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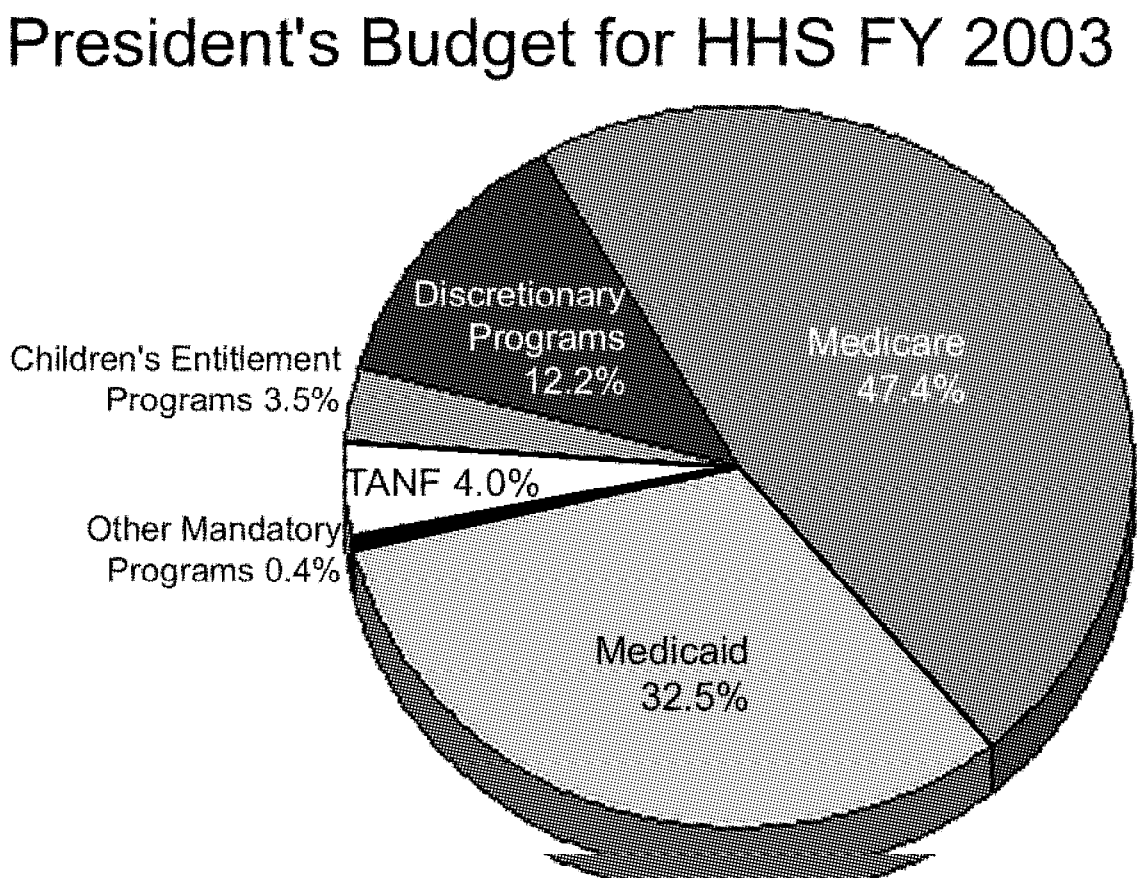
ENSURING A SAFE AND HEALTHY AMERICA

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/- Enacted
Budget Authority.....	$435,485	$468,697	$491,850	+$23,153
Outlays.....	$426,922	$459,609	$488,787	+$29,178
Full-Time Equivalents.....	61,847	65,072	65,658	+586



ENSURING A SAFE AND HEALTHY AMERICA

HIGHLIGHTS:

The fiscal year (FY) 2003 budget for the Department of Health and Human Services (HHS) builds on President Bush's commitment to ensure the health and safety of our nation. After September 11, 2001, HHS employees acted swiftly to support the health care and emergency needs of those affected by the terrorist attacks. In response to this disaster and in anticipation of future threats to America's health care and human services systems, the FY 2003 budget places increased emphasis on protecting our nation's citizens and ensuring safe, reliable health care for all Americans.

The HHS budget also promotes scientific research, builds on our success in Welfare Reform, and provides support for childhood development while delivering a responsible approach for managing HHS resources. Our budget plan confronts both the challenges of today and tomorrow while protecting and supporting the well-being of all Americans. Our budget focuses on:

Protecting the Nation Against Bioterrorism: by providing assistance for State and local preparedness; developing vaccines and maintaining the National Pharmceutical Stockpile; preparing the Nation's hospitals; protecting the Nation's food supply; expanding research infrastructure; and securing facilities to conduct critical scientific work.

Investing in Biomedical Research: by completing the doubling of funding for the National Institutes of Health; financing important research for the war against terrorism; increasing support for cancer research; and, investing in the Global Fund to fight HIV/AIDS, malaria, and tuberculosis.

Increasing Access to Healthcare: by increasing and expanding the number of health centers; increasing the funding for the National Health Service Corps; enhancing patient safety; and narrowing the drug treatment gap.

Building Upon the Successes of Welfare Reform: by supporting the Temporary Assistance for Needy Families program; providing stronger child enforcement tools; continuing child care support to States; and, providing education assistance for older foster children.

Strengthening Medicare: by providing substantial funds for targeted improvements and comprehensive Medicare modernization, including a subsidized prescription drug benefit, better insurance protection and better private options for all beneficiaries; by giving States the flexibility to extend prescription drug coverage to low-income seniors through budget-neutral waivers; by stabilizing the Medicare+Choice program; and, providing new Medigap options.

Supporting Healthy Communities: by initiating a new interdisciplinary prevention effort focused on diabetes, asthma, and obesity; and promoting abstinence.

Improving Management and Performance of Health and Human Services Programs: by supporting the President's Management Agenda; improving budget performance and integration; improving financial performance; ensuring greater competition for commercial activities; expanding electronic government; budgeting for the accrued cost of retirement and health benefits; and creating a citizen-centered Department through strategic management of human capital.

TOTALS

The FY 2003 budget for the Department of Health and Human Services totals $488.8 billion (outlays). This is an increase of $29.2 billion, or 6.3 percent, over the comparable FY 2002 budget. The discretionary component of the HHS budget totals $64.0 billion in budget authority, an increase of 3.9 percent over the FY 2002 budget.

In both FY 2001 and 2002 Emergency Response Fund (ERF) dollars were made

available to HHS for responding to the September 11 terrorist attack. ERF amounts are shown in each agency's budget table as well as in the overall HHS budget table.

PROTECTING THE NATION AGAINST BIOTERRORISM

The Department of Health and Human Services is the lead Federal agency in the fight against bioterrorism. HHS is responsible for preparing for and responding to the medical and public health consequences of bioterrorism. With a total of $4.3 billion, the FY 2003 budget for HHS supports a variety of activities to prevent, identify, and respond to incidents of bioterrorism. These activities are administered through the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Office of the Secretary, the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Food and Drug Administration (FDA). The FY 2003 budget provides increased assistance to State and local entities and further expands the availability of vaccines and drugs in the National Pharmaceutical Stockpile. It also provides funding to prepare the country's hospitals, protect the food supply, and enhance research capacity.

Providing Assistance to State and Local Entities: The FY 2003 budget provides funding for State and local bioterrorism preparedness. CDC's $940 million State and local program emphasizes improved laboratory capacity; enhances epidemiological expertise in the identification and control of diseases caused by bioterrorism; provides for better electronic communication, disease surveillance, and distance learning; and supports a newly expanded focus on cooperative training between public health agencies and local hospitals.

The funding for State and local bioterrorism preparedness provides funding for the Laboratory Response Network, a system of over 80 public health labs specifically developed for identifying pathogens that could be used for bioterrorism. Funding will also support the Health Alert Network, CDC's electronic communications system that provides Internet connectivity to public health departments in our Nation's counties. Additional funding will be used to support epidemiological response and outbreak control, which includes funding for public health and hospital training.

Developing Vaccines and Maintaining the National Pharmaceutical Stockpile: HHS maintains the National Pharmaceutical Stockpile (NPS), which is being expanded in 2002 in order to cover over 20 million individuals for anthrax. HHS is also purchasing in FY 2002, sufficient smallpox vaccines to protect all Americans. The FY 2003 budget proposes $650 million for the NPS and costs related to stockpiling of smallpox vaccines, and next-generation anthrax vaccines currently under development.

Preparing the Nation's Hospitals: The FY 2003 budget provides $518 million for the Hospital Preparedness program to enhance biological and chemical preparedness plans focused on hospitals. This program will also provide funding to upgrade the capacity of hospitals, and outpatient facilities to care for victims of bioterrorism.

Protecting the Nation's Food Supply: Today, the United States has one of the world's safest food supplies. However, since the September 11 attacks, the American people have a heightened awareness about protecting the nation's food imports and food supply at home. The FY 2003 budget includes $98 million in bioterrorism funding for food safety. This will support a substantial increase in the amount of safety inspections for FDA-regulated products that are imported into the country. The level of physical examinations of food imports will be two times the FY 2002 level, and four times the FY 2001 level.

Expanding Research Infrastructure and Securing Facilities to Conduct Critical Scientific Work at CDC: The FY 2003 budget includes a total request of $184 million to construct, repair, and secure facilities at CDC. This entire amount is included in the budget request for the new HHS Health Facilities Construction and Management Fund. Of this total, $120 million is for bioterrorism-related activities.

INVESTING IN BIOMEDICAL RESEARCH

Doubling the Funding for the National Institutes of Health: The FY 2003 budget includes a total of $27.3 billion for NIH. This includes the final installment of $3.7 billion that will achieve the doubling of the NIH budget. With this increase, NIH will further its efforts to support research on diseases that affect the lives of all Americans. The NIH funding increase will also finance important research needed for the war against terrorism. The budget includes $1.75 billion for bioterrorism, including genomic sequencing of dangerous pathogens, development of zebra chip technology, development of an improved anthrax vaccine, and laboratory and research facilities construction and upgrades related to bioterrorism. The FY 2003 budget also provides $5.5 billion for research on cancer throughout all of NIH.

Investing in the Global Fund to Fight HIV/AIDS, Malaria, and Tuberculosis: The FY 2003 budget supports the Global Fund to Fight HIV/AIDS, Malaria, and Tuberculosis. HHS will contribute $100 million to the Fund, and the U.S. Agency for International Development will contribute another $100 million for a total of $200 million in U.S. contributions for FY 2003. These funds support the multilateral trust fund that will provide international resources for prevention, treatment, and care activities to combat these diseases. The Global Fund has been established to enhance the capabilities of public health and health care delivery programs where these infections are endemic and problematic.

NIH supports HIV/AIDS research conducted in collaboration with investigators in developing countries. Support is also provided to international training programs and initiatives to help build research infrastructure and laboratory capacity in these countries.

PROVIDING ACCESS TO HEALTHCARE

The FY 2003 budget for HHS promotes health and secures health services for our nation through programs that educate providers and the public, and that diagnose, treat and prevent disease.

Increasing and Expanding the Number of Health Centers: Health Centers provide family-oriented preventive and primary health care to over 11 million patients through a network of over 3,500 health sites. With an increase of $114 million, the FY 2003 budget builds on the President's Initiative to increase and expand the number of health center sites by 1,200 and to serve an additional 6.1 million patients by FY 2006. The professional care provided at health centers reduces hospitalizations and emergency room use and prevents more expensive chronic disease and disability. Health centers are able to reduce or eliminate disease disparities through chronic disease management and by providing health center patients with a regular source of primary health care. The long-term goal is to increase the number of people who receive high quality primary health care regardless of their ability to pay.

Increasing Funding for the National Health Service Corps: To complement the growth in health centers, the FY 2003 National Health Service Corps (NHSC) funding is increased by 30 percent to $192 million to support over 1,800 individuals who will provide health care in under-served areas.

Enhancing Patient Safety: A major FY 2003 goal is to make a measurable improvement in the safety of health care for Americans. The FY 2003 budget includes $10 million in new funding for the Department-wide patient safety initiative. The

Agency for Healthcare Research and Quality (AHRQ) is spearheading this initiative in coordination with CDC, FDA, and the Centers for Medicare & Medicaid Services (CMS). One priority of the initiative is to improve reporting of adverse events. An additional $5 million in FDA will be dedicated to these efforts in FY 2003.

Another major component of the initiative will be to encourage the adoption of safe but underutilized practices that lead to better patient outcomes. The budget provides $3 million for "Challenge Grants," which AHRQ will use to provide incentives to health care entities to implement new "evidence-based" interventions. AHRQ will use $2 million to train a corps of patient safety experts to provide on-site technical assistance.

Narrowing the Drug Treatment Gap: The Office of National Drug Control Policy (ONDCP) estimates that as many as 5 million Americans are in need of drug abuse treatment services. However, less than a quarter of those who need treatment actually receive services, leaving a treatment gap of 3.9 million individuals. The drug treatment gap revolves around three issues: accessibility, affordability, and availability. The FY 2003 budget provides an increase of $127 million to fund the President's Drug Treatment Initiative. These additional funds will allow States and local communities to provide treatment services to approximately 546,000 individuals, an increase of 52,000 over FY 2002.

BUILDING UPON THE SUCCESSES OF WELFARE REFORM

The FY 2003 budget provides for reauthorization of Temporary Assistance for Needy Families (TANF) and enhancement of related programs. Our proposal will continue to help people move to self-sufficiency, strengthen the goals of work and independence, simplify program administration, maintain fiscal responsibility, and put a new emphasis on family formation activities. The welfare reform reauthorization package builds on the success of the TANF program, provides stronger child support enforcement tools, and provides incentives to States to direct more child support to current and former welfare families. The budget also provides for education assistance for older foster children to help them transition to self sufficiency.

Supporting the Temporary Assistance for Needy Families Program: In order to maintain the TANF program and continue with its successes, the FY 2003 budget maintains the level of $16.7 billion for block grant funding and high performance bonus funding, provides supplemental grants to address historical disparities in welfare spending among States, and improves work requirements. The new direction of this program will be an inter-agency effort that will identify opportunities to better coordinate programs. The FY 2003 budget also provides $100 million for a family formation and illegitimacy reduction initiative.

Providing Stronger Child Support Enforcement Tools: The FY 2003 budget includes proposals to allow States the option to provide families who once received welfare to receive the full amount of child support collected on their behalf. The FY 2003 budget also permits federal cost sharing to States that elect to provide up to $100 per month in child support collections to the family for current welfare recipients; and offset these expanded benefits by strengthening child support collection tools and collecting fees from non-TANF families that benefit from the child support enforcement program.

Supporting Child Care: In FY 2003, child care funding will provide child care assistance to an estimated 2.2 million children with a total budget of $4.8 billion. This includes $2.1 billion in discretionary funds and $2.7 billion in mandatory funds.

Providing Education Assistance for Older Foster Children: The FY 2003 HHS budget provides $60 million for the Independent Living Program to help older foster youth transition to independence after they leave foster care. This program will provide

vouchers to approximately 16,000 young people for college or vocational training in order to develop the skills necessary to lead independent and productive lives.

STRENGTHENING MEDICARE

The FY 2003 budget dedicates $190 billion over ten years for targeted improvements and comprehensive Medicare modernization. This includes a subsidized prescription drug benefit, better insurance protection, and better private options for all beneficiaries; giving States the flexibility to extend prescription drug coverage to seniors through budget-neutral waivers; stabilizing the Medicare+Choice program; and providing new Medigap options.

Providing Access to Prescription Drugs: A prescription drug benefit is a central part of the President's framework for strengthening Medicare. The budget dedicates $20.7 billion over 5 years and $77.1 billion over 10 years, (of the $190 billion) to instituting a transitional low-income drug benefit. In addition, this year, HHS is working to implement a Medicare-endorsed prescription drug discount card which will give beneficiaries immediate access to drug discounts and other valuable pharmacy services. The Administration also proposes to allow States to expand drug coverage to Medicare beneficiaries up to 100 percent of the poverty level at current Medicaid matching rates, much like existing programs that subsidize Medicare premiums and cost-sharing for low-income Medicare beneficiaries. The Administration also proposes to begin to allow Medicare to pay 90 percent of the States cost of expanding coverage for beneficiaries between 100 and 150 percent of poverty, with States being responsible for the remaining 10 percent. This policy would eventually expand drug coverage for up to 3 million beneficiaries who currently do not have prescription drug assistance. Targeted Medicare Reforms include:

Sustaining and Enhancing Medicare+Choice: In order to preserve choice for Medicare's beneficiaries, HHS has placed a priority on improving the current Medicare+Choice payment system so the existing plans remain in the program and new plans are encouraged to join. The FY 2003 budget proposes to reform the current system so that plan payments for minimum update counties are tied to the health care cost increases plans are actually experiencing and payments are adjusted to better reflect beneficiaries' health status. In addition, the budget proposes bonus payments for new types of private plans that enter Medicare+Choice.

Modernizing Medigap: Medicare does not sufficiently protect beneficiaries against the high cost of medical care, particularly catastrophic medical expenses, and those beneficiaries who are sicker generally pay a greater share of their health care costs. The FY 2003 budget proposes to add two Medigap plans to the existing 10 standardized plans. These plans, which offer prescription drug coverage and protect against catastrophic illness, include a buy-down of the cost of Medicare deductibles and co-pays at more affordable premium rates.

Additional Medicare Improvements: The FY 2003 budget proposes a nationwide competitive bidding system for medical equipment in which contracts would be awarded to suppliers that provide quality equipment.

The Administration will work with stakeholders to develop enhanced Federal Employees Health Benefits Program (FEHBP) options for retirees that improve choice, striving to make the range of potential health insurance options available to federal retirees.

SUPPORTING HEALTHY COMMUNITIES

Healthy Communities Initiative: The FY 2003 budget includes $20 million for a Healthy Communities Innovation Initiative—a new interdisciplinary services effort—which will concentrate Department-wide expertise on the prevention of diabetes and asthma, as well as obesity. The purpose of the initiative is to reduce the incidence of these diseases and improve services in five

communities through a tightly coordinated public/private partnership between medical, social, educational, business, civic and religious organizations.

More than 16 million Americans currently suffer from Type II diabetes which is increasingly prevalent in our children. In a recent study conducted by NIH, participants that were randomly assigned to intensive lifestyle intervention experienced a reduced risk of getting Type II diabetes by 58 percent. The Healthy Communities Initiative makes preventing Type II diabetes in children a priority.

Promoting Abstinence: The FY 2003 budget commits $135 million for abstinence education to ensure that more children receive the message that abstinence is the best option for avoiding unintended pregnancies and sexually transmitted diseases. The budget also reflects more targeted performance measures that will evaluate the effectiveness of the investment in abstinence education.

OTHER INITIATIVES

Continuing Support for Head Start: The HHS budget includes $6.7 billion, an increase of $130 million for Head Start, the Nation's premier early childhood education program. This program promotes school readiness for low income children and provides a range of comprehensive child development and health services including physical and dental exams, immunizations, and nutritional services. Head Start aids in the strengthening of families and promotes young children's social capabilities, emotional health, language, early literacy, cognitive development, and physical well-being. These components are critical in preparing our nation's youth for school.

Promoting Safe and Stable Families: HHS proposes a total of $505 million to strengthen States' ability to promote child safety, permanency, and well-being. These additional resources will help States to increase preventive efforts to help families in crisis, keep children with their biological families if safe and appropriate, to return children to their parents if possible, or place children with adoptive families.

Supporting Early Childhood Education and School Readiness Initiative: Through a coordinated effort between the Administration for Children and Families and the National Institute of Child Health and Human Development, programs will build on and expand research on a range of issues concerning early childhood learning.

Supporting the New Freedom Initiative: The goal of this Presidential initiative is to tear down the barriers to equality that face individuals with disabilities. This inter-departmental effort provides for and promotes community integration for people with disabilities by establishing or expanding community-based models of care and support. The FY 2003 budget provides $15.6 million in support of this initiative.

Supporting Tax Credits for Health Insurance: To encourage private health insurance coverage, the President's Budget proposes a new refundable tax credit for low-income individuals and families who are neither covered by an employee plan nor enrolled in public programs, and who may have the most difficulty finding affordable health coverage. It allows States to help certain tax credit recipients increase their purchasing power by joining purchasing pools such as private purchasing groups, state-sponsored insurance purchasing pools, and high-risk pools. Additional details about the refundable health insurance tax credit can be found in the Federal Receipts chapter of *Analytical Perspectives*, as well as in the Treasury Department's budget publications.

IMPROVING MANAGEMENT AND PERFORMANCE OF HEALTH AND HUMAN SERVICES PROGRAMS

The President's vision for government reform is guided by the principles that government should be citizen-centered, results oriented, and active in promoting innovation

through competition. HHS is committed to improving management within the Department and has established its own vision of a unified HHS — "One Department" free of unnecessary layers, collectively strong to serve the American people. The FY 2003 budget supports the President's Management Agenda and presents challenges that include:

Supporting Workforce Planning and Restructuring: The Department will improve program performance and service delivery to our nations citizens by more strategically managing its human capital and ensuring that resources are directed to national priorities. In support of the President's Management Agenda and the goal of "One Department," HHS will reduce duplication of effort by consolidating administrative functions and eliminating management layers to speed decision-making. The Department plans to reduce the number of personnel offices from forty to four; to streamline and to consolidate the public affairs and legislative affairs functions; and consolidate construction funding, leasing, and other facilities management activities. These management efficiencies will allow the Department to redeploy staff and other resources to line programs.

Improving Budget and Performance Integration: HHS continues to be at the forefront of the Government-wide effort to integrate budget and performance. HHS was one of the first Departments to add tables to its Government Performance and Results Act Annual Performance Reports that broadly associate resource dollars and the 900 performance measures Department-wide. Although we work in a challenging environment where health outcomes may not be apparent for several years, and where the Federal dollar may be just one input to complex programs, HHS is committed to demonstrating to citizens the value they receive for the tax dollars they pay.

Improving Financial Accountability: By consolidating and modernizing existing financial management systems at HHS, the Unified Financial Management System (UFMS) will provide a consistent, standardized system for departmental accounting and financial management. The "One Department" approach to financial management and information technology emphasizes the use of resources on an enterprise basis with a common infrastructure, thereby reducing errors and enhancing accountability. Additionally, the use of cost accounting will aid in evaluating HHS program effectiveness and impacts of funding level changes on those programs.

Expanding Information Technology and E-Government Improvements: Information Technology (IT) is a key to providing better government services at reduced costs, and is the foundation for efforts to re-engineer HHS. The Department has drafted an Enterprise IT Five Year Plan to establish a single corporate enterprise system.

Ensuring Competitive Sourcing of Commercial Activities: HHS is committed to providing the highest possible standard of services and will use competitive sourcing as a management tool to study the efficiency and performance of our programs, while minimizing costs overall. The program will be linked to performance reviews to identify those programs and program components where outsourcing can have the greatest impact. Further, the incorporation of performance-based contracting will improve efficiency and performance and result in savings to the taxpayer.

Budgeting for the Accrued Cost of Retirement and Health Benefits: The HHS budget includes funds to pay for the full government share of the accruing cost of retirement and health benefits for current employees. This is a change from the previous practice of allocating a portion of these costs to program accounts and charging the remainder of the cost to central accounts. Budgeting for accrued retirement and health benefit costs in FY 2003 is required by the Administration's proposed Managerial Flexibility Act. This legislation supports the initiative to link budget

and management decisions to performance by ensuring that the full cost of program operations is identified in the program accounts which pay these costs. Each agency's FY 2003 budget includes an estimate of the accrued cost of retirement and health benefits with these costs shown comparably in FY 2001 and 2002. In FY 2003 accrual costs in HHS total $360.1 million in discretionary budget authority. A crosswalk table on page 114 displays the FY 2001-2003 accrual costs for each HHS agency.

GOVERNMENT PERFORMANCE AND RESULTS ACT

HHS is committed to continual improvement in the performance and management of its programs and the Administration's efforts to provide results-oriented, citizen-centered government. The budget request for FY 2003 is accompanied by the annual performance plans and reports required by the Government Performance and Results Act. The performance measures cover the wide range of program activities essential to carrying out the HHS mission. Some notable FY 2001 achievements include:

Ensuring Homeland Security: Preparing the nation to address the dangers of biological and chemical terrorism is a major challenge to public health and healthcare systems. CDC is building capacity at state and local health agencies to quickly investigate unexplained illnesses, detect biological or chemical agents, and effectively communicate bioterrorist events. In FY 2001, all 50 States, four localities, and one U.S. territory were funded to expand epidemiology and surveillance capacity to mitigate health threats of bioterrorism, meeting their goal of funding 55 sites in 2001.

Reducing Erroneous Medicare Payments: CMS has continued to reduce the payment error rate, cutting improper payments from 7.97 percent in FY 1999 to 6.8 percent in FY 2000 and exceeding its targets in both years. CMS, with the assistance of the Office of the Inspector General, is committed to further reducing the error rate to 5 percent by FY 2002. In addition, in 2003, HHS will devote more resources to Medicaid and State Children's Health Insurance Program integrity. To that end, the budget proposes to strengthen federal oversights of States' financial practices and Medicaid program integrity efforts.

Increasing Access For Minority, Low-Income, and Uninsured Americans: HRSA's Community Health Centers and the National Health Service Corps form a cost-effective, integrated safety net for under-served and under-insured children, adults, and migrant workers in approximately 4,000 communities across the country. In FY 2000 these two programs served 9.6 million persons who would otherwise lack access to primary care clinicians. It is estimated that 10.5 million persons were served in FY 2001.

Moving Families Toward Self-Sufficiency: ACF reported that welfare rolls have fallen to historic lows, from over 12 million in August 1996 to 5.4 million in June 2001. Additionally, all States met the Congressionally established work participation rate of 40 percent in FY 2000.

Families Benefitting from Child Support Enforcement: The Child Support Enforcement program broke new records nationwide in FY 2001 by collecting $18.9 billion, $1 billion over FY 2000 levels. In one initiative in FY 2000, the government collected a record $1.4 billion in overdue child support from Federal income tax refunds, and more than 1.42 million families benefitted from these collections.

From combating bioterrorism to promoting stable, self-sufficient families, these measures as well as others included in the 13 performance plans ensure that HHS continues to improve its efforts in ensuring a safe and healthy America.

CONCLUSION

The FY 2003 HHS budget includes progressive initiatives in many areas aimed at protecting the nation and providing better healthcare services. It begins by strengthening homeland security, which includes a

strengthened public health infrastructure. It provides for safe and accessible healthcare. It increases support for the development of our nation's children, especially those at risk. And it provides for improving management and performance of HHS programs. Through these programs and initiatives, HHS will help build a safe and healthy America.

