DEPARTMENT OF HEALTH AND HUMAN SERVICES

Since 2001, the Administration:

- Passed comprehensive Medicare reform legislation adding prescription drug coverage for seniors and modernizing the Medicare program;
- Completed doubling the resources for medical research through the National Institutes of Health;
- Acquired more than enough smallpox vaccine for every American for use in an emergency;
- Improved preparedness for a bioterrorist attack, providing nearly $4.5 billion to States, local governments and hospitals;
- Provided access to health care for an additional three million people through 614 new and expanded health center sites;
- Created education and training vouchers for foster care youth, securing funding to provide $5,000 vouchers to 17,400 eligible youth; and
- Provided a $522 million increase in resources to State and local governments and service providers to expand substance abuse treatment capacity throughout the Nation.

The President's Budget:

- Strengthens and improves Medicare, including taking the first steps to implement the new drug benefits that will become available in 2006;
- Makes Medicare-approved prescription drug discount cards available in 2004, along with a $600 subsidy for low-income beneficiaries;
- Supports marriage and healthy family development;
- Continues to aggressively improve bioterrorism preparedness, including a new $130 million initiative to more rapidly detect and characterize a bioterrorist attack;
- Enhances enforcement of Federal regulations to prevent the introduction or spread of Bovine Spongiform Encephalopathy (or mad cow disease);
- Builds on momentum from the doubling of the National Institutes of Health budget to fund new scientific ideas that can lead to treatments and cures for the world's diseases;

- Improves access to childhood immunizations through enhancements in the Vaccines for Children program;
- Helps 1.6 million additional people receive health care through 332 new and expanded health center sites;
- Provides vouchers for substance abuse treatment services to an estimated 100,000 individuals; and
- Leverages the expertise of the Department to successfully implement the President's Emergency Plan for AIDS Relief to combat the spread of HIV/AIDS globally.

Department of Health and Human Services

Tommy G. Thompson, Secretary

www.hhs.gov 202–619–0257

Number of Employees: 67,000

2005 Discretionary Budget Authority: $66.8 billion

Organization: National Institutes of Health, Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, Food and Drug Administration, Indian Health Service, Administration for Children and Families.

2004 Medicare Trust Funds financial assets: $275.9 billion

Secretary Thompson (surrounded by HHS employees) leads the 2nd Annual Older Americans Month Walk on the National Mall.

OVERVIEW

The Department of Health and Human Services (HHS) is the Federal Government's principal agency for protecting the health of all Americans and for providing essential human services. In terms of budget and programs, HHS has become the largest department in the Federal Government, with almost a quarter of total Federal outlays. The Department manages over 230 programs and 60,000 grants, covering a wide spectrum of activities in public health, income support, basic and applied science, and child development. HHS also handles more than a billion Medicare claims per year.

In the 21st Century, HHS has special new responsibilities in protecting Americans from terrorism. Globalization will demand new approaches in many health and social programs. At the same time, the country is at the dawn of an unprecedented growth in the number and proportion of our older Americans as the baby boomers age. These trends are creating new and urgent demands and HHS must adapt. The 2005 Budget recognizes HHS' evolving role and seeks to ensure that its mission is fulfilled.

Implementing Medicare Reform. On December 8, 2003, the President signed historic legislation making available a prescription drug benefit to approximately 41 million Medicare beneficiaries. The Budget enables the Administration to reform and modernize this vital program.

Supporting Marriage and Healthy Family Development. The Budget reflects the President's commitment to healthy families by proposing several initiatives that support marriage, provide tools to parents, and encourage community and faith-based organizations to support families.

Fighting Bioterrorism. The Budget proposes several initiatives to more quickly detect human illness and contamination of the food supply from a terrorist attack, expand the Nation's laboratory capacity to quickly diagnose biological and chemical contaminants in individuals and food, and continue to strengthen the ability of States, localities, and hospitals to respond to crisis.

Ensuring Access to Health Care. Through several Presidential initiatives, the Budget seeks to increase access to needed care. The Budget proposes an increase of $218 million to enable Health Centers to serve 1.6 million additional people, and an estimated 100,000 individuals will receive vouchers for substance abuse treatment services. It also proposes to allow individuals participating in Health Savings Accounts to deduct their premiums and includes a health care tax credit to facilitate purchase of health insurance by low-income individuals and families.

Enhancing Public Health. The Budget will continue to invest in Indian Health Service infrastructure and prevention activities to improve the health status of American Indians and Alaska Natives; provide a $35 million increase to expand access to treatment for those living with HIV/AIDS; increase funding by $81 million to enable more local communities to develop innovative approaches to diabetes, obesity and asthma; work to extend life saving prevention services to underserved populations that are low-income, underinsured, or uninsured through a $10 million increase to breast and cervical cancer screening services; and provide supportive services to the homeless.

HHS PRIORITIES

Medicare

The Medicare Act of 2003 is Consistent with the President's Principles for Strengthening and Improving Medicare, which:

- Give all seniors access to affordable drug coverage;
- Provide low-income seniors extra help in paying for their prescription drug needs;
- Allow seniors who are happy with the current system to stay where they are—and still get prescription drug coverage;
- Modernize Medicare to give seniors more choices and better benefits;
- Update and streamline regulations and administrative procedures while reducing instances of fraud and abuse; and
- Give more access to comprehensive exams, disease screenings, and other preventive care.

On December 8, 2003, the President signed into law the Medicare Prescription Drug, Improvement, and Modernization Act—the most significant improvement in health care coverage for senior citizens and those with disabilities in nearly forty years. This historic legislation makes available

a prescription drug benefit to all 41 million Medicare beneficiaries, helping them afford the cost of their medicines, and offers other significant improvements as well.

This legislation keeps a national promise to help America's seniors and people with disabilities find affordable medical care in the later years of life. President Lyndon Johnson established that commitment by signing the Medicare Act in 1965. And now, by reforming and modernizing this vital program, the Administration is honoring the commitment of Medicare for this generation of seniors, and for all who follow.

Provisions of the Medicare Act

The President signs the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Prescription Drug Discount Card and Transitional Assistance. Beginning this spring, beneficiaries will be able to save 10-25 percent off the cost of most medicines through a Medicare-approved drug discount card. Seniors would be able to choose a card that they may use at a local pharmacy or through the mail and receive the discount. Since the typical senior spends $1,285 annually on his or her medicines, the card could save a senior who lacks drug coverage as much as $300 annually. The card will provide immediate assistance in reducing the cost of prescription drugs until the full drug benefit goes into effect. Beneficiaries with incomes below 135 percent of the Federal poverty level will receive $600 in transitional assistance to help them with the cost of their prescriptions.

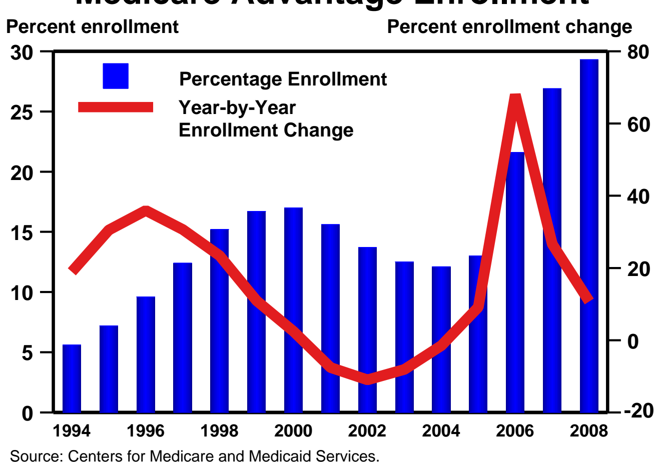
Prescription Drugs. Beginning in 2006, beneficiaries will be able to enroll in the new voluntary drug benefit. Beneficiaries could see their drug spending cut in half under this new benefit. After a $250 deductible, they pay only a 25 percent coinsurance up to $2,250 in spending. In addition, the benefit provides protection against high out-of-pocket prescription drug expenses. A $2, $5, or five-percent coinsurance amount per prescription is all a beneficiary will have to pay once he or she accumulates $3,600 in out-of-pocket prescription spending in 2006. Beneficiaries will still have access to supplemental drug coverage.

Soon, a new Medicare-endorsed prescription drug discount card will be available to Medicare beneficiaries. This symbol means that beneficiaries are assured that cards meet a high standard of quality and customer service.

Beneficiaries will have a choice of Medicare-approved private plans from which to receive their benefit. Plans will receive subsidies from Medicare that will help them keep premiums and cost-sharing low, guard against higher than expected drug costs, and encourage them to participate across the country. There are also additional subsidies that will be paid to employers to preserve retiree health benefits for millions of seniors.

The legislation provides additional coverage for millions of Medicare beneficiaries of limited means and with incomes below 150 percent of poverty. Those beneficiaries with incomes below 135 percent of poverty will pay no monthly premium, no deductible and only $1 to $5 per prescription in cost-sharing. Beneficiaries with incomes between 135 and 150 percent of poverty would pay reduced premiums, a significantly reduced deductible of $50, and cost-sharing of just 15 percent.

More and Better Health Care Choices. Choice is the key to strengthening Medicare. In addition to providing prescription drug coverage, the Medicare Act of 2003 achieves another important goal: to provide seniors and Americans with disabilities with more health care choices so they can get the coverage and health care to meet their needs.



