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FOCUSING ON THE HEALTH AND HUMAN SERVICE CHALLENGES OF THE FUTURE

HIGHLIGHTS

Since the Clinton-Gore Administration began seven years ago, we have worked diligently to improve the health status and welfare of all Americans. We have sought to broaden access to affordable, quality health care. We have enthusiastically supported the advance of scientific research and we have worked to ensure that our Nation's children have a safe and healthy childhood.

Since 1993, we have witnessed the longest economic expansion in history and eliminated the budget deficit. Our challenge is to build on this prosperity by continuing our efforts to expand health care coverage, access and quality, renew support for our children and families, support greater scientific advancement, and create a healthier America.

Therefore, our FY 2001 budget will:

- ***EXPAND HEALTH CARE COVERAGE***

by accelerating enrollment in Medicaid and the State Children's Health Insurance Program (SCHIP), ensuring greater access to insurance for parents of children eligible for SCHIP and Medicaid, providing a Medicare prescription drug benefit, modernizing Medicare, making Medicare more competitive and efficient, improving options for quality long-term care for the elderly under Medicaid, and supporting family caregivers;

- ***RENEW SUPPORT FOR CHILDREN AND FAMILIES***

by making child care accessible, affordable, and of high quality for working families; enhancing Head Start; funding demonstrations for innovative asthma treatments for low-income children, supporting substance abuse programs and graduate medical education of pediatricians, and by taking additional steps to increase child support collections and to direct more of these payments to low-income families;

- ***ENCOURAGE GREATER SCIENTIFIC ADVANCEMENT***

by continuing investments in biomedical science in the National Institutes of Health (NIH) and using science to improve food safety through investments in the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC); and by investing in the Agency for Healthcare Research and Quality (AHRQ) to improve the quality of health care and in conjunction with FDA, to reduce medical errors; and

- ***CREATE A HEALTHIER AMERICA***

by strengthening systems of surveillance to reduce threats from emerging infectious diseases and bioterrorism, and by investing in the public health infrastructure, supporting mental health programs, continuing to fight HIV/AIDS, and working to eliminate racial disparities in health status.

TOTALS

The FY 2001 budget for the Department of Health and Human Services (HHS) totals $421.4 billion in outlays, an increase of $34.1 billion, or 9 percent, over the comparable FY 2000 budget. The discretionary portion of the HHS budget totals $48.6 billion in budget authority, an increase of 11 percent over the FY 2000 level.

EXPAND HEALTH CARE COVERAGE

HHS proposes a health insurance initiative to expand access to quality health care for more Americans, including expanding Medicare coverage for older workers, expanding health insurance access and outreach to children and parents of low-income children. It also restores Medicaid benefits for legal immigrants and ensures continued health insurance for single parents moving from welfare to work.

Over 44 million Americans lack health insurance. Although there are many causes of this problem, it generally results from the high cost of insurance or limited access to coverage. Family health insurance premiums cost on average $5,700–which often represents too large a share of the income for families of modest means trying to make ends meet.

Purchasing affordable, accessible insurance is also a formidable challenge for many older people, workers in transition between jobs, and employees of small businesses, many of whom are moving off of the welfare rolls. Yet, the lack of health insurance can have devastating consequences. The uninsured are three times more likely than the privately insured to not receive needed medical care, 50 to 70 percent more likely to need hospitalization for avoidable conditions like pneumonia or uncontrolled diabetes, and four times more likely to rely on an emergency room or have no regular source of care.

Our budget contains a number of other proposals that address the problems of health care access, affordability, and quality for many Americans. It modernizes the Medicare program, extending the life of the Trust Fund, instituting important management reforms, and providing a new prescription drug benefit and new options for long-term care. It also supports family caregivers of the elderly and the disabled.

HEALTH INSURANCE INITIATIVE:

- ***FAMILYCARE FOR SCHIP AND MEDICAID PARENTS***

This proposal would provide higher Federal matching payments for state coverage of parents of children eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). Under FamilyCare, parents would be covered in the same health insurance plan as their children. States would use the same systems and follow most of the same rules as they do in Medicaid and SCHIP today, and the program would be overseen by the same state agency.

State spending for FamilyCare would be matched at the same higher matching rate as SCHIP (up to 15 percentage points higher than the Medicaid rate). To ensure adequate funding, $50 billion over 10 years would be added to the current state SCHIP allotments. This proposal increases coverage to four million new adults and children over the next 10 years.

- ***ACCELERATING ENROLLMENT IN MEDICAID AND SCHIP***

The State Children's Health Insurance Program (SCHIP) helps children in families with income too high to be eligible for Medicaid but too low to afford private insurance. Enrollment in SCHIP doubled to two million children in FY 1999. However, despite this encouraging trend, millions of children remain eligible but unenrolled in either SCHIP or Medicaid.

The FY 2001 HHS budget includes proposals that would give states needed tools, such as increasing the age eligibility options, the school lunch initiative and presumptive eligibility in additional sites like child care referral centers, which provide coverage to an additional 400,000 children.

EXPANDING HEALTH INSURANCE OPTIONS:

❑ *EXPANDING ACCESS TO HEALTH CARE FOR IMMIGRANTS*

The President proposes $6.5 billion in funding over ten years to give states the option of covering qualified legal immigrants, regardless of when they came to the United States.

The proposal would give states the option to insure children and pregnant women in Medicaid and SCHIP regardless of their date of entry. It would eliminate the 5-year ban, deeming, and affidavit of support provisions enacted as part of welfare reform. The proposal would also require states to provide Medicaid coverage to disabled immigrants who would be made eligible for Supplemental Security Income (SSI) by the FY 2001 budget's SSI restoration proposal. In addition, parents of children who have benefits restored could be covered by the proposed FamilyCare initiative.

❑ *IMPROVING ACCESS TO CARE FOR THE UNINSURED*

HHS proposes $125 million in FY 2001 to expand the initiative started in FY 2000 that will improve access to health care for uninsured workers. Americans who have no health insurance coverage must depend on institutions and individual health professionals to provide services either without payment or on a reduced-fee basis to the uninsured.

This initiative will improve medical care for many of our Nation's uninsured adults by providing grants to assist community-based health care providers to develop and expand integrated systems of care with a focus on primary care, mental health services, and substance abuse services. This initiative will be complemented by a proposed $50 million increase in grants to Community Health Centers.

❑ *MODERNIZING MEDICARE*

This budget proposes a comprehensive reform plan to modernize and strengthen the Medicare program to meet the health, demographic, and financing challenges of the 21st century. We seek to make Medicare more competitive and efficient by modernizing Medicare's benefits.

The President's reform plan expands access to preventive benefits by creating incentives for beneficiaries to take advantage of a number of life-saving Medicare benefits such as colorectal screening and mammograms. The plan would eliminate the coinsurance and deductibles for many Medicare-covered preventive benefits. The plan also provides for a three-year smoking cessation demonstration for beneficiaries and a nationwide health promotion education campaign directed toward all Americans over 50.

❑ *MEDICARE PRESCRIPTION DRUG BENEFIT*

The centerpiece of the President's Medicare reform plan is a voluntary prescription drug benefit that would be affordable and available to all beneficiaries. The drug benefit proposal would have no deductible and pay half of beneficiaries' prescription drug costs up to $2,000 in FY 2003 and up to $5,000 when fully implemented in FY 2009. The benefit would ensure a price discount, ensure that low-income beneficiaries pay no or reduced premiums and cost-sharing, and provide financial incentives for employers to retain retiree health coverage. The net cost of this new benefit, including Medicaid, is $38.1 billion ($28.8 billion in Medicare only) over five years.

❑ *MEDICARE BUY-IN*

The rate of uninsured is growing fastest among people ages 55 to 65 and is expected to increase even faster in the future. Recognizing this, HHS again proposes that

people ages 62 through 65 and displaced workers ages 55 to 65 be allowed to pay premiums to buy into Medicare. This initiative costs $980 million over five years.

ENHANCING MEDICARE MANAGEMENT/FRAUD, ABUSE & CONTRACTOR OVERSIGHT

The Health Care Financing Administration (HCFA) administers Medicare, Medicaid, and SCHIP, and oversees state health insurance regulation of individual and small group markets. HCFA continues to face the important challenge of modernizing administrative infrastructure, while providing superior customer service to more than 70 million beneficiaries. HCFA and its partners also continue their efforts to prevent and detect health care fraud and abuse through the Medicare Integrity Program (MIP) and the Health Care Fraud and Abuse Control (HCFAC) program.

In response to recent recommendations from the HHS Office of the Inspector General (OIG) and the General Accounting Office on contractor financial management practices and other issues, HHS proposes a comprehensive initiative that improves oversight of Medicare contractors responsible for claims processing, beneficiary and provider services, and program integrity.

The HHS budget also provides funds for external reviews of key program areas, the development of a new financial management system and new evaluation protocols. The request adds staff to contractors to establish more rigorous internal control policies, identify control objectives, determine the relevant risks in achieving those objectives, and report reliable information to HCFA.

NURSING HOME INITIATIVE

The HHS FY 2001 budget includes $70.8 million for expanding implementation of the President's Nursing Home Initiative announced in July 1998. In FY 1999, HHS began phasing in key provisions of the initiative. This budget request allows HCFA and other components of HHS to fully implement all provisions of the President's initiative.

Since launching the initiative, HCFA has made significant progress in drafting stronger nursing home enforcement policies. In FY 2001, $37.8 million will be devoted to strengthening state enforcement efforts and improving Federal oversight, expediting investigations of nursing home resident complaints, and looking at ways of moving individuals from nursing homes to community-based services.

Another $19.5 million will supplement state inspection and enforcement activities in dually-certified and Medicaid-only nursing homes, maintain and upgrade the Nursing Home Compare website, and continue national education campaigns to prevent abuse, neglect, and malnutrition in nursing homes.

The HHS budget provides $13.5 million to ensure adequate funding for the Office of the General Counsel and the Departmental Appeals Board to provide more timely judicial hearings and to reduce the backlog of appeals resulting from stronger enforcement actions.

HHS will also submit legislation requiring nursing homes to query the nursing home criminal abuse registry and conduct criminal background checks on new employees, activities which would be financed through user fees.

LONG-TERM CARE

Over five million Americans have significant limitations due to illness or disability and thus require long-term care. Approximately two-thirds of those requiring health care are older Americans. However, millions of adults and a growing number of children have long-term care needs because of a health condition from birth or a chronic illness developed later in life.

Our FY 2001 budget improves equity in Medicaid eligibility between people in home-

and community-based settings and people receiving institutional care; supports partnerships between Medicaid and the Department of Housing and Urban Development to coordinate low-income housing and Medicaid services for the elderly; and encourages the purchase of quality private long-term care insurance by Federal employees.

FAMILY CAREGIVER SUPPORT

The population age 85 and over is expected to increase by 50 percent between 1996 and 2010. Ninety-five percent of disabled older Americans who live in the community depend on informal caregivers, such as spouses, adult children, other relatives and friends, for assistance. While Medicaid is vitally important in paying for institutionalized care, the primary long-term care providers for older persons remaining at home are not social service agencies or government programs; they are families. Studies have found that caregiving exacts a heavy emotional, physical, and financial toll on families. Assistance to caregivers is needed now more than ever.

To support caregivers, HHS proposes to increase spending by $125 million in FY 2001. This request would fund quality respite and other supportive services–teaching caregivers to manage wandering and agitated behavior in late-state Alzheimer's Disease–for approximately 250,000 families.

RENEW SUPPORT FOR CHILDREN AND FAMILIES

The FY 2001 HHS budget strengthens the family by helping Americans better balance the demands of work and parenthood. By providing access to safe, affordable child care, increasing child support collections, and getting more resources to families, the Clinton-Gore Administration stands squarely behind working families in America.

CHILD CARE INITIATIVE

Federal funding for child care has more than doubled under this Administration, providing child care services for approximately 1.75 million children from low-income working families in FY 1999. Nevertheless, millions of families who are eligible for assistance with their child care costs do not receive any help; only about 10 percent of the 15 million low-income children potentially eligible for assistance under Federal eligibility criteria received subsidies.

HHS builds on the successes of previous budgets by proposing an increase in the Child Care and Development Block Grant of $817 million, a 70 percent increase in funding that will provide additional child care subsidies for nearly 150,000 new eligible children in FY 2001. This increase raises the Child Care and Development Block Grant to a level of $2 billion in discretionary funds.

These new funds, combined with the child care funds provided in welfare reform, will enable the program to serve over 2.2 million children in FY 2001, an increase of nearly one million since FY 1997. The block grant is part of the Child Care and Development Fund, the primary Federal subsidy program that helps families pay for child care, which enables low-income parents to work. To ensure that children have access to early childhood programs that promote their cognitive development, the HHS budget includes $3 billion over five years for the Early Learning Fund to help improve child care quality and earlier childhood education for children under five years old.

CHILD SUPPORT ENFORCEMENT

The HHS campaign to assure that children receive the financial support they need from both parents is working. In FY 1999, child support collections reached an all time high of $15.5 billion. Our legislative proposals for FY 2001 provide support through better enforcement tools

and program changes that get more money to families. The package of proposals increases collections paid to families by $1.8 billion over the next five years.

One important proposal builds on our foundation of family first distribution and provides states the option to simplify their rules for distributing child support to a system where families that have left welfare will keep all the child support paid by the noncustodial parent, resulting in increased payments to families of $815 million over five years.

Another key proposal to increase funds to families would provide Federal matching funds to states when they pass on child support collections to families on assistance. Payments to these families would increase by $388 million over five years. Our package also includes a proposed series of strong enforcement techniques that save the Federal government $361 million over five years and increase payments to families by over $650 million over five years.

HEAD START

HHS has been committed to building a strong foundation of success for all of America's low-income children. The Head Start program has been a highly successful example of that commitment. Evidence shows that Head Start produces immediate gains for children and families, including better cognitive functioning and academic preparedness, higher self esteem, and improved physical health. Studies demonstrate that the program also provides long-term benefits, such as better high school attendance rates, less frequent retention in grade, and less need for special education.

The HHS budget request includes $6.3 billion for Head Start, an increase of $1 billion in FY 2001. This increase will provide Head Start services to over 70,000 additional children, bringing total enrollment to nearly 950,000 and keeping us on track to meet the President's goal of enrolling one million children by FY 2002.

ASTHMA INITIATIVE FOR LOW-INCOME CHILDREN

HHS proposes $50 million each in FY 2001 and FY 2002 for demonstration grants to states for testing innovative asthma disease management techniques for children enrolled in Medicaid and SCHIP. This would help those children receive the most appropriate care to control their asthma. Participating states will assess the program's success in averting asthma-related crises through measures such as decreased emergency room visits and hospital stays.

GRADUATE MEDICAL EDUCATION FOR CHILDREN'S HOSPITALS

The HHS budget provides a total of $80 million for the Children's Hospitals Graduate Medical Education (GME), raising the level of support for the Nation's freestanding children's hospitals, by making such payments more consistent with other teaching hospitals. These hospitals train over 25 percent of all U.S. general pediatric residents and the majority of the Nation's pediatric specialists.

SUBSTANCE ABUSE

Illicit drug and alcohol use among American youths is continuing at unacceptable rates. While these rates remain unacceptably high, we have seen a series of encouraging reports that seem to indicate a leveling off and even possible decline in drug use among teens after years of dramatic increases. According to the 1998 National Household Survey on Drug Abuse, illicit drug use among youths aged 12-17 decreased from 11.4 percent in 1997 to 9.9 percent in 1998. The 1998 National Household Survey on Drug Abuse estimates that more than 6.5 million or 9.9 percent of Americans aged 12 and older used an illicit drug in the past year and 19 percent of youth aged 12-17 reported use of alcohol in the previous month.

Nationwide, the need for services to treat individuals who use and are addicted to illegal drugs continues to outstrip the available capacity. The Office of National Drug Control Policy (ONDCP) estimates that as many as five million Americans are in need of substance abuse treatment services, while less than half actually receive services. ONDCP estimates the cost to society of illegal drug use to be approximately $110 billion each year.

The FY 2001 budget includes a total of $3.3 billion, a 6.2 percent increase over FY 2000, for substance abuse treatment and prevention services.

GREATER SCIENTIFIC ADVANCEMENT

Tomorrow's scientific advancements depend on today's investment decisions. In FY 2001, the budget continues our commitment to protect public health and promote scientific expertise by investing in biomedical science, food safety, and health care quality research.

SUPPORTING RESEARCH AT THE NATIONAL INSTITUTES OF HEALTH (NIH)

The FY 2001 budget provides $18.8 billion for NIH, an increase of $1.0 billion or 5.6 percent over FY 2000, to continue to generate new scientific knowledge and develop treatments and new prevention strategies for the many diseases and disabilities which affect the Nation's health. To take advantage of the most promising areas of research, NIH has identified a number of areas of scientific emphasis for increase in FY 2001. They include exploiting genomics, reinvigorating clinical research, harnessing the expertise of allied disciplines, and reducing health disparities at home and abroad. NIH will also place renewed emphasis on research to address domestic and international health disparities that may be associated with race, ethnicity, gender, or socioeconomic status and to find vaccines for HIV/AIDS, tuberculosis, and malaria.

USING SCIENCE TO IMPROVE QUALITY AND REDUCE MEDICAL ERRORS

The recently released study by the Institute of Medicine, *To Err Is Human* (1999), estimates that as many as 98,000 Americans may die each year as a result of preventable medical errors.

HHS proposes an increase of $16 million for the Food and Drug Administration (FDA) to reduce medical errors and adverse events. Reducing medical errors requires FDA to improve its ability to evaluate and respond to the over 400,000 adverse event reports it receives each year.

Currently, FDA has in operation an Adverse Event Reporting System (AERS) in each of its program areas. This funding will initiate the development of an integrated, fully electronic adverse event reporting system across the program areas.

The budget also provides $20 million for the Agency for Healthcare Research and Quality (AHRQ) to conduct research directed toward the reduction of medical errors. As the lead Federal agency in health care quality, AHRQ will collaborate with private sector, nonprofit health care organizations, states, and other Federal agencies to develop national safety goals and best practices to eliminate the occurrences of medical errors.

FOOD SAFETY

Every year an estimated 76 million people get sick, 325,000 are hospitalized, and 5,000 die of foodborne illness.

To reduce the incidence of disease, HHS would provide a $40 million increase for the inter-agency food safety initiative. FDA, the Centers for Disease Control and Prevention (CDC), and the Department of Agriculture (USDA) will continue to coordinate efforts to ensure a safer national food supply and with states and industry to develop a

consistent, high quality set of food codes and standards.

Of the increased funds requested, CDC will use $10 million to enhance food safety by further expanding CDC's award-winning PulseNet, the national network of public health labs that perform DNA "fingerprinting" of disease-causing bacteria. FDA is seeking an additional $30 million to inspect 100 percent of high risk food establishments, complete the National Antimicrobial Resistance Monitoring System (NARMS), and cooperate with USDA, industry, and states to reduce Salmonella.

CREATE A HEALTHIER AMERICA

The FY 2001 budget for HHS promotes healthy living and provides health services for more Americans. While strengthening our public health infrastructure, this budget addresses many of our greatest public health challenges including the tracking of emerging infectious diseases and bioterrorist threats. A healthier America also means that we must work to prevent HIV/AIDS and unwanted pregnancies, provide treatment for mental illness, and eliminate health disparities among our racial and ethnic minorities.

HIV/AIDS PREVENTION, TREATMENT, AND RESEARCH

The FY 2001 budget proposes a discretionary increase of $316 million in HHS for efforts that respond to the HIV/AIDS crisis. The $66 million increase in funding at CDC will be used to encourage individuals at risk to avoid behaviors that can result in the transmission of the disease. Of the $66 million increase, $40 million will go to expand local prevention efforts, including interventions targeted at minority populations of which $10 million will go to support community interventions. The remaining $26 million of the increase will support a continuation of the global AIDS expansion begun last year.

Approximately 750,000 Americans are living with HIV and 200-250,000 of them know their status, but are not receiving health care. The Ryan White Program provides essential medical and related support services for individuals and families with HIV and currently supports 2,630 community-based providers of care.

The budget will invest an additional $125 million in the Ryan White Program, an increase of almost 8 percent over last year's funding level, to provide primary medical care and other crucial support services for people living with HIV and AIDS. With this increase, a total of 141,000 persons will receive AIDS drug therapy through the AIDS Drug Assistance Program (ADAP). These drugs have helped to decrease the progression of HIV to AIDS as well as improve the quality of life for people with HIV/AIDS.

The increase of $105 million for NIH continues an investment that has led to many advances against this disease. NIH will focus on the search for a safe and effective vaccine to prevent infection.

FAMILY PLANNING

HHS proposes an additional $35 million over the FY 2000 appropriation to serve 4,600 family planning clinics to provide family planning services to an additional 500,000 women. These efforts will promote responsibility for healthy reproductive lifestyles.

MENTAL HEALTH

The recently released Surgeon General's Report on Mental Health states that "about one in five Americans experiences a mental disorder in the course of a year." And 60 percent of people with lifetime histories of at least one mental illness neither seek nor obtain help for their illness, and only 25 percent of those seeking help will receive care from a mental health specialist.

The Surgeon General's Report concludes that mental disorders and conditions are treatable. Scientific advances have resulted in new knowledge concerning the biology and dynamics of mental illness, and have led to new and effective models of treatment. Building on the recommendations of the Surgeon General's Report, the budget includes funding to help improve the lives of those who face mental illness.

The FY 2001 budget provides a $60 million, a 17 percent increase, for the Mental Health Block Grant, which provides support to states for services to people with mental illness.

The budget request also continues funding of $78 million for projects provided by the Congress in FY 2000 for Youth Violence Prevention activities. This includes $50 million for the Safe Schools/Healthy Students program which supports activities to increase school safety, mental illness prevention and treatment, and school violence prevention and early intervention services.

PREVENTING EMERGING INFECTIOUS DISEASES AND RESONDING TO BIOTERRORISM

As global threats to peace persist, the need to prepare for domestic terrorism in America remains high.

The President's Budget proposes an increase of nearly 50 percent over last year's funding level, to further develop a national disease surveillance system that can rapidly detect the infectious disease cases that signal the beginning of an outbreak. The increased funding, which brings total funding to $64 million, will ensure that disease outbreak information leads to immediate public health action.

HHS is responsible for preparing for, and responding to, the medical and public health consequences of a bioterrorist event. The President proposes for FY 2001 a total of $265 million for HHS. Of this amount, $149 million is in CDC, $30 million is for the Office of Emergency Preparedness, and $30 million is for research, to continue our preparation for possible acts of bioterrorism.

Activities include the development of surveillance and laboratory capacity to competently and professionally respond to a biological attack of the utmost national importance. Also, NIH requests $45 million for bioterrorism research activities and FDA requests $12 million for expeditious development and approval of new or improved vaccines.

ELIMINATING RACIAL DISPARITIES

Despite improvements in the Nation's overall health outcomes, minority groups still disproportionally bear the burden of disease and illness. In the most recent year, minority men accounted for 70 percent of new cases of HIV and among women, 82 percent were minorities. Other identified areas of health disparities include infant mortality, cancer, heart disease, diabetes, and immunizations. The FY 2001 budget includes $35 million for CDC to support community-based research and demonstration projects to reduce health disparities among racial and ethnic minorities.

In FY 2001, HHS also continues its efforts to provide quality care to Native Americans. Native Americans, as a whole, suffer a greater disease burden than other American populations. For example, Indian people have a 204 percent greater chance of dying from accidents and a 249 percent greater chance of dying from diabetes. The $229 million increase for the Indian Health Service (IHS) over FY 2000 provides resources for additional clinical, preventive, and environmental health services, increases contract support payments for those tribes who provide their own health services, and provides for additional maintenance of IHS hospitals and clinics. This investment helps tribes meet their unique health services challenges and reaffirms our dedication to improving the health status of all Americans.

ENVIRONMENTAL HEALTH RESEARCH IN CDC

HHS proposes for environmental health research in CDC an additional $10 million for a total of $28 million in FY 2001, an increase of 56 percent over FY 2000. Funds will go to evaluate the exposure of men, women and children to toxic substances that cause cancer and assist state and local public health officials to ensure the thorough investigation of cancer clusters.

INVESTING IN THE PUBLIC HEALTH INFRASTRUCTURE

To keep the Department at the cutting edge of public health science and research, HHS proposes to make significant investments in its public health infrastructure.

For CDC, the FY 2001 budget includes $127 million, an increase of $70 million, for construction projects at three laboratory sites. CDC laboratories are relied upon worldwide to help control disease outbreaks and prevent illness and injury. Funds will be used for construction of a laboratory that includes facilities dedicated to the most highly infectious and lethal pathogens handled at CDC such as Ebola, hantavirus and Congo-Crimean hemorrhagic fever, as well as for the study of possible bioterrorist agents. The remaining funding will go to completing the Edward R. Roybal infectious disease lab, design and construction of an environmental health lab, and security and infrastructure improvements at CDC.

HHS also proposes $73 million over two years for construction of a new National Neuroscience Research Center on the main NIH campus. For this facility, the budget includes $47 million in FY 2001 and requests advanced appropriations of $26 million for FY 2002. This trans-NIH center, led by the National Institute of Neurological Disorders and Stroke and the National Institute of Mental Health, will bring together in a shared facility basic and clinical neuroscientists from across NIH who are currently fragmented by location and discipline. The resulting improved collaborations in the new center will speed the rate at which fundamental discoveries are translated into effective therapies for neurological and psychiatric disorders. Our budget also includes $20 million for new lab construction at FDA.

RIGOROUSLY EVALUATING OUR PROGRAM PERFORMANCE

Our budget request for FY 2001 presents the annual performance information required by the Government Performance and Results Act (GPRA) of 1993. Notably, this includes the first GPRA performance report of HHS and its components, which compares FY 1999 results to the goals in our FY 1999 performance plan. Although GPRA reporting must mature before its full value will be realized, our performance report for this year shows improvements for critical HHS initiatives of the past few years.

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that retailers in more states have complied with rules prohibiting tobacco sales to youth than we had projected in our FY 1999 performance plan. HCFA achieved its FY 1999 goal for reductions in Medicare payment errors a year early and pursues increasingly rigorous goals for FY 2000 and FY 2001. ACF and its program partners exceeded performance expectations when they moved 1.3 million welfare recipients into new employment.

Information like this demonstrates that GPRA can be a valuable tool to enhance our efforts to improve programs that serve the American people. As our performance measures continue to mature and performance trends emerge, the GPRA data will serve as important program indicators to support the identification of strategies and objectives to continuously improve programs across HHS.

BUILDING ON OUR SUCCESSES

The HHS FY 2001 budget request builds on many past successes in improving the health and well-being of Americans during the Clinton-Gore Administration. It expands health care coverage, access and quality for more Americans. It renews our support for children and families. It strengthens and modernizes Medicare by providing a much needed prescription drug benefit to all Americans over 65. It encourages greater scientific advancement that is so essential for future health advances. And ultimately, our budget creates a healthier America.

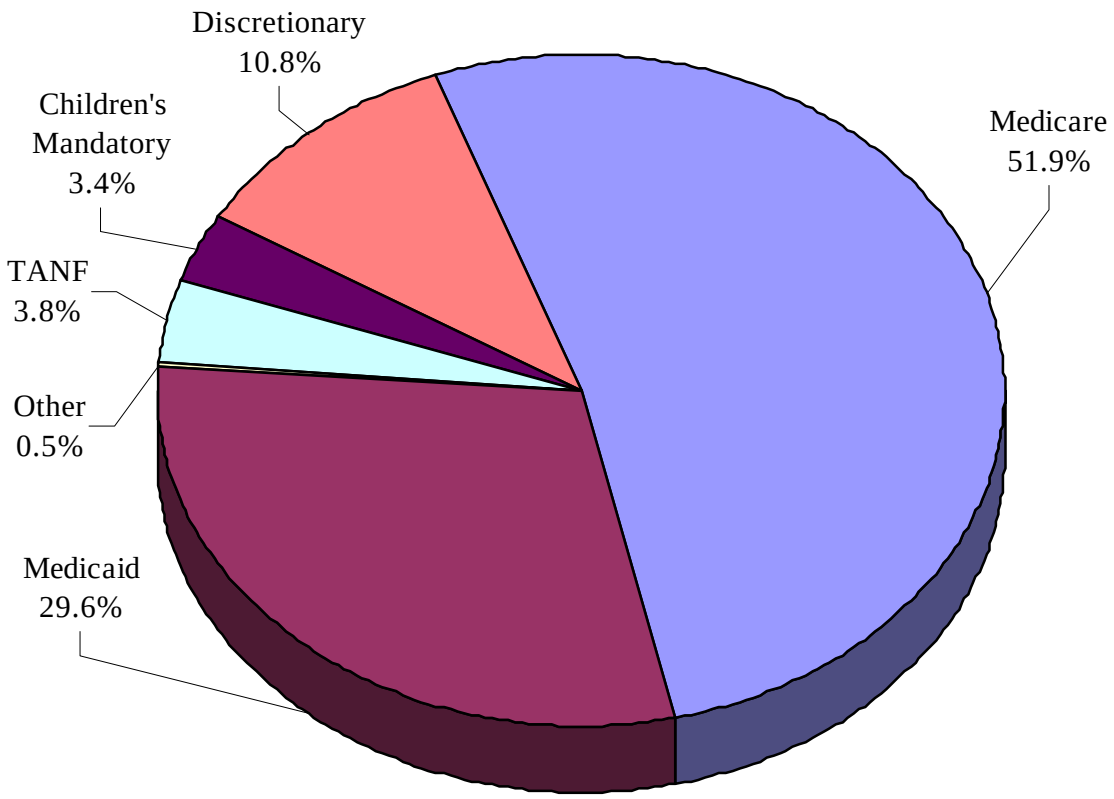
In short, the FY 2001 budget continues our efforts to, in the words of President Clinton, "*embrace all Americans in this time of prosperity and to give every American the chance to succeed at work and at home.*"

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Budget Authority.....	$365,417	$394,820	$427,462	+$32,642
Outlays.....	$359,690	$387,331	$421,387	+$34,056
FTE.....	58,930	61,654	63,157	+1,503

PRESIDENT'S BUDGET FOR HHS
FY 2001



HHS BUDGET BY OPERATING DIVISION

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Food and Drug Administration:				
Program Level	$1,145	$1,228	$1,391	+$163
Budget Authority	981	1,050	1,188	+138
Outlays	952	1,047	1,192	+145
Health Resources and Services Administration:				
Budget Authority	4,351	4,773	4,962	+189
Outlays	3,857	4,550	4,850	+300
Indian Health Service:				
Budget Authority	2,270	2,421	2,650	+229
Outlays	2,193	2,376	2,623	+247
Centers for Disease Control and Prevention:				
Budget Authority	2,642	3,040	3,242	+202
Outlays	2,459	2,763	3,030	+267
National Institutes of Health:				
Budget Authority	15,634	17,840	18,840	+1,000
Outlays	13,795	15,544	17,852	+2,308
Substance Abuse and Mental Health Services:				
Budget Authority	2,487	2,652	2,823	+171
Outlays	2,214	2,451	2,648	+197
Agency for Healthcare Research and Quality:				
Program Level	171	204	250	+46
Budget Authority	100	110	0	-110
Outlays	79	120	92	-28
Health Care Financing Administration:				
Budget Authority	297,147	325,434	349,686	+24,252
Outlays	298,901	319,820	347,607	+27,787

HHS BUDGET BY OPERATING DIVISION, CONTINUED

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Administration for Children and Families /1:				
Budget Authority	38,682	36,360	42,913	+6,553
Outlays	34,493	37,093	40,916	+3,823
Administration on Aging:				
Budget Authority	882	933	1,084	+151
Outlays	879	886	1,020	+134
Departmental Management/Civil Rights /2:				
Budget Authority	751	665	535	-130
Outlays	320	645	516	-129
Office of Inspector General:				
Budget Authority	129	151	164	+13
Outlays	134	143	165	+22
Program Support Center:				
Budget Authority	254	267	272	+5
Outlays	307	270	272	+2
Allowances - Repeal of Delayed Obligations:				
Budget Authority	0	0	0	0
Outlays	0	499	-499	-998
Receipts:				
Budget Authority	-893	-876	-897	-21
Outlays	-893	-876	-897	-21
Total, Health and Human Services:				
Budget Authority	$365,417	$394,820	$427,462	+$32,642
Outlays	$359,690	$387,331	$421,387	+$34,056
Full-Time Equivalents	58,930	61,654	63,157	+1,503

/1 FY 2001 includes $1 billion program increase for Head Start and $1.4 billion advance appropriation for FY 2001 made in the FY 2000 Appropriations bill.

/2 Includes appropriations for the Public Health and Social Services Emergency Fund.

