U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

BUDGET IN BRIEF

FISCAL YEAR 2009

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Department of Health and Human Services
200 Independence Avenue S.W., Washington, D.C. 20201

This document also available at www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf

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ADVANCING THE HEALTH, SAFETY, AND WELL-BEING OF OUR PEOPLE

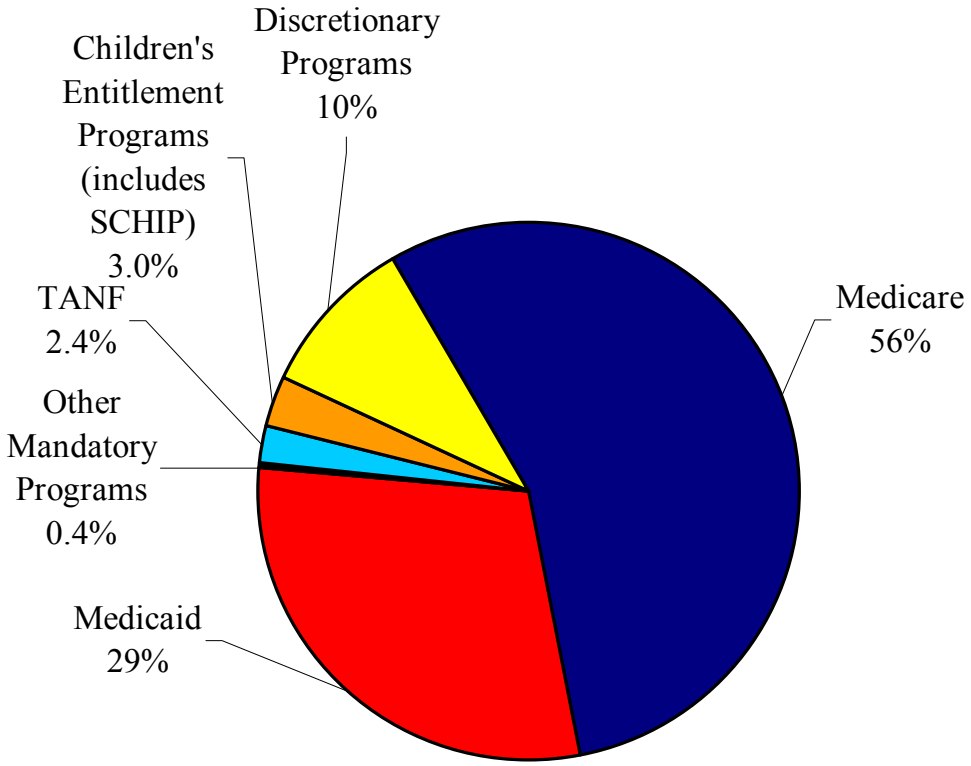
FY 2009 President's Budget for HHS

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Budget Authority.....	656,726	715,790	731,407	+15,617
Outlays.....	670,413	707,723	736,793	+29,070
Full-Time Equivalents.....	63,748	64,750	65,630	+880

Composition of the FY 2009 Budget

$737 Billion



General Notes

Detail in this document may not add to the totals due to rounding.

Budget data in this book are presented "comparably" with the FY 2009 Budget, since the location of programs may have changed in prior years or be proposed for change in FY 2009. This is consistent with past practice, and allows increases and decreases in this book to reflect true funding changes. In addition – consistent with past practice – the FY 2007 figures herein reflect final enacted levels.

ADVANCING THE HEALTH, SAFETY, AND WELL-BEING OF OUR PEOPLE

The Department of Health and Human Services enhances the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

Consistent with the President's goal to balance the Budget by 2012, the HHS Budget includes both new mandatory savings proposals and a fiscally responsible discretionary request.

HHS FY 2009 outlays total $737 billion, which is a net increase of $29 billion over the estimated outlays for FY 2008. The HHS FY 2009 discretionary Budget includes $68.5 billion in budget authority, which is a decrease of $2.2 billion below the FY 2008 enacted level.

The following broad goals represent the mission of the Department of Health and Human Services and help guide the Department in fulfilling the President's vision of a healthier, safer, and more hopeful America. Under the HHS Strategic Plan for FY 2007 – FY 2012, HHS will continue to yield positive results and strive to meet and exceed expectations in the following endeavors:

- *Health Care;*
- *Public Health and Emergency Preparedness;*
- *Human Services; and*
- *Scientific Research and Development.*

HEALTH CARE

Reforming the Health Care Marketplace: When it comes to health care, the tax code is biased in favor of individuals who purchase insurance through their employers. To remove this inequity, the President proposes replacing the existing and unlimited exclusion for employer sponsored insurance with a flat deduction for those with at least catastrophic health insurance. As long as a family has at least a catastrophic health insurance policy, they will be able to deduct $15,000 from their income ($7,500 for an individual). This will foster a true marketplace for health care, encourage competition, improve the efficiency of the system, and reduce the ranks of the uninsured.

Fostering Affordable Choices in the Health Care System: There are two competing philosophies about how to achieve the widely held aspiration that all Americans have access to an affordable basic health insurance policy. One is a Washington-run, government-owned plan, where government makes the choices, sets the prices, and then taxes people to pay the bill. The other, supported by the Administration, is a private market organized by the States where consumers choose, where insurance plans compete, and where innovation drives the quality of health care up and the cost down.

A transformed health care system avoids costly and unnecessary medical visits, and emphasizes upfront, affordable private health insurance options. In addition to its proposed tax reforms and health insurance market-based initiatives, the Administration believes the current health care system could operate more efficiently, without increasing Federal spending on health care, if some portion of indirect public subsidies were redirected to make health insurance affordable for individuals with poor health or limited incomes. The Federal Government would maintain its commitment to the neediest and most vulnerable populations, while giving the States, which are best situated to craft innovative solutions, the opportunity to move people into affordable insurance.

Personalized Healthcare: The FY 2009 Budget supports HHS-wide efforts to achieve individualized treatment for patients by using genetic information and health information technology (IT). The FY 2009 request includes funds in AHRQ to conduct comparative effectiveness research to understand what medical interventions work best for certain patient populations. In addition, the FY 2009 request supports research in FDA and NIH to understand the impacts of genomics on patient care.

CMS Slowing Medicare Growth: The FY 2009 Budget includes a comprehensive package of Medicare legislative and administrative proposals designed to strengthen the long-term financial security of the program. These proposals will encourage provider competition and efficiency, promote high quality care, rationalize payment policies, improve program integrity, and increase high-income beneficiary awareness of and responsibility for health care costs. Slowing the growth of Medicare spending is a

key factor in meeting the President's goal of addressing Medicare's unfunded liability and unsustainable growth in entitlement spending. Net savings from the Medicare legislative package total $12.2 billion in FY 2009 and $178 billion over five years. Net administrative savings total $645 million in FY 2009 and $4.7 billion over five years.

SCHIP: The FY 2009 Budget includes a robust SCHIP reauthorization proposal, increasing funding to States by $19.7 billion through FY 2013. The proposal is fully offset within health care entitlements and refocuses SCHIP on low-income children, as originally intended. The proposal also includes annual Federal outreach grants to States of $450 million over this period to reach SCHIP and Medicaid eligible uninsured children. As a result of these additional resources, the Administration estimates that in 2013, 5.6 million children would be enrolled in SCHIP on average, or nearly nine million children enrolled at some time during the year.

CMS Strengthening Program Integrity: The FY 2009 Budget includes resources and legislation to improve program integrity and reduce improper payments in Medicare and Medicaid. The proposed FY 2009 Health Care Fraud and Abuse Control (HCFAC) program level is $1.3 billion. This includes $198 million in new discretionary funding to support HCFAC activities. These funds are part of a government-wide proposal to fund program integrity activities through an adjustment to discretionary spending totals. This new funding will be used to identify potential fraud and abuse in the new prescription drug benefit and Medicare Advantage programs, and strengthen oversight of the Medicaid program.

CMS Advancing Medicare Contracting Reform: CMS is on track to full implementation of contracting reform nearly two years earlier than the 2011 target set in the Medicare Modernization Act. Contracting reform will transform Medicare claims processing from 40 cost-based contracts to 15 performance-based, competitive contracts, plus 4 specialty contractors. By the end of 2008, CMS will have awarded 12 of the 19 competitive contracts. The FY 2009 Budget includes $109 million to allow CMS to award the remaining contracts by the end of FY 2009. We expect all Medicare Administrative Contractors to be fully operational by FY 2010.

Contracting reform is projected to generate significant administrative savings for the government and providers by reducing the cost of processing Medicare claims. This will yield $2.7 billion in Trust Fund savings over the next five years through more accurate and appropriate payments.

CMS Medicare Prescription Drug Benefit Delivers Strong Results: In 2006, HHS implemented the new prescription drug benefit, the most significant reform of the Medicare program since its inception. The drug benefit is an unparalleled success. The vast majority of all Medicare beneficiaries, including nearly 10 million low-income beneficiaries, are receiving comprehensive prescription drug coverage through Medicare Part D, employer-sponsored retiree health plans, or other creditable coverage. On average, beneficiaries are receiving $1,200 in net value on their prescription drug coverage, and satisfaction with the drug benefit is as high as 85 percent. In 2008, in every State and region, beneficiaries have a broad range of coverage choices available, including at least one plan with monthly premiums below $20, plans with deductibles below the Medicare standard, as well as plans with at least some coverage in the "coverage gap." In FY 2008, the average monthly premium is projected to be lower than the original estimate, decreasing from $41 to approximately $25. Finally, the net projected cost of the Medicare drug program has fallen by nearly $244 billion since its passage in 2003, from about $634 billion to roughly $390 billion over the FY 2004 to FY 2013 time period.

CMS Modernizing Medicaid: For more than a decade, States have been asking for the tools to modernize their Medicaid programs. With the enactment of the Deficit Reduction Act of 2005 (DRA), States now have new options to create programs that are aligned with today's Medicaid populations and the health care environment. The enactment of the DRA was a significant accomplishment of this Administration and its implementation has made important changes that modernize the financing, benefit structure, and infrastructure of Medicaid. The FY 2009 Budget continues efforts to promote the long-term viability of this vital program through several legislative and administrative reforms which together will provide more than $18 billion in savings over five years.

Health IT and EHR Initiatives: The FY 2009 Budget facilitates health IT advancements by supporting the adoption of health IT as a normal cost of business. The FY 2009 Budget supports policies that will encourage physicians and

others to adopt electronic health records (EHRs) and supports technologies for safe, secure health information exchange.

To advance the President's goal for most Americans to have access to EHRs by 2014, the FY 2009 Budget includes $66 million for the Office of the National Coordinator for Health IT. This will support the establishment of a successor to the American Health Information Community to an independent and sustainable public-private partnership, continue health data standards development, support solutions for privacy and security challenges in electronic health information exchange, and support the testing of standards and services to exchange health information across geographic borders.

Physician adoption of EHRs can improve the delivery of health care by preventing medical errors, reducing health care costs, and increasing efficiency. To further the adoption of health IT, $3.8 million is included in the CMS budget for the second year of a demonstration project providing financial incentives for up to 1,200 physician practices to adopt certified EHR systems. The Budget also includes $45 million in AHRQ for health IT investments to enhance patient safety, with an emphasis on ambulatory patient care. In addition, the IHS budget supports the continuation of a comprehensive EHR for all IHS direct health care sites.

Healthcare Transparency: One of the Administration's goals is to provide consumers the ability to gain control of their health care and to have the knowledge needed to make better health care decisions through increased transparency of the medical system. To accomplish these objectives, the Administration is proposing several initiatives. For example, the FY 2009 Budget includes legislative proposals to increase the transparency of health care for Medicare beneficiaries. Hospital value-based purchasing would build upon and could expand reporting of quality of care measures to hospitals. Another proposal would release Medicare claims data to facilitate public reporting, performance measurement, and quality improvement without violating beneficiary or physician privacy. In addition, the FY 2009 request includes $4 million for AHRQ to establish community-based multi-stakeholders collaboratives that publicly report cost and quality information to give consumers and providers the information they need to make informed health care decisions. Finally, the Administration proposes to require employers providing health coverage to employees and their families to report on the Form W-2 provided to employees and the IRS the value of the health coverage provided to the employee. Many employees are unaware of the value of health coverage provided by their employers. This lack of transparency may result in inefficient choices of health coverage, including over-consumption of health coverage by employees.

IHS Health Care for American Indians and Alaska Natives: IHS works together with Tribes to improve the physical and mental health of Indian and Alaskan people. The Budget request of $4.3 billion maintains the provision of clinical and preventive health care services to eligible American Indians and Alaska Natives at the FY 2008 Budget level. The request continues to prioritize direct services, provides an increase for staffing of new and renovated facilities, and will allow IHS to continue to reduce health disparities that affect Tribal communities.

HRSA Health Centers: The FY 2009 Budget provides an increase of $27 million to build on the success of the President's Health Center Initiative and goal to expand sites to high poverty areas. In FY 2008, the Health Center Program surpassed the President's goal of creating 1,200 new or expanded Health Center sites across the Nation. In FY 2009, the Budget will fund up to 40 new access point grants in high poverty areas without access to a Health Center, along with 25 planning grants. With these expansions, Heath Centers will serve more than 17 million clients in FY 2009.

Health Diplomacy Initiative: The FY 2009 Budget includes $3.5 million to deliver direct patient care and train local health workers in rural developing areas outside the U.S. The Initiative also trains U.S. Government medical personnel to provide health care primarily in Latin America for poor populations through U.S. medical and humanitarian missions. Lastly, the Initiative establishes a strategic approach to engage with U.S. Government-funded, non-governmental organizations that provide health care to coordinate their assistance with U.S. Government health efforts.

PUBLIC HEALTH AND EMERGENCY PREPAREDNESS

FDA Food Protection: In order to keep pace with new food sources, advances in production and distribution methods, and growing global commerce, the FY 2009 Budget includes a total funding level of $662 million for FDA's food protection efforts. This increase of $42 million over FY 2008 will support actions consistent with the *Interagency Working Group on Import Safety's*

Action Plan, chaired by Secretary Leavitt, and the *FDA Food Protection Plan*. By preventing most harm before it can occur, enhancing intervention methods at key points in the food production system, and strengthening response capabilities, FDA is aggressively working to keep the U.S. food supply safe from unintentional or deliberate contamination.

FDA Drug Safety: FDA is responsible for ensuring that America's supply of brand name, over-the-counter, and generic drugs are safe and effective, and for quick delivery of innovative and safe drugs to the public. The FY 2009 Budget proposes to commit a total program funding level of $389.5 million, $36.1 million over FY 2008, for drug safety activities. FDA conducts safety surveillance of drugs and biologics through the Adverse Event Reporting System for unexpected health risks. This funding increase will enhance FDA's efforts to improve the safety of drugs on the market and quickly deliver innovative and safe drugs to the public.

Pandemic Influenza Preparedness: Pandemic preparedness is a shared responsibility between the Federal Government, States, local government, and the private sector. Over the past two years, HHS has developed national stockpiles of countermeasures, worked with States to develop and exercise their plans, and provided guidance for a wide range of entities to improve their preparedness for a pandemic.

The FY 2009 Budget includes $507 million to continue funding the President's pandemic influenza preparedness plan. These funds will be used to continue to build vaccine production capacity and to purchase medical countermeasures and Personal Protective Equipment for HHS employee and patient populations, and the IHS and NIH patient populations. HHS will purchase countermeasures to prevent morbidity and mortality, and to increase the workforce available to respond effectively to a pandemic. This investment is consistent with the Department's view of shared responsibility for pandemic preparedness.

The Budget also includes $313 million to fund ongoing activities within the CDC, FDA, NIH and the Office of the Secretary to improve our Nation's ability to prepare for, communicate during, respond to, and contain a potential pandemic influenza outbreak.

In FY 2008, Congress did not appropriate the $870 million requested by the President for continued implementation of the pandemic influenza preparedness plan. This $870 million is still needed to make progress in meeting the objectives of the President's pandemic preparedness plan. The Administration is still considering options regarding this funding, and will reach out to Congress soon.

Advanced Development of Countermeasures: The FY 2009 Budget includes $250 million, an increase of $148 million over FY 2008, to target advanced research and development on promising medical countermeasures in the Office of the Assistant Secretary for Preparedness and Response for threats identified in the HHS Public Health Emergency Medical Countermeasures Enterprise Strategy for Chemical, Biological, Radiological and Nuclear Threats. The Budget requests an additional $25 million to support the advanced development of next generation ventilators to help patients in acute respiratory distress in a pandemic or other public health emergency. Within CDC, $10 million is requested for a new Radiation Laboratory Response Network to determine proper victim treatment after a radiological or nuclear event.

Quarantine Stations: Pandemic and bioterrorism preparedness investments have increased the number of quarantine stations to protect the Nation from the importation of infectious diseases. The FY 2009 Budget includes $53 million, an increase of $33 million, to improve the capabilities of existing quarantine stations and support the development of five international quarantine stations.

Commissioned Corps: The FY 2009 budget for the Office of Public Health and Science includes $30 million to increase training, equipment, and emergency response and operational capacities for the Commissioned Corps. This initiative will support a wide variety of activities including: additional maintenance and development of training modules, team and individual training, and fully staffing and equipping two Health and Medical Response teams of 105 members each.

SAMHSA Treatment Courts: Treatment courts use incentives, sanctions, and close supervision to ensure that offenders experiencing mental health or substance abuse disorders continue with their treatment plans and break the cycle of abuse and incarceration. The FY 2009 Budget includes a total of $40 million for behavioral health services associated with treatment courts, an increase of $30 million over FY 2008.

HRSA and CDC HIV/AIDS Treatment and Prevention: The FY 2009 request provides $2.9 billion for domestic

HIV/AIDS treatment and prevention activities in HRSA and CDC. Within this total, $2.2 billion is provided for Ryan White funded activities, with a continued emphasis on HIV/AIDS medications and support for a comprehensive approach to HIV/AIDS care and treatment for the poor and uninsured. Also within the $2.9 billion total, $691 million is provided for HIV/AIDS activities at CDC targeted at reducing new HIV/AIDS infections, reducing risky behaviors associated with HIV/AIDS transmission, and linking infected persons with needed prevention, care, and treatment services. Within the CDC total, $93 million is for continuation of the domestic HIV/AIDS testing initiative. These funds will increase testing in medical and community-based settings, make voluntary testing a routine part of medical care, and focus on areas and populations with the highest incidence of disease.

HRSA Nursing: The FY 2009 Budget includes $110 million for nursing programs that will support loan repayment for qualified nursing faculty, enrollment in undergraduate and graduate nursing programs, and over 800 scholarships and loan repayment awards for nurses and nursing students who commit to work in facilities with a critical shortage of nurses.

HRSA Cord Blood Stem Cell Bank: The FY 2009 Budget includes $12 million for the Cord Blood Stem Cell Bank to build a genetically and ethnically diverse inventory of high-quality umbilical cord blood for transplantation and to make these cord blood units, as well as other units in the inventories of participating cord blood banks, available to physicians and patients for blood stem cell transplants. An estimated 8,650 new cord blood units will be collected with FY 2009 funding. Blood stem cell transplantation offers the possibility of a cure for Americans with leukemia and other life threatening blood and genetic disorders.

Autism: Through the combined efforts of NIH, CDC, and HRSA, the FY 2009 Budget remains committed to funding efforts to better understand the causes and potential treatments of autism while promoting evidence-based interventions and training for healthcare providers. Between FY 2001 and 2009, HHS annual funding for autism will have increased from a total of $61 million to $181 million. Included in the FY 2009 request is $36 million in HRSA to continue the new Autism and Other Developmental Disorders program.

SAMHSA Substance Abuse Performance Awards: The FY 2009 Budget includes $20 million for new supplemental performance awards to States and Territories that demonstrate superior performance through the Substance Abuse Prevention and Treatment Block Grant. States and Territories have significant flexibility in tailoring services supported through this $1.8 billion funding stream to their unique needs. The establishment of performance-based awards in FY 2009 will provide a financial incentive for States and Territories to improve their substance abuse prevention and treatment services.

SAMHSA Children's Mental Health Services: Children receiving appropriate mental health services demonstrate improved behavioral outcomes, better school performance, and fewer disciplinary and law enforcement encounters. The FY 2009 Budget includes $114 million, an increase of $12 million over FY 2008, for grants to States and localities to support the development of comprehensive community-based systems of care for children and adolescents with serious emotional disorders.

HUMAN SERVICES

ACF Head Start: The FY 2009 Budget includes $7 billion for Head Start, an increase of $149 million over FY 2008, which will maintain FY 2008 enrollment levels and provide approximately 895,000 children with comprehensive child-development services, including 61,000 children in Early Head Start. Head Start helps low-income children arrive at school ready to learn by enhancing their social and cognitive development.

ACF Abstinence-Only Education: The FY 2009 Budget includes $191 million in discretionary and mandatory funding, an increase of $28 million over FY 2008, to provide abstinence-only education to adolescents and create an environment that supports them in postponing sexual activity until marriage. The request also assumes reauthorization of the State Abstinence-Only Education program in FY 2008 and includes $50 million in mandatory funding for a full year of operation in both FY 2008 and FY 2009.

ACF Adoption Incentives: The FY 2009 Budget includes $20 million for adoption incentives, $15 million over FY 2008, for incentive funds to States that successfully increase the number of children adopted from public foster care systems. The Budget proposes legislation that would double the adoption bonus for children age nine and older and increase the adoption bonus for special needs children under the age of nine.

AoA Choices for Independence: The FY 2009 Budget includes $28 million for AoA's Choices for Independence demonstration. Through three inter-related components—Aging and Disability Resource Centers, Evidence-Based Prevention, and Nursing Home Diversion—Choices will help people conserve and extend their personal resources by facilitating informed decision-making about long-term care, diverting seniors away from nursing home care, and empowering the elderly to take more control of their health.

ACF Compassion Capital Fund: The FY 2009 Budget includes $75 million, an increase of $22 million over FY 2008, for the Compassion Capital Fund to support the efforts of community and faith-based organizations to maximize their effectiveness and improve their ability to provide social services. Of this amount, $35 million will support the Communities Empowering Youth program which assists faith-based and community groups to direct youth to social services and healthy activities that offer an alternative to gang involvement.

ACF Mentoring Children of Prisoners: The FY 2009 Budget includes $50 million, an increase of $1 million over FY 2008, to support public and private organizations that create and maintain one-on-one mentoring relationships for children of incarcerated parents and those recently released from prison. Research has shown that children with incarcerated parents are more likely than their peers to commit a crime and become incarcerated themselves. Research also shows that when these children have mentors, they are less likely to use drugs or alcohol, less likely to initiate violence, and more likely to attend and perform well in school.

ACF Child Support Enforcement: Child support collections play a vital role for families transitioning from welfare to self-sufficiency. For low-income families who receive child support, these payments make up over one-quarter of the monthly family budget. Securing regular support from non-custodial parents encourages responsible parenthood and enables families to avoid dependency on public assistance. Child Support Enforcement (CSE) is one of the highest-performing programs in the government; for every dollar invested in this program in FY 2006, CSE collected $4.58 in child support payments. The FY 2009 Budget includes proposals to strengthen enforcement and collections tools – increasing direct collections to families by almost $1.6 billion over five years.

HIPAA Enforcement: The FY 2009 Budget includes an additional $2 million to improve critical HIPAA compliance and enforcement operations at the Office for Civil Rights (OCR). OCR's HIPAA activities also include critical policy development of key priorities in Health IT, Personalized Health Care, and Patient Safety.

Disaster Human Services Case Management: Over one million people were affected by hurricanes Katrina and Rita. The Federal Response to Hurricane Katrina: Lessons Learned identified a need for improved coordination and service delivery to meet the needs of those affected. Within ACF, the request includes $10 million to establish an integrated human services case management system that can provide assistance to disaster victims. These funds will support a national contract that recruits, trains and credentials volunteers who can be dispatched to serve as case managers during a disaster and will provide planning grants to States to establish or improve their capability to respond to disasters.

Scientific Research and Development

National Institutes of Health: With recent advances in genomics, proteomics, computational biology, and many other fields of science, researchers are gaining a broader understanding of the fundamental, molecular mechanisms that lead to disease years before it strikes the patient. This knowledge is laying the cornerstone for efforts to transform the practice of medicine to be personalized, predictive, and pre-emptive, with greater patient and community participation in the active management of their health.

To capitalize on such emerging opportunities, the FY 2009 Budget includes $29.5 billion for NIH, the same level as in FY 2008. These funds will allow NIH to continue to pursue cross-cutting areas of discovery, increase biodefense research, continue support for new research investigators, and continue to refocus its programs for translating clinical research results into clinical practice. In FY 2009, NIH estimates it will support a total of 38,257 research project grants, including 9,757 new and competing awards – approximately the same levels as FY 2008.

Global Mission

HHS recognizes that our job to enhance the health and well-being of Americans does not end at the shoreline. Pathogens and other threats to human health have become as mobile as we are, and have, in some cases, become more deadly through mutations and resistance to drugs. As people move and diseases change, our own health is intertwined with that of people in other nations.

The health of other nations is important, and affects global productivity, stability, security, and good governance. It is clearly in our Nation's interest to address global health concerns and demonstrate the generosity of the American people.

HHS works to improve global health through programs providing direct assistance, technical and program support, training and capacity-building, and research. Areas of emphasis in this Budget include: Safety (food, animal feed, and medical devices), Health Diplomacy, the President's Emergency Plan for AIDS Relief, Quarantine Stations, and Pandemic Influenza.

PRESIDENT'S MANAGEMENT AGENDA (PMA)

The FY 2009 Budget supports HHS efforts to implement the PMA. The PMA encompasses a broad strategy for improving management and program performance and consists of five government-wide initiatives and several program-specific initiatives aimed at promoting responsible stewardship and effective management.

Strategic Management of Human Capital: HHS achieved "Green" status and "Green" progress ratings for Strategic Management of Human Capital in 2007. This rating recognizes HHS accomplishments including: a stronger Senior Executive Service (SES) Performance Management System aligning executives' work to the HHS Strategic Plan and requiring quantifiable, results-oriented performance measures; the implementation of a Department-wide four-tier Performance Management System for all of the Department's employees; HHS's proactive approach to employee survey action planning; implementation of a new Learning Management System that provides a cost-effective tool for training delivery and tracking; and its improved SES Candidate Development Program and Emerging Leaders Program. HHS is investing in human capital management through a Department-wide workforce and leadership succession planning process tied to the accomplishment of the HHS Strategic Plan.

Competitive Sourcing: To date, HHS has conducted competitive sourcing studies for over 45 percent of its available commercial activities. In accordance with P.L. 108-199, Section 647(b), HHS reported total accrued savings of $162 million to Congress on December 17, 2007.

Improved Financial Performance: HHS has maintained a "Green" progress rating on the Improved Financial Performance initiative and continues efforts to improve its "Red" status rating for this area. HHS has made significant strides in its implementation of a Unified Financial Management System (UFMS) to address financial reporting and policy development requirements. HHS successfully executed its second year A-123, Appendix A assessment of Internal Controls Over Financial Reporting and is actively working to ensure that its process for conducting all internal control and compliance type assessments achieves maximum effectiveness and efficiencies. The Department's Risk Management and Financial Oversight Board, comprised of senior level departmental staff, has been monitoring the actions necessary to improve financial performance at the Department.

Eliminating Improper Payments: In the third quarter of FY 2007, HHS was elevated to "Yellow" status for the Eliminating Improper Payments initiative under the PMA and has maintained a "Green" on progress. These achievements reflect significant progress in activities to identify, reduce, and recover improper payments in seven of its largest programs. HHS anticipates reporting error rates for its high-risk programs (Medicare fee-for-service; Medicaid; SCHIP; TANF; Head Start; Foster Care; and Child Care) in the FY 2008 Performance and Accountability Report and continues to develop measurements for the Medicare Advantage and Medicare Prescription Drug programs.

Expanded Electronic Government: The Expanded Electronic Government (E-Gov) Initiative leverages the use of IT to significantly improve HHS's ability to serve its citizens, reduce the costs of delivering those services, and ensure electronic transactions are private and secure. The HHS E-Gov objectives are supported through the integration of IT capital planning and budget processes; implementation of enterprise architecture, security, and project management; and the use of performance measurement and management as a component of enterprise planning and performance life cycle planning processes.

In FY 2007, HHS continually improved its status and progress ratings by implementing 208 HHS-accepted and OMB-approved E-Gov milestones, including the transition to the E-Rulemaking initiative and the migration of internal learning management systems (LMS) to the E-Gov E-Training LMS. In addition, HHS is the Managing Partner for the Grants.gov initiative and the Federal Health Architecture Line of Business (LoB); the co-managing Partner for the Grants Management LoB; and one of three Federal

Grants Centers of Excellence. In FY 2007, 20 staff members from HHS agencies successfully passed their final examinations and received Certified Enterprise Architects designation.

Performance Improvement Initiative (PII): The Performance Improvement Initiative (formerly Budget and Performance Integration) aims to improve program performance and efficiency by ensuring performance information informs funding and management decisions. A summary of HHS program performance is provided in *Performance Highlights*, available at www.hhs.gov/budget/09budget/2009PerformanceHighlights.pdf.

One key to managing effectively is having up-to-date performance data to guide strategic and day-to-day decision-making. The Department is developing an HHS-wide performance reporting system to electronically combine performance information that is currently being gathered and analyzed independently by each agency.

An important component of PII is the Program Assessment Rating Tool (PART). Each program assessed by PART receives a rating of Effective, Moderately Effective, Adequate, Ineffective, or Results Not Demonstrated.

All significant HHS programs, representing 99 percent of HHS's budget, have been assessed through the PART process. In recent years, HHS has greatly reduced the number of programs for which results cannot be demonstrated. In FY 2007, HHS had only 2.4 percent of its programs (measured in budget dollars) for which results could not be demonstrated, compared with 12.4 percent in FY 2005. A list of HHS PART programs is provided as an appendix to the *Performance Highlights*. Detailed information on PART assessments can be found at www.expectmore.gov.

Faith-Based and Community Initiative: HHS has achieved a "Green" status and "Green" progress for four of the last five quarters for the Faith-Based and Community Initiative. HHS's goals for this initiative include implementing a comprehensive outreach and technical assistance strategy; working with State and local officials to expand access to funding; monitoring compliance with the Equal Treatment Regulations; collecting data on participation of faith-based and community organizations (FBCOs) in Federal grant programs; and implementing and evaluating pilot programs to strengthen the partnership between FBCOs and the Federal Government.

Health Information Initiative: The Health Information Initiative promotes Federal efforts to implement health IT systems and products that meet recognized interoperability standards and increase the transparency of health care costs and quality. HHS achieved a "Green" progress rating for the Health Information Initiative in the fourth quarter of FY 2007. This rating recognizes several HHS accomplishments, such as developing recommendations for Federal agency health IT capital investment activities; finalizing a plan on how HHS will achieve a "Green" status rating; and providing draft contracting language requiring that, as health IT systems are acquired, implemented, or upgraded, standards recognized by the Secretary of HHS be implemented.

Real Property Asset Management: HHS reached "Yellow" status for Real Property Asset Management in the first quarter of 2006. HHS was downgraded to a "Yellow" progress rating in the second quarter 2007 and was upgraded to "Green" in the fourth quarter 2007 through the assistance of a PMA Tiger Team to refocus the Department's effort to improve asset management and right size the portfolio. This rating recognizes several HHS accomplishments, including outlining roles and responsibilities for Departmental real property asset management, identifying critical goals and milestones, and developing specific corrective actions to achieve FY 2008 performance targets. Critical next steps to achieve "Green" status are managing real property assets consistent with the Department's Strategic Plan, Asset Management Plan, and Federal Real Property Council performance measures, and demonstrating that inventory and performance data are used in daily decision-making.

	2007	2008	2009	2009 +/- 2008
Food & Drug Administration:				
Program Level	2,008	2,270	2,400	+130
Budget Authority	1,574	1,720	1,771	+51
Outlays	1,563	1,394	1,728	+334
Health Resources & Services Administration:				
Budget Authority	6,487	6,990	6,023	-967
Outlays	6,611	6,460	6,597	+137
Indian Health Service:				
Budget Authority	3,330	3,497	3,475	-22
Outlays	3,265	3,670	3,634	-36
Centers for Disease Control & Prevention:				
Budget Authority	6,082	6,179	5,746	-433
Outlays	5,586	6,567	6,105	-462
National Institutes of Health:				
Budget Authority	29,128	29,457	29,457	-
Outlays	28,115	28,733	29,354	+621
Substance Abuse & Mental Health Services:				
Budget Authority	3,206	3,234	3,025	-209
Outlays	3,179	3,263	3,146	-117
Agency for Healthcare Research & Quality:				
Program Level	319	335	326	-9
Budget Authority	-	-	-	-
Outlays	136	-88	-	+88
Centers for Medicare & Medicaid Services:				
Budget Authority	557,907	615,535	633,751	+18,216
Outlays	571,560	606,929	636,179	+29,250
Administration for Children & Families:				
Budget Authority	47,242	47,345	45,549	-1,796
Outlays	47,228	47,655	46,464	-1,191
Administration on Aging:				
Budget Authority	1,383	1,413	1,381	-32
Outlays	1,359	1,389	1,389	-
Office of the National Coordinator:				
Budget Authority	42	42	18	-24
Outlays	43	29	31	+2
Medicare Hearings and Appeals:				
Budget Authority	60	64	65	+1
Outlays	54	64	65	+1
Office for Civil Rights				
Budget Authority	35	34	40	+6
Outlays	31	35	39	+4
Departmental Management:				
Budget Authority	365	354	380	+26
Outlays	391	303	361	+58
Public Health Social Service Emergency Fund:				
Budget Authority	709	729	1,396	+667
Outlays	2,047	2,155	2,368	+213

	2007	2008	2009	2009 +/- 2008
Office of Inspector General:				
Budget Authority	68	68	71	+3
Outlays	112	41	79	+38
Program Support Center (Retirement Pay, Medical Benefits, Misc. Trust Funds):				
Budget Authority	491	518	554	+36
Outlays	516	513	549	+36
Offsetting Collections:				
Budget Authority	-1,383	-1,389	-1,295	+94
Outlays	-1,383	-1,389	-1,295	+94
Total, Health & Human Services:				
Budget Authority	**656,726**	**715,790**	**731,407**	**+15,617**
Outlays	**670,413**	**707,723**	**736,793**	**+29,070**
Full-Time Equivalents	63,748	64,750	65,630	+880

	2007	2008	2009	2009 +/- 2008
Discretionary Programs (Budget Authority)				
Food & Drug Administration	1,574	1,720	1,771	+51
FDA Program Level	*2,008*	*2,270*	*2,400*	*+130*
Health Resources & Services Administration	6,398	6,864	5,872	-992
HRSA Program Level	*6,446*	*6,916*	*5,921*	*-995*
Indian Health Service	3,180	3,346	3,325	-21
IHS Program Level	*4,103*	*4,282*	*4,261*	*-21*
Centers for Disease Control & Prevention	6,060	6,124	5,691	-433
CDC Program Level	*9,116*	*9,209*	*8,797*	*-412*
National Institutes of Health	28,978	29,307	29,307	--
NIH Program Level	*29,137*	*29,465*	*29,465*	--
Substance Abuse & Mental Health Services	3,206	3,234	3,025	-209
SAMHSA Program Level	*3,327*	*3,356*	*3,158*	*-198*
Agency for Healthcare Research & Quality	--	--	--	--
AHRQ Program Level	*319*	*335*	*326*	*-9*
Centers for Medicare & Medicaid Services	3,141	3,152	3,272	+121
CMS Program Level (Excluding HCFAC)	*3,470*	*3,408*	*3,485*	*+78*
Administration for Children & Families Services	13,839	14,322	13,247	-1,075
ACF Program Level	*13,899*	*14,382*	*13,307*	*-1,076*
Administration on Aging	1,383	1,413	1,381	-32
AoA Program Level	*1,386*	*1,417*	*1,385*	*-32*
Departmental Management	365	354	380	+26
OS Program Level	*410*	*406*	*432*	*+26*
Office for Civil Rights	35	34	40	+6
Office of the National Coordinator	42	42	18	-24
ONC Program Level	*62*	*61*	*66*	*+6*
Medicare Hearings and Appeals	60	64	65	+1
Office of Inspector General	40	43	46	+3
OIG Program Level	*243*	*248*	*275*	*+27*
Health Care Fraud and Abuse Control (Discretionary)	--	--	198	+198
HHS HCFAC Program Level	*942*	*958*	*1,155*	*+197*
Public Health & Social Services Emergency Fund	709	729	1,396	+667
PHSSEF Program Level	*711*	*732*	*1,398*	*+667*
Medicare Eligible Healthcare Accruals (Com. Corps)	36	37	35	-2
DOJ HCFAC Charged To HHS (Program Level Only)	--	--	*19*	*+19*
Physicians Quality Incentive Payment Reduction	--	-151	--	+151
Social Services Block Grant Reduction	--	--	-500	-500
HRSA Loan Fund Balance Rescission	--	-15	-105	-90
CDC Rescissions (Unobligated Balances)	-30	--	--	--
Offset for PHS Evaluation Funds (Prog. Level)	*-810*	*-894*	*-882*	*+12*
HCFAC Funds Included in Agencies Prog. Level	*-175*	*-179*	*-203*	*-24*
Total, Discretionary Budget Authority	**69,016**	**70,621**	**68,464**	**-2,156**
Subtotal, Discretionary Program Level	***74,695***	***76,341***	***74,300***	***-2,040***
Discretionary Outlays	**69,022**	**70,858**	**70,859**	**+1**

COMPOSITION OF THE HHS BUDGET

	2007	2008	2009	2009 +/- 2008
Mandatory Programs (Outlays):				
Medicare	370,790	391,366	407,905	+16,539
Medicaid	190,624	203,788	215,662	+11,874
Temporary Assistance for Needy Families	16,932	17,261	17,356	+95
Foster Care & Adoption Assistance	6,563	6,670	6,886	+216
State Children's Health Insurance Program	6,000	7,600	8,202	+602
Child Support Enforcement	4,238	4,277	3,960	-317
Child Care	2,994	2,978	2,966	-12
Social Services Block Grant**	1,956	1,936	1,727	-209
Other Mandatory Programs	2,677	2,378	2,565	+187
Offsetting Collections	-1,383	-1,389	-1,295	+94
Subtotal, Mandatory Outlays	601,391	636,865	665,934	+29,069
Total, HHS Outlays	**670,413**	**707,723**	**736,793**	**+29,070**

**FY 2009 outlays reflect the mandatory component of SSBG. With proposed discretionary reductions, outlays would be $1,302.

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Program				
Foods	457	510	543	+33
Human Drugs	565	680	739	+58
Biologics	209	236	245	+10
Animal Drugs and Feeds	104	109	119	+11
Medical Devices	273	284	291	+7
National Center for Toxicological Research	42	44	46	+2
Headquarters and Office of the Commissioner	122	133	139	+6
FDA Consolidation at White Oak	26	39	41	+3
GSA Rental Payments	146	159	156	-3
Other Rent and Rent Related Activities	50	61	68	+7
Export/Color Certification Fund	8	10	10	+1
Subtotal, Salaries and Expenses	2,003	2,264	2,397	+133
Buildings and Facilities	5	2	2	--
National Center for Natural Products Research	--	4	--	-4
Total, Program Level /1	**2,008**	**2,270**	**2,400**	**+130**
Less User Fees:				
Current Law				
Prescription Drug (PDUFA)	-352	-459	-511	-52
Medical Device (MDUFMA)	-44	-48	-53	-4
Animal Drug (ADUFA)	-12	-14	-14	--
Mammography Quality Standards Act (MQSA)	-18	-18	-19	-1
Export/Color Certification Fund	-8	-10	-10	+1
Subtotal, Current Law User Fees	-434	-549	-607	-58
Proposed Law				
Human Generic Drug	--	--	-17	-17
Animal Generic Drug	--	--	-5	-5
Subtotal, Proposed Law User Fees	--	--	-21	-21
Total, User Fees	**-434**	**-549**	**-628**	**-79**
Mandatory Proposed Law				
Reinspection	--	--	-23	-23
Export Certification Fund (Foods and Feeds)	--	--	-4	-4
Subtotal, Mandatory Proposed User Fees	--	--	-27	-27
Mandatory BA (Scorekeeping Adjustment)	--	--	*-27*	*-27*
Total, Budget Authority	**1,574**	**1,720**	**1,771**	**+51**
Biodefense (non-add):				
Food Defense	172	171	213	+43
Vaccines/Drugs/Diagnostics	57	56	67	+10
Physical Security	7	7	7	+0.1
Subtotal, Biodefense (non-add)	235	234	287	+53
FTE	9,663	10,070	10,596	+526

1/ FY 2007 and FY 2008 program levels reflected in the Budget Appendix differ due to the timing and availability of user fee collections.

FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration protects the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our Nation's food supply, cosmetics, and products that emit radiation. The FDA also advances the public health by helping to speed innovations that make medicines and foods more effective, safer, and more affordable; and helping the public get the accurate, science-based information they need to use medicines and foods to improve health.

The FY 2009 Budget requests $2.4 billion for the Food and Drug Administration (FDA), a net program level increase of $130 million over FY 2008. The FDA budget includes increased investments to improve the safety of the Nation's food supply and drugs, and increase the safety and accelerate the availability of new and innovative medical products.

PROTECTING THE NATION'S FOOD SUPPLY

American consumers have one of the safest food supplies in the world. New food sources, advances in production and distribution methods, and the growing volume of imports call for a new approach to protecting our food from unintentional or deliberate contamination to maintain the safety of the food supply and protect the public's health.

During 2007, nationwide recalls of domestic and imported food products served as reminders of how dangerous foodborne illness can be. FDA, along with CDC, and State and local health agencies, has continued to act decisively to identify, contain, and prevent outbreaks. For example, contaminated peanut butter led to more than 300 illnesses and at least 50 hospitalizations.

FDA is taking aggressive action to ensure that the American food supply remains safe. In November 2007, the Interagency Working Group on Import Safety, Chaired by Secretary Leavitt, presented the President an *Action Plan for Import Safety* and FDA released its *Food Protection Plan*. The request builds on these strategies and includes $662 million for food protection activities, an increase of $42 million over FY 2008. The *Food Protection Plan* places emphasis on preventing most harm before it can occur, enhancing FDA's intervention methods at key points in the food production system, and strengthening the Agency's ability to respond immediately when problems are identified.

The FY 2009 Budget request provides FDA with increased resources to implement the three core elements of the Food Protection Plan:

- *Prevention:* provide scientific and analytical tools and guidance to industry to better identify and understand risks and the effectiveness of control measures.
- *Intervention:* improve FDA's ability to target and conduct inspection and surveillance, perform laboratory analysis, and be ready to intervene at any time there is a problem.
- *Response:* strengthen Federal response systems and further integrate them with State, local, Federal, and international agencies.

Consistent with the FY 2007 and FY 2008 President's Budgets and the *Food Protection Plan*, the FY 2009 Budget request includes the proposal for two user fees, the Reinspection User Fee and the Export Certification User Fee for food and animal feeds. The first proposal is a $23 million user fee program that requires manufacturers to pay the full costs of reinspections and associated follow-up work due to their failure to meet FDA requirements during an inspection. This proposal rewards firms for complying with health and safety standards while ensuring that companies are charged the costs of reinspection when they fail to meet FDA safety and quality regulations.

Improving Import Safety

In 2007, U.S. consumers purchased approximately $2 trillion worth of imported products from 825,000 importers through over 300 ports-of-entry. Consistent with the Action Plan for Import Safety, FDA and its partners in the Federal Government are shifting the focus from trying to catch unsafe products as they enter the United States to building quality and safety into products before they reach our borders.

This new approach is reflected in two Memoranda of Agreement on food and feed and drugs and medical devices signed by HHS and the Chinese government counterparts on December 11, 2007. These agreements require specific steps and set clear deadlines aimed at protecting the public health and providing safe products to U.S. consumers.

The request also includes a proposal to expand the current drug, animal drug, and medical device export certification user fee program to also include food and animal feed. Export certificates issued by FDA enhance the global competitiveness of American food and animal feed producers by ensuring that U.S. food and animal feed exports meet regulatory requirements. With this expansion, the food and animal feed industry will join other FDA regulated industries in reimbursing the cost of export certificates.

SUPPORTING INNOVATIVE, SAFE, AND AFFORDABLE DRUGS AND BIOLOGICS

In FY 2009, the Budget includes $984 million for the Human Drugs and Biologics programs, an increase of $68 million over FY 2008, including user fees. These funds will improve the review of new drugs and biologics, and ensure the safety and efficacy of drugs along the product life cycle – helping to make medicines safer, more affordable, and more readily available. The FY 2009 Budget includes $14 million in user fees for the review of direct-to-consumer television advertisements. The Administration is committed to working with Congress to expand these efforts through user fees.

Generic Drug Review: Increasing access to safe and affordable generic drugs is a priority at FDA. The Office of Generic Drugs continues to make significant progress in expediting review, allowing FDA to approve more generic drugs each year. The FY 2009 Budget includes a total of $78.2 million for generic drug review activities. This funding level is $16.6 million over FY 2008. Consistent with the FY 2008 Budget, the Budget includes the proposal for an industry-funded generic drug user fee, which will generate $16 million in FY 2009 to speed approval of lower cost generic drugs. Speeding the approval of generic drugs will positively impact the entire health care system by adding these lower cost alternatives to the marketplace.

Drug Safety: Building on the strong record of safe and reliable drugs that has made FDA the gold standard of regulatory agencies worldwide, the FY 2009 Budget proposes to commit a total program funding level of $389.5 million, $36.1 million over FY 2008, for drug safety activities.

Biologics: To address the regulatory challenges of ensuring the safety and efficacy of products including blood and blood products, human tissue, cell and gene therapies, vaccines, and allergenic products, the FY 2009 Budget includes $245 million, $9 million over FY 2008. Of the total funding for these activities, $87 million will be from industry specific user fees. The Budget proposes a new authority for FDA to approve follow-on proteins through a new regulatory pathway that protects patient safety, promotes innovation, and includes a financing structure to cover the costs of this activity through user fees.

ADVANCING MEDICAL DEVICE SAFETY AND DEVELOPMENT

The FY 2009 Budget requests a total of $291 million in budget authority to improve the review and ensure the safety of medical devices, an increase of $7 million over FY 2008. Of the total funding for these activities, $49 million will be from industry-specific user fees, consistent with the intent of the Food and Drug Administration Amendments Act of 2007 reauthorization of the Medical Device User Fee and Modernization Act (MDUFMA). These funds will allow for the continued improvement in application review time while maintaining the consistent quality and safety of approved medical device products.

New and increasingly complex medical devices are making astonishing medical advances possible, in both diagnosis and treatment. MDUFMA fees support the evaluation of post-market studies required as a condition of medical device approval and the systems and analysis needed to identify any safety and effectiveness concerns in medical devices. This activity will reduce medical errors, improve adverse event reporting and facilitate device recall through the Center for Devices and Radiological Health information technology applications to improve post-market tracking of medical devices.

IMPROVING ANIMAL DRUG REVIEWS

Enacted in 2003, the Animal Drug User Fee Act (ADUFA) helped FDA strengthen animal drug pre-market reviews to provide greater public health protection. ADUFA fees ensure that animal drug products subject to FDA approval are safe, effective, and readily available. The ability to collect ADUFA user fees expires on September 30, 2008. The Budget proposes to reauthorize this program for five years.

The Budget proposes a new user fee program, the Animal Generic Drug User Fee Act (AGDUFA). These user fee funds will allow FDA to improve the review process and reduce the backlog of applications for generic animal drugs. The proposal includes $5 million for FY 2009.

Performance Highlight

FDA works to protect the American public against the efforts of terrorist agents and natural disasters by facilitating the development of and access to medical countermeasures. FDA provides its expertise as part of the HHS Public Health Emergency Medical Countermeasures Enterprise, and presents industry with clear and comprehensive guidelines for HHS expectations regarding the development, approval, and utilization policies for medical countermeasures. FDA has set a goal of supporting the development of five new medical countermeasures in FY 2009 in collaboration with its other partners in HHS.

SUPPORTING FDA FACILITIES

The FY 2009 Budget requests $39 million in budget authority for headquarters consolidation at the new FDA campus in White Oak, Maryland. These resources allow FDA to transition to the new consolidated facility under construction by the General Services Administration (GSA). The White Oak Campus will enable FDA to replace existing fragmented facilities with state-of-the-art laboratories and program support facilities. This funding is necessary to equip and outfit the newly constructed GSA buildings, and pay environmental and relocation costs. The Budget request also includes $224 million for GSA rental payments and other rent and rent-related costs in FY 2009.

MANAGEMENT SAVINGS

The FY 2009 Budget includes $9 million in agency-wide administrative savings and management efficiencies. These savings will be realized in areas that have achieved economies related to improved business processes and efficiencies driven by technology improvements.

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Primary Care				
Health Centers:				
Health Centers	1,943	2,022	2,048	+26
High Poverty Areas (non add)	--	--	*26*	*+26*
Health Centers Tort Claims	45	43	44	+0.8
Subtotal, Health Centers	1,988	2,065	2,092	+27
Free Clinics Medical Malpractice	.04	.04	.04	--
Hansen's Disease Center	16	16	16	+0.4
Payment to Hawaii	2	2	2	--
Buildings and Facilities	.2	.2	.1	-0.1
Subtotal, Primary Care	2,006	2,083	2,110	+27
Clinician Recruitment and Service				
National Health Service Corps:				
National Health Service Corps Field	40	40	26	-14
National Health Service Corps Recruitment	85	84	95	+11
Dentist Recruitment (non add)	--	--	*11*	*+11*
Subtotal, National Health Service Corps	126	123	121	-3
Nurse Loan Repayment & Scholarship Program	31	31	44	+13
Loan Repayment / Faculty Fellowships	1	1	--	-1
Subtotal, Clinician Recruitment and Service	158	155	165	+9
Health Professions				
Health Professions Training for Diversity:				
Centers of Excellence	12	13	--	-13
Scholarships for Disadvantaged Students	47	46	--	-46
Health Careers Opportunity Program	4	10	--	-10
Subtotal, Training for Diversity	62	68	--	-68
Training in Primary Care Medicine and Dentistry	49	48	--	-48
Interdisciplinary, Community-Based Linkages:				
Area Health Education Centers	29	28	--	-28
Geriatric Programs	32	31	--	-31
Allied Health and Other Disciplines	4	9	--	-9
Subtotal, Interdisciplinary, Community-Based Linkages	64	68	--	-68
Public Health Workforce Development:				
Public Health/Preventive Medicine; Dental PH Programs	8	8	--	-8
Subtotal, Public Health Workforce Development	8	8	--	-8
Nursing Workforce Development:				
Advance Nursing Education	57	62	--	-62
Nursing Workforce Diversity	16	16	16	+0.3
Nurse Education, Practice and Retention	37	37	37	+1
Nurse Faculty Loan Program	5	8	9	+1
Comprehensive Geriatric Education	3	3	3	+0.1
Subtotal, Nursing Workforce Development	119	126	66	-59
Patient Navigator	--	3	--	-3
Children's Hospital Graduate Medical Education Program	297	302	--	-302
Subtotal, Health Professions	599	623	66	-557
Maternal & Child Health				
Maternal and Child Health Block Grant	693	666	666	--
Autism and Other Developmental Disorders	--	36	36	--
Traumatic Brain Injury	9	9	--	-9
Sickle Cell Service Demonstrations	2	3	2	-0.5
Universal Newborn Hearing Screening	10	12	--	-12
Emergency Medical Services for Children	20	19	--	-19
Healthy Start	102	100	100	--
Family-to-Family Health Information Centers (mandatory)	3	4	5	+1
Subtotal, Maternal and Child Health	838	849	809	-39

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
HIV/AIDS				
Emergency Relief - Part A	604	627	619	-8
Comprehensive Care - Part B	1,196	1,195	1,209	+14
AIDS Drug Assistance Program (non add)	*790*	*808.5*	*815*	+6
Early Intervention - Part C	194	199	199	--
Children, Youth, Women, & Families - Part D	72	74	74	--
Education and Training Centers - Part F	35	34	29	-5
Dental Services - Part F	13	13	13	--
Subtotal, HIV/AIDS	2,113	2,142	2,143	+1
SPNS Evaluation Funding	25	25	25	--
Subtotal, HIV/AIDS	2,138	2,167	2,168	+1
Health Care Systems				
Organ Transplantation	23	23	23	+0.4
Cord Blood Inventory Program	4	9	12	+3
C.W. Bill Young Cell Transplantation Program	25	24	23	-1
Poison Control Centers	23	27	10	-17
Subtotal, Health Care Systems	75	82	68	-14
Rural Health				
Rural Health Policy Development	9	9	9	+0.2
Rural Health Outreach Grants	39	48	--	-48
Rural & Community Access to Emergency Devices	1	1	--	-1
Rural Hospital Flexibility Grants	39	38	--	-38
State Offices of Rural Health	8	8	8	+0.1
Delta Health Initiative	25	25	--	-25
Denali Project	39	39	--	-39
Radiogenic Diseases	2	2	2	--
Black Lung Clinics	6	6	6	+0.1
Subtotal, Rural Health	168	175	25	-150
Public Health Improvement (Facilities and Other Projects)	--	304	--	-304
Parklawn Lease Replacement	--	--	36	+36
Telehealth	7	7	7	+0.1
Family Planning	283	300	300	--
Program Management	146	141	141	--
Vaccine Injury Compensation Program	4	5	5	-0.9
HEAL Direct Operations	3	3	3	+0.1
National Practitioner Data Bank (User Fees)	16	19	19	+0.3
Healthcare Integrity and Protection Data Bank (User Fees)	4	4	--	-4
Total, Program Level	**6,446**	**6,916**	**5,921**	**-995**
Less Funds From Other Sources				
User Fees	-20	-22	-19	+3
PHS Evaluation Funds (HIV/AIDS)	-25	-25	-25	--
Family-to-Family Health Information Centers (mandatory)	-3	-4	-5	-1
Total, Budget Authority	**6,398**	**6,864**	**5,872**	**-992**
FTE	1,770	1,540	1,516	-24

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration provides national leadership, program resources, and services needed to improve access to culturally competent, quality health care.

The FY 2009 Budget requests $5.9 billion for the Health Resources and Services Administration (HRSA), a net decrease of $992 million from FY 2008. Consistent with the FY 2008 request, the Budget places an emphasis on direct medical care, including an expansion of the Health Centers program. In FY 2009, HRSA will:

- Assist States and communities to identify and address unmet service needs and workforce gaps in the health care system;
- Develop integrated service systems to help assure access to essential health care;
- Assure that these systems take into account cultural and linguistic factors, geographic location, and economic circumstances;
- Promote continuous quality improvement in health services delivery and care; and
- Target reductions to programs which are duplicative of other activities or have failed to demonstrate results, including Health Professions and Rural Health.

PROTECTING UNDERSERVED AND AT-RISK POPULATIONS

Health Centers: The FY 2009 Budget includes $2.1 billion for Health Centers, an increase of $27 million over FY 2008. The Budget will continue support for the over 1,000 grantees that provide primary health care services to an estimated 17.1 million low-income patients around the Nation. In FY 2008, the Health Center Program surpassed the President's goal of expanding or creating 1,200 new Health Center sites throughout the Nation. In FY 2009, the President's goal of expanding Health Centers in high poverty areas, which builds on the success of the Health Center Initiative, will fund up to 40 new access point grants and 25 planning grants for applicants demonstrating that they will serve areas with high levels of poverty and no access to an existing Health Center site.

In FY 2009, Health Centers will continue to serve an increasing number of the Nation's underserved:

- 40 percent of all Health Center patients are uninsured;
- 64 percent of Health Center patients are from racial and ethnic minority groups; and
- Over 92 percent of Health Center patients are at or below 200 percent of the Federal poverty level.

The Budget continues to support the Health Center Program's efforts to improve the quality of care and health outcomes among its service population, including improving birth outcomes and controlling chronic diseases like hypertension and diabetes.

As part of an effort to best target those communities with the highest needs, HRSA will amend existing regulations governing the designation of health professional shortage areas and medically underserved populations.

National Health Service Corps: The FY 2009 request includes $121 million for the recruitment and retention of clinicians to the National Health Service Corps (NHSC). Approximately 50 million Americans live in underserved communities, lacking adequate access to primary care

Dental Health

National health surveys and the U.S. Surgeon General's Report on Oral Health in America have identified dental care as the number one unmet health care need in children and special needs populations, as well as one of the top five unmet health care needs for all age groups. The FY 2009 Budget provides $11 million for targeted activities to recruit and retain dentists for service in critical areas. These funds will support 214 loan repayment contracts and scholarships, which will immediately improve access to comprehensive dental services for those most in need, while also helping to increase the number of dentists in future years. In addition to efforts made in recruiting and retaining dentists through the NHSC, HRSA continues to support oral health through a number of programs, including the Ryan White Dental Reimbursement Programs, which support access to oral health care for individuals with HIV infection, and the Health Center program, which provides access to preventive dental care in 83 percent of its facilities.

services. The NHSC places primary care clinicians, including dental, behavioral, and mental health professionals, in communities of greatest need. In FY 2009, the NHSC will support a field strength of more than 3,400 clinicians, with over half of NHSC clinicians assigned to service in community health centers. The Budget provides $11 million for targeted activities to recruit and retain dentists for service in these critical areas.

Ryan White, HIV/AIDS: The FY 2009 request includes $2.2 billion for Ryan White activities and supports a comprehensive approach to address the health needs of persons living with HIV/AIDS, including medical treatment, life saving medications, and access to care. The Ryan White Program addresses the unmet health needs of persons living with HIV by funding primary health care and support services that enhance access to and retention in care. The program reaches over 500,000 individuals each year, making it the Federal Government's largest program specifically for people living with HIV/AIDS.

Expanding the Nurse Workforce: The Budget requests $110 million for nursing education programs to help ensure an adequate supply of nurses in the future. These resources will support loan repayment programs for qualified faculty in schools of nursing and student enrollment in undergraduate and graduate nursing programs. Within the total, the request includes $44 million, an increase of $13 million over FY 2008, to support over 800 scholarships and loan repayment awards for nurses and nursing students who commit to work in facilities with a critical shortage of nurses.

Performance Highlight

A cornerstone of HIV/AIDS treatment and care is access and adherence to comprehensive antiretroviral medications. In FY 2009, $815 million, an increase of $6 million, is requested for the Ryan White AIDS Drug Assistance Program which provides these medications for low-income and underinsured individuals. In FY 2009, approximately 158,900 individuals are estimated to receive medications through the program.

SUPPORTING HEALTHY FAMILIES

Maternal and Child Health Block Grant: The FY 2009 Budget provides $666 million for the Maternal Child Health (MCH) Block Grant. The MCH Block Grant provides funding to States for improving the health of all mothers and their families and reaches across economic lines in serving more than 2.5 million women and 27.5 million children, including 1.4 million children with special health care needs. Partnering with States, the MCH Block Grant provides funding for:

- Public education, outreach, and education;
- Evaluations and quality assurance activities;
- Support for newborn screenings and genetic services; and
- Health care services, such as nutrition counseling.

The activities authorized under Traumatic Brain Injury, Universal Newborn Hearing Screening, and Emergency Medical Services for Children may be supported through the MCH Block Grant, which allows grantees the flexibility to target funds based on community needs. Consistent with the FY 2007 and FY 2008 Budgets, no funding is requested in the FY 2009 Budget for these activities.

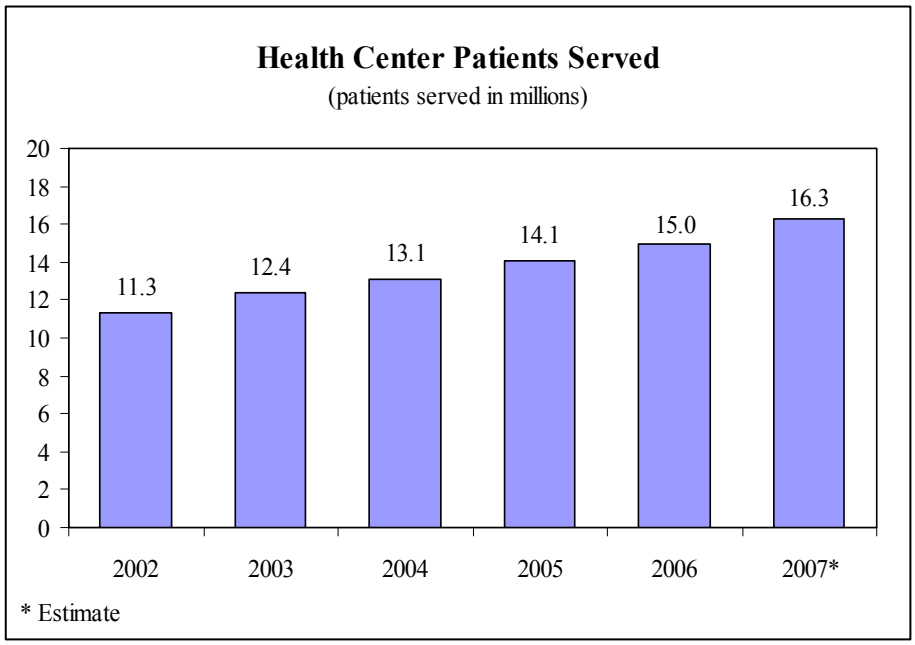
Autism and Other Developmental Disorders: The Budget includes $36 million to continue the new effort to target Autism and Other Related Developmental Disorders. This request supports the HRSA Leadership Education in Neurodevelopmental and Related Disabilities (LEND) and the Developmental Behavioral Pediatric (DBP) training programs and Combating Autism grants. The LEND and DBP programs provide interdisciplinary training to enhance the clinical expertise and leadership skills of professionals dedicated to caring for children with disabilities, including autism. The Combating Autism grants will reduce barriers to early screening and diagnosis by:

- Providing information, education, and coordination;
- Promoting research into evidence-based practice for interventions and for the development of reliable screening tools and intervention guidelines;
- Promoting early screening and intervention; and
- Training providers to diagnose and treat individuals with autism spectrum disorder and other developmental disorders.

Healthy Start: The Budget includes $100 million for Healthy Start. Healthy Start provides intensive services tailored to the needs of high risk pregnant women, infants, and mothers in

geographically, racially, ethnically, and linguistically diverse communities with high rates of infant mortality. The Healthy Start program works with communities in 38 States, the District of Columbia, and Puerto Rico to reduce the incidence of risk factors that contribute to infant mortality.

Family Planning: The FY 2009 request includes a total of $300 million for family planning services to a network of more than 4,400 clinics nationwide serving approximately 5 million individuals each year, 90 percent of whom are from low-income families. Additionally, over 900,000 unintended pregnancies, nearly 800 cases of invasive cervical cancer, and over 1,500 cases of infertility are estimated to be averted as a result of these investments. Counseling and education regarding abstinence are required for all adolescent clients in this program.



SUPPORTING TRANSPLANTATION

The FY 2009 Budget continues support for activities in organ, bone marrow, and cord blood stem cell transplantation through a combined investment of $58 million.

Organ Transplantation: The Budget includes $23 million to support the Organ Transplantation program. Through a national system, the program efficiently and effectively allocates and distributes donor organs to individuals waiting for an organ transplant and supports efforts to increase the supply of donor organs. In FY 2007, over 24,000 organs were transplanted from deceased donors.

Bill Young Cell Transplantation: The Budget also includes $23 million to support the C.W. "Bill" Young Cell Transplantation Program (successor to the National Bone Marrow Donor Registry), which provides support to patients who need a potentially life-saving marrow or cord blood transplant. For some patients who have leukemia, lymphoma, sickle cell anemia, or other inherited metabolic or immune system disorders, a marrow or cord blood transplant offers the hope of living a longer, healthier life.

National Cord Blood Inventory: The National Cord Blood Inventory program provides funds to a network of cord blood banks to build a racially diverse inventory of the highest quality cord blood units for transplantation and makes these and other units at participating cord blood banks available to physicians and patients for blood stem cell transplants. The FY 2009 request of $12 million, an increase of $3 million over FY 2008, supports the collection of approximately 8,650 new cord blood units. In total, approximately 37,280 units will be collected for the National Cord Blood Inventory with funds appropriated for FY 2004 - FY 2009. These units will be available to patients and their physicians through the C.W. "Bill" Young Cell Transplantation program.

TARGETING FUNDS TO DIRECT HEALTH SERVICES

The FY 2009 Budget supports more targeted efforts to provide direct health services for underserved populations through the elimination or reduction of programs which are duplicative of other activities or have failed to demonstrate results. In FY 2009, HRSA will focus on activities that are effective in placing health professionals in medically underserved areas, including the Nurse Loan Repayment and Scholarship Program and the National Health Service Corps.

A Program Assessment Rating Tool (PART) review found that Health Professions programs have not demonstrated an impact on placing health professionals in underserved areas. Similarly, the Children's Hospital Graduate Medical Education Program has not demonstrated its effectiveness in increasing the number of children's health care providers. The Budget proposes eliminating several Health Professions activities, the Children's Hospital Graduate Medical Education Program, and the Patient Navigator Outreach and Chronic Disease Prevention

Program for a total reduction of $557 million.

The Budget also reduces funding for HRSA rural programs by $87 million from FY 2008. A PART assessment found that these programs are similar to other HHS programs that provide resources to rural areas. For example, Medicare's Rural Hospital Flexibility program supports conversion of rural hospitals to Critical Access Hospitals. Most of these conversions have already taken place.

The funding level also includes the elimination of $368 million in Congressional projects included in FY 2008.

OTHER ACTIVITIES AND PROGRAM MANAGEMENT

The Budget requests $141 million for program management. These resources will enable HRSA to manage and operate a wide array of activities.

The President's Health Center Initiative

Launched in 2002, the President's Health Center Initiative has enabled Health Centers to expand and focus on quality improvements and has achieved its goal of 1,200 new or expanded sites in just six years. Through this initiative, investments in the Health Center Program have doubled — growing from just over $1 billion in FY 2000 to over $2 billion in FY 2009. The President's goal to expand Health Centers into high poverty areas has extended the benefits of health care to the hardest-to-penetrate, poorest areas of the Nation. The first grants under this new goal were announced in August 2007, which included 74 grants worth $37 million to establish new access points in low-income areas. Under the goal, Health Center sites will exist in more low-income areas than ever before, helping approximately 300,000 people in some of the poorest communities in the country gain access to primary health care.

The FY 2009 Budget includes $36 million to support HHS-wide costs for a new lease procurement process affecting 2,484 employees in the Parklawn Building and three other smaller offices in suburban Maryland. The current lease on the Parklawn Building expires on July 31, 2010. The building has become functionally obsolete, and it does not meet minimum Federal standards. HRSA is the largest single tenant in Parklawn, and funds are requested centrally in the HRSA budget to most effectively manage the project with the General Services Administration.

Finally, the request repeats the FY 2008 Budget proposal to rescind the Federal portion of grant funds that were awarded to health professions schools through the Health Professions and Nursing Student Loan program, and Health Center Construction loan guarantees. It is estimated that $105 million would be rescinded in FY 2009.

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Services				
Clinical Services:	3,056	3,213	3,256	+42
Contract Health Services (non add)	543	579	588	+9
Preventive Health	123	128	131	+4
Contract Support Costs	270	267	272	+4
Tribal Management/Self-Governance	8	8	8	+.1
Urban Health	34	35	--	-35
Indian Health Professions	31	36	22	-14
Direct Operations	64	64	63	-1
Diabetes Grants	150	150	150	--
Subtotal, Services Program Level	3,736	3,901	3,901	--
Facilities				
Health Care Facilities Construction	26	37	16	-21
Sanitation Facilities Construction	94	94	94	--
Facilities & Environmental Health Support	165	170	169	-1
Maintenance & Improvement	61	59	59	--
Medical Equipment	22	21	21	--
Subtotal, Facilities Program Level	368	381	360	-21
Total, Program Level	**4,103**	**4,282**	**4,261**	**-21**
Less Funds From Other Sources				
Health Insurance Collections	-767	-780	-780	--
Rental of Staff Quarters	-6	-6	-6	--
Diabetes Grants	-150	-150	-150	--
Total, Budget Authority	**3,180**	**3,346**	**3,325**	**-21**
FTE		15,102	15,131	+29

INDIAN HEALTH SERVICE

The Indian Health Service raises the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

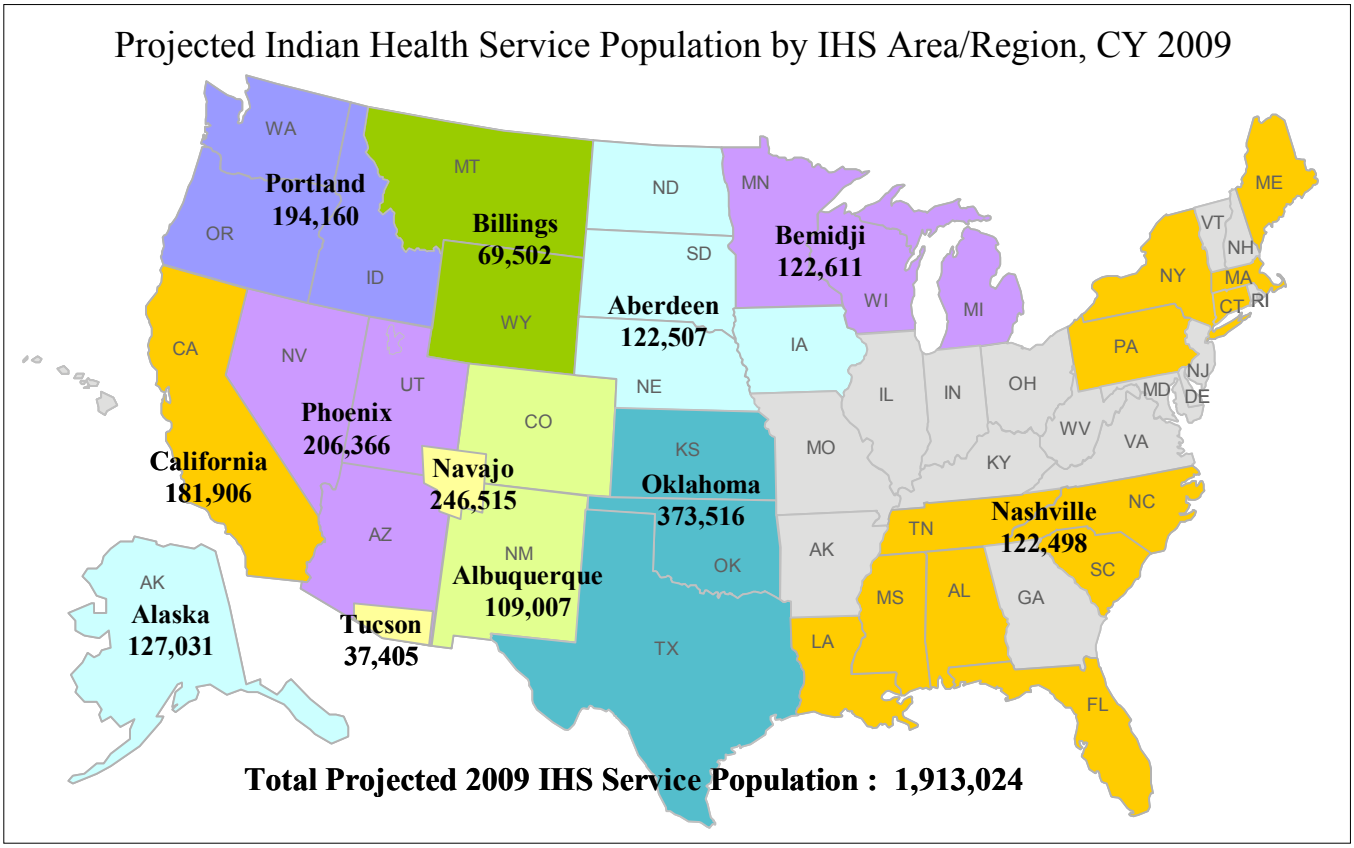
The FY 2009 Budget requests $4.3 billion for the Indian Health Service (IHS). The request prioritizes the provision of health care services, maintaining them at the FY 2008 level. The total request for IHS includes a $21 million reduction in construction costs due to the completion of project stages funded in FY 2008. IHS provides health services for the growing population of eligible American Indians and Alaska Natives to reduce health disparities through preventive health services, primary care, and the expanded use of information technology in partnership with Tribes.

FULFILLING THE UNIQUE ROLE OF THE INDIAN HEALTH SERVICE

The provision of health services to American Indians and Alaska Natives is based on a special relationship between Indian Tribes and the Federal Government. As part of this relationship, IHS is responsible for providing health care to members of more than 560 federally recognized Tribes through direct services in 46 hospitals, 324 health centers, and 309 health stations and Alaska village clinics. IHS also contracts with hospitals and health care providers outside the IHS system to purchase care it cannot provide through its own network.

IHS provides preventive health care and direct medical care. IHS activities include building sanitation systems to provide water and waste disposal for Indian homes; supporting mental health and substance abuse prevention and treatment services; and providing scholarships and loan repayment awards to recruit health professionals, including American Indians and Alaska Natives, to serve in areas with high provider vacancies.

Reducing Resource Disparities in Service Provision: The Budget includes $10 million for the Indian Health Care Improvement Fund to diminish health care disparities among Tribes that, given geographic, climatic, or other circumstances, face greater barriers to providing services. These funds will be allocated to service sites



with the greatest resource deficiencies, as measured by a methodology outlined in the Fund's authorizing legislation.

Construction: The Budget includes $16 million for Health Care Facilities Construction to continue construction of a hospital in Barrow, Alaska. Once completed, the hospital will serve a projected annual user population of 6,142 with 26,760 primary care provider visits and 40,167 outpatient visits each year. Requests for facilities funding throughout the FY 2009 HHS request focus on maintaining existing facilities and completing projects that have already been initiated.

Staffing New and Renovated Health Facilities: Construction and renovation funds for IHS health facilities have been targeted to expand services at sites experiencing overcrowding. These expansions require new staff and operating support. An additional $25 million is included in the FY 2009 Budget to support staffing and operating costs for a new outpatient facility in Phoenix, Arizona, to be completed in 2008; a hospital expansion in Lawton, Oklahoma, completed in 2007; and a future joint venture project, in which IHS will partner with a Tribal entity to provide funds for staffing, equipping, and operating a facility while participating Tribes cover the costs of design and construction. This funding will allow IHS to ensure that new and renovated facilities have the capacity to meet the increasing demand for services at their sites.

Health Insurance Reimbursements: The collection of health insurance reimbursements for the provision of care to people covered by Medicare, Medicaid, and private insurers is essential for IHS facilities to cover the costs of hiring additional medical staff, purchasing equipment, making necessary building improvements, and maintaining accreditation standards. IHS relies on these reimbursements for as much as 50 percent of their operating budgets. In FY 2009, IHS estimates it will receive approximately $780 million in health insurance reimbursements.

Access to Care for Urban Indians: American Indians and Alaska Natives living in urban areas are able to access health care services from a variety of Federal, State, and local providers, including Health Centers operated by HRSA, which are located in every urban area currently being served by an Urban Indian Health Program. As proposed in the FY 2007 and 2008 Budgets, the FY 2009 Budget targets funding for the provision of health care for Indian people living in isolated areas on or near reservations who do not have ready access to services outside the IHS system. The Budget does not include funds for the Urban Indian Health Program.

Performance Highlight

Complications from diabetes can be devastating and potentially fatal if undiagnosed. Lowering blood pressure levels in people with diabetes can reduce the risk of heart disease and stroke by as much as 50 percent, and can reduce the risk of kidney, nerve, and eye disease by 33 percent. Attaining a blood pressure level of 130/80 or lower may help prevent complications from diabetes and can prolong and improve a patient's life.

In order to reduce the risk of complication of diabetes, IHS has increased the proportion of patients with diagnosed diabetes that have achieved blood pressure control from 37 percent in 2006 to 39 percent in 2007. The IHS target for 2008 is to maintain the percentage of patients with diagnosed diabetes screened at 39 percent.

IMPROVING SERVICE DELIVERY

The FY 2009 Budget supports the continual efforts of IHS to improve the delivery of care to eligible American Indian and Alaska Natives. These efforts include health promotion and disease prevention strategies, and the provision of primary care services in IHS facilities and from outside the IHS system where necessary.

Preventive Health Services: IHS recognizes that achieving significant improvements in the health of Indian communities can best be accomplished through a balance between provision of primary care and prevention of disease. Increasingly, the health challenges facing American Indian and Alaska Native populations are related to lifestyle issues such as obesity, poor diet, substance abuse, and unintentional injuries. To promote healthy lifestyles and reduce the incidence of preventable disease, IHS utilizes effective practices at the local level such as public health nursing, community health representatives, health education, and immunizations. These programs embrace American Indian and Alaska Native cultures and serve as a link to accessing care for many Indians who live in rural and isolated communities.

The Budget request of $58 million for Public Health Nursing provides for outreach activities such as health screenings in community settings, home visits, child health screenings, pre- and post-natal care, immunizations, and chronic disease care and case management. These preventive methods reduce the

impact and cost of chronic conditions; for example, promoting breastfeeding can decrease the likelihood of childhood obesity, and case management of chronic diseases like diabetes can reduce complications and morbidity. The Budget also includes $56 million for the Community Health Representatives (CHR) program, in which medically-trained CHRs assist their communities by providing social services, health screenings, referrals for care, and patient education through local outreach and home visits.

Contract Health Services: The Budget request includes $588 million for the purchase of medical care outside the IHS direct care system, including essential services such as inpatient and outpatient care, routine and emergency care, and medical support services, such as diagnostic imaging, physical therapy, and laboratory services. These funds are used in situations where an American Indian or Alaska Native cannot access needed health care services from an IHS facility because of overcrowding or lack of capacity to provide the specialty or emergency services. The Budget also includes $25 million for high cost cases and catastrophic illnesses.

SUPPORTING INDIAN SELF-DETERMINATION

A key component of the Federal Government's relationship with Tribes is the recognition that planning and delivering health services at the local level ensures that communities receive effective, quality health care. Through the Indian Self-Determination and Education Act of 1975, Tribes have the opportunity to assume the administration of programs that were previously carried out by the Federal Government. Currently more than 54 percent of the IHS budget is administered by Tribes, including management of 93 percent of the funds for community-based health education programs, and 75 percent of funds provided for behavioral heath programs. The Budget includes $272 million for contract support costs for Tribes for establishing and maintaining support systems needed to administer self-determination agreements.

Tribal input and consultation are considered an integral part of the way IHS operates at local, area, and national levels. As part of the unique political and legal partnership between the Federal Government and Tribes, HHS and Tribal governing bodies hold an annual department-wide budget consultation in order to provide an opportunity for Tribal leaders to express their budget priorities.