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/- Enacted
Mandatory Programs (Outlays):				
Medicare	$214,926	$223,775	$231,784	+$8,009
Medicaid	129,374	144,751	158,790	+14,039
Temporary Assistance for Needy Families	18,583	18,334	19,399	+1,065
Foster Care & Adoption Assistance	5,711	6,098	6,421	+323
State Children's Health Insurance	3,699	3,689	4,322	+633
Child Support Enforcement	3,281	3,558	3,613	+55
Child Care	2,341	2,535	2,737	+202
Social Services Block Grant	1,851	1,803	1,793	-10
Other Mandatory Programs	1,460	1,325	1,169	-156
Proprietary Receipts	-888	-797	-828	-31
Subtotal, Mandatory (Outlays)	**$380,338**	**$405,071**	**$429,200**	**+$24,129**
Discretionary Programs (BA):				
Food & Drug Administration	$1,140	$1,413	$1,432	+$19
Health Resources & Services Administration	5,583	6,130	5,389	-741
Indian Health Service	2,689	2,824	2,884	+60
Centers for Disease Control and Prevention	3,810	4,182	4,012	-170
National Institutes of Health	20,438	23,623	27,335	+3,712
Substance Abuse & Mental Health Services	2,966	3,141	3,198	+57
Agency for Healthcare Research & Quality	106	3	0	-3
AHRQ Program Level (Non-Add)	*271*	*300*	*252*	*-48*
Centers for Medicare & Medicaid Services	2,265	2,461	2,408	-53
Administration for Children & Families	12,422	13,069	13,057	-12
Administration on Aging	1,254	1,350	1,342	-8
Office of the Secretary	971	3,420	2,961	-459
Subtotal, Discretionary (BA)	**$53,643**	**$61,616**	**$64,019**	**+$2,403**
Emergency Relief Fund (Non-add)	*$126*	*$2,818*	*$0*	*-$2,818*
Non-Emergency Relief Fund (Non-add)	*$53,517*	*$58,798*	*$64,019*	*+$5,221*
Subtotal, Discretionary (Outlays)	**$46,584**	**$54,538**	**$59,587**	**+$5,049**
Total, HHS Outlays	**$426,922**	**$459,609**	**$488,787**	**+$29,178**

HHS BUDGET BY OPERATING DIVISION

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/- Enacted
Food & Drug Administration:				
Program Level	$1,317	$1,605	$1,727	+$122
Budget Authority	1,140	1,413	1,432	+19
Outlays	1,116	1,326	1,440	+114
Health Resources & Services Administration:				
Budget Authority	6,304	6,272	5,532	-740
Outlays	5,119	5,672	5,711	+39
Indian Health Service:				
Budget Authority	2,789	2,924	2,984	+60
Outlays	2,617	2,867	3,044	+177
Centers for Disease Control & Prevention:				
Budget Authority	3,823	4,185	4,015	-170
Outlays	3,173	3,737	4,219	+482
National Institutes of Health:				
Budget Authority	20,535	23,720	27,432	+3,712
Outlays	17,310	20,943	23,573	+2,630
Substance Abuse & Mental Health Services:				
Budget Authority	2,966	3,141	3,198	+57
Outlays	2,740	2,916	3,084	+168
Agency for Healthcare Research & Quality:				
Program Level	271	300	252	-48
Budget Authority	106	3	0	-3
Outlays	36	91	96	+5
Centers for Medicare & Medicaid Services:				
Budget Authority	352,791	378,002	396,335	+18,333
Outlays	350,266	374,694	397,334	+22,640

HHS BUDGET BY OPERATING DIVISION CONTINUED

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/- Enacted
Administration for Children & Families:				
Budget Authority	43,244	44,587	46,966	+2,379
Outlays	43,114	44,637	46,912	+2,275
Administration on Aging:				
Budget Authority	1,254	1,350	1,342	-8
Outlays	1,103	1,287	1,295	+8
Departmental Management/Civil Rights:				
Budget Authority	929	3,375	2,911	-464
Outlays	759	1,715	2,373	+658
Office of Inspector General:				
Budget Authority	172	190	210	+20
Outlays	164	187	210	+23
Program Support Center:				
Budget Authority	320	332	321	-11
Outlays	293	334	324	-10
Proprietary Receipts:				
Budget Authority	-888	-797	-828	-31
Outlays	-888	-797	-828	-31
Total, Health & Human Services:				
Budget Authority	$435,485	$468,697	$491,850	+$23,153
Emergency Relief Fund (Non-add)	*$126*	*$2,818*	*$0*	*-$2,818*
Non-Emergency Relief Fund (Non-add)	*$435,359*	*$465,879*	*$491,850*	*+$25,971*
Outlays	$426,922	$459,609	$488,787	+$29,178
Full-Time Equivalents	61,847	65,072	65,658	+586

FDA OVERVIEW

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Foods	$302	$421	$430	+$9
Drugs	333	383	476	+93
Biologics	147	183	217	+35
Animal Drugs and Feeds	67	90	93	+3
Medical Devices	189	205	215	+10
National Center for Toxicological Research	38	45	43	-2
Other Activities	78	89	97	+8
Non-GSA Rent & Rent Related Activities	33	43	36	-6
GSA Rental Payments	93	105	106	0
Subtotal	**$1,280**	**$1,564**	**$1,713**	**+$149**
Buildings and Facilities	$31	$34	$8	-$26
Export/Certification Fund	6	6	6	0
Bioterrorism (non-add)	*9*	*158*	*159*	*+1*
Food Safety (non-add)	*1*	*98*	*98*	*0*
Vaccines/Drug Therapies/Diagnostics (non-add)	*6*	*47*	*54*	*+7*
Security (non-add)	*2*	*13*	*7*	*-6*
Total Program Level	**$1,317**	**$1,604**	**$1,727**	**+$123**
Amount ERF (non-add)	*2*	*151*	*0*	*-151*
Amount non-ERF (non-add)	*1,315*	*1,453*	*1,727*	*+274*
Less User Fees:				
Prescription Drug User Fee Act (PDUFA)	$156	$169	$272	+$103
Mammography Quality Standards Act (MQSA)/ Export/Certification Fund	22	22	23	+1
Subtotal, User Fees	178	191	295	+104
Total, Budget Authority	**$1,139**	**$1,413**	**$1,432**	**+$19**
Amount ERF (non-add)	*2*	*151*	*0*	*-151*
Amount non-ERF (non-add)	*1,137*	*1,262*	*1,432*	*+170*
FTE	8,996	9,989	10,548	+559

FOOD AND DRUG ADMINISTRATION

MISSION

The Food and Drug Administration's (FDA) mission is to promote and protect the public health by helping safe and effective products reach the market in a timely way, and monitoring products for continued safety after they are in use.

SUMMARY

The FY 2003 budget request for the FDA is $1.7 billion, a net increase of $123 million over FY 2002. Within this total, there are program increases of $155 million, and decreases of $32 million in one-time funding for laboratory construction and security enhancements accomplished in the prior year. Of the funds requested, $295 million will be derived from industry-specific user fees. The increase over FY 2002 is focused on further improvements in the new drug review process (funded by industry user fees), accelerating the review of generic drugs, protecting the Nation against bioterrorism, and improving patient safety. Funds are included in the request to cover the full government share of the accruing cost of all retirement and retiree health care benefits for Federal employees.

FDA protects the public health by preventing injury or illness due to unsafe or ineffective products–foods, drugs, biologics, medical devices, etc. 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.

PRESCRIPTION DRUG USER FEE ACT

The budget includes $272 million in Prescription Drug User Fee Act (PDUFA) fees, an increase of $103 million. PDUFA authorizes the collection of user fees for reviewing drug applications. Reauthorization of PDUFA for five additional years (PDUFA III) starting in FY 2003, is a priority. To date, the PDUFA program has been highly successful in reducing the time needed to review applications for new drugs and biologics, while maintaining the safety standards essential to the public's health. These fees have also enabled the provision of substantially more technical assistance, advice, and rapid responses to special inquiries during the drug development and testing period. As a result, industry has been able to significantly shorten the time needed for drug development and testing.

The Administration will be working with Congress and industry to enact this important legislation in the coming year.

GENERIC DRUGS

The budget includes $46 million for reviewing and ensuring the safety of generic drugs, an increase of $4.6 million. This increase will provide sufficient capacity to act on 75 percent of generic drug applications within a six month time frame, up from about half in FY 2001. Rapid review of these applications is essential to maximize the availability of high quality lower cost prescription drugs.

BIOTERRORISM

The budget includes $159 million, an increase of $1 million for efforts to protect against bioterrorist threats. The request includes resources to monitor, detect and prevent tampering of food imports; ensure an adequate and safe blood supply; and work with other agencies and the private sector to accelerate the development and approval of vaccines, drugs, and diagnostic tests to protect Americans from bioterrorism agents.

Food Safety: The bioterrorism effort will provide $98 million to ensure the safety of the Nation's food supply. While this country has

one of the safest food supplies in the world, much work remains to be done–especially to guard against intentional contamination.

FDA has embarked on a major effort to increase oversight of the Nation's food supply, especially foods imported from other countries. An estimated 673 inspectors, investigators, support scientists, and compliance officers are being hired in FY 2002, and training will be completed in FY 2003. Total work-years will increase by 251 in FY 2003. The level of physical examinations of food imports will be two times the FY 2002 level, and four times the FY 2001 level. FDA expects further improvements as these new staff become experienced, and fully productive.

Nine million dollars of the request will be invested to improve the information technology systems used to protect the food supply. These investments include the Operational and Administrative System for Import Support (OASIS) computer software, which connects with multi-agency import databases to help target inspection resources. The Electronic Laboratory Exchange Network (eLEXNET) that enables State and Federal laboratories to exchange information on pathogens in food will be further expanded.

An additional investment of $7 million to develop better and faster scientific tests, and purchase equipment needed to detect contaminants in foods is also proposed.

Vaccines, Drug Therapies, and Diagnostics: Funding for work on vaccines, drug therapies, and diagnostics will total $54 million, an increase of $7 million. These funds will allow expedited work on bioterrorism vaccines, review of new diagnostic tests, develop radiation safety standards for new security scanners, animal studies to determine the optimal use of drugs and vaccines after exposure, etc. These expedited efforts will be closely integrated with industry and other Federal agencies which are developing and procuring these regulated products.

• ***Blood Safety:*** The request for Vaccines, Therapeutics and Diagnostics includes an increase of $5 million to improve blood safety. Protecting the blood supply is critical to the success of efforts to protect Americans from bioterrorism. This funding will ensure that regulation and blood screening processes are adequate to identify infectious diseases that may enter the blood supply and to protect the public health.

PATIENT SAFETY

An increase of $5 million, for a total of $22 million, will expand efforts to improve patient safety and reduce adverse events from regulated medical products. Efforts will be directed to partner with the private sector to develop technologies such as bar coding medications so that electronic prescription programs and pharmacy dispensing programs can be introduced widely.

FDA will also improve its analysis and follow-up of adverse event reports. Over 300,000 confidential adverse event reports are received 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 implementing an active surveillance system (MeDSun) to provide better statistical information for targeting follow-up efforts. Once implemented, this approach will be expanded to human drugs and biologics. Simultaneously, collaborative work will continue with CDC (hospital acquired infections), AHRQ (safety improvement), and

CMS (Medicare) to develop a common automated interface that would significantly reduce the reporting burden for partnering providers, and provide this confidential information electronically.

Buildings and Facilities/Security: The total budget for buildings and facilities includes $8 million for repairs and improvements, a decrease of $26 million, reflecting completion of the Los Angeles regional laboratory. The budget includes $7 million for security in the Non-GSA Rent and Rent Related Activities line, a decrease of $6 million which reflects completion of one-time upgrades. The security request maintains the enhanced guard services initiated in FY 2002 for FDA's laboratories. In addition, the budget request for the General Services Administration includes $5 million to continue designing the planned FDA headquarters facility in White Oak, Maryland.

HRSA OVERVIEW

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Community Health Centers	$1,179	$1,345	$1,459	+$114
Healthy Communities Innovation Initiative	0	0	20	+20
Organ Transplantation	15	20	25	+5
Abstinence Education	70	90	123	+33
Bioterrorism Hospital Preparedness	0	135	235	+100
Bioterrorism Hospital Infrastructure	0	0	283	+283
Poison Control/EMS for Children	39	40	40	0
Hospital Emergency Relief	35	140	0	-140
National Health Service Corps	127	148	192	+44
Health Professions Programs/Nurse Loan	360	388	110	-278
Bioterrorism Medical School Curriculum	0	0	60	+60
Children's Hospitals Graduate Medical Education	235	285	200	-85
Ryan White HIV/AIDS Activities	1,808	1,911	1,911	0
(AIDS Drug Assistance Program)	*589*	*639*	*639*	*0*
Maternal and Child Health Block Grant/TBI	714	739	739	0
Healthy Start	90	99	99	0
Family Planning	255	266	266	0
Program Management	153	163	161	-2
Health Care Facilities	250	312	0	-312
Rural Health	102	129	75	-54
Telehealth	36	39	6	-33
Denali Commission	10	20	0	-20
Community Access Program/State Planning Grants	140	120	0	-120
Universal Newborn Hearing Screening/Trauma	11	13	0	-13
Bone Marrow/Black Lung/Hansen's Disease	49	49	49	0
Radiation Exposure Compensation	0	4	4	0
Ricky Ray Hemophilia Program	580	0	0	0
National Practitioner Databank (User Fees)	16	16	19	+3
Health Integrity & Protection Databank (User Fees)	4	5	6	+1
Total, HRSA Program Level	**$6,278**	**$6,476**	**$6,082**	**-$394**
Amount ERF (non-add)	*45*	*275*	*0*	*-275*
Amount non-ERF (non-add)	*6,233*	*6,201*	*6,082*	*-119*
Less Funds Allocated From Other Sources:				
Mandatory Abstinence Education Grants to States	$50	$50	$50	$0
Items Financed from PHSSEF (Bioterrorism/Recovery)	45	275	618	+343
Ricky Ray Hemophilia Relief Program	580	0	0	0
User Fees	20	21	25	+4
Subtotal, Funds From Other Sources	$695	$346	$693	+$347
Total, HRSA Discretionary B. A	**$5,583**	**$6,130**	**$5,389**	**-$741**
FTE	1,979	2,084	2,061	-23

HEALTH RESOURCES AND SERVICES ADMINISTRATION

MISSION

The Health Resources and Services Administration (HRSA) improves the nation's health by assuring equal access to comprehensive, culturally competent, quality health care for all. As the "access agency" of the U.S. Department of Health and Human Services, HRSA assures the availability of quality health care to low-income, uninsured, isolated, vulnerable and special needs populations and meets their unique health care needs. Through partnerships with States, local communities and universities, HRSA leverages funds to extend access to health care.

SUMMARY

The FY 2003 budget request for HRSA is $6 billion, a net decrease of $394 million from FY 2002. Most of this reduction is associated with one-time construction projects funded in FY 2002 and the elimination of programs that provide less direct services. In FY 2003, HRSA will continue the Presidential multi-year initiative to increase access to health care for the uninsured by enhancing and strengthening the Health Centers program. To complement the growth in Health Centers, there will be a significant increase in the National Health Service Corps. A new innovative service demonstration program to prevent diabetes, asthma, and obesity at the community level will be initiated. Added resources will increase organ donations and expand abstinence education. Also, a significant investment in preparing our nation's hospitals for bioterrorism is proposed. In FY 2003, the agency will strategically use funding to prepare the health professions workforce for today's challenges while continuing to fund important health programs for mothers and children, persons infected with HIV/AIDS, and other underserved populations. Funds are included in the request to cover the full government share of the accruing cost of all retirement and retiree health care benefits for Federal employees.

INCREASING ACCESS TO HEALTH CARE FOR THE UNINSURED

During the 1990s, the number of Americans who lacked health insurance increased by an average of one million per year. The number of uninsured began to decline in 1999. That trend continued in 2000 and today there are an estimated 39 million people in the U.S. who are uninsured. This decrease was driven in large part by an increase in employment-based health insurance. However, many of our Nation's uninsured live in inner-city neighborhoods and rural communities where there are few or no physicians or health care services. Rates of uninsured are more than double among poor communities, and nearly one quarter of the uninsured are poor. The uninsured are hospitalized at least 50 percent more often than the insured for "avoidable hospital conditions." The Department will continue to work with communities to attract the staff and build the infrastructure needed to serve the uninsured.

Health Centers: The budget provides funding for the second year of the Presidential initiative to strengthen the health care safety net for those most in need: an increase of $114 million, for a total of $1.5 billion, for the Health Center program including Community, Migrant, Homeless, and Public Housing Health Centers is requested. These Centers deliver preventive and primary care services for the neediest, poorest, and sickest patients in rural and inner city areas through a Federal, State, and community partnership approach. In these areas, Health Centers are a proven cost effective component of the health care safety net, serving nearly 13 million people in FY 2003, including more than 750,000 migrant farm workers and their families and more than 600,000 homeless individuals.

HEALTH CENTER PATIENTS
(in millions)

	FY 2001 Actual	FY 2002 Estimate	FY 2003 Estimate
Total	10.5	11.8	12.8
Below poverty	5.7	6.4	6.9
Women/children	6.2	6.9	7.5
Rural	4.9	5.5	6.0
Uninsured	4.3	4.8	5.2

The additional $114 million for Health Centers will build on the more than 3,400 existing sites funded in FY 2002 by expanding the delivery of primary health care services to an additional one million individuals in approximately 90 new sites and 80 expanded existing sites. This increase is the second installment of a multi-year initiative to create 1,200 new or expanded health center sites by 2006.

HEALTH CENTER SITES

	FY 2001 Actual	FY 2002 Estimate	FY 2003 Estimate
Total	3,317	3,447	3,537
Urban	1,819	1,884	1,929
Rural	1,498	1,563	1,608

In FY 2001, Health Centers in the New York area received a special $10 million supplement to serve patients following the terrorist attacks on September 11.

HEALTHY COMMUNITIES INNOVATION INITIATIVE

The FY 2003 budget provides $20 million to initiate a new interdisciplinary services demonstration program that will bring together Department-wide expertise to concentrate on the prevention of diabetes, asthma, and obesity at the community level. The purpose of this demonstration is to encourage the development of innovative efforts in five communities to enhance access to services and change health outcomes through a more tightly coordinated public/private partnership between prevention, medical, social, educational, business, civic and religious organizations.

An estimated 16 million persons have diabetes, the seventh leading cause of death in the United States. The number of persons with diabetes has nearly doubled in the past decade. An estimated 10 million adults and nearly 5 million children currently suffer from asthma. Asthma is responsible for approximately 500,000 hospitalizations, 5,000 deaths, and 134 million days of restricted activity a year. Obesity has been linked to a variety of serious illnesses, including diabetes, heart disease, cancer, and arthritis. Over the past two decades, the number of obese people in the United States has increased more than 50 percent.

INCREASING ORGAN DONATIONS

Nearly 80,000 people are on the national organ transplantation waiting list. In 2001, the number of people awaiting a kidney transplant topped the 50,000 figure for the first time. Each day about 60 people receive an organ transplant, but another 10 to 15 people on the waiting list die because not enough organs are available. Since 1999, HRSA has awarded grants to evaluate strategies for increasing consent to donation and intent to donate coupled with family notification. The budget includes $25 million, an increase of $5 million, to support the Secretary's Gift of Life Donation Initiative, a variety of donation awareness efforts, the network that manages the distribution of organs throughout the United States, and vital data collection that guides community leaders and policy makers.

EXPANDING ABSTINENCE EDUCATION

The teen birth rate in the United States declined over 20 percent between 1991 and 2000 and is now at a record low. The percent of high school students who had ever had sexual intercourse declined throughout this period as well. Despite these recent declines, teen pregnancy and out-of-wedlock sexual activity remain a problem.

"When teens postpone parenthood, it benefits not only their lives, but society as a whole."
Secretary Thompson

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 2003, the budget includes a substantial investment in abstinence education, a total of $123 million and an overall increase of $33 million. Included is an increase of over 80 percent, for a total of $73 million, for the Community-Based Abstinence Education program. This program provides 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. The program targets planning and implementation of community-based, abstinence-only educational interventions designed to reduce the proportion of adolescents who have engaged in premarital sexual activity, including but not limited to sexual intercourse; reduce the incidence of out-of-wedlock pregnancies among adolescents; and reduce the incidence of sexually transmitted diseases among adolescents.

The request also includes $50 million in mandatory funding for Abstinence Education Grants to States. This program provides grants to 59 States and territories to provide mentoring, counseling, and adult supervision to promote abstinence with a focus on those groups which are most likely to bear children out-of-wedlock.

In addition to the HRSA activities, the Adolescent Family Life Program's budget includes $12 million for abstinence activities. Combined with the HRSA activities, the FY 2003 budget achieves the President's goal of supporting abstinence education at $135 million.

PREPARING FOR BIOTERRORISM

In FY 2001, HRSA became involved in the national emergency response and recovery efforts by providing grants to entities that incurred health care-related expenses or lost revenue as a result of their immediate response to the September 11th terrorist attacks. The emergency recovery effort will continue in FY 2002. Also in FY 2002, HRSA will expand its role in emergency preparedness by working with States and hospitals to prepare for future bioterrorist events and other public health emergencies. As part of the President's Homeland Security initiative, HRSA will initiate and broaden activities to prepare the Nation's hospitals ability to better respond during terrorist events.

Hospital Preparedness: The FY 2002 appropriation provided $135 million to initiate a new Hospital Preparedness program for States and Territories to develop and implement biological and chemical preparedness plans focused on hospitals. The FY 2003 budget provides a total of $518 million for these activities, an increase of $383 million, to upgrade the capacity of hospitals, outpatient facilities, emergency medical services systems and poison control centers to care for victims of bioterrorism. This will include new clinical personnel; training in recognition of rare diseases, toxic exposures and their treatment; and development of State-level infrastructure to assess needs; and plan and implement programs.

Disasters and incidents with hundreds, thousands, or tens of thousands of casualties are not generally addressed in hospital disaster plans. Nevertheless, they may occur, and recent terrorist actions...suggest that it would be prudent for hospitals to improve their preparedness for a mass casualty incident.

Office of Emergency Preparedness Report

These funds will also support expenses for necessary infrastructure improvements and expansions (including infectious disease containment systems and other equipment) so that hospitals will be prepared to respond to

bioterrorism acts. The program has three objectives. The first objective is to ensure that there is adequate hospital laboratory capacity throughout the U.S. to diagnose and report on potential biological and chemical agents that might be used by terrorists. The second objective is to help hospitals improve their capabilities to control infection for communicable diseases. The third is to assist hospitals with the purchase of personal protective equipment, infection control facilities and other equipment for decontamination of biological and chemical agents. Hospital applications for infrastructure expenses consistent with the State preparedness plans will be approved and funded in accordance with a prioritization and funding schedule developed and approved by the State in which the hospital is located.

Poison Control Centers: The budget provides $21 million for Poison Control Centers, the same as funding level FY 2002. *The Presidential Task Force on Citizen Preparedness In the War on Terrorism* recommended that the Poison Control Centers be used as a source of public information and public education to provide scientifically based information about the latest threats to the public. The Centers will be part of the National and Statewide Consortia on Hospital Preparedness that will determine best practices and future direction of this program. Further, the Centers have and will enhance the expert services regarding bioterrorism especially as it relates to chemical exposures.

Emergency Medical Services for Children: The budget includes $19 million for Emergency Medical Services for Children. The EMS for Children program is one of the first to come into contact with children in need of emergency health care. It is essential that these health care professionals be prepared to meet the unique needs of children in the event of a bioterrorist attack. The program will provide 56 grant awards to assist States and territories in improving care, promote regional care, and make systems improvements ensuring that all components of an effective EMS for Children program are in place.

PREPARING OUR HEALTH PROFESSIONS WORKFORCE FOR TODAY'S CHALLENGES

Today's health professions workforce faces unique challenges, including addressing the large number of medically underserved communities, being prepared for a bioterrorist event, confronting a general shortage of nurses, addressing the lack of diversity in the workforce, and ensuring adequate support for training in children's teaching hospitals. In FY 2003, HHS strategically provides funding for the programs that most directly target these challenges.

Many of the Public Health Service Act Title VII health professions training grants were created over 40 years ago when a physician shortage was anticipated. Recent research shows that there is no longer a shortage of physicians, however, there does remain a geographic maldistribution of physicians, with too few in inner cities and rural areas.

National Health Service Corps: More than 22,000 health professionals have served with the National Health Service Corps (NHSC) since 1972. Current field strength totals more than 2,300 clinicians/health care professionals whose careers are influencing the outcomes of underserved populations and communities. Many of these clinicians have remained in service after fulfilling their initial NHSC commitments. The budget provides $192 million for NHSC recruitment and field placements, a significant increase of $44 million over last fiscal year.

In the last year, HHS has worked to examine and improve the placement of NHSC clinicians in the underserved areas of greatest need as part of the President's management reform initiative. Specifically, HRSA has changed the practice of awarding new NHSC Loan Repayment Program contracts. Now, all awards are being made at one time rather than on a continuous basis throughout the year.

Contracts are then awarded starting with the neediest area, and continue in descending order until funds are fully expended. This process assures that the underserved areas most in need that successfully recruit a clinician receive NHSC support.

NATIONAL HEALTH SERVICES CORPS
(in millions)

	FY 2001 Actual	FY 2002 Estimate	FY 2003 Estimate
NHSC Recruitment			
Scholarship- Federal.....	$34.2	$39.0	$39.0
Loan Repayment- Federal.	36.6	44.0	44.0
Loan Repayment- State.....	7.2	7.5	7.5
Subtotal, Awards.....	78.0	90.5	90.5
Other.....	5.9	8.5	52.4
Subtotal, Recruitment..	83.9	99.0	142.9
NHSC Field Operations.....	$43.3	$48.5	$48.6
Total, NHSC Funding...	**$127.2**	**$147.5**	**$191.5**

Health Professions: The budget includes $110 million for health professions programs, a reduction of $278 million. In FY 2003, funding resources are strategically used to directly address the challenges currently facing health professionals.

The Nation is currently experiencing a nursing shortage. Demand for nurses is rapidly increasing as a result of a growing and rapidly aging population that needs more health care. The nursing supply is not keeping pace with demand due to a decline in nursing school graduates and an aging of the workforce. Too few young people are choosing nursing as a profession. If no action is taken to remedy this, the current registered nurse shortage will continue to increase, and it is projected that the Nation will face a 13 percent shortage of RNs in 2010.

Percent of Registered Nurses Under Age 35	
1980	41%
2000	18%

The budget provides a total of $99 million for nurse training programs, including $15 million for the Nursing Education Loan Repayment Program, an increase of $5 million.

To ensure a continuing source of scholarships focused on increasing diversity in the health professions and nursing workforce, the $10 million provided for Scholarships for Disadvantaged Students will facilitate the training of health practitioners from disadvantaged backgrounds, helping to increase diversity among health professionals and improve access to health care. This funding level will support approximately 5,500 disadvantaged students and 1,400 disadvantaged graduates.

In order to monitor important trends in the health professions workforce, the FY 2003 budget also provides $1 million for data collection and analysis.

Bioterrorism Health Professional Schools Curriculum Development and Training: This budget includes $60 million for the development of a new Educational Incentives for Curriculum Development and Training Program. The goals of this program will be the development of a healthcare workforce 1) capable of recognizing indications of a bioterrorist event in their patients; 2) that possesses the knowledge and skills to best treat their patients; and 3) that has the competencies to rapidly and effectively inform the public health system of such an event at the community, State, and national level. This will be accomplished in two ways. First, new curricula will be developed or collected from pre-existing sources to provide training in an interdisciplinary setting. The curricula will also foster linkages between clinical practitioners and public health networks. Second, faculty and trainers will be prepared to lead such programs through train-the-trainer programs, as HRSA has successfully employed in numerous other programs.

Children's Graduate Medical Education: The FY 2003 budget includes an investment of $200 million, a decrease of $85 million, to support health professions training in free-standing children's hospitals. The budget proposal represents an effort to moderate spending. Since FY 2000, this program has been expanded seven-fold.

RYAN WHITE

The FY 2003 budget includes $1.9 billion for the Ryan White HIV/AIDS program, maintaining the FY 2002 level. The most recent data indicate that an estimated 500,000 persons received HIV medical care and related supportive services through the Ryan White program. Over the past year, the Ryan White program has had great success in its efforts to continuously improve services to those individuals with HIV/AIDS. Successful efforts include: implementing new policies designed to increase cost effectiveness, improve access to health care, and increase guidance and technical assistance to Ryan White grantees; increasing the number of AIDS Drug Assistance Programs (ADAPs) participating in the section 340B Drug Discount Program from 19 to 50; increasing savings from cost recovery strategies from $24 million in 1997 to a projected $66 million in 2001; increasing from 79 to 87 the number of planning grants to underserved communities through the Early Intervention Services program; enhancing services to keep HIV-infected postnatal females in family-centered systems of care to ensure that they are not lost to HIV treatment and follow-up after delivery; and adding clinical consultation as an integral part of the AIDS Education and Training Centers to make certain that providers receive education and training targeted at management of complex clinical situations.

HRSA assists international AIDS efforts in the development of training programs and materials for health care professionals, which through a partnership with CDC, are shared with foreign countries significantly impacted by the virus.

MATERNAL AND CHILD HEALTH

The budget request includes $739 million for the Maternal and Child Health Block Grant (MCH), including the Traumatic Brain Injury program, the same level as in FY 2002. The MCH Block Grant is a public health program that reaches across economic lines to improve the health of all mothers and children. The Block Grant supports Federal and State partnerships that provide critical services to 26 million women and children. These services include direct health care services for children with special health care needs, the promotion of health and safety in child care settings, and enabling services such as home visiting and nutrition counseling. The MCH Block Grant also provides support for newborn screening, trauma care, lead poisoning, and injury prevention.

The budget also proposes $99 million for the Healthy Start program, maintaining the FY 2002 level. Healthy Start funding supports community-based programs to reduce low birth weight, inadequate prenatal care, and other factors contributing to infant mortality in targeted high risk communities. The evaluation of the first 15 Healthy Start Demonstration sites found promising results: reduced infant mortality by almost 50 percent in two project areas; improved adequacy of prenatal care utilization in eight of the 15 project areas; decreased pre-term birth rate in four project areas; and reduced low birth weight rate in three project areas.

Family Planning: The Family Planning program supports a network of more than 4,500 clinics nationwide serving more than 4.5 million people. Of these people, approximately 90 percent have incomes below 200 percent of Federal poverty level. These clinics provide access to such reproductive health care and preventive services as counseling, routine gynecological care, contraceptive methods and related services, hypertension screening, screening and referrals for breast and cervical cancer, and substance abuse. Counseling and education regarding abstinence are required for all adolescent clients through this program. The FY 2003 budget request includes $266 million, maintaining the FY 2002 support for Title X family planning activities.

