Department of Health and Human Services
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This document also available at www.hhs.gov/budget/docbudget.htm

TABLE OF CONTENTS

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

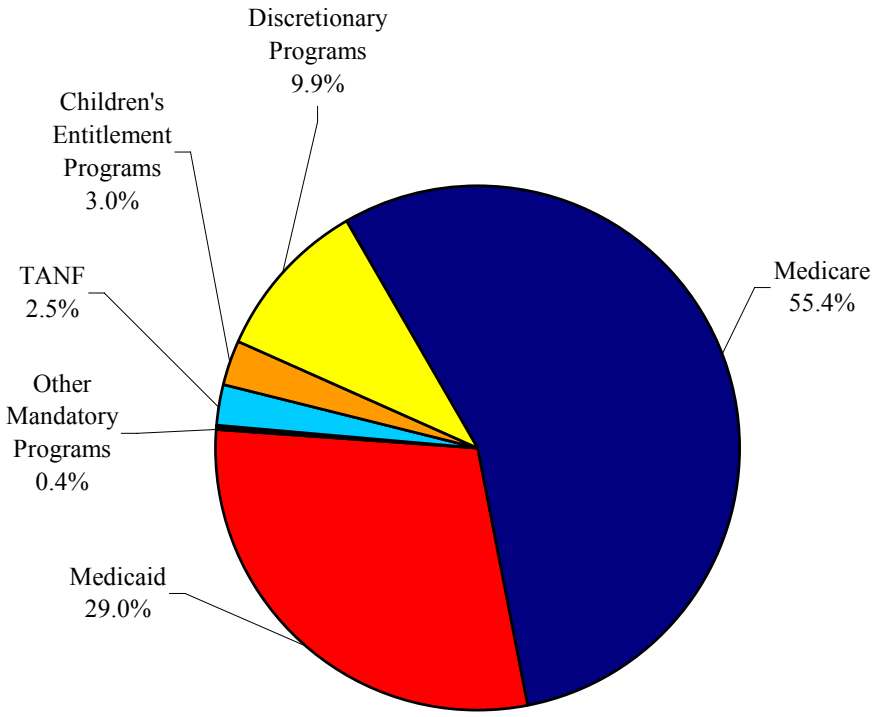
FY 2008 President's Budget for HHS

(dollars in millions)

	2006	2007	2008	
	Actual	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Budget Authority	682,986	641,709	697,323	+55,614
Outlays	612,715	669,636	697,544	+27,908
Full-Time Equivalents	64,182	64,548	66,890	+2,342

Composition of the Budget

(dollars in millions)



General Notes

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

Budget data in this book are presented "comparably" with the FY 2008 Budget, since the location of programs may have changed in prior years or be proposed for change in FY 2008. This is consistent with past practice, and allows increases and decreases in this book to reflect true funding changes. In addition, the FY 2007 President's Budget data in this book reflects Budget Amendments transmitted after release of the FY 2007 President's Budget.

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

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

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

For most programs, the HHS discretionary request for FY 2008 was developed based on the funding level that would be provided were the Congress to continue the current Continuing Resolution for an entire year. As a result, proposed increases and decreases are presented relative to that level. There are some requests that are explained best in comparison to the FY 2007 President's Budget, which is why both 2007 levels are provided throughout this document. The Congress plans to complete appropriations action in the near future, and may modify these FY 2007 Continuing Resolution funding levels. As a result, this document may not reflect final FY 2007 funding levels for all programs.

FY 2008 outlays total $698 billion, which is a net increase of $28 billion over the estimated outlays in a full year FY 2007 Continuing Resolution. The FY 2008 Budget totals $67.6 billion in discretionary program spending, which is an increase of $95 million over the FY 2007 full year Continuing Resolution and an increase of $1.6 billion over the FY 2007 President's Budget.

Secretary Leavitt's priorities help guide HHS in fulfilling the President's vision of a healthier, safer, and more hopeful America. Under the Secretary's plans, HHS will continue to yield positive results and strive to meet and exceed expectations in the following endeavors:

- Transform the Health Care System;
- Provide Health Services to Underserved Populations;
- Strengthen Medicare and Medicaid's Long-Term Financial Security;
- Modernize the Medicare System;
- Advance Medical Research;
- Secure the Homeland;
- Protect Life, Family, and Human Dignity; and
- Improve the Human Condition Around the World.

TRANSFORM THE HEALTH CARE SYSTEM

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

Fostering Affordable Choices in the Health Care System: The Federal Government's current system of paying for health care results in billions of dollars being spent inefficiently, through a patchwork of subsidies and payments to providers. In addition to directly funding the care provided to people enrolled in programs like Medicare and Medicaid, health care entitlement programs finance payments to institutions that either indirectly pay for uncompensated care or subsidize their operating expenses.

The health care system could operate more efficiently if some portion of institutional payments instead were redirected to help people with poor health or limited income afford health insurance. The uninsured often use emergency rooms as a source of primary care, which leads to suboptimal care and spending outcomes. If this public spending were focused on helping the uninsured purchase private insurance, people would receive the care they need in the most appropriate setting. The health care system needs to be transformed in a way that avoids costly and unnecessary medical visits and emphasizes upfront, affordable private health insurance options.

This transformation could happen by subsidizing the purchase of

private insurance for low-income individuals. However, any such health care reforms would need to be State-based and budget neutral within health care spending, not create a new entitlement and not affect savings contained in the President's Budget that are necessary to address the unsustainable growth of Federal entitlement programs. The Federal Government would also maintain its commitment to the neediest and most vulnerable populations, while acknowledging that States are best situated to craft innovative solutions to move people into affordable insurance.

The President has asked the Secretary of Health and Human Services to work with the Congress and the States on an Affordable Choices initiative to reform the health care marketplace.

CMS SCHIP Reauthorization: The FY 2008 Budget proposes to reauthorize the Centers for Medicare and Medicaid Services (CMS) State Children's Health Insurance Program (SCHIP) for five years, consistent with the submission of a five-year Budget to Congress, and focuses each of the program elements on SCHIP's original objective to provide health insurance for uninsured, low-income children at or below 200 percent of the Federal poverty level. Toward this end, the Budget provides approximately $5 billion over 5 years for additional allotment funds.

Health Information Technology: In FY 2008, the Budget requests $118 million for the Office of the National Coordinator for Health Information Technology, an increase of $57 million over the FY 2007 Continuing Resolution level, to continue efforts toward achieving the President's goal for most Americans to have secure personal electronic health records by 2014. The request will support efforts to:

- Implement public-private consensus health information technology (IT) standards.
- Initiate health IT priority projects in up to 12 regions to test the implementation of the American Health Information Community (AHIC) priority initiatives: electronic health records, consumer empowerment, chronic care management, and biosurveillance.
- Develop the Partnership for Health and Care Improvement, a new non-governmental entity that will create a sustainable business model to take over and sustain many of the functions of the AHIC.
- Coordinate efforts needed to develop solutions related to variations in State law, including those related to HIPAA that pose privacy challenges to automated health information exchange.

In addition, the Budget for the Agency for Healthcare Research and Quality (AHRQ) includes $45 million for health IT investments designed to enhance patient safety, with an emphasis on ambulatory patient care.

Personalized Health Care: The FY 2008 request for AHRQ includes $15 million for developing and expanding efforts in personalized health care. Improving the quality and effectiveness of health care, providing the right care to the right patient at the right time, and getting it right the first time remains a challenge in the United States. To face this challenge, this initiative will accelerate the movement toward personalized health care and help bring "next generation" effectiveness of care for individual patients. It undertakes pioneering work in the utilization of health IT for linking clinical care with research, and available genomic data, to accelerate clinical research breakthroughs and integrate them into the healthcare setting.

AHRQ will expand practice-based research networks and their de-identified patient data to generate new knowledge during the course of health care delivery at a lower cost and shorter timeline. The long-term result will be greater medical effectiveness, greater cost effectiveness, advances in clinical practice, and improved quality and safety for patients. This initiative builds on other HHS personalized health care efforts, including the National Institutes of Health (NIH) Genes, Environment, and Health research activities and the Food and Drug Administration (FDA) Critical Path.

CMS and AHRQ Health Care Transparency: One of the Administration's goals is to provide consumers the ability to gain control of their health care and to have the knowledge needed to make better health care decisions through increased transparency in the medical system. To accomplish these objectives, the FY 2008 Budget will support the continued expansion of Ambulatory Quality Alliance Pilots through CMS and AHRQ. CMS established six sites in FY 2006 and will increase this to 18 sites in FY 2007.

CDC Prevention: The request includes $17 million to support the Adolescent Health Promotion Initiative at the Centers for Disease Control and Prevention (CDC),

which aims to help our Nation's youth take responsibility for personal health through actions such as regular physical activity, healthy eating, and injury prevention. The Initiative will help communities implement the School Health Index to develop action plans to improve school health and safety policies and programs. This investment will enable more than 3,600 schools and more than three million young people and their families to take advantage of the science-based resources at HHS to encourage a culture of wellness that aims to halt the epidemic of childhood obesity plaguing our Nation.

FDA Generic Drugs: The Budget requests a total of $87 million for FDA to speed the approval of safe and affordable generic drugs to the public. This level is $23 million above the FY 2007 President's Budget and $25 million above the FY 2007 Continuing Resolution. This includes a new proposed $16 million generic drug user fee which will speed the review process and respond to the growing number of generic drug applications received by FDA every year. With these funds, FDA will increase the number of reviewers and investigators in the Generic Drugs Program and will allow the agency to approve a greater number of generic drugs in FY 2008.

FDA Improving Drug Safety and Strengthening Drug Reviews: To improve the safety of drugs already on the market, the Budget requests a total of $139 million to improve the surveillance systems for these products. This level is $16 million over the FY 2007 President's Budget and $21 million over the FY 2007 Continuing Resolution. This includes funding for access to additional databases for drug and biologic safety surveillance and upgrading the Adverse Event Reporting System to enhance tracking of safety signals.

Recommendations for the reauthorization of the Prescription Drug User Fee Act propose a level of $438 million in FY 2008 to enhance pre-market review, ensure a sound financial footing for the program, and transform the post-market safety system. These two initiatives will work together to modernize the drug safety system, improve the safety of drugs on the market, and quickly deliver innovative and safe drugs to the public.

FDA Food Safety: Enhancing capabilities of the FDA to prevent, detect, and respond to foodborne illness outbreaks is among the agency's highest priorities. The FY 2008 Budget requests a total of $391 million for FDA to develop better and more rapid methods of detecting foodborne illness, improve capacity to respond to outbreaks in the field, and build improved data systems to support the agency's import inspection activities. This level is $16 million above the FY 2007 President's Budget and $11 million above the FY 2007 Continuing Resolution. By increasing the number of food safety experts and expanding the state-of-the-art tools available to these staff, FDA will be better positioned to avoid and control future outbreaks.

PROVIDE HEALTH SERVICES TO UNDER SERVED POPULATIONS

HRSA Health Centers: The FY 2008 Budget provides an increase of $207 million over FY 2007 for the Health Resources and Services Administration (HRSA) to build upon the successes of the President's Health Centers Initiative and support the High Poverty Counties Initiative. By establishing over 220 new access points and funding 120 expanded medical capacity grants to existing health centers in FY 2008, Health Centers will surpass the President's goal of increasing access to primary health care through 1,200 new or expanded health center sites across the Nation. The President's High Poverty Counties Initiative will establish up to 120 new access points in high-poverty counties. With these new access points and expansions, in FY 2008, Health Centers will serve an additional 1.3 million clients for a total of 16.3 million.

IHS Services to American Indians and Alaska Natives: The Indian Health Service (IHS) is working in partnership with Tribes to improve the health of Indian people and eliminate health disparities. The Budget includes an increase of $212 million over FY 2007 for a total of $4.1 billion. This continues the FY 2006 and FY 2007 policy of covering population growth and health care inflation. The additional funds will help IHS achieve its mission by offsetting the rising costs of providing health care to a growing population, which is estimated to increase 1.6 percent to nearly 1.9 million individuals, and covering increased pay costs for Federal and Tribal employees who provide that care.

HRSA Ryan White: The FY 2008 Budget includes $2.2 billion for Ryan White activities, an increase of $95 million over FY 2007. Ryan White CARE Act activities support the health care needs of low-income and uninsured people living with HIV/AIDS, including medical treatment and life saving medications. The CARE Act serves as the "payer of last resort" for individuals with little to no insurance, serving over 500,000 persons impacted by HIV disease each year.

CDC HIV/AIDS Prevention: The FY 2008 Budget provides an additional $93 million in CDC for HIV/AIDS prevention activities. These funds will be used to test more than two million additional Americans, emphasizing regions with the highest numbers of new cases as well as focusing on incarcerated persons and injection drug users. These activities will increase the number of individuals that know they are HIV positive, which will slow the growth in the number of new AIDS cases and reduce the future burden of the disease.

STRENGTHEN MEDICARE AND MEDICAID'S LONG-TERM FINANCIAL SECURITY

CMS Reducing Medicare Growth: The FY 2008 Budget includes a comprehensive package of Medicare legislative and administrative proposals designed to strengthen the long-term financial security of the program. These proposals will encourage efficient payment for services, foster competition, and promote beneficiary involvement in health care decisions. Constraining Medicare spending is a key factor in meeting the President's goal of slowing the growth in entitlement spending. Net savings from the Medicare legislative package total $4.3 billion in FY 2008 and $65.6 billion over five years. Administrative savings total $1.0 billion in FY 2008 and $10.2 billion over five years.

CMS Improving Program Integrity: The FY 2008 Budget includes resources and legislation to improve program integrity oversight and reduce improper payments in the Medicare and Medicaid programs. The proposed FY 2008 Health Care Fraud and Abuse Control (HCFAC) program level is $1.3 billion, $202 million over the FY 2007 level. Included in this program level is $183 million in new discretionary funding to support HCFAC activities. These funds are part of a governmentwide proposal to fund program integrity activities through an adjustment to discretionary spending totals. This new funding will be used to combat fraud and abuse in the new prescription drug benefit and Medicare Advantage programs, and strengthen oversight of the Medicaid program.
To further enhance Medicaid's program integrity, the Budget includes legislative proposals to require States to report performance measures and link Federal grant awards to that performance, and improve existing third party liability policy.

CMS Medicaid Proposals: The Deficit Reduction Act of 2005 made significant reforms to the Medicaid program, bringing it up-to-date with 21st Century health care. The Budget continues to restrain the rate of growth in the program. The Budget proposes Medicaid legislative changes that will save $13 billion over five years and administrative changes that will save $12.7 billion over five years.

MODERNIZE THE MEDICARE SYSTEM

CMS Implementing the Medicare Prescription Drug Benefit: In 2006, HHS implemented the first year of the new prescription drug benefit, the most significant reform of the Medicare program since its inception. The new drug benefit is an unparalleled success with over 39 million people covered. On average, beneficiaries are saving $1,200 annually on their prescription drug costs, and satisfaction with the new benefit is over 75 percent. In every State and region, beneficiaries have a broad range of coverage choices available, including at least one plan with monthly premiums below $20, plans with deductibles below the Medicare standard, and plans that fill the "coverage gap." The average monthly premium has dropped by 42 percent, from an estimated $38 to $22. Finally, the net projected cost of the Medicare drug program has fallen by nearly $200 billion since its passage in 2003, from $634 billion to $445 billion over the FY 2004 to FY 2013 time period.

CMS Advancing Medicare Contracting Reform: CMS is on track toward full implementation of contracting reform nearly two years earlier than the 2011 target set in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Contracting reform will transform Medicare claims processing from 40 cost-based contracts to 15 performance-based, competetive contracts, plus 8 specialty contractors. In 2006, CMS awarded five of the 23 competitive contracts. Another seven contractors will be transitioned in FY 2007, subject to availability of appropriations. The $254 million included in this budget will allow CMS to award all 23 new contracts by the end of FY 2009.

Contracting reform is projected to generate significant administrative savings for the government and providers by reducing the cost of processing Medicare claims. This will yield $2 billion in Trust Fund savings over the next five years through more accurate and appropriate payments.

ADVANCE MEDICAL RESEARCH

National Institutes of Health: Scientific advances from research sponsored by NIH have contributed to dramatic reductions in death rates from heart disease and stroke, declines in cancer incidence and mortality, and increases in cancer survivorship. NIH is laying the cornerstone to transform the practice of medicine to be personalized, predictive, and pre-emptive, with greater patient and community participation in the active management of their health.

To capitalize on emerging opportunities, the FY 2008 Budget requests $28.9 billion for NIH, an increase of $232 million over FY 2007. These funds will allow NIH to expand the number of new and competing research projects by an estimated 566, continue to pursue cross-cutting areas of discovery, provide increased support for new research investigators, and continue refocusing its programs on translating clinical research results into clinical practice.

SECURE THE HOMELAND

Pandemic Preparedness: In August 2005, animal outbreaks of highly pathogenic H5N1 influenza virus had been reported in 12 countries around the world with 112 total human cases confirmed in four of those countries. Just over a year later, in December 2006, the number of countries confirming animal outbreaks had jumped to 53, with 258 total human cases confirmed in 10 of those countries. A pandemic could occur if the H5N1 subtype of the influenza virus acquires the ability to transmit efficiently between humans. Once a pandemic begins, time will be a critical factor in our ability to accomplish the necessary production and delivery of vaccines and other medical countermeasures required to protect the American public.

In FY 2006, Congress appropriated a total of $5.6 billion to fund portions of the President's plan for one-time funds to improve HHS pandemic influenza preparedness efforts. Funds have been used to make progress toward meeting the goals of building the capacity necessary to vaccinate everyone in the United States within six months of an outbreak and providing antiviral treatment courses sufficient for 25 percent of the United States population.

The FY 2008 Budget includes $870 million to continue funding the President's plan. These funds will allow HHS to continue its pandemic preparedness efforts, with a focus on achieving vaccine production capacity and purchasing H5N1 vaccine. These funds will also be used to meet our Federal antiviral purchase goals, as well as for the continued development of rapid diagnostics.

In addition, the Budget includes $322 million to fund ongoing activities within the CDC, FDA, NIH, and the Office of the Secretary to improve our Nation's ability to prepare for, communicate during, respond to, and contain a potential pandemic influenza outbreak.

Bioterrorism and Emergency Preparedness: The FY 2008 Budget includes $4.3 billion that is designated to protect America from a possible bioterrorist attack or other catastrophic public health emergency.

Assistant Secretary for Preparedness and Response – Bringing It All Together: The Pandemic and All-Hazards Preparedness Act of 2006 created the Assistant Secretary for Preparedness and Response (ASPR) to improve coordination and oversight of Federal public health and emergency preparedness activities. The ASPR will administer the National Disaster Medical System (NDMS) and the Hospital Preparedness Cooperative Agreements and coordinate with CDC on other bioterrorism activities, including the Strategic National Stockpile and the Cities Readiness Initiative. The Act also established the Biomedical Advanced Research and Development Authority to facilitate the development of medical countermeasures and vaccines.

The FY 2008 Budget provides $751 million for the ASPR. This funding level includes $53 million for the NDMS, an increase of $6 million over FY 2007, to improve its emergency response capabilities. NDMS was transferred to HHS from the Department of Homeland Security in 2007. The Budget also includes an increase of $135 million above the FY 2007 Continuing Resolution for advanced research and development activities to bridge the gap between basic research and countermeasure procurement and ensure the development of priority countermeasures. The ASPR budget also reflects the transfer of the Hospital Preparedness Cooperative Agreements program from HRSA in 2007.

Preparing for Public Health Emergencies: In FY 2007, the President sought increased funding to improve Federal response efforts to public health emergencies and to respond to the recommendations of the *Federal Response to Hurricane Katrina: Lessons Learned* report. The FY 2008 Budget is $42 million over the FY 2007 Continuing Resolution, which reflects the FY 2007 President's request and additional investments. This level

includes funding to improve the NDMS, and to ensure preparedness and emergency operations through the development of operation plans, training, exercising, and interagency coordination. In addition, the FY 2008 Budget also provides $38 million, an increase of $34 million over FY 2007, to continue the transformation of the Commissioned Corps, so that it can become a rapid deployment force, including the creation of two Health and Medical Response teams. Together, these investments will strengthen the Department's preparedness and response capabilities.

World Trade Center: The FY 2008 Budget includes $25 million for treatment of World Trade Center related illnesses for responders. The HHS World Trade Center Task Force continues to evaluate data and options for how best to ensure that treatment needs of responders are met.

PROTECT LIFE, FAMILY AND HUMAN DIGNITY

SAMHSA Access to Recovery and Methamphetamine Treatment: Since 2004, thousands of Americans have abstained from substance use, obtained employment, and improved their lives through the President's Access to Recovery Initiative, administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). The FY 2008 Budget includes $98 million to continue providing access to a wide array of treatment and recovery support service providers, including faith-based and community-based providers, to individuals experiencing substance abuse. Of this amount, $25 million will continue to support treatment for clients using methamphetamine.

AoA Choices for Independence: The FY 2008 Budget for the Administration on Aging (AoA) includes $28 million for Choices for Independence grants. Choices will help seniors and their families conserve and extend their personal resources by bringing transparency to long-term care, divert seniors away from nursing home care, and empower seniors to take control of their own health through lifestyle and behavioral changes. By expanding options, Choices helps seniors remain at home and in their communities for as long as possible.

ACF Child Abuse Prevention and Nurse Home Visitation: The most recent annual HHS Child Maltreatment Report indicates that each year an estimated 872,000 children in the United States are victims of abuse and neglect. Research has demonstrated that home visitation using trained nurses and strong performance monitoring can reduce incidence of child abuse and neglect and improves other important outcomes for mothers and children. Many States currently support home visitation programs, but these efforts are not always well coordinated or built on research tested approaches. The FY 2008 Budget includes a new $10 million investment to encourage States to use existing funding streams to implement and sustain proven effective home visitation programs.

ACF Abstinence Education: The FY 2008 Budget requests a total of $191 million for Abstinence Education activities, an increase of $28 million over FY 2007 to make additional awards to Community-Based Abstinence Education programs. These organizations focus on adolescents, ages 12 through 18, and work to prevent teenage pregnancy and premarital sexual activity. The Budget maintains funding for State Abstinence Education. Funds are used to support mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those populations most likely to have children out-of-wedlock. The Budget also maintains funding for the abstinence education activities of the Adolescent Family Life program.

Child Support Enforcement: The Office of Child Support Enforcement (CSE) expects to spend approximately $4.1 billion in FY 2008. Since the creation of the CSE program, child support collections within the program have grown annually. Child support collections play an important role for families transitioning from welfare to self-sufficiency. By securing support from non-custodial parents on a consistent basis, families may avoid the need for public assistance, thus reducing government spending. Over five years, the combined legislative proposals in the President's Budget submission for this account will total $19 million in Federal spending, which will in-turn increase direct collections to families by almost $1.4 billion.

ACF Facilitates Interstate Adoption from Foster Care: At the end of FY 2005, there were 513,000 children in foster care, of which 114,000 were waiting to be adopted. The current process for interstate adoption of children in foster care has not supported timely placements. To address this time lag, the FY 2008 Budget includes an additional $10 million to start providing states with incentive payments for each review of the interstate home environment completed within 30 days of the request. The Budget also includes $14 million for the existing

Adoption Incentives program, sufficient to cover estimated incentives States will earn in FY 2007 for timely adoptions within their borders.

ACF Support for Refugees, Entrants, and Unaccompanied Alien Children: The FY 2008 Budget requests a total of $656 million for all refugee programs, an increase of $103 million over FY 2007. The Budget includes an increase of $46 million to maintain current levels of assistance to refugees and other entrants. Services include time-limited cash and medical assistance and social services that emphasize employment, including English language training. An additional increase of $58 million, from $77 million in FY 2007 to $135 million in FY 2008, is also requested to serve the rapidly increasing number of alien minors under the care of ACF. This activity cares for children apprehended by United States law enforcement and taken into care pending resolution of their claims for relief under United States immigration law, or released to an adult family member or responsible adult guardian.

IMPROVE THE HUMAN CONDITION AROUND THE WORLD

In FY 2008, HHS agencies involved in international research, global disease prevention and control activities will continue efforts to respond to health events around the world, which minimize their potential to impact health within the United States. The Budget provides $143 million to detect, contain, and respond to pandemic influenza around the world, as well as conduct clinical trials and research activities in other countries. Other examples of global activities at HHS include CDC, NIH, and HRSA involvement in the President's Emergency Plan for AIDS Relief.

The FY 2008 Budget request for CDC and NIH includes approximately $494 million to support ongoing global HIV/AIDS prevention, care, treatment, surveillance, and capacity-building activities, as well as HIV/AIDS research, training, and research infrastructure programs conducted in collaboration with investigators in developing countries. In addition to these funds, the FY 2008 Budget for NIH includes $300 million to support the United States Government's entire contribution to the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria.

CDC and NIH will continue to work collaboratively with other Federal agencies, national and international organizations, and foreign governments on specific global programs to reduce morbidity and mortality from malaria, polio, measles, influenza, and emerging microbial threats. These efforts emphasize implementing immunization programs where possible; rapidly detecting and controlling disease outbreaks; and developing new vaccines, therapeutics, and diagnostics.

Latin America Initiative: The FY 2008 Budget for the Office of Global Health Affairs includes $1.5 million for a Latin America Health initiative to provide medical training and quality primary health care. This initiative will focus on developing community health workers and other primary health care workers who are desperately needed in the rural developing areas of Central America. Additionally, primary oral health care will be provided to areas that are desperately lacking such care.

IMPROVE DEPARTMENTWIDE MANAGEMENT

The Budget includes a new Nonrecurring Expenses Fund that would be comprised of expired balances of discretionary funds that would otherwise be cancelled. While no funds would be available for use in FY 2008, over the long term, this account will be used to cover nonrecurring expenses that are difficult to predict under normal budget processes, such as capital acquisitions necessary to operate the Department (including facilities and IT infrastructure) and other departmentwide priorities the Secretary considers appropriate.

President's Management Agenda: The FY 2008 Budget supports HHS efforts to improve program management departmentwide. The Budget reflects HHS' efforts to implement the President's Management Agenda (PMA). The PMA serves as a framework for improving management and practices across the Department. The PMA consists of five broad governmentwide management initiatives and four agency-specific program initiatives. HHS plans and accomplishments related to each initiative are described below. Through implementation of the PMA, HHS has taken significant steps to institutionalize its focus on results and achieve improved program performance that is important to the HHS mission and the American taxpayer. HHS develops and implements action plans to achieve PMA goals. Quarterly PMA scorecards assess progress and assign status ratings for achieving the goals of each initiative. The "status" rating indicates how well the agency has performed in meeting the long-term goals of the PMA. The "progress" rating measures the agency's short-term accomplishments that contribute to long-term success.

The scorecards employ a grading system of "green" for full achievement of all goals for a particular initiative, "yellow" for intermediate achievement, and "red" when at least one deficiency is found.

Strategic Management of Human Capital: HHS has achieved green status and green progress ratings for Strategic Management of Human Capital. This rating recognizes several HHS accomplishments, including the implementation of a new four-tier Performance Management System for all of the Department's employees. HHS is planning to implement a new Learning Management System which will enhance the Department's learning and growth opportunities.

Competitive Sourcing: HHS has achieved a green status and green progress rating for Competitive Sourcing for twelve consecutive quarters, dating back to March 2004. To date, HHS has conducted competitive sourcing studies for over 40 percent of its available commercial activities. For studies completed in FY 2006, HHS reported actual gross savings of over $50 million for the benefit of HHS programs and the American taxpayer. HHS plans to maintain high performance in support of Competitive Sourcing. This includes structuring bid competitions to maximize efficiencies and savings, utilizing Most Efficient Organization principles, and continuing to implement an independent savings validation plan.

Improved Financial Performance: HHS has achieved a green progress rating on the Improved Financial Performance initiative and is working to improve its red status rating. The Department has made significant strides in its implementation of a Unified Financial Management System (UFMS). In connection with the implementation of UFMS, the Department has begun to address related financial reporting and policy development requirements. HHS fully implemented the A-123, Appendix A requirement to conduct an assessment of Internal Controls Over Financial Reporting and expects to institutionalize a process for conducting all internal control and compliance type assessments to ensure that maximum efficiencies are realized. The Department created a Risk Management and Financial Oversight Board, which is comprised of senior level departmental staff who have oversight responsibilities for those initiatives and activities related to improving financial performance at the Department.

Expanded Electronic Government: HHS is working to improve its red progress and status rating for the Expanded Electronic Government Initiative. The Department's strategic planning goals and objectives are supported through the integration of IT capital planning and budget processes; implementation of enterprise architecture, security, and project management; and use of performance measurement and management as a component of enterprise planning and performance life cycle planning processes. Enterprise and performance life cycle planning provide a structured framework in which sound business decisions can be made through consistent practices that offer the opportunity for repeatable successes in IT investments and project management.

In FY 2006, HHS migrated all Operating Divisions, except NIH, to GovTrip, one of the government-wide eTravel solutions. HHS also received over 52,000 applications through Grants.Gov, more than triple the agency's FY 2006 goal of 15,000 applications. As a key part of the HHS information security program, HHS began an initiative to implement full-disk encryption for all laptops to more effectively safeguard sensitive data.

Budget and Performance Integration: HHS has maintained its green progress and yellow status rating for five consecutive quarters for the Budget and Performance Integration (BPI) initiative. BPI aims to improve program performance and efficiency by ensuring that performance information informs funding and management decisions. One indicator of program effectiveness, and an important component of BPI, is the Program Assessment Rating Tool (PART). Each program assessed by PART receives a narrative rating of Effective, Moderately Effective, Adequate, Ineffective, or Results Not Demonstrated. To date, 116 programs have been assessed. A list of HHS PART programs is provided as an appendix to this book. Detailed information on PART assessments can be found at www.expectmore.gov.

Broadening Health Insurance Coverage Through State Initiatives: HHS has achieved and maintained a green progress and yellow status rating on the Broadening Health Insurance Coverage goal which seeks to expand health care coverage through the Administration's waiver initiatives such as the Health Insurance Flexibility and Accountability (HIFA) Initiative. Through this innovative approach to demonstrations in Medicaid and SCHIP, States are encouraged to increase the number of individuals with health insurance coverage through maximizing both private health insurance coverage options and employer-sponsored insurance.

As of October 2006, HHS had granted approval to 14 States to potentially enroll nearly one million new people in their programs and had funded case studies of HIFA demonstrations in ten states. HHS will continue to maintain its progress with this goal and is currently funding an evaluation of the impact of HIFA demonstrations on uninsurance rates in States.

Eliminating Improper Payments: HHS has achieved a green progress rating for the Eliminating Improper Payments initiative, reflecting significant progress in its activities to identify, reduce and recover improper payments in seven of its largest programs. HHS is working to improve its red status rating, and is in the initial stages of development to identify improper payments in the Medicare Advantage and the Medicare Prescription Drug programs. Seven HHS programs: Medicare fee-for-service; Medicaid; SCHIP; Temporary Assistance for Needy Families; Head Start; Foster Care; and Child Care; are in different stages of development or implementation of measuring error rates.

Real Property Asset Management: HHS has achieved a green progress rating since September 2004 and reached yellow status for Real Property Asset Management in the first quarter of 2006. This rating recognizes several HHS accomplishments, including development of an Asset Management Plan (AMP) consistent with Federal Real Property Council (FRPC) standards, and a three year timeline for meeting the plan goals and objec-tives. HHS has a second quarter of 2007 target to demonstrate that it is managing real property assets consistent with the Department's Strategic Plan, AMP, and PRPC performance measures, and that inventory and performance data is used in daily decision-making. These are the remaining tasks to achieve green status.

Faith-Based and Community Initiative: HHS has achieved a green status and green progress rating for the Faith-Based and Community Initiative for three consecutive quarters. This rating recognizes several HHS accomplishments, including implementing a comprehensive outreach and technical assistance strategy; working with state and local officials to expand access to Federal funding awarded through them; monitoring compliance with the Equal Treatment Regulations; collecting data on participation of faith-based and community organizations (FBCOs) in Federal grant programs; implementing and evaluating pilot programs to strengthen the partnership between FBCOs and the Federal Government.

HHS BUDGET BY OPERATING DIVISON

(mandatory and discretionary dollars in millions)

	2006	2007	2008	
	Actual	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Food & Drug Administration:				
Program Level	1,876	1,821	2,085	+263
Budget Authority	1,495	1,490	1,641	+151
Outlays	1,444	1,386	1,589	+203
Health Resources & Services Administration:				
Budget Authority	6,093	6,109	5,766	-343
Outlays	6,221	5,920	6,175	+255
Indian Health Service:				
Budget Authority	3,195	3,209	3,421	+212
Outlays	3,253	3,255	3,474	+219
Centers for Disease Control & Prevention:				
Budget Authority	6,390	5,812	5,762	-50
Outlays	5,090	5,679	5,815	+136
National Institutes of Health:				
Budget Authority	28,509	28,618	28,850	+232
Outlays	27,774	28,120	28,576	+456
Substance Abuse & Mental Health Services:				
Budget Authority	3,203	3,205	3,046	-159
Outlays	3,183	3,204	3,144	-60
Agency for Healthcare Research & Quality:				
Program Level	319	319	330	+11
Budget Authority	1	-	-	-
Outlays	1	-	-	-
Centers for Medicare & Medicaid Services:				
Budget Authority	586,015	544,259	600,545	+56,286
Outlays	515,450	569,774	598,977	+29,203
Administration for Children & Families:				
Budget Authority	41,364	47,195	45,327	-1,868
Outlays	46,918	48,022	45,953	-2,069

HHS BUDGET BY OPERATING DIVISION

(mandatory and discretionary dollars in millions)

	2006	2007	2008	
	Actual	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Administration on Aging:				
Budget Authority	1,362	1,363	1,335	-28
Outlays	1,379	1,348	1,342	-6
Office of the National Coordinator:				
Budget Authority	42	42	90	+48
Outlays	15	35	57	+22
Medicare Hearings and Appeals:				
Budget Authority	59	59	70	+11
Outlays	59	59	70	+11
Departmental Management/Civil Rights:				
Budget Authority	393	393	430	+36
Outlays	428	375	405	+30
Public Health Social Service Emergency Fund:				
Budget Authority	5,803	730	1,754	+1,024
Outlays	2,515	3,216	2,663	-553
Office of Inspector General:				
Budget Authority	64	67	70	+3
Outlays	32	64	75	+11
Program Support Center (Retirement Pay, Medical Benefits, Misc. Trust Funds):				
Budget Authority	427	457	491	+34
Outlays	374	477	504	+27
Offsetting Collections:				
Budget Authority	-1,421	-1,298	-1,275	+23
Outlays	-1,421	-1,298	-1,275	+23
Total, Health & Human Services Budget Authority	**682,986**	**641,709**	**697,323**	**+55,614**
Emergency Funding/ Pandemic Influenza (Non-Add)	*5,777*	--	870	+870
Regular Budget Authority (Non-Add)	677,209	641,709	696,453	+54,744
Outlays	**612,715**	**669,636**	**697,544**	**+27,908**
Full-Time Equivalents	64,182	64,548	66,890	+2,342

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Discretionary Programs (Budget Authority)					
Food & Drug Administration	1,495	1,545	1,490	1,641	+151
FDA Program Level	*1,876*	*1,979*	*1,821*	*2,085*	*+263*
Health Resources & Services Administration	6,075	5,829	6,054	5,802	-252
HRSA Program Level	*6,119*	*5,876*	*6,101*	*5,850*	*-251*
Indian Health Service	3,045	3,170	3,059	3,271	+212
IHS Program Level	*3,883*	*4,026*	*3,915*	*4,127*	*+212*
Centers for Disease Control & Prevention	6,390	5,758	5,812	5,792	-20
CDC Program Level	*8,632*	*9,071*	*8,984*	*8,822*	*-163*
National Institutes of Health	28,359	28,268	28,468	28,700	+232
NIH Program Level	*28,517*	*28,427*	*28,626*	*28,858*	*+232*
Substance Abuse & Mental Health Services	3,203	3,134	3,205	3,046	-159
SAMHSA Program Level	*3,324*	*3,260*	*3,326*	*3,168*	*-159*
Agency for Healthcare Research & Quality	--	--	--	--	--
AHRQ Program Level	*320*	*319*	*319*	*330*	+11
Centers for Medicare & Medicaid Services	3,120	3,113	3,076	3,239	+163
CMS Program Level (Excluding HCFAC)	*3,295*	*3,293*	*3,325*	*3,421*	*+96*
Administration for Children & Families	13,718	12,787	13,705	12,829	-877
ACF Program Level	*14,778*	*12,847*	*13,766*	*12,889*	*-877*
Administration on Aging	1,362	1,335	1,363	1,335	-28
AoA Program Level	*1,365*	*1,338*	*1,366*	*1,338*	*-28*
Departmental Management/Office for Civil Rights	393	419	393	430	+36
OS Program Level	*437*	*463*	*438*	*481*	*+44*
Office of the National Coordinator	42	90	42	90	+48
ONC Program Level	*62*	*118*	*62*	*118*	*+57*
Medicare Hearings and Appeals	59	74	59	70	+11
Office of Inspector General	39	44	39	45	+5
OIG Program Level	*248*	*259*	*243*	*266*	*+23*
Health Care Fraud and Abuse Control	--	118	--	183	+183
HHS HCFAC Program Level	*1,023*	*1,049*	*942*	*1,124*	*+181*
Public Health & Social Services Emergency Fund	5,803	889	730	1,754	+1,024
PHSSEF Program Level	*5,807*	*893*	*734*	*1,758*	*+1,024*
Medicare Eligible Healthcare Accruals (Com. Corps)	34	36	36	37	+1
DOJ HCFAC Charged To HHS (Program Level Only)	--	*11*	--	*18*	*+18*
Hurricane Response Funding	90	--	--	--	--
Social Services Block Grant Reduction	--	-500	--	-500	-500
HRSA Loan Fund Balance Rescission (Non-Add In FY 2006)	[-24]	-106	--	-105	-105
CDC Rescissions (Unobligated Balances)	33	--	--	-30	-30
Offset for PHS Evaluation Funds (Prog. Level)	*-811*	*-825*	*-811*	*-839*	*-28*
HCFAC Funds Included in Agencies Prog. Level	*-169*	*-186*	*-175*	*-196*	*-21*
Subtotal, Discretionary Budget Authority	73,195	66,003	67,532	67,628	*+95*
Subtotal, Discretionary Program Level	*78,858*	*71,722*	*73,079*	*73,090*	*+11*
Less Emergency Funding	-5,777	--	--	--	--
Total, Discretionary Budget Authority /1	**67,418**	**66,003**	**67,532**	**67,628**	**+95**
Discretionary Outlays	**67,862**	**n/a**	**69,219**	**69,070**	**-149**

1/ The FY 2007 CR column of the OMB Budget Chapter repeats FY 2006 enacted rescissions (HRSA: $17 million, Smallpox Compensation Fund: $5 million), and $4 million for a completed activity in AoA, which are not displayed in this table.