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Infectious Diseases				
Immunization and Respiratory Disease	585	685	686	+2
Section 317 Discretionary Program (non-add)	*451*	*466*	*465*	*-1*
Pandemic Influenza (non-add)	*70*	*155*	*157*	*+3*
Vaccines for Children	2,736	2,702	2,766	+64
HIV/AIDS, STDs & TB Prevention	1,003	1,002	1,000	-2
Zoonotic, Vector-Borne, and Enteric Diseases	69	68	61	-7
Preparedness, Detection, and Control of Infectious Diseases	153	150	123	-27
Subtotal, Infectious Diseases	4,546	4,607	4,636	+29
Health Promotion				
Chronic Disease Prevention & Health Promotion	825	834	805	-29
Birth Defects, Disability & Health	122	127	127	-1
Subtotal, Health Promotion	947	961	932	-29
Health Information and Service				
Health Statistics	107	114	125	+11
Informatics and Health Marketing	163	163	160	-3
Subtotal, Health Information and Service	270	277	284	+8
Environmental Health and Injury				
Environmental Health	147	154	137	-18
Injury Prevention & Control	136	135	134	-1
Subtotal, Environmental Health and Injury	283	289	271	-18
Occupational Safety & Health	367	437	326	-111
Energy Employee Occupational Illness Compensation Program (non-add) 1/	*52*	*55*	*55*	*--*
World Trade Center Treatment and Screening	*50*	*108*	*25*	*-83*
Global Health	307	302	302	-0.3
Public Health Research	31	31	31	--
Public Health Improvement and Leadership	203	225	182	-43
Preventive Health and Health Services Block Grant	99	97	--	-97
Buildings & Facilities	134	55	--	-55
Business Services Support	378	372	338	-34
Bioterrorism Preparedness				
State and Local Capacity	767	746	609	-137
Upgrading CDC Capacity/Anthrax Research	135	129	139	+10
Botulinin Antitoxin Research	3	--	--	--
Biosurveillance Initiative	71	53	101	+47
Strategic National Stockpile	496	552	570	+19
Subtotal, Bioterrorism Preparedness	1,473	1,479	1,419	-60
ATSDR	75	74	73	-1
User Fees	2	2	2	--
Subtotal, Program Level	9,116	9,209	8,797	-412
Less Funds Allocated from Other Sources				
Vaccines for Children (mandatory)	-2,736	-2,702	-2,766	-64
Energy Employee Occupational Injury Compensation Program (mandatory)	-52	-55	-55	--
PHS Evaluation Transfers	-265	-326	-283	+43
User Fees	-2	-2	-2	--
Total, Discr. Budget Authority	**6,060**	**6,124**	**5,691**	**-433**
FTE	8,579	8,897	8,830	-67

1/The FY 2009 Budget proposes the transfer of administrative funding for the Energy Employee Occupational Illness Compensation Program from the Department of Labor.

CENTERS FOR DISEASE CONTROL AND PREVENTION

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

The FY 2009 request for the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) is $8.8 billion, a decrease of $412 million from FY 2008. CDC is the primary Federal agency for conducting and supporting public health protection through promotion, prevention, preparedness, and research. The FY 2009 request maintains support for the implementation of the Administration's ongoing pandemic influenza preparedness activities; provides increases for domestic HIV testing; maintains and enhances the surveys and statistical programs that are critical to public health programs at Federal, State, and local levels; increases the capacity of the Strategic National Stockpile (SNS); and expands the Nation's quarantine infrastructure to prevent the importation of infectious diseases. The FY 2009 request also includes reductions primarily focused on management and administrative activities. This includes a $31 million reduction from CDC's Individual Learning Accounts.

CDC and Food Safety

CDC has led investigations into nationwide outbreaks of severe foodborne diseases, identifying new foods not previously implicated and directing the attention of the food industry, food safety researchers, and food regulatory agencies to these new problems. The enhanced surveillance for foodborne disease developed over the last decade played a critical role. Early in 2007, 714 cases of Salmonella infection in 48 States were traced by a combined CDC and State investigative group to peanut butter produced at a single factory. As a result, all peanut butter produced at that factory since October 2004 was recalled, the factory was closed and completely rebuilt. The FDA has focused more attention on peanut butter and similar dry processed foods in general. These and other investigations illustrate the need for understanding the ecology of foodborne diseases better in order to develop more effective control measures.

ENHANCING PREPAREDNESS AT PORTS OF ENTRY

Over 150 million international airline passengers fly each year. Since 2001, CDC has increased the number of quarantine stations at international ports of entry into the United States from 8 to 20. The FY 2009 Budget includes $53 million, an increase of $33 million, to support the expansion of the quarantine system to five international stations and to fully staff existing domestic stations. This expansion will enhance CDC's ability to limit the introduction of infectious diseases into the United States. Together, the 25 stations would serve to detect disease in U.S.-bound travelers, refugees, and immigrants and allow for more robust partnership activities with Federal agencies operating at the ports of entry (e.g., Customs and Border Patrol). This expansion will improve CDC's capacity to respond to natural and intentional communicable disease outbreaks of public health significance.

PREPARING FOR PANDEMIC INFLUENZA

CDC is leading multiple preparedness efforts for a potential influenza pandemic. The FY 2009 Budget includes $157 million for pandemic influenza activities. Funding is included to continue international and domestic disease surveillance; to enhance the vaccine registry to track, distribute, and administer limited stocks of influenza vaccine in a pandemic; to develop an ongoing repository of pandemic virus reference strains; and to increase the stock of diagnostic reagents for influenza that would be needed in bulk in the event of a pandemic. CDC is leading efforts to develop a rapid diagnostic to allow doctors and other health professionals to quickly diagnose avian influenza in a clinic office or outpatient setting. A rapid diagnostic is a critical instrument that will guide health professionals in the allocation of scarce countermeasures during a pandemic. In February 2007, CDC published community mitigation guidelines, including social distancing strategies to reduce contact between people. Community strategies that do not involve vaccines or medications (non-pharmaceutical interventions) may serve as a first line of defense to help delay or mitigate the spread of influenza. This is especially important at the outset of a pandemic, when a vaccine that is well-matched to the virus causing illness is not yet likely to be available.

CDC is working with its international partners to enhance its international surveillance, diagnosis, and epidemic

investigative capabilities. CDC is working with its State and local partners to enhance domestic surveillance and to increase demand for influenza vaccine. The FY 2009 Budget display consolidates all pandemic influenza funding in the Coordinating Center for Infectious Disease.

PROTECTING THE NATION AGAINST INFECTIOUS AGENTS

The FY 2009 Budget includes a total of $1.9 billion in discretionary funding and $2.8 billion in mandatory funding for Infectious Diseases, including HIV/AIDS and immunization services for children and adults.

Immunization and Respiratory Diseases: Children can now be protected from more vaccine-preventable diseases than ever before due to advances in biotechnology. In 1985, vaccines for seven diseases were available and recommended for routine use in children in the United States. Now, vaccines for 16 diseases are available and routinely recommended for children and adolescents. CDC's $3.2 billion immunization program has two components: the mandatory Vaccines for Children (VFC) program and the discretionary Section 317 program. The VFC program provides vaccines at no cost to children 18 years of age or younger who are Medicaid eligible, uninsured, American Indians and Alaska Natives, or who receive their immunizations at Federally qualified health centers and have health insurance that does not include coverage for vaccines. Vaccines provided through the VFC program represent 40 percent of all childhood vaccines purchased in the United States.

The discretionary Section 317 program provides funds to support State immunization infrastructure and operational costs as well as many of the vaccines public health departments provide to individuals not eligible for VFC, including adults. The FY 2009 Budget maintains support for the Section 317 program at the FY 2008 level.

HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: The FY 2009 request provides $1 billion, $2 million below FY 2008, to develop, implement, and evaluate effective domestic prevention programs for HIV/AIDS, Viral Hepatitis, STD, and TB.

The FY 2009 Budget request provides $691 million for domestic HIV/AIDS prevention. Within this total, $93 million is for continuation of the domestic HIV/AIDS initiative. In FY 2007, CDC implemented the President's Domestic HIV/AIDS Initiative to increase testing in medical and community-based settings. In addition, CDC expanded its HIV testing recommendations to increase routine HIV screening; foster earlier detection; identify and counsel infected persons and link them to clinical services; and further reduce perinatal transmission of HIV in the United States. The increase in FY 2009 will support expanded testing programs in jurisdictions with the greatest rates of new infections. In addition, funding will support grants to States with specific opt-out testing laws and policies for targeted populations.

The FY 2009 President's Budget requests $152 million for STD and TB prevention programs to provide grants and technical assistance to State and local governments and organizations for prevention and control services. Funds are also included to support surveillance and research.

Zoonotic, Vector-Borne, and Enteric Diseases: The FY 2009 Budget includes $61 million to provide national and international scientific and programmatic leadership to identify, investigate, diagnose, treat, and prevent diseases that are communicable from animals, pathogens, fungi, food and water to humans (e.g., Hanta Virus, West Nile Virus, Lyme Disease). The disease incidence for West Nile Virus has declined since it reached its peak in 2003. Several years of grant funding from CDC has improved State infrastructure in tracking cases of West Nile Virus and other vector-borne diseases. Thus, the request reduces funding for West Nile Virus by $7 million and encourages States to incorporate these activities in ongoing infectious disease grants as the epidemic matures.

Prevention, Detection, and Control of Infectious Diseases: Emerging infectious diseases are unpredictable and continue to threaten our Nation's health and that of every citizen in the world. Most recently, there have been serious outbreaks of drug-resistant Staphylococcus aureus in healthcare settings, schools, and communities. CDC works to limit the impact of infectious diseases by improving the detection of disease emergencies and outbreaks and providing epidemiological and operational response during these events. The FY 2009 Budget of $123 million will continue to support the agency's basic science program for high hazard pathogens. The decrease of $27 million below FY 2008 reflects the discontinuation of funds allocated in FY 2007 and FY 2008 for all other emerging infectious diseases including the special pathogens laboratory. Investments from pandemic influenza funding in FY 2007 allowed for enhancements to laboratory capacity, reductions in

time needed to characterize emerging infections, and improvements in response capabilities. The FY 2009 Budget continues these activities with base resources at the FY 2008 President's Budget request level.

Improving Preparedness and Response to Terrorism

The request includes $1.4 billion, a net decrease of $60 million, for CDC to conduct bioterrorism preparedness activities. The bioterrorism budget supports the Strategic National Stockpile (SNS), critical surveillance, and State and local preparedness efforts.

Strategic National Stockpile:
The request focuses on ensuring a sufficient supply of countermeasures and other medical supplies to protect and care for victims of a bioterrorism attack or other public health emergency. The Budget includes $570 million for the SNS, an increase of $19 million, to finance the procurement of critical pharmaceuticals and vaccines needed to protect Americans from threat agents and support the capacity to deliver drugs, vaccines, and supplies anywhere in the Nation within 12 hours. Increased funds will help support the replacement of expiring product and increasing warehousing costs as the volume of the stockpile increases, and additional products are added through Project BioShield.

Biosurveillance Initiative:
The FY 2009 Budget includes $50 million, an increase of $16 million, for BioSense, CDC's human health surveillance system. The increase in funds will build on the progress made to date and help CDC implement connections with emerging Regional Health Information Organizations and Health Information Exchanges to implement case-based surveillance. The Budget also includes $7 million for continued real-time lab reporting.

Upgrading CDC Capacity:
The FY 2009 request includes $131 million, $10 million above FY 2008, for upgrading CDC capacity. This increase will be used to fund a new radiological Laboratory Response Network, which will facilitate national coordination of expertise, triage protocols, field assessment techniques, and laboratory analysis necessary to determine proper victim treatment after a radiological or nuclear event.

State and Local Preparedness:
In FY 2009, CDC will implement a shortened grant period to better align these grants with State budget cycles and other Federal grant programs. The shorter grant period in FY 2009 reduces the amount of funds needed for States to receive the same month-to-month funding as in FY 2008. In FY 2009, $609 million is requested for State and local preparedness efforts, $137 million below FY 2008, bringing the total investment to $7 billion since September 11, 2001. The request also includes $10 million for the Real-Time Disease Detection pilot program established by the Pandemic and All-Hazards Preparedness Act to maximize the availability and usefulness of real-time information to assess situational awareness capabilities.

Promoting Health and Preventing Chronic Disease

CDC's chronic disease programs include State-based disease prevention and health promotion activities focusing on the use of early detection practices, surveillance, and prevention research. Statistics show that the causes of 70 percent of birth defects and 75 percent of developmental disabilities are unknown.

CDC works to identify and address the causes of these disabilities and supports the development and evaluation of prevention and intervention strategies. Furthermore, CDC aims to prevent death and disability from chronic diseases; promote maternal, infant, and adolescent health; promote healthy personal behaviors and integrate genomics into public health research, policy, and programs. The FY 2009 Budget for Health Promotion includes $805 million for the Chronic Disease Prevention, Health Promotion, and Genomics activities as well as $127 million for Birth Defects, Developmental Disabilities, Disability and Health. It includes a reduction in categorical programs performing activities similar to other CDC programs. This funding level also includes a $10 million reduction to STEPS to a Healthier US. At the close of FY 2008, the 13 STEPS programs ending their five year

Performance Highlight

In FY 2005, the Childhood Immunization Program initiated the vaccine management business improvement project to centralize distribution of all publicly purchased vaccines. This project increases the efficiency of vaccine distribution by consolidating the number of inventory sites that store and distribute vaccines. In FY 2007, CDC reduced the number of inventory sites by 36 percent (from 396 to 253 sites), which substantially exceeded its 17 percent reduction goal. CDC aims to reduce the number of inventory sites by 50 percent (to 198 sites) in FY 2008 and by 98 percent (to 8 sites) in FY 2009. The efficiencies realized from consolidating vaccine distribution and storage sites will enhance CDC's ability to address public health emergencies, reduce vaccine waste, and reduce inventory holding costs.

cycle will not be continued. In FY 2009, these funds will be directed to a redesigned STEPS program to better disseminate lessons learned.

Using Health Information and Service for Public Health

The budget for Health Information and Service includes $284 million for Health Statistics, Health Marketing, and Public Health Informatics. The FY 2009 Budget for Health Statistics includes $125 million, $11 million above FY 2008, to obtain and use health statistics to understand health problems, recognize emerging trends, identify risk factors, and guide programs and policy. With increased resources, CDC's health statistics programs will ensure data availability on key national health indicators such as diet and nutrition, blood pressure, and mental health, and allow for enhancements to national survey systems.

Public health informatics uses information systems and information technology to prevent diseases, disability, and other public health threats. The Public Health Informatics budget request includes $71 million, the same as FY 2008, to continue efforts to define the needs for public health information systems, develop the standards that allow these systems to work together effectively, and design information systems and software that extend the capabilities of public health.

Funding for the Health Marketing activity in FY 2009 is requested at $90 million. This activity focuses on creating and delivering health information using customer-centered and science-based strategies to protect and promote the health of diverse populations.

Environmental Health and Injury Prevention and Control

The Budget includes $271 million for Environmental Health and Injury Prevention and Control activities. The Environmental Health activity aims to protect human health by preventing disability, disease, and death from environmental causes. CDC assists States and local health agencies in developing and increasing their ability and capacity to address environmental health problems. The FY 2009 Budget provides $137 million, $18 million below FY 2008, for Environmental Health. This level eliminates funding for Safe Water activities and does not maintain increases for environmental health laboratory activities included in the FY 2008 enacted level.

The FY 2009 Budget request includes $134 million to support efforts to reduce premature deaths, disability, and the medical costs caused by injuries and violence. Past areas of focus have included residential fire deaths, intimate partner violence, older adult falls prevention, teen driving safety, traumatic brain injury, child abuse and neglect, rape prevention and education, and other injury prevention and control initiatives.

Advancing Occupational Safety and Health

The FY 2009 Budget includes $326 million for Occupational Safety and Health activities. The National Institute for 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 improve workers' safety and health in settings from corporate offices to construction sites and coal mines. Within the total for Occupational Safety and Health, $55 million in mandatory funding is included for CDC's role in the Energy Employees Occupational Illness Compensation Program (EEOICPA). Prior to FY 2009, funding to CDC for EEOICPA was provided through an interagency agreement with the Department of Labor. The Budget also includes $25 million, the same as the FY 2008 President's Budget, to continue treatment of World Trade Center related illnesses for responders. Additional program expenses will be supported with funds from prior years. Currently, CDC funds six clinical centers and two data and coordination centers throughout the New York City metropolitan area.

Supporting Public Health Research

Public Health Research provides evidence to support specific programs, practices, and policies that affect health decisions made by the American public and those responsible for health policies and programs. With funding of $31 million for its health protection research initiative, CDC is building a cadre of health protection researchers, research training programs, and centers of excellence that enable multidisciplinary approaches to public health practice.

Preventive Health and Health Services Block Grant

The FY 2009 Budget eliminates the Preventive Health and Health Services Block Grant. The request focuses resources on higher priority areas and activities with proven records of performance.

MANAGING CDC'S INFRASTRUCTURE AND HUMAN CAPITAL

The FY 2009 Budget includes $163 million in administrative and infrastructure savings through prioritizing and targeting resources to mission-critical efforts.

Business Services Support: CDC has made a variety of improvements and efficiency gains in its business and management operations. For example, CDC became the first Federal civilian agency to successfully implement a High Performing Organization, an innovative alternative to public-private competition. As a result, in 2007 the agency was awarded a President's Quality Award, the highest award given to Executive Branch agencies for management excellence. In addition, CDC has consolidated all common CDC IT infrastructure services to achieve higher performance at lower costs and continues to lead a multi-year effort to shift more staff to frontline public health programs. The FY 2009 Budget includes $338 million, $34 million below FY 2008, for agency-wide operating costs, such as rent, utilities, and security.

Public Health Improvement and Leadership: The FY 2009 President's Budget includes $182 million, $43 million below FY 2008, for Public Health Improvement and Leadership. This activity supports several cross-cutting areas within CDC whose purposes are to ensure the effectiveness of public health programs and science. These funds also support CDC's public health workforce development program, which focuses on ensuring a competent and sustainable workforce prepared to meet current and emerging health promotion and protection priorities. This funding level includes the elimination of $27 million in Congressional projects included in FY 2008, the Director's Discretionary fund, and a general reduction in administrative costs. The FY 2009 Budget also eliminates Individual Learning Accounts. Training will be funded through existing carryover balances and other CDC resources.

Buildings and Facilities: Since 2001, CDC has invested more that $1.7 billion in new laboratories and other facilities. No new funding is requested in FY 2009. Nationwide repairs and improvements of existing facilities will be financed through unobligated balances.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

The request for ATSDR is $73 million, $1 million below FY 2008. Managed as part of CDC, ATSDR is the lead agency responsible for public health activities related to toxic substance exposures. Created in 1980 by the Comprehensive Environmental Response, Compensation and Liability Act – commonly known as the Superfund Law – ATSDR leads Federal public health efforts at Superfund and other sites with known or potential toxic exposures. The Agency's mission is to use the best science, take responsive action, and provide trustworthy health information to prevent and mitigate harmful exposures and related disease. ATSDR continues to be at the forefront in protecting people from acute toxic exposures that occur from hazardous leaks and spills, environment-related poisonings, and natural and terrorism-related disasters.

NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY INSTITUTE

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Institutes				
National Cancer Institute	4,795	4,805	4,810	+5
National Heart, Lung & Blood Institute	2,920	2,922	2,925	+3
National Institute of Dental & Craniofacial Research	389	390	391	+0.4
Natl Inst. of Diabetes & Digestive & Kidney Diseases	1,855	1,857	1,858	+2
National Institute of Neurological Disorders & Stroke	1,535	1,544	1,545	+1
National Institute of Allergy & Infectious Diseases	4,366	4,561	4,569	+8
National Institute of General Medical Sciences	1,936	1,936	1,938	+2
Eunice K. Shriver Natl Inst. of Child Hlth & Human Dev.	1,254	1,255	1,256	+1
National Eye Institute	667	667	668	+1
National Institute of Environmental Health Sciences:				
Labor/HHS Appropriation	642	642	643	+1
Interior Appropriation	79	78	78	--
National Institute on Aging	1,047	1,047	1,048	+1
Natl Inst. of Arthritis & Musculoskeletal & Skin Dis.	508	509	509	+0.5
Natl Inst. on Deafness & Communication Disorders	394	394	395	+1
National Institute of Mental Health	1,404	1,405	1,407	+1
National Institute on Drug Abuse	1,000	1,001	1,002	+1
National Institute on Alcohol Abuse & Alcoholism	436	436	437	+0.4
National Institute of Nursing Research	137	137	138	+0.1
National Human Genome Research Institute	486	487	488	+1
Natl Inst. of Biomedical Imaging & Bioengineering	298	299	300	+2
National Center for Research Resources	1,144	1,149	1,160	+11
Natl Center for Complementary & Alternative Med	121	122	122	+0.1
Natl Center on Minority Health & Health Disparities	199	200	200	+0.2
Fogarty International Center	66	67	67	+0.1
National Library of Medicine	328	329	331	+3
Office of the Director	1,047	1,109	1,057	-52
Buildings & Facilities	81	119	126	+7
Total, Program Level	**29,137**	**29,465**	**29,465**	**--**
Less Funds Allocated from Other Sources				
PHS Evaluation Funds (NLM)	-8	-8	-8	--
Type 1 Diabetes Research (NIDDK) 1/	-150	-150	-150	--
Total, Budget Authority	**28,978**	**29,307**	**29,307**	**--**
Labor/HHS Appropriation	**28,899**	**29,230**	**29,230**	**--**
Interior Appropriation	**79**	**78**	**78**	--
FTE	16,997	17,138	17,254	+116

1/ These funds were pre-appropriated in P.L. 107-360 and the Medicare, Medicaid, and SCHIP Extension Act of 2007.

NATIONAL INSTITUTES OF HEALTH

The National Institutes of Health uncovers new knowledge that will lead to better health for everyone.

The FY 2009 Budget requests $29.5 billion for the National Institutes of Health (NIH), the same level as FY 2008.

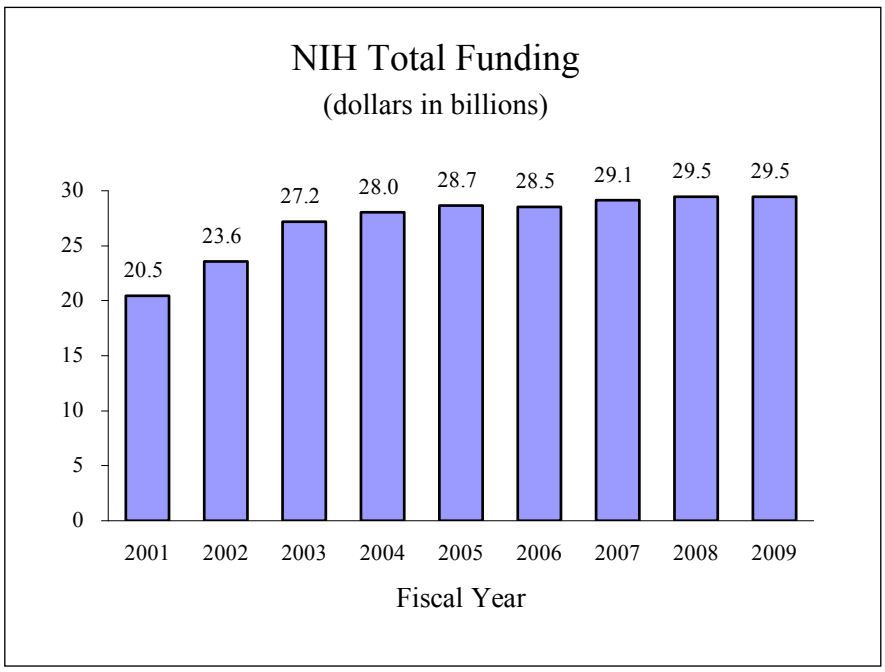
Substantial investment in biomedical research over the past 40 years, led by NIH, has successfully contributed to reducing the morbidity and mortality of many fatal conditions by improving treatments. This has changed the landscape of disease from acute to chronic diseases, which now account for over 75 percent of annual health care expenditures in the United States. The Nation has witnessed dramatic reductions in death rates from heart disease and stroke, declines in cancer incidence and mortality, increases in cancer survivorship, and improvements in the capacity to rapidly diagnose and control new infectious diseases shortly after they emerge.

With recent advances in genomics, proteomics, computational biology, and many other fields of science, researchers are gaining a broader understanding of the fundamental, molecular mechanisms that lead to disease years before it strikes the patient. This knowledge is laying the cornerstone for efforts to transform the practice of medicine from one in which intervention is often indiscriminate and too late in the disease process, to one that will be personalized, predictive, and pre-emptive, with greater patient and community participation in the active management of their health.

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 2009, about 83 percent of the funds appropriated to NIH will flow out to the extramural community, which supports work by more than 300,000 scientists and research personnel affiliated with over 3,100 organizations, including universities, medical schools, hospitals, 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 national and global health challenges. Another six percent will provide for agency leadership, research management and support, and facilities maintenance and improvements.

ADDRESSING RESEARCH PRIORITIES IN FY 2009

In fulfilling its mission, NIH strives to maintain a diverse portfolio of research founded on both public health need and scientific opportunity. The $29.5 billion request in FY 2009 will allow NIH to continue to pursue cross-cutting areas of discovery; increase biodefense research; continue support for new research investigators; and continue to refocus its programs for translating clinical research results into clinical practice. Support will also be provided to continue progress in promising arenas of science related to specific diseases such as cancer, cardiovascular disease, HIV/AIDS, diabetes, obesity, Parkinson's disease, and Alzheimer's disease, while also pursuing new avenues of post-genomics research. Funding is not included in the NIH Budget for the National Children's Study.



NIH Common Fund: The FY 2009 Budget allocates a total of $534 million, an increase of $38 million, or eight percent over FY 2008, to continue support for trans-NIH Common Fund initiatives. This mechanism will continue to serve as an incubator for new projects that can overcome complex research barriers and accelerate the pace of discovery for new disease treatments, prevention strategies, and diagnostics across all Institutes and Centers. The first cohort of projects was organized into three core themes: New Pathways to Discovery; Research Teams of the Future; and Re-engineering the Clinical Research Enterprise. The second cohort, launched in FY 2007, includes projects in the Human Microbiome – characterizing the microbial content of sites in the human body and their relationship to disease; and Epigenomics – studying stable genetic modifications and their relationship to disease. The FY 2009 Budget requests all resources for the Common Fund within the appropriation for the Office of the Director, though most of these funds will ultimately be spent through the Institutes and Centers in coordinated, collaborative efforts.

Biodefense: For FY 2009, the President's Budget proposes a total of $1.7 billion for NIH biodefense efforts, a net increase of $20 million, or 1.2 percent, above FY 2008. Our Nation's ability to detect and counter bioterrorism ultimately depends heavily on the state of biomedical science. Research efforts in FY 2009 will continue to be focused on improving the stability, delivery, and efficacy of vaccines for Category A and B agents; developing candidate therapeutics for high priority viral pathogens such as smallpox and viral hemorrhagic fevers; developing broad spectrum platforms and technologies for next generation biodefense therapeutics; and conducting clinical studies to address the growing threat of antimicrobial resistance.

Within this total, $113 million will be used to expand targeted research efforts devoted to developing medical countermeasures against nuclear, radiological, and chemical threats that could be used as weapons of mass destruction. This is an increase of $19 million, or 20 percent, over FY 2008. For nuclear and radiological countermeasures, NIH will focus on developing drugs to prevent injury from radiological exposure; improving measurements of such exposure; and developing methods or drugs to restore injured tissues and eliminate radioactive materials from contaminated tissues. For chemical countermeasures, NIH will devote special attention to promising drugs and antidotes for nerve agents, poisons, toxic industrial chemicals, and vesicating agents.

Performance Highlight

Goal: By 2011, NIH intends to assess the efficacy of at least three new treatment strategies to reduce cardiovascular morbidity and mortality in persons with type 2 diabetes or chronic kidney disease, a significant public health problem. For both diabetes and kidney disease, premature cardiovascular disease is the major cause of death.

- In FY 2006, NIH presented initial findings from its Look AHEAD (Action for Health in Diabetes) study.
- In FY 2007, NIH enrolled and randomized the total trial population for its FAVORIT (Folic Acid for Vascular Outcome Reduction in Transplantation) trial.
- At present, in FY 2008, NIH is reviewing and evaluating the indicators of Look AHEAD's progress to date. In FY 2009, NIH plans to complete treatment and follow-up of participants in the ACCORD (Action to Control Cardiovascular Risk in Diabetes) study.

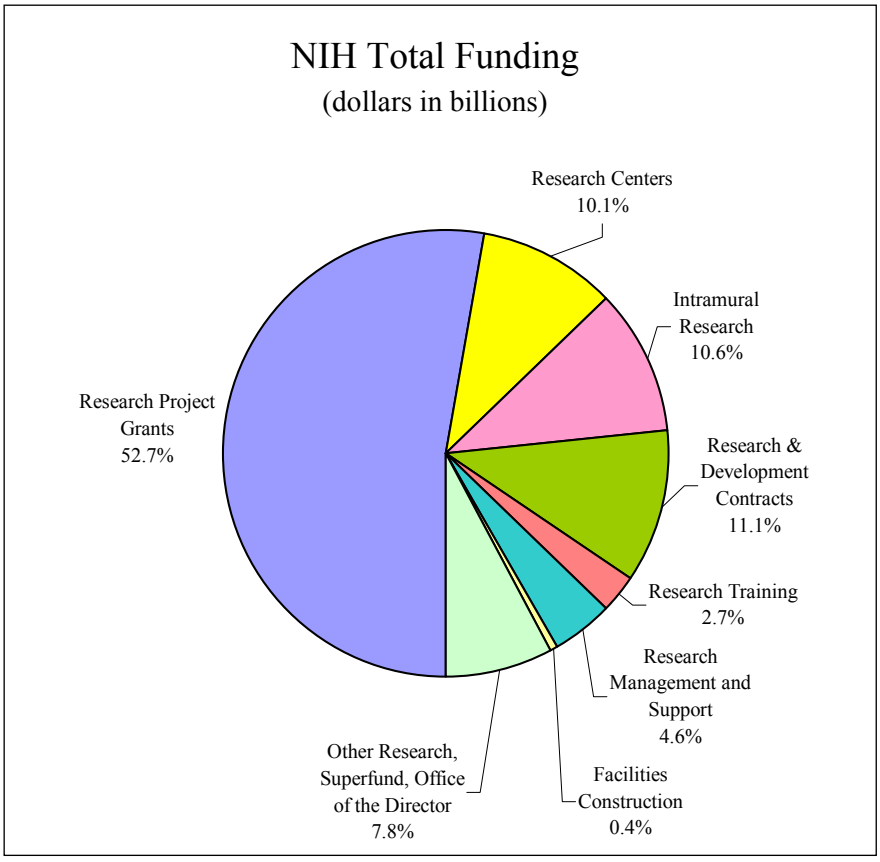
New Investigators: The foundation of the research enterprise is talented, creative, and dedicated research personnel. Fulfilling the NIH mission requires that the agency sustain a vibrant extramural and intramural workforce, including sufficient numbers of new investigators with new ideas and new skills, especially in interdisciplinary fields of research. NIH is working to reverse the trend of increases in the average age of first-time principal investigators obtaining independent research funding from NIH. The FY 2009 Budget includes $71 million across the NIH Institutes and Centers to continue funding for the "Pathway to Independence" program to provide increased and stable support for new research investigators. The program will support a total of approximately 500 awardees, including $15 million for 170 new awards for a third cohort of investigators as the first cohort transition to non-competing grants. Through a variety of efforts, NIH is seeking to maintain support of the historical annual average of about 1,500 total new researchers with investigator-initiated research project grant awards in FY 2009.

Clinical Research Translation: To meet the profound challenges of 21st century medicine and capitalize

on Common Fund initiatives, NIH developed a new Clinical and Translational Science Award (CTSA) beginning in FY 2006. These awards help advance information technology, integrate research networks, stimulate the development of computer-assisted outcome measurement, and improve workforce training. The goal of this effort is to provide the academic home and integrated resources necessary to advance a new intellectual discipline of clinical and translational sciences, create and nurture a cadre of well-trained interdisciplinary teams of investigators, and advance the Nation's health by transforming patient observations and basic discovery research into clinical practice and new treatments. In addition, NIH will continue to transition elements of existing clinical research programs, primarily the General Clinical Research Centers (GCRCs) in the National Center for Research Resources (NCRR), into CTSAs as these programs complete their current funding cycles. In FY 2009, the total CTSA/GCRC program is estimated to be $475 million, including an increase of $20 million in new and reallocated funds within NCRR. Also within the total CTSA/GCRC program, $83 million will be provided from the Common Fund.

Research Project Grants

The $15.5 billion provided in FY 2009 for support of medical research through competitive, peer-reviewed, and investigator-initiated research project grants (RPGs) represents 53 percent of the total NIH budget request. NIH estimates it will support 9,757 new and competing RPGs in FY 2009, nearly the same number as estimated for FY 2008. The average cost of a new and competing research project grant in FY 2009 will be about $361,000, the same as FY 2008. The total number of RPGs to be supported in FY 2009 is expected to be 38,257, also approximately the same level as in FY 2008.



Global AIDS Fund Transfer

Support for the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria is a key component of the President's Emergency Plan for AIDS Relief. The Budget for the National Institute of Allergy and Infectious Diseases includes $300 million, an increase of $5 million over FY 2008, as part of the United States Government's $500 million contribution to the Global Fund in FY 2009. Since its inception in 2001, Global Fund supported programs have expanded the delivery of key services, such as providing 1.4 million people with HIV antiretroviral treatment; providing 3.3 million people with tuberculosis treatment; and distributing 46 million insecticide-treated bed nets to families for protection from malaria.

Intramural Buildings and Facilities

A total of $133 million is requested for NIH Intramural Buildings and Facilities (B&F) in FY 2009, an increase of $7 million above the FY 2008 level. These funds will sustain and improve the physical infrastructure used to carry out quality biomedical research on the NIH campuses. In FY 2009, NIH will focus on upgrading facilities to ensure essential safety and regulatory compliance, as well as on facility repairs and improvements, particularly for the old Clinical Center, to address the most critical utility systems, fire safety, and environmental deficiencies, in order to stabilize the research environment. Within the B&F mechanism total, $8 million is available within the National Cancer Institute for facilities projects at its Frederick, Maryland campus.

NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY MECHANISM

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Mechanism				
Research Project Grants	15,627	15,542	15,523	-19
[# of Non-Competing Grants]	*[26,741]*	*[26,728]*	*[26,759]*	*[+31]*
[# of New/Competing Grants]	*[10,323]*	*[9,771]*	*[9,757]*	*[-14]*
[# of Small Business Grants]	*[1,781]*	*[1,740]*	*[1,741]*	*[+1]*
[Total # of Grants]	*[38,845]*	*[38,239]*	*[38,257]*	*[+18]*
Research Centers	2,934	2,943	2,963	+20
Other Research	1,794	1,809	1,786	-23
Research Training	782	782	786	+5
Research & Development Contracts	2,985	3,242	3,275	+33
Intramural Research	3,043	3,077	3,127	+50
Research Management and Support	1,317	1,341	1,361	+20
Extramural Research Facilities Construction	14	--	--	--
Office of the Director	473	524	432	-92
[NIH Common Fund (non-add)]	*[483]*	*[496]*	*[534]*	*[+38]*
Buildings and Facilities	89	127	133	+7
NIEHS Interior Appropriation (Superfund)	79	78	78	--
Total, Program Level	**29,137**	**29,465**	**29,465**	**--**
Less Funds Allocated from Other Sources				
PHS Evaluation Funds (NLM)	-8	-8	-8	--
Type 1 Diabetes Research (NIDDK) 1/	-150	-150	-150	--
Total, Budget Authority	**28,978**	**29,307**	**29,307**	**--**
Labor/HHS Appropriation	**28,899**	**29,230**	**29,230**	**--**
Interior Appropriation	**79**	**78**	**78**	**--**
FTE	16,997	17,138	17,254	+116

1/ These funds were pre-appropriated in P.L. 107-360 and the Medicare, Medicaid, and SCHIP Extension Act of 2007.

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SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Substance Abuse:				
Substance Abuse Block Grant	1,759	1,759	1,779	+20
PHS Evaluation Funds (non-add)	*79*	*79*	*79*	--
Programs of Regional and National Significance				
Treatment	399	400	337	-63
PHS Evaluation Funds (non-add)	*4*	*4*	*11*	*+7*
Prevention	193	194	158	-36
Subtotal, Substance Abuse	2,350	2,353	2,273	-79
Mental Health:				
Mental Health Block Grant	428	421	421	--
PHS Evaluation Funds (non-add)	*21*	*21*	*21*	--
PATH Homeless Formula Grant	54	53	60	+6
Programs of Regional and National Significance	263	299	155	-144
Children's Mental Health Services	104	102	114	+12
Protection and Advocacy	34	35	34	-1
Subtotal, Mental Health	884	911	784	-126
Program Management	93	93	97	+4
PHS Evaluation Funds (non-add)	*16*	*18*	*22*	*+4*
Saint Elizabeths Hospital	--	--	1	+1
Data Evaluation	--	--	3	+3
Total, Program Level	**3,327**	**3,356**	**3,158**	**-198**
Less Funds Allocated from Other Sources:				
PHS Evaluation Funds	-121	-122	-133	-11
Total, Budget Authority	**3,206**	**3,234**	**3,025**	**-209**
FTE	528	534	528	-6

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

The Substance Abuse and Mental Health Services Administration builds resilience and facilitates recovery for people with or at risk for substance abuse and mental illness.

The FY 2009 Budget requests $3.2 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), a decrease of $198 million from FY 2008. The Budget provides flexibility for States and localities to respond to their unique behavioral health needs; prioritizes programs that leverage local resources to achieve improved health outcomes; enhances efforts to identify substance use before it progresses to addiction; uses the sanctioning power of courts to encourage client retention in treatment; and provides a financial incentive for States and Territories to improve their substance abuse prevention and treatment services. The Budget makes targeted reductions in areas where grantees have not demonstrated improved health outcomes, grant periods are ending, activities can be supported through other funding streams, or efficiencies can be realized.

SUBSTANCE ABUSE

Illicit drug use among American youth has decreased by 24 percent since 2001. During this time, methamphetamine use declined by 64 percent among this population. The FY 2009 Budget, which includes $2.3 billion for substance abuse prevention and treatment activities, seeks to continue this marked improvement among youth and to extend this trend to the broader population.

Supporting Prevention and Treatment: The Budget includes $1.8 billion for the Substance Abuse Prevention and Treatment Block Grant, an increase of $20 million, which will support supplemental performance awards for the top 20 percent of grant recipients that demonstrate superior performance in preventing and treating substance abuse. States and Territories have significant flexibility in tailoring services supported through this funding stream to their unique needs, as evidenced by the fact that more than 10,500 community-based organizations indirectly receive Block Grant funding.

Using the Sanctioning Power of Treatment Courts: The Budget includes a total of $40 million for treatment courts, an increase of $30 million. Drug treatment courts use close supervision, drug testing, and the use of sanctions and incentives to ensure that offenders stick with their treatment plans and to break the cycle of abuse. Of the total, $2 million will support approximately five grant awards for the provision of mental health treatment services in association with a mental health court. Mental health courts seek to reduce recidivism by offering the possibility of dismissal of charges or reduced sentencing upon successful completion of mental health treatment.

Providing Screening and Brief Interventions: The Budget includes $56 million, an increase of $27 million, to support screening for substance use and brief interventions in medical and other community settings. Every day, millions of Americans who are at risk of developing serious substance abuse problems interact with medical professionals and other community service providers. If properly trained, these professionals have an opportunity to identify such clients and initiate a brief intervention or refer them to specialized treatment.

Providing Access to Recovery: The Budget includes nearly $100 million to support 24 Access to Recovery grantees and an evaluation of the program. These grantees provide their clients with a choice among a broad array of substance abuse treatment and recovery support service providers, including faith-based and community-based providers. A total of 160,000 clients will be served over three years. More than 80 percent of clients receiving services through Access to Recovery abstain from substance use. Within the total, $2 million will support the completion of an evaluation of the role of Access to Recovery in advancing positive client outcomes.

Performance Highlight

Illicit drug use among American youth has decreased by 24 percent since 2001. This dramatic reduction is particularly important in light of the fact that early use of drugs increases a person's chances of more serious drug abuse by altering gene expression and brain circuitry.

Source: 2007 Monitoring the Future Survey

Tailoring Prevention Efforts to Local Needs: The Budget includes $95 million to support Strategic Prevention Framework grants to 42 States, Tribes, and Territories. These grantees carry out a needs

assessment using epidemiological data, develop a strategic plan to address their identified needs, and implement evidence-based prevention efforts.

