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INTRODUCTION

I am pleased to present the Department of Health and Human Service's Performance Plan for FY 2004. Our mission is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health and social services. In executing this mission, the Department manages over 300 programs that touch the lives of every American. We are working to protect people from illness and injury in the event of another terrorist attack; control chronic diseases like asthma, diabetes and obesity; expand health care services for rural Americans and people without health insurance; and seek vaccines and cures for the most troubling diseases.

In some cases, Health and Human Services works directly with those in need. Often the Department works with State, local, and tribal governments, and many HHS-funded services are provided at the local level by State, county or tribal agencies, or through private sector grantees. While this Plan concentrates on the Department's discretionary budget, a significant percent of the budget is dedicated to grants and entitlement programs. We are the largest grant making agency in the Federal government, and provide some 60,000 grants per year. The Department's Medicare program is the nation's largest health insurer, handling more than 900 million claims per year.

This Plan provides a summary of the good work that Health and Human Services does. For example:

- ***We will achieve and maintain immunization coverage of at least 90% in children 19- to 35-months of age in seven important vaccines.***
- ***We will review and act upon original generic drug applications within 6 months after submission date.***
- ***We will increase the number of adoptions of children in the public foster care system to 60,000.***

These are just a sample of the performance targets the Department has set for itself. If you would like more detail about a particular agency, I encourage you to look at the individual Annual Performance Plans that can be found at *www.hhs.gov/budget/03gpra*.

The proud history of the Department reaches back to the late eighteenth and nineteenth century, when our predecessors cared for seafarers, and opened a one-room laboratory for disease research. As we enter the twenty-first century, HHS can point to many successes, and anticipate a new environment full of complex challenges. This Plan provides a glimpse on how we intend to succeed in that environment.

Sincerely,

Kerry Weems
Acting Assistant Secretary for Budget, Technology and Finance

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OVERVIEW OF THE HHS ANNUAL PLAN FOR FY 2004

The FY 2004 Department Performance Plan summarizes the performance measures that will lead to accomplishing HHS' strategic goals, as reflected in the Department's draft FY 2003 - 2008 Strategic Plan. Although the Department Strategic Plan is currently in draft, the goals will remain stable and so our Performance Plan organizes programs and measures around the Strategic Plan goals. For example, the first strategic goal, *Reduce the Major Threats to the Health and Well Being of Americans*, integrates the outcomes of several performance measures from the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration.

HHS has over 300 programs, and from these we have selected approximately 40 illustrative programs. For each program or program cluster, we discuss the means and strategies used to achieve each program's objectives and provide examples of performance measures that will help us reach the objectives. Programs that are priorities of the President or the Secretary are identified by the appropriate seal:

The performance measures associated with each program are taken from the agency annual performance plans and are representative of the program's goals. A summary table of the measures is provided at the beginning of each section. Where there is past performance to report, it is included in this summary table. Many new measures for FY 2004 have yet to report performance, and in these instances an asterisk (*) refers the reader to the appropriate agency performance plan.

The associated budget request for FY 2004 is also displayed. Each of these budget figures contribute to an overall total budget for each Strategic Goal. The budget figures associated with each Strategic Goal represent that goal's fraction of the total discretionary budget request of $70 billion. Important note: we also discuss some programs that are part of the mandatory budget, but those dollars are shown in *italics* and have not been added into the totals for each Strategic Goal.

Reduce the Major Threats to the Health and Well Being of Americans

HHS is taking steps to reduce health threats through promotion of healthy behaviors and building partnerships with States, communities, and health professionals. A new prevention initiative, explained under Goal 1, is a coordinated effort that emphasizes healthy behaviors and choices in preventing disease and illness. We also continue to fight substance abuse and the spread of HIV/AIDS.

Enhance the Ability of the Nation's Public Health System to Effectively Respond to Bioterrorism and Other Public Health Challenges

HHS has the lead role in protecting Americans from attacks on our food and health. The

Department has increased bioterrorism spending, and will further enhance the ability of our Nation's health care system to effectively respond to bioterrorism. We intend to extend hospital preparedness and complete the 122-city metropolitan Medical Response System. The Department has made significant progress in developing a smallpox vaccine stockpile and anticipate progress on an anthrax vaccine.

Increase the Percentage of the Nation's Children and Adults Who Have Access to Regular Health Care, and Expand Consumer Choices

The threat of bioterrorism is not the only threat facing the Nation. Disparities in health care for our population are of great concern to HHS, and we are working to expand access to health care for everyone. We seek to expand access to critical health care services for the uninsured, especially in underserved rural and urban areas. The Department also intends to expand the National Health Service Corps to a field strength of over 3,000 and assist nurse training and recruitment activities to ensure that our hospitals and nursing homes remain the best in the world.

Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise

HHS is committed to strengthening the base of qualified health and behavioral science researchers in order to advance the understanding of basic biomedical and behavioral science. The FY 2004 budget includes increases for bioterrorism and non-bioterrorism research. Other priorities include supporting an extramural research community of approximately 50,000 scientists, basic and clinical biomedical research, and completion of the John Edward Porter National Neuroscience Research Center at NIH.

Improve the Quality of Health Care Services

Improving the quality of health care services means reducing medical errors and improving consumer and patient protections. The Department is developing a proposal to modernize the electronic health information infrastructure that will reduce medical errors, increase efficiency and improve the safety in our Nation's hospitals. Similarly, FDA seeks to improve adverse event reporting and AHRQ is focusing on new activities, with an emphasis on small community and rural hospitals, that will focus on the role information technology can play in ensuring safer care.

Improve the Economic and Social Well Being of Individuals, Families, and Communities, Especially Those Most in Need

HHS will continue to support efforts to increase the independence of low income families, welfare recipients, the disabled, and older Americans. The newly-created HHS Office of Disability will oversee the coordination, development, and implementation of programs within HHS that impact people with disabilities. Administration on Aging programs complement existing health care systems, and aim to improve local systems of care by better integrating AoA, Medicare, Medicaid, and other service programs.

Improve the Stability and Development of Our Nation's Children and Youth

The President has outlined the next critical step in education reform: the need to prepare children to read and succeed in school. Our *Good Start, Grow Smart* initiative will support States' efforts to develop literacy guidelines, education and training plans, and coordinate early childhood programs. The Head Start program will implement a national training program, increase the number of children served and support new efforts.

Achieve Excellence in Management Practices

HHS is committed to improving the efficiency and effectiveness of the Department's programs and achieving the goals of the President's Management Agenda, by creating an organization that is citizen-centered, market-based, and results-oriented. As part of our overall commitment to good management, HHS is dedicated to successfully meeting the challenges identified by the Office of the Inspector General.

The table below displays the Department's FY 2004 budget, organized by Strategic Goal. Funding for individual goals may not add precisely to the Department total due to rounding errors.

Goal	Goal Text	Goal Budget	HHS Total
Goal 1	Reducing the Major Threats to the Health and Well Being of Americans	$6,480	
Goal 2	Enhancing the Ability of the Nation's Public Health System to Effectively Respond to Bioterrorism and Other Public Health Challenges	$3,160	
Goal 3	Increasing the Percentage of the Nation's Children and Adults Who Have Access to regular Health Care, and Expanding Consumer Choices	$9,481	
Goal 4	Enhancing the Capacity and Productivity of the Nation's Health Science Research Enterprise	$28,619	
Goal 5	Improving the Quality of Health Care Services	$682	
Goal 6	Improving the Economic and Social Well Being of Individuals, Families, and Communities, Especially Those Most in Need	$4,769	

Goal 7	Improving the Stability and Development of Our Nation's Children and Youth	$10,274	
Goal 8	Achieving Excellence in Management Practices	$2,449	
		Total	$64,845

(Dollars in Millions)

COMPREHENSIVE OVERVIEW OF SELECTED FY 2004 PERFORMANCE MEASURES

Goal 1: Reduce the Major Threats to the Health and Well-being of Americans.

Performance Measure	Agency	Most Recent Results
Prevent 50,000 hospitalizations due to asthma.	CDC	Data unavailable.*
Prevent 75,000 to 100,000 Americans from developing diabetes.	CDC	Data unavailable.
Prevent 100,000 to 150,000 Americans from developing obesity.	CDC	Data unavailable.
Increase by 25% the number of local, state, national and international health policies that incorporate effective prevention elements.	OPHS	FY01 Baseline: 25,064 (website visitors/clearinghouse inquiries.
Increase by 9% the reach of OPHS prevention communications.	OPHS	FY01 Baseline: 11,462,477 (website visitors/clearinghouse inquiries.
Increase by 11 % the number of policies in research institutions that improve the research enterprise.	OPHS	FY01 Baseline: 38,317 (website visitors/clearinghouse inquiries.
Decrease the number of perinatally acquired AIDS cases from the 1998 baseline of 235 cases.	CDC	Met: FY 00: 102.
Reduce the incidence of gonorrhea in women ages 15-44.	CDC	Not met. FY 01: 286/100,000. Target <250
Reduce the number of HIV infections diagnosed among people younger than 25 years old.	CDC	FY 00 baseline: 1,805 cases.
Increase the percentage of TB patients who complete a course of curative TB treatment within 12 months of initiation of treatment.	CDC	Not met. FY 99: 79.9%. Target 85%.
Reduce to or maintain at 0 the number of indigenous cases of measles in children under 5 by 2010. [FY 99: 66; FY 00: 63;.]	CDC	Not met. FY 01: 61 (provisional)
Achieve or maintain immunization coverage of at least 90 percent in children 19- to 35-months of age in at least 7 vaccines.	CDC	Varies. See CDC Report.
95 % of technical assistance events will result in systems, program or practice change.	SAMHSA	Met. FY 01: 96%
Build IT capabilities and capacity through all levels of public health (local, state, and federal) to serve the variety of public health functions.	CDC	Data unavailable.

* More recent data may become available in individual agency Reports.

Performance Measure	Agency	Most Recent Results
Ensure public health IT works as a coherent network and has the ability to connect other groups.	CDC	Data unavailable.
Evaluate network functionality and ensure interoperability, security, and reliability.	CDC	Data unavailable.

Goal 2: Enhance the Ability of the Nation's Health Care System to Effectively Respond to Bioterrorism and Other Public Health Challenges.

Enhance preparedness by assuring that 50 percent of State, territorial, and local projects have written plans to respond to biological, chemical, and mass trauma hazards relating to terrorism.	CDC	Data unavailable.
90 percent of States have developed plans to address surge capacity.	HRSA	Data unavailable.
Improve HHS response assets to support municipalities and states as needed (anticipated).	OASPHEP	Data unavailable.
Coordinate the development and procurement of safer and more effective vaccines against smallpox and anthrax (anticipated).	OASPHEP	Data unavailable.
Oversee the reinforcement and augmenting border coverage of all imported products (anticipated).	OASPHEP	Data unavailable.
Achieve adoption of the Food Code by at least one state agency in 42 States in the USA.	FDA	Met. FY 01: 28 states adopted food code (target 25 states)
Inspect 95 percent of the estimated 7000 high risk domestic food establishments once every year.	FDA	Not met. FY 01: inspected 80% of 6800 food est. (target 90%)
Perform 48,000 physical exams and conduct sample analyses on products with suspect histories.	FDA	FY 01 Baseline data: 12,169 physical exams
Expand Federal/State/local involvement in FDA's eLEXNET system by having 79 laboratories participate in the system.	FDA	Data unavailable.

Goal 3: Increase the Percentage of the Nation's Children and Adults Who Have Access to Regular Health Care and Expand Consumer Choices.

Improve satisfaction of Medicare beneficiaries with the health care services they receive.	CMS	Data unavailable.
Increase annual influenza (flu) and lifetime pneumococcal vaccinations.	CMS	Data unavailable.
Increase biennial mammography rates.	CMS	Met. FY 01: 51.6% (target 51%)
Improve the beneficiary understanding of basic features of the Medicare program.	CMS	Data unavailable.

Increase the percentage of Medicaid two-year old children who are fully immunized.	CMS	Data unavailable.
Decrease the number of uninsured children by working with States to implement SCHIP and by enrolling children in Medicaid.	CMS	Met. FY 01 3,441,000.
Increase the proportion of I/T/U clients (by 2% over FY 03 level) with diagnosed diabetes that have improved glycemic control [FY 01: 30% of I/T/U diabetics have improved glycemic control - a four percent increase over FY 00].	IHS	Met. FY 00 26% (target 25%).
Maintain the proportion of eligible women who have had a Pap Smear within the previous three years at the FY 2003 level.	IHS	Met. FY 01 42% (target 18% increase).
Maintain 100 percent accreditation of all IHS hospitals and outpatient clinics.	IHS	FY 01: 100%
Provide sanitation facilities projects to 18,150 Indian Homes with water, sewage disposal, and/or solid waste facilities.	IHS	Met. FY 01: provided facilities to total of 18,002 homes (target 14,730 homes).
Flexibility Grants: By 2004, 675 appropriate rural facilities will be assisted in converting to Critical Access Hospital (CAH) status.	HRSA	Met. FY 02, 657 hospitals assisted (target 240).
Increase to 13.75 million the number of uninsured and underserved persons served by Health Centers.	HRSA	Not met. FY 01, 10.3 million people were served (target 10.5 million)
Decrease to 6.77 percent the percent of Health Center prenatal patients with births <2,500 grams.	HRSA	Not met. FY 2001 7.13%.
Increase to 900 the number of new nursing loan repayment contracts awarded.	HRSA	Met. FY 2001 443 new contracts (target 200).
Increase to 22% the proportion of NELRP supported nurses serving in critical shortage facilities who extend their contract for a third year.	HRSA	Baseline 21%
Decrease the infant mortality rate to 6.8/1000.	HRSA	Not met. FY 99 7.1/1000
Reduce illness and complication due to pregnancy to 26 per 100 deliveries.	HRSA	1998 baseline: 31.2/100 .
Increase to 96 percent the percent of newborns with at least one screening for each of PKU, hypothyroidism, galactosemia, and hemoglobinopathies.	HRSA	Not met. FY 99 94%.
Increase maternal survival to 8 maternal deaths per 100,000 live births.	HRSA	Data unavailable.
Part A - Serve a proportion of women and racial/ethnic minorities in Title I-funded programs that exceeds their representation in national AIDS prevalence data, as reported by the CDC, by a minimum of five percentage points.	HRSA	Met. FY 00 70.4% (target 57.3%).

For Part B, increase by 4% the number of ADAP clients receiving HIV/AIDS medications through State ADAPs during at least one month of the year.	HRSA	Met. FY 01 73,784 (target 72,000).
Increase by 2% annually the number of persons who learn their serostatus from Ryan White Care Act programs.	HRSA	Data unavailable.
Reduce deaths due to HIV infection below 3.6 per 100,000 people by 2010.	HRSA	Data unavailable.
Maintain at 80 percent the percent of NHSC clinicians retained in service to the underserved.	HRSA	Met. FY 01, 80% of NHSC clinicians remained in service (target 75%).

Goal 4. Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise.

Develop an AIDS vaccine by 2007.	NIH	Met*
Conduct medication development with use of animal models, and begin to conduct Phase I and II trials of two potential treatments for alcoholism: cannabinoid antagonist Rimonabant and corticotropin releasing hormone antagonist Antalarmin.	NIH	Data unavailable.
By 2006, develop one or more prototypes for a low-power, highly directional hearing aiid microphone to help hearing impaired persons better understand speech ina noisy background.	NIH	Data unavailable.
By 2007, demonstrate the feasibility of islet transplantation in combination with immune tolerance induction for the treatment of type I diabetes in human clinical studies.	NIH	Data unavailable.
By 2009, evaluate the efficacy of two novel approaches to prevent weight gain and/or treat obesity in clinical trials in humans.	NIH	Data unavailable.
Develop methods that can classify at least 75% of proteins from sequence genomes according to evolutionary origin and biological structure.	NIH	Data unavailable.
Identify at least one clinical intervention that will delay the progression, delay the onset, or prevent Alzheimer's disease.	NIH	Data unavailable.
By 2010, develop one universal antibiotic effective against multiple classes of biological pathogens.	NIH	Data unavailable.
Determine the efficacy of using salivary diagnostics to monitor health and diagnose at least one systemic disease by 2013.	NIH	Data unavailable.
By 2005, develop two new animal models to use in research on at least one agent of bioterror.	NIH	Data unavailable.
By 2005, develop improved animal models that best recapitulate Parkinson's Disease (PD), based merging scientific findings of genetic or environmental influences, or interactions of genes and the environment on the development of PD.	NIH	Data unavailable.

By FY 2007, identify 20 small molecules that are active in models of nervous system function or disease and show promise as drugs, diagnostic agents, or research tools.	NIH	Data unavailable.
By 2007, evaluate three new treatments strategies for HIV infection in Phase II/III human clinical trials in an effort to identify drugs that are more effective, less toxic, and/or simpler to use than the current recommended HIV treatment regimen.	NIH	Data unavailable.
Establishing the efficacy of stains in preventing progression of atherosclerosis in children with Systemic Lupus Erthermatosus (SLE or lupus).	NIH	Data unavailable.
By 2008, reduce the disparity between African American and white infants in back sleeping by 50 percent to further reduce the risk of Sudden Infant Death Syndrome (SIDS).	NIH	Data unavailable.
Expand the range of available methods used to create, analyze, and utilize chemical libraries, which can be used to discover new medicines. Specifically, use these chemical libraries to discover 10 new and unique chemical structures that could serve as the starting point for new drugs.	NIH	Data unavailable.
Identify the genes that control the risk for the development of age-related macular degeneration and glaucoma in humans.	NIH	Data unavailable.
By 2011, assess the efficacy of at least three new treatment strategies for reducing cardiovascular morbidity/mortality in patients with type 2 diabetes and/or chronic kidney disease.	NIH	Data unavailable.
By 2012, develop a knowledge base on Chemical Effects in Biological Systems using a “systems toxicology or toxicogenomics approach.	NIH	Data unavailable.
By 2005, evaluate 10 commonly used botanicals for inhibition/induction of enzymes that metabolize drugs as a method of identifying potential botanical/drug interactions.	NIH	Data unavailable.
By 2006, integrate nanotechnology-based components into a system capable of detecting specific biomarker(s) (molecular signatures) to establish proof of concept for a new approach to the early detection of cancer and, ultimately, cancer preemption.	NIH	Data unavailable.
By 2005, create the next generation map of the human genome, a so called “halotype map” (HapMap), by identifying the patterns of genetic variation across all human chromosomes.	NIH	Data unavailable.
By 2007, determine the genome sequence of an additional 45 human pathogens and three invertebrate vectors of infectious diseases.	NIH	Data unavailable.
Identify and characterize two molecular interactions of potential clinical significance between bone-forming cells and components of bone. Such interactions are defined as those having significant impact on the actual of bone mass or the actual mechanical performance of bone (i.e., fracture resistance) in laboratory animals.	NIH	Data unavailable.

Build a publicly accessible Collection of Reference Sequences to serve as the basis for medical, functional, and diversity studies. A comprehensive Reference Sequence Collection will serve as a foundation for genomic research by providing a centralized, integrated, non-redundant set of sequences, including genomic DNA, transcript (RNA), and proteome (protein product) sequences, integrated with other vital information for all major research organisms.	NIH	Data unavailable.
By 2009, assess the impact of two major Institutional Development Award (IdeA) programs on the development of competitive investigators and their capacities to compete for NIH research funding.	NIH	Data unavailable.
By 2010, demonstrate through research a capacity to reduce the total years lost to disability (YLDs) in the U.S. by 10 percent by 1) developing treatment algorithms to improve the management of treatment-resistant and recurrent depression and 2) elucidating the mechanisms by which depression influences at least two comorbid physical illnesses (e.g., heart disease, cancer, Parkinson's disease, or diabetes). Major depression is now the leading cause of YLDs in the nation.	NIH	Data unavailable.
By FY 2010, identify culturally appropriate, effective stroke prevention programs for nationwide implementation in minority communities.	NIH	Data unavailable.
Review and act on 90% of standard New Drug Applications within 10 months and 90% of priority NDAs within 6 months.	FDA	Met. FY 01 90% (target 70% of standard NDAs) FY 01 100% (target 90% of priority NDAs).
Complete review and act upon fileable original generic drug applications within 6 months after submission date [FY 01: reviewed 84% of 298 applications (target 50%)].	FDA	Met. FY 01 84% (target: 50%).
Increase the number of drugs that are adequately labeled for children.	FDA	Data unavailable.
Act on 90 percent of Rx to OTC switch applications within 10 months.	FDA	Data unavailable.
Complete review and action on 90 percent of Pre-market Approval Application (PMA) on an estimated 80 (PMA) first actions within 180 days.	FDA	Met. FY 02 97% (target: 90%).
Complete review and action on 95 percent of an estimated 725 PMA supplement final actions within 180 days.	FDA	Met. FY 02 95% (target 90%).
Complete 95 percent of PMA "Determination" meetings within 30 days [FY 01: 100% of 3 (target 95%)].	FDA	Met. FY 01 100% (target 95%).

* More recent data may become available in individual agency Reports.

Goal 5: Improve the Quality of Health Care Services.

Decrease by five percent the hospitalization rates for pediatric Asthma.	AHRQ	Data unavailable.
Produce a CAHPS module for consumer assessments of hospital quality.	AHRQ	Data unavailable.
Five technologies currently shown to be effective in other clinical settings will be tested in nursing homes to evaluate the impact on safety, quality, and cost of care.	AHRQ	Data unavailable.
Decrease the prevalence of restraints in nursing homes.	CMS	Not met. FY 02 9.9% interim data (target 10%).
Decrease the prevalence of pressure ulcers in nursing homes.	CMS	Met. 10.3% interim data (target 9.5%).
Expand implementation of the MeDSuN System to a network of 300 facilities [FY 01: FDA began feasibility testing with 25 hospitals and worked on software changes needed for website health data security (target recruit 75 hospitals to report adverse events)].	FDA	Data unavailable.
Enhance postmarketing drug safety.	FDA	Data unavailable.
Expand the automated extraction of GPRA clinical performance measures and improve data quality.	IHS	Data unavailable.
Build IT capabilities and capacity through all levels of public health (local, state, and federal) to serve the variety of public health functions.	CDC	Data unavailable.
Ensure public health IT works as a coherent network and has the ability to connect other groups.	CDC	Data unavailable.
Evaluate network functionality and ensure interoperability, security, and reliability.	CDC	Data unavailable.

Goal 6: Improve the Economic and Social Well Being of Individuals, Families, and Communities, Especially Those Most in Need.

For FY 2003, increase to 44% the percentage of adult TANF recipients who become newly employed. FY 2004 targets to be established after TANF reauthorization.	ACF	Met. FY 00 46.4% (target 42%).
For FY 2003, increase to 68% the percentage of adult TANF recipients/former recipients employed in one quarter of the year who continue to be employed in the next two quarters.	ACF	Data unavailable.
Increase the targeting index of LIHEAP recipient households having at least one member 60 years or older compared to non-vulnerable LIHEAP recipient households.	ACF	Data unavailable.
Increase the targeting index of LIHEAP recipient households having at least one member 5 years or under compared to non-vulnerable LIHEAP recipient households.	ACF	Data unavailable.

A significant percentage of Older American Act Title III service recipients live in rural areas.	AoA	Data unavailable.
Maintain a high ratio of leveraged funds to AoA funds.	AoA	Data unavailable.

Goal 7: Improve the Stability and Development of our Nation's Children and Youth.

Achieve at least an average 34% gain in word knowledge for children completing the Head Start program.	ACF	Met. FY 00 32% (target 19%).
Achieve at least an average 52% gain in mathematical skills for children completing Head Start programs.	ACF	Met. FY 00 43% (target 30%).
Achieve at least an average 70% gain in letter identification for children completing the Head Start program (the average gain among all children during the pre-K year is 50%). [Goal not met: Gain increased to 38%, falling short of 70%]	ACF	Not met. 38% (target 70%).
Increase the number of children receiving child care services through CCDF, TANF-direct and SSBG funds.	ACF	Data unavailable.
Increase the proportion of centers and homes that serve families and children receiving child care subsidies.	ACF	Data unavailable.
Increase the number of States that encourage provider training through bonuses or other compensation.	ACF	Data unavailable.
Increase the paternity establishment percentage (PEP) to 99%.	ACF	Met. FY 01 102% (target 96%).
Increase the Title IV-D collection rate to 60%.	ACF	Met. FY 01 57% (target 54%).
Increase the number of adoptions of children in the public foster care system to 60,000.	ACF	Not met. FY 01 50,000 (target 51,000).
Of the children who exit foster care through reunification, maintain the percentage of children who do this within one year of placement at 67%. [FY 2001 goal met: 68% (target 67%).]	ACF	Met. FY 01 68% (target 67%).