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Mandatory Programs (Outlays):				
Medicare	$188,349	$200,410	$218,760	+$18,350
Medicaid	108,042	116,117	124,838	+8,721
Temporary Assistance for Needy Families	14,161	14,996	15,828	+832
Foster Care & Adoption Assistance	4,707	5,495	6,294	+799
Child Support Enforcement	2,756	3,053	3,091	+38
Child Care	2,254	2,420	2,958	+538
State Children's Health Insurance	565	1,300	2,117	+817
Social Services Block Grant	1,993	1,623	1,998	+375
Other Mandatory Programs	881	988	1,011	+23
Receipts/Financing Offsets	-893	-876	-897	-21
Subtotal, Mandatory (Outlays)	**$322,815**	**$345,526**	**$375,998**	**+$30,472**
Discretionary Programs (BA):				
Food & Drug Administration	$981	$1,050	$1,188	+$138
Health Resources & Services Administration	4,113	4,645	4,788	+143
Indian Health Service	2,240	2,391	2,620	+229
Centers for Disease Control & Prevention	2,639	3,037	3,239	+202
National Institutes of Health	15,607	17,813	18,813	+1,000
Substance Abuse & Mental Health Services	2,487	2,652	2,823	+171
Agency for Healthcare Research & Quality	100	110	0	-110
Health Care Financing Administration	1,945	1,993	1,866	-127
Administration for Children & Families /1	9,015	8,465	11,638	+3,173
Administration on Aging	882	933	1,084	+151
Office of the Secretary	266	282	304	+22
Public Health & Social Services Emergency	514	414	265	-149
Subtotal, Discretionary (BA)	**$40,789**	**$43,785**	**$48,628**	**+$4,843**
Subtotal, Discretionary (Outlays)	**$36,875**	**$41,805**	**$45,389**	**+$3,584**
Total HHS Outlays	**$359,690**	**$387,331**	**$421,387**	**+$34,056**

/1 FY 2001 includes $1 billion program increase for Head Start and $1.4 billion advance appropriation for FY 2001 made in the FY 2000 Appropriations bill.

FOOD AND DRUG ADMINISTRATION

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Program Level.....	$1,145	$1,228	$1,391	+$163
FTE.....	8,910	9,009	9,510	+501

SUMMARY

The FY 2001 budget request for the Food and Drug Administration is $1,391 million in program level, including $203 million in industry-specific user fees. This 13 percent increase over FY 2000 is targeted to Administration initiatives including assuring the safety of FDA regulated products, Food Safety, Bioterrorism, and Youth Tobacco Prevention.

FDA is a principle consumer protection agency of the Federal government. FDA's mission is to protect the public health through prevention of injury or illness due to unsafe or ineffective products. FDA actively identifies health problems associated with FDA-regulated products and assesses the origin and impact of these health problems. FDA makes every effort to prevent problems that would expose the public to hazards and monitors the marketplace to ensure compliance with the laws and regulations.

ASSURING SAFETY: TODAY AND TOMORROW

Assuring the safety of the food and medical products Americans use today requires FDA to carry out a continuum of activities. First, FDA communicates extensively with industry prior to the submission of new products for review to facilitate a greater understanding of FDA requirements and reduce product development times. Second, FDA must review new products to ensure they are safe and effective. Doing this accurately and quickly requires FDA to maintain a high level of scientific expertise. Third, FDA must have state-of-the-art tracking systems to detect and respond to medical errors or adverse events related to products in the market place that manufacturers did not detect in clinical testing. Finally, FDA must continually monitor the quality assurance processes in production facilities to ensure that food is wholesome, and the medical products Americans use are well-made. FDA must ensure it has both the scientific facilities and the expertise to make prompt and sound judgements on the myriad of advances that are expected from our Nation's investment in biomedical research.

FDA's request for assuring safety includes improvements in premarket review ($42 million), increased postmarket surveillance efforts ($45 million). The postmarket surveillance request includes two new initiatives, Internet Drug Sales and Medical Errors.

BRINGING NEW PRODUCTS TO MARKET

There are two components to FDA's strategy for premarket review. First, FDA is committed to ensuring new products are safe, effective and available in a timely fashion to the American public. Second, FDA must expand its scientific expertise to ensure it has the ability to address the increasing number of new and complex products that result from our Nation's major investment in biomedical research. FDA's budget includes $42 million to improve the quality and timeliness of premarket review today and in the future through a combination of efficient reviews to foster innovation and increased technical expertise, while maintaining FDA's high standards.

Part of the $42 million in FDA's budget request is directed to improving premarket review of the products submitted to FDA. FDA's request will narrow the gaps between statutory performance requirements and what FDA can accomplish – providing for rapid and efficient review of drugs and devices. FDA also seeks to accelerate the process of generic drug review that could significantly decrease the cost of medical care to the American public.

For the last several years FDA has directed its efforts to improving timeliness, while maintaining the quality of product reviews. The FY 2001 budget begins the process of preparing FDA for a new age of rapid biomedical and pharmaceutical innovation. In the next several years FDA expects substantially more complex and numerous applications for innovative health products to be submitted for pre-market review. In order to assure that products are truly safe and effective, FDA must have access to the same scientific expertise as those who's innovations FDA is evaluating. FDA has invested funds in FY 2001 to begin developing the expanded scientific expertise that it will need to meet these increasing demands.

ASSURING THE SAFETY OF PRODUCTS ON THE MARKET

FDA's increase of $45 million for postmarket safety assurance includes two new Presidential Initiatives: ensuring the safety of Internet drug sales ($10 million) and reducing medical errors and adverse events. ($16 million). These activities address new and emerging issues for American public health.

FDA's budget also includes an increase of $19 million to increase FDA's capacity to meet public and statutory expectations for inspections of production facilities and samples of domestic and imported products. FDA currently inspects about 50 percent of biologics facilities, 39 percent device facilities, 27 percent of animal drugs and feeds facilities, and 22 percent of drugs facilities.

INTERNET DRUG SALES

The number of people who use the Internet for the purchase of medical products is growing rapidly, and many consumers, including those in rural areas or those who cannot leave their homes, benefit from the convenience of this new option. However, unsuspecting consumers may fall prey to fly-by-night Internet pharmacies that sell products illegally. The budget includes a $10 million initiative to protect consumers from illegitimate Internet pharmacies that inappropriately prescribe medications, increase the risk of dangerous drug interactions, or sell potentially counterfeited or contaminated drugs. The Administration also seeks legislative authority to enhance FDA's ability to protect Internet consumers separate from this $10 million.

Under the President's initiative, FDA will carry out a public education campaign on safe ways to purchase pharmaceuticals over the Internet. FDA will enable customers to identify legitimate Internet pharmacy sites that operate consistently with State and Federal law. There would also be new civil

penalties for illegal Internet sale of drugs without a valid prescription, and procedures for rapid FDA investigation of potentially illegal sales. FDA would use part of the budget increase to develop a rapid response team and upgrade FDA's computer technology to identify, investigate, and prosecute illegitimate Internet pharmacies. FDA seeks to at least cut in half the current number of illicit domestic sites, and begin work on sales by foreign Internet sites.

REDUCING MEDICAL ERRORS AND ADVERSE EVENT S

The Institute of Medicine's recent report, *To Err Is Human* (1999) estimates that up to 98,000 Americans may die each year as a result of preventable medical errors. FDA's budget includes an increase of $13 million to reduce these medical errors, and an additional $3 million to reduce other adverse events.

Reducing medical errors requires FDA to improve its ability to evaluate and respond to the over 300,000 adverse event reports it receives each year. Currently, FDA has operational an Adverse Event Reporting System (AERS) in each program area. These include, MedSun in Devices, an animal drug system for Animal Drugs and Feeds, and a dietary supplements system for Foods. This funding will initiate the development of an integrated, fully electronic adverse event reporting system within each program area.

Electronic monitoring and surveillance of these adverse event reports will improve FDA's ability to detect patterns in these reports and follow-up rapidly to protect the American public from further errors and adverse events. FDA will also expand its partnerships and collaboration with medical and patient safety organizations, state and local health agencies, and industry organizations.

FOOD SAFETY INITIATIVE

While our Nation has one of the world's safest food supplies in the world, much work remains to be done. Every year an estimated 76,000,000 people get sick, 325,000 are hospitalized, and 5,000 die from foodborne illness. FDA is requesting nearly $109 million, a $30 million increase over FY 2000, to fund advances through the President's Food Safety Initiative.

A number of factors contribute to our need for increased vigilance. Consumer diets are more varied. As a result of advances in food preparation, storage, and transportation, consumers have access to a wider variety of products, both fresh and packaged. A much larger percentage of meals are prepared and consumed outside the home. There has been an increase in vulnerable populations. The increasing proportion of groups such as pregnant women, children, the elderly, and the immuno-compromise have necessitated greater attention toward prevention in these high-risk groups. Finally, with the emergence of new, more lethal pathogens, new preventative strategies are required.

All high-risk facilities will be inspected at least once per year, with follow up inspections where quality assurance processes need improvement.

❑ *INSPECTIONS: COVER 100 PERCENT OF HIGH RISK FOOD ESTABLISHMENTS*

Inspections. The budget continues to expand the resources available to FDA to inspect food processing facilities. All high-risk facilities will be inspected at least once per year, with follow up inspections where quality assurance processes need improvement.

- ***EGG SAFETY: COOPERATIVE WORK WITH USDA, INDUSTRY, AND STATES TO REDUCE SALMONELLA***

Egg safety. The budget includes an increase of $5 million for a new initiative to improve egg safety. Americans consume an average of 234 eggs per person per year. An estimated 1 in 20,000 eggs in the U.S. food supply will contain *Salmonella Enteritidis* (SE) bacteria, which can cause illness if not cooked thoroughly or eaten raw. Generally, SE illness has declined 44 percent between 1994 and 1998, primarily in the Northeast where egg quality assurance efforts have been most intensive. FDA, in cooperation with USDA, seeks to further reduce SE illness by 50 percent by 2005.

- ***SURVEILLANCE: COMPLETE THE NATIONAL ANTIMICROBIAL RESISTANCE MONITORING SYSTEM (NARMS)***

FDA's request provides for the completion of the Nation Antimicrobial Resistance Monitoring System (NARMS). The NARMS system is used to detect and respond to outbreaks of foodborne illness by identifying emerging resistance among foodborne pathogens. Working with CDC, FDA will add national and international data collection sites and monitor additional pathogens. This will provide information essential in regulating the use of antibiotics in food animals.

YOUTH TOBACCO PREVENTION

FDA is requesting $39 million, an increase of $5 million, for the Tobacco Program. The Program seeks to promote and protect the health of our nation's youth by reducing the number of young people who begin to use and become addicted to tobacco products each year. In FY 1999, FDA entered into contracts to conduct compliance checks in all 50 States and 3 Territories -- the District of Columbia, the Virgin Islands, and American Samoa. As a result, in the first quarter of FY 2000, compliance checks will be conducted in every state for the first time since FDA began enforcing the rule to prevent purchase of tobacco products by underage users. Of the $5 million requested increase, FDA intends to allocate $3 million to increase enforcement efforts and $2 million to increase compliance-based outreach efforts.

IMPROVING FDA'S INFRASTRUCTURE

Evaluating state-of-the-art medical and food products requires comparable scientific facilities. FDA's budget includes $43 million over two years (including $20 million in FY 2001) to replace FDA's dilapidated Los Angeles regional laboratory facility. The Los Angeles laboratory performs 23 percent of FDA's foods analyses each year.

FDA's budget also includes an increase of $5 million in one-time costs to move the Center for Food Safety and Applied Nutrition into a new facility at the University of Maryland in College Park. The General Services Administration will complete this facility late in FY 2001. The increase will cover costs associated with telecommunications equipment, moving, and decommissioning of their current facility.

FDA's scientific facility needs are also addressed in the General Services Administration FY 2001 budget. Included is $101 million for FDA's headquarters consolidation at White Oak, Maryland. Together with the $35 million included in GSA's FY 2000 appropriation, GSA will be able to construct consolidated laboratory and office space for the Center for Drug Evaluation and Research (CDER).

FDA's budget also includes an increase of $5 million in rent, reflecting among other things the new regional laboratory in New York.

BIOTERRORISM INITIATIVE

The FY 2001 budget includes $11.5 million for FDA to carry out its unique role in countering the threat of bioterrorism. FDA is responsible for ensuring the safety and efficacy of drug and biological products which will be used to treat and prevent the toxicity of chemical and biological agents. The National Institutes of Health, the Center for Disease Control, the Department of Defense, as well as some in the private sector are working on new vaccines and drugs to reduce these threats. However, FDA cannot review these upcoming drugs and vaccines using conventional methods, which are designed for diseases to which Americans are normally exposed. As a result, FDA must develop new procedures to evaluate the efficacy of these products, and build the capacity to do so timely. Expeditious development and licensing of these new vaccines and drugs is vital to protecting the health of the Nation.

USER FEES

The FY 2001 budget request for FDA includes $203 million in user fees. Of this amount, $19.5 million are proposed, additive user fees. This includes $8.4 million for food additive petitions, $5.8 million for medical devices, and $5.3 million for food export certifications. The fees for food additives will enable FDA to greatly reduce review times for new products. The medical device fees, to be collected on 501K petitions, will be used in part to help offset the cost of third party reviews. The budget also calls for food exporters to cover FDA costs for certifications; drug and device exporters already cover such costs.

The budget includes $149 million in the Prescription Drug User Fee Act (PDUFA) fees, an increase of $4 million. PDUFA authorizes the collection of user fees for reviewing drug applications and was reauthorized as part of the FDA Modernization Act of 1997.

CONSOLIDATING SEAFOOD INSPECTIONS

FDA is responsible for ensuring the safety of seafood Americans consume. The Commerce Department's Seafood Inspection Program provides voluntary inspections and certification services for fish and fishery products on a fee-for-service basis under the authority of the Agricultural Marketing Act of 1946.

The Administration has proposed legislation to make the voluntary inspection program a performance-based organization (PBO) within FDA to provide greater managerial flexibility to respond to industry requests and needs. Establishing this PBO within FDA will enable companies who use their services to work with a single set of inspectors; now, they are inspected by both Commerce and FDA.

FDA OVERVIEW

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Salaries and Expenses:				
Foods	$235	$267	$316	+$49
Seafood Inspection (Transfer)	13	13	13	0
Drugs	288	309	330	+21
Biologics	125	133	153	+21
Animal Drugs and Feeds	43	49	63	+14
Medical Devices	160	169	192	+24
National Center for Toxicological Research	32	34	38	+4
Tobacco	34	34	39	+5
Other Activities	84	78	78	0
Other Rent & Rent Related Activities	26	26	26	0
Subtotal, Salaries and Expenses	**$1,041**	**$1,112**	**$1,248**	**+$137**
GSA Rental Payments	$88	$100	$105	+$5
Buildings and Facilities	11	11	31	+20
Certification Fund	4	4	4	0
Export Certification	1	1	2	+1
Bioterrorism (non-add)	*0*	*8*	*12*	*+4*
Total, Program Level	**$1,145**	**$1,228**	**$1,391**	**+$163**
Less User Fees:				
Current Law:				
Prescription Drug User Fee Act (PDUFA)	$132	$145	$149	+$4
Mammography Quality Standards Act (MQSA)	14	15	15	0
Certification Fund	4	4	4	0
Export Certification	1	1	2	+1
Seafood Inspection--Transfer	13	13	13	0
Proposed Law:				
Foods	0	0	14	+14
Medical Devices	0	0	6	+6
Subtotal, User Fees	**$164**	**$178**	**$203**	**+$25**
Total, Budget Authority	**$981**	**$1,050**	**$1,188**	**+$138**
FTE	8,910	9,009	9,510	+501

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Program Level.....	$4,180	$4,714	$4,859	+$145
FTE.....	2,014	2,152	2,089	-63

SUMMARY

The FY 2001 budget request for the Health Resources and Services Administration is $4.9 billion, a net increase of $145 million over FY 2000. HRSA is the lead agency which has responsibility for ensuring access to health care through a wide range of programs for those who are uninsured, live in medically underserved areas, or have special health care needs such as people living with HIV/AIDs.

PROVIDING ACCESS TO HEALTH CARE FOR THE UNINSURED

Currently there are over 44 million individuals without health insurance in America (24.6 million of these are working people). This number is increasing at a rate of 100,000 per month. A study found that 1 in 4 women without insurance coverage had forgone treatment needed compared to 1 in 17 for those insured. Lack of adequate health care poses as great a risk to the public health as smoking, alcoholism, and obesity.

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The FY 2001 request moves forward on a variety of activities to better ensure access to quality health care. These efforts include strengthening the infrastructure of the health care safety-net and expanding the capacity of community health centers to serve the uninsured. Of the funds requested for FY 2001, HRSA will direct a total of $1.2 billion to these efforts.

HEALTH CARE ACCESS FOR THE UNINSURED

Many of the uninsured rely on safety net providers—hospitals, clinics and other providers who offer a significant volume of health care services for free or for reduced fees—for their health care. Individuals receiving safety net services and the providers themselves face many challenges such as uneven distribution of uninsured individuals, fragmentation of services, insufficient numbers of specific types of providers, rapid growth of managed care, and a growing need for mental health and substance abuse services.

To address these challenges, the budget provides $125 million, a $100 million increase, for the second year of the new Health Care Access for the Uninsured program. Projects will focus on the need for communities to become more efficient, effective providers of care, able to compete in today's health care environment, and to meet the underlying need for services - primary care, mental heath and substance abuse - at the community level. The request

will support the continuation of 10 to 20 grants begun in 2000 and support an additional 40 to 60 communities in 2001. Grants will support development or enhancement of networks to provide more comprehensive care to low income uninsured individuals; assistance with the establishment of financial systems, patient tracking and other computer systems, and telecommunication systems necessary to manage patient needs; and financing to address service gaps identified at the local level.

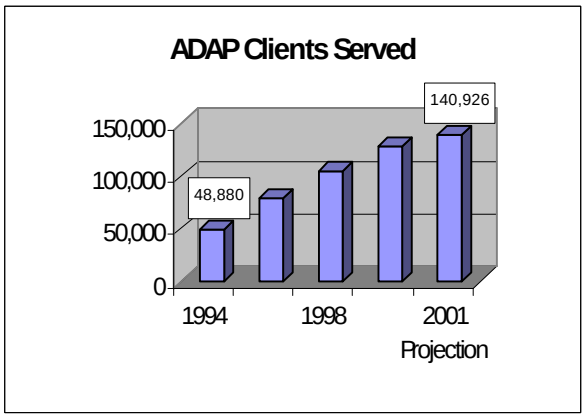
COMMUNITY HEALTH CENTERS

The Community Health Centers provide high quality, community based, culturally competent care to approximately 9 million patients in rural and inner city areas. The care provided by health centers has been proven to reduce hospitalizations and emergency room use, reduce annual Medicaid costs, and help prevent more expensive chronic disease and disability. Medicaid patients served by Health Centers are 22 percent less likely to be hospitalized than Medicaid beneficiaries who obtain care elsewhere.

For FY 2001, the HRSA request for health centers is $1.1 billion, a $50 million increase over the FY 2000 appropriation. These funds will increase the number of health center patients by 100,000 and sites by 22 for a total of 3,205 sites. In addition, funds will support health center users whose insurance status has changed. The number of uninsured served by health centers has increased by nearly 60 percent since 1990. These changes are the result of market pressures including the loss of Medicaid eligibility and the loss of private coverage.

RYAN WHITE

Approximately 750,000 Americans are living with HIV, of these 200,000-250,000 know their status and are not in care. Through the Ryan White Care Act, the third largest public program of HIV/AIDS services in the U.S., essential medical and related support services for individuals and families with HIV will be expanded. This infrastructure currently supports 2,630 community-based providers of care. The budget request for Ryan White includes $1.7 billion, an increase of $125 million for all Ryan White activities. In addition, this increase will allow an additional 2,900 persons to receive AIDS drug therapy through the AIDS Drug Assistance Program (ADAP). These drugs have helped to decrease the progression of HIV to AIDS as well as improve the quality of life for people with HIV/AIDS. The number of clients served through ADAP has increased 114 percent from 1994-1998.



In FY 2001 the Ryan White authorization expires and the program will focus on identifying new methods of bringing and providing medical services and therapies to individuals with HIV disease who are not in the care system; providing quality services through the establishment of accountable service networks; and increasing the service capacity of underserved communities. This is particularly important to minorities. In the most recent year minority men account for 70 percent of new cases and among women 82 percent were minorities.

PERSONS WITH SPECIAL NEEDS

HRSA programs support systems of care for populations who have special health care needs including programs for mothers and children, organ transplantation, and the Ricky Ray Hemophilia Relief Fund.

MATERNAL AND CHILD HEALTH

The budget request includes $869 million to improve the health of mothers and children. Of this total, $799 million is for the Maternal and Child Health (MCH) Block Grant. This level includes a new set-aside of $90 million as HRSA proposes to incorporate the Healthy Start initiative and its activities -- improving perinatal health and decreasing factors which contribute to infant mortality -- into the Maternal and Child Health Block Grant. By merging these two programs, the intent is to more fully disseminate the lessons learned from the demonstration program into the current State MCH programs. Currently, over 24 million mothers and children are served through the block grant.

The FY 2001 request also includes $3 million to continue the second year of the Universal Newborn Hearing Screening program and $1.5 million for the second year of funding to improve access to quality poison control services. A total of $15 million is included for Emergency Medical Services for Children. Each of these programs places emphasis on reaching out to address critical problems faced by children and families.

The request also includes the $50 million annual mandatory appropriation for abstinence education. This program provides grants to 59 States and territories to provide mentoring, counseling, and adult supervision to promote abstinence with a focus on groups most likely to bear children out of wedlock.

ORGAN TRANSPLANTATION

Over 5,000 people die each year waiting for organ transplants and more than 66,000 people are currently waiting for an organ transplant. The request of $15 million, an increase of $5 million, would broaden support for the National Organ and Tissue Donation Initiative and expand activities to increase organ donation. Much of the focus in the coming year will be on replicating projects which have been proven successful and increasing the number of grantees. Ongoing projects include efforts to use the Internet for notifying families of an individual's desire to donate; increasing minority donations; testing donor education strategies in the workplace, at end of life planning sessions, and with driver's license renewals; and finally improving the ability of health professionals to handle end-of-life discussions and care. For the first time in recent years, the number of donors from 1997 to 1998 increased by 6 percent.

RICKY RAY HEMOPHILIA RELIEF FUND

The request also includes $100 million to fund the second year of the Ricky Ray Hemophilia program and will provide compensation to 950 persons or families of persons with hemophilia who have HIV/AIDS as a result of blood transfusions. A special trust fund has been established. HRSA is currently putting in place the administrative apparatus to review claims for compensation – focusing on medical and legal reviews.

FAMILY PLANNING

For many of the 4.5 million individuals, primarily women, who use family planning clinics, these clinics are the sole point of contact with the health care system. These clinics provide access to such reproductive health care and preventative services as counseling, routine gynecological care, hypertension screening, screening and referrals for breast and cervical cancer and

substance abuse. The FY 2001 request for the Title X Family Planning program is $274 million, $35 million over the FY 2000 appropriation.

This proposed spending increase in FY 2001 will allow the Title X program to provide family planning services to an additional 500,000 women. This increase will also allow the Title X program to increase HIV/AIDS prevention activities. As of 1998, women account for 24 percent of all new AIDS cases, up from 7 percent in 1985. In addition, Title X will expand its efforts to reach hard-to-reach populations such as males, substance abusers, and homeless; promote effective partnerships with community-based organizations, and develop culturally and linguistically appropriate information education and communication activities.

HEALTH PROFESSIONS

The FY 2001 budget includes $80 million for the Children's Hospitals Graduate Medical Education (GME), doubling the funding available in FY 2000. These funds will raise the level of GME support for approximately 60 freestanding Children's Hospitals to be more consistent with other teaching hospitals. These hospitals train over 25 percent of all U.S. general pediatric residents and the majority of pediatric specialists.

The FY 2001 request for the remaining health professions programs will work to ensure a diverse workforce that is adequately distributed. The request is $218 million, an $84 million reduction. Within this overall funding level HRSA will focus resources on programs which will help disadvantaged students and reflects the Administration's goal to move away from broad-based categorical programs. Within this level there is a $10 million total increase for the Centers of Excellence and the Health Careers Opportunity programs, both of which have success in increasing diversity by recruiting and retaining promising racial and ethnic minority students in health professions training. Reductions will be taken in broad-based categorical programs that address expanding the supply of primary care and specialty disciplines.

RURAL HEALTH/TELEHEALTH

The budget includes $75 million for rural health and telehealth activities, $18 million below the FY 2000 level. This level includes $6.8 million to support a government-wide Mississippi Delta initiative to support 219 counties recognized by the Congressional creation of the Lower Mississippi Delta Development Commission in 1988. This initiative will enhance health care in a region where the poverty rate is 175 percent of the national average and the per-capita income is 38 percent below the national average.

OTHER HRSA PROGRAMS

The budget proposes $294 million for all remaining HRSA programs including the National Health Service Corp, Bone Marrow, Hansen's Disease, Black Lung, Nursing Loan Repayment, and program management. Funds are not requested for one-time health facility construction and renovation projects for which $112 million was appropriated in FY 2000. In addition, funds are not requested for the one-time Comprehensive Care for the Uninsured State demonstrations begun in FY 2000.

HRSA OVERVIEW

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Health Care Access for the Uninsured	0	$25	$125	+$100
Community Health Centers	925	1,019	1,069	+50
Ryan White Programs:				
Emergency Relief- Title I	505	547	587	+40
Comprehensive Care- Title II	738	824	864	+40
AIDS Drug Assistance Program (Non-add)	461	528	554	+26
Early Intervention- Title III	94	138	171	+33
Pediatric HIV/AIDS- Title IV	46	51	60	+9
Education and Training Centers	20	27	29	+2
Dental Services	8	8	9	+1
Subtotal, Ryan White	**$1,411**	**$1,595**	**$1,720**	**+$125**
MCH Block Grant	805	799	799	0
Universal Newborn Hearing Screening	0	3	3	0
EMS for Children, Poison Control	15	20	17	-3
Organ Transplantation	10	10	15	+5
Ricky Ray Hemophilia Relief Fund		75	100	+25
Family Planning	215	239	274	+35
Health Professions Programs:				
Children's Hospitals GME	0	40	80	+40
Training for Diversity	93	93	103	+10
Other Health Professions	209	209	115	-94
Subtotal, HP	**$302**	**$342**	**$298**	**-$44**
Rural Health/Telehealth	75	94	75	-19
Hansen's Disease Services Programs	24	22	19	-3
Bone Marrow/Black Lung/Facilities/Nurse Loan	26	26	26	0
National Health Service Corp	115	117	117	0
Comprehensive Care for the Uninsured	0	15	0	-15
National Practitioner Databank	16	16	17	+1
Health Integ. & Prot. Databank	1	3	4	+1
Health Care Facilities	65	112	0	-112
Program Management	125	132	131	-1
Abstinence Education	50	50	50	0
Total, HRSA Program Level	**$4,180**	**$4,714**	**$4,859**	**+$145**
Less Funds Allocated From Other Sources:				
Mandatory, Abstinence Education	-50	-50	-50	0
Health Integ. & Prot. Databank	-1	-3	-4	-1
National Practitioner Databank User Fees	-16	-16	-17	-1
Total, Discretionary BA	**$4,113**	**$4,645**	**$4,788**	**+$143**
FTE	2,014	2,152	2,089	-63

INDIAN HEALTH SERVICE

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Program Level.....	$2,669	$2,831	$3,060	+$229
FTE.....	14,586	14,673	14,823	+150

SUMMARY

The Indian Health Service's FY 2001 budget request is $3.1 billion, an increase of $229 million over FY 2000. The budget is composed of $2.6 billion in new budget authority and $440 million in reimbursements. This ten percent increase in budget authority–the largest requested increase in over two decades–reflects the impact of the Department's tribal budget consultations and a continuing Federal Government commitment to provide for the health of members of Federally recognized Tribes. Reimbursements include an estimated $405 million in Medicare, Medicaid and private health insurance collections for the treatment of Indian people.

AGENCY DESCRIPTION

IHS provides health care to 1.5 million American Indians and Alaska Natives who are members of some 560 Federally recognized Tribes. Medical and dental care is provided directly through a network of 49 hospitals, 209 health centers and 285 health stations, satellite clinics, school health centers and Alaska village clinics. These facilities are located primarily in Oklahoma, the Northern Plains, Alaska, the Southwest and along the Pacific Coast. Care provided in IHS facilities is supplemented with care purchased from private sector hospitals and health professionals. IHS also provides preventive health services, through public health nurses and community health representatives, mental health services, alcohol/substance abuse prevention/treatment and provides water, waste water and solid waste disposal systems for Indian communities. In many areas, health services are provided by local Tribes under contract with IHS. In FY 2001 approximately 44 percent of IHS's budget will be tribally controlled. Funding is also provided to urban health grantees operating in 41 cities with large concentrations of Indian people.

CLINICAL, PREVENTIVE, AND ENVIRONMENTAL HEALTH

The FY 2001 budget includes $2.4 billion for clinical preventive and environmental health activities, an increase of $160 million, or seven percent. The additional funds will be used primarily to address a growing population of Indian eligibles, responding to specific diseases/health conditions identified through Tribal consultation, and cover pay and other operating costs.

POPULATION INCREASES

The budget contains an additional $53 million to maintain access to health care as the Indian population increases. Since 1990, the population eligible for services has increased by 27 percent. Within this total, $41 million will be directed to the Contract Health Services program which purchases care from the private sector. Per capita

funding for this program has not kept pace with medical inflation over the past several years. As a result, IHS has limited payment to only the most serious types of injuries and illnesses and restricted specialty care for Indian people suffering from chronic disease. With these additional funds, IHS will be able to purchase such services as chemotherapy, coronary bypass surgery and retinopathy to prevent blindness as a result of diabetes. The additional funds will also allow IHS to provide 1,460 additional hospital days and 57,200 additional visits to doctors and dentists. Included in this request is $12 million to staff the health center at Polacca, AZ–Hopi Tribe, and the hospital at Talihina, OK–Choctaw Tribe. These two facilities will open in FY 2000 and additional funds will pay for the cost of new staff.

REDUCING HEALTH DISPARITIES

While IHS has achieved dramatic improvements in Indian health status over the long run, overall mortality rates for Indian people continue to exceed those of the general population. For example, Indian people have a 249 percent greater chance of dying from diabetes and a 204 percent greater chance of dying from accidents. The budget includes an increase of $35 million to provide additional services in several key areas which have been selected through consultation between IHS and tribal representatives. These areas include: diabetes, cancer, heart and infectious disease ($7 million); domestic community violence prevention, elder and maternal & child health ($7 million); emergency medical services and injury prevention ($6 million); mental health and alcohol/substance abuse prevention/treatment ($6 million) and dental health ($3 million). An additional $6 million in preventive health activities is requested in support of these initiatives. These funds will improve a number of health outcomes, for example: continuing to increase the percentage of diabetics with good glycemic control–up three percentage points from FY 1998 to FY 1999; increasing water fluoridation compliance in the Southwest–by 26 percent since FY 1999; substantially increasing–by 70 percent since FY 1998–the number of Emergency departments which identify and treat victims of family violence or neglect.

INCREASING EQUITY AMONG TRIBES

A high priority of the IHS is to provide comparable levels of health services to Tribes across Indian country. About 60 percent of IHS's budget is used to operate hospitals and outpatient clinics in existing locations making maintenance of equity over time difficult. As requested in the FY 2000 budget, Congress addressed this situation by providing $10 million to those Tribes with the lowest health service levels. An IHS Tribal workgroup is developing a methodology for determining which Tribes should receive funding in FY 2000. For FY 2001, the budget includes a further increase of $8 million for those Tribes with the lowest health service levels.

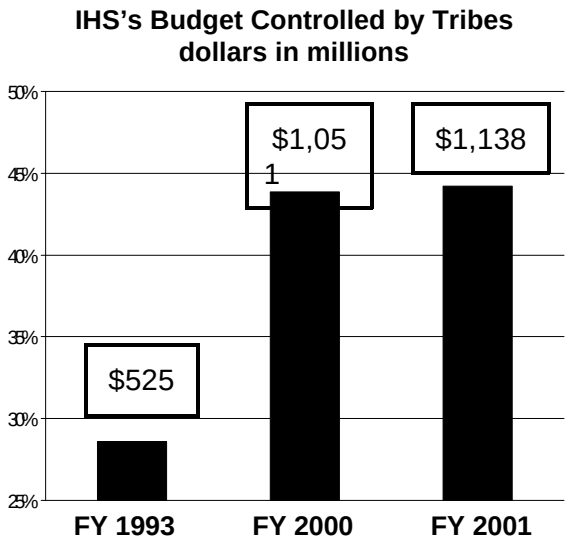
OPERATING EXPENSES/INFORMATION TECHNOLOGY

The budget also includes an increase of $64 million for increased pay costs, additional information technology (including telecommunications equipment) and to increase the amount of epidemiological data comparing Tribes in different Areas/Regions of the United States.