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2006	2007	2008	
		Continuing	President's	+/- 2007
	Actual	Resolution	Budget	Cont. Res.
Mandatory Programs (Outlays)				
Medicare	324,908	367,471	386,492	+19,021
Medicaid	180,625	191,876	201,944	+10,068
Temporary Assistance for Needy Families	16,897	17,318	17,296	-22
Foster Care & Adoption Assistance	6,352	6,533	6,834	+301
State Children's Health Insurance Program	5,451	5,647	6,644	+997
Child Support Enforcement	4,001	4,519	4,085	-434
Child Care	3,060	2,828	2,800	-28
Social Services Block Grant/1	1,848	2,155	1,731	-424
Other Mandatory Programs	3,132	3,368	1,923	-1,445
Offsetting Collections	-1,421	-1,298	-1,275	+23
Subtotal, Mandatory Outlays	544,853	600,417	628,474	+28,057
Total, HHS Outlays	**612,715**	**669,636**	**697,544**	**+27,908**

1/ FY 2008 outlays reflect the mandatory component of SSBG. With proposed discretionary reductions, outlays would be $1,306.

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Program					
Foods	439	450	439	467	+28
Human Drugs	518	553	509	571	+62
Biologics	195	215	192	216	+24
Animal Drugs and Feeds	99	105	90	106	+17
Medical Devices	261	272	238	285	+48
National Center for Toxicological Research	41	34	41	36	-4
Headquarters and Office of the Commissioner	117	119	101	122	+21
GSA Rental Payments	134	149	131	159	+29
Other Rent and Rent-Related Activities	36	43	42	68	+26
FDA Consolidation at White Oak	22	26	27	39	+12
Export/Certification Fund	8	8	8	10	+1
Subtotal, Salaries and Expenses	1,869	1,974	1,816	2,080	+263
Buildings and Facilities	8	5	5	5	--
Total, Program Level	**1,876**	**1,979**	**1,821**	**2,085**	**+263**
Less User Fees:					
Current Law					
Prescription Drug User Fees (PDUFA) /1	305	352	305	339	+34
Medical Device User Fees (MDUFMA)/2	40	44	--	48	+48
Animal Drug User Fees (ADUFA)/2	11	12	--	14	+14
Mammography Quality Standards Act (MQSA)	17	18	18	18	+1
Export/Certification Fund	8	8	8	10	+1
Subtotal, Current Law User Fees	382	434	331	428	+97
Proposed Law					
Generic Drug User Fee	--	--	--	16	+16
Subtotal, Proposed Law User Fees	--	--	--	16	+16
Total, User Fees	**382**	**434**	**331**	**444**	**+113**
Total, Discretionary Budget Authority	**1,495**	**1,545**	**1,490**	**1,641**	**+151**
Less Mandatory Proposed Law User Fees					
Reinspection User Fee	--	22	--	23	+23
Export Certification Fund (Foods and Feeds)	--	4	--	4	+4
Subtotal, Mandatory Proposed User Fees	--	26	--	27	+27
Mandatory BA (Scorekeeping Adjustment)	--	26	--	27	*+27*
Total, Net Budget Authority/3	**1,495**	**1,520**	**1,490**	**1,614**	**+124**
Biodefense (non-add):					
Food Defense	*158*	*178*	*156*	*178*	*+23*
Medical Product Countermeasures	*57*	*57*	*55*	*57*	*+2*
Physical Security	*7*	*7*	*7*	*7*	*+.2*
Subtotal, Biodefense (non-add)	*222*	*242*	*217*	*242*	*+25*
Total FTE	9,806	9,898	9,146	9,997	+851
Budget Authority FTE	7,893	7,931	7,510	7,987	+477
User Fee FTE	1,913	1,967	1,636	2,010	+374

1/ Only assumes inflationary increases to PDUFA in FY 2008.

2/ FDA will not be able to collect MDUFMA and ADUFA user fees under the FY 2007 Continuing Resolution due to failure to meet budget authority triggers.

3/ Net budget authority is contingent upon enactment of proposed mandatory user fees and reciept of estimated collections.

FOOD AND DRUG ADMINISTRATION

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

The FY 2008 budget request for the Food and Drug Administration (FDA) is $2.1 billion, a net program level increase of $263 million over the FY 2007 Continuing Resolution and an increase of $106 million over the FY 2007 President's Budget. The FDA budget includes significant increases to speed approval of generic drugs, modernize the drug safety system, improve the safety of the Nation's food supply, increase safety and improve review of medical devices, and accelerate the availability of new and innovative medical products. The budget also supports FDA consolidation efforts at White Oak, Maryland and pay and rent costs.

The request for FDA is described relative to the FY 2007 President's Budget as opposed to the FY 2007 Continuing Resolution level. Unlike the FY 2007 President's Budget, a straight calculation of the FY 2007 Continuing Resolution assumes $102 million in FDA user fee collections are reduced or terminated. The Administration supports the continuation of these fees and therefore uses the FY 2007 President's Budget as the base for building the FY 2008 Budget policies.

SUPPORTING INNOVATIVE, SAFE, AND AFFORDABLE DRUGS AND BIOLOGICS

In FY 2008, the Budget includes $787 million for the Human Drugs and Biologics programs, an increase of $20 million over the FY 2007 President's Budget and $86 million over the FY 2007 Continuing Resolution. Of the total funding for these activities, $307 million will be from industry-specific user fees. These funds will improve the review of new drugs and biologics and ensure the safety and efficacy of existing products – helping to make medicines safer, more affordable, and more available.

Generic Drug Review: Increasing access to safe and affordable generic drugs is a priority at FDA. In recent years, the Office of Generic Drugs has made significant progress in expediting review, allowing FDA to approve more generic drugs each year, reaching a record high of 510 in FY 2006. Yet submissions of abbreviated new drug applications for generic drugs continue to rise rapidly; from 307 in FY 2001 to 793 in FY 2006, a 158 percent increase. To respond to this dramatic increase, the FY 2008 President's Budget includes a total of $87 million for generic drug review activities. This funding level is $23 million over the FY 2007 President's Budget and $25 million over the FY 2007 Continuing Resolution. The Budget request includes a proposal for an industry-funded generic drug user fee, which will generate $16 million in FY 2008 to speed approval of lower cost generic drugs. With these new resources, FDA expects to approve an estimated 550 generic drugs in FY 2008, an increase of 50 approvals over FY 2007. Speeding the approval of generic drugs will not only increase performance, but will positively impact the entire health care system, which relies on these lower cost alternatives.

Modernizing Drug Safety: Building on the strong record of safe and reliable drugs that has made FDA the gold standard of regulatory agencies worldwide, FDA worked to establish the Drug Safety Oversight Board and enhanced the Adverse Event Reporting System in FY 2006 and FY 2007. The FY 2008 President's Budget proposes to further strengthen and modernize the drug safety system by increasing drug safety funding to a total of $139 million, $16 million over the FY 2007 President's Budget and $21 million over the FY 2007 Continuing Resolution. To continue this modernization, FDA will increase access to additional databases for drug and biologic safety surveillance and analysis and hire epidemiologists and programmers to evaluate these databases. The agency will enhance the ability to track safety signals from adverse event reports by upgrading the Adverse Event Reporting System. FDA will also increase involvement of safety experts throughout product lifecycle, including during design and through continuing review of post-marketing safety studies.

MAKING THE NATION'S FOOD SAFER

Outbreaks of foodborne illness linked to fresh produce have increased in the last ten years. During the past year, FDA, along with the Centers for Disease

Control and Prevention and State and local health agencies, has acted decisively to identify, contain, and prevent outbreaks. FDA is maximizing the agency's available tools to combat foodborne illness, but more must be done to safeguard the Nation's food supply. While improved detection and quick response to outbreaks have helped keep the food supply safe, the increased consumption of fresh produce per capita and increased complexity and reach of food distribution systems continues to threaten food safety.

The FY 2008 President's Budget requests $391 million for food safety activities, an increase of $16 million over the FY 2007 President's Budget and $11 million over the FY 2007 Continuing Resolution. With these funds, FDA will develop better and more rapid methods of detecting foodborne illness outbreaks and increase surveillance capabilities at the Center for Food Safety and Applied Nutrition and in the field. By increasing the number of experts in fresh produce microbiological safety issues and food safety risk analysis, FDA will reduce illness due to contaminated food and allow food back on the shelves quicker once a threat has ceased. FDA will also enhance the capabilities in the field by funding more rapid traceback of produce-related outbreaks, with teams strategically placed in large produce-growing areas and making improvements to import inspection systems. FDA will also enhance emergency response efforts and will develop rapid methods to determine the underlying causes of foodborne contaminations.

Improving the Review and Safety of Medical Devices

As medical devices become ever more diverse, complex, and integral to delivering health care in the United States, the need to improve the system that ensures their safety and proves their efficacy also grows. In response to an increase in the number of device-related adverse events and recalls of malfunctioning devices in recent years, FDA is proposing a Total Product Life Cycle approach to improving device safety and review. The FY 2008 Budget requests a total of $240 million in budget authority to improve review and ensure the safety of medical devices, an increase of $10 million over the FY 2007 President's Budget and $20 million over the FY 2007 Continuing Resolution. This funding level is consistent with the intent of the Medical Devices User Fee and Modernization Act of 2002 (MDUFMA) as modified by the Medical Device User Fee and Stabilization Act in 2005. These funds will lead to marked improvement in application review time while maintaining the consistent quality and safety of approved medical device products.

New and increasingly complex medical devices are making astonishing medical advances possible, in both diagnosis and treatment. MDUFMA fees contribute to the evaluation of post-market studies required as a condition of medical device approval, and the compilation, development, and review of post-market information to identify safety and effectiveness issues. Through additional user fee resources, FDA will be able to review medical device applications for safety and effectiveness in a manner that moves products to the market quickly.

This activity will also reduce medical errors, improve adverse event reporting and facilitate device recall by upgrading Center for Devices and Radiological Health information technology (IT) applications to improve post-market tracking of medical devices. The request also will provide additional staff to handle product recalls and deploy analytical tools to detect adverse events in marketed products.

MDUFMA is also due for reauthorization in FY 2008. FDA is currently working to come to agreement on principles for reauthorization of this important legislation.

Improving Safety and Compliance through User Fees

In addition to the new generic drug user fee detailed above, the

Prescription Drug User Fee

The Prescription Drug User Fee Act (PDUFA) is due for reauthorization in FY 2008. This landmark legislation fundamentally changed the approval of prescription drugs, speeding the delivery of life-saving medications to the public. FDA published a notice in the Federal Register on January 16, 2007, to inform the public of proposed recommendations for PDUFA IV reauthorization. FDA will hold a public meeting on February 16, 2007, to hear comments from the public and the Department will inform Congress of the Administration's formal recommendations afterward. Having not yet completed the public comment period, FDA does not display the PDUFA IV collections estimate in the FY 2008 budget request. PDUFA IV recommendations propose a total of $438 million for FY 2008 to enhance pre-market new drug and biologic review, ensure a strong financial footing for the PDUFA program, and transform of the post-market safety system. The President's Budget supports the reauthorization of PDUFA.

Performance Highlight

According to the Congressional Budget Office, generic drugs save consumers an estimated $8 billion to $10 billion a year compared with the price of trade-name drugs. As the demand for new generic drugs continues to rise, it will be critical for FDA to act on these drugs as quickly as possible because of the large cost savings to the public. In FY 2008, FDA is requesting $87 million for the Generic Drugs Program, which includes a proposal for $16 million in new generic drug user fees to speed generic drug review. These new increases will support more FTE, allowing FDA to handle the growing workload.

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

The second user fee proposes to expand the current drug, animal drug, and medical device export certification user fee program by $4 million to also include food and animal feed. As detailed in last year's budget, export certificates may be requested by firms seeking documentation that exported products are in compliance with United States laws and regulations, importing countries' requirements, and certain national or international standards. These certificates enhance the global competitiveness of American food and animal feed producers by ensuring that the products meet specific legal requirements. With this expansion, the food and animal feed industry will no longer receive preferential treatment through government payment of export certificates. FDA is re-proposing these fiscally responsible fees in FY 2008 which will require industry to pay for the services that FDA renders.

SUPPORTING FDA FACILITIES

Headquarters Consolidation: The FY 2008 Budget requests $39 million in budget authority for headquarters consolidation at the new FDA campus in White Oak, Maryland. This funding level is a $13 million increase over the FY 2007 President's Budget and $17 million above the FY 2007 Continuing Resolution. These resources will be directed to costs for the new consolidated facility under construction by the General Services Administration (GSA). This funding is needed for completion of the project's next phase, which includes cabling, security, and IT and telecommunications equipment for the Center for Devices and Radiological Health building, the Office of Regulatory Affairs and Office of the Commissioner building, Central Shared Used building, and Consolidated Data Center. The FY 2008 GSA budget includes $58 million primarily for design and construction of the Office of the Commissioner Building II and Consolidated Data Center; and design of the Life Sciences II Laboratory Buildings and the Center for Biologics Evaluation and Research/Center for Veterinary Medicine Office Building.

Rent: The Budget request includes an increase of $30 million over the FY 2007 President's Budget and $40 million over the FY 2007 Continuing Resolution for GSA rental payments and other rent and rent-related costs in FY 2008. Rent and rent-related cost have increased significantly in recent years, due to the new White Oak facility and because of higher than anticipated costs for services, such as utilities and security. To cover these increased costs, FDA assessed the product program areas for those bills that cannot be paid through the agency's rent budget. The FY 2008 Budget is requesting all rental costs to be provided in the rent budget lines so that the agency can clearly distinguish between rent cost and program cost in its budget presentation.

TARGETED REDUCTIONS

FDA has conducted an agencywide risk-based analysis aimed at identifying lower priority activities to fund the urgent public health priorities detailed in the FY 2008 budget request. In FY 2008, FDA is proposing a $4 million reduction to the outreach and research coordination budget. These reductions will impact the Office of the Commissioner, Headquarters, and Animal Drugs and Feeds programs.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Health Centers	1,785	1,963	1,765	1,988	+224
(Health Centers Federal Tort Claims - non-add)	*45*	*45*	*27*	*44*	*+17*
Free Clinics Medical Malpractice Coverage	0.04	--	0.55	0.1	-0.4
Office of Pharmacy Affairs (340B Program)	--	3	--	2.9	+3
Nurse Training Programs	150	150	150	105.3	-44
Advanced Education Nursing (non-add)	*57*	*57*	*57*	--	*-57*
Loan Repayment and Scholarship Program (non-add)	*31*	*31*	*31*	*43.7*	*+13*
National Health Service Corps	125	126	126	116	-10
Health Professions Training Activities	145	10	145	10	-135
Children's Hospitals Graduate Medical Education	297	99	297	110	-187
Ryan White HIV/AIDS Activities	2,061	2,158	2,063	2,158	+95
Rural Health	160	27	160	17	-143
Maternal and Child Health Block Grant	693	693	693	693	--
Healthy Start	101	102	102	101	-1
Family Planning	283	283	283	283	--
Traumatic Brain Injury	9	--	9	--	-9
Poison Control	23	13	23	10	-13
EMS for Children	20	--	20	--	-20
Organ Transplantation	23	23	23	23	--
Bone Marrow Donor Registry	25	23	25	23	-2
Cord Blood Stem Cell Bank	4	--	--	2	+2
Telehealth	7	7	7	7	--
Black Lung/Radiation Exposure Compensation	8	8	8	8	--
Hansen's Disease Services Programs	18	18	18	18	--
Universal Newborn Hearing Screening/Trauma	10	--	10	--	-10
Sickle Cell	2	2	2	2	--
Family-to-Family Health Information Centers	--	3	3	4	+1
Program Management	151	148	151	151	--
National Practitioner Data Bank (User Fee)	16	16	16	15	-1
Health Integrity & Protection Data Banks (User Fee)	4	4	4	4	--
Total, Program Level	**6,119**	**5,876**	**6,101**	**5,850**	**-251**
Less Mandatory and Funds From Other Sources					
User Fees	-20	-20	-20	-19	+1
PHS Evaluation Funds (Ryan White)	-25	-25	-25	-25	--
Family-to-Family Health Information Centers (mandatory funds)	--	-3	-3	-4	-1
Subtotal, Funds from Other Sources	-45	-48	-48	-48	--
Total, Discretionary Budget Authority/1	**6,075**	**5,829**	**6,054**	**5,802**	**-252**
FTE	1,808		1,937	1,973	+36

1/ FY 2006 and FY 2007 do not reflect funds for Bioterrorism Preparedness Activities. These funds will be transferred to the Office of the Secretary beginning in FY 2007. Actual funding levels for HRSA were $6,569 in FY 2006, $6,293 in the FY 2007 P.B., and $ 6,549 in the FY 2007 C.R.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

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

The FY 2008 Budget request for the Health Resources and Services Administration (HRSA) is $5.8 billion, a net decrease of $252 million below the FY 2007 Continuing Resolution and a decrease of $26 million below the FY 2007 President's Budget. Millions of families in the United States face barriers to quality health care because of their income, lack of insurance, geographic isolation, or language and cultural barriers. HRSA is the principal Federal agency charged with increasing access to care for these underserved populations. Its mission is to provide national leadership, program resources and services to improve access to culturally competent, quality health care. Some of the populations served by HRSA programs include:

- The 47 million Americans who lack health insurance, many of whom are racial and ethnic minorities;
- Over 50 million underserved Americans who live in rural and poor urban neighborhoods where health care services are scarce;
- African American infants who are still 2.4 times as likely as white infants to die before their first birthday;
- More than one million people living with HIV/AIDS; and
- Over 87,000 Americans who are waiting for an organ transplant.

EXPANDING ACCESS TO QUALITY HEALTH CARE

Health Centers: The Budget supports the final year of the President's Health Centers Initiative, as well as the President's High Poverty Counties Initiative. By establishing over 220 new access points and funding 120 expanded medical capacity grants to existing health centers in FY 2008, the Health Center Program will surpass the goal of increasing access to primary health care in 1,200 communities across the Nation. The President's High Poverty Counties Initiative, which builds on the success of the Health Centers Initiative, will establish up to 120 new access points in high-poverty counties that currently lack a health center site. A total of $207 million is requested to support these expansion activities.

In FY 2008, health centers will serve an estimated 16.3 million patients. Of the population served by health centers, over 91 percent are at or below 200 percent of the Federal poverty level, 64 percent are from racial/ethnic minority groups, and 40 percent are uninsured.

In addition to medical services, 85 percent of Health Centers provide pharmacy services on site or by paid referral, 84 percent provide preventive dental care, and 77 percent provide mental health and substance abuse services.

The Budget request includes $44 million in no-year funding for the Health Centers Federal Tort Claims Program, which provides medical malpractice coverage for the increasing number of Health Center clinicians. The 340B Drug Pricing Program provides discounts or rebates to HHS-assisted programs and hospitals that meet statutory criteria for serving a disproportionate share of low-income patients. Participants include community health centers, Ryan White grantees, Indian Health Service funded Tribal clinics, Title X family planning programs, and Centers for Disease Control and Prevention-funded Sexually Transmitted Disease and Tuberculosis programs. The FY 2008 request of $3 million will be used to continue management improvements, including increased monitoring of compliance with 340B price ceilings and improved accuracy and reliability of the database of participating covered entities.

Free Clinics also play a significant role in meeting the health care needs of the uninsured. The Free Clinics Medical Malpractice fund extends malpractice coverage to medical professional volunteers in

Performance Highlight

In FY 2001, HRSA funded 3,317 health centers sites. Under the President's Health Centers Expansion Initiative, HRSA has increased access to health center services through 899 new and expanded sites (514 new sites and 385 expansions) for a total of 3,831 sites across the country. In FY 2008, HRSA will fund an additional 340 new or expanded sites (220 new sites and 120 expansions), surpassing the goal of establishing 1,200 new or expanded sites by the end of the year, and will reach a total of 16.3 million patients served.

free clinics in order to expand access to health care services to low-income individuals in medically underserved areas. The FY 2008 request of $100,000 supports program operations as well as an effort to determine the impact of extending this coverage on medical professionals' decisions to volunteer.

Ryan White, HIV/AIDS: Each year, Ryan White Comprehensive AIDS Resources Emergency (CARE) Act activities address the unmet health needs of over 500,000 low-income and uninsured people living with HIV disease. The FY 2008 request includes $2.2 billion for Ryan White activities, an increase of $95 million over FY 2007. The FY 2008 request supports a comprehensive approach to address the health needs of persons living with HIV/AIDS, including medical treatment, life saving medications, and access to care. Of this $95 million, approximately $70 million will go toward grants to States, while the remaining will provide additional funding for HIV/AIDS therapies through State AIDS Drug Assistance Programs, bringing the benefits of effective and costly anti-retroviral and other pharmaceuticals within reach of persons with HIV.

Maternal and Child Health Block Grant: The FY 2008 Budget provides $693 million for the Maternal and Child Health (MCH) Block Grant. The MCH Block Grant is a public health program that reaches across economic lines to improve the health of mothers and children. Special efforts are made to build community capacity to deliver such enabling services as care coordination, transportation, and nutrition counseling. The MCH Block Grant supports Federal and State partnerships that provide gap-filling maternal health services to more than 2.3 million women and primary and preventive care to more than 27.8 million infants and children, including approximately 1 million children with special health care needs. The Deficit Reduction Act of 2005 provides $4 million in mandatory funding in FY 2008 for the development and support of family-to-family health information centers.

Consistent with the FY 2007 Budget, no funding is requested in FY 2008 Budget for Traumatic Brain Injury, Universal Newborn Hearing, and Emergency Medical Services for Children. The Activities authorized under these programs may be supported through the MCH Block Grant which allows grantees greater flexibility to direct funds towards to areas of need.

Family Planning: The FY 2008 request includes a total of $283 million for family planning services. The Family Planning program supports a network of more than 4,400 clinics nationwide. Program data reflects that in 2005, these clinics served over 5 million individuals, 90 percent of whom were from low-income families. Additionally, over 900,000 unintended pregnancies are estimated to be averted as a result of Title X family planning services. Counseling and education regarding abstinence are required for all adolescent clients in this program.

Ryan White Reauthorization

In December of 2006, the reauthorization of the Ryan White CARE Act was signed into law by the President. The reauthorized Act:

- Targets money to core life-saving and life-extending medical services;
- Increases accountability through more aggressive oversight of Ryan White CARE Act programs;
- Provides more flexibility to direct funding to areas of greatest need; and
- Standardizes minimum requirements for the AIDS Drug Assistance Program.

Healthy Start: Healthy Start provides services tailored to the needs of high risk pregnant women, infants and mothers in communities with exceptionally high rates of infant mortality. Communities in the 37 States, the District of Columbia, and Puerto Rico that are served by Healthy Start have large minority populations, high rates of unemployment and poverty, and limited access to safe housing and medical providers. Healthy Start supports community driven programs in these communities to reduce the incidence of risk factors that contribute to infant mortality. A total of $101 million is requested for Healthy Start in FY 2008.

Poison Control: The Budget also includes $10 million for the Poison Control Program, a reduction of $13 million below FY 2007. Ninety-five percent of poison control centers (58 of 61 centers) are now certified. Poison centers have been able to stabilize their funding for basic operations and many have partnered with public health and health agencies. In FY 2008, the Budget proposes continuing to assist poison centers to improve their operations and achieve certification and self-sufficiency.

DEVELOPING A HEALTH PROFESSIONS WORKFORCE FOR THE 21ST CENTURY

The FY 2008 Budget reduces funding for Advanced Education Nursing and increases investments in the recruitment of new nurses into the field through loan repayment and scholarship programs. Funding is maintained for workforce diversity and comprehensive geriatric training. The request includes $105 million for these programs.

The National Health Service Corps (NHSC) places primary care clinicians, including dental, mental and behavioral health professionals, in health professional shortage areas in every state and territory. Over its 35-year history, the NHSC program has offered recruitment incentives, such as scholarship and loan repayment support, to over 27,000 health professionals who serve in areas that lack quality basic health care. Over half of NHSC clinicians are assigned to service in community health centers. The FY 2008 request of $116 million, a decrease of $10 million, will continue to support a field strength of more than 3,400 clinicians.

The Budget provides $110 million for the Children's Hospitals Graduate Medical Education (GME) program, a decrease of $187 million below FY 2007 and an increase of $11 million over the FY 2007 President's Budget. GME funds support training in freestanding children's teaching hospitals.

SUPPORTING TRANSPLANTATION

The Budget includes $23 million to support the Organ Transplantation program, which provides:

- Contracts to operate the national Organ Procurement and Transplantation Network and the Scientific Registry of Transplant Recipients;
- Breakthrough Collaboratives to disseminate rapidly best practices in organ donation; and
- Grants to support development and improvement of State donor registries and to educate the public about organ and tissue donation.

The Budget also includes $23 million to support the C.W. "Bill" Young Cell Transplantation Program (successor to the National Bone Marrow Donor Registry), which enables patients to search for a suitable, unrelated bone marrow donor or cord blood product, and which recruits volunteer adult donors of blood stem cells. Blood Stem Cell transplants offer the possibility of a cure for people with leukemia and other life-threatening blood disorders.

The National Cord Blood Inventory program (successor to the Cord Blood Stem Cell Bank program) assists public cord blood banks for the donation, processing and storage of cord blood stem cells for blood stem cell transplantations, as well as research into cellular therapies. The FY 2008 request of $2 million supports the collection of approximately 1,500 new cord blood units. In total, approximately 18,500 units will be collected for the National Cord Blood Inventory with funds appropriated for FY 2004–2008. These units will be available to patients and their physicians through the C.W. "Bill" Young Cell Transplantation program.

TARGETING FUNDS TO DIRECT HEALTH SERVICES

The FY 2008 Budget supports more targeted efforts to provide direct health services for underserved populations. A recent Program Assessment Rating Tool (PART) review found that Health Professions programs have not demonstrated an impact on placing health professionals in underserved areas. Based on this determination, the Budget proposes eliminating several health professions activities. Instead, HRSA will focus on activities that are more effective in placing health professionals in underserved areas.

The Budget also reduces funding for HRSA rural programs by $143 million from FY 2007. A recent PART assessment found these programs to be similar to other HHS programs that provide resources to rural areas. For example, Medicare, through the Critical Access Hospital program, finances payments that improve the profitability of many rural hospitals and promote beneficiary access to care.

OTHER ACTIVITIES AND PROGRAM MANAGEMENT

The Budget requests $151 million for program management. Resources will enable HRSA to manage and operate a wide array of activities as well as to fund Federal pay cost increases.

Finally, the request repeats the FY 2007 Budget proposal to rescind the Federal portion of grant funds that were awarded to health professions schools through the Health Professions and Nursing Student Loan programs, and Health Center Construction loan guarantees. It is estimated that $105 million will be rescinded in FY 2008.

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Services					
Clinical Services	2,857	3,023	2,879	3,125	+246
Contract Health Services (Non-Add)	*517*	*554*	*521*	*570*	*+49*
Preventive Health	117	125	117	130	+13
Contract Support Costs	265	270	265	272	+7
Tribal Management/Self-Governance	8	8	8	8	--
Urban Health	33	--	33	--	-33
Indian Health Professions	31	32	31	32	+1
Direct Operations	62	64	62	65	+3
Diabetes Grants 1/	150	150	150	150	--
Subtotal, Services Program Level	3,523	3,672	3,545	3,782	+237
Facilities					
Health Care Facilities Construction	38	18	37	13	-24
Sanitation Construction	92	94	93	89	-4
Facilities & Environmental Health Support	151	161	160	165	+5
Maintenance & Improvement	58	59	59	58	-1
Medical Equipment	21	22	21	21	--
Subtotal, Facilities Program Level	360	354	370	345	-25
Total, Program Level	**3,883**	**4,026**	**3,915**	**4,127**	**+212**
Less Funds Allocated From Other Sources					
Health Insurance Collections	-681	-700	-700	-700	--
Rental of Staff Quarters	-6	-6	-6	-6	--
Diabetes Grants 1/	-150	-150	-150	-150	--
Total, Budget Authority	**3,045**	**3,170**	**3,059**	**3,271**	**+212**
FTE	15,331		15,356	15,501	+145

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

INDIAN HEALTH SERVICE

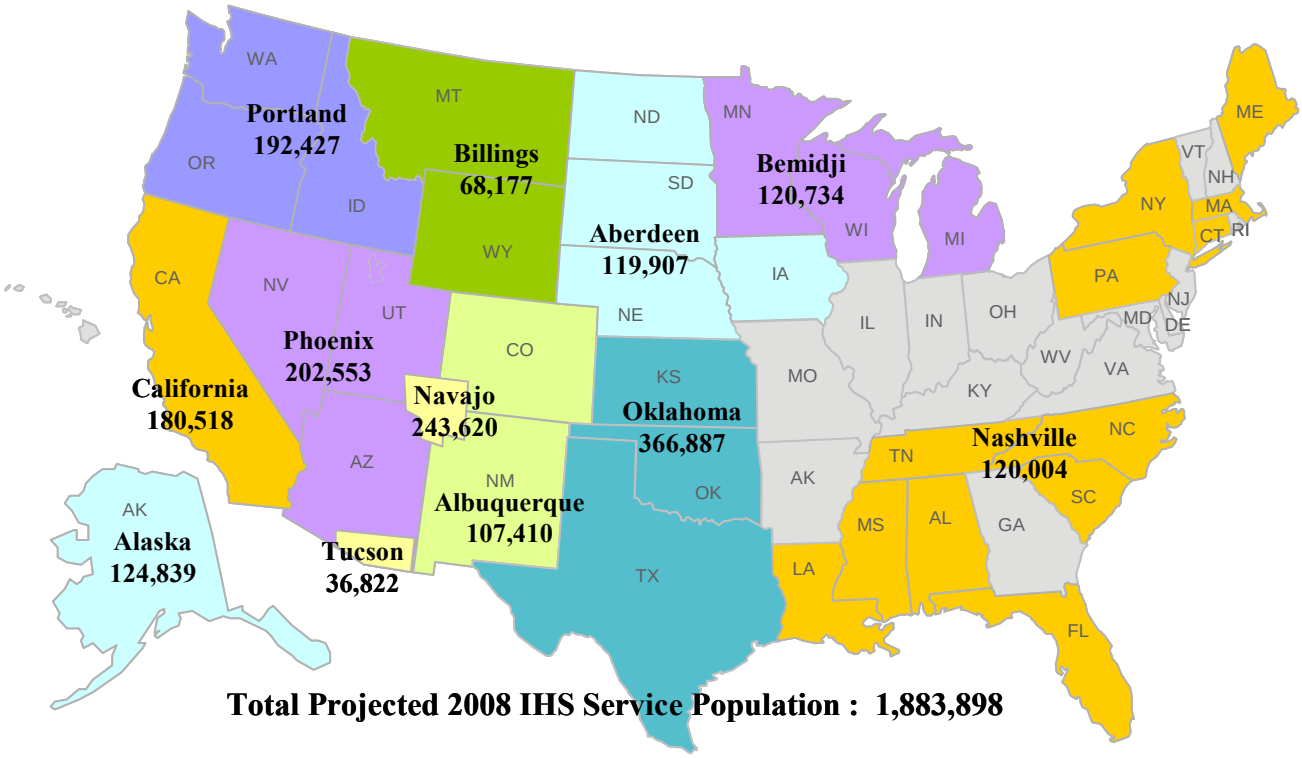
The Indian Health Service raises the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

The FY 2008 Budget request for the Indian Health Service (IHS) is $4.1 billion, a net increase of $212 million over the FY 2007 Continuing Resolution and an increase of $101 million over the FY 2007 President's Budget. The increase in funding for IHS will maintain services for American Indians and Alaska Natives, keeping in step with the rising cost of health care and the growing population of eligible Indian people who suffer disproportionately from health problems. IHS is working in partnership with Tribes to improve the health of Indian people and eliminate health disparities through health promotion and disease prevention, behavioral health, and chronic disease management.

FULFILLING THE UNIQUE ROLE OF THE INDIAN HEALTH SERVICE

The IHS is the principal Federal health care provider for Indian people. As part of the Federal Government's special relationship with Tribal Governments, IHS provides health care to members of more than 560 federally recognized Tribes. The American Indian and Alaska Native population is growing at a faster rate than the United States population as a whole. In 2008, the IHS service population is expected to grow by 1.6 percent over 2007. IHS combines preventive measures–including environmental, educational, and outreach activities–and medical services to provide health care to American Indians and Alaska Natives. Care is provided directly in 48 hospitals, 283 health centers, 320 health stations and Alaska village clinics, and through services purchased from outside the IHS health care system. IHS also builds sanitation systems to provide water and waste disposal for Indian homes, provides scholarships and loan repayment assistance to enable American Indians and Alaska Natives to enter health professions, and supports a system of behavioral health care (mental health, alcohol, and substance abuse prevention and treatment services) in Indian communities.

Projected Indian Health Service Population by IHS Area/Region, CY 2008



Total Projected 2008 IHS Service Population : 1,883,898

Continuing to Serve a Growing Population: The FY 2008 Budget request reflects the investment IHS continues to makes in providing care to a growing population of American Indians and Alaska Natives. These investments are also essential to continue to improve the health of Tribal members as the cost of providing health care rises, and chronic diseases become increasingly prevalent in Indian communities. Funding these increases is consistent with the Administration's Budget requests since FY 2006 and with Congressional action.

Population and the Cost of Providing Care: An additional 30,000 Indian people are expected to seek care in FY 2008, and the cost of this care has increased due to inflation and increased pay costs for the Federal and Tribal employees who provide health care services. Based on past experience, the increase in funds for IHS will provide services to American Indians and Alaska Natives, including more than 200,000 additional outpatient visits in IHS and Tribally operated facilities; 20,000 additional outpatient visits purchased from outside the IHS system; and 43,000 additional public health nursing visits. The FY 2008 Budget includes $41 million for pay costs for Federal and Tribal employees.

Recruitment and Retention of Health Care Professionals: The IHS has a vacancy rate of about 17 percent for health professional positions, including a 17 percent vacancy rate for nurses and a 32 percent vacancy rate for dentists. Because of the remote locations of many IHS facilities and the competitive salaries offered by private hospitals and clinics, recruiting and retaining health professionals, such as physicians, nurses, dentists, optometrists, and pharmacists, is difficult. The Indian Health Professions Program, however, has helped. By FY 2005, IHS had awarded more than 5,657 health professions scholarships since the program's inception in 1977, and scholarship recipients have provided over 12,000 years of obligated service to American Indians and Alaska Natives. The FY 2008 Budget includes $32 million to support scholarships and loan repayments, and to recruit and retain health professionals.

Staffing New Health Facilities: An additional $19 million is included in the FY 2008 Budget request to fund the staffing of a new joint venture facility in Muskogee, Oklahoma, and a Youth Regional Treatment Center in Pyramid Lake, Nevada. When fully operational, these facilities will expand the provision of health care in areas where the existing capacity is most overextended. Including these two sites in FY 2008, IHS will have opened 18 new health facilities since 2001.

Special Diabetes Program for Indians: The prevalence of diabetes among the IHS service population is disproportionately high. In fact, the incidence of diabetes among IHS beneficiaries increased by 45 percent between 1997 and 2004 alone. The diabetes mortality rate for American Indians and Alaska Natives is more than triple the rate for all Americans, and the cost of providing care to an individual with diabetes is approximately five times that of providing care to an individual without diabetes. To control the human and economic burden of the disease, IHS provides grants to over 300 Tribes and Indian organizations to implement interventions proven to prevent diabetes and reduce the medical complications of the disease. In FY 2008, $150 million will be awarded to support diabetes prevention and disease management at the local level. IHS has increased the number of its diabetic patients who maintain ideal blood sugar control from 30 percent in FY 2002 to 37 percent in FY 2006.

Health Insurance Reimbursements: IHS health facilities rely on health insurance reimbursements for as much as 50 percent of their operating budgets. These funds support critical expenditures, such as additional medical staff, equipment, and building improvements. In FY 2008, IHS estimates it will receive a total of $700 million in health insurance reimbursements for providing care to people covered by Medicare, Medicaid, or private health insurance.

Urban Indian Health Program: As proposed in the FY 2007 Budget, IHS has identified its highest priorities and redirected

Performance Highlight

Fetal Alcohol Syndrome (FAS) is the leading known and preventable cause of mental retardation, and rates of FAS are higher among American Indians and Alaska Natives than the general population. Screening with intervention has been shown to be effective in reducing alcohol misuse in pregnancy and to reduce the incidence of FAS.

In an effort to reduce the rate of FAS, IHS has increased the number of women of childbearing age who are screened for alcohol use from 7 percent in 2004 to 11 percent in 2005 and 28 percent in 2006. IHS targets for 2007 and 2008 are to maintain the percentage of appropriate female patients screened at 28 percent.

funds from less critical areas. The IHS FY 2008 Budget request targets funding for the provision of health care on or near reservations in order to serve a population that cannot access health care outside the IHS. The Budget does not include funds for the continuation of the Urban Indian Health program. Unlike Indian people living in isolated rural areas, urban Indians can receive health care through a wide variety of Federal, State, and local providers.

Construction: The Budget includes a total of $89 million for Sanitation Facilities Construction. By providing water and waste disposal systems to more than 320,000 Indian homes since 1960, this program has played a key role in decreasing the rates of infant mortality, gastroenteritis, and other environmentally related diseases. The Budget also includes a total of $13 million for Health Care Facility Construction. Funds will continue construction of a hospital in Barrow, Alaska, which received initial design funding in FY 2005, and will replace the existing facility built in 1965. When complete, this facility will provide inpatient services such as emergency and urgent care, labor and delivery, surgery, dental care, eye care, physical therapy, laboratory services, and community health. It will serve a projected annual user population of 6,142 people with 26,760 primary care provider visits and 40,167 outpatient visits each year. Consistent throughout HHS, requests for facilities funding focus on maintaining existing facilities and completing projects that received initial funding in previous years.

IMPROVING SERVICE DELIVERY

IHS works continually to improve efficiency in order to raise the health of Tribal members to the highest possible level. Strategies include the Director's health initiatives and improvements in health care quality through the contracting of health services. The $88 million requested for health care cost increases and population growth will support the implementation of strategies to improve Indian health.

Health Promotion: To address health issues through health promotion, IHS is focusing efforts on eliminating adverse health factors such as obesity, physical inactivity, smoking, poor diet, substance abuse, and hypertension. The Budget includes $2 million for building effective health promotion practices at the local level; strengthening collaboration with Federal, corporate, foundation and academic entities; and coordinating local efforts by developing community and clinical best practices.

Contract Health Services: IHS contracts with hospitals and health care providers to purchase health care that it cannot economically provide through its own network. The Budget request for $570 million supports the purchase of these services in areas where no IHS direct care facility exists or where the direct care facility cannot provide the required services because they are specialized or the facility is above medical workload capacity. The funds will enable the Contract Health Service program to extend services for health conditions that disproportionately affect American Indians and Alaska Natives, such as diabetes, tuberculosis, HIV/AIDS, hepatitis, substance abuse, and maternal and child health. A portion of these funds are also targeted toward high-cost cases and catastrophic illnesses.

SUPPORTING INDIAN SELF-DETERMINATION

Through the Indian Self-Determination and Education Assistance Act of 1975, Tribes have had the opportunity to assume the administrative role for many programs that were previously carried out by the Federal Government. The Budget includes a total of $272 million for contract support costs in order to enable Tribes to develop and maintain the administrative infrastructure critical to successfully manage these programs. As a result of these funds, Tribes currently administer over one-half of IHS resources through self-determination contracts and compacts, operating approximately one-third of IHS hospitals, 85 percent of its ambulatory health facilities, and 85 percent of the funds for local behavioral health programs.

Self-determination is an important component of the Federal Government's relationship with Tribes. The guiding principle of self-determination is that having health services planned and delivered at the local level is the best way of ensuring that high quality health care is delivered. Tribal input and consultation are central to the way IHS operates at the local, area, and national level.