Goal 8. Achieve Excellence in Management Practices.

Achieve Medicare/Medicaid total expected recoveries and savings per dollar invested of $156:1.	OIG	Data unavailable.
Work with CMS to reduce the Medicare error payment rate to [a rate determined by CMS].	OIG	Data unavailable.
Obtain a clean audit opinion.	ACF	Met. FY 01 clean audit.

Maintain a clean unqualified opinion on CMS's FYs 2002, 2003 and 2004 financial statements.	CMS	Met. FY 01 clean audit.
Complete construction of Infectious Disease Lab, Building 109, to replace Buildings 4, 6, 7, 8 and 9 on the Chamblee Campus. [FY 03: Phase II construction complete]	CDC	Met. FY 02 on schedule.
Design and construct an Environmental Toxicology Lab, Building 110, to replace Buildings 17, 25, 31 and 32 on the Chamblee Campus. [FY 03: Construction on schedule].	CDC	Met. FY 02 construction begun.

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STRATEGIC GOAL 1

Reduce the Major Threats to the Health and Well Being of Americans
Total Requested Discretionary Funds for This Goal in FY 2004:
$6.480 billion

HHS is taking steps to reduce health threats through the promotion of healthy behaviors and building partnerships with States, communities, and health professionals. Reinforcing healthy behaviors in youth, from abstinence to skill building, is critical. The Secretary is leading the Department in *Steps to a Healthier US*, a coordinated HHS effort that emphasizes healthy behaviors and choices in preventing and controlling disease with a special focus on asthma, diabetes and obesity. *Steps* advances President Bush's *Healthier US* Program, which mobilizes the Federal government to alert the American people to the vital health benefits of simple and modest improvements in physical activity, nutrition, and behavioral choices such as eliminating tobacco and illegal drug use.

Prevention is also a hallmark of HHS's approach to fighting HIV/AIDS, sexually transmitted diseases, and tuberculosis. We are making considerable progress slowing the transmission of AIDS from pregnant women to their children, and preventing the spread of tuberculosis. Similarly, the HHS vaccine program protects the population from a wide variety of infectious diseases, including diphtheria, measles, polio, and influenza.

A risk behavior affecting youth and other segments of the U.S. population is substance abuse. Consistent with the Office of National Drug Control Policy's overall recommendations, the FY 2004 budget request makes a third installment on the President's Drug Treatment Initiative, and HHS continues to work with ONDCP to implement an effective drug strategy.

Several illustrative programs at HHS, detailed below, have annual performance measures that speak to reducing the threats to the health and well-being of Americans. These measures are representative of the programs being described and serve as examples of how HHS continues to track their progress towards this strategic goal.

HHS Strategic Goal	Agencies/ Programs	FY 2004 Performance Measures
GOAL 1: Reduce the major threats to the health and well-being of Americans.	CDC Chronic Disease Prevention and Health Promotion	- Prevent 50,000 hospitalizations due to asthma.* - Prevent 75,000 - 100,000 Americans from developing diabetes.* - Prevent 100,000 - 150,000 Americans from developing obesity.*
	OPHS Disease Prevention and Health Promotion	- Increase by 25 % the number of local, State, national and international health policies that incorporate prevention elements identified by OPHS as effective.* - Increase by 9 % the reach of OPHS prevention communications. - Increase by 11 % the number of polices in research institutions that improve the research enterprise.*
	CDC HIV/AIDS, Sexually Transmitted Diseases and Tuberculosis	- Decrease the number of perinatally acquired AIDS cases from the 1998 baseline of 235 cases. [FY 99: 171; FY 00: 102.] - Reduce the incidence of gonorrhea in women ages 15-44. [FY 99: 286/100,000; FY 00: 278; FY 01: 286.] - Reduce the number of HIV infections diagnosed among people younger than 25 years old. [2000 baseline: 1,805 cases.] - Increase the percentage of TB patients who complete a course of curative TB treatment within 12 months of initiation of treatment. [FY 99: 79.9%.]
	CDC Immunization Program	- Reduce to or maintain at 0 the number of indigenous cases of measles in children under 5 by 2010. [FY 99: 66; FY 00: 63; FY 01: 61 (provisional).] - Achieve or maintain immunization coverage of at least 90 percent in children 19- to 35-months of age in at least 7 vaccines. *
	SAMHSA Substance Abuse Prevention and Treatment Block Grant Program	- 95 % of technical assistance events will result in systems, program or practice change. [FY 99: 66% FY 00: 84%; FY 01: 96%]
	CDC Public Health Information Network	-Build IT capabilities and capacity through all levels of public health (local, state, and federal) to serve the variety of public health functions.* - Ensure public health IT works as a coherent network and has the ability to connect other groups.* - Evaluate network functionality and ensure interoperability, security, and reliability.*

** See agency performance plan/report for additional information.*

Chronic Disease Prevention & Health Promotion

Centers for Disease Control and Prevention (CDC)

FY 2004 Budget Request: $834 million

Program Background and Context

Chronic diseases are leading causes of disability and death in the United States. Every year, chronic diseases claim the lives of more than 1.7 million Americans. These diseases are responsible for seven of every 10 deaths in the United States. Chronic diseases cause major limitations in daily living for more than one of every 10 Americans, or 25 million people. CDC's Chronic Disease Prevention and Health Promotion is made up of a variety of efforts, including Breast and Cervical Cancer, Tobacco Use Prevention, Community-Based Prevention Research, Heart Disease and Stroke, Arthritis, the National Program of Cancer Registries, HIV Prevention Among School-Aged Youth, and Behavioral Risk Surveillance.

As the lead Federal agency for protecting the health and safety of Americans, CDC works diligently to prevent disease, injury and disability. Among CDC's highest priorities is to respond forcefully to the epidemics of asthma, diabetes, and obesity that are sweeping all sectors of society.

Each year, asthma causes about 5,000 deaths and 2 million emergency room visits. Nearly 17 million people have diabetes, of which 90 percent to 95 percent of the cases are type 2 diabetes, which is associated with obesity and physical inactivity. In addition, nearly 50 million adults between the ages of 20 and 74 are obese, and more than 108 million adults (61 percent) are either obese or overweight. A recent HHS report cites that 300,000 people die each year from diseases and health conditions related to a sedentary lifestyle and poor eating habits. The HHS report pulled together data from various studies and scientific sources to illustrate the correlation between inactivity and poor health, particularly the onset of diseases such as diabetes and obesity.

Program Performance Planning

Joining with HRSA, AHRQ, and NIH, CDC has begun a coordinated and comprehensive new initiative to prevent asthma, diabetes, and obesity and their complications. The *Healthy Communities Initiative* provides for targeted programs focusing on reducing the health impacts of asthma, diabetes, and obesity. This initiative supports the *Healthy People 2010* goals to promote respiratory health Goal 24), reduce the disease and economic burden of diabetes (Goal 5), and reduce chronic disease associate with diet and weight (Goal 19).

A coordinated grant announcement, application, and review process will assure coordination and integration at the State and local level. The initiative is aimed at achieving:

- ★ ***Preventing 50,000 hospitalizations due to asthma,***
- ★ ***Preventing 75,000 - 100,000 Americans from developing diabetes, and***

★ ***Preventing 100,000 - 150,000 Americans from developing obesity.***

Means and Strategies

The Chronic Disease budget request for FY 2004 is $834 million, an increase of approximately $124 million over the FY 2003 appropriation. Complementing those means are several strategies that CDC has to translate the new science of primary prevention into public health action. The highlighted measures exemplify these strategies.

➢ **Asthma:** In 1999, an estimated 26.7 million Americans reported that they had been diagnosed with asthma sometime in their lives. An estimated 10.5 million reported an asthma attack in the previous 12 months. CDC's Asthma Control Program uses tracking, intervention and partnerships to reduce the number of deaths, emergency room visits, school or workdays missed and limitations on activity due to asthma. So far, 25 States have implemented asthma programs with CDC's help.

➢ **Diabetes:** CDC continues to achieve its targets for increasing the percentage of persons with diabetes who receive annual foot exams. Diabetes is the leading cause of non-traumatic lower extremity amputations, yet over half of the over 80,000 amputations that occur annually could be prevented through appropriate preventive care and treatment. CDC is now establishing a baseline in States with pre-diabetes programs so that, by 2010, they can achieve a 25 percent decrease among people who have pre-diabetes who advance to diabetes.

➢ **Obesity:** Initial CDC programs to address the epidemic of obesity in America have focused on building State capacity to develop comprehensive nutrition and physical activity programs. Since FY 2000, twelve States have been funded to build capacity. They are developing plans for targeted populations, developing partnerships to carry out the plans, and developing, conducting, and evaluating nutrition and physical activity intervention projects in populations.

External Factors

There is currently no way to prevent the initial onset of asthma, and there is no cure. However, people who have asthma can still lead quality, productive lives if they control their asthma. Asthma can be controlled by taking medication and by avoiding contact with environmental "triggers." These environmental triggers include cockroaches, dust mites, furry pets, mold, tobacco smoke, and certain chemicals.

A great deal remains unknown about the risk factors for diabetes, particularly genetic risk factors. A number of studies have shown that lifestyle interventions significantly reduce the risk of developing type 2 diabetes. In high risk populations, type 2 diabetes also appears to be associated with obesity. Researchers are making progress in identifying the exact genetics and "triggers" that predispose some individuals to develop type one diabetes, but prevention, as well as a cure, remains elusive.

Behavioral and environmental factors are the main contributors to overweight and obesity. While these factors provide the greatest opportunities for prevention and

treatment, they are also among the most difficult to influence. Heredity also plays a large role in determining how susceptible people are to overweight and obesity.

Disease Prevention and Health Promotion
Office of Public Health and Science
FY 2004 Budget Request: $139 million

Program Background and Context

Within the Office of Public Health and Science (OPHS), several programs provide leadership within the Department and indeed nationally in promoting health and preventing disease. Some target specific audiences or issues. The Office of Minority Health (OMH) coordinates and monitors efforts related to racial and ethnic minorities. The Office on Women's Health (OWH) is the government's champion and focal point for women's health activities. The Office of Population Affairs/Adolescent Family Life Program (OPA) supports abstinence education programs for teens. The President's Council on Physical Fitness and Sports (PCPFS) promotes physical activity for all ages. The OPHS Office of Disease Prevention and Health Promotion (ODPHP) leads cross-cutting national initiatives within and/or on behalf of the Department. Taken together, OPHS programs provide the coordination needed for agencies to work as "One HHS" in tackling the complex prevention challenges facing our nation.

OPHS, through ODPHP, coordinates President Bush's *HealthierUS* initiative and Secretary Thompson's initiative, *Steps to HealthierUS,* on behalf of the Department. Together, these initiatives focus both on preventing disease by addressing major risk factors (such as physical inactivity and poor nutrition) and on reducing the burden of disease through appropriate health screenings and prevention of secondary conditions. *Steps to a HealthierUS* will have a special emphasis on diabetes, obesity, and asthma. It will promote health information to support responsible health choices, community initiatives to promote and enable healthy choices, health care and insurance systems that put prevention first (reducing risk factors and reducing complications of chronic disease), and State and federal policies that invest in the promise of prevention for all Americans. ODPHP also coordinates the implementation of *Healthy People 2010*. *Healthy People 2010* (HP) supports the President's *HealthierUS* initiative by offering specific goals across a range of health areas. Through concrete objectives and measurable targets, it provides a framework for programs necessary to achieve the President's vision.

The Assistant Secretary for Health monitors and reports on progress so that the nation can judge what works and how far we still have to go to reach our objectives.

In addition, OPHS strengthens the prevention science enterprise through its unique efforts in the areas of assuring research integrity and protecting human subjects. Through its Office of Research Integrity and its Office for Human Research Protections, the research that underpins public health policy and clinical treatments is guided and monitored to ensure adherence to the highest ethical and legal requirements.

Program Performance Planning

OPHS has set performance measures to capture its special contributions to the Department's and the nation's prevention effort. Specifically, OPHS shapes prevention policy at the national, State, and local levels by getting key priorities into the agenda and programs of the myriad stakeholders-public and private-whose efforts are needed to improve the health of individuals and communities. It mobilizes these stakeholders through targeted leadership and broad partnerships. OPHS provides major prevention communication channels for the nation, notably its award-winning Websites: healthfinder®, the national Internet health portal, 4Woman.gov, the OMH Resource Center Web site, and SurgeonGeneral.gov which are used by over 13 million visitors each year.

The following measures illustrate the goals OPHS has set to energize national efforts around sound prevention policies and practices:

- ★ ***Increase by 25 percent the number of local, State, national and international health policies that incorporate prevention elements identified by OPHS as effective.***
- ★ ***Increase by 9 percent the reach of OPHS prevention communications.***
- ★ ***Increase by 11 percent the number of polices in research institutions that improve the research enterprise.***

Means and Strategies

The OPHS budget request for all of its disease prevention and health promotion program is $139 million. To achieve our FY 2004 performance goals in a context of limited resources, OPHS will target several important prevention activities. The following reflect the range of OPHS efforts:

- ➢ OPHS will promote knowledge of "best practices" related to the physical activity, nutrition, overweight and obesity, tobacco use and substance abuse, and preventive screenings as opportunities for individuals, communities, businesses, health care providers, and major organizations to focus their actions for personal and collective health improvement; increase the number for formal agreements with stakeholder organizations to strengthen their own activity related to prevention.
- ➢ OPHS will increase outreach efforts to promote physical activity through its President's Challenge Awards program and the Presidential Sports Award.
- ➢ OPHS will develop a national Hispanic media campaign, building on its successful national radio partnership, Closing the Health Gap, to increase awareness of the health disparities between majority and minority populations and steps consumers can take to assume control of their health.
- ➢ It will increase outreach to women through the National Women's Health Information Center and 4Woman.gov; to the general public through healthfinder.gov; and to under-served populations through special sections on healthfinder-including healthfinder espanol–and on the OMHRC site. It will expand its communication of health and

science messages through newspaper and journal articles and other channels reaching professionals as well as the public.

- ➢ It will increase its abstinence education programs for both pre-adolescents and adolescents, both male and female. These programs will address the prevention of STDs, HIV/AIDS, and other health risks such as tobacco, alcohol, drugs and violence.

External Factors

Achieving our prevention goals depends on numerous health programs and providers, all levels of government, and the efforts of the private sector as well as individual contributions. OPHS' contributions are in many instances the vital first step without which the success of other inputs would be diminished or in jeopardy; in other instances OPHS provides the leadership and "glue" that makes the difference in collective efforts. The complexity of human behavior change, for which the science is still evolving, is a fundamental challenge to the ultimate goal of healthier lives for all Americans.

HIV/AIDS, Sexually Transmitted Diseases and Tuberculosis

CDC

FY 2004 Budget Request $1,281 million

Program Background and Context

CDC has been involved in the fight against HIV/AIDS from the earliest days of the epidemic, and remains a domestic and global leader in HIV/AIDS prevention and control. Through June 2001, over 793,000 Americans were reported with AIDS and 58 percent had died. An estimated 850,000 to 950,000 persons are living with HIV infection in the U.S., and as many as 40,000 new cases develop every year. CDC's approach includes surveillance, early detection, intervention, and prevention.

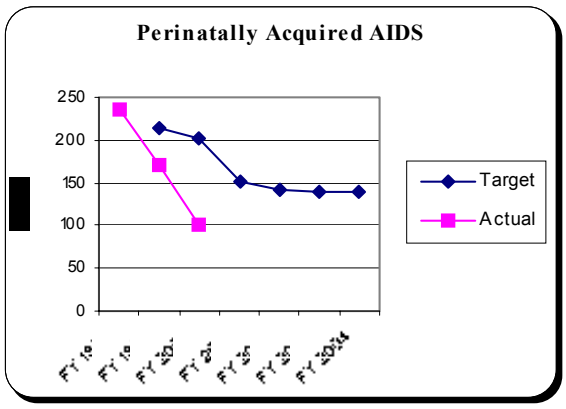
The U.S. continues to record the highest rates of sexually transmitted diseases (STDs) in the industrialized world. CDC assists health departments, health-care providers, and non-governmental organizations by developing, translating, and disseminating science-based information; developing national goals and policies, and other programs that meet the needs of communities. The cost benefit of STD prevention is conservatively estimated to save $10 in direct health care costs for every $1 spent on prevention.

Tuberculosis (TB) was once the leading cause of death in the U.S. Public Health Service Act Section 317E charges CDC with the responsibility of administering a program to prevent, control and eliminate TB. All 50 States and the District of Columbia continue to report TB cases every year, and each new case has the potential to spread if not promptly diagnosed and treated.

Program Performance Planning

CDC has several performance measures for HIV/AIDS, STDs, and TB. Together, these support *Healthy People 2010* goals to prevent HIV infection and related illness and death (Goal 13), prevent sexually transmitted diseases (Goal 25), and prevent infectious diseases (Goal 14). The following measures illustrate key activities in each area:

★ ***Decrease the number of perinatally acquired AIDS cases from the 1998 baseline of 235 cases.***



★ ***Reduce the incidence of gonorrhea in women ages 15-44.***

★ ***Reduce the number of HIV infections diagnosed among people younger than 25 years old.***

★ ***Increase the percentage of TB patients who complete a course of***

curative TB treatment within 12 months of initiation of treatment.

Means and Strategies

The CDC budget for HIV/AIDS, STDs, and TB is $1,281 million, $46 million more than the FY 2003 appropriation. CDC's strategies for dealing with these diseases includes surveillance, education, prevention, and treatment. The performance measures, detailed below, demonstrate CDC's commitment to the strategies:

- Declining rates of perinatally acquired AIDS cases (102 in FY 2000) have been associated with increasing zidovudine use in pregnant women who were aware of their HIV status. CDC has been successful in meeting and exceeding its targets, but must continue to stress treatment and other opportunities to prevent transmission to continue to meet the target of no more than 139 cases in FY 2004.
- ***Reduce the number of HIV infections diagnosed among people younger than 25 years old.***
- The U.S. experienced a 73.9 percent decline in the reported rate of gonorrhea from 1975 to 1997. The rate reflected a one-time increase in 1998, but has since held steady. CDC's goal is to reduce the incidence to 250 cases per 100,000 women.
- The most effective way to reduce the spread of TB is to complete treatment. For this reason, promptly completing a course of treatment is a high priority. CDC aims to achieve a 88 percent completion rate by FY 2004 by designing improved training aids for health departments, and employing outreach workers from language, cultural and ethnic groups that have high TB incidence.

External Factors

Potent new antiretroviral therapies are delaying or preventing the development of AIDS in many HIV-affected persons. But there is no vaccine or cure. And surveillance reveals that HIV/AIDS epidemic are emerging in India, China, the Ukraine, and other parts of the world.

While common bacterial STDs can be controlled and cured, there are no vaccines for bacterial STDs. Only hepatitis B, which is caused by a virus, can be prevented through vaccination. This complicates efforts to reduce these diseases.

An increasing proportion of TB cases in the U.S. are among persons born outside the Country. Foreign-born individuals now account for nearly half of all U.S. TB cases. Also, if a person with TB does not complete a full course of treatment they may develop and spread a drug-resistant strain of the disease. One case of a multi-drug resistant case of TB can cost as much as $1 million to treat.

Childhood Immunization Program

CDC

FY 2004 Budget Request: $621 million

Program Background and Context

CDC protects the health of children from disability and death associated with vaccine-preventable diseases by developing and implementing immunization programs and monitoring vaccine use. Vaccines are responsible for controlling many infectious diseases, including diphtheria, measles, mumps, and pertussis.

Vaccine interventions have reduced cases of all vaccine-preventable diseases by more than 97 percent from peak levels before vaccines were available, making them among the greatest public health achievements of the Twentieth Century. Vaccines are also cost-effective. CDC estimates that every dollar spent on Diptheria-Tetanus-acellular Pertussis vaccine saves $27 that would be spent treating otherwise preventable disease.

Program Performance Planning

CDC has12 performance measures that cover all aspects of its immunization program. The measures support *Healthy People 2010* Goal 14, to prevent disease, disability and death from infectious diseases, including vaccine-preventable diseases. The following measures illustrate key programmatic mission and activities:

★ ***Reduce to or maintain at 0 the number of indigenous cases of measles in children under 5 by 2010.***

★ ***Achieve or maintain immunization coverage of at least 90 percent in children 19- to 35-months of age in at least 7 vaccines.***

Means and Strategies

The following means and strategies illustrate how the program continually strives towards achieving performance measures.

➢ **Resources**: The budget request for FY 2004 is $621 million, an increase of approximately $7 million over the FY 2003 appropriation. There is also $802 million anticipated for the mandatory program, Vaccines for Children.

➢ The effort continues to reduce to zero the number of indigenous cases of vaccine-preventable diseases. Provisional data from FY 2001 reveals that indigenous cases of polio are 0; rubella 19; measles 61; influenza 183; diphtheria two; congenital rubella two; and tetanus 27.

➢ Similarly, CDC has sustained their goal of immunization coverage of at least 90 percent of children ages 19 to35 months.

External Factors

While the U.S. currently has record, or near record, low cases of vaccine-preventable diseases, the viruses and bacteria that cause them still exist. Even diseases that have been eliminated in this country, such as polio, can be introduced by travelers and immigrants. If we stopped immunization, vaccine-preventable diseases would increase to pre-vaccine levels. Before polio vaccine was available, 13,000 to 20,000 cases of paralytic polio were reported each year in the United States.

Substance Abuse Prevention and Treatment Block Grant Program

Substance Abuse and Mental Health Services Administration

FY 2004 Budget Request: $1,785 million

Program Background and Context

The Substance Abuse Prevention and Treatment State Block Grant (SAPTBG) supports State's capacities to respond to the treatment needs of citizens who are at greatest risk of abusing alcohol and illegal drugs. The Block Grant accounts for approximately 40 percent of all public funds expended by the States for substance abuse treatment and prevention (NASADAD, unpublished data). Twenty-two States reported that greater than 50 percent of their total funding for substance abuse prevention and treatment programs came from the Federal block grant. The SAPTBG program provides funding to 60 States and territories (including one Tribal Government) to provide treatment and prevention services for persons abusing alcohol and other drugs or considered to be at risk. The program was established in 1981 as a consolidation of earlier categorical programs in community mental health and substance abuse services

This program also represents a major portion of SAMHSA's contribution to closing the treatment gap, which is a national treatment plan goal shared among SAMHSA, the Office of National Drug Control Policy, and many partners.

Program Performance Planning

SAMHSA has seven performance measures that demonstrate their commitment to closing the treatment gap. Additional measures for State partners are being developed. Currently a Federal Register Notice (FRN) on Performance Partnership Grant developmental measures has been approved by HHS and ONDCP. Comments in response to the FRN will be used in further developing outcome measures with State partners. The SAPTBG supports the Healthy People 2010 goal of reducing substance abuse to protect the health, safety and quality of life for all, especially children. The following measure focuses on empirically based improvements to the quality of treatment systems, programs or practices produced by technical assistance events which are an important component of the block grant program goal.

★ ***SAMHSA will expect that 95 percent of technical assistance events will result in systems, program or practice change.***

Means and Strategies

The performance measure, detailed below, demonstrate SAMHSA's commitment to the strategies:

➢ Additional block grant outcome measures are currently being developed with HHS, ONDCP, OMB and State participation.

➢ The State System Technical Assistance Project (SSTAP) tracking report was

implemented to monitor the status of State's technical assistance activities. This year's survey of the States revealed significant and improved system changes as a result of technical assistance provided. The FY 2001 target for this measure was met at 96 percent, exceeding the FY 2001 expected target of 85 percent. Specifically, there was an 11 percent increase in States satisfaction with how CSAT's technical assistance has led to some improvements in the system over the past 12 months. Ninety-one percent of the States reported CSATs' technical assistance has led to noticeable outcome results, either directly or indirectly linked to the technical assistance. This is a 6 percent increase from FY 2000 survey results (85 percent). In FY 2004, SAMHSA will maintain at 95 percent the technical assistance events that result in systems, program or practice change.

