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

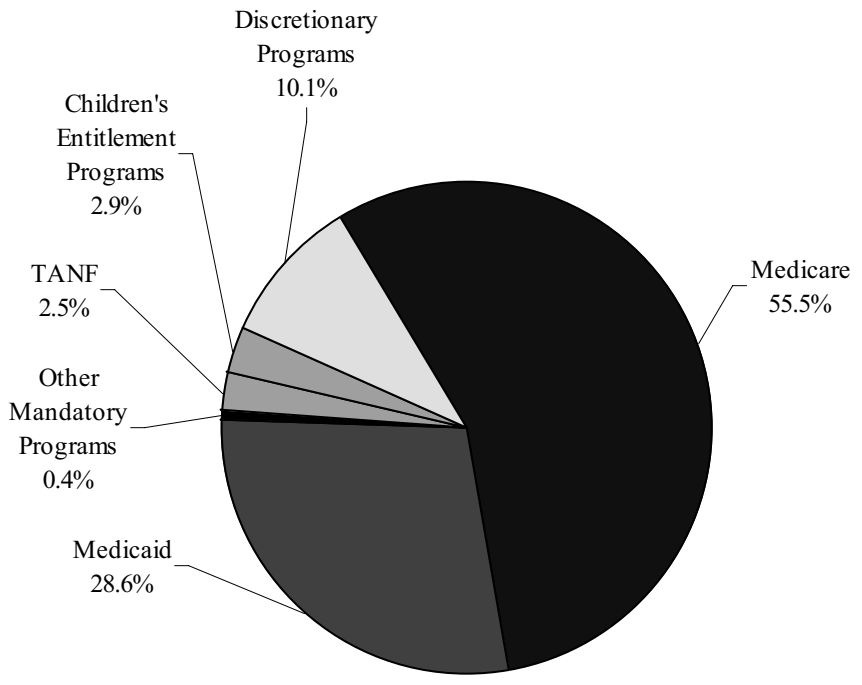
President's Budget for HHS
FY 2007

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Budget Authority	$591,109	$675,209	$696,063	+$20,854
Outlays	$579,970	$639,638	$697,928	+$58,290
Full-Time Equivalents	64,255	66,310	66,971	+661

Composition of the Budget

(dollars in millions)



General Note

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

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

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

The Department of Health and Human Services (HHS) fiscal year (FY) 2007 Budget supports the Department's mission to provide for the health, safety, and well-being of Americans. FY 2007 outlays will total $698 billion, an increase of $58 billion over FY 2006. Consistent with the President's long-term goal to cut the deficit in half by FY 2009, the HHS budget includes both new mandatory savings proposals and a reduction in discretionary spending. The FY 2007 HHS budget totals $74 billion in discretionary program level, a decline of $1.5 billion. In discretionary budget authority, excluding emergency funding, the total is $66.0 billion, a reduction of $1.4 billion.

Secretary Leavitt's 500-day Plan guides HHS in fulfilling the President's vision of a healthier, safer, and more hopeful America. In FY 2007, HHS will strive to fulfill the major tenets of the Secretary's plan to:

- Transform the Healthcare System;
- Secure the Homeland;
- Modernize Medicare and Medicaid;
- Advance Medical Research;
- Protect Life, Family and Human Dignity; and
- Improve the Human Condition Around the World.

Significant initiatives funded in the FY 2007 budget include the Department's ongoing commitment to expand access to quality healthcare; prepare for the possibility of a pandemic influenza outbreak; protect our citizens against the threat of bioterrorism; increase outreach, testing, and treatment for HIV/AIDS; and continue to address the health and human service needs of all Americans.

Transform the Healthcare System

Health Information Technology: The FY 2007 budget request includes $169 million, an increase of $58 million over FY 2006, to continue our effort towards achieving the President's goal for most Americans to have secure personal electronic health records by 2014.

In FY 2007, the request for the Office of the National Coordinator for Health Information Technology (ONC) includes $116 million, an increase of $55 million over FY 2006. Funding will support strategic planning, coordination, and analysis of key technical, economic, and other issues related to public and private adoption of health information technology (IT). The American Health Information Community (The Community) was established in FY 2005 as a Federally-chartered commission to help advance President Bush's call for electronic health records. In early FY 2006, The Community created four workgroups to produce tangible results in the following priority areas: electronic health records, consumer empowerment, chronic care management, and biosurveillance. These workgroups have identified short-term projects that will provide benefits to Americans within the next two years.

The Agency for Healthcare Research and Quality (AHRQ) will continue to work towards the development, adoption, and diffusion of interoperable information technology in a range of healthcare settings with a new emphasis on health IT in ambulatory care settings. The Office of the Assistant Secretary for Planning and Evaluation will conduct independent evaluations of electronic health record adoption and economic factors influencing health IT implementation.

Health Insurance Reform: The President's Budget includes proposals to promote Health Savings Accounts (HSAs). These proposals include tax credits for purchasing HSAs, increasing the amount individuals can contribute to an HSA, and making HSA premiums tax deductible. The Budget also proposes three reforms to the health insurance marketplace: association health plans that will allow small employers and community groups to consolidate purchasing power; a competitive marketplace across State lines that includes strong consumer protections; and medical liability reform to reduce frivolous lawsuits against health care providers.

The President's FY 2007 budget also expands tax deductions on out-of-pocket medical expenses. The increased deduction is designed to make health care more affordable by helping the uninsured pay their health care costs as well as by allowing people with insurance to deduct a greater portion of the money they spend on co-payments, deductibles, and care that is not covered.

Health Centers: The budget provides an increase of $181 million in the Health Resources and Services Administration (HRSA) toward two goals: completing the President's commitment to provide new or

expanded access points in 1,200 communities, and implementing a new initiative to establish new Health Centers in poor counties. In FY 2007, an additional 1.2 million individuals will receive health care through more than 300 new or expanded sites in medically underserved communities throughout the Nation. Of the over 300 new sites, 80 will be in poor rural and urban counties consistent with the President's goal of establishing new health centers in the poorest counties in the Nation.

Domestic HIV/AIDS Initiative: There are two key domestic HIV challenges in the United States: making medical treatment and medication available for HIV-positive low-income Americans, and arresting the spread of HIV by preventing new infections and detecting undiscovered cases. The FY 2007 budget includes $188 million for a new Domestic HIV/AIDS Initiative, of which $95 million will be provided through the Ryan White program for treatment and outreach, and $93 million in the Centers for Disease Control and Prevention (CDC) for increased testing among high-risk populations. The primary objectives of this initiative are to reduce the number of new HIV infections each year, diagnose those Americans currently infected with HIV but do not know it, and provide care and treatment to individuals who have limited or no access to health care.

IHS Population and the Cost of Providing Care: In partnership with Tribes, the Indian Health Service (IHS) is transforming its health care system through its health promotion and disease prevention initiatives and the expanded use of health IT. The budget includes an additional $124 million over FY 2006, for a total of $4 billion, to provide health care for the additional 30,000 people who are expected to seek care in FY 2007, meet the rising cost of providing care, and cover increased pay costs for the Federal and Tribal employees who provide health care.

Critical Path to Personalized Medicine: The budget requests $6 million in the Food and Drug Administration (FDA) for the Critical Path to Personalized Medicine in FY 2007, an investment that will pave the way to more efficient, less expensive clinical trials, and safer, more effective drugs for the American people. This targeted investment will lead to the approval of drugs tailored to individual molecular traits, and will allow health professionals to prescribe safer, more effective medications.

Drug Safety: The FY 2007 budget includes an increase of $4 million to improve the safety of drugs already on the market. FDA will continue to enhance drug safety by modernizing the Adverse Event Reporting System, including integration with the Sentinel System, and acquiring access to large population-based databases, such as those at the Centers for Medicare and Medicaid Services (CMS).

Focusing on the Chronically Ill: Securing health insurance coverage can be a struggle for chronically ill individuals. The FY 2007 Budget promotes adoption of innovative policies to promote insurance among the chronically ill by creating a competitive grant program for States at CMS. The program will make $500 million available annually for these grants.

Secure the Homeland

Pandemic Influenza Plan: The current pandemic threat stems from an outbreak of avian influenza in Asia and Europe. The ability of the H5N1 virus to infect a wide range of hosts, including birds and humans, is of great concern to the medical communty. Although the virus has not yet shown an ability to transmit efficiently between humans, it has the potential to acquire this capability. Once a pandemic began, time would be critical in accomplishing necessary research, development, and delivery of vaccines required to mitigate the pandemic.

To prepare for the possibility of a pandemic, the Administration announced an emergency budget request of $6.7 billion in FY 2006, for HHS to fund a three-year strategic plan to improve pandemic influenza readiness. Congress appropriated $3.3 billion to fund the first year of this plan. One goal of the HHS plan is to build capacity to vaccinate every man, woman, and child in the United States within six months of a pandemic outbreak. Other goals are to have access to enough antiviral treatment courses sufficient for 25 percent of the U.S. population, and to enhance domestic and international public health infrastructure and preparedness. In the meantime, HHS will take all possible steps to protect the Nation against a pandemic threat.

The FY 2007 budget includes a $2.3 billion allowance for the next phase of critical pandemic influenza preparedness activities outlined in the Administration's National Strategy for Pandemic Influenza; an allowance means that a formal request for these funds will be transmitted to Congress in the coming months. This funding supports the continuation of the FY 2006 efforts to expand domestic vaccine production and surge capacities, antiviral stockpiles, research and development on promising new antivirals and vaccines, and supplies for the Strategic National Stockpile (SNS) that would be needed in the event of a pandemic.

In addition, the budget includes $352 million to fund ongoing activities within the CDC, FDA, the National Institutes of Health (NIH), and the Office of the Secretary (OS) to expand surveillance and detection capabilities, as well as to improve our Nation's ability to prepare for, communicate during, respond to, and contain a potential pandemic influenza outbreak.

Emergency Preparedness: The National Response Plan calls on HHS to lead public health and medical services during major medical disasters, including bioterrorist attacks and large-scale public health emergencies. In support of this responsibility, the FY 2007 budget includes $4.3 billion in appropriations to the CDC, HRSA, NIH, and FDA, and $81.6 million in the Public Health and Social Services Emergency Fund (PHSSEF). These amounts include a $68 million increase for the SNS for medical countermeasures, including storage for products purchased through Project BioShield, and a medical surge capacity initiative.

HHS will also continue investing $1.3 billion through the CDC and HRSA to improve State and local public health preparedness. In addition, NIH will increase funding by $110 million to support the advanced development of medical countermeasures for the SNS.

FDA's budget includes an increase of $20 million to continue to improve the protection and safety of the national food supply. Such activities will reduce the morbidity, loss of human life, and economic disruption caused by a terrorist attack or other public health emergency.

Modernize Medicare and Medicaid

Strengthening Long-Term Financial Security of Medicare: The budget includes a comprehensive package of Medicare legislative proposals designed to strengthen the long-term financial security of the program. These proposals will encourage efficient payment for services, foster competition, and promote beneficiary involvement in health care decisions. Net savings from this package total $2.5 billion in FY 2007 and $35.9 billion over five years.

Implementing the Prescription Drug Benefit: As of January 1, 2006, Medicare beneficiaries have access to a prescription drug benefit. The new drug coverage represents the most significant transformation of the Medicare program since its inception. As of this printing, more than 24 million Medicare beneficiaries are already participating in the program. Beneficiaries in every State and region have a broad choice of prescription drug plans from which to choose, including at least one plan with monthly premiums below $21 and plans with zero deductibles or deductibles below the Medicare standard of $250 annually. CMS has marshaled all resources toward assisting beneficiaries, plans, pharmacies, States, and other partners in enrolling beneficiaries in Part D and ensuring that no one loses access to vital prescriptions during the transition.

Reforming and Modernizing Medicaid & SCHIP: The Administration is committed to modernizing the financing, benefit structure, and infrastructure of Medicaid and the State Children's Health Insurance Program (SCHIP). The Deficit Reduction Act of 2005 (DRA) takes important steps toward this goal, including enacting many of the President's FY 2006 budget proposals. This budget seeks to build on the momentum of the DRA. It proposes legislation that will save $1.3 billion over five years. These proposals will pay more appropriate payment levels for Medicaid services and foster greater access and enrollment in these programs.

The budget also proposes a series of administrative actions that will expand on our success with State waivers, improve the financing structure of the Medicaid program, and assure the fiscal integrity of Medicaid and SCHIP. These actions will save $12.2 billion over five years.

Improving Program Integrity: A central goal of the President's Management Agenda (PMA) is to reduce improper payments and improve financial management of Federal programs. Successful program integrity oversight for Medicare and Medicaid is critical to achieving this wider goal. The FY 2007 budget proposes a Health Care Fraud and Abuse Control (HCFAC) program level of $1.2 billion, $30 million more than the FY 2006 level. Included in the FY 2007 program level request is $118 million in new discretionary funding to support HCFAC activities. These funds are part of a government-wide proposal to fund program integrity activities through discretionary spending limits. This new funding will be used to safeguard the new prescription drug benefit and Medicare Advantage programs from fraud and abuse, as well as to enhance oversight of the fast-growing Medicaid program. These resources will complement funds provided in the DRA that are dedicated toward Medicare and Medicaid program integrity activities.

Advance Medical Research

Federal investments in biomedical research have contributed to dramatic reductions in mortality from heart disease and stroke and declining cancer incidence and death rates. Major advances in knowledge about life sciences are also opening dramatic new opportunities for further improvements in preventing, treating, and curing disease and disability. To capitalize on these opportunities, the FY 2007 budget request includes $28.6 billion for NIH. The budget request enables NIH to continue implementing the NIH Roadmap for Medical Research; provides $49 million in resources to expand studies on the connections between genes, the environment, and health; and provides increased support for new research investigators.

Protect Life, Family and Human Dignity

SAMHSA Methamphetamine Treatment Initiative: The number of methamphetamine users has more than doubled from 63,000 in 2002 to 130,000 in 2004. The FY 2007 request includes $25 million within the Access to Recovery program to reduce methamphetamine abuse. The Substance Abuse and Mental Health Services Administration (SAMHSA) funds will be targeted to States with high methamphetamine prevalence to provide vouchers for clinical treatment and recovery support services.

Vouchers to Improve Access to Services: The budget includes new proposals to increase access to a wider array of service options through vouchers, including faith and community-based providers. Through the SAMHSA Access to Recovery program, incentives will be available to States that voluntarily distribute a portion of their Substance Abuse Block Grant funds through a voucher system. In addition, the Administration for Children and Families (ACF) will begin using vouchers to provide maternity group home services to pregnant and parenting homeless youth and proposes to allow the use of vouchers to provide mentoring services to children of prisoners.

AoA Choices for Independence: Choices for Independence will provide seniors and their caregivers with information, assistance, and counseling as they confront difficult decisions about their long-term independence in the community. The FY 2007 request for the Administration on Aging (AoA) includes $28 million to pilot Choices for Independence, which seeks to reduce the current systemic bias in favor of institutional care. By expanding options that rely on private financing and less costly community-based alternatives, this initiative will help seniors remain at home and in their communities for as long as possible.

ACF Helping America's Youth Initiative: In the 2005 State of the Union Address, the President announced a new initiative to help youth at risk of gang influence and involvement as part of a broader outreach effort to at-risk youth. The budget provides $50 million within the Compassion Capital Fund for faith-based and community organizations with a demonstrated history of providing services to youth and families in disadvantaged situations.

ACF Support for Refugees and Other Entrants: The request includes $615 million, an increase of $45 million, to maintain the current level of assistance for refugees and other entrants, and for the care and placement of an increasing number of unaccompanied alien children. Within the request, an additional $5 million will expand assistance for United States citizens or aliens admitted for permanent residence who have been victims of human trafficking.

TANF, Foster Care, and Child Care: Temporary Assistance for Needy Families (TANF), Foster Care, and Child Care are key HHS programs that protect life, family, and human dignity. Under TANF, the Administration proposes an increase of $100 million for a new state grant program for Family Formation and Healthy Marriage. This initiative builds on the $150 million Healthy Marriage and Responsible Fatherhood program that was included in the TANF reauthorization in the DRA. These new programs address areas that the Administration considers vital to the TANF purposes of strengthening families and improving the well-being of children.

The Child Care Entitlement to States program provides $2.9 billion per year for childcare, which provides vital support for working parents. The FY 2007 budget also proposes to provide States with more flexibility in Foster Care so that States can support a continuum of services to families in crisis and children at risk.

Improve the Human Condition Around the World

In FY 2007, HHS agencies involved in international research and global disease prevention and control activities will continue efforts to respond to health events from around the world, which also minimize their potential to impact health within the United States. The budget provides $145 million to detect, contain, and respond to pandemic influenza around the world, as well as conduct clinical trials and research activities in other countries. Other examples of HHS' global activities include CDC, NIH, and HRSA involvement in the President's Emergency Plan for AIDS Relief.

The FY 2007 budget request for CDC and NIH includes approximately $490 million to support ongoing global HIV/AIDS prevention, care, treatment, surveillance, and capacity-building activities, as well as HIV/AIDS research, training, and research infrastructure programs conducted in collaboration with investigators in developing countries. In addition to these funds, the FY 2007 budget for NIH includes $100 million to continue the HHS contribution, initiated in FY 2002, to the Global Fund to Fight AIDS, Malaria, and Tuberculosis.

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

Deficit Reduction Act of 2005

Beginning in FY 2006, implementation of the provisions of the DRA will produce efficiencies and reduce costs for a number of HHS programs, including Medicaid, SCHIP, TANF, and Child Support Enforcement (CSE).

The DRA makes significant improvements to many HHS mandatory programs and produces substantial long-term savings. The DRA provides more appropriate Medicare payment levels to providers, reforms Medicaid prescription drug payments, and makes significant improvements to Medicaid long-term care eligibility and asset transfer policies. Additional funding is made available for the Medicare Integrity Program to improve the accuracy of payments, and a Medicaid integrity program is established. The DRA reauthorizes TANF through 2010. It includes improvements to CSE such as prioritizing collection of medical child support and enhancing enforcement tools.

The DRA also has a number of provisions to improve quality of care, such as incentives for quality data reporting and initiatives to pay for performance.

President's Management Agenda

The FY 2007 budget supports HHS efforts to implement the PMA. The PMA encompasses a broad strategy for improving management and program performance and consists of five government-wide management initiatives and several program-specific initiatives.

The five management initiatives are:

1. Strategic Management of Human Capital;
2. Competitive Sourcing;
3. Improved Financial Performance;
4. Expanded Electronic Government; and
5. Budget and Performance Integration.

HHS, along with other agencies, develops and implements action plans to achieve PMA goals. Quarterly PMA scorecards assess progress and assign status ratings in achieving the goals of each initiative. The scorecards also serve as blueprints for improvement efforts and employ a grading system of *green* for full achievement of all goals for a particular initiative, *yellow* for intermediate achievement, and *red* when at least one deficiency is found. The *progress* rating scores an agency's progress in meeting its quarterly deliverables for each initiative. The *status* rating indicates the overall achievements of an agency for each initiative. As of the first quarter of 2006, HHS achieved a green progress rating for all PMA initiatives.

Strategic Management of Human Capital: HHS has successfully achieved a green status and green progress rating for Strategic Management of Human Capital. This high rating recognizes several HHS accomplishments, including the development of a new four-tier Performance Management System for all of the Department's employees, with full implementation anticipated by January 2007. HHS is planning several upcoming projects to support the Human Capital initiative and maintain this high rating.

Competitive Sourcing: HHS has successfully achieved a green status and green progress rating for Competitive Sourcing for eight consecutive quarters, dating back to March 2004. To date, HHS has conducted competitive sourcing studies for over 40 percent of its commercial activities. For studies completed in FY 2005, HHS projects gross savings of over $100 million for the benefit of HHS programs and the American taxpayer. HHS plans to maintain high performance in support of Competitive Sourcing. This includes structuring bid competitions to maximize efficiencies and savings utilizing Most Efficient Organization principles and implementing an independent savings validation plan.

Improved Financial Performance: HHS continues to implement several reforms to improve the financial performance of the Department, such as streamlining and accelerating the annual financial reporting process and combining annual audited financial statements with program performance information in the Department's Performance and Accountability Report. HHS also continues to implement the Unified Financial Management System within several HHS agencies and the new requirements of OMB Circular A-123 to assess and report on internal controls, and is currently pursuing an initiative to improve access to and use of financial performance information to support program, operations, and management decisions. HHS is striving to continue its green progress rating and improve its status ratings in the upcoming fiscal year.

Expanded Electronic Government: HHS continues to score green for progress for Expanded Electronic Government (e-Gov) which illustrates an enhanced ability to conduct Departmental business and serve the Nation's citizens effectively and efficiently. The Department's strategic planning goals and objectives are supported through the integration of IT capital planning and budget processes; implementation of enterprise architecture, security, and project management; and use of performance measurement and management as a component of enterprise planning and performance life cycle planning processes.

Enterprise planning and performance life cycle planning provide a structured framework in which sound business decisions can be made through consistent practices that offer the opportunity for repeatable successes in IT investments and project management. For example, the goal of the HHS security program

is to ensure the security of HHS information systems and the privacy of the information in those systems by certifying and accrediting 100 percent of critical HHS systems, completing Privacy Impact Assessments (PIAs) for 100 percent of developmental and operational systems, and conducting security awareness training for 100 percent of HHS employees. In FY 2005, HHS certified and accredited 99 percent of its critical systems (the remaining one percent will be certified in FY 2006), completed PIAs for 100 percent of developmental and operational systems, and provided security awareness training to 98 percent of HHS employees.

Budget and Performance Integration (BPI): Budget and Performance Integration (BPI) aims to improve program performance and efficiency by ensuring that performance information is used to inform funding and management decisions. In FY 2007, HHS enhances the integration of budget and performance information. Each agency's performance budget displays how its strategic goals link to Department-wide strategic goals. In addition, agency budget justifications present performance information in sequence with a program's budget justification narrative. The budget presentation along with other successes enabled HHS to achieve a progress rating of green and maintain its BPI status rating at yellow on the PMA scorecard. HHS performance budgets establish the resource needs of HHS programs and identify the results that Americans can expect from their investment in these programs.

The Program Assessment Rating Tool (PART) is an important component of BPI and is used by the Office of Management and Budget (OMB) to assess program performance and improve the quality of performance information. Nearly 100 HHS programs have been assessed in the PART processes for FY 2004 through FY 2007 budgets. These programs account for approximately 79 percent of HHS budgetary resources. Close to 70 percent of the programs assessed received a narrative rating of Effective, Moderately Effective, or Adequate. More detailed information on the PART assessments can be found at http://www.expectmore.gov.

Program Initiatives: In addition to the five government-wide management initiatives, HHS is also responsible for managing the following PMA program initiatives:

- Broadening health insurance coverage through state initiatives;
- Eliminating improper payments;
- Real property asset management;
- Faith-based and community initiatives; and
- Research and development investment criteria.

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HHS BUDGET BY OPERATING DIVISION

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Food & Drug Administration:				
Program Level	$1,801	$1,876	$1,947	+$71
Budget Authority	1,450	1,495	1,545	+51
Outlays	1,320	1,454	1,527	+73
Health Resources & Services Administration:				
Budget Authority	7,402	6,625	6,266	-359
Outlays	7,174	6,496	6,428	-68
Indian Health Service:				
Budget Authority	3,135	3,195	3,320	+125
Outlays	3,112	3,122	3,403	+281
Centers for Disease Control & Prevention:				
Budget Authority	6,210	6,176	5,809	-367
Outlays	6,152	5,393	5,800	+407
National Institutes of Health:				
Budget Authority	28,641	28,578	28,578	0
Outlays	27,154	27,668	28,524	+856
Substance Abuse & Mental Health Services:				
Budget Authority	3,268	3,205	3,134	-72
Outlays	3,203	3,222	3,186	-36
Agency for Healthcare Research & Quality:				
Program Level	319	319	319	0
Budget Authority	0	0	0	0
Outlays	0	0	0	0
Centers for Medicare & Medicaid Services:				
Budget Authority	484,886	581,110	597,013	+15,903
Outlays	484,315	541,721	596,357	+54,636
Administration for Children & Families:				
Program Level	48,707	45,912	46,711	+799
Budget Authority	54,826	40,483	46,700	+6,217
Outlays	46,429	47,248	47,265	+17

HHS BUDGET BY OPERATING DIVISION

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Administration on Aging:				
Budget Authority	$1,393	$1,363	$1,335	-$28
Outlays	1,401	1,358	1,347	-11
Office of the National Coordinator:				
Budget Authority	0	42	88	+46
Outlays	0	17	53	+36
Medicare Hearings and Appeals:				
Budget Authority	58	59	74	+15
Outlays	58	59	74	+15
Departmental Management/Civil Rights::				
Budget Authority	412	393	405	+12
Outlays	400	396	398	+2
Public Health Social Service Emergency Fund: and Pandemic Influenza Preparedness:				
Budget Authority	220	3,142	2,460	-682
Outlays	121	2,106	4,219	+2,113
Office of Inspector General:				
Budget Authority	40	64	69	+5
Outlays	40	86	68	-18
Program Support Center (Retirement Pay, Medical Benefits, Misc. Trust Funds, Health Activities):				
Budget Authority	442	428	443	+15
Outlays	365	441	455	+14
Offsetting Collections:				
Budget Authority	-1,274	-1,149	-1,176	-27
Outlays	-1,274	-1,149	-1,176	-27
Total, Health & Human Services:				
Budget Authority	$591,109	$675,209	$696,063	+$20,854
Emergency Funds/ Pandemic Influenza Allowance (Non-add)	*0*	*3,485*	*2,300*	*-1,185*
Regular Budget Authority (Non-add)	*591,109*	*671,724*	*693,763*	*+22,039*
Outlays	$579,970	$639,638	$697,928	+$58,290
Full-Time Equivalents	64,255	66,310	66,971	+661
Commissioned Corps Detailed Outside HHS	*995*	*995*	995	*0*

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Discretionary Programs (Budget Authority):				
Food & Drug Administration	$1,450	$1,495	$1,545	+$51
FDA Program Level	*1,801*	*1,876*	*1,947*	*+71*
Health Resources & Services Administration	7,324	6,570	6,315	-255
HRSA Program Level	*7,369*	*6,615*	*6,363*	*-252*
Indian Health Service	2,985	3,045	3,170	+124
IHS Program Level	*3,813*	*3,879*	*4,004*	*+124*
Centers for Disease Control and Prevention	6,210	6,176	5,809	-367
CDC Program Level	*7,980*	*8,401*	*8,223*	*-179*
National Institutes of Health	28,491	28,428	28,428	0
NIH Program Level	*28,650*	*28,587*	*28,587*	*0*
Substance Abuse & Mental Health Services	3,268	3,205	3,134	-72
SAMHSA Program Level	*3,392*	*3,327*	*3,260*	*-67*
Agency for Healthcare Research & Quality*	0	0	0	0
AHRQ Program Level	*319*	*319*	*319*	*0*
Centers for Medicare & Medicaid Services	3,319	3,080	3,113	+34
CMS Program Level (Excluding HCFAC)	*3,377*	*3,255*	*3,293*	*+38*
Administration for Children & Families	13,822	13,726	12,787	-940
ACF Program Level	*13,883*	*13,787*	*13,847*	*+60*
Administration on Aging	1,393	1,363	1,335	-28
AoA Program Level	*1,397*	*1,366*	*1,338*	*-28*
Departmental Management/Office for Civil Rights	412	393	405	+12
OS Program Level	*456*	*437*	*449*	*+12*
Office of the National Coordinator	0	42	88	+46
ONC Program Level	*20*	*62*	*116*	*+55*
Medicare Hearings and Appeals	58	59	74	+15
Office of Inspector General	40	39	44	+4
OIG Program Level	*218*	*248*	*250*	*+2*
Health Care Fraud and Abuse Control	0	0	118	+118
HHS HCFAC Program Level	*911*	*1,023*	*1,042*	*+19*
PHSSEF/Pandemic Influenza	220	3,142	160	-2,982
Pandemic Influenza Allowance	0	0	2,300	+2,300
Medicare Eligible Healthcare Accruals (Com. Corps)	33	34	36	+2
DOJ HCFAC Charged To HHS (Program Level Only)	0	0	11	+11
Hurricane Response Funding	0	90	0	-90
Loan Fund Balance Rescission	0	0	-106	-106
Social Services Block Grant Reduction	0	0	-500	-500
Offset for PHS Evaluation Funds (Prog. Level)	*-810*	*-807*	*-821*	*-14*
HCFAC Funds Included in Agencies Prog. Level	*-169*	*-169*	*-180*	*-11*
Subtotal, Discretionary Budget Authority	**$69,026**	**$70,889**	**$68,256**	**-$2,633**
Subtotal, Discretionary Program Level	***$72,916***	***$75,532***	***$74,013***	***-$1,519***
Less Scorekeeping Adjustments:				
FY 2006 Emergency Funding (Pandemic Influenza)	0	-3,320	0	+3,320
FY 2006 Emergency Funding (Other)	0	-165	0	+165
FY 2007 Pandemic Allowance	0	0	-2,300	-2,300
Total, Discretionary Budget Authority**	**$69,026**	**$67,404**	**$65,956**	**-$1,448**
Subtotal, Discretionary Outlays	**$66,552**	**$67,956**	**$70,613**	**+$2,657**

*AHRQ is financed through PHS evaluation funds, which are included in other agencies. Therefore, AHRQ is not included in the HHS total.

**Discretionary amounts shown reflect adjustments for comparability and services provided by other agencies in support of Medicare.

COMPOSITION OF THE HHS BUDGET

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Mandatory Programs (Outlays):				
Medicare	$294,333	$337,922	$387,049	+$49,127
Medicaid	181,720	192,334	199,287	+6,953
Temporary Assistance for Needy Families	17,357	17,406	17,471	+65
Foster Care & Adoption Assistance	6,427	6,603	6,906	+303
State Children's Health Insurance	5,129	5,775	5,948	+173
Child Support Enforcement	3,983	3,903	4,112	+209
Child Care	2,784	2,868	2,909	+41
Social Services Block Grant***	1,822	2,224	1,827	-397
Other Mandatory Programs	1,137	3,796	2,982	-814
Offsetting Collections	-1,274	-1,149	-1,176	-27
Subtotal, Mandatory Outlays	**$513,418**	**$571,682**	**$627,315**	**+$55,633**
Total, HHS Outlays	**$579,970**	**$639,638**	**$697,928**	**+$58,290**

***FY 2007 outlay totals reflect the mandatory component of SSBG. With proposed discretionary reductions, outlays would be $1.4 billion.

FOOD AND DRUG ADMINISTRATION

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Foods	$436	$439	$450	+$11
Human Drugs	496	518	535	+17
Biologics	172	195	210	+15
Animal Drugs and Feeds	98	99	105	+6
Medical Devices	250	261	272	+11
National Center for Toxicological Research	40	41	34	-7
Other Activities	115	117	120	+3
GSA Rental Payments	129	134	146	+12
Other Rent and Rent Related Activities	36	36	36	0
FDA Consolidation at White Oak	21	22	26	+4
Export/Certification Fund	7	8	8	+1
Subtotal, Salaries & Expenses	**$1,801**	**$1,869**	**$1,942**	**+$74**
Buildings and Facilities	0	8	5	-3
Total, Program Level	**$1,801**	**$1,876**	**$1,947**	**+$71**
Less Current Law User Fees:				
Prescription Drug User Fee Act (PDUFA)	-$284	-$305	-$321	-$15
Medical Device User Fees (MDUFMA)	-34	-40	-44	-3
Animal Drugs User Fee Act (ADUFA)	-8	-11	-12	0
Mammography Quality Standards Act (MQSA)	-17	-17	-18	0
Export/Certification Fund	-7	-8	-8	-1
Subtotal, Current Law User Fees	**-350**	**-382**	**-402**	**-20**
Total Discretionary Budget Authority	**$1,450**	**$1,495**	**$1,545**	**+$51**
Less Mandatory Proposed Law User Fees				
Reinspection User Fee	0	0	-22	-22
Export/Certification Fund (Foods and Feeds)	0	0	-4	-4
Subtotal, Mandtory Proposed User Fees	**$0**	**$0**	**-$26**	**-$26**
Mandatory BA (Scorekeeping Adjustment)	*$0*	*$0*	*-$26*	*-$26*
Total Net Budget Authority*	**$1,450**	**$1,495**	**$1,520**	**+$25**
Biodefense (non-add):				
Food Defense	*$150*	*$158*	*$178*	*+$20*
Medical Product Countermeasures	*57*	*57*	*57*	*0*
Security	*7*	*7*	*7*	*0*
Subtotal, Biodefense (non-add)	*$214*	*$222*	*$242*	*+$20*
FTE	9,992	10,176	10,209	+33

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

FOOD AND DRUG ADMINISTRATION

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

The FY 2007 budget request for the Food and Drug Administration (FDA) is $1.9 billion, a net program level increase of $71 million over FY 2006. FDA's budget includes significant increases totaling $126 million to protect the Nation against the threat of an influenza pandemic, ensure the safety and security of our food supply, capitalize on breakthroughs in basic research through the Critical Path to Personalized Medicine Initiative, increase safety of drugs already on the market, and accelerate the availability of new and innovative medical products. These increases are partially offset by $55 million in management and administrative savings. The budget also supports human tissue safety efforts, FDA's consolidation efforts at White Oak, Maryland, and salary and rent costs.

Pandemic Influenza Preparedness

During the past year, the Administration and Congress have acted decisively to build our Nation's defenses against the possibility of an influenza pandemic. Through the *National Strategy for Pandemic Influenza*, HHS and its Federal partners have advanced a comprehensive plan to prepare, detect, and respond in the event of an outbreak. The FY 2006 Defense Appropriations Act provided FDA with $20 million to enhance the regulatory science base to work with the private sector to manufacture influenza vaccines. This supplemental funding augments FDA base resources for an FY 2006 total of $25 million in pandemic influenza activities. In FY 2007, FDA will continue to play a vital role in the plan as the Nation achieves greater preparedness for this threat. The FY 2007 President's Budget requests a total of $55 million for pandemic influenza preparedness, a $30 million increase over FY 2006. The FY 2007 budget includes $15 million in increased funding to accelerate production capabilities for vaccine candidates and for the development of pandemic influenza virus strains used in manufacturing the vaccine in a collaborative effort with CDC. The budget also includes $15 million to safeguard the Nation's food supply and detect and contain animal outbreaks in the event of domestic outbreak. These activities will include improved surveillance systems for poultry and other foods and research on methods and tools to detect and contain transmission of possible foodborne influenza viruses. These investments are consistent with the *HHS Pandemic Influenza Plan* and will better secure our Nation against the threat of a pandemic outbreak.

Protecting the Food Supply

As greater understanding is gained of the many natural and man-made threats that face our Nation's security and safety, continued vigilance is needed to protect our citizens from a threat that is widely known – Bioterrorism. Since 9/11, FDA has made great strides in strengthening the Nation's defenses against the risk of contamination of our food supply. FDA is continuing to implement drastic changes in its oversight of imported foods. FDA has implemented new authority for food facility registration and for record-keeping and administrative detention of suspected foods. The Prior Notice Center is expecting to process up to 20,000 prior notifications for food import shipments per day; greatly increasing the surveillance of imported foods. However, the threat of deliberate contamination of our food is a constant one.

The FY 2007 President's Budget requests a total of $450 million for the Foods program. Within this total, $178 million is devoted to protecting the American people against attacks on the national food supply, a $20 million increase over FY 2006. This request is a part of a continuing effort with the Department of Agriculture (USDA) and the Department of Homeland Security (DHS) to coordinate all strategies used to combat the threat of intentional food contamination. Within the increase, $13 million will be directed to enhance the laboratory surge capacity and national coverage of the Food Emergency Response Network (FERN). FERN is a nationwide network of Federal and State laboratories dedicated to testing for biological, chemical, and radiological threat agents. While FDA and USDA are building FERN surge capacity, the Agency will continue work with DHS to award new funds to existing State labs in geographic regions with the greatest need according to current threat assessments. The budget request will significantly increase FDA's ability to rapidly test threat agents and respond to terrorist attacks.

In addition to laboratory preparedness, this increase will also support field staff that are on the front lines of the battle to protect our food supply. The budget directs $3 million to fund food defense personnel and operations in the

Office of Regulatory Affairs. FDA will also continue its support of the government-wide biosurveillance effort. The FY 2007 budget requests a $2 million increase, for a total of $5 million in biosurveillance activities to provide the earliest possible detection of the intentional release of deadly pathogens into food, water, or the environment. This increase will help coordinate existing food surveillance capabilities with public health and environmental professionals at the State and national levels, under a unified system. The request also includes a $1 million increase used for central response coordination through the Office of Crisis Management. Finally, $1 million will fund research based on food vulnerablility threat assessments developed in collaboration with USDA. This research will focus on closing mission-critical knowledge gaps in food defense by developing technologies to detect and prevent threats to the food supply.

Human Drugs and Biologics

In FY 2007, the budget includes $745 million for the Human Drugs and Biologics programs, an increase of $17 million for the Human Drugs program and an increase of $15 million for the Biologics program over FY 2006. Of the total funding for these activities, $289 million will be from industry-specific user fees. These funds will ensure the safety and efficacy of existing human drugs and biologics – helping to make medicines safer, more affordable, and more available. FDA evaluates all new drugs for safety and efficacy before they enter the market. FDA also monitors the 10,000 drugs that are already on the market to be sure they continue to meet the highest standards of safety and efficacy. In addition, FDA assesses the safety and effectiveness of existing and emerging biological products (including whole blood and blood products), vaccines, and therapeutic products, including cells, gene therapies, and tissues. In FY 2005 FDA approved 593 new and generic drug products and new biological products, resulting in significant therapeutic advances, many new products on the market, and many new treatment uses for existing products.

Critical Path to Personalized Medicine: FDA needs to take advantage of enormous breakthroughs in basic research and facilities enabling medical products to be developed faster, safer, and at less expense. The budget includes $6 million in targeted investment in the critical path to personalized medicine, which will pave the way to more efficient, less expensive clinical trials and safer, more effective drugs for the American public. This will enable FDA to approve prescription drugs for individual groups of people, rather than drugs to treat whole populations. By approving drugs tailored to the individual molecular traits unique to individuals, health professionals will be able to prescribe safer, more effective medical products for every American.

Drug Safety: The budget includes an increase of $4 million for work on improving the safety of drugs on the market, for a total of $39 million in the Office of Drug Safety. With increased resources in FY 2007, FDA plans to modernize the Adverse Event Reporting System (AERS) and establish "AERS II" as the primary source for drug product adverse event data. These resources will also allow FDA to augment AERS data and further its efforts with the Centers for Medicaid and Medicare Services (CMS) to obtain access to valuable drug safety information housed in CMS population-based databases. This collaboration with CMS will be integrated with the Sentinel System, a seamless platform for gathering and evaluating information about adverse events related to the use of medical products. This integration will enable FDA to gather more information from the point of care about potential safety problems and will provide a framework for turning this raw data into useful knowledge about the safe use of medical products. Through this modernization, FDA will continue to ensure that the medical products it regulates are the safest in the world.

Tissue Safety: One of FDA's top priorities is to enhance patient protection by ensuring the safety of medical products, which include human cells, tissues, and cellular and tissue-based products (HCT/P's). Advances in medical science have resulted in a tremendous increase in transplants and other uses of HCT/P's. The number of transplants has grown to about 1 million per year in the U.S. To support a new risk-based approach for tissue regulation, the FY 2007 budget requests a $2 million increase to ensure the safety of tissues. This increase will allow FDA to increase staffing levels for critical functions at

Performance Highlight

One of FDA's many food defense activities, the Prior Notice Center (PNC) identifies imported food and feed products that may be intentionally contaminated with biological, chemical, or radiological agents, or which may pose significant health risks to the American public. Once identified, the PNC takes action to keep these products from entering into the U.S. In FY 2005, FDA exceeded its prior notice performance target of 38,000 reviews, by conducting 86,187 import security reviews. FDA collaborated with Customs and Border Protection to direct field personnel to hold and examine five suspect shipments of imported food; refused 141 lines of food for prior notice violations; and conducted 86,187 intensive security reviews of Prior Notice submissions out of 8,705,847. In FY 2007, FDA expects to continue to conduct import security reviews of products that may pose significant health risks to the American public.

the Center for Biologic Evaluation and Research, and in the field. Funding would increase inspections of facilities by 30 percent.

User Fee Programs

New User Fee Proposals: The FY 2007 President's Budget proposes two new user fee programs. The first proposal is a $22 million user fee program requiring manufacturers and laboratories to pay the full costs of reinspections and associated follow-up work due to their failure to meet FDA requirements during an inspection. This new proposal rewards firms for complying with health and safety standards while ensuring that companies are charged with the costs of reinspection when they fail to meet FDA safety and quality regulations.

The budget also proposes to expand the current drug, animal drug, and medical device export certification user fee program by $4 million to also include food and animal feed. Export certificates may be requested by firms seeking documentation that exported products are in compliance with U.S. laws and regulations, importing countries' requirements, and certain national or international standards. These certificates enhance the global competitiveness of American food and animal feed producers by ensuring that the products meet specific legal requirements. With this expansion, the food and animal feed industry will no longer receive preferential treatment through government payment of export certificates.

Medical Device and Animal Drug Review: The FY 2007 budget includes an increase of $11 million, for a total of $272 million, to ensure medical devices are safe and effective and an increase of $6 million, for a total of $105 million, to ensure the safety and efficacy of animal drugs. These funding levels are consistent with the intent of the Medical Devices User Fee and Modernization Act of 2002 as modified by the Medical Device User Fee and Stabilization Act in 2005; and the Animal Drug User Fee Act. Both of these user fee programs are vital to maintaining the efficiency of FDA's review enterprise while continuing to uphold the stalwart safety record of FDA approved products.

