# DEPARTMENT OF HEALTH AND HUMAN SERVICES

**AT A GLANCE:**

**2006 Discretionary Budget Authority:** $67.2 billion
(Decrease from 2005: 1 percent)

**Major Programs:**

- Medicare
- Medicaid
- State Children's Health Insurance Program
- Health Centers
- Marriage and Healthy Family Development
- Bioterrorism
- Health Care Information Technology

## MEETING PRESIDENTIAL GOALS

### *Promoting Economic Opportunity and Ownership*

- Promoting national health care information technology, with the goal of most Americans having an electronic health record with proper medical privacy protection by 2014.
- Proposing a comprehensive, consumer-driven plan to address the problems of rising health care costs and the uninsured. This plan includes: Health Savings Accounts; Association Health Plans; tax credits; and medical liability reform.

### *Protecting America*

- Strengthening the Nation's preparedness against bioterrorism, through biodefense research and development, biosurveillance early warning systems, hospital and public health preparedness, and defense against intentional contamination of the Nation's food supply.
- Improving the ability to respond to bioterrorism through a new initiative to improve mass casualty care after a catastrophic incident, and augmenting the Strategic National Stockpile of pharmaceuticals and other medical supplies.

### *Supporting a Compassionate Society*

- Ensuring access through Health Centers to high-quality primary and preventative health care for low-income individuals.

## MEETING PRESIDENTIAL GOALS—Continued

- Helping healthy families through initiatives that support marriage, provide assistance to parents, and encourage the development of family-support programs run by community organizations.
- Strengthening and modernizing health care and offering drug coverage for approximately 42 million senior citizens and persons with disabilities through the Medicare program.
- Providing quality health care in a cost-efficient manner to over 46 million low-income individuals, elderly individuals, and individuals with disabilities through the Medicaid program.
- Providing health care coverage to a total of approximately 5.8 million low-income, uninsured children through the State Children's Health Insurance Program.
- Proposing a health insurance tax credit so that millions of Americans will have access to affordable health care.
- Enrolling as many uninsured, eligible children as possible into Medicaid and the State Children's Health Insurance Program through the President's Cover the Kids proposal.

### *Making Government More Effective*

- Developing additional decision support tools at the National Institutes of Health to improve the management of its large and complex scientific portfolio and to better integrate research across its 27 Institutes and Centers.
- Strengthening Medicare program integrity by preventing overpayments, accelerating contractor reform, and rationalizing payments for bad debt.
- Increasing efficiency and lowering costs for Medicaid prescription drugs.
- Proposing to build on past efforts to improve efficiencies and the fiscal integrity of Medicaid and State Children's Health Insurance Program.

# PROMOTING ECONOMIC OPPORTUNITY AND OWNERSHIP

## *Health Information Technology*

The Administration is strongly committed to advancing quality, consumer-driven health care and encouraging collaboration and productivity in the medical services sector. The newly created Office of the National Coordinator for Health Information Technology (HIT) at the Department of Health and Human Services (HHS) coordinates Federal efforts across many initiatives and activities, including:

- Advancing the adoption of HIT by physicians, hospitals, and other providers;
- Implementing electronic prescriptions as mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;
- Developing models for the exchange of Electronic Health Records (EHRs) and other health data nationally and with proper medical privacy protection; and
- Identifying standards and the mechanisms for broad adoption of EHRs.

The 2006 Budget includes $125 million to continue progress in this area, including $75 million in the Office of the Secretary to foster collaboration and develop the conceptual framework and infrastructure for a nationally interoperable HIT network that would interconnect clinicians, personalize care, and improve public health surveillance.

## *Promoting Affordable Health Care*

Rising health costs are an impediment to job and wage growth. When health care costs rise, employers have less to spend on new employees, or on salaries for their existing employees. Rising health care costs impose a burden on families and small businesses and put coverage out of the reach of many Americans. Many businesses—particularly small firms—are struggling with these rising costs. According to the Census Bureau, 45 million people lacked health insurance coverage in 2003, including 8.4 million children.

The President has proposed a comprehensive, consumer-driven plan to address the problems of rising health care costs and the uninsured. His plan includes: Health Savings Accounts (HSAs); Association Health Plans (AHPs) for small businesses, civic groups, and community organizations; tax credits for low-income families; medical liability reform; and electronic health records for all Americans within 10 years.

The President's plan will help reduce the rising cost of health care while improving quality and safety. It will provide new and affordable health coverage options for all Americans—targeted to those who need it most: low-income children and families; employees of small businesses; and the self-employed.

*Health Insurance Tax Credit*. The President proposes a tax credit that will help individuals purchase health insurance and health care. The proposal provides greater choice of insurance products and encourages saving for future health expenses. Individuals under age 65 who are not enrolled in public or employer-sponsored health plans would be eligible. The credit would be refundable and could be paid in advance directly to the health plan. The amount of the credit would depend on an individual's income level. The credit would phase out at incomes of $30,000 for an individual and $60,000 for a family.

## PROMOTING ECONOMIC OPPORTUNITY AND OWNERSHIP—Continued

- *Traditional Health Insurance Tax Credit*. With this option, the credit would pay for 90 percent of the cost of the premium of standard coverage, up to a maximum of $1,000 for an individual, and $3,000 for a family of four.
- *Health Insurance Tax Credit with HSA*. This modification would allow individuals to use a portion of the credit (up to $2,000 for a family of four; $700 for an individual) to purchase a high-deductible health plan while putting the remaining portion of the credit (up to $1,000 for a family of four; $300 for an individual) in an HSA. The money in the HSA belongs to the individual and can be used to pay for medical expenses. Unspent funds from one year would roll over for use in the following year.

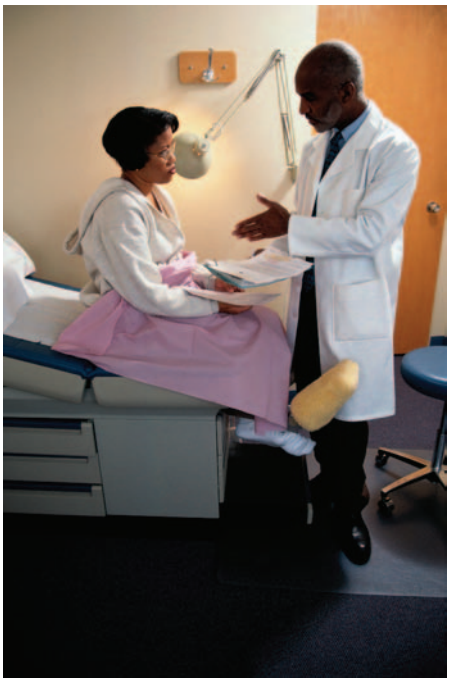
*State Purchasing Pools.* To help low-income individuals purchase coverage with the health insurance tax credit, the Administration proposes providing $4 billion in grants to States to establish purchasing pools. By combining the purchasing power of individuals and families, these pools would offer tax-credit recipients an additional affordable health insurance option and would make it easier and faster to shop for coverage.

