DEPARTMENT OF HEALTH & HUMAN SERVICES

BUDGET IN BRIEF

FISCAL YEAR 2006

The United States Department of Health & Human Services
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Washington, DC 20008

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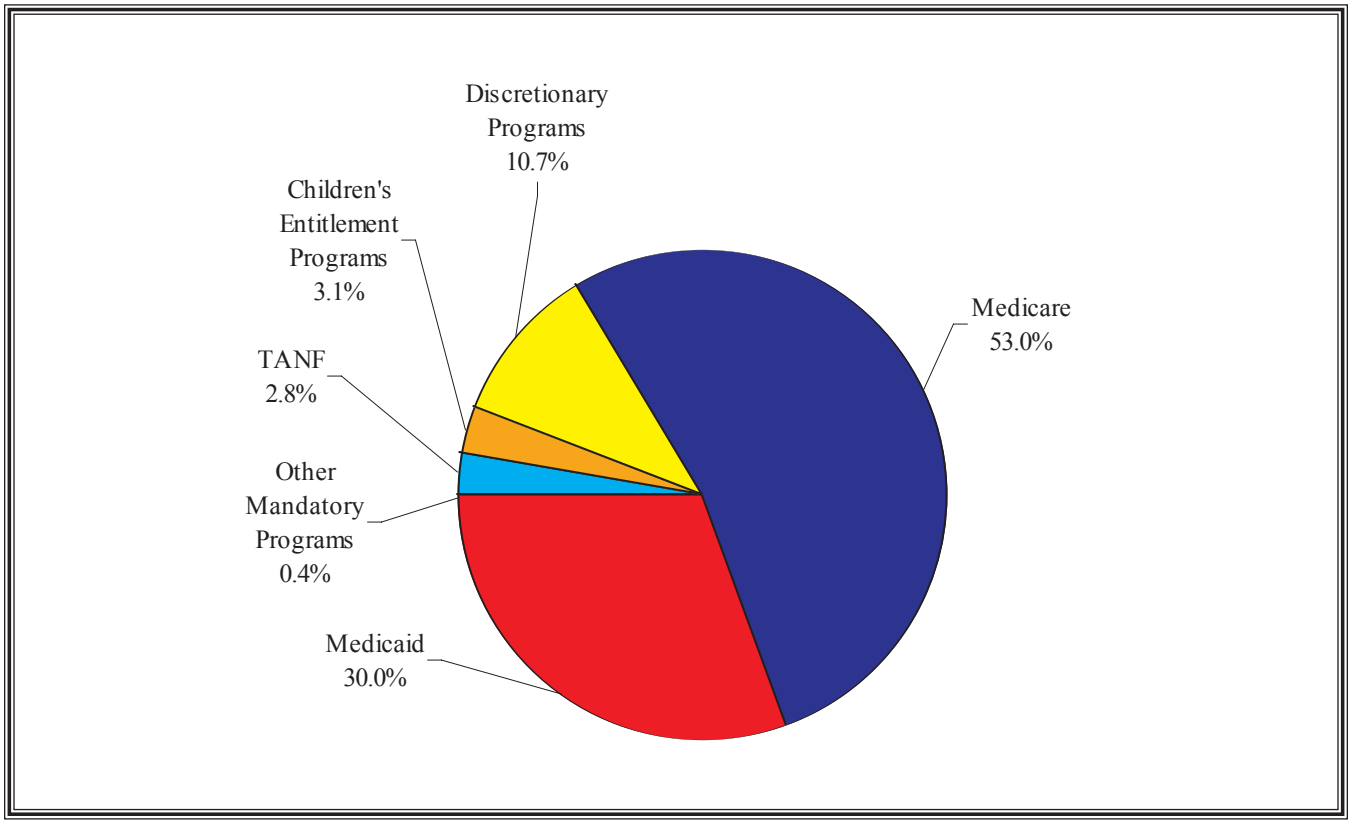
ADVANCING THE HEALTH, SAFETY, AND WELL-BEING OF OUR PEOPLE

President's Budget for HHS
FY 2006

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Budget Authority	$554,393	$581,038	$660,406	+$79,368
Outlays	$542,006	$583,957	$642,188	+$58,231
Full-Time Equivalents	64,244	67,444	67,284	-160

Composition of the Budget



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.

The Department of Health and Human Services (HHS) Fiscal Year (FY) 2006 budget enables the Department to provide for the health, safety, and well-being of Americans. FY 2006 outlays will total $642 billion, an increase of $58 billion over FY 2005 spending. The discretionary portion of the HHS budget totals $67 billion in budget authority and $71 billion in program level.

The Department's budget fosters strong sustained advances in the sciences underlying medicine, in public health, and in social services, and provides effective heath and human services. This budget request builds on the Department's Strategic Plan goals and enables HHS to meet present and future challenges. In FY 2006, resources and efforts will be directed toward:

- Providing access to quality health care, including continued implementation of the Medicare Prescription Drug, Improvement, and Modernization Act;
- Enhancing public health and protecting America;
- Supporting a compassionate society; and
- Improving HHS management, including implementing the President's Management Agenda

The HHS FY 2006 budget will enable the Department to improve the quantity and quality of health care available to Americans by implementing Medicare's prescription drug benefit, completing the President's current Health Center initiative, and launching a new health center effort in the poorest counties. This budget will enable the National Institutes of Health to increase research efforts in developing bioterrorism countermeasures and to fund biomedical research at current levels, will allow the Centers for Disease Control to expand the Strategic National Stockpile, and will support the Food and Drug Administration's efforts to defend the nation's food supply; it will further secure our nation against the threat of bioterrorism.

The Department considered a number of factors in constructing the FY 2006 budget, including the need for spending discipline and program effectiveness to support the Administration's initiative to cut the deficit in half over four years. Specifically, the budget decreases funding for lower-priority programs and one-time projects, consolidates or eliminates programs with duplicative missions, reduces administrative costs, and makes government more efficient.

For example, the budget requests no funding for the Community Services Block Grant and a number of smaller community services programs that were unable to demonstrate results in PART evaluation assessments.

Providing Access to Quality Health Care

Improving Medicare Through the Medicare Modernization Act: Funding for Medicare benefits, which assist 42.7 million elderly and disabled Americans, is estimated to be $394 billion in 2006.

Two of the most important provisions of the Medicare Modernization Act (MMA) are the new voluntary drug benefit, which will begin on January 1, 2006, and the enhanced health plan choices in Medicare Advantage. As a result of these new benefits, beneficiaries will be able to receive voluntary drug coverage as well as new support for their existing drug coverage through Medicare, and access to preferred provider organizations (PPOs), which are the most popular health plan choices for non-Medicare beneficiaries. Beginning in 2006, PPOs will begin to serve beneficiaries on a regional basis thereby promoting competition with other health care programs.

All beneficiaries will continue to have access to affordable care, while those with the lowest incomes and the highest levels of spending on drugs will receive additional assistance. As with current MMA implementation, as new options become available, Medicare will ensure that beneficiaries understand their choices and benefits.

Implementation of the Prescription Drug Benefit Program: Until 2006, the interim Medicare-endorsed prescription drug discount cards and transitional assistance programs will help beneficiaries pay the cost of prescription drugs. Beginning on January 1, 2006, Medicare will help pay for outpatient prescription drugs through private plans. Beneficiaries will have the option of remaining in the traditional fee-for-service program, enrolling separately in private prescription drug plans, or enrolling in integrated Medicare Advantage plans for all Medicare-covered benefits, including drugs. The prescription drug benefit program will be financed through beneficiary premiums (25.5 percent)

and general revenue (74.5 percent) and is projected to cost $58.9 billion in 2006.

Promoting Affordable Health Care: The Administration is strongly committed to meeting the needs of the approximately 45 million Americans who are uninsured. For this reason, the Administration proposes a multi-pronged approach to promoting economic opportunity and ownership, including:

- Health insurance tax credits to facilitate the private purchase of health insurance and Health Savings Accounts (HSAs);
- Grants to States for purchasing pools to help low-income individuals purchase coverage with the health insurance tax credit;
- Tax deductions for individuals with a high-deductible health plan and an HSA;
- Tax rebates to small employers contributing to employees' HSAs;
- Association Health Plans for groups of small businesses, civic groups, and community organizations;
- Medical liability law reforms that increase access to high quality and affordable health care; and
- A competitive marketplace for health insurance that crosses state lines while maintaining strong consumer protections.

Increasing Coverage through Medicaid and the State Childrens' Health Insurance Program: The Department currently projects that Medicaid will cover over 46 million individuals in FY 2006 at a cost to the Federal Government of $193 billion.

HHS proposes to provide States with additional flexibility in Medicaid to further increase coverage among low-income individuals and families without creating additional costs for the Federal Government. States largely agree that current Medicaid rules and regulations are barriers to effective and efficient management. The proposal builds on the success of the State Childrens' Health Insurance Program (SCHIP) in providing acute care for children and families, as well as current efforts to reduce the number of uninsured individuals.

A modernized Medicaid system will give States greater flexibility without the need for burdensome waiver applications. Principles that are employed in SCHIP and emphasize innovation will be expanded to Medicaid beneficiaries, while long-term care reforms will build on successful programs that use consumer direction and home-based care and community-based care to improve satisfaction and lower costs. A modernized Medicaid system will continue to grow at a robust rate to accommodate increases in health care spending.

The President's Budget includes proposals to extend Medicaid benefits to cover uninsured individuals and to expand benefits to those already on Medicaid, an investment of $7 billion over five years. These proposals include demonstration projects to expand access to community-based care for the disabled and elderly, an extension of transitional medical assistance, and an extension of Medicare premium assistance.

The FY 2006 budget also includes program integrity and cost efficiency proposals that will save an estimated $20 billion over five years in Medicaid fraud, waste, and abuse. Representative proposals include a reduction in allowable provider related taxes, an elimination of intergovernmental transfers that unfairly augment a State's share of Federal Medicaid matching funds, and reform the transfer of assets policy for medically needy eligibles applying for Medicaid long-term care.

SCHIP will spend approximately $5.4 billion in FY 2006. Authorization for the program expires at the end of FY 2007. Due to its success at enrolling millions of low-income uninsured children, the President's Budget seeks to re-authorize the program early, and better target the fund in a more timely manner. Under the proposal, the time States have to spend their SCHIP allotments would change from three years to two years. In total, budget proposals that enhance the SCHIP program will cost $992 million over five years.

Health Information Technology: In April 2004, the President expressed his vision for improving the safety, quality, and cost-effectiveness of health care through rapid implementation of secure and interoperable electronic health records. The FY 2006 budget seeks a total of $125 million to make this vision a reality. The Office of the National Coordinator for Health Information Technology (ONCHIT) will provide strategic direction for development of a national interoperable health care system, and encourage clinicians to connect and collaborate within a national Health IT network. The Agency for Health Care Quality and Research (AHRQ) will continue to accelerate the development, adoption, and diffusion of interoperable information technology in a range of health care settings.

Increasing the Capacity and Number of Health Centers: The budget completes the President's five-year commitment to create 1,200 new or expanded health center sites and serve an additional 6.1 million people by 2006. In FY 2006 alone, more than 2.4 million individuals will receive health care through 578 new or expanded sites in rural areas and underserved urban communities. In addition, the President is establishing a new goal to help every poor county in America in need that lacks a

health center and the FY 2006 request funds 40 new health center sites in high-poverty counties.

Increasing Care Available to Native Americans: The budget increases support to 1.8 million members of federally recognized Tribes by $72 million, for a total of $3.8 billion. With these funds, the Indian Health Service will provide high quality health care through 49 hospitals, over 240 outpatient centers, and over 300 health stations and Alaska village clinics. Increases will serve a growing eligible population and meet the rising costs of delivering health care. Resources are included to expand access to care through staffing six newly built health care facilities.

Access to Recovery Drug Treatment Program: Through the Access to Recovery program, HHS will assist States in expanding access to clinical treatment and recovery support services and allow individuals to exercise choice among qualified community provider organizations, including those that are faith-based. The toll of drug abuse on the individual, family, and community is both significant and cumulative. It may lead to lost productivity and educational opportunity, lost lives and to costly social and public health problems including HIV/AIDS, domestic violence, child abuse, and crime. The budget increases support for this initiative by 50 percent for a total of $150 million.

Ryan White: The FY 2006 request provides a total of $2.1 billion for Ryan White programs to ensure a comprehensive approach to provide treatment services to persons living with HIV/AIDS, consistent with the President's reauthorization principles–prioritization, flexibility, and accountability. Over 570,000 people will receive treatment services through Ryan White grant funding in FY 2006.

Enhancing Public Health and Protecting America

Medical Research: Federal investments in biomedical research have fueled major advances in knowledge about life sciences. The FY 2006 budget requests $28.8 billion for the National Institutes of Health (NIH), a net increase of $196 million. The request seeks to capitalize on the resulting opportunities this investment has opened for significant progress in improving the health of the nation by preventing, treating, and curing disease and disability. The budget request enables NIH to continue to implement the Roadmap for Medical Research; enhance collaborations for multidisciplinary neuroscience research; and accelerate efforts to develop and evaluate vaccines against HIV/AIDS. Withing this total, NIH will also increase funding to address critical requirements in biodefense, including a new targeted $50 million research effort to expand the current range of chemical countermeasures.

Preventing Disease: The FY 2006 budget includes targeted efforts to ensure a stable supply of annual influenza vaccine, develop the surge capacity that would be needed in a pandemic, improve low-income children's access to routine immunizations, and improve the response to emerging infectious diseases before they reach the United States.

Influenza
HHS will invest $439 million in targeted influenza activities in FY 2006, in addition to insurance reimbursement payments through Medicare. The request for the Centers for Disease Control (CDC) will fund a three-pronged approach to ensure an adequate supply of annual vaccine. Within the Vaccines for Children (VFC) program, CDC will allocate $40 million in new budget authority to buy a stockpile of pediatric influenza vaccine to guard against late-season surges in demand. The discretionary Section 317 program will use $30 million to get manufacturers to make additional bulk monovalent vaccine that can be turned into finished vaccine if other producers experience problems, or unusually high demand is anticipated. Finally, CDC will expand routine use vaccine procurements to $104 million, including an increase of $20 million targeted to children not eligible for VFC.

A draft Pandemic Influenza Response and Preparedness Plan was issued in August 2004, which lays out action steps in several areas. In support of this plan, NIH has expanded its research investment to approximately $119 million. The budget also increases to $120 million the Department's investment to develop the year-round domestic surge vaccine production capacity that will be needed in a pandemic, including new cell culture vaccine manufacturing processes.

Global Disease Detection
CDC supports a range of efforts to both track and prevent the international spread of infectious diseases. Although modern advances in vaccinations and technology have conquered some diseases, recent outbreaks of infectious diseases such as severe acute respiratory syndrome (SARS) and avian influenza, are reminders of the ability of microbes to adapt and to move across borders. In FY 2006, CDC will invest an additional $12 million to strengthen Global Disease Detection.

Responding to Major Disasters and Emergencies: The National Response Plan calls on HHS to lead public health and medical services during major disasters and emergencies. In support of this responsibility, the FY 2006 budget includes $70 million in targeted investments for the new Federal Mass Casualty Initiative to improve our medical surge capacity. This includes procurement of portable

treatment units through the Strategic National Stockpile, and the tools and infrastructure necessary to mobilize and coordinate medical personnel and volunteers in the event of a major medical emergency. HHS will also invest $1.3 billion in support of on-going work at the Centers for Disease Control and the Health Resources and Services Administration to improve state and local public health and hospital preparedness.

Strategic National Stockpile: HHS has the primary responsibility for ensuring the Nation's citizens have almost immediate access to an adequate supply of the medicines needed to protect them in the event of an attack with weapons of mass destruction, or other major public health emergencies. The Strategic National Stockpile (SNS) includes enough smallpox vaccine to protect every American, and by the end of FY 2006, will have sufficient antibiotics to protect 60 million people from anthrax exposure. The $600 million request includes $50 million to procure portable mass casualty treatment units and $550 million to buy additional medicines, replace those that are losing potency, provide specialized storage, and ensure that medicines and supplies can be made available for use anywhere in the United States within 12 hours.

Safe Food and Safe Drugs: The FY 2006 budget seeks $1.9 billion for the Food and Drug Administration (FDA), a net increase of $81 million above FY 2005. Within the requested increase for FDA, $30 million will be directed to enhancing the agency's national network of food contamination analysis laboratories and support vital research on technologies able to prevent threats to our food supply. Drug safety is also a primary focus, with a $6.5 million (24%) increase dedicated to evaluating and communicating drug safety risks to the public and applying scientific expertise to explore the risks of medical products already on the market. The FY 2006 budget also funds the medical devices program at a level consistent with the intent of the Medical Devices User Fee and Modernization Act of 2002.

Supporting a Compassionate Society

Marriage and Healthy Family Development:

Abstinence Education
Abstinence education programs are part of a comprehensive and continuing effort of the Administration to help adolescents avoid behaviors that could jeopardize their futures. Last year, HHS integrated abstinence education activities with the youth development efforts at the Administration for Children and Families (ACF), by transferring the Community-Based Abstinence Education program and the Abstinence Education Grants to States to ACF. The FY 2006 budget expands activities to educate adolescents and parents about the health risks associated with early sexual activity and provide them with the tools needed to help adolescents make healthy choice. A total of $206 million, an increase of $39 million, is requested for these activities.

Healthy Marriage / TANF Reauthorization
A high priority in the President's Budget is TANF reauthorization. A key element of the President's plan is its support of healthy marriage and responsible fatherhood. The FY 2006 budget includes $1 billion over five years in federal funds to promote healthy marriage through demonstrations, research, and a matching state program. The budget also proposes $200 million in mandatory funding over five years to support responsible fatherhood. With matching state funds, a total of $1.7 billion over five years will help advance this central goal of the TANF program.

Faith Based and Community Initiatives: As part of the larger Faith-Based and Community Initiative, the budget maintains a commitment to strengthen the capacity of faith-based and community organizations.

Compassion Capital Fund
The Compassion Capital Fund advances the efforts of community and charitable organizations, including faith-based organizations, to increase their effectiveness and enhance their ability to provide social services where they are needed. The budget includes $100 million, an increase of $45 million. Among the priorities within the 2006 proposal is an emphasis on supporting anti-gang efforts through community and faith-based organizations.

Mentoring Children of Prisoners
The Mentoring Children of Prisoners program, funded at $50 million, will establish approximately 33,000 new mentoring relationships for children of incarcerated parents or those recently released from prison. Nearly two million children have a parent in a federal or state correctional facility, and research indicates that children with incarcerated parents are more likely than the general population to display a variety of behavioral, emotional, health, and educational problems.

Maternity Group Homes
The budget includes $10 million for Maternity Group Homes, to support community-based, adult-supervised group homes for young mothers and their children. Grantees will provide a range of coordinated services such as child care, education, job training, and counseling and advice on parenting and life skills.

Increasing Care for Children and the Elderly:

Child Support Enforcement
The FY 2006 President's Budget eagerly anticipates congressional action on previously proposed child support enforcement legislation. The President's legislative proposals continue to support healthy, financially strong families by strengthening enforcement tools, enhancing child support automation, and improving collection of medical child support. These proposals offer an impressive $3.4 billion in increased child support collections to families at a total federal cost of $52 million over five years.

Child Welfare Program Option
It is a high priority of HHS to pursue with Congress passage of the Child Welfare Program Option. The Child Welfare Program Option would give States the option to receive their foster care funding as a flexible grant over five years. The flexible option would support a continuum of services to families in crisis and children at risk. This proposal costs $36 million in FY 2006 and it is budget neutral over five years.

Head Start
The budget requests $6.9 billion for Head Start, which will provide comprehensive child development services to 919,000 children of primarily low-income families. The request includes $45 million to support the President's initiative to improve Head Start by funding nine state pilot projects to coordinate state preschool, child care, and Head Start in a comprehensive system of early childhood programs. Head Start programs help ensure that children are ready to succeed at school by supporting their social and cognitive development.

Services for the Elderly
The budget requests a total of $1.4 billion in the Administration on Aging for programs that serve the most vulnerable elderly Americans, who otherwise lack access to healthy meals, preventive care, and other supports that enable them to remain in their home communities and out of nursing facilities. It also continues investments in program innovations to test new models of home and community-based care.

Implementing the President's Management Agenda & Improving Management

The President's Management Agenda (PMA) provides a framework to improve the management and performance of HHS. HHS has taken significant steps to institutionalize its focus on results and achieve improved program performance that is important to the HHS mission and the American taxpayer.

Budget and Performance Integration: Budget and Performance Integration (BPI) aims to improve program performance and results by ensuring that performance information is used to inform funding and management decisions. For FY 2006, HHS operating divisions produced their first "performance budgets" which combine budget and performance information in a single document. With this new format the Department moves from the traditional approach of presenting separate budget justifications and performance plans to the use of one integrated document to present both budget and performance information. This enhances the availability and use of program and performance information to inform the budget process. The new budget format along with other successes enabled HHS to improve its BPI status rating from red to yellow while maintaining a green progress rating on the PMA scorecard.

The Program Assessment Rating Tool (PART) is an important component of BPI and is used to assess program performance and improve the quality of performance information. Sixty five HHS programs were reviewed in the PART process between FY 2004 and 2006. These programs account for more than 74 percent of HHS budgetary resources. Forty-seven of the 65 programs reviewed received a narrative rating of Adequate, Moderately Effective, or Effective. Additional information on PART results for HHS programs is provided in the individual Operating Division sections as well as in the FY 2006 PART table on page 10.

Strategic Management of Human Capital: HHS has successfully achieved a green status and green progress rating for Strategic Management of Human Capital. This high rating recognizes several HHS accomplishments, such as the consolidation of 40 personnel offices dispersed throughout HHS into four Human Resources Centers, which became operational in January 2004. HHS is planning several upcoming projects to support Human Capital and maintain this high rating.

Competitive Sourcing: HHS has successfully achieved a green status and green progress rating for Competitive Sourcing. To date, HHS has conducted competitive sourcing studies for almost 25 percent of its commercial activities. For studies completed in FY 2004 HHS anticipates gross savings of $55 million for the benefit of HHS programs and the American taxpayer. HHS plans to maintain high performance results that support Competitive Sourcing, which include structuring competitions to maximize efficiencies and savings and implementing a savings validation plan.

Improving Financial Management: HHS implemented several processes to improve the financial performance of the Department, such as streamlining and accelerating the annual financial reporting process and combining annual audited financial statements with program perform-

ance information in the Department's Performance and Accountability Report. It also continues to implement the Unified Financial Management System within several HHS agencies.

E-Government / IT Management: HHS has achieved a yellow status and progress rating for Expanded Electronic Government. More than 95 percent of HHS' information systems have certified and accredited security plans. HHS has been working to achieve a more mature Enterprise Architecture (EA) that links performance to strategic and capital planning and budget processes.

Management Initiatives: In addition to the five government-wide management initiatives, HHS is also responsible for managing the following PMA Program Initiatives:

- Broadening health insurance coverage through state initiatives
- Eliminating improper payments
- Real property asset management
- Faith-based and community initiatives
- Research and development invest ment criteria

HHS BUDGET BY OPERATING DIVISION

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Food & Drug Administration:				
Program Level	$1,695	$1,801	$1,881	+$80
Budget Authority	1,386	1,450	1,500	+50
Outlays	1,379	1,317	1,475	+158
Health Resources & Services Administration:				
Budget Authority	6,682	6,890	6,047	-843
Outlays	6,634	6,637	6,529	-108
Indian Health Service:				
Budget Authority	3,072	3,135	3,198	+63
Outlays	3,057	3,009	3,324	+315
Centers for Disease Control & Prevention:				
Budget Authority	4,440	4,572	4,017	-555
Outlays	4,259	4,490	4,436	-54
National Institutes of Health:				
Budget Authority	28,028	28,594	28,740	+146
Outlays	25,759	27,467	28,563	+1,096
Substance Abuse & Mental Health Services:				
Budget Authority	3,234	3,268	3,215	-53
Outlays	3,112	3,191	3,239	+48
Agency for Healthcare Research & Quality:				
Program Level	304	319	319	0
Budget Authority	0	0	0	0
Outlays	69	0	0	0
Centers for Medicare & Medicaid Services:				
Budget Authority	455,511	480,444	565,060	+84,616
Outlays	448,631	487,603	543,719	+56,116
Administration for Children & Families:				
Budget Authority*	48,594	49,198	44,947	-4,251
Outlays	46,125	47,086	47,024	-62

* In FY 2004 Temporary Assistance to Needy Families includes $2 billion for the Contingency Fund to remain available for five years; and $500 million for employment achievement bonuses providing $100 million peryear to the States.

HHS BUDGET BY OPERATING DIVISION

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Administration on Aging:				
Budget Authority	1,374	1,393	1,369	-24
Outlays	1,342	1,367	1,379	+12
Health Information and Technology Initiative:				
Budget Authority	0	0	75	+75
Outlays	0	0	39	+39
Medicare Hearings and Appeals:				
Budget Authority	47	58	80	+22
Outlays	47	58	68	+10
Departmental Management/Civil Rights/ PHSSEF*:				
Budget Authority	2,766	2,751	2,822	+71
Outlays	2,369	2,455	3,047	+592
Office of Inspector General:				
Budget Authority	39	40	40	0
Outlays	21+	40	40	0
Program Support Center (Retirement Pay, Medical Benefits, and Misc. Trust Funds):				
Budget Authority	403	425	444	+19
Outlays	385	417	454	+37
Proprietary Receipts:				
Budget Authority	-1,183	-1,180	-1,148	+32
Outlays	-1,183	-1,180	-1,148	+32
Budget Authority	$554,393	$581,038	$660,406	+79,368
Emergency Response Fund (Non-add)	*$2,818*	*$0*	-$2,818	-2,818
Non-Emergency Relief Fund (Non-add)	*$551,575*	*$581,038*	$663,224	+82,186
Outlays	$542,006	$583,957	$642,188	+58,231
Full-Time Equivalents	64,244	67,444	+67,284	-160
Commissioned Corps Detailed Outside HHS	*1,005*	*1,262*	*+1,262*	0

* Public Health and Social Services Emergency Fund

(dollars in millions)

	Narrative Rating	2005	2006
Health Resources & Services Administration:			
Traumatic Brain Injury	RND	$9	$0
Poison Control Centers	Adequate	$24	$23
Emergency Medical Services for Children	RND	$20	$0
Organ Transplantation	Adequate	$24	$23
Bone Marrow Donor Registry	Moderately Effective	$25	$23
Indian Health Service:			
Health Facilities construction	Effective	$89	$3
Centers for Disease Control and Prevention:			
Epidemic Services and Response	RND	$0	$0
Sexually Transmitted Diseases (STD) and Tuberculosis (TB)	Adequate	$298	$299
Infectious Disease Control	Adequate	$226	$225
Occupational Safety and Health (NIOSH)	Adequate	$286	$286
Buildings and Facilities	Adequate	$270	$30
National Institutes of Health:			
Extramural Research Activities (other than training and facilities)	Effective	$21,146	$21,385
Substance Abuse & Mental Health Services:			
Substance Abuse Prevention PRNS	Moderately Effective	$199	$184
Agency for Healthcare Research & Quality:			
Pharmaceutical Outcomes	Moderately Effective	$27	$26
Administration for Children & Families:			
Assets for Independence	Adequate	$25	$25
Child Welfare -- CAPTA State Grants	RND	$27	$27
Child Welfare -- CBCAP	RND	$43	$43
Child Care (mandatory and discretionary)	Moderately Effective	$4,800	$4,800
Independent Living	RND	$140	$140
Violent Crime Reduction Programs (Shelter and Hotline)	RND	$129	$129
Office of the Secretary:			
Adolescent and Family Life	RND	$31	$31
Women's Health	RND	$29	$29

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Mandatory Programs (Outlays):				
Medicare	$265,062	$290,310	$340,412	+50,102
Medicaid	176,231	188,497	192,718	+4,221
Temporary Assistance for Needy Families	17,725	18,099	18,164	+65
Foster Care & Adoption Assistance	6,340	6,474	6,561	+87
State Children's Health Insurance	4,607	5,343	6,233	+890
Child Support Enforcement	3,815	3,934	4,031	+97
Child Care	2,695	2,718	2,718	0
Social Services Block Grant	1,752	1,764	1,762	-2
Other Mandatory Programs	1,113	1,373	2,038	+665
Proprietary Receipts	-1,183	-1,180	-1,148	+32
Subtotal, Mandatory (Outlays)	**$478,157**	**$517,332**	**$573,489**	**$56,157**
Discretionary Programs (BA):				
Food & Drug Administration	$1,386	$1,450	$1,500	+$50
Health Resources & Services Administration	6,600	6,809	5,972	-$837
Indian Health Service	2,922	2,985	3,048	+$63
Centers for Disease Control and Prevention	4,440	4,572	4,017	-$555
National Institutes of Health	27,878	28,444	28,590	+$146
Substance Abuse & Mental Health Services	3,234	3,268	3,215	-$53
Agency for Healthcare Research & Quality	0	0	0	$0
AHRQ Program Level (Non-Add)	*304*	*319*	*319*	$0
Centers for Medicare & Medicaid Services	2,963	3,267	3,257	-$10
Administration for Children & Families	13,356	13,845	13,126	-$719
Administration on Aging	1,374	1,393	1,369	-$24
Office of the Secretary*	442	451	434	-$17
Health Information Technology	0	0	75	+$75
Medicare Hearings and Appeals	47	58	80	+$22
PHSSEF	2,164	2,339	2,428	+$89
Subtotal, Discretionary (BA)	**$66,806**	**$68,882**	**$67,112**	**-$1,771**
Medicare Eligible Healthcare Accruals (Com. Corps)	27	33	34	+$1
Total, Discretionary (BA)**	**$66,833**	**$68,915**	**$67,146**	**-$1,770**
Subtotal, Discretionary (Outlays)	**$63,849**	**$66,625**	**$68,699**	**$2,074**
Total, HHS Outlays	**$542,006**	**$583,957**	**$642,188**	**+$58,231**

* Including the Office of the Inspector General and th Office for Civil Rights

** Discretionary amounts shown reflect adjustments for the comparability and services provided by other agencies in support of Medicare.

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Salaries & Expenses:				
Foods	$465	$495	$522	+$28
Animal Drugs and Feeds	105	115	118	+3
Human Drugs	513	537	556	+19
Biologics	180	184	191	+7
Medical Devices	252	277	289	+12
National Center for Toxicological Research	40	40	41	+1
Field Inspections and Analysis (non-add)	535	560	590	+30
Other Activities	124	124	127	+3
FDA Consolidation at White Oak	2	21	22	+1
Export/Certification Fund	7	7	8	+1
Subtotal, Salaries & Expenses	**$1,688**	**$1,801**	**$1,874**	**+$73**
Buildings and Facilities	7	0	+7	+7
Total, Program Level	**$1,695**	**$1,801**	**$1,881**	**+$81**
Less User Fees:				
Prescription Drug User Fee Act (PDUFA)	-$250	-$284	-$305	-$21
Medical Device User Fees (MDUFMA)	-32	-34	-40	-6
Animal Drugs User Fee Act (ADUFA)	-5	-8	-11	-3
Mammography Quality Standards Act (MQSA)	-17	-17	-17	0
Export/Certification Fund	-7	-7	-8	-1
Subtotal, User Fees	**-$310**	**-$350**	**-$381**	**-$31**
Total, Budget Authority	**$1,386**	**$1,450**	**$1,500**	**+$50**
Biodefense (non-add):				
Food Defense	*$116*	*$150*	*$180*	*+$30*
Medical Product Countermeasures	*53*	*57*	*57*	*0*
Security	*7*	*7*	*7*	*0*
Subtotal, Biodefense (non-add)	*$175*	*$214*	*$244*	*+$30*
FTE	10,210	10,446	10,242	-204

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 2006 budget request for the Food and Drug Administration (FDA) is $1.9 billion, a program level increase of $81 million over FY 2005 and $614 million over FY 2001. Of the funds requested, the budget proposes $1.5 billion in budget authority, while $381 million will be derived from industry-specific user fees. Significant increases are included to secure our nation's food supply from the risks of contamination and for the Office of Drug Safety to ensure the safety and effectiveness of approved drugs already on the market. The budget also supports increased funding for the premarket review of medical devices as well as drugs and biologics, while continuing to provide funding for the FDA consolidation at White Oak and restoring FDA-wide facilities repair funds.

Protecting the Food Supply

Since 9/11, FDA has strengthened the nation's defenses against the risk of deliberate contamination of our food supply. Approximately 80 percent of our country's food is under FDA's direct regulatory oversight, and the agency has committed substantial effort and resources to combat threats prior to the occurrence of a terrorist event. In FY 2006, FDA will continue to ensure consumers are protected against intentional and accidental risks that threaten our food supply. Within the FY 2006 budget, the Foods program requests a total of $522 million, a $28 million increase over FY 2005 devoted to food defense. The Animal Drugs and Feeds program protects the health and safety of all food producing, companion, or other non-food animals; and assures that food from animals is safe for human consumption. This program is responsible for ensuring the availability of safe and effective veterinary drugs and has the primary role in Bovine Spongiform Encephalopathy (BSE) or "Mad Cow" disease prevention efforts. The budget includes $118 million in the Animal Drugs and Feeds program, a $3 million increase over FY 2005.

Food Defense: The FY 2006 budget requests a $30 million increase over FY 2005, for a total of $180 million devoted to protecting the American people against attacks on the national food supply. This request is a part of a continuing effort with the Department of Agriculture (USDA) and the Department of Homeland Security (DHS) to coordinate all strategies used to combat the threat of intentional food contamination. Within the increase, $20 million will be directed to enhance the laboratory surge capacity and national coverage of the Food Emergency Response Network (FERN). FERN is a nationwide network of Federal and State laboratories dedicated to testing for biological, chemical and radiological threat agents. While FDA and USDA are building FERN surge capacity, the agency will continue work with DHS to award new funds to existing State labs in geographic regions with the greatest need according to current threat assessments. The budget request will dramatically increase FDA's ability to rapidly test threat agents and respond to terrorist attacks.

In addition to laboratory preparedness, $6 million of this request will fund research based on food vulnerability threat assessments developed in collaboration with USDA. This research will focus on closing mission-critical knowledge gaps in food defense through development of technologies able to detect and prevent threats to the food supply. FDA will continue its support of the government-wide biosurveillance effort with a $3 million increase, for a total of $5 million dedicated to providing the earliest possible detection of the intentional release of deadly pathogens into food, water, or the environment. This increase will help coordinate existing food surveillance capabilities with public health and environmental officials at the State and national levels under a unified system. Finally, $1 million of the request will be used for central response coordination through the Office of Crisis Management.

Animal Drugs Premarket Review: The budget includes $11 million derived from industry-specific fees, an increase of $3 million over FY 2005. These funds will allow FDA to improve review times on 90 percent of original new animal drug applications by 40 days, while maintaining the safety of approved animal drugs.

Human Drugs and Biologics

In FY 2006, the budget includes $747 million for the Human Drugs and Biologics, an increase of $19 million for the Human Drugs program and an increase of $7 million in the Biologics program. Of the total spending on these activities, $288 million will be from industry-specific user fees. These funds will ensure the safety and

efficacy of new and existing human drugs and biologics – helping to make medicines safer, more affordable and more available. All new drugs will be evaluated for safety and efficacy before entering the market, and monitoring efforts will be directed toward the 10,000 drugs that are already on the market to be sure they continue to meet the highest standards of safety and efficacy. In addition, existing and emerging biological products, including whole blood and blood products; vaccines; and therapeutic products, including cells, gene therapies, and tissues will be assessed for safety and effectiveness. In FY 2004, FDA approved 534 new and generic drugs and biological products, many of which represent significant therapeutic advances.

Drug Safety: The budget includes an increase of $6.5 million, including $1.5 million in PDUFA user fees, over FY 2005 for the Office of Drug Safety, for a total of $33 million. This represents a 147 percent increase in funds for this office since FY 2001. With increased resources in FY 2006, FDA plans to hire additional staff to increase personnel dedicated to evaluating and communicating drug safety risks to the healthcare community and the American Public. FDA also plans to use additional staff to establish policies and processes regarding safety reviews and risk management, manage increased drug safety monitoring workload and internal communications, and increase scientific expertise available to explore safety risks and signals in various populations. Further, FDA intends to apply more funding to obtaining access to a wide range of clinical, pharmacy and administrative databases. Given the highly fragmented healthcare system in the United States, there is no single healthcare database that the Agency can rely upon to widely monitor drug adverse events. As each drug has its own indication(s) that may result in its differential use in different populations, it is essential that the Center for Drug Evaluation and Research have access to a wide range of databases to adequately assess drug safety.

FDA will continue its efforts to improve the timeliness and availability of drug safety information and will seek alternative strategies for managing drug safety issues. FDA will also increase the use of external experts in evaluating post-marketing safety issues. The agency's actions will be harmonized with the emerging results of an Institute of Medicine (IOM) Study of the Drug Safety System. The IOM committee conducting this study will examine the role of FDA within the health care delivery system and recommend measures to enhance the confidence of Americans in the safety and effectiveness of their drugs.

Prescription Drug User Fee Act (PDUFA): The budget includes $305 million from the Prescription Drug User Fee Act (PDUFA) fees, of which $279 million is available for the Human Drugs and Biologics programs and the remaining $26 million for costs related to the management and operations of the program. During renegotiation of the PDUFA agreement in 2002, FDA sought and received the statutory authority to expend user fees on postmarket risk management. The PDUFA program has since substantially increased the amount of funds devoted to maintaining the safety standards essential to the public's health. These fees have also enabled the provision of more technical assistance, advice, and rapid responses to special inquiries during the drug development period and after drugs are approved for sale. As a result, industry has been able to shorten the time needed for drug development and continually improve the safety profile of marketed drugs.

MEDICAL DEVICES

The FY 2006 budget includes an increase of $12 million, for a total of $289 million to ensure medical devices are safe and effective. This level of funding is consistent with the intent of the Medical Devices User Fee and Modernization Act of 2002 (MDUFMA), which provides a total of $40 million in industry-specific user fees for devices work across FDA.

This request for the Medical Devices program will lead to marked improvement in application review performance while maintaining the consistent quality and safety of approved medical device products. In FY 2006, FDA expects to meet goals stipulating that the agency must review and make decisions on 80 percent of all original premarket medical device applications within 150 and 320 days respectively. These are the most challenging review goals to date, with goals becoming even more ambitious in FY 2007. Additional funding will also be directed towards medical device postmarket safety efforts. MDUFMA fees contribute to the evaluation of postmarket studies required as a condition of medical device approval, and the compilation, development, and review of postmarket information to identify safety and effectiveness issues.

FACILITIES

Headquarters Consolidation:
The FY 2006 budget request includes a total of $22 million in resources directed to move and fit out costs for the new FDA consolidated facility the General Services Administration (GSA) is constructing in White Oak, MD. This funding is needed for completion of the project's next phase, which includes the Center for Devices and Radiological Heath (CDRH) Engineering and Physics Laboratory and the data center consolidation. These resources will

be directed to relocation costs, including move and fit-out of the CDRH lab and communications and data equipment for the consolidated data center. The FY 2006 GSA budget includes $128 million primarily for construction of the second of two Center for Drug Evaluation and Research buildings to be occupied in FY 2007 and the second phase of construction for the consolidated data center.

Buildings and Facilities:
In FY 2006, the budget seeks $7 million to pay for repair and maintenance for FDA-owned facilities nation-wide. FDA inventory includes approximately 40 buildings in 16 separate locations, plus field offices and newly established BSL-3 laboratories. Funding was paused in FY 2005, as FDA utilized carryover balances from the prior year to pay for facility repair.

MANAGEMENT IMPROVEMENTS

In FY 2006, FDA proposes a budget structure change in order to enhance the agency's ability to respond to emerging situations without being hindered in performing mission critical activities. The two major changes are the establishment of a single budget line item for the agency's field inspection and analysis activities (Office of Regulatory Affairs), and changing the display and management of facility rent costs by incorporating rental expenses into program estimates. By making these alterations, the budget will allow greater flexibility in how resources are allocated in response to crisis situations, eliminate the need for many reprogramming requests to Congress, and more accurately portray the cost of operating each program.

FDA will also seek management efficiencies through a $5 million streamlining of information technology efforts and a $1.5 million administrative reduction.
To accomplish this, the agency will spur consolidation of information technology activities and reduce administrative expenses outside the user fee-funded areas. Both of these management improvements support the President's Management Agenda.

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Health Centers	$1,618	$1,734	$2,038	+$304
(Health Center Judgment Fund - non-add)	*45*	*45*	*45*	*0*
Free Clinics Medical Malpractice Coverage	5	0	0	0
Healthy Community Access Program	83	83	0	-83
Nurse Training Programs	142	151	150	-1
National Health Service Corps	170	132	127	-5
Health Professions Training Activities	245	252	0	-252
Scholarships for Disadvantage Students/Workforce Information & Analysis	48	48	11	-37
Children's Hospitals Graduate Medical Education	303	301	200	-101
Bioterrorism Hospital Preparedness	515	491	483	-8
Bioterrorism Medical Training, Curriculum Development	28	28	28	0
Ryan White HIV/AIDS Activities	2,065	2,073	2,083	+10
(AIDS Drug Assistance Program - non-add)	*749*	*788*	*798*	*+10*
Rural Health	142	144	29	-115
Maternal and Child Health Block Grant	730	724	724	0
Healthy Start	98	102	97	-5
Family Planning	278	286	286	0
Traumatic Brain Injury	9	9	0	-9
Poison Control	24	23	23	0
EMS for Children	20	20	0	-20
Organ Transplantation	25	24	23	-1
Bone Marrow Donor Registry	23	26	23	-3
Cord Blood Stem Cell Bank	10	10	0	-10
Telehealth	4	4	4	0
Black Lung/Radiation Exposure Compensation	8	8	8	0
Hansen's Disease Services Programs	20	20	19	-1
Health Care Facilities/Other Improvement Projects	371	483	0	-483
State Planning Grants	15	11	0	-11
Universal Newborn Hearing Screening/Trauma/Sickle Cell	13	13	0	-13
Program Management	155	153	151	-2
National Practitioner Data Bank (User Fee)	16	16	16	0
Health Integrity & Protection Data Banks (User Fee)	4	4	4	0
Total, Program Level	**$7,187**	**$7,373**	**$6,527**	**-$846**
Less Funds Allocated From Other Sources:				
User Fees	-20	-20	-20	0
PHS Evaluation Funds (Ryan White)	-25	-25	-25	0
Public Health and Social Service Emergency Fund	-543	-519	-511	+8
Subtotal, Funds from Other Sources	-588	-564	-555	+8
Total, Discretionary Budget Authority	**$6,599**	**$6,809**	**$5,972**	**-$838**
FTE	1,878	2,034	2,002	-32

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 2006 budget requests $6.5 billion for the Health Resources and Services Administration (HRSA), a net decrease of $846 million from the FY 2005 level. HRSA is the principal Federal agency charged with increasing access to basic health care for those who are medically underserved. HRSA's portfolio of programs and initiatives focus on services through health centers, the Ryan White CARE Act programs, placing physicians in underserved areas, maternal and child health programs, and support for the next generation of nurses. Collectively, these and other programs provide direct services to improve access to care for more than 20 million uninsured or underserved individuals. The HRSA budget supports programs that have shown success in providing direct health care and reduces or eliminates funding for programs that have failed to demonstrate results or are similar to other activities.