The FDA budget requests an additional $5 million for medical device review that will lead to marked improvement in application review time while maintaining the consistent quality and safety of approved medical device products. New and increasingly complex medical devices are making astonishing medical advances possible in both diagnosis and treatment. Through additional user fee resources, FDA will be able to review medical device applications for safety and effectiveness in a manner that will move products to the market quickly. In FY 2007, FDA expects to meet goals stipulating that the Agency review and make decisions on 90 percent of all original premarket medical device applications within 180 and 320 days respectively.

The budget also requests an increase of $2 million for the process of reviewing new animal drug applications. The Animal Drugs User Fee program provides FDA with the ability to provide quality premarket reviews in a cost-efficient and timely manner. These funds will allow FDA to review 90 percent of original new animal drug applications within 200 days.

Facilities

Headquarters Consolidation: The FY 2007 budget request includes a budget authority increase of $4 million for a total of $26 million for headquarters consolidation at White Oak, MD. In addition to this budget authority, FDA will expend $8 million in Prescription Drug User Fee program carryover resources to bring total FY 2007 White Oak resources to $34.5 million. These new resources will be directed to move and costs for the new FDA consolidated facility the General Services Administration (GSA) is constructing in White Oak, MD. This funding is needed for completion of the project's next phase, which includes design and additional costs for the Center for Drug Evaluation and Research Office Building II and the second phase of the Central Shared Data Center. The FY 2007 GSA budget includes $179 million primarily for construction of the Center for Devices and Radiological Health high bay laboratory, the Office of Regulatory Affairs and Office of the Commissioner office complex, and infrastructure costs.

Buildings and Facilities: In FY 2007, the budget seeks $5 million, a decrease of $3 million from FY 2006, to pay for repair and maintenance of FDA-owned facilities nationwide. Resources will fund safety improvements at the National Center for Toxicological Research and food safety laboratories. The request is decreased due to a delay of specific lower priority renovations to regional laboratories.

Strategic Redeployment

The current budget environment requires that every agency, including FDA, closely examine its current expenditures to determine where it can find savings. In FY 2007, FDA is proposing $52 million in strategic redeployment and personnel efficiencies agency-wide . FDA has conducted a risk-based analysis to identify resources that will be redeployed in lower priority public health functions in order to fund the higher priority initiatives that yield the greatest public health benefit. This agency-wide strategic redeployment will allow FDA to conduct priority public health activities at the least cost to the American public.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Health Centers	$1,734	$1,782	$1,963	+$181
(Health Centers Federal Tort Claims - non-add)	*45*	*45*	*45*	*0*
Free Clinics Medical Malpractice Coverage	0.1	0.04	0	-0.04
Healthy Community Access Program	83	0	0	0
Office of Pharmacy Affairs (340B Program)	0	0	3	+3
Nurse Training Programs	151	150	150	0
National Health Service Corps	131	126	126	0
Health Professions Training Activities	252	99	0	-99
Scholarships for Disadvantaged Students	47	47	10	-37
Children's Hospitals Graduate Medical Education	301	297	99	-198
Bioterrorism Hospital Preparedness	487	474	474	0
Bioterrorism Training and Curriculum Development	28	21	12	-9
Ryan White HIV/AIDS Activities	2,073	2,063	2,158	+95
Rural Health	145	160	27	-133
Maternal and Child Health Block Grant	724	693	693	0
Healthy Start	103	102	102	0
Family Planning	286	283	283	0
Traumatic Brain Injury	9	9	0	-9
Poison Control	24	23	13	-10
EMS for Children	20	20	0	-20
Organ Transplantation	24	23	23	0
Bone Marrow Donor Registry	25	25	23	-2
Cord Blood Stem Cell Bank	10	4	0	-4
Telehealth	4	7	7	0
Black Lung/Radiation Exposure Compensation	8	8	8	0
Hansen's Disease Services Programs	20	18	18	0
Health Care Facilities/Other Improvement Projects	483	0	0	0
State Planning Grants	11	0	0	0
Universal Newborn Hearing Screening/Trauma	13	10	0	-10
Sickle Cell	0	2	2	0
Family-to-Family Health Information Centers	0	0	3	+3
Program Management	154	151	148	-3
National Practitioner Data Bank (User Fee)	16	16	16	0
Health Integrity & Protection Data Banks (User Fee)	4	4	4	0
Total, Program Level	**$7,369**	**$6,615**	**$6,363**	**-$252**
Less Mandatory and Funds From Other Sources:				
User Fees	-20	-20	-20	0
PHS Evaluation Funds (Ryan White)	-25	-25	-25	0
Family-to-Family Health Information Centers (mandatory funds)	0	0	-3	-3
Subtotal, Funds from Other Sources	-45	-45	-48	-3
Total, Discretionary Budget Authority	**$7,324**	**$6,570**	**$6,315**	**-$255**
FTE	1,903	1,894	1,864	-30

HEALTH RESOURCES AND SERVICES ADMINISTRATION

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

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

The request for the Health Resources and Services Administration (HRSA) is $6.4 billion, a net decrease of $252 million from the FY 2006 level. HRSA is the principal Federal agency charged with increasing access to basic health care for those who are medically underserved. HRSA works to expand access to high-quality, culturally competent health care; improve health outcomes among America's minority communities; and enhance direct medical care through the use of information and telehealth technology. Through a range of programs and initiatives including Health Centers, Ryan White CARE Act programs, placement of physicians in underserved areas, maternal and child health programs, and support for the next generation of nurses, HRSA improves access to care for more than 20 million uninsured or underserved individuals. The HRSA budget supports programs that have shown success in providing direct health care and reduces or eliminates funding for programs that have failed to demonstrate results or are similar to other activities.

Expanding Access to Quality Health Care

Health Centers: The budget includes funding toward two goals: complete the President's commitment to significantly impact 1,200 communities through new or expanded access points, and begin a new initiative to establish new health centers in poor counties. In FY 2007, an additional 1.2 million individuals will receive health care through more than 300 new or expanded sites in medically underserved communities throughout the Nation. Of the over 300 new sites, 80 will be in poor rural and urban counties consistent with the President's goal of establishing new health centers in the poorest counties in the Nation. A total of $52 million from the increase requested in FY 2007 is directed to the poor county initiative, including $4 million for planning grants for poor counties interested in creating access to primary care services. By the end of FY 2007, 15.8 million patients will be receiving affordable primary and preventive health care at 4,015 sites across the country.

Consistent with Secretary Leavitt's charge to transform the healthcare system, Health Centers are effectively targeted to eliminate health disparities and provide a range of essential services. An estimated 86 percent of Health Center patients are at or below 200 percent of the Federal poverty level. Forty percent of Health Center patients have no health insurance and 64 percent are racial or ethnic minorities. Further, 84 percent of Health Centers provide pharmacy services on site or by paid referral, 82 percent provide preventive dental care, and 75 percent provide mental health and substance abuse services.

The budget request includes $45 million in no-year funding for the Health Centers Federal Tort Claims Program, which provides medical malpractice coverage for the increasing number of Health Center employees.

The request provides $3 million to improve the 340B Drug Pricing program which provides drugs at discounted prices to participating safety-net clinics and hospitals. In FY 2007, funds will be used to improve the collection and analysis of manufacturer drug pricing information to ensure that 340B participants are charged accurate prices for drugs and for other program improvements. Participants in the 340B program include certain Federal grantees and disproportionate share hospitals, such as Health Centers, Ryan White grantees, Hemophilia Treatment Centers, IHS funded tribal clinics, Office of Population Affairs Title X family planning programs, and CDC funded STD and TB programs.

Performance Highlight

In FY 2001, HRSA funded 3,317 health centers sites. Under the President's Health Centers Expansion Initiative, HRSA has increased access to health center services through 777 new (428) and expanded (349) sites, for a total of 3,745 sites across the country. The FY 2007 request will complete the Expansion Initiative to establish 1,200 new (698) or expanded (502) sites for a total 4,015 health center sites.

Ryan White, HIV/AIDS: Each year, Ryan White CARE Act programs provide services to approximately 571,000 individuals who have little or no insurance. The FY 2007 request includes $2.2 billion for Ryan White activities, an increase of $95 million over FY 2006 for a new Domestic HIV/AIDS initiative. Of the $95 million, $70 million will address the on-going problem of State waiting lists and provide care and life-saving medications to those newly diagnosed as a result of increased testing efforts. The remaining $25 million will be used to expand outreach efforts by providing new HIV community action grants to intermediaries including faith and community-based organizations, and

to provide technical assistance and sub-awards to grassroots organizations. Combined with $93 million in new CDC funding, a total increase of $188 million is requested for this initiative in FY 2007.

In 2004, the President articulated his commitment to reauthorize the Ryan White CARE Act by outlining key principles to strengthen this legislation. These principles include: prioritizing lifesaving services for individuals living with HIV/AIDS, including HIV/AIDS medications and primary care; providing more flexibility to target resources to areas that have the greatest needs; and encouraging the participation of any provider, including faith-based and other community organizations that show results, recognizing the need for State and local planning and ensuring accountability by measuring progress. The request will support a comprehensive approach to address the health needs of persons living with HIV/AIDS, consistent with the reauthorization principles. The budget also includes a new authority to increase program flexibility by allowing the Secretary to transfer up to five percent of funding provided for each Part of the Ryan White CARE Act to any other Part.

Maternal and Child Health Block Grant: The Maternal and Child Health (MCH) Block Grant supports Federal and State partnerships that provide gap-filling prenatal health services to more than 2.3 million women and primary and preventive care to more than 26.8 million infants and children, including approximately 1 million children with special health care needs. The budget provides $693 million for the MCH Block Grant. The Deficit Reduction Act of 2005 provides $3 million in mandatory funding in FY 2007 for the development and support of family-to-family health information centers.

Family Planning: The Family Planning program supports a network of more than 4,500 clinics nationwide. Program data reflects that in 2004, 91 percent of individuals served in Title X clinics were from low-income families, and it is estimated that more than 1.1 million unintended pregnancies were averted as a result of Title X family planning services. Counseling and education regarding abstinence are required for all adolescent clients in this program. A total of $283 million is included for this program in FY 2007.

Healthy Start: The request includes $102 million for the Healthy Start program, which supports community driven programs in targeted high risk communities to reduce the incidence of risk factors that contribute to infant mortality.

Developing A Health Professions Workforce for the 21st Century

Today the Nation faces a shortage of approximately 150,000 nurses in our hospitals and other health care facilities. As the population continues to grow and age and medical services advance, the need for nurses will continue to increase. A report issued by the Department, *Projected Supply, Demand, and Shortages of Registered Nurses: 2000-2020*, predicted that the nursing shortage is expected to grow to 29 percent by 2020, compared to a 6 percent shortage in 2000. The request includes $150 million for nursing education programs.

In 2007, Nursing programs will support the recruitment, education, and retention of an estimated 36,750 nurses and nursing students and approximately 956 new loan repayments and scholarships among other activities.

Currently, 35 million people live in communities without adequate access to primary health care due to financial, geographic, cultural, language, and other barriers. Since its inception, the National Health Service Corps (NHSC) has placed more than 27,000 primary care clinicians, including dental, mental, and behavioral health professionals in underserved areas across the country including communities with health centers. Approximately half of NHSC clinicians are assigned to service in health centers sites. The budget includes $126 million to support a field strength of more than 3,400 clinicians. The request also includes $10 million for the Scholarships for Disadvantaged Students program a reduction of $37 million to maintain the FY 2006 request level. In 2007, this program will support 15,000 scholarships.

The budget provides $99 million for the Children's Hospitals Graduate Medical Education (GME) program, a reduction of $198 million. In FY 2007, the budget proposes to reform the GME program to focus limited resources on hospitals with the greatest financial need that treat the largest number of uninsured patients and train the greatest number of physicians. Currently, the GME program provides payments to freestanding children's hospitals to subsidize training costs without regard to financial need.

Preparing America's Health Care System and Providers for Bioterrorism

The Hospital Preparedness program directly supports States' efforts to enhance their capability to provide critical emergency care to America's populations in responding to acts of terrorism and other public health emergencies. The budget requests $474 million in FY 2007 to enhance surge capacity and to continue the development of a complex health and medical response through a single system. As of the end of 2004, 100 percent of States had reached the goal of having surge capacity plans in place. Within the total request for Hospital Preparedness, $25 million in new competitive grants will be directed to one or more metropolitan areas to create state-of-the-art emergency care capability designed to respond to a terrorist attack or other incident requiring mass casualty care and/or containment of infectious agents.

The Emergency System for Advance Registration of Volunteer Healthcare Personnel (ESAR-VHP) program facilitates intra- and inter-State deployment of volunteer health professionals during a mass casualty event or natural disaster. Within two weeks after Hurricane Katrina made landfall, 21 State ESAR-VHP systems were able to deploy over 8,300 credential-verified health professionals to the Gulf region. The FY 2007 request includes funds to continue the development of State ESAR-VHP systems. Efforts will be made to integrate the ESAR-VHP program with the new health care provider credentialing portal, part of the FY 2007 Mass Casualty Initiative.

The budget also includes $12 million for Training and Curriculum Development to prepare health care providers throughout the Nation for a bioterrorism event through competency-based training. In the first two years of this effort's funding, 223,000 healthcare providers and other first responders received preparedness training. In FY 2007, the program will consolidate awards to expert entities that develop curriculum adopting a wholesale training approach.

The budget also includes $13 million for the Poison Control Program, a reduction of $10 million from the FY 2006 level. Fifty-five of 61 poison centers are now certified, making 90 percent of poison centers certified, up from 78 percent in 2001. In FY 2007, the budget proposes achieving efficiencies through better integration and coordination of poison centers to improve performance. HRSA will use funding to support the national toll-free number and leverage funding to support a limited scope effort to qualified poison centers.

Supporting Transplantation

The budget includes $23 million to support the Organ Transplantation program. In FY 2007, this program will provide funding to maintain on–going activities including grants to test new approaches for increasing organ donation and provide reimbursement of travel and subsistence expenses for living organ donors who lack the resources to pay for these expenses. The budget also includes $23 million to support the National Bone Marrow Donor Registry, a reduction of $2 million to maintain the FY 2006 request level. This program enables patients to search for a suitable, unrelated bone marrow or cord blood donor.

While the budget does not seek new funding in FY 2007 for the Cord Blood Stem Cell program, funds provided in FY 2004 through FY 2006 will support the collection of approximately 13,800 new cord blood units by the end of FY 2007. Increasing the number of high quality, diverse, cord blood units in the National Cord Blood Inventory will increase the likelihood that more patients will be able to find an adequately tissue-matched stem cell source for transplantation.

Eliminating Underperforming Programs

Funding for programs which are similar to other activities or have failed to demonstrate results are reduced or eliminated and priority is given to support more targeted efforts to provide direct health services.

A number of HRSA programs are unable to demonstrate outcomes or provide services similar to other programs. Recent Program Assessment Rating Tool (PART) reviews found that the Traumatic Brain Injury program and the Emergency Medical Services for Children program did not document an impact on improving the health or well-being of individuals. The Traumatic Brain Injury and Emergency Medical Services for Children programs are not funded in FY 2007, a reduction of $29 million.

The Medicare Prescription Drug Improvement and Modernization Act will increase spending in rural America by $25 billion over ten years, providing greater access to hospitals, health professionals, and other medical services for rural seniors. The budget reduces $133 million from HRSA rural programs which were found to be similar to numerous other HHS programs that provide resources to rural areas. In addition, $10 million for the Universal Newborn Hearing Screening program is not requested in FY 2007. The primary purpose of this program is not to finance screenings, but rather state-wide efforts to fully implement newborn screening program services. The Maternal and Child Health Block Grant provides States with the flexibility to fund these activities.

The budget maintains support for nursing programs and provides $10 million for scholarships for disadvantaged students. A PART assessment found that, after 40 years of funding, Health Professions programs have not demonstrated an impact on placing health professionals in underserved areas. Based on this determination, the budget proposes the elimination of most general health professions grants, a reduction of $99 million, to direct resources to activities that are capable of placing health care providers in medically underserved communities.

Program Management and Other Activities

The budget requests $148 million for program management, a reduction of $3 million. Resources will enable HRSA to manage and operate a wide array of Federal programs as well as to fund Federal pay cost increases. The budget maintains funding for Telehealth, Hansen's Disease, Black Lung, and Radiation Exposure Compensation. No funds are requested in FY 2007 for the Free Clinics Medical Malpractice program.

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Indian Health Service:				
Clinical Services	$2,762	$2,854	$3,001	+$147
Contract Health Services (Non-Add)	*498*	*517*	*554*	*+37*
Preventive Health	110	117	125	+8
Contract Support Costs	264	265	270	+6
Tribal Management/Self-Governance	8	8	8	0
Urban Health	32	33	0	-33
Indian Health Professions	30	31	32	+1
Direct Operations	62	62	64	+2
Diabetes Grants 1/	150	150	150	0
Subtotal, Services Program Level	$3,418	$3,520	$3,650	+$130
Indian Health Facilities:				
Health Care Facilities Construction	$89	$38	$18	-$20
Sanitation Construction	92	92	94	+2
Facilities & Environmental Health Support	142	151	161	+11
Maintenance & Improvement	55	58	59	+1
Medical Equipment	17	21	22	+1
Subtotal, Facilities Program Level	$395	$359	$354	-$6
Total, Program Level	**$3,813**	**$3,879**	**$4,004**	**+$124**
Less Funds Allocated From Other Sources:				
Health Insurance Collections	-$671	-$678	-$678	$0
Rental of Staff Quarters	-6	-6	-6	0
Diabetes Grants 1/	-150	-150	-150	0
Total, Budget Authority	**$2,985**	**$3,045**	**$3,170**	**+$124**
FTE	15,249	15,549	15,822	+273

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

INDIAN HEALTH SERVICE

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

The FY 2007 budget request is $4.0 billion, a net increase of $124 million over FY 2006. Additional Indian Health Service (IHS) funding is targeted towards offsetting the increased cost of providing health care, continuing to serve a growing population of eligible Indian people, and expanding health care capacity in locations where it is most needed. In partnership with Tribes, IHS is transforming its health care system through its health promotion and disease prevention initiatives and the expanded use of health information technology.

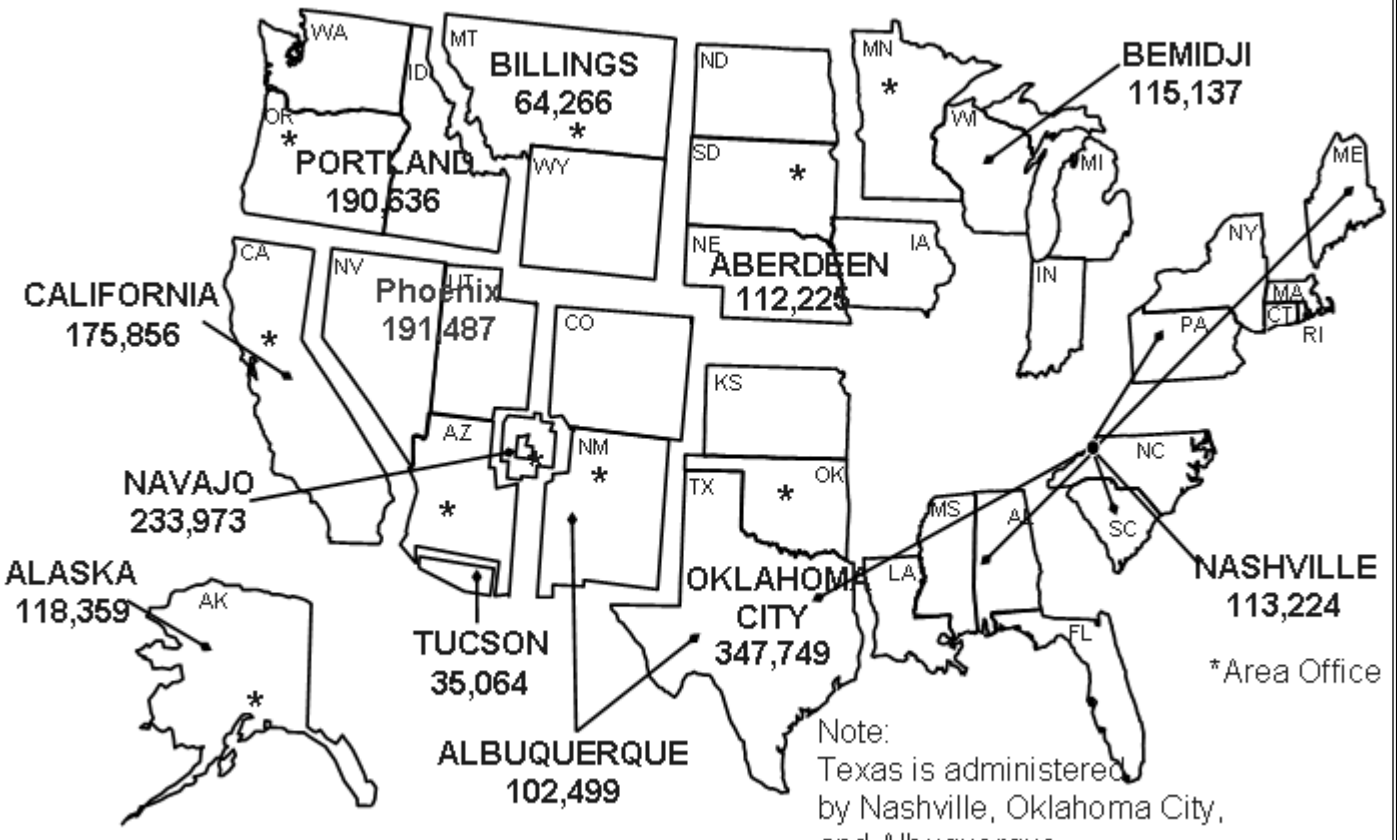
Agency Description

As part of the Federal government's special relationship with Tribal governments, IHS provides health care to members of more than 560 Federally recognized Tribes. An estimated 1.9 million American Indians and Alaska Natives will be eligible for IHS services in 2007, an increase of 1.6 percent over 2006 and 11.3 percent over 2001. Care is provided directly in 48 hospitals, 272 health centers, and nearly 300 health stations and Alaska village clinics. Health facilities are located where there are concentrations of eligible Indian people – the Southwest, Oklahoma, the Northern Plains, and Alaska. IHS also contracts with hospitals and health care providers to purchase health care that it cannot provide economically through its own network. Recognizing that health prevention and disease promotion are critical to improving the health of Indian communities, IHS also builds sanitation systems to provide water and waste disposal for Indian homes, provides diabetes prevention and disease management grants to over 300 Tribes, and supports a system of behavioral health care (mental health services, alcohol and substance abuse prevention and treatment) in Indian communities.

Continuing to Serve a Growing Population

The challenge for IHS is to continue to improve the health of Tribal members as the population increases, the cost of providing health care rises, and chronic disease becomes increasingly prevalent in Indian communities.

Indian Health Service Population by Area, CY 2005



*Projections are based on bridged 2000 Census data.

To meet this challenge, the budget requests additional funds for health care cost increases and population growth. Similar increases were proposed for the IHS and provided by the Congress in FY 2006.

Population and the Cost of Providing Care: The budget includes new funds to serve the additional 30,000 people who are expected to seek care in FY 2007, meet the rising cost of providing services, and cover increased pay cost for the Federal and Tribal employees who provide these services. Based on past experience, these funds will allow IHS to provide a variety of additional services including 76,000 additional outpatient visits in IHS and Tribally operated facilities, 16,000 additional outpatient visits purchased from outside the IHS system, and 17,000 additional public health nursing visits. Tribally operated programs will receive these funds on the same basis as the programs IHS operates directly.

Opening New Health Facilities: Additional FY 2007 funds are included to staff new outpatient facilities in Clinton, OK; Red Mesa, AZ; Sisseton, SD; and St. Paul, AK. A FY 2006 PART review found that IHS was effective in placing new health care facilities in areas where they were most needed. When fully operational, these four facilities will increase the number of primary care provider visits that can be provided at these sites by 81 percent and allow the provision of new services – 24 hour emergency room, optometry, physical therapy, and audiology. IHS has opened 14 new health facilities since 2001, including these four sites.

Special Diabetes Program for Indians: Diabetes is the third leading cause of death among IHS's service population with a mortality rate triple the rate for all Americans. To control this disease, IHS provides grants to over 300 Tribes and Indian organizations. In FY 2007, $150 million will be awarded – $700 million in total over the last five years – to support diabetes prevention and disease management at the local level. By providing additional resources, and developing and using best practice models to ensure that these funds are used effectively, IHS has increased the percentage of its patients maintaining ideal blood sugar control from 30 percent in 2002 to 36 percent in 2005.

Performance Highlight

IHS has increased the proportion of its diabetic patients who maintain ideal blood sugar control from 30 percent in 2002 to 36 percent in 2005. IHS's 2007 target is to keep the portion of its diabetics with ideal blood sugar control at 36 percent and to increase this portion to 40 percent by 2010.

This increase is important. NIH-supported clinical trials have found that an improvement in blood sugar control from poor to ideal results in a 42 percent decrease in total mortality for people with diabetes.

Health Insurance Reimbursements: In FY 2007, IHS expects to receive a total of $678 million in health insurance reimbursements for providing care to people covered by Medicare, Medicaid, or private health insurance. IHS facilities receive Medicare and Medicaid under a cost-based methodology developed in close cooperation with the Centers for Medicare & Medicaid Services (CMS). Health insurance can make up 50 percent of the operating budget of an IHS health facility, supporting additional medical staff, equipment, and building improvements.

The CMS, IHS, and the Social Security Administration are working together with CMS's Tribal Technical Advisory Group – comprised of Tribal leaders – to implement the Medicare prescription drug coverage benefit in Indian Country. Individuals employed by IHS and Tribes have been trained to provide face-to-face beneficiary consultation. These individuals understand the local Indian communities, are culturally competent, and can often speak the local Tribal language.

Urban Indian Health Program: IHS's FY 2007 budget targets additional funding for the provision of health care on or near reservations but does not include funds for the continuation of the Urban Health program. Unlike Indian people living in isolated rural areas, urban Indians can receive health care through a wide variety of Federal, State, and local providers. One health care provider available to low-income urban Americans is the Health Resources and Services Administration's Health Centers program which served 7.3 million urban patients, and 125,000 Native Americans, in 2004. The budget requests $2.0 billion for Health Centers in FY 2007, sufficient to serve 8.8 million urban patients and 150,000 Native Americans.

Construction: The budget includes a total of $94 million for Sanitation Construction. By providing water and waste disposal systems to 300,000 Indian homes since 1960, this program has played a key role in decreasing the rates of infant mortality, gastroenteritis, and other environmentally related diseases. The budget also includes a total of $18 million for Health Facility Construction. Funds will be used to finish a new outpatient facility in Komatke, AZ, which received initial construction funding in FY 2006. When complete, this facility will provide basic ambulatory health care services – dental care, eye care, digital imaging, OB/GYN, laboratory services – and relieve overcrowding in the Phoenix Indian Medical Center.

Consistent throughout HHS, requests for facilities funding focus on maintaining existing facilities but not for new construction projects.

Improving Service Delivery

IHS works continually to improve efficiency in order to raise the health of Tribal members to the highest possible level. The additional resources requested for health care cost increases and population growth will allow the development of more effective strategies to improve Indian health. These strategies include the Directors' health initiatives and improvements in health care quality through the use of health information technology.

Health Initiatives: IHS is working on three interrelated health initiatives–behavioral health, health promotion/disease prevention, and chronic disease management–to help achieve significant improvements in the health of Indian communities. By providing additional funds for population growth and the rising cost of health care, the budget allows IHS and Tribal health programs to focus on these initiatives at the local level.

- As many chronic conditions are linked to life long behavior patterns, they can be prevented by focusing on effective behavioral health interventions. IHS is expanding the focus of local behavioral health programs from crisis intervention to ongoing behavioral health promotion through the use of evidence-based approaches that embrace Tribal traditions and culture as critical foundations for good health.
- The main health challenges in Indian communities are increasingly related to lifestyle issues such as obesity, physical inactivity, poor diet, substance abuse and injuries. To create healthy communities, IHS is building effective health promotion practices at the local level; sponsoring new Federal, corporate, foundation, and academic partnerships; and coordinating local efforts by developing community and clinical best practices and a strategic plan with health promotion and disease prevention coordinators in each of IHS's 12 Regions or Areas.
- Chronic conditions – diabetes, heart disease, cancer – are becoming increasingly prevalent in Indian communities, placing growing demands on the health care system. Building on the success of its diabetes management efforts, IHS is expanding the disease management model to other chronic diseases.

Improving Health Care Through Information Technology: Secretary Leavitt has said, "The use of electronic health records and other information technology will transform our health care system by reducing medical errors, minimizing paperwork hassles, lowering costs and improving quality of care." IHS has long been a leader in this area, launching its Resource and Patient Management System (RPMS) in collaboration with the Veterans Administration in 1984.

In November of 2005, IHS's Clinical Reporting System, an RPMS application, received an award from the Healthcare Information Management System Society, a healthcare industry organization that provides leadership for the optimal use of health care information technology (IT). RPMS received a score of Effective in an FY 2005 PART review and has recently been selected for use by NASA as the health management system that best met its needs.

Another important example of IHS IT innovation is the Electronic Health Record (EHR), which provides a full range of services including medical records management, patient scheduling, data quality control, medical consultations, and reports for practitioners and patients. The EHR system will also have a clinical case management capability for five diseases prevalent in Indian communities – diabetes, cardiovascular disease, asthma, HIV, and obesity. The EHR is presently in use at 24 IHS and Tribal facilities with high user satisfaction and positive effects on patient care reported. The EHR should be available in all IHS sites by 2008.

The budget includes an increase of $11 million for IHS implementation of the Department's Unified Financial Management System (UFMS). In addition to supporting an integrated Department-wide financial management system, UFMS will allow IHS health care facilities to operate in a more business-like manner and improve their collection of health insurance.

Indian Self-Determination

Tribes currently operate one-third of IHS's hospitals, 84 percent of its ambulatory health facilities, and 85 percent of the funds for local behavioral health programs. To enable Tribes to develop the administrative infrastructure critical for successful management of these programs, the budget includes a total of $270 million for contract support costs.

Self-determination works because it is based on the principle that having health services planned and delivered at the local level is the best way of ensuring that high quality health care is delivered. This planning begins with Tribal input and consultation which is central to the way IHS operates at the local, Area and National level. The Federal Government also has a unique legal and political relationship with Tribes. As part of this special relationship, an HHS-wide budget consultation session is held annually to give Tribal leaders the opportunity to consult with HHS on budgetary issues which concern them.

CENTERS FOR DISEASE CONTROL AND PREVENTION

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Infectious Diseases:				
Infectious Diseases	$226	$227	$245	+$19
HIV/AIDS, STDs & TB Prevention	961	947	1,033	+86
Immunization:				
Current Law:				
Section 317 Discretionary Program	493	520	507	-13
Vaccines For Children	1,503	1,958	2,006	+48
Effect of Proposed VFC Improvements:				
VFC	0	0	140	+140
Section 317 Discretionary Program	0	0	-100	-100
Proposed Law Subtotal, Immunization	$1,996	$2,478	$2,554	+$76
Global Health	$317	$381	$381	$0
Bioterrorism:				
State and Local Capacity	$919	$824	$824	$0
Upgrading CDC Capacity/Anthrax Research	158	150	136	-15
Botulinin Antitoxin Research	0	0	3	+3
Strategic National Stockpile	467	525	593	+68
Biosurveillance Initiative	79	133	102	-31
Subtotal, Bioterrorism	$1,623	$1,632	$1,657	+$25
Health Promotion:				
Chronic Disease Prevention & Health Promotion	$900	$839	$819	-$20
Birth Defects, Disability & Health	125	125	110	-14
Health Information and Service:				
Health Statistics	109	109	109	0
Informatics and Health Marketing	120	114	153	+39
Environmental Health and Injury:				
Environmental Health	151	150	141	-9
Injury Prevention & Control	138	139	138	-1
Occupational Safety & Health	251	255	250	-5
Public Health Research	31	31	31	0
Public Health Improvement and Leadership	247	265	190	-75
9/11 Emergency Workers (non-add)	*0*	*75*	*0*	*-75*
Business Services Support	319	299	304	+5
Preventive Health and Health Services Block Grant	119	99	0	-99
Buildings & Facilities	270	158	30	-129
Pandemic Influenza One-Time Emergency Funding	0	77	0	-77
Pandemic Influenza Ongoing Activities (non-add)	*0*	*123*	*188*	*+65*
CDC-wide Pandemic Influenza funding (non-add)	*0*	*200*	*188*	*-12*
ATSDR	76	75	75	0
User Fees	2	2	2	0
Subtotal, Program Level (proposed law)	**$7,980**	**$8,401**	**$8,223**	**-$179**
Less Funds Allocated from Other Sources:				
Vaccines for Children Proposed Law (mandatory)	-$1,503	-$1,958	-$2,146	-$188
PHS Evaluation Transfers	-265	-265	-265	0
User Fees	-2	-2	-2	0
Total, Proposed Law Discr. Budget Authority	**$6,210**	**$6,176**	**$5,809**	**-$367**
FTE	8,657	8,992	9,041	+49

CENTERS FOR DISEASE CONTROL AND PREVENTION

The Centers for Disease Control and Prevention promotes health and quality of life by preventing and controlling disease, injury, and disability.

The FY 2007 budget requests a total program level of $8.2 billion for the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR), a net decrease of $179 million below FY 2006. CDC works with States, communities, and other partners to monitor health, detect and investigate health problems, conduct research to enhance prevention, implement prevention strategies, and promote healthy behaviors. The FY 2007 request supports implementation of the Administration's ongoing pandemic influenza preparedness activities; increased funding for a new domestic HIV/AIDS initiative; improvements in childhood immunizations; and expansions to the Strategic National Stockpile. These increases are offset by reductions in one-time emergency funding, reductions proposed in FY 2006, areas not focused on primary prevention, and CDC-wide administrative efficiencies. CDC's total program level includes $2.1 billion in mandatory Vaccines for Children funding, and $265 million in Public Health Service evaluation transfers.

Preparing for Pandemic Influenza

An influenza pandemic is a global outbreak of disease that occurs when a new influenza virus strain emerges in the human population, causes serious illness, and then spreads easily from person-to-person worldwide. In FY 2006, CDC will invest $200 million in emergency funding to intensify surveillance, containment, and outbreak response measures, establish additional laboratory capacity, and increase the number of quarantine stations, consistent with the the *HHS Pandemic Influenza Plan*. The FY 2007 budget requests $188 million in CDC to enhance our pandemic preparedness. With this funding, CDC will continue ongoing pandemic influenza preparedness efforts and initiate new activities. The reduction in overall pandemic funding is due to one-time resources provided in FY 2006 for CDC laboratories and the advanced development of rapid testing.

During the course of a pandemic, information will be needed to help guide decisions on the allocation of resources such as vaccine, antiviral drugs, and professional staff. New funding is included to develop models and decision tools designed to predict disease patterns using current data, which will be used to inform decision making by public health and other officials. Resources are also included for a vaccine registry needed to track, distribute, and administer influenza vaccines and other countermeasures.

In addition, the budget includes new resources for States to increase demand for annual influenza vaccine. This effort will increase vaccine production capacity and make people more aware of vaccination, especially in the event that a pandemic vaccination campaign is necessary.

CDC will also need to increase its own capacity to prepare for a pandemic. In FY 2007, CDC requests resources to rapidly conduct genetic analysis and establish a reference library of currently circulating influenza viruses in a collaborative effort with FDA. These genetic analyses and reference libraries are needed to rapidly and accurately characterize the current influenza strain for development of an effective vaccine. CDC will also establish laboratory facilities with proper biocontaiment specifications, space and special equipment, animal resources, and trained personnel to conduct these investigations. The request also includes funding to increase the stock of diagnostic reagents for influenza that would be needed in bulk in the event of a pandemic. Funding will provide for the acquisition, storage, shipping, and support of the newly acquired reagents.

The FY 2007 request also supports pandemic influenza efforts initiated in FY 2006. These activities include improvements in domestic disease surveillance by expanding the number of areas able to report near real-time disease detection data through BioSense. Funding is also requested to continue to increase and updgrade quarantine stations at major ports of entry (sea, land, and air). In addition, CDC will continue to support global surveillance and detection activities in endemic, epdimeic, and other high risk countries.

Infectious Diseases

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

HIV/AIDS, Sexually Transmitted Dieases & Tuberculosis Prevention: The FY 2007 request provides $1.0 billion, an increase of

$86 million, to develop, implement, and evaluate effective domestic prevention programs for HIV/AIDS, Sexually Transmitted Diseases (STD), and Tuberculosis (TB).

Each year, approximately 40,000 Americans are infected with HIV/AIDS. The FY 2007 budget request provides $740 million for domestic HIV/AIDS prevention. Within this total, $93 million is for CDC's component of the new $188 million domestic HIV/AIDS initiative focused on HIV testing, outreach, and treatment. The goal of this new initiative is to slow the growth in the number of new AIDS cases and reduce the future burden of the disease. With this funding, CDC will expand rapid testing to communities and populations hardest hit with HIV/AIDS to identify individuals who are infected with the HIV virus, but do not know it. The initiative will test up to 3 million additional Americans with an emphasis on at-risk populations, including low income and minority communities.

The President's Budget requests $293 million in FY 2007 for STD and TB prevention programs to provide grants and technical assistance to State and local governments and organizations for prevention and control services. Funds are also included to support surveillance and research.

Improving Childhood Immunization Coverage: In March 2005, CDC announced a major public health milestone – the elimination of rubella virus in the U.S., which was once a common disease in this country.

CDC's $2.6 billion immunization program has two components: the mandatory Vaccines for Children (VFC) program and the discretionary Section 317 program. The VFC program provides vaccines at no cost to children 18 years of age or younger who are Medicaid eligible, uninsured, American Indians and Alaska Natives, or who receive their immunizations at Federally qualified health centers and who have health insurance that does not include coverage for vaccines. Vaccines provided through the VFC program represent 40 percent of all childhood vaccines purchased in the U.S. The discretionary Section 317 program provides funds to support State immunization infrastructure and operational costs as well as many of the vaccines public health departments provide to individuals not eligible for VFC, including adults. VFC funding increases in FY 2007 due to new vaccine purchases and stockpile procurements.

Children with limited health insurance must receive their vaccinations at a Health Center or a specially designated Federally Qualified Health Center. Legislation is sought to enable these children to obtain VFC vaccines at public health clinics as well, which will improve access and immunization coverage rates. This improved access is projected to expand the VFC program by $140 million while reducing by $100 million the demand for vaccines purchased through the discretionary Section 317 program. The FY 2007 budget also includes $300 million to continue progress toward HHS's goal of establishing a six month vendor managed stockpile of all routinely recommended pediatric vaccines, and catching up on immunizations that were missed during vaccine shortages in recent years.

Ensuring an Adequate Supply of Annual Influenza Vaccine: In FY 2007, CDC will continue to work closely with vaccine manufacturers to ensure access to annual influenza vaccine for the 2007/2008 flu season. Consistent with the *HHS Pandemic Influenza Plan*, CDC's immunization efforts to increase demand for annual influenza will provide vaccine manufacturers with a reliable, growing market that would be an incentive to increase their vaccine production capacity. CDC will also continue to direct $40 million through the VFC program to purchase influenza vaccine for the national pediatric stockpile as protection against annual outbreaks of influenza. The FY 2007 budget does not include $30 million for the bulk monovalent influenza stockpile. The no-year funds provided in FY 2006 can be used to purchase vaccine for the 2007/2008 flu season. Also, vaccine purchased in FY 2006 can be used in the following year if the circulating strain remains the same.

Performance Highlight

The sharply declining trends in perinatal AIDS cases since the 1990's reflect the public health impact achieved through CDC's HIV/AIDS program. CDC has worked to decrease the number of new perinatally acquired AIDS cases from the 235 cases in 1998 to 48 cases in 2005.

CDC has provided pregnant women who are HIV-infected the opportunity to reduce the risk of transmission to their infants and provided them the opportunity to receive life-saving treatments through:

- routine prenatal HIV testing,
- guidance for using rapid tests during labor and delivery or immediately post-partum, and
- the integration of routine prenatal testing into medical practice.

In FY 2007 CDC expects to continue to achieve low levels of perinatally acquired AIDS, exceeding its goal of less than 100 new cases each year.

Infectious Disease Control: Although modern advances have conquered some diseases, the outbreaks of severe acute respiratory syndrome (SARS), monkeypox, and the threat of pandemic influenza are recent reminders of the extraordinary ability of microbes to adapt and evolve. The FY 2007 budget includes $245 million to conduct surveillance, epidemic investigations, epidemiologic and laboratory research, training, and public education programs to develop, evaluate, and promote prevention and control strategies for infectious diseases. This level reduces funding for West Nile Virus by $10 million, reflecting the decrease in cases over the past few years.

Global Health

Every day, two million people cross national borders as tourists, business travelers, immigrants, or refugees. Health events that occur far from our shores influence health within the U.S. The FY 2007 budget totals $381 million for CDC's global health activities.

Through the Global AIDS Program, CDC works in partnership with USAID; HRSA; the Departments of State, Labor, and Defense; other Federal agencies; and multilateral and bilateral partners to ameliorate the global devastation caused by HIV/AIDS. The FY 2007 budget includes $122 million in direct funding for ongoing prevention, care, treatment, surveillance, and capacity-building programs in 25 countries in Asia, Africa, Latin America, and the Caribbean. CDC is also a Federal partner in the President's Emergency Plan for AIDS Relief that is financed through the Department of State. CDC received approximately $440 million from the Department of State in 2005.