The Federal Government also has a unique legal and political relationship with Tribes, and as part of this special relationship, an HHS-wide budget consultation session is held annually to give Tribal leaders the opportunity to consult with HHS on their budgetary priorities.

CENTERS FOR DISEASE CONTROL AND PREVENTION

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Infectious Diseases					
Prevention, Detection, and Control of ID	124	120	124	130	+5
Zoonotic, Vector-Borne, and Enteric Diseases	88	70	80	63	-17
HIV/AIDS, STDs & TB Prevention	963	1,054	964	1,057	+93
Immunization:					
Current Law:					
Section 317 Discretionary Program	454	425	425	425	0
Program Operations & Pandemic Influenza	65	120	65	120	+54
Vaccines For Children 1/	1,974	2,905	2,905	2,762	-143
Current Law Subtotal, Immunization	2,494	3,450	3,396	3,307	-89
Proposed Law:					
Section 317 Discretionary Program	520	445	--	--	--
Vaccines For Children	1,974	3,045	--	--	--
Proposed Law Subtotal, Immunization	2,494	3,490	--	--	--
Global Health	380	381	310	380	+69
Bioterrorism					
State and Local Capacity	823	784	824	698	-125
Upgrading CDC Capacity/Anthrax Research	150	136	150	137	-14
Botulinin Antitoxin Research	--	3	--	--	--
Strategic National Stockpile	524	581	491	581	+90
Biosurveillance Initiative	133	102	78	88	+10
Subtotal, Bioterrorism	1,631	1,606	1,544	1,504	-40
Health Promotion					
Chronic Disease Prevention & Health Promotion	834	818	834	834	+.05
Birth Defects, Disability & Health	124	111	125	125	--
Health Information and Service					
Health Statistics	109	109	109	110	+1
Informatics and Health Marketing	110	150	110	134	+24
Environmental Health and Injury					
Environmental Health	149	141	149	149	--
Injury Prevention & Control	138	138	138	138	--
Occupational Safety & Health	263	250	253	253	--
Public Health Research	31	31	31	31	--
Public Health Improvement and Leadership	264	190	189	190	+1
Business Services Support	318	304	318	320	+2
Preventive Health and Health Services Block Grant	99	--	99	--	-99
Buildings & Facilities	158	30	134	20	-114
Pandemic Influenza First Supplemental	77	--	--	--	--
Pandemic Influenza Ongoing Activities (non-add)	*123*	*188*	--	*+158*	*+158*
CDC-wide Pandemic Influenza funding (non-add)	*200*	*188*	--	*+158*	*+158*
Pandemic Influenza Second Supplemental	200	--	--	--	--
ATSDR	75	75	75	75	+.1
User Fees	2	2	2	2	--
Current Law Subtotal, Program Level	8,632	9,031	8,984	8,822	-163
Proposed Law Subtotal, Program Level	8,632	9,071	8,984	8,822	-163
Less Funds Allocated from Other Sources					
Vaccines for Children Proposed Law (mandatory)	1,974	3,045	2,905	2,762	-143
PHS Evaluation Transfers	265	265	265	266	-1
User Fees	2	2	2	2	--
Current Law Total, Discr. Budget Authority	**6,390**	**5,858**	**5,812**	**5,792**	**-20**
Proposed Law Total, Discr. Budget Authority	**6,390**	**5,758**	**5,812**	**5,792**	**-20**
FTE	8,510		8,823	9,295	+472

1/ The -$143 million decrease in FY 2008 reflects one-time costs in FY 2007 associated with reduced contractual costs, catch-up funding for HPV vaccine, and decreased pediatric vaccine stockpile purchase.

CENTERS FOR DISEASE CONTROL AND PREVENTION

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

The FY 2008 discretionary Budget request for the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) is $5.8 billion, a net decrease of $20 million below the FY 2007 Continuing Resolution and $33 million above the FY 2007 President's Budget. The total program level of $8.8 billion includes $2.8 billion in mandatory Vaccines for Children (VFC) funding, a decrease of $143 million below FY 2007 due to reductions in one-time mandatory costs. CDC works with States, communities, and other partners to monitor health, detect and investigate health problems, conduct research to enhance prevention, implement prevention strategies, and promote healthy behaviors. The FY 2008 request supports implementation of the Administration's ongoing pandemic influenza preparedness activities; funds a new Adolescent Health Promotion initiative; increases support for domestic HIV/AIDS prevention; improves childhood and adolescent immunizations; and expands the Strategic National Stockpile (SNS).

IMPROVING THE HEALTH OF ADOLESCENTS

Since 1980, overweight rates have tripled among the Nation's children and adolescents, leading to the risk that the current generation may become the first generation in United States history that has a shorter life span than their parents. Priority health-risk behaviors that contribute to the leading causes of morbidity and mortality among youth and adults often are established during childhood and adolescence, extend into adulthood, are interrelated, and are preventable. Adolescent health risks, including obesity, can be greatly reduced through preventive actions. Schools provide an important venue to reach adolescents and their families. Additionally, healthy behaviors begin with children and research shows healthier children learn better in schools.

The FY 2008 Budget includes $17 million for the Adolescent Health Promotion Initiative which will enable thousands of local schools to take full advantage of HHS science-based resources to slow the epidemic of childhood obesity.

The School Health Index (SHI) is a self-assessment and planning tool that schools can use to improve their health and safety policies and programs. Schools will use the self-assessment findings to develop action plans which will identify the research-tested strategies they will implement. Once the action plans are developed schools will be eligible to apply for a School Culture of Wellness Grant to help schools implement HHS-developed tools relevant to the school wellness improvements featured in their action plans. Approximately 3,600 Culture of Wellness Schools will be funded around the country, directly reaching more than three million young people and their families.

PREPARING FOR PANDEMIC INFLUENZA

CDC is leading multiple preparedness efforts for a potential influenza pandemic. The CDC FY 2008 Budget includes $158 million for pandemic influenza activities. Funding is included to continue developing models and decision tools designed to predict disease patterns; enhance the vaccine registry to track, distribute, and administer influenza vaccines and other countermeasures; develop an ongoing repository of pandemic virus reference strains; and increase the stock of diagnostic reagents for influenza that would be needed in bulk in the event of a pandemic. CDC is working with its State and local partners on enhancing domestic laboratory and surveillance preparedness efforts and increasing demand for influenza vaccine.

In conjunction with the Department and its international partners, CDC is supporting studies to examine the human-animal interface of influenza virus infection, and is working to develop rapid response and containment capabilities to address outbreaks in other countries. The FY 2008 Budget will support up to 25 quarantine stations.

PROTECTING THE NATION AGAINST INFECTIOUS AGENTS

The FY 2008 Budget includes a total of $1.8 billion in discretionary funding for the Infectious Diseases budget activity and efforts related to the prevention and control of infectious diseases, including HIV/AIDS, and to provide immunization services for children and adults nationwide. The Infectious Diseases budget activity was formally reorganized in FY 2007 to better integrate science,

program, epidemiology, and laboratory activities.
The new four-center structure is organized around vaccine preventable diseases, routes of disease transmission, and preparedness and response functions. The new components within Infectious Diseases are:

- Immunization and Respiratory Diseases;
- HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease (STD), and Tuberculosis (TB) Prevention;
- Zoonotic, Vector-Borne, and Enteric Diseases; and
- Preparedness, Detection, and Control of Infectious Diseases.

Immunization and Respiratory Diseases: CDC's $3.3 billion immunization program has two components: the mandatory VFC program and the discretionary Section 317 program. The VFC program provides vaccines at no cost to children 18 years of age or younger who are Medicaid eligible, uninsured, American Indians and Alaska Natives, or who receive their immunizations at federally qualified health centers and who have health insurance that does not include coverage for vaccines. Vaccines provided through the VFC program represent 40 percent of all childhood vaccines purchased in the United States.

Since FY 2006, the VFC program budget has increased by $780 million due to the introduction of new vaccines including Human Papillomavirus (HPV) Vaccine, Meningococcal Conjugate Vaccine (MCV) and Rotavirus Vaccine.

Both the FY 2007 and FY 2008 Budgets support the purchase of the first vaccine developed to prevent cervical cancer and other diseases in females caused by certain types of genital HPV through the VFC program. The $143 million reduction in FY 2008 reflects one-time costs in FY 2007 associated with reduced contractual costs, catch-up funding, and decreased pediatric vaccine stockpile. HPV is the most common sexually-transmitted virus in the United States and can cause cervical cancer in women and other less common types of cancer in men and women. Approximately 20 million Americans 15 to 49 years of age (approximately 15 percent of the population) are currently infected with HPV. In June 2006, the Advisory Committee on Immunization Practices (ACIP), a national group of experts that advises the CDC on vaccine issues, recommended that HPV vaccine be given to 11-12 year-old girls, and the vaccine can be given to girls as young as nine. The vaccine protects against four HPV types, which together cause 70 percent of cervical cancers and 90 percent of genital warts. In addition, the FY 2007 and FY 2008 VFC budget includes funding to enhance the adolescent infrastructure in States to ensure that young people have access to new vaccines.

The discretionary Section 317 program provides funds to support State immunization infrastructure and operational costs as well as many of the vaccines public health departments provide to individuals not eligible for VFC, including adults. The FY 2006 appropriation for CDC included $30 million to fund the purchase of bulk monovalent influenza vaccine, which would allow for unfinished vaccine to be set aside to package, fill, and label for distribution to the population in the event of a vaccine shortage. Given the recent increase in production capacity for regular vaccine distribution, the FY 2006 funding was not needed for this purpose. The FY 2008 Budget includes the rescission of these funds from CDC's budget, as they were initially no-year funds.

HIV/AIDS, Viral Hepatitis, STD and TB Prevention: The FY 2008 request provides $1 billion, an increase of $93 million, to develop, implement, and evaluate effective domestic prevention programs for HIV/AIDS, Viral Hepatitis, STD, and TB.

Each year, approximately 40,000 Americans are infected with HIV/AIDS. The FY 2008 Budget request provides $745 million, an increase of $93 million, for domestic HIV/AIDS prevention. Within this total, $63 million is for expanded rapid testing in communities and populations hardest hit with HIV/AIDS to identify individuals who are infected with the HIV virus, but do

Mumps Outbreak Response

In 2006, CDC investigated the largest outbreak of mumps in the United States in more than a decade in conjunction with State and local health departments, with over 6,000 reported cases, compared to 314 in 2005. CDC coordinated surveillance activities and field investigations, served as the national reference laboratory for mumps laboratory diagnosis, and provided expert technical assistance to develop and implement prevention and control activities, including revising policy recommendations for prevention and control of mumps in the United States. Because of high vaccination coverage rates in the affected states, the outbreak was much smaller than it would have been in an unvaccinated population. As part of the public health response, over 25,000 doses of Measles, Mumps, and Rubella vaccine were released for outbreak control from the pediatric vaccine stockpile.

not know it. With this increased funding, CDC will test up to two million Americans with an emphasis on at-risk populations, including low income and minority communities. In addition, $30 million is included for States with specific opt-out testing laws for targeted populations.

The FY 2008 President's Budget requests $295 million for STD and TB prevention programs to provide grants and technical assistance to State and local governments and organizations for prevention and control services. Funds are also included to support surveillance and research.

Zoonotic, Vector-Borne, and Enteric Diseases: The FY 2008 Budget includes $63 million to provide national and international scientific and programmatic leadership to identify, investigate, diagnose, treat and prevent diseases that are communicable from animals, pathogens, fungi, food and water to humans (e.g., Hanta Virus, West Nile Virus, Lyme Disease). The FY 2008 level reduces funding for West Nile Virus by $17 million, as States can now leverage existing resources to conduct West Nile activities.

Prevention, Detection, and Control of Infectious Diseases: Infectious diseases continue to threaten our Nation's health and that of every citizen in the world. Although great strides have been made toward preventing and controlling infectious diseases, it remains clear that a disease emerging in one country can rapidly lead to problems around the globe. CDC is well-known for its state-of-the-art laboratories, in which scientists can work with highly pathogenic viruses and bacteria, and its integration of this laboratory capacity with subject matter and epidemiologic expertise. Of a total funding level of $129 million, $5 million in increased funding for CDC laboratory capacity in FY 2008 will build the agency's basic science program for high hazard pathogens, the cadre of scientists that populate it, and its capacity for outbreak response.

IMPROVING PREPAREDNESS AND RESPONSE TO TERRORISM

The request includes $1.5 billion, a net decrease of $40 million, for CDC to conduct bioterrorism preparedness activities. The bioterrorism budget supports the SNS, critical surveillance, and State and local preparedness efforts.

Strategic National Stockpile: Within the above total, priority is given to ensuring a sufficient supply of countermeasures and other medical supplies to protect and care for victims of a bioterrorism attack or other public health emergency. The Budget includes $581 million for the SNS to finance the procurement, warehousing, and maintenance of critical pharmaceuticals and vaccines needed to protect Americans from threat agents and support the capacity to deliver drugs, vaccines, and supplies anywhere in the Nation within 12 hours.

Biosurveillance Initiative: FY 2008 pandemic influenza funding designated to support the Biosurveillance Initiative will serve the dual purpose of enhancing our Nation's ability to prevent the introduction and spread of disease caused by a bioterrorism agent originating abroad and for early detection of domestic outbreaks. This $21 million total investment, $10 million above FY 2007, will increase the number of quarantine stations at major ports of entry, improving the CDC's capacity to respond to natural and intentional infectious disease emergencies.

The FY 2008 Budget includes $57 million for BioSense, CDC's near real-time human health surveillance system. Funds will build on the progress made to date, with some re-design from its earliest conceptual models. The system will focus on catastrophic public health emergencies; increase networking and leveraging capacity through the aggregation of data from local, regional, and national networks; and will provide various levels of data and analyses to front-line users in real-time. The Budget also includes $10 million for continued real-time lab reporting.

Upgrading CDC Capacity: The FY 2008 request includes $137 million for upgrading CDC capacity. With these funds, CDC will continue to improve epidemiological expertise in the

Expanded HIV Testing Recommendations

In September 2006, CDC published the Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings. The purpose of the recommendations is to:

- Increase routine HIV screening of patients, including pregnant women;
- Foster earlier detection of HIV infection;
- Identify and counsel persons with unrecognized HIV infection and link them to clinical and prevention services; and,
- Further reduce perinatal transmission of HIV in the United States.

The number of estimated annual new HIV infections has remained stable at 40,000 for over a decade. These recommendations offer the best opportunity to reduce that number by enabling the 25 percent of all HIV-infected people in the United States who are unaware of their infection to learn their HIV status and link them to clinical and preventative services.

identification and control of diseases caused by terrorism, including better electronic communication, distance learning programs, and cooperative agreement training between public health agencies and local hospitals.

State and Local Preparedness: In FY 2008, $698 million is requested for State and local preparedness efforts, $125 million below FY 2007, making a total investment of $6.4 billion since September 11, 2001. This funding has resulted in all 50 states participating in the Health Alert Network, and 41 out of the 54 States and directly–funded cities meeting the minimum standards for demonstrating preparedness to use SNS assets. With the FY 2008 request, resources will be focused on the State and local Cooperative Agreement Program. CDC is developing and refining performance metrics, in coordination with the Department of Homeland Security, to help ensure that public health departments and grantees are prepared for emergency events and remains committed to assisting State and local health departments prepare and respond to a terrorist attack, infectious disease outbreak, or other public health emergency.

PROMOTING HEALTH AND PREVENTING CHRONIC DISEASE

Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States, accounting for about 70 percent of all deaths. In general, chronic diseases are caused by behaviors that are preventable; for example tobacco use is the single most preventable cause of death and disease, with poor diet and sedentary behavior close behind and on the rise. Birth defects are the leading cause of infant mortality in the United States with more than 120,000 infants born with birth defects each year. An estimated 54 million people in the United States currently live with a disability, and 17 percent of United States children under 18 have some type of developmental disability. Through the Health Promotion budget activity, CDC works to prevent death and disability from chronic diseases; promote maternal, infant, and adolescent health; promote healthy personal behaviors and integrate genomics into public health research, policy, and programs. The FY 2008 Budget for the Health Promotion budget activity includes $834 million for the Chronic Disease Prevention, Health Promotion, and Genomics activities as well as $125 million for Birth Defects, Developmental Disabilities, Disability and Health. This funding level includes $17 million for the new Adolescent Health Promotion Initiative and a $17 million reduction in Steps to a Healthier US due to the completion of the five-year grant cycle for grants funded in FY 2003.

USING HEALTH INFORMATION AND SERVICE FOR PUBLIC HEALTH

The budget for Health Information and Service includes $243 million for Health Statistics, Health Marketing, and Public Health Informatics. The FY 2008 Budget for Health Statistics includes $110 million to obtain and use health statistics to understand health problems, recognize emerging trends, identify risk factors, and guide programs and policy. CDC's health statistics programs will continue to provide data to monitor key national health indicators and address specific research needs in areas that include oral health, mental health, vision, diabetes, and diet and nutrition.

Public health informatics uses information systems and information technology to prevent diseases, disability, and other public health threats. The Public Health Informatics budget request includes $94 million, $24 million above FY 2007, to support continuing efforts to define the needs for public health information systems, develop the standards that allow these systems to work together effectively, and design information systems and software that extend the capabilities of public health. The increase supports continuation of pandemic influenza preparedness activities such as the Vaccine Registry and Real-time assessment and evaluation of interventions.

Funding for the Health Marketing activity in FY 2008 is requested at $39 million. This activity focuses on providing people with knowledge that empowers them to make informed personal choices about their health and on developing and improving systems to give people more opportunities to act on those choices.

ENVIRONMENTAL HEALTH AND INJURY PREVENTION AND CONTROL

The Budget includes $288 million for Environmental Health and Injury Prevention and Control

Performance Highlight

CDC and partners received the prestigious R&D 100 Award in 2006 for development of the "Coal Dust Explosibility Meter – Model 100." This is the first device ever created that provides an immediate capability for determining if coal dust concentrations in active areas of underground coal mines have been sufficiently mixed with rock dust to prevent risk of explosion. Technology used to date to assess coal dust concentrations require lab analysis that may take as long as two weeks to complete. The explosivity meter can be used to avoid this delay and enhance mine safety. The device is being manufactured and marketed for use in the field.

activities. The Environmental Health activity investigates the impact of environmental hazards on human health in order to prevent disability, disease, and death caused by environmental factors. CDC also assists States and local health agencies in developing and increasing their ability and capacity to address environmental health problems. The FY 2008 budget provides $149 million for Environmental Health.

The FY 2008 Budget request includes $138 million to support programs focused on youth violence, residential fire deaths, intimate partner violence, non-fatal fall traumatic brain injury, child abuse and neglect, rape prevention and education, and other injury prevention and control initiatives.

ADVANCING OCCUPATIONAL SAFETY AND HEALTH

The National Institute for Occupational Safety and Health (NIOSH) is the primary Federal entity responsible for conducting research and making recommendations for the prevention of work-related illness and injury. NIOSH translates knowledge gained from research into products and services that improve workers' safety and health in settings from corporate offices to construction sites and coal mines. The FY 2008 Budget includes $253 million for Occupational Safety and Health activities.

SUPPORTING PUBLIC HEALTH RESEARCH

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

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

The FY 2008 Budget continues the FY 2007 President's Budget elimination of the Preventive Health and Health Services Block Grant. Since 1981, the Preventive Health and Health Services Block Grant has provided 61 States, Tribes, and territories with flexible funding the grantee could direct as it deemed appropriate. As CDC strives to improve efficiency, existing resources will be directed to programs which have traditionally addressed similar categorical public health issues.

MANAGING CDC'S INFRASTRUCTURE AND HUMAN CAPITAL

Business Services Support: The FY 2008 Budget includes $320 million for a wide range of agency-wide operating costs, such as rent, utilities, and security. It also funds the business services functions at CDC (such as grants, financial, and facilities management, etc.), and additional mission-support activities.

CDC has made a variety of improvements and efficiency gains in its business and management operations. For example, CDC consolidated 13 information technology infrastructure functions, services, staff and fiscal resources into the Information Technology Services Office, and has merged over 40 public and medical professional inquiry hotlines into a single integrated customer service center.

Public Health Improvement and Leadership: The FY 2008 President's Budget includes $190 million for Public Health Improvement and Leadership. This activity supports several cross-cutting areas within CDC whose purposes are to ensure more efficient and effective science and program development.

Modern and Secure Laboratories and Facilities: Since 2001, CDC has invested more than $1.5 billion in the initiation or completion of construction on more than 2.6 million square feet of laboratory and other facility space. The FY 2008 request includes $20 million, a decrease of $10 million below the FY 2007 President's Budget, for nationwide repairs and improvements of existing facilities. This reduction reflects a Departmentwide focus on finishing projects near completion and maintaining existing facilities.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

ATSDR, managed as part of CDC, is the lead agency responsible for public health activities related to Superfund sites. The FY 2008 request for ATSDR is $75 million. ATSDR develops profiles of the health effects of hazardous substances, assesses health hazards at specific Superfund sites, and provides consultations to prevent or reduce exposure and related illnesses. ATSDR also plays a significant role in planning for and responding to terrorism events, natural disasters, and other large-scale public health emergencies.

NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY INSTITUTE

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Institutes					
National Cancer Institute	4,788	4,751	4,791	4,782	-9
National Heart, Lung & Blood Institute	2,916	2,898	2,919	2,925	+7
National Institute of Dental & Craniofacial Research	389	386	389	390	+1
Natl Inst. of Diabetes & Digestive & Kidney Diseases	1,853	1,844	1,854	1,858	+4
National Institute of Neurological Disorders & Stroke	1,533	1,524	1,534	1,537	+3
National Institute of Allergy & Infectious Diseases 1/	4,379	4,394	4,382	4,592	+210
National Institute of General Medical Sciences	1,934	1,923	1,935	1,941	+6
Natl Inst. of Child Health and Human Development	1,264	1,257	1,264	1,265	+1
National Eye Institute	666	661	666	668	+2
National Institute of Environmental Health Sciences:					
Labor/HHS Appropriation	636	637	641	637	-3
Interior Appropriation	79	78	79	78	-1
National Institute on Aging	1,045	1,039	1,046	1,047	+1
Natl Inst. of Arthritis & Musculoskeletal & Skin Dis	507	504	508	508	+0.3
Natl Inst. on Deafness & Communication Disorders	393	391	393	394	+0.4
National Institute of Mental Health	1,402	1,394	1,403	1,405	+3
National Institute on Drug Abuse	999	994	999	1,000	+1
National Institute on Alcohol Abuse & Alcoholism	435	433	436	437	+1
National Institute of Nursing Research	137	136	137	138	+1
National Human Genome Research Institute	486	483	486	484	-2
Natl Inst. of Biomedical Imaging & Bioengineering	298	296	298	300	+2
National Center for Research Resources	1,109	1,109	1,110	1,112	+3
Natl Center for Complementary & Alternative Med	121	120	121	122	+0.4
Natl Center on Minority Health & Health Disparities	195	194	195	194	-1
Fogarty International Center	66	67	66	67	+0.2
National Library of Medicine	322	321	322	321	-2
Office of the Director 1/	478	509	479	517	+38
Buildings & Facilities	86	81	171	136	-35
Total, Program Level	**28,517**	**28,427**	**28,626**	**28,858**	**+232**
Less Funds Allocated from Other Sources					
PHS Evaluation Funds (NLM)	-8	-8	-8	-8	--
Type 1 Diabetes Research (NIDDK) 2/	-150	-150	-150	-150	--
Total, Budget Authority	**28,359**	**28,268**	**28,468**	**28,700**	**+232**
Labor/HHS Appropriation	**28,280**	**28,190**	**28,389**	**28,621**	**+233**
Interior Appropriation	**79**	**78**	**79**	**78**	**-1**
FTE	16,880		17,216	17,459	+243

1/ Reflects comparable adjustments in FY 2006 and FY 2007 of $50 million from the National Institute of Allergy and Infectious Diseases (NIAID) to the Office of the Secretary for advanced development of biodefense countermeasures, and $18 million from the Public Health and Social Services Emergency Fund in the Office of the Secretary to NIAID for pandemic influenza research.

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

NATIONAL INSTITUTES OF HEALTH

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

The FY 2008 Budget request for the National Institutes of Health (NIH) is $28.9 billion, a net increase of $232 million over the FY 2007 Continuing Resolution, and an increase of $431 million over the FY 2007 President's Budget.

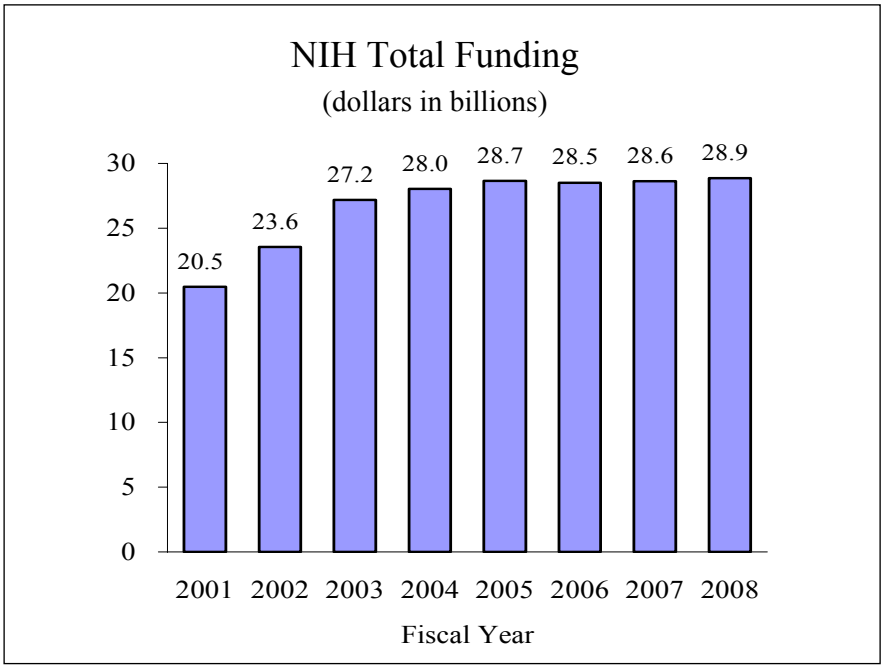
The Nation is making a substantial investment in biomedical research, led by NIH. These investments have yielded significant achievements and have contributed to dramatic reductions in death rates from heart disease and stroke, declines in cancer incidence and mortality, increases in cancer survivorship, and improvements in the capacity to rapidly control new infectious diseases shortly after they emerge. Through strategic investments in advanced technologies and their application, NIH is striving to implement a fundamentally new approach for biomedical research for the 21st century, one which focuses on discovering the molecular mechanisms of disease. This approach is laying the cornerstone for efforts to transform the practice of medicine to be personalized, predictive, and pre-emptive, with greater patient and community participation in the active management of their health.

NIH is the world's largest and most distinguished organization dedicated to maintaining and improving health through medical science. Its budget is composed of 27 appropriations for its Institutes and Centers, Office of the Director, and Buildings and Facilities. In FY 2008, about 84 percent of the funds appropriated to NIH will flow out to the extramural community, which supports work by more than 300,000 scientists and research personnel affiliated with over 3,100 organizations, including universities, medical schools, hospitals, and other research facilities. About 11 percent of the budget will support an in-house, or intramural, program of basic and clinical research activities managed by world-class physicians and scientists. This intramural research program, which includes the NIH Clinical Center, gives our Nation the unparalleled ability to respond immediately to health challenges nationally and worldwide. Another five percent will provide for agency leadership, research management and support, and facilities maintenance and improvements.

ADDRESSING RESEARCH PRIORITIES IN FY 2008

In fulfilling its mission, NIH strives to maintain a diverse portfolio of research founded on both public health need and scientific opportunity. The FY 2008 Budget request will allow NIH to expand the number of competing research project grants; continue to pursue cross-cutting areas of discovery; continue support of biodefense research; expand a program to provide increased support for new research investigators; and continue to refocus its programs for translating clinical research results into clinical practice. Support will also be provided to continue progress in promising arenas of science related to specific diseases such as cancer, cardiovascular disease, HIV/AIDS, diabetes, obesity, Parkinson's disease, and Alzheimer's disease, while also pursuing new avenues of post-genomics research.

With few exceptions, such as the National Cancer Institute, most of the Institutes and Centers will increase between 0.2 percent and 0.4 percent as a result of the crosscutting nature of many of the proposed increases in FY 2008. In any given budget year, Institutes



and Centers will not all receive the same increase or decrease. In developing this budget, one of NIH's highest priorities was increasing support for Research Project Grants, and this priority, as well as other priority increases such as the Pathway to Independence program, is reflected in the allocation by Institute and Center.

NIH Roadmap for Medical Research/Common Fund: The FY 2008 Budget allocates a total of $486 million, an increase of $72 million, or 17 percent, over FY 2007, to continue support for trans-NIH Roadmap initiatives in accordance with the strategic plan developed in September 2003. These funds will be used to target major opportunities and gaps in biomedical research that no single institute at NIH could tackle alone. NIH as a whole can overcome complex barriers and accelerate the discovery of new disease treatments, prevention strategies, and diagnostics. The Roadmap is organized into three core themes: New Pathways to Discovery; Research Teams of the Future; and Re-engineering the Clinical Research Enterprise. The FY 2008 request includes $122 million, an increase of $39 million, in the Office of the Director, and $364 million, an increase of $33 million, in the budgets of the Institutes and Centers for use in a coordinated effort to support these cross-cutting areas of research. The collaborative trans-NIH process for developing and implementing the Roadmap represents an enhanced approach to portfolio management, and sets a new standard to jointly respond to emerging needs and scientific opportunities.

Biodefense: For FY 2008, the President's Budget proposes a total of $1.7 billion for NIH biodefense efforts, a net decrease of $8 million, or 0.4 percent, below FY 2007. With the cycling of non-recurring extramural construction costs into other high priority research areas, biodefense research will grow by $17 million in FY 2008. Our Nation's ability to detect and counter bioterrorism ultimately depends heavily on the state of biomedical science. Research efforts in FY 2008 will be focused on clinically evaluating candidate tularemia and viral hemorrhagic fever vaccines; improving the stability, delivery and efficacy of vaccines for Category A or B agents; developing candidate therapeutics for high priority viral pathogens such as smallpox and viral hemorrhagic fevers; and systematically evaluating microbe-host interactions.

The request also includes $95 million to continue targeted research efforts devoted to developing medical countermeasures against nuclear, radiological, and chemical threats that could be used as weapons of mass destruction. The FY 2008 Budget does not include funds to support extramural grants for biodefense laboratory construction and renovation, a reduction of $25 million from FY 2007. NIH has judged that existing biosafety laboratory space and laboratory space under construction is sufficient to meet current program needs. Funds for the advanced development of medical countermeasures are not included in the NIH budget. These activities will be implemented by the new Assistant Secretary for Preparedness and Response, which was established by the Pandemic and All-Hazards Preparedness Act.

NIH Reauthorization

On January 15, 2007, the President signed the NIH Reform Act of 2006. The new law establishes in statute a Common Fund for the existing NIH Roadmap for Medical Research. The Act specifies the overall organizational size of NIH at the existing number of 27 Institutes and Centers. It establishes a formal, public process, to be lead by a Scientific Management Review Board, to review the structural organizational design of NIH at least once every seven years. In addition, the Act establishes a formal strategic planning process across the entire NIH research portfolio through the creation of the Division of Program Coordination, Planning, and Strategic Initiatives in the Office of the NIH Director, as well as creating a new, comprehensive electronic reporting system to catalogue all NIH research activities and their spending. The new system will use state-of-the-art text mining on NIH projects for more efficient research portfolio analysis.

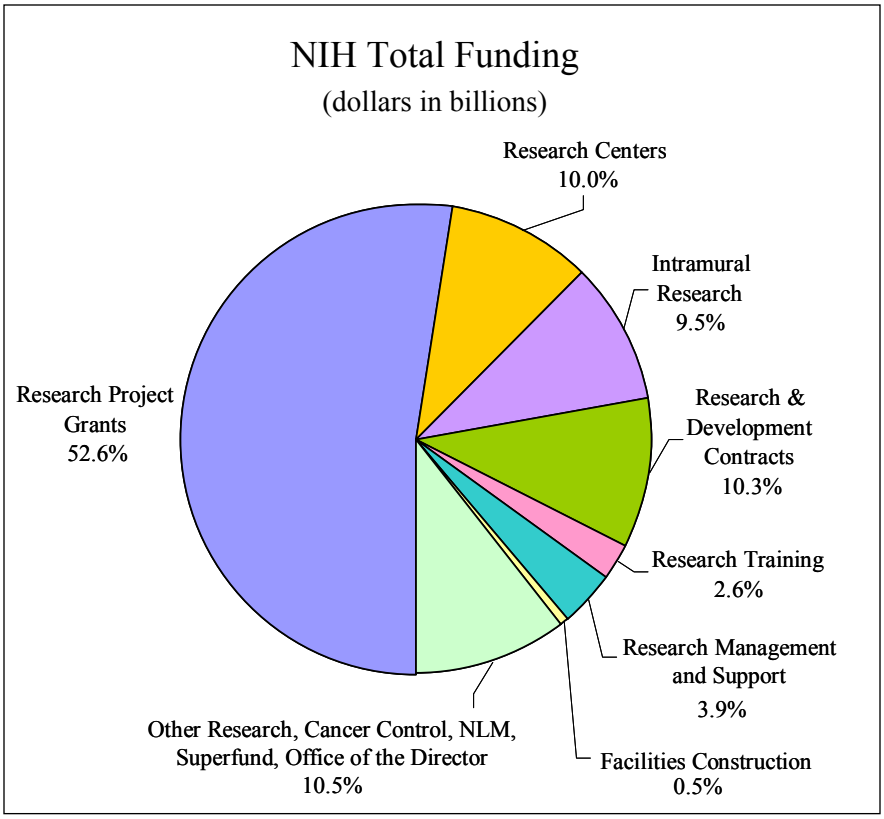
New Investigators: The foundation of the research enterprise is talented, creative, and dedicated research personnel. Fulfilling the NIH mission requires that the agency sustain a vibrant workforce, including sufficient numbers of new investigators with new ideas and new skills, especially in interdisciplinary fields of research. NIH is working to reverse the trend of increases in the average age of first-time principal investigators obtaining independent research funding from NIH. The FY 2008 Budget includes $31 million, an increase of $16 million, to double the funding available across the NIH Institutes and Centers for the "Pathway to Independence" program to provide increased and stable support for new research investigators. NIH estimates it will make 175 new awards in FY 2008, the second year of this initiative.

Clinical Research Translation: NIH has developed a new Clinical and Translational Science Award (CTSA) to meet the profound challenges of 21st century medicine

and capitalize on Roadmap initiatives. These awards will help advance information technology, integrate research networks, stimulate the development of computer-assisted outcome measurement, and improve workforce training. The goal of this effort is to provide the academic home and integrated resources necessary to advance a new intellectual discipline of clinical and translational sciences, create and nurture a cadre of well-trained interdisciplinary teams of investigators, and advance the Nation's health by transforming patient observations and basic discovery research into clinical practice and new treatments. The academic health centers selected for this program will work together as a national consortium. In addition, NIH will continue to transition elements of existing clinical research programs, primarily the General Clinical Research Centers (GCRCs) in the National Center for Research Resources (NCRR), into CTSAs as these programs complete their current funding cycles. In FY 2008, the total CTSA/GCRC program is estimated to be $462 million, including an increase of $20 million in new and reallocated funds within NCRR for this activity.

Research Project Grants

The $15.2 billion provided in FY 2008 for support of medical research through competitive, peer-reviewed, and investigator-initiated research project grants (RPGs) represents 53 percent of the total NIH budget request. NIH estimates it will support 10,188 new and competing RPGs in FY 2008, an increase of 566 over FY 2007. The average cost of a new and competing research project grant in FY 2008 will be about $350,000, with no increases provided for inflation. The apparent decrease of three percent in the average cost per grant is due to the cycling into non-competing status of extremely large HIV/AIDS clinical trials and the Monitoring the Future survey. The total number of RPGs to be supported in FY 2008 is expected to be 38,063, nearly the same number as estimated for FY 2007.



Global AIDS Fund Transfer

Support for the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria is a key component of the President's Emergency Plan for AIDS Relief. The FY 2008 Budget for the National Institute of Allergy and Infectious Diseases includes $300 million, an increase of $201 million over FY 2007, to cover the entire United States Government's contribution to the Global Fund. Since its inception in 2001, the Global Fund in total has supported 154 prevention and treatment programs in 93 countries worldwide, particularly in sub-Saharan Africa, in these three global disease areas.

Intramural Buildings and Facilities

A total of $144 million is requested for NIH Intramural Buildings and Facilities (B&F) in FY 2008, a reduction of $35 million from the FY 2007 level, but an increase of $55 million over the FY 2007 President's Budget. These funds will sustain and improve the physical infrastructure used to carry out quality biomedical research on the NIH campuses. In FY 2008, NIH plans to establish new laboratories within the Clinical Research Center to take advantage of positron emission topography and radiochemistry technologies to develop new diagnostic tools and specialized pharmaceuticals. NIH will also install additional back-up electrical power capacity for the NIH Data Center. Within the B&F total, $8 million are budgeted within the National Cancer Institute for facilities projects at its Frederick, Maryland campus.

NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY MECHANISM

(dollars in millions)

	2006	2007		2008	
		President's	Continuing	President's	+/- 2007
	Actual	Budget	Resolution	Budget	Cont. Res.
Mechanism					
Research Project Grants	15,331	15,199	15,166	15,165	-0.5
[# of Non-Competing Grants]	*[27,362]*	*[26,669]*	*[26,668]*	*[26,098]*	*[-570]*
[# of New/Competing Grants]	*[9,129]*	*[9,290]*	*[9,622]*	*[10,188]*	*[+566]*
[# of Small Business Grants]	*[1,822]*	*[1,829]*	*[1,799]*	*[1,777]*	*[-22]*
[Total # of Grants]	*[38,313]*	*[37,788]*	*[38,089]*	*[38,063]*	*[-26]*
Research Centers	2,805	2,833	2,863	2,898	+34
Research Training	749	756	764	761	-4
Research & Development Contracts	2,667	2,653	2,722	2,965	+243
Intramural Research	2,767	2,752	2,765	2,747	-17
Other Research	2,175	2,204	2,223	2,252	+29
Extramural Research Facilities Construction	30	25	25	--	-25
Research Management and Support	1,109	1,122	1,125	1,135	+10
National Library of Medicine 1/	319	317	319	317	-2
Office of the Director 1/	393	398	396	396	-1
Buildings and Facilities 2/	93	89	178	144	-35
NIEHS Interior Appropriation (Superfund)	79	78	79	78	-1
Total, Program Level	**28,517**	**28,427**	**28,626**	**28,858**	**+232**
Less Funds Allocated from Other Sources					
PHS Evaluation Funds (NLM)	-8	-8	-8	-8	--
Type 1 Diabetes Research 3/	-150	-150	-150	-150	--
Total, Budget Authority	**28,359**	**28,268**	**28,468**	**28,700**	**+232**
Labor/HHS Appropriation	**28,280**	**28,190**	**28,389**	**28,621**	**+233**
Interior Appropriation	**79**	**78**	**79**	**78**	**-1**
FTE	16,880		17,216	17,459	+243

1/ National Library of Medicine (NLM) and Office of the Director funds used for the NIH Roadmap for Medical Research are reflected in the mechanisms of award, and thus, are not included in those organization's budget totals in this table.

