DEPARTMENT OF HEALTH AND HUMAN SERVICES

The President's Proposal:

- Strengthens and improves Medicare, offering more options, including enhanced benefits and prescription drug coverage;
- Reforms child welfare financing by providing states with flexible grants that will encourage innovative child welfare plans with a stronger emphasis on prevention and family support;
- Helps 1.2 million more people receive health care at Health Centers in 2004; and
- Provides a $100 million increase for a prevention initiative to reduce the number of deaths and disabilities caused by diabetes, obesity and asthma.

The Department's Major Challenges:

- Managing a vast information technology system more efficiently and effectively; and
- Creating One HHS from a wide variety of disparate organizational units.

Department of Health and Human Services

Tommy G. Thompson, Secretary

www.hhs.gov 202–619–0257

Number of Employees: 65,000

2003 Spending: $502.0 billion

Major Assets:

Buildings owned or leased: 4,130

Motor vehicles owned or leased: 3,048

Medicare Trust Funds financial assets: $284.5 billion

The Department of Health and Human Services (HHS) is the federal government's principal agency for protecting the health of all Americans and for providing essential human services. The Department manages over 300 programs and 60,000 grants, covering a wide spectrum of activities in public health, income support, basic and applied science, and child development. HHS also handles more than 900 million Medicare claims per year.

HHS Priorities

Fighting Bioterrorism

No HHS activity is now more important than national bioterrorism preparedness. HHS agencies are improving our nation's capacity to prevent, identify, and respond to the consequences of biological weapons.

The importance of preparing and responding to public health emergencies was never clearer than during the aftermath of September 11th and the subsequent anthrax attacks. HHS has been working steadfastly since that time to make strides in our nation's preparedness. In 2002, HHS programs awarded over $1 billion to local health departments and hospitals to improve public health preparedness, and will continue this investment in 2003 and 2004.

Strengthening preparedness also involves the acquisition of vaccines and other countermeasures for bio-defense. The Administration has gained valuable experience and discovered many challenges in recent efforts to ensure an adequate supply of such products, including the smallpox vaccine. Important aspects of the normal budget, acquisition and licensure processes can create delays that may be understandable in other contexts, but are unacceptable in the case of threats from bioterrorism. These delays can obstruct the process of turning scientific discovery into developed products that can protect the American people. It is essential that these barriers be overcome, while still maintaining the discipline they provide and the safety they ensure.

The Administration proposes the creation of three new authorities that will speed the arrival of products that can be used to protect the American people from these threats. The first will allow the government to pre-purchase countermeasures from the private sector as soon as experts agree that a product in development is safe and effective enough to stockpile for use in an emergency, and can ultimately be licensed. The budget authority will be at the Department of Homeland Security and procurement authority will be at HHS. (See the Department of Homeland Security chapter for more details.)

The second new authority will provide the experts at the National Institutes of Health (NIH) with the flexibility they need to hire the best experts, make special purchases, and face other management challenges that can be barriers to quick progress in converting basic scientific discoveries into usable products. The third new authority will allow the Food and Drug Administration (FDA) to work more pro-actively with researchers and industry to allow emergency-use authorization licensure of these countermeasures.

Advancing the President's Initiatives

White House Faith-Based and Community Initiative

Government shouldn't discriminate against faith, government should welcome faith. The power of faith, whether it comes through the Christian church, through Judaism, or through Islam, can change people's lives for the better. And we must welcome that faith in our society.

President George W. Bush
August 7, 2002

Faith-Based and Community Initiative. One of President Bush's first official acts was to create the White House Office of Faith-Based and Community Initiatives. The Office was tasked with leading a "determined attack on need" by strengthening and expanding the role of faith-based and community organizations in addressing the nation's social problems. The President envisions a faith-friendly environment where faith-based organizations can compete equally to provide government-sponsored services.

President Bush also created centers for Faith-Based and Community Initiatives in six cabinet departments—HHS, Agriculture, Education, Housing and Urban Development, Justice, and Labor—as well as in the Agency for International Development.

As a result of a White House report (titled *Unlevel Playing Field*), which documented barriers to fuller participation, the President's Management Agenda will track the progress of agencies in

removing these barriers. While progress has been made in reducing administrative barriers and increasing outreach to community- and faith-based organizations, more needs to be done to move these organizations into the mainstream of service delivery. (Ratings for each of the five cabinet agencies included in the President's original Executive Order are in the agencies' budget chapters.)

In addition, the budget funds five competitive grant programs targeted at faith- and community-based organizations that can provide innovative services at the grassroots level.

Compassion Capital Fund. To build on the efforts of community-based, charitable organizations, the President's Budget continues funding for social services provided by faith-based and community organizations with $100 million for the Compassion Capital Fund. In order to build upon the efforts of charitable organizations, this initiative provides funds to public/private partnerships to support charitable organizations in expanding or emulating model social service programs. These capacity-building entities are responsible for obtaining private matching funds as well as assisting the community and faith-based organizations in seeking private funds. The Compassion Capital Fund also supports and promotes research on "best practices" among charitable organizations.

Mentoring Children of Prisoners. The President recognizes that, as a group, the more than two million children with parents in prison have more behavioral, health, and educational challenges than the population at large. Mentoring by caring adults can brighten the outlook for these children. Therefore, the budget includes $50 million for competitive grants for this purpose.

Promoting Responsible Fatherhood and Marriage. With over 25 million children living in homes without fathers, the Administration seeks to provide $20 million to promote responsible fatherhood and marriage.

Maternity Group Homes. The Administration proposes $10 million to increase support to community-based maternity group homes by providing young, pregnant, and parenting women with access to community-based coordinated services.

Vouchers for Drug Treatment Services. The budget also proposes a $200 million initiative that would provide an additional 100,000 individuals in need of drug treatment with expanded options through vouchers for drug treatment services. This would allow these individuals to determine where they will be served and would provide broader access to drug treatment and social service providers, including those that are faith-based.

Health Centers. Health Centers deliver high-quality, affordable healthcare to over 12 million patients at over 3,500 sites across the United States. As described in the performance volume, evaluations and performance data indicate that the health centers program effectively provides a reliable source of care for low-income and uninsured families. Locally managed health centers offer services that are responsive to the unique needs of their communities.

Hope in the Windy City

Carrie earns her living babysitting for mothers who are working their way off public assistance. She has been a foster parent for over 30 years to seven children, four of whom she has adopted. When her husband died last year, Carrie was left without health insurance. Carrie found care at the Near North Health Service Corporation health center in Chicago, which received an expansion grant last year as part of the President's Initiative. The grant enabled Near North to expand its service capacity and better fulfill its mission to provide care to Carrie and others in need.

Health Resources and Services Administration

The Health Centers Presidential Initiative is creating 1,200 new and expanded health center sites to serve an additional 6.1 million people by 2006. The budget would help

more than one million additional people receive health care in 2004 through 230 new and expanded sites in rural areas and underserved urban neighborhoods.

Innovative Approaches to Drug Treatment. According to the most recent survey by the Substance Abuse and Mental Health Services Administration, nearly 16 million people use illegal drugs. Of these, almost five million individuals struggle with drug dependency and need drug treatment. It is estimated that approximately 100,000 of these people seek treatment but are unable to get help. Effective treatment reduces drug use and the consequences of dependency, like the spread of HIV/AIDS and hepatitis, crime and homelessness. The 2004 Budget proposes $200 million for a new approach to narrowing the treatment gap using vouchers for drug treatment services. The initiative will involve emergency rooms, health clinics, schools, the criminal justice system and other settings to reach out to those in need of drug treatment. Following an assessment of their needs, individuals will be given a voucher and guidance on treatment options, allowing them to determine for themselves where they will best be served. These investments seek to serve an additional 100,000 individuals and are critical to reducing the impact of substance abuse on the nation's youth, families, and communities.