Each year, malaria kills almost 1.2 million people, with the vast majority of victims being young children in Africa. On June 30, 2005, President Bush challenged the world to dramatically reduce malaria as a major killer of children in sub-Sahara Africa by reducing malaria mortality by 50 percent in up to 15 African countries. CDC malaria activities support prevention and control of malaria through collaborative efforts with other Federal agencies, national and international organizations, and foreign governments by working with malaria endemic countries to change and implement policies to decrease malaria, and by conducting research to develop new tools and improve existing interventions against worldwide malaria.

The budget provides $144 million for global polio and measles activities. CDC is part of an international effort to eradicate polio and to reduce measles deaths worldwide. Global polio incidence has declined by more than 99 percent from 1988 to 2004. The number of endemic countries has been reduced from 125 countries in 1988 to six in 2004. About 250,000 lives have been saved and five million cases of childhood paralysis have been avoided.

Terrorism

The request includes $1.7 billion, a net increase of $25 million over FY 2006, for CDC to conduct bioterrorism preparedness activities. The bioterrorism budget supports the Strategic National Stockpile (SNS), Mass Casualty Initiative, critical surveillance and quarantine efforts, and botulinum toxin research. Resources are maintained for State and local preparedness activities.

Strategic National Stockpile and Mass Casualty Initiative: Within this total, priority is given to ensuring a sufficient supply of countermeasures and portable treatment units available to protect and care for victims of a bioterrorism attack or other public health emergency. The SNS will receive a total of $593 million, of which nearly $50 million will finance the purchase, maintenance, and operation of portable hospital units to support the Mass Casualty Initiative. When local healthcare systems are overwhelmed due to a mass casualty event like a bioterrorist attack or nuclear power plant accident, these units can be deployed to expand hospital surge capacity. The remaining funds will finance the procurement, warehousing, and maintenance of critical pharmaceuticals and vaccines needed to protect Americans from threat agents and support the capacity to deliver drugs, vaccines, and supplies anywhere in the nation within 12 hours.

Biosurveillance Initiative: FY 2007 pandemic influenza funding designated to support the Biosurveillance Initiative will serve the dual purpose of enhancing our Nation's ability to prevent the introduction and spread of disease caused by a bioterrorism agent originating abroad and to detect domestic outbreaks early. This investment will increase the number of quarantine stations at major ports of entry and extend BioSense, CDC's near real-time human health surveillance system, to additional users in States and metropolitan areas.

Botulinum Toxin Research: CDC's Environmental Health Laboratory has developed a mass spectrometry method to detect botulinum toxin in people and the nation's milk supply. The request includes $3 million in new funding which will allow CDC to use the mass spectrometry method, that allows for detection of botulinum in 15 seconds, and detects anthrax, ricin, and other toxins used as bioweapons. Additionally, these funds will support the development of quicker, simpler, and more cost effective methods for use in internal and external laboratories. Finally, this investment will lead to the creation of research methods that will help identify the source of the toxin, provide forensic information, and assist epidemiologists in investigating the cause and pathways of

disease. These breakthrough advances will improve the ability to detect contamination and exposure early, leading to prompt, appropriate treatment and prevention of additional exposure.

State and Local Preparedness: CDC remains committed to assisting State and local health departments in preparation and response to a terrorist attack, infectious disease outbreak, or other public health emergency. The FY 2007 President's Budget request includes $824 million for these efforts, bringing the total State and local preparedness investment to approximately $5.4 billion since FY 2002. This funding has resulted in all 50 states participating in the Health Alert Network, and 41 out of the 54 States and directly-funded cities meeting the minimum standards for demonstrating preparedness to use Strategic National Stockpile assets.

Upgrading CDC Capacity and Anthrax Research: The FY 2007 request includes $136 million for upgrading CDC capacity. With these funds, CDC will continue to improve epidemiological expertise in the identification and control of diseases caused by terrorism, including better electronic communication, distance learning programs, and cooperative agreement training between public health agencies and local hospitals. This request provides support for upgrading capacity at CDC, oversight of inter-laboratory transfers of dangerous pathogens and toxins, and laboratory safety inspections. Funding is not included for research on older anthrax vaccines.

Health Promotion

Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States, accounting for 70 percent of all deaths in the U.S. Currently, more than 125 million Americans live with chronic conditions, affecting their quality of life and leading to costly, yet preventable, health problems. In addition, birth defects are the leading cause of infant mortality in the United States with more than 120,000 infants born with birth defects each year.

The FY 2007 budget for the Health Promotion budget activity includes $819 million for the Chronic Disease Prevention, Health Promotion, and Genomics activities as well as $110 million for Birth Defects, Developmental Disabilities, Disability, and Health. The FY 2007 request continues to fund a wide range of activities, including support for: programs to promote healthy behaviors; studies to better understand the causes of these diseases; and surveys to better monitor the health of the Nation. It also includes a reduction in categorical programs not focused on primary prevention.

Health Information and Service

The budget for Health Information and Service includes $262 million for Health Statistics, Health Marketing, and Public Health Informatics.

The FY 2007 budget for Health Statistics includes $109 million to obtain and use health statistics to understand health problems, recognize emerging trends, identify risk factors, and guide programs and policy. CDC's health statistics programs will continue to provide data to monitor key national health indicators and address specific research needs in areas that include oral health, mental health, vision, diabetes, and diet and nutrition.

Public health informatics uses information systems and information technology to prevent diseases, disability, and other public health threats. The request includes $109 million to continue to build on efforts to ensure that public health departments' disease outbreak detection and reporting systems incorporate the common standards that facilitate real-time sharing of key data among public health officials responsible for verifying, investigating, and responding to outbreaks.

Funding for the Health Marketing activity in FY 2007 is requested at $43 million. This activity focuses on providing people with knowledge that empowers them to make informed personal choices about their health and on developing and improving systems to give people more opportunities to act on those choices.

Environmental Health and Injury Prevention and Control

The budget includes $279 million for Environmental Health and Injury Prevention and Control activities.

The Environmental Health activity protects human health from environmental hazards and assists States and local health agencies in developing and increasing their ability and capacity to address environmental health problems. Additionally, CDC provides complete, timely, and accessible data on environmentally related diseases and conditions, including asthma, childhood lead poisoning and genetic diseases; improves the understanding of risk factors for, and causes of, environmentally related diseases and conditions; and develops effective prevention programs. The FY 2007 budget provides $141 million for these activities. Funding is reduced in FY 2007 due to a reduction in activities not focused on primary prevention.

Injuries are the leading cause of death of children and young adults in the U.S. The budget request for FY 2007 includes $138 million to support programs focused on youth violence, residential fire deaths, intimate partner violence, non-fatal fall traumatic brain injury, child abuse and neglect, rape prevention and education, and other injury prevention and control initiatives.

Occupational Safety and Health

The National Institute of Occupational Safety and Health (NIOSH) is the primary Federal entity responsible for conducting research and making recommendations for the prevention of work-related illness and injury. NIOSH translates knowledge gained from research into products and services that improve workers' safety and health in settings from corporate offices to construction sites and coal mines. The FY 2007 budget includes $250 million for NIOSH activities. CDC assists in the implementation of the Energy Employees Occupational Illness Compensation Act of 2000; funds for this activity are provided by the Department of Labor.

Public Health Research

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

Public Health Improvement and Leadership

The FY 2007 President's Budget includes $190 million for Public Health Improvement and Leadership. This activity supports several cross-cutting areas within CDC whose purposes are to ensure more efficient and effective science and program development. The reduction of $75 million in FY 2007 is in no-year funding provided in FY 2006 to follow-up and treat World Trade Center emergency workers.

Business Services Support

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

CDC has made a variety of improvements in its business and management operations. For example, CDC consolidated 13 information technology infrastructure functions, services, staff and fiscal resources into the Information Technology Services Office, and has merged over 40 public and medical professional inquiry hotlines into a single integrated customer service center. Additional funding is included to cover costs associated with rent and UFMS for a total of $304 million.

Management Savings

In FY 2007, CDC will achieve agency-wide administrative and information technology savings totaling $37 million. These savings will be realized in areas related to travel, equipment, consultant contracts, and cost savings due to a new and more efficient method of processing interagency agreements.

Preventive Health and Health Services Block Grant

The Preventive Health and Health Services Block Grant has provided 61 States, tribes, and territories with flexible funding to support primary prevention activities and health services. Funding, however, is flexible and may overlap with other categorical funding and it is difficult to track and measure impact. The FY 2007 budget eliminates Preventive Health and Health Services Block Grant, but provides States the flexibility to use a portion of existing CDC State categorical funding to continue their support of prevention and health promotion activities. This added flexibility maintains the accountability of the categorical programs, while giving States the tools they need to address their specific public health priorities.

Modern and Secure Laboratories and Facilities

Since 2001, CDC has initiated or completed the construction of more than 2.7 million square feet of laboratory and other facility space. The FY 2007 request includes approximately $30 million for nationwide repairs and improvements of existing facilities. This reduction reflects a Department-wide focus on finishing projects near completion and maintaining existing facilities.

Agency for Toxic Substances and Disease Registry

The Agency for Toxic Substances and Disease Registry (ATSDR), managed as part of CDC, is the lead agency responsible for public health activities related to Superfund sites. The FY 2007 request for ATSDR is $75 million. ATSDR develops profiles of the health effects of hazardous substances, assesses health hazards at specific Superfund sites, and provides consultations to prevent or reduce exposure and related illnesses.

NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY INSTITUTE

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Institutes:				
National Cancer Institute	$4,825	$4,794	$4,754	-$40
National Heart, Lung, & Blood Institute	2,941	2,922	2,901	-21
National Institute of Dental & Craniofacial Research	392	389	386	-3
Natl Inst. of Diabetes & Digestive & Kidney Disease	1,864	1,855	1,844	-11
National Institute of Neurological Disorders & Stroke	1,539	1,535	1,525	-10
National Institute of Allergy & Infectious Diseases 1/	4,403	4,383	4,395	+12
National Institute of General Medical Sciences	1,944	1,936	1,923	-12
Natl Inst. of Child Health and Human Development	1,270	1,265	1,257	-7
National Eye Institute	669	667	661	-5
National Institute of Environmental Health Sciences:				
Labor/HHS Appropriation	645	641	637	-4
Interior Appropriation	80	79	78	-1
National Institute on Aging	1,052	1,047	1,040	-7
Natl Inst. of Arthritis & Musculoskeletal & Skin Dis	511	508	505	-3
Natl Inst. on Deafness & Communication Disorders	394	393	392	-2
National Institute of Mental Health	1,412	1,404	1,395	-9
National Institute on Drug Abuse	1,006	1,000	995	-5
National Institute on Alcohol Abuse & Alcoholism	438	436	433	-3
National Institute for Nursing Research	138	137	137	-1
National Human Genome Research Institute	489	486	483	-3
Natl Inst. of Biomedical Imaging & Bioengineering	298	297	295	-2
National Center for Research Resources	1,115	1,099	1,098	-1
Natl Center for Complementary & Alternative Med	122	121	121	-1
Natl Center on Minority Health & Health Disparities	196	195	194	-1
Fogarty International Center	67	66	67	0
National Library of Medicine	323	323	321	-2
Office of the Director 1/	405	528	668	+140
Buildings & Facilities	110	81	81	0
Total, Program Level	**$28,650**	**$28,587**	**$28,587**	**$0**
Less Funds Allocated from Other Sources:				
PHS Evaluation Funds (NLM)	-$8	-$8	-$8	$0
Type 1 Diabetes Research (NIDDK) 2/	-150	-150	-150	0
Total, Budget Authority	**$28,491**	**$28,428**	**$28,428**	**$0**
Labor/HHS Appropriation	**$28,412**	**$28,349**	**$28,350**	**+$1**
Interior Appropriation	**$80**	**$79**	**$78**	**-$1**
FTE	16,881	17,336	17,456	+120

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

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

NATIONAL INSTITUTES OF HEALTH

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

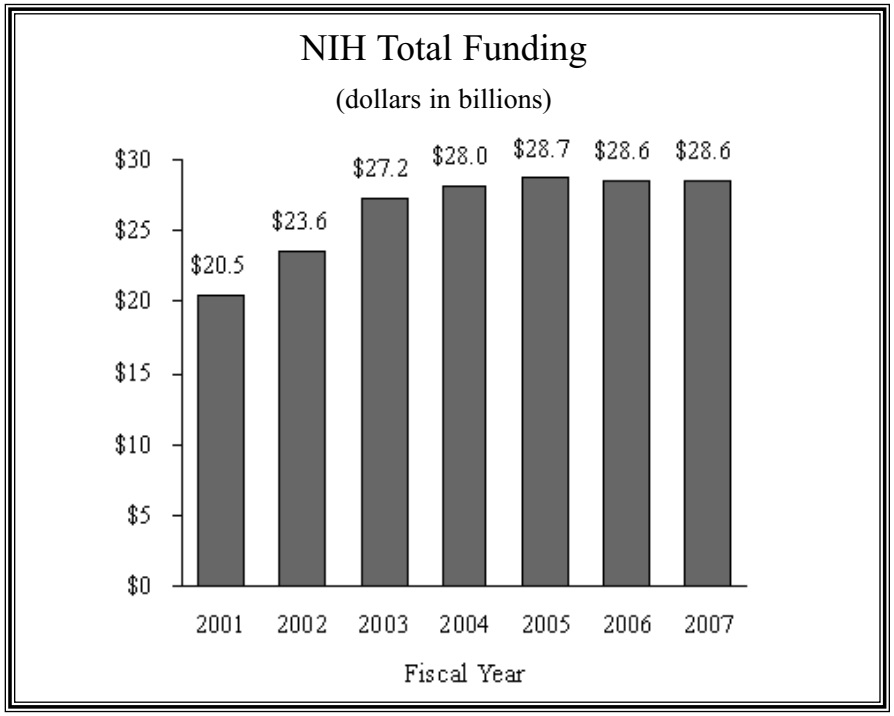
The Nation's substantial investment in biomedical research, led by the National Institutes of Health (NIH), is yielding significant achievements by contributing to dramatic reductions in mortality from heart disease and stroke, declining cancer incidence and death rates, and improving capacity to rapidly control new infectious diseases shortly after they emerge. Major advances in knowledge about life sciences, especially the sequencing of the human genome, are opening dramatic new opportunities for biomedical research and exciting prospects for preventing, treating, and curing disease and disability. To capitalize on these resulting opportunities, the FY 2007 budget requests $28.6 billion for NIH.

NIH is the world's largest and most distinguished organization dedicated to maintaining and improving health through medical science. Its budget is composed of 27 appropriations for its Institutes and Centers, Office of the Director, and Buildings and Facilities. In FY 2007, about 84 percent of the funds appropriated to NIH will flow out to the extramural community, which supports work by more than 200,000 research personnel affiliated with approximately 3,000 university, hospital, and other research facilities. About 11 percent of the budget will support an in-house, or intramural, program of basic and clinical research activities managed by world-class physicians and scientists. This intramural research program, which includes the NIH Clinical Center, gives our Nation the unparalleled ability to respond immediately to health challenges nationally and worldwide. Another five percent will provide for agency leadership and research management and support.

Research Priorities in FY 2007

In fulfilling its mission, NIH strives to maintain a diverse portfolio of research founded on both public health need and scientific opportunity. The FY 2007 budget request will allow NIH to address requirements in biodefense and pandemic influenza; continue to implement the NIH Roadmap for Medical Research; expand an initiative on the connections between genes, the environment, and health; establish a new program to provide increased support for new research investigators; and expand a newly created program focused on translating clinical research results into clinical practice. Support will also be provided to continue progress in promising arenas of science related to specific diseases such as cancer, cardiovascular disease, HIV/AIDS, diabetes, Parkinson's disease, and Alzheimer's disease, while also pursuing new avenues of post-genomics research.

Genes, Environment, and Health: Building on the success of the Human Genome Project and the HapMap project, NIH plans to expand its Genes, Environment, and Health Initiative by $49 million to a total of $68 million in FY 2007. This will be the second year of a multi-year project to accelerate the discovery of major genetic factors that increase the risk of many diseases and disorders with substantial public health impact. The project plans to concentrate on diseases and disorders such as heart disease, diabetes, cancer, stroke, Alzheimer's disease, schizophrenia, osteoporosis, asthma, cataracts, hypertension, Parkinson's disease, autism, and obesity. Additionally, this initiative will develop and field test sophisticated new technologies, such as biosensors, to more rapidly assess the connection between diet, physical activity, and environmental exposures to the genetic factors of these illnesses. The ability to identify the impact of specific DNA variations on



disease promises to lead to health improvements through more focused preventive medicine, the discovery of new drug targets, and more individualized drug prescribing that can be more effective and help avoid adverse side effects.

Biodefense: For FY 2007, the President's Budget proposes a total of $1.9 billion for NIH biodefense efforts, a net increase of $110 million, or 6.2 percent, over FY 2006. Our Nation's ability to detect and counter bioterrorism ultimately depends heavily on the state of biomedical science. Guided by its long-range strategic plan that includes short-, intermediate-, and long-term goals, biodefense research supported by NIH stresses two overarching, complementary, and urgent components: a) basic research on the biology of microbial agents with bioterrorism potential and the properties of the host's response to infection and defense mechanisms; and b) applied research with predetermined milestones for the development of new or improved diagnostics, vaccines, and therapies to improve public health emergency preparedness.

In FY 2007, NIH will create a $160 million fund within the Office of the Director appropriation to devote to the advanced development of biodefense countermeasures that are priority Project BioShield acquisition targets. This represents a comparable $110 million increase over the $50 million included within the FY 2006 base of the National Institute of Allergy and Infectious Diseases for such activities. This initiative will support efforts to work with academia and industry to develop candidate countermeasures from the investigational new drug application stage to the level that these candidate countermeasures could be eligible for acquisition by Project BioShield. The use of NIH funds for this purpose reflects the priority need to expand the Nation's arsenal of biodefense countermeasures. These funds help fill a gap in this critical stage of countermeasure development which has prolonged the Nation's exposure to risks from bioterrorist threats. NIH recently supported similar advanced product development programs for next generation anthrax and smallpox vaccines. The FY 2007 request would support the advanced development of other countermeasures, such as a third-generation anthrax vaccine, anthrax therapeutics, and antivirals for smallpox and viral hemorrhagic fevers.

Also included in the request for the Office of the Director is $96 million, the same level as in FY 2006, to continue targeted research efforts devoted to developing medical countermeasures against nuclear, radiological, and chemical threats that could be used as weapons of mass destruction.

The FY 2007 budget also proposes $25 million, a decrease of $5 million from FY 2006, to continue support for construction and renovation of specialized biosafety laboratories at universities and institutions needed to conduct research on the highly dangerous and infectious pathogens in the biodefense research field. With these FY 2007 funds, NIH will have spent over $576 million since FY 2003 on extramural biodefense construction. The $25 million investment in FY 2007 will be used to construct or renovate additional local-level laboratories to Biosafety Level 3 (BSL-3) standards, and to provide the capacity to support Good Laboratory Practice research processes at selected sites.

Performance Highlight

By 2010, NIH intends to develop one universal antibiotic effective against multiple classes of biological pathogens. From a strategic perspective, a broad spectrum antimicrobial therapeutic could be used either alone, or in combination with currently available therapeutics, to protect individuals exposed or potentially exposed to unknown pathogens. This would provide a valuable countermeasure in the case of an outbreak or bioterrorism attack. In 2005, NIH developed a complete set of in-vitro screening tools that can be used to test compounds for activity against bacterial and viral pathogens. In 2007, NIH plans to use combinatorial chemistry, a technology for creating large populations of molecules or libraries that can be screened en masse and testing them rapidly, in order to develop several compounds for antimicrobial activity.

Pandemic Influenza: In support of the HHS *Pandemic Influenza Preparedness Plan*, the FY 2007 President's Budget requests $35 million in NIH to expand international and domestic pandemic influenza research, an increase of $17 million over FY 2006. Research activities that will be supported by these funds include: assisting in the development and testing of candidate vaccines and drugs produced by Vietnam and other countries with endemic avian influenza; expanding the clinical trials infrastructure and research in Southeast Asia; conducting human-animal interface studies, including the surveillance of diseases in animals in Southeast Asia to better understand how the virus is transferred; and expanding other research to accelerate the development of pandemic influenza vaccines, drugs, and diagnostics. With these funds, total NIH spending on influenza research is expected to grow to $199 million in FY 2007.

NIH Roadmap for Medical Research: The FY 2007 budget allocates a total of $443 million, an increase of $113 million, or 34 percent, over FY 2006, to continue support for the NIH "Roadmap"

initiative in accordance with the strategic plan developed in September 2003. These funds will be used to target major opportunities and gaps in biomedical research that no single institute at NIH could tackle alone, but which the agency as a whole must address in order to overcome barriers and accelerate the discovery of new disease treatments, prevention strategies, and diagnostics. The Roadmap is organized into three core themes: New Pathways to Discovery; Research Teams of the Future; and Re-engineering the Clinical Research Enterprise. The FY 2007 request includes $111 million, an increase of $28 million, in the Office of the Director, and $332 million, an increase of $85 million, in the budgets of the Institutes and Centers for use in a coordinated effort to support the Roadmap. The collaborative trans-agency process for developing and implementing the Roadmap represents an enhanced approach to portfolio management, and sets a new standard for responding to emerging needs and scientific opportunities.

New Investigators: The engines that drive the research enterprise are talented, creative, and dedicated research personnel. Fulfilling the NIH mission requires that the agency sustain a vibrant workforce, including sufficient numbers of new investigators with new ideas and new skills, especially in interdisciplinary fields of research. To help reverse the trend of increased average age of first-time principal investigators obtaining independent research funding from NIH, the FY 2007 budget includes $15 million to establish a new program to provide increased and stable support for new research investigators. NIH also plans to identify and track the progress toward research independence of all predoctoral and postdoctoral researchers supported by NIH regardless of funding mechanism.

Clinical Research Translation: To meet the profound challenges of 21st century medicine and to capitalize on Roadmap initiatives to advance information technology, integrate research networks, stimulate the development of computer-assisted outcome measurement, and improve workforce training, NIH has developed a new Clinical and Translational Science Award (CTSA) program. The goal of this new effort is to provide the academic home and integrated resources necessary to advance a new intellectual discipline of clinical and translational sciences, create and nurture a cadre of well-trained investigators, and advance the health of the nation by transforming patient observations and basic discovery research into clinical practice. In addition, NIH plans to transition elements of existing clinical research programs, primarily the General Clinical Research Centers in the National Center for Research Resources (NCRR), into CTSAs as these programs complete their current funding cycles. In FY 2007, total CTSA funding is estimated to be $361 million, which includes an additional $3 million requested in NCRR for this program.

Research Project Grants

The $15.1 billion provided in FY 2007 for support of medical research through competitive, peer-reviewed, and investigator-initiated research project grants (RPGs) represents 53 percent of the total NIH budget request.

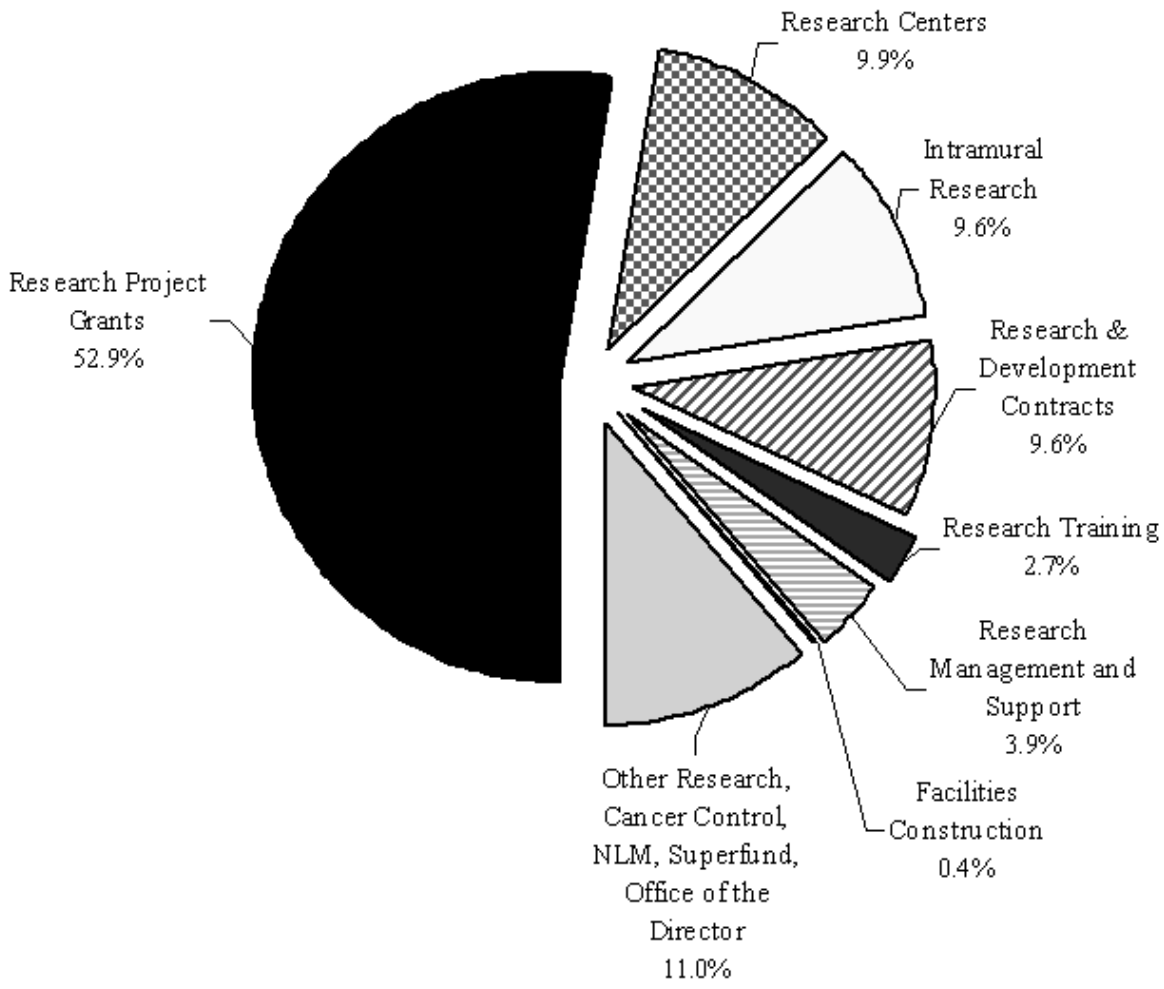
NIH estimates it will support 9,337 competing RPGs in FY 2007, an increase of 275 over FY 2006. Excluding the large cohort of HIV/AIDS clinical trials that are cycling into non-competing status in FY 2007, the average cost of a competing research project grant in FY 2007 will be about $350,000, approximately the same level as in FY 2006, as no increases are provided for inflation on grants. The total number of RPGs to be awarded in FY 2007 is expected to be 37,671. This is 656 fewer grants in total than currently estimated for FY 2006. This reduction is due primarily to a large number of non-competing grants that were initiated during the NIH doubling years coming to completion in FY 2006.

Enhancing Management and Oversight

The FY 2007 budget for the Office of the Director includes $3 million for the new Office of Portfolio Analysis and Strategic Initiatives (OPASI), an increase of $1 million over FY 2006. By FY 2007, OPASI will serve as the center of trans-NIH portfolio management and coordination activities. The mission of OPASI is four-fold: a) to provide NIH and its 27 Institutes and Centers with the methods and information necessary to improve management of their large and complex scientific portfolios; b) to identify - in concert with multiple other inputs - important areas of emerging scientific opportunities or rising public health challenges; c) to assist in accelerating research investments in these areas, focusing on those involving multiple Institutes and Centers; and d) to coordinate and make more effective use of the NIH-wide evaluation process to assess the benefits and impacts of these trans-NIH investments.

FY 2007 NIH Budget

$28.6 Billion - Percent Total by Mechanism



NATIONAL INSTITUTES OF HEALTH
OVERVIEW BY MECHANISM

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Mechanism:				
Research Project Grants	$15,481	$15,355	$15,123	-$233
[# of Non-Competing Grants]	*[27,378]*	*[27,385]*	*[26,468]*	*[-917]*
[# of New/Competing Grants]	*[9,599]*	*[9,062]*	*[9,337]*	*[+275]*
[# of Small Business Grants]	*[1,924]*	*[1,880]*	*[1,866]*	*[-14]*
[Total # of Grants]	*[38,901]*	*[38,327]*	*[37,671]*	*[-656]*
Research Centers	2,731	2,771	2,834	+62
Research Training	756	761	760	0
Research & Development Contracts	2,641	2,700	2,744	+44
Intramural Research	2,756	2,768	2,759	-9
Other Research	2,168	2,176	2,194	+18
Extramural Research Facilities Construction	179	30	25	-5
Research Management and Support	1,079	1,092	1,106	+14
National Library of Medicine 1/	321	320	318	-3
Office of the Director 1/	341	445	557	+112
Buildings and Facilities	118	89	89	0
NIEHS Interior Appropriation (Superfund)	80	79	78	-1
Total, Program Level	**$28,650**	**$28,587**	**$28,587**	**$0**
Less Funds Allocated from Other Sources:				
PHS Evaluation Funds (NLM)	-$8	-$8	-$8	$0
Type 1 Diabetes Research 2/	-150	-150	-150	0
Total, Budget Authority	**$28,491**	**$28,428**	**$28,428**	**$0**
Labor/HHS Appropriation	**$28,412**	**$28,349**	**$28,350**	**+$1**
Interior Appropriation	**$80**	**$79**	**$78**	**-$1**
FTE	16,881	17,336	17,456	+120

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

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

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

(dollars in millions)

	2005	2006	2007	2007 +/-2006
Substance Abuse:				
Substance Abuse Block Grant	$1,776	$1,759	$1,759	$0
Programs of Regional and National Significance:				
Treatment	422	399	375	-24
Prevention	199	193	181	-12
Subtotal, Substance Abuse	**$2,397**	**$2,350**	**$2,315**	**-$36**
Mental Health:				
Mental Health Block Grant	$433	$429	$428	-$0.2
PATH Homeless Formula Grant	55	54	54	0
Programs of Regional and National Significance	274	263	228	-35
Children's Mental Health Services	105	104	104	0
Protection and Advocacy	34	34	34	0
Subtotal, Mental Health	**$901**	**$884**	**$849**	**-$35**
Program Management	$94	$92	$97	+$4
Total, Program Level	**$3,392**	**$3,327**	**$3,260**	**-$67**
Less Funds Allocated from Other Sources:				
PHS Evaluation Funds	-123	-121	-126	-5
Total, Discretionary BA	**$3,268**	**$3,206**	**$3,134**	**-$72**
FTE	535	558	558	0

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

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

The FY 2007 budget requests $3.3 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), a net decrease of $67 million from FY 2006. The request will focus on achieving mental health systems transformation, expand resources available for suicide prevention, build on recent success in reducing youth drug use, and provide targeted resources to prevent and treat methamphetamine dependence and abuse.

Substance Abuse

An estimated 23 million Americans struggle with a serious substance abuse problem for which treatment is needed. Substance abuse leads to lost productivity, the transmission of HIV/AIDS and other communicable diseases, domestic violence, child abuse, criminal involvement, and premature and preventable deaths. The FY 2007 request includes $2.3 billion, a decrease of $36 million, to provide effective substance abuse treatment and prevention activities.

Opening New Pathways to Recovery: The FY 2007 budget provides $375 million, a reduction of $24 million, for Substance Abuse Treatment Programs of Regional and National Significance. Within this level, $98 million is for the Access to Recovery voucher program. Beginning in FY 2007, States will be offered incentives through Access to Recovery to voluntarily distribute a portion of their Substance Abuse Block Grant funds through drug treatment vouchers. Access to Recovery allows individuals seeking clinical treatment and recovery support services to exercise choice among qualified community provider organizations, including those that are faith-based. Distribution of funds through a voucher system promotes innovative drug and alcohol treatment and recovery programs, provides a wider array of treatment and recovery support options, and introduces greater accountability and flexibility into the system.

Methamphetamine abuse causes great harm to children, families, and communities, but it is a treatable problem. Within Access to Recovery, $25 million will be targeted to areas with high methamphetamine prevalence to fund vouchers to cover clinical treatment and/or recovery support services.

Promoting Effective Prevention: Illicit drug use among teens has declined nearly 19 percent since 2001. This budget provides $181 million, a reduction of $12 million, for Substance Abuse Prevention Programs of Regional and National Significance. Of this total, $96 million will be available to implement the Strategic Prevention Framework, a program that enables States to better use prevention resources, implement effective prevention programs, and coordinate prevention among different agencies and funding streams.

The FY 2007 budget maintains funding for assistance to localities in developing infrastructure or conducting interventions to prevent methamphetamine and inhalant abuse.

Substance Abuse Block Grant: A total of $1.8 billion is requested for the Substance Abuse Prevention and Treatment Block Grant, the same level as FY 2006. These funds, which form the cornerstone of States' and Territories' substance-related programs, supported nearly 1.9 million client admissions during the most recent year for which data are available.

Mental Health

Approximately 54 million Americans have a mental illness. The budget includes $849 million for mental health services, a net decrease of $35 million from FY 2006. Through a reform of the Community Mental Health Block Grant, the request prioritizes mental health transformation activities, consistent with the recommendations of the President's Commission on Mental Health.

Methamphetamine Use, Abuse, and Dependence

- In 2004, 1.4 million Americans had used methamphetamine in the past year.
- Treatment admissions of persons with primary methamphetamine use problems increased from 21,000 to 117,000 between 1993 and 2003.
- The number of past month methamphetamine users who met criteria for stimulant dependence or abuse increased from 63,000 in 2002 to 130,000 in 2004.

Source: Office of Applied Studies, SAMHSA, National Survey on Drug Use and Health (NSDUH) and Treatment Episode Data Set (TEDS)

Transforming the Mental Health System: The final report of the President's Commission on Mental Health called for a fundamental overhaul of how mental health care is delivered in America. The FY 2007 budget proposes to reform the Community Mental Health Block Grant as part of transforming the mental health system so that: 1) Americans understand that mental health is essential to overall health; 2) mental health care is consumer and family driven; 3) disparities in mental health services are eliminated; 4) early mental health screening, assessment, and referral to services are common practice; 5) excellent mental health care is delivered and research is accelerated; and 6) technology is used to access mental health care and information. States will direct funds above their minimum allotment for mental health system transformation activities. Of the $428 million provided through the Community Mental Health Block Grant, States will direct at least $153 million for mental health system transformation. In addition, $20 million is included to continue existing State Incentive Grants for Transformation.

Suicide Prevention: For every two victims of homicide in the United States there are three Americans who take their own lives, but suicide is a potentially preventable public health problem. Studies of youth who have committed suicide have found that 90 percent had a diagnosable mental and/or substance abuse disorder at the time of their death. The FY 2007 request maintains funding for activities authorized by the Garrett Lee Smith Memorial Act, supporting state-wide youth suicide intervention and prevention strategies in schools, institutions of higher education, juvenile justice systems, substance abuse and mental health programs, foster care systems, and other youth support organizations. The request also initiates a new $3 million suicide prevention program focused on the American Indian and Alaska Native youth population. Working in collaboration with the Indian Health Service, this program will provide mental health assistance to children, youth, and their families living on Tribal reservations and in Alaska Native villages.

Children's Mental Health: Fifty percent of children with severe emotional disturbances drop out of high school. The budget maintains funding for Children's Mental Health Services to improve the availability, affordability, and appropriateness of services for the estimated 4.5 million to 6.3 million children with serious emotional disturbances. Of children receiving services under this program last year, two-thirds did not require interaction with law enforcement, and 80 percent attended school regularly. A total of $104 million is requested for Children's Mental Health Services in FY 2007.

Performance Highlight

The percentage of children served through Children's Mental Health Services who have no interaction with law enforcement has improved from 47 percent in FY 2002 to 68 percent in FY 2005. The target for FY 2007 is for 70 percent of children served to have no interaction with law enforcement.

Homelessness: Approximately one-fifth of homeless individuals also have serious mental illnesses. The budget includes $54 million to maintain support for an array of individualized services to this vulnerable population through Projects for Assistance in Transition from Homelessness (PATH).

Protection and Advocacy: This request includes $34 million to maintain funding for Protection and Advocacy for Individuals with Mental Illness and supports grants to 57 States and Territories. State protection and advocacy systems address more than 20,000 complaints of abuse, neglect, and civil rights violations annually.

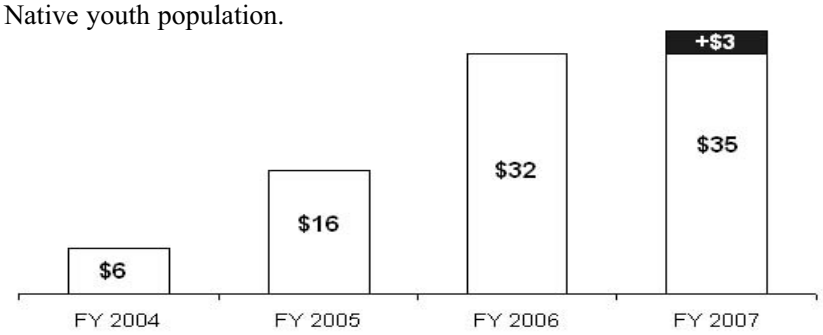
PROGRAM MANAGEMENT

The request includes $97 million to maintain staff and related program management, and to support activities necessary to effectively administer a wide array of Federal programs. This includes an increase of $5 million in PHS Evaluation Funds for the Drug Abuse Warning Network (DAWN) to support the collection of information on the emergence of new illicit substances, health hazards associated with drug abuse, and the impact of drug abuse on the Nation's health care system.

SAMHSA Suicide Prevention Funding

(in millions)

The FY 2007 request maintains funding for existing suicide prevention activities, including Garrett Lee Smith Memorial Act activities, and initiates a $3 million program focused on the American Indian/Alaska Native youth population.



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(dollars in millions)

	2005	2006	2007	2007 +/-2006
Health Costs, Quality and Outcomes Research				
Patient Safety				
Health Information Technology Initiative	$50	$50	$50	$0
Other Patient Safety	34	34	34	0
Subtotal, Patient Safety	$84	$84	$84	$0
Comparative Effectiveness Research	-$15	-$15	-$15	0
Other Quality and Cost Effectiveness Research	162	162	162	0
Subtotal, Health Costs, Quality and Outcomes	$261	$261	$261	$0
Medical Expenditures Panel Surveys	55	55	55	0
Program Support	3	3	3	0
Subtotal, Program Level	**$319**	**$319**	**$319**	**$0**
Less Funds Allocated From Other Sources:				
PHS Evaluation Funds	-319	-319	-319	0
Total, Budget Authority	**$0**	**$0**	**$0**	**$0**
FTE	296	295	299	+4

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

The Agency for Healthcare Research and Quality promotes health care quality improvement by conducting and supporting health services research that develops and presents scientific evidence regarding all aspects of health care.

The FY 2007 request for the Agency for Healthcare Research and Quality (AHRQ) provides a total program level of $319 million, the same as FY 2006. Priority activities include continued efforts to improve patient safety through the implementation of proven information technologies.

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

Health Costs, Quality, and Outcomes

The President's Budget will continue to support improvements through research on the cost effectiveness and quality of health care by providing a total of $261 million for these activities. This total includes $84 million for Patient Safety and $15 million for the Effective Health Care Program authorized by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA).

Patient Safety: Of the total $84 million for patient safety, $50 million will be made available for health information technology (IT) investments designed to enhance patient safety, with an emphasis on ambulatory patient care. AHRQ's significant investment in hospital safety has demonstrated the importance of patient safety reporting systems, computerized physician order entry, and decision support systems to key stakeholders and policymakers. While the use of hospital-based IT for patient safety has been rising, an adoption gap exists in ambulatory care, especially in smaller practices with five or fewer doctors, where 60 percent of physicians continue to practice.

Within the budget for health IT, AHRQ will provide $29 million for the Ambulatory Patient Safety Program with an additional $6 million in general Patient Safety funds. This program has a five-year goal of measurably improving the safety and quality of care for patients in ambulatory environments using health IT. It will complement and contribute to the overall goals and objectives of the President's health IT initiative, the American Health Information Community, and those of the Office of the National Coordinator for Health Information Technology (ONC). AHRQ will examine the best ways to develop, deploy, and evaluate the use of electronic health information systems, both the technology and the processes around it – by addressing systemic barriers to adoption and creating the evidence base for best practices. The program will focus on four cross-cutting care domains to achieve the goal of improvements in: medication safety, patient-centered care, medication management, and integration of decisions support tools. Improvements in these specific areas – all dependent on health IT integration – have been shown to impact the overall quality of care. The program will include special attention to the delivery of high quality care from providers in rural, small community, safety net, and community health center environments.

FY 2007 Ambulatory Patient Safety Program Objectives

- Improve the safety and quality of prescription drug management through the integration and utilization of medication management systems and technologies.
- Improve the delivery and utilization of evidence-based care in ambulatory settings.
- Improve the delivery of patient centered care in ambulatory settings, including a specific focus on transitions of care, personal health records, and improved patient-provider communication.
- Foster the development, deployment, and reporting of measures of safety and quality in ambulatory care settings and across high risk transitions in care.

In addition, AHRQ will continue to fund planning and implementation of health IT solutions in communities that demonstrate the value of health IT in patient safety, quality, and health care costs. Working with public and private partners, AHRQ will use data from hospital information technology investment demonstrations to make the business case for adoption of these tools, and help spread proven technology through the health care system.

The remaining $28 million in AHRQ's patient safety budget supports a variety of activities. In FY 2006, AHRQ provided $3 million in contract funds to initiate activities authorized under the Patient Safety and Quality Improvement Act of 2005. This law establishes patient safety organizations (PSO) nationwide that will collect information about adverse events affecting patient safety, in order to allow for the analysis of such events and development of solutions to decrease their incidence. The major activities in FY 2006 include establishing and maintaining a system to:

- Respond to inquiries about PSOs;
- Review certification of PSOs; and
- Support PSOs through technical assistance.

