Department of Health and Human Services

FY 2005 Budget in Brief

LETTER FROM THE SECRETARY

The President's FY 2005 Budget for the Department of Health and Human Services reflects the Administration's ongoing commitment to enhance the health, well-being, and safety of our Nation's citizens. The $580 billion proposed by the President will enable the Department to continue working with our partners in State and local governments, and in the private and volunteer sectors to improve health benefits, strengthen our defense against bioterrorism, expand access to health care, and serve populations in need.

The Department of Health and Human Services was given a number of challenges by the Administration, many of which have been accomplished. We increased access to health care, completed the doubling of the National Institutes of Health budget, and launched the Global AIDS Initiative. We have also made great strides in building the capacity of grass-roots organizations to meet the needs of our citizens, and in expanding the network of care for the treatment of substance abuse.

Our Nation continues to build its capability to prepare for and respond to the threat of bioterrorism. The Department plays a crucial role in this response, and our FY 2005 budget will enhance the necessary services that contribute to the war on terrorism and protect us against biologic and other threats. We will focus on preparedness at both the domestic and global levels, expand our programs that enable us to rapidly detect and respond to disease, improve the capacity of our laboratories, and ensure the safety of food products.

In the FY 2005 budget, the Department of Health and Human Services will use its resources to effectively impact the Nation's public health infrastructure, focusing on safety and improved health outcomes. We will continue to work towards fulfilling the promise of a safe and healthy Nation, while strengthening support for populations in need. Lastly, the Department will continue its work to improve the management and performance of its programs.

Sincerely,

Tommy G. Thompson

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ACHIEVING A SAFE AND HEALTHY NATION

	2002	2003	2004	2004 +/- 2003
Administration for Children & Families:				
Budget Authority	47,292	47,394	46,990	-404
Outlays	45,649	47,207	47,740	+533
Administration on Aging:				
Budget Authority	1,349	1,341	1,344	+3
Outlays	1,255	1,438	1,341	-97
Departmental Management/Civil Rights/ *PHSSEF:				
Budget Authority	1,863	2,185	2,287	+102
Outlays	811	1,742	2,244	+502
Office of Inspector General:				
Budget Authority	35	39	39	0
Outlays	36	36	39	+3
Program Support Center:				
Budget Authority	386	393	424	+31
Outlays	322	359	410	+51
Proprietary Receipts:				
Budget Authority	-1,295	-1,177	-1,211	-34
Outlays	-1,295	-1,177	-1,211	-34
Total, Health & Human Services:				
Budget Authority	$478,957	$507,835	$537,680	+$29,845
Outlays	$466,050	$502,156	$539,009	+$36,853
Full-Time Equivalents	63,506	65,508	65,525	+17
Commissioned Corps Detailed Outside HHS	*1,131*	*1,281*	*1,281*	*0*

* Public Health and Social Services Emergency Fund

HHS Budget by Composition

	2002	2003	2004	2004 +/- 2003
Mandatory Programs (Outlays):				
Medicare	$228,720	$242,201	$256,336	+$14,135
Medicaid	147,512	162,541	182,543	+20,002
Temporary Assistance for Needy Families	18,749	19,209	18,713	-496
Foster Care & Adoption Assistance	5,885	6,297	6,718	+421
State Children's Health Insurance	3,682	4,751	2,657	-2,094
Child Support Enforcement	3,998	4,174	4,291	+117
Child Care	2,365	2,690	2,813	+123
Social Services Block Grant	1,780	1,792	1,790	-2
Other Mandatory Programs	1,035	1,074	1,203	+129
Proprietary Receipts	-1,295	-1,177	-1,211	-34
Subtotal, Mandatory (Outlays)	**$412,431**	**$443,552**	**$475,853**	**+$32,301**
Discretionary Programs (BA):				
Food & Drug Administration	$1,368	$1,384	$1,406	+$22
Health Resources & Services Administration	6,072	5,356	5,672	+316
Indian Health Service	2,758	2,816	2,890	+74
Centers for Disease Control and Prevention	4,450	4,264	4,231	-33
National Institutes of Health	23,454	27,243	27,743	+500
Substance Abuse & Mental Health Services	3,136	3,195	3,393	+198
Agency for Healthcare Research & Quality	3	0	0	0
AHRQ Program Level (Non-Add)	*299*	*250*	*279*	*+29*
Centers for Medicare & Medicaid Services	2,506	2,457	2,533	+76
Administration for Children & Families	13,057	13,080	13,449	+369
Administration on Aging	1,349	1,341	1,344	+3
Office of the Secretary	411	418	430	+12
PHSSEF	1,487	1,806	1,896	+90
Program Support Center/Commissioned Corps	0	0	13	+13
Subtotal, Discretionary (BA)	**$60,051**	**$63,360**	**$65,000**	**+$1,640**
Subtotal, Discretionary (Outlays)	**$53,619**	**$58,604**	**$63,156**	**+$4,552**
Total, HHS Outlays	**$466,050**	**$502,156**	**$539,009**	**+$36,853**

	2002	2003	2004	2004 +/- 2003
Food & Drug Administration:				
Program Level	$1,551	$1,655	$1,713	+$58
Budget Authority	1,368	1,384	1,406	+22
Outlays	1,126	1,373	1,400	+27
Health Resources & Services Administration:				
Budget Authority	6,209	5,498	5,810	+312
Outlays	5,705	5,848	5,921	+73
Indian Health Service:				
Budget Authority	2,858	2,916	3,040	+124
Outlays	2,811	2,846	3,023	+177
Centers for Disease Control & Prevention:				
Budget Authority	4,450	4,264	4,231	-33
Outlays	3,672	4,214	4,210	-4
National Institutes of Health:				
Budget Authority	23,554	27,343	27,893	+550
Outlays	20,709	23,228	26,484	+3,256
Substance Abuse & Mental Health Services:				
Budget Authority	3,136	3,195	3,393	+198
Outlays	2,885	3,055	3,274	+219
Agency for Healthcare Research & Quality:				
Program Level	299	250	279	+29
Budget Authority	3	0	0	0
Outlays	-66	0	0	0
Centers for Medicare & Medicaid Services:				
Budget Authority	387,749	413,060	442,034	+28,974
Outlays	382,430	411,987	444,134	+32,147

Food and Drug Administration

	2003	2004	2005	2005 +/- 2004
Salaries and Expenses:				
Foods	$408	$410	$470	+$60
Animal Drugs and Feeds	88	88	99	+11
Medical Devices	223	224	252	+28
Drugs	457	476	499	+23
Biologics	165	169	173	+4
National Center for Toxicological Research	40	41	41	0
Other Activities	112	116	118	+2
GSA Rental Payments	108	119	123	+4
Non-GSA Rent & Rent Related Activities	37	39	63	+24
Subtotal, S&E	**$1,637**	**$1,682**	**$1,838**	**+$156**
Buildings and Facilities	8	7	0	-7
Export/Certification Fund	6	7	7	0
Total, Program Level	**$1,652**	**$1,696**	**$1,845**	**+$149**
Less User Fees:				
Prescription Drug User Fee Act (PDUFA)	$223	$250	$284	+$34
Medical Device User Fees (MDUFMA)	25	32	34	+2
Proposed Law, Animal Drugs User Fee Act (ADUFA)	0	5	8	+3
Mammography Quality Standards Act (MQSA)	16	16	17	+1
Export/Certification Fund	6	7	7	0
Subtotal, User Fees	**$271**	**$310**	**$350**	**+$40**
Total, Budget Authority	**$1,381**	**$1,386**	**$1,495**	**+$109**
Biodefense (non-add):				
Food Defense	*$97*	*$116*	*$181*	*+$65*
Medical Product Countermeasures	*53*	*53*	*58*	*+5*
Security	*7*	*7*	*7*	*0*
Subtotal, Biodefense (non-add)	*$157*	*$176*	*$246*	*+$70*
FTE	10,214	10,691	10,844	+153

The FY 2005 budget request for FDA is $1.8 billion, a net program level increase of $149 million. Within this total, there are program increases of $179 million, partially offset by $30 million in management and other savings. Of the funds requested, $350 million will be derived from industry-specific user fees. Significant increases are included to ensure the safety and protection of our food supply; and accelerate the availability of new, safe and effective drugs and medical technologies, including biodefense medical countermeasures. The budget also supports FDA's administrative consolidation efforts – including moving 1700 staff into their consolidated headquarters currently under construction at White Oak in Maryland.

Protecting the Food Supply

FDA is responsible for protecting the food supply directly through its oversight of approximately 80 percent of the U.S. food supply, and indirectly through it's efforts to improve the health of food animals regulated by the U.S. Department of Agriculture (USDA). In FY 2005, through its Foods program, FDA will ensure consumers are protected against intentional and accidental risks against the safety of our food supply and also ensure the safety of dietary supplements and cosmentics. For this work, the budget includes $470 million, a net increase of $60 million. The Animal Drugs and Feeds program protects the health and safety of all food producing, companion or other non-food animals; and, assures that food from animals is safe for human consumption. This program is responsible for ensuring the availability of safe and effective veterinary drugs and has the primary role in Bovine Spongiform Encephalopathy (BSE) or "Mad Cow" prevention efforts. For this work, the budget includes $99 million in the Animal Drugs and Feeds program, a net increase of $11 million. Of this total, $7 million is derived from industry-specific animal drug premarket review fees.

Food Defense: Over the past three years, FDA has bolstered the nation's food defense through increases in port security, food import inspections and additional food security personnel. Specifically, the Agency hired more than 655 additional food security personnel, and, as a result, achieved a five-fold increase in field import examinations between FY 2001 and FY 2003. This feat was accomplished in part as a result of the heightened alert during Operation Liberty Shield when FDA ramped up domestic and import inspection coverage – increasing import inspections to 80,000 by staffing 50 more ports of entry for a total of 90. FDA will soon finalize and implement provisions of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002. These new safeguards will require registration of food facilities, advance notice of food imports, improved record-keeping for imported foods, and will provide authority to detain food when there is credible evidence that it poses a threat of serious adverse health consequences or death.

The budget requests a $65 million major expansion for a total of $181 million dedicated to FDA's efforts to protect Americans from risks of deliberate food contamination. This government-wide strategy will be in coordination with the Department of Homeland Security and the U.S. Department of Agriculture's Food Safety and Inspection Service with the common aim of increasing the ability to detect threats to our nation's food supply. Within the increase, $35 million will be directed to efforts to increase analytic surge testing capacity for biological, chemical and radiological threat agents by enhancing the Food Emergency Response Network (FERN). When completed, FERN will encompass a nationwide network of Federal and State laboratories, greatly promoting the country's ability to respond immediately to terrorist attacks. $15 million of the increase will fund research on technologies capable of detecting and preventing threats to the food supply. Development of these protection strategies will shield the food supply from potential attacks and enable rapid response if needed. To reduce the risk of contaminated food products entering domestic commerce, $7 million will be devoted to increasing import inspectional activities and domestic food establishment inspections. In FY 2005, FDA will conduct 97,000 import field inspections, a more than 60 percent increase over FY 2004 and seven times the amount in FY 2001. FDA will also conduct over 25,500 domestic

exams, nearly eleven times the amount in FY 2001. In addition, $3 million will be used outside Foods to support crisis response operations.

FDA will also direct an added $5 million to finance its role in the government-wide biosurveillance effort designed to provide the earliest possible detection of the international release of deadly pathogens into food, water, or the environment. This increase will help coordinate existing food surveillance capabilities with public health and environmental officials at the State and national levels under a unified system.

Bovine Spongiform Enciphalopathy (BSE) "Mad Cow Disease": In FY 2005, the budget seeks an additional $8 million in Animal Drugs and Feeds to expand BSE or "Mad Cow Disease" prevention efforts for an agency-wide total of $30 million. Since contaminated feed is the only known way for BSE to spread among cattle, efforts will be expanded to ensure their food supply is safe and free of potentially contaminated products. The contamination of cattle feed occurs when byproducts, derived from a contaminated animal, are included in animal foods. All firms handling potentially contaminated products are inspected annually to ensure they are not distributed to animal feed mixers, providing assurance of their exclusion from the animal food supply. In response to the recent case in the State of Washington, FDA halted the distribution of byproducts derived from the contaminated cow, preventing their entrance into commerce. In other program areas, $6 million of the agency-wide total will ensure substances used in the production of drugs and dietary supplements are free of contamination, and donated blood and tissue products are safe.

Animal Drugs Premarket Review: In FY 2004, Congress enacted the Animal Drug User Fee Act (ADUFA). The budget includes $8 million derived from industry-specific fees, bringing the total spending on animal drug premarket review to $36 million. These funds will allow FDA to improve review times on 90 percent of original new animal drug applications by 35 days.

Medical Devices

The FY 2005 budget includes $217 million, a $26 million increase in budget authority to ensure medical technologies are safe, effective and available to Americans as quickly as possible. This level of funding is consistent with the intent of the Medical Device User Fee and Modernization Act of 2002 (MDUFMA). Including $35 million derived from industry-specific user fees, the budget includes a total of $252 million for the Medical Devices program.
The Medical Devices increase will support the necessary investments, including hiring 50 additional staff, to accomplish review goals that become increasingly aggressive through FY 2007. In FY 2005, FDA expects to meet goals related to the review of applications for improvements to existing devices and certain new devices that manufacturers claim are as safe and effective as ones currently in the marketplace. FDA will review 75 percent of applications for each of these application types within 180 and 90 days respectively. This percentage of applications reviewed will become more challenging each year through FY 2007. For breakthrough technologies and other new, innovative devices, ambitious review goals take effect in FY 2006, and in FY 2007 when decisions will be made on 90 percent of applications within 320 days.

Human Drugs and Biologics

In FY 2005, the budget includes $499 million, an increase of $23 million for the Human Drugs program and $173 million, an increase of $4 million in Biologics. Of the total spending on these activities, $253 million will be from industry-specific user fees. These funds will ensure the safety and efficacy of new and existing human drugs and biologics – helping to make medicines safer, more affordable and more available. All new drugs will be evaluated for safety and efficacy before entering the market and monitoring efforts will be directed toward the 10,000 drugs that are already on the market to be sure they continue to meet the highest standards of safety and efficacy. In addition, existing and emerging biological products, including whole blood and blood products; vaccines; and therapeutic products, including cells, gene therapies, and tissues will be assessed for safety and effectiveness. In FY 2003, FDA approved 466 new and generic drugs and biological products, many of which represent significant therapeutic advances.

Biodefense Countermeasures: An increase of $5 million will be used to accelerate the availability of safe and effective biodefense countermeasures. The first request for proposals for procurement of a new generation anthrax vaccine through Project BioShield will be initiated shortly. FDA has been working closely with NIH and industry researchers, and must expand its work on this and other needed countermeasures. In FY 2005, FDA anticipates dedicating a total of 119 staff years in the Biologics program and 81 in the Drugs program to these critically important activities.

Patient Safety: The budget includes $77 million to finance efforts targeted at reducing preventable adverse events. Improving the reporting of adverse events that were potentially related to the proper or improper use of regulated products is a major function of the Agency. Efforts are now underway to take that a step further, helping medical providers avoid medical errors. It is estimated that 45 percent of drug-related medical errors occurred when the wrong drug was dispensed. New requirements for bar code labels on prescription drugs will enable hospitals and pharmacies to avoid many of these errors by implementing new bar code controls. Increased attention will be directed towards ensuring that new drugs and biologics are not only safe and effective for use in adults, but also in the pediatric population. In FY 2003, manufacturer-requested pediatric studies were used to change the labels of 21 medications, making them available for use by children. In FY 2005, efforts to implement the Pediatric Research Equity Act will result in pharmaceutical companies conducting pediatric studies on new drugs and biologics, as well as provide information on the appropriate pediatric dosage and administration.

Generic Drugs: In FY 2005, $53 million is included within the Drugs program to accelerate the availability of safe and effective generic drugs. Generic drugs that are approved are just as safe and effective as their brand-name counterparts, and they often cost 70 percent less. New regulations have been implemented to prevent inappropriate delays related to patent filings – speeding the availability of generic drugs to American consumers and saving them an estimated $35 billion over the next ten years. In FY 2005, it is expected that 399 generic drug applications will be approved, with an 18-month average review time. This is a 50 percent increase in approvals and 14 percent acceleration in review time since FY 2002.

Prescription Drug User Fee Act (PDUFA): The budget includes $284 million from the Prescription Drug User Fee Act (PDUFA) fees, of which $245 million is available for the Human Drugs and Biologics programs and the remaining $39 million for rent and other costs related to the management and operations of the program. 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.

Facilities

The FY 2005 budget includes $186 million for rent and facilities for staff, a net increase of $28 million. This includes $123 million for rental payments to the General Services Administration, and $63 million for costs related to rent and construction. No new appropriations are requested in FY 2005 for facility repair needs, utilizing funds available from prior years instead.
New Headquarters Facility: The FY 2005 budget includes $33 million for the consolidation of FDA's headquarter facilities into their new campus the General Services Administration (GSA) is constructing at White Oak in suburban Maryland. These funds will support telecommunications cabling and equipment, records management consolidation and office hardware and equipment. In December of FY 2004, the Agency completed the move of 125 scientists and laboratory equipment related to drug review into their new Life Sciences laboratory. In FY 2005, 1,700 of Center for Drug Evaluation and Research (CDER) administrative personnel will be relocated to the new CDER Office building that is 50 percent complete and will be ready for occupancy next April. The FY 2005 GSA budget includes $88 million for White Oak – directed primarily at building a medical device and radiological products laboratory to be occupied in FY 2006.

Management Improvements

Consistent with the President's Management Agenda (PMA), the FY 2005 budget request also includes cost savings from FDA completing implementation of its new shared services approach for internal administrative support functions – i.e., facilities management and operations, telecommunications, procurement, travel, information technology support and project management. This will include customer advocated, service level agreements, governance boards, etc., to ensure the quality as well as the cost-effectiveness of these services. These efforts will achieve $23 million in savings throughout the Agency. FDA's budget also includes a $14 million increase in pay.

Health Resources and Services Administration

	2003	2004	2005	2005 +/- 2004
Health Centers	$1,505	$1,617	$1,836	+$219
(Health Center Judgment Fund - non-add)	*40*	*45*	*45*	*0*
Free Clinics Medical Malpractice Coverage	0	5	5	0
Healthy Community Access Program	104	104	10	-94
Nurse Training Programs	113	142	147	+5
National Health Service Corps	171	170	205	+35
Health Professions Training Activities	308	294	11	-283
Children's Hospitals Graduate Medical Education	290	303	303	0
Bioterrorism Hospital Preparedness	514	515	476	-39
Bioterrorism Medical Training, Curriculum Development	28	28	28	0
Smallpox Vaccine Injury Compensation	42	0	0	0
Ryan White HIV/AIDS Activities	2,018	2,045	2,080	+35
(AIDS Drug Assistance Program - non-add)	*714*	*749*	*784*	*+35*
Rural Health	156	143	52	-91
Maternal and Child Health Block Grant	731	730	730	0
Healthy Start	98	98	98	0
Family Planning	273	278	278	0
Traumatic Brain Injury	9	9	9	0
Poison Control/EMS for Children	42	44	44	0
Organ Transplantation	25	25	25	0
Bone Marrow Donor Registry	22	23	23	0
Cord Blood Stem Cell Bank	0	10	10	0
Telehealth	27	4	4	0
Black Lung/Radiation Exposure Compensation	8	7	7	0
Hansen's Disease Services Programs	20	19	19	0
Health Care Facilities/Other Improvement Projects	295	372	0	-372
State Planning Grants	15	15	0	-15
Universal Newborn Hearing Screening/Trauma	13	13	0	-13
Program Management	164	155	158	+3
National Practitioner Data Bank (User Fees)	20	16	16	0
Health Integrity & Protection Data Banks (User Fees)	6	4	4	0
Total, Program Level	**$7,017**	**$7,188**	**$6,578**	**-$610**
Less Funds Allocated From Other Sources:				
User Fees	-25	-20	-20	0
PHS Evaluation Funds (Ryan White)	-25	-25	-25	0
Public Health and Social Service Emergency Fund	-584	-543	-504	+39
Subtotal, Funds from Other Sources	-$634	-$588	-$549	+$39
Total, Discretionary Budget Authority	**$6,383**	**$6,600**	**$6,029**	**-$571**
FTE	1,802	1,858	1,822	-36

The FY 2005 budget requests $6.6 billion for HRSA, a net decrease of $610 million from the FY 2004 level. FY 2005 represents the fourth year of support for the President's multi-year initiative to increase access to health care for the uninsured and underserved by enhancing and strengthening the Health Center program. In order to alleviate the national nursing shortage, HRSA will direct more resources towards basic nurse education, loan repayments, and scholarships. The Agency will increase resources available to respond to national emergencies through the National Health Service Corps. HRSA will also maintain a significant investment in preparing our nation's hospitals and health professions workforce for a bioterrorism event. The Agency will expand support for medications for people living with HIV/AIDS. The budget also supports rural health policy development and State-level infrastructure, to help meet the unique challenges facing rural America, maternal and child health programs, and important transplantation programs.

Expanding Access to Health Care For Medically Underserved Americans

In 2002, the President launched an initiative to expand access to health care by creating 1,200 new or expanded health center sites and serving an additional 6.1 million people by 2006. Since FY 2001, the Health Center program has significantly impacted over 600 communities, serving over 13 million patients – 3 million more than in FY 2001 – 40 percent of whom have no insurance coverage, and many others who have inadequate coverage.

In FY 2005, the budget includes $1.8 billion, an increase of $219 million from FY 2004, resulting in services for an additional 1.6 million individuals in approximately 330 new and expanded sites. At this level, a total of 15 million uninsured and underserved individuals will receive comprehensive preventive and primary care services at over 3,800 health center sites across the country – nearly 7 million in rural areas.

Health centers employ approximately 5,400 physicians and dentists, and 17,000 other health care clinicians – 13 percent more physicians and dentists than in FY 2001, and 20 percent more clinicians. The budget request includes $45 million in no year funding for the Health Centers Federal Tort Claims Program, which provides medical malpractice coverage for the increasing number of health center employees. The budget also provides $5 million in no year funding to maintain support for medical malpractice coverage for volunteer providers in free clinics.

In addition, the FY 2005 budget proposes to reshape the Healthy Communities Access Program (HCAP) to support efficient Health Center networks and successful chronic disease management activities. The reshaped HCAP program, funded at $10 million, will support networks of health centers that increase centers' ability to maximize efficiency, resources, and quality while minimizing costs and duplication of effort. By placing the focus on health centers, resources will better serve patients living with chronic diseases through interdisciplinary teams implementing patient-centered practice models.

Developing A Health Professions Workforce for the 21st Century

Expanding access to health care requires ensuring an adequate supply of nurses. The Nation currently faces a nursing shortage of approximately 168,000 nurses. As the population continues

to grow and age, and medical services advance, the need for nurses will continue to increase. The budget requests $147 million for nursing education programs, an overall increase of $5 million. Since FY 2001, funding for nursing education programs has increased by 75 percent.

In FY 2005, the budget increases support for basic nurse education and retention by $10 million, for a total of $42 million. An additional $32 million, a $5 million increase, is requested to support over 1,000 loan repayments and scholarships that will reduce the financial barrier to nursing education for all levels of professional nursing students. The budget also includes $21 million for diversity, $44 million for advanced nursing education, and maintains an $8 million investment in loans for nurse faculty and support for comprehensive geriatric education. These programs will support the recruitment, education, and retention of 24,000 nurses and nursing students.

Geographic maldistribution of health professionals also remains a major problem for many inner city and isolated rural communities. Over the National Health Service Corps' (NHSC) 30 year history, more than 24,500 health professionals have committed to service in underserved areas across the country. Through a targeted management reform initiative, which began in FY 2002, the NHSC is now better able to assist the neediest communities. The ratio of loan repayments compared to scholarships has increased by over 30 percent, enabling the NHSC to immediately place more health professionals into service in needy communities – increasing the current field strength to more than 4,200 clinicians. The NHSC will continue to work with the Health Center program to help meet its provider needs. Currently, half of NHSC clinicians serve in health centers. The FY 2005 budget continues the expansion of the NHSC with an increase of $35 million, for a total of $205 million. Within this increased funding, $25 million will be directed to a specific new effort to recruit nurses and physicians to serve in health professional shortage areas. As a condition of receiving this assistance, these individuals will incur a service obligation in underserved areas similar to other NHSC scholarship and loan repayment recipients, and will be employees of community facilities. These health care providers will also have a long term reserve commitment to the Public Health Service Commissioned Corps.

To ensure a continuing source of scholarships focused on increasing diversity in the health professions workforce, the FY 2005 budget proposes a $10 million investment in the Scholarships for Disadvantaged Students program. The budget continues the policy of not funding more general training efforts – primary care, interdisciplinary community projects, training for diversity, and public health.

The budget maintains a $303 million investment in health professions training in free-standing children's hospitals, the same as FY 2004. The Program Assessment Rating Tool (PART) assessment found the Children's Hospitals Graduate Medical Education program has a clear purpose and since the program was initiated the percentage of children's hospitals with negative margins has declined.

Preparing America's Health Care System and Providers for Bioterrorism

The mission of the Hospital Preparedness program is to ready hospitals and supporting health care systems – primary care facilities, EMS systems, poison control centers – to deliver

coordinated and effective care to victims of terrorism and other public health emergencies. A recent PART review found that this program has a clear and important purpose and that it is well coordinated with other Federal preparedness efforts.

Between FY 2002 and FY 2004, a total of $1.2 billion has been made available for these efforts in States, Territories, and certain municipalities. By the end of FY 2003, every awardee had staffed a hospital preparedness office and advisory committee, completed a needs assessment, and developed a plan of action in response to the identified needs. Approximately 60 percent of awardees had developed regional hospital plans to address surge capacity and manage a potential epidemic involving at least 500 patients. Awardees are also using funds to conduct disaster drills; enhance communication systems; make infrastructure improvements and expansions so that hospitals have adequate laboratory capacity and improve capabilities to control infection.

The FY 2005 budget requests $476 million to continue progress towards the goal of 100 percent of States having surge capacity plans. Specific areas of emphasis will include surge bed capacity, clinical personnel augmentation, isolation capacity, and hospital-based pharmaceutical caches. HHS is developing a plan to review the funding allocation and will consider whether the current formula could be improved by including indicators such as level of risk, level of preparedness, or measures related to performance.

Our health professions workforce must be prepared to recognize indications of a terrorist event in their patients. The Bioterrorism Training and Curriculum Development program, first initiated in FY 2003, supports 19 cooperative agreements to deliver continuing education to a diverse health care workforce and 12 cooperative agreements to facilitate the training and preparation of current medical, nursing, allied health, and other health professions students. The FY 2005 budget includes $28 million for this activity.

Ensuring Access to Services for People Living with HIV/AIDS

The FY 2005 budget requests $2.1 billion for the Ryan White HIV/AIDS program, a net increase of $35 million over FY 2004. The Ryan White Care Act program provides services to approximately 530,000 individuals each year with little or no insurance. These services include medical care, access to lifesaving pharmaceuticals, dental care, outpatient mental health services, outpatient substance abuse treatment, and home health care.

Within the total FY 2005 request, the budget provides $784 million, an increase of $35 million, for the AIDS Drug Assistance Program to support the purchase of medications for persons living with HIV/AIDS. At this level, monthly utilization of ADAP will increase from approximately 93,800 clients in FY 2004 to approximately 100,000 clients in FY 2005.

HHS continues its commitment to enhance and improve the delivery of health care by Ryan White CARE Act programs to persons living with HIV/AIDS. HRSA is working closely with grantees to fully implement management and improvement programs to enhance the quality of care and services provided to persons living with HIV/AIDS.
HRSA assists international AIDS efforts in the areas of human capacity and antiretroviral program development in foreign countries significantly impacted by the virus. In FY 2005,

HRSA, through a partnership with CDC and USAID, will continue to support the International Mother and Child HIV Prevention Initiative and the President's Emergency Plan for AIDS Relief.

Providing Health Care in Rural Communities

Rural residents tend to have more difficulty accessing health care and poorer health outcomes than their urban counterparts. The rural provisions of the recently enacted Medicare Prescription Drug and Modernization bill will substantially increase the resources available to rural communities – $9 billion over the next 5 years. In addition, nearly 7 of the 15 million patients served by health centers in FY 2005 will be from rural communities. The FY 2005 budget also requests $52 million for targeted rural health programs, including $22 million for the Denali Commission.

As noted in the PART review, independent evaluations indicate that these rural health programs are effective and achieve results. However, PART also found that a less fragmented and more seamless Federal effort could help maximize access, generate effectiveness, yield cost efficiencies, and reduce the number of specific and geographically targeted projects funded each year.

In FY 2005, the budget targets select activities. A total of $17 million is requested for State Offices of Rural Health that monitor and direct State-level strategy for rural health care, and for Federal policy research studies and rural health information dissemination. An additional $13 million is requested for Rural Health Outreach and Network Development grants, which enable community partnerships to implement creative strategies to meet their unique health needs, and for grants to purchase life-saving emergency devices.

Improving Maternal and Child Health

The Department continues to work towards improved health outcomes for all American women and children. The budget requests $730 million for the Maternal and Child Health (MCH) Block Grant, the same as FY 2004. The Block Grant supports Federal and State partnerships that provide critical services to 27 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, lead poisoning, and injury prevention. The budget also includes $98 million for the Healthy Start program, which supports community-driven programs in targeted high risk communities to reduce the incidence of risk factors that contribute to infant mortality.
The budget maintains a $278 million investment in the Family Planning program. The program supports a network of more than 4,600 clinics nationwide that provide access to a wide array of reproductive health care and preventive services to nearly 5 million people. Counseling and education regarding abstinence are required for all adolescent clients through this program.

The budget also includes $53 million to maintain three important emergency services programs: Emergency Medical Services for Children, $20 million; Poison Control Centers, $24 million; and

Traumatic Brain Injury, $9 million. The EMS for Children program will award 51 grants to States and Territories to improve care for the 31 million children and adolescents who are seen in emergency departments each year, and 37 additional grants to medical schools to develop and evaluate improved procedures and protocols for treating children. The Poison Control Center program will award 80 stabilization and enhancement grants to Centers, which provide expert advice to the public 24 hours a day regarding exposure to poisons, and will maintain a national toll-free number. The Traumatic Brain Injury program facilitates State-wide needs assessments and implement action plans, thereby ensuring comprehensive and coordinated services.