PROGRAM MANAGEMENT

The President's Budget requests $161 million for HRSA's program management, a decrease of $2 million from FY 2002. As a result of administrative reforms, HRSA will be able to fully fund Federal pay cost increases as well as the HHS Unified Financial Management System within this funding level. HRSA has accomplished several administrative reforms including: streamlining the Office of the Administrator allowing the Bureaus to take the lead on crosscutting initiatives and consolidating the Information Technology functions. The $2 million reduction reflects projects including the FY 2002 appropriations.

REDIRECTED RESOURCES

Projects Initiated in FY 2002: The FY 2003 budget does not include $419 million to continue projects begun in the FY 2002 appropriation. Of this total, $312 million was for Health Care Facilities, $54 million for rural health programs, $33 million for telehealth activities, and $20 million for the Denali Commission.

Community Access Program and State Planning Grants: The budget proposes to eliminate the $120 million appropriated by Congress in FY 2002, for the relatively new, categorical Community Access Program (CAP) and the State Planning Grants. The Department will meet this need by focusing on the President's commitment to expand direct health care services to the uninsured through Community Health Centers and will 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.

Small Categorical Programs: The budget proposes eliminating the Universal Newborn Hearing Screening and Trauma programs, a decrease of $13 million. The MCH Block Grant provides States the flexibility to fund these activities through the Block Grant. Forty-seven States have already received Universal Newborn Screening grants and 53 Trauma projects have been initiated. States are encouraged to incorporate Trauma/EMS planning into their comprehensive disaster planning processes.

OTHER HRSA PROGRAMS

The budget proposes $53 million for the remaining HRSA programs including Bone Marrow, Hansen's Disease, Black Lung, and the new Radiation Exposure Compensation program, the same level as FY 2002.

IHS OVERVIEW

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Indian Health Service:				
Clinical Services	$2,320	$2,448	$2,505	+$57
Contract Health Services (Non-Add)	*446*	*461*	*468*	*+7*
Preventive Health	97	102	105	+3
Contract Support Costs	248	268	271	+3
Tribal Management/Self-Governance	12	12	12	0
Urban Health	30	31	32	+1
Indian Health Professions	31	31	35	+4
Direct Operations	60	63	63	0
Diabetes Grants /1	100	100	100	0
Subtotal, Services Program Level	**$2,898**	**$3,055**	**$3,123**	**+$68**
Indian Health Facilities:				
Health Facility Construction	$86	$86	$72	-$14
Sanitation Construction	95	95	95	0
Facility & Environmental Health Support	127	134	140	+6
Maintenance & Improvement	51	52	53	+1
Medical Equipment	16	16	16	0
Subtotal, Facilities Program Level	**$375**	**$383**	**$376**	**-$7**
Total, Program Level	**$3,273**	**$3,438**	**$3,499**	**+$61**
Less Funds Allocated From Other Sources:				
Health Insurance Collections	-$479	-$508	-$509	-$1
Rental of Staff Quarters	-5	-6	-6	0
Diabetes Grants /1	-100	-100	-100	0
Total, Budget Authority	**$2,689**	**$2,824**	**$2,884**	**+$60**
FTE	14,660	14,794	14,877	+83

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

INDIAN HEALTH SERVICE

MISSION

The Indian Health Service (IHS) is responsible for raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level in partnership with the population served.

SUMMARY

The IHS FY 2003 budget request is $3.5 billion, a net increase of $61 million over FY 2002. Additional funds are requested to cover the increased costs of providing health services to eligible Indian people. The IHS will receive an estimated $509 million in health insurance reimbursements in FY 2003. These reimbursements are primarily from Medicare and Medicaid. Funds are also included in the request to cover the full government share of the accruing cost of all retirement and retiree health care benefits for Federal employees.

AGENCY DESCRIPTION

IHS provides care to approximately 1.5 million American Indians and Alaska Natives who are members of more than 560 Federally recognized tribes. Health 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 2003 budget includes $468 million for purchased care. Other services include preventive health, mental health, alcohol/substance abuse prevention and treatment, and funding for 34 urban Indian programs. The IHS also builds hospitals, outpatient facilities and sanitation systems for Indian homes.

In many areas, tribes are responsible for managing their health services. Currently, tribes manage about 52 percent of the funds appropriated to IHS.

CONTINUED PROVISION OF HEALTH SERVICES

The number of people eligible for IHS services, 1.5 million, increases at about 2 percent annually. Like any health care provider, IHS experiences increases in the cost of providing services.

The budget includes an additional $47 million to cover increased pay costs for IHS's Federal employees (14,794 FTE) and to allow tribally run health programs to provide comparable pay raises to their own staff.

An additional $17 million is included to phase in additional staff hired for two new hospitals, serving the Navajo tribe in Arizona and the Winnebago and Omaha tribes in Nebraska, and to staff the Parker Health Center, serving the Colorado River tribes in Arizona. While existing IHS facilities serve these tribes, the opening of these modern health facilities will significantly improve both the quality and the quantity of health care provided. When these three facilities are fully operational, they will accommodate a total of 130,000 outpatient visits to health professionals annually, an increase of 31 percent, and make new medical services available at these sites (e.g., inpatient adolescent psychiatric treatment at the Navajo hospital, physical therapy at Parker).

The budget includes an additional $7 million for Contract Health Services to help keep up with the cost of purchasing health care from the private sector. An additional $3 million is also included to improve information processing capacity and to implement regulations protecting patients privacy pursuant to the Health Insurance Portability and Accountability Act.

IHS Health Insurance Reimbursements: Medicare, Medicaid and private (i.e., employer provided) health insurance are becoming an

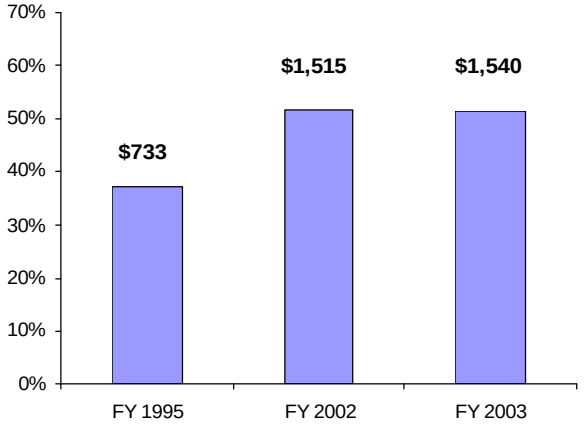
increasingly important component of IHS's budget. These funds now account for 15 percent of the agency's resources, up from 9 percent in FY 1995. The budget currently anticipates collecting $509 million in FY 2003. The Centers for Medicare & Medicaid Services (CMS) and IHS have worked cooperatively to develop cost-based methodologies that reflect the full cost of providing medical care to eligible Indian people. New Medicare/Medicaid rates for IHS facilities will be established later this year, providing further growth in insurance resources.

SUPPORTING INDIAN SELF-DETERMINATION

A steadily growing number of tribes have chosen to assume responsibility for providing their own health care by entering into self-determination contracts/compacts with the IHS. Tribes currently operate one-fourth of the hospitals, three-quarters of the outpatient facilities, and manage 52 percent of the budget, up from 37 percent in FY 1995.

To support continued growth in tribal self-determination, the budget includes a total of $271 million for tribal Contract Support Costs (CSC), an increase of $2.5 million compared to FY 2002. To ensure that the best CSC policies for supporting tribal self-determination are in place, IHS will participate in a CSC policy workgroup along with representatives of the Bureau of Indian Affairs, and the Office of Management and Budget.

PERCENT OF IHS FUNDS MANAGED BY TRIBES
(in millions)



As part of its consultation policy with American Indian and Alaska Native tribes, the Department held two tribal budget consultation sessions in June of 2001. One session, hosted by the Deputy Secretary, covered all HHS agencies, while the other focused solely on the needs and programs of the Indian Health Service.

INVESTING IN HEALTH IMPROVEMENTS

Recruiting and retaining health professionals is one of the challenges IHS faces. Scholarships and school loan repayments are available for health professionals working (or who agree to work) in hard-to-fill locations. The budget includes a total of $35 million, an increase of $4 million, for recruitment. This increase will be used to initiate a special recruitment effort targeted at health professionals that have worked for the military. Funds would support relationships with the Departments of Defense (DOD) and Veterans Affairs (VA) and for scholarships and loan repayment agreements with former DOD and VA health professionals.

In supporting research into the best ways of providing health care to Indian people, HHS works to ensure that the perspectives of Native American researchers are reflected. The budget includes an additional $1.5 million to double funding for the Tribal Epidemiology Program. The regional centers supported by this program allow tribes to work together on disease surveillance and health program evaluation in the areas which are most important to them.

To further support Native American health research, IHS and NIH's National Institute of General Medical Sciences awarded $3 million to eight Native American Research Centers for Health in September of 2001. Funding will be used for research in a number of areas including risk factors for type II diabetes in American Indian Youth and community intervention methods to reduce obesity in Indian children.

FACILITY CONSTRUCTION

The budget includes $72 million for construction of new health facilities. New health facility construction allows IHS to significantly expand capacity at its most overcrowded sites and replace its oldest buildings with modern health facilities. The two hospitals which will be replaced with funds in this budget, Fort Defiance and Winnebago, were both first opened in the 1930s.

Over the last five years, new facilities have opened at: Anchorage, Alaska; Talihina, Oklahoma; Hayes, Montana; Harlem, Montana; White Earth, Minnesota; Polacca, Arizona; Lame Deer, Montana; Parker, Arizona; Spokane, Washington; and Aberdeen, South Dakota.

The $72 million requested will complete four projects: staff quarters for the new Fort Defiance hospital (Navajo Reservation, Arizona); the Winnebago hospital (Winnebago and Omaha tribes, Nebraska); the Pawnee Outpatient Facility (Pawnee Tribe, Oklahoma); and the Saint Paul Outpatient Facility (Pribilof Islands, Alaska). Funds would also continue construction at two facilities, the Red Mesa Outpatient Facility (Navajo Reservation, Utah) and the Pinon Outpatient Facility (Navajo Reservation, Arizona).

When fully operational, these six facilities will accommodate 212,000 outpatient visits to health professionals annually, increasing capacity by 31 percent at these sites. The new facilities will provide better and more efficient health care by housing health services in the same building. They will also allow the provision of medical services that are not currently available at these locations (e.g., the full range of ambulatory care services at Pinon, a 24-hour emergency room at Red Mesa).

Future IHS budgets will be developed through a new comprehensive capital planning process which will allow the Department to balance the need for new construction across all of its agencies.

IHS continues to construct waste water and solid waste disposal systems for Indian homes. The budget includes a total of $95 million for sanitation construction, sufficient to provide services for 3,350 new and 11,455 existing Indian homes. The budget also includes a total of $53 million for Maintenance and Improvements at IHS facilities, an increase of $1 million over FY 2002.

MANAGEMENT IMPROVEMENTS

IHS will initiate management reforms at headquarters and in its 12 Area Offices which will result in a budget savings of $9 million and 100 FTE. These reforms will include: greater use of Internet-based training to reduce training and related travel costs; strict limitations on hiring non-health staff and the acquisition of new office space; reducing the number of IHS staff attending meetings and events; and more careful monitoring of printing and the purchase of administrative supplies.

CDC OVERVIEW

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Centers for Disease Control & Prevention:				
Bioterrorism	$181	$2,298	$1,637	-$661
State and Local Capacity (non-add)	*67*	*940*	*940*	*0*
CDC Capacity (non-add)	*32*	*135*	*159*	*+24*
Pharmaceuticals and Vaccines (non-add)	*51*	*1,157*	*400*	*-757*
Security/Facilities (non-add)	*3*	*46*	*120*	*+74*
Other (non-add)	*29*	*20*	*18*	*-2*
Buildings & Facilities	175	250	64	-186
Chronic Disease Prevention & Health Promotion	756	754	697	-57
HIV/AIDS, STDs & TB Prevention	1,051	1,143	1,143	0
Immunization	556	631	631	0
Environmental Health	140	157	156	-1
Birth Defects, Disability & Health	71	91	90	-1
Epidemic Services & Response	81	83	81	-2
Health Statistics	125	131	130	-1
PHS Evaluation (non-add)	*72*	*23*	*47*	*+24*
Preventive Health Block Grant	135	135	135	0
Injury Prevention & Control	144	151	146	-5
Public Health Improvement	112	150	119	-31
Infectious Disease Control	326	354	345	-10
Occupational Safety & Health	270	287	258	-28
Office of the Director	36	47	48	+1
ATSDR (VA/HUD Appropriation)	78	81	81	-1
Emergency Recovery	13	20	0	-20
Diabetes (Mandatory Funding)	3	3	3	0
User Fees	2	2	2	0
Subtotal, Program Level	**$4,256**	**$6,766**	**$5,765**	**-$1,000**
Amount ERF (non-add)	*16*	*2,136*	*0*	*-2,136*
Amount non-ERF (non-add)	*4,239*	*4,630*	*5,765*	*+1,135*
Less Funds Allocated from Other Sources:				
Public Health and Social Service Emergency Fund	-$191	-$2,259	-$1,517	+$743
Health Facilities Construction Fund	-178	-296	-184	+112
PHS Evaluation (Health Statistics)	-72	-23	-47	-24
Mandatory Budget Authority (Diabetes)	-3	-3	-3	0
User Fees	-2	-2	-2	0
Total, Budget Authority	**$3,810**	**$4,182**	**$4,012**	**-$169**
Amount ERF (non-add)	*0*	*12*	*0*	*-12*
Amount non-ERF (non-add)	*3,810*	*4,170*	*0*	*-4,170*
Labor/HHS Appropriation	**$3,732**	**$4,100**	**$3,932**	**-$169**
VA/HUD Appropriation	**$78**	**$81**	**$81**	**-$1**
FTE	8,228	8,627	8,552	-75

CENTERS FOR DISEASE CONTROL AND PREVENTION

MISSION

The mission of the Centers for Disease Control and Prevention (CDC) is to promote health and quality of life by preventing and controlling disease, injury and disability.

SUMMARY

The FY 2003 budget requests a total of $5.8 billion for the Centers for Disease Control and Prevention (CDC), a decrease of $1 billion, or 15 percent, from FY 2002. This reduction is attributed primarily to a major one-time purchase in FY 2002 of vaccines and other pharmaceuticals to combat bioterrorist threats. The FY 2003 budget for CDC includes $1.5 billion in funds provided through the Public Health and Social Services Emergency Fund (PHSSEF), $184 million in the Health Facilities and Construction Fund, and $47 million in Public Health Service evaluation interagency transfer funds for activities related to Health Statistics.

CDC works with States, local agencies, and partners throughout the Nation and the world to accomplish its public health mission. Together, they monitor health, detect and investigate naturally occurring and man-made 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. Funds are included in the request to cover the full government share of the accruing costs of all retirement and retiree health care benefits for Federal employees.

RESPONDING TO BIOTERRORIST THREATS

The budget includes $1.6 billion, a net decrease of $661 million, for CDC bioterrorism preparedness. This reflects a one-time decrease of $757 million in the costs associated with the procurement of vaccines and pharmaceuticals in FY 2002. CDC's funding for bioterrorism will be awarded under a new approach to State and local preparedness that ensures coordination across public health and medical systems, expects accountability, and recognizes performance.

> ***"Expanding our stockpile so there is a smallpox vaccine for every American if needed prepares us to respond aggressively to minimize the spread of the disease should an outbreak occur."***
>
> ***Secretary Thompson, November 28, 2001***

The anthrax attacks demonstrated that biological agents can be used as weapons of terrorism against civilian populations. Covert releases of smallpox or anthrax could cause widespread death, disability and societal disruption. To counteract the potential impact of bioterrorism, CDC will focus on upgrading capacity at the State and local level, as well as CDC; building the National Pharmaceutical Stockpile; and advancing research.

Upgrading State and Local Capacity: CDC's State and local program emphasizes improved laboratory capacity, enhanced epidemiological expertise in the identification and control of diseases caused by bioterrorism, better electronic communication and distance learning through the Health Alert Network, and a newly expanded focus on cooperative training between public health agencies and local hospitals. The budget includes $940 million, the same level as FY 2002, for State and local bioterrorism preparedness. Within this amount, funds will be available to continue to support the Laboratory Response Network, a system of over 80 public health labs specifically trained in identifying pathogens that could be used for bioterrorism. In addition, expanding the Health Alert Network will continue to be a priority. This is an electronic communications

system that provides Internet connectivity and training to public health departments across the country and will create linkages between these public health departments and health care providers. In addition, resources will be available to support disease detection and outbreak control, including epidemiological and medical response; State, local and regional preparedness planning and coordination; and conduct training exercises that include State public health and hospital systems.

Upgrading CDC Capacity: Funds totaling $159 million, an increase of $24 million, will be used to upgrade scientific response capacity at CDC. Funds will support the acquisition of additional equipment and personnel, including the 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 Stockpile can respond within 12 hours to any point in the country.

The request will support disaster response teams and additional Epidemic Intelligence Service (EIS) Officers for assignment to States. CDC will continue work on the rapid toxic screen, technology that can quickly identify up to 150 chemical threats. CDC also will use funds to continue around-the-clock bioterrorism surveillance and response operations at their Atlanta campuses.

The National Pharmaceutical Stockpile: The budget proposes $400 million for the National Pharmaceutical Stockpile (NPS) and support costs for the 286 million doses of smallpox vaccine to be available by the end of FY 2002. Funds totaling $65 million will be available and used to help States develop systems to distribute NPS assets if deployed.

Anthrax Vaccine Studies: A total of $18 million is requested to continue research evaluations of the anthrax vaccine used to innoculate military personnel, and offered to postal workers and congressional staff. Activities supported by these funds include monitoring adverse events and analyzing dose requirements.

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, analysis carried out at the labs was pivotal in identifying the first cases of West Nile virus ever found in North America.

The FY 2003 budget includes a total request of $184 million to construct, repair and secure facilities of the CDC. This entire amount is included in the budget request for the new HHS Health Facilities Construction and Management Fund.

A priority focus is the construction of an infectious disease/bioterrorism laboratory in Fort Collins, Colorado, and the completion of a second infectious disease laboratory, an environmental laboratory, and a communication and training facility in Atlanta. The Scientific Communications Center will dramatically expand CDC's ability to provide public health training for State and local partners, including distance learning. This facility will also include scientific conference capacity.

CDC labs have tested over 6,000 environmental and blood samples for anthrax.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

CDC supports numerous ongoing activities designed to prevent chronic diseases including cardiovascular disease, diabetes, arthritis and cancer. Chronic disease programs provide a wide array of support to prevent the occurrence and progression of chronic diseases. For example, the budget supports over 500,000 tests for breast and cervical cancer annually and activities which promote

proper diet, exercise and tobacco-use reduction.

The budget includes $697 million for Chronic Disease Prevention and Health Promotion, a net decrease of $57 million, or 8 percent, below FY 2002. This reflects $14 million in program increases, $3 million in management savings and not continuing $68 million in funding for the youth media campaign.

Healthy Communities: The FY 2003 President's Budget continues to encourage State and local innovations that target health risks such as heart disease, increased access to care, and higher quality care. The budget includes $5 million for a national media campaign to promote physical activity, with an emphasis on families and communities. This effort will be done in conjunction with HRSA's new Healthy Communities Innovation initiative.

Breast and Cervical Cancer Screening: The budget includes $203 million for the National Breast and Cervical Cancer Early Screening Detection Program (NBCCEDP), an increase of $9 million above FY 2002. This increase will expand screening, diagnostic, and case management services to women at-risk, especially minority women. Since its inception in 1991, over 3 million screening tests have been provided by the NBCCEDP, with over 10,000 cases of breast cancers and over 700 cases of invasive cervical cancer diagnosed. The program also includes WISEWOMAN preventive services in 12 States that screen for heart disease and diabetes risk factors, and provide dietary and physical activity interventions for women determined at-risk.

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 infections 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.

Domestic HIV efforts have been refocused to help States reduce the number of new infections 50 percent by 2005. The budget continues to support CDC's domestic HIV/AIDS prevention activities, including expanded local efforts that increase the number of people who know their HIV status, and link infected individuals to prevention, care and treatment services.

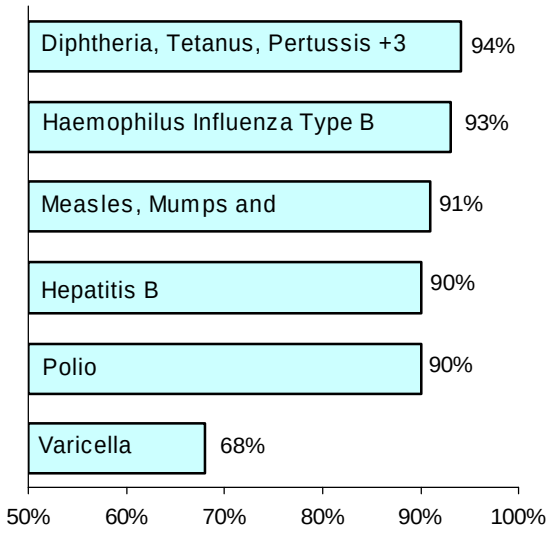
To combat global AIDS, the budget contains $144 million, the same level as FY 2002. An estimated 28 million people, or 70 percent of all individuals with HIV/AIDS in FY 2001, lived in sub-Saharan Africa. Funds will support improved surveillance, voluntary counseling and testing, and care, treatment and prevention of mother-to-child transmission.

CHILDHOOD IMMUNIZATION

Delivery of safe and effective vaccines is one of the most cost-effective methods of preventing illness. The goal for the year 2003 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 2003 immunization budget is $1.5 billion. This includes $631 million in discretionary appropriations to CDC, and $823 million for the mandatory 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 2003 budget requests $135 million for global immunization activities, including polio eradication. While world-wide polio cases were reduced by an estimated 95 percent between 1988 and 2001, a major international effort continues to reach the World Health Organization's goal to certify global polio eradication by 2005.

ENVIRONMENTAL HEALTH

The budget includes $156 million for environmental disease prevention. A major focus in FY 2003 will be the continued development of the Environmental Health Tracking Network which will document links between environmental hazards and chronic diseases. CDC also supports a comprehensive environmental health program that includes prevention of asthma and childhood lead poisoning, public health genetics, and emergency response to chemical and radiological accidents.

BIRTH DEFECTS, DEVELOPMENTAL DISABILITIES, DISABILITY AND HEALTH

More than 150,000 infants are born with birth defects annually in the U.S. One in six American children under the age of eighteen have some type of developmental disability. An estimated 54 million people in the U.S. live with a disability. The Children's Health Act of 2000 called for CDC to establish a new Birth Defects and Developmental Disabilities Center. The FY 2003 budget proposes $90 million for these programs. Activities to be addressed by this center include: education and outreach to increase consumption of folic acid; pilot programs for attention-deficit, hyperactivity disorder; and increased surveillance and State programs that will promote optimal childhood development.

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. Approximately 200 CDC epidemiologists were assigned to States to investigate anthrax outbreaks in 2001. The FY 2003 budget includes $81 million for the Epidemic Services and Response Program. Funds will support CDC's Epidemic Intelligence Service (EIS) officers, medical and scientific professionals trained over two years to be able to detect and control disease outbreaks.

HEALTH STATISTICS

The budget includes $130 million for health statistics. In FY 2003, National Center for Health Statistics (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 $47 million of CDC's health statistics program be financed by PHS evaluation funds.

PREVENTIVE HEALTH BLOCK GRANT

The FY 2003 budget includes $135 million for the Preventive Health and Health Services Block Grant (PHHSBG), the same level as

FY 2002. 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.

Injury Prevention

Nearly 150,000 Americans die each year from injuries. The budget includes a total of $146 million for injury prevention efforts, a reduction of $5 million from FY 2002.

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.

Public Health Improvement

The budget includes $119 million for Public Health Improvement, a decrease of $31 million from FY 2002. Ongoing programs are maintained; the reduction reflects activities that received one-time funding in FY 2002 and deleting the separate funding for "prevention research." This reduction reflects an intent to achieve efficiencies in research activities in the Department.

Primary goals of the Public Health Improvement activity area are also advanced by CDC's bioterrorism programs. The budget maintains funding for work 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 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 and the Racial and Ethnic Approaches to Community Health (REACH 2010) demonstration projects, which seek to eliminate racial disparities in health in areas including chronic and infectious diseases.

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 $345 million to fight infectious diseases, a decrease of $10 million below FY 2002. Infectious Disease activities include efforts to reduce emerging infectious and foodborne diseases, improve patient safety, and provide laboratory support for HIV/AIDS, tuberculosis and immunization programs.

Funds continue to be used to provide assistance to States and localities to detect and prevent the spread of infectious diseases. Funds also will help prevent and control Hepatitis C and combat antimicrobial disease strains.

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 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 $258 million, a decrease of $28 million below FY 2002. This reduction reflects an intent to achieve efficiencies in research activities in the Department. In addition to its on-going activities, NIOSH assists in the implementation of the Energy

Employees Occupational Illness Compensation Act of 2000. Funds for this activity are contained in the budget for the Department of Labor.

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 $81 million for ATSDR. Funding for ATSDR is provided through the Veterans Affairs, Housing and Urban Development Appropriations Subcommittee.

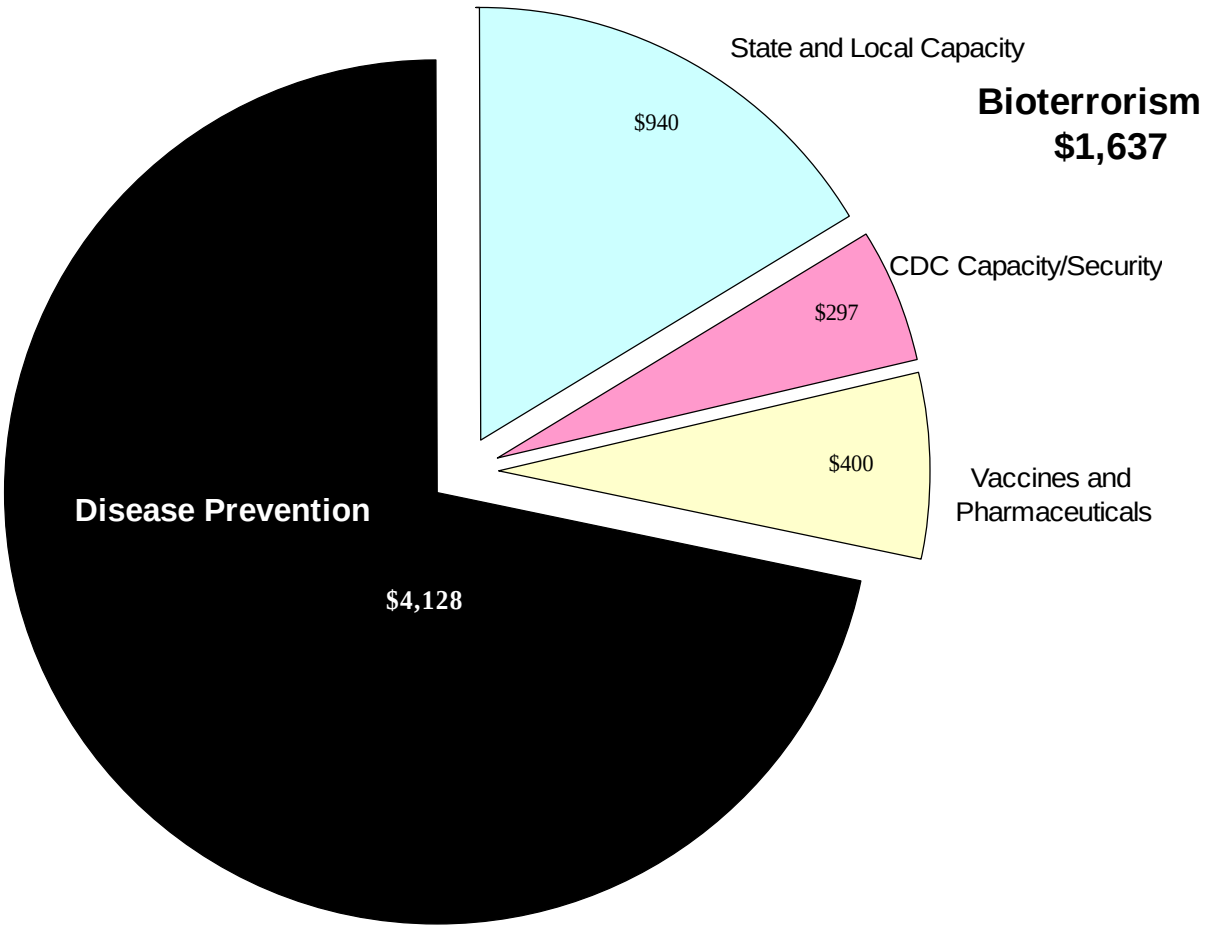
OFFICE OF THE DIRECTOR

The budget includes $48 million for CDC's Office of the Director, an increase of $1 million from the FY 2002 level to cover inflationary pay increases. The Office of the Director manages and directs the public health programs of CDC and implements programs on global health, minority health and womens' health. In FY 2003, CDC will continue to pursue an aggressive strategy to improve financial management of its disease prevention programs and integrate its fiscal systems with the Department's as a whole. Across CDC, management and administrative reforms will provide savings of $27 million. This reflects overall management improvements in the agency consistent with the President's Management reform initiative.

