in its congressional budget justification, with GAO referral after two cycles; the same consequence design applies to the coordination bodies in Data Infrastructure Recommendation 6 and Align and Coordinate Recommendation 1, whose statutes specify missed-cadence reports, non-reprogrammable funds, and mandatory consolidation of predecessor bodies. Public reporting on leadership vacancies, on a 210-day clock, and delays in reconstituting statutorily required advisory bodies, adding to the institute-director appointment and term provisions at 42 U.S.C. § 284(a)(2) and complementing the Federal Vacancies Reform Act (NIH Recommendation 5; Office of the Secretary Recommendation 4).

If Congress does not act. The coordination body convenes under Secretarial authority and the scorecard is published by directive; both depend on the goodwill the diagnosis says cannot be assumed, which is the reason they are proposed for statute. **Responsible entity:** Congress; Senate Finance and House Ways and Means for Section 1142, HELP and Energy and Commerce for the reporting provisions. **Mechanism:** Authorizing legislation with a paired appropriation for Section 1142. **Timeline:** Requires legislation; the joint work plan proceeds administratively in the first year.

What this costs. The Blueprint is an authorization document; it proposes authorized floors and structures, and appropriators set the amounts each year. Two items carry stated new money: the AHRQ floor of $1 billion against an enacted base of $345.4 million, and the HHS evaluation fund at roughly $1 billion, or one percent of the department's discretionary appropriation. Together they are about $1.7 billion a year in new authorized spending, roughly one and a half percent of HHS discretionary spending and about three-hundredths of one percent of the $5 trillion the country spends on health care each year, which is the spending this evidence exists to inform. The remaining proposals restructure money that already flows (the CDC modernization account, the received statistical units' preserved lines, the NIH availability changes) or are financed within the program they serve (the Section 1142 Trust Fund authorization). Several items are deliberately left for appropriators to size, because sizing them is the appropriators' judgment: the vital records milestone payments, the state capacity grants and technical assistance corps, the surge research fund, and the device surveillance expansion. Offsets are structural rather than line-item: mandatory consolidation of the coordination bodies the new ones replace, the five-year sunset that retires Coverage with Evidence Development conditions no one is watching, and

evaluation funded once through a dedicated line rather than negotiated annually through the set-aside. The table below prices each item to the dollar where a dollar figure exists and says so where it does not.

The fiscal table

Every item in this document that asks for money, moves money, or creates work appears in the table below. The status column tells an appropriations reader what kind of ask each item is: new money means a new authorized level or a new budget line; restructured means money that already flows, reorganized; program-financed means the cost is carried inside the program the evidence serves; and sized by appropriators means the Blueprint deliberately names no figure because setting one is the appropriators' judgment. Where the document names a dollar figure, the table repeats it; where it does not, the table says so rather than implying a number exists somewhere else.

#	Item	Amount	Status	Source of funds	Where
1	AHRQ authorized funding floor	$1 billion a year, indexed to inflation, against an enacted FY 2026 discretionary base of $345.4 million; the Friends of AHRQ coalition's standing request of no less than $500 million anchors the current portfolio, and the floor is sized to the expanded mandate the reauthorization adds	New money	Labor-HHS discretionary appropriation	Proposal 1.3
2	HHS evaluation fund	Roughly $1 billion a year, set as one percent of the department's discretionary program spending	New money	New budget line; as the fund phases in, it replaces the case for growing the evaluation set-aside (the annual transfer authority in Section 241 of the Public Health Service Act), which remains for cross-cutting uses	Proposal 5.1
3	Received statistical and workforce units (NCHS; the workforce analysis center and resource files; the national drug use survey)	Existing appropriations move with the functions, preserved as distinct lines	Restructured; no new money	Each unit's current appropriation	Proposals 1.11, 3.5
4	Vital statistics modernization, multi-year authority	Sized by appropriators; the existing data-modernization streams are the starting base	Sized by appropriators	Labor-HHS bill text with the multi-year authority	Proposal 4.3
5	Vital records milestone payments	Sized by appropriators; the structure (payment on	Sized by appropriators	Same account as item 4	Proposal 4.3