Source: Centers for Medicare and Medicaid Services.

One critical choice seniors will have is not to change their health benefits at all. Beneficiaries who choose to remain in Medicare traditional fee-for-service will be able to do so. For other beneficiaries seeking improved benefits and potentially lower costs, the legislation will expand private health plan choices for seniors in a number of important ways.

Seniors will have the option of joining the types of health plans that so many working Americans enjoy but that have been absent from Medicare until now, such as preferred provider organizations. Specifically, the legislation creates the Medicare Advantage program, which will consist of new regional, and new and expanded local health plans. Like Members of Congress and Federal employees, seniors will be able to choose the type of plan and coverage that works best for them. Medicare Advantage plans can also offer the new drug benefit so seniors can choose to receive fully integrated, modern health coverage from a single plan. HHS estimates that, by 2009, more than 30 percent of Medicare beneficiaries will enroll in Medicare Advantage's private health plans.

These private health plans will offer seniors and beneficiaries with disabilities more choices and additional benefits, such as protection from high medical costs. In addition, the private plans will have to compete for beneficiaries' business, which will lead to higher quality health care and lower costs. The legislation also establishes a demonstration of competition between traditional Medicare fee-for-service and private health plans beginning in 2010, while incorporating protections for beneficiaries.

New Preventive Benefits. As of 2005, Medicare will cover a physical exam for new enrollees. For all beneficiaries, cardiovascular screening, blood tests, and diabetes screenings will also be covered.

Strengthening Medicare's Long-Term Financial Security. For the first time ever, the Medicare Act of 2003 creates a new fiscal analysis requirement, the Combined Medicare Trust Fund Analysis, to help policymakers address the future of Medicare's finances. This new fiscal safeguard will put the program on a stronger financial foundation by alerting the President and the Congress when Medicare's dedicated revenues fall below adequate levels.

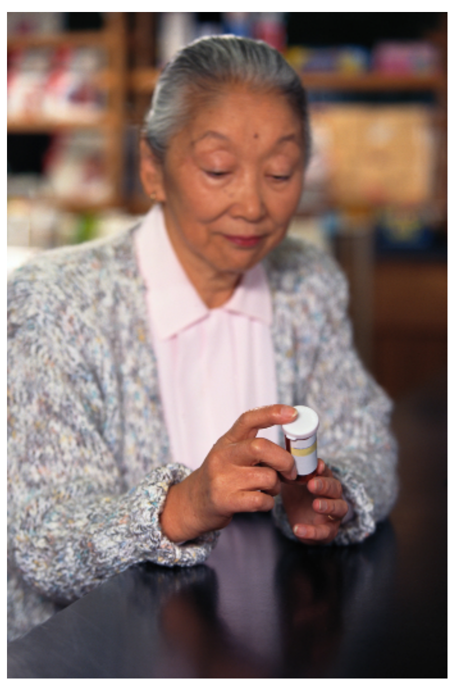
The Combined Medicare Trust Fund Analysis will require a comprehensive analysis of the expenditures and dedicated revenues of both the Hospital Insurance and Supplementary Medical Insurance Trust Funds, providing a complete picture of the financing and commitments of the Trust Funds. The Act requires the Medicare Trustees to issue a warning if dedicated revenues are projected to fall below adequate levels. The President may submit corrective legislation. The Act also allows the Congress to follow expedited procedures for the consideration of legislation to address the Medicare Trustees' warnings. This new process encourages the President and the Congress to take action before dedicated revenues fall below sufficient levels.

Premiums. Under the Act, Federal Medicare subsidies will be better targeted to those individuals who need them the most. Starting in 2007, the Federal subsidy for Medicare Part B premiums will

be smaller for high-income beneficiaries who need less assistance. This will help strategically target Federal funds, and make a wider range of benefits available to more beneficiaries.

Administrative Improvements. The legislation provides regulatory relief so providers can focus on patient care, not burdensome paperwork. HHS will undertake new efforts to help providers and beneficiaries understand Medicare regulations. The Act establishes a Medicare ombudsman to assist beneficiaries who have complaints or need information, and expands efforts to educate Medicare providers about program rules. This overdue regulatory relief will ease the burden on providers and beneficiaries.

Fraud and Abuse. Several measures are included in the Act to combat Medicare waste, fraud, and abuse. For far too long, the prices that Medicare pays for many covered drugs and medical supplies have been higher than those paid by private insurers, other Federal programs, and even individual consumers. The Act establishes new mechanisms that will base Medicare payments for drugs and medical supplies on market prices rather than on antiquated and inflated list prices. The legislation will also help Medicare recover money paid for services and supplies that should have been paid by another party.



A senior examines her prescription drug bottle.

Medicare Providers and Rural Health. The Act increases funding to providers, particularly those in rural areas. This includes payment increases to hospitals, physicians, ambulance services, skilled nursing facilities, and home health agencies that serve rural areas. The legislation increases payments to certain urban providers as well. These payment increases will ensure that beneficiaries can continue to find a Medicare provider wherever and whenever they need care. The Budget builds on the provisions of the legislation and places a priority on Health Centers. Over 50 percent of Health Centers are in rural areas and over 6.5 million of the more than 15 million total health center patients will be served in rural Health Centers in 2005.

Medicare Appeals. The Budget supports reforms put forth in the Medicare Act of 2003 that will make the Medicare appeals process more efficient and effective. The adjudicative function currently performed by Administrative Law Judges at the Social Security Administration will begin to be transferred to HHS. As a result, the judges that adjudicate Medicare appeals will be able to develop greater Medicare expertise and specialization while maintaining the independence from the program that assures a fair review. Also, the Centers for Medicare and Medicaid Services (CMS) will be implementing new mechanisms to reduce the time it takes to process beneficiary and provider appeals.

Medicare Management Reform. The President's Principles for Medicare recognized that a modernized Medicare would require new management practices, and strongly supported the inclusion of management reforms in the Medicare Act of 2003. The Act includes several improvements that will allow HHS to better administer the Medicare program. For example, the legislation provides for a new center within CMS to administer the prescription drug benefit and Medicare Advantage programs. This new center will lead efforts to offer beneficiaries more choices and better benefits through private plans. In addition, the Act addressed some of the management deficiencies noted in the President's Principles. For example, HHS will no longer be limited to only contracting with certain insurance companies for administrative services, and will have the flexibility to contract with the full range of businesses that have health administration expertise. The legislation also provides

the authority for competitively awarded contracts that hold Medicare's contractors accountable for the service they provide to Medicare beneficiaries and providers. Successful implementation of these enhancements will improve program effectiveness and result in better service for Medicare beneficiaries and providers.

Medicare and Medicaid Estimates. Historically, HHS and the Congressional Budget Office (CBO) have provided differing estimates of Medicare and Medicaid spending. It is not uncommon for different assumptions underlying the respective estimates to produce differences in cost projections. This happened in Medicare cost projections in 2002. This year, there are new estimates for these programs. These estimates include the changes resulting from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

When Congress considered this act, CBO estimated the cost of the bill at $395 billion from 2004 to 2013. The Medicare actuaries have recently estimated the cost of the law at $534 billion from 2004 to 2013. Because the Medicare legislation makes far-reaching changes to a complex entitlement program with many new private-sector elements, there is even larger uncertainty in these estimates than usual.

These estimates provide a reasonable range of possible future cost scenarios for Medicare spending. The tremendous uncertainty surrounding estimates of the newly-enacted Medicare law has resulted in a plausible range of estimates of future spending, from the $395 billion estimate from CBO to the $534 billion estimate from the Medicare actuaries. It should be noted that this difference of $139 billion is approximately 2.1 percent of the projected $6.5 trillion in total Federal Medicare and Medicaid spending over the same period, as projected by HHS.

The largest portion of the difference in these cost estimates is attributable to assumptions regarding beneficiary participation, market behavior, and cost growth rates. Even small differences in these assumptions can dramatically change the overall cost estimates. For example, CBO and the Medicare actuaries both assume comparable savings from private-plan management of the drug benefit. CBO, however, assumes that these savings will be realized earlier; the Medicare actuaries assume that it will take longer for plans to achieve maximum savings.

The Administration and the Medicare Trustees have traditionally relied on the estimates of the Medicare actuaries, so the President's 2005 Budget incorporates these higher estimates into its calculation of budgetary totals. Because of the uncertainties involved, as well as the disparity between CBO and HHS estimates, and because CBO and HHS have not yet had ample opportunity to attempt to reconcile their differences, this Budget also includes summary calculations that reflect the lower CBO estimates (see Table S-13).

The Administration will work with CBO to better understand the technical differences between the respective cost estimates and will refine the estimates as appropriate.

Marriage and Healthy Family Development

Research has shown the life-long benefits of growing up in married-parent families. Building and preserving families is not always possible, particularly in violent or destructive situations, but it should always be the goal. The Administration's initiatives to promote marriage and healthy family development have four elements: 1) supporting marriage and families; 2) providing tools to parents; 3) teaching values to children; and 4) encouraging community and faith-based organizations to support families.

Supporting Healthy Marriages. The Budget proposes a State-based competitive matching grant program to support healthy marriages. A limited number of States, territories, and tribal organizations would receive funds to develop innovative approaches to promoting healthy marriage and

reducing out-of-wedlock births. Including a dollar-for-dollar State match, the total available funding for this effort would be $240 million annually. Funds largely would be redirected from the High Performance Bonus in the Temporary Assistance for Needy Families (TANF) program to create this new program.