*Cover the Kids*. Despite the availability of health care coverage through Medicaid and the State Children's Health Insurance Program (SCHIP), millions of children eligible for these programs have not enrolled. The 2006 Budget proposes Cover the Kids, a national outreach campaign that will provide $1 billion in grants over two years. By combining the resources of the Federal government, States, schools, and community organizations, Cover the Kids aims to enroll as many Medicaid- and SCHIP-eligible children as possible.

*Above-the-Line Deduction for Certain Health Insurance Premiums*. Under this proposal, all individuals who purchase a high-deductible health plan in conjunction with a health savings account would be allowed to deduct the amount of the health plan's premium from their taxable income even if they do not itemize their deductions. This new deduction would make high-deductible health plans more affordable.

*Rebate to Small Employers Contributing to Employees' HSAs*. To encourage small employers to contribute to their employees' health savings accounts, the Administration proposes a refundable tax credit. Small employers would receive a tax credit of up to $500 per employee with family coverage and $200 per employee with individual coverage.

*Association Health Plans (AHPs).* The Administration proposes creating AHPs to make available new affordable health insurance policies. Under this proposal, small employers, civic groups, and community organizations can band together and use their purchasing power to negotiate lower-priced coverage for their employees, members, and their families. Previous proposals have limited AHPs to small businesses. This proposal applies not only to small businesses but also to private, non-profit, multi-State entities outside the workplace.



*Medical Liability Reform*. Reforms to medical liability law will increase access to quality, affordable health care for all Americans, while reducing frivolous and time-consuming legal proceedings against doctors and health care providers. The lawsuit burden is driving good doctors out of local communities across the country and raising health care costs for all. Reforming the medical liability system and providing a fair, predictable, and timely medical liability process will improve access to quality health care and reduce health care costs.

*National Marketplace for Health Insurance*. Because individuals can purchase health insurance only in the State in which they live and cannot shop for more affordable coverage in other States, competition among insurers is limited by State boundaries. The Administration proposes creating a competitive marketplace across State lines that maintains strong consumer protections. This new marketplace would allow individuals the freedom to shop for the best buy on health coverage that most effectively meets their needs, and would increase the availability of affordable health coverage.

# PROTECTING AMERICA

*Armed with a single vial of a biological agent small groups of fanatics, or failing states, could gain the power to threaten great nations, threaten the world peace. America, and the entire civilized world, will face this threat for decades to come. We must confront the danger with open eyes, and unbending purpose.*

President George W. Bush
February 11, 2004

## *Strategic National Stockpile*

The Strategic National Stockpile contains drugs, vaccines, and other medical supplies and equipment that can be delivered anywhere in the country within 12 hours of a request for assistance. The Stockpile currently contains enough smallpox vaccine for every American, treatments for anthrax, countermeasures for injuries following a chemical, radiological, or nuclear incident, and treatments for conventional explosive attacks. The 2006 Budget provides additional funding to improve the Nation's ability to respond to biological and chemical weapons attacks with life-saving treatments and supplies, including additional antibiotics to treat anthrax, nerve agent treatments, and chemical countermeasures through the Chempack program. The Budget also includes increased funding for the storage and maintenance of next-generation countermeasures, including a new anthrax vaccine purchased through the President's newly enacted Project BioShield.

## *Biodefense Research and Development*

The Budget continues to invest heavily in research and development that will lead to new countermeasures against the most dangerous threat agents, including those that have been genetically manipulated. Within the 2006 Budget's nearly $29 billion for the National Institutes of Health (NIH), the Administration will continue to fund biodefense research and development activities at $1.8 billion. This includes $50 million for chemical countermeasure development and $47 million for radiological and nuclear countermeasure development. NIH supports basic research, which leads to breakthroughs in scientific knowledge, and applied research and development that converts knowledge into products that can be manufactured in large quantities. Project BioShield can then be used to acquire these countermeasures that will be safer and more effective in protecting Americans.

### *Medical Surge Capacity*

In the event of a large-scale attack in one or more cities, existing medical capacity could be overwhelmed quickly. The President designated HHS as the lead for coordinating Federal support of State and local medical and public health response to mass casualty events. The Budget includes $70 million to improve emergency health care by allowing the Federal Government to purchase and store deployable medical care units, including medical supplies and equipment that can be delivered to an affected area. This initiative will also enhance the Medical Reserve Corps and provide prior training and verification of credentials to ensure the availability of health care providers during such an emergency.

The Budget also proposes nearly $1.3 billion in investments to bolster hospital preparedness and State and local biodefense preparedness. Included in the total for hospital preparedness is $25 million for a targeted, competitive demonstration program to establish a state-of-the-art emergency care capability in one or more metropolitan areas. These emergency care centers will be designed to meet the demands of a terrorist attack or other incident requiring mass casualty care and containment of infectious agents.

### *Biosurveillance and the National Biosurveillance Initiative*

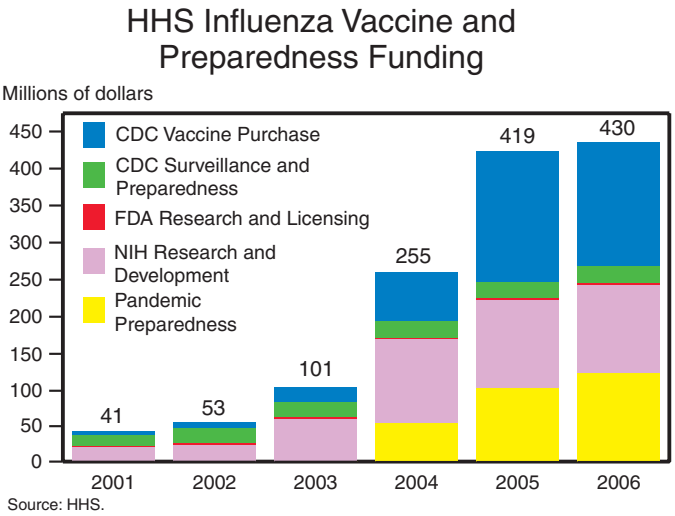
Unlike in conventional attacks, the use of biological weapons may not be immediately apparent. Reducing the time it takes to detect an attack can save many lives. Last year, the President proposed a new biosurveillance initiative to provide earlier indication that an attack has occurred, and to better determine accurately its nature and scope by monitoring human, animal, and plant health, the food supply, and the environment. The 2006 Budget will build on this progress with continued investments in the gathering and analysis of this information.