#	Item	Amount	Status	Source of funds	Where
	to the 57 registration jurisdictions	delivery of defined milestones) is the proposal, the level is Congress's			
6	State capacity floor grants, with a territorial set-aside	Sized by appropriators, including the set-aside percentage	Sized by appropriators	New grants under 42 U.S.C. § 300hh-33	Proposal 5.10
7	Federal technical assistance corps for state and local evidence work	Sized by appropriators; funded by dedicated appropriation rather than billed back to the jurisdictions it serves	Sized by appropriators	Same vehicle as item 6	Proposal 5.10
8	Enhanced Medicaid match for state evidence functions	Rate and cap set in the authorizing text; proposed as a capped multi-state pilot, which bounds the entitlement-side exposure; the 90 and 75 percent matches for Medicaid systems work are the precedent	Program-financed (Medicaid)	Title XIX federal match	Proposal 4.4
9	CDC multi-year data-modernization account	Consolidates existing modernization lines into one multi-year account; the specific consolidation belongs to the appropriators, and the trade is stated plainly: the subcommittee gives up some program-line control in exchange for infrastructure that persists between emergencies	Restructured	Existing CDC appropriations	Proposal 5.11
10	Emergency research readiness appropriation (the surge fund)	Sized by appropriators; pre-positioned funding is scheduled funding, and the committees retain authority over the baseline and activation review	Sized by appropriators	Labor-HHS bill text under 42 U.S.C. § 247d(b)(2)	Proposal 5.9
11	Section 1142 dedicated appropriation (health care effectiveness research for Medicare)	Sized by appropriators in a paired appropriation; the authorization lapsed in FY 1994 and must be reenacted first	Program-financed (Medicare)	Medicare Trust Funds, the arrangement that funded the predecessor agency's technology assessments	Proposals 6.1, 5.14
12	Medicare evidence-generation fund	Sized by Congress in the authorizing text	Program-financed (Medicare)	Medicare Trust Funds, shared financing design with item 11	Proposal 5.7

#	Item	Amount	Status	Source of funds	Where
13	NIH multi-year or advance appropriations	No new money; this changes when funds are available, and the outlay-timing and allocation effects are for the Budget and Appropriations Committees to score	Restructured	Existing NIH appropriations	Proposal 5.2
14	NIH purchasing-power benchmark (the biomedical inflation index)	No cost; an evaluation benchmark on a review cadence, and by design an automatic escalator is what it is not	No new money	Not applicable	Proposal 5.3
15	NIH Common Fund expansion for cross-cutting work	Sized through the annual budget request; new money for coordination rather than redirected institute appropriations	Sized in the budget request	NIH appropriation, Common Fund line	NIH Recommendation 1
16	Separate, additive ARPA-H account	No new spending proposed; a budget-structure change so that ARPA-H growth is visible and does not draw down the NIH base	Restructured	Existing appropriations, separately stated	Proposal 5.5
17	Cross-system joint funding authority (VA, CMS, NIH and partners)	An authority rather than an appropriation; funded by the contributions of the programs that use it	No new money	Participating programs' existing funds	Proposal 5.6
18	FDA device surveillance at the scale of the drug-side system	Sized in the budget request the recommendation directs, benchmarked to what the drug-side Sentinel system costs to run	Sized in the budget request	FDA appropriation and the budget process	FDA Recommendation 2
19	Trusted-messenger partnerships and the listening function	Small recurring grants through cooperative agreements; aggregate sized by appropriators	Sized by appropriators	Existing cooperative-agreement vehicles	Trust and Communications Recommendation 2; Emergency Recommendation 5
20	Trust measurement as a statistical activity	A modest recurring appropriation within existing statistical activities	Sized by appropriators	AHRQ statistical activities	Trust and Communications Recommendation 3
21	OPRE multi-year evaluation funding	No new money; converts existing evaluation funds to multi-year availability with a bar on absorbing them into program administration	Restructured	Existing ACF evaluation funds	Proposal 5.8