- **Resources:** The SAMHSA budget request for the SAPTBG is $1,785 million.

External Factors

SAMHSA's established networks with its grantees and external partners contribute significantly to the effectiveness of the Agency. Partners and stakeholders include participation from multiple sectors including:

- State and local governments;
- Non-profit treatment providers such as community mental health clinics, substance abuse clinics and other community organizations;
- A wide range of grantees such as hospitals, universities, community agencies and research institutes;
- Foundations such as the Robert Wood Johnson Foundation, the Casey Family Foundation and the Kaiser Family Foundation.
- Consumers/clients of substance abuse services and their families.

Partners such as Department of Justice focus on reducing the available supply of illegal drugs. Both a reduction in supply and demand are needed to reduce the treatment gap. In addition, other Federal partners such as Department of Education, National Institutes of Health, and the Office of National Drug Control Policy are working together to increase treatment capacities.

Public Health Information Network

Centers for Disease Control and Prevention

FY 2004 Budget Request: $10 million

Program Background and Context

Public health infrastructure is composed of an array of local, State, and Federal organizations that are further divided into functionally organized units around clinical, health department, laboratory, disease program, and other operational divisions. The complex responsibilities and interactions between these public health partners require significant coordination of information technology and information sharing methodologies to meet general public health as well as emergency preparedness and response needs.

Information technology offers great opportunities for advancing public health. Because public health is being tested by new preparedness and response needs, it is time to advance a unified information technology framework to address these needs. The Public Health Information Network (PHIN) is an initiative that will initially be composed of several current projects, bringing them together in a standards-based framework that will enhance their interoperability. PHIN will support specific information technology functions that cross program boundaries and provide integrated services for an efficient public health information technology infrastructure. The functions of the PHIN will be:

- ➢ Detection and monitoring : support of disease and threat surveillance, national health status indicators
- ➢ Analysis: facilitating real-time evaluation of live data feeds, turning data into information for people at all levels of public health
- ➢ Information resources and knowledge management: reference information, distance learning, decision support
- ➢ Alerting and communications: transmission of emergency alerts, routine professional discussions, collaborative activities
- ➢ Response: management support of recommendations, prophylaxis, vaccination, etc.

Program Performance Planning

The Public Health Information Network supports *Healthy People 2010* Goal 23, to ensure that health agencies have the infrastructure to provide essential public health services effectively. For FY 2004, PHIN has committed to several process-oriented measures. Outputs and outcomes will depend on the partnerships that can be developed with constituent programs and the speed with which partners can implement PHIN standards in the coming year. The measures below illustrate key programmatic objectives for PHIN:

- ★ Build IT capabilities and capacity through all levels of public health (local, state, and federal) to serve the variety of public health programs and functions.
- ★ Ensure public health IT works as a coherent network and has the ability to connect to other groups (i.e., clinical care, law enforcement).

★ Evaluate network functionality and ensure interoperability, security, and reliability.

Means and Strategies

CDC is using several means and strategies to achieve its goal.

➢ **Resources:** The FY 2004 budget request is $10 million, which represents a new budget request for this initiative. These funds are requested in addition to the ongoing funding of systems that will be integrated into this network. Means and strategies will be defined to help the PHIN continually strive towards achieving the performance measures.

➢ At full implementation, PHIN will be a live, secure, Internet-based network for exchanging comparable critical health information between all levels of public health (local, State and Federal) and other critical information systems (clinical care, laboratories, first responders, etc.). The PHIN will connect the diverse groups participating in public health using standards-based collaboration, communications and alerting capabilities. Improved data analysis and visualization including automated algorithms for event detection will aid in more timely public health decision-making.

STRATEGIC GOAL 2

Enhance the Ability of the Nation's Public Health and Health Care Systems to Effectively Respond to Bioterrorism and Other Public Health Challenges.

Total Requested Discretionary Funds for This Goal in FY 2004:
$3.160 billion

HHS has developed a number of initiatives and programs and devoted numerous resources, increasing bioterrorism spending by more than thirteen-fold between 2001 and 2003, to protect Americans from bioterrorist attacks and other public health care challenges. The events of September 11, 2001, and subsequent anthrax attacks have reinforced HHS's role in protecting people in America from attacks on our food and health by enhancing emergency preparedness.

The Office of the Assistant Secretary for Public Health Emergency Preparedness (ASPHEP) was established to direct the Department's efforts in preparing for, protecting against, responding to, and recovering from all acts of bioterrorism and other public health emergencies that affect the civilian population. ASPHEP serves as the focal point within HHS for these activities, directing and coordinating the development and implementation of a comprehensive HHS strategy.

CDC has an integral role in strengthening State and local public health infrastructure to effectively respond to emergencies. HRSA works to prepare hospitals and other medical facilities for the health consequences of bioterrorism and other mass casualty events. NIH conducts and funds a research program to gain the new knowledge needed to develop new or improved diagnostics, drugs and vaccines against the major biological agents most likely to be used by terrorists. FDA works to provide responsive regulatory review of new biodefense medical countermeasures and plays a major role by inspecting high risk domestic food manufacturers and enhancing food import inspections to protect our Nation's food supply and prevent food borne illness.

These measures are representative of the programs being described and serve as examples of how HHS continues to track their progress towards building the necessary infrastructure to respond to bioterrorist and other public health challenges.

HHS Strategic Goal	Agencies/ Programs	FY 2004 Performance Measures
GOAL 2: Enhance the Ability of the Nation's Public Health and Health Care Systems to Effectively Respond to Bioterrorism and Other Public Health Challenges.	Public Health Emergency Preparedness (ASPHEP)	ASPHEP is in the process of developing performance measures. Key activities include: - Improving HHS response assets to support municipalities and states as needed. - Coordinating the development and procurement of safer and more effective vaccines against smallpox and anthrax. - Oversee the reinforcement and augmenting border coverage of all imported products.*
	State and Local Cooperative Agreement (CDC & HRSA)	- Enhance preparedness by assuring that 100 percent of State, territorial, and local projects have written plans to respond to biological, chemical, and mass trauma hazards relating to terrorism. (CDC).* - 100 percent of States have developed plans to address surge capacity. (HRSA).*
	Food Safety (FDA)	- Achieve adoption of the Food Code by at least one state agency in 42 States in the USA [FY 01: 28 states adopted food code (target 25 states)]. - Inspect 95 percent of the estimated 7000 high risk domestic food establishments once every year [FY 01: inspected 80% of 6800 food est. (target 90%)]. - Perform 48,000 physical exams and conduct sample analyses on products with suspect histories (FY 01 Baseline data: 12,169 physical exams). - Expand Federal/State/local involvement in FDA's eLEXNET system by having 79 laboratories participate in the system.*
	Biodefense Medical Counter-Measures Authority (ASPHEP)	ASPHEP is in the process of developing performance measures for the use of this new authority. One of the first priorities is to develop an ongoing threat analysis for biological threat agents and prioritization of these threats. The analysis will include: - An assessment of the potential public health consequences ensuing from terrorist use of these threat agents. - Regular updates from DHS regarding new specific threat information that might require special action with respect to the development of medical countermeasures. - HHS also will assess the scientific feasibility to produce safe and effective medical countermeasures.

** See agency performance plan/report for additional information.*

Public Health Emergency Preparedness Programs

Office of the Assistant Secretary for Public Health Emergency Preparedness

FY 2004 Budget Request: $41.8 million

Program Background and Context

HHS is the lead agency within the Federal government responsible for coordinating the support of 12 Federal agencies in the preparedness for, response to, and recovery from the medical consequences of natural and man-made disasters, including acts of terrorism. The Office of the Assistant Secretary for Public Health Emergency Preparedness (ASPHEP) within the Office of the HHS Secretary was established by the Secretary to integrate HHS's emergency public health preparedness and response programs into a more efficient "One Department" activity. ASPHEP coordinates medical and health related assistance in national emergencies and deploys medical personnel, equipment, and medical products and supplies to assist victims of a major disaster, emergency or terrorist attack.

Program Performance Planning

ASPHEP is in the process of developing performance measures. They direct and coordinate the Department's efforts in the following areas:

- ★ ***Enhancing state and local preparedness.***
- ★ ***Improving HHS response assets to support municipalities and states as needed.***
- ★ ***Coordinating the development and procurement of safer and more effective vaccines against smallpox and anthrax.***
- ★ ***Oversee the reinforcement and augmenting border coverage of all imported products.***

Means and Strategies

Priorities for HHS counter terrorism efforts are the result of the confluence of the priorities articulated by the President in his budget requests and the priorities specified by the Congress in the regular and supplemental appropriations for FY 2002. ASPHEP's budget request for FY 2004 is $41.8 million in the Public Health and Social Services Emergency Fund. HHS is directing its investments toward immediately enhanced preparedness for bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. ASPHEP's primary emphasis areas are as follows:

- ➢ ***State and Local Preparedness:*** With respect to State and local preparedness, ASPHEP will focus on improving the capabilities of state health departments, local health departments, hospitals, and other health care entities to respond to terrorist-related events, including the ability to communicate at all levels among responders and the public during a public health emergency. Capabilities of State and local health departments

will be enhanced with respect to surveillance and epidemiology, laboratories, information technology, public information, and education and training. Hospitals are now developing coordinated preparedness plans to address an expected surge in the number of patients. Local governments must contemplate using non-traditional venues for patient care – e.g., schools, convention centers, sports arenas, and hotels – for distributing antibiotics or accommodating the large numbers of casualties that could result from the intentional release of a biological agent.

➢ ***National Level Preparedness:*** With respect to national-level preparedness, ASPHEP will also focus on improving the infectious disease surveillance and broader emergency response capabilities of the CDC, augmenting the size and scope of materials within the Strategic National Stockpile, and ensuring rapid deployment of these materials as needed. High priority is being accorded to the development of new and improved vaccines for smallpox and anthrax as well as an expanded research program in the genomics of microorganisms likely to be used in terrorism events.

External Factors

The unpredictable nature and extent of natural or man-made disasters is one external factor. Deficiencies in the public health infrastructure, especially in the area of infectious diseases, are substantial and long-standing; and the correction of these deficiencies will require sustained investment over many years. Moreover, the development and commercialization of new diagnostics, drugs, and vaccines are sorely needed but are difficult scientific and technical endeavors that require substantial time and effort.

State and Local Cooperative Agreement

CDC and HRSA

FY 2004 Budget Request: $1,635 million

Program Background and Context

A future terrorist threat to the U.S. may involve biological, chemical, or radiological weapons. Local emergency medical, fire, police, and public health agencies stand on the front lines of any response. How well the U.S. responds, therefore, depends on that local preparedness and the readiness of State and Federal government to augment local efforts.

CDC is key to that Federal augmentation. CDC is responsible for leading national efforts to detect, respond to, and prevent illness and injury that results from the deliberate release of biological agents. Additionally, CDC plays a key role in dealing with health-related issues arising from the release of chemical or radiological agents, as well as mass trauma that could result from the use of weapons of mass destruction.

HRSA also makes a significant contribution to readiness. One effort, the Hospital Preparedness Program, seeks to upgrade the preparedness of States' health care systems to respond to bioterrorist or other mass casualty events.

Program Performance Planning

CDC has performance targets for training and exercises that address preparedness in the face of terrorist events. HRSA has a performance target for upgrading the preparedness of States' health care systems to respond to a bioterrorist or other mass casualty event. They are summarized below:

★ ***Enhance preparedness by assuring that 100 percent of State, territorial, and local projects have written plans to respond to biological, chemical, and mass trauma hazards relating to terrorism. (CDC).***

★ ***100 percent of States have developed plans to address surge capacity. (HRSA).***

Means and Strategies

HHS funding for State and Local Preparedness is $1.5 billion – CDC's budget request for this program in FY 2004 is $940 million; HRSA's budget request for the Hospital Preparedness Program is $518 million. The following means and strategies illustrate how the program will strive towards achieving performance measures:

➢ ***CDC:*** Preparing for a terrorist event continues to be a priority for the U.S. public health community. All facets of the public health system require extensive training in order to effectively respond to such a potential event. CDC provides funding to 50 States, four localities, and eight

territories to enhance bioterrorism preparedness. To ensure that the public health system is prepared for all terrorism hazards, CDC will work with projects to expand preparedness plans for responding to biological, chemical, radiological and mass trauma hazards relating to terrorism. One-hundred percent of States will develop complete all-hazards plans in FY 2004.

- ***HRSA:*** The Hospital Preparedness Program provides funding to States to improve the capacity of the Nation's hospitals to respond to events involving large-scale casualties. In the wake of September 11, 2001, it became clear that there was a need for training in handling casualties of weapons of mass destruction. FY 2004 funding will support the implementation of needs assessments and plans in order to improve the health care system's capability to deal with terrorist and non-terrorist events.

External Factors

The exact nature and extent of injury from a future terrorist event is difficult to quantify. The number of potential targets in the U.S., combined with the wide array of possible chemical, biological, radiological, and explosive weapons that might be available to terrorists creates a nearly infinite range of possibilities.

Food Safety

Food and Drug Administration

FY 2004 Budget Request: $510 million

Program Background and Context

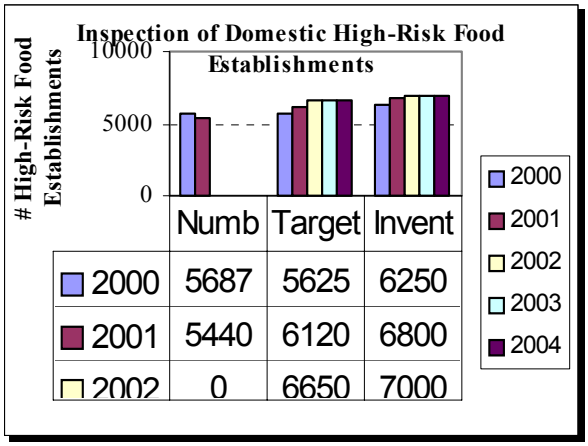
FDA, in close collaboration with other agencies like CDC, U.S. Department of Agriculture, and Environmental Protection Agency, has been working to reduce the incidence of food-borne illness through regulatory action, high risk food inspection activities as well as monitoring and reducing the amount of pesticides in foods. The events of September 11, 2001, reinforced FDA's role in protecting our Nation's food supply by focusing efforts on foods under their statutory authority, which includes all foods apart from meat and frozen and dried eggs, which are regulated by the USDA. FDA has begun the process of hiring and training 655 new investigators, analysts, and other support personnel, as authorized by the FY 2002 Counter Terrorism Supplemental Appropriation. These personnel improve the Agency's capacity to respond to terrorist threats and attacks and augment domestic food safety and security. Many of these employees are investigators and analysts who closely monitor the highest risk imports entering the country, and have enabled FDA to increase border presence by doing more field exams, sample collection and analysis, domestic inspections and laboratory analysis. FDA is projecting a 100 percent increase in physical exams in FY 2002 and 2003 with sustained efforts in FY 2004.

Program Performance Planning

FDA has seven measures geared towards the post-market surveillance and inspections of marketed or imported foods. The following four measures illustrate key activities in effectively responding to and preventing public health emergencies:

★ ***Achieve adoption of the Food Code by at least one state agency in 42 States in the USA.***

★ ***Inspect 95 percent of the estimated 7000 high risk domestic food establishments once every year.***



★ ***Perform 48,000 physical exams and conduct sample analyses on products with suspect histories.***

★ ***Expand Federal/State/local involvement in FDA's eLEXNET system by having 79 laboratories participate in the system.***

Means and Strategies

The following means and strategies illustrate how FDA continues to respond and prevent food-related public health emergencies:

- **Food Code:** In order to reduce the incidence of food-borne illness, FDA continues to encourage States to voluntarily adopt the Food Code, a reference document for regulatory agencies responsible for overseeing food safety in retail outlets, such as restaurants and grocery stores, and institutions. The Food Code results in uniform national standards on food safety, sanitation, and fair dealing that may be uniformly adopted by the retail food industry. It also provides public health and regulatory agencies with practical advice and enforceable provisions in order to mitigate risk factors known to contribute to food-borne illness**.** In FY 2004, FDA will build on their past efforts to increase the number of participating States from 28 in FY 2001 to 42 States in FY 2004.
- **High-Risk Food Inspections:** FDA, in their efforts to prevent food-borne illness, targets high-risk food establishments. They define high-risk as those establishments which produce food with the greatest risk of microbial contamination, including seafood, cheese, fresh vegetables, infant formula, medical foods, among others. In FY 2002, this list was expanded to include food that contains common allergenic substances like nuts and supplements that may be connected to ingredients from countries that have experienced Bovine Spongiform Encephalopathy (BSE). FDA aims to inspect 95 percent of these establishments in FY 2004.
- **Food Import Exams:** The exponential increase in the number of imported food entries combined with the security concerns raised by terrorism has increased the need to protect the food supply by physically examining imported food products. By FY 2004, FDA will have in place a new version of the import field exam, which will include verification that the imported product is the same as which was declared; assessment of security concerns related to labeling and source country; and traditional safety concerns. Some specific strategies include "Warehouse blitz" where inspectors conduct a short-term, intense surveillance of a product at all or selected ports of entry. FDA will also implement a program with Canada and Mexico to enhance advanced identification of transshipped cargo.
- **Laboratory Preparedness:** FDA is actively working to coordinate multiple agencies' efforts in protecting the Nation's food supply. They are building on FY 2001 efforts to develop an electronic Laboratory Exchange Network (eLEXNET), which is a seamless, integrated and secure network enabling the multiple agencies engaged in food safety activities (Federal, State, and local health laboratories on a voluntary basis) to compare, coordinate, and communicate laboratory findings from food samples. This system is a key component of the total food laboratory response network and is

patterned after CDC's laboratory response network. In FY 2004, FDA plans to expand the system with a total of 79 laboratories participating in the network – an increase of 25 laboratories over the FY 2003 target.

Biodefense Medical Countermeasures Authority

ASPHEP

FY 2004 Budget Estimate: $1.3 billion provided in an indefinite appropriation.

Program Background and Context

Some of the most effective defenses against bioterrorism or other public health emergencies are vaccines, antitoxins, and other therapeutics. The application of vaccines in anticipation of a disease threat or therapeutics to treat emerging disease outbreaks reduces the potential for epidemics and the health consequences and mortally that accompany them. HHS has taken the role of the lead Federal agency responsible for carrying out the President's smallpox vaccination policy in order to pre-empt any threat from the virus due to bioterrorism.

To combat future disease threats, natural or manmade, the President's Budget includes a proposal for a BioDefense Medical Countermeasure Authority that will enable HHS, in collaboration with the Department of Homeland Security (DHS), to continue to develop and produce safe and effective pharmaceuticals that can be used to counteract biological agents that pose a threat to the health, safety and security of the Nation. A key component of this authority is a new, permanent, indefinite appropriation that would be used to finance medical countermeasures for which sufficient research has been completed to conclude that the product will ultimately be licensable for that purpose. Within HHS, ASPHEP is responsible for coordinating the Department's involvement with the BioDefense Medical Countermeasure Authority.

Program Performance Planning

ASPHEP is in the process of developing performance measures for the use of this new authority. One of the first priorities for HHS, in collaboration with DHS and consultation with OHS, OSTP and OMB will be to develop and maintain an ongoing threat analysis for biological threat agents and prioritization of these threats. The analysis will include:

- ★ ***An assessment of the potential public health consequences ensuing from terrorist use of these threat agents.***

- ★ ***Regular updates from DHS regarding new specific threat information that might require the special action with respect to the development of medical countermeasures.***

HHS also will assess the scientific feasibility to produce safe and effective medical countermeasures.

Means and Strategies

Whenever a threat analysis and an assessment of scientific/industrial feasibility indicate a confluence of need and opportunity to produce a new biodefense medical countermeasure, the Secretaries of HHS and DHS would recommend to the President the use of funds under this authority. In their recommendations to the President, the Secretaries would certify that this use of the authority is for the purchase and stockpile of a biodefense medical countermeasure for which:

- ★ ***There is currently not a significant commercial market other than homeland security;***

- ★ ***The countermeasure is well characterized and has been scientifically determined to be licensable on the basis of proof of principle established by animal studies, clinical experience, or clinical trials;***

- ★ ***Industrial production of the countermeasure has been judged feasible.***

The first three products expected to meet this criteria are a next-generation smallpox vaccine that can be used for immunization of vulnerable populations, an anthrax vaccine that requires fewer doses than the currently marketed vaccine, and botulism antitoxin. The fund also will finance for preparedness against pandemic influenza. The medical countermeasures financed by the fund would be intended for civilian use only.

External Factors

By its nature, terrorism, including bioterrorism, is unpredictable. New countermeasures could prove ineffective against genetically altered threat agents. Also, new viral strains can be expected to evolve over time and pose unanticipated health consequences.

STRATEGIC GOAL 3

Increase the Percentage of the Nation's Children and Adults Who Have Access to Regular Health Care and Expand Consumer Choices.

Total Requested Discretionary Funds for This Goal in FY 2004:
$9.481 billion

The threat of bioterrorism is not the only threat facing our Nation. Disparities in health care within the U.S. population are of great concern to HHS. We are working to expand health care to all. Therefore, HHS seeks to create new, affordable health insurance options and expand the health care safety net. The FY 2004 budget request continues to expand access to critical health care services for the uninsured, especially in underserved rural and urban areas.

Additionally, we aim to strengthen and improve Medicare as well as help to train an adequate supply of nurses. The FY 2004 budget includes an increased emphasis on expanding baccalaureate training for nurses and an expansion of the nursing loan repayment and scholarship programs. We also plan to expand access to health care services for populations with special needs. Over 530,000 low income and uninsured individuals depend on the Ryan White Care Act program for medical care and other essential support services.

Additional funds, which will be used primarily for increasing operating costs of the health care system, adding staff at three newly constructed health care facilities, and purchasing additional medical care from the private sector (e.g., 500,000 outpatient visits) are needed to maintain and improve access to health care for 1.6 million American Indians and Alaska Natives. These programs have annual performance measures which speak to increasing access to regular health care and the expansion of consumer choices. These measures also represent how HHS continues to track its progress towards this strategic goal.