As described in the section on the Faith-Based and Community Initiative, this initiative will seek to broaden access to a wider range of drug treatment and social service providers, including those that are faith-based, to better serve those who often do not respond to traditional drug treatment.

Generic Drugs. The Administration is committed to making prescription drugs affordable for all Americans. The 2004 President's Budget proposes an increase of $13 million for the FDA to improve access to generic drugs. This increase will speed up generic drug reviews to bring lower cost prescription drugs to consumers more quickly. This increase will also support targeted intramural and extramural programs that will expand the range of generic drugs available and help prevent adverse events involving generic drugs.

Medical Malpractice Reform. Medical liability lawsuits can threaten access to health care by adding to the cost of medicine for taxpayers and families and by discouraging health professionals from providing critical services such as child delivery and trauma surgery. Physicians who want to volunteer their time to provide care to low-income populations can be dissuaded from doing so because they fear being sued. Over the next year, the Administration will work with the Congress to address medical liability. One approach proposed in the budget is to protect health centers from using resources, which could be directed to patient care, for excessive non-economic awards.

National Institutes of Health. With the support of the American people and the Congress, the Administration demonstrated its strong commitment to biomedical research by completing a five-year doubling of the NIH budget. As a result of the doubling, NIH now funds nearly 10,000 more research grants than it did before the doubling began—10,000 more ideas that could lead to vaccines, cures, and treatments to improve human health. NIH can now support the training of over 1,500 more scientists each year than it could in 1998. This investment will help ensure there are enough trained professionals ready to turn today's research advances into tomorrow's medical success stories.

New opportunities in bio-defense, cancer, HIV/AIDS and diabetes research require more interdisciplinary research, resulting in a shift in how medical research is funded and conducted. The role of NIH in developing urgently needed new tests and treatments for bioterror weapons will likely produce new insights into the treatment of other diseases. Building on the research momentum fostered by the Administration, the 2004 Budget provides $27.9 billion for NIH. With this investment, NIH will continue to lead the fight to defeat diseases and dangers to public health.

Fighting Global AIDS. The President's Budget continues the Administration's commitment to combat the spread of HIV/AIDS worldwide. In June 2002, the President announced a $500 million Mother and Child HIV Prevention Initiative focused on countries in Africa and the Caribbean

to treat one million women annually, and to reduce mother-to-child transmission of HIV/AIDS by 40 percent within five years. HHS is participating in this initiative by training physicians and supporting voluntary counseling and testing activities, as well as some treatment activities to help prevent the transmission of HIV from mothers to their infants; and to help those who have contracted HIV. Together with the $200 million pledged in 2003, the budget proposes the remaining $300 million ($150 million each for HHS and the U.S. Agency for International Development—USAID) to meet the President's commitment. In addition, HHS Secretary Thompson is a member of the Board of Directors of the Global Fund, and the 2004 Budget proposes to contribute an additional $200 million ($100 million each for HHS and USAID) to the Global Fund to Fight HIV/AIDS, Malaria, and Tuberculosis.

A young girl learns how to use her asthma inhaler.

Improving the Health of the Nation: The Disease Prevention Initiative. Over the past decade, U.S. deaths and disability due to asthma, obesity, and diabetes have increased substantially, and these diseases continue to take a toll on the health of the nation. Diabetes is the sixth-leading cause of death in the United States, with an estimated 17 million sufferers, and the number of cases is increasing by one million per year. The percentage of adults with diagnosed diabetes increased 49 percent between 1990 and 2000. The number of obesity cases is also on the rise. Since 1980, the prevalence of overweight children has nearly doubled and the prevalence of overweight adolescents has nearly tripled. More than 60 percent of adults and 15 percent of children are overweight or obese, and obesity is associated with 300,000 deaths per year. Approximately 26.7 million people have asthma, of whom approximately five million are children. Asthma is responsible for 5,000 deaths, two million emergency department visits, and nearly half a million hospitalizations each year.

In addition to being among the most prevalent and costly health problems facing the nation, these chronic diseases and conditions are also very preventable. Appropriate preventive measures exist that can reduce or delay their occurrence, cost, and severity. Consistent with the President's HealthierUS Initiative, the 2004 Budget proposes an increase of $100 million, for a targeted disease prevention initiative to combat diabetes, reduce rates of obesity, and alleviate the health complications due to asthma. The Centers for Disease Control and Prevention (CDC), in partnership with other HHS agencies, will provide grants to state or community-level partnerships that can effectively reduce the number of deaths and disabilities caused by these diseases. This program will improve integration and coordination across HHS to address these diseases.

Pandemic Influenza. The budget includes $100 million for a new effort to protect the American people against the possibility of pandemic influenza. To ensure the reliability of vaccine production and increase our ability to quickly produce greater quantities of vaccine in the case of a pandemic, some American vaccine production capacity must be converted from the current egg-based methods to cell-based technology. HHS will work with manufacturers to ensure that cell-based vaccine production capacity is established.

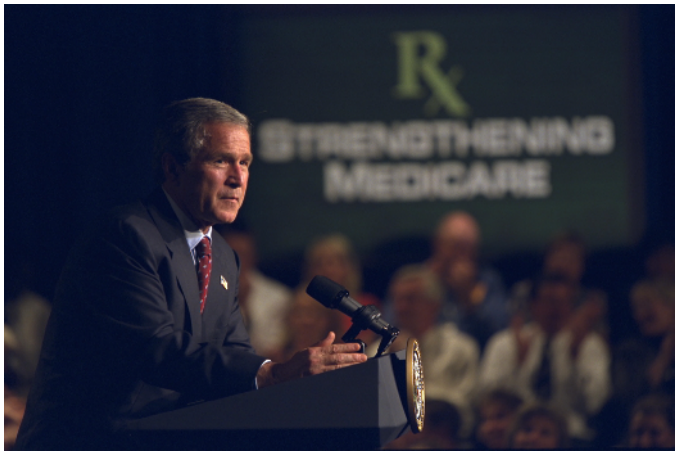
Medicare

Strengthening and Improving Medicare. One of the President's top priorities is to address the problems confronting the Medicare program and make Medicare secure for future generations. In July 2001, the President announced a framework to strengthen Medicare. The President believes any Medicare modernization package should follow these principles.

Principles for Strengthening and Improving Medicare

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

Medicare will spend over $250 billion in 2004 on health care for approximately 41 million senior and disabled citizens. However, the number of elderly and disabled who have insurance coverage through Medicare is not a sufficient measure of the success of the program. In the last 40 years, health care services and delivery have advanced in the private marketplace while the Medicare program has remained in the 1960's.



President Bush speaking about strengthening Medicare.

With its cumbersome structure, the Medicare program is unable to adapt to the changing health care marketplace, let alone be an innovative leader. Medicare's out of date benefit does not provide a prescription drug benefit or catastrophic coverage. Medicare's private plan options are shrinking under the weight of insufficient payments and stultifying regulations. Worse yet, Medicare is not financially secure for the retirement of the Baby Boom generation. As discussed in "The Real Fiscal Danger" chapter of this volume, Medicare has enormous liabilities that put beneficiaries at risk. The actuaries estimate that when we look at the full view of Medicare from a budget perspective, the net liability is $13.3 trillion in net present value terms. This reflects the difference between Medicare payments to the public and Medicare receipts from the public.

