ANNUAL PLAN
FISCAL YEAR 2006

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 Independence Avenue, SW
Washington, DC 20201

TABLE OF CONTENTS

TABLE OF CONTENTS

For more information about budget and performance at
the Department of Health and Human Services,
please visit our website at ***www.hhs.gov\budget\documents.html.***

MISSION

To enhance 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.

VALUES

To deliver results that are useful both to the people and communities that are directly served by the Department's programs and to the taxpayers who pay for these programs. . . . . . ***Deliver Results***

To be an accountable steward of the Department's programs and enhance the efficiency and quality of the services provided. . . . . . ***Be Accountable***

To focus on health promotion and the prevention of disease and social problems, including the prevention and correction of unlawful discrimination in the provision of health and human services. . . . . . ***Focus on Prevention***

To create useful, effective forms of collaboration with partners in regulation, research, service delivery, and management. . . . . . ***Create Collaborations***

To provide accurate, reliable, understandable, and timely information to our partners and customers. . . . . . ***Provide Information***

To apply the most current scientific knowledge when making decisions that affect public well-being. . . . . . ***Seek Scientific Knowledge***

To foster flexibility and encourage innovation in the effective delivery of health and human services programs. . . . . . ***Foster Flexibility and Innovation***

To maintain a work environment that encourages creativity, diversity, innovation, teamwork, accountability, continuous learning, a sense of urgency, enthusiasm, trust, celebration of achievement, and the highest ethical standards. . . . . . ***Maintain a Creative Work Environment***

To work as a single corporate entity with a "One HHS" approach to management. . . . . . ***Work as "One HHS"***

HIGHLIGHTS OF HHS ACCOMPLISHMENTS

65	Percent of Head Start teachers who held an AA, BA, Advanced Degree, or a degree in a field related to early childhood education in FY 2004. (ACF)
69	Percent of American Indian/Alaska Native patients over 65 who have received a pneumovax immunization as of FY 2004. (IHS)
91	Percent of original generic drug applications reviewed and acted on by the Center for Drug Evaluation and Research within six months of submission. (FDA)
91	Percent of children receiving services under the Comprehensive Community Mental Health Services for Children and Their Families program who attended school 75 percent or more of the time in FY 2004. (SAMHSA)
24,928	Number of homes of American Indian/Alaska Native patients receiving appropriate sanitation during FY 2004. (IHS)
70,926	Number of field examinations of imported food by the Center for Food Safety and Applied Nutrition and Office of Regulatory Affairs in FY 2004 (a 6-fold increase from 12,000 field import examinations conducted in FY 2001). (FDA)
86,000	Number of individuals receiving essential HIV/AIDS medications at least one month of the year during FY 2003 through the AIDS Drug Assistance Program. (HRSA)
293,500	Number of severely disabled elders receiving home-delivered meals in FY 2004, allowing them to remain in their homes in the community. (AoA)
5,800,000	Number of children enrolled in the State Children's Health Insurance Program in FY 2003. (CMS)
7,800,000	Number of single nucleotide polymorphisms (SNPs) discovered by 2004 – 4.8 million more than originally planned. (NIH)
12,400,000	Number of people who accessed primary and preventive health care through the Health Centers program in FY 2003 – a 20 percent increase since FY 2001. (HRSA)
30,000,000	Number of Americans who will be protected from the effects of anthrax exposure through purchases of antibiotics from the Strategic National Stockpile made in 2004. (CDC)
42,000,000	Number of individuals covered by Medicare in FY 2004. (CMS)
42,900,000	Number of poor and disabled individuals provided medical assistance by Medicaid in FY 2004. (CMS)

OVERVIEW

The FY 2006 HHS Annual Plan presents an overview of all of the HHS agencies' FY 2006 performance budgets, describes plans for the coming fiscal year, and summarizes HHS' accomplishments in integrating budget and performance. The individual FY 2006 performance budgets provide performance information to improve budget and program management decisions.

The FY 2006 HHS Annual Plan meets the reporting requirements of the Government Performance and Results Act (GPRA). The HHS Annual Plan illustrates the linkages between the HHS performance budgets and the HHS Strategic Plan, as well as highlighting a number of programs that demonstrate the work HHS is doing in support of each of the eight HHS strategic goals.

The FY 2006 HHS Annual Plan includes:

- An overview describing how HHS developed a new performance budget and HHS' approach to planning and performance;
- An update on the President's Management Agenda at HHS;
- A presentation of the HHS budget by strategic goal with program highlights;
- Detailed program narratives describing the progress selected programs are making in support of HHS strategic goals; and
- An appendix that display the HHS discretionary budget by eight strategic goals.

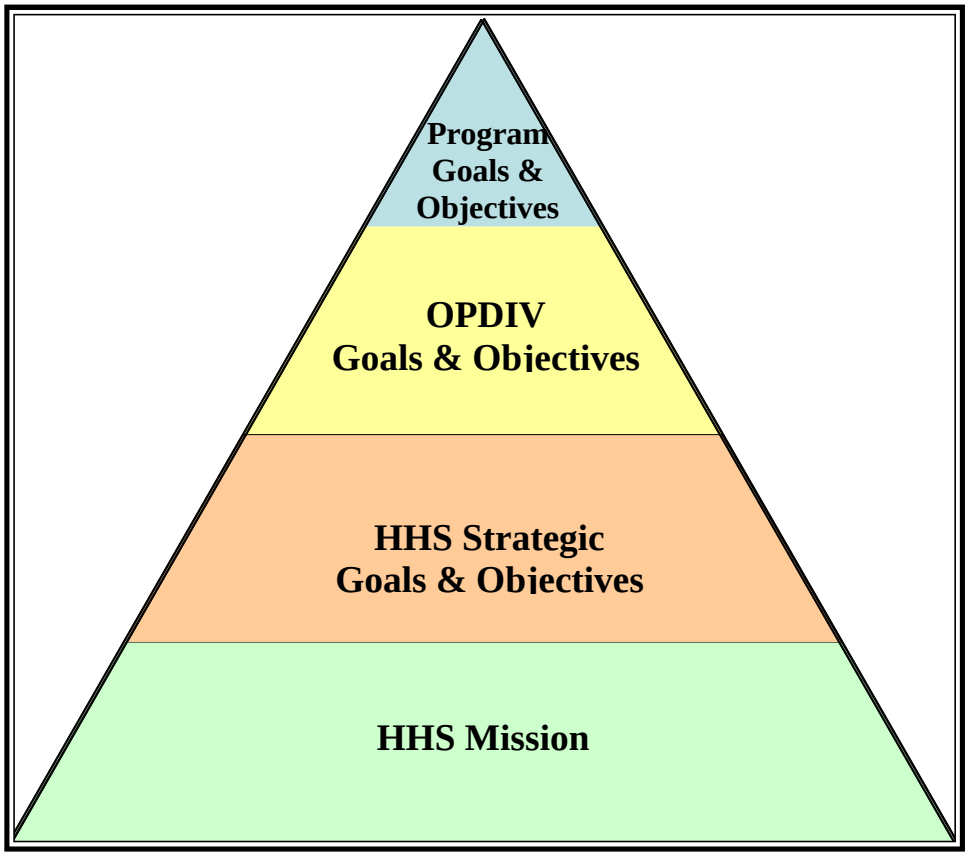
In the program narratives, each program describes how it measures results and includes one or more illustrative performance measures. These measures provide a basis for comparing actual program results with established program performance goals. Each program in the FY 2006 HHS Annual Plan:

- Presents the program level budget and the projected full cost of the program.
- Describes the program's background, context, and purpose including the need that the program addresses.
- Identifies specific goals and targets established by the program and discusses whether they have been met or plans to meet them in the future.
- Highlights an example of the performance measures that define the level of performance to be achieved by the program.
- Presents the results of the Program Assessment Rating Tool (PART) review (when applicable) including a discussion of PART recommendations.
- Discusses external factors affecting program performance.
- Includes a concise description of the program's budget.

PLANNING AND PERFORMANCE AT HHS

As one of the largest Federal agencies, the Nation's largest health insurer, and the largest grant-making agency in the Federal government, HHS manages over 300 programs that serve to improve the health and well-being of the American public. HHS programs impact all Americans by providing health and social services, funding biomedical research, and protecting the public health. The Office of the Secretary has responsibility for providing overall policy guidance and direction to the Operating Divisions (OPDIVs) in achieving the Department's strategic goals and objectives.

HHS serves Americans in coordination with partners in States and local communities. Therefore, the strategic goals, performance goals, and program results reflect the combined commitment and effort of HHS programs and their State, local, Tribal, and non-governmental partners.



In FY 2004, HHS updated its Strategic Plan, identifying eight strategic outcome goals for accomplishing the Department's mission for FY 2004 - 2009. These goals, and accompanying objectives, provide the focus for HHS investments of effort and resources over the next five years based on Secretarial priorities across diverse HHS programs and activities.

HHS uses strategic planning, annual performance planning, and the annual budget process as the tools for reviewing program priorities and harmonizing program activities. Updated every three years, the strategic plan is a key component of performance management and budget and performance integration at HHS. It provides the overarching long term goals and framework for the Department's OPDIVs and Staff Divisions (STAFFDIVs) to use on an annual basis to create performance budgets. In turn, the performance budgets establish the resource needs of HHS programs and demonstrate the results that Americans can expect from their investment in these programs. The performance budgets also report on past performance of all HHS programs.

In exercising its role of providing policy guidance and leadership for the Department's OPDIVs, HHS produces an Annual Plan, which combines performance and budget information, using illustrative programs to describe the work HHS is doing and planning to achieve our strategic goals. The Annual Plan describes the plans for HHS investments of effort and resources for the coming fiscal year as they relate to the five year strategy described in the Strategic Plan. At the close of each fiscal year, HHS produces a Performance and Accountability Report (PAR), which incorporates audited financial statements with performance and management results for the year. The PAR uses the same approach as the Annual Plan, highlighting illustrative programs to describe HHS performance. Together the Annual Plan and the PAR constitute an annual review and planning process for HHS programs.

EVALUATION AND ASSESSMENT

Every year, HHS conducts evaluations to determine program effectiveness, develop performance measures, assess environmental impacts on health and human services, and improve program management. The results of these program evaluations are used by HHS program managers in the annual planning and budget process. The Department also prepares a series of annual reports, at the direction of Congress, describing these evaluation activities: the Research, Demonstration, and Evaluation reports; Public Health Service Evaluation Set-aside reports; and Performance improvement reports.

During the FY 2004 budget formulation process, the Program Assessment Rating Tool (PART) was introduced to assess the effectiveness of all Federal programs. Its overall purpose is to improve program performance and to influence the budget formulation. HHS utilizes PART to inform management and budget decisions, including the FY 2006 Secretary's Budget Council meetings and the FY 2006 Congressional Justifications. Additionally, HHS established a PART Recommendation tracking process to ensure that recommendations made through the PART were being used to improve program performance. Several programs have used PART to update their strategic plans and performance goals.

During the FY 2006 budget process, 22 HHS programs were reviewed using PART, accounting for four percent of the FY 2006 budget request. Since FY 2004, 65 programs, representing 74 percent of HHS' FY 2006 budgetary resources, have been reviewed by PART. Forty-seven HHS programs received a rating of Adequate, Moderately Effective, or Effective. More detailed information on the FY 2006 PARTs reviews is provided in the individual program narratives sections.

THE HHS PERFORMANCE BUDGET

Consistent with the Budget and Performance Integration initiative of the President's Management Agenda, in FY 2006 HHS produced its first performance budgets. In this new format the Department moves from the traditional approach of presenting separate budget justifications and performance plans to the use of one integrated document to present both budget and performance information. Combining budget and performance information together in an integrated fashion enhances the availability and use of program and performance information to inform the budget process.

UPDATE ON THE PRESIDENT'S MANAGEMENT AGENDA AT HHS

The PMA provides a framework for improving the management and performance of the federal government. 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.

The following provides an update on PMA initiatives at HHS.

Department of Health and Human Services FY 2006 President's Management Agenda

INTIATIVE	STATUS	PROGRESS	HIGHLIGHTS
Strategic Management of Human Capital	**Green**	**Green**	***Progress:*** ▪ Consolidated its human resources (HR) personnel into four centers and has achieved greater accountability through its employee appraisals and its Strategic Management System. ▪ Implemented a number of initiatives to improve the skills and abilities of its workforce, including HHS University and the Emerging Leaders Program. ***Upcoming Action:*** ▪ Reduce skills imbalances through workforce reshaping and developmental programs. ▪ Implement HR Accountability program in all HHS HR Centers.
Competitive Sourcing	**Green**	**Green**	***Progress:*** ▪ Completed eight standard public-private competitions in an average of 12 months or less, meeting the new time standard. ▪ Conducted competitive sourcing studies for almost 25 percent of its commercial activities and is anticipated to yield annual savings of $40M+ for the greater benefit of HHS programs and the American taxpayer. ***Upcoming Action:*** ▪ Develop and implement an FY 2005 competition plan designed to maximize efficiencies and savings. ▪ Structure competitions to realize positive net savings. ▪ Finalize and implement savings validation plan.

Department of Health and Human Services FY 2006
President's Management Agenda

INITIATIVE	STATUS	PROGRESS	HIGHLIGHTS
Improved Financial Performance	**Red** 	**Yellow** 	***Progress:*** ▪ Streamlined and accelerated the annual financial reporting process, making financial information more useful in decision-making. ▪ Combined annual audited financial statements with program performance information in the Department's Performance and Accountability Report. ▪ Initiated an HHS-wide analysis to identify the extent to which financial and performance information is used to support "day-to-day" management decisions. ***Upcoming Action:*** ▪ Continue progress in UFMS development and implementation. ▪ Maintain HIGLAS schedule to remove material weaknesses and FFMIA non-compliance by FY 2007.
Expanded Electronic Government	**Yellow** 	**Yellow** 	***Progress:*** ▪ Implanted Earned Value Management to track and manage information technology investments. More than 95 percent of HHS' information systems have certified and accredited security plans. ▪ Deployed the "Secure One HHS" program to raise compliance with security mandates, better security, and better systems at HHS. ▪ Published an Enterprise Architecture linking performance to strategic and capital planning and budget processes. ***Upcoming Action:*** ▪ Execute the Earned Value Management Roadmap to achieve 100 percent American National Standards Institute. ▪ Strengthen the Federal Information Security Management Act plan of action and milestone process within each Agency. ▪ Establish a system-to-system interface with Agencies and work with grant-making Agencies to establish a schedule for placing grant applications on Grants.gov *Apply* mechanism.

Department of Health and Human Services FY 2006 President's Management Agenda			
INITIATIVE	**STATUS**	**PROGRESS**	**HIGHLIGHTS**
Budget and Performance Integration	**Yellow** 	**Green** 	***Progress:*** ▪ Designed a new FY 2006 integrated performance budget by forming a design team with a budget and performance representative from each HHS Agency. ▪ Completed 22 PART assessments in FY 2006, for a total of 65 assessed programs from FY 2004-2006 representing 74 percent of the total HHS budget. Implemented a tracking process to follow-up on PART recommendations. ▪ Developed and piloted a methodology for calculating marginal cost. ***Upcoming Action:*** ▪ Develop a quarterly reporting mechanism for each Agency to demonstrate how performance information is used to make budget decisions. ▪ Expand the use of marginal cost. ▪ Refine and improve the integrated performance budget for FY 2007. ▪ Strengthen the measures used to track program performance, including efficiency measures.

In addition to the five management initiatives, HHS contributes to the following program initiatives.

PMA Program Initiatives:	Status	Progress
Broadening Health Insurance Coverage through State Initiatives	Yellow 	Green 
Eliminating Improper Payments[1]	Red 	
Real Property Asset Management	Red 	Green 
Faith Based and Community Initiative	Yellow 	Green 
[1] Because this is the first quarter that agency efforts were rated, progress scores were not given.		

HHS BUDGET BY STRATEGIC GOALS

In FY 2004 HHS updated its Strategic Plan identifying eight strategic outcome goals for accomplishing the Department's mission for FY 2004 - 2009.

The Strategic Plan contains the following Strategic Goals:

Strategic Goal 1 - *Reduce the major threats to the health and well-being of Americans.*

Strategic Goal 2 - *Enhance the ability of the Nation's health care system to effectively respond to terrorism and other public health challenges.*

Strategic Goal 3 - *Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices.*

Strategic Goal 4 - *Enhance the capacity and productivity of the Nation's health science research enterprise.*

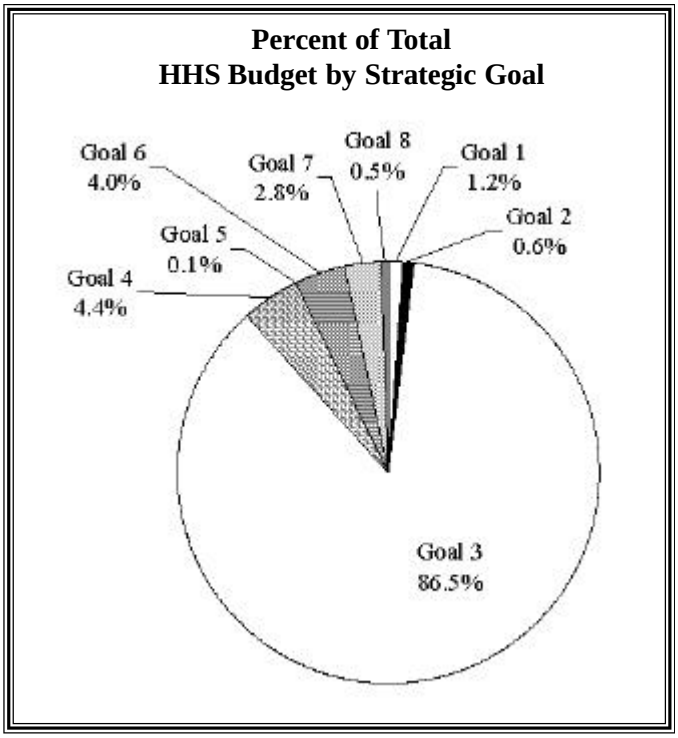
Strategic Goal 5 - *Improve the quality of health care services.*

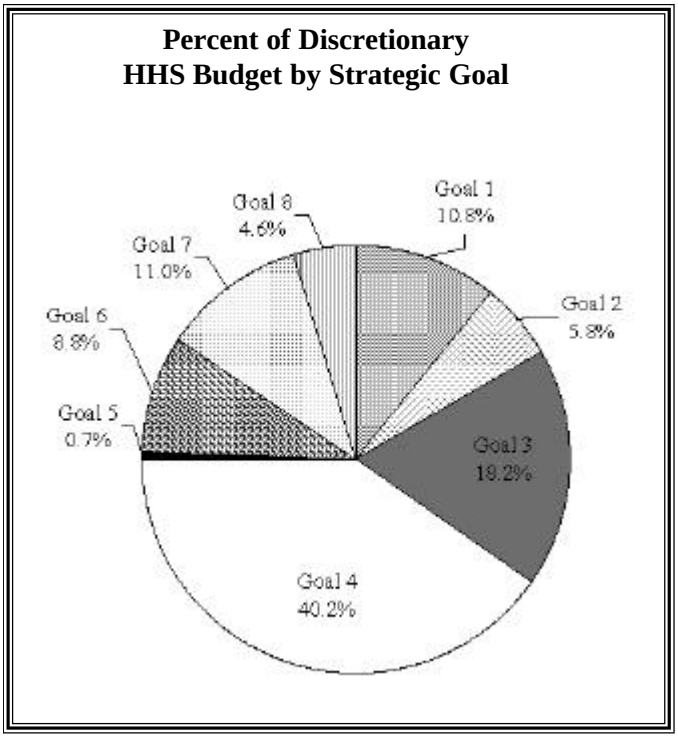
Strategic Goal 6 - *Improve the economic and social well-being of individuals, families, and communities, especially those most in need.*

Strategic Goal 7 - *Improve the stability and healthy development of our Nation's children and youth.*

Strategic Goal 8 - *Achieve excellence in management practices.*

The work of each HHS OPDIV and STAFFDIV contributes to achieving the Department's eight strategic goals. The charts below show a breakdown of the total HHS budget and discretionary budget by HHS strategic goal. The total HHS budget is nearly $661 billion (in program level) of which approximately 89 percent is mandatory spending and 11 percent is discretionary. Medicare and Medicaid account for almost 93 percent of the total





mandatory level and both programs support HHS Strategic Goal 3 – Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices:. As a result, the total budget by strategic goal table is heavily influenced by the size of the Medicare and Medicaid programs.

The HHS discretionary budget totals $71.2 billion (in program level). Each OPDIV carefully assessed their budget in terms of the Department's eight strategic goals, which is displayed in the discretionary pie chart. OPDIVs allocated major program activities to a primary, or core, strategic goal, as opposed to allocating programs across multiple goals. This display should not be used to determine how much each program activity contributes to any one strategic goal since programs may in reality contribute to a number of strategic goals.

For a more detailed account of OPDIV discretionary budget by HHS Strategic Goals, refer to this document's appendix.

PROGRAM HIGHLIGHTS BY STRATEGIC GOAL

The following includes the highlighted programs and performance goals in the FY 2006 HHS Annual Plan and the Department Strategic Goals they support. Greater detail is provided in each program narrative.

Strategic Goal 1 - Reduce the major threats to the health and well-being of Americans:

The Centers for Disease Control and Prevention (CDC) will continue efforts to prevent and control the spread of HIV infections in the United States by engaging in surveillance, research, intervention, capacity building, and evaluation activities. CDC has launched a new initiative, Advancing HIV Prevention (AHP), which has funded health departments, medical providers, and community-based organizations to develop models and demonstrate approaches that address AHP strategies. Through this program and CDC's other domestic HIV prevention activities, CDC will work to reduce the major threats to the health and well-being of Americans from HIV/AIDS.

Vaccines are one of the most successful and cost-effective public health tools for preventing disease and death. In the United States and globally, CDC is engaged in a variety of efforts to ensure all recommended immunizations are provided safely and effectively to children, adolescents and adults. CDC awards grants through two programs: Vaccines for Children, which covers children from birth through age 18 who are Medicaid eligible uninsured, insured but do not have coverage for immunizations, or the working poor; and Section 317 Immunization program, which covers both children and adults primarily at public health clinics who are not eligible for Vaccines for Children. Due to the success of these mechanisms and the partnership they institute between the public and private sector, nationwide childhood immunization coverage rates are now at record high levels.

CDC and its partners are making considerable progress in reducing cigarette smoking among youth. Cigarette use among adolescents is at its lowest level since surveys began monitoring youth smoking. According to data from CDC's Youth Risk Behavior Surveillance System, the percentage of students who reported current cigarette use decreased significantly from 36.4 percent in 1997 to 21.9 percent in 2003.

The Substance Abuse and Mental Health Services Administration (SAMHSA) will continue to make progress towards the President's commitment to reduce current illicit drug use. The Substance Abuse Prevention and Treatment Block Grant supports this strategic goal by bringing effective alcohol and drug treatment and prevention services to every community through a block grant to the States. The Block Grant supports and expands substance abuse prevention and treatment, while providing maximum flexibility to States in addressing their prevention and treatment needs.

Strategic Goal 2 - Enhance the ability of the Nation's health care system to effectively respond to terrorism and other public health challenges:

The Office of Public Health Emergency Preparedness (OPHEP), as the principal coordinator for the Department in carrying out HHS' responsibility for medical and public health preparedness, requires the diverse and unique skills of scientists, public health experts and health care providers at the National Institutes of Health (NIH),

CDC, the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), and SAMHSA. Through its program offices and guidance provided by the Secretary's Advisory Council on Public Health Emergency Preparedness, OPHEP focuses the activities of these agencies; develops and coordinates national policies and plans; provides program oversight; and is the Secretary's public health emergency representative to other Federal, State and local organizations in the preparedness for, response to, and recovery from the medical consequences of natural and man-made disasters, including acts of terrorism.

FDA continues to improve the Nation's health care system to respond to bioterrorism and other public health challenges by ensuring the safety of foods, drugs, biological products, and medical devices, and by providing timely medical products to deal with emerging public health and terror threats. FDA continues to work with other Federal, state and local governments to improve the safety of the national food supply.

HRSA's Bioterrorism Hospital Preparedness Program is designed to enable State and regional planning among local hospitals, emergency medical services systems, health centers, poison control centers, and other health care facilities to improve their preparedness to work together to combat terrorist attacks and deal with infectious disease epidemics and other public health emergencies. HRSA will work to ensure that 100 percent of the Bioterrorism Hospital Preparedness Program awardees, including all 50 States, develop regional plans to address surge (a large and rapid increase in the number of persons requiring care) capacity.

CDC's terrorism efforts are a critical element in the drive to protect the American public from a terrorist attack. Many of CDC's programs are interconnected and strive to provide the best possible coverage and results under the unifying goal of protecting the population. Examples of these efforts include the State and local grants that are designed to increase the resources and capabilities at the State and local level, as well as the Strategic National Stockpile designed to supplement local efforts by reaching and providing advanced treatment to areas affected by a terrorist attack or mass trauma event. By exercising tight fiscal control and utilizing lessons learned, CDC and local agencies continue to increase their capabilities through activities such as integrating communication and information sharing between different levels of government to enable earlier detection and a more effective treatment as demonstrated by the successful response to SARS and the recent influenza outbreaks.

Strategic Goal 3 - Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices:

HRSA's Health Centers Program provides regular access to high quality, family oriented, and comprehensive primary and preventive health care, regardless of patients' ability to pay. HRSA will support 578 new and expanded health center sites and serve an additional 2.4 million people. In total, Health Centers will serve 16.4 million patients, including 10.66 million racial/ethnic minority individuals.

The Indian Health Service (IHS) National Diabetes Program is an integral part of the IHS Hospitals and Health Clinics Program. The mission of the program is to prevent and control diabetes among American Indians and Alaska Natives, recognizing that the disease is one of the major causes of mortality among AI/AN people. The program works with communities to prevent and treat diabetes, as well as oversee the Special Diabetes Program for Indians. IHS has successfully developed the Regional Model Diabetes Program to expedite care and provide education to people with diabetes, as well as develop new approaches to diabetes control as models for other AI/AN communities. In FY 2006, IHS will continue to implement this program.

