TABLE OF CONTENTS

BUILDING A STRONG AND HEALTHY AMERICA

HIGHLIGHTS

The fiscal year (FY) 2002 budget for the Department of Health and Human Services (HHS) delivers on President Bush's vision for a compassionate, responsible approach to governing the Nation. The budget plan seeks new and innovative approaches for delivering services and recognizes the important role of our outside partners – State and local governments, community and faith-based organizations, academic and religious institutions – in improving the health and well-being of all Americans.

The HHS budget reflects the President's commitment to a balanced fiscal framework that puts discretionary spending on a more moderate and sustainable growth path; protects Social Security and Medicare and supports priority initiatives; continues to pay down the national debt; and provides tax relief for all Americans. The budget plan:

Modernizes Medicare and Expands Access to Health Care: by creating an Immediate Helping Hand prescription drug initiative and dedicating resources to support comprehensive Medicare reform; expanding the number of Community Health Centers; reforming the National Health Service Corps; supporting Native American health services; enhancing State flexibility in Medicaid, the State Children's Health Insurance Program (SCHIP), and public health grants; increasing access to substance abuse treatment; and launching a national campaign to encourage organ donation.

Increases Support for America's Children and Families: by dedicating funds within the Child Care and Development Block Grant for after school certificates; protecting our vulnerable and at-risk youth, including children of prisoners and those aging out of foster care; funding organizations that operate community-based, adult-supervised group homes for teenage mothers; promoting responsible fatherhood; recognizing the important role charitable organizations play in improving people's lives; and continuing support for Head Start.

Enhances Scientific Research and Protects Public Health: by providing the largest increase in history for the National Institutes of Health (NIH); supporting research on the cost-effectiveness and quality of health care; protecting patient safety and reducing adverse events; and safeguarding the nation's food supply.

Invests in Infrastructure and Reforms Management: by revitalizing the laboratories and related scientific facilities at the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the NIH; enhancing coordination and reducing duplication of financial management and information technology systems and developing electronic options for grants management; redirecting resources from earmarked projects and lower-priority programs to other areas; and evaluating and improving program performance in accordance with the Government Performance and Results Act.

TOTALS

The FY 2002 budget for the Department of Health and Human Services totals $468.8 billion in outlays, an increase of $38.3 billion, or 8.9 percent, over the comparable FY 2001 budget. The discretionary component of the HHS budget totals $55.5 billion in budget authority, an increase of $2.7 billion, or 5.1 percent, over FY 2001, and $11.0 billion, or 24.6 percent, over FY 2000.

MODERNIZE MEDICARE AND EXPAND ACCESS TO HEALTH CARE

The Medicare program is the centerpiece of our Nation's commitment to protecting the health of senior citizens and the disabled. Medicare's approach to health care coverage has become increasingly dated, and there are significant benefit gaps, including the lack of a prescription drug benefit. Medicare provides fewer coverage options than are enjoyed by employees of large private firms and the Federal government. As a result, many beneficiaries lack access to innovative programs and coverage that would limit their financial exposure. Medicare also has an enormous long-term financing gap. To address these issues, the President proposes to modernize Medicare. The FY 2002 budget also proposes steps to expand health care access.

Modernize Medicare: The FY 2002 budget begins the process of modernizing Medicare to meet the demands of the 21st century. To assist seniors with limited incomes or high drug expenses, the President is putting forward an Immediate Helping Hand prescription drug proposal. Our budget also dedicates resources to support comprehensive Medicare reform, including the addition of prescription drug coverage.

❑ *Immediate Helping Hand:* While approximately 99 percent of employer sponsored health insurance plans offer either a prescription drug benefit or a cap on out-of-pocket drug expenses, Medicare provides no coverage for outpatient prescription drugs. The Immediate Helping Hand proposal will give immediate financial support to States so they can provide prescription drug coverage to beneficiaries with low incomes or high drug expenses. The plan, which will immediately provide coverage for up to 9.5 million beneficiaries, will sunset in four years or once comprehensive Medicare reform is enacted.

While approximately 99 percent of employer sponsored health insurance plans offer either a prescription drug benefit or a cap on out-of-pocket drug expenses, Medicare provides no coverage for outpatient

The Immediate Helping Hand proposal complements and builds on coverage that is currently available in almost half the States and under consideration in most others. It gives States the flexibility to choose how to establish coverage or enhance existing plans. Immediate Helping Hand is fully funded by the Federal Government and the budget includes a total of $46 billion over five years (FY 2001-FY 2005) for this initiative.

Under the Immediate Helping Hand proposal, individuals with incomes up to $11,600 and married couples with incomes up to $15,700 (135 percent of the poverty level) who are not eligible for Medicaid or for a comprehensive private retiree benefit pay no premium and no more than a nominal charge for prescriptions. For individuals with incomes up to $15,000 and married couples with incomes up to $20,300 (175 percent of the poverty level), the proposal provides subsidies for at least half the cost of the premium for high-quality drug coverage. Immediate Helping Hand also includes a catastrophic component that covers all seniors with out-of-pocket drug expenses in excess of $6,000 per year.

❑ *Medicare Reform:* Medicare covers only 53 percent of the average senior's annual medical expenses, and the program's benefit package has not kept pace with advances in medicine. The program also faces a growing financial crisis due to long term demographic and medical cost trends that will increase the number of persons eligible and the cost per beneficiary.

The President proposes to devote nearly $156 billion (including funding for Immediate Helping Hand) this year and over

the next ten years to improve the financial condition of the Medicare program and to modernize the benefits package, including the addition of a prescription drug benefit. Comprehensive reform will also include streamlining the complex regulations and paperwork that govern Medicare, and reforming the management of the Health Care Financing Administration (HCFA), which runs Medicare as well as Medicaid and SCHIP.

Expanding Health Care Access: More than 42 million Americans are uninsured, and at least 48 million do not have regular access to medical care. On average, these people have higher death rates from cancer and heart disease and lower life expectancies than the general population. The HHS budget takes a number of steps to expand access to quality, affordable health care, particularly for some of our most vulnerable populations.

❑ *Community Health Centers:* Many of those who are uninsured or lack access to health care live in either inner city neighborhoods or rural areas where there are few physicians or health care services. Community Health Centers provide high quality, community based care, including preventive and primary care services, to approximately 11 million individuals, 4.4 million of whom are uninsured. Federal, State, and community partnerships currently support over 3,300 health center sites.

The HHS budget launches a multi-year Presidential initiative by proposing an increase of $124 million for Community Health Centers in FY 2002 and supporting 1,200 new or expanded health center sites over five years. This increase will expand the delivery of services to up to one million additional individuals in FY 2002. The long term goal of this expansion is to double the number of people who receive high quality primary health care regardless of their ability to pay.

❑ *National Health Service Corps:* The HHS budget includes $126 million in FY 2002 for the National Health Service Corps (NHSC). Through its scholarship and loan repayment programs, the NHSC has placed over 20,000 health care providers in communities experiencing shortages of health professionals. Targeted management reforms will ensure flexibility to place providers in the neediest communities and more accurately define shortage areas.

❑ *Native American Health Services:* The FY 2002 HHS budget provides $3.0 billion for health care services at the Indian Health Service (IHS), an increase of $151 million, or 5.3 percent, over FY 2001. IHS provides medical care for approximately 1.5 million American Indians and Alaska Natives, both directly through a network of 49 hospitals and over 500 outpatient facilities, and indirectly through purchases of medical care from private sector hospitals and health professionals. In FY 2002, additional funding will cover increases in pay costs for staff at both Federal and Tribal-run facilities and the costs for staff at two new facilities. The FY 2002 budget also provides for the continued expansion of self-determination contracts that allow Tribes to operate their own facilities. The budget includes $50 million for this expansion, primarily for the initial costs of the Navajo Nation assuming the operation of their own health services.

❑ *Medicaid and SCHIP:* The Medicaid and SCHIP programs are proven mechanisms for improving access to health insurance and health care for the poor and near-poor. HHS will work with State partners to stem the growth of Medicaid costs, ensure the fiscally prudent management of the Medicaid and SCHIP programs, improve the way these programs provide health care to the poor and near-poor, and increase State flexibility in using private insurance coverage and coordinating with employment-based insurance for those who have access to it.

❑ *Public Health Grant Flexibility:* The FY 2002 budget gives States greater flexibility to transfer funds among public health grants. This flexibility will encourage states to make more efficient and effective use of Federal resources by allowing them to target and reallocate funds to public health priorities identified at the State and local levels. The budget also includes the President's Healthy Communities Innovation Fund initiative that supports grants to health care improvement projects in State and local communities. Under this initiative, HHS may make available approximately $400 million in existing grant activity for innovations and will work to ensure that the best and broadest range of innovative solutions are funded across the country.

Increasing Access to Substance Abuse Treatment: The Office of National Drug Control Policy (ONDCP) estimates that as many as five million Americans need treatment for substance abuse problems, but more than 2.9 million of them do not receive it. This treatment gap, which persists due to the lack of accessible, affordable, and available treatment, impacts society as well as the individual substance abuser. ONDCP estimates the annual societal costs of illegal drug use at approximately $110 billion.

The FY 2002 budget proposes an increase of $100 million for substance abuse treatment services that will help close the treatment gap. This includes $60 million for the Substance Abuse Block Grant, which is the primary funding source for State substance abuse efforts and supports over 10,500 community-based treatment and prevention organizations. An additional $40 million will support 80 additional Targeted Capacity Expansion (TCE) grants, which provide strategic and rapid responses to emerging trends in substance abuse. A portion of this additional TCE funding is reserved for competitive grants to organizations that provide residential treatment to teenagers.

Organ Donation: The FY 2002 budget request includes $20 million, an increase of $5 million, to launch a national campaign to encourage organ donation. In 1999, organs were recovered from only 6,000 cadaveric donors, and 22,000 transplants were performed, while 6,100 patients died waiting for a transplant. Today, there are some 75,000 patients awaiting organ transplants. The Department will undertake a nationwide effort to expand public information on donation and will honor donor families and living donors who have given the gift of life through organ donation. The campaign will promote donor awareness through partnerships with the transplant, business, education, and religious communities and through grants that support studies and demonstrations of innovative approaches to encourage donation.

INCREASE SUPPORT FOR AMERICA'S CHILDREN AND FAMILIES

Growing up in a stable and supportive family environment is central to enabling children to live happy and successful lives. HHS manages over 40 programs that support our nation's children, including Head Start, Foster Care and Adoption Assistance, Child Support Enforcement, Child Care, Vaccines for Children, and SCHIP. In FY 2002, HHS proposes to spend almost $77 billion, an increase of approximately $3 billion, on programs that help children and youth to realize their dreams. The President is committed to making sure that no child is left behind, and the FY 2002 HHS budget assists children and families to achieve this goal through initiatives to protect at-risk youth, promote responsible parenting, and support the charitable organizations that help to change people's lives.

After School Certificates: The HHS budget supports working parents by increasing total FY 2002 funding for the Child Care and Development Block Grant to

$2.2 billion and creating a $400 million set-aside within this account for a new after school certificate program. This new program will fund grants to States to assist up to 500,000 low-income working parents in paying for after-school care for their children. Certificates will pay for after-school programs with a high-quality educational focus for children up to age 19. The FY 2002 budget also increases mandatory child care funding by $150 million. In FY 2002, total Federal and State funding will enable these programs to serve approximately 2.6 million children, up from 2.1 million this year.

Protecting Vulnerable and At-Risk Youth: The joint Federal-State child welfare system is responsible for ensuring children's safety, creating permanency in children's living arrangements, and promoting healthy child development, but too often it fails to advance these goals. More child welfare funds should be dedicated to child abuse and neglect prevention through education and family support services. The FY 2002 budget enhances programs that support families and protect children with timely interventions that result in permanency for the child.

❑ *Promoting Safe and Stable Families:* HHS proposes a total of $505 million in mandatory funding, $200 million more than FY 2001, for the Promoting Safe and Stable Families program. Resources will enhance preventative efforts to help families in crisis, increasing the likelihood that children who are at-risk of abuse or neglect can live in a permanent home. In cases where children cannot remain with their biological families, funds will support placing them with adoptive families.

HHS also proposes $67 million in discretionary funds for a new Mentoring Children of Prisoners program within the Promoting Safe and Stable Families activity. Through competitive grants to faith-based and community-based groups, this program will help children and parents to maintain connections during the time the parent is imprisoned. Grants will also support family reunification efforts once the parent is released from prison.

❑ *Independent Living Education and Training Vouchers:* Approximately 16,000 youths age out of the foster care system each year. Research has shown that these youths have high rates of homelessness, early pregnancy, mental illness, drug abuse, and unemployment in the first years after they leave the child welfare system. To help these children successfully transition to independence, the HHS budget provides $60 million for education and training vouchers through the Independent Living Program, which supports a range of services including room and board, counseling, and life skills training. Youths who are aging out of foster care can use these vouchers, worth up to $5,000 each, to pay for college tuition or to obtain vocational training.

Maternity Group Homes: The FY 2002 HHS budget includes $33 million for a new program to support group homes for teenage mothers. The initiative provides funding to organizations that operate community-based, adult-supervised group homes for teenage mothers and their children who cannot live with their own families due to abuse, neglect, or other circumstances. Funds will also provide certificates to young mothers to obtain a range of supportive services including education, job training, parenting education, child care, and counseling.

Promoting Responsible Fatherhood: Nearly 25 million children do not live with their fathers, and more than one-third of them do not see their fathers at all during the year. Research shows that approximately 75 percent of the children living in

Nearly 25 million children do not live with their fathers, and more than one-third of them do not see their fathers at all

single-parent homes experience poverty before age eleven, as compared to only 20 percent of children living in two-parent homes. Children living with both parents are also more likely to do better in school, and they experience fewer emotional and behavioral problems, than those living with one parent.

HHS proposes $64 million in FY 2002 for a new initiative to strengthen the role fathers play in their family's lives. Of these funds, $60 million will provide grants to faith-based and community-based organizations that promote successful parenting and marriage and which help low-income and unemployed fathers and their families avoid dependence on welfare. Services provided to fathers will include job training, career education, subsidized employment, and mentoring. The budget also includes $4 million in FY 2002 for special projects of national significance that support State and local efforts to promote responsible fatherhood.

Recognizing the Important Role of Charitable Organizations: The HHS budget takes a number of steps to increase support for charitable organizations that have demonstrated an ability to change people's lives for the better. The budget includes $89 million to create a Compassion Capital fund. Through public and private partnerships, this fund will provide start-up capital, operating funds, and technical assistance to qualified charitable groups that seek to expand or emulate model social services programs. This fund will also finance research and disseminate information on best practices of charitable programs and social service organizations.

In accordance with President Bush's Executive Order, the budget also includes $3 million to establish a Center for Faith-Based and Community Initiatives in the Department. This Center will coordinate departmental efforts to eliminate regulatory and other obstacles to the participation of faith-based and community organizations in the provision of social services.

Our budget also encourages States to provide Charity State Tax Credits for contributions to designated charities that work to address poverty. States could offer a credit against State income taxes of up to 50 percent for the first $500 donated by individuals ($1,000 for married couples). States have the option to use federal funds provided through the Temporary Assistance for Needy Families program to partially offset revenue losses that would result from the tax credits.

Head Start: The HHS budget includes $6.3 billion for Head Start, an increase of $125 million over FY 2001. The Nation's premier early childhood education program, Head Start, ensures that low-income children start school ready to learn and provides a range of comprehensive child development and health services including physical and dental exams, immunizations, and nutritional services. The FY 2002 budget will allow 916,000 children to receive Head Start services, including 55,000 children in Early Head Start, and maintains a competitive salary for teachers. The President has proposed to reform Head Start by making school readiness – pre-reading and numeracy skills – Head Start's top priority.

ENHANCE SCIENTIFIC RESEARCH AND PROTECT PUBLIC HEALTH

Advances in scientific knowledge have resulted in dramatic improvements in the health of the Nation. The FY 2002 HHS budget enhances scientific research and protects public health through investments in biomedical research, health care quality research, patient safety, and food safety.

Enhancing Research at the National Institutes of Health: The HHS budget keeps the President's commitment to doubling the FY 1998 NIH budget by FY 2003. As part of this initiative, the FY 2002 budget proposes a total of $23.1 billion for NIH, an increase of $2.75 billion or 13.5 percent over FY 2001. This is the largest dollar increase ever for NIH and will allow the agency to support over 34,000 research project grants, which is the highest level in history. In FY 2002, NIH will expand its focus on four broad research areas – genetic medicine, clinical research, interdisciplinary research, and health disparities – that show the greatest potential for yielding new scientific knowledge. NIH is also developing strategies to maximize budgetary and management flexibility to meet the challenges that result from this large increase in resources.

The FY 2002 budget proposes an increase of $2.75 billion for NIH, the largest dollar increase ever.

Supporting Research on Healthcare Quality and Outcomes: The FY 2002 budget provides a total program level of $306 million for the Agency for Healthcare Research and Quality (AHRQ), an increase of $36 million or 13.5 percent over FY 2001. AHRQ is the Federal agency with primary responsibility for research on the Nation's health care system. In FY 2002, AHRQ will dedicate $255 million, an increase of $29 million, for research on health care costs, quality, and outcomes. Of this increase, $26 million will support additional research on the cost-effectiveness and quality of healthcare.

Protecting Patient Safety and Reducing Adverse Events: Medical errors are estimated to cause thousands of deaths each year, and the annual cost of health care expenditures related to medical errors is estimated at $29 billion. In 1999, the Institute of Medicine issued the report *To Err Is Human*, which recommended steps to protect patients and reduce medical errors. HHS has undertaken a multi-agency effort to improve patient safety and reduce errors and adverse events.

The FY 2002 budget for FDA supports a number of activities to protect patients and reduce adverse events. The budget includes an additional $10 million to increase inspections and oversight of clinical trials, train clinical trial inspectors, and allow for follow-up of all complaints concerning clinical trials within 30 days. The budget also includes a $35 million increase for two post-market safety assurance programs. Of these funds, an additional $10 million will expand efforts to reduce adverse events from regulated products, for which FDA receives over 300,000 reports each year. The remaining $25 million will increase the number of domestic and foreign inspections FDA performs each year and allow them to conduct additional import analysis and sampling in all product areas.

AHRQ will devote $53 million in FY 2002 to continue its work on identifying ways to reduce medical errors. This effort will include activities to test reporting strategies, develop and test new technologies, research the causes of medical errors, and train providers.

As part of the Department's Patient Safety Task Force, FDA, CDC, AHRQ, and HCFA are working collaboratively to develop a unified reporting system to make it easier for providers to communicate information on adverse events. CDC will use a portion of its infectious disease budget to support this project.

Safeguarding the Nation's Food Supply: The United States has one of the world's safest food supplies. Yet every year an estimated 76 million people become ill, 325,000 are hospitalized, and 5,000 die from a foodborne illness. To help safeguard the

nation's food supply, the FY 2002 budget includes a total of $124 million, an increase of nearly $15 million, for FDA food safety activities. These resources will allow FDA to expand inspections of food manufacturers, improve coverage and inspection rates at import entry points, and focus on illnesses derived from chemicals and pesticides. The FY 2002 budget also includes $34 million for food safety activities at CDC.

In addition, the FY 2002 budget for FDA includes $15 million to enhance efforts to prevent the spread of Mad Cow Disease (Bovine Spongiform Encephalopathy, or BSE). Consumption of meat contaminated with this disease has been linked to the development of a variant of Creutzfeldt-Jakob disease in humans. Scientists have also shown that BSE can be passed among cattle through the feeding of processed animal proteins. FY 2002 funds will allow the FDA to inspect all U.S. feed mills to ensure that quality assurance practices are followed and that there is no co-mingling of processed animal proteins and cattle feed, and to tighten oversight of imported dietary supplements and cosmetics that include animal byproducts.

INVESTS IN INFRASTRUCTURE AND REFORMS MANAGEMENT

HHS manages over 300 programs which account for more than one out of every five dollars spent by the Federal Government. Effectively managing these programs requires making the necessary investments in the infrastructure that supports our operations, as well as taking steps to enhance coordination, reduce duplication, and ensure the efficient use of resources.

Revitalizing Laboratories and Scientific Facilities: The laboratories and facilities at CDC, FDA, and NIH are relied upon to control disease outbreaks, prevent illness and injury, ensure the safety of our food and medical devices, and advance biomedical knowledge. The FY 2002 HHS budget continues to invest in the modernization of these important facilities.

The budget includes $150 million for Buildings and Facilities at CDC. Projects include $52 million for Phase II construction of a laboratory facility dedicated to handling the most highly infectious pathogens such as Ebola and hantavirus, and a related central utility plant; and $84 million to begin construction of the Environmental Toxicology Lab.

In addition, the FDA budget includes $23 million to complete construction of the Los Angeles laboratory and $6 million to pay for one-time costs of the development of the new FDA headquarters facility at White Oak, Maryland.

The FY 2002 budget also includes $307 million for intramural buildings and facilities at NIH. Major projects include $26 million to complete construction of the first phase of the John Edward Porter Neuroscience Research Center and $11 million to begin planning and design of the second phase; $53 million to begin construction of a centralized, multi-level animal facility; and $21 million to begin planning for the repair and renovation of the existing Clinical Center.

Enhance Coordination and Reduce Duplication of Operating Systems: HHS is a large, decentralized Department that relies on a number of systems spread across different agencies to support program operations. The FY 2002 budget invests to streamline financial management and other information technology systems, thereby enhancing coordination across the Department and eliminating unnecessary and duplicate systems.

The HHS budget includes an additional $49.4 million, for a total of $92.5 million in FY 2002, to finance the Department's transition to a unified financial accounting system. The Office of Inspector General has identified major problems with the Department's current accounting system structure, which consists of five separate

systems operated by multiple agencies. HHS plans to replace these antiquated systems with a unified financial management system that will provide standardization, reduce security risks, produce timely and accurate financial information needed for management decision-making, and provide accountability to our external customers.

The FY 2002 HHS budget also includes $30 million to establish a new Information Technology Security and Innovation Fund. The Department's current information technology structure is highly decentralized, heterogeneous, and vulnerable to security threats. HHS will implement an enterprise infrastructure management approach across the Department that will minimize vulnerabilities, maximize cost savings and information sharing, reduce duplication of equipment and services, and better secure systems against viruses and network intrusion.

In addition, HHS will continue to play a lead role in the Federal Grant Streamlining Program. HHS is the largest grant-making agency in the Federal Government, administering more grant dollars than all other Federal agencies combined. HHS will continue to develop electronic options for all grant recipients who would prefer to apply for, receive, and close out their Federal grants electronically.

Redirecting Resources: The FY 2002 HHS budget reflects the President's commitment to put discretionary spending on a more sustainable path and to redirect resources to high priority programs. Over the last several years, the HHS discretionary budget has grown much faster than the rate of inflation. The President's FY 2002 budget moderates this rate of growth while funding national priorities by making targeted reductions to earmarked projects, new programs, and programs that are duplicative or whose goals are better met through other avenues.

The FY 2002 budget eliminates $475 million in earmarked projects and $155 million in funding for activities that were funded for the first time in FY 2001. In addition, the budget shifts $597 million from programs such as Health Professions and the Community Access Program to higher priority activities. To finance other high priority activities, the budget also includes $135 million in new proposed law user fees in FDA and HCFA, and expands the use of Public Health Service Evaluation funds by $244 million.

Continuously Evaluating and Improving Program Performance: The budget request for FY 2002 is accompanied by the annual performance plans and reports required by the Government Performance and Results Act (GPRA) of 1993. These plans and reports continue to mature. The performance measures and targets touch nearly every aspect of the Department's multi-faceted mission. Some notable FY 2000 achievements include:

- HCFA reduced erroneous Medicare payments in FY 2000. Auditors estimated improper payments at $11.9 billion, $1.6 billion less than the previous year. HCFA is pursuing increasingly rigorous goals for FY 2001 and FY 2002.
- The Administration for Children and Families (ACF) reported that 42.9 percent of adult recipients of TANF became employed in FY 1999. This is a primary indicator of success in moving families toward self-sufficiency. It improves on the FY 1998 baseline of 38.7 percent, and exceeds the target of 42 percent.
- CDC reported a reduction of perinatal Group B streptococcal disease – the most common cause of severe infections in newborns – by 70 percent from 1995 to 1999, exceeding the goal.

The 13 performance plans and reports include dozens of other impressive success

stories and demonstrate that HHS is improving the health and well-being of America. GPRA continues to serve as an important mechanism to focus all of HHS on doing the right things and doing them well.

BUILDING A STRONG AND HEALTHY AMERICA

The FY 2002 HHS budget proposes new and innovative approaches for delivering services and working with our outside partners to solve public problems. It begins to modernize Medicare, including the addition of a prescription drug benefit, and expands access to quality health care. It increases support for America's children and families and protects the most vulnerable and at-risk. It enhances our scientific research and translates those advances into improvements in public health. And it makes investments in the infrastructure that supports HHS programs, allowing the Department to enhance coordination and reduce duplication and inefficiency.