AHRQ will continue funding these activities in FY 2007. In addition, a new round of investigator-initiated patient safety grants will be awarded to build on the investments first funded in FY 2001 following the release of the Institute of Medicine's (IOM) 1999 report, *To Err is Human: Building a Safer Health System.*

Effective Health Care Program: The FY 2007 budget provides $15 million in continued support related to Section 1013 of the MMA for the Effective Health Care Program. AHRQ's Effective Health Care Program helps policymakers, clinicians, and patients determine which drugs and other medical treatments work best for certain health conditions. Thirteen new research centers, as well as an innovative center for communicating findings, were named as part of the three-part program.

The $15 million program supports the development of new scientific information through research on the outcomes of health care services and therapies, including drugs and by comparing different therapies for the same condition. By reviewing and synthesizing published and unpublished scientific studies, as well as identifying important issues where existing evidence is insufficient, the program helps provide policymakers, clinicians, and patients with better information for making treatment decisions. Initial reports from the new program were issued this fall, with particular focus on effectiveness of information relevant to Medicare beneficiaries. A new Web site for the program, www.effectivehealthcare.ahrq.gov, has been developed and provides a venue for stakeholders to comment on draft reports and to suggest research topics.

The new program includes three components:

- Comparative Effectiveness Reports – The program builds on an existing network of 13 Evidence–based Practice Centers (EPCs). The EPCs focus on comparing the relative effectiveness of different treatments, including drugs, as well as identifying gaps in knowledge where new research is needed.

- Network of Research Centers – A new network of 13 Developing Evidence to Inform Decisions about Effectiveness research centers (referred to as DEcIDE) carry out accelerated studies, including research aimed at filling knowledge gaps about treatment effectiveness.

- Making Findings Clear for Different Audiences – This innovative effort translates findings in ways appropriate for the needs of the different stakeholders. It also conducts its own program of research into effective communication of research findings, in order to improve usability and rapid incorporation of findings in medical practice.

AHRQ is partnering in this program with the Centers for Medicare & Medicaid Services. As Medicare launches its new drug benefit program this year, it will become increasingly important to have sound information about which drugs and other treatments are proven to be effective for the conditions that are most important for its beneficiaries. Additional priority areas for the program will be identified by the Secretary this year to include the needs of Medicaid and State Children's Health Insurance Programs, as well as Medicare. Public comments are already being solicited for the additional set of priority conditions.

Research and Dissemination Activities Outside Patient Safety: In FY 2007, AHRQ will invest $162 million in research and dissemination activities in prevention, pharmaceutical outcomes, and other research areas to support the quality and cost-effectiveness of health care. A number of AHRQ efforts are oriented toward making research findings accessible. For example, in the Centers for Education and Research Therapeutics program, studies have been underway to gather information that Medicaid programs can use to make coverage and other policy decisions such as drug utilization review, economic effects of beta-blocker therapy in heart failure, and prevalence of type 2 diabetes mellitus in children. Under its Evidence-based Practice Program, AHRQ is developing scientific information for other agencies and organizations on which to base clinical guidelines, performance measures, and other quality improvement tools. For example, one of

AHRQ's Evidence-based Practice Centers recently issued a report on the effects of omega-3 fatty acids in child and maternal health; this research had been requested by the National Institute of Health's Office of Dietary Supplements.

AHRQ will continue to sponsor the U.S. Preventive Services Task Force (USPSTF). The USPSTF has issued clinical recommendations on obesity in children, genetic susceptibility testing for breast and ovarian cancer, glaucoma, and screening for abdominal aortic aneurism in 2005. The Task Force also issued the Pocket Guide to Clinical Preventative Services – a consolidation of recommendations from 2001-2004 in 2005.

Medical Expenditure Panel Surveys (MEPS)

The FY 2007 budget for MEPS includes a request for $55 million, the same as FY 2006. MEPS is the collection of detailed, national data on the health care services Americans use, how much they cost, and who pays for them. It is the only national source of visit-level information on medical expenditures. MEPS provides a better understanding of the quality of care the typical patient receives, and of disparities in the care delivered. MEPS data are critical for tracking the impact of Federal and State programs, including the State Children's Health Insurance Program, Medicare, and Medicaid.

These surveys also provide a substantial portion of the data used to develop two reports required by the Agency's 1999 reauthorization. The reports measure the quality of health care in America and differences in access to health care services for priority populations. The *National Healthcare Quality Report* includes information on patient assessment of health care quality, clinical quality measures of common health care services, and performance measures related to outcomes of acute and chronic disease. The second report – the *National Healthcare Disparities Report* – highlights populations that are at high risk for differences in care. These populations include the elderly, people in inner-city and rural areas, women, children, minorities, low-income groups, and individuals with special health care needs. AHRQ used a formal notice and comment process to solicit public comments on the measures that should be included in the upcoming 2006 report. The current editions of the reports are available on a new Web site, www.qualitytools.ahrq.gov. In addition, the site serves as a Web-based clearinghouse by providing information for health care providers, healthplans, policymakers, purchasers, patients and consumers to take effective steps to improve quality.

In FY 2007, AHRQ will be completely funded through inter-agency transfers of evaluation funds.

Performance Highlight

AHRQ's Patient Safety Improvement Corp (PSIC) training program, established in 2003, seeks to improve patient safety by providing knowledge and skills to teams of State field staff and hospital partners selected by States. One of AHRQ's long-term goals is to successfully deploy hospital practices such that medical errors are reduced nationwide by 2010. As of 2005, 34 states and 48 hospitals/health care systems have participated in the PSIC and have on-site patient safety experts trained through this program. Efforts continue in FY 2006 to deploy on-site patient safety experts trained through the PSIC program in 15 additional states and major health care systems. In FY 2007, the measure is to have 50 participants in the PSIC train-the-trainer program initiate local patient safety training activities.

(dollars in millions)

	2005	2006	2007	2007 +/-2006
Current Law /1:				
Medicare	$339,822	$396,973	$457,669	+$60,696
Medicaid /2	181,720	192,334	199,445	+7,111
SCHIP	5,129	5,775	5,244	-531
State Grants and Demonstrations	84	2472	497	-1,975
Total Outlays, Current Law	**$526,755**	**$597,554**	**$662,855**	**+$65,301**
Offsetting Receipts (Medicare):				
Premiums	-$38,242	-$48,119	-$55,585	-$7,466
State Contribution for Part D	0	-5,819	-7,588	-1,769
Other Offsetting Collections/Receipts	-2,559	-11	-9	+2
Total Net Outlays, Current Law	**$485,954**	**$543,605**	**$599,673**	**$56,068**
Proposed Law:				
Medicare Benefits	-	-	-$2,453	-$2,453
Medicaid Benefits	-	-	-158	-158
SCHIP Benefits	-	-	704	+704
Program Management	-	-	-35	-35
State Grants and Demonstrations	-	-	350	+350
Total Proposed Law	**$0**	**$0**	**-$1,592**	**-$1,592**
Total Net Outlays, Proposed Law /3 /4	**$485,954**	**$543,605**	**$598,082**	**$54,476**

1/ Assumes enactment of the Deficit Reduction Act of 2005.
2/ Net outlays, without outlays for QIs and State low-income determinations.
3/ Total net outlays equal current outlays plus the impact of proposed legislation and offsetting receipts.
4/ Totals may not add due to rounding.

CENTERS FOR MEDICARE & MEDICAID SERVICES

The Centers for Medicare & Medicaid Services assures health care security for beneficiaries.

The Centers for Medicare & Medicaid Services (CMS) is the largest purchaser of health care in the United States, serving about 90 million Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) beneficiaries. The FY 2007 Budget request for CMS is $598.1 billion in net outlays, a $54.5 billion, or 10 percent increase over FY 2006. This request finances Medicare, Medicaid, SCHIP, the Health Care Fraud and Abuse Control Program (HCFAC), State insurance enforcement, and CMS operating costs. Following are policy highlights from the CMS FY 2007 Budget request.

MEDICARE

- In conjunction with steps to promote higher quality care, the Budget includes a set of Medicare proposals saving $2.5 billion in FY 2007 and $35.9 billion over five years. These proposals will implement productivity adjustments in provider payment updates; rationalize payments for certain covered services; expand Medicare Secondary Payer provisions; and extend competitive bidding to laboratory services.
- The 2007 proposed legislation builds on Medicare changes in the Deficit Reduction Act of 2005 (DRA). DRA provisions support Administration priorities, such as using payments to support better performance and promoting quality improvement.
- The new Medicare prescription drug benefit took effect on January 1, 2006, and more than 24 million beneficiaries are already participating in the program. Beneficiaries can choose a plan that best meets their needs, and the cost of coverage is much less than projected.

MEDICAID AND SCHIP

- The Deficit Reduction Act of 2005 (DRA) takes important steps to reform Medicaid and SCHIP by: preserving long-term care for those who need it most by eliminating abuses of asset transfers; reducing payments for Medicaid prescription drugs; giving States more flexibility with regard to program benefits, cost sharing and home and community-based services; and providing new funding sources for program integrity efforts.
- Building on this DRA progress, the Budget proposes Medicaid and SCHIP legislative changes that will save $1.3 billion over five years and administrative changes that will save $12.2 billion over five years.
- The Budget also includes proposals to help the uninsured, including a Cover the Kids initiative to find and enroll Medicaid and SCHIP-eligible children, and changes to Transitional Medical Assistance that will help families transition to work and retain health insurance coverage.

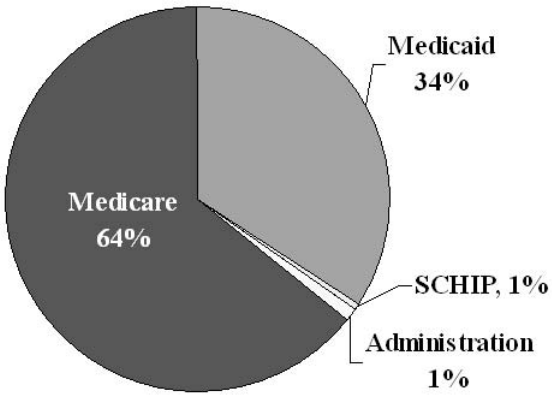
DISCRETIONARY PROGRAM MANAGEMENT

- The Program Management request includes $147 million to support the Administration's commitment to implement Medicare contracting reform required by MMA on an accelerated time line.
- The discretionary Budget also assumes $133 million in administrative savings from eliminating paper claims, checks, and notices from Medicare contractor operations.

OTHER INITIATIVES

- The President's Budget includes a $500 million grant program to promote health insurance coverage of chronically-ill individuals, and a new Medicaid waiver initiative to promote innovative expansions of affordable coverage.

CMS FY 2007 Net Outlays, Proposed Law
$598.1 billion



State Grants and Demonstrations accounts for 0.10% of net outlays

(dollars in millions)

	2005	2006	2007	+/-2006
Current Law:				
HI Trust Fund:				
Part A Benefits	$182,523	$185,845	$203,857	+$18,012
SMI Trust Fund:				
Part B Benefits	149,536	157,264	174,448	+17,184
Part D Benefits /1	0	46,325	70,907	+24,582
Subtotal, Medicare Benefits	**$332,059**	**$389,434**	**$449,212**	**+$59,778**
Other Medicare Payments:				
Stabilization Fund	$0	$0	$1,284	+$1,284
Other Transitional Drug Assistance /1	1,125	134	0	-134
Part B Transfer to Medicaid QIs	242	300	350	+50
Drug Replacement Demonstration	0	99	0	-99
Medicare Advantage Enhanced Premiums	0	109	145	+36
Administrative Activities:				
Administration /2	$4,825	$5,320	$5,023	-$298
HCFAC /3	1,100	1,195	1,223	+28
Quality Improvement Organizations	398	362	414	+52
State Low-Income Determinations	73	20	18	-2
Total Outlays, Current Law	**$339,822**	**$396,973**	**$457,669**	**+$60,696**
Offsetting Collections:				
Premiums	-$38,242	-$48,119	-$55,585	-$7,466
State Contribution for Part D	0	-5,819	-7,588	-1,769
Other Offsetting Collections/Receipts	-2,559	-11	-9	+2
Total Net Outlays, Current Law	**$299,021**	**$343,024**	**$394,487**	**+$51,463**
Proposed Legislation:				
Part A	0	0	-$2,100	-$2,100
Part B	0	0	-460	-460
Program Management	0	0	-35	-35
Premium Offsets	0	0	107	107
Total Medicare Proposed Legislation	**0**	**0**	**-$2,488**	**-$2,488**
Total Net Outlays, Proposed Law	**$299,021**	**$343,024**	**$392,000**	**+$48,975**

1/ The new prescription drug and transitional benefits are a subaccount within the SMI trust fund but are separated here for informational purposes.
2/ Includes CMS Program Management and administrative payments to the SSA and other non-CMS agencies.
3/ Health Care Fraud and Abuse Control, including FBI and OIG.

MEDICARE

(beneficiaries in millions)

	2005	2006	2007	2007 +/-2006
Aged	35.8	36.2	36.7	0.5
Disabled	6.6	6.8	7.0	0.2
Total Beneficiaries	42.4	43.0	43.7	0.7

Medicare will provide health insurance to 43.7 million individuals who are either 65 or older, disabled, or suffer from end–stage renal disease (ESRD). In FY 2007, spending on Medicare benefits will total $449.2 billion.

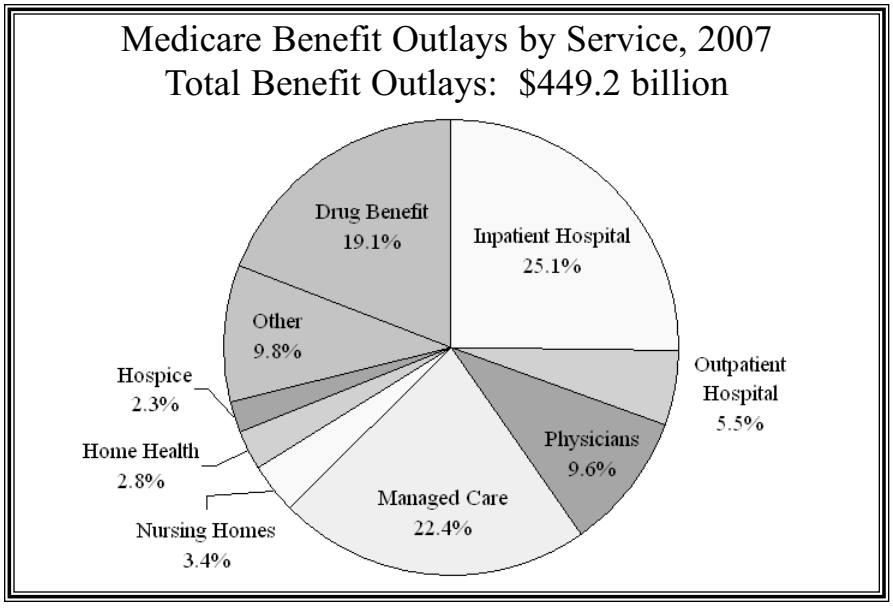
THE FOUR PARTS OF MEDICARE

Part A

- Medicare Part A, or Hospital Insurance (HI), pays for inpatient hospital care, skilled nursing facility care, home health care related to a hospital stay, and hospice care.
- Part A financing comes primarily from a 2.9 percent payroll tax split between employees and employers.
- Individuals with 40 quarters of Medicare-covered employment are entitled to Part A without paying a premium. In 2006, those with 30-39 quarters of Medicare-covered employment pay a Part A monthly premium of $216 and those with less than 30 quarters of covered employment pay a monthly premium of $393.
- In 2006, beneficiaries will pay a $952 deductible for a hospital stay of 1-60 days, and a $119 daily coinsurance for days 21-100 in a skilled nursing facility.
- The 2005 Medicare Trustees report projects the HI Trust Fund's insolvency date at 2020.

Part B

- Medicare Part B, or Supplementary Medical Insurance (SMI), pays for physician services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment, certain home health care, and other medical services and supplies.
- Part B coverage is voluntary, and about 94 percent of Medicare beneficiaries are enrolled in Part B. The 2006 monthly Part B premium is $88.50.
- Approximately 25 percent of Part B costs are financed by beneficiary premiums, with the remaining 75 percent covered by general revenues.



Part C

- Medicare Part C, the Medicare Advantage (MA) program, offers beneficiaries a variety of coverage options including traditional Health Maintenance Organizations (HMOs), preferred provider organizations (PPOs), and private fee-for-service (FFS) plans.
- In 2005, about 13 percent of beneficiaries were enrolled in an MA plan.
- Medicare pays MA plans a capitated monthly payment to provide all Parts A and B services (and Part D if offered by the plan). Plans can also offer additional benefits or vary cost sharing arrangements.
- Beneficiaries pay monthly premiums to MA plans to cover all Medicare services plus any additional benefits. The premium

varies depending on the services offered by the plan, therefore, it can be higher or lower than the regular Part B premium. Many beneficiaries have access to zero premium plans.

Part D

- The new prescription drug benefit, Medicare Part D, took effect on January 1, 2006. Part D offers a standard benefit with a $250 deductible, a monthly premium, and a substantial subsidy for drug costs.
- The standard benefit includes a coverage gap, in which beneficiaries are responsible for all of their drug costs. But once out-of-pocket spending reaches $3,600, Medicare covers 95 percent or more of drug costs.
- Beneficiaries have many options for prescription drug coverage, all with benefits as good as or better than the standard benefit. In general, those in a Medicare Advantage plan will receive their prescription drug benefits through their plan.
- For people who are low income, varying degrees of cost sharing are available, with co-payments ranging from $0 to $5 and low or no monthly premiums.

Part D Prescription Drug Benefit
Cost Sharing by Income Level

Beneficiary Income Level	Annual Deductible	Monthly Premium	Beneficiary Pays	
			drug spending < $5,100	< $5,100
>=150% FPL (standard benefit)	$250	$25 (ave.)	25% from $250-2,250 100% from $2,250-5,100	5%
135-150%FPL*	$50	$0 - $25	15% from $50-5,100	$2-$5 copays
100-135%FPL*	$0	$0	$2 - $5 copays	0%
<100% FPL*	$0	$0	$1 - $3 copays	0%

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

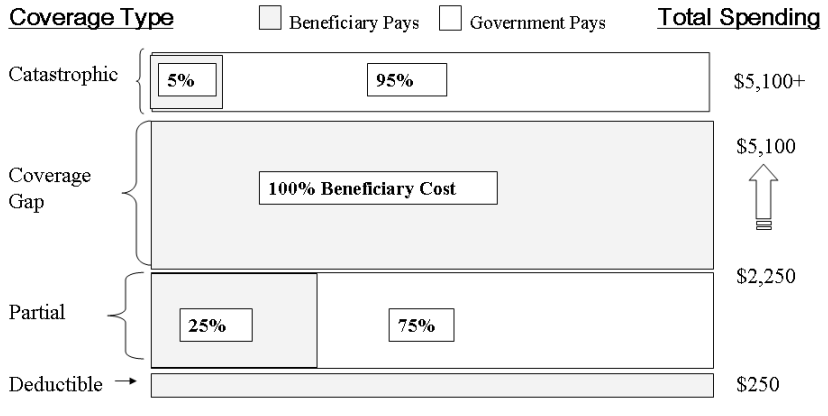
IMPLEMENTING MMA

The Medicare Modernization Act of 2003 (MMA) enacted sweeping changes to transform and modernize the Medicare program. The MMA changes were supported by the Administration in an effort to offer a 21st century benefits package, expand beneficiary choices, introduce competition, and control spending. Timely and effective implementation of MMA reforms is a high priority for the Administration.

Part D Progress: The prescription drug benefit, established by MMA, began on January 1, 2006. Seniors and disabled persons who enroll in the benefit are paying an average monthly premium of about $25 in 2006, well below previous estimates of about $37. Furthermore, beneficiaries have a choice of at least one plan with monthly premiums below $21. In many parts of the country, beneficiaries can enroll in a drug plan for as little as $1.87 per month. Prescription drug plans are available with zero deductibles or deductibles lower than Medicare's standard annual deductible of $250 in every region. CMS and its partners are still promoting the drug benefit and encouraging beneficiaries to sign up by the end of open enrollment in May 2006.

At press time, about 24 million Medicare beneficiaries are participating in the new prescription drug benefit. This figure includes more than six million Medicare-Medicaid dual eligible beneficiaries, over six million in employer-sponsored coverage supported by the retiree drug subsidy, and more than three million beneficiaries who signed up for stand-alone prescription drug coverage. In addition, three million Medicare-eligible Federal retirees will continue to receive drug coverage they already enjoy.

Beneficiary Prescription Drug Spending in 2006
Under Medicare's Standard Drug Benefit



Shaded areas represent $3,600 in beneficiary out-of-pocket spending -- the maximum a beneficiary will spend before catastrophic coverage begins. Estimates do NOT include ~$300 in total annual beneficiary premiums.

Medicare Advantage: The MMA created the MA program to offer more choices and better benefits to Medicare beneficiaries through competition among private health insurance plans. With the passage of MMA, a downward trend in private Medicare plan enrollment has been reversed, and 5.7 million beneficiaries, or nearly 13 percent, are enrolled in MA plans. The MMA increased payments to private plans, and plans have been investing these higher payments in improving benefits for Medicare beneficiaries. Beneficiaries in MA can now save an average of about $100 in out-of-pocket costs compared to traditional Medicare, and beneficiaries in fair to poor health save even more.

In 2006, CMS has contracts with over 360 private health plans, which will offer more than 1,600 benefit options for seniors and the disabled across the Nation. Approximately 98 percent of Medicare beneficiaries now have access to some kind of local private MA plan. More than 80 percent of beneficiaries have access to regional PPO plans. Of the 3,066 counties in the United States, 3,004 will have a participating local plan.

Competitive Bidding: The MMA introduced market competition into the purchase of medical items used to treat Medicare beneficiaries. CMS will implement a competitive bidding program in July 2006 to enable Medicare providers to purchase certain drugs at market prices. In 2007, CMS will expand the use of competitive bidding to the purchase of durable medical equipment (DME) and supplies.

Under this new DME model, CMS will use competitive bidding in selected markets. The MMA requires that competition occur in ten of the largest metropolitan statistical areas (MSAs) starting in 2007, expanding to 80 of the largest MSAs by 2009. CMS will choose the 10 regions they believe will provide the most competitive environment and will be of a size that will not overwhelm their current capacity to conduct a bidding process.

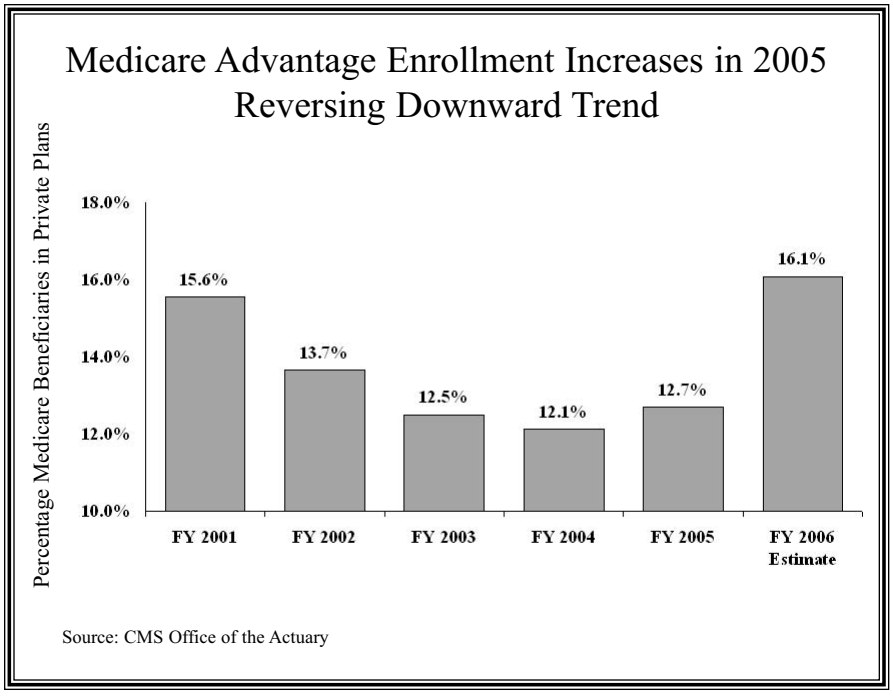
Under a previous DME demonstration project, competitive bidding achieved Medicare savings and this expanded program is expected to produce similar results.

Contracting Reform: The MMA includes provisions that allow the Secretary to introduce greater competition and accountability to the Medicare contracting process. To ensure a sufficient number of private contractors to administer the program, the original Medicare law provided prospective contractors with a number of beneficial provisions such as limiting the type of contractors, requiring cost contracts, and limiting competition for specific functions. The MMA:

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

In February 2005, CMS announced an accelerated strategy to convert from the current cost contracts to the new Medicare administrative contracts (MACs) over the period FY 2006 through FY 2009. This accelerated strategy ensures that expected benefit savings from Medicare contracting reform could come as early as FY 2009. By then, CMS plans to reduce the overall number of contractors from about 50 to 23 (15 Part A/B MACs, 4 durable medical equipment MACs, and 4 home health MACs).

Part of the accelerated strategy includes introducing durable medical equipment Medicare administrative contractors (DME MACs) in 2006. On January 6, 2006, CMS awarded four DME MACs using the full and open competition model envisioned in MMA. The DME MACs will immediately begin



transition activities and assume full responsibility for claims processing on July 1, 2006.

The FY 2007 budget includes $146.8 million to continue the accelerated contracting reform strategy. With this funding, CMS will transition to seven MACs during 2007.

FY 2007 Budget and Legislative Initiatives

In conjunction with Medicare's recently updated benefits, which will promote more effective and prevention-oriented care, the FY 2007 Budget includes a package of Medicare legislative proposals designed to strengthen the long-term financial security of the Medicare program. These proposals build on long-term Administration priorities for Medicare, such as improving quality and preventing medical errors, encouraging efficient and appropriate payment for services, fostering competition, and promoting beneficiary involvement in health care decisions. The net savings from this legislative package is $2.5 billion in FY 2007 and $35.9 billion over 5 years. The following is a summary of the FY 2007 budget and legislative priorities.

Fostering Productivity: To more accurately pay providers for the care furnished to beneficiaries, as well as encourage the adoption of productivity advances, the Budget proposes to include productivity adjustments to providers in the determination of yearly updates.

Specifically, based on the most recent recommendations from the Medicare Payment Advisory Commission (MedPAC) for 2007, the Budget proposes a zero percent payment update for skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities, and an update of the market basket minus 0.45 percent for hospitals. In 2008 and 2009, the payment update for all of these provider categories would be market basket minus 0.4 percent. The Budget also proposes to reduce payment updates for hospice and ambulance services by 0.4 percent for each of the years 2007 through 2009.

Rationalizing Medicare Payments: To ensure that Medicare does not pay health care costs where another insurer is primary, the budget seeks to clarify and expand Medicare secondary payer instances.

In the area of DME, there has been considerable growth in spending, specifically for power wheelchairs and oxygen and oxygen equipment. Moving oxygen and oxygen equipment from continuous rental to the capped rental category would reduce costs for the Medicare program and its beneficiaries. In addition, the budget proposes to reimburse for short-term power wheelchair usage based on actual time used versus paying up front at the full purchase price.

Encouraging Quality and Efficiency: The Administration has undertaken initiatives to hold providers accountable for quality and support care improvements that enhance quality and efficiency. Many of the opportunities to accomplish these goals involve post acute care. Medicare often pays different amounts for post acute care for beneficiaries with similar needs, and often pays more when preventable complications leading to readmissions and other health problems occur in the post acute system. The budget proposes to build on the Administration's quality initiatives by ensuring that patients are served in the most medically appropriate and efficient setting for high quality post acute care.

The Administration supports provider payment reforms that encourage quality, and is considering ways to promote more efficient and high quality physician services. The Administration supports physician payment reforms that do not increase taxpayer, Medicare, or beneficiary costs, such as differential updates initially for physicians that report on quality measures and later for physicians that achieve efficient and high quality care.

Limiting Subsidies to High Income Beneficiaries: MMA requires higher-income beneficiaries to pay a greater share of the Part B premium starting in 2007. Currently, beneficiary premiums cover 25 percent of Part B program costs. Starting 2007, Part B subsidies will be reduced for beneficiaries with an annual income over $80,000 and couples over $160,000.

The budget proposes to build upon the initial steps of MMA by eliminating annual indexing of thresholds for income-related Part B premiums beginning on January 1, 2008. While all beneficiaries would continue to get Medicare subsidies, this change gives beneficiaries increased participation in their health care, while retaining the current growth in subsidies for most beneficiaries.

Medicare Health Savings Accounts: Health Savings Accounts (HSAs) combine a high-deductible health plan with a tax advantaged personal savings account reserved for medical expenses. HSAs give individuals greater ownership over their health care and can be a more economical choice than traditional insurance. More than one million Americans have opted for an HSA since the President signed them into law in December 2003. However, Medicare still does not offer any HSA options. The Administration is developing new Medicare HSA choices for beneficiaries, including allowing people to continue their existing HSAs when they become eligible for Medicare.

Competitive Bidding for Labs: CMS successfully tested a competitive bidding model for DME in Polk County, Florida and San Antonio, Texas. Based on that success, MMA expanded DME competitive bidding nationwide and required a similar competitive process for outpatient

drugs. The Budget proposes to build on these successful competition models by extending competitive bidding to Medicare laboratory services.

Expanding Program Integrity Efforts: The Budget proposes to encourage Medicare providers to collect debts from beneficiaries who have not met their obligations to contribute to their medical care costs. Under this proposal, Medicare would phase out bad debt reimbursement to providers between 2007 and 2011.

In addition to the $1.1 billion provided in statute for Health Care Fraud and Abuse Control (HCFAC) in 2007, the Budget requests an additional $118 million targeted at efforts to protect the new prescription drug benefit and Medicare Advantage programs against fraud, waste and abuse. These funds are part of a Government-wide proposal to fund program integrity activities through a discretionary cap adjustment.

Building on Contracting Reform: The Administration will build on MMA Contracting Reform by working to improve quality and efficiency and better target resources to Quality Improvement Organizations (QIOs).

Strengthening Medicare's Long-Term Financial Security: To support continuing efforts to enhance Medicare's long-term sustainability, the Budget builds on an MMA requirement that the Medicare Trustees Report include a comprehensive fiscal analysis of the program's financing and issues a warning if general revenues are projected to exceed 45 percent of total Medicare financing. If the 45 percent threshold were met and Congress failed to act on recommendations to sustain Medicare's financing, then a four-tenths of one percent reduction to all Medicare payments would be implemented to slow growth, similar to a reduction in the market basket update. The reduction would grow by four-tenths of one percent every year that the 45 percent threshold is exceeded.

Medicare Highlights From the Deficit Reduction Act of 2005

Linking Payment to Performance: Starting in 2007, hospitals will be required to submit data on specified quality measures or have their annual market basket update reduced by two percentage points. The Secretary will develop a plan to implement a value-based purchasing program for inpatient hospital payments, beginning in 2009. Likewise, starting in 2007, home health agencies will be required to submit data on quality measures specified by the Secretary, or incur a two percentage point reduction in their market basket update.

Promoting Efficiency and Quality: By January 2007, DRA requires the Secretary to implement a hospital-focused gain sharing demonstration project in six sites. The projects will improve Medicare quality and efficiency by testing arrangements between hospitals and physicians to govern utilization of hospital resources and encouraging hospitals to share resulting savings with physicians.

Reducing Bad Debt Payments for Skilled Nursing Facilities: Starting in 2006, Medicare reimbursement for skilled nursing facility bad debt will be reduced to 70 percent, consistent with the rate paid to hospitals, except for the bad debt attributable to dual-eligible beneficiaries.

Rationalizing Provider Payments: Effective 2006, the title for DME capped rental items will be transferred to beneficiaries after 13 months of continuous use, saving money for Medicare and its beneficiaries. Another provision produces savings from paying less for multiple diagnostic images. Finally, DRA freezes home health updates in 2006, based on MedPAC reports showing home health agencies enjoying healthy profit margins.

2006 Physician Update: The physician payment update for 2006 is set at zero percent, instead of the previously scheduled -4.4 percent update.

Accelerating Income-Related Part B Premium: The MMA required phase-in of an income related Part B premium over 5 years, from 2007 to 2011. DRA accelerates this time frame, requiring the income-related premium be fully implemented by 2009.

Promoting Efficient Program Administration: To encourage providers to submit clean electronic claims, DRA extends the time period by which contractors must pay paper claims, from 27-30 days to 29-30 days.

Enhancing Program Integrity: DRA provides an additional $100 million in 2006 for the Medicare Integrity Program, to enhance program integrity oversight of the new prescription drug benefit and Medicare Advantage programs.

Medicare Quality Improvement Efforts

Improving quality of care and reducing medical errors are important goals in modernizing Medicare. The Administration supports greater availability of reliable and consistent quality information. The Medicare website now displays quality data that allows consumers to make informed choices by comparing the performance of hospitals, nursing homes, home health agencies, and dialysis facilities. The Administration also supports provider payment reforms that promote quality and efficiency and discourage increased complications and costs. CMS is working with Medicare providers to identify and test budget-neutral incentives that will stimulate improved performance on quality and efficiency measures. The following are additional CMS activities that support efforts to improve quality of care in Medicare.

Expanding Pay-for-Performance: CMS is working to develop and implement payment systems that support higher quality care - the right care for each person every time. These payment reforms can help providers deliver care that prevents complications, avoids unnecessary medical services, and achieves better outcomes at a lower overall cost. CMS is working on several fronts to expand pay for performance initiatives.

Encouraging Quality Data Reporting: In 2002, CMS initiated a voluntary requirement that hospitals report certain quality measures. This concept was adopted by MMA and expanded under DRA. Hospitals now face reductions to their annual payment updates for failure to report on selected quality measures. In early 2006, CMS is also launching a similar voluntary reporting effort for physicians. CMS will collect information on 16 clinical measures and work with doctors to improve data accuracy and clinical care. Comparative facility quality information, available on the Medicare web site, can help guide consumer choices and drive quality improvements.

Conducting Demonstration Programs: CMS is testing several demonstrations and pilot projects to test P4P principles. Using financial incentives, the Premier Hospital Quality Incentive demonstration adjusts hospital payments up or down depending on how they perform on certain quality outcomes measures. Under this project, top performing hospitals have so far received $8.9 million in bonuses based on performance, with improvements in quality and fewer costly complications. The Physician Group Practice Demonstration is testing pay for performance for large physician groups. Physician groups who achieve benefit savings among their patient population using quality improvement approaches will receive performance payments. A series of demonstrations will test if various disease management models can improve health outcomes and reduce costs in Medicare.

Promoting Health Information Technology: CMS is promoting the adoption of health information technology (IT) tools to improve performance and quality outcomes. For example, CMS is providing technical assistance to physicians' offices on how to adopt health IT tools to improve quality through the Doctor's Office Quality Information Technology (DOQ-IT) project. CMS has also developed regulations on standards for e-prescribing and for promoting interoperable record systems.

Quality Improvement Organizations: QIOs–previously Peer Review Organizations–were established by Title XI, Section 1151 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;
- Enhance program integrity by ensuring that Medicare only pays for items that are reasonable and medically necessary; and
- Protect beneficiaries by addressing individual beneficiary's complaints, appeals, and case reviews.

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

In the 7th cycle of contracts (commonly called a Scope Of Work or SOW), QIOs for the first time provided assistance on both the statewide and provider-specific level to nursing homes and home health agencies to improve quality. They also continued ongoing work with hospitals and physicians' offices. Medicare providers improved their quality of care on 29 of 41 clinical quality measures.

Estimated Quality Improvement Organization Funding by Major Task - 8th Contract Cycle (2005-2008)

(in millions)

Clinical Quality Improvement	
Nursing Homes	$107
Home Health Agencies	$70
Hospitals	$137
Physicians' Offices	$171
Part D Work	$66
Public Reporting and Quality Information	
QIO Information Systems/Network Capacity	$92
Developmental Work/Special Studies	$40
Protecting Beneficiaries and the Trust Funds	
Beneficiary Protection	$282
Hosptial Payment Monitering	$55
Support Contracts	$245
Total, QIO Eighth Cycle of Contracts	**$1,265**

On August 1, 2005, QIOs began a new three-year contract cycle. While continuing many existing quality improvement activities, the 8th contract cycle shifts the focus from targeted quality efforts to more systemic improvements. This cycle of contracts is broken into three major areas of work:

- *Clinical Quality Improvement:* QIOs will work with providers to improve the quality of care provided to beneficiaries. New activities include: collaborating with nursing homes to increase the stability of nursing homes' workforce; working nationally with physicians' offices to encourage adoption of health IT; and starting work with prescription drug plans and Medicare Advantage care plans to improve prescription drug therapy.
- *Public Reporting and Quality Information:* QIOs are working with providers to enhance the reporting of quality data and make it more accessible to the public. As part of an increased emphasis on pay for performance activities, QIOs are working with hospitals on the voluntary reporting initiative and will start to work with physicians to improve the data accuracy of reported measures of clinical care.
- *Protecting Beneficiaries and the Trust Funds:* QIOs continue to monitor the accuracy of Medicare payments to hospitals and respond to beneficiary complaints about the quality of care received.

Health Care Fraud and Abuse Control Program

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established the Health Care Fraud and Abuse Control (HCFAC) Program. The FY 2007 budget proposes to fund the HCFAC program through both a mandatory and a discretionary funding stream. Proposed FY 2007 total HCFAC funding is $1.2 billion. Of this amount, $1.1 billion funds the mandatory portion of the program. Within the mandatory amount is $24 million provided in DRA for the Medicare-Medicaid data matching program. The remaining $118.4 million represents new discretionary proposed funding.

The HCFAC program was established to:

- Coordinate Federal, State, and Local law enforcement programs;
- Conduct investigations, audits, and evaluations relating to the delivery of and payment for health care;
- Facilitate enforcement of statutes applicable to health care fraud and abuse;
- Provide for clarification on acceptable business arrangements and issue advisory opinions and special fraud alerts; and
- Provide for the reporting and disclosure of final adverse actions against health care providers, suppliers, or practitioners.

HCFAC Mandatory Funds: The HCFAC Program dedicates $1.1 billion from the Medicare Part A Trust Fund toward combating health care fraud and abuse. The FY 2007 money is allocated into three major parts: 1) $744 million for the Medicare Integrity Program (MIP); 2) $114 million to the Federal Bureau of Investigation (FBI); and, 3) $240.6 million allocated among the Department of Justice (DOJ), the HHS Office of the Inspector General (OIG), and other HHS agencies, including for 2006 CMS, the Administration on Aging (AoA), The Health Resources and Services Administration (HRSA), the Office of the National Coordinator for Health Information Technology (ONC), and the Office of General Counsel (OGC). The programs and projects financed by these funding streams are used to detect and prevent fraud, waste, and abuse through investigations and audits, educational activities, and data analysis. From 1997 to 2004, HCFAC activities have returned approximately $7.3 billion to the Medicare Trust Fund.

Health Care Fraud and Abuse Control (HCFAC) Budget Proposal

(in millions)

	2006	2007	2008
Discretionary Cap Adjustment Proposal			
Department of Justice/FBI	$0.0	$11.3	$17.5
HHS Inspector General	0.0	11.3	17.5
Medicaid and SCHIP Financial Management	0.0	10.1	15.6
Medicare Integrity Program (MIP)	0.0	85.6	132.0
Total Proposed Discretionary Funds	**$0.0**	**$118.4**	**$182.5**
Current Mandatory Funds (including DRA)			
Medicare Integrity Program (MIP)	$832.0	$744.0	$756.0
FBI	$114.0	$114.0	$114.0
OIG and Wedge Funds	$240.6	$240.6	$240.6
Total Current Mandatory Funds	**$1,186.6**	**$1,098.6**	**$1,110.6**
Total Proposed HCFAC Funds	**$1,186.6**	**$1,217.0**	**$1,293.1**
Memorandum			
HHS Program Level Portion of HCFAC Total	*$1,023.1*	*$1,042.2*	*$1,112.2*

The MIP activity in HCFAC provides funds for: medical review; benefits integrity work to identify and refer patterns of fraud to law enforcement; provider and HMO audits of cost reports; Medicare secondary payer activities; and provider education and training. The Administration has requested an additional $85.6 million in discretionary funding to safeguard the Medicare prescription drug benefit and Medicare Advantage. These funds will increase the total MIP funding to $829.6 million in 2007.