The Centers for Medicare and Medicaid Services (CMS) has published final program regulations and will establish a major initiative to educate health care providers and consumers about the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). The MMA, signed into law by the President in early FY 2004, provides enhanced coverage for the lowest income beneficiaries and an immediate prescription drug discount card for all beneficiaries who choose to obtain such a card until the full drug benefit is available nationwide.

CMS, in partnership with the States, will continue to increase the number of low-income uninsured and underserved children who enroll in Medicaid and the State Children's Health Insurance Program (SCHIP). CMS will also continue to assess health care quality for children enrolled in Medicaid and SCHIP through the use of a core set of national performance measures developed with the States. In addition, States will be given the opportunity to obtain technical assistance to improve their reporting on national performance measures and progress in reducing the number of uninsured children.

Strategic Goal 4 - Enhance the capacity and productivity of the Nation's health science research enterprise:

NIH is in the process of establishing a knowledge base on the effects of chemicals and drugs in biological systems in order to better understand the role of gene-environment interactions in disease. In FY 2006, NIH has set a target of enhancing the Chemical Effects in Biological Systems database to add and integrate data on transcriptomics, proteomics, and toxicology for the same chemical compound. In the long-term, this data is expected to lead to the discovery of characteristic gene- and protein-expression signatures that will help classify exposure to these chemicals by their biological activity, and provide a means for predicting effects on human health from such exposure.

Strategic Goal 5 - Improve the quality of health care services:

FDA continues to improve the quality of health care services by reducing medical errors involving FDA-regulated products. FDA also strives to improve patient and consumer safety by increasing the use of health care quality information, strengthening consumer and patient protections, and monitoring the safety of FDA-regulated products already on the market. Innovative programs such as the Adverse Events Reporting System (AERS) for human drugs and the Medical Products Surveillance Network for medical devices provide timely risk information to health care professionals.

In FY 2004, the Agency for Healthcare Research and Quality's (AHRQ) consumer-oriented products included Pocket Guides to Good Health for Adults, Good Health for Children, and Staying Healthy at 50+. AHRQ also produced consumer checklists focusing on women's and men's health at any age. Marketing of these products led to audio releases to over 6 million English and Spanish listeners. Production of these products involved partnerships with professional organizations such as AARP.

AHRQ has been working with clinicians to ensure that its products are user-driven. A free Personal Digital Assistant (PDA) program now allows clinicians to query the U.S. Patient Safety Task Force recommendations by age and gender. Over six months, there have been more than 12,000 downloads and installations of these web-based programs. Ongoing efforts include further refinement of current tools, such as the PDA program, and development of new web-based tools for patients and clinicians.

Strategic Goal 6 - Improve the economic and social well-being of individuals, families, and communities, especially those most in need:

The purpose of Temporary Assistance for Needy Families (TANF) is to increase the self sufficiency and stability of low income families by promoting employment and job readiness as well as activities that support healthy marriages. Welfare reform has been largely successful in increasing the financial independence of recipients since the Personal Responsibility and Work Opportunity Reconciliation Act passed in 1996. In June of 2004, there were 61 percent fewer individuals receiving TANF benefits than in August 1996. As welfare recipients continue to move from welfare to work, the President's TANF reauthorization proposal emphasizes the continued importance of strengthening work participation and achievement of TANF recipients.

In FY 2004, the Administration on Aging (AoA) realized a significant, four percent increase in one year, in a key performance measure: the number of severely disabled elderly individuals who receive Older Americans Act services. AoA is on track to achieve its target of an eight percent increase in FY 2005 over the FY 2003 base, and toward a rigorous 25 percent increase by FY 2007. This performance directly supports AoA's long-term objective of helping elderly individuals remain independent in their homes and communities.

Strategic Goal 7 - Improve the stability and healthy development of our Nation's children and youth:

The mission of Child Support Enforcement (CSE) is to assure that children receive the financial and medical support they need by locating parents, establishing paternity, and enforcing support obligations. Child support is an important source of income to improve the quality of life for children and for families striving for self-sufficiency. The program continues to make impressive gains with FY 2003 collections totaling $21.2 billion. CSE aims to increase the rate of collections of current support (collections on current support/current support owed) from 58 percent in FY 2003 to 62 percent in FY 2006.

Child welfare programs in the Administration for Children and Families (ACF), like Foster Care, Promoting Safe and Stable Families, and Adoption Incentives, provide an array of services to children in at-risk families or children who need to be removed from the home. ACF is dedicated to protecting children, reunifying families when possible, and finding safe and stable permanent homes for children who cannot return to their families. Between FY 2003 and FY 2008, ACF will increase adoptions towards the goal of finalizing adoptions for 327,000 children from the child welfare system.

ACF's Head Start program promotes school readiness by enhancing the social and cognitive development of low-income children through the provision of educational, health, nutritional, social, and other services. ACF is dedicated to averaging 34 percent improvement in children's word knowledge, 52 percent improvement in mathematical skills, 70 percent improvement in letter identification, and 14 percent improvement in social skills.

Strategic Goal 8 - Achieve excellence in management practices:

CMS will continue its focus on maintaining program integrity in the Medicare program, to ensure that it pays the right amount to legitimate providers for covered, reasonable and necessary services to eligible beneficiaries. CMS sets ambitious annual program integrity targets, including reducing the percentage of improper payments made under the Medicare fee-for-service program, as well as reducing the contractor error rate and improving the provider compliance error rate. In addition to the $720 million in mandatory funding for the Medicare Integrity Program, the FY 2006 budget requests $75 million through a discretionary cap adjustment to expand Medicaid program integrity activities and safeguard the Medicare prescription drug benefit and the Medicare Advantage Program. CMS will continue to implement a similar program integrity plan for Medicaid and SCHIP through a pilot project designed to measure improper payments and calculate error rates.

The Office of Inspector General (OIG) will continue to combat fraud, waste, and abuse, and recommend policies designed to promote economy, efficiency, and effectiveness in the programs and management practices of HHS. To accomplish this, OIG will conduct and supervise audits, inspections, and investigations; and provide guidance to the health care industry.

For a comprehensive presentation of FY 2006 HHS programs, performance goals, and budget initiatives, see the individual HHS Operating and Staff Division FY 2006 Performance Budgets.

STRATEGIC GOAL 1

Reduce the Major Threats to the Health and Well-being of Americans.

Highlighted Programs:

1a. National Immunization Program (CDC)

1b. HIV/AIDS Prevention in the U.S. (CDC)

1c. Substance Abuse Prevention and Treatment Block Grant (SAMHSA)

Each year, HHS has the opportunity to renew its commitment to reduce health threats and promote healthy behaviors. This commitment remains a critical priority for FY 2006. This goal supports the Department's vision to improve the health and well being of people in this country and throughout the world. HHS recognizes that this vision can only be accomplished through coordination across the Department, and through partnerships with States, communities, and health professionals. The performance budget for FY 2006 includes programs that promote healthy behavior and choices that will prevent and control disease.

Prevention remains at the center of the HHS approach to fighting HIV/AIDS, sexually transmitted diseases, and tuberculosis. HHS is making considerable progress toward slowing the transmission of HIV from pregnant women to their children and preventing the spread of tuberculosis. Similarly, HHS has made great strides in increasing the number of children who are immunized. Childhood immunization rates are at record high levels, but a substantial number of children in the United States are not adequately protected from vaccine-preventable diseases. The FY 2006 budget funding for immunizations will be used to help ensure that no child, adolescent, or adult will needlessly suffer from a vaccine-preventable disease.

HHS continues to work with the Office of National Drug Control Policy to implement an effective drug strategy that will increase the number of individuals provided with effective substance abuse treatment. The FY 2006 budget provides $150 million in Access to Recovery grants to provide people seeking drug and alcohol treatment with vouchers for a range of appropriate community-based services. Programs such as Access to Recovery serve to promote client choice, expand access to broad array of clinical treatment and recovery support services, including services provided by faith- and community based programs, and increase substance abuse treatment capacity.

The FY 2006 Annual Plan highlights Departmental goals and measures representative of the Department's work to reduce the major threats to the health and well-being of Americans. Programs assessed under this strategic goal include the Centers for Disease Control and Prevention's (CDC) National Immunization Program, HIV/AIDS Prevention programs in CDC, and the Substance Abuse and Mental Health Administration's (SAMHSA) Substance Abuse Prevention and Treatment Block Grant program.

PROGRAM 1A: NATIONAL IMMUNIZATION PROGRAM

Centers for Disease Control and Prevention (CDC)

FY 2006 Budget Request:
$428.7 Million (Discretionary)

FY 2006 Full Cost:
$478.5 Million

FY 2004 PART Rating:
Adequate

✓ ***Performance Measure:*** *Achieve or sustain immunization coverage of at least 90 percent in children 19- to 35 months of age for: four doses DTaP vaccine,[1] three doses Hib vaccine, one dose MMR vaccine,[2] three doses hepatitis B vaccine, three doses polio vaccine, one dose varicella vaccine, and four doses pneumococcal conjugate vaccine.[3]*

PROGRAM DESCRIPTION

The mission of the National Immunization Program (NIP) is to prevent disease, disability and death in children and adults through vaccination. Widespread use of vaccines, particularly among children, has resulted in continuing low levels of vaccine preventable diseases and is one of the most successful and cost-effective public health tools. In carrying out its mission, CDC:

- Awards grants through two programs administered by CDC: Section 317 of the Public Health Service Act and the Vaccines for Children (VFC) Program.
- Provides technical, epidemiological, educational, statistical and scientific assistance to State and local health departments.
- Strives to ensure recommended vaccines will be available for all U.S. children by building a six-month supply of these vaccines in the national pediatric stockpile.
- Strives for vaccine safety by monitoring harmful effects, conducting scientific research, communicating the benefits and risks of vaccines, and supporting the development of new vaccine administration devices and vaccines.
- Conducts research and programs for prevention and control of vaccine-preventable diseases.
- Supports a nationwide framework for effective surveillance of designated diseases for which effective immunizing agents are available.

Vaccines are one of the most successful and cost effective public health tools for preventing disease and death.

COST-EFFECTIVENESS OF VACCINES

For every $1 spent:

- DTaP saves $27
- MMR saves $26
- Perinatal Hepatitis B saves $14.70
- Varicella saves $5.40
- Inactivated Polio (IPV) saves $5.45

1 Due to a shortage of vaccine and temporary change in recommendations, reported by three doses from 2002-2003.

2 Includes any measles-containing vaccine.

3 Performance targets for newly recommended vaccines are reported in GPRA five years after ACIP recommendation. Measures for pneumococcal conjugate vaccine (PCV7) will begin in 2006.

PERFORMANCE ANALYSIS

One of CDC's immunization goals is to ensure that 2-year-olds are appropriately vaccinated. New cases of most vaccine-preventable disease have decreased approximately 99 percent from peak pre-vaccine levels, resulting in lives saved and reduced treatment and hospitalization costs. As CDC's immunization activities increase childhood immunization coverage, the incidence of vaccine-preventable diseases declines significantly. Vaccination coverage levels are at 90 percent or higher for most individual vaccines such as measles, polio, Haemophilus influenzae type b (Hib), and hepatitis B, and three doses of diphtheria tetanus acellular pertussis (DTaP). Examples of the success of immunizations include:

- Measles is a highly infectious, viral illness that can cause severe pneumonia, diarrhea, encephalitis, and death. Measles is no longer endemic in the U.S.
- Only one child in the U.S. was born with Congenital Rubella Syndrome in 2003.
- Rubella cases have declined from 57,600 in 1969, when the vaccine was first available, to a total of seven cases in 2003.
- Hib cases have dropped more than 99 percent among children younger than age 5 since the Hib vaccine was introduced in 1990, and it is no longer the leading cause of meningitis among children younger than 5 years of age in the U.S.
- There have not been any cases of polio reported in the U.S. since 1979.

CDC's National Immunization Program has a total of eight performance measures, including one efficiency measure, three outcome measures, and four output measures.

Performance Measure: Achieve or sustain immunization coverage of at least 90% in children 19- to 35-months of age for: 4 doses DTaP vaccine,[1] 3 doses Hib vaccine, 1 dose MMR vaccine,[2] 3 doses hepatitis B vaccine, 3 doses polio vaccine, 1 dose varicella vaccine, 4 doses pneumococcal conjugate vaccine (PCV7).[3]

Data Source: National Immunization Survey

Year	Target	Actual
2001	90% coverage	DTaP 94%; Hib 93%; MMR 91%; Hepatitis B 89%; Polio 89%; Varicella 76%
2002	90% coverage	DTaP 95%; Hib 93%; MMR 91 %; Hepatitis B 90%; Polio 90%; Varicella 81%
2003	90% coverage	DTaP 96%; Hib 94%; MMR 93%; Hepatitis B 92%; Polio 92%; Varicella 85%
2004	90% coverage	Data available 8/2005
2005	90% coverage	Data available 8/2006
2006	90% coverage	Data available 8/2007

[1] Due to a shortage of vaccine and temporary change in recommendations, reported by 3 doses from 2002-2003.
[2] Includes any measles-containing vaccine.
[3] Performance targets for newly recommended vaccines are reported in GPRA 5 years after ACIP recommendation. Measures for varicella began in 2001. Performance reporting for pneumococcal conjugate vaccine (PCV7) will begin in 2006.

Data for the immunization coverage performance comes from the National Immunization Survey (NIS), which uses a nationally representative sample and provides estimates of vaccination coverage rates that are weighted to represent the entire population, nationally, and by region, State, and selected large metropolitan areas. The NIS was established to provide an ongoing, consistent data set for analyzing vaccination coverage among young children in the U.S. and disseminating this information to interested public health partners. The NIS provides calendar year data.

The target of 90 percent coverage was met in FY 2003 (the most recent year for which results are available) for all of the vaccines, with the exceptions of varicella and pneumococcal conjugate, the most recently introduced routine childhood vaccines. Varicella coverage rates are rising, reaching 85 percent in 2003.

CDC is not accountable for reaching the 90 percent rate of coverage for pneumococcal conjugate vaccine until FY 2006. However, data was reported for the first time in 2003, with a rate of 68 percent for three or more doses. Targets for FY 2005 and FY 2006 remain unchanged at 90 percent.

PART Review

The Section 317 Immunization Grant Program received an Adequate rating through the PART review. This program awards funds to State and local health departments for vaccine purchase and program operations. These immunization grants are only one component of HHS activities that assure the implementation of effective immunization practices and proper use of vaccines to achieve high vaccination coverage levels.

The PART assessment determined that the program has strong management practices and successfully improves vaccination coverage among children. It was recommended that program management and planning be improved to better demonstrate program outcomes and results. Specific PART recommendations include:

- Undergo an independent evaluation on a regular basis, or as needed, to fill gaps in performance information to support program improvement and evaluate effectiveness.
- Establish processes and procedures to measure and/or improve program efficiency - additional steps to improve vaccine distribution should be examined.
- Improve mechanisms linking the program's budget for State immunization program and operations activities to program performance.

In response to this recommendation, CDC has contracted with RTI International to conduct a comprehensive evaluation of the Section 317 grant program performance, management, and operations, and will provide recommendations to improve the efficiencies. This evaluation may include benchmarking the Section 317 grant program against other similar federally funded grant programs within and outside CDC. To date, phase one of the evaluation has been completed which assessed the program mission, performance measures, and objectives in relation to how they are being implemented by CDC and its grantees. An economic evaluation of the relationship between program inputs and outputs was conducted ahead of schedule, and a report of the findings is being finalized.

The program is working to develop a new baseline for an efficiency measure that will be used to help grantees become more cost efficient as they conduct site visits to providers to assess vaccination coverage levels among patients in the providers' practices as part of their Assessment, Feedback, Incentives, and eXchange of Information (AFIX) efforts.

External Factors

Despite great success, there are many challenges in meeting the illustrative performance measure. Obstacles include:

- **Implementing effective strategies in private provider practices** - Private providers may face financial and time constraints that limit their ability to implement provider-based strategies to raise coverage.
- **A complicated vaccination schedule for children** - As more vaccines become available, including combination vaccines with varying antigens, the immunization schedule becomes more complex.
- **Shortages of vaccines** - In the past few years, the United States has experienced shortages of recommended childhood vaccines, as well as a recent shortage of influenza vaccine. Some of these shortages were widespread, while others were localized. Reasons for shortages included companies leaving the market and production problems.

- **Difficulty in acquiring accurate and complete immunization records** - Because children are seen in multiple provider offices, and parents typically do not have complete records, it can be difficult for providers to assess a child's need for specific immunizations.

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 President's Budget includes $428.7 million for the Immunization Program, not including VFC, a reduction of $50 million below FY 2005. The budget includes several components. First, the FY 2006 President's Budget includes two initiatives to increase influenza vaccine coverage in the United States. A supply shortage during the 2004-2005 influenza season highlighted the need to provide incentives to manufacturers to produce sufficient flu vaccine to raise supply and coverage rates nationwide. The President's Budget contains a $30 million initiative for CDC to enter into supply guarantee contracts with influenza vaccine manufacturers and an additional $20 million initiative to provide grants to States targeted to influenza vaccine purchase. Similar to the FY 2005 President's Budget, legislation is sought to enable VFC-eligible children to obtain VFC vaccines at public health clinics; currently they can only receive these vaccines at Community Health Centers and Federally Qualified Health Centers (FQHC). This improved access is projected to expand the VFC program by $140 million while also reducing by $100 million the demand for vaccines purchased with discretionary appropriations. The proposed legislation would also eliminate the price caps on VFC that have excluded some vaccines from the VFC program. Additionally, a portion of the decrease in funding reflects a savings in information technology costs at CDC.

PROGRAM 1B: HIV/AIDS PREVENTION IN THE U.S.

Centers for Disease Control and Prevention (CDC)

FY 2006 Budget Request:
$657.7 Million

FY 2006 Full Cost:
$741.2 Million

FY 2004 PART Rating:
Results Not Demonstrated

PROGRAM DESCRIPTION

Approximately 900,000 Americans are infected with HIV, the virus that causes AIDS, and an estimated 40,000 more are newly infected each year at an estimated lifetime cost of $224,000 per person. One-quarter of those infected are unaware of their infection, yet persons who are aware of their infection are more likely to modify their behaviors to avoid transmission to others. Globally, an estimated 38 million people are infected with HIV and three million people have died of their infection.

The HIV epidemic continues to have a disproportionate impact on racial and ethnic minorities. Nearly 70 percent of new HIV infections occur among minorities. In 2002, African Americans accounted for 54 percent of all new diagnoses of HIV/AIDS.

CDC provides national leadership in preventing and controlling HIV infection by working in collaboration with partners at community, State, and national levels to apply well-integrated, multidisciplinary programs of research, surveillance, risk factor and disease intervention, and evaluation. CDC conducts surveillance and epidemiologic and behavioral research to monitor trends and risk behaviors related to HIV/AIDS and to provide a basis for targeting prevention resources. CDC also provides financial and technical assistance for HIV prevention programs conducted by State, local, and territorial health departments, minority organizations, community-based organizations, business, labor, religious organizations, and training agencies. Supporting these efforts are intervention and operations research, and evaluation activities.

PERFORMANCE ANALYSIS

✓ ***Performance Measure*** *Reduce the number of HIV-infection cases diagnosed each year among people under 25 years of age.*

✓ ***Performance Measure:*** *Decrease the number of perinatally acquired AIDS cases from the 1998 base of 235 cases.*

For FY 2006, CDC's National Center for HIV/AIDS, STD and TB Prevention has a total of eight domestic HIV/AIDS performance measures, including six outcome measures, one output measure, and one efficiency measure.

The overarching HIV/AIDS Prevention goal states:

By 2010, reduce by 25 percent the number of new HIV infections in the United States, as measured by a reduction in the number of HIV infections diagnosed each year among people under 25 years of age, from 2,100 in 2000 to approximately 1,600 in 2010 (data from 25 States with confidential, name-based reporting).

Historically, new AIDS cases (AIDS incidence) have been the basis for assessing needs for prevention and treatment programs. However, potent new antiretroviral therapies are delaying or preventing the development of AIDS in many HIV-infected persons, and AIDS data are no longer sufficient to describe the epidemic. Data on HIV incidence are now needed to monitor the effect of the epidemic. CDC is working with States to implement and improve HIV reporting and is developing methods to estimate HIV incidence nationally.

To address the overarching goal, the program has established the following performance measures:

Performance Measure: Reduce the number of HIV-infection cases diagnosed each year among people under 25 years of age.

The number of HIV-infection cases among persons under 25 years of age diagnosed each year is the best data available to monitor new HIV infections. HIV infections occurring in this group are likely to have been acquired recently and, thus, are a relatively good proxy measure of HIV incidence. In addition, these data enable CDC to look at yearly trends in reported cases by risk, demographic, and geographic variables. In 2003 (the most recent year for which results are available), the results for this measure were 2,331 cases in the 25 States with confidential, name-based HIV reporting.

Performance Measure: Reduce the number of HIV-infection cases diagnosed each year among people under 25 years of age. [1, 2]

Data Source: HIV/AIDS Reporting System

Year	Target [3]	Actual
2001	Not Applicable	2,241 cases [4]
2002	Not Applicable	2,926 cases [4]
2003	Not Applicable	2,331 cases [4]
2004	Overall: 1,900 reported cases (25 areas)	Data Available: 8/2005
2005	Overall: 1,800 reported cases (25 areas)	Data Available: 8/2006
2006	Overall: 2,420 reported cases (30 areas)	Data Available: 8/2007

[1] CDC will continue to revise baseline and targets when data from more states with adequate HIV reporting systems are available.
[2] Data are from 25 states with confidential, name-based HIV reporting. Beginning in 2006, all reported data will be from 30 areas with confidential, name-based HIV reporting.
[3] This measure was first reported in FY 2004 and therefore, targets begin in FY 2004. However, actual performance is shown for previous years because the data was available, even though it was not reported in the form of a measure.
[4] All data have been modified to update annual "actual performance" numbers based on the most recent HIV and AIDS surveillance data. Therefore, some values have changed for prior years.

Data for these measures are from a national surveillance system that collects demographic, clinical, and behavioral information on all AIDS cases diagnosed in the U.S. as well as HIV cases diagnosed in States with HIV reporting requirements. FY 2004 and 2005 targets were set when only 25 States had stable, confidential name-based HIV reporting. Data for FY 2006 will come from 30 areas (29 States and the U.S. Virgin Islands) with confidential, name-based HIV reporting. The FY 2006 target has been raised to 2,420 reported cases to reflect the addition of data from 5 additional areas.

Performance Measure: Decrease the number of perinatally acquired AIDS cases, from the 1998 base of 235 cases.

Data Source: HIV/AIDS Reporting System

Year	Target	Actual
2001	151 cases	100 cases [5]
2002	141 cases	90 cases
2003	<139 cases	58 cases
2004	<100 cases	Data Available: 8/2005
2005	<100 cases	Data Available: 8/2006
2006	<100 cases	Data Available: 8/2007

[5] All data have been modified to update annual "actual performance" numbers based on the most recent HIV and AIDS surveillance data. Therefore, some values have changed for prior years.

Performance Measure: Decrease the number of perinatally acquired AIDS cases from the 1998 base of 235 cases.

Surveillance data reported through December 2003 show sharply declining trends in perinatal AIDS cases. This decline was strongly associated with increasing zidovudine use in pregnant women who were aware of their HIV status. More

recently, improved treatment has also likely delayed onset of AIDS for HIV-infected children. With efforts to maximally reduce perinatal HIV transmission and increase treatment for those infected, the number of cases is likely to remain low. However, declines may be affected by treatment failures and missed opportunities to prevent transmission. Data for 2003 continues to show low levels of perinatally acquired AIDS cases from 90 in 2002 to 58 in 2003. The target for FY 2006 is less than 100 cases.

PART Review

CDC's domestic HIV/AIDS prevention program underwent a PART review for the FY 2004 budget cycle. Following the review, a number of recommendations were provided for the program. These include:

- Develop methods to estimate the level of resources required to reach program goals;
- Hold federal managers accountable for program performance;
- Develop incentives and procedures to measure and achieve efficiencies and cost-effectiveness in program execution;
- Improve oversight of grantee activities; and
- Collect data on program performance and make it available publicly.

CDC is working to implement these recommendations and reports regularly on achieving the milestones established for each recommendation. Currently, CDC is working to complete development of a cost model for HIV incidence; revising federal managers' work plans (both Commissioned Corps and Civil Service) to link performance plans with program performance; reviewing savings from bulk purchase of test kits and train-the-trainer sessions; implementing the first phase of the Program Evaluation Monitoring System (PEMS); and has developed a template to review grantee performance.

External Factors

Factors beyond CDC's control may affect whether CDC is able to reach its HIV-infection reduction goal and targets. For example, if an infected woman does not seek or receive care, an opportunity to prevent perinatal HIV transmission may be missed. Also, an increased number of HIV-positive men and women are living longer, healthier lives because of treatment. Over time, this situation can lead to increased opportunities to transmit HIV. The changing trends in drug use (e.g., current trends in methamphetamine abuse), which are associated with HIV transmission, are another external factor. These external factors pose challenges to HIV prevention. Scientists have also speculated that those persons at risk may be suffering from "prevention fatigue" and may have difficulty maintaining safer behaviors over the years.

Rationale for the Budget Request

The FY 2006 President's Budget for the domestic HIV/AIDS program is $657.7 million, resulting in a reduction of $4.6 million as compared to FY 2005. The decrease in funding reflects a savings in information technology costs at CDC. Total funding will allow CDC to continue its collaborative efforts in research, surveillance, risk factor and disease intervention, and evaluation to prevent and control HIV/AIDS transmission and infection.

PROGRAM 1C: SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

Substance Abuse and Mental Health Services Administration (SAMHSA)

FY 2006 Budget Request:
$1,775.6 Million

FY 2006 Full Cost:
$1,823.4 Million

FY 2005 PART Rating:
Ineffective

✓ ***Performance Measure:*** *Increase the number of clients served.*

PROGRAM DESCRIPTION

SAMHSA's Substance Abuse Prevention and Treatment Block Grant (SAPT) is the cornerstone of the States' substance abuse programs. The block grant's goal is to improve the health of the nation by bringing effective alcohol and drug treatment and prevention services to every community. The program addresses the nation's need for substance abuse treatment and prevention services. This need is evidenced by current findings from SAMHSA's National Survey on Drug Use and Health, including:

An estimated 19.5 million Americans, or 8.2 percent of the population aged 12 or older, were current illicit drug users.