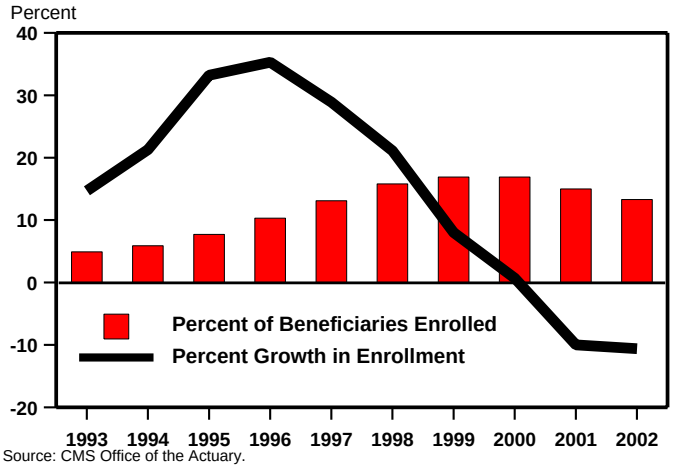
Major Deficiencies in Medicare

Prescription Drugs. Prescription drugs are an increasingly important part of modern medicine, helping to relieve pain, cure disease, and enhance the lives of millions of Americans. Medicare does not cover most outpatient prescription drugs, even though these drugs often replace more expensive hospital care. According to a recent *Health Affairs* study, 22 percent of all seniors surveyed reported going without one or more doses of medication due to costs, with this share rising to 35 percent among those seniors without any drug coverage at all.

Preventive Care. Medicare's coverage of treatments proven to prevent illnesses and save lives is insufficient. For those preventive services Medicare does cover, beneficiaries may face costs in the hundreds of dollars each year in copayments.

Health Plan Options. Medicare+Choice, the program designed to give seniors plan options, including prescription drug coverage, is shrinking due to insufficient payments that bear little relation to increasing health care costs. Where they are available, private plan options give seniors more power. If they are not happy with the service they are receiving, they can simply switch to a different plan. The decline of Medicare+Choice has left beneficiaries with few, if any, health plan options other than the government-managed fee-for-service program.

Medicare+Choice Plan Enrollment



Source: CMS Office of the Actuary.

Cost-Sharing and Catastrophic Coverage. Medicare fails to protect beneficiaries against major out-of-pocket expenditures, hitting the sickest, poorest beneficiaries the hardest. Thus, most beneficiaries must obtain supplemental coverage to fill in Medicare's gaps. Much of the existing supplemental coverage, however, is antiquated and poorly tailored to meet today's health care needs. For example, Medigap—which covers about one-quarter of Medicare beneficiaries—covers a far higher share of the up-front deductibles and cost-sharing than many other private plans, yet few Medigap plans offer prescription drug coverage and even that coverage is thin. According to the U.S. General Accounting Office (GAO), Medicare expenditures for beneficiaries with Medigap insurance were about $2,000 higher than for beneficiaries with Medicare only.

Major Elements of Medicare Modernization. The President's Budget builds upon the President's framework. The budget dedicates $400 billion over 10 years for Medicare modernization including protection against catastrophic costs, better private options for all beneficiaries, and prescription drug coverage.

Providing Access to Prescription Drug Coverage. The drug benefit would protect beneficiaries against high drug expenses and low-income beneficiaries would receive additional assistance. Beneficiaries would have a choice of plans that offer benefits by using some or all of the

Medicare Modernization
(In billions of dollars)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004–2008	2004–2013
Medicare Modernization.....	6	10	33	38	43	46	49	53	58	64	130	400

tools widely available in private drug plans to lower drug costs and improve quality of care. This benefit would support the continuation of the prescription drug coverage that many beneficiaries already receive through employer-sponsored plans and private health insurance plans.

More Choice Through Health Plan Competition. In the short-term, Medicare+Choice's administrative pricing system must be reformed to link plan payments to the rising costs of health care services provided by the plans, particularly prescription drugs. Medicare's coverage will be improved to give beneficiaries the same kind of reliable health care options that all federal employees and many other Americans enjoy. The foundation must be a market-based system in which private plans can bid to provide coverage for beneficiaries at a competitive price. Those beneficiaries who elect a less costly option should be able to keep most of the savings—so in some cases a beneficiary may pay no premium at all.

Modernized Fee for Service. Medicare's benefit package needs to be updated to reflect better the modern-day insurance offered in the private sector. A rationalized system of cost-sharing would end the program's current system of penalizing patients who need acute care. An improved system should also provide catastrophic coverage, ensuring that beneficiaries are protected against high out-of-pocket costs caused by serious illnesses.

A Truthful View of Medicare's Fiscal Status. Given the financial challenges faced by Medicare in the future, the Congress must be extremely careful that legislative changes not add to the long-term unfunded promises faced by the program, which stand at a staggering $13.3 trillion.

Versions of Medicare legislation considered in the 107th Congress would have made progress in expanding beneficiary access to prescription drug coverage, but no bill met the President's principles for strengthening and improving Medicare or did enough to modernize the program for the 21st Century.

Provider Payment Issues. In 2002, Medicare payments to physicians decreased over five percent as a result of a statutorily defined payment formula. The formula would require additional decreases in payments for the next several years. The budget proposes to adjust the physician payment formula for actual data in the current and previous update systems. These adjustments would substantially improve physician payment rates. The Administration will work with the Congress to monitor payment issues for other providers. Credible sources such as the Medicare Payment Advisory Commission (MedPAC) and the GAO have found that many providers are being paid in excess of adequate returns. The Administration will consider how savings from provider payment adjustments could be used to help support a comprehensive Medicare modernization package.

Additional Medicare Improvements

- The Administration will pursue legislation to ensure Medicare more accurately reimburses for covered outpatient drugs, and the cost of administering them.
- Medicare and the Federal Employees Health Benefits Program jointly finance health insurance for about 2.1 million federal retirees and their dependents. The Administration will work with stakeholders to better coordinate these two programs and look to the practices of the private sector to ensure high quality, cost-conscious choices for retirees.
- There is limited information available on the quality of care provided to Medicare beneficiaries nationwide, and many providers struggle to find resources for quality improvement. Today, groundbreaking efforts are underway in the Medicare program to provide public information on the quality of care delivered in hospitals and nursing homes. This information will help consumers make more informed health care choices and enable providers to improve their quality of care. These efforts are part of a larger goal of quality improvement throughout the health care sector.

Centers for Medicare and Medicaid Services (CMS) Program Management. *Medicare Appeals Reform*. The budget includes $129 million for the processing of Medicare appeals. The adjudicative function currently performed by Administrative Law Judges at the Social Security Administration would be transferred to CMS. In addition, the Administration proposes several legislative changes to the Medicare appeals process that would give CMS flexibility to reform the appeals system. These changes will enable CMS to respond to beneficiary and provider appeals in an efficient and effective manner.

Healthy Start, Grow Smart. Infants and toddlers need parents and caregivers who understand the importance of these early years. To help in this goal, the Administration is proposing a new series of booklets called *Healthy Start, Grow Smart*. This monthly guide will be published in both English and Spanish and will be available to parents every month during their baby's first year of life. These booklets provide valuable and age-appropriate information about health, safety, nutritional needs, and early cognitive development that has been proven to help babies thrive. Through the states, HHS will make these pamphlets available to parents with newborns who are receiving Medicaid services.