### *Defending the Nation's Food Supply*

Building upon significant investments in 2005, the President is committed to improving the safety and security of the food and agriculture supply. In 2006, the Food and Drug Administration (FDA) will continue to work with the U.S. Department of Agriculture (USDA) and the Department of Homeland Security to improve protection of the Nation's food supply from intentional or natural contamination. The Budget requests a $30 million increase for the FDA to develop strategies to prevent and mitigate food contamination, as well as testing methods to identify the presence of contamination quickly and accurately. The Nation's food laboratory network will work to analyze food samples more rapidly, which will better help to identify outbreaks and be able to quickly process a surge of samples following a terrorist incident. Each of these activities will be coordinated with USDA, which will receive an increase of $145 million in 2006 to protect the food and agriculture supply from terrorist attacks.

## PROTECTING AMERICA—Continued

### *Protecting the Nation from Influenza and the Threat of an Influenza Pandemic*




Every fall and winter, influenza poses a threat to public health, especially for seniors and others vulnerable to complications from influenza. If a new influenza virus for which we have no immunity or vaccine takes a form that is easily spread, an influenza pandemic could develop and cause terrible damage to public health. The Administration is committed to improving influenza vaccine supply, preventing another influenza vaccine shortage, and helping prepare for a possible pandemic. HHS is enhancing global influenza surveillance to provide an earlier warning of the viruses' emergence; increasing the supply of influenza vaccine; stockpiling large quantities of antiviral drugs; promoting the development of new technologies to produce vaccine more quickly and securely; and investigating promising ways to safely and effectively extend the supply of vaccine doses, especially in a pandemic.

The Budget builds on this progress, maintains a childhood influenza vaccine stockpile, includes a $20 million increase for influenza vaccinations for children and other vulnerable populations, and proposes $30 million to expand the Nation's vaccine supply. The Budget also includes an increase to enhance global disease surveillance and a $21 million increase to work with manufacturers to increase the availability of additional U.S.-licensed vaccine to meet increased supply needs, especially during an influenza pandemic.

### *Strengthening the Safety of Medical Products*

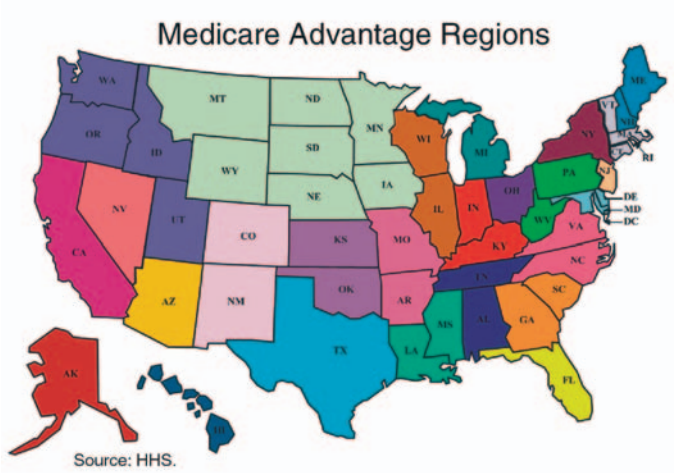
FDA works to ensure the safety of medical products, including prescription and over-the-counter drugs. Before being made available to consumers, medical products undergo a rigorous review by FDA scientists for safety and effectiveness. After approved medical products are made available to consumers, FDA staff review adverse events and respond to any concerns. This system has succeeded in providing American consumers with safe and life-improving medical products for decades.

FDA continues to evaluate its systems and processes to refine its oversight and further improve the safety of medical products. FDA is sponsoring a study by the Institute of Medicine on the effectiveness of the U.S. drug safety system, with an emphasis on the continued safety of medical products already approved for use by FDA. The Institute of Medicine study will examine FDA's role within the health care delivery system and recommend measures to enhance the confidence of Americans in the safety and effectiveness of their drugs. In addition, the 2006 Budget proposes a 24-percent increase for the FDA Office of Drug Safety to enable FDA to continue its track record of success in providing safe and effective medical products to American consumers.

# SUPPORTING A COMPASSIONATE SOCIETY

## *Improving Medicare*

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created improvements to the Medicare program, providing beneficiaries with more choices and enhanced benefits. Seniors and individuals with disabilities will have access to more modernized, higher quality health care. Funding for the Medicare program is projected to be $340 billion in 2006. Medicare consists of four parts:




- Part A: hospital insurance, which provides coverage for hospitals, skilled nursing, hospice, and other related services;
- Part B: supplementary medical insurance, which provides coverage for outpatient hospital, physician, home health, laboratory services, durable medical equipment, and other related services;
- Part C: Medicare Advantage, which finances the full Medicare benefit through private plans; and
- Part D: the new prescription drug benefit.

*Advancing Medicare Advantage.* The MMA created the Medicare Advantage program (Part C) to offer more choices and better benefits to Medicare beneficiaries through competition among private health insurance plans. Beginning in 2006, Preferred Provider Organizations (PPOs) will begin to serve beneficiaries on a regional basis. These regional plans will compete with existing local Medicare Advantage plans to provide health services to beneficiaries. HHS has identified 26 regions across the Nation in which PPO plans will compete to provide services. HHS established these regions to ensure all Medicare beneficiaries, including those in small States and rural areas, have the opportunity to enroll in a PPO and to encourage plans to participate. In 2006, 16 percent of beneficiaries are expected to be enrolled in Medicare Advantage plans, and by 2009, this number is projected to increase to 24 percent.

*Medicare Prescription Drug Benefit.* The MMA created a new prescription drug benefit (Part D) that will begin in 2006. In the interim, the MMA authorized the Centers for Medicare and Medicaid Services (CMS) to offer Medicare beneficiaries a prescription drug discount card. Around six million beneficiaries have signed up for the card since June 2004. Independent studies have shown savings of 20 percent or more off the retail cost of brand name drugs and 30 to 60 percent off generic drugs. In addition, over 1.7 million low-income beneficiaries have begun to receive $600 annually in transitional assistance provided by the Act. These beneficiaries can save up to 90 percent off the average retail price of name-brand drugs when they combine the drug card savings with the $600 transitional assistance.

## SUPPORTING A COMPASSIONATE SOCIETY—Continued

Beginning January 1, 2006, Medicare beneficiaries will be eligible for a subsidized prescription drug benefit that helps lower their drug costs. They will have their choice of enrolling in either prescription drug-only plans or Medicare Advantage drug plans. HHS will conduct extensive outreach efforts to help seniors understand their new choices. Expanded efforts through 1–800–Medicare, community based organizations, and media outreach will ensure that seniors have adequate information to benefit from the new options under the MMA.