- An estimated one million people felt they needed treatment for a drug or alcohol problem but did not receive it.
- About 10.9 million persons aged 12 to 20 reported drinking alcohol in the month prior to the survey interview in 2003 (29.0 percent of this age group). Of these, nearly 7.2 million (19.2 percent) were binge drinkers and 2.3 million (6.1 percent) were heavy drinkers.
- Only 34.9 percent of youths indicated that smoking marijuana once a month was a great risk.

The mechanism used is a block grant to the States and territories. Each State submits an annual plan that describes how the applicant intends to expend the grant. States use block grant funds to support a wide range of treatment and prevention activities, including clinical services, infrastructure development, planning and needs assessment, and prevention programming. The block grant contains a 20 percent set-aside for prevention and a provision for reduction of the block grant funds if the State exceeds a targeted rate of tobacco sales to minors.

PERFORMANCE ANALYSIS

There are separate measures for the treatment and prevention portions of the Substance Abuse Prevention and Treatment Block Grant.

Treatment measures include:

- Number of clients served.
- Number of States and Territories voluntarily reporting performance measures.
- Percentage of States and Territories that express satisfaction with technical assistance provided.
- Percent of technical assistance events that result in system, program, or practice change.

- Percentage of States in appropriate cost bands.
- Percentage of clients reporting change in abstinence at discharge.

Prevention measures include:

- Increase satisfaction with technical assistance.
- Increase services provided within cost bands. (developmental)
- Improvements in non-use and in use among program participants in the last 30 days. (developmental)
- Increase perception of harm of drug use among program participants. (developmental)

Several developmental measures will provide client outcome data in future years.

Performance Measure: Increase the number of clients served.

Data Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Treatment Episode Data Set*

Year	Target	Actual
2001	1,635,422 clients	1,739,796 clients
2002	1,751,537 clients	1,882,584 clients
2003	1,884,654 clients	Data available 09/2005
2004	1,925,345 clients	Data available 09/2006
2005	1,963,851 clients	Data available 09/2007
2006	1,983,490 clients	Data available 09/2008

PART REVIEW

The SAPT Block Grant underwent a PART review during the FY 2005 budget cycle. The program's overall rating was Ineffective, primarily due to the lack of outcome measures, data, and an independent evaluation. The PART review produced three recommendations:

- Develop data for performance measures: The FY 2005 Uniform Block Grant application has been revised to collect new voluntary outcome measures, and States have begun reporting data.
- Conduct independent and comprehensive program evaluation of the national program: An evaluability study of the SAPT Block Grant was completed in December 2004. Plans for a full evaluation are in progress.
- Present performance information disaggregated by State on the website: Expected completion date for this task is September 2005.

SAMHSA has been working with the States, even prior to the PART review, on developing and implementing performance measures. SAMHSA will now be requesting performance information from the States as part of the block grant applications and moving toward a more performance-based program. No changes in funding are required to implement recommendations from the PART review.

EXTERNAL FACTORS

The following external factors affect the performance of the SAPT Block Grant:

- The status of the national economy, including changes in employment and insurance coverage for substance abuse and mental health services.
- The amount of resources that States and communities are able to allocate to prevention and treatment of substance abuse.
- The variation in the supply of (and demand for) illegal drugs such as heroin and cocaine, as well as new addictive substances.

RATIONALE FOR BUDGET REQUEST

The FY 2006 budget of $1,775.6 million will maintain the same program activity level as the FY 2005 President's Budget. Five percent of the budget supports data collection, technical assistance, and program evaluation.

STRATEGIC GOAL 2

Enhance the Ability of the Nation's Health Care System to Effectively Respond to Terrorism and Other Public Health Challenges.

Highlighted Programs:

2a. Field Foods Program (FDA)

2b. Bioterrorism Hospital Preparedness Program (HRSA)

2c. Terrorism Preparedness and Emergency Response Program (CDC)

HHS has a number of initiatives and programs directed at protecting Americans from bioterrorist attacks and other public health challenges. The events of September 11, 2001, and subsequent anthrax attacks have reinforced the HHS role in protecting Americans from attacks on our health and food supply by enhancing preparedness and response capabilities.

The Office of Public Health Emergency Preparedness (OPHEP) was established to direct the Department's efforts in preparing for, protecting against, responding to, and recovering from all acts of bioterrorism and other public health emergencies that could affect the civilian population. OPHEP serves as the focal point within HHS for these activities, directing and coordinating the development and implementation of a comprehensive HHS strategy.

The Food and Drug Administration works to provide responsive regulatory review of new biodefense medical countermeasures and plays a major role by inspecting high risk domestic food manufacturers and enhancing food import inspections to protect our Nation's food supply and prevent food borne illness. The Health Resources and Services Administration works to prepare hospitals and other medical facilities for health consequences of bioterrorism and other mass casualty events. The Centers for Disease Control and Prevention has an integral role in strengthening State and local public health infrastructure to effectively respond to emergencies.

The measures described in this section are representative of HHS progress towards building the necessary infrastructure to respond to bioterrorist and other public health challenges.

STRATEGIC GOAL 2a: FIELD FOODS PROGRAM

Food and Drug Administration (FDA)

FY 2006 Budget Request:
$ 342.7 Million

FY 2006 Full Cost:
$ 371.7 Million

FY 2005 PART Rating:
Moderately Effective

PROGRAM DESCRIPTION

The Field Foods Program promotes and protects the public's health by ensuring that the U.S. food supply is safe, sanitary, wholesome, and honestly labeled, and that cosmetic products are safe and properly labeled. As a result of the terrorist attacks of September 11, 2001, and the passage of the Bioterrorism Act of 2002, the Program took on a food security/defense role to improve further the protection of the Nation's food supply, which is among the world's safest.

The volume of all FDA-regulated imported shipments including food and animal feed has been rising steadily in recent years, and this trend is likely to continue. FDA-regulated imports have been growing at a 24 percent annual rate. In FY 2004, food and animal feed products comprised approximately 70 percent of the imported goods that FDA reviewed. To manage this ever-increasing volume, FDA uses risk management strategies to achieve the greatest public health protection with limited resources.

PERFORMANCE ANALYSIS

Performance Measure: Perform prior notice import security reviews on 38,000 food and animal feed line entries considered to be at high risk for bioterrorism and/or present the potential of a significant health risk.

✓ ***Performance Measure:*** *Perform prior notice import security reviews on 38,000 food and animal feed line entries considered to be at high risk for bioterrorism and/or present the potential of a significant health risk.*

In FY 2006, FDA will continue to focus much of its resources on intensive prior notice import security reviews of products that pose the highest potential bioterrorism risks to the U.S. consumer and market. By FY 2006, FDA expects that the Prior Notice Center will have hired a permanent staff of Reviewers and Watch Commanders that will have achieved the training and gained the experience necessary to expand its scope of targeting to include additional threat parameters. The Prior Notice Center will receive feedback from import field exams and filer evaluations and begin targeting those individuals that continuously violate the law. They will also target commodities based on immediate and potential threats to the integrity and security of the intact food supply chain. In addition, broader surveillance of products imported from countries considered to be at a higher risk for terrorist activities can be incorporated into targeting goals. Strategies used to ensure effective targeting will include:

- Intelligence regarding countries at risk for terrorism;
- Intelligence regarding commodities susceptible to or exploited by terrorism;
- Intelligence specific to shipment or shipping entities;
- Information gleaned from Foreign and Domestic Establishment Inspection Reports that identify security breaches;
- Sample collection and analysis for counterterrorism;
- Prior Notice discrepancies reported during import field exams; and
- Filer evaluation field audits.

Performance Measure: Perform prior notice import security reviews on 38,000 food and animal feed line entries considered to be at high risk for bioterrorism and/or present the potential of a significant health risk.

Data Source:

Year	Target	Actual
2005	38,000	
2006	38,000	

Commissioning MOU with Customs and Border Protection

On Wednesday, December 3, 2003, the Commissioner of the FDA and Customs and Border Protection's (CBP) Deputy Commissioner signed a Memorandum of Understanding between FDA and CBP that allows FDA to commission CBP officers. These commissioned officers will assist FDA with examinations and investigations pursuant to, or based on information obtained under the prior notice requirements (21 U.S.C. 381(m)) and its implementing regulations, at ports or other facilities and locations subject to CBP jurisdiction. As of January 2005, approximately 9,500 CBP officers have been commissioned.

FDA anticipates that the measures that it uses to assess its success in monitoring the safety and security of imported products will continuously evolve as trade practices and information about risks change.

This goal is new for FY 2005 and FY 2006 since the prior notice requirement of the Bioterrorism Act became effective in December of 2003. In FY 2004, FDA collaborated with Customs and Border Protection to direct field personnel to hold and examine 20 suspect shipments of imported food; responded to 20,430 inquiries; and conducted 33,111 intensive reviews of Prior Notice submissions out of 6,294,821 in order to intercept contaminated products before they entered the food supply.

PART REVIEW

In FDA's FY 2005 PART review, FDA was acknowledged and commended for developing eight new long-term outcome and efficiency goals. FDA continues to respond to the sole recommendation from the FY 2005 PART which was to demonstrate progress towards achieving its new long-term outcome goals.

FDA remains committed to improving processes and implementing new initiatives which will ultimately help to achieve the long-term outcome goals. During the past year, FDA has developed baseline data to measure progress on outcome goals; mapped business processes to understand and better align activities and outputs with outcomes and strategic goals; improved processes that support performance targets; and implemented new initiatives that help achieve outcome goals.

EXTERNAL FACTORS

As FDA continues to develop its relationship with the Department of Homeland Security's Customs and Border Protection organization, practices, procedures and regulations may change that will result in changes in prior notice security review activities.

RATIONALE FOR THE BUDGET REQUEST

Prior notice import security reviews are financed within the $342.7 million request for the Field Foods program in the FY 2006 budget. Within this total, FDA plans to allocate $6.5 million to the prior notice import security reviews. This funding level will remain the same as FY 2005.

PROGRAM 2B: BIOTERRORISM HOSPITAL PREPAREDNESS PROGRAM

Health Resources and Services Administration (HRSA)

FY 2006 Budget Request:
$ 483.0 Million

FY 2006 Full Cost:
$ 483.0 Million

FY 2005 PART Rating:
Results Not Demonstrated

PROGRAM DESCRIPTION

The Bioterrorism Hospital Preparedness Program, which is part of the President's Homeland Security Initiative, has the goal of readying hospitals and supporting health care systems to deliver coordinated and effective care to victims of terrorism and other public health emergencies. The program is designed to enable State and regional planning among local hospitals, emergency medical services systems, health centers, poison control centers, and other health care facilities to improve their preparedness to work together to combat terrorist attacks and deal with infectious disease epidemics and other public health emergencies. Through coordination efforts on both the State and Federal levels, the hospital preparedness plans have also been linked with State and local public health preparedness planning funded by the CDC, and, where applicable, the Metropolitan Medical Response Systems funded by the Department of Homeland Security.

This program was initially funded in FY 2002. A major accomplishment of the program was the successful and expedient award of funding to 59 eligible entities in that first year in response to the national emergency heralded by the anthrax attacks in late 2001. These funds enabled awardees to set up hospital preparedness offices with bioterrorism coordinators and medical advisors, begin their needs assessments of hospital preparedness, and begin development of regional preparedness plans. In both FY 2003 and FY 2004, the program made 62 awards to assist awardees to further develop and implement regional preparedness plans. The program has also contracted to establish a national resource center for bioterrorism hospital preparedness. This resource center will serve as a central repository of information, tools, best practices, and technical assistance available to awardees as they continue to implement their work plans.

✓ ***Performance Measure:*** *Percent of awardees that have developed plans to address surge capacity.*

Communication is a key factor in preparedness. Data from progress reports indicate that all jurisdictions are putting in place mechanisms that address gaps in the communications systems among hospital emergency departments, outpatient facilities, emergency medical services systems and State and local emergency management, public health and law enforcement agencies, and poison control centers. Data from a recent hospital preparedness survey indicates that 95 percent of the hospitals surveyed had a mechanism in place for rapid receipt and posting of public health alerts.

PERFORMANCE ANALYSIS

The Bioterrorism Hospital Preparedness Program has five annual performance measures covering the following areas: planning and implementation of plans for regional preparedness to address surge capacity due to a terrorist attack or other public health emergency; ability to secure and distribute pharmaceutical resources required in such emergency events; assessment, acquisition and provision of training related to chemical and radiological response equipment; and demonstration of ability to evaluate, diagnose, and treat adult and pediatric patients in a catastrophic public health emergency. Four of the program's five measures were developed during the FY 2005 PART review process. Data on performance will be obtained from awardees' progress reports, reports of annual drills, periodic surveys, and evaluation reports. Information will be validated through site visits and other monitoring and certification procedures by HRSA. HRSA continues to work on developing and refining measures to determine program success.

Performance Measure: Percent of awardees that have developed plans to address surge capacity.

Performance Measure: Percent of awardees that have developed plans to address surge capacity.		
Data Source: Progress Reports to HRSA		
Year	**Target**	**Actual**
2003		59% (estimated baseline)
2004	90%	89%
2005	100%	Data available 12/2005
2006	100%	Data available 12/2006

A terrorist attack or other large-scale emergency could result in a demand for health care that could rapidly overwhelm the resources in a specific region. Surge capacity is the ability to accommodate a large and rapid increase in the number of persons requiring care. It is a major issue for hospitals across the Nation, and is a key to preparedness for biological, chemical, radiological, or explosive incidents, as well as epidemics of infectious diseases or related disorders. The requirement to develop plans to address surge capacity to deal with potential terrorist and other public health threats is based on the concept that improved outcomes can be achieved when critical components of preparedness are formalized in a plan and organized into a system of care.

With regard to surge capacity, program grantees will address the following issues: (1) hospital bed capacity for both adults and children; (2) capacity for isolation and referral of patients with communicable infections; (3) appropriate staffing; (4) antibiotic and vaccine treatment of adult and pediatric biological exposures; (5) antidote and prophylactic treatment for chemical and radiological exposures; (6) personal protective equipment; (7) capacity for trauma and burn care; (8) capacity for mental health care; (9) communications and information technology, and (10) capacity for mass mortuary activities.

In FY 2004, 89 percent of Hospital Preparedness program awardees had developed surge capacity plans, up from an estimated baseline of 59 percent in 2003. This was only one percentage point below the target. This information was obtained from awardees' March 2004 semi-annual progress reports. The goal is that 100 percent of awardees will have plans to respond to a surge capacity of 500 patients per million population by 2005. In the future, the program will track various aspects of the implementation of these plans.

PART REVIEW

A PART review of the Bioterrorism Hospital Preparedness Program was conducted for the FY 2005 budget. The program received a rating of Results Not Demonstrated. The assessment found that the purpose and importance of this effort are clear and that the effort is well coordinated with other Federal preparedness efforts. The review also noted that the program has not yet demonstrated results due its relative newness and the inherent difficulty of measuring preparedness against an event that does not regularly occur. The program notes, in this context, the added challenge of measuring the relatively new and evolving concept of preparedness.

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

External Factors

There are a variety of factors that make it complicated to develop surge capacity at the regional level. Among the most significant of these are the following:

- It may be relatively easy for an individual hospital to develop surge capacity, but it becomes much more difficult when this is done on a regional basis. Hospitals need to be identified as to their strengths and weaknesses, and the regional system built on that assessment. There will need to be an effort to avoid duplication. Not every hospital needs every capability.
- There is a need to link the hospital system to the public health infrastructure. These two communities have not always had a close pattern of communications and cooperation. In the event of an attack, the health care system will have to be able to mount a collective response with seamless interaction between the State and local health departments, hospitals, and other health care entities.
- Even though it may be possible to supplement the number of hospital beds, one of the most difficult issues is identifying staff that can provide appropriate services. There are issues of credentialing, licensure, and the general availability of additional staff.
- The needs for surge capacity may be quite different in a situation involving infectious diseases (e.g., need for isolation beds) versus a situation involving a mass trauma event. Planning for surge capacity requires planning for a variety of scenarios.

Rationale For Budget

The budget requests $483 million in FY 2006 to continue progress towards the goal of 100 percent of States having the necessary surge capacity plans including elements of the health care provider workforce and pharmaceutical and laboratory services. Of this amount, $25 million will be used to create a state-of-the-art emergency care capability designed to respond to a terrorist attack or other incident requiring mass casualty care and/or containment of infectious agents in one or more metropolitan areas. In addition, HRSA will continue to define the State-based Emergency System for Advance Registration of Volunteer Healthcare Personnel, a system to ensure that volunteer health professionals are able to respond in the event of a mass casualty event.

STRATEGIC GOAL 2c: TERRORISM PREPAREDNESS AND EMERGENCY RESPONSE PROGRAM

Centers for Disease Control and Prevention (CDC)

FY 2006 Budget Request:
$1,616.7 Million

FY 2006 Full Cost:
$1,639.8 Million

FY 2005 PART Rating:
Division of State and Local Readiness: Results Not Demonstrated

✓ ***Performance Measure:***
100 percent of State public health agencies improve their capacity to respond to exposure to chemicals or biological Category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified. The target for FY 2006 is 100 percent.

PROGRAM DESCRIPTION

CDC pursues its terrorism preparedness mission by: (1) investing in preparedness and response efforts; (2) developing new, and maintaining traditional and non-traditional, partnerships; (3) working with provider and first responder organizations to link personal and community health to enhance early intervention activities; and (4) expanding technology. Another key mechanism for advancing national preparedness is the bioterrorism preparedness cooperative agreements that are awarded to 62 State and local grantees.

CDC preparedness activities and investments support a preparedness framework around pre-event, event, and post-event conditions. This framework can be further broken down into seven functional areas.

- Prevention activities include investments made to reduce the number of those at risk by implementing interventions and analyzing information prior to exposure.
- Detection includes investments made to provide real-time data and information to those managing the emergency.
- Reporting includes investments made to increase comprehensive knowledge of the current health and threat status of the public. It involves more reports to local, State and federal public health agencies, either through passive reporting, active reporting, or sophisticated early event warning systems.
- Investigation pertains to investments made to define the health threat agent, extent of exposure, and appropriate interventions.
- Control includes investments made to develop, distribute, and communicate information regarding countermeasures and interventions.
- Recovery includes investments made to provide redundancy and early replication of existing services. Goals for recovery describe the reduction of time needed for the restoration of services, as well as long-term research involving those exposed or involved in the event.
- Improvement provides a framework for assuring gaps in services or science are addressed once uncovered, and that remedies are provided as soon as possible to improve the system.

PERFORMANCE ANALYSIS

CDC's Terrorism Preparedness and Response Program has a total of 20 performance measures, including one efficiency measure, four outcome measures and 15 output measures. The two measures below were established by CDC and OMB during the FY 2005 PART review of the Division of State and Local Readiness.

To address its overall Investigation and Response goal to decrease the time to identify causes, risk factors, and appropriate interventions for those affected by threats to the public's health, the program has established several performance measures including:

Performance Measure: 100 percent of State public health agencies improve their capacity to respond to exposure to chemicals or biological Category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified. The target for FY 2006 is 100 percent.

As of November 2004, 100 percent of grantees have written response plans that cover at least one of the Category A biological agents, chemical agents, or radiation. The following percentages of awardees indicate they have Statewide response plans for the listed agent: Anthrax: 84 percent, Botulism: 70 percent, Plague: 74 percent, Smallpox: 98 percent, Tularemia: 72 percent, Nerve Agents: 44 percent, Blood Agents: 48 percent, Blister Agents: 44 percent, Radiation/Nuclear: 70 percent, and Influenza (Pandemic Flu): 90 percent. Though work has begun, actual progress regarding this performance measure will be reported beginning in December 2005.

Performance Measure: 100 percent of state public health agencies improve their capacity to respond to exposure to chemicals or Category A agents by annually exercising scalable plans and implementing corrective action plans to minimize any gaps identified. [1]

Data Source: Independent on-site assessments

Year	Target	Actual
2001	Not Applicable	Not Applicable
2002	Not Applicable	Not Applicable
2003	Not Applicable	Not Applicable
2004	Not Applicable	Not Applicable
2005	25%	Data Available: 12/2005
2006	100%	Data Available: 12/2006

[1] CDC and OMB established this measure during the FY 2005 PART review of the Division of State and Local Readiness. Though work has begun, actual progress regarding the performance measure will be reported beginning in December 2005.

To address its overall Control goal to decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health, the program has established several performance measures including:

PART REVIEW

CDC's Division of State and Local Readiness underwent a PART review for the FY 2005 budget cycle. It was recommended that independent program evaluations be used to inform strategic planning and program management, and to link performance and budget.

The recommendation for independent evaluations will be realized through use of CDC's internal performance goals for Public Health Disaster Preparedness. The goals are derived from "lessons learned" by responders during real and exercised events and from prevailing opinion of subject matter experts in public health emergency response. The goals reflect current knowledge in an arena that requires more research to establish

definitive benchmarks for performance. Relying on extant knowledge, the performance goals describe both measures of process and measures of outcome. Metrics define individual and organizational performance where credible and practical. The response capabilities of public health agencies will be formally evaluated by independent evaluators using the performance goals after publication in the new Bioterrrosim Cooperative Agreements beginning in 2005.

In addition, CDC will implement a process to link performance and budget for FY 2005 through a series of measures for the Public Health and Social Services Emergency Fund allocation as well as the remainder of the CDC budget. These measures will also be linked to new agency preparedness goals that provide the overarching framework for developing program goals, objectives, and indicators to track and assess performance.

External Factors

External factors greatly impact the program's ability to meet performance goals. Challenges to the achievement of readiness (across CDC and grantees) include the following:

- Preparing for the Unknown and Defining Readiness - The most significant challenge is planning to respond to the unknown. Grantee plans address management of all hazards, including biological, chemical, radiological, nuclear, and mass trauma. For example, while individual grantees may not have primary responsibility for each hazard, the management of a given hazard should be standard across grantees.
- Balancing Public Health Priorities - Terrorism preparedness and response efforts necessitate considerable resources (financial, human, equipment, time). Concurrently, CDC maintains focus on ongoing public health issues (e.g., obesity, heart disease and asthma).
- Grantee Constraints - The ability of State and local public health departments to spend grant funds is subject to jurisdictional budget regulations, State fiscal calendars, complications in contracting, and the lag in receipt of goods and services from contractors. Such considerations hamper grantees' ability to expend funds within the timeframe set by federal guidelines.

Rationale for the Budget Request

The FY 2006 President's Budget for CDC's Terrorism Preparedness and Emergency Response program is $1,616.7 million in total, with the following changes as compared to FY 2005:

- Strategic National Stockpile: +$203.2 million. The programmatic increase will allow for the necessary expansion of the Stockpile's inventory and preparedness resources.
- Upgrading State and Local Capacity: -$129.6 million. State and local capacity building efforts will continue and the decrease reflects completion of many one-time funding efforts in the States, such as purchasing large equipment and laboratory upgrades.
- Anthrax: -$16.7 million. The Anthrax study will be completed in FY 2005.

Additionally, the overall funding reflects a savings in information technology costs at CDC.

STRATEGIC GOAL 3

Increase the Percentage of the Nation's Children and Adults Who Have Access to Health Care Services

3a. Health Centers Program (HRSA)

3b. National Diabetes Program (IHS)

3c. Medicaid and State Children's Health Insurance Program (CMS)

3d. Medicare (CMS)

3e. Quality Improvement Organizations (CMS)

HHS is committed to its many efforts aimed at increasing the percentage of the Nation's children and adults who have access to care and to expanding consumer choices. In FY 2006, the Department will continue to work hard to promote increased access to health care, especially for uninsured and underserved people and for those whose health care needs are not adequately met by the private health care system.

In support of this goal, HHS will continue to promote a wide variety of activities intended to increase access to health care; encourage the development of low-cost health insurance options, reduce health disparities, and to strengthen and improve health care services for targeted populations with special health care needs. HHS entitlement and safety net programs that strive towards these objectives include:

- The Health Centers Program: provides regular access to high quality, family oriented, and comprehensive primary and preventive health care regardless of patients' ability to pay.
- The Indian Health Service National Diabetes Program: works with communities to prevent and treat diabetes in American Indian/ Alaska Native people.
- Medicare: for nearly four decades this program has helped pay medical bills for millions of aged and disabled Americans and has provided them with comprehensive health benefits.
- Medicaid: serves as the primary source of health care for a large population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care.
- State Children's Health Insurance Program: in coordination with Medicaid, SCHIP has stimulated enormous change in the availability of health care coverage for children.
- Quality Improvement Organizations (QIO): Under the direction of CMS, the QIO program consists of a national network of 53 independent physician organizations to promote improved health status.

PROGRAM 3A: HEALTH CENTERS PROGRAM

Health Resources and Services Administration (HRSA)

FY 2006 Budget Request:
$2,037.9 Million

FY 2006 Full Cost:
$2,097.4 Million

FY 2005 PART Rating:
Effective

PROGRAM DESCRIPTION

The Health Centers program is a major component of America's health care safety net for the Nation's indigent populations. Expansion of this program, which is more than 35 years old, is a Presidential initiative to increase health care access for those Americans who are most in need. Millions of Americans are uninsured and lack access to a regular source of health care. Health centers provide regular access to high quality, family-oriented, and comprehensive primary and preventive health care regardless of patients' ability to pay. The ultimate goals of the Health Centers program are to contribute to improvements in the health status of underserved and vulnerable populations and to contribute to the elimination of health disparities. Federal grants to health centers provide about 25 percent of their revenues on average, leveraging three dollars for each Health Centers program dollar spent.

FY 2002 was the first year of the President's Health Centers Initiative to create 1,200 new and expanded health center sites and increase the number of clients served by 6.1 million over a five-year period. In the first three years of the initiative, the program funded 619 sites (334 new sites and 285 significantly expanded sites). To further ensure quality of care, the Health Centers program provides funding for Health Disparity Collaboratives, a quality initiative to improve health outcomes for patients with chronic diabetes, cancer, asthma, depression and cardio-vascular disease. Nationally, more than 500 centers have participated in one or more collaboratives.