Expanding Access to Quality Health Care

Health Centers: The budget will complete the President's commitment to create 1,200 new or expanded health center sites to serve an additional 6.1 million people by 2006. A total of 2.4 million additional individuals will receive health care in 2006 through 578 new or expanded sites in rural areas and underserved urban communities. In addition, the President has established a new goal to help every poor county in America in need that lacks a health center and can support one. The budget includes $26 million to fund 40 new health center sites in high poverty counties. A total of $2.0 billion is requested for the Health Centers program, $304 million over the FY 2005 level.

By the end of FY 2006, the Health Centers program will deliver high-quality, affordable primary and preventive health care to over 16 million patients at more than 4,000 sites across the country. In 2006, health centers will serve an estimated 16 percent of the Nation's population who are at or below 200 percent of the Federal poverty level.

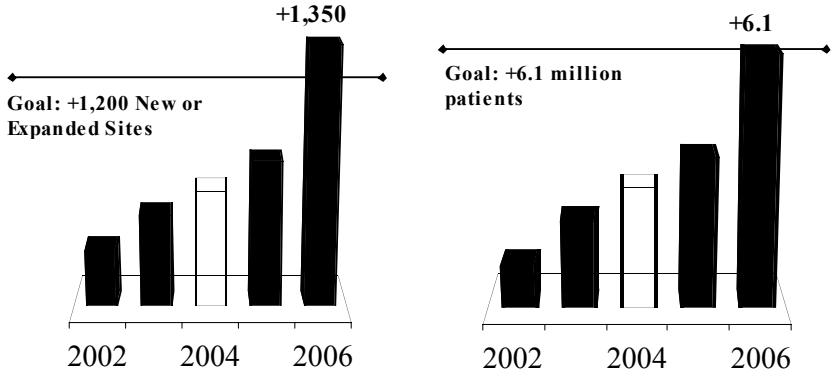
Health centers are effectively targeted to eliminate health disparities and provide a range of essential services. Forty percent of health center patients have no health insurance and 64 percent are racial or ethnic minorities. Further, 83 percent of health centers provide pharmacy services on site or by paid referral, 83 percent provide preventive dental care, and 74 percent provide mental health and substance abuse services.

In 2004, it is estimated that health centers will employ approximately 8,300 physicians and dentists and 15,500 other health care clinicians including nurse practitioners and midwives – 33 percent more physicians and dentists than in FY 2001, and almost 30 percent more clinicians. The budget request includes $45 million in no-year funding for the Health Centers Federal Tort Claims Program, which provides medical malpractice coverage for the increasing number of health center employees.

Ryan White, HIV/AIDS: The Ryan White CARE Act provides services to approximately 571,000 individuals each year with little or no insurance.

The FY 2006 request provides a total of $2.1 billion for Ryan White activities to ensure a comprehensive approach to address the health needs of persons living with HIV/AIDS. In 2004, the President articulated his commitment to reauthorize the Ryan White CARE Act by outlining key principles to strengthen this legislation. These principles include prioritizing lifesaving services for individuals living with HIV/AIDS, including HIV/AIDS medications and primary care; providing more

The FY 2006 request completes the President's initiative to expand access to health care for the uninsured and underserved by creating 1,200 new or expanded health center sites and serving 6.1 million more people.



Ryan White CARE Act Accomplishments

- AIDS mortality has decreased as lives have been extended with HIV/AIDS medications – many of which have been purchased through the AIDS Drug Assistance program.
- Ryan White CARE Act grantees have served clients who reflect the demographics of the epidemic; data shows that the disease now disproportionately impacts minority communities.
- Comprehensive approaches have been developed all across the country recognizing that HIV/AIDS now affects all States, urban, suburban, and rural communities.

flexibility to target resources to areas that have the greatest needs; and, encouraging the participation of any provider, including faith-based and other community organizations that show results, recognizing the need for State and local planning and ensuring accountability by measuring progress. The request will support a comprehensive approach to address the health needs of persons living with HIV/AIDS, consistent with the reauthorization principles.

Maternal and Child Health Block Grant: The budget provides $724 million for the Maternal and Child Health (MCH) Block Grant. The MCH Block Grant supports Federal and State partnerships that provide gap-filling prenatal health services to more than 2.5 million women and primary and preventive care to more than 22.7 million children, including over 1.1 million children with special health care needs. These services include direct health care services for children with special health care needs, the promotion of health and safety in child care settings, and enabling services such as home visiting and nutrition counseling.

Family Planning: The budget maintains the FY 2005 level of $286 million for Family Planning. This program supports a network of more than 4,500 clinics nationwide that provide access to a wide array of reproductive health care and preventive health care services, such as pap tests and breast exams to nearly five million people, primarily low-income women. Counseling and education regarding abstinence are required for all adolescent clients in this program.

Healthy Start and Poison Control: The request includes $97 million for the Healthy Start program, which supports community driven programs in targeted high risk communities to reduce the incidence of risk factors that contribute to infant mortality. The budget also includes $23 million for the Poison Control program, which this year's Performance Assessment Rating Tool (PART) assessment found, has demonstrated progress in reducing emergency room visits due to poisoning, its long term goal.

Developing A Health Professions Workforce for the 21st Century

Today, the Nation faces a shortage of approximately 150,000 nurses in our hospitals and other health care facilities. As the population continues to grow and age and medical services advance, the need for nurses will continue to increase. A report issued by the Department in 2002, *Projected Supply, Demand, and Shortages of Registered Nurses: 2000-2020*, predicted that the nursing shortage is expected to grow to 29 percent by 2020, compared to a 6 percent shortage in 2000.

The budget requests $150 million for nursing education programs, an increase of almost 80 percent since FY 2001. Within this total is a $10 million, or nearly 30 percent, increase over last year for grants to increase the number of baccalaureate prepared nurses and to improve the quality of nursing practice for those already in the workforce through education, practice, and retention grants. At this level, approximately 40 new grants will be awarded.

The request provides $31 million to support approximately 860 loan repayments and scholarships that will reduce the financial barrier to nursing education for all levels of professional nursing students. The budget also includes $21 million for nursing workforce diversity, $43 million for advanced nursing education, and maintains over $8 million in loans for nurse faculty and support for comprehensive geriatric education. These programs will support the recruitment, education, and retention of an estimated 10,700 nurses and nursing students.

Approximately 53 million people reside in communities without access to primary health care due to financial, geographic, cultural, language, and other barriers. Since 1972 when the first 20 clinicians were assigned to serve in underserved communities, the National Health Service Corps (NHSC) has made nearly 26,000 health professionals available to serve in underserved areas across the country. In addition, the NHSC works with the Health Center program to help meet its provider needs. Currently, half of NHSC clinicians serve in health centers. The budget supports a field strength of more than 3,400 clinicians in 2006. Through the enactment of the American Jobs Creation Act of 2004, HRSA will no longer reimburse loan repayment recipients for the tax payment. The FY 2006 request includes $127 million for the NHSC program.

The budget provides $200 million for the Children's Graduate Medical

Education program. This level will provide children's hospitals with substantial resources to train doctors. In 2006, hospitals will receive an estimated per resident payment of $51,145 to support a total of about 4,100 medical interns, residents, and fellows in 61 children's teaching hospitals.

In addition, the request includes $10 million for the Scholarships for Disadvantaged Students program. In 2006, this program will support 2,893 scholarships.

Preparing America's Health Care System and Providers for Bioterrorism

The Hospital Preparedness program directly supports States' efforts to enhance their capability to provide critical emergency care to America's populations in response to acts of terrorism and other public health emergencies. The budget requests $483 million in FY 2006 to continue progress towards the goal of 100 percent of States having the necessary surge capacity plans, including elements of the health care provider workforce and pharmaceutical and laboratory services. As of the end of 2004, 89 percent of States had reached the goal of having plans in place.

In FY 2006, HHS will emphasize performance objectives in relation to the risks and consequences of terrorism. As part of the National Preparedness Goal called for by Homeland Security Presidential Directive 8, HHS is developing performance metrics to help ensure that hospitals and public health departments are emergency ready. These metrics focus on receipt of emergency case reports, incident reporting, laboratory agent testing, patient care, and increasing surge capacity.

Within the $483 million, $25 million is included to create a state-of-the-art emergency care capability designed to respond to a terrorist attack or other incident requiring mass casualty care and/or containment of infectious agents, in one or more metropolitan areas. Funds would be awarded competitively based on, among other factors, threat analysis, quality of design and operational plan, and financial sustainability of the project beyond the Federal funding period.

In addition, HRSA will continue to define a system to ensure that volunteer health professionals are able to respond in the event of a mass casualty event. The Emergency System for Advance Registration of Volunteer Healthcare Personnel is a State-based system, which allows for the pre-registration of volunteer healthcare personnel who wish to respond to an emergency or mass casualty event. The system will enable users to verify the license and other credentials of volunteer health providers.

The budget also includes $28 million for Bioterrorism Training and Curriculum Development to prepare health care providers across the Nation stand ready for a bioterrorism event. The program includes two components: continuing education for health professionals, funded at $25 million; and curriculum development in health professions schools, funded at $3 million.

Supporting Transplantation

This year celebrates the 50th anniversary of the first successful organ transplant in Boston, Massachusetts. Moving forward from the successes achieved since that first kidney transplant, President Bush signed the Organ Donation and Recovery Improvement Act of 2004 which builds on existing efforts, including the Organ Donation Breakthrough Collaborative and the Gift of Life initiative. The budget includes $23 million to support the Organ Transplantation program.

Consistent with this new authority, HRSA will provide grants to qualified organ procurement organizations to support the coordination of organ donation activities; fund the development and implementation of a program to provide reimbursement for subsistence expenses to donating individuals who lack the resources to pay for these expenses; and provide grants to States to develop and improve donor registries. This year, a PART assessment found that the Organ Transplantation program balances the benefits of a system operated by a private organization, the transplantation network, with the need for Federal oversight to ensure public accountability for use of the limited number of deceased donor organs.

The FY 2006 budget requests $23 million to for the National Bone Marrow Donor Registry, which enables patients to search for a suitable, unrelated bone marrow donor. This year, a PART assessment found the National Bone Marrow Donor Registry program to be effective at increasing recruitment and the number of donors on the Registry. The budget does not seek additional funding for the Cord Blood Stem Cell Bank. Almost $20 million will be available to implement the program when the Institute of Medicine (IOM) completes a study on the optimal design for this new effort in 2005. By the end of FY 2006, approximately 19,000 new cord blood units will be added to the National inventory, representing an increase of 24 percent over the current level of approximately 80,000 units.

Eliminating Underperforming Programs

This budget represents a thoughtful analysis of overall available resources. Funding for programs which are similar to other activities or have failed to demonstrate results is reduced or eliminated and priority is given to support more targeted efforts to provide direct health services. In addition, the request

eliminates nearly $483 million in FY 2005 one-time projects, representing almost half of the reduction from the FY 2005 level.

A number of HRSA programs are unable to demonstrate outcomes or provide services similar to other programs. This year, PART reviews found that the Traumatic Brain Injury program did not document an impact on improving the health or well being of individuals with traumatic brain injury and that the Emergency Medical Services for Children program was unable to demonstrate meaningful results. The Traumatic Brain Injury and Emergency Medical Services for Children programs are not funded in FY 2006.

The recently enacted Medicare Prescription Drug, Improvement, and Modernization Act will mean greater access to hospitals, health professionals, and other medical services for rural seniors. The budget reduces $115 million in HRSA rural programs which were found to be similar to numerous other HHS programs that provide resources to rural areas.

The budget refocuses resources on programs that provide direct services to communities in need, including through the Health Centers program. Since FY 2001, over $400 million has been awarded to Healthy Communities Access Program grantees to improve coordination and quality of health care; however, only 15 percent of those funds can be used for direct services. Similarly, over the same time period, $60 million has been awarded to allow States to develop plans to increase health insurance coverage through the State Planning Grant program. Funding for these programs is not included in the FY 2006 budget. In addition, the Universal Newborn Hearing program is not funded in FY 2006. The primary purpose of this program is not to finance screenings, but rather state-wide efforts to manage and track newborn screening activities and for training. The Maternal and Child Health Block Grant provides States with the flexibility to fund these activities.

The budget maintains support for nursing programs and health workforce information and analysis, and funds scholarships for disadvantaged students. A previous PART assessment found that, after 40 years of funding, Health Professions programs have not demonstrated an impact on placing health professionals in underserved areas. Based on this determination, the Administration proposes the elimination of most health professions grants in order to direct resources to activities that are capable of placing health care providers in medically underserved communities.

Program Management and Other Activities

The budget requests $151 million for program management. Resources will enable HRSA to manage and operate a wide array of Federal programs as well as to fund Federal pay cost increases. The budget includes a total administrative cost savings of $12 million including $5 million from the National Health Services Corps and $4 million from transplantation programs.

The request also includes $30 million for Telehealth, Hansen's Disease, Black Lung, and Radiation Exposure Compensation.

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Indian Health Service:				
Clinical Services	$2,653	$2,723	$2,851	+$128
Contract Health Services (Non-Add)	*479*	*498*	*525*	*+27*
Preventive Health	107	110	119	+9
Contract Support Costs	267	264	269	+5
Tribal Management/Self-Governance	8	8	8	0
Urban Health	32	32	33	+1
Indian Health Professions	31	30	31	+1
Direct Operations	61	62	63	+1
Diabetes Grants	150	150	150	0
Subtotal, Services Program Level	$3,309	$3,379	$3,524	+$145
Indian Health Facilities:				
Health Care Facilities Construction	$94	$89	$3	-$86
Sanitation Construction	93	92	94	+2
Facilities & Environmental Health Support	138	142	151	+9
Maintenance & Improvement	55	55	56	+1
Medical Equipment	17	17	18	+1
Subtotal, Facilities Program Level	$397	$395	$322	-$73
Total, Program Level	**$3,706**	**$3,774**	**$3,846**	**+$72**
Less Funds Allocated From Other Sources:				
Health Insurance Collections	-$628	-$633	-$642	-$9
Rental of Staff Quarters	-6	-6	-6	0
Diabetes Grants	-150	-150	-150	0
Total, Budget Authority	**$2,922**	**$2,985**	**$3,048**	**$63**
FTE	15,034	16,251	16,251	0

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 2006 budget request is $3.8 billion, a net increase of $72 million over FY 2005. Indian Health Service (IHS) funding increases are targeted toward the provision of services to a growing population of eligible Indian people. IHS will continue to seek ways to become more efficient and effective in internal operations, helping to leverage funding towards services while improving service quality.

Agency Description

As part of the Federal government's special relationship with Tribes, IHS provides health care to members of more than 560 Federally recognized Tribes. An estimated 1.8 million American Indians and Alaska Natives will be eligible for IHS services in 2006, an increase of 1.6 percent over 2005 and 9.4 percent since 2001.

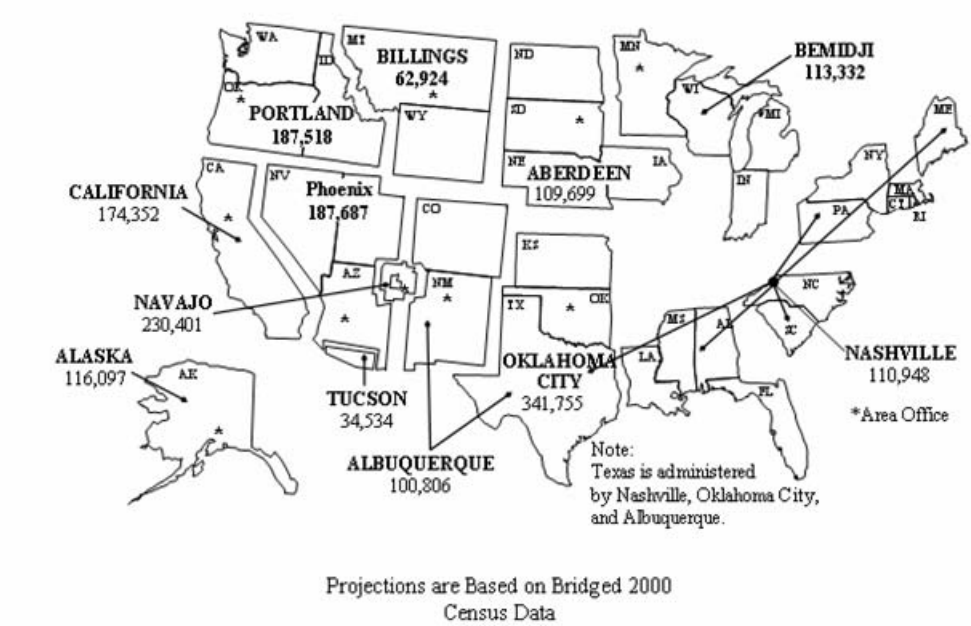
Care is provided directly in 49 hospitals, over 240 outpatient centers, and over 300 health stations and Alaska village clinics located primarily in the Southwest, Oklahoma, the Northern Plains, and Alaska. Tribes currently operate 15 of the hospitals and 80 percent of the smaller facilities under self-determination agreements with the Agency. IHS also contracts with hospitals and health care providers outside of its own network to provide care for Indian people. In addition to providing traditional inpatient and ambulatory care, IHS and Tribes provide extensive disease prevention and health promotion activities, including sanitation construction to provide water and waste disposal for Indian homes, diabetes prevention and disease management, injury prevention, mental health services, and alcohol and substance abuse treatment and prevention. IHS also funds 34 urban Indian health organizations which provide access to care for Indians living in urban areas.

Continuing to Serve a Growing Population

The challenge for IHS is to continue to provide access to quality health care for an increasing population. Additional funding in the FY 2006 budget is targeted to the provision of additional services.

Population and the Cost of Providing Care: The budget includes new funds to provide for the additional 29,000 people who are expected to seek services in FY 2006, cover increased pay costs for the Federal and Tribal employees who provide these services, and meet the rising costs of providing these services. Based on past experience, these

Indian Health Service
Service Population by Area, CY 2004



Projections are Based on Bridged 2000 Census Data

funds will pay for a variety of additional services, including 116,000 additional outpatient visits in IHS and Tribally operated facilities, 7,800 additional outpatient visits purchased from outside the IHS system, and 4,200 additional days of inpatient treatment for alcohol and substance abuse. Funds will go primarily to Clinical Services – operation of hospitals and clinics, purchase of medical care – but also to other IHS programs which are providing additional services and are experiencing increased costs. Tribally operated programs will receive funding on the same basis as the programs IHS operates directly.

Opening New Health Facilities: Additional funds are included to staff six new outpatient facilities in FY 2006, placing larger and more modern health facilities in the areas which most need them to provide additional health services. Tribes have financed construction of two of these facilities, saving IHS $22 million in construction costs. When fully operational, these facilities will increase the number of primary care visits that can be provided at these sites by nearly 75 percent and allow the provision of new services – 24-hour emergency rooms, physical therapy, wellness centers, upgraded diagnostic imaging and laboratory services, and expanded dental services. Including these 6 sites, IHS has opened 13 new health facilities since 2001.

Special Diabetes Program for Indians: Through the Special Diabetes Program for Indians, IHS provides funds to over 300 Tribes and Indian organizations. In FY 2006, IHS will award $150 million – for a total of $650 million in the last five years – to support diabetes prevention and disease management at the local level. The program has substantially increased the availability of services – physical activity specialists; registered dieticians and nurses; wellness and physical activity centers; newer and better medications – which has led to a steady increase in the percentage of diabetic patients with ideal blood sugar control. IHS has recently revised the way it distributes program funds by adding a competitive element in addition to the existing formula grant. In November of 2004, IHS awarded $24 million competitively, funding 66 Diabetes Program demonstration project grants. Thirty-six grants were awarded for prevention of diabetes and 30 were awarded for reduction of cardiovascular disease in people with diabetes. Successful applicants demonstrated a significant burden of diabetes, prior demonstrated success at prevention or treatment, the basic health infrastructure to support planned interventions, and evidence of successful compliance with past program requirements.

Benefits of Improved Blood Sugar Control

IHS has been able to increase the proportion of its diabetic patients who maintain good blood sugar control from 25 percent in FY 1997 to 34 percent in FY 2004. This increase is important. NIH-supported clinical trials have found that an improvement in blood sugar control from poor to ideal results in a 42 percent decrease in total mortality for people with diabetes.

This increase was achieved even while the total number of diabetics the IHS served increased 45 percent during this period.

Urban Indian Health Program: While most IHS services are provided on or near reservations, approximately one percent of the budget is used to provide services to Indian people living in urban areas. Clients of the Urban Indian program commonly experience barriers in accessing basic health services; examples of such barriers include poverty, lack of health insurance, lack of cultural awareness on the part of health professionals, unemployment, and homelessness. IHS funds a total of 34 Urban Indian health organizations to reduce barriers to access in urban areas. In FY 2006, Urban Indian health is funded at $33 million. Urban Indian health organizations also typically leverage funding in order to maximize service provision. IHS provides about half of all funding available to these organizations. Other major funders include Medicaid, State and local programs, and other Federal programs separate from IHS. Services provided vary from outreach, referral and case management to comprehensive care, including: ambulatory medical care; dental services; community education (health education, transportation, patient advocacy); alcohol and substance abuse prevention, treatment and counseling; AIDS and STD information; mental health counseling; and social services.

Health Insurance Reimbursements: In FY 2006, IHS expects to receive a total of $642 million in health insurance reimbursements, including Medicare, Medicaid, and payments from private insurers. This amount represents an increase of $9 million over FY 2005 estimated collections. IHS facilities receive Medicare and Medicaid under a cost-based methodology developed in close cooperation with the Centers for Medicare & Medicaid Services. Health insurance collections are an essential element of the funding that supports IHS hospitals and clinics.

In some cases, insurance revenue represents up to 50 percent of the operating budget of a given facility. This revenue allows IHS to hire additional medical staff and supports activities related to facility operations, such as supplies, equipment, and building utilities and maintenance.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) included several provisions that benefit the American Indian and Alaska Native (AI/AN) population. IHS estimates the transitional assistance credit of $600 per year for low-income Medicare beneficiaries, including AI/ANs, could provide $10 million in new Medicare revenue for prescription drugs dispensed at IHS facilities in FY 2005. The Medicare Part D prescription drug benefit program, when implemented in January 2006, will extend outpatient prescription drug coverage to IHS Medicare beneficiaries and increase Medicare revenues at IHS facilities. Other sections of the MMA expand the benefits covered under Medicare Part B for IHS beneficiaries and allow the IHS to pay for additional medical care by increasing its bargaining power when buying services from non-IHS Medicare-participating hospitals.

Construction: The budget includes a total of $94 million for Sanitation Construction to provide safe water and waste disposal systems to an estimated 20,000 Indian homes. The sanitation program has played a key role in decreasing the rates of infant mortality, gastroenteritis, and other environmentally related diseases over the last thirty years. Consistent throughout HHS, FY 2006 requests for facilities funding focus on maintenance of existing facilities; no funding is requested to initiate new projects. A total of $3 million is included for health facility construction, sufficient to fully fund the Fort Belknap staff quarters project. The Fort Belknap project will provide 24 units of new and 5 units of replacement staff quarters for the Harlem and Hays outpatient facilities in Montana. Available decent local housing makes it easier to recruit and retain health professionals at remote sites.

Improving Service Delivery

IHS is continually working to improve its internal operations so as to target as much funding as possible towards needed services. To this end, IHS will implement a new organization plan, and continue the implementation of new information technology to make patient health records easier to access and track, and to streamline insurance billing processes.

Headquarters Reorganization: Following two years of planning and tribal consultation, IHS announced a reorganization of its headquarters in July, 2004. The reorganization eliminated an administrative layer and moved those offices which had direct contact with Tribes, tribal organizations, and Urban Indian programs into the Office of the Director. The goals of the reorganization are: improved management – with more focus on results rather than oversight; better alignment with field programs; and improved collaboration between IHS and other HHS programs – all leading to improved health care for Indian people.

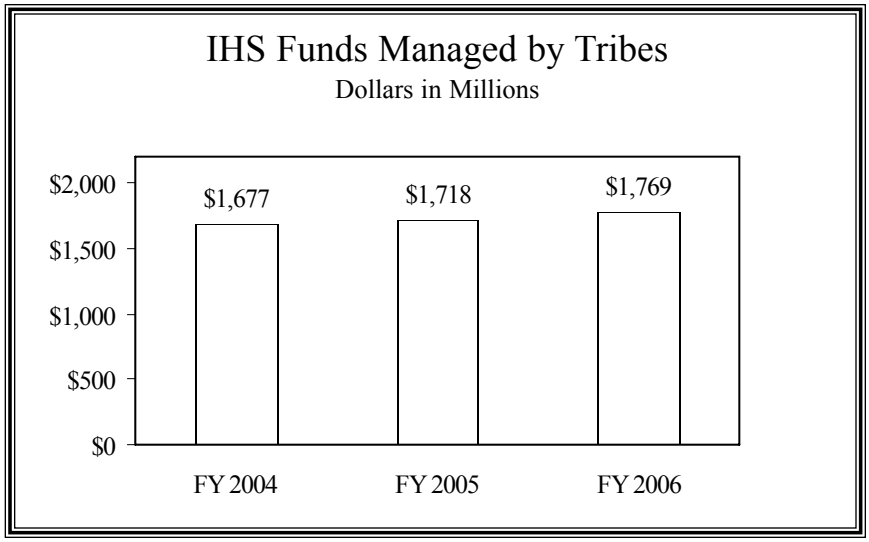
Electronic Health Records: Information technology is vital to improving the efficiency and quality of health facility operations. By improving the quality of patient data, facilities are able to both increase the quality of services and improve operations efficiency. IHS has been a leader among HHS agencies in the use of information technology to improve health facility operations. The majority of IHS facilities currently use a software system that stores patient information and offers the ability to keep life-long medical records for patients. This software will be used to create an electronic health record (EHR) system with clinical case management capabilities for five diseases prevalent among Indian people: diabetes, coronary vascular disease, asthma, HIV, and obesity. The EHR will be implemented in 32 sites by the end of 2005 and IHS anticipates full implementation by 2008. The EHR will:

- Improve patient safety through direct provider order entry;
- Reduce risk to patients through improved and more legible documentation;
- Strengthen protection of private health information through electronic security;
- Improve quality of care through better documentation of services provided to each patient; and
- Increase cost efficiency through improved billing capabilities.

Indian Self-Determination

Tribes continue to increase the number of IHS programs they operate. In FY 2006, Tribes will control an estimated $1.8 billion, or 55 percent of IHS's total budget request. To enable Tribes to develop the administrative infrastructure critical to their ability to successfully manage these programs, the budget includes a total of $269 million for contract support costs, an increase of $5 million over FY 2005. The additional funds will allow IHS to provide contract support costs for the 20 to 25 additional programs it anticipates Tribes will want to take over administration of in FY 2006.

As part of the Federal Government's special relationship with Tribes, an HHS-wide budget consultation session is held annually to give Tribal leaders the opportunity to consult with HHS on budgetary issues which concern them. In order to bring Indian issues to the attention of all parts of the department, the Intradepartmental Council on Native American Affairs was reactivated in 2002. The Council consists of the heads of all HHS agencies and other senior staff.



(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Infectious Diseases:				
Infectious Diseases	221	226	225	-$1
HIV/AIDS, STDs & TB Prevention	964	960	956	-4
Immunization:				
Current Law:				
Section 317 Discretionary Program	469	479	529	+50
Vaccines For Children Routine Vaccinations	1,012	1,147	1,180	+33
VFC Stockpiles & Catch-up Immunizations	40	488	322	-166
Effect of Proposed VFC Improvements:				
VFC	0	0	140	+140
Section 317 Discretionary Program	0	0	-100	-100
Proposed Law Subtotal, Immunization	$1,521	$2,114	$2,072	-$42
Global Health	280	294	306	+12
Global Disease Detection (non-add)	*12*	*22*	*34*	*+12*
Bioterrorism:				
State and Local Capacity	918	927	797	-130
Upgrading CDC Capacity/Anthrax Research	169	157	140	-17
Strategic National Stockpile	398	397	600	+203
Biosurveillance Initiative	22	79	79	0
Subtotal, Bioterrorism	$1,507	$1,560	$1,616	+$56
Health Promotion:				
Chronic Disease Prevention & Health Promotion	818	899	840	-59
Youth Media Campaign (non-add)	*32*	*59*	*0*	*-59*
Birth Defects, Disability & Health	114	125	124	-1
Health Information and Service:				
Health Statistics	90	109	109	0
Informatics and Health Marketing	127	120	115	-5
Environmental Health and Injury:				
Environmental Health	146	148	147	-1
Injury Prevention & Control	137	138	138	0
Occupational Safety & Health	277	286	286	0
Public Health Research	29	31	31	0
Public Health Improvement and Leadership	233	267	207	-60
One-time Earmarked Projects (non-add)	*42*	*60*	*0*	*-60*
Business Services Support	282	279	264	-15
Preventive Health and Health Services Block Grant	132	131	0	-131
Buildings & Facilities	260	270	30	-240
ATSDR	73	76	76	0
User Fees	2	2	2	0
Subtotal, Program Level (proposed law)	**$7,213**	**$8,034**	**$7,543**	**-$491**
Less Funds Allocated from Other Sources:				
Vaccines for Children Proposed Law (mandatory)	-$1,052	-$1,635	-$1,642	-7
Public Health and Social Service Emergency Fund	-1,507	-1,560	-1,616	-56
PHS Evaluation Transfers	-212	-265	-265	0
User Fees	-2	-2	-2	0
Total, Proposed Law Discr. Budget Authority	**$4,440**	**$4,572**	**$4,017**	**-$555**
FTE	8,636	8,837	9,087	250

CENTERS FOR DISEASE CONTROL AND PREVENTION

The Centers for Disease Control and Prevention promotes health and quality of life by preventing and controlling disease, injury, and disability.

The FY 2006 budget requests a total program level of $7.5 billion for the Centers for Disease Control and Prevention (CDC), a net decrease of $491 million below the FY 2005 enacted level. This net change includes programmatic increases of $339 million, including expanded funding for influenza vaccine; improvements in childhood immunizations; expanded global disease detection efforts; and expansions of the Strategic National Stockpile, including a new focus on portable mass casualty treatment units. These increases are offset by completed facility construction projects, one-time projects, reductions in programs that overlap other areas of CDC, internal management efficiencies, and one-time costs in the Vaccines for Children (VFC) program. CDC's total program level includes $1.6 billion in mandatory VFC funding, and $265 million in Public Health Service evaluation transfers.

An array of new challenges face America's public health system: an aging population; increasing population diversity; global travel that can spread diseases; bioterrorism threats; and an epidemic of chronic diseases. At the same time, technology improvements offer CDC new opportunities to increase program efficiency, including health information technology, global communication, rapid diagnostic tools, and public health genomics. As a result, CDC undertook a two-year reorganization process, the Futures Initiative, to maximize the benefit CDC provides to the American people in the 21st century. CDC's budget has been realigned to support this new structure.

CDC is reorganizing most of its programs under four coordinating centers and three coordinating offices. These include Infectious Diseases, Health Promotion, Public Health and Information Services, Environmental Health and Injury, Terrorism, Global Health, and Workforce and Career Development. The coordinating centers and offices lead collaboration within each thematic area and across other areas of CDC. They work with CDC's Office of the Director to improve business practice efficiency; ensure high quality, goal-oriented programs; and provide leadership to operational units. Management and administrative funding has been consolidated from most program lines into two areas: Public Health Improvement and Leadership, and Business Services Support. Two units formerly located in CDC's Office of the Director (OD), the Epidemiology Program Office (EPO) and the Public Health Practice Program Office (PHPPO), will be relocated to integrate core functions across CDC. For example, functions within EPO have been consolidated with Health Information and Services activities, Global Health, and Public Health Improvement and Leadership. This restructuring is consistent with the goals of the Futures Initiative, and the findings of a recent PART review for the Epidemic Services program activity, in that programmatic and administrative redundancies will be reduced and program functions will have a clear and coherent purpose.

Infectious Diseases

Three major programs are overseen by the new Infectious Diseases Coordinating Center: the National Immunization Program; the National Center for Infectious Diseases; and the National Center for HIV, STD, and TB Prevention. The President's FY 2006 budget includes a total of $1.7 billion in discretionary funding for efforts related to the prevention and control of infectious diseases and to provide immunization services for children and adults nationwide.

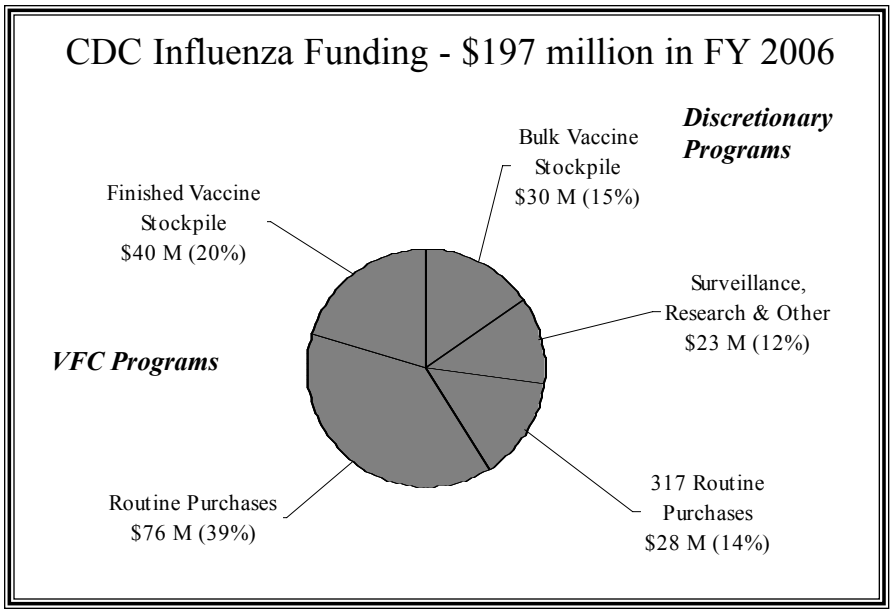
Immunization: CDC's $2.1 billion immunization program is focused on achieving two major health goals of the Nation. CDC seeks to ensure that at least 90 percent of all two-year olds receive the recommended series of vaccines, and CDC has also expanded its role in assuring the adequacy of annual influenza vaccine supplies. This work will be carried out through two streams of funding: Vaccines for Children (VFC) and the Section 317 program. The mandatory VFC program provides free vaccine to approximately 42 percent of the childhood population, including Medicaid recipients, the uninsured, American Indians and Alaskan Natives, and children with limited health insurance that does not cover specific immunizations. VFC also funds the development of a six-month stockpile of all routinely recommended childhood vaccines. The discretionary Section 317 program provides funds for State immunization operational costs and many of the vaccines public health departments provide to individuals not eligible for VFC.

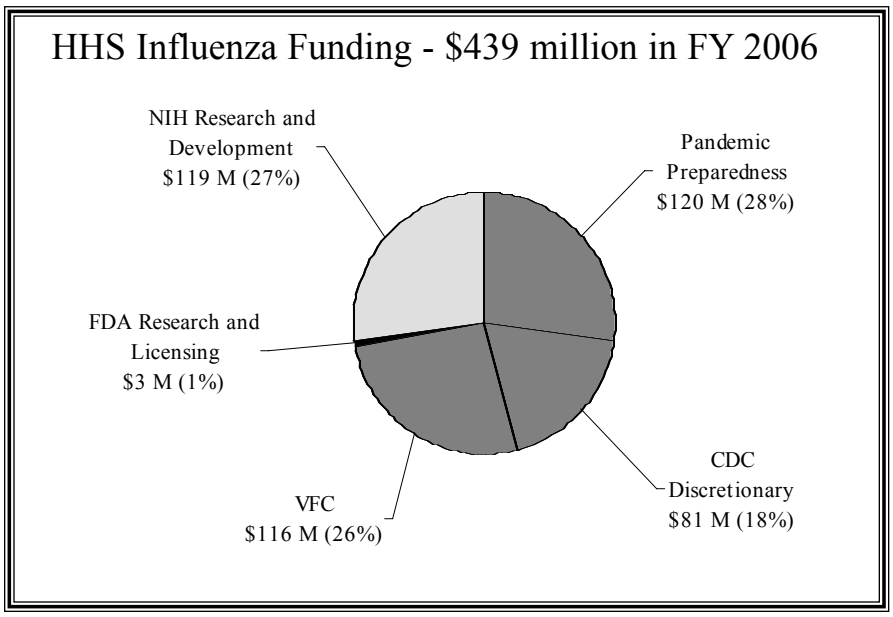
Influenza Vaccine

CDC's agency-wide influenza budget totals $197 million, nine times more funding than in FY 2001. A year ago, HHS worked with vaccine manufacturers to expand production. This was accomplished in part by making influenza a routinely recommended vaccine for young

children, and setting aside $40 million in new budget authority in VFC for a pediatric stockpile of finished doses. In FY 2006, CDC will supplement the pediatric stockpile with $30 million in contracts to expand the production of bulk monovalent influenza vaccine. This will occur through back-end guarantees to manufacturers to increase influenza supply and guarantee higher production levels. CDC will also purchase an estimated additional two million doses of influenza vaccine through a $20 million discretionary funding increase.

Near-term action is being taken to improve the availability of influenza vaccine for this winter and the upcoming (2005-2006) flu season. The Administration's plan reallocates up to $37 million in FY 2005 to expand the availability of influenza vaccine for this and the upcoming (2005-2006) flu season. This includes up to $25 million in reallocations from CDC programs the budget proposes to eliminate in FY 2006, and $12 million provided through the Secretary's authority to transfer funds from accounts in other agencies. Within this amount, $20 million will be used to expand bulk monovalent vaccine production for next winter. The remaining $17 million will be used to finance the importation of foreign influenza vaccine for this winter under Investigational New Drug (IND) authorities. This vaccine has been made available to States, and a contract research organization has been retained to manage IND process requirements of vaccination drives.





Childhood Immunization Improvements

Children who are Medicaid recipients, uninsured, American Indians and Alaskan Natives, and children with limited health insurance that does not cover specific immunizations are entitled to receive VFC vaccines. These children, however, must do so at a Community Health Center or a specially designatedFederally Qualified Health Center. Legislation is sought to enable these children to obtain VFC vaccines at public health clinics as well. This improved access is projected to expand the VFC program by $140 million while also reducing by $100 million the demand for vaccines purchased with discretionary appropriations. The proposed legislation would also eliminate the price caps on VFC that have excluded some vaccines from the VFC program. The budget anticipates substantial FY 2005 progress toward HHS's goal of establishing a six month vendor-managed stockpile of all routinely recommended pediatric vaccines, and catching up on immunizations that were missed during vaccine shortages in recent years. With catchup vaccinations finished, and the stockpile nearing completion, FY 2006 costs will be $166 million below FY 2005 estimates. The stockpile serves dual purposes: vaccines from the stockpile can be distributed in the event of a disease outbreak; and the stockpile will mitigate the effect of any supply disruptions that might occur on the manufacturing side.

HIV/AIDS, STD & TB Prevention: HIV/AIDS, sexually transmitted diseases (STDs), and tuberculosis (TB) are among the most prevalent, costly and preventable infectious diseases in the United States. The President's FY 2006 budget request is $956 million to develop, implement, and evaluate effective domestic prevention programs for these diseases through the National Center for HIV, STD, and TB Prevention (NCHSTP).

Domestic HIV/AIDS Prevention
CDC's core set of prevention activities include surveillance and case reporting, community involvement and intervention, capacity building, and program evaluation. NCHSTP's budget requests $658 million for HIV/AIDS prevention. The CDC-wide domestic HIV/AIDS budget of $727 million also includes funding in school health programs (Chronic Diseases) and blood disorders programs (Birth Defects, Disability, and Health).

CDC's HIV prevention activities over the past two decades have focused on helping uninfected persons at high risk for HIV change and maintain behaviors to keep them uninfected. Despite these efforts, the number of new HIV infections is estimated to have remained stable, and the number of people living with HIV continues to increase. In FY 2003, CDC launched a new prevention initiative, Advancing HIV Prevention (AHP) that capitalizes on new rapid testing techniques that provide on-the-spot results. AHP seeks to expand early diagnosis of HIV infection; facilitate earlier access to quality medical care and treatment; and provide prevention services to reduce the risk of transmission to others.

STD and TB Prevention
The STD and TB prevention programs provide grants and technical assistance to State and local governments and organizations for prevention and control services, as well as conducting surveillance and supporting research related to the prevention, control, and elimination of these diseases. A recent PART review determined that both the STD and TB activities have a clear purpose and address specific and ongoing problems. The review suggested some improvements that the programs have already begun to make, including the distribution of State funding for TB based on need, rather than historical distributions. The program will also examine additional ways to better target State and local funding for STDs.

Infectious Diseases: The National Center for Infectious Diseases works in partnership with State and local public health officials, other federal agencies, medical and public health professional associations, infectious disease experts from academic and clinical practice, and international and public service organizations to prevent illness, disability, and death caused by infectious diseases in the United States and around the world. Although modern advances have conquered some diseases, the outbreaks of severe acute respiratory syndrome (SARS), avian influenza, West Nile virus, and monkeypox are recent reminders of the extraordinary ability of microbes to adapt and evolve. The President's FY 2006 budget includes $225 million to conduct surveillance, epidemic investigations, epidemiologic and laboratory research, training, and public education programs to develop, evaluate, and promote prevention and control strategies for infectious diseases.

A recent PART review indicated that the Infectious Diseases program has a clear purpose and evidence of its impact on controlling disease. The program collaborates with a broad range of partners to target resources and accomplish its mission. The program is measuring progress on new long-term measures focused on foodborne pathogens, bloodstream infections, pneumococcal disease, and hepatitis A. The program will also measure progress in global influenza surveillance and detection as one key indicator of our preparedness for a pandemic influenza outbreak

Global Health

Every day, two million people cross national borders as tourists, business travelers, immigrants, or refugees. World trade moves produce and manufactured goods from one end of the earth to another in a matter of hours or days. However, disease vectors like mosquitoes have no regard for borders. Health events far from our shores are significant in their own right, but also have the potential to influence health within the United States. As a result, CDC supports a range of efforts to both track and prevent the international spread of infectious diseases. CDC has consolidated funding and policy oversight of many of these activities into a new $306 million Global Health budget line. While the Office of Global Health provides policy guidance on the use of funds, the work is carried out by the operating centers that received these funds directly in the past.