2/ Includes $8 million budgeted in the National Cancer Institute for facilities projects at its Frederick, Maryland campus.

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

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SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Substance Abuse					
Substance Abuse Block Grant	1,757	1,759	1,759	1,759	--
PHS Evaluation Funds (non-add)	79	79	79	79	--
Programs of Regional and National Significance:					
Treatment	399	375	399	352	-47
PHS Evaluation Funds (non-add)	*4*	*4*	*4*	*4*	--
Prevention	193	181	193	156	-36
Subtotal, Substance Abuse	2,349	2,315	2,350	2,267	-83
Mental Health					
Mental Health Block Grant	428	428	428	428	--
PHS Evaluation Funds (non-add)	*21*	*22*	*21*	*21*	--
PATH Homeless Formula Grant	54	54	54	54	--
Programs of Regional and National Significance	263	228	263	187	-77
Children's Mental Health Services	104	104	104	104	--
Protection and Advocacy	34	34	34	34	--
Subtotal, Mental Health	883	849	884	807	-77
Program Management	92	97	92	93	+1
PHS Evaluation Funds (non-add)	16	21	16	16	+0
Program Level Total	**3,324**	**3,260**	**3,326**	**3,168**	**-159**
Less Funds Allocated from Other Sources					
PHS Evaluation Funds	121	126	121	121	+0.3
Budget Authority Total	**3,203**	**3,134**	**3,205**	**3,046**	**-159**
FTE	524		540	540	--

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

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

The FY 2008 Budget request for the Substance Abuse and Mental Health Services Administration (SAMHSA) is $3.2 billion, a net program level decrease of $159 million from the FY 2007 Continuing Resolution and $92 million below the FY 2007 President's Budget. The Budget supports activities that improve the quality and availability of substance abuse prevention, addiction treatment, and mental health services. Resources are also provided for Federal and State-level drug and mental health data collection activities.

SUBSTANCE ABUSE

Twenty-three million Americans struggle with a serious substance abuse problem for which treatment is needed. Substance abuse leads to lost productivity, domestic violence, child abuse, criminal involvement, and premature and preventable deaths. The FY 2008 Budget includes $2.3 billion, a decrease of $83 million, to support substance abuse prevention and treatment activities. The Budget makes targeted reductions in areas where grant periods are ending, activities can be supported through other funding streams, or efficiencies can be realized.

Supporting Prevention and Treatment: A total of $1.8 billion is requested for the Substance Abuse Prevention and Treatment Block Grant, the same level as FY 2007. These funds, which form the cornerstone of States' and Territories' substance-related activities, support nearly two million clients annually. In order to encourage improved performance through transparency, in FY 2008 States and Territories will be required to report on the outcomes of clients supported by Block Grant funding.

Providing Access to Recovery: Access to Recovery is a Presidential initiative that provides clients with a choice, through vouchers, among a broad array of substance abuse treatment and recovery support service providers, including faith-based and community-based providers. The Budget includes $98 million for grants administered by States and Tribal organizations and an evaluation of the program.

Within Access to Recovery, $25 million will support treatment for clients using methamphetamine. Methamphetamine abuse causes great harm to children, families, and communities, but it is a treatable problem. Research has shown that between 60 and 70 percent of those receiving treatment report no use of methamphetamine after six months.

Using Substance Abuse Treatment to Prevent Criminal Recidivism: Drug treatment courts provide a successful alternative to incarceration for clients prone to cycle from addiction to crime, incarceration, release, relapse, and recidivism. These courts enable stakeholders to work together to give individual clients the opportunity to improve their lives, including recovering from substance use disorders and developing the capacity and skills to become full-functioning parents, employees, and citizens. Close supervision, drug testing, and the use of sanctions and incentives help ensure that offenders stick with their treatment plans while public safety needs are met. The Budget includes $32 million, an increase of $22 million, more than tripling the number of grants supporting substance abuse treatment services for clients of juvenile, family, and adult drug treatment courts.

Providing Screening and Brief Interventions in General Medical Settings: Early identification of substance use decreases total health care costs by preventing progression toward addiction. Unfortunately, risk signs often go

Performance Highlight

The outcomes for clients served through Access to Recovery are very encouraging. After receiving treatment:

- 81 percent of clients abstain from substance abuse;
- 51 percent improve their family and living conditions; and
- 97 percent have no involvement, or reduce their involvement, with the criminal justice system.

Source: SAMHSA, Services Accountability Improvement System

undetected in general medical settings. The Budget includes $41 million, an increase of $12 million, to support screening, brief intervention, referral, and treatment in general medical and other community settings. In addition to reduced substance use, clients receiving treatment services through existing SAMHSA-supported programs experience a 16 percent improvement in employment and 13 percent improvement in housing stability.

Increased Need for Methamphetamine Treatment

- 192,000 Americans used methamphetamine for the first time in 2005.
- 1,300,000 used methamphetamine in 2005.
- 130,000 were admitted to treatment primarily for methamphetamine use problems in the most recent year for which data are available, a five-fold increase since 1993.

Source: SAMHSA, National Survey on Drug Use and Health, and Treatment Episode Data Set

MENTAL HEALTH

Severe mental illnesses make it difficult to hold a job, go to school, relate to others, and cope with ordinary life demands. In any given year, approximately six percent of adults have a serious mental illness and a similar proportion of children have a serious emotional disturbance. The Budget includes $807 million for mental health services, a net decrease of $77 million from FY 2007. The Budget makes targeted reductions in areas where grant periods are ending, activities can be supported through other funding streams, or efficiencies can be realized.

Transforming the Mental Health System: Today there is unprecedented knowledge regarding how to enable people with mental illness to live, work, learn, and participate fully in their community. The Budget requests $20 million for Mental Health Transformation State Incentive Grants to support States in developing a comprehensive mental health plan and improve their mental health services infrastructure. States receiving awards expand the use of evidence-based practices, use technology to improve access to care, and engage consumers in orienting the system to meet their needs.

Supporting Community Mental Health Services: The Budget includes $428 million, the same level as FY 2007, for the Community Mental Health Services Block Grant, which supports comprehensive, community-based systems of care for adults with serious mental illness and children with serious emotional disturbance. In order to encourage improved performance through transparency, in FY 2008 all States will report on national outcome measures.

Preventing Suicide: Each year approximately 700,000 youth attempt to kill themselves, but suicide can be prevented. This Budget includes a total of $34 million for suicide prevention, including activities authorized by the Garrett Lee Smith Memorial Act, suicide prevention for the American Indian and Alaska Native youth population, a 24-hour national hotline, and a Suicide Prevention Resource Center.

Suicide prevention activities authorized by the Garrett Lee Smith Memorial Act support statewide youth suicide intervention and prevention strategies in schools, institutions of higher education, juvenile justice systems, and other youth support organizations.

Working in collaboration with the Indian Health Service, SAMHSA will support mental health assistance to children, youth, and their families living on Tribal reservations and in Alaska Native villages.

Suicide call lines are a critical tool for preventing suicide. SAMHSA will ensure the continuity of toll-free telephone access from anywhere in the United States to a network of certified local crisis centers. These centers link callers to a suicide prevention worker who is close to where they live.

The Suicide Prevention Resource Center will continue to provide suicide prevention training and resources to assist organizations and individuals to develop suicide prevention interventions and policies.

Performance Highlight

In FY 2005, the most recent year for which data are available, 73 percent of children and adolescents receiving public mental health services reported positive outcomes. This exceeds the performance target of 65 percent and represents an improvement of 13 percentage points over two years.

Preventing School Violence: SAMHSA collaborates with the Departments of Education and Justice through Safe Schools/Healthy Students (SS/HS) to support local partnerships to promote healthy childhood development and prevent substance abuse and violence. The Budget includes $76 million for School Violence Prevention, including $68 million for SAMHSA-supported elements of SS/HS which include interventions to foster early childhood development of mental and physical health, reduce or delay the onset of emotional and behavioral problems, and treat children with serious emotional disturbance.

Improving Children's Mental Health: SAMHSA estimates that more than five percent of children and adolescents have a serious emotional disturbance. With appropriate care, these young people are far more likely to experience success in school and far less likely to enter the juvenile justice system or the institutional care system. The Budget includes $104 million for Children's Mental Health Services for the development of comprehensive community-based systems of care for children and adolescents with serious emotional disorders and their families. Of children receiving services under this program last year, nearly 70 percent did not require interaction with law enforcement and nearly 90 percent attended school regularly.

***Assisting in the Transition from Homelessness*:** Approximately one-fifth of homeless individuals also have serious mental illnesses. Individuals with serious mental illnesses are homeless more often and have greater difficulty exiting homelessness than other people. The Budget includes $54 million to maintain support for an array of individualized services to this vulnerable population through Projects for Assistance in Transition from Homelessness.

Protecting Individuals with Mental Illness: Individuals with mental illnesses and serious emotional disturbances who reside in treatment facilities are particularly vulnerable to neglect and abuse. The Budget includes $34 million to maintain support for State protection and advocacy systems to protect these individuals from abuse, neglect, and civil rights violations. Approximately 80 percent of substantiated allegations of abuse and neglect that are reported to protection and advocacy systems result in positive change for the client.

PROGRAM MANAGEMENT

The Budget includes $93 million, an increase of $1 million from FY 2007, to support staffing and activities to administer SAMHSA programs and fund Federal pay cost increases. These resources support the majority of SAMHSA staff who plan, direct, and administer programs and provide technical assistance and guidance to States, behavioral health professionals, clients, and the general public.

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Health Costs, Quality and Outcomes Research					
Patient Safety:					
Health Information Technology Initiative	50	50	50	45	-5
Personalized Medicine	--	--	--	15	+15
Other Patient Safety	34	34	34	34	--
Subtotal, Patient Safety	84	84	84	94	+10
Effective Healthcare Program	15	15	15	15	--
Other Quality and Cost Effectiveness Research	162	162	162	163	+1
Total, Health Costs, Quality and Outcomes	261	261	261	272	+11
Medical Expenditures Panel Surveys	55	55	55	55	--
Program Support	3	3	3	3	--
Total	**319**	**319**	**319**	**330**	**+11**
FTE	292		292	299	+7

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

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

The FY 2008 Budget request for the Agency for Healthcare Research and Quality (AHRQ) is $330 million, a net increase of $11 million over the FY 2007 Continuing Resolution, which is also an increase of $11 million over the FY 2007 President's Budget. This level provides funding for the Secretary's Personalized Health Care Initiative and the Value-Driven Health Care Initiative. The Budget also supports efforts to improve patient safety through the implementation of proven information technologies and through establishing and maintaining a network of Patient Safety Databases as mandated by the Patient Safety and Quality Improvement Act of 2005.

AHRQ conducts and sponsors health services research to inform decision-making and improve clinical care and the organization and financing of health care. AHRQ evaluates both clinical services and the system in which these services are provided. This work contributes not only to improved clinical care, but also to more cost-effective care. The agency's research agenda is broad and spans from medical informatics to long-term care and from pharmaceutical outcomes to disease prevention.

HEALTH COSTS, QUALITY, AND OUTCOMES

The FY 2008 President's Budget provides a total of $272 million to support improvements through research on the cost effectiveness and quality of health care. The request provides $94 million for Patient Safety. It also provides $15 million for the Effective Health Care Program authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Advancing Personalized Health Care: Improving the quality and effectiveness of health care – providing the right care to the right patient at the right time, and getting it right the first time – remains a challenge in the United States. The FY 2008 request includes $15 million to expand the infrastructure necessary to ensure the Nation's health care system provides good quality care at affordable prices. The initiative will accelerate integration of cutting edge innovations in personalized medicine, including genomics, into clinical practice through an electronic "network of networks." These goals will be met through the creation of a sustainable partnership between public and private payers and delivery systems to support evidence generation as a natural by-product of health care delivery. This effort will further develop three key areas: building data capacity and infrastructure, integrating administrative and clinical data to ensure that costs are tied to outcomes, and accelerating the development of quality measures. The long-term result of this effort will be greater cost effectiveness, other advances in clinical practice, and improved quality and safety for patients. AHRQ will work with agencies across HHS to implement this activity.

Personalized Health Care

Innovations and advances in medicine, science, and technology have radically changed both the course of disease and the treatments Americans receive. Using these advancements to create a more personalized healthcare system can:

- Provide incentive and infrastructure to support and promote collaboration of research networks and data sources to improve healthcare practices and increase the value of healthcare services provided.
- Improve the use of administrative data sources for population-based research and quality assessment by linking clinical information to administrative data.
- Take advantage of existing partnerships and administrative data sources by adding specific clinical information available through Electronic Health Records, prescription data, and laboratory data in a practical approach in order to expand research capacity.
- Build new and link existing practice-based research networks and their de-identified patient data to generate new knowledge during the course of health care delivery at a lower cost and in less time.

Investing in Health IT: The FY 2008 Budget includes $45 million for health information technology (IT) investments designed to enhance patient safety, with an emphasis on ambulatory patient care. AHRQ's significant investment in hospital safety has demonstrated the importance of patient safety reporting systems, computerized provider order entry, and decision support systems to key stakeholders and policymakers. While the use of hospital-based IT for patient safety has been rising, an adoption gap exists in ambulatory care, especially in smaller practices where 60 percent of physicians continue to practice with five or fewer doctors.

Within this total, AHRQ will provide $26 million for the Ambulatory Patient Safety Program to improve the safety and quality of care for patients in ambulatory environments using health IT. It will complement and contribute to the overall goals and objectives of the President's health IT initiative, the American Health Information Community, and those of the Office of the National Coordinator for Health Information Technology. AHRQ will examine the best ways to develop, deploy, and evaluate the use of electronic health information systems, both the technology and the processes around it – by addressing systemic barriers to adoption and creating the evidence base for best practices. The program will focus on four cross-cutting care domains to achieve the goal of improvements in medication safety, patient-centered care, medication management, and integration of decisions support tools. Special attention will be placed on the delivery of high quality care from providers in rural, small community, safety net, and community health center environments. The remaining $19 million for health IT will continue funding for planning and implementation of solutions in communities that demonstrate the value of health IT in patient safety, quality, and health care costs. Working with public and private partners, AHRQ will use data from health information technology investment demonstrations to make the business case for adoption of these tools, and help spread proven technology through the health care system.

Supporting Other Patient Safety Activities: AHRQ's patient safety budget includes $34 million to support a variety of activities. In FY 2006, AHRQ provided $3 million in contract funds to initiate activities authorized under the Patient Safety and Quality Improvement Act of 2005, which establishes patient safety organizations (PSO) nationwide that will collect information from providers about adverse events affecting patient safety. These PSOs work with providers across diverse health care settings to collect information on patient safety events, assisting in analyzing causes of such events, and developing solutions to decrease their incidence.

AHRQ is also establishing definitions for a set of data elements that will enable providers to submit reports to PSOs in a common format, in addition to developing a mechanism for transmission of formatted information among PSOs. AHRQ will continue funding these activities in FY 2008. In addition, a new round of investigator-initiated patient safety grants will be awarded to build on the investments first funded in FY 2001 following the release of the Institute of Medicine's 1999 report, *To Err is Human: Building a Safer Health System.*

Promoting Value-Driven Health care: The FY 2008 Budget provides $4 million for the Value Driven Health Care project, which developed from the AQA Alliance pilot projects, a new effort to enhance person and population-centered care by improving the quality of health care services and reducing health care costs. This activity, a major component of the Secretary's Health Care Transparency Initiative, seeks to give consumers control of their health care so they can make informed decisions. With this funding, AHRQ will establish a nationwide learning network of community-based multi-stakeholder collaboratives to develop an evidence-based approach to dissemination and adoption of best medical practices. Funds will also support a curriculum and implementation component, which will provide the participating communities with evidence, methods and tailored tools for improving health care transparency, quality and value, and cost-containment. The curriculum will be entirely driven by needs of the collaborative sites' leadership.

Advancing the Effective Health Care Program: The FY 2008 Budget provides $15 million in continued support related to Section 1013 of the MMA for the Effective Health Care Program. The AHRQ Effective Health Care Program helps policymakers, clinicians, and patients determine which drugs and other medical treatments work best for certain health conditions. This funding supports the development of new scientific information through research on the outcomes of health care services and therapies, including drugs and by comparing different therapies for the same condition. By reviewing and synthesizing published and unpublished scientific studies, as

Performance Highlight

Covenant Healthcare, a five-hospital system in Milwaukee, Wisconsin, used the AHRQ quality indicators to measure the effectiveness of their Rapid Response Teams trained to intervene early and aggressively when a patient begins showing signs of decline.

The implementation of these Teams resulted in a drop in the Failure to Rescue rate (an AHRQ Patient Safety Indicator) where teams and measures have been in place for more than 12 months. Mortality rates dropped as well.

This successful implementation is one example of the impact of the Data Development Portfolio. This program's long-term outcome measure is to increase the number of organizations that will use databases, products or tools to improve health care quality. AHRQ will continue these efforts in FY 2007 and FY 2008 by recruiting additional organizations to use these tools.

well as identifying important issues where existing evidence is insufficient, the program helps provide policymakers, clinicians, and patients with better information for making treatment decisions. Initial reports from the new program were issued this fall, with particular focus on effectiveness information relevant to Medicare beneficiaries. In FY 2008, AHRQ will continue to partner with the Centers for Medicare & Medicaid Services to generate information about which drugs and other treatments are proven to be effective for the conditions that are most important for its beneficiaries.

Supporting Research and Dissemination Activities Outside Patient Safety: In FY 2008, AHRQ will invest $159 million in research and dissemination activities in prevention, pharmaceutical outcomes, and other research areas to support the quality and cost-effectiveness of health care. These efforts ensure that AHRQ's research findings are accessible to the public. AHRQ will also continue to sponsor the United States Preventive Services Task Force in FY 2008. In FY 2006, AHRQ partnered with the United Health Foundation to distribute more than 400,000 copies of the 2006 Guide to Clinical Preventive Services, a new guide to evidence-based clinical preventive services recommendations, to clinicians nationwide. Some of the key recommendations focus on screening for obesity, breast cancer, abdominal aortic aneurysm, and HIV.

MEDICAL EXPENDITURE PANEL SURVEYS (MEPS)

The FY 2008 Budget for MEPS includes a request for $55 million, the same as FY 2007. MEPS is the collection of detailed, national data on the health care services Americans use, how much they cost, and who pays for them. It is the only national source of visit-level information on medical expenditures. MEPS provides a better understanding of the quality of care the typical patient receives, and of disparities in the care delivered. MEPS data are critical for tracking the impact of Federal and State programs, including the State Children's Health Insurance Program, Medicare and Medicaid.

These surveys also provide a substantial portion of the data used to develop two reports required by the agency's 1999 reauthorization. The reports measure the quality of health care in America and differences in access to health care services for priority populations. The National Healthcare Quality Report includes information on patient assessment of health care quality, clinical quality measures of common health care services, and performance measures related to outcomes of acute and chronic disease. The second report – the National Healthcare Disparities Report – highlights populations that are at high risk for differences in care. These populations include the elderly, people in inner-city and rural areas, women, children, minorities, low-income groups, and individuals with special health care needs. The current editions of the reports are available at www.qualitytools.ahrq.gov.

In FY 2008, AHRQ will be fully funded through inter-agency transfers of evaluation funds.

(dollars in millions)

	2006	2007	2008	
	Actual	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Current Law:				
Medicare	381,792	436,368	464,575	+28,207
Medicaid /1	180,625	191,841	203,886	+12,045
SCHIP	5,451	5,647	5,424	-223
State Grants and Demonstrations	1,269	1,680	496	-1,184
Total Outlays, Current Law	**569,137**	**635,536**	**674,381**	**+38,845**
Offsetting Receipts (Medicare)				
Premiums	-45,108	-52,785	-57,202	-4,417
State Contribution for Part D	-3,630	-8,030	-7,918	+112
Medicare Refunds	-3,202	-3,300	-3,500	-200
Other Offsetting Collections/Receipts	-12	-4	-4	--
Total Net Outlays, Current Law	**517,185**	**571,417**	**605,757**	**+34,340**
Proposed Law:				
Medicare Benefits	--	--	-4,271	-4,271
Medicaid Benefits and Administration	--	35	-1,942	-1,977
SCHIP Benefits	--	--	1,220	+1,220
Program Management	--	--	-35	-35
Total Proposed Law	**--**	**35**	**-5,028**	**-5,063**
Total Net Outlays, Proposed Law /2	**517,185**	**571,452**	**600,729**	**+29,277**

1/ Net outlays without outlays for Qualified Individuals.

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

The FY 2008 Budget request for the Centers for Medicare & Medicaid Services (CMS) is $600.7 billion in net outlays, a net increase of $29.2 billion over the FY 2007 Continuing Resolution. This request finances Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), program integrity efforts, CMS operating costs, and other small programs.

CMS is the largest purchaser of health care in the United States, serving over 92 million Medicare, Medicaid, and SCHIP beneficiaries. Following are policy highlights from the CMS FY 2008 Budget request.

FOSTERING AFFORDABLE CHOICES IN THE HEALTH CARE SYSTEM

The Federal Government's current system of paying for health care results in billions of dollars being spent inefficiently through a patchwork of subsidies and payments to providers. In addition to directly funding the care provided to people enrolled in programs like Medicare and Medicaid, health care entitlement programs finance payments to institutions that either indirectly pay for uncompensated care or subsidize their operating expenses.

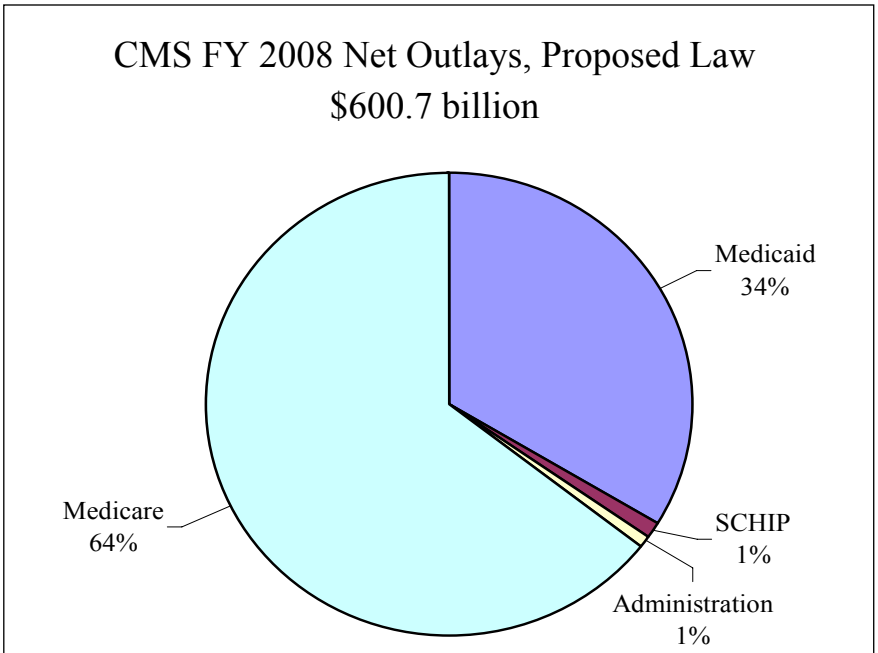
The health care system could operate more efficiently if some portion of institutional payments instead were redirected to help people with poor health or limited income afford health insurance. The uninsured often use emergency rooms as a source of primary care, which leads to suboptimal care and spending outcomes. If this public spending were focused on helping the uninsured purchase private insurance, people would receive the care they need in the most appropriate setting. The health care system needs to be transformed in a way that avoids costly and unnecessary medical visits and emphasizes upfront, affordable private health insurance options.

This transformation could happen by subsidizing the purchase of private insurance for low-income individuals. However, any such health care reforms would need to be State-based and budget neutral, not create a new entitlement and not affect savings contained in the President's Budget that are necessary to address the unsustainable growth of Federal entitlement programs. The Federal Government would also maintain its commitment to the neediest and most vulnerable populations, while acknowledging that States are best situated to craft innovative solutions to move people into affordable insurance.

The President has asked the Secretary of Health and Human Services to work with Congress and the States on an Affordable Choices initiative to reform the health care marketplace.

MEDICARE

The Budget includes a set of Medicare legislative and administrative proposals saving $5.3 billion in FY 2008 and $75.9 billion over five years. Designed to strengthen Medicare's long-term financial security, these proposals encourage efficient payments, foster competition, and promote beneficiary involvement in health care decisions.



State Grants and Demonstrations accounts for 0.08 percent of net outlays.

New program funding totaling $183 million in FY 2008 will help to combat fraud and abuse in the new prescription drug benefit and Medicare Advantage program.

The Medicare prescription drug benefit progresses strongly into its second year. With a net Medicare cost nearly $200 billion below initial estimates over the 2004 to 2013 period and a satisfaction rating topping 75 percent, this new benefit is immensely successful. In 2007, average premiums are down, more plans are offering a zero deductible, and nearly all beneficiaries can access a plan offering at least some coverage in the gap.

MEDICAID AND SCHIP

The budget proposes Medicaid legislative changes that will save $13.0 billion over five years and administrative changes that will save $12.7 billion over five years in order to continue to slow the annual growth in the Medicaid entitlement program.

The President's Budget also proposes to reauthorize SCHIP for five years, increasing the SCHIP allotments by almost $5 billion over five years. The President's Budget proposes to re-focus SCHIP on low-income, uninsured children at or below 200 percent of the Federal poverty level as the program originally intended.

DISCRETIONARY PROGRAM MANAGEMENT

CMS is on track toward implementing contracting reform nearly two years earlier than the 2011 target set in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Contracting reform is projected to generate significant administrative savings to the government and providers by reducing the cost of processing Medicare claims. This initiative will yield nearly $2 billion in Trust Fund savings over the next five years through more accurate and appropriate payments.

(dollars in millions)

	2006	2007	2008	
	Actual	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Current Law:				
Medicare Benefits				
Part A Benefits	181,463	202,545	212,275	+9,730
Part B Benefits	158,021	173,895	181,639	+7,744
Part D Benefits	33,503	49,174	60,119	+10,945
Subtotal, Medicare Benefits	372,986	425,614	454,033	+28,419
Other Disbursements				
Administration /1	5,143	5,007	5,164	+157
HCFAC /2	1,063	1,220	1,314	+94
Quality Improvement Organizations	400	419	402	-17
Miscellaneous Mandatory Disbursements	2,200	4,108	3,662	-446
Total Outlays, Current Law	**381,792**	**436,368**	**464,575**	**+28,207**
Offsetting Collections				
Premiums	-45,108	-52,785	-57,202	-4,417
State Contribution for Part D	-3,630	-8,030	-7,918	+112
Medicare Refunds	-3,202	-3,300	-3,500	-200
Other Offsetting Collections/Receipts	-12	-4	-4	0
Total Net Outlays, Current Law	**329,840**	**372,249**	**395,951**	**+23,702**
Proposed Legislation:				
Part A	--	--	-3,291	-3,291
Part B /3	--	--	-825	-825
Part D	--	--	-77	-77
Program Management	--	--	-35	-35
Premium Offsets	--	--	-78	-78
Total Medicare Proposed Legislation	**--**	**--**	**-4,306**	**-4,306**
Total Net Outlays, Proposed Law	**329,840**	**372,249**	**391,645**	**+19,396**

1/ Includes administrative payments to the Social Security Administration and other non-CMS agencies.

2/ Health Care Fraud and Abuse Control, including Federal Bureau of Investigation and OIG.

3/ Does not include Medicaid Offsets.

In FY 2008, spending on Medicare benefits will total $454.0 billion. Medicare will provide health insurance to 44.6 million individuals who are either 65 or older, disabled, or suffer from end–stage renal disease (ESRD).

THE FOUR PARTS OF MEDICARE

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

Individuals with 40 quarters of Medicare-covered employment are entitled to Part A without paying a premium, but most covered services do require a beneficiary copayment or coinsurance. In 2007, beneficiaries will pay a $992 deductible for a hospital stay of 1-60 days, and $124 daily coinsurance for days 21-100 in a skilled nursing facility.

Medicare Enrollment
(enrollees in millions)

	2006	2007	2008	+/-2007
Aged.....	36.2	36.7	37.3	0.6
Disabled.....	6.9	7.1	7.3	0.2
Total Beneficiaries	**43.1**	**43.8**	**44.6**	**0.8**

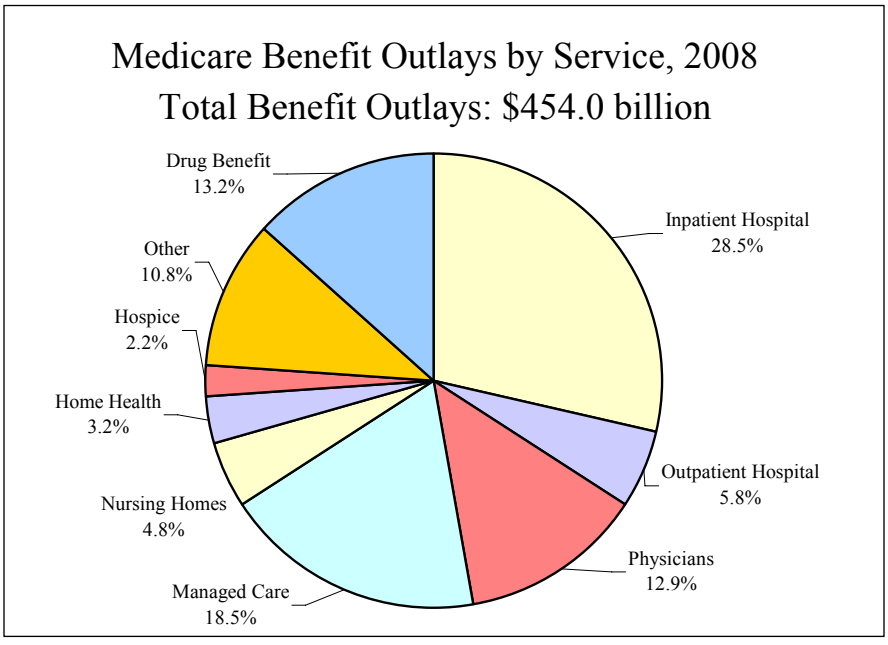
The 2006 Medicare Trustees report projects the HI Trust Fund's insolvency date at 2018.

Part B: Medicare Part B, or Supplementary Medical Insurance, pays for physicians' services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment, certain home health care, and other medical services and supplies. Part B coverage is voluntary, and about 94 percent of Medicare beneficiaries are enrolled. Approximately 25 percent of Part B costs are financed by beneficiary premiums, with the remaining 75 percent covered by general revenues.

Beginning January 1, 2007 Part B premiums are based on income. Most beneficiaries will pay the standard monthly premium of $93.50, but some will pay a higher premium based on their income. Those with annual incomes above $80,000 (single) or $160,000 (married couple) will pay from $105.80 to $161.40.

Part C: Medicare Part C, the Medicare Advantage (MA) program, offers beneficiaries a variety of coverage options including traditional health maintenance organizations, preferred provider organizations, special needs plans, and private fee-for-service plans. In 2006, about 17 percent of beneficiaries were enrolled in an MA plan, reversing a downward trend in private Medicare plan enrollment. All beneficiaries also had access to at least one type of MA plan, up from 77 percent in 2004.

Medicare pays MA plans a capitated monthly payment to provide all Parts A and B services (and Part D if offered by the plan). Plans can charge premiums to cover Medicare beneficiary cost-sharing, plus any additional benefits. The premium varies depending on the services offered by the plan; therefore, it can be higher or lower than the regular Part B premium.



On average in 2006, these plans saved beneficiaries around $82 per month in out-of-pocket expenses compared to traditional Medicare, and beneficiaries with fair or poor health saved more.

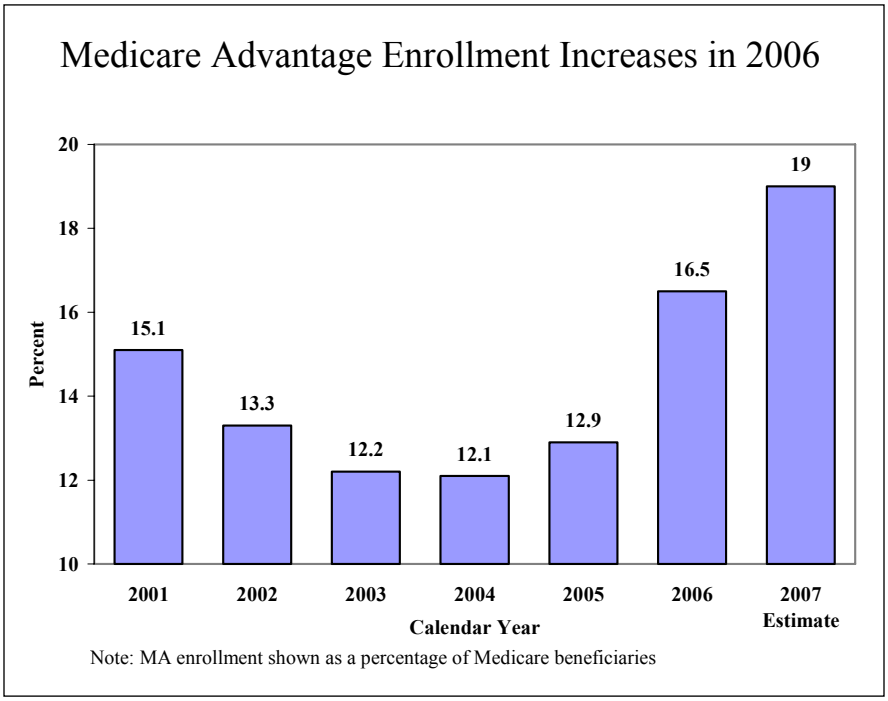
For the first time in 2007, beneficiaries in 39 States have access to Medical Savings Account plans. These plans empower Medicare beneficiaries as consumers with more control over their health care utilization and costs, while providing them with coverage against catastrophic expenses.

Part D: In 2006, HHS implemented the first year of the new Medicare prescription drug benefit, the most significant reform of Medicare since its inception. Medicare Part D offers a standard prescription drug benefit with a 2007 deductible of $265, a reasonable monthly premium, and a substantial subsidy for drug costs. The standard benefit includes a coverage gap in which beneficiaries are responsible for all of their drug costs, but once out-of-pocket spending reaches $3,850, Medicare covers 95 percent or more of drug costs. For people who are low income, varying degrees of cost sharing are available with copayments ranging from $0 to $5.35 and low or no monthly premiums.

Part D has been an unparalleled success. Almost 24 million beneficiaries have coverage through a Part D plan, and another 15 million have creditable coverage through other sources. The estimated average Part D premium for 2007 is just $22, well below the original estimate of $38, and some premiums run as low as $10 per month. In addition, many plans are available with no deductible, and nearly all beneficiaries have access to one or more plans with drug coverage in the "coverage gap."

Through competition and aggressive negotiating, Part D plans produced greater than expected savings in 2006. The most recent estimates show plan payments over the next 10 years (2007 to 2016) are projected to be $113 billion lower than estimated last summer. This reduction is primarily attributable to competition and significantly lower Part D plan bids, as well as slower growth in prescription drug costs. In addition, beneficiaries are saving an average of $1,200 annually on their drug costs.

Beneficiary satisfaction with the prescription drug benefit is high. Independent surveys consistently show that 75 percent of Part D enrollees are satisfied with their drug coverage.



Note: MA enrollment shown as a percentage of Medicare beneficiaries

FY 2008 Legislative Proposals

The budget includes a comprehensive package of Medicare legislative proposals designed to strengthen the long-term financial security of the program. Net savings from the Medicare legislative package total $4.3 billion in FY 2008 and $65.6 billion over five years. The Budget also reduces beneficiary premiums by $5.6 billion over five years.

These Medicare savings are part of a larger Administration effort to address the unsustainable growth of Federal entitlement programs. Our budget reduces Medicare's average annual growth rate over five years from 6.5 percent to 5.6 percent. Finally, these proposals will encourage efficient payment for services, foster competition, improve program integrity, and promote beneficiary involvement in health care decisions. Brief proposal descriptions follow.

Foster Productivity and Efficiency in Medicare

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

- Reduce update factor for inpatient hospitals, outpatient

hospitals, hospices, and ambulance services by -0.65 percent annually starting in FY 2008.

- Zero percent update for skilled nursing facilities and inpatient rehabilitation facilities in 2008 and a -0.65 percent adjustment to the update annually thereafter.

- Zero percent update for home health agencies in 2008 through 2012 and a -0.65 percent adjustment to the update annually thereafter.

- Reduce the annual update for ambulatory surgical centers by -0.65 percent beginning in 2010.

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

Rationalize Medicare Payments and Subsidies

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

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

Value-based Purchasing: Establish budget-neutral incentives for high-quality hospitals and create minimum benchmarks for low-quality hospitals.

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

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

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

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

Improve Program Integrity

Data Clearinghouse: Require group health plans (and other third party payers) to report MSP data, and create a federal clearinghouse for data sharing with other federal health insurance programs, such as Federal Employees Health Benefits, TRICARE, and Veterans Affairs, to identify situations where Medicare is not the primary payer.

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

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

Increase High-Income Beneficiary Awareness and Responsibility for Health Care Costs

Part B Premium Indexing: Eliminate annual indexing of income thresholds for reduced Part B premium subsidies beginning on January 1, 2008.

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

Medicare Prescription Drug benefit Beneficiary Cost Sharing in 2007

Beneficiary Income Level	Annual Deductible	Monthly Premium	Beneficiary Out-of-Pocket Spending For Total Drug Expenditures:	
			≤ $5,451	> $5,451
≥150% FPL (standard benefit)	$265	$22 (avg)	25% from $265-2,400 100% from $2,400-5,451	Greater of 5% or $2.15-5.35 copay
135-150% FPL*	$53	$0 - $22	15% from $53-5,451	Copayment of: $2.15 generic $5.35 brand
100-135% FPL*	$0	$0	Copayment of: $2.15 generic $5.35 brand name	$0
≤100% FPL*	$0	$0	Copayment of: $1 generic $3.10 brand name	$0

FPL=Federal Poverty Level
*At these income levels, beneficiaries must also meet an asset test.

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

FY 2008 Medicare Administrative Proposals

The Medicare budget assumes administrative savings of $1.0 billion in FY 2008 and $10.2 billion over five years. Savings will result from new efforts to strengthen program integrity in Medicare payment systems, correct for inappropriate provider payments, and adjust payments to encourage efficiency and productivity.

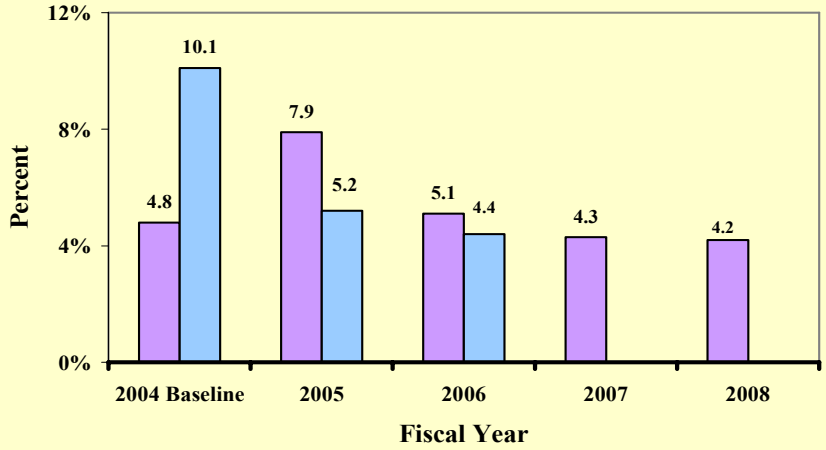
Medicare Highlights from the Tax Relief and Health Care Act of 2006

Linking Payment to Performance: Starting in 2009, outpatient hospital departments will submit data on specified quality measures or have their annual payment increases reduced by two percentage points.