PERFORMANCE ANALYSIS

✓ ***Performance Measure:*** *Increase the number of uninsured and underserved persons served by health centers.*

✓ ***Performance Measure:*** *Continue to assure access to preventive and primary care for racial/ethnic minorities.*

✓ ***Performance Measure:*** *Increase new and expanded health center sites.*

The Health Centers program currently has 17 annual performance measures in the annual Performance Budget that track success in reaching various needy populations, expanding access points, operating efficiently, and providing high quality primary and preventive services. The primary source of performance data is the program's Uniform Data System that collects aggregate administrative, demographic, financial, and utilization data annually from each organization receiving support. These data are regularly validated through over 1,000 automated edit checks and on-site performance reviews. Other data sources include periodic surveys of representative samples of health center patients and their medical records, and special performance assessment studies. The Health Centers program has recently launched a Sentinel Centers Network comprising a representative sample of all centers. When fully

operational, the Sentinel Centers Network will routinely provide patient-level data for timely investigation of program and policy issues. This will reduce the need for special periodic surveys of health center users and medical records.

Performance Measure: Increase the number of uninsured and underserved persons served by health centers.

Growth in the number of persons served by health centers is an indicator of improved access to care. The Health Centers program served 12.4 million people in FY 2003. The increase from 2002 to 2003 represents a growth of more than one million additional persons served, and the second consecutive year in which the number of persons served rose by one million or more.

Performance Measure: Increase the number of uninsured and underserved persons served by health centers.

Data Source: HRSA BPHC Uniform Data System

Year	Target	Actual
2001	10.5 million	10.3 million
2002	11.75 million	11.32 million
2003	12.5 million	12.4 million
2004	13.2 million	Data available 08/2005
2005	14.0 million	Data available 08/2006
2006	16.4 million	Data available 08/2007

Performance Measure: Continue to assure access to preventive and primary care for racial/ethnic minorities.

Access to health care is a key to eliminating health disparities. The number of racial/ethnic minority individuals served by the Health Centers program reached 7.92 million in FY 2003, continuing a steady growth consistent with the overall growth in program clients. The proportion of racial/ethnic minority individuals has remained at 64 percent of total clients, only one percentage point below the target of 65 percent. As the Health Centers program expands existing sites and opens new sites in underserved areas, the program will continue to strive for a racial/ethnic minority representation of 65 percent.

Performance Measure: Continue to assure access to preventive and primary care for racial/ethnic minorities.

Data Source: HRSA BPHC Uniform Data System

Year	Target	Actual
2001	65% (6.83 M)	64% (6.62 M)
2002	65% (7.64 M)	64% (7.24 M)
2003	65% (8.16 M)	64% (7.92 M)
2004	65% (8.58 M)	Data available 08/2005
2005	65% (9.07 M)	Data available 08/2006
2006	65% (10.63 M)	Data available 08/2007

Performance Measure: Increase new and expanded health center sites.

A critical element in expanding access to care for the Nation's most vulnerable populations is the establishment of new health center sites and the expansion of existing sites to provide required facilities, personnel, and services, particularly in communities of greatest need. In FY 2004, the Health Centers program funded 129 new or expanded sites, which exceeded the target.

PART Review

A PART review of the Health Centers program was conducted for the FY 2004 budget. The program was rated Effective, the highest rating a program can achieve. The assessment found that the program purpose is clear, the program is designed to have a unique and significant impact, the program uses performance information to improve

annual administrative and clinical outcomes, and the program is making progress in achieving its long-term outcome goals.

Performance Measure: Increase new and expanded health center sites.		
Data Source: HRSA BPHC Health Center Management Information System		
Year	**Target**	**Actual**
2002	260	302
2003	180	188
2004	124	129
2005	153	Data available 09/2005
2006	578	Data available 09/2006

EXTERNAL FACTORS

The performance of the Health Centers program is impacted by the following factors:

- Because the Health Centers program grant funds provide approximately 25 percent of the revenues of health centers Nation-wide, they rely on Medicaid, Medicare, SCHIP, private insurance, additional patient revenue, and other State and local support for non-patient revenue. Given economic pressure on State budgets, Medicaid and other State funding can be variable.
- The Nation's changing demographic profile, particularly the aging of the population, confronts health centers with a growing number of persons with chronic diseases and co-morbidities. This puts extra pressure on centers to maintain efficiency and productivity in the face of shifts in case-mix.

RATIONALE FOR THE BUDGET REQUEST

The FY 2006 budget of $2,037.9 million is $303.6 million above the FY 2005 appropriation. These funds will be used to complete the President's Health Centers Initiative, including new and expanded sites to serve increased numbers of needy individuals. Funds will also support a new initiative to provide health center coverage in low-income counties. The budget includes $45 million for health center tort claims.

PROGRAM 3B: NATIONAL DIABETES PROGRAM
Indian Health Service (IHS)

FY 2006 Budget Request:
$161.0 Million

FY 2006 Full Cost:
$839.0 Million

FY 2004 PART Rating:
Moderately Effective

✓ ***Performance Measure:***
Increase the proportion of patients with diagnosed diabetes that have demonstrated glycemic control.

PROGRAM DESCRIPTION

The IHS National Diabetes Program is an integral part of the IHS Hospitals and Health Clinics Program. The mission of the IHS National Diabetes Program is to develop, document, and sustain a public health effort to prevent and control diabetes in American Indian/Alaska Native (AI/AN) people. The program works with communities to prevent and treat diabetes, as well as oversee the Special Diabetes Program for Indians Grant Program (SDPI). IHS encourages local efforts to improve diabetes-related health outcomes through lifestyle intervention and appropriate medication use through orientation, training, and monitoring provided by area diabetes consultants.

Glycemic control refers to how well the blood sugars are controlled in a person with diabetes. It is measured with a blood test called the Hemoglobin A1c. The IHS Diabetes Care and Outcomes Audit process divides these levels of control into "Ideal" (<7 percent); "Good" (7.0-7.9 percent); "Fair" (8.0-9.9 percent); "Poor" (10-11.9 percent); and "Very Poor" (>12 percent) categories, based on national diabetes care standards. The attached graph illustrates the ongoing ability of HIS to improve glycemic control in AI/AN populations, as well as improve the percentage of patients with ideal control.

Performance Measure: Increase the proportion of patients with diagnosed diabetes that have demonstrated ideal glycemic control.

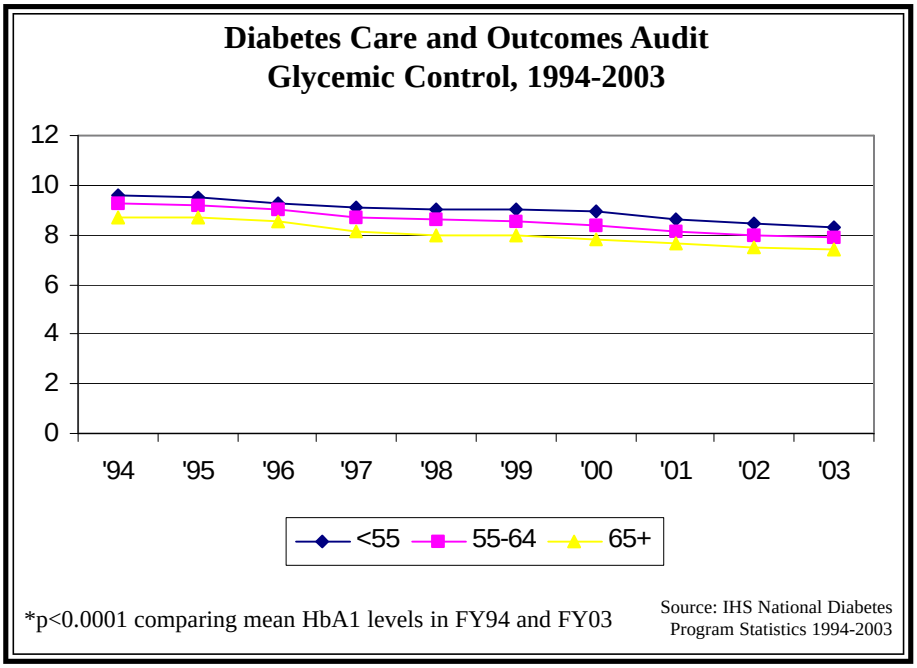
Data Source: Data has historically been obtained from the diabetic audit. Starting in FY 02, a new software application was deployed to allow for electronic data extraction for clinical GPRA indicators (GPRA+) The * represents the result of data obtained from GPRA+.

Year	Target	Actual
2001	Improve from FY 2000 (26%)	29%
2002	Improve from FY 2001 (29%)	30%/25%*
2003	Maintain at FY 2002 level (30%/25%)	31%/28%*
2004	+1 % over FY 2003 level (32%/29%*)	34% /27% *
2005	Maintain at FY 2004 level	Data available 01/2006
2006	Maintain at FY 2005 level	Data available 01/2007

The FY 2004 indicator was to increase the proportion of AI/AN patients that have ideal glycemic control. IHS met the glycemic control indicator based upon the diabetic audit. The 2004 diabetes audit performance showed a 2-percent improvement over the FY 2003 performance level for ideal glycemic control in patients with diagnosed diabetes improving from 32 percent to 34 percent (based upon an audit sample size of 29 percent of known diagnosed diabetics). The FY 2005 and FY 2006 goals are to maintain the FY 2004 results.

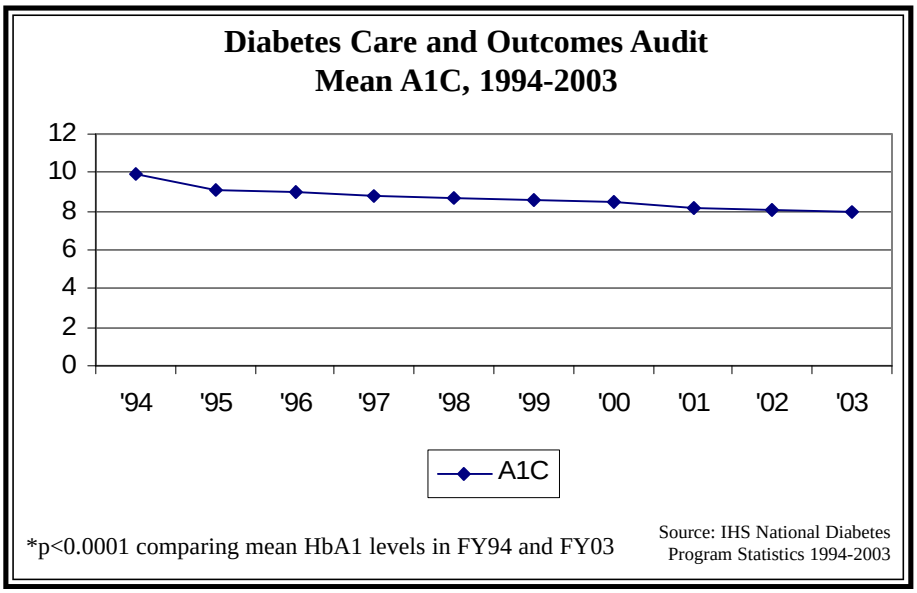
Data from GPRA+ did not show a similar increase. However, there was a nine percent increase in the denominator of GPRA active diabetic patients due to an increased number of sites participating in the GPRA reporting process. There was also an increase in the absolute number of patients in ideal control from

FY 2003 to FY 2004 (in FY 2003- 18,998; in FY 2004- 19,743). This significant increase in newly included patients explains the disparity in the data between the diabetic audit and the comprehensive GPRA electronic data results.



PERFORMANCE ANALYSIS

IHS currently has seven diabetic performance measures within its annual Performance Budget. These measures track different aspects of diabetic care, ranging from blood sugar control to access to dental care for diabetics. This number of measures reflects the critical morbidity that results from the high diabetic disease burden in AI/AN communities. Two data sources, the chart review based audit of diabetics' glycemic control, and the entirely electronic health information system software application (GPRA+) combine to provide reliable performance information. These two data sources have historically shown consistent improvement in our performance on this measure. In addition, the diabetic audit of over 33,769 diabetic patients substantiates the electronic audit of over 116,456 diabetic patients.



HbA1C measures the glucose level (sugar content) of a patient's blood. A lower HbA1C percentage indicates better blood sugar control. These graphs illustrate improving glycemic control among the IHS population, broken into age categories for patients 55 years and older, and among the population as a whole.

PART REVIEW

During the FY 2004 budget process, the IHS PART included a review of the IHS Direct Federal Programs and the Hospital and Clinics Budget, where the funding for diabetes care resides. The program received a rating of Moderately Effective. IHS shared the PART review results with the clinical providers and healthcare facilities, where quality care improvements are operationalized. Ongoing improved trends in diabetes care delivered throughout the IHS demonstrate the public health impact made possible when local, program, and departmental initiatives focus on a common outcome.

The PART review process has also focused attention on the continued importance of assuring valid and reliable performance data addressing diabetic care at all levels of the Indian health system. Ongoing clinical quality initiatives throughout the IHS continue to result in stable, if not improved, clinical outcomes for the AI/AN population.

External Factors

The ongoing and future impact of care to diabetic patients is concerning given several factors:

- Increases in the number of patients receiving care through IHS-funded facilities,
- Increases in pharmaceutical and laboratory costs, and
- Lifestyle changes that can be difficult to incorporate in patients lives.

The programs and activities implemented by the IHS Division of Diabetes Treatment and Prevention provide a strong foundation and new beginning towards a diabetes-free future. However, the diabetes-related health disparities that AI/AN patients already experience may worsen unless access to treatment services keeps up with the growing demand, and additional cost-effective preventive interventions are identified.

Rationale for the Budget Request

The FY 2006 Budget is maintained at the FY 2005 appropriation level, and supports diabetes prevention and disease management at the local level. The program has substantially increased the availability of services – physical activity specialists; registered dieticians and nurses; wellness and physical activity centers; newer and better medications – which has led to a steady increase in the percentage of diabetic patients with ideal blood sugar control.

PROGRAM 3C: MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Centers for Medicare & Medicaid Services (CMS)

FY 2006 Medicaid Budget Request: $192,372.2 Million

FY 2006 Medicaid Full-Cost Budget Request: $192,372.2 Million

FY 2006 SCHIP Budget Request: $4,462.0 Million

FY 2006 SCHIP Full-Cost Budget Request: $4,462.0 Million

FY 2005 SCHIP PART Rating: Adequate

PROGRAM DESCRIPTION

Medicaid is a means-tested health care program for low-income Americans, administered by CMS in partnership with the States. It is the primary source of health care for a large population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care. In coordination with the Medicaid Program, the State Children's Health Insurance Program (SCHIP) has stimulated enormous change in the availability of health care coverage for children.

The Balanced Budget Act of 1997 created SCHIP under Title XXI of the Social Security Act. This program is the largest single expansion of health insurance coverage for children in more than 30 years and improves the access to health care and quality of life for millions of vulnerable children under 19 years of age.

As of September 1999, all States, territories, and the District of Columbia have approved SCHIP plans. CMS continues to review the States' SCHIP plan amendments as the States respond to the challenges of implementing this program. The States continue to be committed to the goals of the SCHIP program including quality, access, and retention.

To assure that both Medicaid and SCHIP reach their potential, CMS has worked with States, other operating divisions of HHS, other Federal Government agencies, and the private sector on a broad array of outreach activities. These activities include providing technical assistance to States to help them improve their programs and promoting the exchange of information among States, community-based organizations, advocacy groups, Government grantees, and private sector groups.

✓ ***Performance Measure:*** *Increase the number of children enrolled in regular Medicaid and SCHIP.*

✓ ***Performance Measure:*** *Improve Health Care Quality Across Medicaid and SCHIP.*

✓ ***Performance Measure:*** *Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Programs.*

SCHIP gives States the option to expand Medicaid (Title XIX) coverage, set up a separate SCHIP program, or have a combination of both a Medicaid expansion and a separate SCHIP program. This flexibility allows States to tailor their children's health insurance programs to individual States'.

For SCHIP, the statutorily mandated allotment for FY 2005 is $4.1 billion, an increase of approximately $900 million over the FY 2004 allotment.

PERFORMANCE ANALYSIS

CMS has developed four performance measures related to Medicaid and SCHIP. With respect to SCHIP, in 1997 CMS implemented the goal to enroll five million children by FY 2005. In order to quantify this

objective, CMS set annual GPRA targets for FYs 2000 through 2002 to enroll at least one million new children in SCHIP and Medicaid per year. CMS changed the FY 2003 target to increase enrollment by five percent over the previous year. This change was made because CMS exceeded the annual GPRA targets for FYs 2000 - 2002 and because States were facing fiscal challenges that may have affected program outreach and enrollment. Economic conditions made it difficult for CMS to achieve its enrollment targets for SCHIP in FY 2004. Therefore, CMS revised its GPRA enrollment targets for FY 2004 to maintain enrollment of children in SCHIP and Medicaid at FY 2003 levels. For FY 2005, CMS set the target at three percent, an increase of approximately one million children, over the FY 2004 level. In FY 2006 CMS has again set the target enrollment increase at three percent or approximately one million children. CMS remains confident that the programs' long-term goals and performance targets will be met. Examples of the Medicaid and SCHIP measures are listed below:

Performance Measure: Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP and Medicaid.

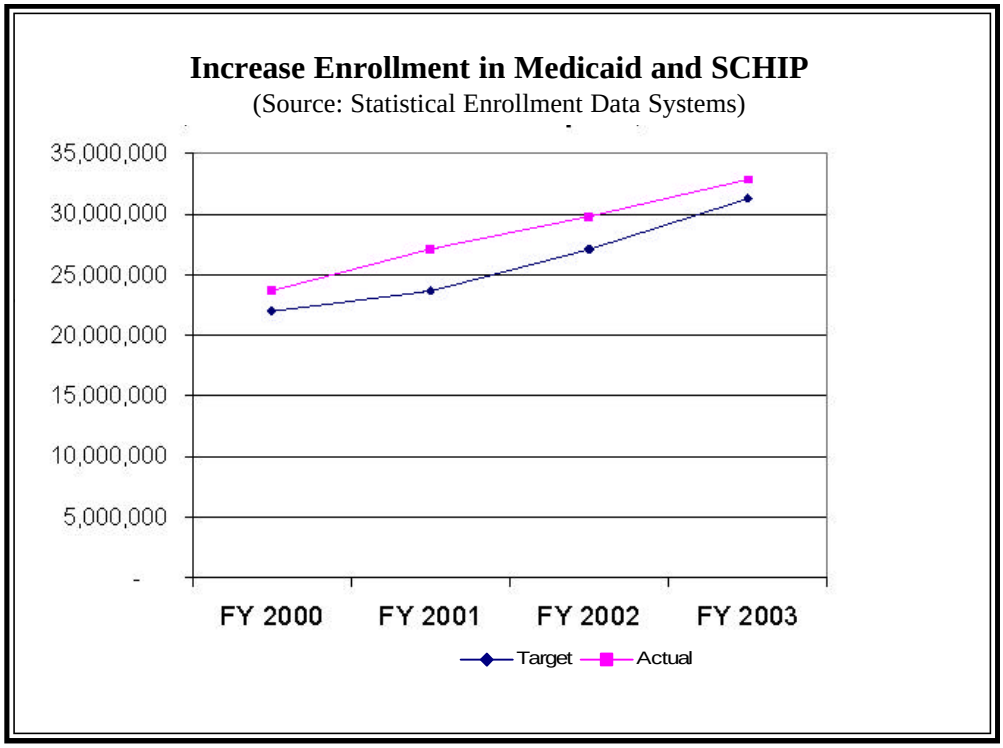
Data Source: Statistical Enrollment Data System

Year	Target	Actual
2001	+1,000,000 over 2000	+2,300,000
2002	+1,000,000 over 2001	+3,100,000
2003	+5% over 2002	+2,200,000
2004	Maintain 2003 levels	Data available 02/2005
2005	+1,000,000/ +3% over 2004	Data available 02/2006
2006	+1,000,000/ +3% over 2005	Data available 02/2007

- Increase the number of children enrolled in regular Medicaid and SCHIP.
- Improve Health Care Quality Across Medicaid and SCHIP.
- Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Programs.

PART REVIEW

During the FY 2004 budget cycle, SCHIP was initially evaluated and received a Moderately Effective PART rating. SCHIP was reassessed in the FY 2005 cycle and received a rating of "Adequate." As a result of the FY 2004 findings, CMS developed an SCHIP Action Plan to address concerns. CMS continues to develop, with States, a core set of national performance measures to evaluate the quality of care received by low-income children. A new annual performance goal was established to use the information gathered from States to establish formal collaborations that will improve health care delivery and quality for Medicaid and SCHIP populations using reliable and valid performance measures. In addition,



CMS will expand the Medicaid Payment Error Rate Measurement (PERM) Program to measure SCHIP improper payments in FY 2005. PERM was originally developed to measure and ultimately reduce Medicaid payment error rates.

A PART assessment has not yet been done on the Medicaid program.

External Factors

In an effort to address budget issues, some States have submitted amendments to increase cost sharing, reduce the period of coverage from 12 to 6 months, and other programmatic changes, which may lead to decreases in enrollment for some States. CMS has also approved SCHIP State plan amendments that allow some States to implement an enrollment cap and/or waiting list. However, as the budget situation improves, some States are making plans to remove these enrollment caps and/or waiting lists and decrease enrollee cost sharing. In addition, many States have eliminated barriers that prevent families from enrolling in Medicaid and SCHIP. For example, many States have simplified application forms and eliminated income verification requirements.

Rationale for Budget Request

Under current law, the estimated Federal share of Medicaid gross obligations is equal to $215.6 billion in FY 2006. These obligations are composed of $181.3 billion for Medicaid benefits, $22.9 billion for obligations incurred by providers but not yet reported, $9.9 billion for Medicaid administrative costs, and $1.5 billion for the CDC Vaccines for Children program.

For FY 2006, the statute authorizes and appropriates $4,050 million for SCHIP allotments to States, the District of Columbia, commonwealths, and territories. Also for FY 2006, the Balanced Budget Refinement Act of 1999 (BBRA) authorized and appropriated an additional $32.4 million for SCHIP allotments to commonwealths and territories. The total funds available for CMS to grant to States, the District of Columbia, commonwealths, and territories for the SCHIP in FY 2006 will be $4,082.4 million. In addition, if any funding from the FY 2003 allotment is not expended by the end of FY 2005, it will become available for redistribution in FY 2006.

According to CMS projections of Medicaid enrollment in FY 2006, 16 percent or 46.3 million of the estimated 290.2 million U.S. residents will be enrolled in Medicaid for the equivalent of a full year during FY 2006. The estimated 21.9 million children who will be served by Medicaid in FY 2006 represent more than one out of every five children in the Nation.

PROGRAM 3D: MEDICARE

Centers for Medicare & Medicaid Services (CMS)

FY 2006 Budget Request:
$399.0 Billion

FY 2006 Full Cost Estimate:
*$399.0 Billion**
**Sale of data user fees not included.*

FY 2005 PART Rating:
Moderately Effective

✓ ***Performance Measure:*** *Implement the New Medicare Prescription Drug Benefit.*

✓ ***Performance Measure:*** *Improve satisfaction of Medicare Beneficiaries with the health care services they receive.*

PROGRAM DESCRIPTION:

CMS administers Medicare, the Nation's largest health insurance program, which covers more than 42 million Americans. Medicare was enacted in 1965 to extend affordable health insurance coverage to the nation's most vulnerable population, the elderly. In 1972, Medicare was expanded to cover the disabled. For nearly four decades, this program has not only helped pay medical bills for millions of Americans, but also provided them with comprehensive health benefits.

CMS's mission is to "assure health care security" for its program beneficiaries. Medicare provides health insurance coverage to the elderly and disabled, ensuring access to the same high quality health care services as the under-65 population. The elderly have health care costs four times those of the under-65 population. The disabled have high total health care expenditures similar to the aged population. Medicare provides a significant public subsidy to finance these health care costs. In the absence of the Medicare program, the elderly and disabled generally would not have sufficient resources to pay for health care.

In December 2003, the President signed into law the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), which provides enhanced coverage for the lowest income beneficiaries and an immediate prescription drug discount card for all beneficiaries until the full benefit is available nationwide. Beginning in 2006, Medicare beneficiaries will have access to a standard Medicare prescription drug benefit. Additionally, the law includes savings for many State governments; increased coverage for preventive services; and provisions for modernizing the drug delivery infrastructure, as well as increased flexibility in the administration of Medicare.

PERFORMANCE ANALYSIS:

There are 18 Medicare-related annual performance goals in the FY 2006 Performance Budget. The Performance Budget has evolved with the enactment of the new Medicare legislation. Four performance goals representing the new Medicare legislation include the prescription drug discount card, the Medicare prescription drug benefit, Medicare contracting reform and the implementation of regional preferred provider organizations.

The enactment of the MMA gives all Medicare beneficiaries access to prescription drug coverage and the collective buying power to reduce

Performance Measure: Implement the new Medicare Prescription Drug Benefit		
Data Source: To be identified as part of the developmental work.		
Year	**Target**	**Actual**
2004	Develop and Publish a Notice of Proposed Rulemaking in the Federal Register with requirements for the new benefit.	Goal met
2005	1) Develop and publish the Final Rule in the Federal Register with requirements for the new benefit. 2) Developmental. Baselines and future targets will be developed to measure Medicare's informational activities, including beneficiary awareness of different features of the new benefit.	
2006	Developmental	

the prices they currently pay for drugs. The Act provides enhanced coverage for the lowest income beneficiaries and an immediate prescription drug discount card for all people with Medicare until the full benefit is available nationwide. The new prescription drug card goal will monitor the progress of implementation by tracking questions coming into the 1-800-MEDICARE call center. Based on information received, CMS will modify the print materials and the website as needed. Medicare beneficiaries began signing up for drug cards on May 3, 2004, with discounts beginning June 1, 2004. Those with incomes below 135 percent of poverty were given immediate assistance through a Medicare-endorsed prescription drug discount card with $600 annually to apply toward purchasing their medications.

Beginning in January 2006, Medicare beneficiaries will have access to a standard prescription drug benefit. The benefit offered by each plan must at least be equal in value to the standard benefit. People with limited savings and low income will receive a more generous benefit package. Data collection will begin in 2006 to monitor the effectiveness of the implementation phase. As of August 3, 2004, CMS met its FY 2004 target by preparing and publishing the Notice of Proposed Rulemaking in the Federal Register for the Prescription Drug Benefit.

"Assuring health care security" covers a wide array of activities, beginning with paying claims for Medicare-covered beneficiary services. Medicare has three components: Hospital Insurance, Supplementary Medical Insurance, and Medicare Advantage. Medicare processes over one billion fee-for-service claims each year, is the nation's largest purchaser of managed health care, and is expected to account for more than 14 percent of the Federal budget in FY 2006. The claims payment activity is supported by CMS's Medicare Operations budget, which funds its contractors (carriers and fiscal intermediaries) and the information technology needed for claims processing.