Medicaid and the State Children's Health Insurance Program

Medicaid. Almost 40 million individuals were enrolled in Medicaid in 2002. Medicaid covers one-fourth of the nation's children and is the largest single purchaser of maternity care and nursing home/long-term care services. The elderly and disabled are one-third of Medicaid beneficiaries, but account for two-thirds of its spending.

State Children's Health Insurance Program (SCHIP). SCHIP was established in 1997 to make available approximately $40 billion over 10 years for states to provide health care coverage to low-income, uninsured children. SCHIP gives states broad flexibility in program design while protecting beneficiaries through federal standards. Approximately 5.3 million children were enrolled in SCHIP programs in 2002.

Both Medicaid and SCHIP rely on state and federal sharing of program expenditures, with the federal contribution based on state per capita income. Total Medicaid spending will be an estimated $311 billion ($177 billion federal share) in 2004. At the beginning of 2003, about $3.2 billion was newly available to state SCHIP programs, in addition to almost $9.7 billion from previous years' allotments. According to HHS, administrative actions and greater state flexibility through waivers have led to more than one million additional people gaining Medicaid or SCHIP coverage since January 1, 2001.

Medicaid and SCHIP Modernization. While states have considerable discretion in designing their Medicaid programs, many states and other stakeholders have complained that the web of Medicaid laws and administrative guidelines is confusing and burdensome, limiting states' flexibility. States frequently request additional flexibility, through waivers, to tailor their public programs to their specific insurance markets, or to expand eligibility to the uninsured beyond the populations they are required by law to cover. The creation of the SCHIP program added further complexity to the already intricate rules for expanding coverage to low-income Americans.

Some see Medicaid as having two distinct purposes and serving two distinct populations: health insurance for children and families, and health insurance and long-term care for certain elderly and disabled people. In addition, states are looking for ways to restructure their Medicaid programs to address the recent growth in program spending at a time when states' revenue sources are low.

Principles for Medicaid and SCHIP Modernization

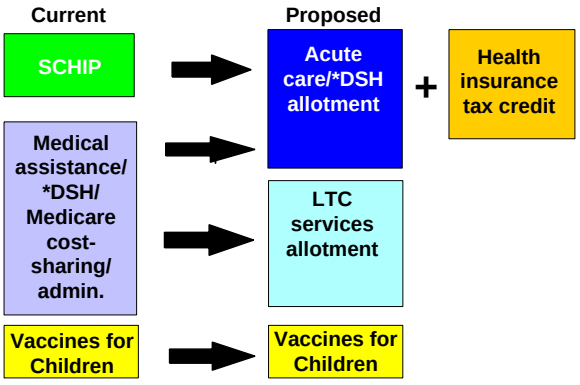
- Provide states the flexibility to design innovative programs without waivers, including increased use of consumer-directed services and home- and community-based care.
- Enhance state capabilities for coordinating with and utilizing the private sector to deliver services.
- Curb the growth of state and federal program costs.
- Simplify the payment policies and rules for these programs.
- Ensure Medicaid and SCHIP funding is clear and accountable to minimize incentives for arbitrary cost-shifting.
- Increase accountability in the state and federal partnership by ensuring that funds are being used to reduce the number of low-income Americans who are uninsured.
- Promote more effective coordination of care for beneficiaries dually eligible for Medicare and Medicaid.

Medicaid has relied on a state and federal matching system for funding: state spending on Medicaid services is matched by the federal government at a state-specific rate. Numerous safeguards have been implemented to ensure fiscal integrity and to avoid abuse of the matching system, but there is often a tension between the states and the federal government over matching payments. For these reasons, the President's Budget proposes State Health Care Partnership Allotments.

In August 2001, the Administration introduced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. HIFA gives states the flexibility they need to design innovative ways to increase access to health insurance coverage for the uninsured, with an emphasis on private health insurance coverage. To date, the Administration has approved seven HIFA demonstrations. Four of these demonstrations use Medicaid and/or SCHIP funds to support enrollment in private employer-sponsored health insurance coverage. (See Update on the President's Management Agenda section of this chapter for the latest scorecard on HIFA.)

Building on the HIFA initiative, the budget proposes to create optional Medicaid and SCHIP allotments for states. Under this proposal, all Medicaid and SCHIP funding would be combined and provided to states selecting this option in two individual allotments: one for acute care and the other for long-term care (LTC). (See the accompanying chart.) States would be allowed to transfer some amount (for example, up to 10 percent) between the Acute and LTC allotments. Under the allotment option, states would be required to provide a specified benefit package for those current Medicaid beneficiaries whose coverage is mandated by current law.

How Allotments Would Change Current Medicaid/SCHIP Funding



*Disproportionate Share Hospital (DSH)

State allotments would be based on 2002 spending, inflated annually by a specified trend rate. States would be required to meet a Maintenance of Effort for spending on Medicaid and SCHIP services, which would increase each year, but at a lower rate than federal growth. States that choose an allotment option would have dramatically broader flexibility in designing health insurance options for low-income, uninsured Americans. As with the HIFA initiative, integration with private insurance options such as premium assistance programs and coordination with any

federal enacted health tax credit would be encouraged. This proposal is designed to be budget neutral over 10 years.

The accompanying table lays out the costs and savings associated with the State Health Care Partnership Allotments option, as well as the budgetary impact of other Medicaid and SCHIP proposals. It is important to note that scoring for both the State Health Care Partnership Allotments and other Medicaid/SCHIP proposals depends on the number of states that take up the option. Generally, the costs and savings associated with the other proposals decrease as more states take up the allotment option.

Medicaid/SCHIP Policies
(In millions of dollars)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004–2008	2004–2013
State Health Care Partnership Allotments	.....	3,258	1,053	1,664	1,213	1,756	2,259	1,759	−153	−4,410	−8,285	8,944	−66
All Other Policies ...	225	154	331	141	117	98	−511	−586	−636	−723	−781	842	−2,396

Again, the use of allotments would be at the state's option. The allotment option assumes that states will be given flexibility in designing their benefit packages, including making it easier to integrate people with disabilities into the community. Therefore, the proposals below that would create new Medicaid demonstrations or fund new or extended coverage apply only to states that do not choose the allotment.

Extending the Availability of 2000 SCHIP Allotments. The Balanced Budget Act of 1997 authorized a capped level of SCHIP funding through 2007. States were given three years to spend their individual allotments. At the end of three years, any unused funds were to be redistributed among states that had spent all of their allotted funds. These redistributed funds were to be available for one additional year, after which any unused funds would revert to the Treasury. An estimated $1.2 billion in SCHIP funds reverted to the Treasury on October 1, 2002, and an estimated $1 billion will revert to the Treasury on October 1, 2003.

The Administration proposes to extend the availability of the allotments set to expire in 2003 for one additional year, until the end of 2004. According to current estimates, extending the SCHIP allotment would allow states to continue coverage for children who are currently enrolled and to continue expanding coverage through HIFA waivers.

As assessed in the Program Assessment Rating Tool (PART), the SCHIP program has been successful in enrolling more than one million new children per year into Medicaid and SCHIP and in decreasing the number of uninsured children in the United States. The goals and management of the SCHIP program will be improved with the implementation of national core performance measures with states and increased financial oversight.

Improving Options for People with Disabilities and Long-term Care Needs. The budget proposes several policies that promote work incentives and home and community-based care options for people with disabilities. These policies build on the New Freedom Initiative announced by the President on February 1, 2001. The New Freedom Initiative is part of a nationwide effort to integrate people with disabilities more fully into society.