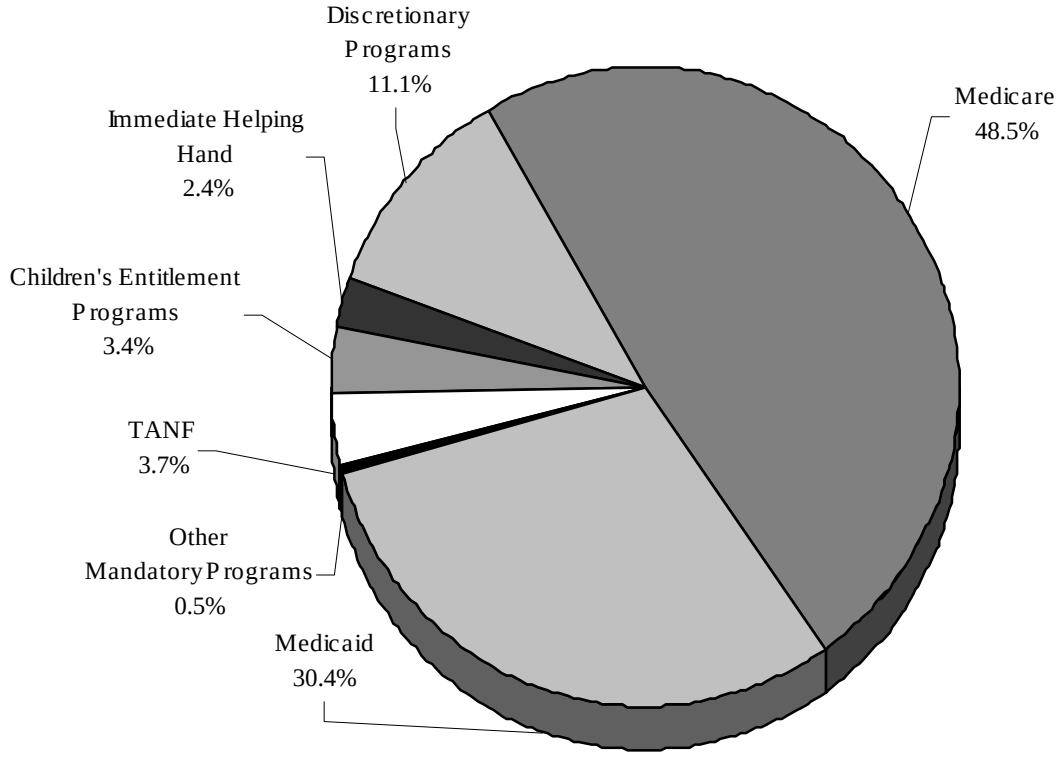
In short, the HHS FY 2002 budget proposes, in the words of President Bush, *"a compassionate, responsible, and courageous policy worthy of a compassionate, responsible, and courageous Nation."*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-2001	Request +/-2000
Budget Authority.....	$392,564	$436,361	$472,856	+$36,495	+$80,292
Outlays.....	$382,738	$430,455	$468,776	+$38,321	+$86,038
Full-Time Equivalents.....	60,522	63,539	64,988	+1,449	+4,466

President's Budget for HHS FY 2002



HHS BUDGET BY OPERATING DIVISION

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-2001	Request +/-2000
Food & Drug Administration:					
Program Level	$1,214	$1,291	$1,414	+$123	+$200
Budget Authority	1,050	1,120	1,211	+91	+161
Outlays	1,023	1,097	1,173	+76	+150
Health Resources & Services Administration:					
Budget Authority /1	4,795	6,340	5,194	-1,146	+399
Outlays	4,379	5,247	5,510	+263	+1,131
Indian Health Service:					
Budget Authority	2,421	2,729	2,807	+78	+386
Outlays	2,374	2,523	2,828	+305	+454
Centers for Disease Control & Prevention:					
Budget Authority	3,268	4,138	3,964	-174	+696
Outlays	2,817	3,382	3,729	+347	+912
National Institutes of Health:					
Budget Authority	17,894	20,454	23,205	+2,751	+5,311
Outlays	15,472	17,836	20,664	+2,828	+5,192
Substance Abuse & Mental Health Services:					
Budget Authority	2,651	2,957	3,029	+72	+378
Outlays	2,499	2,666	2,882	+216	+383
Agency for Healthcare Research & Quality:					
Program Level	204	270	306	+36	+102
Budget Authority	115	105	0	-105	-115
Outlays	56	108	91	-17	+35
Health Care Financing Administration:					
Budget Authority	322,459	354,485	386,527	+32,042	+64,068
Outlays	316,007	354,520	386,751	+32,231	+70,744

1/ FY 2001 includes a one-time $580 million payment to the Ricky Ray Hemophilia Relief Trust Fund.

HHS BUDGET BY OPERATING DIVISION, CONTINUED

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-2001	Request +/-2000
Administration for Children & Families:					
Budget Authority	36,981	43,149	45,787	+2,638	+8,806
Outlays	37,418	42,338	43,870	+1,532	+6,452
Administration on Aging:					
Budget Authority	933	1,103	1,098	-5	+165
Outlays	885	1,017	1,086	+69	+201
Departmental Management/Civil Rights:					
Budget Authority	514	401	456	+55	-58
Outlays	426	352	619	+267	+193
Office of Inspector General:					
Budget Authority	151	164	186	+22	+35
Outlays	156	154	186	+32	+30
Program Support Center:					
Budget Authority	287	291	313	+22	+26
Outlays	181	290	308	+18	+127
Proprietary Receipts:					
Budget Authority	-955	-1,075	-921	+154	+34
Outlays	-955	-1,075	-921	+154	+34
Total, Health & Human Services:					
Budget Authority	$392,564	$436,361	$472,856	+$36,495	+$80,292
Outlays	$382,738	$430,455	$468,776	+$38,321	+$86,038
Full-Time Equivalents	60,522	63,539	64,988	+1,449	+4,466

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-2001	Request +/-2000
Mandatory Programs (Outlays):					
Medicare	$194,870	$216,877	$227,508	+$10,631	+$32,638
Medicaid	117,921	128,853	142,423	+13,570	+24,502
Temporary Assistance for Needy Families	15,464	17,080	17,260	+180	+1,796
Immediate Helping Hand	0	2,500	11,200	+8,700	+11,200
Foster Care & Adoption Assistance	5,453	6,055	6,549	+494	+1,096
Child Support Enforcement	2,906	3,439	3,453	+14	+547
Child Care	2,237	2,423	2,555	+132	+318
State Children's Health Insurance	1,220	4,032	3,355	-677	+2,135
Social Services Block Grant	1,827	1,907	1,809	-98	-18
Other Mandatory Programs	892	1,489	1,421	-68	+529
Proprietary Receipts	-955	-1,075	-921	+154	+34
Subtotal, Mandatory (Outlays)	**$341,835**	**$383,580**	**$416,612**	**+$33,032**	**+$74,777**
Discretionary Programs (BA) /1:					
Food & Drug Administration	$1,050	$1,120	$1,211	+$91	+$161
Health Resources & Services Administration	4,575	5,576	5,019	-557	+444
Indian Health Service	2,391	2,629	2,707	+78	+316
Centers for Disease Control and Prevention	3,265	4,121	3,957	-164	+692
National Institutes of Health	17,867	20,361	23,112	+2,751	+5,245
Substance Abuse & Mental Health Services	2,651	2,957	3,029	+72	+378
Agency for Healthcare Research & Quality	115	105	0	-105	-115
AHRQ Program Level (Non-Add)	*204*	*270*	*306*	*+36*	*+102*
Health Care Financing Administration	1,996	2,242	2,236	-6	+240
Administration for Children & Families	9,109	12,101	12,594	+493	+3,485
Administration on Aging	933	1,103	1,098	-5	+165
Office of the Secretary	545	435	492	+57	-53
Subtotal, Discretionary (BA)	**$44,497**	**$52,752**	**$55,455**	**+$2,703**	**+$10,958**
Subtotal, Discretionary (Outlays)	**$40,903**	**$46,875**	**$52,164**	**+$5,289**	**+$11,261**
Total, HHS Outlays	**$382,738**	**$430,455**	**$468,776**	**+$38,321**	**+$86,038**

/1 The Public Health and Social Services Emergency Fund is being discontinued in this budget but the activities previously funded in this account such as bioterrorism are included in the appropriate agency budgets.

FOOD AND DRUG ADMINISTRATION

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Program Level.....	$1,214	$1,291	$1,414	+$123
FTE.....	8,917	9,219	9,611	+392

SUMMARY

The FY 2002 budget request for the Food and Drug Administration (FDA) is $1,414 million, a net increase of $123 million over FY 2001. Within this total, there are program increases of $143 million, partially offset by a $20 million decrease in contingent appropriations related to drug re-importation. Of the funds requested, $204 million will be derived from industry-specific user fees, including $20 million in proposed fees for food export certificates, and fees to improve the import program. The increase over FY 2001 is targeted to program expansions including food safety, preventing the spread of mad cow disease to the U.S., protecting human research subjects, assuring the safety of FDA-regulated products, and improving infrastructure.

FDA protects the public health by preventing injury or illness due to unsafe or ineffective products. FDA actively identifies health problems associated with FDA-regulated products and assesses the origin and impact of these health problems. FDA makes every effort to prevent problems that would expose the public to hazards, and monitors the marketplace to ensure compliance with laws, regulations, and good manufacturing practices.

PROTECTING THE U.S. FOOD SUPPLY

The FY 2002 President's Budget includes a $15 million increase to enhance efforts to prevent the spread of mad cow disease to the U.S., and an additional $15 million to continue and expand successful food safety activities.

Preventing the Spread of Mad Cow Disease to the U.S: The budget requests an additional $15 million to enhance efforts to prevent the spread of mad cow disease to the United States. Bovine Spongiform Encephalopathy (BSE) has spread from the United Kingdom to continental Europe, and the European Union has ordered the destruction of up to two million cattle at-risk for the disease. It is feared that processed proteins from these cattle will make their way illegally into the U.S., labeled as fishmeal or some other legal product.

Preventing the spread of mad cow disease: FDA will inspect all 9,500 U.S. feed mills to ensure that quality assurance practices are in place and being followed.

FDA plans to strengthen its efforts to keep BSE out of the U.S. and ensure that proteins from infected animals are not being

fed to cattle. First, FDA will biennially inspect all FDA licenced feed mills (1,240) in order to ensure that quality assurance practices are in place and being followed, and that there is no co-mingling of processed animal proteins and cattle feed. In addition, training will be provided to better educate Federal and State inspectors on the regulations for production of cattle feeds and how to best prevent co-mingling. Finally, additional resources will be directed to tighten oversight and inspection of imported dietary supplements and cosmetics that include animal byproducts.

In the mid-1990s, BSE emerged in the United Kingdom, infecting cattle herds, and spreading to people who ate meat from infected animals. Consumption of infected meat has been linked to the development of variant Creutzfeldt-Jakob Disease (vCJD) in humans. Scientists concluded that BSE spread among cattle through processed cattle and sheep proteins used as feed.

The U.S. took two significant actions to prevent the spread of BSE. The Department of Agriculture (USDA) banned the importation of processed cattle and sheep proteins from countries that either experienced or are at risk of experiencing BSE cases. FDA banned feeding any processed cattle and sheep proteins to cattle.

Food Safety: A total of $124 million, an increase of $15 million, is requested to make food safer. While our Nation has one of the safest food supplies in the world, much work remains to be done. First, there is a need to continue efforts to reduce foodborne diseases. Every year an estimated 76,000,000 people get sick, 325,000 are hospitalized, and 5,000 die from foodborne illness. HHS and the Department of Agriculture have collaborated very successfully to ensure the continued safety of our Nation's food supply.

Investment in food safety has resulted in a 20 percent decrease in foodborne illnesses for the nine most common pathogens over the past three years, representing one million fewer cases. FDA scientists have also developed methods for detecting viral and microbial food contaminents more quickly. Additionally, FDA is completing the National Antibiotic Resistance Monitoring System (NARMS) that focuses on emerging antibiotic resistance in food animals.

However, foodborne illness is not the only threat to consumers; chemical pesticides and other contaminants also pose potential health hazards. As a result, the FY 2002 budget will improve FDA's efforts to ensure foods are not contaminated by pesticides and other chemicals. FDA will also expand and improve coverage and inspection rates at import entry points, develop inspection and testing programs for shell eggs to reduce the risk of Salmonella enteriditis, and reduce listeria monocytogenes contamination.

PROTECTING HUMAN RESEARCH SUBJECTS

FDA currently performs about 1,100 inspections related to clinical trials each year, including 600 clinical research sites. FDA also conducts reviews of clinical investigators, investigational review boards (IRBs), sponsors, monitors, and contract research organizations.

The $10 million increase in FY 2002 will allow for a significant increase in inspection and oversight of clinical trials, by approximately 33 percent (375 inspections).

Increased funds will allow FDA to follow-up on 100 percent of complaints concerning clinical trials

Emphasis will be on high-risk trials involving vulnerable populations and sponsor-investigators who have a proprietary interest in the product under study. New funds will also allow for increased training of investigators and improvements in the inspection process for IRBs. Finally,

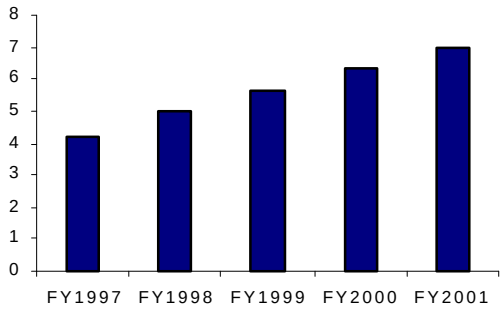
increased funds will allow FDA to follow-up on 100 percent of complaints concerning clinical trials within 30 days of receipt. Currently, response times range from a few days to several months to accomplish these complaint reviews.

ASSURING PRODUCT SAFETY

FDA has significantly accelerated approval of safe and effective products over the last several years. The budget includes an additional $35 million to make comparable improvements in 'post-market' safety assurance programs to maximize benefits and minimize injuries.

Increasing Inspection and Import Sampling Rates: The budget also includes an increase of $25 million to expand capacity to meet public and statutory expectations for inspections of production facilities and increase sampling of imported products. Current resources limit inspections to only about 18 percent of the approximately 129,000 production and storage facilities, and 0.7 percent of the 6.3 million import entries. This includes contracts carried out by State partnerships. Additionally, the number of import entries has increased by 75 percent since FY 1997, from roughly 4 million to an estimated 7 million in FY 2001.

IMPORT LINE ENTRIES
Entries (millions)



FY 2002 funds will allow for an increase in the number of domestic and foreign inspections it performs each year, in an effort to increase the safety of products on the market. An additional 1,800 inspections are anticipated in FY 2002, for a total of 24,500 inspections. Also planned are increased import analysis and sampling in all product areas. FDA will seek to enhance its import monitoring system (Operational and Administrative System for Import Support or OASIS) and link it to other databases. This expansion is linked to enacting and receiving user fees from importers for each import entry that they seek.

Reducing Adverse Events: An increase of $10 million will expand efforts to reduce adverse events from regulated medical products. FDA currently receives over 300,000 confidential adverse event reports each year. Reviews are conducted to detect potential patterns for follow-up. The most common outcome is improved information for medical providers on the safe use of regulated products. This information is also used to determine when unanticipated side effects or usage errors are sufficiently severe that a product should be removed from the market.

The additional funds requested will allow for improved computer systems to compile and analyze these reports, and added staff for follow-up. Improvements in the quality of information FDA receives is also needed. For medical devices, FDA and partner hospitals are testing an active surveillance system (MeDSun) to provide better statistical information for targeting follow-up efforts. Based on results to date, this approach will be expanded to human drugs and biologics. Simultaneously, collaborative work is underway with CDC (hospital acquired infections), AHRQ (health care quality and safety improvement), and HCFA (Medicare) to develop a common automated interface that would significantly reduce the reporting burden for partnering providers,

and provide this confidential information electronically.

DRUG RE-IMPORTATION

The FY 2001 appropriation includes $23 million that FDA can use for pre-implementation activities associated with an expanded authority under the Medicine Equity and Drug Safety Act of 2000, to allow retailers and wholesalers to import prescription drugs. This provision has not been implemented. The FY 2002 budget requests $3 million for continued pre-implementation activities that will be available if the Secretary concludes that the Act would reduce prices without increasing health risks.

INVESTING IN INFRASTRUCTURE

In FY 2002, the budget proposes to invest an additional $17.3 million for infrastructure improvements.

Improving Scientific Infrastructure: Evaluating state-of-the-art medical and food products requires comparable scientific facilities. The budget includes a total of $23 million, an increase of $3 million, to finish replacing a dilapidated Los Angeles regional laboratory facility. The Los Angeles laboratory performs 24 percent of food import analyses conducted each year.

The budget also includes an increase of $6 million in one-time costs to enable the Center for Drug Evaluation and Research (CDER) to occupy a new laboratory that the General Services Administration (GSA) is constructing at White Oak, Maryland. This will cover costs associated with telecommunications and laboratory equipment, moving, and decommissioning of their current facility. In addition, the FY 2002 budget request for GSA includes $9 million for planning the next phase of developing a consolidated FDA headquarters at White Oak.

Improving Information Technology Infrastructure: The FY 2002 budget request includes $8.3 million to begin development of a replacement financial system. This is part of a Department-wide effort to replace antiquated and inflexible systems with modern enterprise support systems. The current system cannot integrate the numerous financial management systems within FDA, nor does it contain a managerial accounting module, which is mandated by the Chief Financial Officer Act.

USER FEES

The FY 2002 budget request includes $203 million in user fees. Of this amount $20 million are new fees for which authorizing legislation is needed. Of this requested increase, $15 million will support the cost of import activities, such as reviewing import entries through its Operational and Administrative System for Import Support (OASIS) import tracking system. A fee would be established per import entry to support the OASIS system in tracking shipments and targeting inspections. An import entry can be a single item or several shipping containers that are brought in together for import. This will enhance FDA's ability to ensure the safety and efficacy of products that are imported for use by American consumers. The remaining $5 million will allow FDA to recover the costs for providing certifications requested by food exporters. Drug and device exporters already cover such costs.

The budget includes $161 million in Prescription Drug User Fee Act (PDUFA) fees, an increase of $12 million. PDUFA authorizes the collection of user fees for reviewing drug applications and was reauthorized as part of the FDA Modernization Act of 1997. To date, the PDUFA program has been highly successful in achieving the objective of reducing the amount of time it takes FDA to review applications for new drugs and biologics,

while maintaining the objectivity and standards of safety that are essential in order to enhance and protect the public's health.

FDA has consistently met its statutory timeframes. The FY 2002 increase will allow FDA to keep up with the increasing number of products submitted for review.

FDA OVERVIEW

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Foods	$280	$285	$319	+$34
Drugs	313	317	348	+31
Biologics	138	140	155	+15
Animal Drugs and Feeds	50	64	82	+18
Medical Devices	172	180	198	+18
National Center for Toxicological Research	36	35	37	+2
Tobacco	6	0	0	0
Other Activities	78	79	95	+16
Other Rent & Rent Related Activities	32	26	32	+6
Subtotal	**$1,105**	**$1,126**	**$1,266**	**+$140**
GSA Rental Payments	93	105	105	0
Buildings and Facilities	11	31	34	+3
Certification Fund	4	5	5	0
Export Certification	1	1	1	0
Subtotal, Program Level	**$1,214**	**$1,268**	**$1,411**	**+$143**
Drug Re-importation (contingent funding)	0	23	3	-20
Total Program Level	**$1,214**	**$1,291**	**$1,414**	**+$123**
Less User Fees:				
Current Law:				
Prescription Drug User Fee Act (PDUFA)	145	149	161	+12
Mammography Quality Standards Act (MQSA)	15	15	16	+1
Certification Fund	4	5	5	0
Export Certification	1	1	1	0
Proposed Law:				
Foods	0	0	5	+5
Imports	0	0	15	+15
Subtotal, User Fees	**$165**	**$170**	**$203**	**+$33**
Total, Budget Authority	**$1,049**	**$1,120**	**$1,211**	**+$91**
FTE	8,917	9,219	9,611	+392

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Program Level.....	$4,717	$6,227	$5,094	-$1,133
Discretionary Budget Authority.....	$4,575	$5,576	$5,019	-$557
FTE.....	2,054	2,268	2,244	-24

SUMMARY

The FY 2002 budget request for the Health Resources and Services Administration (HRSA) is $5 billion, a net decrease of $557 million below FY 2001. Over half of this reduction is associated with one-time projects funded in FY 2001. Within the overall FY 2002 program level no funds are requested for the Ricky Ray Hemophilia Relief Act compensation program, which received a $580 million multi-year appropriation in FY 2001. HRSA is the lead agency which has responsibility for ensuring access to health care through a wide range of programs for those who are uninsured, live in medically underserved areas, or have special health care needs such as people living with HIV/AIDS and people from different linguistic and cultural backgrounds. Through partnerships with States, local communities and universities, HRSA leverages funds to extend the reach of health care beyond Federal dollars.

INCREASING ACCESS TO HEALTH CARE FOR THE UNINSURED

Between 1988 and 1998 the number of uninsured grew by an average of one million people a year. Today, there are 42.6 million people in the U.S. who are uninsured and at least 48 million who lack access to a regular source of health care. Many of our Nation's uninsured and medically underserved people live in inner-city neighborhoods and rural communities where there are few or no physicians or health care services. Three-quarters of the uninsured are in families where at least one person is working full-time. The uninsured are hospitalized at least 50 percent more often than the insured for "avoidable hospital conditions."

Community Health Centers: The budget proposes a presidential initiative to strengthen the health care safety net for those most in need, by providing a $124 million increase, for a total of $1.3 billion for Community and Migrant Health Centers. These Centers deliver preventive and primary care services for the neediest, poorest, and sickest patients in rural and inner city areas,

Additional $124 million for Community and Migrant Health Centers will expand the delivery of primary health care services to up to an additional one million individuals.

through a Federal, State, and community partnership approach. In these areas, Community Health Centers, with the National Health Service Corps (NHSC), are a proven cost effective component of the health care safety net, serving 11 million people, including 625,000 migrant farm workers and their families.

The additional $124 million for Community and Migrant Health Centers will expand the delivery of primary health care services to up to an additional one million individuals by creating approximately 100 new sites and expanding service capacity at 100 existing sites. This increase is the first installment for a multi-year initiative to increase or expand community health center sites by 1,200.

COMMUNITY HEALTH CENTER SERVICES

	Actual FY 1999	Estimates FY 2001-2002
Mammograms	141,216	170,000
Pap Tests	944,483	1 million
Immunizations	1,795,211	2 million
HIV Tests	270,901	300,000

Reforming the National Health Service Corps: Since 1972, the NHSC, through its scholarship and loan repayment programs, has placed over 20,000 health care providers in areas with a health professions shortage.

Through a management reform presidential initiative, the NHSC will be better able to address the neediest communities. Examples of issues to be reviewed include examining the ratio of scholarships to loan repayments and other set-aside, as well as amending the Health Professional Shortage Area definition to reflect other non-physician providers practicing in communities. The NHSC initiative will also encourage more health care professionals to participate in the NHSC by making scholarship fund tax free. These efforts will enable the NHSC to better define shortage areas and better target placements.

ORGAN DONATION

Today, some 75,000 Americans are on waiting lists for organ transplantation. In 1999, organs were recovered from only 6,000 cadaveric donors, and 22,000 transplants were performed. That same year, 6,100 Americans died while awaiting a transplant. The budget request includes $20 million, an increase of $5 million to launch a new national effort to encourage organ donation. In the coming year, HRSA will expand public information on organ and tissue donation. HHS will also conduct national and regional ceremonies to honor donor families and living donors to further promote donor awareness. Ongoing efforts include grants to partner within the transplant, business, education, and religious communities to promote donor awareness, and grants will support demonstrations and studies of innovative approaches. Projects include identifying and implementing physician education strategies, working with attorneys to ensure donation discussions occur during estate planning, and conducting awareness campaigns with the clergy to promote donation within their congregations.

Today, 75,000 Americans are on waiting lists for organ transplantation... The budget request includes $20 million, an increase of $5 million to launch a new national effort to encourage organ donation.

ABSTINENCE AND ADOPTION ACTIVITIES

Each year approximately one million pregnancies occur among teenagers aged 15-19. Almost 190,000 teens 17 years and younger have children. Their babies are often of low birth weight and have disproportionately high infant mortality rates. Teen pregnancy and sexual activity remain significant problems in communities across the country. By focusing on abstinence and personal responsibility, HHS hopes to help develop young people's abilities to make the choices that will lead to successful futures.

Abstinence Education Grants: In FY 2001, HRSA began to implement a new Community-Based Abstinence Education program which will provide support to public and private entities for the development and implementation of Abstinence Education programs for adolescents, ages 12 through 18, in communities across the country. This funding targets planning and implementation of community-based, abstinence-only educational interventions designed to reduce the rate of births to teenagers, the proportion of adolescents who have engaged in sexual intercourse, and the proportion of teenagers who have engaged in risk behaviors, such as tobacco, alcohol, and drug use. The President's Budget includes $30 million, an increase of $10 million, for these grants in FY 2002. For FY 2002, up to 95 grants are anticipated, 25 more than FY 2001.

The request also includes the $50 million mandatory appropriation for Abstinence Education. This program provides grants to 59 States and territories to provide mentoring, counseling, and adult supervision to promote abstinence with a special focus on adolescents.

Adoption Awareness: The budget includes $10 million for adoption awareness activities. This program, first funded in FY 2001, will provide grants to organizations to develop and implement programs to train health centers and other clinics in providing adoption information and referrals to pregnant women. HRSA expects to fund 20 grants and train 600 health professionals. The program will also establish best practice guidelines on the provision of adoption information and referrals.

RYAN WHITE

The FY 2002 budget includes $1.8 billion for the Ryan White HIV/AIDS program, to maintain the FY 2001 level. The Ryan White CARE Act Amendments of 2000 improved and expanded access to care for persons with HIV/AIDS. The Amendments focus on: expanding services to HIV-infected individuals who are not currently receiving care; linking CARE Act providers with other points of access to the health care system; establishing quality management programs; focusing funds on health care services and support services that are health care related; and increasing the service capacity of underserved communities. The President's Budget will support services to approximately 500,000 persons and provide pharmaceuticals to 72,000 persons during the year with HIV/AIDS.

MATERNAL AND CHILD HEALTH

The budget request includes $709 million for the Maternal and Child Health Block Grant (MCH). The MCH Block Grant supports Federal and State partnerships to develop service systems to address the critical challenges in maternal and child health.

The budget also proposes $90 million for the Healthy Start program which supports programs to reduce low birth weight, inadequate prenatal care, and other factors contributing to infant mortality, in targeted high risk communities. This program which previously had been operating as a national demonstration program was authorized in the Children's Health Act of 2000.

Targeting racial, ethnic, geographical and other disparate populations, the program will support 103 projects in FY 2002.

FAMILY PLANNING

The Family Planning program supports a network of 4,600 clinics nationwide serving more than 4.5 million people. Of these people, 89 percent have incomes below 200 percent of Federal poverty guidelines; 77 percent are below 30 years of age. These clinics provide access to such reproductive health care and preventive services as counseling, routine gynecological care, hypertension screening, screening and referrals for breast and cervical cancer, and substance abuse. Abstinence counseling and education are an important part of the program service protocol for adolescent clients. The FY 2002 budget request includes $254 million, maintaining the FY 2001 support for Title X family planning activities.

PROGRAM MANAGEMENT

The President's Budget requests an additional $9 million to HRSA. This increase will be used to meet Federal pay cost increases. It also includes $5 million for information technology activities to improve data coordination across the various grant programs.

REDIRECTED RESOURCES

One-Time Projects: The FY 2002 budget does not continue one-time projects for which $327 million was appropriated in FY 2001. This total includes $251 million in Health Care Facilities, $58 million in rural health and telehealth activities, $10 million in the Denali Commission, $5 million in the Maternal and Child Health Block Grant for special projects, and $3 million in Program Management.

Community Access Program: The budget recommends eliminating $125 million appropriated by Congress in FY 2001, for the relatively new, unproven, categorical Community Access Program. The Department will be working to integrate health care services and give States greater flexibility to merge and align health care delivery through existing channels, such as Medicaid waivers, the State Children's Health Insurance Program (SCHIP), and the Community Health Centers Integrated Services Delivery Initiative. Further, Community Health Centers and Medicaid have proven to be effective mechanisms for increasing access to care and health insurance coverage for the uninsured.

Health Professions: The budget includes $140 million, a $213 million reduction. These training grants were created almost 40 years ago when a physician shortage was looming. Today, a physician shortage no longer exists. To reflect changing priorities, the budget will recommend focusing resources on the Health Professions grants that address current health workforce supply challenges, such as the impending nursing shortage.