Global Disease Detection: The FY 2006 budget requests $34 million, a $12 million increase, for CDC's global disease detection initiative. This initiative aims to recognize infectious disease outbreaks faster, improve the ability to control and prevent outbreaks, and to detect emerging microbial threats. CDC will continue the implementation of a comprehensive system of surveillance by expanding programs and sites abroad. Additional activities include the improvement of early warning systems; researching new viral strains; aiding in collaborations with multinational organizations; and increasing surveillance.

Global AIDS: Through the Global AIDS Program (GAP), CDC works in partnership with USAID; HRSA; the Departments of State, Labor, and Defense; other federal agencies; and multilateral and bilateral partners to ameliorate the global devastation caused by HIV/AIDS. The FY 2006 budget includes $124 million in direct funding for on-going prevention, care, treatment, surveillance, and capacity-building programs in 25 countries in Asia, Africa, Latin America, and the Caribbean. CDC is also a key federal partner in the President's Emergency Plan for AIDS Relief (PEPFAR) that is financed through the Department of State. Approximately $185 million in PEPFAR funding was allocated to CDC in FY 2004 from the Department of State.

Global Polio and Measles: CDC's request allocates $137 million for global polio and measles activities. While tremendous progress has been made with the number of polio-endemic countries declining from 120 in 1988 to six in 2004, a major international effort continues to strive for the 2005 eradication goal set by the World Health Organization. If that goal is achieved, continued vigilance will be required to guard against reappearance.

TERRORISM

The request allocates $1.6 billion to bioterrorism preparedness, a net increase of $56 million over FY 2005. Within this total, priority is given to direct Federal responsibilities to ensure a sufficient supply of countermeasures and portable treatment units are available to protect and care for victims of an attack. The Strategic National Stockpile (SNS) is funded at $600 million, an increase of $203 million above FY 2005. This increase includes $50 million in funding for the Federal Mass Casualty Initiative. The SNS will use these funds to purchase, maintain, and operate portable hospital units that can be deployed to increase hospital surge capacity in the event of a bioterrorist attack. The remaining funding will be used to procure commercially available countermeasures; provide secure, temperature controlled storage for the wide range of medicines and vaccines in the SNS as well as those being procured by Project BioShield; replace medical products that are nearing the end of their useful life; and maintain the capacity to move SNS assets to any location in the United States within 12 hours.

In January 2004, the Administration set a goal of having sufficient antibiotics in the SNS to protect 60 million Americans from the effects of exposure to anthrax. The financing plan included special transfer authorities in FY 2005 to secure coverage of 50 million people and purchase the remaining courses necessary to reach the final 10 million in FY 2006. Since the requested funding flexibilities were not provided in the FY 2005 appropriation, CDC has modified the SNS operating plan to stay on track and achieve the 50 million target in FY 2005. HHS plans to use the Secretary's authority to transfer funds between appropriations to redirect $12 million from bioterrorism grant programs to the SNS, so that the anthrax antibiotic coverage goal can be reached on schedule.

Improving biosurveillance continues to be a high priority, with $79 million provided to continue the interagency biosurveillance initiative. The centerpiece of CDC's efforts in biosurveillance concentrating on electronic disease surveillance is BioSense. BioSense automatically analyzes electronically available health data to highlight a potential public health problem, rather than relying solely on individual case reports from healthcare providers to local public health officials. BioSense will provide public health officials with early warnings on potential outbreaks in their communities. CDC will engage in contracts with health departments and health systems to expand access to local information in the highest risk urban areas. In addition to BioSense, CDC will continue other aspects of the biosurveillance initiative, including improvements to laboratory reporting capacity and increasing the number of border health and quarantine stations at ports of entry.

CDC's commitment to State and local preparedness remains strong; between FY 2002 and FY 2006, CDC will have invested a total of $4.5 billion in this activity. The FY 2006 budget retargets some preparedness resources, making modest reductions in awards to States, and concentrating efforts in directed investments that will benefit the Nation as a whole. Efforts are continuing, as in the Department of Homeland Security, to ensure that the allocation and use of funds reflects the best information on risk and needed performance improvements. For example, CDC will continue the Cities Readiness Initiative that is essential to ensuring local governments can provide medicines to their citizens in time to protect them from released bioterrorism agents. This includes targeted grants and, in FY 2006, additional funding for cooperative work among CDC, the United States Postal Service, and participating cities.

Investments in States have markedly improved capacity. The Laboratory Response Network (LRN) now consists of 134 reference laboratories in all States, up from 91 in 2001. Most can confirm the presence of anthrax and tularemia, as well as perform presumptive screening for smallpox. More than 8,800 clinical laboratory personnel have been trained to play a role in the detection and reporting of public health emergencies. CDC is also expanding the number of trained Federal staff

that are available to States to up to 500. (States can request CDC to detail staff in lieu of a portion of their cash grants.)

In addition to assistance to States and communities, CDC will invest $140 million to continue to upgrade its internal capacities by improving epidemiological expertise in the identification and control of diseases caused by terrorism, including better electronic communication, distance learning programs, and cooperative training between public health agencies and local hospitals. No funding is earmarked for research on older anthrax vaccines as the project is nearing completion; funds were redirected into stockpile purchases.

Health Promotion

Chronic diseases - such as heart disease, cancer, and diabetes - are the leading causes of death and disability in the United States. These diseases account for 7 out of every 10 deaths and affect the quality of life of 90 million Americans. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. In addition, birth defects are the leading cause of infant mortality in the United States. The direct and indirect costs associated with disabilities in the United States exceeds $300 billion annually. The Health Promotion Coordinating Center includes the National Center for Chronic Disease Prevention and Health Promotion, and the National Center on Birth Defects and Developmental Disabilities.
The President's FY 2006 budget includes a total of $964 million to fund a large number of programs that are focused on improving the quality of medical care targeted at chronic diseases, prevention programs, and disabilities.

Chronic Disease Prevention and Health Promotion: Chronic disease prevention programs at CDC have grown continually since 2001, as CDC has broadened its focus beyond preventing infections and seeks to reduce the human and financial impact of chronic diseases. The budget seeks $840 million to maintain at the FY 2005 level a wide range of activities, including support for: programs to promote healthy behaviors; studies to better understand the causes of these diseases; and surveys to better monitor the health of the nation. CDC will maintain its focus on reducing obesity, diabetes, and tobacco use as the $47 million Steps to a Healthier US program matures and the newly-funded State tobacco quitlines become well-established.

Youth Media Campaign (VERB)
The budget does not include funds to continue the VERB: It's What You Do Youth Media Campaign, for which $59 million was provided in FY 2005. VERB was originally designed as a 5-year demonstration project; FY 2005 is the fifth year.

Birth Defects, Developmental Disabilities, Disabilities and Health: CDC's National Center on Birth Defects and Developmental Disabilities works to identify the cause of birth defects and developmental disabilities, to help children develop and reach their full potential, and to promote the health and well-being among people of all ages with disabilities. The budget for activities related to Birth Defects, Developmental Disabilities, Disability and Health for FY 2006 includes $124 million. This funding will be used for many disability programs, including those related to Fetal Alcohol Syndrome, Autism, attention-deficit/hyperactivity disorder (ADHD), Duchenne and Becker Muscular Dystrophy, Disability and Health, monitoring developmental disabilities, limb loss, and spina bifida.

Health Information and Service

The budget for the Health Information and Service Coordinating Center includes $224 million for the National Center for Health Statistics (NCHS) and new centers for Health Marketing and Public Health Informatics.

Health Statistics: The budget requests $109 million for Health Statistics, which maintains funding at the FY 2005 level. Major investments in Health Statistics over the past several years reflect the importance of the data systems of the National Center for Health Statistics (NCHS) to track our progress and inform solutions on a myriad of problems in the public and private health sector. Areas of focus have been to preserve and modernize the Nation's vital statistics system; to expand contracts with States to purchase birth and death data; and to move forward with e-government initiatives to update the content of birth and death records.
Additionally, funds have been used to increase the sample sizes necessary for the National Health and Nutrition Examination Survey (NHANES) and the National Health Interview Survey (NHIS) to provide needed information on a wide range of conditions, diseases, and population subgroups and to address major emerging data gaps in the National Health Care Survey, such as long-term care and assisted living facilities.

Public Health Informatics:
The request includes $68 million for Public Health Informatics. Effective public health response involves many organizations working together and exchanging information. The new realities of terrorism and naturally occurring disease trends require a new level of interoperability that facilitates rapid, secure, and effective communication. The new National Center for Public Health Informatics is responsible for ensuring that

public health departments' new disease outbreak detection and reporting systems incorporate the common standards that facilitate real-time sharing of key data among public health officials responsible for verifying, investigating, and responding to outbreaks. The request reflects a $5 million reduction in funding for the Public Health Information Network as CDC moves from standards design to system implementation.

Health Marketing: CDC's new National Center for Health Marketing will work to connect the agency's research, surveillance, programmatic services, and communication efforts to CDC's customers, the American public. Funding for the Health Marketing activity in FY 2006 is requested at $47 million. The initiatives related to Health Marketing will enhance communication support and improve outreach to CDC's five priority sectors: public health communities; business and workers; education; health care; and other federal agencies.

Environmental Health and Injury

The budget for the Environmental Health and Injury Coordinating Center includes $285 million to maintain funding levels for the National Center for Environmental Health and the National Center for Injury Prevention and Control.

Environmental Health: The budget includes $147 million to maintain ongoing environmental disease prevention programs. The National Center for Environmental Health (NCEH) assists State and local health agencies in developing and increasing their ability and capacity to address environmental health problems, especially asthma and childhood lead poisoning. Additionally, NCEH provides complete, timely, and accessible data on environmentally related diseases and conditions, including asthma, childhood lead poisoning and genetic diseases; improves the understanding of risk factors for, and causes of, environmentally related diseases and conditions; and develops effective prevention programs. The CDC's state-of-the-art environmental laboratories use modern technology to assess human exposure to environmental chemicals, and its effects.

Injury Prevention and Control: Injuries are the leading cause of death of children and young adults in the United States. Injury is a fundamental threat to human health and life, and CDC employs the same scientific methods that prevent infectious diseases to prevent injuries - defining the health problem, identifying the risk and protective factors, and developing and testing prevention strategies. The budget request for FY 2006 includes $138 million to support programs focused on residential fire deaths, intimate partner violence, non-fatal fall traumatic brain injury, child abuse and neglect, rape prevention and education, and other injury prevention and control initiatives.

Occupational Safety and Health

As American workers are getting older and becoming more diverse, working longer hours, and more workers are in temporary positions, the estimated annual cost of occupational injuries in the United States has grown to over $250 billion. The National Institute of Occupational Safety and Health (NIOSH) is the primary federal entity responsible for conducting research and making recommendations for the prevention of work-related illness and injury. NIOSH translates knowledge gained from research into products and services that benefit workers' safety and health in settings from corporate offices to construction sites and coal mines. The budget for FY 2006 includes $286 million for NIOSH activities, level with FY 2005. This includes work on the National Occupational Research Agenda (NORA) and personal protective technology and respirator research for the nation's 50 million miners, firefighters, emergency responders, and health care, agricultural, and industrial workers. In addition to these ongoing activities, NIOSH assists in the implementation of the Energy Employees Occupational Illness Compensation Act of 2000; funds for this activity are provided by the Department of Labor.

NIOSH's recent PART review indicated that the program has a clear purpose and a well-established mechanism for setting priorities to guide budget requests and funding decisions through the National Occupational Research Agenda (NORA). The program is working to further focus its research efforts on having an impact through a Research to Practice initiative. In addition, the program will advance its work with the National Academy of Sciences to develop a standard method of measuring the impact of their research on the occupational safety and health field.

Public Health Research

The FY 2006 request includes $31 million to fund investigator-initiated prevention research projects. Prevention research at CDC is population-based, and targeted to health promotion and disease prevention. All research is proposed by researchers working with communities, health practitioners, and policymakers, and will address the need for a multi-disciplinary approach to health marketing, health communication, and innovative statistical methods to estimate the burden of disease. Research results are expected to form the basis of public health policies and best practices for a range of specific populations and settings.

Public Health Improvement and Leadership

The President's Budget for FY 2006 includes $207 million for Public Health Improvement and Leadership, a new budget line Congress created to more transparently reflect CDC's programmatic funding. This budget line funds the Office of the Director, the newly established coordinating centers, workforce development staff, and the central management costs in each of the operating Centers, Institute, and Offices at CDC. This budget line includes an $8 million Director's Discretionary Fund that will be used to finance developing public needs.
In FY 2005, the Congress also included $60 million in one-time projects in this budget line; these projects are not continued in the FY 2006 request.

Business Services Support

The Business Services Support budget activity, as well as the Leadership and Management sub-budget activity, were created to consolidate CDC's administrative and management costs into two lines and more transparently reflect CDC's programmatic funding. The Business Services Support line includes a wide range of agency-wide operating costs, such as rent, utilities, and security. It also funds the business services functions at CDC (such as grants management, financial management, facilities management, etc.), and additional mission-support activities. CDC has made a variety of improvements in its business and management operations in recent years, as evidenced by recent scores of all green on the PMA scorecard. CDC consolidated 13 information technology infrastructure functions into the new Information Technology Services Office and is consolidating all budget execution functions within CDC's Financial Management Office. Over 40 public and medical professional inquiry hotlines will be merged into a single integrated customer service center. The $15 million reduction in FY 2006 reflects CDC's expectation of continued efficiency improvements under the new organizational structure.

Preventive Health and Health Services Block Grant

Since 1981, the Preventive Health and Health Services Block Grant has provided 61 States, tribes, and territories with flexible funding the grantee could direct as it deemed appropriate. Funding, however, is often duplicative and overlaps with other CDC programs. As CDC strives to improve efficiency, existing resources will be directed to programs which have traditionally addressed similar public health issues.

Modern and Secure Laboratories and Facilities

Since 2001, CDC has initiated or completed the construction of more than 2.7 million square feet of laboratory and other facility space. This year, CDC is completing an Infectious Disease Laboratory, the Scientific Communications Center, the Headquarters and Emergency Operations Center, and the Environmental Toxicology Laboratory. CDC is also initiating construction of a new Environmental Health office facility. The FY 2006 request allocates $7.5 million to fund repairs and improvements for existing facilities, and $22.5 million to complete construction of the Ft. Collins, Colorado Vector Borne Infectious Diseases Replacement Laboratory. No funding is requested to initiate new projects.

The Buildings and Facilities program underwent a PART review for FY 2006. The program uses a master plan of CDC headquarters construction projects, developed by senior managers from CDC's Centers, Institute, and Offices, to target resources. The program is conducting analyses of trade-offs between costs, schedule, and risk for construction projects, and the program has supported targeted studies to guide program improvements. The program has adopted a new outcome measure that will track changes in areas such as the productivity and expansion of laboratory research and techniques resulting from new facilities. The program will also measure performance on meeting scope, schedule, budget, and quality targets.

Agency for Toxic Substances and Disease Registry

The request for ATSDR is $76 million, the same as FY 2005. ATSDR, managed as part of CDC, is the lead agency responsible for public health activities related to Superfund sites. ATSDR develops profiles of the health effects of hazardous substances, assesses health hazards at specific Superfund sites, and provides consultations to prevent or reduce exposure and related illnesses. Funds will also be used for the maintenance costs of the World Trade Center Exposure Registry.

NIH OVERVIEW BY INSTITUTE

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Institutes:				
National Cancer Institute	$4,736	$4,825	$4,842	+$17
National Heart, Lung, & Blood Institute	2,878	2,941	2,951	+10
National Institute of Dental & Craniofacial Research	383	392	393	+1
Natl Inst. of Diabetes & Digestive & Kidney Disease	1,821	1,864	1,873	+9
National Institute of Neurological Disorders & Stroke	1,501	1,539	1,550	+11
National Institute of Allergy & Infectious Diseases	4,303	4,403	4,460	+57
National Institute of General Medical Sciences	1,905	1,944	1,955	+11
Natl Inst. of Child Health and Human Development	1,242	1,271	1,278	+7
National Eye Institute	653	669	673	+4
National Institute of Environmental Health Sciences:				
Labor/HHS Appropriation	631	645	648	+3
VA/HUD Appropriation	78	80	80	0
National Institute on Aging	1,024	1,052	1,057	+5
Natl Inst. of Arthritis & Musculoskeletal & Skin Dis	501	511	513	+2
Natl Inst. on Deafness & Communication Disorders	382	394	397	+3
National Institute of Mental Health	1,381	1,412	1,418	+6
National Institute on Drug Abuse	991	1,006	1,010	+4
National Institute on Alcohol Abuse & Alcoholism	428	438	440	+2
National Institute for Nursing Research	135	138	139	+1
National Human Genome Research Institute	479	489	491	+2
Natl Inst. for Biomedical Imaging & Bioengineering	289	298	300	+2
National Center for Research Resources	1,179	1,115	1,100	-15
Natl Center for Complementary & Alternative Med	117	122	123	+1
Natl Center for Minority Health & Health Disparities	191	196	197	+1
Fogarty International Center	65	67	67	0
National Library of Medicine	317	323	326	+3
Office of the Director	327	358	385	+27
Buildings & Facilities	99	110	82	-28
Nuclear/Radiological Countermeasures Res. (PHSSEF)	0	47	47	0
Chemical Countermeasures Research (PHSSEF)	0	0	50	+50
ONDCP Drug Forfeiture Fund Transfer (NIDA)	4	0	0	0
Total, Program Level	**$28,040**	**$28,649**	**$28,845**	**+$196**
Less Funds Allocated from Other Sources:				
Nuclear/Radiological Countermeasures Res. (PHSSEF)	$0	-$47	-$47	$0
Chemical Countermeasures Research (PHSSEF)	0	0	-50	-50
ONDCP Drug Forfeiture Fund Transfer (NIDA)	-4	0	0	0
PHS Evaluation Funds (NLM)	-8	-8	-8	0
Type 1 Diabetes Research 1/	-150	-150	-150	0
Total, Budget Authority	**$27,878**	**$28,444**	**$28,590**	**+$146**
Labor/HHS Appropriation	**$27,800**	**$28,364**	**$28,510**	**+$146**
VA/HUD Appropriation	**$78**	**$80**	**$80**	**$0**
FTE	17,096	17,543	17,547	+4

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

NATIONAL INSTITUTES OF HEALTH

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

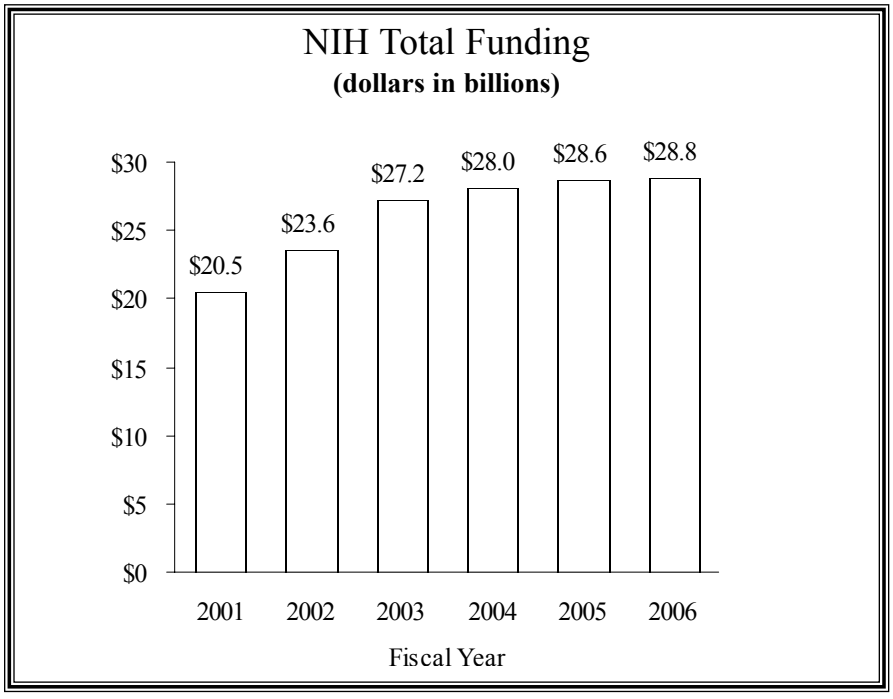
Major advances in knowledge about life sciences, especially the sequencing of the human genome, are opening dramatic new opportunities for biomedical research and heretofore un-imagined prospects for preventing, treating, and curing disease and disability. Investment in biomedical research by the National Institutes of Health (NIH) has driven these advances, and the FY 2006 budget request of $28.8 billion seeks to capitalize on the resulting opportunities to improve the health of the nation.

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 2006, nearly 84 percent of the funds appropriated to NIH will flow out to the extramural community, which supports work by more than 200,000 research personnel affiliated with approximately 3,000 university, hospital, and other research facilities. About 11 percent of the budget will support an in-house, or intramural, program of basic and clinical research activities managed by world-class physicians and scientists. This intramural research program, which includes the NIH Clinical Center, gives our nation the unparalleled ability to respond immediately to health challenges nationally and worldwide. Another 5 percent will provide for research management and support.

Research Priorities in FY 2006

In fulfilling its mission, NIH strives to maintain a diverse portfolio of research founded on both public health need and scientific opportunity. The FY 2006 budget request will allow NIH to address imperative requirements in biodefense; continue to implement the NIH Roadmap for Medical Research; accelerate neuroscience research through enhanced intra-agency collaborations under the NIH Neuroscience Blueprint; and manage a research initiative on developing chemical threat countermeasures. Additional support will be provided to continue progress in promising arenas of science related to specific diseases such as cancer, cardiovascular disease, HIV/AIDS, diabetes, Parkinson's disease, and Alzheimer's disease, while also pursuing whole new avenues of post-genomics research.

Biodefense: For FY 2006, the President's Budget proposes a total of $1.8 billion for NIH biodefense efforts, a net increase of $56 million, or 3.2 percent, over FY 2005. When adjusted for non-recurring extramural facilities construction in FY 2005, research activities in the NIH biodefense program will increase by $175 million, or 11 percent. Of the $1.8 billion total, $1.7 billion is included within the NIH appropriations accounts, and $97 million is budgeted in the Public Health and Social Services Emergency Fund (PHSSEF) for support of targeted research activities to develop countermeasures against nuclear, radiological, and chemical threats.



Our nation's ability to detect and counter bioterrorism ultimately depends heavily on the state of biomedical science. Guided by its long-range strategic plan that includes short-, intermediate-, and long-term goals, biodefense research supported by NIH stresses two overarching, complementary, and urgent components: a) basic research on the biology of microbial agents with bioterrorism potential and the properties of the host's response to infection and defense mechanisms; and b) applied research with predetermined milestones for the development of new or improved diagnostics, vaccines, and therapies needed to control a bioterrorist-caused outbreak. NIH will continue

to ensure full coordination of these research activities with other Federal agencies in the war against terrorism.

In just the past three years, NIH has made tremendous strides towards developing countermeasures to protect all Americans from bioterrorism. For example, researchers supported by NIH have completed the genomic sequencing of at least one strain of all Category A, B, and C agents considered bioterrorism threats. In the area of diagnostics, NIH researchers have developed a rapid test for the presence of antibodies to smallpox that is five-to-ten times more sensitive than standard techniques. An assay has also been developed to simultaneously detect three priority Category A agents, anthrax, plague, and tularemia, in a single sample. Human Phase I trials are being conducted for a DNA vaccine against Ebola, and work is underway on other vaccine candidates against botulism, tularemia, and plague. NIH has also developed and expanded contracts to screen new drugs, develop new animal models, establish a reagent and specimen repository, and provide researchers with genomic, proteomic, and bioinformatic resources related to potential bioterrorism agents. NIH is funding almost 150 grants and contracts with pharmaceutical and biotechnology companies in collaborative projects to develop high-priority biodefense products.

Biodefense research priorities in FY 2006 include continuing the clinical development of vaccines for plague, tularemia, Valley Fever, Ebola, and botulism. NIH will also develop clinical studies of anti-toxin/antibody treatment for anthrax, and, in partnerships with industry and academia, accelerate preclinical development of other promising medical countermeasures, with a focus on therapies. Research will address the need for protection against both naturally occurring threats and ones arising from the risk that biotechnology advances could be used to engineer or modify organisms to evade current medical countermeasures or enhance their virulence.

The FY 2006 budget also requests $30 million to continue support for construction of specialized biosafety laboratories at universities and institutions across the country that are needed to conduct research on the highly dangerous and infectious pathogens in the biodefense research field. Prior to FY 2002, only a few of these specialized laboratories existed in the United States. With these FY 2006 funds, NIH will have spent over $551 million since FY 2003 on extramural biodefense construction. The $30 million investment in FY 2006 will fund an additional Regional Biocontainment Laboratory to support extramural investigators within a region or metropolitan area, bringing the total number of National and Regional Biocontainment Laboratories to 18. Also, these funds will support the construction or renovation of up to six smaller, local-level laboratories to Biosafety Level 3 (BSL-3) standards. Once these facilities are completed, NIH will be able to support over 200 research projects at the same time aimed at developing medical protection from bioterrorism. The national and regional facilities will also back up State and Federal public health laboratories if there is an actual or suspected bioterrorism attack, or when naturally occurring diseases unexpectedly emerge or re-emerge, such as avian influenza and SARS.

With the $97 million budgeted in the PHSSEF for NIH in FY 2006, NIH will use $47 million to continue the nuclear/radiological research effort begun in FY 2005 to improve methods for measuring radiological exposure and contamination, develop drugs to prevent injury from radiological exposure, and develop methods or drugs to restore injured tissues and eliminate radioactive materials from contaminated tissues. The other $50 million will be used to support an initiative on developing new medical countermeasures for chemicals that can be used as weapons of mass destruction.

NIH Roadmap for Medical Research: The FY 2006 budget allocates a total of $333 million, an increase of $98 million over FY 2005, to continue support for the NIH "Roadmap" initiative in accordance with the strategic plan developed in September 2003. These funds will be used to target major opportunities and gaps in biomedical research that no single institute at NIH could tackle alone, but which the agency as a whole must address in order to overcome barriers and rapidly develop new disease treatments, prevention strategies, and diagnostics. The Roadmap is organized into three core themes: New Pathways to Discovery; Research Teams of the Future; and Re-engineering the Clinical Research Enterprise. The FY 2006 request includes $83 million, an increase of $23.5 million, in the Office of the Director, and $250 million, an increase of $74 million, in the budgets of the Institutes and Centers for use in a coordinated effort to support the Roadmap.

HIV/AIDS Research: The FY 2006 budget includes a total of $2.9 billion for HIV/AIDS-related research. This is a net increase of $12 million, or 0.4 percent over FY 2005. In addition to these funds, the FY 2006 budget includes $100 million in NIAID to continue HHS contributions provided since FY 2002 to the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria.

In FY 2006, the NIH HIV/AIDS research program is placing its highest priority on the goal to develop an HIV/AIDS vaccine. This includes programs focused on the discovery, development, and pre-clinical and clinical testing of

vaccine candidates. The evaluation of an HIV/AIDS vaccine will require extensive testing in the United States and in international settings. An integral component of this effort is the Global HIV Vaccine Enterprise initiative, which was announced by the President at the G-8 Summit in Sea Island, Georgia, in June 2004. The Enterprise will support a virtual consortium of research organizations around the world to accelerate HIV vaccine development by enhancing coordination, information sharing, and collaboration globally.
In FY 2006, NIH will devote $49 million, an increase of $34 million over FY 2005, for the second year of this initiative. In the United States, these funds will support the Center for HIV/AIDS Vaccine Immunology that will focus on intensive and highly collaborative projects addressing key immunological roadblocks to the discovery and development of a safe and effective HIV/AIDS vaccine.

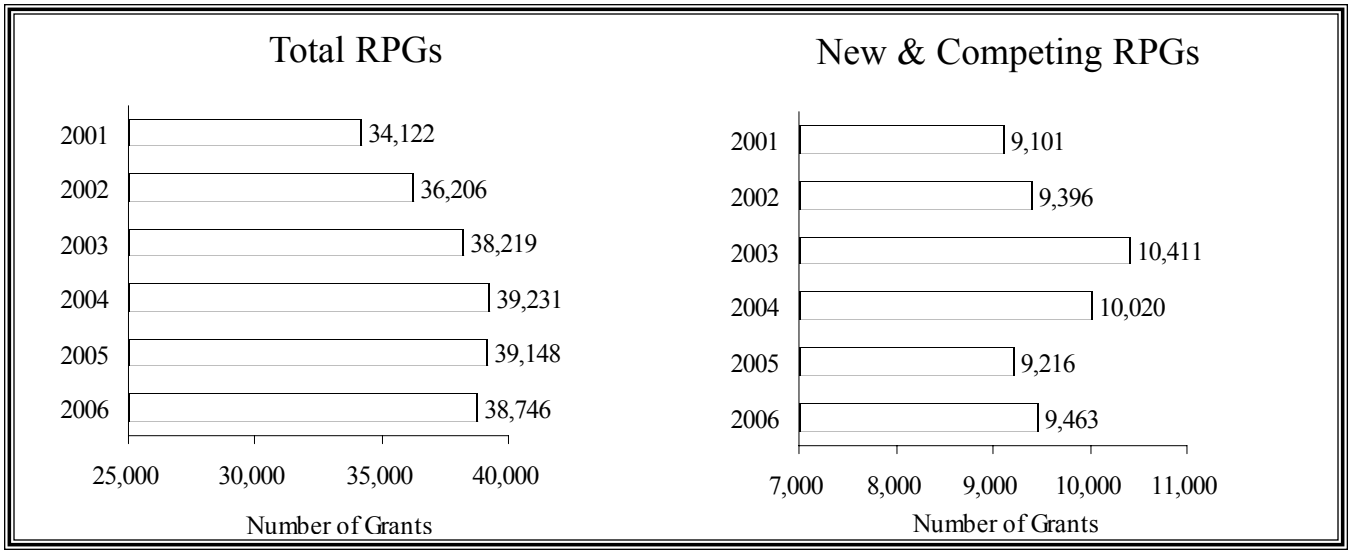
Other key components of the NIH HIV/AIDS research agenda continue to be HIV prevention research, including the development of microbicides, behavioral interventions, and strategies to prevent perinatal transmissions; therapeutics research to develop simpler, less toxic, and cheaper drugs and regimens to treat HIV infection and its complications; international research, particularly to address the critical research and training needs in developing countries; and research targeting the disproportionate impact of the AIDS epidemic on racial and ethnic minority populations in the United States.

NIH Blueprint for Neuroscience Research: In FY 2006, NIH will continue to implement its "Neuroscience Blueprint" that is serving as a framework to enhance the effectiveness of the NIH neurosciences research agenda, which is supported by 15 Institutes and Centers. Advances in the neurosciences and the emergence of powerful new technologies offer many opportunities for Blueprint activities that will enhance the effectiveness and efficiency of neuroscience research. Over the past decade, driven by the science, the NIH neuroscience Institutes and Centers have increasingly joined forces through initiatives and working groups focused on specific disorders. The Blueprint builds on this foundation, making collaboration a day-to-day part of how the NIH does business in neuroscience.
By pooling resources and expertise, the Blueprint can take advantage of economies of scale, confront challenges too large for any single Institute, and develop research tools and infrastructure that will serve the entire neuroscience community.
In FY 2005, participating Blueprint Institutes and Centers are developing an inventory of neuroscience tools funded by NIH and other government agencies, enhancing training in the neurobiology of disease for basic neuroscientists, and expanding ongoing gene expression database efforts, such as the Gene Expression Nervous System Atlas (GENSAT).
In FY 2006, NIH will invest an additional $26 million on Blueprint initiatives that include developing genetically engineered mouse strains specifically for nervous system disease research; training in critical cross-cutting areas such as neuroimaging and computational biology; and supporting specialized, interdisciplinary "core" centers that might focus on areas such as animal models, cell culture, computer modeling, DNA sequencing, drug screening, gene vectors, imaging, microarrays, molecular biology, or proteomics and their applications to neuroscience research.

Research Project Grants

The support of basic medical research through competitive, peer-reviewed, and investigator-initiated research project grants (RPGs) represents 54 percent of the total NIH budget request for FY 2006.

In FY 2006, the NIH budget provides an estimated $15.5 billion, a



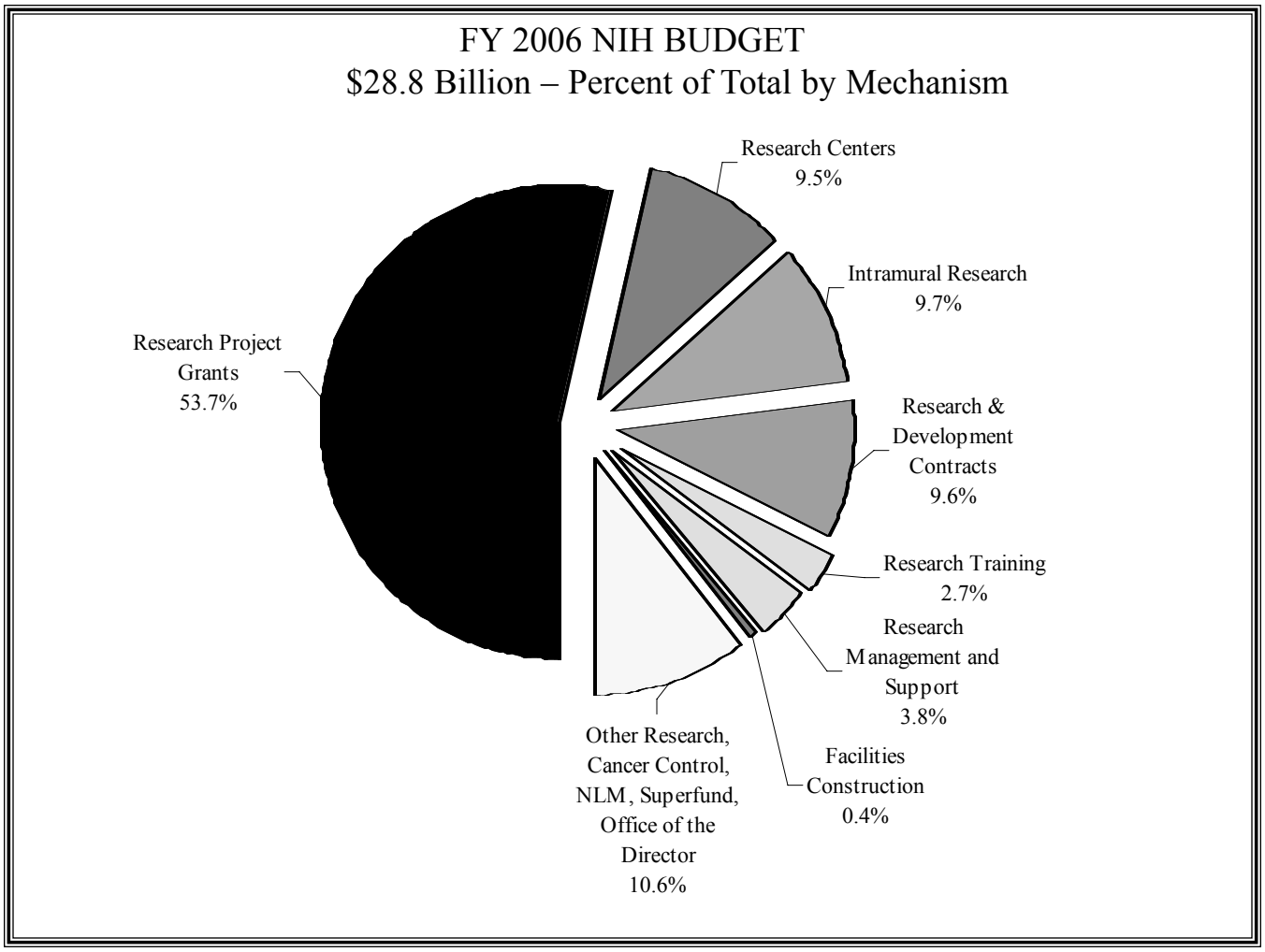
0.4 percent increase over FY 2005, to fund approximately 38,746 total projects. This is 402 fewer grants in total than are expected to be funded in FY 2005. The FY 2006 budget focuses available resources on funding programmatic increases in non-competing continuation grants to which NIH had previously committed, and to maximizing the number of competing RPGs, in lieu of providing inflationary adjustments. Within the total number of grants, NIH estimates it will support 9,463 competing RPGs in FY 2006, an increase of about 247 over FY 2005. Excluding the large cohort of HIV/AIDS clinical trials that are cycling into competing status in FY 2006, the average cost of a competing research project grant in FY 2006 will be about $347 thousand, approximately the same level as in FY 2005.

Facilities Construction

In FY 2006, as discussed above, another $30 million is requested to further expand laboratory space in universities and research institutions around the country critical to biodefense research activities. The budget also includes a total of $90 million for other non-biodefense intramural facilities projects, such as general repairs and improvements across the NIH campuses. Consistent throughout HHS, FY 2006 budget requests for intramural facilities focus on maintenance of existing facilities.

Management Innovations

To better integrate research across its 27 Institutes and Centers, NIH is developing additional decision support tools to improve the management of its large and complex scientific portfolio. This will allow NIH to more efficiently address important areas of emerging scientific opportunities and rising public health challenges. This effort is intended to stimulate accelerated investments in research involving multiple Institutes and Centers, thereby helping to improve the nation's health.



NIH OVERVIEW BY MECHANISM

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Mechanism:				
Research Project Grants	$15,165	$15,438	$15,494	+$56
[# of Non-Competing Grants]	*[27,030]*	*[27,750]*	*[27,092]*	*[-658]*
[# of New/Competing Grants]	*[10,020]*	*[9,216]*	*[9,463]*	*[+247]*
[# of Small Business Grants]	*[2,181]*	*[2,182]*	*[2,191]*	*[+9]*
[Total # of Grants]	*[39,231]*	*[39,148]*	*[38,746]*	*[-402]*
Research Centers	2,541	2,687	2,749	+62
Research Training	745	762	765	+3
Research & Development Contracts	2,820	2,637	2,767	+130
Intramural Research	2,653	2,769	2,792	+23
Other Research	2,131	2,172	2,180	+8
Extramural Research Facilities Construction	119	179	30	-149
Research Management and Support	1,033	1,079	1,090	+11
National Library of Medicine	317	323	326	+3
Office of the Director	327	358	385	+27
Buildings and Facilities	107	118	90	-28
NIEHS VA/HUD Appropriation (Superfund)	78	80	80	+
Nuclear/Radiological Countermeasures Res. (PHSSEF)	0	47	47	0
Chemical Countermeasures Research (PHSSEF)	0	0	50	+50
ONDCP Drug Forfeiture Fund Transfer (NIDA)	4	0	0	0
Total, Program Level	**$28,040**	**$28,649**	**$28,845**	**+$196**
Less Funds Allocated from Other Sources:				
Nuclear/Radiological Countermeasures Res. (PHSSEF)	$0	-$47	-$47	$0
Chemical Countermeasures Research (PHSSEF)	0	0	-50	-50
ONDCP Drug Forfeiture Fund Transfer (NIDA)	-4	0	0	0
PHS Evaluation Funds (NLM)	-8	-8	-8	0
Type 1 Diabetes Research 1/	-150	-150	-150	0
Total, Budget Authority	**$27,878**	**$28,444**	**$28,590**	**+$146**
Labor/HHS Appropriation	**$27,800**	**$28,364**	**$28,510**	**+$146**
VA/HUD Appropriation	**$78**	**$80**	**$80**	**$0**
FTE	17,096	17,543	17,547	+4

(dollars in millions)

	2004	2005	2006	2006 +/-2005
Substance Abuse:				
Substance Abuse Block Grant	$1,779	$1,776	$1,776	$0
Programs of Regional and National Significance:				
Treatment	419	422	447	+25
Prevention	199	199	184	-15
Subtotal, Substance Abuse	**$2,397**	**$2,397**	**$2,407**	**+$10**
Mental Health:				
Mental Health Block Grant	$434	$433	$433	$0
PATH Homeless Formula Grant	50	55	55	0
Programs of Regional and National Significance	241	274	210	-64
Children's Mental Health Services	102	105	105	0
Protection and Advocacy	35	34	34	0
Subtotal, Mental Health	**$862**	**$901**	**$837**	**-$64**
Program Management	$92	$94	$92	-$2
Total, Program Level	**$3,351**	**$3,392**	**$3,336**	**-$56**
Less Funds Allocated from Other Sources:				
PHS Evaluation Funds	-117	-123	-121	+2
Total, Discretionary BA	**$3,234**	**$3,269**	**$3,215**	**-$54**
FTE	519	558	558	0

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 2006 budget requests $3.3 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), a net decrease of $56 million from FY 2005. The request seeks to expand substance abuse clinical and recovery support services through the President's Access to Recovery State Voucher Program, continue to focus on achieving mental health systems transformation with the State Incentive Grants for Transformation, and support State implementation of the Strategic Prevention Framework to prevent young people from initiating drug use. Resources are also provided for Federal and State level drug and mental health data collection activities.

Substance Abuse

An estimated 7.3 million Americans struggle with a serious drug problem for which treatment is needed. Drug abuse has a significant impact on individuals, families, and communities. Every day substance use leads to lost productivity, the transmission of HIV/AIDS and other communicable diseases, domestic violence, child abuse, criminal involvement, and premature and preventable deaths. The FY 2006 request supports efforts to provide effective substance abuse treatment and to stop drug use before it occurs. The budget includes $2.4 billion, a net increase of $10 million for effective substance abuse treatment and prevention activities.

Opening New Pathways to Recovery: Effective substance treatment has been shown to reduce an individual's illegal drug use by nearly half and criminal activity by 80 percent. Treatment also increases employment and decreases homelessness; results in improved physical and mental health; and reduces risky sexual behaviors.

The FY 2006 budget proposes a 50 percent increase for the President's Access to Recovery State Voucher program for a total funding level of $150 million. Access to Recovery allows individuals seeking clinical treatment and recovery support services to exercise choice among qualified community provider organizations, including those that are faith-based. This program recognizes that there are many pathways of recovery from addiction. Through Access to Recovery, individuals are assessed, given a voucher for appropriate services, and provided with a list of service providers from which they can choose. The proposed FY 2006 increase will expand this innovative program to an additional seven States, for a total of 22 States participating. These States will have flexibility to design an approach to focus on areas of greatest need.

The request also includes $31 million for the Screening, Brief Intervention, Referral and Treatment program. Through this program, States are able to expand the continuum of care to include services for non-dependent drug users. In FY 2006, SAMHSA plans to fund an additional two States, for a total of nine.