The Budget also includes $7 million for new grants to respond to emerging needs identified by States and local communities. For example, a community facing an upsurge in abuse of prescription drugs or methamphetamine could receive funding to implement a proven prevention effort such as school or family-based programming. These new grants will leverage local resources and promote sustainability by requiring a matching contribution by the grant recipient.

Reducing the Burden of HIV/AIDS Among Minority Populations: The Budget includes $112 million to foster behavioral health among African American, Latino, and other ethnic and racial minority populations experiencing disproportionate increases in HIV/AIDS. In recognition that substance abuse is often linked to the transmission of new HIV/AIDS cases, the Budget maintains support for culturally competent evidence-based interventions that prevent the onset and reduce the progression of substance abuse and the transmission of HIV among minority populations.

In addition, clients diagnosed with HIV/AIDS who experience mental disorders frequently do not receive mental health treatment that could improve their medical outcomes, quality of life, and adherence with their broader treatment regimen. The Budget maintains support for HIV-related mental health treatment in minority communities which disproportionately experience barriers to quality treatment.

MENTAL HEALTH

The Budget includes $784 million for mental health services. Few families in the United States are untouched by mental illness. One in four adults suffers from a diagnosable mental disorder in a given year. Among this quarter of the population, one in five suffers from a serious mental illness. A similar proportion of children have a serious emotional disturbance.

Supporting Community Mental Health Services: The Budget includes $421 million for the Community Mental Health Services Block Grant. States and Territories have significant flexibility in tailoring services supported through this funding stream to their unique needs. Each State and Territory develops its own plan for improving community-based services and reducing reliance on hospitalization. This plan is reviewed by consumers of mental health services and their family members, as well as service providers and State officials.

Improving Children's Mental Health: The Budget includes $114 million, an increase of $12 million, for grants to States and localities to support the development of comprehensive community-based systems of care for children and adolescents with serious emotional disorders. Grant recipients increase their matching contribution over the six-year grant period as a means of promoting sustainability of the local systems of care. As a result, 80 percent of the local systems of care established through this program have been sustained at least five years beyond the Federal grant period. An evaluation of this program found that children receiving services demonstrate improved behavioral outcomes, better school performance, and fewer disciplinary and law enforcement encounters.

Assisting in the Transition from Homelessness: Individuals with serious mental illnesses have greater difficulty exiting homelessness than other people. The Budget includes $60 million, an increase of $6 million, for grants to States and Territories to provide assistance to individuals suffering from severe mental illness who are facing homelessness. States and Territories match at least 33 percent of the Federal investment in this program, enabling more clients to be enrolled in services and to advance along the path toward having a permanent place to live.

Preventing Youth Violence: Violence in schools compromises the educational climate and endangers students and teachers. Through Safe Schools/Healthy Students, SAMHSA collaborates with the Departments of Education and Justice to help local partnerships draw on the best practices of education, justice, law enforcement, social, and mental health services to promote healthy child development and prevent violence. SAMHSA-supported interventions foster early childhood development of mental and physical health, reduce or delay the onset of emotional and behavioral problems, and treat children with serious emotional disturbance. The Budget includes $76 million for the prevention of violence among youth.

Preventing Suicide: More than 30,000 individuals die from suicide in the United States every year. The Budget includes $34 million specifically targeted to prevent suicide. In addition to these targeted resources, the broader investments made by SAMHSA in the prevention and treatment of mental and substance abuse disorders also play a key role in preventing suicide.

Suicide is the third leading cause of death among young people. The Budget maintains funding for activities authorized by the Garrett Lee Smith Memorial Act which support intervention and prevention strategies in schools, institutions of higher education, juvenile justice systems, and other youth support organizations.

The Budget continues to support 24-hour, toll-free telephone access to a network of certified local crisis centers available to anyone in suicidal crisis. It is estimated that more than 600,000 calls will be answered in FY 2009.

The Budget also maintains support for a Suicide Prevention Resource Center which provides training and resources to assist organizations and individuals to develop suicide prevention interventions and policies.

Protecting Individuals with Mental Illness: Individuals with mental illnesses and serious emotional disturbances who reside in treatment facilities are particularly vulnerable to neglect and abuse. The Budget includes $34 million to support State protection and advocacy systems to protect these individuals from abuse, neglect, and civil rights violations.

Tailoring Mental Health Services to Emerging Needs: The Budget makes targeted reductions to existing categorical mental health project grants in favor of new grants to respond to needs identified by States and local communities. The Budget includes $7 million for mental health grants to support the provision of services to children, families, and older adults; efforts targeted to individuals experiencing homelessness, post-traumatic stress, or co-occurring disorders; or initiatives to respond to other emerging local needs identified by State and local communities. These new grants will leverage local resources and promote sustainability by requiring a matching contribution by the grant recipient.

PROGRAM MANAGEMENT

The Budget includes $97 million, an increase of $4 million over FY 2008, for the administration of SAMHSA programs and the support of national data collection. The increase of $4 million supports enhanced data precision, accuracy, and analysis through the National Survey on Drug Use and Health.

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Health Costs, Quality and Outcomes Research				
Patient Safety Research:				
Health Information Technology	50	45	45	--
General Patient Safety Research	34	34	32	-2
Subtotal, Patient Safety	84	79	77	-2
Effective Healthcare Program	15	30	30	--
Health Insurance Decision Tool	--	--	6	+6
Value-Driven Health Care	--	4	4	--
Other Quality and Cost Effectiveness Research	162	164	151	-13
Total, Health Costs, Quality and Outcomes	261	277	268	-9
Medical Expenditures Panel Surveys	55	55	55	--
Program Support	3	3	3	--
Total, Program Level	**319**	**335**	**326**	**-9**
Less Funds From Other Sources				
PHS Evaluation Funds	-319	-335	-326	+9
Total, Budget Authority	**--**	**--**	**--**	**--**
FTE	295	299	300	+1

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

The Agency for Healthcare Research and Quality is charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans.

The FY 2009 Budget request for the Agency for Healthcare Research and Quality (AHRQ) is $326 million, a $9 million decrease from FY 2008. The request maintains funding for comparative effectiveness research, funds the development of new research tools to help States develop affordable health plans for low-income individuals, and promotes transparency in health care quality and costs. The Budget also supports efforts to improve patient safety through investments in health IT and through a network of patient safety databases mandated by the Patient Safety and Quality Improvement Act of 2005.

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. The agency's research agenda is broad and spans from medical informatics to long-term care and from comparative effectiveness research to disease prevention.

HEALTH COSTS, QUALITY, AND OUTCOMES

The FY 2009 President's Budget provides a total of $268 million to support improvements through research on the cost-effectiveness and quality of health care. Highlighted investments include:

Advancing Effective Health Care: The FY 2009 Budget provides $30 million, the same as FY 2008, for AHRQ's Effective Health Care Program. This program helps policymakers, clinicians, and patients determine which drugs and medical treatments work best for certain health conditions. This funding supports research on the outcomes of health care services and therapies, by comparing different therapies for the same condition. Because comparative effectiveness research emphasizes what medical interventions work best for whom, the investment provides the necessary scientific foundation to understand how genomics can impact patient care and advance personalized medicine. In FY 2009, AHRQ will continue to partner with CMS to generate information about which drugs and other treatments are proven to be effective, and for whom, for the conditions that are most important for its beneficiaries.

Helping States Develop Affordable Health Plans: The FY 2009 request includes $6 million to launch the Health Insurance Decision Tool to help States develop affordable health plans at an affordable price. It will also provide Federal decision makers with the information they need for evaluating States' proposals and understanding the impacts of Federal initiatives on the overall U.S. healthcare system.

AHRQ will develop information on the benefits for the privately insured and on what factors consumers consider in making decisions with respect to their choice of plans. The data AHRQ collects through the Medical Expenditure Panel Survey (MEPS) and the Consumer Assessment of Health Plans Survey provides a starting point for filling these identified gaps.

Promoting Value-Driven Health Care: The FY 2009 Budget provides $4 million for the Value Driven Health Care Initiative, which developed from the Ambulatory Care Quality Alliance pilot projects, to improve the quality of health care services and to reduce health care costs. This activity, a major component of the Secretary's Health Care Transparency Initiative, seeks to give consumers control of their health care so they can make informed decisions. With this funding, AHRQ will continue to support community-based multi-stakeholder collaboratives that publicly report cost and quality information in their communities to give consumers and providers the information they need to monitor quality in making health care decisions.

Performance Highlight

AHRQ seeks to provide valuable information for the Medicare prescription drug program. Specifically, AHRQ aims to reduce the number of hospital admissions for upper gastrointestinal (GI) bleeding for those between 65 and 85 years of age and to reduce the costs associated with these admissions. This goal supports AHRQ's mission to improve the safety, quality, and effectiveness of healthcare. The AHRQ Centers for Education and Research on Therapeutics have conducted studies and projects that relate to the inappropriate use of products that can cause bleeding. In FY 2007, the costs associated with the number of hospital admissions for upper GI bleeding decreased by about 5 percent. By FY 2009, the program will strive to achieve a 6 percent reduction from the baseline for costs associated with GI bleeding in individuals between 65 and 85 years of age.

Investing in Health IT: The FY 2009 Budget includes $45 million for health IT investments designed to enhance patient safety, with an emphasis on ambulatory patient care. Although the use of hospital-based IT for patient safety has been rising, an adoption gap exists in ambulatory care, especially in smaller practices where 60 percent of physicians continue to practice with five or fewer doctors. To address this adoption gap and to improve the safety and quality of care for patients in ambulatory environments using health IT, AHRQ will use $29 million for the Ambulatory Patient Safety Program. This funding includes $7 million in new health IT grants to support the next phase of Ambulatory Patient Safety activities. AHRQ will address systemic barriers to adoption and create the evidence base for best practices. Special attention will be placed on the delivery of high quality care from providers in rural, small community, safety net, and community health center environments.

The remaining $15 million for health IT will continue funding for planning and implementation of solutions in communities that demonstrate the value of health IT in patient safety, quality, and health care costs.

Supporting Other Patient Safety Activities: AHRQ's patient safety budget includes $32 million to support a variety of activities. Since FY 2006, AHRQ provided funds to initiate activities authorized under the Patient Safety and Quality Improvement Act of 2005, which establishes patient safety organizations nationwide that will collect information from providers about adverse events affecting patient safety. In FY 2009, these funds will allow AHRQ to continue its work creating a network of patient safety databases.

Supporting Research and Dissemination Activities Outside Patient Safety: In FY 2009, AHRQ will invest $151 million in research and dissemination activities in prevention, pharmaceutical outcomes, and other research areas to support the quality and cost-effectiveness of health care and ensure findings are accessible to the public. AHRQ will also continue to sponsor the United States Preventive Services Task Force in FY 2009.

MEDICAL EXPENDITURE PANEL SURVEYS

The FY 2009 request for MEPS is $55 million, the same as FY 2008. 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 person, family and visit-level information on medical expenditures. MEPS provides 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, Medicare and Medicaid.

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(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Current Law:				
Medicare /1	375,396	396,283	425,521	+29,238
Medicaid /2	190,624	203,753	217,537	+13,784
SCHIP	6,000	7,600	6,097	-1,503
State Grants and Demonstrations	1,275	929	859	-70
Total Net Outlays, Current Law	**573,295**	**608,565**	**650,014**	**+41,449**
Proposed Law:				
Medicare Benefits	--	105	-12,180	-12,285
Medicaid	--	35	-1,875	-1,910
SCHIP	--	--	2,105	+2,105
Program Management	--	--	-35	-35
State Grants and Demonstrations	--	--	75	+75
Premiums and Interfund Transactions	--	--	13	+13
Total Proposed Law	**--**	**140**	**-11,897**	**-12,037**
Total Net Outlays, Proposed Law /3 /4	**573,295**	**608,705**	**638,117**	**+29,412**

1/ Current law Medicare outlays net of offsetting receipts.

2/ Net outlays net of Qualified Individuals.

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

4/ Includes non-CMS administration.

CENTERS FOR MEDICARE & MEDICAID SERVICES

The Centers for Medicare & Medicaid Services ensures effective, up-to-date health care coverage and promotes quality care for beneficiaries.

The FY 2009 Budget request for the Centers for Medicare & Medicaid Services (CMS) is $711.2 billion in mandatory and discretionary outlays, a net increase of $32.7 billion over the FY 2008 level. This request finances Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), program integrity efforts, CMS operating costs, and other small programs.

CMS is the largest purchaser of health care in the United States, serving 92 million Medicare, Medicaid, and SCHIP beneficiaries. Following are policy highlights from the CMS FY 2009 Budget request.

FOSTERING AFFORDABLE CHOICES IN THE HEALTH CARE SYSTEM

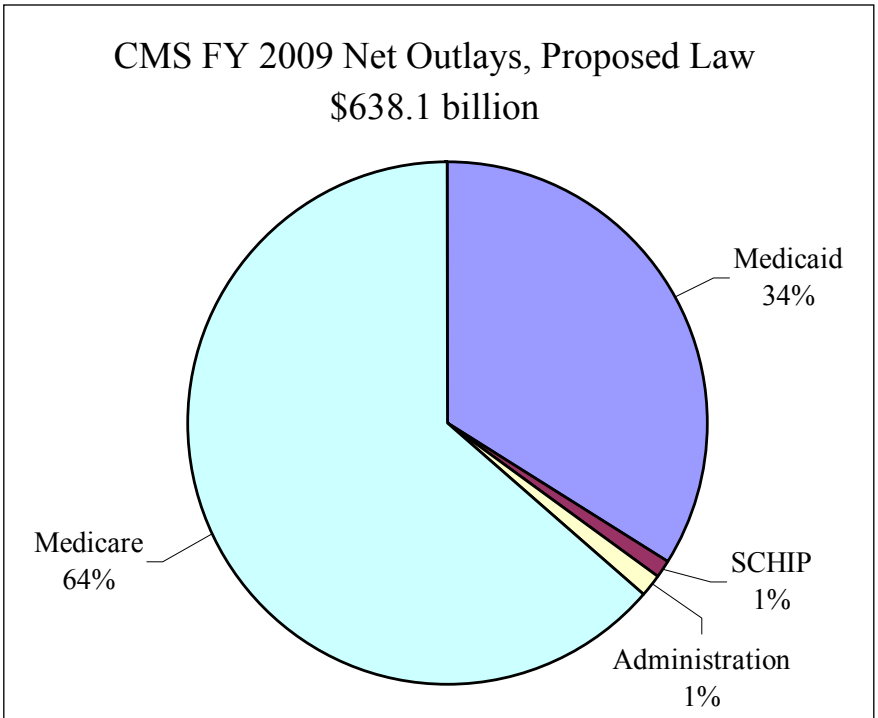
Over the past year, Secretary Leavitt has spoken with Members of Congress, the Nation's governors, and others about opportunities to improve Americans' access to affordable insurance.

The Federal Government's current system of paying for health care results in billions of dollars being spent inefficiently through a patchwork of subsidies and payments to providers. In addition to directly funding the costs of health care for enrollees, the Medicare and Medicaid programs make separate payments that subsidize providers' operating expenses and indirectly fund the cost of uncompensated care. The health care system could operate more efficiently if some portion of these indirect subsidies were redirected to make health insurance affordable for individuals with poor health or limited incomes. Without access to health insurance, the uninsured often use emergency rooms as a source of primary care, which leads to suboptimal care and unnecessary expense. Helping the uninsured purchase private insurance would ensure that they receive the care they need in the most appropriate setting.

The health care system needs to be transformed in a way that avoids costly and unnecessary medical visits, and emphasizes upfront, affordable private health insurance options. This transformation could occur by subsidizing the purchase of private insurance for low-income individuals. However, any health care reforms need to be State-based and budget neutral, and must not result in the creation of a new entitlement program or reduce the savings proposed in the President's Budget. Such a transformation would allow the Federal Government to maintain its commitment to the neediest and most vulnerable populations and also allow the States, which are best situated to craft innovative solutions, to move people into affordable insurance.

MEDICARE

The Budget includes a set of Medicare legislative and administrative proposals saving $12.8 billion in FY 2009 and $182.7 billion over five years. Designed to strengthen Medicare's long-term financial security, these proposals encourage efficient payments, enhance program integrity, and promote beneficiary



Note: State Grants and Demonstrations accounts for 0.15 percent of net outlays.

involvement in health care decisions. The Medicare Trustees issued a funding warning in their 2007 report for the first time, indicating that, for two consecutive years, more than 45 percent of projected Medicare expenditures will require funding from general tax revenue – rather than dedicated resources – over the next six years.

The Medicare prescription drug benefit continues to perform strongly and under budget. With a net Medicare cost nearly $244 billion below initial estimates over the 2004 to 2013 period and satisfaction ratings as high as 85 percent, this benefit is immensely successful. In 2008, premiums average $25, and beneficiaries in every State have access to at least one plan with premiums under $20 per month.

New program funding totaling $198 million in FY 2009 will help to identify any potential fraud and abuse in the prescription drug benefit and Medicare Advantage programs.

The Budget includes a package of legislative proposals to enhance competition and accountability in CMS's contracts with Medicare Quality Improvement Organizations (QIOs). The Budget proposes to eliminate statutory barriers that limit competition and prevent efficiencies, consistent with CMS's reform of contracts with Fiscal Intermediaries and Carriers.

MEDICAID AND SCHIP

The FY 2009 Budget proposes Medicaid legislative changes that will save $17.4 billion over five years and administrative changes that will save $800 million over five years in order to continue to slow the annual growth in the Medicaid entitlement program.

The Budget includes a robust SCHIP reauthorization proposal, fully offset within health care entitlements, that refocuses SCHIP on low-income children, as originally intended. The Budget also includes outreach grants to States, localities, schools, and community-based organizations to reach uninsured children eligible for SCHIP or Medicaid. As a result of these additional resources, the Administration estimates that in 2013, 5.6 million children would be enrolled in SCHIP on average, or nearly nine million children enrolled at some time during the year.

DISCRETIONARY PROGRAM MANAGEMENT

CMS is on track to implement contracting reform nearly two years earlier than the 2011 target set by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Contracting reform is projected to generate significant administrative savings to the government and providers by reducing the cost of processing Medicare claims. This initiative will yield nearly $2.7 billion in Trust Fund savings over the next five years through more accurate and appropriate payments.

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Current Law:				
Outlays				
Benefits and Related Expenses /1	434,592	459,144	491,388	+32,244
Administration /2	6,169	6,918	7,194	+276
Total Outlays, Current Law (CL)	440,761	466,062	498,582	+32,520
Offsetting Receipts				
Premiums and Offsetting Receipts /3	-65,365	-69,779	-73,061	-3,282
Current Law Outlays, Net of Offsetting Receipts	**375,396**	**396,283**	**425,521**	**+29,238**
Proposed Law:				
Legislative Proposals	--	+105	-12,202	-12,202
Total, Medicare Proposals	**--**	**+105**	**-12,202**	**-12,307**
Total Net Outlays, Proposed Law	**375,396**	**396,388**	**413,319**	**+16,931**

1/ Includes Medicare benefit payments (including refundable payments made to providers and plans), transfers to Medicaid, and additional Medicare Advantage benefits.
2/ Includes Program Management, non-CMS administration, HCFAC, and QIOs.
3/ Includes beneficiary premiums, State contributions to Part D, and other offsets.

In FY 2009, net proposed law spending on Medicare benefits will total $413.3 billion. Medicare will provide health insurance to 45.5 million individuals who are either 65 or older, disabled, or suffer from end–stage renal disease (ESRD).

THE FOUR PARTS OF MEDICARE

Part A: Medicare Part A, or Hospital Insurance, pays for inpatient hospital care, skilled nursing facility care, home health care related to a hospital stay, and hospice care. Part A financing comes primarily from a 2.9 percent payroll tax split between employees and employers.

Individuals with 40 quarters of Medicare-covered employment are entitled to Part A without paying a premium, but most covered services do require a beneficiary copayment or coinsurance. In 2008, beneficiaries will pay a $1,024 deductible for a hospital stay of 1-60 days, and $128 daily coinsurance for days 21-100 in a skilled nursing facility.

Part B: Medicare Part B, or Supplementary Medical Insurance (SMI), pays for physicians' services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment, certain home health care, and other medical services and supplies. Part B coverage is voluntary, and about 93 percent of Medicare beneficiaries are enrolled in Part B. Approximately 25 percent of Part B costs are financed by beneficiary premiums, with the remaining 75 percent covered by general revenues.

As of January 1, 2007, Part B premiums are based on income. Most beneficiaries will pay the standard monthly premium of $96.40 in 2008, but some will pay a higher premium based on their income. Those with annual incomes above $82,000 (single) or $164,000 (married couple) will pay from $122.20 to $238.40 per month.

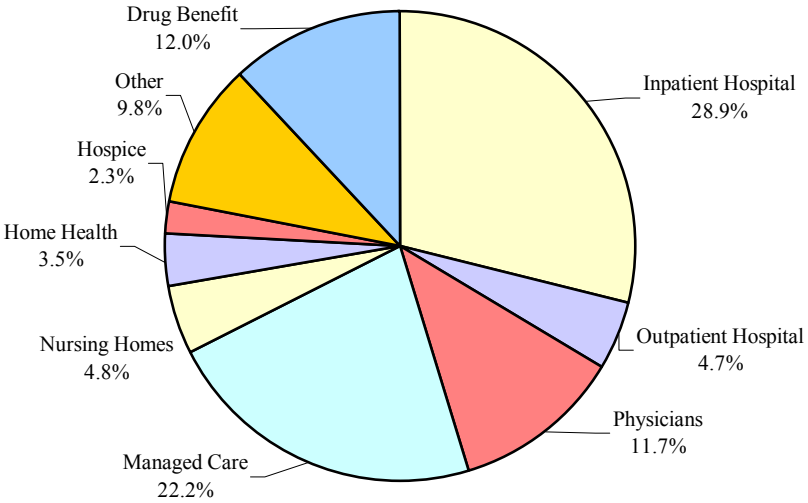
Part C: Medicare Part C, the Medicare Advantage (MA) program, offers beneficiaries a variety of coverage options including traditional health maintenance organizations, preferred provider organizations, special needs plans, and private fee-for-service plans. In 2007, about 20 percent of beneficiaries were enrolled in an MA plan, continuing the trend of increasing private Medicare plan enrollment. All beneficiaries also had access to at least one type of private MA plan, up from 77 percent in 2004.

Medicare pays MA plans a capitated monthly payment to provide all Parts A and B services

Medicare Enrollment
(enrollees in millions)

	2007	2008	2009	2009 +/-2008
Aged.....	36.7	37.4	38.1	+0.7
Disabled.....	7.2	7.3	7.4	+0.1
Total Beneficiaries	**43.9**	**44.6**	**45.5**	**+0.8**

Medicare Benefit Outlays by Service, 2009
Current Law Baseline: $485.9 billion



(and Part D if offered by the plan). Plans can also offer additional benefits not available under the traditional fee-for-service Medicare program or a variety of cost sharing arrangements. Beneficiaries pay a monthly Part D premium to MA plans to cover all Medicare services plus any additional benefits. The Part D premium varies depending on the services offered by the plan; therefore, it can be higher or lower than the regular Part B premium. On average, these plans provided beneficiaries around $86 per month in extra value in 2007 through additional benefits and reduced cost sharing.

As of 2008, all States offer Medical Savings Account plans to beneficiaries. These plans empower Medicare beneficiaries as consumers with more control over their health care utilization and costs, while providing them with coverage against catastrophic expenses.

Part D: In 2006, HHS implemented the first year of the new prescription drug benefit, the most significant reform of Medicare since its inception. Medicare Part D offers a standard prescription drug benefit with a 2008 deductible of $275, a reasonable monthly premium, and a substantial subsidy for drug costs. The standard benefit includes a coverage gap in which some beneficiaries are responsible for all of their drug costs, but once out-of-pocket spending reaches $3,850, Medicare covers 95 percent or more of drug costs. For people who are low-income, varying degrees of cost sharing are available with co-payments ranging from $0 to $5.60 in 2008 and low or no monthly premiums.

Part D has been an unparalleled success. The vast majority of all Medicare beneficiaries, including nearly 10 million low-income beneficiaries, are receiving comprehensive prescription drug coverage through Medicare Part D, employer-sponsored retiree health plans, or other creditable coverage. The average Part D premium for 2008 is approximately $25, 40 percent below the original estimate of $41. In every State, beneficiaries have access to at least one plan with premiums under $20. In addition, many plans are available with no deductible and all beneficiaries have access to one or more plans with drug coverage in the coverage gap.

Through competition and aggressive negotiating, Part D plans once again produced greater than expected savings in 2007. The most recent estimates show that net Part D costs are $244 billion lower over the 2004-2013 period. Savings to beneficiaries have been significant as well, averaging $1,200 annually.

Beneficiary satisfaction with the prescription drug benefit is high. Independent surveys indicate that as high as 85 percent of Part D enrollees are satisfied with their current coverage.

Medicare Prescription Drug Benefit Beneficiary Cost Sharing in 2008

Beneficiary Income Level	Annual Deductible	Monthly Premium	Beneficiary Out-of-Pocket Spending For Total Drug Expenditures:	
			≤$5,726	> $5,726
≥150% FPL (standard benefit)	$275	$ 25 (avg)	25% from $275-2,510 100% from $2,510-5,726	Greater of 5% or $2.25-5.60 copay
135-150% FPL*	$56	$0-$25	15% from $56-5,726	Copayment of: $2.25 generic $5.60 brand
100-135% FPL*	$0	$0**	Copayment of: $2.25 generic $5.60 brand name	$0
≤100% FPL*	$0	$0**	Copayment of: $1.05 generic $3.10 brand name	$0

FPL=Federal Poverty Level

*At these income levels, beneficiaries must also meet an asset test.

**Monthly prescription drug premium will be $0 if beneficiary enrolls in a basic Part D plan with a premium that is below the low-income premium subsidy amount (or within $1 of the premium subsidy amount).

FY 2009 Legislative Proposals

The Budget includes a package of Medicare legislative proposals designed to strengthen the long-term financial security of the program. Net savings from the Medicare legislative package total approximately $12.2 billion in FY 2009 and $178.0 billion over five years. The Budget also reduces beneficiary premiums by $6.2 billion over five years.

These Medicare savings are part of a larger Administration effort to address the unsustainable growth of Federal entitlement programs. The Budget reduces Medicare's average annual growth rate over five years from 7.2 percent to 5.0 percent. Finally, these proposals will: encourage provider competition, efficiency, and high-quality care; rationalize payment policies; increase beneficiary responsibility

for health care costs, improve Medicare's fiscal sustainability, and improve program integrity. Brief proposal descriptions follow.

Encourage Provider Competition, Efficiency, and High Quality Care

Provider Payment Updates: Adjust provider payments to recognize providers who reach efficiencies that restrain costs, including:

- Zero percent market basket/CPI update in 2009 through 2011 for inpatient hospitals, long-term care hospitals, skilled nursing facilities, hospices, outpatient hospitals, and ambulance services, followed by a full update less 0.65 percent annually thereafter.
- Zero percent market basket/CPI for inpatient rehabilitation facilities and ambulatory surgical centers in 2010 and 2011, followed by a full CPI update less 0.65 percent annually thereafter.
- Zero percent market basket update for home health agencies in 2009 through 2013, followed by a full market basket update less 0.65 percent annually thereafter.

Hospital Value-Based Purchasing: Establish incentives for hospitals to improve and attain high-quality care.

Never Events: Prohibit Medicare payment for "never" events (preventable adverse events such as surgery on wrong body part). Hospitals would also be required to report occurrences of never events or receive a reduced annual update.

Competitive Bidding: Expand the successful competitive acquisition policy to include clinical laboratory services.

Rationalize Medicare Payment Policies

Indirect Medical Education (IME) Payments: Eliminate duplicate IME payments to hospitals for Medicare Advantage beneficiaries.

IME Add-On Payments: Adjust the IME add-on payment from 5.5 percent to 2.2 percent over three years, starting FY 2009, to better align it with costs per case teaching hospitals may face.

Hospital Capital Payments: Reduce hospital capital payments by 5 percent in FY 2009 to ensure they are appropriately aligned with capital costs.

Hospital Disproportionate Share (DSH) Payments: Phase-in a 30 percent reduction in hospital DSH payments over two years starting FY 2009 to better align these payments with Medicare's estimated cost of providing health care to low-income patients.

Post Acute Care: Move toward site-neutral post-hospital payments to limit inappropriate incentives for five conditions commonly treated in both skilled nursing facilities and inpatient rehabilitation facilities.

Power Wheelchair Rentals: Establish a 13 month rental period for power wheelchairs to ensure that Medicare and its beneficiaries no longer pay excessively for the purchase of equipment that could have been rented.

Oxygen Rentals: Reduce the rental period for most oxygen equipment from 36 to 13 months, which will lower Medicare and beneficiary spending, and revise the monthly payment amount.

End-Stage Renal Disease Payment Modernization: Align payment rate for certain dialysis services in hospital-based and freestanding facilities starting in 2009; bundle payments for dialysis services and rebase the first year of the new payment system starting 2011.

Medicare as Secondary Payer (MSP): Better align payments for working beneficiaries by extending MSP status for beneficiaries with ESRD from 30 to 60 months for large employers.

Hospital Geographic Reclassification: Apply the geographic reclassification budget neutrality requirement at the State level. Required budget neutrality would be achieved by adjusting the wage index for all hospitals within the State rather than reducing the standardized amount for hospitals nationwide.

Improve Program Integrity

Bad Debt: Eliminate bad debt reimbursements for unpaid beneficiary cost-sharing over four years for all providers. Medicare currently pays 70 percent of unpaid beneficiary co-pays and deductibles to hospitals and skilled nursing facilities.

Mandamus Jurisdiction: Limit Mandamus jurisdiction as a basis for obtaining judicial review of claims arising under the Medicare statute, and clarify the Secretary's authority to resolve appeals of Medicare determinations.

Federal Payment Levy Program (FPLP): Allow Medicare provider payments to be included in the FPLP, a program that electronically matches delinquent tax debts with federal payments disbursed by the government. This will allow the Treasury Department to levy a portion of a provider's Medicare reimbursement against an outstanding tax debt.

Increase Beneficiary Responsibility for Health Care Costs

Part B Premium Indexing: Eliminate the annual indexing of income thresholds for reduced Part B premium subsidies beginning on January 1, 2009.

Part D Premium Subsidies: Reduce Part D premium subsidies based on the same income thresholds that apply to reduced Part B premium subsidies, including no annual indexing.

Use and Release of Medicare Claims Data: Seek broader authority to release Medicare fee-for-service claims and other data for purposes of quality improvement, performance measurement, and public reporting. This proposal will improve the transparency and availability of comparative health care cost and quality data for beneficiaries.

Improve Long-Term Fiscal Sustainability: Apply sequester of -0.4 percent to all Medicare provider payments when general fund contributions exceed 45 percent. The sequester order would increase each year by -0.4 percent until general revenue funding is brought back to 45 percent.

FY 2009 MEDICARE ADMINISTRATIVE PROPOSALS

The Budget assumes net Medicare administrative savings of $0.6 billion in FY 2009 and $4.7 billion over five years, resulting from proposals to strengthen program integrity, correct for inappropriate provider payments, and adjust payments to encourage efficiency and productivity, specifically: withhold Medicare payment for certain conditions if they were not present at the time of hospital admission; increase the inpatient length of stay threshold that triggers transfer payment adjustments; correct for case mix distribution in the skilled nursing payment system; phase-out the hospice-specific wage index adjustment over three years; and strengthen program integrity in Medicare payment systems to root out excessive or inappropriate payments. Included in the administrative package is a proposal to permanently base Part D risk scores on eligible enrollees, at a cost of $0.4 billion in FY 2009 and $3.2 billion over five years.

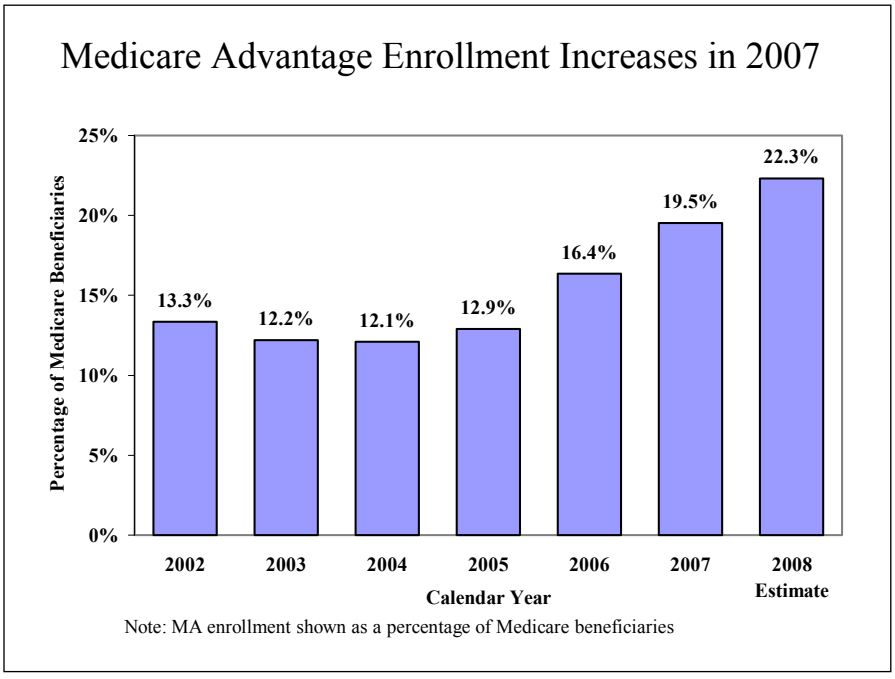
MEDICARE HIGHLIGHTS FROM THE MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007

Reforming Physician Payments: The previously scheduled 2008 physician payment update of approximately -10 percent is replaced with a +0.5 percent update through June 30, 2008. The Act also extends the Physician Quality Reporting Initiative. The geographic index floor for the work component of the physician payment also was extended, along with a 5 percent bonus payment to physicians in physician-shortage areas.

Medicare Advantage Changes: Special Needs Plans authority is extended through December 31, 2009. The Act removes $1.4 billion from the Regional Preferred Provider Organization stabilization fund.

Changing Hospital Requirements and Payments for Certain Facilities: Long-term care hospitals will have new facility and medical review requirements, and there will be a limited moratorium on the development of new long-term care hospitals. The Act also temporarily lowers the market basket for inpatient rehabilitation facilities to zero percent and freezes the services compliance threshold at 60 percent.

Extending Therapy Caps: The Act extends the exceptions process for Medicare therapy caps through June 30, 2008.



Note: MA enrollment shown as a percentage of Medicare beneficiaries

Identifying Medicare Secondary Payor Beneficiaries: Group health plans and liability insurers are required to submit data to HHS to identify Medicare Secondary Payor beneficiaries.

Reforming Part B Drug Prices: The Act adjusts Average Sales Price for Part B Drugs to a volume-weighted system.

Equalizing Diagnostic Lab Test Payments: Certain diabetes lab tests for home use will be reimbursed at the same rate as other glycated hemoglobin tests.

MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS

QIOs assist providers seeking to improve the quality of care delivered to Medicare beneficiaries and respond to beneficiary complaints about the quality of care received. These quality improvement efforts are essential to the Administration's goals to modernize and strengthen the Medicare program.

9th Scope of Work (SOW): Starting August 1, 2008, approximately $1.1 billion will be provided to QIOs to start the next three year contract cycle. The 9th SOW includes significant reforms to the management and performance of the QIO program. The major goals of the 9th SOW include preventing illness and harm to patients, and promoting efficient and high quality health care. It also advances the Secretary's health priorities by supporting three of the four pillars of value-driven health care: promoting EHRs; leveraging industry standards and quality measures; and advancing performance-based payments. The 9th SOW will measurably reduce illness, injury, and re-hospitalization.

Clinical Quality Efforts: In the 9th SOW, clinical care efforts will focus on three major themes:

- Prevention: QIOs will work on reducing chronic kidney disease, addressing disparities in the treatment of diabetes, increasing the rate of cancer screenings, expanding testing in diabetes care, and increasing vaccinations for influenza and pneumococcal pneumonia.
- Patient Pathways: QIOs will work with communities to reduce unnecessary re-hospitalizations through improvements in care during the transition of patients from hospitals to outpatient care.
- Patient Safety: QIOs will focus on improving healthcare processes to avoid the development of pressure ulcers, the use of restraints, and the spread of methicillin resistant staphylococcus aureus. Additional efforts will address drug safety in the Part D program and the prevention of infections in surgical care.

In addition to the three clinical quality themes, QIOs will work on a fourth theme to protect beneficiaries by responding to quality of care complaints.

New Performance Management Strategy: The 9th SOW includes several innovations in QIO contract management including:

- On-going performance management reviews, mid-contract checks on performance, and financial consequences if contractors do not maintain pre-specified performance levels.
- Better targeting of funding to areas with the lowest performing providers.
- Reallocating funding for poor performing QIOs.

Estimated Quality Improvement Organization Funding by Major Task – 9th Contract Cycle (2008-2011)
(in millions)

	Funds
Clinical Quality Improvement	
Prevention	115
Patient Pathways	65
Patient Safety	225
Provider Performance	15
Protecting Beneficiaries/Case Review/Annual Payment Update Integration	
Case Review	171
Annual Payment Update Reviews	28
Infrastructure, Support and Special Initiatives	
Theme Implementation/Support Infrastructure	48
QIO Standard Data Processing	189
Other Support Contracts/Special Projects	245
Total, QIO Ninth Cycle of Contracts	**1,099**

Note: Funding levels have been rounded.

- Introducing competition in awarding QIO quality work.

- Refocusing QIO work on clinical quality efforts and away from payment enforcement.

FY 2009 QIO Legislative Proposals

The FY 2009 Budget includes five legislative proposals, saving $80 million over five years, to further improve management and performance of the QIO program:

- Allow the Secretary to determine the geographic scope of QIO contracts, moving from State-based only contracts to local, regional or national contracts;

- Expand the pool of eligible QIO contractors to include other quality organizations;

- Allow for early termination of contracts without panel review for poor performing QIOs;

- Eliminate conflicts of interest between beneficiary protection and clinical improvement activities by establishing stricter contractor standards in reviewing beneficiary complaints; and

- Expand the statutory authority of QIOs to include quality improvement activities.

PROGRAM INTEGRITY OVERSIGHT

Health Care Fraud and Abuse Control (HCFAC): The FY 2009 Budget proposes to fund the HCFAC program through both mandatory and discretionary funding streams. The FY 2009 HCFAC program level is $1.3 billion, over $200 million more than in FY 2008. Of this total program level, $1.1 billion is mandatory and $198 million is discretionary.

HCFAC Mandatory Funds: The $1.1 billion in mandatory funds are financed from the Medicare Part A Trust Fund. This funding is allocated into three major parts: (1) the Medicare Integrity Program (MIP); (2) the Federal Bureau of Investigation (FBI); and (3) the HCFAC Account, which is divided among the Department of Justice (DOJ), the HHS Office of Inspector General (OIG), and other HHS agencies through an annual negotiation process. Activities financed by this funding are used to detect and prevent heath care fraud, waste and abuse through investigations, audits, educational activities, and data analysis.

For 2009, the Budget proposes the following changes to the HCFAC account to streamline its administration: (1) splitting the current funding provided jointly to HHS and DOJ into separate funding streams; (2) eliminating the annual negotiations process between the two Departments; and (3) requiring the FBI and the MIP to contribute to the annual HCFAC report.

The mandatory HCFAC funding has a proven record of returning money to the Medicare Trust Fund for each dollar spent. For MIP, the return on investment (ROI) is 13 to 1, and for the HCFAC Account, the ROI is 4 to 1. From 1997 to 2007, HCFAC activities (excluding MIP) have returned over $10 billion to the Trust Fund.