New Freedom Initiative. The budget reproposes four demonstrations to promote home and community based care for individuals with disabilities. Two of the demonstrations provide respite care services for caregivers of disabled children and adults. Unrelieved caregiver burden is a major contributing factor to institutionalization of individuals with disabilities; respite care is the service often requested by families to keep a family member with a disability at home. The third demonstration will test the therapeutic effectiveness and cost-effectiveness of providing a home- and community-based alternative to psychiatric residential treatment for children enrolled in Medicaid. The fourth demonstration will test methods to alleviate workforce shortages of direct care workers in the community.


A man tends to his garden.

"Money Follows the Individual" Rebalancing Demonstration. The budget proposes to create a five-year demonstration that finances Medicaid services for individuals who transition from institutions to the community. Federal grant funds would pay the full cost of home and community-based waiver services for one year, after which the participating states would agree to continue care at the regular Medicaid matching rate. This demonstration would also test whether increased use of home and community-based services reduces spending on institutional care, as some advocates believe.

Ticket-to-Work Spousal Exemption. This proposal would give states the option to continue Medicaid eligibility for the spouses of individuals with disabilities who return to work. Under current law, individuals with disabilities might be discouraged from returning to work because the income they earn could jeopardize their spouse's Medicaid eligibility. This proposal would extend to spouses the same Medicaid coverage protection offered to workers with disabilities.

Presumptive Eligibility for Home and Community-based Care Services. The budget proposes to establish a state option enabling Medicaid presumptive eligibility for institutionally qualified individuals who are discharged from hospitals into the community.

Long-term care options. The Administration also plans to explore other options to expand Americans' access to and ability to afford long-term care. The Administration proposals include $40 million in Real Choice Systems Change Grants to provide financial assistance for states to develop systems that support community-based care alternatives for persons with disabilities who require institutional care.

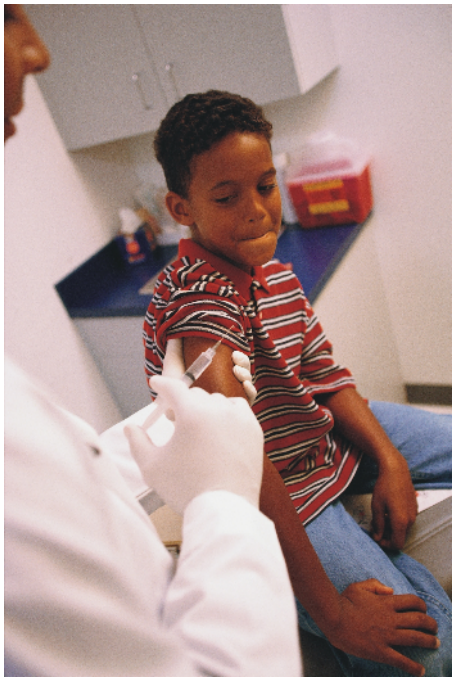
Continuity of Coverage for Special Populations. The budget includes policies to improve or continue health coverage already available through certain programs.

Transitional Medicaid Assistance (TMA). TMA provides health coverage for former welfare recipients after they enter the workforce. TMA extends up to one year of health coverage to families who lose Medicaid eligibility because of employment earnings.

The budget proposes to extend TMA for five years with statutory modifications, including a state option to eliminate TMA reporting requirements and provide 12 months of continuous eligibility regardless of changes in families' financial status. In addition, the budget proposes a waiver of the TMA requirement for states that currently provide health benefits for families at 185 percent of the federal poverty level, which is the statutorily mandated income eligibility level. Finally, there will be an option to allow TMA recipients to purchase private health insurance. These changes will allow for consistent enrollment of TMA beneficiaries while easing the administrative burden on states.

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

Premium Assistance for Low-income Medicare Beneficiaries. Medicare Part B premiums are just over $700 per beneficiary ($58.70/month) in 2003, a substantial amount for low-income individuals. The Administration proposes that Medicaid continue to pay Part B premiums for five years for individuals whose income is between 120 and 135 percent of poverty. States would continue to receive a 100 percent federal match for these benefits.



Through the VFC Program this young child receives his vaccination shot.

Vaccines for Children (VFC). The VFC program provides free vaccine to certain categorically-eligible children: Medicaid recipients, the uninsured, American Indians and Native Alaskans, and the underinsured. VFC covers all routinely recommended childhood vaccines, including measles/mumps/rubella, chicken pox, and polio.

The Administration is proposing legislation to change two provisions of VFC to improve access. First, the Administration proposes to lift the price cap on the tetanus-diphtheria booster, which will facilitate its availability at no cost to VFC-eligible children. Second, the Administration is proposing to allow underinsured children to receive VFC-funded vaccine at state and local health departments, rather than only at Federally Qualified Health Centers and Rural Health Centers, as is currently required.

Because VFC is administered separately from Medicaid and SCHIP, these proposals would apply to states that choose the allotment option and also to those that do not.

Prescription Drugs in Medicaid

Medicaid Drug Coverage and Payment. Pharmaceutical manufacturers must pay a rebate, shared between the states and federal government, on prescription drugs dispensed to Medicaid beneficiaries. Under current law, this rebate equals the larger of 15.1 percent of the Average Manufacturer Price (AMP) or the difference between AMP and the manufacturer's best price.

Over the past year, it has become evident that the best price component of the rebate can be confusing, as it is not always clear which prices a manufacturer must include when calculating and reporting to CMS its best price. In addition, best price may serve to limit the discounts that private-sector purchasers are able to negotiate with pharmaceutical manufacturers. The Administration is interested in exploring with the Congressional Committees of jurisdiction policy options in this area that would improve the Medicaid drug pricing and reimbursement system and generate program savings.

Pharmacy Plus Waivers. The 2003 Budget included the Pharmacy Plus initiative, through which states are encouraged to expand Medicaid drug-only coverage to low-income senior citizens and people with disabilities. Since the 2003 Budget was transmitted to the Congress, HHS has approved

five Pharmacy Plus waivers and more waivers are pending. Pharmacy Plus is part of the Administration's overall strategy to assist Medicare beneficiaries with drug spending before a drug benefit is available to all beneficiaries as part of a modernized Medicare program. Pharmacy Plus waivers are available to states for the elderly and those with disabilities with incomes below 200 percent of the poverty level and must be budget neutral over the life of the waiver.

Medicaid/SCHIP Program Integrity. One of the Administration's continuing priorities for the Medicaid and SCHIP programs is ensuring their fiscal integrity. The Administration has already made considerable progress in Medicaid/SCHIP program integrity. The 2004 Budget proposes to build upon this success.

Enhancing Medicaid and SCHIP Program Integrity. In 2004, HHS will devote more resources to Medicaid and SCHIP program integrity. This effort will include increasing the number of audits and evaluations of state Medicaid programs, reestablishing and elevating the importance of financial management oversight at CMS and outsourcing appropriate activities to private firms. In addition, HHS will develop a methodology to measure Medicaid and SCHIP improper payments, including producing error rates. The budget proposes to allocate $20 million in Health Care Fraud and Abuse Control funding in 2004 to help finance this initiative.

Upper Payment Limits. Regulations issued over the past two years have curtailed the use of the Upper Payment Limit, through which some states were able to draw down federal matching funds without putting up state dollars and to redirect Medicaid funding to non-Medicaid programs and purposes. The Administration will continue to monitor this issue and propose regulations as necessary.

Health Care Tax Credits

The Administration again proposes tax policies that will facilitate individuals' purchase of health insurance and health care, including long-term care. These proposals are discussed in detail in the Tax Expenditures chapter of the *Analytical Perspectives* volume.