Promoting Effective Prevention: National survey data confirm a 17 percent decrease in teenage drug use over the past three years, resulting in 600,000 fewer youth using illicit drugs. This decrease represents the lowest levels of teen drug use since the peak levels in the 1990s and holds promise for the

Access to Recovery

Fourteen States and one Tribal organization were awarded Access to Recovery funding in FY 2004, the first year of funding for this Presidential Initiative. The funded entities have identified target populations that include youth, individuals involved with the criminal justice system, women, individuals with co-occurring disorders, and homeless individuals.

Access to Recovery Principles:

- Consumer Choice – The process of recovery is a personal one. Achieving recovery can take many pathways: physical, mental, emotional, or spiritual. With a voucher, people in need of addiction treatment and recovery support will be able to choose the programs and providers that will help them most. Increased choice protects individuals and encourages quality.
- Outcome Oriented – Success will be measured by outcomes, principally abstinence from drugs and alcohol, and including attainment of employment or enrollment in school, no involvement with the criminal justice system, stable housing, social support, access to care, and retention in services.
- Increased Capacity – Access to Recovery will expand the array of services available including medical detoxification, inpatient and outpatient treatment modalities, residential services, peer support, relapse prevention, case management, and other recovery support services.

future as most addicted adults begin using drugs at a young age.

The FY 2006 request continues efforts to achieve the President's goal of reducing illicit drug use. The request prioritizes programs that build capacity for comprehensive prevention services. Of the $184 million for Prevention, $93 million will enhance efforts to implement the Strategic Prevention Framework. The Strategic Prevention Framework is a five-step process to promote youth development, reduce risk-taking behaviors, build on assets, and prevent problem behaviors. The five steps are: (1) conduct needs assessments; (2) build State and local capacity; (3) develop a comprehensive strategic plan; (4) implement evidence-based prevention policies, programs, and practices; and (5) monitor and evaluate program effectiveness, sustaining what has worked well. SAMHSA awarded its first Strategic Prevention Framework State Incentive Grants in FY 2004 to a total of 21 States and Territories.

A recent Program Assessment Rating Tool review identified SAMHSA's competitive prevention grant program as making a unique contribution by focusing on regional and emerging problems. It also found that funds were effectively targeted to activities with the best opportunity to succeed in the areas of greatest need.

Substance Abuse Block Grant: A total of $1.8 billion is requested for the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the same level as FY 2005. The SAPT Block Grant provides funding to over 10,500 community-based organizations and is the cornerstone of States' substance abuse financing, accounting for at least 40 percent of public funds expended for prevention and treatment.

MENTAL HEALTH

The budget includes $837 million for mental health services, a net decrease of $64 million from FY 2005. The request prioritizes Mental Health Transformation activities, consistent with the recommendations of the President's Commission on Mental Health, through funding for SAMHSA's competitive State Incentive Grants for Transformation and the Community Mental Health Services Block Grant. For all other discretionary grant activities, funding is provided to cover all continuation grants.

Transforming the Mental Health System: The final report of the President's Commission on Mental Health, which was released in 2003, called for a fundamental overhaul of how mental health care is delivered in America – to achieve the promise of recovery for families and children. The FY 2006 budget proposes $26 million for State Incentive Grants for Transformation, an increase of $6 million over FY 2005. These infrastructure grants will provide support for developing comprehensive State mental health plans to reduce system fragmentation, and increase services and supports available to people living with mental illness.

SAMHSA will award 8 State Incentive Grants for Transformation in FY 2005 and 3 new grants in FY 2006, for a total of 11. New grantees will engage in State planning and coordination activities, with involvement from agencies, such as criminal justice, housing, child welfare, labor and education. In the second year of funding, States will be able to use 85 percent of funds to support programs at the community level as proposed in their State Plan. The remaining 15 percent will continue to support planning activities.

In addition, the FY 2006 budget maintains funding for the Community Mental Health Services Block Grant. The Block Grant is an important component of SAMHSA's transformation efforts, as it is the only Federal program that provides funds to every State to provide services and improve the public mental health system. The Block Grant also gives States a flexible source of services funding to initiate transformation activities on a state-wide basis.

Suicide Prevention: Suicide is currently the 11th leading cause of death among all age groups, taking the lives of approximately 30,000 Americans each year. It is the third leading cause of death for adolescents. Studies of youth who have committed suicide have found that 90 percent had a diagnosable mental disorder at the time of their death. In FY 2006, SAMHSA will continue its efforts to prevent youth suicide. The request continues the activities authorized under the Garrett Lee Smith Memorial Act that were funded in FY 2005. It supports state-wide youth suicide early intervention and prevention strategies in schools, juvenile justice systems, substance abuse and mental health programs, foster care systems, and other child and youth support organizations. The request also provides funding for institutions of higher education to enhance services for students with mental and behavioral health problems through educational seminars, hotlines, informational materials, and training programs. SAMHSA will also provide funding for a national cross-site evaluation and the Suicide Prevention Resource Center, which in FY 2005 placed a more detailed emphasis on adolescent suicide.

Other Mental Health: The budget maintains funding for community-based systems of care for children and youth, State grants providing outreach and services for homeless individuals through Projects for the Assistance for

Transition from Homelessness, and protection and advocacy activities. It also provides resources to increase access to mental health services to some of our most vulnerable citizens including individuals with co-occurring mental health and substance abuse disorders, older Americans, and traumatized children.

Program Management

The budget includes $92 million to maintain staff, and related program management, and to support activities necessary to effectively administer a wide array of Federal programs. SAMHSA has improved the efficiency of its grant programs through contract consolidations and streamlined grant announcements.

(dollars in millions)

	2004	2005	2006	2006 +/-2005
Health Costs, Quality and Outcomes Research				
Patient Safety				
Health Information Technology Initiative	$50	$50	$50	$0
Other Patient Safety	30	34	34	0
Subtotal, Patient Safety	$80	$84	$84	$0
Comparative Effectiveness Research	0	15	15	0
Other Quality and Cost Effectiveness Research	166	162	162	0
Subtotal, Health Costs, Quality and Outcomes	$246	$261	$261	$0
Medical Expenditures Panel Surveys	55	55	55	0
Program Support	3	3	3	0
Subtotal, Program Level	**$304**	**$319**	**$319**	**$0**
Less Funds Allocated From Other Sources:				
PHS Evaluation Funds	-304	-319	-319	0
Total, Budget Authority	**$0**	**$0**	**$0**	**$0**
FTE	290	296	296	0

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

The Agency for Healthcare Research and Quality promotes health care quality improvement by conducting and supporting health services research that develops and presents scientific evidence regarding all aspects of health care.

The FY 2006 request for the Agency for Healthcare Research and Quality (AHRQ) provides a total program level of $319 million, the same as FY 2005. Priority activities include continued efforts to improve patient safety through the implementation of proven information technologies, and new comparative effectiveness research anticipated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

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. AHRQ supports the translation of research into measurable improvements in the care Americans receive. AHRQ has forged cooperative relationships with major health care organizations to ensure that research funded by the agency is implemented by the major players in the health system. The agency's research agenda is broad and spans from medical informatics to long-term care; from pharmaceutical outcomes to prevention to responses to bioterrorism.

Health Costs, Quality, and Outcomes

The President's Budget will continue to support improvements through research on the cost effectiveness and quality of health care by providing a total of $261 million. This total includes $84 million for Patient Safety and $15 million for comparative effectiveness research authorized by the MMA.

Patient Safety: The patient safety research portfolio for AHRQ was dramatically expanded in FY 2001 in response to the Instititute of Medicine's report, To Err Is Human. In FY 2004, AHRQ redirected much of its patient safety funding to accelerate the adoption of health information technologies that are proven to reduce medical errors and, by doing so, reduce the cost of health care. In FY 2005 and FY 2006, AHRQ will continue to direct $50 million of its patient safety resources to information technology investments designed to enhance patient safety, with an emphasis on small community and rural hospitals/health care systems. These investments will encourage uptake of technologies such as computerized physician order entry, computer monitoring for potential adverse drug events, automated medication dispensing, computerized reminder systems to improve compliance with guidelines, handheld devices for prescription information, computerized patient records, and patient-centered computerized support groups. The first awards for implementation of these technologies were made in summer 2004.

AHRQ grants provided up to 50 percent of the total project costs, with a maximum of $500,000 per year per project. Working with public and private partners, AHRQ will use data from Hospital Information Technology investment demonstrations to make the business case for adoption of these tools, and help spread proven technology through the healthcare system.

AHRQ's FY 2004 plan laid the groundwork for the challenge the President has issued to the health care system to enable the majority of Americans to be able to benefit from secure electronic health records within ten years. Outside AHRQ, the FY 2006 request includes a new $75 million account in the Office of the National Coordinator for Health Information Technology (ONCHIT) to finance targeted activities needed to bring together the health care providers in each region to adopt standards-based, interoperable Electronic Health Records systems. Reaching the President's ten-year goal requires initiating, in FY 2005, regional collaborations to assist health care providers in the deployment of interoperable applications.

Five Steps to Safer Health Care

1. Ask questions if you have doubts or concerns.
2. Keep and bring a list of ALL the medicines you take.
3. Get the results of any test or procedure.
4. Talk to your doctor about which hospital is best for your health needs.
5. Make sure you understand what will happen if you need surgery.

Excerpts from Five Steps to Safer Health Care. Patient Fact Sheet. *July 2003. AHRQ Publication No 03-M007. Agency for Healthcare Research and Quality, Rockville, MD.*

www.ahrq.gov/consumer/5steps.htm

As a result, AHRQ has decided to direct $14 million in FY 2005 to jump-start these collaborations in a number of regions, with funds derived from a combination of an internal reallocation of $11.5 million into patient safety and an additional $2.5 million provided by the Secretary's authority to transfer limited amounts between agencies. This additional investment will enhance existing and future efforts in pharmaceutical outcomes, comparative effectiveness, and improved care delivery. In FY 2006, continuation of these collaborations will be provided through the new ONCHIT account.

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

The remaining $24 million in AHRQ's patient safety budget supports a variety of activities. AHRQ will continue to work collaboratively with the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services, to develop a common Web interface for medical providers that will both enhance the usefulness of adverse event information and reduce the reporting burden for their partners in the health care community.

Comparative Effectiveness Research: In FY 2006, AHRQ will continue a $15 million research portfolio to develop state-of-the-art information about the effectiveness of interventions, including prescription drugs, for ten top conditions affecting Medicare beneficiaries. This work, authorized by section 1013 of the MMA, is being initiated in FY 2005. This new initiative is focused solely on conditions that are common and costly among those whose health care is funded by Medicare, Medicaid, and the State Children's Health Insurance Program. The list of priority conditions was developed with substantial input from the public and stakeholders; HHS used both public listening sessions and systems for receipt of written comments similar to that used to solicit public comments on regulatory changes under consideration. This research will take the form of systematic reviews and syntheses of the scientific literature. Researchers will focus on the evidence of outcomes, comparative clinical effectiveness and the appropriateness of use of pharmaceuticals, health care services, and other health care items.

10 Priority Conditions for Comparative Effectiveness Research

- Ischemic heart disease
- Cancer
- Chronic obstructive pulmonary disease/asthma
- Stroke, including control of hypertension
- Arthritis and non-traumatic joint disorders
- Diabetes mellitus
- Dementia, including Alzheimer's disease
- Pneumonia
- Peptic ulcer/dyspepsia
- Depression and other mood disorders

Research and Dissemination Activities Outside Patient Safety: In FY 2006, AHRQ will invest $162 million in research and dissemination activities in prevention, pharmaceutical outcomes, informatics, and other areas to support the quality and cost-effectiveness of health care. A number of AHRQ efforts are oriented toward making research findings accessible. For example, in the CERTs program, studies have been underway to gather information that Medicaid programs can use to make coverage and other policy decisions such as drug utilization review, economic effects of beta-blocker therapy in heart failure, and prevalence of type 2 diabetes mellitus in children. Under its Evidence-based Practice Program, AHRQ is developing scientific information for other agencies and organizations on which to base clinical guidelines, performance measures, and other quality improvement tools. For example, one of AHRQ's Evidence-based Practice Centers (EPC) recently issued a report on the effectiveness of laser treatment and vacuum-assisted closure on wound healing; this research had been requested by the American Association of Health Plans.

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

Medical Expenditure Panel Surveys

The FY 2006 budget for Medical Expenditure Panel Surveys (MEPS) includes a request for $55 million, the same as FY 2005. MEPS is the collection of detailed, national data on the health care services Americans use, how much they cost, and who pays for them. It is the only national source of visit-level information on medical expenditures. MEPS 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 (SCHIP), Medicare and Medicaid.

These surveys also provide a substantial portion of the data used to develop two reports, required by the agency's 1999 reauthorization, that seek to measure the quality of health care in America and differences in access to health care services for priority populations. The National Healthcare Quality Report includes information on patient assessment of health care quality, clinical quality measures of common health care services, and performance measures related to outcomes of acute and chronic disease. The second report – the National Healthcare Disparities Report – highlights populations that are at high risk for differences in care. These populations include the elderly, people in inner-city and rural areas, women, children, minorities, low-income groups, and individuals with special health care needs. AHRQ used a formal notice and comment process to solicit public comments on the measures that should be included in the upcoming 2005 report. The current editions of both reports are available on a new Web site, www.qualitytools.ahrq.gov. In addition, the site serves as a Web-based clearinghouse by providing information for health care providers, health plans, policymakers, purchasers, patients and consumers to take effective steps to improve quality.

In FY 2006, AHRQ will be fully funded through inter-agency transfers of evaluation funds.

CENTERS FOR MEDICARE & MEDICAID SERVICES

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Current Law:				
Medicare /1	$301,505	$333,442	$401,059	+$67,617
Medicaid /2	176,231	188,272	192,562	+4,290
SCHIP	4,607	5,343	5,434	+91
State Grants and Demonstrations	48	200	399	+199
Total Outlays, Current Law	**$482,391**	**$527,257**	**$599,454**	**+$72,197**
Premiums	-32,140	-38,010	-55,508	-17,498
Other Offsetting Collections/ Receipts	-189	0	0	0
Total Net Outlays, Current Law	**$450,062**	**$489,247**	**$543,946**	**$54,699**
Proposed Law:				
SMI Transfer to Medicaid for QIs	0	0	230	$230
Medicaid Benefits	0	225	156	-$69
SCHIP Benefits	0	0	799	$799
State Grants and Demonstration	0	0	400	$400
Total Proposed Law	**$0**	**$225**	**$1,585**	**$1,360**
Premiums, Proposed Law	$0	$0	-$35	-$35
Total Net Outlays, Proposed Law /3	**$450,062**	**$489,472**	**$545,496**	**$56,024**

1/ Benefits (including Medicare Transitional Drug Assistance and Medicare Prescription Drug), QIOs, administration (including State low-income determinations for Medicare Part D), and Medicare Part B transfer to Medicaid for QIs.

2/ Net outlays, without FY 2004/05 outlays for QIs; without FY 2005/06 State low-income determinations.

3/ Total net outlays equal current outlays minus the impact of proposed legislation

CENTERS FOR MEDICARE & MEDICAID SERVICES

The Centers for Medicare & Medicaid Services assures health care security for beneficiaries.

The FY 2006 budget request for the Centers for Medicare & Medicaid Services (CMS) is $545.5 billion in net outlays, a $56.0 billion or 11.4 percent increase over FY 2005. The request finances Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), the Health Care Fraud and Abuse Control Program (HCFAC), the Health Insurance Portability and Accounting Act (HIPAA), and CMS operating costs.

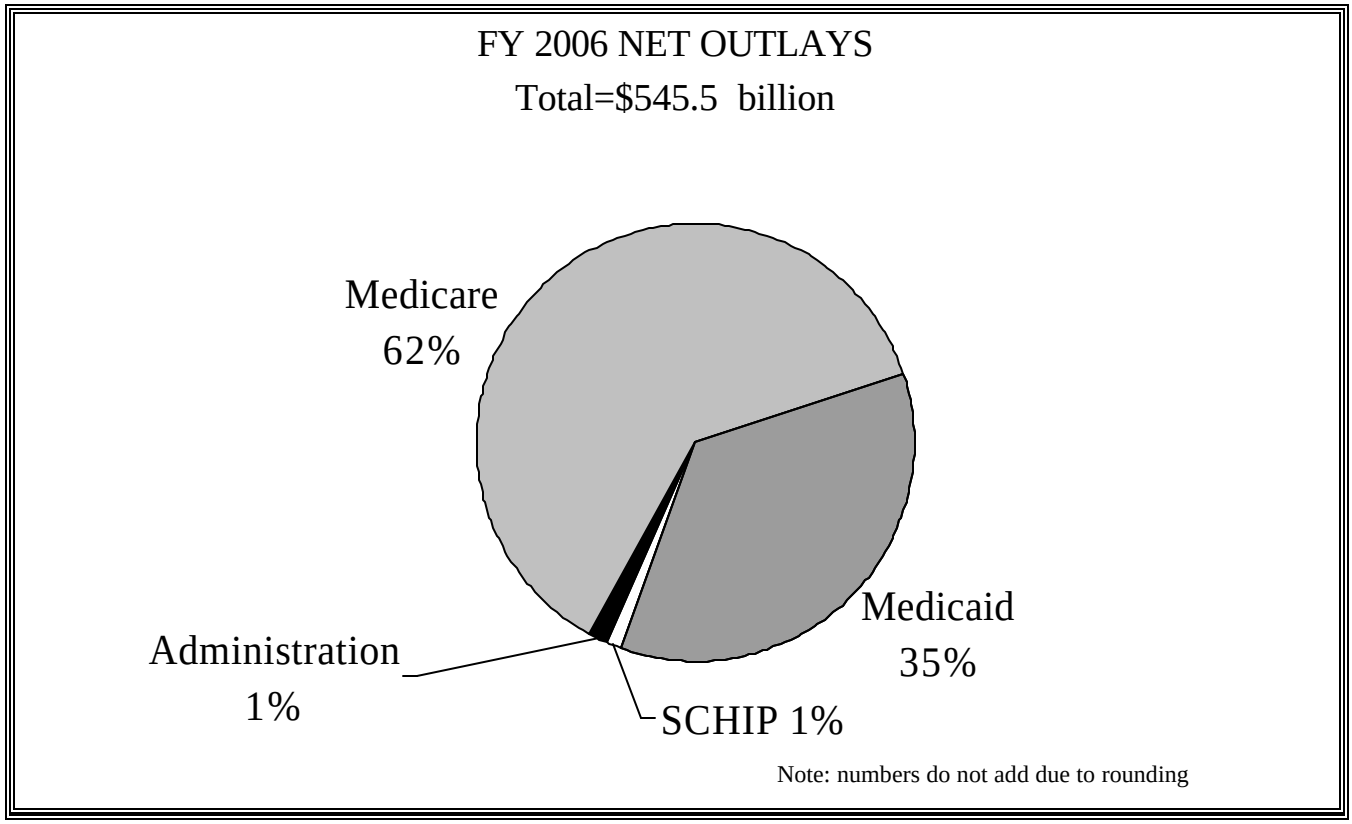
Our FY 2006 budget request supports several key Presidential and Secretarial priorities:

- Implementing the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provisions, specifically the prescription drug benefit.
- Investing in information technology (IT) infrastructure to support growth and change in the Medicare and Medicaid programs.
- Promoting the effective use of IT as a central strategy to improve quality and Agency effectiveness.
- Maximizing program integrity efforts in all our programs.
- Developing evidence-based approaches to integrating technology with medical care; and
- Improving the quality of health care for all our beneficiaries.

Building upon the success of the Health Insurance Flexibility and Accountability (HIFA) waivers and SCHIP, the Administration plans to work diligently with the Congress to develop a Medicaid modernization plan. This plan would introduce more State flexibility and fiscal stability into the program. The Administration proposes to provide States with additional flexibility in Medicaid to further increase coverage among low-income individuals and families without creating additional costs for the Federal Government. This proposal would build on the success of SCHIP to provide acute care for children and families, as well as efforts to reduce the number of uninsured individuals.

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

Finally, the budget proposes to restrict the use of intergovernmental transfers and cap Federal payments to individual State and local government providers.



MEDICARE MODERNIZATION ACT IMPLEMENTATION

On December 8, 2003, the President signed into law the historic Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). MMA transformed the Medicare program by significantly expanding private health plan options (Part C) and adding a prescription drug benefit (Part D) to traditional fee-for-service hospital insurance (Part A) and supplementary medical insurance (Part B). In 2004, Medicare beneficiaries benefitted from improvements to provide modern, prevention-oriented health care to our Nation's elderly and disabled populations. In June, the prescription drug discount card began providing beneficiaries lower prices for their medications, and these discounts will continue until the full drug benefit is implemented. In 2005, beneficiaries will receive new preventive benefits, such as a "Welcome to Medicare" physical. And, in 2006, for the first time in the history of Medicare, beneficiaries will be able to participate in a new benefit that offers outpatient prescription drug coverage. With all the improvements to Medicare, CMS will conduct extensive outreach efforts to help seniors understand their new choices. Expanded efforts through 1-800 Medicare, www.medicare.gov, community-based organizations, and media outreach will ensure that seniors have the information they need to select from the many new options available.

PRESCRIPTION DRUG DISCOUNT CARD

MMA established a temporary prescription drug discount card program to immediately help Medicare beneficiaries reduce their out-of-pocket spending on drugs until the full Medicare drug benefit begins in January 2006. Enrollment in the discount card program began in May 2004, and discounts and transitional assistance began in June 2004. As of June, CMS had contracted with organizations to make a total of 38 national and 33 regional discount cards available, and amended 83 Medicare Advantage contracts to include exclusive cards for their members. To date, nearly 6.2 million beneficiaries have enrolled in the discount card program, and more are enrolling every day. Included in the 6.2 million are the 1.7 million beneficiaries who are currently receiving the $600 low-income transitional assistance credit in conjunction with their discount cards.

Seniors are seeing real savings on their prescription drug costs. In October 2004, CMS found that beneficiaries were obtaining discounted prices that were about 12 to 21 percent less than the national average prices for commonly used brand name drugs at retail pharmacies. Beneficiaries who use generic drugs obtained even larger savings from 28 to 75 percent below typical prices for commonly used generics. And, low-income beneficiaries who received the $600 transitional assistance credit on their discount cards experienced reductions as much as 90 percent off national average retail pharmacy prices when they used the Medicare discount card together with their transitional assistance. Independent studies have demonstrated similar results; beneficiaries save about 20 percent off the retail cost of brand name drugs and up to 60 percent off the cost of generic drugs as a result of the discount card program.

VOLUNTARY PRESCRIPTION DRUG BENEFIT

Beginning January 1, 2006, approximately 42.7 million Medicare beneficiaries will be eligible to enroll in a new subsidized prescription drug benefit that helps lower out-of-pocket prescription drug costs. Beneficiaries choose either a new stand-alone private plan that adds prescription drug coverage to their traditional Medicare fee-for-service coverage, or beneficiaries can enroll in a private plan that provides both medical and drug benefits from one source. Success in this effort requires CMS to establish major new information systems, to educate and enroll beneficiaries, and to review and approve drug plan bids.

CMS has been actively preparing to implement this historic new benefit. CMS published proposed rules in August 2004, and in December, issued formulary guidance. On January 3, 2005, the United States Pharmacopia issued model guidelines for drug categories and classes to provide a standard framework for the development of formularies. Plans' formularies are required to provide beneficiaries with a choice of drugs within each category and class that appropriately reflects current medical practice. CMS will review individual formularies to ensure that plans provide access to medically necessary drugs and do not discriminate against any sub-groups of beneficiaries. Also in December, the Secretary announced the establishment of 34 prescription drug plan regions after significant input from stakeholders. These regions represent the new service delivery areas for the prescription drug plans beginning in 2006. Most importantly, CMS has taken every opportunity to receive input from stakeholders about the new drug benefit. In December 2004, CMS held numerous open door forums on sponsor applications, bidding, formularies, and risk-adjustment, and posted materials on the www.cms.hhs.gov website for

potential sponsors' use, including a draft plan benefit package, solvency standards, bid instructions, and a pricing tool.

CMS has met, and will continue to meet, many key milestones in 2005 to ensure that the benefit is implemented on time. In January 2005, CMS published the final rule establishing the drug benefit. The new rules ensure the drug benefit will:

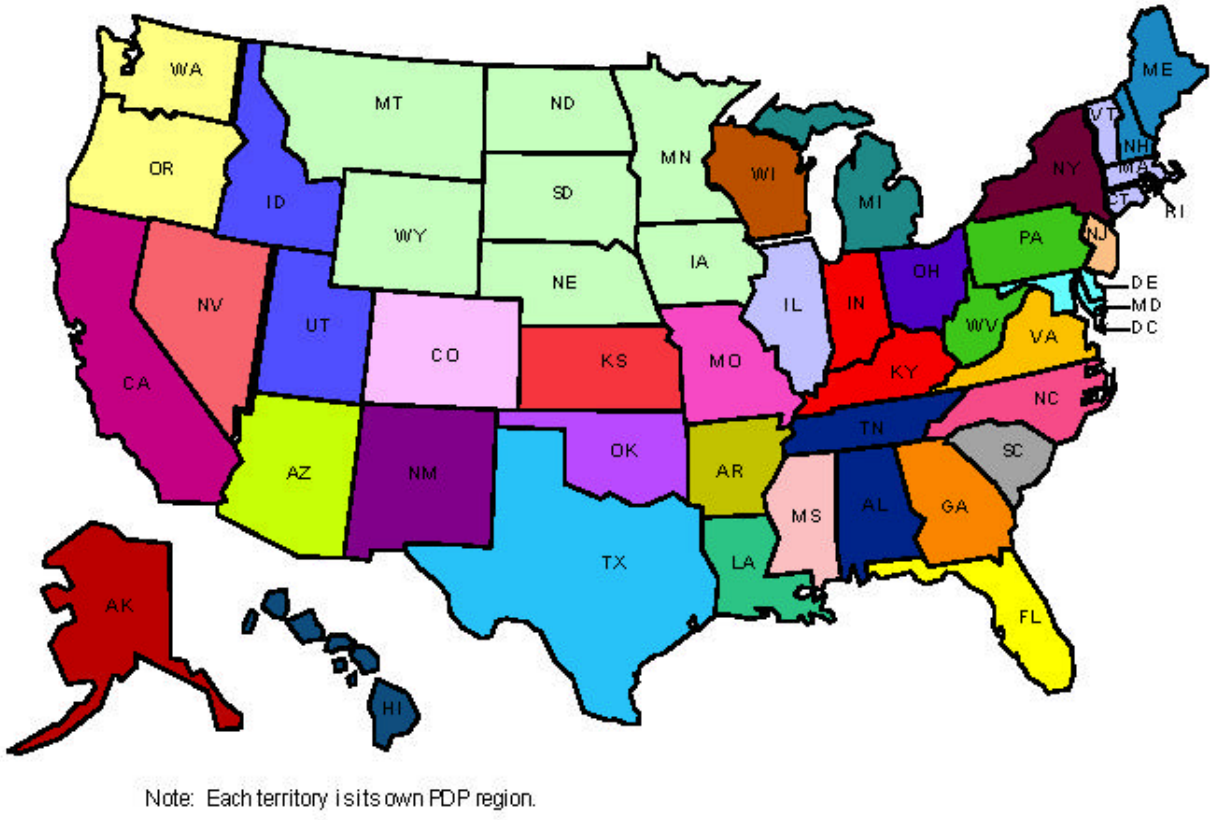
- Offer comprehensive help to those who need it most– people with very high prescription drug costs and people with low incomes– and for those with low incomes, comprehensive help at little or no cost;
- Give beneficiaries a choice of at least two drug plans that will cover a comprehensive set of both brand name and generic drugs;
- Ensure beneficiaries have convenient access to pharmacies, generally within just a few miles or less of their homes;
- Guarantee that Medicare beneficiaries living in nursing facilities will be able to enroll in a drug plan and take advantage of the new benefit, since all prescription drug plans will contract with long-term care pharmacies; and,
- Ensure that full benefit dual eligible beneficiaries who have both full Medicaid and Medicare benefits are automatically enrolled in a drug plan effective January 1, 2006, (with an option to change plans) so that they have no gap in coverage during the transition to the Medicare benefit.
- Facilitate enrollment of beneficiaries who have been determined eligible for the low-income subsidy but have not chosen a plan.

In upcoming months, CMS will conduct nationwide conferences for potential sponsors and greatly expand beneficiary education activities. Plans' applications are due in March 2005, formulary information is due in April 2005, and plan bids are due to CMS in June 2005. CMS plans to approve packages by September, and beneficiary enrollment in the new drug plans will begin November 15, 2005 and continue until May 15, 2006.

Drug plans will typically cover about half of beneficiaries' drug costs, and all beneficiaries will have an out-of-pocket limit on how much they pay for their prescription drugs. The proposed beneficiary premium for the new Medicare drug benefit is designed so that, on average, a non-low income beneficiary pays about 25 percent of the drug premium. The remaining 75 percent will be subsidized by the Federal Government.

Medicare will provide additional financial assistance to low-income

Prescription Drug Benefit Regions



Note: Each Territory (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and Virgin Islands) is its own PDP

beneficiaries. Beneficiaries with incomes below 135 percent of poverty will pay no monthly premium, no deductible, and nominal co-payments per prescription. Beneficiaries with incomes between 135 and 150 percent of the Federal Poverty Level will pay reduced premiums, a $50 deductible, and reduced cost-sharing.

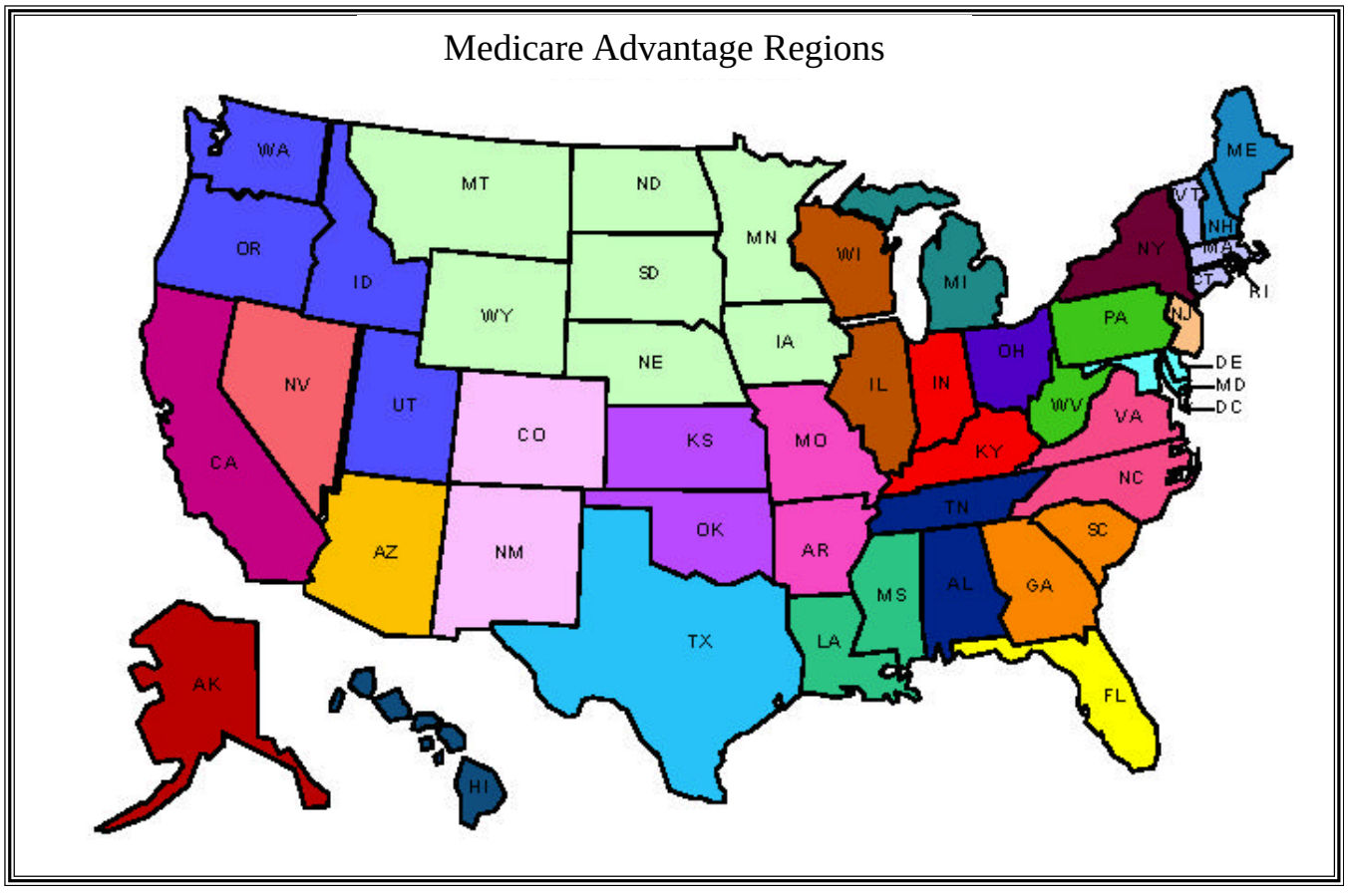
Medicare will pay subsidies to employers that continue to offer retiree health benefits to seniors. Medicare will permit employers and unions to continue providing drug coverage to their Medicare-eligible retirees while retaining their current plan designs that are at least equivalent to the standard Part D drug benefit, and allow them to use the retiree drug subsidy to reduce the cost of providing generous coverage. Sponsors of employer and union plans who offer a drug benefit as good as, or better than, Medicare's drug benefit will be able to apply for the subsidy, which is estimated to roughly average $668 per beneficiary in 2006. Plan sponsors will have to incur costs at least equal to the gross value of the Part D benefit (taking into account the effect of beneficiary out-of-pocket spending and beneficiary premiums).

State Effects

Under Part D of MMA, States are relieved of a significant portion of the costs of providing pharmaceutical benefits to individuals eligible for both Medicare and Medicaid. States maintain some percentage of the financial responsibility for providing drugs to these individuals. In 2006, States will be expected to pay 90 percent of this amount. This percentage will be phased down to 75 percent by FY 2015, where it will remain thereafter.

States will also participate in the eligibility determination process for the low-income drug benefit. For the Part D low-income drug benefit, eligibility will be determined by either the State Medicaid agency, with States receiving their regular matching funds for associated administrative costs, or by the Social Security Administration, with additional funds authorized to cover new administrative costs.

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



MEDICARE ADVANTAGE

MMA created the Medicare Advantage (MA) program to offer more choices and better benefits to Medicare beneficiaries through competition among private health insurance plans. In 2006, 16 percent of beneficiaries are expected to be enrolled in private plans, and by 2010, this number is projected to increase to about 25 percent. Currently, five million beneficiaries are enrolled in Medicare Advantage. MMA increased payments to private plans, and plans have been investing these higher payments in improving benefits for Medicare beneficiaries. Recent studies indicate that beneficiaries enrolled in a Medicare Advantage plan have overall savings for their Medicare and non-Medicare benefits of over $700 per year in out-of-pocket costs for the average beneficiary and nearly $2,000 in savings for those beneficiaries in poor health compared to traditional Medicare for beneficiaries without supplemental coverage from an employer or Medicaid.

New regional plans will begin on January 1, 2006, and provide the most significant expansion to private plan options since the Balanced Budget Act of 1997. Regional plans will have a network of doctors and hospitals that contractually agree to provide health care services at a specified rate but also allow enrollees to go outside the network for care. Unlike local plans, which serve individual counties and groups of counties chosen by the plan sponsor, the new regional PPOs will bid to serve one of 26 regions. The goal of these larger regional markets is to bring more plan options to rural areas by grouping States together with similar payment rates and patient care trends, and to achieve a target population size. These factors, coupled with existing organizational relationships and learning from plans about their intentions to participate in the Medicare program in certain areas, were critical in determining the region design.

CMS has been actively preparing throughout 2004 and will continue in 2005 to seamlessly implement this historic new expansion in private plans. In 2004, CMS published the proposed rule and guidance to plans as to how to transition to Medicare Advantage (MA), held open door forums on bidding and the MA application process, and released draft applications. In January 2005, CMS published the final rule, and in upcoming months, CMS will conduct nationwide conferences for potential sponsors, including benefit package seminars. CMS will accept bids through June 6, subsequently review marketing materials, and then approve plans in September. Marketing to beneficiaries can begin in October, and enrollment will begin on November 15, 2005 and continue until May 15, 2006. CMS is working to simplify the application process to make it as efficient and non-duplicative as possible.

PREVENTIVE BENEFITS

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

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

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

CMS is also collaborating on education and outreach with the American Cancer Society, the American Diabetes Association, and the American Heart Association. The campaign will help maximize attention to Medicare's new preventive benefits and help seniors use them.

CONTRACTING REFORM

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

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

CMS is requesting $58.8 million to implement Medicare contracting reform in FY 2006. With this amount, CMS plans to implement an accelerated strategy that features two cycles of contractor conversions from the old Title XVIII contracts to the new Medicare administrative contracts over a period FY 2006 through FY 2008. In FY 2006, CMS will cover the costs of contractor and data center transitions and terminations. This accelerated strategy ensures that expected savings from Medicare contracting reform could come as early as FY 2009.

FRAUD AND ABUSE

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

- Revision of average wholesale price (AWP) payments for Medicare's covered outpatient drugs provided in a doctor's office to average sales price (ASP).
- Creation of the Program Advisory and Oversight Committee (PAOC) to review and provide advice on implementation of the competitive bidding program for durable medical equipment (DME), enteral nutrition, and off-the-shelf orthotics.
- Implementation in early FY 2005 of a pilot program to conduct National and State background checks on workers in long-term care settings. The goal of the pilot is to identify efficient, effective, and economical processes for long-term care facilities or providers to conduct background checks on employees with direct access to residents and patients.

COST CONTAINMENT/LONG TERM FINANCIAL SECURITY

Section 801 of MMA requires the Medicare Board of Trustees of the Hospital Insurance Trust Fund (Part A) and the Supplementary Medical Insurance Trust Fund (Part B and Part D) to assess whether Medicare's "excess general revenue funding" exceeds 45 percent. As defined in the law, excess general revenue funding is equal to Medicare's total outlays minus dedicated financing (primarily payroll taxes and premiums). Trustees will be required to include the following information in their annual reports starting in 2005:

- General revenue Medicare growth projections as a percentage of the total Medicare outlays;
- Financial analysis of the combined Medicare Part A and Part B trust funds if general Medicare revenue funding were limited to 45 percent of total Medicare outlays;
- A determination as to whether there is projected to be "excess general Medicare revenue funding" for any of the succeeding six fiscal years in their annual reports. If there is an affirmed determination of excess general Medicare revenue funding for two consecutive annual reports, this will be treated as a funding warning for Medicare. In the event of a Medicare funding warning the law provides special legislative conditions for Medicare legislation submitted by the President to Congress;
- Comparisons with growth trends for gross domestic product, private health costs, national health expenditures, and other appropriate measures; and
- Expenditures and trends in expenditures under Part D.

$1 BILLION IMPLEMENTATION FUNDING

MMA authorized and appropriated $1 billion in two-year funding for CMS to implement MMA. CMS is tracking its MMA expenditures by

$1 Billion Spending Plan by Major Provision

(dollars in millions)

	FY 2004	FY 2005	FY 2004-2005
Drug Card	$166	$62	$229
Rx Drug Benefit	127	256	384
Regulatory Reform	6	45	51
Contracting Reform	6	21	27
Fee-for-Service Improvements	32	62	94
Overhead (All Provisions*)	35	181	216
Total by Provisions	$373	$627	$1,000

* Includes $25 million for the Office of the Inspector General.

$1 Billion Spending Plan by Major Activity

(dollars in millions)

	FY 2004	FY 2005	FY 2004-2005
Education/Outreach*	$230	$206	$436
Information Technology	69	207	276
Research	19	33	53
Adminstration	22	46	68
Other Contracts**	33	136	168
Total by Activity	$373	$627	$1,000

* Includes administrative costs for mailings.
** Includes $25 million for the Office of the Inspector General.

major provision in the bill as well as by several broad activity categories. The tables display our actual spending in FY 2004 and estimated spending in FY 2005 by provision and by activity. In FY 2005, $25 million will be transferred to the Office of the Inspector General.

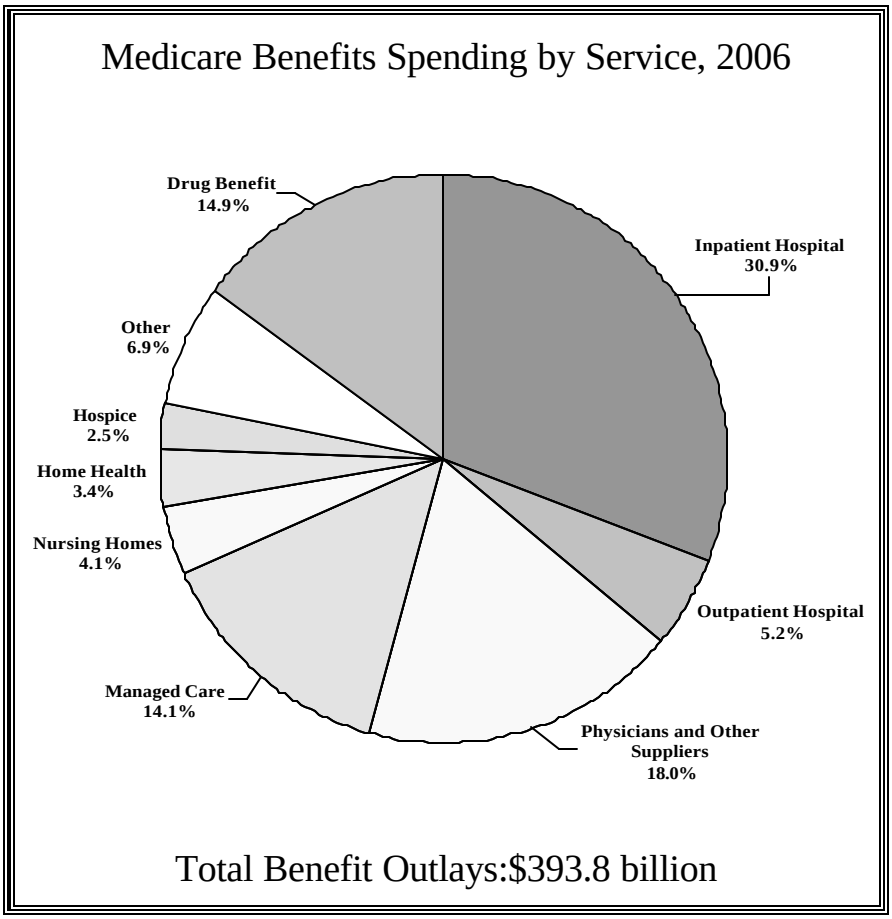
HEALTH SAVINGS ACCOUNTS

MMA establishes Health Savings Accounts (HSAs). HSAs allow individuals with high deductible plans (a deductible of at least $1,000 for individual plans and at least $2,000 for family plans) to contribute up to the lesser of the deductible amount or $2,650 for individuals and $5,250 for families in 2005 to a tax-advantaged account. The maximum contribution amount is indexed and increases each year. Individuals may withdraw money from their HSA on a tax free basis to pay for medical expenses below the deductible, as well as other qualified medical expenses such as prescription drugs, over the counter drugs, long-term care services, and COBRA insurance. Any money used for non-qualified medical expenses is taxable and subject to an additional 10 percent tax.