Supporting Transplantation

Each day approximately 68 people in the United States receive a life-saving organ transplant, but another 17 people die because the demand for transplantable organs far exceeds the available supply. The FY 2005 budget includes $25 million to maintain support for the Organ Transplantation program, which funds the network that manages the distribution of organs throughout the United States and the national registry of transplant recipients that assists in organ allocation. The program will also award 25 grants to evaluate strategies for increasing the consent to donate and to refine methods for identifying those patients with the greatest medical need for transplantation.

Each year approximately 38,000 Americans under 55 years old are diagnosed with leukemia and other blood and genetic diseases, and about 16,000 of them cannot be successfully treated with therapy other than a blood stem cell transplant. Blood stem cells can be obtained from the bone marrow or circulating blood of volunteer adult donors or collected from the newest source – umbilical cord and placenta after a normal birth. The FY 2005 budget requests $23 million to maintain the National Bone Marrow Donor Registry, which enables patients to search for a suitable, unrelated bone marrow donor. The budget also includes $10 million to maintain the newly funded Cord Blood Stem Cell Bank. This level of funding, along with the FY 2004 funds, would increase the national inventory of cord blood stem cells by approximately 25 percent.

Other HRSA Programs

The budget proposes $30 million for the remaining HRSA programs including Telehealth, Hansen's Disease, Black Lung, and Radiation Exposure Compensation, maintaining FY 2004 levels.

Program Management

The budget requests $158 million for HRSA's program management, an increase of $3 million over the FY 2004 level. Resources requested will enable HRSA to manage and operate a wide array of Federal programs as well as to fund Federal pay cost increases.

Indian Health Service

	2003	2004	2005	2005 +/- 2004
Indian Health Service:				
Clinical Services	$2,560	$2,618	$2,693	+$75
Contract Health Services (Non-Add)	*475*	*479*	*497*	*+18*
Preventive Health	103	107	112	+5
Contract Support Costs	269	267	267	0
Tribal Management/Self-Governance	8	8	8	0
Urban Health	31	32	33	+1
Indian Health Professions	31	31	31	0
Direct Operations	60	61	62	+1
Diabetes Grants	100	150	150	0
Subtotal, Services Program Level	$3,162	$3,274	$3,356	+$82
Indian Health Facilities:				
Health Care Facilities Construction	$82	$94	$42	-$52
Sanitation Construction	93	93	103	+10
Facilities & Environmental Health Support	132	138	143	+5
Maintenance & Improvement	56	55	55	0
Medical Equipment	17	17	17	0
Subtotal, Facilities Program Level	$380	$397	$360	-$37
Total, Program Level	**$3,542**	**$3,671**	**$3,716**	**+$45**
Less Funds Allocated From Other Sources:				
Health Insurance Collections	$586	$593	$593	$0
Rental of Staff Quarters	6	6	6	0
Diabetes Grants	100	150	150	0
Total, Budget Authority	**$2,850**	**$2,922**	**$2,967**	**+$45**
FTE	15,020	16,145	16,251	+106

The IHS FY 2005 budget request is $3.7 billion, a net increase of $45 million over FY 2004. Additional funds are requested primarily for the provision of safe water and sewage disposal for Indian communities and to purchase additional health care from non–IHS hospitals and health providers. The IHS anticipates receiving $593 million in health insurance reimbursements in FY 2005, primarily from Medicare and Medicaid.

Agency Description

The IHS is the primary source of medical care for the 1.6 million American Indians and Alaska Natives who are members of more than 560 Federally recognized tribes. Care is provided through a network of 49 hospitals and over 500 outpatient clinics and smaller facilities located primarily in the Southwest, Oklahoma, the Northern Plains and Alaska. Tribes currently operate 15 of the hospitals and three–quarters of the clinics and smaller facilities under self–determination contracts with the Agency. The IHS also purchases medical care for Indian people from non–IHS hospitals and health providers and funds 34 urban Indian health organizations. In addition to providing medical treatment, IHS carries out substantial prevention and wellness activities including diabetes prevention and disease management, sanitation construction to provide water and waste disposal for Indian communities, injury prevention, mental health services, and alcohol/substance abuse treatment and prevention.

Access to Health Care

The population IHS serves increases annually at approximately 2 percent. Like any health care provider, IHS also experiences increases in the cost of providing care.
Contract Health Services: The budget includes $497 million, an increase of $18 million over FY 2004, to purchase health care from non–IHS hospitals and health providers. This funding increase, combined with the additional purchasing power provided in the recently enacted Medicare Prescription Drug, Improvement, and Modernization Act, will allow the purchase of an estimated 35,000 additional outpatient visits or 3,000 additional days of inpatient care. Section 506 requires hospitals that participate in Medicare to provide inpatient treatment services to IHS at rates determined by the Secretary. Contract Health Service funds purchase specialty care, including most types of surgery, and are used to purchase all medical care for Tribes that do not have an IHS facility nearby.

Opening New Health Facilities: An additional $23 million is included to add staff at five outpatient facilities scheduled to open during FY 2005. Tribes financed construction of three of these facilities saving IHS $37 million in construction costs. When fully operational, these facilities will double the number of primary care provider visits that can be provided at these sites and also provide new services.

Health Facility Construction: The budget includes $42 million to complete construction of two outpatient facilities, serving the Navajo Nation at Red Mesa, Arizona and the Sisseton–Wahpeton Sioux Tribe at Sisseton, South Dakota, and provide necessary staff housing for the health facilities at Zuni, New Mexico and Wagner, South Dakota. When completed, the outpatient facilities will provide an additional 36,000 primary care provider visits, replace the Sisseton hospital, which was built in 1936, and bring 24 hour emergency care to the Red Mesa area for the first time. IHS will add thirteen units of staff quarters and replace 16 house trailers built during the 1950s and 1960s and excessed to Zuni. Having decent local housing available will make it easier to recruit and retain health professionals at these sites.

Urban Indian Health Program: In addition to providing health care to Indian people on or near reservations, IHS also provides over $30 million annually to thirty–four urban Indian health organizations providing services in cities with large numbers of Indian people. These organizations provide primary medical services, basic preventive health services, outreach and

referral services and alcohol and drug treatment. IHS funds account for about half of all funds available to these organizations, major non–IHS funders are Medicaid, other Federal programs, and State and local governments. A Program Assessment Rating Tool (PART) review of the Urban Program found it has demonstrated progress on its long–term goals as well as improved efficiencies and cost effectiveness.

Pay Costs: The budget includes an additional $36 million to cover increased pay costs for Federal and Tribal employees who operate health facilities, and carry out prevention and wellness programs.

Health Insurance Reimbursements: IHS facilities receive Medicare and Medicaid under a cost–based methodology developed in close cooperation with the Centers for Medicare & Medicaid Services. IHS expects to receive a total of $593 million from health insurance in FY 2005, primarily from Medicare and Medicaid, but including nearly $50 million in third party employer provided health insurance.

Preventive Health Improvements

IHS has long recognized that preventing disease and promoting wellness are often the most cost effective ways to raise the health status of Indian people to the highest level. Substantial funds are devoted to these activities in order to reduce the need for expensive medical treatment. The budget request continues these investments in the areas of diabetes, additional sanitation construction and several smaller activities.

Diabetes: Through the Special Diabetes Program for Indians grant program, IHS provides funds to over 300 tribes and Indian organizations. In FY 2005, IHS will award $150 million. Over the past four years, $500 million has been provided to support diabetes prevention and disease management activities at the local level. The program has substantially increased the availability of services including basic clinical exams, newer treatment medications and therapies, laboratory tests to assess diabetes control and complications, screening for diabetes and pre–diabetes in a variety of locations, nutrition education, and physical fitness activities. These services have led to a steady increase in the percent of diabetic patients with Ideal blood sugar control. Starting in FY 2004, the program will include a new competitive grant activity to identify successful examples of preventing the onset of type II diabetes or of cardiovascular disease among diabetics.

Sanitation Construction: The budget includes $103 million for sanitation construction – an increase of 11 percent or $10 million over FY 2004 – to provide safe water and waste disposal systems to an estimated 22,000 homes. The sanitation program has played a key role in decreasing the rates of infant mortality, gastroenteritis, and other environmentally related diseases over the last thirty years. A recent review of the program found that it demonstrated increased long–term cost efficiencies and that it was optimally designed.

Additional Preventive Health Investments: The budget requests $7 million for three specific investments which will strengthen the ability of IHS to prevent disease and promote wellness. An additional $2 million is requested to expand the Director's Health Promotion and Disease

Prevention Initiative. Effective low cost health interventions can be designed and implemented by people with knowledge of their local communities. Funds will support implementation of 50 local community interventions, best practice dissemination, and training for community members. The request also adds $3 million for epidemiol-ogy centers. The seven existing epidemiology centers provide information for about half of the population IHS serves, but do not cover the Navajo, Oklahoma, Billings, or California areas. Additional funds will add three or four new centers and increase support for the seven existing centers.

Some 50,000 Alaska Natives live in communities with no access to IHS hospitals or outpatient facilities except by air travel. Community Health Aides/Practitioners (CHA/Ps) are the only local source of health care in many of these communities and are critical to reducing the high transportation costs of bringing people to treatment. An additional $2 million will add 30 CHA/Ps for a total of 516.

Information Technology: The budget includes $69 million for information technology, an increase of $4.5 million compared to FY 2004. A PART review of IHS's major information system – the Resource and Patient Management System (RPMS) – found that RPMS compared favorably with similar Federal information systems and consistently scores well on information system reviews.

Supporting Indian Self-Determination

Tribes continue to increase the number of IHS programs they operate, both in dollar terms and as a percentage of the Agency's budget. In FY 2005, Tribes will control an estimated $1.8 billion, or 56 percent of IHS's total budget request.
To bring Indian issues to the attention of all parts of the Department, the Secretary has reactivated the Intradepartmental Council on Native American Affairs. To better understand the conditions in Indian country, the Secretary or Deputy Secretary has visited Tribal Leaders and Indian reservations in all twelve IHS areas, accompanied by senior HHS staff.

Centers for Disease Control and Prevention

	2003	2004	2005	2005 +/- 2004
Chronic Disease Prevention & Health Promotion:				
Steps To A Healthier US Initiative	$15	$44	$125	+$81
Youth Media Campaign	51	36	5	-31
Breast and Cervical Cancer	199	210	220	+10
Diabetes, Obesity, and Other Programs	525	564	566	+2
Subtotal, Chronic	$790	$853	$915	+$62
Environmental Health	183	183	184	+1
Health Statistics	126	128	150	+22
Immunization				
Current Law:				
Section 317 Discretionary Program	643	643	644	+1
Vaccines For Children Mandatory Program	1,174	1,208	1,208	0
Vaccines stockpile (non-add)	*168*	*204*	*230*	*+26*
Effect of Proposed Law Changes:				
VFC	0	0	165	+165
Section 317	0	0	-110	-110
Proposed Law Subtotal, Immunization	$1,818	$1,851	$1,907	+$56
HIV/AIDS, STDs & TB Prevention	1,147	1,141	1,143	+2
Epidemic Services & Response	77	92	92	0
Global Disease Detection (non-add)	*0*	*15*	*15*	*0*
Infectious Disease Control	359	369	401	+31
Global Disease Detection (non-add)	*0*	*9*	*36*	*+27*
Subtotal, Global Disease Detection (non-add)	*0*	*24*	*51*	+27
Bioterrorism (other than facilities)				
State and Local Capacity	939	934	829	-105
CDC Capacity/Research	177	175	150	-25
Supplemental in FY 03--smallpox administration	100	0	0	0
Biosurveillance Initiative	0	0	130	+130
Subtotal, Bioterrorism	$1,216	$1,110	$1,110	$0
Preventive Health Block Grant	134	133	133	0
Injury Prevention & Control	148	154	154	0
Birth Defects, Disability & Health	98	113	113	0
Public Health Improvement Program Level	153	172	113	-59
Occupational Safety & Health	273	277	279	+2
Office of the Director	49	59	60	+1
Buildings & Facilities	286	260	81	-179
ATSDR	82	73	77	+4
User Fees	2	2	2	0
Subtotal, Program Level (current law)	**$6,942**	**$6,972**	**$6,859**	**-$113**
Subtotal, Program Level (proposed law)	**$6,942**	**$6,972**	**$6,914**	**-$58**
Less Funds Allocated from Other Sources:				
Vaccines for Children Current Law (mandatory)	$1,174	$1,208	$1,208	$0
Proposed Law Changes	0	0	165	165

Public Health and Social Service Emergency Fund	1,216	1,110	1,110	0
PHS Evaluation	210	212	249	+37
User Fees	2	2	2	0
Total, Current Law Budget Authority	**$4,340**	**$4,440**	**$4,290**	**-$150**
Total, Proposed Law Budget Authority	**$4,340**	**$4,440**	**$4,180**	**-$260**
FTE	8,715	8,569	8,569	0

The FY 2005 budget requests a total program level of $6.9 billion for the Centers for Disease Control and Prevention (CDC), a net decrease of $58 million below FY 2004. This net change includes $341 million in expansions of on-going programs such as Steps To A Healthier US and the National Breast and Cervical Cancer Early Detection Program; new detection initiatives for bioterrorism and naturally occurring infectious diseases; improvements in childhood immunizations; and a major reinvestment in the health statistics needed for decision-making in both government and the private sector. The increases are partially offset by the completion of some new facilities, earmarked projects, and retargeting of funds in some areas. The FY 2005 budget for CDC also includes $1.4 billion in mandatory immunization funding and $249 million in Public Health Service evaluation transfer funds.

Chronic Disease Prevention and Health Promotion

More than 1.7 million Americans die of chronic diseases - such as heart disease, cancer, and diabetes - each year, accounting for 79 percent of all U.S. deaths. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. The budget includes $915 million for Chronic Disease Prevention and Health Promotion, a net increase of $62 million over FY 2004.

Steps To A Healthier US Initiative: The FY 2005 Budget includes $125 million, an increase of $81 million for the Steps To A Healthier US Initiative. Of this request $115 million, (including $71 million of the increase) will be used to expand the State and community grant program initiated this past September to reduce the prevalence of diabetes, obesity, and asthma-related complications through prevention initiatives. Existing grantees will receive funding to carry out the plans they are preparing to implement, and new projects will be started in additional States, cities, and tribes. The initial 12 grants reach 23 communities including seven large cities, one Tribal consortium, and four State-based grants that cover 15 smaller cities and rural areas. These funds will help implement community-based programs targeting those at high risk for diabetes, obesity, and asthma. Philadelphia plans to expand supervised physical activity programs aimed at students with chronic diseases at schools. In Michigan, a consortium of American Indian Tribes will implement a program that seeks to encourage the consumption of highly nutritious traditional foods and pass on wisdom and cultural practices about them. New Orleans will develop neighborhood walking and bicycling plans to build a more "walkable and bikeable city. A total of $10 million will be used to expand the Diabetes Detection Initiative, which targets at-risk populations to identify undiagnosed diabetes. The aim of this initiative is to reach these populations where they live, work, and play through a customized, tailored approach with the aim of identifying undiagnosed diabetes. The program design promotes the self-identification of risk status, follow up to a health provider to assess the need for a diagnostic test, and the administration of appropriate diagnostic tests, if indicated.

National Breast and Cervical Cancer Early Detection Program: CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has helped to increase mammography use by women aged 50 and older by 20 percent since the program's inception in 1991. NBCCEDP targets low-income women with little or no health insurance and has helped to reduce disparities in screening for women from racial and ethnic minorities. CDC will increase support to States in order to conduct outreach and pay for additional breast and cervical cancer screens for underserved women. The budget for NBCCEDP is $220 million for FY 2005, an increase of $10 million. With the requested increase, CDC projects providing an additional 32,000 diagnostic and screening services to women who are hard-to-reach, have rarely, or have never been screened for these cancers.

Youth Media Campaign: The budget requests $5 million for the VERB It's What You Do Youth Media Campaign targeted to increase and maintain regular physical activity among tweens (youth ages 9-13) through paid media, partnerships, and community efforts. These funds will enable CDC to maintain a library of proven media messages for distribution as public service announcements.

Environmental Health

The budget contains $184 million to maintain ongoing environmental disease prevention programs. The National Center for Environmental Health (NCEH) assists State and local health agencies in developing and increasing their ability and capacity to address environmental health problems, especially asthma and childhood lead poisoning. Additionally NCEH provides complete, timely, and accessible data on environmentally related diseases and conditions, including asthma, childhood lead poisoning and genetic diseases; improves the understanding of risk factors for, and causes of, environmentally related diseases and conditions; and develops effective prevention programs. The CDC's state of the art environmental laboratories use modern technology to assess human exposure to environmental chemicals, and its effects.

Health Statistics

The budget requests $150 million for Health Statistics, an increase of $22 million over FY 2004. This investment reflects the importance of the data systems of the National Center for Health Statistics (NCHS) to track our progress and inform solutions on a myriad of problems in the public and private health sector. This increase will position the surveys of NCHS to meet new challenges. This new investment will preserve and modernize the Nation's vital statistics system. CDC will expand contracts with States to purchase birth and death data and move forward with e-government initiatives to update the content of birth and death records. The increase will also provide the robust sample sizes necessary for the National Health and Nutrition Examination Survey (NHANES) and the National Health Interview Survey (NHIS) to provide needed information on a wide range of conditions, diseases, and population subgroups. Additionally funds will address major emerging data gaps in the National Health Care Survey, such as long-term care and assisted living facilities.

Immunization

A significant health goal of the Nation is to ensure that at least 90 percent of all two-year olds receive the full series of vaccines. The budget request of $1.9 billion includes two streams of funding to improve immunization rates. The mandatory Vaccines for Children (VFC) program provides free vaccine to Medicaid recipients, the uninsured, American Indians and Alaskan Natives, and children with limited health coverage that does not cover specific immunizations. The discretionary Section 317 program provides funds for State immunization operational costs and many of the vaccines provided in public health clinics.

The budget includes three important immunization initiatives. First, under current law, CDC will continue to build a six-month, vendor-managed stockpile of all routinely recommended childhood vaccines. In FY 2003, CDC invested $168 million in the VFC program to begin building these stockpiles of varicella, Hepatitis A and B, pneumococcal conjugate (PCV), and (Hib) vaccines. Between FY 2004 and FY 2006, CDC plans to invest an additional $583 million to meet the target quantities for a six-month stockpile. The stockpile serves dual purposes. Vaccines from the stockpile can be distributed in the event of a disease outbreak. The stockpile will also mitigate the effect of any supply disruptions that might occur on the manufacturing side. Second, with $40 million in each of fiscal years 2004 and 2005, CDC will, for the first time, create a stockpile of children's influenza vaccine under the VFC program. The flu season of 2003-2004 was a reminder of the need for rapid access to vaccines. This stockpile would provide a vendor-managed supply of between 4 to 6 million doses of vaccine, enough to provide the high-risk population of children aged 6–23 months with the two doses each would need. The flu vaccine stockpile could also be made available for older children as needed.

Finally, in FY 2005 legislation will be proposed to improve access to VFC vaccines for children already entitled to them, through two changes. First, the proposed legislation will expand the number of access points for children whose private insurance does not cover immunizations by allowing them to receive their VFC vaccines at State and local public health clinics. Currently, these children must go to specially designated Federally Qualified Health Centers to receive VFC vaccines – even if they visit a different public health clinic for all of their other medical needs. The second change proposed in this VFC legislation will restore tetanus and diphtheria vaccines to the VFC program. The VFC statute, as enacted in 1993, caps prices for the three vaccines that were in use prior to enactment of the legislation. The price caps are so low, however, that the tetanus booster vaccine was removed from the VFC program in 1998 when no vendor would bid on the contract. With these legislative changes, an additional $165 million will be added annually to the VFC budget to cover the additional vaccines that will be provided under this program. These changes will reduce by $110 million the demand for Vaccines financed through the Discretionary 317 Immunization Program.

The immunization budget will continue to provide $151 million for global immunization activities, including polio eradication. While tremendous progress has been made with the number of polio-endemic countries declining from 120 in 1988 to seven in 2003, a major international effort continues to strive for the goal set by the World Health Organization: global polio eradication by 2005.

HIV/AIDS, Sexually Transmitted Diseases, and Tuberculosis: HIV/AIDS, sexually transmitted diseases (STDs) and tuberculosis (TB) are among the most prevalent, costly and preventable

infectious diseases in the United States. The request for HIV, STD, and TB Prevention budget activity is $1,143 million.

Global AIDS Program (GAP): Through the Global AIDS Program (GAP), CDC works in partnership with USAID, HRSA, the Department of State and other federal agencies, and multilateral and bilateral partners to ameliorate the devastation caused by HIV/AIDS. The budget requests a total of $143 million in CDC for on-going prevention care, treatment, surveillance, and capacity-building programs in 25 countries in Asia, Africa, Latin America, and the Caribbean.

The expertise and infrastructure established in GAP are being utilized to support the President's Emergency Plan for AIDS Relief (PEPFAR) announced in the State of the Union address in January 2003. The Emergency Plan, authorized by Congress, incorporates the President's International Mother to Child HIV Prevention Initiative. Fourteen of the Global AIDS Program countries are part of the President's International Mother to Child HIV Prevention Initiative, jointly implemented with USAID and other Federal Agencies. For greater government-wide integration under the direction of the Global AIDS Coordinator, the FY 2005 President's Budget will present Mother to Child Prevention Initiative Activities in the Department of State. Although there has been a shift in the placement of funding, CDC will continue to be a major implementing agency for this vital initiative.

Domestic HIV/AIDS Prevention: The budget requests a total of $790 million for CDC's Domestic HIV/AIDS Prevention and Research activities, of which $696 million is in the National Center for HIV, STD, and TB Prevention (NCHSTP) and $94 million is in the National Center for Infectious Diseases (NCID) and the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). CDC's HIV prevention activities over the past two decades have focused on helping uninfected persons at high risk for HIV change and maintain behaviors to keep them uninfected. Despite these efforts, the number of new HIV infections is estimated to have remained stable, and the number of people living with HIV continues to increase. Therefore, the CDC has launched a new prevention initiative, Advancing HIV Prevention: New Strategies for a Changing Epidemic (AHP). AHP is aimed at reducing barriers to the early diagnosis of HIV infection, and if positive, increasing access to quality medical care, treatment, and ongoing prevention services. AHP emphasizes the use of proven public health approaches to reduce the incidence and spread of diseases, as well as capitalizing on new rapid test technologies, interventions that bring persons unaware of their HIV status to HIV testing, and behavioral interventions that provide prevention skills to people living with HIV. This new intervention will help CDC and its partners to target funds more efficiently and directly to those people greatest in need.

Epidemic Services and Response/Infectious Diseases

Although modern advances have conquered some diseases, the outbreaks of severe acute respiratory syndrome (SARS) and West Nile Virus are recent reminders of the extraordinary ability of microbes to adapt and evolve. In response to these events, CDC has developed a new Global Disease Detection Initiative within its Epidemic Services and Response and Infectious Disease Control Programs. The overall FY 2005 budget request for Epidemic Services and

Response includes $92 million to coordinate public health surveillance at CDC and provide support to the "disease detectives" that determine the cause of outbreaks and develop the countermeasures that stem the spread of illness. The Infectious Disease Control request is $401 million, an increase of $31 million over FY 2004. The increases in Infectious Disease Control target $2 million for State and local health departments for surveillance, response, and research for West Nile Virus activities. An additional $27 million increase is for the new global disease detection initiative in coordination with existing programs in Epidemic Services and Response. This new initiative's total funding for FY 2005 is $51 million and it will implement a comprehensive system of surveillance by expanding CDC programs in five countries (Kenya, China, Brazil, Kazakhstan, and Thailand) and creating new sites in six countries (Uganda, Zimbabwe, Botswana, Ghana, Cote d'Ivoire, and Guatemala). Additionally, the Global Disease Detection Initiative will improve early warning systems, research new viral strains, and aid in collaborations with multinational organizations. The goals of this initiative are to recognize infectious disease outbreaks faster, improve the ability to control and prevent outbreaks, and to detect emerging microbial threats.

Bioterrorism

The President's Budget includes $1.1 billion for bioterrorism preparedness, the same level as FY 2004. Within this amount, funds will be redirected to carry out a new interagency biosurveillance initiative to prepare against a potential bioterrorist attack. CDC, in coordination with FDA, the Department of Homeland Security and the Department of Agriculture, will be working to improve the response to bioterrorism through early detection. CDC's budget includes $130 million in FY 2005 for its role in this initiative, the largest component of which is an investment of $100 million in its human health surveillance project, "BioSense" BioSense is an advanced approach to infectious disease surveillance that, unlike traditional approaches, does not rely upon mandatory or voluntary case reports from healthcare providers to public health officials, but uses automated analysis techniques on electronically available health data to highlight a potential public health problem. This will be integrated into a unified system. In addition to developing better surveillance capacity, CDC will invest an additional $20 million to improve laboratory reporting capacity and to advance integration between public health and commercial laboratories. The remaining $10 million will increase the number of border health and quarantine stations from 8 to up to 25.

CDC's commitment to State and local preparedness remains strong; between FY 2002 and FY 2004, CDC invested a total of $2.9 billion in this activity. This year, CDC has budgeted another $829 million. In FY 2005, HHS will be re-targeting preparedness resources, making modest reductions in awards to States, and concentrating efforts in more directed investments that will benefit States and communities as well as the Nation as a whole. A specific example is the biosurveillance initiative. CDC will be entering into contracts directly with health departments and health systems to build a more complete network of health information, which will assist in earlier threat detection. It will provide public health officials with a sense for the health status of their community and support them in providing early and effective public health response.

Investments in States have markedly improved capacity: the Laboratory Response Network (LRN) now consists of 109 reference laboratories distributed throughout all 50 States. There are

also 59 Biosafety level 3 (BSL-3) laboratories located in 50 States -- nearly three times the number reported in 1999. Fifty members (46 percent) of the LRN are now able to rule out the existence of smallpox, and 24 (22 percent) laboratories can test for the existence of the smallpox virus on a real-time basis.

In addition to assistance to States and communities, CDC will invest $150 million to continue to upgrade its internal capacities by improving epidemiological expertise in the identification and control of diseases caused by terrorism, including better electronic communication, distance learning programs, and cooperative training between public health agencies and local hospitals. Investments in CDC's Health Alert Network now mean that 89 percent of all health departments across the country receive instant electronic messages about emerging health threats and public health emergencies. Additionally, in 2002 and 2003, CDC produced and delivered 35 smallpox education and training programs. CDC currently estimates reaching approximately 1.3 million health professionals through a multimedia approach to smallpox training. CDC will continue to fund the 22 university-based Centers for Public Health Preparedness (CPHP) to ensure that frontline public health workers have the competencies to respond to emerging health threats.

Working in collaboration with the U.S. Department of Agriculture (USDA), CDC implemented the notification of possession of select agents and published an interim final rule in the Federal Register on December 13, 2002 for facilities that possess, use, or transfer agents or toxins deemed a threat to public health and to animal or plant products. CDC has a goal to inspect 300 laboratories in accordance with the rule in 2004.

Preventive Health and Health Services Block Grant

Since 1981 the Preventive Health and Health Services Block Grant has provided its 61 grantees (States, Tribes, and territories) with funds to tailor prevention and health promotion programs to address their particular needs. The budget for FY 2005 is $133 million. States use these funds to carry out a variety of activities including: helping rural health departments to eliminate food and water contamination, supporting childhood lead poisoning testing, and providing statewide public health education.

Injury Prevention and Control

Injuries are the primary killer of children and young adults in the United States. Injury is a fundamental threat to human health and life, and CDC employs the same scientific methods that prevent infectious diseases to prevent injuries - defining the health problem, identifying the risk and protective factors, and developing and testing prevention strategies. The budget for FY 2005 includes $154 million to support programs focused on residential fire deaths, intimate partner violence, non-fatal fall traumatic brain injury, child abuse and neglect, rape prevention and education, and other injury prevention and control initiatives.

Birth Defects, Developmental Disabilities, Disabilities and Health

Birth defects are the leading cause of infant mortality in the United States. Additionally, the direct and indirect costs associated with disabilities in the United States exceeds $300 billion

annually. CDC's National Center for Birth Defects, and Developmental Disabilities works to identify the cause of birth defects and developmental disabilities, to help children develop and reach their full potential, and to promote the health and well-being among people of all ages with disabilities. The budget for FY 2005 includes $113 million for these activities. This funding will be used for many disability programs including those related to Fetal Alcohol Syndrome, Autism, Attention-Deficit/ Hyperactivity Disorder (ADHD), Duchenne and Becker Muscular Dystrophy, Disability and Health, monitoring development disabilities, limb loss, and spina bifida.

Public Health Improvement

The budget for FY 2005 requests a total of $113 million. The $59 million reduction from FY 2004 reflects one-time Congressional projects that are not being continued in 2005 and funding for research activities at $16 million. Funding is maintained for REACH 2010 (Racial and Ethnic Approaches to Community Health) which is intended to help racial and ethnic minority communities mobilize and organize their resources to support effective and sustainable programs that will contribute to the elimination of health disparities. The National Electronic Disease Surveillance System (NEDSS) is also included in the Public Health Improvement Line.

Occupational Safety and Health

The estimated annual cost of occupational injuries in the United States is more than $240 billion. The National Institute of Occupational Safety and Health (NIOSH) is the primary federal entity responsible for conducting research and making recommendations for the prevention of work-related illness and injury. NIOSH translates knowledge gained from research into products and services that benefit workers safety and health in settings from corporate offices to construction sites and coal mines. The budget for FY 2005 includes $279 million for NIOSH activities including work on the National Occupational Research Agenda (NORA); and personal protective technology and respirator research for the nation's 50 million miners, firefighters, emergency responders, and health care, agricultural, and industrial workers. In addition to its ongoing activities, NIOSH assists in the implementation of the Energy Employees Occupational Illness Compensation Act of 2000; funds for this activity are provided by the Department of Labor.

Office of the Director

The budget for the Office of the Director (OD) for FY 2005 is $60 million. This includes funds for the Public Health Information Network (PHIN), which will build upon and integrate existing public health communication systems and will create public health data standards necessary for interoperability between the health care sector and local, State, and federal public health authorities. CDC and the Office of the Director will also continue to coordinate management attention to achieving results in accordance with the President's Management Agenda.