Updating Physician Payments: The previously scheduled 2007 physician payment update of -5 percent is eliminated and replaced with a zero percent update. In addition, a 1.5 percent bonus payment is established for physicians who report quality measures in 2007. Also in 2007, the floor is extended for physician labor costs in certain rural areas. This Act also establishes a Physician Assistance and Quality Initiative Fund, totaling $1.35 billion in 2008, to promote physician payment and quality improvement initiatives in 2008.

Performance Highlight

Aggressive oversight and new efforts to improve payment accuracy cut the percentage of improper fee-for-service Medicare claims payments by 15 percent from 2005 to 2006. This is a $10.8 billion reduction in improper payments. For 2008, CMS targets a further reduction in the Medicare error rate to 4.2 percent.



Enhancing Program Integrity: Spending for certain parts of the Health Care Fraud and Abuse Control program for fiscal years 2007 through 2010 will increase by CPI-U inflation; after 2010, spending is capped at 2010 levels.

Expanding Recovery Audit Contractors: The recovery audit contractor program, currently running in three States, will expand to all States by 2010. Under this program, private contractors conduct audit and recovery activities with respect to payments made under Medicare Parts A or B. Recovered overpayments, less contract contingency and administration costs, are returned to the Medicare trust funds.

Reducing the Medicare Advantage Stabilization Fund: This Act reduces the funds available in the MA stabilization fund by $6.5 billion and limits the availability of the remaining $3.5 billion to expenditures during 2012 and 2013.

Establishing Coverage for Part D Vaccine Administration: In 2007, payment for the administration of Part D-covered vaccines is covered under Part B. Beginning in 2008, Part D plans will cover these costs.

Updating Payments for Dialysis Services: Payment rates for ESRD facilities increase by 1.6 percent beginning April 1, 2007.

Medicare Quality Improvement Efforts

Improving quality of care and reducing medical errors are important goals in modernizing Medicare. The Administration supports greater transparency of information about the price and quality of care. In addition, the Administration supports budget neutral payment reforms that reward improved quality of care through value-based purchasing.

Transparency: CMS is working to improve the transparency of information on price and quality of services provided to Medicare beneficiaries.

Providing Quality Data: The Medicare website now displays quality data that allows consumers to make informed choices by comparing the performance of hospitals, nursing homes, home health agencies, and dialysis facilities.

Working with Partners to Improve Quality Information: Through the Better Quality Information (BQI) for Medicare Beneficiaries initiative, CMS is partnering with the Agency for Healthcare Research and Quality to expand the Ambulatory Quality Alliance Pilots. The BQI initiative will continue to expand in FY 2008, providing information on healthcare quality, through quality "alliances" with providers, consumers, and payers. CMS is providing $27 million toward 18 BQI sites in 2007 from the Quality Improvement Organization (QIO) program.

Expanding Value-Based Purchasing and Improving Provider Quality Efforts: CMS is working to develop and implement payment systems that support high quality care – the right care for each person every time. These payment reforms can help providers deliver care that prevents complications, avoids unnecessary medical services, and achieves better outcomes at a lower overall cost.

CMS is working collaboratively with private and public organizations to stimulate high quality care and improve efficiency.

- CMS will publish a report this year, as required by the Deficit Reduction Act of 2005 (DRA), on how to implement hospital value-based purchasing in 2009.
- The DRA requires hospitals to report an expanded set of quality measures or see their payment updates reduced by 2 percent. CMS is requiring hospitals to report on 21 measures.
- Building off its successful efforts among hospitals, CMS will continue to expand its voluntary quality reporting program for physicians in 2007.
- The new Tax Relief and Health Care Act of 2006 establishes a quality reporting requirement for physicians, outpatient, and ambulatory surgical centers, and CMS is developing an implementation plan.
- CMS has multiple research demonstrations in the field that will test various value-based purchasing methods for hospitals, physicians, and disease management plans.

Quality Improvement Organizations: The QIO program serves the following functions:

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

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

Health Care Fraud and Abuse Control (HCFAC)

(B.A. in millions)

	2006	2007	2008
Discretionary Cap Adjustment Proposal			
Department of Justice/FBI	-	-	17.5
HHS Inspector General	-	-	17.5
Medicaid and SCHIP Financial Management	-	-	10.1
Medicare Integrity Program (MIP)	-	-	137.8
Total Proposed Discretionary Funds	**-**	**-**	**183.0**
Current Mandatory Funds (including TRHCA)			
Medicare Integrity Program (MIP)	832.0	744.0	756.0
FBI	114.0	118.2	120.6
OIG and Wedge Funds	240.6	249.5	254.4
Total Current Mandatory Funds	**1,186.6**	**1,111.7**	**1,131.0**
Total Proposed HCFAC Funds	**1,186.6**	**1,111.7**	**1,314.0**
Memorandum			
HHS Program Level Portion of HCFAC Total	*1,023.1*	*942.2*	*1,124.8*

In FY 2008, CMS will begin the next cycle of contracts called the 9th Scope of Work (SoW). The 8th SoW, funded at $1.231 billion over 2005-2008, focused on clinical quality improvements, public reporting and quality information, and protecting beneficiaries and the Trust Funds. Work on the 9th SoW will build on the 8th SoW and recommendations made by the Institute of Medicine. The Administration is working to improve quality, oversight, and efficiency, and better target resources in the QIO program.

PROGRAM INTEGRITY OVERSIGHT

Health Care Fraud and Abuse Control (HCFAC): The FY 2008 budget proposes to fund the HCFAC program through both mandatory and discretionary funding streams. The FY 2008 HCFAC program level is $1.3 billion, over $200 million more than in FY 2007. Of this total program level, $1.1 billion is mandatory and $183.0 million is discretionary.

HCFAC Mandatory Funds: The $1.1 billion in mandatory funds are financed from the Medicare Part A Trust Fund. This funding is allocated into three major parts: 1) the Medicare Integrity Program (MIP); 2) the Federal Bureau of Investigation; and 3) the HCFAC Account, which is divided among the Department of Justice (DOJ), the HHS Office of Inspector General (OIG), and other HHS agencies through an annual negotiation process. Activities financed by this funding are used to detect and prevent heath care fraud, waste and abuse through investigations, audits, educational activities, and data analysis. The mandatory HCFAC funding has a proven record of returning money to the Medicare Trust Fund for each dollar spent. For the MIP program, the return on investment (ROI) is 13 to 1, and for the HCFAC Account, the ROI is 4 to 1. From 1997 to 2005, HCFAC activities have returned approximately $8.85 billion to the Trust Fund.

HCFAC Discretionary Funds: As part of a governmentwide proposal to fund proven program integrity activities through an adjustment to discretionary spending totals, the FY 2008 budget requests $183 million in discretionary HCFAC funding. This total will be allocated among the Medicare and Medicaid programs at CMS, as well as the OIG and DOJ. These funds are intended to complement the program integrity activities funded with mandatory HCFAC dollars.

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

Reducing Erroneous Medicare Payments: The significant reduction in the Medicare fee-for-service error rate from 2005 to 2006 can be attributed largely to efforts through the Comprehensive Error Rate Testing (CERT) program to educate providers about problems with medical record documentation and methods to improve their accuracy and completeness. The CERT program tracks payment accuracy data at the contractor, provider, and service levels. When data reveal a pattern indicating a payment problem, CMS works with contractors to develop corrective action plans.

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

(dollars in millions)

	2008 President's Budget	Five Year 2008-2012
Medicare Legislative Proposals		
Foster Productivity and Efficiency in Medicare:		
Hospital Update at Market Basket (MB) -0.65% Annually Starting FY 2008	-720	-13,790
Skilled Nursing Facility Update at 0% in 2008 and MB -0.65% Annually Thereafter	-1,010	-9,210
Inpatient Rehabilitation Facility Update at 0% in 2008 and MB -0.65% Annually Thereafter	-230	-1,910
Hospice Payment Update at MB -0.65% Annually Starting FY 2008	-60	-1,140
Outpatient Hospital Update at MB -0.65% Annually Starting FY 2008	-120	-3,360
Ambulance Fee Schedule Update at CPI-0.65% Annually Starting FY 2008	-10	-360
Ambulatory Surgical Center Update at CPI-0.65% Annually Starting FY 2010	--	-90
Home Health Update at 0% from 2008-2012 and MB -0.65% Annually Thereafter	-410	-9,680
Introduce Competitive Bidding for Clinical Laboratory Services	-110	-2,380
Subtotal, Foster Productivity and Efficiency	-2,670	-41,920
Rationalize Medicare Payments and Subsidies:		
Eliminate Duplicate Hospital IME Payments for Medicare Advantage Beneficiaries	-381	-4,370
Eliminate Payments for Never Events	-30	-190
Establish Hospital Value-Based Purchasing Program (budget neutral)	--	--
Set Base Payment for 5 Post-Acute Conditions Treated in SNFs and IRFs	-470	-2,930
Establish 13-Month Rental Period for Power Wheelchairs	-70	-530
Reduce Rental Period for Oxygen Equipment from 36 to 13 Months	-110	-2,380
Extend Medicare Secondary Payer Status for ESRD from 30 to 60 Months	-160	-1,080
Subtotal, Rationalize Medicare Payments and Subsidies	-1,221	-11,480
Improve Program Integrity:		
Establish Federal Data Sharing Clearinghouse (Medicare Secondary Payer)	-50	-640
Phase-Out Medicare Bad Debt Payments Over 4 Years	-180	-7,150
Limit Use of Mandamus Jurisdiction to Obtain Judicial Review of Medicare Determinations	--	-80
Subtotal, Improve Program Integrity	-230	-7,870
Increase High-Income Beneficiary Responsibility for Health Care Costs:		
Eliminate Annual Indexing of Income-Related Part B Premiums (Benefit & Revenue Impact)	-543	-7,135
Establish Income-Related Part D Premium Consistent with Part B (Benefit & Revenue Impact)	-357	-3,242
Subtotal, Increase High-Income Beneficiary Responsibility	-900	-10,377
Improve Long-Term Sustainability:		
Apply -0.4% Sequester When Medicare Fund Warning is Triggered	--	--
Subtotal, Improve Long-Term Sustainability	--	--
Other/Interactions:		
1-Year QI Extension/Interactions Reducing Beneficiary Part B Premiums /1	750	6,030
Subtotal, Interactions	750	6,030
Total, Medicare Legislative Proposals	**-4,271**	**-65,618**
Medicare Administrative Proposals		
Improve Medicare Efficiency, Productivity, and Program Integrity	-1,000	-10,235
Total, Medicare Administrative Proposals	**-1,000**	**-10,235**
Total, Medicare Budget Proposals	**-5,271**	**-75,853**

1/ The $425 million Medicare effect of the QI extension proposal in FY 2008 is not scoreable for PAYGO purposes.

MEDICAID

(dollars in millions)

	2006	2007	2008	
	Actual	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Current Law:				
Benefits /1	171,485	181,959	193,871	+11,912
State Administration	9,141	9,882	10,015	+133
Total Outlays, Current Law	**180,625**	**191,841**	**203,886**	**+12,045**

1/ Includes Vaccines for Children Outlays.

Federal and State Governments jointly fund Medicaid, a program that provides medical assistance to certain low-income groups. The Federal Government's share of a State's expenditures is called the Federal Medical Assistance Percentage (FMAP). The FMAP has a floor rate of 50 percent and for FY 2008, the highest FMAP is 76.29 percent. Overall, the Federal Government will pay for approximately 57 percent of medical assistance payments.

In FY 2008, HHS estimates that approximately 50 million individuals in States and Territories will be covered by Medicaid. This includes children, the aged, blind, and/or disabled, and people who meet eligibility criteria under the old Aid to Families with Dependent Children (AFDC) program. Additionally, Medicaid will cover many other individuals who are eligible for benefits through waivers and amended State plans with somewhat higher income eligibility limits. The Medicaid current law baseline assumes passage of a full-year Continuing Resolution. In FY 2008, the Federal share of current law Medicaid outlays is expected to be $204 billion. This is a $12 billion (6.3 percent) increase over projected FY 2007 spending.

HOW MEDICAID WORKS

States are required to cover individuals who meet categorical and financial eligibility levels. This includes individuals who qualified under the 1996 AFDC rules; most Supplemental Security Income (SSI) recipients; pregnant women and children under age 6 whose family income is at or below 133 percent of the Federal poverty level (FPL); children ages 6 to 19 whose family income is below the FPL, all of whom are commonly referred to as "the categorically eligible." States may also cover "medically needy" individuals. These individuals meet the categorical eligibility criteria, but have too much income or too many resources to meet the financial criteria. This includes pregnant women through a 60-day post-partum period, children under age 18, newborns and certain protected blind individuals. In FY 2007, the FPL for a family of three was $17,170 in the continental United States. For more information, see www.aspe.hhs.gov/poverty/07poverty.shtml.

On February 8, 2006 President Bush signed the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171). The DRA was an important step in bringing mandatory spending under control and reforming Medicaid. In

Medicaid Enrollment

(enrollees in millions)

	2006	2007	2008
Aged 65 and Over	4.9	5.0	5.1
Blind and Disabled	8.3	8.5	8.6
Needy Adults	10.8	11.1	11.3
Needy Children	22.9	23.5	24.0
Territories	1.0	1.0	1.0
Total	**47.9**	**49.1**	**50.0**

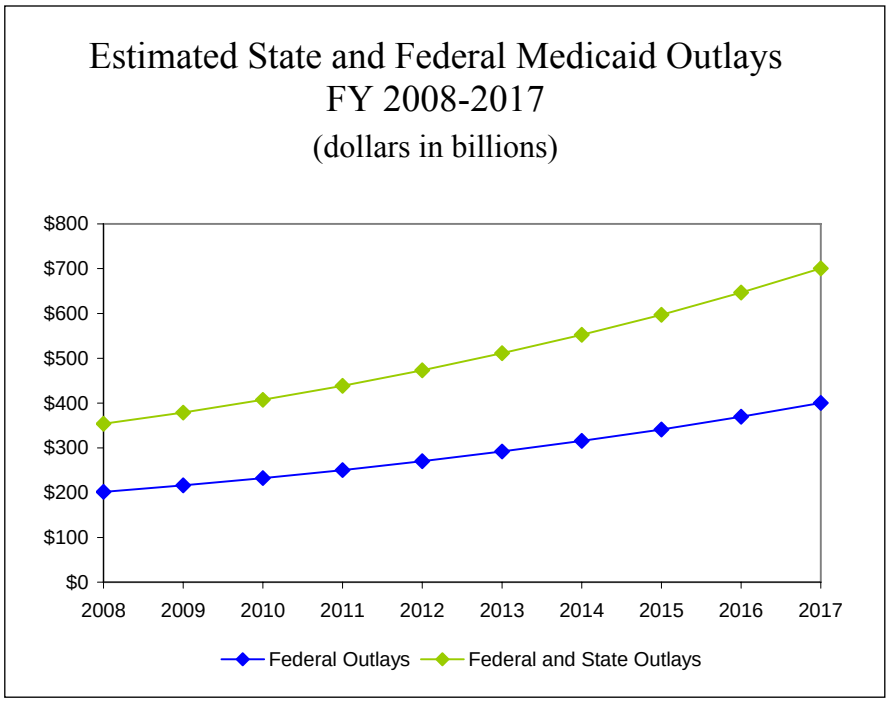
the long run, the biggest challenge to the budget is mandatory spending–or entitlement programs–like Medicare, Medicaid, and Social Security. Together, these programs are now growing faster than the economy and the population—and nearly three times the rate of inflation. By 2030, projected spending for Medicare, Medicaid, and Social Security alone will be almost 60 percent of the entire Federal budget. The annual growth of entitlement programs needs to be slowed to affordable levels.

The DRA reduces Medicaid spending for prescription drugs so that taxpayers do not have to pay inflated prices. The law gives governors more flexibility to design Medicaid benefits that efficiently and affordably meet State needs, and it closes loopholes that allowed higher income people to game the system by transferring assets in order to qualify for Medicaid benefits.

The President's Budget continues to exercise fiscal discipline in Medicaid. It proposes $1.9 billion in Medicaid savings in FY 2008 and approximately $13.0 billion in savings over five years. The President's proposals slow the average annual growth in Medicaid over the next five years from 7.3 percent a year to 7.1 percent a year.

FY 2008 Proposed Legislation

Last year the DRA made important strides in modernizing the financing, benefit structure, and infrastructure of Medicaid. The FY 2008 President's Budget continues these efforts to restrain unsustainable growth rates in this vital program.



Medicaid Administrative Services Reforms

Streamline Administrative Match Rates: Creates consistency in the administrative matching structure across Medicaid, by proposing to align all administrative reimbursement rates in Medicaid at 50 percent.

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

Medicaid Reimbursement Reforms

Require State Reporting and Link Performance to Reimbursement: Requires States to report on Medicaid performance measures and link performance to Federal Medicaid grant awards.

Reimburse Targeted Case Management (TCM) at 50 percent: Aligns reimbursement for TCM services with the standard administrative matching rate of 50 percent.

Medicaid Pharmacy Reforms

Rationalize Pharmacy Reimbursement: Builds on changes to pharmacy reimbursement in the DRA by reducing the Federal upper limit reimbursement for multiple source drugs to 150 percent of the average manufacturer price of the lowest priced drug in the group.

Allow Optional Managed Formulary: Allows States to use private sector management techniques to leverage greater discounts through negotiations with drug manufacturers.

Require Tamper-Resistant Prescription Pads: Requires all States where providers use hand-written prescription pads to use "tamper-resistant" pads.

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

Program Integrity Reforms

Expand Asset Verification Demonstration: Expands a Social Security Administration (SSA) pilot using electronic financial records for verifying an applicant's assets to appropriate HHS programs. State Medicaid agencies would be required to establish pilots in locations where SSA is operating such a pilot.

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

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

Long Term Care Reform

Define Home Equity Definition at $500,000: Removes the State option to increase the $500,000 home equity limit to $750,000 by proposing to codify the substantial home equity definition at $500,000.

Authorization Extensions and Modifications

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

Extend Transitional Medical Assistance (TMA): Extends TMA which allows families to remain eligible for Medicaid for up to 12 months after they lose welfare cash benefits due to increased earnings. The Tax Relief and Health Care Act of 2006 (P.L. 109-432) extends TMA through June 30, 2007. This legislative proposal extends TMA through September 30, 2008.

Extend Qualified Individuals (QI) Program: Extends premium assistance for QIs, Medicare beneficiaries with incomes of at least 120 percent and less than 135 percent FPL and who have limited financial resources, through September 30, 2008. The QI extension will continue Federal coverage of Medicare Part B premiums.

Other

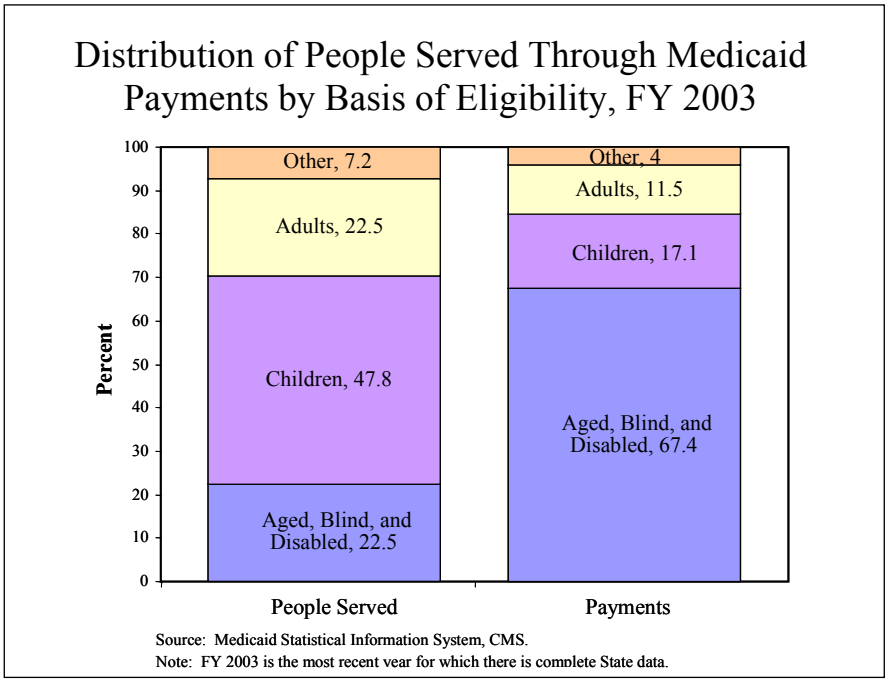
Extend Refugee Exemption: This SSA proposal, which has a Medicaid impact, extends the seven-year exemption to eight years so that refugees and asylees will have one additional year to complete the citizenship application process without penalty.

ADMINISTRATIVE PROPOSALS

The President's Budget also announces plans for several administrative initiatives that achieve additional Medicaid savings. The Administration believes it can implement the following initiatives through either regulatory or sub-regulatory guidance.

Revise Payments for Government Providers: Builds on past CMS efforts to curb questionable financing practices by recovering Federal funds that are diverted from government providers and retained by the State. In addition, this proposal caps payments to government providers to no more than the cost of furnishing services to Medicaid beneficiaries.

School-Based Services: Announces planned administrative actions to phase out Medicaid reimbursement for some services, including transportation and administrative claiming related to Medicaid services provided in schools.



Eliminate Medicaid Graduate Medical Education (GME): Clarifies that Medicaid will no longer be available as a source of funding for GME. Paying for GME is outside of Medicaid's primary purpose, which is to provide medical care to low-income populations.

Clarify Rehabilitation Services: Proposes a regulation clearly defining allowable services that may be claimed as rehabilitation services, which are optional Medicaid services typically offered to individuals with special needs or disabilities to help improve their health and quality of life.

Issue Guidance Defining 1915(b)(3) Services: Announces regulation clarifying which services provided under section 1915(b)(3) of the Social Security Act will be allowed.

Third Party Liability- Eliminate "Pay&Chase" for Pharmacy: Requires States to uphold the cost avoidance standard for pharmacy claims, and eliminates waivers that permit "pay and chase."

Payment Reform: Clarify Provider Tax Policy: Clarifies the mechanism by which Congress originally intended the provider tax limitations to operate.

Codify Disproportionate Share Hospital (DSH) Provisions in Regulation: Provides further clarification of allowable DSH costs that may be claimed for Federal reimbursement.

Medicaid Commission

The Secretary established the Medicaid Commission in May 2005 to provide recommendations on ways to modernize the Medicaid program. Many of the Commission's preliminary recommendations, released in September 2005, were incorporated into the DRA. This past December, the Commission released its final report detailing recommendations to ensure the long-term sustainability of Medicaid.

Some of the Commission's recommendations include:

- Promote individual responsibility and planning for long-term care needs.
- Give States greater flexibility to design Medicaid benefits packages.
- Aggressively promote and support the implementation of health IT.

The full Medicaid Commission report is available at www.aspe.hhs.gov/medicaid/.

RECENT PROGRAM DEVELOPMENTS

Tax Relief and Health Care Act of 2006 (P.L. 109-432): In addition to tax provisions that address Medical Savings Accounts and Health Savings Accounts, this law included provisions related to Medicaid, including:

Extension of Transitional Medical Assistance (TMA) and Abstinence Education Program: Extends TMA and Abstinence education programs through June 30, 2007.

Provider Taxes: Codifies the maximum rate at which a State can tax its health care providers at six percent, in effect on November 1, 2006. Beginning January 1, 2008 through FY 2011, the rate will be temporarily reduced to 5.5 percent.

DSH Allotments: Provides FY 2007 DSH allotments for Tennessee and Hawaii.

Medicaid DRA Technical Corrections: Clarifies that Medicaid beneficiaries at less than 100 percent of the FPL continue to pay no more than nominal cost sharing and sets an aggregate cap for their cost sharing at five percent of family income, and expands exemption from DRA citizenship documentation requirements to beneficiaries of Medicare, SSI, SSDI, old-age and survivors insurance benefits as a result of disability, and Titles IV-B or IV-E foster children.

Key DRA Implementation Issues: The DRA enables Medicaid to better respond to the health care needs of 21st century Americans. For example, when the program was established in the 1960s, institutional care was the norm for long-term care services. Provisions in the DRA represent the most important reforms in 15 years to end the longstanding Medicaid bias toward institutional care. Institutional care may still be the best choice for many, but the DRA helped make home- and community-based care a real option for Medicaid beneficiaries. The law created strong financial incentives and opportunities for States through options like Money Follows the Person and Cash and Counseling, which give disabled Medicaid beneficiaries, their caregivers, and families the ability to choose the optimal setting for long-term care needs.

The DRA also permits Medicaid to cover more people at lower cost, with care that is portable and has greater continuity. This approach has already seen promise through

demonstrations in States where innovative programs enable Medicaid to work better with mainstream insurance to increase access to affordable health coverage.

Medicaid Flexibility: The Administration has maintained its focus on providing States with options to expand the use of Medicaid with a focus on flexibility. States can apply limited premiums and cost sharing for certain groups of Medicaid beneficiaries and services, as well as provide Medicaid coverage to certain groups of individuals through enrollment in benchmark benefit packages, similar to those offered in the SCHIP.

Medicaid Transformation Grants: This program provides new grant funds to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under Medicaid. Congress authorized and appropriated $75 million in each FY 2007 and FY 2008. Grants to 27 States were awarded in January 2007.

Reforming Long-Term Care and Services for the Disabled: Beginning January 1, 2007, both home-and community-based services (HCBS) for the elderly and self-directed personal assistance services for the elderly and disabled became optional benefits for States.

Money Follows the Person Demonstration: This demonstration supports State efforts to "rebalance" their long-term support systems by offering $1.75 billion over five years in competitive grants to States.

The Family Opportunity Act (FOA): The FOA was included as part of the DRA and includes a provision that allows States to offer middle-income families with disabled children the option of buying into Medicaid. FOA includes a demonstration that provides States with the opportunity to offer home and community based alternatives to psychiatric residential treatment facilities for children as part of the New Freedom Initiative first proposed by the President. The FOA also restores Medicaid eligibility for certain SSI beneficiaries.

Medicaid Integrity Program: The Medicaid Integrity Program was implemented in FY 2006. The Secretary is promoting Medicaid integrity by entering into contracts with eligible entities to carry out certain specified activities including reviews, audits, identification of over-payments, education, and technical support to States.

Medicaid Growth: The slowdown in Medicaid growth has resulted from many actions, including the shift in drug costs for the dually-eligible to the new Medicare drug benefit. While nursing home care, community-based long-term care costs, and payments to health plans are significant contributors to the growth in Medicaid outlays, the Administration's continued focus on eliminating fraud and abuse will assist in reducing outlays in the future.

Performance Highlight

Medicaid received a rating of Adequate in its 2006 Program Assessment Rating Tool (PART) review. As a result of the PART process, CMS developed a range of new performance measures, including:

- Increase the number of States that demonstrate improvement related to access and quality health care through the Medicaid Quality Improvement Program;
- Track return on investment resulting from implementation of the Medicaid Integrity Program; and
- Increase percentage of beneficiaries who receive home and community based services.

MEDICAID AND SCHIP PROPOSALS

(outlays in millions)

	2008 President's Budget	Five Year 2008-2012
Medicaid Legislative Proposals		
Streamline Administrative Match Rates	-945	-5,315
Implement Cost Allocation	-280	-1,770
Require State Reporting and Link Performance to Reimbursement	--	-330
Reimburse Targeted Case Management at 50 Percent	-200	-1,160
Rationalize Pharmacy Reimbursement	-160	-1,200
Allow Optional Managed Formulary	-160	-870
Require Tamper Resistant Prescription Pads	-35	-210
Replace Best Price with Budget Neutral Rebate	--	--
Expand Asset Verification Demonstration	-65	-640
Enhance Third Party Liability	-10	-85
Define Home Equity Definition at $500,000	-70	-430
Extend Section 1915(b) Waiver Period	--	--
Modify HIPAA	--	--
Extend Transitional Medical Assistance (TMA)	460	665
Extend Qualified Individual (QI) Program /1	425	425
Adjustment for QI Transfer from Medicare /1	-425	-425
Subtotal, Medicaid Legislative Proposals	-1,465	-11,345
Other Proposals with Impact on Medicaid		
Refugee Exemption Extension	33	99
SCHIP Reauthorization (Medicaid Impact)	-510	-1,770
Total, Medicaid Legislative Proposals	**-1,942**	**-13,016**
Medicaid Administrative Proposals		
Revise Payments for Government Providers	-530	-5,000
School Based Services: Eliminate Admin./Transportation	-615	-3,645
Eliminate Medicaid Graduate Medical Education	-140	-1,780
Clarify Rehabilitation Services	-230	-2,290
Issue Guidance Defining 1915(b)(3) Services	--	--
Third Party Liability: Eliminate Pay and Chase for Pharmacy	--	--
Payment Reform: Clarify Provider Tax Policy	--	--
Codify DSH Provisions in Regulation	--	--
Total, Medicaid Administrative Proposals	**-1,515**	**-12,715**
Total, Medicaid Budget Proposals	**-3,457**	**-25,731**
SCHIP Legislative Proposals		
SCHIP Reauthorization	1,220	5,930
Total, SCHIP Legislative Proposals	**1,220**	**5,930**
Total, Medicaid and SCHIP Budget Proposals	**-2,237**	**-19,801**

1/ States pay the Medicare Part B premium costs for QIs, which are in turn offset by a reimbursement from Medicare Part B.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(dollars in millions)

	2006	2007	2008	
	Actual	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Current Law:				
Total Outlays	**5,451**	**5,647**	**5,424**	**-223**

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

SCHIP is a partnership between Federal and State Governments that helps provide children with the health insurance coverage they need. The program improves access to health care and quality of life for millions of vulnerable children under 19 years of age. SCHIP reaches children whose families have incomes too high to qualify for Medicaid, but too low to afford private health insurance.

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

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

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

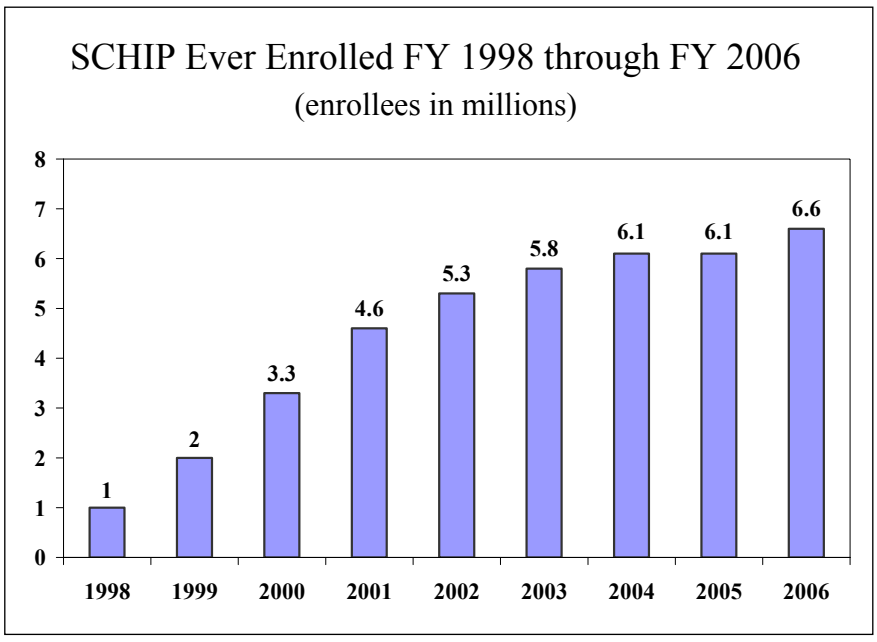
Generally, SCHIP targets Medicaid-ineligible uninsured children who are under 19 years old from families with incomes at or below 200 percent of the Federal poverty level (FPL).

IMPLEMENTATION AND ENROLLMENT

Every State, the District of Columbia, and all five Territories have had approved SCHIP plans since September 1999. As of January 2007, States have received approval for 16 Medicaid expansion programs, 18 separate programs, 22 combination programs, and 275 State plan amendments.

As of January 18, 2007, 27 States and the District of Columbia cover children in families with incomes up to and including 200 percent of the FPL. Sixteen States cover children above that level. Of the 16, eight States cover children up to and including 300 percent of the FPL. One State, New Jersey, covers children up to 350 percent of the FPL.

During FY 2006, 6.6 million children were enrolled in SCHIP. This represents an increase of approximately 473,000 children, or 7.7 percent, over FY 2005 enrollment.



PROPOSED LEGISLATION

SCHIP Reauthorization: The authorization for SCHIP expires at the end of FY 2007. The Administration proposes to reauthorize SCHIP for five years, consistent with submission of a five-year Budget to the Congress, and focuses each of the program elements on SCHIP's original objectives to provide health insurance coverage for uninsured, low-income children at or below 200 percent of the FPL. Toward this end, the Budget provides approximately $5 billion over five years for additional allotment funds.

RECENT PROGRAMS DEVELOPMENT

National Institutes of Health Reform Act of 2006 (P.L. 109-482)
FY 2007 Funding Shortfalls: Requires the Secretary to redistribute unspent FY 2004 and FY 2005 State SCHIP allotments to some of the 14 States experiencing shortfalls in FY 2007. Funding is to be redistributed on a monthly basis, in the order by which States realize monthly funding shortfalls. Redistributed funds can only be used for populations eligible for SCHIP under the State plan on October 1, 2006. Regular Federal matching for coverage of populations other than children or pregnant women (instead of enhanced Federal matching normally available) will apply using redistributed funds.

Use of certain SCHIP funds for Medicaid Expenditures: Extends the ability of certain "qualifying States" to use up to 20 percent of available SCHIP allotment amounts for FY 2006 and FY 2007 as Federal matching funds to provide medical assistance under Medicaid for individuals under age 19 who are not eligible for SCHIP and whose family income exceeds 150 percent of the FPL. "Qualifying States" are those States that, prior to the implementation of SCHIP, were providing medical assistance to this population under Medicaid.

SCHIP PERFORMANCE

When SCHIP began in FY 1998, CMS adopted a goal of enrolling five million children by FY 2005. CMS exceeded this enrollment goal by 1.1 million children in FY 2005. For FY 2008, CMS is focusing on a goal to improve health care quality across the SCHIP program. States will collect measures related to access to care, asthma medications, and child wellness visits. These performance measures involve improving health care quality across the SCHIP program and support HHS Strategic Goal three: Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices.

SCHIP WAIVERS

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

The Administration has promoted the Health Insurance Flexibility and Accountability (HIFA) waiver, one type of section 1115 waiver, for States to develop comprehensive insurance coverage for individuals at twice the FPL and below, using SCHIP and Medicaid funds. The Administration places a particular emphasis on broad, statewide approaches that maximize both private health insurance coverage and employer sponsored insurance. As of January 2007, CMS has approved 15 HIFA demonstration waivers that could expand coverage to nearly one million people.

The DRA prohibited the use of Title XXI funds for the coverage of non-pregnant childless adults, other than caretaker relatives. The provision, effective October 1, 2005, did not apply to existing waivers or to the extension, renewal, or amendments of any existing waivers.

STATE GRANTS AND DEMONSTRATIONS

(dollars in millions)

	2006	2007	2008	
	Actual	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Current Law B.A.:				
Ticket to Work Grant Programs	82	43	44	+1
Qualified High-Risk Pool Grant Programs	90	--	--	--
State Pharmaceutical Assistance Program Grants	63	--	--	--
Emergency Services for Undocumented Aliens	250	250	250	--
Hurricane Katrina Relief	2,000	--	--	--
Program of All-Inclusive Care for the Elderly (PACE):				
PACE Rural Site Development Grants	8	--	--	--
PACE Fund for Outlier Costs /1	10	10	--	-10
Survey of Retail Drug Prices	5	5	5	--
Partnership for Long Term Care	3	3	3	--
Alternate Non-Emergency Network Providers	50	--	--	--
Psychiatric Residential Treatment Demonstration	--	21	37	+16
Money Follows the Person (MFP):				
MFP Demonstration	--	249	298	+49
MFP Evaluations and Technical Support	--	1	2	+1
Medicaid Transformation Grants	--	75	75	--
Medicaid Integrity Program	5	50	50	--
Total B.A.	**2,566**	**707**	**764**	**+57**

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

STATE GRANTS AND DEMONSTRATIONS

The State Grants and Demonstrations budget account represents a diverse group of program activities that impact a variety of intended targets. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and the Deficit Reduction Act of 2005 (DRA) added many new activities to this account. Much of the account focuses on Medicaid-related programs, which are discussed in the Medicaid section, such as Money Follows the Person Rebalancing Demonstration and Medicaid Transformation Grants. Selected program activity highlights follow.

TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT

The Ticket to Work and Work Incentives Improvement Act of 1999 authorized two grant programs designed to assist States in developing services and supports to aid the competitive employment of people with disabilities by extending Medicaid coverage to these individuals.

Section 203 provides grants to States to develop State infrastructure to help individuals with disabilities gain employment and retain their health care coverage. Through FY 2007, 49 States and the District of Columbia were approved for Section 203 funding.

Section 204 provides for a demonstration to provide health care coverage to workers who have physical or mental impairments that, without medical assistance, will result in disability. Seven States have been awarded funding for Demonstrations to Maintain Independence. The demonstrations will be used to evaluate the impact of providing Medicaid benefits to a working person with a potentially severe disability.

QUALIFIED HIGH-RISK POOLS

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

Section 6202 of the DRA and the State High Risk Pool Extension Act of 2006 authorized funding for seed and operational grants for State high-risk health insurance pools. For FY 2006, DRA appropriated $75 million for operational grants to help fund existing qualified high-risk pools, and 31 States received grants. An additional $75 million per year is authorized for FY 2007 through FY 2010, but no funds are currently appropriated. The DRA also appropriated $15 million for seed grants, available through FY 2007, to assist States in creating and initially funding high-risk pools. Five States have received seed grants and CMS plans to conduct an additional solicitation in 2007 to attract newly qualified States.

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS

Section 1011 of the MMA appropriated $250 million per year in FY 2005 through FY 2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified non-citizens who are not eligible for Medicaid. Two-thirds of these funds ($167 million) will be allotted for paying providers in all 50 States and the District of Columbia, based on their relative percentages of the total number of undocumented aliens. The remaining one-third ($83 million) will be allotted for providers in six States with the largest number of undocumented alien apprehensions.

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

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Programs of All-Inclusive Care for the Elderly (PACE) provide comprehensive Medicare and Medicaid services, under a managed care arrangement, to individuals age 55 and over who are eligible for nursing home care. PACE organizations receive a fixed monthly Medicare and Medicaid payment to cover these comprehensive services for participants.

In FY 2006, the DRA created a grant program for the development of new rural PACE sites. Fifteen providers received grants totaling $7.5 million in 2006, with funds available for expenditure through FY 2008. The DRA also established a technical assistance program for rural PACE providers and a $10 million fund for demonstration outlier payments. These funds are available to rural PACE pilot sites through 2010.