MEDICARE

Medicare provides health insurance to 42.7 million individuals who are either 65 or older, disabled, or suffer from end–stage renal disease (ESRD). In FY 2006, spending on Medicare benefits will total $394 billion.

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



PART A

- Medicare Part A pays for inpatient hospital care, skilled nursing facility care, home health care related to a hospital stay, and hospice care.
- Individuals with 40 quarters of Medicare-covered employment are entitled to Part A without paying a premium.
- Financing comes primarily from a 2.9 percent payroll tax split between employees and employers.
- The most recent Medicare Trustees report projected the Hospital Insurance (HI) Trust Fund's insolvency date at 2019.
- In 2005, beneficiaries will pay a $912 deductible for a hospital stay of 1-60 days, and a $114 daily coinsurance for days 21-100 in a skilled nursing facility.
- The 2005 Part A premium is $206 per month for people with 30-39 quarters of Medicare-covered employment, and $375 per month for people with 29 or fewer quarters of such coverage.

PART B

- Medicare Part B pays for physician services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment, certain home health care, and other medical services and supplies.
- Supplementary Medical Insurance (SMI) coverage is voluntary. Approximately 95 percent of Medicare's beneficiaries are enrolled in Part B.
- Approximately 25 percent of Part B costs are financed by beneficiary premiums ($78.20 per month in 2005), with the remaining 75 percent of costs covered by general revenues.

PART C

- Medicare Part C, the Medicare+Choice program, has changed to the Medicare Advantage program under MMA.
- Medicare Advantage offers beneficiaries a variety of coverage options, including traditional HMOs, preferred provider organizations (PPO), and private fee-for-service plans.
- Currently, five million beneficiaries are enrolled in a Medicare Advantage plan.
- Medicare Advantage plans receive a capitated monthly payment to provide all Part A and B services, plus whatever additional benefits and cost sharing arrangements the plan provides.

PART D

Prescription Drug Standard Benefit: In 2006, the standard benefit offers:

- a $250 deductible;
- a modest average monthly premium estimated at less than $37, based on choice of plan; and,
- a 75 percent subsidy for drug costs between $251 and $2,250.
- Once a beneficiary pays $3,600 out-of-pocket ($5,100 in total costs), the Federal Government will pay all costs for covered drugs except for nominal cost-sharing.
- The cost-sharing, once the beneficiary reaches the out-of-pocket limit, is equal to the greater of:

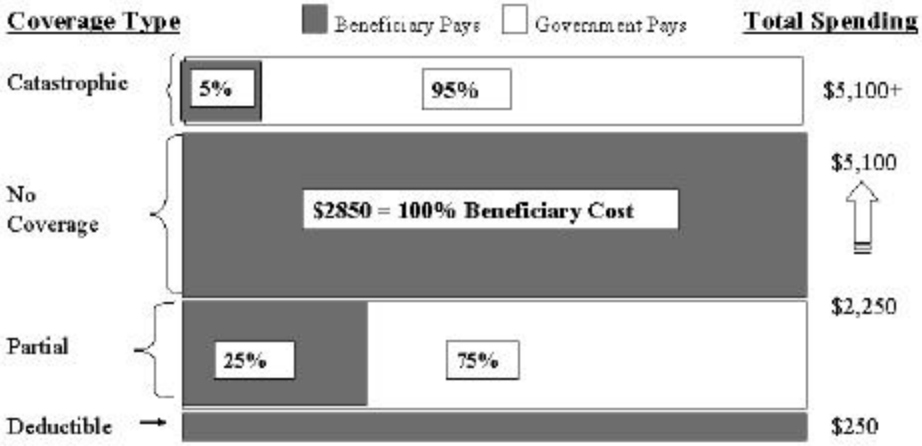
  (1) a co-payment of $2 for a generic drug or preferred drug / $5 for any other drug, or,

  (2) 5 percent co-insurance.

Prescription Drug Low-Income Benefit: In 2006, low-income Medicare beneficiaries will receive generous assistance in purchasing their prescription drugs, as follows:

- All Medicaid full-benefit dual eligible beneficiaries will pay no deductible, no premiums, and no co-payments after the out-of-pocket limit is reached.
- Full-benefit dual eligible beneficiaries with incomes at or below 100 percent of poverty will have co-payments of up to $1 for generics and $3 for brand name drugs up to the out-of-pocket limit.
- Full-benefit dual eligible beneficiaries with incomes above 100 percent of poverty will have co–payments of up to $2 for generics and $5 for brand name drugs up to the out-of-pocket limit.
- Institutionalized dual eligibles will pay no premiums, deductibles, or cost-sharing.
- Non-full-benefit dual eligible beneficiaries with incomes below 135 percent of poverty and assets up to $6,000 per individual (or $9,000 per couple) in 2006 will have no deductibles, no premiums, and co-payments of up to $2 for generics and $5 for brand name drugs up to the out-of-pocket limit. They will have no co-payments for drug costs once their total drug costs reach $5,100.
- Non-full benefit dual eligible beneficiaries with incomes below 135 percent of poverty and assets that exceed $6,000 but do not exceed $10,000 per individual (or $9,000 and $20,000 per couple) in 2006 will have no premiums, a $50 deductible, and have nominal cost sharing not to exceed 15 percent co-insurance. They will have co-payments of up to $2 for generics and $5 for brand name drugs once their total drug costs reach $5,100.
- Non-dual eligible beneficiaries with incomes below 150 percent of poverty and assets up to $10,000 per individual (or $20,000 per couple) in 2006 will have a sliding scale premium subsidy that is based on income, a reduced deductible of $50, and cost-sharing not to exceed 15 percent co-insurance for costs up to the

Beneficiary Prescription Drug Spending in 2006 Under Medicare's Standard Drug Benefit



Shaded areas represent $3600 in beneficiary out-of-pocket spending -- the maximum a beneficiary will spend before catastrophic coverage begins. Estimates do NOT include ~$420 in annual premiums.

out-of-pocket threshold. Once these beneficiaries reach total drug costs of $5,100, they will pay only nominal cost-sharing of up to $2 and $5 co-payments.

- For non-full-benefit dual eligible beneficiaries, low-income subsidy eligibility will be determined by State Medicaid agencies or by the Social Security Administration.

PROGRAM ASSESSMENT RATING TOOL (PART)

The Office of Management and Budget (OMB) developed the Program Assessment Rating Tool (PART) to evaluate programs in a systematic manner, using numeric scores that rate overall program effectiveness and highlight strengths and weaknesses. In FY 2003, the Medicare program was evaluated. Medicare was rated as "Moderately Effective" and found to be strong overall, but needed modernizing to reflect the evolution of health care since its inception in 1965. With enactment of MMA, many of these issues have been addressed and new performance measures were added to reflect these new responsibilities.

The program was not re-evaluated during FY 2004. However, CMS is addressing the following three recommendations from the PART evaluation:

- Agency commitment to timely implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;
- Greater emphasis on sound program and financial management; and
- More effort to link Medicare payment to provider performance.

MEDICARE ADMINISTRATIVE IMPROVEMENTS

In coming years, HHS will make changes to rationalize several components of Medicare's payment systems. Specialty hospitals, which tend to be physician-owned and focus on patients with specific medical conditions or who need surgical procedures, are a small but growing segment of the health care industry. MedPAC, the Congressional advisory committee for Medicare issues, conducted extensive research and found that there are problems in the physician ownership of hospitals and in the way Medicare pays for hospitals. The Administration will seek to refine the inpatient hospital payment system and related provisions of regulations to ensure a more level playing field between specialty and non-specialty hospitals.

With regard to Medicare Advantage, the Budget will phase in over four years the savings from the full implementation of risk adjustment payments to account for different health status of beneficiaries in Medicare Advantage plans. The phase-in will begin in 2007 and will be completed by 2010, and is projected to produce savings to the extent that Medicare Advantage plans serve healthier beneficiaries, on average, compared to fee-for-service. The Budget also proposes to improve payment accuracy for patients who are transferred from inpatient hospitals to post-discharge acute settings, such as nursing facilities. Lastly, HHS will refine the Skilled Nursing Facility Prospective Payment System in 2006 to ensure appropriate payments for certain high-cost cases.

HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM (HCFAC)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established the Health Care Fraud and Abuse Control (HCFAC) Program. For the first time, the FY 2006 budget proposes to fund the HCFAC program through both a mandatory and a discretionary funding stream. Proposed FY 2006 total HCFAC funding is $1.155 billion. Of this amount, $1.075 billion funds the mandatory portion of the program. The HIPAA statute capped HCFAC spending at this level since FY 2003. The remaining $80 million represents new discretionary proposed funding for the program.

The HCFAC program was established to:

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

HCFAC Mandatory Funds: The HCFAC Program dedicates $1.075 billion from the Medicare Part A Trust Fund combating health care fraud and abuse. The money is allocated into three major parts:
1) $720 million for the Medicare Integrity Program (MIP);
2) $114 million to Federal Bureau of Investigation (FBI); and,
3) $240.6 million in "wedge" funds that are divided among the Department of Justice (DOJ), the HHS Inspector General, and other HHS agencies, including CMS, AoA, and the Office of General Counsel (OGC). The programs and projects

financed by these funding streams are used to detect and prevent fraud, waste, and abuse through investigations and audits, educational activities, and data analysis. From 1997 to 2003, the HCFAC Account has returned approximately $6.2 billion to the Medicare Trust Fund.

The MIP activity in HCFAC provides funds for: medical review; benefits integrity work to identify and refer patterns of fraud to law enforcement; provider and HMO audits of cost reports; Medicare secondary payer activities; and provider education and training. The Administration has requested an additional $75 million in discretionary funding to safeguard the Medicare prescription drug benefit and Medicare Advantage. These funds will increase total MIP funding to $795 million in 2006. For the mandatory funding, MIP is expected to save the Medicare Trust Funds $10 billion in FY 2006 through recoveries, claims denials, and accounts receivable, a 14:1 return on investment.

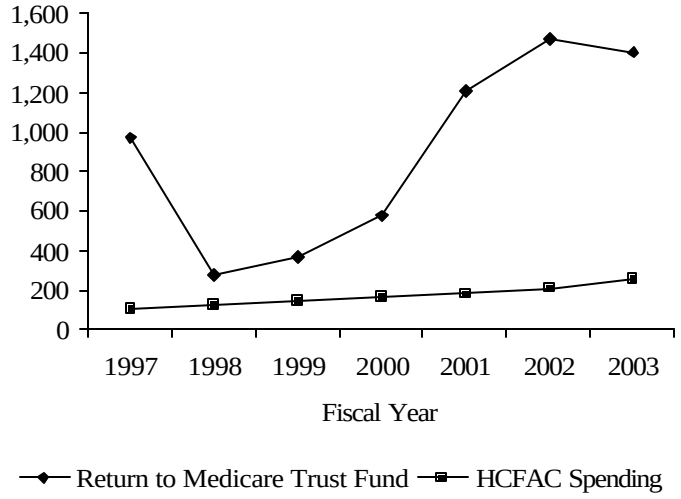
The FBI uses its $114 million allocation for health care fraud enforcement and investigations. In addition, the FBI provides operational support for national initiatives focusing on pharmaceutical diversion, chiropractic fraud, medical clinics, and transportation providers.

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

HCFAC Discretionary Funds: As part of the government-wide approach to funding program integrity activities, the budget proposes a $80 million discretionary cap adjustment for HCFAC in FY 2006 and $120 million in FY 2007, for a total of $200 million over two years. The additional HCFAC funds will enhance efforts to safeguard the Medicare prescription drug benefit and Medicare Advantage program ($75 million) and expand efforts for safeguarding the Medicaid and SCHIP programs ($5 million).

Returns to the Medicare Trust Fund from the HCFAC Account, 1997–2003

(dollars in millions)



Note: Medicare Integrity Program and FBI HCFAC spending and return on investment amounts are not reflected on this table. This table is consistent with the FY 2003 annual report.

MEDICARE ERROR RATE

The Medicare fee-for-service error rate for FY 2004 is 9.3 percent. The Medicare Integrity Program is the primary source of funds to lower the Medicare payment error rate. The Department lowered the Medicare payment error rate from 14 percent in FY 1996 to 6.3 percent in FY 2002 (as measured by OIG). FY 2003 was the first year that CMS was responsible for estimating the national Medicare error rate. CMS developed the Comprehensive Error Rate Testing (CERT) Program and the Health Payment Medicare Program (HPMP) to estimate the Medicare payment error rate using a sample size of 140,000-170,000 claims. The OIG used a sample size of approximately 6,000 claims and produced only one statistically significant number (the national error rate). CERT/HPMP provides contractor, provider type, and benefit service-specific error rates at statistically significant levels. CERT allows CMS to see contractor level performance data that the agency can use as a tool to manage and correct payment errors. Reducing the Medicare payment error rate is a major priority in the Department's effort to implement the President's Management Agenda.

The Administration's health care fraud, waste, and abuse control efforts have made remarkable progress in protecting the Medicare Trust Funds. Medicare Trustee's reports have cited our health care fraud, waste, and abuse control efforts as a contributing factor in

slowing Medicare spending growth. We hope to bring similar success to the state-administered Medicaid and SCHIP programs as well.

QUALITY IMPROVEMENT

Quality Improvement Organizations (QIOs) –previously Peer Review Organizations– were established by Title XI, Section 1151 of the Social Security Act, Part B, to serve the following functions:

- Improve the quality of care for beneficiaries by ensuring that professionally recognized standards of care are met;
- Enhance program integrity by ensuring that Medicare only pays for items that are reasonable and medically necessary; and
- Protect beneficiaries by addressing individual beneficiary's complaints, appeals, and case review.

QIOs are a central player in the Administration's efforts to improve the quality of care provided to Medicare beneficiaries. QIOs assist providers seeking to improve the quality of care delivered in nursing homes, home health agencies, and physicians offices. These quality improvement efforts are essential to the Administration's goals to modernize and strengthen the Medicare program.

In November 2002, HHS and CMS launched the national Nursing Home Quality Initiative (NHQI). The initiative provides new comparative information to consumers and resources to facilities all aimed at improving nursing home quality of care. Since 2002, the number of measures has been expanded from 8 to 15, reflecting improvements in quality measurement and endorsement by the National Quality Forum. Over the past two years, significant improvement has been achieved in a number of the publicly reported quality measures. The on-going CMS nursing home survey and certification activities are also part of the NHQI, and have a dedicated funding stream through the Survey and Certification budget (see the Program Management, Survey and Certification sections).

The Nursing Home Quality Initiative was followed in the spring of 2003 with Phase I of Home Health Compare, which provides comparative information on 11 home health quality indicators for beneficiaries in five demonstration States. Following phase I, HHS and CMS launched a national Home Health Quality Initiative in November 2003.

CMS is in the process of completing implementation of the Hospital Quality Alliance, which will provide comparative outcomes data on hospitals. To date, over 3,800 eligible hospitals have voluntarily participated. With incentives built into MMA, nearly all eligible hospitals are participating. The results of these public information programs will be better informed consumers and providers that are better able to identify what they must do to improve quality.

CMS and the Administration continue to encourage excellence in care by exploring provider payment reforms that link quality to Medicare reimbursement in a cost neutral manner. Such payment reforms would be flexible enough to support innovations in health care delivery.

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

Estimated Quality Improvement Organization Seventh Scope of Work (SOW) by Major Tasks

(dollars in millions)

	SOW Total FY 2002-2006
Nursing Homes and Home Health Quality Initiatives	$185.2
Inpatient Quality and Safety Improvement	$88.0
Physician Office Quality and Safety Improvement	$110.8
Reducing Disparities and Improving Rural Care	$39.3
Interpret/Promote Public Information	$44.8
Transition to Hospital Public Reporting	$49.8
National and State Level Monitoring of Payment Errors	$24.5
Best Practices in Hospitalization and Procedures	$13.9
Beneficiary Protection and Outreach*	$158.7
Systems Capacity and Maintenance	$81.7
Other Spending (including developmental work and support contracts)	$357.6
Total, QIO Seventh SOW	**$1,154.3**

*Increased by $14.3 million to conduct BIPA 521 reviews.

MMA expanded QIO responsibilities to include work with Medicare Advantage and Prescription Drug Plans to improve prescription choices and medication therapy management.

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes. CLIA also introduced user fees to finance survey and certification activities at clinical laboratories. User fees are credited to the Program Management account but are available until expended for CLIA activities. CMS determines the workloads of each State survey agency by taking the total number of laboratories and subtracting waived laboratories, laboratories issued certificates of provider-performed microscopy, State-exempt laboratories, and accredited laboratories.

The CLIA program has 184,036 laboratories registered with CMS, 21 percent of which are subject to routine inspection (every two years) under the program. The remainder are exempted. Workload projections for the FY 2005-2006 cycle include 20,674 surveys of non-accredited laboratories, 790 State validation surveys of accredited laboratories, and approximately 1,502 follow-up surveys and complaint investigations.

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

HCFAC LEGISLATIVE PROPOSAL

(dollars in millions)

	2006	2007	Total
Department of Justice/FBI	$0.0	$1.5	$1.5
HHS			
IG	0.0	1.4	1.4
Medicaid and SCHIP Financial Management	5.0	10.2	15.2
CMS Medicare Intergrity	75.0	106.5	181.5
Total HCFAC Discretionary Funds	**$80.0**	**$119.6**	**$199.6**
Total Mandatory Funds	**$1,074.6**	**$1,074.6**	**$2,149.2**
Total HCFAC Funds	**$1,154.6**	**$1,194.2**	**$2,348.8**

MEDICARE TRUST FUND OVERVIEW

(beneficiaries in millions)

	2004	2005	2006	2006 +/-2005
Aged	35.3	35.6	36.0	+0.4
Disabled	6.2	6.5	6.7	+0.2
Total Beneficiaries	41.5	42.1	42.7	+0.6

MEDICARE OUTLAYS

(outlays in millions)

	2004	2005	2006	2006 +/-2005
Current Law:				
HI Trust Fund:				
Part A Benefits	163,764	178,889	182,566	+3,677
SMI Trust Fund:				
Part B Benefits	131,379	145,975	152,397	+6,422
Part D Benefits	-	-	58,492	+58,492
Transitional Drug Assistance*	191	1,155	361	-794
Subtotal, Medicare Benefits	**$295,334**	**$326,019**	**$393,816**	**+67,797**
Other Medicare Payments:				
Other Transitional Drug Assistance*	25	65	0	-65
Part B Transfer to Medicaid QIs	168	190	0	-190
Drug Replacement Demonstration	0	400	100	-300
Medicare Advantage Enhanced Premiums	0	0	109	+109
Administrative Activities:				
Administration**	4,367	4,290	5,030	+740
MMA Implementation***	167	968	364	-604
HCFAC****	1,051	1,075	1,155	+80
Quality Improvement Organizations	393	362	386	+24
State Low-Income Determinations	-	73	99	+26
Total Outlays, Current Law	**$301,505**	**$333,442**	**$401,059**	**+67,617**
Offsetting Collections:				
Premiums	-32,140	-38,010	-55,508	-17,498
Other Offsetting Collections/Receipts	-189	0	0	0
Total Net Outlays, Current Law	**$269,176**	**$295,432**	**$345,551**	**+50,119**
Proposed Legislation:				
Part B Transfer to Medicaid for QIs	-	-	+230	+230
Part B Medicaid Premium Interaction	-	-	-35	-35
Total Medicare Proposed Legislation	**$0**	**$0**	**$195**	**+195**
Total Net Outlays, Proposed Law	**$269,176**	**$295,432**	**$345,746**	**+50,314**

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

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

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

**** Health Care Fraud and Abuse Control, including FBI and OIG.

MEDICAID

Medicaid is a jointly-funded, Federal-State program that provides medical assistance to certain low-income groups. In FY 2006, approximately 46.3 million individuals, including children, the aged, blind, and/or disabled, and people who meet eligibility criteria under the old Aid to Families with Dependent Children (AFDC) program will be covered by Medicaid. Additionally, many other individuals will receive Medicaid benefits through waivers and amended State plans with somewhat higher income eligibility limits. Under current law, the Federal share of Medicaid outlays is expected to be about $192.6 billion in FY 2006. This is a $4.3 billion (2.3 percent) increase over projected FY 2005 spending.

BACKGROUND

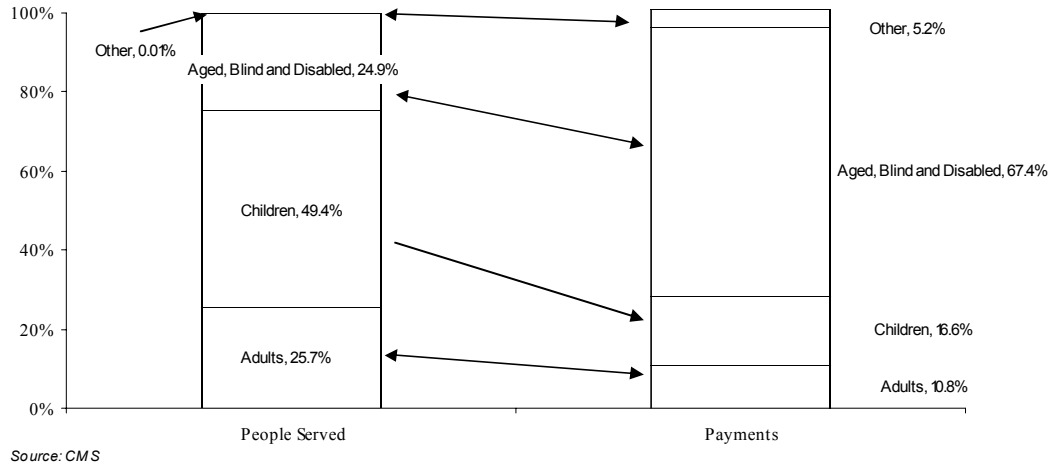
Under Medicaid, State expenditures for medical assistance are matched by the Federal government using a formula based on average per capita income in each State relative to national per capita income. Federal matching rates for FY 2006 will range from 50 to 76 percent for medical assistance payments. Overall, the Federal government pays for about 57 percent of total Medicaid expenditures. In addition to medical assistance payments, the Medicaid appropriation funds the Vaccines for Children program and the Federal share of Medicaid State and local administrative costs.

Historically, eligibility for Medicaid has been based on qualifying under the cash assistance programs of AFDC or Supplemental Security Income (SSI). With the creation of the Temporary Assistance for Needy Families (TANF) program in 1996 (which replaced AFDC) eligibility for Medicaid and cash assistance were de-linked. Medicaid eligibility remains tied to AFDC program rules in place as of July 16, 1996. All those who qualify under the 1996 AFDC rules and most SSI recipients, commonly referred to as the "categorically eligible," must be covered under State Medicaid programs. States must cover three additional groups: 1) pregnant women and infants whose family income does not exceed 133 percent of the Federal poverty level; 2) all children under the age of 19 living in families with incomes below the poverty level; and 3) all children under age 6 with incomes below 133 percent of the Federal Poverty Level. In 2004, the poverty level for a family of three was $15,670 in most of the United States (for a family of three in Alaska, the poverty level was $19,590 and for a family of three in Hawaii, the poverty level was $18,020).

States have the option to cover some individuals not eligible under AFDC or SSI rules and may cover people at higher incomes by disregarding a portion of their incomes. States may also cover "medically needy" individuals. Such individuals meet the categorical eligibility criteria, but have too much income or too many resources to meet the financial criteria.

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

Distribution of People Served through Medicaid Payments by Basis of Eligibility, FY 2002



Source: CMS

Program Developments

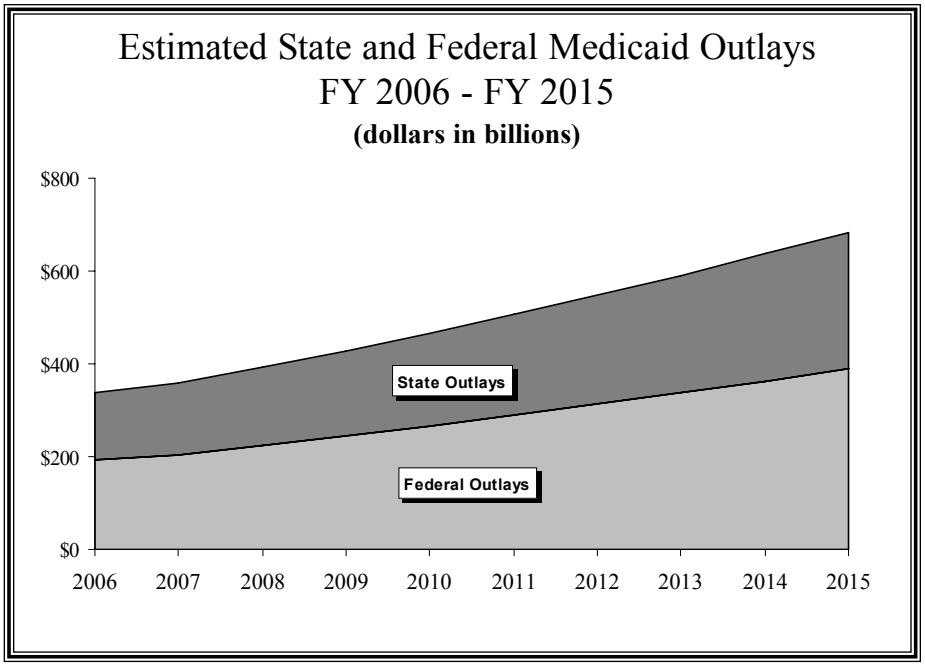
Medicaid Growth: Prescription drug spending, nursing home care, community-based long-term care costs, and payments to health plans are significant contributors to growth in Medicaid outlays. These expenditures are expected to continue to contribute to growth in future years. State programs providing "enhanced payments" to institutional providers have also played a significant role in driving-up Federal Medicaid costs at an accelerated rate.

Waivers: States have sought waivers under section 1115 of the Social Security Act to expand health care coverage to low-income, uninsured populations that do not otherwise meet Medicaid eligibility criteria and to test innovative approaches in health care service delivery. Although demonstrations vary greatly, most employ a similar overall approach: expanding the use of managed care for the Medicaid population.

To date, CMS has approved 30 Statewide comprehensive health care reform demonstrations in 27 States. CMS has also approved two sub-State health reform demonstrations and 15 demonstrations specifically related to family planning.

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

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



Pharmacy Plus: The introduction of the Medicare prescription drug benefit assumed much of the cost of pharmaceutical benefits otherwise covered by Pharmacy Plus waivers. The Department and CMS continue to work closely with states that have Pharmacy Plus waivers to enable them to provide the same level of coverage under the new Medicare prescription drug program.

Medicaid Legislative Proposals

The following sections contain FY 2006 legislative proposals.

Medicaid and SCHIP Modernization

The Administration proposes to provide States with additional flexibility in Medicaid to further increase coverage among low-income individuals and families without creating additional costs for the Federal Government. This proposal would build on the success of SCHIP to provide acute care for children and families, as well as current efforts to reduce the number of uninsured individuals.

A modernized Medicaid system will give States greater flexibility without the need for burdensome waiver applications. Principles that are employed in SCHIP and emphasize innovation will be expanded to Medicaid beneficiaries, while long-term care reforms will build on successful programs that use consumer direction and home- and community-based care to improve satisfaction and lower costs. A modernized Medicaid system will continue to grow at a robust rate to accommodate increases in health care spending.

New Freedom Initiative Proposals

The President's Budget includes six policies that promote home and community-based care options for people with disabilities. These policies build on the President's New Freedom Initiative, which is part of a nationwide effort to integrate people with disabilities more fully into society.

Money Follows the Person Rebalancing Demonstration: This proposal is consistent with the Administration's effort to promote the use of at-home care as an alternative to nursing homes for elderly and disabled Americans. Under the "Money Follows the Person" demonstration, at-home care

combines cost effective benefits with increased independence and quality of life for the beneficiary.

In this five-year demonstration project, Federal grant funds would pay for home and community-based waiver services for individuals who move from institutions into at–home care. These costs would be funded at a Federal matching rate of 100 percent for the first year of each individual's participation. As a condition of receiving the enhanced match, the participating State would agree to continue care after the first year at the regular Medicaid matching rate and to reduce institutional long-term care. This proposal authorizes $1.75 billion in funding for this demonstration over five years.

Home and Community-Based Care Demonstrations: The Budget includes three demonstrations proposals to encourage home and community-based care for children and adults with disabilities:

- Community Alternative to Children's Residential Treatment Facilities: This demonstration enables States to offer home and community-based services to children who would otherwise be served in psychiatric residential treatment facilities. This 10-year demonstration would permit the delivery of intensive mental health services for children in their homes and communities and allow the Department to evaluate the cost of providing these services outside of institutions. The cost for this proposal in FY 2006 is $5 million and $99 million over five years.

- Respite for Caregivers of Disabled Adults: This proposal creates a demonstration that tests whether respite care, or temporary care, reduces primary caregiver "burn-out" that often leads to institutionalization of individuals with disabilities. The cost for this proposal in FY 2006 is $7 million and $134 million over five years.

- Respite for Caregivers of Children with a Substantial Disability: This demonstration allows States to provide respite care to caregivers of children with substantial disabilities. The demonstration would enable the Department to collect specific data about the cost and utilization of respite services for caregivers of disabled children. The cost for this proposal in FY 2006 is $1 million and $23 million over five years.

Spousal Exemption: This proposal protects Medicaid coverage of an individual married to a disabled individual participating in a work incentive program under 1619(b) of the Social Security Act. Currently, if an individual is Medicaid eligible and the individual's spouse participates in the 1619(b) program, the spouse's earnings could cause the individual to lose his/her Medicaid coverage. This proposal will cost $17 million for FY 2006 and $102 million over five years.

Presumptive Eligibility: Establishes a State Medicaid option allowing presumptive eligibility for institutionally-qualified individuals who are discharged from hospitals into the community. This will increase the number of Medicaid beneficiaries who receive home and community-based services rather than institutional care. This proposal has no cost associated with it.

OTHER MEDICAID LEGISLATIVE PROPOSALS

Extension and Simplification of Transitional Medical Assistance: Transitional Medical Assistance (TMA) was created to temporarily extend health coverage for former welfare recipients after they enter the workforce. TMA allows families to remain eligible for Medicaid for up to 12 months after they lose welfare cash benefits due to earnings from work. This provision was enacted along with welfare reform and was scheduled to sunset in September 2002. Congress has already extended this program through March 31, 2005. This proposal will extend TMA benefits through September of 2006.

In addition to this extension, the 2006 President's Budget includes proposals to simplify eligibility for TMA benefits to the low-income working poor. There are three provisions to the proposal:

- States will be given the option to offer 12 months of continuous coverage to eligible participants.

- States may waive income reporting requirements for beneficiaries.

- States that offer Medicaid eligibility for children and families with incomes up to 185 percent of poverty may waive TMA assistance altogether.

This proposal will cost $560 million in FY 2006 and $560 million over five years.

Partnership for Long Term Care Insurance: Eliminates the legislative prohibition on developing more Partnership programs. The Partnership for Long Term Care (LTC) was formulated to explore alternatives to current long-term care financing by blending public and private insurance. Four States (California, Connecticut, Indiana, and New York) currently have partnerships whereby private insurance is used to cover the initial cost of LTC. Consumers who purchase Partnership-approved insurance policies can become eligible for Medicaid services after their private insurance is utilized, without divesting all their assets as is typically required to meet Medicaid eligibility criteria. This proposal is budget neutral.

Extension of Premium Assistance to Qualified Individuals: Under the Qualified Individuals (QI) program, Medicaid pays Medicare Part B premiums for Medicare beneficiaries with incomes between 120 and 135 percent of poverty. Part B premiums currently cost a beneficiary $78.20 per month – a 17.4 percent increase over 2004. States will continue to be fully reimbursed for the cost of the program. This one-year extension is estimated to cost $230 million in FY 2006.

Improvements to the Vaccines for Children Program: Vaccines for Children (VFC) is a CDC-administered, Medicaid funded program that administers free vaccines to eligible children. The President's Budget would improve the program by allowing under-insured children to receive VFC administered inoculations at State and local health departments in addition to Federally Qualified Health Centers and Rural Health Centers. This proposal will cost an additional $140 million in FY 2006 and $700 million over five years.

Payment Reforms: The Administration proposes to further improve the integrity of the Medicaid matching rate funding mechanism by curbing the use of financing arrangements that States use to avoid the legally determined State match requirement. Through various mechanisms, government providers return Federal Medicaid funds back to the States. States, in turn, recycle these funds by using them to draw down additional Federal dollars. The Budget proposes to build on current CMS efforts to curb these questionable financing practices by matching only those funds kept by providers as payment for services.

In addition, current law allows States to make Medicaid payments to providers far in excess of the actual costs of services. States use this additional money to leverage Federal reimbursements in excess of their Medicaid matching rate or for other purposes. To avoid this misuse of funds, the President's budget proposes to limit reimbursement levels to no more than the cost of providing services. These proposals save $5.9 billion over five years.

Reforming Provider Taxes: The budget proposes two changes to the current law regulating provider taxes. Under current rules, taxes imposed on providers may not exceed 6 percent of total revenues and must be applied uniformly across all health care providers in the same class. The first change proposes to phase down this allowable tax rate from 6 percent to 3 percent. Second, the Budget proposes that managed care organizations (MCOs) meet the same provider tax requirements as other classes of health providers. This proposal saves $231 million in FY 2006 and $3.17 billion over five years.

Strengthening Medicaid Reimbursement Policies: The President's budget proposes three changes to Medicaid reimbursement policy. First, the budget proposes to clarify which services may be claimed under targeted case management (TCM). Second, the Administration seeks lower reimbursement for TCM services to the administrative matching rate of 50 percent. Currently States are shifting costs into Medicaid that are the obligation of other programs and are using expanded definitions of allowable services. These two proposals save $129 million in FY 2006 and $3.1 billion over five years.

In addition, the Administration proposes to codify Medicaid "free care" policy in regulation. Currently, the Medicaid program asserts that States cannot bill the Federal Medicaid program for any service that would be provided to non-Medicaid eligible individuals free of charge. The most prominent example of this type of service is school nurse care. This regulatory change seeks to codify this policy in regulation to eliminate any legal ambiguity surrounding this topic. This regulatory change has no budget impact.

Reforming Transfer of Assets Requirements: Current law requires individuals applying for Medicaid long-term care services to divest all but a minimum level of assets before becoming eligible. If applicants transfer assets at below market value to avoid these requirements, Medicaid rules hold them subject to delays in eligibility. Despite these sanctions, creative estate planning often allows individuals to garner Medicaid eligibility status without divesting their assets. The budget proposes to curtail this practice by tightening existing rules regarding transfers of assets. This proposal saves $99 million in FY 2006 and $1.48 billion over five years.

Medicaid Administrative Claiming: The President's budget proposes to curtail inefficient Medicaid administrative spending patterns by establishing an allotment for Medicaid administrative claiming. This proposal saves $1.13 billion over five years.

Medicaid and SCHIP Financial Management: The Department plans to continue its efforts to root out erroneous and fraudulent uses of Medicaid and SCHIP funding. Along with an increase in the number of audits and evaluations of State Medicaid programs, the budget proposes to allocate $20 million from the Health Care Fraud and Abuse Account and $5 million in discretionary funding to finance this work.

Amending the Medicaid Drug Rebate Formula: The Medicaid program requires all drug manufacturers to pay a rebate for all drugs covered by Medicaid. The calculations for this rebate involve a

figure called lowest private market price or best price. This figure functions as a price floor, which prohibits manufacturers from negotiating deep discounts with large non-Medicaid purchasers such as hospitals and HMOs. The Administration proposes replacing best price with a budget neutral flat rebate, allowing private purchasers to negotiate lower drug prices. This proposal will have no effect on the Medicaid budget.

Restructure pharmacy reimbursement: In a recent House Energy and Commerce Committee hearing, the members focused their attention on government overpayment for prescription drugs in Medicaid. The President's Budget proposes a system that more closely aligns pharmacy reimbursement to pharmacy acquisition costs. This proposal saves $542 million in FY 2006 and $5.4 billion over five years.

Health Insurance Portability and Accountability Act Proposals: Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996 to increase the continuity, portability and accessibility of health insurance. The President's Budget proposes two legislative changes to ensure that Medicaid and SCHIP beneficiaries receive the benefits of HIPAA related coverage. The first change establishes the determination of eligibility for Medicaid or SCHIP as a qualifying event to allow access to employer-sponsored insurance (ESI). This change allows families to enroll in ESI through special enrollment even if they have missed their employer's open period for enrollment. The second change requires SCHIP programs to issue certificates of creditable coverage, which, in turn, verifies the period of time an individual is covered by a specific health insurance policy.

OTHER LEGISLATIVE PROPOSALS WITH MEDICAID IMPACTS

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

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

These two proposals will be budget neutral in FY 2006, but will save the Federal Government $45 million over five years.

Refugee and Asylee Exemption Extension: Under current law, most legal immigrants who entered the country on or after August 22, 1996, and some who entered prior to that date are not eligible for SSI until they have resided in the country for five years or have obtained citizenship. Refugees and asylees on SSI are currently exempted from this ban for the first seven years they reside in the United States. To assure that refugees and asylees have ample time to complete the citizenship process, the President's Budget proposes extending the current seven-year exemption to eight. The proposal will cost the Federal Government $40 million in FY 2006 and $145 million over five years.

SSA Initial State Disability Review: The Social Security Administration has proposed a management improvement initiative that has an impact on the Medicaid program. The proposal establishes a standard for accuracy in SSI disability awards identical to the one that applies to the Social Security Disability Insurance Program. This provision will help ensure that only individuals who are disabled will receive SSI disability benefits and related Medicaid coverage. This program will save the Medicaid program $2 million in FY 2006, and $113 million over five years.

Cover the Kids: This legislative proposal provides $1 billion in grants (in the State Grants and Demonstrations account) over two years to States, schools, and community organizations to enroll and provide coverage to many eligible, but not enrolled, children in Medicaid and SCHIP. CMS estimates that this legislative proposal will cost Medicaid $389 million in FY 2006 and $4.1 billion from FY 2006 through FY 2010.

MEDICAID ENROLLMENT

(enrollees in millions)

	2004	2005	2006
Aged 65 and Over	4.2	4.2	4.8
Blind and Disabled	7.7	7.7	8.4
Needy Adults	10.7	11.1	11.2
Needy Children	21.2	21.7	21.9
Total*	**43.7**	**44.7**	**46.3**

* Numbers may not add due to rounding.

MEDICAID OUTLAYS

(outlays in millions)

Current Law:	2004 Actual	2005 Enacted	2006 Request	2006 +/- 2005
Benefits*	$168,172	$179,160	$182,759	$3,598
State Administration	$8,059	$9,112	$9,803	$691
Total Net Outlays, Current Law*	**$176,231**	**$188,272**	**$192,562**	**$4,289**

* Includes Vaccines for Children Outlays.

** Number may not add due to rounding.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

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

SCHIP is a partnership between Federal and State governments that helps provide children with the health insurance coverage they need. The program improves access to health care and the 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.

Title XXI appropriated almost $40 billion to the program over 10 years (FY 1998 through FY 2007). States with an approved SCHIP plan are eligible to receive an enhanced Federal matching rate, which ranges from 65 to 85 percent, drawn from a capped allotment.

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

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

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

IMPLEMENTATION AND ENROLLMENT

Every State, the District of Columbia, and all five Territories have approved SCHIP plans. As of January 2005, States have received approval for 17 Medicaid expansion programs, 18 separate programs, 21 combination programs, and 226 State plan amendments.

Today, 11 States cover children in families with incomes up to 250 percent of the FPL. Of these States, seven cover children above that level. Six of the States cover children up to 300 percent of the FPL, and one State, New Jersey, covers children up to 350 percent of the FPL.

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

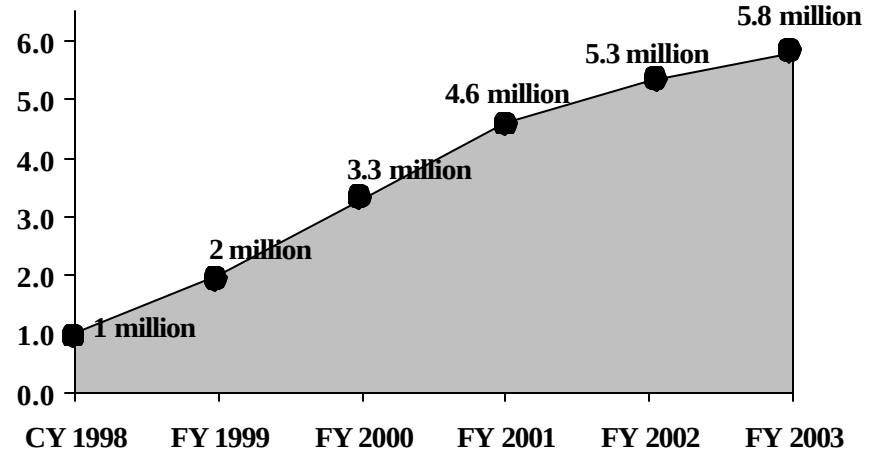
SCHIP PERFORMANCE

When SCHIP began in 1997, CMS adopted a goal of enrolling five million children by FY 2005. Specifically, CMS has set annual target goals for FYs 2000 through 2003 to enroll at least 1 million new children in SCHIP and Medicaid per year. CMS has exceeded these enrollment goals every year.

The Office of Management and Budget developed the Program Assessment Rating Tool (PART) to evaluate programs in a systematic manner, rating program effectiveness and highlighting strengths and weaknesses. SCHIP was assessed using the PART tool in the FY 2004 cycle and it received a rating of "Moderately Effective." It was then reassessed in the FY 2005 cycle and received a rating of "Adequate." As a result of the PART findings, CMS developed an SCHIP Action Plan to further strengthen the program.