HHS Strategic Goal	Agencies/ Programs	FY 2004 Performance Measures
GOAL 3: Improve the Quality of Health Care Services	CMS Medicare	-Improve satisfaction of Medicare beneficiaries with the health care services they receive.* -Increase annual influenza (flu) and lifetime pneumococcal vaccinations [FY 01: 67.4% (flu), FY 01: 63.3% (pneumococcal]. -Increase biennial mammography rates [FY 01: 51.6% (target 51%)]. -Improve the beneficiary understanding of basic features of the Medicare program (Developmental).*
	CMS Grants to States for Medicaid/ Medicaid Agencies	-Increase the percentage of Medicaid two-year old children who are fully immunized (Developmental).*
	CMS State Children's Health Insurance Program	-Decrease the number of uninsured children by working with States to implement SCHIP and by enrolling children in Medicaid [FY 02: 1,200,000].
	IHS Indian Health Services	-Increase the proportion of I/T/U clients (by 2% over FY 03 level) with diagnosed diabetes that have improved glycemic control [FY 01: 30% of I/T/U diabetics have improved glycemic control - a four percent increase over FY 00]. -Maintain the proportion of eligible women who have had a Pap Smear within the previous three years at the FY 2003 level [FY 01: 21% of women received pap screening within one year, 42% within in three years - increase over FY 00 levels, 12% within one year, 18% within three years]. -Maintain 100 percent accreditation of all IHS hospitals and outpatient clinics [FY 01: 100%, FY 00: 100%].
	IHS Sanitation Facilities Construction	-During FY 2004, provide sanitation facilities projects to 18,150 Indian Homes with water, sewage disposal, and/or solid waste facilities [FY 01: provided facilities to 3,551 new/like new homes, 14,451 existing homes, total of 18,002 homes (target total 14,730 homes)].
	HRSA Rural Health	-Flexibility Grants: By 2004, 675 appropriate rural facilities will be assisted in converting to Critical Access Hospital (CAH) status [By FY 2002, 657 hospitals have been assisted (target 240)].
	HRSA Community Health Centers	-Increase to 13.75 million the number of uninsured and underserved persons served by Health Centers [In FY 2001, 10.3 million people were served (target 10.5 million)].* -Decrease to 6.77 percent the percent of Health Center prenatal patients with births <2,500 grams [FY 2001 7.13%].*

HHS Strategic Goal	Agencies/ Programs	FY 2004 Performance Measures
	HRSA Nursing Workforce Development	-Increase to 900 the number of new nursing loan repayment contracts awarded [In FY 2001 there were 443 new contracts (target 200)]. -Increase to 22% the proportion of NELRP supported nurses serving in critical shortage facilities who extend their contract for a third year [baseline 21%].*
	HRSA Maternal and Child Health Block Grant	-Decrease the infant mortality rate to 6.8/1000 [Healthy People 2010- In FY 1999 the infant mortality rate was 7.1/1000].* -Reduce illness and complication due to pregnancy to 26 per 100 deliveries [In 1998 there were 31.2/100 illnesses/complications due to pregnancy.].* -Increase to 96 percent the percent of newborns with at least one screening for each of PKU, hypothyroidism, galactosemia, and hemoglobinopathies [Healthy People 2010 - in FY 1999 the rate was 94%.].* - Increase maternal survival to 8 maternal deaths per 100,000 live births.
	HRSA Ryan White AIDS Program	-Part A - Serve a proportion of women and racial/ethnic minorities in Title I-funded programs that exceeds their representation in national AIDS prevalence data, as reported by the CDC, by a minimum of five percentage points [In FY 2000, 70.4% of Part A recipients were racial/ethnic minorities; compared to 57.3 AIDs prevalence.]. -For Part B, increase by 4% the number of ADAP clients receiving HIV/AIDS medications through State ADAPs during at least one month of the year [FY 2001 73,784 clients received medications (target 72,000)]. -Increase by 2% annually the number of persons who learn their serostatus from Ryan White Care Act programs. New performance measure.* - Reduce deaths due to HIV infection below 3.6 per 100,000 people by 2010.
	HRSA National Health Service Corps Program	-Increase to 79 percent the percent of NHSC clinicians retained in service to the underserved [In FY 2001, 80% of NHSC clinicians remained in service beyond the period of service commitment (target 75%).].

**See agency performance plan/report for additional information.*

Medicare

The Centers for Medicare & Medicaid Services

FY 2004 Estimated Budget: *$282,801 million*

Program Background and Context

The CMS administers Medicare, the Nation's largest health insurance program, which covers more than 41 million Americans. Medicare provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. For over three decades, this program has helped pay medical bills for millions of Americans, providing them with comprehensive health benefits they can count on.

Program Performance Planning

CMS's primary mission is to assure health care security for its beneficiaries. Also, CMS strives to encourage choice in the Medicare beneficiary community for medical coverage while maintaining high-quality care. There are 25 measures associated with this program for FY 2004. The following measures illustrate the key programmatic mission and activities:

- ★ ***Improve satisfaction of Medicare beneficiaries with the health care services they receive.***
- ★ ***Increase annual influenza (flu) and lifetime pneumococcal vaccinations.***
- ★ ***Increase biennial mammography rates.***
- ★ ***Improve the beneficiary understanding of basic features of the Medicare program (Developmental).***

Means and Strategies

The following means and strategies illustrate how the program continually strives towards achieving its performance measures:

- ➢ **Beneficiary Satisfaction:** The CMS's multi-year efforts to improve beneficiary satisfaction with the health care received apply to both managed care and fee-for-service (FFS). For the increases to be statistically significant, there are long-term targets with reporting due at the end of the 5-year period.
- ➢ The CMS's ongoing efforts to improve beneficiary satisfaction include continuing to collect and share Consumer Assessment Health Plans Surveys (CAHPS) information from beneficiaries and making specific presentations to individual Medicare Managed Care plans, to Quality Improvement Organizations (QIOs) at meetings of the American Health Quality Association, and to beneficiaries on the Medicare Health Plan Compare website.
- ➢ **Adult Immunizations:** FY 2001 marked the first reporting year for which a new data source (Medicare Current Beneficiary Survey, MCBS) was used to measure annual flu and lifetime pneumococcal immunization rates. This source also includes institutionalized beneficiaries and more accurately reflects CMS's interventions.
- ➢ The CMS and the CDC are actively addressing the unknown impact of the

2000 and 2001 flu vaccine shortages and delayed delivery on their adult immunization performance measure and are closely monitoring recent trends.

- **Mammography:** The CMS intends to increase the percentage of Medicare women age 65 and over who receive a mammogram every two years.
- Since the National Committee for Quality Assurance (NCQA) revised its technical specifications for the breast cancer screening measure, CMS is currently modifying baseline and future targets, beginning with FY 2003, to attain consistency with the FY 2002 HEDIS® measure and to reflect changes in billing codes for digital mammograms, conversion of film to digital images, and for computer-aided screening.
- **Beneficiary Understanding:** To promote beneficiary and public understanding of CMS and its programs, CMS is developing a goal to improve beneficiary awareness of (1) the core features of Medicare needed to use the program effectively, and (2) CMS sources from which additional information can be obtained if needed.
- The CMS works across the organization to ensure maximum and efficient use of existing infrastructures to carry key Medicare messages and information to beneficiaries including those vulnerable populations who have problems with access to information. The CMS's National *Medicare & You* Education Program (NMEP) is an example of one beneficiary-centered program that strives to provide information to improve awareness of Medicare core features and sources using a variety of information channels (including print materials mailed to all beneficiaries, toll-free telephone service, an Internet site, and direct counseling support through the State Health Insurance & Assistance Program). In addition to the NMEP, other national and local programs strive to raise beneficiary awareness from different perspectives; for example, public nursing home campaigns through the Quality Improvement Organizations.
- **Resources:** Medicare benefit outlays for Fy 2004 are $278,632 million in FY 2004, an increase of approximately $11,000 million from FY 2003.

External Factors

Adult Immunizations: The recent flu vaccine shortages and delayed immunizations have impacted the delivery of immunizations. The inability to quantify the impact of these shortages to date reduces the confidence we have in achieving our targets for the affected years, and for reliably setting future targets. The CMS and the CDC are actively addressing the unknown impact of the 2000 and 2001 flu vaccine shortages and delayed delivery on our adult immunization performance goals and are closely monitoring recent trends.

Mammography: In late 2001 - early 2002, there was a great deal of controversy in the press regarding the effectiveness of mammography. Even though there were subsequent press releases from the Department of Health and Human Services and other governmental agencies affirming the recommendations for regular mammography screening and the need for mammography screening, continued outreach and education may be especially important at this time to ensure that women with Medicare get screening mammograms on a regular basis. The CMS remains committed to its mammography efforts.

Grants to States for Medicaid/Medicaid Agencies

The Centers for Medicare & Medicaid Services

FY 2004 Estimated Budget: *$176,754 million*

Program Background and Context

Medicaid is a means tested health care entitlement program financed by States and the Federal Government. Approximately 43 percent of the funding came from the States and 57 percent from the Federal Government in FY 2001. All 50 States, the District of Columbia, and the five territories (Puerto Rico, Virgin Islands, American Samoa, Northern Mariana Islands, and Guam) have established Medicaid programs within broad Federal guidelines governing eligibility, provider payment levels, and benefit packages.

Program Performance Planning

The Medicaid program is a Federal-State partnership intended to provide health care to vulnerable populations. Three measures have been selected to represent this program for FY 2004.

- ➢ The percentage of Medicaid two-year old children who are fully immunized.
- ➢ Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring and ultimately reducing Medicaid payment error rates.
- ➢ Health care quality across the Medicaid and State Children's Health Insurance Program (SCHIP) assessed through the CMS/State Performance Measurement Partnership Project.

The following measure illustrates one of the key programmatic missions and associated activities of the Medicaid program:

- ★ ***Increase the percentage of Medicaid two-year old children who are fully immunized (Developmental).***

Means and Strategies

The following means and strategies illustrate how the program continually strives towards achieving its performance measure:

- ➢ The CMS, working in conjunction with the States and the District of Columbia, has developed a three-stage process for its Medicaid immunization measure.
- ➢ During the baseline development years, CMS will work closely with the States to assist them in developing a baseline methodology to measure immunization rates of two-year old Medicaid children and technical assistance will be provided through CDC and CMS as determined necessary by States and CMS.
- ➢ The CMS has worked closely with States, the CDC, and the American Public Human Services Association (APHSA) to develop a strategy for this performance goal, and APHSA will continue to act as a liaison between the States and CMS.

➢ **Resources:** The Administration's most recent estimate of Medicaid benefits was in the President's Budget for FY 2004, released in February 2003. Using President's Budget estimates Medicaid benefit outlays are projected to be $176,754 million in FY 2004, an increase of approximately $14,388 million over FY 2003.

External Factors

The original developmental timeline for the goal allotted one year for development and reporting of baseline measures for the States. After working with Group I States for a year, it became evident that more time would be needed by States to fully develop their measurement methodologies. Reasons for the extension include variations in State reporting cycles for immunization data, data problems, and staff and resource limitations.

State Children's Health Insurance Program

The Centers for Medicare & Medicaid Services

FY 2004 Estimated Budget: *$5,090 million*

Program Background and Context

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP). This program makes an unprecedented investment towards improving the quality of life for millions of vulnerable, uninsured, low-income children. The statute authorizes and appropriates an annual amount that CMS grants to States and territories with an approved SCHIP plan. States were given the option to expand their Medicaid program, establish a separate SCHIP program or a combination of both. Currently, all States and territories have approved SCHIP plans. Many States are submitting plan amendments and 1115 waivers to further expand insurance coverage under SCHIP.

Program Performance Planning

The implementation of SCHIP has driven enormous change in the availability of health care coverage for children and in the way government-sponsored health care is delivered. The following measure illustrates the key programmatic mission and activities:

★ ***Decrease the number of uninsured children by working with States to implement SCHIP and by enrolling children in Medicaid.***

Means and Strategies

The following means and strategies illustrate how the program continually strives towards achieving its performance measure:

➢ According to the Statistical Enrollment Data System (SEDS), approximately 4.6 million children participated in SCHIP-funded coverage (either a separate child health program or a Medicaid expansion) in FY 2001, and many more were enrolled in "regular" Title XIX Medicaid through increased outreach efforts and application simplification strategies undertaken as a result of SCHIP.

➢ To assure that both Medicaid and SCHIP fulfill their potential, CMS is working with States, various operating divisions within HHS, other Federal agencies, and the private sector on a broad array of outreach activities.

➢ **Resources:** The statutorily mandated allotment for FY 2004 is $5,090 million, an increase of approximately $400 million over the FY 2003 allotment.

External Factors

Despite many successes of SCHIP, many eligible children and families are not enrolled in SCHIP or Medicaid. Recent

studies reveal that key barriers include: 1) burdensome application or eligibility determination processes; 2) lack of awareness about the programs; 3) assumptions by families that they are not eligible; and 4) the lingering stigma attached to government-sponsored assistance.

IHS Health Services

Indian Health Service

FY 2004 Budget Request: $2,127 million

Program Background and Context

Hospital and Health Clinic funding, including insurance reimbursement (e.g. Medicare, Medicaid), supports inpatient and ambulatory care and support services such as nursing, pharmacy, laboratory, nutrition, medical records provided in facilities run by the Indian Health Service, Tribal, or Urban groups (I/T/U). IHS continues to focus funding on evidence-based treatment and prevention strategies in addressing those health conditions that disproportionately affect American Indian/Alaskan Natives (AI/AN) like diabetes, obesity, heart disease among others. In the face of a growing population and health care inflation, IHS has been successful in achieving many of their performance measures such as managing diabetes by keeping blood sugar under control as well conducting necessary screenings; improving pap smear and mammography rates among eligible women; and maintaining 100 percent accreditation of all IHS run hospitals. In FY 2004, with continued collaboration with CDC and other agencies as well as proposed increases in Special Diabetes Funding, IHS will aim to improve the quality of care for AI/ANs.

Program Performance Planning

This program has 21 performance measures geared towards all facets of the hospitals and clinics funding. The following measures illustrate IHS' commitment to treatment standards, prevention, and overall quality of Indian/Tribal/Urban hospitals and clinics:

- ★ ***During FY 2004, improve the FY 2003 performance level for glycemic control in the proportion of I/T/U clients with diagnosed diabetes.***
- ★ ***During FY 2004, maintain the proportion of eligible women who have had a Pap Smear within the previous three years at the FY 2003 level.***
- ★ ***During FY 2004, maintain 100 percent accreditation of all IHS hospitals and outpatient clinics.***

Means and Strategies

The following means and strategies illustrate how IHS aims to curb rising mortality rates in AI/AN communities and improve the quality of care:

- ➢ **Diabetes Standards of Care:** IHS continues to implement evidence-based standards of care in managing diabetes, which improve diabetic patient outcomes. These standards include improving diagnosed diabetics' blood sugar and blood pressure control through medication and healthy lifestyle changes; assessing diabetics for LDL cholesterol, which impacts heart disease mortality; assessing diabetics for end-stage renal disease; and a new performance initiative for FY 2004, increasing the rate of diabetics who have received a retinal

screening in preventing diabetes-related blindness.

- AI/AN diabetics will also benefit from the $50 million increase requested *Special Diabetes Program for Indians Funding* in FY 2004. In addition to the program's emphasis on primary prevention, a third of these grants specifically focus on managing diabetes complications, which will in some instances supplement local efforts to implement the standards of care and will improve performance on GPRA measures. Additionally, IHS will continue to negotiate better wholesale prices on newer, more effective medications to help improve diabetics' overall health status.
- **Pap Smear Screening:** IHS will encourage all IHS providers to provide screening and necessary follow-up services for eligible women. IHS will also provide additional training for providers to perform colposcopy and work to aggressively track abnormal Pap Smears in order to prevent cervical cancer.
- Pap screening rates will also be part of the Performance Appraisal of each IHS Area Director to encourage local participation.
- The proposed FY 2004 IHS budget will support the capacity to maintain current screening levels in the face of population growth and rising costs of treatment.
- **100 percent Accreditation of IHS Hospitals, Health Clinics:** IHS will continue to build on past success by maintaining 100 percent accreditation from the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and the American Association of Ambulatory Health Centers (AAHC). IHS will continue to rely on Area Offices and Headquarters in providing support and the local I/T/U multidisciplinary team, which provides ongoing quality management for local hospitals and clinics.

External Factors

IHS faces challenges in the recruitment and retention of health care providers, particularly in the most rural areas. Poverty is also a major challenge. IHS serves several of the poorest communities in the country. The relationship between higher levels of morbidity and mortality for both acute and chronic diseases and conditions is well documented worldwide. Additionally, there is a lack of cost-effective interventions for chronic diseases.

Sanitation Facilities Construction
Indian Health Service
FY 2004 Budget Request: $114 million

Program Background and Context

The IHS Sanitation Facilities Construction Program is an integral component of the IHS disease prevention activity and has provided AI/AN potable water and waste disposal facilities since 1960. As a result of such activities, infant mortality rates for gastroenteritis and other environmentally related diseases have decreased by 80 percent since 1973. IHS, in collaboration with Tribes and other agencies, designs and builds water connections and solid waste facilities in those areas that are economically feasible and in need. In FY 2004, IHS will continue to address sanitation and clean water needs. Currently, 92.5 percent of AI/AN homes have safe water in the home compared with 99 percent of all U.S. homes. Navajo and Alaska, in particular, face some of the largest deficiencies with only 83 percent of Navajos and 65 percent of Alaskan Natives having safe water in the home. IHS will work towards long term goals to significantly reduce clean water and sewage deficiencies by 2010 in the face of population growth.

Program Performance Planning

This program has one measure aimed at providing new and upgraded water connections and/or solid waste facilities for AI/AN:

★ ***During FY 2004, provide sanitation facilities projects to 18,150 Indian Homes with water, sewage disposal, and/or solid waste facilities.***

Means and Strategies

The following means and strategies illustrate how the Sanitation Facilities Program aims towards reducing the overall need for clean water and solid waste facilities:

➢ **Assessing Need:** The program utilizes The Sanitation Deficiency System (SDS) and Project Data Systems to track AI/AN homes that lack water or sewage facilities or need an upgrade because of aging infrastructure or more rigorous regulations.

➢ **Leveraging Outside Contributions from EPA, HUD:** IHS, in FY 2004, will continue its partnerships with these agencies in obtaining grants to build more sanitation facilities. IHS will continue to collaborate with State and Tribal agencies in conducting environmental reviews and community planning activities.

➢ IHS will utilize funding in FY 2004 to expand the number of new and upgraded sanitation facilities.

External Factors

The need for sanitation facilities continues to rise due to new environmental laws, population growth, inflation and the continued cost of upgrading deteriorating

facilities to continue to provide safe services. In addition, there is the impact of the economy on new housing starts, which based on end of year 2001 data caused approximately 1000 homes to be constructed that could not be served with IHS funds.

Rural Health

Health Resources and Services Administration

FY 2004 Budget Request: $85.3 million

Program Background and Context

HRSA's Office of Rural Health Policy (ORHP) is the only office in the Department solely concerned with the rural health care needs of the nation. It is active in coordinating rural health care programs and policies within HRSA, with CMS, and with other Federal Departments such as the Department of Agriculture and the Department of Housing and Urban Development. OHRP also provides leadership for the Secretary's Rural Task Force. Programs administered by ORHP include Rural Health Policy Development, Rural Health Outreach Grants, Rural Access to Emergency Devices, Rural Hospital Flexibility Grants, State Offices of Rural Health and the Denali Project.

Program Performance Planning

HRSA's FY 2004 performance plan includes 6 performance measures for the rural health programs. The following measure exemplifies HRSA's commitment to enhanced program performance in rural health :

★ ***Flexibility Grants: By 2004, 675 appropriate rural facilities will be assisted in converting to Critical Access Hospital (CAH) status.***

Means and Strategies

OHRP engages in a wide spectrum of activity, from research and policy development to demonstration grants for new rural service delivery systems. OHRP employs various tools and strategies to enhance program performance:

- The State Offices of Rural Health program strengthens rural health care delivery systems by creating a focal point for rural health in each State and coordinating rural health at local levels; resulting in the creation of a national rural information network.
- The Flex Program has established a tracking project permitting ORHP to provide feedback and "best practice" information to States, as well assessing responsiveness to technical assistance needs.
- In FY 2004, the Rural Network Development Awards will increase to 20.
- **Resources:** The budget request for FY 2004 is $85.3 million, an increase of approximately $5 million over the FY 2003 President's budget. The $5 million increase in the Rural Health Outreach grants program will support the development of a model for the Extended Stay Primary Care Clinic, and expand its current small hospital improvement initiative from the Mississippi Delta to other isolated rural communities. A $10 million increase in the Rural Hospital Flexibility Grants program will support frontier technology and health care models demonstrations through technology and capital

equipment grants to health care providers in rural areas.

External Factors

Factors which can impact program performance are: 1) amount of State/local resources devoted to rural health; 2) financial stability of rural hospitals; 3) numbers of uninsured and underinsured; 4) managed care; 5) impact of biological, chemical or radiological weapons-surge capacity; and 6) health care delivery via telecommunication and Internet access to health information and services.

Community Health Centers

Health Resources and Services Administration

FY 2004 Budget Request: $1,627 million

Program Background and Context

This community based network delivers preventive and primary care services for the neediest, poorest and sickest patients in rural and inner city areas through a Federal, State and community partnership approach.

Program Performance Planning

HRSA's FY 2004 Performance Plan contains 13 performance measures for the Health Centers program. The following measures exemplify the program's commitment to providing quality health care to underserved populations:

★ ***Increase to 13.75 million the number of uninsured and underserved persons served by Health Centers.***

★ ***Decrease to 6.77 percent the percent of Health Center prenatal patients with births <2,500 grams.***

Means and Strategies

The Health Centers program employs numerous strategies to assure underserved populations receive quality health services:

➢ HRSA's health disparities collaboratives address prevention and chronic disease management for underserved populations and has generated outstanding nationally recognized outcomes.

➢ Health Centers are successful in leveraging other funding; only 25 percent of Health Centers' revenues come from the Federal Health Center grant.

➢ Health Centers are enrolling their patients in the SCHIP program.

➢ In FY 2004, 120 new Health Center-access points will be established and 110 existing sites will be expanded.

A. **Resources:** The budget request for FY 2004 is $1,627 million, an increase of approximately $170 million over the FY 2003 President's budget. This increase will enable the program to fund additional access points and expand services at existing sites, thereby serving an additional 1.2 million persons.

External Factors

Numerous factors can impact Health Centers program performance including: 1) the availability of primary care providers willing to serve underserved populations; 2) the economy; 3) declining State revenues; 4) increase in market pressures; and 5) emerging populations.

Nursing Workforce Development

HRSA

FY 2004 Budget Request: $98 million

Program Background and Context

HRSA's Bureau of Health Professions currently administers programs which collectively address Nursing Workforce Development namely; Advanced Education Nursing (Section 811 of the Public Health Service Act), Nursing Workforce Diversity (Section 821 of the Public Health Service Act), Nurse Education, Practice and Retention Grants (Section 831 of the Public Health Service Act), and the Nursing Education Loan Repayment Program (Section 846(h) of the Public Health Service Act). New authorities are part of the Nurse Reinvestment Act which amends and expands existing Title VIII legislation. Collectively these new authorities which include Public Service Announcements, Nurse Scholarships, Nurse Faculty Loans and Comprehensive Geriatric Education address factors which will help alleviate the nursing shortage.

Program Performance Planning

HRSA's current GPRA plan includes specific performance measures for only the Nursing Education Loan Repayment Program (NELRP). Performance for the other nursing programs is aggregated with all other Title VII and Title VIII health professions programs. HRSA is currently examining the feasibility of establishing separate performance measures for the programs associated with Nursing Workforce Development. In the interim, the performance measures for the NELRP will be used as proxies:

- ★ ***Increase to 900 the number of new nursing loan repayment contracts awarded.***
- ★ ***Increase to 22% the proportion of NELRP supported nurses serving in critical shortage facilities who extend their contract for a third year.***

Means and Strategies

The following means and strategies are employed to affect improved program performance:

- ➢ NELRP is employing enhanced marketing strategies which should result in a broader distribution of contract awards to RNs working in eligible health facilities in more States.
- ➢ In FY 2004, HRSA will increase opportunities for individuals from disadvantaged backgrounds to pursue nursing education. The Nursing Workforce Diversity Program will implement the scholarship authority.
- ➢ **Resources:** The budget request for FY 2004 is $98 million. This request reallocates the base funding for Advanced Education Nursing, Nursing Workforce Diversity and Nurse Education, Practice and Training. It will also provide an increase of $12 million for the Nursing Education Loan Repayment Program and

provide funds to implement the new nursing authorities established in the Nurse Reinvestment Act.

External Factors

Factors which will effect program performance are: 1) nursing workforce shortage; 2) aging workforce; 3) aging population; 4) public health requirements for a bioterrorism response (surge capacity); and 5) technology and emerging health care issues.

Maternal and Child Health Block Grant

Health Resources and Services Administration

FY 2004 Budget Request: $751 million

Program Background and Context

The mission of the Maternal and Child Health (MCH) Block Grant program, as authorized under Title V of the Social Security Act, is to improve the health of all mothers, children and their families. Created as a partnership with State Title V programs which have broad State discretion, the MCH Block Grant appropriated formula grant funds are used for a number of activities including; capacity and systems building, public information and education, outreach and program linkage, support for newborn screening, lead poisoning and injury prevention, support services for children with special health care needs, and the promotion of health and safety in child care settings.

Program Performance Planning

The FY 2004 HRSA Performance Plan contains seven performance measures for the MCHBG Program. Measures listed below reflect the broad nature of the program's impact:

- ★ ***Decrease the infant mortality rate to 6.8/1000. {Healthy People 2010}***
- ★ ***Reduce illness and complication due to pregnancy to 26 per 100 deliveries.***
- ★ ***Increase to 96 percent the percent of newborns with at least one screening for each of PKU, hypothyroidism, galactosemia, and hemoglobinopathies. {Healthy People 2010}***
- ★ ***Increase maternal survival to 8 maternal deaths per 100,000 live births.***

Means and Strategies

The Maternal and Child Health Bureau employs various means and strategies to achieve program performance:

- ➢ Special Projects of National Significance (SPRANS) and Community Integrated Service Systems (CISS) activities fund grants or contracts which have produced guidelines for, as examples, child health supervision, nutrition care during pregnancy, and childhood injury prevention.
- ➢ In FY 2003, special Title V funded improvement projects will address such topics as adolescent health, SIDS, medical homes and child care health and safety. SPRANS and CISS complement and help ensure the success of State Title V, Medicaid and SCHIP programs.
- ➢ **Resources:** The budget request for FY 2004 is $751 million, $19 million more than the FY 2003 President's budget request. This request is for Federal funds to the States, SPRANS, and CISS activities.