Modern and Secure Laboratories and Facilities

CDC is continuing its work to modernize its physical infrastructure. In 2003 CDC completed the critical Environmental Health Laboratory and the Parasitology Laboratory. Between 2002

and 2003, CDC is completing more than 1.6 million square feet of laboratory and other facility space. The Environmental Health Laboratory completed in FY 2003 specializes in biomonitoring; this new laboratory enabled staff to develop a rapid toxic scree n to quickly analyze up to 150 chemicals likely to be used by terrorists. In 2005, CDC will complete an Infectious Disease Laboratory, the Scientific Communications Center, the Headquarters and Emergency Operations Center, and the Environmental Toxicology Laboratory. The request for Buildings and Facilities in FY 2005 includes $81.5 million to complete the Fort Collins, Colorado Bio Safety Level 3 Laboratory; to continue work on the East Campus Laboratory Consolidation Project; and to provide for nation-wide maintenance, repairs, and improvements. ATSDR (Agency for toxic substances and disease registry):

ATSDR is managed as part of CDC and is the lead agency responsible for public health activities related to Superfund sites. ATSDR develops profiles of the health effects of hazardous substances, assesses health hazards at specific Superfund sites, and provides consultations to prevent or reduce exposure and related illnesses. ATSDR also maintains the World Trade Center Exposure Registry to track the health effects of 100,000 to 200,000 individuals who may have been impacted by exposure to substances at the World Trade Center site. The President's Budget for FY 2005 for ATSDR is $77 million, a $4 million increase over FY 2004. Increases in the budget will be directed to ATSDR's work with EPA and other federal, State, and local environmental public health agencies to evaluate sites that received vermiculite from Libby, Montana, to identify past and present exposure pathways and to determine whether a public health hazard, has existed or continues to exist. Increases will also fund the maintenance costs of the World Trade Center Exposure Registry. A recent PART review determined that ATSDR had strong program design and management practices. The PART review suggested some improvements that ATSDR has undertaken. ATSDR is reviewing and clarifying its long term goals and measures to directly capture the impact of the agency on mitigating disease. CDC has eliminated administrative and management redundancies between ATSDR and CDC's National Center for Environmental Health.

National Institutes of Health
Overview by Institute

	2003	2004	2005	2005 +/- 2004
Institutes:				
National Cancer Institute	$4,584	$4,736	$4,870	+$134
National Heart, Lung, & Blood Institute	2,792	2,878	2,964	+86
National Institute of Dental & Craniofacial Research	371	383	394	+11
Natl Inst. of Diabetes & Digestive & Kidney Disease	1,721	1,821	1,876	+55
National Institute of Neurological Disorders & Stroke	1,455	1,501	1,546	+45
National Institute of Allergy & Infectious Diseases	3,703	4,303	4,426	+123
National Institute of General Medical Sciences	1,847	1,905	1,960	+55
Natl Inst. of Child Health and Human Development	1,204	1,242	1,281	+39
National Eye Institute	632	653	672	+19
National Institute of Environmental Health Sciences:				
Labor/HHS Appropriation	612	631	650	+19
VA/HUD Appropriation	84	78	80	+2
National Institute on Aging	993	1,025	1,056	+31
Natl Inst. of Arthritis & Musculoskeletal & Skin Dis	486	501	515	+14
Natl Inst. on Deafness & Communication Disorders	370	382	394	+12
National Institute of Mental Health	1,339	1,382	1,421	+39
National Institute on Drug Abuse	961	991	1,019	+28
National Institute on Alcohol Abuse & Alcoholism	416	429	442	+13
National Institute for Nursing Research	130	135	139	+4
National Human Genome Research Institute	464	479	493	+14
Natl Inst. for Biomedical Imaging & Bioengineering	280	289	298	+9
National Center for Research Resources	1,139	1,179	1,094	-85
Natl Center for Complementary & Alternative Med	113	117	121	+4
Natl Center for Minority Health & Health Disparities	186	192	197	+5
Fogarty International Center	62	65	67	+2
National Library of Medicine	306	317	325	+8
Office of the Director	286	327	360	+33
Buildings & Facilities	639	99	100	+1
Nuclear/Radiological Countermeasures Research	0	0	47	+47
ONDCP Drug Forfeiture Fund Transfer (NIDA)	4	5	0	-5
Total, Program Level	**$27,178**	**$28,041**	**$28,805**	**+$764**
Less Funds Allocated from Other Sources:				
Nuclear/Radiological Countermeasures Res. (PHSSEF)	$0	$0	-$47	-$47
ONDCP Drug Forfeiture Fund Transfer (NIDA)	-4	-5	0	+5
PHS Evaluation Funds (NLM)	-8	-8	0	+8
Type 1 Diabetes Research 1/	-100	-150	-150	0
Total, Budget Authority	**$27,066**	**$27,878**	**$28,607**	**+$729**
Labor/HHS Appropriation	**$26,983**	**$27,800**	**$28,527**	**+$727**
VA/HUD Appropriation	**$84**	**$78**	**$80**	**+$2**

FTE.....	17,596	17,522	17,522	0

1/ These funds were pre-appropriated in the Benefits Improvement and Protection Act of 2000 and P.L. 107-360.

Overview by Mechanism

Mechanism:	2003	2004	2005	2005 +/- 2004
Research Project Grants	$14,239	$15,109	$15,512	+$403
[# of Non-Competing Grants]	*[25,757]*	*[27,094]*	*[27,351]*	*[+257]*
[# of New/Competing Grants]	*[10,393]*	*[10,135]*	*[10,393]*	*[+258]*
[# of Small Business Grants]	*[2,020]*	*[2,199]*	*[2,242]*	*[+43]*
[Total # of Grants]	*[38,170]*	*[39,428]*	*[39,986]*	*[+558]*
Research Centers	2,425	2,552	2,704	+152
Research Training	712	749	764	+15
Research & Development Contracts	2,395	2,817	2,706	-111
Intramural Research	2,547	2,662	2,768	+106
Other Research	2,119	2,214	2,264	+50
Extramural Research Facilities Construction	495	118	150	+32
Research Management and Support	921	985	1,017	+32
National Library of Medicine	306	317	325	+8
Office of the Director	286	327	360	+33
Buildings and Facilities	646	107	108	+1
NIEHS VA/HUD Appropriation (Superfund)	84	78	80	+2
Nuclear/Radiological Countermeasures Research	0	0	47	+47
ONDCP Drug Forfeiture Fund Transfer (NIDA)	4	5	0	-5
Total, Program Level	**$27,178**	**$28,041**	**$28,805**	**+$764**
Less Funds Allocated from Other Sources:				
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PHS Evaluation Funds (NLM)	-8	-8	0	+8
Type 1 Diabetes Research 1/	-100	-150	-150	0
Total, Budget Authority	**$27,066**	**$27,878**	**$28,607**	**+$729**
Labor/HHS Appropriation	**$26,983**	**$27,800**	**$28,527**	**+$727**
VA/HUD Appropriation	**$84**	**$78**	**$80**	**+$2**
FTE	17,596	17,522	17,522	0

1/ These funds were pre-appropriated in the Benefits Improvement and Protection Act of 2000 and P.L. 107-360.

Major advances in knowledge about life sciences, especially the sequencing of the human genome, are opening dramatic new opportunities for biomedical research and heretofore un-imagined prospects for preventing, treating, and curing disease and disability. Investment in biomedical research by NIH has driven these advances, and the FY 2005 budget request seeks to capitalize on the resulting opportunities to improve the health of the nation. Building on the research momentum generated by the fulfillment of the President's commitment to complete the

five year doubling of the NIH budget, the FY 2005 request provides $28.8 billion for NIH. This is an increase of $764 million, or 2.7 percent, over the FY 2004 level. These funds will support a record total of nearly 40,000 research project grants in FY 2005, including an estimated 10,393 new and competing awards, an increase of 258 over FY 2004.

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. In FY 2005, nearly 85 percent of the funds appropriated to NIH will flow out to the extramural community, which supports work by more than 212,000 research personnel affiliated with about 2,800 university, hospital, and other research facilities. About 11 percent of the budget will support an in-house, or intramural, program of basic and clinical research activities managed by world-class physicians and scientists. This intramural research program, which includes the NIH Clinical Center, gives our nation the unparalleled ability to respond immediately to health challenges nationally and worldwide. Another 4 percent will provide for research management and support.

Research Priorities in FY 2005

In fulfilling its mission, NIH strives to maintain a diverse portfolio of research founded on both public health need and scientific opportunity. The FY 2005 budget request will allow NIH to address imperative requirements in biodefense; implement the NIH Roadmap for Medical Research; pursue an obesity research initiative; and manage a research initiative on developing nuclear and radiological threat countermeasures. Additional support will be provided to continue progress in promising arenas of science related to specific diseases such as cancer, HIV/AIDS, diabetes, Parkinson's disease, and Alzheimer's disease; while also pursuing whole new avenues of post-genomics research.

Biodefense: For FY 2005, the President's budget proposes a total of $1.7 billion for NIH biodefense efforts, an increase of $121 million, or 7.5 percent, over FY 2004. Our nation's ability to detect and counter bioterrorism ultimately depends heavily on the state of biomedical science. Guided by its long-range strategic plan that includes short-, intermediate-, and long-term goals, NIH's biodefense research stresses two overarching, complementary, and urgent components: a) basic research on the biology of microbial agents with bioterrorism potential and the properties of the host's response to infection and defense mechanisms; and b) applied research with predetermined milestones for the development of new or improved diagnostics, vaccines, and therapies. NIH will continue to ensure full coordination of these research activities with other Federal agencies in the war against terrorism.

In just the past two years, NIH has made tremendous strides towards developing countermeasures to protect all Americans from bioterrorism. For example, researchers supported by NIH have sequenced genomes representative of all bacteria considered bioterrorism threats, and are sequencing genomes for at least one strain of every potential viral and protozoal bioterrorism pathogen. NIH has also developed and expanded contracts to screen new drugs; develop new animal models; establish a reagent and specimen repository; and provide researchers with genomic, proteomic and bioinformatic resources related to potential bioterrorism agents. NIH is funding more than 100 grants and contracts with pharmaceutical and

biotechnology companies in collaborative projects to develop high-priority biodefense products. Work on a second-generation anthrax vaccine has rapidly progressed to the point that a vaccine product is expected to be ready for procurement later this year through the new DHS BioShield program.

In FY 2005, NIH will complete the national network of extramural Regional Centers of Excellence for Biodefense and Emerging Infectious Diseases Research, including awarding the last two of the planned 10 regional centers. Also in FY 2005, NIH will continue testing a range of candidate vaccines in clinical and pre-clinical studies, including third-generation vaccines against smallpox; a DNA vaccine to prevent Ebola virus; and new vaccines for plague, tularemia, Rift Valley Fever, and other viral hemorrhagic fevers, such as Marburg and Lassa viruses.

The FY 2005 budget requests $150 million to continue support for construction of specialized biosafety laboratories at universities and research institutions across the country. Prior to FY 2002, only a few of these specialized laboratories existed in the United States that were capable of conducting research on potential bioterrorism agents. The $150 million investment in FY 2005 will fund an additional 20 Level 3 laboratories in metropolitan areas throughout the country. Once these facilities are completed, we will be able to support over 200 research projects at the same time aimed at developing medical protection from bioterrorism. These facilities will also back up State and Federal public health laboratories if there is an actual or suspected bioterrorism attack. This increase in FY 2005 will be funded as a result of the completion of NIH's applied research on new anthrax and smallpox vaccines.

The ability to mitigate the health effects of radiation exposure in the potential event of the use of a limited nuclear or radiological device in a terrorist attack presents a critical challenge for which little progress has been made in the last 40 years. The FY 2005 biodefense request for NIH includes $47 million for the Public Health and Social Services Emergency Fund to support specific targeted research activities needed to develop medical countermeasures to more rapidly and effectively treat nuclear or radiological injuries. This research initiative will focus on a) developing drugs that can be used to prevent injury from radiological exposure; b) improving methods for measuring radiological exposure and contamination; and c) developing methods or drugs to restore injured tissues and eliminate radioactive materials from contaminated tissues.

NIH Roadmap for Medical Research: In an effort to target major opportunities and gaps in biomedical research that no single institute at NIH could tackle alone, the FY 2005 budget allocates a total of $237 million for the "Roadmap" initiative, an increase of $109 million over FY 2004. The request includes $60 million in the Office of the Director, an increase of $25 million, and $177 million, an increase of $84 million, in the budgets of the Institutes and Centers and used in a coordinated effort to support the Roadmap.

The Roadmap will help transform new scientific knowledge that will result in tangible benefits for the American public of new treatments, prevention strategies, and diagnostics through overcoming barriers to rapid progress in biomedical research. The Roadmap is organized into three core themes: New Pathways to Discovery; Research Teams of the Future; and Re-engineering the Clinical Research Enterprise.

HIV/AIDS Research: The FY 2005 budget includes a total of $2.9 billion for HIV/AIDS-related research. This is an increase of $80 million, or 2.8 percent over the FY 2004 level. In addition to these funds, the FY 2005 budget includes $100 million in NIAID to continue HHS contributions provided since FY 2002 to the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria.

The FY 2005 NIH HIV/AIDS research agenda continues the following overarching themes: HIV prevention research, including development of vaccines, microbicides, behavioral interventions, and strategies to prevent perinatal transmissions; therapeutics research to develop simpler, less toxic, and cheaper drugs and regimens to treat HIV infection and its complications; international research, particularly to address the critical research and training needs in developing countries; and research targeting the disproportionate impact of the AIDS epidemic on racial and ethnic minority populations in the United States. All of these efforts require a strong foundation in basic science.

NIH research has heavily informed the President's Emergency Plan for AIDS Relief. NIH research proved the safety and efficacy of a drug regimen for preventing transmission of HIV from an infected mother to her newborn that is more affordable and practical than any other course of therapy examined to date. The NIH-sponsored study demonstrated that a single oral dose of the antiretroviral drug, nevirapine, given to an HIV-infected woman in labor and another dose given to her baby within three days of birth reduced the transmission rate by about half compared with a course of AZT given only during labor and delivery. Additional data from this study demonstrated the continued benefit and safety of nevirapine in reducing mother-to-child transmission of HIV up to 18 months, even in a breastfeeding population.

Obesity: The epidemic of obesity threatens the Nation's health by sharply increasing the incidence of type 2 diabetes, fatty liver disease, kidney failure, and cardiovascular and other diseases. However, dramatic advances in our understanding of how appetite and weight are regulated offer new opportunities to develop methods to treat obesity and to prevent type 2 diabetes and other obesity-related diseases. In FY 2005, NIH plans to expand its obesity research portfolio by $40 million, for a total of $440 million. This includes a targeted, $22 million, trans-NIH initiative that will seek to better understand the neurobiological, genetic, behavioral, and environmental basis of obesity and its co-morbid conditions; improve strategies for maintaining healthy weight in adults and children, particularly in primary care, school, and workplace settings; and develop new therapeutic anti-obesity modalities to complement lifestyle interventions.

This obesity initiative will complement the ongoing work of NIH on diabetes, including, for example, efforts to build upon the Secretary's Diabetes Detection Initiative by discovering new approaches to accurately and effectively diagnose type 2 diabetes; and moving forward with a full-scale, landmark, clinical trial to test the best approaches to lowering the risk of heart disease and stroke in adults with type 2 diabetes.

Research Project Grants

The support of basic medical research through competitive, peer-reviewed, and investigator-initiated research project grants (RPGs) represents 54 percent of NIH's total budget request for FY 2005.

In FY 2005, the NIH budget provides $15.5 billion, a 2.7 percent increase over FY 2004, to fund 39,986 total projects, the highest level in the agency's history. This is 558 more grants in total than are expected to be funded in FY 2004. Within this total, NIH estimates it will support 10,393 competing RPGs in FY 2005, an increase of 258 over FY 2004. The average cost of research project grants will increase in the aggregate by 1.3 percent.

Facilities Construction

During FY 2004, both the Mark O. Hatfield Clinical Research Center and part of the John E. Porter National Neurosciences Research Center are scheduled to open, which together will provide an additional 1,115 gross square feet of laboratory and patient research space to NIH's main campus in Bethesda, Maryland. These two new major research assets have been designed and will be managed specifically to allow the NIH Institutes and Centers to work more collaboratively to speed the pace of fundamental discoveries and their translation into effective therapies and prevention strategies. In addition, over the past two years, approximately $800 million has been appropriated for both intramural and extramural biosafety laboratory construction which are currently in design stages. In FY 2005, as discussed above, another $150 million is requested to further expand laboratory space in universities and research institutions around the country critical to biodefense research activities. The budget also includes a total of $108 million for other non-biodefense intramural facilities projects, such as general repairs and improvements across NIH's nearly 200 total buildings. No funds are requested for non-biodefense extramural research facilities construction grants. Over the past 10 years, $633 million have been appropriated for non-biodefense extramural construction projects. In FY 2005, NIH's budget places a higher priority on the support of additional research project grants.

Substance Abuse and Mental Health Services Administration

	2003	2004	2005	2005 +/- 2004
Substance Abuse:				
Substance Abuse Block Grant	$1,754	$1,779	$1,832	+$53
Programs of Regional and National Significance:				
Treatment	317	419	517	+98
Prevention	197	199	196	-3
Subtotal, Substance Abuse	**$2,268**	**$2,397**	**$2,545**	**+$148**
Mental Health:				
Mental Health Block Grant	$437	$434	$436	+$2
PATH Homeless Formula Grant	43	50	55	+5
Programs of Regional and National Significance	245	241	271	+30
Children's Mental Health Services	98	102	106	+4
Protection and Advocacy	34	35	35	0
Samaritan Initiative	0	0	10	+10
Subtotal, Mental Health	**$857**	**$862**	**$913**	**+$51**
Program Management	$87	$92	$92	$0
Total, Program Level	**$3,212**	**$3,351**	**$3,550**	**+$199**
Less Funds Allocated from Other Sources:				
PHS Evaluation Funds	-74	-117	-121	-4
Total, Discretionary BA	**$3,138**	**$3,234**	**$3,429**	**+$195**
FTE	534	546	546	0

The FY 2005 budget requests $3.6 billion for SAMHSA, a net increase of $199 million, or 6 percent, over FY 2004. The request continues the President's commitment to reduce current illicit drug use by doubling the Access to Recovery State Voucher program initiated in FY 2004. The budget includes the implementation of the new substance abuse Strategic Prevention Framework, a new initiative to transform the mental health system in response to the recommendations of the President's Commission on Mental Health, and increases funding for services targeted towards homeless individuals. Resources are also provided to enhance Federal and State level drug and mental health data collection activities.

Substance Abuse

In February 2002, the President set aggressive goals to reduce youth drug use by 10 percent in two years and 25 percent in five years. National survey data confirm that the President's two-year goal has been exceeded. Current use of any illicit drug among students declined 11 percent between 2001 and 2003, resulting in 400,000 fewer teen drug users. However, with this decrease in drug use, there continues to be an unmet need for treatment services. In 2002, 88,000 individuals recognized they needed treatment, but were unable to attain it. The request continues to expand clinical treatment and recovery support services to people with drug and alcohol problems. It includes $2.5 billion, a net increase of $148 million, or 6 percent, for substance abuse treatment and prevention activities.

Expanding Access to Treatment: The FY 2005 budget represents the fourth year of the President's commitment to expand drug treatment and recovery support services over five years. The request proposes to double funding for the Access to Recovery State Voucher program for a total funding level of $200 million. The initiative would allow individuals seeking clinical treatment and recovery support services to exercise choice among qualified community provider organizations, including those that are faith-based. The program's emphasis is on results – measured by outcomes including decreased or no substance use, no involvement with the criminal justice system, attainment of employment or enrollment in school, family and living conditions, social support, access/capacity, and retention in services. Approximately 100,000 people will receive services through this program in FY 2005.

Promoting Effective Prevention: Current research shows that science–based substance abuse prevention is effective not only in preventing youth from initiating substance use in the first place, but also in reducing the number of addicted individuals. This budget includes $196 million to implement SAMHSA's new Strategic Prevention Framework. The Strategic Prevention Framework's objectives are to promote the use of performance measures and evaluation tools by substance abuse prevention providers; to increase substance abuse prevention programming throughout the United States, and to support the implementation of effective prevention programs in States and communities. Through the Strategic Prevention Framework, SAMHSA builds capacity within States and the prevention field to promote resiliency and decrease risk factors in individuals, families, and communities. The budget will focus on efforts to enhance implementation of effective programs at the community level, with an emphasis on the prevention of underage drinking.

Substance Abuse Block Grant: A total of $1.8 billion is requested for the Substance Abuse Prevention and Treatment (SAPT) Block Grant, an increase of $53 million over FY 2004. The SAPT Block Grant provides treatment services to over 425,000 individuals and supports over 10,500 community-based organizations. It is the cornerstone of States' substance abuse financing, accounting for at least 40 percent of public funds expended for prevention and treatment.

A recent Program Assessment Rating Tool (PART) identified the SAPT Block Grant as the only Federal program that provides funds to every State to support State-wide substance abuse treatment and prevention services, noting that the program has adopted new long-term outcome measures and annual outcome and output measures. SAMHSA is undergoing a transition from Block Grants to Performance Partnerships, in which all States will be required to provide

outcome information that can be aggregated to monitor program performance. The same performance measures that are to be used in Access to Recovery will be adopted for Performance Partnerships.

Mental Health

The budget includes $913 million for mental health services, a net increase of $51 million over FY 2004. The request provides resources for a new initiative to respond to the recommendations of the President's Commission on Mental Health and increases access to mental health services to some of our most vulnerable citizens.

Transforming the Mental Health System: In July 2003, the President's Commission on Mental Health released its final report, calling for a fundamental overhaul of how mental health care is delivered in America – to achieve the promise of recovery for families and children. SAMHSA has the lead role for HHS in developing an action agenda to incorporate the Report's recommendations into service delivery improvements. As an important step in reshaping this delivery system, the budget proposes $44 million for State Incentive Grants for Transformation. These new grants will support the development of comprehensive State mental health plans to reduce system fragmentation, and increase services and supports available to people living with mental illness. In the first year, States will establish a planning dialogue across multiple service systems and agencies, such as criminal justice, housing, child welfare, labor and education. In subsequent years, 85 percent of funds may be used to support programs at the community level as proposed in the State Plan. The remaining 15 percent will continue to support State planning and coordination activities.

Homeless Services: Recent studies have found that 20 percent of individuals experiencing chronic homelessness also have a serious mental illness. The request includes $10 million for the HHS contribution for the Samaritan initiative, an Administration-wide initiative to reduce chronic homelessness jointly administered with the Departments of Housing and Urban Development, and Veterans Affairs. This initiative will support service providers that better enable access to the full range of services that chronically homeless people need including housing, outreach and support services such as mental health services, substance abuse treatment, and primary health care. Priority will be given to grantees who initiate activities to expand access to mainstream Federal programs for those who experience chronic homelessness. The request also includes $55 million for the Projects for Assistance in Transition from Homelessness (PATH), a $5 million increase over FY 2004. These funds will allow grantees to reach out to 154,000 homeless individuals, getting them off the streets and into mental health and substance abuse treatment services, as well as adequate housing.

Other Mental Health: The budget also supports assistance to States in developing programs for individuals with co-occurring mental health and substance abuse disorders, and continues to support efforts with other Federal partners on youth violence.

A total of $436 million is requested for the Community Mental Health Services Block Grant to support comprehensive community services to approximately 220,000 adults with serious mental illness and children with serious emotional disturbances. A recent PART review determined that

the Mental Health Block Grant is the only Federal program that provides funds to every State to provide State-wide community-based mental health services. The program has adopted new long-term outcome measures to advance strategic planning and will be converting to Performance Partnerships in FY 2005. This transition from Block Grants to Performance Partnerships will require States to collect and report performance data to better measure program effectiveness.

Program Management

The budget includes $92 million to maintain staff, and related program management and support activities necessary to effectively administer a wide array of Federal programs. As part of the President's Management Agenda, SAMHSA has implemented changes in its grant announcements, creating process efficiencies within the Agency and leading to increased clarity for applicants. Under the new process, four standard grant announcements have been created based on common elements such as purpose, standard of evidence base, award size, eligibility, allowable activities, and review criteria. Each of the grant announcements include standard performance measures, ensuring increased accountability Agency-wide.

Agency for Health Research and Quality

	2002	2003	2004	2005	2005 +/-2004
Health Costs, Quality and Outcomes Research.....	$248	$253	$246	$246	$0
Patient Safety Research (non-add).....	*55*	*60*	*80*	*84*	*+4*
Medical Expenditures Panel Surveys.....	49	53	55	55	*0*
Program Support.....	3	3	3	3	0
**Subtotal, Program Level.....	**$299**	**$309**	**$304**	**$304**	**$0**
Less Funds Allocated From Other Sources:.....					
PHS Evaluation Funds.....	$296	-$304	-$304	-$304	$0
Public Health & Social Services Emergency Fund....		-5	0	0	0
**Total, Budget Authority.....	**$3**	**$0**	**$0**	**$0**	**$0**
FTE.....	278	287	294	294	0

The FY 2005 request for AHRQ provides a total program level of $304 million, the same as FY 2004. This request reflects priority of a continued focus on improving patient safety and reducing medical errors, through the implementation of targeted efforts to make safety-improving technologies available to hospitals and health systems.

AHRQ conducts and sponsors health services research to inform decision-making and improve clinical care and the organization and financing of health care. AHRQ evaluates both clinical services and the system in which these services are provided. This work contributes not only to improved clinical care, but also to more cost-effective care. In FY 2004 and FY 2005, AHRQ supports the translation of research into measurable improvements in the care Americans receive. 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. The agency's research agenda is broad and spans from medical informatics to long-term care; from pharmaceutical outcomes to prevention to responses to bioterrorism.

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 $246 million. Within this total funding, spending on patient safety efforts will increase from $80 million to $84 million.

Patient Safety: Of the total $84 million, $50 million again will be made available for health system-based information technology investments designed to enhance patient safety, with an emphasis on small community and rural hospitals and systems and the importance of partnerships across communities.

Information technology has the potential to improve the quality, safety and efficiency of health care by helping health care professionals make the best decisions and by assuring that those decisions are implemented as intended. These investments will continue to encourage uptake of technologies such as computerized physician order entry, computer monitoring for potential adverse drug events, automated medication dispensing, computerized reminder systems to improve compliance with guidelines, handheld devices for prescription information, computerized patient records, and patient-centered computerized support groups. The first awards for implementation of these technologies will be made in summer 2004. AHRQ will provide up to 50 percent of the total project costs, up to $500,000 per year per project.

Adoption of information technology applications requires the development of a business case for these tools. Working with public and private partners, AHRQ will help use data from hospital IT investment demonstrations to help spread proven technology through the healthcare system.

AHRQ will continue to invest $10 million on the development of clinical terminology, messaging standards, and other tools needed to accelerate the use of cost-effective healthcare information technology. AHRQ will fund research to identify barriers and practical solutions to the development and use of health information systems to support quality improvements and patient safety, since one major obstacle is the lack of clinical terminology and messaging standards that support interoperability. These priority projects will support patient safety in the U.S., develop a common vision for health information technology and standards across the health care spectrum, and promote and accelerate efforts needed to make that vision a reality in the U.S.

The remaining $24 million in AHRQ's patient safety budget supports a variety of activities. AHRQ will continue to work collaboratively with the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services, 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. This streamlined reporting system will integrate data from such systems as the National Healthcare Safety Network operated by CDC as well as the reporting systems for drugs, biologics, vaccines, and medical devices operated by FDA.

This past year, AHRQ launched a monthly, peer-reviewed, Web-based medical journal that showcases patient safety lessons drawn from actual cases of near-errors. Morbidity and Mortality Rounds on the Web helps to educate providers about ways to prevent errors, in a blame-free environment. AHRQ has also been working with external partners such as the American Academy of Pediatrics to put together a fact sheet for pediatricians and parents of children: "20 Tips to Help Prevent Medical Errors in Children." Finally, AHRQ will continue a number of research grants and contracts designed to understand how technologies, workforce, and organizational structure affect patient safety, as well as a program to train safety experts to assist States and local healthcare organizations in developing a safety focus.

Research and Dissemination Activities Outside Patient Safety: In FY 2005, AHRQ will invest $162 million in research and dissemination activities in prevention, acute-and long-term care, pharmaceutical outcomes, informatics, and other areas to support the quality of health care. The FY 2005 budget enables AHRQ to renew several grant programs that help support the health

care quality infrastructure. These include Building Research Infrastructure & Capacity Program (BRIC), Minority Research Infrastructure Support Program (M-RISP), Centers for Education and Research on Therapeutics (CERTs) program, and Practice-Based Research Networks (PBRNs). In addition, AHRQ will fund $6 million in new grants and contracts for Research Empowering America's Changing Healthcare System (REACHES). These grants and contracts will expand work in the area of adopting research findings in real-world settings, assessing their impact and generalizability, and promoting rapid uptake of successful efforts.

A number of AHRQ efforts are oriented toward making research findings accessible. For example, in the CERTs program, studies are underway to gather information that Medicaid programs can use to make coverage and other policy decisions such as drug utilization review, economic effects of beta-blocker therapy in heart failure, and prevalence of type 2 diabetes mellitus in children. Under its Evidence-based Practice Program, AHRQ is developing scientific information for other agencies and organizations on which to base clinical guidelines, performance measures, and other quality improvement tools. For example, this past year, AHRQ's Minnesota-based Evidence based Practice Center (EPC) set out to review medical literature to answer questions such as: What are the current indications for, and outcomes from, primary total knee replacement? What factors explain disparities in the utilization of total knee replacement in different populations?

AHRQ will also continue to chair the U.S. Preventive Services Task Force. The USPSTF has issued clinical recommendations on colorectal cancer, breast cancer, osteoporosis, hormone replacement therapy, depression, and aspirin chemoprevention for patients at risk for heart disease.

Medical Expenditure Panel Surveys (MEPS)

The FY 2004 budget for MEPS includes a request for $53 million, the same as the FY 2004 level. MEPS is the collection of detailed, national data on the health care services Americans use, how much they cost, and who pays for them. It is the only national source of visit-level information on medical expenditures. MEPS to continue to inform 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. One of the agency's recent accomplishments is the publication of two first-ever two reports, required by the agency's 1999 reauthorization, that represent the first national comprehensive effort to measure the quality of health care in America and differences in access to health care services for priority populations.

National Reports on Quality and Disparities in Health Care: The National Healthcare Quality Report includes 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.