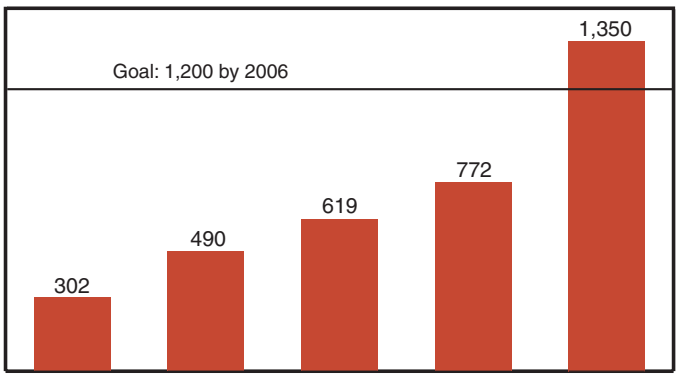
The drug plans will receive subsidies from Medicare to help keep premiums and cost-sharing low. Additional subsidies will be paid to employers to encourage them to continue to offer retiree health benefits to millions of seniors. This will assist beneficiaries in retaining the employer sponsored coverage to which they have grown accustomed.

In addition, Medicare will provide generous additional assistance to low-income beneficiaries. For those beneficiaries with incomes below 135 percent of poverty, they will pay no monthly premium, no deductible, and very small co-payments per prescription. Beneficiaries with incomes between 135 and 150 percent of poverty will pay reduced premiums, a $50 deductible, and reduced cost-sharing.

### *Improving Health Centers*

Health Centers deliver high-quality, affordable primary and preventive health care to nearly 14 million patients, regardless of ability to pay, at 3,740 sites across the United States annually. In 2006, Health Centers will serve an estimated 16 percent of the Nation's population at or below 200 percent of Federal Poverty Line.

Completing the President's Health Centers Initiative
New and Expanded Sites Since 2001




Source: HHS.

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. Almost 2.4 million additional individuals will receive health care in 2006 through over 570 new or expanded sites in rural areas and underserved urban neighborhoods. The President has established a new goal to create a Health Center in every poor county 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. Faith-based and community programs will be encouraged to compete for these grants.

### *Modernizing Medicaid and SCHIP Coverage*

Medicaid was created nearly 40 years ago to provide access to health care for individuals on welfare, based on health care available at that time. Over that time span, Medicaid has grown far faster than most Federal entitlement programs. The Budget calls for specific reforms to Medicaid that promote better care for low-income Americans, more local control for States, fair payments to providers, and better accountability measures so that Medicaid's fiscal condition will improve.

In 2006, funding for Medicaid is projected to be $338 billion, about $193 billion of which is paid by the Federal Government. Since 1998, SCHIP has made available approximately $40 billion over 10 years for States to provide health care coverage to targeted low-income, uninsured children. Since the beginning of the Administration, enrollment in SCHIP has grown by over one million children to a total of approximately 5.8 million in 2003.

Even though Medicaid will serve more than 46 million Americans in 2006, it operates under outdated rules. Medicaid excludes millions of individuals who are well below the Federal poverty level because program rules remain tied to welfare eligibility categories. While the President's Health Centers Initiative has provided access to health care for many uninsured individuals, many are still left with the choice of seeking health care through hospital emergency rooms, contributing to the growing burden of uncompensated care among hospitals.

Instead of helping these individuals get better coverage, States often reluctantly decline to expand coverage because Medicaid rules do not easily support many up-to-date, efficient approaches to expanding coverage. Moreover, millions of senior citizens and individuals with disabilities in need of long-term care are provided only with the choice of leaving their homes for institutional care to get the support they need. There is now widespread evidence that updating Medicaid to keep pace with the people it serves, and better coordinating it with SCHIP, can lead to better coverage, better health care, and a more sustainable cost structure for the States and the Federal Government.

*Medicaid and SCHIP Modernization.* In addition to proposing an increase in Federal resources for covering the uninsured (the elements of which were outlined in the Promoting Economic Opportunity and Ownership section of this chapter), 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.

States generally regard the complex array of Medicaid laws, regulations, and administrative guidance as overly burdensome, with the result being higher costs for covering fewer beneficiaries. In response, the Administration has granted waivers that allow States to extend Medicaid coverage to higher income and non-traditional populations, such as childless adults. For example, in 2001, the Administration introduced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. This initiative emphasizes the coordination of currently available Medicaid and SCHIP funding with private insurance. Through these waiver programs and the HIFA initiative, States have found that they can provide health care to more beneficiaries with the same amount of funding by changing delivery systems and using mainstream coverage, including managed care and coordination with employer plans.

SCHIP provides States with more flexibility than Medicaid, allowing States to cover targeted populations, incorporate private sector insurance options, provide appropriate benefit packages, and maximize public dollars.

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

## SUPPORTING A COMPASSIONATE SOCIETY—Continued

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.

### *Enhancing Medicaid and SCHIP Coverage*

Apart from program modernization, the following proposals will enhance coverage under both Medicaid and SCHIP.

*SCHIP Reauthorization.* The authorization for the SCHIP program expires at the end of 2007. Due to its success at enrolling millions of low-income uninsured children, the 2006 Budget proposes to reauthorize this program early. The Administration will seek authority to better target SCHIP funds in a more timely manner.

*Transitional Medical Assistance (TMA).* TMA provides Medicaid coverage for former welfare recipients after they enter the workforce. The Budget proposes to extend TMA for one year with certain 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. These changes will allow for consistent enrollment of TMA beneficiaries while easing the administrative burden on States.

*Medicare Premium Assistance*. The Administration proposes to continue Medicare Part B premium assistance for Medicare beneficiaries between 120 and 135 percent of the Federal poverty level for one year. In 2005, these premiums will be $78.20 per month. States receive 100 percent Federal funding for these benefits.

*Vaccines for Children (VFC).* VFC provides all recommended childhood vaccines, free of charge, to four categories of eligible children: Medicaid beneficiaries, American Indians/Alaskan Natives, the uninsured, and the underinsured (those without coverage for a particular vaccine). The Administration proposes to improve vaccine access by allowing underinsured children to receive VFC-funded vaccines at State and local health clinics, rather than only at Federally Qualified Health Centers and Rural Health Centers.

*Health Insurance Portability and Accountability Act (HIPAA).* Since enacted in 1996, HIPAA has increased the continuity, portability, and accessibility of health insurance. To ensure that Medicaid and SCHIP beneficiaries receive the benefits of HIPAA coverage, the Administration proposes two legislative changes. Under this proposal, eligibility for a Medicaid/SCHIP Employer-Sponsored Insurance (ESI) Program would be a qualifying event, which would allow families to enroll in ESI immediately through special enrollment. This proposal also would require SCHIP programs to issue certificates of creditable coverage, which promote portable health coverage by verifying the period of time an individual was covered by a specific health insurance policy.