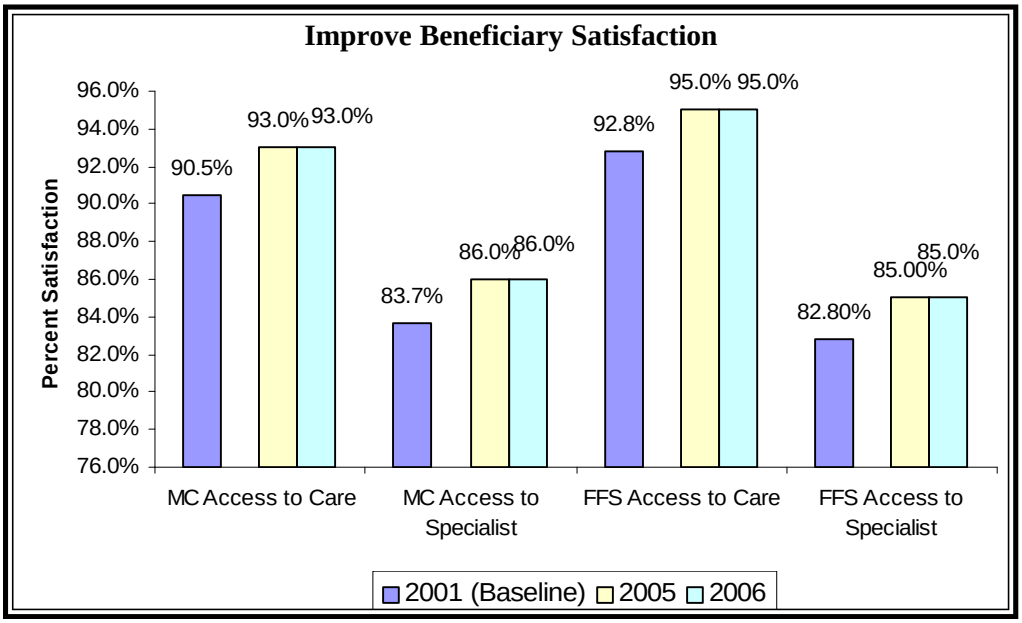
CMS collaborates with health care providers and suppliers to promote improved health status for its beneficiaries through the Quality Improvement Organizations and other State and local partners. This includes quality improvement initiatives in nursing homes. In addition, through the Survey and Certification program, CMS meets its responsibilities for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found.

CMS administers comprehensive outreach and education programs to keep beneficiaries informed and aware of the benefits and choices available to them. Through regular and continuous national surveys, CMS continuously seeks to ensure that Medicare beneficiaries are aware of the program and their options, and are satisfied with the care they receive as well.

One of CMS's ultimate goals is to assure satisfaction of its primary customer - the Medicare beneficiary. CMS currently measures satisfaction using beneficiary responses to questions regarding access to care and specialists in both fee-for-service (FFS) and managed care (MC). This performance measure is used to improve the already high satisfaction rate beneficiaries have with the Medicare program.

The following graph illustrates this beneficiary satisfaction performance goal, measuring 5-year targets from the baseline year of FY 2001 to FY 2005, and maintaining the targets for FY 2006.

CMS considers survey data on beneficiary access to care and access to a specialist to be valid measures of satisfaction. Given the type of survey for a large group of people and considering the unrelated factors that could influence responses, CMS knows that targets of 100 percent are unrealistic. Its targets are set for a 5-year period so that the percentage increases are large enough to be statistically meaningful.



In the meantime, cyclical data is shared with plans and beneficiaries to assist in quality improvement initiatives and beneficiary plan choice, respectively.

CMS will pursue accomplishment of this measure through a combination of specific means and strategies.

- Collecting and sharing annual data from the Consumer Assessment of Health Plans Survey (CAHPS) with health plans and Quality Improvement Organizations for use in better management of health plans.
- Sharing the CAHPS data with Medicare beneficiaries through various means, including the National Medicare & You Education Program.
- Ensuring strategies are in place for CMS to remain a responsive and dynamic Agency that serves the American public. There will also be focused attention on citizen-centered governance in FY 2005 and beyond.
- Emphasizing citizen-centered governance by identifying significant processes and services, expanding resources in a way that enhances service to the public, being accountable stewards of Agency resources, and monitoring and evaluating effectiveness.
- Communicating, collaborating, and cooperating with key customers, both public and private, to help achieve the desired outcomes.

Performance Measure: Improve satisfaction of Medicare beneficiaries with the health care services they receive.

Data Source: Consumer Assessment Health Plans Survey, using managed care (MC) and fee-for-service (FFS) measures for access to care and access to specialist

Year	Target	Actual
2001	Develop baselines/targets	Baselines MC Care: 90.5% MC Specialist: 83.7% FFS Care: 92.8% FFS Specialist: 82.8% Goal met
2002	Collect (& share) data to achieve by the end of CY 2004 (in FY 2005): MC Care: 93% MC Specialist: 86% FFS Care: 95% FFS Specialist: 85%	Goal met
2003	Same as FY 2002	Goal met
2004	Same as FY 2003	Goal met
2005	MC Care: 93% MC Specialist: 86% FFS Care: 95% FFS Specialist: 85%	
2006	MC Care: 93% MC Specialist: 86% FFS Care: 95% FFS Specialist: 85%	

PART REVIEW:

During the FY 2005 PART process, the Medicare program was assessed and received a rating of Moderately Effective. In general, the PART results indicated that CMS has set comprehensive long-term performance goals that reflect the Medicare program's mission across several dimensions including critical care and program efficiency, with ambitious timeframes for meeting these goals. However, the PART indicated that features of the Medicare program reflect its outdated statutory design. It was commented that the program contained some deficiencies with respect to program and financial management. With enactment of the MMA, many of these issues have been addressed and new performance measures were added to reflect these new responsibilities. CMS is addressing the following three recommendations from the PART evaluation:

1. Greater emphasis on sound program and financial management.
2. Increase linkage of Medicare payment to provider performance.
3. Agency commitment to timely implementation of MMA.

EXTERNAL FACTORS:

Prior to the enactment of the MMA, Medicare was criticized as outdated and in need of reform. The major provisions of the new law will include a prescription drug benefit, an interim prescription drug discount card, regulatory reform, contracting reform, the establishment of the Medicare Advantage program, and a significant amount of beneficiary and provider education.

CMS will be challenged over the next several years to establish regulations, empower stakeholders (providers and contractors), educate health care beneficiaries/consumers, and implement the many provisions included in this new law.

RATIONALE FOR BUDGET REQUEST:

Title XVIII of the Social Security Act instructs the Secretary to provide covered Medicare benefits for eligible beneficiaries. CMS requests a budget to carry out this mandate, while pursuing continuous improvements in the Medicare program.

PROGRAM 3E: QUALITY IMPROVEMENT ORGANIZATIONS PROGRAM

Centers for Medicare & Medicaid Services (CMS)

FY 2006 Budget Request:
TBD

FY 2006 Full Cost Estimate:
TBD

FY 2005 PART Rating:

Separate PART evaluation not done on QIOs. This program is included under the Medicare program which received a rating of Moderately Effective.

PROGRAM DESCRIPTION

Under the Quality Improvement Organizations (QIO) program, formerly known as the Peer Review Organizations (PRO) program, CMS maintains contracts with 53 independent organizations. In addition, through the Quality Improvement Organizations and other State and local partners, CMS collaborates with health care providers and suppliers to promote improved health status, including quality improvement in nursing homes. The QIO responsibilities are specifically defined in the portion of the contract called the Scope of Work (SOW). Each SOW is three years in duration and each SOW can vary the activities the QIOs perform. Funding patterns tend to vary substantially from year to year. The QIO program is funded directly from the Medicare trust funds, rather than through the annual Congressional appropriations process.

QIOs are currently operating under the seventh SOW. The eighth SOW is under development and is to go into effect August 2005.

PERFORMANCE ANALYSIS

In addition to our influenza/pneumococcal immunization goal featured in this section, four other annual performance goals represent the broad scope of QIO program activities in the FY 2006 performance budget. They are:

- Improve early detection of breast cancer among Medicare beneficiaries age 65 years and older by increasing the percentage of women who receive a mammogram.
- Improve the care of diabetic beneficiaries by increasing the rate of hemoglobin A1c and cholesterol (LDL) testing.
- Protect the health of Medicare beneficiaries by optimizing the timing of antibiotic administration to reduce the frequency of surgical site infections.
- Protect the health of Medicare beneficiaries by increasing the percentage of dialysis patients with fistulas as their vascular access for hemodialysis.

Featured below is a graph depicting our goal to increase influenza and pneumococcal vaccinations among beneficiaries age 65 and older followed by performance detail and measures being taken to improve results.

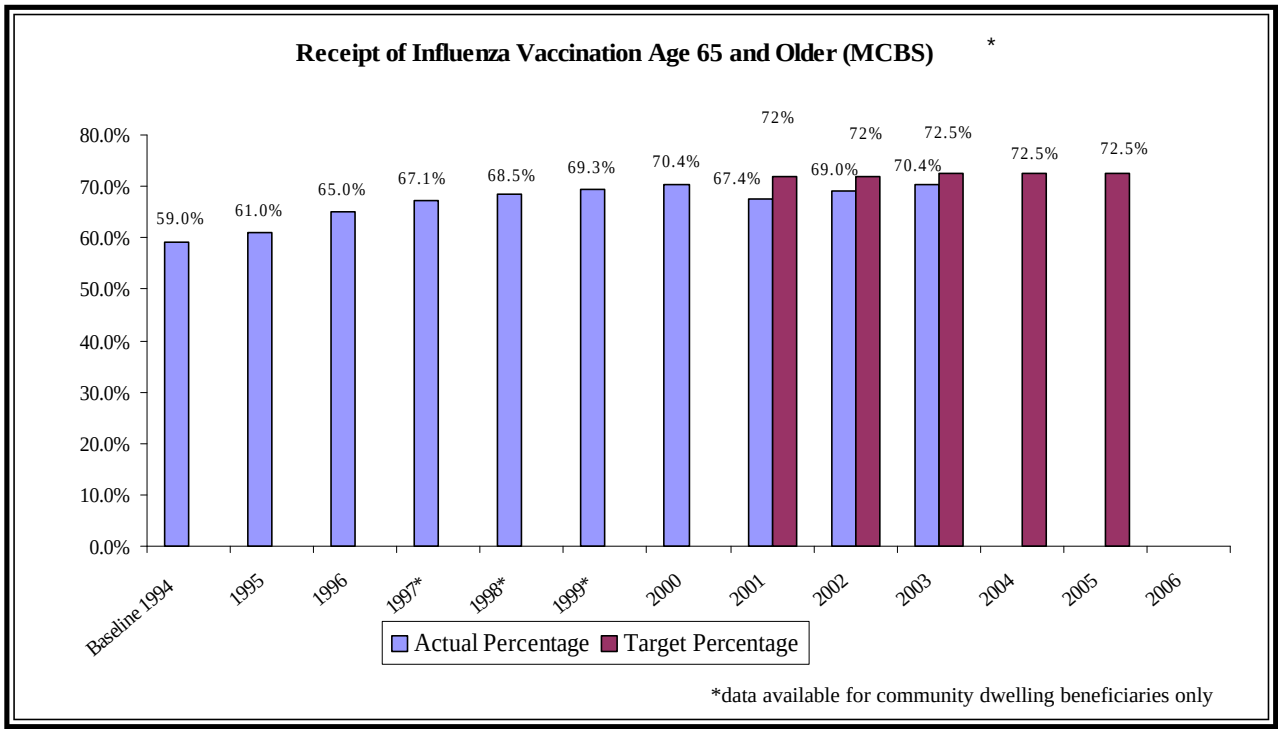
✓ ***Performance Measure:***
Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal

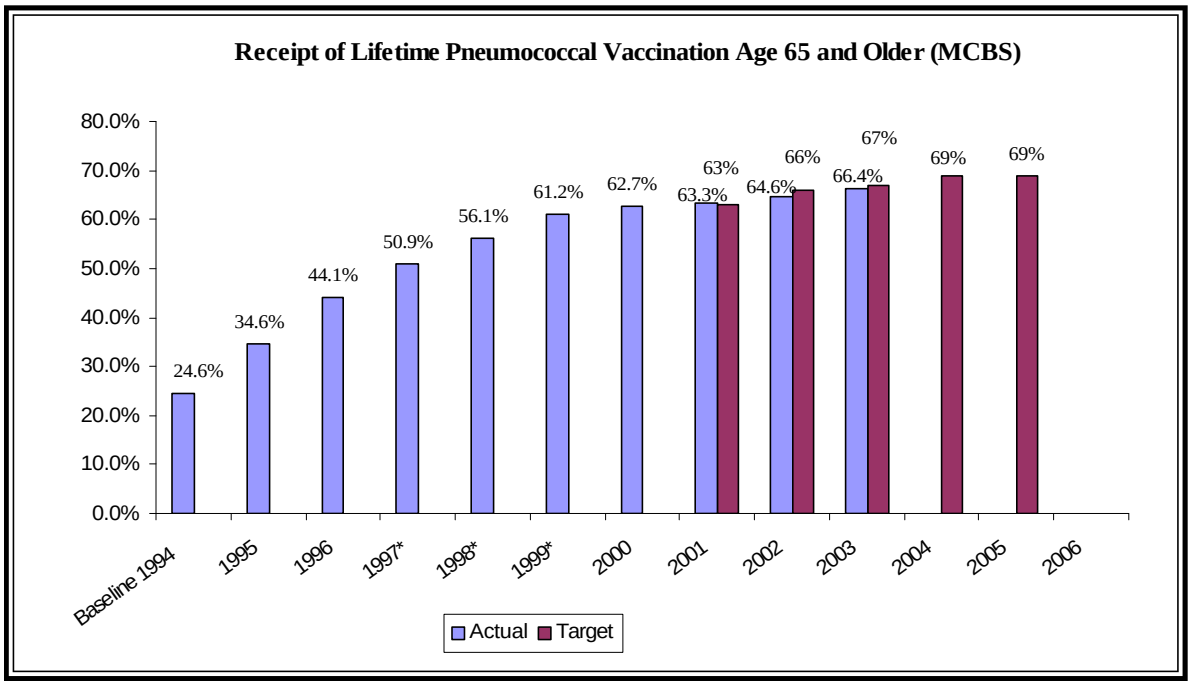
In 2001 and 2002, the National Center for Health Statistics reported influenza and pneumonia to be the primary causes of death for a significant number of older adults. For all persons age 65 or older, the Advisory Committee on Immunization practices (ACIP) and other leading authorities recommend lifetime vaccination for pneumococcal pneumonia and annual vaccination for influenza.

The most effective strategy for improving patient access to adult immunizations is the implementation of standing orders. This occurs when non-physician personnel vaccinate according to a physician-approved protocol without direct physician involvement at the time of immunization. To support this evidence-based intervention, CMS and CDC have been working together to develop a strategy to increase the use of standing orders for influenza and pneumococcal vaccinations. In October 2002, standing orders were established for influenza and pneumococcal vaccinations in nursing homes, hospitals, and home health agencies that serve Medicare and Medicaid beneficiaries. Additionally, CMS raised the reimbursement rates for influenza and pneumococcal immunization and their administration fees in 2003.

Performance Measure: Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal.		
Data Source: Medicare Current Beneficiary Survey.		
2001	Influenza: 72% Pneumococcal: 63%	Influenza: 67.4% Goal not met Pneumococcal: 63.3% Goal met
2002	Influenza: 72% Pneumococcal: 66%	Influenza: 69% Goal not met Pneumococcal: 64.6% Goal met
2003	Influenza: 72.5% Pneumococcal: 67%	Influenza: 70.4% Goal not met Pneumococcal: 66.4% Goal met
2004	Influenza: 72.5% Pneumococcal: 69%	Data available 12/2005
2005	Influenza: 72.5% Pneumococcal: 69%	Data available 12/2006
2006	Influenza: Developmental Pneumococcal: Developmental	

In 2004, CMS instructed Medicare contractors to publish a notice in their physician and provider newsletter and on their Web sites encouraging physicians and providers to order influenza vaccine early in anticipation of increased demand in Fall 2004.





Based on challenges concerning influenza vaccine supply and distribution, CMS will focus efforts for influenza vaccination on some of its subpopulations (e.g., nursing homes, ESRD facilities) where it can have greater impact. In addition, the pneumococcal target will be reevaluated. All baselines and FY 2006 targets will be developed in FY 2005.

PART Review

See PART Review for the Medicare Program. The QIO program is considered part of Medicare and will not undergo a separate PART evaluation.

External Factors

Manufacturing and distribution shortages of the flu vaccine have, in part, affected our ability to reach our influenza targets. Producing the specific strain needed in a given flu season has also been a challenge which has affected supply.

During the 2003-2004 flu season, all 50 states experienced early outbreaks of influenza and many cases of the flu, which created great demand among the public to seek immunizations, especially for children who were being hit hard by the epidemic. As a result of the public's demand for flu vaccine, the CDC, in December, changed its public health recommendation for the remaining vaccine from offering to all people to targeting high-risk individuals for immunization. There remain external challenges to increasing the influenza and pneumococcal vaccination rates. However, CMS has taken several steps, which should help to reduce known barriers to flu and pneumoccocal vaccinations and contribute to higher rates in the next few years' data:

(1) Increased use of standing orders in Fall 2002 to include nursing homes, hospitals, and home health agencies serving Medicare and Medicaid beneficiaries.

(2) Raised reimbursement rates in 2003 for influenza and pneumococcal immunizations.

(3) Exemption of paper roster billing for Medicare covered vaccinations from the Administrative Simplification Compliance Act (ASCA) rules (to remove administrative barriers).

(4) Medicare contractor-published notice in physician/provider newsletters and on their websites encouraging physicians and providers to order influenza vaccine early in anticipation of increased demand in Fall 2004.

QIOs are also working in collaboration with beneficiaries, providers, managed care plans, community groups and other interested partners to design and implement immunization quality improvement projects. These projects are conducted in hospitals, long-term care facilities, dialysis facilities, physician offices, home health agencies and public health clinics. They combine education for healthcare workers, a plan for identifying high-risk patients, and efforts to remove administrative and financial barriers that prevent patients from receiving influenza and pneumococcal vaccines.

RATIONALE FOR BUDGET REQUEST:

The general authority for the QIO program is found in section 1863(g) of the Social Security Act, as amended. Procedural and specific requirements can be found at sections 1151-1161 of the Social Security Act, as amended. The statutory mission of the QIO program is to improve the efficiency, effectiveness, economy and quality of services delivered to Medicare beneficiaries.

STRATEGIC GOAL 4

Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise

HHS recognizes the important role research plays in improving the Nation's health. As a result, many of the strategies that HHS has identified as important components in achieving its other strategic goals incorporate a research base. This goal, therefore, focuses on creating the underlying knowledge and strategies that improve and maintain the research infrastructure that produces advances in health science.

HHS is committed to advancing the understanding of the environmental factors that contribute to human disease. In order to accomplish this objective, HHS will continue to support basic, clinical, and applied biomedical and behavioral research, with stringent peer review for scientific quality of research proposals; and will develop and implement processes for setting research priorities that ensure that research is responsive to public health needs, scientific opportunities, and advances in technology.

HHS places a high priority on improving the coordination, communication, and application of health research results. Strategies to meet this objective include:

- Provide for easy access by academia and industry to HHS databases and findings from HHS research, with appropriate privacy and confidentiality protection.
- Expand the use of electronic technology and media channels to gather and transfer research information to researchers, practitioners, and the public.
- Establish quality standards for the dissemination and strategic application of consumer/ communication research findings.
- Establish partnerships with health professional associations, industry groups, patient representatives, community groups, disability groups, and purchasers of care to more widely disseminate research findings.
- Support "implementation research" to determine how innovative, effective interventions can be implemented in actual settings and populations, including the means to reach diverse communities.
- Ensure that consumer research, demonstration, and evaluation results are communicated effectively across HHS agencies and to all decisionmakers.
- Support development of data-based quality of care and outcome measurement systems to track adoption of evidence-based practices.

HHS commitment to enhancing the capacity and productivity of the Nation's health science research enterprise is demonstrated, for example, by the development of the Chemical Effects in Biological Systems (CEBS). Investment in this research will provide important information for identifying toxic substances in the environment, and help to treat people at the greatest risk of diseases caused by environmental pollutants or toxicants.

PROGRAM 4A: KNOWLEDGE BASE ON CHEMICAL EFFECTS IN BIOLOGICAL SYSTEMS

National Institutes of Health (NIH)

FY 2006 Budget Request:
$11.8 Million

FY 2006 Full Cost:
$12.3 Million

FY 2006 PART Rating:
This program has not been reviewed, but extramural research activities in total were reviewed and received a rating of Effective.

✓ ***Performance Measure:*** *Enhance the CEBS to allow the capture and integration of transcriptomics, proteomics, and toxicologic data for the same compound.*

PROGRAM DESCRIPTION

Chemicals and mixtures in the environment and other air and water pollutants contribute to the burden of human disease. The problems of identifying environmental factors involved in the etiology of human disease and performing safety and risk assessments of drugs and chemicals have long been formidable issues. The prediction of potential human health risks involves consideration of (1) the diverse structure and properties of thousands of chemicals and other stressors in the environment, (2) the time and dose parameters that define the relationship between exposure and disease, and (3) the genetic diversity of organisms used as surrogates to determine adverse chemical effects.

A new scientific field, toxicogenomics, has evolved to examine how chemical exposures disrupt biological processes at the molecular level. Toxicogenomics involves the collection, interpretation, and storage of information about gene and protein activity in order to identify toxic substances in the environment, and to help treat people at the greatest risk of diseases caused by environmental pollutants or toxicants.

Because the pattern of regulation of various genes is different for different chemicals, scientists hope that these characteristic "signatures" will be useful in classifying exposure to these chemicals and other stressors by their biological activity. They will also provide a means of potentially predicting effects on human health from chemicals about which little is known. To enable this predictive capability, NIH is establishing a knowledge base on Chemical Effects in Biological Systems (CEBS). The system will contain data on global gene expression, protein expression, metabolite profiles, and associated chemical/stressor-induced effects in multiple species.

The strategies used to achieve program results are as follows:

- The Chemical Effects in Biological Systems database object model will be extended to include toxicology/pathology fields that allow the import, export, and linking of such fields to molecular expression data.
- A data portal that will load toxicology/pathology data will be created.
- A molecular expression and toxicology/pathology database of environmental chemicals and drugs featuring simple query download capability will be created.

- The FY 2006 measure (Enhance the CEBS to allow the capture and integration of transcriptomics, proteomics, and toxicologic data for the same compound) will enable a key step in the knowledge base development. It will provide the tools necessary to collect data on changes in genes, proteins, and metabolites, as well as the toxic effects of a chemical.

Mechanisms and monitoring to support the project include:

- CEBS program is supported by a combination of intramural contracts and extramural grants.
- The contracts are monitored weekly by the project officer and other intramural staff, the contracts have projected deliverables as one marker of satisfactory performance.
- The project officer and intramural staff are part of the National Center for Toxicogenomics (NCT) of the Division of Intramural Clinical and Basic Research. Performance/progress reports are submitted regularly.
- NCT has a Computational Toxicogenomics and Bioinformatics Advisory Group of outside experts that meet annually to review the performance in developing the CEBS database.
- The extramural coordinator provides oversight of the extramural grantees.

PERFORMANCE ANALYSIS

Performance measures for this goal are outcomes. Annual targets are set to meet the program goal of developing a knowledge base on chemical effects in biological systems using a systems toxicology or toxicogenomics approach by 2012. However, one target is highlighted for reporting purposes.

The first target for this goal, to launch a pilot prototype database project to test the design and implementation of the database components and system architecture, was met as scheduled in 2003. Sources that verify that the FY 2003 performance target was achieved include the CEBS web site at http://cebs.niehs.nih.gov/ and the publications listed below. An account to access CEBS can be provided to permit independent verification of the launching of the database.

YEAR	PERFORMANCE TARGETS
2003	Launch a pilot prototype database project to test the design and implementation of the knowledge base components and system architecture.
2004	Create the capability to import, export, and link molecular expression data by extending the Chemical Effects in Biological Systems (CEBS) database object model to include toxicology/pathology fields, and by creating a data portal that will load toxicology data.
2005	Create and provide public access to a global molecular expression and toxicology/pathology database of environmental chemicals and drugs (CEBS), featuring simple query download capability.
2006	Enhance the CEBS to allow the capture and integration of transcriptomics, proteomics, and toxicologic data for the same compound.

Performance Measures: The FY 2006 target is to enhance the CEBS knowledge base to allow the capture and integration of transcriptomics, proteomics, and toxicologic data for the same compound to optimize utility of the data. The 2006 measure reflects the progressive work being done to achieve the overarching goal of developing a CEBS knowledge base.

This target is being achieved in rational steps that began with the launch of a CEBS prototype database system to explore the management, integration, mining, and analysis of microarray, histopathology, and clinical chemistry data. CEBS currently allows loading of individual data sets from microarray experiments but it does not have the capability of integrating data from multiple data sets for a single compound. In FY 2004, the CEBS

ToxArm was designed and implemented to capture information on toxicogenomics study design and toxicology/ pathology outcome datasets.

Measurement data will come from:

- Public accessibility of intramural databases and commercial software to built a prototype CEBS,
- Object models to capture molecular expression data,
- Raw data sets from contributing laboratories, and
- Input data will be verified using a combination of automated and manual verification/curation.

PART REVIEW

This goal has not been specifically reviewed by PART; however, extramural research activities in total were reviewed for the FY 2006 process and received an Effective rating.

EXTERNAL FACTORS

Accuracy of Data. Data generated from microarrays, proteomics, toxicology, histopathology, and clinical chemistry will be managed in developing the CEBS. This data must be accurate in order to precisely define biological/toxicological pathways. Similarly, information about the biological effects of chemicals and other agents and their mechanism of action will be collected from the literature and stored. The NIH relies on international data capture guidelines (e.g., MIAME, minimal information about a microarray experiment) and counterpart databases, such as the European Bioinformatics Institute Tox-ArrayExpress, to enhance the number and quality of microarray and toxicogenomics data sets.