RECOVERY FUNDING

The emergency supplemental appropriations of $16 million in FY 2001 and $20 million in FY 2002 were provided for recovery and relief efforts in response to the attacks of September 11th. Funds were provided for environmental hazard control, worker safety screening, medical supplies and immediate security measures implemented at CDC's campuses.

FY 2003 CDC BUDGET
Total Budget = $5.8 billion
(dollars in millions)



NIH OVERVIEW (by Institute/Center)

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Institutes:				
National Cancer Institute	$3,735	$4,210	$4,725	+$515
National Heart, Lung, & Blood Institute	2,293	2,582	2,798	+217
National Institute of Dental & Craniofacial Research	307	345	374	+29
Natl Inst. of Diabetes & Digestive & Kidney Disease	1,307	1,471	1,609	+138
National Institute of Neurological Disorders & Stroke	1,176	1,332	1,443	+112
National Institute of Allergy & Infectious Diseases	2,069	2,542	3,999	+1,457
National Institute of General Medical Sciences	1,532	1,726	1,881	+155
Natl Inst. of Child Health and Human Development	982	1,117	1,218	+101
National Eye Institute	509	583	632	+49
National Institute of Environmental Health Sciences:				
Labor/HHS Appropriation	508	571	620	+48
VA/HUD Appropriation	63	81	76	-5
National Institute on Aging	789	896	972	+76
Natl Inst. of Arthritis & Musculoskeletal & Skin Dis.	396	450	488	+38
Natl Inst. on Deafness & Communication Disorders	302	343	372	+29
National Institute of Mental Health	1,108	1,254	1,359	+105
National Institute on Drug Abuse	782	891	968	+77
National Institute on Alcohol Abuse & Alcoholism	342	386	418	+33
National Institute for Nursing Research	105	121	131	+10
National Human Genome Research Institute	382	431	467	+36
Natl Inst. for Biomedical Imaging & Bioengineering	69	112	121	+9
National Center for Research Resources	812	1,013	1,091	+79
Natl Center for Complementary & Alternative Med	89	105	114	+9
Natl Center for Minority Health & Health Disparities	132	158	187	+29
Fogarty International Center	51	57	64	+6
National Library of Medicine	242	282	315	+33
Office of the Director	192	239	259	+20
Buildings & Facilities	161	326	633	+307
ONDCP Drug Forfeiture Fund Transfer (NIDA)	10	10	0	-10
Type 1 Diabetes Research 1/	97	97	97	0
Total, Program Level	**$20,544**	**$23,730**	**$27,432**	**+$3,702**
Amount ERF (non-add)	*0*	*191*	*0*	*-191*
Amount non-ERF (non-add)	*20,544*	*23,539*	*27,432*	*+3,893*
Less Funds Allocated from Other Sources:				
ONDCP Drug Forfeiture Fund Transfer (NIDA)	-$10	-$10	$0	+$10
Type 1 Diabetes Research 1/	-97	-97	-97	0
Total, Budget Authority	**$20,438**	**$23,623**	**$27,335**	**+$3,712**
Amount ERF (non-add)	*0*	*191*	*0*	*-191*
Amount non-ERF (non-add)	*20,438*	*23,433*	*27,335*	*+3,902*
Labor/HHS Appropriation	**$20,375**	**$23,542**	**$27,259**	**+$3,717**
VA/HUD Appropriation	**$63**	**$81**	**$76**	**-$5**
FTE	16,525	17,471	17,696	+225

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

NATIONAL INSTITUTES OF HEALTH

MISSION

The mission of the National Institutes of Health (NIH) is to uncover new knowledge about the prevention, detection, diagnosis, and treatment of disease and disability.

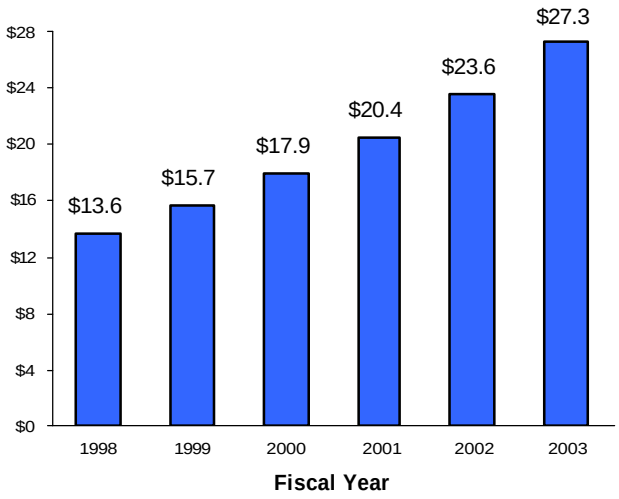
SUMMARY

The FY 2003 budget request for NIH includes $27.3 billion to fulfill the President's promise to complete the doubling of NIH's budget by FY 2003, from the FY 1998 level of $13.6 billion. This is an increase of $3.7 billion, or 15.7 percent, over FY 2002. This last installment of the President's five-year doubling plan would be the largest year-to-year dollar increase ever for NIH. With the completion of this doubling commitment, the Nation's research capacity is poised to accelerate the pace of new discoveries about basic biological functions, speed the clinical research needed to develop new medicines and technologies, and hasten the advancement of new approaches to diagnose, treat, and prevent diseases and disabilities.

The request fulfills the President's promise to complete the doubling of NIH's budget by FY 2003, from the FY 1998 level of $13.6 billion.

NIH is the world's largest and most distinguished organization dedicated to maintaining and improving health through medical science. Its 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 opportunities, such as the development of research resources or the sequencing and mapping of the human genome.

NIH TOTAL FUNDING
(dollars in billions)



Approximately 83 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 university, hospital, and other research facilities. About 11 percent of the budget 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 2003, approximately two percent of the budget is devoted to replacing, modernizing, and repairing NIH's intramural research facilities.

Funds are included in the request to cover the full government share of the accruing cost of all retirement and health care benefits for Federal employees.

RESEARCH PRIORITIES IN FY 2003

With the increases proposed for FY 2003, NIH will engage in new and expanded efforts

in genomics, proteomics, therapeutics, and prevention. FY 2003 funds will be used to address converging arenas of scientific opportunity and public health, such as bioterrorism, cancer, HIV/AIDS, diabetes, Parkinson's disease, Alzheimer's disease, asthma, and minority health.

Bioterrorism Research: Following the September 11 terrorist attacks, the biomedical research enterprise of this Nation was called upon to initiate new efforts to combat the consequences of these terrorist actions and threats. In FY 2003, the number one program priority for the increases requested in the NIH budget is supporting research needed for the war against terrorism. In coordination with the Federal Office of Homeland Security and the HHS Office of Public Health Preparedness, NIH recently conducted an assessment of the status and direction of biomedical research in the areas of bioterrorism prevention and treatment. From this assessment, NIH has prepared a plan of robust research initiatives designed to develop countermeasures to neutralize bioterrorist threats from micro-organisms such as smallpox, anthrax, tularemia, and plague.

In FY 2003, the number one program priority for the increases requested in the NIH budget is supporting research needed for the war against terrorism.

The FY 2003 budget includes nearly $1.8 billion to begin implementing this plan. This is over a six-fold increase above NIH's bioterrorism spending in FY 2002 and represents 40 percent of the total NIH increase for FY 2003. While NIH's bioterrorism funds are requested to be appropriated directly to its budgets, NIH will work with the Office of Public Health Preparedness to ensure full coordination with other HHS and Federal agencies.

NIH's bioterrorism research plan calls for NIH to: (1) expand basic research on the physiology and genetics of potential bioterrorism agents, the immune system function and response to each potential agent, and the pathogenesis of each disease; (2) accelerate discovery, development, and clinical research of next generation vaccines, therapies, and diagnostic tests, such as those using zebra chip technology, for potential bioterrorism agents; and (3) expand research infrastructure at both the intramural and extramural levels in order to be able to conduct this research in safe and up-to-date facilities. At the heart of the NIH bioterrorism research plan is the establishment of a series of extramural Centers of Excellence for Bioterrorism and Emerging Infections, which will provide researchers with specialized equipment and tools, including biosafety level (BSL) 3 or 4 research laboratories; and conduct specialized research training. Another initiative is the use of challenge grants to attract the long-term interest and support of industry and academia in developing biomedical tools to combat, detect, and diagnose diseases caused by bioterrorism agents.

To carry out these plans, the President's FY 2003 budget specifically includes $977 million for basic and applied research; $250 million for anticipated procurement in FY 2003 of anthrax vaccines currently under development and testing; and $521 million for construction and renovation of BSL 3 or 4 laboratory facilities for extramural and intramural bioterrorism researchers, as well as physical security improvements to the NIH campuses.

Substantial positive spin-offs are strongly anticipated for other diseases from this large investment in bioterrorism research. Advancing knowledge in the arena of diagnostics, therapeutics, and vaccines in general should have enormous impact on the ability to diagnose, treat, and prevent major killer-diseases such as malaria, tuberculosis, HIV/AIDS, West Nile fever, influenza, etc. The enhanced understanding of molecular and cellular immune mechanisms will lead to improvements in treating and preventing immune-mediated diseases such as lupus and

rheumatoid arthritis. Other areas benefitting substantially from bioterrorism research will include cancer, immune-mediated neurological diseases, allergic and hypersensitivity diseases, as well as preventing the rejection of transplanted organs.

Cancer Research: Within the FY 2003 budget, NIH will spend an estimated $5.5 billion for research on cancer throughout all of NIH. This is an increase of $629 million, or 12.8 percent, over FY 2002.

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Currently, one of every two men and one of every three women in the United States will develop some type of cancer over the course of their lives. Approximately 8.4 million Americans alive today have a history of cancer, and nearly 25 percent of all deaths in our country are due to cancer. Thirty years ago, when the war on cancer was declared, many scientists believed cancer was one disease that would have a single cure. New research indicates that cancer is actually more than 200 diseases, all of which require different treatment protocols.

However, there is encouraging news: recent reports show that from 1992 to 1998, cancer incidence rates declined in men and cancer death rates declined in both men and women. Promising cancer research is leading to major breakthroughs in treating and curing various forms of cancer. For example, in May 2001, the Food and Drug Administration announced its approval in near-record time of the drug Gleevec as an oral treatment for chronic myelogenous leukemia (CML), a cancer characterized by too many white blood cells in the bone marrow.

Gleevec represents a new class of cancer drugs designed to zero in on specific cancer-causing molecules, eliminating cancer cells while avoiding serious damage to other, non-cancerous cells. This advance shows that molecular targeting of unique cancer-causing proteins in tumors can work in treating cancer, provided that the target is correctly chosen. The road to its discovery was paved through knowledge culled from more than 40 years of studies, much of it funded by NIH, that probed the molecular events associated with cancer development, the use of new technologies that enabled scientists to move in directions previously beyond reach, and quite often, unanticipated opportunity.

HIV/AIDS Research: The FY 2003 budget includes a total of $2.8 billion for HIV/AIDS-related research. This is an increase of $255 million, or 10 percent over the FY 2002 level.

NIH's HIV/AIDS research continues to focus on four main themes: 1) prevention research, including vaccines, microbicides, and other biomedical and behavioral interventions, to reduce HIV transmission here in the U.S. and around the world; 2) therapeutic research to treat those already infected; 3) international research, particularly to address needs in developing countries; and 4) research targeting the disproportionate impact of AIDS on minority populations in the U.S. In FY 2003, NIH funding for AIDS vaccine research will grow to $422 million, a 24 percent increase over FY 2002 and 185 percent over FY 1998.

The FY 2003 budget for NIH also includes $100 million in NIAID to continue the HHS contribution initiated in FY 2002 to the Global Fund to Fight HIV/AIDS, Malaria, and Tuberculosis. These funds support the development of a multilateral trust fund that will leverage additional international resources for prevention, treatment, and care activities to combat these diseases. The Global Fund has been established with the objective of enhancing the capabilities of public health and health care delivery programs in areas of the world where these infections are endemic. With this HHS contribution and the

contribution from other agencies, the United States will have met its commitment of $500 million to this effort.

Within NIH, the Global AIDS Research Initiative and Strategic Plan, developed by the Office of AIDS Research last year, reaffirmed NIH's long-standing commitment to international HIV/AIDS research. NIH supports a growing portfolio of HIV/AIDS research conducted in collaboration with investigators in developing countries, and supports international training programs and initiatives to help build research infrastructure and laboratory capacity in these countries.

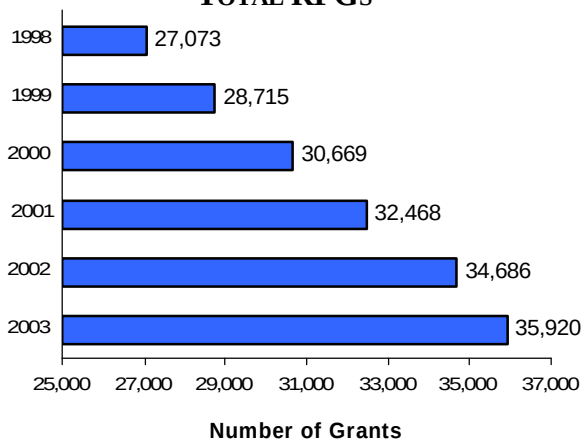
Institutional Development Awards (IDeA) Program: For FY 2003, the budget includes $185 million for the Institutional Development Awards (IDeA) program, an increase of $25 million or 16 percent, over FY 2002. These funds are included within the request for the National Center for Research Resources (NCRR). The IDeA program is designed to broaden the geographic distribution of NIH funding by enhancing the competitiveness of research institutions in States often less successful in obtaining grant funding.

Extramural Loan Repayment Programs: In FY 2003, NIH plans to spend nearly $60 million in total for the four loan repayment programs for extramural researchers that were first authorized and funded in FY 2002. Those eligible for these programs include extramural scientists engaged in pediatric and clinical research, scientists from disadvantaged backgrounds conducting clinical research, and scientists conducting research on minority health disparities issues. These loan repayment programs provide an important tool for recruiting outstanding investigators into these specific areas of research. In the FY 2003 budget, NIH places an emphasis on the pediatric and clinical research loan repayment programs, for which it plans to double funding from $28 million to $56 million to support 554 loan repayment contracts.

RESEARCH PROJECT GRANTS

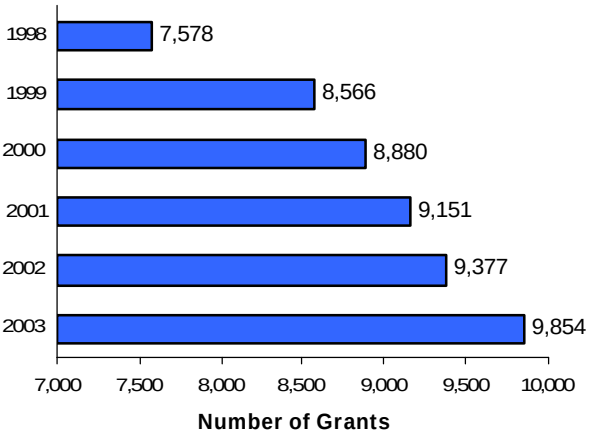
The support of basic medical research through competitive, peer-reviewed, and investigator-initiated research project grants (RPGs) represents 50 percent of NIH's total budget.

TOTAL RPGS



In FY 2003, the NIH budget provides $13.7 billion, a 9.9 percent increase over FY 2002, to fund 35,920 total projects, the highest level in the agency's history. This is 1,234 more grants in total than are expected to be funded in FY 2002, and an increase of 8,847 over the total awarded in FY 1998.

NEW AND COMPETING RPGS



Within this total, NIH estimates it will support 9,854 new and competing RPGs in FY 2003, an increase of 477 over FY 2002 and itself a record high. NIH plans to adjust the average value of new and competing RPG awards by 4.0 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 $369,500, a 44 percent increase over FY 1998. The budget includes language that gives NIH the flexibility to fully fund multi-year grants in the first year they are awarded.

RESEARCH FACILITIES CONSTRUCTION

A combined total of $873 million is requested in FY 2003 for extramural and intramural NIH-funded research facilities construction projects. Of this, $521 million is related to the fight against bioterrorism and $352 million is associated with general biomedical research. While requested in the NIH budget, these resources would be transferred to the Health Facilities Construction and Management Fund in the Departmental Management account to allow these projects to be co-managed, along with other HHS construction projects, by the Office of the Assistant Secretary for Administration and Management. This reflects HHS's commitment to improve HHS-wide capital planning.

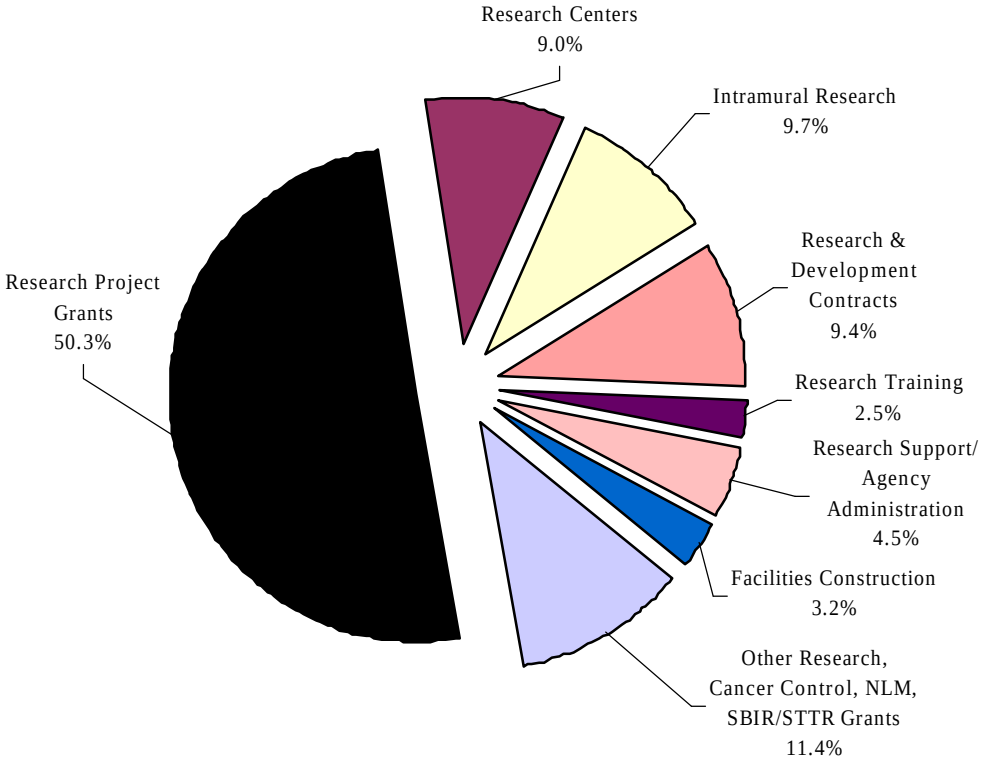
Extramural Research Facilities Construction: For FY 2003, the budget proposes a total of $240 million for extramural research facilities construction grants, an increase of $125 million, or 109 percent. This includes $150 million requested in the NIAID budget specifically for construction and renovation of BSL 3 or 4 laboratories at the planned extramural Centers of Excellence for Bioterrorism and Emerging Infections. The NCRR budget includes $77 million to expand the capacity of other research institutions to perform or improve the quality of their biomedical and behavioral research. Grantees will also be invited to apply to use these funds to improve physical security at extramural research laboratories. In addition, the National Center for Minority Health and Health Disparities requests $8 million in FY 2003 to initiate construction and renovation projects at its extramural Centers of Excellence for Research Education and Training, as authorized by P.L. 106-525, and the National Cancer Institute plans to spend $5 million for extramural facilities projects.

Intramural Buildings and Facilities: A total of $633 million is requested for NIH intramural buildings and facilities (B&F) in FY 2003. This includes $371 million for projects designated to enhance NIH's bioterrorism research capacity, and $262 million for facilities projects that are for campus-wide research infrastructure improvements.

The $371 million for intramural bioterrorism research facilities will fund construction of a BSL 4 laboratory at NIH's Ft. Detrick campus in Frederick, Maryland ($105 million); a BSL 3 facility for NIH's own Center for Bioterrorism and Emerging Infections on the NIH main campus in Bethesda, Maryland ($186 million); and improvements to physical security at NIH's research campuses ($80 million).

The $262 million requested for other intramural facilities projects includes $172 million to complete construction of Phases I and II of the John Edward Porter Neuroscience Research Center. When completed, this project will bring together, in a shared facility, basic and clinical neuroscientists from across NIH. 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 remaining $90 million will be used for other specific facilities projects across NIH, including continuing transitional renovations for the existing Clinical Center building ($24 million) and other safety and health improvements, mechanical systems upgrades, and general repairs and improvements across NIH's nearly 200 total buildings ($66 million.)

FY 2003 NIH BUDGET
$27.3 Billion – Percent of Total by Mechanism



NIH OVERVIEW (by Mechanism)

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Mechanism:				
Research Project Grants	$11,107	$12,511	$13,748	+$1,237
[# of Non-Competing]	*[23,317]*	*[25,309]*	*[26,066]*	*[+757]*
[# of New/Competing]	*[9,151]*	*[9,377]*	*[9,854]*	*[+477]*
[Total # of Grants]	*[32,468]*	*[34,686]*	*[35,920]*	*[+1,234]*
Small Business Innovation Research (SBIR)/ Small Business Technology Transfer (STTR) Grants	$418	$481	$556	+74
Research Centers	1,846	2,127	2,466	+339
Research Training	590	654	689	+34
Research & Development Contracts	1,337	1,780	2,575	+795
Intramural Research	2,013	2,296	2,644	+348
Other Research	1,673	1,902	2,163	+261
Extramural Research Facilities Construction	78	115	240	+125
Research Management and Support	720	829	971	+143
National Library of Medicine	242	282	315	+33
Office of the Director	192	239	259	+20
Buildings and Facilities	161	326	633	+307
NIEHS VA/HUD Appropriation (Superfund)	63	81	76	-5
ONDCP Drug Forfeiture Fund Transfer (NIDA)	10	10	0	-10
Type 1 Diabetes Research 1/	97	97	97	0
Total, Program Level	**$20,544**	**$23,730**	**$27,432**	**+$3,702**
Less Funds Allocated from Other Sources:				
ONDCP Drug Forfeiture Fund Transfer (NIDA)	-$10	-$10	$0	+$10
Type 1 Diabetes Research 1/	-97	-97	-97	0
Total, Budget Authority	**$20,438**	**$23,623**	**$27,335**	**+$3,712**
Labor/HHS Appropriation	**$20,375**	**$23,542**	**$27,259**	**+$3,717**
VA/HUD Appropriation	**$63**	**$81**	**$76**	**-$5**
FTE	16,525	17,471	17,696	+225

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

SAMHSA OVERVIEW

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Substance Abuse:				
Substance Abuse Block Grant	$1,665	$1,725	$1,785	+$60
Programs of Regional and National Significance:				
Treatment	256	291	358	+67
Prevention	175	198	153	-45
Subtotal, Substance Abuse	**$2,096**	**$2,214**	**$2,296**	**+$82**
Mental Health:				
Mental Health Block Grant	$420	$433	$433	$0
Path Homeless Formula Grant	37	40	47	+7
Programs of Regional and National Significance	203	230	223	-7
Children's Mental Health Services	92	97	97	0
Protection and Advocacy	30	32	32	0
Subtotal, Mental Health	**$782**	**$832**	**$832**	**$0**
Program Management	$88	$95	$80	-$15
Emergency Response & Recovery	28	10	0	-10
Total, Program Level	**$2,994**	**$3,151**	**$3,208**	**+$57**
Amount ERF (non-add)	*28*	*10*	*0*	*-10*
Amount non-ERF (non-add)	*2,966*	*3,141*	*3,208*	*+67*
Less Funds Allocated from Other Sources:				
PHSSEF	-$28	-$10	-$10	$0
Total, Discretionary BA	**$2,966**	**$3,141**	**$3,198**	**+$57**
FTE	593	607	579	-28

SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION

MISSION

The Substance Abuse and Mental Health Services Administration's (SAMHSA) 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.

SUMMARY

The FY 2003 budget request for SAMHSA is $3.2 billion, a net increase of $57 million, or two percent, over the FY 2002 enacted level. The SAMHSA budget focuses on narrowing the substance abuse treatment gap and maintaining mental health services. Funds are included in the request to cover the full government share of the accruing cost of all retirement and retiree health care benefits for Federal employees.

REDUCING THE DRUG TREATMENT GAP

In an effort to reduce the treatment gap, an increase of $127 million has been included to fund the President's Drug Treatment initiative. In total, SAMHSA's budget proposes $2.3 billion for substance abuse treatment and prevention activities. These additional funds will allow States and local communities to provide treatment services to approximately 546,000 individuals, an increase of 52,000 over FY 2002.

In an effort to reduce the treatment gap, an increase of $127 million has been included to fund the President's drug treatment initiative.

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 drug abuse treatment services. However, fewer than half actually receive services, leaving a treatment gap of 3.9 million individuals.

SAMHSA's 2000 National Household Survey estimates that 14 million Americans used an illicit drug in the past month. Further, 9.7 percent of youth aged 12-17 reported illicit drug use in the past month. Marijuana is the most commonly used illicit drug. It is used by 76 percent of current illicit drug users. In 2000, an estimated 6.5 million persons had tried ecstasy at least once in their lifetime. This represents an increase of 1.4 million individuals over the estimated 5.1 million users in 1999.

Marijuana is the most commonly used illicit drug. It is used by 76 percent of current illicit drug users.

Illicit drug use impacts more than the individual user. ONDCP estimates the cost to society (e.g. law enforcement, health care cost, and productivity loss) to be approximately $143 billion each year.

A total of $1.8 billion is requested for the Substance Abuse Prevention and Treatment (SAPT) Block Grant, an increase of $60 million over FY 2002. The SAPT Block Grant is the cornerstone of States' substance abuse programs, and provides support for over 10,500 community-based treatment and prevention organizations.

The budget also includes an increase of $67 million to support programs that provide direct substance abuse treatment services. In FY 2003, SAMHSA will begin a new $50 million program for approximately 12 States within the targeted capacity expansion authority. Funds would be allocated to States based on their commitment to

performance goals and relative need. The results of the National Household Survey would measure State performance. SAMHSA will also consider factors such as States leveraging other funds and the efficiency and effectiveness of the State's treatment system. This program would require a commitment to achieving performance goals.

Substance abuse prevention will be reduced by $45 million, and greater emphasis will be placed on providing treatment services. These prevention activities are largely research focused. The budget proposal reflects an intent to achieve efficiencies in research activities in the Department.

Over the past several years, many SAMHSA-sponsored projects have proven to be successful in providing effective treatment services. For example, a program for youth and families in St. Petersburg, Florida, reported that within six months of intake into treatment the percentage of adolescents with no past-month drug use increased from 4 percent to 34 percent. Another success story is an HIV/Substance Abuse program in Wilmington, Delaware. The goal of this program is to provide a comprehensive array of substance abuse, mental health, HIV education and medical services to drug dependent women in Wilmington. Of those women in treatment for 12 months or longer, 75 percent of clients were found to remain drug free.

MENTAL HEALTH

The budget includes $832 million for mental health activities, which maintains the FY 2002 funding level. Mental health activities will continue to work to improve service quality and expand capacity. Within this amount, $47 million has been included for the Projects for Assistance in Transition from Homelessness (PATH) program. This is a $7 million increase over FY 2002. These funds will allow SAMHSA to reach out to 163,000 homeless individuals in an effort to get them off the streets and into mental health and substance abuse treatment services as well as adequate housing.

Included in the President's request is $10 million to assist States and local organizations in developing solutions to the mental health problems that result from bioterrorism and other traumatic events.

In FY 2003, SAMHSA will support the President's New Freedom Commission on Mental Health. This commission will study and make recommendations for the mental health delivery system, including recommendations on the availability and delivery of new treatments and technologies for people with severe mental illness. The budget also reduces funding for Programs of Regional and National Significance by $7 million. This reduction reflects efficiencies to be achieved in research activities in the Department.

Program Management/Data Collection: The FY 2003 budget reflects the Administration's interest in restructuring and delayering the Federal workforce. The budget includes $80 million for program management, a decrease of $15 million over FY 2002. The budget also reflects a reduction of 28 FTE.