TRIBAL CONTRACT SUPPORT COSTS

The budget includes $269 million for Contract Support Costs, an increase of $40 million or 18 percent over FY 2000. Contract Support Costs are additional costs which Tribes incur when they take over the operation of local health programs from the IHS. Tribes and tribal organizations currently operate 13 hospitals and 385 of the other health facilities through contracts with IHS authorized by the Indian

Self-Determination Act. In FY 2001 these contractors will receive approximately 44 percent of IHS's total budget to provide health services to their members.



Due primarily to rapid growth in the number of Tribes wishing to contract, tribal requests for Contract Support Costs exceeded the amount provided by $70 million by the end of FY 1998. Since that time, the Department, Tribes, and the Congress have worked diligently to resolve this situation. Congress provided a total increase of $60 million for Contract Support Costs in FY 1999 and FY 2000 to address the needs of both existing and new contracts.

The additional +$40 million increase requested in FY 2001 will first be used to fund new contracts. IHS estimates that $12.5 million will be needed for new contracts, but, since contracting is a tribal option, the amount actually needed could be much higher. To the extent the $40 million is not needed for new contracts it will be used to increase Contract Support Costs funding for existing contracts.

FACILITY AND SANITATION CONSTRUCTION

The budget includes a total of $162 million for sanitation and health care facility construction, an increase of $20 million, or 14 percent over FY 2000. Within the request, IHS will devote $65 million to health facility construction. These funds are for the replacement of the Fort Defiance Hospital and to design its staff quarters (Navajo Tribe), to continue construction of the new Winnebago Hospital (Winnebago and Omaha Tribes) and to complete the Parker Health Center (Colorado River Tribes).

In addition to replacement of large facilities, $2.5 million is requested for a new grant program to help Tribes construct small outpatient facilities. IHS also proposes a total of $2 million to design the replacement Pawnee Health Center and $1 million for modular dental units in various locations.

The budget includes a total of $97 million, or a $5 million increase, to build sanitation systems which provide water, wastewater, and solid waste disposal systems for Indian homes and communities. The additional funds will allow IHS to serve 60 new or like new homes and 420 existing homes.

OTHER IHS PROGRAMS

The budget includes $31 million, an increase of $3 million, for the Urban Health program, or 11 percent over FY 2000. Funds will be used to reduce health disparities for Indian people living in urban areas. An additional $6 million is requested to bring more health professionals into the Agency and for additional increased pay costs.

INDIAN HEALTH SERVICE

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Indian Health Service:				
Clinical Services	$1,934	$2,039	$2,174	$135
Contract Health Services (nod add)	*386*	*407*	*448*	*+41*
Preventive Health	87	92	103	+11
Contract Support Costs	204	229	269	+40
Urban Health	26	28	31	+3
Health Professions/Direct Operations	91	93	99	+6
Diabetes Grants /1	30	30	30	0
Subtotal, Health Services Program Level	**$2,372**	**$2,511**	**$2,706**	**$195**
Indian Health Facilities:				
Environmental Health	$108	$116	$130	+14
Facility Construction	41	50	65	+15
Sanitation Construction	89	92	97	+5
Maintenance & Improvement / Medical Equipme	59	62	62	0
Subtotal, Health Facilities Program Level	**$297**	**$320**	**$354**	**+$34**
Total, Program Level	**$2,669**	**$2,831**	**$3,060**	**+$229**
Less Funds Allocated From Other Sources:				
Insurance Collections	-394	-405	-405	0
Quarters	-5	-5	-5	0
Diabetes	-30	-30	-30	0
Total, Budget Authority	**$2,240**	**$2,391**	**$2,620**	**+$229**
FTE	14,586	14,673	14,823	+150

/1 These mandatory funds are appropriated in the Balanced Budget Act of 1997.

CENTERS FOR DISEASE CONTROL AND PREVENTION

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Program Level.....	$2,912	$3,339	$3,534	+$195
FTE.....	7,491	7,923	8,061	+138

SUMMARY

The FY 2001 budget requests a total of $3.5 billion for the Centers for Disease Control and Prevention (CDC), an increase of $201 million, or six percent, over FY 2000. The FY 2001 budget for CDC includes $149 million in funds provided through the Public Health and Social Services Emergency Fund (PHSSEF) for activities related to bioterrorism.

CDC is the lead public health agency for promoting health and quality of life by preventing and controlling disease, injury and disability. CDC works with States, local public health agencies, and partners throughout the Nation and the world to accomplish this mission. Together, they monitor health, detect and investigate disease outbreaks and other health problems, conduct research, develop and advocate sound health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthy environments, and provide public health leadership and training.

MODERN, SECURE LABORATORIES

The laboratories at CDC are relied upon worldwide to help control disease outbreaks and prevent illness and injury. For example, CDC labs house one of the two official reference samples of smallpox.

To carry out its mission, CDC needs modern, secure laboratory facilities. Much of CDC's lab space is overcrowded and outdated.

The FY 2001 budget includes $127 million, an increase of $70 million, for design and construction projects at three laboratory sites. First, CDC will use $86 million of these funds to begin construction of a laboratory that includes facilities dedicated to the most highly infectious and lethal pathogens handled at CDC. This new building will include a Biosafety Level 4 laboratory for research on diseases that need to be highly contained such as Ebola, hantavirus and Congo-Crimean hemorrhagic fever. Also included at the planned facility will be labs to support work on infectious disease agents that could potentially be used by terrorists. The budget commits funds in FY 2002 and FY 2003 to complete construction of this laboratory project.

Second, the budget includes $20 million to complete the Edward R. Roybal infectious disease laboratory. This building will be used for research on measles, food-borne diseases, rotavirus and antibiotic resistance pathogens.

Third, $8 million will fund the design and begin construction of environmental health labs, and complete support laboratories that will replace facilities constructed during the 1940's. The remaining $13 million will fund security and infrastructure improvements and annual repairs to existing facilities. The security improvements include a centralized security control room, additional lighting, security cameras, and a new transhipment center. The funding for these projects is included under the line item, "Buildings and Facilities."

RESPONDING TO BIOTERRORIST THREATS

The budget includes $149 million, a decrease of $6 million in the PHSSEF, for CDC bioterrorism preparedness. The decrease reflects the completion of projects begun in FY 2000.

Bioterrorist attacks are likely to be covert and symptoms will frequently resemble less serious diseases at first. State and local public health officers must be able to obtain, analyze, and share surveillance information rapidly, and mount control measures quickly if they are to prevent widespread illness, death, disability and societal disruption caused by terrorist attacks.

The budget includes $78 million to expand State and local bioterrorism preparedness, including epidemiological and laboratory enhancements, detection of outbreaks and electronic communications. Funds will also support laboratory regulation of hazardous biological and chemical agents.

Funds totaling $18 million, an increase of $3 million over FY 2000, will upgrade capacity at CDC, including continued development of a rapid toxic screen that can quickly identify up to 150 chemical threats, additional training for the Epidemic Intelligence Service and increased biological lab capacity.

The remaining $52 million will be used to continue development of the National Pharmaceutical Stockpile that will be used in the event of a bioterrorist attack. When completed, the stockpile will respond to threats posed by smallpox, anthrax, plague, botulism, tularemia and hazardous chemical agents.

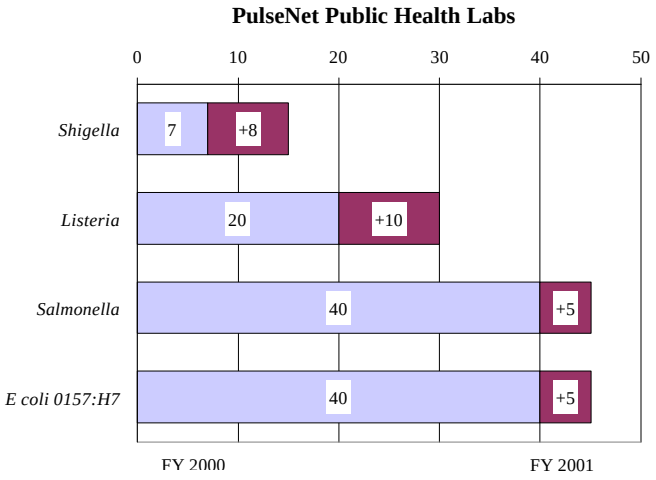
INFECTIOUS DISEASES

The budget includes $202 million to fight infectious diseases, an increase of $26 million, or 15 percent, over FY 2000.

FOOD SAFETY INITIATIVE

Foodborne diseases are estimated to cause 5,000 deaths and 76 million illnesses in the United States each year. Disease outbreaks of *E coli* 0157: H 7 in 1999 demonstrate the need for expanded investment in food safety.

The budget proposes $39 million for food safety, an increase of $10 million, or 34 percent, above FY 2000. These funds will support activities under the Food Safety Initiative in which CDC participates with FDA and USDA. CDC will further expand the award-winning PulseNet, the national network of public health labs that perform DNA "fingerprinting" of disease-causing bacteria. Expansions include



E coli 0157:H7 and *Salmonella* (5 more

States), *Listeria Monocytogene* (10 more States), *Shigella Sonnei* (8 more States).

EMERGING INFECTIOUS DISEASES

Dramatic increases in international commerce and travel, changes in the environment, and increasing stresses on our public health infrastructure have contributed to both the emergence and the rapid transmission of drug resistant and new bacteria, fungi, parasites, and viruses. The outbreak of West Nile encephalitis in the New York area highlights the potential for new disease threats to erupt.

Emerging infectious diseases contribute substantially to the burden of disease borne by the American public. For example, 1999 provisional estimates of the direct cost of influenza and pneumonia total $19 billion, with nearly 95,000 deaths in 1998, ranking fifth among all causes of death due to illness.

The budget proposes a total of $123 million for emerging infectious diseases, an increase of $25 million, or 25 percent above the FY 2000 level. Of this increase, $20 million would support the development of a national electronic disease surveillance network, which will enhance the ability of State and local public health officials to respond to multi-State outbreaks of diseases and to share information, both among themselves and with CDC, about emerging infectious disease emergencies and trends. The remaining $5 million in infectious diseases would fund demonstration projects in surveillance, counseling, testing, referral and education activities to combat Hepatitis C infections.

HIV/AIDS AND STDS

The budget includes $795 million for HIV/AIDS, an increase of $66 million, or nine percent over FY 2000. This increase is focused in two areas–domestic prevention and global AIDS.

The budget includes a $40 million increase to expand local prevention efforts, including interventions targeted toward minority populations, and the "Know Your Status" campaign. An additional $10 million would be redirected from other HIV/AIDS activities to support community planning interventions.

To combat global AIDS, the budget contains $61 million, an increase of $26 million increase, or 74 percent, above FY 2000. It is estimated that currently there are 22 million adults and 1 million children living with HIV/AIDS in the Sub-Saharan region of Africa.

5,500 deaths related to AIDS occur in the Sub-Saharan region of Africa each day.

ELIMINATING SYPHILIS

The budget includes $151 million for STD prevention and control, an increase of $15 million, or 11 percent over FY 2000. This increase will expand the recently announced National Syphilis Elimination Initiative. Half of all new cases of syphilis in the United States are concentrated in only 28 counties (1 percent of all U.S. counties). This initiative will include a special emphasis on minority populations where rates in 1998 were as much as 34 times higher than for white Americans.

The nation has a rare opportunity to eliminate syphilis in the U.S.

CHILDHOOD IMMUNIZATION

The Childhood Immunization Initiative (CII) has been a major Administration priority. Delivery of safe and effective vaccines is the most cost-effective method of preventing illness. This investment has enabled the Nation to continue to exceed the goal of at least 90 percent of 2-year-old

children receiving the *most critical vaccines*.

The goal for the year 2000 is to ensure that at least 90 percent of all two-year-olds receive the *full series of vaccines* and that a vaccination system is built that will sustain and further improve high coverage levels.

The FY 2001 immunization budget is $999 million. This includes $530 million to be appropriated to CDC, and $469 million in Medicaid funds for the Vaccines for Children (VFC) program.

The discretionary request for immunizations in FY 2001 includes an increase of $10 million for the purchase of vaccines to immunize underinsured children through the public health system. Also included is $13 million for vaccine safety, an increase of $5 million. Funds would be used to enhance surveillance of adverse events following immunization, and improve communication of vaccine safety issues.

The FY 2001 budget requests $91 million for global polio eradication. If needed, additional funds will be redirected to the polio effort from funds used to purchase domestic vaccines. While world-wide polio cases were reduced more than 85 percent between 1988 and 1999, a major international increase in effort will be needed to reach the World Health Organization's goal to eliminate polio.

ADOLESCENT SMOKING AND HEALTH

The budget includes $103 million for CDC support of State tobacco control, an increase of $5 million, or 5 percent, above the FY 2000 level. This amount will support national programs and media activities for States, surveillance and research conducted at CDC, and international control efforts. CDC's activities would continue to provide States the capacity to conduct science-based tobacco control programs proven to be effective in reducing teen-smoking. CDC's National Tobacco Control Program (NTCP) – previously two anti-smoking initiatives for States, the American Stop Smoking Intervention Study (ASSIST – transferred from the National Institutes of Health), and Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT) – will provide grants to States totaling $65 million.

ENVIRONMENTAL HEALTH

The budget includes $99 million for environmental disease prevention, an increase of $10 million, or 11 percent, above FY 2000. This increase would support the National Biomonitoring Program which measures exposure of the U.S. population to toxic substances known to cause cancer, birth defects and other disease. This initiative will target vulnerable populations such as children, women of childbearing age, the elderly and minorities.

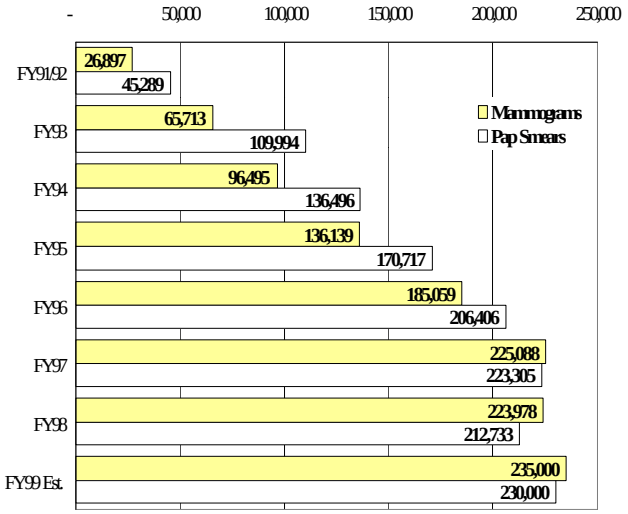
BREAST AND CERVICAL CANCER SCREENING

The budget includes $171 million for the National Breast and Cervical Cancer Early Screening Detection Program (NBCCEDP), an increase of $5 million above FY 2000. This increase will expand screening, diagnostic, and case management services to women at risk, especially minority women. Since its inception in 1991, over 2 million screening tests have been provided by the NBCCEDP, with over 6,000 cases of breast cancers and over 500 cases of invasive cervical cancer diagnosed. The program also includes demonstration projects that screen for heart disease and diabetes risk factors, and provide dietary and physical activity interventions for women determined at risk.

DEMONSTRATIONS TO REDUCE HEALTH DISPARITIES IN MINORITY POPULATIONS

Race and ethnicity correlate with persistent, and often growing, health disparities among U.S. populations. This increasing problem demands national attention. In response to the President's Initiative on Race, HHS is committed to developing a comprehensive strategy to reduce health disparities among ethnic and minority groups.

Number of Mammogram and Pap Smear Screening Among NBCCEDP Participants



The budget includes $35 million to continue and expand new demonstration projects in communities across the country which address six identified areas of health disparities: infant mortality, cancer, heart disease, diabetes, HIV infections, and child and adult immunizations. Thirty-two projects were planned with funds provided in FY 1999, twenty of which can begin implementation with FY 2000 funding. The budget request includes funds to implement an additional 2 demonstrations in FY 2001. Communities will be able to apply these funds to address health problems that they perceive as their greatest needs. Funds will also support planning projects that focus on health disparities in Native American populations.

NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH (NIOSH)

NIOSH establishes and disseminates scientific and public health information necessary to ensure safe and healthful working conditions for millions of American working men and women. Research will continue to include occupational lung disease, musculoskeletal injuries, cancers, traumatic injuries, reproductive disorders, neurotoxic disorders, cardiovascular disease, noise-induced hearing loss, dermatologic conditions, and protective equipment. These efforts will help to address solutions to occupational disease and workplace safety concerns in those fields where the dangers are the greatest. CDC's budget includes $220 million for NIOSH, an increase of $5 million over the FY 2000 level. This increase will support the National Occupational Research Agenda (NORA), NIOSH's research program developed cooperatively with academic centers and industry.

VIOLENCE AGAINST WOMEN

Nearly 2 million American women – including more than 1 million under the age of eighteen—experienced domestic or sexual violence in 1996. The budget includes a total of $87 million, an increase of $5 million above the FY 2000 level, for CDC to support the Department's Initiative to combat Violence Against Women (VAW). CDC has a key role in ensuring that the Department's response to VAW–including both prevention and service delivery–is supported by science. CDC will use its

approach of improving public health prevention to work with State and community partners to help increase the effectiveness of VAW practitioners. Specifically, CDC and its partners will use a scientific approach to evaluate services and bring in new partners, such as businesses and educational institutions, to improve service delivery and provide prevention opportunities.

HEALTH STATISTICS

The budget includes $110 million, an increase of $5 million over the FY 2000 level, for expanded support of HHS health survey and data collection efforts. Major statistical systems operated by NCHS track change in health and health care, plan, target, and assess the effectiveness of public health programs, and identify health problems, risk factors, and disease patterns in the United States. These funds will be used to expand the National Vital Statistics program ($750 thousand), the National Health Interview Surveys ($750 thousand), the National Health Care Surveys ($750 thousand), and the National Health and Nutrition Examination Survey (NHANES; $1.8 million). Nearly $1 million would be used to strengthen CDC's intramural statistical program.

EPIDEMIC SERVICES

The budget includes $86 million for Epidemic Services, a decrease of $18 million below FY 2000. The FY 2000 level included one-time funding to evaluate the currently administered anthrax vaccine and its potential for adverse effects. CDC's epidemic services program conducts applied research to solve public health problems and achieve prevention goals.

PREVENTION CENTERS

CDC's Prevention Centers program provides grants to academic institutions for applied research designed to develop innovative strategies in disease prevention and health promotion. The Centers focus in one or more of the following populations: children and youth; older adults and disabled persons; minorities; and rural populations. The budget includes $15 million for Prevention Centers, a decrease of $3 million below FY 2000.

OTHER ACTIVITIES

The budget does not continue $9 million in funding for global malaria prevention, and $5 million for prevention of global micronutrient deficiency. The FY 2000 levels included one-time funding for projects in these programs. In FY 2000, the global malaria prevention program provided diagnostic, consultative and epidemiologic support and training to host countries. The global micronutrient deficiency program established baseline information on nutritional status to international partners and supported proven, cost-effective methods to deliver nutrients, such as iron and iodine, through dietary diversification and food supplements.

In addition, the budget includes a $2 million decrease for CDC's Office of the Director. This also reflects one-time funding for projects at academic research centers.

Programs that are maintained at FY 2000 funding levels include prevention research, the Preventive Health and Health Services Block Grant, tuberculosis, and childhood lead poisoning.

AGENCY FOR TOXIC SUBSTANCES DISEASE RESEARCH (ATSDR)

ATSDR is funded through Superfund, which is managed by the Environmental Protection Agency. ATSDR performs public health activities related to Superfund Toxic Waste sites. These include health

consultations, epidemiological surveillance, profiles of the health effects of hazardous substances, and education of health care providers near Superfund sites. EPA's budget proposed $64 million for ATSDR, a decrease of $6 million below FY 2000.

CDC OVERVIEW

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Centers for Disease Control and Prevention:				
Infectious Diseases	$137	$176	$202	$26
Emerging Infectious Diseases (non-add)	*79*	*98*	*123*	*+25*
Food Safety (non-add)	*19*	*29*	*39*	*+10*
Chronic Disease Prevention and Health Promotion	299	375	385	+10
Tobacco (non-add)	*74*	*98*	*103*	*+5*
Immunization	448	510	530	+20
Race and Health Demonstration Projects	10	30	35	+5
Sexually Transmitted Diseases	124	136	151	+15
HIV/AIDS	657	730	795	+66
Global AIDS (non-add)	--	*35*	*61*	*+26*
Breast and Cervical Cancer	159	166	171	+5
Occupational Safety and Health	200	215	220	+5
Injury	64	90	95	+5
Violence Against Women (non-add)	*0*	*10*	*15*	*+5*
Health Statistics	94	105	110	+5
1% Evaluation (non-add)	*68*	*72*	*77*	*+5*
Prevention Research	15	15	15	-
Preventive Health Block Grant	195	179	179	-
Rape Prevention	*45*	*44*	*44*	-
Tuberculosis	120	128	128	-
Childhood Lead Poisoning	38	38	38	-
Prevention Centers	13	18	15	-3
Epidemic Services	86	104	86	-18
Buildings and Facilities	18	57	127	+70
Office of the Director	31	38	36	-2
Bioterrorism (PHSSEF)	124	155	149	-6
EPA Superfund Allocation (ATSDR)	76	70	64	-6
Mandatory Budget Authority (Diabetes)	3	3	3	-
User Fees	2	2	2	-
Subtotal , Program Level	**$2,912**	**$3,339**	**$3,534**	**+$195**
Less Funds Allocated from Other Sources :				
Bioterrorism (PHSSEF)	-124	-155	-149	+6
1% Evaluation (Health Statistics)	-68	-72	-77	-5
EPA Superfund Allocation (ATSDR)	-76	-70	-64	+6
Mandatory Budget Authority (Diabetes)	-3	-3	-3	-
User Fees	-2	-2	-2	-
Total, Budget Authority	**$2,639**	**$3,037**	**$3,239**	**+$202**
FTE	7,491	7,923	8,061	+138

NATIONAL INSTITUTES OF HEALTH

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Budget Authority.....	$15,597	$17,813	$18,813	+$1,000
FTE.....	15,329	16,673	17,070	+397

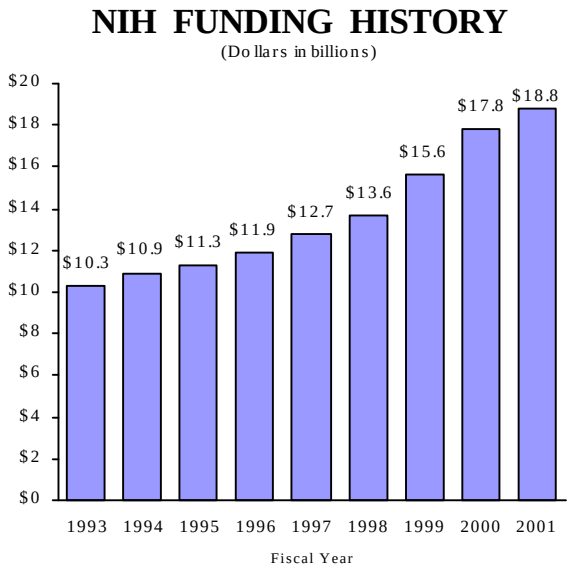
SUMMARY

The FY 2001 budget requests $18.8 billion for the National Institutes of Health (NIH), an increase of $1.0 billion, or 5.6 percent, over the FY 2000 level.

NIH is the world's largest and most distinguished organization dedicated to maintaining and improving health through medical science. At the end of a century in which the average life expectancy in the United States increased by nearly 30 years, triumph over disease and disability has become a realistic goal.

The Institutes and Centers funded by NIH's 25 appropriations support research activities that extend from basic research exploring the fundamental workings of biological systems, to studies that examine disease and treatments in clinical settings, to prevention and to population-based analyses of health status and needs. The missions of individual Institutes and Centers may focus on a given disease, such as cancer, mental illness, or infectious diseases; on a particular organ, such as the heart, kidney, or eye; or on a stage of development, such as childhood or old age. In other instances, a mission might encompass cross-cutting needs and opportunities, such as the development of research resources or the sequencing of the human genome.

Approximately 82 percent of the funds appropriated to NIH flows out to the extramural community, which supports research by more than 50,000 researchers



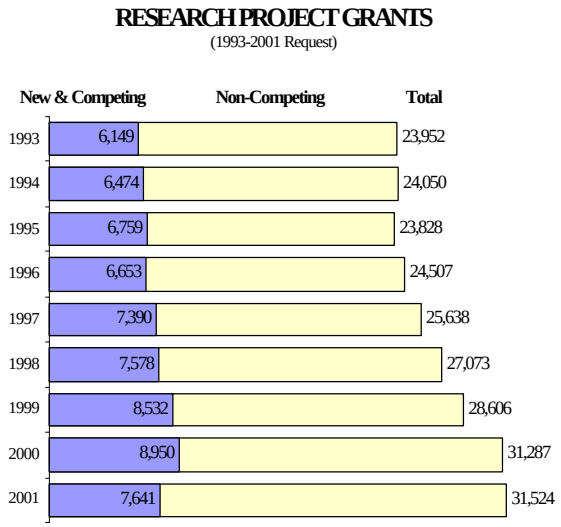
affiliated with some 2,000 university, hospital, and other research facilities in all 50 States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and points abroad. A small percentage of the budget – approximately 10 percent – supports a core program of basic and clinical research activities administered and staffed by NIH's own physicians and scientists. The remaining 8 percent provides for research management and support, agency administration, and intramural facilities.

RESEARCH THEMES

New advances for preventing and treating disease, never before thought possible, are within reach. With the increases requested for FY 2001, NIH plans to continue to focus on four programmatic themes: 1) to exploit genomics by accelerating the human genome project; expanding work on model animal systems; learning to gather and use complex biological information; and building bioinformatics; 2) to reinvigorate clinical research by recruiting, training, and retaining clinical investigators; strengthening clinical research centers; supporting clinical trials, networks, and databases; and developing partnerships with managed care organizations, foundations, industries and other Federal agencies; 3) to harness the expertise of allied disciplines, such as chemistry, engineering, computer science, mathematics, optics, and physics in order to work with medical scientists in, for example, designing new drugs; imaging molecules, chromosomes, cells, and organs; developing biomaterials; and analyzing bioinformatics and clinical data; and 4) to reduce health disparities at home and abroad through research, training, testing interventions, and building international research capacity.

RESEARCH PROJECT GRANTS

The support of basic medical research through competitive, peer-reviewed, and investigator-initiated research project grants (RPGs) continues to be one of NIH's highest funding priorities. These grants support new and experienced investigators in broad-based research programs. In FY 2001, the NIH budget provides $10.3 billion, a 6.1 percent increase over FY 2000, to fund an estimated 31,524 projects, the highest total level ever. This represents an additional 237 total grants over FY 2000. NIH estimates it will support 7,641 new and competing RPGs in FY 2001. This number is 1,309 below estimated FY 2000 levels, largely as a result of the record high number of continuation grants. To ensure that NIH can maintain a healthy number of new awards, especially for first-time investigators, non-competing RPGs will be limited to increases of 2 percent on average for recurring costs and competing RPGs will receive average cost increases of 2 percent over FY 2000. With this, the average cost of a new and competing RPG award will rise to about $321,500, a 26 percent increase over FY 1998.



BIOMEDICAL INFORMATION SCIENCE AND TECHNOLOGY INITIATIVE

Beginning in FY 2000, NIH is supporting a new, trans-agency, inter-disciplinary Biomedical Information Science and Technology Initiative (BISTI). Medical researchers are amassing enormous amounts of information today–from the Human Genome project, clinical trials, statistics, population genetics, and imaging research–thereby creating large repositories of information, far surpassing all of the information collected previously. Critical to efforts to analyze and form bridges between these databases is the emerging field of bioinformatics that brings together cross-disciplinary expertise and technologies in biology, computer science, and mathematics. The BISTI initiative encompasses several

mechanisms of research support: RPGs, for interdisciplinary grants in bioinformatics; research centers, for National Programs of Excellence in Biomedical Computing Support; National Research Service Awards, to begin training a new generation of researchers with cross-disciplinary skills; and the National Library of Medicine, to develop informatics and molecular computational biology projects, as well as projects in intramural research, R&D contracts, other research grants, and research support. NIH plans to devote $110 million in FY 2000 and $147 million in FY 2001 to this new initiative.

ELIMINATING HEALTH DISPARITIES

A key component of the Nation's effort to eliminate health disparities among populations in the United States is medical research and research training, and NIH plans to expand its support of these activities. Beginning in FY 2000, every NIH Institute, Center, and programmatic unit will participate in developing a Trans-NIH Strategic Plan for Research on Health Disparities. This plan will serve to connect all the components of NIH in constructive, multidisciplinary collaborations leading to a better understanding of the causes of health disparities; new and improved prevention strategies, diagnostics, and treatments to reduce health disparities; an expanded scientific workforce committed to this goal; and enhanced communication of research results to scientists, health professionals, affected communities, and the public. This strategic plan will be developed through an open process with substantial public input, particularly from representatives of groups experiencing significant health disparities.

Every NIH Institute, Center, and programmatic unit will participate in developing a Trans-NIH Strategic Plan for Research on Health Disparities.

NIH will establish the Office for Research on Minority Health (ORMH) as the Coordinating Center within the Office of the Director which will integrate the various research resources of the Institutes and centers towards the goal of significantly reducing health disparities. Additionally, NIH will seek legislative authority for the Coordinating Center to award grants for minority health research under exceptional circumstances, when Institutes or Centers are unable to fund such research that has been identified as a priority. NIH seeks an increase of $20 million for ORMH for the purposes of increasing its current innovative grant resources, facilitating the establishment of a Coordinating Center, and providing exceptional circumstances research grants.

HIV/AIDS RESEARCH

The FY 2001 budget requests a total of $2.1 billion for AIDS-related research in NIH. This is an increase of $105 million, or 5.2 percent over the FY 2000 level. It represents a 97 percent increase in funding for NIH AIDS-related research since FY 1993.

Investment in HIV/AIDS research has led to many advances against this disease. Ground-breaking NIH research in basic biology has led to a revolution in drug design and diagnostic methods that are benefitting the fight not only against AIDS, but also against many other life-threatening diseases. This basic research has been the foundation for the development of a new class of drugs, known as protease inhibitors, that are extending the length and quality of life for

many HIV-infected individuals. But many problems remain. It is critical to develop simpler, less toxic, and cheaper drug regimens. NIH is focusing research on behavioral and biomedical interventions to prevent transmission. For example, NIH-sponsored clinical trials demonstrated that the administration of AZT to HIV-infected pregnant women and to their infants dramatically reduced the rate of HIV transmission from mother to infant. NIH intervention research is also focused on populations at risk, particularly women and minorities. One of the highest research priorities remains the search for a safe and effective vaccine to prevent infection. NIH funding for AIDS vaccine research will increase by 12 percent in FY 2001. This increase is in concert with the President's vaccine initiative that also calls for a step-up in research on malaria and tuberculosis.

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The FY 2001 President's budget includes all of NIH's AIDS-related funds in a single appropriation account for the Office of AIDS Research (OAR), consistent with the provisions of the NIH Revitalization Act of 1993. The Director of OAR will transfer funds to the Institutes in accordance with the scientific priorities of the annual comprehensive plan for AIDS research developed by OAR along with the Institutes. The Administration supports a consolidated AIDS appropriation within NIH as a vital part of ensuring a coordinated and flexible response to the AIDS epidemic.

EXTRAMURAL RESEARCH FACILITIES CONSTRUCTION

For FY 2001, the budget proposes to maintain the FY 2000 level of $73 million for extramural research facilities construction projects administered by the National Center for Research Resources (NCRR) These funds are awarded on a competitive basis to public and non-profit private entities to expand, remodel, renovate, or alter existing or construct new research facilities in order to expand their capacity to perform or improve the quality of their biomedical and behavioral research. In general, these NIH grants are limited to 50 percent of the total cost of the facility projects. Twenty-five percent of the appropriated funds for this program are earmarked by statute for institutions of emerging excellence. In addition to NCRR, the National Cancer Institute provides about $3 million a year for extramural research laboratory renovations.

BUILDINGS AND FACILITIES

A total of $149 million is requested for NIH intramural buildings and facilities (B&F), a decrease of $16 million, or 10 percent, below FY 2000. A total of $73 million is requested over two years for construction of a new National Neuroscience Research Center on the main NIH campus. For this facility, the budget includes $47 million in FY 2001 and requests advanced appropriations of $26 million for FY 2002. This trans-NIH center, led by the National Institute of Neurological Disorders and Stroke and the National Institute of Mental Health, will bring together, in a shared facility, basic and clinical neuroscientists from across NIH who are currently fragmented by location and discipline. The resulting improved collaborations in the new center will speed the rate at which fundamental discoveries are translated into effective therapies for neurological and psychiatric disorders.