Children's Hospitals Graduate Medical Education: The FY 2002 budget includes a significant investment of $200 million to support health professions training in free-standing children's hospitals. The budget proposal represents an effort to moderate spending. Congress, in FY 2001, expanded the program from $40 million to $235 million.

Small Categorical Programs: The budget includes a total of $41 million, a reduction of $9 million, for four small categorical programs including Universal Newborn Hearing Screening, Emergency Medical Services for Children, Poison Control Centers, and Trauma/Emergency Medical Services. These programs have received substantial funding increases in the past two years.

OTHER HRSA PROGRAMS

The budget proposes $144 million for the remaining HRSA programs including Rural Health, Telehealth, State Planning Grants, Bone Marrow, Hansen's Disease, Black Lung, and Nursing Loan Repayment.

In addition, funds are not requested for the Ricky Ray Hemophilia Relief Fund. The total funding appropriated to date, $655 million, is estimated to be sufficient to make payments on all eligible petitions received to date.

HRSA OVERVIEW

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Community Health Centers	$1,019	$1,169	$1,293	+$124
National Health Service Corps	114	125	126	+1
Organ Transplantation	10	15	20	+5
Abstinence Education (Advance from Prior Year)	0	20	30	+10
Abstinence Education Grants to States	50	50	50	0
Adoption Awareness	0	10	10	0
Ryan White HIV/AIDS Activities	1,594	1,808	1,808	0
(AIDS Drug Assistance Program)	*528*	*589*	*589*	*0*
Maternal and Child Health Block Grant	709	714	709	-5
Healthy Start	90	90	90	0
Family Planning	239	254	254	0
Program Management	131	145	154	+9
Health Care Facilities	118	251	0	-251
Rural Health/Telehealth	98	137	79	-58
Denali Commission	0	10	0	-10
Community Access Program	25	125	0	-125
Health Professions Programs	302	353	140	-213
Children's Hospitals Graduate Medical Education	40	235	200	-35
Universal Newborn Hearining Screening	3	8	7	-1
EMS for Children/Poison Control Centers	20	39	32	-7
Trauma/Emergency Medical Services	0	3	2	-1
State Planning Grants	15	15	15	0
Bone Marrow	18	22	22	0
Hansen's Disease	22	20	20	0
Black Lung/Facilities/Nursing Loan	8	8	8	0
Ricky Ray Hemophilia Relief Program	75	580	0	-580
National Practitioner Databank (User Fees)	14	17	17	0
Health Integrity & Protection Databank (User Fees).	3	4	8	+4
Total, HRSA Program Level	**$4,717**	**$6,227**	**$5,094**	**-$1,133**
Less Funds Allocated From Other Sources:				
Abstinence Education Grants to States	50	50	50	0
Ricky Ray Hemophilia Relief Program	75	580	0	-580
User Fees	17	21	25	+4
Subtotal, Funds From Other Sources	**$142**	**$651**	**$75**	**-$576**
Total, HRSA Discretionary B. A.	**$4,575**	**$5,576**	**$5,019**	**-$557**
FTE	2,054	2,268	2,244	-24

INDIAN HEALTH SERVICE

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Program Level.....	$2,857	$3,204	$3,311	+$107
FTE.....	14,676	14,824	14,958	+134

SUMMARY

The Indian Health Service (IHS) FY 2002 budget request is $3.3 billion, a net increase of $107 million over FY 2001. Additional funds are requested to cover the increased costs of providing health services to eligible Indian people and to support Indian Self-Determination by moving from Federally run to tribally run programs. IHS will also receive $499 million in health insurance reimbursements in FY 2002, a projected increase of $29 million compared to FY 2001. These reimbursements are primarily from Medicare and Medicaid.

AGENCY DESCRIPTION

IHS provides care to 1.5 million American Indians and Alaska Natives who are members of 556 Federally recognized Tribes. Care is provided directly in 49 hospitals and over 500 outpatient clinics and smaller facilities located primarily in Alaska, along the Pacific Coast, the Southwest, Oklahoma, and the Northern Plains. IHS also purchases medical care from private sector hospitals and health professionals; the FY 2002 budget includes $446 million for purchased care. Other services include preventive health (including mental health care and alcohol/substance abuse prevention and treatment), construction of waste water and solid waste disposal systems for Indian homes and funding for 34 urban Indian programs.

In many areas, Tribes are responsible for managing their health services. Currently, Tribes are responsible for about 53 percent of appropriated funds. The Navajo Nation has submitted a proposal to move to a tribally managed health care program that serves its 250,000 tribal members. Implementation of this contract would give Tribes management responsibility over 62 percent of IHS's appropriated funds in FY 2002.

CONTINUED PROVISION OF HEALTH SERVICES

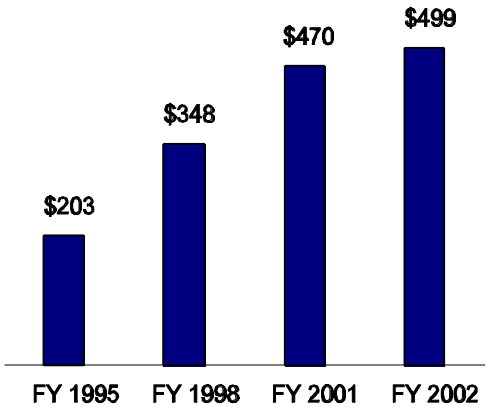
The number of people eligible for IHS services increases at about two percent annually. Like any health care provider, IHS experiences increases in the cost of providing services.

The budget includes an additional $55 million to fully cover increased pay costs for IHS's Federal employees (14,824 FTE) and to allow tribally run health programs to provide comparable pay raises to their own staff. An additional $11 million is also included to staff the new outpatient clinic serving the Colorado River Tribes at Parker, Arizona and to begin staffing the new Fort Defiance hospital which will open late in FY 2002. A $4 million increase is also included to upgrade IHS's information

infrastructure, in order to make its information systems better able to respond to data requests.

Increasing IHS Health Insurance Reimbursements: In FY 2002, IHS will receive an estimated $499 million in health insurance reimbursements – primarily from Medicare and Medicaid. IHS and the Health Care Financing Administration have worked cooperatively to develop a cost-based reimbursement methodology to better reflect the full cost of providing services. For example, IHS health facilities will receive $185 for each Medicaid outpatient visit in 2001, an increase of eight percent over the amount received in 2000. This methodology, together with better efforts to enroll eligible Indian people and legislative changes expanding the scope of covered services, has led to an increase in health insurance reimbursements of 146 percent since FY 1995.

IHS HEALTH INSURANCE REIMBURSEMENTS
(dollars in millions)



The recently enacted Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 allows IHS to begin to receive Medicare reimbursements for services provided by physicians and other health care professionals covered under the Medicare fee schedule. This new legislative authority, together with the 2001 rate increases, will increase insurance reimbursements by $29 million over FY 2001.

Diabetes: The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 increased IHS's annual diabetes funding to $100 million through FY 2003, up from $30 million in FY 2000. These funds increase services to American Indian and Alaska Native people, consistent with the lessons learned through existing diabetes prevention and treatment programs at clinical and community sites. For example, foot care programs in Minnesota have reduced amputations while school health programs in Nebraska have increased physical activity to reduce childhood obesity, a risk factor for diabetes. To assist local diabetes programs, IHS has already developed 15 best practices models including cardiovascular risk, primary prevention, pharmaceuticals, and blood sugar improvement.

Diabetes prevalence among Indian people is now triple the rate for non-Hispanic whites. IHS began funding 318 diabetes programs throughout Indian country in FY 1998. Seventy percent of programs have increased their emphasis on diabetes prevention for adults (e.g., diet, exercise, blood pressure control) while 56 percent have increased emphasis on diabetes prevention for children (e.g., increased physical activity). Prevention is a primary focus. Estimates of the average cost of a diabetic's care ranges from $5,000 to $9,000 annually. IHS has increased the number of diabetic patients with improved glycemic and blood pressure

Diabetes prevalence among Indian people is now triple the rate for non-Hispanic whites... IHS has increased the number of diabetic patients with improved glycemic and blood pressure control to reduce their need for costly medical care.

control to reduce their need for costly medical care.

Increasing Equity Among Tribes: A high priority of the IHS is to provide comparable levels of health services to Tribes across Indian country. The FY 2002 budget includes a further increase of $8 million to address equity among Tribes.

SUPPORTING INDIAN SELF-DETERMINATION

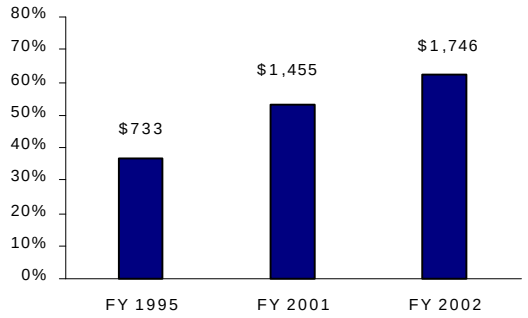
A rapidly growing number of Tribes have chosen to assume responsibility for providing their own health care by entering into self-determination contracts with the IHS. Tribes currently operate one-fourth of IHS hospitals, three-quarters of the outpatient facilities, and 53 percent of the budget, up from 37 percent in FY 1995.

Beginning on January 1, 2002, the Navajo Nation has proposed to assume responsibility for health services for its 250,000 tribal members, including 6 hospitals and 19 outpatient facilities, with a FY 2001 budget of $349 million. Under the proposed Navajo contract, Tribes will control 62 percent of the IHS budget in FY 2002.

The Navajo Nation has proposed to assume responsibility for health services for its 250,000 tribal members.

The budget includes a total of $50 million primarily to support transition of Navajo health services from Federal to tribal management and to support similar transitions for other Tribes. Of this $50 million, $40 million is included for additional Contract Support Costs to allow Tribes, such as the Navajo Nation, to develop the administrative infrastructure necessary to efficiently operate their health care programs.

PERCENT OF IHS FUNDS MANAGED BY TRIBES



Within the $50 million, $10 million is included for the transitional costs IHS will incur in transferring responsibility for health services to the Navajo Nation. This will be the largest health services transfer ever undertaken by the IHS; nearly 3,600 Federal employees, 24 percent of the Agency's total workforce, currently provide services to the Navajo Nation.

FACILITY CONSTRUCTION

The budget includes $38 million for construction of new health facilities. A total of $14 million is requested for Fort Defiance. These funds will complete the hospital portion of the complex and begin building the staff quarters which are needed for this remote facility that serves the Navajo Tribe in Arizona and New Mexico. Within the total, $24 million is included to fully fund the construction of the new Winnebago hospital serving the Winnebago and Omaha Tribes in Nebraska.

REDIRECTED RESOURCES

The budget request does not continue funding for two facility construction programs: Joint Venture Demonstration Projects and the Small Ambulatory Facility Program. Both programs were first funded by Congress in FY 2001 for a total of $15 million. The budget request does not include funds for three one-time projects totaling $4 million in FY 2001.

IHS OVERVIEW

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Indian Health Service:				
Clinical Services	$2,064	$2,267	$2,361	+$94
Contract Health Services (Non-Add)	*407*	*446*	*446*	*0*
Preventive Health	92	96	100	+4
Contract Support Costs	229	248	288	+40
Tribal Management/Self Governance	12	12	12	0
Urban Health	28	30	30	0
Indian Health Professions	30	30	30	0
Direct Operations	51	53	66	+13
Diabetes Grants /1	30	100	100	0
Subtotal, Services Program Level	**$2,536**	**$2,836**	**$2,987**	**+$151**
Indian Health Facilities:				
Health Facility Construction	$50	$86	$38	-$48
Sanitation Construction	92	94	94	0
Facility & Environmental Health Support	116	121	126	+5
Maintenance & Improvement	48	51	50	-1
Medical Equipment	15	16	16	0
Subtotal, Facilities Program Level	**$321**	**$368**	**$324**	**-$44**
Total, Program Level	**$2,857**	**$3,204**	**$3,311**	**+$107**
Less Funds Allocated From Other Sources:				
Health Insurance Collections	-$431	-$470	-$499	-$29
Rental of Staff Quarters	-5	-5	-5	0
Diabetes Grants /1	-30	-100	-100	0
Total, Budget Authority	**$2,391**	**$2,629**	**$2,707**	**+$78**
FTE	14,676	14,824	14,958	+134

/1 These Mandatory Funds were originally appropriated in the Balanced Budget Act of 1997

CENTERS FOR DISEASE CONTROL AND PREVENTION

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Program Level.....	$3,342	$4,202	$4,093	-$109
FTE.....	7,862	8,165	8,267	+102

SUMMARY

The FY 2002 budget requests a total of $4.1 billion for the Centers for Disease Control and Prevention (CDC), a net decrease of $109 million, or three percent, below FY 2001. This includes $122 million in program increases, offset by reductions of $231 million. The FY 2002 budget for CDC includes $127 million in Public Health Service evaluation interagency transfer funds for activities related to Health Statistics.

CDC is the lead public health agency for promoting health and quality of life by preventing and controlling disease, injury and disability. CDC works with States, local public health agencies, and partners throughout the Nation and the world to accomplish this mission. Together, they monitor health, detect and investigate disease outbreaks and other health problems, conduct research, develop and advocate sound health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthy environments, and provide public health leadership and training.

MODERN, SECURE LABORATORIES AND FACILITIES

The work conducted in laboratories at CDC is relied upon worldwide to help control disease outbreaks and prevent illness and injury. For example, the labs house one of the two official reference samples of smallpox, and analysis carried out at the labs was instrumental in identifying the first cases of West Nile virus ever found in North America.

The FY 2002 budget includes $150 million for Buildings and Facilities. A priority focus is construction of an infectious disease laboratory, an environmental laboratory, and in FY 2003, a communication and training facility. In FY 2002, CDC will use $52 million of these funds for Phase II construction of a facility that includes laboratories dedicated to the most highly infectious and lethal pathogens handled at CDC, and a related central utility plant. The new facility will include a Biosafety Level 4 laboratory for research on diseases that need to be highly contained such as Ebola, hantavirus and Congo-Crimean hemorrhagic fever. Also included at the planned facility will be labs to support work on infectious disease agents that could potentially be used by terrorists.

Work conducted in laboratories at CDC is relied upon worldwide to help control disease outbreaks and prevent illness and injury.

Second, $84 million will begin construction of the Environmental

Toxicology Lab at the Chamblee Campus. This facility includes core lab space for bioterorism preparedness activities at the National Center for Environmental Health.

An additional $14 million will be allocated to the ongoing maintenance of existing laboratories and support structures. The funding for these projects is included in the line item "Buildings and Facilities."

RESPONDING TO BIOTERRORIST THREATS

The budget includes $182 million, an increase of $1 million for CDC bioterrorism preparedness. This includes $13 million in program increases, offset by $12 million in reductions to programs that received one-time funding in FY 2001. New technologies have made it easier for terrorists to use biological and chemical weapons against civilian populations. Some possible scenarios could include the covert release of biological agents, such as smallpox or anthrax. State and local public health officers must be able to detect potential bioterrorist events and mount control measures quickly if they are to prevent widespread death, disability and societal disruption caused by terrorist attacks.

State and local public health officers must be able to detect potential bioterrorist events and mount control

The budget includes $77 million, an increase of $10 million, or 14 percent above FY 2001, for State and local bioterrorism preparedness. This includes funding for epidemiological and laboratory enhancements, the detection of outbreaks, and the Health Alert Network, CDC's electronic communications effort to provide Internet connectivity to community public health departments. Awards are made to public health departments in all fifty States and New York City, Los Angeles, Chicago and Washington D.C. Funds also will support laboratory regulation of hazardous biological and chemical agents. An additional $10 million will support national planning efforts and the development of a bioterrorism action plan.

Funds totaling $22 million will upgrade capacity at CDC, including continued development of a rapid toxic screen that can quickly identify up to 150 chemical threats; additional training for the Epidemic Intelligence Service; and increased biological lab capacity, including further development of a Rapid Response and Advanced Technology (RRAT) Lab at the National Center for Infectious Diseases. The RRAT lab specializes in the triage and analysis of biological specimens suspected as potential agents of terrorism.

The budget proposes $52 million for the National Pharmaceutical Stockpile that will be used in the event of a bioterrorist attack. The stockpile is being developed to respond to threats posed by smallpox, anthrax, plague, botulism, tularemia and hazardous chemical agents.

Also included in the budget is $18 million to continue research evaluations of the anthrax vaccine used to innoculate military personnel. Activities supported by these funds include monitoring adverse events and analyzing dose requirements.

INFECTIOUS DISEASES

Conquering many infectious diseases was one of the greatest triumphs of 20th century medicine and public health. However, the U.S. continues to confront a new infectious disease threat each year including, Ebola virus, hantavirus, lyme disease, toxic shock syndrome, Hong Kong flu, Nipah virus and West Nile virus. In addition, foodborne diseases are estimated to cause 5,000 deaths and 76 million illnesses in the U.S. each year.

The budget includes $332 million to fight infectious diseases, an increase of

$14 million, or four percent, over FY 2001. This budget activity includes efforts to reduce emerging infectious and foodborne diseases, improve patient safety, and provide laboratory support for HIV/AIDS, tuberculosis and immunization programs.

The budget increase will be used to expand assistance to States and localities to strengthen their capacity to detect and prevent the spread of infectious diseases. Funds also will increase efforts to prevent and control Hepatitis C, and increase sentinel surveillance of influenza, including novel strains that could cause a global pandemic.

Patient Safety: Medical errors are estimated to cause thousands of deaths and cost $29 billion in excess health care expenditures in the U.S. each year. CDC will use a portion of the budget increase for infectious diseases to work with the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Health Care Financing Administration to develop a unified reporting system for partnering hospitals to make it easier for providers to communicate information on adverse events. CDC will use information it receives through the Sentinel Patient Safety Network to help reduce hospital-acquired infections.

HIV/AIDS, STDs AND TB

Over the last two decades, HIV/AIDS prevention and treatment have advanced dramatically. Annually, the number of new AIDS cases in the U.S. continues to decline. However, new HIV cases still number over 40,000 each year. Worldwide, 16,000 people become infected each day, including 1,600 infants through mother-to-child transmission. The budget includes $1.1 billion for prevention and control of HIV/AIDS, sexually transmitted diseases and Tuberculosis, an increase of $24 million, or two percent over FY 2001. Within the increase, $20 million is for domestic and international prevention of HIV/AIDS.

Domestic HIV efforts will be refocused to help States reduce the number of new infections 50 percent by 2005.

Domestic HIV efforts will be refocused to help States reduce the number of new infections 50 percent by 2005. The budget includes an $11 million increase for CDC's domestic HIV/AIDS prevention activities, including expanded local efforts that will increase the number of people who know their HIV status, and link infected individuals to prevention, care and treatment services.

To combat global AIDS, the budget contains $117 million, an increase of $12 million, or 11 percent, above FY 2001. It is estimated that 22 million people live with HIV in sub-Saharan Africa and cumulative AIDS deaths in the region total over 12 million, more than 80 percent of all AIDS deaths since the epidemic started. Funds will support improved surveillance, voluntary counseling and testing, and care, treatment and prevention of mother-to-child transmission.

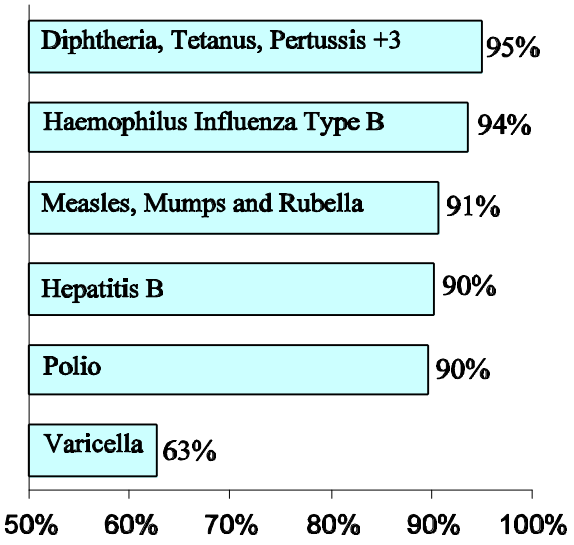
CHILDHOOD IMMUNIZATION

Delivery of safe and effective vaccines is the most cost-effective method of preventing illness. The goal for the year 2002 is to ensure that at least 90 percent of all two-year-olds receive the full series of vaccines and that a vaccination system is built that will sustain and further improve high coverage levels. Immunization rates at or above 90 percent for all children under age three are the best way to prevent outbreaks of vaccine preventable diseases.

The FY 2002 immunization budget is $1.4 billion, an increase of $42 million, or three percent, over the FY 2001 current estimate. This includes $575 million in discretionary appropriations to CDC, and $796 million for the Vaccines for Children

(VFC) program. Over 2 million newborns each year depend upon CDC funded vaccines.

U.S. PERCENTAGE OF IMMUNIZED CHILDREN 19 TO 35 MONTHS



The FY 2002 budget requests $107 million, an increase of $1 million, for global immunization activities, including polio eradication. While world-wide polio cases were reduced by an estimated 95 percent between 1988 and 2000, a major international increase in effort will be needed to reach the World Health Organization's goal to certify global polio eradication by 2005.

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, AND HEALTH

The Children's Health Act of 2000 called for CDC to establish a new Birth Defects and Developmental Disabilities Center. This center will carry out a range of activities previously funded in Environmental Health, including prevention of autism, fetal alcohol syndrome and spina bifida. The FY 2002 budget proposes $76 million, an increase of $6 million, or eight percent for these programs. This includes $11 million in program increases, offset by $5 million in reductions to programs that received one-time funding in FY 2001. Activities to be addressed by this new center include: education and outreach, to increase consumption of folic acid; pilot programs, for attention-deficit, hyperactivity disorder; and increased surveillance and new State programs that will promote optimal childhood development.

OCCUPATIONAL SAFETY AND HEALTH

The National Institute for Occupational Safety and Health (NIOSH) establishes and disseminates scientific and public health information necessary to ensure safe and healthful working conditions for millions of American working men and women. Research will continue to address solutions to occupational disease and workplace safety concerns in those fields where the dangers are the greatest.

The budget includes $266 million for NIOSH, an increase of $6 million, or two percent over the FY 2001 level. This increase will support the National Occupational Research Agenda (NORA), NIOSH's research program developed cooperatively with academic centers and industry.

Energy Employees Occupational Illness Compensation Act of 2000: In addition to its on-going activities, NIOSH will assist in the implementation of the Energy Employees Occupational Illness Compensation Act of 2000. Sixty million in mandatory funding was appropriated to the Department of Labor (DOL) in FY 2001 for administrative costs, which can be transferred to various Federal agencies depending on their workload. The FY 2002 budget includes $136 million in DOL, an increase of $76 million over FY 2001, for the various agencies' administrative costs.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Of the top ten causes of death, chronic diseases account for the first four – heart disease, cancer, stroke and chronic

obstructive pulmonary diseases. CDC supports numerous ongoing activities designed to prevent chronic diseases including cardiovascular disease, diabetes, arthritis and cancer. Chronic disease programs provide over 200,000 breast and cervical cancer screenings annually and promote proper diet, exercise and tobacco-use reduction.

The budget includes $575 million for Chronic Disease Prevention and Health Promotion, a decrease of $175 million, or 23 percent, below FY 2001. This reflects $27 million in reductions to programs that received one-time funding in FY 2001, not continuing a new $125 million youth media campaign, and $23 million in reallocations to support new initiatives.

ENVIRONMENTAL HEALTH

The budget includes $137 million for environmental disease prevention. This includes $3 million in program increases, offset by $4 million in reductions to programs receiving one-time funding in FY 2001. CDC supports a comprehensive environmental health program that includes assessments of human exposure to toxic contaminants, prevention of asthma and childhood lead poisoning, public health genetics, and emergency response to chemical and radiological disasters.

EPIDEMIC SERVICES AND RESPONSE

CDC's epidemiologists are the "disease detectives" that determine the cause of outbreaks and develop the countermeasures that stem the spread of illness. The FY 2002 budget includes $80 million, an increase of $3 million, or four percent above FY 2001, for the Epidemic Services and Response Program. Funds will support training activities, such as the Field Epidemiology Training Program (FTEP), which prepares public health practitioners in other countries to detect and respond to disease outbreaks.

PUBLIC HEALTH IMPROVEMENT

The new Public Health Improvement budget line funded at $110 million brings together cross-cutting activities that seek to improve the overall public health system. A primary goal of this program is to upgrade the public health infrastructure by developing integrated computer-based surveillance and electronic communications systems, such as the National Electronic Disease Surveillance System (NEDSS). Funds also will support CDC's Public Health Practice Program Office (PHPPO), which provides training and performance measurement of public health activities at the State, local and national level; the Racial and Ethic Approaches to Community Health (REACH 2010) demonstration projects, which seek to eliminate racial disparities in health in areas including chronic and infectious diseases; and Prevention Research.

INJURY PREVENTION

Nearly 150,000 Americans die each year from injuries. The budget includes a total of $144 million for injury prevention efforts, an increase of $1 million over FY 2001. This includes $45 million previously funded through the Crime Bill and displayed as part of the Preventive Health Block Grant.

CDC will continue an emphasis on preventing violence against women and youth violence by developing a National Violent Death Reporting System and continuing to expand the National Resource Center for Youth Violence Prevention.

HEALTH STATISTICS

The budget includes $127 million, an increase of $5 million over the FY 2001 level, for health statistics. In FY 2002, NCHS will support the National Health Interview Survey, the National Health and Nutrition Examination Survey, the National Vital Statistics System, and the National Health Care Survey. These surveys, along

with NCHS research and analytic programs, provide information critical to monitoring the dynamics of health and health care, and provide the underpinnings for biomedical research, health policy, and public health practice. The budget requests that CDC's health statistics program be financed entirely by PHS evaluation funds in FY 2002.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

ATSDR is managed as part of CDC and performs public health activities related to Superfund Toxic Waste sites. These include health consultations, epidemiological surveillance, profiles of the health effects of hazardous substances, and education of health care providers near Superfund sites. The budget includes $78 million for ATSDR, an increase of $3 million over the FY 2001 level. ATSDR is funded through the Veterans Affairs, Housing and Urban Development appropriations subcommitee. Prior to FY 2001, ATSDR was funded through the Environmental Protection Agency.

PREVENTIVE HEALTH BLOCK GRANT

The FY 2002 budget includes $135 million for the Preventive Health and Health Services Block Grant (PHHSBG), the same level as FY 2001. Funds totaling $45 million provided previously through the Crime Bill and included in the Block Grant budget activity line will now be included within Injury Prevention.

The PHHSBG provides States with funds for preventive health services including emergency medical services, school-based fluoridation and the control of rodents. Block grant funds also may be used to achieve progress toward the Healthy People 2010 goals, especially in areas of cardiovascular disease, cancer and public health education.