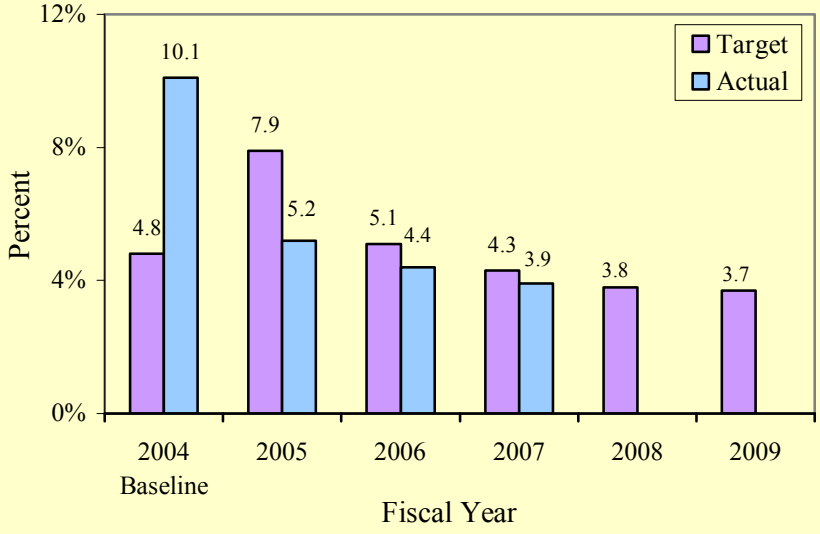
HCFAC Discretionary Funds: As part of a government-wide proposal to fund proven program integrity activities through an adjustment to discretionary spending totals, the FY 2009 Budget requests $198 million in discretionary HCFAC funding. This total will be allocated among the Medicare and Medicaid programs at CMS, as well as the OIG and DOJ. These funds are intended to complement the program integrity activities funded with mandatory HCFAC dollars.

Health Care Fraud and Abuse Control (HCFAC)
(in millions)

	2007	2008	2009	2009 +/- 2008
Discretionary Cap Adjustment Proposal:				
Department of Justice/FBI	--	--	19.0	+19
HHS Inspector General	--	--	19.0	+19
Medicaid and SCHIP Financial Management	--	--	13.0	+13
Medicare Integrity Program (MIP)	--	--	147.0	+147
Total Proposed Discretionary Funds	--	--	**198.0**	**+198**
Current Mandatory Funds (including TRHCA):				
Medicare Integrity Program (MIP)	744.0	756.0	768.0	+12
FBI	118.2	121.0	124.7	+4
OIG and Wedge Funds	249.5	255.2	263.1	+8
Total Current Mandatory Funds	**1,111.7**	**1,132.2**	**1,155.8**	**+24**
Total Proposed HCFAC Funds	**1,111.7**	**1,132.2**	**1,353.8**	**+222**

Performance Highlight

Aggressive oversight and efforts to improve payment accuracy cut the percentage of improper fee-for-service Medicare claims payments by 11 percent from 2006 to 2007. This is a $10.8 billion reduction in improper payments compared to 2004. For 2009, CMS targets a further reduction in the Medicare error rate to 3.7 percent.



The Medicare program has experienced significant transformation since 2003, and Medicaid spending is now on par with Medicare, thereby elevating the need for enhanced program integrity oversight. The HCFAC discretionary funds will be used to safeguard the new Medicare prescription drug benefit and MA plans against fraud and abuse, as well as to expand financial management oversight of the Medicaid program.

Reducing Erroneous Medicare Payments: The significant reduction in the Medicare fee-for-service error rate from 2006 to 2007 can be attributed largely to efforts through the Comprehensive Error Rate Testing (CERT) program to educate providers about problems with medical record documentation and methods to improve their accuracy and completeness. The CERT program tracks payment accuracy data at the contractor, provider, and service levels. When data reveal a pattern indicating a payment problem, CMS works with contractors to develop corrective action plans. Aggressive oversight efforts have resulted in a significant reduction in the number of improper Medicare claims payments, which declined from 14.2 percent in 1996, to 4.4 percent in 2006, to 3.9 percent in 2007. This solid improvement is a result of continued efforts initiated by CMS and its contractors to use detailed data analysis in targeting areas where erroneous claims processing, inaccurate billing and provider error result in waste, fraud and abuse.

In 2006, CMS began measuring the accuracy of payments to MA plans and addressing potential risks. By reviewing monthly managed care payments, CMS can examine whether beneficiaries are eligible for a plan, how payments are made, and what happens when a beneficiary's enrollment is terminated. CMS is currently developing a comprehensive Part D oversight program, building on the successful fee-for-service approach. This program will build strong safeguards in areas of particular vulnerability such as eligibility, bidding process, and retail pharmacy fraud.

(dollars in millions)

	2009	2009 +/- 2013
Medicare Legislative Proposals		
Encourage Provider Competition, Efficiency, and High-Quality Care:		
Hospital Update: Freeze 2009-2011; Market Basket (MB) -0.65% Annually Thereafter	-3,990	-64,200
Skilled Nursing Facility Update: Freeze 2009-2011; MB -0.65% Annually Thereafter	-990	-17,030
Hospice Update: Freeze 2009-2011; MB -0.65% Annually Thereafter	-350	-5,140
Inpatient Rehab Facility Update: Freeze 2010-2011; MB -0.65% Annually Thereafter /1	-510	-4,820
Long-Term Care Hospital Update: Freeze 2009-2011; MB -0.65% Annually Thereafter /1	-320	-2,940
Outpatient Hospital Update: Freeze 2009-2011; MB -0.65% Annually Thereafter	-580	-6,050
Ambulance Update: Freeze 2009-2011; CPI -0.65% Annually Thereafter	-60	-1,270
Ambulatory Surgical Center Update: Freeze 2010-2011; CPI-0.65% Annually Thereafter	0	-450
Home Health Update: Freeze 2009-2013; MB -0.65% Annually Thereafter	-440	-11,030
Establish Hospital Value-Based Purchasing Program	--	-1,650
Eliminate Payments for Never Events	--	-190
Introduce Competitive Bidding for Clinical Laboratory Services	-110	-2,290
Quality Improvement Organization Proposals:		
Allow Secretary to Determine Geographic Scope of Contracts	--	-50
Expand Pool of Contractors Eligible for QIO Work	--	-30
Allow for Early Termination of Contracts without Panel Review	--	--
Eliminate Conflict of Interest Between Beneficiary Protection and Clinical Quality Activities	--	--
Make QIO Authority to Conduct Quality Improvement Activities More Explicit	--	--
Subtotal, Encourage Provider Competition, & High Quality Care	-7,350	-117,140
Rationalize Medicare Payment Policies:		
Eliminate Duplicate Hospital IME Payments for Medicare Advantage Beneficiaries	-1,010	-8,850
Reduce Indirect Medical Education Add-On from 5.5% to 2.2% Over 3 Years	-890	-12,900
Reduce Hospital Capital Payments by 5 Percent in FY 2009	-490	-3,050
Reduce Hospital Disproportionate Share Payments by 30 Percent Over 2 Years	-1,750	-20,690
Set Base Payment for 5 Post-Acute Conditions Treated in SNFs and IRFs	-250	-1,650
Establish 13-Month Rental Period for Power Wheelchairs	-80	-720
Reduce Rental Period for Oxygen Equipment from 36 to 13 Months	-210	-3,000
End-Stage Renal Disease (ESRD) Payment Modernization	-10	-1,060
Extend Medicare Secondary Payer Status for ESRD from 30 to 60 Months	-110	-1,110
Budget Neutrality within State for Purposes of Geographic Reclassification	--	--
Subtotal, Rationalize Medicare Payment Policies	-4,800	-53,030

(dollars in millions)

	2009	2009 - 2013
Improve Program Integrity:		
Phase-Out Medicare Bad Debt Payments Over 4 Years	-250	-8,460
Limit Use of Mandamus Jurisdiction for Judicial Review of Medicare Determinations	--	-60
Include Medicare Providers in the Federal Payment Levy Program (FPLP)	--	--
Subtotal, Improve Program Integrity	-250	-8,520
Increase High-Income Beneficiary Responsibility for Health Care Costs:		
Eliminate Annual Indexing of Income-Related Part B Premiums (Benefit & Revenue Impact)	-110	-2,570
Establish Income-Related Part D Premium Consistent with Part B (Benefit & Revenue Impact	-350	-3,180
Seek Broader Authority to Release Medicare Fee-for-Service Claims Information	--	--
Subtotal, Increase High-Income Beneficiary Responsibility	-460	-5,750
Improve Long-Term Fiscal Sustainability:		
Apply -0.4% Sequester When Medicare Fund Warning is Triggered	--	--
Subtotal, Improve Long-Term Fiscal Sustainability	--	--
Other/Interactions:		
1-Year QI Extension/Interactions Reducing Beneficiary Part B Premiums /2	692	6,474
Subtotal, Interactions	692	6,474
Total, Medicare Legislative Proposals	**-12,167**	**-177,965**
Medicare Administrative Proposals		
Improve Medicare Efficiency, Productivity, and Program Integrity	-645	-4,739
Total, Medicare Administrative Proposals	**-645**	**-4,739**
Total, Medicare Budget Proposals	**-12,812**	**-182,704**

1/ Includes the impact of repealing certain provisions of Sections 114 and 115 of the Extension Act of 2007.

2/ The $270 million Medicare effect of the QI extension proposal is not scoreable for PAYGO purposes.

MEDICAID

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Current Law:				
Benefits /1	181,088	193,628	207,234	+13,606
State Administration	9,536	10,125	10,303	+178
Total Outlays, Current Law	**190,624**	**203,753**	**217,537**	**+13,785**
Proposed Law:				
Legislative Proposals	--	35	-1,875	-1,910
Total, Medicaid Proposals	**--**	**35**	**-1,875**	**-1,910**
Total Net Outlays, Proposed Law	**190,624**	**203,788**	**215,662**	**+11,875**

1/ Includes Vaccines for Children Outlays.

Federal and State Governments jointly fund Medicaid, a mandatory spending program that provides medical assistance to certain low-income groups. The Federal Government's share of a State's expenditures is called the Federal medical assistance percentage (FMAP). The FMAP has a floor rate of 50 percent and for FY 2009, the highest FMAP is 75.84 percent. Overall, the Federal Government will pay for approximately 57 percent of medical assistance payments.

In FY 2009, HHS estimates that approximately 51 million individuals in States, Territories, and Commonwealths will be covered by Medicaid. This includes children, the aged, blind, and/or disabled, and people who meet eligibility criteria under the old Aid to Families with Dependent Children (AFDC) program. Additionally, Medicaid will cover many other individuals who are eligible for benefits through waivers and amended State plans with somewhat higher income eligibility limits. In FY 2009, the Federal share of current law Medicaid outlays is expected to be $218 billion. This is a $13.8 billion (6.8 percent) increase over projected FY 2008 spending.

HOW MEDICAID WORKS

States are required to cover individuals who meet categorical and financial eligibility levels. This includes individuals who qualified under the previous AFDC rules; most Supplemental Security Income recipients; pregnant women and children under age 6 whose family incomes are at or below 133 percent of the Federal poverty level (FPL); and children ages 6 to 19 whose family incomes are at or below the FPL, all of whom are commonly referred to as the "categorically needy."

States may also cover "medically needy" individuals. These individuals meet the categorical eligibility criteria, but have too much income or too many resources to meet the financial criteria. This group includes pregnant women through a 60-day post-partum period, children under age 18, newborns and certain aged, blind, or disabled individuals. For 2008, the FPL for a family of four is $21,200 in the continental United States. For more information on the HHS poverty guidelines, see http://aspe.hhs.gov/poverty/.

The President's Budget continues to exercise fiscal discipline in Medicaid. It proposes nearly $2 billion in Medicaid savings in

Medicaid Enrollment

(enrollees in millions)

	2007	2008	2009
Aged 65 and Over	5.0	5.1	5.2
Blind and Disabled	8.5	8.6	8.7
Adults	11.1	11.3	11.5
Children	23.5	24.0	24.4
Territories	1.0	1.0	1.0
Total	**49.1**	**50.0**	**50.8**

FY 2009 and $17.4 billion in savings over five years. The President's proposals slow the average annual growth in Medicaid over the next five years from 7.4 percent to 7.1 percent.

LEGISLATIVE PROPOSALS

One of the significant accomplishments of this Administration was the enactment of the Deficit Reduction Act of 2005 (DRA) which made important changes that modernized the financing, benefit structure, and infrastructure of Medicaid. The FY 2009 President's Budget continues these efforts to restrain growth rates and promote the long-term viability of this vital program.

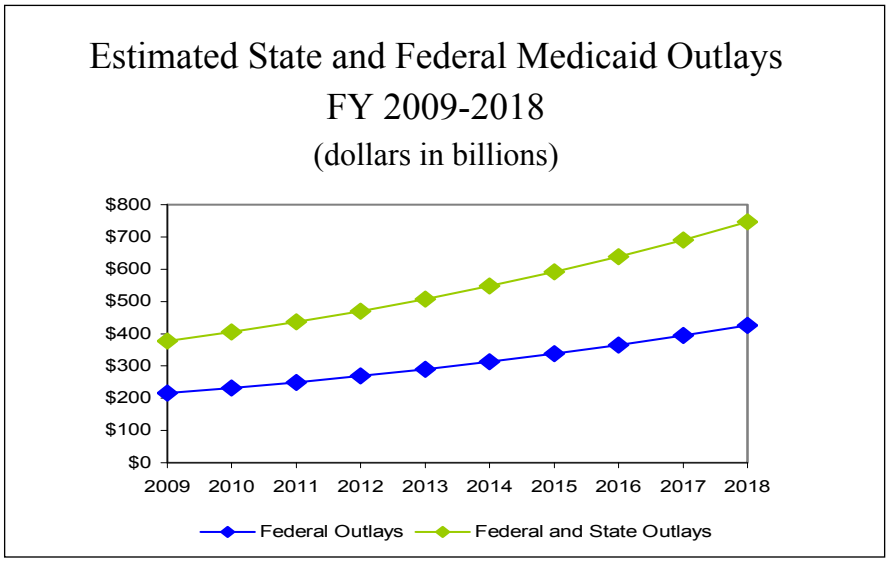
Long-Term Care

Maintain Substantial Home Equity Amount at $500,000: Removes the State option to increase the $500,000 home equity limit to $750,000 by proposing to codify the substantial home equity definition at $500,000. Starting in 2011, this limit will be subject to the CPI inflation factor.

Redesign Acute Care Benefits for Optional Long-Term Care (LTC) Groups: Establishes a State Plan Amendment option to expand on the flexibility provided in the DRA, which allows States to offer private sector-type coverage to certain Medicaid populations.

Managed Care

Repeal Section 1932(a)(2) Special Rules: Gives States greater flexibility in coordinating care for special populations by allowing them to enroll populations described in Section 1932(a)(2) of the Social Security Act into managed care programs under the State plan.



Extend Section 1915(b) Waiver Period: Extends the renewal period for 1915(b) "freedom of choice" waivers from two to three years to simplify program administration.

Prescription Drugs

Replace Best Price with Budget Neutral Rebate: Replaces the "best price" component of the Medicaid drug rebate formula with a budget neutral flat rebate. Medicaid best-price interferes with the marketplace by deterring manufacturers from offering lower prices to other drug purchasers.

Rationalize Pharmacy Reimbursement: Builds on changes to pharmacy reimbursement in the DRA by reducing the Federal upper limit reimbursement for multiple source drugs to 150 percent.

Program Integrity

Enhance Third Party Liability: Strengthens current law by enabling States to avoid costs for prenatal and preventive pediatric claims where a third party is responsible; collecting medical child support where health insurance is derived from a non-custodial parent's obligation to provide coverage; and recovering Medicaid expenditures from beneficiary liability settlements.

Modify Asset Verification: Provides technical corrections to the web-based asset verification demonstration included in the TMA, Abstinence Education, and QI Programs Extension Act of 2007 (P.L. 110-90) and extends the demonstration permanently.

Publish Annual Actuarial Report: Increases transparency through the publication of an annual actuarial report. This proposal also includes an administrative action.

Implement Cost Allocation: Recoups duplicative administrative costs inappropriately included in the Temporary Assistance for Needy Families (TANF) block grants.

Implement Medicaid Pay-for-Performance: Requires States to report on Medicaid performance measures and link performance to Federal Medicaid grant awards. This proposal also includes an administrative action.

Require State Participation in the Public Assistance Reporting Information System (PARIS): Enhances information sharing between States and effectively

verifies an applicant's eligibility for services through State and Federal data matching.

Mandate National Correct Coding Initiative: Promotes correct coding by providers and prevents inappropriate billing for services that have been improperly coded.

Reimbursement

Align Administrative Match Rates: Creates consistency in the administrative matching structure across Medicaid, by aligning all reimbursement rates for administrative activities in Medicaid at 50 percent.

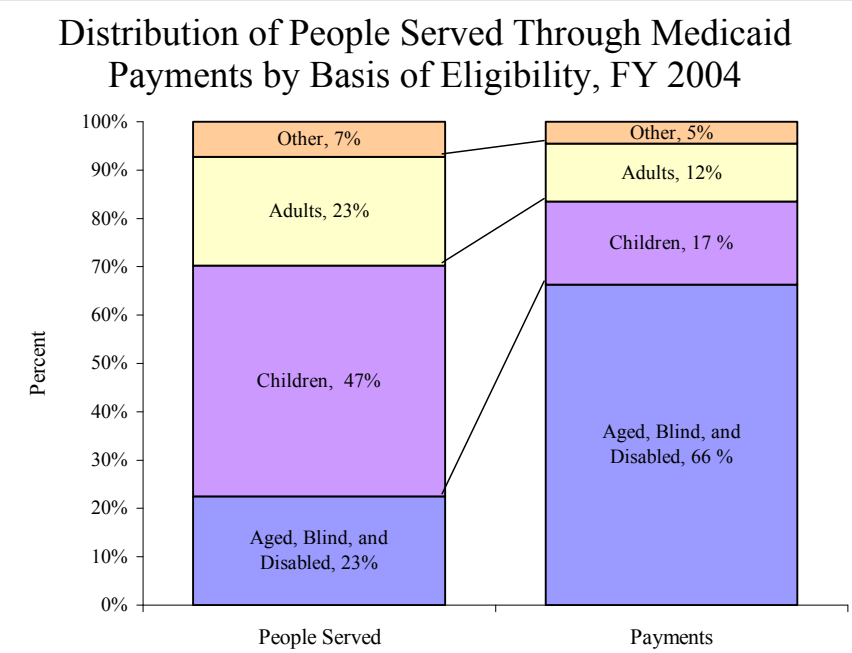
Align Family Planning Match Rate: Brings uniformity to the matching rate structure for most covered services provided under Medicaid by aligning the reimbursement rate for family planning services and supplies to a State's regular FMAP.

Align Case Management Match Rate: Aligns reimbursement for Targeted Case Management services with the standard administrative matching rate of 50 percent.

Align Qualified Individuals Program Match Rate: Brings uniformity to the matching rate structure for most covered services provided under Medicaid by aligning the reimbursement rate for the qualifying individuals program to a State's regular FMAP.

Enhancements

Extend Qualified Individuals (QI) Program: Extends premium assistance for QIs, Medicare beneficiaries with incomes between 120 and 135 percent FPL who have limited financial resources, through September 30, 2009. The extension will continue Federal coverage of Medicare Part B premiums.



Source: Medicaid Statistical Information System, CMS.
Note: FY 2004 is the most recent year for which there is complete State data.

Extend Transitional Medical Assistance (TMA): Extends TMA allowing families to remain eligible for Medicaid for up to 12 months after they lose welfare cash benefits due to increased earnings. Extends TMA through September 30, 2009.

Modify Health Insurance Portability and Accountability Act (HIPAA): Includes two legislative changes to ensure that Medicaid and State Children's Health Insurance Program (SCHIP) beneficiaries receive the benefits of HIPAA-related coverage, which increases the continuity, portability, and accessibility of health insurance.

Increase Flexibility for Premium Assistance: Provides States with greater flexibility for determining cost effectiveness and information sharing with employers to streamline the implementation of Medicaid employer-sponsored insurance programs. This proposal also includes an administrative action.

Extend Refugee Exemption: This SSA proposal, which has a Medicaid impact, extends from seven to eight years the length of time refugees and asylees have to complete the citizenship application process without penalty.

ADMINISTRATIVE ACTIONS

The President's Budget also announces plans for several initiatives that the Administration will implement through either regulatory or sub-regulatory guidance.

Clarify Inflation Protection in Partnership LTC Programs: Establishes that long-term care insurance policies that include Future Purchase Option inflation protection do not qualify as Partnership policies.

Issue Regulation Defining 1915(b)(3) Services: Specifies which services are allowable for managed care savings under section 1915(b)(3) of the Social Security Act.

Performance Highlight

Increase the number of States that demonstrate improvement related to access and quality health care through the Medicaid Quality Improvement Program: CMS has a performance measure tracking States participation in the Medicaid Quality Improvement Program, which seeks to help States achieve safe, effective, efficient, timely, equitable, and patient-centered care. CMS has a target of eight States participating in FY 2008, and nine states in FY 2009. The program was first implemented in FY 2007, the baseline year.

Issue Free Care Regulation: Codifies in regulation the long-standing Medicaid "free care" policy. Under this policy, providers cannot bill Medicaid for services furnished to the public and other payors at no cost.

RECENT PROGRAM DEVELOPMENTS

Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173)—Medicaid Related Provisions

SCHIP: Amends Title XXI to extend SCHIP funding through March 31, 2009. (See the SCHIP section for more information.)

Extension of Transitional Medical Assistance and Qualified Individuals Programs: Extends TMA and QI programs through June 30, 2008.

Extension of Disproportionate Share Hospital (DSH) Allotment Adjustments: Amends Title XIX to extend the Medicaid DSH allotments for the States of Tennessee and Hawaii, with adjustments through June 30, 2008.

Regulation Implementation Moratoria: Prohibits the Secretary of Health and Human Services from taking action before June 30, 2008 to impose any restrictions relating to Medicaid coverage or payment for rehabilitation services or school-based administration and school-based transportation, if such restrictions are more restrictive in any aspect than those applied to such areas as of July 1, 2007.

Implementation of Tamper-Resistant Prescription Pads: A requirement that all paper Medicaid prescriptions be written on "tamper-resistant" pads was included in P.L. 110-28. Subsequent legislation, P.L. 110-90, delayed implementation of the pads' use through March 31, 2008. This proposal was included in the FY 2008 President's Budget.

Final Rule: Eliminate Inappropriate Claiming for School-Based Services: To address long-standing concerns about improper billing by school districts as determined by both HHS's Inspector General and the Government Accountability Office, this final rule specifies that Federal financial participation under the Medicaid program will not be available for school-based administrative and certain transportation costs. Final rule published December 28, 2007; moratorium issued in P.L. 110-173 which prevents implementation through June 30, 2008.

Proposed Rule: Clarify Rehabilitation Services: This proposed rule defines allowable services that may be claimed as rehabilitation services and excludes payments for services intrinsic to programs other than Medicaid. Proposed rule published August 13, 2007; moratorium issued preventing implementation through June 30, 2008 in P.L. 110-173.

Proposed Rule: Eliminate Medicaid Graduate Medical Education (GME): This proposed rule would clarify that costs associated with GME programs are not considered medical assistance expenditures and thus not eligible for Federal Medicaid funding. Proposed rule published May 23, 2007; moratorium issued preventing implementation through May 25, 2008 in P.L. 110-28.

Final Rule: Revise Payments for Government Providers: This rule builds on past CMS efforts to curb questionable financing practices by recovering Federal funds that are diverted from government providers and retained by the State, and caps payments to government providers to no more than the cost of furnishing services to Medicaid beneficiaries. Final rule displayed at the Federal Register May 25, 2007; moratorium issued preventing implementation through May 25, 2008 in P.L. 110-28.

Reducing Erroneous Payments: In FY 2007, CMS nationally implemented the Payment Error Rate Measurement (PERM) program to measure improper payments in Medicaid and SCHIP and to comply with the Improper Payments Information Act of 2002 (P.L.107-300). PERM includes reviews of fee-for-service and managed care claims, as well as beneficiary eligibility reviews. HHS expects to report a comprehensive error rate for Medicaid and SCHIP in 2009. After rates are established, States will analyze findings, identify causes of errors, and develop and implement corrective action plans.

MEDICAID AND SCHIP PROPOSALS

(outlays in millions)

	2009	2009 -2013
Medicaid Legislative Proposals		
Maintain Substantial Home Equity Amount at $500,000	-80	-480
Redesign Acute Care Benefits for Optional LTC Groups	-20	-650
Repeal Section 1932(a)(2) Special Rules	-100	-2,100
Extend Section 1915(b) Waiver Period	--	--
Replace Best Price with Budget Neutral Rebate	--	--
Rationalize Pharmacy Reimbursement	-195	-1,110
Enhance Third Party Liability	-35	-470
Modify Asset Verification	-82	-1,200
Publish Annual Actuarial Report	--	--
Implement Cost Allocation	-280	-1,770
Implement Medicaid Pay-for-Performance Incentives	--	-310
Require State Participation in PARIS	-5	-135
Mandate National Correct Coding Initiative	-5	-105
Align Administrative Match Rates	-950	-5,485
Align Family Planning Match Rate	-570	-3,335
Align Case Management Match Rate	-200	-1,100
Align Qualified Individuals (QI) Program Match Rate /1	-200	-200
Extend QI Program /2	+470	+470
Extend Transitional Medical Assistance (TMA)	+485	+695
Modify HIPAA	--	--
Increase Flexibility for Premium Assistance	--	-140
Subtotal, Medicaid Legislative Proposals	-1,767	-17,425
Other Medicaid Interactions		
Extend Refugee Exemption	+32	+92
SCHIP Reauthorization (Medicaid Impact)	+130	+235
QI Adjustment /2	-270	-270
Total, Medicaid Legislative Proposals	**-1,875**	**-17,368**
SCHIP Legislative Proposals		
SCHIP Reauthorization	+2,105	+18,685
[Allotments (non-add)]	*[1,500]*	*[19,740]*
Total Outlays, SCHIP Legislative Proposals	**+2,105**	**+18,685**
Total, Medicaid and SCHIP Legislative Proposals	**+230**	**+1,317**
Medicaid Administrative Actions		
Clarify Inflation Protection in Partnership LTC Programs	--	--
Issue Regulation Defining 1915(b)(3) Services	-100	-800
Issue Free Care Regulation	--	--
Total, Medicaid Administrative Actions	**-100**	**-800**

1/ Assumes extension of QI Program.

2/ States pay the Medicare Part B premium costs for QIs, which are in turn offset by a reimbursement from Medicare Part B of $270 million in FY 2009 to the Federal Medicaid program. The result is a net Medicaid impact of zero.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Current Law:				
Total Outlays	6,000	7,600	6,097	-1,503
Proposed Law:				
Total Outlays	6,000	7,600	8,202	+602

The Balanced Budget Act of 1997 (BBA) (P.L. 105-33) created the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. The FY 2009 Budget includes a robust SCHIP reauthorization proposal, fully offset within health care entitlements.

SCHIP is a partnership between Federal and State Governments that helps provide low-income children with the health insurance coverage they need. The program improves access to health care and quality 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 BBA appropriated almost $40 billion in mandatory funding to the program over 10 years (FY 1998 through FY 2007). The "Medicare, Medicaid, and SCHIP Extension Act of 2007" (P.L. 110-173) recently provided additional funding for the program through March 2009. 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. For FY 2009, the highest match rate is 83.09 percent.

States have a high degree of flexibility in designing their programs. They can implement SCHIP by:

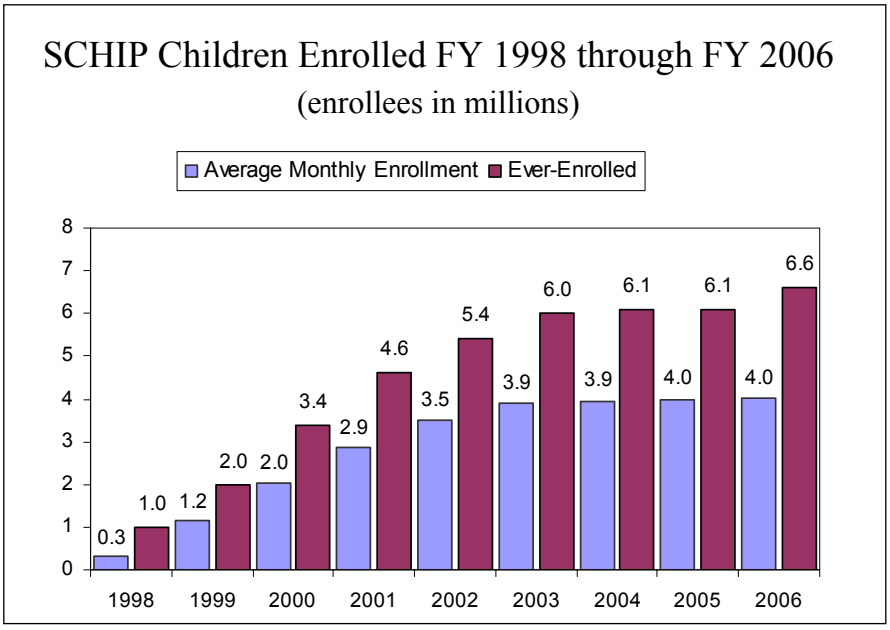
- Expanding Medicaid;
- Creating a new, non-Medicaid Title XXI separate State program; or
- A combination of both approaches.

Generally, SCHIP targets Medicaid-ineligible uninsured children who are under 19 years old from families with incomes at or below 200 percent of the Federal poverty level (FPL).

IMPLEMENTATION AND ENROLLMENT

Every State, the District of Columbia, and all five Territories have had approved SCHIP plans since September 1999. As of October 2007, States and Territories have received approval for 14 Medicaid expansion programs, 18 separate programs, and 29 combination programs. As of January 18, 2008, 303 State plan amendments have been approved.

As of January 2, 2008, 7 States cover children in families with income below 200 percent of the FPL, and 24 States cover children in families with incomes at 200 percent of the FPL. Nineteen States and the District of Columbia cover children above that level. Of the 20, 11 States cover



children up to and including 300 percent of the FPL. One State, New Jersey, covers children up to 350 percent of the FPL. During FY 2006, 6.6 million children were enrolled at any time during the year in SCHIP. This represents an increase of approximately 473,000 children, or 7.7 percent, over FY 2005 enrollment.

Performance Highlight

When SCHIP began in FY 1998, CMS adopted a goal of enrolling five million children by FY 2005. CMS exceeded this enrollment goal by over a million children. Looking forward, CMS has created a new performance goal focused on increasing enrollment in SCHIP through FY 2012. Targets include:

- Increasing FY 2009 enrollment 3 percent over FY 2006.
- Increasing FY 2012 enrollment 12 percent over FY 2006.

Legislative Proposals

SCHIP Reauthorization*:* The President's Budget includes a robust proposal that refocuses SCHIP on low-income children, increasing SCHIP State allotments by $19.7 billion through FY 2013. As a result of these additional resources, the Administration estimates that in 2013, 5.6 million children on average would be enrolled in SCHIP, or nearly nine million children enrolled at some time during the year (see text box for more information).

Outreach Grants*:* Proposes annual outreach grants of $50 million in FY 2009, and $100 million in each of the following four years (further discussed in the State Grants and Demonstrations section) to States, localities, schools, and community-based organizations to enroll uninsured children eligible for Medicaid and SCHIP.

Recent Program Developments

Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173)

FY 2008 and FY 2009 Funding: Funding for SCHIP expired at the end of FY 2007. The Extension Act provides additional allotments for States, Commonwealths, and Territories for FY 2008 and FY 2009, available through March 2009. In addition, the Act provides funding for States with projected spending in excess of available funding.

Use of certain SCHIP funds for Medicaid Expenditures: Extends the ability of certain "qualifying States" to use up to 20 percent of available SCHIP allotment amounts for FY 2008 and FY 2009 through March 2009 as Federal matching funds to provide medical assistance under Medicaid for individuals under age 19 who are not eligible for SCHIP and whose family income exceeds 150 percent of the FPL. "Qualifying States" are those States that, prior to the implementation of SCHIP, were providing medical assistance to this population under Medicaid.

U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110-28)

Provided an additional $650 million for States experiencing FY 2007 spending in excess of available funding.

August 17, 2007 State Health Official Letter (Crowd-Out Policy)

CMS clarified how existing statutory and regulatory requirements regarding crowd-out apply to States covering, or seeking to cover, children above 250 percent of the FPL, to prevent the substitution of SCHIP for private insurance.

SCHIP Reauthorization Proposal

The President's Budget proposes $19.7 billion in increased State allotment funding through FY 2013 to ensure low-income children, not eligible for Medicaid, receive coverage. As a result of these additional resources, the Administration estimates that in 2013, 5.6 million children would be enrolled in SCHIP on-average, or nearly nine million children enrolled at some time during the year. In addition, the proposal:

- Provides funding to meet anticipated State need in covering low-income, uninsured children.
- Includes annual outreach grants of $50 million in FY 2009 and $100 million in each of FY 2010 through 2013 to reach SCHIP and Medicaid eligible uninsured children.
- Continues efforts to prevent the substitution of SCHIP for private insurance.
- Clarifies eligibility for SCHIP by clearly defining income.
- Transitions adults from SCHIP to Medicaid.

SCHIP Performance

When SCHIP began in FY 1998, CMS adopted a goal of enrolling five million children by FY 2005. CMS exceeded this enrollment goal by over a million children. Now, CMS is focusing on increasing enrollment by 12 percent over FY 2006. (See text box.)

STATE GRANTS AND DEMONSTRATIONS

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Current Law Budget Authority:				
Program of All-Inclusive Care for the Elderly (PACE):				
PACE Rural Site Development Grants	--	--	--	--
PACE Fund for Outlier Costs /1	--	--	--	--
Survey of Retail Drug Prices	5	5	5	--
Partnership for Long Term Care	3	3	3	--
Medicaid Integrity Program	50	50	75	+25
Alternate Non-Emergency Network Providers	--	--	--	--
Psychiatric Residential Treatment Demo. and Evaluation	22	37	49	+12
Money Follows the Person (MFP):				
MFP Demonstration	248	299	349	+50
MFP Evaluations and Technical Support	2	1	1	--
Medicaid Transformation Grants	75	75	--	-75
Katrina Relief	--	--	--	--
Qualified High-Risk Pool Grant Programs /2	--	--	--	--
Katrina/ Rita Hurricane Support	--	--	--	--
Emergency Services for Undocumented Aliens	250	250	--	-250
State Pharmaceutical Assistance Program	--	--	--	--
Background Check - Direct Patient Access	--	--	--	--
Ticket to Work Grant Programs	43	44	45	+1
Total, Budget Authority	**698**	**764**	**527**	**-237**
Current Law Outlays:				
Katrina/ Rita Hurricane Support	41	0.2	--	--
Program of All-Inclusive Care for the Elderly (PACE):				
PACE Rural Site Development Grants	0.3	7	--	-7
PACE Fund for Outlier Costs /1	--	5	3	-3
Survey of Retail Drug Prices	2	3	3	--
Partnership for Long Term Care	3	3	3	--
Medicaid Integrity Program	7	97	75	-22
Alternate Non-Emergency Network Providers	--	28	22	-6
Psychiatric Residential Treatment Demo. and Evaluation	3	33	42	+9
Money Follows the Person (MFP):				
MFP Demonstration	2	217	348	+132
MFP Evaluations and Technical Support	--	1	2	+1
Medicaid Transformation Grants	3	72	75	+3
Katrina Relief	876	163	--	-163
Qualified High-Risk Pool Grant Programs /2	54	13	--	-13
Emergency Services for Undocumented Aliens	208	221	221	--
State Pharmaceutical Assistance Program	20	--	--	--
Background Check - Direct Patient Access	9	8	--	-8
Ticket to Work Grant Programs	45	57	65	+8
Total, Outlays	**1,275**	**929**	**859**	**-71**

1/ PACE outlier funding was re-appropriated in FY 2007 pursuant to the Tax Relief and Health Care Act of 2006.

2/ The Consolidated Appropriations Act, 2008 (P.L. 110-161), directed CMS to provide $49 million for State high risk insurance pools for FY 2008, which will be administered in the Program Management budget.

STATE GRANTS AND DEMONSTRATIONS

The State Grants and Demonstrations budget funds a diverse group of program activities that impact a variety of intended targets. The Deficit Reduction Act of 2005 (DRA) (P.L. 109-171), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L. 108-173) added many new activities to this account. Selected program activity highlights follow.

LEGISLATIVE PROPOSALS

Qualified High-Risk Pools

The President's FY 2009 Budget proposes $75 million in both FY 2009 and 2010 for grants to help States offer health insurance options to hard-to-insure populations as authorized by the State High Risk Pool Extension Act of 2006 (P.L. 109-172).

Outreach Grants

The President's FY 2009 Budget proposes annual outreach grants of $50 million in FY 2009, and $100 million in each of the following four years to States, localities, schools, and community-based organizations to enroll low-income uninsured children eligible for Medicaid and SCHIP.

RECENT PROGRAM DEVELOPMENTS

DEFICIT REDUCTION ACT (P.L. 109-171)

Survey of Retail Drug Prices

Section 6001 of the DRA requires the Secretary to contract with a vendor to conduct a survey of retail prices. Five million dollars has been appropriated for each of FY 2006 through FY 2010.

Expansion of State Long-Term Care Partnership Program

The expansion of the State Long-Term (LTC) Care Partnership Program, enacted under section 6021 of the DRA, established authority for all States to implement LTC partnership plans that provide a dollar for dollar disregard of assets or resources equal to the insurance benefit payments on behalf of the individual. The provision bestows standards for reciprocity among partnership States unless they notify the Secretary of their decision to exempt themselves. The DRA provides $3 million in each of FY 2006 through FY 2010 for a National Clearinghouse for LTC to educate beneficiaries on all types of LTC insurance. In addition, the DRA provides $1 million over the same period for annual reports to Congress on the status of the Partnership for LTC Programs.

Medicaid Integrity Program

The Medicaid Integrity Program (MIP) was established by section 6034 of the DRA and was implemented in FY 2006. Congress has appropriated resources to the MIP as follows: $5 million in FY 2006; $50 million in each of FY 2007 and 2008; and, $75 million in FY 2009, and for each year thereafter. The Secretary is promoting Medicaid integrity by entering into contracts with eligible entities to carry out certain specified activities including reviews, audits, identification of over-payments, education, and technical support to States.

Alternate Non-Emergency Network Providers

Section 6043 of the DRA affords a State the option to impose higher cost sharing for non-emergency care furnished in a hospital emergency department without a waiver and authorized $50 million in Federal grant funds over FY 2006 through FY 2009 to establish alternate non-emergency service providers or networks of providers. CMS released the solicitation on August 15, 2007 and expects to make all awards before the end of FY 2008.

Home and Community-Based Services Alternatives to Psychiatric Residential Treatment Facilities for Children

The five-year demonstration authorized by section 6063 of the DRA provided up to 10 States with funds totaling no more than $217 million with the opportunity to provide home and community-based services to individuals under the age of 21 as alternatives to psychiatric residential treatment facilities.

Money Follows the Person Demonstration

Section 6071 of the DRA established this demonstration which allows States to work towards sustaining their Medicaid programs while helping individuals achieve independence. States are awarded competitive grants along with an increased Medicaid matching rate for transitioning individuals from an institutional setting to a qualified home or community-based setting. The DRA appropriated $1.75 billion over five years (FY 2007-2011) for this demonstration. Thirty-one grants were awarded to States totaling $1.4 billion in FY 2007.

Medicaid Transformation Grants
Established by section 6081 of the DRA, this program provides new grant funds to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under Medicaid. Congress authorized and appropriated $75 million in each of FY 2007 and 2008. CMS awarded all $150 million in FY 2007 to 42 States and Puerto Rico through two grant solicitation rounds.

Qualified High-Risk Pools
State high-risk health insurance pools target certain individuals who cannot otherwise obtain or afford health insurance in the private market, primarily due to pre-existing health conditions. In general, high-risk pools are operated through State established non-profit organizations, many of which contract with private insurance companies to collect premiums, administer benefits, and pay claims.