In FY 2003, SAMHSA will continue to engage in an extensive national data collection effort to evaluate both the prevalence of drug addictions and the effectiveness of efforts to treat or prevent these problems. A total of $107 million in FY 2003 will be directed to a wide variety of national surveys and data efforts. Within this amount, $11 million is included for the National Treatment Outcomes Monitoring System (NTOMS). This is an increase of $6 million over FY 2002. These funds will be used to continue the collection of data on an ongoing basis and provide drug treatment providers nationwide with a source of information needed to identify changes in drug facilities. The purpose of NTOMS is to continuously provide the information needed to identify change in drug abuse treatment outcomes.

In addition to NTOMS, there are three 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 NHSDA is currently the only national source of information on substance abuse problems and treatment in the general public. For the NHSDA, approximately 70,000 people were 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.

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 (2000) showed that there were approximately 600,000 drug-related emergency room visits in the U.S.

DASIS provides a comprehensive national data set on substance abuse treatment facilities, clients and treatment admissions. Currently there are more than 16,500 treatment facilities in the U.S. which serve over one million clients.

AHRQ OVERVIEW

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Research on Health Costs, Quality and Outcomes	$228	$249	$185	-$64
Patient Safety (non-add)	*50*	*55*	*60*	*+5*
Translating Research Into Practice, Consumer Assessment of Health Plans, and Healthcare Cost and Utilization Project (non-add)	*14*	*14*	*14*	*0*
Quality, Cost-Effectiveness and Intramural Research (non-add)	*164*	*180*	*112*	*-68*
Medical Expenditures Panel Surveys	41	49	53	+5
Health Coverage Data Improvement (Current Population Survey)	0	0	10	+10
Program Support	3	3	3	0
Subtotal, Program Level	**$271**	**$300**	**$251**	**-$49**
Less Transfers: PHS Evaluation Funds	$165	$297	$251	-$46
Total, Budget Authority	**$106**	**$3**	**$0**	**-$3**
FTE	275	294	294	0

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

MISSION

The mission of the Agency for Healthcare Research and Quality (AHRQ) is to support, conduct, and disseminate research that improves the outcomes and quality of health care, reduces costs, improves patient safety, and broadens access to services.

SUMMARY

The FY 2003 request for AHRQ provides a total program level of $251 million, a decrease of $49 million, or 16 percent, from FY 2002. This reduction reflects an intent to achieve efficiencies in research activities in the Department. In FY 2003, AHRQ will be fully funded through inter-agency transfers of evaluation funds. The budget will place a priority on:

- Improving patient safety and reducing the number of medical errors;
- Providing additional information for new national reports on quality and disparities in health care;
- Encouraging adoption of evidence-based clinical, system and policy practices.

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 contributes not only to improved clinical care, but also to more cost-effective care. 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. Funds are included in the request to cover the full government share of the accruing cost of all retirement and retiree health care benefits for Federal employees.

HHS will begin to streamline research through its Research Coordination Council (RCC), which will evaluate Department-wide research priorities to ensure that efficiencies are realized.

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 $185 million, $64 million less than the FY 2002 level. Within this total funding patient safety efforts will increase from $55 million to $60 million, and funding for Translating Research Into Practice, the Consumer Assessment of Health Plans, and the Healthcare Cost and Utilization Project will total $14 million, the same as in FY 2002.

Patient Safety: An increase of $5 million over FY 2002, for a total of $60 million, is dedicated to patient safety research. This major research effort will test new technologies to reduce errors through the provision of challenge grants to hospitals and health systems as well as development of a program to train patient safety experts, who will assist States and local health organizations in developing a patient safety focus.

Through the Department's Patient Safety Task Force, AHRQ, the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services are working collaboratively to develop a common Web 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. An example of this collaborative effort has been the agencies' work on a pilot project to decrease infection rates associated with dialysis in patients with End Stage Renal Disease by coordinating clinical information that health systems are required to report to the individual agencies.

Translating Research Into Practice (TRIP): To reduce the gap between the care known to be effective and the everyday care people receive, AHRQ supports TRIP grants. Areas of focus include preventive services for adolescents, improved treatment for stroke and diabetes, and pain management. Recently these activities have expanded to include an important focus on overcoming the existing racial and ethnic disparities in care. For example, a current TRIP grantee is developing and testing an evidence-based asthma case management model for low-income minority children enrolled in 29 Head Start programs.

Health Care Cost and Utilization Project: A public-private partnership to build a multi-State health care data system, the Health Care Cost and Utilization Project (HCUP) databases include inpatient databases from 26 participating States. These detailed, de-identified data facilitate research about healthcare costs, delivery and quality as they vary across the country, contributing to the National Quality Report, the National Disparities Report, and the HCUP Factbook series–an in-depth profile of inpatient care.

Consumer Assessment of Health Plans (CAHPS): AHRQ developed and continually updates the CAHPS survey, which private benefit plan managers use to provide information to their customers. CAHPS data on 280 plans are available to nearly 40 million Medicare beneficiaries, and to more than 90 million Americans, to help them select health care plans.

MEDICAL EXPENDITURE PANEL SURVEYS

The President's Budget provides $53 million, an increase of $5 million for the Medical Expenditure Panel Surveys (MEPS). MEPS is the collection of detailed, national data on the health care services Americans use, how much they cost, and who pays. The majority of the increase reflects a continuation of FY 2002 efforts to expand the MEPS sample size.

Enhancements in MEPS will lead to a better understanding of the quality of care the typical patient receives, and of disparities in the care delivered. MEPS data are critical for tracking the impact of Federal and State programs, 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 1999 reauthorization also calls for the development of a report on populations that are at high risk for disparities in care. These populations include the elderly, people in inner-city and rural areas, women, children, minorities, low-income groups, and individuals with special health care needs.

Health Coverage Data Improvement: To support State efforts, HHS is interested in improving the reliability of State-level estimates of the uninsured obtained through the Census Bureau's Current Population Survey (CPS). Of the five existing government surveys, only one, the CPS, currently produces annual estimates of the uninsured at the State level. Beginning FY 2003, $10 million each year will go toward the expansion and enhancement of information collected in the CPS. This increase will provide more comprehensive information for States and the Federal government to use in the development of plans to expand coverage of the uninsured.

CMS OVERVIEW

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Current Law:				
Medicare /1	$240,939	$251,858	$259,989	+$8,131
Medicaid	129,374	144,751	158,692	+13,941
SCHIP	3,699	3,689	4,362	+673
State Grants and Demonstrations	2	18	30	+12
Total Outlays, Current Law	**$374,014**	**$400,316**	**$423,073**	**+$22,757**
Premiums	-23,748	-25,622	-27,347	-1,725
Total Net Outlays, Current Law	**$350,266**	**$374,694**	**$395,726**	**+$21,032**
Proposed Law:				
Medicare	$0	$0	$1,680	$1,680
Medicaid/ SCHIP	0	0	58	58
State Grants and Demonstrations	0	0	0	0
User Fees	0	0	-130	-130
Total	**$0**	**$0**	**$1,608**	**+$1,608**
Total Net Outlays, Proposed Law /2	**$350,266**	**$374,694**	**$397,334**	**+$22,640**

/1 Includes benefits and administration.
/2 Total net outlays equal current law outlays minus the impact of proposed legislation and offsetting receipts.

CENTERS FOR MEDICARE & MEDICAID SERVICES

MISSION

The Centers for Medicare & Medicaid Services' mission is to assure health care security for beneficiaries.

SUMMARY

The FY 2003 budget request for the Centers for Medicare & Medicaid Services (CMS) is $397.3 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 CMS' operating costs. This budget reflects an increase of $22.6 billion over FY 2002.

The FY 2003 President's Budget includes important proposals for modernizing Medicare, a program that represents the Nation's commitment to our seniors and disabled. It dedicates $190 billion over ten years (2003-2012) to support the President's framework for improvements, including: providing prescription drug coverage for low-income beneficiaries; incentives to expand and maintain managed care options; adding new Medigap plans; taking a full view of Medicare solvency, and addressing Medicare's financial status.

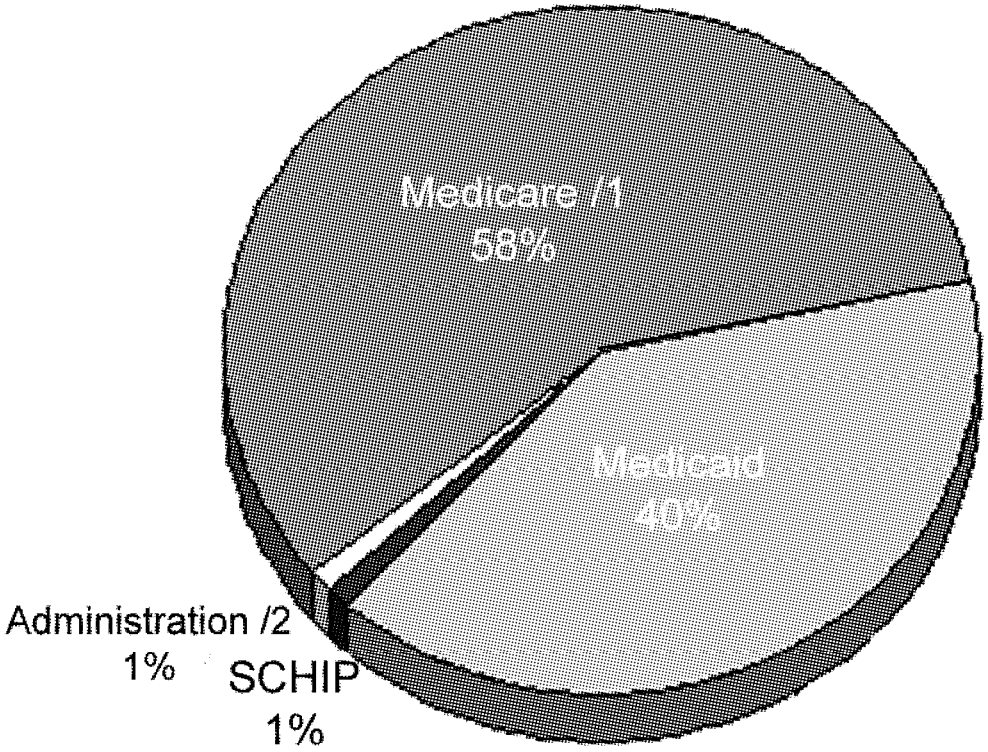
The centerpiece of our Medicare initiatives is the expansion of drug coverage to low-income seniors. Under this proposal, we take immediate steps to make prescription drugs more affordable for the neediest Medicare beneficiaries until more comprehensive changes are enacted. The budget provides $1.2 billion in FY 2003 and $77.1 billion over 10 years (FY 2003-2012) for this effort.

The President's Budget proposes new Medicaid initiatives to: strengthen the financial integrity of the Medicaid program and improve opportunities and alternatives for people with disabilities through the New Freedom Initiative. The budget includes a proposal to extend the availability of expiring SCHIP funds until FY 2006.

In addition, the President's Budget proposes a new refundable tax credit for low-income individuals and families who are neither covered by an employee plan nor enrolled in public programs, and who may have the most difficulty finding affordable health coverage. At State option, certain tax credit recipients may be able to increase their purchasing power by joining purchasing pools such as private purchasing groups, state-sponsored insurance purchasing pools, and high-risk pools. To the extent parents of children enrolled in Medicaid and SCHIP participate, the family may be able to obtain coverage from one source.

CMS FY 2003 Net Outlays

Total=$397.3 billion:



/1 Includes benefits only.
/2 Includes program management, HCFAC, QIOs, and other administrative funding.

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 2003, the program will serve nearly 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. Enrollees pay 25 percent of Part B costs (or $54 per month in 2002), with remaining costs covered by general revenue.

- Part C – The Medicare+Choice program offers beneficiaries a variety of coverage options, including a traditional HMO, a preferred provider organization (PPO), or a private fee-for-service plan. Currently, 5.6 million, or 14 percent of beneficiaries, are enrolled in a Medicare+Choice plan. These figures are lower compared to two years ago, when 6.3 million beneficiaries, or 15.8 percent of all beneficiaries, were enrolled. This drop in enrollment reflects the large number of plans, about 374, that have left the Medicare+Choice program or reduced their service areas in the last four years.

Medicare Spending Growth: Under current law, Medicare gross benefit outlays are projected to increase from $255 billion in FY 2003 to $428 billion in FY 2012. The program is expected to grow at 5.7 percent per year during this period. Part A benefit outlays are projected to grow from $146 billion in FY 2003 to $236 billion in FY 2012, at an average annual growth rate of 5.2 percent. Part B benefit outlays are expected to grow from $109 billion in FY 2003 to $193 billion in FY 2012. The Part B average annual growth rate during the projection period is 6.2 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 CMS, and the Fraud and Abuse Control Program which is administered by a number of agencies including the Administration on Aging, the Office of the Inspector General, the Office of the General Counsel, and the Department of Justice.

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. CMS also funds provider education and training activities associated with preventing fraud, waste and abuse and audits of managed care plans.

In FY 2003, HIPAA authorizes $720 million for MIP, a $20 million increase over FY 2002 and the final cap on spending as mandated by law. Within this level, CMS 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, CMS 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 initial results are expected in FY 2002.

HIPAA also created the Fraud and Abuse Control Program. This program funds many 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 $32 million in FY 2003 over FY 2002, to $241 million. In FY 2002, CMS received $2.7 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 made progress in protecting the Medicare Trust Funds. In FY 2001, the last year for which we have data, $1.4 billion was identified in savings from MIP activities, representing a 7.5:1 return on our investment. These efforts, in addition to improved provider compliance, have cut the Medicare overpayment error rate in half from FY 1996 through FY 2000, from 14 percent to 6.8 percent. We have set a goal of further reducing the error rate to 5 percent by FY 2002. Recent Medicare Trustees' 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 several years.

Peer Review Organizations: In FY 2002 Peer Review Organizations (PROs) will be renamed Quality Improvement Organizations (QIOs). 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, hospital issued notices of noncoverage, and Emergency Medical Treatment and Labor Act (EMTALA) "dumping" violations.

In 2002, the first round of PRO contracts will end and the above duties will be fulfilled by QIOs under a new round of contracts. In addition to continuing the national quality improvement projects from the last round of PRO contracts, QIOs will expand previous quality work in nursing homes, home health agencies, and physicians' offices. This work will be coupled with expanded data collection on hospital performance and an information campaign to turn data on provider performance into a useful tool for beneficiaries in making informed healthcare decisions. The next round of three year contracts commits approximately $1 billion to these efforts.

STRENGTHENING MEDICARE

This budget builds upon the President's framework for Medicare reform, dedicating funds for Medicare modernization, including a subsidized prescription drug benefit, better insurance protection, and better private options for all beneficiaries. To pave the way, the budget proposes immediate reforms including transitional prescription drug coverage for low-income beneficiaries, incentives to expand and maintain managed care options, new Medigap plans, and a full view of Medicare solvency.

The President's Principles for Medicare Reform:

- All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.
- Modernized Medicare should provide better coverage for preventive care and serious illnesses.
- Today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.
- Medicare should make available better health insurance options, like those available to all Federal employees.
- Medicare legislation should strengthen the program's long-term financial security.
- The management of the government Medicare plan should be strengthened to improve care for seniors.
- Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced.
- Medicare should encourage high-quality health care for all seniors.

Providing Access to Prescription Drugs: While drugs were not a standard part of health insurance coverage when Medicare was created, they are an integral part of modern medicine today. However, with few exceptions, Medicare does not cover outpatient prescription drugs. This budget allocates $20.7 billion over five years and $77.1 billion over ten years for States to expand drug coverage to low-income beneficiaries. This proposal, which lays the groundwork for a prescription drug benefit for all Medicare beneficiaries, will:

- Allow States to expand drug-only coverage to Medicare beneficiaries up to 100 percent of poverty at the regular Medicaid match rate.
- Allow Medicare to pay for 90 percent of the cost of expanding coverage for Medicare beneficiaries between 100 and 150 percent of poverty. States would only be responsible for the remaining 10 percent.

This budget also outlines actions that the Administration can take right now to help beneficiaries obtain the prescription drugs they need. HHS is working to implement a Medicare-endorsed prescription drug discount card, which will give beneficiaries access to discounts on their prescription drug purchases and other valuable pharmacy assistance. In addition, the Administration will develop model drug waivers, which will help States expand drug-only coverage to Medicare beneficiaries and implement cost-containment strategies for their Medicaid populations. The Secretary recently approved a similar waiver for Illinois.

Sustaining and Enhancing Medicare+Choice: The absence of prescription drug coverage is not the only serious gap in the Medicare benefit package: beneficiaries are increasingly unable to obtain coverage through Medicare+Choice plans. Although Medicare+Choice was established to offer beneficiaries a private plan option for their health coverage, the program faces significant challenges that threaten beneficiary choice. Few new types of plans (such as preferred provider organizations, or PPOs) have entered the program, and many plans are withdrawing. In fact, 374 plans have left the Medicare+Choice program or reduced their service areas in the past four years, affecting 2.2 million beneficiaries.

The most important reason that plans are withdrawing from the program is that Federal payments to Medicare+Choice plans have not kept pace with rising health care costs.

To preserve choice for Medicare beneficiaries and reconcile past discrepancies in payment rates, this budget will:

- Tie plan payments to the health care cost increases plans are actually experiencing

by raising payments for plans that have recently received only minimum updates by 6.5 percent in CY 2003.

• Give managed care plans more flexibility in designing their plans, and propose bonus payments for new types of private plans that enter Medicare+Choice.

Modernizing Medigap: Because Medicare does not protect beneficiaries against the high cost of medical care, more than 85 percent of beneficiaries in traditional Medicare obtain supplemental insurance. Some beneficiaries receive supplemental coverage through an employer or Medicaid, but more than one quarter purchase "Medigap" plans, which typically have higher premiums.

To improve the coverage available through Medigap, this budget will add two Medigap plans to the existing ten standardized plans. These plans improve upon the existing ones by:

• Offering prescription drug coverage;

• Protecting beneficiaries against catastrophic illness; and,

• Including a buy-down of the cost of Medicare deductibles and co-pays at a more affordable premium cost than the most popular Medigap plans today.

Additional Medicare Improvements: This budget includes other targeted changes to ensure efficient and appropriate Medicare payments. These additional improvements include:

• Expanding competitive bidding for durable medical equipment (DME) nationally to ensure Medicare provides quality services and supplies at much lower prices. This proposal builds on the highly successful 1999-2002 demonstration in two Florida and Texas localities that yielded $6.8 million in savings to Medicare over three years.

• Requiring insurers and entities sponsoring group health plans to periodically report those beneficiaries for whom Medicare could be a secondary payer.

• Extending existing legislation to continue addressing variations in graduate medical education payments.

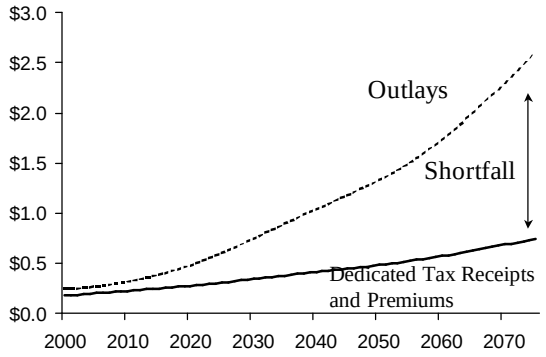
• Enhancing Federal Employees Health Benefits Program (FEHBP) options for retirees that improve their health insurance options.

• Working with Congress to smooth out adjustments in the physician update system in a budget neutral manner.

• Extending Medicare premium assistance for certain qualified individuals.

A Full View of Medicare's Financial Health: Currently, there is no comprehensive measure of Medicare's financial health that accounts for both Part A and Part B Trust Fund financing. The Medicare Trustees acknowledge this disconnect in their 2001 Trustees report by stating that, "Although this report focuses on the financial status of the Hospital Insurance (HI) Trust Fund, it is important to recognize the financial challenges facing the Medicare program as a whole and the need for integrated solutions."

MEDICARE OUTLAYS EXCEED PAYROLL TAXES AND PREMIUMS
(dollars in trillions)



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

To this end, the Administration has developed a comprehensive measure of Medicare's financial health. The new measure compares payroll tax and premium revenues to Medicare's combined program costs. As the table above shows, when you isolate Medicare premiums and payroll taxes against Medicare expenditures, there is no Medicare surplus. In fact, this measure of the program reveals a deficit.

When Medicare is examined in this more comprehensive manner, the projected SMI deficit overwhelms surplus HI revenues. This shortfall is projected to be $46 billion in FY 2003 and $553 billion over the next ten years.

Comprehensive Medicare Modernization: This budget proposes immediate steps to improve access to prescription drugs and expand Medicare's health insurance options. However, comprehensive modernization is necessary to update Medicare's benefit package to include a prescription drug benefit, protect beneficiaries against high out-of-pocket costs and improve health insurance plan options.

FY 2003 PROPOSED MEDICARE LEGISLATION

(dollars in millions)

	1-YEAR FY 2003	5-YEARS FY 03-07	10-YEARS FY 03-12
IMMEDIATE STEPS TOWARD MODERNIZATION			
Expansions:			
Providing Access to Prescription Drugs:			
Transitional Low-Income Drug Benefit	1,200	20,700	77,100
Sustaining and Enhancing Medicare+Choice (M+C):			
Increase M+C Payments to Reflect Actual Experience /1	700	3,700	3,700
Provide Bonus Payments to Encourage Plans to join M+C /2	70	440	440
Subtotal, Medicare+Choice Proposals	770	4,140	4,140
Extend Premium Assistance for Low-Income Seniors	80	80	80
Subtotal, Expansions	**2,050**	**24,920**	**81,320**
Savings:			
Modernizing Medigap:			
Establish Two New Medigap Plans with Prescription Drug Coverage	-100	-720	-1,740
Ensuring Efficient and Appropriate Medicare Payments:			
Expand Competitive Bidding for Durable Medical Equipment	-240	-1,990	-5,050
Require Insurers to Provide Medicare Secondary Payer Data	-30	-450	-1,170
Extend Existing Legislation on Graduate Medical Education Payments	0	-60	-570
Subtotal, Appropriate Payments	-270	-2,500	-6,790
Subtotal, Savings	**-370**	**-3,220**	**-8,530**
Premium Interactions /3	0	245	1,389
TOTAL, IMMEDIATE STEPS TOWARD MODERNIZATION	**1,680**	**21,945**	**74,179**
MEDICARE MODERNIZATION /3	**0**	**28,160**	**115,980**
TOTAL 2003 MEDICARE PROPOSED LAW	**1,680**	**50,105**	**190,159**

/1 M+C pricing reform sunsets with implementation of competitive reform in 2006; the outyear impact (2006 and after) of this proposal is reflected in the Medicare Modernization line.
/2 Bonus payments continue when competitive reform is implemented; the outyear impact (2006 and after) of this proposal is reflected in the Medicare Modernization line.
/3 For 2006-2010, the premium impact of the M+C proposals is reflected in the Medicare Modernization line, not the Premium Interactions line.

MEDICARE TRUST FUND OVERVIEW

(beneficiaries in millions)

	2001	2002	2003	+/-
Aged	34.3	34.5	34.7	+0.2
Disabled	5.6	5.8	6.0	+0.2
Total Beneficiaries	39.9	40.3	40.7	+0.4

MEDICARE OUTLAYS

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Current Law:				
HI Benefits	135,979	141,432	145,870	+4,438
SMI Benefits	100,514	105,289	108,907	+3,618
Subtotal, Medicare Benefits	**$236,493**	**$246,721**	**$254,777**	**+$8,056**
Administration /1	3,261	3,672	3,888	+216
HCFAC /2	796	865	915	+50
Peer Review Organizations	329	535	409	-127
Transfers to Medicaid	60	65	0	-65
Total Outlays, Current Law	**$240,939**	**$251,858**	**$259,989**	**+$8,130**
Premiums	-23,748	-25,622	-27,347	-1,725
Total Net Outlays, Current Law	**$217,191**	**$226,236**	**$232,642**	**+$6,405**
Proposed Legislation:				
Medicare Benefits	0	0	1,680	+1,680
Proposed User Fees	0	0	-130	-130
Total Medicare Proposed Legislation	**$0**	**$0**	**$1,550**	**+$1,550**
Total Net Outlays, Proposed Law	**$217,191**	**$226,236**	**$234,192**	**+$7,955**

1/ Includes Administrative payments to the SSA and other non-CMS 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 2003, it will cover approximately 40.4 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 and in many States groups that meet higher income limits. Under current law, the Federal share of Medicaid outlays is expected to be about $158.7 billion in FY 2003. This is a $13.9 billion (9.5 percent) increase over projected FY 2002 spending.

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 2003 are projected to range from 50 to 76 percent for medical assistance payments. The Federal matching rate on average is approximately 57 percent. In addition to medical assistance payments, the Medicaid appropriation funds the CDC's Vaccines for Children program and the Federal share of Medicaid State and local administration.

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 September 30, 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 10.8 percent from FY 2000 to FY 2001. Prescription drug spending, nursing home, community-based long-term care costs and payments to health plans 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, enhanced payments will contribute to higher spending growth for a number of years during the transition period.

MEDICAID LEGISLATIVE PROPOSALS

Extension of Transitional Medical Assistance: Transitional Medical Assistance (TMA) is a program created to provide health coverage for former welfare recipients after they enter the workforce. TMA allows families to remain eligible for Medicaid for up to12 months after they are no longer eligible for welfare due to earnings from work. This provision was enacted in Welfare Reform and was scheduled to sunset in September 2001. Congress extended the sunset date until September 30, 2002. The budget proposal would extend TMA for another year, costing $350 million in FY 2003.

Drug Rebates Based on Average Wholesale Price (AWP): The FY 2003 budget would create savings of $290 million in FY 2003 and $5.5 billion over five years by changing the way the Medicaid drug rebate is calculated from the difference between a manufacturer's best price and the Average Manufacturer's Price (AMP) to the difference between the best price and the Average Wholesale Price (AWP). Manufacturers would be required to report both AMP and AWP to HHS.

New Freedom Initiative: The President's New Freedom Initiative is part of a nationwide effort to remove barriers to community living for people with disabilities. As part of this initiative, HHS is proposing three new demonstrations on the mandatory side of the budget at a cost of $207 million over five years. Two of the demonstrations would provide respite services, one for caregivers of disabled adults and the other for caregivers of children with substantial disabilities. The third demonstration would make home and community based waiver services available to children residing in psychiatric residential treatment facilities. In addition, HHS is proposing to fund a $9 million discretionary demonstration designed to address shortages of community direct care workers. This would be funded through CMS' Research, Demonstrations, and Evaluation portion of the budget.

Extending the Availability of Expiring SCHIP Funds: According to current estimates, $3.2 billion in SCHIP funds will return to the Treasury at the end of FY 2002 and 2003. The budget proposal would extend the availability of these expiring funds to States until FY 2006. This would save the Medicaid program $730 million from FY 2003 to FY 2007. See the SCHIP Section of the Budget in Brief for more detail.

Child Support Enforcement Proposal: The Child Support Enforcement proposal would save the Medicaid program $40 million over five years. This proposal requires States to review child support cases every three years, thereby increasing the number of State medical child support reviews for TANF recipients. A higher rate of reviews would result in more children receiving private health insurance and consequently decrease the number of children who receive their health care through the Medicaid program.

Disability Determination Proposal: The Social Security Administration has proposed a management improvement that has a Medicaid impact. The proposal would save the Medicaid program $82 million over five years by establishing a standard for accuracy in SSI disability awards identical to the one which applies to the Social Security Disability Insurance program. This provision will help ensure that only individuals who are disabled will receive SSI disability benefits and related Medicaid coverage.

OTHER HHS INITIATIVES

HHS will undertake several administrative actions to strengthen the Medicaid program.

Medicaid Program Integrity:

Upper Payment Limits: The FY 2003 budget will strengthen the management and enforcement of Federal Medicaid payment policies.

School-Based Health Services: CMS will complete and publish school-based Medicaid claiming guides for administrative claiming, medical services claiming and transportation claiming. CMS will begin work on a regulation to ban contingency fee arrangements related to school-based health services.

Model Prescription Drug Waivers: The budget proposes a model drug waiver, which will allow states to expand drug-only coverage to low-income Medicare beneficiaries and implement private-sector benefit management techniques in their Medicaid programs.

Medicaid and SCHIP Reform: The Administration has committed to reducing some of the burdens associated with Medicaid laws and administrative guidelines. It also aims to ease the additional complexity created by interactions between SCHIP and Medicaid eligibility rules. As a first step, the Administration introduced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative in August 2001.

The HIFA demonstration initiative encourages States to develop comprehensive insurance coverage for individuals at twice the Federal poverty level and below using Medicaid and SCHIP funds. It gives States the flexibility to increase health insurance coverage through support of private group health coverage and simplifies the waiver application process. Arizona and California received the first HIFA waivers in December 2001 and January 2002, respectively.

The Administration will continue to build on the HIFA demonstration initiative in FY 2003. HHS will consult with stakeholders to develop proposals that would give States the statutory authority to provide broader coverage to low-income uninsured persons and allow States the flexibility to design their Medicaid programs without seeking waivers. States will be encouraged to use current resources to extend coverage to more of their neediest residents and reduce the number of people without health insurance coverage.