Reforming Welfare

Welfare Reform Reauthorization. In 1996, the Congress passed legislation to create the Temporary Assistance for Needy Families (TANF) program, replacing Aid to Families with Dependent Children and related welfare programs. Considered one of the most successful federally funded domestic programs in decades, TANF is a $16.7 billion a year block grant with bonuses for performance. States have significant flexibility in designing the eligibility criteria and benefit rules for their TANF programs, which require and reward work in exchange for time-limited benefits.

The Administration reproposes its plan to extend TANF, which expired on September 30, 2002. The Administration's plan maintains funding, strengthens work participation requirements, supports healthy marriages and family formation, and provides a more accessible contingency fund.

Strengthening Programs for Children. To better serve vulnerable children, the President's Budget is proposing reforms to several programs within the Administration for Children and Families.

Head Start. The Administration's Good Start, Grow Smart initiative has made modest progress in improving Head Start to date, by sharpening the focus on school readiness, improving teacher training and mandating a system to assess the success of Head Start programs in preparing children for school. However, Head Start is only a piece of an uncoordinated and overlapping puzzle of federal, state and local programs that are failing to meet the social and academic needs of pre-school age children, particularly those most disadvantaged economically. To address this problem, the President's plan will provide states with the opportunity to exercise more control over Head Start, so that they

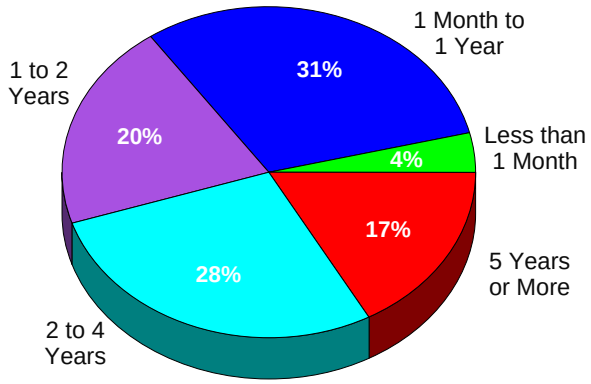
can better coordinate with state pre-school and other preparatory programs. In addition, the President plans to move responsibility for managing the Head Start program from HHS to the Department of Education. Under the President's plan, 2004 would be a transition year during which HHS would continue to manage the program. The Department of Education would assume full responsibility for the Head Start program in 2005.

The proposed changes reflect the problems identified in the Head Start PART. The Good Start, Grow Smart initiative provides a mechanism to assess the performance of Head Start programs and address the lack of coordination among early education and care programs.

Promoting Safe and Stable Families. To fortify states' ability to strengthen families and to promote child safety, permanency, and well-being, the budget maintains the large increase in funding over 2002 enacted levels to $505 million. This program also helps to promote adoption and provides post adoption support to families.

Education Assistance for Older Foster Children. The budget includes $60 million in the Foster Care Independence Program to help older foster care youth transition to adulthood and self-sufficiency after leaving foster care. This initiative would provide vouchers of up to $5,000 for education or vocational training to help youth aging out of foster care develop the skills to lead independent and productive lives.

Average Length of Stay in Foster Care



Source: Adoption and Foster Care Analysis and Reporting System, interim FY 2000 data.

Child Welfare Program Option. The President's Budget includes a new legislative proposal to introduce an option available to all states to participate in an alternative financing system for child welfare that will better meet the needs of each state's foster care population. States choosing to participate will face fewer administrative burdens and will receive funds in the form of flexible grants. This will serve as an incentive to create innovative child welfare plans with a stronger emphasis on prevention and family support, and increased flexibility in services provided and population served.

State flexibility will be coupled with accountability—by holding states to high standards of performance—to ensure the best outcomes regarding safety, permanency, and well-being for vulnerable children and their families. Participating states will be required to continue to: maintain the child protections outlined in the Adoption and Safe Families Act, agree to maintain existing levels of state investment in child welfare programs, and conduct an independent third party evaluation of their programs.

Child Support Enforcement. The President's Budget re-proposes the child support provisions in the TANF reauthorization proposal. In addition, the Administration has developed a package of proposals to increase the government's ability to collect child support more effectively through state and tribal participation. The package includes proposals to streamline current data-matching and introduce new efforts for seizing child support payments. It also increases funding for visitation programs, which include counseling and mediation services between non-custodial parents and their children.

Child Support Enforcement Aggressively Pursues Gambling Proceeds

In 2000, gambling earnings of $25 billion were reported on over six million tax forms. These earnings are likely to be a significant source of untapped income for recovery of overdue child support. Under a new initiative, the Administration would expand current income intercept opportunities for payment of delinquent child support (as is now done for lottery winnings) to include winnings from other gaming sources (such as casinos, keno and jai alai). To execute this proposal, a secure federal website would be developed that would match data in HHS's database of delinquent child support debtors with gambling winners' information. If the gambling winner is shown to be delinquent in paying child support, winnings will be withheld and distributed to the family. This proposal may deter delinquent parents from gambling, and also would encourage payment of timely child support and responsible parenthood. It is estimated that an additional $709 million would be collected for families over five years.

Department of Health and Human Services

Enhancing Public Health

Indian Health Service. The 2004 Budget will invest in Indian Health Service (IHS) health infrastructure and prevention activities with the goal of improving the health status of American Indians and Alaska Natives. PART findings discussed in the *Performance and Management Assessments* volume support continued investment in these areas. The Administration will invest in staffing and related operating costs for new IHS facilities that will begin to serve patients, and increase funding for the construction of sanitation facilities so that IHS can increase services to the neediest homes in its inventory. The Administration also proposes to increase funding for the Special Diabetes Program for Indians for prevention activities, and increase funding for specialty health care, not available through IHS or tribal providers, to reduce the number of claims denied after these funds have been exhausted.

Ryan White HIV/AIDS Program. The Ryan White HIV/AIDS program is a comprehensive approach to ensuring medical care, provision of antiretroviral treatments, counseling and testing, and home health care for people living with HIV/AIDS. With improved drug treatments, care, and support, there has been a steady increase in the number of people living longer with HIV/AIDS. The Administration supports funding for prevention, treatment and care, and is working to ensure funds are used effectively and in communities that are most impacted by HIV/AIDS. The 2004 Budget includes a $100 million increase for the Ryan White AIDS Drug Assistance Program (ADAP) to help purchase drug treatments for those living with HIV/AIDS. These additional resources for state ADAPs will provide services for an additional nearly 9,200 people.

Health Care Providers. The budget includes a $23 million increase for the National Health Service Corps to broaden access to health care by directing doctors and other health care professionals into medically underserved areas. It will increase efforts to recruit underrepresented minorities and other students and health professionals from disadvantaged backgrounds for participation in the program. The budget also proposes to improve the placement of foreign physicians who seek to provide care to rural and other underserved areas following completion of their training.

The 2004 Budget also proposes to redirect resources from health professions grants for advanced nursing to the Nursing Education Loan Repayment and Scholarship Program, which provides education loan repayments and scholarships to registered nurses in exchange for a commitment to serve in health care facilities with too few nurses. The advanced nursing grants do not address the overall basic nursing shortage.

Breast and Cervical Cancer Screening and Treatment. Detecting and treating breast and cervical cancer early continues to be an Administration priority. The Centers for Disease Control and Prevention's (CDC's) breast and cervical cancer program supports screening services for low-income, underinsured, or uninsured women between the ages of 50 and 64 years, and has provided over 3.5 million screening tests to over 1.5 million women. The budget proposes a $10 million increase for the breast and cervical cancer program, in addition to the $9 million increase requested in 2003. Overall, these funding increases would support an additional 61,000 screenings, which would improve access to these critical health services. Through the Medicaid program, almost every state has expanded health coverage for breast cancer treatment to uninsured women who are screened under CDC's program.