HURRICANE KATRINA RELIEF

Section 6201 of the DRA appropriated $2 billion to provide care through Hurricane Katrina waivers. Payments have been made to States for a range of health-care related costs, including administrative costs. Thirty-two States received approval for Katrina-related waivers. Eight of those States also received approval for uncompensated care pool funding.

The DRA provided the Secretary with discretion to use funding to restore health care in impacted counties and parishes. In January 2007, the Secretary announced the availability of $160 million in funding to three States (Alabama, Louisiana, and Mississippi) impacted by Hurricane Katrina for payments to qualifying hospitals and skilled nursing facilities that may face financial pressure because of changing wage rates that are not reflected in Medicare payment methodologies. An additional $15 million in grant funds was made available for professional health care workforce sustainability in the Greater New Orleans area.

SURVEY OF RETAIL DRUG PRICES

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

Effective January 1, 2007, the Federal upper reimbursement limit is set at 250 percent of the average manufacturer price (without prompt pay discounts extended to wholesalers) for drugs on the Federal upper limit list (FUL). It requires a FUL to be established for each multiple source drug for which the Food and Drug Administration has rated two or more products therapeutically and pharmaceutically equivalent.

EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP PROGRAM

The expansion of the State Long-Term Care Partnership Program, enacted under Section 6021 of the DRA, establishes authority for all States (outside of the original four State demonstrations) to implement long-term care partnership plans that provide dollar-to-dollar disregard of assets or resources equal to the insurance benefit payments on behalf of the individual. The provision bestows standards for reciprocity among partnership States unless they notify the Secretary of their decision to exempt themselves. Additionally, the DRA established a National Clearinghouse for Long-Term Care information to educate beneficiaries on all types of long-term care insurance.

ALTERNATE NON-EMERGENCY NETWORK PROVIDERS

Section 6043 of the DRA affords a State the option to impose higher cost sharing for non-emergency care furnished in a hospital emergency department without a waiver and authorizes $50 million in Federal grant funds over four years for States to establish alternate non-emergency service providers or networks of providers. CMS will have two competitive grant solicitations. The first solicitation will include FY 2007; the second solicitation will include FY 2008 and FY 2009.

HCBS ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN

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

PROGRAM MANAGEMENT

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Medicare Operations	2,201	2,145	2,121	2,304	+183
Survey and Certification	258	284	258	294	+36
Federal Administration	641	655	633	643	+10
Research	69	42	42	34	-8
Revitalization Plan	24	23	23	--	-23
Subtotal 1/	3,194	3,148	3,076	3,274	+198
Reimbursable Spending /2	152	144	144	147	+3
User Fees /2	-152	-144	-144	-147	-3
Survey and Certification User Fee Proposal	--	-35	--	-35	-35
Total	**3,194**	**3,113**	**3,076**	**3,239**	**+163**
FTE 3/	4,716		4,538	4,581	+43

1/ Excludes $105 million attributable to the Tax Relief and Health Care Act of 2006.

2/ Includes Clinical Laboratory Improvement Act of 1988, data spending, coordination of benefits for the Medicare prescription drug program, and MA/prescription drug program information campaign.

3/ The FTE totals include HCFAC and State Grants funded FTEs. CMS will fund the following FTE from the HCFAC and State Grants accounts: FY 2006 - 90 FTE; FY 2007 -119 FTE; FY2008 - 153 FTE.

The FY 2008 Budget request for CMS Program Management is $3.27 billion, a net increase of $198 million over the FY 2007 Continuing Resolution and a $126 million increase above the FY 2007 President's Budget. The Budget also continues support for a proposed user fee on health care facilities for certain revisit surveys. This fee, if enacted, will offset the CMS appropriation request by $35 million, to a total of $3.24 billion on a proposed law basis.

This request excludes $105 million in administrative funding authorized in the Tax Relief and Health Care Act of 2006 to be spent in FY 2007 and FY 2008.

With the funding requested for FY 2008, CMS will achieve its priority goals: continue third year of operations of the new drug benefit; maintain accelerated implementation of Medicare contracting reform; sustain beneficiary education efforts; survey health facilities at mandated frequencies; make targeted investments in information technology (IT); conduct a basic level of research; and administer basic operations.

BUDGET ACCOUNT SUMMARIES

Medicare Operations: The Medicare Operations budget request is $2.3 billion, an increase of $183 million, or 8.6 percent, above the FY 2007 Continuing Resolution level. The bulk of the CMS Program Management budget, or 70 percent, is included in this budget line. Medicare Operations funds mission-critical contractor and IT activities necessary to administer the Medicare program and implement activities required by legislation. Top priority activities for FY 2008 include:

Contracting Reform: The budget requests $253.8 million to implement contracting reform, almost double the FY 2007 Continuing Resolution level. CMS is on track to implement contracting reform nearly two years earlier than the 2011 target set in Medicare Prescription Drug, the Improvement, and Modernization Act of 2003 (MMA).

Medicare Contracting Reform Transition Schedule

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

Contracting reform will transform Medicare claims processing from 40 cost-based contracts to 15 performance-based, competitive contracts (plus eight specialty contractors). In 2006, CMS awarded five of the 23 competitive Medicare Administrative Contracts (MACs). In FY 2007, CMS plans to award an additional seven MACs and begin transferring Medicare claims workloads to these new contractors, depending on appropriations. The FY 2008 request will allow CMS to transition all 23 contracts by the end of FY 2009.

Contracting reform is projected to generate significant administrative savings to the government and providers by reducing the cost of processing Medicare claims, and yield $2 billion in Trust Fund savings over the next five years through more accurate and appropriate payments. Contracting reform includes other features that will introduce greater competition and accountability to the Medicare contracting process:

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

Durable Medical Equipment (DME) Competitive Bidding: MMA required CMS to implement a new competitive bidding model to pay for certain DME, and final regulations will be published in the spring 2007. The request includes $45.5 million to establish the administrative structure to support this requirement, a first time funding request. DME competitive bidding is projected to yield significant mandatory Trust Fund savings totaling about $1.7 billion over the next five years.

Ongoing Contractor Operations and Support: About half, or about $1.1 billion, of the FY 2008 Medicare Operations request supports ongoing contractor operations, two percent above the current FY 2007 level. Contractors will process an estimated 1.3 billion fee-for-service claims in FY 2008, a 4.9 percent increase over FY 2007.

Beneficiary Education and Outreach: Medicare Operations includes $221.9 million for mandated and other beneficiary education and outreach activities through the National Medicare & You Education Program (described in a later section).

Healthcare Integrated General Ledger and Accounting System (HIGLAS): The Budget requests $163.3 million for HIGLAS, a new state-of-the-art accounting system for CMS. HIGLAS is an important fiscal and program integrity tool, necessary to achieve a clean Chief Financial Officer audit opinion. Of this total, $113.4 million supports ongoing HIGLAS operations at 11 contractors that will be "live" at the end of FY 2007, plus six new contractors in FY 2008. The remaining $49.9 million will be used to develop additional HIGLAS modules focused on administrative accounting. Since its launch in FY 2005, HIGLAS has already had a positive impact on the Trust Funds, collecting $70 million in benefits that would not otherwise have been realized.

IT Systems and Infrastructure: The budget includes $378.5 million for IT activities, excluding IT to support activities described above. This includes funding for systems to manage and administer the new Part D benefit, as well as CMS's data center and telecommunications infrastructure. CMS has transferred its Revitalization funding to this budget line and requests $10 million to continue IT modernization activities.

Federal Administration: For FY 2008, the President's Budget requests $643.2 million for CMS Federal administrative costs. This is an increase of $10.1 million (1.6 percent) from the FY 2007 Continuing Resolution level. About 80 percent of this funding covers personnel compensation and benefits.

This funding will support a total Full Time Equivalent (FTE) complement, including discretionary and other accounts, of 4,581 in FY 2008, 43 more FTE than the CY 2007 Continuing Resolution level. Of this total, 3,105 FTE will staff the central office and 1,476 FTE will staff the regional offices.

CMS will continue to support the Healthy Start, Grow Smart program. The program pays for printing costs and postage for a series of 13 informational brochures in English, Spanish, Chinese, and Vietnamese to new Medicaid mothers.

Research, Demonstrations and Evaluation: The FY 2008 Research, Demonstrations and Evaluation budget request is $33.7 million, a net decrease of $7.8 million from the FY 2007 Continuing Resolution.

This request fully funds the Medicare Current Beneficiary Survey (MCBS) at $14.4 million. The MCBS, a continuous, multi-purpose survey that represents the Medicare population, aids CMS in monitoring and evaluating the Medicare program. The Budget also includes $10 million to fund Real Choice Systems Change grants. The grants will assist States in designing and implementing improvements to community-based support systems that enable people with disabilities and long-term illnesses to live and participate in community life.

The remaining $9.3 million supports ongoing basic research, such as monitoring prospective payment systems and evaluating MMA and Deficit Reduction Act of 2005 (DRA) demonstrations and pilots.

Survey and Certification Frequencies

Type of Facility	FY 2007 President's Budget	FY 2007 Continuing Resolution	FY 2008 President's Budget
Long-Term Care Facilities*	Every Year	Every Year	Every Year
Home Health Agencies*	Every 3 Years	Every 3 Years	Every 3 Years
Accredited Hospitals	2% Per Year	2% Per Year	2.5% Per Year
Non-Accredited Hospitals	Every 4.5 Years	Every 7 Years	Every 4.5 Years
Organ Transplant Facilities	N/A	N/A	Every 3 Yrs
ESRD Facilities	Every 3.5 Years	Every 5 Years	Every 3.5 Years
Hospices, Outpatient Physical Therapy, Outpatient Rehabilitation, Portable X-Rays, Rural Health Clinics, and Ambulatory Surgical Centers	Every 6 Years	Every 39 Years	Every 6 Years

*Legislatively Mandated

Survey and Certification: The FY 2008 Survey and Certification budget request is $293.5 million. The Medicare Survey and Certification Program works to ensure the safety of beneficiaries and the quality of care provided in health facilities – two critical CMS responsibilities. All facilities participating in the Medicare and Medicaid programs must undergo an inspection when entering the program, and on a regular basis thereafter, to ensure compliance with Federal health, safety, and program standards. CMS contracts with State agencies to conduct these inspections.

To ensure survey frequencies meet statutory requirements and Administration policy goals, CMS requests an increase of $35 million, or 14 percent over the FY 2007 Continuing Resolution. This request will allow States to inspect long-term care facilities and home health agencies at their legislatively mandated frequencies and maintain recertification at policy levels for all other facility types (see table this page).

CMS expects States to complete nearly 25,000 inspections and over 45,000 complaint visits in FY 2008. Between FY 2002 and FY 2008, the number of Medicare-certified facilities increased by 16 percent. As the number of facilities continues to grow, demands to survey statutorily mandated facilities limit the attention and resources that State agencies can spend on other facility types. The FY 2008 budget directs additional resources toward non-statutory facilities, such as hospitals and ambulatory surgical centers, to ensure appropriate oversight.

National Medicare & You Education Program

(dollars in millions)

	2007 Continuing Resolution	2008 President's Budget
Beneficiary Materials (e.g., Handbook).....	43.5	47.1
1-800-MEDICARE Toll Free Line.....	196.0	180.4
Internet.....	18.7	20.1
Community-Based Outreach /1.....	43.6	37.6
Program Support Services /2.....	34.8	20.5
Total, NMEP Program Level	**336.6**	**305.6**

1/ Includes State Health Insurance Assistance Program grants

2/ Includes multi-media campaign and consumer research

OTHER CMS ADMINISTRATIVE ACTIVITIES

The National Medicare & You Education Program (NMEP): The total FY 2008 program level for NMEP is $305.6 million, a decrease of $31 million from the FY 2007 Continuing Resolution level. The NMEP program level includes funding from Program Management, MMA user fees, and QIOs. Beneficiary education remains a top priority for CMS, as recent enhancements to Medicare have given beneficiaries more responsibility for making their own health care decisions.

The bulk of the NMEP request – $180.4 million, or 59 percent – supports 1-800-MEDICARE, which provides customer service in English and Spanish 24 hours a day, seven days per week. Compared to the FY 2007 Continuing Resolution level, the call center request is $15.6 million lower. CMS anticipates approximately 22 million calls in FY 2008 and call wait times under five minutes throughout the year. The remaining NMEP funding supports other important beneficiary education activities. About $47 million will be used to distribute more than 45 million Medicare & You handbooks, approximately one million more than in FY 2007. Another $20 million will support 310 million page views at www.medicare.gov, 90 million over FY 2007. As one-on-one counseling is the best method to help beneficiaries navigate their health plan options, the budget allocates at least $30 million for State Health Insurance Assistance Program (SHIP) grants. More than 13,000 counselors in over 1,300 community based organizations will provide one-on-one assistance to beneficiaries on complex Medicare-related topics. Finally, NMEP includes $5.0 million for a multimedia campaign, including paid advertising and a mobile office tour.

Legislation Supporting the Discretionary Budget: The FY 2008 budget includes a $35 million user fee proposal, as included in the FY 2007 Budget. If enacted, this proposal could recover from industry the costs associated with corrective action follow-up surveys. The Medicare Survey and Certification program revisit user fee allows the Secretary to assess a fee for follow-up visits to health care facilities cited for deficiencies during either certification/ recertification or substantiated complaint surveys. This fee will build greater accountability into the survey and certification program and create an incentive for facilities to correct deficiencies and ensure quality of care.

ADMINISTRATION FOR CHILDREN AND FAMILIES

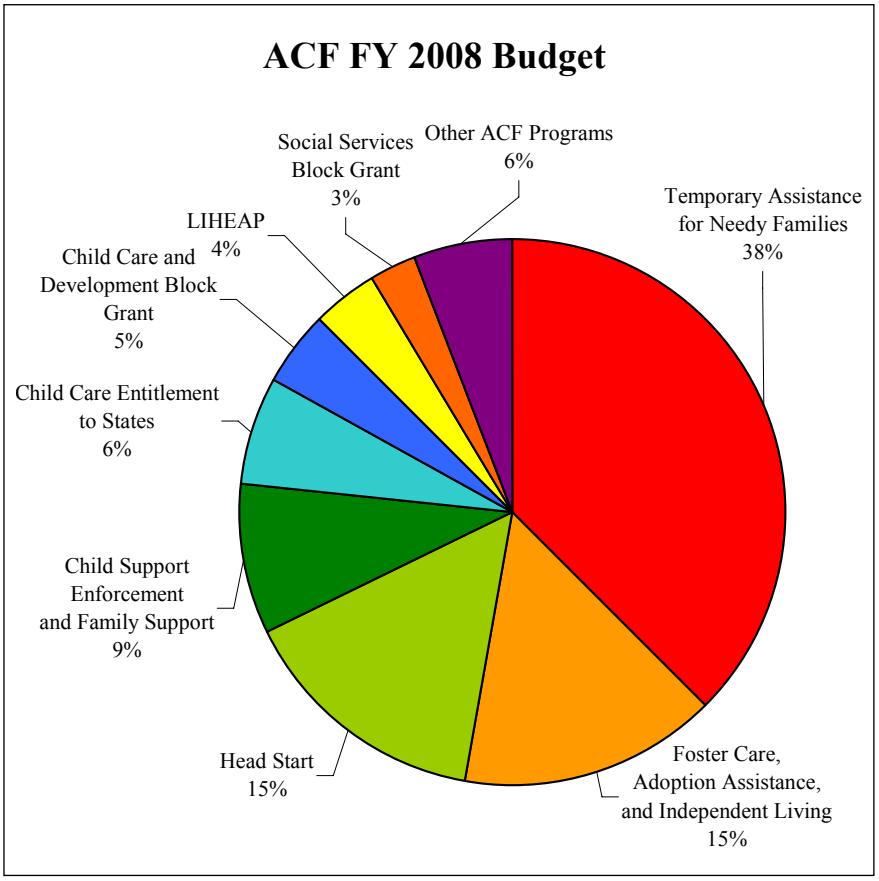
(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Discretionary					
Program Level	14,778	12,847	13,766	12,889	-877
Budget Authority	13,718	12,787	13,705	12,829	-877
Entitlement					
Program Level/1	32,041	32,864	33,439	32,448	-991
Total, ACF Program Level	**46,819**	**45,711**	**47,205**	**45,337**	**-1,868**
Memoranda Entry					
Emergency Hurricane Funding	640	--	--	--	--

1/ Entitlement program level reflects proposed reduction in the authorized funding level for the Social Services Block Grant, which scores as discretionary savings in FY 2008. It does not reflect funding for abstinence education, which is included in discretionary program level.

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

The FY 2008 Budget request for the Administration for Children and Families (ACF) is $45.3 billion, a net decrease of $1.9 billion below the FY 2007 Continuing Resolution and a decrease of $374 million below the FY 2007 President's Budget. ACF administers over 60 programs to fulfill its mission of serving America's children and families. The discretionary Budget includes additional funding for programs serving children and refugees, $6.8 billion for Head Start, and reductions totaling $1.0 billion for the Community Services block grant and the Low Income Home Energy Assistance Program. The mandatory Budget includes $17.1 billion for Temporary Assistance for Needy Families, $6.9 billion for Foster Care and related programs, $4.0 billion for Child Support Enforcement and Family Support, and a proposed reduction of $500 million to the Social Services Block Grant.



ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY SPENDING

The Administration For Children and Families
Department of Health and Human Services

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Head Start	6,782	6,786	6,789	6,789	--
Child Abuse	95	95	95	106	+10
Nurse Home Visitation (non add)	--	--	--	*10*	*+10*
Interstate Home Study Incentives	--	--	--	10	+10
Adoption Incentives	18	30	12	14	+2
Adoption Awareness	13	13	13	13	--
Child Welfare Programs	333	333	333	333	--
Promoting Safe and Stable Families	89	89	89	89	--
Independent Living	46	46	46	46	--
Runaway and Homeless Youth Programs	103	103	103	103	--
Child Care & Development Block Grant (discretionary)	2,061	2,062	2,062	2,062	--
Subtotal, Children's Programs	2,757	2,771	2,752	2,775	+22
Compassion Capital Fund	64	100	64	75	+11
Communities Empowering Youth Program (non-add)	*30*	*50*	*30*	*35*	*+5*
Mentoring Children of Prisoners	49	40	49	50	+1
Center for Faith Based and Community Initiatives	1	1	1	1	--
Subtotal, Faith and Community Based Programs	115	141	115	126	+11
Abstinence					
Discretionary Grants	109	137	109	137	+28
PHS Evaluation Funds	5	5	5	5	--
State Grants (Mandatory)	50	50	50	50	--
Subtotal, Abstinence Program Level	163	191	163	191	+28
Refugees					
Refugee and Entrant Assistance	492	510	475	521	+46
Transitional and Medical Assistance (non-add)	*265*	*282*	*248*	*294*	*+46*
Victims of Trafficking (non-add)	*10*	*15*	*10*	*15*	*+5*
Unaccompanied Alien Children	77	105	77	135	+58
LIHEAP					
Formula Grants	1,980	1,782	1,980	1,500	-480
Emergency Contingency Fund	180	--	181	282	+101
Subtotal, LIHEAP Budget Authority	2,160	1,782	2,161	1,782	-379
Program Level with Mandatory 06 funds	*3,160*	*1,782*	*2,161*	*1,782*	*-379*
Community Services					
Community Services Block Grant	630	--	630	--	-630
Assets for Independence	24	24	24	24	--
Other Community Services	40	--	40	--	-40
Subtotal, Community Services	694	24	695	24	-670
Developmental Disabilities	171	171	171	171	--
Voting Access Programs (non-add)	*16*	*16*	*16*	*16*	--
Violent Crime Reduction	128	128	128	128	--
Native American Programs	44	44	44	44	--
Social Services Research & Demonstration	12	6	12	6	-6
Social Services R&D: PHS Funds (non-add)	*6*	*6*	*6*	*6*	--
Federal Administration	183	188	183	197	+14
Improper Payments, (non add)	*5*	*6*	*5*	*11*	*+6*
Total, Discretionary Program Level	**14,778**	**12,847**	**13,766**	**12,889**	**-877**
Less Funds From Other Sources					
PHS Evaluation Funds	-11	-11	-11	-10	--
Abstinence State Grants	-50	-50	-50	-50	--
LIHEAP, Mandatory	-1,000	--	--	--	--
Total Discretionary Budget Authority	**13,718**	**12,787**	**13,705**	**12,829**	**-877**
SSBG Proposed Discretionary Savings	--	-500	--	-500	-500
Head Start Emergency Hurricane Funding	90	--	--	--	--
Total Scoreable Discretionary Budget Authority	**13,808**	**12,287**	**13,705**	**12,329**	**-1,377**
FTE (including those financed with mandatory funds)	1,260		1,280	1,319	+39

ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY SPENDING

The FY 2008 discretionary Budget request for ACF is $12.8 billion, a net decrease of $877 million below the FY 2007 Continuing Resolution and an increase of $42 million over the FY 2007 President's Budget. The Budget funds a newly authorized program to encourage adoption of children in foster care and proposes a new program to reduce child abuse. Additional funding is requested for abstinence education, the Compassion Capital Fund, and refugee programs, particularly to care for children who enter the country unaccompanied by their parents. The Budget reduces funding for the Low Income Home Energy Assistance Program by $379 million and eliminates funding for the Community Services Block Grant, which is funded at $630 million in FY 2007 and is unable to demonstrate long-term outcomes.

GIVING KIDS A HEAD START

The Budget request continues to fund Head Start at $6.8 billion to provide 919,000 children with services, including 62,000 in Early Head Start. Head Start programs help ensure that children are ready to succeed at school by supporting their social and cognitive development. The Head Start program has enrolled nearly 25 million children since it began in 1965.

Head Start is an effective intervention for early childhood development and has now developed tools to measure its effectiveness. The National Reporting System (NRS) assesses all four-and five-year-old children at the beginning and end of the year in order to determine their skills and measure their progress. In 2006, Head Start's Program Assessment Rating Tool rating was upgraded from Results Not Demonstrated to Moderately Effective. This was due, in large part, to NRS outcome information that showed Head Start's contribution to reductions in the school readiness gap between low income children and their peers.

IMPROVING THE WELL BEING OF CHILDREN AND THEIR FAMILIES

The FY 2008 Budget includes $2.8 billion for a range of programs that protect children from abuse and neglect, promote adoption of children in foster care, support State child welfare systems, and assist low-income families in paying for child care. An increase of $20 million is included for two new programs in this area.

Child Abuse Prevention:
The Budget includes a total of $106 million for programs to reduce the incidence of child maltreatment and provide services to those who are its victims. The Child Abuse State Grant program plays a key role in the prevention of child abuse and neglect including post-investigative services such as individual counseling, case management, and parent education. Other programs help complete the continuum of prevention efforts by providing funds for community-based efforts including public awareness and education activities and by supporting research on child maltreatment and training and technical assistance.

Nurse Home Visitation:
The most recent annual HHS Child Maltreatment Report indicates that each year an estimated 872,000 children in the United States are victims of abuse and neglect. Research has demonstrated that home visitation using trained nurses and strong performance monitoring can reduce incidence of child abuse and neglect and improve other important outcomes for mothers and children. Over 35 States currently support home visiting programs using various State, local, and Federal funding streams including Medicaid, Temporary Assistance for Needy Families (TANF), and the Maternal and Child Health Block Grant. These efforts are not always well coordinated nor do they consistently follow proven effective program models. The Budget includes a new $10 million investment to encourage States to use existing funding streams to successfully implement and sustain evidence based home visitation programs.

Adoption: At the end of FY 2005, there were 513,000 children in foster care, 114,000 of whom were waiting to be adopted. The Budget request includes $10 million for the Interstate Home Study Program authorized by the Safe and Timely Interstate Placement of Foster Children Act of 2006. The current process for interstate adoption of children in foster care has not

Home Visitation Programs Will Save Money by Reducing Child Abuse and Neglect

- Incidents of child abuse and neglect can cause life long problems. Home visitation programs targeting high risk families can save society $6,000 to $17,000 per child served by reducing the number of incidents.

Source: Washington State Institute for Public Policy, 2004

supported timely placements. In FY 2005, children adopted by a family in another state were in foster care an average of one year longer than children adopted within the same State. To address this time lag, ACF will provide States with an incentive payment of $1,500 for each review of the interstate home environment completed within 30 days of the request. States also earn incentives for timely adoptions within their borders. The Budget also includes $14 million for the Adoption Incentives program, sufficient to cover the estimated incentives States will earn in FY 2007.

Child Welfare: The Budget requests $333 million for Child Welfare Services to help State public welfare agencies keep families together. These activities include interventions, so that children will not have to be removed from their homes; development of alternative placements (e.g., foster care, adoption) for children who must be removed from their homes; and reunification services, so that children can return home if appropriate.

Other Children's Programs: The Promoting Safe and Stable Families program provides funds for each State to operate a coordinated program of family preservation services, community-based family support services, time-limited reunification services, and adoption promotion and support services. A total of $454 million is requested for these activities, of which $89 million is financed through discretionary resources. The Budget requests $46 million for the Independent Living Education and Training Vouchers program, which provides up to $5,000 for costs associated with college or vocational training for foster care youth ages 16 to 21.

The Budget also requests $103 million for Runaway and Homeless Youth programs which support public and private organizations to establish and operate shelters for youth, provide outreach services, and operate maternity group homes.

Child Care: The discretionary Budget request continues to fund the Child Care and Development Block Grant (CCDBG) program at $2.1 billion. This program helps low-income families succeed at work and remain self-sufficient by providing assistance with the cost of child care when the parents work or participate in education or training.

The Budget requests a total of $5 billion for child care, including $2.9 billion in mandatory funds, sufficient to provide assistance to an estimated 1.6 million children each month. Combined Federal and related State child care funding provides child care assistance to 2.1 million children per month.

SUPPORTING FAMILIES TROUGH FAITH AND COMMUNITY-BASED ORGANIZATIONS

The Budget requests $126 million to fund faith-based and community organizations, an increase of $11 million over FY 2007. Funds will support grassroots organizations in expanding services in their communities through the Compassion Capital Fund and the Mentoring Children of Prisoners program. The Center for Faith-Based and Community Initiatives leads HHS efforts to better utilize faith and community-based organizations and works with agencies across the Department to eliminate barriers to their participation.

Compassion Capital Fund: The goal of the Compassion Capital Fund is to increase the effectiveness of grassroots faith-based and community organizations, thereby enhancing their ability to provide social services. The Budget requests $75 million for the Compassion Capital Fund, an increase of $11 million. These funds support grants to intermediary organizations with experience in providing training and technical assistance to smaller faith-based and community organizations. Since the program began in 2002, $206 million has been awarded to more than 4,500 organizations, including sub-awards made by intermediary grantees.

Within the Compassion Capital Fund, $35 million is requested for the Communities Empowering Youth program. This funding will build the capacity of faith-based and community groups to foster supportive relationships with youth and direct them to social services and healthy activities that provide an alternative to gang involvement.

Mentoring Children of Prisoners: The request includes $50 million to support public and private organizations that provide one-on-one mentoring for children of incarcerated parents and those recently released from prison. In the 1990's, the number of children with a parent in a Federal or State correctional facility increased by over 100 percent, from about 900,000 to about 2 million. Research indicates that children with incarcerated parents are six times more likely than the general population to become incarcerated themselves. Research also indicates that when such children have mentors, they are less likely to use drugs or alcohol, less likely to initiate violence, and more likely to attend and perform well in school. On September 28, 2006, President

Bush signed the Child and Family Services Improvement Act of 2006. The Act reauthorized the mentoring children of prisoners program and included an Administration supported initiative to use vouchers to expand access to mentors and give families of incarcerated children a choice of mentoring programs in their areas.

Supporting Abstinence Education

The Budget requests a total of $191 million for Abstinence Education activities, an increase of $28 million over FY 2007. These funds will support 234 grants to community-based organizations, an increase of 63 awards. The Budget includes $50 million in mandatory funds for the State Abstinence Education program. Outside of ACF, the Budget requests $13 million for abstinence education activities as part of the Adolescent Family Life program, which is located within the Office of Public Health and Science.

ACF's abstinence education programs provide grants to community- and faith-based organizations, and States. The Community-Based Abstinence Education program targets the prevention of teenage pregnancy and premarital sexual activity. The State Abstinence Education program enables States to support mentoring, counseling, and adult supervision to promote abstinence from sexual activity. Within the Community-Based Abstinence Education program, $10 million is included to continue a national public awareness campaign designed to help parents communicate with their children about the health risks of early sexual activity.

Providing Assistance to Refugees and Unaccompanied Alien Children

Refugee and Entrant Assistance: The Budget requests $521 million to provide cash, medical assistance, and services for refugees, asylees, Cubans/Haitians, and victims of torture and trafficking, $46 million more than FY 2007. The increase will provide eight months of cash and medical assistance and continue to support State and Voluntary Agency administered social services that emphasize employment related activities, including English language training. The Budget request supports 70,000 refugee arrivals, the same as FY 2007. The Budget includes an additional $5 million for the Victims of Trafficking program to support a recently authorized grant program for domestic victims of trafficking.

Performance Highlight

The percentage of refugees participating in the Voluntary Agency Matching Grant program that enter employment has increased from 51 percent in 2001 to 74 percent in 2005. The 2008 target for the percent of refugees entering employment is 78 percent.

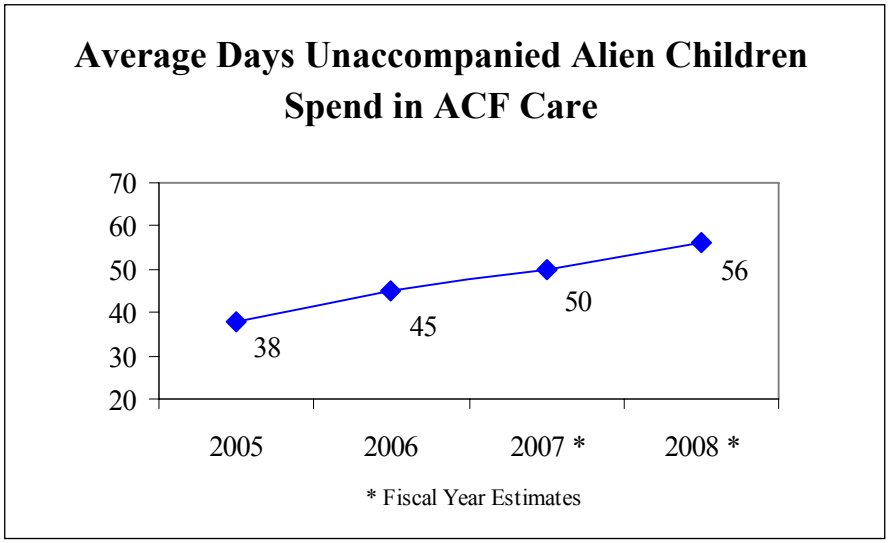
Unaccompanied Alien Children: The Unaccompanied Alien Children (UAC) program provides for the care and placement of unaccompanied alien minors who are apprehended in the United States by Homeland Security agents, Border Patrol officers, or other law enforcement, and taken into care pending resolution of their claims for relief under United States immigration law, or released to an adult family member or responsible adult guardian. Since the program was transferred from the former Immigration and Naturalization Service in 2003, the Office of Refugee Resettlement has increased the use of more appropriate shelter and foster care placements, and provided support for increased medical costs. The Budget requests $135 million for the UAC program, $30 million more than the FY 2007 Budget request and $58 million more than the FY 2007 level, to provide care, placements, and cover the cost of medical care for an increasing number of children. Current estimates indicate that ACF will serve 10,350 children in FY 2008, 15 percent more than FY 2007, and that the amount of time UAC spend in ACF care will continue to increase. Two factors contributing to longer stays are more complex immigration proceedings and delays in the issuance of travel documents by foreign governments needed for children to return to their countries of origin.

Providing Home Energy Assistance to Low-Income Households

The Budget requests $1.8 billion for the Low Income Home Energy Assistance Program (LIHEAP), the same as the FY 2007 President's Budget, and a net $379 million reduction compared to the FY 2007 level. The FY 2008 request includes $282 million for the Contingency Fund, $101 million more than is available for FY 2007, to allow LIHEAP funding to be targeted more effectively to States experiencing unanticipated energy emergencies. Contingency funds are available for release in a heating or cooling emergency, such as extreme temperature or high fuel prices, or to meet energy needs related to a natural disaster.

Helping Low-Income Families Save

The Budget proposes $24 million for the Assets for Independence



(AFI) program which helps low-income individuals increase their economic self-sufficiency through savings. Under this program, amounts saved by participating low-income individuals are matched by AFI funds when savings are used for specific purposes – a first home, paying for post-secondary education, or capitalizing a business. Under this program, the amount of money saved by participants increased by 48 percent between FY 2004 and FY 2005. AFI grantees also provide intensive financial counseling and economic literacy education.

OTHER ACF PROGRAMS

Developmental Disabilities: Nearly four million Americans have severe, chronic, and permanent disabilities attributable to mental and/or physical impairments. The Budget requests $171 million to help ensure that individuals with developmental disabilities have opportunities for independence, productivity, and integration into the community, and can participate in the design of, and have access to, culturally competent support services. Included in this request is $16 million to increase voter participation by individuals with disabilities.

Violent Crime Reduction: The Budget requests $128 million for programs that provide immediate shelter for victims of family violence and their dependents, as well as prevention and intervention services for families in abusive situations. Funds also support operation of the National Domestic Violence Hotline, a 24 hour toll-free number which provides information to victims of domestic violence, including referrals to local shelters.

Native Americans: A total of $44 million is requested for the Administration for Native Americans to promote self-sufficiency through competitive grants for community-based social and economic development. Funds are used to develop and support stable and diversified local economies including business expansion, job creation, social service provision, Native language preservation, and training in the use and control of natural resources.

Community Services: The FY 2008 Budget continues the policy of not requesting funds for the Community Services Block Grant (CSBG) and three smaller community services programs, a total decrease of $670 million. CSBG lacks national performance measures, does not award funds on a competitive basis, and does not hold grantees accountable for program results. Key CSBG services targeting employment, housing, nutrition, and health care also are provided by other Federal programs.

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

Federal Administration: The Budget requests $197 million to support staffing and other activities needed to administer the programs of ACF. Consistent with the President's Management Agenda, the Budget supports efforts to reduce improper payments in several key ACF program areas, including TANF, Child Care, and Foster Care. A total of $11 million is requested for prevention of improper payments, an increase of $6 million above the FY 2007 Continuing Resolution level. Funds will be used to establish error rates for major ACF programs in cooperation with States. Improper payment activities can yield substantial savings. In the last two years, ACF has identified over $600 million in improper payment activities in the Head Start and Foster Care programs.

ADMINISTRATION FOR CHILDREN AND FAMILIES: ENTITLEMENT SPENDING

(dollars in millions)

	2006	2007	2008	
	Actual	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Current Law B.A.:				
Temporary Assistance for Needy Families /1	17,059	17,059	17,059	--
Contingency Fund / 2	--	--	--	--
Child Care Entitlement to States /3	2,917	2,917	2,917	--
Child Support Enforcement and Family Support (net)	3,322	4,399	3,950	-449
Foster Care, Adoption Asst., Independent Living	6,620	6,941	6,877	-64
Children's Research and Technical Asst. (net) /4	58	58	58	--
Promoting Safe and Stable Families /4	365	365	365	--
Social Services Block Grant /5	1,700	1,700	1,700	--
Total, Current Law B.A. /6	**32,041**	**33,439**	**32,926**	**-513**
Proposed Law B.A.:				
Temporary Assistance for Needy Families /1	17,059	17,059	17,059	--
Contingency Fund / 2	--	--	--	--
Child Care Entitlement /3	2,917	2,917	2,917	--
Child Support Enforcement and Family Support (net)	3,322	4,399	3,957	-442
Foster Care, Adoption Asst., Independent Living	6,620	6,941	6,892	-49
Children's Research and Technical Asst. (net) /4	58	58	58	--
Promoting Safe and Stable Families /4	365	365	365	--
Social Services Block Grant /5	1,700	1,700	1,200	-500
Total, Proposed Law B.A. /6	**32,041**	**33,439**	**32,448**	**-991**

1/ TANF B.A. does not reflect adjustments for first quarter FY 2006 funds appropriated in FY 2005 as part of the TANF Emergency Response and Recovery Act of 2005 (TERRA, P.L. 109-068). TERRA appropriated $5,071 million of FY 2006 TANF funds in FY 2005. In FY 2006, the Deficit Reduction Act (DRA, P.L. 109-171) pre-appropriated TANF funds through FY 2010.

2/ In FY 2006, DRA extended the availability of unobligated Contingency Fund balances through FY 2010. ACF estimates that at the end of FY 2008 $1.703 billion will remain unobligated in this account.

3/ Child Care Entitlement B.A. does not reflect adjustments for the first quarter FY 2006 funds appropriated in FY 2005 as part of TERRA. TERRA appropriated $991 million of FY 2006 Child Care funds in FY 2005. In FY 2006, DRA pre-appropriated Child Care Entitlement funds through FY 2010.

4/ These accounts include funding pre-appropriated by the DRA.

5/ SSBG B.A. does not include $550 million provided for SSBG as emergency hurricane funding in Defense Appropriations Act for FY 2006 (P.L. 109-148).

6/ Totals for ACF Entitlements do not reflect hurricane adjustments noted above, pre-appropriated abstinence education funding or pre-appropriated LIHEAP funding. Please see Discretionary Program Level for this pre-appropriated funding.

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

ADMINISTRATION FOR CHILDREN AND FAMILIES: ENTITLEMENT SPENDING

The FY 2008 Budget request for ACF Entitlements is $32.4 billion, a net decrease of $991 million over the FY 2007 Continuing Resolution. ACF serves the Nation's most vulnerable populations through entitlement programs such as Temporary Assistance for Needy Families (TANF), the Child Care Entitlement to States (CCES), Child Support Enforcement (CSE), Foster Care, Adoption Assistance, Independent Living, Promoting Safe and Stable Families, and the Social Services Block Grant (SSBG).

The $991 million decrease in budget authority is due to decreases in CSE, Foster Care, Adoption Assistance and Independent Living, and SSBG. The $442 million decrease in budget authority for CSE reflects a projected one-time reimbursement of approximately $200 million to California pending a successful compliance review of its State Automated Data Processing System as well as an expected decline in State and Federal spending in FY 2008 in response to provisions in the Deficit Reduction Act of 2005 (DRA). The $49 million decrease in Foster Care, Adoption Assistance, and Independent Living budget authority is due primarily to a decrease in foster care children and payments. The $500 million decrease in SSBG budget authority reflects the proposal to reduce the authorization of SSBG to $1.2 billion from $1.7 billion.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

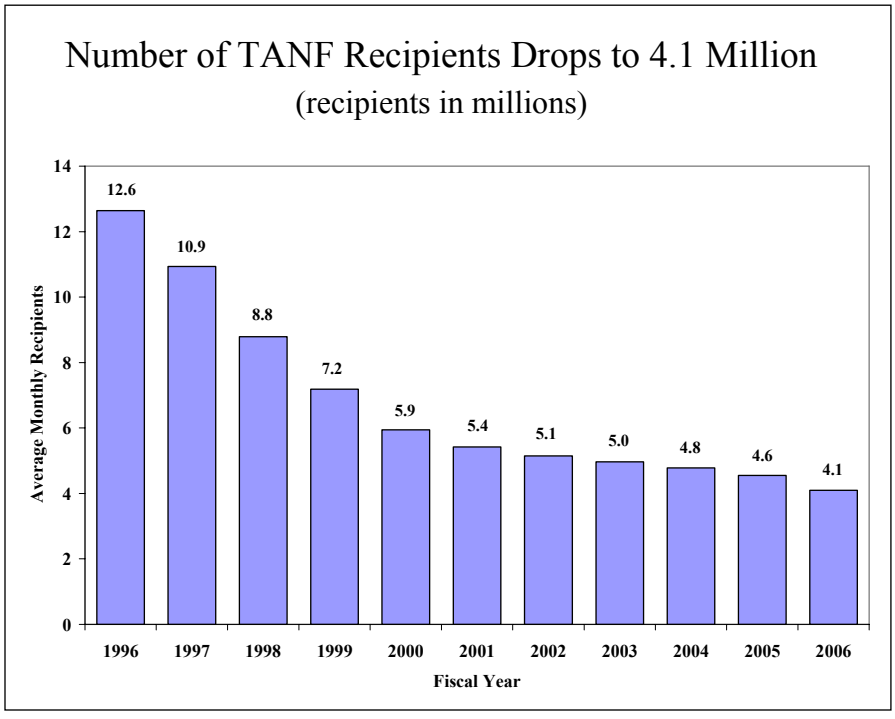
On February 8, 2006, TANF was reauthorized through 2010 by the Deficit Reduction Act of 2005 (DRA). TANF provides approximately $16.9 billion annually to States, Territories, and eligible Tribes for the design of creative programs to help families transition from welfare to self-sufficiency. States have tremendous flexibility in determining how to use their TANF dollars. The DRA also provided $150 million in new funds for the Healthy Marriage Promotion and Responsible Fatherhood program.