The budget also requests $6 million to

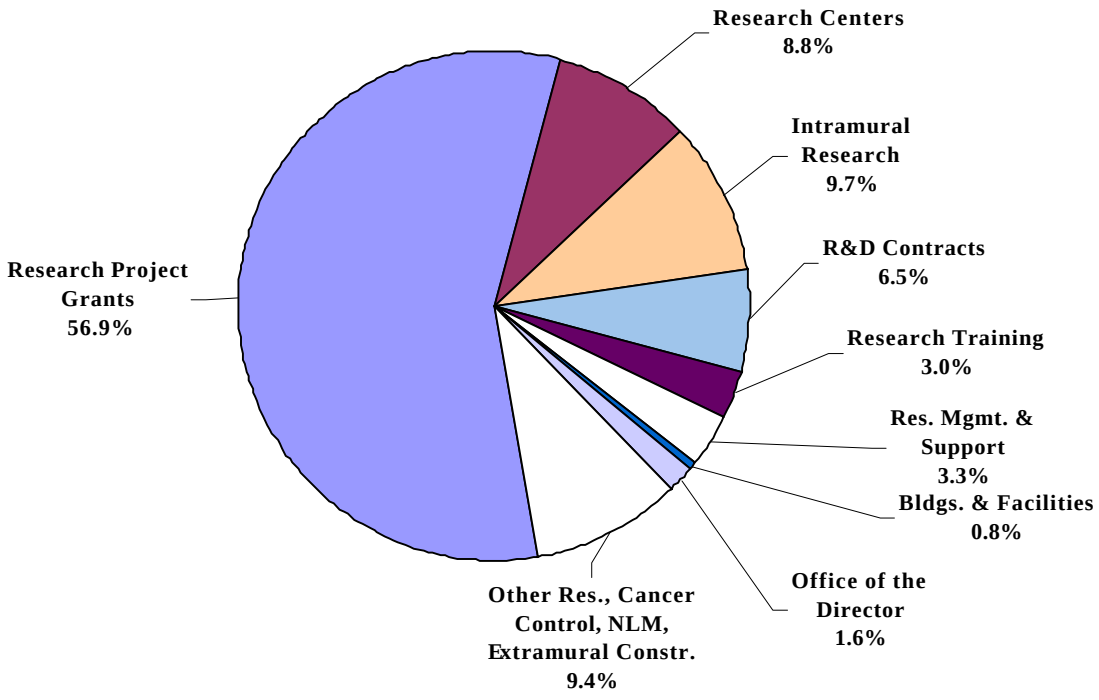
fund the schematics and design development of a centralized, multi-level animal facility, or vivarium. This facility will consolidate ongoing programs in the current sprawling and aging Building 14 through 28 complex, as well as meet modern animal research needs.

The remaining B&F funds will be used for child care facilities, general maintenance; repairs; renovations; and essential safety and health improvements.

CENTRAL SERVICES FINANCING

Following an in-depth review of the funding process for NIH centralized research support services and administrative activities, NIH has developed a new business model dedicated to improving costs and improving the quality of services provided by NIH's central services activities, such as information technology support, scientific review, and other research services support. NIH has developed a new, less complex funding formula for allocating the costs of these services to each Institute that will go into effect in FY 2001. The FY 2001 budget request includes a one-time budget neutral adjustment by Institute for this new central services assessment method. FY 1999 and FY 2000 Institute funding data has been made comparable for this adjustment.

FY 2001 NIH Budget
$18.8 Billion - Percent of Total by Mechanism



NIH OVERVIEW (by Institute/Center)

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Institutes:				
National Cancer Institute	$2,657	$3,067	$3,250	+$183
National Heart, Lung, and Blood Institute	1,710	1,961	2,070	+109
National Institute of Dental and Craniofacial Research	220	249	263	+14
Natl Inst. of Diabetes & Digestive & Kidney Disease.	976	1,119	1,186	+67
National Institute of Neurological Disorders & Stroke	868	996	1,050	+54
National Institute of Allergy & Infectious Diseases	768	881	935	+54
National Institute of General Medical Sciences	1,171	1,317	1,389	+73
Natl Inst. of Child Health and Human Development	676	770	811	+41
National Eye Institute	385	439	463	+24
National Institute of Environmental Health Sciences	381	435	461	+26
National Institute on Aging	598	684	722	+38
Natl Inst. Of Arthritis & Musculoskeletal & Skin Dis.	301	344	363	+19
Natl Inst. On Deafness & Communication Disorders	229	262	276	+14
National Institute of Mental Health	740	846	896	+50
National Institute on Drug Abuse	419	469	496	+27
National Institute on Alcohol Abuse and Alcoholism.	243	274	289	+15
National Institute for Nursing Research	64	82	85	+3
National Human Genome Research Institute	280	332	353	+22
National Center for Research Resources	465	569	603	+34
Natl Center for Complementary & Alternative Med	50	68	71	+3
Fogarty International Center	23	29	33	+4
National Library of Medicine	178	210	225	+15
Office of the Director	212	237	262	+25
Office of AIDS Research 1/	1,793	2,006	2,111	+105
Buildings & Facilities	191	165	149	-16
EPA Superfund Allocation (NIEHS)	60	60	49	-11
ONDCP Drug Forfeiture Fund Transfer (NIDA)	10	10	10	0
Diabetes Research 2/	27	27	27	0
Subtotal, Program Level	**$15,693**	**$17,909**	**$18,898**	**+$989**
Less Funds Allocated from Other Sources:				
EPA Superfund Allocation (NIEHS)	-$60	-$60	-$49	+$11
ONDCP Drug Forfeiture Fund Transfer (NIDA)	-10	-10	-10	0
Diabetes Research 2/	-27	-27	-27	0
Subtotal, Budget Authority	**$15,597**	**$17,813**	**$18,813**	**+$1,000**
FTE	15,329	16,673	17,070	+397

1/ FY 1999 figure includes $6.1 million of facilities funds related to the new Vaccine Research Facility.
2/ These funds were pre-appropriated in the Balanced Budget Act of 1997.

NIH OVERVIEW (by Mechanism)

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Mechanism:				
Research Project Grants	$8,475	$9,741	$10,333	+$591
[No. of Non-Competing]	*[20,074]*	*[22,337]*	*[23,883]*	*[+1,546]*
[No. of New/Competing]	*[8,532]*	*[8,950]*	*[7,641]*	*[-1,309]*
[Total No. of Grants]	*[28,606]*	*[31,287]*	*[31,524]*	*[+237]*
Small Business Innovation Research (SBIR)/ Small Business Technology Transfer (STTR) Grants	315	362	381	+18
Research Centers	1,385	1,561	1,654	+94
Research Training	509	550	564	+14
R&D Contracts	1,022	1,127	1,224	+97
Intramural Research	1,567	1,746	1,823	+77
Other Research	1,114	1,395	1,457	+61
Extramural Research Facilities Construction	33	76	76	-1
Research Management and Support	541	591	614	+23
National Library of Medicine	182	215	230	+15
Office of the Director	256	282	309	+27
Buildings and Facilities	197	165	149	-16
EPA Superfund Allocation (NIEHS)	60	60	49	-11
ONDCP Drug Forfeiture Fund Transfer (NIDA)	10	10	10	0
Diabetes Research 1/	27	27	27	0
Subtotal, Program Level	**$15,693**	**$17,909**	**$18,898**	**+$989**
Less Funds Allocated from Other Sources:				
EPA Superfund Allocation (NIEHS)	-$60	-$60	-$49	+11
ONDCP Drug Forfeiture Fund Transfer (NIDA)	-10	-10	-10	0
Diabetes Research 1/	-27	-27	-27	0
Subtotal, Budget Authority	**$15,597**	**$17,813**	**$18,813**	**+$1,000**
FTE	15,329	16,673	17,070	+397

1/ These funds were pre-appropriated in the Balanced Budget Act of 1997.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Program Level	$2,487	$2,652	$2,835	+$183
FTE	632	686	686	0

SUMMARY

The FY 2001 budget request for the Substance Abuse and Mental Health Services Administration (SAMHSA) is $2.8 billion, an increase of $171 million, or 6.4 percent, over the FY 2000 enacted level. The SAMHSA budget focuses on enhancing mental health and substance abuse services, as well as narrowing the gaps in treatment for these conditions.

SAMHSA's mission is to improve the quality and availability of prevention, early intervention, treatment and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness. SAMHSA accomplishes its mission through its Centers—Mental Health Services (CMHS), Substance Abuse Treatment (CSAT), and Substance Abuse Prevention (CSAP).

MENTAL HEALTH

The recently released Surgeon General's Report on Mental Health provides the Nation with a sobering picture of the prevalence of mental illness. According to the report, 1 in 5 Americans will experience a serious mental disorder in their lifetime. It is estimated that approximately 63 million Americans experienced some type of mental disorder. Of these Americans, 5.6 million adults and over 1 million children and adolescents were disabled by the most severe and persistent mental illnesses.

According to the Surgeon General, the annual costs of mental illness in health care dollars spent and productivity lost are over $150 billion. However, the social costs to individuals, their families, and communities can never be quantified. Perhaps the most disturbing of these facts is that 60 percent of people with lifetime histories of at least one mental illness neither seek nor obtain help for their illness, and only 25 percent of those seeking help will receive care from a mental health specialist.

60 percent of people with lifetime histories of at least one mental illness neither seek nor obtain help for their illness.

In response to the Surgeon General's report, the Substance Abuse and Mental Health Services Administration will play a major role in the Departmental Mental Health initiative, addressing the improvements needed in the mental health services system. The SAMHSA FY 2001 budget builds on and advances recent discoveries in mental health treatment and prevention by providing $731 million for

Mental Health services, an increase of $100 million, or 16 percent, over FY 2000.

A principal component of the Mental Health budget request is $416 million for the Mental Health Services Block Grant, an increase of $60 million, or 17 percent, over FY 2000. These funds provide States with needed resources to support comprehensive community-based care for adults with serious mental illnesses and children with serious emotional disturbances. In FY 1999, the States used Block Grant funds to provide services to an estimated 150,000 individuals.

This budget also includes $30 million for a new Targeted Mental Health Capacity Expansion (TCE) program to help establish needed prevention, early identification, and intervention services. The new TCE program includes two components: a $10 million Prevention and Early Intervention Program focusing on individuals at risk or in the early stages of mental illness, and a $20 million Local Mental Health System Enhancement Program to help develop service capacity in non-mental health settings where the majority of individuals come for mental health care. Examples of these settings include primary care, foster care, Head Start, the criminal justice system, and substance abuse treatment centers.

The FY 2001 budget request continues funding of $78 million for Knowledge Development and Application (KDA) projects included by the Congress in FY 2000 for Youth Violence Prevention activities, and $50 million of these resources will fund approximately 70 second and third year grants for the Safe Schools/ Healthy Students program. The Safe Schools projects, which are jointly administered by the Departments of Justice, Education, and HHS, support activities to increase school safety, mental health prevention and treatment, and school violence prevention and early intervention services. The remaining funds will support School and Community Action Grants.

The request includes $87 million for Children's Mental Health Services, an increase of $4 million over FY 2000. This program seeks to expand the service capacity at the local level for those communities that have developed the infrastructure to offer collaborative interagency support to children and their families. The $4 million increase will allow organizations to provide services to an additional 1,700children.

The budget request also includes $35 million, an increase of $5 million, for the PATH Homeless Formula Grant to provide support services to individuals who are homeless or at risk of homelessness. In FY 1997, the most recent year for which data is available, 360 local agencies and/or counties received funding, providing services to a total of 57,731 clients.

SUBSTANCE ABUSE

The 1998 National Household Survey on Drug Abuse estimates that more than 6.5 million Americans aged 12 and older used an illicit drug in the past year. Further, 19 percent of youth aged 12-17 reported use of alcohol in the previous month. These rates are unacceptable. Moreover, the U.S. Census projects a significant increase in the number of 12 to 20-year-olds over the next 15 years.

Nationwide, there continues to be a great need to expand the capacity to treat individuals who use and are addicted to illegal drugs. The Office of National Drug Control Policy estimates that as many as 5 million Americans are in need of substance abuse treatment services. However, less than half actually receive services, leaving a treatment gap of approximately 2.9 million individuals.

The treatment gap affects more than just those in need of treatment. ONDCP estimates the cost to society of illegal drug use to be approximately $110 billion each year. The FY 2001 budget includes a total of more than $2 billion for substance abuse treatment and prevention services.

REDUCING THE TREATMENT GAP

Efficient treatment that is widely available is a sound, cost-effective method of reducing the health and societal costs of illegal drugs. SAMHSA projects that $1.04 billion will be used for treatment services in FY 2001. In total, these new treatment funds will allow States to provide treatment services to approximately 415,000, an increase of 16,000 individuals over FY 2000.

The budget request includes $1.63 billion for the Substance Abuse Prevention and Treatment Block Grant, an increase of $31 million over FY 2000. The Block Grant is the cornerstone of States' substance abuse programs, and provides support for over 10,500 community-based treatment and prevention organizations.

The request also provides $163 million for Targeted Treatment Capacity Expansion, an increase of $49 million, or 43 percent, above the FY 2000 enacted level. The new effort addresses the treatment gap by supporting rapid and strategic responses to the demand for treatment services, primarily focusing on emerging drug problems. The goal of the program is to create and/or expand integrated, creative and community-based responses to targeted and well-documented substance abuse problems.

SUBSTANCE ABUSE PREVENTION

These trends in drug use signal a continued need to build upon prevention programs that work and continue the development of new programs for future use.

The budget seeks a total of $142 million for Knowledge Development and Application, Targeted Capacity Expansion, and High Risk Youth programs within the Center for Substance Abuse Prevention (CSAP). These funds support maintaining, expanding, and disseminating the knowledge base in substance abuse prevention, while allowing States the flexibility to target needed prevention services quickly, accurately, and efficiently.

Through CSAP's leadership, State Incentive Grants have changed the national standard for substance abuse prevention. These three-year grants assist States in coordinating and developing state-wide prevention plans and the numerous funding streams for prevention activities. To date, 21 State Incentive Grants (SIGs) have been funded, with an additional 4 to be funded in FY 2000. Overall, these funds have helped over 1,000 communities implement proven prevention service models. In FY 2001, the CSAP will provide funding for an additional 14-16 SIGs.

States are also continuing to reduce the percent of retailers who unlawfully sell tobacco products to minors. The Synar Amendment Implementation Activities program works with States to reduce the rate of tobacco sales to minors to an overall level at or below 20 percent September 20, 2002. In FY 1998, 12 States reported violation rates at or below 20 percent, and we expect all States to achieve the 20 percent goal by September 20, 2002.

DATA COLLECTION/PROGRAM MANAGEMENT

SAMHSA engages in an extensive national data collection effort to evaluate both the prevalence of these conditions and the effectiveness of its programs at treating or preventing them.

The most notable data collection effort undertaken by SAMHSA is the National Household Survey on Drug Abuse (NHSDA). The Survey is currently the only source of information on substance abuse problems and treatment in the general public, and its data are used to study trends in the use of, and attitudes concerning, both legal and illicit substances. The survey is also an invaluable and unique source of information for studying the causes of substance abuse, the demand for treatment, and the effectiveness of service programs. The NHSDA provides a critical foundation for

evaluating the success of Federal efforts to treat and prevent this chronic disease. In FY 2001, SAMHSA projects this service will cost $41 million.

The FY 2001 budget, consistent with the recommendations of the National Drug Control Strategy, also includes a new National Treatment Outcomes Monitoring System (NTOMS). NTOMS will measure and assess substance abuse treatment on a national level. NTOMS data will reflect the increase or decrease in accessibility to treatment, the demand for illegal substances, waiting time to enter treatment programs, and the number of chronic substance abusers. Further, NTOMS will provide valuable information about changes in the substance abuse treatment gap. The total cost of NTOMS in FY 2001 is projected to be $5 million.

The budget includes $60 million for Program Management, an increase of $1 million. This increase will allow SAMHSA to address important issues such as Youth Violence, Targeted Treatment Capacity, and respond to the rapidly widening substance abuse and mental health treatment gaps.

SAMHSA OVERVIEW

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Mental Health:				
Mental Health Block Grant	$289	$356	$416	$60
Targeted Capacity Expansion	0	0	30	30
PATH Homeless Formula Grant	26	31	36	5
Knowledge Development and Application	96	137	137	0
Children's Mental Health Services	78	83	87	4
Protection and Advocacy	23	25	26	1
Subtotal, Mental Health	**$512**	**$632**	**$732**	**$100**
Substance Abuse:				
Targeted Capacity Expansion	$133	$194	$248	$54
Substance Abuse Treatment	55	114	163	49
Substance Abuse Prevention	78	80	85	5
Substance Abuse Block Grant	1585	1600	1631	31
Knowledge Development and Application	193	160	145	-15
Substance Abuse Treatment	115	100	95	-5
Substance Abuse Prevention	78	60	50	-10
High Risk Youth	7	7	7	0
National Data Collection Activities (1% Set-aside)	0	0	12	12
Subtotal, Substance Abuse	**$1,918**	**$1,961**	**$2,043**	**$82**
Program Management	57	59	60	+1
Total, Program Level	**$2,487**	**$2,652**	**$2,835**	**$183**
Less Funds Allocated from Other Sources:				
1% Set-aside	0	0	-12	-12
Total Discretionary BA	**$2,487**	**$2,652**	**$2,823**	**$171**
FTE	632	686	686	0

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Program Level.....	$171	$204	$250	+$46
FTE.....	253	285	294	+9

SUMMARY

The FY 2001 request for the Agency for Healthcare Research and Quality (AHRQ) provides a program level of $250 million, an increase of $46 million, or 22.6 percent, over FY 2000. The budget reflects a major commitment to the improvement of the quality of patient care provided by the American health care system. In FY 2001 the budget will place a priority on:

- reducing the number of medical errors;
- using health information systems to improve the quality and effectiveness of medical care;
- improving employee health services for on-the-job injuries.

AHRQ accomplishes its mission of supporting, conducting, and disseminating research on the availability, quality, and costs of services through partnerships with academic institutions, medical societies, managed care organizations, and health care payers. The agency uses research project grants to colleges and universities to capitalize on the expertise of academic institutions. In addition, AHRQ has forged cooperative relationships with major health care organizations to ensure that research funded by the agency is implemented by the major players in the health system. For example, AHRQ, in conjunction with the American Academy of Pediatrics and major insurers, has created Evidence Based Practice Centers (EPC's) to focus on common or expensive medical problems. Other examples of AHRQ's partnerships include the National Guideline Clearinghouse and the Consumer Assessments of Health Plans, a tool to assist 90 million consumers and employers with the selection of health care plans. AHRQ will be fully funded through inter-agency transfers.

HEALTH COSTS, QUALITY, AND OUTCOMES

Research on Health Costs, Quality, and Outcomes is funded at $206 million in FY 2001, an increase of +$41 million. This research focuses heavily on illnesses with high medical and social costs.

MEDICAL ERRORS

A recent report issued by the Institute on Medicine documented the alarming number of medical errors, which cause between 44,000 and 98,000 deaths per year in the United States. The President has asked the Quality Interagency Coordination Task Force (QuIC), in which AHRQ has a lead role, to review the IOM report and develop strategies for reducing medical errors. In FY 2001, AHRQ will dedicate $20 million to conduct research directed toward reduction of medical errors.

As the lead Federal agency in health care quality, AHRQ will collaborate with the private sector, non-profit health care organizations, and other federal agencies to develop national safety goals and best practices to eliminate the occurrences of medical errors.

One focus will be the application of information technologies and computerized decision support systems to identify and prevent medical errors in clinical practice. AHRQ will expand research into causes of medical errors and methods of error prevention to complement technological innovations.

> ***We have the finest health care system in the world . . . but too many families have been the victims of medical errors that are avoidable. . . that are unacceptable.***
>
> President William J. Clinton

The technological advancements and error prevention research is intended to lead to significant improvements in the quality and efficiency of our nation's health care system and save the lives of thousands of Americans.

EMPLOYEE HEALTH

Our Nation's efforts to reduce workplace injuries have been very successful over the years. However, more work is needed to assist those who suffer from work-related injuries or illness. In FY 2001, AHRQ will direct $10 million in research to improve employee health services. AHRQ will focus on research on improving the quality of the health care delivery systems through which employees receive health care services; the quality of the health care workplace and its impact on the quality and outcomes of care; and the outcomes and effectiveness of clinical services employees receive.

HEALTH INFORMATION TECHNOLOGY

AHRQ will dedicate $10 million toward the development of health information technology applications. The use of information systems and computerized decision support systems has the potential to improve the quality, efficiency, and outcomes provided by the health care system.

For example, an Indiana University research project demonstrated that physicians, reminded by computer, were twice as likely to give flu vaccine to patients at high risk during the winter, reducing hospitalizations and errors by 10 to 30 percent. This work will make evidence-based information more accessible to health care decision makers. Expansion of information technology applications will also enhance AHRQ's capacity to carry out health outcomes research and generate new knowledge about the quality and effectiveness of our nation's health care system.

BIOTERRORISM

The FY 2000 appropriation included $5 million in the Public Health and Social Service Emergency Fund for research on health services issues. AHRQ will evaluate rapid response systems and the most effective clinical interventions for people exposed to chemical and biological agents. AHRQ will also bring together representatives of clinicians, hospitals, and emergency departments to inform current and future research agendas, with a specific focus on primary care practice networks. Continuation costs of up to $3 million are anticipated for projects initiated in FY 2000.

MEDICAL EXPENDITURE PANEL SURVEYS

Medical Expenditures Panel Surveys (MEPS) are funded at $40.8 million in FY 2001, an increase of $4.8 million. MEPS provides detailed, national data on the health care services Americans use, how much they

cost, and who pays for them.

Enhancements in the MEPS budget will provide AHRQ with increased ability to examine quality, cost, access, and use of clinical preventive services. This information will lead to better understanding of health disparities and will provide critical data for closing the gaps in medical care. It will also help to track the impact on care by Federal and State programs, including the Child Health Insurance Program (CHIP).

AHRQ OVERVIEW

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Research on Health Costs, Quality, and Outcomes.....	$139	$166	$207	+$40
Medical Expenditures Panel Surveys.....	29	36	41	+$5
Program Support.....	2	2	2	+$1
Subtotal, program level.....	**$170**	**$204**	**$250**	**+$46**
Less Transfers: PHS 1% Evaluation Funds.....	-$71	-$89	$250	+$161
Less Bioterrorism (PHSSEF).....	$0	-$5	$0	+$5
Total , BA.....	**$100**	**$110**	**$0**	**+$110**
FTE.....	253	285	294	+9

HEALTH CARE FINANCING ADMINISTRATION

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Budget Authority	$297,147	$325,434	$349,686	+$24,252
Outlays	$298,901	$319,820	$347,607	+$27,787
FTE	4,219	4,363	4,435	+72

SUMMARY

The FY 2001 budget request for the Health Care Financing Administration (HCFA) is $347.6 billion to finance Medicare and Medicaid, the State Children's Health Insurance Program (SCHIP), the Health Care Fraud and Abuse Control Program (HCFAC), State insurance enforcement, and HCFA's operating costs (see figure 1 for the distribution of spending). This budget reflects an increase of $27.8 billion over FY 2000. Spending for the Medicare, Medicaid, and SCHIP programs represent 82 percent of the total HHS budget for FY 2001.

The President's FY 2001 budget includes important legislative proposals for the Medicare program. Major initiatives will add a voluntary, affordable prescription drug benefit for all beneficiaries; modernize fee-for-service Medicare; expand access to preventive benefits; enable thousands of people aged 55-65 to buy into Medicare; continue the fight against Medicare waste, fraud, and abuse; and ensure that Medicare payment is fair.

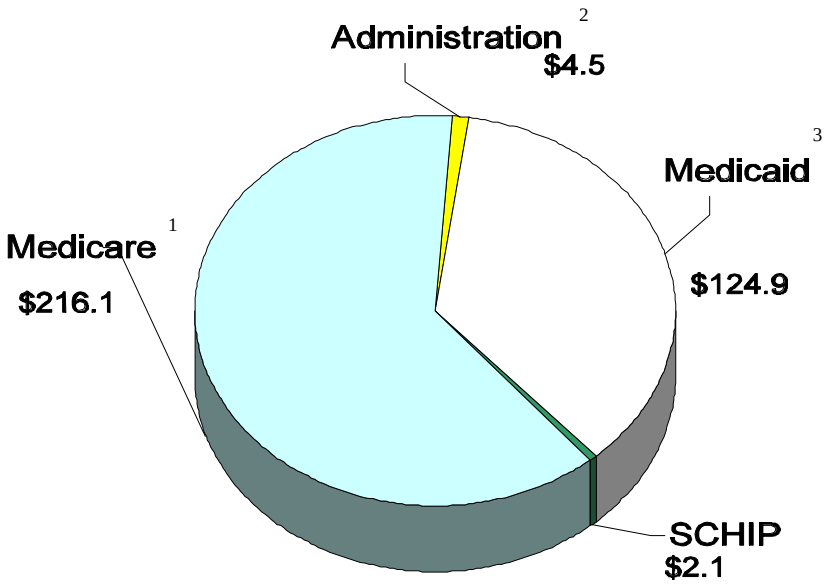
In addition, new user fee legislation in HCFA's discretionary budget will enable HCFA to meet new workload, such as implementing the Balanced Budget Act and the Balanced Budget Refinement Act, while more effectively administering Medicare, Medicaid, and SCHIP.

The budget also includes major new proposals to greatly increase the number of insured individuals. The FamilyCare program will give States the option to expand health care coverage to parents of children eligible for Medicaid or SCHIP. States will have increased flexibility to use outreach funds and to use less restrictive eligibility determination methods for children and their parents who are eligible for, but not enrolled in, Medicaid and SCHIP. States will also have the option to extend Medicaid and SCHIP coverage for certain groups, including qualified aliens, children and pregnant women.

To serve Medicaid beneficiaries better, the budget offers more choices to long-term care beneficiaries and addresses public health concerns through proposals focusing on treating asthma, covering smoking cessation drugs and treating breast and cervical cancer for uninsured women. Medicaid will more efficiently target spending through changes in drug reimbursement laws and reduce administrative payments to States by the amounts of common administrative costs that were included in their TANF grants.

HCFA FY 2001 Net Outlays

Total = $347.6 Billion



1 Includes benefits only.
2 Includes program management, HCFAC, PROs, and other administrative funding.
3 Includes state grants and demonstration funding.

MEDICARE

SUMMARY

Medicare is the Federal health insurance program for people age 65 or older and people under age 65 who are disabled or suffer from end-stage renal disease (ESRD). In FY 2001, the program will serve approximately 40.1 million eligible individuals. Medicare consists of three parts:

- Part A—Hospital Insurance (HI) pays for inpatient hospital care, some skilled nursing facility care, home health care related to a hospital stay, and hospice care. The HI program is funded through the HI Trust Fund. The Trust Fund receives most of its income from the HI payroll tax (2.9 percent of payroll, split between employers and employees).

- Part B—Supplementary Medical Insurance (SMI) Part B coverage is optional. However, 94 percent of those enrolled in Part A enroll in Part B. Part B pays for medically necessary physician services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment, home health care, and certain other medical services and supplies. The SMI program is funded through the SMI Trust Fund. Enrollees pay 25 percent of Part B costs (or $45.50 per month in 2000), with remaining costs covered by general revenue.

- Part C—The Medicare+Choice Program, which is available to most beneficiaries, offers beneficiaries the option of receiving their Medicare benefits through private organizations such as managed care plans. Currently about 17 percent of beneficiaries have chosen to enroll in a Medicare+Choice plan.

MEDICARE REFORM

The President's FY 2001 budget proposes a comprehensive reform plan to modernize and strengthen the Medicare program to meet the health, demographic, and financing challenges it faces in the 21st century. This historic plan will: 1) make Medicare more competitive and efficient; 2) modernize Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protections for preventive benefits; and 3) make an unprecedented long-term financing commitment to the program that would extend solvency of the Hospital Insurance Trust Fund to at least 2025.

PRESCRIPTION DRUG BENEFIT

The centerpiece of the President's Medicare reform plan is a voluntary outpatient prescription drug benefit that would be affordable and available to all beneficiaries. The net cost of this new benefit, including Federal Medicaid costs, is $38.1 billion ($28.8 billion in Medicare only) over five years. The President's drug benefit proposal would:

- Have no deductible and pay half of all beneficiaries' prescription drug costs up to $2,000 in FY 2003 and up to $5,000 when fully implemented in 2009;

- Ensure beneficiaries a price discount for each prescription purchased similar to that offered by many employer-sponsored plans, even after the $5,000 limit is reached;

- Cost $26 per month beginning in 2003 and $51 per month when fully phased-in by 2009;

- Ensure that beneficiaries with incomes below 135 percent of poverty pay no premiums or cost-sharing for the drug benefit, and offer premium assistance to those with incomes between 135 and 150 percent of poverty;

- Provide financial incentives for employers to retain retiree health coverage if they offer prescription drug coverage that is at least equivalent to the Medicare drug benefit; and

- Be administered primarily by private sector pharmaceutical benefit managers (PBMs).

FEE-FOR-SERVICE MODERNIZATION

The President's plan gives traditional fee-for-service Medicare new private sector purchasing and quality management tools to improve care and constrain costs, saving $3.2 billion over five years. This package of modernization proposals would:

- Create a new Medicare preferred provider option (PPO) in which beneficiaries pay less cost sharing when using providers in the PPO network and are guaranteed the highest quality care through national quality standards;

- Expand the successful Centers of Excellence demonstration as a permanent part of the Medicare program;

- Competitively pay for voluntary disease management services, such as patient assessment, telephone consultations and home nursing visits, to improve care and achieve savings for patients with a particular diagnosis;

- Introduce competitive bidding and pricing negotiations in setting payment rates for Part B services (except physician services) to achieve savings for beneficiaries and the Medicare program, improve provider performance, and strengthen quality; and

- Reform the contracting process to allow the Secretary to use competition to select Medicare claims processing contractors, choose entities other than insurance companies as fiscal agents, and determine which functions are performed under these contracts.

COMPETITIVE DEFINED BENEFIT

The competitive defined benefit proposal complements modernization of the Medicare program by injecting price competition into managed care payments. This proposal would start in 2003, after the new Medicare+Choice risk adjustment system is almost fully implemented. It saves $1.8 billion over five years for the Medicare program, including significant savings for beneficiaries. The competitive defined benefit proposal:

- Bases managed care payments on competitively bid prices, not a flat rate set by the government; and

- Allows beneficiaries who choose a low cost managed care plan to keep up to 75 percent of the savings, which they can keep or use to purchase extra benefits.

EXPAND ACCESS TO PREVENTIVE BENEFITS

The President's reform plan creates incentives for beneficiaries to take advantage of life-saving preventive benefits and establishes important health promotion initiatives. Specifically, the plan would:

- Eliminate coinsurance and deductibles for Medicare-covered preventive benefits, such as colorectal screening, mammography, prostate cancer screening, pelvic exams, bone mass measurement, and diabetes self-management, at a cost of $1.0 billion over five years;

- Initiate a three-year demonstration to provide smoking cessation services to Medicare beneficiaries; and

- Launch a new nationwide health promotion education campaign targeted to all Americans over the age of 50.

RATIONALIZE COST SHARING AND MEDIGAP

To help offset the cost of benefit improvements, the President's plan saves $2.7 billion over five years by rationalizing current cost sharing requirements. It also proposes improvements to the Medigap market that expand opportunities and options for individuals to enroll in Medigap plans. To accomplish these goals, the plan:

- Reinstates cost-sharing for clinical laboratory services, including a 20 percent coinsurance, to prevent over-utilization and reduce fraud;

- Indexes the annual $100 deductible, which has been fixed since 1991, to inflation starting in 2003;

- Provides easier access to Medigap if a beneficiary is in an HMO that leaves Medicare;

- Expands the Medigap enrollment period for individuals with disabilities and End Stage Renal Disease (ESRD);

- Encourages efforts to add a new, lower cost Medigap option with low copayments and authorizes the Secretary to study the benefits of having traditional Medicare offer a Medigap-like plan.

MEDICARE BUY-IN

Another initiative in the Administration's Medicare reform plan provides the opportunity for certain individuals between the ages of 55-65 to buy in to Medicare. These individuals are among the most difficult to insure, have less access to health care, and are twice as likely as 45-54 year olds to have health problems. The three initiatives included in this proposal cost $980 million over five years and will:

- Enable Americans ages 62-65 to buy into Medicare, by paying a full premium;

- Provide vulnerable displaced workers over 55 access to Medicare by offering those who have involuntarily lost their jobs and their health insurance a similar buy-in option;
- Provide Americans over 55, whose companies terminate their retiree health coverage, a new insurance option by extending "COBRA" continuation coverage until age 65.

To help people afford the Medicare buy-in, the FY 2001 budget also proposes a new tax credit equal to 25 percent of premium costs. This credit would be available to people ages 62 to 64 and displaced workers ages 55 to 65.