Improving Health Care Quality and Safety. The 2004 Budget continues the President's commitment to improve the quality of healthcare and patient safety in health care settings. The budget proposes $84 million in the Agency for Healthcare Research and Quality for patient safety activities to test and develop new interventions that may be reproducible across health care systems. The patient safety total includes a new $50 million initiative to demonstrate hospital-based information technology solutions, including an emphasis on small community and rural hospitals. These activities are complemented by Medicare incentives to reward hospitals that provide information on quality of care. They are also complemented by new FDA safety initiatives to use modern health information systems to provide faster and more complete information on safety problems involving drugs and devices, so that adverse events involving these products can be avoided.

Social Service Program Reforms. The President's Budget seeks to promote the economic and social well-being of children, youth, the elderly and families. To help low- income households cover home heating and cooling costs, the budget provides $2 billion. This amount includes a contingency fund of $300 million for unanticipated needs that may arise. The Homeland Security Act transfers authority for the care and placement of unaccompanied alien children from the Department of Justice's Immigration and Naturalization Service to HHS. Along with the transfer of authority, the Homeland Security Act requires a stronger focus on the appropriate treatment of these children. HHS and the Department of Justice will coordinate efforts to complete the transfer of responsibilities in a manner that fully protects the interests of the children.

The President's Budget proposes to fund the Community Services Block Grant (CSBG) at $495 million for 2004, a $75 million reduction from the 2003 President's Budget request level of $570 million. The CSBG program provides funding to a largely static group of organizations, called Community Action Agencies (CAAs). CSBG funds provide only a small part of these organizations' budgets, and it is unclear what outcomes are produced as a result of federal funds. When CSBG is reauthorized, the Administration intends to develop a set of performance measures to be consistently applied by all states and CAAs to ensure program outcomes and accountability. If reformed, the Administration will again assess the appropriate level of direct federal investment.

The 2004 President's Budget provides $1.3 billion for Administration on Aging programs. This level includes an increase of $2.8 million over the 2003 Budget level to fund the White House Conference on Aging. The 2004 Budget also continues the proposal to merge the Administration on Aging's nutrition programs for the elderly with the Department of Agriculture's Nutrition Services Incentive Program.

Performance Evaluation of Select Programs

The PART was used to evaluate 31 different HHS programs. The accompanying table displays selected programs and their assessments. For more information, see the *Performance and Management Assessments* volume.

Program	Rating	Explanation	Recommendation
IHS Sanitation Facilities Construction Program: providing potable water and waste disposal facilities for American Indian/Alaska Native Homes	Moderately Effective	The purpose is clear and the program uses sound management practices. The program uses performance information for planning and management and has effective cost control and audit functions. The program has not been subjected to a recent cost benefit analysis or comprehensive evaluation.	$20 million increase in funding, so that the program can serve more of the neediest homes in its inventory and conduct an independent, comprehensive evaluation of the program.
Health Centers: providing high quality care to underserved populations	Effective	The purpose is clear and the program is well managed. Evaluations, reports, and performance measures indicate the program's positive impact. The program is hampered by growing tort claim liabilities and did not plan for this rapid growth.	$169 million increase; improve oversight of malpractice claims, and explore further opportunities to collaborate in substance abuse and other areas.
Substance Abuse Treatment Programs of Regional and National Significance	Adequate	Program is well managed, but has not used performance information to improve outcomes. A 1997 evaluation found drug treatment grants were effective. No evidence supports the impact of research related activities. The program lacks data on new measures.	$200 million increase for a new approach to expanding treatment through vouchers for services, redirect resources from research to services and increase support for a survey of drug treatment outcomes.

Program	Rating	Explanation	Recommendation
Domestic HIV/AIDS Prevention: providing leadership on HIV/AIDS prevention through surveillance, applied research, and grants to state health departments and community-based organizations.	Results Not Demonstrated	The program purpose is clear, the program has had regular comprehensive evaluations and developed new annual performance goals, but the new goals lack data to indicate progress. The estimated annual number of new HIV infections has not declined and has remained at 40,000 for much of the past decade. The program's long-term outcome goals should be consistent with its budget. The program has also had difficulty with inappropriate spending by some of its grantees.	Maintain funding to continue to address the estimated 40,000 new infections, especially among minorities and women.
National Health Service Corps: placing health professionals in underserved areas	Moderately Effective	The purpose is clear and the program is well managed. Evaluations and reports indicate the program is effective at increasing health care access.	$23 million increase to place more doctors and other health professionals in areas facing a shortage of health providers and increase recruitment of minorities and others from disadvantaged backgrounds into the program.
Maternal and Child Health Block Grant: providing assistance to states and communities to improve the health of all mothers and children, reduce infant mortality, and provide access to comprehensive pre-and post-natal care	Moderately Effective	The program purpose is clear and has had a significant impact on the health of mothers and children. The program regularly collects timely and credible performance data and uses this information for planning and management. The Block Grant has not undergone a comprehensive evaluation.	$19 million increase to support the program's strong performance and to ensure continued efforts to improve the health of mothers and children.

Common Measures

Health Common Measure

A powerful way of evaluating and improving program performance is to develop common measures for programs with similar goals. This year, the federal government developed common measures regarding the effectiveness and efficiency of similar programs in different departments. The 2004 Budget takes the first step toward comparing the performance of federal health care systems by displaying newly developed access, quality, and efficiency common measures for HHS' Health Centers and the IHS and the Departments of Veterans Affairs' and Defense's health systems. IHS provides both inpatient care as well as routine and emergency outpatient care while Health Centers provide primary and prevention health care on an outpatient basis. Health Centers and the IHS serve

low income/minority populations and American Indian and Alaska Native (AI/AN) populations, respectively. As illustrated in the accompanying tables, the Health Centers and IHS serve primarily women and individuals under age 30. These populations face higher rates of diseases including diabetes, heart disease, HIV/AIDS and cancer and have a lower life expectancy than the general population. For example, death due to alcoholism is seven times higher and death due to diabetes is four times higher for AI/ANs.

The 2004 Budget analysis considered the most recently available data for these programs and displays the results in each Department's budget chapter. The accompanying common measures table displays, for the two HHS programs, the average cost of patient care, provider appointments for outpatient visits, and the quality of care for those with diabetes. It is important to compare similar programs in the proper context, ensuring comparability of the data. In the future, measures will be further refined and displayed together.