HEALTHY COMMUNITIES INITIATIVE

The FY 2002 President's Budget seeks to encourage State and local innovations that target health risks such as heart disease, increased access to care, and higher quality care. Nine programs in CDC, HRSA and HCFA, which total about $400 million annually are included in the initiative. This includes about $185 million in CDC programs for cardiovascular disease, diabetes, prostate cancer, tobacco use, and demonstration projects to reduce racial and ethnic health disparities (REACH 2010).

OFFICE OF THE DIRECTOR

CDC is engaged in an on-going, aggressive strategy to improve financial management of its disease prevention programs. Several recent external reviews of fiscal practice found a commitment to excellence, but needed upgrades of outdated systems and practices. The FY 2002 budget includes $49 million, an increase of $8 million, or 19 percent, over FY 2001. Of this increase, $4 million is to replace CDC's aging accounting system with an enterprise-wide business solution. Additional funds will support management training activities to continue skills development of financial staff.

NEW BUDGET STRUCTURE

The FY 2002 President's Budget includes a revised budget structure for CDC which more closely aligns funding with the centers, institutes and offices that manage these programs. For example, in the FY 2001 budget, the Infectious Disease budget activity provided funding for six centers and offices at CDC, while the National Center for Infectious Diseases (NCID) received funding from seven budget activities. In the FY 2002 budget, all funding in the Infectious Disease line will be for NCID programs. Similarly, NCID will

receive funding only for Infectious Diseases and through cross-cutting activities. Other funding that has gone to NCID is reclassified as infectious disease funding. FY 2000 and FY 2001 appropriations are displayed comparably so that policy increases and decreases are clearly represented.

The budget display reduces the number of activity lines from nineteen to fifteen, and reduces the number of sub-activities by an estimated 70 percent. This information will be supplemented with estimates of spending on specific diseases which CDC, like NIH, will post on its website (www.cdc.gov).

CDC OVERVIEW

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Centers for Disease Control & Prevention:				
Infectious Disease Control	$254	$318	$332	+$14
Immunization	475	553	575	+22
HIV/AIDS, STDs & TB Prevention	854	1,044	1,068	+24
Birth Defects, Disability & Health	50	70	76	+6
Chronic Disease Prevention & Health Promotion	531	750	575	-175
Environmental Health	88	137	137	-1
Epidemic Services & Response	69	77	80	+3
Occupational Safety & Health	226	260	266	+6
Injury Prevention & Control	132	143	144	+1
Health Statistics	112	122	127	+5
PHS Evaluation (non-add)	*72*	*72*	*127*	*+55*
Preventive Health Block Grant	135	135	135	0
Public Health Improvement	92	111	110	-1
Buildings & Facilities	57	175	150	-25
Office of the Director	39	42	49	+8
ATSDR (VA/HUD Appropriation)	70	75	78	+3
Bioterrorism	153	181	182	+1
Diabetes (Mandatory Funding)	3	7	7	0
User Fees	2	2	2	0
Subtotal, Program Level	**$3,342**	**$4,202**	**$4,093**	**-$109**
Less Funds Allocated from Other Sources:				
Health Statistics (PHS Evaluation)	-72	-72	-127	-55
Diabetes	-3	-7	-7	0
User Fees	-2	-2	-2	0
Total, Budget Authority	**$3,265**	**$4,121**	**$3,957**	**-$165**
Labor/HHS Appropriation	**$3,195**	**$4,047**	**$3,879**	**-$168**
VA/HUD Appropriation	**$70**	**$75**	**$78**	**+$3**
FTE	7,862	8,165	8,267	+102

NATIONAL INSTITUTES OF HEALTH

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Budget Authority.....	$17,867	$20,361	$23,112	+$2,751
FTE.....	16,022	17,434	17,960	+526

SUMMARY

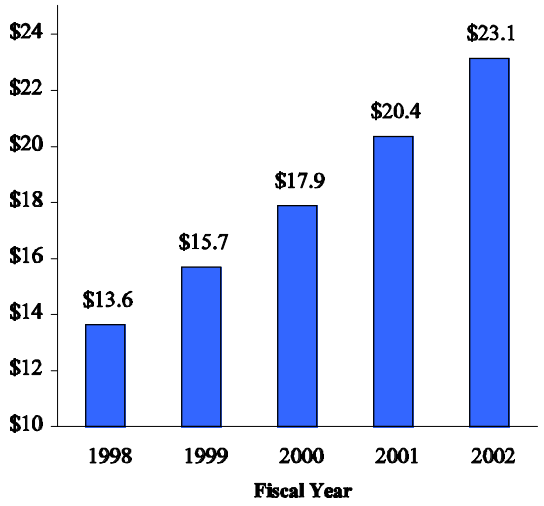
The FY 2002 budget requests $23.1 billion for the National Institutes of Health (NIH), an increase of $2.75 billion, or 13.5 percent, over the FY 2001 level. The request reflects a Presidential initiative to double NIH's FY 1998 funding level by FY 2003, with FY 2002 representing the fourth installment of this five-year plan. This proposed expansion for FY 2002 would be the largest year-to-year dollar increase ever for NIH, and reflects nearly a 70 percent increase over FY 1998.

Expansion for FY 2002 would be the largest year-to-year dollar increase ever for NIH.

NIH is the world's largest and most distinguished organization dedicated to maintaining and improving health through medical science. The research that is conducted and supported by NIH ranges from basic research exploring the fundamental workings of biological systems, to studies that examine disease and treatments in clinical settings, to prevention, and to population-based studies of health status and needs. These cutting-edge efforts offer the promise of breakthroughs in preventing and treating any number of diseases.

NIH's budget is composed of 27 appropriations for its Institutes and Centers, Office of the Director, and Buildings and Facilities. The missions of individual Institutes and Centers may focus on a given disease, such as cancer, mental illness, or infectious diseases; on a particular organ, such as the heart, kidney, or eye; or on a stage of development, such as childhood or old age. In other instances, a mission might encompass cross-cutting needs and opportunities, such as the development of research resources or the sequencing and mapping of the human genome.

NIH TOTAL FUNDING
(dollars in billions)



Approximately 84 percent of the funds appropriated to NIH flows out to the

extramural community, which supports work by more than 50,000 researchers affiliated with about 2,000 universities, hospitals, and other research facilities. A small percentage of the budget – approximately 11 percent – supports a core program of basic and clinical research activities administered and staffed by NIH's own physicians and scientists. Another four percent provides for research management and support and overall agency administration. In FY 2002, approximately one percent of the budget is devoted to replacing, modernizing, and repairing NIH's intramural research facilities.

With its recent large infusion of resources, NIH has worked diligently to make sure that those resources are managed properly. The agency is in the process of developing additional strategies to ensure that the FY 2002 and subsequent increases are spent in the most efficient and effective way, with an eye to maximize budgetary and management flexibility in the future.

With its recent large infusion of resources, NIH has worked diligently to make sure that those resources are managed properly.

RESEARCH THEMES

With the increase requested for FY 2002, NIH plans to focus on four broad areas which it believes have the greatest potential for yielding new scientific knowledge that can lead to innovative strategies for diagnosing, treating, and preventing disease. These areas of unprecedented scientific opportunities include:

Genetic Medicine: The recent deciphering of the human genetic code is one of the greatest achievements in the history of science. This draft map of the human genome, as well as those of animal models, provides researchers with a means of understanding the most basic elements of human form and function and the role of each gene or combinations of genes in human health and disease. This information can then be used, for example, to develop improved diagnostic techniques and individualized therapies with greater effectiveness and fewer side effects.

Clinical Research: Successfully translating advances in understanding fundamental human biology into improvements in human health requires clinical research. NIH plans to continue its efforts to reinvigorate clinical research by recruiting, training, and retaining clinical investigators; strengthening clinical research centers; and supporting clinical trials, networks, and databases in many disease areas, such as HIV/AIDS, diabetes, tuberculosis, malaria, neuro-degeneration; and mental illness.

Interdisciplinary Research: Increasingly, opportunities for medical research advances are requiring biological scientists to work with experts in other allied fields, such as chemistry, mathematics, physics, computer science, and engineering. By harnessing this interdisciplinary expertise, faster progress can be made in, for example, designing new drugs; imaging molecules, chromosomes, cells, and organs; developing biomaterials; and analyzing the wealth of data being generated about genetic, molecular, and cellular events and how they interact clinically.

Health Disparities: A key component of the Nation's effort to eliminate health disparities among populations in the U.S. is medical research and research training, and NIH plans to expand its support of these activities. NIH has spent much of the past year developing a Trans-NIH Strategic Plan for Health Disparities. This plan will serve to connect all the components of NIH in constructive, multidisciplinary collaborations leading to a better understanding of the causes of health disparities; new and

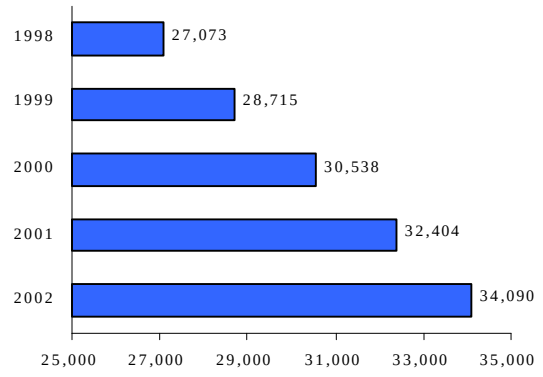
improved prevention strategies, diagnostics, and treatments to reduce health disparities; an expanded scientific workforce committed to this goal; and enhanced communication of research results to scientists, health professionals, affected communities, and the public.

The FY 2002 President's Budget also requests $158 million for the recently established National Center on Minority Health and Health Disparities (NCMHD). This represents an increase of $26 million, or 20 percent, over the FY 2001 level. These additional funds will be used to establish a Centers of Excellence program to conduct research on minority health and health disparities, and support research training and two new loan repayment programs for extramural minority and health disparities researchers.

RESEARCH PROJECT GRANTS

The support of basic medical research through competitive, peer-reviewed, and investigator-initiated research project grants (RPGs) represents 54 percent of NIH's total budget.

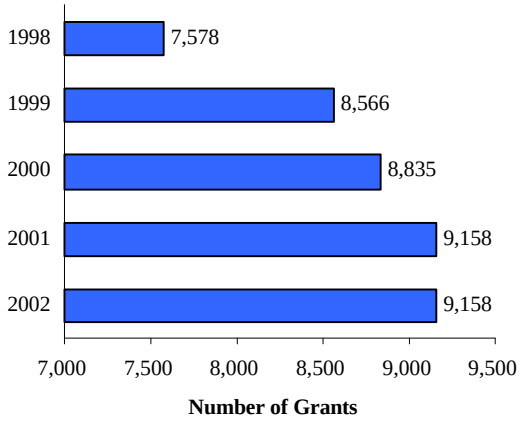
TOTAL RPGS



In FY 2002, the NIH budget provides $12.5 billion, a 12.6 percent increase over FY 2001, to fund 34,090 total projects, the highest level in the agency's history. This is 1,686 more grants in total than are expected to be funded in FY 2001.

Within this total, NIH estimates it will support 9,158 new and competing RPGs in FY 2002, the same number as in FY 2001 and itself a record high. NIH plans to adjust the average value of new and competing RPG awards by 4.3 percent to reflect projected increases in the costs of carrying out biomedical research and development. This will raise the average cost of a new research start to about $348,000, a 36 percent increase over FY 1998.

NEW AND COMPETING RPGS



HIV/AIDS RESEARCH

The FY 2002 budget includes a total of $2.5 billion for AIDS-related research in the budgets of the NIH Institutes and Centers, as jointly determined by the Director of NIH and the Director of NIH's Office of AIDS Research. This is an increase of $258 million, or 11.5 percent over the FY 2001 level. It represents a 56 percent increase in funding for NIH AIDS-related research since FY 1998.

In FY 2002, funding will be guided by NIH's comprehensive AIDS research plan, developed by the NIH Office of AIDS Research, in consultation with the Institutes and Centers. Four major themes frame the FY 2002 Plan: 1) prevention research to reduce HIV transmission here in the U.S. and around the world; 2) therapeutic research to treat those already infected;

3) international research priorities, particularly to address needs in developing countries; and 4) research targeting the disproportionate impact of AIDS on minority populations in the U.S.

HIV/AIDS prevention research includes a focus on developing a safe and effective vaccine; understanding how to change the behaviors that lead to HIV transmission; developing effective and acceptable female-controlled chemical and physical barrier methods to reduce the spread of HIV; and exploring lower-cost alternatives to reduce transmission from infected mothers to their infants. NIH funding for AIDS vaccine research will grow to $357 million, a 27 percent increase over FY 2001 and 141 percent over FY 1998.

Funding for AIDS vaccine research will grow to $357 million, a 27 percent increase over FY 2001 and 141 percent over FY 1998.

NIH research in basic biology has been the foundation for the development of a new class of drugs, known as protease inhibitors, that are extending the length and quality of life for many HIV-infected individuals. However, many problems remain, making it critical to develop simpler, less toxic, and cheaper drug regimens.

NIH has recently established a new Global AIDS Research effort to expand collaboration with investigators in developing countries. Also, research to address the disproportionate impact of the HIV/AIDS epidemic on U.S. racial and ethnic communities continues to be a high priority.

ANTI-BIOTERRORISM RESEARCH

Included in the NIH budget request for FY 2002 is $93 million for anti-bioterrorism research and support. NIH will continue to emphasize generating genome sequence information on potential bioterrorism agents, such as the organisms that cause anthrax, tularemia, and plague. This genomics research, coupled with other basic research on biological threats, is expected to lead to advances in developing rapid diagnostic methods, antimicrobial therapies, and new vaccines for the most likely bioterrorism agents.

In addition, NIH's role in Departmental anti-bioterrorism efforts is being expanded in FY 2002 to include support for the ongoing Oravax smallpox development contract managed by CDC, as well as support of new intergovernmental efforts to develop a next-generation anthrax vaccine.

EXTRAMURAL RESEARCH FACILITIES CONSTRUCTION

For FY 2002, the budget proposes to increase funding for extramural research facilities construction projects by $22 million, or 28 percent, to $100 million. This includes $97 million administered by the National Center for Research Resources (NCRR) and $3 million provided by the National Cancer Institute (NCI). These funds are awarded on a competitive basis to public and non-profit private entities to expand, remodel, renovate, or alter existing or construct new research facilities in order to expand their capacity to perform or improve the quality of their biomedical and behavioral research. In general, these NCRR grants are limited to 50 percent of the total cost of the facility projects.

BUILDINGS AND FACILITIES

A total of $307 million is requested for NIH intramural buildings and facilities (B&F) in FY 2002. This investment represents about one percent of the total NIH budget. These funds will be used to expand and modernize the infrastructure for scientists and research support staff working primarily on the 60-year-old NIH campus in Bethesda, Maryland. Major projects include $26 million to complete construction of the

first phase of the John Edward Porter Neuroscience Research Center, and $11 million to begin planning and design of the second phase of this complex. When completed, this project will bring together, in a shared facility, basic and clinical neuroscientists from across NIH who are currently fragmented by location and discipline. The resulting improved collaborations in the new Center will speed the rate at which fundamental discoveries are translated into effective therapies for neurological and psychiatric disorders.

The budget also requests $53 million to begin construction of a centralized, multi-level animal facility, or vivarium. This facility will consolidate ongoing programs in the current aged and sprawling Building 14 through 28 complex, as well as meet modern animal research needs.

For FY 2002, $21 million is included to begin planning for the repair and renovation of the existing Clinical Center (Building 10) after its hospital and related laboratory components are moved to the adjoining new Mark O. Hatfield Clinical Research Center in FY 2003.

The remaining $196 million in B&F funds will be used for other specific facilities projects across NIH, including upgrading and expanding mechanical and utility systems in several facilities ($35 million); a variety of essential safety and health improvements ($32 million); other interim and transitional renovations for the existing Clinical Center building ($29 million); completing the final phase of renovations and upgrades to Building 6, the oldest operational laboratory building on the NIH campus ($20 million); construction of a new parking facility to help make up for the loss of major parking areas due to new construction on the NIH campus ($14 million); and general repairs and improvements across NIH's nearly 200 total buildings ($66 million).

NEW INSTITUTES AND CENTERS

In FY 2001, Congress created two new Institutes or Centers within NIH. First, Congress elevated the Office of Research on Minority Health out of the Office of the Director (OD) to become the National Center for Minority Health and Health Disparities (NCMHD). The FY 2002 budget request for NCHMD is discussed above. Second, Congress established the new National Institute for Biomedical Imaging and Bioengineering (NIBIB). The NIH budget includes $40 million for this new Institute in FY 2002, compared to the $2 million its predecessor, the OD Office of Bioengineering, Bioimaging, and Bioinformatics expects to spend in FY 2001. NIBIB will be responsible for accelerating the development of new bioimaging, bioengineering, and informatics technologies with clinical and medical research applications; improving coordination in this area at NIH and with other Federal agencies; and supporting the training of researchers skilled in these technologies.

OFFICE OF RESEARCH ON WOMEN'S HEALTH

The President's Budget for the NIH OD includes approximately $50 million for the Office of Research on Women's Health (ORWH), an increase of nearly $28 million over the FY 2001 level. With this increase, ORWH will support new research activities on women's health and new career development programs for women scientists in international health and interdisciplinary research. These research activities will focus on reproductive health concerns; lung cancer prevention for young girls and women; the impact of care-giving roles on health-related quality of life issues; gender differences in kidney and urologic health; and through new interdisciplinary research centers, multi-systemic diseases in women, such as obesity.

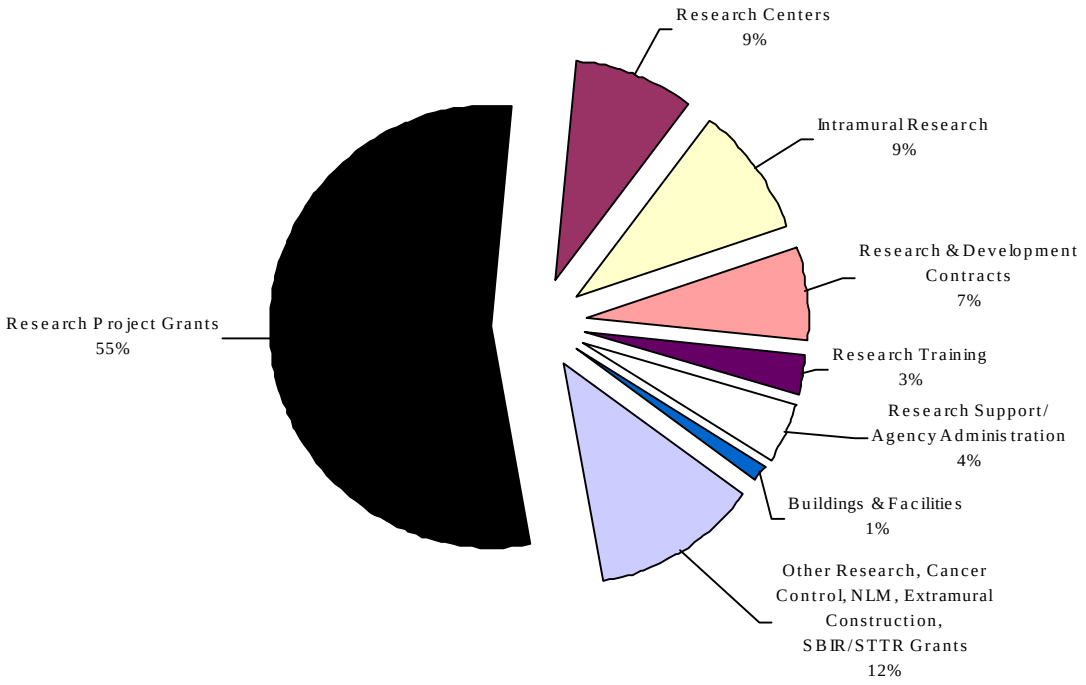
EXTRAMURAL LOAN REPAYMENT PROGRAMS

Congress also authorized several new loan repayment programs for extramural researchers in FY 2001.For FY 2002, NIH plans to spend $28 million to award 261 contracts for loan repayments to extramural scientists engaged in pediatric and clinical research.

In addition, the budget request for the National Center for Minority Health and Health Disparities includes $4 million for two other new extramural loan repayment programs; one on clinical research for individuals from disadvantaged backgrounds, and the other related to research on minority health disparities issues.

FY 2002 NIH BUDGET

$23.1 Billion – Percent of Total by Mechanism



NIH OVERVIEW (by Institute/Center)

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Institutes:				
National Cancer Institute	$3,296	$3,738	$4,177	+$439
National Heart, Lung, & Blood Institute	2,025	2,299	2,567	+268
National Institute of Dental & Craniofacial Research	269	306	342	+36
Natl Inst. of Diabetes & Digestive & Kidney Disease	1,141	1,304	1,458	+154
National Institute of Neurological Disorders & Stroke	1,030	1,177	1,316	+139
National Institute of Allergy & Infectious Diseases	1,812	2,063	2,355	+292
National Institute of General Medical Sciences	1,371	1,540	1,720	+180
Natl Inst. of Child Health and Human Development	861	979	1,097	+118
National Eye Institute	450	511	571	+61
National Institute of Environmental Health Sciences:				
Labor/HHS Appropriation	443	503	562	+59
VA/HUD Appropriation	60	63	70	+7
National Institute on Aging	688	786	880	+94
Natl Inst. Of Arthritis & Musculoskeletal & Skin Dis	349	397	444	+47
Natl Inst. On Deafness & Communication Disorders	264	301	337	+36
National Institute of Mental Health	974	1,107	1,238	+132
National Institute on Drug Abuse	687	781	907	+126
National Institute on Alcohol Abuse & Alcoholism	293	341	382	+41
National Institute for Nursing Research	90	105	118	+13
National Human Genome Research Institute	336	382	427	+45
Natl Inst. for Biomedical Imaging & Bioengineering	0	2	40	+38
National Center for Research Resources	674	817	974	+157
Natl Center for Complementary & Alternative Med	69	89	100	+11
Natl Center for Minority Health & Health Disparities	98	132	158	+26
Fogarty International Center	43	50	56	+6
National Library of Medicine	215	246	276	+29
Office of the Director	162	188	232	+45
Buildings & Facilities	165	154	307	+153
ONDCP Drug Forfeiture Fund Transfer (NIDA)	10	10	10	0
BBA/BIPA Diabetes Research 1/	27	93	93	0
Subtotal, Program Level	**$17,903**	**$20,464**	**$23,215**	**+$2,751**
Less Funds Allocated from Other Sources:				
ONDCP Drug Forfeiture Fund Transfer (NIDA)	-10	-10	-10	0
BBA/BIPA Diabetes Research 1/	-27	-93	-93	0
Subtotal, Budget Authority	**$17,867**	**$20,361**	**$23,112**	**+$2,751**
Labor/HHS Appropriation	**17,807**	**20,298**	**23,042**	**+2,744**
VA/HUD Appropriation	**60**	**63**	**70**	**+7**
FTE	16,022	17,434	17,960	+526

1/ These funds were pre-appropriated in the Balanced Budget Act of 1997 and the Benefits Improvement and Protection Act of 2000.

NIH OVERVIEW (by Mechanism)

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Mechanism:				
Research Project Grants	$9,769	$11,117	$12,518	+$1,401
[# of Non-Competing]	*[21,703]*	*[23,246]*	*[24,932]*	*[+1,686]*
[# of New/Competing]	*[8,835]*	*[9,158]*	*[9,158]*	*[0]*
[Total # of Grants]	*[30,538]*	*[32,404]*	*[34,090]*	*[+1,686]*
Small Business Innovation Research (SBIR)/ Small Business Technology Transfer (STTR) Grants	$362	$414	$474	+$59
Research Centers	1,562	1,857	2,080	+223
Research Training	540	592	645	+54
Research & Development Contracts	1,157	1,326	1,595	+268
Intramural Research	1,761	1,959	2,159	+200
Other Research	1,435	1,675	1,878	+203
Extramural Research Facilities Construction	77	78	100	+22
Research Management and Support	601	693	779	+86
National Library of Medicine	215	246	276	+29
Office of the Director	162	188	232	+45
Buildings and Facilities	165	154	307	+153
NIEHS VA/HUD Appropriation (Superfund)	60	63	70	+7
ONDCP Drug Forfeiture Fund Transfer (NIDA)	10	10	10	0
BBA/BIPA Diabetes Research 1/	27	93	93	0
Subtotal, Program Level	**$17,903**	**$20,464**	**$23,215**	**+$2,751**
Less Funds Allocated from Other Sources:				
ONDCP Drug Forfeiture Fund Transfer (NIDA)	-10	-10	-10	0
BBA/BIPA Diabetes Research 1/	-27	-93	-93	0
Subtotal, Budget Authority	**$17,867**	**$20,361**	**$23,112**	**+$2,751**
Labor/HHS Appropriation	**$17,807**	**$20,298**	**$23,042**	**+$2,744**
VA/HUD Appropriation	**$60**	**$63**	**$70**	**+$7**
FTE	16,022	17,434	17,960	+526

1/ These funds were pre-appropriated in the Balanced Budget Act of 1997 and the Benefits Improvement and Protection Act of 2000.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Program Level.....	$2,651	$2,957	$3,058	+$101
FTE.....	611	632	632	0

SUMMARY

The FY 2002 budget request for the Substance Abuse and Mental Health Services Administration (SAMHSA) is $3 billion, a net increase of $101 million or 3.4 percent, over the FY 2001 enacted level. The SAMHSA budget focuses on enhancing substance abuse treatment services, narrowing the substance abuse treatment gap, increasing data collection activities and maintaining mental health services.

SAMHSA's mission is to improve the quality and availability of prevention, early intervention, treatment and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness. SAMHSA accomplishes its mission through its Centers: Mental Health Services (CMHS), Substance Abuse Treatment (CSAT), and Substance Abuse Prevention (CSAP).

REDUCING THE DRUG TREATMENT GAP

In an effort to reduce the treatment gap, $100 million has been included to fund the President's drug treatment initiative. In total, SAMHSA's budget proposes $2.2 billion for substance abuse treatment and prevention activities. These additional funds will allow States and local communities to provide treatment services to approximately 437,000 individuals, an increase of 17,000 over FY 2001.

The 1999 National Household Survey on Drug Abuse estimates that 14.8 million Americans used an illicit drug in the past month. Further, 10.9 percent of youth aged 12-17 reported illicit drug use in the past month. An estimated 2.3 million persons used marijuana for the first time in 1998. This translates to approximately 6,400 new marijuana users per day, of which more than two-thirds were under 18 years of age. Among the 471,000 first-time users of heroin, a quarter were under age 18 and another 47 percent were age 18-25.

In an effort to reduce the treatment gap, $100 million has been included to fund the President's drug treatment

Nationwide, there continues to be a great need to expand the capacity to treat individuals who use and are addicted to illegal drugs. The drug treatment gap revolves around three issues: accessibility, affordability, and availability. The Office of National Drug Control Policy (ONDCP)

estimates that as many as 5 million Americans are in need of substance abuse treatment services. However, fewer than half actually receive services, leaving a treatment gap of 2.9 million individuals.