Intellectual Capital. In addition to data issues, manpower issues can be expected to have an adverse impact on achieving this goal. There are a finite number of individuals with the expertise to accomplish the tasks outlined above, both intramurally and extramurally. Consequently, the necessary intellectual capital might be unavailable and it may be increasingly difficult to recruit. To manage this risk, CEBS has taken the lead in this field by collaborating with national and international organizations to insure that their efforts can dovetail with the CEBS knowledge base.

RATIONALE FOR THE BUDGET REQUEST

The NIH budget for FY 2006 of $11.4 million for this project will include monies needed for accomplishing the performance goals of the CEBS project.

Part of the funds proposed for FY 2006 will be used to support a new contract. The purpose of that contract will be to investigate new proteomics technologies, the data from which will be incorporated into CEBS. The remaining funds will be to support the efforts of the current contractors to continue the development of CEBS and to generate microarray data that will become part of the knowledge base.

STRATEGIC GOAL 5
Improve the Quality of Health Care Services

5a. Medical Product Surveillance Network (FDA)

5b. Prevention Portfolio (AHRQ)

Improving the quality of life in the United States includes improving the quality of the health care services that people receive. This strategic goal is to improve health care services by reducing medical errors, improving consumer and patient information, and accelerating the development and use of electronic health information. To achieve this goal, HHS will continue implementation of a variety of strategies designed to improve the delivery of health care services. These strategies include the development and dissemination of evidence based practices, information systems, new technologies for the home and clinical setting, and improved reporting systems for medical errors and adverse events.

Health quality improvement at HHS also means translating new knowledge of effective health services into strategies, educational tools, and information to help clinicians and health care policy makers improve health care quality. HHS will work to expand provider networks to disseminate health care quality information, enabling consumers to make informed choices.

HHS will provide leadership to promote the development of a national health information infrastructure that takes advantage of the most current technology available. This will involve attention to the secure and confidential treatment of health information, adoption of national data standards, and research on the applications of a national health information infrastructure that informs consumers, patients, professionals, and other decision makers alike.

HHS is committed to reducing medical errors and does so through programs such as the Food and Drug Administration (FDA) Medical Product Surveillance Network System (Medsun). This program was found to be representative of the Department's advancements under this strategic goal. When fully implemented, Medsun will improve patient safety by serving as an advance warning system for device problems, and a laboratory for research and two-way communication between FDA and each user-facility. Also assessed under this strategic goal are the prevention programs of the Agency for Healthcare Research and Quality (AHRQ).

PROGRAM 5A: MEDICAL PRODUCT SURVEILLANCE NETWORK
Food and Drug Administration (FDA)

FY 2006 Budget Request:
$34.0 Million

FY 2006 Full Cost:
$39.8 Million

FY 2005 PART Rating:
Moderately Effective

✓ ***Performance Measure:*** *Expand implementation of Medical Product Surveillance Network (Medsun) to a network of 350 facilities.*

PROGRAM DESCRIPTION

The FDA Modernization Act (FDAMA) mandates that FDA replace universal user facility reporting with the Medical Product Surveillance Network (Medsun), a network of user facilities that together will provide a representative profile of reports from major medical device product users such as hospitals. When fully implemented, Medsun will serve as an advance warning system for device problems; a laboratory for research and two-way communication between FDA and the user-facility community to improve patient safety through recognition and management of use-related errors and to offer feedback to manufacturers to improve device design.

Medsun is designed to improve FDA decision making about device problems by generating more useful and diverse reports from trained, engaged reporters. The program collects reports on deaths and serious injuries associated with the use of medical devices, and the participating facilities are also highly encourage to submit reports about close calls. Reports on close calls allow FDA to evaluate a device issue before patient injury occurs. Better information allows more timely signal detection and enhances FDA's ability to analyze and react to problems. A key component of Medsun is to offer easily accessible information related to safe device use. Medsun participants receive a continuous stream of feedback including newsletters, educational materials, publications and other information related to patient safety and device use.

Medsun includes collaborations with a number of other Center for Devices and Radiological Health (CDRH) components and initiatives to expand the active surveillance. A recent pilot study expanded reporting procedures for collecting data on problems with laboratory tests. A new collaboration with the CDRH Home Health Care Committee will allow better communication exchange between the FDA and Home Health Care agencies.

The Medsun performance goal supports the Department's Strategic Goal 5 – Improve Quality of Health Care Services, its Objective 5.1 – Reduce Medical Errors, and FDA's Strategic Goal – Patient and Consumer Safety. Medsun is also a critical component towards achieving FDA's long-term outcome goal to increase the percent of the population covered by active surveillance, which will allow for more rapid identification and analysis of adverse events *[Increase by 50% the patient population covered by active surveillance of medical product safety by 2008]*.

PERFORMANCE ANALYSIS

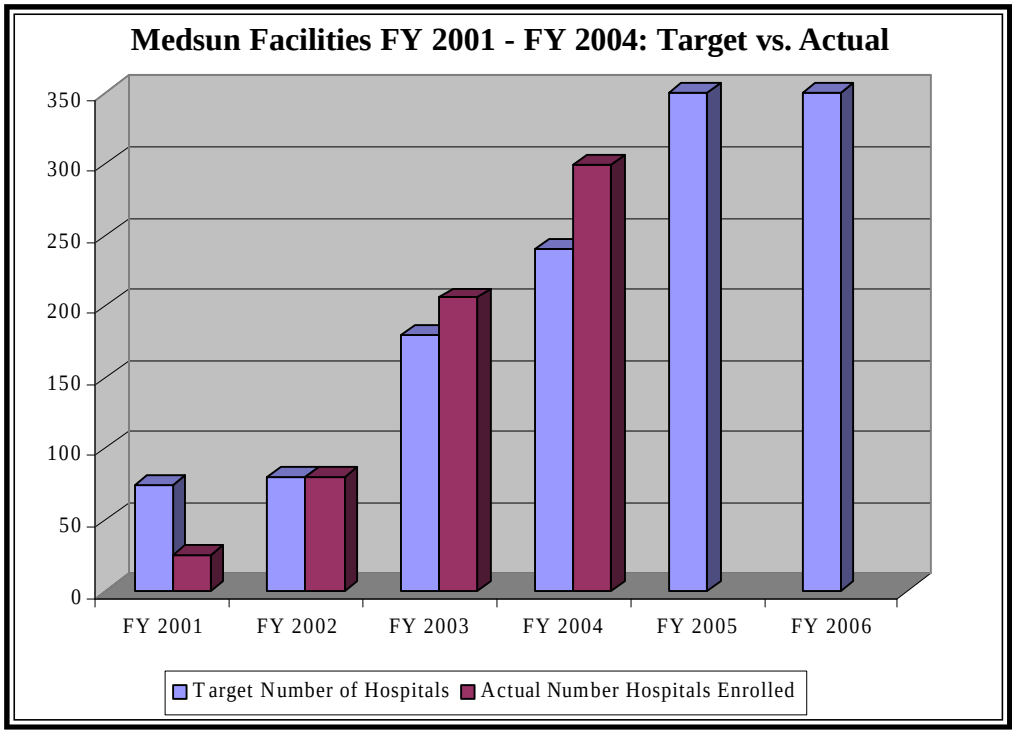
Performance Measure: Expand implementation of Medical Product Surveillance Network (Medsun) to a network of 350 facilities		
Data Source:		
Year	**Target**	**Actual**
2005	350 facilities	
2006	350 facilities	

Performance Measure: Expand implementation of Medical Product Surveillance Network (Medsun) to a network of 350 facilities.

In FY 2005 FDA intends to increase the number of facilities in the Medsun network to 350. In FY 2006, FDA will continue to recruit additional facilities, but will begin to replace existing facilities that have decided to place a low priority on participating in this voluntary network. This will increase the overall effectiveness of the system while holding the total number of facilities to 350, which FDA believes is the optimum size. FDA exceeded its goal of 240 facilities in FY 2004 by enrolling a total of 299 hospitals as of October 2004. In FY 2004 Medsun developed a number new programs, including training, an workshop on electro-surgical units, a project to evaluate common problems with sutures, an engineering audio conference, a collaboration with ECRI on auto suture devices, a study on pulmonary catheters, a study on drug eluting stents, and a pilot of the LabSun program for clinical laboratory reporting. On a recent survey of the Medsun participants, 78 percent responded that participation in Medsun has improved patient safety in their hospitals. In FY 2003, the Agency met its goal by recruiting a total of 206 facilities into Medsun. In FY 2002, FDA recruited, trained and had functioning 80 facilities for the network. In FY 2001, FDA did not meet the goal of recruiting 75 hospitals, as most of the effort that year was focused on resolving internal policy issues and addressing information technology security requirements. During FY 2002, FDA extended software development to accommodate Internet-based reporting system (interactive web-based form and database), and took steps to ensure that facilities reporting information had Internet access to secure servers.

The data sources are the CDRH Adverse Events Reports and the reports generated from the Medsun users. The reliability of the data contained in this report is excellent to the best of FDA's knowledge. The numbers provided for fiscal years 2001, 2002, and 2003 reflect actual recruitment. Those were the targeted number of facilities and all goals have been met to date.

The Following Chart Shows the actual progress of Medsun from FY 2001-2004 along with the FY 2001-2006 target levels:



PART REVIEW

In FY 2005, the FDA was assessed as an entire program. FDA was acknowledged and commended for developing eight new long-term outcome and efficiency goals. FDA continues to respond to the sole recommendation from the FY 2005 PART which is to demonstrate progress towards achieving its new long-term outcome goals.

FDA remains committed to improving processes and implementing new initiatives which will ultimately help to achieve the long-term outcome goals. During the past year, FDA has developed baseline data to measure progress on outcome goals; mapped business processes to understand and better align activities and outputs with outcomes and strategic goals; improved processes that support performance targets; and implemented new initiatives that help achieve outcome goals.

EXTERNAL FACTORS

The amount of funding allocated to the Medsun project remains an important factor in determining its success. If funded at requested levels, Medsun will be able to achieve its goals. There will be a significant detrimental effect on performance if the budget funding levels are not maintained at the request level.

RATIONALE FOR THE BUDGET REQUEST

The Medsun program is financed within the $213.4 million request for CDRH.in the FY 2006 budget. Within this total, FDA plans to allocate $34 million to the Medsun program. The goal for FY 2006 will be to maintain a cohort of 350 sites, replacing sites that wish to leave the program or have not been active participants. This will help to increase the number and quality of reports, which in turn will lead to earlier diagnosis of adverse events. The enhancement of the adverse events data system and linkages with other health care systems is the first line of defense against medical errors, supporting the Department's initiative to improve the quality of health care services.

PROGRAM 5B: PREVENTION PORTFOLIO

Agency for Healthcare Research and Quality (AHRQ)

FY 2006 Budget Request:
$ 5.6 Million

FY 2006 Full Cost:
$ 5.8 Million

✓ ***Performance Measure:*** *Increase the quality and quantity of preventive care delivered in the clinical setting especially focusing on priority populations.*

✓ ***Performance Measure:*** *Improve the timeliness and responsiveness of the United States Preventive Services Task Force (USPSTF) to emerging needs in clinical prevention.*

✓ ***Performance Measure:*** *Increase the number of partnerships that will adopt and promote evidence-based clinical prevention.*

PROGRAM DESCRIPTION

Prevention is a vital component of AHRQ's mission to improve the quality, safety, efficiency and effectiveness of health care for all Americans. This can be accomplished by developing new knowledge about what preventive services are effective for patients, identifying ways to improve the delivery of useful preventive services by providers, helping health care systems incorporate knowledge into practice, and providing stakeholders with the knowledge needed to improve preventive health care. These efforts fully support AHRQ's mission by improving the effectiveness and efficiency of health care delivery.

Through AHRQ's prevention efforts, the agency aims to increase the adoption and delivery of evidence-based clinical prevention services to improve the health of all Americans. This work is done through both the development of evidence-based clinical prevention recommendations, through the U.S. Preventive Services Task Force (USPSTF), as well as through dissemination and implementation of these guidelines into practice. The Task Force is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. The Prevention Dissemination and Implementation program facilitates the health care system to improve the delivery of evidenced-based clinical preventive services. This requires the engagement of the entire health care delivery system, including clinicians, health care provider organizations, employers and insurers, and consumers. By identifying how these recommendations can improve the delivery of effective health care, AHRQ can facilitate the adoption of the Task Force recommendations among public (Federal, State, tribal, local) and private partners. Working through these partnerships, the program facilitates healthcare systems' incorporation of clinical preventive services into routine clinical practice. Adoption of beneficial and timely clinical preventive recommendations by clinicians and health care systems is a measure of the success of AHRQ's prevention efforts.

PERFORMANCE ANALYSIS

There are three overarching measures of success for clinical prevention efforts at AHRQ:

- Increase the quality and quantity of preventive care delivered in the clinical setting especially focusing on priority populations.
- Improve the timeliness and responsiveness of the USPSTF to emerging needs in clinical prevention.

- Increase the number of partnerships that will adopt and promote evidence-based clinical prevention.

Performance Measure: Increase the quality and quantity of preventive care delivered in the clinical setting especially focusing on priority populations.

Performance Measure: Increase the quality and quantity of preventive care delivered in the clinical setting especially focusing on priority populations.		
Data Source: PBRN Resource Center report from provider focus groups – FY 2004		
Year	**Target**	**Actual**
2004	Benchmark best practices for delivery of clinical preventive services.	Completed benchmarking of provider groups.
2005	Establish baseline of quality and quantity of preventative services delivered.	
2006	Increase the number of users of clinical prevention products by 10 percent.	

During FY 2004, the Prevention Portfolio underwent significant organizational changes to align with the agency's mission. To identify gaps in the adoption of clinical prevention in the health care setting, AHRQ conducted a series of customer-driven meetings and focus groups with health care providers and key health care stakeholders, including health care delivery organizations and health care purchasers. Through these efforts, AHRQ has begun to identify the best practices for the delivery of clinical preventive services among a diverse group of users. In FY 2004, consumer-oriented products included Pocket Guides to Good Health for Adults, Good Health for Children, and Staying Healthy at 50+. AHRQ also produced consumer checklists focusing on women's and men's health at any age. Marketing of these products led to audio releases to over six million English and Spanish listeners. Production of these products involved partnerships with professional organizations such as AARP.

In AHRQ's efforts to enhance the use of evidence-based prevention recommendations, the agency has been working with clinicians to ensure that its products are user-driven. Given the key importance of health information technology in improving the quality of U.S. health care, the agency has been developing IT tools and products that will help clinicians do the right thing during busy clinical practice. A free Personal Digital Assistant (PDA) program now allows clinicians to query the USPSTF recommendations by age and gender. Over six months, there have been more than 12,000 downloads and installations of these web-based programs. Ongoing efforts will include further refinement of current tools, such as the PDA program, and development of new web-based tools for patients and clinicians.

Performance Measure: Improve the timeliness and responsiveness of the USPSTF to emerging needs in clinical prevention.

The USPSTF was first convened by the U.S. Public Health Service in 1984 to systematically review the evidence of effectiveness of clinical preventive services. The mission of the Task Force is to evaluate the benefits of individual services and to create age-, gender-, and risk-based recommendations about services that should routinely be incorporated into primary medical care. Furthermore, when evidence is insufficient in an area, the recommendation helps to identify the research agenda for clinical preventive services.

Performance Measure: Improve the timeliness and responsiveness of the United States Preventive Services Task Force (USPSTF) to emerging needs in clinical prevention.		
Data Source: USPSTF internal tracking database/ USPSTF Topic Updating Protocol		
Year	**Target**	**Actual**
2005	Establish baseline measures for timeliness and responsiveness.	
2006	Increase the number of annual topics reviewed by the task force by 10 percent.	

To date, the Task Force has reviewed over 70 topics in the area of primary and secondary clinical prevention that

address issues of screening, counseling, and chemoprophylaxis. These topics range from screening for obesity to counseling to taking aspirin to prevent a first heart attack. In FY 2004, the Task Force eliminated its backlog of topics, as evidenced by releasing 20 new recommendations. In addition, AHRQ engaged primary clinicians to address the situation where there is insufficient evidence for the Task Force to make a recommendation. In collaboration with other Federal agencies, AHRQ is facilitating the communication of these research gaps directly to funding agencies in order to shape research agendas in the area of clinical prevention.

Performance Measure: Increase the number of partnerships that will adopt and promote evidence-based clinical prevention.

AHRQ is leading improvement in clinical prevention for the healthcare sector. Developing partnerships with large delivery systems such as States, health plans, and purchasers can help to improve the delivery of clinical preventive services and improve the health of Americans.

Performance Measure: Increase the number of partnerships that will adopt and promote evidence-based clinical prevention.		
Data Source: OCKT product tracking/ Prevention portfolio internal program tracking for D & I Program		
Year	**Target**	**Actual**
2004	Produce fact sheets for adolescents, seniors, and children. Partner with appropriate professional societies and advocacy groups.	Completed
2005	Establish baseline of partnerships with the prevention portfolio promoting clinical prevention.	
2006	Increase the number of partnerships adopting evidence-based clinical prevention by 5 percent.	

During FY 2004, new private and public partnerships were developed to facilitate the adoption of the evidence-based clinical prevention. On the private side, AHRQ partnered with large employers, such as General Motors, as well as the National Business Group on Health, a consortium of larger employers and purchasers. On the Federal side, AHRQ has become an instrumental part of the Department's Steps to a Healthier US. Through a multi-year partnership with CDC, AHRQ has assumed the lead for the health care sector's efforts to improve healthy behaviors and clinical prevention. As part of this multi-year partnership with CDC, AHRQ will provide technical assistance to support the health care sector in the Steps to a Healthier US grantee communities and their role in preventing chronic illness.

PART Review

The Prevention Portfolio has not been assessed using PART.

External Factors

The future demands on the Prevention Portfolio are impacted by the following trends and public awareness:

- The greater focus on prevention in the Medicare Modernization Act, including the new Welcome to Medicare visit, will place greater emphasis on the appropriate use of clinical preventive services.
- The emphasis on health information technology will require new tools and approaches, such as preventive services reminders in electronic health records, as more effective methods of dissemination and implementation.
- Unhealthy lifestyle behaviors (smoking, inactivity, and diet) contribute significantly to the morbidity and mortality of Americans. While clinicians realize the importance of counseling patients, they are faced with many obstacles, including insufficient reimbursement for counseling on prevention.

RATIONALE FOR BUDGET REQUEST:

The FY 2006 budget of $5.8 million will support clinical prevention at AHRQ. An estimated $3.0 million will be reinvested program funds to support the improved delivery of clinical preventive services. The reinvested portion will focus on improving the delivery of clinical preventive services, expanded generation of evidence-based recommendations, and diversified dissemination and implementation activities with Federal and private partners, which will highlight the effective use of health information technology.

STRATEGIC GOAL 6

Improve the Economic and Social Well-Being of Individuals, Families, and Communities, Especially Those Most in Need

6a. Temporary Assistance for Needy Families (ACF)

6b. Aging Services Program (AoA)

HHS promotes and supports interventions that help disadvantaged and distressed individuals, families, and communities improve their economic and social well-being. To achieve this strategic goal, HHS supports targeted efforts to increase the independence and stability of low-income families, people with disabilities, older Americans, Native Americans, victims of domestic violence, refugees, and distressed communities. HHS will also continue to support community and faith-based organizations that provide services to individuals and communities in need.

Representative performance measures discussed in this section relate to Administration on Aging (AoA) programs targeting elderly residents of rural areas and the Administration for Children and Families' Temporary Assistance for Needy Families (TANF) program, whose recipients have become newly employed and remain employed.

PROGRAM 6A: TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

Administration for Children and Families (ACF)

FY 2006 Budget Request:
$17,148.6 Million

FY 2006 Full Cost:
$17,215.6 Million

✓ ***Performance Measure:*** *Increase percent of TANF recipients employed in a quarter that are still employed in the next two consecutive quarters.*

PROGRAM DESCRIPTION

The purpose of TANF is to increase self-sufficiency by promoting employment and by providing opportunities that increase job readiness and support healthy marriages. TANF is also designed to reduce out-of-wedlock pregnancies and to encourage the formation and maintenance of two-parent families. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) dramatically changed the Nation's welfare system from one of income support to a system that provides time-limited assistance with work requirements. The TANF program replaced the former Aid to Families with Dependent Children (AFDC), Job Opportunities and Basic Skills Training (JOBS), and Emergency Assistance (EA) programs, ending the Federal entitlement to assistance.

PRWORA requires that States and Territories administer programs, while Tribes have the option to administer their own programs. States, Territories, and Tribes each receive a block grant allocation with a requirement for States to maintain a historical level of State spending known as Maintenance of Effort (MOE). The block grant covers benefits, administrative expenses, and services. States, Territories, and Tribes determine eligibility and benefit levels, as well as which services will be provided to needy families.

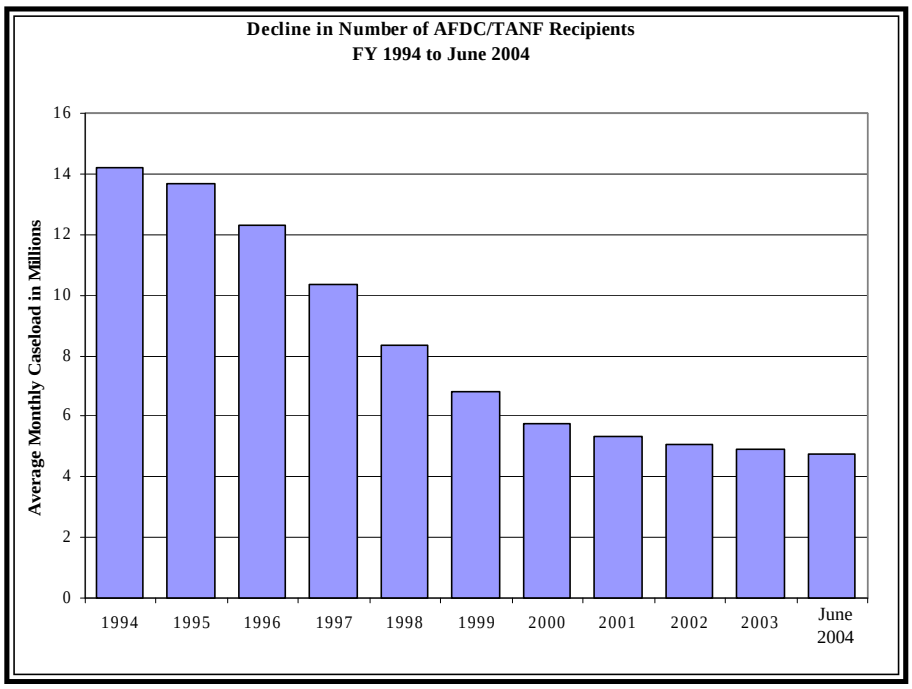
Performance Measure: Increase the percentage of adult TANF recipients/former recipients employed in one quarter of the year who continue to be employed in the next two consecutive quarters.

Data Source: National Directory of New Hires (NDNH) and UI Wage Records
* Measure changed from employment over one quarter to two quarters. 64 percent is the new target for the revised measure.

Year	Target	Actual
2001	84% (64%*)	63%
2002	65%	59%
2003	68%	59%
2004	68%	Data available 10/2005
2005	68%	Data available 10/2006
2006	68%	Data available 10/2007

PERFORMANCE ANALYSIS

While further progress is needed, welfare reform has been widely recognized as a success. The number of families dependent on TANF is less than half of August 1996 levels, and the number of TANF recipients has continued to decline through June 2004. Large numbers of people continue to move from welfare to work. Job retention rates are promising, and forty nine States met the overall work participation requirements in FY 2003. Critics of welfare reform predicted mass increases in child poverty. In fact, between 1996 and 2003, the child poverty rate fell from 20.5 percent to 17.6 percent. The poverty rate for African-American children dropped from 39.9 percent to 33.6 percent.

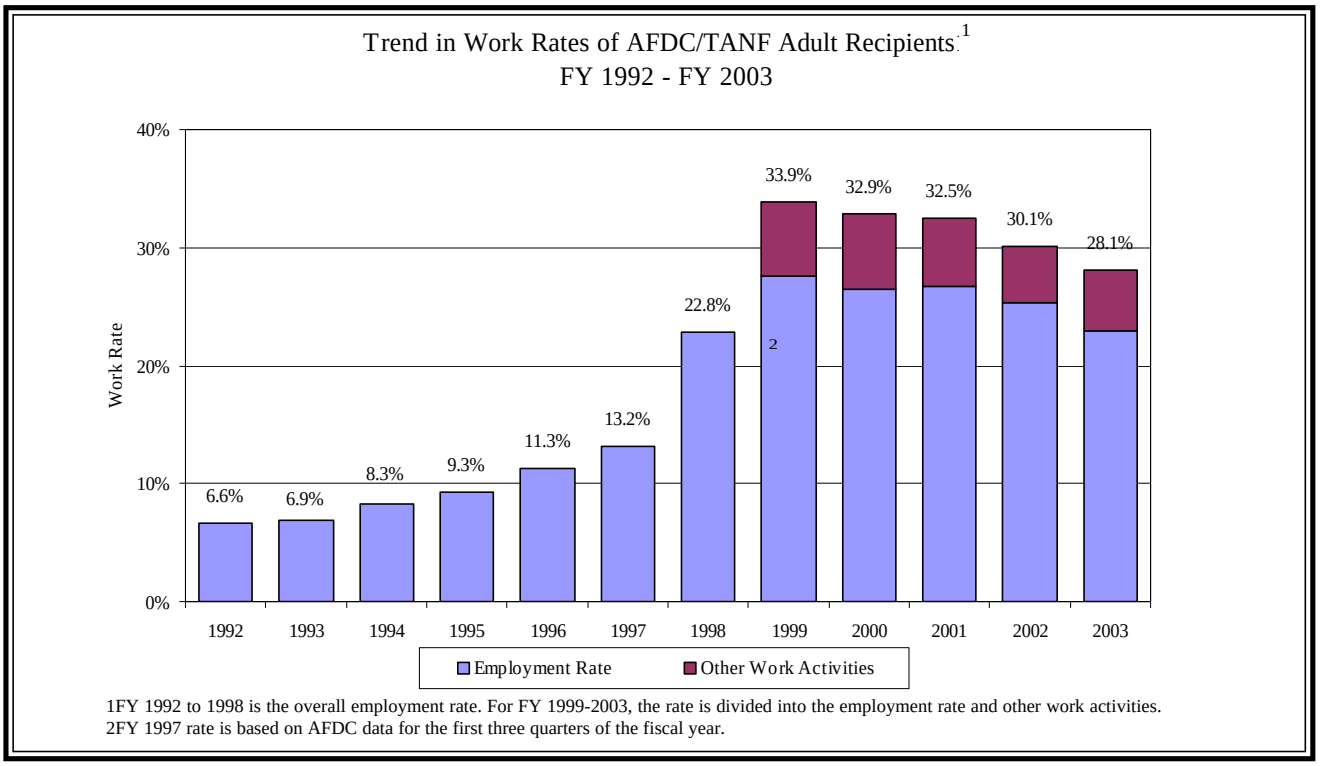


In FY 2003, 28 percent of adult recipients were working (including employment, work experience, and community service), compared to less than 7 percent in 1992 and 11 percent in 1996. The recent decline in work rates underscores the importance of welfare reform reauthorization.