The second report – the National Healthcare Disparities Report – highlights populations that are at high risk for differences 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. The NHDR was developed in partnership with other HHS agencies to ensure synergy with existing efforts.

The first editions of both reports are available on a new Web site, www.qualitytools.ahrq.gov. In addition, the site serves as a Web-based clearinghouse by providing information for health care providers, health plans, policymakers, purchasers, patients and consumers to take effective steps to improve quality. Both the NHQR and the NHDR will be released annually. AHRQ has budgeted $3 million in FY 2005 for these projects.

In FY 2005, AHRQ will be fully funded through inter-agency transfers of evaluation funds.

Centers for Medicare & Medicaid Services

CMS Summary

	2003	2004	2005	2005 +/- 2004
Current Law:				
Medicare /1	$277,866	$302,610	$331,261	+$28,651
Medicaid /2	160,693	177,107	183,197	+6,090
SCHIP	4,355	5,232	5,299	+67
State Grants and Demonstrations	15	47	304	+257
Total Outlays, Current Law	**$442,929**	**$484,996**	**$520,061**	**+$35,065**
Premiums	-28,433	-32,169	-36,839	-4,670
Other Offsetting Collections/ Receipts	-58	0	0	0
Total Net Outlays, Current Law	**$414,438**	**$452,827**	**$483,222**	**$30,395**
Proposed Law:				
Medicare Administration	$0	$0	-$205	-$205
Medicare Benefits	0	0	-150	-$150
SMI Transfer to Medicaid for QIs	0	0	136	$136
Medicaid Administration	0	0	-380	-$380
Medicaid Benefits	0	175	-753	-928
Total Proposed Law	**$0**	**$175**	**-$1,352**	**-$1,527**
Premiums, Proposed Law	$0	$0	$36	$36
One-Time Military Service Credits Adjustment	$0	$0	$181	$181
Total Net Outlays, Proposed Law /3	**$414,438**	**$453,002**	**$482,087**	**$29,085**

1/ Includes benefits, administration, Medicare Transitional Drug Assistance, and the Medicare Prescription Drug Account.
2/ Net outlays, without FY 2003/04 outlays for QMBs; without FY 2005 State low-income determinations.
3/ Total net outlays equal current outlays minus the impact of proposed legislation and offsetting receipts.

The FY 2005 budget request for the Centers for Medicare & Medicaid Services (CMS) is $482.1 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 $29.1 billion over FY 2004.

On December 8, 2003, President Bush signed the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) into law. This is the most significant overhaul of the Medicare program since its inception in 1965, adding a long overdue prescription drug benefit and expanded health choices for seniors. A top priority for CMS and HHS will be the timely implementation of the sweeping changes in the law, starting with providing Medicare beneficiaries a discount prescription drug card by June 2004.

Building upon the success of the Health Insurance Flexibility and Accountability (HIFA) and Pharmacy Plus waivers, the Administration plans to work diligently with the Congress to develop a Medicaid modernization plan. This plan would introduce more State flexibility and fiscal stability into the program. As under last year's proposal, States will have the option of receiving their SCHIP and Medicaid funding together in an allotment. The allotment option requires States to provide a specified benefit package for current Medicaid beneficiaries whose coverage is mandated by law.

The budget also includes significant new efforts to extend services to the disabled and those in need of long–term care services through the New Freedom Initiative. In addition, it provides assistance to vulnerable populations transitioning from welfare to work through the extension of the Transitional Medical Assistance Program.

Finally, the budget proposes to restrict the use of certain intergovernmental transfers and cap Federal payments to individual State and local providers. This will improve program integrity and help stem the tide of rising costs in the Medicaid program.

Medicare Modernization Act

On December 8, 2003, the President signed into law the historic Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This Administration and Congress worked together to provide over 40 million Medicare beneficiaries with more choices in health care coverage and better health care benefits. This law represents the most significant and sweeping expansion of the Medicare program since its enactment in 1965. As the President said, this new law will ease the burden of high prescription drug costs on seniors and will give them the extra help they need with these costs. MMA will strengthen and modernize Medicare while still providing beneficiaries with the option to remain in traditional Medicare. MMA creates a new Part D prescription drug benefit, allows for competition among health plans to foster innovation and flexibility in coverage, removes restrictions on Health Savings Accounts (HSA), offers regulatory relief, and requires an analysis of Medicare's potential long-term reliance on general tax-payer revenues.

Discount Drug Card

The MMA establishes a new Medicare approved prescription drug discount card program that will immediately help Medicare beneficiaries reduce their out–of–pocket spending on drugs. All Medicare beneficiaries, except those who already have Medicaid drug coverage, will be able to

enroll in a prescription drug discount card program that allows them to use a Medicare approved discount card in their local pharmacy. Seniors and individuals with disabilities could save on average 10 to 15 percent on their total drug costs, with savings of 25 percent or more off retail prices on individual prescriptions. Beneficiaries can find comparative information about drug card sponsors through www.medicare.gov and 1–800–MEDICARE after April 2004. Card enrollment begins as early as May 2004, and discounts and transitional assistance begin in June 2004.

Discount cards will help to reduce out-of-pocket drug costs until the Medicare drug benefit takes effect on January 1, 2006. HHS estimates that the typical senior without drug coverage, who spends $1,285 annually on medicine, could save as much as $300 annually with their discount card. Beneficiaries will pay no more than $30 annually in 2004 and 2005 to enroll. Beneficiaries can also apply for transitional assistance (TA). TA, for individuals whose income is less than $12,123 each year or for married couples whose income is less than $16,362 (based on 2003 Federal Poverty Levels), provides up to $600 per year for purchasing drugs. Medicare will cover the cost of the enrollment fee for these low-income cardholders.

Beneficiaries will have a choice of at least two Medicare approved cards, and they can change cards during an open enrollment period prior to 2005 or if they move or enroll in a Medicare managed care plan. Any company interested in providing a discount card must offer price reductions on at least one medication per category in more than 200 therapeutic categories of drugs.

Voluntary Prescription Drug Benefit

The Administration delivered on the promise to provide Medicare beneficiaries with prescription drug coverage. MMA establishes a new voluntary prescription drug benefit under a new Medicare Part D. The legislation implements many of the principles outlined in the President's Framework to Modernize and Improve Medicare. It especially helps those with low incomes and those with high drug expenses. HHS places a high priority on educating Medicare beneficiaries about these new choices and improved benefits. HHS will publish the proposed rule implementing the drug benefit in calendar year 2004, and the final rule in calendar year 2005. Beginning January 1, 2006, approximately 40.7 million Medicare beneficiaries who are entitled to Part A or enrolled in Part B will have access to prescription drug benefits under the new Part D. Beneficiaries can choose between at least two qualifying private drug plans from which to receive their benefit. The law provides for a government fallback plan for areas without at least two plan choices.

Current Medicare beneficiaries can enroll during an initial open enrollment period between November 2005 and May 2006. For beneficiaries eligible for Medicare in the future, Part D enrollment will correspond to the enrollment period for Part B. At enrollees' option, Part D premiums may be paid directly to the prescription drug plan or their Medicare Advantage plan, deducted from the beneficiary's Social Security check, or paid through an electronic funds transfer.

Beneficiaries can choose to enroll in a stand-alone private drug plan or a Medicare Advantage prescription drug plan to get their prescription drugs. Federal subsidies will encourage plan participation and better enrollee benefits. Plans will negotiate drug prices with manufacturers and provide these lower prices to beneficiaries. Beneficiaries will receive monthly detailed explanations of their drug benefits from their plan.

Beneficiaries will be able to get the types of drugs they need. Although plans are permitted to use formularies, formularies have to meet statutory standards. Formularies have to include drugs within each therapeutic category and class of covered Part D drugs, so beneficiaries keep their drug choices. And, beneficiaries can appeal to have a non-formulary drug covered, if their formulary does not make their preferred drug available and a doctor certifies the drug is necessary.

HHS will develop an electronic prescription program for Part D covered prescription drugs. Electronic standards will reduce the number of prescribing errors that occur each year and protect Medicare beneficiaries against the possibility of medication errors.

State Effects

Under Part D of the MMA, States are relieved of a significant portion of the costs of providing pharmaceutical benefits to individuals eligible for both Medicare and Medicaid. This relief is mitigated somewhat by a provision that mandates States maintain some percentage of the financial responsibility for providing drugs to these individuals. State contributions will be determined by first calculating the per capita payment for dually eligible individuals. This figure will be multiplied by the number of fully dually eligible individuals in the State to calculate a Statewide total. In 2005, States will be expected to pay 90 percent of this amount. This percentage will be phased down to 75 percent by FY 2015, where it will remain thereafter.

In addition to this Maintenance of Effort provision, States will also be expected to participate in the eligibility determination process for the drug benefit. For the Part D low–income drug benefit, eligibility will be determined by either the State Medicaid agency, with States receiving their regular matching funds for associated administrative costs, or by SSA, with additional funds authorized to cover new administrative costs.

The MMA also includes two other provisions that will effect State Medicaid programs. The first of these introduces significant changes to the Medicaid Disproportionate Share Hospital program (DSH). The first major change increases FY 2004 DSH allotments by 16 percent without regard to a current cap, which ensures that States will not draw down DSH money in excess of 12 percent of their total spending on medical assistance. The second major provision changes the definition of low DSH States from States with DSH programs accounting for between 0 and 1 percent of their total Medicaid program, to States whose DSH programs represent 0 and 3 percent of total Medicaid spending. These low DSH States will be given 16 percent increases in their DSH caps each fiscal year between 2004 and 2009.

Finally, the MMA created a new program to assist States with paying for uncompensated medical care for undocumented aliens. The law establishes an annual $250 million fund, which

will be allotted among the States each year between FY 2005 and 2008. Two-thirds of this money will be distributed based on the relative percentages of undocumented aliens in each State and the District of Columbia. One third will be allotted among the six States with the largest number of undocumented alien apprehensions. The amounts set aside for each State will not be dispersed through the State itself. The law requires the Secretary to directly pay hospitals, doctors, and other providers for their otherwise uncompensated costs of providing emergency health care to undocumented aliens.

Medicare Advantage

The new law replaces Medicare+Choice with the Medicare Advantage program under Part C of Medicare. MMA changes how private plans will be paid in 2004 and thereafter. MMA allows for plans to be compensated appropriately for the increasing costs of caring for Medicare beneficiaries. Private plans will be able to use these enhanced payments to offer beneficiaries more generous coverage and to provide additional benefits that traditional Medicare may not. For example, plans can provide Medicare beneficiaries with lower premiums, broader benefits, or an improved physician network. With better compensation, more private plans will voluntarily enter the Medicare market and improve beneficiaries' plan choices.

Local managed care plans will continue to be offered on a county-wide basis. Beginning in 2006, Medicare Advantage will also include coordinated care plans that offer both in- and out-of-network required services on a regional basis. There will be at least 10 regions, but no more than 50. Each regional plan must offer a maximum limit on out-of-pocket expenses and a unified deductible. Also beginning in 2006, the Secretary will determine Medicare Advantage payment rates by comparing plan bids to a benchmark. Plans will bid to provide benefits, and the Federal Government will pay the plans the amounts they bid. If the plan's bid is below the benchmark, the beneficiary will receive 75 percent of the difference, either through additional benefits or lower cost-sharing. If the Medicare Advantage plan's bid is above the benchmark, the beneficiary will pay the additional amount. Beneficiaries in Medicare Advantage plans will not be required to enroll in the new prescription drug program, but beneficiaries can choose to receive an integrated benefit (medical and prescription drugs) through Medicare Advantage.

Comparative Cost Adjustment Demonstration

The MMA authorizes a six year demonstration of direct competition between Medicare fee-for-service (FFS) and private plans beginning in 2010. The demonstration will be conducted in Metropolitan Statistical Areas (MSA) with two local Medicare Advantage plans and local private plan participation of not less than 25 percent. The Secretary will choose not more than six qualified MSAs to participate in the demonstration. Medicare Advantage plans will continue to be paid what they bid, and traditional FFS and Medicare Advantage premiums will vary depending on plan and local FFS costs. Low-income beneficiaries in the demonstration areas will be protected from premium increases, and premiums of FFS beneficiaries will not increase or decrease annually by more than 5 percent relative to the FFS Part B premium.

Fee-for-Service Providers

MMA includes numerous provisions affecting Medicare providers, including rural providers. Following are highlights of these changes:

Rural Providers: For rural hospitals, MMA equalizes urban and rural standardized amounts under the inpatient hospital prospective payments system and reduces the labor-related share of the wage index from 71.1 percent to 62 percent. In addition, the Disproportionate Share Hospital (DSH) payment adjustment is increased from 5.25 percent to 12 percent for qualified hospitals. Rural hospitals with fewer than 100 beds will be protected from payment reductions associated with the outpatient prospective payment system for an additional two years.

For Critical Access Hospitals (CAHs), MMA increases their bed limit from 15 to 25, allows periodic interim payments, loosens rules on distinct part rehabilitation and psychiatric units, and increases reimbursement for services to 101 percent of reasonable costs.

Physicians in newly established scarcity areas receive a 5 percent bonus payment. Physicians in certain low-cost areas with geographic adjustment factors below one will receive increased payments that raise this factor to one, from 2004 to 2006. Home health agencies in rural areas will receive a 5 percent increase in Medicare payments for one year starting April 1, 2004. Ambulance providers receive a 2 percent increase in reimbursement for rural ground trips, and an increase in payment for ground ambulance trips over 50 miles. Rural hospice providers are allowed more freedom to allow nurse practitioners to act as the attending physician for a beneficiary who elects hospice.

Inpatient Hospitals: For fiscal years 2005 through 2007, hospitals will receive the full market basket update if they submit 10 quality measures established by the Secretary. If hospitals do not submit the quality measures in any of these years, they will receive an update of market basket minus 0.4 percentage points.

Physicians: The physician conversion update factor for 2004 and 2005 will be 1.5 percent, rather than the –4.5 percent update originally scheduled for 2004. Starting in 2003, the formula for calculating the sustainable growth rate (SGR) will be modified. The GDP factor will now be based on a 10-year rolling average, replacing the current factor which measures the one year change from the preceding year.

Skilled Nursing Facilities (SNFs): MMA increases the per diem payment amount by 128 percent for a SNF resident with AIDS, effective until the time the Secretary certifies that SNF case mix adjustment has been appropriately modified to cover the increased costs of caring for these residents.

Home Health Agencies: Home health payments are increased by the full market basket during the last quarter of calendar year 2003 and the first quarter of 2004. The update for the remainder of 2004, as well as 2005 and 2006, is the home health market basket increase minus 0.8 percentage points.

Durable Medical Equipment (DME): The payment update for most DME items and services is frozen from 2004 to 2008, or until competitive bidding is implemented.

Preventive Benefits

The MMA introduces a number of provisions that will expand preventive benefits coverage beginning January 1, 2005. Beneficiaries whose Medicare Part B coverage begins on or after January 1, 2005, will be covered for an initial preventive physical examination within six months of enrollment. This examination will include counseling or referral with respect to screening and preventive services such as pneumococcal, influenza, and hepatitis B vaccinations; screening mammography; screening pap smear and pelvic exam; prostate cancer screening; colorectal cancer screening; diabetes outpatient self-management services; bone mass measurement; glaucoma screening; medical nutrition therapy services; cardiovascular screening blood test; and diabetes screening test.

The diabetes screening test, only given to beneficiaries at risk for diabetes, will include a fasting plasma glucose test and other such tests approved by the Secretary.

The cardiovascular screening blood tests and the diabetes screening test do not have a deductible or co-pays (since Medicare pays 100 percent for clinical laboratory tests), so beneficiaries do not incur any cost. This is an additional incentive for those with limited resources who might not otherwise access these benefits.

Also, screening and diagnostic mammography will be excluded from the outpatient prospective payment system and paid separately under the physician fee schedule.

Part B Cost Sharing

MMA increases monthly Part B premiums for beneficiaries with higher incomes beginning in January 2007. Prior to MMA, the Part B premium for all beneficiaries, regardless of income, was set at 25 percent of estimated program spending in a given year. Under MMA, individuals with incomes above $80,000 and married couples with incomes above $160,000 will be subject to higher monthly premium amounts. The increases will be calculated on a sliding scale basis and phased in over a five year period. The highest category on the sliding scale will be for individuals with incomes above $200,000 (or $400,000 for a married couple).

MMA also makes changes to the Medicare Part B deductible. The deductible will remain $100 in 2004, increase to $110 in 2005, and in subsequent years, be indexed to inflation. Specifically, starting in 2006, the deductible will be increased by the same annual percentage as the monthly Part B premium increase (i.e., essentially the growth rate in Medicare Part B program expenditures).

Regulatory Reform

MMA includes a number of administrative and operational reforms. For example, regulatory reform provisions require the establishment of overpayment recovery plans in case of hardship; prohibit contractors from using extrapolation to determine overpayment amounts except under specific circumstances; describe the rights of providers when under audit by Medicare

contractors; require the establishment of standard methodology to use when selecting a probe sample of claims for review; and prohibit a supplier or provider from paying a penalty resulting from adherence to guidelines. In addition, MMA allows physicians to reassign payment for Medicare services to entities with which the physicians have an independent contractor arrangement. Finally, under the new law, final regulations are to be published within three years, and all measures of a regulation are to be published as a proposed rule before final publication.

Contracting Reform

The MMA includes provisions that allow the Secretary to introduce greater competitiveness and flexibility to the Medicare contracting process. To ensure a sufficient number of private contractors to administer the program, the original law setting up Medicare provided prospective contractors with a number of
beneficial provisions such as limiting the type of contractors, requiring cost contracts, and limiting competition for specific functions. The new law:

- Removes the distinction between Part A contractors and Part B contractors;
- Allows the Secretary to renew contracts annually for up to five years;
- Requires that all contracts must be re-competed at least every five years;
- Limits contractor liability; and
- Allows incentive payments to improve contractor performance.

Fraud and Abuse

MMA includes several provisions to combat health care fraud and abuse in the Medicare and other CMS programs. Highlights of these provisions are:

- Refinement of the average wholesale price (AWP) payments for Medicare's covered outpatient drugs provided in a doctor's office.
- Establishment of a competitive bidding program that would replace the current Medicare fee schedule payments for durable medical equipment (DME), enteral nutrition, and off-the-shelf orthotics. The competitive program will phase in all metropolitan statistical areas (MSA) over a three year period beginning in 2007.
- Development of quality and clinical standards for payment to DME suppliers.
- Implementation of a three-year pilot program in up to 10 States to conduct national and State background checks on workers in long-term care settings. The pilot program would identify efficient, effective, and economical processes for long term care facilities or providers to conduct background checks on employees with direct access to residents and patients.

Cost Containment/Long Term Financial Security

A provision in the new MMA will now require that annual reports of the Medicare Board of Trustees of the Hospital Insurance Trust Fund (Part A) and the Supplementary Medical Insurance Trust Fund (Part B) assess whether Medicare's "excess general revenue funding" exceeds 45 percent. As defined in the law, excess general revenue funding is equal to Medicare's total outlays minus dedicated financing. Dedicated financing includes Medicare payroll taxes; premiums for Part A, Part B, and Part D; transfers from the Railroad Retirement accounts;

taxation of certain OASDI benefits; State transfers for Medicare coverage of beneficiaries who receive public assistance; and gifts. The Trustees will be required to include the following information beginning in their 2005 annual report:

- General revenue Medicare growth projections as a percentage of the total Medicare outlays for each year within a seven-fiscal-year timeframe, and 10, 50, and 75 years after the fiscal year being reported;
- Financial analysis of the combined Medicare Part A and Part B trust funds if general Medicare revenue funding were limited to 45 percent of total Medicare outlays;
- A determination as to whether there is projected to be "excess general Medicare revenue funding" for any of the succeeding six fiscal years in their annual reports. If there is an affirmed determination of excess general Medicare revenue funding for two consecutive annual reports, this will be treated as a funding warning for Medicare. The President may then submit to Congress proposed legislation to respond to the warning;
- Comparisons with the growth trends for the gross domestic product, private health costs, national health expenditures, and other appropriate measures; and
- Expenditures and trends in expenditures under Part D.

The law requires the Medicare Trustees to issue a "warning" if general revenues are projected to exceed 45 percent of Medicare spending in a year within the next seven years. If the Trustees issue such a warning in two consecutive years, the law provides special legislative conditions for the consideration of proposed legislation submitted by the President to address the excess general revenue funding.

Appeals Reform

MMA changes the Medicare fee–for–service appeals process. It requires the Social Security Administration (SSA) and HHS to develop and implement a plan for transferring the Medicare hearings function from SSA to HHS, while maintaining independence of the administrative law judges hearing the cases from CMS. MMA specifies that a plan for this transfer must be submitted to Congress and the GAO by April 1, 2004, and the transfer must occur between July 1 and October 1 of calendar year 2005. MMA struck the statutory language that requires SSA ALJs to hear appeals of local coverage determinations.

MMA also changes the requirements for presentation of evidence, notices, and the number of qualified independent contractors (QICs). It reduces the number of QICs required by Section 521 of the Benefits Improvement and Protection Act of 2000 (BIPA) from at least 12 to at least four. It requires providers and suppliers to present all evidence for an appeal at the reconsideration level. Previously, evidence could be presented at any stage of the appeals process. MMA also provides for the use of beneficiaries' medical records in reconsiderations.

MMA increases the timeframes for decision-making at the lower levels of the appeals process to 60 days from 30. It requires the dollar amounts in controversy to be adjusted annually, and the Secretary to establish a process to expedite access to judicial review for legal issues that cannot be resolved administratively. Lastly, the MMA requires the Secretary to establish a process for waiving disapproval of nurse-aide training programs if an imposed civil money penalty (CMP) is not related to quality of care.

Health Savings Accounts

MMA establishes Health Savings Accounts (HSAs). HSAs allow individuals with high deductible plans (a deductible of at least $1,000 for individual plans and at least $2,000 for family plans) to contribute up to the lesser of the deductible amount or $2,600 for individuals and $5,150 for families in 2004 to a tax-advantaged account. The maximum contribution amount is indexed and increases each year. Individuals may withdraw money from their HSA on a tax free basis to pay for medical expenses below the deductible, as well as other qualified medical expenses such as prescription drugs, over the counter drugs, long-term care services, and COBRA insurance. Any money used for non-qualified medical expenses is taxable and subject to an additional 10 percent tax.

Medicare

Medicare provides health insurance to 41.6 million individuals who are either 65 or older, disabled, or suffer from end–stage renal disease (ESRD). In FY 2005, spending on Medicare benefits will total $324.5 billion.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) represents the largest transformation of the Medicare program in a generation, adding a prescription drug benefit and expanded health care choices to the existing program. The four parts of Medicare are summarized in the Medicare Fact Sheet.

Medicare has not traditionally covered outpatient prescription drugs and long-term care. As a result, many beneficiaries have some form of supplemental insurance to fill Medicare's gaps. The four major sources of supplemental coverage include: employer-sponsored benefits, a Medigap policy, Medicaid, and Medicare Advantage plans, the majority of which are HMOs.

Program Assessment Rating Tool (PART)

The Office of Management and Budget (OMB) developed the Program Assessment Rating Tool (PART) to evaluate programs in a systematic manner, using numeric scores that rate overall program effectiveness and highlight strengths and weaknesses. In FY 2003, the Medicare program was evaluated. Medicare was rated as "Moderately Effective" and found to be strong overall, but needed modernizing to reflect the evolution of health care since its inception in 1965. The Medicare Program PART summary identified three areas of improvement:

- Greater emphasis on sound program and financial managment;
- Legislative changes to modernize the benefit package to include prescription drug coverage and protection against catastrophic costs; and
- More effort to link Medicare payment to provider performance.

The passage of MMA addresses two of these items, enacting both a prescription drug benefit and contracting reform.

Health Care Fraud and Abuse Control Program (HCFAC)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established the Health Care Fraud and Abuse Control (HCFAC) Program to:

- coordinate Federal, State, and Local law enforcement programs;
- conduct investigations, audits, and evaluations relating to the delivery of and payment for health care;
- facilitate enforcement of statutes applicable to health care fraud and abuse;
- provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts; and
- provide for the reporting and disclosure of final adverse actions against health care providers, suppliers, or practitioners.

The HCFAC Program dedicates $1.07 billion from the Medicare Part A Trust Fund toward combating health care fraud and abuse. The money is allocated into three major parts: 1) $720 million for the Medicare Integrity Program (MIP); 2) $114 million to Federal Bureau of Investigation (FBI); and, 3) $240.6 million in "wedge" funds that are divided among the Department of Justice (DOJ), the HHS Inspector General, and other HHS agencies, including CMS, AoA, and the Office of General Counsel (OGC). The programs and projects financed by these funding streams are used to detect and prevent fraud, waste, and abuse through investigations and audits, educational activities, and data analysis. Egregious cases of health care fraud are also prosecuted in the courts. From 1997 to 2002, the HCFAC Program has returned approximately $4.9 billion to the Medicare Trust Fund.

The MIP activity in HCFAC provides funds for: medical review; benefits integrity work to identify and refer patterns of fraud to law enforcement; provider and HMO audits of cost reports; Medicare secondary payer activities; and provider education and training. Total funding for MIP has been capped at $720 million since 2002. For this investment, MIP is expected to save the Medicare Trust Funds $9.9 billion in 2005 through recoveries, claims denials, and accounts receivable, a 14:1 return on investment.

The FBI uses its $114 million allocation for health care fraud enforcement and investigations. In addition, the FBI provides operational support for national initiatives focusing on pharmaceutical diversion, chiropractic fraud, medical clinics, and transportation providers.

The remaining $240.6 million in wedge monies finance a variety of anti-fraud and abuse activities. DOJ uses its portion of the wedge for civil and criminal prosecutions of health care professionals and providers. The HHS Inspector General uses its share to bring about judgements and settlements related to health care fraud and abuse and to work with CMS to develop and implement recommendations to correct systemic vulnerabilities detected during HHS/OIG evaluations and audits. The remaining wedge monies go to HHS and are used primarily for: Medicaid financial management oversight and data analysis projects to detect patterns of fraud, educational activities at AoA , and investigative and litigation support at OGC.

Medicare Error Rate

Medicare Integrity Program is the primary source of funds to lower the Medicare payment error rate. The Department has lowered the Medicare payment error rate from 14 percent in FY 1996 to 5.8 percent in FY 2003, after adjusting for an unusually high non-response rate. We have set a goal of further reducing the error rate to 4 percent by FY 2008. Reducing the Medicare payment error rate is a major priority in the Department's effort to implement the President's Management Agenda.

FY 2003 was the first year that CMS was responsible for estimating the national Medicare error rate. Prior to that time, the Office of the Inspector General (OIG) performed the national Medicare payment error rate. The OIG used a sample size of approximately 6,000 claims each year to determine its estimate.

CMS developed the Comprehensive Error-Rate Testing (CERT) and the Health Payment Medicare Program (HPMP) to estimate the Medicare payment error rate using a sample size of 140,000-170,000 claims. Whereas, the OIG rate produced only one statistically significant number (the national error rate), CERT and HPMP provide contractor, provider type, and benefit service-specific error rates at statistically significant levels. CERT allows CMS to see contractor level performance data that the agency can use as a tool to manage and correct payment error.

In its first year using CERT, CMS encountered some difficulties in estimating the error rate. CMS received fewer responses from health care providers than OIG received in previous years. Because lack of response equated with payment error, the CERT rate was considerably higher than the OIG's 6.3 percent rate from FY 2002. We believe that the higher non-response rate was not a fair representation of payment error in the Medicare program. The contractor was asked to re-work their estimate to lower the non-response rate to a level comparable to previous years. When this was done, the rate came down to 5.8 percent compared to the original statistically significant 9.8 percent. CMS is in the process of implementing improvements to the CERT survey methodology to ensure that the adjustments made this year will not be necessary in future estimates.

The Administration's health care fraud, waste, and abuse control efforts have made progress in protecting the Medicare Trust Funds. Recent Medicare Trustee's reports have cited our health care fraud, waste, and abuse control efforts as a contributing factor in the slower Medicare spending growth experienced over the last several years. We hope to bring similar success to the state-administered Medicaid and SCHIP programs as well.

Quality Improvement Organizations (QIO)

QIOs (previously Peer Review Organizations) were established by Title XI, Section 1151 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.

QIOs are a central player in this Administration's efforts to improve the quality of care provided to Medicare beneficiaries. Under their current three year funding plan, totaling $1.1 billion (see table below), QIOs are part of groundbreaking efforts underway in Medicare to promote public awareness of the quality of care delivered in nursing homes, hospitals, home health agencies, and physicians offices, and to assist providers seeking to improve on measures of quality. These quality improvement efforts are essential to the Administration goals to modernize and strengthen the Medicare program.

In November 2002, HHS and CMS launched the national Nursing Home Quality Initiative (NHQI). The initiative provides new comparative information to consumers and new resources to facilities all aimed at improving nursing home quality of care. This ground breaking initiative was followed in the spring of 2003 with Phase I of Home Health Compare, which provides comparative information on 11 home health quality indicators for beneficiaries in eight demonstration States.

CMS is in the process of completing implementation of the Hospital Quality Initiative, which will provide comparative outcomes data on hospitals. To date, over 2,300 hospitals have pledged to join this voluntary effort. With incentives built into the MMA, most hospitals are expected to participate. The results of these public information programs will be better informed consumers and providers better able to identify what they must do to improve quality.

On January 15, 2003, a CMS study published in the Journal of the American Medical Association showed that we are making important progress in improving health care quality. The study shows that from 1998 to 2000, there has been across-the-board improvement in a series of health care quality measures tracked by QIOs. For instance, the study shows that the percentage of diabetic patients screened for cholesterol problems rose from 56 percent to 74 percent and that the percentage of patients receiving beta-blockers at hospital discharge, which reduce complications in patients who have had a heart attack, rose from 72 percent to 79 percent. Despite these improvements, the study reports that more than a quarter of Medicare beneficiaries still do not receive important services that could protect them from disease or prolong life.

Clinical Laboratory Improvement Amendments of 1988 (CLIA)

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 to finance survey and certification activities at clinical laboratories. User fees are credited to the Program Management account but are available until expended for CLIA activities. CMS determines the workloads of each State survey agency by taking the total number of laboratories and subtracting waived laboratories, laboratories issued certificates of provider-performed microscopy, State-exempt laboratories, and accredited laboratories.