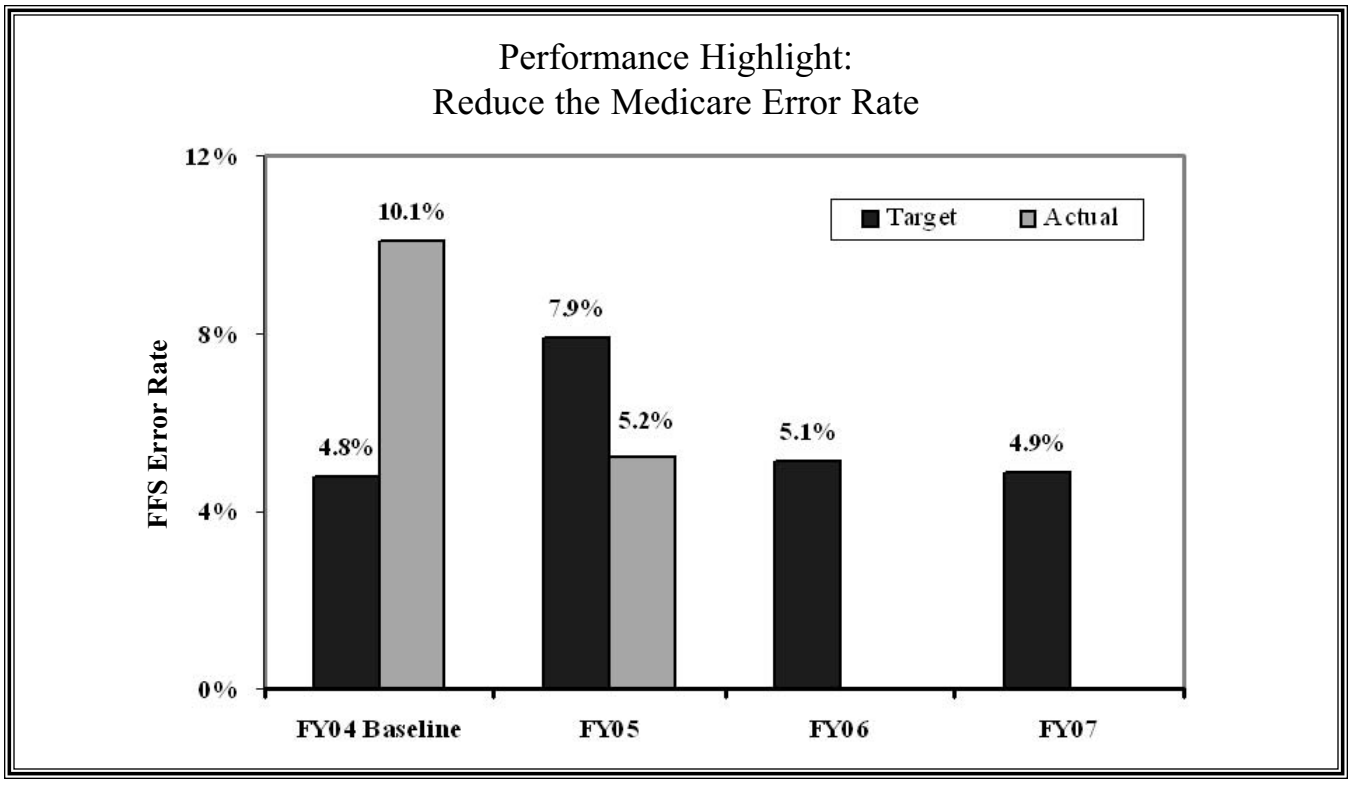
The FBI uses its $114 million allocation for health care fraud enforcement and investigations. In addition, the FBI provides operational support for national anti-fraud initiatives focusing on pharmacies, chiropractic services, medical clinics, and transportation providers.

The remaining $240.6 million finances a variety of anti-fraud and abuse activities. The HHS OIG uses its share to: a) bring about judgements and settlements related to health care fraud and abuse; and b) develop and implement recommendations, in conjunction with CMS, for correcting systemic vulnerabilities detected during evaluations and audits. The funding not allocated to the OIG is known as the "wedge." DOJ uses its portion of the wedge for civil and criminal prosecutions of health care professionals and providers. The remaining wedge monies go to HHS and are used primarily for: SCHIP and Medicaid financial management oversight; educational activities at AoA; supporting the Healthcare Integrity and Protection Data Bank; fraud prevention research by ONC; and investigative and litigation support at OGC.

HCFAC Cap Adjustment: As part of a Government-wide proposal to fund program integrity activities through a discretionary cap adjustment, the Budget requests discretionary HCFAC funding totaling $118.4 million in FY 2007 and $182.5 million in FY 2008. These amounts will be allocated among DOJ and OIG, as well as the Medicaid and Medicare programs at CMS. These funds are intended to complement the program integrity activities funded with mandatory HCFAC funds. Mandatory HCFAC funds have been capped since FY 2002, while at the same time, the Medicare program has experienced significant transformation and growth in Medicaid has put spending in that program on par with Medicare, thereby elevating the need for enhanced financial management oversight. The two-year, discretionary HCFAC request will be used to safeguard the new Medicare prescription drug benefit and Medicare Advantage plans against fraud, waste, and abuse, as well as to expand program integrity oversight of the Medicaid program.

Reducing Erroneous Medicare Payments

CMS announced in November 2005 that in just one year, aggressive oversight and new efforts to improve payment accuracy have cut the percentage of improper fee-for-service Medicare claims payments by half, from 10.1 percent in 2004 to 5.2 percent in 2005, a $9.5 billion reduction in improper payments. As part of its future performance goals, CMS has targeted further reducing the Medicare error rate to 5.1 percent in 2006 and 4.9 percent by 2007.



MIP is the primary source of funding to lower Medicare improper payments and finances the Comprehensive Error Rate Testing (CERT) program. CERT is the primary management tool for reducing the percentage of erroneous Medicare payments. Implemented in 2003, CERT allows CMS to estimate the Medicare error rate using a sample size of approximately 160,000 fee-for-service claims. Further, the program tracks payment accuracy data at the contractor, provider, and service levels, allowing CMS to identify where problems exist and more effectively target improvement efforts to address those problems.

The significant reduction in the Medicare FFS error rate from 2004 to 2005 can be attributed largely to a marked reduction in errors from claims with no documentation and insufficient documentation. These reductions are linked to efforts through CERT to educate providers about problems with medical record documentation and methods to improve their accuracy and completeness. When CERT data reveal a pattern that indicates a payment problem, CMS works with contractors to develop corrective action plans.

In 2005, CMS began an assessment of the risk for improper payments to Medicare Advantage plans and will take a series of steps starting this year to measure the accuracy of these payments in detail and address potential risks. By reviewing monthly managed care payments, CMS will examine whether beneficiaries are eligible for a plan, how payments are made, and what happens when a beneficiary's enrollment is terminated. Likewise, this year CMS will begin work to identify and prevent fraud and abuse of the new prescription drug benefit, through contractors called Medicare Rx Integrity Contractors (MEDICS).

Clinical Laboratory Improvement Amendments of 1988

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes. CLIA also introduced user fees to finance survey and certification activities at clinical laboratories. User fees are credited to the Program Management account but are available until expended for CLIA activities. CMS determines the workloads of each State survey agency by taking the total number of laboratories and subtracting waived laboratories, laboratories issued certificates of provider-performed microscopy, State-exempt laboratories, and accredited laboratories.

The CLIA program has 186,360 laboratories registered with CMS, 20 percent of which are subject to routine inspection (every 2 years) under the program. The remainder are exempted. Workload projections for the FY 2006-2007 cycle include 20,582 surveys of non-accredited laboratories, 826 State validation surveys of accredited laboratories, and approximately 1,441 follow-up surveys and complaint investigations.

Data support the contention that CLIA has improved the overall quality of laboratory testing in the nation. On average, the number of quality deficiencies decreases approximately 40 percent from the first round of laboratory surveys to the second, with further decreases in subsequent surveys.

MEDICARE LEGISLATIVE PROPOSALS

(dollars in millions)

	2007	2007 -2011
PART A		
Hospital Update at Market Basket (MB) -0.45% in 2007 and -0.4% in 2008 & 2009	-$480	-$6,610
Skilled Nursing Facility Update at 0% in 2007 and MB -0.4% in 2008 & 2009	-660	-5,110
Home Health Update at 0% in 2007 and MB -0.4% in 2008 & 2009	-170	-1,710
Inpatient Rehabilitation Facility Update at 0% in 2007 and MB -0.4% in 2008 & 2009	-220	-1,590
Reduce Hospice Payment Update by 0.4% from 2007-2009	-40	-550
Establish Federal Data Sharing Clearinghouse (Medicare Secondary Payer)	-20	-310
Extend Medicare Secondary Payer Status for ESRD from 30 to 60 Months	-50	-470
Phase-Out Medicare Bad Debt Payments Over 4 Years	-80	-3,420
Adjust Payment for Hip & Knee Replacements in Post Acute Care Settings	-380	-2,430
Subtotal, Part A	-$2,100	-$22,200
PART B		
Outpatient Hospital Update at MB -0.45% in 2007 and -0.4% in 2008 & 2009	-$70	-$1,470
Home Health Update at 0% in 2007 and MB -0.4% in 2008 & 2009	-180	-1,820
Reduce Ambulance Fee Schedule Update by 0.4% from 2007-2009	-10	-290
Phase-Out Medicare Bad Debt Payments Over 4 Years	-70	-2,760
Expand Competitive Bidding to Laboratory Services	0	-1,430
Eliminate Indexing of Thresholds for Income-Related Part B Premium	0	-40
Pay for Short-Term Power Wheelchairs Based on Actual Use	-50	-460
Limit Oxygen Rental Period to 13 Months	0	-6,550
Establish Federal Data Sharing Clearinghouse (Medicare Secondary Payer)	-20	-270
Extend Medicare Secondary Payer Status for ESRD from 30 to 60 Months	-60	-510
Subtotal, Part B	-$460	-$15,600
PREMIUM INTERACTIONS		
Interactions with Part B Indexing Proposal	-$40	-$1,900
Interactions with Part B Benefit Savings Proposals	148	3,809
Subtotal, Premium Interactions	$107	$1,909
SUBTOTAL MEDICARE PROPOSALS	**-$2,453**	**-$35,891**
MEMORANDUM [non-add]		
Net Impact of Premium Indexing Proposal (Benefit Savings + New Revenue)	*-40*	*-1,940*

MEDICAID

(dollars in millions)

Current Law:	2005 Actual	2006 Enacted	2007 Request	2006 +/- 2005
Benefits /1	$173,336	$182,930	$190,095	$7,165
State Administration	8,384	9,404	9,350	-54
Total Net Outlays, Current Law/2	**$181,720**	**$192,334**	**$199,445**	**$7,111**

1/ Includes Vaccines for Children Outlays.
2/ Number may not add due to rounding.

Medicaid is a jointly-funded, Federal-State program that provides medical assistance to certain low-income groups. In FY 2007, approximately 52.9 million individuals, including children, the aged, blind, and/or disabled, and people who meet eligibility criteria under the old Aid to Families with Dependent Children (AFDC) program, will be covered by Medicaid. Additionally, many other individuals will receive Medicaid benefits through waivers and amended State plans with somewhat higher income eligibility limits. The Medicaid current law baseline assumes passage of the Deficit Reduction Act of 2005 (DRA). In FY 2007, the Federal share of current law Medicaid outlays is expected to be $199.45 billion. This is a $7.11 billion (3.7 percent) increase over projected FY 2006 spending.

BACKGROUND

Under Medicaid, 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 per capita income. The Federal medical assistance percentage (FMAP) rates for FY 2007 will range from 50 to 76 percent for medical assistance payments. Overall, the Federal Government pays for approximately 57 percent of total Medicaid expenditures. In addition to medical assistance payments, the Medicaid appropriation funds the Center for Disease Control and Prevention's Vaccines for Children program and the Federal share of Medicaid State and local administrative costs.

Historically, eligibility for Medicaid had been based on qualifying under the cash assistance programs of AFDC or Supplemental Security Income (SSI). With the creation of the Temporary Assistance for Needy Families (TANF) program in 1996 (which replaced AFDC), eligibility for Medicaid and cash assistance were de-linked. Medicaid eligibility, however, remains tied to AFDC program rules in place in 1996. All those who qualify under the 1996 AFDC rules and most SSI recipients, commonly referred to as the "categorically eligible," must be covered under State Medicaid programs. States must cover three additional groups: 1) pregnant women and infants whose family income does not exceed 133 percent of the Federal poverty level; 2) all children under six living in families with incomes under 133 percent of the Federal poverty level; and 3) children aged six through 18 years living in families with incomes below the poverty line. In 2006, the Federal poverty level for a family of three was $16,600 in the continental United States.

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.

Generally, States are required to provide a core of 13 mandatory services to eligible needy recipients, including: inpatient and outpatient hospital care; health screening, diagnosis, and treatment for children; family planning; physician services; and nursing facility services to individuals over 21. States may also elect to

Medicaid Enrollment

(enrollees in millions)

	2005	2006	2007
Aged 65 and Over	4.6	5.2	5.3
Blind and Disabled	8.1	8.8	8.9
Needy Adults	24.3	25.1	25.8
Needy Children	11.1	11.5	11.9
Territories	1.0	1.0	1.0
Total 1/	**49.1**	**51.6**	**52.9**

1/ Numbers may not add due to rounding.

cover any of over 30 specified optional services, which include prescription drugs, clinic services, dental care, eyeglasses, and services provided in intermediate care facilities for those with developmental disabilities.

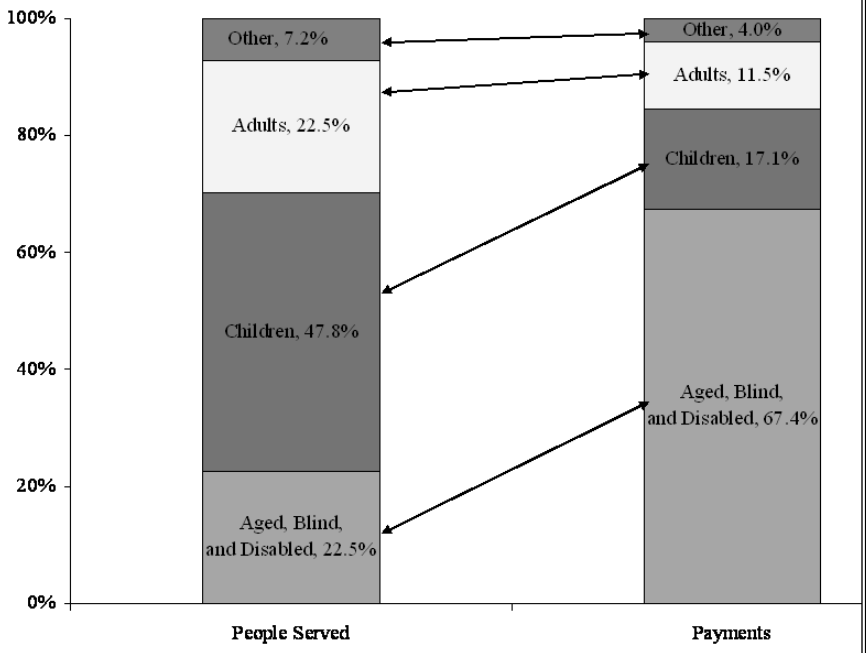
Medicaid Highlights From the Deficit Reduction Act of 2005

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

Money Follows the Person Rebalancing Demonstration: This demonstration, which builds on the President's New Freedom Initiative, will help States rebalance their long-term health care systems between institutional and home and community-based services (HCBS) by awarding selected States with an enhanced matching rate to pay for HCBS for individuals transitioning from institutional care to a setting of their choice.

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

Distribution of People Served Through Medicaid Payments by Basis of Eligibility, FY 2003



Source: Medicaid Statistical Information Statistics (MSIS), CMS (www.cms.hhs.gov/MSIS/)

Expanded Access to Home and Community-Based Services (HCBS) for the Elderly and Disabled: Beginning January 1, 2007, HCBS for elderly and disabled will become an optional benefit for States. $1 million is also appropriated for the period of FY 2006 through FY 2010 for measuring quality in HCBS programs.

Optional Choice of Self-Directed Personal Assistance Services: Beginning January 1, 2007, self-directed personal assistance services for the elderly and disabled would become an optional benefit for States.

Asset Transfer Reform: The DRA includes several provisions to increase penalties or change the rules regarding asset transfers in order to deter individuals from transferring assets so that they may become eligible for Medicaid long-term care services. These changes include lengthening the look-back period from three years to five years and changing the penalty period start date; altering how annuities are treated; modifying the "income-first" rule regarding community spouses; disqualifying individuals with substantial home equity from receiving long-term care assistance except where the spouse or minor or disabled child lives in the home or in instance of undue hardship; and requiring residents of Continuing Care Retirement Communities to spend down resources before applying for Medicaid while considering an individual's entrance fees as a resource.

Flexibility in Cost Sharing and Benefits: The DRA allows States to apply limited premiums and cost sharing for certain groups of Medicaid beneficiaries and services, and sets special rules for cost sharing for non-preferred prescription drugs and non-emergency care provided in emergency rooms. Premiums and cost sharing are limited to five percent of family income. Additionally, the DRA allows States to provide Medicaid coverage to certain groups of individuals through enrollment in benchmark benefit packages, similar to those offered in the State Children's Health Insurance Program (SCHIP).

Health Care Fraud and Abuse: The DRA includes several provisions which build on existing efforts to strengthen Medicaid and SCHIP program integrity. These provisions establish a new Medicaid Integrity Program; increase funding for the Medicare-Medicaid data matching program to find abuse patterns; provide incentives for States to enact and enforce false claims acts; prohibit providers from billing Medicaid multiple times for the same drug; enhance third party liability; improve enrollment documentation requirements; and create Medicaid transformation grants for States to use to adopt innovative cost-saving methods.

Prescription Drugs: The DRA contains several provisions that reform Medicaid payment for prescription drugs, including expanding the Federal Upper Limit list and collecting drug surveys and reports; collecting utilization data for physician administered drugs; expanding access to the 340B drug discount program to children's hospitals for inpatient drugs; and specifying how authorized generic drugs sold to another manufacturer are to be reflected when manufacturers report average manufacturer price and best prices.

Changes in Medicaid Funding: The DRA includes five provisions that adjust Medicaid funding to certain States and Territories and provide financing reform to certain services provided by Medicaid. The provisions include managed care organization provider tax reform; clarifications to Medicaid case management and targeted case management benefit reimbursement; an increase in the disproportionate share hospitals allotment for the District of Columbia; enhancement of the match rate for Alaska; and an increase in Medicaid payments to the Territories.

Emergency Services Furnished by Non-contract Providers for Medicaid Managed Care Enrollees: The DRA requires Medicaid providers without Medicaid managed care plan contracts to accept as payment in full no more than the amount otherwise applicable outside of managed care less any payments for indirect costs of medical education and direct costs of graduate medical education.

Other DRA Provisions with Medicaid Impacts

Child Support Enforcement Provisions: Two Child Support Enforcement provisions within the DRA have an effect on the Medicaid baseline. The first provision allows States to seek medical child support for children from both custodial and non-custodial parents. The second provision requires States to review child support orders for TANF cases every three years.

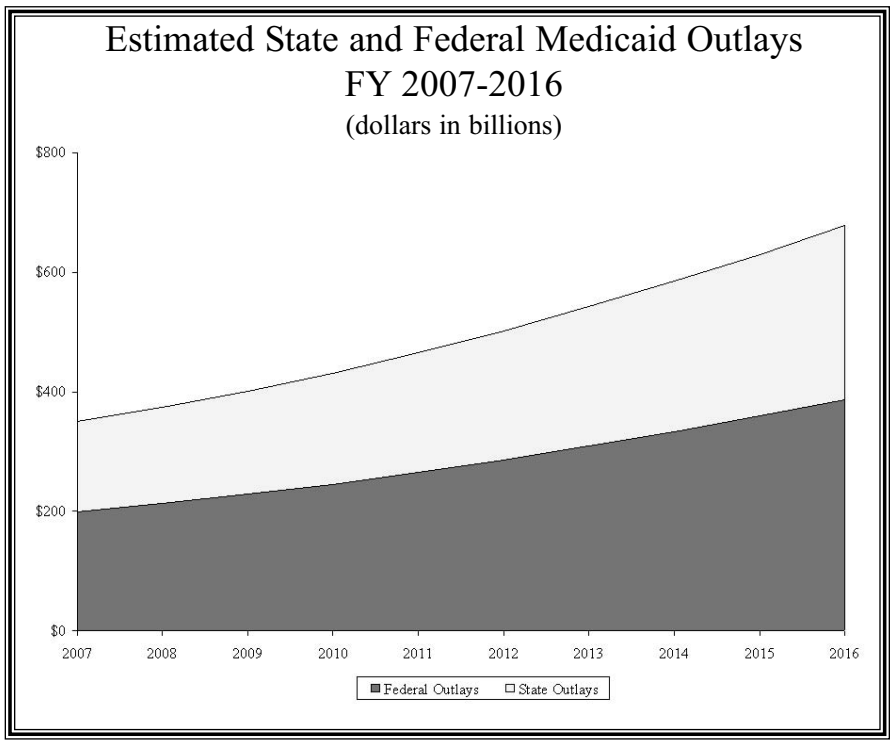
Hurricane Katrina Relief: The DRA appropriates $2 billion to provide care through Hurricane Katrina Waivers. Payments will be made to States for a range of health-care related costs, including some administrative costs.

Recent Program Developments

Medicaid Growth: Nursing home care, community-based long-term care costs, and payments to health plans are significant contributors to the growth in Medicaid outlays. These expenditures are expected to continue to contribute to growth in future years. State programs providing "enhanced payments" to institutional providers have also played a significant role in driving-up Federal Medicaid costs.

Waivers: States have sought waivers under section 1115 of the Social Security Act to expand health care coverage to low-income, uninsured populations that do not otherwise meet Medicaid eligibility criteria and to test innovative approaches in health care service delivery through demonstration programs. Although demonstrations vary greatly, many employ the approach of expanding the use of managed care for the Medicaid population.

To date, CMS has approved 32 State-wide comprehensive health care reform demonstrations in 29 States. CMS has also approved two sub-State health reform demonstrations and 15 demonstrations specifically related to family planning. The DRA legislation provides new opportunities for innovative waivers to improve health care coverage.



Health Insurance Flexibility and Accountability (HIFA): In August 2001, President Bush announced the HIFA demonstration, a new section 1115 initiative. HIFA demonstrations enable States to use Medicaid and SCHIP funds in concert with private insurance options to expand coverage to low-income, uninsured individuals, with a focus on those at or below 200 percent of the Federal poverty level.

A more in-depth discussion of HIFA waivers is included in the SCHIP section.

Extension of Premium Assistance to Qualified Individuals: The qualified individuals (QI),Transistional Medical Assistance (TMA), and Abstinence Programs Extension and Hurricane Katrina Unemployment Relief Act of 2005 (P.L.109-91) extends premium assistance for QI under Medicare through September 30, 2007. The QI extension will continue Federal coverage of Medicare Part B premiums, which are just over $1,052 per beneficiary annually ($87.70 per month) in 2006, a 12.1 percent increase over 2005, and will cost $350 million in FY 2007.

Medicaid and SCHIP Financial Management: The Administration proposes a continuation of activities associated with measurement of improper payments in Medicaid and SCHIP with the goal of reporting error rates for components in both Medicaid and SCHIP in the 2007 Performance and Accountability Report and a final completed error rate by 2008.

FY 2007 Proposed Legislation

The President's Budget includes legislative proposals to expand use of Medicaid benefits and a limited number of savings proposals.

Extension of Transitional Medical Assistance: TMA was created to temporarily extend health coverage for former welfare recipients after they enter the workforce. TMA allows families to remain eligible for Medicaid for up to 12 months after they lose welfare cash benefits due to increased earnings. This provision, enacted with welfare reform, was scheduled to sunset in September 2002 and has been extended several times. The DRA extends TMA through December 31, 2006. This legislative proposal extends TMA through September 30, 2007 and costs $180 million in FY 2007 and $360 million over five years.

Health Insurance Portability and Accountability Act (HIPAA) Proposals: Congress passed HIPAA in 1996 to increase the continuity, portability, and accessibility of health insurance. The President's Budget proposes two legislative changes to ensure that Medicaid and SCHIP beneficiaries receive the benefits of HIPAA-related coverage. The first change establishes the determination of eligibility for Medicaid or SCHIP as a qualifying event to allow access to employer-sponsored insurance (ESI). This change allows families to enroll in ESI through special enrollment even if they have missed their employer's open period for enrollment. The second change requires SCHIP programs to issue certificates of creditable coverage, which promote portable coverage by verifying the period of time an individual is covered by a specific health insurance policy. These proposals are budget neutral.

Cover the Kids: This legislative proposal provides $100 million in annual grants (in the State Grants and Demonstrations account) for States, working with schools and community organizations, to enroll and provide coverage to many eligible children in Medicaid and SCHIP. CMS estimates that this legislative proposal will result in additional Medicaid spending of $203 million in FY 2007 and $2 billion from FY 2007 through FY 2011 (please see the SCHIP and State Grants and Demonstrations chapters for additional cost estimates on this proposal).

Strengthening Third Party Liability: This proposal would allow States to avoid costs for prenatal and preventive pediatric care claims where a third party is responsible through a non-custodial parent's obligation to provide coverage for a limited time while assuring protection for providers and beneficiaries. In addition, legislation would be proposed to explicitly permit States to use liens against liability settlements to recover Federal matching payments. These proposals save $90 million in FY 2007 and $525 million over five years.

Strengthening Medicaid Reimbursement Policies: The Budget proposes to lower reimbursement for targeted case management services to the administrative matching rate of 50 percent. This legislative proposal saves $208 million in FY 2007 and $1.2 billion over five years.

Amending the Medicaid Drug Rebate Formula: The Medicaid program requires all drug manufacturers to pay a rebate for all drugs covered by Medicaid. The calculations for this rebate involve a figure called best price which is the lowest price available to retailers. This figure functions as a price floor, which prohibits manufacturers from negotiating deep discounts with large non-Medicaid purchasers such as hospitals and HMOs. This proposal would also help to administratively simplify drug rebate calculations and allow private purchasers to negotiate lower drug prices. Because this proposal is budget neutral, the States will not be disadvantaged by lower prices, which large volume, private purchasers may get.

Restructure Medicaid Prescription Drug Reimbursement: This proposal builds on DRA changes to the Federal upper limit for multiple source drugs. The Budget proposes to limit reimbursement for multiple source drugs to 150 percent of the average

manufacturers' price. This will continue efforts to further reduce Medicaid overpayments for prescription drugs. States would have the flexibility to support innovative approaches to lower drug costs, such as paying pharmacists more when they help patients use less expensive generic drugs. This proposal saves $130 million in FY 2007 and $1.3 billion over five years.

Allowing States to Use Managed Formularies: This legislative proposal will allow States to use private sector management techniques to leverage greater discounts through negotiations with drug manufacturers. This proposal saves $15 million in FY 2007 and $177 million over five years.

Medicaid Administration Cost Allocation: This proposal will reduce duplicate Medicaid payments that were improperly included in TANF block grants and also charged to Medicaid. The 1996 welfare reform law capped Federal funding for administrative costs under TANF and eliminated the open-ended matching structure for administrative costs in AFDC. Under the AFDC structure, States generally allocated most of the common eligibility determination costs for AFDC, Medicaid, and Food Stamps to AFDC/TANF. As a result, administrative costs associated with Medicaid were inappropriately included in the TANF block grant and also charged to Medicaid. This proposal recoups Medicaid administrative costs assumed in the TANF block grant, saving $280 million in FY 2007 and $1.8 billion over five years.

Administrative Proposals

Strengthening Third Party Liability: Requires States to uphold the cost avoidance standard for pharmacy claims, thereby eliminating what is known as "pay and chase." Currently, certain States may pay a claim up front and then seek reimbursement from liable parties. This proposal saves $105 million in FY 2007 and $430 million over five years.

Reforming Provider Taxes: HHS will seek a regulatory change to provider tax policy. Under current rules, taxes imposed on providers may not exceed six percent of total revenues and must be applied uniformly across all health care providers in the same class. The regulatory change will phase down the allowable provider tax rate from six percent to three percent. This proposal does not generate savings in FY 2007 but saves $2.1 billion over five years. Additionally, HHS will release regulations clarifying existing policies used to determine what provider taxes comply with statute and regulations.

Capping Payments to Government Providers: Builds on past CMS efforts to curb questionable financing practices by recovering Federal funds that are diverted from government providers and retained by the State. In addition, this proposal caps payments to government providers to no more than the cost of furnishing services to Medicaid beneficiaries. This proposal saves $384 million in FY 2007 and $3.8 billion over five years.

Medicaid Reimbursement Policies: The Administration plans to clarify, through regulation, provisions related to disproportionate share hospitals. The Budget also proposes to clarify allowable services that can be claimed as rehabilitation services, and to prohibit Federal reimbursement for school-based administration or ransportation costs; these administrative changes save $840 million in FY 2007 and $5.9 billion over five years.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(dollars in millions)

	2005	2006 Projected	2007 Request	2006 +/- 2007
Current Law				
Total Outlays	$5,129	$5,775	$5,244	-$531

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

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

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

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

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

Generally, SCHIP benefits can be received by Medicaid-ineligible uninsured children who are under 19 years old and from families below 200 percent of the Federal Poverty Level (FPL).

Implementation and Enrollment

Every State, the District of Columbia, and all five Territories have had approved SCHIP plans since September 1999. As of January 2006, States have received approval for 17 Medicaid expansion programs, 19 separate programs, 20 combination programs, and 251 State plan amendments.

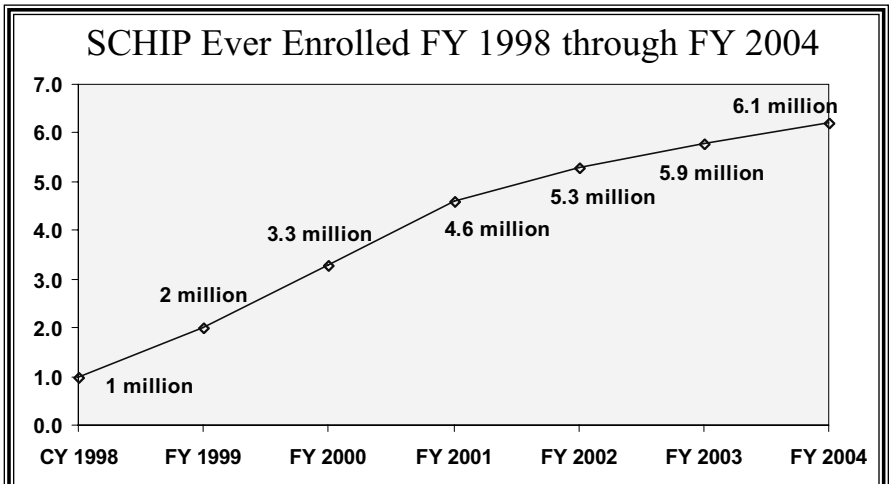
Today, 36 States and the District of Columbia cover children in families with incomes up to and including 200 percent of the FPL. Fourteen States cover children above that level. Of the 14, five States cover children up to and including 300 percent of the FPL, and one State, New Jersey, covers children up to 350 percent of the FPL.

During FY 2004, 6.1 million children were enrolled in SCHIP. This represents an increase of 200,000 children, or three percent, over FY 2003 enrollment.

SCHIP Performance

When SCHIP began in FY 1998, CMS adopted a goal of enrolling five million children by FY 2005. CMS has exceeded this enrollment goal with a total of 6.1 million children. For FY 2007, SCHIP is focusing more on a target goal regarding the number of children who have access to quality health care. The new performance measure involves the improvement of the quality of health care across the SCHIP program and supports HHS Strategic Goal three: Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices.

The Office of Management and Budget developed the Program Assessment Rating Tool (PART) to evaluate programs in a systematic manner, rating program effectiveness and highlighting strengths and weaknesses. SCHIP was rated as Adequate for FY 2005. As a result of



NOTE: FY 2005 enrollment data were not complete at print time.

the PART process, CMS developed an SCHIP Action Plan to further strengthen the program. Consistent with the Government Performance and Results Act, CMS is working with States to develop long-term SCHIP goals related to national core performance measures as well as providing technical assistance to States to help improve collection of performance measurement data.

SCHIP Reports and Evaluations

States are required to annually assess the operation of their SCHIP State plans and report to the Secretary by January 1 of each fiscal year. The Balanced Budget Refinement Act of 1999 (BBRA) required an independent evaluation of 10 States which was submitted to Congress in October 2005.

BBRA also directed the Secretary, through the Inspector General, to evaluate SCHIP every three years. SCHIP is evaluated in two separate areas: The number of children enrolled in separate SCHIPs that were eligible for Medicaid and SCHIPs progress towards reducing the number of uninsured children across the Nation. The recent report released by the Office of Inspector General (OIG) in the fall of 2005, found that only one percent of children enrolled in separate SCHIPs were eligible for Medicaid. OIG recommended that CMS work closely with States regarding inconsistent calculations and a lack of documentation which could lead to incorrect determinations in the future.

Currently, the OIG is working on an evaluation regarding Program Integrity and Monitoring. This evaluation was started in FY 2005. The next required evaluation of SCHIP will be conducted in FY 2007 and will be reported in FY 2008.

SCHIP Waivers

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

The Administration has promoted a relatively new section 1115 approach, the Health Insurance Flexibility and Accountability (HIFA) waivers, for States to develop comprehensive insurance coverage for individuals at twice the FPL and below, using SCHIP and Medicaid funds. These demonstration waivers target vulnerable, uninsured populations, such as pregnant women, parents and children on Medicaid and SCHIP, and other adult caregiver-relatives with incomes less than twice the FPL. The Administration places a particular emphasis on broad Statewide approaches that maximize both private health insurance coverage and employer sponsored insurance. As of January 2006, CMS has approved 11 HIFA demonstration waivers.

SCHIP Highlights From the Deficit Reduction Act 2005

Eliminate FY 2006 Funding Shortfalls: Appropriates $283,000,000 for FY 2006 to States experiencing SCHIP budget shortfalls to be allotted by the Secretary. Does not redistribute unspent allotments, and any unspent portions of the allotments expire on October 1, 2006.

Prohibition of Coverage of Non-Pregnant Childless Adults with SCHIP Funds: Prohibits the use of Title XXI funds for the coverage of non-pregnant childless adults, other than caretaker relatives. The provision does not apply to any current waivers or to the extension, renewal, or amendment of any existing waivers. The effective date is October 1, 2005.

Use of certain SCHIP funds for Medicaid Expenditures: Extends the ability of certain qualifying States to use up to 20 percent of available allotment amounts for fiscal years 1998, 1999, 2000, 2001, 2004 or 2005 (currently 1998-2001) as Federal matching funds to provide medical assistance under Title XIX for individuals under age 19 who are not eligible for SCHIP and whose family income exceeds 150 percent of the FPL. "Qualifying States" are those States that, prior to the implementation of SCHIP, were providing medical assistance to this population under Title XIX. The 11 qualifying States are: CT, HI, MD, MN, NH, NM, RI, TN, VT, WA, and WI. The effective date is October 1, 2005.

Findings of the Congressionally Mandated SCHIP Evaluation October 2005

- SCHIP is mainly serving low-income children who would otherwise be uninsured (identified target population);
- SCHIP coverage did not lead to widespread crowd-out of private health insurance coverage;
- Once children are enrolled in SCHIP, the majority remain enrolled for at least 12 months; and
- Children's access to primary health care is good under SCHIP.

HIFA: Expanding Health Care Coverage

In August 2001, the Administration invited States to participate in the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. The main goals of the HIFA initiative are:

- to encourage innovation in the Medicaid and SCHIP programs;
- give States the programmatic flexibility to increase health insurance; and
- simplify the waiver process.

States use HIFA demonstrations to expand health care coverage. As of November 2005, CMS has approved HIFA demonstrations that could expand coverage to more than 800,000 people.

Recent Program Developments

Medicaid and SCHIP Financial Management: The Administration proposes a continuation of activities to measure improper payments in Medicaid and SCHIP with the goal of reporting error rates for components in both Medicaid and SCHIP in the 2007 Performance and Accountability Report with a final completed error rate by 2008.

Proposed Legislation

Cover the Kids: This legislative proposal provides $100 million annually in grants (in the State Grants and Demonstrations account) to States, schools, and community organizations to enroll and provide coverage to many eligible, but not enrolled, children in Medicaid and SCHIP. The proposal increases SCHIP spending by $69 million in FY 2007 and $330 million over five years.

Health Insurance Portability and Accountability Act (HIPAA): The Administration proposes two legislative changes to ensure that Medicaid and SCHIP beneficiaries receive the benefits of HIPAA coverage:
(1) Eligibility for a Medicaid/SCHIP Employer-Sponsored Insurance (ESI) would be a qualifying event allowing families to enroll in ESI immediately through special enrollment; and
(2) SCHIP programs would be required to issue certificates of creditable coverage, which promote portable health coverage by verifying the period of time an individual was covered by SCHIP.

SCHIP Redistribution: The President's Budget proposes to address State shortfalls in FY 2007 that may occur for some States by seeking the authority to better target SCHIP funds in a more timely fashion.

MEDICAID AND SCHIP PROPOSALS

(outlays in millions)

	2007	2007-2011
Medicaid Legislative Proposals		
Transitional Medical Assistance	$180	$360
Vaccines for Children	140	700
HIPAA Modifications	0	0
Cover the Kids (Medicaid Impact)	203	1,978
Expanding Third Party Liability	(90)	(525)
Reduce TCM Match to 50 Percent	(208)	(1,187)
Amend Medicaid Drug Rebate Formula	0	0
Restructure Pharmacy Reimbursement	(130)	(1,285)
Optional Managed Formulary for Prescription Drugs	(15)	(177)
Recoup Admin. Costs Assumed in TANF	(280)	(1,770)
SUBTOTAL MEDICAID PROPOSED LAW	**($200)**	**($1,906)**
OTHER PROPOSALS WITH IMACT ON MEDICAID		
Refugee Exemption Extension	$42	$134
TOTAL MEDICAID PROPOSED LAW	**($158)**	**($1,772)**
Medicaid Administrative Proposals		
Third Party Liability: Eliminate Pay and Chase for Pharmacy	($105)	($430)
Phase Down of Provider Tax	0	(2,070)
Capping Government Providers	(384)	(3,812)
Stricter Reimbursement Policies for Rehabilitation Services	(225)	(2,286)
School Based Services: Eliminate Admin./ Transportation	(615)	(3,645)
Payment Reform: Issue Provider Tax Regulation	0	0
Codify DSH Provisions in Regulation	0	0
SUBTOTAL MEDICAID ADMINISTRATIVE PROPOSALS	**($1,329)**	**($12,243)**
SCHIP Legislative Proposals		
Cover the Kids (SCHIP Impact)	$69	$330
Modify Redistribution: Address 2007 Shortfalls	635	110
TOTAL SCHIP PROPOSED LAW	**$704**	**$440**
TOTAL MEDICAID AND SCHIP/1	**($783)**	**($13,575)**

1/ Totals may not add due to rounding.

STATE GRANTS AND DEMONSTRATIONS

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Current Law/1:				
Budget Authority				
Ticket to Work Grant Programs	$81	$82	$42	-$40
Qualified High-Risk Pools Grant Programs	0	90	0	-90
Background Checks-Nursing Home Staff	0	0	0	0
State Pharmaceutical Assistance Program Grants	62	62	0	-62
Emergency Services for Undocumented Aliens…….	250	250	250	0
Hurricane Katrina Relief*	-	2,000	0	-2,000
Health Care Infrastructure Improvement Program	142	0	0	0
Program of All-Inclusive Care for the Elderly (PACE):				
PACE Rural Site Development Grants	-	8	0	-8
PACE Fund for Outlier Costs	-	10	0	-10
Drugs Surveys and Reports*	-	5	5	0
Partnership for Long Term Care*	-	3	3	0
Non-Emergency Medical Transportation Programs	-	12	13	+1
Psychiatric Residential Treatment Demonstration*	-	0	21	+21
Money Follows the Person (MFP):				
MFP Demonstration*	-	0	249	+249
MFP Evaluations and Technical Support*	-	0	1	+1
Medicaid Transformation Grants*	-	0	75	+75
Medicaid Integrity Program*	-	5	50	+45
Home and Community Base Services Waivers /2	-	0	0	0
Total Budget Authority	**$535**	**$2,527**	**$709**	**-$1,818**
Proposed Law:				
Budget Authority				
Cover the Kids Outreach*	-	-	$100	+$100
Chronically Ill grants	-	-	500	+500
Total Proposed Law	-	-	$600	+$600

1/ Assumes enactment of the Deficit Reduction Act of 2005.
2/ $200,000 was appropriated for FY 2006 and FY 2007.

*Discussion of these program activities is included in the Medicaid section.

STATE GRANTS AND DEMONSTRATIONS

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

The Ticket to Work and Work Incentives Improvement Act

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) authorized two grant programs designed to assist States in developing services and supports to aid the competitive employment of people with disabilities by extending Medicaid coverage to these individuals. Section 203 of the Act provided an appropriation each year from FY 2001 to FY 2011 for Medicaid Infrastructure Grants. These grants provide funding to States to build Medicaid infrastructure and supports, conduct outreach activities, explore new service options, and form partnerships to improve the employment environment for people with disabilities. Section 204 provides for an appropriation of $42 million for each of the fiscal years from 2001 to 2004, and $41 million for both FY 2005 and FY 2006 for Demonstration to Maintain Independence projects.

Through FY 2005, a total of 49 States and the District of Columbia have been approved for funding from the Infrastructure Grant Program (Section 203). There are 31 States with Medicaid buy-ins and one additional State has a plan amendment under review. As of September 30, 2005, there were about 67,000 workers receiving Medicaid benefits under the buy-in options. A total of 28 States applied for and received continuation grant awards in FY 2006. Eleven States received new competitive grant awards in FY 2006. In addition, two States, Kentucky and New York, and the District of Columbia, will continue to carry-out employment goals for the working disabled population by spending previous grant awards in FY 2006 through a no-cost extension of funding.

The Demonstration to Maintain Independence and Employment program (Section 204) has funded grants projects in several States. For FY 2006, six States and the District of Columbia are continuing grant programs targeted to specified populations to support continued work. Unexpended carryover funds can be used to continue these projects through FY 2009.

Qualified High-Risk Pools

Section 6202 of the DRA extends the authority for grants to States for high-risk health insurance pools. The state high-risk pools program was initially created by the Trade Act of 2002, which authorized $20 million in seed grants for the creation and initial operation of high-risk pools and $40 million per year for fiscal years 2003 and 2004 to support existing high-risk pools.

For FY 2006 $15 million is authorized and appropriated for seed grants to assist states in creating and initially funding qualified high-risk pools. An additional $75 million is authorized for FY 2006 for grants to help support existing qualified state high-risk pools.