Since welfare reform was enacted through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, States are spending less on cash assistance payments and more on education and training, child care, and other work supports to help families achieve self-sufficiency. In 1998, States spent 63 percent of combined State and Federal funds on cash assistance and in FY 2005 States spent 44 percent. In addition, States may transfer up to a combined 30 percent of their TANF funding to the Child Care and Development Fund (CCDF) and SSBG with not more than 10 percent transferred to SSBG.

Welfare reform is widely regarded as a success. TANF caseloads continue to decrease. As of September 2006, 4.1 million individuals received TANF benefits – 66 percent fewer than in August 1996. From September 2005 to September 2006 TANF caseloads dropped 8 percent for individuals and 6.5 percent for families.

TANF Performance: The TANF program achieved success towards its primary goal of moving TANF recipients from welfare to work and self-sufficiency. In FY 2005:

- 64 percent of former and current TANF recipients employed in one quarter were still employed in the next two consecutive quarters,



exceeding the FY 2004 rate of 59 percent but missing the target of 68 percent.

- 36 percent of recipients attained higher earnings over two quarters, exceeding the target of 29 percent.

TANF Legislative Proposals: The Budget includes a proposal that extends the authorization for Supplemental Grants for Population Increases in Certain States through 2010. Providing $319 million annually, the supplemental grants are awarded to certain States based on either increases in their populations or low levels of welfare spending before 1996.

In addition, the FY 2008 Budget includes a proposal simplifying the two-parent work requirement in the TANF program. This budget neutral proposal encourages equal treatment of two-parent and single-parent families by requiring the same State work participation rate.

CHILD CARE ENTITLEMENT TO STATES

The FY 2008 Budget includes $2.9 billion for the CCES, a component of the CCDF. CCES is composed of mandatory and matching funds. Two percent of the mandatory entitlement funds are reserved for eligible Indian Tribes and Tribal organizations. The program requires States to spend at least 70 percent of CCES on families receiving TANF, transitioning from TANF, or at risk of becoming eligible for TANF. States must also spend a minimum of four percent of all child care funds to improve the quality and availability of healthy and safe child care for all families.

Child Care Performance: In FY 2005, ACF achieved all four of its CCDF performance measures. The program maintained the rate of eligible low-income families being served. CCDF also increased the proportion of regulated providers serving subsidized children. To improve child care quality, CCDF expanded the number of accredited child care providers. The program also successfully encouraged more States to implement early learning guidelines which are linked to school standards and used in the professional development of early child care providers.

CHILD SUPPORT ENFORCEMENT AND FAMILY SUPPORT PROGRAMS

CSE is a joint Federal, State, and local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders. Title IV-D of the Social Security Act establishes child support services that are available for all families with a non-custodial parent, regardless of welfare status. The FY 2008 President's Budget request is $4.0 billion for CSE and Family Support Programs.

Child support collections play an important role for families transitioning from welfare to self-sufficiency. By securing support from non-custodial parents on a consistent basis, families may avoid the need for public assistance, thus reducing government spending. Custodial families that have never received TANF get all child support collected on their behalf. Child support collections on behalf of families receiving TANF and some collections on behalf of former TANF recipients are shared between the State and Federal Governments as reimbursement for providing TANF benefits. As a result of the DRA, the Federal Government will share in the cost of State options to distribute more collections directly to current and former TANF families, beginning in FY 2008.

The Federal Government shares in the financing of this program by providing matching funds for general State administrative costs and paternity testing, as well as the funding of incentive payments. The CSE program also includes a

Performance Highlight

The CSE program continues to make strong gains in child support collections, as well as support order and paternity establishment. In FY 2005:

- Child support collections hit $23 billion, serving an estimated 16 million child support cases.
- CSE established paternity for over 1.6 million children.
- CSE had a 98 percent paternity establishment rate for all non-marital births in the previous year, meeting the target of 98 percent.
- CSE surpassed its target for establishing child support orders, generating support orders for 76 percent of all child support cases.
- For every dollar invested in the program, CSE collected $4.58 in child support, exceeding their target of $4.42. CSE aims to increase its cost-effectiveness ratio to $4.63 by FY 2008.

capped entitlement of $10 million annually for grants to States to facilitate non-custodial parents' access to and visitation of their children.

Other family support programs funded in this account include Payments to Territories and Repatriation. Payments to Territories funds $38 million in State maintenance assistance programs for eligible aged, blind, and disabled residents of Guam, Puerto Rico, and the Virgin Islands, per Title XVI of the Social Security Act.

The Repatriation program, authorized by Section 1113 of the Social Security Act, provides assistance to United States citizens and their dependents who are returning from foreign countries and are deemed to be destitute, mentally ill, or in need of emergency evacuation due to threatened armed conflict, civil strife, or natural disasters. This program is capped at $1 million annually, but the FY 2008 President's Budget seeks to increase the cap to $5 million. On July 27, 2006, President Bush signed the Returned Americans Protection Act of 2006, temporarily raising the Repatriation funding limit from $1 million to $6 million for FY 2006. Funds from that Act supported the emergency evacuation from Lebanon of over 12,000 individuals, covering costs associated with the reception, temporary care, and transportation of these individuals to their final destinations.

Child Support Enforcement and Family Support Programs Legislative Proposals: The FY 2008 President's Budget includes two new legislative proposals that will give Tribes operating CSE programs the same access as States to apply for program waivers and utilize important enforcement tools. This request also includes several child support proposals from previous President's Budgets aimed at increasing collections and improving States' efforts to collect medical support on behalf of children. The proposals also recognize that healthy families need more than financial support alone and increase resources for Access and Visitation Programs to support and facilitate non-custodial parents' access to and visitation of their children. In FY 2008, these proposals will cost the Federal Government $5 million, while increasing collections to families by $32 million. Over five years, the combined proposals for this account will generate a net Federal cost of $19 million while increasing collections to families by almost $1.4 billion.

Additionally, the FY 2008 President's Budget proposes raising the annual cap on Repatriation from $1 million to $5 million. The current limitation of $1 million has been in place since FY 1987 and is no longer sufficient to continue operation of this program. Increasing the cap will provide the flexibility necessary to meet increasing programmatic needs and accommodate a quick response to emergency repatriation situations.

Child Support Legislative Proposals

- Grant Tribal CSE programs access to Section 1115 demonstrations.
- Provide Tribal child support enforcement programs with access to passport denial or revocation and multi-state financial institution data matching.
- Require health care plan administrators to notify child support agencies when a child loses health coverage. This will alert IV-D caseworkers of potential lapses in children's coverage so they can work to secure alternative coverage, if necessary.
- Allow Federal seizure of accounts in multi-state financial institutions, to enable families in interstate situations to better benefit from the data match.
- Require intercept of gambling proceeds, a significant source of untapped income for recovery of overdue child support.
- Provide for garnishment of Longshore and Harbor Worker's Compensation Act benefits.
- Increase funding for access to and visitation grants to support noncustodial parents' access to and visitation of their children.
- Authorize direct Tribal access to Federal Parent Locator Service.
- Authorize contractors and IV-D Tribes to access tax offset data.
- Give States the ability to collect past-due child support by withholding a limited amount of OASDI payments from beneficiaries, if appropriate.

CHILDREN'S RESEARCH AND TECHNICAL ASSISTANCE

The FY 2008 President's Budget includes $58 million to support child support enforcement training and technical assistance efforts; operation of the Federal Parent Locator Service (FPLS), which assists States in locating absent parents; and welfare research. Of this amount, $37 million will be devoted to: 1) CSE training and technical assistance ($12 million) and 2) FPLS operations ($25 million). The remaining $21 million will fund welfare research ($15 million) and continue the National Survey of Child and Adolescent Well-Being ($6 million), a longitudinal study of the well-being of children who come into contact with the child welfare system.

FOSTER CARE, ADOPTION ASSISTANCE, AND INDEPENDENT LIVING PROGRAMS

The FY 2008 Budget request for the Foster Care, Adoption Assistance, and Independent Living programs is $6.9 billion in budget authority. These programs, authorized by Title IV-E of the Social Security Act, support safe living environments for vulnerable children and prepare older foster youth for independence.

Of the total request, $4.6 billion in budget authority will support the Foster Care program. This is a $164 million decrease from the FY 2007 level and includes the effects of the legislative proposals (described later in this chapter) and the decline in the Foster Care caseload. The funds will be used to provide maintenance payments, administration, training, and data systems. The proposed level of funding will support approximately 211,000 children each month, about two percent fewer than needed assistance in 2007.

The Budget includes $2.2 billion in budget authority for the Adoption Assistance program, which supports families that adopt special-needs children. This is an increase of $115 million over the FY 2007 level. These funds will be used to provide maintenance payments to adoptive families, administrative payments for the costs associated with placing a child in an adoptive home, and training for professionals and adoptive parents. The proposed level of funding will support approximately 427,000 children each month.

The Budget also contains $140 million in budget authority for the Independent Living Program, the same as the FY 2007 level. This program funds services for youth who will likely remain in foster care until they turn the age of 18 and for former foster children between the ages of 18 and 21.

Foster Care, Adoption Assistance, and Independent Living Performance: The Foster Care, Adoption Assistance, and Independent Living programs demonstrated success in improving safety, permanency, and well-being of children in FY 2005, the latest year for which complete performance data is available. Working with the States, these programs met the goal of minimizing disruptions to the continuity of family and other

Child Welfare Program Option Proposal

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

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

Under the Flexible Funding Plan States Will Be Required to:

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

The proposal provides access to the TANF Contingency Fund from which States may receive additional funding under certain circumstances if a severe foster care crisis were to arise.

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

relationships for children in foster care by decreasing the number of placement settings per year for a child in care. The programs also met goals to provide children in foster care with permanency and stability in their living situations by improving the timeliness of reunification, if possible, and promoting guardianship or adoption when reunification is not possible.

Foster Care and Adoption Assistance Legislative Proposals: The FY 2008 President's Budget includes two legislative proposals for Foster Care and related programs. The budget neutral alternative funding option proposal (see the Child Welfare Program Option Proposal box) would provide States the option to receive their foster care funding as a flexible grant over five years to support a continuum of services to families in crisis and children at risk.

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

PROMOTING SAFE AND STABLE FAMILIES

The Promoting Safe and Stable Families (PSSF) program is a capped entitlement program designed to assist States in coordinating services related to child abuse prevention and family preservation. The FY 2008 request for PSSF maintains funding at $365 million – the same level as FY 2007.

President Bush signed the Child and Family Services Improvement Act of 2006 (P.L. 109-288) into law on September 28, 2006. The new law reauthorizes and amends the PSSF program for FY 2007 through FY 2011. The law creates two set-asides under PSSF. The first set-aside, $5 million in FY 2008, supports State spending on monthly caseworker visits. The second set-aside creates competitive regional partnership grants to increase the well-being of, and improve the permanency outcomes for, children affected by methamphetamine or other substance abuse. The set-aside is $35 million in FY 2008. The law also limits administrative costs to 10 percent of the total State expenditures for PSSF, and reauthorizes the basic Court Improvement Program without change through FY 2011.

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

SOCIAL SERVICES BLOCK GRANT

SSBG, a capped entitlement, provides flexible grants to States for the delivery of social services. Programs or services that are frequently supported by SSBG funds include child care, child welfare, home-based services, employment services, case management, adult protective services, prevention and intervention programs, and special services for people with disabilities. SSBG is funded at $1.2 billion for FY 2008, a reduction of $500 million from its FY 2007 funding level. The President's Budget proposes permanently reducing SSBG to this level.

Social Services Block Grant Performance: SSBG received a rating of Results Not Demonstrated in the 2005 PART assessment. The PART identified several weaknesses, noting that the block grant's flexibility and lack of State reporting requirements make it difficult to measure performance. The FY 2008 request acknowledges these weaknesses and proposes a reduction in SSBG to direct funding to programs that better demonstrate results.

ACF ENTITLEMENT – OUTLAYS OVERVIEW

(outlays in millions)

	2006	2007	2008	
	Actual	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Current Law Outlays:				
Temporary Assistance for Needy Families /1	16,897	17,318	17,296	-22
Contingency Fund /1	77	103	91	-12
Child Care Entitlement to States /1	3,060	2,828	2,800	-28
Child Support Enforcement and Family Support (net)	4,001	4,519	4,078	-441
Foster Care, Adoption Asst., Independent Living	6,352	6,533	6,821	+288
Children's Research and Technical Asst. (net) /1	57	64	58	-6
Promoting Safe and Stable Families /1	328	360	361	+1
Social Services Block Grant /2	1,848	2,155	1,731	-424
Total, Current Law Outlays /3	**32,620**	**33,880**	**33,236**	**-644**
President's Budget Outlays:				
Temporary Assistance for Needy Families /1	16,897	17,318	17,296	-22
Contingency Fund /1	77	103	91	-12
Child Care Entitlement /1	3,060	2,828	2,800	-28
Child Support Enforcement and Family Support (net)	4,001	4,519	4,085	-434
Foster Care, Adoption Asst., Independent Living	6,352	6,533	6,834	+301
Children's Research and Technical Asst. (net) /1	57	64	58	-6
Promoting Safe and Stable Families /1	328	360	361	+1
Social Services Block Grant /2	1,848	2,155	1,306	-849
Total, Proposed Law Outlays /3	**32,620**	**33,880**	**32,831**	**-1,049**

1/ These accounts include funds pre-appropriated by the Deficit Reduction Act of 2005 (P.L. 109-171).

2/ SSBG outlays include the $550 million provided for SSBG as emergency hurricane funding in Defense Appropriations Act for FY 2006 (P.L. 109-148). The proposed law outlays include the impact of the $500 million reduction in Social Services Block Grant funding that is through appropriations action in FY 2008 and therefore scores as discretionary savings in FY 2008.

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

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

ACF ENTITLEMENT LEGISLATIVE PROPOSALS

(outlays in millions)

	2008 President's Budget	Five Year 2008-2012
Temporary Assistance for Needy Families		
Continue Supplemental Grants for Population Increases /1	--	+1,137
Simplify Separate Two-Parent Work Requirement	--	--
Subtotal	--	+1,137
Contingency Fund		
Child Welfare Program Option - Contingency Fund Access /2	--	+34
Subtotal	--	+34
Child Support Enforcement and Family Support Payments /3		
Tribal Access to 1115 Demonstrations	--	--
Tribal Access to Passport Denial or Revocation and MSFIDM Data Match	--	--
Send COBRA Notice to IV-D Agency	+1	+9
Federal Seizure of Accounts in Multi-State Financial Institutions	--	-14
Require Intercept of Gaming Proceeds	+3	-2
Garnishment of Longshore and Harbor Worker's Compensation Act Benefits	--	-4
Increase Access and Visitation Funding	+2	+32
Direct Tribal Access to the Federal Parent Locator Service	--	--
Contractor and Tribal Acccess to Tax Data	--	--
OASDI Benefit Match	-1	-5
Raise the Cap for Repatriation to $5 million	--	+3
Subtotal	+5	+19
Foster Care and Adoption Assistance		
Child Welfare Program Option	+8	+6
Increase D.C. Match Rate	+5	+27
Subtotal	+13	+33
Social Services Block Grant		
Reduce Authorization for SSBG by $500 million /4	-425	-2,420
Subtotal	-425	-2,420
Total	**-407**	**-1,197**

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

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

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

4/ The Budget proposes a one-year reduction in Social Services Block Grant funding through appropriations action in FY 2008, which scores as discretionary savings for FY 2008. The budget further proposes to make this reduction permanent for FY 2009 and beyond, which scores as mandatory savings.

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Program Innovations	25	35	25	35	+11
Choices for Independence Demonstration (Non Add)	--	*28*	--	*28*	*28*
Home & Community-Based Supportive Services	350	351	351	351	--
Nutrition Services					
Home-Delivered Meals	182	181	182	181	-1
Congregate Meals	385	383	385	383	-2
Nutrition Services Incentive Program	148	147	148	147	-1
Subtotal, Nutrition Programs	715	712	715	712	-4
National Family Caregiver Support Services	156	154	156	154	-2
Protection of Vulnerable Older Americans	20	19	20	19	-1
Aging Network Support Activities	13	13	13	13	--
Services for Native Americans					
Native American Nutrition & Supportive Services	26	26	26	26	--
Native American Caregiver Support Services	6	6	6	6	--
Subtotal, Services for Native Americans	32	32	32	32	--
Program Administration	18	18	18	19	+1
Senior Medicare Patrols (HCFAC)	3	3	3	3	--
Preventive Health Services	21	--	21	--	-21
Alzheimer's Demonstration Grants	12	--	12	--	-12
Total, Program Level	**1,365**	**1,338**	**1,366**	**1,338**	**-28**
Less Funds Allocated From Other Sources					
Senior Medicare Patrols (HCFAC)	-3	-3	-3	-3	--
Total, Budget Authority	**1,362**	**1,335**	**1,363**	**1,335**	**-28**
FTE/1	123		115	120	+5

1/ Includes 10 FTE in FY 2006 related to the White House Conference on Aging which were funded out of appropriations from prior years.

ADMINISTRATION ON AGING

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

The FY 2008 Budget request for the Administration on Aging (AoA) is $1.3 billion, the same as the FY 2007 President's Budget and a net decrease of $28 million from the FY 2007 Continuing Resolution. The request includes $28 million within Program Innovations for Choices for Independence demonstration projects (Choices), which will seek to empower older individuals and their families to make informed decisions about their long-term care options, plan ahead for their long-term care needs, and conserve and extend their personal resources through the use of low-cost community-based alternatives. The Budget request also provides funding for core formula grant programs, which deliver nutrition, supportive services and caregiver support through the national aging services network.

LOOKING FORWARD: PROGRAM INNOVATIONS AND CHOICES FOR INDEPENDENCE

Over the last few years, funding in Program Innovations has been used to launch a number of initiatives that have sought to improve access to health and long-term care. These activities have provided the foundation for Choices. The request includes $28 million for Choices, which has three components, each building off existing HHS activities and best practices in the field.

- ***Consumer Empowerment:*** Choices will help individuals make informed decisions about their care options, plan ahead for their long-term care needs and streamline their access to both publicly and privately supported long-term care programs.
- ***Healthy Lifestyle:*** Choices will utilize low-cost, community level interventions to assist seniors to make behavioral changes that have proven effective in reducing the risk of disease and disability.
- ***Community Living Incentives:*** Choices will give States a flexible funding source, not tied to particular service categories, that they can use to help moderate-to-low income individuals avoid or delay unnecessary institutional care and spend-down to Medicaid.

Reauthorization of the Older Americans Act

On October 17, 2006, President Bush signed into law the 16th reauthorization of the Older Americans Act. This Act is designed to ensure the dignity and independence of our older citizens by supporting their desire to remain living in their own homes and communities.

AoA will rigorously evaluate Choices to ensure that States are effectively meeting defined performance outcomes. In addition to funding for Choices for Independence, the Budget request for Program Innovations maintains funding for ongoing projects of National significance that provide demonstrated benefits to elderly Americans.

PROVIDING HOME AND COMMUNITY-BASED SUPPORT

Home and Community-Based Supportive Services provide funding for an array of in-home and community-based supports that help seniors to remain independent, active, and at home. These activities serve as the foundation for the national aging services network, which includes over 29,000 community service providers that coordinate, integrate, and deliver a broad array of home and community-based long-term care services for the elderly. Services provided for seniors and their caregivers include access services such as transportation, and case management; in-home services such as personal care, chore, and homemaker assistance; and center-based community services such as senior center, adult day care, respite care, disease prevention and health promotion. In support of these programs, the FY 2008 request for Home and Community-Based Supportive Services is $351 million.

ENSURING ADEQUATE NUTRITION

Many elderly individuals have limitations in activities of daily living, which make it difficult for them to care for themselves. The FY 2008 request for Nutrition programs– including Congregate and Home-Delivered Nutrition Services and the Nutrition Services Incentive Program–totals $712 million. Nutrition services ensure that millions of older adults have access to the nutritious food they need to stay healthy and decrease their risk of disability. Congregate meal settings also provide opportunities

for social engagement and meaningful volunteer roles, which contribute to overall health and well-being. Additionally, these programs provide related services such as nutrition screening, assessment, education, and counciling to vulnerable elders at home and in group settings.

Taking Care of Family Caregivers

Families are the Nation's major provider of long-term care, but societal changes including geographic separation of families and smaller family size, are placing greater pressure on caregivers. Caregivers often experience conflicts between work and care-giving, with 62 percent reporting that they have had to make adjustments, such as changing or reducing work hours or taking time off, to accommodate their care giving. The FY 2008 Budget includes $154 million for the National Family Caregiver Support Program, which supports family and informal caregivers by providing information and assistance, counseling and training, respite, and other services that help them care for their loved one at home for as long as possible.

Supporting Native American Nutrition and Support Activities

The Budget requests $32 million for Native American seniors: $26 million for nutrition and supportive services, and $6 million for Native American caregivers and the seniors they assist. These two programs offer a smart, cost-effective way to meet the needs of a growing population of tribal elders by offering home and community-based supportive, nutrition, and caregiver services. Together the programs are critical to allowing Native American elders to remain at home, in the community, or on the reservation, which they prefer.

Protecting the Rights of Seniors

Protection programs support activities that improve the quality of care for residents of long-term care facilities and increase public and professional awareness of elder abuse. The FY 2008 request includes $19 million to help protect the rights and dignity of vulnerable seniors both at home and in institutional settings. The request also includes $13 million for Aging Network Support Activities that help seniors and families obtain information about their care options and benefits, and assists States, Tribes and community providers of aging services to carry out their mission. These ongoing projects provide critical support for the national aging services network and help support the activities of AoA core service delivery.

Streamlining and Modernizing

In FY 2008, no funding is requested for Preventive Health Services or for Alzheimer's Disease Demonstration Grants, the same as the FY 2007 President's Budget request. Prevention is already a focus and an underlying principle of each of the AoA services provided by States and communities. States can also continue to use their Home and Community-Based Supportive Services dollars for a large portion of their Preventive Health Activities. Most States have received funding for one or more demonstrations that tested and implemented successful, cost-effective approaches for serving persons with Alzheimer's Disease. The lessons learned and the models developed through these demonstrations are ready to be integrated into ongoing service programs.

Administering Programs

AoA works with and through the national aging services network to develop coordinated systems of care in States and localities and helps to increase their responsiveness to the needs and preferences of older people and their family caregivers. A total of $19 million is requested for Program Administration to carry out this mission by maintaining staffing levels and for related program management and support activities.

Performance Highlight

Program efficiency is a necessary and important measure of performance for AoA programs. One of the key performance measures for efficiency is to increase the number of State program clients served per million dollars of funding (with no decline in service quality). In FY 2005, AoA served 6,937 clients per million dollars of funding, an increase of 6 percent over FY 2004, which continues a trend of increasing efficiency each year since FY 1999.

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Commissioned Corps Transformation/Trng.....	4	28	4	38	+34
Latin America Medical Diplomacy Initiative.....	--	--	--	1.5	+1.5
Other General Departmental Management.....	354	355	354	352	-2
Evaluation Activities.....	40	40	40	47	+7
Health Care Fraud and Abuse Control.....	5	5	5	5	--
Subtotal, GDM Program Level	403	428	403	444	+41
Less funds from other sources:					
Evaluation Activities.....	40	40	40	47	+7
Health Care Fraud and Abuse Control.....	5	5	5	5	--
Total, GDM Budget Authority	**358**	**383**	**358**	**392**	**+34**
FTE 1\.....	1,484		1,517	1,673	+156

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

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

The FY 2008 Budget request for General Departmental Management (GDM) is $392 million, a net increase of $34 million over the FY 2007 Continuing Resolution and an increase of $9 million over the FY 2007 President's Budget.

The GDM account supports those activities associated with the Secretary's roles in administering and overseeing the organization, programs, and activities of the Department. These activities are carried out through 15 Staff Divisions.

The FY 2008 budget request provides increased funding for the following activities:

Commissioned Corps: The FY 2008 budget request includes $38 million for the Transformation of the Public Health Service's (PHS) Commissioned Corps, an increase of $34 million above FY 2007. This is the Department's multi-year process to revitalize and improve the Corp's ability to respond to public health emergencies and deliver timely and effective public health services in underserved and hazardous situations. This effort will involve the establishment of two Health and Medical Response teams, which will provide a highly trained, quick response asset, ready to immediately deploy to emerging public health situations and emergencies.

Additionally, Transformation activities will focus on modernizing the force strength and management of the Commissioned Corps, streamlining the assignment and deployment process, and increasing our ability to recruit talented candidates to become Commissioned Corps officers. To accomplish this, FY 2008 funding will be used to develop new systems to support total force management; train and equip officers to respond to emerging public health threats and situations; and to improve response operations and develop a team-oriented deployment process.

Latin America Medical Diplomacy Initiative: The FY 2008 budget request includes $1.5 million for a new initiative within the Office of Global Health Affairs (OGHA). OGHA will work with other Federal agencies, the governments of Panama and neighboring countries, and other non-governmental organizations to provide medical education and training, and quality primary health care, including oral health care. This training in Central America will focus on developing

community health workers, primary health care workers, and other health professionals who are desperately needed in rural and developing areas in the region.

Other General Departmental Management: The FY 2008 budget request includes $352 million to fund offices which provide leadership, policy, legal, and administrative guidance to HHS components, and also includes funding to continue the following GDM activities:

Office of Population Affairs OPA/Adolescent Family Life (AFL): The FY 2008 budget includes $30 million to provide support for the AFL demonstration and research program authorized under Title XX of the PHS Act. Through the grants awarded under this program AFL provides funding in three areas; care demonstration projects, prevention projects, and research projects. This request includes $13 million in abstinence-only prevention projects, as defined by the Welfare Reform legislation (P.L. 104-193).

Office of Minority Health (OMH): The OMH request of $44 million will provide funding to continue disease prevention, health promotion, service demonstration, and educational efforts to reduce and ultimately eliminate disparities in racial and ethnic minority populations. The request for OMH includes a reduction of $3 million below the FY 2007 Continuing Resolution, to reflect the natural end point of some projects, and a reduction in other demonstration projects and cooperative agreements.

Office on Women's Health (OWH): The OWH request of $27 million will provide funding to continue the advancement of women's health programs through the promotion and coordination of research, service delivery, and education both throughout HHS agencies and offices, with other government organizations, and with consumer and health professional groups. The request for OWH includes a reduction of $1 million below the FY 2007 Continuing Resolution, to reflect a decrease in three grant funded projects.

Minority HIV/AIDS: The FY 2008 budget includes $52 million to support innovative approaches to HIV/AIDS prevention and treatment in minority communities heavily impacted by this disease. These funds allow the Department to continue priority investments and public health strategies targeted to reduce the disparities and burden of HIV/AIDS in racial and ethnic minority populations.

Afghanistan: Included in the FY 2008 request for OGHA is $6 million to continue support of HHS health care initiatives in Afghanistan, particularly in the areas of maternal and child health.

PHS Evaluation Funds: The FY 2008 request also includes $47 million for PHS Evaluation Funds, as authorized by section 241 of the United States PHS Act. These funds will support policy research and evaluation activities in the Office of the Assistant Secretary for Planning and Evaluation, as well as, evaluation activities in the Office of Public Health and Science and the Office of the Assistant Secretary for Resources and Technology.

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Total, Program Level	59	74	59	70	+11
FTE	274		360	382	+22

The Office of Medicare Hearings and Appeals provides the basic mechanisms through which individuals and organizations who are dissatisfied with Medicare determinations affecting their rights to, or their participation in, the Medicare program may administratively appeal these determinations, in accordance with the requirements of the Administrative Procedures Act and the Social Security Act.

The FY 2008 Budget request for the Office of Medicare Hearings and Appeals (OMHA) is $70 million, an increase of $11 million over the FY 2007 Continuing Resolution and a decrease of $4 million below the FY 2007 President's Budget. Funds are being requested from the Federal Hospital Insurance and Supplemental Medical Insurance Trust Funds to hear cases under Title XVIII of the Social Security Act, and related provisions in Title XI of the Act.

The creation of OMHA was mandated by Section 931 of Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), enacted on December 8, 2003. MMA transferred the responsibility for hearing Medicare appeals at the Administrative Law Judge (ALJ) level – the third level of Medicare claims appeals – from the Social Security Administration (SSA) to the HHS Office of the Secretary. The Medicare Benefits Improvement and Protection Act of 2000 (BIPA) also mandated that ALJ appeals be heard within 90 days after receipt of a request from a Medicare appellant for such a hearing.

In July 2004, the OMHA Transition Office was created to manage the transfer of the ALJ appeals function from SSA, establish OMHA, and enable OMHA to begin hearing ALJ cases during the last quarter of FY 2005. OMHA officially opened its doors on July 1, 2005, and is now in its second year of operation. To date, OMHA has received over 37,000 Medicare Parts A, B, C and D appeals cases from across the United States containing approximately 146,000 claims.

OMHA's central office and Atlantic Field Office are co-located in Arlington, Virginia. Other field offices include: the Southern Field Office in Miami, Florida; the Midwestern Field Office in Cleveland, Ohio; and the Western Field Office in Irvine, California. OMHA has successfully implemented the video-teleconference technology which provides appellants with more timely hearings, closer to their homes, and with more access points.

With the requested funding level of $70 million, OMHA will be able to process the full projected ALJ appeal workload for Medicare Parts A, B, C and D cases received within the BIPA mandated timeframe by continuing to utilize state-of-the-art technology, maintaining the required federal and contract staffing levels, and increasing access to hearing sites and services for appellants.

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

	2006	2007		2008	
		President's	Continuing	President's	+/- 2007
	Actual	Budget	Resolution	Budget	Cont. Res.
Budget Authority	42	90	42	90	+48
PHS Evaluation Funds	19	28	19	28	+9
Program Level	**61**	**118**	**61**	**118**	**+57**
FTE	6		28	38	+10

The Office of the National Coordinator for Health Information Technology provides counsel to the Secretary of HHS and Departmental leadership for the development and nationwide implementation of an interoperable health information technology infrastructure.

The FY 2008 Budget request for the Office of the National Coordinator for Health Information Technology (ONC) is $118 million, a net increase of $57 million over the FY 2007 Continuing Resolution, and the same as the FY 2007 President's Budget. ONC was created in April 2004 by Presidential Executive Order to address strategic planning, coordination, and analysis related to the public and private adoption of health information technology (IT). In FY 2008, ONC's Budget will support new efforts to ensure the adoption of health IT nationwide through the development of data standards and the implementation of projects on priority areas identified by the American Health Information Community (AHIC). These activities reflect the Administration's commitment to ensuring that secure, interoperable electronic health records are available to patients and their doctors anytime and anywhere, which will reduce medical errors and improve efficiency.

LAUNCHING THE DATA STANDARDS INITIATIVE

Standards are a critical element of the foundation of the national health IT agenda and a necessary building block for achieving the President's health IT goals. In FY 2008 ONC will invest $5 million to establish a fund within HHS for health data standards development, and other related activities, to support the HHS implementation of public-private consensus standards. The Federal Government has played an important role in seeing that health data standards are available for both private sector and Federal use. This funding will allow HHS to work with the private sector to support data standards development and terminology mapping within the health IT industry.

ESTABLISHING PRIORITY PROJECTS IN HEALTH IT

The FY 2008 request includes $22 million to encourage the adoption of health IT through the implementation of AHIC recommendations, and the

Performance Highlight

Secretary Leavitt recently announced that 10 percent of physician offices had adopted electronic health record systems that met the four criteria set by the Institute of Medicine, listed below:

- computerized prescription ordering;
- computerized test ordering;
- inclusion of electronic test results; and
- electronic physician notes.

ONC will continue to monitor the adoption rate in physicians' offices as well as in small practices on an annual basis in order to measure progress in achieving the President's goal of most Americans having access to electronic medical records by 2014.

development of a new Partnership for Health and Care Improvement to eventually take over the AHIC responsibilities.

The AHIC has identified four breakthrough projects critical to the adoption of health IT, which include electronic health records, consumer empowerment, chronic care management, and biosurveillance. With this funding, ONC will fund up to 12 communities to test the implementation of these four priority areas. The goal of these projects is to measure the value of sharing specific types of health information in a secure and reliable way. This will also allow HHS to collect important information on costs, quality of care, and consumer and provider satisfaction with the implementation of these breakthroughs.

Transitioning the medical and health industry to capitalize on the advantages of reliable, secure, and instantaneous information exchange requires multiple changes in our healthcare system. In order to facilitate these necessary changes, efforts need to be made to set standards for data exchange, develop the Nationwide Health Information Network (NHIN), develop business models, educate the public, and develop many other health IT areas. Much of these efforts have been driven by the AHIC recommendations.

The FY 2008 Budget includes funding to transition the activities of the AHIC to a public-private Partnership for Health and Care Improvement. This public-private entity will sustain the Administration's vision to accelerate the adoption of health IT nationwide and provide a foundation for the long-term success of the Administration's quality and transparency initiatives. The Partnership will serve as the coordinating governance body for work related to the development and reporting of information about the quality and value of health care provided.

SUPPORTING OTHER ONC ACTIVITIES

The FY 2008 Budget continues support of key activities that will be accomplished through strategic partnerships and coordination in the public and private sectors, including:

- Assuring appropriate privacy and security protections of electronic health information;
- Advancing the NHIN trial implementations toward production networks and helping to constitute the "network of networks" that will be the NHIN;
- Developing Personal Health Record architectures that will be integrated with the NHIN architecture. These consumer-centric architectures will allow consumers to control who else can access their personal health data;
- Developing and harmonizing standards that are required for health information data portability. This will include a process to maintain and update these standards over time;
- Continuing the support of the Certification Committee for Health IT, which in 2006 certified 39 electronic health record systems; and
- Supporting state consensus efforts to address state health IT policy issues nationwide.

HHS-WIDE HEALTH IT EFFORTS

In addition to funds requested within the ONC, the FY 2008 request includes $45 million in the Agency for Healthcare Research Quality to advance the use of health IT to enhance patient safety and $2 million in the Office of the Assistant Secretary for Planning and Evaluation for independent evaluations of electronic health record adoption and economic factors influencing health IT implementations in the health sector.

OFFICE OF THE SECRETARY
OFFICE FOR CIVIL RIGHTS

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Total, Program Level	**35**	**36**	**35**	**37**	**+2**
FTE	261		249	255	+6

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

The FY 2008 budget request for the Office for Civil Rights (OCR) is $37 million, a net increase of $2 million over the FY 2007 Continuing Resolution and an increase of $1 million over the FY 2007 President's Budget. The budget supports OCR's activities as the primary defender of the public's right to nondiscriminatory access to and receipt of Federally funded health and human services – from hospitals and nursing homes to Head Start and senior centers. In addition, it supports OCR's significantly expanded compliance responsibilities that protect the rights of individuals' personal health information under the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

OCR assesses compliance with nondiscrimination and Privacy Rule requirements through:

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

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

Key priorities for OCR in FY 2007 and FY 2008 are: ensuring understanding of and compliance with the HIPAA Privacy Rule; promoting adequate privacy protections in health information technology and patient safety organizations; increasing non-discriminatory access to quality health care and human services, including adoption, foster care, and Temporary Assistance for Needy Families (TANF); supporting the New Freedom Initiative and appropriate services in most integrated settings for persons with disabilities; and promoting non-discrimination and privacy protections in emergency preparedness and response.

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

ENSURING PRIVACY AND CONFIDENTIALITY IN HEALTH CARE

HIPAA – Health Information Privacy: OCR is responsible for administering and enforcing the HIPAA Privacy Rule, which protects the privacy of individually identifiable health information maintained or transmitted by health plans, health providers, and clearinghouses. Since the compliance date of April 14, 2003, OCR has responded to more than 18,500 complaints. Of the approximately 6,000 complaints where OCR had the authority to

investigate, OCR found no violation in about 2,000 and obtained corrective action from the investigated entities in over 4,000 cases.

OCR also has reached hundreds of thousands of covered entities and consumers through educational conferences, a toll-free call line, and an interactive website to answer questions about the Privacy Rule.

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

Patient Safety: OCR is taking a lead role in fulfilling the Department's mandate to improve patient safety by defining and enforcing the confidentiality and privacy protections afforded by the Patient Safety and Quality Improvement Act of 2005.

ENSURING NON-DISCRIMINATORY ACCESS TO HEALTH CARE AND HUMAN SERVICES

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

OCR investigates complaints, initiates compliance reviews, and provides technical assistance to programs receiving federal funds. OCR works with Federal and State partners and with providers and consumers groups, including faith-based organizations to ensure non-discriminatory access to health and human services. For example, OCR is working in partnership with the American Hospital Association and state hospital associations to apprise hospitals of their responsibilities under civil rights law, and provide technical assistance to achieve effective communication with persons with disabilities and limited English proficiency.

In FY 2008, OCR will continue to focus on equal access to quality health services to eliminate health disparities and a broad range of non-discrimination issues in human services, including adoption, foster care, and TANF.

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

OFFICE OF THE SECRETARY
PROGRAM SUPPORT CENTER

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Expenses	**632**	**617**	**617**	**647**	**+30**
FTE	1,211		1,246	1,276	+30

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

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

ADMINISTRATIVE OPERATIONS SERVICE

The FY 2008 estimated expenses for the Administrative Operations Service (AOS) are $200 million, an increase of $5 million above FY 2007. The increase of $5 million represents an expansion of the Cooperative Administrative Support Units customer base. AOS provides a wide range of administrative and technical services within the Department, both in headquarters and in the regions, and to customers throughout the Federal Government.

FEDERAL OCCUPATIONAL HEALTH SERVICE

The FY 2008 estimated expenses for the Federal Occupational Health Service (FOHS) are $145 million, an increase of $4 million above the FY 2007 level. The increase of $4 million represents anticipated increased reimbursements from other Federal agencies. The FOHS provides occupational health services for Federal employees, including health and wellness programs, employee assistance, work/life, and environmental health and safety services. Over 800,000 Federal employees in 45 Federal departments and agencies are serviced by FOHS.