External Factors

Other factors which may impact program performance are: 1) the economy; 2) declining State revenues; 3) maternal characteristics such as race/ethnicity, age, education, and smoking; 4) the number of uninsured; and 5) advances in technology.

Ryan White AIDS Program

Health Resources and Services Administration

FY 2004 Budget Request: $2,010 million

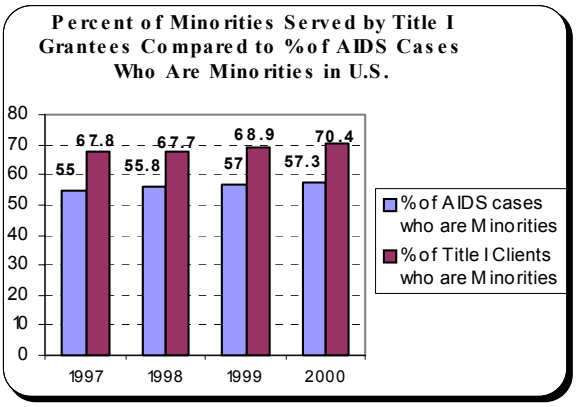
Program Background and Context

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act programs, authorized by Title XXVI of the Public Health Service Act, funds the provision of HIV medical care and related services for low-income and medically underserved persons. There are four major Titles of the Ryan White CARE Act. Title I, the HIV Emergency Relief Grants (Part A), provides funding to eligible metropolitan areas disproportionately impacted by the HIV epidemic for the provision of ambulatory outpatient health and support services. Title II, HIV CARE Act Grants to States (Part B), provides formula grants for the purpose of providing health care and support services for people living with HIV disease. A separate earmark under Part B provides funding for HIV/AIDS therapies through the AIDS Drug Assistance Program (ADAP). Title III funds programs that provide early intervention services. Title IV funds HIV Pediatric Grants. The CARE Act also provides funding for AIDS Education Training and Dental Reimbursement.

Program Performance Planning

The FY 2004 HRSA Performance Plan has 16 FY 2004 performance measures for all the CARE Act programs noted above. The following examples reflect HRSA's commitment to enhanced program performance:

★ ***Part A - Serve a proportion of women and racial/ethnic minorities in Title I-funded programs that exceeds their representation in national AIDS prevalence data, as reported by the CDC, by a minimum of five percentage points.***



★ ***For Part B, increase by 4% the number of ADAP clients receiving HIV/AIDS medications through State ADAPs during at least one month of the year.***

★ ***Increase by 2% annually the number of persons who learn their serostatus from Ryan White Care Act programs.***

★ ***Reduce deaths due to HIV infection below 3.6 per 100,000 people by 2010.***

Means and Strategies

The following tools and strategies are employed toward the achievement of improved program performance:

➢ Ensure resources and services are provided to low-income and medically underserved persons in minority communities.

- ➢ Require coordination between CARE Act grantees in the development of a Statewide Coordinated Statement of Need.
- ➢ By 2001, State ADAPs participating in the Section 340 Drug Discount Program increased to 50 increasing cost recovery savings to a projected $65.5 million.
- ➢ **Resources:** The budget request for FY 2004 is $2,010 million, an increase of approximately $100 million over the FY 2003 President's Budget. This increase is for Part B and is designated for State AIDS Drug Assistance programs.

External Factors

The performance of the Ryan White Care Act programs may be helped or hindered by various factors including: 1) advances in therapeutics; 2) rate of growth of the epidemic; 3) State and local commitments and resources; 4) insurance coverage; and 5) cost of care, support services and anti-retroviral drug therapy.

National Health Service Corps Program

Health Resources and Services Administration

FY 2004 Budget Request: $213 million

Program Background and Context

The National Health Service Corps (NHSC) program assists health professional shortage areas to meet their primary, oral, and mental health service needs. Over its 30 year history, the NHSC has offered recruitment incentives such as scholarships and loan repayment support to more than 22,000 health professionals committed to serving the underserved. For example, NHSC provides a culturally competent workforce for Federally-funded Health Centers and other sites which find it difficult to recruit clinicians. Over 50 percent of the NHSC field strength serve in Health Centers.

Program Performance Planning

The following performance measure demonstrates the program's effectiveness in reaching the underserved:

★ ***Maintain at 80 percent the percent of NHSC clinicians retained in service to the underserved.***

Means and Strategies

➢ The NHSC will employ the following tools to forward their retention goal:

➢ The NHSC Annual Retention Report and the program evaluation conducted in 2000 demonstrate that the rate of retention in service to the underserved is increasing.

➢ To continue careful monitoring of this trend, NHSC plans to measure retention at one year after service obligation ends, and to follow cohorts of clinicians over their working lives to assess retention at longer intervals.

➢ In FY 2004, the NHSC will increase scholarship awards and loan repayments.

➢ **Resources:** The budget request for FY 2004 is $213 million, an increase of approximately $23 million over the FY 2003 President's budget. The increase will support the additional scholarships and loan repayments better enabling NHSC to support the need of grant-supported Health Centers to recruit additional primary care physicians in line with the President's Initiative to increase Health Center access points by 1,200 in five years.

External Factors

Factors impacting program performance are: 1) health care workforce pipeline issues; 2) the ability of communities to attract providers; and 3) the economy.

Strategic Goal 4

Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise.

***Total Requested Discretionary Funds for This Goal in FY 2004:* $28.619 billion**

HHS is committed to strengthening the base of qualified health and behavioral science researchers to advance the understanding of basic biomedical and behavioral science, whereby, NIH, the world's largest and most distinguished organization dedicated to maintaining and improving health through medical science, is leading the efforts to meet these objectives as well as advancing the understanding of basic biomedical and behavioral science.

HHS is also committed to accelerating the private sector development of new drugs, biologic therapies, and medical technology. The FDA's Center for Drug Evaluation and Research (CDER) meets their mission by thoroughly reviewing all new drug applications, generics applications, over-the-counter labeling and assuring the availability of drugs to treat victims of a potential bioterrorism or terrorist attack.

The Medical Devices and Radiological Health Program is responsible for ensuring the safety and effectiveness of medical devices and eliminating unnecessary human exposure to manmade radiation, of which, pre-market review is a major program component. The medical device industry is growing rapidly and devices submitted for review are becoming increasingly complex.

these programs have annual performance measures which speak to enhancing the capacity and productivity of the Nation's Research Enterprise. These programs represent HHS' continued efforts to seek enhancement in Health Science Research.

HHS Strategic Goal	Agencies/ Programs	FY 2004 Performance Measures
GOAL 4: Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise.	NIH	- By 2007, determine the genome sequence of an additional 45 human pathogens and three invertebrate vectors of infectious diseases.* - By 2005, develop a genome-wide haplotype map by identifying the haplotype blocks and the common haplotypes in the human genome.* - By 2005, develop two new animal models for at least one agent of bioterror.* - By 2010, develop one universal antibiotic effective against multiple classes of biological pathogens.* **- Increase awareness of NIH-sponsored research results among the general public.*** - Increase the pool of clinician researchers trained to conduct patient-oriented research.*
	FDA Human Drugs	- Review and act on 90% of standard New Drug Applications within 10 months and 90% of priority NDAs within 6 months [FY 00: reviewed 79% of 92 Std. NDAs (target 50%); reviewed 100% of 10 priority NDAs (target 90%)]. - Review and act upon 90 percent of fileable original generic drug applications within 6 months after submission date [FY 01: reviewed 84% of 298 applications (target 50%)]. - Increase the number of drugs that are adequately labeled for children.* - Act on 90 percent of Rx to OTC switch applications within 10 months.*
	FDA Medical Devices	- Review and complete 90 percent of Pre-market Approval Application (PMA) first actions within 180 days [FY 01:Reviewed 97% of 70 PMAs (target 90%)]. - Review and complete 90 percent of PMA supplement final actions within 180 days [FY 01: Reviewed 98.4% of 641 (target 90%)]. - Complete 95 percent of PMA "Determination" meetings within 30 days [FY 01: 100% of 3 (target 95%)].

** See agency performance plan/report for additional information.*

NIH Research

The National Institutes of Health

FY 2004 Budget Request: $27,893 million

Program Background and Context

Founded in 1887, the National Institutes of Health (NIH) is the Federal focal point for medical research in the United Sates. NIH funds research on diseases and conditions ranging from the rarest genetic disorder to the common cold. NIH supports research of non-Federal scientists in universities, medical centers, hospitals, and research institutions throughout the country and abroad; conducts research in its own laboratories; helps to train research investigators; and fosters communication of medical information to the public, health care providers, and the scientific community.

Program Performance Planning

NIH invests the public's resources and support for medical science in three basic and interrelated ways. First and foremost, NIH conducts and supports medical research. Second, it contributes to the development and training of the pool of scientific talent. Third, it participates in the support, construction, and maintenance of the laboratory facilities necessary for conducting cutting-edge research. For FY 2004, NIH has 35 goals. Of those goals, 24 are associated with the research program. The research outcomes section of that program has 11 goals. The following measures illustrate the key programmatic mission and activities:

- ***By 2007, determine the genome sequence of an additional 45 human pathogens and three invertebrate vectors of infectious diseases.***
- ***By 2005, develop a genome-wide haplotype map by identifying the haplotype blocks and the common haplotypes in the human genome.***
- ***By 2005, develop two new animal models for at least one agent of bioterror.***
- ***By 2010, develop one universal antibiotic effective against multiple classes of biological pathogens.***
- ***Increase awareness of NIH-sponsored research results among the general public.***
- ***Increase the pool of clinician researchers trained to conduct patient-oriented research.***

Means and Strategies

The following means and strategies illustrate how NIH continues to strive toward achieving its performance measures:

- **Genomic research:** NIH's genomic research focuses on the human genome, the genomes of animal models, and pathogen genomes. Two specific genomic research goals are:
  - Utilizing the sequence of the human genome, NIH is generating a map of

patterns of genetic variation across populations, a "haplotype" map.
- Initiating sequencing of the genomes of additional pathogens, to continue generating sequence information, which can be exploited in many ways for drug and vaccine discovery and development.

➢ **Biodefense research**: NIH has a detailed strategic plan for biodefense research. Two of NIH's goals in this arena are as follows:
- Animal models will be critical to FDA approval of biodefense therapies and vaccines, since, in most cases, clinical trials in humans to test efficacy are not possible or ethical. Development of promising candidate therapies and vaccines is being delayed because of the lack of standardized animal models in which to evaluate these candidates. New models need to be developed, particularly for non-human primates.
- Microbes that were once easily controlled by antimicrobial drugs are causing infections that no longer respond to treatment with these drugs. In addition, new, frightening, and unforeseen infectious disease threats have emerged, including threats posed by agents of bioterrorism. A "universal antibiotic," a drug effective against a wide spectrum of infectious diseases, would help address these challenges.

➢ **Awareness of NIH Research Results:** NIH is focusing on: 1) enhancing NIH operations to improve the communication of research results; 2) strengthening collaborations with other organizations involved in health communications; 3) developing and implementing communication campaigns on specific health issues; and 4) increasing the public's awareness of specific health issues and the role of NIH.

➢ To improve the communication of research results, NIH is enhancing the online health information resource, MEDLINEplus; partnering with providers and volunteers to extend the impact of the *Know Stroke: Know the Signs. Act in Time.* campaign; using media approaches to communicate the importance of eating five fruits and vegetables a day; collaborating to foster implementation of cholesterol clinical practice guidelines; implementing campaigns regarding identification and treatment of hearing loss; and disseminating resources to assist hearing professionals in following up on early identification of hearing loss.

➢ **Clinician Researchers:** NIH established and continues to support three new career development mechanisms designed to encourage patient-oriented research. The award curriculum development, protected time for clinicians to pursue research and mentor beginning clinical investigators, and supervised study and research for clinically trained professionals with the potential for productive clinical research careers. NIH expects that the activities stimulated by the awards will help to increase the number of clinicians trained to conduct high-quality, patient-oriented clinical research.

➢ **Resources:** The budget request for FY 2004 is $27,893 million. Medical innovation is one of the principal foundations on which America's past

successes in improving health and healthcare have been built. The investment in NIH research - both basic and clinical investigations - have led to new understandings about the most intricate biological and behavioral processes of life. NIH will continue to support research to expand fundamental knowledge about the nature and behavior of living systems with the goals of improving existing, and developing new, strategies for the diagnosis, treatment, and prevention of disease; and reducing the burdens of disease and disability. The increase in the NIH budget will also support public health concerns such as biodefense, health disparities, and the special needs of vulnerable populations.

External Factors

More than $8 out of every $10 appropriated to NIH flow out to the scientific community at large. This "extramural" system is premised on *independence*, embodied in "investigator-initiated" research; on *self-governance*, embodied in peer review of scientists by scientists as the primary basis for judging the merits of research proposals and awarding funds; and on the powerful incentive of *competition* among the most highly trained scientists in the world. Thus, the majority of research funded by the NIH is conducted by investigators located at universities, hospitals, and other research facilities external to the NIH. This external factor means that achievement of NIH's research outcome goals is highly dependent on the actions of individuals and institutions outside of the NIH.

Human Drugs Programs, *Pre-Market Review*

Food and Drug Administration

FY 2004 Budget Request: $454 million

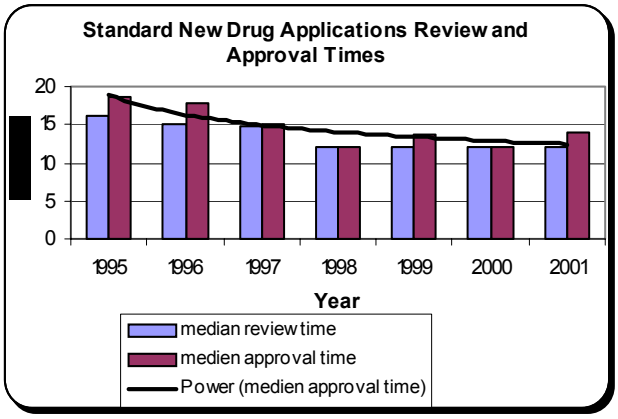
Program Background and Context

In meeting their mission to "promote public health by assuring that safe and effective drugs are available to the American people", CDER thoroughly reviews all new drug and generic drug applications; works on developing Over-the-Counter (OTC) medication labeling and increasing the range of OTC medication available on the market; increases the availability of drugs adequately labeled for children; and with the September 11 terrorist attack, assures the availability of drugs to treat victims of a bioterrorism or terrorist attack. CDER with major reforms such as the Prescription Drug User Fee Act (PDUFA) has significantly shortened review times without compromising patient safety. Under PDUFA, FDA has approved over 30 new medicines for Cancer, 37 medicines for AIDS among others. They have also increased the range of generic drugs on the market, which saves the American public and government $8 to $10 billion each year according to the Congressional Budget Office. In FY 2001, FDA approved the generic for Prozac and Pepcid. They will continue to make improvements in both generic and new drug reviews in FY 2004.

Program Performance Planning

This program has eight performance measures geared towards a range of pre-market drug review activities. The following measures illustrate how new PDUFA III legislation will improve review times and streamline review process and how FDA continues to increase the range of generic and OTC medications available as well as improving the safety and effectiveness of medication for children.

★ ***Meet PDUFA III commitments for the review of original New Drug Applications (NDAs).***



★ ***Review and act upon 90 percent of fileable original generic drug applications within 6 months after submission date.***

★ ***Increase the number of drugs that are adequately labeled for children.***

★ ***Act on 90 percent of Rx to OTC switch applications within 10 months.***

Means and Strategies

The following means and strategies illustrate how CDER strives towards increasing the availability of safe and effective drugs:

- **New Drug Application Reviews:** Under PDUFA and re-authorized, PDUFA II and III, FDA will continue to collect user fees which provide additional resources to hire more medical and scientific reviewers, support staff and field investigators to speed up the application process, as well as to build a needed IT infrastructure. In FY 2004, FDA will collect increased user fees under PDUFA III to help address financial challenges experienced in PDUFA II. The amount of user fees collected in the last years of PDUFA II were substantially less than the cost of performing review activities. FDA will establish a fee structure to address this shortfall.
- ***Information Technology Enhancements:*** PDUFA III also called for a number of IT enhancements. FDA has developed a new performance goal for FY 2004 aimed at increasing the number of electronic submission of drug applications which helps improve pre-market review efficiency.
- **Generic Drugs:** FDA continues to refine the review process to decrease review times such as increasing the amount of electronic submissions. A proposed increase in FY 2004 will go towards improving review times by hiring additional reviewers and inspectors to increase inspections of domestic and foreign firms associated with generic drug production. Money will also fund research on bioequivalence methods & standards, which will evaluate ways to enable approval of generic drugs in areas that currently lack generic alternatives, such as inhalational or topical drug products. This proposed increase will also support IT enhancement and increase coverage of imported generic drugs to better monitor the quality of finished drug products and bulk drug substances from overseas will also help FDA achieve their pre-market review goal.
- **Pharmaceuticals for Children:** FDA continues to encourage pharmaceutical companies to conduct pediatric drug studies through written requests by granting six month exclusivity. These studies have uncovered crucial dosing and safety information to help Pediatricians and other prescribers treat children. The 2002 Best Pharmaceuticals for Children Act (BPCA) renews this authority and allows for the collection of user fees for reviewing pediatric supplements. FDA will also partner with NIH to update a Priority List of drugs. A proposed FY 2004 increase will support the implementation of BPCA through hiring 36 additional FTEs. The increase will support their FY 2004 target by issuing written requests for studies, reviewing studies, making necessary labeling changes within the 6 month time frame, enhancing surveillance of adverse events in children, and coordinating the development of off-patent drugs with NIH. FDA will partner with NIH in increasing the number of pediatric studies.
- ***Over-the-Counter Medication*:** FDA has devoted extensive resources to having safe and effective OTC drug products in

the US. FDA will continue to work towards their goal of increasing the range of OTC medication available to American consumers by considering key foreign drugs and key potential "prescription (Rx)-to-OTC switches". With a proposed increase, FDA will devote resources towards increasing the staff dedicated to OTC review and to updating existing monographs in order to achieve FY 2004 targets of acting on 90 percent of Rx-to-OTC applications within 10 months and completing 10 monographs ("recipes" for marketing OTC drug products without the need for FDA pre-clearance).

External Factors

Review times are contingent on the quality and complexity of the sponsor's application. FDA helps to improve new drugs applications through industry sponsor conferences and other support activities funded by User fees.

Medical Devices, *Pre-Market Review*

Food and Drug Administration

FY 2004 Budget Request: $217 million

Program Background and Context

The Medical Devices and Radiological Health Program is responsible for ensuring the safety and effectiveness of medical devices and eliminating unnecessary human exposure to manmade radiation from medical, occupational, and consumer products. Of which, pre-market review is a major program component. Medical device manufacturers must seek FDA clearance or approval of their products to ensure that marketed devices meet tough safety regulations. The medical device industry is rapidly growing and devices submitted for review are becoming increasingly complex. Some of the devices approved in FY 2001 include the first Automated External Defibrillator (AED) for children, implants for the treatment of extreme obesity, and the first glucose monitoring device that doesn't puncture the skin. The program plans to improve review times in FY 2004 through streamlining the review process and other strategies.

Program Performance Planning

The Center for Devices and Radiological Health (CDRH) at FDA has seven performance measures geared towards pre-market review. The following measures illustrate key statutory review activities:

- ★ ***Review and complete 90 percent of Pre-market Approval Application (PMA) first actions within 180 days.***
- ★ ***Review and complete 90 percent of PMA supplement final actions within 180 days.***
- ★ ***Complete 95 percent of PMA "Determination" meetings within 30 days.***

Means and Strategies

The following means and strategies illustrate how CDRH continually strives towards improving the review process while maintaining tough safety standards:

- ➢ **PMAs First Actions:** PMAs are often high-risk devices, which can significantly improve patient treatment. In FY 2004, they will continue to redirect resources to the review of higher risk devices. FDA will also continue to expedite the review process through re-engineering, by holding early meetings with manufacturers, modular review etc. This goal is geared towards the first cycle of the review process as PMA review generally requires multiple cycles.
- ➢ **PMA Supplement Final Actions:** These supplements are generally added features to already approved devices or technology changes. FDA continues to offer manufacturers the option of "real time" reviews, which are conducted via

teleconference or face to face and enable manufacturers to discuss all FDA review issues at one time.

- **Review Process Improvements:** FDA will drastically improve review times over a five year period by increasing time for reviewer training; updating guidance to industry; enhancing IT; more pre-approval inspections; and increased collaboration with industry to improve the application process. With such funding in place, FDA will adopt additional performance goals which speak to total decision time – the total time spent by FDA in reviewing devices.

External Factors

As in CDER, review times are contingent on how complete device applications are as well the level of device complexity. Proposed MTEA legislation calls for increased coordination with industry, which will ultimately serve to improve the quality of applications.

STRATEGIC GOAL 5

Improve the Quality of Health Care Services.
Total Requested Discretionary Funds for This Goal in FY 2004: **$682 million**

This goal aims to improve the quality of health care services by reducing medical errors, improving consumer and patient protection, and accelerating the development and use of electronic health information. Our FY 2004 budget includes requests to reach this goal. The programs discussed in this section illustrate HHS's commitment to health care research; upholding health, safety and quality standards in institutions that serve Medicare and Medicaid beneficiaries; and modernizing electronic health information for the ultimate outcome of improving patient safety and health care quality. The Agency for Health Care Research and Quality (AHRQ) continues to be at the forefront of health care quality research in promoting improvements in clinical health systems and practices. AHRQ's patient safety request of $84 million includes $38 million in new activities will focus on enhancing the role of information technology in hospitals by incorporating interoperable clinical and message standards which will help to modernize our electronic infrastructure. Of this amount, $26 million will be set aside for patient safety and quality IT activities in small community and rual hospitals. Indian Health Service (IHS) continues to enhance their IT system and use of electronic patient information, which enables IHS to provide quality health care to individual patients, as well as track population health statistics.

CMS continues to focus their efforts on improving the quality of care of CMS beneficiaries in nursing homes. FDA, with a proposed $4 million increase, will enhance adverse event surveillance and in-house medical error tracking systems. Finally, CDC will continue to build their emergency preparedness through the Public Health Information Network. These programs, among others, illustrate HHS' commitment to improving health care quality.

HHS Strategic Goal	Agencies/ Programs	FY 2004 Performance Measures
GOAL 5: Improve the Quality of Health Care Services	AHRQ Research on Health Care Quality and Outcomes	-Decrease by five percent the hospitalization rates for pediatric Asthma. [Baseline will be established in FY 2003.] -Produce a CAHPS module for consumer assessments of hospital quality.* -Five technologies currently shown to be effective in other clinical settings will be tested in nursing homes to evaluate the impact on safety, quality, and cost of care.*
	CMS Nursing Home Quality- State Survey and Certification Program	-Decrease the prevalence of restraints in nursing homes. [FY 02: 9.9% (interim data), (Target: 10%)/ FY 01: 10% (Target: 10%)] -Decrease the prevalence of pressure ulcers in nursing homes. [FY 02: 10.3% (interim data), (Target: 9.5%)/ FY 01: 10.5% (Target: 9.6%)]
	AHRQ, FDA, IHS Information Technology for Hospitals, Pharmacies, and Healthcare Providers	- Expand implementation of the MeDSuN System to a network of 300 facilities [FY 01: FDA began feasibility testing with 25 hospitals and worked on software changes needed for website health data security (target recruit 75 hospitals to report adverse events)]. -Enhance postmarketing drug safety.* - Expand the automated extraction of GPRA clinical performance measures and improve data quality.*

** See agency performance plan/report for additional information.*

Research on Health Care Quality and Outcomes

Agency for Healthcare Research and Quality

FY 2004 Budget Request: $279 million

Program Background and Context

AHRQ promotes health care quality improvement by conducting and supporting health services research that develops and presents scientific evidence regarding all aspects of health care. The Agency's mission is to improve the outcomes and quality of health care services through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other health conditions.