Illicit drug use impacts on more than the individual user. ONDCP estimates the cost to society to be approximately $110 billion each year. The $100 million budget initiative provides increases for the Substance Abuse Block Grant (SABG) and the Targeted Capacity Expansion Program.

A total of $1.7 billion is requested for the SABG, an increase of $60 million over FY 2001. The SABG is the cornerstone of States' substance abuse programs, and provides support for over 10,500 community-based treatment and prevention organizations.

The request also provides $201 million for the Targeted Capacity Expansion Program (TCE) within the Programs of Regional and National Significance, an increase of $40 million or 25 percent above the FY 2001 enacted level. The increase will support an additional 80 grants for a total of 380 grants to be made available through TCE. Among the additional grants, $8 million is included for competitive grants to provide residential treatment programs for teenagers with substance abuse problems, and $6 million is included to provide treatment services to teens in an outpatient setting. TCE grants are designed to support rapid strategic response to emerging trends, (e.g., ecstasy and methamphetamine).

Data Collection: SAMHSA engages in an extensive national data collection effort to evaluate both the prevalence of these conditions and the effectiveness of its programs at treating or preventing them.

SAMHSA has three main surveys which serve as the major source of information to Federal and State officials in their efforts to fight substance abuse. The surveys are: the National Household Survey on Drug Abuse (NHSDA); the Drug Abuse Warning Network (DAWN); and the Drug and Alcohol Services Information System (DASIS). The budget supports the surveys at approximately $76.8 million, an increase of $17 million.

The NHSDA is currently the only national source of information on substance abuse problems and treatment in the general public. For the NHSDA there were approximately 70,000 people surveyed. The data is used to study trends and attitudes in the use of both legal and illicit substances. The survey is also an invaluable and unique source of information for studying the causes of substance abuse, the demand for treatment, and the effectiveness of service programs. The NHSDA was recently expanded to produce State level estimates on an annual basis. The expanded survey will allow comparisons between States on the prevalence of substance abuse.

DAWN is the Nation's data system that collects data on drug-related visits to hospital emergency departments and drug related deaths. The most recent survey showed that there were approximately 554,932 drug-related emergency room visits in the U.S. The goal of DAWN is to provide data to enhance the study of the health consequences of substance abuse and the impact of drug use on the Nation's health care system.

DASIS provides a comprehensive national data set on substance abuse treatment facilities, clients and treatment admissions. Currently there are 13,455 treatment facilities in the U.S. which serve over one million clients.

MENTAL HEALTH

The budget includes $766 million, a decrease of $16 million for mental health activities. Highlights within the total are: $420 million for the Mental Health Block Grant for States to provide community-based care for adults with serious mental illness and children with serious emotional disturbances;

$90 million to address violence in our children's schools; and
$7 million for a program to treat mental health disorders related to HIV/AIDS. Of the $16 million reduction, $11 million is the result of one-time projects funded in FY 2001 and $5 million from the completion of projects that provide greater knowledge about the provision of mental health services.

SAMHSA OVERVIEW

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Substance Abuse:				
Substance Abuse Block Grant.....	$1,600	$1,665	$1,725	+$60
Programs of Regional and National Significance:				
Treatment.....	214	256	296	+40
Prevention.....	147	175	175	0
National Data Collection Activities.....	0	12	29	+17
Subtotal, Substance Abuse	**$1,961**	**$2,108**	**$2,225**	**+$117**
Mental Health:				
Mental Health Block Grant.....	$356	$420	$420	0
Path Homeless Formula Grant.....	31	37	37	0
Programs of Regional and National Significance.....	136	203	187	-16
Children's Mental Health Services.....	83	92	92	0
Protection and Advocacy.....	25	30	30	0
Subtotal, Mental Health	**$631**	**$782**	**$766**	**-$16**
Program Management.....	59	67	67	0
Total, Program Level.....	**$2,651**	**$2,957**	**$3,058**	**+$101**
Less Funds Allocated from Other Sources:				
PHS Evaluation Funds.....	0	0	-29	-29
Total, Discetionary BA.....	**$2,651**	**$2,957**	**$3,029**	**+$72**
FTE.....	611	632	632	0

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Program Level.....	$204	$270	$306	+$36
FTE.....	266	294	294	0

SUMMARY

The FY 2002 request for the Agency for Healthcare Research and Quality (AHRQ) provides a program level of $306 million, an increase of $36 million, or 13.5 percent over FY 2001. This growth rate reflects a major commitment to the improvement of the quality of patient care provided by the American health care system. In FY 2002, AHRQ will be fully funded through inter-agency transfers of evaluation funds. The budget will place a priority on:

- Improving cost effectiveness and quality of medical care;
- Reducing the number of medical errors and improving patient safety;
- Providing national reports required by Congress on quality and disparities in health care.

AHRQ conducts and sponsors health services research to inform decision-making and improve clinical care, and the organization and financing of health care. AHRQ supports the translation of research into measurable improvements in the care Americans receive. This work not only improves health care, but also contributes to obtaining better value for the Nation's health care spending. AHRQ accomplishes its mission through partnerships with other Federal agencies, academic institutions, medical societies, managed care organizations, and health care payers.

The Agency supports research project grants and research contracts at colleges and universities to capitalize on the expertise of academic institutions. In addition, AHRQ has forged cooperative relationships with major health care organizations to ensure that research funded by the Agency is implemented by the major players in the health system.

HEALTH COSTS, QUALITY, AND OUTCOMES

The President's Budget will continue to support improvements through research on the cost effectiveness and quality of health care by providing a total of $255 million, which is an increase of $29 million above FY 2001.

Quality and Cost-Effectiveness: There continues to be a strong need to develop ways to measure and improve the quality and cost-effectiveness of care. AHRQ is also working to identify strategies that improve access and foster the appropriate use of health care, which includes reducing unnecessary expenditures. In FY 2002, the Agency for Healthcare Research and Quality will use an increase of $26 million to support research needed to improve the quality and cost-effectiveness of care.

The Evidence-Based Practice Centers (EPCs) are among the most visible examples of AHRQ's work to implement the most effective medical practices. Each of the 12 EPCs has a five-year contract to review assigned specific topics in clinical care. Topics selected must be common, expensive, and significant for the Medicare and Medicaid populations. Examples of recent topics include management of childhood ear infections, prostate cancer, and stable angina therapies.

In FY 2002, the Agency for Healthcare Research and Quality will use an increase of $26 million to support research needed to improve the quality and cost-effectiveness of care.

AHRQ supports Translating Research Into Practice (TRIP) grants to move the results of research into daily practice. Areas of focus include preventive services for adolescents, improved treatment for stroke and diabetes, and pain management.

Patient Safety: In FY 2002, an increase of $3 million over FY 2001, for a total of $53 million, is dedicated to patient safety research. This major research effort will develop and test new technologies to reduce errors, research the causes of medical errors, provide training, and test reporting strategies through large demonstrations in States to provide information for further research and improvements.

AHRQ, the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Health Care Financing Administration are working collaboratively to develop a common interface for medical providers that will both enhance the usefulness of adverse event information and reduce reporting burden for their partners in the health care community.

MEDICAL EXPENDITURE PANEL SURVEYS

The President's Budget provides $49 million, an increase of $8 million for the Medical Expenditure Panel Surveys (MEPS). MEPS are the collection of detailed, national data on the health care services Americans use, how much they cost, and who pays.

Enhancements in MEPS will lead to a better understanding of the quality of care the average health care consumer receives, and of disparities in the care delivered. MEPS data is critical for tracking the impact of Federal and State programs on care, including the State Children's Health Insurance Program (SCHIP), Medicare and Medicaid.

National Reports on Quality and Disparities in Health Care: Much of the increase in MEPS will support two new reports required by AHRQ's 1999 reauthorization. The first report, anticipated in FY 2003, is on national trends in the quality of the Nation's health care. This report will include information on patient assessment of health care quality, clinical quality measures of common health care services, and performance measures related to outcomes of acute and chronic disease.

AHRQ's reauthorization also calls for a report on populations that are at high risk for disparities in care. These populations include the elderly, inner-city and rural areas, women, children, minorities, low-income groups, and individuals with special health care needs.

To complete the reports, AHRQ will supplement the data collected through MEPS with other data-collection efforts at the Agency, and non Federal data sources. These additional sources of data are supported by the increase for research on health costs, quality and outcomes.

AHRQ OVERVIEW

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Research on Health Costs, Quality and Outcomes	$165	$226	$255	+$29
Medical Expenditures Panel Surveys	36	41	49	+8
Program Support	2	3	3	0
Subtotal, Program Level	**$204**	**$270**	**$306**	**+$36**
Less Transfers: PHS Evaluation Funds	89	165	306	+141
Total, Budget Authority	**$115**	**$105**	**$0**	**-$105**
FTE	266	294	294	0

HEALTH CARE FINANCING ADMINISTRATION

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Budget Authority	$322,459	$354,485	$386,527	+$32,042
Outlays	$316,007	$354,520	$386,751	+$32,231
FTE	4,446	4,610	4,632	+22

SUMMARY

The FY 2002 budget request for the Health Care Financing Administration (HCFA) is $386.8 billion in net outlays. The request finances Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), the Health Care Fraud and Abuse Control Program (HCFAC), State insurance enforcement, and HCFA's operating costs. This budget reflects an increase of $32.2 billion over FY 2001.

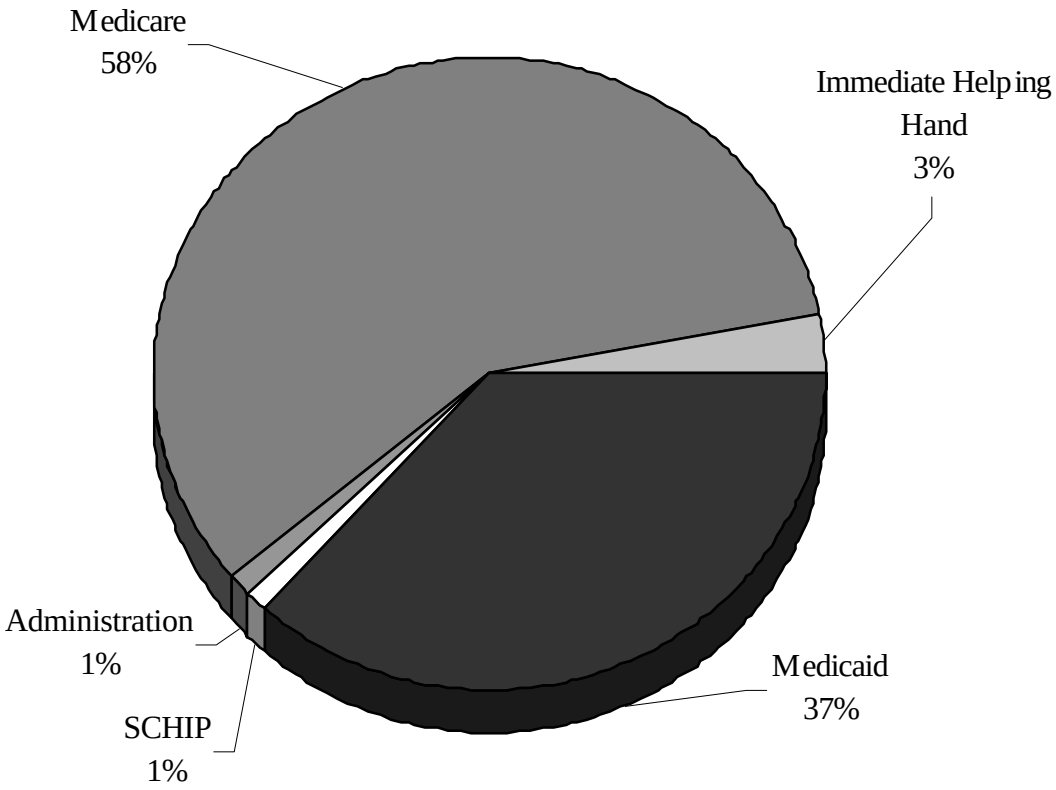
The President's FY 2002 budget includes important proposals for modernizing the Medicare program, a program which represents our Nation's commitment to our seniors and the disabled. Major initiatives include: funding the Immediate Helping Hand program; modernizing HCFA's infrastructure to better serve beneficiaries over the long-term, including taking steps to decrease the regulatory burden; investing in HCFA's accounting systems to strengthen operations and realize long-term efficiencies; and continuing our fight against Medicare waste, fraud, and abuse. We will continue to make important improvements to the Medicare coverage process by making it more open, understandable, and predictable for beneficiaries, providers, Congress and the public.

The President's FY 2002 budget includes nearly $156 billion – nearly $3 billion this year and $153 billion over ten years (FY 2002-2011) – to reform Medicare and provide immediate prescription drug coverage to low-income seniors and those with high out-of-pocket drug costs.

The President's Budget also protects the integrity of the Medicaid program. Last year, Congress took an important step to protect the integrity of the Medicaid program by passing legislation to address the "upper payment limit" (UPL) loophole, which allowed States to draw down billions of dollars in Federal matching payments for hospitals and nursing homes without any assurance that these payments were used for their intended purposes. But this legislation only partially addressed the problem, because it created a higher upper payment limit for non-State government operated hospitals. The President's Budget closes the loophole by prohibiting new hospital loophole plans from receiving the higher upper payment limit proposed in the Department's final rule implementing the upper payment limit legislation.

HCFA FY 2002 NET OUTLAYS

Total = $386.8 billion:



MEDICARE

CURRENT MEDICARE ACTIVITY

Overview: Medicare is the Federal health insurance program for people age 65 or older and people under age 65 who are disabled or suffer from end-stage renal disease (ESRD). In FY 2002, the program will serve approximately 40 million eligible individuals. Medicare consists of three parts:

- Part A – Hospital Insurance (HI) is an entitlement for all qualified beneficiaries. Part A pays for inpatient hospital care, some skilled nursing facility care, home health care related to a hospital stay, and hospice care. The HI program is funded through the HI Trust Fund, which receives most of its income from the HI payroll tax (2.9 percent of payroll, split evenly between employers and employees). The Medicare Trustees recently reported that the HI Trust Fund's depletion date has improved slightly, from 2025 to 2029, but HI spending will begin to exceed tax receipts by 2016.
- Part B – Supplementary Medical Insurance (SMI) coverage is optional. However, 94 percent of those enrolled in Part A enroll in Part B. Part B pays for medically necessary physician services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment, home health care, and certain other medical services and supplies. The SMI program is funded through the SMI Trust Fund. Enrollees pay 25 percent of Part B costs (or $50 per month in 2001), with remaining costs covered by general revenue. The SMI Trust Fund does not face insolvency like the HI Trust Fund since the law allows SMI to tap into the general fund to ensure its solvency.
- Part C – The Medicare+Choice Program, which is available to most beneficiaries, offers the option of receiving Medicare benefits through private organizations such as managed care plans.

Recently, there has been much discussion about the relationship of the budget to Medicare's Trust Funds. Some would like to set aside the "surpluses" accruing to the HI Trust Fund from the rest of the budget and permanently require budget surpluses equal to these Trust Fund "surpluses."

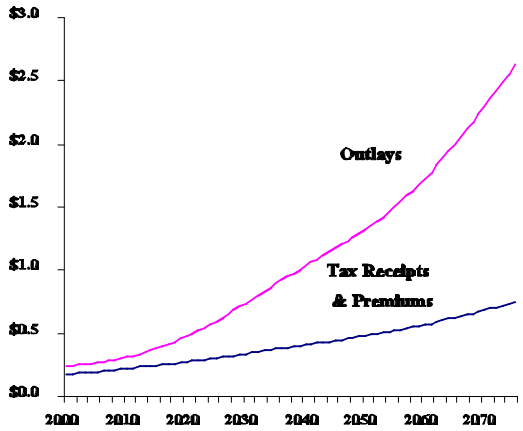
In a sense this argument is moot, in that the President's proposed Additional Needs and Contingency Reserve far exceeds the "surpluses" in the HI Trust Fund over the period 2002-2011. Nonetheless, viewing Medicare HI activities in isolation is flawed.

The President's Budget spends every penny of Medicare tax and premium collections over the next ten years on Medicare. When you isolate all Medicare revenues and expenditures, there is no Medicare Part A surplus. In fact, a comprehensive analysis of the Medicare program, which takes into account the Supplemental Medical Insurance Trust Fund (Part B), as well as the HI Trust Fund (Part A), reveals there is a deficit. The Medicare program today will require a $1.2 trillion transfer from the general fund to meet expenditures over the period 2002-2011. These annual transfers from the general fund are nothing more than the government making paper transactions with itself. They have no economic consequences and should not be considered when you look at

Medicare from the perspective of the Federal Budget. Moreover, a significant part of the HI surplus is due to an accounting gimmick that shifted a portion of the home health expenditures from HI to SMI to extend the solvency date of the HI Trust Fund. The shift had no economic consequence, nor did it change total Medicare spending, but it did have the effect of making the HI Trust Fund appear more "solvent."

Therefore, when Medicare is examined in this more comprehensive manner, over the period 2002-2011, the projected HI surplus is overwhelmed by the SMI deficit. As such, Medicare as a whole is running a deficit, not a surplus. This deficit is projected to be $645 billion over the next ten years, or $52 billion in FY 2002.

MEDICARE OUTLAYS VS. TAX RECEIPTS AND PREMIUMS
(Dollars in Trillions)



NOTE: Outlays include Part A and Part B in constant 2000 dollars.

Comprehensive Measure of Medicare's Solvency: Currently, there is no comprehensive measure of Medicare's solvency that accounts for SMI finances, as well as HI. This underestimates the magnitude of Medicare's financial problem. The Medicare Trustees acknowledge this disconnect in their 2001 Trustees report by stating that, "Although this report focuses on the financial status of the HI Trust Fund, it is important to recognize the financial challenges facing the Medicare program as a whole and the need for integrated solutions." To this end, the Administration will work to establish a comprehensive measure of Medicare's solvency in order to assess the overall financial picture of the program.

Medicare+Choice: Medicare offers beneficiaries a variety of coverage options. Beneficiaries may choose to remain in the traditional fee-for-service program or enroll in a Medicare+Choice plan, which could be a traditional HMO, a preferred provider organization, or a private fee-for-service plan.

Currently, about 5.8 million, or about 15.6 percent of beneficiaries, are enrolled in a Medicare+Choice plan. These figures are lower compared to last year, when 6.3 million beneficiaries, or about 17 percent of all beneficiaries, were enrolled. This drop in enrollment reflects the large number of plans, about 316, that have left the Medicare+Choice program or reduced their service areas in the last three years.

Medicare+Choice plans have left the program for a variety of reasons, including increased costs, slower Medicare payment increases and difficulty in maintaining provider networks. To address these concerns, BIPA increased payments to Medicare+Choice plans by about $11 billion over five years. While Medicare+Choice organizations generally used the money to enhance provider payments, some plans reduced premiums and enhanced prescription drug coverage.

Medicare Spending Growth: Under current law, Medicare gross benefit outlays are projected to increase from $252 billion in FY 2002 to $447 billion in FY 2011. The program is expected to grow at 6.6 percent per year during this period. Part A benefit outlays are projected to grow from $142 billion in FY 2002 to $241 billion in

FY 2011, at an average annual growth rate of 6.1 percent. Part B benefit outlays are expected to grow from $110 billion in FY 2002 to $207 billion in FY 2011. The Part B average annual growth rate during the projection period is 7.3 percent.

Health Care Fraud and Abuse Control Program (HCFAC): Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the HCFAC Program. The program combats health care fraud, waste, and abuse. Included within this overarching program is the Medicare Integrity Program (MIP), which is run by HCFA, and the Fraud and Abuse Control Program.

MIP consists of financial audits of provider cost reports, medical and utilization reviews of individual claims, and the identification of Medicare beneficiaries who have other insurance plans with primary responsibility for paying claims. Funds are also earmarked to support detection and investigation of program fraud and abuse. HCFA also funds provider education and training activities associated with preventing fraud, waste and abuse and audits of managed care plans.

In FY 2002, HIPAA authorizes $700 million for MIP, a $20 million increase over FY 2001. Within this level, HCFA will fund activities that will stop unnecessary payments before they leave the Trust Funds through pre-payment review and provider education. These actions help lower the payment error rate cited in recent Chief Financial Officer's reports.

Also under MIP, HCFA is developing contractor-specific error rates that will gauge the progress the agency is making in correcting payment errors by providers. This effort began in Summer 2000 and HCFA hopes to begin getting usable information in FY 2002.

HIPAA also created the Fraud and Abuse Control Program. This program funds much of the health care investigational and prosecutorial activities of the HHS Office of Inspector General and the Department of Justice. The Fraud and Abuse Control Program increased $27 million in FY 2002 over FY 2001, to $209 million. In FY 2001, HCFA received $2.5 million from this account to work with States that wish to develop Medicaid payment error rates.

The Administration's health care fraud, waste, and abuse control efforts have paid off handsomely. In FY 1999, the last year for which we have data, $9.9 billion was identified in savings from MIP activities, representing an 18:1 return on our investment. In addition, we have also cut the Medicare overpayment error rate in half from FY 1996 through FY 2000, from 14 percent to 6.8 percent. Recent Medicare Trustee's reports have cited our health care fraud, waste, and abuse control efforts as a contributing factor in the slower Medicare spending growth experienced over the last three years.

Peer Review Organizations: Peer Review Organizations (PROs) were established by Title XI of the Social Security Act, Part B, to serve the following functions:

- Improve the quality of care for beneficiaries by ensuring that professionally recognized standards of care are met;
- Enhance program integrity by ensuring that Medicare only pays for items that are reasonable and medically necessary; and,
- Protect beneficiaries by addressing individual beneficiary's complaints, and hospital issued notices of noncoverage and Emergency Medical Treatment and Labor Act (EMTALA) "dumping" violations.

In FY 2002, PROs will begin a new round of work; HCFA is developing the new requirements for this work. Current PRO contracts include performance standards that will provide benchmarks for: national and

local health improvement projects; a program to prevent payment errors; a project to improve quality of care for Medicare+Choice beneficiaries; and a project to reduce the disparity between care received by minorities and all other beneficiaries.

PROPOSED LAW

The President's FY 2002 budget includes nearly $156 billion – nearly $3 billion this year and $153 billion over ten years (FY 2002-11) – to reform Medicare and provide immediate prescription drug coverage to low-income seniors and those with high out-of-pocket drug costs.

Immediate Helping Hand (IHH): The President's FY 2002 budget allocates nearly $46 billion – approximately $3 billion in FY 2001 and approximately $43 billion over four years (FY 2002-2005) – for States to provide prescription drug coverage for low-income beneficiaries and those with catastrophic drug costs. The IHH proposal is funded from general revenue and surpluses, not Medicare Trust Fund dollars.

- The IHH proposal complements and builds on plans that are currently available in almost half the States.
- Individuals with incomes up to $11,600 and married couples with incomes up to $15,700 who are not eligible for Medicaid or a comprehensive private retiree benefit would pay no premium and no more than a nominal charge for prescriptions.
- Individuals with incomes up to $15,000 and married couples with incomes of up to $20,300 would receive subsidies for at least half the cost of the premium for high-quality drug coverage.
- Individuals of any income level with out-of-pocket drug costs exceeding $6,000 per year would receive catastrophic coverage.
- IHH is fully funded by the Federal government and provides States with the flexibility to choose how to establish coverage or enhance existing plans. States choosing to participate in the program would receive an allocation based on the State's share of Medicare beneficiaries with incomes below 175 percent of poverty.
- This proposal would not create a new entitlement program; rather, IHH would sunset in December 2004 or as soon as a comprehensive Medicare prescription drug benefit is implemented.

Medicare Reform: Comprehensive Medicare reform is an urgent priority. We need to increase the quality of care provided to seniors and the disabled, to streamline burdensome and inflexible bureaucratic controls, and to improve the program's financing. The Medicare program has not kept pace with modern medicine. Today, Medicare covers just over half of the average senior's annual medical expenses and the benefits package is lacking. Moreover, Medicare faces a looming fiscal crisis. A full assessment of the health of both the Part A and Part B Trust Funds reveals that spending exceeds the total of tax receipts and premiums dedicated to Medicare and that gap is expected to widen dramatically. Even without a financing problem, Medicare modernization would be necessary to ensure beneficiaries get high quality health care. The President's budget devotes $110 billion beginning in FY 2005 to urgently needed modernizations.

The President is committed to modernizing Medicare. Under the President's principles for reform, Medicare should:

- Provide better coverage options, streamline regulations, and provide higher quality care;
- Ensure that all seniors have affordable access to prescription drug coverage as part of a modernized Medicare program;
- Provide better options for protection against high out-of-pocket expenses, particularly for low-income seniors; and,
- Ensure greater overall financial security, including an accurate measure of the financial status of the program as a whole, without raising payroll tax rates.

MEDICARE TRUST FUND OVERVIEW

(beneficiaries in millions)

	2000	2001	2002	+/-
Aged	34.2	34.3	34.6	+0.3
Disabled	5.3	5.6	5.7	+0.1
Total Beneficiaries	39.5	39.9	40.3	+0.4

MEDICARE OUTLAYS

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Current Law:				
HI Benefits	$125,992	$135,092	$141,843	+$6,751
SMI Benefits	88,875	102,698	110,124	+7,426
Subtotal, Medicare Benefits	**$214,867**	**$237,790**	**$251,967**	**+$14,177**
Administration /1	2,912	3,267	3,552	+285
HCFAC /2	715	820	860	+40
Peer Review Organizations	279	505	424	-81
Transfers to Medicaid	0	170	70	-100
Total Outlays, Current Law	**$218,773**	**$242,552**	**$256,873**	**+$14,321**
Premiums	-21,907	-23,433	-27,034	-3,601
Total Net Outlays, Current Law	**$196,866**	**$219,119**	**$229,839**	**+$10,720**
Proposed Legislation:				
Medicare Benefits	$0	$0	$0	$0
Proposed User Fees	0	0	-115	-115
Premium Interaction	0	0	20	+20
Total Medicare Proposed Legislation	**$0**	**$0**	**-$95**	**-$95**
Total Net Outlays, Proposed Law	**$196,866**	**$219,119**	**$229,744**	**+$10,625**

1/ Includes Administrative payments to the SSA and other non-HCFA agencies.
2/ Health Care Fraud and Abuse Control, includes FBI, excludes OIG.

MEDICAID

SUMMARY

Medicaid is a jointly-funded, Federal-State program that provides medical assistance to certain low-income groups. In FY 2002, it will cover approximately 34.3 million individuals including children, the aged, blind, and/or disabled and people who meet eligibility criteria under the old Aid to Families with Dependent Children (AFDC) program. Under current law, the Federal share of Medicaid outlays is expected to be about $143 billion in FY 2002. This is a $14 billion (11 percent) increase over projected FY 2001 spending.