MEDICAID ENROLLMENT

(average enrollees in millions)

	2001	2002	2003
Aged 65 and Over	4.1	4.2	4.3
Blind and Disabled.....	7.2	7.5	7.7
Needy Adults	7.7	8.4	8.8
Needy Children.....	18.0	18.9	19.6
Total /1.....	**36.9**	**39.0**	**40.4**

/1 Numbers may not add due to rounding.

MEDICAID OUTLAYS

(outlays in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/- Enacted
Current Law:				
Benefits /1.....	$123,093	$136,458	$149,550	+$13,092
State Administration	6,281	8,293	9,142	+849
Total Net Outlays, Current Law ..	**$129,374**	**$144,751**	**$158,692**	**+$13,941**

/1 Includes Vaccines for Children Outlays.

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 (FPL) (who are not eligible for Medicaid) are eligible for SCHIP.

IMPLEMENTATION & ENROLLMENT

As of September 1999, SCHIP plans were approved for all 50 States, the District of Columbia, and five Territories. As of January 2002, States have received approval for 21 Medicaid expansion programs, 16 separate programs, 19 combination programs and 101 State plan amendments. Today, 25 States cover children in families with incomes at 200 percent of the FPL, and 12 States cover children above that level.

Over the course of FY 2001, 4.6 million children enrolled in SCHIP. This represents a 38 percent increase over FY 2000 enrollment.

SCHIP REPORTS AND EVALUATIONS

Congress required several SCHIP evaluations in statute. Title XXI required States to assess the operation of their SCHIP State plans and report to the Secretary by January 1 of each fiscal year. The statute also directed each State to submit to the Secretary State evaluation reports by March 31, 2000. These reports are available on the Centers for Medicare & Medicaid Services (CMS) website. As the statute also requires, the Secretary will make a report on the States' evaluations available to Congress and the public early this year.

The Balanced Budget Refinement Act of 1999 (BBRA) provided $10 million for an independent SCHIP evaluation of ten States. The first interim evaluation report is scheduled to be submitted to Congress early this year, and a final report is due to Congress early in 2004.

BBRA also directed the Secretary through the Inspector General to evaluate SCHIP every three years on State compliance with the requirement that SCHIP applicants must be first screened for Medicaid, and if eligible, be enrolled in Medicaid. The Office of Inspector General (OIG) released two reports in February 2001 — OEI-05-00-00240 and OEI-05-00-00241. BBRA directed the Comptroller General to monitor the OIG audits and submit a report to Congress following each audit.

SCHIP FINAL RULE

On January 11, 2001, a SCHIP final rule was issued in the Federal Register. After careful review of this final rule and reconsideration of the public comments received on the NPRM published on November 8, 1999, the Administration made revisions to certain provisions. The revised provisions, as well as the unchanged provisions in the January final rule, became effective on August 24, 2001. The major modified provisions:

- Provided States the option to require Social Security Numbers from applicants;

- Gave States the flexibility on how to inform applicants about Medicaid;

- Created one cumulative cost-sharing maximum as prescribed by statute;

- Gave States the option to report on primary language;

- Expanded the definition of "Secretary-approved coverage" to include any Section 1115 children's benefit package.

On June 22, 2001, a letter to State Health Officials provided a summary of the changes, which can be found on the worldwide web at http://hcfa.hhs.gov/init/sho62201.htm.

SCHIP WAIVERS

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. SCHIP waivers have been granted to New Jersey, Rhode Island, Wisconsin and Minnesota. Through a waiver, these States offer health insurance coverage to uninsured parents of children eligible under either SCHIP or Medicaid and to pregnant women. There are several States with pending SCHIP 1115 waivers currently under review.

HEALTH INSURANCE AND FLEXIBILITY AND ACCOUNTABILITY (HIFA) DEMONSTRATION INITIATIVE

The Administration has committed to reducing some of the burdens associated with Medicaid laws and administrative guidelines. It also aims to ease the additional complexity created by interactions between SCHIP and Medicaid eligibility rules. As a first step, the Administration introduced the HIFA demonstration initiative in August 2001.

The HIFA demonstration initiative encourages States to develop comprehensive insurance coverage for individuals at twice the Federal poverty level and below using SCHIP and Medicaid funds. It gives States the flexibility to increase health insurance coverage through support of private group health coverage and simplifies the waiver application process.

In December 2001, Arizona received a HIFA waiver to extend coverage to 27,000 childless adults with incomes up to 100 percent of the FPL, and an additional 21,000 uninsured parents of Medicaid and SCHIP children with incomes up to 200 percent of FPL. In January 2002, California received a HIFA waiver to provide coverage to nearly 300,000 uninsured parents and relative caretakers of children who are eligible for Medicaid or SCHIP with family incomes at or below 200 percent of the FPL.

LEGISLATIVE PROPOSALS

Extending the Availability of Expiring SCHIP Funds: The Benefits Improvement and Protection Act of 2000 (BIPA) created new rules for redistribution and availability of unspent FY 1998 and FY 1999 SCHIP allotments. BIPA established a new reallocation formula where States would be entitled to either receive redistributed funds or retain a proportion of the unused funds. Of the unspent FY 1998 allotments, about $720 million were redistributed to 12 States and all the Territories, and $1.3 billion were retained by the remaining States. These funds and the unspent FY 1999 funds will remain available through FY 2002.

According to current estimates, a total of $3.2 billion in SCHIP funds will return to the Treasury at the end of FY 2002 and 2003. The budget proposal would extend the availability of FY 1998, 1999 and 2000 funds until FY 2006.

This extension of availability will allow every State to retain some of their SCHIP funds, which will enable more States to maintain their current coverage levels as well as provide additional health coverage to more uninsured Americans under HIFA.

FUTURE REFORM

Medicaid and SCHIP Reform: As mentioned previously, in August 2001, the Administration introduced the HIFA demonstration initiative, which gives States the flexibility they need to design innovative ways to increase access to health insurance coverage for the uninsured. Building on HIFA, the Administration will work with stakeholders to develop proposals that will give States: 1) the statutory authority to provide broader coverage to low-income uninsured Americans and 2) the flexibility to design innovative programs without the use of waivers. States will be encouraged to use current resources to extend coverage to more of their neediest residents and reduce their uninsured population.

SCHIP ENROLLMENT

(average enrollees in millions)

	2001	2002	2003
Children, Total /1.....	3.0	3.9	4.3

/1 This figure does not include children covered with regular Medicaid match after SCHIP allotment is exhausted.

Note: Average enrollees are derived by adding enrollees in each month of the year and dividing by 12.

SCHIP OUTLAYS

(dollars in millions)

	2001 Actual	2002 Projected	2003 Projected	2002 +/- 2003
Current Law				
Total Outlays.....	$3,699	$3,689	$4,362	+$673

MEDICAID AND SCHIP PROPOSALS

(dollars in millions)

	FY 2003	FY 2003-2007	FY 2003-2012
MEDICAID PROPOSALS			
New Freedom Initiative	$8	$207	$741
Tax Credits for Health Insurance Coverage Buy-In	$0	$80	$180
Drug Rebates Based on AWP	($290)	($5,450)	($17,640)
Extension of Expiring SCHIP Funds	$30	($730)	($740)
Extension of Transitional Medicaid	$350	$350	$350
ACF: Child Support Enforcement	$0	($40)	($210)
SSI: Disability Determination	$0	($82)	($641)
TOTAL, MEDICAID	**$98**	**($5,665)**	**($17,960)**
SCHIP PROPOSALS			
Extension of Expiring SCHIP Funds *	($40)	$1,180	$1,250
TOTAL, SCHIP	**($40)**	**$1,180**	**$1,250**
TOTAL, MEDICAID AND SCHIP	**$58**	**($4,485)**	**($16,710)**

* The effect of the tax credits for health coverage buy-in proposal on SCHIP outlays (an increase of $10 million over five years and $20 million over ten years) is included in the extension of expiring funds proposal.

Medicare Proposals Administered Through Medicaid **			
Low-Income Drug Benefit for Medicare Beneficiaries	$1,200	$20,700	$77,100
Premium Assistance for Low-Income Medicare Beneficiaries (QI1s)	$80	$80	$80

** Medicaid receives offsetting collections from Medicare to finance these proposals.

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.

Rhode Island, Mississippi, Texas, and the District of Columbia were awarded a total of $77 million in funds for six-year demonstrations in FY 2001. These demonstrations will help people with HIV/AIDS, multiple sclerosis, and bipolar illness and/or schizophrenia.

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.

Thirty-eight States have received Infrastructure Grants so far ranging from $1.5 to $5.8 million over four years.

The demonstration program and infrastructure grants complement the President's New Freedom Initiative by encouraging states to provide supports for people with disabilities who choose to live and work in the community.

STATE GRANTS AND DEMONSTRATIONS

(outlays in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/- Enacted
Budget Authority.....	$62	$67	$72	+$5
Outlays.....	$2	$18	$30	+$12

The Ticket to Work and Work Incentives Improvement Act was signed into law on December 17, 1999. However, the demonstration grants were not appropriated until FY 2001.

PROGRAM MANAGEMENT OVERVIEW

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Medicare Operations.....	$1,357	$1,534	$1,675	+$141
Survey and Certification.....	242	254	248	-6
Federal Administration.....	528	555	587	+32
Research.....	138	117	28	-89
CMS Budget Authority Subtotal /1.	**$2,265**	**$2,461**	**$2,538**	**+$78**
CLIA/HMO and Data Spending.....	$45	$45	$45	$0
National Medicare Education Program ..	17	17	16	-1
Reimbursable Spending Subtotal....	**$62**	**$62**	**$62**	**$0**
CLIA/Sale of Data/HMO User Fees.....	-45	-45	-45	0
National Medicare Education Program...	-17	-17	-16	+1
User Fee Subtotal.....	**-$62**	**-$62**	**-$62**	**$0**
Proposed Discretionary User Fees.....	$0	$0	-$130	-$130
Proposed Budget Authority	**$2,265**	**$2,460**	**$2,408**	**-$52**
Proposed Outlays.....	$2,265	$2,460	$2,408	-$52
FTE.....	4,520	4,569	4,476	-93

/1 Numbers may not add due to rounding.

PROGRAM MANAGEMENT

PROGRAM MANAGEMENT REQUEST

Overview: CMS' FY 2003 Program Management budget request is $2.5 billion in budget authority, a $77.5 million or 3.2 percent increase over the FY 2002 appropriation. The total program level request is $2.6 billion. This level assumes $130 million in proposed user fees in addition to the $61.2 million in offsetting collections from Medicare+Choice plans for the National *Medicare&You* Education Program (NMEP), the user fees for the Clinical Laboratory Improvement Amendments program, and for the sale of data.

The two proposed user fees for paper and duplicate claims total $130.0 million. As proposed, the appropriation would be reduced by the amount of the fees upon enactment of user fee legislation. Assuming these fees are enacted, CMS' proposed law budget authority request is $2.4 billion.

In constructing this budget submission, CMS had to re-examine its priorities and make some difficult choices. For instance, CMS faces several outstanding and costly legislative requirements, but insufficient funds to fully implement all of them. This budget provides significant funding ($64.1 million) for implementing Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification provisions. In fact, the Secretary has given CMS a Department-wide leadership role in implementing HIPAA.

However, the budget does not include funding to implement appeals reform as required by Sections 521 and 522 of the Benefits Improvement and Protection Act of 2000 (BIPA). CMS will address implementing BIPA after FY 2003. Further, CMS re-prioritized funding for its routine activities in this budget, significantly reducing its research portfolio and scaling back other operational needs. CMS will require additional funding to implement any new legislation passed by Congress.

The Program Management account provides staff and resources for administering Medicare, Medicaid, the State Children's Insurance Program (SCHIP), and various HIPAA activities. With these funds, CMS: coordinates and oversees the work of contractors who process 987 million claims; answers beneficiary and provider inquiries; conducts claims hearings and reconsiderations; 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 CMS programs; and informs beneficiaries regarding their health care options in the Medicare program.

Recent budget reconciliation legislation, including HIPAA, the Balanced Budget Act of 1997 (BBA), the Balanced Budget Refinement Act (BBRA) of 1999, and BIPA, have increased CMS' responsibilities.

In addition, CMS, 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 (ITMRA), the Government Information Security Reform Act of 2000 (GISRA), the Debt Collection Improvement Act of 1996 (DCIA), and the Government Performance and Results Act of 1993 (GPRA). These seven laws have had a significant impact on CMS' operations and have required substantial new investment, without commensurate increase in administrative resources.

Medicare Operations: The Medicare Operations budget supports a broad array of activities. The budget is $1.7 billion, an

increase of $141 million, or 9.2 percent, over the FY 2002 appropriation. This includes National *Medicare&You* Education Program (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 operations 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.

In this budget, CMS has made the transition from three major spending 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 CMS 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.

In FY 2003, CMS will process 987 million claims and answer an estimated 40 million inquiries. There has been a slight increase in the unit cost to process a claim in recent years. In FY 2003, the unit cost to process a Part A claim will be $0.89, slightly higher than current FY 2002 unit cost projections of $0.88 for a Part A claim. Part B unit costs will remain the same in FY 2003 as it was in FY 2002 at $0.67.

Approximately 67 percent of the FY 2003 Medicare operations program level request will be spent on Medicare contractor on-going operations including processing claims, appeals, inquiries, and provider assistance. CMS will spend $1,128 million in FY 2003, a 4.4 percent increase over the FY 2002 level. Medicare contractors expect to see a 2 percent increase in claims over FY 2002, partially due to a large number of beneficiaries who left Medicare+Choice (M+C) and returned to the fee-for-service program.

Legislative mandates comprise 16 percent of the Medicare Operations budget and are funded at $270 million in FY 2003, a 62 percent increase over FY 2002. The bulk of this substantial increase reflects CMS assuming a key leadership role in implementing HIPAA's administrative simplification provisions and an expansion of funding for NMEP.

Systems maintenance spending will be $85.0 million in FY 2003, a $10.9 million or 15 percent increase over FY 2002. Much of this increase is to improve the systems maintenance process so that changes could be made more efficiently.

CMS Operations spending will be $102.9 million in FY 2003, an increase of $5.3 million or 5.4 percent, over FY 2002. Most of this increase covers increased data center costs and improved independent testing for standard systems changes.

Funding decreases occur in the Program Improvements and Enterprise activities within Medicare Operations. Program Improvements will be funded at $19.0 million in FY 2003, a $28.8 million or a 60.2 percent decrease below FY 2002 levels. The reduction reflects the completion of funding for the managed care system redesign. FY 2003 represents the last year of funding for this activity. Meanwhile, Enterprise activities will be funded at $59.3 million, a reduction of $0.8 million or 1.3 percent.

Finally, CMS will provide $11 million towards the Department-wide Information Technology (IT) Infrastructure Improvement Plan to support efforts to coordinate and improve IT.

Federal Administration: For FY 2003, the President's budget requests $587.2 million for CMS' Federal administrative costs. This is an increase of $31.9 million over the FY 2002 enacted level. The FY 2003 appropriation request supports a staffing level of 4,476 FTE, a reduction of 93 FTE over the FY 2002 request. In addition to the 93 FTE reduction, the 4,476 level already reflects a transfer of 63 FTE as part of the Department's efforts to eliminate duplications of effort and consolidate administrative functions (these FTE are not shown as a reduction). The additional funding of $31.9 million will allow CMS to cover pay increases, fully fund its 4,476 FTE level, and continue work on HIPAA and HIGLAS efforts.

It also supports the extensive data processing requirements for the Medicare and Medicaid programs, and necessary maintenance of CMS' many automated systems. In addition, the request includes $7 million in funding for the ongoing Enterprise System Security Initiative, and the national Medicaid information system.

Both FY 2002 and FY 2003 totals reflect CMS's costs relating to accrual of employee retirement and annuitant health benefits.

Research, Demonstrations and Evaluation: The FY 2003 budget requests $28.4 million for the Research, Demonstrations and Evaluation program, $88.8 million less than the FY 2002 enacted level. This reduction includes the elimination of $61.9 million in FY 2002 earmarked projects and other program items not requested in last year's President's budget.

The significant decrease also reflects CMS' need to invest scarce resources on activities that are central to its mission. Further, the FY 2003 request for RD&E is consistent with HHS plans to streamline research through its Research Coordination Council (RCC). This forum will evaluate Department-wide research priorities to ensure that efficiencies are realized and research funding priorities are consistent with the Administration's priorities, including assessing reform options for Medicare and Medicaid.

At the $28.4 million request level, a small number of high-priority research projects will be funded. These projects include the Medicare Current Beneficiary Survey, demonstration projects in support of the President's New Freedom Initiative, evaluating CMS programs and developing alternatives, and implementing a scaled back number of projects mandated by the BBA, BBRA, and BIPA.

Survey and Certification: Ensuring the safety of beneficiaries and the quality of care provided in health facilities are two of CMS' most critical responsibilities. CMS contracts with State agencies to inspect health facilities providing services to Medicare and Medicaid beneficiaries and to ensure compliance with Federal health, safety, and program standards.

CMS' FY 2003 budget request is $247.6 million, 2.7 percent below the FY 2002 appropriation, but 2.3 percent above the FY 2002 President's Budget request. The FY 2003 request reflects the transfer of $16.9 million in support contracts to the QIO (formerly known as PROs) account.

Included in this total is $35.7 million to continue implementing activities associated with the Nursing Home Oversight Improvement Program (NHOIP), 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. CMS will also continue to invest money to expedite investigation of resident complaints within a ten-day time frame.

Of the total request, $203.7 million will allow CMS to inspect long-term care facilities and home health agencies at their legislatively mandated frequencies. CMS also will maintain the FY 2002 recertification levels for ESRD facilities, non-accredited hospitals, hospices, rural health clinics, ambulatory surgical centers, outpatient physical therapy, and outpatient rehabilitation facilities. CMS expects to complete a total of 23,340 initial or annual inspections. In addition, CMS estimates conducting nearly 44,000 visits in response to beneficiary or family complaints.

The remaining $8.2 million will fund base support contract activities. These activities include 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 curricula development for surveyor training. The QIO program is assuming four activities totaling $16.9 million that were previously funded from the Survey and Certification account: accuracy reviews of information submitted on the Minimum Data Set for nursing homes and the Outcome and Assessment Information System (OASIS) for home health care, operation of the Quality Improvement and Evaluation System (QIES), and home health quality indicator development. These activities will not be funded from the Survey and Certification account.

National Medicare&You Education Program: In FY 2003, the NMEP will continue to fund the following activities: mailings to beneficiaries with general information about Medicare, plus specific information on plans available in their areas; 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; and community-based outreach activities such as those provided by the State Health Insurance Assistance Programs (SHIPS).

In FY 2003, CMS will also continue to provide the enhanced service levels it began in FY 2002. These include 24 hour a day, seven day a week access to customer service representatives at 1-800-MEDICARE, and the implementation of a web-based decision tool on http://www.medicare.gov.

The President's Budget provides approximately $149.6 million to finance NMEP activities. NMEP is funded through a variety of sources, including $122 million from Program Management, as well as an estimated $11.6 million in the PRO/QIO account, and $16 million in Medicare+Choice user fees.

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 174,500 laboratories registered with CMS, 22.7 percent of which are subject to routine inspection (every 2 years) under the program. Workloads for each inspection

period includes a 5 percent sample review of the 16,300 accredited laboratories, surveys of 20,800 non-accredited laboratories, State validation surveys of 800 accredited laboratories, approximately 1,600 follow-up survey and complaint investigations.

PROGRAM MANAGEMENT PRIORITIES

HIGLAS: CMS currently has no uniform financial management system to account for the tens of billions of dollars spent on Medicare benefits each year. Contractors use 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. This system and those of other Department agencies make it difficult to integrate the Department's overall accounts. Nevertheless, CMS has obtained a clean audit opinion for the past few years.

The General Accounting Office (GAO) and the Office of Inspector General (OIG) have echoed concerns regarding CMS' financial accounting systems in recent reports to the Congress. In sum, the new system will improve the detection and collection of money owed to the Medicare Trust Funds; the retention of a clean opinion on financial statements without more expensive, alternative efforts; and compliance with financial management statutory requirements.

Furthermore, one of the Secretary's top priorities is to better centralize the Department's financial accounting process through a Unified Financial Management System (UFMS). A major segment of UFMS is the Healthcare Integrated General Ledger Accounting System (HIGLAS).

HIGLAS represents a coordinated approach to improving the accounting and financial management processes used by CMS' 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 CMS' legacy accounting system and systems that currently support its procurement, travel management, grants management, and asset management. In FY 2003, CMS plans to spend $51 million for both the contractor and internal accounting systems. HIGLAS is an important component of CMS' Medicare contractor oversight. We will be requesting two-year appropriations authority for these funds.

HIGLAS will ensure that CMS can meet all of these objectives by creating a state-of-the-art uniform agency-wide accounting system. HIGLAS information will feed into the Department-wide system to allow the Department to produce automated audited reports.

Beneficiary Education: One of CMS' top priorities is making sure that beneficiaries and their caregivers are active and informed participants in their health care decisions. Last year, CMS implemented a number of new and expanded services to help beneficiaries better understand their health care options and where they can obtain information about them. CMS plans to continue these enhanced and expanded services in FY 2003:

- *Expanded call center services.* Beginning in October 2001, customer service representatives at 1-800-MEDICARE were available 24 hours a day, seven days a week.

- *Development of a web-based decision tool.* This tool, which became available in October 2001, enhances the databases currently available on http://www.medicare.gov by allowing beneficiaries to narrow down the

health plan choices available in their zip codes based on the features that are most important to them.

• *Beneficiary education campaign.* CMS launched a $30 million media campaign to help beneficiaries make informed decisions about their health plan options. The campaign, which coincided with the 2002 open enrollment period, encouraged beneficiaries to call 1-800-MEDICARE and visit http://www.medicare.gov with their Medicare questions.

Preliminary data indicate that the 1-800-MEDICARE call centers received 2.1 million calls during the open enrollment period, a 50 percent increase over the 2001 open enrollment period. CMS credits the media campaign with this increase in call volume. One particular achievement is the increase in Spanish-language calls, which have increased 80 percent over the 2001 open enrollment period.

CMS will continue to ensure that the toll-free line is able to accommodate increased call volume in FY 2003.

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

CMS has surveyed the systems and databases that support the Medicare claims processing function and has developed a plan to modernize a number of mission critical systems. These actions make it possible 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 a major priority. These systems efforts ensure that information technology (IT) deployments are standardized throughout the Department, when appropriate, and allow easier data access across agencies.

The Nursing Home Oversight Improvement Program: The President's Budget for CMS commits $86 million in mandatory and discretionary funds to the Nursing Home Oversight Improvement Program (NHOIP) in FY 2003, an increase of 17.8 percent over CMS' FY 2002 amount. CMS is committed to working with residents and their families, advocacy groups, providers, States, and Congress to ensure that residents receive the quality care and protection they deserve.

CMS has made significant strides in the areas targeted by the NHOIP. In conjunction with States, CMS 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. CMS also conducts more frequent inspections of nursing homes with repeated serious violations.

HIPAA Implementation: The administrative simplification provisions of HIPAA are projected to yield nearly $30 billion in health sector savings over ten years. The Department is committed to realizing these efficiencies and completing full implementation of the administrative simplification standards. CMS has been given a lead role with HHS to achieve this objective.

The FY 2003 budget includes $64.1 million for HIPAA administrative simplification. First, $9.6 million of this total

will ensure CMS, as a health plan, is compliant with the Transaction Rule Standards by the new October 2003 deadline. Second, $10 million will be used to conduct testing with Medicare providers to ensure they submit HIPAA-compliant claims. Third, $10 million will be used to conduct outreach and education efforts with providers, States, and other CMS partners. Finally, $34.5 million will be used to complete development and start operation of a system to assign identifiers to health plans and providers.

Management Reform: One of the top priorities of this Administration is strengthening management and improving performance. Towards this end, CMS is fully participating in the Department's efforts to implement the President's Management Agenda, specifically:

- Working with the Department to consolidate Legislative Affairs and Public Affairs offices into two Departmental offices.

- Participating in the Unified Financial Management System, of which HIGLAS is an integral component.

- Developing its strategic human resources (HR) plan. This plan includes an automated HR system which is expected to be functioning by the end of FY 2002, with the completion of final analysis and reports by FY 2003.

LEGISLATION SUPPORTING THE DISCRETIONARY BUDGET

The FY 2003 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.

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 2.3 percent of Part A claims and 17 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 ($70 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 987 million claims over the course of a year ($60 million).

ACF OVERVIEW: DISCRETIONARY SPENDING

(dollars in millions)

	2001 Enacted	2002 Enacted	2003 Request	Request +/-Enacted
Strengthening Families:				
Compassion Capital Fund	$0	$30	$100	+$70
Mentoring Children of Prisoners	0	0	25	+25
Promoting Responsible Fatherhood	0	0	20	+20
Maternity Group Homes	0	0	10	+10
Center for Faith Based and Community Initiatives	0	2	2	0
Head Start 1/	$6,200	$6,537	$6,667	+$130
Promoting Safe and Stable Families (PSSF):				
Discretionary	$0	$70	$200	+$130
Mandatory (non-add)	*305*	*305*	*305*	*0*
Subtotal, PSSF Program Level (non-add)	$305	*$375*	*$505*	*+$130*
Independent Living:				
Discretionary	$0	$0	$60	+$60
Mandatory (non-add)	*140*	*140*	*140*	*0*
Subtotal, Independent Living Program Level (non-add)	*$140*	*$140*	*$200*	*+$60*
Child Care & Development Block Grant (CCDBG):				
Child Care & Development Block Grant	$1,990	$2,090	$2,090	$0
Research and Evaluation Fund	10	10	10	0
Subtotal, Child Care	$2,000	$2,100	$2,100	$0
Community Services:				
Community Services Block Grant	$600	$650	$570	-$80
Individual Development Accounts	25	25	25	0
Community Services Discretionary Programs	57	63	45	-18
Subtotal, Community Services	$682	$738	$640	-$98
LIHEAP:				
Regular Appropriation	$1,400	$1,700	$1,400	-$300
Emergency Contingency Fund	300	300	300	0
Supplemental Appropriation	300	0	0	0
Subtotal, LIHEAP	$2,000	$2,000	$1,700	-$300
Refugees:				
Refugee and Entrant Assistance	$447	$461	$453	-$8
Victims of Torture (non-add)	*10*	*10*	*10*	*0*
Subtotal, Refugees	$447	$461	$453	-$8
Native Americans	46	46	45	-1
Developmental Disabilities	133	140	140	0
Child Abuse/Welfare	425	421	421	0
Federal Administration	185	192	192	0
Social Services Research & Demonstrations	38	31	21	-10
Mandatory (non-add)	*0*	*0*	*15*	*+15*
Discretionary (non-add)	*38*	*31*	*6*	*-25*
Early Learning Fund	20	25	0	-25
Runaway and Homeless Youth	69	88	88	0
Adoption Incentives/Awareness	53	56	56	0
Violence Against Women	134	142	142	0
Emergency Relief Fund	24	0	0	0
Total, ACF Discretionary Program Level	**$12,456**	**$13,079**	**$13,082**	**+$3**
Amount ERF (non-add)	*24*	*0*	*0*	*0*
Amount non-ERF (non-add)	*12,432*	*13,079*	*13,082*	*+3*
Less Funds Allocated from Other Sources:				
Emergency Relief Fund	-$24	$0	$0	$0
Social Services R&D: Mandatory	0	0	-15	-15
1% / 2% Fed. Admin. Funds (pre-appropriated)	-10	-10	-10	0
Total, ACF Discretionary B. A.	**$12,422**	**$13,069**	**$13,057**	**-$12**
FTE	1,420	1,537	1,492	-45

/1 FY 2001, FY 2002 and FY 2003 funding levels included $1.4 billion advanced appropriation for subsequent year.

ADMINISTRATION FOR CHILDREN AND FAMILIES

MISSION

The Administration for Children and Families (ACF) provides national leadership through programs that assist low-income, disadvantaged families and individuals to lead economically and socially productive lives, for children to develop into healthy adults, and for communities to become more prosperous and supportive of their members.

SUMMARY

The FY 2003 budget request for ACF totals $47 billion, a net increase of $2.4 billion, or 5.3 percent, over FY 2002. Of these funds, $13.1 billion is the discretionary program level and $33.9 billion is the entitlement budget authority. Funds are included in the request to cover the full government share of the accruing cost of all retirement and retiree health care benefits for Federal employees.

STRENGTHENING FAMILIES/SUPPORTING COMMUNITIES

The President's Budget focuses attention on four competitive grant programs, targeted at faith- and community-based organizations that can deliver innovative services at the grassroots level. 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.