#	Item	Amount	Status	Source of funds	Where
22	Evidence workforce programs	Existing authorities and training lines first; any new statutory program is stated in the Legislative Proposals and sized there or by appropriators	Sized by appropriators	Existing training and fellowship authorities	Workforce Recommendations 2 through 5
23	GAO capacity for the reporting and review duties this document assigns it	Sized by appropriators; the GAO appropriation should carry the staffing to act within the statutory periods	Sized by appropriators	Legislative branch appropriation for GAO	Proposal 3.5 and the clock provisions throughout
24	Agency implementation staffing (coverage reconsiderations, consideration records, the scorecard, registries, compliance reporting)	Unpriced here by design: the workload lands inside agencies whose staffing this document proposes to rebuild, and each agency prices its share in its congressional budget justification, where the evidence-use scorecard consequence already directs attention	Priced in agency budget justifications	Each agency's operating appropriation	Office of the Secretary Recommendation 3 and the consequence provisions throughout

Two reading notes. First, the only rows that add authorized spending are the first two, and together they come to about $1.7 billion a year, the figure the paragraph above puts in proportion. Second, the sentence that governs every row is the one this section already states: every funding structure here is a request to appropriators, holds only as long as they sustain it, and is designed to make disinvestment visible and attributable rather than impossible.

Sequencing

The agenda above sorts into three moves. The AHRQ reauthorization is the anchor and should be introduced at the start of the next congressional session; it carries the receptions, the Task Force, the statistical protections, and the funding floor as one institutional proposal. The protection proposals in Proposals 2 and 3 should be settled through legal expert review first, because the post-*Slaughter* drafting pattern determines their final form across every vehicle; the pattern itself is now fixed, and what remains is the position-by-position principal-officer question. The durable core under Proposal 1 is the contingency if the reauthorization stalls. The funding architecture moves on the appropriations calendar and does not wait for the authorizing vehicles: appropriations bill text for the evaluation fund, the Section 1142 appropriation, readiness funding, and state capacity grants can be pursued in the first cycle, with authorizing pairs following. Everything in this section is designed so that a Congress can act on any piece without waiting for the whole.

The agenda at a glance

The table below is the pull-sheet version of this section: every ask, its statutory hook, the committees of jurisdiction, and the vehicle. Committee abbreviations: HELP (Senate Health, Education, Labor, and Pensions); E&C (House Energy and Commerce); SFC (Senate Finance); W&M (House Ways and Means); Approps (Appropriations Committees, Labor-HHS subcommittee unless noted); HSGAC and Oversight (the civil-service committees); SVAC and HVAC (Veterans' Affairs Committees). "Reauth" is the AHRQ reauthorization bill in Proposal 1.