In addition, the Budget includes a $120 million annual fund to conduct research and demonstration projects, and to provide technical assistance primarily focusing on family formation and healthy marriage activities. This provision would be principally funded by eliminating the Illegitimacy Reduction Bonus in the TANF program. These funds can be more effectively spent on developing innovative approaches to supporting family formation and healthy marriages.

Parent-Mentor Early Education Initiative. Head Start has a long history of parent involvement. This initiative would build on that legacy by offering training for between 2,000 and 3,000 Head Start parents in a science-based curriculum designed to improve early language and literacy skill outcomes. This cadre of parent-mentors would then train tens of thousands of Head Start parents throughout the country. The initiative would support the goal of increasing school readiness, at a cost of at least $3 million, which would be financed from existing Head Start funding.

Promoting Responsible Fatherhood and Marriage. With over 25 million children living in homes without fathers, the Administration seeks to promote responsible fatherhood and marriage by providing $50 million to assist non-custodial fathers in becoming more involved in their children's lives.

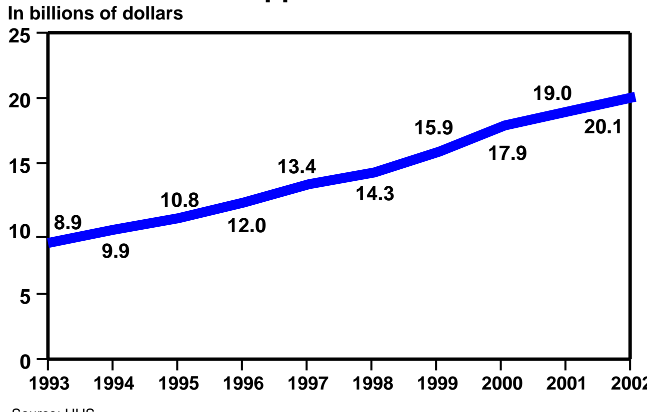
Supporting the Recruitment of Foster and Adoptive Parents. The President's Budget calls for the recruitment of 35,000 new foster and adoptive parents in five years. This goal will help thousands of the most vulnerable children find the benefits of a permanent and loving family, and thus improve their chances for success later in life. By meeting this goal, the number of children in institutional, group, or multi-child settings will be significantly reduced. To support a call for more foster and adoptive parents, HHS will launch a public service campaign in the spring of 2004.

Responsible Choices. The consequences of teenage sexual activity and non-marital childbearing are many and serious for teens, their families, their communities, and society. Over three-fifths of teen mothers live in poverty at the time of their child's birth, and over four-fifths eventually live below poverty. There are substantial disparities in the educational attainment of teen mothers compared to young women who delay sexual activity. Equally important are the physical consequences. Each year, there are 15 million new sexually transmitted disease cases in the United States and one-quarter of them are teenagers.

Abstinence Education grants provide support to communities and States to develop, implement, and evaluate programs for 12 to 18 year olds that promote abstinence and encourage youth to make responsible and healthy choices. In addition, grants financed through these activities also advance parent education and outreach, media campaigns, and research related to abstinence education.

To further the commitment to these activities, to ensure teens have a forum where they can be supported in their decision to abstain, and to provide parents with the tools they need to talk to their children about responsible choices, the Budget doubles the President's financial commitment to $270 million.

Expanding Child Support Enforcement. The Child Support Enforcement (CSE) program is designed to help low-income and vulnerable families with children become self-sufficient by obtaining support from the children's non-custodial parents. As the accompanying chart and Program Assessment Rating Tool (PART) demonstrate, the CSE program is making improvements in distributing collections to families, in addition to meeting other goals, such as collecting current and past-due



support and establishing support orders. To further increase the Government's ability to collect child support more effectively, the Administration continues to propose the child support provisions included in the President's 2003 and 2004 Budgets. The Budget also includes new proposals to improve the establishment of medical support for the children without health insurance in the CSE system.

Preventing and Treating Child Abuse. The President's 2005 Budget includes a $52 million increase for child abuse prevention through the Child Abuse Prevention and Treatment Act (CAPTA) State Grants and the Community-Based Child Abuse Prevention (CBCAP) program. This increase will support new mandates in CAPTA, recently reauthorized as the Keeping Children and Families Safe Act of 2003. With this increase in funding, States will be able to reach more children and families with prevention services rather than screening out all but the most at risk. In fact, State child protective service systems will be able to decrease the average time to service provision from 48 to 30 days. This funding increase will also allow an additional 55,000 families to receive CBCAP services.

Community-Based Child Abuse Prevention (CBCAP)

In Arizona, CBCAP helps support the Healthy Families Arizona (HFA) program, which is a nationally recognized home visiting program designed to assist new parents with multiple stressors in their lives. HFA provides services to enhance parent/child interaction, promote healthy child growth and development, and prevent child abuse and neglect. In New Mexico, CBCAP helps support the Statewide Graduation, Reality and Dual-role Skills (GRADS) program, which is currently operating in 36 local school districts throughout the State. The GRADS projects are designed to assist pregnant or parenting students, male or female, to remain in school through graduation, receive early prenatal care, deliver normal weight babies, and develop positive parenting skills.

Bovine Spongiform Encephalopathy Prevention

On December 23, 2003, the Department of Agriculture (USDA) announced the discovery of a single cow in the United States infected with Bovine Spongiform Encephalopathy (BSE), commonly known as mad cow disease. There is strong evidence that indicates the cow was imported into the United States. The Food and Drug Administration (FDA) is working aggressively with USDA to prevent the spread of BSE in the United States (see USDA chapter for additional discussion). The Budget includes an additional $8.3 million, or nearly 40-percent increase, at the FDA to enhance enforcement of Federal regulations to prevent the introduction or spread of BSE. These regulations have been credited as a key factor in the Nation's ability to prevent the introduction or spread of BSE in the United States. The additional funding will help ensure that animal feed fed to cows is free of materials believed to be the primary sources of cattle-to-cattle spread of the infectious BSE agent.

National Institutes of Health

Last February, during a visit to the National Institutes of Health (NIH) in Bethesda, Maryland, President Bush praised NIH as a center of excellence and a center of the brilliance of the American people. The President fulfilled his commitment to double the NIH Budget by 2003, so that NIH could make every effort to fulfill its scientific mission of improving the health and well being of the American people. Over the course of this doubling, the dedicated and talented scientists and researchers funded by NIH have made numerous notable discoveries towards treatments or cures to the diseases that plague our Nation and our world. Four new antiretroviral drugs were licensed in 2003 by FDA, bringing new hope to individuals who may have exhausted other HIV/AIDS treatment options. Other novel approaches to HIV prevention are being studied and validated, and the number of HIV vaccines in development and testing is greater than ever before. In the 1990s, death rates from the four most common cancers—lung, breast, prostate, and colorectal—continued to decline. Among the many fruits of NIH research are: a promising drug that could slow the functional decline in Parkinson's disease; a new, quick, and accurate assessment of heart disease risk; a new tool to fight kidney disease in African Americans; and a safe and inexpensive treatment for blood clots. Through unprecedented growth in knowledge, technology, and resources, NIH is committed to accelerating these trends through the discovery, development, and delivery of effective interventions.

Roadmap for Medical Research—Accelerating Progress

The five-year doubling of the National Institutes of Health (NIH) budget, completed in 2003, accelerated the pace of scientific discovery and heightened public expectations. NIH, led by Director Elias Zerhouni, M.D., is carefully charting a new roadmap for NIH research that will speed research discoveries from the bench to the bedside. The Roadmap highlights the most compelling scientific initiatives that NIH will pursue over the next 10 years, which will have the most profound impact on the progress of medical research in the United States and worldwide. The initiative centers around three themes—New Pathways to Discovery, Research Teams of the Future, and Reengineering Clinical Research.

The Roadmap will:

- Allow NIH to better understand complex biological systems through new technologies, databases, and other resources;
- Encourage interdisciplinary research that is creative, unexplored, and high-risk and that possesses a greater chance for groundbreaking discovery; and
- Develop new partnerships among organized patient communities, community-based physicians, and academic researchers so that basic research discoveries can be quickly transformed into diagnostics, drugs, treatments, or prevention methods.

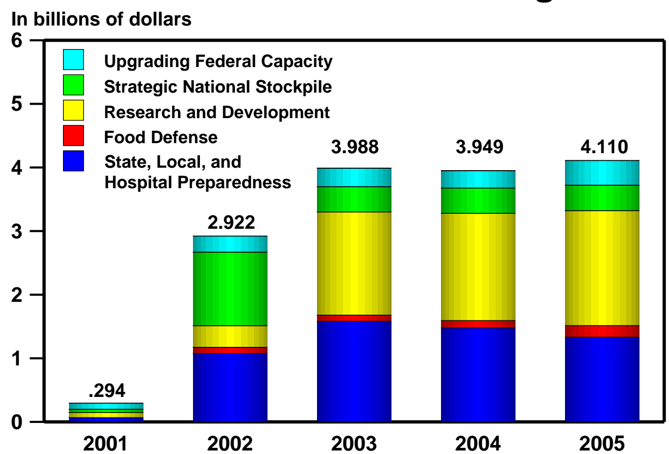
As NIH ushers in the next century of biomedical research, it is beginning to transform our medical research capabilities and speed the movement of research discoveries from the bench to the bedside. The NIH Roadmap, initiated in 2003, provides a framework for the strategic investments that NIH needs to make to optimize its entire research portfolio by charting new pathways to discovery, designing research teams of the future, and re-engineering the clinical research enterprise. In 2005, NIH will begin to fully implement Roadmap initiatives that will foster interdisciplinary scientific teams; public-private partnerships; shared resources; high-risk, high-payoff research that will encourage innovation and breakthroughs; and integrated clinical research networks.