Thirty-five states currently operate high-risk pools. These programs target individuals who cannot otherwise obtain or afford health insurance in the private market, primarily due to pre-existing health conditions, who are at risk for being uninsured. In general, high-risk pools are operated through state established non-profit organizations, many of whom contract with private insurance companies to collect premiums, administer benefits, and pay claims.

Pilot Program for Background Checks on Nursing Home Employees

Section 307 of the MMA created a $25 million pilot program to identify efficient, effective, and economical procedures for long-term care facilities or providers to conduct background checks on prospective direct patient access employees. Seven States (Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin) are participating in the pilot program, which runs through FY 2007. Information gathered from this pilot will inform CMS about the cost associated with conducting background checks, the impact and effectiveness of a background check program, and possible unintended consequences of implementing such a program on a nationwide basis.

Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens

The MMA appropriated $250 million per year in FY 2005 through FY 2008 for payments to eligible providers for emergency health services provided to undocumented aliens and some other non-citizens. Two-thirds of these funds ($167 million) will be allotted for paying providers in all 50 States and the District of Columbia, based on their relative percentages of the total

number of undocumented aliens. The remaining one-third ($83 million) will be allotted for providers in six States with the largest number of undocumented alien apprehensions.

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

State Pharmaceutical Assistance Program Grants

The MMA provided grants in FY 2005 and FY 2006 to State Pharmaceutical Assistance Programs (SPAPs) to educate Part D eligible individuals, enrolled in the SPAPs, about prescription drug coverage available through the Medicare prescription drug benefit.

Health Care Infrastructure Improvement Program

MMA established the Health Care Infrastructure Improvement Program (HCIIP) to provide loans to qualifying hospitals for projects designed to improve health care infrastructure. Projects may include construction, renovation, or other capital improvements. In order to receive assistance, the qualifying hospital must be engaged in cancer research and be either designated by the National Cancer Institute as a cancer center or designated by the State legislature as the official cancer institute of the State prior to December 8, 2003.

The Secretary is authorized to forgive HCIIP loans if the hospital establishes an outreach program for cancer prevention, early diagnosis and treatment for a substantial majority of the residents of the State, a similar outreach program for multiple Indian tribes, and either unique research resources or an affiliation with an entity that has unique research resources.

CMS published the HCIIP application process, selection criteria, and conditions for loan forgiveness in the Federal Register on September 30, 2005. The public comment period ended on November 29, 2005. The deadline for HCIIP application was December 29, 2005, and CMS expects to award loans in early to mid FY 2006.

HCIIP is authorized for the period between FY 2004 through FY 2008. Funding for the program is $142 million.

Program of All-Inclusive Care for the Elderly

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

The DRA authorized two new PACE grant programs. The first program provides site development grants for up to 15 new rural PACE sites and establishes a technical assistance program for rural PACE providers. The second grant program establishes a fund for outlier costs for FY 2006 to remain available through FY 2010.

Non-Emergency Medical Transportation Program

The Non-emergency Medical Transportation Fund gives States the option to establish non-emergency medical transportation brokerage programs for Medicaid recipients without access to transportation. Programs may include wheelchair van, taxi, stretcher car, bus passes, and secured transportation.

FY 2007 Legislative Initiatives

Focus on the Chronically Ill: Chronically ill individuals often struggle to secure health insurance coverage. The Administration proposes creating a program whereby States compete to receive funds for implementing innovative policies to promote insurance among the chronically ill. For this effort, $500 million would be available annually.

Cover the Kids: This legislative proposal, which is discussed in the Medicaid and SCHIP sections, will cost $500 million over five years.

PROGRAM MANAGEMENT

(dollars in millions)

	2005	2006	2007	2007 +/-2006
Medicare Operations	$2,285	$2,150	$2,145	-$4
Survey and Certification	259	258	284	+25
Federal Administration	642	653	655	+3
Research	110	69	42	-28
Revitalization Plan	24	24	23	-1
CMS Budget Authority Subtotal /1 /2	**$3,319**	**$3,154**	**$3,148**	**-$5**
Reimbursable Spending /3	$58	$101	$144	+$43
User Fees /3	-58	-101	-144	-43
Survey and Certification User Fee Proposal	0	0	-35	-35
Comparable Proposed BA/Approp. Level /1	**$3,319**	**$3,154**	**$3,113**	**-$40**
FTE /4	4,664	4,632	4,603	-29

1/ Numbers may not add due to rounding.
2/ The 2006 column includes $74 million for Program Management appropriated by the DRA.
3/ Includes Clinical Laboratory Improvement Act of 1988, sale of data, coordination of benefits for the Medicare prescription drug program, and MA/prescription drug program information campaign.
4/ The FTE totals exclude HCFAC and State Grants funded FTEs. CMS will fund the following FTEs from the HCFAC and State Grants accounts: FY 2005 - 84 FTEs; FY 2006 - 123 FTEs; FY 2007 - 200 FTEs.

The CMS FY 2007 Program Management appropriation request is $3.15 billion in budget authority, $68.6 million, or 2.2 percent, above the adjusted FY 2006 appropriated level. When the $74 million DRA administrative funding is added to the FY 2006 appropriation, the FY 2007 request is virtually unchanged from the prior year.

The budget request reflects savings from eliminating paper transactions at Medicare contractors (totaling $133 million) and includes $35 million in collections from a proposed user fee on health care facilities for certain revisit surveys. This fee, if enacted, will offset the CMS appropriation request by $35 million, to a total of $3.11 billion on a proposed law basis.

With the funding requested for FY 2007, CMS will be able to achieve its priority program and management goals. This request will allow CMS to: continue implementing Part D and other Medicare Modernization Act of 2003 (MMA) programs; maintain an accelerated schedule for implementing contracting reform; sustain beneficiary education efforts; survey health facilities at mandated frequencies; make targeted investments in IT; conduct a basic level of research; and cover basic operations.

BUDGET ACCOUNT SUMMARIES

Medicare Operations: The Medicare Operations budget request is $2.1 billion, a decrease of $4.3 million, or 0.2 percent, below FY 2006, including Deficit Reduction Act of 2005 (DRA) spending. This level assumes $133 million in savings from eliminating paper from Medicare contractor transactions.

The Medicare Operations portion of the CMS Program Management account funds a variety of activities that support the mission-critical operations necessary to administer the Medicare program, such as:

- *Ongoing Contractor Operations and Support:* funds day-to-day Medicare contractor activities such as processing claims, handling claims appeals, enrolling providers, and answering provider and beneficiary inquiries. This activity pays

for fee-for-service support functions such as provider toll free lines and provider education and training.

- *Information Technology:* includes maintaining fee-for-service and managed care systems used to pay claims, developing and installing a new accounting system, running the data center and communications network, and developing systems and infrastructure to implement new program requirements.

- *Legislative Mandates:* funds functions required under seven budget reconciliation and financial management laws enacted in the last ten years, including MMA, such as the new drug benefit, contracting reform, Medicare education, new appeals processes, and Health Insurance Portability and Accountability Act (HIPAA) administrative simplification.

Just over half, or about $1,084 million, of the FY 2007 Medicare Operations request goes toward ongoing contractor operations, about 8.4 percent below the 2006 level. Contractors are projected to process 1.2 billion fee-for-service claims in FY 2007, a modest 0.8 percent increase over FY 2006 that reflects current assumptions that more beneficiaries will shift from Medicare fee-for-service to Medicare Advantage. In addition, contractors will process 66 million inquiries and 6.3 million appeals. Projected Part A claims processing unit costs in 2007 are 96 cents per claim, the same as 2006. Part B unit costs will decline from a projected 65 cents per claim to 53 cents per claim, largely as a result of savings expected from eliminating paper from Medicare operations.

About $283 million, or about 13 percent, of the Operations request supports information technology (IT) activities. Ongoing maintenance of systems that support claims processing and accounting activities account for the majority, or $197 million, of this total – an increase of $26 million over 2006. Another $76 million supports enterprise activities (data center, communications), and $10.2 million supports Department-wide IT priorities, including the Enterprise Information Technology Fund and the Unified Financial Management System.

The remaining $778 million, or 36 percent, of the FY 2007 Operations request will support Medicare activities mandated in various pieces of legislation. Of this amount, nearly $508 million supports MMA implementation. MMA priorities funded in this total include: IT support and oversight and management of the drug benefit and Medicare Advantage programs ($120 million); continuing our accelerated contracting reform time line ($147 million); and support of MMA-mandated education activities, such as 1-800-MEDICARE, the handbook, and Internet ($151 million).

Non-MMA mandates comprise the other $270 million of Operations activities in the legislative mandates category. Important initiatives within this amount include: the transition of four more contractors to the new Healthcare Integrated General Ledger Accounting System or HIGLAS ($49 million); support of new appeals activities, including the first full operational year for the four Qualified Independent Contractors, or QICs ($89 million); ongoing, non-MMA education activities ($93.4 million); and ongoing support of HIPAA administrative simplification activities, including enumeration of plans and providers and enforcement ($24 million).

Federal Administration: For FY 2007, the President's Budget requests $655.4 million for CMS Federal administrative costs. This is an increase of $2.6 million, or 0.4 percent, from FY 2006 including funding for DRA.

The Federal Administration portion of the CMS budget supports a total of 4,531 Full Time Equivalent (FTE) in FY 2007, 29 fewer than in 2006. Of this total, 3,031 FTEs will staff the central office and 1,500 FTEs will staff the regional offices. Agency-wide, CMS will support a total of 4,803 FTE in FY 2007– 48 FTE over 2006 when Health Care Fraud and Abuse Control (HCFAC), new Medicaid program integrity staff, and the Clinical Laboratory Improvement Act of 1988 (CLIA) reimburseable employees are included. This increase is attributable to a DRA requirement that CMS hire another 100 FTE for Medicaid financial management oversight activities.

CMS requests $12.9 million to continue the Healthy Start, Grow Smart program. This will support the printing costs and postage for a series of 13 informational brochures in English and Spanish to new Medicaid mothers. These brochures are distributed at the time of birth and monthly over the first year of the child's life. Each publication focuses on activities that stimulate infant brain development and build skills children need to be successful in school. In addition, each Healthy Start pamphlet includes vital health and safety information for new parents. The Healthy Start, Grow Smart program has disseminated over 21.7 million brochures in 24 States and the District of Columbia. Approximately 11 percent of the brochures are in Spanish and 89 percent are in English. CMS is also working with the American Hospital Association to distribute to small rural hospitals, which may not have the funds to print their own high quality educational materials for new mothers.

Research, Demonstrations and Evaluation: The FY 2007 budget requests $41.5 million for the Research, Demonstrations and Evaluation program, $27.9 million, or 40 percent, less than the FY 2006 level including DRA. Most of this reduction is attributable to eliminating the Real Choice Systems Change Grants. This request includes almost

$28 million to continue and refine projects initiated in previous years and $13.6 million for MMA-related activities.

Ongoing research activities include the Medicare Current Beneficiary Survey, beneficiary information campaign evaluations, refinement and monitoring of prospective payment systems, and support for legislative mandates in the Balanced Budget Act of 1997 (BBA), the Balanced Budget Refinement Act of 1999 (BBRA), and the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA).

The remaining $13.6 million for MMA-related research supports projects such as monitoring beneficiary access to covered drugs and evaluating numerous demonstrations and pilots mandated by the MMA.

Survey and Certification: The FY 2007 Survey and Certification budget request is $283.5 million. The Medicare Survey and Certification Program works to ensure the safety of beneficiaries and the quality of care provided in health facilities - two of CMS' most critical responsibilities. When entering the program, and on a regular basis thereafter, all facilities participating in the Medicare and Medicaid programs must undergo an inspection to ensure compliance with Federal health, safety, and program standards. CMS contracts with State agencies to conduct these inspections.

In order to maintain the survey frequencies set out in statute and policy, CMS requires an increase of $25.4 million, or 9.8 percent over the FY 2006 budget. This request will allow States to inspect long-term care facilities and home health agencies at their legislatively mandated frequencies, and to maintain recertification levels for End Stage Renal Disease (ESRD) facilities, non-accredited hospitals, hospices, rural health clinics, ambulatory surgical centers, outpatient physical therapy facilities, and outpatient rehabilitation facilities at levels included in budget requests for the past few years.

Survey and Certification Frequencies

Type of Facility	Recertification Level FY 2005	Recertification Level FY 2006 Appropriation	Recertification Level FY 2007
Long-Term Care Facilities*	Every Year	Every Year	Every Year
Home Health Agencies*	Every 3 Yrs	Every 3 Yrs	Every 3 Yrs
Accredited Hospitals	1% Per Year	1% Per Year	2% Per Year
Non-Accredited Hospitals	Every 3 Yrs	Every 5 Yrs	Every 5 Yrs
ESRD Facilities	Every 3 Yrs	Every 3 Yrs	Every 4 Yrs
Hospices	Every 6 Yrs	Every 9 Yrs	Every 6 Yrs
Outpatient Physical Therapy	Every 6 Yrs	Every 9 Yrs	Every 6 Yrs
Outpatient Rehabilitation	Every 6 Yrs	Every 9 Yrs	Every 6 Yrs
Portable X-Rays	Every 6 Yrs	Every 9 Yrs	Every 6 Yrs
Rural Health Clinics	Every 6 Yrs	Every 9 Yrs	Every 6 Yrs
Ambulatory Surgery Centers	Every 6 Yrs	Every 9 Yrs	Every 6 Yrs

*Legislatively mandated

Between FY 2001 and FY 2006, the Medicare Survey and Certification budget increased by 6.6 percent. At the same time, the number of facilities that CMS surveys increased by 12.8 percent, from 44,725 facilities in FY 2001 to 50,468 facilities in FY 2006. Growth is expected to continue through 2007. CMS expects to complete over 24,500 initial and recertification inspections in FY 2007, along with 48,000 visits responding to beneficiary and family complaints.

Recent reports from the Government Accountability Office (GAO) and the Office of the Inspector General (OIG) highlight the need for federal oversight to ensure quality of care. The GAO placed aspects of survey and certification, particularly oversight of nursing homes and ESRD facilities, into a high risk category. Maintaining survey and certification frequencies at or above the levels mandated by policy and statute is critical to protecting the health and well-being of beneficiaries and ensuring that federal dollars support only quality care.

Revitalization: The FY 2007 budget request includes $22.8 million in two-year budget authority to continue modernizing CMS information technology systems. This funding level is a reduction of $1.2 million from the FY 2006 appropriation of $24.0 million. The Medicare program has relied on a number of antiquated legacy systems that have been characterized by the GAO and the Department's OIG as inflexible, not secure, and obsolete. Since the implementation of this fund in FY 2004, CMS has successfully modernized its mid-tier and mainframe computing platform, developed the ability to support health plan and provider services over the Internet, updated legacy systems in conjunction with the Medicare drug benefit, and documented thousands of business requirements to begin redesigning Medicare fee-for-service claims processing systems.

In FY 2007, the Revitalization Plan continues the process of streamlining the agency's Medicare fee-for-service claims processing systems ($12.1 million), modernizing CMS information technology data structure ($8.2 million), and developing and leveraging a mature enterprise architecture ($2.5 million). These modernization efforts improve

efficiency, enable e-gov and other new business activities, improve systems security at CMS, and help prepare CMS systems for increases in claims processing as "baby boomers" become eligible for Medicare benefits.

The Revitalization Plan continues the Agency's commitment to provide CMS systems the flexibility and security needed to take on growing Medicare workloads and health care options, while providing future beneficiaries with the information that they need to make informed choices.

Medicare Contracting Reform Transition Schedule	
Projected Transition Completion Date	**Type of Medicare Administrative Contractor to be Transitioned:**
CY 2006	4 Durable Medical Equipment
CY 2007	1 Part A/B
CY 2008	7 Part A/B – Cycle 1
CY 2009	7 Part A/B – Cycle 2 4 Home Health

Program Management Priorities

Contracting Reform: The MMA included provisions that change the way CMS contracts with the entities responsible for receiving, processing, and paying Medicare claims. Replacing the legacy claims processing contracts, MMA establishes Medicare Administrative Contractors (MACs), regional contractors that process both Part A and Part B claims. Unlike legacy contractors, MACs are procured through the competitive Federal Acquisition Regulation process.

The Department has adopted an accelerated schedule that requires all MAC transitions to be complete by FY 2009. In FY 2006, CMS awarded its first MAC contracts to the four contractors that process durable medical equipment claims. Before the year is completed, CMS will also award its first Part A and B MAC. In FY 2007, CMS plans to compete an additional seven MACs and begin transferring Medicare claims workloads to these new contractors.

It is necessary that funding be available in the beginning of FY 2008 to continue implementing this transfer of workload even under a continuing resolution. To ensure funding is available in the first quarter of FY 2008, appropriations language is included to make the $146.8 million in FY 2007 two-year funding. The budget would also include appropriation language that would support CMS's transition plans for FY 2008. This language would ensure a stable and timely transition for the new contractors.

Paperless Initiative: The FY 2007 budget submission also includes savings from our proposal to increase efficiency by greatly reducing paper from Medicare operations. CMS processes 145 million paper claims, mails over 42 million paper checks, and sends 66 million paper remittance advices. This budget submission reflects administrative proposals that will increase electronic transactions in the Medicare program by October 1, 2006. The budget assumes that these actions will result in savings of up to $133 million. These savings are reflected in the FY 2007 Medicare Operations request.

The National Medicare & You Education Program: Beneficiary education is a top priority for CMS, especially as the new benefit options are implemented. CMS must ensure that beneficiaries have the essential information they need to make complex and personal health choices.

The total FY 2007 program level for the National Medicare & You Education Program (NMEP) is $316 million, a decrease of $6 million from FY 2006. In FY 2007, over 58 percent of NMEP funding covers the 1-800-MEDICARE helpline. The balance will be used for beneficiary materials, CMS websites, community based outreach, the National advertising campaign, and program support.

The Medicare & You Handbook: In FY 2007, CMS expects to distribute more than 43 million handbooks to beneficiaries and stakeholders, approximately one million more handbooks than in FY 2006. The handbooks are offered in English and Spanish, and in Braille, audiocasette, or large print formats.

The 1-800-MEDICARE line: This toll-free line provides access to customer service representatives in English and Spanish 24 hours a day, seven days per week. CMS anticipates approximately 33 million calls in FY 2007, a decrease of approximately 14 million calls over the FY 2006 current estimate. Call volume is expected to drop following the initial Part D enrollment period.

The www.medicare.gov Web Site: This beneficiary-centered web site provides beneficiaries and stakeholders a variety of real-time, interactive tools that enable users to receive information on their benefits, plans, and medical options. The website is integrated into the desktop that the 1-800-MEDICARE operators use to respond to calls. CMS expects 500 million page views in FY 2007.

National Medicare & You Education Program (NMEP)

FY 2007 Program Level Request in Millions

Activity	Total
Beneficiary Materials (e.g. Handbook).....	$43.5
1-800-MEDICARE Toll Free Line.....	184.7
Internet.....	18.7
Community-Based Outreach /1.....	43.6
Program Support Services /2.....	25.3
Total, NMEP Program Level.....	**$315.8**

1/ Includes State Health Insurance and Assistance Program (SHIP) grants
2/ Includes multi-media campaign and consumer research

National Multimedia Campaign: The new prescription drug benefit is available to all Medicare beneficiaries, and each beneficiary needs to consider the options that suit his or her needs best. For example, beneficiaries will have to decide whether to enroll in a stand alone drug plan, a Medicare Advantage regional plan that offers a prescription drug benefit, keep their retiree drug coverage, or choose not to enroll now and possibly pay more for the drug benefit if they choose to enroll at a later date. As a result of these complexities, the FY 2007 multimedia campaign will employ techniques to spread messages at the local level, and to tailor messages to meet the needs of specific audiences.

Community-Based Outreach: CMS administers and conducts many outreach programs, including the State Health Insurance Assistance Programs (SHIPs) grants. Research has shown that beneficiaries prefer one-to-one assistance. CMS will continue its successful grant relationship with the SHIPs, which are located in all 50 States and the territories. SHIPs provide one-to-one counseling to beneficiaries on complex Medicare-related topics, including Medicare entitlement and enrollment, health plan options, Medigap and long-term care insurance, Medicaid, and prescription drug assistance. During FY 2006, CMS expanded its partnerships to an estimated 14,000 local networks and coalitions.

HIGLAS: One of the Secretary's top priorities is to centralize the Department's financial accounting process through its Unified Financial Management System (UFMS). UFMS is expected to achieve greater economies of scale, eliminate duplication, mitigate security risks, and provide timely and accurate financial information. A major component of UFMS is the Healthcare Integrated General Ledger Accounting System or HIGLAS, which will perform the accounting for over one billion Medicare claims processed each year as well as the everyday administrative financial dealings of CMS. The development of HIGLAS will also help CMS and the Department to fulfill the financial management portion of the President's Management Agenda.

In FY 2007, the President's Budget requests $139 million ($49 million in two-year money in Medicare Operations and $90.4 million in systems maintenance costs also in Medicare Operations). As CMS implements HIGLAS at additional contractors, systems maintenance costs will increase.

CMS began developing HIGLAS in FY 2001. Thus far, CMS has transitioned five contractors to HIGLAS and plans to transition two more in FY 2006. Implementation of HIGLAS is being coordinated with the implementation of Medicare contracting reform and the conversion from legacy contracts to the new MACs.

In FY 2007, CMS will implement HIGLAS at four additional Medicare contractors, begin rolling out the administrative accounting module at CMS central office, complete other payment management system interfaces, and attain 52 percent of total CMS costs under HIGLAS accounting.

Legislation Supporting the Discretionary Budget

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

DRA Administrative Funds in FY 2006

For FY 2006 only, the DRA appropriates $74 million in funds that support CMS program management activities. Specifically, Section 6203 of DRA appropriates $60 million for implementation of the act, with $30 million each coming from the Medicare Trust Funds and the General Fund. In addition, Sections 5006-5008 provide a total of $14 million to administer and evaluate three projects.

ADMINISTRATION FOR CHILDREN AND FAMILIES: DISCRETIONARY SPENDING

dollars in millions

	2005	2006	2007	2007 +/- 2006
Head Start	$6,843	$6,786	$6,786	0
Faith-Based and Community Initiative Programs:				
Compassion Capital Fund, including Helping America's Youth	$55	$64	$100	+$36
Mentoring Children of Prisoners	50	49	40	-9
Center for Faith-Based and Community Initiatives	1	1	1	0
Subtotal, Faith-Based Community Initiative	$106	$115	$141	+$26
Abstinence Education:				
Community-Based Abstinence Education	$104	$113	$141	+$28
State Abstinence Education Program	50	50	50	0
Subtotal, Abstinence Education	$154	$163	$191	+$28
Refugee:				
Refugee and Entrant Assistance	$431	$493	$510	+$17
Unaccompanied Alien Children	54	77	105	+28
Subtotal, Refugees	$485	$570	$615	+$45
LIHEAP:				
Block Grant (discretionary)	$1,885	$1,980	$1,782	-$198
Block Grant (mandatory)	0	0	250	+250
Subtotal, Block Grant	$1,885	$1,980	$2,032	+$52
Contingency Fund (discretionary)	298	181	0	-181
Contingency Fund (mandatory)	0	0	750	+750
Subtotal, Contingency Fund	$298	$181	$750	+$569
LIHEAP, Program Level	2,182	2,161	2,782	621
Less Mandatory BA (Non-Add)	*0*	*0*	*-1,000*	*-1,000*
Discretionary, BA (Non-Add)	*2,182*	*2,161*	*1,782*	*-379*
Child Welfare Services and Training	297	294	294	0
Abandoned Infants Assistance Programs	12	12	12	0
Promoting Safe and Stable Families (discretionary portion)	99	89	89	0
Independent Living (discretionary portion)	47	46	46	0
Adoption Incentives	9	18	30	+12
Adoption Opportunities and Adoption Awareness	40	40	40	0
Child Abuse Programs	102	95	95	0
Child Care & Development Block Grant	2,083	2,062	2,062	0
Developmental Disabilities	169	171	171	0
Native Americans	45	44	44	0
Community Services:				
Community Services Block Grant	$637	$630	$0	-$630
Individual Development Accounts	25	24	24	0
Community Services Discretionary Programs	65	40	0	-40
Subtotal, Community Services	$727	$695	$24	-$670
Violent Crime Reduction	129	128	128	0
Runaway and Homeless Youth	104	103	103	0
Early Learning Fund	36	0	0	0
Social Services Research & Demonstration	32	12	6	-6
Federal Administration	185	183	188	+5
Total, Discretionary Program Level	**$13,883**	**$13,787**	**$13,847**	**+$60**
Less Mandatory BA and Funds from Other Sources:				
PHS Evaluation Funds	-11	-11	-11	0
State Abstinence Education Program	-50	-50	-50	0
LIHEAP, Mandatory BA	0	0	-1,000	-1,000
Total, Discretionary Budget Authority	$13,822	$13,726	$12,787	-$940
Adjustments to Discretionary BA				
Head Start Emergency Hurricane Funding	*0*	*90*	*0*	*-90*
Social Services Block Grant Proposed Discretionary Savings	*0*	*0*	*-500*	*-500*
Total, Adjusted Discretionary BA	*$13,822*	*$13,816*	*$12,287*	*-$1,530*
FTE	1,330	1,327	1,319	-8

ADMINISTRATION FOR CHILDREN AND FAMILIES

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

The Administration for Children and Families promotes the economic and social well-being of children, youth, families, and communities, giving special attention to vulnerable populations, such as children in low-income families, refugees, Native Americans, and the developmentally disabled.

The Administration for Children and Families (ACF) administers over 60 programs that provide services to children, families, and communities through cooperative efforts with Federal, State, local, and Tribal governments, and through public and private non-profit organizations. The FY 2007 budget for ACF totals $46.7 billion, a net increase of $795 million, or 2 percent above FY 2006. The discretionary budget includes $6.8 billion for Head Start and $685 million in program reductions. Among the mandatory programs, the FY 2007 budget includes $17.2 billion for Temporary Assistance for Needy Families, $6.9 billion for Foster Care and related programs, and a proposed reduction of $500 million to the Social Services Block Grant to help fund more effective discretionary programs.

Administration for Children and Families
Total Program Level
(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Discretionary:				
Program Level	$13,883	$13,787	$13,847	+$60
Budget Authority	13,822	13,726	12,787	-940
Entitlement:				
Program Level	34,824	32,129	32,864	+735*
Total, ACF Program Level	**$48,707**	**$45,916**	**$46,711**	**+$795**
Memoranda Entry:				
Emergency Hurricane Funding	0	640	0	-640

* Proposed reduction in authorized funding level for Social Services Block Grant scores as discretionary savings.

DISCRETIONARY SPENDING

The FY 2007 discretionary budget totals $13.8 billion, a net increase of $60 million above FY 2006. This includes a net increase for the Low Income Home Energy Assistance Program (LIHEAP) of $621 million, which is comprised of a reduction of $379 million in the budget and a one-time increase of $1 billion from the Deficit Reduction Act of 2005. The budget eliminates the Community Services Block Grant, which was funded at $630 million in FY 2006 and is unable to demonstrate long-term outcomes.

HEAD START

The budget request includes $6.8 billion for Head Start to provide 917,000 children with services including 62,000 children in Early Head Start. The President's Good Start Grow Smart Initiative strengthens Head Start by providing information on child development and early learning to teachers, caregivers, parents, and grandparents and by closing the gap between research and practice in early childhood education. The National Reporting System, a key component of the initiative, will assess all four- and five-year-old children at the beginning and end of the year to determine some of the skills with which they enter Head Start, their level of achievement when they leave Head Start, and the progress they make during the year. This information will support the success of the Head Start program in preparing children for school.

Head Start programs help ensure that children are ready to succeed at school by supporting social and cognitive development. Head Start programs provide comprehensive child development services, including educational, health, nutritional, social, and other services, primarily to low-income families. They also engage parents in their child's preschool experience by helping them achieve their own educational and literacy goals as well as employment goals, supporting parents' role in their children's learning, and emphasizing the direct involvement of parents in the administration of local Head Start programs. The Head Start program has enrolled nearly 24 million children since it began in 1965.

Faith-Based and Community Initiative

The budget continues a commitment to fund faith-based and community organizations. A total of $141 million in ACF will support grassroots organizations in expanding services to their communities. The HHS Center for Faith-Based and Community Initiatives (CFBCI) leads the Department in efforts to better utilize faith-based and community-based organizations in providing effective services. CFBCI works with Agencies across the Department to eliminate barriers in regulations, policies, and procedures to the participation of faith-based and other community organizations and to propose the development of innovative pilot and demonstration programs.

Helping America's Youth Initiative: In the 2005 State of the Union Address, the President announced a new initiative to help youth at risk of gang influence and involvement as part of a broader outreach effort to at-risk youth. The Helping America's Youth Initiative helps children and youth by emphasizing the importance of family, school and community. The budget provides $50 million for this initiative within a total of $100 million requested for the Compassion Capital Fund. Grants will be awarded to faith-based and community organizations with a demonstrated history of providing services to youth and families in disadvantaged situations. Priority will be given to applicants who plan to serve areas with significant gang activity.

Compassion Capital Fund: The Compassion Capital Fund advances the efforts of community and charitable organizations, including faith-based organizations, to increase their effectiveness and enhance their ability to provide social services where needed. A total of $50 million is for grants to intermediary organizations that provide training and technical assistance to grassroots organizations in accessing funding sources, administering programs, expanding services, and replicating promising approaches. These grantees also provide sub-awards to some of the organizations receiving training and technical assistance. In addition, funds support targeted capacity building mini-grants awarded to increase their capacity to deliver services to at-risk youth, the homeless, or those living in rural communities or to provide marriage education.

Since the program began in 2002, $148 million has been awarded to more than 3,000 organizations including sub-awards made by intermediary grantees. This includes the targeted capacity building mini-grants, which began in the second year of the program with 52 awards and grew to 310 awards in FY 2005.

Mentoring Children of Prisoners: The request includes $40 million, a decrease of $9 million, to enable public and private organizations to establish or expand projects that provide one-to-one mentoring for children of incarcerated parents and those recently released from prison. In a recently completed review with the Performance Assessment Rating Tool (PART), the program received a rating of Results Not Demonstrated. The program will continue to monitor progress and will assess grantees' abilities to achieve positive youth outcomes and use the analysis to inform program development. Nearly two million children have a parent in a Federal or State correctional facility, a number that more than doubled over the 1990s. Research indicates that children with incarcerated parents are seven times more likely than the general population to become incarcerated themselves and are more likely to display a variety of behavioral, emotional, health, and educational problems. As part of reauthorization, ACF proposes to allow the use of vouchers to provide mentoring services to children of prisoners.

First Lady's Helping America's Youth Initiative

On October 27, 2005, Mrs. Laura Bush convened the White House Conference on Helping America's Youth at Howard University in Washington, D.C. More than 500 parents, youth, educators, civic leaders, faith-based and community service providers, foundations, researchers, and experts in child development gathered to discuss various problems facing America's youth and proven solutions in overcoming those challenges. Also, the First Lady unveiled the Community Guide to Helping America's Youth, a web-based guide with up-to-date research on youth development and effective programs. The guide is available at www.helpingamericasyouth.gov.

Abstinence Education

The budget requests a total of $204 million for Abstinence Education activities, an increase of $28 million, and supports increasing funding for abstinence education programs to $270 million by 2009. ACF administers two abstinence education programs – the Community-Based Abstinence Education program and the State Abstinence Education program – which total $191 million. Within the HHS Office of Public Health and Science, the budget also includes $13 million for abstinence education activities as part of the Adolescent Family Life program.

ACF's abstinence education programs provide grants to community-based organizations, including faith-based organizations, as well as to States to develop and implement abstinence programs. The Community-Based Abstinence Education program focuses on

adolescents, ages 12 through 18, and targets the prevention of teenage pregnancy and premarital sexual activity. The State Abstinence Education program enables States to create or augment existing abstinence education programs and where appropriate, provide mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups most likely to bear children out-of-wedlock. Within the Community-Based Abstinence Education program, the budget provides up to $10 million to continue a national public awareness campaign designed to help parents communicate with their children about health risks of early sexual activity. The request maintains support for evaluation of abstinence education programs.

Refugee Programs

Refugee and Entrant Assistance: The budget requests $510 million to support services for refugees, asylees, Cubans/Haitians, and victims of torture and trafficking, $17 million more than the FY 2006 level. The increase will maintain access to a full eight months of cash and medical assistance and will continue to support State-administered social services that emphasize employment-related services, such as job preparation, placement, and retention, provided concurrently with English language training. The State Department's funded refugee ceiling for 2007 is 70,000, the same as FY 2006. Refugee Transitional and Medical Services was rated Effective by a recent PART review, the highest rating possible and one that approximately only 15 percent of Federal programs have achieved. The budget includes an additional $5 million for the Victims of Trafficking program, for a total of $15 million, to establish and expand assistance programs for United States citizens or aliens admitted for permanent residence who have been victims of trafficking that occurs at least in part within the United States. The request also includes support for services, including rehabilitation, social, and legal services for those who have experienced torture.

Performance Highlight

The percent of refugees served by the Matching Grant program that enter employment has increased from 51 percent in 2001 to 72 percent in 2004. In FY 2007 the percent of refugees served through this program that enter employment will increase to 77 percent.

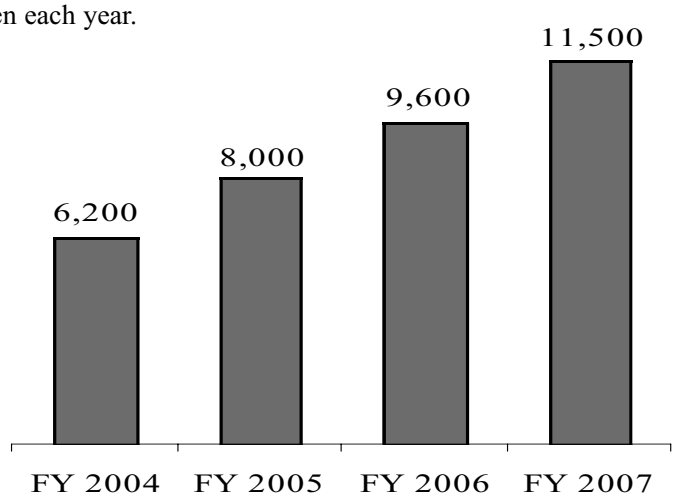
Unaccompanied Alien Children: The Unaccompanied Alien Children (UAC) program provides a safe and appropriate environment for unaccompanied alien minors who are apprehended in the U.S. by Homeland Security agents, Border Patrol officers or other law enforcement until custody can be transferred to a relative or appropriate guardian or until the child is returned to his or her country of origin. Since the program was transferred from the former Immigration and Naturalization Service in 2003, the Office of Refugee Resettlement has increased the use of less restrictive shelter and foster care placements and provided necessary support for improved medical care. The FY 2007 budget for the UAC program of $105 million is $28 million more than the FY 2006 level to meet anticipated increases in the number of minors in care. Current estimates indicate that the number of UAC will increase by over 40 percent from 8,000 in FY 2005 to approximately 11,500 in FY 2007. In FY 2007, the Office of Refugee Resettlement will continue the pro bono legal services program and will undertake more thorough background checks of sponsors prior to the placement of these children.

Low Income Home Energy Assistance Program (LIHEAP)

The FY 2007 President's Budget requests $1.8 billion for the LIHEAP Block Grant, which provides home energy assistance through grants to States, Tribes and Territories. The Deficit Reduction Act of 2005 includes $250 million for the LIHEAP Block Grant and $750 million for the Contingency Fund in FY 2007. When considered together, a total of $2.8 billion is available in FY 2007, an increase of

Annual Placements of Unaccompanied Alien Children

Since the Unaccompanied Alien Children program was transferred to ACF from the former Immigration and Naturalization Service in 2003, the program has provided care and shelter for an increasing number of children each year.



$621 million over FY 2006. Amounts in the Contingency Fund are available for release in a heating or cooling emergency such as extreme temperature or high fuel prices or to meet energy needs related to a natural disaster. In FY 2005, HHS released $27 million from the Contingency Fund to States hit hardest by Hurricane Katrina. And, in January 2006, HHS released $100 million from the Contingency Fund to all States to assist with heating and energy costs this winter.

For the past several years, almost 5 million households per year received LIHEAP assistance to help them get through the winter months. The program also provides cooling assistance to about 400,000 households, and weatherization assistance to about 90,000 more. Of the households receiving heating assistance, about one-third include a member 60 years or older; about half have at least one person with a disability; and about one-fifth include at least one child five years old or younger.

Child Welfare, Adoption and Child Abuse

The FY 2007 budget includes $606 million for a range of programs that support child welfare systems, adoption efforts, and child abuse prevention. These efforts support the Secretary's long-term goal that children are protected from abuse and neglect.

Child Welfare: The Child Welfare Services program helps State public welfare agencies improve their child welfare services with the goal of keeping families together. Grants are also provided to develop and improve education and training programs and resources for child welfare professionals through the Child Welfare Training program and to prevent the abandonment of infants and young children exposed to HIV/AIDS and drugs through the Abandoned Infants Assistance Program. The budget requests $306 million for these efforts.

The budget requests $46 million for the Independent Living Education and Training Vouchers program, which provides up to $5,000 for costs associated with college or vocational training for foster care youth ages 16 to 21. The Promoting Safe and Stable Families program provides funds for each State to operate a coordinated program of family preservation services, community-based family support services, time-limited reunification services, and adoption promotion and support services. The FY 2007 budget includes a total of $434 million, of which $89 million is financed through discretionary resources.

Adoption: At the end of FY 2004, there were 518,000 children in foster care, of which 118,000 were waiting to be adopted. The FY 2007 request includes $30 million, an increase of $12 million, for the Adoption Incentives program. States can earn bonus payments by increasing the number of adoptions of children in foster care over previous years. Additional funds will support an expected increase in the number of bonus-earning adoptions. The budget also includes $27 million for the Adoption Opportunities program to support grants that facilitate the elimination of barriers to adoption and $13 million for Adoption Awareness programs that support adoption efforts, including adoption of children with special needs, through training and a public awareness campaign.

Child Abuse: The most recent annual HHS Child Maltreatment Report indicates that each year an estimated 906,000 children in the United States are victims of abuse and neglect. The budget includes a total of $95 million for programs to reduce the incidence of child maltreatment and provide services to those who are victims. The Child Abuse State Grant program plays a key role in the prevention of child abuse and neglect including post-investigative services such as individual counseling, case management and parent education. Other programs help complete the continuum of prevention efforts by providing funds for community-based efforts including public awareness and education activities and by supporting research on child maltreatment and training and technical assistance.

Child Care

The Child Care and Development Block Grant (CCDBG) program to States, Territories and Tribes provides direct child care assistance payments to low-income families when the parents work or participate in education or training. States have flexibility in developing child care programs and policies that meet the needs of children and parents within each State. CCDBG also supports research and evaluation of innovative child care subsidy policies and web-based access to reports, data, and other research-related information.

ACF's most recent data indicates that $4.8 billion in total Federal child care funds, including $2.1 billion in discretionary funds, provide child care assistance to approximately 1.7 million children each month. However, when combined with other Federal and related State funds, child care assistance is available to 2.3 million children, representing an estimated 28 percent of children eligible under State rules.

Developmental Disabilities

Today, there are nearly four million Americans with developmental disabilities. Developmental disabilities are severe, chronic disabilities attributable to mental and/or physical impairment, which manifest before age 22 and are likely to continue indefinitely. The budget requests $155 million for programs that support partnerships with State governments, local communities, and the private sector to assist people with developmental disabilities to reach their maximum potential through increased independence, productivity, inclusion, and community integration.

Disabled Voter Services: The Voting Access for Individuals with Disabilities grant programs provide support to States to make polling places accessible to individuals with disabilities in a manner that provides the same opportunity for access and participation, including privacy and independence, as other voters. Grants also provide individuals with disabilities with information about the accessibility of polling places and train election officials, poll workers, and election volunteers on how best to promote the access and participation of individuals with disabilities. The 2007 President's Budget maintains $16 million for these efforts.

Native Americans

The programs of the Administration for Native Americans promote the goal of self-sufficiency by providing social and economic development opportunities. The budget request includes a total of $44 million for these programs which, through discretionary grants, provide financial assistance, training and technical assistance to eligible Tribes and Native American organizations. Funds support a range of projects from the creation of new jobs and development or expansion of business enterprises and social service initiatives to the formulation of environmental ordinances and training in the use and control of natural resources.

Community Services Programs

The budget proposes $24 million for the Individual Development Accounts (IDA) program. IDAs are dedicated savings accounts for low-income individuals that can be used for purchasing a first home, paying for post-secondary education, or capitalizing a business. This demonstration program provides grants to agencies that in turn empower low-income individuals to save by providing matching contributions for savings and intensive financial counseling and economic literacy education.

The FY 2007 budget continues the policy of not requesting funds for the Community Services Block Grant (CSBG) and a number of smaller community services programs, a total decrease of $670 million. CSBG lacks national performance measures and does not award funds on a competitive basis. In addition, key CSBG services targeting employment, housing, nutrition, and health care are also provided by other Federal programs. The budget is consistent with a recent PART review, in which the program received a rating of Results Not Demonstrated. In addition, the budget does not fund the Community Economic Development, Rural Community Facilities, and Job Opportunities for Low-Income Individuals programs.

Other Children and Families Activities

The budget maintains funds for programs that offer safe havens and access to services for victims of domestic violence and runaway and homeless youth. The Family Violence Prevention and Services program provides grants to States and Tribes to prevent incidents of family violence, provide immediate shelter and related assistance for victims of family violence, and support prevention services for perpetrators. The budget also supports a national toll-free hotline to provide information and assistance to victims of domestic violence. The Runaway and Homeless Youth program supports public and private organizations to establish and operate runaway and homeless youth shelters. Also, ACF will begin using vouchers to provide maternity group home services as part of the Runaway and Homeless Youth program.