#	Ask	Statutory hook	Committees	Vehicle and instrument
1.1	Expand AHRQ's statutory mandate	Amend 42 U.S.C. § 299b	HELP; E&C	Reauth
1.2	Secretary-appointed AHRQ Director, five-year term, for-cause removal	42 U.S.C. § 299c-5	HELP; E&C	Reauth
1.3	Authorized funding floor: $1 billion, indexed	New authorization	HELP; E&C	Reauth
1.4	Mandatory grantmaking timelines: two self-executing triggers, rank-order award default, GAO as recorder	Amend 42 U.S.C. §§ 299b, 299c-4	HELP; E&C	Reauth
1.5	CIPSEA designation made and maintained	44 U.S.C. § 3562(a)	HELP; E&C	Reauth
1.6	Codify the Task Force: six elements	Amend 42 U.S.C. § 299b-4	HELP; E&C	Reauth
1.7	NCDs must consider EPC reports	Amend 42 U.S.C. § 1395y(l)	SFC; E&C; W&M	Reauth
1.8	AHRQ-PCORI division of labor	New provision	HELP; E&C	Reauth
1.9	Federal HSR coordination body, AHRQ chair	New; anchor at 42 U.S.C. § 299	HELP; E&C	Reauth
1.10	NHQDR cadence and expanded disaggregation	Amend 42 U.S.C. § 299a-1	HELP; E&C	Reauth
1.11	Receive NCHS, NCHWA/AHRF, and NSDUH	Amend 42 U.S.C. §§ 242k, 294n	HELP; E&C	Reauth
1.12	Primary care research and modernized patient-safety authority as core functions	Amend 42 U.S.C. § 299b, § 299b-3	HELP; E&C	Reauth
1.13	Digital health provision replacing Sec. 914(a)	Amend 42 U.S.C. § 299b-1	HELP; E&C	Reauth
1.14	Durable core if the vehicle stalls: anti-impoundment; grantmaking timelines and defaults	Amend 42 U.S.C. §§ 299b, 299c-4	HELP; E&C; Approps	Rider or narrow bill
2.1	Removal-protection drafting pattern (terms, notice, severability, career protections)	42 U.S.C. §§ 282, 299c-5, 242k; Title 38	HELP; E&C; SVAC; HVAC	Every protection vehicle
2.2	Interim-governance rule for every protected position	Each position's enabling statute	HELP; E&C; SVAC; HVAC	Uniform pattern

#	Ask	Statutory hook	Committees	Vehicle and instrument
3.1	Limit political-appointee role in award decisions	Amend 42 U.S.C. § 289a and AHRQ parallel	HELP; E&C	Freestanding
3.2	Evidence-synthesis statutory firewall	New; Medicare-actuary model	HELP; E&C	Freestanding
3.3	ACIP statutory protections	42 U.S.C. §§ 217a, 300gg-13(a)(2), 1396s	HELP; E&C; SFC; W&M	Freestanding
3.4	Analytic and scientific workforce protections	Parallel to 5 U.S.C. chs. 75 and 23	HSGAC; Oversight; HELP	Freestanding
3.5	NCHS release schedule and GAO reporting	Amend 42 U.S.C. § 242k	HELP; E&C	Reauth or freestanding
3.6	VA research protections	New Title 38 provisions	SVAC; HVAC	Freestanding
3.7	HICPAC statutory protections alongside ACIP; statutory continuity element	42 U.S.C. § 217a	HELP; E&C	Freestanding
3.8	Two-scale reclassification protection (government-wide; HHS)	New; parallel to 5 U.S.C. chs. 75 and 23	HSGAC; Oversight; HELP	Freestanding
3.9	Conferred IG jurisdiction over analytic-office personnel patterns; automatic restoration	Amend the Inspector General Act as applied to HHS	HSGAC; Oversight	Freestanding
4.1	Codify the information blocking prohibition and exceptions as they stand; annual enforcement reporting	Amend 42 U.S.C. § 300jj-52	HELP; E&C	Freestanding
4.2	CDC electronic reporting framework: direct receipt, Section 308(d) clarification, deemed transmission, spending-power conditions, ONC certification for electronic case and laboratory reporting	New, adjacent to 42 U.S.C. § 300hh-33; amend 42 U.S.C. § 242m(d)	HELP; E&C; SFC; W&M	Freestanding
4.3	Vital statistics modernization: multi-year authority, milestone funding	Amend 42 U.S.C. § 242k	HELP; E&C; Approps	Reauth plus bill text
4.4	Federal-state data standards; Medicaid analytic match	Amend 42 U.S.C. § 1396b(a) (enhanced match); § 1396w-8 foundation	SFC; E&C; W&M; Approps	Freestanding plus bill text
5.1	HHS evaluation fund, on the order of 1 percent of discretionary program spending	New budget line	Approps; HELP; E&C if mandatory	Bill text (or mandatory authorization)
5.2	NIH multi-year budget authority or advance appropriations	42 U.S.C. § 282a	Approps; HELP; E&C	Authorization plus bill text
5.3	BRDPI and budget-composition review on a cadence	42 U.S.C. § 283	HELP; E&C	Report language first, then statute