MEDICAID SAVINGS PROPOSAL

Medicaid Upper Payment Limit (UPL) Reform: The FY 2002 budget would save $606 million in FY 2002 by taking further steps to restrict the Medicaid "upper payment limit" loophole. This proposal would prohibit new hospital UPL plans approved after December 31, 2000 from receiving the higher upper payment limit proposed in the final rule. The final rule had allowed local government-operated hospitals to receive up to 150 percent of what Medicare would pay for the same services. This is known as the upper payment limit.

OTHER PROPOSALS

Health Care Tax Credits: The Administration will encourage the purchase of private health insurance through health care tax credits.

Increased State Flexibility: The Administration will explore a range of options for reforming Medicaid and the State Children's Health Insurance Program (SCHIP) to improve the way these programs provide health care to the poor and near-poor. After consulting with the States, the Administration will develop ideas to increase State flexibility and ensure that Medicaid and SCHIP are being effectively used to promote health insurance coverage. The review of these programs will emphasize giving States the flexibility to use private insurance, when possible, and to coordinate with employment-based insurance for those who have access to it. Within the framework of increased State flexibility, the Administration will also work with States to maintain and reinforce the fiscal integrity of the Medicaid and SCHIP programs by controlling Medicaid costs and ensuring the fiscally prudent management of these programs.

BACKGROUND

Under Medicaid, State expenditures for medical assistance are matched by the Federal government using a formula based on per capita income in each State relative to the national average. Federal matching rates for FY 2002 are projected to range from 50 to 76 percent for medical assistance payments. The Federal matching rate on average is approximately 57 percent.

Historically, eligibility for Medicaid has been based on qualifying under the cash assistance programs of AFDC or Supplemental Security Income (SSI). With passage of the Temporary Assistance for Needy Families (TANF) program in 1996, which replaced AFDC, eligibility for Medicaid and cash assistance were de-linked. However, Medicaid eligibility remains tied to AFDC program rules in place as of July 16, 1996. All those who qualify under the 1996 AFDC rules and most SSI recipients, commonly referred to as the "categorically eligible," are covered under State Medicaid programs. States have the

option to cover some individuals not eligible under AFDC or SSI rules (e.g., people with higher incomes in institutions, low-income pregnant women and children, and aged, blind, and disabled people below the poverty line), and may cover people at higher incomes by disregarding a portion of their incomes. States may also cover "medically needy" individuals. Such individuals meet the categorical eligibility criteria, but have too much income or too many resources to meet the financial criteria.

Medicaid covers pregnant women and infants whose family income does not exceed 185 percent of the Federal poverty level. Medicaid coverage of children ages 6 through 18, born after September 30, 1983, whose family income does not exceed 100 percent of the Federal poverty level, is being phased in. By 2002, all children under the age of 19 living below the poverty level will be eligible for Medicaid.

In addition, Medicaid pays Medicare premiums, deductibles, and copays for certain low-income seniors and disabled individuals.

Generally, States are required to provide a core of 13 mandatory services to eligible categorically needy recipients, including: inpatient and outpatient hospital care; health screening, diagnosis, and treatment to children; family planning; physician services; and, nursing facility services to individuals over 21. States may also elect to cover any of over 30 specified optional services, which include prescription drugs, clinic services, dental, eyeglasses, and services provided in intermediate care facilities for those with mental retardation.

Medicaid outlays grew 9.1 percent from FY 1999 to FY 2000. Prescription drug spending, nursing home and community-based long term care costs have been significant contributors to this expenditure growth, and are expected to continue to contribute to program growth in future years. State programs providing "enhanced payments" to institutional providers have also played a significant role in driving up Medicaid costs at an accelerated rate. Although recently issued regulations will eventually curtail much of the impact of these payments, the transition periods and increase in hospital payment limits included in the new rules will contribute to higher spending growth for a number of years.

WAIVER ACTIVITY

States have considerable flexibility in structuring the Medicaid program, including determining provider payment rates and certification standards, and developing alternative health care delivery programs. In addition, waivers of various portions of Federal law are also available to States.

Numerous States have restructured eligibility and coverage under Medicaid through the use of demonstration waivers granted under section 1115 of the Social Security Act. A number of States are using section 1115 demonstration waivers to reform health care by expanding coverage without increasing the amount the Federal government would spend otherwise.

CHANGES IN MEDICAID DUE TO THE BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000 (BIPA)

The Benefits and Improvement and Protection Act of 2000:

- Increased funds for safety net hospitals by setting FY 2001 State-specific disproportionate share hospital (DSH) allotments at FY 2000 levels adjusted for inflation and setting FY 2002 allotments at FY 2001 levels adjusted for inflation. It also allows States to provide public hospitals DSH payments up to 175 percent of net uncompensated care costs for two years. In addition to these DSH provisions, BIPA provided special funding for certain

public hospitals that meet selected criteria.

- Directed the Secretary of HHS to finalize the regulation addressing a reimbursement loophole that threatens the fiscal integrity of the Medicaid program. The regulation was published January 12, 2001 and took effect March 13, 2001. (Refer to the Medicaid Savings Proposal section of this chapter.)
- Established a new payment system for health centers starting in FY 2001 that is based on centers' FY 1999 and 2000 reasonable costs.
- Extended, through FY 2002, existing Medicaid eligibility for those leaving welfare for work, allowing these beneficiaries to maintain Medicaid coverage for 12 months. BIPA also simplifies enrollment for low-income Medicare beneficiaries that qualify for Medicaid and permits States to use more sites, such as schools and homeless shelters, to enroll children in Medicaid or SCHIP.

MEDICAID OVERVIEW

(average enrollees in millions)

	2000	2001	2002
Aged 65 and Over	3.9	3.9	4.0
Blind and Disabled	6.7	6.8	6.9
Needy Adults	6.3	6.4	6.4
Needy Children	16.5	16.8	17.0
Total	**33.4**	**33.9**	**34.3**

MEDICAID OUTLAYS

(outlays in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/- Enacted
Current Law:				
Benefits /1	$111,832	$121,855	$135,034	+$13,179
State Administration	6,089	6,998	7,995	+997
Total Net Outlays, Current Law	**$117,921**	**$128,853**	**$143,029**	**+$14,176**

/1 Includes Vaccines for Children Outlays.

MEDICAID PROPOSALS: COSTS AND SAVINGS

(dollars in millions)

	FY 2002	FY 02-06	FY 02-11
Savings Proposals:			
Medicaid Upper Payment Limit.....	-$606	-$6,877	-$17,376
Cost Proposal:			
VA Nursing Home Extension (Medicaid effect).....	$0	$0	+$1,200
Total Outlays, Proposed Law.....	**-$606**	**-$6,877**	**-$16,176**

STATE GRANTS AND DEMONSTRATIONS

THE TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT (TWWIIA)

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) expanded State options under Medicaid for workers with disabilities.

In addition to the two optional Medicaid categories created by TWWIIA, the legislation also created new grants to fund both a demonstration program and a grant program.

The demonstration program ($250 million from FY 2001-2006) allows States to receive Federal financial participation to develop a program to provide Medicaid-equivalent coverage to workers with health conditions which, without medical treatment, will cause them to become disabled and qualify for Supplemental Security Income or Social Security Disability Insurance. The demonstration will determine whether providing health coverage prevents deterioration in their health condition.

The Medicaid Infrastructure Grant Program (section 203 of TWWIIA) makes $150 million available over five years (from FY 2001-2005) to States to design, establish and operate programs that provide items and services to people with disabilities who work. These funds may also be used to conduct outreach campaigns to educate beneficiaries about the availability of such programs. The minimum award to States is $500,000 per fiscal year.

In February 2001, as part of the New Freedom Initiative, the President indicated that he would direct Federal agencies, including HHS, to continue to swiftly implement TWWIIA.

STATE GRANTS AND DEMONSTRATIONS

(outlays in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/- Enacted
Budget Authority.....	$0	$62	$67	+$5
Outlays.....	$0	$16	$29	+$13

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

BACKGROUND

The Balanced Budget Act of 1997 (BBA) created the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act.

SCHIP is a partnership between Federal and State governments that helps provide children with the health coverage they need. SCHIP reaches children whose families have incomes too high to qualify for Medicaid but too low to afford private health insurance.

Title XXI appropriated almost $40 billion to the program over ten years (FY 1998 through FY 2007). States with an approved SCHIP plan are eligible to receive an enhanced Federal matching rate, which ranges from 65 to 85 percent, drawn from a capped allotment.

States have a high degree of flexibility in designing their programs. They can implement SCHIP by: 1) expanding Medicaid, 2) creating a new, non-Medicaid Title XXI separate State program, or 3) a combination of both approaches. Generally, uninsured children up to 18 years old in families at or below 200 percent of the Federal poverty level (who are not eligible for Medicaid) are eligible for SCHIP.

There were several changes to the SCHIP program in the Balanced Budget Refinement Act of 1999 (BBRA). BBRA changed the SCHIP allotment formula to stabilize States' annual SCHIP allotments effective for FY 2000 allotments and beyond. BBRA also provided additional budget authority of $249 million for U.S. Territories. BBRA improved data collection and evaluation activities by providing $10 million to the Department of Commerce to increase the sample size of the Current Population Survey (CPS) and $10 million for a SCHIP evaluation of 10 States. BBRA directed the Inspector General to audit, and the GAO to report to Congress, every three years on State compliance with the requirement that SCHIP applicants must be first screened for Medicaid, and if eligible, are enrolled in Medicaid. BBRA directed the Secretary to establish a data clearinghouse on Federal health programs and children's health.

IMPLEMENTATION & ENROLLMENT STATUS

As of September 1999, SCHIP plans were approved for all 50 States, the District of Columbia, and five Territories. As of March 2001, States have received approval for 21 Medicaid expansion programs, 16 separate programs, and 19 combination programs, with eight amendments under review. In FY 2000, 3.3 million children were enrolled in SCHIP – a 70 percent increase over the number of children enrolled in FY 1999.

The scope of coverage under SCHIP continues to increase. Many States have adopted additional expansions of coverage. At the end of FY 2000, 24 States covered children in families with incomes up to 200 percent of the Federal poverty level. Eleven States went beyond that and covered children above 200 percent of poverty with six States covering children with incomes up to 300 percent of poverty. New Jersey covers children in SCHIP up to 350 percent of poverty.

SCHIP WAIVER STATUS

Section 1115 waivers allow States to waive certain provisions of Federal law to demonstrate innovative methods for improving children's coverage and the quality of services for children. In January 2001, the first waivers granted in the

SCHIP program were awarded to New Jersey, Rhode Island and Wisconsin. Through a waiver, these States will offer health insurance coverage to parents of children eligible under either SCHIP or Medicaid. In addition, New Jersey's and Rhode Island's demonstration projects will expand coverage to pregnant women. Currently, there are several States seeking waivers.

CHANGES DUE TO THE BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000 (BIPA)

BIPA introduced the following changes to the SCHIP program:

Special Rule for Redistribution and Availability of Unspent FY 1998 and FY 1999 SCHIP Allotments: BBA required that States that did not use annual SCHIP allotments within three years must return all unused funds to the Federal government for redistribution to States that have already exhausted their allotments. BIPA established a new reallocation formula for FY 1998 and FY 1999 allotments whereby States would be entitled to either receive redistributed funds or retain a proportion of the unused funds, which remain available through FY 2002. Each Territory that expends its allotment receives 1.05 percent of the total amount available for redistribution. States that retain funds may use up to 10 percent of the funds for outreach activities.

Created Presumptive Eligibility in SCHIP: BIPA gave authority to States to make a child presumptively eligible for SCHIP. If the child is later found ineligible for the program, States can claim those costs as a benefit cost instead of within the 10 percent spending cap used for administrative costs.

THE SCHIP FINAL RULE

The SCHIP Final Regulation was published in the Federal Register on January 11, 2001. The final rule provides States with additional flexibility in certain areas such as:

- Premium assistance programs, also referred to as employer-sponsored insurance;
- Substitution prevention; and,
- Self-identification of American Indians and Alaska Natives.

The final rule also contains patient protections such as access to health care specialists and access to emergency services when and where the need arises. The rule underscores the statute on policy areas such as ensuring that children are enrolled in the program for which they are eligible and ensuring that cost-sharing is nominal.

The SCHIP final rule has been placed on hold for 60 days until June 11, 2001 per the President's Executive Memorandum to withhold implementation of pending, but not yet implemented, regulations.

SCHIP OVERVIEW

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Total Outlays, Current Law /1.....	$1,220	$4,032	$3,355	-$677

Note: There is no proposed law in SCHIP for FY 2002.

/1 The total outlays include program spending in separate SCHIP, combination, and Medicaid expansion programs.

PROGRAM MANAGEMENT

PROGRAM MANAGEMENT REQUEST

Overview: HCFA's FY 2002 Program Management budget request is $2.35 billion in budget authority, a $109 million or 4.9 percent increase over the FY 2001 appropriation. The total program level request is $2.4 billion. This level assumes $17 million in user fee collections from Medicare+Choice plans for the National Medicare Education Program (NMEP), as well as user fees for the Clinical Laboratory Improvement Amendments program and for the sale of data.

This budget also includes two proposed user fees totaling $115 million. Because this amount is already reflected in HCFA's FY 2002 current law request of $2.35 billion, the enactment of these user fees would offset the appropriation by the amount of the proposals. To facilitate this process, we will submit "trigger" language authorizing the collection and spending of the fees and a proposed legislation schedule. If the Appropriations Committees adopt the "trigger" language for one or more user fee proposals, and the fees are enacted, HCFA's appropriation would be reduced by an amount equivalent to the estimated collections.

The Program Management account provides staff and resources for administering Medicare, Medicaid, the State Children's Insurance Program (SCHIP), and various Health Insurance Portability and Accountability Act of 1996 (HIPAA) activities. With these funds, HCFA: coordinates and oversees the work of contractors who process 970 million claims; answers beneficiary and provider inquiries; surveys health care facilities to ensure quality of care is provided to Medicare beneficiaries; conducts research to improve payment, service delivery, and quality for all HCFA programs; and informs beneficiaries regarding their health care options in the Medicare program.

HCFA's responsibilities have grown with each new major health care law or budget reconciliation. HIPAA, the Balanced Budget Act of 1997 (BBA), the BBRA of 1999, and the Benefits Improvement and Protection Act of 2000 (BIPA) gave HCFA new responsibilities.

In addition, HCFA, like all Federal agencies, must comply with government reform legislation, such as: the Chief Financial Officer (CFO) Act of 1990, the Government Management Reform Act of 1994, the Federal Financial Management Improvement Act (FFMIA) of 1996, the Information Technology Management Reform Act of 1996, the Debt Collection Improvement Act of 1996, and the Government Performance and Results Act of 1993. These six laws alone have had a significant impact on HCFA's operations and have required substantial new investment without providing a commensurate increase in administrative resources.

Medicare Contractors: The Medicare contractors' budget supports a broad array of operational activities. The budget is $1.52 billion, an increase of $165 million over the FY 2001 appropriation, including NMEP funding.

By law, the Medicare program is administered by private insurance companies, or contractors. Contractor responsibilities include: processing claims and making benefit payments; responding to the needs and inquiries of Medicare beneficiaries and health care providers and suppliers; and developing and implementing management changes to improve program operations. In

addition, Medicare contractors funds a variety of mission critical information technology systems. For example, it funds managed care systems, standard processing systems, and maintenance on current contractor systems.

HCFA is making a transition in this budget from three major categories (Claims Processing, Productivity Investments, and Beneficiary and Provider Services) to more descriptive categories:

- *Ongoing Activities*: carriers' and fiscal intermediaries' regular activities, such as processing claims, holding hearings and appeals, answering inquiries, and educating providers and beneficiaries.
- *Systems Maintenance*: activities to keep shared claims processing systems current.
- *Operations*: Common Working File (CWF) operations, funding for termination costs of contractors leaving the program, and moving all contractors to three standard processing systems.
- *Enterprise-Wide*: the HCFA Data Center (contractor-operated), the Medicare data communications network, and hardware and software maintenance.
- *Legislative Mandates*: funding for implementing new legislation such as HIPAA, BBA, BBRA, BIPA, CFO, and FFMIA.
- *Program Improvements*: replacement of the Medicare managed care processing system and the CWF system, contractor oversight, and reducing regulatory burden on health care providers.

To allow time to adjust to these new categories, this section will refer to the traditional Claims Processing, Productivity Investments, and Beneficiary and Provider Services categories in describing this year's budget request.

In FY 2002, HCFA will process 970 million claims and answer 40 million inquiries. There has been a slight increase in the unit cost to process a claim in recent years. In FY 2002, the unit cost to process a Part A and Part B claim will be $0.88 and $0.67, respectively, slightly higher than current FY 2001 unit cost projections of $0.87 for a Part A claim and $0.66 for a Part B claim.

Approximately 65 percent of the FY 2002 Medicare contractors program level request will be spent on processing claims ($988 million in FY 2002, a 21.5 percent increase over the FY 2001 level). The Medicare contractors expects to see 44 million more claims than FY 2001, partially due to a large number of beneficiaries who left Medicare+Choice (M+C) and returned to the fee-for-service program.

Beneficiary and provider services comprise 23 percent of the Medicare contractors budget. At $356 million in FY 2002, this portion of our request is 21 percent higher than our FY 2001 submission. This amount will pay for telephone, written, and walk-in communications with beneficiaries and providers, including toll-free lines for both beneficiaries and providers. These activities rise with the enactment of every new piece of legislation dealing with Medicare.

A portion of the funding for the NMEP can also be found in this line. The annual Medicare handbook, as well as other beneficiary and provider publications and services, are funded under this activity. This money also supports the hearings and reconsiderations stages of the claims process. Medicare fiscal intermediaries and carriers handle the initial portion of the appeals process following an adverse ruling on a claim. We will spend $107 million in FY 2002 to carry out this important

function, an 11 percent increase over FY 2001.

The final portion of Medicare contractors funding is productivity investments. Productivity investments enhance the efficiency and cost effectiveness of Medicare's claims process. In FY 2002, HCFA will fund: Medicare contractor Oversight, including the HCFA Integrated General Ledger Accounting System (HIGLAS); consolidation of contractor claims processing to three standard systems; and contractor non-renewal costs incurred when a Medicare contractor leaves the Medicare program.

Federal Administration: For FY 2002, the President's budget requests $531.7 million for HCFA's Federal administrative costs. This is an increase of $27 million over the FY 2001 operating plan. The FY 2002 appropriation request supports a staffing level of 4,632 FTE, a slight increase from the current FTE levels of 4,610 FTE. The additional funding of $27 million will allow HCFA to cover pay increases, fully fund its 4,632 FTE level, and begin work on the Financial Accounting and Control System (FACs), an internal system integral to HCFA's financial management efforts. It also supports the extensive data processing requirements for the Medicare and Medicaid programs, as well as necessary maintenance of HCFA's many automated data systems.

Research, Demonstrations and Evaluation: The FY 2002 budget requests $55.3 million for the Research, Demonstrations and Evaluation program, $83 million less than the FY 2001 enacted level. This reduction includes the elimination of $87 million in FY 2001 earmarked projects and other program items not requested in last year's President's Budget plus $4 million in money dedicated to BIPA research projects.

HCFA's research program supports research and demonstration projects to develop and implement new health care financing policies and to evaluate the impact of HCFA's programs on beneficiaries, providers, States, other customers and partners. Information from HCFA's research program is used by Congress, the Executive Branch, and States to improve the efficiency, quality, and effectiveness of the Medicare, Medicaid, and SCHIP programs.

Basic research funds will also be used to conduct evaluations of Medicare+Choice, SCHIP, Medicaid State Reform, and NMEP.

In addition to basic research, this budget funds the Medicare Current Beneficiary Survey, which continues to be a critical source of data on health care usage and health status of Medicare beneficiaries. Finally, the research budget includes $19.2 million for Congressional research required by BBA, BBRA, and BIPA.

Survey and Certification: Ensuring the safety and quality of care provided by health facilities is one of HCFA's most critical responsibilities. HCFA contracts with State agencies to inspect health facilities providing services to Medicare and Medicaid beneficiaries and ensure compliance with Federal health, safety, and program standards.

HCFA's FY 2002 budget proposes $242.1 million to fund survey and certification activities, the same level of funding as FY 2001. Included in this total is $27.8 million to continue implementing activities associated with the Nursing Home Oversight Improvement Program, such as: imposing immediate sanctions on nursing homes found guilty of a second offense that causes actual harm to residents; conducting more frequent inspections of nursing homes with repeat violations; and conducting more focused reviews of a nursing home's efforts to prevent bed sores, dehydration, and malnutrition. HCFA will also continue to invest money to expedite investigation of resident complaints within a ten-day time frame.

Another $190.6 million will allow us to inspect long-term care facilities, home health agencies, and accredited hospitals at the legislatively mandated frequencies. For the remaining facility types, HCFA will maintain the FY 2001 recertification levels. HCFA expects to complete a total of almost 25,000 initial or annual inspections. In addition, we estimate conducting more than 40,000 visits in response to beneficiary or family complaints.

The remaining $23.8 million will fund base support contract activities, most notably: operation of the Quality Improvement and Evaluation System (QIES), which contains quality outcome data that surveyors can use to better target on-site inspections of poor performing providers; maintenance and enhancements to the Online Survey Certification and Reporting (OSCAR) data system, which contains information on nursing home survey results and outcomes; support services for surveying psychiatric hospitals; and accuracy reviews of the information submitted on the Minimum Data Set for nursing homes and the Outcome and Assessment Information System (OASIS) for home health care.

National Medicare Education Program: In the FY 2002 budget, HCFA will continue to fund activities that will help beneficiaries understand and assess their options under the Medicare program, including Medicare+Choice.

The NMEP will fund activities to inform Medicare beneficiaries of their options, including original Medicare, health maintenance organization (HMO), preferred provider organization (PPO) and private fee-for-service plans. NMEP will also provide complete and comprehensible information about these options to facilitate their decision-making process. The President's budget provides approximately $80.5 million to finance NMEP activities. NMEP is funded through a variety of sources, including $52 million from Program Management, as well as an estimated $11.5 million in the Peer Review Organization (PRO) account, and $17 million in Medicare+Choice user fees.

In FY 2002, the NMEP will fund the following activities: mailings to beneficiaries with general information about Medicare, plus specific information on plans available in their area; a toll-free telephone service staffed by customer service representatives able to provide information on available plans; *www.medicare.gov*, the user-friendly Internet site that provides comparative information on plans by zip code; as well as other programs involving State and local entities.

Clinical Laboratory Improvement Amendments: The Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes. CLIA '88 also introduced user fees for clinical laboratories to finance survey and certification activities. User fees are credited to the Program Management account but are available until expended for CLIA activities.

The CLIA program is fully operational, with about 169,600 laboratories registered with HCFA; about 27 percent of the laboratories are subject to routine inspection (every 2 years) under the program. Workloads for each inspection period include a 5 percent sample review of the 17,000 accredited laboratories, surveys of 23,100 non-accredited laboratories, State validation surveys of 850 accredited laboratories, and approximately 1,700 follow-up survey and complaint investigations.

PROGRAM MANAGEMENT PRIORITIES

HIGLAS: HCFA currently has no uniform financial management system to account for the tens of billions of dollars spent on Medicare benefits each year.

Contractors use ad hoc, PC-based spreadsheets and a series of fragmented and overlapping systems to maintain their accounts receivable. Further, most do not use more rigorous double entry accounting methods or claims processing systems with general ledger capabilities. The current approach to financial management makes it difficult to verify the accuracy of reported activities, which increases the risk of administrative and operational errors and misstatements.

The General Accounting Office (GAO) and the Office of Inspector General (OIG) have echoed the concerns regarding HCFA's financial accounting systems in recent annual reports to the Congress. In sum, the current system is inadequate to: detect and collect money owed to the Medicare Trust Funds; retain a clean opinion on financial statements without more expensive, alternative efforts; and comply with financial management statutory requirements. The HCFA Integrated General Ledger Accounting System (HIGLAS) will ensure that HCFA can meet all of these objectives by creating a state-of-the-art uniform Medicare accounting system.

HIGLAS represents a coordinated approach to improving the accounting and financial management processes used by HCFA's Medicare contractors to administer the Medicare Parts A and B programs, and the agency's central administrative accounting and financial management processes. The goals of HIGLAS are to deploy an integrated, enterprise-wide financial management solution to support administrative and program financial management needs. The project will focus on the contractors' accounts receivable, accounts payable, general ledger, and reporting processes and replace HCFA's legacy accounting system and systems that currently support its procurement, travel management, grants management, and asset management. In FY 2002, HCFA plans to spend $53 million for both IGLAS and FACS. HIGLAS is an important component of HCFA's Medicare contractor Oversight.

Capital Improvements: A number of HCFA's information technology systems are antiquated and require upgrading or outright replacement. HCFA is now in the midst of redesigning and replacing its Medicare managed care system. A system that was built to accommodate a small beneficiary population enrolling in a small number of risk health maintenance organizations is being replaced by a system to accommodate a larger number of beneficiaries enrolling and disenrolling in a great variety of managed care plans.

HCFA has surveyed the systems and databases that support the claims processing function and has developed a plan to upgrade or replace a number of mission critical systems to take advantage of the new computing and communications power available now and in the near future. The Secretary is fully supportive of these efforts and has made this as a major priority for the Department, dedicating $36 million in HCFA's Medicare contractors for capital improvement.

The Nursing Home Oversight Improvement Program: The President's Budget commits $67.3 million in mandatory and discretionary funds to the Nursing Home Oversight Improvement Program (NHOIP) in FY 2002, which enables HCFA to continue ensuring quality care for our Nation's nursing home residents. The NHOIP has enabled HCFA to make numerous improvements in our nation's nursing homes. In conjunction with States, HCFA now: imposes immediate sanctions against nursing homes that have caused harm to a resident in consecutive survey cycles, focuses on preventing bed sores, malnutrition, and abuse as part of the annual nursing home survey; investigates complaints alleging actual harm to residents within ten days; and staggers surveys and conducts visits on weekends, early mornings and

evenings, when quality, safety and staffing problems may be more likely to occur. HCFA also conducts more frequent inspections of nursing homes with repeated serious violations. A preliminary report published last summer and updated in December 2000 found significant progress in several areas targeted by the NHOIP:

- almost 12 percent of nursing home surveys were begun during off-hours as compared to 1 percent in 1998;
- the percentage of special focus facilities with findings of immediate jeopardy to resident health or safety has dropped from 27 percent to 2 percent;
- State surveyors are identifying more facilities that fail to prevent or care for bed sores and are also citing more nursing homes for abuse; and,
- the number of imposed per-instance civil money penalties increased 15 fold between FY 1999 and FY 2000.