The CLIA program is fully operational, with 177,400 laboratories registered with CMS, 24 percent of which are subject to routine inspection (every 2 years) under the program. The remainder are exempted. Workload projections for the FY 2005-2006 cycle include 20,550 surveys of non-accredited laboratories, 802 State validation surveys of accredited laboratories, and approximately 1,520 follow-up surveys and complaint investigations.

Data support the contention that CLIA has improved the overall quality of laboratory testing in the nation. The number of quality deficiencies decreased approximately 40 percent from the first laboratory survey to the second, with further decreases in subsequent surveys.

Medicare Legislative Proposals

The CMS budget includes a net savings of $130 million in FY 2005 from two Medicare legislative proposals. One proposal will eliminate the 15 month durable medical equipment (DME) rental option by requiring that continuous rentals be converted to purchase after 13 months. This proposal eliminates access problems beneficiaries confront when DME suppliers move, sell their business, or go into bankruptcy and can no longer offer the DME rental to the beneficiary by converting rentals to purchases under a faster time frame. It is also more cost effective for both beneficiaries and the Medicare program to purchase rather than rent DME for long periods of time due to the additional two months worth of rental payments and the cost of semi-annual maintenance fees.
The second proposal will allow CMS to use the Administration for Children and Families' quarterly wage data base to determine secondary payer status. The quarterly wage data base contains employment and possible employer-sponsored health insurance data. Accessing this data base will help CMS to more quickly identify instances where Medicare coverage is secondary to a beneficiary's (or their spouse's) employee health coverage, thereby reducing improper payments. Both of these proposals are included in appropriations language in the budget request.

Medicare Trust Fund

	2003	2004	2005	2005 +/-2004
Aged	34.9	35.3	35.7	+0.4
Disabled	6.0	6.3	6.6	+0.3
Total Beneficiaries	40.9	41.6	42.3	+0.7

Medicare Outlays

	2003	2004	2005	2005 +/-2004
Current Law:				
HI Benefits	$150,970	$166,182	$181,350	+15,168
SMI Benefits	121,628	127,786	140,455	+12,669
Transitional Drug Assistance /1	-	2,321	2,792	+471

Subtotal, Medicare Benefits	**$272,598**	**$296,289**	**$324,597**	**+28,308**
Other Medicare Activities:				
Stabilization Fund /2	-	-	-	-
Administration /3	3,779	3,893	4,207	+314
MMA Implementation /4	-	671	753	+82
Drug Demonstration	-	190	250	+60
HCFAC /5	1,027	1,075	1,075	0
Quality Improvement Organizations	350	367	379	+12
Transfers to Medicaid	112	125	0	-125
Total Outlays, Current Law	**$277,866**	**$302,610**	**$331,261**	**+28,651**
Offsetting Collections:				
Premiums	-28,433	-32,169	-36,839	-4,670
Other Offsetting Collections/Receipts	-58	0	0	0
Total Net Outlays, Current Law	**$249,375**	**$270,441**	**$294,422**	**+23,981**
Proposed Legislation:				
Medicare Benefits	0	0	-150	-150
SMI Transfer to Medicaid for QIs	0	0	+136	+136
Proposed User Fees	0	0	-205	-205
Premium Interactions	0	0	+36	+36
One-Time Military Service Credits Adjustment	0	0	+181	+181
Total Medicare Proposed Legislation	**$0**	**$0**	**-$2**	**-2**
Total Net Outlays, Proposed Law	**$249,375**	**$270,441**	**$294,420**	**+23,979**

/1 The new prescription drug and transitional benefits are a subaccount within the SMI trust fund but are separated here for informational purposes.

/2 Stabilization Fund will begin in FY 2007.

/3 Includes administrative payments to the SSA and other non-CMS agencies.

/4 Reflects estimates of $1.5 billion appropriated in MMA for CMS and SSA implementation. Actual outlays

/5 Health Care Fraud and Abuse Control, including FBI and OIG.

Medicaid

Medicaid is a jointly-funded, Federal-State program that provides medical assistance to certain low-income groups. In FY 2005, approximately 43.6 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 will be covered by Medicaid. Additionally, many other individuals will receive Medicaid benefits through waivers and amended state plans with higher income eligibility limits. Under current law, the Federal share of Medicaid outlays is expected to be about $183.2 billion in FY 2005. This is a $6.1 billion (3.4 percent) increase over projected FY 2004 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 per capita income. Federal matching rates for FY 2005 will range from 50 to 75 percent for medical assistance payments. The average Federal matching rate is about 57 percent. In addition to medical assistance payments, the Medicaid appropriation funds the Vaccines for Children program and the Federal share of Medicaid State and local administrative costs.

Historically, eligibility for Medicaid has been based on qualifying under the cash assistance programs of AFDC or Supplemental Security Income (SSI). With the creation of the Temporary Assistance for Needy Families (TANF) program in 1996 (which replaced AFDC) eligibility for Medicaid and cash assistance were de-linked. 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 must cover two additional groups: 1) pregnant women and infants whose family income does not exceed 185 percent of the Federal poverty level; and 2) all children under the age of 19 living below the poverty level.

States have the option to cover some individuals not eligible under AFDC or SSI rules 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.

Generally, States are required to provide a core of 13 mandatory services to eligible needy recipients, including: inpatient and outpatient hospital care; health screening, diagnosis, and treatment for 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.

Program Developments

Medicaid Growth: Prescription drug spending, nursing home, community-based long-term care costs, and payments to health plans are significant contributors to growth in the Medicaid outlays. These expenditures are expected to continue to contribute to 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. According to State estimates, the fastest growing service category in the Medicaid program is prescription drugs. States expect the prescription drug category, which includes the drug rebate offsets, to grow by $2.4 billion, or 13 percent, between FY 2004 and FY 2005. The State-estimated increase for prescription drugs accounts for 41.2 percent of the total FY 2005 benefit growth.

Waivers: States have sought waivers under section 1115 of the Social Security Act to expand health care coverage to low-income, uninsured populations and to test innovative approaches in

health care service delivery. Many of the demonstrations include the Temporary Assistance for Needy Families (TANF) and related populations, and some include the elderly and the disabled. Although demonstrations vary greatly, most employ a common overall approach: expanding the use of managed care for the Medicaid population.

To date, CMS has approved 27 Statewide comprehensive health care reform demonstrations in 23 States. CMS has also approved two sub-State health reform demonstrations and 12 demonstrations specifically related to family planning.

Health Insurance Flexibility and Accountability (HIFA): In August 2001, President Bush announced the Health Insurance Flexibility and Accountability (HIFA) demonstration, a new section 1115 initiative. HIFA enables States to use Medicaid and SCHIP funds in concert with private insurance options to expand coverage to low-income, uninsured individuals, with a focus on those with incomes at or below 200 percent of the Federal Poverty Level.

A more in-depth discussion of HIFA waivers is included in the SCHIP section.

Pharmacy Plus: The Administration developed the Pharmacy Plus waivers under section 1115 to help low-income seniors and people with disabilities who need assistance with prescription drug costs. Pharmacy Plus is directed to Medicare beneficiaries and other low-income seniors and people with disabilities with income of 200 percent or less of the Federal Poverty Level (FPL) who are not eligible for full Medicaid benefits. Four states have approved Pharmacy Plus demonstrations (Florida, Illinois, South Carolina, and Wisconsin) and Maryland has revised its Statewide 1115 demonstration to add a pharmacy benefit.

The Administration is working to address how the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) will effect the management of the Pharmacy Plus initiative.

Medicaid and SCHIP Reform

The past year has witnessed increasing dialogue on the subject of Medicaid and SCHIP modernization. States have continued to express concerns about the complexity of administering the Medicaid program. Federal regulation of the Medicaid program is an increasing burden on the ability of the States to address the unique needs of their low-income uninsured residents. The Secretary is encouraged by the current discussion and will look for new and innovative ways to address these concerns in the coming year. Building on the foundation of last year's Medicaid and SCHIP modernization proposal, the Secretary will work with Congress to pass an option for States to receive Medicaid and SCHIP funds in the form of flexible allotments. This strategy will provide States with the greatest potential for innovation and stability of funding.

Medicaid Legislative Proposals

New Freedom Initiative Demonstrations: The President's Budget reproposes three demonstration projects under the New Freedom Initiative. Each promotes at-home care as an alternative to institutionalization. The demonstrations are:

- Respite services to the caregivers of disabled adults.
- Respite services to caregivers of children with severe disabilities.
- Home and community–based services for children currently residing in psychiatric residential treatment facilities.

These three demonstrations will cost $13 million in FY 2005, and $256 million over five years. They will be funded out of mandatory Medicaid dollars.

There is a fourth demonstration project that addresses shortages of community direct care workers. This project is funded out of the CMS Research, Demonstrations, and Evaluation budget and costs $2.9 million in FY 2005.

Money Follows the Individual Rebalancing Demonstration: The Administration is also committed to promoting the use of at-home care as an alternative to nursing homes for elderly and disabled Americans. Under the "Money Follows the Individual" demonstration, at-home care combines cost effective benefits with increased independence and quality of life for the beneficiary.

In this five-year demonstration project, Federal grant funds would pay for home and community-based waiver services for individuals who move from institutions into at–home care. These costs would be funded at a matching rate of 100 percent for the first year of each individual's participation. As a condition of receiving the enhanced match, the participating State would agree to continue care after the first year at the regular Medicaid matching rates and to reduce institutional long–term care. This demonstration will be have no cost in FY 2005 and will cost $500 million over five years.

Living with Independence, Freedom, and Equality (LIFE) Accounts: Under this proposal, States would have the option of allowing individuals who self-direct all of their community-based long-term care services to accumulate savings and still retain eligibility for Medicaid and Supplemental Security Income (SSI). Under current law, beneficiaries are discouraged from accumulating savings because it could jeopardize their eligibility for Medicaid or SSI. This legislative proposal is estimated to be cost neutral.

Spousal Exemption: This proposal extends eligibility for Medicaid benefits to the spouses of individuals with a disability individuals entering the workforce. The lack of spousal coverage is a significant impediment to employment for many low-income individuals with a disability, and this exemption smooths the road to independence. The Federal government will invest $17 million in this program for FY 2005 and $102 million over five years.

Presumptive Eligibility for Community-Based Services: This proposal will establish a State Medicaid option allowing presumptive eligibility for institutionally-qualified individuals who are discharged from hospitals into the community. This will increase the number of Medicaid beneficiaries who receive home and community-based services rather than institutional care. This proposal will have no effect on the Medicaid budget.

Extension and Simplification of Transitional Medical Assistance (TMA): TMA was created to provide health coverage for former welfare recipients after they enter the workforce. TMA allows families to remain eligible for Medicaid for up to 12 months after they lose welfare benefits due to earnings from work. This provision was enacted along with welfare reform and was scheduled to sunset in September 2001. Congress has extended this program under PL 108–89 through March 31, 2004.

In addition to this extension, the 2005 President's Budget includes proposals to simplify eligibility for TMA benefits to the low-income working poor. There are three provisions to the proposal.

- States will be given the option to offer 12 months of continuous coverage to eligible participants.
- States may waive income reporting requirements for beneficiaries.
- States that offer Medicaid eligibility for children and families with incomes up to 185 percent of poverty may waive their TMA program requirements.

This proposal will cost $558 million in FY 2005 and $3.24 billion over five years.

Partnership for Long Term Care: This proposal would eliminate the legislative prohibition on developing more Partnership programs. The Partnership for Long Term Care (LTC) was formulated to explore alternatives to current long-term care financing by blending public and private insurance. Four States (California, Connecticut, Indiana, and New York) currently have these partnerships whereby private insurance is used to cover the initial cost of LTC. Consumers who purchase Partnership-approved insurance policies can become eligible for Medicaid services after their private insurance is utilized, without divesting all their assets as is typically required to meet Medicaid eligibility criteria. This proposal has no costs associated with it.

Extension of Premium Assistance to Qualified Individuals (QI): Under the QI program, Medicaid pays Medicare Part B premiums for Medicare beneficiaries with incomes between 120 and 135 percent of poverty. Currently Part B premiums cost about $799 a year. The Administration recognizes the economic burden these premiums place on low-income beneficiaries and proposes to extend the QI benefit through FY 2005. States will continue to be fully reimbursed for the cost of the program. This extension is estimated to cost $136 million in FY 2005.

Disability Determination Proposal: The Social Security Administration has proposed a management improvement that has a Medicaid impact. The proposal requires that 50 percent of all favorable adult disability benefit decisions be reviewed to verify eligibility. The program will save money in the Medicaid program by insuring that only legally disabled individuals are eligible for Medicaid services due to their SSI status. The proposal saves the Medicaid program $3 million in FY 2005.

Improvements to the Vaccines for Children (VFC) Program: VFC is a CDC administered, Medicaid funded program that administers free vaccines to eligible children. The Administration is proposing two legislative changes to the program. First, the President's Budget proposes to lift the price cap on the tetanus-diphtheria booster, thereby increasing access for VFC eligible

children. Second, the President's Budget would allow under-insured children to receive VFC administered inoculations at State and local health departments in addition to Federally Qualified Health Centers and Rural Health Centers. These proposals will cost an additional $165 million in FY 2005.

Medicaid Program Integrity: Throughout the life of the Medicaid program, States have used intergovernmental transfers (IGT) as a means of inappropriately drawing down inordinate amounts of Federal Medicaid funding. Past State funding mechanisms that manipulated the Medicaid Upper Payment Limit, Disproportionate Share Hospital payments, and provider taxes and donations would have been impossible without the use of intergovernmental transfers. The FY 2005 President's Budget proposes to further improve the fiscal integrity of Medicaid by curbing IGTs that are in place solely to undermine the statutorily determined Federal matching rate. The budget proposes to cap Medicaid payments to individual State and local government providers at the cost of providing services to Medicaid beneficiaries and restrict the use of ceratin intergovernmental transfers. This proposal will save the Federal Government $1.5 billion in FY 2005 and $9.6 billion over five years.

Child Support Enforcement Proposals: The Administration for Children and Families (ACF) has proposed two changes that have an effect on the Medicaid baseline. Both proposals affect the Child Support Enforcement program. The first proposal would allow States to seek medical child support for children from both the custodial and non-custodial parent. States would also be able to enforce these support orders against the custodial parent. ACF expects this change to increase children's access to private sources of health care.

The second legislative change mandates that all States review child support orders for Temporary Assistance for Needy Families (TANF) families every three years. Under current law, States review child support orders every three years if instructed to do so by the custodial parent or at the State's own discretion. This change would mandate that States undertake these reviews. ACF believes that required reviews would result in the discovery of increased levels of private health insurance among non-custodial parents. This increased access to private health insurance would lead to a decrease in Medicaid costs among TANF families.

These two proposals will be budget neutral in FY 2005, but will save the Federal Government $50 million over five years.

Refugee and Asylee Exemption Extension: Under current law, most legal immigrants who entered the country on or after August 22, 1996, and some who entered prior to that date are not eligible for SSI until they have resided in the country for five years or have obtained citizenship. Refugees and asylees on SSI are currently exempted from this ban for the first seven years they reside in the United States. Procedural delays and asylee waiting lists have created a situation in which seven years may not be enough for these groups of immigrants to gain American citizenship. To assure that refugees and asylees have ample time to complete the citizenship process, the President's Budget proposes extending the current seven year exemption to eight years. The policy would continue through 2007. The proposal will cost the Federal Government $29 million in FY 2005 and $132 million over five years.

Temporary Assistance for Needy Families (TANF) Cost Allocation Adjustment: This FY 2005 appropriations language proposal will reduce the Federal reimbursement for administrative costs of Medicaid by $300 million to reflect the share assumed in the Temporary Assistance for Needy Families (TANF) block grant and will prohibit States from using TANF funds to pay these costs during FY 2005. In the past, costs common to AFDC, Medicaid and Food Stamps were charged to the former AFDC program and included in each State's TANF base year. This proposal allows the recovery of amounts that were funded in the TANF block grant that States now charge to Medicaid. This one time reduction will eliminate the dual payment to States for certain administrative costs in the administration of the Medicaid program that was created by the TANF welfare reform legislation. This proposal will be in effect for only FY 2005, and will save approximately $300 million for the Federal Government.

Reduce the Enhanced Federal Matching Rate for Information and Claims Management Systems: Under current law States receive a 90 percent matching rate on all expenditures related to the design, development, and implementation of Medicaid claims processing and information retrieval systems. A new proposal, included in the FY 2005 Medicaid appropriations request, would reduce this matching rate to 75 percent, which is consistent with other enhanced matching rates. This one-year change will save the Federal Government approximately $80 million in FY 2005.

Medicaid Outlays

Current Law:	2003 Actual	2004 Enacted	2005 Request	Request +/- Enacted
Benefits /1	$152,673	$168,239	$173,878	$5,639
State Administration	$8,021	$8,868	$9,319	$450
Total Net Outlays, Current Law	**$160,693**	**$177,107**	**$183,197**	**+$6,090**

/1 Includes Vaccines for Children Outlays.

Medicaid Enrollment

	2003	2004	2005
Aged 65 and Over	4.3	4.4	4.4
Blind and Disabled	7.8	8.0	8.1
Needy Adults	10.5	10.8	10.9
Needy Children	19.3	19.7	20.2
Total /1	**41.9**	**42.9**	**43.6**

/1 Numbers may not add due to rounding.

State Children's Health Insurance Program

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 insurance coverage they need. The program improves the access to health care and the qualify of life for millions of vulnerable children under 19 years of age. SCHIP reaches children whose families have incomes too high to qualify for Medicaid, but too low to afford private health insurance.

The number of uninsured children has decreased since the inception of SCHIP. In fact, even in the recent period of State budget constraints, the uninsurance rate among children continued to decline, from 10.5 percent in FY 2002 to 9.4 percent in the first half of FY 2003.

Title XXI appropriated almost $40 billion to the program over 10 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:

- expanding Medicaid,
- creating a new, non-Medicaid Title XXI separate State program, or
- a combination of both approaches.

Generally, Medicaid-ineligible, uninsured children, who are under 19 years old, in families below 200 percent of the Federal Poverty Level (FPL), can receive SCHIP benefits.

Implementation and Enrollment

Every State, the District of Columbia, and all five Territories have approved SCHIP plans. As of January 2004, States have received approval for 19 Medicaid expansion programs, 18 separate programs, 19 combination programs, and 186 State plan amendments.

Today, 40 States cover children in families with incomes up to 200 percent of the FPL. Of these States, 13 cover children above that level. Five of the States cover children up to 300 percent of the FPL, and one State covers children up to 350 percent of the FPL.

During FY 2003, preliminary estimates show 5.8 million children enrolled in SCHIP. This represents an increase of half a million, or 9 percent, over FY 2002 enrollment.

SCHIP Performance

When SCHIP began in 1997, CMS adopted a goal of enrolling five million children by FY 2005. Specifically, CMS set annual target goals for FYs 2000 through 2002 to enroll at least 1 million

new children in SCHIP and Medicaid per year. CMS has exceeded these enrollment goals every year.

The Office of Management and Budget (OMB) developed the Program Assessment Rating Tool (PART) to evaluate programs in a systematic manner, rating program effectiveness and highlighting strengths and weaknesses. SCHIP was initially evaluated by OMB in the FY 2004 cycle and received a score of 71. It was then reassessed in the FY 2005 cycle and received a score of 66 and a rating of "Adequate." As a result of OMB's findings, CMS developed an SCHIP Action Plan to further strengthen the program.

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 required by the statute, the Secretary submitted a report on the States' evaluations, which was made available to Congress and the public in December 2002. In addition to this report to Congress, CMS has planned future evaluations to examine the SCHIP program in greater detail.

The Balanced Budget Refinement Act of 1999 (BBRA) also required HHS to conduct an independent evaluation of 10 States. The interim evaluation report was submitted to Congress in February 2003. A final report is expected to be presented to Congress in 2004.

BBRA also directed the Secretary, through the Inspector General, to evaluate SCHIP every three years. The OIG is instructed to evaluate 1) State compliance with the requirement that Medicaid-eligible children are not enrolled in SCHIP, and 2) State progress made in reducing the number of uninsured children. The Office of Inspector General (OIG) released two reports in February 2001 that fulfill these requirements. To satisfy the OIG's requirement to submit these evaluations every three years, the OIG has completed the first round of studies and will publish its report in accordance with the BBRA mandate sometime this year.

As directed by BBRA, the Comptroller General submitted a report to Congress monitoring these OIG audits. The Comptroller General's report suggests that the OIG expand the study to include a more diverse sample of States. The scope of the OIG follow-up studies is expanded to more comprehensively assess the SCHIP program by analyzing a broader array of States.

SCHIP Waivers

The requirements of Federal law and regulations can be waived by the Department of Health and Human Services (HHS) to give States the programmatic flexibility to increase health insurance coverage and encourage innovation in their SCHIP programs. Waivers allow States to improve children's coverage and the quality of services for children. Using section 1115 waivers, States can more effectively tailor their programs to meet local needs and can experiment with new approaches to providing health care services to SCHIP recipients.

As of January 2004, SCHIP waivers were approved for Maryland, Minnesota (2), New Jersey, New Mexico (2), New York, Ohio, Rhode Island (2), and Wisconsin. These Section 1115 waivers provide health insurance to uninsured children, their parents, and pregnant women.

States can also use a new section 1115 approach, the Health Insurance Flexibility and Accountability (HIFA) waivers, to develop comprehensive insurance coverage for individuals at twice the Federal poverty level and below, using SCHIP and Medicaid funds.
Since December 2001, the Administration has approved eight HIFA demonstration waivers that affected SCHIP, in Arizona, California, Colorado, Illinois, Michigan, New Mexico, New Jersey, and Oregon. These demonstration waivers target vulnerable, uninsured populations, such as pregnant women, parents and children on Medicaid and SCHIP, and other adults with incomes less than twice the Federal Poverty Level.

Recent Legislation

On August 15, 2003, President Bush signed P.L. 108-74. The law restores $1.2 billion in FY 1998 and FY 1999 SCHIP funds, and makes them available to States until September 30, 2004. The law also extends $2.2 billion in FYs 2000 and 2001 SCHIP funds and revises the rule for redistributing the unspent funds from those allotments. For the FYs 2000 and 2001 allotments, the law allows States that do not spend their entire allotment within the three-year period of availability to keep half of those respective year's unspent amounts. The other half would be redistributed to States that have spent their entire amount of the respective year's allotments. The law also extends the availability of funds from the FY 2000 allotments through September 30, 2004, and the availability of the FY 2001 allotment through September 30, 2005.

The law also gives some relief to States that expanded their Medicaid programs to cover additional, low-income children prior to the enactment of SCHIP. These States are given the option to use up to 20 percent of any available SCHIP allotments from FYs 1998, 1999, 2000, or 2001 to pay for certain Medicaid expenditures. Only Medicaid expenditures for individuals under age 19 whose family income exceeds 150 percent of the Federal poverty level qualify under this provision.

Under P.L. 108-74, Connecticut, Minnesota, New Hampshire, Tennessee, Vermont, Washington, and Wisconsin are considered "qualifying" States and can use these SCHIP allotments for certain Medicaid expenditures. Subsequently, P.L. 108-127 was passed, which defines Hawaii, Maryland, New Mexico, and Rhode Island as "qualifying" States.

Legislative Proposals

Special Enrollment Period in Group Market for Medicaid/SCHIP Eligibles: This legislative proposal would make it easier for Medicaid and SCHIP beneficiaries to enroll in private health insurance, by making eligibility for Medicaid and SCHIP a trigger for private health insurance enrollment outside the plan's open season. This proposal will help States implement premium assistance programs in Medicaid and SCHIP.

Please see the Medicaid section for additional proposals that affect SCHIP.

SCHIP Outlays

	2003	2004 Projected	2005 Projected	2004 +/- 2005
Current Law				
Total Outlays	$4,355	$5,232	$5,299	+$67

Medicaid and SCHIP Proposals

	2005	2005-2009
MEDICAID PROPOSALS		
Spousal Exemptions	$17	$102
New Freedom Demonstration	$13	$256
Presumptive Eligibility for Community Based Services	$0	$0
"Money Follows the Individual" Rebalancing Demonstration	$0	$500
Partnerships for Long-term Care	$0	$0
LIFE Accounts	$0	$0
Vaccines for Children (VFC) Adjustments	$165	$810
Extension of Transitional Medical Assistance with Modifications	$558	$3,240
QI-1 transfer from Part B	$136	$136
Medicaid Program Integrity	($1,542)	($9,649)
TOTAL OTHER PROPOSALS	**-$653**	**-$4,605**
OTHER PROPOSALS WITH IMPACT ON MEDICAID/SCHIP		
Child Support Enforcement - Medical Support From Either Parent	$0	-$35
Child Support Review and Adjustment	$0	-$15
Refugee Exemption Extension	$39	$132
SSA Disability Determinations (non-add)	-$3	-$237
TOTAL OTHER PROPOSALS	**$36**	**-$155**
TOTAL MEDICAID AND SCHIP	**-$617**	**-$4,760**

State Grants and Demonstrations

	1999 Actual	2003	2004	2005	Request +/- Enacted
Budget Authority	$0				
Ticket to Work grant programs.....		$72	$77	$81	+$4
Qualified High-Risk Pools grant programs....		$60	$40	$0	-$40
Federal Reimbursement of Emergency Health Services - Undocumented Aliens……		$0	$0	$250	+$250
Total Budget Authority.....		**$132**	**$117**	**$331**	**$214**
Outlays					
Ticket to Work grant programs.....		$15	$16	$28	+$12
Qualified High-Risk Pools grant programs....		$0	$31	$26	-$5
Federal Reimbursement of Emergency Health Services - Undocumented Aliens……..		$0	$0	$250	+$250
Total Outlays.....	**$0**	**$15**	**$47**	**$304**	**$257**

/1 The Ticket to Work and Work Incentives Improvement Act was signed into law on December 17, 1999. The legislation established appropriations for the grant programs starting in FY 2001.

The Ticket to Work and Work Incentives Improvement Act (TWWIIA)

Ticket to Work and Work Incentives Improvement Act of 1999 authorized two grant programs designed to assist States in developing services and supports to aid the competitive employment of people with disabilities by extending Medicaid coverage to these individuals. Section 203 of the Act provides an appropriation each year from FY 2001 to FY 2011 for Medicaid Infrastructure Grants. These grants provide funding to States to build Medicaid infrastructure and supports, conduct outreach activities, explore new service options, and form partnerships to improve the employment environment for people with disabilities. Section 204 provides for an appropriation of $42 million for each of the fiscal years from 2001 to 2004, and $41 million for both FY 2005 and FY 2006 for Demonstration to Maintain Independence projects. The demonstration program will evaluate the potential benefits of providing Medicaid services to workers with physical or mental impairments that, without medical intervention, are likely to result in disability.

In FY 2005, the budget authority provided by statute for the two grant programs totals $81 million. Medicaid Infrastructure Grants are authorized and appropriated for $40 million of non-matched Federal funding. Demonstration to Maintain Independence and Employment is authorized and appropriated for $41 million. States must match Federal funding for this demonstration program at the normal Federal matching rate.

As of December 31, 2003, 43 entities (42 States and the District of Columbia) were approved for funding from the Infrastructure Grant Program since its inception. For fiscal year 2004, 29 entities (28 States and the District of Columbia) will receive funding through the Medicaid Infrastructure Grant program. With this funding, States plan to make systemic changes to the Medicaid program that will help individuals with disabilities gain employment and retain their health care coverage. These changes are designed to increase and improve Medicaid buy in programs, enhance State personal assistance service programs, and explore other employment support options.

Three States (Rhode Island, Texas, and Mississippi) and the District of Columbia were awarded Demonstration to Maintain Independence and Employment grant funding since the program was started. States implementing demonstration grant programs will provide Medicaid equivalent services to targeted populations of working individuals with disabilities. The demonstration projects will be used to evaluate the impact of providing Medicaid benefits to a working person with a potentially severe disability. The State demonstration projects approved so far will cover the HIV/AIDS, Multiple Sclerosis, and Bi-Polar/Schizophrenia populations.

Qualified High-Risk Pools

The Trade Adjustment Assistance Reform Act of 2002 (TAA) establishes two grant programs for States to provide health insurance coverage through high-risk pools. The first program makes available a total of $20 million to States that, as of the day of enactment of the TAA, do not already have a qualified high-risk pools. These funds will be used for the creation and initial operation of pools. The second program makes available $40 million in both 2003 and 2004 for grants to States with existing qualified high-risk pools to be used for the operation of their pools.

States that do not have existing qualified high-risk pools and will be eligible to apply for up to $1 million each to create and initially operate a qualified high-risk pool. The TAA legislation makes available $20 million in FY 2003 for these "seed grants." This money will be available until the end of FY 2004. In November 2002, the Secretary sent letters and instructions to the governors and State insurance commissioners to announce the availability of the seed grants and invite them to apply for funding. Applications must be received before March 31, 2004 to be considered for the grants. Two states, Maryland and South Dakota, have received seed grant funding of $1 million each.

The legislation also makes available $40 million in both FY 2003 and FY 2004 for the States that already operate qualified pools that meet the requirements of the statute. The FY 2003 money will be available until the end of FY 2004 and the FY 2004 money will be available until the end of FY 2005. CMS published a Federal Register Notice on May 2, 2003 announcing the availability of funding and inviting States to apply. Twenty States applied for the first round of funding and $29.8 million was awarded to the following 16 States: Alaska, Arkansas, Colorado, Connecticut, Illinois, Indiana, Iowa, Kansas, Kentucky, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, North Dakota, and Oklahoma.

Federal Reimbursement of Emergency Health Services for Undocumented Aliens

The MMA created a new program to assist States with paying for uncompensated medical care for illegal aliens. The law establishes an annual $250 million fund, which will be allotted among the States each year between FY 2005 and 2008. Two-thirds of this money will be distributed based on the relative percentages of undocumented aliens in each State and the District of Columbia. One third will be allotted among the six States with the largest number of undocumented alien apprehensions. The amounts set aside for each State will not be dispersed through the State itself. The law requires the Secretary to directly pay hospitals, doctors, and other providers for their otherwise uncompensated costs of providing emergency health care to undocumented aliens.