Compassion Capital Fund: The President's Budget includes an increase of $70 million, for a total of $100 million for the Compassion Capital Fund. This program, which was initiated in FY 2002, supports faith- and community-based efforts to deliver services by providing grants to finance the start-up costs of charitable organizations.

Mentoring Children of Prisoners: As a group, the two million children with parents in prison have more behavioral, health, and educational problems than the population at large. Mentoring by caring adults can improve the outlook for these children. The President's Budget includes $25 million to fund an estimated 10 grants to public and private entities to enable them to establish or expand programs providing mentoring for children of incarcerated parents, an extremely vulnerable group. These one-on-one relationships will meet a part of the child's need for involvement with a caring and supportive adult who provides a positive role model. Funds are available to community-based organizations, and State and local governments.

> ***"The paramount goals is compassionate results, and private and charitable groups, including religious ones should have the fullest opportunity permitted by law to compete on a level playing field, so long as they achieve valid public purposes, like curbing crime, conquering addiction, strengthening families and overcoming poverty."***
>
> ***George W. Bush***

Promoting Responsible Fatherhood and Healthy Marriages: Over 25 million children live in homes without fathers. To assist non-custodial fathers to become more involved in the lives of these children, the budget provides $20 million in competitive grants to faith- and community-based organizations to encourage and help fathers to support their families and avoid welfare, improve fathers' ability to manage family business affairs, and encourage and support healthy marriages and married fatherhood.

Maternity Group Homes: Too often young pregnant mothers and their children

who lack safe and stable environments are vulnerable to abuse and neglect and often end up on welfare, in foster care, in homeless shelters, or living on the street.

The President's Budget provides $10 million for the Maternity Group Homes program to support adult-supervised community-based group homes for mothers who cannot live safely with their own families. Approximately 80 grantees will provide a range of coordinated services such as childcare, education, job training, counseling and advice on parenting and life skills.

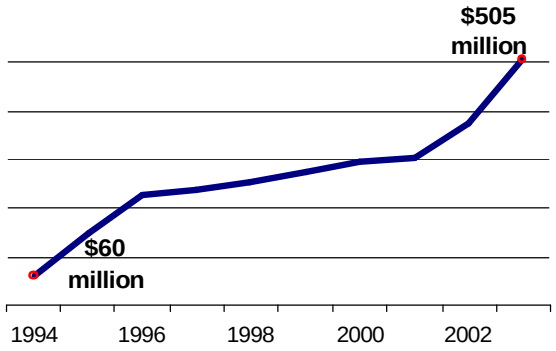
Center for Faith-Based and Community Initiatives (CFBCI): In March, 2001, Secretary Thompson established the CFBCI. During the past year, CFBCI conducted the first Department-wide audit of grant programs to identify existing barriers to the participation of faith-based and other community organizations. CFBCI is working across the Department to eliminate barriers in regulation, rules, internal guidance, policies and procedures; to propose the development of innovative pilot and demonstration programs; and to promote and ensure compliance with existing Charitable Choice legislation. The Center was an integral part of SAMHSA's National Mental Health Summit in New York City (Nov. 2001) highlighting the vital role of faith-based organizations in times of crisis. The CFBCI is involved in the Secretary's priority issues: homelessness, organ donation, New Freedom Initiative, grant funding, mental health, and prevention. Outreach activities include numerous workshops and presentations to HHS program areas, other government agencies, special interest groups and faith and community groups. The budget includes $1.6 million to support the work of the Center.

SUPPORTING HEALTHY FAMILIES AND CHILDREN

Working in concert with the President's Strengthening Families programs, ACF funds a core set of activities that promote healthy children and families.

Promoting Safe and Stable Families/Independent Living: To strengthen States' ability to promote child safety, permanence, and well-being, the budget increases funding by $130 million for the Promoting Safe and Stable Families program for a total of $505 million in FY 2003. These additional resources will help States to increase preventive efforts to help families in crisis, keep children with their biological families if safe and appropriate, return children to their parents if possible, or place children with adoptive families.

PROMOTING SAFE AND STABLE FAMILIES FUNDING, FY 1994 - FY 2003



The budget also includes an increase of $60 million, for a total of $200 million, for the Independent Living Program to help older foster youth transition to independence after they leave foster care.

Approximately 16,000 young people leave foster care each year when they reach age 18 without an adoptive family or other guardian. Research indicates that these young adults experience alarming rates of homelessness, early pregnancy, mental illness, unemployment, and drug abuse in the first years after they leave the foster care system. This increase provides funding for a voucher program to help cover the costs of college tuition or vocational training to help former foster youth develop the skills to lead independent and productive lives.

Child Welfare/Abuse Programs: In FY 2003, the President's Budget includes $421 million, maintaining the FY 2002 level,

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.

These funds combined with the funding for Promoting 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, children will be moved to adoption more quickly so that they become part of a safe and stable environment as quickly as possible. In addition, if appropriate and safe, other services can either prevent a child's removal from his or her family or support timely family reunification in cases where temporary removal is necessary.

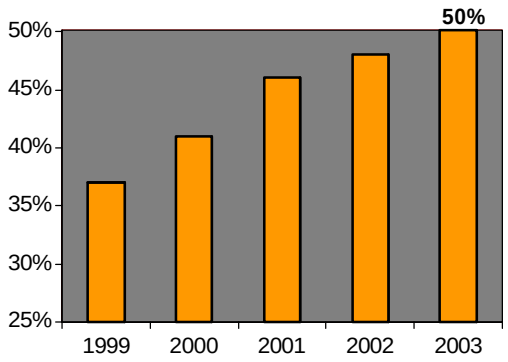
Adoption Incentives/Awareness: The budget includes a total of $56 million for efforts that support and encourage adoptions. Funds are available to States to enhance their overall adoption program as well as competitive grants to train health care professionals and continue a national media campaign, informing the public about the adoption of children with special needs.

HEAD START

The President's Budget request includes $6.7 billion for Head Start, an increase of $130 million over FY 2002. In FY 2003, almost 915,000 children will receive Head Start services including 62,000 children in Early Head Start. The funding increase will maintain current enrollment levels, strengthen training and technical assistance, and support competitive salaries for Head Start teachers.

In FY 2003, the Department will continue to focus on early literacy through investments in teacher quality and credentialing and, specialized efforts such as Head Start Centers of Excellence on Literacy and the Head Start Family Literacy Project. In 2003, Head Start will meet its statutory goal, assuring that 50 percent of all Head Start educators have a college degree.

PERCENT OF HEAD START EDUCATORS WITH COLLEGE DEGREES



The Head Start program has a long tradition of delivering comprehensive and high quality services designed to foster healthy development in low-income children. In addition, the entire range of Head Start services is responsive and appropriate to each child's and family's developmental, ethnic, cultural, and linguistic heritage and experience.

CHILD CARE

The Child Care and Development Block (CCDBG) grant program provides funds to States, territories, and tribes to assist low-income families, including families receiving temporary public assistance, and those transitioning from public assistance in obtaining child care so they can work, attend training, or education opportunities.

In FY 2003, child care funding will provide child care assistance to an estimated 2.2 million children with a total budget of $4.8 billion including $2.1 billion in discretionary funds and $2.7 billion in mandatory funds.

Subsidized child care services are available to eligible families through certificates or contracts with providers. Parents may select any legally operating child care provider. Child care providers serving children must meet basic health and safety requirements set by States and tribes. These requirements must address prevention and control of infectious

diseases, including immunizations; building and physical premises safety; and minimum health and safety training.

COMMUNITY SERVICES PROGRAMS

The Community Services Programs in ACF fund a range of community services activities providing housing and employment assistance, education and training services, nutrition, energy, health and substance abuse assistance as well as economic development opportunities.

The budget proposes a total of $640 million, a reduction of $98 million from FY 2002. The budget instead, targets funds to Presidential Initiatives and ongoing programs which perform similar purposes at the community-based level.

LOW INCOME HEATING AND ENERGY ASSISTANCE PROGRAM (LIHEAP)

The FY 2003 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 contingency funds are 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.

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

SPECIAL POPULATIONS

In FY 2003, the budget includes a total of $638 million in support of programs which serve a variety of special populations. These programs provide cash and medical assistance, and social services to refugees, financial support to Native Americans for social and economic development, and for efforts to fully integrate individuals with disabilities into our communities.

Refugee and Entrant Assistance: The budget requests $453 million in FY 2003, a reduction of $8 million, for refugees, asylees, and victims of torture and trafficking. The FY 2003 request maintains eight months of cash and medical assistance and access to social service programs to an estimated 75,000 refugees, 24,000 asylees, 20,000 Cubans/Haitians, and 1,000 victims of trafficking.

Of the funds requested, ACF will allocate $227 million to Transitional and Medical Services, $151 million to Social Services, $50 million to Targeted Assistance, and $5 million to Preventative Health. The budget also includes $10 million to support domestic treatment activities authorized by the Torture Victims Relief Act.

In FY 2003, $10 million will support efforts to identify and assist those who are found to be victims of trafficking.

Native American Programs: The budget includes a request of $45 million, a reduction of $1 million, for the programs of the Administration for Native Americans. Through direct grants, contracts, and interagency agreements, Native American programs provide financial assistance for social and economic development and governance, training and technical assistance, and research, demonstration and evaluation. The programs foster a balanced developmental approach at the community level through three major goals: self-governance, economic development, and social development. The budget does not continue projects begun in the FY 2002 Congressional appropriation.

Developmental Disabilities: There are nearly 4 million Americans with developmental disabilities. Developmental disabilities are severe, chronic disabilities attributable to mental and/or physical impairment, which manifest before age 22 and are likely to continue indefinitely.

In FY 2003, the budget request includes $140 million, the same level as FY 2002 for programs that support partnerships with State governments, local communities, and the private sector to assist people with developmental disabilities to reach maximum potential through increased independence, productivity, and community integration.

OTHER ACF

The Federal Administration request is $192 million in FY 2003. This level will fund an estimated 1,492 FTE in FY 2003. Management and administrative reforms will provide savings of $5.8 million. These reforms will include workforce restructuring and consolidation.

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 2003 budget includes a total of $21 million in discretionary and mandatory funding for research activities.

In addition, funds are not included to continue the Early Learning Fund, which was funded in FY 2002 at $25 million. Instead the budget supports similar activities, promoting early literacy in the Department of Education and the Head Start program.

Programs funding domestic violence prevention and support for runaway and homeless youth are maintained at FY 2002 levels.

ENTITLEMENT PROGRAM SUMMARY

The Department's FY 2003 ACF budget includes $33.9 billion in budget authority for entitlement programs. This is a 7.6 percent increase over the FY 2002 level. The ACF entitlement programs serve some of the nation's most vulnerable populations through programs such as TANF, Child Support, the Child Care Entitlement, and Adoption Assistance. This year's request also includes legislative proposals for the reauthorization of TANF and the Child Care Entitlement and modifications in the Child Support Enforcement program.

TEMPORARY ASSISTANCE TO NEEDY FAMILIES

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 dramatically changed the nation's approach to income support of low-income families. PRWORA replaced individual entitlements to welfare with time-limited assistance accompanied by work requirements through the new Temporary Assistance for Needy Families (TANF) program. PRWORA also created a new partnership between States and the Federal government, giving States considerable flexibility to design their own TANF programs.

Welfare reform is widely regarded as a success. According to State reports, work effort among current welfare recipients in FY 2000 was three times its 1996 levels. According to the most recent data available from HHS studies, 80 percent of former welfare recipients worked at some point during the year. Former recipients generally earn between $6.50-9.00 per hour and their earnings rise, on average, over the course of their first year off of welfare.

The TANF block grant, a capped annual entitlement of approximately $16.7 billion, provides funds to States, Territories and eligible Tribes to design creative programs to help families transition from welfare to self-sufficiency. A bonus to reward high performing States is authorized through FY 2003. Two elements of funding for States, supplemental grants and the contingency fund, expired at the end of FY 2001.

States have tremendous flexibility in determining how to use their TANF dollars. States now spend less on cash assistance than during initial years of TANF implementation and more on helping families achieve

self-sufficiency. States may transfer up to a combined 30 percent of their TANF funding to either the Child Care and Development Block Grant or the Social Services Block Grant (SSBG). Starting in FY 2003, transfers to SSBG will be limited to 4.25 percent.

TANF Legislative Proposals

The FY 2003 President's Budget proposes to build on the considerable successes of welfare reform and reauthorize Temporary Assistance for Needy Families. The proposal includes five years of funding for Family Assistance Grants to States and Territories at current levels; supplemental population grants at the FY 2001 level of $319 million as well as renewal of the $2 billion Contingency Fund with modified MOE and reconciliation requirements to make it more accessible for States.

The proposal will include changes to work provisions to improve the ability of the program to promote work and self-sufficiency. Finally, the proposal replaces the bonus to reduce out-of-wedlock births with a new initiative to fund research, demonstrations, and technical assistance efforts, primarily directed at building strong families, reducing out-of-wedlock pregnancies, and promoting healthy marriages.

Child Care Entitlement to States

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 amended the Child Care and Development Block Grant Act (CCDBG). The current Child Care and Development Fund consists of CCDBG, which combined four child care programs, and the child care entitlement. The Child Care Entitlement is composed of mandatory and matching funds. Two percent of the mandatory entitlement funds are reserved for Indian tribes and tribal organizations. The Child Care Entitlement is closely tied to the TANF program. States are mandated to spend at least 70 percent of the Child Care Entitlement on families receiving TANF, transitioning from TANF, or at-risk of becoming eligible for TANF. States must also spend a minimum of four percent of the all child care funds - mandatory, matching, and discretionary - 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 2003, HHS is requesting the reauthorization of the Child Care Entitlement at $2.7 billion. This is equal to the FY 2002 funding level. States are allowed maximum flexibility in developing child care programs. These funds, combined with the requested $2.1 billion in discretionary child care funding, will continue to provide valuable support for working families and help move families from welfare to work.

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. Child support services are available for all families, regardless of whether or not a parent receives welfare. Child support collections play an important role for families transitioning from welfare to self-sufficiency, particularly in light of time-limits on receipt of cash assistance.

The CSE program continues to make impressive gains. Child support collections hit a record $18.9 billion in FY 2001. In FY 2000, the program set a new record amount of $1.6 billion collected in overdue child support from Federal income tax refunds. Last year, the National Directory of New Hires (NDNH) helped locate more than three million non-custodial parents. In addition, paternity was established for almost 1.6 million children in FY 2000.

The Federal government shares in the financing of this program by providing a 66 percent match rate for general State administrative costs and an enhanced match rate for paternity testing. In addition, States receive incentive payments based on their performance on five key measures: paternity establishment, support order establishment, collections on current support, collections on past-due support, and cost effectiveness. 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. In FY 2003, the Federal government will spend an estimated $3.9 billion for these costs.

The CSE program assists families in obtaining the support they are owed from non-custodial parents. Families in which a custodial parent has never received cash assistance receive all child support collected on their behalf. 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.

CHILD SUPPORT LEGISLATIVE PROPOSALS

The President's Budget contains a number of child support initiatives, including proposals that give States incentives to pass through additional child support to families currently on welfare and to simplify distribution rules to the benefit of families who formerly received cash assistance. Beginning in FY 2005, the Federal government will share in the costs of State efforts to expand policies for passing through and disregarding child support for TANF families.

In addition, the President's Budget proposes to do the following: Require States to review and adjust child support orders for families receiving TANF at least every three years beginning in FY 2004; reduce the threshold for denying passports to non-custodial parents owing overdue child support from $5000 to $2500; and give States the ability to collect past-due child support by withholding a limited amount of OASDI payments from beneficiaries in appropriate cases. Finally, the 2003 President's Budget requires States to charge a $25 annual fee to families who receive child support collections through the IV-D program and who have never received assistance.

CHILDREN'S RESEARCH AND TECHNICAL ASSISTANCE (CRTA)

The FY 2003 President's Budget requests $52.7 million in funds for welfare research and technical assistance for states. Of this amount, $37.7 million is devoted to two child support set-asides: one for training and technical assistance ($12.6 million) and the other to assist in operating the Federal Parent Locator Service (FPLS) ($25.1 million). 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.

The President's Budget proposes reauthorization of $15 million annually in preappropriated mandatory funds for welfare research through 2007. These funds will support research on the effects of welfare reform and on ways to improve the welfare system.

FOSTER CARE, ADOPTION ASSISTANCE, AND INDEPENDENT LIVING PROGRAM

The FY 2003 budget request for the Foster Care, Adoption Assistance, and the Independent Living programs is $6.6 billion. These programs provide essential services to vulnerable children by supporting safe living environments and preparing foster children for independence.

Of the total request, $4.9 billion will support the Foster Care program. This is a $171 million decrease from last year's request. The funds will be used for maintenance payments and administrative costs for approx-

imately 249,400 children each month. In addition, States may use the funds for training and for the operation and development of the Statewide Automated Child Welfare Information Systems (SACWIS), a computer-based data and information collection system.

The budget includes $1.6 billion for the Adoption Assistance program, which supports families that adopt special needs children. This is an increase of $159 million over the FY 2002 request. These funds will be used to provide maintenance payments to adoptive families, administrative payments for the costs associated with placing a child in an adoptive home, and training professionals and adoptive parents. The proposed level of funding will support approximately 327,900 children each month.

The budget also contains $200 million for the Independent Living Program (ILP). This includes $140 million in mandatory funds, the same as the FY 2002 request, for a variety of services to ease the transition from foster care for youth who will likely remain in foster care until they turn 18 and former foster children between the ages of 18 and 21. The total request also includes $60 million in new discretionary funds for an education and training voucher program for the approximately 16,000 youths who age out of foster care each year.

PROMOTING SAFE AND STABLE FAMILIES

The Promoting Safe and Stable Families (PSSF) program is a capped entitlement program designed to assist States to coordinate services related to child abuse prevention and family preservation and to provide community-based family support, time-limited family reunification, and adoption promotion and support services. States generally must spend at least 20 percent of their funds on each of the above four categories. The Adoption and Safe Family Act of 1997 (AFSA) established that a child's health and safety must be of paramount concern in any efforts made by a State to preserve or reunify a child's family. The FY 2003 request for PSSF is $505 million, which includes $305 million in mandatory funds and $200 million in discretionary. This is a $130 million increase over the total FY 2002 request. Tribes are allotted one percent of the mandatory funds and two percent of the discretionary funds. The FY 2003 budget also includes $25 million in discretionary funds for competitive grants to community-based groups, charitable organizations, and State and local governments to expand or establish programs that provide mentors to children of prisoners.

SOCIAL SERVICES BLOCK GRANT

The Social Services Block Grant (SSBG), a capped entitlement, provides funds to assist States in delivering social services and allows States substantial discretion in allocating funds in order to best suit their specific needs. The FY 2003 request for SSBG is $1.7 billion. This is the same level as FY 2002. Programs or services that are frequently supported by SSBG funds include child care, child welfare (foster care, adoption and protective services), home-based services, employment services, case management, adult protective services, prevention and intervention programs, and special services for the disabled.

ACF OVERVIEW ENTITLEMENT SPENDING

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/- Enacted
TANF/1	$16,689	$16,689	$19,009	+$2,320
Child Care Entitlement	2,571	2,717	2,717	0
Child Support Enforcement & Family Support (net BA)	3,092	3,448	3,517	+$69
Foster Care/Adoption Assistance	6,401	6,622	6,609	-$13
Children's Research & Technical Assist (net BA) /2	39	37	53	+$16
Promoting Safe and Stable Families	305	305	305	0
Social Service Block Grant	1,725	1,700	1,700	0
Total, Budget Authority	**$30,822**	**$31,518**	**$33,910**	**$2,392**

/1 FY 2001 figure does not include supplemental grants, the Contingency Fund, or the High Performance Bon since budget authority for these funding sources was made available in prior years. The FY 2003 figure inclu $2 billion for the Contingency Fund and $319.5 million for supplemental grants.
/2 In both FY 2001 and FY 2002, Congress rescinded $21 million in budget authority from this account. The FY 2003 request includes $15 million for welfare research.

ACF PROPOSED ENTITLEMENT LEGISLATION

(dollars in millions)

	FY 2003	FY 03-07	FY 03-12
TANF (BA in millions)			
State and Territory Family Assistance Grants	$16,567	$82,835	$165,670
Matching Grants to Territories	15	75	150
Supplemental Grants	319	1,595	3,190
High Performance Bonus	[400]	1,000	2,000
Research, Demonstration, and Technical Assistance Activities	100	500	1,000
Tribal Work Program	8	40	80
Contingency Fund	2,000	2,000	4,000
TANF Subtotal	$19,009	$88,045	$176,090
Child Support Enforcement /1			
Optional Pass Through and Disregard above Current Effort	0	79	231
Optional Simplified Distribution	0	390	1,237
Review and Adjustment of Child Support Orders	0	-40	-160
Reduce Threshold for Passport Denial to $2500	-1	-10	-20
$25 Annual Fee for Never-TANF Cases with Collections	-59	-338	-814
OASDI Benefit Match	-6	-38	-78
Child Support Enforcement Subtotal	-66	43	396

/1 All of the child support proposals, with the exception of the user fee and a portion of the impact of mandatory review and adjustment, increase or decrease gross budget authority across the Federal government due to offsetting collections received by the Treasury. The combination of user fee and mandatory review and adjustment proposals save $242 million over 5 years and $598 million over 10 years in CSE administrative costs.

CHILD SUPPORT ENFORCEMENT OVERVIEW: COLLECTIONS & COSTS

(dollars in millions)

	2001 Actual	2002 Estimate	2003 Estimate	2003 +/-2002
Total Collections Distributed:				
Non-TANF Families	$16,250	$17,750	$19,296	+$1,546
TANF/Foster Care families	329	371	373	+2
TANF program	2,192	2,224	2,270	+46
Foster Care program	51	55	60	+5
Total	**$18,822**	**$20,400**	**$21,999**	**+$1,599**
Distributed to TANF/Foster Care Programs				
Net Federal Share	$811	$796	$823	+$27
State Share (includes incentives and hold harmless payments)	1,432	1,483	1,507	+24
Total	**$2,243**	**$2,279**	**$2,330**	**+$51**
Administrative Costs :				
Federal Share	$2,945	$3,452	$3,483	+$31
State Share	1,737	1,888	2,011	+123
Costs	**$4,682**	**$5,340**	**$5,494**	**+$154**
Program Costs (Distributed Collections minus Costs):				
Federal Costs	$2,134	$2,656	$2,660	+$4
State Costs	305	405	504	+99
Net Costs to Taxpayer	**$2,439**	**$3,061**	**$3,164**	**$103**

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

AOA OVERVIEW

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Nutrition Services:				
Home-Delivered Meals	$195	$223	$225	+$2
Congregate Meals	484	492	492	0
Grants for Native Americans	25	28	28	0
Subtotal, Nutrition Programs /1	**$704**	**$743**	**$745**	**+$2**
National Family Caregiver Support	$125	$141	$141	$0
Supportive Services and Centers	325	357	357	0
Training, Research & Discretionary Projects	36	38	28	-10
Aging Network Support Activities	2	2	2	0
Preventive Health Services	21	21	21	0
Protection of Vulnerable Older Americans	14	18	18	0
Alzheimer's Disease	9	11	11	0
Program Administration	18	19	19	0
PHSS Emergency Funds	1	0	0	0
Senior Medicare Patrols (HCFAC)	2	2	3	+1
Total, Program Level	**$1,257**	**$1,352**	**$1,345**	**-$7**
Amount ERF (non-add)	*1*	*0*	*0*	*0*
Amount non-ERF (non-add)	*1,256*	*1,352*	*1,345*	*-7*
Less Funds Allocated From Other Sources:				
Senior Medicare Patrols (HCFAC)	-$2	-$2	-$3	-$1
PHSS Emergency Funds	-1	0	0	0
Total, Budget Authority	**$1,254**	**$1,350**	**$1,342**	**-$8**
FTE	120	124	120	-4

/1 Includes $150 million in nutrition funding for the elderly appropriated to the Department of Agriculture in FY 2001 and FY 2002.

ADMINISTRATION ON AGING

MISSION

The Administration on Aging's (AoA's) mission is to serve as the Federal focal point for older persons, providing funding for essential home and community-based programs across the country to help America's rapidly growing older population remain healthy, actively engaged and able to live independently in their own homes and communities.

SUMMARY, SERVING THE NATION'S ELDERLY AND THEIR CAREGIVERS

The FY 2003 budget request for the AoA is $1.3 billion. This level maintains funding for AoA core services consistent with the FY 2002 appropriation. Funds are also included in the request to cover the full government share of the accruing cost of all retirement and retiree health care benefits for Federal employees.

Under the Older Americans Act, funds are distributed primarily by formula. Services are provided through a nationwide network of State, tribal and area agencies on aging to over 29,000 local service providers.

NUTRITION PROGRAMS

The budget requests a total of $745 million for the Nutrition Programs, an increase of $2 million over FY 2002. This increase will be used to provide home-delivered meals to the most frail and at-risk elderly. Funds will provide an estimated 302 million meals in FY 2003.

This year is the 30th anniversary of the Nutrition Programs which began as a $2 million three-year demonstration and research project. In 1978, Congress expanded the scope of the programs, recognizing the importance of home-delivered meals, and authorized a separate Home-Delivered Nutrition Services Program. Total funding for the Congregate, Home-Delivered and Native American meals programs have increased more than eight-fold over the last thirty years. During this time, these programs have provided almost 6 billion meals to at-risk older persons. The Nutrition Programs form the foundation of the AoA, providing access and linkages to a wide variety of other community-based services needed to maintain the health and independence of older adults. The 2000 amendments to the Older Americans Act recognized that the Nutrition Programs are now much more than simply "meals" programs. In addition to providing meals, the Nutrition Programs also offer nutrition screening, education and counseling as necessary to maintain the health and independence of older adults.

The Nutrition Programs also help older persons 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 research, meal preparation is difficult or impossible for 41 percent of home delivered meal recipients, and 77 percent have difficulty with one or more activities of daily living. AoA also provides funding directly to tribes and to organizations serving Native Hawaiians that is used to provide nutrition services.

Nutrition funds under the Older Americans Act are currently appropriated to both the Administration on Aging and the Department of Agriculture (USDA). AoA, as the lead agency, distributes most of the funds and has greater interaction with service providers. Funding from both agencies is currently distributed to the same service providers and used for the same purposes. To simplify program management at the Federal, State and local level, the President's Budget proposes to consolidate this funding in AoA. In FY 2003, $150 million of nutrition funding is included

in the AoA request which had previously been appropriated to the Department of Agriculture. These funds will be distributed to States consistent with the current USDA allocation formula. Funding for these USDA activities was $150 million in FY 2001 and FY 2002.

HELPING THE PEOPLE WHO CARE FOR THE ELDERLY–NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

"More than 7 million Americans devote themselves to this noble responsibility. Family caregivers dedicate an average of 20 hours per week in care for their loved ones and, in some cases, fulfill their multiple responsibilities around the clock."

George W. Bush
November 2001

In FY 2001, States received their first funding under the new National Family Caregiver Support Program which helps family members provide care for the elderly at home. The FY 2003 budget includes $141 million to maintain funding at the FY 2002 level. These funds may be used for: information about existing services; assistance with locating such services; counseling, organization of support groups and the provision of caregiver training; respite care; and supplemental services. States have used this funding in a number of innovative ways: telehealth technology links caregivers to support networks, and educational presentations, and connects long distance caregivers with their relatives; donated computers were retrofitted and used to establish an online support group staffed by a registered nurse; Caregiver Resource Centers were established in public libraries; and retirees received training and are used to provide respite care.

In addition, the budget includes $11 million for the Alzheimer's Disease Demonstration Grant program. These grants improve the quality of services provided to those suffering from Alzheimer's Disease by moving findings and approaches from theory to practice. For example, many grantees are developing culturally competent services for minority populations with limited English proficiency. In FY 2002, AoA will fund approximately seven new Demonstration Grants for a total of 32.

SUPPORTIVE SERVICES

Supportive Services activities improve the quality of life for elderly Americans by providing information and referral; transportation and assistance; chore, homemaker and personal care services; and the provision of adult day care. Transportation is vital, particularly in areas which are typically underserved by public transportation where more than 70 percent of older Americans live. In FY 2003, AoA estimates that the aging network will provide 51 million rides, providing older Americans with the means to visit health professionals, pharmacies and grocery stores. The budget includes $357 million for Supportive Services, the same level as in FY 2002.

OTHER PROGRAMS

The FY 2003 request includes $41 million to fund activities which: teach older Americans to adopt healthier lifestyles in order to delay or prevent the onset of chronic disease (Preventive Health); protect vulnerable older Americans from abuse/neglect and give them greater control over their living situations (Protection of Vulnerable Older Americans); and identifies local resources available for older Americans and their caregivers (Aging Network Support Activities). Funding for these activities are maintained at the FY 2002 level.