SCHIP REPORTS AND EVALUATIONS

Congress required several SCHIP evaluations in statute. Title XXI required States to assess the operation of their SCHIP State plans and report to the Secretary by January 1 of each fiscal year. The statute also directed each State to submit to the Secretary evaluation reports by March 31, 2000. These reports are available on the Centers for Medicare & Medicaid Services website, www.cms.hhs.gov. As required by the statute, the Secretary submitted a report on the States' evaluations, which was made available to Congress and the public in December 2002. In addition to this report to Congress, CMS has



NOTE: FY 2004 enrollment data were not available at print time.

planned future evaluations to examine the SCHIP program in greater detail.

The Balanced Budget Refinement Act of 1999 (BBRA) also required HHS to conduct an independent evaluation of 10 States. The interim evaluation report was submitted to Congress in February 2003. A final report is expected to be presented to Congress in early 2005.

BBRA also directed the Secretary, through the Inspector General, to evaluate SCHIP every three years. The Office of the Inspector General (OIG) is instructed to evaluate: 1) State compliance with the requirement that Medicaid-eligible children are not enrolled in SCHIP, and 2) State progress made in reducing the number of uninsured children. The OIG released two reports in February 2001 that fulfill these requirements. To satisfy the requirement to submit these evaluations every three years, the OIG released its evaluation of States' progress in reducing the number of uninsured children in August 2004. In 2005 the OIG will release its second evaluation of States' compliance with the requirement that Medicaid-eligible children are not enrolled in SCHIP.

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

HIFA: Expanding Health Care Coverage

In August 2001, the Administration invited States to participate in the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. The main goals of the HIFA initiative are:

- to encourage innovation in the Medicaid and SCHIP programs;
- give States the programmatic flexibility to increase health insurance; and
- simplify the waiver process.

States use HIFA demonstrations to expand health care coverage. As of January 2005, CMS has approved nine SCHIP HIFA demonstrations expanding coverage to 821,750 people. As of November 2004, 289,000 people were enrolled in SCHIP HIFA demonstrations.

SCHIP WAIVERS

The requirements of Federal law and regulations can be waived by the Secretary of the Department of Health and Human Services to give States the programmatic flexibility to increase health insurance coverage and encourage innovation in their SCHIP programs. Waivers allow States to improve coverage and quality of services available to beneficiaries. Using section 1115 of the Social Security Act, States can more effectively tailor their programs to meet local needs and can experiment with new approaches to providing health care services to SCHIP recipients. Section 1115 waivers provide health insurance to uninsured children, parents, caretaker guardians, pregnant women, and childless adults.

The Administration has promoted a new section 1115 approach, called the Health Insurance Flexibility and Accountability (HIFA) waivers, for States to develop comprehensive insurance coverage for individuals at twice the Federal Poverty Level and below, using SCHIP and Medicaid funds. These demonstration waivers target vulnerable, uninsured populations, such as pregnant women, parents and children on Medicaid and SCHIP, and other adults with incomes less than twice the Federal Poverty Level.

As of January 2005, 16 SCHIP Section 1115 waivers were approved for Alaska, Arizona, California, Colorado, Idaho, Illinois, Maryland, Michigan, Minnesota, Missouri, New Jersey, New Mexico (2), Oregon, Rhode Island and Wisconsin. Of these 16 waivers, nine are HIFA demonstration waivers (Arizona, California, Colorado, Idaho, Illinois, Michigan, New Jersey, New Mexico, and Oregon).

LEGISLATIVE PROPOSALS

Cover the Kids: This legislative proposal provides $1 billion in grants (in the State Grants and Demonstrations account) over two years to States, schools, and community organizations to enroll and provide coverage to many eligible, but not enrolled, children in Medicaid and SCHIP. CMS estimates that this legislative proposal will cost SCHIP $129 million in FY 2006 and $535 million from FY 2006 through FY 2010.

Medicaid and SCHIP Modernization: The Administration proposes modernizing Medicaid and SCHIP by giving States greater flexibility to tailor their programs to meet the needs of their populations without complex waiver applications. This proposal builds on current efforts to reduce the number of uninsured individuals and responds to feedback about current program structure (please see the Medicaid section for further details).

SCHIP Reauthorization and Redistribution: Under current law, SCHIP is authorized and appropriated through FY 2007. This legislative proposal seeks to reauthorize the program early to better target SCHIP funds in a more timely manner. The proposal would reauthorize SCHIP at current law levels.

Please see the Medicaid and State Grants and Demonstrations sections for additional proposals that affect SCHIP.

SCHIP OUTLAYS

(dollars in millions)

	2004	2005 Projected	2006 Projected	2005 +/- 2006
Current Law				
Total Outlays.....	$4,607	$5,343	$5,434	+$91

MEDICAID AND SCHIP PROPOSALS

(dollars in millions)

	2006	2006-2010
MEDICAID PROPOSALS		
Medicaid and SCHIP Modernization	NA	NA
Extension of Transitional Medical Assistance with Modifications	$560	$560
Extension of Medicare Premium Assistance (QI)	$230	$230
Expansion of Vaccines For Children	$140	$700
Medicaid/SCHIP as a Qualifying Event for Employer Sponsored Ins.	$0	$0
Cover the Kids (Medicaid Impact)	$389	$4,053
Money Follows the Indivdiual Rebalancing Demonstration	$0	$500
Home and Community-Based Care Demos	$13	$256
Long-Term Care Insurance	$0	$0
Spousal Exemption	$17	$102
Payment Reforms	$0	($5,869)
Phase Down of Safe Harbor Tax	($231)	($2,768)
Managed Care Provider Tax Reform	$0	($399)
Reduce Targeted Case Management Match to 50 Percent	($129)	($1,049)
Define Eligible Services for Targeted Case Management	$0	($2,035)
Reform of Transfer of Assets Policy	($99)	($1,476)
Medicaid Administrative Claiming	$0	($1,130)
Amend Medicaid Drug Rebate Formula	$0	$0
Restructure Pharmacy Reimbursement	($542)	($5,385)
Pharmacy Plus Demonstrations	$0	$0
SUBTOTAL MEDICAID PROPOSALS	**$348**	**-$13,710**
OTHER PROPOSALS WITH IMPACT ON MEDICAID		
Medical Child Support From Either Parent	$0	-$15
Child Support Review and Adjustment	$0	-$30
Refugee Exemption Extension	$40	$145
SSA Disability Determinations	-$2	-$113
SUBTOTAL OTHER PROPOSALS	**$38**	**-$13**
ADJUSTEMENT FOR QI TRANSFER FROM MEDICARE	**-$230**	**-$230**
TOTAL FOR MEDICAID PROPOSED LAW	**$156**	**-$13,953**
SCHIP LEGISLATIVE PROPOSALS		
Cover the Kids (SCHIP Impact)	$129	$535
SCHIP Reauthorization	$670	$457
SCHIP Certificates of Creditable Coverage	$0	$0

STATE GRANTS AND DEMONSTRATIONS

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Budget Authority				
Ticket to Work Grant Programs.....	$77	$81	$81	$0
Qualified High-Risk Pools Grant Programs.....	$40	$0	$0	$0
Background Checks-Direct Patient Access.....	$25	$0	$0	$0
State Pharmaceutical Assistance Program.....	$0	$62	$63	+$1
Federal Reimbursement of Emergency Health Services - Undocumented Aliens……	$0	$250	$250	$0
Cover the Kids Outreach.....	$0	$0	$500	+$500
State Purchasing Pools.....	$0	$0	$400	+$400
Total Budget Authority.....	**$142**	**$393**	**$1,294**	**$901**
Outlays				
Ticket to Work Grant Programs.....	$27	$43	$38	-$5
Qualified High-Risk Pools Grant Programs.....	$21	$23	$40	+$17
Background Checks-Direct Patient Access.....	$0	$9	$8	-$1
State Pharmaceutical Assistance Program.....	$0	$62	$63	+$1
Federal Reimbursement of Emergency Health Services - Undocumented Aliens……	$0	$63	$250	+$187
Cover the Kids Outreach.....	$0	$0	$200	+$200
State Purchasing Pools	$0	$0	$200	+$200
Total Outlays.....	**$48**	**$200**	**$799**	**$599**

THE TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT

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

In FY 2006, the budget authority provided by statute for the two grant programs totals $81.8 million. Medicaid Infrastructure Grants are authorized and appropriated for $40.8 million of non-matched Federal funding. The Demonstration to Maintain Independence and Employment is authorized and appropriated for $41 million. States must match Federal funding for this demonstration program at the normal Federal matching rate.

Through 2004, 49 entities (48 States and the District of Columbia) were approved for funding from the Infrastructure Grant Program Section 203 since its inception. There are 31 States with Medicaid buy-ins and three additional States have plan amendments under review. As of September 30, 2004, there were just over 70,000 workers receiving Medicaid benefits under the buy-in options. Since January 1, 2000, there has been a ten-fold increase in participation. A total of 15 States and the District of Columbia have applied for and will receive continuation awards in FY 2005. In addition, one State, West Virginia, will continue to carry-out employment goals for the working disabled population by spending previous grant awards in FY 2005 through a no-cost extension of funding. Of the $35 million (FY 2004) that has been appropriated for the upcoming grant year, $21.8 million was granted to States. The reason for the large discrepancy

in the FY 2004 appropriation and funding amount is that States are enrolling fewer participants in Medicaid buy-in programs than Congress originally anticipated. Higher levels of funding are legislatively related to the yearly amount of Medicaid buy-in service costs expended by a State. States may be hesitant to enroll individuals in the optional buy-in category because of budget shortfalls. The remaining funding rolled over into the FY 2005 appropriation. With this funding, the recipients plan to make systemic changes that will help individuals with disabilities gain employment and retain their health care coverage. These changes are designed to increase Medicaid buy-in programs and enhance State personal assistance service programs.

Six States (Kansas, Louisiana, Minnesota, Mississippi, Rhode Island, and Texas) and the District of Columbia were awarded Demonstration to Maintain Independence and Employment grant funding since the program was started. States implementing demonstration grant programs will provide Medicaid-equivalent services to targeted populations of working individuals with disabilities. The demonstration projects will be used to evaluate the impact of providing Medicaid benefits to a working person with a potentially severe disability. The State demonstration projects approved so far will cover individuals with all types of disabilities including HIV/AIDS and various mental illnesses.

Qualified High-Risk Pools

The Trade Adjustment Assistance Reform Act of 2002 (TAA) established two grant programs for States to provide health insurance coverage through high-risk pools. The first program made available a total of $20 million to States that, as of August 6, 2002, did not already have a qualified high-risk pool. These funds were used for the creation and initial operation of pools. The second program made available $40 million per year for FY 2003 and FY 2004 for grants to States with existing qualified high-risk pools to be used for the operation of their pools.

States that did not have existing qualified high-risk pools were given until March 31, 2004 to apply for up to $1 million each to create and initially operate a qualified high-risk pool. The TAA legislation made available $20 million in FY 2003 for these "seed grants." Six States received a total of $4.2 million in seed grant funding before the authority lapsed at the end of FY 2004.

The TAA also made available $40 million per year for FY 2003 and FY 2004 for the States that already operate qualified pools that meet the requirements of the statute. The FY 2003 money was available until the end of FY 2004 and the FY 2004 money will be available until the end of FY 2005. CMS published a Federal Register Notice on May 2, 2003 announcing the availability of funding and inviting States to apply. All $40 million was awarded for FY 2003, divided among 19 States. To date, $25.5 million of FY 2004 funding has been awarded, divided among fourteen States. We expect that the remaining $14.5 million for FY 2004 funding will be awarded before the deadline at the end of FY 2005.

Federal Reimbursement of Emergency Health Services for Undocumented Aliens

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

Pilot Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities or Providers

Section 307 of the MMA creates a $25 million pilot program that runs through the end of FY 2007 to evaluate State and national background checks of direct patient access employees of long-term care facilities or providers. On December 22, 2004, CMS selected seven States to participate in the pilot program: Alaska, Idaho, Michigan, Nevada, New Mexico, South Carolina, and Wisconsin. Subsequently, South Carolina withdrew from the program. CMS extended an offer to Illinois (one of the alternate States) to participate in the pilot and is awaiting their response. Information gathered from this pilot will inform CMS about the cost associated with conducting background checks, the impact and effectiveness of a background check program, and possible unintended consequences of implementing such a program on a nationwide basis.

State Pharmaceutical Assistance Program

The State Pharmaceutical Assistance Program provides funds to educate Part D eligible individuals enrolled in the Program about prescription

drug coverage available through Part D of the MMA.

Legislative Proposals

Cover the Kids: Despite the availability of health care coverage through Medicaid and SCHIP, millions of children eligible for these programs have not enrolled. This proposal will provide $1 billion in grants over two years to States, schools, and community organizations with the aim of enrolling as many Medicaid- and SCHIP-eligible children as possible.

State Purchasing Pools: To help low-income individuals purchase coverage with the health insurance tax credit, the Administration proposes providing for establishing purchasing pools. By combining the purchasing power of individuals and families, these pools would offer tax-credit recipients an additional affordable health insurance option and would make it easier and faster to shop for coverage. This proposal costs $200 million in FY 2006 and $1.7 billion over five years.

PROGRAM MANAGEMENT

(dollars in millions)

	2004**	2005**	2006	2006 +/-2005
Medicare Operations	$1,723	$1,747	$2,190	+$443
Survey and Certification	253	261	261	-
Federal Administration	581	586	657	+71
Research	79	78	45	-33
Revitalization Plan	30	24	24	-
CMS Budget Authority Subtotal*	**$2,665**	**$2,696**	**$3,177**	**+481**
Rescissions	-28	-24	0	+24
Appropriation, net	**$2,637**	**$2,673**	**$3,177**	**+505**
Adjustments for Comparaability				
Appeals Function (Medicare Operations)	-47	-8	-	+8
MMA**	$373	$602	-	-$602
CLIA, Data Spending, and Reimbusables	$60	$45	$45	-
Medicare Advantage/ PDP User Fee activity	12	13	56	+43
Reimbursable Spending Subtotal	**$72**	**$58**	**$101**	**$43**
CLIA/Sale of Data User Fees & Reimb	-60	-45	-45	-
Medicare Advantage/PDP User Fee	-12	-13	-56	-43
Reimbursable Income Subtotal	**-$72**	**-$58**	**-$101**	**-$43**
Comparable BA/Approp. Level* **	**$2,963**	**$3,267**	**$3,177**	**-$89**
FTE** ***	4,514	4,843	4,843	0

* Numbers may not add due to rounding.

** Includes funding and FTE associated with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 adminstrative funds appropriated in FY 2004 for two years. However, Section 1015(d) of P.L. 108-173 authorizes the President to transfer some of these funds from CMS to SSA.

*** The FTE totals exclude HCFAC-funded FTEs. CMS will fund the following FTEs from the HCFAC account: FY 2004 -- 3 FTEs; FY 2005 -- 100 FTEs; FY 2006--100 FTEs.

MMA IMPLEMENTATION

(in millions)

	FY 2004	FY 2005	FY 2006	2006 +/-2005
Medicare Operations	325	510	478	-32
Federal Administration	39	59	62	3
Research	9	33	20	-13
Total*	**$373**	**$602**	**$560**	**-$42**

* FY 2005 total excludes the $25 million for the Office of the Inspector General.

PROGRAM MANAGEMENT

The comparable CMS FY 2006 Program Management budget request is $3.2 billion in budget authority, an $89 million or 2.7 percent decrease over FY 2005. However, FY 2004 and FY 2005 are transitional years for CMS. In FY 2004 and FY 2005 funding is higher to allow for the start-up activities associated with the MMA. Many of these start-up activities are expected to be substantially complete by FY 2006, and CMS' focus will begin to shift from start-up to oversight and administration. The shift in activities and changes in funding complicate the comparison of the FY 2006 request with prior years. The FY 2006 request does not propose any new user fees.

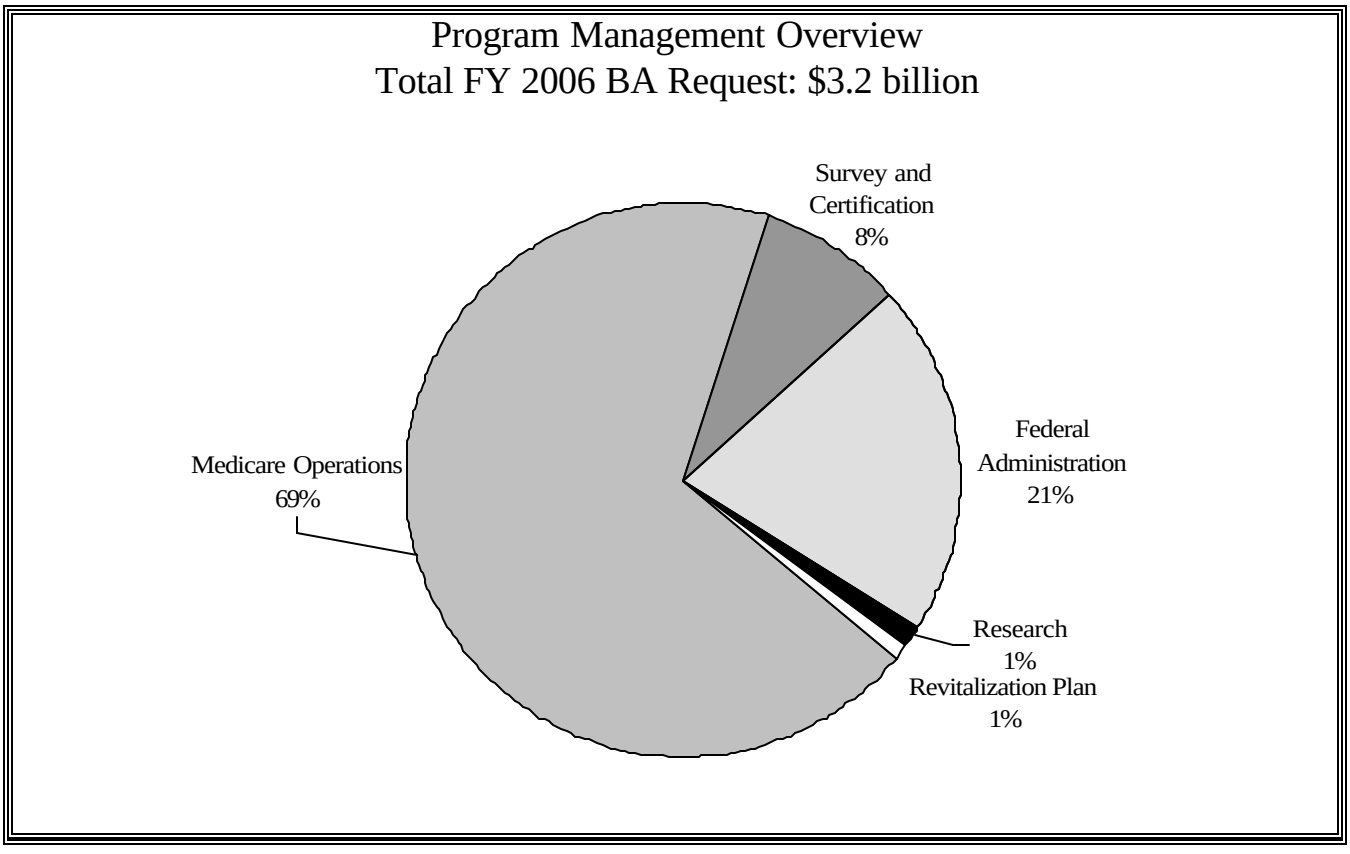
The FY 2006 budget request includes all funding for CMS operations to support Medicare, Medicaid, and SCHIP related activities. Also, this request now includes funding to administer and implement the new MMA activities as well as the budget, legislative, and management priorities of the Administration, including: educating beneficiaries about their health plan and benefit choices; improving financial management performance through ongoing implementation of the healthcare integrated general ledger accounting system (HIGLAS); and strategically managing human resources.

All comparisons in the following sections are on a comparable basis (e.g., FY 2005 levels include MMA implementation funds).

Medicare Operations: The Medicare Operations budget supports a broad array of activities. The budget is $2.2 billion, a decrease of $42.8 million or 1.9 percent below total FY 2005 resources. The Medicare fee-for-service program is administered by private contractors. Contractor responsibilities include: processing claims and making benefit payments; responding to the needs and inquiries of Medicare beneficiaries and health care providers and suppliers; and developing and implementing management changes to improve program operations. In addition, Medicare Operations funds a variety of mission critical information technology systems. For example, it funds managed care systems, standard processing systems, and maintenance of current contractor systems.

CMS Medicare Operations includes:

- Carriers' and fiscal intermediaries' regular activities, such as processing claims, holding hearings and appeals, answering inquiries, and educating providers and beneficiaries.
- Activities to keep shared claims processing systems current, Common Working File (CWF), and managed care systems maintenance.



- Funding provider services such as toll-free lines and training, and other operational costs.
- Funding for the Consolidated Information Technology Infrastructure Contract (CITIC), the Medicare data communications network, and hardware and software maintenance.
- Funding for implementing legislation such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Balanced Budget Act of 1997 (BBA), the Balanced Budget Refinement Act of 1999 (BBRA), the Benefits Improvement and Protection Act of 2000 (BIPA), the Federal Financial Management Improvement Act of 1996 (FFMIA), the Chief Financial Officers Act of 1990, and the of MMA.

In FY 2006, CMS will process 1.1 billion claims and answer approximately 50 million inquiries. In FY 2006, the unit cost to process a Part A claim will be $0.96, the same as the FY 2005 unit cost projection. Part B unit costs are estimated to remain constant at $0.65 in FY 2006.

Approximately 53 percent of the FY 2006 Medicare operations program level request will be spent on processing claims, on-going appeals (as distinguished from the new appeals process), inquiries, and provider assistance. Medicare contractors expect a 1 percent decrease in total claims volume below the FY 2005 estimate due to beneficiaries shifting from Medicare fee-for-service to Medicare Advantage. Hence, CMS will spend $1.2 billion in FY 2006, a 4.3 percent decrease below FY 2005 estimates.

Legislative mandates comprise 34 percent of the Medicare Operations budget and are funded at $750 million in FY 2006, a 4 percent decrease from the FY 2005 spending level. The FY 2006 request for Medicare Operations MMA activities is $32.2 million below FY 2005 spending levels at $477.6 million. This spending request is consistent with the commencement of the new Medicare drug benefit beginning on January 1, 2006 and the continuing MMA activities such as Medicare contracting reform.

Of the remaining spending in Medicare Operations, operations support spending will be $265.6 million in FY 2006, an increase of $37.7 million or 16.5 percent over FY 2005. Enterprise activity spending remains relatively steady at $60.6 million, a decrease of just $1.9 million below FY 2005. Systems maintenance costs will be increasing $56.3 million to $187.9 million in FY 2006. Systems maintenance will now include the maintenance costs for the portions of HIGLAS-- the new health care integrated general ledger accounting system -- that will be on-line at the contractor level in FY 2006.

Finally, CMS will provide $10.1 million towards the Department-wide Information Technology (IT) Enterprise Infrastructure Fund ($7.1 million) and Unified Financial Management System ($3.0 million).

Federal Administration: The President's Budget requests $657.4 million for CMS Federal administrative costs. This is an increase of $16.5 million or 2.6 percent over FY 2005.

The Program Management budget supports a total of 4,843 FTE, of which 3,209 FTE will staff the central office and 1,634 FTE will staff the regional offices. The Federal Administration account supports a staffing level of 4,761 direct FTE, a straight line from FY 2005. Ten additional FTE are funded in Medicare Operations, and the remaining 72 FTE are funded through user fees. The FY 2006 budget assumes 500 of CMS total FTE will be involved in MMA implementation. This request supports the agency's Government Performance and Results Act (GPRA) goals through the development of a comprehensive workforce planning process and automated system. CMS is implementing a strategic human resources (HR) plan to ensure that the agency has the human capital it needs to accomplish its mission.

CMS requests $13 million to continue the Healthy Start, Grow Smart program. This will support the printing costs and postage for a series of 13 informational brochures in English and Spanish to new mothers supported by Medicaid. These brochures are distributed at the time of birth and monthly over the first year of the child's life. Each publication focuses on activities that stimulate infant brain development and build skills these children need to be successful in school. In addition, each Healthy Start pamphlet includes vital health and safety information for new parents. The Healthy Start, Grow Smart program has disseminated over 20.7 million brochures in 24 States and the District of Columbia. Approximately 10 percent of the brochures are in Spanish and 90 percent in English. CMS is also working with the American Hospital Association to target small rural hospitals, which may not have the funds to print their own high quality educational materials for new mothers.

Research, Demonstrations and Evaluation: The FY 2006 budget requests $45.2 million for the Research, Demonstrations and Evaluation program, $65.0 million less than FY 2005. This request includes $25.5 million to continue and refine projects initiated in previous years and $19.7 million for MMA-related activities.

Ongoing research activities include the Medicare Current Beneficiary Survey, beneficiary information campaign evaluations, refinement and monitoring of prospective

payment systems, and support for legislative mandates in BBA, BBRA, and BIPA.

The remaining $19.7 million of the request will support MMA-related research projects including monitoring beneficiary access to covered drugs and evaluating numerous demonstrations and pilots mandated by MMA.

The budget does not requets continued funding for Real Choice Systems Change Grants. After five years, these grants have largely accomplished ther goals of helping States make improvements to their home and community-based health care delivery service systems. The President's New Freedom Initiative provides $858 million (outlays) to support home and community-based services for individuals with disabilities.

Survey and Certification: The FY 2006 budget request is $260.7 million, $2 million more than the 2005 level. Ensuring the safety of beneficiaries and the quality of care provided in health facilities are two of CMS most critical responsibilities. CMS contracts with State agencies to inspect health facilities providing services to Medicare and Medicaid beneficiaries and to ensure compliance with Federal health, safety, and program standards.

Included in this total is $25.7 million to support and implement activities associated with the Nursing Home Oversight Improvement Program (NHOIP), such as: investigating, processing, and reporting complaints that allege actual harm within 10 days; imposing immediate sanctions on nursing homes found guilty of a second offense that causes actual harm to residents; developing a systematic, more comprehensive survey process to more effectively detect critical quality of care problems; staggering inspection times to include a set amount begun on weekends and evenings; and focusing surveys on repeat offenders with serious violations. NHOIP activities are part of the wider CMS Nursing Home Quality Initiative (NHQI), which receives additional funding from the Quality Improvement Organizations budget (see the Medicare Quality Improvement section).

Of the total request, $244.4 million will allow States to inspect long-term care facilities and home health agencies at their legislatively mandated frequencies, as well as maintain the FY 2005 recertification levels for ESRD facilities, non-accredited hospitals, hospices, rural health clinics, ambulatory surgical centers, outpatient physical therapy, and outpatient rehabilitation facilities. CMS expects to complete over 23,200 initial or recertification inspections. In addition, CMS expects to conduct 52,500 visits in response to beneficiary or family complaints.

The remaining $16.3 million will fund base support contract activities. These activities include maintenance and enhancements to the Online Survey Certification and Reporting (OSCAR) data system, which contains information on nursing home survey results and outcomes; support services for surveying psychiatric hospitals; and curricula development for surveyor training.

Revitalization Plan: The FY 2006 budget request includes $24.2 million in two-year funds to continue funding efforts by CMS to revitalize the Agency's long-term information technology systems. This funding level is the same as the FY 2005 appropriation. The Medicare program has relied on a number of antiquated legacy systems that have been characterized by the Government Accountability Office (GAO) and the Department's Office of the Inspector General (OIG) as inflexible, not secure, and obsolete. MMA will require extensive upgrading of CMS information technology systems.

The Revitalization Plan will continue the process of modernizing the agency's Medicare fee-for-service claims processing systems ($15.2 million), and modernizing CMS information technology data structure ($9.1 million). These modernization efforts improve efficiency, enable e-gov activities, and improve systems security at CMS, and help prepare CMS systems for the increase in claims processing as today's "baby boomers" become eligible for Medicare benefits.

The Revitalization Plan continues the Agency's commitment to provide the flexibility and security needed to take on the growing workload and health care options and provide future beneficiaries with the information that they need to make informed choices.

PROGRAM MANAGEMENT PRIORITIES

Implementing the Prescription Drug Benefit and Regional PPOs: In FY 2006, CMS will implement the new Medicare prescription drug benefit and the new regional Medicare Advantage plans. The first half of FY 2006 encompasses key education and open enrollment periods. Success of this enormous effort depends on CMS implementing major new information technology systems, conducting intelligent and focused outreach, and educating beneficiaries so that they choose the best options to fit their health needs. In FY 2006, CMS requests $560 million for MMA activities, including implementing prescription drug plans, regional PPOs, the new Medicare preventive benefits, numerous fee-for-service improvements, and initiating contracting reform.

The National Medicare & You Education Program: Beneficiary education is a top priority for CMS, especially as CMS implements the

new benefit options. CMS must ensure that beneficiaries have the essential information they need to make complex and personal choices. Many beneficiaries have two or more chronic conditions, have less than a high school education, and many have cognitive impairments. It is vital that CMS invest resources in reaching the most vulnerable population.

The total FY 2006 budget request for the NMEP is $318.2 million, a decrease of $22.2 million from the FY 2005 level. In FY 2006, over 54 percent of the NMEP funding covers the 1-800-MEDICARE helpline 24 hours a day, seven days per week. The remaining funds will be used for beneficiary materials, CMS websites, community-based outreach, the national advertising campaign, and program support services.

- The Medicare & You Handbook: In FY 2006, CMS expects to distribute more than 42 million handbooks to beneficiaries and stakeholders, approximately one million more handbooks than in FY 2005. The handbooks are offered in English and Spanish, and in Braille, audiocassette, or large print formats. Each month, approximately 250,000 new beneficiaries receive the handbook as they enroll in Medicare.

- The 1-800-MEDICARE line: This toll-free line provides access to customer service representatives in English and Spanish 24 hours a day, seven days per week. CMS is anticipating approx imately 32 million calls in FY 2006, an increase of approxi mately 8.9 million calls over the FY 2005 current estimate. Costs include telecommunications network management, interactive voice response, personnel and training costs of call center operators, and fulfillment of requests for printed information. CMS is implementing call center technology that will modernize and improve its customer service system.

- The www.medicare.gov web site: This beneficiary-centered web site provides beneficiaries and stakeholders a variety of real-time, interactive tools that enable users to receive information on their benefits, plans, and medical options. The website is integrated into the desktop that the 1-800-MEDICARE operators use to respond to calls. CMS expects that there will be 411 million page views in FY 2006. CMS is invest ing in FY 2005 to be able to support the enrollment demands that will begin in FY 2006.

- National Multimedia Campaign: Under the new prescription drug benefit, beneficiaries will have to decide whether to enroll in a stand alone drug plan, a Medicare Advantage regional plan that offers a prescription drug benefit, keep their retiree drug coverage, or choose not to enroll now and possibly pay more for the drug benefit if they choose to enroll at a later date. As a result of these complexities, the FY 2005 multimedia campaign will employ techniques to spread messages at the local level, and to tailor messages to meet the needs of specific audiences.

- Community-Based Outreach: CMS administers and conducts many outreach programs including the State Health Insurance and Assistance Programs (SHIPs) grants, Regional Education About Choices in Health (REACH), and Health Outreach Zeroing In On Needs (HORIZONS). Research has shown that beneficiaries prefer one-to-one assistance. CMS will continue its successful grant relationship with the SHIPs, which are located in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. SHIPs provide one-to-one counseling to beneficiaries on complex Medicare-related topics, including Medicare entitlement and enrollment, health plan options, Medigap and long-term care insurance, Medicaid, and prescription drug assistance. During FY 2004, an estimated 1,200 counselors at over 1,100 local SHIPs served more than 1.7 million beneficiaries.

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

In FY 2006, the President's Budget requests $149.8 million ($79.9 million in two-year money in Medicare Operations and $69.9 million in systems maintenance costs also in Medicare Operations) for HIGLAS. As contractors adopt HIGLAS, systems maintenance costs will increase. The portion of HIGLAS dealing with the agency's administrative accounts has been transferred from Federal Administration to Medicare Operation keeping all HIGLAS funding in one place and as two-year funding.

CMS began developing HIGLAS in FY 2001. Thus far, CMS has

demonstrated that the application can support the integrated general ledger and Medicare financial management requirements; conducted performance tests demonstrating that HIGLAS can process 3.5 million transactions per day and support 52 Medicare contractors; and begun implementation of HIGLAS at two pilot contractors in FY 2004 and additional contractors in FY 2005.

In FY 2006, CMS will implement HIGLAS at additional Medicare contractors as well as roll out the administrative accounting module at CMS central office, complete other payment management system interfaces, and attain statutory compliance by accounting for 52 percent of total CMS costs.

Appeals Reform: The budget requests $51.5 million to implement Medicare appeals reform as required by BIPA Sections 521 and 522 and as modified by the MMA. Of this total, CMS requests $44 million for Qualified Independent Contractors (QICs) to process Medicare redeterminations originating from both carriers and fiscal intermediaries (FI). The QICs will begin processing the FI workload in FY 2005. The carrier workload will be phased in to the QICs in 2006. The funding requested allows CMS to fund eight QICs. In addition, the budget also includes $7 million for enhancements to the Medicare appeals system and $0.5 million for national and local coverage determinations.

MMA requires that the Office of the Secretary (DHHS) assume responsibility for processing cases currently handled by the Social Security Administration's (SSA) administrative law judges (ALJ) by FY 2006. By law, SSA will continue hearing Medicare cases until the function transfers to the Office of the Secretary. Thus, funds previously included in the CMS budget request for paying SSA to adjudicate Medicare claims appeals are now included in the Office of the Secretary's budget request. Please refer to the Medicare Hearings and Appeals section of the Budget-in-Brief for additional information.

HIPAA Implementation: The CMS budget request includes $39.5 million for HIPAA implementation activities. CMS was tasked with implementing the non-privacy administrative simplification provisions of HIPAA. In October 2002, CMS was also given the responsibility for enforcing the HIPAA Administrative Simplification security, transactions and code sets, and identifier standards.

The FY 2006 request includes $18.3 million to begin activities related to the National Plan and Provider Enumeration System. Activities include maintaining the enumeration system and enumerating approximately 1.3 million health care providers. The request also includes funding for enforcement of HIPAA transactions and code sets, security, and identifier standards; compliance outreach; implementing local systems changes, new standards, and technical modifications; and operating and maintaining the HIPAA data center.

LEGISLATIVE PROPOSAL FOR THE DISCRETIONARY BUDGET

As part of a government-wide initiative, the Administration is proposing legislation to add funding in the discretionary budget by increasing budget caps to increase resources for the Health Care Fraud and Abuse Control account and the Medicare Integrity Program. This additional funding will support program integrity efforts for the new activities under MMA as well as Medicaid.

CMS PERFORMANCE HIGHLIGHTS

The primary CMS mission is to assure health care security for its beneficiaries. To ensure that CMS remains a responsive, dynamic, and relevant government agency that serves its citizens, CMS will continue to focus attention on citizen-centered governance in FY 2006 and beyond.

Consistent with the principles of the Government Performance and Results Act (GPRA), CMS has focused on identifying a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as a steward of taxpayer dollars. CMS' FY 2006 performance budget reinforces CMS, HHS, and Administration priorities including the HHS Strategic Plan and CMS strategic goals.

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

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

In 2003, CMS implemented a new method for measuring improper payments. The new method resulted in a higher rate of provider non-response and a higher error rate of 9.8 percent. The Comprehensive Error Rate Testing (CERT) program was initiated in FY 2003 and has produced a national error rate for each year since its inception. In 2004, CMS began reporting gross error rates in addition to the net error rates previously reported. This change was necessary in order to comply with new Improper Payments Information Act (IPIA) requirements. CMS adjusted its baseline to reflect the change in reporting. The new baseline is

10.1 percent. In the meantime, CMS will continue to work with its partners in conducting everyday business of ensuring Medicare claims are paid properly.

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

A key performance goal is to increase the percentage of female Medicare beneficiaries age 65 and older who receive a biennial mammogram. In FY 2003, 51.3 percent (target 51.5 percent) of female beneficiaries received a biennial mammogram. CMS believes this rate may represent under-reporting because of a "technical claims processing issue."

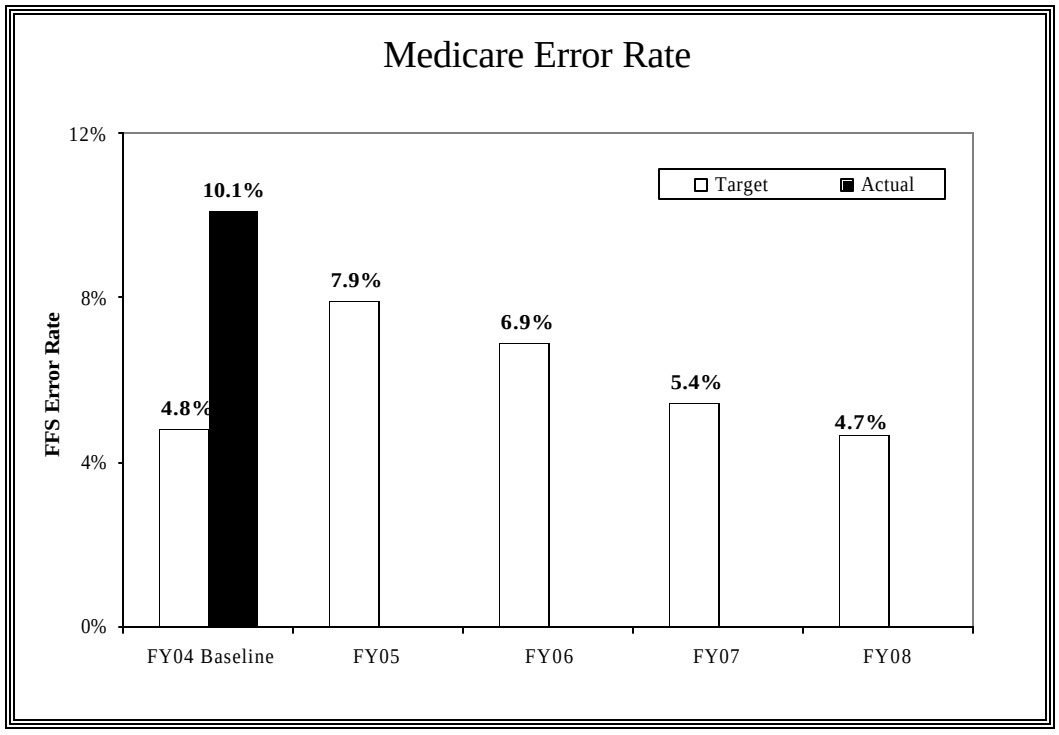
Diabetes is a highly-prevalent condition in the Medicare population. Many complications of the disease, such as blindness, can be prevented or delayed with appropriate monitoring and treatment. While continuing emphasis on diabetic eye exams, CMS is replacing this goal in FY 2006 with a goal to increase the rate of hemoglobin A1c and lipid screening in this highly prevalent population at high risk for cardiovascular complications. For FY 2003, CMS exceeded its target (of 68.9 percent) at 69.3 percent.

One of the QIO goals is to protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime pneumococcal vaccination. For FY 2003, 70.4 percent (target 72.5 percent) received an influenza vaccination and 66.4 percent (target 67 percent) received a pneumococcal vaccination. Shortages of vaccination were among the reasons for not reaching this target.

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

CMS and States exceeded the FY 2003 goal to increase by 5 percent more children enrolled in SCHIP or Medicaid over the FY 2002 level. In fact, CMS and the States increased enrollment by 2,200,000 children or 7.2 percent. The most recent Bureau of Census' Current Population Survey (CPS) data (three-year rolling average for FY 2001-FY 2003) suggested that there were approximately 5.7 million children who lacked health insurance coverage, down from over 7.5 million in 1997 (FY 1996-FY 1998). In addition, a recent CDC survey found that the percentage of uninsured children dropped from 13.9 percent in 1997 to 10.1 percent in 2003.

CMS continues to collaborate with States to improve health care delivery and quality for Medicaid and SCHIP populations using performance measures. CMS continues to work with States to explore strategies to effectively use performance measures to quantify and stimulate measurable improvement in delivering quality health care.



Beneficiary Education: In order for Medicare beneficiaries to have greater knowledge of Medicare and its benefits, CMS is focusing on a number of

educational programs. These programs not only provide information about Medicare but also gauge the beneficiaries' awareness of Medicare benefits.

One performance measure is to improve the effectiveness of disseminating Medicare information to beneficiaries. In order to help beneficiaries make informed health care decisions, CMS employs a variety of strategies through many CMS beneficiary-centered programs to maximize information channels and to ensure that targeted audiences, are reached with the "right information at the right time." In FY 2004, CMS continued to track beneficiary understanding of the Medicare Advantage and Fee-for-Service programs.

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

FY 2004 CMS Performance Highlights

- 79 percent of the measures were reported.
- Of the 79 percent of goals reported, 88 percent of the measures met or exceeded the target.
- Approximately 40 percent of the measures supported the President's Management Agenda.
- SCHIP has exceeded its enrollment goal every year.
- At 61.1 percent, CMS surpassed its FY 2003 target of 60.5 percent through optimizing the timing of antibiotic administration to reduce the frequency of surgical site infection in Medicare beneficiaries.
- 69.3 percent of diabetic beneficiaries received a biennial eye exam, exceeding the target of 68.9 percent (FY 2003).

ACF: DISCRETIONARY SPENDING

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Head Start	$6,775	$6,843	$6,888	+$45
Abstinence Education:				
Community-Based Abstinence Education	$74	$104	$143	+$39
Abstinence Education Grants to States	50	50	50	0
Subtotal, Abstinence Education	$124	$154	$193	+$39
Faith-Based and Community Initiative Programs:				
Compassion Capital Fund	$48	$55	$100	+$45
Mentoring Children of Prisoners	50	50	50	0
Maternity Group Homes	0	0	10	+10
Center for Faith-Based and Community Initiatives	1	1	1	0
Subtotal, Faith-Based Community Initiative	$99	$106	$161	+$55
Refugee:				
Refugee and Entrant Assistance	$394	$430	$489	+$59
Unaccompanied Alien Children	53	54	63	+9
Subtotal, Refugees	$447	$484	$552	+$68
Child Welfare Services	290	290	290	0
Child Welfare Training	7	7	7	0
Abandoned Infants Assistance Programs	12	12	12	0
Promoting Safe and Stable Families (discretionary)	99	98	105	+7
Independent Living (discretionary)	45	47	60	+13
Adoption Incentives	8	32	32	0
Adoption Opportunities	27	27	27	0
Adoption Awareness	13	13	13	0
Child Abuse Programs	90	102	102	0
Child Care & Development Block Grant:				
Block Grant	$2,078	$2,073	$2,073	0
Research and Evaluation Fund	10	10	10	0
Subtotal, Child Care	$2,088	$2,083	$2,083	0
LIHEAP:				
Regular Appropriation	$1,789	$1,885	$1,800	-$85
Emergency Contingency Fund	99	297	200	-97
Subtotal, LIHEAP	$1,888	$2,182	$2,000	-$182
Developmental Disabilities	165	168	168	0
Native Americans	45	45	45	0
Community Services:				
Community Services Block Grant	$642	$637	$0	-$637
Individual Development Accounts	25	25	25	0
Community Services Discretionary Programs	64	65	0	-65
Subtotal, Community Services	$731	$727	$25	-$702
Violence Crime Reduction	129	129	129	0
Runaway and Homeless Youth	105	104	104	0
Early Learning Fund	33	36	0	-36
Social Services Research & Demonstration	19	32	6	-26
Federal Administration	178	185	185	0
Total, Discretionary Program Level	**$13,417**	**$13,906**	**$13,187**	**-$719**
Less Funds Allocated from Other Sources:				
PHS Evaluation Funds	-11	-11	-11	0
Abstinence Education Grants to States	-50	-50	-50	0
Total, Discretionary Budget Authority	**$13,356**	**$13,845**	**$13,126**	**-$719**
FTE	1,338	1,382	1,313	-69

ADMINISTRATION FOR CHILDREN AND FAMILIES

The Administration for Children and Families promotes the economic and social well-being of children, youth, families, and communities, giving special attention to vulnerable populations, such as children in low-income families, refugees, Native Americans, and the developmentally disabled.