*Improving Options for People with Disabilities*. The Budget includes several 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 five-year demonstration would finance 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 of a beneficiary's care, after which the State would agree to continue this care at the regular Medicaid matching rate.

- *Home and Community-based Care Demonstrations and Programs.* The Budget includes proposals to encourage home and community-based care for children and adults with disabilities, such as demonstrations to provide respite care for caregivers of adults and children. Another demonstration will test the effectiveness of providing home and community-based alternatives to psychiatric residential treatment for children enrolled in Medicaid. States will have the option to continue Medicaid eligibility for spouses of individuals with disabilities who return to work. States will also have the option to provide Medicaid presumptive eligibility for institutionally qualified individuals who are discharged from hospitals into the community.
- *Long-Term Care Insurance*. The 2006 Budget would promote the use of long-term care (LTC) insurance by eliminating the Federal legislative ban on new LTC Partnership Programs, which are a proven approach to lowering Medicaid costs while giving consumers and families more control and involvement in their long-term care services. Through these programs, consumers who purchase and use Partnership-approved insurance can become eligible for Medicaid services after their insurance coverage is exhausted without having to divest all of their assets, as is typically required.

## *Faith-Based and Community Initiative*

*Compassion Capital Fund*. To advance the efforts of community-based, charitable organizations, including faith-based organizations, the President's 2006 Budget provides $100 million for the Compassion Capital Fund, to enhance their ability to provide social services, expand their organizations, diversify their funding sources, and create collaborations to better serve those in need. Among the priorities within the 2006 proposal is an emphasis on supporting anti-gang efforts through community and faith-based organizations. Since 2002, a total of $149 million has been given directly to more than 300 organizations and sub-grants to more than 3,000 grass-roots organizations.

*Mentoring Children of Prisoners*. As a group, the more than two million children with parents in prison have more behavioral, health, and educational problems than other children. Mentoring by caring adults can improve the long-term outcomes for children whose parents are incarcerated. In 2004, HHS awarded $8.9 million in continuation grants and $37 million in 169 new grants to programs that provide mentoring services to these children. The Budget includes $50 million for competitive grants. Since 2003, this program has been working toward providing over 70,000 new mentors for children with a parent in prison.

*Maternity Group Homes*. The 2006 Budget also provides $10 million to increase support to community-based maternity group homes by providing young pregnant mothers with access to community-based coordinated services.

*Access to Recovery.* In 2004, HHS awarded Access to Recovery (ATR) grants to 14 States and one tribal organization to create substance abuse treatment voucher programs. ATR is designed to give addicted individuals the ability to choose from a range of effective treatment and recovery support options, including faith-based and community providers. The 2006 Budget includes $150 million

## SUPPORTING A COMPASSIONATE SOCIETY—Continued

Wisconsin issued the first Access to Recovery voucher to Kimberly Washington (left), a 41-year old mother from Milwaukee, Wisconsin whose addiction and related felony convictions are a barrier to employment and to raising her children. Ms. Washington chose Meta House because the agency provides residential treatment and recovery support services, and it will allow her one-year old baby to live with her in treatment once she is ready for re-unification. She and her Access to Recovery coordinator (right) developed a Recovery Support Team, including her service providers, probation officer, church, family, and others to help her achieve and sustain recovery post-treatment. Ms. Washington said that "...knowing there's someone, or something, like an angel on my shoulder gives me hope, and motivation, that I will not fail this time—someone will be there."

to maintain existing commitments and expand access to effective treatment in additional States. States will hold providers accountable for results and reward those providers most effective at helping clients to achieve recovery from addiction.

### *Marriage and Healthy Family Development*

The Administration's initiatives to promote marriage and healthy family development are built around four strategies:

1) Support marriage and families;
2) Provide tools to parents;
3) Teach children how to be good family members and citizens; and
4) Encourage community organizations, including faith-based organizations, to support families.

*Supporting Healthy Marriages and Responsible Fatherhood*. The Budget proposes to direct $240 million to new efforts to support healthy marriages and responsible fatherhood. Of this amount, $100 million, plus dollar for dollar matching contributions from States, would fund competitive grants for States, territories, and tribal organizations to develop innovative approaches to promote healthy marriages. The Budget includes $100 million for research, demonstration projects, and technical assistance, primarily focusing on family formation and healthy marriage activities. To support these programs, funds would be redirected from the Temporary Assistance for Needy Families High Performance Bonus ($100 million) and the Illegitimacy Reduction Bonus ($100 million).

The Administration also proposes to create a $40 million per year grant program, through faith- and community-based organizations, that helps non-custodial fathers become more involved in their children's lives. More than 25 million children live in homes without fathers.

*Abstinence Only Education*. Last year, President Bush announced the expansion of the initiative to educate teens and parents about the health risks associated with early sexual activity and to help

teens make healthy choices. As part of this initiative, the President directed the Department as follows:

- Develop research-based standards for abstinence education curricula;
- Conduct a review of the consistency of messages in all federal programming for youth addressing teen pregnancy prevention, family planning, and STD and HIV/AIDs prevention;
- Develop a public education campaign designed to help parents communicate with their children about the risks associated with early sexual activity; and
- Provide grants to communities and States to develop and implement abstinence-only programs and for Federal evaluation of these programs.

In support of this initiative, by 2008 funding for these programs will increase to a total of $270 million.

### *Refugee and Entrant Assistance*

Refugees come to the United States for protection from persecution and in search of freedom, peace, and opportunity. The Office of Refugee Resettlement provides programs to help refugees, asylees, trafficking victims, and other beneficiaries achieve economic self-sufficiency and social adjustment. The Budget includes $552 million, or an increase of $68 million, to assist States and faith-based and community organizations in resettling the growing number of refugees, and for the care and placement of unaccompanied alien minors in safe and appropriate environments.

Carlos, a 15-year old Guatemalan who never knew his parents and was raised by relatives, journeyed to the United States through Mexico with an older cousin in search of his mother and a better education. His journey was mostly by foot and bus. While residing in shelter care in Phoenix, Carlos exhibited developmental and physical delays. With the help of intensive services from the Unaccompanied Refugee Minor (URM) program in the Office of Refugee Resettlement, the child's mother and grandmother were advised of the child's exceptional needs and thus were more prepared to handle his serious medical issues. The URM program completed a home suitability assessment, confirmed that the mother was prepared to care for Carlos, prepared Carlos to join his mother, and worked aggressively to complete family reunification.

### *Reforming Welfare*

*Temporary Assistance for Needy Families (TANF).* The Administration continues to pursue its plan to reauthorize the TANF program, which provides grants to States for programs that assist needy families with children. TANF grants also promote work and the formation of married-parent families in order to reduce dependence on government benefits. The Administration's plan maintains funding, strengthens work requirements, supports healthy marriages and family formation, and increases State flexibility.