NIH is one of 12 major research and development (R&D) agencies that plan, manage, and assess their R&D programs consistent with the R&D investment criteria developed by the Administration, which are discussed in detail in the chapter on R&D in the *Analytical Perspectives* volume. Consistent with the R&D criteria, the two-tiered NIH peer review system ensures that only the most relevant and high-quality proposals are funded.

Since NIH is a public institution, the mission of NIH includes not only fostering the highest scientific achievement possible, but also doing so in a way that is accountable to the taxpayers. The doubling of NIH's budget has yielded the world's largest investment in biomedical research, which demands responsible stewardship and dedication to scientific progress. Management changes, including fully funding research project grants, are underway to ensure NIH has the flexibility to respond to the world's complex biomedical research problems and also financially and administratively prepare for the future.

Bioterrorism

Enhancing Biosurveillance. Unlike conventional attacks, the intentional use of biological weapons may not be immediately apparent. Reducing the time it takes to detect an attack can save many lives. The Budget includes a biosurveillance initiative to provide earlier indication that an attack has occurred and to improve the ability to determine accurately its size and scope. This initiative will improve surveillance capacity in the areas of human health, food supply, and environmental monitoring, and will improve integration and analysis of this information at local, State, and national levels, including a new capacity for the integration and analysis of this improved information.



The Department of Homeland Security, HHS, and USDA will participate in this effort. It will be the responsibility of HHS to enhance the surveillance of human illness to detect and respond to an attack. The Budget includes $130 million for three specific improvements in this area. First, improved monitoring of public health data could give an early indication of problems occurring in the general population. For example, synthesizing information from nurse call lines, over the counter drug sales, and selected laboratory tests may provide an emerging picture of an attack before a large number of actual cases arrive in emergency rooms. Second, funding is proposed to improve the capacity of the Nation's laboratory network to diagnose biological and chemical samples, and to advance linkages between public health and commercial laboratories. Third, the Budget supports expanding from 8 to 25 the number of border health and quarantine stations in selected ports of entry to augment the ability to detect and deal with cases of infectious disease as they enter this country.

Defending the Nation's Food Supply. The Budget includes an increase of $65 million for FDA to improve the protection of the Nation's food supply from intentional or natural contamination. FDA will enhance surveillance of the food supply to identify potential outbreaks or attacks as early as possible. FDA will conduct research to develop strategies to prevent and mitigate food contamination, as well as develop testing methods to identify the presence of contamination quickly and accurately. The Nation's food laboratory network will be expanded to allow for more rapid analysis of food samples to assist in the identification of potential outbreaks or attacks. Each of these food defense activities

will be coordinated with USDA, which will receive an increase of $302 million in 2005 to protect the food and agriculture supply from terrorist attacks.

Building the Strategic National Stockpile. The Strategic National Stockpile contains drugs, vaccines, and other medical supplies and equipment that can be delivered to anywhere in the country within 12 hours of a request for assistance. The Administration proposes to transfer funding for the Stockpile from the Department of Homeland Security to HHS to take full advantage of its medical and scientific expertise. The Stockpile contains enough smallpox vaccine for every American, treatments for anthrax, and countermeasures and treatments for injuries following a chemical attack or explosion. During 2003, the Stockpile was expanded to include burn and blast, radiological, and enhanced pediatric treatment capabilities, and the ability of State and local entities to respond to a nerve agent attack by initiating the Chempack program. The 2005 Budget includes authority to increase funding to augment the supply of antibiotics to protect the public against anthrax exposure.

Strengthening State, Local, and Hospital Preparedness. Nearly $4.5 billion has been provided to bolster State, local, and hospital biodefense preparedness since September 11, 2001. The Budget continues support for these investments by proposing an additional $1.3 billion in 2005, bringing the total to $5.8 billion. Equally important as this continued financial support are the steps being taken to ensure that we can tell what preparedness improvements have been made, and where vulnerabilities remain so that they can be targeted with these continued investments. HHS is engaged with State and local partners to establish performance indicators and standards and reassess the distribution of funds, to ensure that these investments are properly directed. HHS is also working with the Department of Homeland Security and other Federal departments and agencies in a coordinated effort to develop a national preparedness goal and related metrics that will help assess the Nation's readiness and determine preparedness assistance needs. These steps will help maximize the effect of each dollar toward reducing our actual vulnerabilities to potential attacks.

Presidential Initiatives

Health Centers. Health Centers deliver high-quality, affordable health care to over 13 million patients at 3,600 sites across the United States. Health Centers serve individuals that live in underserved and rural areas and their clients include low income individuals, migrant farm workers, homeless individuals, school children, individuals in need of drug and alcohol treatment, and HIV/AIDS infected individuals. In many areas, Health Centers are the only primary care facilities readily available. Locally managed Health Centers offer services that are responsive to the unique needs of their communities.

The Number of Health Centers Patients Has Increased

Millions of patients

2001	2002	2003	2004	2005
10.5	11.3	12.5	13.2	14.8

Source: Department of Health and Human Services.

The President's Health Centers Initiative is creating 1,200 new and expanded health center sites to serve an additional 6.1 million people by 2006. The Budget would help more than 1.6 million additional low-income individuals receive health care in 2005 through 332 new and expanded sites in rural areas and underserved urban neighborhoods.

Access to Quality Substance Abuse Treatment. Nearly 12 million Americans reported an addiction to drugs or alcohol in 2002. The Budget continues the Administration's commitment to give individuals in search of substance abuse treatment greater choices to achieve personal recovery. This initiative includes the second year of the Access to Recovery program, which makes grants to States

to provide vouchers to individuals for substance abuse treatment. As discussed in the Faith-Based and Community Initiative section, Access to Recovery will provide $200 million to enable 100,000 new individuals to obtain substance abuse treatment services, including from faith- and community-based treatment providers.

Health Care Information Technology. The Administration will work with those involved in health care information technology to advance the effort to translate information technology opportunities into higher quality, safer and more efficient health care for all Americans.

In support of this effort, the Budget proposes $50 million in new funding to support State or regional demonstration grants to test the feasibility of information exchange among health care settings and to fund other innovative information technology projects that improve health care quality.

These efforts will also help to accelerate public-private efforts to adopt health data standards begun under the President's Consolidated Health Informatics initiative, to set uniform standards for the exchange of clinical health information within the Federal Government. In 2003, standards in 5 of 24 health data domains were endorsed, addressing areas such as laboratory test results and retail pharmacy transactions.

In addition, the Budget continues the President's commitment to improve the quality of care and patient safety in all health care settings by proposing $84 million in the Agency for Healthcare Research and Quality. Within this total, $50 million will fund grants to continue efforts to promote, accelerate, and demonstrate the development and adoption of information technology, including in small and rural communities where health information technology penetration has been low.

Global AIDS. The Centers for Disease Control and Prevention (CDC) is working in 25 countries in Africa, Asia, Latin America, and the Caribbean to combat the spread of HIV/AIDS and improve treatment and care. The President's Global AIDS Coordinator will rely on CDC to play a key role in implementing the President's Emergency Plan for AIDS Relief in collaboration with the U.S. Agency for International Development and other public and private partners. Over the last year, the Administration successfully launched the President's Mother and Child HIV Prevention Initiative to reach one million women annually and cut the transmission of HIV from mother to child by 40 percent within five years. The Budget builds on these and other successes to rapidly and effectively bring help to those in need and meet the President's goals to prevent seven million new HIV infections, treat at least two million HIV-infected people, and provide care for at least 10 million people, including orphans, affected by HIV/AIDS.

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

White House Faith-Based and Community Initiatives

We ought not to fear faith, we ought not to discriminate against faith-based programs. We ought to welcome what I call neighborhood healers in the compassionate delivery of help so that people can experience the greatness of our country.

President George W. Bush
July 2003

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

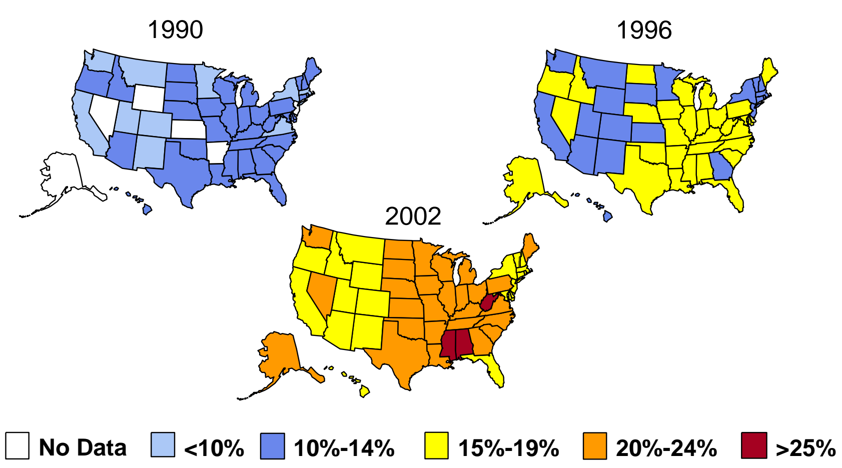
Overall, the White House Office of Faith-Based and Community Initiatives focuses its efforts on the following populations—at-risk youth, ex-offenders, the homeless, the hungry, substance abusers, those with HIV/AIDS, and welfare-to-work families. The Budget funds five competitive grant programs targeted at faith- and community-based organizations that can provide innovative services at the grassroots level.