The Administration for Children and Families's (ACF's) over 60 programs provide services to children and families, including Native Americans, persons with disabilities, and refugees, and communities through cooperative efforts between Federal, State, local, and Tribal governments, and through public and private non-profit organizations. The FY 2006 budget request for ACF totals $45 billion, a net decrease of $4.3 billion, or 9 percent below FY 2005.

DISCRETIONARY SPENDING

The FY 2006 discretionary budget totals $13.1 billion, a net decrease of $719 million or 5 percent below FY 2005. This decrease primarily reflects the elimination of programs that have been unable to demonstrate long-term outcomes.

HEAD START

The budget request includes $6.9 billion for Head Start to provide 919,000 children with services including 62,000 children in Early Head Start. The budget includes a $45 million increase to support the President's initiative to improve Head Start by funding nine State pilot projects to promote coordination of State preschool programs, child care programs, and Head Start into a comprehensive system of early childhood programs. Consistent with the President's comprehensive Head Start reauthorization proposal, these new pilot projects will provide States with assistance to strengthen the program and, through coordination, improve other preschool programs. ACF will continue to support the goals of the President's Good Start Grow Smart Initiative to strengthen Head Start by providing information on child development and early learning to teachers, caregivers, parents, and grandparents and by closing the gap between research and practice in early childhood education.

Head Start programs help ensure that children are ready to succeed at school by supporting the social and cognitive development of children. Head Start programs provide comprehensive child development services, including educational, health, nutritional, social, and other services, to primarily low-income families. They also engage parents in their child's preschool experience by helping them achieve their own educational and literacy goals as well as employment goals, supporting parents' role in their children's learning, and emphasizing the direct involvement of parents in the administration of local Head Start programs.

ABSTINENCE EDUCATION

The budget increases funding for Abstinence Education activities by $39 million totaling $206 million. Of this total, ACF will administer $193 million through two programs – the Community-Based Abstinence Education program and the Abstinence Education Grants to States program. Within the Office of Public Health and Science (OPHS), the budget also includes $13 million for the abstinence activities conducted through the Adolescent Family Life program. By 2008, funding for all abstinence education programs will increase to a total of $270 million.

ACF's abstinence education programs provide grants to communities and States to develop and implement abstinence programs. These programs focus on educating adolescents, ages 12 through 18, and creating a positive environment within communities to support adolescent decisions to postpone sexual activity and, where appropriate, mentoring, counseling, and adult supervision to promote abstinence with a focus on those groups which are most likely to bear children out of wedlock.

The budget provides up to $10 million for a public awareness campaign designed to help parents communicate with their children about health risks of early sexual activity. ACF and OPHS will work together on the public awareness campaign efforts. The budget also continues to support evaluation of abstinence education programs.

FAITH-BASED AND COMMUNITY INITIATIVE

The budget maintains a commitment to fund faith-based and community organizations, including a total of $161 million in ACF to help grassroots organizations expand services to their communities, mentor children of prisoners, and provide a safe place for young pregnant and parenting mothers. As part of the larger Faith-Based and Community Initiative, these programs help empower those at the community level who can best identify the social and health problems to address the unmet needs of Americans. The Center for Faith-Based and Community Initiatives works with Agencies across the Department to eliminate barriers in regulations, rules, internal guidance, policies and procedures, and practices to the participation of faith-based and other community organizations; to propose the development of innovative pilot and demonstration programs; and to expand Charitable Choice provisions.

Compassion Capital Fund: The Compassion Capital Fund advances the efforts of community and charitable organizations, including faith-based organizations, to increase their effectiveness and enhance their ability to provide social services where they are needed. Among the priorities within the 2006 proposal is an emphasis on supporting anti-gang efforts through community and faith-based organizations. The budget provides $100 million, an increase of $45 million over the FY 2005 level.

In its first two years, the Compassion Capital Fund, which began in FY 2002, awarded intermediary grants to 31 organizations which in turn awarded over $24 million in sub-awards to over 1,700 grassroots organizations. Grants are also directly awarded to faith-based and community organizations for capacity-building activities, as well as for research into best practices and to develop a national resource center and information clearinghouse. These capacity-building mini-grants began in the second year of the program with 52 awards and grew to 102 awards the following year.

Mentoring Children of Prisoners: The request includes $50 million, maintaining the FY 2005 level, to provide grants of up to $5 million to enable public and private organizations to establish or expand projects that provide mentoring for children of incarcerated parents and those recently released from prison. Grantees are required to become gradually more self-sufficient through public-private partnerships. These programs will establish approximately 33,000 mentoring relationships a year. Nearly 2 million children have a parent in a Federal or State correctional facility, a number that more than doubled over the 1990s. Research indicates that children with incarcerated parents are seven times more likely than the general population to become incarcerated themselves and are more likely to display a variety of behavioral, emotional, health, and educational problems.

Maternity Group Homes: The budget includes $10 million for the Maternity Group Homes program, a recently authorized component of the Runaway and Homeless Youth program. These funds will support adult-supervised community-based group homes for young mothers and their children who cannot live safely with their own families. These women are vulnerable to abuse and neglect, and often end up in homeless shelters or on the streets. Grantees will provide a range of coordinated services such as child care, education, job training, and counseling and advice on parenting and life skills.

Refugee Programs

Refugee and Entrant Assistance: The budget requests $489 million in FY 2006 to support services for refugees, asylees, Cubans/Haitians, and victims of torture and trafficking, $59 million more than the FY 2005 level. The increase will maintain access to a full eight months of cash and medical assistance and up to 60 months of social services programs such as English language training, case management, employment preparation, and job placement and retention services. The State Department's refugee entrant ceiling for 2006 is 70,000 or 20,000 higher than 2005. Between 1993 and 2003, the employment rate of refugees increased by almost 70 percent, to a level approaching the U.S. population as a whole. In addition, the request includes support for services, including rehabilitation, social, and legal services for those who have experienced torture as well as benefits and services for up to 1,000 victims of trafficking.

Unaccompanied Alien Children: The Unaccompanied Alien Children (UAC) program provides a safe and appropriate environment for minors until custody can be transferred to a relative or appropriate guardian or until the child is returned to his or her country of origin. Since the program was transferred from the former Immigration and Naturalization Service in 2003, the Office of Refugee Resettlement has increased the use of less restrictive shelter and foster care placements, and provided necessary support for improved medical care. The FY 2006 budget for the UAC program of $63 is $9 million more than the FY 2005 level to meet anticipated increases in the number of minors in care. Current estimates indicate that the number of UACs will increase by over 30 percent from 6,200 in FY 2004 to almost 8,200 in FY 2006. In FY 2006, the Office of Refugee Resettlement will expand the pilot pro bono services program to a national level and continue efforts to reunite UACs with family members in the United States.

Child Welfare, Adoption and Child Abuse

The FY 2006 budget includes $648 million for a range of programs that support child welfare systems, adoption efforts, and child abuse prevention.

Child Welfare: The Child Welfare programs support States and localities in their efforts to keep families together. Services offered include preventive intervention, where appropriate, so that children can remain in their homes; identifying alternative placements like foster care when necessary; and reunification services so that a child can return home. Grants are also provided to develop and improve education and training programs and resources for child welfare professionals and to prevent the abandonment of infants and young children exposed to

HIV/AIDS and drugs. The budget requests $309 million for these efforts.

The Independent Living Education and Training Vouchers program provides up to $5,000 for costs associated with college or vocational training for foster care youth ages 16 to 21. The FY 2006 request of $60 million will provide more than 2,600 additional youth with vouchers through this program. The Promoting Safe and Stable Families program provides funds for each State to operate a coordinated program of family preservation services, community-based family support services, time-limited reunification services, and adoption promotion and support services. The FY 2006 budget includes a total of $410 million, of which $105 million is financed through discretionary resources, and will be used to expand services provided to children and families.

Adoption: The FY 2006 request includes $32 million for the Adoption Incentives program. States can earn bonus payments by increasing the number of adoptions of children in foster care over previous years. At the end of FY 2003, there were 523,000 children in foster care, of which 118,000 were waiting to be adopted. Bonuses are based on the total number of children adopted, the adoption of children with special needs who are under the age of nine, and, as part of the recent program reauthorization, the adoption of children over the age of nine. Data show that once a child waiting for adoption reaches eight or nine years old, that child is more likely to continue in foster care than to be adopted. This newest bonus recognizes the current reality and targets incentives to older children by providing a $4,000 bonus for each older child adoption over the baseline regardless of whether the State qualifies for the other bonuses. Payments can be used toward recruiting prospective adoptive parents, child welfare staff training, and post-adoption family support services. The budget also includes $40 million for grant programs that facilitate the elimination of barriers to adoption and support adoption efforts, including adoption of children with special needs, through training and a public awareness campaign.

Child Abuse: The most recent annual HHS Child Maltreatment Report indicates that each year an estimated 896,000 children in the United States are victims of abuse and neglect. The budget includes a total of $102 million for programs to reduce the incidence of child maltreatment and provide services to those who are victims. The Child Abuse State Grant program plays a key role in the prevention of child abuse and neglect including post-investigative services such as individual counseling, case management, and parent education. Other programs help complete the continuum of prevention efforts by providing funds for community-based efforts including general public awareness and education activities and by supporting research on child maltreatment and training and technical assistance on improved methods and procedures to prevent and treat child abuse and neglect. Program Assessment Rating Tool (PART) assessments completed this year concluded that the State child abuse prevention and treatment programs address specific and existing needs and are effectively managed.

Child Care

The Child Care and Development Block Grant (CCDBG) program to States, Territories, and Tribes provides direct child care assistance payments to low-income families when the parents work or participate in education or training. States have flexibility in developing child care programs and policies that meet the needs of children and parents within each State. CCDBG also supports research and evaluation of innovative child care subsidy policies and web-based access to reports, data, and other research-related information.

ACF's most recent data indicates that $4.8 billion in total Federal child care funds, including $2.1 billion in discretionary funds, provide child care assistance to approximately 1.8 million children each month. However, when combined with other Federal and related State funds, child care assistance is available to 2.4 million children, representing an estimated 28 percent of children eligible under State rules.

This year, a PART assessment found that CCDBG plays a critical role for families transitioning from welfare to work and that child care subsidies expand parental access to a range of care options. The assessment concluded that the program structure and use of vouchers maximizes parental choice and creates incentives for States to develop a single coherent system for families.

Low Income Home Energy Assistance Program

The FY 2006 budget requests a total of $2 billion for the Low Income Home Energy Assistance Program. The request includes $1.8 billion for formula block grants to States and $200 million for contingency funding. The contingency funds are available for release in a heating or cooling emergency such as extreme temperature or high fuel prices or to meet energy needs related to a natural disaster.

LIHEAP provides heating and cooling benefits to approximately 4.5 million households each year. Of the households receiving heating assistance, about one-third include a member 60 years or older, about half include a person with a disability, half include a child under age 18, and about one-third do not receive any other public assistance.

Developmental Disabilities

Today, there are nearly 4 million Americans with developmental disabilities. Developmental disabilities are severe, chronic disabilities attributable to mental and/or physical impairment, which manifest before age 22 and are likely to continue indefinitely. The budget requests $168 million for programs that support partnerships with State governments, local communities, and the private sector to assist people with developmental disabilities to reach their maximum potential through increased independence, productivity, inclusion, and community integration.

Disabled Voter Services: The Voting Access for Individuals with Disabilities grant programs provide support to States to establish, expand, and improve access to the election process to the over 20 million individuals with disabilities who are of voting age. Of the $168 million for Developmental Disabilities, $15 million will support these efforts. Grant awards have supported a range of activities including developing a training video for election officials, poll workers, and volunteers on providing assistance to voters with visual impairments and surveying polling places to determine accessibility needs.

Native Americans

The programs of the Administration for Native Americans promote the goal of social and economic self-sufficiency. The budget request includes a total of $45 million for these programs which, through direct grants, contracts, and interagency agreements, provide financial assistance for social and economic development and governance, training and technical assistance, and research, demonstration and evaluation. Funds support a range of projects from establishment of new Tribal employment offices to the formulation of environmental ordinances and training in the use and control of natural resources.

Community Services Programs

The budget proposes $25 million for the Individual Development Accounts (IDA) program. IDAs are dedicated savings accounts for low-income individuals that can be used for purchasing a first home, paying for post-secondary education, or capitalizing a business. This demonstration program provides grants to agencies that in turn empower low-income individuals to save by providing matching contributions for savings and intensive financial counseling and economic literacy education. This year, a PART assessment found the IDA program to both provide benefits to low-income and low-wealth families and produce knowledge about the effects of the Federal asset-based policy on these families.

The FY 2006 budget does not request funds for the Community Services Block Grant (CSBG) and a number of smaller community services programs. The CSBG program has been unable to demonstrate results as noted in its previous PART assessment. The budget also does not request funds for Community Economic Development, Rural Community Facilities, Community Food and Nutrition, Job Opportunities for Low-Income Individuals, and National Youth Sports. The Administration proposes to focus economic and community development activities through a more targeted and unified program to be administered by the Department of Commerce.

Other Children and Families Activities

The budget maintains funds for programs that offer safe havens and access to services for victims of domestic violence and runaway and homeless youths. This year a PART assessment determined the programs serving victims of domestic violence allow States flexibility to provide a combination of shelter stays, related assistance, and non-residential services. The assessment also indicated that the National Domestic Violence Hotline is efficiently run and continues to respond to a steadily increasing number of calls while ensuring consistent quality of services. Based on the PART findings, ACF, working with an existing national advisory group, will develop appropriate national grantee-supported performance outcome measures and demonstrate improved efficiencies and cost effectiveness.

The FY 2006 budget does not request funds to continue the Early Learning Fund, which was provided $36 million in FY 2005. The Administration continues to target resources on similar activities which promote early literacy in the Department of Education and the Head Start program.

Research/Federal Administration

There is continuing interest and need for sound research to help guide efforts to assist low-income families become and remain economically self-sufficient and to strengthen families. The FY 2006 budget includes $6 million in PHS evaluation funds for the Social Services Research and Demonstration program which will support cutting-edge research and evaluation projects in areas of critical national interest.

The request includes $185 million in FY 2006 to support staffing and maintain activities to administer the programs of ACF. Consistent with the President's Management Agenda, the budget supports efforts to reduce erroneous and improper payments in several key ACF program areas, including Child Care, Head Start, and Foster Care, and supports a continued focus on the Public Assistance Reporting Information System (PARIS), a voluntary program for States to share public assistance data to maintain program integrity and detect and reduce erroneous payments.

ACF: ENTITLEMENT SPENDING

(dollars in millions)

	2004	2005	2006	+/- 2005
Current Law Budget Authority				
TANF	$19,167	$17,881	$16,689	-$1,192
High Performance Bonus non add*	*$200*	*$1,000*	*$0*	*-$1,000*
TANF Contingency Fund**	$1,958	$1,958	$0	-$1,958
Child Care Entitlement	$2,732	$2,717	$2,717	$0
Child Support Enforcement & Family Support (net BA)***	$4,413	$4,074	$3,322	-$752
Foster Care/Adoption Assistance/Independent Living Program	$6,814	$6,806	$6,620	-$186
Children's Research & Technical Assist (net BA)	$56	$45	$34	-$11
Promoting Safe and Stable Families	$305	$305	$305	$0
Social Service Block Grant	$1,700	$1,700	$1,700	$0
Total, Budget Authority	**$37,345**	**$36,486**	**$31,387**	**-$4,099**

	2004	2005	2006	+/- 2005
Current Law Outlays				
TANF	$17,725	$18,070	$17,918	-$152
TANF Contingency Fund	$0	$30	$39	$9
Child Care Entitlement	$2,695	$2,718	$2,718	$0
Child Support Enforcement & Family Support (net outlays)	$3,815	$3,934	$4,081	$147
Foster Care/Adoption Assistance/Independent Living Program	$6,340	$6,474	$6,619	$145
Children's Research & Technical Assist (net outlays)	$34	$49	$47	-$2
Promoting Safe and Stable Families	$336	$301	$305	$4
Social Service Block Grant	$1,752	$1,764	$1,762	-$2
Total, Outlays	**$32,697**	**$33,340**	**$33,489**	**$149**

* FY 2005 includes $1 billion for High Performance Bonuses. These funds are available for obligation for the period of FY 2005-FY 2009.
** FY 2004 and FY 2005 Contingency Funds are prior year funds, not new budget authority. This funding is available for obligation through 2009. In FY 2004, no States chose to draw down these funds.
***The decrease in Child Support budget authority from FY 2005 to FY 2006 is due to projected carry over balances. The FY 2006 BA refl the use of prior year funds.

The ACF entitlement programs serve some of the Nation's most vulnerable populations through programs such as Temporary Assistance for Needy Families (TANF), Child Support Enforcement (CSE), the Child Care Entitlement to States, Foster Care, Adoption Assistance, and Independent Living. ACF entitlement outlay estimates for FY 2006 are $33.5 billion, an increase of $149 million in entitlement spending from FY 2005. This overall increase is a combination of a small decrease in TANF outlays and typical growth in Child Support and Foster Care.

This year's budget includes the anticipated reauthorization of TANF and the Child Care Entitlement to States. In the Child Support Enforcement program the budget also includes modifications, which increase both financial collections and medical support to families. In Foster Care, the budget includes an option for States to receive their foster care funds in the form of a flexible grant. The Foster Care budget also clarifies the eligibility definition and modifies the matching rate for the District of Columbia. Additional information on FY 2006 legislative proposals can be found in the TANF, CSE, Foster Care, Adoption Assistance, and Independent Living sections.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) dramatically changed the Nation's approach to income support for low-income families. PRWORA replaced the individual entitlement to welfare with time-limited assistance and work requirements. PRWORA also created a new partnership between States and the Federal Government, giving States considerable flexibility to design their own TANF programs.

TANF provides approximately $16.9 billion annually to States, Territories, and eligible Tribes for the

creative programs to help families transition from welfare to self-sufficiency. States have tremendous flexibility in determining how to use their TANF dollars. Since welfare reform, States are spending less on cash assistance payments and more on education and training, child care, and other work supports to help families achieve self-sufficiency. For example, in 1998, States spent 63 percent of combined State and Federal funds on cash assistance; in FY 2003 States spent 39 percent. In addition, States may transfer up to a combined 30 percent of their TANF funding to either the Child Care and Development Fund or the Social Services Block Grant (SSBG) with not more than 4.25 percent of this transferred to SSBG. The FY 2005 appropriations bill overrides the 4.25 percent transfer cap and provided for a 10 percent SSBG transfer authority.

Welfare reform is widely regarded as a success. TANF caseloads continue to decrease. As of June 2004, 4.7 million individuals received TANF benefits— 61.4 percent fewer than in August 1996. From June 2003 to June 2004 caseloads dropped 4.4 percent for individuals and 3 percent for families. National data from the Current Population Survey suggest that even during the economic downturn, women leaving welfare or at risk for coming onto welfare continue to find employment.

The TANF program expired at the end of FY 2002. To date, Congress has provided funding through March 31, 2005 for TANF State and Terroritory Family Assistance Grants, Supplemental Grants, Matching Grants to Territories, and the Contingency Fund.

TANF Performance

The TANF program achieved success towards its primary goal of moving TANF recipients from welfare to work and self-sufficiency. In FY 2003:

The President's TANF Reauthorization Proposal

Strengthens the Federal-State-Tribal-Territories Partnership by Providing Full Funding and Flexibility:

- Funds State Family Assistance Grant and Family Assistance Grants for Territories at current levels for five years — $16.6 billion annually.
- Reinstates authority for Supplemental Grants for Population Increases in Certain States — $319 million annually.
- Reauthorizes the Child Care and Development Fund — $4.8 billion in total mandatory and discretionary funds in FY 2006.
- Establishes a more accessible contingency fund with more flexible Maintenance of Effort requirements, allowing States to count child care and separate State program expenditures — $2 billion is available over five years.
- Allows for 10 percent transfer to SSBG.

Maximize Self-Sufficiency through Work:

- Requires TANF participants to engage in work-related activities and employment for 40 hours a week, with at least 24 hours in direct work activities. States have discretion to define other countable activities. States may count certain activities like substance abuse treatment or rehabilitation as meeting the work requirement for three months.

Promote Child-Well Being , Healthy Marriage, and Responsible Fatherhood:

- Eliminates the bonus to reduce out-of-wedlock births and creates an initiative to fund research, demonstrations, and technical assistance, targeted to family formation and healthy marriage — $100 million annually.
- Establishes matching grant program for States and Tribes to develop innovative approaches to promoting healthy marriages — $100 million annually.
- Provides $40 million annually in mandatory funds to promote responsible fatherhood.

Improve Program Performance:

- Modifies the reward for high performing States to focus on employment–based results —$100 million annually.

Program Integration:

- Enables broader State welfare and workforce program integration through new demonstrations. States can request demonstration authority to integrate aspects of Federal programs, including program eligibility and reporting requirements.

- 39 percent of adult TANF recipients became newly employed, up from 36 percent in FY 2002 but short of the target of 44 percent.
- 33 percent of recipients attained higher earnings over two quarters, exceeding the target of 29 percent.
- Job participation rates declined from 30 percent in FY 2002 to 28 percent in FY 2003. The recent decline in work rates underscores the importance of welfare reform reauthorization and strengthening work requirements.

TANF Legislative Proposals

The FY 2006 budget reproposes the President's FY 2004 and FY 2005 plan to build on the considerable successes of welfare reform and to reauthorize TANF. The President's proposal strengthens work requirements while allowing States greater flexibility in determining what should count as work. The proposal strengthens marriage and families, making child well-being a central tenet of the legislation (see the box outlining the President's TANF Reauthorization Plan on the previous page). The President's proposal includes $200 million annually to promote healthy marriage through demonstrations, research, and a matching grant program. The FY 2006 Budget also requests $40 million for the Promotion and Support of Responsible Fatherhood as mandatory funding.

Child Care Entitlement to States

The Child Care Entitlement to States, which was preappropriated under PRWORA, is a component of the Child Care and Development Fund (CCDF). The Child Care Entitlement is composed of mandatory and matching funds. Two percent of the mandatory entitlement funds are reserved for eligible Indian Tribes and Tribal organizations. States are mandated to spend at least 70 percent of the Child Care Entitlement on families receiving TANF, transitioning from TANF, or at risk of becoming eligible for TANF. States must also spend a minimum of 4 percent of all child care funds to improve the quality and availability of healthy and safe child care for all families.

For FY 2006, the budget funds the Child Care Entitlement at $2.7 billion. This is equal to the funding level provided in FY 2005. These funds will continue to provide valuable support for working families who are moving from welfare to work.

Child Care Performance

The Child Care and Development Fund helps families achieve and maintain self-sufficiency and improve the overall quality of child care. The Child Care Bureau collaborates with the Head Start Bureau, Department of Education, and the Health Resources and Services Administration to achieve these goals. In addition to improving access and affordability of child care, the Child Care Bureau is working with States to use early learning guidelines to improve the school readiness skills of young children from low-income families.

In the Program Assessment Rating Tool (PART) assessment for the FY 2006 budget, the Child Care Entitlement received a "Moderately Effective" rating. The assessment notes that the program is critical to families transitioning from welfare to work, and that the program is improving how it tracks the availability, accessibility, and affordability of child care for low-income families.

Child Support Enforcement

The Child Support Enforcement (CSE) program is a joint Federal, State, and local partnership that ensures financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders. Child support services, as mandated in Title IV-D of the Social Security Act, are available for all families with a non-custodial parent, regardless of whether or not the custodial parent receives welfare.

Child support collections play an important role for families transitioning from welfare to self-sufficiency, particularly in light of time limits on receipt of cash assistance. Families in which a custodial parent has never received cash assistance, receive all child support collected on their behalf. State and Federal Governments share child support collections on behalf of families receiving TANF and some collections on behalf of former TANF recipients. States can choose to pass through a portion of the State share of collections to these families as well.

The Federal Government shares in the financing of this program by providing a 66 percent match rate for general State administrative costs and 90 percent for paternity testing. The CSE program also includes a capped entitlement of $10 million annually for grants to States to facilitate non-custodial parents' access to and visitation of their children. In addition, States receive incentive payments based on their performance on five key measures: paternity establishment, support order establishment, collections on current support, collections on past-due support, and cost effectiveness. In FY 2006, the Federal Government will spend an estimated $4.2 billion for all of these costs.

CSE Performance

The CSE program continues to make impressive gains on order and paternity establishment, and collections:

- Child support collections hit a record $21.2 billion in FY 2003, serving an estimated 16 million child support cases.
- The CSE collected $1.6 billion in overdue child support from Federal income tax refunds in tax year 2003 on behalf of more than 1.6 million families.
- CSE established paternity for almost 1.5 million children in FY 2003.

CSE tracks performance using measures that cover the key elements of child support enforcement such as paternity and order establishment and collection of current and back support. Highlights include:

- For every dollar invested in the program in FY 2003, CSE collected $4.32 in child support, far exceeding their target of $4.25. CSE aims to increase the cost-effectiveness ratio to $4.49 by FY 2006.
- In FY 2003, CSE achieved a current collection rate of 58 percent, meeting their target. This measure tracks regular and timely payment of support. CSE seeks to increase the collection rate to 62 percent by FY 2006.

In the PART assessments for the FY 2005 budget, CSE received a rating of "Effective" and continues to be one of the highest rated block/formula grants of all reviewed programs government-wide. This high rating is due to its strong mission, effective management, and demonstration of measurable progress toward meeting annual and long term performance measures.

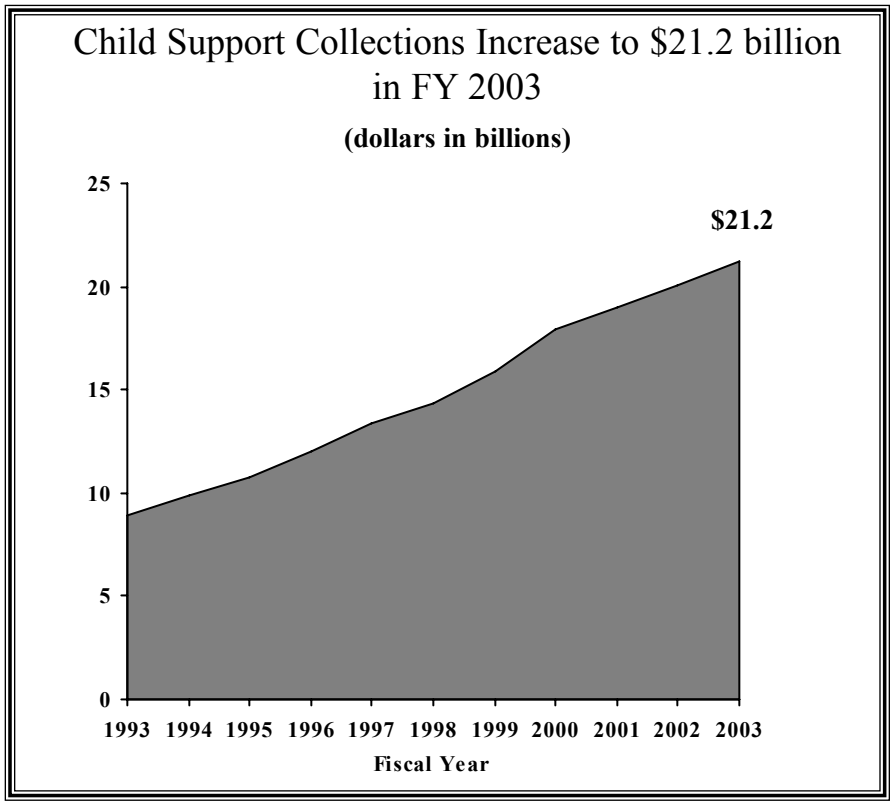
Child Support Legislative Proposals

The budget anticipates the enactment of the child support provisions included in the President's TANF Reauthorization proposal, as well as two proposals from FY 2005 budget aimed at improving and increasing the collection of medical child support (see box outlining these child support proposals on the following page). These proposals will also improve automation tools, strengthen existing enforcement tools, and assist families in gaining self-sufficiency. Overall these proposals have a significant impact in terms of savings and increased collections for families:

- In FY 2006, these proposals will save $50 million in child support administrative costs and increase the Federal share of collections by $13 million. These result in a net Federal savings of $63 million while increasing collections to families by $147 million.
- Proposals for mandatory review and adjustment and health insurance from either parent proposals generate Medicaid savings of $45 million over five years.
- Proposals for optional pass through and disregard; and optional simplified distribution have significant Food Stamp savings of $114 million over five years.
- In total, these child support proposals offer an impressive $3.4 billion in increased collections to families for a net Federal cost of $52 million over five years.

Children's Research and Technical Assistance

The FY 2006 President's Budget includes $49 million to support child support enforcement training and technical assistance efforts; operation of the Federal Parent Locator Service (FPLS), which assists States in locating absent parents; and welfare research. Of this amount, $34 million will be devoted to: 1) training and technical assistance ($11 million) and 2) operating FPLS ($23 million). The funds appropriated for these activities are equal to 1 and 2 percent respectively of the Federal share of child support collections during the preceding year. The remaining $15 million will fund



welfare research as included in the President's TANF reauthorization proposal.

Foster Care, Adoption Assistance, and Independent Living Programs

The FY 2006 budget request for the Foster Care, Adoption Assistance, and the Independent Living programs is $6.6 billion. These programs, authorized by Title IV-E of the Social Security Act, provide essential services to vulnerable children by supporting safe living environments and preparing for independence older foster youth who are likely to age out of the system.

Of the total request, $4.6 billion will support the Foster Care program. This is a $252.5 million decrease from last year's request and includes the effects of the legislative proposals described in the following section. The funds will be used for maintenance payments and administrative costs for approximately 230,300 children per average month, a 1.3 percent decrease over 2005. In addition, States may use the funds for training and for the operation and development of the Statewide Automated Child Welfare Information Systems (SACWIS), a computer-based data and information collection system.

The budget includes $1.8 billion for the Adoption Assistance program, which supports families that adopt special-needs children. This is an increase of $26.9 million over the FY 2005 request. These funds will be used to provide maintenance payments to adoptive families, administrative payments for the costs associated with placing a child in an adoptive home, and training for professionals and adoptive parents. The proposed level of funding will support approximately 369,500 children each month.

The budget also contains $140 million for the Independent

Child Support Enforcement Legislative Proposals

Proposals to Enhance and Increase Collection of Medical Child Support:

- Require health care plan administrator to notify the IV-D agency when a child loses health coverage. The Proposal will help alert IV-D workers of potential lapses in children's coverage so they can work to secure alternative coverage, if necessary.
- Require State child support enforcement agencies to seek medical support for children through health insurance available to either parent. The proposal recognizes that it may be more suitable for some children to be covered under their custodial parent. States will have the option to enforce orders against custodial parents. This will result in savings to the Medicaid program — $ 15 million over 5 years.

Proposals to Enhance Automation and Significantly Increase Collections to Families:

- Federal seizure of accounts in multi-state financial institutions, which will enable more families in interstate situations to benefit from this 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 Worker's Compensation Act benefits
- Provide Federal matching of insurance claims and settlements databases for recovery of past due support.
- Increase funding for access and visitation grants in support of the Administration's commitment to strengthening fatherhood and parenting skills and increasing family stability.
- Authorize direct Tribal access to Federal Parent Locator Service.
- Authorize contractors and IV-D Tribes to access tax offset data.

Proposals Under Welfare Reform to Further Assist Families Gain Self-Sufficiency:

- Assist families on TANF and formerly on TANF by sharing in the costs of State efforts to pass through and disregard child support for TANF families; a second proposal simplifies distribution rules for the benefit of former TANF families.
- Require States to review and adjust child support orders at least every three years for families receiving TANF.
- Reduce the threshold for denying passports to non-custodial parents owing overdue child support from $5,000 to $2,500.
- Give States the ability to collect past-due child support by withholding a limited amount of OASDI payments from beneficiaries, if appropriate.
- Require States to charge a $25 annual fee to families who have never received AFDC or TANF assistance and receive child support collections through the IV-D program.

Living Program (ILP), the same as the FY 2005 request. This program funds a variety of services to ease the transition from foster care for youth who will likely remain in foster care until they turn 18 and former foster children between the ages of 18 and 21.

Title IV-E Performance

The Foster Care, Adoption Assistance, and Independent Living programs demonstrated success in improving safety, permanency, and well-being of children. Working with the States, the Children's Bureau strives to minimize the disruption 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. The programs also provide children in foster care permanency and stability in their living situations by improving the timeliness of reunification, if possible, or guardianship and adoption.

The Foster Care program received a rating of "Adequate" from the Program Assessment Rating Tool (PART) in FY 2005. This is an improvement over the "Results Not Demonstrated" rating received for FY 2004. The better rating can be attributed to completing adoptions for 268,000 children with child welfare involvement from FY 1997 through FY 2002. The programs also received a higher rating due to new program performance measures, an initiative to develop an error rate, and improved program management. The proposed alternative financing system for Foster Care, discussed in the next section, would address PART findings to further improve the program. In the PART assessment for the FY 2006 budget, ILP received a "Results Not Demonstrated" rating because the program needs to develop a data system to track program participation and outcomes. HHS is committed to improving PART ratings in line with the President's Management Agenda initiative on Budget and Performance Integration.

Child Welfare Program Option Proposal

States That Choose the Grant Option Would Be Able to Use the Funds for:

- Foster care payments
- Prevention activities
- Permanency efforts
- Case management
- Administrative activities
- Training for child welfare staff
- Other such 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,
- Agree to 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 from which States may receive additional funding under certain circumstances if a severe foster care crisis were to arise. 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 Legislative Proposals

The FY 2006 President's Budget includes three legislative proposals for Foster Care and related programs. The alternative funding proposal, detailed in the Child Welfare Program Option box (see above), would allow States the option to receive their foster care funding as a flexible grant over five years to support a continuum of services to families in crisis and children at risk. This proposal will increase budget authority by $36 million in FY 2006, and it is budget neutral over five years.

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

child is removed or the home where the child is living. This proposal would amend the statute to come into accord with the Department's long-standing policy. This proposal saves $84 million in FY 2006 and $399 million over five years.

The third proposal brings the Foster Care and Adoption Assistance matching rate for the District of Columbia in line with the District's matching rate in Medicaid and SCHIP. This would increase the Federal matching rate for the District of Columbia from 50 percent to 70 percent and cost the Federal government $8 million in FY 2006 and $40 million over five years.

Promoting Safe and Stable Families

The Promoting Safe and Stable Families (PSSF) program, under Title IV-B of the Social Security Act is a capped entitlement program to assist States in coordinating services related to child abuse prevention and family preservation. These services include community-based family support, family preservation, time-limited reunification services, and adoption promotion and support services. States generally must spend at least 20 percent of their funds on each of the above four categories. The Adoption and Safe Family Act of 1997 (ASFA) established that a child's health and safety must be of paramount concern in any efforts made by a State to preserve or reunify a child's family. The FY 2006 request for PSSF includes $305 million in mandatory funds provided by formula to States.

Social Services Block Grant

The Social Services Block Grant (SSBG), a capped entitlement, under Title XX of the Social Security Act, provides funds to States for delivering social services and allows States substantial discretion in allocating funds in order to best suit their specific needs. SSBG is funded at $1.7 billion for FY 2006. This is the same level as FY 2005. Programs or services that are frequently supported by SSBG funds include child care, child welfare, home-based services, employment services, case management, adult protective services, prevention and intervention programs, and special services for people with disabilities.

CHILD SUPPORT ENFORCEMENT: COLLECTIONS & COSTS

(dollars in millions)

	2004	2005 Estimate	2006 Estimate	2006 +/- 2005
Total Collections Distributed:				
All Families	$19,410	$20,520	$21,894	+$1,374
TANF program	$1,977	$1,974	$2,028	+$54
Federal Share	$1,092	$1,087	$1,097	+$10
State Share	$885	$887	$895	+$8
Foster Care program	$76	$78	$82	+$4
Federal Share	$43	$44	$46	+$2
State Share	$33	$34	$36	+$2
Total	**$21,463**	**$22,572**	**$24,004**	**+$1,432**
Administrative Costs:				
Federal Share	$3,540	$3,610	$3,716	+$106
State Share	$1,760	$1,856	$1,913	+$57
Total	**$5,300**	**$5,466**	**$5,629**	**+$163**
Incentive Payment to States	**$454**	**$446**	**$458**	**+$12**
Program Costs (Costs minus Distributed Collections):				
Federal Costs	$2,859	$2,925	$3,018	+93
State Costs	$388	$489	$501	+12
Net Costs to Taxpayers	**$3,247**	**$3,414**	**$3,519**	**+105**

NOTE: Program Costs equal the Administrative Costs minus the portion of collections distributed to TANF and Foster Care Programs. The Federal costs also include incentive payments to States.

TANF LEGISLATIVE PROPOSAL

(dollars in millions)

	2004	2005	2006	Five Year 2006-2010
2006 President's Budget, Current Law	**$19,167**	**$19,839**	**$16,689**	**$86,403**
TANF	$17,209	$17,881	$16,689	$84,445
Contingency Fund*	$1,958	$1,958	$0	$1,958
Legislative Changes, Budget Authority				
State and Territory Family Assistance Grants		$0	$0	$0
Matching Grants to Territories		$0	$0	$0
Supplemental Grants		$128	$319	$1,595
Redirect High Performance Bonus**		-$500	$0	-$500
Family Formation Grants		$100	$100	$500
Research, Demonstration, Technical Assistance		$100	$100	$500
Responsible Fatherhood		$40	$40	$200
Elimination of the Illegitimacy Bonus***		-$100	-$100	-$500
Tribal Work Program		$0	$0	$0
Contingency Fund		$42	$0	$42
SUBTOTAL, Legislative Changes		**-$190**	**$459**	**$1,837**
2006 President's Budget, Proposed Policy	**$19,167**	**$19,649**	**$17,148**	**$88,240**

Explanation of decrease from FY 2005 to FY 2006: In FY 2005, current law estimates assume half-year funding of Supplemental Grants and routine appropriations of the High Performance Bonus and the Contingency Fund.

* FY 2004 and FY 2005 Contingency Funds are prior year funds, not new budget authority.. This funding is available for obligation through FY 2009. FY 2004 no States drew down these funds.

** Current law estimates assume $1 billion in BA in FY 2005. Under the FY 2004 President's Budget, $500 million will be redirected towards Family Formation Grants.

*** PB 06 eliminates the out-of-wedlock bonus and funds TANF research, demonstration, and technical assistance which is geared in part towards Family Formation efforts.

CSE LEGISLATIVE PROPOSALS

(dollars in millions)

	FY 2006			FY 2006 - 2010		
	Admin Costs	Fed. Share Collections	Collections to Families	Admin Costs	Fed. Share Collections	Collections to Families
Health Insurance from Either Parent**	$0	$0	$0	$3	$0	$0
Send COBRA Notice to IV-D Agency	1	0	0	6	0	0
Federal Seizure of Accounts in Multi-State Financial Institutions	1	4	67	4	52	934
Require Intercept of Gaming Proceeds	3	3	54	40	48	860
Provide for Garnishment of Longshore and Harbor Worker's Compensation Act Benefits	0	0	10	0	4	90
FPLS Access to Insurance Settlement Databases	0	0	1	0	6	116
Increased Access and Visitation Funding	2	0	1	32	0	16
Direct Tribal Access to Federal Parent Locator Service (FPLS)	0	0	0	0	0	101
Contractor and Tribal Access to Tax Data	0	0	0	0	0	0
Optional Pass Through and disregard above Current Effort***	0	0	0	0	-92	169
Optional Simplified Distribution***	0	0	0	0	-541	984
Mandatory Review and Adjustment of Child Support Orders**	0	0	0	96	136	0
Reduce Threshold for Passport Denial to $2500	0	1	3	0	9	35
$25 Annual Fee for Never -TANF Cases with Collections	-57	0	0	-315	0	0
OASDI Benefit Match	0	5	11	0	33	65
Also Included in Child Support/Family Support Account						
Raise the Cap for Repatriation to $5 million	0			3		
Child Suport Enforcement Subtotal*	-$50	$13	$147	-$131	-$345	$3,369
Current Law	$3,322			$22,008		
Proposed Law	$3,272			$21,877		

* In FY 2006, these proposals save $50 million in child support administrative costs and increase the Federal share of collections by $13 million. This results in a net Federal savings of $63 million while increasing collections to families by $147 million.

** The mandatory review and adjustment and health insurance from either parent proposals have Medicaid savings, $45 million over five years.

*** The optional pass through and disregard and optional simplified distribution proposals have significant Food Stamp savings, $114 million over five years. In total, these child support proposals offer an impressive $3.4 billion in increased collections to families for a net Federal cost of $52 million over five years.

TITLE IV-E CHILD WELFARE LEGISLATIVE PROPOSALS

(dollars in millions)

	2004	2005	2006	Five Year 2006-2010
2006 President's Budget Current Law				
Budget Authority	$6,814	$6,806	$6,620	$35,955
Outlays	$6,340	$6,474	$6,619	$35,786
Legislative Changes:				
Child Welfare Program Option				
Budget Authority	$0	$0	$36	$0
Outlays	$0	$0	$7	$2
Home of Removal				
Budget Authority	$0	$0	-$84	-$399
Outlays	$0	$0	-$72	-$383
DC Matching Rate				
Budget Authority	$0	$0	$8	$40
Outlays	$0	$0	$7	$38
SUBTOTAL, Legislative Changes				
Budget Authority	**$0**	**$0**	**-$40**	**-$359**
Outlays	**$0**	**$0**	**-$58**	**-$343**
2006 President's Budget Proposed Policy				
Budget Authority	**$6,814**	**$6,806**	**$6,580**	**$35,596**
Outlays	**$6,340**	**$6,474**	**$6,561**	**$35,443**

Note: IV-E includes Foster Care, Adoption Assistance, and Independent Living.