In FY 2004, AHRQ will concentrate new funding on projects to advance the Secretary's efforts to improve patient safety and quality by ensuring that health information infrastructures are made available in hospitals, primarily in small and rural communities.

Program Performance Planning

AHRQ is currently restructuring performance measurement to provide a greater focus on programmatic outcomes. In FY 2004, AHRQ's plan includes 23 performance measures which support both long-term and shorter-term performance goals. AHRQ's plan has a mix of agency-specific performance measures and broad health outcome goals which may be impacted by the results of AHRQ research. Examples of both types of performance measurement for Health Care Quality and Outcomes are as follows:

- ★ ***Decrease by five percent the hospitalization rates for pediatric asthma.***
- ★ ***Produce a CAHPS module for consumer assessments of hospital quality.***
- ★ ***Five technologies currently shown to be effective in other clinical settings will be tested in nursing homes to evaluate the impact on safety, quality and cost of care .***

Means and Strategies

The following are examples of strategies which AHRQ will employ to enhance program performance:

- ➢ **Secretary's Prevention Initiative:** AHRQ will award about 20 challenge grants to implement the *Secretary's Prevention Initiative* to applicants demonstrating expertise in working with patients, providers, and health care systems to prevent diabetes, obesity and asthma and their complications.
- ➢ These grants will be awarded within four AHRQ program areas currently meeting the above criteria: Practice Based Research Networks (PBRNs),

Integrated Delivery System Research Networks (IDSRNs), Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED) and Translating Research into Practice (TRIP).

- **Electronic Health Information:** For the 21st Century Health Care Initiative, AHRQ will implement demonstration projects focused on important issues such as Computerized Physician Order Entry, Electronic Medical Records and Electronic prescribing and laboratory data, and enhancing the clinical health care-public health information infrastructure interface.
- AHRQ will also facilitate the application of health information technology into practice by expanding its Patient Safety Challenge Grants, which provide incentives to put systems-based interventions in place in healthcare organizations to accelerate the use of existing IT knowledge, reduce medication errors, reduce hospital acquired infections and improve compliance with accepted clinical care guidelines.
- **Resources:** The budget request for Research on Health Costs, Quality and Outcomes for FY 2004 is $279 million. AHRQ will spend $26 million for research grants to small community and rural hospitals to assist with information technology developments that will improve health care quality and patient safety.

External Factors

A number of external factors will impact AHRQ program performance including: 1) the economy; 2) advances in medical treatments; 3) advances in IT; 4) managed care; 5) declining State and local revenues; 6) financial status of hospitals; and 7) emphasis on public health preparedness for bioterrorism.

Nursing Home Quality - State Survey and Certification Program

Centers for Medicare and Medicaid Services

FY 2004 Budget Request: $248 million

Program Background and Context

The State Survey and Certification program ensures that institutions providing health care services to Medicare and Medicaid beneficiaries meet Federal health, safety and quality standards. As part of the Nursing Home Oversight Improvement Program, surveyors have been instructed to pay particular attention to nursing homes' use of physical restraints and to their ability to prevent and treat pressure ulcers.

Program Performance Planning

The Survey and Certification program includes funds to strengthen and continue activities focused on ensuring that CMS beneficiaries in nursing homes receive quality care in a safe environment. The program currently has three measures which speak to the heart of the program. The following measures illustrate key programmatic mission and activities:

- ★ ***Decrease the prevalence of restraints in nursing homes.***
- ★ ***Decrease the prevalence of pressure ulcers in nursing homes.***

Means and Strategies

The following means and strategies illustrate how the program continually strives towards achieving performance measures:

- ➢ **Physical Restraints**: State and CMS surveyors who conduct annual inspections of nursing homes pay close attention to nursing homes' use of restraints and cite nursing homes for deficient practices when they discover that residents are restrained without clear medical reason.
- ➢ CMS will continue to stress restraint reduction as a program goal, maintaining the target at 10 percent while evaluating the effect of current policies and considering the introduction of new ones.
- ➢ CMS will be conducting a training program for State surveyors, which will be broadcast by satellite and carried live over the internet. The topic of the program is reducing physical restraint use in nursing homes.
- ➢ **Pressure Ulcers**: CMS sponsors a variety of pressure ulcer activities, including: a satellite broadcast education program; enhancing methods of surveyor detection of pressure ulcers using Minimum Data Set (MDS) data and quality indicator reports; more detailed guidance to surveyors to detect pressure ulcer assessment and treatment deficiencies; and national education programs in the prevention and treatment of pressure ulcers.
- ➢ CMS is developing a program to educate providers about more accurate assessment and coding in the

identification of pressure ulcers, as well as new protocols aimed at onsite audit procedures that will verify the accuracy of nursing homes' MDS assessments.

- ➢ CMS will examine the methodology used to calculate the prevalence of pressure sores to see if improvements in that methodology may be made to decrease the effect of random variation on the reported measure.
- ➢ **Resources:** The budget request for FY 2004 is $248 million. This request will fund initial surveys and complaint visits and continue the FY 2003 President's budget Nursing Home Oversight Improvement Program (NHOIP) activities. This request will also allow for the inspection of long-term care facilities at the legislatively-mandated frequencies.

External Factors

The prevalence of pressure ulcers in nursing homes appears to have increased slightly over the 2001 baseline. There are several plausible explanations for the increase in prevalence. First, if there has been an increase in case-mix (severity of illness) of the nursing home population, it is possible and even likely there would be an associated increase in the prevalence of related conditions, including pressure ulcers. It is also possible the facilities have responded positively to the educational efforts, and are more carefully assessing residents and more accurately staging and coding pressure ulcers.

Information Technology for Hospitals, Pharmacies, and Healthcare Providers

AHRQ, FDA, IHS

Program Background and Context

A key element of this strategic goal is the development of electronic health information infrastructure to improve patient care and especially, patient safety. In particular, AHRQ as discussed earlier in this section, FDA, and IHS are some of the HHS agencies which are developing technology to prevent medical errors.

FDA is well known for their post-market regulatory role in tracking the effectiveness and safety of medical devices, human drugs and biologics on the market. This program is also linked to Strategic Goal 2 in that such IT systems help the agency respond to public health challenges. In order to improve the quality of care for patients, FDA continues their efforts to maintain their Adverse Event Reporting Systems (AERS) database where physicians and others report any adverse reactions to drugs or therapeutic biological products. Medical Device Surveillance Network (MeDSuN), another adverse event system, is actually placed in several health care facilities and tracks injuries or deaths attributed to use or misuse of medical devices.

IHS utilizes an integrated health information system throughout its health care delivery network. This system, RPMS (Resource Patient Management information System) consists of an integrated suite of clinical, administrative, and financial software applications. This system enables IHS to provide quality health care to individual patients as well as track population health statistics. The RPMS system supports individual clinical endeavors through applications that include, for example, immunization tracking, diabetes case management, and pharmacy; these diverse but integrated applications result in an individual electronic patient health summary. This summary is used by the providers to track clinical information as well as guide medical care decisions.

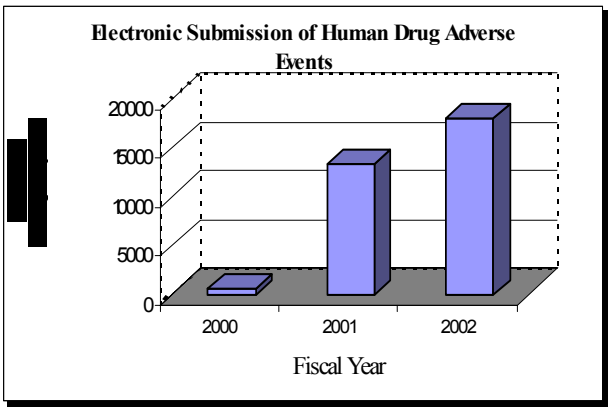
Population health is monitored using aggregate data retrieved from RPMS. This data enables IHS to track clinical quality. Quality is measured by pre-determined guidelines (e.g. Healthy People 2010 measures, GPRA, HEDIS – measures which track health care quality in managed care organizations), and reports are available for review at a local, regional and national level.

Program Performance Planning

These various agencies have devoted a number of performance measures for the implementation, maintenance, or expansion of IT devoted to improving the quality of patient care. The following measures illustrate key programmatic activities:

- ***FDA: Expand implementation of the MeDSuN System to a network of 300 facilities.***

➢ ***FDA: Enhance postmarketing drug safety.***



➢ ***IHS: Expand the automated extraction of GPRA clinical performance measures and improve data quality.***

Means and Strategies

The following means and strategies illustrate how these programs are striving to enhance electronic health information:

➢ **FDA MeDSuN:** In order to determine the level of injuries and deaths associated with medical device usage or mis-usage, FDA continues to work towards developing a representative network of medical device users by recruiting and enrolling health care facilities to report device usage. Of the proposed $4 million for FY 2004, $2 million will go towards expanding facility participation in the Medical Device Surveillance Network (MeDSuN) as well as enhancing error monitoring, electronic reporting, and special reporting for in vitro diagnostics. FDA will increase the enrollment to 300 facilities in FY 2004. This will entail maintaining current facilities and recruiting new facilities to participate in the program. Additionally, FDA plans to use the cohort of 300 facilities to pilot the effectiveness of various incentives, to pilot use of the MeDSuN facilities as a laboratory to obtain specific medical product information, and encourage reporting by the facilities.

➢ **FDA AERS:** In calendar year 2001, FDA received over 285,000 reports of suspected drug related adverse events for entry into the Adverse Events Reporting System. The Agency thoroughly reviews adverse event reports and if necessary, disseminates "Dear Healthcare Professional" letters or takes regulatory action. FDA is also coordinating with Medical Device contractors in implementing a "drug" MeDSuN where health professionals in user facilities can input adverse drug events. They would use the proposed $2 million increase in FY 2004 to support the hiring of 15 additional FTEs and to design and implement improvements to AERS such as more electronic reporting; risk-based guidance to industry; and greater analytic capability.

➢ **IHS automated extraction of data:** IHS continues to emphasize the value of 'transparent' data extraction for providers in health care facilities. IHS developed and deployed a new software application, GPRA+, in FY 2002. This application, coupled with ongoing efforts to improve clinical data quality, should result in increasingly reliable, accurate, and timely data.

➢ **Medication errors:** Recognition and monitoring of medication errors is a crucial part of improving health quality. The IHS is in the process of

evaluating ways to standardize medication error reporting, and implementing ways to reduce these errors. IHS plans on determining a baseline medication error rate, and identifying the root causes for the most frequent medication errors.

- **Quality Health Care for Diabetics:** IHS routinely evaluates care to diabetic patients, based upon national quality diabetic standards. IHS also monitors additional indicators that are important to our diabetic populations. This aggregate data allows IHS to track and improve the quality of care delivered to diabetic patients.

External Factors

Overall, FDA's success in expanding these systems for the end goal of preventing and reducing medical errors hinges on the health community's ability to adequately report adverse events related to medication, therapeutic biologics or even medical devices. MeDSuN depends on the cooperation of various health care facilities across the country as well as the technology infrastructure necessary for full implementation. In FY 2001, for example, FDA devoted resources to addressing security requirements, infrastructure necessary for full implementation.

IHS' success is dependent upon ongoing support for our current health information system (RPMS), as well as our ability to procure additional support and enhancements. Many of these new software applications can be successfully developed "in house". Success is also dependent on cooperation from health care providers and support staff, availability of training, and deployment issues. Tribes can elect to use RPMS or other health information systems. At the current time, the majority of tribal programs continue to use RPMS, and export aggregated data to the national IHS program. Tribal sharing of data will continue to be critical to our ability to report on clinical quality indicators.

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STRATEGIC GOAL 6

Improve the Economic and Social Well Being of Individuals, Families, and Communities, Especially Those Most in Need.

Total Requested Discretionary Funds for This Goal in FY 2004: $4,769 billion

To achieve this strategic goal, HHS will continue to support efforts to increase the independence of low income families, welfare recipients, the disabled, older Americans, Native Americans and Refugees. HHS is committed to supporting families who care for their disabled children at home and provide scholarships to increase the number of direct support workers who assist individuals with developmental disabilities. Also, the Department will support community and faith-based organizations who are providing services to individuals transitioning from welfare to self-sufficiency. Additionally, the Department is focusing on increasing the proportion of older Americans who stay active, healthy and independent and provide assistance to families who are the mainstay of long-term care for elderly persons.

The HHS programs, detailed in this section, have annual performance measures that speak to improving the economic and social well-being of individuals, families, and communities. These measures serve as examples of how HHS will improve the economic and social well being of individuals, families and the communities.

HHS Strategic Goal	Agencies/ Programs	FY 2004 Performance Measures
GOAL 6: Improve the Economic and Social Well Being of Individuals, Families, and Communities, Especially Those Most in Need	ACF TANF	- For FY 2004, increase to 44% the percentage of adult TANF recipients who become newly employed. {FY 2000 46.4% (target 42%.) - For FY 2004, increase to 66% the percentage of adult TANF recipients/former recipients employed in one quarter of the year who continue to be employed in the next two quarters.* {In FY 2000, 65% of employed recipients/former recipients sustained employment for the subsequent two quarters (the target of 83% was not attained because the measure was revised to capture employment in the two subsequent quarters instead of just the second subsequent quarter; a much more rigorous standard.}
	ACF LIHEAP	- Increase the targeting index of LIHEAP recipient households having at least one member 60 years or older compared to non-vulnerable LIHEAP recipient households. [In FY 2001, the targeting index was 90]* -Increase the targeting index of LIHEAP recipient households having at least one member 5 years or under compared to non-vulnerable LIHEAP recipient households. [In FY 2001, the targeting index was 109.]*
	AoA Community-Based Services Program	- A significant percentage of Older American Act Title III service recipients live in rural areas. [FY 1999: 33.6%; FY 2000: 32.9%] - Maintain a high ratio of Leveraged funds to AoA funds. [FY 2000: $1.90 to $1.00; FY 2001: $2.10 to $1.00]

* See agency performance plan/report for additional information

Temporary Assistance for Needy Families (TANF)

Administration for Children and Families

FY 2004 Budget Request: *$17,609 million*

Program Background and Context

The purposes of the TANF program are to: a) provide time-limited assistance to needy families; b) reduce dependency by promoting job readiness, work and marriage; c) prevent out-of-wedlock pregnancies; and d) encourage the formation and maintenance of two-parent families. Under Title IV-A of the Social Security Act, as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), States and territories receive a block grant allocation and are required to operate their own programs. States determine eligibility and benefit levels and services offered. Tribes have this option, as well.

Program Performance Planning

The primary goal of the TANF legislation is to move recipients from welfare to work and self-sufficiency. In partnership with States, ACF has achieved unprecedented levels of performance.

TANF shares a common goal with the more than 48 job training programs in 10 Federal agencies – to improve participants' employment and earnings. While these programs vary considerably in the types of services provided and target populations served, these agencies (ACF/HHS, Department of Labor, Education, Housing and Urban Development, Interior, and Veteran's Affairs) in coordination with the Office of Management and Budget, have developed a common set of measures for job training and employment. Two of these measures are listed below and reflect TANF's core goal to move individuals from welfare to work:

- ★ ***For FY 2004, increase to 44 percent the percentage of adult TANF recipients who become newly employed.***
- ★ ***For FY 2004, increase to 66 percent the percentage of adult TANF recipients/former recipients employed in one quarter of the year who continue to be employed in the next two consecutive quarters.***

Means and Strategies

ACF will employ various tools and strategies to enhance TANF program performance.

- ➢ ACF provides leadership to States, Territories and Tribes as they design and implement their programs. Efforts include an aggressive technical assistance and outreach approach, including a Peer Technical Assistance Network.
- ➢ PRWORA established work participation standards and created a High Performance Bonus incentive system for FY1999-FY2003. State and Territories receive financial rewards for

high performance and significant improvement as well as penalties for not meeting the work participation targets. The Administration's Reauthorization proposal restructures these grants to focus on employment achievement.

- **President's TANF Reauthorization Proposal:** The Administration's FY 2004 budget reproposes its FY 2003 TANF reauthorization proposal. The FY 2004 Budget requests *$17,609 million* for Family Assistance Grants to States, Tribes and Territories; Matching Grants to Territories; Supplemental Grants; and Native Employment Works at their current levels. The request also includes funding for High Performance Bonus. Contingency Fund is available from prior years. The proposal also strives to strengthen families. It includes a matching grant program for initiatives to promote healthy marriages. The proposal would also replace the out-of-wedlock bonus with a new initiative to fund research, demonstrations, and technical assistance activities, primarily targeted towards family formation.

External Factors

The performance of the TANF program will be significantly impacted by a number of factors which may help or hinder performance goal achievement including: 1) the national economy; 2) wage and employment rates; 3) social and demographic trends such as divorce and non-marital birth rates; and 4) increasing proportion of clients with barriers to employment such as lack of fluency in English, mental health problems, substance abuse, disability or domestic violence.

Low-Income Home Energy Assistance Program (LIHEAP)

Administration for Children and Families

FY 2004 Budget Request: $2,000 million

Program Background and Context

The purpose of LIHEAP is to assist low-income households that pay a high proportion of household income for home energy to meet their immediate needs. States, Federally or State-recognized Indian Tribes/Tribal organizations, and Insular Areas receive Federal LIHEAP block grants to administer the program at the community level. The LIHEAP statute targets two priority groups of low-income households needing energy assistance: 1)Vulnerable Households; and 2) High Energy Burden Households. Vulnerable households are defined as households with frail older individuals, individuals with disabilities, or very young children that meet LIHEAP income eligible standards.

Program Performance Planning

Last year ACF introduced the following two new performance measures which focus on targeting assistance to vulnerable households:

- ★ ***Increase the targeting index of LIHEAP recipient households having at least one member 60 years or older compared to non-vulnerable LIHEAP recipient households.***
- ★ ***Increase the targeting index of LIHEAP recipient households having at least one member five years or under compared to non-vulnerable LIHEAP recipient households.***

Means and Strategies

ACF will use the following tools and strategies to enhance program performance:

- ➢ Development of a LIHEAP brochure that includes information relating health and safety issues to vulnerable and high energy-burden household needs for energy assistance.
- ➢ Partnering with other HHS offices such as the *Head Start* Bureau, the Administration on Aging and the Developmental Disabilities Administration for dissemination of the outreach brochure at the community level.
- ➢ **Resources:** The budget request for the block grant for FY 2004 is $1,700 million, plus an $300 million emergency fund. This will enable States to better meet energy emergencies due to extremes in temperature. Over the past year, States have seen an increase in the number of applications/requests for energy assistance.

External Factors

There are a number of external factors which will impact on program performance. In addition to the key factor, the weather, other factors are: 1) volatility in prices for key heating fuels; 2) the economy; 3) wage

and employment rates; and 4) declining State revenues.

Community Based Services Programs

Administration on Aging

FY 2004 Budget Request: $1,344 million

Program Background and Context

The Community-Based Services Program (CBSP) provides grants to States to provide comprehensive social and supportive services to vulnerable elderly individuals and their family caregivers. Intended to complement existing medical and health-care systems, for a fraction of the cost, the CBSP supports some of life's most fundamental functions for elderly individuals at risk of institutionalization, including: food for the undernourished; critical transportation for the immobile; respite and support for caregivers; and personal care to those who need assistance getting in and out of bed. AoA carries out the CBSP through a national aging network that includes 56 State Units on Aging, 655 Area Agencies on Aging, 236 Indian Tribal Organizations, and over 29,000 public, private and voluntary direct service providers. This includes over 10,000 senior centers, of which more than half (6,000) are "community focal points" that coordinate and integrate services in the community, specifically for the elderly. The CBSP is the primary instrument of AoA and the national aging network to help vulnerable elderly individuals maintain their independence in the community and avoid institutionalization in facilities such as nursing homes. The CBSP and related programs are critical to the success and enhancement of President's *New Freedom Initiative*, and integration of services is a high priority of the Secretary and AoA to ensure coordination and program efficiency in support of the elderly.

Program Performance Planning

The CBSP currently has 22 performance measures across four focus areas: *1) targeting services to the vulnerable; 2) systems integration and efficiency; 3) program output; and 4) consumer-based program outcomes.* Measurable outcomes based on national CBSP consumer assessment surveys across six service domains become available late in 2002 to assess CBSP program impacts. Existing program data demonstrate effectiveness in targeting services to those who need services the most, and in integrating Federal, State and local resources in support of the elderly, as the following results for FY 2000 illustrate:

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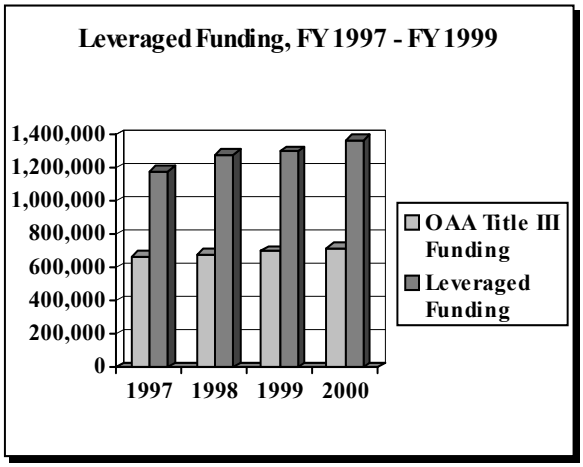
- ★ ***Approximately 10 percent of U.S. elderly individuals are poor and over 30 percent of CBSP clients are poor. Fewer than one-quarter of the elderly population lives in rural areas and over 33 percent of CBSP clients live in rural areas.***
- ★ ***State and local entities leverage almost $2 in funding from other sources for every $1 AoA provides for CBSP. For the most vulnerable elderly who need intensive services such as personal care, adult day care and home-delivered***

meals, network entities leverage $3 for every dollar AoA provides.



Means and Strategies

Based on the analysis of performance measures and other program data, AoA has identified a number of tools and strategies in its FY 2004 budget to effect improved program performance:

- Improve State and community integration of funding, services, and health and social supports by identifying and replicating model systems integration practices across the nation.
- Focus elderly client independence efforts on preventive health programs that improve health and well-being, and coordinate CBSP efforts with the Secretary's Prevention Initiative.
- Foster enhanced development newly authorized caregiver services under the CBSP through rapid and coordinated dissemination of caregiver demonstration innovations currently under development throughout the aging network.
- Under the Secretary's "One HHS" initiative, AoA is working to enhance partnerships with CMS, CDC, HRSA, AHRQ, IHS, NIH, and other HHS components to improve service integration at the community level on behalf of vulnerable elderly individuals.
- Consistent with HHS emphasis, focus program assessment activities on the quality of access to services by elderly individuals living in rural areas, and on the availability of services of greatest need to rural elders, such as transportation.
- **Resources:** The budget request for FY 2004 is $1,344 million.

External Factors

AoA and the State and local entities that comprise the aging network work together to address challenges that can affect performance. Nevertheless, selected external factors may in given years affect the achievement of performance targets. The following are illustrations of factors that can affect program results:

- Economic factors, such as increases in the price of gasoline, have affected the level of transportation services that State and area agencies can provide.
- Demographic factors, such as the rapid growth of the elderly population, will have a significant effect on the level of services that will be required in the future.
- Reliance on dispersed entities for program data has effected the timeliness of the availability of program data in the past. However, AoA and the States have reduced delays in program data availability by nine months, will continue to reduce such time lags, and will increasingly rely on sample survey

data, which become available on a more timely basis.

STRATEGIC GOAL 7

Improve the Stability and Development of Our Nation's Children and Youth.

Total Requested Discretionary Funds for this Goal in FY 2004:
$10.274 billion

HHS has a number of effforts to improve the stability and development of our nation's children and youth. These efforts include promoting family formation and healthy marriages and instituting creative and innovative ways to improve the learning readiness of preschool children. Additionally, we aim to increase the involvement and financial support of non-custodial parents in the lives of their children and increase the percentage of children and youth living in a permanent, safe environment.