Program Management

	2003	2004	2005	2005 +/-2004
Medicare Operations	$1,667	$1,701	1,794	+$93
Survey and Certification.....	253	251	270	+19
Federal Administration.....	572	577	589	+12
Research.....	74	78	68	-10
Revitalization Plan.....	0	30	24	-5
CMS Budget Authority Subtotal /1.....	**$2,565**	**$2,637**	**$2,746**	**+109**
CLIA/HMO and Data Spending.....	$45	$45	$45	$0
National Medicare Education Program	16	14	14	0
Reimbursable Spending Subtotal.....	**$61**	**$59**	**$59**	**$0**
CLIA/Sale of Data/HMO User Fees.....	-45	-45	-45	0
National Medicare Education Program.....	-16	-14	-14	0
User Fee Subtotal.....	**-$61**	**-$59**	**-$59**	**$0**
Proposed Discretionary User Fees.....	$0	$0	-$205	-$205
Proposed Budget Authority	**$2,565**	**$2,637**	**$2,541**	**-$96**
Proposed Outlays.....	$2,565	$2,637	$2,541	-$96
FTE /2.....	4,599	4,586	4,580	-6

1/ Numbers may not add due to rounding.
2/ Does not include funding and FTE associated with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Program Management Request

The CMS FY 2005 Program Management budget request is $2.7 billion in budget authority, a $109 million or 4.1 percent increase over the FY 2004 Congressional Conference level. As in past years, CMS is proposing to finance $205 million of this budget authority with proposed user fees. The two proposed fees are for duplicate and unprocessable claims and the filing of certain Medicare appeals. If the fees are enacted, Program Management budget authority would be lowered by the amount of the fee passed.

The FY 2005 budget request includes funding for CMS operations to support Medicare, Medicaid, and SCHIP related activities. These funds are in addition to the $1 billion provided by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) budget, legislative, and management priorities of the Administration, including: reforming the Medicare appeals process; educating beneficiaries about their health plan and benefit choices; reducing burden on our partners; improving financial management performance through ongoing

implementation of the healthcare integrated general ledger accounting system (HIGLAS); and strategic management of human resources.

Medicare Operations: The Medicare Operations budget supports a broad array of activities. The budget is $1.8 billion, an increase of $93 million or 5.5 percent over FY 2004.

The Medicare program administered by private 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.
CMS Medicare Operations includes:

- Ongoing Activities: carriers' and fiscal intermediaries' regular activities, such as processing claims, holding hearings and appeals, answering inquiries, and educating providers and beneficiaries.
- Information Technology Systems Maintenance and On-Going Operations: activities to keep shared claims processing systems current, Common Working File (CWF), and managed care systems maintenance.
- Operations: funding provider services and Medicare contractor oversight.
- Enterprise-Wide Activities: funding for the CMS Data Center (contractor-operated), the Medicare data communications network, and hardware and software maintenance.
- Legislative Mandates: funding for implementing legislation such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Balanced Budget Act of 1997(BBA), the Balanced Budget Refinement Act of 1999 (BBRA), the Benefits Improvement and Protection Act of 2000 (BIPA), the Federal Financial Management Improvement Act of 1996 (FFMIA), and the Chief Financial Officers Act of 1990. Funding for implementation of MMA has been appropriated separately from this request.
- Program Improvements: funds the long-term care initiative.

In FY 2005, CMS will process 1.1 billion claims and answer an estimated 51 million inquiries. We expect little change in the unit cost to process a claim from FY 2004 estimates. In FY 2005, the unit cost to process a Part A claim will be $0.87, the same as the estimate in FY 2004 unit cost projections. Part B unit costs are estimated to dip from $0.65 estimated in FY 2004 to $0.63 in FY 2005.

Approximately 68 percent of the FY 2005 Medicare operations program level request will be spent on Medicare contractor on-going operations including processing claims, on-going appeals (as distinguished from the new appeals process), inquiries, and provider assistance. CMS will spend $1.2 billion in FY 2005, a 2.4 percent increase over FY 2004 estimates. Medicare contractors expect a 4 percent increase in total claims volume over the FY 2004 estimate.

Legislative mandates comprise 21 percent of the Medicare Operations budget and are funded at $377 million in FY 2005, a 24 percent increase over the FY 2004 enacted level.

CMS dedicates $5 million to a special Long-Term Care (LTC) Clearinghouse initiative. CMS will continue to work with the Administration on Aging to develop a national clearinghouse for individuals and families to obtain information on long-term care services and financing options. A communications campaign is planned to promote the initiative.

Of the remaining spending in Medicare Operations, systems maintenance and on-going information technology operations spending will be $121.6 million in FY 2005. CMS operations spending will be $14.6 million in FY 2005. Enterprise activity spending will remain steady at $53.7 million or an increase of $0.6 million over FY 2004. Program Improvements will be funded at $5 million in FY 2005 reflecting the fact that many of last year's program improvements have been absorbed in the MMA and in regular Medicare Operations.

Finally, CMS will provide $10 million towards the Department-wide Information Technology (IT) Enterprise Infrastructure Fund ($7.4 million) and Unified Financial Management System ($2.6 million).

Federal Administration: For FY 2005, the President's Budget requests $589.2 million for CMS Federal administrative costs. This is an increase of $12 million or 2.1 percent over FY 2004.

The CMS budget proposes a total of 4,580 FTE, of which 3,040 FTE will staff the central office and 1,540 FTE will staff the regional offices. The FY 2005 CMS Federal Administration account supports a staffing level of 4,398 direct FTE, a straight line from FY 2004. The remaining 182 FTE are funded elsewhere in the CMS budget. Within the total level, 10 new FTE are earmarked for CMS actuarial staff to support on-going Medicare modernization analysis.

CMS FTE request supports the agency's Government Performance and Results Act (GPRA) goals through the development of a comprehensive workforce planning process and automated system. Approximately 44 percent of FTE are eligible to retire between 2004 and 2009. Therefore, CMS has created and is implementing a strategic human resources (HR) plan to ensure that the agency has the human capital it needs to accomplish its mission.

CMS requests $13 million to continue the Healthy Start, Grow Smart program. This will support the printing costs and postage for a series of 13 informational brochures in English and Spanish to new Medicaid mothers. These brochures are distributed at the time of birth and monthly over the first year of the child's life. Each publication focuses on activities that stimulate infant brain development and build skills these children need to be successful in school. In addition, each Healthy Start pamphlet includes vital health and safety information for new parents. The Healthy Start, Grow Smart program has disseminated over 8.8 million brochures in 37 states and the District of Columbia. Approximately 14 percent of the brochures are in Spanish and 86 percent in English. CMS is also working with the American Hospital Association to target small rural hospitals, which may not have the funds to print their own high quality educational materials for new mothers.

The CMS Federal Administration budget also includes $3 million to continue implementing the national and local coverage appeal provisions of BIPA section 522. In addition, the request

includes $3.7 million to support HIGLAS, a component of the Department's Unified Financial Management System (UFMS).

Research, Demonstrations and Evaluation: The FY 2005 budget requests $68.3 million for the Research, Demonstrations and Evaluation program, $9.5 million less than the FY 2004 level. This request includes $40 million to support Real Choice Systems Change Grants, $2.9 million for the President's New Freedom Initiative, and $25.4 million to continue and refine projects initiated in previous years.

For the second year, the budget proposes $40 million to continue funding for Real Choice System Change Grants. These grants will help States improve community- based support systems to enable people with disabilities and long-term illnesses to live and participate in their communities. These changes allow children and adults with disabilities or long-term illnesses to (1) live in the most integrated community setting possible, (2) exercise choices about their living environment, and (3) obtain quality services in a manner as consistent as possible with community living preferences and priorities. In FY 2003, 87 new Real Choice System Change Grants were awarded.

The budget requests $2.9 million for New Freedom Demonstrations. The demonstrations will continue State efforts to provide community-based care for people with disabilities to improve the availability and quality of home-based and community-based services. These grants will also help States identify best practices and develop models to increase access to personal assistance services for specific populations. Research will also be conducted to identify future approaches to meet the care needs of the developmentally disabled population.

Another $25.4 million of the request will continue and refine projects initiated in previous years. These include the Medicare Current Beneficiary Survey, beneficiary information campaign evaluations, refinement and monitoring of prospective payment systems, and support for legislative mandates in the BBA, BBRA, and BIPA.

Survey and Certification: The FY 2005 budget request is $270.4 million, an increase of $19.1 million over the 2004 level. 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.

Included in this total is $25 million to support and implement 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 10-day time frame.

Of the total request, $227.7 million will allow States to inspect long-term care facilities and home health agencies at their legislatively mandated frequencies, as well as maintain the FY

2004 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 24,000 initial or recertification inspections. In addition, CMS estimates conducting 51,900 visits in response to beneficiary or family complaints.

The remaining $17.7 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.

Revitalization Plan: The FY 2005 budget request includes $24.4 million in two-year money to continue funding for the second year of the multi-year Revitalization Plan. This is $5.2 million below the FY 2004 level. The Medicare program has relied on a number of antiquated legacy systems that have been characterized by the General Accounting Office (GAO) and the Department's Office of the Inspector General (OIG) as inflexible, not secure, and obsolete. In addition to base problems, extensive changes required by the MMA will require extensive upgrading of CMS IT systems.

The Revitalization Plan will begin the process of modernizing the agency's Medicare fee-for-service claims processing systems ($21.1 million), modernizing CMS information technology data structure ($2.3 million), and revamping the agency's internal infrastructure ($1 million). These modernization efforts improve efficiency, enable e-gov activities, and improve systems security at CMS, and our Medicare contractors.

The Revitalization Plan is an important step toward providing the flexibility and security needed to take on the growing workload and health care options and provide future beneficiaries with the information that they need to make informed choices.

Program Management Priorities

Appeals Reform: The CMS FY 2005 budget includes $129 million to implement Medicare appeals reform as required by BIPA and modified by MMA. Of this amount, $126 million will go towards fee–for–service claims appeals and $3 million will go towards coverage appeals. The $129 million allows CMS to implement 4 Qualified Independent Contractors (QIC) ($65 million), reimburse the Social Security Administration (SSA) for continuing to process Medicare appeals for three-quarters of the year ($50 million), fund start-up costs for the transfer of the administrative law judge (ALJ) function ($8 million), provide funding for CMS new appeals system ($3 million), and continue the appeals process for coverage determinations ($3 million). The four QICs will be operational by mid-FY 2005 and able to process approximately 200,000 second level appeals.

Currently, SSA continues to process Medicare appeals for fee-for-service claims in dispute that rise to the ALJ level. HHS and SSA entered into a MOU to allow SSA to continue processing the 2004 Medicare hearings workload. The Secretary signed a memorandum of understanding (MOU) with the Commissioner of SSA. The Department intends to enter into a similar

arrangement with SSA in FY 2005, which will be in effect until the function transfers to HHS in the last quarter of FY 2005. Thus, the CMS budget request includes $50 million to reimburse SSA to continued processing of Medicare cases, until the function transfers to HHS.

The National Medicare & You Education Program: Beneficiary education is a high priority for CMS. CMS educates beneficiaries about their current benefits and future choices so they can be informed health care consumers.

The FY 2005 budget provides $173.1 million (program level) to finance NMEP activities. This represents a $20.1 million increase over FY 2004. NMEP is funded through a variety of sources, including $142.1 million from Program Management, $17 million from the Quality Improvement Organization account, and $14 million from user fees. CMS will continue to enhance beneficiary services in FY 2005, including investing:

- $61 million for customer service representatives to be available for beneficiaries on 1–800–MEDICARE 24-hours-a-day, 7-days-a-week; and
- $32.5 million for the national advertising campaign, which encourages beneficiaries to call 1-800-MEDICARE and visit www.medicare.gov with their Medicare questions.

CMS anticipates 9.1 million calls on 1-800 MEDICARE in FY 2005, up from an FY 2003 call volume of 5.6 million calls. The increase is due mostly to questions concerning the new benefits available under the MMA.

NMEP funds additional national and local education efforts. CMS will publish and mail 40 million Medicare & You handbooks, and send additional Medicare information to consumers. CMS will continue community-based outreach activities with the State Health Insurance Assistance Programs (SHIPs), and will allow the Territory of Guam the opportunity to participate in SHIP for the first time. NMEP funds will support Regional Education About Choices in Health (REACH), which focuses on local-level support involving health fairs and town hall meetings, and Health Outreach Zeroing In On Needs (HORIZONS), which improves health education communication to Medicare beneficiaries from minority populations.

Beneficiaries use the www.medicare.gov website. CMS expects 79 million page views in FY 2005. The most popular databases on the website include Nursing Home Compare, the Medicare Personal Plan finder, and the Participating Physician directory.

HIGLAS: One of the Secretary's top priorities is to centralize the Department's financial accounting process through its Unified Financial Management System (UFMS). UFMS is expected to achieve greater economies of scale, eliminate duplication, mitigate security risks, and provide timely and accurate financial information. A major component of UFMS is the Healthcare Integrated General Ledger Accounting System (HIGLAS) which will perform the accounting for over one billion Medicare claims processed each year as well as the everyday administrative financial dealings of CMS. The development of HIGLAS will also help CMS and the Department to fulfill the financial management portion of the President's Management Agenda.

In FY 2005, the President's Budget requests $78.3 million ($74.6 million in two-year money in Medicare Operations and $3.7 million in Federal Administration) an increase of $21 million above the FY 2004 President's Budget request.

CMS began developing HIGLAS in FY 2001. Thus far, it has mapped software requirements and piloted a number of aspects of the system, including the fit of the chosen software product to Medicare requirements and the gaps in the software that must be further developed. Currently, CMS is in the process of validating and user–testing parts of the claims payment processing cycle at two contractor pilot sites. Later this year, CMS will test all functions of the claims payment processing system at these two pilot sites.

In FY 2005, CMS expects to begin administrative system planning, as well as implementing the claims payment processing systems at additional contractor sites. By the end of FY 2005, HIGLAS should be installed at contractor sites comprising 75 percent of accounts receivable and more than 50 percent of accounts payable transactions. At that point, CMS will reach an acceptable standard to eliminate a material weakness in its financial status and maintain its clean financial audit opinion.

The Nursing Home Oversight Improvement Program: The President's budget for CMS commits a total program level of $84.0 million in mandatory and discretionary funds to the Nursing Home Oversight Improvement Program (NHOIP) in FY 2005, a decrease of $8.5 million over the CMS FY 2004 amount. In addition to the $37.6 million discretionary request ($32.6 from Survey and Certification and $5 million from Federal Administration), there is $46.4 in mandatory Medicaid funding to support NHOIP. CMS is committed to working with residents and their families, advocacy groups, providers, States, and Congress to ensure that residents receive quality care and protection.

In conjunction with States, CMS successfully 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 CMS FY 2005 President's Budget request includes $21.1 million for HIPAA implementation activities. CMS was tasked with implementing the administrative simplification provisions of HIPAA. In October 2002, CMS was also given the responsibility for enforcing the HIPAA Administrative Simplification security, transactions, identifiers, and code sets standards.

The FY 2005 request includes $12 million to begin activities related to the National Plan and Provider Enumeration System. Activities include creating an enumeration system and enumerating one million providers. The request also includes funding for enforcement, compliance outreach, and implementing local systems changes, new standards, and technical modifications.

Legislation Supporting the Discretionary Budget

The FY 2005 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.

Duplicate Claim Penalty: Allows the Secretary to assess a fee for each duplicate or unprocessable claim submitted by providers. Duplicate or unprocessable claims are a drain on a system that must process over a billion claims over the course of a year ($195 million).

Appeals Filing Fee: This allows the Secretary to assess a $50 fee for providers who wish to elevate a fee-for-service appeal to the QIC level of adjudication. Beneficiaries will not be charged this fee. CMS expects 200,000 providers to file these appeals ($10 million).

CMS Performance Highlights

The primary CMS mission is to assure health care security for its beneficiaries. The Annual CMS Performance Plan and Report (APP) emphasizes this focus by helping CMS expand its resources in a way that enhances service to the public, being accountable stewards of Agency resources, and monitoring and evaluating the effectiveness of its programs. To reinforce the linkage between performance goals, program activities, and dollar amounts, CMS organizes the APP by budget category. These linkages ensure that, in setting performance goals, CMS selects goals that are representative of the full range of Agency activities and resources. As a result of the enactment of the MMA, CMS added three new goals to the APP to track the efforts of implementing the prescription drug discount card, prescription drug benefit, and Medicare contractor reform.

Following are some of the CMS performance achievements and advancements that support important Administration priorities:

Program Integrity: CMS program integrity efforts ensure the Medicare program pays the right amount to a legitimate provider for covered, reasonable and necessary services that are provided to an eligible beneficiary. CMS is also committed to assisting interested States in developing methodologies and conducting pilot studies to measure and ultimately reduce Medicaid payment error rates.

CMS cut the Medicare fee-for-service error rate by more than half over the past few years, going from 14 percent in FY 1996 to 6.3 percent in FY 2002. Although CMS did not meet its target of a five percent error rate in FY 2003, they were successful in reducing the rate to 5.8 percent. In 2003, CMS implemented a new method for measuring improper payments. The new method resulted in a higher rate of provider non-response and a higher error rate of 9.8 percent. CMS believed this higher rate of non-response was due to changes in the sampling method and resulted in a distorted error rate computation. CMS re-estimated the error rate to adjust for the higher rate of non-response by providers, and calculated an adjusted rate of 5.8 percent for 2003. CMS will implement improved survey methods to ensure that more providers respond in future surveys.

Quality Improvement: Improving the quality of care for Medicare beneficiaries is one of the primary objectives for CMS. Several of the Quality Improvement Organizations' (QIOs) national quality priorities are reflected in performance goals and represent health conditions that affect a large number of beneficiaries and impose a significant burden on the health care system. A sampling of these conditions are highlighted below:

A key performance goal is to increase the percentage of female Medicare beneficiaries age 65 and older who receive a biennial mammogram. CMS surpassed its FY 2002 target of 52 percent by reaching 52.2 percent.

Diabetes is a highly prevalent condition in the Medicare population. Many complications of the disease, such as blindness, can be prevented or delayed with appropriate monitoring and treatment. CMS plans to continue the quality goal to increase special eye exams for beneficiaries with diabetes. For FY 2002, CMS exceeded its target (of 68.6 percent) at 69.6 percent.

One of the QIO goals is to protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime pneumococcal vaccination. For FY 2002, 69 percent (target 72 percent) received an influenza vaccination and 64.6 percent (target 66 percent) received a pneumococcal vaccination. Shortages of vaccination were among the reasons for not reaching this target.

Children's Health Care: The implementation of State Children's Health Insurance Program (SCHIP) has stimulated enormous change in the availability of health care coverage for children and in the way government-sponsored health care is delivered. The energy invested by States and Territories, communities, and the Federal Government has resulted in significant expansions in coverage, as well as new systems for enrolling children in health care coverage.

CMS and States exceeded the FY 2002 goal to enroll an additional 1,000,000 children in SCHIP or Medicaid over the previous year's level. In fact, CMS and the States enrolled 2,7500,000 children over the FY 2001 level. According to the Statistical Enrollment Data System (SEDS), approximately 5.3 million children participated in SCHIP-funded coverage (either a separate child health program or a Medicaid expansion) in FY 2002, and many more were enrolled in "regular" Title XIX Medicaid through increased outreach efforts and application simplification strategies undertaken as a result of SCHIP.

CMS is also developing a performance goal for immunization of two-year olds on Medicaid. In FY 2003, CMS continued to work with States on its project to increase the percentage of Medicaid two-year old children who are fully immunized.

CMS is developing a goal to establish formal Federal-State collaborations for improving health care delivery and quality for Medicaid and SCHIP populations using performance measures. CMS continues to work with States to explore strategies to effectively use performance measures to quantify and stimulate measurable improvement in delivering quality health care.

Beneficiary Education: In order for Medicare beneficiaries to have greater knowledge of Medicare and its benefits, CMS is focusing on a number of educational programs. These programs not only provide information about Medicare but also gauge the beneficiaries' awareness of Medicare benefits.

One performance measure is to improve the effectiveness of disseminating Medicare information to beneficiaries. In order to help beneficiaries make informed health care decisions, CMS employs a variety of strategies through many CMS beneficiary-centered programs to maximize information channels and to ensure that targeted audiences, are reached with the "right information at the right time." In FY 2003, CMS continued to track beneficiary understanding of the Medicare Advantage program..

To promote beneficiary and public understanding of CMS and its programs, CMS developed a goal to improve and measure beneficiary awareness of (1) the core features of Medicare needed to use the program effectively, and (2) CMS sources from which additional information can be obtained.

Administration for Children and Families
Discretionary Spending

	2003	2004	2005	2005 +/- 2004
Marriage and Healthy Family Development Initiative:				
Community-Based Abstinence Education	$55	$74	$186	+$112
Abstinence Education State Grants	50	50	50	0
Promoting Responsible Fatherhood/Healthy Marriage	0	0	50	+50
Child Abuse State Grants	22	22	42	+20
Community-Based Child Abuse Prevention	33	33	65	+32
Subtotal, Marriage and Healthy Family Development Initiative	$160	$179	$393	+$214
Head Start	$6,667	$6,775	$6,944	+$169
Faith-Based and Community Initiative Programs:				
Compassion Capital Fund	$35	$48	$100	+$52
Mentoring Children of Prisoners	10	50	50	0
Maternity Group Homes	0	0	10	+10
Center for Faith-Based and Community Initiatives	1	1	1	0
Subtotal, Faith-Based Community Initiative	$46	$99	$161	+$62
LIHEAP:				
Regular Appropriation	$1,788	$1,789	$1,800	+$11
Emergency Contingency Fund	0	99	200	+101
Subtotal, LIHEAP	$1,788	$1,888	$2,000	+$112
Adoption Incentives /1	43	8	32	+24
Child Care & Development Block Grant:				
Block Grant	$2,076	$2,078	$2,090	+$12
Research and Evaluation Fund	10	10	10	0
Subtotal, Child Care	$2,086	$2,088	$2,100	+$12
Refugee:				
Refugee and Entrant Assistance	$444	$394	$419	+$25
Unaccompanied Alien Children	37	53	54	+1
Subtotal, Refugees	$481	$447	$473	+$26
Developmental Disabilities	160	165	165	0
Community Services:				
Community Services Block Grant	$646	$642	$495	-$147
Individual Development Accounts	25	25	25	0
Community Services Discretionary Programs	64	64	32	-32
Subtotal, Community Services	$735	$731	$552	-$179
Native Americans	45	45	45	0
Child Welfare Programs	337	336	339	+3
Adoption Awareness	13	13	13	0
Violence Against Women	129	129	129	0
Runaway and Homeless Youth	105	105	105	0
Early Learning Fund	34	33	0	-33
Child Abuse Discretionary Activities	34	35	27	-8
Promoting Safe and Stable Families (discretionary)	99	99	200	+101
Independent Living (discretionary)	42	45	60	+15
Social Services Research & Demonstration	35	19	6	-13
PHS Evaluation Funds (non-add)	*6*	*6*	*0*	*-6*
Federal Administration	172	178	190	+12
Total, Discretionary Program Level	**$13,211**	**$13,417**	**$13,934**	**+$517**
Less Funds Allocated from Other Sources:				
PHS Evaluation Funds	-6	-11	-5	+6
Abstinence State Grants	-50	-50	-50	0

Total, Discretionary Budget Authority.....	**$13,155**	**$13,356**	**$13,879**	**+$523**
FTE.....	1,390	1,425	1,425	0

/1 Reflecting the new bonus for older children enacted in the 2003 reauthorization of the Adoption Incentives program, payments to States increased from an actual $15 million in FY 2003 to an estimated $35 million FY 2004 and $32 million in FY 2005.

The FY 2005 budget request for ACF totals $46.6 billion, a net decrease of $2.4 billion, or 5 percent below the FY 2004 level. The decrease from FY 2004 reflects that $2.5 billion under TANF is available for FY 2004 through FY 2009. Of total funds, $13.9 billion is the discretionary program level and $32.7 billion is the entitlement budget authority.

Discretionary Spending

The FY 2005 discretionary budget totals $13.9 billion, a net increase of $517 million or 4 percent over the FY 2004 level.

Marriage and Healthy Family Development Initiative

The budget includes an initiative to build on the research that there are life-long benefits of growing up in married-parent families. This initiative, comprised of new and existing programs, has four elements: 1) supporting marriage and families; 2) providing tools to parents; 3) teaching values to children; and 4) encouraging community and faith-based organizations to support families.

Responsible Choices: The initiative will educate teens and parents about the risks associated with early sexual activity and provide the tools needed to help teens make responsible choices. To accomplish this goal, the budget doubles funding for Abstinence Education activities totaling $273 million, of which $236 million will be administered by ACF.

The Community-Based Abstinence Education program, funded at $186 million, will support up to 440 grants to public and private entities for the development and implementation of abstinence-only education programs for adolescents, ages 12 through 18, in communities across the country. This program, which began in FY 2001, is unique in that it funds projects focused entirely on educating young people and creating a positive environment within communities that support teen decisions to postpone sexual activity until marriage.

In addition to the Community-Based discretionary grant program, ACF will administer the $50 million Abstinence Education Grants to States program. This program provides grants to 59 States and Territories for mentoring, counseling, and adult supervision to promote abstinence with a focus on those groups which are most likely to bear children out of wedlock.

HHS is proposing to transfer administration of the Community-Based Abstinence Education and Abstinence Education Grants to States programs from the Health Resources and Services Administration to ACF. This move will foster linkages with ACF's existing efforts to promote comprehensive positive youth development and reduce teen pregnancy.

Within the Office of Population Affairs, the budget also doubles funding for the abstinence activities conducted through the Adolescent Family Life program and supports a new public awareness campaign to help parents communicate with their children about the health risks.

Responsible Fatherhood and Healthy Marriage: Over 25 million children are growing up in homes without fathers. These children face a greater chance of living in poverty, performing poorly in school, and developing emotional and behavioral problems. The Administration is committed to making responsible fatherhood and healthy marriage a national priority and will continue to work with Congress to enact legislation to assist non-custodial fathers to become more involved in the lives of their children. The budget includes $50 million for 75 competitive grants to faith-based and community organizations, along with Indian Tribes and Tribal organizations, to encourage and help fathers to support their families, avoid welfare, improve fathers' ability to manage family business affairs, and support healthy marriages and married fatherhood.

Preventing and Treating Child Abuse: The most recent annual HHS Child Maltreatment Report indicates that each year an estimated 903,000 children in the United States are victims of abuse and neglect including 1,300 child deaths. As part of this initiative, the FY 2005 request doubles funding for two State child abuse grant programs totaling $107 million, to reduce the incidence of child abuse and neglect and provide services to those who are victims. Additional support for the Community-Based Child Abuse Prevention program will fund prevention services including, parent education and home visiting, available to an additional 55,000 children and families. Funding for the Child Abuse State Grant program will shorten the time to the delivery of post-investigative services by 40 percent and increase the number of children receiving those services by almost 20 percent. Examples of post-investigative services include individual counseling, case management, and in-home services such as encouraging good hygiene and positive nutritional habits, providing parent education and lessons in positive discipline.

Supporting Healthy Marriages: The initiative builds further upon the Administration's TANF Reauthorization proposal, which includes $1 billion over five years to promote healthy marriage and family formation. The budget proposes to increase Federal funds available for this purpose to $1.2 billion over five years – a $160 million increase over the original TANF proposal. For a complete discussion of the TANF proposal, see the ACF Entitlement Spending section.

Head Start

The budget request includes $6.9 billion for Head Start, an increase of $169 million over the FY 2004 level. In FY 2005, 919,000 children will receive Head Start services including 62,000 children in Early Head Start. In FY 2005, ACF will continue to emphasize the goals of the President's Good Start Grow Smart Initiative to strengthen Head Start by partnering with States to improve early childhood education; providing information on child development and early learning to teachers, caregivers, parents, and grandparents; and closing the gap between research and practice in early childhood education.

The FY 2005 request includes $45 million to support the President's initiative to improve Head Start by funding nine State pilot projects to coordinate State preschool programs, Federal child care grants, and Head Start into a comprehensive system of early childhood programs. Last year, the President proposed a comprehensive reauthorization of the Head Start program with the goal of strengthening the program and, through coordination, improving preschool programs in general to help ensure that children are prepared to succeed in school. These new pilot projects will provide States with assistance to implement these reforms. The budget also includes an increase of $124 million to allow grantees to maintain competitive salaries for Head Start teachers and to support program enhancements to promote early literacy and cognitive development. Funds are also included for training and technical assistance.

Head Start will also contribute to the President's Marriage and Healthy Family Development Initiative. In FY 2005, it will offer training for between 2,000 and 3,000 Head Start parents in a science-based curriculum designed to improve early language and literacy skill outcomes. Those parents trained would then become mentors and train thousands of other parents throughout the Country.

Head Start programs are designed to promote school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social, and other services. Head Start programs enhance cognitive, language and socio-emotional development to enable each child to develop the early reading and mathematic skills they need to succeed in school. They also fully engage parents in their child's preschool experience by helping them achieve their educational, literacy and employment goals, supporting parent's role in their children's learning, and by emphasizing the direct involvement of parents in the administration of local Head Start programs.

Faith-Based and Community Initiative

The budget maintains a commitment to fund faith-based and community organizations including a total of $161 million in ACF to help grass-roots organizations expand services to their communities, mentor children of prisoners, and provide a safe place for young pregnant and parenting mothers. As part of the larger Faith-Based and Community Initiative, these programs offer a fresh approach to addressing the unmet needs of Americans. The initiative creates results by empowering those at the community level who can best identify the social and health problems and produce change.

Since the creation of the Center for Faith-Based and Community Initiatives (CFBCI) in 2001, it has worked with Agencies across the Department to eliminate barriers in regulations, rules, internal guidance, policies and procedures, and practices to the participation of faith-based and other community organizations; to propose the development of innovative pilot and demonstration programs; and to expand Charitable Choice provisions. Outreach activities include providing technical assistance to faith-based and community groups on relevant HHS program areas, including such Presidential initiatives as the Compassion Capital Fund and the Mentoring Children of Prisoners program.

Compassion Capital Fund: The budget provides a total of $100 million for the Compassion Capital Fund, doubling the FY 2004 level. Initiated in FY 2002, the Compassion Capital Fund awards grants to organizations which provide technical assistance to help faith-based and community organizations access funding sources, operate and manage their programs, develop and train staff, expand the reach of programs into the community, and replicate promising programs. Funds are also awarded for smaller capacity-building grants, research into best practices, and to develop a national resource center and information clearinghouse. At the level requested in FY 2005, an estimated 78 intermediary organizations will be funded.