Overview of Health Centers and the IHS Health Care Systems—2004 Budget

(In millions of dollars)

	Health Centers	IHS
Number of individual patients	13,750,000	1,236,000
Male and female individual patients (percent)	59% (Female) 41% (Male)	54% (Female) 46% (Male)
Average age of individual patients	30	23
Cost directed to in-house services, excluding contract service (percent)	—	50%
Number of medical workers	10,800	1,392
Annual appropriations request (in millions of dollars)	1,627	2,890

Health Care Common Measures

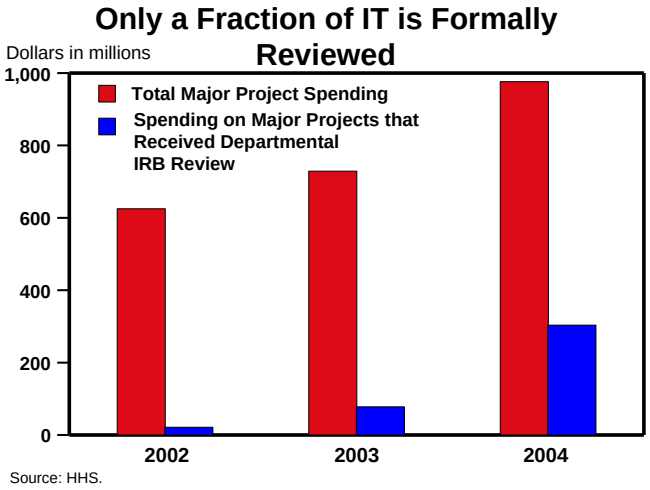
Common Measures/Description	Goal	Health Centers		IHS	
		2001 Actual	2002 Estimate	2001 Actual	2002 Estimate
Cost—Average cost per individual (total federal and other obligations)	New in 2005 Budget	$448	$467	$2,721	$2,828
Efficiency—Annual number of outpatient appointments per medical worker	New in 2005 Budget	3,528	3,475	2,955	2,955
Quality—The percentage of diabetic patients who received a blood sugar level test (HbA1c) in the past year	New in 2005 Budget	74.8%	75.0%	95.0%	95.0%

Note: Medical workers include the equivalent number of full-time and part-time physicians, physician assistants, dentists, nurse practitioners, and nurse-midwife providers. The IHS level also includes non-medical spending such as community water and sewer, and environmental health. Health Center diabetes data are only collected from the 40 percent of grantees that are participating in a health disparities initiative.

Rural Water Common Measures

The 2004 Budget also compares the rural water activities of HHS' Indian Health Service, the Department of the Interior's Bureau of Reclamation, the Department of Agriculture's Rural Utilities Service, and the Environmental Protection Agency. See the Department of the Interior chapter for further information on this initiative.

Update on the President's Management Agenda



Source: HHS.

HHS faces major management challenges in administering a dozen separate operating divisions that are spread over vast geographical distances and cover an enormous variety of programs. Key priorities in meeting these challenges are using information technology (IT) more effectively and streamlining organizational structures to create One HHS.

Information Technology . The largest grant-making agency in the federal government, HHS has led the government-wide E-Grants initiative aimed at creating online citizen access to grant program forms and information. HHS is also leading the government-wide Consolidated Health Informatics initiative, focused on improving healthcare quality by formulating health data standards. To improve IT management, HHS will expand Department-wide oversight of IT projects to strengthen capital planning and eliminate low-priority and duplicative investments.

Organizational Restructuring . HHS consolidated 40 human resources offices into seven units in 2002, and continues to streamline and consolidate administrative functions across the Department. Improved coordination of these activities will create management efficiencies and cost savings, and will advance the Department toward its One HHS goal.

	Human Capital	Competitive Sourcing	Financial Performance	E-Government	Budget and Performance Integration
Status					
Progress					

HHS has established internal accountability standards to strengthen management agenda efforts. The Department has consolidated duplicative administrative offices, implemented new recruitment programs to address its human capital challenges, and competitively sourced commercial functions such as cleaning services, building maintenance, clerical support, and IT development. A comprehensive financial management corrective action plan has been implemented to resolve internal control weaknesses, and HHS is preparing to measure error rates in state-administered benefit programs such as Head Start, Foster Care, Child Care, TANF, and SCHIP. To advance E-Government, HHS is focused on strengthened HHS management of Enterprise Architecture, IT capital planning and investment control, and IT security. The E-Grants initiative has progressed toward its goal of a single portal for federal grants applications, and the Consolidated Health Informatics initiative is close to creating its first new federal health data standards. In integrating budgeting with performance, HHS has accomplished a notable increase in its number of reportable national health outcome measures and will hold managers accountable for results through performance-based employment contracts.

Initiative	Status	Progress
Broadened Health Coverage Through State Initiatives		
Faith-Based and Community Initiative		

Arrow indicates change in status since baseline evaluation on June 30, 2002.

Broadened Health Coverage Through State Initiatives. The HIFA demonstration initiative emphasizes integration of Medicaid, SCHIP, and private health insurance coverage options to reduce the number of uninsured. Seven HIFA demonstrations have been approved to date. Four of these demonstrations (New Mexico, Maine, Illinois and Oregon) use Medicaid and/or SCHIP funds to support enrollment in employer sponsored health insurance coverage. An evaluation of HIFA demonstrations will be performed by the Urban Institute in 2003.The Administration has also encouraged states to apply for Pharmacy Plus demonstrations to extend Medicaid drug-only coverage to certain low income elderly or disabled. Five Pharmacy Plus demonstrations have been approved (Illinois, Wisconsin, Maryland, South Carolina, and Florida) which promise to provide pharmacy coverage to as many as 750,000 low-income elderly.

Faith-based and Community Initiative. HHS has made substantial progress in identifying and eliminating regulatory and administrative barriers to the full participation of grassroots faith-based and community organizations (FBO/CBOs) in the delivery of services. In response to audits conducted by the Department's Center for Faith-Based and Community Initiatives, HHS has improved outreach to FBO/CBOs by establishing 1–800 numbers, streamlining web-based access and providing single points of contact in key agencies. Training initiatives are giving small and novice grantees the tools to compete for grants. HHS is also making strides in implementing a series of pilot projects to test innovative ways to improve program services by involving FBO/CBOs. Because the majority of HHS-funded social service programs are administered by states, a major challenge facing the initiative is ensuring that FBO/CBOs have a level playing field to compete for the opportunity to provide these services.

Department of Health and Human Services

(In millions of dollars)

	2002 Actual	Estimate	
		2003	2004
Spending			
Discretionary Budget Authority:			
Food and Drug Administration	1,368	1,385	1,406
Program Level	*1,552*	*1,671*	*1,713*
Health Resources and Services Administration	6,122	5,383	5,679
Indian Health Service	2,758	2,817	2,889
Program Level	*3,386*	*3,458*	*3,582*
Centers for Disease Control and Prevention	4,404	4,243	4,230
Program Level	*4,427*	*4,291*	*4,283*
National Institutes of Health	23,182	27,244	27,742
Program Level	*23,279*	*27,344*	*27,892*
Substance Abuse and Mental Health Services Administration	3,136	3,195	3,393
Program Level	*3,136*	*3,195*	*3,409*
Agency for Healthcare Research and Quality	3	—	—
Program Level	*300*	*250*	*279*
Centers for Medicare and Medicaid Services [1]			
Program Administration	2,369	2,417	2,533
MedPAC/OCR/GDM/AHRQ Administration	22	18	18
Administration for Children and Families	13,057	13,080	13,449
Administration on Aging	1,200	1,341	1,344
Office of the Inspector General	36	40	39
Office of the Secretary	364	369	380
Program Support Center Legislative Proposal	—	—	13
Public Health and Social Services Emergency Fund	1,671	1,807	1,898
Total, Discretionary budget authority [2]	59,692	63,339	65,013
Mandatory Outlays:			
Medicare			
Existing law	224,786	237,926	246,040
Legislative proposals	—	50	6,055
Medicaid/SCHIP			
Existing law	151,204	167,154	181,909
Legislative proposals	—	175	3,356
All other programs			
Existing law	32,505	34,019	34,097
Legislative proposals	—	3	154
Total, Mandatory outlays	408,495	439,327	471,611

[1] Amounts appropriated to the Social Security Administration (SSA) from HI/SMI accounts are included in the corresponding table in the SSA chapter.

[2] Includes $1.6 billion in 2002 supplemental funding.