Research/Federal Administration

There is continuing interest and need for sound research to help guide efforts to assist low-income families become and remain economically self-sufficient and to strengthen families. The FY 2007 budget includes $6 million in PHS evaluation funds, a decrease of $6 million, for the Social Services Research and Demonstration program which will support cutting-edge research and evaluation projects in areas of critical national interest.

The request includes $188 million in FY 2007, an increase of $5 million, to support staffing and maintain activities to administer the programs of ACF. Consistent with the President's Management Agenda, the budget supports efforts to reduce erroneous and improper payments in several key ACF program areas, including Temporary Assistance for Needy Families (TANF), and supports a continued focus on the Public Assistance Reporting Information System (PARIS), a voluntary program for States to share public assistance data to maintain program integrity and detect and reduce erroneous payments. The budget includes funding for enhanced single State audits in three to five States in an effort to develop an error rate methodology which will help reduce improper payments.

ADMINISTRATION FOR CHILDREN AND FAMILIES: ENTITLEMENT SPENDING

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Current Law Budget Authority /1				
TANF				
Program Level	$17,209	$17,058	$17,058	$0
Adjustment for Emergency Hurricane Funding /2	*5,139*	*-5,070*	-	-
Budget Authority	*22,348*	*11,988*	*17,058*	*5,070*
TANF Contingency Fund, B.A. /3	1,958	0	0	0
Child Care Entitlement				
Program Level	2,717	2,917	2,917	0
Adjustment for Emergency Hurricane Funding /2	*991*	*-991*	-	-
Budget Authority	*3,708*	*1,926*	*2,917*	*991*
Child Support Enforcement & Family Support, Net B.A. /4	4,074	3,322	3,953	631
Foster Care/Adoption Asst./Independent Living, B.A.	6,806	6,708	6,941	233
Children's Research & T.A., B.A.	55	58	58	0
Promoting Safe & Stable Families, B.A.	305	365	365	0
Social Services Block Grant				
Program Level	1,700	1,700	1,700	0
Adjustment for Emergency Hurricane Funding /5	-	*550*	-	-
Budget Authority	*1,700*	*2,250*	*1,700*	*-550*
Total, ACF Entitlements Program Level /6	**$34,824**	**$32,128**	**$32,992**	**$864**

	2005	2006	2007	2007 +/- 2006
Current Law Outlays /1				
TANF	$17,357	$17,406	$17,461	$55
TANF Contingency Fund	43	131	90	-41
Child Care Entitlement	2,784	2,868	2,909	41
Child Support Enforcement & Family Support (net outlays)	3,983	3,903	4,105	202
Foster Care/Adoption Asst. /Independent Living	6,427	6,603	6,879	276
Children's Research & T.A. (net outlays)	38	65	60	-5
Promoting Safe & Stable Families	308	319	352	33
Social Services Block Grant /7	1,822	2,224	1,827	-397
Total, ACF Entitlements Outlays	**$32,762**	**$33,519**	**$33,683**	**$164**

1/ Numbers may not add due to rounding. Current law assumes enactment of the Deficit Reduction Act of 2005.
2/ Represents first quarter FY 2006 funds appropriated in FY 2005 for the TANF and Child Care programs as part of the TANF Emergency Response and Recovery Act of 2005 (TERRA), $5,071 for TANF and $991 for Child Care. The TANF adjustment also includes $68 million in FY 2005, for the forgivable Federal Loans to State Welfare Programs made available to Louisiana, Mississippi, and Alabama through TERRA.
3/ FY 2005 Contingency Fund B.A. is available for obligation through FY 2010. ACF estimates that at the end of FY 2007 $1.768 billion will remain unobligated in this account.
4/ The Child Support Enforcement FY 2006 B.A. and FY 2007 B.A. reflect the availability of prior year funds.
5/ Represents $550 million provided for SSBG as emergency hurricane funding in Defense Appropriations Act for FY 2006.
6/ Total ACF Entitlements Program Level does not reflect $50 million for pre-appropriated abstinence education program, see Discretionary Program Level.
7/ FY 2006 and FY 2007 outlays for the Social Services Block Grant reflect projected spending of the $550 million in supplemental hurricane relief funding.

The Administration for Children and Families serves some of the Nation's most vulnerable populations through entitlement programs such as Temporary Assistance for Needy Families (TANF), the Child Care Entitlement to States, Child Support Enforcement (CSE), Foster Care, Adoption Assistance, Independent Living, Promoting Safe and Stable Families, and the Social Services Block Grant (SSBG). The ACF entitlement outlay estimates for FY 2007 are $33.7 billion, an increase of $164 million in entitlement spending from FY 2006. This overall increase is a combination of a $55 million increase in TANF outlays and typical growth rate increases in Child Support, Foster Care, and Adoption Assistance. This year's budget includes the reauthorization of TANF and related programs, as well as other program modifications included in the Deficit Reduction Act of 2005 (DRA).

The FY 2007 President's Budget also includes proposals to improve the efficiency and effectiveness of ACF entitlements. The budget provides additional funding for TANF. This includes new Family Formation and Healthy Marriage State grants, continuing the Supplemental Grant for Population Increases through 2010, and restoring the TANF Contingency Fund to $2 billion. In the Child Support Enforcement program, the budget includes modifications which increase both financial collections and medical support to families. The budget also includes proposals in Foster Care, including an option for States to receive their foster care funds as a flexible grant.

Temporary Assistance for Needy Families

TANF provides approximately $16.5 billion annually to States, Territories, and eligible Tribes for the design of creative programs to help families transition from welfare to self-sufficiency. States have tremendous flexibility in determining how to use their TANF dollars. Since welfare reform, through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), States are spending less on cash assistance payments and more on education and training, child care, and other work supports to help families achieve self-sufficiency. In 1998, States spent 63 percent of combined State and Federal funds on cash assistance, and in FY 2004 States spent 32 percent. In addition, States may transfer up to a combined 30 percent of their TANF funding to the Child Care and Development Fund and the SSBG with not more than 10 percent transferred to SSBG.

Welfare reform is widely regarded as a success. TANF caseloads continue to decrease. As of June 2005, 4.5 million individuals received TANF benefits – 64 percent fewer than in August 1996. From June 2004 to June 2005 TANF caseloads dropped six percent for individuals and four percent for families.

The TANF program expired at the end of FY 2002. Congress continued the program through a series of extensions. The budget assumes passage of DRA, which reauthorized the TANF program through 2010. For more information, see the program developments section.

TANF Performance

The TANF program achieved success towards its primary goal of moving TANF recipients from welfare to work and self-sufficiency. In FY 2004:

- 35 percent of adult TANF recipients became newly employed, up from 34 percent in FY 2003, but short of the target of 44 percent.
- 37 percent of recipients attained higher earnings over two quarters, exceeding the target of 29 percent.
- Job participation rates increased from 31 percent in FY 2003 to 32 percent in FY 2004.

In the 2005 PART assessments, the TANF program received a Moderately Effective rating. The assessment notes that TANF has produced modest, but statistically significant increases in employment and earnings among welfare recipients as well as reduced caseloads, poverty, and welfare dependency. The assessment also emphasized the importance of welfare reform reauthorization and strengthening work requirements.

TANF Program Developments

The DRA addresses several critical Presidential initiatives affecting TANF, including: (1) reauthorizing the TANF program through FY 2010; (2) strengthening work participation requirements; (3) creating and providing $150 million for a program focused on the promotion of healthy marriage and responsible fatherhood; (4) reinstating authority for the Supplemental Grants for Population Increases; and (5) eliminating funding for both the Bonus to Reward High Performance States and the Bonus to Reward Decreases in Illegitimacy.

The DRA strengthens work participation requirements by updating the base year for the caseload reduction credit from 1995 to 2005. With the decreases in TANF caseloads since the enactment of PRWORA, most States have had a zero, or nearly zero, target rate for participating in work activities. Updating the base year for the caseload reduction credit will reestablish a meaningful work participation rate requirement.

The DRA also includes $150 million for a program focused on the promotion of healthy marriage and responsible fatherhood – areas the Administration considers vital to the TANF purposes of strengthening families and improving the well-being of children.

TANF Legislative Proposals

The Budget includes three proposals for TANF that will increase budget authority by $332 million in FY 2007

and by $1,789 million over five years from FY 2007 through FY 2011. The first proposal, Family Formation and Healthy Marriage State Grants, provides $100 million per year for competitive State grants that will be targeted to innovative approaches to promoting healthy marriage and reducing out-of-wedlock births. The grants will require a dollar-for-dollar match and States can use Federal TANF funds to meet the match requirement. These grants expand upon the efforts to support Healthy Marriage and Responsible Fatherhood in the DRA ($150 million per year). In addition, the budget proposes legislation to add $232 million in FY 2007 to fully fund the TANF Contingency Fund at the original $2 billion level and modify the fund to make it easier for States to access by changing the definition of maintenance of effort and simplifying the annual reconciliation process. The third proposal continues the authorization for Supplemental Grants for Population Increases through 2010, consistent with the authorization of TANF under DRA.

Child Care Entitlement to States

The FY 2007 budget includes $2.9 billion for the Child Care Entitlement to States, a component of the Child Care and Development Fund. Beginning in FY 2006, the DRA provides an increase of $200 million from the FY 2005 appropriation. These funds will provide valuable support for working families who are moving from welfare to work.

The Child Care Entitlement is composed of mandatory and matching funds. Two percent of the mandatory entitlement funds are reserved for eligible Indian Tribes and Tribal organizations. States are mandated to spend at least 70 percent of the Child Care Entitlement on families receiving TANF, transitioning from TANF, or at risk of becoming eligible for TANF. States must also spend a minimum of four percent of all child care funds to improve the quality and availability of healthy and safe child care for all families.

Child Care Performance

CCDF helps families to achieve and maintain self-sufficiency by improving access to affordable, high quality child care. The Child Care Bureau collaborates with the Head Start Bureau, Department of Education, and the Health Resources and Services Administration to achieve these goals.

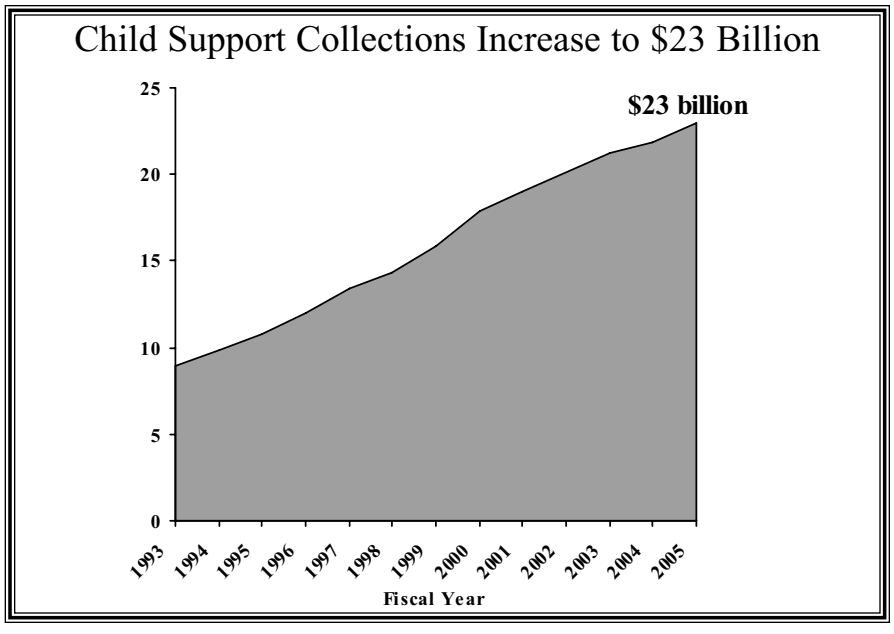
In the 2004 PART assessment, CCDF received a Moderately Effective rating. The assessment notes that the program is critical to families transitioning from welfare to work, and that the program is improving how it tracks the availability, accessibility, and affordability of child care for low-income families.

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. Child support services, as mandated in Title IV-D of the Social Security Act, are available for all families with a non-custodial parent, regardless of welfare status. In FY 2007, the Federal government will spend an estimated $4.1 billion on Child Support Enforcement efforts.

Child support collections play an important role for families transitioning from welfare to self-sufficiency, particularly in light of time limits on receipt of cash assistance. By securing support from non-custodial parents on a consistent and continuing basis, families may avoid the need for public assistance, thus reducing government spending. Families in which a custodial parent has never received cash assistance receive all child support collected on their behalf. Child support collections on behalf of families receiving TANF and some collections on behalf of former TANF recipients are shared between the State and Federal Governments as reimbursement for providing TANF benefits. States have the option to pass through a portion of monthly child support collections to current TANF families. Additionally, States may opt to pass through all child support collections to former TANF families.

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



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

Child Support Performance

The CSE program continues to make strong gains in child support order and paternity establishment, as well as collections of current and back support. Highlights include:

- Child support collections hit a record $23 billion in FY 2005, serving an estimated 16 million child support cases.
- CSE established paternity for almost 1.6 million children in FY 2004.
- In 2004, CSE had a 99 percent paternity establishment rate for all non-marital births in the previous year, exceeding their target of 98 percent.
- CSE surpassed its target for establishing child support orders in 2004, generating support orders for 74 percent of all child support cases.
- For every dollar invested in the program in FY 2004, CSE collected $4.38 in child support, exceeding their target of $4.35. CSE aims to increase its cost-effectiveness ratio to $4.56 by FY 2007.

In its 2003 PART assessment, CSE received a rating of Effective and continues to be one of the highest rated block/formula grants of all reviewed programs Governmentwide. This high rating is due to its strong mission, effective management, and demonstration of measurable progress toward meeting annual and long term performance measures.

Child Support Program Developments

The DRA includes a series of provisions to strengthen and improve the CSE program. These provisions incorporate several critical Presidential initiatives, including: State options to direct more child support collections to children and families; new efforts to increase collections such as expanding passport denial, mandatory review and adjustment of support orders, improving processes for identifying proceeds from insurance settlements, and requiring States to consider both parents' access to health insurance coverage when establishing child support orders; and an annual user fee of $25 for child support cases with collections to families who have never received TANF assistance. Additionally, the Federal match rate for genetic testing is reduced from 90 percent to 66 percent and States will be prohibited from using incentive payments as a State share of costs for purposes of claiming Federal matching funds.

Overall, DRA provisions improve collection of medical child support, strengthen existing collection and enforcement tools, reduce Federal expenditures, and allow States the option to provide additional support to families who need it most. Combined, these provisions generate a net Federal savings of $62 million in FY 2007 and $2.1 billion over five years.

Child Support Legislative Proposals

The budget continues to support several child support proposals that have been included in recent budgets. These provisions will enhance automation tools, strengthen existing enforcement tools, further improve the collection of medical child support, and assist families in gaining self-sufficiency. In FY 2007, these proposals will cost $7 million in child support costs and increase the Federal share of collections by $9 million. Over five years, these combined child support proposals will generate a net Federal savings of $17 million while increasing collections to families by almost $1.6 billion.

CHILDREN'S RESEARCH AND TECHNICAL ASSISTANCE

The FY 2007 President's Budget includes $58 million to support child support enforcement training and technical assistance efforts; operation of the Federal Parent Locator Service (FPLS), which assists States in locating absent parents; and welfare research. Of this amount, $37 million

Child Support Enforcement Legislative Proposals

- Require health care plan administrator to notify the IV-D agency when a child loses health coverage. The proposal will help alert IV-D workers of potential lapses in children's coverage so they can work to secure alternative coverage, if necessary.
- Federal seizure of accounts in Multi-State financial institutions, which will better enable families in interstate situations to benefit from this data match.
- Require intercept of gambling proceeds, a significant source of untapped income for recovery of overdue child support.
- Provide for garnishment of Longshore and Harbor Worker's Compensation Act benefits
- Increase funding for access to and visitation grants to support non-custodial parents' access to and visitation of their children.
- Authorize direct Tribal access to Federal Parent Locator Service.
- Authorize contractors and IV-D Tribes to access tax offset data.
- Give States the ability to collect past-due child support by withholding a limited amount of OASDI payments from beneficiaries, if appropriate.

will be devoted to: 1) Child Support Enforcement training and technical assistance ($12 million) and 2) FPLS operations ($25 million). The DRA specifies that funds for these activities be equal to the greater of one percent and two percent respectively of the total amount paid to the Federal Government for its share of child support collections for the preceding year or the amount appropriated for these activities in FY 2002. The remaining $21 million will fund welfare research ($15 million) and continue the National Survey of Child and Adolescent Well-Being ($6 million), a longitudinal study of the well-being of children who come into contact with the child welfare system.

Foster Care, Adoption Assistance, and Independent Living Programs

The FY 2007 budget request for the Foster Care, Adoption Assistance, and Independent Living programs is $6.9 billion. These programs, authorized by Title IV-E of the Social Security Act, provide essential services to vulnerable children by supporting safe living environments and preparing for independence older foster youth who are likely to age out of the system.

Of the total request, $4.8 billion will support the Foster Care program. This is a $101 million increase from last year's appropriation and includes the effects of the legislative proposals and program developments described in the following sections. The funds will be used for maintenance payments and administrative costs for approximately 231,000 children per average month in 2007, a 0.5 percent decrease from 2006. In addition, States may use the funds for training and for the operation and development of the Statewide Automated Child Welfare Information Systems (SACWIS), a computer-based data and information collection system.

The budget includes $2.0 billion for the Adoption Assistance program, which supports families that adopt special-needs children. This is an increase of $164 million over the FY 2006 appropriation. These funds will be used to provide maintenance payments to adoptive families, administrative payments for the costs associated with placing a child in an adoptive home, and training for professionals and adoptive parents. The proposed level of funding will support approximately 420,000 children each month.

The budget also contains $140 million for the Independent Living Program, the same as the FY 2006 appropriation. This program funds a variety of services to ease the transition from foster care for youth who will likely remain in foster care until they turn the age of 18 and for former foster children between the ages of 18 and 21.

Foster Care, Adoption Assistance, and Independent Living Performance

The Foster Care, Adoption Assistance, and Independent Living programs demonstrated success in improving safety, permanency, and well-being of children in FY 2004. Working with the States, these programs met the goal of minimizing disruptions to the continuity of family and other relationships for children in foster care by decreasing the number of placement settings per year for a child in care. The programs also met goals to provide children in foster care with permanency and stability in their living situations by improving the timeliness of reunification, if possible, and promoting guardianship or adoption when reunification is not possible.

The Adoption Assistance program received a rating of Moderately Effective in the 2005 PART assessment. The PART found that the program increases permanent placement of foster care children, leading to both improved child well-being and reduced Federal and State spending. In the 2004 PART assessment, ILP received a Results Not Demonstrated rating because the program needs to develop a data system to track program participation and outcomes. The Foster Care program received a rating of Adequate from the 2003 PART. This is an improvement over the Results Not Demonstrated rating received in 2002. The program received a higher rating due to new program performance measures, progress towards program goals, an initiative to develop an error rate, and improved program management. The proposed alternative financing system for Foster Care, discussed in the next section, would address PART findings to further improve the program.

Foster Care Program Developments

The DRA includes two provisions to clarify policies for Foster Care and related programs. The first provision clarifies federal matching of foster care administrative costs by specifying that claims for Federal matching funds for administrative costs for "candidates" for Federal foster care benefits involving children placed in the home of a relative who is not a licensed foster care provider are limited to no longer than 12 months. The second provision clarifies and reinforces the current law rule that a child is eligible for Federal foster care or adoption assistance based solely on the AFDC-eligibility of the original home from which he or she was removed (in response to the Ninth Circuit Court of Appeals decision in Rosales v. Thompson).

Foster Care Legislative Proposals

The FY 2007 President's Budget includes two legislative proposals for Foster Care and related programs. The alternative funding proposal, detailed in the Child Welfare Program Option box (see right), would allow States the option to receive their foster care funding as a flexible grant over five years to support a continuum of services to families in crisis and children at risk. This proposal will increase budget authority by $25 million in FY 2007 and it is budget neutral over five years.

Child Welfare Program Option Proposal

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

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

Under the Flexible Funding Plan States Will Be Required to:

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

The proposal provides access to the TANF Contingency Fund from which States may receive additional funding under certain circumstances if a severe foster care crisis were to arise. A $30 million set-aside will be available for Federally recognized Indian Tribes, and a one-third of one percent set-aside will be available for monitoring and technical assistance of State foster care programs.

The second proposal aligns the Foster Care and Adoption Assistance matching rate for the District of Columbia with the District's matching rate in Medicaid and SCHIP. This would increase the Federal matching rate for the District of Columbia from 50 percent to 70 percent. This proposal will cost the Federal Government $7 million in FY 2007 and $30 million over five years.

Promoting Safe and Stable Families

The Promoting Safe and Stable Families (PSSF) program is a capped entitlement program designed to assist States in coordinating services related to child abuse prevention and family preservation. These services include community-based family support, family preservation, time-limited reunification services, and adoption promotion and support services. States generally must spend at least 20 percent of their funds on each of the above four categories. The Adoption and Safe Family Act of 1997 established that a child's health and safety must be of paramount concern in any efforts made by a State to preserve or reunify a child's family. The FY 2007 request for PSSF includes $365 million in mandatory funds provided by formula to States.

Promoting Safe and Stable Families Program Developments

The DRA adds a new $20 million provision for Strengthening Courts through the Promoting Safe and Stable Families program. In addition, DRA increased budget authority by $40 million for FY 2006 from $305 million to $345 million. The budget proposes to maintain this new level of mandatory funding, $365 million, in the straightline reauthorization of this program.

Social Services Block Grant

The Social Services Block Grant (SSBG), a capped entitlement, provides funds to States for delivering social services and allows States substantial discretion in allocating funds in order to best suit their specific needs. Programs or services that are frequently supported by SSBG funds include child care, child welfare, home-based services, employment services, case management, adult protective services, prevention and intervention programs, and special services for people with disabilities. SSBG is funded at $1.2 billion for FY 2007, a reduction of $500 million from FY 2006. The 2005 PART identified several weaknesses of the block grant, noting that the flexibility of the SSBG makes it difficult to measure performance and that the breadth of services provided by SSBG funds can overlap with other categorical and flexible Federal social service programs.

ACF ENTITLEMENT PROPOSED LAW B.A.

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Total ACF Entitlement Current Law Program Level /1	$34,824	$32,129	$32,993	$864
2007 President's Budget Proposed Law:				
Programs with Changes to Current Law in 2007				
TANF				
Program Level	$17,209	$17,058	$17,158	+$100
Adjustment for Emergency Hurricane Funding /2	*5,139*	*-5,070*	-	-
Budget Authority	*22,348*	*11,988*	*17,158*	*5,170*
TANF Contingency Fund, B.A. /3	1,958	0	232	232
Child Support Enforcement & Family Support, Net B.A. /4	4,074	3,322	3,960	638
Foster Care/Adoption Assistance/Independent Living Program, B.A.	6,806	6,708	6,973	265
Social Services Block Grant				
Program Level /5	1,700	1,700	1,200	-500
Adjustment for Emergency Hurricane Funding /6	-	*550*	-	-
Budget Authority /5	*1,700*	*2,250*	*1,200*	*-1,050*
Programs that Maintain Current Law in 2007				
Child Care Entitlement				
Program Level	$2,717	$2,917	$2,917	$0
Adjustment for Emergency Hurricane Funding /2	*991*	*-991*	-	-
Budget Authority	*3,708*	*1,926*	*2,917*	*991*
Children's Research & Technical Assist, B.A.	55	58	58	0
Promoting Safe and Stable Families, B.A.	305	365	365	0
Total, ACF Entitlement Program Level /7	**$34,824**	**$32,128**	**$32,863**	**$735**

1/ Assumes enactment of the Deficit Reduction Act of 2005.

2/ Represents first quarter FY 2006 funds appropriated in FY 2005 for the TANF and Child Care programs as part of the TANF Emergency Response and Recovery Act of 2005 (TERRA), $5.07 billion for TANF, and $991 million for Child Care. The TANF adjustment also includes $68 million in FY 2005, for the forgivable Federal Loans to State Welfare Programs made available to Louisiana, Mississippi, and Alabama through TERRA.

3/ FY 2005 Contingency Fund B.A. is available for obligation through FY 2010. ACF estimates that at the end of FY 2007 $1.768 billion will remain unobligated in this account.

4/ The Child Support Enforcement FY 2006 B.A. and FY 2007 B.A. reflect the availability of prior year funds.

5/ The Budget proposes a one-year reduction in Social Services Block Grant funding through appropriations action, which scores as discretionary savings.

6/ Represents $550 million provided for SSBG as emergency hurricane funding in Defense Appropriations Act for FY 2006.

7/ Total ACF Entitlements Program Level does not reflect $50 million for pre-appropriated abstinence education program, see Discretionary Program Level.

ACF ENTITLEMENT LEGISLATIVE PROPOSALS

(outlays in millions)

	2007	2007-2011
2007 President's Budget Current Law Baseline/1	**$33,762**	**$141,926**
Legislative Changes:		
Temporary Assistance for Needy Families (TANF)		
Contingency Fund	$16	$152
Continue Supplemental Grants for Population Increases/2	0	834
Family Formation State Grants	10	385
TANF subtotal	**$26**	**$1,371**
Child Support Enforcement and Family Support Payments		
Send COBRA Notice to IV-D Agency	1	9
Federal Seizure of Accounts in Multi-State Financial Institutions	0	(19)
Require Intercept of Gaming Proceeds	0	(5)
Garnishment of Longshore and Harbor Worker's Compensation Act Benefits	0	(4)
Increase Access and Visitation Funding	2	32
Direct Tribal Access to the Federal Parent Locator Service.	0	0
Contractor and Tribal Acccess to Tax Data	0	0
OASDI Benefit Match	(5)	(33)
Raise the Cap for Repatriation to $5 million	0	3
CSE and Family Support subtotal	**($2)**	**($17)**
Foster Care and Adoption Assistance		
Child Welfare Program Option	22	(6)
Increase D.C. Match Rate	5	29
Child Welfare subtotal	**$27**	**$23**
Social Services Block Grant (SSBG)		
Reduce Authorization for SSBG by $500 million/3	(425)	(500)
SSBG subtotal	**($425)**	**($500)**
ACF Entitlement Proposed Law Subtotal	**($374)**	**$877**
2007 President's Budget Proposed Law Outlays	**$33,388**	**$142,803**

1/ Entitlement baseline includes outlays for TANF; Child Support Enforcement and Family Support; Foster Care, Adoption Assistance and Independent Living; Social Services Block Grant; Promoting Safe and Stable Families; and Child Care Entitlement to States. Current law baseline assumes enactment of the Deficit Reduction Act of 2005.

2/ The Deficit Reduction Act continues the Supplemental Grant through FY 2008. The 2007 President's Budget extends the authorization for the Supplemental Grants through 2010, consistent with the authorization of TANF.

3/ The budget proposes a one-year reduction in SSBG funds through appropriations action, which scores as discretionary savings.

(dollars in millions)

	2005	2006	2007	2007 +/-2006
Program Innovations	$43	$25	$36	+$11
Choices for Independence (Non Add)	*0*	*0*	*28*	*+28*
Home and Community-Based Supportive Services and Centers	354	351	351	0
Nutrition Services:				
Home-Delivered Meals	$183	$182	$181	-$1
Congregate Meals	387	385	384	-1
Nutrition Services Incentive Program	149	148	147	-1
Subtotal, Nutrition Programs	**$719**	**$715**	**$712**	**-$3**
National Family Caregiver Support	$162	$162	$160	-$2
Protection of Vulnerable Older Americans	19	20	19	-1
Aging Network Support Activities	13	13	13	0
Grants for Native Americans	26	26	26	0
Program Administration	18	18	18	0
Senior Medicare Patrols (HCFAC)	3	3	3	0
Preventive Health Services	22	21	0	-21
Alzheimer's Demonstration Grants	12	12	0	-12
White House Conference on Aging	5	0	0	0
Total, Program Level	**$1,397**	**$1,366**	**$1,338**	**-$28**
Less Funds Allocated From Other Sources:				
Senior Medicare Patrols (HCFAC)	-$3	-$3	-$3	$0
Total, Budget Authority	**$1,393**	**$1,363**	**$1,335**	**-$28**
FTE	118	127	129	+2

ADMINISTRATION ON AGING

The Administration on Aging promotes the dignity and independence of older Americans and helps society prepare for an aging population.

The FY 2007 budget request for the Administration on Aging (AoA) is $1.3 billion. This includes $28 million within Program Innovations to pilot Choices for Independence, which seeks to help older individuals and their families conserve and extend their personal resources and remain at home through the use of low-cost community-based alternatives. The budget request also provides funding for core formula grant programs, which deliver nutrition, supportive services and caregiver support through the national aging services network. Finally, the budget includes small reductions in core services totaling -$6.5 million.

In FY 2006, the first wave of the baby boomers will turn 60. They will add to the over 49 million Americans who already are age 60 or older, including the over 5 million who are older than age 85. While advances in medicine and technology are enabling seniors to live longer and more active lives, those of more advanced age are at increased risk of chronic disease and disability.

The FY 2007 budget request seeks to address these challenges by accelerating some of the key systems changes that are needed to fully prepare for the aging of the baby boomers and their long-term living needs.

Choices for Independence will advance the President's New Freedom Initiative; it also strengthens the roles of the Older Americans Act (OAA) and individual States in promoting consumer choice, control and independence.

Program Innovations

Program Innovations funds have in past years provided the framework to test new models of home and community-based care. The lessons learned from these projects led AoA to invest $28 million in Choices for Independence, which is intended to help older individuals delay or avoid the need for expensive nursing facility care.

Choices has three components, each of which builds off existing HHS programs and best practices in the field. The first component, Consumer Empowerment, will help individuals make informed decisions about their care options, plan ahead for their long-term care needs and streamline their access to publicly supported long-term care programs. The Healthy Lifestyle component will assist seniors to make behavioral changes that have proven effective in reducing the risk of disease and disability. Finally, Community Living Incentives will give States more flexibility in helping moderate-to-low income individuals avoid or delay institutionalized care.

In addition to funding for Choices for Independence, the budget request for Program Innovations maintains funding for activities of ongoing national significance, including national resource centers and intergenerational opportunities. Finally, funds will support program evaluation for Choices and other activities.

Home and Community-Based Supportive Services

The FY 2007 request for Home and Community-Based Supportive Services is $351 million. This grant program to States and Territories serves as the foundation for the national aging services network by helping to bring together and coordinate a variety of activities for seniors, and includes funding for multipurpose senior centers that coordinate and integrate services for the elderly.

The array of services provided to seniors and their caregivers includes access services such as transportation, case management and information and referral; in-home services such as personal care, chore, and homemaker assistance; and community services such as adult day care, respite care and disease prevention, health promotion and physical fitness programs. Together, these services help keep seniors independent and enable them to stay in their homes and communities as long as possible, delaying the need for costly institutional care.

Addressing Long-Term Care

The approaches adopted as part of Choices for Independence will provide seniors with expanded supports at home, helping to delay or avoid the need to spend-down their assets to afford expensive nursing home care. Studies consistently indicate that seniors express an overwhelming preference to remain at home and out of long-term nursing facilities if at all possible. Choices has three components: Consumer Empowerment, Healthy Lifestyles and Community Living Incentives.

Nutrition Programs

The FY 2007 request for Nutrition programs–including Congregate and Home-delivered Meals and the Nutrition Services Incentive Program–totals $712 million, over half of AoA's funding. Nutrition services help over 2 million older adults have access to the nutritious food they need to stay healthy and decrease their risk of disability. Congregate meal settings also provide opportunities for social engagement and meaningful volunteer roles, which contribute to overall health and well-being. Finally, while meals are the core service, these programs also provide related services such as nutrition screening, assessment, education, and counseling to vulnerable elders at home and in group settings.

Family Caregiver Support Services

The FY 2007 budget includes $160 million for the National Family Caregiver Support Program. Services, which are closely integrated with other AoA core services programs, include information, training, counseling, respite and in-home assistance with activities of daily living. Now in its sixth year of operation, the program has demonstrated results: data indicate that it has positively affected caregivers' ability to provide support and care to their loved ones.

Native American Nutrition and Supportive Services

The budget requests $26 million for nutrition and supportive services grants for Native American seniors. These grants will enable 238 Tribal organizations serving approximately 300 tribes to continue to provide American Indians, Alaska Natives, and Native Hawaiian elders with nutritional and supportive services that help them remain healthy and independent. In addition, $6 million is included within Family Caregivers for services for Native American caregivers and the seniors they assist. These services are closely integrated with AoA nutrition and supportive services and include information, training, counseling, respite and in-home assistance.

Protection and Aging Network Support

The FY 2007 request includes $19 million to help protect the rights and dignity of vulnerable elders both at home and in institutional settings, and $13 million for ongoing projects that help seniors and families to obtain information about their care options and benefits, and which assist States, Tribes and community providers of aging services to carry out their mission. Protection activities help increase the quality of care for residents of long-term care facilities and increase public and professional awareness of elder abuse. Aging Network Support funds activities such as Eldercare Locator and Pension Counseling services, as well as Senior Medicare Patrols, a program that educates seniors about potential Medicare fraud.

Program Eliminations

No funding is requested for Preventive Health Services or for Alzheimer's Disease Demonstration Grants for FY 2007. Prevention is already a focus and an underlying principle of each of the AoA services provided by States and communities; States can continue to use their community-based supportive services dollars as they do now for a large portion of their preventive health activities. Further, most States have received funding for one or more demonstrations that tested and implemented successful, cost-effective approaches for serving persons with Alzheimer's Disease. The lessons learned and the models developed through these demonstrations are ready to be integrated into ongoing service programs; a number of States have already done so.

Program Administration

A total of $18 million is requested to maintain staffing levels, cover staffing costs related to implementation of the Choices for Independence initiative, and for related program management and support activities necessary to effectively administer a wide array of AoA programs. This request also supports efforts to strengthen management through greater efficiencies and economies of scale in information technology, financial systems, and personnel operations.

Performance Highlight

Two of AoA's long-term performance goals address caregivers: Increase to 75 percent the percentage of caregivers who report that OAA services definitely help them provide care longer; and increase the total number of caregivers served to one million. In FY 2004, 52 percent of caregivers reported that services helped them care longer for an older individual, a 4 percent increase over FY 2003. Also in FY 2004, AoA exceeded its target of serving 500,000 caregivers by five percent.

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GENERAL DEPARTMENTAL MANAGEMENT

(dollars in millions)

	2005	2006	2007	+/- 2006
General Departmental Management:				
Adolescent Family Life.....	$31	$30	$30	$0
Office of Minority Health.....	50	56	46	-10
Office on Women's Health.....	29	28	28	0
Minority HIV/AIDS	52	52	52	0
Afghanistan.....	6	6	6	0
Embryo Adoption Awareness Campaign...	1	2	2	0
Commissioned Corps.....	4	4	14	+10
Other General Departmental Management	204	180	190	+10
Evaluation Activities.....	39	40	40	0
Health Care Fraud and Abuse Control	5	5	5	0
Total, GDM Program Level.....	**$421**	**$403**	**$413**	**+$10**
Less funds from other sources:				
Evaluation Activities.....	$39	$40	$40	$0
Health Care Fraud and Abuse Control	5	5	5	0
Total, GDM Budget Authority.....	**$377**	**$358**	**$368**	**+$10**
FTE 1/.....	1,508	1,572	1,607	+35

1/ Includes OS SSF FTE.

GENERAL DEPARTMENTAL MANAGEMENT

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

The FY 2007 budget request for GDM provides a total program level of $413 million, including appropriations of $368 million, interagency transfers of $40 million in evaluation funds, and $5 million in health care fraud and abuse funds.

The GDM account supports those activities associated with the Secretary's roles in administering and overseeing the organization, programs, and activities of the Department. These activities are carried out through 15 Staff Divisions (STAFFDIVs). The GDM budget request for FY 2007 totals $413 million an increase of $10 million or 3 percent above the comparable FY 2006 level. The GDM request provides funding for the following activities:

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

Office of Minority Health (OMH): The OMH request of $46 million, a net $10 million decrease from FY 2006, provides funding to continue disease prevention, health promotion, service demonstration, and educational efforts to reduce and ultimately eliminate disparities for racial and ethnic minority populations. The reduction is attributed to a FY 2006 Congressional earmark which is not continued in FY 2007.

Office on Women's Health (OWH): The OWH request of $28 million, the same as the FY 2006 level, will provide funding to continue the advancement of women's health programs through the promotion and coordination of research, service delivery, and education – both throughout HHS agencies and offices, with other government organizations, and with consumer and health professional groups.

Minority HIV/AIDS: The FY 2007 request includes $52 million, the same level as FY 2006, to support innovative approaches to HIV/AIDS prevention and treatment in minority communities heavily impacted by this disease. These funds allow the Department to continue priority investments and public health strategies targeted to reduce the disparities and burden of HIV/AIDS in racial and ethnic minority populations.

Afghanistan: Included in the FY 2007 request for the Office of Global Health Affairs (OGHA) is $6 million to continue support of HHS health care initiatives in Afghanistan, particularly in the areas of maternal and child health.

Embryo Adoption Awareness Campaign: The FY 2007 budget request includes $2 million to continue the Embryo Adoption public awareness campaign grant award program.

Commissioned Corps: The FY 2007 budget request includes $14 million for the Transformation of the Public Health Services (PHS) Commissioned Corps, an increase of $10 million above FY 2006. This is the Department's multi-year process to revitalize and improve the Corps' ability to respond to public health emergencies and deliver timely and effective public health services in underserved and hazardous situations. This effort will involve modernizing the force strength and management of the Corps, streamlining the assignment and deployment process, and increasing our ability to recruit talented candidates to become Corps officers.

The FY 2007 funding will be used to develop new systems to support total force management; train and equip officers to respond to emerging public health threats and situations; and to improve response operations and develop a team-oriented deployment process.

Other General Departmental Management (GDM): The FY 2007 budget request includes $190 million to fund offices which provide leadership, policy, legal, and administrative guidance to HHS components.

One of the offices included in Other GDM is the Office on Disability (OD). OD has been charged to: lead the HHS New Freedom Initiative; and oversee, coordinate, develop, and implement disability programs and initiatives within HHS that affect persons with disabilities.

OFFICE OF MEDICARE HEARINGS & APPEALS

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Program Level.....	$58	$59	$74	+$15
FTE.....	63	325	360	+35

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

The FY 2007 budget request for the Office of Medicare Hearings and Appeals (OMHA) is $74 million, an increase of $15 million over the FY 2006 level. Funds are being requested from the Federal Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) Trust Funds to hear cases under Title XVIII of the Social Security Act, and related provisions in Title XI of the Act.

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

In July 2004, the OMHA Transition office was created to manage the transfer of the ALJ appeals function from SSA, establish OMHA, and enable OMHA to begin hearing ALJ cases during the last quarter of FY 2005. The newly-hired Acting Chief ALJ assumed full responsibility for OMHA operations in March 2005. OMHA officially opened its doors on July 1, 2005, and is now functionally staffed and operational.

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

With the requested funding level of $74 million, OMHA will be able to process the full ALJ appeal workload for Medicare Parts A, B, C and D cases received within the BIPA mandated timeframe by utilizing state-of-the-art technology, hiring appropriate levels of staffing and increasing access to hearing sites and services by appellants.

EMERGENCY PREPAREDNESS

(dollars in millions)

	2005	2006	2007	2007 +/-2006
Pandemic Influenza				
Agency Budgets	$0	$238	$273	+$35
PHSSEF	99	3,082	79	-3,003
Subtotal, Pandemic Influenza	$99	$3,320	$352	-$2,968
Allowance	0	0	2,300	2,300
Total, Pandemic Influenza - Program Level	**$99**	**$3,320**	**$2,652**	**-$668**
Terrorism Preparedness				
Agency Budgets	$4,098	$4,133	$4,289	+$156
PHSSEF	61	60	82	+22
Subtotal, Terrorism Preparedness	$4,159	$4,193	$4,371	+$178
Other PHSSEF	$60	$0	$0	$0
Total, PHSSEF	**$220**	**$3,142**	**$160**	**-$2,982**
FTE (OS PHSSEF)	102	181	203	+22

* FY 2006 funding shown comparably. Congress appropriated $3.3 billion to the Public Health and Social Services Emergency Fund ($200 million in CDC) and $20 million to FDA.

To protect our Nation from the threat of pandemic influenza, the FY 2007 request includes $352 million in HHS-wide funding to build on current efforts to implement the *HHS Pandemic Influenza Plan.* The budget also includes a $2.3 billion allowance for the next phase of critical preparedness activities needed to reach our goals of:

- Being able to provide pandemic influenza vaccine to every man, woman, and child within six months of detection;
- Providing access to enough antivi ral treatment courses sufficient for twenty-five percent of the U.S. population; and
- Enhancing domestic and interna tional public health infrastructure and preparedness.

The $2.3 billion is shown in the budget as an allowance, which means a formal request for these funds will be transmitted to Congress in the coming months. Also included in the FY 2007 budget request is approximately $4.4 billion designated to protect Americans from a possible terrorist attack. Funding for these activities is appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) and to agencies. The PHSSEF request includes $82 million in FY 2007 and finances HHS preparedness and response activities to protect the Nation against bioterrorist attacks and other public health emergencies.

PANDEMIC INFLUENZA

When major changes occur to the influenza strain genetic structure, widespread disease and death can result. Animals are the most likely reservoir for these emerging viruses, and avian viruses have played a role in the three such global events - called pandemics - that occurred in the 20th century. The current pandemic influenza threat, the H5N1 virus strain, stems from an outbreak of avian influenza in Asia and Europe. The ability of the H5N1 virus to infect a wide range of hosts, including birds and humans, is of great concern to the public health community. Although the virus has not yet shown an ability to transmit efficiently between humans, through genetic mutation or exchange of genetic material with a human influenza virus, it might acquire this capability. While it is impossible to know whether the currently circulating H5N1 virus will cause a human pandemic, such a pandemic could cause an additional 90,000 to

300,000 + deaths in the U.S., especially if adequate vaccines were not available quickly. Once a pandemic began, there would be a small window of opportunity to accomplish the necessary research, development, and delivery of vaccines required to mitigate its impact.