The main purpose of TANF is to enable recipients to be self-sufficient and ACF's eight performance measures for this program relate specifically to achieving economic independence, particularly the job retention and earnings measures. The data source for these measures is the National Directory of New Hires (NDNH) and the Unemployment Insurance (UI) Wage Records. Of the five measures for which data are available for FY 2003, ACF met or exceeded one measure: "increasing the earnings of TANF recipients".

ACF focuses on work achievement by emphasizing program performance on the job retention rates of current/former TANF recipients. For the measure, "increase (from FY 2000) the percentage of adult TANF recipients/former recipients employed in a quarter that were still employed two consecutive quarters later," the performance remained constant at 59 percent from FY 2002 to FY 2003, missing the FY 2003 target of 68 percent.

The current employment retention measure (one quarter plus two subsequent quarters) represents a more



1FY 1992 to 1998 is the overall employment rate. For FY 1999-2003, the rate is divided into the employment rate and other work activities.
2FY 1997 rate is based on AFDC data for the first three quarters of the fiscal year.

rigorous measure than the previous measure (one quarter plus one subsequent quarter). When setting the 68 percent target, ACF did not consider the dampening effect of the caseload reduction credit in decreasing work participation rate requirements for States. In fact, for the past four years, nearly 60 percent of the adult TANF recipients have not engaged in any work or work preparation activities. The pending TANF reauthorization legislation will address this issue by strengthening current work requirements to ensure that adult TANF recipients are engaged in work or activities leading to employment. ACF is reviewing future retention targets because it will take time to regulate and implement the new work requirements once Congress passes reauthorization legislation.

ACF exceeded its target for increasing the percentage rate of earnings gained by employed adult TANF recipients between a base quarter and subsequent quarter with actual performance in FY 2003 of 33 percent (target 29 percent). FY 2005 and FY 2006 targets are also 29 percent.

The President's welfare reauthorization proposal provides tools for ACF and its State partners to build on the successes of the 1996 reforms, including initiatives for demonstrations and research to promote healthy marriage, strengthen work participation requirements, and increase funding flexibility for States. Initiatives that promote responsible fatherhood, encourage the formation and maintenance of healthy married, two-parent families, and reduce out-of-wedlock pregnancies are critical building blocks leading to greater family stability and self-sufficiency.

PART REVIEW

The TANF program has not been reviewed.

EXTERNAL FACTORS

Economic conditions affect several of the performance measures used under the TANF program, such as the job entry rate and the job retention rate. The recent decline in some performance measures from their 1999 peaks is probably attributable to the weakened labor market. However, numerous studies have looked at the relationship between welfare reform and the economy and concluded that the effects of welfare policy have been much greater than the effect of the economy. Regardless of the economic climate, welfare recipients are much more likely to enter employment and achieve self sufficiency when State welfare programs are designed to help clients take advantage of economic opportunities.

RATIONALE FOR BUDGET REQUEST

Even with the notable progress of welfare reform, much remains to be done, and States still face many challenges. This Administration is committed to continuing to ensure every American has the resources available to move not just from welfare to work, but toward self-sufficiency by doing the following:

- Asking States to help every family they serve achieve the greatest degree of self-sufficiency possible through a creative mix of work and additional constructive activities
- Helping States and communities find effective ways to promote healthy marriages and responsible fatherhood and reduce out-of-wedlock childbearing
- Improving the management (and, therefore, the quality of programs and services made available to families); and
- Allowing States to integrate the various welfare and workforce assistance programs operating in their States.

The past success of the first wave of welfare reform efforts provides a unique opportunity to move to the next phase as evidenced by the Administration's welfare reform legislation and the ongoing efforts of the Congress to enact welfare reform legislation. The FY 2006 budget follows the framework proposed in the President's FY 2005 budget request, which includes reauthorization of TANF. The reauthorization proposal maintains current program funding levels for the following activities: Family Assistance Grants to States, Tribes and Territories ($16.6 billion); Matching Grants to Territories ($15 million); and Tribal Work Programs ($7.6 million). The reauthorization proposal reinstates authority for both the Contingency Fund ($2 billion over five years) and Supplemental Grants for Population Increases ($319 million). In addition, the reauthorization proposal establishes three new programs, including: a new TANF Research, Demonstration and Technical Assistance program ($100 million), which will focus on the promotion of family formation and healthy two-parent marriage activities; a new matching grant program focused on marriage promotion ($100 million); and a program designed to promote responsible fatherhood activities ($40 million). The costs of these programs are offset by eliminating the Illegitimacy Reduction Bonus and by reducing the High Performance Bonus. Finally, the proposal includes bonuses on employment achievement ($500 million over five years).

PROGRAM 6B: AGING SERVICES PROGRAM
Administration on Aging (AOA)

FY 2006 Budget Request:
$1,400.8 Million

FY 2006 Full Cost:
$1,400.8 Million

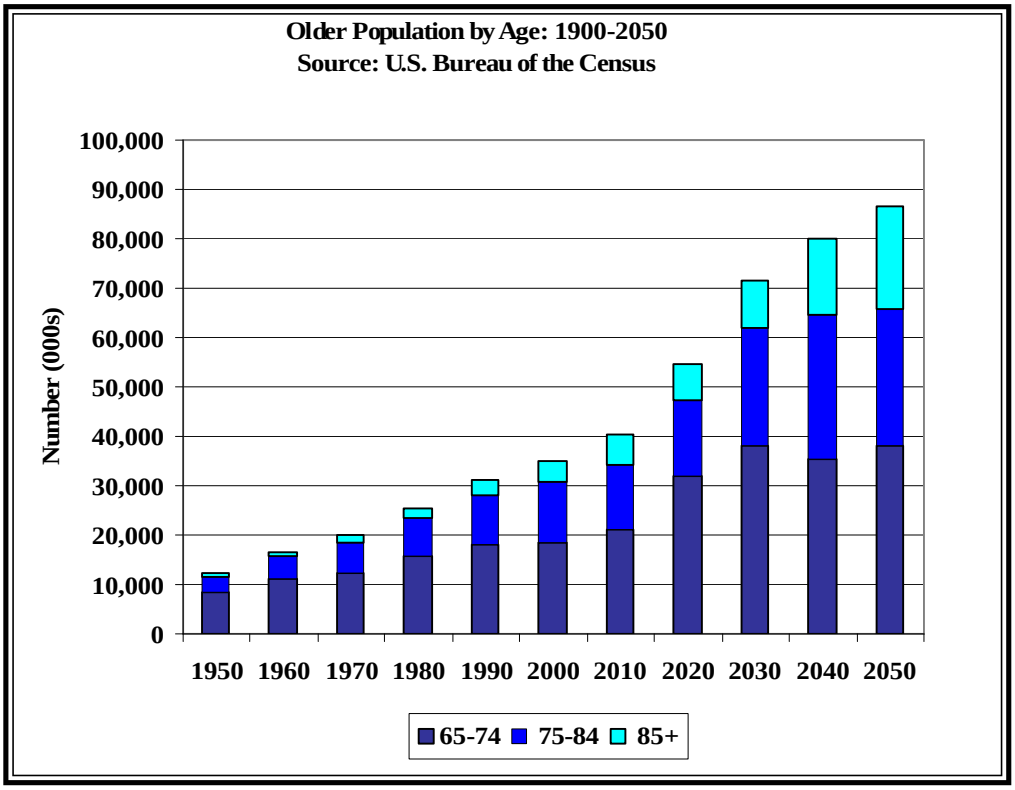
FY 2005 PART Rating:
Moderately Effective

✓ ***Performance Measure:*** *Increase the number of severely disabled clients who receive home-delivered meals.*

PROGRAM DESCRIPTION:

The Aging Services Program of AoA, which consolidates all AoA programs, provides grants to states, tribal organizations, and other community service providers forming a network to make comprehensive social and supportive services available to vulnerable elderly individuals and their family caregivers in order to help keep America's rapidly growing older population healthy, secure and independent in the community, where they prefer to reside. AoA programs, for a fraction of the cost of institutional care, are helping families to keep their loved ones at home for as long as possible. These services complement existing medical and health care systems and support some of life's most basic functions: food for the undernourished; transportation for the immobile; respite and counseling for caregivers; and personal care to those who need assistance getting in and out of bed, feeding and bathing themselves.

A review of aging demographics shows how critical the need for cost-effective services that allow seniors to remain independent is and will continue to be in the future: There are more than 4.6 million seniors who are age 85 and over, and these numbers are growing faster than any other age cohort. They are projected to total 5.1 million by 2005 and 9.6 million by the year 2030. While advances in medicine and technology are enabling seniors to live longer and more active lives than ever before, those of advanced age are also at increased risk of chronic disease and disability. Older Americans with chronic conditions are often unable to perform basic activities of daily living, and may require assistance to remain at home and avoid the need for institutional care. The May 1999 General Accounting Office report,



Adults with Severe Disabilities: Federal and State Approaches for Personal Care and Other Services, found that "obtaining personal care on what is often a daily basis is critical for avoiding institutionalization…. Without help from family, friends, or public programs, affording such assistance may be problematic."

PERFORMANCE ANALYSIS:

Performance Measure: Increase the number of severely disabled clients who receive home-delivered meals.		
Data Source: State Program Report (SPR)		
Year	**Target**	**Actual**
2003	Baseline: 280,000	New in FY 2004
2004	291,200 (Base + 4%)	293,500
2005	302,000 (Base + 8%)	02/2007
2006	322,000 (Base + 15%)	02/2008

Increasing the number of severely disabled clients who receive selected home and community-based services from AoA and the aging network is one of AoA's four targeting measures. Targeting measures and the indicators associated with them - while supporting HHS's strategic goals - are different from AoA's efficiency and client assessment measures, in that they ensure that AoA and the aging network focus services specifically on the most vulnerable of the elder populations. The targeting mechanism allows AoA to discourage entities from simply channeling resources to and reporting on the easy-to-serve clients to give the appearance of improving efficiency and quality performance while the hardest-to-reach and often the neediest go wanting. Instead, AoA and the aging network measure how well those who are at most risk of institutionalization – disabled, poor, and rural clients – are served. This measure was new in FY 2004 and is expected to gradually increase severely disabled clients served from the FY 2003 base of 280,000 (which is 25 percent of total clients) – first by 8 percent in FY 2005, then by 15 percent in FY 2006, reaching a peak of 25 percent over the base served in FY 2007. This demonstrates the capacity of the network to effectively serve nursing home eligible individuals. The data that support this indicator are collected in AoA's new annual national surveys of aging network clients.

PART REVIEW

AoA's Community-Based Services Program, which constitutes over 90 percent of the AoA Aging Services Program as a whole, has undergone two PART reviews. In the FY 2005 budget process, AoA received a rating of Moderately Effective, which was a significant improvement over the FY 2004 assessment (Results Not Demonstrated). AoA achieved the improved score through enhancements to its strategic plan, the development of efficiency measures, and the assignment of ambitious performance targets, such as the one for serving older persons who are severely disabled. AoA has continued to make improvements in response to the FY 2005 PART review by conducting detailed program evaluations for its program activities, and by better linking PART results and performance results to program budget requests.

EXTERNAL FACTORS

Economic factors, such as declining state budgets and high fuel costs, can affect performance related to Older American's Act (OAA) objectives. However, these factors will not significantly affect efforts to achieve OAA objectives to reach out to disabled elders with critical services and will assist in controlling long-term spending for the nation.

RATIONALE FOR BUDGET REQUEST:

The AoA budget request for FY 2006 for the Aging Services Program is $1,400.8 million.

STRATEGIC GOAL 7

Improve the Stability and Healthy Development of Our Nation's Children and Youth

7a. Child Support Enforcement (ACF)

7b. Child Welfare (ACF)

7c. Head Start (ACF)

In order to promote the development and stability of our nation's children and youth, HHS will continue several efforts in FY 2006. HHS will continue to support the social and cognitive development of preschool children; provide supports for family formation and healthy marriages; support programs that increase the involvement and financial support of non-custodial parents; and increase the percentage of children and youth living in a safe and stable environment.

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

The Child Support Enforcement program assures that support is available to children by locating parents and by establishing paternity and support obligations. These efforts will continue to be an integral part of the Department's effort to increase parental responsibility by promoting the involvement of non-custodial parents in the lives of their children.

The Child Welfare programs will continue to support States and localities in their efforts to keep children safe. Services offered include preventive intervention, where appropriate, so that children can remain in their homes, identifying alternative placements like foster care when necessary, and reunification services so that a child can return home. HHS will also support research and demonstrations that will focus on the prevention and treatment of child abuse, neglect, and family violence.

This section highlights ACF Child Support Enforcement, Child Welfare, and Head Start programs. Their representative performance measures illustrate the Department's continuing commitment to improving the stability and promoting the development of our Nation's children and youth.

PROGRAM 7A: CHILD SUPPORT ENFORCEMENT

Administration for Children and Families (ACF)

FY 2006 Budget Request:
$3,271.6 Million

FY 2006 Full Cost:
$3,312.5 Million

FY 2005 PART Rating:
Effective

✓ ***Performance Measure:***
Increase the Title IV-D collection rate (collections on current support/current support owed).

PROGRAM DESCRIPTION

The mission of Child Support Enforcement (CSE) is to assure that children receive the financial and medical support they need by locating parents, establishing paternity, and enforcing support obligations. Child support is an important source of income for improving quality of life for children and for families striving for self-sufficiency.

The Office of Child Support Enforcement works in collaboration with State agencies. State and local governments administer the CSE program, and the Federal Government reimburses States for 66 percent of administrative costs and 90 percent of paternity testing costs. The Federal role is to provide direction, guidance, technical assistance, oversight, and some critical services to States' CSE Programs for activities mandated under title IV-D of the Social Security Act (referred to as IV-D hereafter).

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) has had a dramatic impact on the child support program. This law added major new responsibilities for both State and Federal staff and provided a number of enforcement tools to ensure that children are financially supported by both parents.

One key provision of PRWORA is that all States must have a program to collect information about newly hired employees in a State Directory of New Hires (SDNH). States match new hire reports against their child support records to locate parents, establish child support orders, or modify existing orders. To address the large number of cases where the parent who owes child support works in another State, PRWORA established the National Directory of New Hires (NDNH). The NDNH is a national repository of records from the SDNH, quarterly wage and unemployment insurance data from the State Employment Security Agencies, and new hire and quarterly wage data from Federal agencies. States also submit data to be matched against the NDNH.

Another mandate from PRWORA was the creation of the Federal Case Registry (FCR). The FCR is a national database that includes all child support cases handled by State child support agencies, and all support orders established or modified on or after October 1, 1998. It assists States in locating parents that live in different States to establish, modify, or enforce child support obligations, establish paternity, enforce State law regarding parental kidnapping, and establish or enforce child custody or visitation determinations.

PRWORA also provided enforcement tools, particularly important for collecting past-due child support. One tool is the Financial Institution Data Match (FIDM), which is an additional means for locating the assets of individuals owing child support obligations. State child support programs may issue liens or levies on the accounts of the non-custodial parent to collect past-due child support. Another tool provided to States and the Federal Government is Passport Denial. PRWORA requires the Secretary of State to refuse to issue a passport to any person certified by the Secretary of the Department of Health and Human Services as owing a child support debt greater than $5,000. The Secretary of State may also take action to revoke, restrict, or limit a passport previously issued to an individual owing such a child support debt.

PERFORMANCE ANALYSIS

The Child Support Enforcement program continues to make impressive gains. Since the creation of the CSE program, child support collections within the program have grown annually. States have increased collections by using a wide variety of approaches such as income withholding, offset of income tax refunds, and reporting to credit bureaus. In addition, States are continuing to reap the benefits of the tools provided by PRWORA, and

Performance Measure: Increase the Title IV-D collection rate (collections on current support/current support owed).

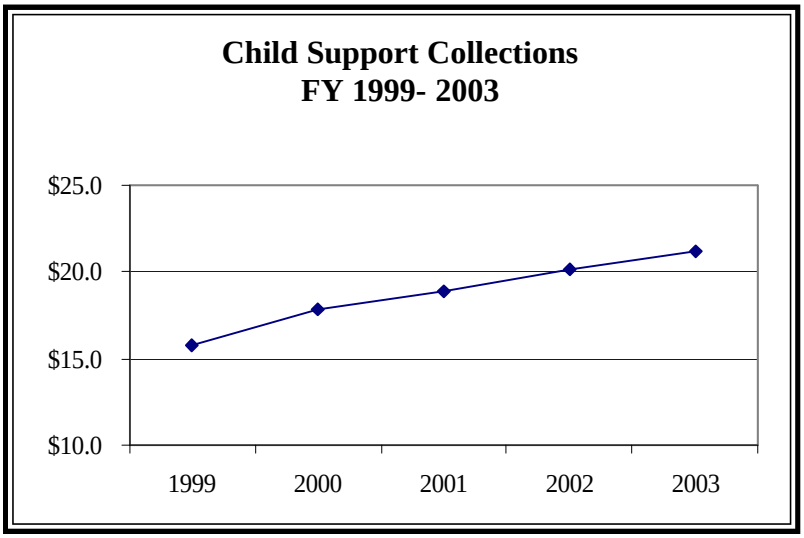
Data Source: OSCE Form 157

Year	Target	Actual
2001	54%	57%
2002	55%	58%
2003	58%	58%
2004	60%	Data available 09/2005
2005	61%	Data available 09/2006
2006	62%	Data available 09/2007

- CSE collected $21.2 billion in FY 2003, serving an estimated 16 million child support cases.
- The Federal Government collected $1.6 billion in overdue child support from Federal income tax refunds for tax year 2003 on behalf of more than 1.6 million families. This is an effective tool for collecting on child support arrears.
- The number of paternities established or acknowledged was 1.5 million in FY 2003. Of these, over 860,000 were established through in-hospital acknowledgement programs.
- Voluntary reports by the States indicate that the Passport Denial program resulted in collections of over $11.3 million in lump sum child support payments in FY 2003 and $34.7 million overall since 1998. The Department of State denies as many as 60 passports every business day. This is also an effective tool for collecting on child support arrears.

ACF measures CSE program success using five measures, which are part of the incentive system and used to gauge the achievement of the goals and objectives in the National CSE Strategic Plan. In FY 2003, the latest year for which we have data, CSE met three: percentage of cases with support orders; increase cost-effectiveness ratio; and increase the IV-D collection rate for current support.

The collection rate for current support is a proxy for the regular and timely payment of support and compares total dollars collected for current support in IV-D cases with total



dollars owed for current support in IV-D cases. In FY 2003, CSE achieved a collection rate for current support of 58 percent, meeting the 58 percent target. CSE has increased it target for this measure from the FY 2005 target of 61 percent to 62 percent for FY 2006.

For the other CSE measures, CSE will adjust targets accordingly:

- Maintain the paternity establishment percentage target at 98 percent for FY 2005 and FY 2006. This measure compares paternities established during the fiscal year with the number of non-marital births during the preceding fiscal year. The rate includes paternities established by the IV-D program and paternities established by hospital-based programs.
- Raise its child support order establishment target rate from FY 2005 target of 71 percent to 72 percent for FY 2006. A support order is needed to collect child support. This measure directly indicates achievement of the performance target by comparing the number of IV-D cases with support orders with the number of IV-D cases.
- Increase the target for percentage of cases with child support arrearages that pay some amount from FY 2005 target of 61 percent to 62 percent in FY 2006. This measure compares the total number of IV-D cases paying any amount toward arrears with the total number of IV-D cases with arrears.
- Raise the cost-effectiveness ratio target (total dollars collected per $1 of expenditures) from $4.42 for FY 2005 to $4.49 for FY 2006. This measure compares total IV-D child support dollars collected by States with total IV-D dollars expended by States for administrative costs.

ACF and its partners use several reporting systems to track the activities, which support the achievement of the above measures. ACF has partnerships with the Social Security Administration and the Federal Parent Locator Service, which allow States to locate parents and locate their place of employment for wage withholding and medical support purposes.

States currently maintain information on the necessary data elements for the five program measures. Most States use an automated system to maintain these data, while a few maintain the data manually. Federal law mandated that all States have a comprehensive, statewide, automated CSE system in place by October 1, 1997. In FY 2003, 48 States, the District of Columbia and three Territories indicated compliance with the single statewide child support enforcement automation requirements of the Family Support Act of 1998 and are FSA-certified. Forty-eight States, the District of Columbia and three Territories have been PRWORA certified as of May 19, 2004. Continuing implementation of these systems, in conjunction with cleanup of case data, will improve the accuracy and consistency of reporting.

PART REVIEW

The CSE program was assessed using the PART for the FY 2005 budget. The program received a rating of Effective. It was recommended that the program continue to build on their success in child support collection, improve medical support enforcement (provision of medical insurance for children), and encourage responsible parenthood.

EXTERNAL FACTORS

A number of interacting factors either help or hinder performance goal achievement, including: (1) State TANF program structures and policies; (2) the national economy; (3) wage and unemployment rates; and (4) demographic and social trends such as divorce and non-marital birth rates. These and other external factors affect State agency caseloads, paternity establishment workloads, and ability to collect support payments.

RATIONALE FOR BUDGET REQUEST

The President's FY 2006 budget request of $3.272 billion assumes Congressional action on legislation proposed in the FY 2003, FY 2004 and FY 2005 President's Budgets. The President's legislative proposals will continue to move the program toward a focus on financially strong families and away from the historic purpose of recouping Federal and State welfare outlays. The combined effect of the legislative proposals is increased child support collections, which will result in increased rates of current support collected, arrears collections, and the cost-effectiveness ratio.

PROGRAM 7B: CHILD WELFARE

Administration for Children and Families (ACF)

FY 2006 Budget Request:
$7,582.6 Million

FY 2006 Full Cost:
$7,583.5 Million

FY 2005 PART Rating:
Adequate:
Foster Care

FY 2006 PART Rating:
Results Not Demonstrated:
Independent Living Program
Community Based Child Abuse Prevention
Child Abuse Prevention and Treatment State Grants

PROGRAM DESCRIPTION

The purpose of ACF's Child Welfare programs, under Titles IV-B and IV-E of the Social Security Act, is to prevent maltreatment of children, provide in-home services for at-risk children and families, find temporary placements for children who must be removed from their homes, and achieve safe and stable permanent outcomes for children removed from their homes. Foster Care provides a stable environment for those children who cannot remain safely in their homes, and assures children's safety and well-being while their parents attempt to resolve the difficulties that led to the out-of-home placement. When the family can not be reunified, Foster Care provides a stable environment until the child can be placed permanently with an adoptive family or in a guardianship arrangement. Adoption Assistance funds are available for a one-time payment for the costs of adopting a child as well as for monthly subsidies to adoptive families for care of the child. In December 2003, President Bush signed the Adoption Promotion Act of 2003, which reauthorizes the adoption incentive payments program first created by the Adoption and Safe Families Act of 1997. The act creates enhanced incentives for "older child adoption," namely adoption from foster care of children who are nine years of age or older. It maintains the existing incentives for other foster children.

PERFORMANCE ANALYSIS

Overall, ACF's child welfare programs have eight performance measures. ACF met or exceeded the targets for four of the measures in FY 2003, the most recent year for which data is available.

✓ ***Performance Measure:*** *Increase the number of adoptions toward achieving the goal of finalizing adoptions for 327,000 children from the child welfare system between FY 2003 - FY 2008.*

Since 2000, the number of adoptions per year has flattened and annual targets for adoptions from the child welfare system have not been met. There were 49,000 adoptions in FY 2003. The FY 2003 target of 58,500 adoptions was not met, in part because the decline in the total number of children in foster care during the period was not anticipated. The number of children in care declined from 567,000 in FY 1999 to 532,000 in FY 2002 (see the figure below). In addition, targets did not take into account that the average age of the children waiting for adoption would increase by almost one year during this same period, making it more challenging to find adoptive homes for the children. ACF adjusted adoption targets for future years to reflect this new information, and starting in FY 2004, we anticipate a much slower rate of growth in the number of adoptions.

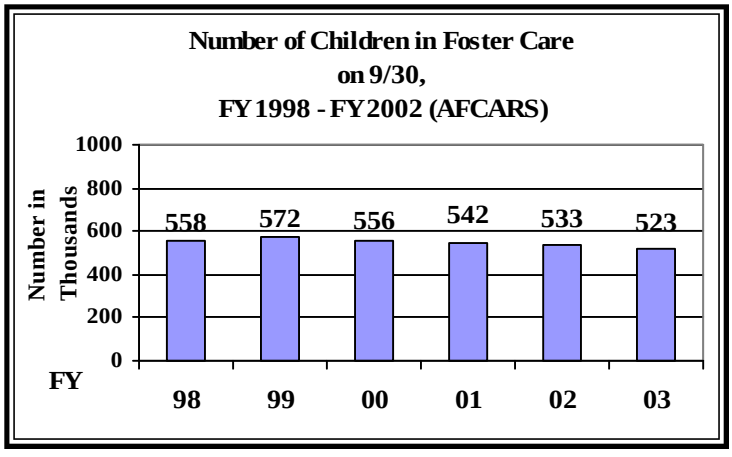
ACF also changed the performance measure for adoptions to: increase the number of adoptions toward achieving the goal of finalizing adoptions for 327,000 children with public child welfare involvement between FY 2003- FY 2008. The previous measure was derived from the goal of doubling the number of adoptions over a five year period, thereby emphasizing the specific year in which an adoption was finalized rather than the finalization of the adoption itself. For example, the target number of adoptions in performance measures from FY 1999 through FY 2002 was 194,500. The actual number of adoptions finalized was 199,000-4,500 more than projected. The adoption rate (number of adoptions divided by the number of children in care at the end of the prior year) actually increased from 8.4 percent in FY 1999 to 9.7 percent in FY 2002. Under the new measure, the FY 2006 target for adoptions is to finalize adoptions for 56,000 children towards the goal of finalizing adoptions for 327,000 children with public child welfare involvement between FY 2003 and FY 2008.