CONSTRAIN OUTYEAR GROWTH

To ensure that the Medicare spending does not significantly increase after most Balanced Budget Act (BBA) savings provisions expire in 2002, the President's plan includes out-year policies from FY 2003 to FY 2005 that protect against excessive growth rates, but are more modest than those included in BBA. These proposals, which save $6.4 billion over five years, would:

- Reduce the inpatient hospital Prospective Payment System (PPS) payment update each year by 0.8 percent for urban hospitals and 0.4 percent for rural hospitals;
- Set PPS-exempt hospital payment updates in relation to their target amounts through 2005, and apply PPS update reductions when these hospitals are under PPS;
- Continue PPS and PPS-exempt hospital capital payment reductions of 2.1 percent and 15 percent, respectively;
- Reduce laboratory payment updates by the Consumer Price Index (CPI) minus 1 percent;
- Reduce the ambulance payment update by CPI minus one percent; and
- Reduce payment updates for durable medical equipment, parenteral & enteral nutrition, and prosthetics & orthotics by CPI minus one percent.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21ST CENTURY

Despite the significant savings expected from the President's proposals to modernize Medicare and make it more competitive, most experts recognize that additional financing will be necessary to maintain basic services and quality over time. Because of the strong belief that the Baby Boom generation should not pass a Medicare financing crisis to its children, the President proposes that a significant portion of the surplus be dedicated to strengthening the program. Specifically, his plan:

- Dedicates nearly $400 billion of the surplus over ten years to extend the life of the Part A Trust Fund until at least 2025 and help finance a universal prescription drug benefit.

OTHER MEDICARE LEGISLATIVE PROPOSALS

The FY 2001 President's budget includes additional proposals, beyond Medicare reform, that will improve coverage for vulnerable populations, combat fraud, waste and abuse, and encourage appropriate and cost-efficient payments for services Medicare provides.

IMPROVING COVERAGE FOR VULNERABLE POPULATIONS

The FY 2001 budget includes two proposals that improve coverage policy for vulnerable Medicare populations. Together, these proposals cost $45 million over five years. These initiatives would:

- Extend Medicare Part A coverage indefinitely for disabled individuals who return to work, removing the four-and-one-half year time limit recently enacted under the Work Incentives Improvement Act; and

- Permanently extend coverage of immunosuppressive drugs to transplant patients for a total of 48 months and revises policies recently enacted under the Balanced Budget Refinement Act of 1999 (BBRA).

FIGHTING FRAUD, WASTE, AND ABUSE

In the continuing effort to ensure that the Medicare program effectively manages Medicare dollars, the budget proposes the following initiatives, totaling about $3.1 billion over five years:

- Eliminate the physician mark-up for outpatient drugs by limiting Medicare payment to 83 percent of the average wholesale price;

- Reduce misuse of partial hospitalization services by: prohibiting providers from furnishing partial hospitalization services in a beneficiary's home or other inpatient or residential setting; allowing the Secretary to establish more stringent standards for community mental health centers; imposing civil monetary penalties when a physician falsely certifies the need for these services; and clarifying the scope of and eligibility for the benefit in statute;

- Require private insurance companies to provide Medicare Secondary Payer information; and

- Reduce Medicare's reimbursement rate for Epogen (EPO) by $1 to better reflect current market prices.

ENSURING MEDICARE PAYMENT IS FAIR

Despite the slow-down in Medicare growth over recent years, there is still evidence to suggest that Medicare pays too much for some services and has not received all the benefits of cost-efficiencies that have occurred in the marketplace. In an effort to ensure Medicare continues to pay appropriately and accurately for services furnished to beneficiaries, the budget includes savings proposals totaling $4.9 billion over five years to:

- Reduce from 55 to 45 the percentage Medicare pays hospitals for bad debt and reduce other provider bad debt payments by 45 percent;

- Reduce laboratory payments by 30 percent for four common lab tests where data show Medicare overpays compared to the private sector;

- Establish a national payment limit for orthotics and prosthetics;

- Eliminate Health Professional Shortage Area (HPSA) bonus payments for non-primary care physicians in urban areas;

- Return to the original phase-in schedule for Medicare+Choice risk adjustment in 2002; and

- Move one Medicare+Choice payment from the start of FY 2003 to the end of FY 2002.

MANAGED CARE OPTIONS

Medicare offers beneficiaries a variety of coverage options. Beneficiaries may choose to remain in the traditional fee-for-service program or join a managed care plan. In fee-for-service, beneficiaries choose from almost any doctor, hospital, or health care provider. In managed care, beneficiaries receive virtually all care from the plan's doctors and health care providers.

The BBA expanded the types of plans available to beneficiaries including provider sponsored organizations (PSO) and preferred

provider organizations (PPO).

Currently, more than 6 million or about 17 percent of beneficiaries are enrolled in a managed care plan. Enrollment in managed care has grown dramatically over the last five years. While some managed care organizations have recently decided to dis-enroll from the Medicare program, the number of managed care enrollees has not been greatly affected.

Medicare pays a set monthly amount, or capitated amount, to managed care plans for each beneficiary enrolled. Managed care plans have been attractive to beneficiaries because they generally cover more services and have fewer out of pocket costs than fee-for-service.

MEDICARE SPENDING GROWTH

Under current law, Medicare benefit outlays are projected to increase from $240.1 billion in FY 2001 to $309.0 billion in FY 2005. The program is expected to grow at 6.5 percent per year during this period. Part A benefit outlays are projected to grow from $139.9 billion in FY 2001 to $178.8 billion in FY 2005, at an average annual growth rate of 6.3 percent. Part B benefit outlays will grow from $100.3 billion in FY 2001 to $130.2 billion in FY 2005. The Part B average annual growth rate during the projection period is 6.8 percent.

HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM (HCFAC)

Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) establishes the HCFAC Program to combat health care fraud, waste, and abuse. Included within this overarching program is the Medicare Integrity Program (MIP) and the HCFAC Account. Through the efforts of HCFA and its partners, these programs return many more dollars to the Medicare Trust Funds for each dollar spent fighting fraud, waste, and abuse. HIPAA established a stable and reliable funding source for these efforts and the Secretary's Operation Restore Trust (ORT) initiative has guided the Departments efforts. Following a successful demonstration phase, the ORT initiative has gone nationwide. MIP and HCFAC Account spending have been at the heart of this new effort.

The Medicare Integrity Program consists of financial audits of provider cost reports, medical and utilization reviews, and the identification of Medicare beneficiaries who have other insurance plans with primary responsibility for paying claims. Funds are also earmarked to support detection and investigation of program fraud and abuse. HCFA also funds provider education and training activities associated with anti-fraud activities and audits of managed care plans.

In FY 2001, HIPAA authorizes $680 million for MIP, a $50 million increase over FY 2000. Within this level, HCFA will continue its policy of funding activities that will stop unnecessary payments before they leave the Trust Funds through pre-payment review and provider education. These actions help lower the payment error rate cited in recent Chief Financial Officer's reports.

HCFA has taken full advantage of its new contracting authority under MIP and developed a set of overarching contractors to concentrate on more specialized areas of fraud, waste, and abuse in the Medicare program. These new contractors complement efforts by the current fiscal intermediaries and carriers to prevent overpayments, detect improper payments, coordinate with HCFA's many program integrity partners, and enforce HCFA's program integrity efforts.

HIPAA also created the HCFAC Account. This Account funds much of the health care investigational and prosecutorial activities of the HHS Office of Inspector General and the Department of Justice. The HCFAC Account will increase $24 million in FY 2001 over FY 2000, to $182 million.

The Administration's health care fraud,

waste, and abuse control efforts have paid off handsomely since the beginning the ORT demonstration project. We have returned more than $1.6 billion to the Trust Funds and the MIP program has prevented $5.3 billion from leaving the Trust Fund over the last twelve-month period through its pre-payment efforts. We have also cut the Medicare overpayment error rate in half from FY 1996 through FY 1998. The most recent Medicare Trustee's report cited our health care fraud, waste, and abuse control efforts as a contributing factor in the slower growth of the Medicare program.

PEER REVIEW ORGANIZATIONS

Peer Review Organizations (PROs) were established in Title IX of the Social Security Act, Part B, to serve the following functions:

- Improve the quality of care for beneficiaries by ensuring that professionally recognized standards of care are met;

- Protect program integrity by ensuring that Medicare only pays for items that are reasonable and medically necessary; and

- Protect beneficiaries by addressing individual beneficiary's complaints, hospital issued notices of noncoverage and EMTALA (dumping) violations.

In FY 2001, Peer Review Organization's contracts include performance standards which will be used to provide benchmarks for major initiatives, including: national and local health improvement initiatives; a program to prevent payment errors; a project to improve quality of care for Medicare+Choice beneficiaries; and an initiative to reduce the disparity between care received by minorities and all other beneficiaries.

FY 2001 PROPOSED MEDICARE LEGISLATION

(dollars in millions)

MEDICARE REFORM PROPOSALS	1-YEAR FY 2001	5-YEARS FY 01-05
SAVINGS PROPOSALS:		
Provider Payment Changes (thru 2005):		
Reduce Hospital Update by 0.8 Percent (Urban) & 0.4 Percent (Rural).....	0	-4,300
Reduce PPS-Exempt Hospital Updates.....	0	-840
Reduce PPS Capital Payments by 2.1 Percent.....	0	-630
Reduce PPS-Exempt Capital Payments by 15 Percent.....	0	-160
Reduce Laboratory Payment Update by CPI Minus 1 Percent.....	0	-180
Reduce Ambulance Update by CPI Minus 1 Percent.....	0	-10
Reduce DME, PEN, and P&O Updates by CPI Minus 1 Percent.....	0	-250
Subtotal, Provider Payment Changes.....	0	-6,370
Fee-for-Service Modernization:		
Medicare PPO Option.....	0	-1,700
Centers of Excellence.....	0	-1,185
Disease Management.....	0	0
Competitive Acquisition.....	0	-100
Contracting Reform.....	0	-200
Subtotal, FFS Modernization.....	0	-3,185
Cost-Sharing Changes:		
Reinstate Cost-Sharing for Laboratory Services.....	0	-2,400
Index Part B Deductible to CPI.....	0	-300
Subtotal, Cost Sharing Changes.....	0	-2,700
Competitive Defined Benefit:	0	-1,800
Interactions:	+175	+3,005
Subtotal, Medicare Reform Savings.....	**+175**	**-11,050**
COST PROPOSALS:		
Prescription Drug Benefit (net impact).....	0	+28,780
Eliminate Cost-Sharing for Preventive Services.....	0	+1,000
Medicare Buy-In.....	0	+980
Subtotal, Medicare Reform Costs.....	**0**	**+30,760**
Total Medicare Reform.....	**+175**	**+19,710**

FY 2001 PROPOSED MEDICARE LEGISLATION

(dollars in millions)

OTHER MEDICARE LEGISLATIVE PROPOSALS	1-YEAR FY 2001	5-YEARS FY 01-05
SAVINGS PROPOSALS:		
Fighting Fraud, Waste and Abuse:		
Reduce EPO Payment by 10 Percent	-65	-400
Require Insurers to Provide MSP Data	-40	-800
Reduce Misuse of Partial Hospitalization Benefit	-30	-250
Clarify Scope of and Eligibilty for Partial Hospitaliztion Benefit	-50	-430
Eliminate Physician Mark-Up of Outpatient Drugs	-130	-1,190
Subtotal, Fraud & Abuse	-315	-3,070
Ensuring Medicare Payment is Fair:		
Reduce Medicare Bad Debt Payments	-340	-2,280
Reduce Lab Payments by 30 Percent for Four Lab Tests	-80	-660
Establish National Payment Limit for Orthotics and Prosthetics	-110	-930
Eliminate HPSA Bonus Payments for Non-Primary Care Physicians in Urban Areas	-30	-190
Return to 2002 Phase-In for Medicare+Choice Risk Adjustment	0	-810
Shift Timing of One Medicare+Choice Payment	0	0
Subtotal, Fair Payment	-560	-4,870
Subtotal, Other Medicare Savings	**-875**	**-7,940**
COST PROPOSALS:		
Improving Coverage for Vulnerable Populations:		
Permanently Extend Part A Coverage for Working Disabled	0	+10
Expand Coverage for Immunosuppressive Drugs	+10	+35
Subtotal, Other Medicare Costs	**+10**	**+45**
Total Other Medicare	**-865**	**-7,895**
TOTAL 2001 MEDICARE LEGISLATION	**-690**	**+11,815**

MEDICARE TRUST FUND OVERVIEW

(beneficiaries in millions)

	1999	2000	2001	+/-
Beneficiaries Enrolled (in Millions):				
Hospital Insurance (HI)	38.8	39.3	39.7	0.4
Supplementary Medical Insurance (SMI)	36.9	37.3	37.7	0.3

(dollars in millions) /1

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Current Law:				
HI Benefits	$129,107	$129,216	$139,869	+$10,653
SMI Benefits	79,187	90,574	100,273	+$9,699
Subtotal, Medicare Benefits	**$208,294**	**$219,790**	**$240,142**	**+$20,352**
Administration /2	$2,706	$3,069	$3,182	+$113
HCFAC /3 (including Medicare Integrity Program)	642	744	820	+$76
Peer Review Organizations (PROs)	213	485	422	-$63
Transfers to Medicaid	0	50	60	+$10
Total Outlays, Current Law	**$211,855**	**$224,138**	**$244,626**	**+$20,488**
Premiums	(21,561)	(21,735)	(23,340)	(1,605)
Total Net Outlays, Current Law	**$190,294**	**$202,403**	**$221,286**	**+$22,093**
Proposed Legislation::				
Medicare Benefits	$0	$0	-$690	-$690
Program Management	$0	$0	$250	$250
Proposed User Fees	0	0	-220	-$220
Total Medicare Savings	**$0**	**$0**	**-$660**	**-$660**
Total, Net Outlays, Proposed Law	**+$190,294**	**+$202,403**	**+$220,626**	**+$18,223**

/ 1 Numbers may not add due to rounding.

/ 2 Includes Administration payments to SSA and other non-HCFA agencies, and proprietary receipts.

/ 3 Health Care Fraud and Abuse Control, includes FBI, excludes OIG.

MEDICAID

SUMMARY

Medicaid is a jointly funded, Federal-State program that provides medical assistance to certain groups of low-income people and others with special health care needs. In FY 2001, it will cover approximately 33.9 million individuals including children, the aged, blind, and/or disabled and people who meet eligibility criteria under the old AFDC program. Under current law, the Federal share of Medicaid outlays is expected to be about $125 billion in FY 2001. This is an $9 billion (7.5 percent) increase over projected FY 2000 spending.

LEGISLATIVE PROPOSALS

There are approximately 11 million uninsured children under age 18 in the country, including 4 million who are eligible for Medicaid, but remain uninsured.

The President's health care proposals will give States the opportunity to greatly increase the number of insured through several major initiatives. The FamilyCare Program, $10 billion in Medicaid funding and $3.6 billion in SCHIP funding over five years, will give States the option to expand health care coverage to parents of children eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). This will allow parents to enroll in the same health care program as their children and greatly increase the likelihood that children will be enrolled in health insurance.

The budget contains initiatives to accelerate enrollment of uninsured children eligible for Medicaid and SCHIP by giving States the option to share federally-funded free and reduced-price school lunch program eligibility information with the State Medicaid agency, and expanding the sites that may determine presumptive eligibility. States will also be required to apply the same applicability and eligibility simplifications to the Medicaid program as States apply to the SCHIP program.

States will also have the option to expand coverage by extending benefits to immigrants who lost coverage due to welfare reform, expanding eligibility for children through age 20, and extending transitional Medicaid. States will have the option to extend Medicaid to individuals with incomes up to 300 percent of SSI, giving individuals a choice of home and community-based care settings and preventing individuals from being forced into a nursing home. HHS will also work with HUD to further enhance and expand home and community-based services.

In FY 2001, the budget will include $77 million in Medicaid spending to assist in addressing public health concerns through proposals focusing on treating asthma, covering smoking cessation drugs, and breast and cervical cancer treatment for uninsured women. Taken together, these proposals are expected to increase Federal spending by about $16 billion over five years. An additional $9 billion in spending comes from interaction with Medicare proposals.

The FY 2001 budget also contains Medicaid proposals that will save the Federal Government about $3 billion over the next five years. The savings reflect reductions in Medicaid administrative costs from recoupment of shared administrative expenses that were included in the TANF block grant, changes in the Medicaid rebate law for generic drugs and providing the Average Manufacturers Price of prescription drugs to the States. Savings can also be attributed to new Secretarial enforcement tools and interactions with the Medicare program. New child support enforcement measures will also contribute $170 million over five years in savings to the program.

FAMILYCARE INITIATIVE

This proposal will allow States to receive enhanced Federal matching funds to expand health care coverage to parents of children eligible for Medicaid or SCHIP. Parents would be covered in the same program as their children to make health care as easy and accessible as possible. Additional funding for this initiative would be provided through increased allotments to the SCHIP program. (Please see the SCHIP section for details.)

RESTORE MEDICAID TO LEGAL IMMIGRANT PREGNANT WOMEN

States will have the option to extend Medicaid to qualified legal immigrant pregnant women regardless of their date of entry to the United States, including those who entered the country after August 22, 1996. Coverage would be the same as that provided to other Medicaid beneficiaries. This proposal ensures that their children, who will be United States citizens, will get the best possible start in life.

STATE OPTION TO COVER LEGAL IMMIGRANT CHILDREN UNDER MEDICAID AND/OR SCHIP

States will be given the option to extend Medicaid and SCHIP coverage to qualified legal immigrant children regardless of their date of entry to the United States, including those who entered the country after August 22, 1996. These children lost eligibility for Medicaid coverage due to changes in Federal law under Welfare Reform. This proposal would help achieve the goal of providing access to comprehensive health care for all vulnerable children. Parents of children who have benefits restored would also be eligible through the Administration's proposed FamilyCare Program initiative.

MEDICAID FOR IMMIGRANTS WITH RESTORED SSI

The budget proposes to restore SSI for qualified aliens, regardless of age, who entered the country on or after August 22, 1996, who became disabled after they entered, and who have been residing in the United Stated for at least five years. Under current law, these individuals are barred from SSI under restrictions imposed by the Welfare Reform law enacted in 1996. In most States, restoration of SSI would mean restoration of Medicaid because their Medicaid eligibility is based on receipt of SSI. This proposal will allow legal immigrants who recently entered the country and became disabled after entry to receive the same benefits as legal immigrants who entered the country before August 22, 1996.

MEDICAID AGE EXPANSION

Legislation is being proposed giving States the option to provide Medicaid and SCHIP coverage to children ages 19 and 20 up to the same poverty-related income levels as they use for younger children. Under current law, States choosing to expand Medicaid coverage to older children only do so under limited circumstances. In general, they can only make older children eligible for Medicaid at lower AFDC related levels. The Medicaid expansion would be matched at regular Medicaid rates. (See the SCHIP section for details on the related SCHIP proposal.)

EXTEND AND SIMPLIFY TRANSITIONAL MEDICAID

These proposals make permanent the requirement to provide Medicaid for up to 12 months to families in transition from welfare to work. Current law authorizes this requirement only through FY 2001. The proposal would also simplify procedures by eliminating excessive Medicaid reporting requirements during the transition period, thus making it more likely that these families

will remain enrolled in the program. Finally, the proposal would replace the requirement to provide Medicaid to families in transition from welfare to work in a State which has elected to cover all families with incomes below 185 percent of poverty, a group that would subsume virtually all families in transition from welfare to work.

PERMIT HIGHER INCOME ELIGIBILITY STANDARDS FOR PEOPLE NEEDING AN INSTITUTIONAL LEVEL OF CARE

The budget gives States the option to extend Medicaid to individuals with incomes up to 300 percent of the SSI limit ($1,532 per month in 2000) who receive Medicaid long-term care services in the community, if the State has determined them to need an institutional level of care. States would be permitted to target this eligibility option to individuals receiving specific kinds of long-term care services, such as personal care services. Under current law, an individual may only qualify for Medicaid under the higher-income level if they enter a nursing home, or if they are served under a State's Home and Community-Based waiver program for long-term care. Typically, lower-income eligibility levels for non-waiver, non-institutional settings prevent many individuals from qualifying. This proposal allows for equity between settings, and ensures that individuals have a real choice and are not, in effect, forced into entering a nursing home.

PROVIDE $100 MILLION IN COMPETITIVE HUD GRANT FUNDS

This proposal (which has no costs to the Medicaid program) will provide funds to qualified low-income elderly housing projects (section 202 HUD projects) to convert them to assisted-living facilities, as long as those facilities provide Medicaid home and community-based services and accessible services for non-Medicaid residents.

This proposal provides a unique opportunity for cooperation between HHS and HUD, and would allow residents to "age in place" by funding the conversion of their homes into assisted-living facilities. To ensure that the low-income elderly have access to the option, only sites that agree to bring Medicaid home and community-based services into the converted assisted-living facilities would qualify for the grants.

SHARE SCHOOL LUNCH INFORMATION OPTION

This initiative will provide new options to find and enroll uninsured children through schools. At State option, State Medicaid agencies would be allowed to access eligibility information for children from the federally-funded free and reduced price school lunch program unless their parents opt not to release the information. The proposal's sole purpose is outreach and enrollment of eligible children.

States would also be allowed to use this information to presumptively enroll potentially eligible children in Medicaid and SCHIP while their applications are formally processed.

EXPAND PRESUMPTIVE ELIGIBILITY

The proposal will allow States to expand the types of sites that perform presumptive eligibility determinations to includes child care referral centers, child care centers, homeless shelters, agencies that determine eligibility for IV-D medical Child Support, TANF and SCHIP, and other entities approved by the Secretary. This builds on the Balanced Budget Act State option that allowed Medicaid providers and those determining eligibility for WIC, Head Start, and Child Care and Development Block Grant services to determine presumptive

eligibility for children. This option can help States provide critical health care services to children pending official enrollment, and increases the likelihood that families complete the application process.

ALIGN SCHIP AND MEDICAID TO ELIMINATE ENROLLMENT BARRIERS

To simplify the enrollment process, States would be required to use the same easy application and income verification process for children eligible for Medicaid (in poverty-related eligibility groups) as they use in their SCHIP program. (See SCHIP section for related proposals.)

ASTHMA DISEASE MANAGEMENT INITIATIVE

This proposal would provide $50 million for each of FY 2001 and FY 2002, on a competitive basis, to selected State Medicaid programs to test and evaluate the effectiveness of innovative disease management approaches to identify and treat pediatric asthma. These efforts are intended to provide an incentive for more effective use of ongoing Medicaid funds for outreach, case management, and treatment benefits to reduce costly asthma-related medical crises (such as emergency room visits and hospital stays) and to improve the quality of life for children with asthma and their families.

COVERAGE OF SMOKING CESSATION DRUGS

The budget requires States to cover prescription and certain non-prescription smoking cessation drugs for Medicaid beneficiaries. Costs for these drugs will be matched at the regular Medicaid matching rate. States will have the authority to decide which non-prescription drugs they will cover.

BREAST AND CERVICAL CANCER TREATMENT

This proposal would create a new Medicaid eligibility option for States to cover uninsured women who have been diagnosed with breast cancer or cervical cancer through the CDC's early detection program. Women covered under this option would receive a full Medicaid benefits package for the entire time they require cancer treatment. States would also have the option to allow qualified entities to determine such women to be presumptively eligible for up to two months so that cancer treatment can begin without delay while the regular application process takes place.

MEDICAID SAVINGS PROPOSALS

REDUCE STATES' ADMINISTRATIVE PAYMENTS

This proposal addresses projected Federal cost increases in the Medicaid program arising from changes in the way States charge administrative costs to the Federal Food Stamp, Medicaid, and Temporary Assistance for Needy Families (TANF) programs. Similar to the Agricultural Research law passed in 1998, this legislation would direct the Secretary to reduce each State's Medicaid grant award by the amount of administrative costs charged to AFDC in each State's TANF base year that could have legitimately been charged to Medicaid. This proposal does not prevent States from using funds from their TANF block grants to cover the adjustment.

REBATES FROM GENERIC DRUG MANUFACTURERS

Currently, brand-name drug manufacturers must pay a dollar-for-dollar rebate to the Medicaid program if they increase the price of their drugs in excess of increases in the consumer price index-urban (CPI-U). Generic drug manufacturers were not subject to this requirement in the drug

rebate program because it was believed that generic drug prices would not rise faster than inflation. Recent price increases in generic drugs have demonstrated the need for the CPI-U adjustment for generic as well as brand name drugs.

MAKE MANUFACTURER PRICES PUBLIC FOR MEDICAID COVERED DRUGS

This proposal would allow the Secretary to make the average manufacturer price (AMP) for Medicaid covered drugs available to the States so that States can use this data to accurately set Medicaid drug reimbursement rates.

NEW SECRETARIAL ENFORCEMENT TOOLS

The Budget proposes to create a new intermediate enforcement tool that would authorize the Secretary to reduce a State's Federal matching rate by up to 0.5 percent when the State fails to comply with Federal requirements. Reductions would remain in effect until the State corrects the violation and complies with Federal rules. This tool would give the Secretary additional flexibility to respond to State violations. Secretarial enforcement tools under current law demand both that the violation be substantial and the financial penalty be extreme, such as withholding all of Federal Financial Participation (FFP). This proposal tool would allow less extreme enforcement measures.

CHILD SUPPORT ENFORCEMENT

See ACF Entitlement section for description.

BACKGROUND

Medicaid is a voluntary program, initiated and administered by the States. State expenditures for medical assistance are matched by the Federal government using a formula based on per capita income in each State relative to the national average. Federal matching rates for FY 2001 are projected to range from 50 to 76 percent for medical assistance payments. Historically, the Federal matching rate on average is approximately 57 percent.

Historically, eligibility for Medicaid has been based on qualifying under the cash assistance programs of Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). With passage of the Temporary Assistance for Needy Families (TANF) program in 1996, which replaced AFDC, eligibility for Medicaid and cash assistance were de-linked. However, Medicaid eligibility remains tied to AFDC program rules in place as of July 16, 1996. All those who qualify under the 1996 AFDC rules and most SSI recipients, commonly referred to as the "categorically eligible," are covered under State Medicaid programs. States have the option to cover some individuals not eligible under AFDC or SSI rules (e.g., people with higher incomes in institutions, low-income pregnant women and children, and aged, blind, and disabled people below the poverty line), and may cover people at higher incomes through the use of income disregards. States may also cover "medically needy" individuals. Such individuals meet the categorical eligibility criteria, but have too much income or too many resources to meet the financial criteria.

Medicaid covers pregnant women and infants whose family income does not exceed 185 percent of the Federal poverty level. Medicaid coverage of children ages 6 through 18, born after September 30, 1983, whose family income does not exceed 100 percent of the Federal poverty level, is being phased in. By 2002, all children under the age of 19 living below the poverty level will be eligible for Medicaid.

In addition, Medicaid pays Medicare premiums and cost-sharing for certain low-income seniors and disabled individuals.

Under the Balanced Budget Act, two new

Medicaid eligibility groups consisting of low-income Medicare beneficiaries were created, Qualified Individuals (QIs) 1 and 2. QI1s are Medicare beneficiaries with incomes from 120 to 135 percent of the poverty level. This group is eligible for a full subsidy of their Part B premiums. QI2s are Medicare beneficiaries with incomes from at least 135 to 175 percent of the poverty level. This group is eligible for a partial subsidy of their Part B premiums.

Generally, States are required to provide a core of 13 mandatory services to eligible categorically needy recipients. Those mandatory Medicaid services include: inpatient and outpatient hospital care, health screening, diagnosis, and treatment to children, family planning, physician services, and nursing facility services to individuals over 21. States may also elect to cover any of over 30 specified optional services, which include prescription drugs, clinic services, dental, eyeglasses, and services provided in intermediate care facilities for those with mental retardation.

Federal Medicaid outlays rose dramatically from FY 1989 through FY 1992, at a 25 percent average annual rate. However, outlay growth slowed to less than 12 percent in FY 1993 and continued to decline to 3.9 percent in 1997. The slow in the rate of Medicaid increases is due to many factors, including legislative changes (such as limits on provider specific taxes and donations), decreases in the projected growth of SSI caseloads, higher employment, and State efforts to control costs. In 1999, there was a slight increase in the growth rate. Medicaid outlays grew 6.7 percent over 1998. The recent growth in the Medicaid program can largely be attributed to higher reported administrative costs. Administrative costs grew 19 percent from FY 1999 over FY 1998, compared to 6.6 percent growth in benefit payments.

WAIVER ACTIVITY

States have considerable flexibility in structuring the Medicaid program, including determining provider payment rates and certification standards, and developing alternative health care delivery programs. In addition, waivers of various portions of Federal law are also available to States.

Numerous States have restructured eligibility and coverage under Medicaid through the use of demonstration waivers granted under Section 1115 of the Social Security Act. A number of States are using Section 1115 demonstration waivers to reform health care by expanding coverage without increasing the amount the Federal government would spend otherwise.

Since 1993, this Administration has approved 20 Section 1115 demonstrations in Arkansas, Delaware, Florida, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Vermont and Wisconsin, and is committed to working cooperatively with additional States to support innovative ideas.

CHANGES IN MEDICAID DUE TO THE BALANCED BUDGET REFINEMENT ACT OF 1999 (BBRA)

The BBRA of 1999 required HCFA to make a few changes in the Medicaid program. Among the changes to the program were:

COST BASED REIMBURSEMENT OF FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

The Balanced Budget Act (BBA) phased out the Medicaid requirement to pay FQHCs and rural health clinics based on cost. The 2000 phase-out–where payments are based on the 95 percent of costs–would be extended for 2001 and 2002 under BBRA. In FY 2003, payments will be based on 90 percent and in FY 2004 on 85 percent of

costs. The GAO will conduct a study of the impact of the cost reimbursement phase-out, and will evaluate different payment approaches.

EXTENSION OF $500 MILLION FUND

The welfare reform law put aside a $500 million fund for States to offset the costs of simplifying their eligibility systems and conducting outreach. For nearly 30 States, the funding sunsets this year. The BBRA eliminated the sunset and extended the availability of this fund until it is expended.

CHANGES TO DISPROPORTIONATE SHARE HOSPITALS (DSH) PAYMENTS

The BBRA adjusted the DSH allotments for Washington, D.C., Minnesota, New Mexico and Wyoming to correct an error in the base year used to calculate the allotments under BBA.

CHANGES IN MEDICAID DUE TO THE TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT (TWWIIA)

The Ticket to Work and Work Incentives Improvement Act of 1999 expands State options under Medicaid for workers with disabilities. States have two optional Medicaid buy-in categories that would: (1) allow individuals who would be eligible, except for increased income, for Supplemental Security Income (SSI) and therefore for Medicaid, to buy into health care coverage; and/or (2) permit States to continue coverage for working individuals with disabilities whose medical conditions remain severe but who would otherwise lose eligibility due to medical improvement.

TWWIIA also allows States to participate in two State grants and demonstration programs. These are described in the next section.

CHANGES IN MEDICAID DUE TO THE FOSTER CARE INDEPENDENCE ACT

The Foster Care Independence Act of 1999 provided States with the option of continuing Medicaid coverage for adolescents ages 18 to 21 leaving foster care.

MEDICAID OVERVIEW

(average enrollees in thousands)

	1999	2000	2001
Enrollment:			
Aged 65 and Over	3,800	3,800	3,900
Blind and Disabled	6,600	6,700	6,800
Needy Adults	6,400	6,500	6,600
Needy Children	16,100	16,400	16,600
Total	**32,900**	**33,400**	**33,900**

MEDICAID OUTLAYS

(outlays in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Current Law				
Benefits /1	$102,565	$109,737	$116,917	+$7,180
State Administration	5,478	6,380	7,259	879
Total Net Outlays, Current Law	**$108,042**	**$116,117**	**$124,175**	**+$8,058**
Proposed Legislation				
Savings	0	0	-355	-355
Costs	0	0	1,018	+1,018
Subtotal, Proposed Legislation	**$0**	**$0**	**+$663**	**+$663**
Total Net Outlays, Proposed Law /2	**$108,042**	**$116,117**	**$124,838**	**+$8,721**

/1 Includes Vaccine for Children Outlays.
/2 Numbers may not add due to rounding.