(dollars in millions)

	2004	2005	2006	2006 +/-2005
National Family Caregiver Support	$159	$162	$162	$0
Home and Community-Based				
Supportive Services and Centers	354	354	354	0
Nutrition Services:				
Home-Delivered Meals	$180	$183	$183	$0
Congregate Meals	387	387	387	0
Nutrition Services Incentive Program	148	149	149	0
Subtotal, Nutrition Programs	**$715**	**$719**	**$719**	**0**
Program Innovations	$34	$43	$24	-$19
Aging Network Support Activities	13	13	13	0
Protection of Vulnerable Older Americans	19	19	19	0
Preventive Health Services	22	22	22	0
Grants for Native Americans	26	26	26	0
Alzheimer's Disease	12	12	12	0
Program Administration	17	18	18	0
Senior Medicare Patrols (HCFAC)	4	3	3	0
White House Conference on Aging	3	5	0	-5
Total, Program Level	**$1,378**	**$1,396**	**$1,372**	**-$24**
Less Funds Allocated From Other Sources:				
Senior Medicare Patrols (HCFAC)	-$4	-$3	-$3	$0
Total, Budget Authority	**$1,374**	**$1,393**	**$1,369**	**-$24**
FTE	117	126	123	-3

ADMINISTRATION ON AGING

The Administration on Aging promotes the dignity and independence of older Americans and helps society prepare for an aging population.

Summary

The FY 2006 budget request for the Administration on Aging (AoA) is $1.4 billion. This amount maintains funding for AoA core services at the FY 2005 level, including community-based supportive services, elderly nutrition, and caregiver support. It also continues investments in program innovations to test new models of home and community-based care. Funding for the White House Conference on Aging, scheduled for October 2005, was completed in the FY 2005 appropriation.

Over 47 million Americans are age 60 and over, including more than 4.6 million who are age 85 and over, and these numbers are increasing rapidly with the aging of the baby boom generation. While advances in medicine and technology are enabling seniors to live longer and more active lives than ever before, those of advanced age are also at increased risk of chronic disease and disability. Older Americans with chronic conditions may be unable to perform basic activities of daily living, and many of them require assistance to remain at home and avoid the need for institutional care.

Studies have repeatedly found that if given the choice, older Americans overwhelmingly express a preference for long-term care services that allow them to remain at home. AoA is addressing these challenges through its efforts to create a more balanced system of long-term care and to focus on care in the community. The infrastructure of AoA's aging services network–one of the largest providers of home and community-based long-term care services–provides an important foundation for these efforts.

AoA programs provide services to elders at home and in the community through a nationwide network of State, Tribal, and area agencies on aging and through over 29,000 local service providers. These services complement existing medical and health care systems and support some of life's most basic functions: nutrition, transportation, respite and counseling for caregivers, and personal care to those who need assistance with activities of daily living such as bathing and eating.

Nutrition Programs

Nutrition programs–including Congregate and Home-delivered Meals and the Nutrition Services Incentive Program–total $719 million, over half of AoA's funding. Nutrition services help over two million older adults have access to the nutritious food they need to stay healthy and decrease their risk of disability. Meals served in a congregate setting also provide opportunities for social engagement and meaningful volunteer roles, which contribute to overall health and well-being. Finally, while meals are the core service, these programs also provide related services such as nutrition screening, assessment, education, and counseling.

Funding for nutrition programs is significantly leveraged: 61 and 67 percent of funding for Congregate and Home-Delivered meals, respectively, comes from sources other than the Older Americans Act. Priority for the receipt of meals is given to those who are in greatest economic or social need, with particular attention to older low-income and minority adults as well as individuals residing in rural communities.

Home and Community-Based Supportive Services

The FY 2006 request for Home and Community-Based Services is $354 million. This grant program to States and Territories supports the implementation of comprehensive and coordinated service systems for older individuals and their families. The array of services provided by these grants helps to keep seniors as independent as possible and enables them to stay in their homes and communities as long as possible, delaying the need for costly institutional care.

Services provided include transportation assistance; information and referral services; chore, homemaker and personal care services; and adult day care. These services are offered through multi-purpose senior centers which function as community focal points to coordinate and integrate services for the elderly, or through other community-based settings. In the last fiscal year for which data is available, AoA provided nearly 36 million rides to help seniors visit doctors, pharmacies, grocery stores,

State Flexibility in Using Nutrition Funding

As authorized by the Older Americans Act, States may transfer up to 30 percent of funding between Home-Delivered and/or Congregate Nutrition Services and Home and Community-Based Supportive Services. States may also transfer 40 percent of funding between Home-Delivered and Congregate Nutrition Services. This option allows greater flexibility for individual States to better meet the needs of their seniors.

meal sites, and senior centers. Information and referral services helped empower individuals and families to make informed choices about their service and care needs. Personal care and homemaker services enabled elders to live with dignity at home through assistance with activities of daily living.

National Family Caregiver Support Program

The National Family Caregiver Support Program is another critical element in rebalancing the system of long-term care towards community-based programs and away from institutional care. Family caregivers have always been the main source of long-term care services provided in the United States. AoA is committed to assisting these caregivers by providing grants to States and Territories for developing multifaceted systems of support for family caregivers of disabled elders, as well as for grandparents caring for disabled grandchildren. The FY 2006 budget includes $162 million for the National Family Caregiver Support Program; this includes $6 million to support Native American caregivers. Support services for caregivers include information, training, counseling, respite, and assistance services. Research indicates that informal caregiving supports can have a significant impact on the health and well-being of caregivers, delay the need for institutionalization of the care recipient, and significantly reduce costs to Medicare, Medicaid and private payers.

Caregivers' Economic Value

The number of unpaid informal caregivers (spouses, adult children, relatives, and friends) or elderly individuals is estimated to be 23 million or more. A study in the journal *Health Affairs* estimated that this informal care, if provided by home care aides, would cost $257 billion annually.

Program Innovations

AoA continues to identify more cost-effective and efficient ways of delivering services and to implement positive change in systems of care. The FY 2006 request of $24 million for Program Innovations supports projects for local service programs to improve access, better integrate services, and increase emphasis on prevention. Projects funded by the program include:

- Aging and Disability Resource Centers – 24 of which have been funded to date – that serve as highly visible and accessible resources for elders and their families to gain access to information on the full range of public and private long-term care options;
- Integrated Care Management projects that improve the quality of care for seniors by identifying and supporting innovations that involve partnerships with managed care organizations or capitated financing arrangements;
- Evidence-Based Disease Prevention grants that translate research results into community-level prevention programs;
- Partnerships to help States rebalance their long-term care systems, integrate services at the community level, and promote healthy and active aging;
- Outreach to seniors – particularly the disadvantaged – on the Medicare Modernization Act and the introduction of new prescription drug and preventive health benefits.

These and other projects are critical for ensuring the continued effectiveness of AoA's core service delivery programs, by finding ever more efficient and relevant methods for meeting the needs of America's elderly population. The budget does not continue one-time FY 2005 projects.

Protection, Prevention, and Aging Network Support

The FY 2006 request includes $54 million for health promotion and disease prevention programs, including health screenings, physical fitness, and medication management. These programs promote healthy lifestyles and help delay or prevent the onset of chronic disease; and also protect vulnerable elders from abuse and exploitation through training, outreach, and technical assistance to State and community elder advocacy programs.

Native American Nutrition and Supportive Services

The budget requests $26 million for grants for Native Americans. These grants will enable 243 tribal organizations serving approximately 300 Tribes to continue to provide American Indians, Alaskan Natives, and Native Hawaiians who are over the age of 60 with nutritional and supportive services which help them remain healthy and independent.

Alzheimer's Disease Demonstration Grants

The FY 2006 budget also includes $12 million for the Alzheimer's Disease Demonstration Grant program. These grants improve the quality of services provided to those suffering from Alzheimer's Disease by assisting States to incorporate new research findings, innovative approaches to care, and cultural competencies into their state-wide systems of home and community-based services.

Program Administration

A total of $18 million is requested to maintain staffing levels, and for related program management and support activities necessary to effectively administer a wide array of AoA programs. This request also supports efforts to strengthen management through greater efficiencies and economies of scale in information technology, financial systems, and personnel operations.

White House Conference on Aging

The White House Conference on Aging is scheduled for October 23-26, 2005, in Washington, D.C. The last White House Conference occurred in 1995. The purpose of the Conference is to develop recommendations for the President and Congress on policy and research issues in the field of aging.

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
General Departmental Management:				
Adolescent Family Life	$31	$31	$31	$0
Office of Minority Health	55	50	47	-3
Office on Women's Health	29	29	29	0
Minority HIV/AIDS	50	52	52	0
IT Security and Innovation Fund	15	15	15	0
Afghanistan	5	6	6	0
Embryo Adoption Awareness Campaign	1	1	1	0
Other General Departmental Management	174	190	178	-12
Evaluation Activities	41	40	40	0
Health Care Fraud and Abuse Control	5	5	5	0
Total, GDM Program Level	**$406**	**$419**	**$404**	**-$15**
Health Information Technology Initiative:				
Health IT	$0	$0	$75	+$75
Evaluation Activities	1	3	3	0
Total, Health IT Program Level	**$1**	**$3**	**$78**	**+$75**
Medicare Hearings and Appeals:				
Medicare Hearings and Appeals	$47	$58	$80	+$22
Total, MH&A Program Level	**$47**	**$58**	**$80**	**+$22**
Public Health and Social Services Emergency Fund:				
PHSSEF	$2,164	$2,339	$2,428	+$89
Total, PHSSEF Program Level	**$2,164**	**$2,339**	**$2,428**	**+$89**
Total, DM Program Level	**$2,618**	**$2,819**	**$2,990**	**+$171**
Less funds from other sources:				
Evaluation Activities	$42	$43	$43	$0
Health Care Fraud and Abuse Control	5	5	5	0
Total, DM Budget Authority	**$2,571**	**$2,771**	**$2,942**	**+$171**
FTE	1,570	1,873	2,053	+180

DEPARTMENTAL MANAGEMENT

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

Departmental Management (DM) includes funding for four appropriation accounts in the Office of the Secretary: General Departmental Management (GDM); Health Information Technology; Medicare Hearings and Appeals; and Public Health and Social Services Emergency Fund (PHSSEF).

The FY 2006 budget request for GDM provides a total program level of $404 million, including appropriations of $359 million, interagency transfers of $40 million in evaluation funds (including $18 million in evaluation funds from the former Policy Research account), and $5 million in health care fraud and abuse funds.

The FY 2006 DM request also reflects funding for two new appropriation accounts: Health Information Technology, including appropriations of $75 million and interagency transfers of $3 million in evaluation funds; and funding of $80 million for Medicare Hearings and Appeals.

The FY 2006 DM budget request also includes a total of $2.4 billion for the PHSSEF account.

Health Information Technology

The FY 2006 budget request includes a total of $78 million for Health Information Technology (IT). The Office of the National Coordinator for Health Information Technology (ONCHIT) was created in April 2004 by Presidential Executive Order, to address strategic planning, coordination, and analysis related to key technical, economic and other issues surrounding the public and private adoption of Health IT. This request will support ONCHIT's efforts to coordinate Federal efforts across many initiatives and activities, including:

- Implementing electronic prescribing as an option for program providers, as mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003;
- Developing interoperability standards and prototypes for the secure exchange of Electronic Health Records (EHR) and other health data;
- Working with regional collaborations to assist health care providers in the deployment of interoperable applications;
- Identifying standards and mechanisms for the broad adoption of EHR, including the evaluation of physician incentives and other strategies; and
- Realizing the overarching economic and health benefits of Health IT, while reducing the risks associated with EHR adoption.

The FY 2006 budget request will enable ONCHIT to provide strategic direction for a national interoperable health care system, and to encourage clinicians to connect and collaborate within a national Health IT network. The Administration also plans to propose expansion of the Department's Health IT investment in FY 2005. The National Coordinator will work with the Agency for Healthcare Research and Quality (AHRQ) and the National Library of Medicine to develop regional collaborations for the deployment of interoperable applications, and to accelerate the development of standards and prototypes.

In addition to funds requested within Departmental Management for Health IT, the FY 2006 request for AHRQ includes $50 million to advance the use of Health IT to enhance patient safety.

Medicare Hearings and Appeals

The FY 2006 budget request includes $80 million in Medicare Trust Funds to support a new Office of Medicare Hearings and Appeals (OMHA), as mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). MMA transferred 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 Office of the Secretary at HHS by no later than October 1, 2005. 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 such a hearing. To be able to meet this timeframe, OMHA plans to invest heavily in technology and to utilize video-teleconferencing (rather than face-to-face hearings) for the majority of cases.

General Departmental Management

The GDM account supports those activities associated with the Secretary's roles in administering and overseeing the organization, programs, and activities of the Department. These activities are carried out through 15 Staff Divisions (STAFFDIVs). The GDM budget request for FY 2006 totals

$404 million, a decrease of $15 million or 4 percent below the comparable FY 2005 level. The GDM request provides funding for the following activities:

Office of Population Affairs (OPA)/Adolescent Family Life: The Adolescent and Family Life (AFL) request of $31 million will continue to provide support for the AFL demonstration and research program authorized under Title XX of the Public Health Service (PHS) Act. Through the grants awarded under this program, AFL provides funding in three areas: care demonstration projects, prevention projects, and research projects. This request includes $13 million in abstinence-only prevention projects, as defined by the Welfare Reform legislation (P.L. 104-193). Further, OPA also administers the Family Planning program under Title X of the PHS Act, which is funded through the Health Resources and Services Administration (HRSA).

Office of Minority Health: The Office of Minority Health request of $47 million, a $3 million decrease from FY 2005, will provide funding to continue disease prevention, health promotion, service demonstration, and educational efforts that focus on health concerns that cause the high rate of death in racial and ethnic minority communities. The reduction is attributed to FY 2005 Congressional earmarks which are not continued in FY 2006.

Office on Women's Health: The Office on Women's Health request of $29 million, the same as FY 2005, will provide funding to continue the advancement of women's health programs through the promotion and coordination of research, service delivery, and education – both throughout HHS agencies and offices, with other government organizations, and with consumer and health professional groups.

Minority HIV/AIDS: The FY 2006 request includes $52 million, the same level as FY 2005, to support innovative approaches to HIV/AIDS prevention and treatment in minority communities heavily impacted by this disease. These funds allow the Department to continue priority investments and public health strategies targeted to reduce the disparities and burden of HIV/AIDS in racial and ethnic minority populations.

Information Technology Security and Innovation Fund: The FY 2006 budget request includes $15 million to continue funding for the IT Security and Innovation Fund. Projects funded through the IT Security and Innovation Fund focus on HHS enterprise-wide investments, notably: enterprise architecture, key E-Government projects, HHS common IT infrastructure services, and security and infrastructure to enable HHS common administrative systems.

Afghanistan: Included in the FY 2006 request for the Office of Global Health Affairs is $6 million to continue support of HHS health care initiatives in Afghanistan, particularly in the areas of maternal and child health.

Embryo Adoption Awareness Campaign: Included in the President's Budget request for the first time is $1 million to continue the Embryo Adoption pubic awareness campaign grant award program. The purpose of the campaign is to educate Americans about the existence of frozen embryos (resulting from in-vitro fertilization) which are available for adoption.

Other General Departmental Management: The FY 2006 budget request includes $178 million to fund offices which provide leadership, policy, legal, and administrative guidance to HHS components.

One of the offices included in Other GDM is the Office on Disability (OD). Established in 2002 in support of President Bush's New Freedom Initiative, OD has been charged to: lead the HHS New Freedom Initiative; oversee, coordinate, develop and implement disability programs and initiatives within HHS that affect persons with disabilities; ensure that persons of every age with disabilities have a voice within HHS; and heighten the interaction of programs within HHS and with Federal, State, community and private sector partners.

Public Health and Social Services Emergency Fund and Bioterrorism

The FY 2006 request funds HHS bioterrorism and other emergency preparedness activities in two ways. The Public Health and Social Services Emergency Fund (PHSSEF) provides $2.4 billion for pandemic influenza preparedness and bioterrorism efforts in the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Office of the Secretary, and targeted countermeasure research at the National Institutes of Health. Direct appropriations are also provided to NIH and the Food and Drug Administration for their bioterrorism efforts.

Bioterrorism: The HHS FY 2006 request includes $4.2 billion for bioterrorism, a net increase of $154 million above FY 2005. Of the total, $2.3 billion is funded through the PHSSEF, and $1.9 billion through NIH and FDA accounts. The FY 2006 budget supports thr new Federal Mass Casualty Initiative, a model emergency response demonstration, a new chemical countermeasures research initiative, and expanded procurement funding for the Strategic National Stockpile (SNS).

Mass Casualty Initiative
The FY 2006 President's Budget includes $70 million within HHS for a new Federal Mass Casualty Initiative. Since FY 2002, HRSA has funded work to expand state and local hospital capacity to treat mass casualties. This new initiative reflects the concern that local medical systems will need added assistance in the case of an attack involving the use of weapons of mass destruction. The FY 2006 request includes a three-pronged effort. First, the request for the SNS includes $50 million in new funding for the purchase, maintenance, and operation of portable hospital units that can be deployed to increase hospital surge capacity in the event of a bioterrorist attack. Second, the Medical Reserve Corps (MRC) budget includes an increase of $12.5 million for a total of $22 million. The MRC is the Citizen Corps component that organizes local volunteers to assist regular medical response professionals and facilities during a large-scale local emergency. Finally, $7.5 million will finance the development and updating of systems designed to rapidly access credentialing information on healthcare providers in an emergency. These systems will be able to obtain data from federal, state, and non-government sources, including the State-based Emergency System for Advance Registration of Volunteer Healthcare Personnel.

Strategic National Stockpile
The FY 2006 President's Budget includes $600 million for the Strategic National Stockpile (SNS), an increase of $203 million above FY 2005. This increase includes $50 million for the purchase of portable mass casualty treatment units. In addition to housing these new units, the SNS finances the procurement of commercially available countermeasures, such as anthrax antibiotics to cover 60 million people, and the replacement of pharmaceuticals and supplies that have lost potency. This appropriation also includes funding for specialized facilities needed to store SNS and BioShield procured countermeasures, including enough smallpox vaccine for every American. Finally, funds are necessary to maintain the capacity to move SNS assets anywhere in the U.S. within 12 hours and to provide technical assistance to State and local governments participating in the Cities Readiness Initiative; this initiative seeks to upgrade their ability to provide anthrax antibiotics to all residents within 48 hours of an anthrax event.

National Institutes of Health
The FY 2006 request for the National Institutes of Health (NIH) biodefense activities totals $1.8 billion, a net increase of $56 million, or 3.2 percent, above FY 2005. Within this amount, research and development funding will increase $175 million, partially offset by a $119 million reduction in extramural laboratory construction funding. Of the NIH total, $97 million is budgeted in the PHSSEF to develop countermeasures against chemical, nuclear, and radiological threats. NIH will use $47 million to continue work initiated in FY 2005 on nuclear and radiological countermeasures. In FY 2006, the President's Budget includes an additional $50 million to complement this work with a new targeted research effort to expand the current range of chemical countermeasures. Of the funds directly appropriated to NIH, $1.7 billion will fund basic research addressing both naturally occurring threats and the risk of biotechnology advances leading to engineered or modified organisms that could evade current medical countermeasures or enhance their virulence. These research efforts will focus on the biology of microbial agents with bioterrorism potential, the properties of the host's response, and applied research and advanced development of new or improved diagnostics, vaccines, and therapies. A complementary investment of $30 million is requested to expand extramural laboratory capacity to conduct biodefense research. This additional funding raises the five-year NIH investment total to $1 billion for the construction of intramural and extramural biodefense facilities.

Food Defense
The budget for FDA includes $244 million for bioterrorism activities. This total includes $180 million for food defense, an increase of $30 million above FY 2005. This request includes $20 million to increase analytic surge testing capacity for biological, chemical, and radiological threat agents for the Food Emergency Response Network (FERN), $6 million for research, and $1 million to continue development of an Emergency Response and Operations Network. Finally, FDA will use $3 million, for a total of $5 million, to coordinate food surveillance activities within the Biosurveillance Initiative.

HRSA Curriculum Development and Education
The request maintains the FY 2005 level of $28 million. The Bioterrorism Training and Curriculum Development program is designed to provide bioterrorism-related continuing education and training opportunities for practicing health care providers and support for new emergency preparedness curricula in health professions schools.

State and Local Preparedness
CDC and HRSA continue to demonstrate a strong commitment to preparing States and local public health departments and hospitals to prepare against public health emergencies and acts of bioterrorism. A total of $6.7 billion will have been invested between FY 2002 and FY 2006. The FY 2006 request includes $1.3 billion for this work, including $25 million for one or more competitive grants for a model

emergency response demonstration. This net reduction of $138 million reflects the targeting of resources to direct Federal efforts, including portable mass casualty treatment capacity that can assist any State and expanded countermeasure readiness. HHS will also re-evaluate State and local preparedness funding formulas in an attempt to assure that allocations reflect risk and performance.

Upgrading CDC Capacity and Anthrax Research
The FY 2006 request includes $140 million for upgrading CDC capacity. With these funds, CDC will continue to improve epidemiological expertise in the identification and control of diseases caused by terrorism, including better electronic communication, distance learning programs, and cooperative training between public health agencies and local hospitals. This request provides support for upgrading capacity at CDC, national planning efforts, oversight of inter-laboratory transfers of dangerous pathogens and toxins, and laboratory safety inspections. No funding is earmarked for research on older anthrax vaccines, as the project is nearing completion; funds were redirected into the Strategic National Stockpile.

Office of the Secretary
The FY 2006 request for the PHSSEF bioterrorism activities includes $81 million for the Office of the Secretary. This amount includes an increase of $20 million over FY 2005 to fund the new Mass Casualty Initiative discussed above, as well as:

The President's Budget includes $41 million to support the Office for Public Health and Emergency Preparedness' (OPHEP) ongoing operations, including the Secretary's Emergency Response Team, and the International Early Warning Surveillance efforts. This appropriation also allows OPHEP to target advanced research projects and support the development of an effective risk communication and information strategy for the public. OPHEP also manages HHS's role in Project BioShield countermeasure needs analysis and is responsible for procuring these DHS-funded countermeasures for the SNS.

Cybersecurity funding is maintained at $10 million in FY 2006 for cybersecurity. These funds continue to protect the Department's information technology infrastructure from cyber-terrorist attacks. These funds will provide continuous security monitoring for all HHS systems, assets, and services.

EMERGENCY PREPAREDNESS

Pandemic Influenza: The budget includes $120 million, an increase of $21 million, to ensure the Nation has the vaccine production capacity to respond to an influenza pandemic. It is normal for influenza strains to change slightly from year to year. When major changes occur to the influenza strain genetic structure, widespread disease and death can result. Three such global events - called pandemics - occurred in the 20th century. Such a pandemic could cause an additional 90,000 to 300,000+ deaths in the U.S., especially if adequate vaccines were not available quickly. Once a pandemic began, time would be critical in accomplishing necessary research, development, and delivery of vaccines required to mitigate the pandemic.

The Department issued a draft Pandemic Influenza Response and Preparedness Plan in August, 2004. This plan lays out action steps in several areas. This appropriation is focused on expanding the year-round domestic vaccine surge production capacity that would be needed in a pandemic. It will finance contracts with vaccine manufacturers to develop and license influenza vaccines using new production techniques and establishing a domestic manufacturing capability. Second, HHS will continue to ensure a year-round supply of specialized eggs needed for domestic production of currently licensed vaccines. Moreover, manufacturers will be encouraged to license and implement new processing and other technologies to improve vaccine yields from both new cell culture vaccines and existing egg-based vaccines. In addition, HHS will sponsor development and licensing of antigen-sparing strategies that would increase the number of individuals who could be vaccinated from a given amount of bulk vaccine product. Finally, the budget maintains the flexibility to redirect these funds to initiate pandemic vaccine production at any time a pandemic appears imminent.

BIOTERRORISM

(dollars in millions)

	2004	2005	2006	2006 +/-2005
Bioterrorism, Public Health and Social Services Emergency Fund				
Centers for Disease Control and Prevention:				
Upgrading State and Local Capacity	$918	$927	$797	-$130
Biosurveillance Initiative	22	79	79	0
Upgrading CDC Capacity/Anthrax Research	169	157	140	-$17
Strategic National Stockpile	398	397	600	$203
Federal Mass Casualty Initiative (non-add)	*0*	*0*	*50*	*+50*
Subtotal, CDC	**$1,507**	**$1,560**	**$1,616**	**+$56**
Health Resources and Services Administration:				
Hospital Preparedness and Infrastructure	$515	$491	$483	-$8
Emergency Response Demonstration (non-add)	*0*	*0*	*25*	*+25*
Education Incentives for Medical Curriculum	28	28	28	0
Subtotal, HRSA	**$543**	**$519**	**$511**	**-$8**
Office of the Secretary:				
Office of Public Health and Emergency Preparedness	$41	$41	$41	0
CyberSecurity	10	10	10	0
Medical Reserve Corps	10	10	22	+12
Healthcare Provider Credentialing	0	0	8	+8
Subtotal, Office of the Secretary	**$61**	**$61**	**$81**	**+$20**
National Institutes of Health:				
Nuclear/Radiological Countermeasures (NIH)	$0	$47	$47	-$0
Chemical Countermeasures (NIH)	0	0	50	+50
Subtotal, NIH PHSSEF	**$0**	**$47**	**$97**	**+$50**
Subtotal, PHSSEF Bioterrorism	**$2,111**	**$2,187**	**$2,305**	**+$118**
Bioterrorism, Agency Budgets				
National Institutes of Health:				
Research	$1,629	$1,539	$1,664	+$125
Subtotal, Research including PHSSEF funding	*1,629*	*1,586*	*1,761*	*+175*
Extramural Laboratory Construction	0	149	30	-119
Subtotal, Appropriated to NIH Accounts	$1,629	$1,688	$1,694	+$6
Subtotal, NIH including PHSSEF funding	***1,629***	***1,735***	***1,791***	**+56**
Food and Drug Administration:				
Food Safety	$116	$150	$180	+$30
Vaccines/Drugs/Diagnostics	53	57	57	0
Physical Security	7	7	7	0
Subtotal, Appropriated to FDA Accounts	**$176**	**$214**	**$244**	**+$30**
Total Bioterrorism Funding	**$3,916**	**$4,089**	**$4,243**	**$154**
Public Health and Social Services Emergency Fund, Non-Bioterrorism				
Pandemic Influenza	$50	$99	$120	+$21
Transformation of the Commissioned Corps	3	3	3	0
Hurricane Relief Efforts	0	50	0	-50
Subtotal, Non-Bioterrorism	**$53**	**$152**	**$123**	**-$29**
Total, PHSSEF	**$2,164**	**$2,339**	**$2,428**	**+$89**

OFFICE FOR CIVIL RIGHTS

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Program Level.....	$34	$35	$35	$0
FTE.....	244	268	268	0

The Department of Health and Human Services (HHS), through the Office for Civil Rights (OCR) promotes and ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination, 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 2006 budget request for OCR is $35 million, the same as the FY 2005 level. The budget supports the activities of OCR 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 the significantly expanded compliance responsibilities of OCR that protect the rights of individuals with respect to their health information as provided in 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 resolution, pre-grant and preventative compliance reviews; monitoring corrective action plans; and carrying out public education, voluntary compliance, training, and technical assistance activities. The work of OCR protects individual rights and simultaneously supports HHS goals for strengthening the health and well-being of individuals, families, and communities by improving access to HHS programs and activities.

Some key priorities for OCR in FY 2005-FY 2006 are: increasing access by vulnerable populations to quality health care; promoting non-discrimination in adoption and foster care and Temporary Assistance for Needy Families (TANF); enhancing provision of appropriate services in the most integrated setting for individuals with disabilities; and ensuring understanding of and compliance with the Privacy Rule.

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 intended recipients free from discrimination on the basis of race, national origin, disability, age, and sex. The efforts of OCR also maintain public trust and confidence that the health care system will maintain the privacy of protected health information while ensuring access to care.

New Freedom Initiative and Olmstead

OCR is involved in a variety of efforts to increase the independence and quality of life of persons with disabilities, including those with long-term needs. 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 (NFI) and Executive Order 13217, which commits the U.S. 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 Olmstead v. L.C. decision.

During FY 2006, the efforts of OCR will continue its NFI leadership role, improving access to community-based services for people with disabilities through technical assistance to States and Olmstead complaint resolution.

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

OCR ensures compliance with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, requiring recipients of HHS Federal financial assistance to ensure

that their policies and procedures do not exclude or limit, or have the effect of excluding or limiting, the participation of beneficiaries on the basis of race, color, or national origin. These efforts, which reach beneficiaries of all health and human services programs that HHS funds, seek to achieve voluntary compliance and corrective efforts when violations are found.

In FY 2004, OCR and the HHS Administration for Children and Families (ACF) entered into an agreement with the Ohio Department of Job and Family Services and the Hamilton County Job and Family Services to resolve civil rights violations identified by OCR and ACF regarding race discrimination in adoption placements. OCR also recently collaborated with the Department of Justice (DOJ) and the U.S. Department of Agriculture to produce a video and informational brochure in multiple languages to advise service providers and consumers with limited English proficiency (LEP) about their responsibilities and rights under Title VI.

In FY 2006, OCR will continue to focus on a broad range of Title VI access issues including non-discrimination in adoption, foster care, and TANF, as well as access to quality health services. For example:

- To support the HHS HIV/AIDs initiative, OCR has initiated a disparities outreach partnership with a regional Public Health Service Office of Minority Health (OMH) to plan conferences and other activities focusing on HIV/AIDs in minority communities in all five States in Region VI. OCR and its Federal partners will work with providers and consumer groups, including faith-based organizations in those States, to inform minorities of their rights to non-discriminatory access to prevention education and treatment, and to assist OMH efforts to address social, cultural, and other potential barriers to access.

HIPAA - Health Information Privacy

OCR is responsible for implementing and enforcing the HIPAA Privacy Rule. Compliance with the HIPAA Privacy Rule was required for most covered entities as of April 14, 2003, when the responsibility for OCR to enforce the Privacy Rule commenced. The Rule protects the privacy of individually identifiable health information maintained or transmitted by health plans, health providers, and clearinghouses. This landmark rule provides individuals, for the first time, with Federal protection against the inappropriate use and disclosure of personal health information.

FY 2004 was the first full year during which OCR received and investigated complaints under the Privacy Rule. Because the Privacy Rule does not provide a private right of action, OCR is the only government entity to which aggrieved parties can turn for redress, through civil monetary penalties. (DOJ is charged with enforcing Privacy Rule criminal violations). The number of complaints OCR has received since the April 14, 2003 compliance date now exceeds 10,000. OCR resolved more than 4,400 of these complaints in FY 2004. OCR has also reached tens of thousands of covered entities and consumers through conferences, a toll-free call line, and an interactive website providing answers to specific questions about the Rule, which has received more than 2.5 million hits.

In FY 2006, OCR will continue to:

- Promote compliance with the Privacy Rule by complaint investigation and developing and providing outreach and guidance to covered entities and the public; and
- Analyze and provide recommendations with respect to implementation of the Privacy Rule to promote its workability; and issue additional guidance, as needed, to aid in implementation and to dispel misconceptions.

Cross-Cutting Civil Rights Activities

The work of OCR often addresses more than one of its legal authorities. Certain population groups may face multiple barriers to services that cross-cut race, national origin, disability, and age non-discrimination authorities, and that may also raise issues involving privacy of health information.

In FY 2006, OCR will continue to build upon its successes in working with other HHS components and Federal agencies to coordinate its cross-cutting initiatives.
For example:

- OCR will continue to work with ACF, States, local governments, and other service providers to ensure that TANF programs remain free from discriminatory barriers that could prevent minorities and individuals with disabilities from obtaining the training and jobs that can lead to self-sufficiency.
- OCR will continue to work with DOJ to coordinate compliance activities involving the Privacy Rule, disability rights, and access to services by LEP persons.

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	2004	2005	2006	2006 +/- 2005
Program Level /1.....	$199	$225	$200	-$25
FTE	1,500	1,507	1,395	-112

1/ The FY 2006 level assumes $160 million for Medicare and Medicaid related fraud, waste, and abuse activities, the maximum allowed under the Health Care Fraud and Abuse Control Program and budget authority of $40 million.

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

For FY 2006, the Office of Inspector General (OIG) requests a discretionary appropriation of $40 million, the same as the FY 2005 discretionary level. OIG will also receive between $150 and $160 million in FY 2006 from the Health Care Fraud and Abuse Control (HCFAC) Account for Medicare and Medicaid related fraud, waste, and abuse activities. In addition to this, in FY 2005 OIG received $25 million to fight fraud, waste, and abuse associated with the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). The FY 2006 budget request proposes to extend the date that OIG can obligate this $25 million by one year, from FY 2005 to FY 2006.

Over the FY 2005 - FY 2006 period, OIG will use its discretionary funding to continue its work across the non-Medicare and non-Medicaid areas of HHS, which are public health, children and families, aging, and department-wide activities. The funding level of OIG for FY 2006 allows OIG to continue its efforts in:

- Bioterrorism oversight, investigations, audits, and evaluations;
- Grant oversight and reviews that cover internal controls, accounting controls, performance measurements, and program evaluation; and
- Nation-wide involvement with the 10 Project Save Our Children (PSOC) Task Forces that identify, investigate, and prosecute individuals who willfully avoid the payment of their child support obligations.

In addition to this, OIG will continue its HCFAC activities to identify and prosecute health care fraud; prevent future fraud, waste, or abuse; protect HHS program beneficiaries; and ensure the solvency of the Medicare Trust Fund; as well as play an active role in implementation of the MMA.

BIOTERRORISM

OIG has an important role in furthering the Department's bioterrorism efforts and ensuring the security of HHS programs, staff, facilities, and equipment. In FY 2006, OIG has a variety of activities planned. For example:

- Bioterrorism Investigations. Since the events of September 11, 2001, OIG has received numerous requests for information and investigations relating to terrorist and bioterrorist activity. On December 13, 2002, HHS issued the interim final rule for Possession, Use, and Transfer of Select Agents and Toxins, 42 CFR Part 73. Based upon these new regulations, OIG will pursue violations of regulations concerning possession, use, and transfer of select agents and toxins through civil monetary penalties.
- Hospital Surge Capacity. OIG will review the surge capacity guideline of the Health Resources and Services Administration (HRSA) Hospital Bioterrorism Preparedness Program, which calls for States to accommodate 500 patients per one million population. OIG will conduct onsite evaluations in a small number of States to determine the extent to which the guideline is being met and also survey all States to gain a broad overview of how this guideline is being met, if States are encountering barriers, and their interaction with HRSA to facilitate preparedness.

GRANTS OVERSIGHT

OIG plans to review Department grant programs to determine whether they are appropriately monitored and

managed throughout the grant life cycle. OIG will assess mechanisms in place to ensure that proper procedures are used to award grants, fund them, account for expenditures, and verify that they are used only for authorized purposes. The work of OIG will include review of performance measures used to determine the nature and value of the product of the grants, as well as the methods used to evaluate the individual grants and grant programs as a whole. The reviews of OIG will cover internal controls, accounting controls, performance measurements, and program evaluation.

OIG anticipates conducting grant oversight activities in FY 2005-FY 2006 that touch almost every Operating Division within HHS and include such diverse issues as patient safety, the National Electronic Disease Surveillance System, nursing workforce development, Native American diabetes prevention / treatment, and community health centers.

Child Support Enforcement Program

OIG will continue its coverage of all 50 States and the District of Columbia by its multi-agency task forces (PSOC Task Forces) that identify, investigate, and prosecute individuals who willfully avoid payment of their child support obligations under the Child Support Recovery Act. These task forces bring together State and local law enforcement and prosecutors, United States Attorneys' Offices, the OIG, United States Marshals Service personnel, the Federal Bureau of Investigation, State and county child support personnel, and all other interested parties.

As of September 30, 2004, the task force units have received over 8,200 cases from the States. As a result of the work of the task forces, 494 Federal arrests have been executed and 458 individuals sentenced. The total ordered amount of restitution related to Federal investigations is over $22.8 million. There have been 352 arrests at the State level and 310 convictions or civil adjudications to date, resulting in over $17.3 million in restitution being ordered.

Health Care Fraud and Abuse

Through the Health Insurance Portability and Accountability Act (HIPAA), OIG receives mandatory funding for its activities that focus on fraud, waste, abuse, and efficiency improvements in the Medicare and Medicaid programs. The Act provides for minimum and maximum amounts of funding that are decided each year by the Secretary of HHS and the Attorney General. Starting in FY 2003, and each year thereafter, the maximum amount available to OIG for its HCFAC Program is capped at $160 million.

OIG works with the Centers for Medicare & Medicaid Services (CMS), other HHS agencies, and the Department of Justice to ensure that funds due to the Medicare Trust Fund or CMS are recovered through audits and investigations, and provides recommendations for statutory, regulatory, and program changes that could strengthen program integrity.

Medicare Prescription Drug, Improvement, and Modernization Act

In FY 2005 OIG received $25 million to fight fraud, waste, and abuse associated with the implementation of the MMA. The FY 2006 budget request proposes to extend the date that OIG can spend this $25 million by one year, from FY 2005 to FY 2006. Under the MMA, OIG is tasked with several mandatory requirements, as well as general oversight activities.

Initially, OIG will focus on audits of drug manufacturers and surveys to monitor the market prices of Medicare Part B drugs; statutory requirements relating to safe harbors for electronic transmission of drug prescriptions and collaborative efforts of Federally Qualified Health Clinics; effects of Medicare payment rates on the availability of hematology and oncology drugs; prices of drugs included in the End-Stage Renal Disease composite rate; payment methods for training residents in non-hospital settings; and notices to beneficiaries relating to hospital lifetime reserve days. Even without specific mandates, OIG is expected to conduct investigations, audits, and evaluations and provide advice and technical assistance on all aspects of the Medicare program. Examples of planned work include:

- Graduate Medical Education (GME) Voluntary Supervision in Nonhospital Settings. The MMA requires that OIG study the appropriateness of alternative payment methodologies for GME involving the costs of training residents in nonhospital settings.
- Beneficiary Understanding of Drug Discount Card Program. OIG will assess beneficiary understanding of the Medicare Prescription Drug Discount Card program and materials CMS provides to beneficiaries, as well as determine if beneficiary materials comply with MMA requirements and if beneficiaries understand the program.
- Administrative Costs. Using the Federal Employees Health Benefit guidelines, OIG will examine the administrative amounts currently claimed by managed care organizations (MCOs). Congress has expressed interest in how MCOs determine funding amounts to meet administrative costs, which must be allocable, allowable, reasonable, and limited under the program.

PROGRAM SUPPORT CENTER

(dollars in millions)

	2004	2005	2006	2006 +/-2005
Expenses	$507	$536	$542	+$6
FTE	1,119	1,379	1,379	0

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

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

Human Resources Service

The FY 2006 estimated expenses for the Human Resources Service (HRS) are $61 million, the same as the revised FY 2005. HRS provides an extensive array of personnel systems, administration and management, training, and payroll services. These include automated personnel and payroll systems support, equal employment opportunity, and workforce development.

Financial Management Service

The FY 2006 estimated expenses for the Financial Management Service (FMS) are $57 million, the same as the revised FY 2005. FMS supports the financial operations through the provision of grant payment services for Departmental and other Federal grant and program activities; accounting and fiscal services; debt and travel management services; and rate review, negotiation, and approvals for departmental and other Federal grant and program activities to HHS and other Federal agencies.

Administrative Operations Service

The FY 2006 estimated expenses for the Administrative Operations Service (AOS) are $88 million, the same as the revised FY 2005. AOS provides a wide range of administrative and technical services within the Department, both in headquarters and in the regions, and to customers throughout the Federal Government. The major areas of service are real and personal property management, technical support and communications management, and management of regional contracts for administrative support.

Federal Occupational Health Service

The FY 2006 estimated expenses for the Federal Occupational Health Service (FOHS) are $175 million, an increase of $5 million above the revised FY 2005 level. The increase of $5 million represents anticipated increased reimbursements from other Federal agencies. The FOH provides occupational health services, including health, wellness, employee assistance, work/life, safety, and environmental and industrial hygiene-related services to more than 174 Federal components across the country.

Strategic Acquisition Service

The FY 2006 estimated expenses for the Strategic Acquisition Service (SAS) are $117 million, an increase of $1 million above the revised FY 2005 level. The increase reflects anticipated increased reimbursements. The SAS is responsible for providing leadership, policy, guidance, and supervision to the procurement operations of the PSC and for improving procurement

operations within HHS. The SAS provides strategic sourcing services; acquisition management; and provides pharmaceutical, medical, and dental supplies to HHS and other Federal agencies. The SAS will streamline procurement operations in HHS through activities such as the reduction of duplicate contracts, the use of consolidated contracts, and implementation of new procurement practices designed to provide higher quality procurement services.

HUMAN RESOURCES CENTERS

The FY 2005 estimated expenses for the Human Resources Center (HRC) are $44 million, the same as the revised FY 2005. The HR Centers represent a consolidation of human resources services within the Department, with sites located in Rockville, Baltimore, and Atlanta. In cooperation with their customers, the Centers have implemented human capital strategies that identify, recruit, hire, and retain employees with the skills to accomplish the mission of HHS.

RETIREMENT PAY & MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

(dollars in millions)

	2004	2005	2006	2006 +/-2005
Retirement Payments.....	$227	$242	$256	+$14
Survivor's Benefits.....	14	14	16	+$2
Medical Care for Retirees and Survivors	53	55	57	+$2
Accrued Medical Benefits for over-65...	27	33	34	+$1
Total, Budget Authority.....	**$321**	**$344**	**$363**	**$19**

This appropriation provides for annuities of retired Public Health Service (PHS) Commissioned Officers; payment to survivors of deceased retired officers; and medical care to active duty PHS commissioned officers, retirees, and dependents of members and accrued medical benefit payments for PHS Commissioned Corps officers and beneficiaries over age 65.

The FY 2006 request of $363 million is a net increase of $19 million over the FY 2005 level. This amount reflects increased retirement payments of $14 million, increased survivor benefits of $2 million, increased medical care benefits costs of $2 million, and increased accrual medical benefit payments for officers and beneficiaries over age 65 of $1 million.