Through the State High Risk Pool Extension Act of 2006 (P.L. 109-172), Congress authorized $75 million in grant monies for each of FY 2007 through 2010. The Consolidated Appropriations Act, 2008 (P.L 110-161), directed CMS to provide $49 million for State high risk health insurance pools for FY 2008, which will be administered in the Program Management budget.

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT (P.L. 108-173)

Federal Reimbursement of Emergency Health Services Furnished To Undocumented Aliens
Section 1011 of the MMA appropriated $250 million for each of FY 2005 through FY 2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified non-citizens who are not eligible for Medicaid. Two-thirds of these funds ($167 million) have been allotted for paying providers in all 50 States and the District of Columbia, based on their relative percentages of the total number of undocumented aliens. The remaining one-third ($83 million) was for providers located in the six States with the largest number of undocumented alien apprehensions.

The Secretary must directly pay hospitals, certain physicians, and ambulance providers, including Indian Health Service and Tribal organizations, for unreimbursed costs of providing services required by the emergency service provision of the Social Security Act.

TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT (TWWIIA) (P.L. 106-170)

The 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 working people with disabilities by extending Medicaid coverage to these individuals.

Section 203 of the Act provided grants to States to build infrastructure to help individuals with disabilities gain employment and retain their health care coverage. Through FY 2007, the most recent year funding was available, 49 States and the District of Columbia were approved for Section 203 funding.

Section 204 of the Act established a demonstration to provide health care coverage to workers who have physical or mental impairments that, without medical assistance, would potentially end up on disability. Currently, seven States and the District of Columbia have been awarded funding for Demonstrations to Maintain Independence. The demonstrations will be used to evaluate the impact of providing Medicaid benefits to a working person with a potentially severe disability.

PROGRAM MANAGEMENT

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Discretionary Administration				
Medicare Operations	2,183	2,159	2,340	+181
Survey and Certification	258	281	293	+12
Federal Administration	642	631	643	+12
Research	57	31	31	--
High-Risk Insurance Pools	--	49	--	-49
Total, Discretionary	**3,141**	**3,152**	**3,307**	**+156**
Mandatory Administration /1				
Tax Relief and Health Care Act	105	--	--	--
Medicare, Medicaid, and SCHIP Extension Act	--	115	--	-115
Total, Mandatory	**105**	**115**	**--**	**-115**
Subtotal, Discretionary and Mandatory	**3,246**	**3,267**	**3,307**	**+41**
Reimbursbale Administration				
Reimbursable Spending /2	224	141	178	+37
User Fees /2	-224	-141	-178	-37
Survey and Certification User Fee Proposal	--	--	-35	-35
Program Total	**3,246**	**3,267**	**3,272**	**+6**
FTE /3	4,526	4,477	4,457	-20

1/ Directed administrative spending under the Tax Relief and Health Care Act of 2006 and the Medicare, Medicaid, and SCHIP Extension Act of 2007 are not included above breakout.
2/ Includes Clinical Laboratory Improvement Act of 1988, data spending, coordination of benefits for the Medicare prescription drug program, and MA/prescription drug program information campaign.
3/ The FTE totals include HCFAC and State Grants funded FTEs. CMS will fund the following FTEs from the HCFAC and State Grants accounts: FY 2007 - 121 FTEs; FY 2008 - 160 FTEs; FY 2009 - 200 FTEs.

The FY 2009 discretionary budget request for CMS Program Management is about $3.31 billion, a net increase of $156 million over enacted FY 2008. The Budget again proposes a user fee on health care facilities for certain revisit surveys. This fee, if enacted, will offset the CMS appropriation request by $35 million, to $3.27 billion on a proposed law basis.

With the funding requested for FY 2009, CMS will achieve its priority goals: continue operation of the new drug benefit; maintain implementation of Medicare contracting reform and durable medical equipment (DME) competitive bidding; sustain beneficiary education efforts; survey health facilities at mandated frequencies; make targeted investments in IT; conduct a basic level of research; and administer basic operations.

BUDGET ACCOUNT SUMMARIES

Medicare Operations: The Medicare Operations budget request is $2.3 billion, an increase of $181 million, or 2.9 percent, above FY 2008. The bulk of the CMS Program Management budget, or 71 percent, is spent on Medicare Operations. Medicare Operations funds mission-critical contractor and IT activities necessary to administer the Medicare program and implement

Medicare Contracting Reform Transition Schedule

Projected Completion Date	Medicare Administrative Contractor to be Transitioned	Number of Contractors
CY 2006	Durable Medical Equipment	4
CY 2007	Part A/B	1
CY 2008	Part A/B - Cycle 1	7
CY 2009	Part A/B - Cycle 2	7

activities required by legislation. Top priority activities for FY 2009 include:

Contracting Reform: The Budget requests $108.9 million to implement contracting reform. CMS is on track to implement this important reform before the 2011 target set in the MMA.

Contracting reform will transform Medicare claims processing from 40 cost-based contracts to 15 performance-based, competitive contracts (plus four specialty contractors). In 2008, CMS will have awarded 12 of the 19 competitive Medicare Administrative Contracts (MACs). In FY 2009, CMS plans to award an additional 7 MACs and begin transferring Medicare claims workloads to these new contractors, depending on appropriations. The FY 2009 request will allow CMS to transition all 19 contracts by the end of FY 2009.

Contracting reform is projected to generate significant administrative savings to the government and providers by reducing the cost of processing Medicare claims, and will yield $2.7 billion in Trust Fund savings over the next five years through more accurate and appropriate payments. Contracting reform includes other features that will introduce greater competition and accountability to the Medicare contracting process:

- Removes the distinction between Part A and Part B contractors;
- Removes the restriction limiting claims processing contracts to health insurance companies;
- Allows renewal of contracts annually for up to five years;
- Requires that all contracts be re-competed at least every five years;
- Limits contractor liability; and
- Allows incentive payments to improve contractor performance.

Durable Medical Equipment Competitive Bidding: MMA required CMS to implement a new competitive bidding model to pay for certain DME by 2009. The request includes $47.5 million to establish the administrative structure to support this requirement. DME competitive bidding is projected to yield significant mandatory Trust Fund savings totaling about $5.3 billion over the next five years.

Ongoing Contractor Operations and Support: About half, or about $1.0 billion, of the FY 2009 Medicare Operations request supports ongoing contractor operations, 5 percent above the current FY 2008 level. Contractors will process an estimated 1.3 billion fee-for-service claims in FY 2009, a 2 percent increase over FY 2008.

Beneficiary Education and Outreach: Medicare Operations includes $318.7 million for mandated and other beneficiary education and outreach activities through the National Medicare & You Education Program (described in a later section).

Healthcare Integrated General Ledger and Accounting System (HIGLAS): The Budget requests $162.1 million for HIGLAS, a state-of-the-art accounting system for CMS. HIGLAS is an important fiscal and program integrity tool, necessary to achieve a clean Chief Financial Officer audit opinion. Of this total, $126.4 million supports ongoing HIGLAS operations at 14 contractors that will be "live" at the end of FY 2008, plus 7 new contractors in FY 2009. The remaining $35.7 million will be used to develop additional HIGLAS modules. Through 2011, HIGLAS is projected to yield $560 million in benefits that would not otherwise have been realized.

IT Systems and Other Supporting Activities: The Budget includes $374.8 million for IT activities (excluding IT to support activities described above) and other support activities. This includes funding for systems to manage and administer Medicare Advantage and the new Part D benefit, CMS's data center and telecommunications infrastructure, funding for HIPAA, qualified independent contractor appeals, and the CFO audit.

This amount also includes $40.3 million to begin converting to ICD-10, a classification system of diseases, injuries, and medical conditions developed by the World Health Organization. The ICD-10

code set, currently used by much of the industrialized world, will make it easier to determine if a claim was appropriately billed, provide more specific data necessary for value-based purchasing, and help prevent fraud and abuse.

Federal Administration: For FY 2009, the President's Budget requests $643.2 million for CMS Federal administrative costs, $12 million above the FY 2008 level.

Of this total, $522.2 million will support a complement of 4,148 direct Full Time Equivalents in FY 2009. CMS will continue to support the Healthy Start, Grow Smart program. The program pays for printing costs and postage for a series of 13 informational brochures in English, Spanish, Chinese, and Vietnamese to new Medicaid mothers.

Research, Demonstrations and Evaluation: The FY 2009 Research, Demonstrations and Evaluation budget request is $31.3 million, which maintains the FY 2008 level.

This request fully funds the Medicare Current Beneficiary Survey (MCBS) at $14.4 million. The MCBS, a continuous, multi-purpose survey that represents the Medicare population, aids CMS in monitoring and evaluating the Medicare program. The Budget also includes $7.5 million to fund Real Choice Systems Change grants. These grants will assist States in designing and implementing improvements to community-based support systems that enable people with disabilities and long-term illnesses to live and participate in community life.

The Budget includes $3.8 million to fund the second year costs of implementing a multi-year demonstration project that will encourage physician practices to adopt electronic health records (EHRs). The demonstration design will show that streamlining health care management with EHRs will reduce medical errors and improve quality of care for 3.6 million Americans. The program will provide financial incentives for up to 1,200 physician practices using certified EHRs to meet certain clinical quality measures. CMS anticipates that the adoption of EHRs will produce savings for Medicare over time by improving the quality of care.

Survey and Certification Frequencies

Type of Facility	2007	2008	2009
Long-Term Care Facilities*	Every Year	Every Year	Every Year
Home Health Agencies*	Every 3 Years	Every 3 Years	Every 3 Years
Accredited Hospitals	1.5% Per Year	1% Per Year	1% Per Year
Non-Accredited Hospitals	Every 4.4 Years	Every 5 Years	Every 5 Years
Organ Transplant Facilities	N/A	Every 3 Years	Every 3 Years
ESRD Facilities	Every 4 Years	Every 4 Years	Every 4.6 Years
Hospices, Outpatient Physical Therapy, Outpatient Rehabilitation, Portable X-Rays, Rural Health Clinics, and Ambulatory Surgical Centers	Every 14 Years	Every 10 Years	Every 11.5 Years

*Legislatively Mandated

The remaining $5.6 million supports ongoing basic research, such as monitoring prospective payment systems and evaluating MMA and DRA demonstrations and pilots.

Survey and Certification: The FY 2009 Survey and Certification budget request is $293 million. This program works to ensure the safety of beneficiaries and the quality of care provided in health facilities – two critical CMS responsibilities. All facilities participating in the Medicare and Medicaid programs must undergo an inspection when entering the program, and on a regular basis thereafter, to ensure compliance with Federal health, safety, and program standards. CMS contracts with State agencies to conduct these inspections.

To ensure survey frequency levels are sufficient to safeguard patient safety and quality, the Budget requests an increase of $12 million, or 4 percent, over FY 2008. This

National Medicare & You Education Program

(dollars in millions)

National *Medicare & You* Education Program (NMEP)

FY 2008 Program Level Request in Millions

Activity	2008	2009
Beneficiary Materials (e.g. Handbook).....	42.5	50.4
1-800-MEDICARE Toll Free Line/1.....	256.1	268.5
Internet.....	16.9	18.4
Community-Based Outreach /2.....	57.6	41.9
Program Support Services /3.....	18.5	17.4
Total, NMEP Program Level/4.....	**$391.6**	**$396.6**

/1 Includes funding previously allotted to Medicare contractors for claims-related inquiries
/2 Includes State Health Insurance and Assistance Program (SHIP) grants
/3 Includes multi-media campaign and consumer research
/4 Includes funding from Program Management, user fee, QIO, and the Medicare, Medicaid, and SCHIP Extension Act of 2007

request will allow States to inspect long-term care facilities and home health agencies at their legislatively mandated frequencies and to nearly maintain FY 2008 survey frequencies for all other facility types (see table on previous page). This funding is essential to continue to improve the quality of care in nursing homes through rigorous survey and enforcement processes.

CMS expects States to complete over 23,000 certifications and over 44,000 complaint visits in FY 2009, an increase of approximately 2,700 visits over the FY 2008 level. Between FY 2002 and FY 2009, the number of Medicare-certified facilities increased by 16 percent. The FY 2009 Budget directs resources toward surveying non-statutory facilities, such as hospitals and ambulatory surgical centers, to ensure appropriate oversight of these providers.

OTHER CMS ADMINISTRATIVE ACTIVITIES

The National Medicare & You Education Program (NMEP): The total FY 2009 program level for NMEP is $397 million, an increase of $5 million from the FY 2008 level which includes $15 million from the Medicare, Medicaid, and SCHIP Extension Act of 2007. The FY 2009 NMEP program level includes funding from Program Management, MMA user fees, and QIOs. Beneficiary education remains a top priority for CMS, as recent enhancements to Medicare have given beneficiaries more responsibility for making their own health care decisions.

The bulk of the NMEP request – $268.5 million, or 70 percent – supports 1-800-MEDICARE, which provides customer service in English and Spanish 24 hours per day, seven days per week. Compared to the FY 2008 level, the call center request is $12.4 million higher. CMS anticipates approximately 34.5 million calls in FY 2009 and call wait times at about eight minutes throughout the year. The remaining NMEP funding supports other important beneficiary education activities. About $50.4 million will be used to distribute more than 42 million Medicare & You handbooks, approximately 1 million more than in FY 2008. Another $18.4 million will support CMS's websites which provide interactive decision-making tools for beneficiaries and important information for providers. Internet usage continues to grow. In FY 2009, CMS expects 470 million page views at www.medicare.gov, 15 million over FY 2008. As one-on-one counseling is the best method to help beneficiaries navigate their health plan options, the Budget allocates $41.9 million for State Health Insurance Assistance Program (SHIP) grants and other community-based outreach. More than 13,000 counselors in over 1,300 community-based organizations will provide one-on-one assistance to beneficiaries on complex Medicare-related topics. Finally, NMEP includes $17.4 million for support services, including a multimedia advertising campaign.

Legislation Supporting the Discretionary Budget:
The FY 2009 Budget includes $35 million in user fees to finance survey and certification activities. CMS would charge revisit user fees to health care facilities cited for deficiencies during initial certification, recertification or substantiated complaint surveys. This proposal would recover from industry the costs associated with corrective action follow-up surveys. This fee will build greater accountability into the survey and certification program and create an incentive for facilities to correct deficiencies and ensure quality of care.

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ADMINISTRATION FOR CHILDREN AND FAMILIES

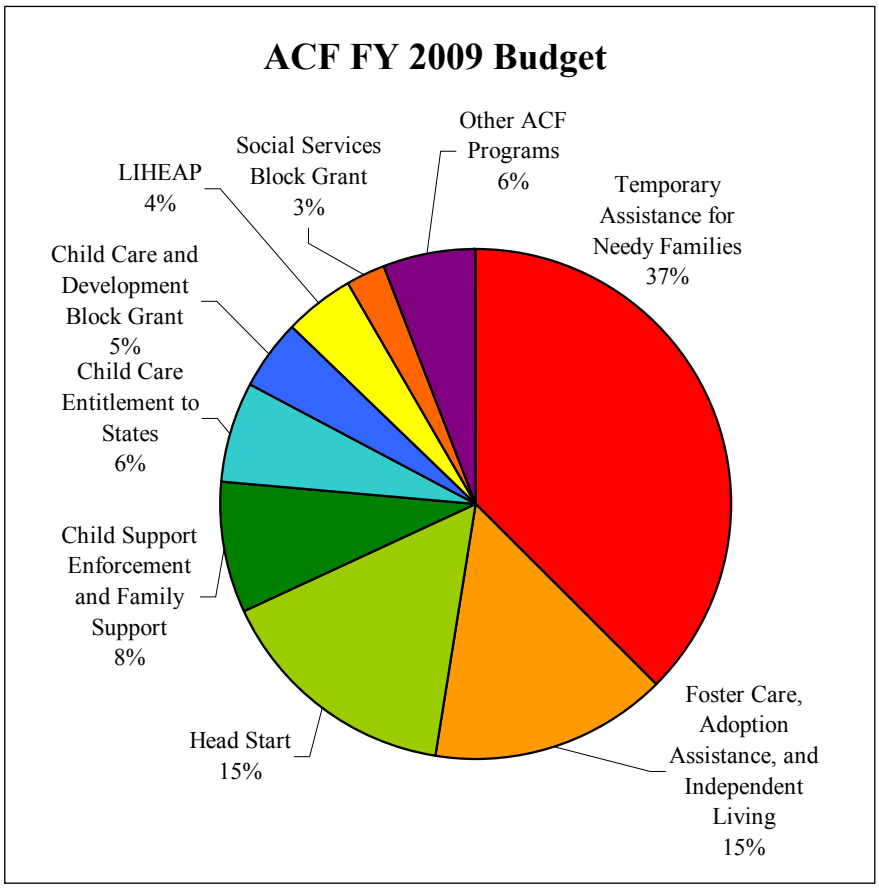
(dollars in millions)

	2007	2008	2009	2009 +/-2008
Discretionary				
Program level	13,899	14,382	13,307	-1,076
Budget Authority	13,839	14,322	13,247	-1,075
Entitlement				
Program Level /1	33,353	32,974	32,254	-720
Total, ACF Program level	**47,252**	**47,356**	**45,561**	**-1,796**

/1 Entitlement program level reflects proposed reduction in the authorized funding level for the Social Services Block Grant, which scores as discretionary savings in FY 2009. It does not reflect funding for mandatory abstinence which is included in discretionary program level.

The Administration for Children and Families promotes the economic and social well-being of children, youth, families, and communities, focusing particular attention on vulnerable populations, such as children in low-income families, refugees, Native Americans, and people with developmental disabilities.

The FY 2009 Budget request for the Administration for Children and Families (ACF) is $45.6 billion, a net decrease of $1.8 billion from FY 2008. ACF administers over 60 programs to fulfill its mission of serving America's children and families. The discretionary Budget includes additional funding for Head Start, a new initiative to help families recover from disasters, Adoption Incentives, the Compassion Capital Fund, and Abstinence-Only Education. The mandatory Budget includes $17.1 billion for Temporary Assistance for Needy Families (TANF), $6.9 billion for Foster Care and related programs, $3.8 billion for Child Support Enforcement and Family Support, and a proposed reduction of $500 million to the Social Services Block Grant.



ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY SPENDING

(dollars in millions)

	2007	2008	2009	2009 +/-2008
Head Start	6,889	6,878	7,027	+149
Disaster Human Services Case Management	--	--	10	+10
Children's Programs				
Adoption Incentives	5	4	20	+15
Adoptions, Children's Health Act	13	12	12	--
Child Abuse Programs	95	105	105	--
Home Visitation (non add)	--	*10*	*10*	--
Child Welfare Programs	333	327	327	--
Promoting Safe and Stable Families (discretionary)	89	63	63	--
Independent Living (Vouchers)	46	45	45	--
Runaway and Homeless Youth Programs	103	113	113	--
Child Care & Development Block Grant (discretionary)	2,062	2,062	2,062	--
Subtotal, Children's Programs	2,746	2,743	2,759	+15
Faith and Community Based Organizations				
Compassion Capital Fund (CCF)	64	53	75	+22
Communities Empowering Youth (non-add)	*30*	*30*	*35*	*+5*
Mentoring Children of Prisoners	49	*49*	50	+1
Center for Faith-Based and Community Initiatives	1	1	1	--
Subtotal, Faith and Community Based Programs	115	103	126	+24
Abstinence				
Community Based Grants (discretionary)	109	109	137	+28
State Grants (mandatory) *	50	50	50	--
PHS Evaluation Funds	5	5	4	-0.1
Subtotal, Abstinence Program Level	163	163	191	+28
Refugee Programs				
Transitional and Medical Services	266	296	287	-9
Unaccompanied Alien Children	95	133	114	-19
Other Refugee Programs	227	227	227	--
Subtotal, Refugee Programs	588	656	628	-28
LIHEAP				
State Formula Grants	1,980	1,980	1,700	-280
Emergency Contingency Fund	181	590	300	-290
Subtotal, LIHEAP	2,161	2,570	2,000	-570
Developmental Disabilities	171	180	180	--
Violent Crime Reduction	128	125	125	--
Native Americans	44	46	46	--
Community Services Programs	695	722	24	-698
Assets for Independence (non add)	*24*	*24*	*24*	--
Social Services Research & Demonstration	12	21	6	-15
PHS Evaluation Funds (non add)	*6*	*6*	*6*	*-0.2*
Federal Administration	188	184	195	+11
Total, Program Level	**13,899**	**14,382**	**13,307**	**-1,076**
Less Funds From Other Sources				
Abstinence, State Grants	-50	-50	-50	--
PHS Evaluation Funds	-11	-11	-10	+0.3
Total Discretionary Budget Authority	**13,839**	**14,322**	**13,247**	**-1,075**
Social Services Block Grant discretionary savings	--	--	-500	-500
Total Scoreable Discretionary Budget Authority	**13,839**	**14,322**	**12,747**	**-1,575**
FTE (including those financed with mandatory funds)	1,229	1,299	1,299	--

* Proposed legislation will reauthorize this program, providing $50 million in both FY 2008 and FY 2009.

ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY SPENDING

The FY 2009 discretionary Budget request for ACF is $13.2 billion, a net decrease of $1.1 billion from FY 2008. Including the $500 million in discretionary savings from reducing the Social Services Block Grant, the FY 2009 discretionary Budget is $1.6 billion less than FY 2008. Additional funding is requested for Head Start, a new initiative to develop a disaster human services case management system, Adoption Incentives, the Compassion Capital Fund, and Abstinence-Only Education. Consistent with both the FY 2007 and FY 2008 Budgets, the request for the Low Income Home Energy Assistance Program (LIHEAP) is below the prior year and funds are not requested for the Community Services Block Grant.

GIVING KIDS A HEAD START

The Budget request funds Head Start at $7 billion, an increase of $149 million over FY 2008, to maintain enrollment at FY 2008 levels and provide approximately 895,000 children with comprehensive child-development services, including 61,000 children in Early Head Start. Head Start programs help low-income children arrive at school ready to learn by enhancing their social and cognitive development. Since the program began in 1965, it has served nearly 25 million children.

Improving Head Start

On December 12, 2007, President Bush signed the Improving Head Start Act of 2007. The Act reauthorized the Head Start program and will help ensure its continued success by increasing competition among Head Start providers, improving coordination of early childhood delivery systems, and strengthening education performance standards.

MEETING HUMAN SERVICE NEEDS AFTER DISASTERS

Hurricanes Katrina and Rita affected over one million people, many of whom suddenly found themselves in need of human services. *The Federal Response to Hurricane Katrina: Lessons Learned* identified the need for greater coordination among the Federal Government, State governments, and non-governmental organizations during a disaster and for an integrated human services case management system that can provide assistance in a seamless manner. In response, HHS has been given the lead to develop this integrated system and the FY 2009 Budget includes $10 million for Disaster Human Services Case Management. This new initiative will fund a national contract that recruits, trains, and credentials volunteers who can be dispatched to serve as case managers during a disaster and will provide planning grants to States to establish or improve their capability to respond to disasters. To determine the best way to create such a system, ACF is currently doing a pilot project in collaboration with ASPR and FEMA. The pilot project will provide the information necessary to make key policy decisions for implementing this effort in FY 2009.

IMPROVING THE WELL BEING OF CHILDREN AND THEIR FAMILIES

America's future depends upon how well the Nation protects and nurtures its children. The FY 2009 discretionary Budget includes $2.8 billion for programs providing a broad range of services that contribute to children's cognitive and social development, health and safety.

Adoption Incentives: ACF awards incentive funds to States that successfully increase the number of children adopted from their public foster care systems. These awards have contributed to substantial increases in adoptions since the mid-1990s but some groups of children remain less likely to be adopted. In particular, older children now constitute almost half of the pool of children waiting for adoptive families but less than a third of adopted children. To provide greater adoption incentives to States, new proposed legislation includes a doubling of the adoption bonus for children age nine and older, and a 50 percent increase in the adoption bonus for special needs children who are under the age of nine. States also would receive a bonus if they had more children adopted than were adopted in FY 2007. States would be required to spend bonus funds for finalizing adoptions or other permanency options. The Budget includes $20 million for adoption incentives, $15 million more than FY 2008, to pay for the new incentives. Under the new legislation, ACF estimates paying bonuses for nearly 4,000 adoptions in FY 2009. Bonuses were paid for 2,250 adoptions in FY 2007. The Budget also maintains funding for the adoption promotion activities authorized by the Children's Health Act.

Home Visitation Initiative: The FY 2009 Budget requests $10 million for second-year

funding for the Home Visitation initiative. Funds are used for competitive grants that encourage States to use existing funding sources to implement and sustain proven effective, home visitation programs. Research shows that evidence-based home visitation programs reduce the incidence of child abuse and neglect, preterm births, and arrests for parents and children.

Child Abuse Prevention: The most recent data from the annual HHS Child Maltreatment Report indicates that an estimated 899,000 children in the United States are victims of abuse and neglect. The Budget includes a total of $105 million for programs to prevent child maltreatment and to provide services to children who are abused and neglected, the same as FY 2008. The Child Abuse Prevention and Treatment Act State Grant program plays an integral role in strengthening States' child protective service systems, including improving their investigation of abuse, their training for child protection workers, and their programs to prevent and treat child abuse and neglect. Other programs help complete the continuum of prevention efforts by supporting community based efforts to increase public awareness and by providing funds for research on child maltreatment and training and technical assistance.

Child Welfare: The Budget request includes $327 million for Child Welfare Services, the same as FY 2008, to help State public welfare agencies promote the safety, permanence, and well-being of children. These activities include services to at-risk families to prevent children from being removed; development of alternative placements (e.g., foster care, adoption) for children who must be removed from their homes; and reunification services, so that children can return home to their families where appropriate.

Promoting Safe and Stable Families: The Promoting Safe and Stable Families program provides funds for each State to coordinate their services to support and preserve families. The Budget request maintains funding at a total of $428 million, of which $63 million is financed through discretionary resources. These funds enable States to operate family preservation services, community-based family support services, time-limited reunification services, and adoption promotion and support services.

Other Children's Programs: The Budget request maintains funding at $45 million for the Independent Living Education and Training Vouchers program, which provides up to $5,000 per year for costs related to post-secondary education for foster care youth ages 16 to 21. The Budget also requests $113 million for Runaway and Homeless Youth programs, the same as FY 2008. These programs support public and private organizations to establish and operate shelters for youth, to offer support services such as crisis intervention and counseling, and to provide street-based outreach and education.

Performance Highlight

The percent of youth living in a safe and appropriate setting after leaving ACF-funded Transitional Living Program services increased from 78 percent in 2003 to 86 percent in 2007.

Child Care: The Budget requests a total of $5 billion for the Child Care Development Fund (CCDF), which includes $2.1 billion in discretionary funds for the Child Care and Development Block Grant (CCDBG) and $2.9 billion in mandatory funds. Discretionary funding is maintained for CCDBG to provide direct child care assistance payments to low-income families when parents work or participate in education or training to support them in becoming and remaining self-sufficient.

The $5 billion requested for CCDF is sufficient to provide assistance to an estimated 1.6 million children each month. When combining CCDF with child care spending in related State and Federal programs, total funds for child care will provide assistance to 2.6 million children per month.

SUPPORTING FAMILIES THROUGH FAITH AND COMMUNITY-BASED ORGANIZATIONS

The Budget requests $126 million to fund faith-based and community organizations, an increase of $24 million over FY 2008.

Compassion Capital Fund: The Compassion Capital Fund supports the efforts of grassroots community and faith-based organizations to maximize their effectiveness and improve their ability to provide social services. The Budget requests $75 million for the Compassion Capital Fund, an increase of $22 million over FY 2008. These funds support grants to intermediary organizations with experience providing training and technical assistance to smaller faith-based and community organizations as well as faith and community based programs that address the needs of distressed communities. The Budget requests $35 million within the Compassion Capital Fund for the Communities Empowering Youth program. This funding will assist faith-based and community groups to develop

supportive relationships with youth and direct them to social services and healthy activities that offer an alternative to gang involvement.

Mentoring Children of Prisoners: The request includes $50 million, an increase of $1 million over FY 2008, to support public and private organizations that create and maintain one-on-one mentoring relationships for children of incarcerated parents and those recently released from prison. Research has shown that, without intervention, children with incarcerated parents are more likely than their peers to commit a crime and become incarcerated themselves. Research also indicates that when such children have mentors, they are less likely to use drugs or alcohol, less likely to initiate violence, and more likely to attend and perform well in school.

Supporting Abstinence-Only Education

Including mandatory funding, the ACF Budget requests a total of $191 million for Abstinence-Only Education activities, an increase of $28 million over FY 2008. The discretionary request supports 272 grants to community-based organizations, an increase of 84 awards, to provide abstinence-only education to adolescents and create an environment that supports them in postponing sexual activity until marriage. Funding is also included for public awareness campaigns. Last summer, HHS unveiled *Parents Speak Up* to encourage parents to talk to their children about waiting to have sex. Research indicates that youth look to their parents for guidance on making decisions about sex but parents often need practical advice about how to begin these discussions.

The Budget includes $50 million in mandatory funds for the State Abstinence-Only Education program, which enables States to support mentoring, counseling, and adult supervision to promote abstinence. Under current law, this program is only funded for the first three quarters of FY 2008, for a total of $38 million. The Budget assumes reauthorization of the program for a full year of operations ($50 million) in both FY 2008 and FY 2009. Outside of ACF, the Budget continues to provide $13 million for abstinence-only education within the Adolescent Family Life program, which is located within the Office of Public Health and Science.

Providing Assistance to Refugees and Unaccompanied Alien Children

Refugee and Entrant Assistance: The Budget requests $628 million to provide services for refugees and other entrants, unaccompanied alien children, and victims of torture and trafficking, $28 million less than FY 2008. This decrease reflects the continued availability of refugee funding appropriated in prior years when the number of arriving refugees and entrants was less than anticipated. Time-limited cash and medical assistance is provided, along with language instruction and job training, allowing refugees/entrants to become employed as quickly as possible. Last September, the Administration raised the refugee ceiling from 70,000 to 80,000, in part to accommodate those Iraqis whose lives are at risk because of their association with U.S. efforts to build a better Iraq. ACF has sufficient Transitional and Medical Service funds to provide eight months of assistance to 80,000 refugee arrivals in FY 2008 and the Budget includes sufficient funds to continue to provide this level of support in FY 2009.

The Budget request includes $114 million for the Unaccompanied Alien Children (UAC) program which provides care for unaccompanied alien minors who are apprehended in the United States by Homeland Security agents, Border Patrol officers, or other law enforcement. These children remain in ACF custody pending resolution of their relief claims under U.S. immigration law, or their release to an adult family member or responsible adult guardian. The UAC budget request includes an additional $5 million to respond to the special needs of children with psychiatric and behavioral disorders brought on by exposure to traumatic events, including trafficking, abuse, or violence.

Providing Home Energy Assistance to Low-Income Households

The Budget requests $2 billion for LIHEAP, $570 million less than FY 2008. The LIHEAP program includes a Block Grant, which assists low-income households to heat and cool their homes, and a Contingency Fund that targets States experiencing emergencies.

The request for the Block Grant is $1.7 billion, $200 million more than was requested last year. The Contingency Fund request is $300 million, $18 million more than was requested last year. LIHEAP is not the only source of

assistance for low-income households with high home energy bills. In FY 2006, States supplemented their LIHEAP funds with $2.7 billion in non-Federal funding.

HELPING LOW-INCOME FAMILIES SAVE

The Budget maintains funding at $24 million for the Assets for Independence program which enables low-income individuals to save earned income, acquire long-term assets, and achieve economic self-sufficiency. Program participants can combine their own savings with public and private matching funds in Individual Development Accounts (IDAs) to assist them to purchase a new home, capitalize a business, or pursue higher education. From FY 2005 to FY 2006, participants increased the amount of earned income they deposited into their IDAs by 46 percent. During that same period, there was an increase of 52 percent in participant savings used for asset purchases.

OTHER ACF PROGRAMS

Developmental Disabilities: The Budget request maintains funding at the FY 2008 level of $180 million to help ensure that more than four million Americans with developmental disabilities have access to consumer-centered culturally competent support services and opportunities for independence, productivity, and integration into community life. These funds are also used to protect the legal and human rights of individuals with disabilities and to increase their voter participation.

Violent Crime Reduction: The Budget request maintains funding at $125 million for programs that prevent incidents of family violence and provide intervention services and immediate shelter for victims of family violence and their dependents. Funds also support operation of the 24 hour toll-free National Domestic Violence Hotline, which provides crisis intervention, information, and referrals to victims of domestic violence.

Native Americans: A total of $46 million is requested to maintain funding for the Administration for Native Americans to promote self-sufficiency through competitive grants for community-based social and economic development. Funds are used primarily to develop and support stable and diversified local economies including business expansion, job creation, and social service provision. The Budget includes $2 million for the second year of funding for the preservation of Native American languages as authorized by the Esther Martinez Native American Language Preservation Act.

Community Services: The FY 2009 Budget continues the policy of not requesting funds for the Community Services Block Grant (CSBG) and three smaller community services programs, a total decrease of $698 million. CSBG lacks national performance goals and measures, does not award funds on a competitive basis, and does not hold grantees accountable for program results. Key CSBG services targeting employment, housing, health, substance abuse needs, and emergency services duplicate the activities of other Federal programs. The Budget policy is consistent with the Program Assessment Rating Tool (PART) conclusion that the program has not demonstrated results.

Research: There is a continuing need for sound research to help low-income families become economically self-sufficient. The Budget includes $6 million for the Social Services Research and Demonstration program to support research and evaluation projects in areas of critical national interest.

Federal Administration: The Budget requests $195 million to support staffing and other administrative activities, an increase of $11 million over FY 2008, including $4 million to implement the newly reauthorized Head Start Act. Funds are also included to reduce improper payments, consistent with the President's Management Agenda. Improper payment reduction activities can yield substantial savings. For ACF programs with established error rates, ACF estimates improper payments of $344 million in FY 2006.

ADMINISTRATION FOR CHILDREN AND FAMILIES: ENTITLEMENT SPENDING

(dollars in millions)

	2007	2008	2009	2008 +/- 2009
Current Law B.A.:				
Temporary Assistance for Needy Families /1	17,059	17,059	16,739	-320
Contingency Fund /2	--	--	--	--
Child Care Entitlement to States	2,917	2,917	2,917	--
Child Support Enforcement and Family Support (net)	4,399	3,998	3,759	-239
Foster Care, Adoption Asst., Independent Living	6,855	6,877	6,872	-5
Children's Research and Technical Asst. (net)	58	58	58	--
Promoting Safe and Stable Families (mandatory only)	365	365	365	--
Social Services Block Grant	1,700	1,700	1,700	--
Total, Current Law B.A. /3	**33,353**	**32,974**	**32,410**	**-564**
Proposed Law B.A.:				
Temporary Assistance for Needy Families /1	17,059	17,059	17,059	--
Contingency Fund /2	--	--	--	--
Child Care Entitlement	2,917	2,917	2,917	--
Child Support Enforcement and Family Support (net)	4,399	3,998	3,766	-232
Foster Care, Adoption Asst., Independent Living	6,855	6,877	6,889	+12
Children's Research and Technical Asst. (net)	58	58	58	--
Promoting Safe and Stable Families (mandatory only)	365	365	365	--
Social Services Block Grant /4	1,700	1,700	1,200	-500
Total, Proposed Law B.A. /3	**33,353**	**32,974**	**32,254**	**-720**

1/ In FY 2006, the Deficit Reduction Act (DRA, P.L. 109-171) pre-appropriated TANF funds through FY 2010. However, the DRA funds the Supplemental Grants only through FY 2008. The 2009 President's Budget extends the authorization for the Supplemental Grants beyond FY 2008 (cost shown on proposed law B.A. line), consistent with the authorization of TANF.

2/ In FY 2006, DRA extended the availability of unobligated Contingency Fund balances through FY 2010. ACF estimates that at the end of FY 2009 $1.217 billion will remain unobligated in this account.

3/ Totals for ACF Entitlements do not reflect pre-appropriated abstinence education funding. Please see Discretionary Program Level for this pre-appropriated funding.

4/ Proposed law budget authority includes the impact of the $500 million reduction in Social Services Block Grant funding that is proposed through appropriations action in FY 2009 and therefore scores as discretionary savings in FY 2009.

Note: ACF Entitlement Spending in outlays is displayed on the ACF Entitlement - Outlays Overview table, found at the conclusion of this chapter.

ADMINISTRATION FOR CHILDREN AND FAMILIES: ENTITLEMENT SPENDING

The FY 2009 Budget request for ACF Entitlements is $32.3 billion, a net decrease of $720 million, or two percent, from the FY 2008 funding level. ACF serves the Nation's most vulnerable populations through entitlement programs such as Temporary Assistance for Needy Families, the Child Care Entitlement to States, Child Support Enforcement, Foster Care, Adoption Assistance, Independent Living, and Promoting Safe and Stable Families.

The decrease in budget authority for FY 2009 is due to implementation of provisions from the Deficit Reduction Act of 2005 (DRA) (P.L. 109-171) in Child Support Enforcement and a proposal to decrease funding for the Social Services Block Grant, a program that has failed to demonstrate results.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

On February 8, 2006, TANF was reauthorized through 2010 by the DRA. 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 DRA also provided $150 million in funds for the Healthy Marriage Promotion and Responsible Fatherhood program.

States have enormous flexibility under TANF to determine their own eligibility criteria, benefit levels, and types of services and benefits available to TANF recipients. In addition, States may transfer up to a combined 30 percent of their TANF funding to the Child Care and Development Fund (CCDF) and Social Services Block Grant (SSBG), with not more than 10 percent transferred to SSBG.

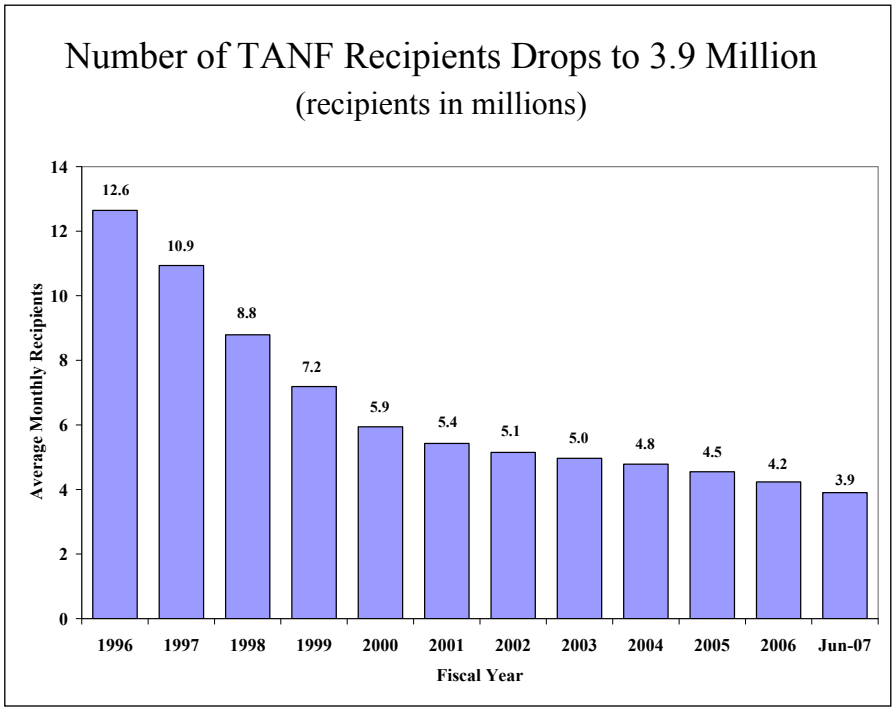
Since welfare reform was enacted through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), States are spending less on cash assistance and more on education and training, child care, and other work supports to help families achieve self-sufficiency. In 1998, States spent 63 percent of combined State and Federal funds on cash assistance, compared to 41 percent in FY 2006.