MEDICAID PROPOSALS: COSTS AND SAVINGS

	FY 2001	FY 01-05
SAVINGS PROPOSALS		
Cost Allocation	-260	-2,063
Child Support Enforcement	-10	-170
Generic Drug Rebate	-35	-265
Provide Beneficiary with New Enforcement Tools	-10	-50
Publicize the AMP	-20	-400
Medicaid Interactions with Medicare	-20	-100
SUBTOTAL: MANDATORY MEDICAID SAVINGS	-355	-3,048
COST PROPOSALS		
Restore Benefits to Immigrant Children/Pregnant Women	61	670
Restore SSI to Qualified Immigrants (5-year ban, no deeming)	0	513
Asthma Initiative	50	100
300% Eligibility Expansion	15	140
Presumptive Eligibility	15	305
Extend Transitional Medicaid	0	1,550
Family Care Initiative	600	10,200
Medicaid and CHIP Age Expansions	114	650
Smoking Cessation with Match	12	66
School Lunch Initiative	5	119
Align Medicaid and CHIP Eligibility	126	1,561
Breast Cancer	15	220
Interactions Among Medicaid Policies	5	95
Interactions with Medicare Drug Benefit Proposal	0	9,331
SUBTOTAL: MANDATORY MEDICAID COSTS	1,018	25,520
TOTAL MANDATORY MEDICAID	**663**	**22,472**

STATE GRANTS AND DEMONSTRATIONS

THE TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT (TWWIIA)

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWIIA) expanded State options under Medicaid for workers with disabilities. These are described above.

In addition to the two optional Medicaid categories created by TWWIIA, the Act also created new mandatory health grants to fund both a demonstration program and a grant program.

The demonstration program ($250 million over 2001-2006) would allow States to receive Federal financial participation to develop a program to provide Medicaid-equivalent coverage to workers with health conditions which, without medical treatment, will cause them to become disabled and qualify for SSI/SSDI. The demonstration will determine whether providing health coverage prevented deterioration in their health condition.

The Medicaid Infrastructure Grant Program (Section 203 of the legislation) makes $150 million available over five years (beginning in FY 2001) to States to design, establish and operate State infrastructures that provide items and services to people with disabilities who work. Funds may also be used to conduct outreach campaigns to educate beneficiaries about the availability of such infrastructures. The minimum award to States is $500,000 per fiscal year.

LEGISLATIVE PROPOSALS

HOMELESS INITIATIVE

This proposal provides $10 million in mandatory funding in FY 2001 for competitive grants to States to improve coordination among health and other programs addressing the needs of the homeless with the purpose of increasing homeless enrollment in these programs. Grants would be awarded to five to seven States with innovative plans to provide outreach to homeless populations and coordinate activities across Medicaid, SCHIP, Mental Health and Substance Abuse Block Grants, TANF, and Food Stamps.

STATE GRANTS AND DEMONSTRATIONS

(outlays in millions)

	1999 Actual	2000 Enacted	2001 Request /1	Request +/- Enacted
Current Law				
Grants & Demonstrations.....	$0	$0	$16	+$16
Total Net Outlays, Current Law /2.....	**$0**	**$0**	**$16**	**+$16**
Proposed Legislation				
Savings	0	0		0
Costs.....	0	0	10	+10
Subtotal, Proposed Legislation	**$0**	**$0**	**+$10**	**+$10**
Total Net Outlays, Proposed Law	**$0**	**$0**	**$26**	**+$26**

/1 The Ticket to Work and Work Incentives Improvement act was signed into law on December 17, 1999. However, the demonstration grants are not appropriated until FY 2001.

/2 Note that budget authority for this program is higher than the projected outlays. BA is as follows: FY 01, $62 million.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SUMMARY

The bi-partisan Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. This program makes an unprecedented investment in improving the quality of life for millions of uninsured children.

In 1998, there were an estimated 11 million children — one in seven — who were uninsured. The majority of these children live in families that earn too much to qualify for Medicaid, but not enough to purchase private insurance. The SCHIP program targets these children and helps them obtain health insurance.

IMPLEMENTATION STATUS

The number of States enrolling children under approved plans has grown since FY 1998. As of September 1999, SCHIP plans were approved for all 50 States, the District of Columbia, and five Territories. States have received approval for 24 Medicaid expansion programs, 15 separate programs, and 17 combination programs. As of January 2000, 37 State plan amendments received approval, and another 18 amendments are under review. With the exception of Hawaii, Washington, and Wyoming, as of the end of Fiscal Year 1999, 53 programs were in operation serving nearly two million children.

The scope of coverage under SCHIP is increasing. Many States initially adopted modest expansions of coverage under SCHIP, but since then proposed further expansions of coverage. By the end of Fiscal Year 1999, 30 States' SCHIP plans cover children in families with incomes up to 200 percent of the Federal poverty level. Of the 30, five States cover children in families with incomes up to 300 percent of poverty; one State covers up to 350 percent of poverty.

CHANGES TO SCHIP DUE TO THE BALANCED BUDGET REFINEMENT ACT OF 1999 (BBRA)

STABILIZED THE SCHIP ALLOTMENTS

BBRA included a new allotment formula to stabilize States' annual SCHIP allotments in four ways: 1) it bases the allotments more on the number of low-income children (below 200 percent of the FPL) rather than the number of uninsured children because the data for low-income children are more stable; 2) it sets floors so that allotments cannot decrease by more than 10 percent from States' previous years' allotments or decrease by more than 30 percent of the FY 1999 allotments; 3) it sets ceilings on allotments so no State's allotment can increase by more than 45 percent over a State's FY 1999 allotment, and 4) it uses data from the three most recent calendar years instead of the three most recent fiscal years. The new formula is effective for Fiscal Year 2000 allotments and beyond. Prior to this change, State allotments could fluctuate significantly from year to year.

ADDITIONAL BUDGET AUTHORITY FOR COMMONWEALTHS AND TERRITORIES

For the period from FY 2000 through FY 2007, Commonwealths and Territories receive a total of $249 million for their SCHIP programs. Prior to this change, Commonwealths and Territories received only 0.25 percent (about $11 million per year for 5 Territories) of each year's total annual SCHIP allotment.

IMPROVED DATA COLLECTION AND EVALUATION OF THE SCHIP PROGRAM

Also effective upon enactment of BBRA on November 29, 1999 are the following:

- Provides $10 million to the Department of Commerce (beginning in FY 2000) to increase the sample size of the Current Population Survey (CPS) to provide reliable state-level estimates of the number of uninsured children by income, age and race.

- Provides $10 million (in FY 2000, available through FY 2002) to the Secretary for a Federal evaluation of the SCHIP program using a sample of 10 States. This report is due to Congress on December 31, 2001.

- Directs the Inspector General to audit, and the GAO to report to Congress, every three years on State compliance with the requirement that SCHIP applicants that are found to be eligible for Medicaid are enrolled in Medicaid and progress made in reducing the number of uninsured.

- Requires that all data relating to children in SCHIP and Medicaid be coordinated with the data requirements in the Maternal and Child Health Block grant.

- Directs the Secretary, through the Assistant Secretary for Planning and Evaluation (ASPE) to establish a data clearinghouse on Federal health programs and children's health.

OUTREACH ACTIVITY

Outreach continues to be a priority to ensure that as many eligible children as possible are enrolled in SCHIP. The Administration is committed to providing leadership to sustain and enhance ongoing outreach efforts.

In a February 1998 Executive Memorandum, President Clinton directed 11 Federal departments and agencies to form an Interagency Taskforce on children's health outreach to develop ways to educate families and enroll children in both Medicaid and SCHIP. In October 1999, the Taskforce released its annual Interagency Report on children's health insurance outreach.

In February 1999, the Administration, along with the National Governors' Association, launched a nationwide children's health outreach initiative called the "Insure Kids Now" campaign, which includes radio spots to promote the national toll-free telephone number, posters, outreach kits, and a Fall back-to-school campaign.

In October 1999, at the annual meeting of the American Academy of Pediatrics, the President announced that over $9 million in private/public research funds will be dedicated to identifying effective children's health insurance strategies. He also charged Cabinet Secretaries to develop strategies to institutionalize school-based outreach, and to distribute a new guidance for States and schools on funding options for school-based outreach.

SCHIP PROPOSED RULE

The SCHIP Notice of Proposed Rulemaking (NPRM), published in the Federal Register on November 8, 1999, codifies the SCHIP guidance documents to the States. In developing the proposed rule, HCFA consulted with the States, Congressional staff, the National Governors' Association, and numerous advocacy groups.

The SCHIP NPRM contains strong patient protections such as access to health care specialists and access to emergency services when and where the need arises. The NPRM also addresses issues such as ensuring that children are enrolled in the program for which they are eligible, ensuring that cost-sharing be nominal, and requiring a

meaningful benefit package in States creating a separate SCHIP program. The comment period on the proposed rule closed on January 7, 2000. The Department is carefully reviewing comments and plans to issue the final rule this year.

LEGISLATIVE PROPOSALS

FAMILYCARE PROGRAM

The FamilyCare Program proposal builds on States' success in implementing their SCHIP programs by expanding the coverage for parents of children eligible for Medicaid and SCHIP. Research indicates that children are more likely to be enrolled in health insurance if their parents are also enrolled.

Under FamilyCare, States would receive an enhanced match for covering parents in the same program (either Medicaid or SCHIP) as their children. To be eligible for the enhanced matching rate for the costs of covering parents, States would have to cover children, up to age 19, up to 200 percent of the Federal poverty level without waiting lists, and initiate or expand coverage for low-income parents above eligibility levels in place as of January 1, 2000. States must cover lower-income parents before they cover parents with higher incomes.

In 2006, States are required to cover parents up to 100% FPL at an enhanced matching rate even if they have not expanded coverage for children up to 200 percent of the FPL. Also, States would get an enhanced match for all children in families with incomes above the mandatory Medicaid levels as well as for parents above 100 percent of the FPL.

FamilyCare would also permit States to pool allotments with employer contributions toward the purchase of private coverage. Families that are eligible for FamilyCare will be able to access their employer's health plan as long as that health plan meets FamilyCare standards, and the employer contributes at least half the premium cost.

To pay for the cost of covering parents, the SCHIP allotments would be increased beginning in FY 2002. An additional $50 billion in allotments would be made available over the next ten years. (See Medicaid section on related proposal.)

RESTORE SCHIP TO LEGAL IMMIGRANT CHILDREN AND PREGNANT WOMEN

The President's Budget would give States the option to insure legal immigrant children and pregnant women in Medicaid and SCHIP regardless of their date of entry. It would eliminate the current five-year ban, deeming, and affidavit of support provisions. The proposal would also require States to provide Medicaid coverage to disabled immigrants who would be made eligible for SSI by the FY 2001 budget's SSI restoration proposal. Parents of children who have benefits restored would be covered by the proposed FamilyCare Program. (See Medicaid section on related proposal.)

ALIGNING MEDICAID AND SCHIP ELIGIBILITY RULES

States would be required to make their Medicaid and SCHIP eligibility rules be equally simple. We encourage States to use this opportunity to simplify and streamline eligibility across both Medicaid and SCHIP programs. The proposal requires that both Medicaid and SCHIP eligibility rules conform in three areas: (1) the use of the same assets test; (2) simplifying eligibility requirements, such as using a mail-in application; and (3) conducting eligibility redeterminations no more frequently than once a year. (See Medicaid section on related proposal.)

EXPAND PRESUMPTIVE ELIGIBILITY OPTION

This proposal would expand the type of qualified entities that can determine children to be presumptively eligible for Medicaid and SCHIP. The additional presumptive eligibility sites could include schools, child

care centers, homeless shelters, agencies that determine eligibility for Medicaid, TANF, and SCHIP. (See Medicaid section for details on related proposal.)

MEDICAID AND SCHIP AGE EXPANSION

This proposal would give States the option to provide Medicaid to children aged 19 and 20 up to the same poverty-related income levels as they use for younger children. States that choose this Medicaid option would also be permitted to include children aged 19 and 20 in their SCHIP programs. (See Medicaid section on related proposal.)

SHARE SCHOOL LUNCH INFORMATION OPTION

This proposal would allow State Medicaid and SCHIP agencies to access eligibility information for children from the federally-funded free and reduced-price school lunch program unless their parents opt not to release the information. Confidentiality safeguards will ensure that the information obtained will not be used for any purpose other than outreach and enrollment in Medicaid and SCHIP. (See Medicaid section on related proposal.)

BACKGROUND

The State Children's Health Insurance Program (SCHIP) is a partnership between the Federal and State governments that will help provide children with the health coverage they need to grow up healthy. The Balanced Budget Act of 1997 created SCHIP under Title XXI of the Social Security Act. SCHIP was designed to reach children whose families have incomes too high to qualify for Medicaid but too low to afford private health insurance.

Title XXI appropriated almost $40 billion to the program over ten years, beginning in FY 1998 through FY 2007. States with an approved SCHIP plan are eligible to receive an enhanced Federal matching rate drawn from a capped allotment. States receive Federal reimbursement for expenditures under Title XXI based on the enhanced Medicaid matching rate which ranges from 65 to 85 percent.

States have a high degree of flexibility in designing their programs. They can implement SCHIP by: 1) expanding Medicaid, 2) creating a new, non-Medicaid Title XXI separate State program, or 3) a combination of both approaches.

Generally, uninsured children ages 0 to 18 years old in families at or below 200 percent of the Federal poverty level who are not eligible for Medicaid are eligible for SCHIP.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM OVERVIEW

(dollars in millions)

	FY 1999 Actual	FY 2000 Estimate	FY 2001 Estimate	Request +/- Enacted
Total Outlays, Current Law /1:	$565	$1,300	$1,905	+$605
Proposed Legislation:				
Total Cost to SCHIP.....	-	-	$212	+$212
Total Outlays /2 /3.....	$565	$1,300	$2,117	+$817

/1 Numbers may not add due to rounding
/2 The total outlays for SCHIP represent an estimate of program spending in separate SCHIP programs.
/3 Because States have the option to expand SCHIP coverage through expanding Medicaid, outlays for Medicaid expansion are not included in the outlay estimates and are part of the Title XIX account.

SCHIP PROPOSALS	**FY 2001**	**FY 01-05**
Coster Proposals		
FamilyCare Program	$200	$3,600
Restore SCHIP to immigrant children	$2	$25
Age expansion	$6	$35
Align Medicaid and SCHIP eligibility	$4	$49
School lunch initiative	$0	$6
TOTAL SCHIP	**$212**	**$3,715**

PROGRAM MANAGEMENT

SUMMARY

HCFA's FY 2001 Program management appropriation request is $2,086 million, a $93 million increase over the FY 2000 appropriation. This appropriation level does not include funding for the National Medicare Education Program (NMEP) or other current user fees.

The Budget also includes proposed user fees totaling $220 million. If enacted, the appropriation would be reduced by the amount of these user fees. To facilitate this process, the Administration has included "trigger" language in the Budget. If a fee is enacted, the appropriation would be reduced automatically by the amount of the new fees expected. If all the user fees are enacted, HCFA's budget authority request would be $1,866 million.

The Program Management account provides resources for administering the Medicare, Medicaid, and State Children's Health Insurance Program, as well as enforcing State insurance requirements. The Program Management account provides the staff and resources necessary to administer these programs, totaling $343 billion. HCFA implements statutory changes and coordinates the work of contractors, State agencies, and the provider and beneficiary communities to ensure the smooth operation of these programs. HCFA also safeguards the integrity of the Medicare Trust Funds and the General Fund.

While HCFA's core functions–e.g., modernizing Medicare, processing claims, etc. – are vital and continue to expand, HCFA's Program Management budget has not kept pace with workloads since FY 1994. In constant dollars, HCFA's FY 2000 appropriation remains below FY 1994 spending levels. This has required HCFA to find more cost effective methods to accomplish its mission and goals as established in its strategic plan. This has been especially difficult since the responsibilities of the agency were greatly expanded in that same time period. Because of the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Balanced Budget Act of 1997 (BBA), and the Balanced Budget Refinement Act of 1999 (BBRA), HCFA now has the responsibility to implement a number of new programs. These programs include the State Children's Health Insurance Program, new managed care options, enforcement of State insurance requirements under HIPAA as well as a number of demonstrations, studies, and systems changes. In the FY 2000 appropriation, Congress provided HCFA its total requested level of Program Management funding as amended. These additional resources have facilitated improved program management.

NURSING HOME QUALITY INITIATIVE

The Department's FY 2001 budget includes a total of $70.8 million in discretionary and mandatory resources to implement the President's Nursing Home Initiative announced in July 1998, including money for HCFA, the Office of the General Counsel, and Departmental Appeals Board.

Since launching the Initiative over a year ago, HCFA has made significant progress in implementing stronger enforcement policies. For instance: States must impose immediate sanctions on nursing homes found to have caused actual harm to a resident on two consecutive surveys; surveyors are required to investigate all complaints alleging actual harm to a resident within ten days; States stagger the start times of their annual surveys, with at least 10 percent begun on weekends or off hours; States more frequently inspect nursing homes with repeated serious violations; and new

inspection protocols allow surveyors to better detect and prevent bedsores, malnutrition, and resident abuse. The FY 2001 request will allow HCFA and other components of the Department to expand implementation of this important Presidential Initiative.

The majority of the $70.8 million for the initiative -- $57.3 million -- resides in HCFA's budget request. This includes $37.8 million in discretionary program management funds to: strengthen State surveyor inspection and enforcement efforts; expedite investigations of resident complaints; improve Federal oversight of State surveyor efforts; and conduct demonstrations on methods to move residents from nursing homes to community-based services.

HCFA's budget also includes $19.5 million in mandatory resources. About $15.9 million in Medicaid matching funds will supplement State inspection and enforcement activities in dually-certified and Medicaid-only nursing homes. The other $3.6 million is Peer Review Organization funding that will be used to maintain and upgrade the Nursing Home Compare website and continue national education campaigns to prevent abuse, neglect, and malnutrition in nursing homes.

The remaining $13.5 million will ensure adequate legal resources for the Office of the General Counsel and Departmental Appeals Board to provide judicial hearings and administrative and court litigation in a timely manner, and reduce the backlog of appeals resulting from stronger enforcement actions being taken under the Initiative.

As part of the Initiative, the Administration also plans to submit legislation to Congress requiring nursing homes to query the nursing home criminal abuse registry and conduct criminal background checks on new employees to determine whether nursing home workers have a history of abusing residents. The costs for these activities will be financed through user fees. The President's budget projects that HHS will collect $4.3 million in fees to query the abuse registry, and that the Department of Justice and States will collect $41.1 million in fees to conduct criminal background checks.

NURSING HOME INITIATIVE	**FY 2001**
Funding Source	*millions*
HCFA:	
Discretionary	
Medicare Survey and Certification	29.7
Federal Administration	6.1
Research	2.0
Mandatory	
Medicaid Survey and Certification	15.9
Peer Review Organizations	3.6
Subtotal, HCFA	$57.3
Departmental Management:	
Discretionary	
Office of the General Counsel	9.0
Departmental Appeals Board	4.5
Subtotal, Departmental Managemen	$13.5
Total, Nursing Home Initiative	**$70.8**

HCFA's Medicare Contractor Oversight Initiative

HCFA, in cooperation with the Department and the Department's Office of the Inspector General (OIG), has begun improving oversight of its Medicare contractors responsible for claims processing, beneficiary and provider services, and program integrity. This initiative follows upon recent OIG and General Accounting Organization reports on contractor practices and the lack of sufficient oversight.

This Initiative will be comprehensive, encompassing program operations, financial management, monitoring of electronic data processing, and establishing an integrated general ledger for all contractor transactions.

The FY 2001 request includes funding for external reviews of key program areas, the development of a new management information system, new evaluation

protocols, and additional staff to perform financial management oversight functions. In addition, this request adds staff to contractors that will establish the internal control environment, identify control objectives, determine the relevant risks in achieving those objectives, and report reliable information to HCFA.

IMPLEMENTING THE BALANCED BUDGET ACT OF 1997 (BBA) AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HCFA has fully implemented 70 percent of the 335 individual BBA provisions affecting HCFA programs and made substantial progress on many of the remaining provisions. With Y2K compliance no longer a concern, HCFA will resume work on the remaining BBA provisions as well as the new provisions of the Balanced Budget Refinement Act of 1999 (BBRA).

In FY 2001, HCFA will continue to work on the development and implementation of new payment methods, including prospective payment for home health agencies, inpatient rehabilitation facilities, and outpatient hospital care, and risk adjustment for Medicare+Choice plans. HCFA will also launch the new competitive bidding demonstration for durable medical equipment. The President's budget also includes a request to increase the authorization of the Medicare+Choice information campaign to $150 million. HCFA's plans to educate beneficiaries about their choices through the national distribution of the 2000 *Medicare and You* handbook, the *www.medicare.gov* website, State Health Insurance Assistance Program (SHIP) activities, and Local health information fairs to assist beneficiaries during the open enrollment season.

HCFA will also implement a number of HIPAA activities in FY 2001. HCFA will continue its work in developing industry-wide standards for certain administrative and financial health care transactions outlined in HIPAA's administrative simplification provisions. HCFA is also charged with overseeing and, in cases where States do not implement insurance protections, enforcing insurance reform provisions. The FY 2001 request provides funding for these activities.

INFORMATION TECHNOLOGY

HCFA has developed a new architecture for its information technology needs and a capital assets plan to guide its systems formation.

Meanwhile, HCFA must maintain its information technology capabilities in FY 2001 to support BBA and HIPAA activities. The agency must improve system security, continue to redesign its managed care system to support the new Medicare+Choice program, and collect encounter data from managed care plans as required by the BBA.

MEDICARE CONTRACTORS

The Medicare Contractor program level budget will increase $57 million, from $1,244 million in FY 2000 to $1,301.3 million in FY 2001. By law, the Medicare program is administered through private organizations. Responsibilities of these contractors include: processing claims and making benefit payments, performing certain functions to ensure the appropriateness of Medicare payments and to protect the Medicare Trust Funds, developing management improvements called productivity investments, and responding to the needs of its many customers and stakeholders, Medicare beneficiaries, and the provider community.

The FY 2001 contractor budget also proposes $136 million in user fees allowing the Secretary to: assess a $1 fee on any claim not submitted electronically, assess a fee for duplicate or unprocessable claims submitted by providers, and charge providers and suppliers a fee to cover the costs of

initially enrolling and renewing enrollment in the Medicare program.

Approximately 62 percent of the FY 2001 contractor program level request, or $812 million, has been designated for claims processing, an 0.4 percent increase over FY 2000. From 1995 through FY 1998, HCFA's success in controlling processing costs has resulted in reduced unit costs of processing claims. HCFA expects unit cost rates to increase slightly in FY 2001 as the factors that were responsible for past year efficiencies, such as use of electronic claims and consolidating claims processing systems, reach optimal levels. HCFA expects that its claims processing workload will increase 3.5 percent in FY 2001, from 887.7 million claims in FY 2000 to 918.4 claims in FY 2001. The slower than usual growth in Medicare fee-for-service claims is attributable to beneficiaries taking advantage of Medicare + Choice options offered under BBA. HCFA anticipates that increased managed care enrollment will continue to slow the growth in claims and billings.

Beneficiary and provider services comprise 23 percent of the Medicare Contractors FY 2001 program level request, or $300 million, the same level as the FY 2000 appropriation. The fee-for-service portion of the National Medicare Education Program is funded from this allotment. The FY 2001 amount includes no funding for the one-time Long-Term Care national education campaign funded in FY 2000. However, this amount will maintain funding for the Medicare beneficiary toll-free telephone lines, timely hearings and reconsiderations, prompt responses to provider and beneficiary inquiries, provider education and training, and Medicare participating physicians activities. HCFA will continue its innovative use of audio response units (ARUs) for telephone inquiries, as well as continuing its use of the telephone to conduct hearing reviews and reconsiderations. These activities reduce program administrative costs while providing better customer service. Increased activity in the area of fraud and abuse is expected to increase beneficiary communications and hearings and appeals activity.

The budget request allocates $149 million for productivity investments. Productivity investments enhance the cost-effectiveness and quality of contractor operations and are part of the long-term reform of Medicare administration. Productivity investment costs include expanding the new customer-oriented toll-free telephone system, greater standardization of contractor systems, and redesigning the managed care processing system. In FY 2001, HCFA will resume moving its remaining contractors to one of its three standard claims processing systems. Work on migrating contractors to the standard systems for Part A, Part B and durable medical equipment was suspended while the agency proceeded with the important work of making all Medicare systems millennium compliant.

FEDERAL ADMINISTRATION

For FY 2001, the President's budget requests $495.9 million for HCFA's Federal administrative costs. This is an increase of $13 million over the FY 2000 budget. This direct appropriation request supports a staffing level of 4,353 FTE, an increase of 120 FTE over FY 2000 levels, the new FTE are needed to continue the President’s Nursing Home Quality Initiative and strengthen oversight of Medicare contractors. It also supports the extensive data processing requirements for the Medicare and Medicaid programs, as well as necessary maintenance and enhancement of HCFA’s many automated data systems.

Also included in the FY 2001 budget is legislation authorizing the Secretary to collect initial registration and annual renewal fees from Medicare+Choice managed care plans. These fees are estimated to generate revenues of $36.7 million to finance new responsibilities under HIPAA, BBA, and BBRA.

For instance, an increasing number of States have chosen not to perform all or part of their HIPAA insurance enforcement duties. Under HIPAA, HCFA is responsible for performing these duties on behalf of the States within its discretionary administrative budget. Similarly, Federal Administration dollars must fund new BBA and BBRA activities such as reviewing new managed care plans under Medicare+Choice as well as administering the Children's Health Insurance Program.

The President's budget also includes $6.1 million in resources for the Nursing Home Quality Initiative to strengthen Federal oversight and training of State surveyors.

RESEARCH, DEMONSTRATIONS AND EVALUATION

The FY 2001 budget requests $55.0 million for the Research, Demonstrations and Evaluation program, which is $6.8 million less than the level enacted in FY 2000. HCFA's research program supports research and demonstration projects to develop and implement new health care financing policies and to evaluate the impact of HCFA's programs on its beneficiaries, providers, States, other customers and partners. Information from HCFA's research program is used by Congress, the Executive Branch, and States to improve the efficiency, quality, and effectiveness of the Medicare, Medicaid, and SCHIP programs.

Basic research funds will also be used to conduct evaluations of the Medicare+Choice Program, the SCHIP Program, Medicaid State Reform, and the Beneficiary Information Campaign. The Nursing Home Transition Grant Program, a major departmental initiative to move people out of nursing homes and into community-based alternatives, will be implemented and evaluated. Additionally, HCFA is planning projects in the areas of Mental Health and Asthma as part of wider departmental initiatives.

In addition to basic research, this budget funds the Medicare Current Beneficiary Survey, which continues to be a critical source of data on health care usage and health status of Medicare beneficiaries.

SURVEY AND CERTIFICATION

Ensuring the safety and quality of care provided by health facilities is one of HCFA's most critical responsibilities. HCFA contracts with State agencies to inspect health facilities providing services to Medicare and Medicaid beneficiaries and ensure compliance with Federal health, safety, and program standards.

HCFA's FY 2001 budget proposes $234 million to fund its survey and certification activities, a 14.4 percent increase over the FY 2000 appropriated level. Included in this total is $29.7 million to continue implementing activities associated with the President's Nursing Home Initiative, such as: imposing immediate sanctions on nursing homes found guilty of a second offense that causes actual harm to residents; conducting more frequent inspections of nursing homes with repeat violations; and conducting more focused reviews of a nursing home's efforts to prevent bed sores, dehydration, and malnutrition. HCFA will also invest more money to expedite investigation of resident complaints within the ten-day time frame announced last March.

The FY 2001 budget also proposes two survey and certification user fees totaling $63 million. Under these proposals, the Secretary or States would be allowed to charge user fees to cover the full cost of facilities' initial surveys ($13 million) and 33 percent of the costs for recertification surveys ($50 million) in FY 2001. The latter proposal will eventually result in 100 percent user fee recovery by FY 2003.

Another $182.3 million of the total survey and certification request will fund direct survey activities, such as: annual inspections of nursing homes, surveys of home health agencies once every two years,

and a 15 percent recertification cycle for other non-long-term care facilities (e.g., hospices, rural health clinics, and ambulatory surgical centers). In addition, this funding level will allow HCFA to decrease the survey intervals for ESRD facilities and non-accredited hospitals from once every six to once every three years.

The remaining $22.1 million in the FY 2001 survey and certification request will fund base support contract activities, most notably: operation of the Quality Improvement and Evaluation System (QIES), which contains quality outcome data that surveyors can use to better target on-site inspections of poor performing providers; enhancements to the OSCAR data system, which contains information on nursing home survey results and outcomes; improved Federal and State surveyor training; and support services for surveying psychiatric hospitals.

The FY 2001 budget also proposes to achieve a savings of $10 million in survey costs by basing spending projections on price rather than cost. For the first time, survey and certification budget estimates are estimated from a "bottom up" approach based on actual State-expenditures versus a "top down" approach that uses a national spending target distributed among States. This movement toward a price-based budget methodology will allow HCFA to begin reducing variations in State survey unit costs and holding States more accountable to stronger price and performance measures.

Finally, to help finance HCFA's survey and certification activities, the FY 2001 budget proposes two survey and certification user fees totaling $63 million. Under these proposals, the Secretary or States would be allowed to charge user fees to cover the full cost of facilities' initial surveys ($13 million) and 33 percent of the costs for recertification surveys ($50 million) in FY 2001. The latter proposal will eventually result in 100 percent user fee recovery by FY 2003.

NATIONAL MEDICARE EDUCATION PROGRAM

In the 2001 budget, HCFA will continue to fund activities that will help beneficiaries understand and assess their options under the Medicare program, including Medicare+Choice.

The National Medicare Education Program (NMEP) will fund activities to inform beneficiaries of their options–including traditional Medicare, HMOs, and PPO–and provide complete and comprehensible information about these options to facilitate their decision-making process. The President's budget provides up to $150 million in user fees, subject to annual appropriations, to improve and expand NMEP activities related to Medicare+Choice.

In FY 2001, the NMEP will fund the following activities: mailings to beneficiaries with general information about Medicare, plus specific information on plans available in their area; a toll-free telephone service staffed by customer service representatives able to provide information on available plans; *medicare.gov*, the user-friendly internet site that provides comparative information on plans by zip code; as well as other initiatives involving State and Local entities.

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

The Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes. CLIA '88 also introduced user fees for clinical laboratories to finance survey and certification activities. User fees are credited to the Program Management account but are available until expended for CLIA activities. Effective January 31, 2000 the process of CLIA test categorization will

transfer from CDC to FDA. The transfer will allow laboratory device manufacturers to only submit applications to one agency for both approval and categorization.

The CLIA program is fully operational, with about 171,000 laboratories registered with HCFA; about 26 percent of the laboratories are subject to routine inspection (every 2 years) under the program. Workloads for each inspection period include a 3 percent sample review of the 17,400 accredited laboratories, and surveys of 26,000 non-accredited laboratories.

LEGISLATION SUPPORTING THE DISCRETIONARY BUDGET

The President's FY 2001 Budget includes a number user fee proposals, as well as a contracting reform package to assist HCFA in becoming a more efficient and cost effective organization.

PAPER CLAIM USER FEE:

Allows the Secretary to assess a $1 fee on any claim not submitted electronically. This fee could be waived at the discretion of the Secretary due to compelling circumstances ($83 million).

DUPLICATE CLAIM USER FEE:

Allows the Secretary to assess a fee for duplicate or unprocessable claims submitted by providers ($53 million).

MEDICARE+CHOICE ORGANIZATION USER FEE:

Authorizes the Secretary to collect fees from Medicare+Choice managed care plans to cover the costs associated with initial registrations and annual renewals to the Medicare program ($21 million).

SURVEY AND CERTIFICATION USER FEES:

Authorizes the Secretary to impose or require the State to impose a user fee for initial certification surveys and for recertification surveys. The initial survey user fee will cover the total cost of the survey, starting in FY 2001 ($13 million). The recertification survey fee will only cover 33 percent of costs in FY 2001, but will increase to cover 66 percent of costs in FY 2002, and 100 percent of costs by FY 2003 ($50 million).

MEDICARE+CHOICE USER FEE:

Authorizes the Secretary to assess up to $150 million in user fees on Medicare managed care organizations for the operation of the Medicare+Choice Information Campaign, a part of the National Medicare Education Program (NMEP). The BBRA lowered the user fee from up to $100 million to $19 million in FY 2001 based on a formula in statute. At the $19 million level, operation of the NMEP would effectively cease.

CONTRACTING REFORM:

Key provisions of the President's Medicare reform plan give the Secretary of Health and Human Services increased flexibility in contracting for claims processing, payment, and other Medicare intermediary and carrier functions. The provisions bring Medicare contracting authority into closer alignment with the general government contracting rules contained in the Federal Acquisition Regulation (FAR), while preserving certain essential flexibility in the awarding and renewal of contracts currently available to the Secretary under Medicare law.

PROVIDER RE-ENROLLMENT TO THE MEDICARE INTEGRITY PROGRAM (MIP)

Shifts this activity and the overpayment collection function from the Program Management discretionary budget to the mandatory budget MIP account. As an eligible function under MIP, these fraud-

related activities will enjoy a stable funding source. The Program Management funding used for this purpose will fund additional contractor FTEs that will establish and implement financial management controls under the Administration's Medicare contractor oversight initiative.

NURSING HOME INITIATIVE:

As part of the Initiative, the Administration proposes requiring nursing homes to query the nursing home criminal abuse registry and conduct criminal background checks on new employees. The costs for these activities will be financed through user fees. The President's budget projects that HHS will collect $4.3 million in fees to query the abuse registry, and that the Department of Justice and States will collect $41.1 million in fees to conduct criminal background checks. The legislation will also allow more trained nursing home employees to help feed residents at meal times.