Management Reform: The Medicare program, with ever increasing pages of regulations, administrative guidelines, and other endless directives issued on a monthly basis, leaves providers and beneficiaries often bewildered and frustrated. The current system is too complex, too centralized, and becoming more so each year. Burdensome regulations and other central directives force providers to take time away from patients to comply with excessive and complex paperwork.

The GAO concluded as recently as January 2001 in its *High-Risk Update* that HCFA "lacks sufficient information on newly designed payment systems to determine whether providers are being paid appropriately for the services they deliver."

Reforming HCFA will include employing every strategy appropriate to enhance quality health care options for beneficiaries rather than relying on increasingly punitive regulations, arbitrary and multiple pricing systems, and delays to maintain the status quo.

One of the top priorities of this Administration is improving management. The Administration intends to consider fundamental changes to HCFA's mission and structure in order to successfully administer the Medicare, Medicaid, and State Children's Health Insurance programs. HCFA will undertake a major effort to modernize and streamline its operations to effectively manage these programs.

Implementing Legislation: HCFA has made substantial progress towards implementing legislation. In particular, HCFA has:

- Successfully implemented 249 of the 359 separate Balanced Budget Act (BBA) provisions, or 70 percent of the BBA provisions.
- Fully implemented 85 of the 126, or 67 percent, of the Balanced Budget Refinement Act (BBRA) changes.
- Implemented the Ticket to Work and Work Incentives Improvement Act.
- Completed work on the health insurance reform and fraud and abuse prevention sections of the Health Insurance Portability and Accountability Act (HIPAA).

LEGISLATION SUPPORTING THE DISCRETIONARY BUDGET

The FY 2002 President's Budget includes two user fee proposals that, if enacted, could improve the efficiency and lower the cost of processing Medicare claims in the future. In addition, the Secretary is requesting that Medicare's contracting process be modernized by eliminating costly provisions that stifle competition and drive up administrative costs.

Paper Claim User Fee: Allows the Secretary to assess a $1.50 fee on any claim not submitted electronically. Paper claims are expensive to process compared to electronic claims. Converting a large percentage of the remaining three percent of Part A claims and 18 percent of Part B claims that are submitted as paper will help lower processing costs. This fee could be waived at the discretion of the Secretary for providers whose special circumstances make it very difficult for them to comply with the submission requirements ($65 million).

Duplicate Claim User Fee: Allows the Secretary to assess a $1.50 fee for each duplicate or unprocessable claim submitted by providers. Duplicate or unprocessable claims are a drain on a system that must process 970 million claims over the course of a year ($50 million).

Medicare Contracting Reform: One of the Secretary's major commitments in improving Medicare is the reform of an antiquated and inefficient contracting system incorporated in law since the program's beginning. Among the issues that the Secretary wishes to address are:

- Allowing carriers to include entities that are not health insurance organizations;
- Providing Secretarial flexibility in contracting for and in assigning fiscal intermediaries;
- Eliminating special provisions for terminating contracts;
- Repealing fiscal intermediary requirements that are not cost-effective; and,
- Providing more Secretarial flexibility with respect to renewing contracts and the transfer of functions.

PROGRAM MANAGEMENT OVERVIEW

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Medicare Contractors.....	$1,239	$1,357	$1,522	+$165
Survey and Certification.....	210	242	242	0
Federal Administration.....	486	505	532	+27
Research.....	61	138	55	-83
HCFA Budget Authority Subtotal.....	**$1,996**	**$2,242**	**$2,351**	**+$109**
CLIA/HMO and Data Spending.....	$45	$45	$45	$0
National Medicare Education Program ...	95	17	17	0
Reimbursable Spending Subtotal.....	**$140**	**$62**	**$62**	**$0**
CLIA/Sale of Data/HMO User Fees.....	-45	-45	-45	0
National Medicare Education Program....	-95	-17	-17	0
User Fee Subtotal.....	**-$140**	**-$62**	**-$62**	**$0**
Proposed Discretionary User Fees.....	$0	$0	-$115	-$115
Proposed Budget Authority	**$1,996**	**$2,242**	**$2,236**	**-$6**
Proposed Outlays.....	$1,996	$2,242	$2,236	-$6
FTE.....	4,446	4,610	4,632	+22

HCFA SUMMARY

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Current Law:				
Medicare Trust Fund	$218,773	$242,552	$256,873	+$14,321
Medicaid	117,921	128,853	143,029	+14,176
SCHIP	1,220	4,032	3,355	-677
State Grants and Demonstrations	0	16	29	+13
Total Outlays, Current Law	**$337,914**	**$375,453**	**$403,286**	**+$27,833**
Premiums	-21,907	-23,433	-27,034	-3,601
Total Net Outlays, Current Law	**$316,007**	**$352,020**	**$376,252**	**+$24,232**
Proposed Law:				
Medicare	$0	$0	$0	$0
Medicaid	0	0	-606	-606
SCHIP	0	0	0	0
State Grants and Demonstrations	0	0	0	0
Immediate Helping Hand /2	0	2,500	11,200	+8,700
Premium Interaction	0	0	20	+20
User Fees	0	0	-115	-115
Total	**$0**	**$2,500**	**$10,499**	**+$7,999**
Total Net Outlays, Proposed Law /1	**$316,007**	**$354,520**	**$386,751**	**+$32,231**

/1 Total net outlays equal current law outlays minus the impact of proposed legislation and offsetting receipts.

/2 The Immediate Helping Hand figure for FY 2001 reflects proposed law and has not been enacted.

ADMINISTRATION FOR CHILDREN AND FAMILIES

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Program Level.....	$38,381	$43,149	$44,387	+$1,238
FTE.....	1,470	1,532	1,547	+15

SUMMARY

The FY 2002 budget request for the Administration for Children and Families (ACF) totals $44.4 billion, a net increase of $1.2 billion, or 2.9 percent, over FY 2001. Of these funds, $12.6 billion is the discretionary program level and $31.8 billion is the entitlement budget authority.

The Administration for Children and Families is the Department's lead agency for programs that promote the economic and social well-being of families, children, individuals, and communities.

DISCRETIONARY PROGRAM SUMMARY

The ACF discretionary budget totals $12.6 billion, a net increase of $514 million. The total includes increases to strengthen families, support services for at-risk children and youth, and continue support for Head Start.

STRENGTHENING FAMILIES

Support that results in successful outcomes for those in need can come from many sources, not just the Government. In every instance where this Administration sees a responsibility to help people, it will look to faith-based organizations, charities, and community groups that have shown the ability to change lives. These groups will not replace Government, but rather partner with it to make life better for those in need. Too many Americans suffer despair and poverty despite numerous government programs. For example:

In every instance where this Administration sees a responsibility to help people, it will look to faith-based organizations, charities, and community groups that have shown the

- As many as 15 million young people are at risk of not reaching productive adulthood because of crime, drugs, and other problems that make it difficult to get an education or obtain a job.
- As many as 1.5 million children have a parent in prison.
- Over half a million children are in foster care, more than one-fifth of whom are awaiting adoption.
- Nearly one-in-six families with children live on an annual income of $17,000 or less.

The FY 2002 budget includes a multifaceted approach to achieve effective interventions on behalf of children and families in need.

Compassion Capital Fund: The President's Budget includes $89 million for a Compassion Capital Fund to support the creation of public/private partnerships to provide start-up capital and operating funds to qualified charitable organizations that wish to expand or emulate model social services programs. Areas to be highlighted include mentoring children of prisoners, after school child care, and elder care.

The President's Budget includes $89 million for a Compassion Capital Fund...

Supporting Children of Prisoners: America is home to 1.5 million children of prisoners on an average day. Low-income children of prisoners suffer disproportionate rates of many severe social problems including substance abuse, gang involvement, early childbearing, and delinquency. The President's Budget includes $67 million to fund activities to assist children while their parents are in prison, maintaining children's connection to an imprisoned parent, and to support family reunification.

After School Programs: The FY 2002 budget includes a $400 million set-aside for after school certificates within the Child Care and Development Block Grant. Funding will provide certificates for up to 500,000 low-income parents of children up to 19 years of age. These funds will assist parents in obtaining after-school child care in programs with a high-quality educational focus.

Maternity Group Homes: The President's Budget provides $33 million for maternity group homes. Through community based adult-supervised group homes or apartment clusters, young mothers and their children, who are unable to live with their own families because of abuse, neglect, or other circumstances, will have access to safe and stable environments. Funds will support certificates to individuals for services and assist providers – including faith-based and charitable organizations – in establishing and operating these facilities. These facilities will offer child care, education, job training, counseling, and advice on parenting skills.

Promoting Responsible Fatherhood: In 1960, less than 10 million children did not live with their fathers, today the number is nearly 25 million. The budget includes $64 million for programs that promote responsible fatherhood. Funding will be provided to faith-based and community organizations that help unemployed and low-income fathers and their families avoid or leave cash welfare, as well as for programs that promote successful parenting and marriage. Within the $64 million, $4 million is for Projects of National Significance to support the expansion of State and local responsible fatherhood efforts.

Office of Faith-Based and Community Programs: On January 29, 2001, the President issued an Executive Order formally establishing the Office of Faith-Based and Community Initiatives. On March 20, 2001, Secretary Thompson established the HHS Center for Faith-Based and Community Initiatives. The Center will coordinate departmental efforts to eliminate barriers to the participation of faith-based and other community organizations in providing social services. The budget includes $3 million to support the Center.

CHILD CARE

Reliable, high quality child care is essential both to parents' continued employment and to children's health and intellectual development. The FY 2002

budget includes $2.2 billion for the discretionary Child Care and Development Block Grant (CCDBG), an increase of $200 million over FY 2001. Within the total available, the budget creates a new $400 million set-aside for after school child care certificates. The certificates will assist up to 500,000 parents in obtaining after school child care with a high-quality education focus. By including the certificates, an estimated 2.6 million children will be served by the Child Care Development Fund.

HEAD START

The President's Budget request includes $6.3 billion for Head Start, an increase of $125 million over FY 2001. In FY 2002, 916,000 children will receive Head Start services including 55,000 children in Early Head Start. The increase will provide sufficient funds to maintain current enrollment levels, strengthen training and technical assistance, and support competitive salaries for Head Start teachers.

In FY 2002, the Administration will reform Head Start by making school readiness – pre-reading and numeracy skills – Head Start's top priority. The President has proposed to move Head Start to the Department of Education to strengthen this new emphasis. The Administration also supports an early reading initiative, funded by the Department of Education, to help prepare young children to read in existing pre-school and Head Start programs.

As America's premier early childhood education program, Head Start ensures that low-income children start school ready to learn. Head Start promotes reading in several ways, by mandating performance standards and teacher qualifications in the Head Start Act, through technical assistance and professional staff development, and through research to monitor outcomes.

Head Start also provides children with comprehensive child development and health services including, immunizations, physical and dental exams, and nutritional services.

LOW INCOME HEATING AND ENERGY ASSISTANCE PROGRAM (LIHEAP)

The FY 2002 budget provides a total of $1.7 billion for LIHEAP, including $1.4 billion for formula block grants to States and $300 million for contingency funding. The continency funds will be available for release in a heating or cooling emergency – such as extreme temperature or high fuel prices, or to meet energy needs related to a natural disaster. The budget proposes to eliminate the requirement that the President declare a budgetary emergency before HHS releases funds to one or more States; this change results from government-wide proposals related to emergency funding.

LIHEAP normally provides heating and cooling benefits to approximately 4.3 million households each year. Of the recipient households, approximately one-third include an elderly member, one-third include a person with a disability, nearly half include a child under age 18, and 22 percent of recipients do not receive any other public assistance.

REFUGEE AND ENTRANT ASSISTANCE

The budget requests $445 million in FY 2002. This request will provide eight months of cash and medical assistance and access to social service programs to an estimated 100,000 refugees and 21,000 Cubans, Haitians, and victims of trafficking. Of the funds requested, ACF will allocate $237 million to Transitional and Medical Services, $144 million to Social Services, $49 million to Targeted Assistance, and $5 million to Preventative Health. The budget includes $10 million to support domestic treatment activities authorized by the Torture Victims Relief Act.

Victims of Trafficking: Within the amounts above, the FY 2002 budget includes up to $10 million to support the newly authorized Trafficking Victims Protection Act. The Trafficking Act makes victims of severe forms of human-trafficking eligible for services as a refugee. Based on State Department estimates, the budget includes funding to provide services for up to 1,000 trafficking victims.

NATIVE AMERICAN PROGRAMS

The budget includes a request of $44 million for the programs of the Administration for Native Americans. Funds are awarded competitively, primarily for Social and Economic Development Strategies grants, which promote self-sufficiency for individuals, Tribes and Native American communities. Grants are also provided for native language preservation and the development of tribal environmental regulations.

The Native American Program has received an increase of $9 million in funding since FY 2000. The number of grantees served has grown by 25 percent for a total of 261 grantees.

DEVELOPMENTAL DISABILITIES

The budget includes a request of $133 million for Developmental Disabilities programs. The Developmental Disabilities program helps States to ensure that all persons with developmental disabilities are able to access services for enhanced independence, productivity, integration, and inclusion in the community.

CHILD WELFARE/ABUSE PROGRAMS

In FY 2002, the President's Budget includes $411 million to support States and localities in their efforts to protect children by strengthening families, and preventing abuse and neglect. These funds will help to provide services to prevent child abuse and neglect, and to intervene in cases in which child maltreatment has been reported.

In 1999, an estimated 1.6 million children received services to prevent child abuse and neglect. An estimated 2.9 million children were the subject of an investigation or assessment pertaining to child abuse or neglect, and 826,000 children were found to be victims of maltreatment.

These funds, combined with the large increase in mandatory funding for Safe and Stable Families and the Foster Care Independent Living program, will provide States with much needed funding to strengthen services provided to children and families in the child welfare system. With these services more families will be kept together, or children will be moved to adoption more quickly so that they become part of a safe and stable environment as quickly as possible.

FEDERAL ADMINISTRATION

The Federal Administration request is $182 million, an increase of $8 million. This level will fund an estimated 1,547 FTE in FY 2002. These funds will support critical travel and monitoring systems responsibilities, Federal pay raises, and all other general overhead expenses.

SUPPORTING SOCIAL SERVICES RESEARCH

Central to the ACF mission is sound research to help guide State and local efforts to help low-income families become and remain economically self-sufficient and to strengthen families. The FY 2002 budget includes a total of $27 million for research, of which $6 million is discretionary funding. The remaining $21 million is mandatory funding made available by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).

REDIRECTED RESOURCES

In FY 2002, resources are redirected in some areas to fund higher priority needs in others. The budget does not fund the Early Learning Fund and three Community Services programs including National Youth Sports, Rural Community Facilities, and Community Food and Nutrition, for a total reduction of $48 million. The budget also does not include $28 million in one-time projects for Social Services Research ($11 million), Child Abuse ($16 million), Native American ($2 million), and Developmental Disability ($200,000) programs that were funded in FY 2001 appropriations.

ENTITLEMENT PROGRAM SUMMARY

The Department's FY 2002 ACF budget includes $31.8 billion in budget authority for entitlement programs. This total includes pre-appropriated funding for the Temporary Assistance for Needy Families (TANF) program and the Child Care Entitlement to States. The ACF entitlement budget also includes proposals to increase funding for Promoting Safe and Stable Families and the Independent Living Program. In addition, the President's Budget includes a proposal to give States the option to count as TANF expenditures the costs of offering a charitable State tax credit.

CHILD CARE ENTITLEMENT TO STATES

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (welfare reform) amended the Child Care and Development Block Grant Act (CCDBG) by consolidating four former child care programs and creating an entitlement portion of the block grant that includes both matching and mandatory funds. Currently, all States receive discretionary and entitlement funds. The entitlement funds help States provide subsidies to working families and require States to spend a minimum of four percent of the funds to improve the quality and availability of healthy and safe child care for all families. Additional amounts of the discretionary funds are also set aside for quality improvements and research and referral activities.

For FY 2002, welfare reform authorized and pre-appropriated entitlement funds (matching and mandatory) of $2.7 billion for child care programs, a $150 million increase over FY 2001. States are allowed maximum flexibility in developing child care programs. These funds, combined with the requested $2.2 billion in discretionary child care funding, will continue to enhance support for working families and to help move families from welfare to work.

The Child Care Entitlement funds include: 1) Mandatory Child Care, 2) Matching Child Care, and 3) Training and Technical Assistance.

TEMPORARY ASSISTANCE TO NEEDY FAMILIES

The TANF block grant, a single capped entitlement of approximately $16.7 billion annually, provides funds to States to design creative programs to help families transition from welfare to self-sufficiency. Under TANF, recipients must engage in work activities to receive time-limited assistance. According to State reports, more than 1.2 million parents on welfare went to work between 1998 and 1999. Overall, 43 percent of welfare recipients entered the work force in 1999 compared with 39 percent in 1998. Not only are these adults working, but their incomes are rising as time goes on, a critical component of staying off of welfare. In 1999, States reported an average earnings increase of 22 percent for former welfare recipients over a period of two quarters. Last year, States reported an average increase of 24 percent.

Welfare reform legislation authorizes the following activities:

- Family Assistance Grants to States, Tribes and Territories;
- Matching Grants to Territories;
- Bonus to Reward Decrease in Out-of-Wedlock births;
- Bonus to Reward High Performance States;
- Tribal Work Programs; and,
- Loans for State Welfare Programs.

Up to a combined 30 percent of TANF funds may be transferred to either the Child Care and Development Block Grant or the Social Services Block Grant (SSBG). Starting in FY 2002, transfers to SSBG will be limited to 4.25 percent of TANF funds. States are transferring large amounts of their TANF funds to the Child Care and Development Block Grant, in response to the increased needs in this program.

TANF Legislative Proposals

The FY 2002 President's Budget contains a new proposal that would allow States to partially offset, at State option, costs of a Charitable State Tax Credit (CSTC) with funding from the TANF program. States that offer a CSTC would provide a credit (of up to 50 percent of the first $500 for individuals and $1,000 for married couples) toward State income or other taxes for contributions to charities designated by States as addressing poverty and its impact (defined as consistent with purposes of the TANF program). States who choose to offset the cost of this credit with TANF dollars would be required to meet maintenance of effort and matching requirements. This proposal is budget neutral over ten years.

Children's Research and Technical Assistance (CRTA)

Welfare reform authorizes and appropriates funds for welfare research and technical assistance for States. The FY 2002 total is $62 million.

Included in this total is $21 million in pre-appropriated mandatory funds, of which $15 million is for welfare research and $6 million is for a longitudinal child welfare study. These funds will also support welfare research on the effects of welfare reform and on ways to improve the welfare system.

The remaining $41 million of the request includes two child support set-asides: one for training and technical assistance and the other to assist in operating the Federal Parent Locator Service (FPLS). The funds appropriated for these activities are equal to one and two percent respectively of the amount paid to the Federal government for its share of child support collections during the preceding fiscal year.

Child Support Enforcement

The Child Support Enforcement (CSE) program is a joint Federal, State and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders. The program provides critical support for working families and assists in the transition to self-sufficiency. In FY 2002, an estimated total of $5.4 billion in Federal and State dollars will be spent in order to collect $21.2 billion in payments. This represents a nine percent gain in collections over FY 2001 and an expected total return of about $4 for every $1 invested in the administration of the program. Since the inception of the program in FY 1975, over $100 billion has been collected. In FY 2000, the program set a new record amount of $1.4 billion collected in overdue child support from Federal income tax refunds.

Last year, the National Directory of New Hires (NDNH) helped locate more than 3.5 million non-custodial parents. In addition, paternity establishment rose to 1.6 million in 1999.

The Federal government shares in the financing of this program by providing incentive payments, a 66 percent match rate for general State administrative costs, and an enhanced match rate for paternity testing and specified automated systems requirements. The CSE program also includes a capped entitlement of $10 million annually for grants to States to facilitate non-custodial parents' access to and visitation of their children.

The CSE program strengthens families by helping children get the support they are owed from non-custodial parents. In non-TANF cases, child support collections are forwarded to the custodial family. By securing support on a consistent and continuing basis, families may avoid the need for public assistance, thus potentially reducing future welfare, Food Stamp, and Medicaid spending. Applicants for TANF assign their rights to support payments to the State as a condition of receipt of assistance. Child support collections on behalf of families receiving TANF and some collections on behalf of former TANF recipients are shared between the State and Federal government.

As noted above, a portion of the Federal share of child support collections is paid to the States as incentive payments. Previously, Federal incentive payments to States were based on the State's cost effectiveness in operating the program and the amount of payments collected. Following passage of the Child Support Performance and Incentive Act of 1998, a new incentives structure was put into place using five key measures: paternity establishment, support order establishment, collections on current support, collections on past-due support, and cost effectiveness. This new system will be fully imiplemented in FY 2002.

FOSTER CARE, ADOPTION ASSISTANCE AND INDEPENDENT LIVING PROGRAM

The FY 2002 budget requests $6.7 billion in budget authority for the Foster Care, Adoption Assistance and Independent Living programs.

Of the total request, $5.1 billion will provide Foster Care payments on behalf of about 290,700 children each month. This request will also fund State administration, including child welfare information systems, training, and State data systems.

For the Adoption Assistance program, about $1.4 billion will provide payments for families who adopt special needs children. Monthly payments are made on behalf of adopted children until their 18th birthday. The proposed level of funding will support approximately 301,600 children each month.

The budget includes $140 million to fund the Independent Living Program, and an additional $60 million for the legislative proposal described below.

FOSTER CARE-RELATED LEGISLATIVE PROPOSALS

Independent Living Program (ILP): Approximately 16,000 youth age out of the foster care system annually. Young people interested in higher education or vocational training often do not have the resources to pay for these opportunities. This proposal would provide $60 million to States to support these young people in furthering their education, through either college or technical training, and increase the prospect that they will be able to secure work and become contributing members of adult society. States receive funds to implement this program based on the number of youth in the foster care system from ages 16 to 21.

Promoting Safe and Stable Families: The Adoption and Safe Families Act of 1997 reauthorized and expanded the Promoting Safe and Stable Families program (formerly known as the Family Preservation and

Support program). The FY 2002 request includes $505 million, a $200 million increase over FY 2001, for States and eligible Indian tribes.

The Promoting Safe and Stable Families program supports State child welfare agencies and tribes in providing for the best interests of the child through: family preservation services, family support services, time-limited family reunification services, and adoption promotion and support services.

SOCIAL SERVICES BLOCK GRANT

Through a pre-appropriated block grant, the Social Services Block Grant (SSBG) allows States the flexibility to provide or supplement social services at the State and local levels. SSBG is funded at $1.7 billion for FY 2002 and provides direct social services and resources that link human service delivery systems together. Programs or services most frequently supported by SSBG include child care, child welfare (foster care, adoption and protective services), elder care, drug abuse prevention and treatment activities, home-based services, employment services, prevention and intervention programs, and services for the disabled.

ACF OVERVIEW: DISCRETIONARY SPENDING

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Strengthening Families:				
Compassion Capital Fund	$0	$0	$89	+$89
Promoting Responsible Fatherhood	0	0	64	+64
Maternity Group Homes	0	0	33	+33
Mentoring Children of Prisoners	0	0	67	+67
Office of Faith Based	0	0	3	+3
Child Care & Development Block Grant:				
Child Care & Development Block Grant	$1,173	$1,990	$2,190	+$200
After School Certificate Set-Aside (non-add)	*0*	*0*	*400*	*+400*
Research and Evaluation Fund	10	10	10	0
Subtotal, CCDBG	**$1,183**	**$2,000**	**$2,200**	**+$200**
Head Start 2/	$5,266	$6,200	$6,325	+$125
LIHEAP 1/	$1,100	$1,400	$1,400	$0
LIHEAP Emergency Contingency Fund	900	300	300	0
Available for Obligation (non-add)	*0*	*0*	*0*	*0*
Subtotal, LIHEAP	**$2,000**	**$1,700**	**$1,700**	**$0**
Refugees:				
Refugee and Entrant Assistance	$426	$433	$445	+$12
Victims of Torture (non-add)	*7*	*10*	*10*	*0*
Carry-over Funds	72	12	0	-12
Subtotal, Refugees	**$498**	**$445**	**$445**	**$0**
Native Americans	35	46	45	-1
Developmental Disabilities	122	133	133	0
Child Abuse	72	88	72	-16
Child Welfare	339	339	339	0
Federal Administration	158	174	182	+8
Social Services Research & Demonstrations	28	37	27	-10
Social Services R&D: Mandatory (non-add)	*0*	*0*	*21*	*+21*
Early Learning Fund	0	20	0	-20
Runaway and Homeless Youth	64	69	69	0
Adoption Incentives	42	43	43	0
Community Services:				
Community Services Block Grant	$528	$600	$600	$0
Individual Development Accounts	10	25	25	0
Other Discretionary Programs	57	58	30	-28
Subtotal, Community Services	**$594**	**$683**	**$655**	**-$28**
Violence Against Women	118	134	134	0
Total, ACF Discretionary Program Level	**$10,519**	**$12,111**	**$12,625**	**+$514**
Less Funds Allocated from Other Sources:				
Social Services R&D: Mandatory	0	0	-21	-21
1% / 2% Fed. Admin. Funds (pre-appropriated)	-10	-10	-10	0
Head Start Advance Appropriation	-1,400	0	0	0
Total, ACF Discretionary B. A	**$9,109**	**$12,101**	**$12,594**	**+$493**
FTE	1,470	1,532	1,547	+15

/1 Of the $900 million in Emergency Contingency funds appropriated in FY 2000, $155 million was obligated in FY 2001.
/2 FY 2001 and FY 2002 funding levels included $1.4 billion advanced appropriation for subsequent year.

ACF OVERVIEW ENTITLEMENT SPENDING

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/- Enacted
TANF/1	$16,689	$16,689	$16,679	-$10
Child Care Entitlement	2,367	2,567	2,717	+150
Child Support Enforcement & Family Support (net BA)	1,010	3,321	3,448	+127
CSE &FS Program Obligations (non-add)	*3,353*	*3,748*	*3,908*	*+160*
Foster Care/Adoption Assistance	5,697	6,401	6,682	+281
Children's Research & Technical Assist (net BA)	39	40	62	+22
Promoting Safe and Stable Families	295	305	505	+200
Social Service Block Grant	1,775	1,725	1,700	-25
Total, Budget Authority	**$27,872**	**$31,048**	**$31,793**	**+$745**

NOTE: FY 2002 levels include legislative proposals and reflect preappropriated amounts for TANF, Child Care and Children's Research and Technical Assistance.

1/ FY 2002 amount reflects anticipated State penalities against family assistance grants.