The President signs an executive order for equal protection of the law for faith-based and community organizations.

- *Compassion Capital Fund.* To build on the efforts of community-based, charitable organizations, the President's 2005 Budget continues funding for social services provided by faith-based and community organizations with $100 million for the Compassion Capital Fund. This initiative provides funds to public/private partnerships to support charitable organizations in expanding or emulating model social service programs. These capacity-building entities are responsible for obtaining private matching funds as well as assisting the faith-based and community organizations in seeking private funds. In 2003, HHS awarded 60 new grants totaling $8.1 million to these organizations to help expand and strengthen their ability to provide social services to those in need, and approximately $24 million to support 21 continuing grants.
- *Mentoring Children of Prisoners.* As a group, the more than two million children with parents in prison have more behavioral, health, and educational problems than the population at large. Mentoring by caring adults can brighten the outlook for these children. In 2003, HHS awarded nearly $9 million in grants to 52 organizations to train adult volunteers as mentors to children whose parents are incarcerated. The Budget includes $50 million for competitive grants for this purpose.
- *Maternity Group Homes.* The Administration also proposes $10 million to increase support to community-based maternity group homes by providing young, pregnant, and parenting women with access to community-based coordinated services.
- *Access to Recovery.* The Budget continues the Access to Recovery initiative, which includes $200 million to provide vouchers for substance abuse treatment to 100,000 new individuals in need. Access to Recovery will increase substance abuse treatment capacity and give thousands of Americans in search of care greater choices and access to treatment. This recognizes the power of recovery that faith- and community-based programs can have. Individuals who receive vouchers will have the choice to select the programs and providers that will help them the most to achieve recovery, including community- and faith-based providers.

Diabetes, Obesity and Asthma. The Administration successfully launched the STEPS to a HealthierUS initiative in 2003 to give local communities the tools they need to address diabetes, obesity and asthma. According to CDC's National Health and Nutrition Examination Survey, nearly one of every three adults is obese and nearly 15 percent of young people are now overweight. CDC estimates that one in every three children born in 2000 could develop

The Prevalence of Obesity* is on the Rise...



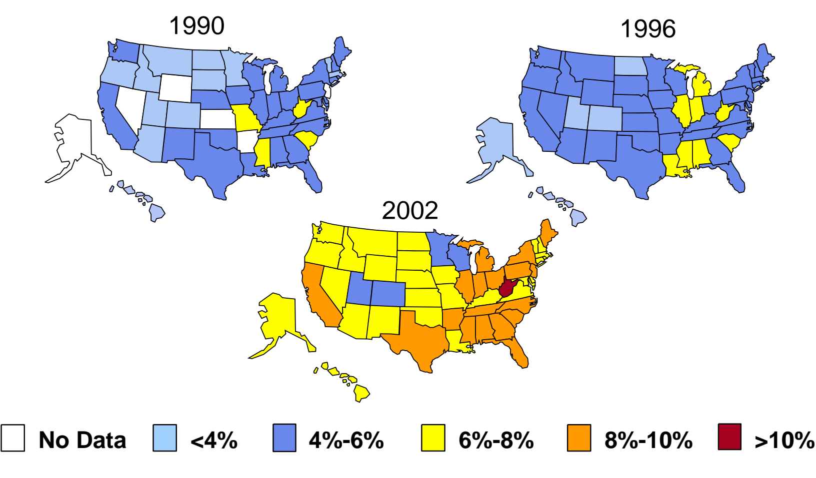
*Approximately 30 pounds overweight
Source: Behavioral Risk Factor Surveillance System, CDC.

diabetes over their lifetime, if the Nation's diet and physical activity patterns do not improve. An estimated 20 million Americans have asthma and 12 million report having an asthma attack in the last year. Lack of physical activity, poor diet, and tobacco use are key risk factors for these and other chronic conditions and diseases.

The Budget includes $125 million to provide funding and model programs to State and local partnerships to encourage healthy behaviors among target populations. STEPS will challenge these community coalitions to make real what researchers have long been telling us—increasing physical activity and improving nutrition, quitting smoking, and improving disease management can help prevent these conditions and their consequences.

Transformation of Mental Health Care in America. Mental illness is the leading cause of disability in the western world. Between five and seven percent of American adults suffer from serious mental illness. Suicide takes the lives of nearly 30,000 Americans every year. The societal cost of mental illness in the United States, including lost productivity, is estimated at $79 billion each year.

...Rates of Diabetes are also Increasing.



Includes Gestational Diabetes
Source: Behavioral Risk Factor Surveillance System, CDC.

In April 2002, the President created the New Freedom Commission on Mental Health to examine the mental health service delivery system and make recommendations to enable individuals who suffer from mental illness to recover and fully participate in their communities. The Commission found that many barriers impede care for people with mental illnesses, often leading to unnecessary and costly disability, homelessness, school failure, and incarceration. In response to the Commission's findings, the Substance Abuse and Mental Health Services Administration will provide grants to approximately 14 State governors' offices for the development of comprehensive State mental health plans that span the multiple service systems and State agencies involved in meeting the complex needs of people with mental illness. These grants will improve the mental

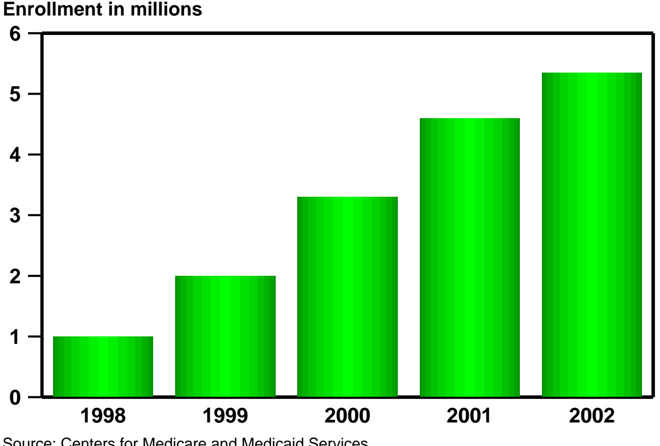
> *Mental disability is not a scandal; it is an illness. And like physical illness, it is treatable, especially when the treatment comes early.*
>
> President George W. Bush
> April 2002

health care delivery infrastructure and hold States accountable for making sure consumers achieve positive outcomes.

Medicaid and the State Children's Health Insurance Program Overview

Medicaid. Close to 42 million individuals were enrolled in Medicaid in 2003. Medicaid covers approximately one-fourth of the Nation's children and is the largest single purchaser of maternity care and nursing home/long-term care services in the United States. In 2003, the elderly and those with disabilities represented approximately 30 percent of Medicaid beneficiaries but accounted for two-thirds of its spending. Total Medicaid spending will be an estimated $322 billion ($182 billion Federal share) in 2005.

State Children's Health Insurance Program (SCHIP). SCHIP was established in 1997 to make available approximately $40 billion over 10 years for States to provide health care coverage to low-income, uninsured children. SCHIP gives States broad flexibility in program design while protecting beneficiaries through Federal standards. Since the beginning of the Administration, enrollment in SCHIP has grown by over 1 million children, to approximately 5.3 million in 2002.



Source: Centers for Medicare and Medicaid Services.

The SCHIP redistribution law (P.L 108–74), signed by the President in August 2003, prevented over $2 billion in unspent SCHIP funds from expiring and helped alleviate the effect of declining SCHIP funding allocations between 2002 and 2004 for States ramping up their programs. This law will allow States to continue coverage for children who are currently enrolled.

Medicaid and SCHIP Modernization. Over the past year, the Administration has held productive discussions with stakeholders on ways to modernize the Medicaid and SCHIP programs based on an Administration proposal included in the 2004 Budget. A common complaint among States is that the complex array of Medicaid laws, regulations, and administrative guidance is confusing, overly burdensome, and serves to stifle State innovation and flexibility. The creation of the SCHIP program created new opportunities for States, but because rules governing Medicaid and SCHIP differ in significant respects, coordination of the two programs has proven difficult. As a result, States frequently request waivers to tailor their Medicaid and SCHIP programs to their specific insurance markets or to expand eligibility to the uninsured beyond mandatory groups.

A mother accompanies her daughter to a doctor's visit.

States' years of experience with implementing home- and community-based waiver programs, waiver programs to extend Medicaid coverage to higher income and non-traditional populations, and the SCHIP program provide States with a wealth of knowledge and a multitude of strategies to design more efficient and effective programs. Further, in August 2001, the Administration introduced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. Eight States currently have HIFA waivers. Approximately 175,000 people are currently covered under these waivers with another 585,000 people anticipated to be enrolled. These experiences give States knowledge of the flexibility they need to design tailored, innovative approaches to increase access to health insurance coverage for the uninsured. The Administration remains committed to enacting legislation, which will reform Medicaid and SCHIP to give States as much flexibility as possible with predictable financing.