MANDATORY LEGISLATIVE PROPOSALS

CANCER CLINICAL TRIALS

In addition, the Administration is proposing new mandatory legislation permitting payment for the care of beneficiaries participating in cancer clinical trials as part of a three-year demonstration.

This demonstration will provide information on the cost of coverage of the cancer clinical trials while affording access to cutting edge experimental treatment. Beginning in FY 2001, $750 million (over three years) would be provided for this demonstration.

PROGRAM MANAGEMENT OVERVIEW

Program Management -- discretionary
(dollars in millions)

	FY 1999 Approp.	FY 2000 Enacted	FY 2001 Request	Request +/- Enacted
Medicare Contractors	$1,265	$1,244	$1,301	$57
Survey and Certification	175	205	234	29
Federal Administration	455	483	496	13
Research	50	62	55	(7)
HCFA Discretionary Budget Authority	**$1,945**	**$1,993**	**$2,086**	**$93**
CLIA	43	43	43	-
Nursing Home Registry	-	-	4	4
Sale of Data/FQHMO applications	2	2	2	-
Medicare + Choice Information	95	95	100	5
Subtotal	**2,085**	**2,133**	**2,235**	**102**
Medicare + Choice Information Proposed Increase	-	-	50	50
Medicare + Choice Information Proposed User Fee	-	-	-50	-50
CLIA User Fees -- Current Law	-43	-43	-43	0
Nursing Home Registry User Fee	-	-	-4	-4
Sale of Data/FQHMO applications -- Current Law	-2	-2	-2	-
Managed Care User Fees -- Current Law	-95	-95	-100	-5
Proposed User Fees	0	0	-220	-220
Proposed BA (including New User Fees)	**$1,945**	**$1,993**	**$1,866**	**-127**
Proposed Outlays	**$1,945**	**$1,993**	**$1,866**	**-$127**
FTE /1	4,219	4,363	4,435	72

/1 In FY 2000, 50 employees are being paid out of the $150 million for the Y2K compliance effort funded out of the Public Health and Social Services Emergency Fund (PHSSEF).

Program Management -- Mandatory

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Clinical Trials	0	0	250	+250
Total	**$0**	**$0**	**$250**	**+$250**

(obligations in millions /1)

HCFA SUMMARY

(dollars in millions) /1

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Current Law:				
Medicare Trust Fund	$211,855	$224,138	$244,626	+20,488
Medicaid	108,042	116,117	124,175	+8,058
SCHIP	565	1,300	1,905	+605
State Grants and Demonstrations	0	0	16	+16
Total Outlays, Current Law	**+$320,462**	**+$341,555**	**+$370,723**	**+29,168**
Premiums	-$21,561	-$21,735	-$23,340	-1,605
Total Net Outlays, Current Law	**+$298,901**	**+$319,820**	**+$347,383**	**+$27,563**
Proposed Law:				
Medicare	$0	$0	-$690	-$690
Medicaid	0	0	663	+663
Program Management	0	0	250	
SCHIP	0	0	212	+212
State Grants and Demonstrations	0	0	10	+10
User Fees	0	0	-220	-220
Total	0	0	225	+225
Total Net Outlays, Proposed Law /2	**$298,901**	**$319,820**	**$347,607**	**$27,787**

/1 Numbers may not add due to rounding

/2 Total net outlays equal current law outlays minus the impact of proposed legislation

ADMINISTRATION FOR CHILDREN AND FAMILIES

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Discretionary Program Level	$9,022	$9,874	$11,668	+$1,794
Entitlement Program Level	29,667	27,895	31,275	3,380
Total, ACF Program Level	$38,689	$37,769	$42,943	+$5,174
FTE	1,509	1,500	1,560	+60

SUMMARY

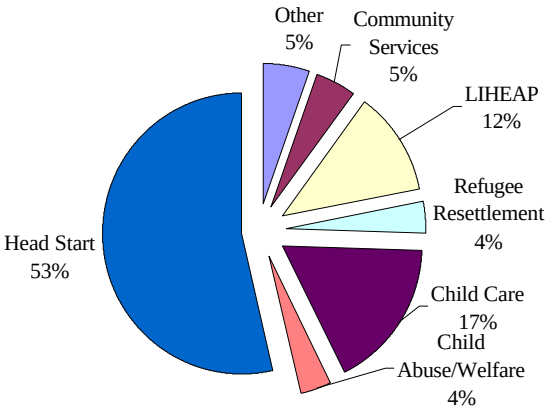
The FY 2001 budget request for the Administration for Children and Families (ACF) totals $42.9 billion, an increase of $5.2 billion, or 14 percent, over FY 2000. Of these funds, $11.7 billion is discretionary program level and $31.3 billion is entitlement budget authority.

The Administration for Children and Families is the Department's lead agency for programs that promote the economic and social well-being of families, children, individuals, and communities. Its programs, including Head Start, child care, child support, family violence, foster care and adoption, and Temporary Assistance for Needy Families (TANF), are at the heart of the Federal effort to strengthen families and give all children a chance to succeed.

DISCRETIONARY PROGRAM SUMMARY

The FY 2001 discretionary budget request for the Administration for Children and Families (ACF) is $11.7 billion, an increase of $1.8 billion, or 18 percent, over FY 2000.

FY 2001 Discretionary Funding $11.7 billion



HEAD START

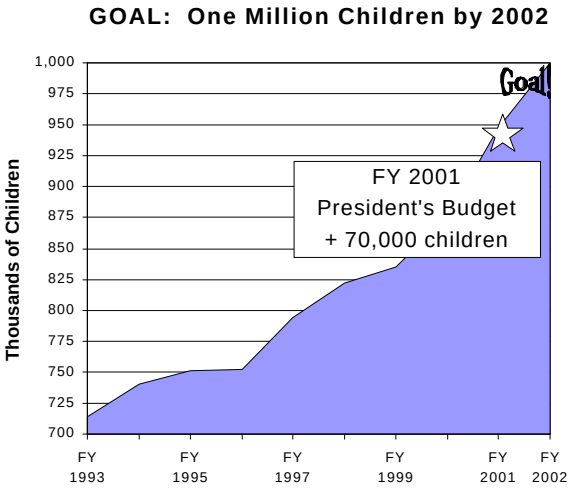
The President's Budget request includes $6.3 billion for Head Start, a 19 percent increase over the FY 2000 appropriation. This $1 billion increase will provide Head Start services to over 70,000 additional children, bringing total enrollment to nearly 950,000 -- well on the way to reaching the President's goal of enrolling one million children by 2002.

Reaching the President's Goal of One Million Children by 2002.

In addition, a significant share of the FY 2001 funds available for expansion will

be reserved for grantees to address unserved and underserved populations, including recent immigrants and limited English proficient (LEP) populations. Programs serving migrant and seasonal farmworkers will receive their full share of cost-of-living and quality improvement funds as well as additional expansion funds.

Research findings continue to support the importance of Head Start in the lives of low-income children. Preliminary findings from the Head Start Family and Child Experiences Survey (FACES) reveal that Head Start classroom quality is good, and that Head Start children show growth in vocabulary, math and social skills over the Head Start year. Further research is planned to explore the impact of Head Start. Last year, an advisory panel was convened to provide recommendations; a contract will be awarded this year.



QUALITY HEAD START SERVICES

As America's premier early childhood education program, Head Start ensures that low-income children start school ready to learn. Since 1993, Head Start enrollment has increased by 23 percent. The FY 2001 request reflects not only a commitment to increasing Head Start enrollment, but also a dedication to continued improvements in program quality. The 1998 reauthorization act calls for dedicating 47.5 percent of the increase requested this year, or $418 million, to support activities aimed at reducing class size, improving classroom facilities, enhancing staff training, improving school readiness, obtaining safer and better equipment, and attracting and retaining well-trained staff members.

EARLY HEAD START

In 1995, Early Head Start was established to serve children ages zero to three in recognition that the earliest years are critical to children's growth and development. In FY 2001, funding for Early Head Start will be $564 million, or 9 percent of the total Head Start appropriation. With these funds, 54,000 children ages zero to three and their families will receive early, continuous, intensive and comprehensive child development and family support services. The FY 2001 request supports an increase of 10,000 children.

CHILD CARE

A recent report, “Access to Child Care for Low-Income Working Families,” found that only 10 percent of the 14.7 million children eligible for child care subsidies under Federal guidelines receive them. Reliable, high-quality child care is essential both to parents' continued employment and to children's health and intellectual development. Recognizing the need to increase the availability and quality of affordable child care, the FY 2001 budget includes $2 billion for the discretionary Child Care and Development Block Grant (CCDBG), an increase of $817 million. With the funds requested, nearly 150,000 additional children will receive child care subsidies, significantly expanding access to high-quality child care.

The aforementioned report on access to child care found that a family of three with an income of $15,000 would pay between 24 percent and 45 percent of their income on

child care without assistance. If this same family received a CCDBG-funded child care subsidy, they would only need to spend between 1 percent and 7 percent of their income on child care. Clearly, for parents struggling to leave welfare or to stay off of welfare, child care subsidies can be critical to their ability to make ends meet.

IMPROVING QUALITY

Research shows that quality child care programs have a positive effect on children's cognitive performance, language development, social adjustment, and overall behavior. The funds requested for FY 2001 will support continuing improvements in child care quality. The President's Budget dedicates $223 million to improve the quality of child care. These funds are in addition to the amounts States are currently required to spend. Also included is $19 million to support school-age child care and resource and referral activities.

The President's Budget also includes $600 million in mandatory funds to establish a new Early Learning Fund. The Early Learning Fund is a critical investment in our youngest and most vulnerable children. More on this initiative can be found in the ACF entitlement section.

STRENGTHENING RESEARCH

In FY 2000, ACF funded $10 million of new child care research, demonstration and evaluation activities. Included in the request is $10 million to continue these research efforts in FY 2001. With these funds, ACF will continue to develop the capacity for ongoing research and data collection, partner with States to strengthen the capacity for cross-cutting research on issues affecting welfare recipients and low-income working families, and encourage field-initiated research on child care.

RUNAWAY AND HOMELESS YOUTH

The budget includes a request of $74 million, an increase of $10 million. As part of the Departmental Mental Health Initiative, these funds will support centers and State collaboration efforts to provide earlier mental health-oriented services to youth at-risk of becoming runaways and/or homeless. Currently, there are over 350 centers across the country being supported through this grant program.

FAMILY VIOLENCE

As part of the Department's violence against women initiative, the budget includes $134 million, an increase of $16 million, for Family Violence programs. These funds will enhance the services provided to women and their families.

Of the amount requested, $117 million is for the Grants for Battered Women's Shelters program, an increase of $16 million. These grants help States and Tribes provide immediate shelter and related services to victims of abuse and their dependents as well as domestic violence awareness activities. The requested funding increase will be used to expand services, particularly to underserved populations.

These funds will also be used to increase support for the National Domestic Violence Hotline, for which $2 million is requested. In addition, a total of $15 million is included for the Sexual Abuse Prevention for Runaway, Homeless and Street Youth program.

NATIVE AMERICAN PROGRAMS

The budget includes a request of $44 million for the programs of the Administration for Native Americans, an increase of $9 million, or 25 percent over FY 2000. This proposed increase reflects the interests and concerns expressed to the Department during Tribal budget consultations.

Funds are awarded competitively, primarily for Social and Economic Development Strategies grants, which lead to self-sufficiency for individuals, Tribes and Native American communities. Grants are also provided for Native Language preservation and the development of tribal environmental regulations. In awarding grants, special attention will be given to energy development and creation of tribal codes and ordinances.

COMMUNITY SERVICES PROGRAMS

The budget provides $540 million for Community Services programs, a decrease of $53 million.

COMMUNITY SERVICES BLOCK GRANT

The Community Services Block Grant program provides States, territories, and Indian tribes with a flexible source of funding to help reduce poverty, including services to address employment, education, housing assistance, energy and health services. In FY 2001, $510 million is requested for the Block Grant.

INDIVIDUAL DEVELOPMENT ACCOUNTS (IDAS)

FY 1999 was the first year of funding for a new program to empower low-income individuals to save for a home, post-secondary education, or a new business. In FY 1999, over 10,000 individuals had the opportunity to open IDAs as a result of these funds.

The President's Budget includes $25 million for IDAs, more than doubling the size of the program. These funds will support 110 non-profit organizations administering IDA demonstrations, serving an additional 20,500 low-income individuals.

JOB OPPORTUNITIES FOR LOW-INCOME INDIVIDUALS PROGRAM (JOLI)

The budget also includes a request of $5 million for the Job Opportunities for Low-Income (JOLI) program. The JOLI program provides vital support to help low-income families, including many leaving TANF, to succeed and advance at work. Funds are used to help revitalize low-income communities and to create job opportunities for poor families, and are critical in linking organizations engaged in community development to the welfare reform and working families agenda.

OTHER COMMUNITY SERVICES PROGRAMS

The budget does not fund the Community Economic Development, Rural Community Facilities, Neighborhood Innovative Projects, National Youth Sports or Community Food and Nutrition programs.

DEVELOPMENTAL DISABILITIES

The Developmental Disabilities program helps States to ensure that all persons with developmental disabilities are able to access services for enhanced independence, productivity, integration, and inclusion in the community. The FY 2001 request for Developmental Disabilities is $122 million, the same level as in FY 2000.

CHILD WELFARE/CHILD ABUSE

In FY 2001, the budget request of $411 million provides for a range of programs that help States and local communities protect children by strengthening families and preventing abuse.

In addition, $42 million will be directed to Adoption Incentives. The Adoption Incentives program was one of the innovative approaches to increasing adoptions advanced in the President's "Adoption 2002 Initiative." These funds are

used to pay States bonuses for increasing their number of adoptions. States have been extremely successful at doing so, increasing the number of adoptions from 31,000 in 1997 to 36,000 in 1998, the first year used to determine States' bonuses.

SOCIAL SERVICES RESEARCH

The FY 2001 budget includes a total of $28 million for social services research, of which $7 million is discretionary funding. Research and evaluation efforts will continue to focus on moving families from welfare to work, promoting responsible parenthood and fostering child well-being. The results of this research provide credible information about welfare reform strategies and family and child well-being. Of the funds requested, $21 million is mandatory funding made available by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

The budget request for LIHEAP is $1.1 billion. The budget also requests $300 million in emergency contingency funds to meet energy-related needs due to a natural disaster, extreme weather or other emergency.

LIHEAP provides heating and cooling benefits to approximately 4 million households each year. Of the recipient households, approximately 35 percent include an elderly member, 28 percent include a person with a disability, 48 percent include a child under age eighteen, and 24 percent of recipients do not receive any public assistance at all. Many beneficiaries are working low-income families who are unable to meet their heating/cooling costs.

REFUGEE AND ENTRANT ASSISTANCE

The budget request for the Refugee and Entrant Assistance program in FY 2001 is $432 million. This request will provide eight months of benefits for an estimated 80,000 refugees and 20,000 Cuban/Haitian entrants. Of the funds requested, ACF will allocate $225 million to Transitional and Medical Services, $143 million to Social Services, $50 million to Targeted Assistance and $5 million to Preventive Health. The budget also includes $10 million to fund the domestic treatment activities authorized by the Torture Victims Relief Act.

In addition, the budget proposes to broaden the purposes of the emergency fund appropriated in FY 1999 to ensure that ACF can respond to future emergency refugee situations.

FEDERAL ADMINISTRATION

The Federal Administration request is $165 million, an increase of $17 million. The requested increase would provide funds for approximately 1,560 full-time-equivalent staff – an increase of 60 over FY 2000 – in such key areas as child welfare monitoring, tribal TANF, tribal child support enforcement, Head Start and child care.

ACF OVERVIEW: DISCRETIONARY SPENDING

(dollars in millions)

DISCRETIONARY PROGRAMS:	1999 Actual	2000 Enacted	2001 Request	Request +/-Enacted
Head Start /1 /2	$4,658	$5,267	$6,267	+$1,000
Child Care & Development Block Grant /1 /3	1,000	1,183	2,000	+817
Runaway and Homeless Youth	59	64	74	+10
Violence Against Women	105	118	134	+16
Native Americans	35	35	44	+9
Community Services Block Grant	500	528	510	-18
Individual Development Accounts	10	10	25	+15
JOLI	5	5	5	0
Discretionary Programs	47	50	0	-50
Subtotal, Community Services	$562	$593	$540	-$53
Developmental Disabilities	119	122	122	0
Child Abuse/Welfare	404	411	411	0
Adoption Incentives	20	42	42	0
Social Services Research	27	28	7	-21
Pre-Appropriated Research/Evaluation	0	0	21	+21
Subtotal, Social Services Research	$27	$28	$28	$0
LIHEAP Regular Funding /1	1,100	1,100	1,100	0
Contingency Fund	300	300	300	0
Subtotal, LIHEAP	$1,400	$1,400	$1,400	0
Refugee and Entrant Assistance	481	454	432	-22
Refugee Carryover Balance (non-add)	*66*	*28*	*0*	*0*
Federal Administration	144	148	165	+17
Pre-Appropriated Federal Administration /4	8	9	9	0
Subtotal, Federal Administration	$152	$157	$174	+$17
Total, Program Level	**$9,022**	**$9,874**	**$11,668**	**+$1,794**
Less Funds Allocated from Other Sources:				
Head Start Advance Appropriation (net)	0	1,400	0	0
Pre-Appropriated Research/Evaluation	0	0	21	+21
Pre-Appropriated Federal Administration /4	8	9	9	0
Total, Discretionary Budget Authority	**$9,014**	**$8,465**	**$11,638**	**+$3,173**
FTE	1,509	1,500	1,560	60

/1 P.L. 106-113 (FY 2000 appropriation) provides advanced FY 2001 funding.

/2 FY 2001 and FY 2002 funding levels include $1.4 billion advance appropriation for subsequent year.

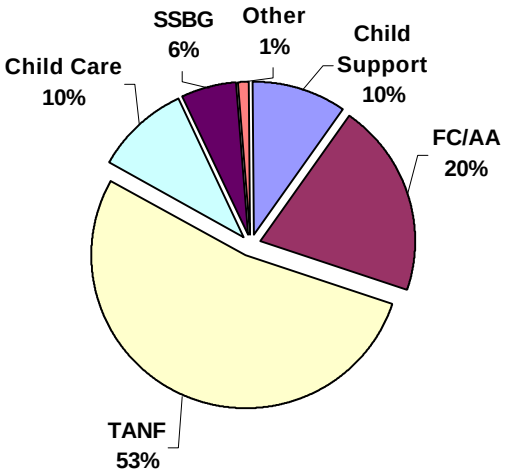
/3 The budget includes +$817 million for FY 2001 and an advance appropriation of $2 billion for FY 2002.

/4 1%-2% funds (Public Law 104-193)

ENTITLEMENT PROGRAM SUMMARY

SUMMARY

The Department's FY 2001 ACF Budget includes $31 billion in outlays for entitlement programs. This total includes pre-appropriated funding for the Temporary Assistance for Needy Families (TANF) program and the Child Care Entitlement to States. The ACF entitlement budget also requests funding for increases in Child Care, Child Support Enforcement, Foster Care, Adoption Assistance, and Independent Living, and Promoting Safe and Stable Families. The figure below illustrates the distribution of entitlement funds across various ACF programs, including legislative proposals. The Other category includes Promoting Safe and Stable Families, Repatriation, and Children's Research and Technical Assistance.



In FY 2001, ACF continues its efforts at moving families from welfare to self-sufficiency. Important initiatives will expand child care and improve child support and child welfare efforts. The Child Care Initiative will help to support working families by improving the quality of early learning programs and making child care more affordable and accessible. New Child Support legislation will increase payments to families by streamlining the program to make it work better for families and children and creating new, important enforcement mechanisms. The Budget also includes a proposal to improve child welfare programs for tribal families.

CHILD CARE ENTITLEMENT TO STATES

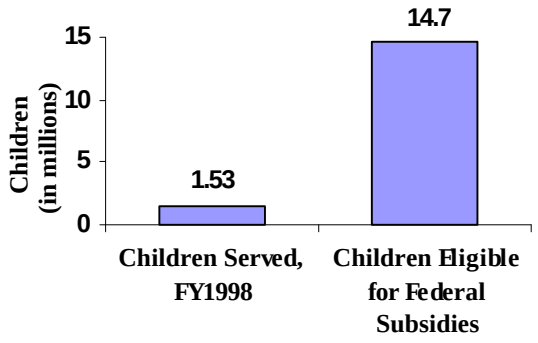
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (referred to as welfare reform) amended the Child Care and Development Block Grant Act (CCDBG) by consolidating four former child care programs. Currently, all States receive discretionary funds, mandatory funds and matching funds. These funds help States provide subsidies to working families and require States to spend a minimum of 4 percent of the funds to improve the quality and availability of healthy and safe child care for all families. Additional amounts of the discretionary funds are also set-aside for quality improvements and research and referral activities.

For FY 2001, welfare reform authorized and pre-appropriated entitlement funds (matching and mandatory) of $2.6 billion for child care programs and allowed States maximum flexibility in developing child care programs. These funds, combined with the requested $2.0 billion in discretionary child care funding, will further the Administration's commitment to supporting working families and moving families from welfare to work. (Additional information on discretionary funding, including the requested $817 million increase, can be found in the ACF discretionary section).

The Child Care Entitlement portions of the fund currently include the following: 1) Mandatory Child Care, 2) Matching Child Care, and funds for 3) Training and Technical Assistance.

CHILD CARE INITIATIVE

Studies indicate that working families across the country are struggling to find safe, affordable, and high quality child care for their children. As the figure below indicates, the combined mandatory and discretionary child care funds allow us to serve a small percentage of children eligible for these funds under the maximum Federal eligibility criteria.



The overwhelming majority of children today are in child care before entering school. However, the children of these working parents often spend their days in settings that do not promote healthy child development, and the quality of care is often quite poor.

The FY2001 Budget funds the critical need for additional child care that is safe, healthy and promotes early learning. The Administration tackles the problem in many way. In HHS, the President's Child Care Initiative includes a discretionary increase to the Child Care Development Block Grant of $817 million and a $600 million Early Learning Fund to improve the quality of early learning environments and promote school readiness. In the Department of Treasury, in addition to increased tax credits for businesses that invest in child care facilities, the Initiative expands the Dependent Care Tax Credit and makes it refundable. The Budget also significantly increases funding for after school care through the 21st Century Learning Fund in the Department of Education.

CHILD CARE ENTITLEMENT LEGISLATIVE PROPOSAL

In addition to the discretionary increase request discussed previously, a key component of the President's Child Care Initiative is funding for a new Early Learning Fund.

EARLY LEARNING FUND:

The budget includes $3 billion over five years in entitlement funds for an Early Learning Fund to foster early childhood development, emergent literacy, and school readiness and to improve child care safety and quality. Recent research found that almost half of the infants and toddlers in child care centers were in care that lacked basic sanitary and safety conditions. Other studies indicate that children in higher quality child care programs develop stronger language, reading and math skills and fewer behavior problems than children in mediocre or poor quality programs. The better the child care program, the more likely the child is to enter school ready to learn. The Fund will provide States with dollars for community level challenge grants to support programs that improve early learning and the quality and safety of child care for children up to age five.

TEMPORARY ASSISTANCE TO NEEDY FAMILIES

The TANF block grant, a single capped entitlement of approximately $17 billion annually, provides funds to States to design creative programs to help families transition from welfare to self-sufficiency. Under TANF, recipients must engage in work

activities to receive time-limited assistance. Over the past five years, the number of families on welfare has dropped by over 40 percent, to under 2.5 million families– more than 1.3 million adults on welfare went to work between 1997 to 1998. Not only are these adults working, their income is rising as time goes on, a critical component of staying off of welfare. Our most recent data indicate an average earnings increase of 23 percent for former welfare recipients from their first quarter of employment to their third quarter.

Welfare reform authorizes and pre-appropriates about $17 billion annually to States for the following activities:

- Family Assistance Grants to States, Tribes and Territories;
- Matching Grants to Territories;
- Bonus to Reward Decrease in Out-of-Wedlock Births;
- Supplemental Grants for Population Increases;
- Bonus to Reward High Performance States;
- Tribal Work Programs; and,
- Loans for State Welfare Programs.

Up to a combined 30 percent of TANF funds may be transferred to either the Child Care and Development Block Grant or the Social Services Block Grant (SSBG). Starting in FY2001, transfers to SSBG are limited to 4.25 percent of TANF funds. States are transferring large amounts of their TANF funds to the Child Care and Development Block Grant, in response to the increased needs in this program.

TANF Legislative Proposals

The FY 2001 President's Budget includes the following TANF legislative proposal.

Supplemental Grants for Population Increases:

With the rapid decline in welfare caseloads, the budget proposes to limit the Supplemental Grants for Population Increases at the FY 1998 level. Seventeen States are eligible for this grant, based on population growth and/or lower than average State welfare spending per low-income person. This proposal will save $240 million in Budget Authority in FY2001.

Children's Research and Technical Assistance (CRTA)

Welfare reform authorizes and appropriates funds for welfare research and technical assistance for States. The FY 2001 total is $58.6 million.

Included in this total is $21 million in pre-appropriated mandatory funds for the following activities: $15 million for welfare research, and $6 million for a longitudinal child welfare study. These funds will also support welfare research on the effects of welfare reform and on ways to improve the welfare system.

The remaining $38 million in this fund includes two child support set-asides: one for training and technical assistance and the other to assist in operating the Federal Parent Locator Service (FPLS). The funds appropriated for these activities are equal to one and 2 percent respectively of the amount paid to the Federal government for its share of child support collections during the preceding fiscal year.

Child Support Enforcement

The Child Support Enforcement (CSE) program is a joint Federal, State and Local partnership that seeks to ensure financial and emotional support for children from both parents by locating non-custodial parents, establishing paternity, and establishing and enforcing child support orders. The program provides critical support for working families

and assists in the transition to self-sufficiency. In FY 2001, an estimated total of $4.7 billion in Federal and State dollars will be spent in order to collect $19 billion in payments. This represents a 9 percent gain in collections over FY 2000 and a total return of more than $4 for every $1 invested in the administration of the program. Since the inception of the program in FY 1975, over $100 billion has been collected. Success in the program also includes a new record amount of $1.3 billion collected in overdue child support from Federal income tax refunds. In addition, the National Directory of New Hires has helped locate more than 2.8 million delinquent parents and paternity establishment rose to 1.45 million in 1998, a more than three-fold increase from 516,000 in 1992.

The Federal government shares in the financing of this program by providing incentive payments, a 66 percent match rate for general State administrative costs, and an enhanced match rate for paternity testing and specified automated systems requirements. The CSE program also includes a capped entitlement of $10 million annually for grants to States to facilitate non-custodial parents' access to and visitation of their children.

The CSE program strengthens families by helping children get the support they are owed from non-custodial parents. In non-TANF cases, child support collections are forwarded to the custodial family. By securing support on a consistent and continuing basis, families may avoid the need for public assistance, thus potentially reducing future welfare, Food Stamp, and Medicaid spending. Applicants for TANF assign their rights to support payments to the State as a condition of receipt of assistance. Child support collections on behalf of families receiving TANF and some collections on behalf of former TANF recipients are shared between the State and Federal government.

As noted above, a portion of the Federal share of child support collections is paid to the States as incentive payments. Previously, Federal incentive payments to States were based on the State's cost effectiveness in operating the program and the amount of payments collected. Following passage of the Child Support Performance and Incentive Act of 1998, a new incentives structure was put into place using five key measures: paternity establishment, support order establishment, collections on current support, collections on past-due support, and cost effectiveness. This new system is being phased in starting in FY 2000.

CHILD SUPPORT LEGISLATIVE PROPOSALS

The Federal government has a strong interest in seeing that a nation-wide child support system is effective. Over the last two years, the Administration took the lead in bringing stakeholders together to examine the current financing structure of the Child Support program. In addition to holding discussion meetings across the country, we conducted research and analysis on the funding of the program. Many of the proposals in this year's budget were an outgrowth of our consultations over the past two years.

The budget proposes Child Support legislation with various changes that focus on increasing payments to families and making the child support system work better.

PROGRAMMATIC CHANGES TO GET MORE MONEY TO FAMILIES:

The budget includes four proposals to simplify the child support system and/or get more money to families.

- Optional Pass-through & Disregard: The proposal provides Federal matching funds for new State policies that pass-through child support collections to families and disregard

these funds when determining assistance levels for TANF families. Under this proposal, the Federal government would share in the cost of amounts above a State's current pass-through and disregard policy distributed to TANF families and disregarded, up to the greater of $100 per month or $50 over current State efforts. Increased collections to families: $388 million over five years. Federal cost: $97 million over five years.

- Optional Simplified Distribution: This proposal allows States to adopt simplified rules for distributing child support collections. Under the simplified formula, collections received on behalf of families receiving TANF benefits would be retained by the Federal and State governments as reimbursement for assistance (as under current law) and child support collected on behalf of families who no longer receive assistance would be paid to the families. The policy would be implemented starting in FY2002. Increased collections to families: $815 million over five years. Federal cost: $396 million over five years.

- Technical fix to remove national cap from incentives: This proposal is a revenue neutral technical improvement to the incentive system enacted in the Child Support Performance and Incentives Act of 1998. The technical change improves the methodology for awarding incentive payments to States by creating a per State maximum level of incentives, eliminating State to State competition for nationally capped funds.

- Review and Adjustment of Child Support Orders: This proposal, previously proposed in the FY2000 Budget, requires States to review and adjust child support orders for TANF families every three years. Benefits include increasing the number of children with private health insurance and increasing collections to families, thereby reducing families reliance on public benefit programs. Federal savings: $232 million over five years.

BETTER ENFORCEMENT TO GET MORE MONEY TO FAMILIES

The budget includes four new measures to increase child support collections from parents who owe past-due child support.

- Automated Data Match and Attachment of Gambling Proceeds: This proposal provides for the intercept of large gambling winnings of non-custodial parents with child support arrears. Increased collections to families: $348 million over five years. Federal savings: $189 million over five years.

- Reduction of Threshold for Passport Denial to $2,500: The proposal denies passports to delinquent non-custodial parents with more than $2,500 in child support arrears, lowering the threshold from $5,000 under current law. Increased collections to families: $36 million over five years. Federal savings: $9 million over five years.

- SSA Benefit Match: In order to collect past due support, this proposal offsets Old Age, Survivor, and Disability Social Security benefits. Increased collections to families: $102 million over five years. Federal savings: $67 million over five years.

- Booting Vehicles of Non-Custodial Parents Owing at Least $1,000 in Child Support: Adds vehicle booting to the set of enforcement tools available to States to encourage non-custodial parents to enter into payment of child support arrears. Increased collections to families: $183 million over five years. Federal savings: $96 million over five years.

Two additional important proposals are included: 1) a proposal to provide Secretarial discretion to exclude doctors with child support arrearages from participation in Medicare and 2) a proposed State requirement to have procedures in place to require individuals who owe overdue child support to pay or engage in work activities. The budget also re-proposes to eliminate the enhanced match for paternity establishment, conforming the Federal match rate for paternity testing to the lower overall child support administrative match rate (a shift from 90 percent to 66 percent). A summary chart can be found at the end of this section detailing costs and savings associated with each legislative proposal.

FOSTER CARE, ADOPTION ASSISTANCE AND INDEPENDENT LIVING PROGRAM

The FY 2001 budget requests $6.4 billion in Budget Authority for the Foster Care, Adoption Assistance and Independent Living programs. This request represents an increase of $739 million over the FY 2001 appropriation.

Of the total request, $5.1 billion will provide Foster Care payments on behalf of about 341,700 children each month. This request will also fund State administration, including child welfare information systems, training, and State data systems.

For the Adoption Assistance program, about $1.2 billion will provide payments for families who adopt special needs children. Monthly payments are made on behalf of adopted children until their 18th birthday. The proposed level of funding will support approximately 256,400 children each month.

The budget includes $140 million to fund the Independent Living Program.

THE FOSTER CARE INDEPENDENCE ACT OF 1999

This act, enacted in November 1999, increased the Independent Living Program level from $70 million to $140 million. Several provisions from the FY 2000 President's Budget were included, such as: increasing funding, allowing States to use funds to pay for room and board for former foster youths, and allowing States to expand Medicaid eligibility to youths up to age 21 who were eligible for foster care at age 18.

FOSTER CARE-RELATED LEGISLATIVE PROPOSALS

INDEPENDENT LIVING PROGRAM (ILP) SUPPLEMENTAL APPROPRIATION FOR FY 2000:

On the same day the Foster Care Independence Act of 1999 was passed, Congress appropriated $105 million for ILP for FY 2000, as was originally requested in the FY 2000 President's Budget. The FY 2001 budget includes a supplemental request for $35 million for FY 2000 to bring the appropriation up to the level States are entitled to under this new statute.