### *Strengthening Programs for Children*

*Early Childhood (Good Start, Grow Smart).* Because it is important for children to enter school ready to learn, the Administration has worked to improve early childhood programs through the Good Start, Grow Smart initiative. The goals of this initiative are:

- Strengthening Head Start;

## SUPPORTING A COMPASSIONATE SOCIETY—Continued

- Working with states to improve early childhood learning; and
- Providing parents, teachers, and caregivers with information on early learning.

*Head Start*. The Budget supports reauthorization of Head Start and provides $6.9 billion, including $45 million to support State implementation of a demonstration authority to promote better coordination of existing programs, improve services for families and children, and achieve better results with the resources already being used.

*Independent Living Education and Training Vouchers*. The Budget commits $60 million to the Foster Care Independent Living Program to help older foster care youth transition to adulthood and self-sufficiency after leaving foster care. This program provides vouchers of up to $5,000 for education or vocational training to help youth aging out of foster care develop skills and lead independent and productive lives.

*Child Welfare Program Option*. The 2006 Budget seeks legislation to introduce an option for all States so they can choose an alternative system for foster care. Flexible financing will allow States to design programs with a stronger emphasis on child-abuse prevention, family support, and increased flexibility in providing services.

### *Battling HIV/AIDS*

*Global AIDS*. The President's Emergency Plan for AIDS Relief is a bold strategy to combat the global HIV/AIDS pandemic. Under the President's five-year, $15 billion plan, the Administration has moved quickly and efficiently to mobilize the scientific and programmatic expertise, leadership, and resources of HHS and other Federal government agencies and their partners. The goals of the plan are to prevent seven million new HIV infections, treat two million HIV-infected people, and provide care for 10 million people affected by HIV/AIDS by 2008. The 2006 Budget will continue progress toward meeting these goals by preventing 3.8 million infections, treating 860,000 HIV-infected people, and providing care for 4.3 million people affected by HIV/AIDS.

*Domestic AIDS*. The Budget invests over $17 billion for domestic AIDS treatment, prevention, and research, including almost $2.1 billion for the Ryan White program and its comprehensive approach to address the health needs of persons living with HIV/AIDS. Through this program, low-income individuals living with HIV/AIDS receive medical care, counseling and testing, and other support services. The Budget provides for a continued investment in the AIDS Drug Assistance Program that helps provide life-saving antiretroviral drug treatments to those who otherwise could not afford them.

### *Reforming Community and Economic Development Programs*

The Budget proposes a $3 billion program within the Department of Commerce to support communities' efforts to meet the goals of improving their economies and quality of life. This initiative will consolidate programs across the Federal Government into a more targeted, unified program that sets accountability standards in exchange for flexible use of the funds. HHS programs consolidated into this initiative are the Community Services Block Grant, Community Economic Development, and Rural Community Facilities. (See the Department of Commerce chapter for more details.)

# MAKING GOVERNMENT MORE EFFECTIVE

## *The National Institutes of Health*

The National Institutes of Health (NIH) will receive nearly $29 billion. Overall, NIH's research program has rated well in its Program Assessment Rating Tool (PART) performance assessments and is an effective mechanism for promoting biomedical breakthroughs. 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 public health challenges. The Administration is committed to this new effort, which will stimulate accelerated investments in research involving multiple Institutes and Centers, thereby helping improve the Nation's health.

## *Medicaid and SCHIP*

*Program Integrity.* Medicaid's complexity and open-ended finance structure encourages efforts by States to draw down Federal matching funds, sometimes inappropriately. These financing practices undermine the Federal-State partnership required by the Medicaid statute and jeopardize the financial stability of the Medicaid program. The 2006 Budget proposes to build on past efforts to improve efficiencies and the fiscal integrity of Medicaid and SCHIP—and even with these reform efforts, Medicaid's future spending is expected to increase at a robust 7.2 percent growth rate over 10 years.

The Administration proposes to further improve the integrity of the Medicaid matching rate basis of funding by proposing steps to curb financing arrangements that have been used by a number of States to avoid the legally determined State matching funds requirements. Through various mechanisms, Federal funds are returned from providers back to the State and "recycled" to draw additional Federal dollars.

- *Recovering Federal Funds Diverted From Providers*. Some States keep a portion of Federal payments intended for providers. The Budget proposes to build on CMS efforts to identify and recover diverted payments that are not used for their intended purpose.
- *Capping Payments to Government Providers*. Under current law and regulation, States continue to have ample opportunities to make excessive payments to individual government providers above their costs for the purpose of leveraging additional Federal dollars. The 2006 Budget proposes to limit Federal reimbursement to no more than cost to curb excessive payments and still preserve a State's ability to pay reasonable rates to providers.
- *Reforming Provider Taxes*. Under certain conditions, States may use the proceeds of taxes collected from a certain class of health providers to help finance the State's share of Medicaid expenses. Under current rules, the tax cannot exceed six percent of revenues and must be applied uniformly across all health care providers in the same class (e.g., all hospitals). The 2006 Budget proposes to phase down the allowable tax rate from six percent to three percent and

## MAKING GOVERNMENT MORE EFFECTIVE—Continued

require that managed care organizations be treated the same as other classes of health care providers with respect to provider tax requirements.