In FY 2002, Compassion Capital Fund grantees provided capacity-building training and technical assistance to many local grassroots organizations. In addition, these grantees made over $10 million available directly to 565 faith-based and community organizations in 34 States to support a range of activities including reduction of homelessness, positive youth development, and transitioning individuals who had been incarcerated back into the community. In FY 2003, the Compassion Capital Fund expanded to begin work in 10 States, plus the District of Columbia, and provided one-time capacity-building grants to smaller faith-based organizations to expand existing services to at-risk youth and people who are homeless.

Mentoring Children of Prisoners: The request includes $50 million, maintaining the FY 2004 level, to provide grants of up to $5 million each to enable public and private organizations to establish or expand projects that provide mentoring for children of incarcerated parents and those recently released from prison. In FY 2003, programs linked 6,000 children with a mentor. In FY 2004 and continued in FY 2005, programs will serve five times as many children, offering a mentoring relationship to over 30,000 children with a focus on nutrition, physical health, and messages about abstinence.

Between 1991 and 1999, the number of children with a parent in a Federal or State correctional facility increased by more than 100 percent, from approximately 900,000 to almost 2 million. Studies indicate that children with incarcerated parents have a seven times greater chance than the general population of becoming incarcerated themselves and are more likely to succumb to substance abuse, gangs, early childbearing, and delinquency. This program helps children through the time their parents are imprisoned, including efforts to keep children connected to a parent in prison, and increases the chances that the family can successfully come together when the parent is released.

Maternity Group Homes: The budget includes $10 million for the recently authorized Maternity Groups Homes program. These homes provide pregnant and parenting youth access to transitional living opportunities, an alternative to the environments of violence and despair which many young pregnant mothers face, to secure brighter futures for their children. These funds will support adult-supervised community-based group homes for mothers who cannot live safely with their own families and a range of coordinated services including child care, job training, and counseling.

Low Income Home Energy Assistance Program (LIHEAP)

The FY 2005 budget requests a total of $2.0 billion for LIHEAP, an increase of $112 million. This includes $1.8 billion for formula block grants to States and $200 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 4.6 million households each year. Of the households receiving heating assistance, about one-third include an elderly member 60 years or older, over one-third include a person with a disability, almost one-half include a child under age 18, and over one-third do not receive any other public assistance.

Adoption Incentives

The Adoption Incentives program provides bonus payments to States that are successful in increasing the number of children adopted from the public foster care system. Despite recent progress, at the end of FY 2002, there were over 534,000 children in foster care, almost 120,000 of whom had adoption as their permanent placement goal. Further, half of those children waiting to be adopted were over the age of nine.

The FY 2005 request includes $32 million to support all bonus earning adoptions estimated to be completed in the prior year. Beginning in FY 2004 as part of the recent program reauthorization, and continued in FY 2005, States will be eligible to receive an award specifically for the adoption of children over the age of nine. States would be eligible to receive up to $8,000 per child to use toward recruiting prospective adoptive parents, child welfare staff training, and post-adoption family support services. Reflecting the new bonuses, payments to States increased from $15 million in FY 2003 to an estimated $35 million FY 2004.

Data shows that once a child waiting for adoption reaches eight or nine years old, the probability that the child will continue to wait in foster care exceeds the probability that the child will be adopted. This new bonus recognizes the need to move older children out of foster care and into caring permanent homes. States will continue to be eligible for bonus payments based on the total number of children adopted and the adoption of children with special needs who are under the age of nine.

Child Care

The Child Care and Development Block Grant program to States, Territories and Tribes assists low-income families in accessing quality child care for children when the parents work or participate in education or training. While the majority of the funds support direct child care assistance payments for parents, funds are also used to provide consumer education to parents to enable them to make good child care choices; to assist States in implementing health, safety, licensing, and registration standards; and for research on innovative child care strategies.

ACF's most recent data indicates that $4.8 billion in Federal and related State child care funds provides child care assistance to approximately 1.8 million children each month. However, when combined with other Federal and related State funds, child care assistance is available to 2.5 million children, representing an estimated 27 percent of children eligible under State rules.

Refugee Programs

Refugee and Entrant Assistance: The budget includes $419 million in FY 2005 to support refugees, asylees, Cubans/Haitians, and victims of torture and trafficking. The FY 2005 request is sufficient to provide a full eight months of cash and medical assistance and access to social service programs such as English language training, case management, employment preparation, and job placement and retention services for an estimated 95,000 annual entrants, including 50,000 refugee entrants. In addition, the budget continues support for services, including rehabilitation, social, and legal services for those who have experienced torture as well as benefits to victims of trafficking.

Unaccompanied Alien Children: Since the Unaccompanied Alien Children (UAC) program was transferred to HHS in 2003, as part of the Homeland Security Act, ACF has worked to ensure that children are cared for in the least restrictive setting appropriate by increasing the use of shelter and foster care facilities and reducing the use of secure detention facilities. Currently, there are approximately 600 children in care at any given time, 20 percent more than when the program was transferred. In addition, the Homeland Security Act and existing legal requirements, resulting from a class-action settlement with the former Immigration Naturalization Service, mandated that ACF assume additional responsibilities including a mechanism to coordinate and assign pro-bono attorneys for UACs, a new system to maintain current and accurate information about the children in care, and enhanced medical services. In FY 2004, funding for the UAC program nearly doubled reflecting the higher number of children in care and to begin work in meeting new and existing requirements. The FY 2005 request includes a total of $54 million to maintain the current level of program support.

Developmental Disabilities

Today, there are nearly four 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 2005, the budget request includes $165 million for programs that support partnerships with State governments, local communities, and the private sector to assist people with developmental disabilities to reach their maximum potential through increased independence, productivity, and community integration. This past year, a Program Assessment Rating Tool (PART) review found that the activities of the Administration for Developmental Disabilities (ADD) and its grantees complement other public and private efforts by striving to provide services that fill service gaps. ADD is planning to conduct a comprehensive, independent evaluation to inform program improvements.

Since 2002, when Secretary Thompson announced its creation, the Office on Disability (OD) has been the focal point within HHS for the implementation and coordination of policies, programs, and special initiatives related to disabilities. The Office's more recent achievements include co-sponsoring a symposium on home-ownership for persons with disabilities to develop a roadmap to help all consumers understand how States, communities, and local constituent organizations

can offer for home-ownership and coordinating an intergovernmental planning initiative to assist States and local communities develop and implement action plans to address the health, human service, employment, education, housing, and transportation needs of young adults (16-30 years) with disabilities.

Disabled Voter Services: The FY 2005 President's Budget maintains $15 million for the Disabled Voter Services programs. These programs provide support to States to establish, expand, and improve access for the election process to the over 20 million individuals with disabilities who are of voting age. In FY 2003, first-time grant awards supported a range of activities including facilitating web-based communication between people with disabilities and election officials and developing a training video for election officials, poll workers, and volunteers on providing assistance to voters with visual impairments.

Community Services Programs

Community services programs fund an array of programs and activities providing housing and employment assistance, education and training services, nutrition, energy assistance, health and substance abuse treatment, as well as economic development opportunities.

The budget proposes a total of $552 million in support of the Community Services Block Grant (CSBG), Individual Development Accounts and other community services programs. This is $179 million less than the FY 2004 level. Of this overall decrease, $147 million is in the block grant. The budget request is consistent with the President's reauthorization proposal to develop rigorous performance measures and target funds to programs which have demonstrated success.

The cornerstone of the President's CSBG reauthorization proposal is to strengthen accountability and performance outcomes of the CSBG program. The Administration continues to work toward legislation that provides for the Secretary, in consultation with the States and the Community Action Agencies (CAA), to establish a set of national outcome measures and standards that would be universally applied in providing services and administering programs using CSBG funds. Non-performing CAAs may lose their historical designation and be subject to a State-run award competition, open to other area community-based organizations.

A recent PART assessment of the CSBG program found that while the program has a clear purpose and addresses a specific need, it has not developed adequate national performance measures making results difficult to demonstrate. Both the CSBG funding reduction included in the FY 2005 budget and the reauthorization proposal are consistent with the PART assessment.
Native Americans

The budget request includes a total of $45 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.

Other Children and Families Activities

The FY 2005 budget includes $339 million for ACF's Child Welfare programs to support States and localities in their efforts to keep families together. Services offered include preventive intervention, where appropriate, so that children will not have to be removed from their homes, identifying alternative placements like foster care when necessary, and reunification services so that a child can return home. Funds are also included to train child welfare service providers, remove barriers to adoption, and to reduce the abandonment of infants and young children exposed to HIV/AIDS and drugs.

In addition, the budget includes $13 million for the Adoption Awareness program to support efforts to encourage adoptions. The budget also maintains funds for programs that offer safe havens and access to services for victims of domestic violence ($129 million) and runaway and homeless youths ($105 million). As noted in a PART assessment conducted this past year, runaway and homeless youth programs have a clear purpose, address a specific need, and are not redundant or duplicative of any Federal, State, local, or private effort. The programs are developing new performance measures with ambitious targets and expect to demonstrate results with data from a redesigned data collection system.

The FY 2005 budget does not request funds to continue support of the Early Learning Fund, which was provided $33 million in FY 2004. The Administration continues to target resources on similar activities which promote early literacy in the Department of Education and the Head Start program. The budget also includes a reduction in discretionary child abuse grants due to the completion of one-time projects.

For a complete discussion of the Promoting Safe and Stable Families and Independent Living Education and Training Vouchers programs see the ACF Entitlement Spending section.
Research/Federal Administration

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 2005 budget includes $6 million for the Social Services Research and Demonstration program.

The request includes $190 million in FY 2005 to maintain related program costs and support activities to administer the programs of ACF. Consistent with the President's Management Agenda, the budget supports efforts to reduce erroneous and improper payments including adding a new data element in Head Start program reviews to confirm eligibility determinations and working with States to identify improper payments under the Child Care and Development Fund. The budget includes $2 million for the Public Assistance Reporting Information System (PARIS), a voluntary program for States to share public assistance data to maintain program integrity and detect and reduce erroneous payments. In FY 2005, ACF continues support for child welfare monitoring to ensure that State child welfare agency practice is in conformity with Federal child welfare requirements and to assist States in enhancing their capacity to help children and families achieve positive outcomes.

Entitlement Spending

The Department's FY 2005 ACF budget includes $32.7 billion in budget authority for entitlement programs. The apparent $2.8 billion decrease from FY 2004 is somewhat misleading because FY 2004 includes $2.5 billion under TANF that is available from FY 2004 through FY 2009. Regarding the decrease in Child Support Enforcement, States estimate that they will spend almost $400 million less on Child Support Enforcement than expected in FY 2005.

The ACF entitlement programs serve some of the Nation's most vulnerable populations through programs such as Temporary Assistance for Needy Families (TANF), Child Support Enforcement, the Child Care Entitlement, Foster Care, Independent Living, and Adoption Assistance. This year's request anticipates the reauthorization of TANF and the Child Care Entitlement. The budget also includes modifications in the Child Support Enforcement program, which increase both financial collections and medical support to families. In Foster Care, the budget includes an option for States to receive their foster care funds in the form of a flexible grant as well as a clarification of the eligibility definition.

Temporary Assistance for Needy Families

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) dramatically changed the Nation's approach to income support for low-income families. PRWORA replaced the individual entitlement to welfare with time-limited assistance accompanied by work requirements through the new 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. TANF caseloads have continued to decrease. Almost 5 million individuals were receiving TANF benefits in June 2003 — 60 percent fewer than August 1996. According to State reports, work effort among current welfare recipients in FY 2001 was three times the 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 after leaving welfare. When employed, TANF leavers typically worked 40 hours per week and earned between $6.50-9.00 per hour, and their earnings rise, on average, over the course of their first year off of welfare.

TANF provides approximately $16.9 billion annually to States, Territories, and eligible Tribes for the design of creative programs to help families transition from welfare to self-sufficiency. The program expired at the end of FY 2002. However, to date, Congress has provided funding for TANF State Family Assistance Grants through March 31, 2004. Other components authorized through that date include supplemental grants and the contingency fund.

States have tremendous flexibility in determining how to use their TANF dollars. States now spend much less on cash assistance payments than during initial years of TANF implementation and more on education and training, child care, and other work supports to help families achieve self-sufficiency. In 1998, States spent 63 percent of combined State and Federal funds on cash assistance and in FY 2002 spent only 37 percent. States may transfer up to a combined 30

percent of their TANF funding to either the Child Care and Development Fund or the Social Services Block Grant (SSBG) with not more than 4.25 percent transferable to SSBG. The FY 2004 appropriation provides for a 10 percent SSBG transfer authority.

TANF Legislative Proposals

The FY 2005 budget reproposes the President's FY 2003 plan to build on the considerable successes of welfare reform and reauthorize TANF. The President's proposal strengthens work requirements while allowing States greater flexibility in determining what should count as work. The proposal also strives to strengthen marriage and families, making child well-being a central tenet of the legislation (see the box outlining the President's TANF Reauthorization Plan). In addition, the FY 2005 budget request builds on the reauthorization proposal by adding a total of $40 million per year, over the $200 million per year included in reauthorization, to increase support for healthy marriage and family formation.

Child Care Entitlement to States

The Child Care and Development Fund consists of the discretionary Child Care and Development Block Grand (CCDBG) and the Child Care Entitlement funds preappropriated under TANF. The Child Care Entitlement is composed of mandatory and matching funds. Two percent of the mandatory entitlement funds are reserved for eligible Indian Tribes and Tribal organizations. States are mandated to spend at least 80 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 4 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 2005, the budget funds the Child Care Entitlement at $2.7 billion. This is equal to the funding level provided in FY 2004. These funds 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, as mandated in Title IV-D of the Social Security Act, are available for all families with a non-custodial parent, regardless of whether or not the custodial 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. 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 Governments. States can choose to pass through a portion of the collections to these families as well.

The Federal Government shares in the financing of this program by providing a 66 percent match rate for general State administrative costs and 90 percent 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 noncustodial parents' access to and visitation of their children. In FY 2005, the Federal government will spend an estimated $4.4 billion for all of these costs.

The CSE program continues to make impressive gains:

- Child support collections hit a record $20 billion in FY 2002, serving an estimated 16 million child support cases.
- IV-D child support professionals collected $326,000 per FTE in FY 2002. States have increased collections by using a variety of approaches like income withholding, and offset of income tax refunds, among other tools provided by PRWORA.
- The government collected$1.5 billion in overdue child support from Federal income tax refunds, which benefitted more than 1.4 million families in tax year 2002.
- Also in 2002, using the Federal Parent Locator Services (FPLS), the Federal Office of Child Support Enforcement provided information to States on more than 4.5 million non–custodial parents.
- CSE established paternity for almost 1.5 million children in FY 2002.

In a recent Program Assessment Rating Tool (PART) assessment, CSE received a rating of "Effective" with a score of 90, making it the highest rated block/formula grant of all reviewed programs government-wide. This high rating is due to its strong mission, effective management, and demonstration of measurable progress toward meeting annual and long term performance measures.

Child Support Legislative Proposals

The budget anticipates the enactment of the child support provisions in the President's 2003 welfare reform proposal, FY 2004 budget, as well as two new proposals aimed at improving and increasing the collection of medical child support (see box outlining FY 2003, FY 2004, and FY 2005 proposals).

Children's Research and Technical Assistance (CRTA)

The FY 2005 President's Budget includes $49 million in this account. Of this amount, $34.4 million is devoted to: 1) training and technical assistance ($11.5 million) and 2) operating the FPLS ($23 million). The funds appropriated for these activities are equal to 1 and 2 percent respectively of the amount paid to the Federal government for its share of child support

collections during the preceding fiscal year. The remaining $15 million funds welfare research. through FY 2008.

Foster Care, Adoption Assistance, and Independent Living Programs

The FY 2005 budget request for the Foster Care, Adoption Assistance, and the Independent Living programs is $6.8 billion. These programs, authorized by Title IV-E of the Social Security Act, provide essential services to vulnerable children by supporting safe living environments and preparing for independence older foster youth who are likely to age out of the system.

Of the total request, $4.9 billion will support the Foster Care program. This is a $119 million decrease from last year's request and includes the effects of the legislative proposals described in the following section. The funds will be used for maintenance payments and administrative costs for approximately 233,000 children per average 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 $1.8 billion for the Adoption Assistance program, which supports families that adopt special-needs children. This is an increase of $70 million over the FY 2004 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 for professionals and adoptive parents. The proposed level of funding will support approximately 375,900 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 2004 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 Foster Care program received a rating of "Adequate" from the Program Assessment Rating Tool (PART). This is an improvement over the Results Not Demonstrated rating received for FY 2004. The better rating can be attributed to completing adoptions for 268,000 children with child welfare involvement from FY 1997 through FY 2002. The programs also received a higher rating due to new program performance measures, an initiative to develop an error rate, and improved program management. The proposed alternative financing system for Foster Care, discussed in the next section, would address PART findings to further improve the program. HHS is committed to improving PART ratings in line with the President's Management Agenda initiative on Budget and Performance Integration.

Foster Care Legislative Proposals

The FY 2005 President's Budget includes a legislative proposal for an alternative funding option for foster care, and a legislative proposal to clarify eligibility criteria for IV-E foster care maintenance payments related to home of removal. The alternative funding proposal, detailed in the Child Welfare Program Option box (see above), would allow States the option to receive

their foster care funding as a flexible grant over five years to support a continuum of services to families in crisis and children at risk.

The second proposal would clarify the process for determining title IV-E eligibility in the Foster Care program. On March 3, 2003, the Court of Appeals for the 9th Circuit held in Rosales v. Thompson that a child living with an interim caregiver may be eligible for title IV-E foster care even though the child would not have been eligible in the home from which the child was legally removed. The Rosales decision contravenes the Department's long-standing interpretation of the Social Security Act stipulating that eligibility is based upon the home from which the child is removed, not the home of the interim caretaker. HHS never has interpreted the statute to mean that states may consider whether the child is eligible in either the home from which the child is removed or the home where the child is living. This proposal would amend the statute to come into accord with the Department's long-standing policy.

Promoting Safe and Stable Families

The Promoting Safe and Stable Families (PSSF) program is a capped entitlement program designed to assist States in coordinating services related to child abuse prevention and family preservation. These services include community-based family support, family preservation, time-limited reunification services, 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 2005 request for PSSF includes $305 million in mandatory funds.

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. SSBG is funded at $1.7 billion for FY 2005. This is the same level as FY 2004. Programs or services that are frequently supported by SSBG funds include child care, child welfare, home-based services, employment services, case management, adult protective services, prevention and intervention programs, and special services for people with disabilities.

Performance Highlights

HHS programs demonstrate, through their aggressive performance goals and annual achievement, the Department's commitment to its strategic goals and priorities. The programs highlighted below show the commitment of HHS to improving the economic and social well-being of individuals, families and communities, and improving the stability and development of our Nation's youth.

Temporary Assistance for Needy Families:The Temporary Assistance for Needy Families (TANF) program achieved remarkable success towards its primary goal of moving TANF recipients from welfare to work and self-sufficiency. In FY 2002, all States met the work

requirement for all families and 83 percent of States with two-parent family programs met the rigorous two-parent family work participation rate. As of FY 2002, 36 percent of adult TANF recipients became newly employed, 59 percent of recipients or former recipients who were employed retained their jobs over at least two quarters and 33 percent attained higher earnings over two quarters.

Child Care Development Fund: The Child Care and Development Fund helps families achieve and maintain self-sufficiency and improve the overall quality of child care. The Child Care Bureau collaborates with the Head Start Bureau, Department of Education, and the Health Resources and Services Administration to achieve these goals. HHS estimates that in FY 2004 and 2005, CCDF funds will provide subsidies to at least 2.5 million children on an average monthly basis. CCDF is developing and implementing new and improved performance measures to better meet HHS performance goals in the future. For example, in the FY 2005 performance plan, CCDF is introducing two measures to track literacy, language, pre-reading, numeracy, and school readiness.

Child Support Enforcement: Child Support Enforcement (CSE), which assures that assistance in obtaining support is available to children, consistently performs well. In FY 2002 the CSE program exceeded its targets for three of its performance measures. CSE increased the percentage of IV-D cases that have support orders to 70 percent, increased the collection rate for current support to 58 percent, and increased the percentage of paying cases among IV-D arrearage cases to 60 percent. The program also improved its performance on paternity establishment to 95 percent in FY 2002 from 91 percent in FY 2001.

Foster Care, Adoption Assistance, and Independent Living: The Foster Care, Adoption Assistance and Independent Living programs demonstrated success in improving safety, permanency, and well-being of children. In CY 2002, the programs surpassed the targets for the performance measure on safety. The programs also performed well on permanency measures. In FY 2002, 68 percent of children who exited the foster care system exited through reunification within one year of placement. The programs also improved on the family and child well-being measure by ensuring that 81 percent of children who had been in care less than 12 months had no more than two placement settings in FY 2002.

Child Support Enforcement: Collections and Costs

	2003*	2004 Estimate	2005 Estimate	2005 +/- 2003
Total Collections Distributed:				
All Families	$18,960	$20,270	$21,641	+$1,371
TANF program	2,062	2,082	2,131	+49
Federal Share**	1,128	1,147	1,174	+27
State Share	924	935	957	+22
Foster Care program	49	50	52	+2
Federal Share	28	28	29	+1
State Share	21	22	23	+1

Total	**$21,071**	**$22,402**	**$23,824**	**+$1,422**
Administrative Costs:				
Federal Share	$3,592	$3,898	$3,941	+$43
State Share	1,784	1,871	2,036	+165
Total	**$5,376**	**$5,769**	**$5,977**	**+$208**
Incentive Payment to States	**$461**	**$454**	**$446**	**-$8**
Program Costs (Costs minus Distributed Collections):				
Federal Costs	$2,897	$3,177	$3,184	+7
State Costs	378	460	610	+150
Net Costs to Taxpayers	**$3,275**	**$3,637**	**$3,794**	**+157**

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

ACF Proposed Entitlement Legislation

	FY 2005	FY 05-09
TANF (BA in millions)		
State Family Assitance Grants	$16,489	$82,443
Territory Family Assitance Grants	$78	$389
Matching Grants to Territories	15	75
Supplemental Grants	319	1,597
High Performance Bonus	[400]	500
Family Formation, Research, Demonstration, and Techincal Assitance Activities	240	1,200
Tribal Work Program	8	38
Contingecy Fund [Non-add]	[2,000]	2,000
TANF Subtotal	$17,149	$88,242
Child Support Enforcement /1		
Health Insurance from Either Parent /2	$0	$3
Send COBRA Notice to IV-D Agency	1	5
Federal Seizure of Accounts in Multi-State Financial Institutions	-2	-43

Require Intercept of Gaming Proceeds.....	-1	-22
Provide for Garnishment of Longshore and Harbor Worker's Compensation Act Benefits.....	-1	-9
FPLS Access to Insurance Settlement Databases.....	0	-8
Increased Funding for Access and Visitation	2	32
Direct Access for Indian Tribes to the Federal Income Tax Refund Offset Program and the Federal FPLS.....	0	0
Contractor and Tribal Access to Tax Data.....	0	0
Optional Pass Through and disregard above Current Effort /3.....	0	102
Optional Simplified Distribution /3.....	0	615
Review and Adjustment of Child Support Orders /2.....	0	-40
Reduce Threshold for Passport Denial to $2500.....	-1	-10
$25 Annual Fee for Never -TANF Cases with Collections.....	-55	-305
OASDI Benefit Match.....	-6	-38
Child Suport Enforcement Subtotal.....	-$64	$282

Child Welfare (BA in millions)

Child Welfare Program Option.....	$37	$0
Clarify IV-E Eligibility Process.....	-$77	-$375
Contingency Fund /4.....	0	0
Child Welfare Subtotal.....	-$40	-$375

/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 Tresasury.

/2 These numbers do not reflect savings to Medicaid.

/3 These numbers do not reflect savings to Food Stamps.

/4 The Child Welfare Program Option will provide States access to the TANF Contingency Fund. from FY 2004 - FY 2008 and $40 million from FY 2004 - FY 2013.

Administration on Aging

	2003	2004	2005	2005 +/-2004
National Family Caregiver Support.....	$155	$159	$162	+$3
Home and Community-Based				
Supportive Services and Centers.....	356	354	357	+$3
Nutrition Services:				
Home-Delivered Meals.....	$181	$180	$181	+$1
Congregate Meals.....	385	387	389	+2
Nutrition Services Incentive Program.....	149	148	149	+1
Subtotal, Nutrition Programs	**$715**	**$715**	**$719**	**+$4**
Program Innovations.....	$29	$34	$24	-$10
Aging Network Support Activities.....	13	13	13	0
Preventive Health Services.....	22	22	22	0
Grants for Native Americans.....	27	26	26	0
Protection of Vulnerable Older Americans.....	19	19	19	0
Alzheimer's Disease.....	13	12	12	0
Program Administration.....	18	17	18	+1
Senior Medicare Patrols (HCFAC).....	3	3	3	0
White House Conference on Aging.....	0	3	5	+2
Total, Program Level.....	**$1,370**	**$1,377**	**$1,380**	**+$3**
Less Funds Allocated From Other Sources:				
Senior Medicare Patrols (HCFAC).....	-$3	-$3	-$3	$0
Total, Budget Authority.....	**$1,367**	**$1,374**	**$1,377**	**+$3**

The FY 2005 budget request for AoA is $1.4 billion. This amount includes increases to test new models of home and community-based care and provide nutrition, caregiver, and supportive services. The budget also includes $5 million for the second year of funding for the White House Conference on Aging.

One of the most critical issues facing elderly Americans today is that of long-term care. Elderly citizens overwhelmingly state a preference to live at home as long as possible. Even small amounts of support can make a significant impact in enabling elders to remain in their homes and out of institutional care. The FY 2005 budget continues to emphasize AoA programs that work together to support elders at home and in the community. Services are provided through a nationwide network of State, Tribal and area agencies on aging and by over 29,000 local service providers.

National Family Caregiver Support Program

Family caregivers have always been the main source of long-term care services provided in the United States. AoA is committed to assisting family caregivers by providing them with the resources to help them keep their loved ones at home or in the community. The FY 2005 budget includes $162 million for the National Family Caregiver Support Program. For a minimal cost, this national program provides information, training, counseling, respite and assistance services that support the efforts of America's caregivers. Research indicates that informal caregiving supports can have a significant impact on the status of caregivers, delay the need for institutionalization, and significantly reduce costs to Medicare, Medicaid and private payers. Caregivers provide an invaluable resource to their loved ones:

- Approximately 95 percent of all older adults who experience limitations in their daily activities have family members involved in their personal care.
- 22.4 million households are involved in providing care to persons aged 50 and older. These households are expected to increase to 39 million by 2007.
- The economic value of informal caregiving is estimated to be valued at $257 billion.
- The average caregiver is a 46 year-old married female who works outside the home.

Home and Community-based Supportive Services and Centers

Home and Community-Based Supportive Services provide a variety of activities that enable elderly Americans to remain at home and in their communities. Three categories of services – access, in-home, and community – work together to improve the quality of life for elderly Americans. The budget for these services totals $357 million.

Activities including transportation assistance, information and referral, chore, homemaker and personal care services, and adult day care, to help seniors to remain independent for as long as possible. AoA has established a target to provide an estimated 40 million rides in FY 2005 to help seniors visit health professionals, pharmacies, and grocery stores. Information and referral services will empower individuals and families to make informed choices about their service and care needs. Personal care and homemaker services will enable elders to live with dignity at home through assistance with activities of daily living. These services are provided through senior centers and in other community-based settings.

Nutrition Programs

The budget requests a total of $719 million for nutrition programs. Through a variety of State and community mechanisms, these programs provide nutritious meals to the nation's most frail and at-risk elderly. Through the three nutrition programs and additional leveraged resources, AoA's goal is for States to provide more than 300 million meals in FY 2005. These programs also provide supplemental nutrition screening, education, and counseling services which further enable elders to maintain their own health and independence.

Scientific evidence shows that adequate nutrition is essential for healthy aging and the prevention or delay of chronic disease and related disabilities. Research also indicates that meal preparation at home is difficult or impossible for many older Americans, and that the availability of a home-delivered meal is crucial to their ability to function independently at home. For example, 79 percent of home-delivered meal recipients have at least one limitation with activities of daily living, and 30 percent have limitations with three or more – a level of frailty consistent with nursing home residents. In many cases, home-delivered meals are the first in-home service an older adult receives, and the program is therefore also a primary access point for other in-home supportive services.

The Congregate Nutrition Services program supports the provision of meals to elderly individuals in a variety of social settings such as senior centers and faith-based organizations. In addition to serving as a primary source of food for many participants, the program presents critical opportunities for social engagement and meaningful volunteer roles which contribute to individuals' overall health and mental well-being.

In FY 2003, the Department successfully transferred the Nutrition Services Incentive Program (NSIP) from the Department of Agriculture to AoA. Funds continue to be distributed by its historic formula, which is based on the number of meals served in the prior year. Under the Older Americans Act, States can elect to receive commodities in lieu of cash for part or all of their NSIP allocation. In FY 2004, 11 States have elected this option.

Program Innovations

AoA continues to seek ways to leverage funding at the State and community level to support seniors at home. To this end, it is crucial to ensure that seniors have access to all available resources in their home communities.

In FY 2003, AoA first partnered with the Centers for Medicare and Medicaid Services to establish Aging and Disability Resource Centers in 12 States. These centers serve as reliable resources and help to eliminate the confusion and frustration many older Americans face as they search for information about long-term care by providing objective information about the options – both public and private – that are available to them. They also provide information on best practices and assist States in replicating the significant strides that several other States have made in creating more citizen-centered systems of care by reducing nursing home expenditures and increasing community-based choices, while containing costs.

In FY 2004, AoA expects to establish centers in an additional 12 States, and is requesting an investment of $11 million (an increase of $6 million) in FY 2005 to further expand this collaboration with CMS.

In FY 2003, AoA launched an Evidence-Based Prevention Grants program to demonstrate how community-based aging services providers can effectively deliver programs that can reduce the risk of disease and disability in the older population. AoA funded 13 local projects and a national technical assistance center. AoA is partnering with CDC, ARHQ, and the National Institute on Aging, as well as several private foundations on this initiative, which is translating research into practice at the community level. This activity will continue in FY 2005. The net $8 million reduction in Program Innovations is due to the completion of one-time projects.