TRIBAL CHILD WELFARE

The budget will include $5 million in Foster Care and Adoption Assistance for a two-tiered approach to looking at Tribal child welfare programs. HHS plans to conduct a comprehensive assessment of Indian child welfare programs, focusing on their strengths and the challenges they face in providing the services, protections and procedural requirements associated with the Federal foster care program. In addition, we propose to make grants to a limited number of tribes to enable them to strengthen the capacity of their tribal child welfare programs by addressing issues such as staff training and retention, licensing of foster care homes, conducting criminal background checks of prospective foster and adoptive parents, operating case review systems, and developing automated data collection systems. We believe that these efforts will enable us to develop improved technical assistance to tribes, better assess future policy directions, and develop models for strengthening tribal child welfare programs on a larger scale.

PROMOTING SAFE AND STABLE FAMILIES

The Adoption and Safe Families Act of 1997 reauthorized and expanded the Promoting Safe and Stable Families program (formerly known as the Family Preservation and Support program). The FY 2001 request includes $305 million, a $10 million increase over FY 2000, for States and eligible Indian tribes.

The Promoting Safe and Stable Families program supports State child welfare agencies and tribes in providing: family preservation services, family support services, time-limited family reunification services, and adoption promotion and support services.

SOCIAL SERVICES BLOCK GRANT

The Social Services Block Grant (SSBG) allows States the flexibility to provide or supplement social services at the State and Local levels. SSBG funding provides direct social services and resources that link human service delivery systems together. Programs or services most frequently supported by SSBG include child care, child welfare (foster care, adoption and protective services), elder care, drug abuse prevention and treatment activities, home based services, employment services, prevention and intervention programs, and services for the disabled.

SSBG LEGISLATIVE PROPOSAL

The FY 2001 President's Budget requests funding at $75 million above the authorization level set in the Transportation Equity Act for the 21st Century of $1.7 billion for this program. This increase would maintain SSBG at the FY2000 level of $1.775 billion stabilizing funding for these critically important programs. Of this amount, $25 million will be available to support second-chance homes for teen parents and their children who cannot live at home or with other relatives.

AFDC AND RELATED PROGRAMS

Welfare reform replaced the Aid to Families with Dependent Children (AFDC) Benefits, State and Local Administration, Emergency Assistance, AFDC Child Care, and Job Opportunities and Basic Skills Training (JOBS) programs with TANF and the Child Care Entitlement programs.

During FY 2001, we expect to completely phase out funding for the repealed programs. Estimates for FYs 1999 and 2000 represent claims for expenditures incurred before these programs were repealed. These claims will be funded by carry over balances from prior years.

FY 2001 PROPOSED ACF LEGISLATION

(dollars in millions /1)

	FY 2001	FY 01-05
CHILD SUPPORT ENFORCEMENT:		
Optional $100 (or $50 above) Pass-through & Disregard /2 :	+5	+97
Optional Simplified Distribution /2 /3:	0	+396
Remove Cap from Incentives:	0	0
Automated Data Match and Attachment of Gambling Proceeds:	-8	-189
Reduce Threshold for Passport Denial to $2,500:	-1	-9
SSA Benefit Match (OASDI):	-11	-67
Booting Vehicles for Non-custodial Parents Owing at Least $1,000:	-3	-96
Reduce Match for Paternity Laboratory Tests from 90 to 66 Percent:	-8	-41
Mandatory Review of Child Support Orders /4:	+24	-232
Subtotal, Child Support Enforcement /5.....	**-2**	**-141**
CHILD CARE:		
Early Learning Fund:	+600	+3,000
Subtotal, Child Care.....	**+600**	**+3,000**
TANF:		
Freeze Supplemental Grants at FY 1998 Level:	-240	-240
Allow TANF to Offset Reduction to Medicaid Administrative Payments	+208	+353
Subtotal, TANF.....	**-32**	**+113**
SSBG:		
Increase Authorization Level by $75 million in FY2001:	+75	+75
Subtotal, SSBG.....	**+75**	**+75**
Foster Care/Adoption Assistance:		
Tribal Child Welfare:	+5	+5
Subtotal, FC/AA.....	**+5**	**+5**
TOTAL ACF PROPOSED LAW IMPACT.....	**$646**	**$3,052**

/1 Negative numbers are savings, positive numbers are costs. Except where noted, all figures represent Budget Authority.
/2 Includes savings from reductions in Food Stamps.
/3 This proposal begins in FY 2002.
/4 The savings from this proposal include savings to the Medicaid program totaling $170 million by FY 2005. Child support totals combine increased administrative costs and savings due to increased collections.
/5 The budget also includes two additional child support proposals on work requirements for non-custodial parents and exclusion of doctors with child support arrearages from Medicare. These proposals are discussed in the chapter.
/6 This proposal has outlay effects, but no impact on budget authority.

CHILD SUPPORT ENFORCEMENT OVERVIEW: Collections and Costs

(dollars in millions) /1

	1999 Actual	2000 Enacted	2001 Request /2	Request +/- Enacted
Total Collections Distributed:				
Non-TANF Families	$12,984	$14,687	$16,153	+$1,466
TANF/FC families	106	90	109	+19
TANF program	2,337	2,238	2,335	+97
FC program	35	37	38	+1
Total	**$15,462**	**$17,052**	**$18,635**	**+$1,583**
Distributed to TANF Program:				
Net Federal Share	$868	$851	$872	$21
State Share (includes incentives and hold harmless payments)	1469	1387	1463	+76
Total	**$2,337**	**$2,238**	**$2,335**	**+$97**
Administrative Costs (Outlays):				
Federal Share	$2,635	$2,832	$3,051	$219
State Share	1392	1568	1680	+112
Costs	**$4,027**	**$4,400**	**$4,731**	**+$331**
Program Saving and Costs (Collections minus Costs):				
Federal Costs	$1,767	$1,981	$2,179	+$198
State Savings/Costs	($77)	$181	$217	+36
Net Costs	**$1,690**	**$2,162**	**$2,396**	**+$234**

/1 Numbers may not add due to rounding. Costs are positive, savings are (negative).

/2 Numbers reflect legislative proposals.

ACF OVERVIEW: ENTITLEMENT SPENDING

(dollars in millions) /1

PROGRAM	1999 Actual	2000 Enacted	2001 Request /2	Request +/- Enacted
TANF /3/4	$17,693	$16,689	$16,439	-$250
Child Care Entitlement /3/5	2,167	2,367	3,167	+800
Child Support Enforcement(obligations)	2,523	2,828	3,100	+272
Foster Care/Adoption Assistance	4,922	5,662	6,401	+739
Children's Research & Technical Assist (net BA) /3	52	39	59	+20
Promoting Safe and Stable Families	275	295	305	+10
Social Service Block Grant	1,909	1,775	1,775	0
Repatriation/Territories	16	24	24	0
Total, Program Level/BA	**$29,667**	**$27,895**	**$31,275**	**+$3,380**

/1 Numbers do not add due to rounding and the effect of AFDC/EA/JOBS/Related programs having excess prior year BA as the account was closed out.
/2 Numbers include legislative proposals.
/3 Majority of funding is preappropriated.
/4 FY1999 actuals include funding for supplemental grants and High Performance Bonus.
/5 The $800 million increase includes $200 million in funds pre-approrpiated in PRWORA and the $600 million Early Learning Fund.

ADMINISTRATION ON AGING

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Program Level.....	$883	$934	$1,085	+$151
FTE.....	120	147	167	+20

SUMMARY

The FY 2001 budget request for the Administration on Aging (AoA) is $1.1 billion, an increase of $151 million, or 16 percent over FY 2000. The increase will allow the Agency to respond to the needs of our nation's growing older population. Since 1900, the number of Americans sixty-five and older has grown from 3 million to 34 million. The Census Bureau predicts that this number will increase to 70 million by 2030 when the last members of the "Baby Boom" generation reaches the age of sixty-five.

AoA's goal is to improve the quality of life for all older Americans by helping them to remain independent and productive. Through the Older Americans Act, funds are distributed–primarily by formula–through a nation-wide network of State, Tribal and Area Agencies on Aging, to some 27,000 local service providers. AoA funds also support service and delivery system innovations to more effectively assist older persons and their families.

FOSTERING INDEPENDENCE

Title III of the Older Americans Act provides for the development of systems of supportive services which offer a continuum of care to enable older individuals to maintain maximum independence in a home environment. AoA is proposing to increase funding for Supportive Services by $140 million, 45 percent above FY 2000. Of the additional $140 million requested, $125 million is for the provision, through Subtitle D, of supportive services which will assist families who care for older relatives and $15 million, through Subtitle B, is for core Supportive Services.

Some 3 to 4 million older individuals rely on care from family and close friends to remain at home.

Some 3 to 4 million older individuals rely on care from family and close friends to remain at home. If formal services were used instead, they would cost between $45 billion and $75 billion annually.

Half of all caregivers are themselves over the age of 65. The majority are women, and one-third of all caregivers have full time jobs. Research shows that their rates of depression are significantly higher than non-caregivers of the same age. With the $125 million requested, AoA estimates that quality respite care and other supportive services–teaching caregivers to manage wandering and agitated behavior in late-state Alzheimer's Disease–could be provided to 250,000 families.

The $15 million requested for core Supportive Services–Subtitle B–will support: information and referral; transportation and escort services; chore, homemaker and personal care services; and the provision of adult day care. With the additional funds

requested, AoA expects to provide more than six million additional rides, 2 million additional hours of homemaker and personal care services and 845,000 additional hours of adult day care.

STATE AND LOCAL INNOVATIONS—MENTAL HEALTH SERVICES

Older people commit suicide 50 percent more often than those under sixty-five. According to the Surgeon General's Report on Mental Health, depression is the leading risk factor for suicide in older adults but is neither well recognized nor treated.

According to the Surgeon General's Report on Mental Health, depression is the leading risk factor for suicide in older adults but is neither well recognized nor treated.

AoA is requesting an increase of $5 million as part of a Department-wide Mental Health Initiative. Funds will be used to train the Aging Network to be able to detect, refer, and provide supportive linkages and other services to assist persons to receive help from professionals in the mental health system. Additionally, funds will be used to work with the mental health system on the destigmatization of mental illness among older adults. Funding for mental health is requested through the State and Local Innovations program.

GRANTS FOR NATIVE AMERICANS

The budget includes an additional $5 million, or 26 percent, to provide meals and supportive services for Native Americans. Tribal organizations, and organizations serving Native Hawaiians, are eligible to receive funds directly from AoA under Title VI of the Older Americans Act. Because they receive less funding from State, Tribal and private sources, and smaller contributions from those they serve, these organizations are significantly more dependent on AoA for their funds. AoA provides 73 percent of funding for Tribal grantee home delivered meals. The additional $5 million will allow grantees to respond to a growing population of Native American elders. Tribal grantees report a 20 percent increase in the number of elders eligible for services between 1996 and 1999. The additional funding will increase the number of meals served by 307,000 for a total of 3.1 million meals.

NUTRITION PROGRAMS

The budget includes a request of $522 million for congregate and home delivered meals, the same level of funding as in FY 2000. The nutrition programs have been shown to be effective in improving the nutritional status, and thereby the overall health, of their participants. Participants in these programs have characteristics placing them at increased nutritional and health risk. Compared with eligible non-participants, they are older, poorer, more likely to live alone and more likely to be members of racial or ethnic minority groups. Since FY 1997, funding for nutrition programs has increased by 11 percent. FY 2001 funding will allow the purchase of 279 million meals, an increase of 43 million over the number of meals served in FY 1997, the most recent year for which data is available.

OTHER AOA PROGRAMS

The budget request also includes $16 million for Preventive Health Services, $13 million for Vulnerable Older Americans, and $6 million for the Alzheimer's Disease program which was transferred from the Health Resources and Services Administration in FY 1999. These activities are all funded at their FY 2000 levels.

A total of $17 million is requested for

Program Administration, an increase of $1 million over FY 2000. The additional funds will allow AoA to hire additional staff to increase its ability to disseminate information, especially through the National Aging Information Center; provide better technical assistance to States; and improve data analysis for performance measures. The increase will also support increased pay costs for existing staff and fund additional administrative and support services. AoA will also expand the number of program staff funded through the Operation Restore Trust program in order to fulfill increased responsibilities in detecting health care fraud and abuse against seniors.

AOA OVERVIEW

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/-Enacted
Administration on Aging:				
Supportive Services	$310	$310	$450	+$140
Care Giver Activities (non add)	*0*	*0*	*125*	*+125*
Grants for Native Americans	19	19	24	+5
State and Local Innovations	18	31	36	+5
Nutrition Programs	486	522	522	0
Preventive Health	16	16	16	0
Alzheimer's Disease/Vulnerable Elderly	18	19	19	0
Program Management	15	16	17	+1
Operation Restore Trust	1	1	1	0
Total, Program level	**$883**	**$934**	**$1,085**	**+$151**
Less Funds Allocated From Other Sources:				
Operation Restore Trust	-$1	-$1	-$1	$0
Total, Budget Authority	**$882**	**$933**	**$1,084**	**+$151**
FTE	120	147	167	+20

DEPARTMENTAL MANAGEMENT

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Program Level.....	$257	$307	$330	+$23
FTE.....	1,313	1,483	1,572	+89

SUMMARY

Departmental Management (DM) consolidates activities funded under two appropriation accounts in the Office of the Secretary: General Departmental Management (GDM) and Policy Research. The FY 2001 budget request provides a program level of $330 million for Departmental Management, including an appropriation of $246 million, intra-agency transfers of $21 million in one-percent evaluation funds, $60 million in bioterrorism funds and $3 million in health care fraud and abuse funds.

GENERAL DEPARTMENTAL MANAGEMENT

The GDM account supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department in administering, and overseeing the organization, programs and activities of the Department. These activities are carried out through nine Staff Divisions (STAFFDIVs), including the Immediate Office of the Secretary, the Departmental Appeals Board (DAB), and the Offices of Public Affairs, Legislation, Planning and Evaluation, Management and Budget, Intergovernmental Affairs, General Counsel (OGC), and Public Health and Science (OPHS). The GDM budget request for FY 2001 totals $313 million, an increase of $23 million (8 percent) from the FY 2000 enacted level.

The FY 2001 budget request includes a total of $13.5 million for OGC's and DAB's efforts under the President's Nursing Home Initiative (NHI), to improve the quality of nursing home care in this country. Working with the Health Care Financing Administration, OGC will use the added funds to provide litigation support for a increase number of sanctions against nursing homes that violate patient health and safety rules. As a result of appeals by the nursing homes against such sanctions, both DAB's judicial hearings caseload and OGC's administrative and court litigation workloads will continue to expand dramatically. The requested funding increase will ensure adequate OGC and DAB staff to handle these workloads in a timely and efficient manner, and to decrease current caseload backlogs.

OPHS, the largest GDM STAFFDIV, is headed by the Assistant Secretary for Health/Surgeon General, who serves as senior advisor to the Secretary on public health and science issues. The ASH/SG also exercises management responsibility for ten OPHS operational programs, including the following:

OFFICE OF MINORITY HEALTH

The request includes $39 million to improve disease prevention, health promotion, and health service delivery for disadvantaged and minority individuals. This

funding also supports research to improve the health status of racial and ethnic minority populations in the United States, which continues to lag behind the health status of the American population as a whole. In addition these funds will support activities aimed at reducing the risk of acquiring or transmitting HIV/AIDS, and at increasing access to services and treatment.

OFFICE ON WOMEN'S HEALTH

The request of $16 million provides funding to advance women's health programs through the promotion and coordination of research, service delivery, and education throughout HHS agencies and offices, with other government organizations, and with consumer and health professional groups. This request includes a $1 million (6 percent) increase over the FY 2000 enacted level.

OFFICE OF EMERGENCY PREPAREDNESS

The budget request of $12 million will be used to manage and coordinate the health, medical and health-related social services that are provided by the Federal government to victims of catastrophic disasters through the Federal Response Plan's Emergency Support Function (ESF) #8. Under ESF #8, HHS coordinates the support of twelve Federal agencies in the preparedness for, response to, and recovery from natural and man-made disasters.

Also in FY 2001, OEP will continue to carry out tasks from the National Security Council to assess and remedy any shortfalls in the health and medical consequence response capabilities that will be necessary in the event of a terrorist use of a weapon of mass destruction, whether chemical, biological or nuclear. Funding for these bioterrorism activities are included in the Public Health and Social Services Emergency Fund.

OFFICE OF POPULATION AFFAIRS

The request of $8 million provides support for the Adolescent Family Life (AFL) Demonstration and Research program authorized under Title XX of the Public Health Service Act. Through these grants, AFL provides funding for three areas: care demonstration projects, prevention projects, and research projects. In addition, OPA administers the Family Planning program under Title X of the Public Health Service Act (this program is funded through the Health Resources and Services Administration).

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

The budget request of $8 million includes an increase of $4 million (100 percent) over the FY 2000 enacted level. These funds will support the implementation of the Secretary's initiative to promote health and prevent disease and disability through Healthy People 2010.

HEALTH INFORMATICS INITIATIVE

The GDM request also includes $20 million to implement a new Health Informatics Initiative. This Initiative encompasses a powerful set of crosscutting and agency-specific investments in information systems and health data, aimed at strengthening the information base for decision-making. The Initiative ensures that HHS's wealth of health information and information systems resources are coordinated and prioritized, enabling HHS to enhance its role as a leader in the development, use, and dissemination of health information. The Initiative includes HHS efforts aimed at:

- developing, adopting and implementing national data standards;
- assuring secure and confidential electronic transmission of health

information within the public health and health care delivery systems;

- strengthening health information confidentiality protection;

- enhancing the capacity of federal, State and local partners to participate in the next generation of health information systems;

- developing improved methods and tools;

- providing public access to relevant health data and information; and

- investigating the potential uses of information technology in reducing deaths and injuries caused by medical errors.

The Initiative's ultimate goal is to improve patient care and health outcomes through the efficient and effective use of data and information.

POLICY RESEARCH

The FY 2001 budget request for DM also includes $17 million for the Policy Research account, to support research on issues of national significance. Policy Research examines broad issues that cut across agency and subject lines, as well as new policy approaches developed outside the context of existing programs.

Priority issues that will be examined are those related to welfare reform, health care insurance reform, family support and independence, poverty, at-risk children and youth, aging and disability, science policy, and improved access to health care and support services.

DEPARTMENTAL MANAGEMENT OVERVIEW

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
General Departmental Management:				
GDM Staff Divisions	$116	$122	$132	+$10
Office of the General Counsel, NHI (non-add)	*0*	*7*	*9*	*+2*
Departmental Appeals Board, NHI (non-add)	*1*	*3*	*5*	*+2*
OPHS Program Offices:				
Minority Health	36	38	39	+1
Women's Health	15	15	16	+1
Emergency Preparedenss	15	10	12	+2
Council on Physical Fitness & Sports	1	1	1	0
Adolescent Family Life	18	19	8	-11
US-Mexico Border Health Commission	1	1	1	0
Other Health Activities	0	5	0	-5
Health Informatics Initiative	0	0	20	+20
1% Evaluation funds	22	22	21	-1
Bioterrorism	17	55	60	+5
Health Care Fraud and Abuse Control funds	2	2	3	+1
Total, GDM Program Level	**$243**	**$290**	**$313**	**+$23**
Policy Research	14	17	17	0
Total, DM Program Level	**$257**	**$307**	**$330**	**+$23**
Less funds from other sources:				
1% Evaluation funds	22	22	21	-1
Bioterrorism	17	55	60	+5
Health Care Fraud and Abuse Control funds	2	2	3	+1
Total, DM Budget Authority	**$216**	**$228**	**$246**	**$18**

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Program Level	$514	$414	$265	-$149
FTE.....	0	0	0	0

SUMMARY

The FY 2001 President's Budget request provides $265 million in the Public Health and Social Services Emergency Fund (PHSSEF).

The PHSSEF FY 2001 budget request of $265 million includes: $209 million for a variety of activities in the Department's Countering Bioterrorism initiative; $50 million to continue to address the AIDS crisis facing minority communities; $4 million for tobacco litigation support at the Department of Justice (DoJ); and $2 million for critical infrastructure protection activities.

COUNTERING BIOTERRORISM

Because terrorism is a nation-wide threat, programs and activities to address and respond to this threat are a part of a government-wide effort. HHS has the responsibility to meet the public and medical needs associated with terrorist events.

The FY 2001 request for the PHSSEF includes a total of $209 million for the continuation of HHS anti-bioterrorism efforts. These funds are intended to:

- improve and enhance the nation's public surveillance network–by strengthening our detection, epidemiological, laboratory and electronic communication capacities;
- strengthen capabilities to provide a medical and public health response to chemical and biological weapons attacks;
- create and maintain a stockpile of pharmaceuticals, vaccines and other materials for civilian use if massive treatment is needed; and
- accelerate research, development and regulatory review/approval of rapid diagnostics, antibiotics/ antivirals and vaccines.

The funds in the PHSSEF are allocated to the Office of Emergency Preparedness and the Centers for Disease Control and Prevention. In addition to the funds requested for Bioterrorism in this account, the National Institutes of Health has requested $45 million for research activities in FY 2001 and the Food and Drug Administration is requesting $12 million for expeditious development and licensure of

new/improved vaccines for anthrax and botulinum.

AIDS IN MINORITY COMMUNITIES

The FY 2001 request includes $50 million specifically targeted to address HIV/AIDS prevention, treatment and infrastructure/ capacity development needs within the African-American and other racial and ethic minority communities. These funds allow the Department to continue to invest in initiatives that will create a sound foundation to achieve a durable and sustainable response to reduce the burden of HIV/AIDS in racial and ethnic minority populations. Funds from the PHSSEF are allocated to lead health agencies to complement on-going efforts.

YEAR 2000 COMPUTER CONVERSION

The FY 2001 budget requests no funds for Y2K activities. All funds remaining from FY 1999 and all funds provided in FY 2000 will enable the Department to complete it's Y2K related activities with no additional funding requirements.

TOBACCO LITIGATION SUPPORT

The FY 2001 request includes $4 million for tobacco litigation support. These funds will provide litigation support to the Department of Justice for research, document management in suits against US tobacco companies seeking compensation for the cost of tobacco-related illness borne by Federal health programs.

CRITICAL INFRASTRUCTURE PROTECTION

Finally, the FY 2001 President's Budget request for the PHSSEF includes $2 million for activities associated with the public health infrastructure such as:

- developing a hospital and health care system that links to transportation, public safety and emergency medical systems for use during transportation incidents, natural disasters, heat waves, terrorist events and medical emergencies;

- assisting public safety and health officials in the assessment, mitigation, and protection of threats to water systems; and

- developing weapons of mass destruction (WMD) agent and WMD mass casualty survivable facilities.

PHSSEF OVERVIEW

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Bioterrorism:				
Center for Disease Control and Prevention.....	$124	$154	$149	-$5
Office of Emergency Preparedness.....	16	55	60	+5
Agency for Healthcare Research and Quality.....	0	5	0	-5
Subtotal, Bioterrorism	**$140**	**$214**	**$209**	**-$5**
HIV/AIDS.....	$50	$50	$50	0
Year 2000 Computer Conversion.....	$324	$150	$0	-$150
Tobacco Litigation Support.....	$0	$0	$4	+$4
Critical Infrasturcture Protection.....	$0	$0	$2	+2
Total, PHSSEF, Program Level/ Budget Authority 1/2/.....	**$514**	**$414**	**$265**	**-$149**
FTE.....	0	0	0	0

/1 The FY 1999 Actuals reflect a comparable transfer to CDC of $33 million for polio and measles ($28 million) and environmental health laboratory ($5 million).

/2 The FY 2000 enacted level reflects a comparable transfer to: CDC of $74 million for the Global Health Initiative ($69 million) and the environmental health laboratory ($5 million); NIH of $20 million for challenge grants; and HSRA of $75 million for the Ricky Ray Hemophilia Relief Fund Act.

OFFICE FOR CIVIL RIGHTS

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Program Level.....	$21	$22	$24	+$2
FTE.....	210	220	237	17

SUMMARY

The FY 2001 budget request for the Office of Civil Rights (OCR) is $24 million, an increase of $2 million over the FY 2000 level. OCR is responsible for enforcing civil rights statutes that prohibit discrimination in Federally-assisted health care and social services programs. These statutes prohibit nondiscrimination on the basis of race, national origin, disability, age, and in limited instances, sex and religion.

Among the most significant issues that OCR addresses are the effects of discrimination on racial disparities in health care; implementation of the Supreme Court's 1999 decision in the Olmstead case concerning the provision of services in the most integrated setting to persons with disabilities; nondiscriminatory implementation of Temporary Assistance to Needy Families (TANF) and welfare-to-work programs; assessment of the effects of managed care on services to minority and disability communities, and removal of discriminatory barriers to access for immigrant populations.

OCR also implements inter-ethnic adoption civil rights requirements intended to prevent racial and national origin discrimination in foster care and adoption placements. In addition, OCR coordinates implementation of the regulation that prohibits discrimination against persons with disabilities in programs and activities conducted by HHS. OCR also coordinates government-wide enforcement of the Age Discrimination Act.

OCR enforces nondiscrimination requirements by processing and resolving discrimination complaints, conducting reviews and investigations, monitoring corrective action plans, and carrying out voluntary compliance, outreach and technical assistance activities. Each of OCR's compliance activities ensures that individuals are treated in a nondiscriminatory manner by health and human services provider agencies or facilities. OCR's work protects individual rights and simultaneously supports HHS goals for improving the health and well-being of individuals, families and communities.

The majority of OCR's FY 2001 budget increase is intended to ensure that civil rights and nondiscriminatory access to health care and services are an integral part of the Department's initiative to eliminate racial disparities in health care. This budget request supports a significant quality access improvement initiative designed to eliminate racial disparities and improve the quality of health care for racial and ethnic minorities. The request will enable expansion of an initiative undertaken in Nassau County, New York to five additional regions. The initiative uses Title VI of the Civil Rights Act of 1964 to determine the potential role of racial discrimination in the apparent racial disparities in access to and quality of health

care. In FY 2001, OCR will expand a small Los Angeles field office to be opened in late FY 2000. Los Angeles is by far the largest U.S. metropolitan area in which OCR does not currently have a physical presence. Through this office, OCR will be able to serve a very diverse population by addressing the priority civil rights issues noted above.

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request \1	Request +/- Enacted
Program Level.....	$129	$151	$164	+$13
FTE.....	1,273	1,432	1,539	+107

/1 Assumes $130 million for Medicare related fraud and abuse activities, the maximum allowed unde Health Care Fraud and Abuse Control program.

SUMMARY

For FY 2001, the Office of Inspector General (OIG) requests a discretionary appropriation of $34 million, an increase of $3 million above the FY 2000 discretionary level. The OIG will also receive between $120 and $130 million in FY 2001 from the Health Care Fraud and Abuse Control (HCFAC) Account for Medicare related fraud and abuse activities.

The OIG's statutory mission is to: improve HHS programs and operations and protect them against fraud, waste and abuse. By conducting independent and objective audits, evaluations, and investigations, OIG provides timely, useful, and reliable information and advice to HHS officials, the Administration, the Congress and the public.

In the FY 2000-2001 period, the OIG will focus on the following program priorities:

INCREASING COLLECTIONS IN THE CHILD SUPPORT ENFORCEMENT PROGRAM

OIG will expand its multi-agency task forces to identify, investigate, and prosecute individuals who willfully avoid their payment of their child support obligations under the Child Support Recovery Act. These task forces will bring together State and local law enforcement and prosecutors, United States Attorneys' Offices, the OIG, Marshall Services personnel, the FBI, State and county child support personnel, and all other interested parties from the 18 states covered by the task forces. As of December 1999, OIG has opened 860 child support cases nationwide, which have resulted in 173 convictions, and court-ordered restitution of over $11.2 million in payments to custodial parents.

CHILD SUPPORT

OIG will examine a wide range of child support issues, including reviewing the operation of the expanded Federal Parent Locator Service, the performance and effectiveness of the new National Directory of New Hires, and the Federal Case Registry of child support orders. In addition, OIG will look at the effectiveness of the Uniform Interstate Protocol in collecting child support across State lines. OIG reviews will also examine methods for increasing child support collections.

SAFE, AVAILABLE AND AFFORDABLE CHILD CARE

OIG will examine subsidy systems for child care, focusing on issues such as health and safety, licensing standards and fraud and abuse potential. Attention will focus on improving quality of care provided to

children and low-income working families. OIG will identify opportunities to prevent abuse of disabled children in institutions, nursing homes, and group homes.

TANF PROGRAM

OIG will work with Federal and State offices in their implementation of welfare reform. OIG will focus on reviewing how Federal and state offices are achieving successful outcomes and performance in welfare programs.

FOSTER CARE

OIG will perform new investigative audit work to review States' efforts to identify, investigate and preclude abuse and neglect in foster care. OIG will examine States' efforts to ensure identification and investigation of child abuse and neglect, the States' performance of background checks on persons having contact with children in foster care, States' maintenance and sharing information from the child abuse and neglect central registry, and sharing of information when foster and adoptive parents move from one agency to another.

PUBLIC HEALTH FRAUD

Investigations of fraud in public health programs are diverse, complex, and often critical to protecting the health of the American people. These investigations will address grant and contract fraud, research fraud, and other allegations of wrongdoing. This area is of particular interest in view of expected increases in program grant funding.

FINANCIAL STATEMENTS

OIG will perform audits for the purpose of expressing opinions on the financial statements of certain reporting entities in the Department, as identified under the CFO Act of 1990 and the Government Management Reform Act of 1994.

The OIG has strengthened its partnerships with other Federal Agencies, such as the Department of Justice and the Internal Revenue Service. Also, included in these relationships are State Governments, ombudsmen, and the private sector including local aging organizations, all of whom are working toward similar goals. OIG continues to form partnerships with the health care industry to publicize "best practices," promote voluntary compliance plans, establish an adverse action data bank, and consult on broad program integrity strategies. This multi-disciplinary approach will continue to enhance the office's ability to carry out its mission.

PROGRAM SUPPORT CENTER

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Expenses	$270	$314	$326	+$12
FTE	1,071	1,108	1,114	+6

SUMMARY

The Program Support Center (PSC) became operational in FY 1996 and was formed by combining administrative activities formerly located in the Office of the Secretary (OS), and funded by the OS Working Capital Fund (WCF), with activities from the former Office of the Assistant Secretary for Health (OASH), and funded by the Public Health Service (PHS) Service and Supply Fund (SSF). The formation of the PSC resulted from the Department's REGO II analysis with a goal of further streamlining and minimizing duplication of functions in the provision of cost effective administrative services to components of the Department and other Federal agencies on a service-for-fee basis. Services are provided in three broad areas: human resources, financial management, and administrative operations.

HUMAN RESOURCES SERVICE

The FY 2001 estimated expenses for the Human Resources Service (HRS) are $44 million, an increase of $1 million above the FY 2000 level. HRS provides a full range of personnel management services including personnel and payroll systems support; personnel operations services for civilian and commissioned personnel; training and career development; employee and labor relations; and administration of the Board for Corrections of PHS Commissioned Corps personnel records.

FINANCIAL MANAGEMENT SERVICE

The FY 2001 estimated expenses for the Financial Management Service (FMS) are $47 million, an increase of $2 million above the FY 2000 level. FMS supports the financial operations of HHS and other departments through the provision of payment management services for Departmental and other Federal grant and program activities such as the Departments of State, Interior and Treasury; accounting and fiscal services; debt management services; and the review, negotiation and approval of rates, including indirect cost rates, research patient care rates, and fringe benefit rates.

ADMINISTRATION OPERATIONS SERVICE

The FY 2001 estimated expenses for the Administrative Operations Services (AOS) are $235 million, an increase of $13 million above the FY 2000 level. AOS supports the administrative management functions within the Department in the areas of property and

material management, and support services ranging from commercial graphics to mail distribution and telecommunications services. The Telecommunications Improvement Project consolidates telephone services under one contract with substantial savings in telephone bills to agencies located in Maryland.

PROGRAM SUPPORT CENTER ENTITLEMENT SPENDING

(dollars in millions)

	1999 Actual	2000 Enacted	2001 Request	Request +/- Enacted
Retirement Pay and Medical Benefits for Commissioned Officers:				
Retirement Payments	$159	$172	$176	+$4
Survivor's Benefits	$12	$12	$12	$0
Medical Care	$28	$30	$31	+$1
Military Service Credits	$2	$1	$1	$0
Total	**$201**	**$215**	**$220**	**+$5**

SUMMARY

This appropriation provides for retirement payments to Public Health Service (PHS) Commissioned Officers and payment to survivors of deceased retired officers. This account also funds the provision of medical care to active duty and retired members and to dependents of active duty, retired and deceased members of the PHS Commissioned Corps. In addition, this account includes amounts to be paid to the Social Security Administration (SSA) for military service credits which are earned by active duty Commissioned Officers for non-wage income.