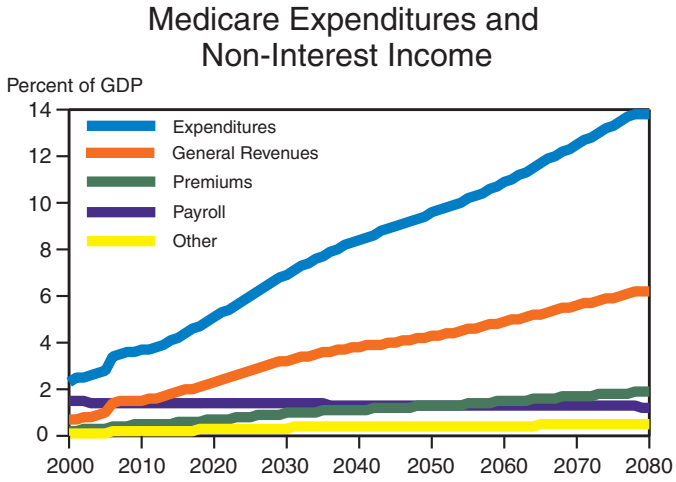
- *Strengthening Reimbursement Policies for Selected Medicaid Services.* The 2006 Budget proposes: 1) clarifying allowable services that can be claimed under targeted case management (TCM), and rehabilitation services; 2) aligning Federal reimbursement for TCM services with administrative matching rate of 50 percent; and 3) codifying in regulation CMS reimbursement policies for services provided free of charge to the public.
- *Strengthening Medicaid Requirements for Questionable Asset Transfers.* To qualify for Medicaid long term care services, an individual may only retain nominal assets. Applicants who transfer assets at less than fair market value are subject to delays in Medicaid eligibility. With estate planning, however, Medicaid applicants can retain their assets and qualify for Medicaid without any delays. In conjunction with the long-term care partnership proposal, the Budget proposes to strengthen existing requirements for questionable asset transfers as part of an effort to promote personal responsibility and planning for long-term care expenses.
- *Medicaid Administrative Claims*. The Administration proposes establishing individual State allotments for Medicaid administrative claims. Medicaid administrative claims operate under an open-ended financing framework, which does not encourage States to administer the program as efficiently as possible. In some instances, there is evidence that States have attempted to shift administrative costs associated with other social service programs to Medicaid. For these reasons, the Administration proposes to create new incentives for program administration by establishing administrative claim allotments that will encourage cost-effective methods for operating the program.
- *Medicaid and SCHIP Financial Management*. In 2006, HHS will continue to devote more resources to Medicaid and SCHIP financial management. This effort will include increasing the number of audits and evaluations of State Medicaid programs, and elevating the importance of financial management oversight at HHS. The Budget proposes to allocate $25 million from the Health Care Fraud and Abuse Account to finance this initiative.

*Medicaid Prescription Drugs*. The Budget makes several proposals to increase efficiency and lower costs in Medicaid prescription drugs, one of the fastest growing segments of the Medicaid budget.

- *Amend Medicaid Drug Rebate Formula*. All drug manufacturers must pay a rebate to States in order to have their drugs covered by Medicaid. Part of the rebate formula is the lowest private market price, also called best price. Best price effectively acts as a price floor, preventing manufacturers from negotiating deep discounts with large purchasers such as hospitals and HMOs. The Administration proposes to replace best price with a budget neutral flat rebate, allowing private purchasers to negotiate lower drug prices.
- *Restructure Pharmacy Reimbursement*. The House Energy and Commerce Committee recently held a hearing that documented substantial and rising Government overpayment for prescription drugs in Medicaid. The Administration proposes moving to a system that more closely aligns pharmacy reimbursement with pharmacy acquisition cost, while providing adequate payment for dispensing prescriptions.
- *Pharmacy Plus Demonstrations*. Pharmacy Plus Medicaid demonstrations provide a drugs-only Medicaid benefit to certain aged and disabled beneficiaries not otherwise eligible for Medicaid. Pharmacy Plus was intended as a placeholder program in the absence of a universal drug benefit under Medicare. With the introduction of the Medicare drug benefit, Pharmacy Plus has achieved its goal. CMS will continue to work closely with States that have Pharmacy Plus

programs to enable them to provide comparable coverage to their beneficiaries under the new Medicare drug benefit at the same or lower cost to the States.

### *Medicare Financial Enhancements*




Source: 2004 Annual Report of the Board of Trustees for the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

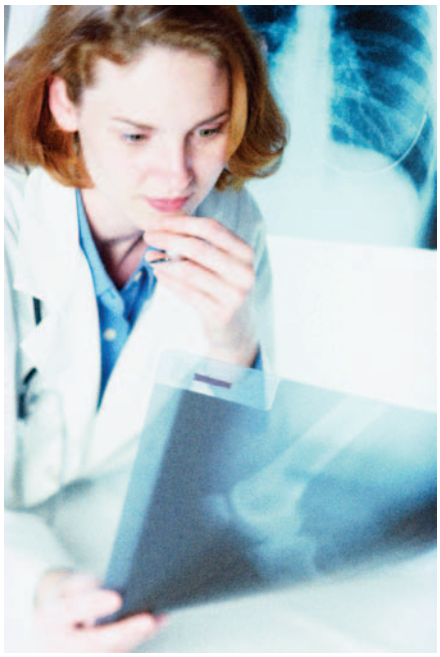
*Strengthening Medicare's Long-Term Financial Security*. Medicare is financed by two separate trust funds, the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund. This bifurcated trust fund structure finances Medicare as if the program offers two separate, unrelated benefits, instead of recognizing that Medicare provides integrated, comprehensive health insurance coverage. The MMA took steps to address this problem, and requires the Medicare Trustee's Report to include a new, comprehensive fiscal analysis, the Combined Medicare Trust Fund Analysis. This analysis examines the program's financing as a whole, and provides the President and the Congress with a warning if Medicare's dedicated revenues are projected to fall below adequate levels in seven years. The Administration supports a unified trust fund for Medicare, which would provide an integrated financing structure for the program's comprehensive benefit package.

*Improving Quality*. Medicare currently pays all health care providers equally for the same service, regardless of the efficiency or the quality of services furnished. The Administration has promoted accountability for quality, creating initiatives to collect data from Medicare providers on quality measures and making them publicly available. Better measures of efficiency and quality in health care suggest that Medicare can improve payments for high-quality care. The Administration will take further steps to encourage excellence in care by exploring provider payment reforms that link quality to Medicare reimbursement in a cost neutral manner. Such payment reforms should be flexible enough to support innovations in health care delivery.

*Administrative Improvements*. In the coming years, HHS will make changes to rationalize several components of the payment system. 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 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.

## MAKING GOVERNMENT MORE EFFECTIVE—Continued



*Program Integrity.* Medicare program integrity efforts have yielded billions of dollars in savings. The Budget continues this effort with $1.1 billion from the Health Care Fraud and Abuse Control Account to fight improper Medicare payments. The Budget requests $75 million for efforts to protect the new Medicare prescription drug program and Medicare Advantage against fraud, waste, and error, and these funds will be included in a Government-wide proposal to fund program integrity activities through a discretionary cap adjustment.

Additionally, HHS will strengthen program integrity by preventing overpayments, accelerating contractor reform and rationalizing payments for bad debt. HHS will institute several data processing improvements that will reduce overpayments. The Budget provides funding to continue the modernization of Medicare's data systems to this end. HHS will also accelerate implementation of a new process for awarding contracts to administrative contractors, which will enhance Medicare's ability to hold contractors accountable for their program integrity performance. Lastly, the Budget proposes to rationalize the reimbursement of bad debt to promote efficiency and ensure equitable treatment across providers.

### *MMA Implementation*

*CMS Operations and Efficiencies*. HHS has initiated an extensive effort to implement the many provisions of the MMA. In 2004, CMS reorganized to improve the oversight and administration of Medicare Advantage and the prescription drug benefit and provide more support for improving quality and efficiency in Medicare. HHS has begun outreach efforts to ensure that beneficiaries can get the most out of their new choices, and develop new procedures to enroll beneficiaries and employers in the new benefit. In 2005 and 2006, HHS will also implement other provisions of the MMA, such as contractor reform for Medicare's administrative contractors and changes to payments for Part B Covered Drugs.