Performance Measure: Increase the number of adoptions toward achieving the goal of finalizing adoptions for 327,000 children from the child welfare system between FY 2003 – FY 2008.

Data Source: Adoption and Foster Care Analysis and Reporting System

Year	Target	Actual
2001	51,000	50,000
2002	56,000	53,000
2003	58,500	49,000
2004	53,000	Data available 10/2005
2005	54,000	Data available 10/2006
2006	56,000	Data available 10/2007

Data for child welfare is reported by States to ACF through the Adoption and Foster Care Analysis Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS). Both AFCARS and NCANDS conduct extensive edit-checks for internal reliability. For AFCARS, more than 700 edit checks are conducted each time data are submitted, a minimum of two times a year per state, to improve data quality and the results are sent to the states. In addition, all edit check programs are shared with the states. Finally, compliance reviews for AFCARS are currently being piloted, and State Automated Child Welfare Information System (SACWIS) systems are undergoing reviews to determine the status of their operation. To speed improvement in these data, the agency funds the National Resource Center for Information Technology in Child Welfare. This Resource Center provides technical assistance to states to improve reporting to AFCARS and NCANDS, improve statewide information systems, and better utilize their data. Finally, within the past year and half, ACF has implemented the AFCARS Project that includes a detailed review of all aspects of AFCARS by Federal staff and participation of the field in identifying possible changes to improve the system. All of these activities should continue to generate additional improvements in the data over the next few years.



PART REVIEW

The Foster Care program was assessed using the PART in FY 2004 and reassessed in FY 2005, resulting in a rating of Adequate. PART recommendations include that the program should develop and introduce legislation that would permit the flexible use of funding to meet program goals.

In FY 2006, the Chafee Foster Care Independence program (Independent Living), the Community Based Child Abuse Prevention Program (CBCAP), and the Child Abuse Prevention and Treatment State Grants program (CAPTA) were each evaluated by PART. The Independent Living program received a rating of "results not demonstrated" because the program has not developed program specific performance measure or implemented a system to track data on program participants. CBCAP and CAPTA State Grants also received ratings of Results Not Demonstrated."

External Factors

Illegal drug use among parents has one of the most significant effects on foster care. In some States, the biggest increase in children placed for adoption is among newborns, due in large part to drug abuse. Overall economic conditions may also indirectly affect foster care, since if unemployment rises, fewer families may be able to take in foster children or adopt children.

Rationale for Budget Request

The FY 2006 request represents the Administration's effort to sustain the important child welfare initiatives put forth in recent years. This strategic goal area is composed of 14 separate discretionary and mandatory programs, which in the aggregate represent total funding of $7.6 billion in the FY 2006 request. The request continues support for the President's and the Secretary's priority child welfare initiatives at the FY 2005 enacted level. Approximately $200 million in program reductions in the Foster Care and Adoption Assistance programs are a result of adjustments in baseline spending estimates.

PROGRAM 7C: HEAD START

Administration for Children and Families (ACF)

FY 2006 Budget Request:
$6,843.1 Million

FY 2006 Full Cost:
$6,901.3 Million

FY 2005 PART Rating:
Results Not Demonstrated

PROGRAM DESCRIPTION

Intended for preschoolers from low-income families, the basic philosophy guiding the Head Start program is that children benefit from high quality early childhood experiences. Head Start promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social, and other services. Programs emphasize cognitive, language, and socio-emotional development to enable each child to develop and function at his or her highest potential. Head Start engages parents in their children's learning and helps parents to make progress toward their educational, literacy, and employment goals.

Head Start continues to emphasize its role as a national laboratory to test and refine educational approaches, and to use child outcomes to help guide program development. Recognition of emerging research, changing needs, and developing trends enable the Head Start Bureau to make resources available for targeted programmatic improvements. Head Start conducts research, demonstration, and evaluation activities to test innovative program models and to assess program effectiveness. In FY 1994, the Early Head Start program was established in recognition of mounting evidence that the earliest years, from birth to three years of age, matter a great deal to children's growth and development.

PERFORMANCE ANALYSIS

In the past three years, the Head Start program has almost achieved its target to have 80 percent of children who complete the Head Start program rated as having excellent or good health by their parents. In 2001 and 2002, 79 percent of children were rated as having excellent or good health.

✓ ***Performance Measure:*** *Achieve goal of at least 80 percent of children competing the Head Start program rated by parent as being in excellent or very good health.*

Head Start has a total of eleven performance measures that indicate progress toward achieving its goals.

Overall, children in Head Start programs are gaining in word knowledge, emergent literacy, language skills, mathematics, and social skills. In 2002:

- In word knowledge, the target was to achieve at least an average 32 percent or 10.0-scale point increase. The program reached the target of 32 percent.
- In letter identification, the target was to reach a 70 percent or a 3.4-scale point gain. The program received a 38 percent or a 2.0-scale point gain.

- In mathematical skills, the goal was to achieve 43 percent or a 3.0-scale point increase. The program met the target of 43 percent.
- In social skills, the goal was to gain 10 percent or 1.4-scale points. The actual gain was 13 percent or 1.9-scale points, thereby exceeding the target.

HHS has increased the percentage (and exceeded the target) of teachers with AA, BA, advanced degree, or a degree in a field related to early childhood education. The FY 2004 target was 56 percent, which is above the requirements of the Head Start Act, of 50 percent. The actual percentage in 2004 was 67.7 percent.

Performance Measure: Achieve goal of at least 80 percent of children completing the Head Start program rated by parent as being in excellent or very good health.

Data Source: Family and Child Experiences Survey (FACES)

Year	Target	Actual
2001	80%	79%
2002	80%	79%
2003	80%	Data available 12/2005
2004	80%	Data available 12/2006
2005	80%	
2006	80%	

Head Start did not meet its target of increasing the percentage of Head Start children who receive necessary treatment for emotional or behavioral problems. The Head Start Bureau will, in FY 2005, require its training and technical assistance (T/TA) providers to increase the assistance provided to grantees in this area. Current efforts in the area of mental health will be reevaluated to determine what other changes or improvements can be implemented that will help Head Start programs better work with children who have emotional or behavioral problems.

HHS continues to explore the data available from the Head Start National Reporting System (NRS) and will seek to find the best ways to use NRS information in conjunction with other Head Start research, program data, and other efforts such as program review monitoring. It is anticipated that with continued evaluation and consistency of implementation and reporting the NRS will be an increasingly valuable part of the broader system of program performance measurement, reporting, and program reviews in Head Start. The Secretary's Advisory Committee on Head Start Accountability and Educational Performance Measures will inform decisions at HHS about how best to use NRS data in ways that will help grantees improve the school readiness of Head Start children.

The Family and Child Experiences Survey (FACES) is a longitudinal study of a nationally representative sample of 3,200 children and families in 40 Head Start programs which provides data for the Head Start child outcomes measures. Full implementation began in the fall of 1997 and includes assessment of the same children before and after their Head Start experience (whether one or two years), as well as in the spring of kindergarten and the spring of first grade. Data sources include parent interviews, staff interviews, teacher questionnaires, classroom observations, and direct child assessments. FACES, designed as a periodic, longitudinal data collection activity, provided the baseline data for 1999.

All local programs receiving Head Start funds are required to submit an annual Program Information Report tracking program participation statistics such as the age of children, the kind of education program they receive, and the medical, dental, and mental health services the children receive. Annual one-time questions capture information about children's families and the kind of support services required such as job training, education, housing, counseling, and other community based services. This data collection is automated to improve the efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2,600 respondents. The data yielded are used for several performance measures reported.

PART REVIEW

The Head Start program received a PART assessment in FY 2004 and received a rating of Results Not Demonstrated. The PART recommended that the program:

- Create a new system to assess every Head Start center on its success in preparing children for schools.
- Propose legislation to better integrate Head Start, child care, and state-operated preschool programs.
- Develop annual performance measures that assess the progress of individual grantees in improving school readiness.
- Better measure the impact on children.

EXTERNAL FACTORS

Economic conditions and health issues affect the Head Start program. The existence of State-funded pre-K programs and salaries paid to teachers also affect the market for the Head Start program in various ways.

RATIONALE FOR BUDGET REQUEST

The FY 2006 request is $6.9 billion, an increase of $45 million over the FY 2005 enacted level. These funds will be used by 1,600 local grantees to promote the school readiness of approximately 919,000 children by enhancing their social and cognitive development. The increase will support State implementation of a new $45 million pilot project to promote better coordination of their State preschool, Head Start and child care programs into a comprehensive system which would address the needs of low-income preschool-aged children and their families. This pilot project (which builds on the comprehensive reauthorization proposal submitted to Congress in FY 2004) would assess the extent to which States could better meet the needs of low-income children and their families, by increasing coordination, reducing bureaucratic overlap, and achieving more cost efficiencies if they were able to have a greater role in administering all the programs in their State focused on pre-school age children.

STRATEGIC GOAL 8
Achieve Excellence in Management Practices

8a. Medicare Integrity Program (CMS)

8b. Office of Inspector General (OS)

HHS is committed to improving the efficiency and effectiveness of the Department's programs by creating an organization that has a citizen-based focus, is results oriented, and is market-driven, where practicable. The President's Management Agenda identifies key elements needed for HHS to achieve its commitment to effective management. In particular, HHS is dedicated to improving management of our financial resources; using competition to obtain the best price for services acquired; improving the management of our human capital and tying human capital goals to program performance goals; using technology wisely and in a cost effective manner; and achieving budget and performance integration.

In FY 2006, HHS will continue to recruit appropriately skilled employees through the Emerging Leaders program. HHS will also use the Program Assessment Rating Tool (PART) evaluation to inform budget decisions, program improvements, legislative proposals, and management actions (to date roughly 40 percent of HHS programs have been assessed in the PART process).

Two initiatives described in further detail in this section are listed below.

- Medicare Integrity Program: program integrity efforts ensure the Medicare program pays the right amount to legitimate providers for covered, reasonable, and necessary services that are provided to eligible beneficiaries.
- Office of Inspector General: combats fraud and abuse; and recommends policies designed to promote economy, efficiency, and effectiveness in HHS programs by conducting and supervising audits, evaluations, inspections, and investigations.

PROGRAM 8A: MEDICARE INTEGRITY PROGRAM

Centers for Medicare & Medicaid Services (CMS)

FY 2006 Budget Request:
$1.18 Billion

FY 2006 Full Cost:
$1.18 Billion

FY 2004 PART Score:
Effective

PROGRAM DESCRIPTION

CMS program integrity efforts ensure the Medicare program pays the right amount to legitimate providers for covered, reasonable and necessary services that are provided to eligible beneficiaries. These activities are primarily funded through the Hospital Insurance Trust Fund by the Medicare Integrity Program (MIP), established by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The MIP includes medical review and benefit integrity activities, provider education and training, Medicare secondary payer activities, and provider audits. CMS's overall program integrity efforts are supplemented by funding from the CMS Program Management account and other funds made available from the Health Care Fraud and Abuse Control (HCFAC) account.

The complexity of Medicare payment systems and policies and the number of contractors, providers, and insurers involved in the Medicare fee-for-service program create vulnerabilities. CMS has implemented an error rate reduction plan designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate. Other efforts designed to reduce Medicare's improper payment rate include: improving customer service, clarifying documentation guidelines, strengthening enrollment and improving industry compliance.

In addition to the national error rate, Comprehensive Error Rate Testing (CERT) outcomes include contractor-specific error rates, as well as a Medicare provider compliance error rate. These rates will allow CMS to quickly identify emerging trends in managing Medicare contractor performance.

✓ ***Performance Measure:***
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program.

CMS's medical review activities will emphasize appropriate corrective actions for identified claims payment errors. In addition, CMS will stress a quality improvement program, to ensure that the decisions made by medical review staff are accurate and consistent, and provide a thorough and efficient medical review process. This approach will enable CMS to reduce the claims payment error rate and assure providers and beneficiaries that it is operating the program in a responsible manner.

In provider education and training, CMS will emphasize educational activities that communicate appropriate billing practices in compliance with Medicare rules, regulations, and manual instructions. Sharing data analysis with local medical societies, professional associations, and other provider organizations will be used to effectively target CMS's efforts.

In support of MIP activities, improved provider enrollment will ensure that CMS enrolls only legitimate providers. Plans are being developed or are already underway to: provide stricter standards and stronger conditions of participation; conduct onsite visits to verify legitimacy and compliance with standards; increase the frequency of reenrollment; and collect better ownership and financial solvency information.

PERFORMANCE ANALYSIS

CMS started measuring the percentage of improper payments made under the Medicare program in 1996 and created a goal to reduce this percentage. CMS now has five goals representing MIP. These include reducing the contractor error rate and improving the provider compliance error rate. The CERT program was initiated in FY 2003 and has produced a national error rate for each year since its inception. The OIG produced error rate information for years before those included in the FY 2003 report. In 2004, CMS began reporting gross error rates in addition to the net error rates previously reported. This change was necessary in order to comply with new Improper Payments Information Act (IPIA) requirements.

The following measure illustrates one of MIP's key programmatic activities:

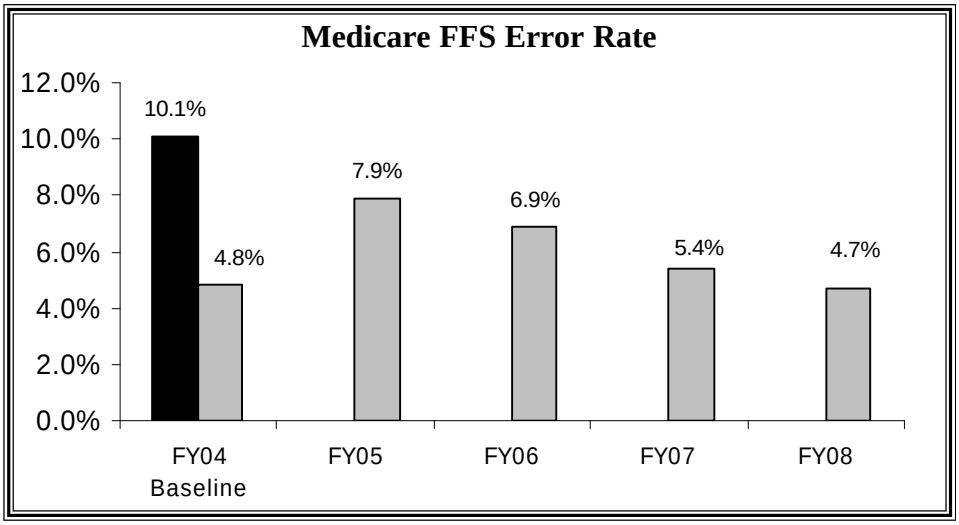
One of CMS's major goals is to pay claims properly the first time. Paying right the first time saves resources and ensures the proper expenditure of limited Medicare trust fund dollars. During the FY 2002 Program Assessment Rating Tool (PART) process, CMS worked with OMB to set ambitious annual targets for its program integrity goals for FY 2004 and beyond. CMS is confident that by addressing specific high-risk areas, it will achieve success in reaching these aggressive annual targets.

Performance Measure: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program

Data Source: CMS assumed responsibility for measuring the Medicare fee-for-service error rate beginning in FY 2003 with oversight by the OIG. Error rate information for years prior to the FY 2003 report was compiled by the OIG.

Year	Target	Actual
2001	6.0	6.3
2002	5.0	6.3
2003	5.0	5.8 [1]
2004	4.8	10.1 (recalculated baseline)
2005	7.9	
2006	6.9	

[1] This figure has been adjusted to account for the high provider non-response experienced in 2003. Had the adjustment not been made, the national paid claims error rate would have been 9.8 percent



PART REVIEW

The FY 2004 Medicare Integrity Program PART assessment completed in 2002 found that the program has a clear purpose, is managed well overall, and relies on performance measures that are directly relevant to the program purpose. This is reflected in the substantial reduction of the Medicare error rate and CMS's development of its own CERT program. The CERT program was initiated in FY 2003; as such, the CERT program produced a Medicare fee-for-service error rate for FY 2003.

MIP received one of the highest scores (85) of all programs. The assessment noted that CMS is developing sub-national performance measures to produce contractor-, provider-, and benefit-specific error rates, and developing provider compliance rates to identify providers who need assistance with accurate billing. The assessment also noted that, although CMS has an effective national performance measure, it did not require Medicare fiscal intermediaries and carriers to commit to specific error rates. CMS contracts with fiscal intermediaries and carriers on a cost basis and budgets most MIP funds based on activity level. As a result, very few of these contracts relate pay to performance. New Medicare contracting reform changes enacted in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) will allow CMS to competitively bid for these contracts that were previously cost-based contracts.

CMS intends to further reduce the Medicare fee-for-service error rate to 4.7 percent by FY 2008. Furthermore, CMS added two new program integrity goals in the FY 2004 Annual Performance Plan measuring the Medicare Contractor Error Rate and the decreasing the Medicare Provider Compliance Error Rate.

External Factors

MIP's ability to leverage private sector entities through its contracting authority has proven to be effective. Additionally, new Medicare contractor reform legislation, enacted through the MMA, will further enhance MIP's effectiveness. Section 911 of the Act establishes the Medicare fee-for-service Contracting Reform Initiative (MCRI) that will be implemented over the next several years. Under this provision, CMS will replace the current Medicare fiscal intermediary and carrier contracts, using competitive procedures, with new Medicare Administrative Contractor (MAC) contracts by October 2011. The new MAC contracts may be renewed annually based on performance for a period of five years, but they must be re-competed every five years.

Rationale For Budget Request

For FY 2006, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides $720 million for MIP, the capped amount available for this program since FY 2003. In addition to this mandatory funding, the FY 2006 budget requests $75 million through a discretionary cap adjustment to expand program integrity activities related to the Medicare prescription drug benefit and the Medicare Advantage Program. This additional funding will protect the newly enacted benefit against fraud, waste, and abuse.

PROGRAM 8B: OFFICE OF INSPECTOR GENERAL
Office of Secretary (OS)

FY 2006 Budget Request:
$39.8 Million

FY 2006 HCFAC Request:
$160 Million

FY 2006 Full Cost:
$199.8 Million

FY 2004 HCFAC PART Rating:
Results Not Demonstrated

PROGRAM DESCRIPTION

The Office of Inspector General (OIG) combats fraud and abuse; and recommends policies designed to promote economy, efficiency, and effectiveness in HHS programs. It accomplishes its purpose by conducting and supervising audits, inspections, and investigations; and providing guidance to the health care industry. Over 80 percent of OIG resources are devoted to the Health Care Fraud and Abuse Control (HCFAC) Program, which was mandated in 1996 by the health care fraud and abuse provisions of the Health Insurance Portability and Accountability Act (HIPAA). The HCFAC Program is a joint responsibility of the Secretary of HHS and the Attorney General. Its purpose is to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse, including the conduct of investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States. The program came about in response to the need to provide more resources to combat the large and growing level of health care fraud and abuse, and to take aggressive action to avoid insolvency of the Medicare Trust Fund.

The remaining nearly 20 percent of the OIG operating budget is dedicated to fighting fraud, waste, and abuse in all other HHS programs; specifically, all public health, human services, and research programs, as well as general departmental oversight.

PERFORMANCE ANALYSIS

✓ ***Performance Measure:***
Return on Investment.

The OIG has used return on investment (ROI)-an efficiency measure-as its key performance measure since the implementation of GPRA. Savings, its numerator, is an outcome measure, and by relating it to the cost of operating the OIG, it is a measure of cost-effectiveness and efficiency.

The savings that are used to calculate ROI consist of expected recoveries of funds resulting from successful prosecutions in the courts and out of court settlements; and savings from funds not expended as a result of OIG audits, investigations, and inspections, as determined by the Congressional Budget Office (CBO). ROI provides a clear focus on results for OIG managers as they direct the program and allocate its resources.

OIG effectiveness and efficiency, as measured by ROI, have improved each year since the measurement began. In FY 2000, ROI stood at $104:1 ($104 saved for each dollar in the OIG operating budget). The

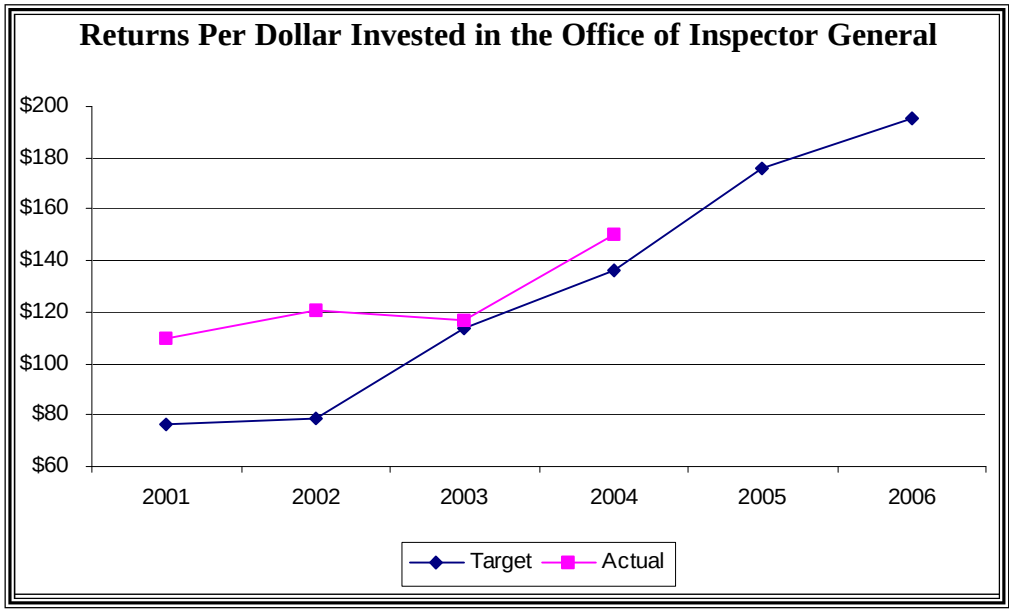
ROI for FY 2004 was $150:1. Based on this strong performance, the target for FY 2005 was raised from $155 to $176, and the initial target for FY 2006 was set at $196. Savings resulting from OIG recommendations that led to several provisions of the Medicare Modernization Act of 2003 explain the sharp increase.

Performance Measure: OIG Return on Investment.

Data Source: (1) Savings reported in the OIG Semiannual Reports and (2) OIG Budget

Year	Target	Actual
2001	$76	$110
2002	$79	$121
2003	$114	$117
2004	$136	$150
2005	$176	
2006	$195	

Data verification and validation is done internally as part of long-established processes that lead to issuance of the legislatively-mandated Semiannual Report to Congress. The Government Accountability Office (GAO) performs validity checks of OIG savings achieved by the HCFAC Program, which accounts for nearly all such savings. The savings associated with legislative changes are provided by CBO, and those associated with regulatory changes are provided by the relevant Operating Division of the Department.



PART REVIEW

A PART review of the HHS OIG portion of the HCFAC Program was conducted for the FY 2004 budget. It was rated Result Not Demonstrated. The assessment found that the program lacked a baseline of the amount of fraud in the healthcare system against which to measure the program's progress in meeting its objectives. Although the sought after baseline has not been identified, the results, one measure of which is return on investment, suggest that the program is carrying out its mandate effectively.

EXTERNAL FACTORS

New or changed laws related to Medicare, Medicaid, and all other HHS programs present OIG with oversight challenges that can only be known after their implementation. Initial efforts to address newly identified priorities can only come as a result of reassigning staff from planned work to previously unplanned but higher priority work. This is a reality of the environment in which the OIG works.

RATIONALE FOR BUDGET REQUEST

The FY 2006 discretionary budget request is $39,813,000. Although this amount is lower than the FY 2005 appropriation, it supports the annualized January 2005 pay raise, the anticipated January 2006 pay raise, and the OIG share of the Department IT infrastructure and UFMS investments. OIG also receives between $150 -$160 million from the HCFAC Account each year, as established by HIPAA, to combat fraud, waste, and abuse in Medicare, Medicaid, and the State Children's Health Insurance Program. This mandatory amount has been capped in this range since FY 2003. In FY 2005 OIG received $25 million to fight fraud, waste, and abuse associated with the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act. The FY 2006 budget request proposes to extend the date that OIG can obligate this $25 million by one year, from FY 2005 to FY 2006.

APPENDIX

DISCRETIONARY PROGRAM LEVEL BUDGET BY STRATEGIC GOAL

(program level, dollars in millions)

OPDIV	Total	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6	Goal 7	Goal 8
FDA	1,881	-	180	-	1,504	70	-	-	127
HRSA	6,527	-	534	5,847	-	-	-	-	146
IHS	3,846	-	-	3,846	-	-	-	-	-
CDC	7,543	4,884	1,647	-	426	115	-	-	471
NIH	28,845	-	1,694	-	26,825	-	-	-	326
SAMHSA	3,336	2,407	-	837	-	-	-	-	92
AHRQ	319	37	37	-	133	100	8	-	3
CMS [1]	4,101	-	-	2,597	-	-	-	-	1,504
ACF	13,187	129	-	-	-	-	4,979	7,892	187
AoA	1,372	22	-	-	-	14	1,319	-	18
Departmental Management [2]	799	279	84	-	40	164	-	1	232
OIG	200	-	-	-	-	-	-	-	200
OCR	35	-	-	10	-	9	14	1	0
PHS Evaluation Funds	(791)	-	-	-	-	-	-	-	-
Total, Program Level [3]	71,200	7,758	4,176	13,137	28,928	473	6,320	7,895	3,305

1 The FY 2006 HCFAC wedge funding is a straight-line from FY 2005 and is subject to change.

2 Departmental Management includes Pandemic Flu, Health Information Technology, and Medicare Hearings and Appeals.

3 The sum of the goals does not add across to the total because the $791 million offset for PHS Evaluation Funds is not distributed.