FINANCIAL MANAGEMENT SERVICE

The FY 2008 estimated expenses for the Financial Management Service (FMS) are $95 million, an increase of $8 million above FY 2007. Beginning in FY 2007, FMS will fully assume responsibility for operations and maintenance support for the Department's Unified Financial Management Services. FMS supports the financial operations through the provision of fund accounting, disbursement, financial reporting, financial statement preparation, payroll accounting, and debt management and collection services; support for Federal grantor and contracting agencies for the negotiation and approval of indirect cost, fringe benefits and other specialty rates used by not-for-profit organizations receiving Federal awards; and grant disbursement, cash management, and grant accounting support services.

HUMAN RESOURCES SERVICE

The FY 2008 estimated expenses for the Human Resources Service (HRS) are $64 million, an increase of $2 million above FY 2007. The $2 million increase represents system enhancements and staff-related costs. HRS provides an extensive array of personnel systems, administration and management, training, and payroll liaison services. These include compensation and medical benefits for Commissioned Corps officers, liaison services between the new civilian payroll service provider (DFAS) and HHS employees, automated personnel and time and attendance systems support, equal employment opportunity, workforce development, and training management.

Strategic Acquisition Service:
The FY 2008 estimated expenses for the Strategic Acquisition Service (SAS) are $90 million, an increase of $10 million above FY 2007. The increase of $10 million represents $8 million for the HHS consolidated acquisition system and $2 million for anticipated new business. The SAS is responsible for providing leadership, guidance, and supervision to the procurement operations of the PSC and for improving procurement operations within HHS. The SAS provides acquisition services, strategic sourcing services (including a Strategic Sourcing Center of Excellence); and provides pharmaceutical, medical, and dental supplies to HHS and other Federal agencies.

Human Resources Centers:
The FY 2008 estimated expenses for the Human Resources Center (HRC) are $53 million, an increase of $1 million above FY 2007 for anticipated pay and rent increases. The HR Centers represent a consolidation of human resources services within the Department, with sites located in Rockville and Baltimore, Maryland and Atlanta, Georgia. The centers provide human resources strategic programs, customer service, and workforce relations support for HHS customers.

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

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Retirement Payments	269	292	292	318	+26
Survivor's Benefits	17	18	18	18	--
Medical Care for Retirees and Survivors	57	61	61	67	+6
Accrued Medical Benefits for over-65	34	36	36	37	+1
Total, Budget Authority	**377**	**407**	**407**	**440**	**+33**

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

The FY 2008 request of $440 million is a net increase of $33 million over the FY 2007 level. This amount reflects increased retirement payments of $26 million, increased medical care benefits costs of $6 million, and increased accrued medical benefit payments for officers and beneficiaries over age 65 of $1 million.

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Direct discretionary appropriation	39	44	39	45	+5
Discretionary HCFAC	--	11	--	18	+18
Mandatory HCFAC	160	166	166	169	+3
Medicaid Integrity Program	25	25	25	25	--
Audit and Investigations Reimbursements	10	10	10	10	--
Medicare Modernation Act	14	--	--	--	--
Never Events	--	3	3	--	-3
Total, Budget Authority	**248**	**259**	**243**	**268**	**+23**
FTE	1,447		1,585	1,701	+116

Under the authority of the Inspector General Act, we improve HHS programs and operations and protect them against fraud, waste, and abuse. By conducting independent and objective audits, evaluations, and investigations, we provide timely, useful, and reliable information and advice to Department officials, the Administration, the Congress, and the Public.

The FY 2008 Budget request for the Office of Inspector General (OIG) is $45 million, a net increase of $5 million over the FY 2007 Continuing Resolution, which is an increase of $1 million over the President's Budget. Over the FY 2007 – FY 2008 period, OIG will use its discretionary funding to continue its work across the non-Medicare and non-Medicaid areas of HHS, which are public health, children and families, aging, and department-wide activities. The funding level of OIG for FY 2008 allows OIG to continue its efforts in:

- grant oversight and reviews that cover internal controls, accounting controls, performance measurements, and program evaluation;
- nationwide involvement with the 10 Project Save Our Children (PSOC) Task Forces that identify, investigate, and prosecute individuals who willfully avoid the payment of their child support obligations;
- reviews of drug and device safety and safeguards over controlled substances; and
- oversight of the Department's emergency preparedness and response spending.

In addition to this, OIG will continue its Heath Care Fraud and Abuse Control (HCFAC) activities to identify and prosecute health care fraud; prevent future fraud, waste, or abuse; protect HHS program beneficiaries; and ensure the solvency of the Medicare Trust Fund; as well as play an active role in the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

GRANTS OVERSIGHT

OIG will continue to review Department grant programs to determine whether they are appropriately monitored and managed throughout the grant life cycle. OIG will assess mechanisms in place to ensure that proper procedures are used to award grants, fund them, account for expenditures, and verify that they are used only for authorized purposes. OIG anticipates conducting grant oversight activities in FY 2007 – FY 2008 that touch almost every Operating Division within HHS and include such diverse issues as patient safety, the Community Health Centers, Head Start Enrollment of Disabled Children, TANF error rate, HIV/AIDS, and fraud awareness.

CHILD SUPPORT ENFORCEMENT PROGRAM

OIG will continue its coverage of all 50 States and the District of Columbia by its multi-agency task forces (PSOC Task Forces) that identify, investigate, and prosecute

individuals who willfully avoid payment of their child support obligations under the Child Support Recovery Act. These task forces bring OIG together with State and local law enforcement and prosecutors, United States Attorneys' Offices, United States Marshals Service, State and county child support personnel, and all other interested parties.

Drug and Device Safety and Safeguards

The public health service programs are the country's first line of defense against acute and chronic diseases and in the Administration's efforts to promote and enhance the continued good health of the American people. OIG plans reviews in the areas of select agents, compliance inspections of drug manufacturers, adverse event reporting for medical devices, and enforcement of food facility registration requirements.

Emergency Preparedness

As the Department continues to develop the nation's capacity to respond to emergencies of all types, OIG will conduct cross-cutting work activities to ensure the integrity of public funds spent on bioterrorism, pandemic influenza, and other preparedness activities. OIG will also conduct retrospective activities to assess the Department's effectiveness while carrying out its National Response Plan ESF8 responsibilities after Hurricanes Katrina and Rita and during the Gulf-coast rebuilding efforts, and prospective work activities to address issues related to the safety and security of select agents in private and state laboratories.

Health Care Fraud and Abuse

In addition to planned discretionary work, OIG is provided mandatory funding to conduct work through the HCFAC program and Medicaid Integrity Program as authorized by the Health Insurance Portability and Accountability Act of 2003 and the Deficit Reduction Act of 2005 respectively. In the execution of these program activities, OIG works with the Centers for Medicare & Medicaid Services (CMS), other HHS agencies, and the Department of Justice to ensure that funds due to the Medicare Trust Fund or CMS are recovered through audits and investigations, and provides recommendations for statutory, regulatory, and program changes that could strengthen program integrity. These activities will identify and prosecute health care fraud; prevent future fraud, waste, or abuse; protect HHS program beneficiaries; and ensure the solvency of the Medicare Trust Fund; as well as play an active role in the implementation of the MMA.

EMERGENCY PREPAREDNESS

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Pandemic Influenza					
Agency Budgets	516	352	164	322	+158
PHSSEF	5,074	--	--	870	+870
Subtotal, Pandemic Influneza	5,590	352	164	1,192	+1,028
Terrorism Preparedness					
Agency Budgets	3,532	3,607	3,496	3,508	+12
PHSSEF	651	810	652	781	+129
Subtotal, Terrorism Preparedness	4,183	4,417	4,148	4,289	+141
World Trade Center First Responders	--	--	--	25	+25
Total, Emergency Preparedness	9,773	4,769	4,312	5,506	+1,194

To protect our Nation from the threat of pandemic influenza the FY 2008 request includes $1.2 billion in HHS-wide funding to implement the HHS Pandemic Influenza Plan. Also included in the FY 2008 Budget request is approximately $4.3 billion for bioterrorism and emergency preparedness activities. Funding for these activities is appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) and directly to agencies. The PHSSEF request includes $1.8 billion to protect the Nation against these threats and for the screening and treatment of World Trade Center responders.

PANDEMIC INFLUENZA

The FY 2008 request for pandemic preparedness includes $870 million in no-year funding for another year of the HHS Pandemic Influenza Plan, with a focus on expanding cell and egg-based vaccine capacity, purchasing antivirals, and accelerating research and development of rapid diagnostic tests. In addition to this request, a total of $322 million will fund ongoing annual activities at the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), the National Instutites of Health (NIH), and within the HHS Office of the Secretary (OS).

A pandemic is a global disease outbreak. A flu pandemic occurs when a new influenza virus emerges for which people have little or no immunity, and for which there is no vaccine. The disease spreads easily person-to-person, causes serious illness, and can sweep across the country and around the world in very short time. Widespread disease and death can result. Animals are the most likely reservoir for these emerging viruses, and avian viruses have played a role in the three such global events. The current pandemic influenza threat, the H5N1 virus strain, stems from an outbreak of avian influenza in Asia, Europe, the Middle East and Africa. The ability of the H5N1 virus to infect a wide range of hosts, including birds and humans is of concern to the public health community. Although the virus has not yet shown an ability to transmit efficiently between humans, through genetic mutation or exchange of genetic material with a human influenza virus, it might acquire this capability. In August 2005, animal outbreaks of highly pathogenic H5N1 had been reported in twelve countries around the world with 112 total human cases confirmed in four of those countries. Just over a year later, in December 2006, the number of countries confirming animal outbreaks jumped to 53, with 258 total human cases confirmed in ten of those countries. While it is impossible to know whether the currently circulating H5N1 virus will cause a human pandemic, such a pandemic could cause tens or hundreds of thousands of deaths in the United States, especially if adequate vaccines were not available quickly. Once a pandemic begins, there will be a small window of opportunity to accomplish the necessary research, development, and delivery of vaccines required to mitigate its impact.

On November 1, 2005, the President requested a total of $7.1 billion in emergency funding for pandemic influenza preparedness activities, of which $6.7 billion of the HHS Pandemic Influenza Plan. This funding was requested in FY 2006 to fund a three-year preparedness effort to ensure that the Nation could effectively respond in the event of a pandemic. In December 2005, Congress appropriated $3.3 billion in emergency funding in a FY 2006 supplemental. In June 2006, Congress appropriated an additional $2.3 billion in emergency funding through a second FY 2006 supplemental.

Since December 2005, HHS has funded the first stage of pandemic preparedness activities, including: expanding domestic vaccine production and surge capacity; enlarging H5N1 vaccine and antiviral drug stockpiles; supporting advanced development of cell culture and antigen sparing influenza vaccines, rapid diagnostics and new antiviral drugs; stockpiling medical supplies and ventilators; improving State and local preparedness; enhancing FDA's regulatory science base; and expanding surveillance, research, and international collaboration efforts of CDC, NIH, the Office of Global Health Affairs and the Office of the Assistant Secretary for Preparedness and Response.

HHS Preparedness Funding Highlights: Of the $5.6 billion FY 2006 emergency funding total, approximately $4.1 billion has been allocated to activities designed to increase vaccine production capacity and stockpiles of vaccines, antivirals, and other medical supplies, in support of the following efforts:

- Establishing high-volume domestic surge capacity through vaccine purchase and retrofit of egg-based facilities;
- Accelerating development of cell-based vaccine capabilities;
- Purchasing enough antivirals for 25 percent of the population and six million courses for contain-ment, including 50 million Federally-purchased treatment courses and 31 million courses purchased by States using Federal subsidies; and
- Procuring N95 respirators, surgical masks, ventilators, IV antibiotics, syringes and other PPE and medical supplies for the Strategic National Stockpile (SNS).

Of the $4.1 billion total, HHS has allocated $650 million for advanced development work on promising antiviral drugs and antigen-sparing strategies that would decrease the amount of vaccine needed to protect an individual.

To help create a seamless network of Federal, State, and local preparedness, HHS has allocated $770 million for State and local preparedness activities, including subsidizing State purchases of antivirals. The supplemental funds have also provided a total of $400 million to the CDC to intensify domestic and international surveillance, containment, and outbreak response measures, enhance and continue risk communication activities, establish additional laboratory capacity, and to develop and deploy rapid diagnostic test kits. A total of $96 million is funding international activities, vaccine registry planning, and research activities

HHS Pandemic Influenza Progress to Date

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

- On May 4, 2006, HHS awarded contracts to five cell-based manufacturers totaling $1 billion to accelerate development and production of new technologies for influenza vaccine.
- As of February 1, 2007, HHS has 4 million courses of H5N1 vaccine on hand and 2.7 to 3.5 million courses on order.
- As of February 1, 2007, HHS has 21.7 million courses of antivirals on hand and 14.1 million courses on order.
- As of January 5, 2007, HHS has the following medical supplies available in the SNS:
  - N95 Respirators – 81.5 million on hand; 23.4 million on order
  - Surgical Masks – 49.7 million on hand; 1.7 million on order
- On November 15, 2006, HHS awarded contracts to 4 companies for the development of a new rapid diagnostic test for avian influenza.
- In 2006, HHS awarded a total of $325 million for State and local preparedness and conducted pandemic influenza summits in every State.
- HHS has supported activities in approximately 40 countries to improve detection and containment capabilities, and is also implementing programs through regional partners.

within OS and NIH, and $20 million is supporting the FDA's efforts to enhance the regulatory science base to work with the private sector to manufacture influenza vaccines.

FY 2008 Activities: In FY 2008, HHS will invest an additional $870 million in no-year funds and $322 million in annual funds to complete the final phase of critical preparedness activities outlined in the National Strategy for Pandemic Influenza, consistent with the President's FY 2006 emergency request.

With the no-year funding, HHS will continue to work toward its goal to acquire 20 million egg-based courses of pre-pandemic vaccine by 2009. Currently, HHS has approximately 4 million courses of H5N1 clade 1 vaccine on hand. With FY 2006 supplemental funding, HHS has ordered 2.7 to 3.5 million courses of H5N1 vaccine. The term "clade" refers to the genetic variants (antigenic drift) of an influenza virus strain. Additional funds are included to accelerate cell-based technologies. Funds will be used for clinical trials needed to license cell-based vaccine and for facility costs. HHS will continue its commitment to accelerate cell-based technologies so that together with the egg-based manufacturing capacity, manufacturers can produce enough vaccine for every American within six months of the onset of a pandemic.

In FY 2008, HHS will also complete its purchase of antivirals for 25 percent of the population and six million courses to contain isolated outbreaks. The Budget includes funds to accelerate research and development for rapid diagnostic tests. Such tests would enable doctors and field epidemiologists to quickly and accurately test patients for avian influenza H5N1 and other emerging influenza viruses, as well as more common influenza viruses. The goal is to create a test that would detect seasonal human influenza viruses and differentiate influenza A H5N1 from seasonal human influenza viruses within 30 minutes.

In addition to the $870 million, a total of $322 million is requested in the budgets of the CDC, FDA, NIH, and OS and will finance ongoing preparedness activities including:

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

EMERGENCY PREPAREDNESS

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Pandemic Influenza:					
Activities Funded with No-Year Funding					
Vaccines and Antivirals:					
Achieve Production Capacity and/or Buy Vaccine	2,963	--	--	543	+543
Purchase Antivirals	511	--	--	248	+248
Advanced Dev. of Antigen Sparing Techniques and Antiviral Drugs	650	--	--	--	--
Subtotal, Vaccines and Antivirals	4,124	--	--	791	+791
Enhance Strategic National Stockpile	170	--	--	--	--
State and Local Preparedness	600	--	--	--	--
Antiviral Subsidy to States	170	--	--	--	--
Vaccine Registry	10	--	--	--	--
Rapid Diagnostics (CDC)	--	--	--	79	+79
Subtotal, FY 2006 Emergency Funding	5,074	--	--	870	+870
Activities Funded in the Agency Budgets					
CDC	400	188	--	158	+158
FDA	20	50	50	51	+1
NIH	18	35	35	35	--
Office of the Secretary	78	79	79	78	-1
Subtotal, Agency Budgets	516	352	164	322	+158
Transfer to USAID	30	--	--	--	--
Total, Pandemic Influenza Plan Funding	**5,620**	**352**	**164**	**1,192**	**+1,028**
Total, HHS Pandemic Influenza Plan Funding	**5,590**	**352**	**164**	**1,192**	**+1,028**

BIOTERRORISM AND EMERGENCY PREPAREDNESS

The FY 2008 Budget request for HHS bioterrorism and emergency response activities is $4.3 billion, a net increase of $141 million over the FY 2007 Continuing Resolution and a decrease of $128 million below the FY 2007 President's Budget. These funds are designated to protect Americans from a possible bioterrorist attack or other public health emergency, and are appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) and directly to agency budgets.

PHSSEF Activities: The FY 2008 Budget request for the PHSSEF is $781 million, a net increase of $129 million over the FY 2007 Continuing Resolution and a decrease of $29 million below the FY 2007 President's Budget. The PHSSEF request will support coordination of preparedness and response activities across HHS to improve the Nation's ability to prepare for, respond to and recover from an attack or other public health emergency.

Assistant Secretary for Preparedness and Response: Pursuant to the Pandemic and All-Hazards Preparedness Act (P.L. 109-417) which was enacted on December 19, 2006, the new Office of the Assistant Secretary for Preparedness and Response (ASPR) was created as the principal advisor to the Secretary for HHS preparedness and response activities. ASPR coordinates the bioterrorism and emergency preparedness activities of HHS agencies, develops and coordinates national policies and plans, provides program oversight, and serves as the Secretary's public health emergency representative to other Federal, State and local organizations. HHS is the primary agency for the Federal government's Emergency Support Function (ESF) #8, preparedness for and response to the health consequences of disasters, including terrorist incidents involving weapons of mass destruction under the National Response Plan.

The request includes an increase of $42 million to enhance the Department's efforts as proposed in the in the *Federal Response to Hurricane Katrina: Lessons Learned* report. HHS is actively working to implement its 22 action items from the Report and this funding level is consistent with the FY 2007 Budget amendment request. Without improved Federal, State, local and regional coordination, emergency response will be slower and less effective, putting lives in jeopardy.

The request also includes $53 million for the National Disaster Medical System (NDMS), which transferred to HHS from the Department of Homeland Security in 2007, an increase of $6 million over FY 2007, to implement emergency readiness response improvements.

In addition, the Budget provides $211 million to target advanced research and development on promising medical countermeasures and to manage the Project BioShield program. ASPR is responsible for the newly created Biomedical Advanced Research and Development Authority (BARDA), to coordinate all Federal efforts to research and produce vaccines and countermeasures against potential plagues and bioweapons.

The ASPR request also includes $414 million for the Hospital Preparedness Cooperative Agreement Grants Program. This program transfers from the Health Resources and Services Administration (HRSA) in 2007, as outlined in the Pandemic and All-Hazards Preparedness Act. These grants will increase medical surge capacity in preparation for a mass casualty event resulting from a terrorist attack, large-scale natural disaster, or pandemic which places local emergency medical and public health services on the front line. Funding also supports the Emergency System for Advance Registration of Volunteer Health Professionals program, which has been working to establish a national network of state-based programs that manage the information needed to effectively use health professional volunteers in an emergency.

Medical Reserve Corps: The request includes $15 million for the Medical Reserve Corps in FY 2008, an increase of $5 million over the FY 2007 Continuing Resolution. Comprised of medical and public health volunteers, these professionals contribute their expertise to local public health initiatives on an ongoing basis. The increase will enhance the leverage of these efforts during a national catastrophic emergency.

Health Care Provider Credentialing Portal: The FY 2008 Budget provides $3 million to finance the development and updating of credentialing systems. Funds will be used to create a mechanism to conduct primary source verification of

health care professionals' credentials from relevant Federal, State, and non-governmental sources before, during, and after a mass casualty event.

Cybersecurity: The request maintains level funding at $10 million in FY 2008 for cybersecurity. These funds continue to protect the Department's information technology infrastructure from cyber-terrorist attacks by providing continuous security monitoring for all HHS systems, assets, and services.

In addition to funding in the PHSSEF, another $3.5 billion in bioterrorism funding is requested directly in the appropriations for the Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), the National Instutites of Health (NIH), and the Office of the Secretary.

HIGHLIGHTED BIOTERRORISM PREPAREDNESS ACTIVITIES

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

Detection and Containment: The FY 2008 Budget supports biosurveillance efforts including BioSense, a human health surveillance system at CDC that leverages data from local, regional, and national networks. Utilizing these information technology tools, Federal, State, and local health officials will have access to real-time data that could potentially be the first sign of a public health emergency. The FY 2008 request also includes $137 million for upgrading CDC capacity. With these funds, CDC will continue to improve epidemiological expertise in the identification and control of diseases caused by terrorism, including better electronic communication, distance learning programs, and cooperative agreement training between public health agencies and local hospitals.

FDA also plays a critical role in early detection through its food defense program. To protect our Nation's food supply, $178 million is included in this request, the same level as FY 2007. This request supports key food defense activities, such as developing analytic surge testing capacity for biological, chemical, and radiological threat agents for the Food Emergency Response Network. FDA will also work to coordinate food surveillance activities within the Biosurveillance Initiative.

Emergency Preparedness and Response: To minimize injury and loss of life resulting from a terrorist attack, our Nation must also have the ability to effectively prepare for and respond to such an event. The FY 2008 request includes $38 million, an increase of $34 million over the FY 2007 Continuing Resolution for Commissioned Corps. The General Department Management budget request includes these funds to transform the Commissioned Corps into a force that is ready to rapidly respond to public health challenges and health care crises that can result from natural disasters, technological catastrophes, terrorist attacks, and other extraordinary needs.

HHS continues to demonstrate a strong commitment to prepare States and local public health departments and hospitals for public health emergencies and acts of bioterrorism. In FY 2008, $1.1 billion is requested for such efforts, making a total investment of over $9 billion since September 11, 2001. The Upgrading State and Local Capacity Grants Program at CDC and the Hospital Preparedness Cooperative Agreement Grants Program at ASPR prepare States and local public health departments and hospitals for public health emergencies and acts of terrorism.

Protection and Treatment: A vital part of our bioterrorism readiness efforts is to quickly protect Americans that have been exposed

Preparedness and Response: A Coordinated Effort

The vision of Office of the Assistant Secretary for Preparedness and Response is a Nation prepared to prevent, respond to and recover from the health effects of a disaster. The investments proposed in this budget will support continued capacity building at the local level as our highest priority. Additional investments will expand Federal assets available to support communities to prevent, respond to and recover from disasters. This includes investments in needed medical countermeasures, human response assets such as those found in the National Disaster Medical System, and development of broad based partnerships to ensure systems of support that extend beyond the Federal capacity. Effective preparedness and response is a wide enterprise. It involves many different components from the local to the Federal, private and public. The goal is to strengthen the whole enterprise through these proposed investments.

to a biological, chemical, or radiological threat agent and to treat those who have become sick following an exposure. Research activities in this arena are critical, because our Nation's ability to counter bioterrorism ultimately depends on the state of biomedical science.

The FY 2008 Budget request for NIH biodefense activities is $1.7 billion, a net decrease of $8 million below the FY 2007 Continuing Resolution and the FY 2007 President's Budget. These funds will support basic and applied research on agents with bioterrorism potential which will lead to the availability of new or improved vaccines and therapies created to protect or treat persons exposed to threat agents. The FY 2008 request does not include funding for extramural biodefense construction, as in previous years, and the advanced development of medical countermeasures funding is now requested in ASPR to improve coordination with the Project BioShield acquisition program.

For many threat agents, effective countermeasures, such as vaccines and pharmaceuticals, already exist and are available for purchase. In the event of a large scale terrorist attack, rapid access to large quantities of these vaccines and medications is critical for saving lives. The FY 2008 President's Budget includes $581 million for CDC's Strategic National Stockpile, a federally owned repository of these types of countermeasures. Additionally, the stockpile contains medical supplies and hospital beds that would be need in a mass casualty event. As a critical part of our Nation's defense against a bioterrorist attack, Strategic National Stockpile funding will continue to support the ability to distribute these assets anywhere in the country within 12 hours of an event.

SUPPORTING TREATMENT FOR WORLD TRADE CENTER RESPONDERS

Since 2002, HHS has been dedicated to tracking and screening World Trade Center responders and others exposed to the dust, debris, and stressors of the September 11, 2001 attacks. Currently, HHS is overseeing the expenditure of $75 million in funds for the treatment, screening, and monitoring of World Trade Center workers and responders. The FY 2008 Budget includes an additional $25 million for treatment of World Trade Center related illnesses for these individuals. The World Trade Center Task Force, comprised of the Department’s top science and public health policy experts, continues to evaluate data and ensure options for how best to ensure treatment needs of responders are met.

EMERGENCY PREPAREDNESS

(dollars in millions)

	2006	2007		2008	
	Actual	President's Budget	Continuing Resolution	President's Budget	+/- 2007 Cont. Res.
Bioterrorism and Emergency Preparedness:					
Direct Appropriations to Agency Budgets					
Centers for Disease Control and Prevention:					
Upgrading State and Local Capacity	823	784	824	698	-125
Biosurveillance Initiative	78	102	78	88	+10
Upgrading CDC Capacity	137	136	137	137	--
Anthrax Research	14	--	14	--	-14
Botulinum Toxin Research	--	3	--	--	--
Strategic National Stockpile	524	581	491	581	+90
Subtotal, CDC	1,576	1,606	1,544	1,504	-40
National Institutes of Health:					
Biodefense Research	1,604	1,610	1,610	1,628	+18
Radiological/Nuclear Countermeasures Research	46	47	47	48	+1
Chemical Countermeasures Research	49	50	50	48	-2
Subtotal, NIH Research	1,700	1,706	1,706	1,723	+17
Extramural Laboratory Construction	30	25	25	--	-25
Subtotal, NIH	1,730	1,731	1,731	1,723	-8
Food and Drug Administration:					
Food Defense	158	178	156	178	+23
Vaccines/Drugs/Diagnostics	57	57	55	57	+2
Physical Security	7	7	7	7	+0.24
Subtotal, FDA	222	242	217	242	+25
Office of the Secretary:					
Revitalization of Commissioned Corps	4	28	4	38	+34
Subtotal, Direct Appropriations	3,532	3,607	3,496	3,508	+12
Office of the Secretary, PHSSEF					
Assistant Secretary for Preparedness and Response (ASPR):					
Operations	9	13	9	13	+4
Preparedness and Emergency Operations	15	48	15	48	+33
National Disaster Medical System (NDMS)	47	47	47	53	+6
Hospital Preparedness Grants 1/	474	452	474	414	-60
Training and Curriculum Development 1/	21	12	21	--	-21
Advanced Research and Development 2/	54	165	54	189	+135
BioShield Management	--	22	--	22	+22
International Early Warning Surveillance	9	9	9	9	+0.04
Media/Public Information Campaign	3	2	3	2	-0.36
Subtotal, ASPR	632	771	632	751	+118
Other Office of the Secretary:					
Healthcare Provider Credentialing	--	7	--	3	+3
Security Coordination and Improvement	--	--	--	2	+2
CyberSecurity	9	9	9	10	+1
Medical Reserve Corps	10	22	10	15	+5
Subtotal, Other Office of the Secretary	19	39	19	30	+11
Subtotal, PHSSEF	651	810	652	781	+129
Total	**4,183**	**4,417**	**4,148**	**4,289**	**+141**

1/ Reflects comparable adjustments in FY 2006 and FY 2007 from Health Resources and Services Administration to the Office of the Secretary for preparedness and emergency reponse programs.

2/ Reflects comparable adjustments in FY 2006 and FY 2007 of $50 million from the National Institute of Allergy and Infectious Diseases (NIAID) to the Office of the Secretary for advanced development of biodefense countermeasures.

HHS PARTed* PROGRAMS

(dollars in millions)

	PART Cycle	Narrative Rating
Food and Drug Administration:		
Overall	CY 2003	Moderately Effective
Health Resources and Services Administration:		
Health Centers	CY 2002	Effective
Health Professions	CY 2002	Ineffective
Maternal and Child Health Block Grant	CY 2002	Moderately Effective
National Health Service Corps	CY 2002	Moderately Effective
Nursing Education Loan Repayment and Scholarship	CY 2002	Adequate
Ryan White	CY 2002	Adequate
Children's Hospital Graduate Medical Education Program	CY 2003	Adequate
Rural Health Activities	CY 2003	Adequate
Emergency Medical Services for Children	CY 2004	RND
National Bone Marrow Donor Registry	CY 2004	Moderately Effective
Organ Transplantation	CY 2004	Adequate
Poison Control Centers	CY 2004	Adequate
Traumatic Brain Injury	CY 2004	RND
Family Planning	CY 2005	Moderately Effective
Health Care Facilities Construction	CY 2005	RND
Healthy Community Access Program	CY 2005	Ineffective
State Planning Grant Program - Uninsured	CY 2005	Ineffective
Trauma/Emergency Medical Services	CY 2005	Adequate
Universal Newborn Hearing Screening	CY 2005	Moderately Effective
Black Lung Clinics	CY 2006	Ineffective
Free Clinics Medical Malpractice Coverage	CY 2006	Adequate
Hansen's Disease Services Program	CY 2006	Moderately Effective
Healthy Start	CY 2006	Moderately Effective
National Practitioner/Health Integrity Data Banks	CY 2006	Effective
Radiation Exposure Screening and Education Program	CY 2006	Ineffective
Telehealth	CY 2006	Moderately Effective
Indian Health Service:		
Federally Administered Activities	CY 2002	Moderately Effective
Sanitation Facilities Construction	CY 2002	Moderately Effective
Resource and Patient Management System	CY 2003	Effective
Urban Health	CY 2003	Adequate
Health Facilities Construction	CY 2004	Effective
Tribally Operated Health Programs	CY 2005	Adequate
Centers for Disease Control and Prevention:		
317 Immunization Program	CY 2002	Adequate
Breast and Cervical Cancer	CY 2002	Adequate
Diabetes	CY 2002	Adequate
Domestic HIV/AIDS Prevention	CY 2002	RND
Agency for Toxic Substances and Disease Registry	CY 2003	Adequate
State/Local Public Preparedness	CY 2003	RND
Buildings and Facilities	CY 2004	Adequate
Infectious Diseases	CY 2004	Adequate

	PART Cycle	Narrative Rating
Occupational Safety and Health	CY 2004	Adequate
Sexually Transmitted Diseases / Tuberculosis	CY 2004	Adequate
Environmental Health	CY 2005	Adequate
Global Immunizations	CY 2005	Effective
Health Statistics	CY 2005	Moderately Effective
Strategic National Stockpile	CY 2005	Moderately Effective
Birth Defects and Developmental Disabilities	CY 2006	Moderately Effective
Chronic Disease Prevention	CY 2006	Moderately Effective
Injury Prevention and Control	CY 2006	Moderately Effective
Terrorism: Intramural Activities	CY 2006	RND
Terrorism: Biosurveillance	CY 2006	RND
National Institutes of Health:		
HIV / AIDS Research	CY 2003	Moderately Effective
Extramural Research Activities	CY 2004	Effective
Buildings and Facilities	CY 2005	Effective
Intramural Research	CY 2005	Effective
Extramural Construction	CY 2006	Moderately Effective
Extramural Research Training and Research Career Development	CY 2006	Effective
Substance Abuse and Mental Health Services Administration:		
Children's Mental Health Services	CY 2002	Moderately Effective
Projects for Assistance in Transition from Homelessness	CY 2002	Moderately Effective
Substance Abuse Treatment Prog. of Region. & Nation. Signif.	CY 2002	Adequate
Mental Health Block Grant	CY 2003	Adequate
Substance Abuse Prevention & Treatment Block Grant	CY 2003	Ineffective
Substance Abuse Prevention Proj. of Region. & Nation. Signif.	CY 2004	Moderately Effective
Mental Health Prog. of Region. & Nation. Signif.	CY 2005	RND
Protection and Advocacy for Individuals with Mental Illness	CY 2005	Moderately Effective
Agency for Healthcare Research and Quality:		
Data Collection and Dissemination	CY 2002	Moderately Effective
Patient Safety	CY 2003	Adequate
Pharmaceutical Outcomes	CY 2004	Moderately Effective
Centers for Medicare & Medicaid Services:		
Medicare Integrity Program	CY 2002	Effective
Medicare Program	CY 2003	Moderately Effective
SCHIP	CY 2003	Adequate
Medicaid	CY 2006	Adequate
Administration for Children and Families:		
Refugee and Entrant Assistance: Target. Assist. & Soc. Serv.	CY 2002	Adequate
Child Support Enforcement	CY 2003	Effective
Community Services Block Grant	CY 2003	RND
Developmental Disabilities	CY 2003	Adequate
Foster Care	CY 2003	Adequate
LIHEAP	CY 2003	RND
Assets for Independence	CY 2004	Adequate
Child Care	CY 2004	Moderately Effective
Child Welfare: Child Abuse Prevnt. & Treatmnt. Act State Grant.	CY 2004	RND
Child Welfare: Community-Based Child Abuse Prevention	CY 2004	RND

	PART Cycle	Narrative Rating
Child Welfare: Independent Living	CY 2004	RND
Violent Crime Reduction Programs	CY 2004	RND
Adoption Assistance	CY 2005	Moderately Effective
Adoption Incentives	CY 2005	Adequate
Adoption Opportunities	CY 2005	Adequate
Mentoring Children of Prisoners	CY 2005	RND
Refugee and Entrant Assistance: Transition & Medical Services	CY 2005	Effective
Social Services Block Grant	CY 2005	RND
Temporary Assistance for Needy Families	CY 2005	Moderately Effective
Victims of Trafficking	CY 2005	Moderately Effective
Abstinence Education	CY 2006	Adequate
Child Welfare Services	CY 2006	Moderately Effective
Compassion Capital Fund	CY 2006	RND
Head Start	CY 2006	Moderately Effective
Promoting Safe and Stable Families	CY 2006	Moderately Effective
Runaway and Homeless Youth	CY 2006	Effective
Unaccompanied Alien Children	CY 2006	Adequate
Administration on Aging:		
Overall	CY 2003	Moderately Effective
Office of the Secretary:		
Bioterrorism Hospital Preparedness	CY 2003	RND
Adolescent and Family Life	CY 2004	RND
Women's Health	CY 2004	RND
Office of Disease Prevention and Health Promotion	CY 2005	RND
Office of Minority Health	CY 2005	RND
OGHA: Afghanistan Health Initiative	CY 2005	RND
OGHA: US Mexico Border Health Commission	CY 2005	RND
Commissioned Corps: Readiness and Response Program	CY 2006	Adequate
Office of the National Coordinator	CY 2006	RND
Office of Medicare Hearings and Appeals	CY 2006	RND
Office for Civil Rights		
Office for Civil Rights	CY 2005	Moderately Effective
Office of Inspector General:		
Health Care Fraud and Abuse Control	CY 2002	RND
Multi-Agency PARTs		
CDC/ Department of State/United States Agency for International Development		
President's Emergency Plan for AIDS Relief		
Other Bilateral Programs	CY 2005	Adequate
Focus Countries	CY 2005	Moderately Effective
HRSA/Department of Justice		
Vaccine Injury Compensation	CY 2005	Adequate

ACRONYMS

A

ACF	Administration for Children and Families
ACIP	Advisory Committee on Immunization Practices
ADA	American with Disabilities Act
AFDC	Aid to Families with Dependent Children
AFI	Assets for Independence
AFL	Adolescent and Family Life
AHIC	American Health Information Community
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
AoA	Adminstration on Aging
AOS	Administrative Operations Service
ASPR	Assistant Secretary for Preparedness and Response
ATSDR	Agency for Toxic Substances and Disease Registry

B

B&F	Buildings and Facilities
B.A.	Budget Authority
BARDA	Biomedical Advanced Research and Development Authority
BBA	Balanced Budget Act of 1997
BIPA	Medicare Benefits Improvement and Protection Act of 2000
BQI	Better Quality Information

C

CARE	Comprehensive AIDS Resources Emergency Act
CCDBG	Child Care and Development Block Grant
CCDF	Child Care and Development Fund
CCES	Child Care Entitlement to States
CDC	Centers for Disease Control and Prevention
CERT	Comprehensive Error Rate Testing
CMS	Centers for Medicare & Medicaid Services
CPI-U	Consumer Price Index - Urban
CSBG	Community Services Block Grant
CSE	Child Support Enforcement
CTSA	Clinical and Translational Science Award
CY	Calendar Year

D

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

E

EHR	Electronic Health Record
ESF	Emergency Support Function
ESRD	End Stage Renal Disease

F

FAS	Fetal Alcohol Syndrome
FDA	Food and Drug Administration
FMAP	Federal Medical Assistance Percentage
FMS	Financial Management Services
FOA	Family Opportunity Act
FOHS	Federal Occupational Health Service
FPL	Federal Poverty Level
FPLS	Federal Parent Locator Service
FTE	Full Time Equivalent
FUL	Federal upper limit
FY	Fiscal Year

G

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

H

HCBS	Home- and Community-Based Services
HCFAC	Health Care Fraud and Abuse Control
HHS	Department of Health and Human Services
HI	Federal Hospital Insurance
HI	Hospital Insurance (Trust Fund)
HIFA	Health Insurance Flexibility and Accountability
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMO	Health Maintenance Organization
HPV	Human Papillomavirus
HRC	Human Resources Center
HRS	Human Resources Service
HRSA	Health Resources and Services Administration
HSA	Health Savings Accounts

I

IHS	Indian Health Service
IME	Indirect Medical Education
IT	Information Technology; Health Information Technology

ACRONYMS

L

LIHEAP	Low Income Home Energy Assistance Program

M

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

N

NCRR	National Center for Research Resources
NDMS	National Disaster Medical System
NHSC	National Health Service Corps
NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases
NIEHS	National Institute of Environmental Health Sciences
NIH	National Institutes of Health
NLM	National Library of Medicine
NMEP	National Medicare & You Education Program
NRS	National Reporting System

O

OASDI	Old Age, Survivors, and Disability Insurance
OCR	Office for Civil Rights
OGHA	Office of Global Health Affairs
OIG	Office of Inspector General
OMHA	Office of Medicare Hearings and Appeals
ONC	Office of the National Coordinator for Health Informtion Technology
OS	Office of the Secretary

P

PACE	Program of All-Inclusive Care for the Elderly
PART	Program Assessment Rating Tool
PATH	Projects for Assistance in Transition from Homelessness
PDUFA	Prescription Drug User Fee Act
PHS	Public Health Service
PHSSEF	Public Health and Social Services Emergency Fund
PSC	Program Support Center
PSO	Patient Safety Organization
PSOC	Project Save Our Children
PSSF	Promoting Safe and Stable Families

Q

QIO	Quality Improvement Organization

R

ROI	Return on Investment
RPG	Research Project Grant

S

SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Strategic Acquisition Service
SCHIP	State Children's Health Insurance Program
SHI	School Health Index
SHIP	State Health Insurance Assistance Program
SNS	Strategic National Stockpile
SoW	Scope of Work
SPAP	State Pharmaceutical Assistance Program
SS/HS	Safe Schools/Healthy Students
SSA	Social Security Administration
SSBG	Social Services Block Grant
SSI	Supplemental Security Income
STD	Sexually Transmitted Diseases

T

TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TERRA	TANF Emergency Response and Recovery Act of 2005
TMA	Transitional Medical Assistance
TPLC	Total Product Life Cycle

U

UFMS	Unified Financial Management System

V

VFC	Vaccines for Children