Grants for Native Americans

The FY 2005 request includes $26 million for grants for Native Americans. These grants will enable 243 Tribal organizations serving approximately 300 tribes to continue to provide services to American Indians, Alaskan Natives, and Native Hawaiians who are over the age of 60, by providing nutritional and supportive services which help them remain healthy and independent.

Prevention, Protection, and Network Support

The FY 2005 request includes $54 million to fund activities which educate older Americans about healthier lifestyles in order to delay or prevent the onset of chronic disease; protect vulnerable older Americans from abuse/neglect and empower them to assert greater control over their living situations; and identify additional local resources available for older Americans and their families.

Alzheimer's Grants

The FY 2005 budget also includes $12 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 incorporating new research findings, innovative approaches to care, and cultural competencies into actual home and community-based services.

White House Conference on Aging

The FY 2005 Budget requests a total of $5 million for a White House Conference on Aging, to take place by December 2005, as called for in the Older Americans Act. The Conference will provide a national forum on aging issues.

Program Administration

A total of $18 million is requested to maintain staffing levels, and for related program management and support activities necessary to effectively administer a wide array of AoA programs. This request also supports efforts to strengthen management through greater

efficiencies and economies of scale in information technology, financial systems, and personnel operations.

Departmental Management

	2003	2004	2005	2005 +/- 2004
General Departmental Management:				
Adolescent Family Life	$31	$31	$44	+$13
Natl Abstinence Education Campaign	0	0	10	+10
Physical Fitness & Sports	1	1	1	0
Office of Minority Health	56	55	47	-8
Office on Women's Health	29	29	29	0
Office for Human Research Protections	7	7	7	0
National Vaccine Program Office	7	7	7	0
CCRF/ Reserve Affairs	1	1	1	0
Minority HIV/AIDS	50	50	53	+3
Office of Global Health Affairs	4	9	9	0
Health Care IT	0	0	50	+50
IT Security and Innovation Fund	20	15	18	+3
Other General Departmental Management	153	155	162	+7
Evaluation Activities	22	22	22	0
Health Care Fraud and Abuse Control	5	5	5	0
Total, GDM Program Level	**$386**	**$387**	**$465**	**+$78**
Policy Research:				
Broad-Based Research	$18	$21	$29	+$8
State Innovation Fund	2	0	0	0
Total, PR Program Level	**$20**	**$21**	**$29**	**+$8**
Total, GDM and PR Program Level	**$406**	**$408**	**$494**	**+$86**
Public Health and Social Services Emergency Fund:				
PHSSEF	$2,266	$2,164	$2,225	+$61
Total, PHSSEF Program Level	**$2,266**	**$2,164**	**$2,225**	**+$61**
Total, DM Program Level	**$2,672**	**$2,572**	**$2,719**	**+$147**
Less funds from other sources:				
Evaluation Activities	$40	$43	$51	+$8
Health Care Fraud and Abuse Control	5	5	5	0

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

The FY 2005 budget request for GDM and Policy Research provides a total program level of $494 million, including appropriations of $438 million, interagency transfers of $51 million in evaluation funds, and $5 million in health care fraud and abuse funds. The FY 2005 budget request for the PHSSEF account is $2.2 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 13 Staff Divisions (STAFFDIVs). The GDM budget request for FY 2005 totals $465 million, an increase of $78 million or 20.1 percent above the comparable FY 2004 level. The GDM request provides funding for the following activities:

Office of Population Affairs (OPA)/Adolescent Family Life (AFL): The AFL request of $44 million will continue to provide support for the 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 doubles abstinence-only prevention projects, as defined by the Welfare Reform legislation (P.L. 104-193) from $13 million to $26 million. 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 (HRSA).

National Abstinence Education Campaign: The request of $10 million will provide funding to create a campaign designed to help parents communicate with their children about the risks associated with early sexual activity.

Office of Minority Health (OMH): The OMH request of $47 million, an $8 million decrease from FY 2004, 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. The reduction is attributed to FY 2004 Congressional earmarks which are not continued in FY 2005.

Office on Women's Health (OWH): The OWH request of $29 million, the same as FY 2004, 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 Human Research Protections (OHRP): The OHRP request of $7 million, the same as FY 2004, 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 expand its public education campaign.

National Vaccine Program Office (NVPO): The NVPO request of $7 million will be used to provide leadership and coordination among Federal agencies as they work together to carry out the goals of the National Vaccine Plan. The National Vaccine Plan provides a framework, including goals, objectives, and strategies for pursuing the prevention of infectious diseases through immunizations. The NVPO is also the lead on the development of the U.S. Pandemic Influenza plan. Funds are also requested in the Public Health and Social Services Emergency Fund to ensure the Nation has the capacity to provide vaccines in a pandemic.

Commissioned Corps Readiness Force (CCRF): The CCRF request of $1 million will continue to support a cadre of approximately 1,300 active duty U.S. Public Health Service officers, qualified with special training and skills and ready to rapidly deploy in emergency situations.

Minority HIV/AIDS: The FY 2005 request includes $53 million, an increase of $3 million or 7 percent from FY 2004, to support innovative approaches to HIV/AIDS prevention and treatment in minority communities heavily impacted by this disease. 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.

Office of Global Health Affairs (OGHA): The OGHA request of $9 million will continue to promote the health of the world's population by advancing the Department's global strategies and partnerships. The OGHA request includes $5 million to continue support of HHS health care initiatives in Afghanistan.

Health Care IT: The request of $50 million will be used to fund State, regional, or local demonstration grants to test the feasibility of information exchange among health care settings, and other innovative information technology projects that improve health care.

Information Technology Security and Innovation Fund: The FY 2005 budget request includes $18 million, an increase of $3 million from FY 2004, to continue funding for the IT Security and Innovation Fund. Projects funded through the IT Security and Innovation Fund focus on HHS enterprise-wide investments, notably: enterprise architecture, key E-Government projects, HHS common IT infrastructure services, and on security and infrastructure to enable HHS common administrative systems.

Other General Departmental Management (GDM): The FY 2005 budget request includes $162 million, an increase of $7 million from FY 2004, to fund offices which provide leadership, policy, legal, and administrative guidance to HHS components.

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 2005 request for Policy Research includes $29 million to support evaluation activities. It is proposed that in FY 2005 the entire $29 million request be derived through interagency transfers of evaluation funds.

Broad-Based Research: The FY 2005 Policy Research budget request of $29 million, an $8 million increase from FY 2004, will 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.

Of the total $8 million increase, $2 million will be used to continue support of the National Electronic Health Information Initiative, to focus on national electronic health information systems. This initiative will accelerate the development and adoption of the technology and national standards necessary for Electronic Health Record Information Systems and their use by the health care and public health systems, as well as related support for the National Health Information Infrastructure.

In addition, $6 million will support the Current Population Survey (CPS), which is conducted by the Bureau of the Census. The CPS is the only government survey that produces annual estimates of the uninsured at the State level. Improved data will help States make informed decisions about their Medicaid, SCHIP, and other State-run insurance programs.

HHS agencies will conduct significant health services and policy research in FY 2005. This body of research covers a wide range of subjects, from assessing the quality of health care provided to the nation's elderly, to evaluating the effectiveness of programs aimed at reducing health risk behaviors among teens and other high-risk populations. The HHS Research Coordination Council (RCC), chaired by the Assistant Secretary for Planning and Evaluation, works to ensure that agencies collaborate in the conduct of health services research in order to ensure the most efficient and effective use of research resources in support of the primary mission and objectives of HHS.

Public Health and Social Services Emergency Fund (PHSSEF)

The PHSSEF provides $2.2 billion, a net $61 million increase above FY 2004. This includes $2.1 billion for bioterrorism and counterterrorism and $100 million to ensure that an adequate supply of vaccine could be produced for the Nation in the event of a pandemic. The PHSSEF is the source of funding for over half of the overall HHS terrorism budget of $4.1 billion.

Pandemic Influenza: The budget includes $100 million, an increase of $50 million, to ensure the Nation has the capacity to respond to an influenza pandemic. The influenza strains circulating usually change somewhat from year to year. Periodically, there is a major change in the virus's genetic structure resulting from a strain that can cause widespread disease and death. Three such global epidemics - called pandemics - occurred in the 20th century. Such a pandemic could cause an additional 90,000 to 300,000+ deaths in the U.S., especially if adequate vaccine were not available quickly. Once a pandemic began, it would be too late to accomplish the many key activities required to minimize this toll. Funds will be used to provide appropriate incentives for vaccine manufacturers to establish new domestic capacity using new manufacturing techniques that can be scaled up rapidly.

Bioterrorism: The HHS FY 2005 budget includes $4.1 billion for bioterrorism and counterterrorism activities. This is $154 million above FY 2004, and reflects several major changes: an inter-governmental biosurveillance initiative, a research portfolio on countermeasures against nuclear and radiological threats, and the return of both funding for and

management of the Strategic National Stockpile to HHS. Funds contained in this request support activities in the Centers for Disease Control and Prevention (CDC), HRSA, Office of the Secretary, the nuclear and radiological countermeasures research at the National Institutes of Health (NIH), and the Strategic National Stockpile. In addition, both the Food and Drug Administration (FDA) and NIH receive direct appropriations for their bioterrorism activities. HHS continues to work with the Department of Homeland Security (DHS) on moving countermeasures against terrorism from the research phase to the advanced scale-up and production phase. Specifically, HHS is developing a contract for the purchase of an advanced anthrax vaccine - the first procurement to be made under the BioShield appropriations for DHS.

- Biosurveillance: the FY 2005 request introduces a new interagency biosurveillance initiative to prepare against a potential bioterrorist attack. CDC and FDA, in coordination with DHS, the Environmental Protection Agency, and the Department of Agriculture, will be working to improve the response to bioterrorism through early detection. The budget for CDC includes $130 million in FY 2005 for its role in this initiative, the largest of which is an investment of $100 million in its human health surveillance project, "BioSense." BioSense is an advanced approach to infectious disease surveillance that, unlike traditional approaches, does not rely upon mandatory or voluntary case reports from healthcare providers to public health officials, but uses automated analysis techniques on electronically available health data to highlight a potential health problem. In addition to developing better surveillance capacity, CDC will invest an additional $20 million to improve laboratory reporting capacity and to advance integration between public health and commercial laboratories, and an additional $10 million to increase the number of border health and quarantine stations from 8 to up to 25.
- Food Defense: The budget for FDA includes $246 million for bioterrorism activities. This total includes $181 million for food defense activities, which represents an increase of $65 million over FY 2004. The total food defense increase includes an additional $35 million to increase analytic surge testing capacity for biological, chemical, and radiological threat agents for the Food Emergency Response Network (FERN), $15 million for research, $7 million for domestic inspections and field exams, and $3 million to develop an Emergency Response and Operations Network. FDA will use $5 million to coordinate food surveillance activities within the biosurveillance initiative.
- National Institutes of Health: The FY 2005 request for NIH biodefense and other counterterrorism activities includes $1.7 billion, a net increase of $121 million from FY 2004. Of this total, $47 million is budgeted in the Public Health and Social Services Emergency Fund to be managed by NIH for support of targeted research activities needed to develop nuclear and radiological threat countermeasures. This research effort will improve methods for measuring radiological exposure and contamination as well as developing drugs that can be used to prevent injury from radiological exposure and developing methods or drugs to restore injured tissues and eliminate radioactive materials from contaminated tissues.

Of the bioterrorism funds directly appropriated to NIH, $1.5 billion will fund basic research on the biology of microbial agents with bioterrorism potential and the properties of the host's response applied research for the development of new or improved diagnostics, vaccines, and

therapies. A complementary investment of $150 million is requested for developing this extramural capacity to conduct biodefense research - a top priority of the FY 2005 budget. The research and development of biodefense can only be performed safely and effectively in specialized and secure biocontainment research facilities. Critical research on a comprehensive range of biodefense countermeasures needed to respond to future potential bioterror attacks. Work on a second-generation anthrax vaccine has rapidly progressed to the point that a vaccine product is expected to be ready for procurement later this year through the new DHS BioShield program. DHS has been assigned responsibility to finance the procurement of biodefense medical countermeasures. HHS will continue to provide the scientific leadership needed to determine what countermeasures are needed.

- Strategic National Stockpile (SNS): The FY 2005 budget includes $400 million and reflects the Administration's plan to return the fiduciary management of the SNS to HHS. This change will better align and parallel the Federal role with the roles of the State and local public health departments, the lead agencies for planning and deployment of SNS assets. HHS has a long history of strong relationships with State and local public health officials, who rely on the scientific and clinical expertise that exists in HHS. This change will clarify for State and local officials a single Federal focal point for both strategic stockpile operations and public health emergency response.
- CDC Capacity and Anthrax Research: The FY 2005 request for the PHSSEF includes $150 million for CDC to continue to improve epidemiological expertise in the identification and control of diseases caused by terrorism, including better electronic communication; distance learning programs; and cooperative training between public health agencies and local hospitals. This request provides support for upgrading capacity at CDC, national planning efforts, oversight of inter-laboratory transfers of dangerous pathogens and toxins, laboratory safety inspections, and anthrax research. Included in this total is funding to support the expanded role of CDC in regulating transfer of select biological agents.
- HRSA Curriculum Development and Education: The FY 2005 request for the PHSSEF includes $28 million for curriculum development, the same as the FY 2004 level. This program is focused on medical curricula for instruction on the detection and treatment of diseases that can be caused by bioterrorism. The Bioterrorism Training and Curriculum Development program, first initiated in FY 2003, facilitates the training and preparation of current medical, nursing, allied health, and other health professions students.
- State and Local Preparedness: The commitment at CDC and HRSA to preparing States and hospitals to respond to public health emergencies remains strong: between FY 2002 and FY 2004, CDC invested a total of $2.9 billion in State and local preparedness and HRSA invested a total of $1.2 billion. In FY 2005, CDC has budgeted another $829 million and HRSA another $476 million.

Investments in States have markedly improved capacity: the Laboratory Response Network (LRN) now consists of 109 functional reference laboratories distributed throughout all 50 States. There are also 59 biosafety level 3 (BSL-3) laboratories located in 50 States - nearly three times the number reported in 1999. Fifty members of the LRN are now able to rule out the existence of smallpox, and 24 labs can test for the existence of the smallpox virus on a real-time basis. After several years of targeted funding from HRSA, every State, Territory, and funded

municipality has a staffed hospital preparedness office and advisory committee, has completed a needs assessment, and has developed a plan of action in response to the identified needs. The FY 2005 budget requests $476 million to continue progress towards the goal of 100 percent of States developing surge capacity plans, including communication and connectivity among hospitals, outpatient facilities, public health departments, emergency medical services units, and other health care entities.

- Office of the Secretary: The FY 2005 request for the PHSSEF includes $62 million for the Office of the Secretary, the same as FY 2004.
- Office of the Assistant Secretary for Public Health and Emergency Preparedness (ASPHEP): Funding is maintained at $42 million in FY 2005. This includes funding for the ongoing operations of ASPHEP at headquarters and in the field; supports the Secretary's Emergency Response Team and the Department's International Early Warning Surveillance efforts; provides funding for bioterrorism preparedness, planning, and evaluation studies and an advance research program to promote a national bioscience research and development effort related to civilian biodefense; and to continue the development of an effective risk communication and information strategy for the public. FY 2005 will mark the second year of funding for the procurement of medical countermeasures in DHS. This procurement strategy is an unprecedented effort to manage the development and acquisition of up to $6 billion of drugs, vaccines, other biologics and supplies to be supplied to the SNS. ASPHEP has begun planning the operational structure to conduct the acquisition of vaccines and other pharmaceuticals that can be used to combat smallpox, anthrax, plague, and botulism.
- Medical Reserve Corps: Funding is maintained at $10 million in FY 2005 for the Medical Reserve Corps, the Citizen Corps component that organizes local volunteers to assist regular medical response professionals and facilities during a large-scale local emergency, such as an influenza epidemic or a hazardous materials spill. Program oversight is the responsibility of the Office of the Surgeon General. It is estimated that approximately 200 grants to small cities, rural counties, and large metropolitan areas will be awarded in FY 2004.
- CyberSecurity: The FY 2005 request for the PHSSEF includes $10 million to protect the Department's information technology infrastructure from cyber-terrorist attacks. These funds will provide continuous security monitoring for all HHS systems, assets, and services.

Bioterrorism Overview

	2003	2004	2005	2005 +/-2004
Public Health and Social Services Emergency Fund				
Centers for Disease Control and Prevention:				
Upgrading State and Local Capacity.....	$939	$934	$829	-$105
Biosurveillance	0	0	$130	+130

Initiative.....				
Supplemental appropriations (Smallpox).....	$100	0	0	0
Upgrading CDC Capacity.....	157	157	142	-15
Anthrax Vaccine Research.....	18	18	8	-10
Independent Studies.....	2	0	0	0
Subtotal, CDC	$1,216	$1,109	$1,109	$0
Health Resources and Services Administration:				
Hospital Preparedness and Infrastructure.....	$514	$515	$476	-$39
Education Incentives for Medical Curriculum.....	28	28	28	0
Smallpox Compensation.....	42	0	0	0
Subtotal, HRSA.....	$584	$543	$504	-$39
Office of the Secretary:				
OASPHEP:				
Operations	$13	$13	$13	$0
Advanced Research.....	5	5	5	0
International Security Early Warning Surveillance.....	9	9	9	0
Emergency Response Team.....	3	3	3	0
Preparedness, Planning and Evaluation.....	7	7	7	0
Media/Public Information Campaign.....	5	5	5	0
Subtotal, OASPHEP.....	42	42	42	0
CyberSecurity.....	10	10	10	0
Medical Reserve Corps.....	10	10	10	0

Subtotal, Office of the Secretary.....	$61	$61	$61	$0
Agency for Healthcare Research and Quality.....	$5	0	0	$0
Strategic National Stockpile (Transferred back from DHS) 1/...	$398	$398	$400	+2
Nuclear/Radiological Countermeasures (NIH).....	$0	$0	$47	+47
Subtotal, PHSSEF Bioterrorism.....	**$2,264**	**$2,111**	**$2,122**	**+$11**
Pandemic Influenza.....	$0	$50	$100	+$50
Total, PHSSEF.....	**$2,264**	**$2,161**	**$2,222**	**+$61**

	2003	**2004**	**2005**	**2005 +/-2004**
Food and Drug Administration:				
Food Safety.....	$97	$116	$181	+$65
Vaccines/Drugs/Diagnostics.....	53	53	58	+5
Physical Security.....	7	7	7	0
Subtotal FDA.....	$157	$176	$246	+$70
National Institutes of Health:				
Research.....	$687	$1,428	$1,499	+$71
rPA Anthrax Vaccine Intermediate Scaleup.....	123	117	0	-117
MVA Smallpox Vaccine Intermediate Scaleup.....	0	75	45	-30
Extramural Physical Security & Facilities.....	373	0	150	+150
Intramural Physical Security & Facilities.....	370	0	0	0
Subtotal NIH.....	$1,554	$1,620	$1,694	+$74

CDC Physical Security and Facilities.....	$20	$0	$0	$0
Subtotal, Bioterrorism Activities in Agency Budgets.....	$1,731	$1,796	$1,940	+$144
Total Bioterrorism Funding.....	**$3,995**	**$3,908**	**$4,062**	**+$154**

1/ Displayed comparably--transferred to DHS in FY03 and back to HHS in FY05.

Office for Civil Rights

	2003	2004	2005	2005 +/- 2004
Program Level.....	$33	$34	$35	+$1
FTE.....	244	268	268	0

The FY 2005 budget request for OCR is $35 million, an increase of $1 million over the FY 2004 level. OCR conducts public education; outreach; complaint investigation and resolution; and other compliance activities to prevent and eliminate discriminatory barriers, ensure the privacy of protected health information, and enhance access to quality HHS-funded health care and social services programs. OCR is responsible for enforcing civil rights statutes that prohibit discrimination on the basis of race; national origin; disability; age; and, in limited instances, sex and religion.

Some of the key priorities that the work of OCR currently supports and will continue to support during FY 2004 and FY 2005 include: increasing access to health services, improving the quality of health care, working toward independence, leaving no child behind, protecting and effectuating the rights of vulnerable populations, and minimizing health differences and disparities - "Closing the Gaps."

The budget priorities of OCR for FY 2005 concentrate on:

- increasing access to and receipt of nondiscriminatory quality health care and treatment and social services, while protecting the integrity of HHS Federal financial assistance; and
- ensuring understanding of and compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

OCR will address a broad array of concerns including: the New Freedom Initiative and the Olmstead executive order; Title VI (race, color, and national origin) access and disparities in health and human services programs; and privacy of protected health information - HIPAA.

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 the compliance activities for OCR ensures that individuals are treated in a nondiscriminatory manner by health and human services providers or facilities. The work of OCR 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.

New Freedom Initiative and Olmstead

OCR is involved in a range of efforts to increase the independence and quality of life of persons with disabilities, including those with long-term needs. OCR continues to support the President's New Freedom Initiative and the Supreme Court's Olmstead decision in a variety of ways.

OCR provides expert consultant technical assistance to States as they continue to develop comprehensive plans consistent with the requirements of Olmstead. This 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 will continue its participation in the HHS New Freedom Initiative Work Group, which serves as a forum to coordinate, develop, and implement HHS disability policy and specific tasks and projects that facilitate the community integration of people with disabilities. The activities of OCR in this work group have included serving on a subgroup to devise solutions to barriers to community integration posed by inadequate housing and employment opportunities.

Title VI (Race, Color, and National Origin) Access Initiatives

OCR ensures compliance with and enforcement of the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, requiring recipients of HHS Federal financial assistance to ensure that their policies and procedures do not exclude or have the effect of excluding or limiting the participation of beneficiaries in their programs on the basis of race, color, or national origin. In FY 2005, OCR will continue to focus on a broad range of Title VI access issues including disparities in access, quality, and availability of health services. For example:

- OCR will focus technical assistance, public education, and awareness activities about civil rights issues in quality health care access by vulnerable rural populations such as person with disabilities, African-Americans, Native Americans, and national origin minorities in Southwestern, Midwestern, and Southern states.

HIPAA - Health Information Privacy

For the past three years OCR prepared for, then began implementing, a new compliance, policy development, public education, outreach, and technical assistance responsibility for protecting the privacy of health information under HIPAA. OCR developed policy guidance, public education, and technical assistance materials for health care providers, health plans, and clearinghouses that maintain individuals' health information, as well as the public. The HIPAA Privacy Rule took effect April 14, 2003. In FY 2005, the resources of OCR will support:

- promoting compliance with the Privacy Rule by receiving, investigating and resolving complaints, and reviewing the compliance of covered entities;
- developing policy guidance and public education and technical assistance materials for covered entities and providing direct technical assistance to covered entities and the public; and

- analyzing and making recommendations with respect to any changes in the Privacy Rule to promote workability, and issuing additional guidance, as needed, to aid in implementation and to dispel misconceptions.

Cross-Cutting Civil Rights Activities

The work of OCR often addresses more than one of its legal authorities simultaneously. For example, certain population groups may face multiple barriers to services that cross-cut race, national origin, disability, and age nondiscrimination authorities.

- In FY 2005, OCR will continue to work with the Administration for Children and Families, states, local governments, and other service providers to ensure that TANF welfare-to-work programs remain free from discriminatory barriers that could prevent minorities and individuals with disabilities from obtaining the training and jobs that can lead to self-sufficiency.
- OCR is making technical assistance available to all states and territories to ensure that the application processes for HHS-funded programs do not contain barriers to access for vulnerable populations and person with disabilities.

Office of Inspector General

	2003	2004	2005	2005 +/- 2004
Program Level \1.....	$197	$199	$200	+$1
FTE	1,582	1,549	1,502	-47

1/ The FY 2004 and FY 2005 levels assume $160 million for Medicare and Medicaid related fraud and abuse activities, the maximum allowed under the Health Care Fraud and Abuse Control program.

For FY 2005, the Office of Inspector General (OIG) requests a discretionary appropriation of $40 million, an increase of $1 million over the FY 2004 discretionary level. OIG will also receive between $150 and $160 million in FY 2005 from the Health Care Fraud and Abuse Control (HCFAC) Account for Medicare and Medicaid related fraud and abuse activities. In the FY 2004 - FY 2005 period, 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.

The funding level of OIG for FY 2005 allows OIG to continue its efforts in:

- bioterrorism oversight, investigations, audits, and evaluations;
- grant oversight and reviews that cover internal controls, accounting controls, performance measurements, and program evaluation; and
- nationwide involvement with the ten Project Save Our Children (PSOC) Task Forces that identify, investigate, and prosecute individuals who willfully avoid the payment of their child support obligations.

In addition to this, OIG will continue its HCFAC activities to identify and prosecute health care fraud, prevent future fraud or abuse, protect HHS program beneficiaries, and ensure the solvency of the Medicare Trust Fund.

Bioterrorism

OIG has an important role in furthering the Department's bioterrorism efforts and ensuring the security of HHS programs, staff, facilities, and equipment. In FY 2005, OIG has a variety of activities planned. For example:

- Bioterrorism Investigations: after September 11, 2001, OIG received numerous requests for information and investigations relating to terrorist and bioterrorist activity. On December 12, 2002, HHS issued the interim final rule for Possession, Use, and Transfer of Select Agents and Toxins, 42 CFR Part 73. Based upon these new regulations, OIG will pursue violations of regulations concerning possession, use, and transfer of select agents and toxins through Civil Monetary Penalties.
- Follow-up on Departmental Laboratory Security: OIG will perform selected follow-up reviews at the National Institutes of Health (NIH), Centers for Disease Control and

Prevention (CDC), and Food and Drug Administration (FDA) laboratories, focusing on whether these facilities have implemented the recommendations of OIG for bolstering physical security and determining if additional safeguards are necessary.

Grants Oversight

OIG plans to review Department grant programs to determine whether they are appropriately monitored and managed throughout the grant life cycle. OIG 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. The work of OIG 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. The reviews of OIG will cover internal controls, accounting controls, performance measurements, and program evaluation.

OIG anticipates conducting grant oversight activities that touch almost every Operating Division within HHS in the FY 2004 - FY 2005 period (NIH, CDC, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Administration for Children and Families, and programs such as breast and cervical cancer detection, the Ryan White Care Act, and Head Start).

Child Support Enforcement Program

OIG will continue its coverage of all 50 States by its multi-agency task forces (PSOC Task Forces) that 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 December 31, 2003, OIG opened 2,310 child support cases nationwide resulting in 815 Federal convictions and court-ordered restitution of $37.5 million. The task forces have resulted in an additional 293 convictions at the State level and $12.4 million in restitution.

Health Care Fraud and Abuse

Through the Health Insurance Portability and Accountability Act (HIPAA), 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. Starting in FY 2003, and each year thereafter, the maximum amount available to OIG for its HCFAC Program is capped at $160 million. 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

	2003	2004	2005	2005 +/-2004
Expenses.....	$491	$517	$545	+$28
FTE.....	1,289	1,419	1,419	0

The 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, financial management, administrative operations, strategic acquisitions service, Federal occupational health, and HR centers. The customers of the PSC 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 2005 estimated expenses for the Human Resources Service (HRS) are $53 million, representing an increase of $1 million above the FY 2004 funding level. The increase of $1 million is for increases in pay, rent, and contractual costs. HRS provides an extensive array of personnel and payroll systems administration and management, training, and payroll services. These include automated personnel and payroll systems support, equal employment opportunity, and workforce development. During FY 2004, the personnel operations portion of HRS was consolidated into the Human Resources Centers, described in a separate section entitled "Human Resources Centers" below.

Financial Management Service

The FY 2005 estimated expenses for the Financial Management Service (FMS) are $56 million, the same as FY 2004. 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 and travel management services; and rate review, negotiation, and approvals for departmental and other Federal grant and program activities to HHS and other Federal agencies.

Administrative Operations Service

The FY 2005 estimated expenses for the Administrative Operations Service (AOS) are $90 million, an increase of $2 million above the FY 2004 level. This increase reflects anticipated

increases for pay, rent, and contracts. AOS provides a wide range of administrative and technical services within the Department, both in headquarters and in the regions, and to customers throughout the Federal Government. The major areas of service are real and personal property management, technical support and communications management, management of regional contracts for administrative support, freedom of information act services, and management of the business functions of the PSC.

Federal Occupational Health Service

The FY 2005 estimated expenses for the Federal Occupational Health Service (FOHS) are $195 million, an increase of $22 million above the FY 2004 level. The increase of $22 million represents anticipated increased reimbursements from other Federal agencies. The FOH provides occupational health services, including health, wellness, employee assistance, work/life, safety, and environmental and industrial hygiene-related services to more than 160 Federal components across the country.

Strategic Acquisition Service

The FY 2005 estimated expenses for the Strategic Acquisition Service (SAS) are $99 million, an increase of $2 million above the FY 2004 level. The increase reflects anticipated increased reimbursements. The SAS is responsible for providing leadership, policy, guidance, and supervision to the procurement operations of the PSC and for improving procurement operations within HHS. The SAS provides strategic sourcing services; acquisition management; and provides pharmaceutical, medical, and dental supplies to HHS and other Federal agencies. The SAS will streamline procurement operations in HHS through activities such as the reduction of duplicate contracts, the use of consolidated contracts, and implementation of new procurement practices designed to provide higher quality procurement services.

Human Resources Centers

The FY 2005 estimated expenses for the Human Resources Center (HRC) are $46 million, an increase of $1 million above the FY 2005 level. The increase is for pay and other costs. The HR Centers represent a consolidation of human resources services within the Department, with sites located in Rockville, Baltimore, and Atlanta. The HR Centers will implement strategic human capital strategies designed to identify, recruit, hire, and retain employees with the skills to accomplish the mission of HHS.

Retirement Pay and Medical Benefits for Commissioned Officers

	2003	2004	2005	2005 +/-2004
Retirement Payments.....	$214	$228	$241	+$13
Survivor's Benefits.....	13	14	15	+$1
Medical Care.....	64	80	75	-$5
Total, Budget Authority.....	**$291**	**$322**	**$331**	**$9**

This appropriation provides for annuities of retired Public Health Service (PHS) Commissioned Officers; payment to survivors of deceased retired officers; and medical care to active duty PHS commissioned officers, retirees, and dependents of members and retirees of the PHS Commissioned Corps.

The FY 2005 request of $331 million is a net increase of $9 million over the FY 2004 level. This amount reflects increased retirement payments of $13 million, increased survivor benefits of $1 million, and increased medical benefits costs of $5 million.