ACF PROPOSED ENTITLEMENT LEGISLATION

(dollars in millions)

	FY 2002	FY 02-06	FY 02-11
TANF Charitable State Tax Credit (outlays).....	$0	$850	$0
Promoting Safe and Stable Families (BA).....	200	1,000	2,000
Foster Care/Adoption Assistance/Independent Living Program (BA)....	60	300	600
Total, ACF Proposed Law Impact.....	**$260**	**$2,150**	**$2,600**

CHILD SUPPORT ENFORCEMENT OVERVIEW: COLLECTIONS AND COSTS

(dollars in millions)

	2000 Actual	2001 Estimate	2002 Estimate	2002 +/-2001
Total Collections Distributed:				
Non-TANF Families	$15,159	$16,903	$18,593	+$1,690
TANF/Foster Care families	139	139	140	+1
TANF program	2,360	2,403	2,431	+28
Foster Care program	44	49	52	+3
Total	**$17,702**	**$19,494**	**$21,216**	**+$1,722**
Distributed to TANF/Foster Care Programs:				
Net Federal Share	$938	$924	$907	-$17
State Share (includes incentives and hold harmless payments)	1,487	1,528	1,576	+48
Total	**$2,425**	**$2,452**	**$2,483**	**+$31**
Administrative Costs (Obligations):				
Federal Share	$2,806	$3,248	$3,414	+$166
State Share	1,649	1,842	2,011	+169
Costs	**$4,455**	**$5,090**	**$5,425**	**+$335**
Program Costs (Distributed Collections minus Costs):				
Federal Costs	$1,868	$2,324	$2,507	+$183
State Savings/Costs	162	314	435	+121
Net Costs to Taxpayer	**$2,030**	**$2,638**	**$2,942**	**+$304**

NOTE: Program Costs equal the Administrative Costs minus the portion of collections distributed to TANF and Foster Care Programs.

ADMINISTRATION ON AGING

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Program Level.....	$934	$1,105	$1,100	-$5
FTE.....	119	122	124	+2

SUMMARY

The FY 2002 budget request for the Administration on Aging (AoA) is $1.1 billion, a net decrease of $5 million compared to FY 2001. The net decrease is a result of the non-continuation of $18 million for 34 one-time Training, Research and Discretionary projects funded in FY 2001. The FY 2002 budget includes increases of $13 million to provide additional services to our Nation's growing older population and their caregivers. The Census Bureau predicts that the number of Americans age 65 and older will grow by about one percent per year for the next decade before increasing rapidly to 70 million in 2030, more than twice the number in 1997.

THE OLDER AMERICANS ACT

AoA's goal is to improve the quality of life for all older Americans by helping them to remain independent and productive. Through the Older Americans Act, funds are distributed – primarily by formula – through a nation-wide network of State, Tribal and area agencies on aging, to some 29,000 local service providers.

On November 13, 2000, the Older Americans Act was reauthorized for the first time since 1992. The reauthorization added a new National Family Caregiver Support Program to provide assistance to caregivers of older family members. More than five million older individuals rely on care from family and close friends to remain at home. The role of the caregiver is difficult; half are themselves over the age of 65, and one-third have full time jobs. Research shows that caregiver's rates of depression are significantly higher than non-caregivers of the same age.

> ***"We must do all we can to ensure that our older residents can remain at home and receive care from loved ones for as long as possible. This money will allow States to develop systems of support to ease the burden on hundreds of thousands of family caregivers nationwide."***
>
> Secretary Thompson

To address this situation, the FY 2002 budget request includes a total of $127 million for the National Family Caregiver Support Program, an increase of $2 million over the previous year. States received their first caregiver awards on February 15, 2001.

In addition to creating the Family Caregiver Support Program, the Older Americans Act was modified to give States, area agencies and Tribes important new flexibility to maximize the effectiveness of their program activities.

NUTRITION SERVICES

AoA nutrition services help older persons to remain in their homes and communities. Research has indicated that for many, the availability of a home delivered meal is crucial to their ability to function independently at home. According to this same evaluation, meal preparation is difficult or impossible for 41 percent of program recipients, and 77 percent have difficulty with one or more daily activity.

The budget request includes $562 million for nutrition services overall, a four percent increase for home-delivered meals and a nine percent increase for Grants for Native Americans. With the additional funding requested, the three nutrition programs will be able to provide 301 million meals in FY 2002, an increase of 7 million meals over FY 2001.

SUPPORTIVE SERVICES

The FY 2002 budget also includes an additional $2 million for Supportive Services, for a total of $327 million. Supportive Services include information and referral; transportation and assistance; chore, homemaker and personal care services; and the provision of adult day care. Transportation is a critical service, particularly in areas which are typically underserved by public transportation where more than 70 percent of older Americans live. According to a 1997 AARP study, one quarter of the 75-plus age group does not drive, and this number is expected to increase as the population ages. In FY 2001, AoA estimates that the aging network will provide 48.7 million rides, providing older Americans with the means to visit health professionals, pharmacies and grocery stores.

TRAINING, RESEARCH AND DISCRETIONARY PROJECTS

A total of $18 million is included to continue innovative projects that initiate, develop, and test best practices in serving the elderly (e.g., state-wide legal hotlines, health care anti-fraud, waste and abuse projects). The FY 2002 budget does not include $18 million for 34 one-time projects funded in FY 2001.

OTHER PROGRAMS

The budget request also includes $2 million for aging network support activities (e.g., Eldercare Locator and Pension Counseling), $21 million for Preventive Health Services, $14 million for Protection of Vulnerable Older Americans – including Ombudsman and Elder Abuse Prevention activities – and $9 million for Alzheimer's Disease Demonstration Grants. These programs are all funded at their FY 2001 levels.

A total of $18 million is requested for Program Administration, an increase of $1 million over FY 2001. Additional funds will support 124 FTE, an increase of two FTE, fund inflationary increases, and allow AoA to expand efforts to better serve stakeholder populations through areas such as e-government and information and outreach activities.

AOA OVERVIEW

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
National Family Caregiver Support.....	$0	$125	$127	+$2
Nutrition Services:				
Home-Delivered Meals.....	147	152	158	+6
Grants for Native Americans.....	19	23	25	+2
Congregate Meals.....	374	379	379	0
Subtotal, Nutrition Programs.....	**$540**	**$554**	**$562**	**+$8**
Supportive Services and Centers.....	$310	$325	$327	+$2
Training, Research & Discretionary Projects.....	30	36	18	-18
Aging Network Support Activities.....	2	2	2	0
Preventive Health Services.....	16	21	21	0
Protection of Vulnerable Older Americans	13	14	14	0
Alzheimer's Disease.....	6	9	9	0
Program Administration.....	16	17	18	+1
Operation Restore Trust	1	2	2	0
Total, Program Level.....	**$934**	**$1,105**	**$1,100**	**-$5**
Less Funds Allocated From Other Sources:				
Operation Restore Trust	-$1	-$2	-$2	$0
Total, Budget Authority.....	**$933**	**$1,103**	**$1,098**	**-$5**
FTE.....	119	122	124	+2

DEPARTMENTAL MANAGEMENT

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Program Level.....	$515	$399	$471	+$72
FTE.....	1,421	1,542	1,649	+107

SUMMARY

Departmental Management (DM) consolidates the activities funded under two appropriation accounts in the Office of the Secretary: General Departmental Management (GDM) and Policy Research. The FY 2002 budget request provides a total program level of $471 million for DM, including appropriations of $424 million, interagency transfers of $39 million in evaluation funds, and $8 million in health care fraud and abuse funds.

GENERAL DEPARTMENTAL MANAGEMENT

The GDM account supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department, in administering and overseeing the organization, programs and activities of the Department. These activities are carried out through nine Staff Divisions (STAFFDIVs). The GDM budget request for FY 2002 totals $450 million, an increase of $68 million or 18 percent from the comparable FY 2001 enacted level.

Of the increase requested, $12 million is for improving a variety of administrative and legal functions: alleviating large pending caseloads in the Departmental Appeals Board; addressing caseload management and workforce planning in the Office of the General Counsel; improving the work environment, security and safety of HHS employees in the Hubert H. Humphrey Building; implementing the Distance Learning Network, an Internet-based system for providing training to HHS employees; and adding a modest number of essential staff to manage and analyze budgetary and operations activities.

The GDM request also includes the following program-related increases:

Office on Women's Health (OWH): The OWH request of $27 million will provide funding to advance women's health programs through the promotion and coordination of research, service delivery, and education, both throughout HHS agencies and offices, with other government organizations, and with consumer and health professional groups. This request includes a $10 million (59 percent) increase over the FY 2001 enacted level. These additional funds will allow OWH to: support new efforts on minority women's health and women's cancers; increase women's access to comprehensive care; continue support for Violence Against Women programs; and promote a greater focus on women's health issues at the State and local levels.

Office of Population Affairs (OPA): The request of $28 million provides support for the Adolescent Family Life (AFL) demonstration and research program authorized under Title XX of the Public

Health Service (PHS) Act. Through the grants awarded under this program, AFL provides funding in three areas: care demonstration projects, prevention projects, and research projects. This request is a $4 million (4 percent) increase over the FY 2001 enacted level and will allow AFL to expand the prevention program, which focuses on postponing early sexual activity in order to prevent adolescent pregnancies, as well as sexually-transmitted diseases and HIV/AIDS. This request also continues to provide for abstinence-only prevention projects, as defined by the Welfare Reform legislation (P.L. 104-193). Finally, OPA also administers the Family Planning program under Title X of the PHS Act; that program is funded through the Health Resources and Services Administration.

Office of Minority Health (OMH): The OMH request includes $43 million to improve disease prevention, health promotion, and health service delivery for disadvantaged and minority individuals. The request does not include $6 million for one-time projects in the FY 2001 enacted level. OMH funding also supports research to improve the health status of racial and ethnic minority populations in the U.S., which continues to lag behind the health status of the American population as a whole. In addition, these funds support activities aimed at reducing the risk of acquiring or transmitting HIV/AIDS, and at increasing access to services and treatment.

Office of Disease Prevention and Health Promotion: The budget request of $10 million is an increase of $3 million (35 percent) over the FY 2001 enacted level. These funds will be used to continue and expand the implementation of the Healthy People 2010 effort to promote health and prevent disease and disability in the American population.

Office of Emergency Preparedness: The budget request of $14 million will be used to manage the medical and health-related social services provided by the Federal government to victims of catastrophic disasters through Emergency Support Function (ESF) #8 of the Federal Response Plan. Under ESF #8, HHS coordinates the support of twelve Federal agencies in the preparedness for, response to, and recovery from both natural and man-made disasters.

Office of Human Research Protections: In FY 2001, the Office of Protection from Research Risks was moved from the National Institutes of Health to the Office of the Secretary, where it became the Office of Human Research Protections (OHRP). The FY 2002 budget request of $7 million will be used to: ensure implementation of Departmental regulations for the protection of human subjects; negotiate formal written assurances of compliance with institutions engaged in research covered by OHRP; investigate and oversee institutional compliance; and fund professional and public education.

HIV/AIDS in Minority Communities: The FY 2002 request includes a continuation of $50 million to address the high-priority HIV prevention and treatment needs of minority communities heavily impacted by HIV/AIDS. These funds allow the Department to continue priority investments and public health strategies targeted to reduce the disparities and burden of HIV/AIDS in racial and ethnic minority populations.

Bioterrorism: The FY 2002 request includes $69 million, an increase of $9 million, to continue the Department's efforts to prepare for the health and medical consequences of a bioterrorism incident.

Of this total, $51 million is for the Office of Emergency Preparedness to direct its efforts to the following activities in FY 2002:

- Establish 25 new Metropolitan Medical Response Systems (MMRS)

and add a bioterrorism component to the MMRSs established in FY 2001;

- Provide training, pharmaceutical supplies and equipment to 44 Disaster Medical Assistant Teams and four National Medical Response Teams;
- Enhance the Salt Lake City MMRS, and purchase specialized equipment and supplies for the 2002 Winter Olympics.

The bioterrorism request also includes $10 million for the Department's cyber-security efforts, to begin a program to ensure continuous operation of the bioterrorism prevention infrastructure (e.g., communication systems, data banks and facilities). This program will include: an analysis of HHS's critical IT assets involving bioterrorism programs; establishing a bioterrorism Public Key Infrastructure (PKI) to verify the identities of bioterrorism responders; developing and operating bioterrorism security programs including detection and response capabilities; and purchasing necessary infrastructure software.

Finally, the bioterrorism request includes $8 million for the continuation of research on anthrax and smallpox vaccines.

Information Technology Security and Innovation Fund: Although HHS's current information technology (IT) systems are functioning, they are very decentralized and heterogeneous, and therefore have vulnerabilities that need to be corrected. The FY 2002 budget request includes $30 million to establish an IT Security and Innovation Fund. These funds will be used to leverage approaches that will allow the Department to achieve security for its data and information in a standardized way. By establishing an Enterprise Infrastructure Management (EIM) framework, and consolidating the capital planning and management of its IT assets, the Department will be better able to reduce or eliminate duplication of effort and to contain risks. EIM is an operational IT management framework that will protect the Department's IT operating infrastructure by: restructuring management practices and functional boundaries; providing automated tools to reduce workloads for users and systems administrators; and promoting the use of enterprise software and service contracts across the Department.

POLICY RESEARCH

Policy Research examines broad issues that cut across agency and subject lines, as well as new policy approaches developed outside the context of existing programs. The FY 2002 request for Policy Research includes $3 million for a new State Innovation Fund and $18 million to continue evaluations.

State Innovation Fund: New approaches for integrating diverse funding streams, expanding services to new populations, and designing service delivery systems often emerge from innovations at the State or local level. Therefore, the FY 2002 budget provides $3 million for a new program to provide grants to States (selected competitively) to design, demonstrate, and evaluate new models for delivering health services, long-term care, and/or human services to low-income adults, families, and children. States will be encouraged to integrate separate but related services funded by different programs and/or provided by different agencies. The grants will be of two types: planning grants and demonstration grants. Measurable indicators of performance to facilitate evaluation of the outcomes of the demonstrations will be a key ingredient of the program.

Broad-Based Research: The FY 2002 budget includes $18 million to support research on issues that cut across agency and subject lines, as well as new approaches developed outside the context of an existing program. Priority issues that will be

examined are those related to: the well-being of children and youth; the outcomes of welfare reform and the status of low-income families; reform of major public-sector programs, especially Medicare and access for those who lack health insurance; promoting and expanding consumer-directed home and community-based services; nursing home quality; managed care and disability; post-acute care; employment and disability; active aging; and science policy.

It is proposed that in FY 2002 the entire $18 million request be derived through interagency transfers of evaluation funds.

DM OVERVIEW

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
General Departmental Management:				
GDM Staff Divisions	$131	$128	$143	+$15
Program Offices:				
Office on Women's Health	15	17	27	+10
OPA/Adolesent Family Life	19	24	28	+4
Office of Minority Health	38	49	43	-6
Office of Disease Prevention and Health Promotion	5	7	10	+3
Office of Emergency Preparedness	10	12	14	+2
Office of Human Research Protections 1/	2	6	7	+1
Minority HIV/AIDS 2/	50	50	50	0
Y2K 2/	144	0	0	0
Bioterrorism 1/	55	60	69	+9
IT Security and Innovation Fund	0	0	30	+30
One-Time Projects	6	4	0	-4
Evaluation funds	21	21	21	0
Health Care Fraud and Abuse Control funds	2	4	8	+4
Total, GDM Program Level	**$498**	**$382**	**$450**	**+$68**
Policy Research:				
Broad-Based Research	17	17	18	+1
State Innovation Fund	0	0	3	+3
Total, PR Program Level	**$17**	**$17**	**$21**	**+$4**
Total, DM Program Level	**$515**	**$399**	**$471**	**+$72**
Less funds from other sources:				
Evaluation funds	21	21	39	+18
Health Care Fraud and Abuse Control funds	2	4	8	+4
Total, DM Budget Authority	**$492**	**$374**	**$424**	**+$50**
FTE	1,421	1,542	1,649	+107

1/ Comparable adjustments shown for FY 2000 and FY 2001.

2/ Comparable adjustment shown for FY 2000.

OFFICE FOR CIVIL RIGHTS

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Program Level.....	$23	$28	$32	+$4
FTE.....	215	259	276	+17

SUMMARY

The FY 2002 budget request for the Office for Civil Rights (OCR) is $32 million, an increase of $4 million over the FY 2001 level. OCR is responsible for enforcing civil rights statutes that prohibit discrimination in Federally-assisted health care and social services programs. These statutes prohibit nondiscrimination on the basis of race, national origin, disability, age, and in limited instances, sex and religion.

Among the most significant issues that OCR addresses are: implementation of the Supreme Court's 1999 decision in the *Olmstead* case concerning the provision of services in the most-integrated setting to persons with disabilities; the effects of discrimination on racial disparities in health care; nondiscriminatory implementation of TANF and welfare-to-work programs; assessment of the effects of managed care on services to minority and disability communities; and removal of discriminatory barriers to access for immigrant populations, including language barriers affecting individuals with limited English proficiency.

In FY 2001, OCR assumed new responsibilities for providing technical assistance related to privacy of health information. OCR also implements inter-ethnic adoption civil rights requirements intended to prevent racial and national origin discrimination in foster care and adoption placements. In addition, OCR coordinates implementation of the regulation that prohibits discrimination against persons with disabilities in programs and activities conducted by HHS, and government-wide enforcement of the Age Discrimination Act.

OCR enforces nondiscrimination requirements by processing and resolving discrimination complaints, conducting reviews and investigations, monitoring corrective action plans, and carrying out voluntary compliance, outreach, technical assistance and public education activities. Each of OCR's compliance activities ensures that individuals are treated in a nondiscriminatory manner by health and human services provider agencies or facilities. OCR's work protects individual rights and simultaneously supports HHS goals for strengthening the health and well-being of individuals, families and communities by improving access to HHS programs and activities.

***OLMSTEAD* AND OTHER FY 2002 PRIORITIES**

A primary focus of OCR's requested FY 2002 budget increase is expanded technical assistance related to the *Olmstead* decision. OCR will support the President's New Freedom Initiative by providing expert consultant technical assistance to States as

they develop comprehensive plans consistent with the requirements of the Supreme Court's *Olmstead* decision. The decision found that unnecessary institutionalization of individuals is a violation of the Americans with Disabilities Act, and that under appropriate circumstances individuals have a right to receive care in the "most integrated" setting that is appropriate for them. OCR is using a more intense technical assistance approach that supplements its normal complaint investigation procedures to assist States in developing system-wide plans for moving people from costly institutional settings into community-based care.

OCR also will develop further its technical assistance program for helpinghealth care providers, plans and other related entities implement privacy protections related to individuals' health information.

In FY 2002, OCR will continue to focus on new priorities, such as quality access improvements designed to eliminate racial disparities and improve the quality of health care for racial and ethnic minorities. OCR also will focus on improving access to the Medicaid and SCHIP programs by removing possible discriminatory barriers. OCR plans to increasingly involve the faith-based community in its coalition-building activities.

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Program Level \1.....	$151	$164	$186	+$22
FTE	1,374	1,524	1,680	+156

1/ The FY 2002 level assumes $150 million for Medicare and Medicaid related fraud and abuse activities, the maximum allowed under the Health Care Fraud and Abuse Control program.

SUMMARY

For FY 2002, the Office of Inspector General (OIG) requests a discretionary appropriation of $36 million, an increase of $2 million above the FY 2001 discretionary level. The OIG will also receive between $140 and $150 million in FY 2002 from the Health Care Fraud and Abuse Control (HCFAC) Account for Medicare and Medicaid related fraud and abuse activities.

The OIG's statutory mission is to improve HHS programs and operations and protect them against fraud, waste and abuse. By conducting independent and objective audits, evaluations, and investigations, OIG provides timely, useful, and reliable information and advice to HHS officials, the Administration, the Congress and the public.

In the FY 2001-FY 2002 period, the OIG will use its discretionary funding to continue its work across the non-Medicare and non-Medicaid areas of HHS, which are public health, children and families, aging and department-wide activities.

INCREASING COLLECTIONS IN THE CHILD SUPPORT ENFORCEMENT PROGRAM

The OIG will expand its multi-agency task forces to identify, investigate, and prosecute individuals who willfully avoid payment of their child support obligations under the Child Support Recovery Act. These task forces bring together State and local law enforcement and prosecutors, United States Attorneys' Offices, the OIG, U.S. Marshal Service personnel, the Federal Bureau of Investigations, State and county child support personnel, and all other interested parties from the 25 states covered by the task forces. Through March 7, 2001, the OIG has opened over 1,329 child support cases nationwide resulting in 361 convictions, and court-ordered restitution of nearly $22 million in payments to custodial parents. The Child Support Task Forces have resulted in an additional 264 arrests on the State level and 220 convictions or civil adjudications, resulting in $8.6 million in restitution.

PUBLIC HEALTH PRIORITIES

The OIG plans to conduct audits and inspections of programs and activities at HHS public health agencies. Programs experiencing increased funding may be more vulnerable to mismanagement, fraud, or abuse. The OIG also will focus on program effectiveness issues, such as the Food and Drug Administration's oversight responsibilities in clinical trials, and the National Institutes of Health's process for providing biomedical technology developed in its intramural laboratories to the private sector to facilitate transfer of Federal technology to the marketplace. In addition, it will investigate referrals from the Office of Research Integrity, and assess such cross-cutting activities as agencies' compliance with the directive on critical infrastructure protection.

The OIG also will examine States' strategies for addressing the substance abuse treatment needs of welfare recipients, particularly treatment programs funded through Substance Abuse and Mental Health Services Administration grants.

SAFE AND STABLE FAMILIES

Recent studies requested by the Congress found that approximately one million American children are victims of abuse and neglect annually and that many of these children and their families fail to receive adequate protection and treatment.

The OIG will determine whether State Child Protective Service referrals were properly prioritized and resolved and whether any service delays could result in further occurrences of child abuse and/or neglect. The OIG will examine recidivism rates and the extent of State outreach efforts to alert the community to the problem of child abuse. In foster care programs, the OIG will examine States' processes, efforts and challenges in eligibility determinations for foster care services and the Medicaid program, preventing abuse when children are in foster care, and recruitment of foster care parents.

AGENCY MANAGEMENT

The OIG plans to conduct audits of the data collection and measurement systems used for HHS agencies' performance measures to test for reliability and validity of the data. In particular, the OIG will examine the use of State-supplied data by the Administration for Children and Families for performance measurement, including measures for Temporary Assistance for Needy Families.

The OIG also will work to fulfill specific statutory obligations, such as annual evaluations of the security programs and practices of HHS information systems.

HEALTH CARE FRAUD AND ABUSE

Through the Health Insurance Portability and Accountability Act, the OIG receives mandatory funding for its activities that focus on fraud, abuse and efficiency improvements in the Medicare and Medicaid programs. The Act provides for minimum and maximum amounts of funding that are decided each year by the Secretary of HHS and the Attorney General. The OIG works with the Health Care Financing Administration (HCFA), other HHS agencies and the Department of Justice to ensure that funds due to the Medicare Trust Fund or HCFA are recovered through audits and investigations, and provides recommendations for statutory, regulatory and program changes that could strengthen program integrity.

PROGRAM SUPPORT CENTER

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Expenses.....	$249	$294	$308	+$14
FTE.....	1,069	1,114	1,114	0

SUMMARY

The Program Support Center (PSC) was created in 1995 to streamline and minimize duplication of traditional administrative services. The PSC provides services on a competitive, fee-for-service basis to customers throughout HHS, as well as to at least 14 other Executive departments and 20 independent Federal agencies. The activities and services of the PSC are supported through the HHS Service and Supply Fund, a revolving fund. The Fund does not receive appropriated resources, but is funded entirely through charging its customers for their use of services and products. Services are provided in three broad areas: human resources, financial management, and administrative operations. The PSC's customers include HHS agencies and other Federal agencies and organizations, such as components of the Departments of Agriculture, Commerce, Defense, Education, Energy, Housing and Urban Development, Interior, Justice, Labor, State, Transportation, Treasury and Veterans Affairs.

HUMAN RESOURCES SERVICE

The FY 2002 estimated expenses for the Human Resources Service (HRS) are $53 million, a decrease of $1 million below the FY 2001 level. The $1 million decrease represents $2 million in reduced contractor support for the Enterprise Human Resources and Payroll project, offset by $1 million in pay and other increases. HRS provides a full range of human resources services, including automated personnel and payroll systems support, personnel and payroll processing, staffing and classification, employee and labor relations, and commissioned officer personnel support.

FINANCIAL MANAGEMENT SERVICE

The FY 2002 estimated expenses for the Financial Management Service (FMS) are $53 million, an increase of $2 million above the FY 2001 level. The increase is for pay and other costs ($1.6 million), increased computer information technology charges to support new customer grants ($.5 million), and systems maintenance support ($.4 million) that will ensure continued functionality and support of customer requirements for the Travel Management System and the Accounting for Pay System. FMS supports the financial operations of

HHS and other departments through the provision of payment management services for Departmental and other Federal grant and program activities; accounting and fiscal services; debt management services; and the review, negotiation and approval of rates, including indirect cost rates, research patient care rates, and fringe benefit rates. The FMS also provides specialized ADP systems development in the area of workforce management.

ADMINISTRATIVE OPERATIONS SERVICE

The FY 2002 estimated expenses for the Administrative Operations Service (AOS) are $201 million, an increase of $11 million above the FY 2001 level. The $11 million increase is for pay and other costs ($3 million), replenishment of the pharmaceutical supply inventory ($7 million), and increased demand for services in the Kansas City Common Administrative Support Unit ($1 million). AOS provides a wide array of administrative management services within the Department, both in headquarters and in the regions, and to customers throughout the Federal Government. The major areas of service are property and materiel management, acquisitions management, and support services ranging from commercial graphics to mail distribution and telecommunications services. The Telecommunications Improvement Project consolidated telephone services under one contract with substantial savings in telephone bills to HHS agencies located in Maryland. Additionally, the Supply Service Center provides pharmaceutical supplies to Federal customers worldwide.

FINANCIAL MANAGEMENT SYSTEM

In FY 2002, the PSC will invest $1 million as part of a Department-wide effort to improve the HHS financial management systems by moving towards a unified financial management system. A unified financial management system will allow HHS to increase standardization, reduce security risks, and help to produce timely, reliable agency level and Department-wide financial information. The financial information is needed to manage HHS and to provide accountability to external stakeholders. The PSC maintains one of the five existing Departmental financial systems. While capitalizing on efforts already begun by some HHS agencies, the PSC will conduct a management study in FY 2002 to analyze alternatives and define requirements.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

(dollars in millions)

	2000 Actual	2001 Enacted	2002 Request	Request +/-Enacted
Retirement Payments.....	$158	$176	$196	+$20
Survivor's Benefits.....	11	12	13	+1
Medical Care.....	32	31	32	+1
Military Service Credits.....	1	1	1	0
Total, Budget Authority.....	**$202**	**$220**	**$242**	**+$22**

SUMMARY

This appropriation provides for retirement payments to Public Health Service (PHS) Commissioned Officers and payment to survivors of deceased retired officers. This account also funds the provision of medical care to active duty and retired members and to dependents of active duty, retired and deceased members of the PHS Commissioned Corps. In addition, this account includes amounts to be paid to the Social Security Administration (SSA) for military service credits which are earned by active duty Commissioned Officers for non-wage income.