Welfare reform is widely regarded as a success. TANF caseloads continue to decrease. As of June 2007, 3.9 million individuals received TANF benefits – 68 percent fewer than in August 1996. From June 2006 to June 2007, TANF caseloads dropped six percent.

TANF Performance: The TANF program achieved success towards its primary goal of moving TANF recipients from welfare to work and self-sufficiency. In FY 2006:

- 36 percent of adult TANF recipients became newly employed, exceeding the target of 35 percent.
- 65 percent of former and current TANF recipients employed in one quarter were still employed in the next two consecutive quarters, exceeding the target of 61 percent.
- TANF recipients and former recipients showed an increase in earnings of 34 percent between a base quarter and two subsequent quarters.

TANF Legislative Proposals: The Budget includes a proposal that extends the authorization for Supplemental Grants for



Population Increases in certain States through 2010. Without an extension, the authority for these grants will expire at the end of FY 2008. Providing $319 million annually, the supplemental grants are awarded to certain States based on either increases in their populations or low levels of welfare spending before 1996.

In addition, the FY 2009 Budget includes a proposal that eliminates the separate two-parent work participation rate in the TANF program. This budget neutral proposal encourages equal treatment of two-parent and single-parent families by requiring the same State work participation rate.

Performance Highlight

The CSE program continues to make strong gains in child support collections, as well as support order and paternity establishment. In FY 2006:

- Child support collections reached $23.9 billion, benefiting an estimated 16 million families.
- CSE established paternity for over 1.7 million children, a 3.7 percent increase from the previous year.
- CSE had a 98 percent paternity establishment rate for all non-marital births in the previous year, meeting the target of 98 percent.
- CSE surpassed its target for establishing child support orders, generating support orders for 77 percent of all child support cases.
- For every dollar invested in the program, CSE collected $4.58 in child support, exceeding their target of $4.49. CSE aims to increase its cost-effectiveness ratio to $4.70 by FY 2009.

CHILD CARE ENTITLEMENT TO STATES (CCES)

The FY 2009 Budget includes $2.9 billion for the CCES, a component of the Child Care and Development Fund (CCDF). CCES is composed of mandatory and matching funds. Two percent of the mandatory entitlement funds are reserved for eligible Indian Tribes and Tribal organizations. The program requires States to spend at least 70 percent of CCES on families receiving TANF, transitioning from TANF, or at risk of becoming eligible for TANF. States must also spend a minimum of four percent of all child care funds to improve the quality and availability of healthy and safe child care for all families.

Child Care Performance: ACF continues its efforts to improve the quality of child care providers. In CY 2006, the latest year for which complete performance data is available, CCDF increased the number of accredited child care centers and homes by six percent over the previous year. The program also continues to influence State policies related to school readiness. In CY 2007, CCDF successfully encouraged more States to implement early learning guidelines linked to the education and training of caregivers, preschool teachers, and administrators.

CHILD SUPPORT ENFORCEMENT (CSE) AND FAMILY SUPPORT PROGRAMS

CSE is a joint Federal, State, Tribal, 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. Title IV-D of the Social Security Act establishes child support services that are available for all families with a non-custodial parent, regardless of welfare status. The FY 2009 President's Budget request is $3.8 billion in net budget authority for CSE and Family Support Programs.

Child support collections play an important role in helping families transition from welfare to self-sufficiency. By securing support from non-custodial parents on a consistent basis, families may avoid the need for public assistance, thus reducing Government spending. Custodial families that have never received TANF get all child support collected on their behalf. Child support collections on behalf of families receiving TANF and some arrearage collections on behalf of former TANF recipients are shared between the State and Federal Governments as reimbursement for providing TANF benefits. As a result of the DRA, the Federal Government will share in the cost when States opt to distribute more collections directly to current and former TANF families, beginning in FY 2009.

The Federal Government shares in the financing of this program by providing matching funds for general State administrative costs and paternity testing, as well as the funding of incentive payments. The CSE program also includes $10 million annually for grants to States to facilitate non-custodial parents' access to and visitation with their children.

Other family support programs funded in this account include Payments to Territories and Repatriation. Payments to

Territories funds approximately $35 million in State maintenance assistance programs for eligible aged, blind, and disabled residents of Guam, Puerto Rico, and the Virgin Islands, per Title XVI of the Social Security Act.

The Repatriation program, authorized by section 1113 of the Social Security Act and the Act of July 5, 1960, provides assistance to United States citizens and their dependents who are returning from foreign countries and are deemed to be destitute, mentally ill, or in need of emergency evacuation due to threatened armed conflict, civil strife, or natural disasters. The cap for this program is $1 million annually.

Child Support Enforcement and Family Support Programs Legislative Proposals: The FY 2009 President's Budget includes a new legislative proposal that will make technical changes to ensure that all child support enforcement services are available in international support cases.

This request also includes several child support proposals from previous President's Budgets aimed at increasing collections and improving States' efforts to collect medical support on behalf of children. The proposals also recognize that healthy families need more than financial support alone and increase resources for Access and Visitation Programs to support and facilitate non-custodial parents' access to and visitation with their children. This request also includes proposals to provide Tribal CSE programs with access to the same waivers and important enforcement tools that States have. In FY 2009, these proposals will cost the Federal Government $6 million, while increasing collections to families by $30 million. Over five years, the combined proposals for this account will generate a net Federal cost of $21 million while increasing collections to families by nearly $1.6 billion.

Additionally, the FY 2009 President's Budget proposes raising the authorization for the annual cap on Repatriation from $1 million to up to $5 million. The current limitation of $1 million has been in place since FY 1987 and is no longer sufficient to continue operation of this program. Increasing the cap will provide the flexibility necessary to meet growing programmatic needs and accommodate a quick response to emergency repatriation situations.

Child Support Legislative Proposals

- Make technical amendments to title IV-D to ensure that international cases receive access to all child support services.
- Grant Tribal CSE programs access to Section 1115 demonstrations.
- Provide Tribal child support enforcement programs with access to passport denial or revocation and multi-state financial institution data matching.
- Require health care plan administrators to notify child support agencies when a child loses health coverage. This will alert Title IV-D caseworkers of potential lapses in children's coverage so they can work to secure alternative coverage, if necessary.
- Allow Federal seizure of accounts in multi-state financial institutions, to enable families in interstate situations to better benefit from the data match.
- Require intercept of gambling proceeds, a significant source of untapped income for recovery of overdue child support.
- Provide for garnishment of Longshore and Harbor Workers' Compensation Act benefits.
- Increase funding for access and visitation grants to support non-custodial parents' access to and visitation with their children.
- Authorize direct Tribal access to the Federal Parent Locator Service.
- Authorize contractors and Title IV-D Tribes to access tax offset data.

CHILDREN'S RESEARCH AND TECHNICAL ASSISTANCE

The FY 2009 President's Budget includes $58 million for activities in three areas: child support enforcement training and technical assistance; operation of the Federal Parent Locator Service (FPLS) which assists States in locating absent parents; and research on welfare and child well-being. Of the total, $12 million will fund CSE training and technical assistance, and $25 million will support FPLS operations. The remaining $21 million will fund welfare research ($15 million) and continue the National Survey of Child and Adolescent Well-Being ($6 million), a longitudinal study on the well-being of children who come into contact with the child welfare system.

FOSTER CARE, ADOPTION ASSISTANCE, AND INDEPENDENT LIVING PROGRAMS

The FY 2009 Budget request for the Foster Care, Adoption Assistance, and Independent Living programs is $6.9 billion in budget authority. These programs, authorized by Title IV-E of the Social Security Act, support safe living environments for vulnerable children and prepare older foster youth for independence.

Of the total request, $4.5 billion in budget authority will support the Foster Care program. This is a $118 million decrease from the FY 2008 level. This decrease reflects Foster Care caseload declines which are partially offset by modest proposed legislative expansions described later in this chapter. The funds will be used to provide maintenance payments, administration, training, and support for data systems. The proposed level of funding will support approximately 203,200 children each month, about two percent fewer children than in FY 2008.

The Budget includes $2.3 billion in budget authority for the Adoption Assistance program, which supports families that adopt special-needs children. This is an increase of $130 million over the FY 2008 level. 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 430,400 children each month, an increase of five percent over FY 2008.

The Budget also contains $140 million in budget authority for the Independent Living Program, the same as the FY 2008 level. This program funds services for youth who will likely remain in foster care until they turn the age of 18 and for former foster children between the ages of 18 and 21.

Child Welfare Program Option Proposal

States that Choose the Program Option Could Use the Funds for:

- Foster care payments
- Prevention activities
- Permanency efforts
- Case management
- Administrative activities
- Training for child welfare staff
- Other similar child welfare activities

Under the Flexible Funding Plan States Will Be Required to:

- Continue to uphold the child safety protections outlined in the Adoption and Safe Families Act
- Maintain existing levels of State investment in child welfare programs
- Continue to participate in the Child and Family Services Reviews

The proposal provides access to the TANF Contingency Fund for States in the event that a severe foster care crisis arises.

A $30 million set-aside will be available for federally recognized Indian Tribes, and a one-third of one percent set-aside will be available for monitoring and technical assistance of State foster care programs.

Foster Care, Adoption Assistance, and Independent Living Performance: The Foster Care, Adoption Assistance, and Independent Living programs demonstrated success in improving safety, permanency, and well-being of children in FY 2006, the latest year for which complete performance data is available. Working with the States, these programs met the goal of minimizing disruptions to the continuity of family and other relationships for children in foster care by decreasing the number of placement settings per year for a child in care. In FY 2006, over 83 percent of children who had been in care less than 12 months had no more than two placement settings, exceeding the target of 80 percent.

The programs also met goals to provide children in foster care with permanency and stability in their living situations by improving the timeliness of reunification, if possible, and promoting guardianship or adoption when reunification was not possible. In FY 2006, over 39 percent of children exited foster care (within two years of placement) either through guardianship or adoption, exceeding the target of 35 percent.

The Foster Care program received a rating of Moderately Effective in the 2007 Program Assessment Rating Tool (PART) review, an improvement from the rating of Adequate it received during the 2003 PART review. The improved performance rating is due in part to the program's use of Child and Family Services Reviews to develop new management strategies and provide direct technical assistance to States.

Foster Care and Adoption Assistance Legislative Proposals: The FY 2009 President's Budget includes two legislative proposals for Foster Care and related programs. The budget neutral alternative funding option proposal (see the Child Welfare Program Option Proposal box) will provide States with the option to receive their foster care funding as a flexible grant over five years to support a continuum of services for families in crisis and children at risk.

The second proposal aligns the Foster Care and Adoption Assistance matching rate for the District of Columbia with the District's matching rate for Medicaid. The revised Federal matching rate would increase from 50 percent to 70 percent for these programs. This change provides equal treatment between the States and the District of Columbia.

PROMOTING SAFE AND STABLE FAMILIES (PSSF)

Promoting Safe and Stable Families is a program designed to assist States in coordinating services related to child abuse prevention and family preservation. This program has two distinct funding streams, one discretionary and one mandatory. The total FY 2009 request for PSSF is $428 million. The mandatory portion of this request provides funding for this capped entitlement at $365 million – the same level as FY 2008.

The Child and Family Services Improvement Act of 2006 (P.L. 109-288) reauthorized and amended the PSSF program for FY 2007 through FY 2011. The law created two set-asides; $10 million in FY 2009 to support State spending on monthly caseworker visits and $30 million for competitive regional partnership grants to increase the well-being of, and improve the permanency outcomes for, children affected by methamphetamine or other substance abuse. The law also limited administrative costs to 10 percent of the total State expenditures for PSSF, and reauthorized the basic Court Improvement Program without change through FY 2011.

Promoting Safe and Stable Families Performance: PSSF received a rating of Moderately Effective in the 2006 PART. The PART found that PSSF is a critical component of the continuum of care provided through the State-administered child welfare system. Further, PART concluded that PSSF makes effective use of Child and Family Services Reviews to devise new management strategies and direct technical assistance resources.

SOCIAL SERVICES BLOCK GRANT (SSBG)

SSBG is a capped entitlement which provides flexible grants to States for the provision of social services ranging from child care to residential treatment. SSBG is funded at $1.2 billion for FY 2009, a reduction of $500 million from its FY 2008 funding level. The President's Budget further proposes to eliminate SSBG beginning in FY 2010, as scarce Federal resources are better used in targeted programs with measurable outcomes.

Social Services Block Grant Performance: SSBG received a rating of Results Not Demonstrated in the 2005 PART assessment. The PART identified several weaknesses, noting that the block grant's flexibility and lack of State reporting requirements make it difficult to measure performance. Additionally, the broad array of social services funded through SSBG often overlap with other Federal programs. The FY 2009 request acknowledges these weaknesses and proposes to phase out this program since it cannot demonstrate results.

ACF ENTITLEMENT – OUTLAYS OVERVIEW

(outlays in millions)

	2007	2008	2009	2009 +/- 2008
Current Law Outlays:				
Temporary Assistance for Needy Families /1	16,876	17,030	16,821	-209
Contingency Fund	56	231	271	+40
Child Care Entitlement to States	2,994	2,978	2,966	-12
Child Support Enforcement and Family Support (net)	4,238	4,277	3,953	-324
Foster Care, Adoption Asst., Independent Living	6,563	6,670	6,872	+202
Children's Research and Technical Asst. (net)	70	58	61	+3
Promoting Safe and Stable Families (mandatory only)	370	362	362	--
Social Services Block Grant	1,956	1,936	1,727	-209
Total, Current Law Outlays /2	**33,123**	**33,542**	**33,033**	**-509**
President's Budget Outlays:				
Temporary Assistance for Needy Families /1	16,876	17,030	17,085	+55
Contingency Fund	56	231	271	+40
Child Care Entitlement	2,994	2,978	2,966	-12
Child Support Enforcement and Family Support (net)	4,238	4,277	3,960	-317
Foster Care, Adoption Asst., Independent Living	6,563	6,670	6,886	+216
Children's Research and Technical Asst. (net)	70	58	61	+3
Promoting Safe and Stable Families (mandatory only)	370	362	362	--
Social Services Block Grant /3	1,956	1,936	1,302	-634
Total, Proposed Law Outlays /2	**33,123**	**33,542**	**32,893**	**-649**

1/ In FY 2006, the Deficit Reduction Act (DRA, P.L. 109-171) pre-appropriated TANF funds through FY 2010. However, the DRA funds the Supplemental Grants only through FY 2008. The 2009 President's Budget extends the authorization for the Supplemental Grants beyond FY 2008 (cost shown in proposed law line), consistent with the authorization of TANF. FY 2009 proposed law outlays include an interaction effect with the proposal to reduce SSBG funding by $500 million in that year.

2/ Totals for ACF Entitlements do not reflect pre-appropriated abstinence education funding. Please see Discretionary Program Level for this pre-appropriated funding.

3/ The proposed law outlays include the impact of the $500 million reduction in Social Services Block Grant funding that is proposed through appropriations action in FY 2009 and therefore scores as discretionary savings in FY 2009.

Note: ACF Entitlement budget authority is displayed on the ACF Entitlement - Budget Authority Overview table at the beginning of this section.

ACF ENTITLEMENT LEGISLATIVE PROPOSALS

(outlays in millions)

	2009	2009 - 2013
Temporary Assistance for Needy Families		
Continue Supplemental Grants for Population Increases /1	+236	+1,475
Eliminate Separate Two-Parent Work Participation Rate	--	--
TANF Interaction with Phase Out of SSBG /2	+28	+41
Subtotal, Temporary Assistance for Needy Families	+264	+1,516
Contingency Fund		
Child Welfare Program Option - Contingency Fund Access /3	--	+26
Subtotal, Contingency Fund	--	+26
Child Care Entitlement to States		
Child Care Entitlement Interaction with Phase Out of SSBG /2	--	+182
Subtotal, Child Care Entitlement to States	--	+182
Child Support Enforcement and Family Support Programs /4		
International Child Support Technical Amendments	--	--
Tribal Access to 1115 Demonstrations	--	--
Tribal Access to Passport Denial or Revocation and MSFIDM Data Match	--	--
Send COBRA Notice to IV-D Agency	+1	+9
Federal Seizure of Accounts in Multi-State Financial Institutions	--	-14
Require Intercept of Gaming Proceeds	+3	-5
Garnishment of Longshore and Harbor Worker's Compensation Act Benefits	--	-4
Increase Access and Visitation Funding	+2	+32
Direct Tribal Access to the Federal Parent Locator Service	--	--
Contractor and Tribal Acccess to Tax Data	--	--
Raise the Cap for Repatriation to $5 million	--	+3
Subtotal, Child Support Enforcement and Family Support Programs	+6	+21
Foster Care and Adoption Assistance		
Child Welfare Program Option	+8	+2
Increase D.C. Match Rate	+6	+32
Foster Care and Adoption Assistance Interaction with Phase Out of SSBG /2	--	+176
Subtotal, Foster Care and Adoption Assistance	+14	+210
Social Services Block Grant		
Phase Out Funding for SSBG /2	-425	-7,028
Subtotal, Social Services Block Grant	-425	-7,028
Total	**-141**	**-5,073**

1/ The DRA funds the Supplemental Grants through FY 2008. The 2009 President's Budget extends the authorization for the Supplemental Grants beyond FY 2008, consistent with the authorization of TANF.

2/ The Budget proposes a $500 million reduction in SSBG funding in FY 2009 through appropriations action, which scores as discretionary savings for FY 2009. The Budget proposes to eliminate SSBG funding beginning in FY 2010. This proposal interacts with several programs (TANF, Foster Care / Adoption Assistance, and the Child Care Entitlement), causing their outlay rates to increase compared to current law levels.

3/ The Foster Care and Adoption Assistance proposal for a Child Welfare Program Option provides access to the Contingency Fund for States that participate in the option if they experience significant increases in their foster care caseload and meet certain other conditions.

4/ The estimates for Child Support Enforcement and Family Support proposals reflect total federal impact.

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Program Innovations	24	31	33	+2
Choices for Independence (non-add) /1	--	*16*	*28*	*+12*
State and Community-Based Services				
Home and Community-Based Supportive Services	351	351	351	--
Nutrition Programs:				
Congregate Nutrition Services	399	411	411	--
Home-Delivered Nutrition Services	188	194	194	--
Nutrition Services Incentive Program	148	153	153	--
Subtotal, Nutrition Program	735	758	758	--
Preventive Health Services	21	21	--	-21
Family Caregiver Support Services	156	153	153	--
Subtotal, State and Community-Based Services	1,263	1,284	1,263	-21
Services for Native Americans				
Native American Nutrition and Support Services	26	27	27	--
Native American Caregiver Support Services	6	6	6	--
Subtotal, Services for Native Americans	32	33	33	--
Protection of Vulnerable Older Americans				
Long-Term Care Ombudsman Program	15	16	16	--
Prevention of Elder Abuse and Neglect	5	5	5	--
Subtotal, Protection of Vulnerable Older Americans	20	21	21	--
Aging Network Support Activities	13	15	13	-2
Alzheimer's Disease Demonstration Grants	12	11	--	-11
Program Administration	18	18	19	+1
Health Care Fraud and Abuse Control	3	3	3	--
Total, Program Level	**1,386**	**1,417**	**1,385**	**-32**
Less Funds From Other Sources				
Health Care Fraud and Abuse Control	-3	-3	-3	--
Total, Budget Authority	**1,383**	**1,413**	**1,381**	**-32**
FTE	112	116	120	+4

1/ The FY 2008 Consolidated Appropriations Act appropriated funding for Choices for Independence under Aging Network Support Activities. This table has been comparably adjusted.

ADMINISTRATION ON AGING

The mission of the Administration on Aging is to develop a comprehensive, coordinated and cost-effective system of home and community-based services that helps elderly individuals to maintain their independence and dignity in their homes and communities.

The FY 2009 Budget requests $1.4 billion for the Administration on Aging (AoA), $32 million below FY 2008. The request supports AoA's core programs, which help families keep their loved ones at home for as long as possible with services that complement existing medical and health care systems and support some of life's most basic functions. The Budget also includes investments in strategies that will empower older individuals and their families to take greater control over the services they need to meet their long-term care needs.

LOOKING FORWARD: CHOICES FOR INDEPENDENCE

The request includes $28 million for Choices for Independence, a limited demonstration designed to test the effectiveness of giving individuals greater choice in using home and community-based alternatives for their long-term care needs. This approach is consistent with individuals' preference to receive their care at home and in the community. Choices will help people conserve and extend their personal resources by bringing transparency to long-term care, diverting seniors away from nursing home care, and empowering seniors to take more control of their health.

Choices has three components:

- *Aging and Disability Resource Centers*: Choices will use "single-entry points" to help individuals make informed decisions about their care options, plan ahead for their long-term care needs, and streamline their access to both publicly and privately-supported long-term care.
- *Evidence-Based Prevention*: Choices will use low-cost, community-level interventions to assist seniors to make behavioral changes that have proven effective in reducing the risk of disease and disability.
- *Nursing Home Diversion*: Choices will provide non-Medicaid home and community-based services to help high-risk individuals avoid nursing home placement and spend-down to Medicaid.

Choices will be tested in three to five States using a randomized, controlled design to evaluate its effectiveness in helping individuals remain at home and reducing Medicaid costs.

In addition to funding for Choices for Independence, the Budget request for Program Innovations includes funding for ongoing national projects.

PROVIDING HOME AND COMMUNITY-BASED SUPPORT SERVICES

The FY 2009 request for Home and Community-Based Supportive Services is $351 million, the same as FY 2008. Home and Community-Based Supportive Services provide funding for a broad range of services that enable older individuals to remain healthy, independent, at home, and in their communities. These activities serve as the foundation for the national aging services network, whose 29,000 community service providers coordinate, integrate, and deliver a broad array of home and community-based services to seniors. Services provided include access assistance such as transportation and case management; in-home services such as personal care, chore, and homemaker assistance; and site-based community services such as senior centers, adult day care, respite care, and health promotion.

Performance Highlight

Measuring the ability of AoA's programs to effectively target the neediest and most vulnerable seniors is an important indicator of program performance for AoA. Efforts to improve program efficiency and quality must be complemented by a focus on serving the neediest individuals—an outcome consistent with the intent of the Older Americans Act. One of AoA's key performance measures is to increase the number of severely disabled clients who receive selected home and community-based services. AoA served 10 percent more severely disabled clients in FY 2006 than in FY 2005. This trend is sure to continue with new efforts at targeting the most vulnerable elders at risk of institutional placement.

Ensuring Adequate Nutrition

The FY 2009 request maintains funding for Nutrition programs, including Congregate and Home-Delivered Nutrition Services and the Nutrition Services Incentive Program, at $758 million. Nutrition services ensure that millions of older adults have access to the nutritious food they need to stay healthy and to reduce the risk of disability. Nutrition services, especially those provided in congregate settings, also offer participants opportunities to create informal support networks, which further contributes to overall health and well-being.

These programs also provide a range of related services including nutrition screening, assessment, education and counseling. These services help older participants to identify their nutrition needs, which can improve management of chronic health conditions such as hypertension and diabetes.

Supporting Family Caregivers

Families are the Nation's major provider of long-term care. The FY 2009 Budget includes $153 million for Family Caregiver Support Services, which support family and informal caregivers by providing information, assistance, counseling, training, respite, and other services that help them care for their loved ones at home. Caregivers often experience conflicts between work and caregiving. Studies have shown that providing these kinds of support services can reduce caregiver depression, anxiety, and stress and enable them to provide care longer, thereby avoiding or delaying the need for costly institutional care.

Supporting Native American Nutrition and Support Activities

The Budget requests $33 million for Native American seniors: $27 million for Nutrition and Supportive Services and $6 million for Native American caregivers and the seniors they assist. These two programs offer an array of support services, including transportation, congregate and home-delivered meals, personal care, respite care, and counseling and training for caregivers, that help Native American elders to remain independent and in the community.

Protecting the Rights of Seniors

Protection programs support activities that improve the quality of care for residents of long-term care facilities and increase public and professional awareness of elder abuse. Together these activities help protect the rights and dignity of vulnerable elders. The FY 2009 request includes $21 million to support these activities through the Long-Term Care Ombudsman program and the Prevention of Elder Abuse, Neglect, and Exploitation program.

The request also includes $13 million for Aging Network Support Activities that provide critical and ongoing support for the national aging services network and help support the activities of AoA's core service delivery programs. Ongoing projects help to provide accessible health and retirement information to seniors and families; detect, deter, prevent, and report waste, fraud, and abuse in the Medicare and Medicaid programs; and protect the rights and dignity of vulnerable elders.

Streamlining and Modernizing

In FY 2009, no funding is requested for Preventive Health Services or for Alzheimer's Disease Demonstration Grants, the same as the FY 2008 President's Budget request. Prevention continues to be a focus and an underlying principle of each of the AoA services provided by States and communities and an important component of Choices for Independence. States can also continue to use their Home and Community-Based Supportive Services dollars for Preventive Health Activities. Further, most States have received funding for one or more demonstrations that tested and implemented successful, cost-effective approaches for serving persons with Alzheimer's Disease. The lessons learned and the models developed through these demonstrations are ready to be integrated into ongoing service programs.

Administering Programs

AoA achieves its mission by overseeing the development of coordinated systems of care in States and localities that are responsive to the needs and preferences of older people and their family caregivers. A total of $19 million is requested for Program Administration to carry out this mission by maintaining staffing levels and for related program management and support activities.

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Commissioned Corps Transformation/Training....	10	4	30	+26
Health Diplomacy Initiative.....	--	--	4	+4
Other General Departmental Management.....	355	350	346	-4
Evaluation Activities.....	40	47	47	--
Health Care Fraud and Abuse Control.....	5	6	6	--
Subtotal, GDM Program Level	410	406	432	+26
Less funds from other sources:				
Evaluation Activities.....	40	47	47	--
Health Care Fraud and Abuse Control.....	5	6	6	--
Total, GDM Budget Authority	**365**	**354**	**380**	**+26**
FTE 1\.....	1,406	1,406	1,515	+109

1\ Includes Office of the Secretary, Service and Supply Fund FTE.

General Departmental Management supports the Secretary in his role as chief policy officer and general manager of the Department.

The FY 2009 Budget request for General Departmental Management (GDM) is $432 million, a net increase of $26 million over FY 2008.

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 15 Staff Divisions.

The FY 2009 Budget request provides increased funding for the following activities:

Commissioned Corps: The FY 2009 Budget request includes $30 million for the Transformation of the Public Health Service's (PHS) Commissioned Corps, an increase of $26 million above FY 2008. This request supports the Department's multi-year process to revitalize and improve the Corps' ability to respond to public health emergencies and deliver timely and effective public health services in underserved and hazardous situations. This effort will involve the establishment of two 105-member Health and Medical Response teams, which will provide a highly trained, quick response asset, ready to immediately deploy to emerging public health situations and emergencies.

Additionally, Transformation activities will focus on modernizing the force strength and management of the Commissioned Corps, streamlining the assignment and deployment process, and increasing our ability to recruit talented candidates to become Commissioned Corps officers. To accomplish these goals, FY 2009 funding will be used to develop new systems to support total force management; train and equip officers to respond to emerging public health threats and situations; and to improve response operations and develop a team-oriented deployment process.

Health Diplomacy Initiative: The FY 2009 Budget request includes $4 million for an initiative within the Office of Global Health Affairs (OGHA). OGHA will work with other Federal agencies, the governments of Panama and neighboring countries, and other non-governmental organizations to provide medical education and training, and quality primary health care, including oral health care. This training in Central America will focus on developing community health workers, primary health care workers, and other health professionals who are

desperately needed in rural and developing areas in the region.

Other General Departmental Management: The FY 2009 Budget request includes $346 million to fund offices which provide leadership, policy, legal, and administrative guidance to HHS components, and also includes funding to continue the following GDM activities:

Office of Population Affairs OPA/Adolescent Family Life (AFL): The FY 2009 Budget includes $30 million 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 includes $13 million in abstinence-only prevention projects, as defined by the Welfare Reform legislation (P.L. 104-193).

Office of Minority Health (OMH): The OMH request of $43 million will provide funding to continue disease prevention, health promotion, service demonstration, and educational efforts to reduce and ultimately eliminate disparities in racial and ethnic minority populations. The request for OMH includes a reduction of $6 million below FY 2008, to reflect the natural end point of some projects, and a reduction in other demonstration projects and cooperative agreements.

Office on Women's Health (OWH): The OWH request of $28 million will provide funding to continue the advancement of women's health programs through the promotion and coordination of research, service delivery, and education throughout HHS agencies and offices, with other government organizations, and with consumer and health professional groups. The request for OWH includes a reduction of $3 million below FY 2008 to reflect one-time funding of some programs.

Minority HIV/AIDS: The FY 2009 Budget includes $52 million, the same as FY 2008, to support innovative approaches to HIV/AIDS prevention and treatment in minority communities disproportionately 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.

Afghanistan: Included in the FY 2009 request for OGHA is $6 million to continue support of HHS health care initiatives in Afghanistan, particularly in the areas improving the quality of maternal and neo-natal health care for Afghan mothers and their babies. The Afghanistan Health Initiative has increased the core knowledge and clinical skills of the physicians and other health-care professionals at Rabia Balkhi Women's Hospital (RBH), as well as helped the Ministry of Public Health implement its national health strategy and build capacity to sustain these public-health and medical investments in RBH.

PHS Evaluation Funds: The FY 2009 request also includes $47 million for PHS Evaluation Funds, as authorized by section 241 of the PHS Act. These funds will support policy research and evaluation activities in the Office of the Assistant Secretary for Planning and Evaluation, as well as evaluation activities in the Office of Public Health and Science and the Office of the Assistant Secretary for Resources and Technology.

OFFICE OF THE SECRETARY
OFFICE OF MEDICARE HEARINGS AND APPEALS

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Total, Program Level.....	60	64	65	+1
FTE.....	356	374	374	--

The Office of Medicare Hearings and Appeals provides an independent forum for the fair and efficient adjudication of Medicare appeals for beneficiaries and other parties. This mission is carried out by a cadre of knowledgeable Administrative Law Judges exercising judicial and decisional independence under the Administrative Procedures Act, with the support of a professional legal and administrative staff.

The FY 2009 Budget requests $65 million for the Office of Medicare Hearings and Appeals (OMHA), a net increase of $1 million over FY 2008. Funds are being requested from the Federal Hospital Insurance and Supplementary Medical Insurance Trust Funds to hear cases under Title XVIII of the Social Security Act, and related provisions in Title XI of the Act.

OMHA was established by Section 931 of Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), enacted on December 8, 2003. MMA transferred the responsibility for hearing Medicare appeals at the Administrative Law Judge (ALJ) level – the third level of Medicare claims appeals – from the Social Security Administration to the HHS Office of the Secretary. The Medicare Benefits Improvement and Protection Act of 2000 (BIPA) also mandated that ALJ appeals be heard within 90 days after receipt of a request from a Medicare appellant for a hearing. OMHA began processing cases on July 1, 2005, and to date has received almost 65,000 appeals from across the United States, containing approximately 280,000 claims.

OMHA administers the program in four field offices, including the Southern Field Office in Miami, Florida; the Midwestern Field Office in Cleveland, Ohio; the Western Field Office in Irvine, California; and the Atlantic Field office in Arlington, Virginia. OMHA extensively utilizes video-teleconference (VTC) and telephone hearings to provide appellants with hearings which are more timely, closer to their homes and with a broad array of access points. VTC technology, which is now commonly used throughout the country in courtrooms and for telemedicine, plays a critical role in OMHA's ability to both meet the BIPA timeframes and provide expanded access for appellants to ALJ hearings.

With the requested funding level of $65 million, OMHA will be able to process the projected ALJ appeals workload for Medicare Parts A, B, C and D as well as Medicare entitlement and eligibility appeals, within the BIPA mandated timeframe. OMHA will accomplish this by continuing to utilize state-of-the-art technology, maintaining necessary staffing levels, and increasing access to hearing sites and services for appellants.

OFFICE OF THE SECRETARY
OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Budget Authority	42	42	18	-24
PHS Evaluation Funds	19	19	48	+29
Total, Program Level	**61**	**61**	**66**	**+6**
FTE	23	28	28	--

The Office of the National Coordinator for Health Information Technology leads, coordinates, and stimulates public and private sector activities that promote the development, adoption, and use of health information technologies to achieve a healthier Nation..

The FY 2009 Budget request for the Office of the National Coordinator for Health Information Technology (ONC) is $66 million, $6 million over FY 2008. The request supports efforts to achieve the President's goal of most Americans having access to electronic health records by 2014. Access to electronic health records will allow physicians to access a patient's medical history without asking the patient to fill out lengthy medical history forms. Granting consumers access to their own medical histories empowers them to direct their own health care.

In addition to funds requested within ONC, the FY 2009 request for other HHS agencies includes funds to advance the Administration's Health IT agenda. The FY 2009 request includes $45 million in the Agency for Healthcare Research Quality to advance the use of health IT to enhance patient safety and $3 million in the Office of the Assistant Secretary for Planning and Evaluation for independent evaluations of electronic health record adoption and economic factors influencing health IT in coordination with ONC. The CMS budget request also includes resources to carry out the second year of a demonstration project to encourage small physician practices to adopt electronic health records.

ONC's Strategic Plan will guide and coordinate actions across the Federal Government and in the private sector where feasible. These activities reflect the Administration's commitment to ensure that secure, interoperable electronic health records are available to patients and their doctors anytime and anywhere, which will reduce medical errors and improve efficiency.

PRIVACY AND SECURITY

The Federal Government must fulfill an important role in balancing the technical capabilities to exchange health information and the privacy and security policies that protect patients' health information. The ONC FY 2009 request will support efforts to assure appropriate Federal privacy and security protections of electronic health information and to support State consensus efforts to address patient protections. ONC's role to ensure adequate Federal protections and facilitate multi-State collaboration is essential to build public confidence and trust for national health information exchange.

TRANSITION TO THE AHIC SUCCESSOR

The FY 2009 request will enable HHS to transition the activities of the American Health Information Community (AHIC) to an independent and sustainable public-private partnership, serving as the AHIC Successor. The AHIC Successor will engage affected stakeholders to execute the necessary planning, policy making, consensus building, and priority setting to promote the widespread adoption of health IT in the public and private sectors. The AHIC Successor will provide a foundation for the long-term success of the Administration's goals to use health IT to improve health care quality and transparency. ONC will transition an appropriate subset of the AHIC's current activities to the AHIC Successor as it matures.

Performance Highlight

ONC supports the Certification Commission for Healthcare Information Technology (CCHIT), which certifies health IT products for the marketplace. Since CCHIT's inception less than two years ago, it has certified 105 electronic health record products for office-based physicians. In FY 2009, ONC will continue to support CCHIT to increase the number of certified health IT products available for physicians' offices to use to improve patient care.

STANDARDS DEVELOPMENT AND IMPLEMENTATION

ONC's FY 2009 request will develop health data standards and ensure they are available for both private sector and Federal use. Funding will support the standards harmonization process, which is necessary for IT systems to exchange data across different health care settings. ONC will expand the scope of the technology certification process to ensure that the certification criteria for health IT products incorporates the most recent standards. Funding will also provide a consolidated resource for Federal agencies as they transition to harmonized standards and advance the national health IT agenda.

DEVELOPING A TECHNICAL ARCHITECTURE TO ADVANCE ADOPTION OF HEALTH IT

Transitioning the medical and health industry to capitalize on the advantages of reliable and secure health information exchange requires multiple changes in our healthcare system. The FY 2009 request includes $26 million to expand health information exchange network capabilities across additional markets and communities. This funding will allow ONC to advance the Nationwide Health Information Network trial implementations. These trial implementations will demonstrate the feasibility of successfully interconnecting clinicians nationwide to exchange health information securely across health care settings. Based on these activities, ONC will issue a report identifying various methods to structure consumer permissions, which includes the manner and degree to which individuals specify who can, and cannot, access their health information. In addition, ONC will continue to monitor the adoption rate in physicians' offices as well as in small practices on an annual basis to measure progress in achieving the President's goal of most Americans having access to electronic health records by 2014.

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Total, Program Level.....	35	34	40	+6
FTE.....	240	240	255	+15

The Office for Civil Rights promotes and ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination and that the privacy of their health information is protected while ensuring access to care. Through prevention and elimination of unlawful discrimination and by protecting the privacy of individually identifiable health information, OCR helps HHS carry out its overall mission of improving the health and well-being of all people affected by its many programs.

The FY 2009 Budget request is $40 million for the Office for Civil Rights (OCR), $6 million over FY 2008. The Budget supports OCR's activities as the primary defender of the public's right to nondiscriminatory access to and receipt of Federally funded health and human services – from hospitals and nursing homes to Head Start and senior centers. In addition, it supports OCR's significantly expanded compliance responsibilities that protect the rights of individuals' personal health information under the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

OCR assesses compliance with nondiscrimination and Privacy Rule requirements through:

- complaint investigation, resolution, and corrective action monitoring;
- public education;
- technical assistance; and
- compliance reviews, including civil rights pre-grant reviews of new Medicare provider applicants.

OCR's work protects individual rights while supporting HHS goals for strengthening the health and well being of individuals, families, and communities by improving access to HHS programs.

Key priorities for OCR in FY 2008 and FY 2009 are: ensuring understanding of and compliance with the HIPAA Privacy Rule; promoting adequate privacy protections in health IT and patient safety organizations; increasing non-discriminatory access to quality health care and human services, including adoption, foster care, and Temporary Assistance for Needy Families (TANF); promoting best practices for effective communication in hospital settings with persons who are deaf or hard of hearing and limited English proficient persons; developing a Federal civil rights curriculum for medical schools to help narrow disparities in health care quality, access and patient safety; supporting the New Freedom Initiative and appropriate services in most integrated setting for persons with disabilities; and promoting non-discrimination and privacy protections in emergency preparedness and response.

Through these varied efforts, OCR promotes integrity in the expenditure of Federal funds by ensuring that these funds support programs which provide access to services by qualified participants free from unlawful discrimination on the basis of race, color, national origin, disability, age, religion or sex. OCR's efforts also promote public trust and confidence that the health care system will maintain the privacy of protected health information while ensuring access to care.

ENSURING PRIVACY AND CONFIDENTIALITY IN HEALTH CARE

HIPAA – Health Information Privacy: OCR is responsible for administering and enforcing the HIPAA Privacy Rule, which protects the privacy of individually identifiable health information maintained or transmitted by health plans, health providers, and clearinghouses. Since the compliance date of April 14, 2003, OCR has responded to more than 24,000 complaints. Of the approximately 7,700 complaints where OCR has had the authority to investigate, OCR found no violation in about 2,500 and has

obtained corrective action from the investigated entities in over 5,000 cases. OCR's FY 2009 request includes $2 million and 13 FTE to improve OCR's critical HIPAA compliance and enforcement operations.

OCR also has reached hundreds of thousands of covered entities and consumers through educational conferences and an interactive website to answer questions about the Privacy Rule. OCR's FY 2009 request includes $331,000 and two FTE to initiate a comprehensive national educational campaign to improve the public's understanding of the Privacy Rule, targeting areas identified during OCR's enforcement activities with particular emphasis on clarifying to health care providers and law enforcement when health information can be shared, in response to the recent Virginia Tech tragedy.

Health IT: OCR is an active participant in the development of standards for a national health information infrastructure. OCR provides policy support to the HHS leadership to ensure consideration of privacy and civil rights issues in the development process.

Patient Safety: OCR is taking a lead role in fulfilling the Department's mandate to improve patient safety and reduce the incidence of events that adversely affect patient safety by establishing and enforcing the confidentiality protections afforded by the Patient Safety and Quality Improvement Act of 2005.

ENSURING NON-DISCRIMINATORY ACCESS TO HEALTH CARE AND HUMAN SERVICES

OCR works to ensure non-discriminatory access to health and human services and to reduce health disparities. These efforts ensure equal access to and receipt of HHS funded services regardless of race, national origin, disability, age, religion or sex, as required by federal law.