As with last year, all Medicaid and SCHIP funding would be combined and provided to States selecting this option. The allotment option requires States to provide a specified benefit package for current Medicaid beneficiaries whose coverage is mandated by law.

Medicaid and SCHIP Program Integrity. One of the Administration's continuing priorities for Medicaid and SCHIP is ensuring their fiscal integrity. The 2005 Budget proposes to build on past efforts to improve Federal oversight of these programs and to ensure that Federal taxpayer dollars for Medicaid are going to their intended purpose.

- *Financial Management.* In 2005, HHS will continue to devote more resources to Medicaid and SCHIP financial management. This effort will include increasing the number of audits and evaluations of State Medicaid programs, measuring improper payments, and elevating the importance of financial management oversight at CMS. The Budget proposes to allocate $20 million from the Health Care Fraud and Abuse Control program to help finance this initiative.
- *Intergovernmental Transfers and Upper Payment Limits.* Medicaid's open-ended financing structure encourages efforts to draw down Federal matching funds in any way possible, some of which are not appropriate. These financing practices undermine the Federal-State partnership and jeopardize the financial stability of the Medicaid program.

In 2001 and 2002, the Congress and the Administration took steps to curb the "upper payment limit" loophole. Through this loophole, States made excessive Federal Medicaid payments to local government-owned hospitals and nursing homes without a corresponding State contribution. In many cases, the providers returned all or a portion of the payments to the State via an intergovernmental transfer (IGT). IGTs are money transfers from one level of government to another; for example, from a county hospital to a State government. Once the funds are returned to the State they may be used for other purposes, such as paying for non-Medicaid or even non-health related activities.

The Administration proposes to further improve the integrity of the Medicaid matching rate system by proposing steps to curb IGTs that are in place solely to avoid the legally-determined State financing.

The Administration also proposes to cap Medicaid payments to individual government providers to no more than the cost of providing services to Medicaid beneficiaries. Under current law and regulation, States continue to have ample opportunities to make excessive payments to individual government providers far above their costs for the purpose of leveraging additional Federal dollars.

Limiting Federal reimbursement to no more than cost would curb excessive payments and still preserve a State's ability to pay reasonable rates to such providers. These actions would help promote fiscal integrity and ensure that Federal taxpayer dollars are being used appropriately to serve the important mission of Medicaid.

Improving Options for People with Disabilities and Long-Term Care Needs. The Budget includes several policies that promote home- and community-based care options for people with disabilities and appropriate planning for an individual's long-term care needs. Many of these policies build on the New Freedom Initiative announced by the President on February 1, 2001. The New Freedom Initiative is part of a nationwide effort to integrate people with disabilities more fully into society.

In July 2003, the Administration submitted the New Freedom Initiative Medicaid Demonstrations Act of 2003 legislation.

A senior goes for a walk.

- *New Freedom Initiative.* This initiative comprises four demonstrations to promote home- and community-based care for children and adults with disabilities. Two of the demonstrations provide respite care for caregivers of disabled children and adults. The third demonstration will test the effectiveness of providing home- and community-based alternatives to psychiatric residential treatment for children enrolled in Medicaid. The fourth demonstration will continue to test ways to alleviate workforce shortages of direct care workers in the community.
- *"Money Follows the Individual" Rebalancing Demonstration.* This five-year demonstration would finance Medicaid services for individuals who transition from institutions to the community. Federal grant funds would pay the full cost of home- and community-based waiver services for one year, after which the participating States would agree to continue care at the regular Medicaid matching rate.
- *Protecting Medicaid Coverage for Spouses of Certain Workers with Disabilities.* States would be given the option to continue Medicaid eligibility for the spouses of individuals with disabilities who return to work. Under current law, individuals with disabilities might be discouraged from returning to work because the income they earn could jeopardize their spouse's Medicaid eligibility. This proposal would extend to spouses the same Medicaid coverage protection offered to workers with disabilities.
- *Presumptive Eligibility for Home and Community Based Care Services.* This proposal establishes a State option allowing Medicaid presumptive eligibility for institutionally qualified individuals who are discharged from hospitals into the community.
- *Systems Change Grants.* The Budget proposes $40 million to continue the Real Choice Systems Change grants to provide financial assistance for States to develop systems that support community-based care alternatives for people with disabilities who require an institutional level of care.
- *Consumer Direction.* In addition to the above proposals, the Budget includes a new proposal that would give States the option of allowing individuals who self-direct all of their community-based long-term care services to accumulate savings and still retain eligibility for Medicaid and Supplemental Security Income (SSI). Under current law, beneficiaries are discouraged from accumulating savings because it could jeopardize their eligibility for Medicaid or SSI.

- *Long-Term Care Options.* The Budget would promote the use of long term care (LTC) insurance by eliminating the ban on LTC Partnership programs. Through Partnership programs, consumers who purchase and use Partnership-approved insurance can become eligible for Medicaid services after their insurance coverage is exhausted without having to divest all of their assets, as is typically required.

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

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

  The Budget proposes to extend TMA for five years with statutory modifications, including a State option to eliminate TMA reporting requirements and provide 12 months of continuous eligibility regardless of changes in families' financial status. In addition, the Budget proposes a waiver of the TMA requirement for States that currently provide health benefits for families at 185 percent of the Federal poverty level, which is the statutorily mandated income eligibility level. These changes will allow for consistent enrollment of TMA beneficiaries while easing the administrative burden on States.

- *Premium Assistance for Low-income Medicare Beneficiaries.* Medicare beneficiaries whose income falls between 120 and 135 percent of poverty and who meet the asset test are eligible to have their Part B premiums covered by the Medicaid program. These premiums rose by 13.5 percent in 2004, to $800 per year ($66.60 per month), a considerable amount for these individuals. The Administration proposes to extend this program for one year. States receive 100 percent Federal funding for these benefits.

- *Vaccines for Children (VFC).* The VFC program provides free vaccine to four groups of categorically-eligible children: Medicaid recipients, American Indians and Native Alaskans, the uninsured, and the underinsured (those whose insurance does not cover vaccinations). VFC covers all childhood vaccinations recommended by the Advisory Committee on Immunization Practices.

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

A young child waits for her vaccination shot.

Helping the Uninsured

The Administration has worked to give more Americans affordable, high-quality insurance coverage through a number of proposals.

Health Savings Accounts (HSAs). When the President signed the Medicare reform legislation into law, Americans gained access to health savings accounts. HSAs allow individuals to buy less expensive high-deductible plans and to save pre-tax dollars for out-of-pocket medical expenses. In addition to these savings, under a new Administration proposal, individuals participating in HSAs would be allowed to deduct their premiums for the high-deductible insurance plan from their taxable income. HSAs are available to everyone who has a high-deductible plan, which is defined as having an annual deductible of at least $1,000 for individual coverage and at least $2,000 for family coverage. Individuals, their employers, or both can contribute funds up to the amount of the deductible, subject to a cap of $2,600 for individuals and $5,150 for families. The money not spent would stay in the account and earn interest tax-free. People over age 55 can contribute additional money to the account without penalty. These accounts will help more American families get the health care they need at a price they can afford.

Trade Adjustment Assistance Reform Act of 2002 (TAA) Tax Credit. The Trade Adjustment Assistance Reform Act of 2002 provides assistance to Americans who lose their jobs because of trade. Individuals certified to receive TAA benefits and individuals between the ages of 55 and 64 receiving benefits from the Pension Benefit Guaranty Corporation are eligible for a tax credit to help them purchase health insurance for themselves and their families. The tax credit is equal to 65 percent of the premium. It is refundable, so even individuals paying little or no income tax can receive the credit to help purchase health insurance. The credit can be claimed on the income tax return at the end of the year, or paid in advance by the Internal Revenue Service each month directly to the health plan.

Health Care Tax Credit. The Administration again proposes a tax credit that will facilitate individuals' purchase of health insurance and health care. Individuals under age 65 who are not enrolled in public or employer-sponsored health plans would be eligible. The credit would pay for 90 percent of the cost of the premium, up to a maximum of $1,000 for an individual and $3,000 for a family of four. The percentage of the credit would depend on an individual's income level. The credit would be phased out at $30,000 for an individual and $60,000 for a family. Like the TAA tax credit, the Health Care Tax Credit is refundable and can be paid in advance directly to the health plan.

Enhancing Public Health

Indian Health Service. The Budget will continue to invest in Indian Health Service (IHS) health infrastructure and prevention activities to improve the health status of American Indians and Alaska Natives (AI/AN). The Administration will invest in completing the construction of new and replacement health care facilities and staffing and related operating costs for completed facilities. IHS has developed new long-term goals through PART reviews over the last two years to address obesity in AI/AN children served in IHS, tribal, and urban facilities. IHS will establish a national baseline of AI/AN childhood heights and weights and will target resources for healthy growth and development for prevention of diabetes and other chronic diseases.

A nurse checks the blood pressure of a child in an Indian Health Services clinic.