Training, Research, and Discretionary Programs: A total of $28 million is included to continue innovative programs that initiate, develop, and test best practices in serving the elderly (e.g., State-wide legal hotlines and health care anti-fraud waste and abuse programs). Funding for these programs is

reduced by $10 million, primarily from one-time, one-year projects initiated in the FY 2002 appropriation.

New innovative programs will also be funded to test their effectiveness. Several major AoA programs–including the Nutrition Programs now celebrating their 30th anniversary and the Long-Term Care Ombudsman Program–were originally developed as innovative demonstration programs.

Program Administration: A total of $19 million is requested to support 120 FTE. AoA will initiate management and administrative reforms to achieve savings of $487,000 and 4 FTE. These savings will be achieved through consolidation of regional administration support activities within AoA's headquarters office and consolidation of AoA's consumer communications function.

DM OVERVIEW

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
General Departmental Management:				
Adolescent Family Life	$24	$29	$31	+$2
Physical Fitness & Sports	1	1	1	0
Office of Minority Health	49	50	47	-3
Office on Women's Health	18	27	29	+2
Office of Emergency Preparedness	12	15	16	+1
Office for Human Research Protections	6	7	8	+1
Minority HIV/AIDS	50	50	50	0
IT Security and Innovation Fund	0	22	20	-2
Other General Departmental Management 1/	183	182	192	+10
Evaluation Activities	21	21	21	0
Health Care Fraud and Abuse Control	4	4	6	+2
Total, GDM Program Level	**$368**	**$408**	**$421**	**+$13**
Policy Research:				
Broad-Based Research	$16	$18	$18	$0
State Innovation Fund	0	2	2	0
Total, PR Program Level	**$16**	**$20**	**$20**	**$0**
Total, GDM and PR Program Level	**$384**	**$428**	**$441**	**+$13**
Public Health and Social Services Emergency Fund:				
PHSSEF	$362	$2,661	$2,295	-$366
Total, PHSSEF Program Level	**$362**	**$2,661**	**$2,295**	**-$366**
Health Facilities Construction and Management Fund:				
Construction and Mgmt Fund	$420	$737	$1,057	+$320
Total, Construction and Mgmt Program Level	**$420**	**$737**	**$1,057**	**+$320**
Total, DM Program Level	**$1,166**	**$3,826**	**$3,793**	**-$33**
Amount ERF (non-add)	*124*	*2,555*	*0*	*-2,555*
Amount non-ERF (non-add)	*1,042*	*1,271*	*3,793*	*+2,522*
Less funds from other sources:				
Evaluation Activities	$21	$39	$39	$0
Health Care Fraud and Abuse Control	4	4	6	+2
Construction and Mgmt Fund - NIH Transfers	241	441	873	+432
Total, DM Budget Authority	**$900**	**$3,342**	**$2,875**	**-$467**
Amount ERF (non-add)	*124*	*2,464*	*0*	*-2,464*
Amount non-ERF (non-add)	*776*	*878*	*2,875*	*+1,997*
FTE	1,676	1,840	1,827	-13

1/ Includes comparable adjustments in FY 2001 and FY 2002 to reflect consolidation of Department-wide public affairs and legislative affairs activities.

DEPARTMENTAL MANAGEMENT

MISSION

The mission of Departmental Management (DM) is to support the Secretary in his role as chief policy officer and general manager of the Department.

SUMMARY

Departmental Management (DM) includes funding for four appropriation accounts in the Office of the Secretary: General Departmental Management (GDM), Policy Research, the Public Health and Social Services Emergency Fund (PHSSEF), and the Health Facilities Construction and Management Fund.

The FY 2003 budget request for GDM and Policy Research provides a total program level of $441 million, including appropriations of $396 million, interagency transfers of $39 million in evaluation funds, and $6 million in health care fraud and abuse funds. Funds are included in the request to cover the full government share of the accruing cost of all retirement and retiree health care benefits for Federal employees.

The FY 2003 budget request for the PHSSEF account is $2.3 billion, and the FY 2003 budget request for the new Health Facilities Construction and Management Fund is $1.1 billion.

GENERAL DEPARTMENTAL MANAGEMENT

The GDM account supports those activities associated with the Secretary's roles in administering and overseeing the organization, programs and activities of the Department. These activities are carried out through ten Staff Divisions (STAFFDIVs). The GDM budget request for FY 2003 totals $421 million, an increase of $13 million or 3 percent above the comparable FY 2002 enacted level.

In FY 2003, the Department's structure of over 50 Public Affairs offices and more than 20 Legislative Affairs offices will be streamlined and consolidated. These offices, spread throughout 13 operating divisions, will be consolidated in order to more efficiently carry out the mission of the Department. A total of $28 million in budget authority, is included in the budget request, which is attributable to these consolidation activities.

The GDM request also provides funding for program-related activities, including the following:

Office of Population Affairs (OPA): The request of $31 million, an increase of $2 million, will provide 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 also continues to provide for abstinence-only prevention projects, as defined by the Welfare Reform legislation (P.L. 104-193). Further, OPA also administers the Family Planning program under Title X of the PHS Act, which is funded through the Health Resources and Services Administration.

Office of Minority Health (OMH): The OMH request of $47 million, a $3 million decrease from FY 2002, will provide funding to continue disease prevention, health promotion, service demonstration, and educational efforts that focus on health concerns that cause the high rate of death in racial and ethnic minority communities. OMH plays a key role in the Department's Initiative to Eliminate Racial and Ethnic Disparities in Health. The reduction is attributed to projects initiated in the FY 2002 appropriation which are not continued in FY 2003.

Office on Women's Health (OWH): The OWH request of $29 million, an increase of $2 million, will provide funding to continue the advancement of 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.

Office of Emergency Preparedness (OEP): The budget request of $16 million will be used to manage the medical and health-related 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 the medical consequences of both natural and man-made disasters.

Office of Human Research Protections (OHRP): The FY 2003 budget request of $8 million will be used to accomplish the following: 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. Beginning in FY 2002, OHRP will provide funding to expand the activities of the Office of International Activities. This office will establish and maintain relationships with international organizations and entities which are stakeholders in the fields of medical research and protection of human subjects.

HIV/AIDS in Minority Communities: The FY 2003 request includes $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.

Information Technology Security and Innovation Fund: The FY 2003 budget request includes $20 million to continue funding for the 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 continuing the establishment of an Enterprise Infrastructure Management (EIM) framework, and consolidating the capital planning and management of its IT assets, the Department has been better able to reduce duplication of effort and contain risks.

POLICY RESEARCH

The Policy Research account 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 2003 request for Policy Research includes $2 million to continue the State Innovation Fund and $18 million to continue evaluation activities.

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. The FY 2003 budget provides $2 million to continue a program to provide competitive grants to States to design, demonstrate, and evaluate new models for delivering health and/or human services at the community level to low-income adults, children, and families. States are encouraged to integrate separate but related services funded by different programs and/or provided by different agencies. The grants are of two types: planning grants and demonstration grants. Measurable indicators of performance to facilitate evaluation of the outcomes of the demonstrations are a key ingredient of the program.

Broad-Based Research: The FY 2003 Policy Research budget also 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 2003 the entire $18 million request again be derived through interagency transfers of evaluation funds.

HHS will sharpen the focus of policy-oriented research and foster greater interactions among its research programs through its Research Coordination Council (RCC). This forum will evaluate Department-wide research priorities to ensure that efficiencies are realized.

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND (PHSSEF)

The PHSSEF provides $2.3 billion of HHS's total bioterrorism request of $4.3 billion and includes funds for HRSA, CDC, SAMHSA and the Office of the Secretary. Total funding for HHS bioterrorism is $1.3 billion higher than in FY 2002, though the share funded through the PHSSEF declines by $209 million. The PHSSEF provides funding for State and local preparedness, pharmaceutical procurement and Federal medical and public health response. Funding for research and next-generation anthrax vaccine purchase is included in the NIH budget request; regulatory oversight funding is requested in FDA; and CDC laboratory funding is requested in the new HHS Health Facilities Construction and Management Fund.

In addition, a total of $121 million in the FY 2001 emergency supplemental funding and $180 million in the FY 2002 emergency supplemental was made available for recovery and relief efforts in response to the attacks of September 11th.

- ***State and Local Preparedness:*** Through the Office of Public Health Preparedness, the Office of the Secretary is coordinating the efforts of CDC, HRSA and the Office of Emergency Preparedness (in the Office of the Secretary) to help States develop the personnel, procedures and systems needed to detect and respond to a potential bioterrorist attack.

Centers for Disease Control and Prevention: The FY 2003 request for the PHSSEF includes $1.5 billion for CDC, a decrease of $735 million due primarily to the one-time acquisition of smallpox vaccine and pharmaceuticals in FY 2002. This request provides support for State and local activities, further development of the National Pharmaceutical Stockpile, upgrading capacity at CDC, expanding national planning efforts, oversight of inter-laboratory transfers of dangerous pathogens and toxins, laboratory safety inspections, and anthrax research.

Health Resources and Services Administration: The FY 2003 request for the PHSSEF includes $618 million for HRSA, an increase of $483 million above the FY 2002 level. In addition to support for regional and local hospital preparedness and poison information centers, HRSA's request includes a new program to assist hospitals in funding bioterrorism infrastructure improvements. Also, funds are provided for a new program focused on medical curricula for instruction on the detection and treatment of diseases that can be caused by bioterrorism. Funds also will be used to address the unique needs of children during and following a terrorist attack.

Office of the Secretary: The FY 2003 request for the PHSSEF includes $150 million for the Office of the Secretary, an increase of $33 million over the FY 2002 level.

- ***Office of Emergency Preparedness (OEP):*** Funds totaling $107 million, an increase of $36 million, are requested for OEP. This includes $50 million, an increase of $25 million, for the Medical Response Systems in heavily populated regions of the country, and $10 million for a new Citizen Preparedness initiative to recruit retired and inactive medical professionals and other personnel for volunteer services needed to

combat bioterrorism. Funds totaling $11 million, an increase of $1 million, are for OEP's expanded responsibilities in managing and developing the National Disaster Medical System (NDMS), which includes partnerships with the Departments of Defense and Veterans Affairs and the Federal Emergency Management Agency to provide medical resources during natural or man-made disasters, after transportation accidents, or other public health emergencies.

• ***Office of Pubic Health Preparedness (OPHP):*** Funds totaling $33 million, a net decrease of $8 million, are included for OPHP. This reflects a $13 million decrease in one-time implementation costs for command and control systems completed in FY 2002, and an additional $5 million for a new public information campaign. The role of OPHP is to direct and coordinate the implementation of the Department's bioterrorism programs.

• ***CyberSecurity:*** The FY 2003 request for the PHSSEF includes $10 million, an increase of $5 million, to protect the Department's information technology infrastructure from cyber-terrorist attacks.

Substance Abuse and Mental Health Services Administration: The FY 2003 request for the PHSSEF includes $10 million for SAMHSA. Funds will be used to assist State and local organizations in developing solutions to the mental health problems that result from bioterrorism and other traumatic events.

Other Bioterrorism: Funds totaling $1.8 billion, an increase of $1.3 billion, are included for bioterrorism activities in the following agency requests:

• ***National Institutes of Health:*** The FY 2003 request includes $1.8 billion, an increase of $1.5 billion, a six-fold increase from FY 2002. In addition to NIH's role in anthrax vaccine procurement, this request includes $977 million for basic and applied research and $521 million for construction of research facilities, both intramural and extramural labs.

• ***Food and Drug Administration:*** Funds totaling $159 million, an increase of $1 million, are requested in the FY 2003 FDA request. This includes $98 million, the same level as FY 2002, for food safety inspections and protection of the food supply; $54 million, an increase of $7 million, for FDA's efforts to develop and regulate vaccines/drugs and diagnostics; and $7 million, a decrease of $6 million for security at FDA labs. This reduction reflects the completion of one-time physical improvements made in FY 2002.

• ***CDC Physical Security and Facilities:*** The FY 2003 request includes $120 million for security improvements and construction of facilities related to CDC's bioterrorism program. This includes a new infectious disease/bioterrorism laboratory in Fort Collins, Colorado. Of this amount, $20 million will improve security, including expanded closed-circuit video monitoring, of CDC's campuses. These funds are contained in the new HHS Health Facilities Construction and Management Fund.

HEALTH FACILITIES CONSTRUCTION AND MANAGEMENT FUND

Newly created beginning with FY 2003, this fund provides resources for intramural and extramural facilities maintenance and construction activities across HHS. This account includes facilities construction funds for the Centers for Disease Control and Prevention, and transfers funds from the National Institutes of Health. The FY 2003 budget request reflects a total program level of $1,057 billion for this fund, including direct appropriations of $184 million and interagency transfers of $873 million. This new consolidated capital budgeting and management process will help to improve project planning and oversight, including setting priorities and linking resources to program outcomes. In addition, HHS will establish a process to include the Indian Health Service and Food and Drug Administration facility projects in the Department-wide priority-setting process.

BIOTERRORISM OVERVIEW

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Public Health and Social Services Emergency Fund:				
Centers for Disease Control and Prevention:				
Upgrading State and Local Capacity	$67	$940	$940	$0
Upgrading CDC Capacity	22	116	144	+28
National Pharmaceutical Stockpile	51	645	300	-345
Smallpox Vaccine	0	512	100	-412
Anthrax Vaccine Research	18	18	18	0
Overall Planning for Preparedness and Response	9	8	11	+3
Deterrence	1	11	4	-7
Independent Studies	11	2	0	-2
Subtotal, CDC	$178	$2,252	$1,517	-$735
Health Resources and Services Administration:				
Hospital Preparedness and Infrastructure	$0	$135	$518	+$383
Education Incentives for Medical Curriculum	0	0	60	+60
EMS for Children	0	0	19	+19
Poison Control	0	0	21	+21
Subtotal, HRSA	$0	$135	$618	+$483
Office of the Secretary:				
Office of Emergency Preparedness:				
Operations	$4	$5	$6	$0
FY 2002 Olympics/ Special Events	2	7	3	-4
Noble Training Center	3	4	4	0
DMAT/NMRT development and training	7	20	23	+4
MMRS	17	25	50	+25
Citizen Preparedness	0	0	10	+10
NDMS Enhanced Readiness	0	10	11	+1
Office of Public Health Preparedness:				
Operations	0	10	10	0
Advanced Research	30	5	5	0
Command, Control and Communication	0	13	0	-13
National Security Early Warning Surveillance	0	10	10	0
Biological Detection and Assessment Teams	0	3	3	0
Media/Public Information Campaign	0	0	5	+5
CyberSecurity	0	5	10	+5
Subtotal, OS	$63	$117	$150	+$33
Substance Abuse and Mental Health Services Adminis.	0	0	10	+10
Recovery Activities	$121	$158	$0	-$158
Total, PHSSEF	**$362**	**$2,661**	**$2,295**	**-$366**
Amount Bioterrorism	*241*	*2,504*	*2,295*	*-209*
Amount non-Bioterrorism	*121*	*158*	*0*	*-158*

BIOTERRORISM OVERVIEW CONTINUED

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Other Bioterrorism and Recovery Activities:				
Food and Drug Administration:				
Food Safety	$1	$98	$98	$0
Vaccines/Drugs/Diagnostics	6	47	54	+7
Physical Security	2	13	7	-6
Subtotal FDA	$8	$158	$159	+$1
National Institutes of Health:				
Research	$53	$183	$977	+$794
Physical Security & Facilities	0	92	521	+430
Anthrax Vaccine Procurement	0	0	250	+250
Subtotal NIH	$53	$274	$1,748	+$1,473
CDC Physical Security & Facilities/1	3	46	120	+74
Recovery Activities	0	23	0	-23
Subtotal, Other Bioterrorism	$64	$501	$2,027	+$1,526
Total, PHSSEF and Other Bioterrorism/ Recovery	**$426**	**$3,162**	**$4,322**	**+$1,160**
Amount Bioterrorism	*305*	*2,982*	*4,322*	*+1,340*
Amount non-Bioterrorism	*121*	*180*	*0*	*-180*

1/ Displayed on a comparable basis -- appropriated in the PHSSEF in FY 2001 and FY 2002.

HEALTH FACILITIES CONSTRUCTION AND MANAGEMENT FUND

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Health Facilities Construction and Management Fund :				
Centers for Disease Control.....	$178	$296	$184	-$112
National Institutes of Health [Transfers] *.....	242	441	873	+432
Buildings and Facilities Account.....	161	326	633	+307
National Institute of Allergy and Infectious				
Diseases.....	0	0	150	+150
National Center for Research Resources.....	78	110	77	-33
National Center for Minority Health				
and Health Disparities.....	0	0	8	+8
National Cancer Institute.....	3	5	5	0
Total, Construction Program Level.....	**$420**	**$737**	**$1,057**	**+$320**
Less funds from other sources:				
National Institutes of Health [Transfers].....	$242	$441	$873	+$432
Total, Construction Budget Authority.....	**$178**	**$296**	**$184**	**-$112**
FTE.....	0	0	0	0

* Excludes $75 million appropriated to NIH Building and Facilities account in FY 2002 for transfer to the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria.

OFFICE FOR CIVIL RIGHTS

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Program Level.....	$30	$34	$36	+$2
FTE.....	223	273	271	-2

MISSION

The Office for Civil Rights (OCR) promotes and ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination. Through prevention and correction of unlawful discrimination and protection of the privacy of medical information, OCR helps HHS carry out its overall mission of improving the health and well-being of all people affected by its many programs.

SUMMARY

The FY 2003 budget request for the OCR is $36 million, an increase of $2 million over the FY 2002 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; implementation and enforcement of medical privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA), the effects of discrimination on racial disparities in health care; nondiscriminatory implementation of the Temporary Assistance to Needy Families (TANF) program 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.

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.

HIPAA Medical Privacy

During FY 2001 and FY 2002, OCR has been preparing for implementation of a new compliance, policy development, public education, outreach, and technical assistance responsibility for protecting the privacy of medical information under HIPAA. OCR is developing policy guidance, public education, and technical assistance materials for health providers, health plans, and clearing houses that maintain individuals' medical information. With final implementation of the HIPAA privacy rule in April 2003, OCR's resources will also support the investigative, legal, and related administrative expenses associated with implementing compliance with and enforcement of the rule.

New Freedom Initiative and *Olmstead*

A primary focus of OCR's requested FY 2003 budget increase is continued and 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.

Other FY 2003 Priorities

In FY 2003, 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.

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Program Level \1.....	$172	$190	$210	+$20
FTE	1,443	1,588	1,641	+53

1/ The FY 2003 level assumes $160 million for Medicare and Medicaid related fraud and abuse activities, the maximum allowed under the Health Care Fraud and Abuse Control program.

MISSION

Under the authority of the Inspector General Act, we improve HHS programs and operations and protect them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations and investigations, we provide timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the Public.

SUMMARY

For FY 2003, the Office of Inspector General (OIG) requests a discretionary appropriation of $50 million, an increase of $5 million above the comparable FY 2002 discretionary level. The OIG will also receive between $150 and $160 million in FY 2003 from the Health Care Fraud and Abuse Control (HCFAC) Account for Medicare and Medicaid related fraud and abuse activities.

In the FY 2002-FY 2003 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 to all 50 States (29 States and the District of Columbia currently covered) 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. Marshals Service personnel, the Federal Bureau of Investigation, State and county child support personnel, and all other interested parties. From 1998 to 2001, the OIG has opened over 1,359 child support cases nationwide resulting in 431 Federal convictions and court-ordered restitution of over $20 million. The Child Support Task Forces have resulted in an additional 259 convictions at the State level and $9.9 million in restitution.

SECURITY

The OIG plans on increasing its role in ensuring the security of HHS programs, staff, facilities, and equipment. OIG will complete

audits of physical security of NIH and FDA laboratories and of the CDC headquarters facility in Atlanta, Georgia. In addition, OIG will audit CDC's oversight of facilities handling certain biological agents and toxins (select agents). OIG will initiate reviews at universities to determine the adequacy of controls designed to prevent select agents from coming into the possession of bioterrorists. OIG will audit CDC's National Pharmaceutical Stockpile Program for its purchase validity, compliance, and proper maintenance. Finally, OIG will determine how FDA plans to carry out its bioterrorism activities and ensure that appropriate controls are in place to adequately protect buildings, data, and other Federal property.

OVERSIGHT OF GRANTS

The OIG plans to review Departmental grant programs to determine whether they are appropriately monitored and managed throughout the grant life cycle. We will assess mechanisms in place to ensure that proper procedures are used to award grants, fund them, account for expenditures, and verify that they are used only for authorized purposes. Our work will include review of performance measures used to determine the nature and value of the product of the grants, as well as the methods used to evaluate the individual grants and grant programs as a whole. Our reviews will cover internal controls, accounting controls, performance measurements, and program evaluation. Currently OIG is assessing ACF oversight and grantee performance in terms of futhering ACF's goal of promoting economic and social well being of children, families, and communities. Reviews will soon begin of CDC's and HRSA's HIV/AIDS programs, and subsequently of other HHS grant programs. We will also assess the Department's grantmaking and monitoring processes as a whole and will recommend improvements as needed.

HEALTH CARE FRAUD AND ABUSE

Through the Health Insurance Portability and Accountability Act (HIPAA), 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 Centers for Medicare & Medicaid Services (CMS), other HHS agencies, and the Department of Justice to ensure that funds due to the Medicare Trust Fund or CMS 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)

	2001 Actual	2002 Enacted	2003 Request	Request +/-Enacted
Expenses.....	$414	$415	$452	+$37
FTE.....	1,189	1,275	1,224	-51

MISSION

The Program Support Center's (PSC) mission is to provide measurable, qualitative, and cost-effective government support services.

SUMMARY

The Program Support Center (PSC) was created 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 six broad areas: human resources, commissioned corps personnel, financial management, administrative operations, Federal occupational health, and Office of Chief Information Officer. 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, Veterans Affairs, and the U.S. Postal Service.

HUMAN RESOURCES SERVICE

The FY 2003 estimated expenses for the Human Resources Service (HRS) are $43 million, an increase of $6 million above the FY 2002 level. This increase is comprised of $3 million for costs associated with the Enterprise Human Resource Project, $2 million reserve for software replacement, and approximately $1 million for the FY 2003 pay raise and other inflationary costs. HRS provides a full range of human resources services, including automated personnel and payroll systems support, personnel and payroll processing, staffing and classification, and employee and labor relations.

COMMISSIONED PERSONNEL SERVICE

The FY 2003 estimated expenses are $18 million, which is at the same level as FY 2002 estimated expenses, with minor adjustments for pay and inflationary increases. The Commissioned Personnel Service integrates the development, implementation, and evaluation of a comprehensive program for personnel management, medical support systems, and pay administration for the U.S. Public Health Service (PHS) Commissioned Corps. CPS provides a full range of personnel services and activities to the Department of Health and Human Services and non-HHS agencies that employ the PHS Commissioned Corps officers and to the active-duty, inactive, and retired officers' populations.

FINANCIAL MANAGEMENT SERVICE

The FY 2003 estimated expenses for the Financial Management Service (FMS) are $57 million, an increase of $1 million above the FY 2002 level. The increase is for pay and other costs. 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 2003 estimated expenses for the Administrative Operations Service (AOS) are $193 million, an increase of $10 million above the FY 2002 level. This increase is for pay and other costs ($2 million) and replenishment of the pharmaceutical supply inventory at the Supply Service Center ($8 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.

FEDERAL OCCUPATIONAL HEALTH

The FY 2003 estimated expenses for the Federal Occupational Health (FOH) are $131 million, an increase of $10 million above the FY 2002 level. This increase is comprised of $9 million in anticipated increased reimbursements from other Federal agencies, and $1 million for increases in pay and other costs. The FOH provides occupational health services, including health, wellness, employee assistance, work/life, safety, environmental and industrial hygiene-related services to more than 160 Federal components across the country. The FOH services are provided through interagency agreements as authorized under the Government Management Reform Act and the Economy Act.

OFFICE OF CHIEF INFORMATION OFFICER

In FY 2003, the PSC will invest $10 million to fund Departmental Information Technology efforts. The OCIO is responsible for the overall coordination and management of a PSC-wide information technology program. The OCIO directs PSC's IT infrastructure and communications networks; provides systems integrity functions regarding quality assurance, security, and critical infrastructure; provides customer liaison services to resolve issues and improve customer service; and monitors and evaluates the performance of information resource investments through a capital planning and investment control process.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

(dollars in millions)

	2001 Actual	2002 Enacted	2003 Curr. Law	2003 Prop. Law		Request +/-Enacted
Retirement Payments.....	$194	$208	$222	*[$222]*	*/1*	-$208
Survivor's Benefits.....	11	12	13	*[13]*	*/1*	-$12
Medical Care.....	39	41	15	15		-$26
Military Service Credits.....	1	1	1	1		0
Total, Budget Authority.....	**$245**	**$262**	**$251**	**$16**		**-$246**

/1 The FY 2003 Budget proposes that the $235 million in retirement and survivor benefits be paid by a new retirement fund within HHS that will reflect full acrual of retirement costs.

SUMMARY

This appropriation provides for retirement payments to Public Health Service (PHS) Commissioned Officers and payment to survivors of deceased retired officers.

Beginning in FY 2003, the PSC will continue to pay $16 million in medical benefits for those under age 65 from this account. Under the President's proposal, the budget assumes accrual of health benefit costs for under age 65 annuitants in FY 2004. Medical benefits for those aged 65 and over would be paid in FY 2003 from the DoD's Medicare-Eligible Retiree Health Care Fund under P.L. 107-107.

As part of the Administration's initiative to reflect full accrual of retirement costs, the FY 2003 budget proposes the creation of a new retirement fund in HHS to be known as the "Public Health Service Commissioned Corps Retirement Fund." This new fund would continue to pay the same retirement and survivor benefits that are paid to annuitants under the current appropriation, but it would also reflect the full accrued retirement costs associated with the annuitant group. In previous budgets, the retirement accrual amounts have not been reflected in the OPDIV budgets and have instead been funded on a "pay as you go" basis in the existing retirement pay and medical benefits appropriation account.

CROSSWALK FOR COSTS OF ACCRUED HEALTH AND RETIREMENT BENEFITS PROPOSAL

(dollars in millions)

	Current Law	Accrued Costs	Proposed Law
FY 2001 Discretionary Programs (BA):			
Food & Drug Administration	$1,093	$47	$1,140
Health Resources & Services Administration	5,568	15	5,583
Indian Health Service	2,628	61	2,689
Centers for Disease Control and Prevention	3,756	54	3,810
National Institutes of Health	20,359	79	20,438
Substance Abuse & Mental Health Services	2,962	4	2,966
Agency for Healthcare Research & Quality	104	2	106
AHRQ Program Level (Non-Add)	*269*	*2*	*271*
Centers for Medicare & Medicaid Services	2,237	28	2,265
Administration for Children & Families	12,412	10	12,422
Administration on Aging	1,253	1	1,254
Office of the Secretary	953	18	971
Subtotal, FY 2001 Discretionary (BA)	**$53,324**	**$319**	**$53,643**
FY 2002 Discretionary Programs (BA):			
Food & Drug Administration	$1,361	$52	$1,413
Health Resources & Services Administration	6,114	16	6,130
Indian Health Service	2,759	65	2,824
Centers for Disease Control and Prevention	4,124	58	4,182
National Institutes of Health	23,536	87	23,623
Substance Abuse & Mental Health Services	3,137	4	3,141
Agency for Healthcare Research & Quality	3	0	3
AHRQ Program Level (Non-Add)	*298*	*2*	*300*
Centers for Medicare & Medicaid Services	2,432	29	2,461
Administration for Children & Families	13,058	11	13,069
Administration on Aging	1,349	1	1,350
Office of the Secretary	3,401	19	3,420
Subtotal, FY 2002 Discretionary (BA)	**$61,274**	**$342**	**$61,616**

See page 9 for a discussion of the Administration's initiative to budget for the accrued cost of retirement and health benefits.

CROSSWALK FOR COSTS OF ACCRUED HEALTH AND RETIREMENT BENEFITS PROPOSAL

(dollars in millions)

	Current Law	Accrued Costs	Proposed Law
FY 2003 Discretionary Programs (BA):			
Food & Drug Administration	$1,377	$55	$1,432
Health Resources & Services Administration	5,373	16	5,389
Indian Health Service	2,815	69	2,884
Centers for Disease Control and Prevention	3,951	61	4,012
National Institutes of Health	27,244	91	27,335
Substance Abuse & Mental Health Services	3,193	5	3,198
Agency for Healthcare Research & Quality	0	0	0
AHRQ Program Level (Non-Add)	*250*	*2*	*252*
Centers for Medicare & Medicaid Services	2,378	30	2,408
Administration for Children & Families	13,046	11	13,057
Administration on Aging	1,341	1	1,342
Office of the Secretary	2,940	21	2,961
Subtotal, FY 2003 Discretionary (BA)	**$63,659**	**$360**	**$64,019**