As part of the President's *Good Start, Grow Smart* initiative, Head Start will be implementing a new accountability system whereby Head Start programs will assess enrolled children against established standards of learning in early literacy, language, and numeracy skills.

ACF anticipates continuing to promote the availability of child care services as a key element in its strategy for helping families achieve economic independence and supporting child development and school readiness.

The Child Support Enforcement program assures that support is available to children by locating parents, establishing paternity and support obligations, and is an integral part of the Department's effort to increase parental responsibility by promoting fathers' involvement in the lives of their children.

Programs such as Foster Care and Independent Living provide safe and stable environments for those children who cannot remain safely in their own homes.

This Administration has developed a number of program initiatives, emphasizing the involvement of faith and community-based organizations, to strengthen the nation's families; namely 1) the Compassion Capital Fund, 2) the Promotion and Support of Responsible Fatherhood and Healthy Marriage program, 3) the Mentoring Children of Prisoners program and 4) the Maternity Group Homes program.

The HHS programs in this section, and their representative performance measures, illustrate our commitment to improving the stability and development of our nation's children and youth. They are examples of how HHS continues to track progress towards this strategic goal.

HHS Strategic Goal	Agencies/ Programs	FY 2004 Performance Measures
GOAL 7: Improve the stability and development of our Nation's children and youth.	ACF Head Start	-Achieve at least an average 34% gain in word knowledge for children completing the Head Start program (the average gain among all children during the pre-K year is 19%). {Goal met: 32% gain maintained in FACES 2000} -Achieve at least an average 52% gain in mathematical skills for children completing Head Start programs (the average gain among all children during the pre-K year is 30%). {Goal met: 43% gain maintained in FACES 2000} -Achieve at least an average 70% gain in letter identification for children completing the Head Start program (the average gain among all children during the pre-K year is 50%). {Goal not met: Gain increased to 38%, falling short of 70% }*
	ACF Child Care	-Increase the number of children receiving child care services through CCDF, TANF-direct and SSBG funds. {New Measure: Baseline will be established in FY 2003.}* -Increase the proportion of centers and homes that serve families and children receiving child care subsidies. {New measure: Baseline will be established in FY 2003**.}** * -Increase the number of States that encourage provider training through bonuses or other compensation. {New measure: Baseline will be established in FY 2003.}*
	ACF Child Support Enforcement	-Increase the paternity establishment percentage (PEP) to 99%. {FY 2001 goal met: 102% (target 96%) (represents current paternity establishments and completion of backlog cases).} -Increase the Title IV-D collection rate to 60%. {FY 2001 goal met**:** Collection rate 57% (target 54%)}
	ACF Strengthening Families	-Increase the number of States implementing initiatives to promote healthy marriages. {New TANF measure: Baseline will be established in FY 2003.}*
	ACF Foster Care/ Adoption Assistance/ Child Welfare	-Increase the number of adoptions of children in the public foster care system to 60,000. {FY 2001 goal not met: 50,000 adoptions (target 51,000).}* -Of the children who exit foster care through reunification, maintain the percentage of children who do this within one year of placement at 67%. {FY 2001 goal met: 68% (target 67%).}

***** *See agency performance plan/report for additional information.*

Head Start

Administration for Children and Families

FY 2004 Budget Request: $6,816 million

Program Background and Context

Head Start provides grants to local public and private non-profit and not-for-profit agencies to provide comprehensive child development services to children and families. Intended primarily for pre-school age children in low income families, Head Start promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social, and other services. As part of the President's *Good Start, Grow Smart* initiative, Head Start will be implementing a new accountability system whereby Head Start programs will assess enrolled children against established standards of learning in early literacy, language, and numeracy skills.

Program Performance Planning

The Head Start program currently has numerous performance measures reflecting program performance for literacy, language and numeracy based on a national sample of information collected in the Family and Children Experiences Survey. They will be developing new measures to capture performance as reflected by the new outcome-based performance system once it is implemented. Examples of Head Start performance measures for FY 2004 are as follows:

- ★ ***Achieve at least an average 34 percent gain in word knowledge for children completing the Head Start program. (The average gain among all children during the pre-K year is 19 percent.)***
- ★ ***Achieve at least an average 52 percent gain in mathematical skills for children completing the Head Start program. (The average gain among all children during the pre-K year is 30 percent.)***
- ★ ***Achieve at least an average 70 percent gain in letter identification for children completing Head Start. (The average gain among all children during the pre-K year is 50 percent.)***

Means and Strategies

ACF will employ numerous tools and strategies to affect improved program performance and enhanced program performance monitoring, consistent with the President's *Good Start, Grow Smart* initiative.

- ➢ Implement Head Start's National Reporting System of child development outcomes.
- ➢ Implement a national training program in early literacy teaching techniques for nearly 50,000 Head Start teachers.
- ➢ Continue funding research efforts designed to identify the most effective early literacy and teaching strategies for children.
- ➢ Continue to support the Head Start Family Literacy Project which will work with

Head Start programs to improve the quality of family literacy services.

- Funding selected Centers of Excellence on Literacy which will develop research-based training materials that can be shared with Head Start grantees.
- **Resources:** The budget request for FY 2004 is $6,816 million, an increase of approximately $148 million over the FY 2003 President's budget. This increase will allow Head Start to serve 14,200 additional children, support the National Reporting System and continue other efforts to improve early literacy.

External Factors

The performance of the Head Start program will be significantly impacted by a number of factors which may help or hinder performance goal achievement including: 1) changes in local resources available to support low-income children, such as the availability and quality of child care and public school-supported pre-school programs; 2) changes in the demographic make-up of Head Start children, such as more non-English speaking children; 3) changes in the availability of health resources, such as Medicaid; and 4) changes in the Head Start workforce due, for example, to higher turnover rates of Head Start teachers because of wage competition from similar programs.

Child Care

Administration for Children and Families

FY 2004 Budget Request: $4,850 million (mandatory & discretionary)

Program Background and Context

The Child Care and Development Fund (CCDF) was established under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to help working low-income families achieve and maintain economic self-sufficiency and to improve the overall quality of child care. Administered by ACF in partnership with State and local governments, CCDF consists of Mandatory, Matching and Discretionary funds (Child Care Development Block Grant). TANF and Social Services Block Grant (SSBG) funds are also used for child care. ACF anticipates continuing to promote the availability of child care services as a key element in its strategy for helping families achieve economic independence and supporting child development and school readiness.

The Children's Bureau is actively engaged, with Head Start and the Department of Education, in implementing the President's *Good Start, Grow Smart* initiative. This initiative, designed to ensure that child care and early childhood programs maximize the opportunity to further early learning and literacy in young children, will require States to develop voluntary guidelines for school readiness. This will involve State CCDF Lead Agencies as well as State Education agencies.

Program Performance Planning

ACF is in the process of revising the performance measures for the Child Care program for FY 2004. Current measures underestimate Federally-subsidized child care services because they exclude children served through non-CCDF Federal funding streams including SSBG and TANF-direct. The FY 2004 ACF plan includes five child care performance measures, four of which are developmental. ACF will be developing baselines for these measures in FY 2003. Examples of FY 2004 measures are the following:

- ★ ***Increase the number of children receiving child care services through CCDF, TANF-direct and SSBG funds.***
- ★ ***Increase the proportion of centers and homes that serve families and children receiving child care subsidies.***
- ★ ***Increase the number of States that encourage provider training and education through bonuses or other compensation.***

The third performance measure, which is new, will assess State efforts to encourage or require increased provider training. Given the association that exists in research between provider training/compensation, child care quality and outcomes for children, this measure will serve as a proxy for quality and outcomes for children. Longer term, in connection with reauthorization of the CCDF , including the *Good Start, Grow Smart* set-aside, the Bureau will consult with States and others about a more direct approach to assessing child outcomes, which could include a measure based on

State assessment of school readiness at kindergarten entry.

Means and Strategies

ACF employs numerous tools and strategies to address the availability and quality of child care services and improve program performance.

- The Child Care Bureau partners with Head Start to sponsor the QUILT (Quality in Linking Together) project that Head Start and child care grantees as well as State pre-kindergarten programs form partnerships toward the provision of full-day, full-year early childhood services.
- ACF partners with HRSA's Maternal and Child Health Bureau to sponsor the Healthy Child America Campaign in order to improve health and safety in child care.
- The Child Care Bureau is currently placing special emphasis on partnering with *Head Start* and the Department of Education to implement the President's *Good Start Grow Smart* initiative.
- ACF provides extensive technical assistance to improve the quality of State and Tribal data submission. The Child Care Automation Resource Center and the new State Data and Research Capacity Grants assist States in resolving data reporting problems and enhance their capacity to report accurate data.
- **Resources:** The $4,817 million budget request for FY 2004 includes *$2,700* million for mandatory programs, $2,100 million for the Child Care and Development Block Grant. In part, these funds could promote statewide planning and implementation of efforts related to developing and refining early learning guidelines, expanding professional development capacity, and supporting cross-program coordination.

External Factors

The performance of the Child Care program will be impacted by other factors which may help or hinder the achievement of performance goals including: 1) the national economy; 2) State Fiscal conditions, and 3) TANF caseload trends.

Child Support Enforcement Program

Administration for Children and Families

FY 2004 Budget Request: *$4,500 million*

Program Background and Context

The mission of ACF's Child Support Enforcement (CSE) program is to assure that assistance in obtaining support is available to children by locating parents, establishing paternity and support obligations, and modifying and enforcing those obligations. ACF's Office of Child Support Enforcement (OCSE) works in cooperation with State agencies to aggressively implement the program and assure that performance goals are achieved. In addition, OCSE is an integral part of the Department's effort to increase parental responsibility by promoting fathers' involvement in the lives of their children.

Program Performance Planning

The ACF Performance Plan for FY 2004 includes five performance measures for Child Support Enforcement. These measures are consistent with the performance measures used in the new performance-based incentive formula, which rewards States for achieving performance targets. The following examples of CSE measures illustrate the program's commitment to assessing program outcomes and improving program performance:

★ ***Increase the paternity establishment percentage (PEP) to 99 percent.***

★ ***Increase the Title IV-D collection rate to 60 percent.***

Means and Strategies

The following means and strategies illustrate how the program continually strives towards achieving performance measures:

- The incentive funding to States for performance on five measures continues to be instrumental in driving the CSE program toward achievement of its performance targets. Incentive funding to States is based on the following: paternity establishment, current support collection, arrears cases paying, and cost effectiveness.
- Data Reliability Audits of performance data are conducted by Federal auditors.
- ACF partners with the Treasury Department's Financial Management Service to implement the IRS Tax Refund Offset and Administrative Payment Offset programs to offset income tax refunds and selected Federal payments to delinquent child support obligations.
- The Federal Parent Locator Service helps to locate non-custodial parents, as well as their employers and wages.
- The National Directory of New Hires and the Federal Case Registry help to locate absent parents across State lines.

- ACF partners with the State Department to deny passports to non-custodial parents who do not fulfill their child support obligations.
- ACF operates the Multi-State Financial Institution Data Match (MSFIDM) with financial partners, which assists in identifying non-custodial parent assets.
- ACF's Project Save Our Children, is a partnership with the Department of Justice, U.S. Attorneys, the Federal Bureau of Investigation, the HHS Inspector General and numerous State and local law enforcement agencies to address criminal non-payment of support.
- The FY 2004 President's Budget contains proposals to enhance and expand the existing automated enforcement infrastructure, which is crucial for meeting performance targets. The proposals also identify new enforcement tools.
- **Resources:** The budget estimate for FY 2004 is $4,525 million.

External Factors

The performance of the Child Support Enforcement program will be significantly impacted by a number of factors which may help or hinder performance goal achievement including: 1) the effect of State TANF program structures and policies; 2) the five-year time limit on TANF benefits, which makes child support even more critical for family self-sufficiency; 3) the national economy; 4) wage and employment rates; 5) demographic and social trends such as divorce and non-marital birth rates.

Foster Care/Adoption Assistance/Child Welfare

Administration for Children and Families

FY2004 Budget Request: $7,555 million (mandatory and discretionary)

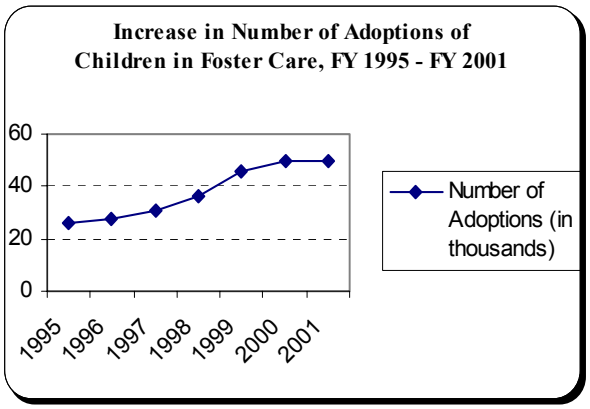
Program Background and Context

ACF administers an array of Child Welfare programs in partnership with State and local governments. The purposes of ACF's Child Welfare programs are to prevent maltreatment of children in troubled families, protect children from abuse, and find permanent placements for those who cannot safely return to their homes. Programs such as Foster Care and Independent Living provide safe and stable environments for those children who cannot remain safely in their own homes. The Child Welfare Services and Promoting Safe and Stable Families programs provide services to children and families with a focus on protecting children and strengthening families. When a child cannot be reunified with his/her family, programs such as Adoption Assistance, Adoption Incentives and Adoption Opportunities strive to place the child permanently with an adoptive family.

Program Performance Planning

ACF's FY 2004 Performance Plan includes six performance measures focusing on program outcomes. The measures are the same as those used in the Child and Family Services (CFS) reviews. ACF's focus on outcomes in Child Welfare and the excellence of these performance measures was recognized by Harvard University in 2001. ACF was one of 15 finalists out of 3,000 applicants in Harvard University's Innovation in American Government competition. Examples of the performance measures are listed below:

★ ***Increase the number of adoptions of children in the public foster care system to 60,000.***



★ ***Of the children who exit the foster care system through reunification, maintain the percentage of children who do this within one year of placement at 67 percent.***

Means and Strategies

ACF is employing a number of strategies to affect enhanced program performance in child welfare as follows:

➢ The final implementing regulations for the Adoption and Safe Families Act of 1997 established procedures for foster care eligibility reviews and State plan reviews.

- The 10 Child Resource Centers provide training and technical assistance to State and local agencies on permanency planning, adoption, family-centered practice, youth development, legal issues, abandoned infants, child maltreatment, community-based family resource services, and information technology.
- ACF has also established a new approach to monitoring State child welfare programs by establishing the CFS review process, which focuses on outcomes for children and families in the areas of safety, permanency, and child and family well-being; and systematic factors that impact the States' capacity to deliver services leading to improved outcomes. By FY 2004, at least one CFS review will have been completed in each State, and a second review will have begun for some States.
- In the FY 2004 President's Budget there is a proposal for a new program option for Foster Care, which will help the program reach its performance measures. States choosing to participate will receive their foster care funds in the form of flexible grants, which will serve as an incentive to create innovative child welfare programs with an emphasis on providing services that prevent children from being placed in foster care and on strengthening families. In addition, States will have increased flexibility in services provided and population served and will face fewer administrative burdens.
- **Resources:** The budget request for FY 2004 is *$6,814 million* for Foster Care/Adoption Assistance and Independent Living (mandatory), $339 million for Child Welfare Programs, $56 million for Adoption Incentives/Adoption Awareness, $505 million for Promoting Safe and Stable Families (mandatory and discretionary) and $60 million for Independent Living (discretionary).

External Factors

The performance of the Child Welfare programs will be impacted by other factors which may help or hinder the achievement of performance goals including: 1) the economy, including employment and wage rates; 2) the success of employment programs implemented under TANF; 3) the success of initiatives which promote healthy marriages and enhanced involvement of fathers in children's lives; 4) the availability of low-cost housing; 5) the availability of substance abuse treatment; and 6) social and demographic trends such as divorce and non-marital births.

Strengthening Families

Administration for Children and Families

FY 2004 Budget Request: $180 million (discretionary)

Program Background and Context

This Administration has developed a number of program initiatives emphasizing the involvement of faith and community-based organizations to strengthen the nation's families; namely 1) the Compassion Capital Fund, 2) the Promotion and Support of Responsible Fatherhood and Healthy Marriage program, 3) the Mentoring Children of Prisoners program and 4) the Maternity Group Homes program. Additionally, under the TANF reauthorization proposal, the Administration has a Family Formation initiative as well as some research and technical assistance dedicated to this effort.

As part of the Administration's initiative to provide increased support to faith-based and community-based organizations and to build upon the efforts of charitable organizations, the Compassion Capital Fund provides funds to public/private partnerships to support charitable organizations in expanding or emulating model social service programs.

This Administration is committed to making responsible fatherhood and healthy marriage national priorities. To reverse the rise of father absence and its subsequent impact on our Nation's children, the Administration proposes targeting funds for the Promotion and Support of Responsible Fatherhood and Healthy Marriage program. This program funds activities by public entities and non-profit community entities, including religious organizations and Indian Tribes and tribal organizations, for demonstration service projects designed to test promising approaches to promote and support involved, committed and responsible fatherhood, and to encourage and support healthy marriages between parents raising children, i.e. for those couples who choose marriage for themselves, to provide the skills and knowledge necessary to form and sustain healthy marriages.

Legislation was enacted in 2001 to amend Title IV-B subpart 2 of the Social Security Act to create a discretionary program (Mentoring Children of Prisoners) to provide competitive grants to State and local governments, Indian Tribes and consortia, and faith and community-based organizations to mentor children of prisoners and those recently released from prison.

The Maternity and Group Homes Program helps protect and support those young pregnant mothers and their children who lack safe and stable environments in which to live. These women are vulnerable to abuse and neglect and often end up on welfare, in foster care, in homeless shelters or on the streets and their children are at high risk of being teen parents themselves. To break this cycle, funds will be targeted

for community-based, adult supervised group homes for young mothers and their children.

Program Performance Planning

As new program initiatives under this Administration, there is, as yet, no baseline data to be used in the development of performance measures. Performance measures will be developed after program data becomes available. ACF anticipates funding 95 grants under the Compassion Capital Fund, 30 grants under the Promotion and Support of Responsible Fatherhood and Healthy Marriage program, 10 grants under the Mentoring Children of Prisoners program and 45 grants under the Maternity Group Homes program.

Means and Strategies

- ACF will fund grants as described above with a strong emphasis on the involvement of faith-based and community-based organizations.
- **Resources:** The $180 million budget request for FY 2004 is $25 million more than the FY 2003 President's budget request and includes $100 million for the Compassion Capital Fund, $50 million for Mentoring Children of Prisoners, $10 million for Maternity Group Homes and $20 million for the Promotion and Support of Responsible Fatherhood and Healthy Marriages.

External Factors

Numerous external factors may impact the future success of these programs. Examples are 1) the economy; 2) societal attitudes; 3) trends in charitable giving; 4) sentencing and parole policies; 5) the media/public opinion; 6) financial incentives/disincentives toward marriage including tax policy; and 7) trends in child bearing.

STRATEGIC GOAL 8

Achieve Excellence in Management Practices

***Total Requested Discretionary Funds for this Goal in FY 2004*: $2.449 billion**

HHS is committed to improving the efficiency and effectiveness of the Department's programs and achieving the goals of the President's Management Agenda, by creating an organization that is citizen-centered, market-based and results-oriented. As part of our overall commitment to good management, HHS is dedicated to successfully meeting the challenges identified by the Office of Inspector General. Included in HHS's many efforts is the work to reduce erroneous payments and the dedication to maintaining clean opinions in HHS audited financial statements coupled with the push to meet accelerated reporting requirements.

The Department is diligently working with both CMS and ACF to reduce erroneous payments. At CMS, through Health Care Fraud and Abuse Control (HCFAC) Program efforts, HHS has implemented aggressive efforts to reduce erroneous payments, including fraud and abuse in both the Medicare and Medicaid programs. For example, in Medicaid, CMS is committed to assisting interested States in developing methodologies and conducting pilot studies to measure Medicaid payment accuracy rates. HHS currently has 12 states participating in a Medicaid Payment Accuracy Measurement pilot. HHS anticipates expanding this pilot to 25 states in FY 2004.

FY 2001 was the first time HHS and all of its operating divisions received clean audit opinions for audited financial statements. HHS will continue its efforts to retain clean audit opinions. Over the next several years, HHS will increase efforts to expand and enhance the financial analysis already performed.

HHS is implementing an ambitious restructuring plan aimed at consolidating and automating administrative functions, re-engineering business processes, de-layering organizations to speed decision-making and reducing the number of management layers. One specific issue being addressed is the expected significant numbers of retirements in FY 2004 and FY 2005. However, the Departmental recruitment and retention strategy developed in FY 2002 will help HHS meet the changes that this surge in retirements will provide.

HHS believes that these highlighted efforts, combined with all other HHS initiatives will allow HHS to maintain excellence in its management practices.

HHS Strategic Goal	Agencies/ Programs	FY 2004 Performance Measures
GOAL 8: Achieve Excellence in Management Practices.	OIG HCFAC Program	-Medicare/Medicaid total expected recoveries and savings per dollar invested of $156:1 in FY 2004.* -Work in partnership with CMS to reduce the Medicare Payment Error Rate as to be determined by CMS.*
	ACF and CMS Clean Audits	-Obtain a clean audit opinion for ACF for FYs 2002, 2003 and 2004. [FY99-01: Clean audit opinion] -Maintain a clean unqualified opinion on CMS's FYs 2002, 2003 and 2004 financial statements. [FY99-01: Clean audit opinion]
	CDC Facilities Improvement	- Complete construction of Infectious Disease Lab, Building 109, to replace Buildings 4, 6, 7, 8 and 9 on the Chamblee Campus. [FY 03: Phase II construction complete] - Design and construct an Environmental Toxicology Lab, Building 110, to replace Buildings 17, 25, 31 and 32 on the Chamblee Campus. [FY 03: Construction on schedule]

** See agency performance plan/report for additional information.*

Health Care Fraud and Abuse Control Program

Office of Inspector General

FY 2004 Estimated Budget: $150 - $160 million

Program Background and Context

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, HIPAA or the Act) created the HCFAC Program (at Section 1128C of the Social Security Act) and specifically funds the OIG HCFAC Program. The Act coordinates health care fraud enforcement activities in a single program, led by HHS and the Department of Justice (DOJ), and provides powerful new criminal and civil enforcement tools and resources to combat health care fraud.

The Act appropriates monies from the Medicare Trust Fund to the HCFAC Account in amounts that the Secretary and Attorney General jointly certify are necessary to finance anti-fraud activities. The maximum amounts available are specified in the Act. Certain of these sums are to be available only for the activities of the HHS OIG.

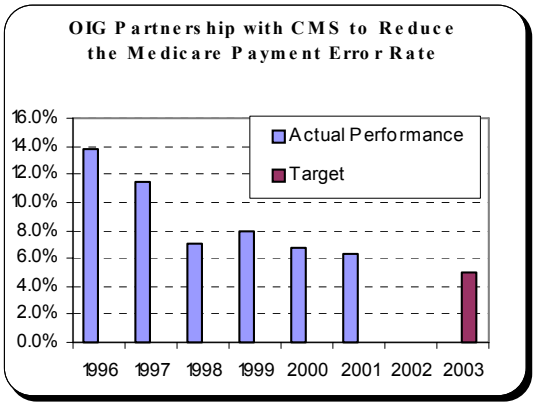
The increased resources made available under HIPAA have enabled OIG to enhance its efforts to both detect fraud, waste and abuse and to prevent it. Equally important, OIG's prevention activities reduce the government's enforcement costs and program losses.

In addition to funding the OIG HCFAC Program, the Medicare Trust Fund also funds the Medicare Integrity Program managed though CMS - at a funding level of $720 million in FY 2003.

Program Performance Planning

The OIG HCFAC Program has the following measures that are representative of the program and illustrate key programmatic mission and activities:

- ★ ***Medicare/Medicaid total expected recoveries and savings per dollar invested of $156:1 in FY 2004***
- ★ ***Work in partnership with CMS to reduce the Medicare Payment Error Rate as to be determined by CMS***



Means and Strategies

The OIG role features collaboration with other Department components, other Federal units such as DOJ and State and local agencies such as the State Medicaid Fraud Control Units. OIG and its HCFAC partners emphasize an interdisciplinary and intergovernmental approach to improve the government's ability to identify fraudulent and abusive health care providers and correct systemic problems. The coordinated effort draws on the talents of local aging organizations and State survey officials and

ombudsmen in identifying and reporting fraud and abuse. The 1-800-HHS-TIPS Hotline is an important part of the program. In addition, OIG continues to form associations with the health care industry to publicize "best practices," promote voluntary compliance plans and consult on program integrity strategies.