#	Ask	Statutory hook	Committees	Vehicle and instrument
5.4	NIH funding-distribution annual report	Extend 42 U.S.C. § 282(b)(4)	HELP; E&C	Freestanding or reauth
5.5	Separate, additive ARPA-H account	42 U.S.C. § 290c	Approps	Bill text
5.6	Cross-system joint funding authority	New; model at 42 U.S.C. § 282a(c)	HELP; E&C; SVAC; HVAC	Freestanding
5.7	Medicare evidence-generation fund	New	SFC; W&M; Approps	Authorization plus bill text
5.8	OPRE multi-year evaluation funding, absorption bar	New	Approps	Bill text
5.9	Emergency research readiness appropriation	42 U.S.C. § 247d(b)(2)	Approps	Bill text
5.10	State capacity grants and technical assistance corps	42 U.S.C. § 300hh-33	Approps	Bill text
5.11	CDC data-modernization multi-year account; lapsed authorizations package	New; 42 U.S.C. § 247d-4	Approps; HELP; E&C	Bill text plus authorization
5.12	CED five-year sunset with affirmative re-issuance	Amend 42 U.S.C. § 1395y	SFC; W&M; E&C	Freestanding
5.13	CMMI pre-registration linked to expansion and certification	Amend 42 U.S.C. § 1315a(c)	SFC; W&M; E&C	Freestanding
5.14	Medicare Trust Fund financing for Section 1142 evidence work	Amend 42 U.S.C. § 1320b-12	SFC; W&M	Authorization plus bill text
5.15	Private and congressional right of action under the Impoundment Control Act (bounded option)	Amend 2 U.S.C. ch. 17B; model H.R. 10014	Budget; Approps; Judiciary	Freestanding
6.1	Reauthorize and fund Section 1142	42 U.S.C. § 1320b-12	SFC; W&M; Approps	Freestanding plus bill text
6.2	Codify RePORTER-grade reporting, all HHS evidence funders	New	HELP; E&C	Freestanding
6.3	Codify the HHS Chief Science Officer	New	HELP; E&C	Freestanding
6.4	Vacancy and advisory-body reporting	42 U.S.C. § 284(a)(2)	HELP; E&C	Freestanding
6.5	Evidence-use scorecard as statutory reporting with passback finding and GAO referral	New	HELP; E&C	Freestanding
6.6	Coordination-body consequences: missed-cadence reports, non-reprogrammable funds, mandatory consolidation	New	HELP; E&C	With the body's authorization

About This Document

How it was made

AcademyHealth staff drafted every section, with named leads responsible for each agency and cross-cutting section. The document then underwent external review in five rounds, by seven reviewers in all, with backgrounds in congressional relations, public health law, federal agency leadership, public health practice, and philanthropy, plus an internal editorial pass, a plain-language accessibility pass, a board review, and a legal expert review of the constitutional and statutory questions the recommendations raise. When reviewers disagreed with the text or with each other, staff adjudicated the disagreement and recorded the decision. Two legal questions the document identifies are assigned to a further round of legal expert review before any legislative vehicle is introduced; the text notes this where they arise.

The role of AI

Staff used an AI assistant (Anthropic's Claude) throughout: for drafting and editing support, structural and consistency checks across a document of this size, assembling the final files, and verifying citations. The judgments are ours. AcademyHealth staff made every recommendation, framing choice, and position in this document.

We want to be clear about the trade-off, because it's the same one this document makes about evidence elsewhere. AI assistance made a review process possible that human hours alone would not have supported: every citation and link in this document was checked against its live source twice, using machine-assisted sweeps that a staff of our size could not have run by hand. It also introduced risks of its own. AI tools can generate references that look right but are not, so the verification protocol treated every citation as unproven until confirmed. Errors that the process caught, whatever their origin, were corrected before release. That risk is not different in kind from human error, which requires the same checking and confirmation, and in both cases any errors that remain are ours. We think that's the honest way to use these tools: for the labor, never for the judgment, with verification designed on the assumption that any step can fail.

Acknowledgments

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