### *Update on the President's Management Agenda*

The following table provides an update on HHS' implementation of the President's Management Agenda as of December 31, 2004.

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

HHS successfully consolidated its human resources personnel into four centers and achieved greater accountability through its employee appraisals and its Strategic Management System. Additionally, it has implemented a number of initiatives to improve the skills and abilities of its workforce including HHS University and its Emerging Leaders Program.

HHS' strategic approach to competitive sourcing is facilitated by the use of evaluation factors such as mission, outcomes, and commercial market-place composition to identify commercial activities available for competition. In 2004, HHS completed a total of 33 streamlined studies of 365 FTEs and five standard studies of 351 FTEs. The average time for completion was 69 days for streamlined studies and 285 days for standard competitions. As a result, HHS estimates gross savings of over $250 million for completed 2003 studies and $55 million for completed 2004 studies, as they are fully implemented over a five-year period.

In E-Gov, HHS is implementing Earned Value Management to track and manage information technology investments. More than 95 percent of HHS' information systems have certified and accredited security plans.

| Initiative | Status | Progress |
|---|---|---|
| Faith-Based and Community Initiative |  |  |
| Real Property Asset Management |  |  |
| Eliminating Improper Payments |  |  |
| Broadening Health Insurance Coverage through State Initiatives |  |  |

To improve the overall management of its real property assets, HHS has a three-part strategy: 1) develop an asset management plan; 2) maintain a real-time inventory of owned, leased, and otherwise managed properties; and 3) track performance measures, which are consistent with the Federal Real Property Council's guidance. HHS plans to complete these activities by December 2005.

HHS' annual Performance and Accountability Report (PAR) includes an annual estimated improper payments error rate and amount for Medicare, which accounts for nearly 50 percent of improper payments that have been measured. For 2004, the Medicare error rate was 10.1 percent, or $21.7 billion. For the first time, HHS reported improper payments for Head Start in the 2004 PAR, with an estimated error rate of 3.9 percent, or $255 million. HHS is working to reduce improper payments, expand the number of programs reporting estimated improper payment estimates, and improve the accuracy of these estimates. (Because this is the first quarter that agency efforts in the Eliminating Improper Payments Initiative were rated, progress scores were not given.)

The Administration has developed several model Medicaid demonstrations to foster State innovation in reducing the number of uninsured. To date, the Administration has approved 23 demonstrations and the Urban Institute is conducting a study to assess the impact of Health Insurance Flexibility and Accountability demonstrations on rates of uninsurance.

## Department of Health and Human Services

(In millions of dollars)

| | 2004 Actual | Estimate | |
|---|---|---|---|
| | | 2005 | 2006 |
| **Spending** | | | |
| Discretionary Budget Authority: | | | |
| Food and Drug Administration | 1,362 | 1,433 | 1,487 |
| *Program level (non-add)* | *1,695* | *1,801* | *1,881* |
| Health Resources and Services Administration | 6,677 | 6,806 | 5,982 |
| *Program level (non-add)* | *7,323* | *7,373* | *6,541* |
| Indian Health Service | 2,921 | 2,984 | 3,048 |
| *Program level (non-add)* | *3,639* | *3,774* | *3,846* |
| Centers for Disease Control and Prevention [1] | 4,440 | 4,584 | 4,017 |
| *Program level (non-add)* | *6,062* | *6,312* | *5,901* |
| National Institutes of Health | 27,733 | 28,444 | 28,590 |
| *Program level (non-add)* | *27,896* | *28,650* | *28,845* |
| Substance Abuse and Mental Health Services Administration | 3,234 | 3,268 | 3,215 |
| *Program level (non-add)* | *3,351* | *3,392* | *3,336* |
| Agency for Healthcare Research and Quality | — | 3 | — |
| *Program level (non-add)* | *304* | *321* | *319* |
| Centers for Medicare and Medicaid Services [2] | 2,579 | 2,666 | 3,178 |
| *Program level (non-add)* | *2,358* | *3,445* | *3,999* |
| MedPAC/OCR/GDM/AHRQ Administration | 19 | 19 | 19 |
| Discretionary HCFAC | — | — | 80 |
| Administration for Children and Families | 13,288 | 13,537 | 13,127 |
| *Program level (non-add)* | *13,292* | *13,599* | *13,187* |
| Administration on Aging | 1,374 | 1,393 | 1,369 |
| Office of the Secretary | 393 | 405 | 385 |
| *Program level (non-add)* | *497* | *508* | *517* |
| Health Information Technology | — | — | 75 |
| Office of Medicare Appeals [3] | 58 | 58 | 80 |
| Program Support Center: Medicare eligible retiree accrual | 27 | 33 | 34 |
| Office of the Inspector General | 39 | 40 | 40 |
| Public Health and Social Services Emergency Fund | 2,164 | 2,269 | 2,428 |
| Subtotal, Discretionary budget authority | 66,308 | 67,942 | 67,154 |
| Medicare Reform Administrative Expenses [2] | 1,000 | — | — |
| Total, Discretionary budget authority | 67,308 | 67,942 | 67,154 |
| *Memorandum: Budget authority from enacted supplementals* | — | *350* | — |
| Total, Discretionary outlays | 64,520 | 67,095 | 69,002 |

## Department of Health and Human Services—Continued

(In millions of dollars)

| | 2004 Actual | Estimate | |
|---|---|---|---|
| | | 2005 | 2006 |
| Mandatory Outlays: | | | |
| Medicare: | | | |
| Existing law | 264,890 | 290,310 | 340,217 |
| Legislative proposal [4] | — | — | 195 |
| Medicaid/SCHIP: | | | |
| Existing law | 180,838 | 193,615 | 197,996 |
| Legislative proposal | — | 225 | 955 |
| All other programs: | | | |
| Existing law | 32,255 | 33,144 | 33,561 |
| Legislative proposal | — | 38 | 565 |
| Total, Mandatory outlays | 477,983 | 517,332 | 573,489 |
| Total, Outlays | 542,503 | 584,427 | 642,491 |

[1] For comparability, the 2004 budget authority level reflects the creation of the Global AIDS Coordinator and program levels reflect a childhood immunizations legislative proposal.

[2] Amounts appropriated to the Social Security Administration (SSA) from the Hospital Insurance and Supplementary Medical Insurance accounts are included in the corresponding table in the SSA chapter.

[3] Reflects comparable Medicare Appeals funding levels for 2004 and 2005.

[4] Medicaid proposal to subsidize Medicare cost sharing.