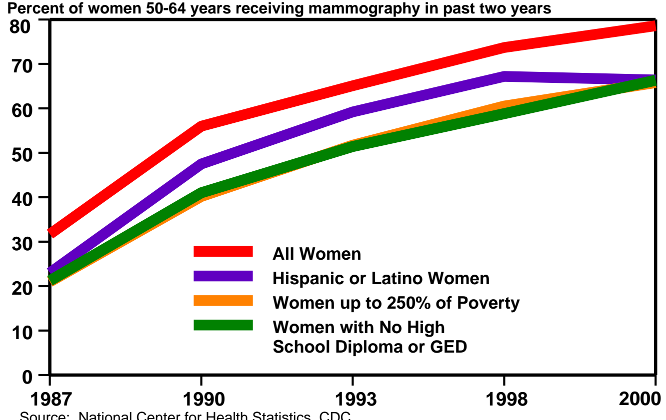
Changes in the HIV/AIDS Response. The Centers for Disease Control and Prevention (CDC) is responding to troubling indications of an increase in HIV/AIDS by building the capacity of community-based organizations and reaching out to high-risk individuals who may be unaware of their infection and more likely to spread the disease. CDC is reducing barriers to early diagnosis of HIV infection through rapid HIV testing and counseling, referring patients to quality medical care, and by enabling community organizations to support prevention services. By increasing the number of people who receive testing and reducing the time between testing and results, more individuals can obtain care early and take steps to limit the spread of this disease.

The Ryan White HIV/AIDS program is a comprehensive approach to ensuring medical care, provision of antiretroviral treatments, counseling and testing, and home health care for individuals living with HIV/AIDS. The Budget includes a $35 million increase for the Ryan White AIDS Drug Assistance Program to help purchase drug treatments for those living with HIV/AIDS.

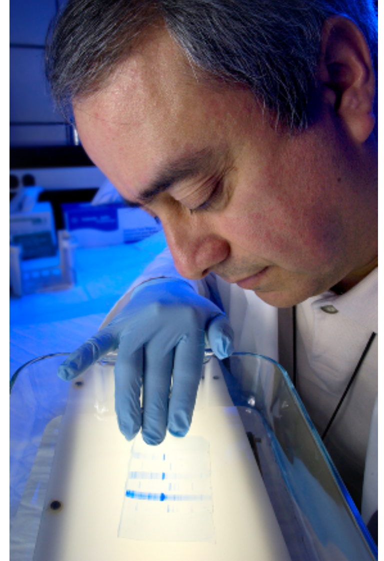
Health Care Providers. The Budget includes a $40 million increase for the National Health Service Corps and the Nursing Education Loan Repayment and Scholarship Program to broaden access to health care by directing doctors, nurses, and other health care professionals into medically underserved areas. The Budget redirects resources from health professions grants for advanced nursing to health professions grants for basic nursing education to address nursing shortages.

Homelessness. In March 2003, HHS released a strategic plan for ending chronic homelessness, beginning with developing a department-wide, comprehensive approach. In response, the Budget includes $390 million in HHS to provide health care, job training, substance abuse and mental health treatment, and other services to the homeless, a nine-percent increase over 2004. The Budget includes $10 million in HHS for the Samaritan Initiative, a joint initiative with the Department of Housing and Urban Development and the Department of Veterans Affairs to provide grants for permanent housing linked with supportive services, including health care, life skills, job training, and substance abuse treatment, for the chronically homeless.

Breast and Cervical Cancer Screening and Treatment. Routine screening can prevent cervical cancer, and early detection of breast cancer increases the five-year survival rate to 97 percent. The number of women receiving mammograms has increased significantly over time, but there are still health disparities between groups, as shown in the accompanying graph. The CDC provides breast and cervical cancer screenings to underserved populations that are low-income, underinsured or uninsured. The Budget proposes a $10 million increase to provide an additional 32,000 screenings and further the aims of this Administration priority.



Health Information. The Budget proposes an increase of $22 million, or 17 percent, for the National Center for Health Statistics to strengthen the collection of information in areas such as the functioning of the health care system, rates of cholesterol in the U.S. population, and long-term care services. Current and accurate information in these and other areas plays a vital role to help policymakers, health care workers, and the public make more informed choices.



CDC scientist Anthony Sanchez examines the purified structural proteins of the virus causing SARS. Working with scientists around the globe, CDC identified the SARS outbreak as caused by a previously unrecognized coronavirus.

Infectious Disease Detection and Control. The Budget proposes $51 million, a $28 million increase, for a new global disease detection effort that will strengthen the Nation's ability to rapidly detect, diagnose, and respond to infectious diseases wherever they occur. The CDC will enhance global disease surveillance; build partnerships with international health entities and other nations; and conduct the necessary training, laboratory science, and education to contain potential epidemics and protect the public's health.

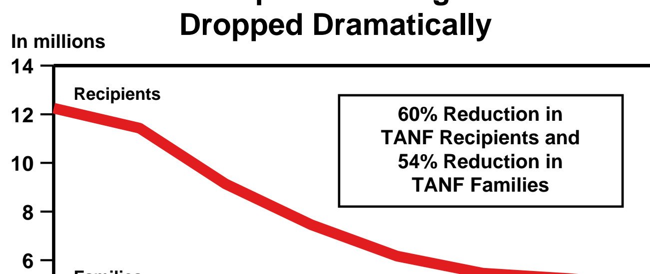
Reforming Welfare

In 1996, the Congress passed legislation to create the Temporary Assistance for Needy Families (TANF) program, replacing Aid to Families with Dependent Children and related welfare programs. TANF is a $16.9 billion a year block grant with bonuses for performance. States have significant flexibility in designing the eligibility criteria and benefit rules for their TANF programs, which require and reward work in exchange for time-limited benefits.

TANF is considered one of the most successful federally funded domestic programs in decades. Nationally, the TANF caseload (number of cash recipients) has declined 60 percent since the program's inception, while average monthly earnings of those employed increased by 49 percent from 1996 to 2001. As a result, States are using an increasing portion of welfare dollars on services to help individuals retain and advance in their jobs.

Building on these successes, the Administration continues to pursue its plan to extend the TANF program. The Administration's plan maintains funding, strengthens work participation requirements, supports healthy marriages and family formation, and provides a more accessible contingency fund.

Number of People Receiving Welfare Has Dropped Dramatically



Source: Administration for Children and Families.

Strengthening Programs for Children

Head Start. In April 2002, building on his Administration's emphasis on preschool programs, President Bush announced the Good Start, Grow Smart preschool education initiative with three goals:

- Strengthening Head Start;
- Partnering with States to improve early childhood education; and
- Providing information on child development and early learning to teachers, caregivers, parents, and grandparents and closing the gap between research and practice in early childhood education.

The initiative recognizes that for Head Start, achieving program goals means not only improving children's health and nutrition, but preparing them to succeed in kindergarten and beyond. Research shows that Head Start can achieve better school-readiness for its children by specifying particular skills and abilities to be taught in pre-reading, language, mathematics, cognitive skills,

Improving Head Start

As we raise educational standards, which we must do, each of our children needs an equal opportunity to meet those standards. And creating that opportunity must begin early, even before school starts. On the first day of school, children need to know letters and numbers. They need a strong vocabulary. And they need to love books. These are the building blocks of learning, and this nation must provide them.

President George W. Bush
April 2002

and social/emotional competencies. The Budget increases Head Start by $169 million, including $45 million to support State implementation of a demonstration authority to promote better coordination of existing programs, to improve services for families and children, and to achieve better results with the resources already being used.

In the five years from 1998 to 2002, more than 230,000 children in foster care were placed in adoptive homes—nearly the same number that had been adopted in the previous 10 years combined. Despite this progress, more than 126,000 foster children still need an adoptive family. To learn how you, too, can become an adoptive parent, go to www.adoptuskids.org.

Promoting Safe and Stable Families. To fortify States' ability to strengthen families and to promote child safety, permanency, and well-being, the Budget maintains funding at $505 million, a $130 million increase over 2002 enacted levels. This program also helps to promote adoption and provides post-adoption support to families.

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

Child Welfare Program Option. The President's 2005 Budget seeks legislation to introduce an option for all States to choose an alternative system for foster care that will better meet the needs of the child welfare population. States choosing to participate will face fewer administrative burdens and will receive funds in the form of flexible grants. This will serve as an incentive to create innovative child welfare plans with a stronger emphasis on prevention and family support, and increased flexibility in services provided and population served.

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

Services for Children, Families and the Elderly

The 2005 Budget continues the President's commitment to the economic and social well-being of children, families, and the elderly. The Budget provides $2 billion to help low-income households cover home heating and cooling costs. This amount includes a contingency fund of $200 million for unanticipated needs that may arise. The President's 2005 Budget proposes to fund the Community Services Block Grant (CSBG) at $495 million for 2005. CSBG provides funds to States for social services to reduce poverty and increase self-sufficiency. The Administration has been developing a set of national outcome-based goals for the CSBG program. CSBG's upcoming reauthorization should incorporate a similar set of goals and ensure that they are met by all Community Action Agencies (CAAs) that receive CSBG funds. Underperforming CAAs should be subject to competition with community and faith-based groups.

Rebalancing the long-term care system provides people of all ages with choices and opportunities for independence, including the opportunity to receive support at home and in the community.