OCR investigates and resolves complaints, initiates compliance reviews, and provides technical assistance to programs receiving federal financial assistance. OCR works with Federal and State partners and with providers and consumer groups, including community- and faith-based organizations to ensure non-discriminatory access to health and human services. For example, OCR is working in partnership with the American Hospital Association and State hospital associations to apprise hospitals of their responsibilities under civil rights law and to provide technical assistance to achieve effective communication with persons who are deaf and hard of hearing and limited English proficient persons. Similarly, OCR is working in collaboration with the American Association of Medical Colleges and NIH's National Heart, Lung and Blood Institute to deploy a Federal civil rights curriculum for medical schools to address the responsibility that physicians have for providing equal access to treatment in compliance with civil rights laws to help narrow disparities in health care quality, access and patient safety.

In FY 2009, OCR will continue to focus on equal access to quality health services and a broad range of non-discrimination issues in human services, including adoption, foster care, and TANF.

New Freedom Initiatives and Olmstead: OCR is the HHS agency with authority and responsibility to protect the rights of persons with disabilities under the Americans with Disabilities Act (ADA). It plays a leading role in carrying out the President's New Freedom Initiative and Executive Order 13217, which commits the United States to a policy of community integration for individuals with disabilities, and calls upon the Federal Government to enforce the ADA through complaint investigation and alternative dispute resolution and to work with States to swiftly implement the Supreme Court's *Olmstead v. L.C.* decision.

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Expenses	583	642	699	+57
FTE	1,128	1,220	1,249	+29

The Program Support Center provides customer-focused administrative services and products for the Department of Health and Human Services.

The Program Support Center (PSC) was created to streamline and minimize duplication of traditional administrative services. The PSC provides services on a competitive, fee-for-service basis to customers throughout HHS, as well as to 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 five broad areas: human resources, financial management, administrative operations, strategic acquisitions, and health care resources. 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, Homeland Security, Housing and Urban Development, Interior, Justice, Labor, State, Transportation, Treasury, Veterans Affairs, and the United States Postal Service.

ADMINISTRATIVE OPERATIONS SERVICE

The FY 2009 estimated expenses for the Administrative Operations Service (AOS) are $263 million, an increase of $21 million above FY 2008. The increase of $21 million represents an expansion of the Cooperative Administrative Support Units customer base, Application Hosting business line, pay increases and rent increases. AOS provides a wide range of administrative and information technical services within the Department, both in headquarters and in the regions, and to customers throughout the Federal Government.

FEDERAL OCCUPATIONAL HEALTH SERVICE

The FY 2009 estimated expenses for the Federal Occupational Health Service (FOHS) are $134 million, an increase of $6 million above the FY 2008 level. The increase of $6 million represents anticipated increased reimbursements from other Federal agencies, pay increases, rent increases and miscellaneous increases. The FOHS provides occupational health services for Federal employees, including health and wellness programs, employee assistance, work/life, and environmental health and safety services. Over 1.5 million Federal employees in 45 Federal departments and agencies are serviced by FOHS.

FINANCIAL MANAGEMENT SERVICE

The FY 2009 estimated expenses for the Financial Management Service (FMS) are $116 million, an increase of $14 million above FY 2008. In FY 2007 FMS assumed full responsibility for operations and maintenance support for the Department's Unified Financial Management System. FMS supports the financial operations through the provision of fund accounting, disbursement, financial reporting, financial statement preparation, payroll accounting, and debt management and collection services; support for Federal grantor and contracting agencies for the negotiation and approval of indirect cost, fringe benefits and other specialty rates used by not-for-profit organizations receiving Federal awards; and grant disbursement, cash management, and grant accounting support services.

ENTERPRISE SUPPORT SERVICE

The FY 2009 estimated expenses for the Enterprise Support Service (ESS) are $51 million, an increase of $4 million above FY 2008. The $4 million increase represents system enhancements and staff-related costs. ESS provides an extensive array of personnel systems, administration and management, training, and payroll liaison services. These include compensation and medical benefits for Commissioned Corps officers, liaison services between the Defense Finance and Accounting Service (DFAS) and HHS employees, automated personnel and time and attendance systems support, equal employment opportunity, workforce development, and training management.

Strategic Acquisition Service: The FY 2009 estimated expenses for the Strategic Acquisition Service (SAS) are $64 million, an increase of $9 million above FY 2008. The increase of $9 million is for the HHS consolidated acquisition system and for anticipated new business. The SAS is responsible for providing leadership, guidance, and supervision to the procurement operations of the PSC and for improving procurement operations within HHS. The SAS provides acquisition services, strategic sourcing services (including a Strategic Sourcing Center of Excellence); and provides pharmaceutical, medical, and dental supplies to HHS and other Federal agencies.

Human Resources Activities: The FY 2009 estimated expenses for the Human Resources Centers are $68 million, an increase of $4 million above FY 2008 for expanding capabilities with existing systems and anticipated pay and rent increases. The HR Centers represent a consolidation of human resources services within the Department, with sites located in Rockville and Baltimore, Maryland, and Atlanta, Georgia. The centers provide human resources strategic programs, customer service, and workforce relations support for HHS customers.

Business Technology Optimization: The FY 2009 estimated expenses for the Business Technology Optimization (BTO) are $4 million, an increase of $1 million above FY 2008 for anticipated new business. BTO offers project management services to identify, develop, and implement business solutions that assist HHS components in maximizing return on their information technology (IT) investments and ensures that IT solutions are supportive of strategic business goals.

OFFICE OF THE SECRETARY
RETIREMENT PAY & MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Retirement Payments	287	312	339	+27
Survivor's Benefits	18	19	19	+0
Medical Care for Retirees and Survivors	66	66	76	+10
Accrued Medical Benefits for over-65	36	37	35	-2
Total, Budget Authority	**407**	**434**	**469**	**+35**

The FY 2009 request of $469 million is a net increase of $35 million over FY 2008. This request 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 accrued medical benefit payments for PHS Commissioned Corps officers and beneficiaries over age 65.

This appropriation also funds the provision of medical care to active duty and retired members of the Corps under the age of 65, and dependents of deceased members. This account includes payments to the Department of Defense Medicare-eligible Retiree Healthcare Funds for the accrued costs of health care for beneficiaries over the age of 65.

This appropriation reflects increased costs in medical benefits, and annualization of amounts paid to retirees and survivors, and a net increase in the number of retirees and survivors during FY 2009.

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	2007	2008	2009	2009 +/-2008
Direct discretionary appropriation	40	43	46	+3
Discretionary HCFAC	--	--	19	+19
Mandatory HCFAC	166	170	175	+5
Medicaid Integrity Program	25	25	25	--
Audit and Investigations Reimbursements	10	10	10	--
Never Events	3	--	--	--
Total, Program Level	**243**	**248**	**275**	**+27**
FTE	1,513	1,570	1,662	+92

Under the authority of the Inspector General Act, the OIG improves HHS programs and operations and protects them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations, the OIG provides timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the public.

The FY 2009 Budget request for the Office of Inspector General (OIG) is $46 million, a net increase of $3 million over FY 2008. In addition to the discretionary appropriation, OIG will continue to receive mandatory funding through the Health Care Fraud and Abuse Control Program (HCFAC) – authorized by the Health Insurance Portability and Accountability Act of 1996, the Deficit Reduction Act of 2005, and Tax Relief and Health Care Act of 2006.

OIG will use its discretionary funding in FY 2009 to continue providing program integrity and oversight services to support the management and operation of more than 300 programs throughout the Department. These programs are found in every agency of HHS and also include Presidential and Secretarial priorities such as all-hazards emergency preparedness.

In addition to OIG's oversight of HHS programs using the discretionary appropriation, during FY 2009 OIG will continue to use its mandatory appropriations for efforts that protect the safety of Medicare and Medicaid program beneficiaries and contribute to the financial solvency of the programs.

Specific priority areas associated with OIG's discretionary and mandatory funding streams include:

DISCRETIONARY PRIORITIES

Emergency Preparedness and Response: Recent events such as the Gulf Coast hurricanes of 2005, the emerging threat of a global influenza pandemic, and the terrorist attacks of September 11, 2001, underscore the importance of having a comprehensive national public health infrastructure that is prepared to rapidly respond to public health emergencies of all types. As a result, in 2007 HHS was delegated increased responsibility to act as the lead Agency for coordinating the public health response in the National Response Plan. OIG assesses how well HHS programs and grantees plan for, recognize, and respond to health threats; the security of HHS and grantee laboratory facilities; the management of grant programs and funds by the Department and grantees; and the capacity of responders at all levels of Government to respond in a coordinated way to protect public health.

Oversight of Food, Drug, and Medical Device Safety: OIG has elevated the priority of its oversight responsibilities of public health agencies – such as FDA and NIH – in response to several high-profile issues related to food, drug, and medical device safety. These agencies are required to have policies and programs in place that create safeguards to ensure the integrity of medical research endeavors, protect human research subjects, and provide for pre-approval and post-approval monitoring of regulated medical products and treatments. OIG will continue its oversight and inspection work in this critical area during FY 2009.

Grants Oversight: HHS handles more grant money than all other Federal agencies combined.

Accordingly, OIG will continue providing oversight to ensure that HHS grants are appropriately monitored and managed throughout the grant life-cycle. In FY 2009 OIG will continue to assess mechanisms in place to ensure that proper procedures are used to award grants, fund them, account for expenditures, and verify that they are only used for authorized purposes. OIG anticipates conducting grant oversight activities in FY 2008 – 2009 that touch almost every agency within HHS and include such diverse issues as patient safety, community health centers, Head Start, TANF error rate, and HIV/AIDS prevention and treatment.

Child Support Enforcement Program: OIG will continue to provide coverage of all 50 States and the District of Columbia through its multi-agency task forces that identify, investigate, and prosecute individuals who willfully avoid payment of their child support obligations under the Child Support Recovery Act. OIG's task forces bring together State and local law enforcement and prosecutors, United States Attorneys' Offices, United States Marshals Service, and State and county child support personnel, among other interested parties.

Ethics Program Oversight and Enforcement: OIG has long been involved in oversight and enforcement related to the Department's ethics program. Prior OIG work has identified vulnerabilities in the Department's oversight of outside activities and potential conflicts of interest. OIG is directing continued attention to ensuring the effectiveness of the Department's ethics program and management of conflicts of interest.

Other Discretionary Priorities: OIG's funding in FY 2009 will also support continued oversight and compliance efforts, including the annual financial statement audits and Federal Information Security Management Act compliance. This funding will also enable OIG to continue funding the security detail for the HHS Secretary.

MANDATORY PRIORITIES

HCFAC Program and Medicaid Integrity Program (MIP): Several mandatory appropriations fund OIG's oversight of the Medicare and Medicaid programs. OIG works closely with CMS, other HHS agencies, the Department of Justice and State governments to recover funds owed to the Medicare Trust Fund or CMS. In FY 2009 OIG will continue this important work by building upon existing research and developing independent and objective assessments of threats to program integrity.

In FY 2009 OIG will use HCFAC and MIP funds to identify and prosecute perpetrators of health care fraud; conduct audits, investigations, and inspections that identify causes of and methods for preventing fraud, waste, and abuse; and protect the well-being of HHS program beneficiaries.

EMERGENCY PREPAREDNESS

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Pandemic Influenza				
Ongoing Activites	138	302	313	+10
No-Year Funding	--	--	507	+507
Subtotal, Pandemic Influneza	138	302	820	+517
Terrorism Preparedness				
Agency Budgets	3,452	3,445	3,494	+49
PHSSEF	717	654	811	+156
Subtotal, Terrorism Preparedness	4,169	4,099	4,305	+205
Total, Emergency Preparedness	**4,308**	**4,402**	**5,124**	**+723**

To protect our Nation from the threat of pandemic influenza the FY 2009 request includes $820 million in HHS-wide funding to implement the *HHS Pandemic Influenza Plan.* Also included in the FY 2009 Budget request is approximately $4.3 billion for bioterrorism and emergency preparedness activities. Funding for these activities is appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) and directly to agencies.

PANDEMIC INFLUENZA

The FY 2009 request for pandemic influenza preparedness includes $507 million in no-year funding for the next phase of the *HHS Pandemic Influenza Plan* to expand egg-based vaccine capacity and purchase medical countermeasures and medical supplies for HHS employee and patient populations. In addition to this request, a total of $313 million will fund ongoing annual activities at FDA, CDC, NIH, and within the HHS Office of the Secretary (OS).

In August 2005, animal outbreaks of highly pathogenic H5N1 had been reported in 12 countries around the world with 112 total human cases confirmed in four of those countries. Just over two years later in December 2007, the number of countries confirming animal outbreaks has jumped to 61, with 348 total human cases confirmed in 14 of those countries. While the majority of human cases to date can be attributed to exposure to infected poultry, and sustained human-to-human transmission has not been observed, the human infections have been severe. Overall, 62 percent of human cases have been fatal. History shows that the mortality rate of a human pandemic virus is not likely to be this high. However, even a two percent case-fatality rate, as was seen in the 1918 pandemic, would constitute a public health catastrophe. Once a pandemic begins, time will be a critical factor in our ability to accomplish the necessary production and delivery of vaccines and other medical countermeasures required to mitigate the pandemic. The threat associated with the ongoing occurrence of human cases and animal outbreaks must not be dismissed.

On November 1, 2005, the President requested a total of $7.1 billion in emergency funding for pandemic influenza preparedness activities, of which $6.7 billion was for implementation of the *HHS Pandemic Influenza Plan*. This funding was requested in FY 2006 to fund a staged preparedness effort to ensure the Nation could effectively respond in the event of a pandemic. In FY 2006, Congress appropriated $5.6 billion in emergency funding for HHS through two FY 2006 emergency supplemental appropriations. HHS has used these funds to advance the Nation's pandemic preparedness by expanding and diversifying domestic vaccine production and surge capacity; enlarging H5N1 pre-pandemic vaccine and antiviral drug stockpiles; supporting advanced development of cell culture and antigen sparing influenza vaccines and new antiviral drugs; supporting advanced development of point-of-care clinical diagnostics; stockpiling medical supplies and ventilators; improving State and local preparedness; expanding risk communication efforts; enhancing FDA's regulatory science base; and expanding surveillance, research, and international collaboration efforts of CDC, NIH, and the HHS Office of Global Health Affairs.

In FY 2008, Congress did not appropriate the $870 million requested by the President for continued implementation of the pandemic influenza preparedness plan. This $870 million is still needed to make progress in meeting the objectives of the President's pandemic preparedness plan. The Administration is still considering options regarding this funding, and will reach out to Congress soon.

FY 2009 Pandemic Preparedness Priorities: The request includes $425 million to continue to build vaccine production capacity while working toward the goal to acquire 20 million egg-based courses of pre-pandemic vaccine for stockpiling. Currently, HHS has approximately 13 million courses of H5N1 vaccine on hand and on order. To make pre-pandemic vaccine and ensure surge capacity for domestic vaccine manufacturers, the request includes $42 million to maintain a ready supply of eggs for the production of vaccine. A secure supply of eggs will be critical to continue production of egg-based vaccines during an influenza pandemic, given the potential impact of an influenza pandemic on the domestic poultry population.

Pandemic preparedness is a shared responsibility among Federal, State, and local governments, businesses, schools, individuals and families. As part of a comprehensive Federal Government effort to stockpile countermeasures for its critical employees, the FY 2009 request includes $40 million for HHS to purchase medical countermeasures for its critical employees and contractors, as well as the IHS patient population. These countermeasures will be purchased for HHS clinical employees to prevent morbidity and mortality, and to increase the workforce available to effectively respond to a pandemic. Medical supplies for IHS patient populations will ensure HHS is meeting its responsibility to its own populations and setting an example for State and local governments, and the private sector.

HHS Pandemic Influenza Progress to Date

In FY 2006, HHS was appropriated $5.6 billion to improve the Nation's pandemic preparedness. Accomplishments include:

- HHS has completed the purchase of 50 million courses of antiviral drugs for the Federal portion of its antiviral drug stockpile goal.
- HHS has purchased the following medical supplies for the SNS:
  104 million N95 Respirators
  52 million Surgical Masks
- HHS has completed clinical evaluation of a new 5-target PCR rapid diagnostic test for avian and seasonal influenza. This high-throughput assay test will be used in all U.S. public health laboratories and internationally at World Health Organization reference laboratories.
- HHS has awarded a total of $576 million for State and local preparedness, including medical surge capacity.
- HHS has deployed teams of experts to help investigate suspected cases of human transmission of infection with influenza A in 12 countries in Asia, Africa, and Europe. It also supports pandemic influenza preparedness activities in 40 countries around the world.

In addition to the $507 million, a total of $313 million is requested in the budgets of the CDC, FDA, NIH and OS to finance ongoing preparedness activities including:

- Expanding international and domestic surveillance and detection capabilities;
- Accelerating research and development of rapid diagnostic tests, to enable the accurate allocation of scarce countermeasures;
- Improving pandemic preparedness and response capabilities;
- Developing a vaccine registry to assess vaccine distribution, safety and efficacy;
- Improving our Nation's ability to contain a potential pandemic influenza outbreak; and
- Supporting international efforts designed to strengthen the public health and vaccine manufacturing infrastructure, expand surveillance systems, and improve preparedness and response capabilities in countries with the highest numbers of confirmed H5N1 cases.

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Pandemic Influenza:				
No-Year Funding:				
Vaccine:				
Achieve capacity and/or buy courses from egg-based manufacturer.....	--	--	425	+425
Contract to purchase 5 years worth of eggs for vaccine production.....	--	--	42	+42
Subtotal, Vaccine	--	--	467	+467
Shared Responsibility:				
Countermeasures and PPE for HHS Clinical and Patient Populations.....	--	--	40	+40
Subtotal, Shared Responsibility	--	--	40	+40
Subtotal, No-Year Funding	--	--	507	+507
Ongoing Activities				
CDC.....	70	155	157	+3
FDA.....	33	38	42	+4
NIH.....	35	34	35	+1
OS.....	--	75	78	+3
Subtotal, Ongoing Activities	138	302	313	+10
Total, Program Level	**138**	**302**	**820**	**+517**

EMERGENCY PREPAREDNESS

BIOTERRORISM AND EMERGENCY PREPAREDNESS

The FY 2009 Budget requests $4.3 billion for HHS bioterrorism and emergency response, a net increase of $208 million over FY 2008. These funds are to protect Americans from a possible bioterrorist attack or other public health emergency, and are appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) and directly to agency budgets.

PHSSEF ACTIVITIES

The FY 2009 Budget request for the PHSSEF bioterrorism and emergency preparedness activities is $811 million, a net increase of $156 million over FY 2008. The PHSSEF request will support coordination of preparedness and response activities across HHS to improve the Nation's ability to prepare for, respond to, recover from and reduce the adverse health effects of public health emergencies and disasters.

Assistant Secretary for Preparedness and Response: The Office of the Assistant Secretary for Preparedness and Response (ASPR) coordinates the bioterrorism and emergency preparedness activities of HHS agencies; develops and coordinates national policies and plans; provides program oversight; and serves as the Secretary's public health emergency representative to other Federal, State and local agencies. Since the enactment of the Pandemic and All-Hazards Preparedness Act (PAHPA) ASPR has published the Public *Health Emergency Medical Countermeasures Enterprise Strategy for Chemical, Biological, Radiological and Nuclear (CBRN) Threats*, *Public Health Emergency Medical Countermeasures Enterprise Implementation Plan*, and the draft *Biomedical Advanced Research and Development Authority (BARDA) Strategic Plan*. ASPR has also established the National Biodefense Science Board, increased the focus on at-risk individuals as part of preparedness planning, and taken the lead in implementing Homeland Security Presidential Directive 21, which establishes a *National Strategy for Public Health and Medical Preparedness*.

The Budget provides $250 million to target advanced research and development on promising medical countermeasures, an increase of $148 million over FY 2008. Within ASPR, BARDA is responsible for coordinating Federal efforts to develop and procure vaccines and countermeasures against potential plagues and bioweapons. Funds will support the advancement of medical countermeasures for 12 biological threat agents, volatile nerve agents, and radiological and nuclear threats. These funds will support research on selected countermeasure candidates with the greatest potential for purchase under Project BioShield and delivery to the Strategic National Stockpile (SNS). The request also includes $22 million to manage Project BioShield, slightly more than FY 2008. In addition to these funds for advanced research and development, $25 million is included to support the advanced development of next generation ventilators to help patients in acute respiratory distress in a pandemic or other public health emergency. Funds will support the development of ventilators with a shorter production time, lower cost, and greater portability.

The ASPR request also includes $362 million for the Hospital Preparedness Program, a decrease of $62 million from FY 2008. This program transferred from HRSA to ASPR in 2007. In FY 2009 ASPR will implement a shortened grant period to start the grant period in future fiscal years on June 1, to better align with State budget

Investments for a Nation Prepared against All Hazards

In the year since the enactment of the Pandemic and All-Hazards Preparedness Act, ASPR has taken an active role in the Nation's preparedness.

Preparing the Nation against Smallpox and Anthrax

- Contract awarded for 20 million doses of MVA smallpox vaccine, intended for use in immunocompromised individuals, for delivery to the Strategic National Stockpile over the next five years.
- Purchase of 18 million courses of AVA anthrax vaccine by Project BioShield for delivery into the SNS, starting in October 2007.

Response to Hurricane Dean

- HHS pre-staged and deployed assets, including two Field Medical Stations (500 bed capacity) and two Disaster Medical Assistance Teams.
- HHS increased patient evacuation capacity by bringing over 250 ambulances and 20 air ambulances to Texas from outside the State.

cycles and other Federal grant programs. The shorter grant period in FY 2009 reduces the amount of funds needed for the States to receive the same month-to-month funding as in FY 2008. Funding also supports the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program, which works to establish a national network of State-based programs that manage the information needed to effectively use health professional volunteers in an emergency, and will complete operational and compliant systems in the States in FY 2009.

The request includes $53 million for the National Disaster Medical System (NDMS), which transferred to HHS from the Department of Homeland Security in 2007, an increase of $7 million over FY 2008, to implement emergency readiness response improvements. The request will support training, exercises, and supplies for over 100 Disaster Medical Assistance Teams, Disaster Mortuary Operational Response Teams, and other NDMS Teams to improve the Nation's capacity to respond to a terrorist attack or other public health emergency.

The request also includes $34 million for Preparedness and Emergency Operations, an increase of $17 million over FY 2008. ASPR directs and coordinates HHS-wide capabilities of preparing for and responding to bioterrorism and other public health and medical emergencies. ASPR also coordinates activities with other Departments and Agencies as the leader of Emergency Support Function #8 of the National Response Framework. This funding will support improved regional response coordination, the development of emergency response capabilities, and systems upgrades and infrastructure enhancements in the Secretary's Operations Center. These investments will enhance HHS's capabilities to deploy, coordinate, and communicate effectively during a response. The system will be designed to work collaboratively with ESAR-VHP.

The Budget provides $29 million for other ASPR activities including operations, planning and communications, and international early warning surveillance, an increase of $5 million over FY 2008. This funding will support the first National Health Security Strategy in FY 2009, consistent with PAHPA and development of international preparedness and response capabilities.

Medical Reserve Corps: Comprised of medical and public health volunteers, the Medical Reserve Corps contributes its expertise to local public health initiatives on an ongoing basis. The request includes $15 million for the Medical Reserve Corps in FY 2009, an increase of $6 million over FY 2008, to enhance the leverage of these efforts during a national catastrophic emergency.

Health Care Provider Credentialing Portal: The FY 2009 Budget request for Health Care Provider Credentialing is $3 million to finance the development and updating of credentialing systems. Funds will be used to create a mechanism to conduct primary source verification of health care professionals' credentials from relevant Federal, State, and non-governmental sources before, during, and after a mass casualty event.

Cybersecurity: The request provides $12 million for cybersecurity, an increase of $3 million, to protect the Department's information technology infrastructure from cyber-terrorist attacks by providing continuous security monitoring for all HHS systems, assets, and services.

Office of Security and Strategic Information: The Budget includes $5 million for the Office of Security and Strategic Information (OSSI), an increase of $1.5 million over FY 2008. OSSI is responsible for the development, maintenance, and operation of policy and programming in areas of physical security, personnel security, communications security and strategic information. OSSI is also the point of contact for all of HHS in working with the Director of National Intelligence.

HIGHLIGHTED BIOTERRORISM PREPAREDNESS ACTIVITIES

In addition to funding in the PHSSEF, another $3.5 billion in bioterrorism and emergency preparedness funding is requested directly in the appropriations for CDC, FDA, NIH, ACF, and OS.

Morbidity, loss of human life, and economic disruption caused by a terrorist attack or natural disaster could be substantially reduced through effective preparedness. The request focuses on early detection and containment of an infectious outbreak, ensuring proper preparedness and response to an event, and having the countermeasures needed to treat and protect citizens against potential harmful exposures.

Detection and Containment: The FY 2009 Budget increases CDC's quarantine program by $33 million to allow CDC to establish 25 fully staffed quarantine stations by the end of FY 2009. This expansion will improve CDC's capacity to

respond to natural and intentional communicable disease emergencies of public health significance by catching disease at the border and preventing it from spreading to the American public. The request also provides $50 million for BioSense, an increase of $16 million over FY 2008. The Budget also includes $10 million for Real Time Disease Detection to support 62 grantees and Poison Control Center awardees to develop a real-time public health data detection and reporting system. Utilizing these tools, Federal, State, and local health officials will have access to real-time data that could potentially be the first sign of a public health emergency.

Within CDC $10 million is provided for a new radiological Laboratory Response Network to improve epidemiological expertise in the identification of illnesses caused by terrorism, which will facilitate national coordination of expertise, triage protocols, field assessment techniques, and laboratory analysis to determine proper victim treatment after a radiological or nuclear event.

FDA also plays a critical role in early detection through its food defense program. To protect our Nation's food supply, $213 million is included in this request, an increase of $43 million over FY 2008, to support the goals of the *FDA Food Protection Plan*. This request supports key food defense activities, including support for the Food Emergency Response Network. FDA will also work to coordinate food surveillance activities within the Biosurveillance Initiative.

Emergency Preparedness and Response: To minimize injury and loss of life resulting from a terrorist attack, our Nation must also have the ability to effectively prepare for and respond to such an event.

The FY 2009 request provides $30 million, an increase of $26 million over FY 2008, to transform the Commissioned Corps into a force that is ready to rapidly respond to public health challenges and health care crises resulting from natural disasters, terrorist attacks, and other needs.

The request also includes $10 million for the development of a Disaster Human Services Case Management planning and coordination effort in ACF. This new effort will fund a national contract to recruit, train, and credential qualified volunteers who can be dispatched to serve as case managers during a disaster and will provide planning grants to States to establish or improve their capability to provide human services to disaster victims. This program will be a collaboration between ACF, ASPR, and the Federal Emergency Management Agency consistent with the command structure and reporting requirements in the National Incident Management Plan and the National Response Framework.

HHS continues to demonstrate a strong commitment to prepare States and local public health departments and hospitals for public health emergencies and acts of bioterrorism. In FY 2009, $972 million is requested for such efforts, making a total investment of over $10 billion since September 11, 2001. The Upgrading State and Local Capacity Grants Program at CDC and the Hospital Preparedness Cooperative Agreement Grants Program at ASPR prepare States and local public health departments and hospitals for public health emergencies and acts of terrorism.

Protection and Treatment: Our bioterrorism readiness relies on quickly protecting Americans that have been exposed to a biological, chemical, or radiological threat agent and treating those who have become sick following an exposure. Our Nation's ability to counter bioterrorism ultimately depends on advancing biomedical science to develop next generation countermeasures.

The FY 2009 Budget request for NIH biodefense activities is $1.7 billion, and includes a $19 million increase for radiological/nuclear countermeasures research. These funds will support basic and applied research on agents with bioterrorism potential which will ultimately lead to the availability of new or improved vaccines and therapies to protect or treat persons exposed to threat agents. This effort addresses a critical threat area to enhance our preparedness for a dirty bomb or other radiological or nuclear disaster.

In the event of a large scale terrorist attack, rapid access to large quantities of vaccines and medications is critical for saving lives. The FY 2009 President's Budget includes $571 million, a $20 million increase, for CDC's Strategic National Stockpile, a Federally-owned repository of countermeasures. Additionally, the stockpile contains medical supplies and hospital beds that would be needed in a mass casualty event. As a critical part of our Nation's defense against a bioterrorist attack, SNS funding will continue to support the ability to distribute these assets anywhere in the country within 12 hours of an event.

(dollars in millions)

	2007	2008	2009	2009 +/- 2008
Bioterrorism and Emergency Prepedness:				
Direct Appropriations to Agency Budgets				
Centers for Disease Control and Prevention:				
Upgrading State and Local Capacity	767	746	609	-137
Biosurveillance Initiative	71	53	101	+47
Upgrading CDC Capacity	123	121	131	+10
Anthrax Research	12	8	8	--
Botulinum Toxin Research	3	--	--	--
Strategic National Stockpile	496	552	570	+19
Subtotal, CDC	1,473	1,479	1,419	-60
National Institutes of Health:				
Biodefense Research	1,624	1,633	1,635	+2
Radiological/Nuclear Countermeasures Research	46	46	57	+11
Chemical Countermeasures Research	50	49	57	+8
Subtotal, NIH Research	1,720	1,728	1,748	+20
Extramural Laboratory Construction	14	--	--	--
Subtotal, NIH	1,735	1,728	1,748	+20
Food and Drug Administration:				
Food Defense	172	171	213	+43
Vaccines/Drugs/Diagnostics	57	56	67	+10
Physical Security	7	7	7	--
Subtotal, FDA	235	234	287	+53
Adminstration for Children and Families:				
Disaster Human Services Case Management Initiative	--	--	10	+10
Office of the Secretary:				
Revitalization of Commissioned Corps	10	4	30	+26
Subtotal, Direct Appropriations	3,452	3,445	3,494	+49
Office of the Secretary, PHSSEF				
Assistant Secretary for Preparedness and Response (ASPR): /1				
Operations	8	10	14	+4
Preparedness and Emergency Operations	14	17	35	+18
National Disaster Medical System (NDMS)	47	46	53	+7
Hospital Preparedness Grants	474	423	362	-62
Training and Curriculum Development	21	--	--	--
Advanced Research and Development	104	102	250	+148
Advanced Development of Ventilators	--	--	25	+25
BioShield Management	16	21	22	+1
International Early Warning Surveillance	9	9	9	+0.3
Policy, Strategic Planning, and Communications	3	4	5	+1
Subtotal, ASPR	694	633	776	+143
Other Office of the Secretary:				
Healthcare Provider Credentialing	--	--	3	+3
Office of Security and Strategic Information (OSSI)	3	3	5	+2
CyberSecurity	9	9	12	+3
Medical Reserve Corps	10	10	15	+6
Subtotal, Other Office of the Secretary	22	22	35	+13
Subtotal, PHSSEF	717	654	811	+156
Total, Bioterrorism and Emergency Reponse	**4,169**	**4,099**	**4,305**	**+205**

1/ FY 2007 amounts have been revised to reflect the reallocation of $8 million in carryover funds to maintain funding at FY 2006 levels. Also, comparable adjustments have been made for the funding of the Office of Policy and Strategic Planning, which was established in FY 2007, and for the transfer of funding for the Office of Security and Strategic Information.

HHS Program Assessment Rating Tool (PART)

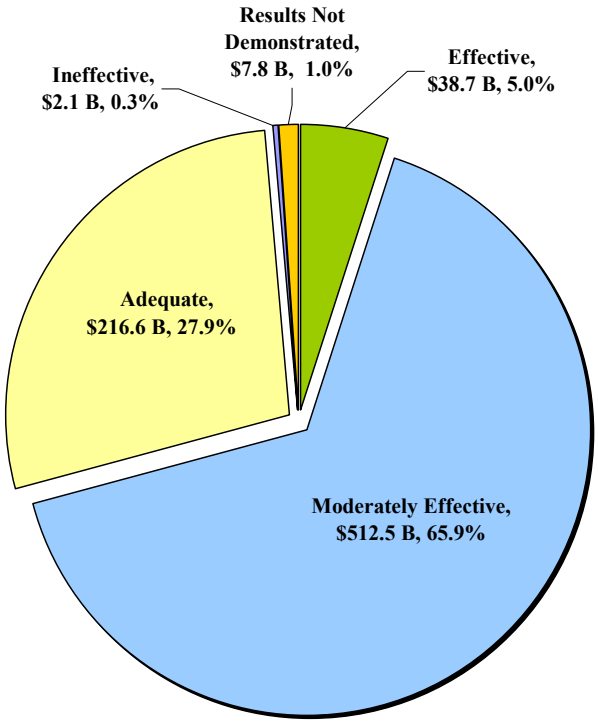
The Nation expects the projects and activities it funds to achieve results. A key gauge of Federal program effectiveness is the Program Assessment Rating Tool (PART), introduced in 2002. Its overall purpose is to assess program performance and results. The PART contains four sections: program purpose and design, strategic planning, program management, and program results. Programs receive ratings of Effective, Moderately Effective, Adequate, Ineffective, and Results Not Demonstrated (RND).

HHS uses PART results to inform management and budget decisions throughout the year to improve program performance and efficiency. PART results are included each year in the Department's summer budget development process. Additionally, HHS ensures that programs use the PART information to improve program performance, especially programs that received an RND rating.

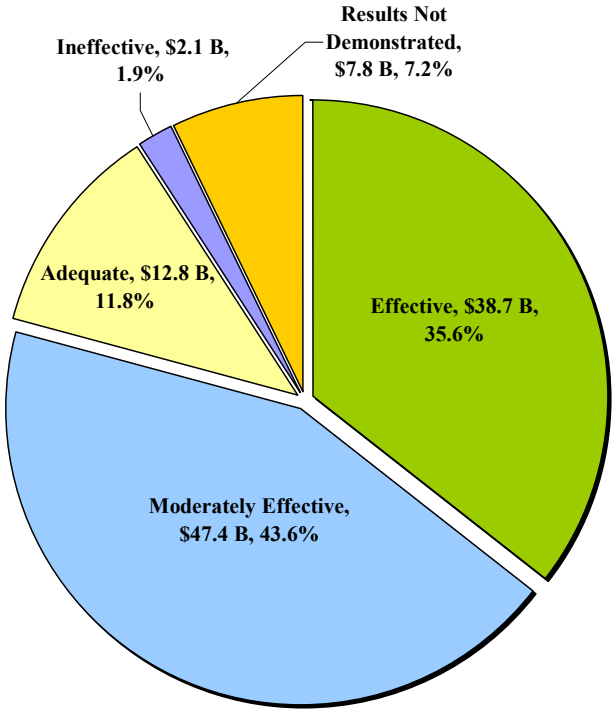
Since 2002, all significant HHS programs, and 99 percent of HHS's budget, has been assessed through the PART process. Overall, programs representing nearly 97 percent of HHS's budget were rated Adequate or better. Most important, HHS also greatly reduced the number of programs for which results cannot be demonstrated – in other words, programs which lack adequate measures that would indicate whether or not they are effective. For more detailed information on PART results for HHS programs, please see www.ExpectMore.gov.

HHS PART Ratings (by dollar)

PART Ratings for all HHS Programs



PART Ratings Excluding Medicare and Medicaid



VALUES BASED ON FY 2008 ENACTED FUNDING LEVELS

ACRONYMS

A

ACF	Administration for Children and Families
ADA	American with Disabilities Act
ADUFA	Animal Drug User Fee Act
AFDC	Aid to Families with Dependent Children
AFL	Adolescent and Family Life
AGDUFA	Animal Generic Drug User Fee Act
AHIC	American Health Information Community
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
AoA	Administration on Aging
AOS	Administrative Operations Service
ASPR	Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry

B

B&F	Buildings and Facilities
B.A.	Budget Authority
BARDA	Biomedical Advanced Research and Development Authority
BBA	Balanced Budget Act of 1997
BIPA	Medicare Benefits Improvement and Protection Act of 2000
BTO	Business Technology Optimization

C

CCDBG	Child Care and Development Block Grant
CCDF	Child Care and Development Fund
CCES	Child Care Entitlement to States
CCHIT	Certification Commission for Healthcare Information Technology
CDC	Centers for Disease Control and Prevention
CERT	Comprehensive Error Rate Testing
CHR	Community Health Representatives
CMS	Centers for Medicare & Medicaid Services
CPI-U	Consumer Price Index - Urban
CSBG	Community Services Block Grant
CSE	Child Support Enforcement
CTSA	Clinical and Translational Science Award
CY	Calendar Year

D

DBP	Developmental Behavioral Pediatric
DME	Durable Medical Equipment
DOJ	Department of Justice
DRA	Deficit Reduction Act of 2005
DSH	Disproportionate Share Hospitals

E

EEOICPA	Energy Employees Occupational Illness Compensation Program
EHR	Electronic Health Record
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
ESRD	End Stage Renal Disease
ESS	Enterprise Support Service

F

FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FMAP	Federal Medical Assistance Percentage
FMS	Financial Management Services
FOHS	Federal Occupational Health Service
FPL	Federal Poverty Level
FPLP	Federal Payment Levy Program
FPLS	Federal Parent Locator Service
FTE	Full Time Equivalent
FY	Fiscal Year

G

GCRC	General Clinical Research Centers
GDM	General Departmental Management
GME	Graduate Medical Education
GSA	General Services Administration

H

HCFAC	Health Care Fraud and Abuse Control
HHS	Department of Health and Human Services
HI	Federal Hospital Insurance
HI	Hospital Insurance (Trust Fund)
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HRC	Human Resources Center
HRSA	Health Resources and Services Administration

I

IDA	Individual Development Accounts
IHS	Indian Health Service
IME	Indirect Medical Education
IT	Information Technology

ACRONYMS

L

LEND	Leadership Education in Neurodevelopmental and Related Disabilities
LIHEAP	Low Income Home Energy Assistance Program
LTC	Long-Term Care

M

MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MCBS	Medicare Current Beneficiary Survey
MCH	Maternal and Child Health
MDUFMA	Medical Device User Fee and Modernization Act
MEPS	Medical Expenditure Panel Surveys
MIP	Medicaid Integrity Program
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MSP	Medicare as Secondary Payer

N

NBSB	National Biodefense Science Board
NCRR	National Center for Research Resources
NDMS	National Disaster Medical System
NHSC	National Health Service Corps
NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases
NIEHS	National Institute of Environmental Health Sciences
NIH	National Institutes of Health
NIOSH	The National Institute for Occupational Safety and Health
NLM	National Library of Medicine
NMEP	National Medicare & You Education Program

O

OCR	Office for Civil Rights
OGHA	Office of Global Health Affairs
OIG	Office of Inspector General
OMH	Office of Minority Health
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Information Technology
OS	Office of the Secretary
OSSI	Office of Security and Strategic Information
OWH	Office on Women's Health

P

PACE	Program of All-Inclusive Care for the Elderly
PAHPA	Pandemic and All-Hazards Preparedness Act
PART	Program Assessment Rating Tool
PERM	Payment Error Rate Measurement
PHS	Public Health Service
PHSSEF	Public Health and Social Services Emergency Fund
PII	Performance Improvement Initiative
PMA	President's Management Agenda
PSC	Program Support Center
PSOC	Project Save Our Children
PSSF	Promoting Safe and Stable Families

Q

QI	Qualified Individual
QIO	Quality Improvement Organization

R

RBH	Rabia Balkhi Women's Hospital
ROI	Return on Investment
RPG	Research Project Grant

S

SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Strategic Acquisition Service
SCHIP	State Children's Health Insurance Program
SHIP	State Health Insurance Assistance Program
SNS	Strategic National Stockpile
SOW	Scope of Work
SSA	Social Security Administration
SSBG	Social Services Block Grant
SSI	Supplemental Security Income
STD	Sexually Transmitted Diseases

T

TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TMA	Transitional Medical Assistance
TWWIIA	Ticket to Work and Work Incentives Improvement Act of 1999

U

UAC	Unaccompanied Alien Children
UFMS	Unified Financial Management System

V

VFC	Vaccines for Children
VTC	Video Teleconference

Acronyms 1