External Factors

A wide array of external influences can affect OIG's HCFAC efforts for any one year. Trials and appeals may take years, with resolution well after the investigative work is completed. Thereafter, recoveries may occur over additional years under staggered payment schedules. Key portions of the enforcement process are outside the control of OIG and are the responsibility of their partners (e.g., prosecution of cases, settlement, collection of recoveries and implementation of recommended improvements). Although this fosters the collaboration envisioned by HIPAA, it also contributes to sometimes significant delays between OIG actions and positive outcomes. Because of this, for expected recoveries OIG is instituting a calculation of a moving average, based on the prior three years. This average figure will be used to calculate the target for the upcoming year's recoveries. For example, the goal for HCFAC recoveries for FY 2004 represents a 10 percent target increase over the average annual expected recoveries for the prior three years, FY 1999-2001.

Numerical goals have an additional drawback. OIG cannot tie individual performance to a specific number of criminal prosecutions or dollars recovered, since to do so either (1) conditions employee performance on matters partly outside their control (e.g., prosecutions) or (2) creates the appearance of a bounty system. Both risk rendering the performance plan unenforceable. However, aggregate numbers relating to enforcement actions remain a good indicator of the vitality of the program. These numbers, such as numbers of exclusions, settlements under patient dumping cases, criminal convictions and the like, are all tracked and reported in the annual report of HCFAC accomplishments prepared by the Attorney General and the Secretary.

As a part of the HIPAA legislation, the Act provides for enhanced funding for anti-fraud efforts. Specifically, the Act automatically appropriates monies from the Trust Fund to a Fraud and Abuse Control Account in amounts that the Secretary and Attorney General jointly certify each year as necessary to finance anti-fraud activities. Maximum amounts available for certification are specified in the Act. In FY 2002, the maximum amount was $209 million, in FY 2003 it is $241 million. Funding for all years after FY 2003 is fixed at the FY 2003 level of 241 million.

The statute provides that a significant amount of these funds be made directly available to OIG. For FY 2002 a range of $140-$150 million was specified. The actual amount provided to OIG was $145 million. The range specified for FY 2003 is $150-160 million. Like the amount for the HCFAC program as a whole, this range is fixed for all future years.

Reduce Payment Error Rates

Centers for Medicare & Medicaid Services and Administration for Children and Families

Program Background and Context

Proper financial management is essential for the operation of viable federal and state administered health care programs. HHS is committed to ensuring that its federal programs and the state programs it oversees utilize strong financial management practices and to supporting the President's Management Agenda. In addition to other efforts, one particular financial management practice HHS has already started using and will expand in the future is the measurement of payment error rates for many of its largest programs.

Medicare

Program Performance Planning

CMS started measuring the percentage of improper payments made under the Medicare fee-for-service program in 1996 and created a goal to reduce this percentage. The purpose of this goal is to continue to reduce the percentage of improper payments made under the fee-for-service program. One of CMS's key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars.

Means and Strategies

The complexity of Medicare payment systems and policies and the number of contractors, providers and insurers involved in the Medicare fee-for-service program create vulnerabilities. CMS has implemented a Corrective Action Plan (CAP) designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate. Examples of the positive effects of CMS's corrective actions on reducing improper payments are illustrated in both the 1998 and 1999 OIG reports.

CMS exceeded its GPRA targets for 1999 and 2000. In general, the substantial reduction in the error rate demonstrates that the Medicare contractor claims processing system is working well. Furthermore, during previous audits, a significant portion of improper payments reported were attributable to documentation errors. However, in FY 1998, documentation errors accounted for only $2.1 billion, a substantial decline from the $8.7 billion reported in FY 1996. OIG attributed much of the substantial improvement in this category to the CMS CAP. CMS agreed to continue these corrective actions in response to both the FY 1998 and 1999 audits.

In FY 2001, CMS did not reach the target of six percent, however CMS continued its success by reducing the error rate to 6.3

percent. CMS will further reduce the error rate by continuing to focus its corrective actions on areas of vulnerability identified by OIG. CMS believes that by aggressively addressing specific high risk areas it will continue to be successful in reducing the fee-for-service error rate.

CMS is in the process of improving its ability to measure its Medicare fee-for-service error rate by developing error rates for each specific Medicare contractor that processes claims. This improvement will allow CMS to develop contractor-specific error rates as well as determine national error rates for specific provider and claims types. For a discussion of CMS's new Comprehensive Error Rate Testing (CERT) program, that CMS will be using in FY 2004 to aid in their analysis of the error rate, see CMS's FY 2004 GPRA plan.

Medicaid

Program Performance Planning

Through the Payment Accuracy Measurement (PAM) program, CMS is currently developing a payment accuracy measurement methodology. The PAM project is in the second year of a five-year time line.

Means and Strategies

In FY 2002, the Center for Medicaid and State Operations (CMSO) worked with nine states to develop and pilot test various state-specific payment accuracy measurement methodologies. In FY 2003, CMSO is working with 12 states to pilot test the PAM Model that CMSO is developing.

In FY 2004, the progress reports and findings from the FY 2002 and FY 2003 pilot years will be used to produce a draft of the final specifications for the CMS PAM Model that will be pilot tested in up to 25 states. The successful pilot test of the CMS PAM Model in these 25 states will provide CMS/CMSO with the final specifications for a methodology that can be implemented in all states in FY 2005. State participation in the PAM pilot is strictly voluntary, and the federal government is paying 100 percent of pilot project costs. Even if full federal funding was provided on an ongoing basis, a federal statutory mandate clearly will be required to get all states to institute a standardized PAM process. After full implementation of the methodology across all states, the baseline payment accuracy data for the Medicaid program at the national level will be available.

SCHIP

Program Performance Planning

HHS will submit a SCHIP action plan for the development and implementation of a SCHIP payment accuracy measurement project.

Means and Strategies

HHS recommends that of the FY 2003 $10 million HCFAC Program wedge fund (money not directly available to OIG) program integrity money, $3.7 million be used to fund the SCHIP PAM pilot. The funds will support state SCHIP pilot projects and expanded work by CMSO’s technical consultants.

HHS plans to solicit states, initially targeting the 12 states participating in the FY 2003 Medicaid PAM project, to test the Medicaid PAM methodology in their SCHIP programs. Of the 12 pilot states, three have stand-alone SCHIP programs, three have Medicaid-expansion SCHIP programs and

six operate both types of SCHIP programs. Most states, including these 12, are facing severe administrative budget and staffing pressures. As a result, even with 100 percent federal funding, it will be a challenge for HHS to enlist as many as a dozen states in the SCHIP pilot.

ACF

ACF is committed to improving the financial performance of its programs, a key element of the President's Management Agenda. Currently, HHS and ACF are involved in discussions with OMB on ways to enhance program integrity and financial management practices. HHS' efforts to improve financial management include developing error rates for some of its most important programs. Plans to measure error rates in Head Start, Foster Care, and TANF are under development.

Clean Audit

Department-wide Initiatives, and Administration for Children and Families and Centers

Program Background and Context

Federal agencies' financial statements are audited to reassure the public that those statements fairly and accurately represent the agency's financial condition. A clean and timely audit opinion on these statements is essential if decision-makers within the agency, the Office of Management and Budget and Congress are to use this information. The Administration and Secretary have set HHS-wide priorities to improve financial management. HHS has created a strategic plan to, among other things, support these priorities through achieving a clean audit opinion for the Department as a whole and for its operating divisions individually.

Program Performance Planning

HHS is addressing improvement in financial reporting reflective of its third consecutive year of a clean opinion for the Department. Also in FY 2001, it achieved clean opinions for all of its major operating divisions. In FY 2002, HHS is addressing the issue of accelerating its financial audit and reporting and improving its financial analysis process to ensure high quality financial information is available timely. In support of this effort, many operating divisions have clean opinion performance goals and/or measures. The following are just two examples that are representative of the programs:

★ ***Obtain a clean audit opinion for the Administration for ACF for FYs 2002, 2003 and 2004.***

★ ***Maintain a clean unqualified opinion on CMS's FYs 2002, 2003 and 2004 financial statements.***

Means and Strategies

ACF received a clean opinion from auditors for FY 1999 - 2001 - a major accomplishment that contributed significantly to the Department's clean opinion. Nevertheless, this is only one step, albeit a significant one, towards financial accountability to the public. Although ACF has achieved a clean opinion for three years, improvements to its accounting systems and services are still needed, especially with OMB-required compressed deadlines beginning with the FY 2002 audit cycle.

CMS's goal is to maintain a clean opinion, which indicates that their financial statements fairly present, in all material respects, the financial position, net costs, changes in net position, budgetary resources and financing of CMS. Since FY 1998, CMS has made significant improvements on their financial statements. In addition, they continue to develop the analytical tools necessary to perform more expansive trend analysis of critical financial data to identify potential errors or misstatements. Their long-term plan is to implement an integrated general ledger accounting system.

- On FY 1998 statements, they obtained a qualified opinion because auditors found deficiencies in several aspects of the Medicare contractors' accounts receivable.
- In FY 1999, FY 2000 and FY 2001 CMS received clean opinions.
- During FY 2001, they tested financial management internal controls at thirteen Medicare contractors using certified public accounting (CPA) firms, conducted contractor performance evaluation reviews of financial management issues at six Medicare contractors and reviewed accounts receivable balances at twelve Medicare contractors using CPA firms.

External Factors

For FY 2004, the audit cycle must be completed by November, more than two months earlier than previous years. ACF is working closely with the Department to meet these increasingly shortened audit deadlines. While ACF is committed to achieving future clean opinions, the abbreviated cycles are creating major resource challenges. ACF is working to improve the linkage of financial management systems and data to program performance and results and provide more accurate and timely data to financial/ program managers to foster informed decision-making.

Improved Human Capital Management

Department-wide Initiatives

Program Background and Context

The Department's employees – our human capital – are a key to accomplishing our mission and goals. Mission accomplishment requires that we align our human capital with the Department's strategic direction. This requires workforce planning – having the right people with the right skills doing the right jobs at the right time. It also means knowing what those skills are, how the requirements are changing and how our workforce is changing, so that we can take the steps to find, recruit, hire and keep the workforce that we will need.

Program Performance Planning

HHS has assertively moved to align its human capital programs with the Department's mission. These initiatives to improve human capital management are part of our efforts to implement the President's Management Agenda, aimed at making HHS a more citizen-centered Department.

Our efforts include systematically eliminating unnecessary management layers, so that there will be no more than four levels from the front-line worker to the top decision-makers. As part of its restructuring plan, HHS is consolidating its 40 human resources offices into four Departmental HR servicing sites by the end of FY 2003.

The Department-level HR consolidation is mirrored by efforts in all HHS Operating Divisions to consolidate administrative functions, eliminate duplicative offices and re-deploy staff to mission functions. These actions are just part of the Department's efforts to align its human capital to its strategic direction.

Workforce planning has pointed out issues of growing retirement eligibility and "hot spots" in resignations and turnover. HHS's cross-cutting Recruitment and Retention Plan has put in place initiatives to address these issues by recruiting, hiring and keeping the workforce we will need in the future.

The Department's Recruitment and Retention plan has fostered several Departmental human capital initiatives of note, including the Emerging Leaders Program, an innovative career intern program to develop future leaders; the HHS Corporate University, consolidating common needs training in one place; an exit interview project to analyze why employees leave; and a retention study to develop information on the factors that influence employees to stay with HHS. Taken together, these targeted actions to find, hire, place, develop and keep employees with critical skills are the cornerstone of aligning HHS's human capital to mission accomplishment.

Means and Strategies

These efforts cut across HHS. As Departmental initiatives, they are reflected and supported in the OPDIV plans. The Department's human capital initiatives can be summed up in five cross-cutting efforts:

- Implement Departmental recruitment and retention strategies;

- ➢ Develop and implement strategic workforce plans to respond to and eliminate skills imbalances;
- ➢ Consolidate administrative functions to eliminate duplication and increase efficiency and effectiveness;
- ➢ De-layer organizations to no more than four management layers to speed decision-making; and
- ➢ Deploy staff to mission-related functions to improve HHS as a citizen-centered Department.

Facilities Improvement

Centers for Disease Control and Prevention

FY 2004 Budget Request: $114 million

Program Background and Context

Subsequent to its post-World War II origins, CDC grew to respond to new public health threats. As it grew, the organization spread out over several locations throughout the Atlanta metropolitan area. Many employees work in 23 leased buildings. Some CDC scientists conduct experiments on infectious micro-organisms in wooden buildings that were constructed as temporary facilities almost 60 years ago.

CDC undertook a facility planning effort to consolidate its Atlanta operations into two secure campuses. The highest priorities in this effort include completion of the Emerging Infectious Disease Lab, construction of the Scientific Communications Center, design and construction of the East Campus Consolidated Lab Project and start of construction of the Headquarters and Emergency Operations Center, all at the Roybal Campus. The highest priorities also include completion of the Environmental Toxicology Lab at the Chamblee Campus and annual repair and improvements to CDC's nationwide facilities.

Program Performance Planning

CDC has nine performance measures that address design, construction and completion of its various facilities projects. The following measures are representative of the projects and programmatic activities:

★ ***Complete construction of Infectious Disease Lab, Building 109, to replace Buildings 4, 6, 7, 8 and 9 on the Chamblee Campus***

★ ***Design and construct an Environmental Toxicology Lab, Building 110, to replace Buildings 17, 25, 31 and 32 on the Chamblee Campus***

Means and Strategies

The following means and strategies illustrate how the CDC Buildings and Facilities effort strives towards achieving performance measures.

➢ **Resources:** The FY 2004 Budget request is for $114 million. An important resource CDC is employing is a new director of facilities management and planning who has a Ph.D. in civil engineering.

➢ The construction of Infectious Disease Lab, Building 109, to replace Buildings 4, 6, 7, 8 and 9 on the Chamblee Campus has been consistently on schedule. Phase II construction is expected to be complete in FY 2003 and CDC's target is to occupy the new lab in FY 2004.

➢ Construction has begun on the Environmental Toxicology Lab, Building 10, to replace Buildings 17, 25, 31 and 32 on the ChambleeCampus. CDC's performance target is to complete construction by FY 2004.

MAJOR MANAGEMENT CHALLENGES

Introduction

HHS Performance Plans and Reports address a number of important management issues that can affect overall performance, or are linked to fraud, waste and abuse. Below are some of the most important challenges identified in the OIG's list of Top Management Challenges, which identifies the issue and summarizes progress. For more information on OIG activities and reports, visit *http://oig.hhs.gov.*

In addition, another perspective of overall Department management issues is detailed in GAO-01-748, *Health and Human Services - Status of Achieving Key Outcomes and Addressing Major Management Challenges*.

Bioterrorism Preparedness

Events of and since September 11, 2001 have underscored the need for the necessary infrastructure and tools to respond to potential future terrorist events, including bioterrorism and other public health emergencies. HHS is responsible for much of the nation's federal health care resources and programs. CDC has specific, key responsibilities to help protect the nation from, and respond to, acts of bioterrorism.

The OIG's concern centers on HHS' vulnerabilities to outside threats, and the readiness and capacity of responders at all levels of government to protect the public health. The OIG is evaluating the effectiveness of CDC's bioterrorism effectiveness efforts, and plans to continue security and health system preparedness studies.

Federal, state, and local health departments are working cooperatively to ensure that bioterrorist attacks are detected early and responded to appropriately. As part of this effort, CDC has taken steps to increase the supply of pharmaceuticals needed in the event of chemical, biological, or radiological attacks. CDC has funded five state environmental health laboratories to provide additional surge capacity in the event of a major chemical terrorism incident. CDC's has expanded the existing bioterrorism cooperative agreements to fund all states, four localities, and eight territories. All jurisdictions now receive funding for each of the key elements of bioterrorism preparedness and response, which are: preparedness planning and readiness assessment, surveillance and epidemiology, laboratory capacity, communications and information technology, health risk communication and information dissemination, and education and training.

Grants Management

Departmental discretionary grants were estimated to total over $35 billion in FY 2002. Those discretionary grant programs are numerous and diverse, and vigilance is required to assure that monitoring systems are established to assess whether grants are administered in accordance with applicable laws, regulations, terms and conditions. In addition, monitoring systems must be sufficient to assess achievement of targeted goals, objectives and outcomes.

The OIG has initiated a two-part grant management review plan, and is studying grant-making and oversight processes in several HHS agencies. Reviews are also assessing individual grantee program activities and stewardship of funds.

A wide variety of Departmental activities are currently underway which focus on assessing grantee-progress in achieving grant outcomes and monitoring grantee compliance with grant requirements. Specifically, operating divisions are continuing their efforts to establish performance goals in various grant programs by requiring applicants, as part of their grant application proposals, to identify performance targets to be achieved by the end of each budget period. In addition, targeted reviews of specific grant operations within the Department are currently underway or being planned. These reviews examine a variety of pre-award and post-award activities performed by an HHS awarding agency. HHS operating divisions also administer a Grants Management Balanced Scorecard enabling operating divisions to assess perceptions of performance by soliciting feedback from a variety of internal and external users/customers. The results provide indicators as to how well an operating division is performing a variety of pre-award and post-award grant award activities enabling operating divisions to develop and implement action plans to address areas targeted for improvement.

Pricing Prescription Drugs

Because prescription drugs are such a significant part of 21st century medical care to help ensure proper treatment and maximum wellness, it is important that Medicare and Medicaid beneficiaries' access to pharmaceuticals is not hindered by disproportionate overpricing.

The OIG has found that HHS pays too much for prescription drugs for both Medicare and Medicaid. For example, Medicare payments for 24 leading drugs in CY 2000 were $887 million higher than actual wholesale prices available to physicians and suppliers, and $1.9 billion higher than prices available through the Federal Supply Schedule. OIG reports have indicated that the average wholesale price that Medicare has used to establish drug prices bore little resemblance to actual prices available elsewhere.

CMS continues collecting and analyzing data on drug pricing. For example, CMS is studying non-Medicare drug pricing of selected drugs covered under Medicare part B to determine the feasibility of other approaches to more accurately determine an Average Wholesale Price. CMS is prepared to utilize a single contractor to determine payment rates to eliminate the current variation in contractor prices.

Protection of Critical Infrastructure

HHS is addressing Information Technology Security as one of its top management priorities. IT security is a prominent part of the HHS Enterprise Information Technology Strategic Plan, which established an enterprise approach to project planning and implementation for critical infrastructure services in HHS. Furthermore, providing health care to the elderly and the disabled, facilitating research, preventing and controlling disease, and other critical missions all depend on information technology.

Recent OIG assessments found weaknesses in entity-wide security, access controls, service continuity and segregation of duties. While the OIG has not found any evidence that these weaknesses have been exploited, they leave the Department potentially vulnerable to unauthorized access to sensitive information, malicious changes, improper payments, and disruption of critical operations.

HHS is addressing information security as one of its top priorities. IT security is a prominent part of the HHS Enterprise Information Technology Strategic Plan. Based on plan priorities, contracts were awarded in FY 2002 to install multi-tier virus protection across HHS; implement vulnerability scans of critical HHS systems; and to provide perimeter protection for all Internet access points. For FY 2003, contracts are in place to establish round-the-clock monitoring of security alerts; to provide certification and accreditation for all Critical Infrastructure Protection assets; reduce Government Information Security Reform Act corrective action items and continue the Project Matrix process through the implementation of a Phase 2 Analyses of Critical Assets. The HHS CIO and CIO Council will continue to provide Departmental oversight for the Security Program to ensure that all HHS security and privacy requirements are met.

Nursing Facilities

Nursing facilities provide residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.

The OIG continues to review financial controls and quality of care provided in nursing homes. The OIG has found some services that were paid for twice, and has examined overutilization and underutilization of Part B therapy in nursing homes.

CMS has made significant gains in assuring that services being paid under the skilled nursing facility prospective payment system (SNF PPS) by fiscal intermediaries are not also billed to and paid by carriers. In April 2002, CMS implemented common working file (CWF) edits that will detect and deny cases in which carriers are being billed for services that the CWF shows to be in a Medicare covered Part A stay during the period in which the supplier billed the carrier for the service. In July 2002, CMS also implemented edits that will detect and mark payments that were made by carriers for persons in the course of a Medicare covered SNF stay where the SNF claim did not post to the CWF record before the carrier claim was paid, thus resulting in an incorrect payment. In January 2003, CMS plans to implement CWF edits that will detect similar incorrect cases in the fiscal intermediary claims processing system. In addition, CMS has developed a website application that can be used by a physician, practitioner or supplier to determine if a service at the Common Procedure Coding System (HCPCS) level should be billed to the SNF or to the carrier. Finally, CMS has made significant strides in its oversight of the SNF PPS through

a program safeguard contract that examines the minimum data set 2.0 resident assessment data, including some on-sight reviews at nursing homes.

Medicaid Payment System

Accuracy in the federal share of Medicaid costs is important to help ensure fairness across all state Medicaid programs as well as assure these federal health care dollars reach and achieve their maximum intended health care purposes.

The OIG found that some States inappropriately inflated the federal share of Medicaid by requiring public providers to return Medicaid payments to the state governments through intergovernmental transfers. Once the payments were returned, the states used the funds for toher purposes, some of which were unrelated to Medicaid.

To curb abuses and ensure that state Medicaid payment systems promote economy and efficiency, CMS issued a final rule, effective March 13, 2001, which modified upper payment limit regulations in accordance with the Benefits Improvement and Protection Act of 2000. The regulatory action created three aggregate upper payment limits—one each for private, state, and non-state government-operated facilities. The new regulations will be gradually phased in and become fully effective on October 1, 2008. The CMS projected that these revisions would save $55 billion in federal Medicaid funds over the next 10 years. The CMS intends to develop regulations that will outline accountability standards that states must address when making Medicaid disproportionate share hospital expenditures.

Accuracy of Medicare Fee-for Service Payments

To help ensure the financial integrity of the Medicare program, continued access to Medicare benefits, as well as the long-term viability of the Medicare trust fund, it continues to be essential that documented and accurate bills are submitted for correct payment for properly rendered health care services.

Based on a statistical sample, the OIG estimated that improper Medicare benefit payments made during FY 2001 totaled $12.1 billion, or about 6.3 percent of the $191.8 billion in processed fee-for-service payments reported y CMS. While progress is being made, the OIG's analysis indicates that problems remain.

CMS reported that the FY 2001 error rate is less than half of the 13.8 percent reported for FY 1996. Corrective actions enhanced internal pre- and post-payment controls; targeted vulnerable program areas; and educated providers regarding documentation guidelines and common billing errors. In FY 2003, CMS will fully implement the Comprehensive Error Rate Testing (CERT) program. The CERT program will produce national, contractor specific, and benefit category specific fee-for-service paid claims error rates. With CERT, CMS has set a target to reduce the national error rate to 4 percent by FY 2008 and developed two new performance goals for FY 2004. The goals are Provider Compliance Rate - to be reduced 20 percent per year and the Medicare Contractor Specific Error Rates - all would be at or below the national error rate of 4 percent by FY 2008.

Medicare Contractors

Because of the crucial role Medicare contractors play in helping facilitate efficient and effective health care delivery to 39.5 million Medicare beneficiaries, it is important that they be held accountable for their role in the health care financing and delivery system.

The OIG expressed an unqualified opinion on the CMS FY 1999 through 2001 financial statements largely because CMS continued to contract for validation and documentation of accounts receivable. However, OIG's FY 2001 financial statement audit disclosed that the lack of a fully integrated financial management system continued to impair the reporting of accurate financial information.

To address these problems, CMS has made significant improvements in this area over the last few years, as evidenced by the unqualified opinions on CMS' 1999, 2000, 2001, and 2002 financial statements. CMS has begun to implement the Healthcare Integrated General Ledger Accounting System, expected to be fully operational at the end of FY 2007. CMS has also continued to revise and clarify financial reporting and debt collection policies and procedures based on audit and review findings.