According to Secretary Leavitt: "...Preparation saves lives. We have an opportunity to become the first generation in history to prepare for a pandemic." To engage in pandemic influenza preparation activities, in FY 2006, the Administration announced an emergency budget request of $7.1 billion, of which $6.7 billion was for HHS pandemic influenza activities. The HHS request was broken down into funding needs over the course of three years, $3.2 billion in FY 2006, $2.3 billion in FY 2007, and $1.1 billion in FY 2008. Congress appropriated $3.3 billion in emergency funding in FY 2006 for HHS.

Following the release of this emergency budget request, HHS released the *HHS Pandemic Influenza Plan*, a detailed guide for how the Nation's healthcare system can prepare and respond to an influenza pandemic. The HHS plan delineates four components of preparedness and response necessary to effectively respond to a pandemic, which include:

- Increasing capacity to produce pandemic influenza antivirals and vaccines, and increasing stockpiles of these countermeasures;
- Intensifying surveillance and containment measures;
- Creating a seamless network of Federal, State, and local preparedness; and
- Developing public education and communication materials to keep the public informed.

Of the $3.3 billion FY 2006 emergency funding total, approximately $2.3 billion is funding activities designed to increase vaccine production capacity and stockpiles of vaccines and antivirals. Specifically, $1.6 billion supports private sector contracts to:

- Establish high-volume domestic surge capacity to protect the entire U.S. population within six months of detection by 2010; and
- Increase industrial capacity to manufacture 20 million courses of pre-pandemic egg-based vaccine for the Strategic National Stockpile by 2009.

Additionally, HHS is allocating $350 million to fund advanced development work on promising antiviral drugs and antigen-sparing strategies that would decrease the amount of vaccine needed to protect an individual. Approximately $361 million will finance the procurement of enough antiviral courses to treat 20 million people and six million additional courses designated to contain one to two isolated domestic outbreaks.

To help create a seamless network of Federal, State, and local preparedness, $520 million is funding a variety of State and local preparedness activities and subsidizing State purchases of antivirals. An additional $162 million in emergency funding will go to increase supplies needed in a pandemic, such as ventilators and personal protective equipment in the Strategic National Stockpile. The Centers for Disease Control and Prevention (CDC) will invest $200 million to intensify surveillance, containment, and outbreak response measures and establish additional laboratory capacity. Additionally, $96 million is funding international, communications, and research activities within the Office of the Secretary (OS) and the National Institutes of Health (NIH), and $20 million is supporting the Food and Drug Administration's (FDA) work with influenza vaccine manufacturers.

The FY 2007 budget includes a $2.3 billion allowance related to the next phase of critical preparedness activities outlined in the *National Strategy for Pandemic Influenza*, consistent with the President's FY 2006 emergency request of $7.1 billion, and $352 million in annual funding. The $2.3 billion will support planned efforts to expand:

- Domestic vaccine production and surge capacities;
- Stockpiles of antivirals;
- Research and development on promising new antivirals and vaccines; and
- Quantities of ventilators, portable hospital units, and other medical supplies in the Strategic National Stockpile needed in the event of a pandemic.

An additional $352 million is requested in the budgets of the CDC, FDA, NIH, and OS and will finance ongoing activities including:

- Expanding surveillance and detection capabilities;
- Improving pandemic preparedness and response capabilities;
- Establishing a vaccine registry to assess vaccine distribution, safety, and efficacy; and
- Improving our Nation's ability to contain a potential pandemic influenza outbreak.

Of this total, $145 million will support international efforts designed to strengthen the public health and vaccine manufacturing infrastructure, expand surveillance systems, and improve preparedness and response capabilities in countries in Southeast Asia with the highest numbers of confirmed H5N1 cases.

PANDEMIC INFLUENZA

(dollars in millions)

Activities Funded with FY 2006 Emergency Funding:	**2006**	**2007**
Vaccines and Antivirals:		
Achieve Production Capacity and/or Buy Vaccine	$1,611	
Purchase Antivirals	361	
Advanced Dev. of Antigen Sparing Techniques and Antiviral Drugs	350	
Subtotal, Vaccines and Antivirals	$2,322	
Enhance Strategic National Stockpile (PPE, ventilators, etc.)	162	
State and Local Preparedness	350	
Antiviral Subsidy to States (31 million treatment courses)	170	
Subtotal, Activities Funded with FY 2006 Emergency Funding	**$3,004**	
Activities Funded in the Agency Budgets:		
CDC		
One-Time	$77	0
Ongoing	123	$188
Subtotal, CDC	$200	$188
FDA	20	50
NIH	18	35
Office of the Secretary	78	79
Subtotal, Activities Funded in the Agency Budgets	**$316**	**$352**
FY 2007 Allowance	0	2,300
Total HHS, Pandemic Influenza Plan Funding	**$3,320**	**$2,652**

Terrorism Preparedness

The HHS FY 2007 request includes $4.4 billion for terrorism preparedness activities, a net increase of $178 million above FY 2006.

PHSSEF Activities: Of the terrorism preparedness total request, $81.6 million is funded through the PHSSEF. These funds will support activities within the Office of the Secretary (OS), including the Mass Casualty Initiative, the Medical Reserve Corps, cybersecurity efforts for the Department, and ongoing operations, emergency response, international surveillance activities, and targeted advanced research projects in the Office of Public Health Emergency Preparedness. The $20 million increase over FY 2006 will support the OS portion of the Mass Casualty Initiative, and the remainder of funds will support:

- *Office for Public Health and Emergency Preparedness OPHEP):* The President's Budget includes $43 million for OPHEP's ongoing operations, including the Secretary's Emergency Response Team and International Early Warning Surveillance efforts. This appropriation also allows OPHEP to target advanced research projects and support the development of an effective communication and information strategy for the public. OPHEP also manages HHS' role in Project BioShield medical countermeasure acquisition needs analysis.
- *Cybersecurity:* Funding is maintained at $9 million in FY 2007 for cybersecurity. These funds continue to protect the Department's information technology infrastructure from cyber-terrorist attacks. These funds will provide continuous security monitoring for all HHS systems, assets, and services.

In addition to funding in the PHSSEF, another $4.3 billion in bioterrorism funding is requested directly in the appropriations for CDC, HRSA, FDA, NIH, and General Departmental Management.

Highlighted Terrorism Preparedness Activities

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

Detection and Containment: The FY 2007 President's Budget request supports the goal to rapidly contain and detect an outbreak by providing continued funding for CDC's Biosurveillance Initiative. This funding will allow CDC to improve the capabilities of the existing quarantine stations, expand the number of stations, and expand critical ongoing work in BioSense, an advanced approach to infectious disease surveillance capable of highlighting a potential outbreak early. The request also includes increased funding of $3 million in CDC to develop techniques that will improve CDC and State and local health departments' ability to rapidly detect exposure to or contamination by botulinum toxin and other toxins used as bioweapons. The development of these techniques will improve early detection, leading to prompt treatment and prevention of additional exposure.

FDA also plays a critical role in early detection through its food defense program. To protect our Nation's food supply, $178 million, an increase of $20 million over FY 2006, will continue support for food defense activities, such as developing analytic surge testing capacity for biological, chemical, and radiological threat agents for the Food Emergency Response Network (FERN). FDA will also work to coordinate food surveillance activities within the Biosurveillance Initiative.

Emergency Preparedness and Response: To minimize injury and loss of life resulting from a terrorist attack, our Nation must also have the ability to effectively prepare for and respond to such an event.

CDC and HRSA continue to demonstrate a strong commitment to prepare States and local public health departments and hospitals for public health emergencies and acts of bioterrorism. Approximately $7 billion will have been invested between FY 2002 and FY 2006 by CDC and HRSA in these efforts. A further $1.3 billion is requested for such efforts in FY 2007.

The FY 2007 President's Budget also includes $79 million within HHS for the Mass Casualty Initiative. Since FY 2002, HRSA has funded an expansion of State and local hospital surge capacity to be able to respond to a mass casualty event involving the use of weapons of mass destruction. The FY 2007 Mass Casualty Initiative builds on these activities, and the requested funds will support the four-pronged initiative:

- *Federal Medical Shelters:* Includes almost $50 million (+$39 million over FY 2006) for the purchase, maintenance, and operation of portable hospital units, to be maintained by the Strategic National Stockpile, that can be deployed to increase hospital surge capacity in the event of a bioterrorist attack.
- *Medical Reserve Corps:* Includes an increase of $12 million to expand the Medical Reserve Corps (MRC), the Citizen Corps

component that organizes local volunteers to assist regular medical response professionals and facilities during a large-scale local emergency.

- *Health Care Provider Credentialing Portal:* Includes $7 million in new funding to finance the development and updating of systems designed to create a mechanism to conduct primary source verification of health care professionals' credentials from relevant Federal, State and non-governmental sources both before, during, and after a mass casualty event.

- *Revitalization of the Commissioned Corps:* Includes an increase of $10 million in the General Departmental Management budget to transform the Commissioned Corps into a force that is ready to respond rapidly to public health challenges and health care crises that can result from natural disasters, terrorist attacks, technological catastrophes, and other extraordinary needs.

Protection and Treatment: A vital part of our bioterrorism readiness efforts includes the ability to quickly protect Americans that have been exposed to a biological, chemical, or radiological threat agent and to treat those who have become sick following an exposure. Research activities in this arena are critical, because our Nation's ability to counter bioterrorism ultimately depends on the state of biomedical science. The FY 2007 President's Budget includes $1.9 billion for biodefense efforts within the NIH. These funds will support basic and applied research on agents with bioterrorism potential and advanced development efforts, which will lead to the availability of new or improved vaccines and therapies created to protect or treat persons exposed to threat agents. Of this total, NIH will invest $160 million for the advanced development of biodefense countermeasures that are priority Project BioShield acquisition targets. This represents an increase of $110 million over the FY 2006 level. As in FY 2006, $96 million will be designated for targeted research efforts to develop medical countermeasures against radiological, nuclear, and chemical threats.

For many threat agents, effective countermeasures, such as vaccines and pharmaceuticals, already exist and are available for purchase. In the event of a large scale terrorist attack, rapid access to large quantities of these vaccines and medications is critical for saving the lives of those exposed. The FY 2007 President's Budget includes $593 million, an increase of $68 million over FY 2006, for CDC's Strategic National Stockpile (SNS), a federally-owned repository of these types of countermeasures. Additionally, the SNS contains medical supplies and hospital beds that would be needed in a mass casualty event. As a critical part of our Nation's defense against a bioterrorist attack, SNS funding will continue to support the ability to distribute these assets anywhere in the country within 12 hours of an event.

Increasing State and Local Preparedness for Bioterrorism Events

CDC's Terrorism Preparedness and Emergency Response program enhances the ability of the Nation's healthcare system to effectively respond to bioterrorism and other public health challenges. CDC addresses the ongoing problem of threats from intentional release of smallpox, anthrax or plaque, chemical attacks and other threats such as an influenza pandemic. CDC's Strategic National Stockpile (SNS) supplies access to medical countermeasures for these threats quickly when needed. However, to be effective, State and local public health agencies must be prepared to use material contained in the SNS. In 2005, CDC exceeded its goal of 70 percent for State and local preparedness, with 76 percent (41 out of the 54 States and directly-funded cities) meeting the minimum standards for demonstrating preparedness to use SNS assets. The FY 2007 target is to achieve a level of 90 percent of grantees meeting the minimum standards.

TERRORISM PREPAREDNESS

(dollars in millions)

	2005	2006	2007	2007 +/-2006
Direct Appropriations to Agency Budgets:				
Centers for Disease Control and Prevention:				
Upgrading State and Local Capacity	$919	$824	$824	$0
Biosurveillance Initiative	79	133	102	-31
Upgrading CDC Capacity/Anthrax Research	158	150	136	-15
Botulinum Toxin Research	0	0	3	+3
Strategic National Stockpile	467	525	593	+68
Subtotal, CDC	**$1,623**	**$1,632**	**$1,657**	**+$25**
Health Resources and Services Administration:				
Hospital Preparedness and Infrastructure	$487	$474	$474	$0
Model Emergency Room (non-add)	*0*	*0*	*25*	*+25*
Education Incentives for Medical Curriculum	28	21	12	-8
Subtotal, HRSA	**$515**	**$495**	**$487**	**-$8**
National Institutes of Health:				
Research	$1,548	$1,655	$1,770	+$115
Advanced Development Fund (non-add)	*0*	*50*	*160*	*+110*
Nuclear/Radiological Countermeasures (NIH)	47	47	47	0
Chemical Countermeasures (NIH)	0	50	50	0
Extramural Laboratory Construction	149	30	25	-5
Subtotal, NIH	**$1,743**	**$1,781**	**$1,891**	**+$110**
Food and Drug Administration:				
Food Safety	$150	$158	$178	+$20
Vaccines/Drugs/Diagnostics	57	57	57	0
Physical Security	7	7	7	0
Subtotal, FDA	**$214**	**$222**	**$242**	**+$20**
Office of the Secretary:				
Revitalization of Commissioned Corps	**$3**	**$3**	**$13**	**+$10**
Subtotal, Direct Appropriations	**$4,098**	**$4,133**	**$4,289**	**+$156**
PHSSEF:				
Office of the Secretary:				
Office of Public Health and Emergency Preparedness	$41	$41	$43	+$2
CyberSecurity	10	10	9	0
Medical Reserve Corps	10	10	22	+12
Healthcare Provider Credentialing	0	0	7	+7
Subtotal, PHSSEF	**$61**	**$60**	**$82**	**+$22**
Total, Terrorism Preparedness	**$4,159**	**$4,193**	**$4,371**	**+$178**

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Budget Authority	0	$42	$88	+$46
PHS Evaluation Funds	$20	19	28	+9
Program Level	**$20**	**$61**	**$116**	**+$55**
FTE	4	30	38	+8

The Office of the National Coordinator for Health Information Technology provides leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care and the ability of consumers to manage their care and safety.

The FY 2007 budget request includes a total of $116 million for the Office of the National Coordinator for Health Information Technology (ONC). ONC was created in April 2004 by Presidential Executive Order, to address strategic planning, coordination, and analysis related to key technical, economic and other issues surrounding the public and private adoption of health information technology (health IT). ONC is well underway with initiatives to create adoption breakthroughs and to develop industry infrastructure to realize the President's goal.

This request will support key initiatives and activities that will be accomplished through strategic partnerships and coordination in the public and private sectors, including:

- Advancing the goals of health IT and assuring that the privacy and security of health records are protected;
- Continuing the development of production-quality prototypes for Nationwide Health Information Networks (NHINs) which will enable secure exchange of electronic health records (EHR) and other health data;
- Developing personal health record architectures that will be integrated with the NHIN architecture, which will allow personal health information data to be controlled by the consumer and not just by clinicians and providers;
- Developing and harmonizing standards that are required for health information data portability, which will include a process to maintain and update these standards over time;
- Continuing the development of a certification process for health IT, which will include refinements to existing certification criteria for inpatient and ambulatory EHRs as well as new criteria related to the NHIN architecture; and
- Evaluating variations in State laws and organization-level business policies around privacy and security practices, including variations in implementations of HIPAA privacy and security requirements. Lessons will be incorporated into the NHIN prototypes.

In addition to funds requested within ONC, the FY 2007 request includes $50 million in the Agency for Healthcare Research Quality to advance the use of health IT to enhance patient safety. There is also $4 million in the Office of the Assistant Secretary for Planning and Evaluation for independent evaluations of EHR adoption and economic factors influencing health IT implementations in the health sector.

Health Information Technology as a Tool During National Disasters

During Hurricane Katrina, thousands of patients' medical records were destroyed and many patients and health professionals did not have access to medication and prescription drug records. The Office of the National Coordinator for Health Information Technology facilitated a collaborative response to Hurricane Katrina that involved more than 150 organizations. These organizations developed and launched KatrinaHealth.org, an online service for authorized health professionals to gain electronic access to the medication history and prescriptions for evacuees. The site enables authorized physicians and pharmacies to review critical medications, coordinate care, and avoid potential medication errors, when renewing or prescribing new medications for 1.1 million Gulf Coast evacuees.

OFFICE FOR CIVIL RIGHTS

(dollars in millions)

	2005	2006	2007	2007 +/- 2006
Program Level.....	$35	$35	$36	+$1
FTE/1.....	247	259	259	0

1/Excludes two reimbursable FTE in FY 2006 and FY 2007

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

The FY 2007 budget request for OCR is $36 million, an increase of $1 million over the FY 2006 level. The budget supports OCR's activities as the primary defender of the public's right to nondiscriminatory access to and receipt of Federally funded health and human services - from hospitals and nursing homes to Head Start and senior centers. In addition, it supports OCR's significantly expanded compliance responsibilities that protect the rights of individuals with respect to their health information as provided in the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

OCR assesses compliance with nondiscrimination and Privacy Rule requirements through complaint resolution; new Medicare applications' civil rights reviews and preventative compliance reviews; monitoring corrective action plans; and providing public education, voluntary compliance, training, and technical assistance activities.

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

Among OCR's key priorities during FY 2006 and FY 2007 are: increasing access by vulnerable populations to quality health care; promoting non-discrimination in adoption and foster care and Temporary Assistance for Needy Families (TANF); enhancing provision of appropriate services in the most integrated setting for individuals with disabilities; and ensuring understanding of and compliance with the HIPAA Privacy Rule.

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

New Freedom Initiative and *Olmstead*

OCR is involved in a variety of efforts to enhance the independence and quality of life of persons with disabilities, including those with long-term needs. OCR is the HHS agency with authority and responsibility to protect the rights of persons with disabilities under the Americans with Disabilities Act (ADA). It plays a leading role in carrying out the President's New Freedom Initiative (NFI) and Executive Order 13217. This commits the U.S. to a policy of community integration for individuals with disabilities, and calls upon the Federal Government to enforce the ADA through complaint investigation and alternative dispute resolution, and to work with States to implement the *Olmstead* decision.[1]

[1]The June 22, 1999 Supreme Court decision that affirmed the right of individuals with disabilities to live in their community rather than in enforced institutionalization.

OCR has played an active role using all of these mechanisms to implement the ADA. Through technical assistance, along with OCR's complaint investigation and resolution activities, OCR has resolved numerous *Olmstead* complaints, enabling persons of all ages with physical and mental disabilities to return to or remain in their communities with adequate supports. OCR's website summarizes the satisfactory resolution of more than 250 recent individual and systemic complaints filed with OCR to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.

During FY 2007, OCR will continue its NFI leadership role, improving access to community-based services for people with disabilities through technical assistance to States and *Olmstead* complaint resolution.

Title VI (Race, Color, and National Origin) Access Initiatives

OCR ensures compliance with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, requiring recipients of HHS Federal financial assistance to ensure that their policies and procedures do not exclude or limit, or have the effect of excluding or limiting, the participation of beneficiaries on the basis of race, color, or national origin. These efforts, which reach beneficiaries of all health and human services programs that HHS funds, seek to achieve voluntary compliance and corrective efforts when violations are found.

OCR works with Federal and State partners and with providers and consumer groups, including faith-based organizations, to ensure non-discriminatory access to health and human services and to eliminate health disparities. OCR also recently collaborated with the Department of Justice (DOJ) and the U.S. Department of Agriculture to produce a video and informational brochure in multiple languages to advise service providers and consumers with limited English proficiency (LEP) about their responsibilities and rights under Title VI.

In FY 2007, OCR will continue to focus on a broad range of Title VI access issues including non-discrimination in adoption, foster care, and TANF, as well as access to quality health services to eliminate health disparities.

HIPAA - Health Information Privacy

OCR is responsible for implementing and enforcing the HIPAA Privacy Rule. Compliance with the HIPAA Privacy Rule was required for most covered entities as of April 14, 2003, when the responsibility for OCR to enforce the Privacy Rule commenced. The Rule protects the privacy of individually identifiable health information maintained or transmitted by health plans, health providers, and clearinghouses. This landmark Rule provides individuals, for the first time, with Federal protection against the inappropriate use and disclosure of personal health information.

Because the Privacy Rule does not provide a private right of action, OCR is the only government entity to which aggrieved parties can turn for redress through civil monetary penalties. OCR received 15,475 complaints between the April 14, 2003 compliance date and the close of FY 2005, of which 10,622 have been resolved. OCR has also reached tens of thousands of covered entities and consumers through conferences, a tool-free call line, and an interactive website providing answers to specific questions about the Rule, which has received more than 2.75 million hits.

In FY 2007, OCR will continue to:

- Promote compliance with the Privacy Rule by complaint investigation and developing and providing outreach and guidance to covered entities and the public; and
- Analyze and provide recommendations with respect to implementation of the Privacy Rule to promote its workability and issue additional guidance, as needed, to aid in implementation and to dispel misconceptions.

Cross-Cutting Activities

The work of OCR often addresses more than one of its legal authorities. Certain population groups may face multiple barriers to services that cross-cut race, national origin, disability, and age nondiscrimination authorities, and that may also raise issues involving privacy of health information.

In FY 2007, OCR will continue to build upon its successes in working with other HHS components and Federal agencies to coordinate its cross-cutting initiatives in support of Departmental initiatives and the Secretary's 500-Day Plan. For example:

- OCR will continue to work with HHS agencies and other partners to carry out the NFI, including the Federal Mental Health Action Plan.
- OCR will continue to work with HHS agencies and other partners to support the Departmental initiative to eliminate racial and ethnic health disparities.
- OCR will continue to work within HHS on privacy issues in health information technology and with DOJ to coordinate compliance activities involving the Privacy Rule, disability rights, and access to services by LEP persons.

OFFICE OF INSPECTOR GENERAL

(dollars in millions)

	2005	2006	2007	+/- 2006
Program Level /1.....	$218	$248	$250	+$2
FTE	1,452	1,623	1,623	0

1/ The FY 2007 level assumes $160 million for Medicare and Medicaid related fraud, waste, and abuse activities, the maximum allowed under the Health Care Fraud and Abuse Control Program (HCFAC) and budget authority of $44 million. Also included in FY 2007 is $11.3 million under the discretionary caps proposal, $25 million in FY 2006 and FY 2007 for the Medicaid Integrity Program in the Reconciliation Bill, and $7 million in FY 2005 and an estimated $10 million in FY 2006 and FY 2007 for funds the OIG is authorized to receive for reimbursement of the costs of conducting audits, investigations and compliance monitoring.

Under the authority of the Inspector General Act, the Office of Inspector General (OIG) improves HHS programs and operations and protects 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 Department officials, the Administration, the Congress, and the public.

For FY 2007, the Office of Inspector General (OIG) requests a discretionary appropriation of $44 million. OIG will also receive between $150 and $160 million in FY 2007 from the Health Care Fraud and Abuse Control (HCFAC) Program for Medicare and Medicaid related fraud, waste, and abuse activities. In addition to this, the FY 2007 budget includes HCFAC discretionary funding. As part of a government-wide approach to funding program integrity activities, the budget proposes a discretionary cap increase of $119.6 million in FY 2007. OIG would receive $11.3 million in funding under this proposed initiative in FY 2007.

Over the FY 2006 - FY 2007 period, OIG will use its discretionary funding to continue its work across the non-Medicare and non-Medicaid areas of HHS, which are public health, children and families, aging, and department-wide activities. The funding level of OIG for FY 2007 allows OIG to continue its efforts in:

- Granting oversight and reviews that cover internal controls, accounting controls, performance measurements, and program evaluations, and assisting the Department to identify sources of improper payments;
- Nationwide involvement with the 10 Project Save Our Children (PSOC) Task Forces that identify, investigate, and prosecute individuals who willfully avoid the payment of their child support obligations; and
- Reviews of drug and device safety and safeguards over controlled substances.

In addition to this, OIG will continue its HCFAC activities to identify and prosecute health care fraud; prevent future fraud, waste, or abuse; protect HHS program beneficiaries; and ensure the solvency of the Medicare Trust Fund; as well as play an active role in the implementation of the MMA.

Grants Oversight

OIG plans to review Department grant programs to determine whether they are appropriately monitored and managed throughout the grant life cycle. OIG will assess mechanisms in place to ensure that proper procedures are used to award grants, fund them, account for expenditures, and verify that they are used only for authorized purposes. The work of OIG will include review of performance measures used to determine the nature and value of the product of the grants, as well as the methods used to evaluate the individual grants and grant programs as a whole. The reviews of OIG will cover internal controls, accounting controls, performance measurements, and program evaluation.

OIG anticipates conducting grant oversight activities in FY 2006 - FY 2007 that touch almost every Operating Division within HHS and include such diverse issues as patient safety, the Community Health Centers, Head Start Enrollment of Disabled Children, HIV/AIDS, and fraud awareness.

Child Support Enforcement Program

OIG will continue its coverage of all 50 States and the District of Columbia by its multi-agency task

forces (PSOC Task Forces) that identify, investigate, and prosecute individuals who willfully avoid payment of their child support obligations under the Child Support Recovery Act. These task forces bring together State and local law enforcement and prosecutors, United States Attorneys' Offices, the OIG, U.S. Marshals Service personnel, State and county child support personnel, and all other interested parties.

Drug and Device Safety and Safeguards

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

Health Care Fraud and Abuse

Through the Health Insurance Portability and Accountability Act (HIPAA), OIG receives mandatory funding for its activities that focus on fraud, waste, abuse, and efficiency improvements in the Medicare and Medicaid programs. The Act provides for minimum and maximum amounts of funding that are decided each year by the Secretary of HHS and the Attorney General. Starting in FY 2003, and each year thereafter, the maximum amount available to OIG for its HCFAC Program is capped at $160 million. In addition to this, the FY 2007 discretionary budget includes HCFAC funding as part of a government-wide approach to funding program integrity activities. OIG would receive an additional $11.3 million in FY 2007. OIG works with the Centers for Medicare & Medicaid Services (CMS), other HHS agencies, and the Department of Justice to ensure that funds due to the Medicare Trust Fund or CMS are recovered through audits and investigations, and provides recommendations for statutory, regulatory, and program changes that could strengthen program integrity.

PROGRAM SUPPORT CENTER

(dollars in millions)

	2005	2006	2007	2007 +/-2006
Expenses.....	$509	$611	$651	+$40
FTE.....	1,180	1,309	1,379	70

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

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

Administrative Operations Service

The FY 2007 estimated expenses for the Administrative Operations Service (AOS) are $151 million, an increase of $5 million above FY 2006. AOS provides a wide range of administrative and technical services within the Department, both in headquarters and in the regions, and to customers throughout the Federal Government. The major areas of service are real and personal property management, technical support and communications management, management of regional contracts for administrative support, and management of Cooperative Administrative Support Units in three cities government-wide (New York City, Kansas City, and Denver).

Federal Occupational Health Service

The FY 2007 estimated expenses for the Federal Occupational Health Service (FOHS) are $193 million, an increase of $6 million above the FY 2006 level. The increase of $6 million represents anticipated increased reimbursements from other Federal agencies. The FOHS provides occupational health services for Federal employees, including health and wellness programs, employee assistance, work/life, and environmental health and safety services. Over 1,500,000 Federal employees in 45 Federal departments and agencies are serviced by FOHS.

Financial Management Service

The FY 2007 estimated expenses for the Financial Management Service (FMS) are $86 million, an increase of $26 million above FY 2006. The increase of $26 million represents the transfer of UFMS operations and maintenance support. Beginning in FY 2007, FMS will provide operations and maintenance support for the Department's Unified Financial Management Services. Prior to FY 2006, operations and maintenance support was provided by the UFMS Project Management office. FMS supports the financial operations through the provision of fund accounting, disbursement, financial reporting, financial

statement preparation, payroll accounting, and debt management and collection services; support for Federal grantor and contracting agencies for the negotiation and approval of indirect cost, fringe benefits and other speciality rates used by not-for-profit organizations receiving Federal awards; and grant disbursement, cash management, and grant accounting support services.

Human Resources Service

The FY 2007 estimated expenses for the Human Resources Service (HRS) are $66 million, the same as FY 2006. HRS provides an extensive array of personnel systems, administration and management, training, and payroll liaison services. These include compensation and medical benefits for Commissioned Corps officers, liaison services between the new civilian payroll service provider (DFAS) and HHS employees, automated personnel and time and attendance systems support, equal employment opportunity, workforce development, and training management.

Strategic Acquisition Service

The FY 2007 estimated expenses for the Strategic Acquisition Service (SAS) are $79 million, the same as FY 2006. The SAS is responsible for providing leadership, policy, guidance, and supervision to the procurement operations of the PSC and for improving procurement operations within HHS. The SAS provides strategic sourcing services; acquisition management; and provides pharmaceutical, medical, and dental supplies to HHS and other Federal agencies. The SAS will streamline procurement operations in HHS through activities such as the reduction of duplicate contracts, the use of consolidated contracts, and implementation of new procurement practices designed to provide higher quality procurement services at reduced cost.

Human Resources Centers

The FY 2007 estimated expenses for the Human Resources Center (HRC) are $53 million, an increase of $2 million above FY 2006. The HRC represents a consolidation of human resources services within the Department, with sites located in Rockville, Baltimore, and Atlanta. The centers provide human resources strategic programs, customer service, and workforce relations support for HHS customers. The HRC serves as the principal advisor to customer organizations on matters related to strategic human capital planning, recruitment and placement, position classification and management, compensation and pay administration, executive resources, workforce planning, labor and employee relations, employee services, and employee benefits, entitlements and advisory services.

RETIREMENT PAY & MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

(dollars in millions)

	2005	2006	2007	2007 +/-2006
Retirement Payments.....	$236	$256	$267	+$11
Survivor's Benefits.....	15	16	16	0
Medical Care for Retirees and Survivors	55	57	59	+2
Accrued Medical Benefits for over-65...	32	34	36	+2
Total, Budget Authority.....	**$338**	**$363**	**$378**	**+$15**

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

The FY 2007 request of $378 million is a net increase of $15 million over the FY 2006 level. This amount reflects increased retirement payments of $11 million, increased medical care benefits costs of $2 million, and increased accrued medical benefit payments for officers and beneficiaries over age 65 of $2 million.

PARTS* COMPLETED BY OMB FOR THE FY 2007 BUDGET

(dollars in millions)

	Narrative Rating	FY 2006 Enacted	FY 2007 Requests
Health Resources and Services Administration:			
Family Planning (managed by OPHS)	Moderately Effective	$283	$283
Universal Newborn Hearing Screening	Moderately Effective	10	0
Trauma Care	Adequate	0	0
Vaccine Injury Compensation (jointly with DoJ)	Adequate	65	66
Health Care Facilities Construction	RND**	0	0
State Planning Grant Program	Ineffective	0	0
Healthy Community Access Program	Ineffective	0	0
Indian Health Service:			
Tribal-Operated Health Programs	Adequate	1,786	1,858
Centers for Disease Control and Prevention:			
Global AIDS Program (jointly with State and USAID)		123	122
PEPFAR: Focus Countries	Moderately Effective		
PEPFAR: Other Bilateral Programs	Adequate		
Global Immunizations	Effective	145	144
Environmental Health	Adequate	150	141
Health Statistics	Moderately Effective	109	109
Strategic National Stockpile	Moderately Effective	523	593
National Institute of Health:			
Intramural Research	Effective	2,956	2,946
Buildings and Facilities	Effective	89	89
Substance Abuse & Mental Health Services:			
Mental Health PRNS	RND	263	228
Protection and Advocacy for Individuals with Mental Illness	Moderately Effective	34	34
Administration for Children and Families:			
Adoption Opportunities	Adequate	27	27
Adoption Incentives	Adequate	18	30
Adoption Assistance	Moderately Effective	1,883	2,047
Refugee and Entrant Assistance (Transitional and Medical Services)	Effective	265	282
Victims of Trafficking	Moderately Effective	10	15
Mentoring Children of Prisoners	RND	50	40
Social Services Block Grant	RND	1,700	1,200
Temporary Assistance for Needy Families	Moderately Effective	17,059	17,391
Office of the Secretary:			
Office of Global Health Affairs			
Afghanistan	RND	6	6
USMBHC	RND	4	4
Office of Minority Health	RND	56	47
Office of Disease Prevention and Health Promotion	RND	7	7
Office for Civil Rights	Moderately Effective	34	36

*PART is Program Assessment Rating Tool

** Results not Demonstrated

ACRONYMS

ACF	**Administration for Children and Families**
ADA	**Americans with Disabilities Act of 1990**
ADUFA	**Animal Drug User Fee Act**
AERS	**Adverse Event Reporting System**
AFDC	**Aid to Families with Dependent Children**
AFL	**Adolescent Family Life**
AHRQ	**Agency for Healthcare Research and Quality**
AI/AN	**American Indian/Alaska Native**
ALJ	**Administrative Law Judge**
AoA	**Administration on Aging**
AOS	**Administative Operations Service**
ASFA	**Adoption and Safe Family Act of 1997**
ATSDR	**Agency for Toxic Substances and Disease Registry**
BA	**Budget Authority**
BBA	**Balanced Budget Act of 1997**
BBRA	**Balanced Budget Refinement Act of 1999**
BIPA	**Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000**
BPI	**Budget and Peformance Integration**
BSL	**Biosafety Level**
BSL-3	**Biosafety Level 3**
CARE	**Comprehensive AIDS Resources Emergency**
CCDBG	**Child Care and Development Block Grant**
CCDF	**Child Care and Development Fund**
CDC	**Centers for Disease Control and Prevention**
CERT	**Comprehensive Error Rate Testing**
CFBCI	**Center for Faith/Based and Community Initiatives**
CLIA	**Clinical Laboratory Improvement Act of 1988**
CMS	**Centers for Medicare & Medicaid Services**
CRTA	**Children's Research and Technical Assistance**
CSBG	**Community Services Block Grant**
CSE	**Child Support Enforcement**
CTSA	**Clinical and Translational Science Award**
D.C.	**District of Columbia**
DAWN	**Drug Abuse Warning Network**
DEcIDE	**Developing Evidence to Inform Decisions about Effectiveness**
DFAS	**Defense Finance and Accounting Services**
DHS	**U.S. Department of Homeland Security**
DME	**Durable Medical Equipment**
DNA	**Deoxyribonucleic Acid**
DOJ	**Department of Justice**
DOQ-IT	**Doctor's Office Quality Information Technology**
DRA	**Deficit Reduction Act of 2005**
DSH	**Disproportionate Share Hospital**
e-Gov	**Electronic government**
EHR	**Electronic Health Record**
EPC	**Evidence Based Practice Centers**

ACRONYMS

ESAR-VHP	**Emergency System for Advance Registration of Volunteer Health Care Professionals**
ESI	**Employer-Sponsored Insurance**
ESRD	**End Stage Renal Disease**
FBI	**Federal Bureau of Investigation**
FDA	**Food and Drug Administration**
FERN	**Food Emergency Response Network**
FFS	**fee-for-service**
FMAP	**Federal Medical Assistance Percentage**
FMS	**Federal Medical Shelters**
FMS	**Financial Management Service**
FOA	**Family Opportunity Act**
FOHS	**Federal Occupational Health Service**
FPL	**Federal Poverty Level**
FPLS	**Federal Parent Locator Service**
FTE	**Full Time Equivalent**
FUL	**Federal Upper Limit**
FY	**Fiscal Year**
GAO	**Government Accountability Office**
GDM	**General Departmental Management**
GME	**Graduate Medical Education**
GPRA	**Government Performance and Results Act**
GSA	**General Services Administration**
H5N1	**Hemagglutinin-5 Neuraminidase-1**
HCBS	**Home and Community Based Services**
HCFAC	**Health Care Fraud and Abuse Control**
HCIIP	**Heath Care Infrastructure Improvement Program**
HCT/P's	**Human cells, tissues, and cellular and tissue-based products**
Health IT	**Health Information Technology**
HHS	**Health and Human Services**
HI	**Hospital Insurance (Trust Fund)**
HIFA	**Health Insurance Flexibility and Accountability**
HIGLAS	**Healthcare Integrated General Ledger Accounting System**
HIPAA	**Health Insurance Portability and Accountability Act**
HIPDB	**Healthcare Integrity and Protection Data Bank**
HIV	**Human Immunodeficiency Virus**
HIV/AIDS	**Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome**
HMO	**Health Maintenance Organization**
HRC	**Human Resources Center**
HRS	**Human Resources Service**
HRSA	**Health Resources and Services Administration**
HSA	**Health Savings Accounts**
IDA	**Individual Development Accounts**
IHS	**Indian Health Service**
ILP	**Indpendent Living Program**
IOM	**Intitute of Medicine**
IT	**Information Technology**

ACRONYMS

LEP	**Limited English Proficiency**
LIHEAP	**Low Income Home Energy Assistance Program**
MA	**Medicare Advantage**
MAC	**Medicare Administrative Contractor**
MB	**Market Basket**
MCH	**Maternal and Child Health**
MDUFMA	**Medical Device User Fee and Modernization Act**
MEDICS	**Medicare Drug Integrity Contractor**
MedPAC	**Medicare Payment Advisory Commission**
MEPS	**Medical Expenditure Panel Surveys**
MFP	**Money Follows the Person**
MIP	**Medicare Integrity Program**
MMA	**Medicare Modernization Act of 2003**
MQSA	**Mammography Quality Standards Act**
MRC	**Medical Reserves Corps**
MSA	**Metropolitan Statistical Area**
MSIS	**Medicaid Statistical Information Statistics**
NASA	**National Aeronautics and Space Administration**
NCI	**National Cancer Institute**
NCRR	**National Center for Research Resources**
NFI	**New Freedom Initiative**
NHIN	**National Health Information Network**
NHSC	**National Health Service Corps**
NIAID	**National Institute of Allergy and Infectious Diseases**
NIDDK	**National Institute of Diabetes & Digestive & Kidney Diseases**
NIEHS	**National Institute of Environmental Health Sciences**
NIH	**National Institutes of Health**
NIOSH	**National Institute of Occupational Safety and Health**
NLM	**National Library of Medicine**
NMEP	**National Medicare & Youth Education Program**
NSDUH	**National Survey on Drug Use and Health**
OAA	**Older Americans Act**
OASDI	**Old age, survivors, and disability insurance**
OB/GYN	**Obstetrics/Gynecology**
OCR	**Office for Civil Rights**
OD	**Office on Disability**
OGC	**Office of the General Counsel**
OGHA	**Office of Global Health Affairs**
OIG	**Office of Inspector General**
OMB	**Office of Management and Budget**
OMH	**Office of Minority Health**
OMHA	**Office of Medicare Hearings and Appeals**
ONC	**Office of the National Coordinator for Health Information Technology**
OPA	**Office of Population Affairs**
OPA/AFL	**Office of Population Affairs / Adolescent Family Life**
OPASI	**Office of Portfolio Analysis and Strategic Initiatives**

ACRONYMS

OPDIV	**Operating Division**
OPHEP	**Office of Public Health Emergency Preparedness**
OPHS	**Office of Public Health & Science**
OS	**Office of the Secretary**
OWH	**Office on Women's Health**
P.L.	**Public Law**
P4P	**Pay for Performance**
PACE	**Programs of All-Inclusive Care for the Elderly**
PARIS	**Public Assistance Reporting Information System**
PART	**Program Assessment Rating Tool**
PATH	**Projects for Assistance in Transition from Homelessness**
PDUFA	**Prescription Drug User Fee Act**
PEPFAR	**President's Emergency Plan for AIDS Relief**
PHS	**Public Health Service**
PHSSEF	**Public Health and Social Service Emergency Fund**
PIA	**Program Impact Assessment**
PMA	**President's Management Agenda**
PNC	**Prior Notice Center**
PPO	**Preferred Provider Organization**
PRWORA	**Personal Responsibility and Work Opportunity Act of 1996**
PSC	**Program Support Center**
PSIC	**Patient Safety Improvement Corps**
PSO	**Patient Safety Organizations**
PSOC	**Project Save Our Children**
PSSF	**Promoting Safe and Stable Families**
QI	**Qualified Individual**
QIC	**Qualified Independent Contractor**
QIO	**Quality Improvement Organization**
RND	**Results not Demonstrated**
RPGs	**Research Project Grants**
RPMS	**Resource and Patient Management Systems**
SACWIS	**Statewide Automated Child Welfare Information Systems**
SAMHSA	**Substance Abuse and Mental Health Services Administration**
SARS	**Severe Acute Respiratory Syndrome**
SAS	**Strategic Acquisition Service**
SCHIP	**State Children's Health Insurance Program**
SHIP	**State Health Insurance Assistance Program**
SMI	**Supplemental Medical Insurance**
SNS	**Strategic National Stockpile**
SOW	**Scope of Work**
SOW	**Statement of Work**
SPAP	**State Pharmaceutical Assistance Program**
SSA	**Social Security Administration/Social Security Act**
SSBG	**Social Services Block Grant**
SSI	**Supplemental Security Income**
STAFFDIVs	**Staff Divisions**

ACRONYMS

STD	**Sexually Transmitted Disease**
T.A.	**Technical Assistance**
TANF	**Temporary Assistance for Needy Families**
TB	**Tuberculosis**
TEDS	**Treatment Episode Data Set**
TERRA	**TANF Emergency Response and Recovery Act of 2005**
TMA	**Transitional Medical Assistance**
TWWIIA	**Ticket to Work and Work Incentives Improvement Act**
UAC	**Unaccompanied Alien Children**
UFMS	**Unified Financial Management Services**
USAID	**United States Agency for International Development**
USDA	**U.S. Department of Agriculture**
USMBHS	**United States-Mexico Border Health Commission**
USPSTF	**U.S. Preventive Services Task Force**
VFC	**Vaccines for Children program**