The President's 2005 Budget also proposes $1.4 billion for Administration on Aging programs. As the number of older Americans increases, one of the major challenges the Nation faces is the current bias in the long-term care system toward institutional care. Despite the fact that seniors express an overwhelming preference to remain at home and in the community for as long as possible, and that community-based services are more cost effective than institutional care, approximately 71 percent of public funding for long-term care still goes to institutional care. For these reasons, the Administration supports efforts to create a more balanced system of long-term care. Thus, the 2005 Budget includes an increase of $7 million over the 2004 Budget level to support increased funding for the Aging and Disability Resource Centers and to focus on community-based and citizen-centered systems of care, integrated access to care, and assisting family caregivers. The 2005 Budget also includes an increase of $1.7 million to fund the White House Conference on Aging.

PERFORMANCE EVALUATION OF SELECT PROGRAMS

The Budget continues to focus on improving program performance. Eighteen of HHS' programs were assessed using the Program Assessment Rating Tool (PART), which evaluated the programs' design and purpose, strategic planning efforts, how well they are managed, and whether they are generating positive results for taxpayers. Below are some of the highlights and recommendations from the PART evaluations. For further details on HHS' performance assessments, see the White House budget website at *www.whitehouse.gov/omb/budget/*.

Program	Rating	Explanation	Recommendation
Office of Child Support Enforcement (CSE)	Effective	The program has strong management practices with financial incentives and penalties awarded to States based on meeting the specific performance measures. This has allowed for the demonstration of progress toward meeting its long-term and annual performance goals, including improved efficiencies and cost effectiveness. Independent evaluations indicate the program's effectiveness in achieving results.	Re-propose the child support provisions included in the President's 2003 and 2004 Budgets. Support new proposals to improve the establishment of medical support for the children without health insurance in the CSE system.
Food and Drug Administration (FDA)	Moderately Effective	The program has a clear mission and a unique Federal role in protecting public health. FDA has a challenging set of annual performance goals to allow for measurement of performance results. In general, FDA does a good job of meeting its annual performance goals. Financial management at FDA is sound. The agency is working to improve collaborative efforts with interested parties and other Federal agencies.	Monitor progress in meeting new long-term outcome goals. The FDA's long-term outcome goals were developed for the Budget during the PART process, and address agency performance in a wide range of activities.
National Institutes of Health: HIV/AIDS Research	Moderately Effective	The program is a flexible and cross-cutting program designed to give the NIH Office of AIDS Research the responsibility to plan, coordinate, fund, and evaluate AIDS research priorities across many institutes.	Adopt the revised goal by extending the timeline for developing an AIDS vaccine from 2007 to 2010, to more realistically reflect the state of the science. Develop targets for the revised goal.

Program	Rating	Explanation	Recommendation
Developmental Disabilities Grant Programs	Adequate	The programs have a clear purpose and complement other public and private efforts to support individuals with developmental disabilities. As the Administration for Developmental Disability grants are not used to provide direct services, it is difficult to link budget and performance.	Strengthen performance measurements and explore, in 2004, the feasibility and design of a comprehensive, independent evaluation of the grant programs.
Children's Hospitals Graduate Medical Education Payment Program	Adequate	The program fulfills the statutory requirements, but is duplicative of other Federal, State, and private efforts. Children's hospitals are more likely to be financially secure than other hospitals.	Contingent upon the results of pilot studies, verify 100 percent of hospitals' reported data on bed counts, case-mix index, and number of discharges by 2008. Examine whether the program can improve efficiency by paying hospitals on a quarterly basis.

UPDATE ON THE PRESIDENT'S MANAGEMENT AGENDA

The table below provides an update on HHS' implementation of the President's Management Agenda as of December 31, 2003.

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

Arrow indicates change in status rating since evaluation as of September 30, 2003.

HHS implemented performance-based employment contracts for all SES and managers, as well as for more than 70 percent of its workforce. HHS also completed some large competitive sourcing studies, including studies of real property management and extramural support services studies, each involving 700 employees. Based on NIH's preliminary estimates, these competitions are expected to generate savings of $196 million over the next five years and were both won by in-house teams and were conducted within 12 months.

HHS accelerated the preparation of its Performance and Accountability Report to November 15, one year in advance of the Government-wide deadline, while maintaining a clean audit opinion and making progress in resolving internal control weaknesses. HHS made strong progress in calculating the full cost of program performance and working to improve the results of about 30 percent of its programs that have been rated ineffective or have been unable to demonstrate results because they lack performance measures or adequate data.

In E-Gov, HHS' greatest challenges are improving information technology systems' security and implementing standard tracking of costs, project schedules, and performance. In December 2003, HHS unveiled a single comprehensive website, *Grants.gov*, that contains information about all Federal grant programs, including the ability to make electronic applications.

Initiative	Status	Progress
Broadening Health Care Coverage Through State Initiatives	Yellow	Green
Faith-Based and Community Initiative	Yellow	Green

Broadening Health Care Coverage Through State Initiatives. The Administration has developed several model Medicaid demonstrations in three areas to foster State innovation in reducing the number of uninsured. The Health Insurance Flexibility and Accountability Initiative (HIFA) emphasizes the coordination of currently available Medicaid and SCHIP funding with private insurance. The Pharmacy Plus initiative encourages States to extend Medicaid drug-only coverage to certain low income elderly or disabled. Finally, the Independence Plus initiative gives families and individuals direct choice, control, and responsibility for their home care and personal care services. To date, the Administration has approved eight HIFA demonstrations, five Pharmacy Plus demonstrations and four Independence Plus demonstrations. In addition, the Urban Institute is in the process of conducting a study which will assess the impact on HIFA demonstrations on rates of uninsurance.

Faith-based and Community Initiative. HHS has promulgated regulations for charitable choice legislation and made other regulatory and administrative changes to eliminate barriers to the full participation of grassroots faith-based and community-based organizations (FBCOs) in the delivery of services. HHS is also implementing a series of pilot projects that involve mentoring children of prisoners, supporting marriage and fatherhood, providing access to substance abuse recovery programs and supporting networks of HIV care. As part of its outreach and technical assistance efforts, HHS has awarded grants to umbrella organizations to assist small and novice grantees in navigating the grant application process and is providing training directly to grassroots organizations. HHS is working to ensure that FBCOs have full access to formula grant programs administered by State and local agencies.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(In millions of dollars)

	Actual		Estimate	
	2001	2003	2004	2005
Spending				
Discretionary Budget Authority:				
Food and Drug Administration	1,097	1,242	1,386	1,495
Program Level	*1,268*	*1,652*	*1,695*	*1,845*
Health Resources and Services Administration [1]	5,588	6,444	6,677	6,039
Program Level	*5,650*	*7,031*	*7,200*	*6,591*
Indian Health Service	2,629	2,850	2,921	2,967
Program Level	*3,205*	*3,510*	*3,639*	*3,685*
Centers for Disease Control and Prevention [2]	3,938	4,351	4,589	4,181
Program Level	*4,082*	*6,058*	*6,052*	*5,941*
National Institutes of Health	20,368	26,971	27,878	28,607
Program Level	*20,468*	*27,079*	*28,041*	*28,805*
Substance Abuse and Mental Health Services Administration	2,964	3,138	3,234	3,429
Program Level	*2,963*	*3,212*	*3,351*	*3,550*
Agency for Healthcare Research and Quality	105	—	—	—
Program Level	*270*	*309*	*304*	*304*

DEPARTMENT OF HEALTH AND HUMAN SERVICES—Continued

(In millions of dollars)

	Actual		Estimate	
	2001	2003	2004	2005
Centers for Medicare and Medicaid Services [3]				
Program Administration	2,242	2,565	2,637	2,541
Program Level	*2,332*	*2,626*	*2,696*	*2,805*
MedPAC/OCR/GDM/AHRQ Administration	17	18	18	19
Administration for Children and Families	12,389	12,999	13,286	13,880
Administration on Aging	1,103	1,309	1,374	1,377
Office of the Inspector General	34	37	39	40
Office of the Secretary	344	386	385	464
Program Level	*378*	*490*	*501*	*588*
Public Health and Social Services Emergency Fund [4]	195	2,144	2,164	2,225
Subtotal, Discretionary budget authority	53,013	64,454	66,589	67,264
Medicare Reform Administrative Expenses [3]	—	—	1,000	—
Medicare/Medicaid Offsets	—	—	—	–494
Total, Discretionary budget authority	53,013	64,454	67,589	66,770
Total, Discretionary outlays	45,936	59,615	64,094	66,555
Mandatory Outlays:				
Medicare				
Existing law	211,357	242,660	262,685	286,263
Legislative Proposals	—	—	—	136
Medicaid/SCHIP				
Existing law	133,073	165,048	182,339	188,496
Legislative Proposals	—	—	175	−753
All other programs				
Existing law	32,201	33,716	33,964	33,889
Legislative proposals	—	—	−12	128
Total, Mandatory outlays	376,631	441,424	479,151	508,159
Total, Outlays	422,567	501,039	543,245	574,714

[1] For comparability, program levels reflect exclusion of abstinence education funding, because these activities have been transferred to the Administration for Children and Families in 2005.

[2] For comparability, program levels reflect the creation of the Global AIDS Coordinator, the shift of the National Vaccine Program Office, and a childhood immunizations legislative proposal.

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

[4] For comparability, the 2001 data reflect transfers related to the creation of the Department of Homeland Security.